Agenda

Trust Board Meeting in Public - Appendices

Tuesday, 10 September 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			Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 24 July 2024	Chair		12:35	Approve
2.2	Action Log				Note
3.	**Opening Matters**				
3.1	Chief Executive Update	Chief Executive		12:40	Note
3.2	Council of Governors Report (May 2024)	Lead Governor		12:45	Assurance
3.3	Governance Review - Board Designations	Company Secretary		12:50	Approve
4.	**Performance, Risk and Assurance**				
4.1	Trust Risk Register *	Chief Nursing Officer	3	13:00	Assurance
4.2	Board Assurance Framework *		43	13:05	Assurance
4.3	Integrated Quality Performance Report *	Chief Delivery Officer	81	13:10	Assurance
5.	**Board Story Presentation**				
5.1	Physician Associates at Medway Maritime Hospital	Prof. Hasib Ahmed		13:20	Present
6.	**Board Assurance Reports**				
6.1	Quality Assurance Committee (Aug 2024)	Chief Medical Officer, Chief Nursing Officer, Committee Chair		13:30	Assurance
6.2	People Committee (July 2024)	Chief People Officer, Committee Chair		13:35	Assurance
6.3	Finance, Planning and Performance Committee (July and Aug 2024)	Chief Finance Officer, Committee Chair		13:40	Assurance

7. Papers					
~ WELLBEING BREAK - 10 minutes ~					
7.1	Finance Report (Month 4) *	Chief Financial Officer	133	14:00	Note
7.2	Financial Recovery Plan Report * • Feedback from NHSE • Breakeven recovery plan		142	14:15	Note
7.3	Maternity CNST Compliance Assurance Report *	Director of Midwifery	152	14:30	Assurance
7.4	Perinatal Quality Surveillance Report *		175		Assurance
7.5	Perinatal Cultural Leadership Report *		209		Assurance
7.6	Maternity Claims, Incidents, Complaints Triangulation Report *		213		Assurance
7.7	Infected Blood Inquiry Report *	Chief Medical Officer	226	14:50	Assurance
7.8	Annual Reports: a) Safeguarding * b) IPC * c) Medical Appraisal and Revalidation *	Chief Nursing Officer Chief Nursing Officer Chief Medical Officer	251 299 339	14:55	Note
7.9	Patient First Achievements *	Chief Delivery Officer	363	15:05	Assurance
7.10	Q1 Learning from Deaths *	Chief Medical Officer		15:10	
8. Closing Matters					
8.1	Questions from the Council of Governors and Public	Chair	Verbal	15:15	Note
8.2	Escalations to the Council of Governors				
8.3	Any Other Business				
8.4	Reflections				
8.5	Date and time of next meeting: Wednesday, 13 November 2024				

Key – Patient First Domains *** Appendices available in separate meeting paper pack.**

Quality
Patients
People
Sustainability
System and Partnership

Trust Risk Register Report

Louise Furlong; Head of Quality & Safety

September 2024

Executive Summary

NHS Medway NHS Foundation Trust

	Assurance
Risk Management	

The Trust Risk Register has 221 approved risks in total
25 risks are scoring 15 and above.

17 new risks added
22 risks are awaiting review, and
16 risks awaiting approval.

54 risks have been closed down
18 risks have had the score reduced since their last review,
2 risks have had the score increased since their last review, and
8 risks have been rejected.

All Executive Members have been invited to review each of their risk profiles on a monthly basis.

Full Assurance	Partial Assurance	Limited Assurance

SIOR - Risk Management

NHS Medway NHS Foundation Trust

Successful Deliverables

- 54 risks have been closed in August
- 83% of risks were reviewed within their required timeframe in August (Down from 89% in July)
- 88% of risks scoring 15+ have been reviewed within the required timeframe in August (Up from 67% in July)
- Risks are now a standing agenda item for all groups and committees
- 47% of risks now have actions assigned to address the gaps in controls (Up from 43% in July))

Risks Closed in August

Risk ID: 1053
Risk Title: Risk of inability to provide adequate plain film service due to ageing equipment and increased downtime.
Rationale for closure: Amalgamated with 2125(overall risks in imaging of aging/aged equipment)

Risk ID: 1116
Risk Title: Failure of the Trust POD system for transporting blood samples to Pathology – Extremely old and needs upgrade
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158)

Risk ID: 1247
Risk Title: Increased downtime of equipment and increased time to source parts due to the age of plain film equipment.
Rationale for closure: Amalgamated with 2125(overall risks in imaging of aging/aged equipment)

Risk ID: 1336
Risk Title: There are trees within the estate that could cause human harm or damage to property if they fall.
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1363
Risk Title: End of Life and support of Philips FD20
Rationale for closure: Amalgamated with 2125(overall risks in imaging of aging/aged equipment)

Risk ID: 1378
Risk Title: Lift availability
Rationale for closure: Risk agreed for closure by E&F Senior Management Team. Lifts 14 and 15 are now in operation. There is now complete cover should both lifts 8 and 10 be taken out of action. This risk can now be closed as there is sufficient spare capacity should lifts 8 or 10 fail, and also sufficient capacity during the refurbishment of lifts 8 or 10.

Risk ID: 1381
Risk Title: Drain blockages caused by clinical wipes and tree root ingress into drains
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety Ref 2158

Risk ID: 1384
Risk Title: Management of Contractors and Sub Contractors
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1387
Risk Title: Emergency Lighting system - non compliance
Rationale for closure: Risk closed and linked to HTM 05-01 Managing Healthcare Fire Safety Ref 2166

Risk ID: 1389
Risk Title: RADON - Underground Access Tunnel
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risks Closed in August

Risk ID: 1450
Risk Title: General condition and security of the laundry building impacting staff safety and welfare
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1454
Risk Title: Potential loss of heating and hot water to Rowan and Willow House
Rationale for closure: Duplication of 1836. Risk agreed for closure by E&F Senior Management Team

Risk ID: 1460
Risk Title: Band 5 & Junior Midwives allocated to work within the community midwifery setting
Rationale for closure: No B5 are now in community and not envisaged to be required moving forward - no longer a risk

Risk ID: 1484
Risk Title: DSPS Air Handling Unit and Chilling Plant
Rationale for closure: Risk closed and linked to HTM03-01 Specialised Ventilation for Healthcare Premises

Risk ID: 1485
Risk Title: 2000 Development Air Handling Units - End of Useful Life
Rationale for closure: Risk closed and linked to HTM03-01 Specialised Ventilation for Healthcare Premises

Risk ID: 1487
Risk Title: D Block - Undercroft service level between Levels 2 and 3
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1491
Risk Title: Theatre lights non-repairable beyond end of 2023.
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1495
Risk Title: D Block Heating Pumps
Rationale for closure: Risk agreed for closure by E&F Senior Management Team as repairs and replacements have been carried out.

Risk ID: 1500
Risk Title: Retiring Extramed, loss of key handover information and ability to contact trace infections via electronic handover
Rationale for closure: Agreed at IPCPG - Agreed at IPCPG that due to the potential solutions for contact tracing that this risk can be closed.

Risk ID: 1501
Risk Title: Air handling unit (ventilation) is 22 years old and has reached the end of it's useful life - Not compliant with HTM 03-01: 2021
Rationale for closure: Risk closed and linked to HTM03-01 Specialised Ventilation for Healthcare Premises

Risk ID: 1509
Risk Title: New Side Theatres BMS Controls
Rationale for closure: Risk closed and linked to HTM03-01 Specialised Ventilation for Healthcare Premises

Risk ID: 1518
Risk Title: Lack of risk assessments relating to all estates activities
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action

Risks Closed in August

Risk ID: 1520
Risk Title: Risk of harm to users of the site as a result of traffic control measures
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1521
Risk Title: Boundary Wall - Unsure of condition
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1522
Risk Title: Asbestos Register - Areas of non-compliance and control
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action (Ref 2135).

Risk ID: 1523
Risk Title: No PPM (Planned Preventative Maintenance) system or process in place for Estates.
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1530
Risk Title: Drainage/Manholes – Internal and external. Lack of understanding of drainage surface/subsurface systems and manhole status.
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1531
Risk Title: Flooring – the flooring across the trust has been left in many areas.
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1546
Risk Title: CCU - Air Handling Units in ceiling void
Rationale for closure: Risk closed and linked to HTM03-01 Specialised Ventilation for Healthcare Premises

Risk ID: 1547
Risk Title: Theatres 5, 6 & 7 - Chiller
Rationale for closure: Risk Closed and linked to HTM03-01 Specialised Ventilation for Healthcare Premises (Ref 2094).

Risk ID: 1548
Risk Title: Potential failure of theatre 8 absorption chiller
Rationale for closure: Risk agreed for closure by E&R Senior Management Team.
A recent repair has replaced two out of four fans. The system is operational. The chiller is scheduled to be replaced as part of the decarbonisation project, so only has a remaining life of c. 18 months.
Risk is currently mitigated by the repair, funding identified for the replacement and a programme of works is in the pipeline.

Risk ID: 1549
Risk Title: Non-Compliance with Regulation 10 of The Workplace (Health, Safety and Welfare) Regulations 1992
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1581
Risk Title: Risk of cross transmission to staff as decontamination of equipment process not being followed
Rationale for closure: Risk discussed and agreed/approved for closure at Estates and Facilities Senior Team Risk Review Group as per agreement with IPC.

Risks Closed in August

Risk ID: 1591
Risk Title: Breach of COSHH Regulations in Delivery Suite as a result of Nitrous Oxide Workplace Exposure Limit (WEL) being breached.
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action Ref 2135

Risk ID: 1593
Risk Title: Keats Ward Temperature Control
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action (ref 2135).

Risk ID: 1602
Risk Title: Closed Protocol Nurse Call System becoming Obsolete
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1630
Risk Title: Theatres 9 and 10 UCV Canopy Inverters
Rationale for closure: Risk agreed for closure (inverters replaced and verification complete).

Risk ID: 1656
Risk Title: Fire Safety
Rationale for closure: Risk closed and linked to HTM 05-01 Managing Healthcare Fire Safety

Risk ID: 1668
Risk Title: Excessive heat gains site-wide in periods of warm weather impacting patient safety and staff welfare
Rationale for closure: Risk closed and linked to Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action (ref 2135).

Risk ID: 1678
Risk Title: Risk of legionella/pseudomonas as a result of thermostatic mixer valve use across the Trust
Rationale for closure: Risk closed and linked to HTM04-01 Safet Water in Healthcare Premises

Risk ID: 1699
Risk Title: Failure to Provide Agreed Level of Imaging Cover To Theatres Due to Poor Quality Imaging Equipment
Rationale for closure: Amalgamated with 2125(overall risks in imaging of aging/aged equipment). LB closed as requested by CMO.

Risk ID: 1708
Risk Title: Failure to learn from incidents, complaints, inquests, claims and deaths
Rationale for closure: Close risk as all gaps now mitigated i.e. there is no backlog of serious incidents, incident learning is live and current, CLIPS report is embedded and shared widely, PSIRF has been rolled out across the trust,
improved communications for sharing learning and more robust process in place to oversee actions and improvements from incidents

Risk ID: 1741
Risk Title: Risk of harm to maternity staff whilst lone working
Rationale for closure: Lone worker devices are now supplied to all CMWS

Risk ID: 1785
Risk Title: Potential failure of obsolete Distribution Boards
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risks Closed in August

Risk ID: 1813
Risk Title: Non-Compliance against National Standards of Healthcare Cleanliness (NSOC) for Pest Control
Rationale for closure: Risk discussed and agreed/approved for closure at Estates and Facilities Senior Team Risk Review Group as per agreement with Decontamination Group.

Risk ID: 1817
Risk Title: Contract cleaners operating unsupervised in health records building may lead to breaches in GDPR
Rationale for closure: Risk discussed and agreed/approved for closure at Estates and Facilities Senior Team Risk Review Group as contract cleaners are no longer attending the off site building

Risk ID: 1828
Risk Title: Current enteral feed contract is due to expire and being reviewed for re-tender jointly with MCH.
Rationale for closure: Risk agreed at DGB for closure as the contract has been extended for 2years.

Risk ID: 1836
Risk Title: Insufficient boiler capacity in Rowan and Willow House accommodation blocks in order to heat residential rooms
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1837
Risk Title: Roof leaks impacting on service delivery
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 1868
Risk Title: Loss of the Dental Imaging Machine
Rationale for closure: Amalgamated with 2125(overall risks in imaging of aging/aged equipment). LB closed as requested by CMO.

Risk ID: 2005
Risk Title: Various environmental issues affecting Nelson ward which may impact patient safety
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety (ref 2158).

Risk ID: 2080
Risk Title: Call bell/emergency buzzer in assessment unit not audible across ward
Rationale for closure: Call bell now installed so alarm can be heard in corridor by Doctors Office

Risk ID: 2119
Risk Title: Dilapidated cupboards and countertops in CEPOD Theatre impacting IPC and patient safety
Rationale for closure: Risk closed and linked to Backlog Maintenance impacting on the infrastructure and clinical safety.

Risk ID: 2141
Risk Title: BloodTrack upgrade, revalidation and maintenance overdue
Rationale for closure: Update from DGB 20/08/24 - Reviewed by the Directors and discussed at DGMB - it was decided that as all plans to mitigate issues are in place, the risk can be closed.

Risks Rejected in August

8 Risks were rejected in August

The number of rejected risks broken down by category are as below**:**

Risk Already Resolved - 1

Incorrect Form Completed – 5

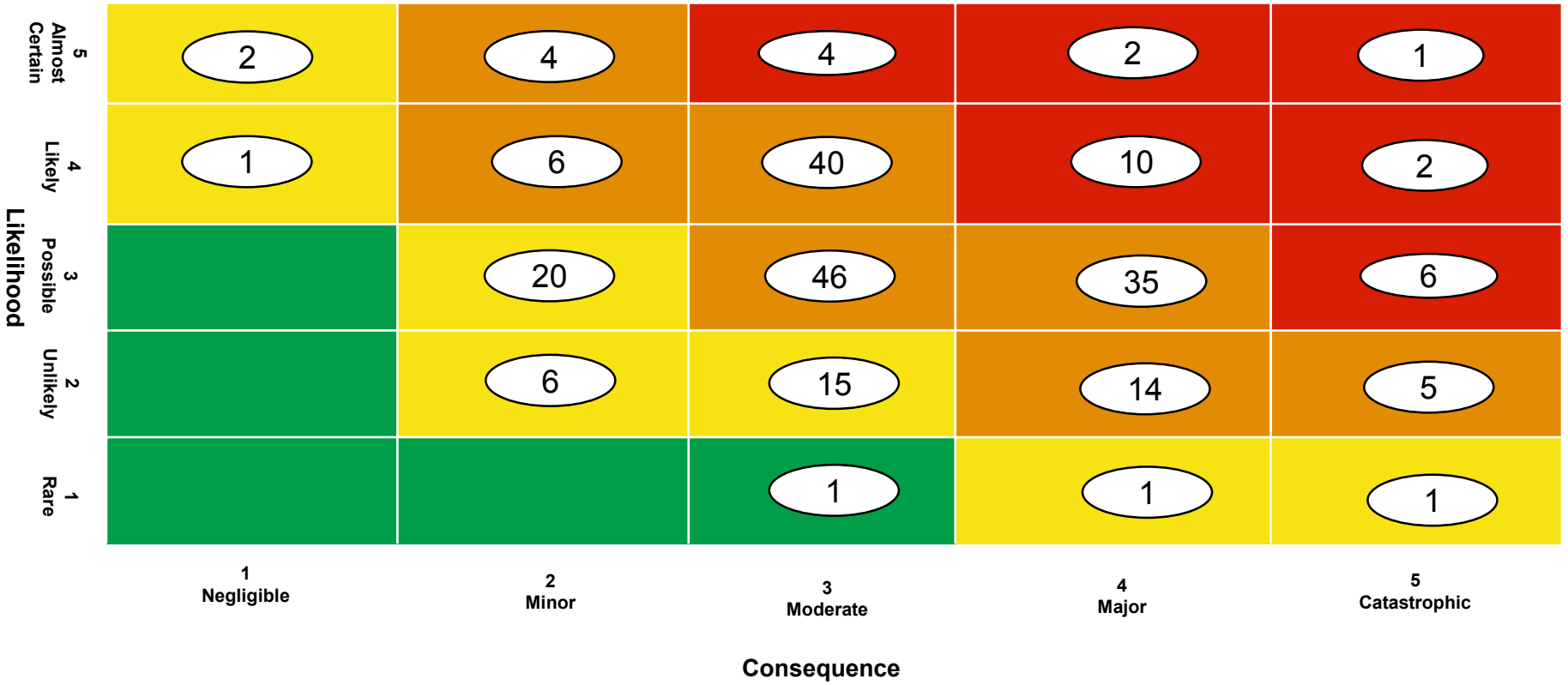
Duplication – 2

No Reason Given - 0

All risk originators were contacted to advise of the reasons for rejection, and where applicable asked for incidents to be raised instead.

Trust Risk Register – Heat Map

The heat map summaries the total number of risks assigned to each score.



Risks scoring 25

2060 - Capital allocation vs requirements

Risks scoring 20

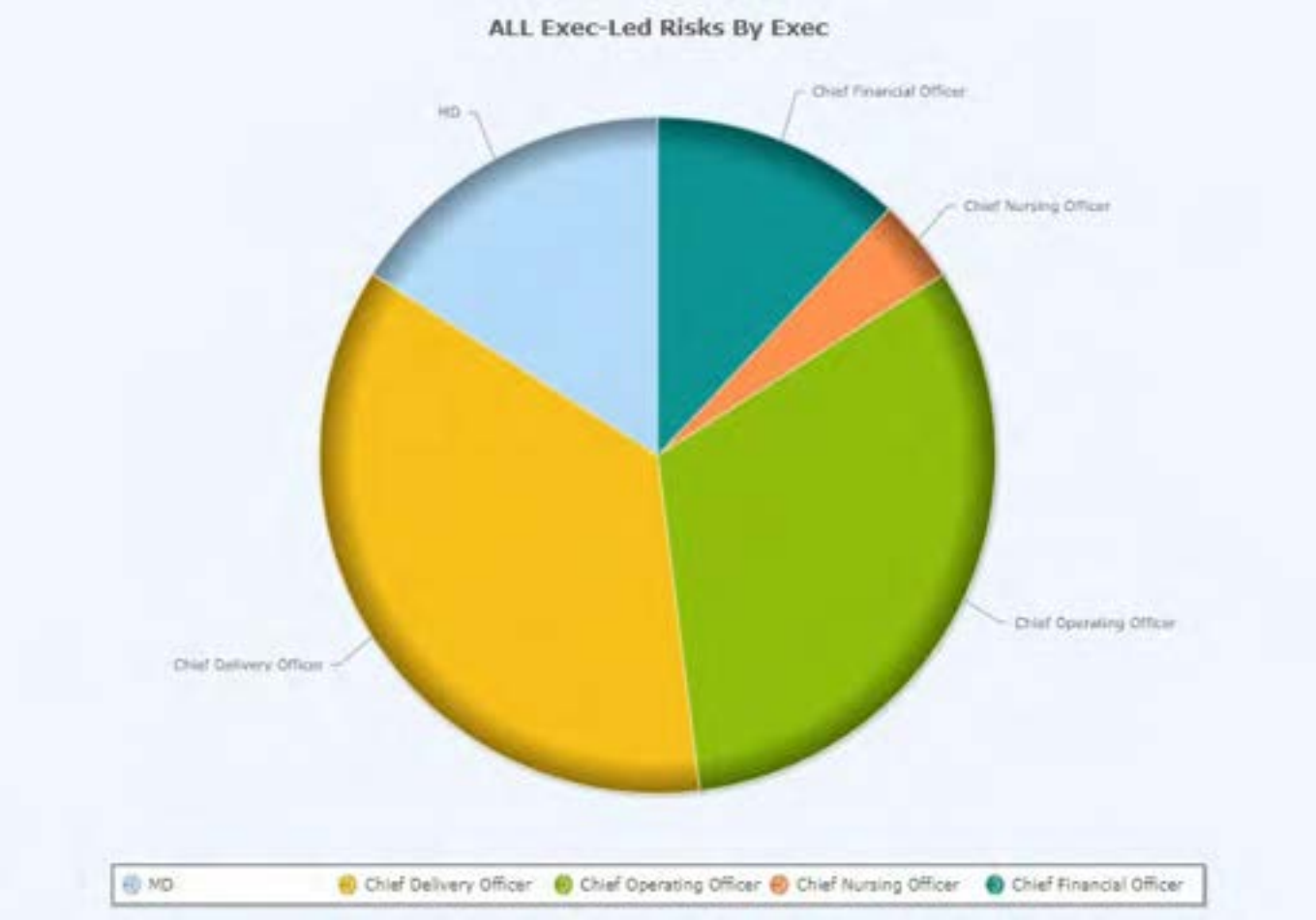
2083 - The Trust is not actively 'culling or destroying' Medical Records which is a breach of the Records Management Code of Practice

2052 - If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk.

1711 - Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of leavers information.

1133 - Insufficient Midwifery Staffing impacting the ability to provide patient care.

‘Extreme’ Risks by Executive



25 Risks scoring 15+

CDO – 9 (36%)

CFO – 3 (12%)

CMO – 4 (16%)

CNO – 1 (4%)

COO – 8 (32%)

CPO – 0 (0%)

CEO – 0 (0%)

NHS
Medway
NHS Foundation Trust

CDO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1025	07/04/22	31/03/25	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	A number of issues have been identified with Euroking maternity system, inclusive of: - Back-copying of answers and - Duplication of records caused by failed data migration (Sep 2020) These issues have resulted in no assurance of reporting output and may result in issues relating to patient safety, data quality, statistical analysis, CNST and clinical information. The impact may be financial implication by way of the ICO or harm to patients as a result of incorrect patient information being available.	- Manual data adjustments made to ensure MSDS is uploaded and local data reported. - Local data reconciliation being done to expose gaps occurring together with close working relationships between BI and Maternity. - Manual review and individual case file analysis underway - Gone into capital planning for 24/25. Sited on risk through digital data and technology group.	MNSCAB CGMB DMB IGG RCASC Euroking to be standing agenda item at IGG meetings as agreed with DPO from October 2023 onwards until issue resolved	- System supplier not acting on need. - Lack of funding to procure new system. - No reconciliation between System, System Reporting solution & automated Data Output. - EuroKing supplier will not provide mapping for fields. -National risk identified by Another EuroKing Trust -Some legal records are overwritten or completed when none was there. - Uncertainty of where liability arises should euroking be cause or causative factor of any incident/harm etc. - Depending on the provisions of the Trust's contract with Magentus Software (the company that supplies this system), liability for the technical issues might sit with them, However, the Trust in any event would be liable for the issues caused through the actions of the Trust employees using the system - e.g. copy-pasting, failing to check that the correct patient's record has been accessed.		9	15 (5x3)	3 (1x3)	—	Trude McLaren

NHS Medway NHS Foundation Trust

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1408	30/08/2022	31/08/2024	Emergency Bleep/Pager system reliability	Emergency pager/Bleep system is unreliable and has failed on multiple occasions in the 6months leading up to risk being raised. Emergency requests for critical clinical staff support teams has to reverted to the use of radios. The implementation of this plan is a manual distribution task.	Radio's used as back up option to replace the bleeps in the event of failure. Funding secured for Everbridge system, to go live Summer 24. Testing undertaken by existing supplier. Tightening up of process for twice daily test calls.	Pager system maintenance contractor to assess system and complete health check and carry out required replacement of components to improve reliability.	No sufficient number of radios to circulate in event of bleep failure. Existing telecomms contract expires in approx. 18months, wider review of system to take place in anticipation of this.		4	15 (5x3)	5 (1x5)	—	Adrian Billington
2052	26/04/2024	31/03/2025	If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk.	The efficiencies target for 2024/25 is £21.6m / 5% of income. The Trust has not identified the full value of efficiencies at the start of the financial year. If the trust does not deliver its efficiency programme then the financial performance against control total could be at risk. (NB - there is a statutory duty to breakeven.) Linked to BAF risk 5b	• Scrutiny and challenges at the Efficiencies Delivery Group. • Fortnightly check and challenge sessions with divisions. • Financial Improvement Director and PMO in place. • Supported by / participants of the system productivity and efficiency group.	• Reporting to Efficiency Delivery Group and the Finance, Performance and Planning Committee (identified vs target, delivered vs budget [in-month and YTD]). • External audit value for money procedures. • Internal audit procedures on a cyclical basis. • SOF reporting / meetings with NHSE, including leveraging knowledge and best practice from Intensive Support Team. • Model Health System and other benchmarking.	• Financial culture and awareness. • Capacity and use of benchmarking. • Efficiencies identified at start of financial year equate to circa £12m, however the risk assessed position of each of these schemes equates to only £4m		9	20 (4x5)	10 (2x10)	▼	Linda Longley

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1645	04/09/2023	31/08/2024	Unsupported Server Operating Systems	The Trust is running outdated and unsupported operating systems on a number of servers that host clinical and administrative systems.. The Trust had up until January 2023 purchased extended support arrangements (ESU) from Microsoft, however the extended support period is no longer offered for further renewal. This means that Microsoft is no longer providing security updates or technical support for this operating system, which leaves the organization's servers vulnerable to security threats and software vulnerabilities. There is a small number of Servers running Server 2003. Due to the age of these servers and the lack of an active support arrangement. These servers are at increased risk of a cyber attack due to their increased vulnerability	- The Trust has invested in licensing and data centre hardware to enable the mitigation of these risks. - The ITPMO is actively running a project to review server operating systems and work associated with this mitigation. - Implement Security Measures such as firewall restrictions, intrusion detection and prevention systems, and utilise existing antivirus software to reduce the risk of a security breach. - Regular Vulnerability Scanning to identify any security vulnerabilities and to take appropriate remedial action. - Limit Access to these servers to limited authorized personnel only. -Capital Allocation 23/24, project: 21/22-159 Cyber Security - Server supporting clinical systems have been prioritised and upgraded. - Aiming to have all upgrades complete within year.	The ITPMO will document the associated remediation plan and provide a schedule of works. Highlight reports and compliance to this plan will be provided at Project and Digital Board. Although this has not been requested yet. The Trust may need to report on this progress to NHSE in a similar way to how PC/Laptop OS migrations were reported.	Until the remediation works are completed, the Trust is at increased risk of: Cyber Security Risks: Since the operating system is no longer receiving security updates, any new security vulnerabilities discovered by hackers or cybercriminals will not be patched by Microsoft, leaving the organization's servers at risk of cyber attacks. Compliance Issues: The organization is in breach of compliance requirements of the DSPT and Cyber Essentials until at least 90% f servers are on supported operating systems. Business Disruption: Any security breaches or vulnerabilities discovered could result in business disruption and potential loss of data.		9	16 (4x4)	4 (2x2)	–	Craig Allen

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1864	20/11/2023	28/11/2025	Maternity Information System coming to end of contract; need alternative system	Euroking contract end date is 03 December 2025. Need to begin exploring options for alternative system as Euroking does not meet service needs.	Discussions with LMNS and Trust IT Directors re sourcing alternative system. Scoping to be reviewed.	Labour ward forum Care Group Governance Board Divisional Board MNSCAB			9	15 (3x5)	4 (2x2)	–	Sam Chapman
2083	20/05/2024		The Trust is not actively 'culling or destroying' Medical Records which is a breach of the Records Management Code of Practice	Due to the lack of resources available, the Trust is not currently culling or destroying patient records in line with the Public Records Act and retention schedules as set out in the Records Management Code of Practice. The impact is that organisations may be asked for evidence to demonstrate that they operate a satisfactory records management regime. There is a range of sanctions if satisfactory arrangements are not in place i.e. regulatory intervention leading to conditions being imposed upon the organisation, or monetary penalty issued by the ICO.	- Culling and destruction is not being undertaken due to limited resources within the department.	- Information Governance Group.	- To pull files back from off site external providers has a cost implication - business case. - Tighter process to be implemented around files being destroyed i.e. cannot be destroyed via 'red confidential bins'.		9	20 (5x4)	8 (2x4)	–	Jo Lambert

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1880	21/12/23		Lack of digital clinical safety officers and digital clinical risk expertise to support Digital and EPR deployments	There is only 1 nominated Clinical Safety Officer for the trust. There are a number of high priority digital and EPR deployments which require risk review and over sight by a clinical safety office for each project. The impact is that DCB0160 are being submitted without sufficient evidence, risk analysis or time resource to review and support a safe an secure healthcare system deployment, upgrade or decommission. Resulting in delays in system deployment or unsafe deployments activities which may result in unknow harm to patients without full risk review and analysis of the impact of digital clinical change. Lack of standardise operating procedures and governance in place to over see the range of deployments.	1 Clinical Safety Officer 2 P.A. a week, CNIO, CCIO and EPMA Pharmacist are clinical safety officer trained with role experience. Digital midwife trained as CSO with limited experience supports hazard log reviews with the CSO team. Quality Manager non clinical, supports the CSO activity and the hazard log reviews	Clinical Safety Officer EPR meetings held 2 weekly, Clinical Safety Group meetings to review live and PMO risk DCB0160 activity. EPR workstream meeting. Clinical safety reviews are part of the project management activity. Team now using the NHSE digital clinical safety templates and associated documentation.	Lack of resource to complete the number of clinical safety case reports and associated governance activity required to meet the NHS digital clinical safety standards. Increase in number of clinical safety activity timeline against financial and clinical safety priorities. Clinical safety activity is very resource hungry, with competing deadlines for resource. The process is not stream lined with differing processes for PMO and EPR. CCIO and CSO The follow up activity required by the CSO post system deployment, upgrade, decommissioning is carried out by CNIO/ CCIO or Project managers which may not always be appropriate when transferring clinical risk to operational owners. ,	1. Authority to process SOP 2. Agree asset owner and system specific security policy 3. CSO report requirements for programme milestones	4	16 (4x4)	4 (1x4)	–	Kerry O'Reilly

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2068	31/05/2024		Limitations of EPR/EPMA System Functionality potentially impacting Patient Safety	Limitations of the EPR and EPMA systems impacting patient safety, quality of care, patient experience and staff efficiencies.	- IT resource audit carried out. - ART audit monitoring. - Corporate Project raised for deteriorating patients. - ED Staff trained how to discharge the patient from ED to the inpatient ward. - Dr and Pharmacy Staff have been trained to identify and correct issue/re-prescribe. - Pharmacy check daily medication errors - ED staff are checking on duplications of patient allocations. -- POCT Database correctly records results - EPMA Incorrect scheduling of as required frequency - report available for late administration. - Prescribers are trained to know that the EPMA/EPR clinical decision support tool will only alert for interactions between medications and allergies/intolerances. - For certain medications such as paracetamol the maximum dose limit within 24 hours is stated in the medications administration information which displays at the point of prescribing, - Working with the vendor to update the system to support	- Digital Data and Technology Group - EPR Clinical Implementation Group is a route for staff to raise problems if they are encountering difficulties. - EPMA Huddle - IT Service Desk Reporting - Incident reporting. - Pharmacy Governance Group for EPMA related incidents. - There is constant training review. Weekly meetings in place to receive updates from the vendor on updating the EPMA software to support dose range limits.	- Delayed Recording of Observations on EPR. - Sunrise NEWS. - DTA link from Sunrise EPR to PAS not set correctly to allow the 'admit via' pop up to display - The Emergency Department EPR allows users to admit more than one patient at a time into a bed location - POCT Blood Gas results not recorded electronically on EPR. - POCT Incorrect capillary blood glucose ranges on EPR therefore, results being entered manually - EPMA Incorrect scheduling of 'as required' frequency. - EPMA Lack of dose range limits when prescribing. - EPMA Order reconciliation manager does not transfer between ED to inpatient. - Patients admitted to ED corridors will be discharged without an inpatient discharge summary - ED require discharge tracking board view on Sunsirse EPR to manage	1. Solution for EPR bed allocation 2. Review lack of dose range limits when prescribing on EPMA	4	16 (4x4)	4 (1x4)	—	Kerry O'Reilly

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2127	05/08/2024		3rd Party Cyber Security	The Trust operates its own internal data centres and servers for the majority of its IT systems. However, the Trust also has hosting and/or managed service arrangements with some suppliers. These providers are potential targets for cyber-attacks and/or cyber crime. As seen with the Synnovis cyber attack impacting London Hospitals following a successful ransomware attack 03/06/2024.	Cyber Security assurances are requested of hosted service/data providers at the point of procurement currently.	The level of assurance currently requested satisfies DSPT requirements. however recent events such as the international outages caused by Crowd Strike have shown the limitations of existing data and assurance.	Cyber assurances from suppliers are gained at point of procurement but there is not an established process to repeat these assurances currently. There is also limited information held on hosting solutions and supporting software such as AV used by managed service providers.		9	15 (3x5)	4 (2x2)	–	Craig Allen

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CFO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1861	17/11/2023		Trust Cash Flow	Due to an ongoing deficit whereby costs exceed income, The Trust is operating with a cash shortfall. If the I&E forecast deficit run rate aligns with the cash run rate then and there is no movement in working balances the deficit support cash offered by NHSE up to £27.8m for 2024/25 should balance the cash position at year end without the need to employ any other mitigation. However if the profile of I and E is different, then mitigations may be required in year/in month to balance daily cash. This does not currently look to be the case and there are disputes from the prior year within creditors which we are planned to be settled in year. These factors indicate a material cash shortfall for the year. The impact of a cash shortfall could be as severe as not being able to pay staff and suppliers if strategies are not in place to manage and mitigate this.	- £1.4m minimum cash balance is to be held at all times as set by NHSE. This equates to approx 2 weeks of weekly payroll or supplier payments. - Monthly cash flow forecasting - controlled payment runs enabling a risk assessed strategy and slipping of creditors in line - Enforcement of SFIs which require approval for varying of terms in new contracts that require prepayments, advances or payment terms beyond standard 30 days - apply for deficit support PDC cash from NHS up to the maximum value of our forecast deficit - apply for additional working capital PDC cash to settle prior year creditor balances relating to disputes ie NKPS, NHS Property Services - Enhance debt management procedures - bi- weekly treasury meetings with Financial Services, Financial Management, Contracts and Procurement in attendance, - review of existing debtor and supplier payments profile terms - reconciling and monitoring I&E v cash run rates to identify risks and further actions/controls	- daily cash flash reports for the week ahead to CFO - monthly reports and review to FPPC & Trust Board	- Trust I&E forecast run rate does not currently reconcile to cash run rate excluding efficiencies - estimated risk £16m - Trust I&E forecast includeds £22m efficiencies a material % of which is either unidentified or non cash releasing.estimated risk £16m - All cash support from NHSE is offered as PDC which will increase I&E PDC dividends by the annual charge of 3.5%.		9	16 (4x4)	8 (2x4)	—	Isla Fraser

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2058	25/04/2024	31/03/2025	Unchecked staff growth	The Trust has seen growth in worked WTEs in the 12 months to March 2024 of c9%. Continued growth without funding/additional income through tariff - particularly where this is unplanned or without appropriate oversight and scrutiny - will push the Trust into larger deficits.	- Vacancy control panel - Investment governance process - Month end budget holder review - Safer staffing reviews - Business planning triangulation, incl. headroom in budgets - Rostering controls - Weekly check/challenge	- FPPC monthly reporting - NHSE productivity metrics data	- Timely scrutiny of temp staffing requests - Habitual use of temp staffing / understanding of coverage already provided in budgets		9	15 (3X5)	5 (1X5)	—	Dominika Kimber
2060	25/04/2024	31/03/2025	Capital allocation vs requirements	The Trust receives a capital allocation/limit from the ICS, which in turn receives its limit from NHSE. Our actual allocation is only approximately two thirds of this value at a little under £13m. (Any third party funding/PDC that can be secured allows us to spend over and above that sum.) Given the estates survey in early 2024, together with the 5-year capital programme request list and 2024/25 capital commitments, this sum is significantly below our needs. This could put patient and staff safety at risk.	- 5-year capital programme list - Investment governance policy and templates, including prioritisation matrix - Estates Strategy - Medical devices replacement programme - Applications to access additional funding	- Reporting to FPP	- Availability of funding - Estates Strategy under development	1. Estates Strategy 2. Capital Funding	9	25 (5x5)	10 (2x5)	—	Paul Kimber

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CMO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1502	04/04/2022	26/06/2024	Non-Compliance to SAR & FOI Timeframes which gives rise to potential enforcement action and penalties	The Trust is currently non-compliant with the statutory timeframes due to significant backlogs for SARS & FOI with a risk of enforcement action and penalties	- Business Case approved by ICB and requires recruitment to positions - 4 posts on fixed term contracts (8months) - Assigned 1 individual to admin role daily to deal with phone calls and emails in order to minimise disruption to workload - Processes constantly monitored in order to make improvements at earliest opportunity. - Addition of twice weekly meeting where issues are raised internally - Proposal to temporarily reduce disclosure rules put forwards to address backlog - Associate Director of Legal and Integrated Governance Manager to investigate actual SARs and FOI position ahead of next IGG on 5th February 2024 - IGM reviewed (07032024) 92 SARs of which 15 were not added to the SARs database. Raised with IGL, member of SARs team going through email inbox and adding SARs onto database (this will likely raise our non-compliance stats as ALL SARs will now be recorded)	- Weekly reports to Director of Integrated Governance, Patient Safety & Quality - Reports onwards to CMO/Caldicott Guardian - Information Governance Meetings, onward Assurance & Escalation report to RCAG	- Lack of funding for the additional positions - fixed term positions likely to end soon - Requests for email information requires liaison with NHS Digital and adds to backlog - IG Meetings not routinely held. - Trust written to by ICO in regards to case not dealt with in a timely manner - Backlog circa 900 for SARS with approx. 800 breached - Backlog circa 110 for FOIs with approx. 70 breached - Actual SARS and FOI position unknown as tools available to Trust to extend timeframes may not have been utilised.	1. All SARs team to undertake ICO approved training 2. Benchmarking of resource vs demand 3. Streamlining of database – adding cases 4. Process standardisation – templates 5. Request access to SSO for IG team 6. Streamline of database – reports 7. Review access requests pre 1st April 2024 8. Review access requests post 1st April 2024	9	20 (5x4)	8 (2x4)	–	April Howard

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1285	07/04/2022	01/03/2026	Lack of adequate critical care consultants to manage the critical care unit	There is a risk that lack of adequate critical care consultant could lead to patients safety and experience concerns, including the closure of some critical care beds. Increased patient morbidity and mortality as a result of over-stretched critical care consultants Poor morale amongst the consultant workforce leading to increased sick leave and consultants leaving, thereby exacerbating the situation	• An approach of reduction of critical care beds based on staff availability • There are critical care consultants: albeit not enough • One post recruited to (2023) • Regular short-term locum • Many weekends are covered and 1 consultant has been recruited.	• Planned Divisional Governance Meeting • Business Planning - Operational risk owner to provide • Chief Medical Officer Team meeting	• Staff morale is very low, needing an incentive for current workforce and advertisement agreement to enable competitive recruitment • National shortage of critical care consultants • Next potential recruitment February 2025 • Lost 3 posts to neighbouring Trusts in last 12months • A3 exercise required to explore lack of applications • Currently there are two slots available with 1 consultant WFH and 1 vacancy	1. JD review	9	16 (4x4)	4 (1x4)	—	Rachel Krol

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1711	29/09/2023	31/03/2025	Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of leavers information.	The Trust processes around retention, archiving and disposal of personal information relating to members of staff who have left the Trust is not clear, and as such the Trust may be in breach of their regulatory duties - this may lead to financial and reputational damage to the Trust. This will relate to locally recorded personal information and local personal files, as well as official HR records (occupational health, payroll, employee relations, training records etc.)This is also relevant to SARs.	- Records held directly by HR are stored in electronic files	- information Governance Group - risk and compliance assurance sub-committee	- No retention, archiving of files - Very variable across Trust	1. Initial discussion with HR, OD and ER on data flows re staff info 2. Review of records management policy 3. HR to update their information asset and flow registers 4. Training and communication to staff on responsibilities of staff data retention, archiving and destruction	9	20 (5x4)	4 (1x4)	–	April Howard

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2163	20/08/2024		DCMO Workforce	The CMO is supported by a single DCMO for max 24 hours per week, covering a wide portfolio supporting the breadth of the CMO portfolio. The previous DCMO working the same hours, only supported the appraisal and revalidation, and CMO HR processes, with around 400 connected Dr's. There are now around 600 connected Dr's and the DCMO appraisal revalidation and HR responsibilities have increased in proportion to the increase in Dr's. There are many other aspects of the CMO portfolio that the DCMO is required to cover.	The CMO and DCMO meet on a weekly basis and discuss priorities for the week. The CMO and DCMO are developing a PID to support the appointment of a second DCMO.	- It is usually possible to support the highest priority actions.	This has resulted in an unsustainable situation with areas that should be covered by the CMO and deputy(ies) not being supported to a reliable standard including areas related to Clinical Effectiveness and Outcomes, interface with primary care, non medical professional workforce, Babies, Children and Young People (BCYP), Mental Health, Information governance, GIRFT and aspects of medical productivity and finance. It is not possible to cover all the required portfolio actions, leading to delays and in some cases failure to progress aspects of the portfolio		4	15 (5x3)	6 (2x3)	—	Jeremy Davis

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CNO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1133	07/04/22	31/03/25	Insufficient Midwifery Staffing impacting the ability to provide patient care.	Insufficient midwifery workforce to meet demand. • Inability to provide 1:1 care in labour. • Avoidable delays in the IOL pathway. • Poor patient experience. • Potential for adverse clinical outcome. • Poor staff morale and burnout. • Inability to implement continuity of carer in line with national directive.	• Enhanced Bank Rates: encourage staff • Weekly workforce meeting with senior sisters • Rolling recruitment to fill vacancies • Vacancy increased to 21.12 and maternity leave 11.72 • Mitigate risk by movement of staff across the unit based on acuity and capacity. • Senior Sisters, specialist midwives and matrons working clinically to support ward staff • Regular HOM Briefing to staff and Board Level Safety Champions walk around to support staff. • Support staff for retention • Workforce improvement plan • Working closely with CCCU to determine next steps for 3rd year students • LMNS (Local Maternity Network System) • ICB Maternity Lead	CGB MNSCAB DMB RISK MEETING	• Staff retention and international recruitment options • 2nd and 3rd year students will attend Surrey University and qualify in 2025		4	20 (4x5)	4 (1x4)	–	Kate Harris

COO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2055	25/04/2024	31/03/2025	ERF / elective activity plans	The Trust must deliver ambitious activity plans in 24/25 - over and above that delivered in 23/24 - in order to meet its planned deficit of £29m.	- Activity performance monitoring	- Reporting to FPPC			9	20 (5x4)	9 (3x3)	—	Paul Kimber
1901	04/01/2024		Access Control	Access Control uses a system of cards and readers to unlock doors. Access Control management is weak allowing access by staff to areas where they are not authorised, and may prevent staff accessing areas they need to during an emergency. Contractors and other visitors given access using Access Control along with staff who leave are not removed from the system and may still have access.	- Mortuary and Pharmacy areas access restricted to an agreed list of staff. - Most hospital staff currently are unaware of their Access Levels.	Reports issued to mortuary of entry and entitlement to check access entitlement.	Access control is not managed according to the principles of the Access Control Paper Aug 2023. Staff can find they have access to areas where they are not permitted. There is no overarching policy or SOPs. Access can be granted in one of five different locations with no control and no audit process. Staff and contractors who no longer work in the Trust still have working access control tokens. There are many more tokens registered on the system that there are staff. Recent bid to provide staff and software to manage the system was declined meaning that the Trust cannot perform a lockdown and may not be able to monitor and prevent access to sensitive areas such as mortuary and pharmacy.		4	16 (4x4)	4(1x4)	—	Neil Adams

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1856	20/04/2022	23/12/2024	Faulty TURBT & TURP sets due to age of equipment may result in harm to staff and patients	TURBT and TURP sets required for urology procedures in theatres are more than 10 years old and many have been condemned due to being faulty and unrepairable. Some instruments are bent and damaged and can overheat, which can cause harm to patient and staff. The number of sets available for these procedure are now minimum and therefore lists have to be planned with certain number of patients to save being cancelled on the door. The impact is cancellation of cancer patients and breaching constitutional targets.	- -all faulty sets taken out of circulation - -fast track sets to save cancelling patients due to lack of equipment - -PID written by Urology team for new equipment	- Daily reporting from IHSS - Review of theatre lists	- lack of equipment and approval to purchase new	1. PID for new equipment	4	16 (4x4)	4 (1x4)	—	Sharon Kaur

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2033	27/082024	02/12/2024	Capacity vs Demand will cause delays to cancer patients being discussed at MDT and delay incidental findings	Due to no additional sessions currently there is an increasing backlog of reporting effecting all patient groups. Radiologists continue to report during core hour sessions however the core hours does not provide enough reporting to cover demand. This will cause delays to cancer patients being discussed at MDT as well as the potential to delay incidental findings often seen on routine scans. Delays will become apparent at clinic appointments where reports will not be available resulting in wasted appointments and increased waiting list times.	- VCP requests continue to be submitted for agreement of additional sessions.	No guarantee that sessions will be approved each week and no plan for the backlog to be addressed.	System of additional sessions sign off not guaranteed and as such we can expect the backlog to remain and continue to grow. Although these are being agreed most weeks there is now a significant backlog that needs addressing. the number of sessions currently being approved is not enough to make inroads into the backlog at a pace that will reduce it.		4	16 (4x4)	4 (1x4)	—	Lorraine Beccon shall

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2125	27/08/2024		Aging/aged imaging equipment reduces clinical confidence and efficiency, potentially impacting Quality and Patient Safety	Multiple imaging equipment aged/aging -2 Image Intensifiers (II's) -CR Reader (Sittingbourne Hospital & North Wing X-ray -Medway, General imaging) -Philips FD20 -Dental Imaging Machine - Scanner in Nuclear Medicine Reduces clinical confidence and efficiency, potentially impacting Quality and Patient Safety.	2 Image Intensifiers (II's) Both machines are on the multivendor contract to ensure maintenance and breakdown cover. Staff optimising image quality but often times the images are suboptimal CR Reader -Monitoring of capacity Limited GP walk-in Service, Utilisation of X-ray room to facilitate A&E patients and some GP bookings Staff using ALARP (As Low As Reasonable Practicable) principle to optimise doses as much as possible. Philips FD20 Annual preventative maintenance Medical Physics completing annual QA Dental Imaging Machine DVH undertaking dental imaging for Cancer pts. at Sidcup site Sittingbourne can offer OPG imaging and this is offered to all patients that attend the department for this examination.	-2 Image Intensifiers (II's) Use of Medical physics to QA and monitor quality and doses given to patients -CR Reader (Sittingbourne Hospital & North Wing X-ray -Medway, General imaging) Imaging governance meeting -Philips FD20 Continuous monitoring -Dental Imaging Machine DVH's offer is for a limited period - Scanner in Nuclear Medicine	-2 Image Intensifiers (II's) Difficulty in sourcing parts Low image quality Unable to provide agreed level of Imaging cover to Theatres due to poor quality Imaging Equipment -CR Reader CR Reader yet to be sourced, is on end of life. Increased radiation doses to patients. Reduced image quality. Lengthy downtime periods -Philips FD20 Philips may not be able to fix or source part anymore soon. Funding required for replacement of machine -Dental Imaging Machine Repair of existing machine is not possible Sittingbourne's equipment also being condemned - Scanner in Nuclear Medicine two scanners both 11 years old. The manufacturers recommended age is 7 years. likely to cause increased down time		4	15 (5x3)	3 (1x3)	—	Lorraine Beccon shall

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2158	27/08/2024	31/07/2030	Backlog Maintenance impacting on the infrastructure and clinical safety	The Trust has a backlog maintenance figure of £120m pounds (£107m under ERIC reporting criteria). The current level of funding from capital funds is approximately 20% of the amount required to address the backlog over five years. As backlog maintenance will increase over time, there is a risk that the infrastructure will become too dilapidated and unsafe to provide clinical services.	- - A condition survey using the NHS's approved 'A risk-based methodology - for establishing and managing backlog' completed in January 2024 by - NIFES Consulting - - A condition based asset register completed in March 2024 by NIFES - Consulting. - - An established Estates maintenance team with detailed site knowledge - who proactively and reactively manage maintenance failures.	- Capital approval process which requires bids to be supported by evidence of risk. - Estates and Facilities Group	- Failure of the Trust POD system - Drain blockages caused by clinical wipes and tree root ingress -General condition and security of the laundry building - Theatre lights non-repairable - Condition of Boundary Wall. - Flooring across the Trust - Closed protocol nurse call system becoming obsolete. - Potential failure of obsolete distribution boards. - Roof Leaks impacting on service delivery. - Environmental issues affecting Nelson Ward. - Dilapidated cupboards and countertops in CEPOD Theatre.. - No consistent methodology for determining spending priorities based on clinical, financial, safety and operational impacts of failure. - Insufficient staff to complete all essential planned maintenance tasks.		4	16 (4x4)	4 (1x4)	▼	Paul Norman Brown

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2166	27/08/2024		Non Compliance with HTM 05-01 Managing Healthcare Fire Safety	Non compliance with recommendations and guidance for the management of fire safety in healthcare buildings. A fire on site could lead to: - Loss of life - Injury or harm to people, including patients, staff and visitors etc. - Loss or damage to buildings, infrastructure and equipment - Reputational damage - Impact on patient services/care - Financial impact Fire Safety is multi-faceted and as such, the risk score is impacted by - Detection - Compartmentation - Suppression - Emergency Lighting - Training - Management - Housekeeping (Site safety)	- Mandated annual fire safety training for all Trust employees - Optional annual fire warden training available to all Trust employees - In-house fire response service provided to attend all detector and call-point activations on a 24/7 basis - Departmental fire risk assessments - Annual inspection of all fire doors on site - Repair or replacement of fire doors as required - Fire safety team involved in planning stages of all capital projects - Weekly fire alarm tests undertaken - 5-day week presence from fire alarm engineers - New fire alarm being systematically installed - Fire damper inspections undertaken in March 2023 - All cladding replaced on-site post-grenfell. - Walkarounds undertaken by fire safety team to check controls	- Competent person appointed for Fire - Monthly Fire Safety Group - Monthly Health, Safety & Security Group - Appointed Authorised Engineer (AE) for Fire - Annual Audit by AE - Annual Audit by Kent Fire and Rescue Service (KFRS) - Roles and Responsibilities of designated individuals recorded within the Corporate Fire Safety Policy	- Management: No methodology of dealing with smokers. - No consequence to rule-breakers. - ED Misting system cannot be commissioned whilst occupied and therefore will not function. - No smoking cessation group established. - Pembroke ward compartmentation inadequate. - Nelson Ward Fire Alarm has faults which prevents some sounders from sounding. - Panel 4 faults mean that large parts of Red Zone require manual notification to Switchboard on activation. - Non-compliance with emergency lighting system.		4	15 (3x5)	5 (1x5)	–	Neil Adams

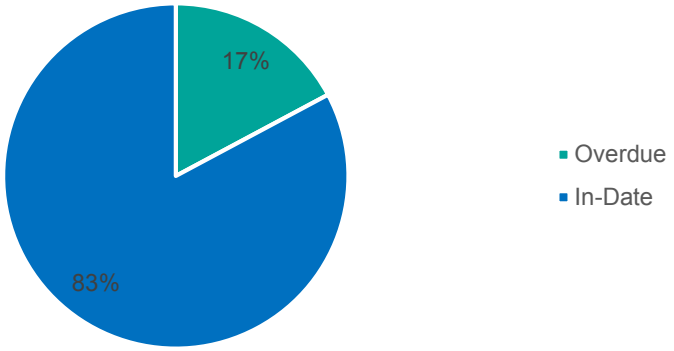
Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2167	27/08/2024		Rochester CDC Implementation is behind schedule which could impact on patient care	Rochester CDC implementation is behind schedule and continues to slip. Legal teams cannot agree basic access rights, fundamental for safe service operation, leaving the Trust exposed to future litigation. Impacts include capital slippage, lost revenue and poor patient care leading to late diagnosis.	- Area not in use and at project stage.	Estates & Facilities Group	Lack of governance over a controlled zone for radiation and a dispute regarding lease terms.		4	15(5x3)	3 (1x3)	—	Brian Edwards

Approved Risks

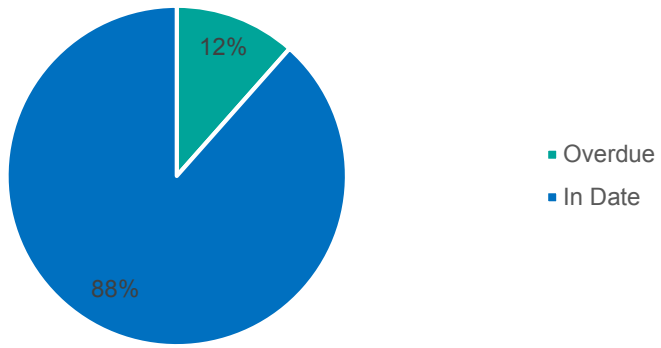
Of the 221 approved risks;
- 38 have breached their review date

Of the 25 ‘extreme risks’;
- 3 have breached their review date

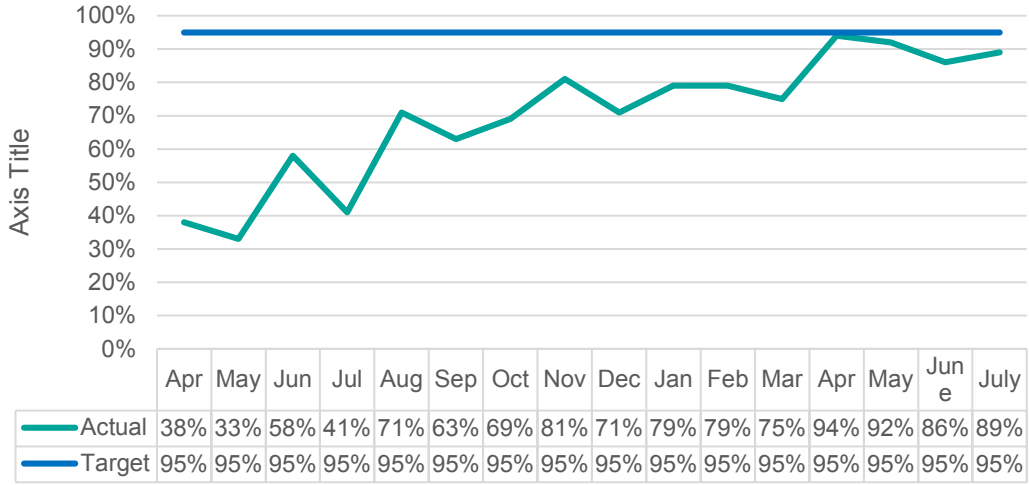
Risks by Review Status



'Extreme' Risks by Review Status



Review Date by Month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun e	July
Actual	38%	33%	58%	41%	71%	63%	69%	81%	71%	79%	79%	75%	94%	92%	86%	89%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Cancer & Access– Deep Dive

NHS Medway NHS Foundation Trust

The C&A Risk Register has 4 approved risks in total, 0 of which is ‘extreme’

1 new risks added, of which
0 risks are awaiting review, and
1 risk is awaiting approval.

2091- Limited workforce in Sickle Cell service, no SLA in place resulting in poor patient experience and staff overwhelmed (Score 3x4 = 12)

0 risks have been closed down in August

100% of risks have been reviewed within their required timeframes

Oldest risk: 26th July 2023 (*Risk ID: 1729 – Lack of service provision for Breast Family History clinic*)

Action Required

NHS Medway NHS Foundation Trust

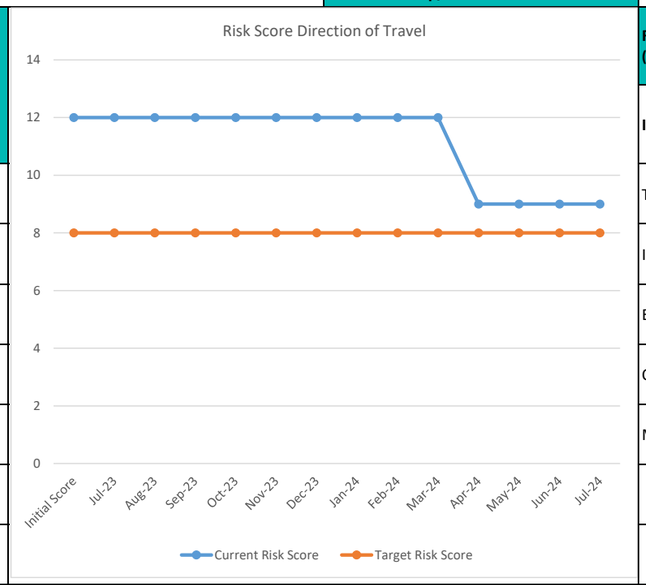
Ref	Action	Owner	Date	Status
01	95% of approved risks to have been reviewed within timeframe	Risk Owners with oversight by IGT	31 July 23	Overdue. Review rate currently at 89%
02	Review of process for new risks to ensure they are approved in a timely way with 95% approved within 1 month of being raised	IGT	31 July 23	Process complete. 95% target not yet achieved
03	100% of approved risks are fully completed	Risk Owners with oversight by IGT	31 July 23	Complete
04	Quarterly reporting against Risk Management KPIs	IGT	31 July 23	Complete
05	Consolidate all EPR and EPMA Risks into 2 singular risks as agreed with MD and CNO. These 2 new risks should focus on functionality of the system and staff not following processes/using workarounds	Kerry O'Reilly with support from IGT	31 July 23	Complete
06	Assign every risk to the 'group or committee' responsible for onward monitoring	IGT	31 July 23	Complete
07	Work with divisions to 'cascade' information relating to the difference between incidents and risk	IGT	31 Oct 23	Complete
08	To draft a revised risk approvals and BAF process	Co.Sec	TBC	Drafted
09	To create a separate issues log and transfer issues across from the risk register to this	IGT	31 Oct 24	Not yet started

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1a
Executive Owner	Chief Nursing Officer
Operational Owner	Nicola Lewis, Associate Director of Patient Experience
Primary Risk Grouping	Patient
CQC Domain	Responsive

Objective:	Providing outstanding, compassionate care for our patients and their families, every time.
Principal Risk Name & Description	Low uptake as a result of patient feedback fatigue due to patients not being able to see the improvement being made from completing a survey makes.
Relevant Group/Committee	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	3	3	**9**	—
Current Risk Score	3	3	**9**	—
Target Risk Score	2	4	**8**	
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	14.6%	13.9%	16.2%	15.2%	15.6%	15.4%	15.2%	
Inpatients FFT Response Rate	45.0%	40.3%	44.7%	53.4%	47.3%	51.6%	52.9%	48.4%	
Emergency Care FFT Response Rate	45.0%	9.7%	7.5%	10.0%	8.8%	9.1%	9.6%	9.1%	
Outpatient FFT Response Rate	45.0%	10.1%	9.2%	9.9%	9.8%	9.6%	9.9%	9.8%	
Maternity FFT Response Rate	45.0%	38.7%	30.4%	49.5%	47.6%	39.1%	34.1%	39.9%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

This is the local target for the FFT response rate as part of the patient first breakthrough objective and the patient experience strategy. The risk score was raised in June as the response rate scores for ED and OPD reamin low and maternity response rate dropped in comparison to the months previously. There is little likelyhood that covid will have an impact on FFT response rate in the near future

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Quality Improvement Projects have been commenced based on patient feedback Engaging with patients to understand why they do not complete the FFT survey Change of SMS text provider Widened scope of text distribution Increasing use of electronic devices Paper surveys have been discontinued Posters and QR codes disseminated	Increased uptake in FFT responses in all areas Improvement in recommend rate and overall experience of care Improved response for completed surveys versus opened and incomplete surveys via text Improvement in recommend rate and overall experience of care CQC surveys / data Patient Experience Group

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

Agree to remove response rate as a driver metric	to keep as a watch metric and agreed at Execs	30/06/2024	Complete	CNO	**AGREED**
Errors in data with the FFT questionnaire on GATHER	To review all areas line by line to ensure accuracy when patients are completing the survey on gather	30/04/2024	Complete	Malou Bengtsson-Wheeler	16/04/24 S&A areas completed. Other divisions will be completed by the end of April. **Delays with mapping the data. DDoN's have been asked to return this information by the 17th May, complete** - to close this action
Closure of feedback loop from patient feedback from FFT to patients/carers/staff and visitors	1a Regular updates regarding improvements made based on patient feedback on Trust website, social media and patient information. 1b Comms and patient exp team to create SOP for quarterly updates on the website.	31/03/2024	Complete	Nicola Lewis, Associate Director of Patient Experience	15/01/2024 Information is being passed onto patients via social media however, the Patient information group to commence January 2024. Comms will update when the new website is launched in late March 2024. the due date to change in line with the launch of the new website. Update 16/04/24 - new website has been launched and feedback is being shared to close the communication loop. propose to close this action.
Low response feedback rate in ED in OPD areas	2 Targeted focus with improvement initiatives in OPD in ED such as, an FFT champion each shift, FFT infomration placement for patients to understand why it is important to complete the feedback survey	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	OPD Staff are engaging clinical teams in each clinic to provide a reminder to each patient to provide feedback if they get a text in OPD. action reviewed and split into 2 new actions for tracking and assurance. This action to be closed. **Action closed January 2024**
Some wards still utilising paper surveys	3 Business case to be written to Lease patient experience IPADS. This work is being carried out with the estates and facilities team to include digital meal ordering. Tablets to be fixed and returned to the wards for FFT use.	31/07/2023	Overdue	Nicola Lewis, Associate Director of Patient Experience	Proposal is awaiting input from the director of IT and Estates and facilities team. The aim for this to be ready is w/c 02/10/2023. 16/10/23 update was received from DoIT which have been reflected in the BC. Further discussion is required with EH prior to submission. 09/11/23 an audit to account for all tablets in clinical areas was completed in October. scoping to be completed by the transformation team / CNO / COO to agree next steps. 15.01.24 update - PMO are supporting this action with the aim to close by the end of February. update 07/03/24 - action to be extended and proposal for closure is early MAy 2024. update 16/04/24 - Tablets are with the IT team, proposal paused for purchasing or leasing IPADS until the Tablets are fixed. to review this action in May 2024 **update May 24 - 2 tablets have been fixed they are being trialled on OPD and ICU. update - 12/08/24 to consider closing this action as this has not moved forward for many months and no clear timeline for conclusion.**
Low response FFT rate in ED	A3 has commenced in AEM, led by the HoN and Matrons	30/07/2024	Complete	Kathy Ward (HoN) and Kate Holmes (DDoN)	A3 countermeasures devleoped with the team. ADPE supporting. This action due date has been extended as the project will be long term. April 2024 - an improvement focus will commence in the ED during 'quality week' to support ED staff to work through challenges and identify countermeasure solutions in the last week of May. this work is being supported by the CNO team and integrated governance team with interventions from the CNS teams throughout the week. Recommend rate reduced to 85%. **complete - to close this action.**

Low FFT response rate in OPD areas	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas. • ADPE to attend the OPD patient experience meeting to promote the use of FFT. • New divisional structure commenced in late 2023, areas in OPD to be updated on Gather and refresh of the system to commence in the next reporting period		Complete	Chris O'Connell (Matron) Laura Potter (DDoN / AHP Acting)	actions are complete. A marginal rise in FFT reposne has been noted. **16/04/24 propose the action to be closed**
Poor response rate and uptake from text messages sent to patients	4 To review the reasonable adjustments requried for patients who may not be able to afford data / Wifi to connect to the survey. To provide adjustments for patients who may have dyslexia. To request assistance from the comms team to engage with patients who receive a text following an appointment or admission but do not provide their feedback to identify themes and trends.	15/12/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	this action has been reviewed with the action to understand national themes and trends for low reposne rates and reasons for not engaging. **To be considered for closure please**

Trust Risk Register Aligned to Board Assurance Framework	Ref:	Current Risk Score:
	Ref:	Current Risk Score:
	Ref:	Current Risk Score:
	Ref:	Current Risk Score:
	Ref:	Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	12th August 2024
Date of Next Review:	12th September 2024

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1b	**Objective:**	Providing outstanding, compassionate care for our patients and their families, every time.
Executive Owner	Chief Nursing Officer		
Operational Owner	Nicola Lewis, Associate Director of Patient Experience	**Principal Risk Name & Description**	Potential lack of patient feedback standardisation approach could result in development of multiple approach to feedback questions and data collection which could lead to data variation which cannot be used for benchmarking across the Trust
Primary Risk Grouping	Patient		
CQC Domain	Responsive	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	3	**12**	N
Risk Score at Last Review	3	3	**9**	—
Current Risk Score	3	3	**9**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	High			
Adequacy of Controls	Adequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	14.6%	13.9%	16.2%	15.2%	15.6%	15.4%	15.2%	
Inpatients FFT Response Rate	45.0%	40.3%	44.7%	53.4%	47.3%	51.6%	52.9%	48.4%	
Emergency Care FFT Response Rate	45.0%	9.7%	7.5%	10.0%	8.8%	9.1%	9.6%	9.1%	
Outpatient FFT Response Rate	45.0%	10.1%	9.2%	9.9%	9.8%	9.6%	9.9%	9.8%	
Maternity FFT Response Rate	45.0%	38.7%	30.4%	49.5%	47.6%	39.1%	34.1%	39.9%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

actions complete - to close this risk please

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Original surveys approved by Senior teams based on NHSE guidance All survey requests to be approved via the Executive Team All survey changes actioned by Gather Team	Gather system and FFT feedback to benchmark the responses in each

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. An increase in requests for new or changes to the FFT surveys have been received from different clincal areas	1. Full review of all FFT surveys to take place and cross reference the relevance against all clinical areas	31/07/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	All surveys have been reviewed and updated. This action is complete and awaiting approval with Execs. . 15/01/24 all reviews for surveys are complete and published on Gather. Action to be closed update 14/06/24 - questoins on the surveys reduced to 3 only plus free text boxes. **TO BE CLOSED**
2. action targets for response rate removed but added as a watch metric. **propose to close this risk**		30/06/2024	Complete	Nicola Lewis, Associate Director of Patient Experience	to close

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

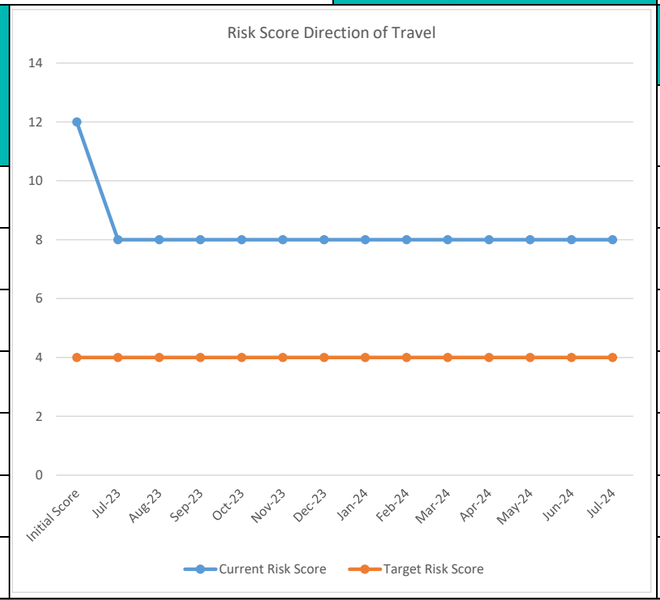
Risk submitted to QAC for proposal of closure October 2023. Target score reached

Date of Last Review:	12th July 2024
Date of Next Review:	N/A

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1c	**Objective:**	Providing outstanding, compassionate care for our patients and their families, every time.
Executive Owner	Chief Nursing Officer		
Operational Owner	Nicola Lewis, Associate Director of Patient Experience	**Principal Risk Name & Description**	Potential lack of delivery across other True North Domains could lead to patients not recommending our services as a place to receive care
Primary Risk Grouping	Patient		
CQC Domain	Responsive	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	2	4	**8**	—
Current Risk Score	2	4	**8**	—
Target Risk Score	1	4	**4**	
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Total FFT Recommended Rate	95.0%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	90.1%	
Inpatients FFT Recommended Rate	95.0%	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%	93.5%	
Emergency Care FFT Recommended Rate	95.0%	68.9%	71.6%	77.1%	70.2%	74.9%	73.0%	72.6%	
Outpatient FFT Recommended Rate	95.0%	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%	92.2%	
Maternity FFT Recommended Rate	95.0%	85.8%	88.8%	99.4%	96.5%	92.6%	88.0%	91.9%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

National target and evidence of exemplary care. Risk score has reduced as the recommend rate has increased consistently within inpatient areas.
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Developing specifc improvements based on feedback themes and trends from patients	All actions are monitored via driver huddles, catch ball and SDR Patient Experience Group

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
A3 refresh for the breakthrough objective setting 24-25	focus is on staff attitude and communicaton	30/06/2024	On Track/Not Yet Due	All	new actions to be generated by 31/07/24

Errors in data with the FFT questionnaire on GATHER	To review all areas line by line to ensure accuracy when patients are completing the survey on gather	30/04/2024	**Complete**	Malou Bengtsson-Wheeler	S&A division complete. **Awaiting an update from the 3 remaining divisions by 17th May. Update 14/06/24 -**
Low recommend and response rate in ED	To consider standing up a quality event which engages all the clinical quality teams to support patient care in ED - a break the cycle week. This is awaiting a final approval with the senior teams	01/06/2024	Complete	Nikki Lewis / Wayne Blowers / Steph Gorman	a week to support the quality of care will commence in late April. Plans to support this are underway. **This is planned for W/C 20th May. Thefore the action due date has been updated.**
Operational flow and processes in maternity have caused a reduction in recommend rate over the last 2 months.	Maternity teams to implement a deep dive / A3 into the issues surrounding induction of Labour	31/07/2024	On Track/Not Yet Due	Alison Herron, Director of Midwifery / Kate Harris, Head of Midwifery	This project will be running for 1 year
Noise at Night	A full evalutation of the noise at night project to be completed	31/08/2023	Overdue	Divisional Directors of Nursing	15/01/2024 awaiting the evaluation report from DDoNs. 16/04/24 - no further update
Staff attitude has been a theme from patient feedback, PALS and Complaints in maternity areas	A3 deep dive into issues surrounding staff attitude, with intentional rounding from senior staff out of hours	31/08/2023	Complete	Kate Harris, Head of Midwifery	Maternity A3 and action are complete 15/09/2023. action to be closed
Staff attitude has been a theme from patient feedback in inpatient areas	A3 deep dive discussions have commenced with further detail around actions and improvements will be collated with the CNO and team	30/11/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	the A3 for staff attitude to be shared at the PE Group / QPSSc and QAC. **To be closed**
Staff attitude and concerns at night have been raised from patient on inpatient areas	A rota for senior staff support and visibility has been developed with the CNO. The approach to be approved at the next CNO meeting	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	**to be closed**
Low recommend rate in OPD and ED	Clinicans in OPD to offer a reminder to patients complete the survey following their consultation. Actions are being collated in care group huddles to improve the FFT recommend rate, these are escalated	30/11/2023	Complete	Outpatients / ED Team	to separate this into 2 separate actions.**to close this action.**
Low recommend Rate in ED	to meet with the ED teams and join their huddles. Restart A3	01/01/2024	Complete	Kathy Ward (HoN) Kate Holmes (DDoN)	Complete. **Action to be closed**
Low recommend rate in OPD	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas.	15/02/2024	Complete	Chris O'Connell (Matron) Laura Potter (DDoN/AHP interim)	**complete - to be closed**

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

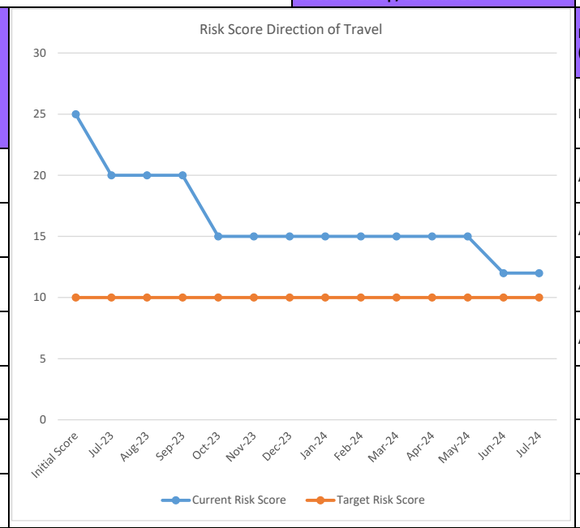
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation

Date of Last Review:	12 August 2024
Date of Next Review:	12 September 2024

QUALITY BOARD ASSURANCE FRAMEWORK

Risk ID:	2a	**Objective:**	Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have
Executive Owner	Chief Medical Officer		
Operational Owner	James Alegbeleye, Medical Director for Quality and Safety	**Principal Risk Name & Description**	Lack of timely escalation and treatment of deteriorating patients
Primary Risk Grouping	Quality		
CQC Domain	Safe	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, ▬, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	N
Risk Score at Last Review	3	4	**12**	▬
Current Risk Score	3	4	**12**	▬
Target Risk Score	2	5	**10**	▬
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Avoidable 2222 Calls - Total	16	2	0	3	3	0	6	2	
Avoidable 2222 Calls - Cardiac Arrest	1	0	0	1	2	0	2	1	
Avoidable 2222 Calls - Peri-Arrest	3	2	0	1	1	0	4	1	
ALS/BLS Training Compliance	85.0%	81.0%					81.4%	81.2%	

Context Summary
(Patient First problem statement, current situation)

We have patients in the hospital who die unnecessarily and the data tells us that this is more likely at the weekend than during the week. From analysis we have identified that possible delay or failure to monitor or escalate is one of the biggest causes of “death” harm incidents behind implementation of care or ongoing monitoring.

Rationale for Current Score

Risk reviewed with CMO on 06/12/2023 - Avoidable 2222 data demonstrates special cause variation statistically significant reduction in trustwide avoidable 2222’s. Score remains at 3x5 as frequency of avoidable 2222 has reduced but not yet to such a point that likelihood can be reduced to 2 (Unlikely) from current likelihood of 3 (Possible).

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Delays in whole patient pathway from initial deterioration to patient receiving correct treatment in correct part of hospital. Investigating critical care reasons for delay in taking patient. Ongoing work with Care Group leads focusing on 'culture change'. CITO (digital critical care information) now available for all medical staff. Cardiac and peri – arrest proforma in process of being implemented onto EPR. ART team feeing back the trends with avoidable ART calls. Resolved Issues - Investigating delays in review by Surgeons not answering bleep (Pilot for Surgical Teams to attend Hospital @ Night huddle with ART to support response times out of hours, SOP updated to reflect this change to process and engagement will be fully effective from 1 March 2023with new rota in place to support) - resolved. A3 started regarding ALS and EPALS compliance, and arrangements for providing this training. Resus Service now attending doctors (in training) inductions to manually gather Resus certificates data for ESR. - Resolved	These are reviewed in weekly 'huddle' and remain under review until marked as complete. Training and funding for ALS/EPALS – funding confirmed and has been requested by Divisions as part of Business planning. Status paper drafted which will provide clear countermeasures to deal with known gaps.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1a. Doctors not ALS/BLS Trained	1a. Improve ALS/BLS training compliance	22/05/2023	Overdue	Chief Medical Officer	**15.08.2024 Percentage has improved to BLS 81.42% - non compliance were medical team. JA to email each medical director for each division** 11.06.2024 Action closed - given to division to be responsbile for ensuring staff are trained/attend training. 06.05.2024 - Ongoing 15.04.2024 - Divisional directors will work with Resus team to identify staffs who are non-cmpliant 11.03.24: Als 81% BLS - 73% YTD average only at 80%, target not yet achieved. Work ongoing with action plan. Service Managers working with respective areas on

2a. EPR system needs optimisation	2a. Cardiac and pre-arrest proforma on to EPR	24/04/2024	Overdue	Tamara Stephens, Sherwin Sinocruz	**15.08.2024 - Update available september** 10.07.2024 - Pilot started. 11.06.2024 - To be piloted in June 06.05.2024 - still in pilot change and wants to ensure the functionality is correct. Pilot in progress – feedback by end of may 11.03.24: going through testing Ongoing SIM testing referral tool for escalation. Re-design complete and awaiting electronic completion
2b. EPR system needs optimisation	2b. Electronic SBAR referral tool for escalation	24/04/2024	Overdue	Emma Coutts	**15.08.2024 - Being tested** 10.07.2024 Deferred to July - update 17/07/2024 11.06.2024 Deferred to June 06.05.2024 - updated its on HOLD for the time being bcos of delay in Order Comms launch. EC noted that it is a part of EPR project 11.03.24 : Going through testing 20/03/2024 This has been moved through to testing which will take place 08/02/2024 and will then be taken back to the EPR Board for approval.
2c. EPR system needs optimisation	2c. ABG/Point of Care Testing integration with EPR	22/04/2024	Overdue	Tamara Stevens, Kerry O'Reilly, Dilip Pillai	**15.08.2024 Not yet agreed - requires large amount of funding which has not yet been approved** 10.07.2024 Deferred to July - needs investment 11.06.2024 Deferred to July 06.05.2024 - This will be taken on following order comms and upgrade which will mean there is change freeze, discussion under way this will not take place until July. meet with SS mid July to re ignite. Order Comms live is 16.04.2024 11.03.24: deferred to 20/04/2024 Awaiting Order Comms Switch on 04/2024
2d. EPR system needs optimisation	2d. Medicus ART clinical entry integration with EPR	31/03/2025	On Track/Not Yet Due	Dilip Pillai, Kerry O'Reilly, Emma Coutts, James Alegbeleye, Zohreen Amir	**15.08.2024 requires large amount of investment not yet approved** 10.07.2024 Ongoing work Due 31/07/2024 11.06.2024 Ongoing 06.05.2024 - This is a technically challenging project, and needs to be explored . We will be looking at the technically feasibility. To look into this update in a month time (May 22). There will be an integration cost involved of £6000 which has been reduced by £3000 if the trust can complete this integration along with the update that MEDICUS will be completing for us . To be confirmed if this can be sought from the critical care budget in line with the ICU IT Medicus costing. Update due 21/02/2024. MAy go through Stategic Filter? corporate project
2e. EPR system needs optimisation	2e. **ReSPECT/DNACPR/TEP development + electronic integration with community ICS and Trust	01/09/2024	On Track/Not Yet Due	James Alegbeleye, Zohreen Amir, Dilip Pillai	**15.08.2024 - TEP electronic version created and being tested roll out in september** 10.07.2024 Work ongoing pilot EPR team. update 17/07/2024 11.06.2024 TMB Group & pilot July 06.05.2024 - ChP/ZA to update after cancer palliative care divisional meeting & TMB group to meet again on 5th June to finalise TEP 15.04.2024 - Update: Going through Governance approval before piloting 11.03.24 going through consultation final version available soon Larger project, pending JaA work + recruiting next Darzi fellow. Discussions/review ongoing around content, electronic integration and whether there can be a single form across the community and Trust. Not yet complete, ongoing discussions
2f. EPR system needs optimisation	2f. Rewrite of TEP form	30/06/2023	Complete	James Alegbeleye	See action ref 2e. **This has been marked as complete despite ongoing work as it is now included in action 2e.**
3a. Failure to escalate/escalate/gap in clinical plan: Gap in knowledge of SOP/Standard	3a. Targeted NEWS/Alert training to be mandatory for all staff	15/11/2023	Complete	Emma Coutts	Complete
3b. Failure to escalate/escalate/gap in clinical plan: NEWS not captured as per standards	3b. A3 on timeline for NEWS	01/09/2024	On Track/Not Yet Due	Jamie Moore, Kate Holmes, Emma Coutts	**15.08.2024 Ongoing - huge cost - alternative NEW dashboard has been rolled out** 10.07.2024 Ongoing due september 2024 - needs investment to buy new machines. 11.06.2024 Note to Comms to distrbute to clinical teams. DD asked to look into their business needs. 06.05.2024 - Ongoing 11.03.24 Bring back by end of march 2024 Three streams - i) Ensure Observations are undertaken as needed; ii) ward scores visible on whiteboards; iii) Streamline and automate processes for uploading results to EPR and acting upon these. Updates om all three by 06/03/2024
3c. Failure to escalate/escalate/gap in clinical plan: Lack of data, ownership, review delays	3c. Metavision critical care virtual ward for ITU outliers reintroduced - SOP to be written on referrals	08/11/2023	Complete	Rachel Krol	It has become clear that Metavision is not suitable for this and RaK is pursuing other options. Marked as complete as moved to BAU in critical care
3d. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3d. Tazocin PGD	08/11/2023	Complete	Emma Coutts, Rachel Krol, Godwin Simon	Upon review, this action is not required.
3e. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3e. Metraminol in ED, SOP to be implemented	08/11/2023	Complete	Emma Coutts, Godwin Simon	Marked as complete as moved to BAU

3f. Failure to escalate/escalate/gap in clinical plan: Board rounds and handover pilot	3f. Escalation on board rounds	08/11/2023	Complete	Jamie Moore, Kate Holmes, Dilip Pillai, Tracy Stocker	This is now BAU. Ongoing, trial on Harvey and Pembroke for ward handovers is now underway, using WOW's to share information amongst team.
3g. Patients leaving ICU/HDU do not always have an appropriate level; of consultant and other senior review, knowledge of patient, and escalation of care when transferred to a ward. Also concerns re admission handover and access to parent teams whilst on ICU	3g. Review of ICU pathway including admission, parent clinical team review whilst patient on ICU/HDU and medical and nursing handover arrangements when patient leaves ICU/HDU	13/03/2024	Overdue	Chris Parokkaran, Rachel Krol, Howard Cottam	**15.08.2024 meeting end of august** 10.07.2024 medical/surgical ongoing disucssion - update 17/07/2024 11.06.2024 A3 still ongoing, develop SOP 06.05.2024 - progress is slow, possible away day to complete work, work on SOP - due 05/06/2024 15.04.2024 - Ongoing A3 11.03.24 - Ongoing discussions A3
4a. Failure of appropriate delivery of care, monitoring and escalation by specialist team whilst awaiting transfer, lack of ownership of patient care	4a. SRO led session to establish full root cause and key tests of change and engagement with wider stake holder group	31/03/2025	On Track/Not Yet Due	Howard Cottam	**15.08.2024 - 'This is not my patient'** 10.07.2024 update needed 11.06.2024 To meet in July - ongoing 06.05.2024 - SRO - led session to establish full root cause and key tests of change and engagement with wider stake holder group. - 03/07/2024 11.03.24 Ongoing A3 completed. HoC workign with other DMD's re how to mitigate
5a. End of Life Decision being made at night rather than earlier in the day. End of Life decisions are often not prioritised and therefore, are not always completed by the end of the day.	5a. Discussed and agreed at QPSC that action is required but multi-disciplinary meeting needed and learning	24/04/2024	Overdue	Emma Coutts	**15.08.2024 - ongoing work to understand reason / clinical team encourage to make descision during day and work with pallative care team to raise awareness on early descision making of EOL** 11.06.2024 to be discussed 12.06.2024 - true north mortality a3 refresh 06.05.24 - EC to provide weekly data - Multi-disciplinary meeting needed and learning to report back to Huddle. Discussed and agreed at Qpssc that action is required 15.04.2024 - Expected data analysis 11.03.24 data collected ongoing Clincal fellow & Emma Weekly data to be provided. Audit presentation to be reviewed at quality huddle on 21/02/2024.
6a. Epilepsy following cardiac arrest - reduced awareness of time critical drugs	6a. Clarify status of non-avoidance of 2222 call - Review case of epileptic patient and clarify whether this was a non-avoidable 2222 call.	08/11/2023	Complete	Godwin Simon, Tamara Stephens, Emma Coutts, Rachel Krol	Missed dosage working group to look at report and identify ongoing actions to resolve issue. Drugs issues to be raised on risk register for both Divisions - JD to circulate list of time critical drugs to doctors for comment. Pharmacy students currently working on this list as a project supervised by Chief Pharmacist. **Action complete.**

Trust Risk Register Aligned to Board Assurance Framework	Risk 1433: Delayed recording of Observations on EPR	Current Risk Score: 20
	Risk 1539: Blood Gas results not recorded electronically on EPR	Current Risk Score: 12

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

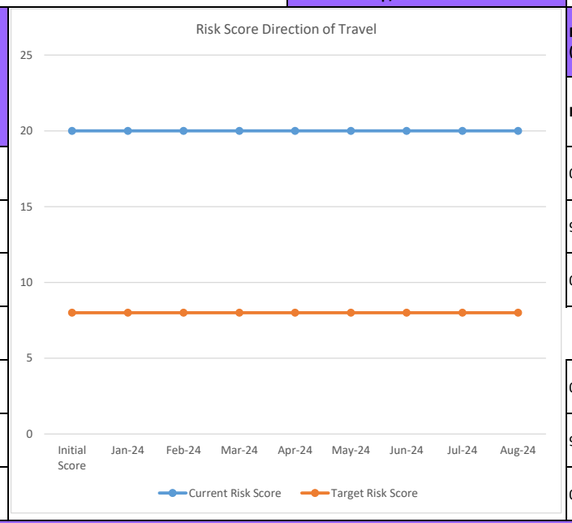
Investigations taken forward - new rota in place
Current status - Hospital at Night - working well

Date of Last Review:	15 August 2024
Date of Next Review:	15 September 2024

QUALITY BOARD ASSURANCE FRAMEWORK

Risk ID:	2b	**Objective:**	Compliance with SAR & FOIR release deadlines
Executive Owner	Chief Medical Officer		
Operational Owner	Information Governance Manager	**Principal Risk Name & Description**	Non-Compliance to SAR & FOIR timeframes which gives rise to potential enforcement action and penalties (Risk 1502)
Primary Risk Grouping	Quality		
CQC Domain	Safe; Well-Led	**Relevant Group/Committee**	Information Governance Group

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	4	**20**	N
Risk Score at Last Review	5	4	**20**	—
Current Risk Score	5	4	**20**	—
Target Risk Score	2	4	**8**	▼
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Average**	**Comments:**
0 PALS Complaints in relation to SARs	<2	4	3	5	3	2	0	1	3	
90% released within deadlines	>90%	46%	33%	17%	*41%*	*40%*	*17%*	N/A	32%	*Data for May-July 24 is not yet finalised as SARs have 30, 60, or 90 day deadlines.*
0 backlog	<30	860	910	870	770	777	790	675	807	Figures from May 24 onwards provide a more accurate picture of backlog of breached SARs post data validation & with the inclusion of requests not yet added to the database.
0 Internal Review Requests in relation to FOIRs	<2	3	1	1	0	3	2	0	1	
90% released within deadlines	>90%	67%	69%	47%	39%	47%	57%	N/A	54%	
0 backlog	<30	124	148	121	107	73	55	41	96	

Context Summary
(Patient First problem statement, current situation)

We have patients, staff, or members of the public whom have raised a Subject Access Request (SAR) for their own data or on behalf of another living person, or have raised a Freedom of Information Request (FOIR) for Trust data, and information has not been provided to them within the legal timeframes. The legal timeframes are: 30 days for SAR, unless complex in which case this can be extended to 60 days or 90 days; the deadline is 20 days for a FOIR. The ICO have issued guidance to the Trust, with an expectation that the Trust have successfully tackled our backlog and ongoing requests by the next formal meeting in February 2025. There is a risk of regulatory action, including monetary penalty, if the backlog of SARs and FOIRs is not cleared and new requests are not dealt with within legal timeframes.

Rationale for Current Score

The backlog of SARs remains high, although starting to reduce slowly. Historic cases for 2023 are steadily being closed, but new breaches from 1st April 2024 onwards are increasing as we are receiving an increasing number of SARs per month

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The Information Governance Manager has: reviewed and streamlined processes at the Trust for SARs, and staff have undertaken training on ICO-compliant processes. The database that logs information requests has been streamlined, with data quality improvements made to enable clearer reporting anticipated for August 24, and a standarised written process for staff to follow when logging and responding to requests is now in place. Templates have been provided to staff to standardise acknowledgement of requests, including for ID, consent, and search term clarifications. Forensic searching has been mapped as a 2nd step, with email requests instead taken as a 1st step, reducing the time spent reviewing information for redaction.	Staff feedback is reviewed in weekly team meetings. Weekly data provided to Execs to gauge impact of resourcing vs demand and progress on trajectories.

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**		**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1a. All SARs team to undertake ICO-approved training	28/03/2024		Complete	Information Governance Manager	26/03/2024

2a. There have been new systems implemented (such as CITO) and the decommissioning of systems (such as Symphony) had an impact on the SARs team as there are more systems for the SARs team to check to fulfil requests.	2a. Information Governance Manager meeting with ICT digital lead to review any potential improvement of systems. Access to Single Sign On for SARS team proposed (i.e. SmartCard), as staff swap between systems frequently in a similar way to clinicians.	30/04/2024		Not possible	Information Governance Manager	Some of the ICT systems have been confirmed as not possible to amend to enable 'select all' buttons when staff are selecting, for example 50+ documents. Further request to be made in relation to Single Sign On.
3a. Review of SARs backlog	3a. Information Governance Manager and Information Governance Lead are updating the database to enable better reports to show all outstanding SARs to see if they are actual SARs or Police/Social Services/other healthcare providers' requests, and whether there are gaps in the processes that need to be closed. 3b. Once we have a list of the actual outstanding SARs, to check that we received a) proof of ID, and/or b) valid consent (where requests are not made by the data subjects, but by their solicitors/relatives). Where this has not been done, a member of the SARs team will write to the requestors to seek what is missing (planned to commence 22nd Apr 2024). 3c. Information Governance Manager and Information Governance Lead to review all SARs received in March and in Apr 2024, and, where cases may involve large number of files and sensitive data or are complex or other reasons, the SARs team are to write to the requestors to notify them that we will be taking up to further 2 months to comply with the request (planned to commence 22nd Apr 2024 by Information Governance Manager)	30/04/2024		Complete	Information Governance Lead	PDSA cycle in progress, with staff testing and reviewing updated processes, and regular feedback opportunities
4a. Resourcing vs demand	4a. Information Governance Manager benchmarking staff FTE against monthly SARs/FOIRs intake & backlog 4b. Review of SARs backlog. 4c. Review of FOIR backlog.	31/03/2024		Complete	Information Governance Manager	Benchmarking complete and additional resourcing request made as part of Business Planning preparation.

Trust Risk Register Aligned to Board Assurance Framework	Risk 1502: Non-Compliance to SAR & FOI Timeframes which gives rise to potential enforcement action and penalties
	Risk 1932: The current structure and function of the IG team may result in the Trust been unable to meet its statutory responsibilities

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

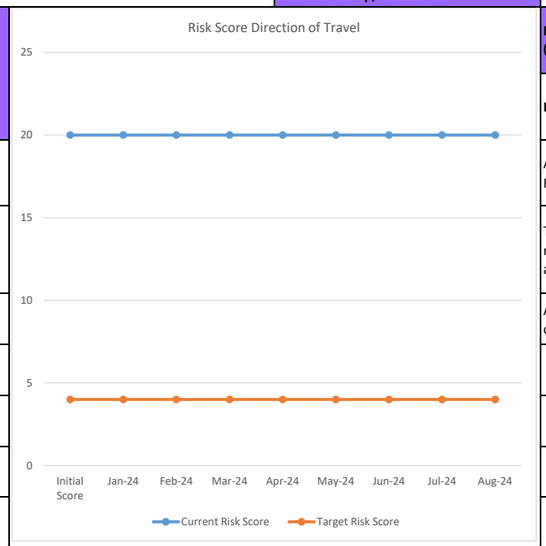
Challenge to progress is an increase in FOIRs and the backlog of SARs. Management of these challenges is: staff training, database update for more responsive reports, standardised and improved processes. Request has been made for temporary additional resource to clear existing backlog and 12-month Band 4 to provide cross-cover for the team on all types of information requests to prevent future breaches of SARs and FOIRs.

Date of Last Review:	16th August 2024
Date of Next Review:	5th September 2024

QUALITY BOARD ASSURANCE FRAMEWORK

Risk ID:	2c	**Objective:**	Compliance with records retention requirements
Executive Owner	Chief Medical Officer		
Operational Owner	Informaton Govenance Manager	**Principal Risk Name & Description**	Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of patient and staff information (Risk 1711)
Primary Risk Grouping	Quality		
CQC Domain	Safe	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	3	**9**	N
Risk Score at Last Review	5	4	**20**	—
Current Risk Score	5	4	**20**	—
Target Risk Score	1	4	**4**	▼
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Uncontrolled			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Average**	**Comments:**
All 20 departments have an up to date Information Asset Register	18	2	2	2	3	3	3	3	3	
The Trust follows a Records Management Policy, adhering to a retention lifecycle (target that 100% of policies are reviewed and updated by July 2024) with a quarterly audit	95%	0	0	0	50%	55%			55%	
All staff leaver information is retained, archived, and disposed off within legal timeframes	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Context Summary
(Patient First problem statement, current situation)

The Trust processes around retention, archiving and disposal of personal information relating to members of staff who have left the Trust is not clear, and as such the Trust may be in breach of their regulatory duties - this may lead to financial and reputational damage to the Trust.

Rationale for Current Score

Records do not appear to be centrally located, with instead disparate strands of locally recorded personal information.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The Information Governance Manager has started discussions with HR, OD, and ER leads to go through staff data flows to identify how the Trusts processes personal data.	Quarterly review of Information Asset Register updates, to enable mapping of any retained staff information and decision from Information Asset Owner (in line with Records Management Policy) to retain, archive, or destroy information.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)					
	Action	**Due Date**	**Revised Completion Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1a. An improvement of HR, OD, and ER processes in relation to retention and archiving of files	1a. Data flow mapping by HR, OD, ER on their information assets. 1b. Review of Records Management Policy. 1c. Training of staff in relation to Records Management Policy requirements.	30/06/2024	01/10/2024	Off-Track	1a. Information Asset Owners 1.b Information Governance Manager 1c. Information Governance Manager	Mapping of data processed by HR, ER, OD has begun. Records Management Policy under review. 1c. Information Asset Owner became available via NHSEngland on 08072024 and this will be progressed internally to become available to staff.

1.b Audit of off-site storage and assurance on security and culling and destruction process being followed.	Review of off-site storage, with culling and destruction of over-retained records and a review of record practices.	30/09/2024		On-Track	Medical Records Manager	Review meeting 19/08/2024, with paper to IGG 2nd September 2024.

Trust Risk Register Aligned to Board Assurance Framework	1711: Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of patient and staff information.	

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

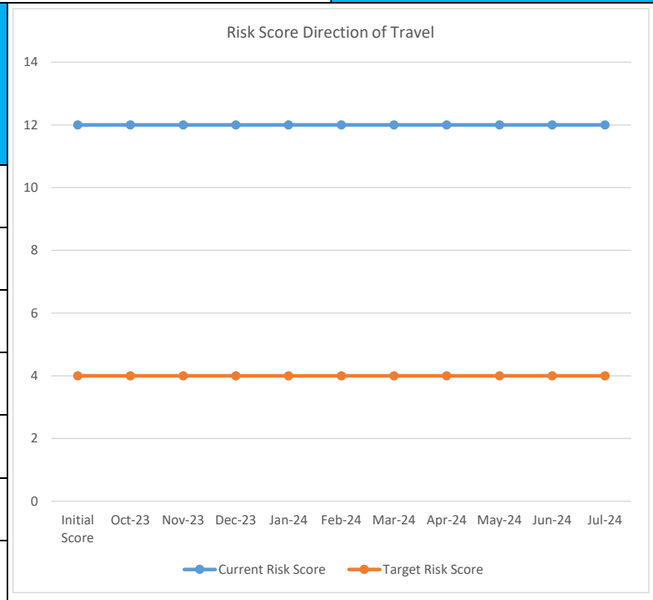
Date of Last Review:	16th August 2024
Date of Next Review:	5th September 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3d
Executive Owner	Chief People Officer
Operational Owner	Dominika Kimber, Deputy Chief People Officer
Primary Risk Grouping	People
CQC Domain	Well-Led

Objective:	To be the employer of choice and have the most highly engaged staff within the NHS
Principal Risk Name & Description	There is a risk the Trust is unable to retain sufficient levels of staff to ensure safe staffing levels, which results in higher turnover and in turn higher than expected levels of recruitment.
Relevant Group/Committee	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	**N**
Risk Score at Last Review	3	4	**12**	**—**
Current Risk Score	3	4	**12**	**—**
Target Risk Score	2	2	**4**	**—**
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Agency Spend	3.7%	2.7%	1.2%	2.1%	2.4%	1.5%	1.7%	1.9%	
HR KPI - Time to Hire (days)	42.0	60.0	66.0	61.0	55.3	47.9	54.0	57.4	
Care Hours Per Patient Day (CHPPD)	9.5	9.2	9.05	9.81	9.96	9.48	9.41	9.5	
Voluntary Turnover First 2 Years of Employment (in month)	1.0%	0.6%	1.4%	0.8%	0.8%	1.0%	1.9%	1.1%	
Voluntary Turnover (Annual)	12.0%	9.7%	9.4%	9.0%	8.7%	8.6%	8.6%	9.0%	
Contractual Vacancy Rate (%)	9.0%	3.4%	2.9%	8.0%	7.7%	7.6%	7.8%	6.2%	
HR KPI - OH pre-employment checks reviewed within 2 working days.	90.0%	9.0%	37.9%	43.3%	28.4%	63.0%	81.0%	43.8%	

Context Summary
(Patient First problem statement, current situation)

The Trust's refreshed People Breakthrough Objective revealed much higher than expected level of voluntary turnover in the first two years of employment. The overall voluntary turnover rate also exceeds the set target, which indicates difficulties with our ability to retain staff. Countermeasures developed through the People BO include proactive measures such as Stay Conversations, re-launched as part of the Intention to Leave process. High turnover leads to increased recruitment activity, which results in extended time to hire, poor candidate experience and Trust losing applicants during the recruitment process. High number of new employees requiring OH clearance also impacts on the team's effectiveness and the overall time to hire. Recruitment efforts continue to deliver safe staffing levels and enable the Trust to maintain vacancy rates below the set targets.

Rationale for Current Score

The Trust's metrics indicate that there are no risks to its ability to staff clinical or corporate areas substantively. Ongoing Junior Doctors' dispute with the Government risks of industrial action by all staff groups can have a negative effect on the staffing levels however this would be temporary and safe staffing levels would be ensured. There is however an indication that the candidate experience during the recruitment process results in the process being inefficient due to the number of candidates withdrawing before their appointment (this KPI needs to be developed).

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
1. NHS Long Term Workforce Plan and MFT People Strategy aligned to the Plan. 2. Retention programmes across Trust. 3. Attraction: Resourcing plans based on local, national and international recruitment. 4. Temporary staffing delivery: a. NHSE agency ceiling reporting in place; b. Monthly breach report to NHSE; c. Reporting to Board of substantive to temporary staffing paybill. 5. Workforce redesign: a. SDR review of hard to recruit posts and introduction of new roles; b. Reporting to People Committee apprenticeship levy and apprenticeships. 6. Operational: a. Operational KPIs for HR processes and teams reported monthly. 7. Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015 and international nursing offers in place. 8. Bi-weekly CNO led meetings focussing on recruitment, retention, education and develepment of nursing and midwifery and CSW staff 9. People Breakthrough Objective focussed on staff turnover in the first 24 months of employment	1. HR&OD performance meeting monitoring the People Strategy and operational HR KPIs. 2. 'Our People' true north and breakthrough is monitored through the Trust Management Board SDR. 3. Monitoring of KSS benchmarking during elevated national turnover. 5. Monthly SDR including discussion on workforce, vacancies, recruitment plan and temporary staffing. 6. Regular reports to People Committee a. Resourcing Report b. Temporary staffing utilisation c. Safe staffing report 7. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) 8. Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. 9. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Safe staffing levels for the periods of industrial action.	1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is an ongoing action for the periods of strike action.
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	2a. We are exploring robotic automation of the elements of the recruitment process with a view of outsourcing this process from another NHS organisation	31/08/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Exploring procurement routes
	2b. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Progressing well
	2c. Review of the end to end medical recruitment process. Recommendations for improved efficiency to be produced.	31/08/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is aligned with Action 3 - A3 on medical recruitment
3. We need to understand how we might improve our retention by preventing resignations.	3a.Stay Conversations to be offered as an action as part of Staff Survey action planning (where staff indicated intention to leave the organisation)	30/04/2024	Complete	Dominika Kimber, Deputy Chief People Officer	Action Plans for the identified areas include stay conversations
	3b. Develop Stay Conversations to be rolled out within the teams where turnover is higher than average.	30/03/2024	Complete	Lisa Webb, Associate Director OD	
	3c. Continue to embed Intention to Resign process within the divisions	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	HR BPs to address individual cases where resignation was not processed through the Intention to Resign process
	3d.Regular staff surveys to be rolled out, including Pulse Surveys and New Employee Surveys	30/09/2024	On Track/Not Yet Due	Lisa Webb, Associate Director OD	New action
4. We need to improve our understanding of the reasons why staff leave clinical areas difficut to recruit to.	4a.Intention to Resign process is going to be linked with the VCP process for vacant roles.	30/04/2024	Complete	Dominika Kimber, Deputy Chief People Officer	This approach is now in place and is being piloted, regular feedback from HR BPs is obtained
	4b. Continue to promote Intention to Resign process and Exit Interviews through team huddles and HR BPs.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
5. Consider implementation of recruitment and retention premia for difficult to recruit and retain roles, including medics	5. New approach to be explored with the system and new policy written.	30/04/2024	Overdue	Dominika Kimber, Deputy Chief People Officer	Development of an ESR report to identify difficult to recruit areas.
6. Improve performance of the Occupational Health team	6. Address staffing issues (FTEs and job roles) through the investment case	31/05/2024	Overdue	Lisa Webb, Associate Director OD	Outcome of the business case is pending 14/08/24 Business case

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

External labour market - addressed through annual skills demand profile through operational planning returns to ICB (education commissioning shortages) and continued international recruitment to address domestic skills shortage through ethical recruitment.
Our ability to retain staff through competitive rewards packages is limited due to the Trust's financial position and a natonally agreed rates of pay, therefore we plan to develop and promote Trust's Employee Value Proposition through the refreshed Employer Brand.

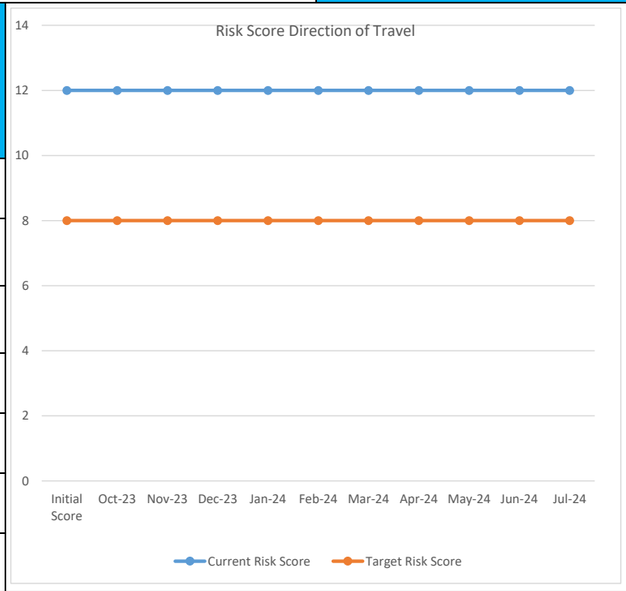
Date of Last Review:	12 August 2024
Date of Next Review:	12 September 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3e
Executive Owner	Chief People Officer
Operational Owner	Dominika Kimber, Deputy Chief People Officer
Primary Risk Grouping	People
CQC Domain	Well-Led

Objective:	To be the employer of choice and have the most highly engaged staff within the NHS
Principal Risk Name & Description	There is a risk that staff will not feel confident to raise concerns and that their concerns will be dealt with by the organisation. This may lead to worsening engagement levels and quality of patient care.
Relevant Group/Committee	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	**N**
Risk Score at Last Review	3	4	**12**	**—**
Current Risk Score	3	4	**12**	**—**
Target Risk Score	2	4	**8**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Staff Survey Engagement Score	6.93	6.63	6.65	6.65	6.65	6.65	6.65	6.65	
Staff Survey Question: *If I spoke up about something that concerned me, I am confident my organisation would address my concern* (Q25F)	48.7%	42.0%	41.5%	41.5%	41.5%	41.5%	41.5%	41.6%	2021,22 and 23 survey results are between 39% and 41%. National average is 47-48%
Staff Survey Question: *My organisation respects individual differences.* (Q21)	70.0%	65.7%	67.9%	67.9%	67.9%	67.9%	67.9%	67.5%	2021 survey - 61.7%; 22 Survey - 65.7%, 23 Survey - 67%. National average 70%
Staff Appraisal Rate	90.0%	88.8%	89.3%	88.9%	87.9%	88.6%	89.0%	88.7%	
Uptake of Management Essentials Training	120ANN	14	9	16	15	15	18	87	
New metric on incidents reported once we have sufficient data from the Anti-Bullying and Harassment Group									

Context Summary
(Patient First problem statement, current situation)

Our staff engagement across the Trust has improved slightly for the last three years; however, remains in the lowest quartile which impacts on our ambition to have a better work culture, improved productivity, improving patient experience and outcomes. Analysis of Staff survey questions which have the highest correlation with staff engagement levels releaved two questions where the gap to the national average result is the highest (e.g. If I spoke up about something that concerned me, I am confident my organisation would address my concern and My organisation respects individual differences.). This indicates that, in order to improve staff engagement, we should address lack of confidence in the speak up process and perceived lack of respect of individual differences by the organisation.
The Trust has been in the lowest quartile for staff survey results (score 6.63, rank 94/126) for staff engagement for the last five years but has improvement in the last financial year to the threshold between quartile 3 and 4 having improved by 18 trust rank score.
National Staff Survey 2023 return rate shows decline in staff engagement with the Survey, from 40% in 2022 to 37% in 2023.
There appears to be an increase in staff raising concerns using formal channels, these relate to violence and aggression in ED and more general reports of bullying and harassment.
Current management essentials training does not link management / leadership behaviours with staff engagement levels.

Rationale for Current Score

Key Existing Controls
(What are we currently doing about the risk?)

1. Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'
2. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian
3. Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change which is embedded in induction.
4. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme.
5. Communication routes well established in Trust
6. Freedom to speak up guardians are in place.
7. VBR in place Qualitative and quantitative values-based appraisal to continue to embed values into the Trust culture.
8. Culture Intervention: Principles of 'Just Learning Culture' are embedded in all HR processes and into training (e.g. management essentials, Trust Induction) delivered to staff.
9. New Starter Survey ICB led project is under way and the results are being analised.
10. Refreshed Strategic Leadeship Initiative (Leadership and Behaviours)

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. HR&OD performance meeting monitoring the People Strategy and operational HR KPIs.
2. JSC and JLNC in place.
3. 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan)
4. Annual report to the Board on staff survey results
5. Regular reports to People Commitee:
   a. Freedom to Speak Up Guardian report
   b. Leadership Development programme
   c. Wellbeing Guardian quarterly assurance report
   d. Staff survey results annual report
6. New Starter Survey (ICB) will be analised and actions reported to the People Committee.
7. Welcome On-Board meetings have restarted and feedback is collated for repoirting to the People Commitee.

Gaps in Controls	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. We need to ensure that Leadership and Management behaviours make a clear link with staff engagement levels. This is part of the People Startegic Initiative.	1. Staff Compact to be reviewed and updated to include new / additional leadership behaviours. This links with the NHSE Behaviours Framework which is being developed.	01/10/2024	On Track/Not Yet Due	Lisa Webb	Whilst awaiting the national Behaviours Framework, we are starting development of examples of negative behaviours through engagement with staff and network reps. 12/07/24 Head of ED and OD have gone out to the
2. Management essentials to be reviewed to identify gaps which deliver skills required to improve staff engagement levels. This is part of the People Strategic Initiative.	2a. In conjunction with colleagues in East Kent, review our management essentials offer and identify modules for development / collaborative work. This links with the NHSE Behaviours Framework & Management training which is being developed.	01/10/2024	On Track/Not Yet Due	Lisa Webb	Head of Wellbeing and Staff Experience & Head of OD are liaising with East Kent to progress .12/07/24 - OD are developing questions/survey for an evaluation form to support the measurement of impact of the training. 14/08/24 First iteration of survey avialable on impact.
	2b. Launch of Leadership and Manangement Matrix	01/10/2024	On Track/Not Yet Due	Lisa Webb	3/08/24 Matrix complete and approved. Mapping to leaders and managers on ESR underway, comms prepared in readiness for launch
3. Currently we have little data which could be used to improve staff retention e.g. reasons behind our high turnover of staff in the first two years of employment.	3. Design Stay Conversations which will be rolled out to the teams/departments as a proactive retention tool.	30/03/2024	Complete	Lisa Webb	
4.We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	4a. ICB New Starter Survey 2023 results need to be analised and actions assigned to the respective teams.	01/09/2024	On Track/Not Yet Due	Lisa Webb	In depth analysis of the data is underway. A dedicated T&F Group will be established to discuss actions. 12/07/24 This has been on hold due to vacant Head of Well being and staff experince. To commence August 2024. 13/08/24 New strater survey - welcome
	4b. MFT own New Starter Survey, replicating ICB survey is going to be launched.	01/08/2024	Complete	Lisa Webb	New Head of Wellbeing and Employee Experience will be taking this action forward . 12/07/24 Welcome Aboard survey to commence July 2024 13/08/24 Welcome Aboard has been launched
5.We need to see an increase in appraisal completion and ensure that the level is sustained.	5a. Identify areas where completion falls below 90% and raise in care group/team meetings.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Action to be progressed by HR BPs.
	5b. Appraisal completion rates to be discussed at the weekly Exec meeting for Executive actions	Ongoing	On Track/Not Yet Due	Lisa Webb	
6. We need to improve perception of appraisals and their addedd value, to improve engagement levels.	6. QA process to be rolled out. Feedback to be provided to the HR and OD Performance Group.	31/03/2024	Complete	Lisa Webb	
7. Review Trust's Freedom to Speak Up Policy and process for comissioning investigations.	7. FTSU process has been reviewed. Policy needs to be updated and published.	31/01/2024	Complete	Katrina Ashton	
8. We need to provide staff with alternative ways of raising concerns with the organisation.	8. Launch and promote Dignity at Work Advisors.	31/01/2024	Complete	Dominika Kimber, Deputy Chief People Officer	
9. Improve staff confidence that the organisation listens to their concerns and implements improvements.	9a. Communicate lessons and improvements implemented from staff feedback and concerns/grievances. Design a dedicated intranet page where these reports will be accesible.	30/06/2024	Complete	Dominika Kimber, Deputy Chief People Officer	
	9b. To launch and promote new FTSU process	30/09/2024	On Track/Not Yet Due	Leon Hinton, CPO	
	9c. To support engagement carried out by Sylvia Stevenson	30/09/2024	On Track/Not Yet Due	Leon Hinton, CPO	

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

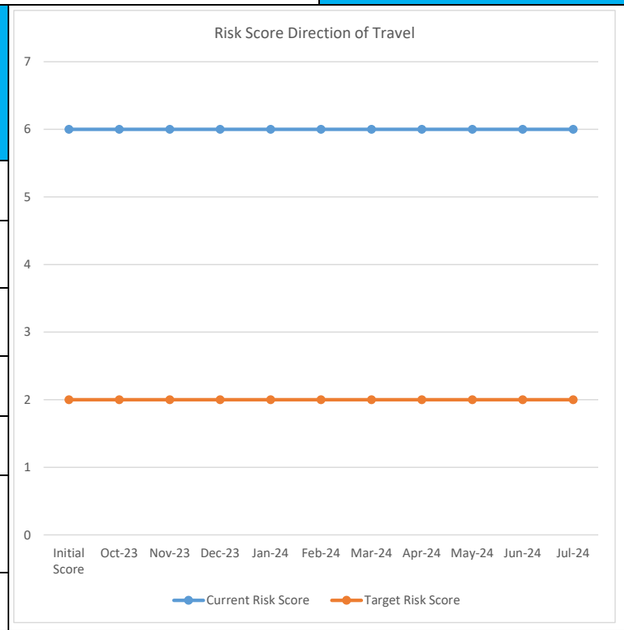
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)	
Factors which are external to the Trust and not in our control are likely to have a negative impact on staff engagement and morale (worstening financial situation, cost of living crisis, recession).	
Date of Last Review:	12 August 2024
Date of Next Review:	12 September 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3f
Executive Owner	Chief People Officer
Operational Owner	Alister McClure, Head of Equality and Inclusion
Primary Risk Grouping	People
CQC Domain	Well-Led

Objective:	To be the employer of choice and have the most highly engaged staff within the NHS
Principal Risk Name & Description	Should the Trust fail to deliver its strategic objectives relating to EDI, there is a risk that our people will not be able to thrive at work and that the Trust will not meet its statutory obligations to its employees. This may lead to poor employee experience and negative impact on staff wellbeing, both at work and in general. IMPACT: Failure to meet the requirements of the Equality Act 2010; increase in staff turnover; increase recruitment and retention challenges; and therefore impact negatively on quality of patient care and experience.
Relevant Group/Committee	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	2	**6**	**N**
Risk Score at Last Review	3	2	**6**	**—**
Current Risk Score	3	2	**6**	**—**
Target Risk Score	1	2	**2**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
WRES 5 and 6	29% 20%	35.86% 25.4%	35.86% 25.4%	35.86% 25.4%	35.86% 25.4%	35.86% 25.4%	35.86% 25.4%		WRES 5 - % of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. WRES 6 - % of BAME staff experiencing
WRES 8	15.0%	18.1%	18.1%	18.1%	18.1%	18.1%	18.1%		% of BAME staff responding to say they had personally experienced discrimination at work from managers, team leaders, or other colleagues
WDES 4a I and 4a ii	33% 15%	34.5% 19.5%	34.5% 19.5%	34.5% 19.5%	34.5% 19.5%	34.5% 19.5%	34.5% 19.5%		% of staff with a lon term illness experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months; and % of staff
WDES 4b	48.0%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%		% of staff with a long term illness saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months
WDES indicator 8 (Reasonable Adjustment)	75.0%	70%	70%	70%	70%	70%	70%		% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
% BAME Staff at Band 8a and above (AFC)	20.00%	n/a	n/a	n/a	16.90%	16.90%	16.90%		Baseline established from the WRES Data. % of AfC Band 8a and above who are BAME. (Whole workforce BAME % AfC is 32%; target set as an in year stretch to 20%)
Medical staff Gender Pay Gap	15.0%	N/A	17.9%	17.9%	17.9%	17.9%	17.9%		Changed to Medical Pay Gap, as this is the main driver of our pay gap

Context Summary
(Patient First problem statement, current situation)

The measures of equality, diversity and inclusion, as expressed through the Workforce Race and Disability Equality Standards (WRES, WDES) and gender pay gap demonstrate areas of disproportionality lower than expected protected characteristics as a ratio of the Trust population. This in turn may have a direct impact on staff engagement from underrepresented groups, lower diversity of thought, lower motivation, which in turn can also affect staff performance, professional conduct, quality of patient care and retention.

Rationale for Current Score

WRES and WDES are currently only assessed annually; periodic calculations could be made only for the quantifiable measures such as pay gaps.

Key Existing Controls
(What are we currently doing about the risk?)

1. Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure EDI elements are embedded and aligned to NHS Long Term Workforce Plan and People Promise
2. Action Plans are in place for the WRES, WDES and in development for the Gender Pay Gap
3. Key policies include Anti-bullying, Harassment and Conflict Resolution, and Reasonable Adjustment and Modified Duties.
4. Right skills: 30 Advisors and 60 investigators trained in Dignity at Work (bullying and harassment) complaints; EDI Mandatory Training and EDI element of Management Essentials
5. Culture Intervention: Culture and wellbeing programmes (including NHSEI Culture, Engagement and Leadership programme), wellbeing champions, staff equality networks
6. Non-Executive Wellbeing Champion; Executive Champions for some staff networks
7. Staff networks in place: LGBTQ, BAME, Disability and Wellbeing (DAWN), Womens'. Development of the Faiths and Beliefs (FaBs) Network
8. Revision and further communication of the Anti-Discrimination Statement

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. 2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting)
2. 'Our People' programme fortnightly review meeting which includes the NHS People Plan
3. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.
4. Regular reports to the People Committee and the Equality and Inclusion Steering Group, including:
   a. Freedom to Speak Up Guardian report
   b. Leadership Development programme
   c. Wellbeing Guardian quarterly assurance report
   d. Staff survey results
   e. IQPR data
   f. EDI Metrics (Pay Gap, WRES, WDES, and Action Plans)
   g. Staff survey results
   h. Statutory mandatory training update

Gaps in Controls

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff.	1a. Review of the People Startegic Initiative (Leadership and Behaviours) and implementation of the agreed actions.	Ongoing	On Track/Not Yet Due	Dominika Kimber	
	1b. Development of Behaviours Framework (aligned with Trust Values, incorporating all existing tools referencing behaviours e.g. Compact, Our Leadership Way, Nolan Principles)	31/12/2024	On Track/Not Yet Due	Esther Sodunke/Lisa Webb	NHSE plan to develop a similar Framework - we are liaising with them to check how this work may overlap . 12/07 National framework launching in October to take forward once launced
	1c. Development of examples of negative staff behaviours to be included in the Behaviours Framework	30/10/2024	On Track/Not Yet Due	Alister McClure / Kiran Mann	Consultation with staff networks initially, using examples of negative/uncivil behaviours recorded to Datix 12/07/24 Will have by the end of September following feedback rebiew
2. Executive team and Trust Board have committed to EDI Objectives as part of their personal objectives (HIA1); although now signed off, work is required over 2024/25 to support delivery of those objectives	2. Periodic meetings with Executive Team and whole board to support delivery of HIA1 Objectives that were agreed before 31 March 2024	31/07/2024	Complete	Alister McClure	HIAs now developed; quartlery check from August, BAU
3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactve measures can be taken.	3a. Anti-bullying and harassment group to be reviewed and re-established.	31/01/2024	Complete	Dominika Kimber	Reviewed and meeting monthly
	3b. All Network Leads were offered regular informal meetings with Senior HR team to offer an opportunity to discuss issues in confidence and to agree what actions should be taken	30/04/2024	Complete	Dominika Kimber	Metings are now taking place monthly
	3c. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan)	31/01/2024	Complete	Dominika Kimber	Published and communicated
	3d. New duty to protect staff from sexual harassment and actions relating to the Sexual Safety Charter will be embedded into Trust's policies and processes	31/07/2024	Overdue	Dominika Kimber	Reviewing poicies and drafting policy statement. Sourcing online training
	3e. Trends reported by the Anti-Bullying and Harassment Group to be dicussed within divisions and directirates and actions taken reported for assurance to the ABH Group	Ongoing	On Track/Not Yet Due	Leon Hinton, CPO	
4. Advice and signposting regarding concerns around discrimination (bullying and harassment) must be easily accessible and volunteer advisors must be competent and trained in their roles.	4a. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI.	31/01/2024	Complete	Alister McClure	Programme launched in February

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Poor adherance to the Trust values may lead to the worstening employee and patient experience with negative impacts on quality of care and patient safety and the Trust's reputation amongst the patients, their families, current and prospective employees.

Date of Last Review:	12 August 2024
Date of Next Review:	12 September 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4b	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Tanya McKie, Divisional Director of Operations	**Principal Risk Name & Description**	Not meeting the RTT standards brings a risk to the quality of care we are providing our patients as well as their overall experience.
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	2	4	**8**	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
RTT Incomplete Performance	92.0%	51.4%	50.6%	51.3%	51.75%	51.21%	50.00%	51.0%	

Context Summary
(Patient First problem statement, current situation)

% of patients that have been treated within 18weeks from referral to treatment

Rationale for Current Score

Risk reviewed and still remains appropriate. RTT postion continues to decline. The total number of patients over 65 weeks has increased largely due to endoscopy. Mutual aid for Endoscopy continues with Dartford and outsourcing to PPG, both organisations now taking RTT patients. Ongoing Industrial action has also had a negative impact waiting times due to clinic cancellations

Key Existing Controls
(What are we currently doing about the risk?)

The trust had 18 x 78 week breaches majority of which relate to ENDO and all related to endoscopy capacity. 3 78 week waits due to ENT
A request has come from exec to complete an affordability chart on elective WLI which will be done in the next few weeks.

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

Weekly RTT meeting including robust review of RTT process
Reports direct to COO
Monthly reporting to TMB
Focus on clinical urgent and then long waits
Patient P control in operation
Use of ERF monies to support increased activity
Breach validation plus clinical harm

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. There is a risk associated with the junior doctor strike which has increased the PTL.	1 - Cancellations continue in line with IA in order to provide safe care on wards	Unknown	Complete	Trustwide	
2. Increase risks due to onging industrial action	2 - Cancellations continue in line with IA in order to provide safe care on wards	Unknown	Complete	Trustwide	
3 Lack of Endoscopy capacity in K&M	3-Ongoing work with ICB/NHSE to provide additional capacity	Unknown	Complete	Nicola Cooper	
4 Lack of RTT training programme for operational managers	4-Training programme design underway for non-clinical and clinical staff	01/07/2024	On Track/Not Yet Due	Nicola Cooper	

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Trust has agreed to hit no 65 week breaches by September 2024.
Increase in winter presentations may negatively impact RTT performance.
No sustainable long term solution for Endiscopy currently - continuing with mutual aid to support Cancer/RTT/DM01 performance. In the short term the Trust have agreed a fund a mobile endoscopy unit to be situation at the acute site for the next 12 months to support with additional capacity whilst long term plan considered

Date of Last Review:	15 August 2024
Date of Next Review:	15 September 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4c	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Nicola Cooper, Divisional Director of Operations	**Principal Risk Name & Description**	Lack of operational performance for example not meeting constitutional measures (new quality indicators)
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	3	4	**12**	—
Current Risk Score	3	4	**12**	—
Target Risk Score	1	4	**4**	—
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Average time in EC Dept (mins)	7	389.0	335.4	300.9	306.01	317	316.9	327.5	
Ambulance HO delays > 60mins	0	5	6	3	3	2	2	4	
ED 12 Hour Breaches	0	798	798	523	588	618	661	664	
IP Discharge Before Noon	40%	14.6%	12.9%	12.6%	14.0%	12.2%	16.7%	13.8%	
Total ED 4 Hour Performance	78%	70.4%	77.6%	81.1%	78.6%	78.6%	78.7%	77.5%	

Context Summary
(Patient First problem statement, current situation)

The Trust is currently achieving national KPIs of 78%, the Breakthrough objective for flow and discharge is to achieve 76% performance for ED consistently by December 2024. This has been met month on month since March 2024. Our ambition is to improve flow across the Trust and reduce patient waiting times. This will support our ED performance targets, avoid delays and contribute to smooth flow through the organisations.

Rationale for Current Score

The score reflects the continued challenge and deterioration with our MFFD position and the estate/evironment restrictions that impact on the ability to achieve escalation capacity. However these controls are strengthened by the current Flow and Discharge Programme under the Patient First Programme, and ongoing work to explore alternatives to ED, admission and delayed discharge.

Key Existing Controls
(What are we currently doing about the risk?)

Continuing to embed the Acute Medical Model
Reviewing the Full capacity protocol, opel triggers and actions
Embeding fit to sit/pulling next patients to wards
Focused work through the HARIS group
Reviewing existing protocols and processes to achieve improvements
Improving relationships with SECAmb and working in partnership has mitigated high numbers of ambulance handover delays increace in Virtual beds to 155 by end of Q4 currently av. 75 virtual beds for early supported discharge and admission avoidance
Single Point of Access pilot - completed, looking at restart of interim model with full rollout in October 2024
Rota of Senior Operational staff on the shop floor
safeHaven 24 hour mental health provision

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

Ongoing review of current systems and processes
Breakthrough huddles weekly
SDR score card reflecting performance
Safer staffing huddles to support safe flow
Care group SDRs currently being implemented
Dedicated daily support on the floor to prevent 4 hour breaches
Live validation and review of 4 hour breaches

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. Need to consider benefit realisation for the Acute Medical Model and unintended consequences Standard work for Board Round Processes	1. Care Group to review and implement and bring to Divisional management Board.	31/03/2022	Complete	Linda Stevens, General Manager / Kathy Ward, Head of Nursing / Chris Parokkaran, Clinical Director	
2. Full utilisation of community capacity at all times to support flow	2. Exec escalation for ICB support.	01/04/2024	On Track/Not Yet Due	Linda Stevens, General Manager / Kathy Ward, Head of Nursing / Chris Parokkaran, Clinical Director	
3. Review In-reach support from Spec Med to ED	3. Review current in-reach with clinical leads	19/03/2024	Overdue	Chris Parokkaran/Nicola Cooper	SOP drafted for expectations of in-reach. Next draft to include CSN
4	4				

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Heatmap of ED doctor rota complete - potential of moving overnight staffing to daytime to meet activity requirements

Date of Last Review:	06 August 2024
Date of Next Review:	06 September 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4d	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Nicola Cooper, Divisional Director of Operations	**Principal Risk Name & Description**	Shared quality of care and performance across the heath and Care Partnership may impact on the Trusts quality and safety through increased ambulance handovers, patient acuity, mortality and admissions.
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, ▬, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	3	**12**	▬
Current Risk Score	4	3	**12**	▬
Target Risk Score	1	4	**4**	▬
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Total ED 12 Hour Breaches	0	798	798	523	588	618	661	664	
Total 4 hour performance	78%	78.4%	77.6%	81.1%	78.6%	79.3%	78.7%	79.0%	
>14 day LOS		380	375	397	382	391	399	387	Currently based on sum of 'Those discharged between 14 and 20 days' and 'Discharged 21 Days or Over'
#NCTR								#DIV/0!	Due to the TT deployment BI are not able to supply figures from October.
Average wait to 1st OPA (days)	60	104.18	103.42	106.82	105.26	108.92	103.3	105.3	

Context Summary
(Patient First problem statement, current situation)

There is a risk that conflicting priorities, fianancial pressures and/or ineffective governance results results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care. Examples of this could included but are not limited to: changes in ambulance attendances resulting in increased demand and poorer patient experience, increase in Medically Fit for Discharge (MFFD) patients 'blocking' access to Acute hospital beds, and increases in levels of risk held within the Acute setting.

Rationale for Current Score

Conflicting priorities, infancy of ICB and systems and processes supporting are not yet well established. Despite this, good working relationships exist with focus on key metrics for all providers, and established forums to capture and resolve unintended consequnces of any sytem-based decisions. Deterioration in performance of system partners (community, Medocc) contributing to increased risk in last quarter, additionally the sustained high number of NCTR patients in MFT beds.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
• LAEDB - Oversight dashboard • Kent and Medway Integrated Care Board • Kent and Medway Intregrated Care Partnership Joint Committee • Joint development of plans at ICS level • Kent CEOs Meeting • Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans • Trust-wide Flow and Discharge Corporate Project	• Dashboard capturing actions and unintended consequences on system partners • Evidence attendance at ICS and ICP meetings • Updated ICP and ICS risk register, reflecting input from system organisations • Risk Report monthly • Finance Committee report to Board • Internal review and monitoring of access to care metrics with exec oversight

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. LAEDB Refresh, pulling together renewed dahsboard to capture actions and impact across all agreed system KPIs	1. Review of LAEDB ToR, agenda and required reports	31/08/2023	Complete	Chief Operating Officer	Extended due to AL in July.

2. Trajectory for Medocc Performance		2. To work with MEDOCC to agree trajectory for sustained improvements	31/08/2023	Overdue	Chief Operating Officer	Some incremental improvement seen but not yet sustained
3		3				
4		4				
Trust Risk Register Aligned to Board Assurance Framework			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)						
Date of Last Review:	08 August 2024					
Date of Next Review:	08 September 2024					

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4e
Executive Owner	Chief Operating Officer
Operational Owner	Tracy Stocker, Director of Operations for Flow & Integration
Primary Risk Grouping	Systems & Partnerships
CQC Domain	Safe

Objective:	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Principal Risk Name & Description	There is a risk of financial impact if we are unable to increase flow and close escalation areas.
Relevant Group/Committee	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	16	N
Risk Score at Last Review	4	4	16	—
Current Risk Score	4	4	16	—
Target Risk Score	1	4	4	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Average**	**Comments:**
Pre Noon Discharge - G&A Adult > 1 Day LoS (Including Transfer to ADL)	40%	14.6%	12.9%	12.6%	14.0%	12.2%	16.7%	13.8%	
Avg. Length of Stay - G&A Adult > 1 Day LoS	7	11.7	12.1	11.5	11.1	11.1	12	11.6	
Bed Occupancy - G&A Adult > 1 Day LoS	92%							#DIV/0!	Due to the TT deployment BI are not able to supply figures from October.
NCTR at Midnight (count) - Month Average	80	112	96	101	98	104	104	102.5	
IP Discharges - - G&A Adult > 1 Day LoS (Including Transfer to ADL)		1812	1920	1861	2096	1908	2061	1943	

Context Summary
(Patient First problem statement, current situation)

The Trust has a high number of escalation beds open due to high demand for beds and reduced care capacity which is impacting discharge numbers and flow. The functioning of these escalation area's puts added pressure on the financial position of the Trust, as well as placing pressure on the wellbeing of our clinical teams as staffing levels are spread over a wider demographic throughout the Trust. By focusing on reducing the length of stay of our inpatients will increaces the potential for the reduction of escalation beds and will have a posative impact on both financial and operational efficiencies.

Rationale for Current Score

The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity our increase in patients without a criteria to reside (100 - 150) and the low discharge profile reduces flow and increases demand for bed capacity. The improvement activity taking place requires a cultural and transformational change as well as informed training to support best practice which will take some time to fully embed.
The availability of residential and home care capacity has been significantly impacted by many factors including cost of living, reduced funding and the impact of the covid pandemic. The impact of this has left MFT with very high numbers of patients across our bed base without a criteria to reside. These patients are at risk of functional deterioration and further complications from hospital acquired infections and disability, tissue damage and low mood. The combined impact of reduced care capacity and increased LoS in an acute bed is not only costly, more importantly it impacts the well being of our patients and staff. There are many things causing increased length of stay for patients without a criteria to reside that are not within our gift to improve, however efficiencies can be made in reducing LoS for patients not requiring care after discharge (PW 0), including standardised processes and discharge planning. in addition to this there is a risk relating to data quality regarding discharge date and time, this is currently being investigated to ascertain the extent of the issue and develop process to mitigate this.
There are increased delays to dscharging PW1 and PW3 patients dur to a change in comissioned services for Medway PW2, lack of availability for complex nursing PW3 placements. TS is working with partners to resolve these issues and new PW2 pathways being developed which will enable time monitoring. Ongoing system demand is continuing to impact flow and ED capacity. There are still delays in discharging ps via PW1 -3. MFT requires assurance from system partners on availability for on-ward ToC and pathway work to improve discharge opportunities.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The Trust has alined the reducing LoS work into a corporate project within Patient First Flow and Discharge, this is focusing on systems and processes that will improve discharge planning and expedite the patients journey home. A training programme is being developed to ensure consistency and standardisation in Board Rounds to support actions for early discharge planning and avoid unneccesary delays to discharge. A National MADE requirement has enabeled us to review board round functions, attendance and processes; there is also a large amount of data from this event which will help us identify oportunities for improved flow and reduced delays. The wards should apply a full MDT conribution to the care and consequent discharge of our patients following SAFER princiles and the Red to Green concept. Integrated Duscharge Team (IDT) are SME's regarding discharge pathways and processes, they work with LA and and community partners and support ward teams across the Trust with discharge planning and management of PW 1-3 and complex patients. TeleTracking, Virtual Wards and the opening of Amhurst Court beds will support reducing bed occupancy and improve transfer of care timeescalse. these mitigations will require time to bed in (Amhurst Court to Open)	Regular management meetings to monitor and support progress on improving discharge processes throughout the Trust. This is monitored via; Flow and Discharge Corporate project, These workstreams review current position on a regular basis as well as seek further opportnities whilst following Patient First methodology, improving pre-noon discharge breakthrough objective hudles, HCP Discharge Group, Efficiencies Group and LAEDB. Data dashboards including the Flow dashboard (MFT) and the Discharge dashboard (HCP) to capture current performance and help create realistic trajectories for improvement moving forward.

Gaps in Controls	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. An operational plan that supports the closure of escalations area's. Full collaboration with system partners in discharging patients that have no criteria to reside in an acute bed. Cultural change within clinical teams across the Trust. Training programme that emphasises golden standard discharge processes.	1. Both Divisions providing senior oversight of BR's to support discharge planning against EDD.	31/03/2023	Complete	Divisional Management Teams	New action to be agreed as part of the Corporate programme to improve flow and reduce LoS 16/02/24 Action complete, BR improvement within the new F&D corporate project. Asurance via 4th action below
2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MDT, Snr review	2. Each care group attends a LLoS meeting BiWeekly chared by6 DoOF&I	31/10/2023	Complete	Care Group Management Teams	update 20/11/23 these meeting are in diaries and LoS for all IP >14 days for CTR and NCTR
3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS	3. HaCP discharge group reviewing pathways via an action plan following the Vital Hub audit	31/08/2024	On Track/Not Yet Due	Tracy Stocker, Director of Operations for Flow & Integration	action plan has been drawn up by the HCP discharge group, however, HCP have delayed the review of the pathways until Jan. TS has discussed this with the COO and is writing a PID for a solution to this. 16/02/24 HACP decideing on plan to review, MFT waiting for HaCP exec decision. All discharge related work through the HCP has been stopped pending HCP / ICB decisions on the Transfer of Care functions. this is due in Q2 of 24/25.
4 Board Round improvement as part of the reducing LoS CP.	4. Re-embed SAFER, red2green and operationalise electronic BR's as part of the Flow and Discharge Corporate Project6	31/08/2024	On Track/Not Yet Due	Tracy Stocker, Director of Operations for Flow & Integration	Work with the care groups has started. Work with Sapphire and with Planned care ward commenced in early november 16/02/2024 Five wards have been supported with BR and escalation improvement. Further wards to be planned.

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

The Trust regularly has 100+ patients bedded within the Trust that have no criteria to reside. Exploratory work needs to be constructed to understand what can be done to expedite the journey home for these patients. Initial focus should be on pathway 0 patients that require little intervention and are within the Trusts own ability to discharge.
The KPMG Audit on Discharge Data published in April along with the Vital Hub audit on LoS and discharge processes have a number of recommendations being reviewed at HaCP level alongside the Patient First Flow and Discharge project to make improvements. This will form basis for all future training materials as processes will be confirmed, creating a standardised approach to discharge throughout the Trust and allow Clinicians to embed the golden standard of discharge that our patients expect.

LoS efficiency work to support effective Board Rounds (sept '23), Virtual wards and the mobilisation of 41 beds at Amhurst Court in October will support the trust in reducing LoS across the acute wards. There is an element of concern with our partner organisations ability to meet the demand for PW 1-3 moving into winter and MFT are working with the wider HaCP to manage these pathways more efficiently and to mitigate additional risk of increased LoS and reduced flow across our beds.

All discharge work relating to the HCP has been paused pending ToC development and review. MFT have started a programme of work through the Flow and Discharge corporate project to improve discharge planning and EDD setting which will lead to improvements in LoS and bed occupancy. it is acknowledged that this needs to be a back to basics approach that is delivered to be fully embedded.

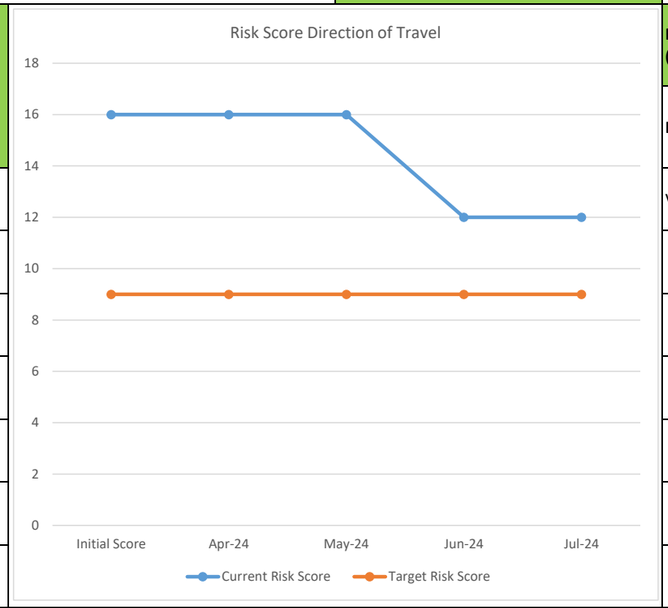
The Board Rounding project requires some PMO / Transformation resource to move forwards, this is a mission critical corporate project and this additional resource is recognised a fundamental success to re-educate and embed SAFER BR process. The HCP is still reviewing ToC services and no improvement work will be commenced regarding discharge, ToC Hub, reducing complex pathways until this review and remodel has been completed. MFT have commenced the Faculty Frontier AI project which will work on EDD accuracy and support discharge planning. run concurrently with the BR project we should be in a position to reduce this risk. there are no timescales set for this yet.

Date of Last Review:	13 August 2024
Date of Next Review:	13 September 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5a	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Delivery of the in-year control total
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	3	**12**	▼
Current Risk Score	4	3	**12**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**YTD**	**Comments:**
Variance to control total	0.0	2.6	1.3	-0.3	0.1	-0.3	0.0	-0.5	YTD position is for 2024/25 only, i.e. from April 2024. Adverse due to industrial action costs in June - assumed this will be managed nationally.

Context Summary
(Patient First problem statement, current situation)

The Trust agrees a plan at the start of the year with the ICB and NHSE – the deficit that has been agreed (after technical adjustments) is known as the Trust's control total and equates to £27.8m in 2024/25.
Performance in recent years has been adverse to that control total (including after "allowable misses").
Given the inherent risks within the plan (e.g. current position on unidentified/unapproved efficiencies) there is a risk that the Trust does not meet its control total.
The Trust currently remains in NHSE's Recovery Support Programme ("RSP") as a result of its financial performance.

Rationale for Current Score

The Trust is reporting £0.5m adverse to plan for Q1, arising due to industrial action costs. Our current working assumption is that there will be a national solution for such expenditure or that it will otherwise be an "allowable miss".
The Trust has an unmitigated forecast outturn risk of c£12m - mitigations against this risk are known and under implementation, however there is a residual risk estimated of c£4m at this time. The consequence is therefore currently considered to be "moderate / 3".
Until such time as there is greater assurance over these items the probability of variance is considered as 31-90% and hence is "likely / 4".

Key Existing Controls
(What are we currently doing about the risk?)

- Approved Integrated Improvement Plan ("IIP") with core workstreams and key enablers, including a workstream in respect of 24/25 financial plan delivery.
- Robust business planning/budget setting
- Weekly executive-led check and challenge sessions re. efficiencies/mitigations
- Access operational group
- Budget statements/budget holder meetings
- Full staffing of PMO
- NHSE Improvement Director support and NHS Intensive Support team
- Application of "Grip and Control" checklists, and "Core/Level 2-3-4" NHSE controls
- Self-assessment and implementation of HFMA sustainability checklist
- VCP and enhanced non-pay controls

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

- Weekly Breakthrough Objective huddle
- Check and challenge reporting
- Finance, Planning and Performance Committee reporting, coupled with Trust Board reporting
- SDR's
- Appraisals / objective setting
- Oversight and RSP meetings
- External and Internal Audit

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. Roster controls /demand templates	1a. Medical staffing project underway to deliver a roster solution.	31/03/2025	On Track/Not Yet Due	Chief Medical Officer	Roster specialist recruitment underway.
	1b. Reconciliation of budgets to rosters	~~31/07/2024~~ 30/09/2024	Overdue	Finance Business Partners & HR	A number of care groups have had their rosters and budgets reconciled. Work is ongoing to complete this work, which is anticipated by end of Q2.
2. Budget sign-off 24/25	2. Budgets to be signed off by divisions	31/07/2024	Overdue	Finance Business Partners	All clinical divisions budgets have been signed off by divisonal leadership. Some Corporate budgets outstanding, but no issues anticipated.
3. Documented Standard Operating Procedure for month end variance analysis and forecasting.	3. Approval of SOP	31/08/2024	On Track/Not Yet	Deputy Chief Financial Officer	Issued to FPPC for approval

Trust Risk Register Aligned to Board Assurance Framework	2057: Unfunded inflation	Current Risk Score: (4 x 3 = 12)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)
	2055: ERF / Elective recovery plans	Current Risk Score: (5 x 3 = 15)
	2052: 24/25 efficiency programme	Current Risk Score: (5 x 4 = 20)
	1861: Cash holdings depleting may result in Trust running out of cash	Current Risk Score: (4 x 2 = 8)

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Industrial action at the end of June 2024 was not assumed as part of business planning. Expenditure in month 3 to cover this action was c£0.5m.

Date of Last Review:	14 August 2024
Date of Next Review:	15 September 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5b	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Delivery of the Trust's financial strategy
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	3	3	**9**	▼
Current Risk Score	3	3	**9**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**YTD**	**Comments:**
Number of open Oversight Framework 4 exit criteria for finance	0	6	6	6	6	6	6		The Trust had an oversight meeting on 22 July with the next due in September. We are targeting a December exit.

Context Summary
(Patient First problem statement, current situation)

The Trust strategy sets out a vision of underlying breakeven (transition out of deficit) by 2028/29, although we are challenging ourselves (and being challenged) to achieve this earlier. Without clear enablers, system and NHSE support and full alignment to the clinical strategy, this could be at risk.
The Trust currently remains in SOF4.

Rationale for Current Score

The Trust Board has approved the Integrated Improvement Plan.
On the basis of Systems and Partnership governance risk, this is considered "moderate" / 3. The likelihood is deemed "possible" / 3.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Patient First True North and governance - Trust Board approved Finance Strategy - Working alongside NHSE Intensive Support directors - Development and implementation of an IIP - ICS financial recovery work being undertaken (of which the Trust is engaged)	- Self-assessment against the exit criteria - Delivery/monitoring against IIP - Oversight and RSP meetings

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Findings from KPMG report remain open	1. Implementation of KPMG financial improvement recommendations	Various	On Track/Not Yet Due	Various	Monthly update reporting to Trust Executive group. 26/60 actions closed.
2. Exit from Oversight Framework level 4	2a. Implementation of IIP	Various	On Track/Not Yet Due	Various	IIP approved through Trust Board. Implementation ongoing.
	2a. Tracking of IIP	Monthly until exit	On Track/Not Yet Due	Chief Delivery Officer	Submissions ongoing

Trust Risk Register Aligned to Board Assurance Framework		
	2058: Unchecked staff growth	Current Risk Score: (5 x 3 = 15)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)
	2060: Capital allocation vs requirements	Current Risk Score: (5 x 5 = 25)
	2057: Unfunded inflation	Current Risk Score: (4 x 3 = 12)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)
	2055: ERF / Elective recovery plans	Current Risk Score: (5 x 3 = 15)

	2052: 24/25 efficiency programme	Current Risk Score: (5 x 4 = 20)
	1861: Cash holdings depleting may result in Trust running out of cash	Current Risk Score: (4 x 2 = 8)
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)		
Date of Last Review:	14 August 2024	
Date of Next Review:	15 September 2024	

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5c
Executive Owner	Chief Financial Officer
Operational Owner	Deputy Chief Financial Officer
Primary Risk Grouping	Sustainability
CQC Domain	Well-Led

Objective:	Living within our means providing high quality services through optimising the use of our resources.
Principal Risk Name & Description	Unfunded services
Relevant Group/Committee	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	2	**8**	▼
Current Risk Score	4	2	**8**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Partial			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**YTD**	**Comments:**
Identified annualised value of under-/un-funded services provided	-	10,050	15,383	15,383					All items flagged to the Commissioner for decision in 24/25 planning and contracting. Little/none assumed in 24/25 plan.

Context Summary
(Patient First problem statement, current situation)

The Trust has experienced significant growth, e.g. in its workforce, with no correlating growth in activity, i.e. it has become less productive. This has been coupled over the years with the provision of services that have not been commissioned/funded. These factors contribute towards the adverse/deficit financial performance.

Rationale for Current Score

A number of the services referred to have been run for some time and relate to activity undertaken each week. In extremis, the Trust could choose to cease service provision, although no quality impact assessment has been completed to outline what that would mean for staff and patients. The likelihood is therefore classified as "likely / 4".
Given the funding is not assumed in operating plans, there is no financial impact under the status quo - this represents an opportunity. The consequence is therefore scored as "minor" / 2.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Business planning / contract negotiations - Correspondence and meetings between provider and commissioner outlining issues and actions - Seek support from operational/clinical colleagues at the commissioner/NHSE.	- Business planning / operating plan sign off (e.g. by Executive, Finance Planning and Performance Committee, Trust Board) - SLA

Gaps in Controls
(What additional controls and assurances should we seek?)

1. Consensus between Trust and commissioner in respect of commissioned services / de-scoping.

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Contract review meetings to reach proposals for presentation to Boards	30/09/2024	On Track/Not Yet Due	Chief Financial Officer	Contract signed - unfunded services separately communicated.

Trust Risk Register Aligned to Board Assurance Framework	2058: Unchecked staff growth	Current Risk Score: (5 x 3 = 15)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

System affordability is a clear issue.

Date of Last Review:	14 August 2024
Date of Next Review:	15 September 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5d	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Capital allocation / funding
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	5	**20**	N
Risk Score at Last Review	5	5	**25**	—
Current Risk Score	5	5	**25**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Partial			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**YTD**	**Comments:**
In-year capital allocation from system (Target is the planned depreciation and amortisation value for the Trust in-year.)	20.3	12.8	15.5	15.5	15.5				System operating capital allocation is £12.8m; additional £0.7m awarded to support CDC overruns and £2m for 23/24 ED performance. Excludes £6m
In-year additional capital funding (no min/max target set)	n/a	1.9	9.7	9.7	9.7				Key items include: PDC funding of CDC (£2.5m); PDC frontline digitisation/EPR (£1.9m); Decarbonisation grant (£5.3m).
5-year capital programme - in-year request (no target)	n/a	63.3	63.3	63.3	63.3				Excluding decarbonisation plans and 6-facet survey findings.

Context Summary
(Patient First problem statement, current situation)

Capital allocations from the system have been below the Trust's depreciation level, and there are no guarantees of receipt of additional capital funds. Without sufficient investment the Trust may not realise its strategic aims and/or could compromise quality and safety, particularly in light of backlog maintenance reports.

Rationale for Current Score

The latest backlog maintenance report for the Trust indicates critical works that far exceed the in-year and even a multi-year allocation from system operational capital.
Given the value and the classification of these works, this is scored as 5 x 5.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Completion of Trust prioritisation matrix, including risk register entries - Programme review and approval by Trust Executive each financial year - Proposal paper drafted setting out options to address findings of the 6-Facet survey - Submission of capital plans and requests via the system to secure minimum fair share of operating capital allocation - Application for additional capital funds where available, e.g. PDC, charity, grants, etc.	- Internal audit core financial controls audit - External audit opinion on accounts and VFM - Risk register entries - Trust Investment Group and Investment Delivery Group governance and reporting, e.g. to Finance, Planning and Performance Committee

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

1. Consideration of strategic capital funding applications	**Action**	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
	1a. Risk based proposals on a preferred way forward in respect of 6-Facet survey risks (investment proposal will subsequently be required to be prepared)	30/06/2024	Overdue	Director of Estates and Facilities	Due to come back to Trust Execs in w/c 26/8.

Trust Risk Register Aligned to Board Assurance Framework	2060: Capital allocation vs requirements	Current Risk Score: (5 x 5 = 25)

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

The Trust has secured a grant totalling c£25m over two years (with the Trust required to contribute £3.5m) for the purpose of supporting site decarbonisation.	
Date of Last Review:	14 August 2024
Date of Next Review:	15 September 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5e	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Financial culture
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	3	4	**12**	▼
Current Risk Score	3	4	**12**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**YTD**	**Comments:**
Number of lapsed budget holder training (no.)	0	75	75	75	73	73	54		
Number of lapsed budget holder training (%)	0%	36%	36%	36%	35%	35%	26%		

Context Summary
(Patient First problem statement, current situation)

A number of independent reports into the drivers of deficit at the Trust have identified the financial culture of the organisation as a contributory factor in the performance. Without addressing the culture the Trust may struggle to deliver its financial plans.
Failure to address this as an issue could impact the Trust's exit from SOF4.

Rationale for Current Score

Consequence: staffing and competence - moderate error(s) due to poor attendance for key training.
Likelihood: expected to occur at least weekly / >31% of staff have not attended.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Budget holder meetings Budget holder training Finance Training Policy Mandatory objective in appraisal form Sustainability workstream within Patient First Communication via senior managers meetings and Trust Management Board Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee. Better Business Case trained staff.	Previously performance review meetings - now Strategic Deployment Reviews. Care group and divisional board meetings. Budget holder meetings Efficiency Delivery Group / Check and Challenge sessions Finance, Planning and Performance Committee Trust Board Oversight meetings Internal audit

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Budget holder training is not yet part of statman.	1. Take proposal for inclusion as statman through TMB.	31/07/2024	Overdue	Deputy Chief Financial Officer	Reviewed at TMB and supported - awaiting final approval

Trust Risk Register Aligned to Board Assurance Framework	Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

A wider leadership training programme is being explored at the Trust, which would require individuals to complete specified elements of financial training. The Trust Investment Group has approved expansion of the Financial Management team to support divisions in their finance needs/obligations. This includes anticipated funding from the NHSE Intensive Support Team/RSP funding in 24/25.	
Date of Last Review:	14 August 2024
Date of Next Review:	15 September 2024

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

July - 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	30	5	18	15	15
Systems & Partnerships	13	9	15	16	5	5
Quality	52	14	9	14	4	4
Patients	8	15	3	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, (30), however the Patients domain shows the highest % of statistical improvement metrics (~58% 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 significant statistical change and as such are showing common variation.
- Overall, 69 metrics are now showing improved statistical variance (-2 from last month) against 34 which are showing concern (+2 from last month).

Issues, Concerns & Gaps

- Mortality - Indices show little improvement; SHMI is now at the highest value the Trust has seen. Clinical documentation remains a concern especially amongst non-elective patients with a zero comorbidity score despite previous A&E attendances.
- ED & Flow - The hospital has 61.6 overnight admissions per year to each bed whereas the average for England is 55 overnight admissions per year to each bed. To put this in another way, the hospital has 548 beds but a hospital with its workload would normally have 593 beds.
- Access - Cardiology workshop identified areas for improvement and insourcing company will provide a short term solution to try and eliminate 65 week waiters.
- Workforce - 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.
- Finance - The Trust has a significant capital maintenance backlog and would require external allocations in order to be able to deliver all identified works in the medium term.

Actions & Improvements

- Patient Experience - An AI project is underway with PWC who are working with the divisions to create a chatbot to manage the queries from appointments more efficiently. This will directly contribute in the reduction of concerns.
- Incident Management - A business case is being developed to support the automated NEWS score recording and a NEWS Dashboard is being developed.
- Mortality - A new SJR app, reporting dashboard and training for reviewers currently going through the last stages of procurement.
- ED & Flow - Flow and discharge corporate project is in place that meets bi-weekly involving staff from all areas of the Trust and community partners focused on improving discharges to support movement out of ED
- Workforce - Delivery of targeted improvement plan developed and governed by anti-bullying and harassment group.
- Finance - Identification, development, implementation and delivery of the efficiencies/waste reduction programme.

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	5	0	1
FFT	11	21	3	8	0	12
PALS	3	2	2	1	0	0
Patient Experience	1	1	0	2	0	0
PHSO	2	3	1	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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	95.0%			89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%

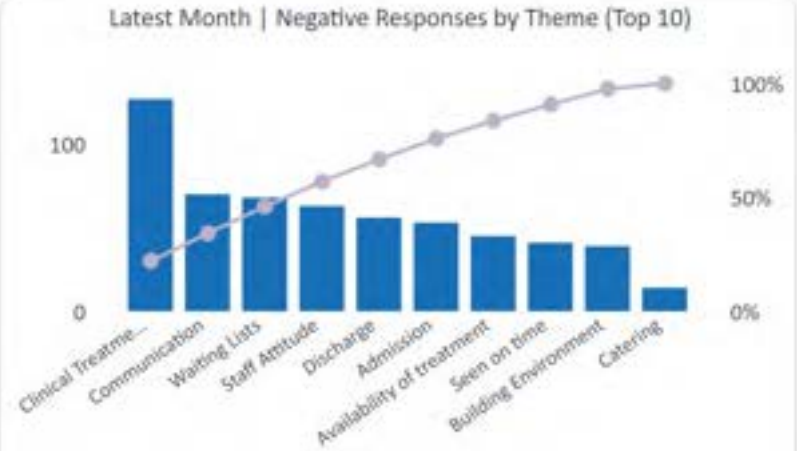
True North Domain: Patients

KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

2	1	0	0	7



Key Messages

- Recommend rate has reached 91.1% overall which is the highest achieved to date
- Response rate has doubled overall in 23-24 since 22-23 which is a great achievement yielding over 60k responses from patients in the last year.
- Inpatient FFT recommend rate is 0.5% off target overall.

Issues, Concerns & Gaps

- A reduction has been seen overall in the number of negative responses by theme however clinical treatment remains the highest contributor
- Issues remain with patients reporting difficulties being able to contact someone from their medical team in regards to appointments / results. This information correlates with PALS enquiries

Actions & Improvements

- A formal project / A3 group are working on the actions required to improve the concerns raised about contacting staff about appointments
- An AI project is underway with PWC who are working with the divisions to create a chatbot to manage the queries from appointments more efficiently. This will directly contribute in the reduction of concerns

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Patients	FFT			Inpatients FFT Recommend %	95.0%			Watch is red for 4 reporting periods	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%
				Emergency Care FFT Recommend %	85.0%			Watch is red for 4 reporting periods	68.9%	71.6%	77.1%	70.2%	74.9%	73.0%
				Outpatient FFT Recommend %	95.0%			Watch is red for 4 reporting periods	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%
	Patient Experience			Mixed Sex Accommodation Breaches	0			Watch is red for 4 reporting periods	278	90	110	108	89	26
	Complaints			Complaints Breached %	5.0%			Watch is red for 4 reporting periods	55.6%	82.8%	60.7%	34.5%	21.4%	6.7%

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Patients	FFT			Total FFT Recommend %	95.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%
				Total FFT Response Rate %	-		Special cause of improving nature or lower pressure due to (H)igher values	14.6%	13.9%	16.2%	15.1%	15.6%	15.4%
				Inpatients FFT Recommend %	95.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%
				Inpatients FFT Response Rate %	-		Special cause of improving nature or lower pressure due to (H)igher values	41.5%	44.9%	51.9%	48.1%	51.8%	53.0%
				Outpatient FFT Recommend %	95.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%
				Outpatient FFT Response Rate %	-		Special cause of improving nature or lower pressure due to (H)igher values	9.9%	9.2%	9.9%	9.7%	9.6%	9.9%
				Maternity FFT Response Rate %	-		Special cause of improving nature or lower pressure due to (H)igher values	38.7%	30.7%	49.1%	47.6%	39.0%	34.1%
	Complaints			Complaints	-		Special cause of improving nature or lower pressure due to (L)ower values	25	29	28	23	27	21
				Complaints Open - Month End	-		Special cause of improving nature or lower pressure due to (L)ower values	87	91	91	66	53	31
				Complaints Acknowledged Within 3 Working Days %	95.0%		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%		Special cause of improving nature or lower pressure due to (L)ower values	55.6%	82.8%	60.7%	34.5%	21.4%	6.7%
	PALS			PALS Open - Month End	-		Special cause of improving nature or lower pressure due to (L)ower values	80	79	100	122	108	52
				PALS Converted to Complaints	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	1	0	0

Patients

KPI Improvements - Special Cause Variation

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

Patients

Key Messages

- Mixed sex breaches have significantly reduced as a consequence of the admission and discharge lounge closing overnight and not used as a bedded facility. The top contributors are ICU and Trafalgar patients who require a step down to a ward bed
- Complaints position remains stable with 31 cases open at month end
- 4 complaints re-opened – Higher than average but anticipated due to the complexity of the cases
- Breached complaints position is improving at 6.7%
- Open PALS position remains stable
- 1 upheld Ombudsman case – the first to be upheld or partially upheld for 9 months

Issues, Concerns & Gaps

- The procedure of admitting patients who identify as non-binary or trans is not clear to staff when managing their care in single sex bays
- Response timeframe for amber complaints does not align to response timeframes for NHSE

Actions & Improvements

- The operating procedure for admitting patients is being updated to reflect the recent changes in legislation and will be updated in conjunction with the lead for EDI. This procedure will require consultation with patients and education and training provision for staff, in order to clarify guidance for staff in relation to patients who identify as non-binary or trans.
- Testing is underway to upgrade the software on Teletracking.
- Complaint handling policy is currently being reviewed to reflect NHSE timeframes for responding to complaints.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Patients	FFT			Total FFT Recommend %	95.0%			89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%
				Total FFT Response Rate %	-			12.1%	10.7%	12.9%	13.9%	12.0%	12.3%	14.6%	13.9%	16.2%	15.1%	15.6%	15.4%
				Inpatients FFT Recommend %	95.0%			93.5%	91.3%	90.7%	92.2%	93.3%	92.3%	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%
				Inpatients FFT Response Rate %	-			33.8%	30.1%	37.2%	45.8%	38.6%	36.5%	41.5%	44.9%	51.9%	48.1%	51.8%	53.0%
				Emergency Care FFT Recommend %	85.0%			73.1%	74.8%	75.2%	67.9%	69.2%	64.7%	68.9%	71.6%	77.1%	70.2%	74.9%	73.0%
				Emergency Care FFT Response Rate %	-			8.4%	6.2%	9.8%	8.7%	7.5%	8.2%	9.9%	7.6%	10.2%	8.8%	9.1%	9.6%
				Outpatient FFT Recommend %	95.0%			91.6%	92.0%	91.1%	92.4%	91.9%	91.5%	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%
				Outpatient FFT Response Rate %	-			8.3%	8.1%	8.5%	8.7%	7.6%	8.6%	9.9%	9.2%	9.9%	9.7%	9.6%	9.9%
				Maternity FFT Recommend %	95.0%			87.8%	92.5%	92.5%	90.5%	82.7%	88.5%	85.8%	88.8%	99.4%	96.5%	92.6%	88.0%
				Maternity FFT Response Rate %	-			31.5%	31.5%	33.5%	26.1%	14.5%	30.9%	38.7%	30.7%	49.1%	47.6%	39.0%	34.1%
	Patient Experience			Mixed Sex Accommodation Breaches	0			83	109				486	278	90	110	108	89	26
	Complaints			Complaints	-			42	35	28	32	19	20	25	29	28	23	27	21
				Complaints Closed	-			45	52	35	38	30	22	20	25	28	48	40	43

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Patients	Complaints			Complaints Open - Month End	-			124	107	100	95	84	82	87	91	91	66	53	31
				Complaints Re-Opened	-			2	7	1	2	2	2	1	6	1	3	2	4
				Complaints Acknowledged Within 3 Working Days %	95.0%			95.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%			61.4%	63.9%	42.9%	41.2%	40.6%	62.5%	55.6%	82.8%	60.7%	34.5%	21.4%	6.7%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			425	388	416	528	428	496	463	417	480	428	446	500
				PALS Closed	-			411	371	384	550	485	709	460	418	459	406	460	556
				PALS Open - Month End	-			317	334	365	346	289	77	80	79	100	122	108	52
				PALS Converted to Complaints	-			6	4	0	0	0	0	0	0	0	1	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			0	0	0	0	1	0	0	0	1	0	2	1
				PHSO Cases Closed - Partially Upheld	-			1	0	1	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Upheld	-			0	0	0	0	0	0	1	0	0	0	0	1
				PHSO Cases Closed - Not Upheld	-			0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-			0	1	0	0	0	0	1	4	0	0	0	0

Quality

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

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Incident Management	16	13	7	10	3	8
IPC	7	2	0	2	1	0
Medicines	5	0	0	2	1	0
Mortality	17	2	3	14	1	2
Pressure Ulcer	6	0	1	2	1	0
Falls	14	1	0	11	0	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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	95.0%			99.2%	99.2%	99.3%	99.0%	99.6%	99.0%	98.9%	99.4%	98.6%	99.3%	98.5%	98.9%

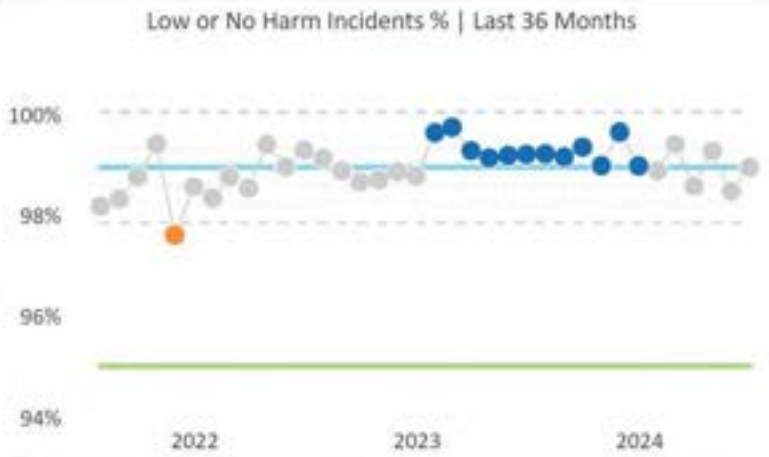
True North Domain: Quality

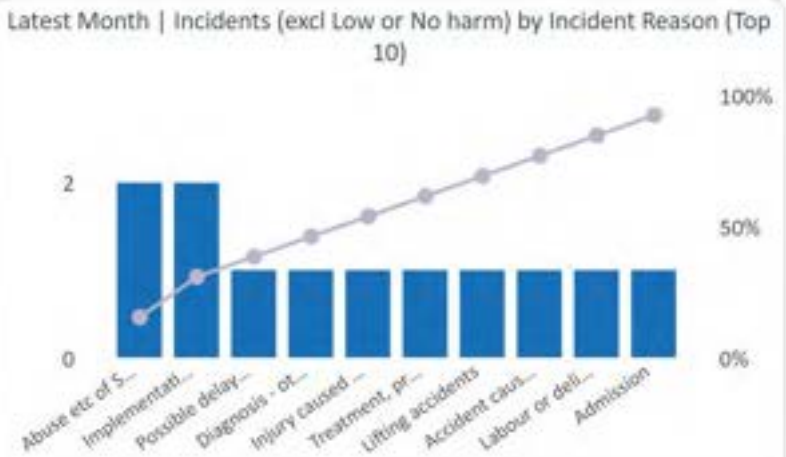
KPI Threshold: 95.0%

Sub Domain KPIs: 20

Variation Summary:

9	0	5	3	3





Key Messages

- 98.9% of all incidents reported resulted in low or no harm.
- 7 incidents in July caused moderate harm or above (4 harm levels to be confirmed at IRG).
- There were 5 Incidents resulting in a moderate or severe harm in July, (3 moderate and 2 severe).
- 1 maternal death, not thought to be caused by omissions in care.

Issues, Concerns & Gaps

- Clinical incidents with harm as moderate or above has decreased by 41.6% compared to June.
- 4 patients possibly came to harm due to omissions in care (harm tbc).
- 1 patient came to harm due to omissions in care.

Actions & Improvements

- Violence and aggression group in place to address abuse issues.
- Thematic review into delays in recognising death is in progress.
- Thematic review into cancer PTL process to identify human procedural steps that present a human error risk.
- Improvement actions for falls and pressure ulcers being progressed in line with QIPs.
- A business case is being developed to support the automated NEWS score recording and a NEWS Dashboard is being developed.
- All SIs have been submitted to ICB for closure.

Quality

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

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	1.30%			1.31%	1.44%	1.53%	1.19%	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%

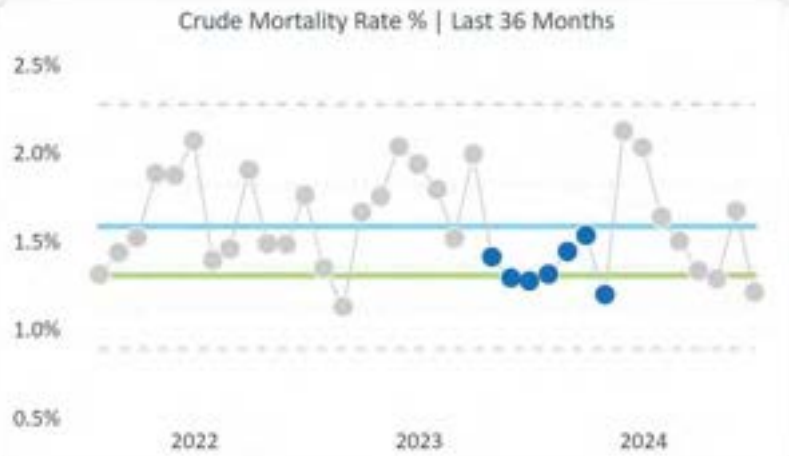
True North Domain: Quality

KPI Threshold: 1.30%

Sub Domain KPIs: 13

Variation Summary:

10	0	2	1	0



Key Messages

- HSMR for the period of Apr 23- Mar 24 is 113.7 and 'higher than expected'.
- The high value is due to a high crude rate and despite improvement, expected rate continues to fall.
- Contributing factors to the deteriorating expected rate include: cohorts of non-elective patients with zero comorbidity scores, an increase in younger patients (under 65s), an increase in over 75s with a frailty condition which is not currently adjusted for in HSMR.
- SHMI for the period of Feb23- Mar 24 is 1.19. Many of the factors affecting HSMR will affect SHMI.
- In patient deaths have increased, whilst out of hospital deaths is decreasing.
- 11.2% deaths subject to SJR- no avoidable deaths identified.
- 4/13 cases rated poor care, 3/13 rated good following SJR.

Issues, Concerns & Gaps

- SHMI and HSMR remain outside the expected range
- 10 out of 17 speciality M&M meetings conducted in July
- Clinical documentation remains a concern especially amongst non-elective patients with a zero comorbidity score despite previous A&E attendances
- SJR reviews in July revealed an issues with DNAR/TEP form completion and teams not considering previous DNAR/TEP forms.
- Communication between clinical teams and with families and carers remains a top theme.
- Medical Examiner Office has raised concerns with an increase in team making direct referrals to the Coroners Office for causes that do not require referrals.
- Learning: Alert needed on EPR for patient who already have a TEP/DNAR in place; remove non-stocked drug preparations from EPMA to prevent them being prescribed, oncology clinic letters should be available to help decision making, documented records of multiple admissions not available as patient under SMART.

Actions & Improvements

- Weekly ongoing improvement work for Mortality A3 refresh focusing on root causes in the increase in mortality indices and countermeasures to improve metrics and LfD process
- Weekly meetings to update on 12 recommendations from NICHE
- New SJR app, reporting dashboard and training for reviewers currently going through the last stages of procurement.
- New SJR SOP for single review process agreed at MMSG- phase 1 implementation date September 24, phase 2 implementation date October 24.
- Clinical coding and LfD presenting to speciality teams in line with Jnr Dr rotation around the importance of documentation and accurate primary diagnosis.
- Education to be provided to clinical colleagues on the process for referring to the coroner i.e. via the MEO

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0			Watch is red for 4 reporting periods	9	6	10	4	12	7
				Serious Incidents Responded to Within 60 Days %	95.0%			Watch is red for 4 reporting periods	16.7%	50.0%	50.0%	0.0%	0.0%	0.0%
				EDNs Completed Within 24hrs %	90.0%			Watch is red for 4 reporting periods	78.5%	77.9%	77.5%	80.3%	78.4%	81.6%
	Mortality			Avoidable 2222 Calls – Cardiac Arrest	1			Driver is red latest reporting period	0	0	1	2	0	2
				Avoidable 2222 Calls – Peri-Arrests	3			Driver is red latest reporting period	2	0	1	1	0	4
				HSMR (All)	100			Watch is red for 4 reporting periods	113.15	113.79				
				SHMI	1			Watch is red for 4 reporting periods	1.18	1.19				
				Fractured NOF Within 36 Hours	92.0%			Watch is red for 4 reporting periods	73.7%	60.0%	60.0%	51.5%	52.5%	
				SJRs Completed %	12.5%			Watch is red for 4 reporting periods	7.3%	6.8%	9.2%	4.5%	9.2%	11.2%

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Incident Management			Serious Incidents	-		Special cause of improving nature or lower pressure due to (L)ower values	2	1	2	0	1	0
				Serious Incidents Open - Month End	-		Special cause of improving nature or lower pressure due to (L)ower values	28	20	17	15	9	8
				Serious Incidents Closed by ICB 1st Time %	-		Special cause of improving nature or lower pressure due to (H)igher values	50.0%	55.6%	100.0%	50.0%	100.0%	100.0%
				Never Events	0		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 %	-		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%		Special cause of improving nature or lower pressure due to (H)igher values	78.5%	78.0%	77.5%	80.3%	78.4%	81.6%
	Falls			Falls Resulting in Death	0		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		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	Mortality			Expected Death Rate %	-		Special cause of improving nature or lower pressure due to (L)ower values	3.6%	3.6%				
	VTE			VTE Risk Assessment Completed %	95.0%		Special cause of improving nature or lower pressure due to (H)igher values	99.2%	99.7%	99.1%	99.3%	99.5%	99.7%
	Health & Safety			Resuscitation Training Compliance %	-		Special cause of improving nature or lower pressure due to (H)igher values	82.4%	83.8%	83.1%	83.0%	83.8%	83.6%
				Mental Capacity Act Training Compliance %	-		Special cause of improving nature or lower pressure due to (H)igher values	81.7%	83.1%	84.0%	84.9%	85.1%	85.6%
	Legal & Information Governance			Regulation 28 Reports	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

- The ward accreditation programme has been re-worked and re-launched with successes from Tennyson ward who were awarded with Silver.
- Reduction in falls overall and no falls resulting in moderate or severe harm in July.
- Intensive support provided by the TVN team to Will Adams, ED and Phoenix to improve compliance in ASSKING audits and reduction in HAPU's
- VTE risk assessments remain above the required standard
- Clinical lead for trauma and orthopaedics now appointed and will take on the NAFF agenda so progress is imminent

Issues, Concerns & Gaps

- Poor compliance in some clinical areas with completing audits and patient falls assessments
- 1 grade 4 hospital acquired pressure damage reported in July,
- Issues identified with prescribing thromboprophylaxis following completion of the VTE assessment

Actions & Improvements

- The Falls team have successfully delivered training and education to over 100 staff in July
- The Falls dashboard has been developed to support the deconditioning work that will be taken forwards as a corporate project
- 10 wards have successfully achieved over 6 months – 1 year HAPU harm free . These wards have been commended for their work
- A new VTE A3 working group has been established to address the concerns regarding accurate prescription

Maternity

Key Messages

Perinatal Quality – Incidents: 1 incident moderate harm or above for maternity – maternal death (Referral to MSNI/MBRRACE, Coroner Notified, Maternal death policy followed, Support given to family and staff. 136 incidents reported in Maternity, 23 low harm. 15 Incidents reported in Neonatal, 2 low harm relating to TPN extravasation. **Perinatal Quality – PMRT:** 4 MBRRACE reportable deaths- all reported within required timeframe (25+6 NND on NICU at day 11, 24+0 NND at home following un-booked pregnancy and unassisted birth, 2 TOP – MBRRACE notifiable but not for PMRT.1 Maternity PMRT review - graded B, C. **Staffing:** Midwifery vacancy for July 2024- 17.68 WTE with 10.34 WTE awaiting start date. Maternity Leave – 9.64. Band 3 MSW vacancy 2.12 WTE with a further 6.60 awaiting start date. **Training:** Fetal Monitoring and NBLS training >90% for midwives and doctors in training. PROMPT Training >90% for midwives and MSWs and theatre staff. <90% for Obstetric & Anaesthetic consultants & doctors in training. NBLS training >90% for NICU Nursing, NICU doctors in training and ANNP. 89% for midwives and 84% for neonatal consultants. NICU Nursing QIS on trajectory to achieve 90% for external NLS course by October 2024. **Listening to Women and Families – Service Users and MNVP:** Positive feedback from MNVP regarding communication with service users – No negative feedback for 2 months. Positive feedback for IOL pathway. Plan for "Whose Shoes" event in October 2024. Co-produced Benchmarking against national Birth-trauma report underway. Patient survey of Call the Midwife undertaken. **Staff Feedback:** Board Level Safety Champion Engagement Session held in month. Staff concerns included: Capacity and estates in MCU, Patient flow in Triage. Staff concerns re. MCU and Triage to be incorporated into MCU/Triage QI project being lead by consultant midwives. Culture survey questions finalised and staff given opportunity to respond in Autumn 2024. Celebration of 25 Years of Maternity and Neonatal at MFT Site in July with positive engagement from staff and the community. **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. On track for all actions, with exception of Safety Action 8 which has appropriate actions in place to mitigate risk. 93% compliance with SBLCB v3. 98.7% compliance with Consultant Must/Should attend audit.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: Thematic review of UVC related incidents underway on neonatal unit. PPH and 3rd and 4th degree tears continue to be themes. **Perinatal Quality - PMRT:** Concerns raised from PMRT included communication, pain relief and failure to follow uniform policy. **Training:** PROMPT Training <90% for obstetric & anaesthetic doctors. 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. **Risk:** (1133) midwifery staffing remains highest risk – Score 20. EuroKing Risks (1864 & 1025) – Score 15. (2078) added regarding risk to providing timely fetal medicine scanning due to failing/out of date equipment. – Score 12.Upgrade of Neonatal Gantry System (ITU) Score 9. **Listening to Women and Families – Service Users and MNVP:** Communication, staff attitude and care planning continue to be a theme of service user feedback via PALS/Complaints. Await outcome of LMNS MNVP service provision review. **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. Plans made for launch of OASI bundle and training programme being developed. Hot and Cold debriefs held for all staff involved in maternal death. Staff praised for their professionalism and team work in emergency situation. Ongoing support being offered to family by senior team and bereavement team. **Perinatal Quality – PMRT:** Working with anaesthetic team to ensure bereaved families are offered pain relief in timely manner. Review of communication around results, and that this meets their expectation/understanding. Reminder to all staff to follow uniform policy. **Staffing:** Improved retention rate Jan-July 2023 17 leavers, Jan-July 2024 – 7 leavers with no leavers anticipated in next 3 months. Culture Survey planned for Autumn 2024. Workforce Action plan refreshed for 2024/25. Working with LMNS and Trust HR team to improve workforce level data reported outside organisation. **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:** Business case for EuroKing approved in Division, to be presented to Execs. **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 neurodiverse women and birthing people.- to commence in September. Work commenced with MNVP lead to engage Roma community. Plan to review "Top 5" languages of PIL to better support 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. Anonymous Safety Champion Feedback form to be launched alongside of poster and other staff comms to reinvigorate the role. **External:** QI work identified within SBL bundle and to be presented to LMNS with next submission in September 2024.Second CNST Board report to be presented in September 2024, with a further report for November and final report with Board Level Declaration to be presented in January 2025 before March submission. Sharing progress with LMNS via formal meetings and peer assurance process. Learning from Consultant must/Should attend aligns with themes already identified from incident reviews and appropriate actions in place to address. (PPH and 3rd/4th degree tears) .

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Incident Management			Low or No Harm Incidents %	95.0%			99.2%	99.2%	99.3%	99.0%	99.6%	99.0%	98.9%	99.4%	98.6%	99.3%	98.5%	98.9%
				Total Incidents Reported	-			1,650	1,766	1,984	2,155	1,686	1,366	1,337	1,329	1,191	1,228	1,179	1,229
				Clinical Incidents with Harm (Moderate and above)	0			10	8	11	16	6	9	9	6	10	4	12	7
				Incidents Open - Month End	-			1,340	1,691	2,156	2,414	2,980	2,772	2,736	2,775	2,728	1,619	1,664	1,764
				Incidents Overdue - Month End	-			218	388	479	701	1,142	1,654	1,773	1,734	1,798	656	729	814
				Serious Incidents	-			4	7	7	16	2	4	2	1	2	0	1	0
				Serious Incidents Closed	-			14	12	11	6	9	9	2	9	5	2	7	1
				Serious Incidents Open - Month End	-			40	35	30	40	33	28	28	20	17	15	9	8
				Serious Incidents Responded to Within 60 Days %	95.0%			0.0%	40.0%	25.0%	33.3%	66.7%	56.3%	16.7%	50.0%	50.0%	0.0%	0.0%	0.0%
				Serious Incidents Closed by ICB 1st Time %	-			35.7%	75.0%	81.8%	100.0%	100.0%	88.9%	50.0%	55.6%	100.0%	50.0%	100.0%	100.0%
				Never Events	0			0	0	0	1	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-			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 %	-			72.7%	66.7%	83.3%	100.0%	100.0%	71.4%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Incident Management			RIDDOR Incidents	-			5	4	2	0	0	4	5	2	2	2	0	1
				RIDDOR Compliance %	-			40.0%	75.0%	0.0%	-	-	75.0%	40.0%	100.0%	100.0%	100.0%	-	100.0%
				Health & Safety Incidents	-			118	118	96	108	85	119	151	115	128	97	85	98
				Sharps Injuries	-			14	10	6	12	10	7	17	8	5	10	9	14
				Violence & Aggression Incidents	-			109	136	127	138	176	193	252	173	203	166	174	157
				Assaults - Patient on Staff	-			63	75	55	64	60	64	99	78	108	70	76	71
				EDNs Completed Within 24hrs %	90.0%			71.5%	74.2%	77.9%	77.6%	74.4%	75.4%	78.5%	78.0%	77.5%	80.3%	78.4%	81.6%
	Falls			Low or No Harm Falls %	95.0%			96.2%	97.8%	97.4%	95.9%	98.9%	100.0%	97.9%	100.0%	94.6%	98.8%	99.0%	100.0%
				Falls - Total	-			78	92	78	74	88	77	94	80	74	85	102	93
				Falls - Low Harm	-			25	26	23	11	30	24	22	17	15	19	23	29
				Falls - Moderate Harm	-			2	0	2	1	0	0	0	0	2	1	1	0
				Falls - Severe Harm	0			1	2	0	1	1	0	2	0	2	0	0	0
				Falls Resulting in Death	0			0	0	0	1	0	0	0	0	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Falls			Falls per 1,000 Bed days	-			5.08	5.96	5	4.99	5.88	5.08	6.68	5.23	5.07	5.77	7.28	6.39
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24			26	27	25	30	20	23	25	24	15	16	19	19
				Pressure Ulcers - Grade 2	-			5	5	3	6	3	5	8	5	8	8	6	8
				Pressure Ulcers - Grade 3	-			0	0	0	1	0	0	2	3	7	8	13	10
				Pressure Ulcers - Grade 4	-			0	0	3	1	2	0	0	0	0	0	0	1
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.69	1.75	1.60	2.02	1.34	1.52	1.78	1.57	1.03	1.09	1.36	1.31
	Medicines			Medicine Errors - Total	-			101	74	87	97	70	63	90	81	88	61	68	99
				Low or No Harm Medicine Errors %	95.0%			99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	98.4%	100.0%	100.0%
	IPC			IPC Incidents	-			54	41	56	39	53	35	45	50	38	54	31	66
				C-Diff Cases - Hospital Acquired Total	-			1	5	3	3	5	3	4	8	4	4	2	4
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	33			25	30	33	36	41	44	48	56	4	8	10	14
				C-Diff Cases - Hospital Acquired (HOHA)	-			0	3	3	3	3	1	3	6	2	3	2	4
				E.coli Cases - Hospital Acquired	-			9	4	9	5	8	2	6	4	6	3	5	6

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	IPC			E.coli Cases - Hospital Acquired YTD (Cumulative)	73			28	32	41	46	54	56	62	66	6	9	14	20
				MRSA Cases - Hospital Acquired	0			0	0	1	1	0	0	0	0	0	0	0	0
				MSSA Cases - Hospital Acquired	-			1	2	4	3	1	4	3	2	4	1	0	0
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			15	17	21	24	25	29	32	34	4	5	5	5
	Mortality			Crude Mortality Rate %	1.30%			1.31%	1.44%	1.53%	1.19%	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%
				Avoidable 2222 Calls – Cardiac Arrest	1			0	1	1	2	2	1	0	0	1	2	0	2
				Avoidable 2222 Calls – Peri-Arrests	3			4	2	0	2	0	3	2	0	1	1	0	4
				Avoidable 2222 Calls	16			4	3	1	4	2	4	2	0	3	3	0	7
				HSMR (All)	100			112	113.20	113.33	109.96	110.31	113.50	113.15	113.79				
				Expected Death Rate %	-			3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.6%	3.6%				
				SHMI	1			1.13	1.16	1.15	1.13	1.14	1.16	1.18	1.19				
				Fractured NOF Within 36 Hours	92.0%			76.7%	31.3%	52.1%	71.9%	50.0%	71.4%	73.7%	60.0%	60.0%	51.5%	52.5%	
				Number of Deaths Reviewed via SJR	-			9	8	12	13	8	13	12	11	13	6	13	13
				SJRs Completed %	12.5%			7.0%	6.3%	7.8%	9.7%	4.3%	6.5%	7.3%	6.8%	9.2%	4.5%	9.2%	11.2%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Mortality			Total Number of Deaths Due to Failings in Care	-			0	0	0	0	0	1	0	0	1	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	1	1	1	0	1	1	1	1	2	0	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%			99.4%	99.7%	98.9%	99.5%	99.0%	99.4%	99.2%	99.7%	99.1%	99.3%	99.5%	99.7%
	Maternity			Caesarean Section %	-			44.9%	47.3%	46.7%	51.6%	48.8%	49.6%	52.0%	44.2%	43.5%	44.2%	50.5%	42.5%
				Elective C-Section %	-			16.9%	22.0%	21.0%	21.5%	17.6%	19.8%	19.6%	19.2%	21.0%	17.2%	19.8%	17.3%
				Emergency C-Section %	-			28.0%	25.3%	25.6%	30.0%	31.2%	29.8%	32.3%	24.9%	22.5%	27.0%	30.7%	25.2%
				PPH greater than 1000mls	-			56	30	39	49	54	35	44	41	37	45	37	38
				Total Number of Still Births Greater Than 24 weeks Gestation	-			1	2	2	3	0	1	3	0	0	3	2	0
				Neonatal Deaths	-			4	4	0	1	4	1	2	3	0	1	0	1
				Maternity Serious Incidents	-			0	0	0	0	1	2	2	1	0	0	0	0
				Maternity HSIB Referrals	-			0	0	0	0	1	2	2	1	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	0	0	1	2	1	1	0	0	0	0	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	Risk & Policy			Risks Open - Low (Month End Snapshot)	-										6	4	6	4	2
				Risks Open - Moderate (Month End Snapshot)	-										55	57	55	50	53
				Risks Open - High (Month End Snapshot)	-										171	160	162	159	175
				Risks Open - Extreme (Month End Snapshot)	-										33	30	26	25	24
	Health & Safety			Resuscitation Training Compliance %	-			78.6%	79.5%	81.3%	81.6%	81.2%	82.2%	82.4%	83.8%	83.1%	83.0%	83.8%	83.6%
				Mental Capacity Act Training Compliance %	-			81.3%	80.6%	80.3%	80.6%	81.5%	81.4%	81.7%	83.1%	84.0%	84.9%	85.1%	85.6%
	Legal & Information Governance			Inquests Received	-			18	16	6	8	21	15	14	8	14	13	10	13
				Inquest Hearings	-			6	6	6	12	3	5	10	8	8	6	5	10
				Regulation 28 Reports	-			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	29	12	26	31	8	17
Emergency Care	6	9	1	7	1	3

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 %

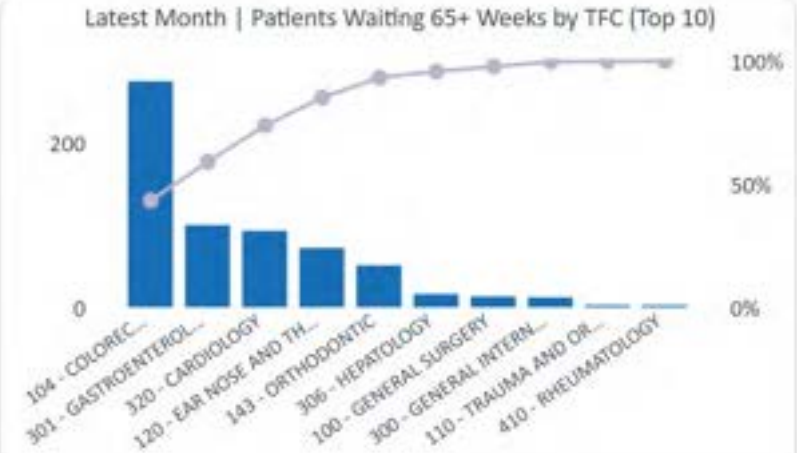
Type	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	54.0%			56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.5%	50.3%

True North Domain: Systems & Partnerships

KPI Threshold: 54.0%

Sub Domain KPIs: 26

Variation Summary: 9 | 7 | 7 | 2 | 1



Key Messages

Ongoing delays with endoscopy contributing to poor performance within gastro and colorectal – the on-site mobile unit will support improvement with an additional 392 units of capacity and PPG will provide a further 200 units from September. Cardiology are in conversation with an insourcing company to provide additional weekend clinics and try to eliminate 65 week waiters.

Issues, Concerns & Gaps

Endoscopy capacity remains an issue however the new mobile unit will provide significant additional capacity to mitigate this. Cardiology workshop identified areas for improvement and insourcing company will provide a short term solution to try and eliminate 65 week waiters. 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 to ensure that the increased capacity is fully utilised

Additional Rheumatology clinics to support long waiters at Fleet, DVH.

Systems & Partnerships

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

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	78.0%			75.9%	76.6%	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%

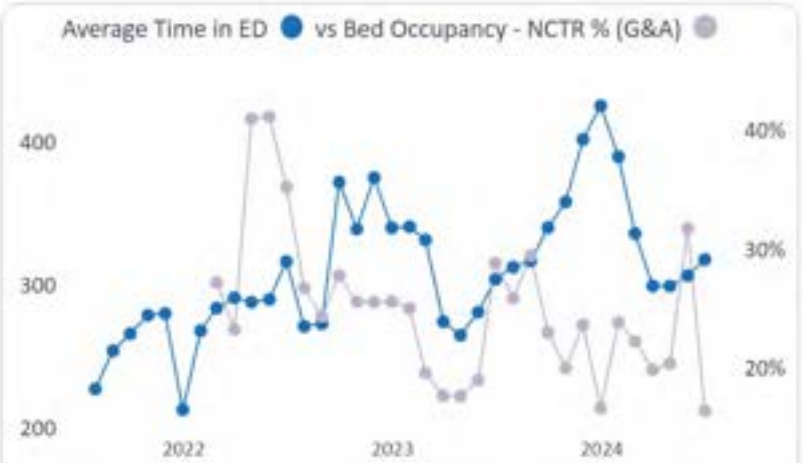
True North Domain: Systems & Partnerships

KPI Threshold: 78.0%

Sub Domain KPIs: 11

Variation Summary:

4	0	1	3	3



Key Messages

Consistently over achieving against the 78% threshold - July 78.7%

Issues, Concerns & Gaps

LOS and NCTR patients impacting ability to move DTAs out of ED department increasing longer waits in ED

Number of patients >12 hours in department continues to be a challenge however we are seeing an improvement in August 2023.

The hospital has 61.6 overnight admissions per year to each bed whereas the average for England is 55 overnight admissions per year to each bed. To put this in another way, the hospital has 548 beds but a hospital with its workload would normally have 593 beds.

Actions & Improvements

Meeting 13.08.2024 re breach validation – process agreed that clinical staff will support flow coordinators with breach reason to ensure that clinical/speciality breaches etc.. are captured correctly

Flow and discharge corporate project is in place that meets bi-weekly involving staff from all areas of the Trust and community partners focused on improving discharges to support movement out of ED

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Systems & Partnerships	Access			RTT 65+ Week Waiters	0			Driver is red for 2 reporting periods	286	235	284	404	549	635
				RTT 52 Week Breaches	1,250			Watch is red for 4 reporting periods	1,886	2,159	2,360	2,610	2,834	2,939
				OP Average Time to First Appointment (days)	60			Watch is red for 4 reporting periods	104.05	103.36	106.96	104.59	108.83	102.63
				Operations Cancelled by Hospital on Day	0			Watch is red for 4 reporting periods	7	10	16	18	15	19
				Cancer USC Performance %	93.0%			Watch is red for 4 reporting periods	73.0%	72.8%	73.4%	70.1%	68.7%	
				Cancer USC Performance - Breast Symptomatic %	93.0%			Watch is red for 4 reporting periods	38.4%	4.2%	2.9%	0.0%	9.9%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%			Watch is red for 4 reporting periods	86.4%	92.6%	75.0%	94.6%	92.6%	
				Cancer 62 Day Treatment - GP Refs %	85.1%			Watch is red for 4 reporting periods	68.1%	68.2%	67.4%	67.6%	68.2%	
				Cancer 28 Day Faster Diagnosis %	77.0%			Watch is red for 4 reporting periods	73.0%	66.0%	56.5%	53.7%	52.3%	
				DM01 Performance %	73.1%			Watch is red for 4 reporting periods	66.7%	66.9%	65.4%	67.1%	67.4%	67.6%
	Emergency Care			Type 1 EC 4 Hour Performance %	75.0%			Watch is red for 4 reporting periods	63.5%	69.3%	69.5%	70.6%	68.8%	68.5%
				Total EC 12 Hour DTAs	0			Watch is red for 4 reporting periods	798	798	521	588	618	663
				Average Time in EC Department - Excl. Type 5 (mins)	240			Watch is red for 4 reporting periods	389.04	335.25	298.57	298.55	305.83	317.08

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Systems & Partnerships	Emergency Care			Ambulance Handover Delays (> 60 mins)	0			Watch is red for 4 reporting periods	5	6	3	3	2	2

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Systems & Partnerships	Access			Outpatient DNA Rate %	10.0%		Special cause of improving nature or lower pressure due to (L)ower values	6.2%	6.2%	6.2%	6.4%	6.3%	6.3%
				OP First to Follow Up Ratio	-		Special cause of improving nature or lower pressure due to (L)ower values	1.87	1.84	1.89	1.77	1.76	1.82
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%		Special cause of improving nature or lower pressure due to (H)igher values	72.2%	90.0%	71.4%	71.4%	81.6%	
	Emergency Care			Total EC 4 Hour Performance %	78.0%		Special cause of improving nature or lower pressure due to (H)igher values	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	77.9%	83.0%	86.9%	84.0%	84.7%	84.1%
				Type 1 EC 4 Hour Performance %	75.0%		Special cause of improving nature or lower pressure due to (H)igher values	63.5%	69.3%	69.5%	70.6%	68.8%	68.5%
				Ambulance Handover Delays (> 30 mins)	-		Special cause of improving nature or lower pressure due to (L)ower values	90	103	67	49	73	59
				Ambulance Handover Delays (> 60 mins)	0		Special cause of improving nature or lower pressure due to (L)ower values	5	6	3	3	2	2
				30 Day Readmission Rate	13.0%		Special cause of improving nature or lower pressure due to (L)ower values	10.0%	9.8%	10.0%	10.4%	8.9%	7.9%

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. Collaborative review of booking processes between MFT and PPG to provide a further 200 units of capacity.
ENT have improved their position and majority of over 65 week waits now have a TCI. Cardiology are in discussion with an insourcing company to tackle the 65 week waiters before the end of September. Long term plans reviewed at the Cardiology workshop to tackle the RTT
Rheumatology locum to provide additional clinics to eliminate 65 week waiters at the Fleet site

Issues, Concerns & Gaps

Increase in number of gastro patients waiting over 65 weeks (92) 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 by accurate validation

Endoscopy capacity remains an issue however in September there will be a significant increase in 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 reviewing potential outsourcing for one stop weekend clinics to reduce 65 week waiters before the end of September

Additional rheumatology clinics with the support of the locum Consultant

Emergency Care

Key Messages

Consistently over achieving against the 78% threshold - July 78.7%

Issues, Concerns & Gaps

LOS and NCTR patients impacting ability to move DTAs out of ED department increasing longer waits in ED

Number of patients >12 hours in department continues to be a challenge – July 6.7%

The hospital has 61.6 overnight admissions per year to each bed whereas the average for England is 55 overnight admissions per year to each bed. To put this in another way, the hospital has 548 beds but a hospital with its workload would normally have 593 beds.

Actions & Improvements

Meeting 13.08.2024 re breach validation – process agreed that clinical staff will support flow coordinators with breach reason to ensure that clinical/speciality breaches etc… are captured correctly

Flow and discharge corporate project is in place that meets bi-weekly involving staff from all areas of the Trust and community partners focused on improving discharges to support movement out of ED
Please add your commentary here

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%			56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.5%	50.3%
				RTT 65+ Week Waiters	0			176	220	246	217	237	257	286	235	284	404	549	635
				RTT 40+ Week Waiters	-			4,235	4,370	4,395	4,523	5,311	5,569	5,927	6,296	6,434	6,627	6,662	6,771
				RTT Waiting List Size	-			39,676	40,403	41,150	41,562	42,487	43,133	43,716	44,646	44,751	44,491	44,528	44,632
				RTT 52 Week Breaches	1,250			1,143	1,209	1,291	1,441	1,439	1,659	1,886	2,159	2,360	2,610	2,834	2,939
				OP Average Time to First Appointment (days)	60			88.39	96.12	98.44	98.32	94.83	98.83	104.05	103.36	106.96	104.59	108.83	102.63
				Outpatient DNA Rate %	10.0%			7.4%	8.9%	7.5%	7.0%	7.5%	6.3%	6.2%	6.2%	6.2%	6.4%	6.3%	6.3%
				OP First to Follow Up Ratio	-			2.05	1.99	2.03	1.89	1.95	1.96	1.87	1.84	1.89	1.77	1.76	1.82
				Operations Cancelled by Hospital on Day	0			5	14	9	20	12	15	7	10	16	18	15	19
				Cancelled Operations Not Rescheduled < 28 Days %	-			80.0%	21.4%	22.2%	70.0%	75.0%	53.3%	42.9%	50.0%	50.0%	66.7%	73.3%	15.8%
				Urgent Operations Cancelled for 2nd Time	0			0	2	1	3	2	0	2	1	2	5	1	0
				Day Case Rate %	-			86.1%	85.5%	87.0%	85.9%	86.2%	87.9%	87.3%	86.1%	86.0%	85.4%	84.9%	83.1%
				Average Elective Length of Stay (days)	3			2.60	2.74	3.32	3	2.79	2.54	2.55	3.20	2.93	3.45	2.83	2.79

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10			4.50	4.89	4.83	4.79	4.81	4.66	4.63	4.28	4.51	4.50	5.37	6.04
				104 Day Cancer Waits	-			12	10	17	17	7	13	12	14	16	9	17	
				Cancer USC Performance %	93.0%			88.5%	93.4%	90.2%	85.8%	92.7%	84.9%	73.0%	72.8%	73.4%	70.1%	68.7%	
				Cancer USC Performance - Breast Symptomatic %	93.0%			41.7%	83.1%	80.0%	63.5%	69.4%	58.4%	38.4%	4.2%	2.9%	0.0%	9.9%	
				Cancer 31 Day First Treatment Performance %	98.2%			98.2%	98.8%	98.1%	93.6%	99.2%	97.0%	98.7%	98.4%	94.9%	98.1%	97.2%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%			100.0%	91.7%	97.5%	100.0%	100.0%	91.2%	100.0%	100.0%	90.5%	100.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%			85.0%	95.0%	93.9%	93.8%	100.0%	81.3%	86.4%	92.6%	75.0%	94.6%	92.6%	
				Cancer 62 Day Treatment - GP Refs %	85.1%			74.8%	78.9%	65.6%	68.1%	79.0%	72.5%	68.1%	68.2%	67.4%	67.6%	68.2%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%			76.7%	83.3%	81.3%	81.6%	78.4%	80.3%	72.2%	90.0%	71.4%	71.4%	81.6%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%			87.5%	65.9%	72.4%	85.2%	74.1%	73.3%	47.6%	95.7%	77.6%	84.2%	80.0%	
				Cancer 28 Day Faster Diagnosis %	77.0%			74.0%	70.0%	66.6%	65.2%	69.8%	63.1%	73.0%	66.0%	56.5%	53.7%	52.3%	
				Cancer 28 Day Faster Diagnosis Screening %	-			66.1%	61.9%	68.5%	74.1%	76.7%	47.7%	79.3%	76.5%	72.2%	76.7%	74.5%	
				DM01 Performance %	73.1%			59.8%	61.6%	61.3%	62.1%	56.6%	59.5%	66.7%	66.9%	65.4%	67.1%	67.4%	67.6%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	78.0%			75.9%	76.6%	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%			81.8%	82.3%	82.6%	78.7%	73.8%	75.7%	77.9%	83.0%	86.9%	84.0%	84.7%	84.1%
				IP Discharged Before Noon % (Inc transfers to ADL)	-			17.4%	17.0%	16.8%	17.3%	15.0%	14.1%	14.3%	12.6%	12.6%	13.9%	12.2%	16.6%
				Type 1 EC 4 Hour Performance %	75.0%			64.2%	65.8%	65.2%	62.0%	52.9%	59.1%	63.5%	69.3%	69.5%	70.6%	68.8%	68.5%
				Total EC 12 Hour DTAs	0			387	572	742	766	785	953	798	798	521	588	618	663
				Average Time in EC Department - Excl. Type 5 (mins)	240			311.69	316.19	339.48	357.44	401.11	424.67	389.04	335.25	298.57	298.55	305.83	317.08
				Number of ED Arrivals by Ambulance	-			2,978	3,009	3,107	3,137	3,167	3,281	2,956	3,173	2,981	2,993	2,869	2,919
				Ambulance Handover Delays (> 30 mins)	-			42	46	73	85	177	161	90	103	67	49	73	59
				Ambulance Handover Delays (> 60 mins)	0			2	3	1	3	10	9	5	6	3	3	2	2
				Bed Occupancy - NCTR % (G&A)	-			25.8%	29.4%	22.9%	19.9%	23.6%	16.6%	23.8%	22.2%	19.8%	20.3%	31.7%	16.3%
				30 Day Readmission Rate	13.0%			9.1%	9.3%	10.1%	9.7%	10.1%	9.2%	10.0%	9.8%	10.0%	10.4%	8.9%	7.9%

People

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

NHS Medway NHS Foundation Trust

Leon Hinton

Chief People Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	10	21	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	32	12	1	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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	6.93			6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65

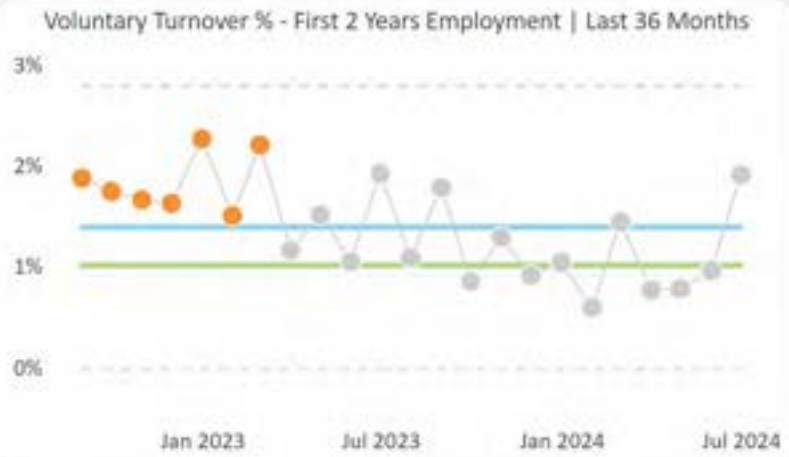
True North Domain: People

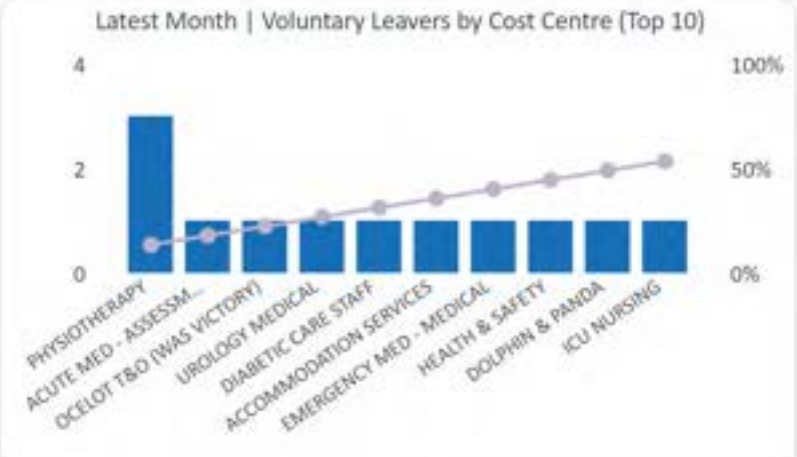
KPI Threshold: 6.93

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 July 2024 reporting significantly off target in month. The majority of leavers had stay conversations as part of the new intention to leave process; reasons for all have been reviewed by the divisional teams for learning and action.

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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	Workforce			Voluntary Turnover % - First 2 Years Employment	1.00%			Driver is red latest reporting period	0.6%	1.4%	0.8%	0.8%	0.9%	1.9%
				Staff Appraisal Rate %	90.0%			Watch is red for 4 reporting periods	89.1%	89.6%	89.5%	88.9%	88.5%	89.0%
				Voluntary Turnover %	8.0%			Watch is red for 4 reporting periods	9.7%	9.4%	9.1%	8.8%	8.7%	8.7%
				Sickness Absence Rate - Total %	4.0%			Watch is red for 4 reporting periods	4.9%	4.3%	4.4%	4.7%	5.1%	4.9%
				Sickness Absence Rate - Short Term %	2.0%			Watch is red for 4 reporting periods	2.4%	2.0%	2.2%	2.2%	2.4%	2.3%
				Sickness Absence Rate - Long Term %	2.0%			Watch is red for 4 reporting periods	2.5%	2.3%	2.2%	2.5%	2.7%	2.6%
				Time to Hire - AfC	42			Watch is red for 4 reporting periods	60	66.10	61.10	55.30	47.90	54
				Bank Spend %	10.0%			Watch is red for 4 reporting periods	11.7%	8.6%	11.1%	10.2%	10.4%	12.1%
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%			Watch is red for 4 reporting periods	78.9%	78.9%	79.6%	80.4%	79.9%	79.8%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%			Watch is red for 4 reporting periods	44.5%	43.7%	43.4%	43.9%	46.7%	48.0%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%			Watch is red for 4 reporting periods	63.6%	66.9%	65.8%	66.3%	68.7%	72.6%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%			Watch is red for 4 reporting periods	77.6%	76.7%	77.2%	79.3%	80.5%	81.9%
				StatMan: Adult Basic Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	80.9%	82.1%	80.9%	81.1%	82.1%	81.9%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	StatMan			StatMan: Mental Health Liaison Service Compliance %	85.0%			Watch is red for 4 reporting periods	71.2%	77.8%	77.3%	80.0%	81.4%	81.7%
				StatMan: New Born Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	78.5%	82.9%	82.0%	80.2%	80.8%	79.9%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	77.6%	79.1%	78.4%	78.4%	79.7%	78.0%
	Compliance			DBS Compliance %	100.0%			Watch is red for 4 reporting periods	99.7%	99.7%	99.7%	99.7%	99.7%	99.8%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	Workforce			National Staff Engagement Score	6.93		Special cause of improving nature or lower pressure due to (H)igher values	6.65	6.65				
				Staff Appraisal Rate %	90.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.1%	89.6%	89.5%	88.9%	88.5%	89.0%
				Staff in Post (FTE)	-		Special cause of improving nature or lower pressure due to (H)igher values	5,003.02	5,031.72	5,040.40	5,034.17	5,034.29	5,035.56
				Staff Leavers (FTE)	-		Special cause of improving nature or lower pressure due to (L)ower values	35.66	53.55	37.79	43.58	40.21	61.65
				Vacancy Rate %	9.0%		Special cause of improving nature or lower pressure due to (L)ower values	3.4%	2.9%	8.1%	7.7%	7.6%	7.8%
				Voluntary Turnover %	8.0%		Special cause of improving nature or lower pressure due to (L)ower values	9.7%	9.4%	9.1%	8.8%	8.7%	8.7%
				Agency Spend %	3.7%		Special cause of improving nature or lower pressure due to (L)ower values	2.7%	1.1%	2.1%	2.4%	1.5%	1.7%
	Safe Staffing			Staff Fill Rate - Total %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.6%	92.3%	95.1%	94.7%	94.6%	94.8%
				Staff Fill Rate % (Total) - Registered Nurse	-		Special cause of improving nature or lower pressure due to (H)igher values	90.0%	89.9%	91.7%	90.7%	90.1%	90.2%
				Care Hours per Patient Day (CHPPD)	9.50		Special cause of improving nature or lower pressure due to (H)igher values	9.20	9.05	9.82	9.98	9.48	9.41
	Diversity			Diversity of Workforce %	-		Special cause of improving nature or lower pressure due to (H)igher values	40.5%	40.8%	41.1%	41.5%	42.0%	42.0%
	StatMan			StatMan Training Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	87.9%	87.7%	88.1%	88.8%	89.0%	89.2%
				StatMan: Conflict Resolution Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.1%	94.5%	94.9%	95.2%	95.0%	95.0%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-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%	95.6%	95.9%	96.0%	95.9%
				StatMan: Fire Safety Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	82.9%	81.2%	84.2%	85.9%	84.5%	85.6%
				StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	93.6%	94.0%	94.3%	94.8%	95.4%	95.4%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	87.2%	88.0%	89.1%	91.2%	92.7%	92.2%
				StatMan: Infection Prevention L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.9%	97.5%	97.0%	97.1%	97.6%	96.7%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.0%	90.1%	91.4%	92.3%	93.1%	93.2%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.4%	97.3%	96.7%	96.9%	97.3%	96.2%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	63.6%	66.9%	65.8%	66.3%	68.7%	72.6%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.4%	97.0%	96.6%	97.0%	97.4%	96.4%
				StatMan: Advanced Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	71.8%	75.2%	79.1%	83.7%	85.4%	85.1%
				StatMan: Adult Basic Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	80.9%	82.1%	80.9%	81.1%	82.1%	81.9%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	80.2%	80.2%	85.6%	83.0%	80.9%	80.5%
				StatMan: Anaphylaxis Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.8%	91.7%	90.3%	89.7%	89.9%	90.8%

People

Key Messages

- The Trust's breakthrough objective to reduce voluntary turnover for individuals with less than 24 months service reports off target for the month (met business rules for six out eight months), opposing the continued improvement to the Trust's overall voluntary leaver rate (above target, improving).
- 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 but improving. Focus on the corporate areas performance (off track) is focus for July and August.
- Medical staffing time to hire is now on target at 42.6 days. Successful recruitment to difficult to appoint roles including consultant anaesthetists.
- Continued improvements to nursing bank fill rate for demand at 84.9%.
- New occupational health handbook (updated and integrated policies) now live to support employees and services.

Issues, Concerns & Gaps

- Absence remains above target with an improvement for July; however, this remains higher than normal for July. Reasons for sickness remain high for musculoskeletal-related absences, cold/flu and pregnancy-related. Triangulation meetings for employee relations, wellbeing and occupational health now underway for root cause determination and countermeasures.
- 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).
- Significant increase in bank spend for July, this is to be reviewed against demand and HR data.

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 ready for launch on 15 August 2024;
- Positive action policy out for consultation;
- Inclusion by Design (IBD) Training in delivery, 11 sessions between July 2024 and April 2025

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	Workforce			National Staff Engagement Score	6.93			6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65				
				Voluntary Turnover % - First 2 Years Employment	1.00%			1.1%	1.8%	0.8%	1.3%	0.9%	1.0%	0.6%	1.4%	0.8%	0.8%	0.9%	1.9%
				Staff Appraisal Rate %	90.0%			91.8%	90.1%	89.9%	89.9%	89.2%	89.1%	89.1%	89.6%	89.5%	88.9%	88.5%	89.0%
				Staff in Post (FTE)	-			4,793.29	4,789.07	4,870.78	4,906.26	4,935.04	4,956.89	5,003.02	5,031.72	5,040.40	5,034.17	5,034.29	5,035.56
				Staff Leavers (FTE)	-			129.36	82.43	65.89	57.12	46.37	39.76	35.66	53.55	37.79	43.58	40.21	61.65
				Staff Starters (FTE)	-			164.09	102.71	133.28	78.48	45.43	86.30	68.08	46.99	53.41	21.66	34.84	55.56
				Vacancy Rate %	9.0%			6.1%	5.5%	5.1%	5.2%	4.6%	4.2%	3.4%	2.9%	8.1%	7.7%	7.6%	7.8%
				Voluntary Turnover %	8.0%			11.4%	11.3%	10.9%	10.9%	10.7%	10.2%	9.7%	9.4%	9.1%	8.8%	8.7%	8.7%
				Voluntary Turnover (ICS) %	-			1.2%	1.4%	0.9%	1.2%	1.0%	0.8%	0.7%	1.0%	0.6%	0.9%	0.8%	1.2%
				Sickness Absence Rate - Total %	4.0%			4.7%	4.9%	4.9%	4.5%	5.1%	5.5%	4.9%	4.3%	4.4%	4.7%	5.1%	4.9%
				Sickness Absence Rate - Short Term %	2.0%			2.4%	2.7%	2.4%	2.2%	2.9%	3.2%	2.4%	2.0%	2.2%	2.2%	2.4%	2.3%
				Sickness Absence Rate - Long Term %	2.0%			2.3%	2.2%	2.5%	2.3%	2.2%	2.3%	2.5%	2.3%	2.2%	2.5%	2.7%	2.6%
				Time to Hire - AfC	42			71.50	78.40	66.70	62.10	60.40	88.10	60	66.10	61.10	55.30	47.90	54

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	Workforce			Time to Hire - Medical	70			83.70	92	89.60	65.30	147.70	107	76	54.90	91.30	66.70	58.90	42.60
				Agency Spend %	3.7%			2.9%	3.0%	2.6%	3.5%	2.7%	2.0%	2.7%	1.1%	2.1%	2.4%	1.5%	1.7%
				Bank Spend %	10.0%			13.8%	9.8%	12.2%	10.9%	11.0%	13.1%	11.7%	8.6%	11.1%	10.2%	10.4%	12.1%
	Safe Staffing			Staff Fill Rate - Total %	85.0%			90.5%	88.1%	89.5%	92.8%	90.0%	91.1%	91.6%	92.3%	95.1%	94.7%	94.6%	94.8%
				Staff Fill Rate % (Total) - Registered Nurse	-			86.3%	84.8%	87.7%	89.3%	88.2%	88.8%	90.0%	89.9%	91.7%	90.7%	90.1%	90.2%
				Care Hours per Patient Day (CHPPD)	9.50			9.15	9.03	9.05	9.18	9.06	9.10	9.20	9.05	9.82	9.98	9.48	9.41
	Diversity			Diversity of Workforce %	-			-	38.6%	39.2%	39.7%	40.0%	40.3%	40.5%	40.8%	41.1%	41.5%	42.0%	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%	21.4%
	StatMan			StatMan Training Compliance %	85.0%			83.7%	84.9%	86.1%	86.7%	87.5%	87.4%	87.9%	87.7%	88.1%	88.8%	89.0%	89.2%
				StatMan: Conflict Resolution Compliance %	85.0%			92.0%	92.4%	92.7%	93.5%	94.0%	93.5%	94.1%	94.5%	94.9%	95.2%	95.0%	95.0%
				StatMan: EDI Compliance %	85.0%			94.3%	94.2%	94.3%	95.0%	95.5%	95.4%	95.4%	95.4%	95.6%	95.9%	96.0%	95.9%
				StatMan: Fire Safety Compliance %	85.0%			83.7%	83.2%	83.1%	82.5%	82.1%	81.7%	82.9%	81.2%	84.2%	85.9%	84.5%	85.6%
				StatMan: Freedom to Speak Up Compliance %	85.0%			87.7%	89.5%	90.5%	91.7%	92.7%	93.0%	93.6%	94.0%	94.3%	94.8%	95.4%	95.4%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	StatMan			StatMan: Freedom to Speak Up Compliance % - Managers	85.0%			74.0%	76.6%	79.4%	82.4%	83.7%	86.8%	87.2%	88.0%	89.1%	91.2%	92.7%	92.2%
				StatMan: Health Safety and Welfare Compliance %	85.0%			90.2%	88.3%	86.7%	86.7%	89.8%	89.3%	89.6%	89.2%	88.9%	88.9%	90.1%	90.8%
				StatMan: Infection Prevention L1 Compliance %	85.0%			93.6%	93.9%	94.8%	95.8%	95.6%	96.3%	96.9%	97.5%	97.0%	97.1%	97.6%	96.7%
				StatMan: Infection Prevention L2 Compliance %	85.0%			87.1%	87.7%	89.1%	89.0%	89.6%	88.8%	88.7%	88.5%	89.7%	89.6%	89.1%	88.6%
				StatMan: Information Governance Compliance %	85.0%			89.7%	89.9%	90.8%	90.7%	90.9%	90.4%	91.0%	90.8%	91.6%	91.8%	91.1%	89.9%
				StatMan: Moving and Handling L1 Compliance %	85.0%			47.3%	66.6%	77.9%	83.2%	85.8%	87.4%	89.0%	90.1%	91.4%	92.3%	93.1%	93.2%
				StatMan: Moving and Handling L2 Compliance %	85.0%			83.9%	81.0%	80.6%	80.7%	81.2%	79.2%	78.9%	78.9%	79.6%	80.4%	79.9%	79.8%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%			50.6%	48.0%	44.1%	44.9%	45.1%	45.0%	44.5%	43.7%	43.4%	43.9%	46.7%	48.0%
				StatMan: Patient Safety L1 Compliance %	85.0%			92.9%	93.5%	94.3%	94.5%	95.1%	95.3%	95.4%	88.6%	87.7%	90.3%	91.7%	91.3%
				StatMan: Patient Safety L2 Compliance %	85.0%			-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%			92.3%	92.4%	93.7%	94.9%	96.1%	94.6%	96.0%	97.0%	97.1%	97.3%	97.6%	96.0%
				StatMan: Prevent WRAP Compliance %	85.0%			90.3%	88.1%	87.3%	87.3%	87.6%	86.9%	87.2%	87.8%	88.3%	89.1%	88.3%	89.0%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%			93.6%	94.1%	94.0%	95.0%	96.0%	95.8%	96.4%	97.3%	96.7%	96.9%	97.3%	96.2%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	StatMan			StatMan: Safeguarding Adults Level 2 Compliance %	85.0%			91.6%	93.0%	93.1%	93.2%	94.0%	92.0%	91.8%	91.1%	91.3%	92.3%	92.5%	91.8%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%			36.6%	43.6%	48.2%	54.5%	57.2%	59.6%	63.6%	66.9%	65.8%	66.3%	68.7%	72.6%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%			92.7%	93.4%	94.2%	94.6%	95.5%	96.0%	96.4%	97.0%	96.6%	97.0%	97.4%	96.4%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%			88.3%	88.0%	85.7%	84.6%	84.4%	82.8%	83.2%	82.9%	84.5%	86.0%	86.2%	87.2%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%			82.2%	80.8%	80.9%	82.0%	80.0%	79.9%	77.6%	76.7%	77.2%	79.3%	80.5%	81.9%
				StatMan: Advanced Life Support Compliance %	85.0%			71.8%	77.0%	77.7%	76.6%	74.5%	74.5%	71.8%	75.2%	79.1%	83.7%	85.4%	85.1%
				StatMan: Adult Basic Life Support Compliance %	85.0%			79.4%	81.4%	82.7%	82.4%	81.4%	82.0%	80.9%	82.1%	80.9%	81.1%	82.1%	81.9%
				StatMan: Adult Immediate Life Support Compliance %	85.0%			78.6%	75.8%	74.3%	74.4%	75.1%	76.3%	80.2%	80.2%	85.6%	83.0%	80.9%	80.5%
				StatMan: Anaphylaxis Compliance %	85.0%			83.2%	84.4%	87.7%	90.2%	90.1%	91.1%	91.8%	91.7%	90.3%	89.7%	89.9%	90.8%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%			73.2%	72.7%	80.4%	81.8%	81.5%	76.4%	65.5%	74.1%	72.4%	68.3%	83.9%	85.9%
				StatMan: Mental Health Liaison Service Compliance %	85.0%			72.6%	69.5%	68.0%	66.3%	70.7%	71.7%	71.2%	77.8%	77.3%	80.0%	81.4%	81.7%
				StatMan: New Born Life Support Compliance %	85.0%			72.8%	73.4%	77.3%	77.5%	71.7%	73.4%	78.5%	82.9%	82.0%	80.2%	80.8%	79.9%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%			74.0%	75.4%	77.7%	77.7%	78.2%	79.3%	77.6%	79.1%	78.4%	78.4%	79.7%	78.0%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	StatMan			StatMan: Paediatric Immediate Life Support Compliance %	85.0%			78.7%	72.2%	68.9%	64.1%	70.7%	76.1%	87.7%	83.4%	83.5%	84.1%	85.5%	85.9%
	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%	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%	99.8%

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	22	2	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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	£0.00m			3.91m	3.67m	3.04m	2.98m	1.75m	3.33m	-2.56m	2.76m	0.28m	-0.10m	0.14m	-0.07m

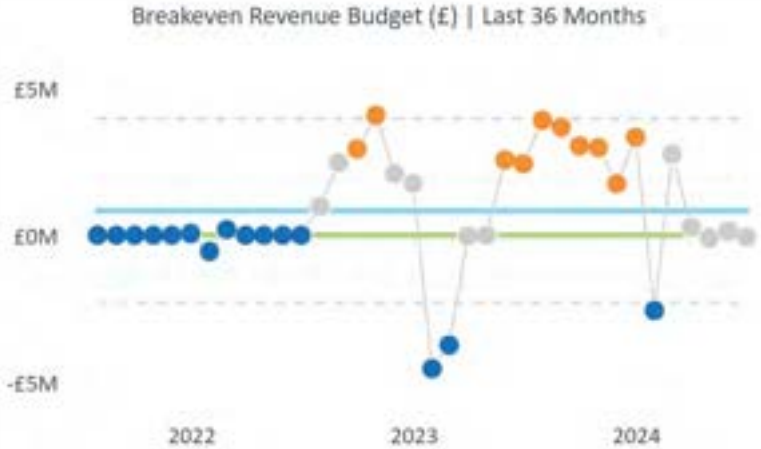
True North Domain: Sustainability

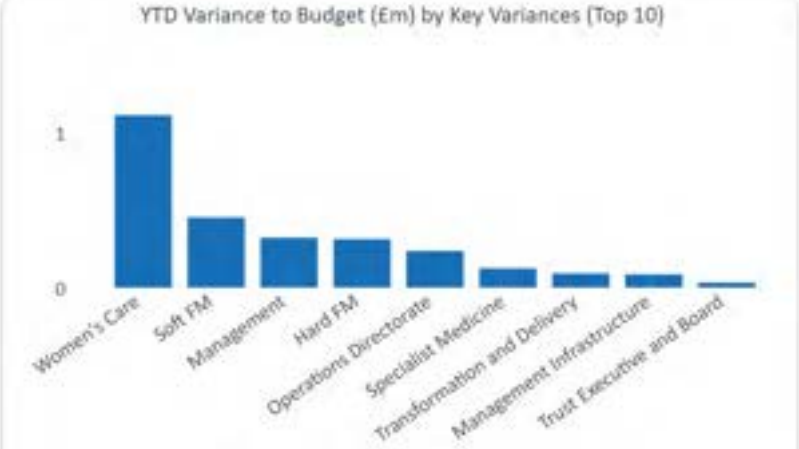
KPI Threshold: £0.00m

Sub Domain KPIs: 12

Variation Summary:

9	1	1	0	1





Key Messages

The Trust reports on plan for the month and £0.5m adverse YTD, driven by over £0.5m 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 and run-rate improvements, i.e. those which will reduce our actual current expenditure, are key to deliver the outturn and exit run-rate requirement.

The Trust has a significant capital maintenance backlog and would require external allocations in order to be able to deliver all identified works in the medium term.

Actions & Improvements

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

To mitigate the above, continued resilience in managing/controlling the 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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Sustainability	Financial Position			Total Financial Overspend (£)	£0.00m			Driver is red for 2 reporting periods	6.02m	19.01m	1.56m	0.61m	1.62m	1.37m
				(Surplus) / Deficit (£)	£0.00m			Watch is red for 4 reporting periods	-15.51m	2.47m	3.57m	3.33m	2.85m	2.31m

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Sustainability	Financial Position			Actual Worked FTE	-		Special cause of improving nature or lower pressure due to (H)igher values	5,542.70	5,570.28	5,475	5,452.75	5,470.54	5,531.73

Sustainability

Key Messages

The Trust is reporting £0.5m adverse to plan for the year to date at month 4 (July 2024). This is driven by over £0.5m 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 and run-rate improvements, i.e. those which will reduce our actual current expenditure, are key to deliver the outturn and exit run-rate requirement.

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.

The Trust has a significant capital maintenance backlog and would require external allocations in order to be able to deliver all identified works in the medium term.

Actions & Improvements

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

To mitigate the above, continued resilience in managing/controlling the 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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m			3.91m	3.67m	3.04m	2.98m	1.75m	3.33m	-2.56m	2.76m	0.28m	-0.10m	0.14m	-0.07m
				Total Financial Overspend (£)	£0.00m			5.33m	4.83m	5.43m	5.17m	5.79m	6.32m	6.02m	19.01m	1.56m	0.61m	1.62m	1.37m
				(Surplus) / Deficit (£)	£0.00m			4.90m	4.66m	3.84m	3.78m	2.55m	4.13m	-15.51m	2.47m	3.57m	3.33m	2.85m	2.31m
				Agency Spend (£)	-			0.74m	0.80m	0.65m	0.88m	0.68m	0.54m	0.71m	0.42m	0.55m	0.61m	0.40m	0.44m
				Income (£)	-			-35.35m	-36.35m	-35.74m	-36.63m	-39.02m	-38.07m	-56.72m	-52.27m	-37.37m	-37.52m	-37.02m	-39.81m
				Income (£) vs Budget	£0.00m			-1.02m	-0.58m	-1.18m	-2.07m	-4.45m	-3.49m	-8.38m	-16.46m	0.50m	0.33m	0.85m	-0.93m
				Total Pay Spend (£)	-			25.75m	26.83m	25.24m	24.93m	25.00m	26.71m	25.99m	37.01m	25.67m	25.86m	26.29m	26.13m
				Total Pay Spend (£) vs Budget	£0.00m			4.04m	3.22m	3.25m	3.70m	3.17m	4.85m	4.10m	14.99m	-0.46m	-0.05m	0.76m	0.03m
				Total Non-Pay Spend (£)	-			12.52m	11.77m	12.22m	13.18m	14.42m	13.35m	13.09m	15.22m	12.96m	12.65m	11.48m	13.56m
				Total Non-Pay Spend (£) vs Budget	£0.00m			1.04m	0.74m	0.97m	1.17m	3.01m	1.95m	1.72m	3.85m	0.30m	-0.33m	-1.26m	0.91m
				Actual Worked FTE	-			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	5,531.73
				Actual Worked FTE vs Budget	0			211.60	150.93	284.50	204.96	264.97	332.87	347.90	361.66	-27.32	-17.51	7.26	50.36

Finance report

For the period ending 31 July 2024

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(2,381)	(2,310)	71	The Trust is reporting a £12.2m deficit year to date (YTD), this being £0.5m adverse to the July plan submission; this is due to £0.5m of costs associated with covering industrial action, for which we anticipate a national solution.
Donated asset depreciation	24	25	1	
In-month total	**(2,357)**	**(2,285)**	**72**	
YTD total	**(11,720)**	**(12,216)**	**(496)**	
Efficiencies Programme				
In-month	1,730	2,182	452	The efficiency programme has over achieved in-month by £0.5m and under achieved by £0.4m YTD. There remains a balance of unidentified budget out efficiencies against the plan; this continues to be focused on by all services, as well as implementing operational controls to reduce expenditure.
YTD	4,576	4,198	(378)	
Cash				
Month end	4,900	9,611	5,712	The cash balance is £5.7m favourable to plan. This is due to additional revenue support drawn to ensure the Trust can pay creditors before contract payments are received on the 15th of the month.
Capital				
YTD				Capital investment for 2024/25 is planned at £31.4m; there have been no change since month 3.
Capex	7,093	2,873	(4,220)	£5.1m is yet to be allocated to projects from operational capital.
Leases	5,250	0	(5,250)	The adverse performance is mainly due to the CDC project where leases expected to be finalised by May are still unresolved, affecting both lease capitalisation and works expenditure. The Sheppey lease with NHS Property Services is expected to be signed before the end of Month 5. The Rochester lease with CHP has been added to the Trust risk register and escalated to The ICB and NHSE in order to avoid sliappage across further financial years.
Total	**12,343**	**2,873**	**(9,470)**	
Annual Forecast	**31,423**	**31,423**	0	

2. Income and expenditure

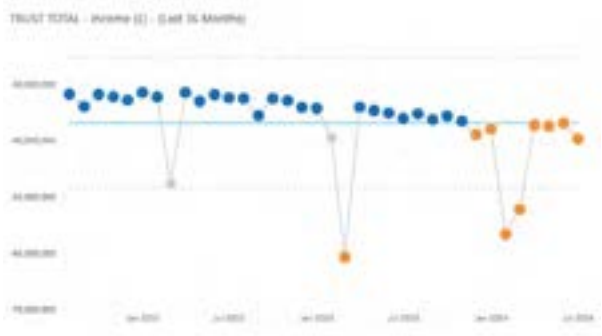
£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	33,234	34,439	1,205	133,972	130,236	(3,737)
High cost drugs	2,196	2,621	425	8,642	9,597	956
Other income	2,112	2,736	624	8,523	11,841	3,318
Donated Asset Adjustment	-	14	14	-	49	49
Total income	**37,542**	**39,810**	**2,268**	**151,137**	**151,723**	**586**
Nursing	(10,309)	(10,528)	(219)	(41,165)	(41,996)	(831)
Medical	(8,058)	(8,484)	(426)	(32,412)	(33,257)	(845)
Other	(7,677)	(7,120)	556	(31,186)	(28,699)	2,487
Unidentified efficiencies	985	-	(985)	2,129	-	(2,129)
Total pay	**(25,058)**	**(26,132)**	**(1,074)**	**(102,634)**	**(103,952)**	**(1,318)**
Clinical supplies	(4,782)	(5,228)	(446)	(20,154)	(19,739)	414
Drugs	(1,181)	(1,319)	(138)	(4,544)	(4,476)	68
High cost drugs	(2,196)	(2,621)	(425)	(8,642)	(9,660)	(1,018)
Other	(4,717)	(4,391)	325	(18,943)	(16,779)	2,164
Unidentified efficiencies	516	0	(516)	1,532	0	(1,532)
Total non-pay	**(12,360)**	**(13,560)**	**(1,199)**	**(50,751)**	**(50,655)**	**96**
EBITDA	**124**	**118**	**(6)**	**(2,248)**	**(2,883)**	**(635)**
Non-operating exp.	**(2,505)**	**(2,428)**	**76**	**(9,563)**	**(9,181)**	**382**
Reported surplus/(deficit)	**(2,381)**	**(2,310)**	**71**	**(11,811)**	**(12,064)**	**(253)**
Adj. to control total	**24**	**25**	**1**	**91**	**(152)**	**(243)**
Control total	**(2,357)**	**(2,285)**	**72**	**(11,720)**	**(12,216)**	**(496)**

1. Clinical income reports adverse performance of £3.7m YTD; this is due to centrally held items from planning that have not yet materialised, including the mobile endoscopy funding/activity, under delivery of ERF stretch income targets (including capture and counting) and funding of Ruby ward. High cost drugs favourable income is offset with expenditure reported in non-pay.
2. The 'other income' favourable variance is mainly due to medical education income (£1.3m YTD) following an updated schedule from NHS England (Workforce, Training and Education), estates and facilities income above plan for retail catering, car parking and the transport pilot. (£0.3m), Provider to Provider contract within CCCS (£0.5m) and further inflation funding for the consultant pay award.
3. The July pay run-rate has decreased by £0.2m - this includes £0.5m of costs incurred to provide cover for the junior medical staff industrial action; at this stage no funding has been agreed or assumed in the position. Additional costs associated with the GP action are being collated. The total staffing increase in-month is 18 WTE, which excludes the impact of industrial action bank cover. The increase is due to sickness and to avoid dropping theatre sessions.
4. The overall pay variance is adverse by £1.3m YTD, being a deterioration of £1m from month 3 primarily due to the unidentified efficiencies. Temporary staff numbers have increased overall by 53 WTE; these continue to be required to cover vacancies and sickness, remaining a focus for the services to challenge all temporary staff bookings.
5. Nursing staff report an adverse performance of £0.2m in-month and £0.8m YTD. This continues to be from pressures in emergency and acute care (£0.5m) as well as Frailty (£0.3m). The medical overspend arises due to unfunded industrial action costs.
6. The 'clinical supplies' favourable variance includes reserves held centrally for the Endoscopy mobile unit (now expected in August 2024) and for cost pressures/business cases identified during business planning that are not yet approved through governance processes.
7. The unidentified efficiencies are a combination of the gap between devolved divisional targets and the identified schemes, as well approved schemes in progress that require budget holder approval before they can be actioned through the budgets.

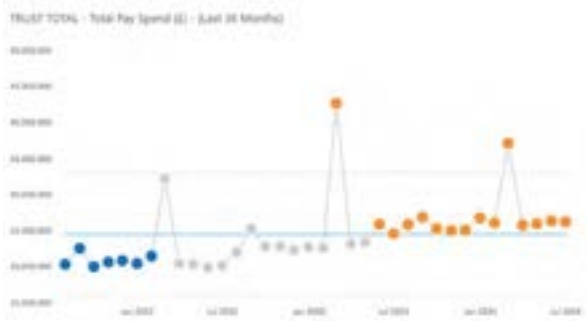
3. Run-rate

The charts below are examples of some of the statistical process control (SPC) charts available from the business intelligence platform; by analysing the changes in the run-rate over time, the divisions can understand different variations within particular areas of spend and whether results are as expected.

Income



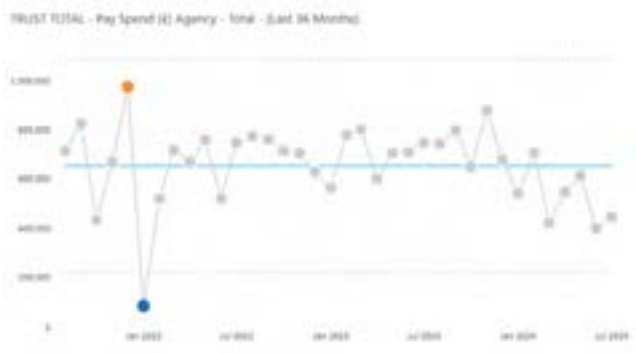
Pay



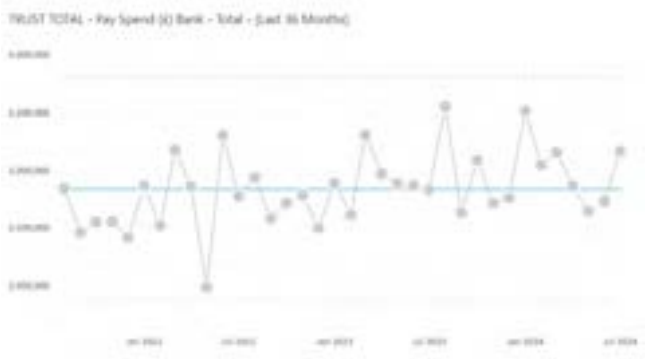
Full Time Equivalents worked

Non-pay

Agency

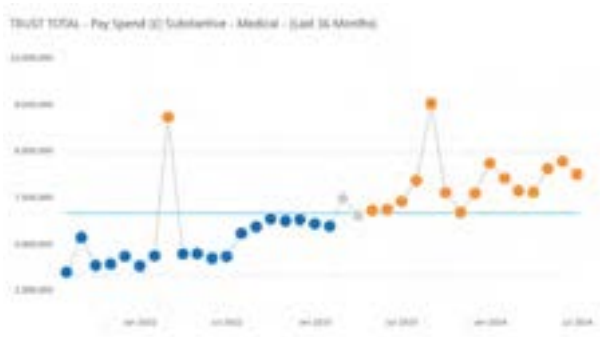


Bank



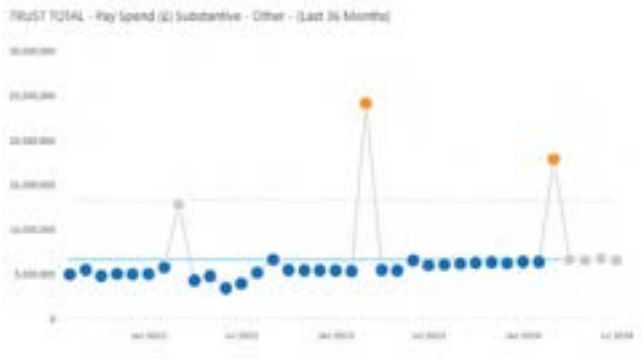
The pay spends results for March in each of the three years include the impact of the additional 6.3% pension costs, for which there is a corresponding increase to income as represented in the first chart. The total spend includes the impact of the pay awards, industrial action and the gradual growth in the workforce, for example increases for escalation capacity, service transformation, ERF activity and approved business cases (CDC, Virtual Wards, Teletracking, etc.), as well as unfunded cost pressures and areas of overspending which have been addressed through budget setting and the financial sustainability breakthrough objective. When comparing the total number of FTE to March, there has been a reduction of 40 FTE - this results from tighter controls over rostering and bank bookings that continues to be prioritised across all divisions.

Medical pay total

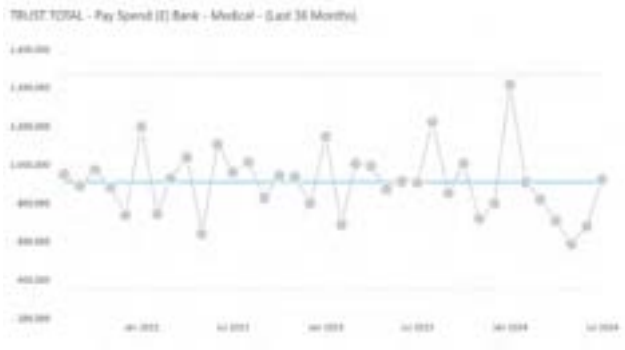


Nursing pay total

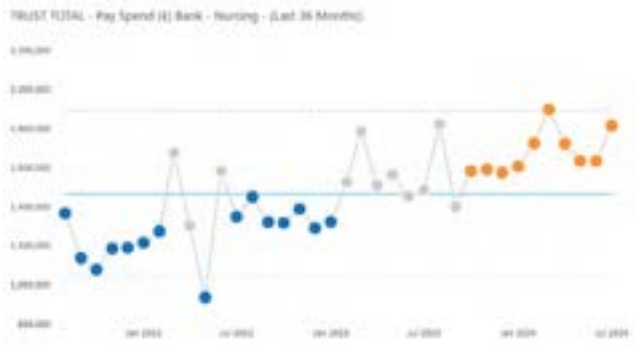
Other staff pay



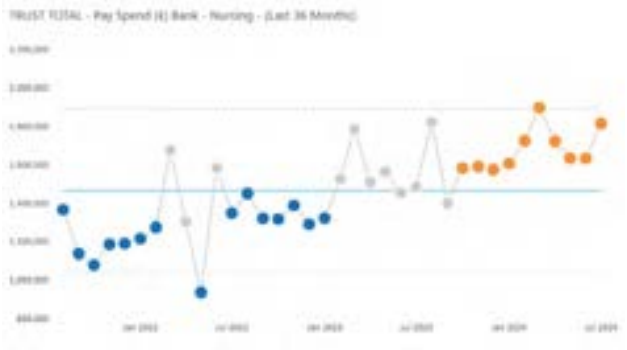
Medical bank



Nursing bank



Other Staff bank



Medical agency

Nursing agency

Other Staff agency

Medical pay costs increase in May includes the pay award and backdated costs for April'24, The June costs also include £0.5m industrial action costs. Medical temporary staff usage has increased in month by £0.2m, mainly due to pressures across the Surgery and Anaesthetics division.

Nursing temporary staff expenditure in-month has increased by £0.2m predominately across theatres and enhanced care
The April bank spend include the increase in rates, of which the estimated monthly impact is £0.2m.

The increase in other agency staff is due to higher cost of the bed turnaround team which has been recruited to and the agency will now cease, and a increase in the costs of agency pharmacists.

4. Statement of Financial Position

Prior year end	£'000	Month end actual	Var on PY.
281,888	**Non-current assets**	**278,430**	**(3,458)**
6,556	Inventory	6,888	332
29,573	Trade and other receivables	38,338	8,765
21,042	Cash	9,611	(11,431)
57,171	**Current assets**	**54,837**	**(2,334)**
(357)	Borrowings	(71)	286
(57,536)	Trade and other payables	(50,838)	6,698
(1,166)	Other liabilities	(5,245)	(4,079)
(59,059)	**Current liabilities**	**(56,154)**	**2,905**
(3,073)	Borrowings	(3,009)	64
(1,307)	Other liabilities	(1,307)	0
(4,380)	**Non-current liabilities**	**(4,316)**	**64**
275,620	**Net assets employed**	**272,797**	**(2,823)**
489,836	Public dividend capital	499,078	9,242
(275,397)	Retained earnings	(287,462)	(12,065)
61,181	Revaluation reserve	61,181	0
275,620	**Total taxpayers' equity**	**272,797**	**(2,823)**

Key messages:

1. Non-current assets are £3.5m lower than year end, being the net impact of investment expenditure of £2.8m and £6.3m depreciation

2. In month 4 the Trust has net current liabilities of £1.3m, an improvement on month 3 due to the increased cash balance.

3. Trade and other receivables are £38.3m (104% of one month's income); £15.8m (42%) relates to invoices raised and awaiting payment.

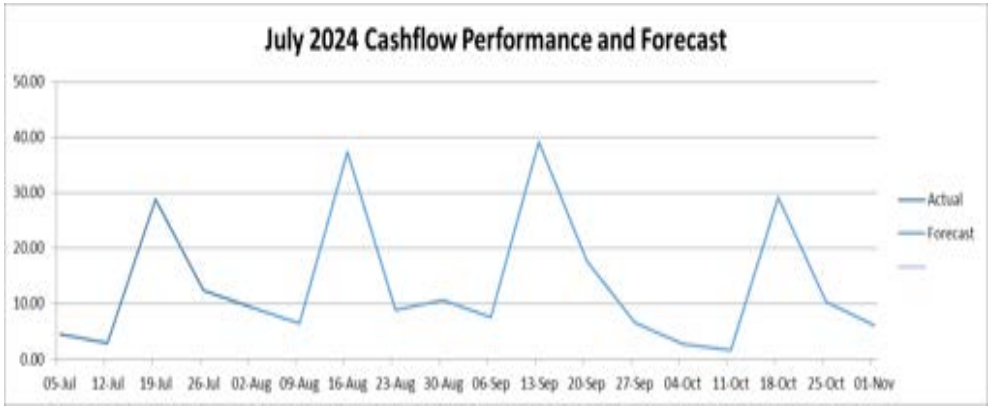
4. Cash has decreased by £11.4m since the year end due to payment of prior year capital creditors (approx. £5.7m) and the I&E deficit (£12.1m) net of additional revenue support received.

5. Trade and other payables are £50.8m (137% of one month's expenditure); £27.2m (54%) relates to invoices received and awaiting payment.

5. Cash

13-week cash forecast

	Actual					Forecast												
£m	05/07/24	12/07/24	19/07/24	26/07/24	02/08/24	09/08/24	16/08/24	23/08/24	30/08/24	06/09/24	13/09/24	20/09/24	27/09/24	04/10/24	11/10/24	18/10/24	25/10/24	01/11/24
BANK BALANCE B/F	**5.46**	**4.43**	**2.94**	**28.78**	**12.36**	**9.25**	**6.42**	**37.45**	**8.83**	**10.69**	**7.54**	**39.17**	**17.70**	**6.59**	**2.80**	**1.64**	**29.13**	**10.35**
Receipts																		
NHS																		
Contract																		
Income	0.29	0.37	38.02	0.52	0.61	0.07	34.24	0.00	0.00	0.00	34.62	0.00	0.00	0.00	0.00	38.45	0.00	0.00
Other	0.24	0.17	0.32	0.13	0.17	0.88	0.47	0.25	0.35	0.31	0.47	0.25	0.54	0.25	0.31	0.47	0.54	0.25
Total receipts	**0.53**	**0.53**	**38.33**	**0.65**	**0.78**	**0.95**	**34.72**	**0.25**	**0.35**	**0.31**	**35.09**	**0.25**	**0.54**	**0.25**	**0.31**	**38.92**	**0.54**	**0.25**
Payments																		
Pay Expenditure (exc	(0.52)	(0.52)	(3.98)	(20.19)	(0.48)	(0.52)	(0.46)	(23.93)	(0.49)	(0.46)	(0.46)	(11.13)	(13.78)	(0.49)	(0.46)	(3.89)	(20.55)	(0.49)
Non Pay Expenditure	(1.04)	(1.38)	(8.43)	(1.87)	(3.39)	(3.25)	(2.75)	(4.94)	(2.73)	(3.00)	(3.00)	(5.04)	(3.00)	(3.56)	(1.00)	(4.74)	(10.40)	(4.00)
Capital Expenditure	(0.00)	(0.12)	(0.08)	(0.01)	(0.02)	(0.02)	(0.48)	0.00	(0.27)	0.00	0.00	(0.50)	0.00	0.00	0.00	(2.80)	0.00	0.00
Total payments	**(1.56)**	**(2.02)**	**(12.49)**	**(22.07)**	**(3.89)**	**(3.78)**	**(3.69)**	**(28.86)**	**(3.49)**	**(3.46)**	**(3.46)**	**(16.67)**	**(16.78)**	**(4.05)**	**(1.46)**	**(11.44)**	**(30.95)**	**(4.49)**
Net Receipts/ (Paym	**(1.03)**	**(1.49)**	**25.84**	**(21.42)**	**(3.11)**	**(2.83)**	**31.03**	**(28.61)**	**(3.14)**	**(3.16)**	**31.63**	**(16.42)**	**(16.24)**	**(3.80)**	**(1.16)**	**27.49**	**(30.41)**	**(4.24)**
Funding Flows																		
DH Revenue Support	0.00	0.00	0.00	5.00	0.00	0.00	0.00	0.00	5.00	0.00	0.00	0.00	2.63	0.00	0.00	0.00	0.24	0.00
Working Capital Supp	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.50	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.50	0.00	0.00	0.00	1.89	0.00
Loan Repayment/Inte	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(5.05)	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**5.00**	**0.00**	**0.00**	**0.00**	**0.00**	**5.00**	**0.00**	**0.00**	**(5.05)**	**5.13**	**0.00**	**0.00**	**0.00**	**11.63**	**0.00**
BANK BALANCE C/F	**4.43**	**2.94**	**28.78**	**12.36**	**9.25**	**6.42**	**37.45**	**8.83**	**10.69**	**7.54**	**39.17**	**17.70**	**6.59**	**2.80**	**1.64**	**29.13**	**10.35**	**6.11**



The overall cash balance has increased by £4.1m in July.

£45.6m of cash was received in month

£37.8m NHS contract income for the month (including £3.7m Education and Training), £5m revenue support funding and £2.8m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£41.3m of cash was paid out by the Trust in month

£15m (36%) in direct salary costs to substantive and bank employees.

£10m (24%) employer costs to HMRC and NHSP.

£16.3m (40%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

6. Forecast, risks and mitigations

The Trust has established a Task and Finish Group, chaired by the Committee Chair and attended by a number of Trust Executives, to review and gain assurance over the forecast outturn.

The Trust continues to report delivery of its control total for 2024/25 to NHSE.

7. Conclusions

The Finance, Planning and Performance Committee is asked to note the report and financial performance, which is a £2.3m deficit in-month and £12.2m deficit YTD, this being £0.5m adverse to the latest plan submitted to NHSE. The adverse variance is driven by £0.5m of industrial action costs, following national guidance to exclude any assumptions of such in the plan. We therefore anticipate a national solution to this cost pressure.

For the year ahead, the Trust must implement effective cost control processes to manage the run-rate, as well as identify efficiencies and reduce waste in order to deliver sustainable financial performance and the £27.8m deficit control total. In addition to the annual deficit, the Trust is targeting an exit run-rate for the year of a monthly deficit of no more than £1.5m – cash-releasing improvements are therefore critical in achieving that performance.

Linked to the above, our cash position is being closely monitored. We continue to draw down against the deficit support funding from NHSE/DHSC as mitigation during this financial year. Delivery of the forecast will be crucial in maintaining cash autonomy.

Alan Davies
Chief Financial Officer
August 2024

Forecast Outturn

28 August 2024

Overview

NHS Medway NHS Foundation Trust

- The Trust completed a swift forecast exercise, supported by the NHSE Financial Improvement Director, following closure of the month 3 results.
- This forecast has evolved since that time and currently indicates an unmitigated deficit of £38.6m against a control total deficit of £27.8m, i.e. adverse by £10.8m.
- An Executive-led Task & Finish Group - chaired by the Non-Executive Chair of the Finance, Planning and Performance Committee – has met weekly since 5th August 2024. The purpose of the group is primarily to:
  1. Develop greater clarity and assurance over the forecast outturn
  2. Develop, implement and oversee mitigating actions as required to deliver the control total
- The forecast is summarised into “21 lines” of favourable and adverse drivers of performance. Each line has an assigned Executive lead responsible for delivering the above.
- A clear set of actions have been developed in a separate, detailed paper - this document presents a summary.
- There is a commitment from the Trust Executive and their teams to close the gap and deliver the control total in 2024/25. An update on the specific actions will be provided at the Board meeting on 10th September.

“21 lines” – efficiencies and cost pressures

NHS Medway NHS Foundation Trust

#	Title	Impact £’000	Lead	Background	Key action(s)
1	Efficiencies	(6,269)	Nick	Shortfall in identification and in-year delivery of schemes.	Drive existing schemes to deliver more. Identify and implement new schemes – the principal ones being medical job planning and AI call handling, which could deliver up to a further £1m this financial year. Trust Exec to revisit operational efficiencies (reduction of worked FTEs) both in respect of: - Paper drafted for comment setting out the rationale for targets, progress made, safer staffing and remaining opportunities/area of focus. - Divisions to focus on those areas of opportunity and confirm line-by-line the posts that will be removed. - Recruitment pipeline to remove premium costs of temporary staffing.
2	ED - nurse rosters	(1,347)	Sarah	Nursing rosters do not match allocated budgets. Safer staffing review undertaken in ED nursing – current staff deployment is in line and therefore overspent.	PID to be updated and presented to Trust Executives (due w/c 2 Sep) and Trust Board, including reference to business case for capital works (several years ago) and additional investment in broader ED services (SDEC, frailty, etc.). Potential for small in-year run-rate reduction if approved and staff recruited substantively.
3	ED – practitioners	(440)	Sarah		
4	Safer staffing	-	Sarah	Three wards omitted in budget setting.	None - budget allocated from reserves.

“21 lines” – efficiencies and cost pressures

#	Title	Impact £’000	Lead	Background	Key action(s)
5	Escalation	(286)	Alison	Unbudgeted escalation capacity remains open in Emerald Short Stay, mainly from NCTR across the Trust.	Incremental costs of **all** escalation to be separately identified (inclusive of SDEC, ADL, etc.) within the divisional forecasts. Under current conditions the Executive view is that these cannot be de-escalated due to NCTR numbers and entering winter. The Trust is working with system partners on Transfer of Care / Discharge to Assess models but longer term will seek for these beds to be funded.
6	Premium costs of temp. staffing	(530)	Alison	Principally within the S&A division (and notionally in anaesthetics).	Further analysis required to fully understand the driver, including any additional income benefit which may be offsetting this pressure. Mitigations to be confirmed thereon.
7	Activity-driven drugs pressures	(567)	Nick	Expenditure above budget on drugs.	Deep dive underway to understand driver(s) of Trust drugs pressures, including those which are activity-driven and those arising from inflation. Mitigating actions to be developed to respond to those drivers.
8	2nd mobile MRI	-	Nick	Now agreed by NHSE that this can count towards CDC targets. Full costs and associated income are included within the divisional forecast.	CDC trading account – see reserves section.

“21 lines” – income

#	Title	Impact £’000	Lead	Background	Key action(s)
9	Income over/under performance	(1,852)	Nick	HCD being treated as within block by commissioner.	Contract variation required from commissioner or otherwise c£1.7m to be charged as passthrough. This was requested from the commissioner in a side letter at the point of signing the 24/25 contract; the response was that this should be managed through growth funding.
10	ERF	(1,672)	Nick	Due to timing, the income plan (based on 23/24 forecast outturn plus full year capacity introduced) and divisional activity plans were not fully triangulated. This has given rise to divisional elective overperformance against activity plans but adverse at consolidated Trust level. No capture and counting has been recognised in YTD, but £1m forecast delivery by year end (out of £1.5m planned). Phasing in plan of mobile endoscopy unit versus installation.	Divisional challenge to deliver further elective activity, e.g. through additional sessions, productivity improvements, etc. Capture and counting to report through weekly Executive governance, including workplan and target areas. Updated activity, workforce, income and expenditure analysis required for mobile endoscopy unit.
11	Medical Education	1,957	Alison	The benefit of this income is reported here, however the costs it funds (overheads, accommodation, etc.) are forecast elsewhere and incurred irrespective.	Trading account for medical education to be presented to and approved by CMO.

“21 lines” – income

#	Title	Impact £’000	Lead	Background	Key action(s)
12	Other cost and volume clinical income	(278)	Alan	NHSE HCD, insulin pumps and excluded devices.	Monitor and ensure mitigated, e.g. through reduced expenditure.
13	Ruby Ward	(3,835)	Jayne	Funding not contracted by lead commissioner.	Contact made with NHSE, who have indicated this is available, hence will be pursued in full. (NB – as the cost of running the ward has reduced from the original £3.8m calculation and been taken as an efficiency; there is a risk that the Trust only receives the revised cost sum, meaning there could remain a pressure against plan of c£1.2m to resolve.)

“21 lines” – reserves

#	Title	Impact £’000	Lead	Background	Key action(s)
14	CNST reserve	-	Alan	Maternity rebate from CNST – assumed to be spent non-recurrently as intended.	None – to be invested as intended.
15	Incremental drift reserve	2,245	Alan	Reserve to cover potential costs of staff moving up spine points in year.	Based on staff still in post the cost pressure over and above divisional budgets (i.e. that may require issuing from reserve) would be c£1.9m, although not all of this will necessary be required (e.g. should staff leave or not be awarded the increment). Approx. £0.5m of the above is already in the run-rate and hence forecast, i.e. a risk of up to c£1.4m. Position proposed that divisions must absorb any future incremental drift costs within existing budgets – TBC.
16	CDC reserve	2,500	Alan	Monies held back in reserve acknowledging delayed start of CDCs.	CDC trading account required, covering delayed costs and income, mobile MRI, efficiency recognised and reserves. All income and expenditure is noted as being included in divisional forecasts and hence this trading account to be signed off by the division and COO.

“21 lines” – reserves

NHS Medway NHS Foundation Trust

#	Title	Impact £’000	Lead	Background	Key action(s)
17	Non-pay inflation reserve	1,980	Alan	Created for stated purpose based on tariff funding uplift.	Minimal calls on this reserve have been made to date. Position proposed that divisions must absorb any future inflationary costs within existing budgets – TBC.
18	Other reserves	850	Alan	Held for investment based on business plans.	Reject unless self-financing. Monitor through Trust Investment Group.
19	Consultants pay award	(2,600)	Alan	Pressure arising in year from consultant pay award (not funded).	Reiterate pressure to and seek funding in full from commissioner.
20	June plan improvement reserve	(1,100)	Alan	Deficit improvement between May and June submissions to NHSE.	Items identified to mitigate/deliver this improvement already included in baseline forecast.
21	Reserves and budget variances	432	Alan	Various – amalgamation of favourable and adverse movements individually immaterial.	Separately identify and monitor.

“21 lines” – summary

#	Title	Impact £’000
1	Efficiencies	(6,269)
2-8	Cost pressures	(3,171)
9-13	Income	(5,680)
	Sub-total	**(15,120)**
14-21	Reserves	4,307
	Total unmitigated risk	**(10,813)**
	Funding sought from commissioners:	
9	HCD funding	1,700
13	Ruby Ward funding	2,800
	Trust risk after commissioner funding issues	**(6,313)**

The table opposite sets out the summary risk by category (driven by the detail in the previous slides).

Those items for which we seek additional funding will be re-escalated via the CFO and Executive team with the relevant commissioner (essentially Ruby Ward and HC Drugs)

There is of course a risk that these are unfunded and present a pressure to the Trust for mitigation.

If successful, the Trust would need to mitigate a further £6.3m through improved efficiencies delivery, operational efficiencies and cost control.

Key actions required

NHS Medway NHS Foundation Trust

1. Close the £6.2m gap on waste reduction efficiencies, through existing and new schemes.
2. The Trust Executive is committed to driving further headcount reductions (primarily temporary staffing) to deliver greater operational efficiencies, particularly in those areas of identified opportunity. As part of this identify how the ~400FTE reduction targets agreed in May will be achieved (currently ~100 FTE in forecast).
3. Hold discussions with commissioners and NHSE to negotiate/agree additional funding where shortfalls exist (primarily Ruby Ward and HC Drugs. Further mitigations to be identified where funding not provided.)
4. Further scrutinise the £3.1m of cost pressures with actions developed and implemented to reduce/mitigate.
5. Confirm that all reserves (unless otherwise assumed above) are no longer available for distribution to Divisions and will be used to support the Trust position. Confirm with Divisions how they will manage any residual risk e.g. incremental drift, non-pay inflation.
6. A further update will be provided at the Trust Board for its meeting on 10 September, including the more specific actions agreed with Exec Leads and assessment of financial mitigation.

The forecast will continue to be developed at each month end, particularly in light of agreed/implemented actions.

Maternity (and perinatal) Incentive Scheme – Year 6 Compliance Update Report

Trust Board September 2024

Executive Summary

- CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025
- Anticipate declaring compliance with all 10 Safety Actions within the required reporting period.
- Safety Action 8 currently off-track due to compliance figures <90% for some staff groups. This has been escalated appropriately and actions are in place to mitigate this risk. It is anticipated that compliance >90% will be achieved for all staff groups.
- Monthly reporting via MNSCAG and reporting to each Trust Board until submission.
- Review and presentation dates agreed with LMNS for key requirements prior to submission of compliance to MFT Trust Board in January 2025.
- Trust Board requested to formally note NICU medical and Nursing staffing position (within Safety Action 4 slides) in Trust Board minutes that BAPM compliant for NICU Medical Staff and NICU Nursing Qualified in Speciality =59%. NICU nursing vacancy reduced to 2.69 WTE across all bandings. QIS reduced in line with reduction in vacancy.
- NICU Nursing action plan in place, request Trust Board to formally approve action plan (within Safety Action 4 slides) so this can be shared with the LMNS and ODN as per CNST requirements.
- Safety Action 9 - Trust Board requested to confirm in minutes that The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.
- Safety Action 9 - Update on SCORE survey presented as part of separate full Perinatal Leadership report and Trust Board requested to minute progress and monitoring of actions.

CNST Year 6 Self-Assessment

True North	Safety Action	Description	May 2024	June 2024	July 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?			

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.

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.	
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 100% of eligible 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	100% of reports for 2024 published within 6 months of death.	
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.
- NHSR have updated requirements and cases from 8 December 2023 to 1 April 2024 will be excluded from external verification.
- Quarterly report to Trust Board September 2024 detailing losses and PMRT findings and actions as required.

Issues, Concerns, Gaps:

- Published CNST Guidance does not reflect current update to external verification period – NHSR have confirmed this will be reflected on declaration form.
- Difficulties in obtaining external obstetric attendance at PMRT meetings across LMNS.

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 now added to support lead bereavement midwife.
- Share learning from PMRT cases via Maternal Compass Governance Newsletter where required. .
- Actions from PMRT reviews now incorporated into central Action Log for improved oversight and accountability.
- PMRT cases to be added to incident spreadsheet to support thematic review in line with other incidents across the service.
- LMNS to support with supporting external obstetric cover for PMRT reviews.

True North: Quality

Safety Action 1: PMRT
EMBRRACE Generated Report –Perinatal Losses 2024 – Eligible for reporting to MBRRACE and PMRT required

NHS Medway NHS Foundation Trust

Case ID	Baby	Live birth	Date of birth	Date of death	Date reported	Gestation at birth (weeks)	Surveillance case status	Date surveillance first closed	Review status	Date review opened	Date draft report first available	Date review first published	Working days to notify	Months to complete surveillance	Parents informed of review	Parents views sought	Months to start review	Months to draft report	Months to publish report
91348	1 of 1	No	14/01/2024	14/01/2024	15/01/2024	25	Surveillance complete	21/01/2024	Review complete	21/01/2024	13/03/2024	15/04/2024	0	< 1	Yes	Yes	< 1	< 2	< 4
91665	1 of 1	Yes	28/01/2024	01/02/2024	02/02/2024	31	Surveillance complete	12/02/2024	Review complete	12/02/2024	17/04/2024	08/05/2024	1	< 1	Yes	Yes	< 1	< 3	< 4
91681	1 of 1	No	04/02/2024	04/02/2024	04/02/2024	32	Surveillance complete	12/02/2024	Review complete	12/02/2024	24/05/2024	25/06/2024	0	< 1	Yes	Yes	< 1	< 4	< 5
91949	1 of 1	No	16/02/2024	16/02/2024	18/02/2024	38	Surveillance complete	01/03/2024	Review complete	05/03/2024	24/05/2024	14/06/2024	0	< 1	Yes	Yes	< 1	< 4	< 4
91950	2 of 2	Yes	13/02/2024	18/02/2024	18/02/2024	26	Surveillance complete	04/03/2024	Review complete	13/03/2024	10/05/2024	12/05/2024	0 (has death(s) not eligible for notification)	< 1	Yes	Yes	< 1	< 3	< 3
92000	1 of 1	No	19/02/2024	19/02/2024	20/02/2024	27	Surveillance complete	01/03/2024	Review complete	13/03/2024	11/06/2024	14/06/2024	1	< 1	Yes	Yes	< 1	< 4	< 4
92128	1 of 1	No	25/02/2024	25/02/2024	28/02/2024	22	Surveillance complete	04/03/2024	Review complete	22/04/2024	11/06/2024	14/06/2024	2	< 1	Yes	Yes	< 2	< 4	< 4
92485	2 of 5	Yes	17/03/2024	19/03/2024	21/03/2024	23	Surveillance complete	25/03/2024	Review complete	03/05/2024	21/05/2024	24/05/2024	3 (has death(s) not eligible for notification)	< 1	Yes	Yes	< 2	< 3	< 3
92485	1 of 5	Yes	17/03/2024	22/03/2024	21/03/2024	23	Surveillance complete	25/03/2024	Review complete	25/03/2024	21/05/2024	24/05/2024	3 (has death(s) not eligible for notification)	< 1	Yes	Yes	< 1	< 2	< 3
92735	1 of 1	No	07/04/2024	07/04/2024	08/04/2024	23	Surveillance complete	22/04/2024	Writing report	22/04/2024	12/07/2024	Not set	0	< 1	Yes	Yes	< 1	< 4	Review report not published
93366	1 of 1	No	16/05/2024	16/05/2024	20/05/2024	30	Surveillance complete	20/05/2024	Reviewing	20/05/2024	Not set	Not set	2	< 1	Yes	Yes	< 1	Draft report not published	Review report not published
93373	1 of 1	No	18/05/2024	18/05/2024	20/05/2024	39	Surveillance complete	20/05/2024	Reviewing	20/05/2024	Not set	Not set	0	< 1	Yes	Yes	< 1	Draft report not published	Review report not published
93375	1 of 1	No	19/05/2024	19/05/2024	20/05/2024	39	Surveillance complete	20/05/2024	Reviewing	First session opened on 11/06/2024	Not set	Not set	0	< 1	Yes	Yes	< 1	Draft report not published	Review report not published
94009	2 of 2	No	25/06/2024	25/06/2024	26/06/2024	32	Surveillance complete	26/06/2024	Reviewing	26/06/2024	Not set	Not set	1	< 1	Yes	Yes	< 1	Draft report not published	Review report not published
94242	1 of 1	Yes	09/07/2024	09/07/2024	10/07/2024	Not known/not set	Surveillance complete	12/07/2024	Reviewing	12/07/2024	Not set	Not set	1	< 1	Yes	Yes	< 1	Draft report not published	Review report not published

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	May 2024 Scorecard showing pass for 11 out of 11 elements - continue to monitor monthly and review 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	May 2024 Scorecard showing 98.8% compliance with this requirement. Continue to monitor monthly until submission.	

Key Messages:

- On Track to achieve compliance with Safety Action 2

Issues, Concerns, Gaps:

- No gaps currently identified.

Actions & Improvements:

- Euroking update postponed until October 2024 therefore CNST data (July) will not be at risk.

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: May 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	335			
CQIMDQ14	385	375	102.7		Passed
CQIMDQ15	380	385	98.7		Passed
CQIMDQ16	340	380	89.5		Passed
CQIMDQ24	335	340	98.5		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	225	385	58.4	Passed
CQIMDQ08	385	390	98.7	Passed
CQIMDQ09	385	375	102.7	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	385	375	102.7		Passed
CQIMDQ11	180	385	46.8		Passed
CQIMDQ12	25	385	6.5		Passed
CQIMPPH	20	385		47	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	385	375	102.7		Passed
CQIMDQ22	380	385	98.7		Passed
CQIMDQ23	340	385	88.3		Passed
CQIMPreterm	40	380		103	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	385	375	102.7		Passed
CQIMDQ15	380	385	98.7		Passed
CQIMDQ16	340	380	89.5		Passed
CQIMDQ18	220	385	57.1		Passed
CQIMDQ20	15	200	7.5		Passed
CQIMTears	15	200		65	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	385	375	102.7	Passed
CQIMDQ15	380	385	98.7	Passed
CQIMDQ16	340	380	89.5	Passed
CQIMDQ18	220	385	57.1	Passed
CQIMDQ26	385	385	100.0	Passed
CQIMDQ27	410	410	100.0	Passed
CQIMDQ28	195	410	47.6	Passed
CQIMVBAC	10	50	20.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	385	375	102.7	Passed
CQIMDQ31	390	390	100.0	Passed
CQIMDQ32	340	390	87.2	Passed
CQIMDQ33	390	390	100.0	Passed
CQIMDQ34	220	390	56.4	Passed
CQIMDQ36	385	385	100.0	Passed
CQIMDQ37	160	385	41.6	Passed
CQIMDQ38	385	390	98.7	Passed
CQIMDQ39	330	385	85.7	Passed
CQIMRobson01	10	55	18.2	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	35	45	77.8	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	50	65	76.9	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	410	375	109.3	Passed
CQIMDQ04	405	410	98.8	Passed
CQIMDQ05	50	405	12.3	Passed
CQIMSmokingBooking	50	405	12.3	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	385	385	100.0	Passed
CQIMSmokingDelivery	45	385	11.7	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	405	410	98.8	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

	Requirement	Lead	Actions/progress	Compliance status
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**
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	Reduction in RDS admissions for babies born to diabetic mothers by 5-10% registered with Trust Quality Team July 2024	
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	Presented to LMNS on 11 July 2024 with progress update to be presented in October 2024.	

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 MNSCAG 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:

- 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.

True North: Patients

Safety Action 3: Transitional Care and ATAIN – QI Project

NHS Medway NHS Foundation Trust

Key Messages:

- 40% of term admissions in NICU for RDS are babies of diabetic women following no labour LSCS at 37 weeks gestation.
- *Vision:* Reduce RDS term admissions following elective CS
- *Goal:* 5-10% reduction in term admissions to NICU of babies with RDS from diabetic women within 6 months from start of project

Proposal to drive improvement

- Patient information & standardised antenatal counselling
- Timing of delivery >38 weeks.

Next Steps:

- Co-produce information for parents with MNVP and service users.
- Review guidelines for timing of delivery for suitable babies to 38 weeks to reduce requirement for steroids/risk of RDS admission

1) Problem Statement .

40% of Term admissions to NICU for RDS are babies of diabetic women following no labour LSCS.

2) Current Situation

RDS is the leading cause for term neonatal admission at MFT. Of those babies admitted 1 in 3 are from pre-existing or gestational diabetic mothers who have a no labour caesarean section at 37 weeks gestation.

What is the process?

Patient discussion of mode & timing of delivery, consent & discussion regarding steroids in multiple locations by varying people. Including diabetes MDT antenatal clinic, FMU, Obstetric triage, maternity care unit & Pearl ward.

Who leads the pathway?

Miss Shah diabetes obstetric lead consultant. Jo Wainwright & Tiffany Moore Diabetes specialist lead midwives.

What are the metrics?

Data has been collected on:

- Reason for admission to neonatal unit
- Antenatal risk factors
- Mode of delivery & gestation at birth
- Administration of antenatal corticosteroids
- Type of intervention on NICU & length of stay

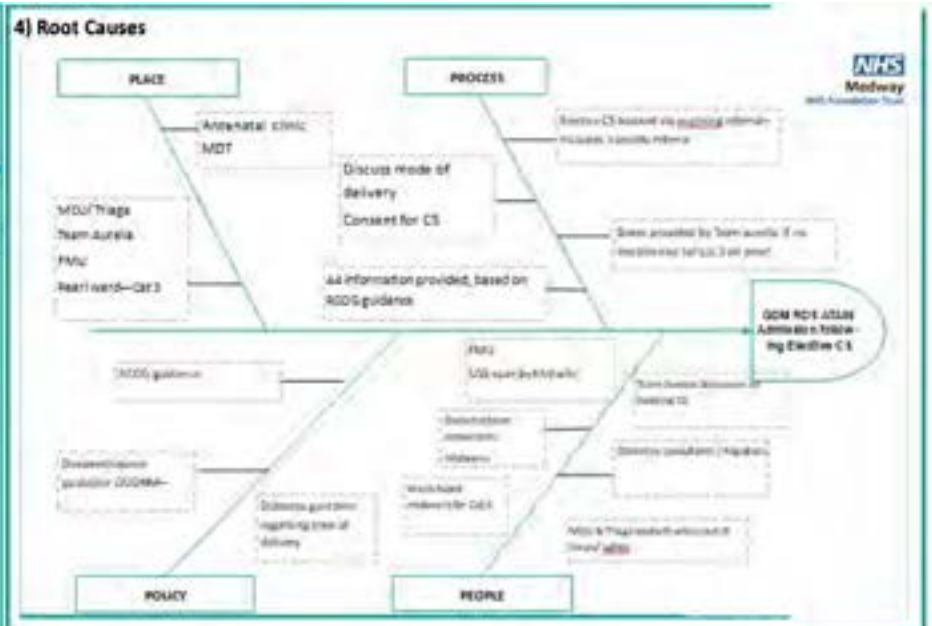
Data is collected from a variety of sources including Euroking, written maternity documentation & Badgernet.

3) Vision and Goals

Vision: Reduce RDS term admissions following elective CS

Goals: 5-10% reduction in Term admission to NICU of babies from diabetic women within 6 months (January 2025)

4) Root Causes



5) Countermeasures

Concern	Cause	Countermeasure
Patient information	• Lack of standardised information leaflet • Lack of understanding– reading age, language,.	• Develop PIL reflective of MFT data collated from ATAIN audit in conjunction with the MNVP • Incorporate RCOG national guidance
Counselling of patients	• Range of locations & level of qualifications who discuss options with patients • Availability of information for patients to take home for further reflection	• Standardised counselling approach • Education to all those involved in consenting patients for steroids
Timing of delivery	• Look at potential cohort of diabetic women to be delivered after 37+6	• Identify patients who delivery at 38 weeks gestation is within National & local guidance.

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

Key Messages: On Track

- The CNST criteria for employing short & long -term locum Doctors audited for 2024
- 100% compliant with RCOG guidance for short-term locums (including doctors who work exclusively on Bank)
- 100% compliant with RCOG guidance for long-term locums (RCOG guidance includes those directly engaged by Trusts for more than 2 weeks, but not on a substantive contract). All doctors on fixed term contracts have been through the appropriate employment and recruitment checks, undertake and have access to the appropriate systems and have appropriate clinical supervision.
- Ongoing compliance with compensatory rest for Consultants and Senior Specialist and Specialist doctors as reflected in obstetric rotas.
- 98.77% compliant with RCOG guidance for incidents in which consultants must or should attend.
- NICU nursing vacancy reduced to 2.69 WTE across all bandings. QIS reduced in line with reduction in vacancy.
- QIS= 59%
- NICU QIS action plan updated to include retention actions to support rolling programme of recruitment and training.
- Ongoing compliance with anaesthetist on-call with dedicated obstetric on-call rota.
- Ongoing compliance with BAPM requirements for neonatal medical staffing.

Issues, Concerns & Gaps:

- NICU nursing staffing not meeting BAPM QIS standards.
- 98.77% compliant with RCOG Must/Should attend criteria.

Actions & Improvements

- Trust Board requested to formally note NICU medical and Nursing staffing position in Trust Board minutes.
- NICU Nursing action plan in place, request Trust Board to formally approve action plan so this can be shared with the LMNS and ODN as per CNST requirements.
- Patient level audit of all births from Jan-June 2024 now completed against RCOG Must/Should attend criteria. This data is triangulated with CRIG data and instances of consultant attendance recorded on the bedstate.

True North: People

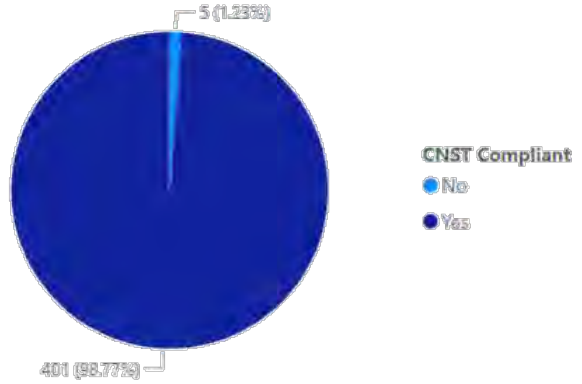
Safety Action 4- Intrapartum Events Meeting RCOG Must and Should attend Criteria

- CNST Year 6, continues with the expectation set in CNST year 4 and year 5, that Trusts monitor compliance of consultant attendance at 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.
- All births from Jan-June 2024 (2147) were reviewed with 406 documented on EuroKing as having an intrapartum event requiring consultant/senior doctor attendance.
- 401/406 cases reviewed were deemed complaint with Consultant/Senior Doctor attendance against RCOG guidance.
- 5 cases deemed not complaint.

- All cases were reviewed at CRIG independently of the audit.
  - 3 Ongoing MOH (PPH >2L)
  - 1 4th degree tear repair
  - 1 PPH (1.5L-2L) (should attend)

- Of the three ongoing MOH incidents, all were at the cusp of 2L when decision was made by senior doctor to transfer to theatre and were being actively managed before total EBL >2L was assessed.
- The consultant was informed of 2 of these incidents.
- PPH 1.5-2L only requires consultant attendance if senior doctor not available/not deemed competent. As registrars were unable to attend consultant should have been called and attended.
- 4th degree tear was not escalated to the consultant and repaired by registrar.

Compliance with RCOG Must/Should attend criteria Jan-June 2024



Issues, concerns & Gaps

- Appropriate escalation of cases on cusp of Must attend criteria
- Escalation of cases where senior doctor is competent but not available.
- Detection and repair of 4th degree tears

Actions & Improvements

- Review of MOH protocol and checklist
- Refresh and reminder to all staff about RCOG Must/Should attend criteria, including trigger sheets on delivery suite/obstetric theatres
- Review of PPH management, including local criteria for escalating to consultant. Continue monthly audit from EK – with cross reference to CRIG reviews and Bedstates with quarterly reporting to support thematic analysis.
- Share at Labour Ward Forum/Audit/team meetings
- Onward reporting to LMNS and Trust Board as per CNST requirements.

True North: People

Safety Action 4: Neonatal Nursing QIS action Plan

Action No.	Action Required	Update	Owner	Target Date	Completion Date	Current Position
Recruitment						
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%. **June 2024** - QIS currently 59% - this is due to recruitment to band 5 vacancies which increases the staff base of non-QIS trained nurses, therefore reduces the overall percentage. Currently 6 on course for 2023/24 with trajectory for September QIS is 64% with an additional 6 to start in September 2024. If no changes to current establishment >70%.	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. **July 2024 - Band 6 Vacancy now 0.89 WTE**	NICU Matron	01/09/2024	30/07/2024	
3	Recruit to Band 5 vacancy	Ensure band 5 vacancies are advertised and recruited to in a timely way to optimise staffing. Advertised to ensure newly qualified student nurses are eligible to apply. Current band 5 vacancy 1 WTE Oct 2023 – current band 5 vacancy 0 June 2024 - Band 5 vacancy remains 0 - 33 band 5s in workforce **July 2024 - Band 5 vacancy 1.8WTE**	NICU Matron	30/09/2023	30/09/2023	
4	Workforce Review	Establishment review including Dinning tool which takes into consideration acuity and cot days in individual neonatal units. **Sept 2023 Workforce review completed.**	NICU Matron	30/09/2023	30/09/2023	

True North: People

Safety Action 4: Neonatal Nursing QIS action Plan

Action No.	Action Required	Update	Owner	Target Date	Completion Date	Current Position
Retention						
5	Support staff wellbeing with employment of clinical psychologist to support reflective practice sessions with staff.	Clinical psychologist commenced in February 2024 and is now established in post and conducting reflective practice sessions with staff (and parents).	NICU Matron	30/06/2024	01/05/2024	
6	Strengthened PDN team to support staff to undertake training and development opportunities.	PDN team now consists of 5 members of staff and support nursing staff with accessing internal and external opportunities.	NICU Matron	30/11/2024		
7	Ensure there is a climate of psychological safety across unit and support staff to share feedback and concerns	SCORE survey undertaken November 2023 and to be re-surveyed in Autumn 2024. Staff developed action plan in place, with NICU specific deep dive of responses. Maternity and Neonatal Collaborative Hour Launched April 2024 to promoted shared learning and working across maternity and neonatal services and encourage staff to share both clinical and personal reflections.	NICU Matron	30/11/2024		

Neonatal Medical Staffing – July 2024

NHS Medway NHS Foundation Trust

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

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

True North: People

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.	ADOM	Bi-annual reporting schedule in place. Report to MNSCAB May 2024 and to trust Board July 2024. Next Workforce report due to Trust Board in January 2025.	
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.	ADOM	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.	ADOM	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.**	ADOM	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	ADOM	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.	ADOM	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 April 2024	BRAG May 2024	BRAG June 2024	BRAG July 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				

Trust: Medway NHS Foundation Trust

ICB: South East

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6
Review Quarter	Q1 (Interim)	Q1 (Final)	Q2 (Interim)	Q2 (Final)	Q3 (Interim)	Q3 (Final)	Q4
Assurance Review Date	10/10/23	07/10/23	20/12/23	23/01/24	13/03/24	16/04/24	12/07/24
Element 1	20%	30%	70%	70%	90%	90%	90%
Element 2	35%	35%	75%	80%	95%	95%	100%
Element 3	0%	0%	100%	100%	100%	100%	100%
Element 4	20%	20%	60%	60%	100%	100%	100%
Element 5	48%	52%	70%	74%	89%	93%	93%
Element 6	17%	17%	50%	67%	67%	67%	67%
TOTAL	34%	37%	70%	74%	90%	91%	93%

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

Key Messages: On Track

- Achieved 93% overall compliance across the 6 elements, with 3 elements now at 100% for Quarter 4.
- 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.
- 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 – Element 5 presented in June and Element 1 to present in August.
- Action plan in place to achieve 100% for all elements, with 6 actions on track and 28 completed.
- Stretch targets agreed with LMNS across the elements already achieving 100% to drive continued improvement.
- Focus on QI across all elements, with evidence of QI work to be included in submission for Q1 2024/25

Issues, Concerns & Gaps

- Business case for specialist nursing to support MDT diabetic clinic (0.6WTE Diabetic Nurse required) not approved in business planning.
- Diabetic dietician approved in business planning but no progress on recruitment noted.
- Quit date targets for element 1 remain challenging across the LMNS
- National withdrawal of qfFN (Fetal Fibronectin) for assessing pre-term labour

Actions & Improvements:

- Funding for diabetic nurse being considered from CNST funds. PID to go to TIG in September.
- Swap to Stop programme now running to support smokers to quit. SIP midwife to audit successful quits against engagement with service to help understand the effectiveness of support offered to service users who engage.
- Using Partosure in place of qfFN. Audit for Q1 24/25 underway to assess use. Plans to consider transvaginal cervical scanning for all in suspected pre-term labour when staffing allows for training and roll out.
- Sustained compliance with CGM use in diabetic patients and 100% compliance for HbA1c readings at start of 3rd trimester.
- LMNS assessment of MFT as having well-embedded processes with robust monitoring & good awareness of our position and areas for improvement.
- QI work to be included in submission for Q1.
- Continue to engage with LMNS quarterly meetings and Learning and Sharing Forums.

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 MNVP to coproduce local maternity services.

Key Messages: On track

- Supported LMNS lead to review meeting attendance within Trust as system-wide move to include MNVP leads as core members of key meetings as per CNST Year 6 requirements. Awaiting outcome of LMNS Board for details of revised MNVP service model
- Co-production and engagement work continues, including work on supporting patients with neurodiversity, the IOL patient facing information and MCU/Triage project.
- MNVP lead continues engagement work with local communities, including marginalised groups those who have experienced poor outcomes.
- MNVP and Service user engagement to support work on Birth Trauma and Neurodiversity pathways.
- MNVP and newly appointed Patient Experience and EDI Lead to work together to seek feedback and maintain relationships with service users and families.
- Results of Picker Survey 2024 expected in September 2024 and plan to review with MNVP to coproduce action plan based on results and free text. This will be shared with MNSCAG and LMNS in October/November 2024.

Issues, Concerns, Gaps:

- Awaiting outcome of LMNS Board for future MNVP service model and how this will support CNST requirements.
- 2022/2023 Picker Survey Action plan have some outstanding actions. (6 outstanding, 18 completed)

Actions & Improvements:

- Supported LMNS lead to review meeting attendance within Trust as system-wide move to include MNVP leads as core members of key meetings as per CNST Year 6 requirements. Awaiting outcome of LMNS Board for details of revised MNVP service model
- Co-production and engagement work continues, including work on supporting patients with neurodiversity, the IOL patient facing information and MCU/Triage project.
- Results of Picker Survey 2024 expected in September 2024 and plan to review with MNVP to coproduce action plan based on results and free text. This will be shared with MNSCAG and LMNS in October/November 2024.
- Finalise 2022/2023 Picker CQC Action plan by October 2024.
- Review 2024 Picker CQC survey and co-produce action plan with MNVP.

True North: People

NHS Medway NHS Foundation Trust

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
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)

Key Messages: Off Track with Actions to Deliver

- Compliance for PROMPT below 90% for all medical groups.
- >90% for Midwives and doctors in Training for Fetal monitoring training
- > 90% for NICU nurses, ANNP and Doctors in training for NBLS
- CNST removed requirements for first responders to have "intermediate standard" life-support training, but encourage Trusts to work towards this..
- NICU attending deliveries are 81% compliant with NLS training (external) with a further 6 to attend course in October to bring total compliance to 92%

Issues, Concerns, Gaps:

- <90% for PROMPT training for medical groups..
- Medical staff non-attendance due to DNA or removal from rota due to staffing issues
- No obstetric faculty within PROMPT team currently.
- Support required from anaesthetic lead to secure anaesthetic consultant attendance.

Actions & Improvements:

- HOM to meet with obstetric CD to assign new obstetric PROMPT lead.
- PROMPT training sessions to be reallocated in rota. Service manager to support. 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.
- PROMPT pack now purchased to support with community & pre-hospital prompt as well as supporting in situ simulations.
- Working with NICU education leads to ensure any rotation of staff is updated on ESR in a timely manner to ensure accurate compliance figures ahead of November deadline.

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				
	March 2024	May 2024	June 2024	July 2024
Midwives	90%	92%	94%	**94%**
MA & MSW	92%	90%	90%	**95%**
Theatre Nurses and ODNs	93%	87%	89%	**90%**
Obs Consultants	72%	45%	60%	**67%**
Obs SpR/SHO	85%	78%	80%	**87%**
Anaesthetic Consultant	75%	21%	25%	**80%**
Aneas. SpR/SHO	82%	82%	80%	**80%**

Neonatal Basic Life Support Training				
	December 2023	May 2024	June 2024	July 2024
Midwives	91%	91%	89%	**89%**
NICU Nurses	89%	94%	93%	**94%**
Neonatal Consultants	90%	92%	84%	**86%**
Neonatal doctors	94%	90%	90%	**90%**
ANNP	100%	100%	100%	**100%**

Fetal Monitoring Training and Assessment					
	Dec 2023	March 2024	May 2024	June 2024	July 2024
Midwives	100%	97.7%	98%	96%	**97%**
Obstetric Consultants	89%	100%	94%	87.5%	**92%**
Doctors in training	80%	100%	100%	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.

NHS Medway NHS Foundation Trust

Key Messages:

- The Trust has embedded the perinatal quality surveillance model (PQSM) with monthly reporting via MNSCAG 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 MNSCAG and up to trust Board
- The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.
- A Non-executive director (NED) is working with the Board safety champion and complete monthly staff engagement sessions (face to face and virtual)
- The Trust Claims scorecard is triangulated against incidents and complaints and this is reported via MNSCAG and onwards to Trust Board.
- SCORE Survey Completed and action plan in place with plans for local re-survey in Autumn 2024
- Quad attended Perinatal Leadership Programme and quarterly reporting in place to MNSCAG and onwards to Trust Board.

Issues, Gaps & Concerns:

- Awaiting relaunch of Frontline Safety Champions.
- PQSM does not reflect changes to patient safety reporting/PSIRF and Learning From Patient Safety Events (LFPSE).
- 6 Actions outstanding from 2023 SCORE Survey

Actions & Improvements :

- PQSM report to be presented to Divisional Board monthly.
- IQPR slides contain all PQSM information for Trust Board under appropriate headings and are supported by quarterly reports.
- Repeat SCORE survey in Autumn 2024 for both maternity, neonatal and paediatrics.
- To continue to engage with the LMNS for regional shared learning via Quality Performance meeting and ensure reflective learning within MFT from other Trusts identified concerns/issues.
- GM and ADOM working closely with Obstetric and Neonatal CD to continue work of perinatal leadership programme. Patient Safety Collaborative continuing the programme for 2024/25
- Utilise Board Level Safety Champions to escalate risks and provide supportive challenge.
- Safety Champion SOP updated and information pack for Safety Champions Updated. Re-launch planned for Autumn 2024.
- Huddle Boards now in place to support “you said, we did” information for all staff, alongside established Teams Talks and Friday News (now Maternity Matters).
- Maternity Senior team to meet with Head of Patient Safety to review reporting under LFPSE and how this is reflected in reporting levels of harm for PQSM.
- Maternity team to work with LMNS to seek clarity from NHSR regarding requirements for CNST and PQSM going forward.
- Trust Board requested to confirm in minutes that The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.
- Update on SCORE survey presented as part of Perinatal Leadership report and Trust Board requested to minute progress and monitoring of actions.

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 report in January 2024	
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 report in January 2024	
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Risk Midwives	Record to be presented to Trust Board via CNST report in January 2024	
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:

NHS Medway NHS Foundation Trust

Actions and Next Steps:

- Monthly reporting to MNSCAG with Bi-monthly reporting to Trust Board until submission.
- August Report to be presented to Trust Board in September.
- November report to contain all remaining items Trust Board required to note by 30 November.
- January 2025 Report to contain final assurance and present Trust declaration form ahead of submission in March 2025.
- Continue to engage Safety Action leads to attend LMNS review meetings
- Continue to engage with LMNS CNST Peer Assurance Group and upload relevant evidence to NHS Futures platform to support LMNS assurance.
- Support LMNS assurance visit.
- Collate evidence archive and make available to Executives via Shared Drive as per CNST Year 6.

Perinatal Surveillance – Quarterly Report Q1 24-25

Trust Board September 2024

Executive Summary

- CNST Year 6 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9)
- Monthly updates aligned with the minimum dataset of the PQSM are submitted monthly to QPSCC and QAC (within IQPR) along with a detailed report to every Trust Board.
- This report provides quarterly oversight for Q1 2024/25 and includes the following:
  - Incidents - Increase in number of incidents reported in this quarter maternity =353 (335 in Q4) with 99% of incidents reported as no or low harm and 4 incidents reported as Moderate Harm or above and NICU 47 reported (34 in Q4) with 100% of incidents reported as no or low harm.
  - Investigations – 1 MNSI referral, 1 MNSI investigation closed with action to review risk assessments in telephone triage, 1 postpartum (7 months) maternal death in the community (March 2024) but Trust not informed until June 2024. PSIRF/LFPSE events relating to 3/4th degree tear and PPH greater than 1litre with audits and actions in place to address these.
  - PMRT - 9 MBRRACE reportable cases in Q1, 36 actions currently open relating to PMRT cases with Communication and documentation being the most common themes.
  - Risks - Currently 13 risks in maternity and 2 in Neonatology, with highest risk of 20 related to midwifery workforce challenges and 2 scored 15 relating to MIS.
  - Workforce/Staffing - Midwifery staffing remains a challenge with true vacancy rate remaining high across the quarter, with continued high levels of maternity leave. Positive midwifery workforce retention rates with below average leavers per month over quarter. Trajectory in place with new staff joining each month and main influx of newly qualified staff arriving in Jan-Feb 2025. NICU Nursing vacancy rate reduced from 8.03WTE in Q4 to 2.69 across all bands.
  - Training - Overall compliance for Maternity and Neonatal Staff for mandatory training has increased to 92.63% (NICU) 86.51% (Maternity and Obstetrics), Fetal monitoring training >90% for all staff groups, Midwives, MSWs and Theatre staff >90% for PROMPT training with Anaesthetic and obstetric doctors <85% with actions in place to address, Increase in compliance with ABLS, NBLS training and Safeguarding adults Level 3 increased to 78% for midwifery staff (71% in Q4), with trajectory in place to achieve Trust target.
  - Staff and Service User Feedback - Strong working relationship with Maternity and Neonatal Voices Partnership, Overall improvement in FFT response rate and recommend rate across the quarter, peaking in April with 49% response rate and 99% recommend. Positive staff feedback regarding newly established Maternity & Neonatal Collaborative Hour (MNCH) – forum for sharing and learning.
  - Safeguarding - Ongoing effective partnership working with outside agencies, Improvements noted in non-CP case holder supervision compliance. Information has been sent to all staff to complete the Adults Level 3 and Children Level 3 training to achieve compliance targets.

Incidents, investigations and PMRT

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q1 24/25
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.

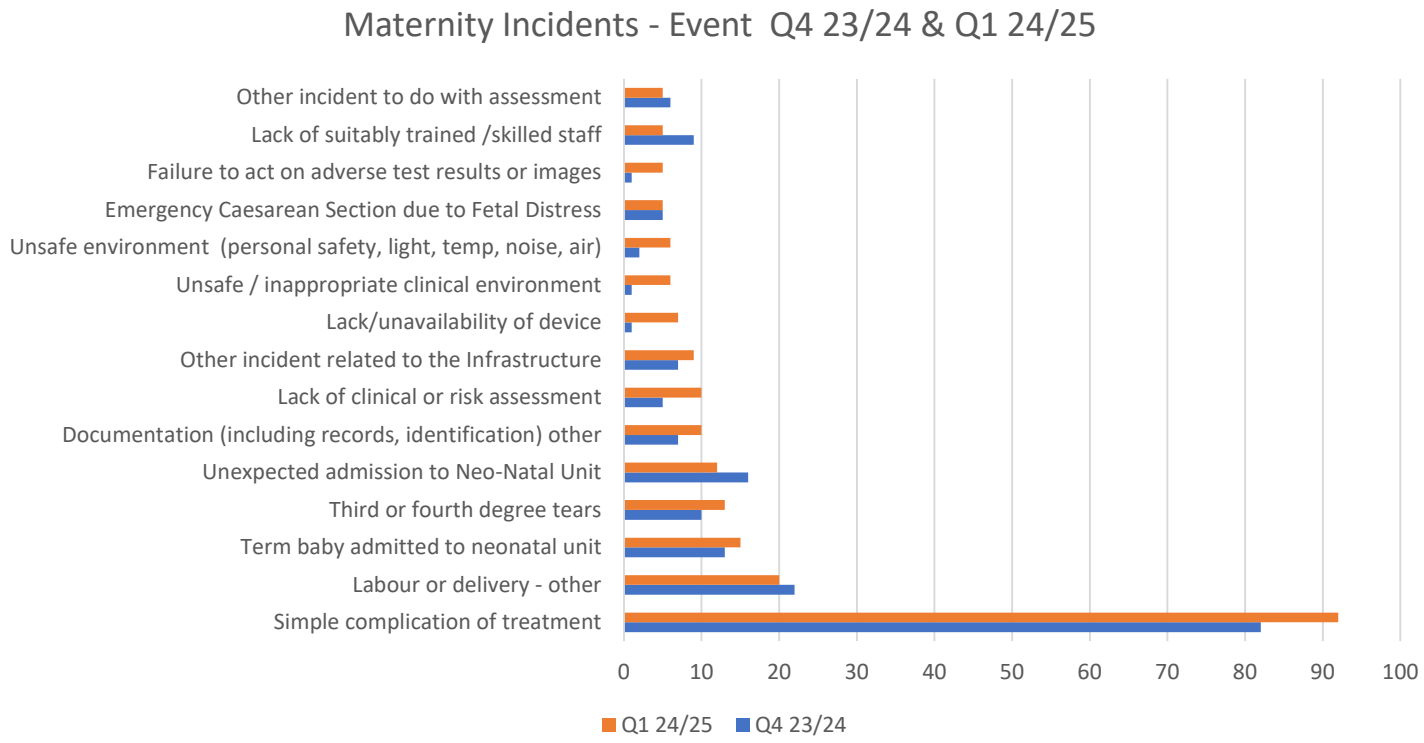
NHS Medway NHS Foundation Trust

Key Messages:

- Increase in number of incidents reported in quarter 353 (335 in Q4)
- 99% of incidents reported are no or low harm.
- 4 incidents reported as Moderate Harm or above
  - Misdiagnosed 3rd degree perineal tear requiring referral to tertiary centre to repair subsequent fistulas and complications.
  - Insulin prescription incorrectly prescribed by primary care for type 1 diabetic patient. Patient attended Maternity Unit for support and noted to be in DKA.
  - 2 incidents relating to staff trips & falls.

Actions & Improvements:

- Bespoke education sessions on prevention, detection and repair of perinatal trauma held in June 204.
- Prevention and detection of perineal trauma to be part of essential skills from July 2024. Plan to introduce RCOG OASI bundle across unit.



Top Three themes in maternity incidents for (sub-category) for Q1:

- Labour or Delivery (58)↓
- PPH > 1L (74) ↑
- Injury/Poor outcome for mother (15)

Top Three Maternity Incidents by event for Q4 :

- Simple complication of treatment (92) ↑
- Labour & Delivery – other (20) ↓
- Term baby admitted to Neonatal Unit (15)

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q1 24/25
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
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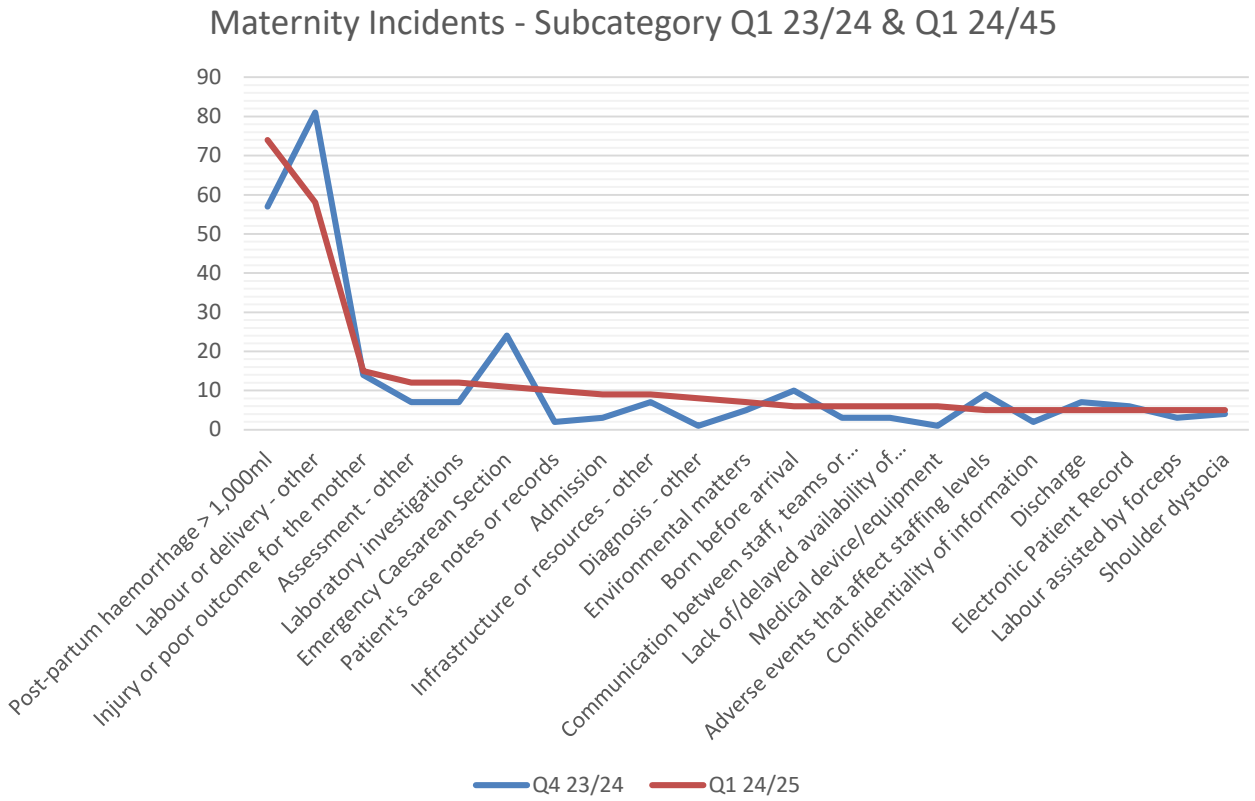
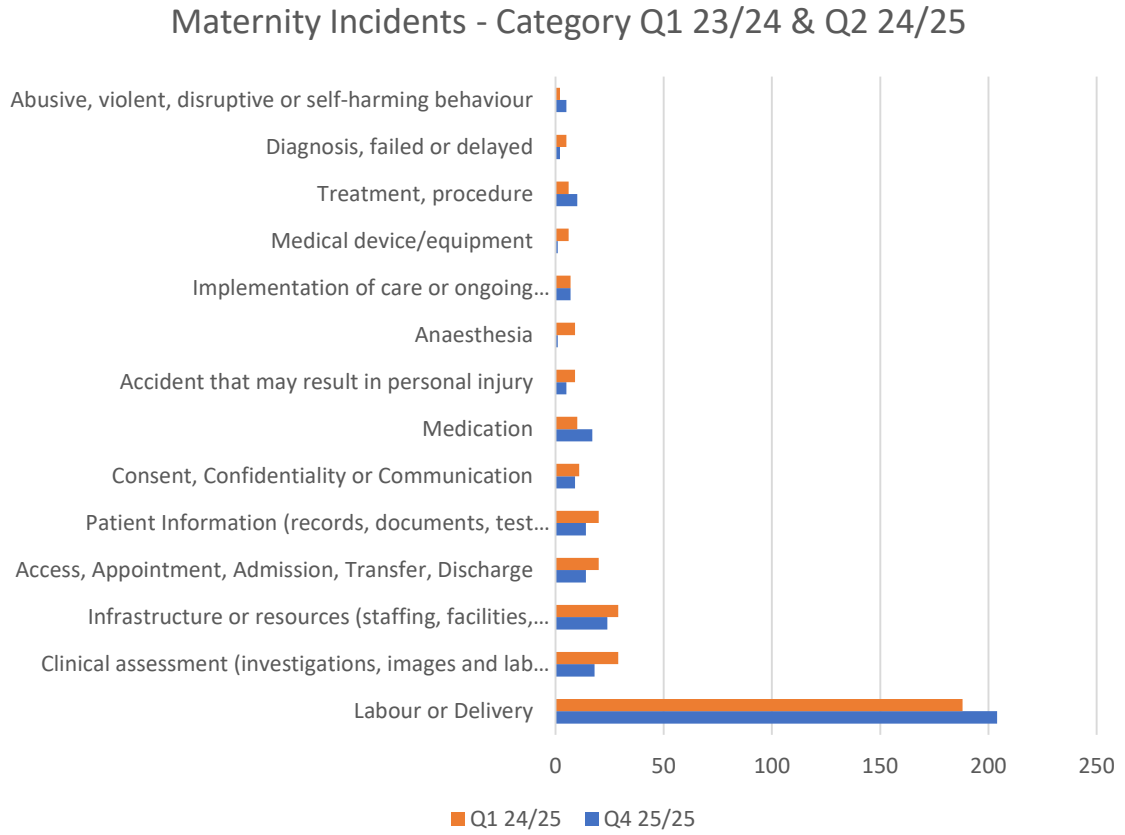
NHS Medway NHS Foundation Trust





Top Three themes in maternity incidents for (sub-category) for Q1:

- Labour or Delivery (58)↓
- PPH > 1L (74) ↑
- Injury/Poor outcome for mother (15)

Top Three themes in maternity incidents for (Category) for Q1:

- Labour or Delivery (188)↓
- Clinical Assessment (investigations, images & lab tests (29) ↑
- Infrastructure or resources (staffing, facilities, environment) (29) ↑

True North: Quality

Perinatal Surveillance Tool: Quarterly Report

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

Issues, Concerns & Gaps:

- Labour and delivery (188)
    - PPH >1000mls (75)
    - Injury/Poor outcome for mother (15) - 13 relating to 3rd degree tears
- Clinical assessment (investigations, images and lab tests) (29)
    - 12 relating to laboratory tests
        - Rejected samples
        - MCU investigations log not being reviewed and actioned.
- Infrastructure or resources (staffing, facilities, environment) (29)
    - 6 Relating to inability to scan patients in fetal medicine in accordance to guidance (risk ID 2078 score 12 (4x3))
    - 5 relating to staffing (risk ID 1133 score 20 (5x4)

Actions & Improvements:

- Learning from datix and incident investigations, including MSNI cases incorporated into mandatory training in 2024.
- All PPH >1500mls reviewed at CRIG. PPH audit to commence with review of threshold for escalation to consultant by Labour Ward Lead.
- Carbetocin Trial to commence.
- Education and training on prevention, detection and management of perineal trauma being run by perineal consultant. Presentation of 3rd and 4th degree audit at Audit meeting in June 2024 with plan agreed to move from STOMP to RCOG OASI bundle to reduce incidence and improve diagnosis of any tears.
- OASI To be added to essential skills and doctors Training from July 2024.
- Maternity engaged in Trust-wide blood sample A3 thinking project to reduce rejected samples.
- Registrar now rostered to complete review of all outstanding investigations.
- Mapping and scoping exercise being completed in Fetal Medicine to assess flow and scanning capacity. Replacement machines included on equipment bid.
- Exploration of servicing contract to ensure timely repair and availability of loan machines in times of equipment malfunction

True North: Quality

Perinatal Surveillance Tool: Quarterly Report

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

Key Messages:

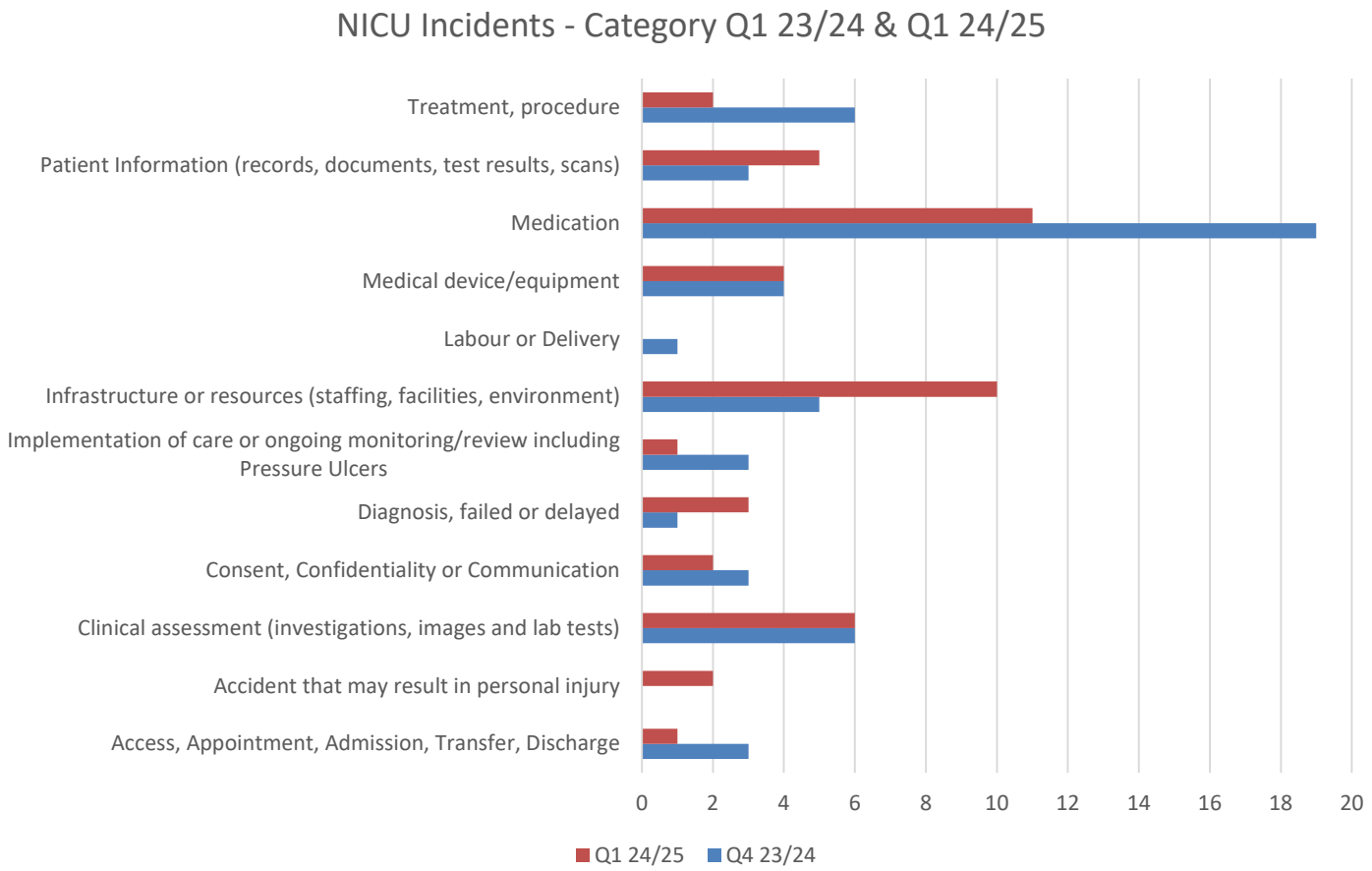
- Increase in incidents reported in Q1 with 47 reported (34 in Q4)
- 100% of incidents reported are no or low harm.
- Medication incidents include errors/delays in administering milk to babies.
- 0 SIs or HLIs in Q1

Top 3 NICU Incidents by Category

- Medication (11)
- Infrastructure or resources (10)
- Clinical assessment (investigations, images and lab tests (6)

Actions and Improvements

- Increased IPC surveillance following MRSA case
- Doctor assigned to check NIPE as a failsafe
- Awareness drive completed by education team to update staff on new UVC stocks.



True North: Quality

Perinatal Surveillance Tool Data Dec 2023 – PSIRF Investigations & Maternity & Newborn Safety Investigations (MNSI)
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

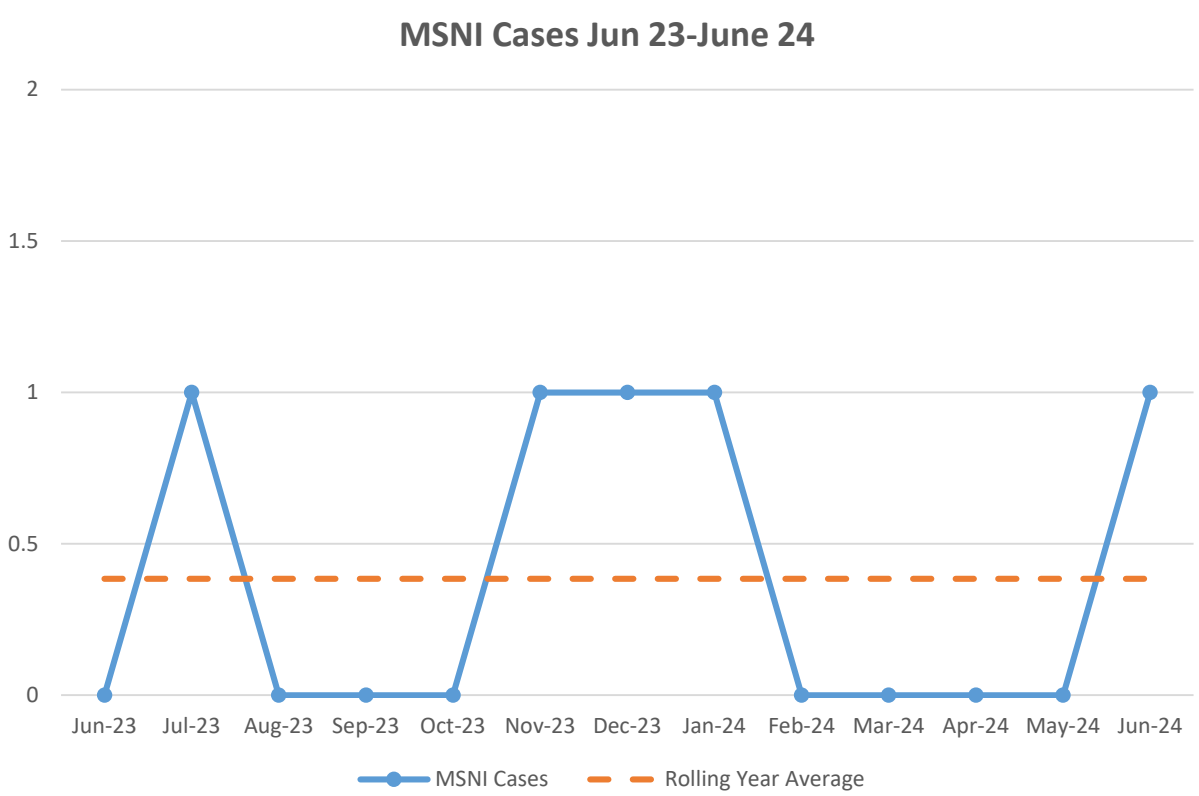
Key Messages:

- 1 MNSI Referrals in Q1
  - Baby referred following difficult instrumental delivery with baby subsequently showing seizure activity.
  - 1 MNSI investigation closed in Q1 – HIE –1 action for Trust –

  "The Trust to review risk assessments in telephone triage to support staff to recognise when a category one ambulance transfer to hospital may be indicated."
  - 1 postnatal maternal death in the community in March 2024 at 7 months postpartum. Trust not informed until June 2024. MBRRACE reportable – outside MNSI criteria (42 days pp)

Actions and Improvements .

- Review and update Call the Midwife guidance to incorporate trigger list to prompt staff when Obstetric emergency's require a CAT 1 Ambulance.
- Once guideline updated and approved to be disseminated to relevant staff members via Team meetings
- Audit compliance with trigger list/CTM guidance and share at team meetings/audit for learning
- Implement recording of CTM calls to support quality and training
- Work with key stakeholders within acute and community settings to ensure any maternal death within 1 year post partum is escalated to the Head of Midwifery and the maternal death policy followed.



True North: Quality

Perinatal Surveillance Tool Data Q1– PSIRF

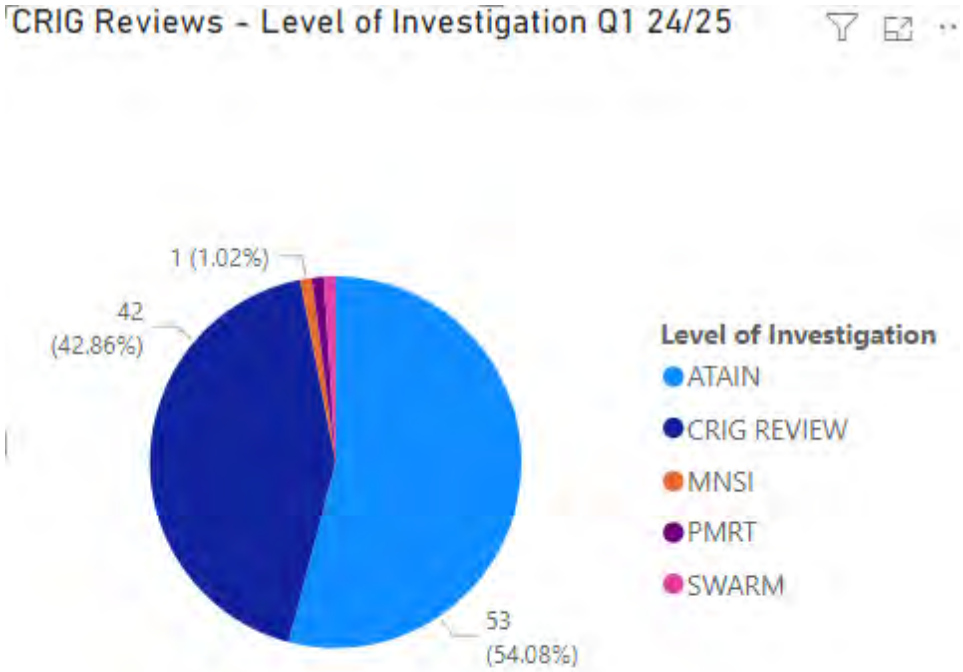
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.

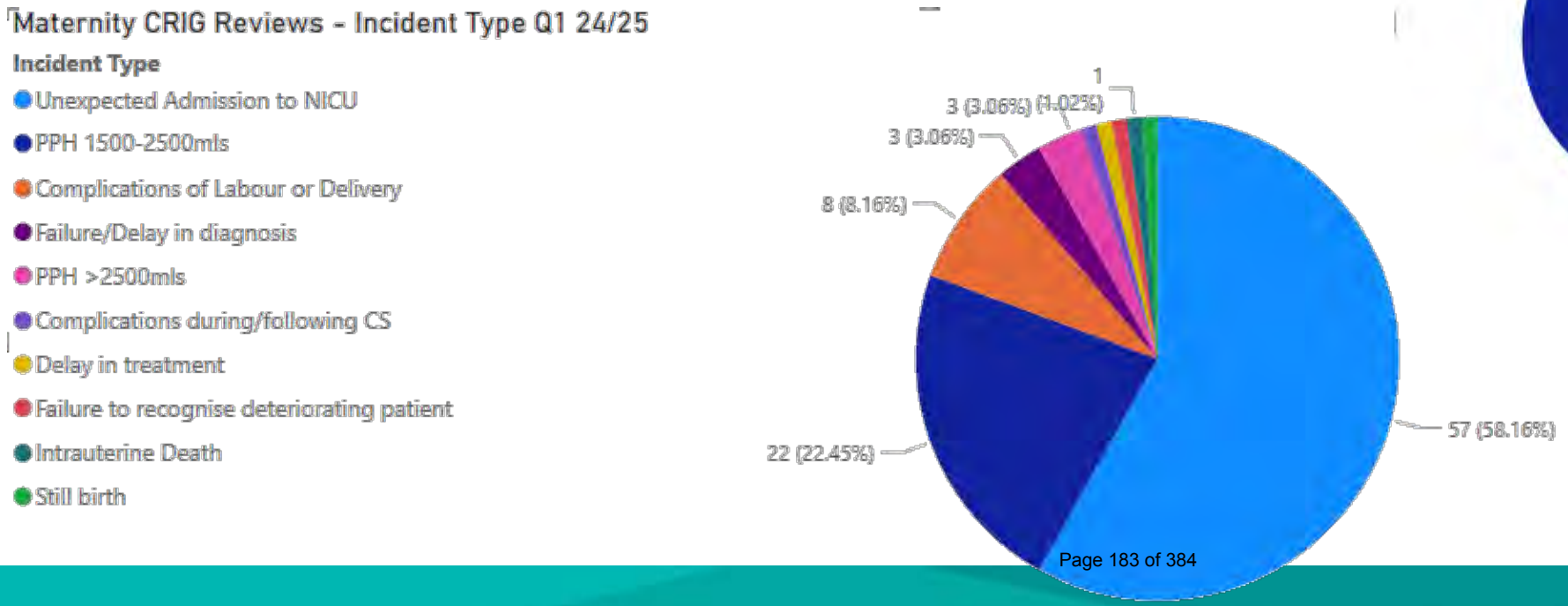
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages :

- 97 cases reviewed at MDT CRIG meeting in Q1
  - 56 ATAIN Reviews ↑
  - 42 CRIG Reviews ↑
  - 1 SWARM
  - 1 case to PMRT



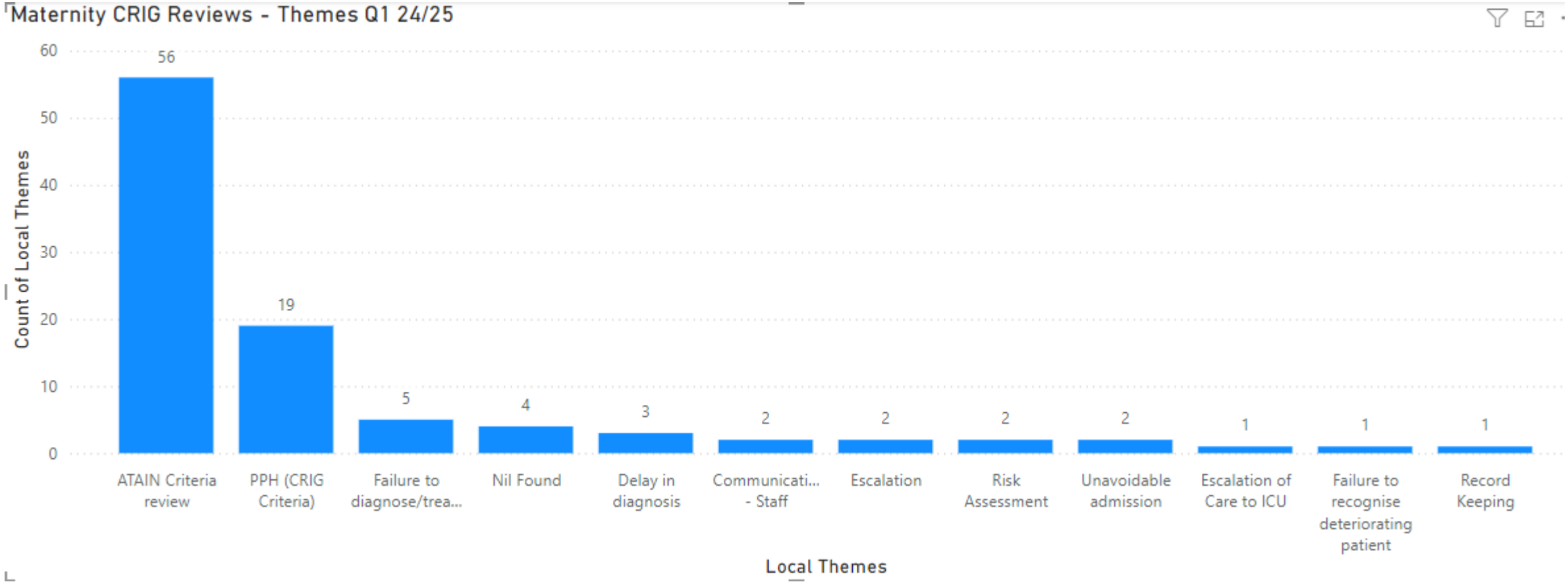


True North: Quality

Perinatal Surveillance Tool Data Q1– PSIRF

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.

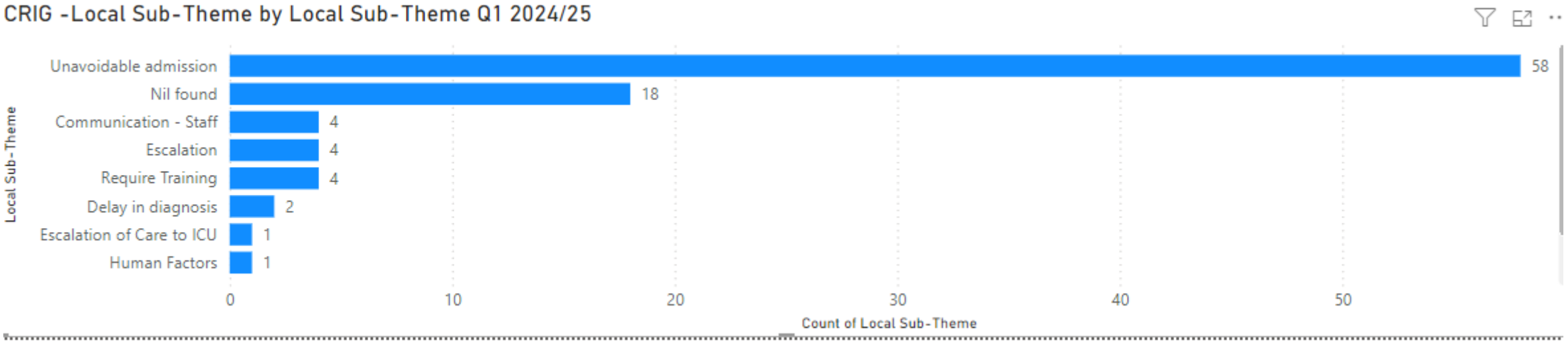


True North: Quality

Perinatal Surveillance Tool Data Q4– PSIRF

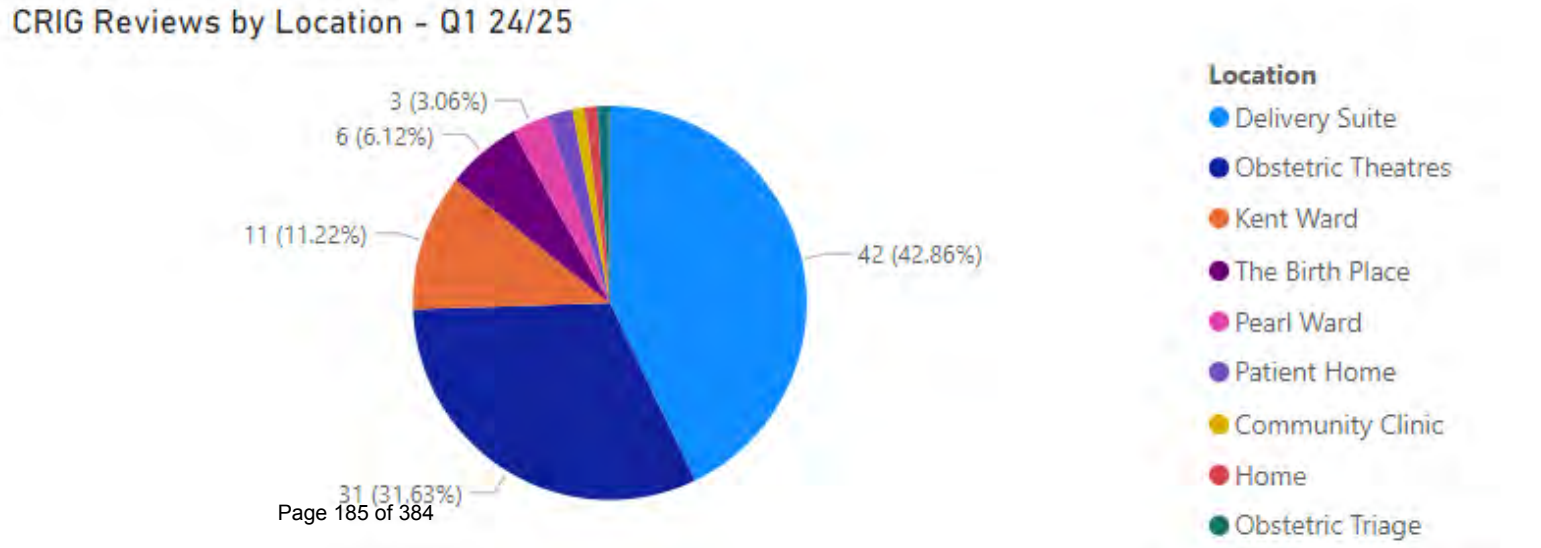
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.

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



Key Messages :

- With the exception of PPH and Term admissions the key themes for incidents reviewed at CRIG for Q1 are:
- Communication between staff
- Escalation
- Training
- Delay in diagnosis

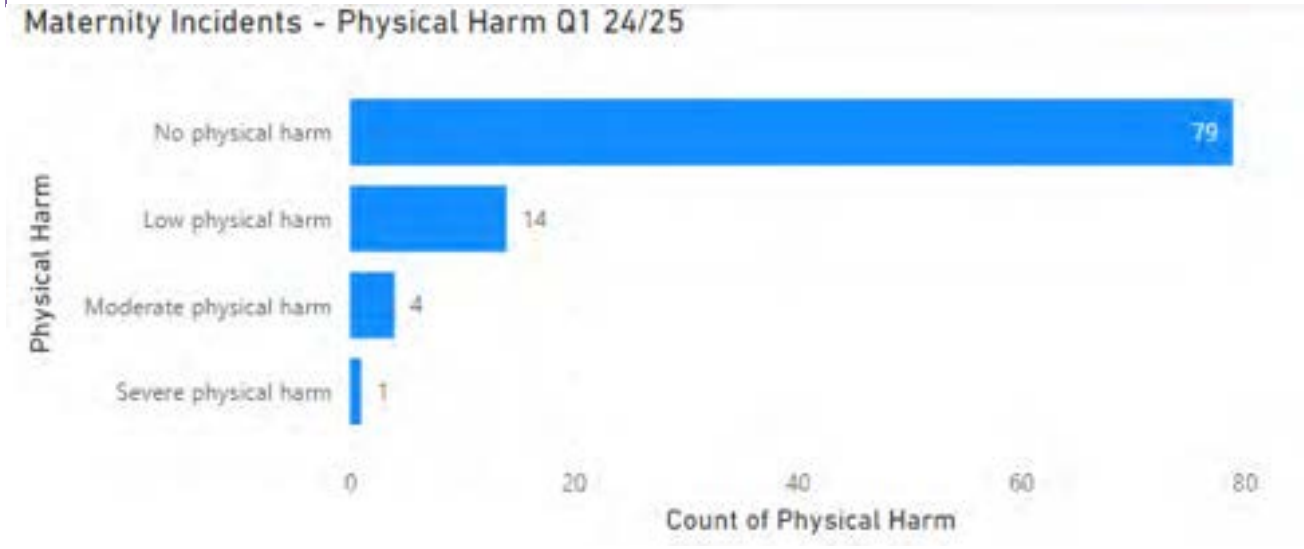


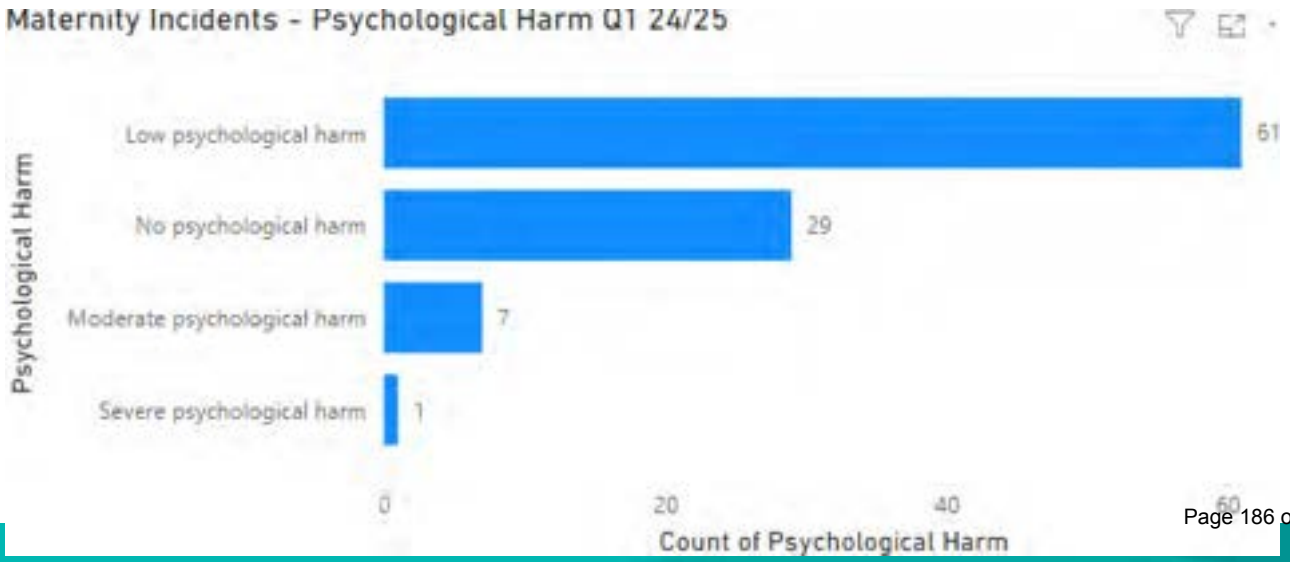
True North: Quality

Perinatal Surveillance Tool Data Q1– PSIRF

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

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





Key Messages :

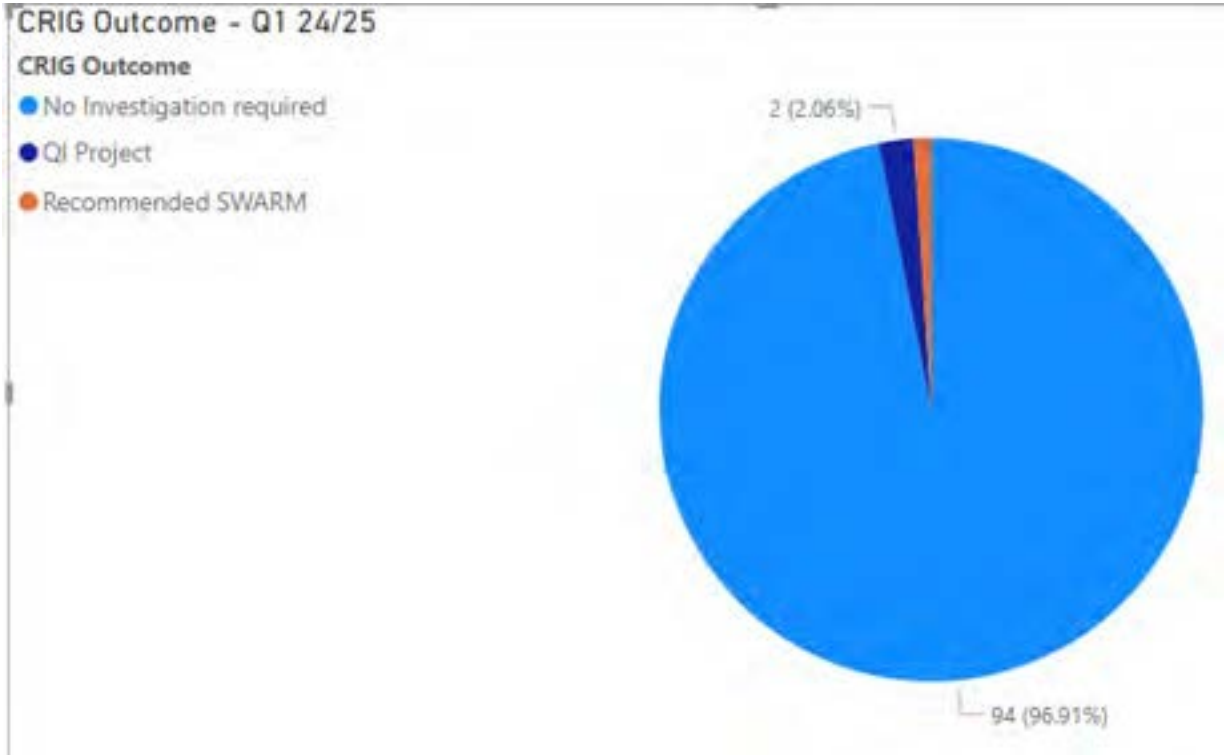
- Learning from Patient Safety Events (LFPSE) criteria of physical and psychological harm now recorded against all CRIG incidents.
- 1 Incidence of severe physical harm relates to 3rd degree tear noted on previous slides.
- 1 incidence of severe physiological harm – IUD – PRMT review
- Moderate physical harm
  - MNSI referral
  - Missed 3rd degree tear
  - 4th degree tear repaired without consultant present
  - 3rd degree tear, >2L PPH and transfer to ITU
- Moderate psychological harm
  - MNSI referral
  - PPH (2)
  - 3rd degree tears as above
  - 3rd degree tear, >2L PPH and ITU transfer
  - Still birth

True North: Quality

Perinatal Surveillance Tool Data Q1– PSIRF

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.



Issues, concerns, gaps:

- Datix reports still pulling historical categories of harm and therefore these incidents not pulling in reports on severity.
- Prevention, detection and management of 3rd and 4th degree tears
- Escalation of deteriorating patient.
- Challenge of ensuring robust review under PSIRF model as cases that would previously have been escalated to full review are now only reviewed locally unless they fall within wider PSIRF themes/actions.

Actions and improvements

- Maternity team to meet with Patient Safety team to review how level of harm is recorded and reported along with DOC requirements in view of move to LFPSE.
- Training and education on 3rd and 4th degree tear as outlined on previous slide.
- Case review of ITU transfer to be included in PROMPT training.
- Threshold for escalation of PPH being reviewed by Labour Ward Lead with consideration of escalation at 1.5L active bleeding rather than 2L as per RCOG guidance.
- PPH QI audit/clinical trial underway.
- All perinatal losses reviewed at PMRT with parents views incorporated into to investigation.
- HOM to engage with Trust patient safety team PSIRF review to discuss concerns.

Perinatal Surveillance Tool Q1 2024/25– Perinatal Mortality Review Tool

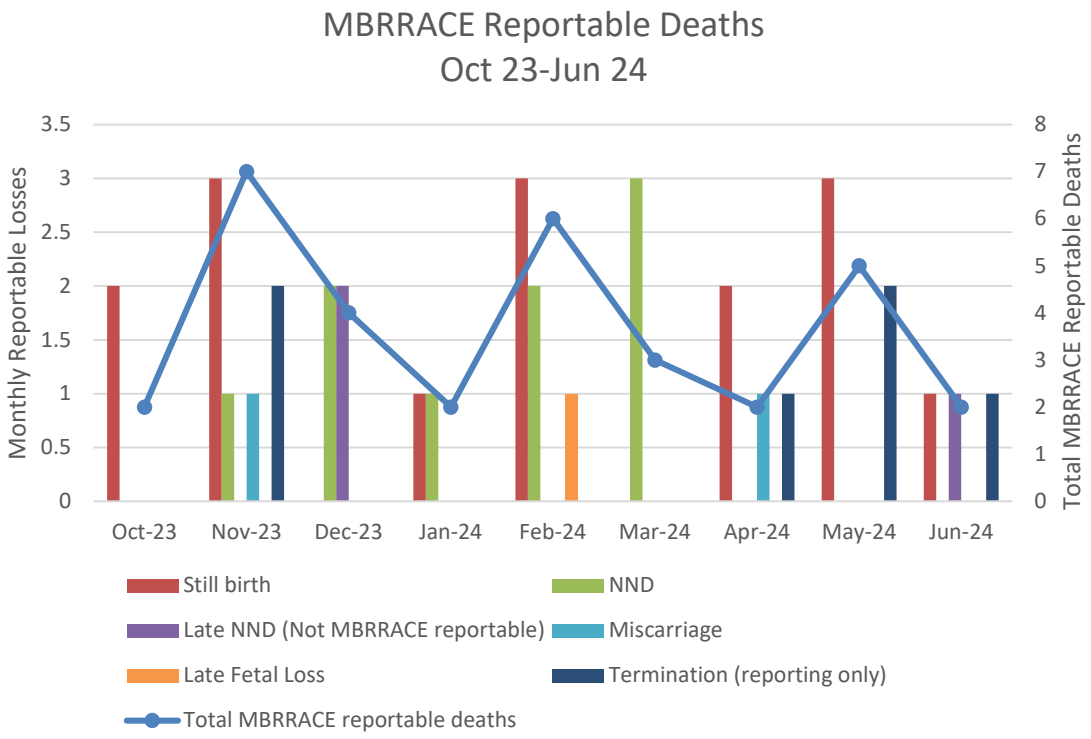
Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

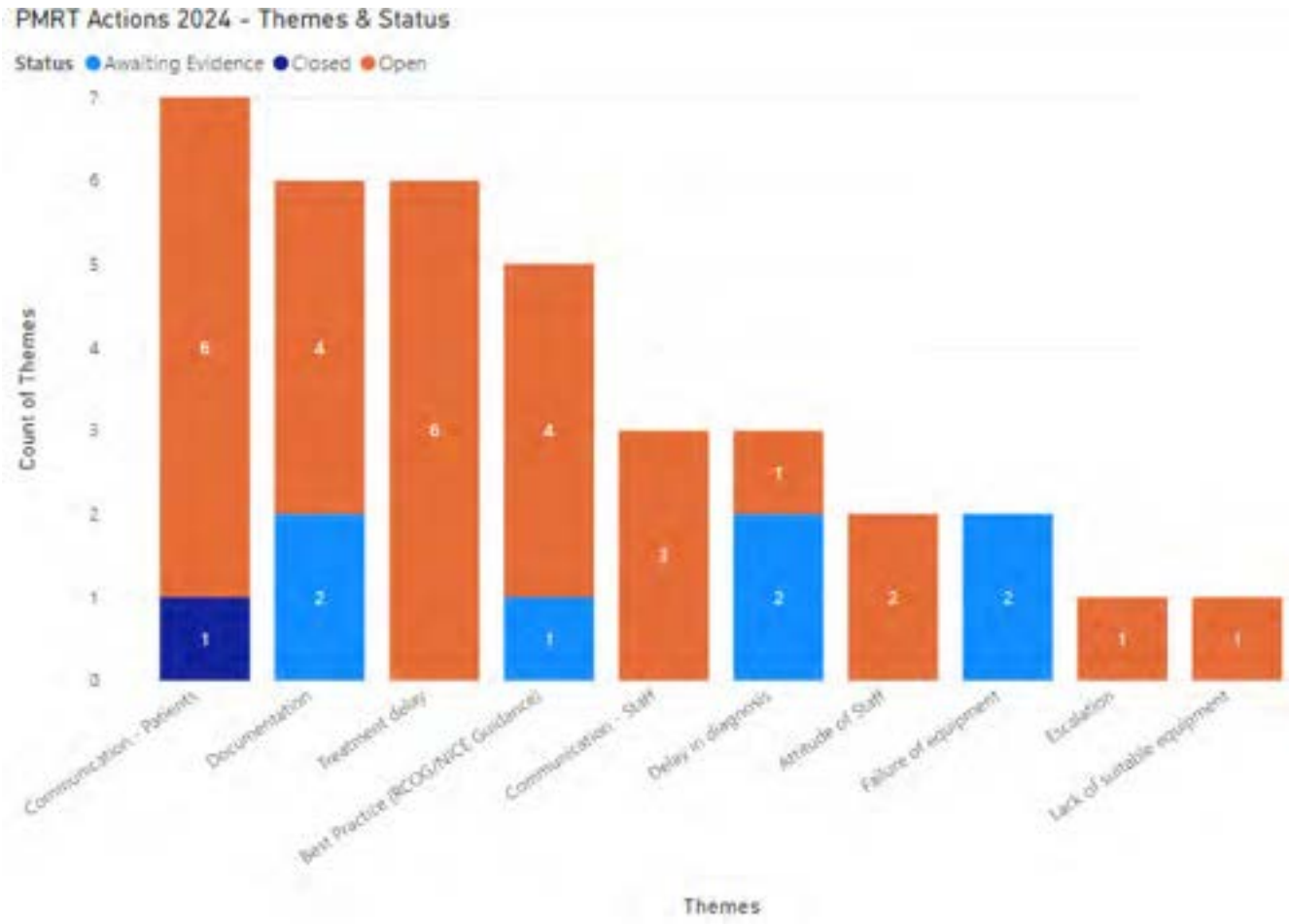
Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Key Messages :

- 9 MBRRACE reportable cases in Q1
- All cases reported within CNST/MBRRACE timeframes
- 10 PMRT reviews completed in Q1.
- 36 actions currently open relating to PMRT cases – Communication and documentation being the most common themes





Perinatal Surveillance Tool Q1 2024/25– Perinatal Mortality Review Tool

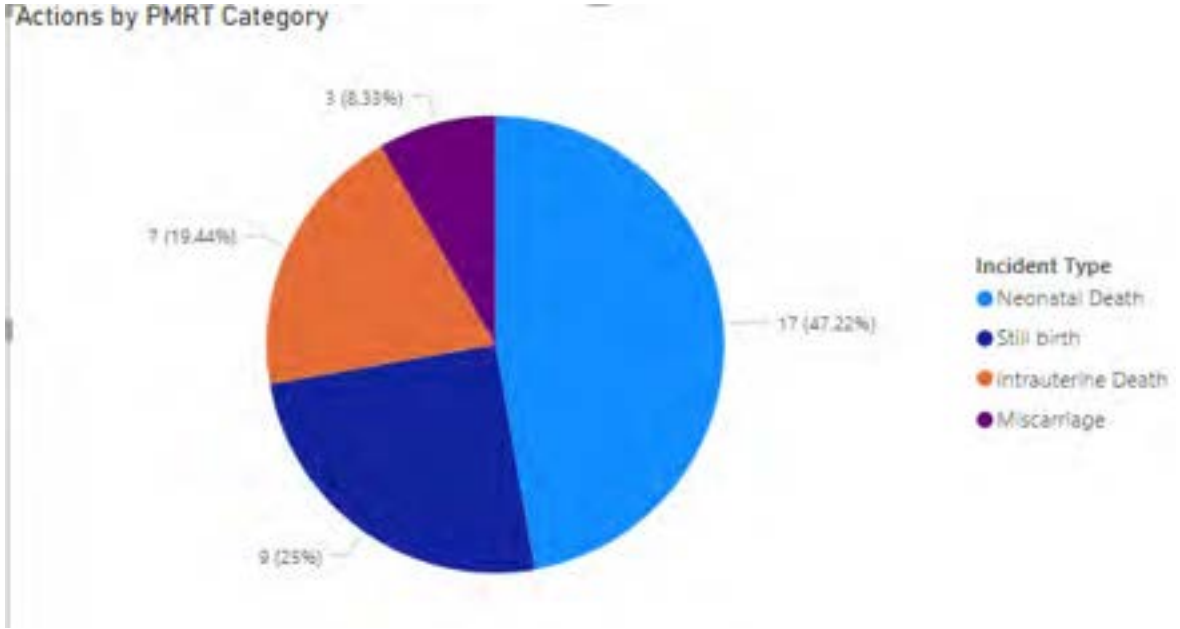
Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

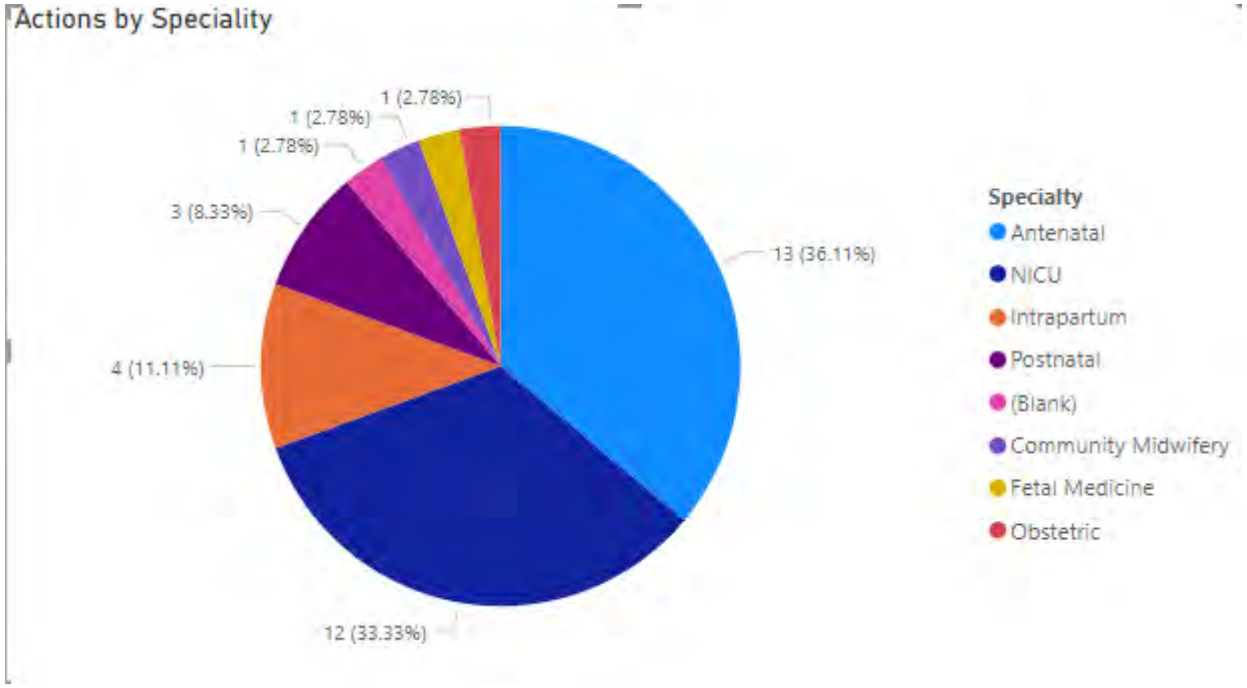
Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Key Messages :

- Actions broken down by PMRT category and specialty





Perinatal Surveillance Tool Q1 2024/25– Perinatal Mortality Review Tool

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

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

Medway NHS Foundation Trust

Issues, Concerns, Gaps:

- Communication during antenatal, intrapartum and postnatal period flagged as a concern across a number of PMRT cases in quarter.
- Delay in pathology results following a loss.
- Delay in issuing of Death Certificates
- Documentation and delay in diagnosis also presented as a theme across a number of PMRT cases.

Actions & Improvements:

- Protocol for Bedside scanner developed to ensure availability for use at all times across maternity wards.
- Review neonatal respiratory guidelines to ensure optimal management within first 24 hours of admission.
- Training for staff on protocol for emergency buzzers.
- Share learning at team meetings and Top 5
- Co-produced information booklet for bereaved families produced – awaiting care group sign-off and printing.
- Calls to “Call the Midwife” to be recorded – SOP awaiting final Trust approval before go-live.
- Arrange meetings with Medical Examiners office to review process for death certificates.
- Add key learning to Essential skills teaching.
- Update neonatal resuscitation guidance to support documentation
- Working with compliance manager to ensure actions from PMRT recommendations are SMART

MBRRACE Reportable Loses Q4

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
4	1	Stillbirth	25+1	Eary onset growth restriction	PMRT	A,A Identified early and managed on appropriate pathway.
4	2	Neonatal death	20+0		N/A	MBRRACE reportable - not for PMRT
4	3	Late fetal loss	22+2	Turners	PMRT	A,A - histology completed at Maidstone not GOSH
4	4	Stillbirth	27+0	Severe Early Onstet Fetal Growth Restriction & Placental insufficiency	PMRT	A,A - Not cared for in Bluebell as it was already in use - Parents happy with care and praised midwives. Action to ensure parents located away from main delivery suite area if possible when bereavement area unavailable
4	5	Stillbirth	32+3	Chorioamnionitis	PMRT	C, B - Staff communication, bedside scanner - actions on action log.
4	6	Stillbirth	38+5	Placental Abruption	PMRT	B, B - Baby needed to be transferred to GOSH for post-mortem, not offered to take baby home, communication.
4	7	Neonatal death	31+0	Severe Growth Restriction	PMRT	A,A,A -Baby born at neighbouring Trust - actions regarding thermal management during transfer (baby cold) and not documented whether trans warmer was used. Cranial scans not documented as having had consultant review.
4	8	Neonatal death	26+2	Prematurity	PRMT/Coroner	A,A,A, - Interpreter service not used, nutritional management of baby was sub-optimal. Inquest.
4	9	Neonatal death	23+3	Extreme Prematurity - Twin	PMRT	B,B,B - Partogram not used, possible missed opportunity for admission, fetal tissue not identified within placenta, delay in issuing of death certificate, Baby 1 had issue with chest drain (not secured)
4	10	Neonatal death	23+3	Extreme Prematurity - twin	PRMT	B,A,B - No neonatal concerns. Other concerns same as baby 1.
4	11	Neonatal death	21+5	Extreme Prematurity	MBRRACE Reportable only	MBRRACE reportable - not for PMRT Provided comfort care only, parents unhappy with outcome

MBRRACE Reportable Loses Q1

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
1	1	Miscarriage	23+5	Unexplained - despite all investigations	PMRT	B,C - Pain relief not managed appropriately, communication poor, failure to follow uniform policy
1	2	Termination	26+2	Fetal Abnormality	MBRRACE Reportable only	
1	3	Termination	22+3	Fetal Abnormality	MBRRACE Reportable only	
1	4	Termination	22+5	Fetal Abnormality	MBRRACE Reportable only	
1	5	Stillbirth	30+2	Unexplained	PMRT	
1	6	Stillbirth	39+2	Fetal Abnormality	PMRT	
1	7	Stillbirth	39+2	Unexplained	PMRT	
1	8	Late Neonatal Death	Born 24 weeks - died 6 weeks post delivery	Extreme Prematurity	PMRT Only Not MBRRACE reportable	PMRT and Coroner case
1	9	Termination	32+4	Fetal Abnormality	MBRRACE Reportable only	
1	10	Stillbirth	32+4	Unexplained	PMRT	

Maternity Risks

NHS Medway NHS Foundation Trust

Patient FIRST

Executive Summary – Risks

Currently 13 risks in maternity and 2 in Neonatology

Two risk with scores 15 to 20 (Maternity)

Highest risk related to midwifery workforce challenges

All mitigations and scores have been reviewed within required timeframes

Maternity and Neonatal Risks

Risk ID	Maternity Risk	Mar-24	July 24
1133	Insufficient Midwifery Staffing impacting the ability to provide patient care.	20	20
1864	Maternity Information System coming to end of contract	15	15
1025	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	15	15
2078	Inability to provide timely fetal medicine service due to failing equipment/out of date	-	12
1131	Delays in IOL	12	12
1460	Potential failure to appropriately risk assess women in the community due to lack of experienced Midwives allocated to work within the community setting.	9	9
1128	Community Midwifery Premises	6	6
1300	Unable to access patient records at community antenatal clinics	9	9
1737	Inconsistent and inaccurate data being shared outside the organisation	6	6
1302	Movement of staff to support acuity on Delivery Suite creates red flags in other areas	6	6
1741	Risk of harm to maternity staff whilst lone working	6	6
2044	Insufficient Transcutaneous Bilirubinometer (TCB) Monitors in Community Midwifery	5	5
2079	Glucose meters not suitable for neonatal use -	-	6

Risk ID	NICU Risk	Mar-24	July 24
1148	Lack of available space in NICU for equipment storage	8	8
1984	Upgrade of Gantry System (ITU)	-	9

Workforce – training and clinical safe staffing

Perinatal Surveillance Tool Q1 2024/25– Midwifery Workforce

Ambition: To ensure safe staffing workforce model is in place.

Goal: To have a workforce that is staff to the required level.

NHS Medway NHS Foundation Trust

Key Messages :

- Midwifery staffing remains a challenge with true vacancy rate remaining high across the quarter.
- Long term sick leave also reduced across quarter with continued high levels of maternity leave.
- Positive midwifery workforce retention rates.
- Recruitment and Retention Midwife and Patient Experience and EDI midwife successful.
- Additional MSWs recommended as part of Birth rate+ 2023 now in establishment and recruitment ongoing.
- Below average leaves per month over quarter.

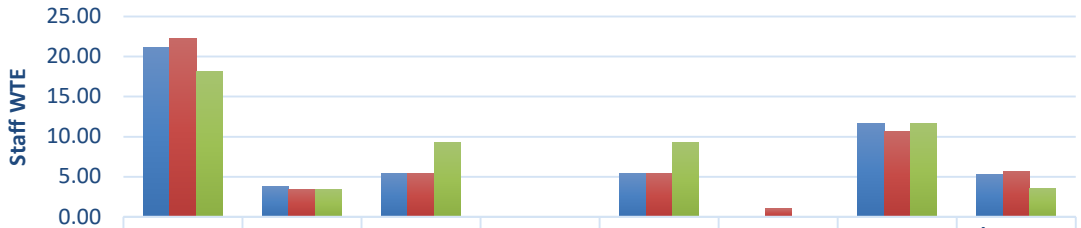
Issues, concerns, gaps:

- Vacancy rate in midwifery staff continues to be a challenge.
- Shortfall in newly qualified midwives due to the impact of the displacement of CCCU students.
- Long-term sickness increased in quarter.

Actions and improvements

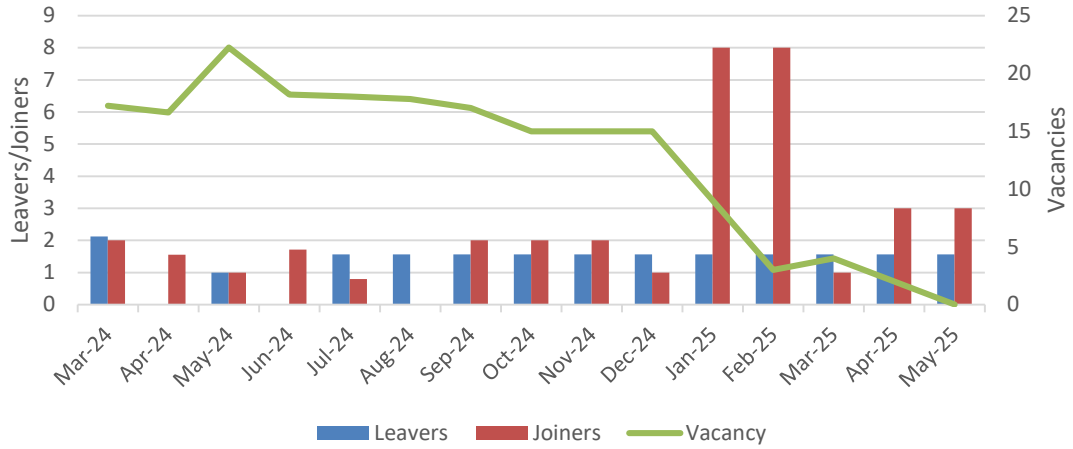
- Appropriate oversight and escalation of workforce concerns with Action plan for 2024/24 in place.
- Working locally, regionally and internationally to support recruitment.
- Working to support wellbeing of staff to maintain good retention rates.
- Surrey University taken on CCCU students with anticipated graduation date of March 2025.
- Long-term sickness has been managed inline with Trust policy.

Midwifery Staffing April 24-Jun 24



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Apr-24	21.12	3.77	5.42	0.00	5.42	0.00	11.72	5.32
May-24	22.23	3.48	5.42	0	5.42	1	10.64	5.72
Jun-24	18.16	3.48	9.26	0	9.26	0	11.64	3.6

Midwifery Workforce Mar 24-May 25



Perinatal Surveillance Tool Q4 2023/24 – NICU Nursing Workforce

Ambition: To ensure safe staffing workforce model is in place.
Goal: To have a workforce that is staff to the required level.

Medway NHS Foundation Trust

Key Messages :

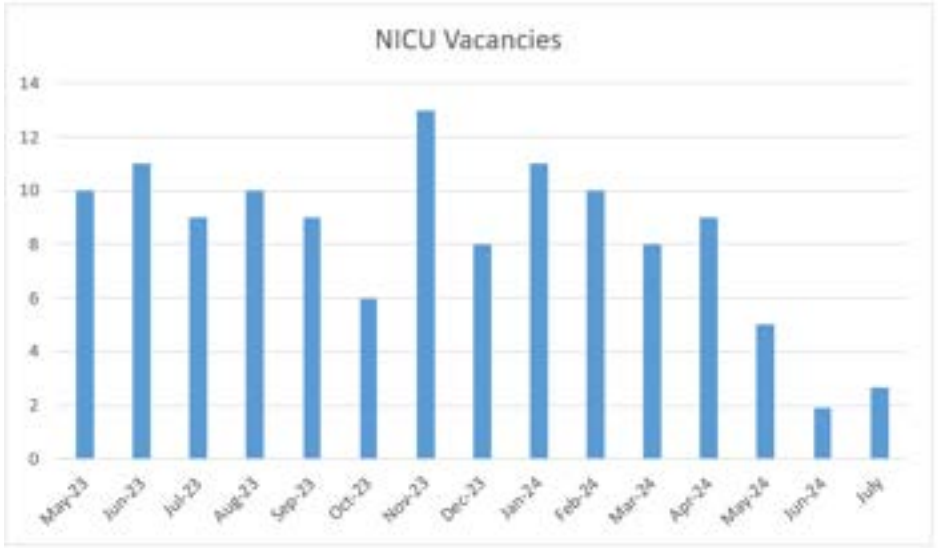
- NICU Nursing vacancy rate reduced to from 8.03WTE in Q4 to 2.69 across all bands. (Band 6 0.89 WTE, Band 5 1.8 WTE)
- QIS = 59% (reduction in vacancy reduces QIS)
- Recruitment and retention payments continuing for all QIS staff.
- Escalated bank rate offered to mitigate gaps in clinical nursing workforce.

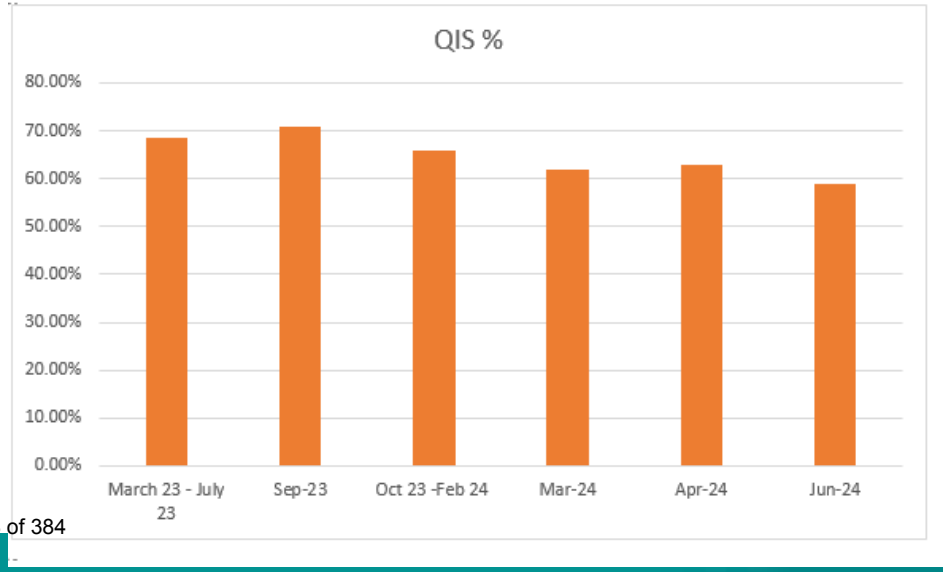
Issues, concerns, gaps:

- NICU workforce <70% QIS.
- Offering opportunities to make Medway NICU attractive to staff.

Actions and improvements

- 6 staff currently on QIS course, with a further 6 to commence in September.
- Staff education plan being developed for year ahead to ensure all learning needs are captured and facilitated.
- Learning contract to be introduced for staff to aid retention.
- Work with staff to promote wellbeing and career development opportunities.
- QIS action plan updated to included recruitment and retention actions.





Perinatal Surveillance Tool Q1 2024/25– Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.

Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust

Key Messages:

- Fetal monitoring training >90% for all staff groups
- 2 PROMPT training days running per month to support >90% compliance (previously 1 day per month).
- Midwives, MSWs and Theatre staff >90% for PROMPT training.
- Anaesthetic and obstetric doctors <85%
- Midwifery essential skills 90% compliance.
- Increase in compliance with ABLS, NBLS training and Safeguarding adults Level 3 Increased to 78% for midwifery staff (71% in Q4), however the latter remains below Trust target.
- Overall compliance for Maternity and Neonatal Staff for mandatory training has increased to 92.63% (NICU) 86.51% (Maternity and Obstetrics)
- CNST Year 6 reporting period for training compliance >90% is December 2023 to 30 November 2024.

Issues, concerns, gaps:

- PROMPT training currently below 85% for all medical groups.
- A number of mandatory training topics remain below Trust target.
- Have not met training trajectory for Safeguarding Adults Level 3 – 78% midwifery staff, 55% medical staff

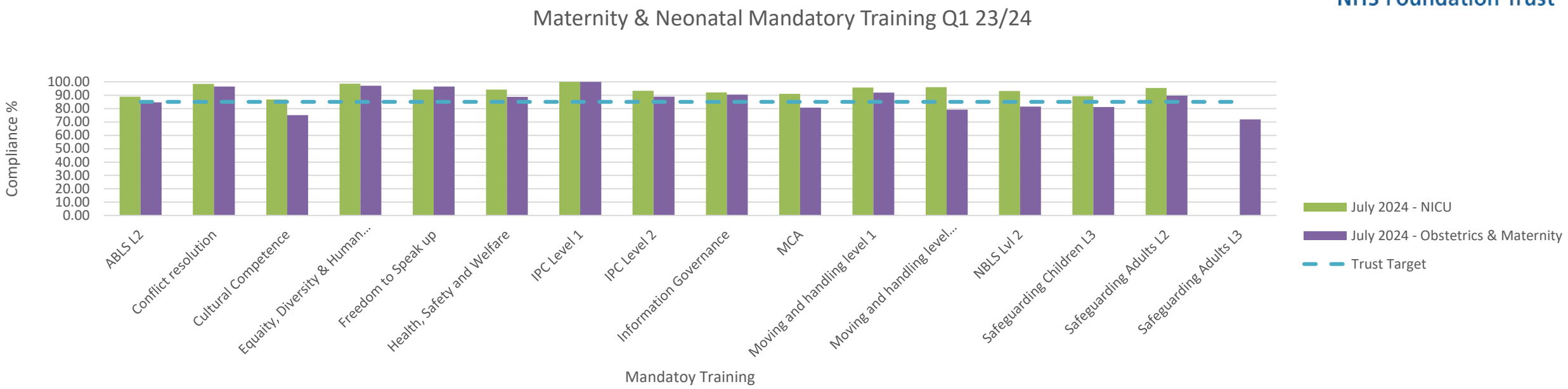
Actions and improvements

- All SIMS now conducted in clinical area, responsive to service user feedback, incidents and service developments.
- SBAR included in PROMPT and essential skills.
- All new starters receive PROMPT training within 3 months.
- Education team to flag with Service Manager and General Manager non-attendance by medical team to ensure rebooking. Midwifery non-attendance escalated to senior sister.
- Mandatory training compliance to form part of appraisal process
- Senior sisters to identify individual staff needs and to roster attendance to support compliance.
- Those with significant lapse in training compliance to have 1:1 review with matrons/clinical supervisor.
- Midwife now qualified as moving and handling assessor and able to undertake workplace assessments for moving and handling training and ability to ensure staff trained in maternity specific scenarios (e.g. pool transfer, maternal collapse)

Perinatal Surveillance Tool Q3 2023/24 – Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust



Fetal Monitoring Training and Assessment	Q4 23/24	Q1 24/25
Midwives	97.7%	97%
Obstetric Consultants	100%	92%
Doctors in training	100%	100%

PROMPT training	Q4 23/24	Q1 24/25
Midwives	90%	94%
MA & MSW	92%	95%
Theatre Nurses and ODNs	93%	90%
Obs Consultants	72%	67%
Obs SpR/SHO	85%	87%
Aneaesthetic Consultant	75%	80%
Aneas. SpR/SHO	82%	80%

Essential Skills March 2024	Q4 23/24	Q1 24/25
Midwives	90%	93%

Feedback – including MNVP Service users and MFT maternity and neonatal staff

Perinatal Surveillance Tool Data Q4 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

Key Messages:

- Strong working relationship with Maternity and Neonatal Voices Partnership Lead who provides service user feedback and works to support multiple co-production streams across the service including:
    - Review of complaint responses
    - Maternity Triage/MCU QI Project
    - Co-produced action plan based on service user feedback
    - Benchmarking and action plan against National Birth Trauma report.
    - Review of patient information leaflets for bereavement
    - Review of IOL patient facing information, including leaflet and padlet.
    - Supporting interviews as part of stakeholder groups
- MNVP lead on MNSCAG bi-monthly for service user feedback update.
- Overall improvement in FFT response rate and recommend rate across the quarter, peaking in April with 49% response rate and 99% recommend.
- Patient stories/service user feedback now embedded into MNSCAG.
- Successful bid to NHSE Funding to support the implementation of Martha's Rule.
- Service user part of stakeholder group for patient experience and EDI midwife panel. Service user had previously had negative experience during first delivery much improved experience when having second baby.

Maternity FFT	Jan	Feb	Mar	April	May	June
Recommend Rate	88.5%	85.8%	88.8%	99.4%	96.5%	92.6%
Response Rate	30.9%	38.7%	30.7%	49.1%	47.6%	39.0%

Issues, concerns, gaps:

- Ongoing challenges to engage with service users, particularly those from minority groups.
- Service user feedback identified lack of clear pathway and accommodations for neurodiverse service users.
- Capacity of MNVP lead to meet national requirements
- No parent information for TC

Actions and improvements

- Plans for "Whose shoes" Oct 2024 and 15 Steps Challenge December 2024.
- Co-production of action plan following service user feedback from LMNS.
- Co-production of parent information for TC – including virtual tour antenatal counselling for high-risk groups.
- Working party established including MNVP and service users to review pathways for neurodiverse service users.
- LMNS MNVP Engagement and Coproduction lead working on new proposal for MNVP structure/capacity to support national requirements whilst maintaining service user engagement.

Perinatal Surveillance Tool Data Q4 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

During our stay on the Transitional Care we were visited by a number of the Infant Feeding Team as I wanted to establish breastfeeding. At each visit the whole team were kind, understanding and allowed me to share my worries with no judgement. They came with solutions to problems, and made me feel confident in my ability to feed my baby. After 5 days on the ward, I was very keen to begin a plan to take my baby home and begin our next chapter as a family of 3, however there were still concerns with my baby's ability to breastfeed as she was still very sleepy. In walked the Infant Feeding Lead Midwife, with a plan to strip back feeding plans and no longer use the NG tube, she advised that for next 24hrs I do nothing but skin to skin to help reset her, regulate her temperature and encourage her to feed on demand. She listened to my concerns, was kind and reassuring and I felt very safe in her hands. To support her was the infant feeding support worker who even came to see us that night at 11pm, helped the baby latch on and was a friendly face during a challenging time. Over the next 24 hours I bonded with my baby, fed her regularly and began to rebuild my confidence in my ability to breastfeed my baby and safely take her home.

I had my first baby 5 years ago at Medway, it was my first baby and I found the experience to be quite scary. I wasn't really told what was going on and I felt out of control.
I have just had my second baby at Medway and I was very nervous. Things though have really changed, the staff were really friendly and kept telling us what was going on and what to expect. I felt like I had choices when I was pregnant and when I was in labour which I don't remember having last time.
Really great care and a healthy baby, we couldn't be happier "

Perinatal Surveillance Tool Data Q1 2024/2025– Staff Feedback
Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.
Goal: To ensure staff feedback forms and integral part of service improvement

NHS Medway NHS Foundation Trust

Key Messages:

- 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.
- Positive staff feedback regarding newly established Maternity & Neonatal Collaborative Hour (MNCH) – forum for sharing and learning.
- Engaged in LMNS staff listening event – themes of feedback included culture, staffing, system, training & safety

Issues, concerns, gaps:

- Need to relaunch frontline Safety Champions following changes in staff and leadership roles.
- LMNS staff feedback concerns identify increased need to share improvements and changes with staff.
- Missing equipment or long delays in returning from EME/lack of tracking of equipment.

Actions and improvements

- 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.

Safeguarding Performance Report

SIOR - Safeguarding

Successful Deliverables

- Actions from Maternity LCSPR that can be completed have been , next action due with Vulnerable pregnancy policy review at the end of 2024
- Ongoing effective partnership working with outside agencies
- Improvements noted in non-cp case holder supervision compliance

Next Steps

- Continue work with community teams to increase compliance of supervision, and to then complete similar process with hospital teams.
- Promote Pre Birth Assessment Threshold for timely referrals - to be included in vulnerable pregnancy guideline

Identified Challenges

- DNA monthly dip sample audit completed for the last quarter and only 46% of services users that required a DNA checklist were completed
- Recruitment to Maternity Safeguarding Leave Cover to take place in August. Need to ensure adequate handover.

Next Steps

- DNA monthly dip sample to continue to have increased oversight of compliance , community senior sister to ensure midwives are provided additional training or support if ongoing non-compliance of following the policy
- DNA dip sample audit to be included quarterly in SOG reports

Opportunities

- Implementation of antenatal toxicology testing

Next Steps

- Recommendation from LCSPR was to implement antenatal toxicology screening in Maternity. This has been delayed, contact has been made to seek costings and practicalities of routine testing with DVH and Kings , awaiting response. Escalated to senior management and consideration needed if we continue with this process or review at a later date

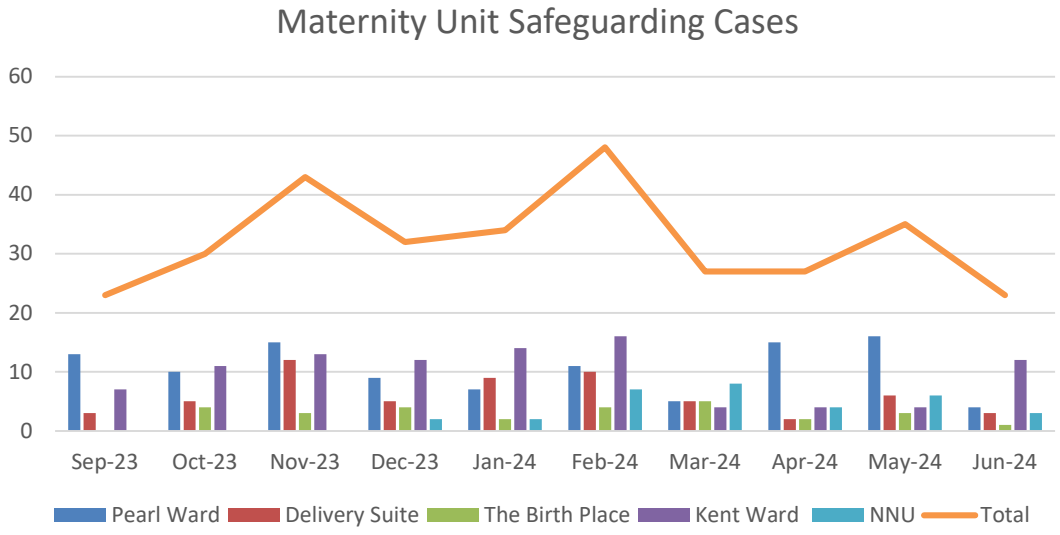
Risks

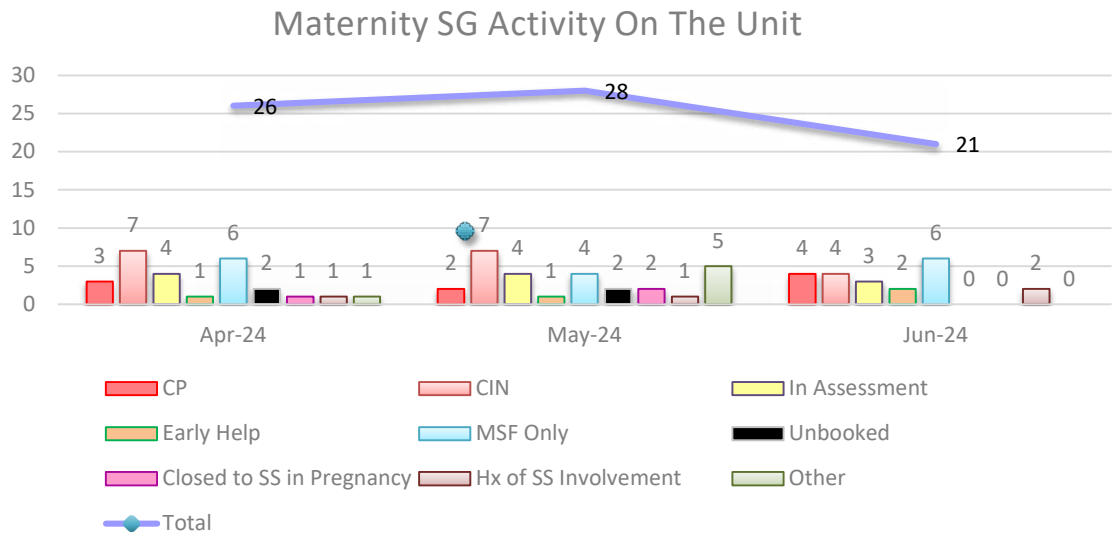
- Maternity staff are currently non-compliant for Adults and Children Level 3
- Although CP-IS checking has been implemented in maternity a recent review of processes has highlighted that admissions to the unit are not being checked

Next Steps

- Information has been sent to all staff to complete the Adults Level 3 AND Children Level 3 training as a priority . Monthly compliance update sent to all Senior Sisters/ Matrons/ Head of Maternity for continued oversight and review
- All new bookings are being checked on CP-IS by community MTA's, Ward Clerks are being re allocated smart cards and training to be provided, how to guide and information to be sent to Midwives In Charge and hospital senior sisters to check Unbooked pregnancies when attending the unit whilst Ward Clerks await training- Awaiting Smart Cards for Ward Clerks.

Safeguarding Related Incidents/ Activity – Maternity Unit





Key Messages:

- Maternity Safeguarding had oversight of 23 services users on the maternity wards in June 2024. Support was given to 3 Babies on the neonatal unit.
- There has been a total of 3 Child Protection cases. All pre birth planning was completed and pre discharge planning meetings held as required.
- There has been a reduction in safeguarding activity across the unit this month, however this is expected to increase in July and August with 14 families on a CP and 15 families on a CIN expected to deliver. This does not include those in assessment or other safeguarding concerns raised

Issues, Concerns & Gaps:

- Concerns have been raised by ward staff that some maternity support forms do not have clear plans for discharge home, which is causing delays and additional stress for families and work for ward teams

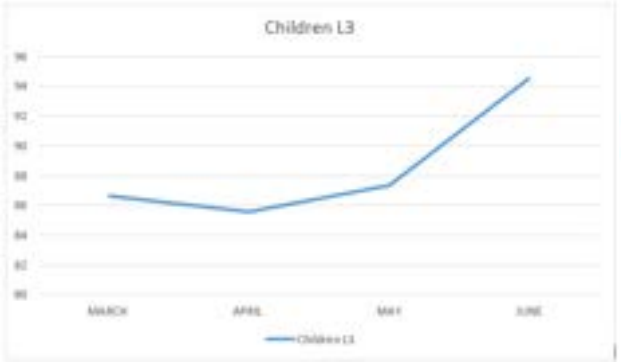
Actions & Improvements:

- Email sent to all maternity teams, including senior sisters and matrons to share the importance of appropriate planning at 36 week mandatory MSF updates and examples of what the plan may look like.
- Ongoing work with Kent Social care to implement agreed Pre Discharge process between service – Awaiting District social care meeting to present to service leads for agreement. Once implemented to duplicate process with Medway Social care.

SIOR - Patients

Successful Deliverables

- 11 inpatients with safeguarding concerns (JUNE)
- Safe guarding Level 3 staff statman compliance 94.51
- Embedded NIC handover
- Improved communication
- New lone worker guideline created.



Next Steps

SG L3 compliance:
March 86.67%
APRIL 85.556%
MAY 87.36%
April 94.51%

Identified Challenges

- Improved communication between NICUs within the Network is required to ensure seamless transfers of care
- Ensure guidelines are kept updated

Next Steps

- Work with BadgerNet Leads to move all NICU Safeguarding documentation to BadgerNet so it will be paperless, and will then be more visual to all NICU staff for information sharing
- NOAH working to improve lone worker guidance
- Update NICU Safeguarding Guideline to reflect recent Rapid Review actions and add Escalation Flowchart

Opportunities

- New staff supported to complete mandatory training during their supernumery induction period
- Weekly meetings are face to face, ensuring positive information sharing
- Reinstated SHARED forms – Improving handover and communication between Maternity and NICU
- Add safeguarding documentation to BadgerNet

Next Steps

- Continue to work closely with the multi professional team.
- Continue to support team to complete training
- Organise with BadgerNet leads to implement new area for documentation

Risks

- Missed information, as currently hybrid style of paper and BadgerNet - Working with BadgerNet to get this added to the system, online handover sheet required
- Risk of loan working within the community setting – Guideline has been updated

Next Steps

- Encourage staff to book into classroom training sessions and plan learning before competency expires
- Transfer all safeguarding documentation on BadgerNet EPR
- Risk assessments completed for all home visits
- Staff reporting as safe after each visit
- Create Escalation Flowchart for NICU Clinical Band 7's to follow when Outreach out of office

Perinatal Culture and leadership Programme (PCLP) & SCORE survey

Trust Board September 2024

Executive Summary

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

Perinatal Culture and Leadership July

Medway NHS Foundation Trust

Key Messages:

- Awaiting re-launch of programme from national team – first meeting set up for August 2024 with new Quad members.
- Divisional Culture was added as potential cause for staff absenteeism at Divisional Driver meeting.
- SCORE survey to be repeated in Autumn 2024, to include all of WCYP.
- Regular engagement with Trade Unions and Management.
- Awaiting appointment of new Freedom to speak up Guardian for Trust.
- 13 actions completed, 3 on track. 2 actions overdue and 1 action off track
- Staff wellbeing and reward systems in place – including "Star of the Month" and nomination of staff for local and external recognition.
- "You Said/We Did" feedback incorporated into huddle boards across the unit.
- Shared learning and good practice shared from CRIG via email, staff newsletters and governance newsletters.
- Staff and key stakeholder engagement in core projects/workstreams including MCU/Triage QI, Neurodiversity, Birth Trauma review

	SCORE Survey
Completed	**13**
Overdue	**2**
Off Track with actions to deliver	**1**
On Track	**3**
Total Number of actions	19
Percentage of actions completed/on track	84%

Issues, Gaps and Concerns:

- Breaks audit not finalised due to data entry error. Manual audit so requires repeat audit to correct error.
- Escalation policy not updated to include "re-briefs".
- Divisional and Trust sign-off for Hardwiring in community premises PID required. (has had care group sign-off)
- NICU psychologist post was recruited but post-holder has since resigned.

Actions and Improvements:

- Finalise breaks audit by end of August 2024 so findings and actions can be shared prior to next SCORE survey.
- Escalation policy to be reviewed at Guideline group in August.
- Monitor Divisional Culture and absenteeism via Divisional Drive meetings.
- SCORE survey to be repeated in Autumn 2024, to include all of WCYP.
- Recruit to NICU psychologist post.
- Re-Launch Safety Champions across Maternity & Neonatal to support a safe culture and psychological safety, including opportunities for anonymous staff feedback.
- Trust Board requested to minute the progress against the SCORE Survey Action plan is being monitored and appropriate support is being sought to complete actions and implement recommendations.

Next Steps

- Complete overdue and off track actions from 2023 Survey as priority and continue to monitor/complete remaining outstanding actions.
- Full Quad engagement with PSC re-launch of programme.
- Locally devised SCORE survey to be launched in Autumn with opportunity for all staff to review and contribute to action plan.
- Continue quarterly reporting to MNSCAG and Trust Board as per CNST Year 6 requirements.

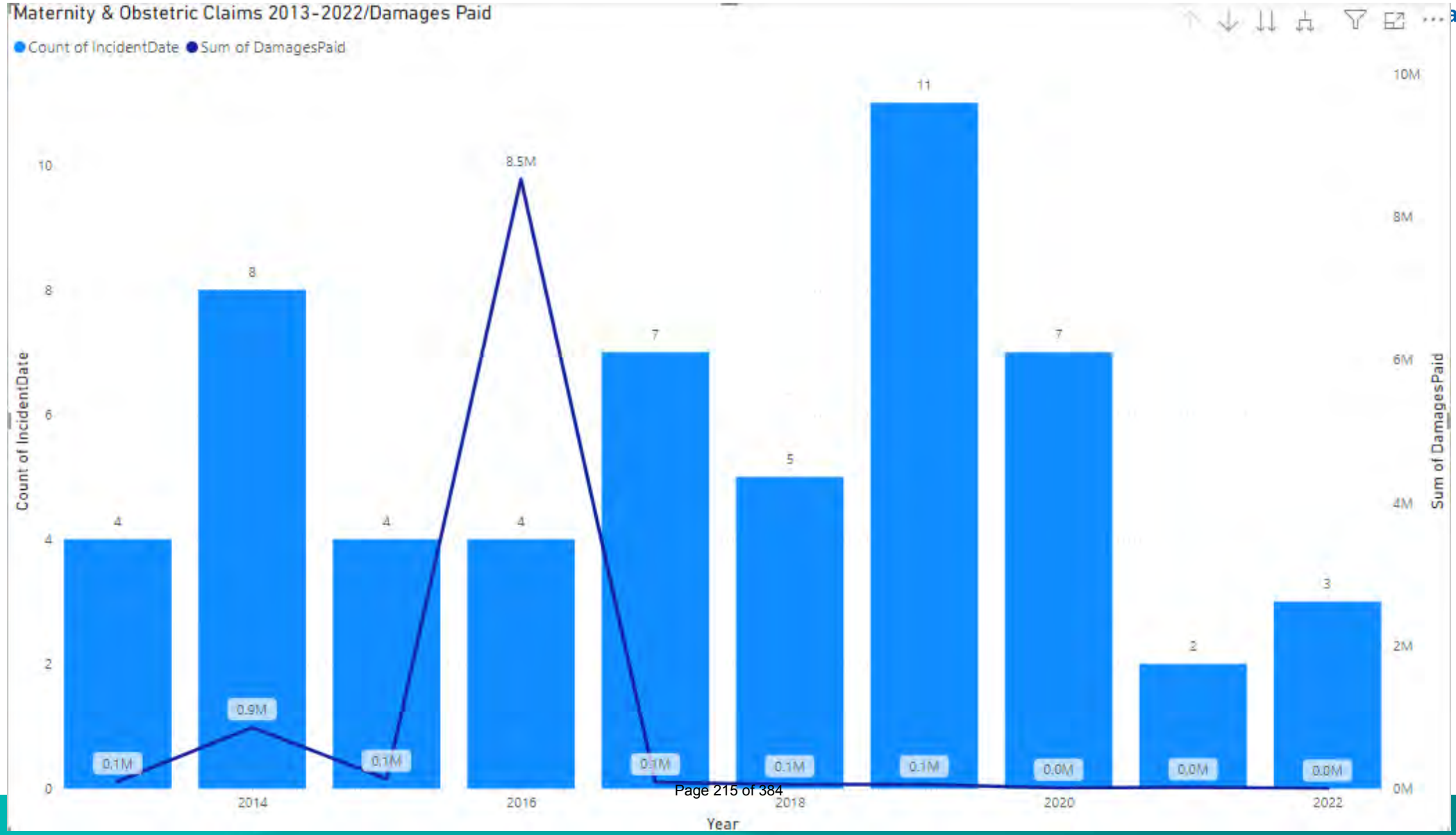
Maternity Claims Scorecard: Thematic Review July 2024

Trust Board September 2024

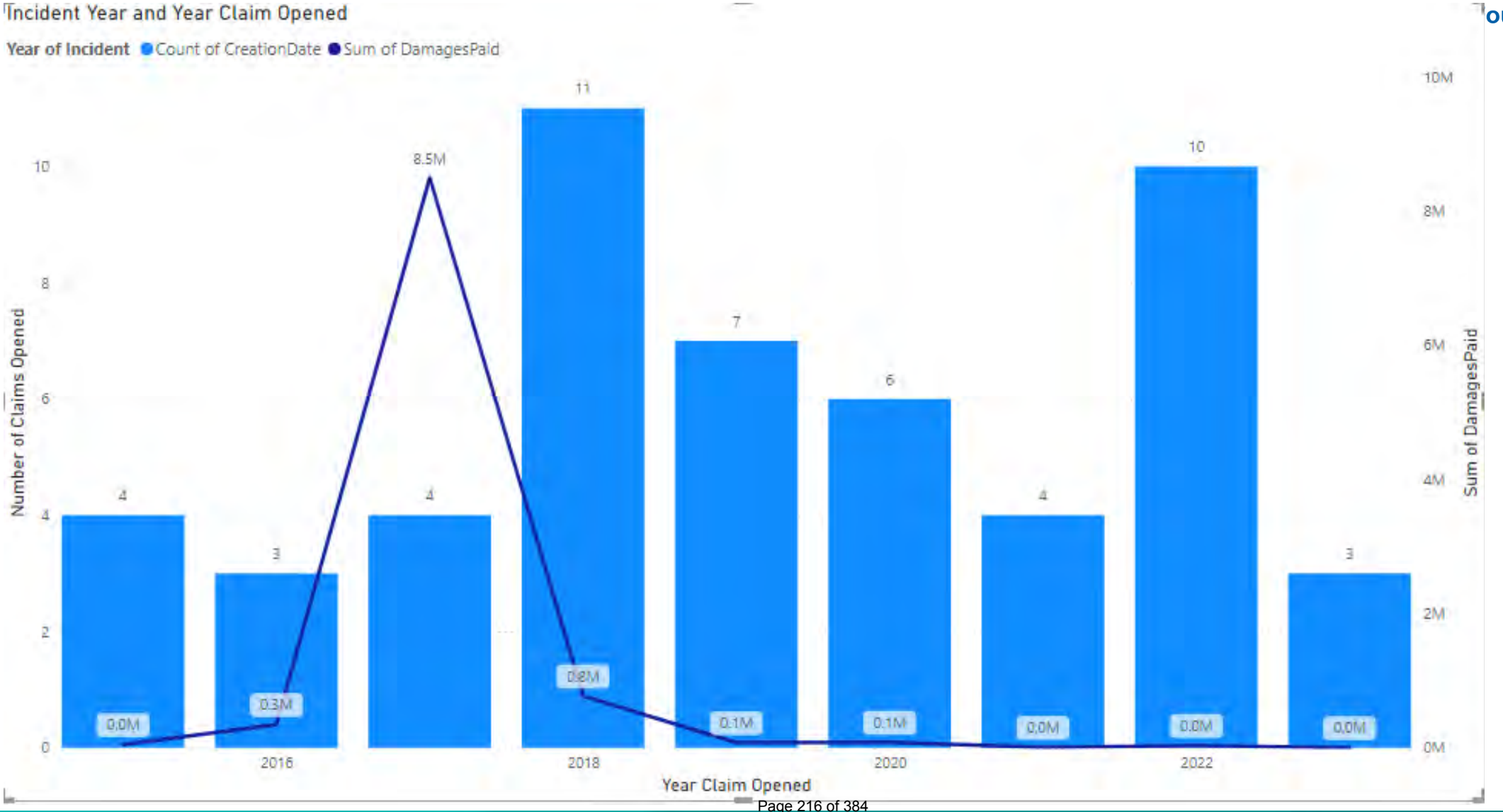
Overview

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

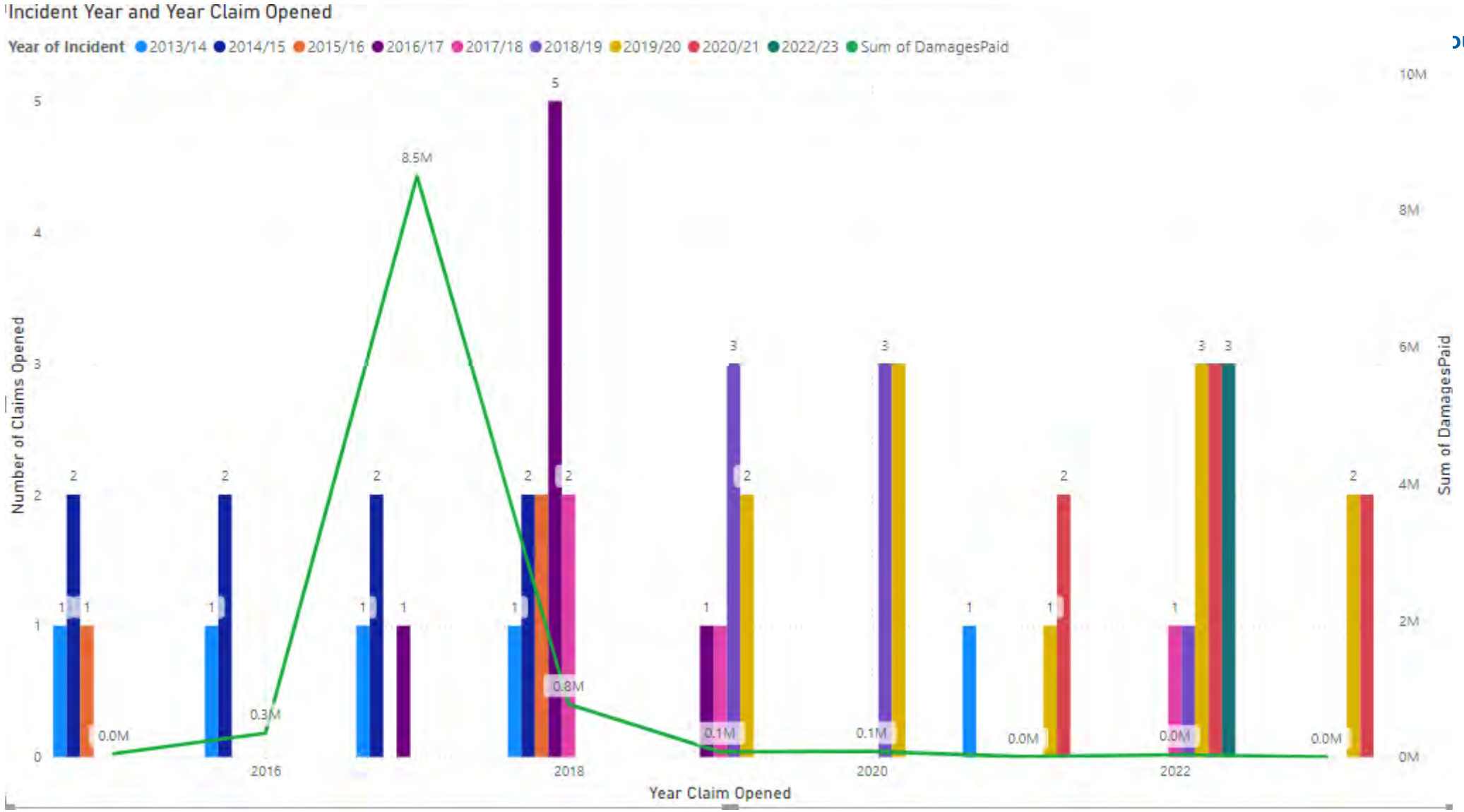
Claims – Yearly Breakdown (by incident date)



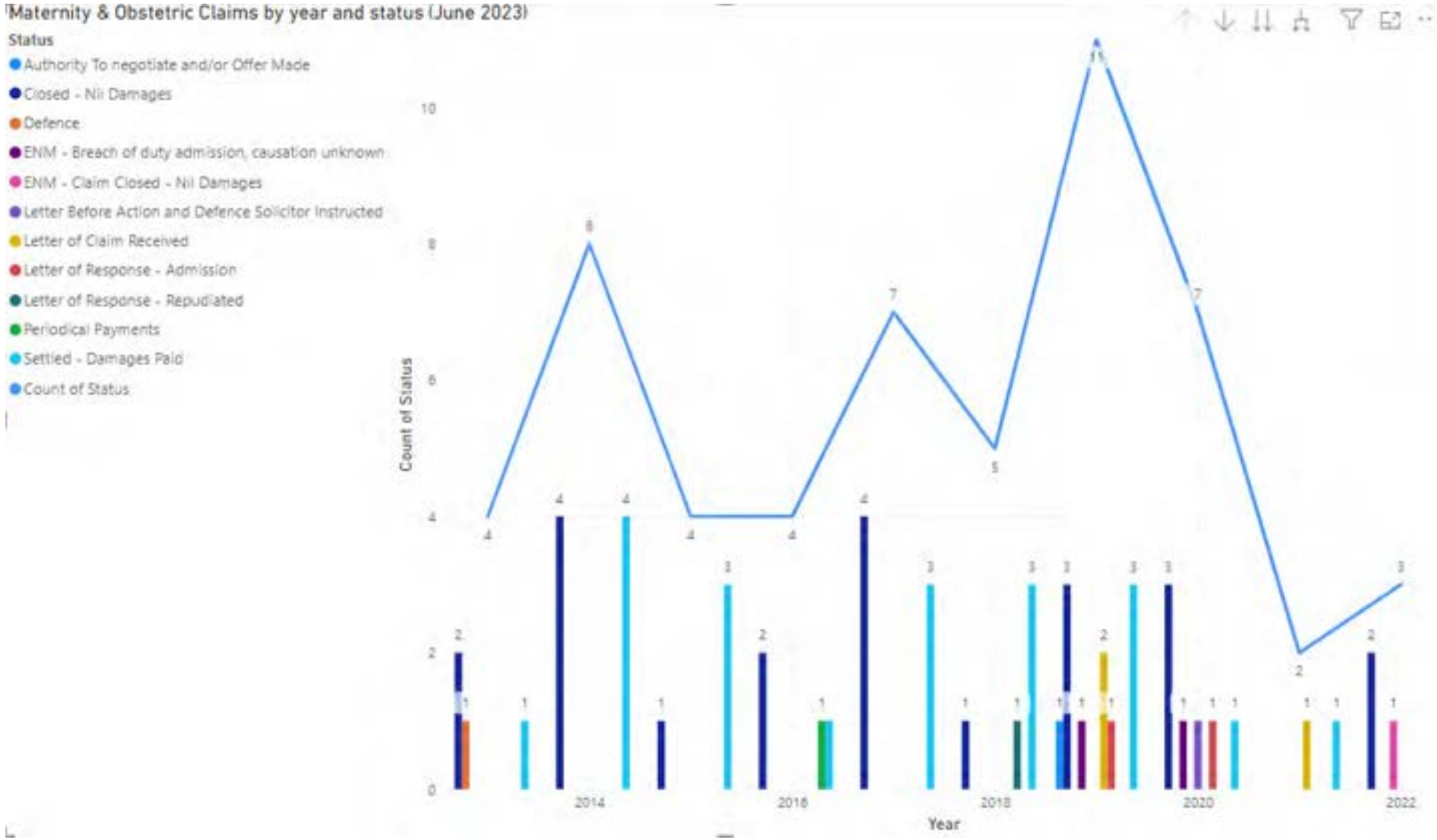
Claims – Yearly Breakdown (by date claim opened)



Claims – Yearly Breakdown (by date claim opened)



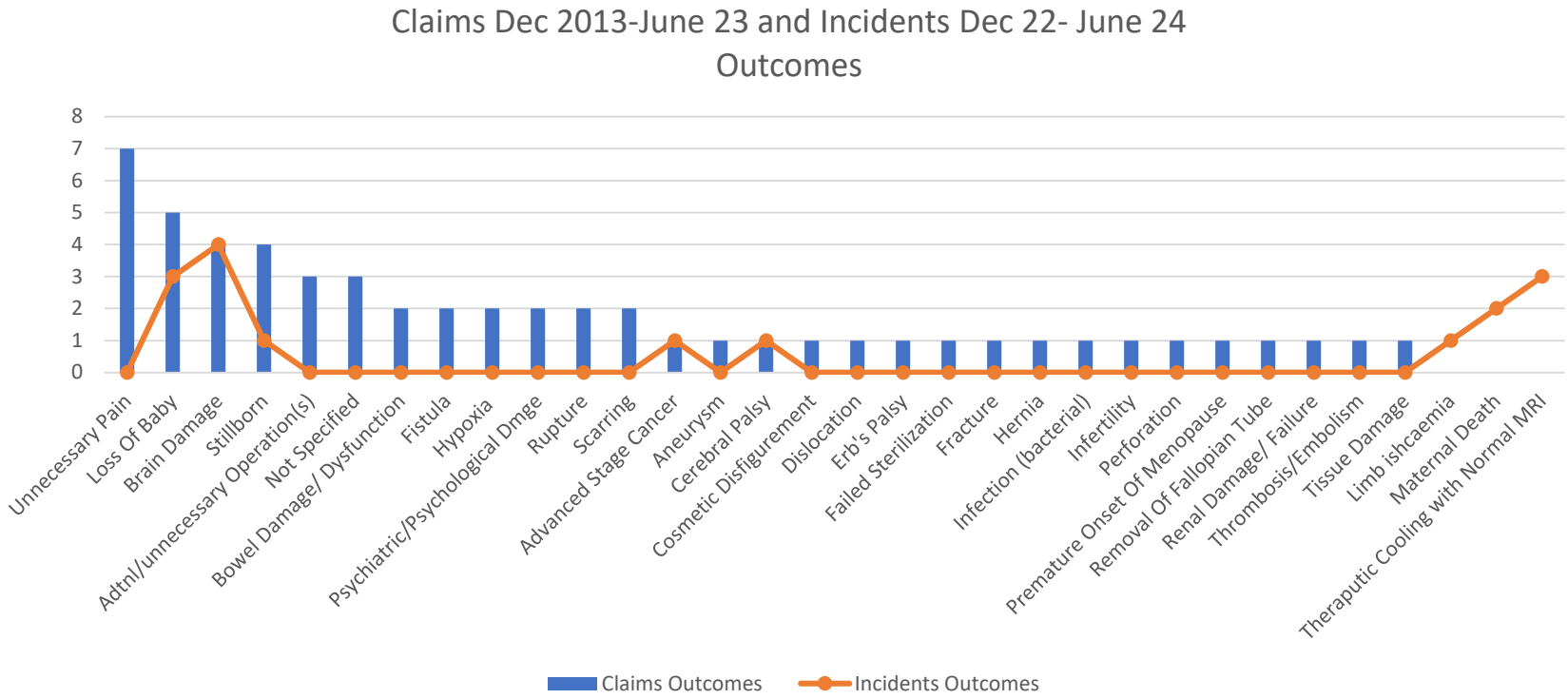
Claims – Yearly Breakdown – by incident date



Claims – Key messages

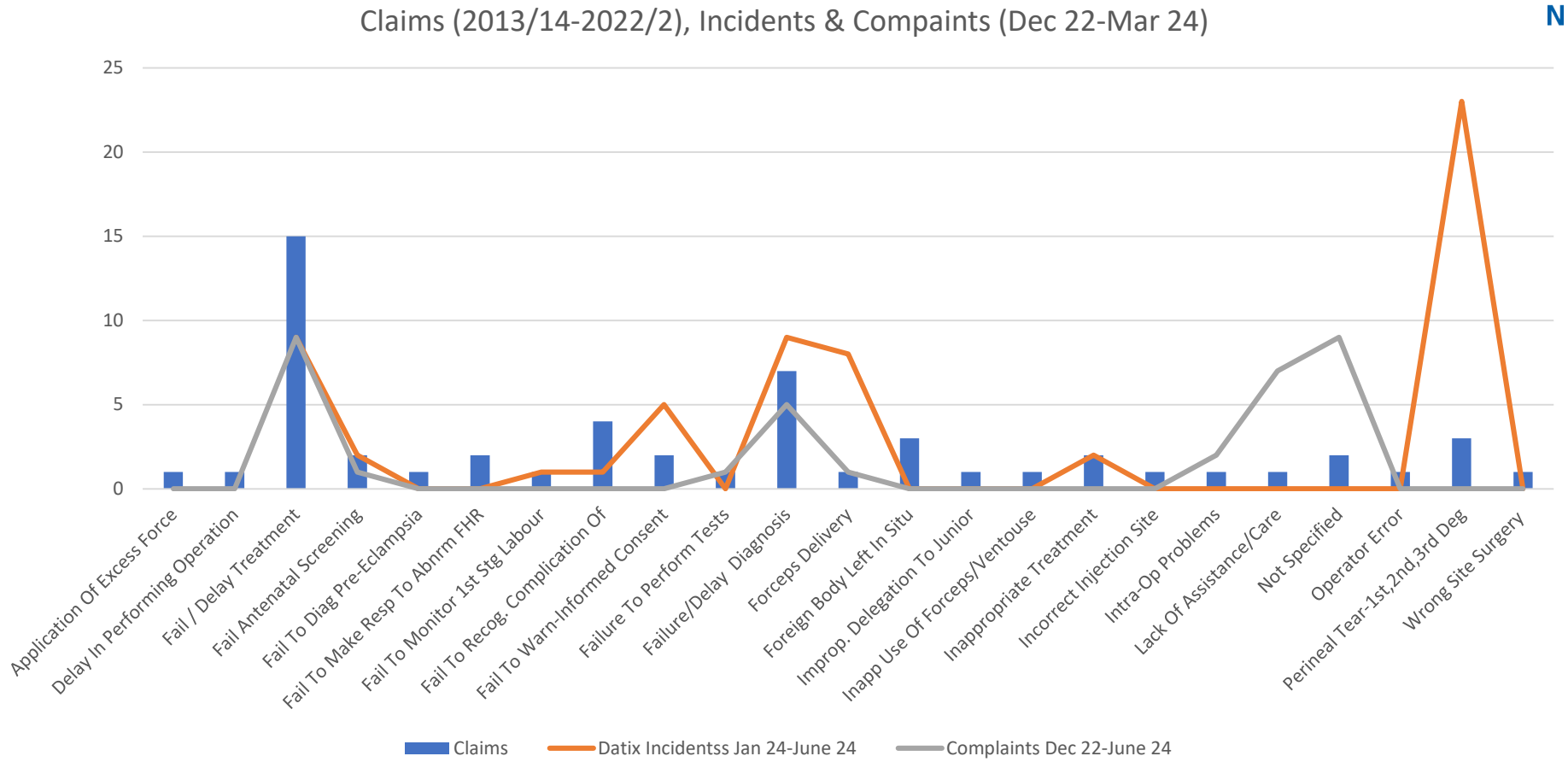
- Charts demonstrate 1-2 year period between date of incident and claim being opened.
- Therefore, reduction in claims for incidents from past 2-3 years is reflective of this and anticipate more claims will be opened for these years when the next scorecard is published in September 2024.
- Reviewing the damages paid, only one significant payment made in past 10 years, relating to a case from 2016 of HIE II with failure to act on abnormal CTG results. This case was notified to Each Baby Counts at the time and was also investigated as an SI, Complaint and a supervisor of midwives investigation as was the practice at the time.
- Significant learning was made from that case and since that incident, the Maternity team has a robust in-house Fetal Monitoring Training, with dedicated obstetric and midwifery leads that oversee training, guidelines and Quality Improvement work.
- MFT have developed robust guidelines for physiological CTG interpretation and worked with the LMNS to implement regional fetal monitoring guidelines.

Claims Injuries/Outcomes



- Review of claimed injury/outcome from claims scorecard along with outcomes from the 16 MNSI/SIs from December 2022-April 2024 reveal a correlation in outcomes.
- Due to MNSI referral process, babies who require therapeutic cooling but have a good prognosis on MRI account for 3 of the incidents in the period.

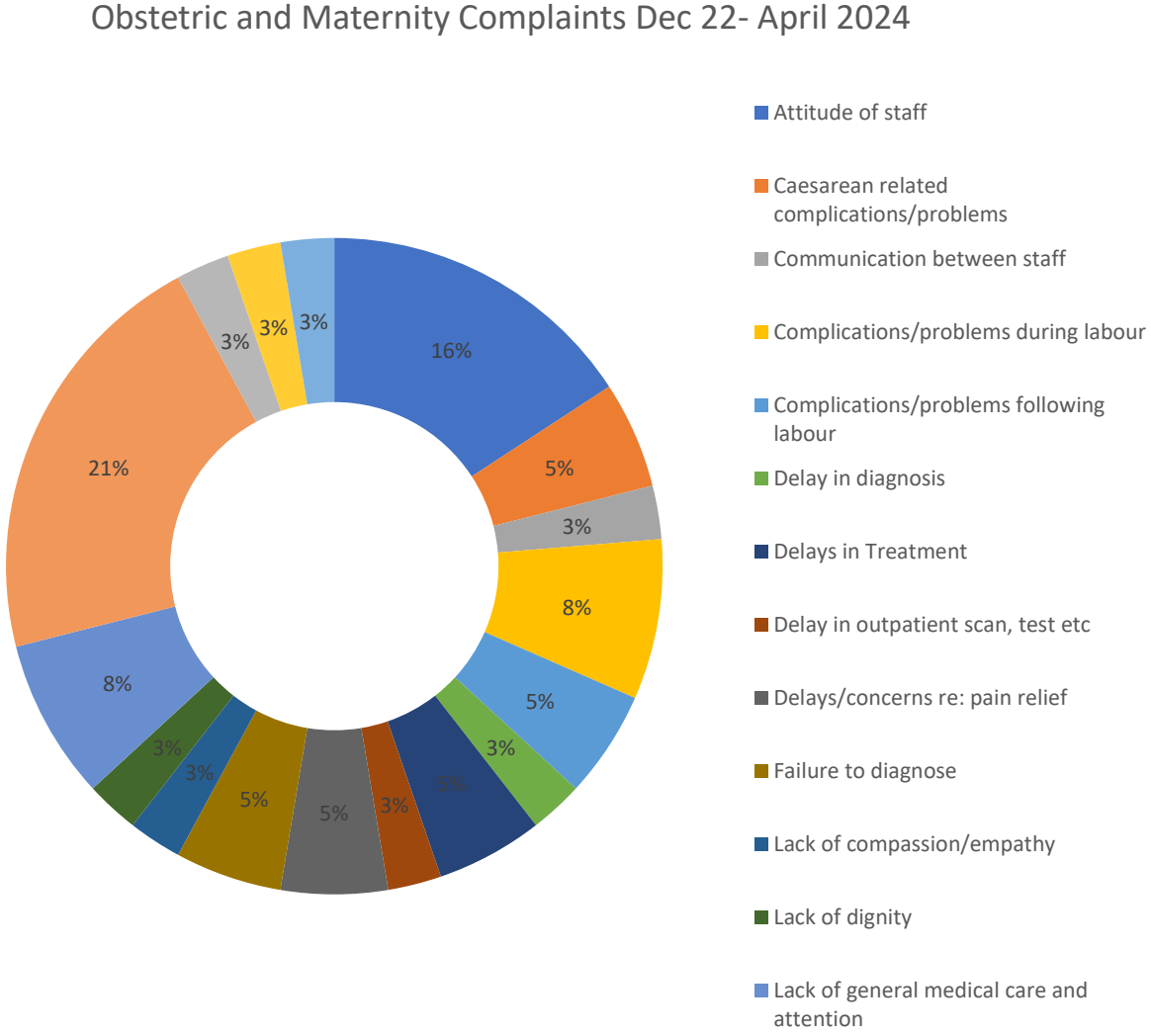
Claims Injuries/Outcomes



- Incidents from claims score cared mapped against complaints for Dec 22-Jun 24 and Datix incidents Jan-June 24 (based on event/subcategory)

Complaints and Service User Feedback

- Majority of complaints continue to reflect concerns regarding compassion, care and attention and staff attitude.
- 9 relate to failure/delay to diagnose and 9 relate to failure/delay to treatment and these are more aligned with the themes of claims on scoreboard.
- 7 relate to complications during labour and delivery, including caesarean.
- Communication and consent continues to be a theme across datix, complaints and incidents. In response, informed consent training is being offered to all staff via monthly audit meeting and essential skills training. Taking consent is also included in PROMPT.
- Working groups have been established to review care and consent pathways for service users with neurodiversity.
- Patient facing information is reviewed by MNVP leads to ensure appropriate readability.
- Working to ensure key information is available in top-5 language to facilitate informed decision making.
- Using technology such as padlets, QR codes and social media to reach service users and provide information in easy to access formats.
- Patient Experience and EDI midwife to start in July 2024 to support work on communication and consent across a number of work streams.
- Working with service users and MNVP to review patient information and actively seeking service user feedback to help identify areas where further improvement in communication or informed consent could be achieved. All actions to be captured in BAF and monitored via MNSCAG.

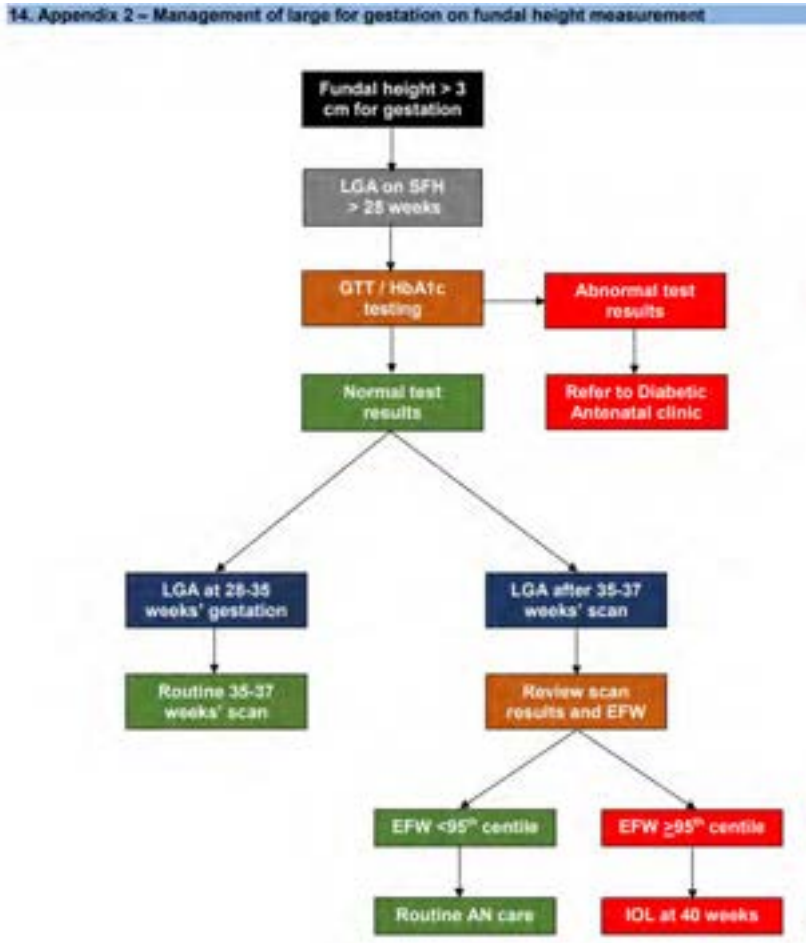


Claims Closed in Quarter

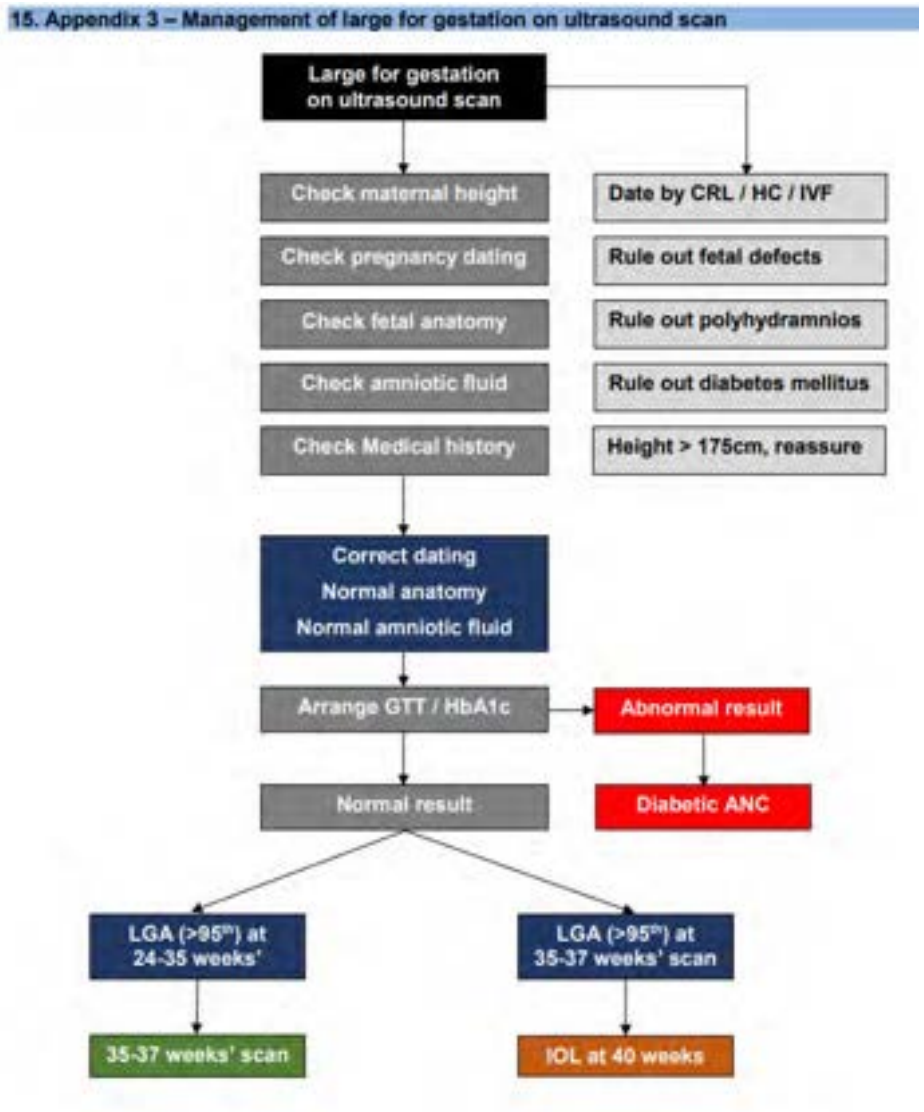
- Claim closed with damages paid in Q1 2024/25 relating to a baby born to a mother with high-BMI and additional risk factors for shoulder dystocia in 2007. Mother was not counselled regarding these risk factors and despite the baby measuring large on scan. Mother proceeded to SROM but failed to progress in the second stage. Trial of instrumental was discussed and consented and ventouse and forceps were both trialled unsuccessfully. Ventouse was reapplied and baby's head was delivered, but noted to have right arm in posterior position. McRobert's position initiated and suprapubic pressure applied and baby was delivered weighing 4.5kg. Baby suffered from Erbs Palsy, Group 2 OBPI.
- **Findings/Learning:**
- In view of raised BMI, clinically large fetus, oxytocin augmentation and prolonged second stage, vaginal delivery should have been abandoned in favour of a lower segment caesarean.
- Mother should have been offered LSCS rather than instrumental.
- Consent form for instrumental did not include risk of shoulder dystocia.
- **Current Datix Incidents/Practice**
- 22 Datix raised in from April 2023 to June 2024 relating to shoulder dystocia. All report low and no harm.
- 1 CRIG review for baby with fatal anomaly who was delivered vaginally following should dystocia – mother was counselled of high-risk of shoulder dystocia. SWARM requested for case due to staff communication and care pathways rather than management of Shoulder dystocia.
- Large for Gestational Age pathway in place, with diagnosis of LGA made >35 weeks with full review of all risk/contributory factors including counselling of women on mode and timing of delivery.
- Shoulder dystocia is an obstetric emergency and is covered in MDT PROMPT training and in situ SIM
- Risk assessment and stratification for all women at every appointment.

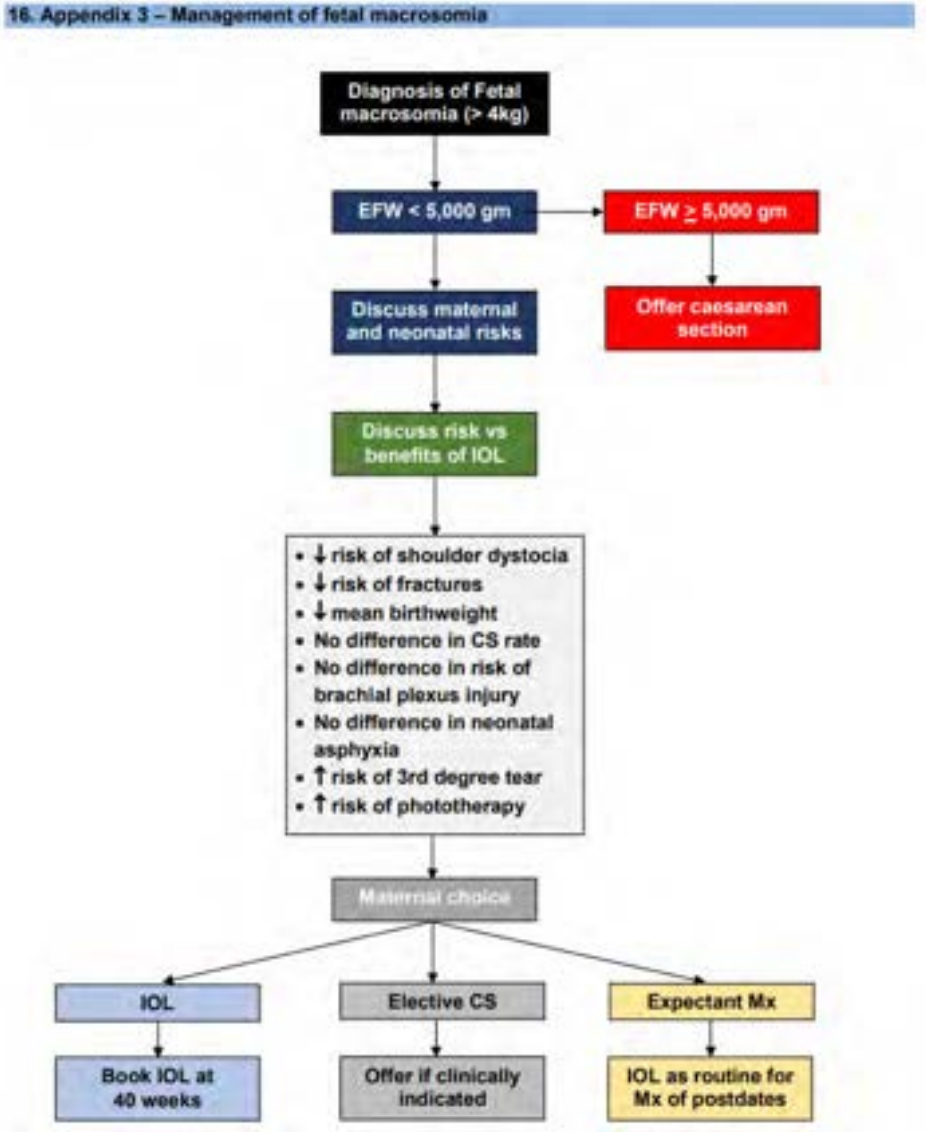
LGA pathway

Medway NHS Foundation Trust



LGA pathway


15. Appendix 3 – Management of large for gestation on ultrasound scan
Large for gestation on ultrasound scan
Check maternal height
Check pregnancy dating
Check fetal anatomy
Check amniotic fluid
Check Medical history
Date by CRL / HC / IVF
Rule out fetal defects
Rule out polyhydramnios
Rule out diabetes mellitus
Height > 175cm, reassure
Correct dating
Normal anatomy
Normal amniotic fluid
Arrange GTT / HbA1c
Abnormal result
Diabetic ANC
Normal result
LGA (>95th) at 24-35 weeks'
35-37 weeks' scan
LGA (>95th) at 35-37 weeks' scan
IOL at 40 weeks


16. Appendix 3 – Management of fetal macrosomia
Diagnosis of Fetal macrosomia (> 4kg)
EFW < 5,000 gm
EFW ≥ 5,000 gm
Discuss maternal and neonatal risks
Offer caesarean section
Discuss risk vs benefits of IOL
↓ risk of shoulder dystocia
↓ risk of fractures
↓ mean birthweight
No difference in CS rate
No difference in risk of brachial plexus injury
No difference in neonatal asphyxia
↑ risk of 3rd degree tear
↑ risk of phototherapy
Maternal choice
IOL
Elective CS
Expectant Mx
Book IOL at 40 weeks
Offer if clinically indicated
IOL as routine for Mx of postdates

Next steps

- Continue quarterly reporting to MNSCAG and Trust Board as per CNST Year 6 requirements.
- Review and refresh dataset when 2023/24 scorecard is released.
- Review 2023/24 data with legal and NHSR to ensure accuracy and correct mapping.
- Continue to include learning from claims, incidents and complaints into training including PROMPT, fetal monitoring and in situ Sim.

Appendix 1: Infected Blood Inquiry and Blood donor surveillance (NHSBT)

Key points:

Safety measures built in blood transfusion:

- Blood transfusion is highly regulated. Blood Establishments (NHSBT Tooting , supplier) and Blood Bank (Medway Blood Transfusion) must comply with the Good Manufacturing Practice (GMP) and Blood Safety and Quality Regulations 2005 (BSQR 2005)are regularly audited by internal and external inspectors i.e. Medicines and Healthcare Products Regulatory Authority (MHRA)
- Blood Compliance Report is submitted to MHRA on an annual basis. Last MHRA inspection was in April 2023 – no critical deficiency found. Other findings accepted, actions completed and submitted to MHRA with no further actions.
- Blood donation is voluntary in the UK.
- Improved donor selection by the use of donor selection guidelines and confidential donor questioning.
- Robust IT system for documentation with built-in algorithm that complies with BSQR,GMP, ISO 15189:2022, NICE guidance, BSH guidelines and has passed rigorous validation and verification. Regular review process also in place to provide continued assurance with frequency determined by national and local policies.
- Improved donation testing methodologies e.g.use of Nucleic Acid-PCR techniques
- Quarantining of donations process in place
- Product processing methodologies such as leucodepletion using commercial filter containing polyester fibres to remove white blood cells believed to be associated with the agent responsible for the transmission of vCJD.
- Mandatory Testing on every donation in the UK – ABO and Rh, antibody screen, Hep B surface antigen, antibody to HIV (anti-HIV1/2), antibody to Hep C Virus (anti-HCV), antibody to syphilis. In addition, all donations are tested for presence of HCV RNA using a NAT and antibody to Human T-cell Leukaemia Virus (HTLV 1 and 2)
- Discretionary testing include malaria, West Nile Virus, T. Cruzi,
- Piercers e.g. body piercing, tattoos, acupuncture , donation deferral after 6 months and undergo anti-HBc testing –details on the transfusion guidelines found in JPAC website
- Post donation reporting – donor to report symptoms within 14 days post donation
- Deferral procedure and 'Permanent Exclusion' procedures in place for reactive donors
- Viral inactivation process used in the manufacture of fractionated plasma products such as coagulation factors (Factor VII, Anti-Thrombin III,etc), Albumin products, Immunoglobulin products (prophylactic anti-D,ect)
- Recall procedures in place – Internal and External
- Batch Pre-Acceptance Testing process in place for reagents, kits to ensure no performance deterioration in transit and storage.
- Cold Chain maintenance of temperature controlled storage equipment –blood fridges, platelet incubator, plasma freezer. Evidence of service, maintenance, calibration, mapping and revalidation of equipment completed on a regular basis depending on the required schedule.
- Electronic vein-to-vein transfusion software that traces the donor to the receiving patient. Supports electronic positive patient identification, electronic pre-transfusion checklist, electronic documentation of collection, arrival of unit to the ward, begin and end of transfusion, and document transfusion reaction. System used at Medway is BloodTrack.
- Robust Quality Management System that provides assurance and customer confidence that Medway has systems and procedures in place to produce high quality service/product as stated in the Blood Transfusion Quality Manual and Blood Transfusion policies and SOPs.
- Incident Management, reporting to Haemovigilance Scheme such as SABRE/SHOT
- Document retention process in place in compliance to RCPATH 'Retention and Storage of Pathological records and specimens 2015'

- Continued compliance to NICE, BSH, Patient Safety Alerts, SHOT recommendations
- Governance -Hospital Transfusion Team and Hospital Transfusion and Thrombosis Group and Patient Safety Group. Regular Meetings to escalate any issues relating to Blood Transfusion for discussion and Action
- Haematology Consultant and BMS advice and support available 24/7
- BMS Empowerment to challenge inappropriate requests
- Availability of alternatives to transfusion e.g. IV Iron, Tranexamic acid, Vit B12, Folate, EPO, Cell Salvage machine in theatres

Details for the above is covered below. Extracts taken from JPAC website and Blood Transfusion Policies and Procedure.

1. Blood donation testing

Background

Blood donations have been tested for infections since the 1940s when testing for markers of treponemes indicating syphilis (or other disease such as yaws or pinta that are also caused by Treponema) first began. Since then, screening for other blood-borne infections has been introduced as follows:

1a. Hepatitis B virus (HBV)

Screening donations for hepatitis B surface antigen (HBsAg) began in 1972. HBV DNA testing began on 1 April 2009 in Filton as a by-product of the introduction of triplex NAT testing. HBV DNA testing was subsequently introduced at Manchester on 10 August 2009 and Colindale on 3 December 2009, when all donations in England were HBV DNA tested. HBV DNA testing began on 27 April 2009 in the Republic of Ireland and 1 June 2009 in Wales. Scotland and Northern Ireland began HBV DNA testing on 22 March 2010.

1b. Human Immunodeficiency Virus (HIV)

Donation screening for antibodies to HIV (anti-HIV) began in 1985. Some England centres started using combined antigen-antibody screening for HIV (HIV Ag/Ab) in 2001 with all using HIV Ag/Ab by the end of 2005. Northern Ireland and Republic of Ireland Blood Transfusion Services introduced combined Ab/Ag testing in 2011 and 2016 respectively. Although not mandatory, HIV RNA testing has been introduced as a by-product of duplex and subsequently triplex assays. HIV RNA testing was introduced in Scotland and Northern Ireland in 2002 and some parts of England and Wales from November 2003 but did not become universal until 2007.

1c. Hepatitis C virus (HCV)

Donation screening for antibodies to hepatitis C virus (anti-HCV) began in 1991. HCV RNA testing was introduced on a pilot basis in April 1999 and became a mandatory test carried out on all blood donations from 2002. 6

1d. Human T-cell lymphotropic virus I and II (anti-HTLV)

Testing for antibodies to human T-cell lymphotropic virus I and II (anti-HTLV) was piloted in Scotland in 2000 and started UK-wide in 2002. Testing in the UK was conducted in pools until 2013 when singleton testing was implemented in England from 27 February 2013. Scotland switched to singleton testing in 2015, Northern Ireland in 2016 and Wales switched in 2018. Republic of Ireland used singleton testing from 2002. In January 2017, NHSBT tested donations from new donors and donations used for non leucodepleted blood components.

1e. Hepatitis E virus (HEV)

Donation screening for HEV RNA started in 2016 on a proportion of donations in order to supply HEV-screened components for specific patient groups and extended in 2017 to all blood donations: SNBTS March 1st 2017, NHSBT April 2017, NIBTS 30th May 2017 in pools of 24.

Table A: Tests performed on blood donations within the UK blood services in 2021 by country

2021 blood services tested for	England	Northern Ireland	Scotland	Wales	Republic of Ireland	Guernsey	Isle of Man
HBsAg	yes	yes	yes	yes	yes	yes	yes
HBV DNA	yes	yes	yes	yes	yes	no	no
Anti-HCV	yes	yes	yes	yes	yes	yes	yes
HCV RNA	yes	yes	yes	yes	yes	no	no
HEV RNA	pools 24	pools16	pools16	pools16	singles	no	by NHSBT
Combined HIV Ab/Ag	yes	no	yes	yes	yes	yes	yes
HIV Ab only	no	yes	no	no	no	no	no
HIV RNA	yes	yes	yes	yes	yes	no	no
Anti-HTLV	new and non-leuco depleted	yes	yes	yes	yes	yes	yes
Anti-treponeme	yes	yes	yes	yes	yes	yes	yes

In 2021, all donations were screened for HBV using HBsAg and HBV DNA screening performed in pools of 24 for England, Northern Ireland, Scotland and Wales, and in singletons for Republic of Ireland.

In 2021, all donations were screened for HCV using anti-HCV and HCV RNA screening performed in pools of 24 for England, Northern Ireland, Scotland and Wales, and in singletons for Republic of Ireland.

In 2021, all donations were screened for HIV using combined HIV Ab/Ag assay, except Northern Ireland where HIV Ab assay is used and HIV RNA screening performed in pools of 24 for England, Northern Ireland, Scotland and Wales, and singletons for Republic of Ireland.

In 2021, all donations were screened for HTLV antibodies, except England where anti-HTLV screening performed on new and non-leucodepleted donations.

In 2021, all donations were screened for treponemal antibodies indicating syphilis including treated past infections as well as some non-sexually acquired treponemal infections such as Yaws and Pinta, rarely seen in the UK.

In 2021, all donations were screened for HEV RNA performed in pools of 24 for England, in pools of 16 for Northern Ireland, Scotland and Wales, and in singletons for Republic of Ireland. Wales do not perform confirmatory testing for HEV RNA. England performed HEV RNA screening for the Isle of Man from 24 July 2020.

In 2021 the UK blood services continued to collect convalescent plasma from recovered coronavirus patients for use in treatment trials. These donations were subject to the same screening and additional testing requirements as blood and apheresis donations with additional SARS-CoV-2 antibody testing. Donations in England were mainly collected via plasmapheresis.

In 2021 NHSBT began collecting plasma for medicine from April 2021. These donations were subject to the same screening and additional testing requirements as blood and apheresis donations. They will also be screened for Hepatitis A and Parvovirus B19.

Jersey outsourced their donation testing in 2018 due to laboratory refurbishment and have not resumed reporting.

Additional testing

Other additional (discretionary) tests may be performed including the detection of antibodies to hepatitis B core antigen (anti-HBc), malaria (2001) and Trypanosoma cruzi (Chagas disease, 1998) and nucleic acid testing (NAT) for West Nile virus (WNV, 2012). These tests are only performed if information given by the donor suggests that they may have been at risk for these infections.

Anti-HBc testing was previously performed for donations from donors reporting a recent piercing (for example acupuncture, ear, or body piercing and or tattooing), inoculation incident, flexible endoscopy, or history of jaundice or HBV infection. At the end of November 2017, anti-HBc testing 8 ceased for donors with recent endoscopy, piercing and complementary therapies (for example acupuncture).

Malaria testing is performed where the donor reports a relevant travel history, residency or past infection. Donors are deferred for 4 months post-travel before testing up to 12 months (the deferral was shortened from 6 to 4 months in 2017). Donors are deferred for 4 months post residency before testing at any time. Donors are deferred for 3 years post treatment or malaria illness before testing at any time. Donations repeat reactive for malarial antibodies have been sent for confirmatory reference antibody testing since 30 August 2007. Donations confirmed antibody positive have been tested for malarial DNA by PCR from April 2010.

T. cruzi antibody testing was introduced in 1998. There is a 6-month deferral for rural travel, transfusion in South America or because they are of South American origin followed by testing. The deferral was shortened to 4 months in January 2021.

In 2012, **WNV NAT (West Nile Virus Nucleic Acid Testing)** testing of donations from donors returning from WNV affected areas was introduced in pools of 6 and replaced the temporary deferral of these donors. Testing continues each year between 01 May and 30 November.

Additional testing indications can be found in the donor selection guidelines on the Transfusion Guidelines website

Data on additional (discretionary) testing performed by NHSBT is reported monthly via the following sources:

1. an electronic report from PULSE (the NHSBT national donor database) of the monthly aggregate number of blood donations given an additional test by marker
2. an electronic line listing of donations sent for anti-HBc testing along with screen results
3. an electronic list of the repeat reactive and confirmed positive malaria and T. cruzi cases from Microbiology Services surveillance
4. an electronic list of the reference results for samples sent for confirmatory anti-HBc testing from the Microbiology Service Laboratory (MSL)
5. characteristics of donors sent for confirmatory anti-HBc testing are collected via the infected donor scheme and from PULSE

Infected blood donors

- When a marker of infection is detected in a blood donation, the donor is offered a post-test discussion, which may be held in a blood centre or more commonly by telephone
- The donor is informed of their positive test results and the clinician explains what these test results mean and ascertains a likely source or risk factor for the infection, if possible.
- The clinician also discusses any infection control measures, testing and treatment of contacts and advises the donor that they will no longer be able to donate blood. Where appropriate, the donor is referred to the appropriate services for specialist care.

- Clinicians in blood centres in the UK (excluding Scotland) and Republic of Ireland pass anonymised information about infected blood donors to the Epidemiology Unit infected blood donor surveillance scheme using a standard electronic proforma.

- This information includes the characteristics of the infected donors (date of birth, gender, first part of postcode), details of their donating history (if any, with details of their most recent previous donation) and any behaviour that could be associated with the donor's infection.

- Infected donors are classified by the Epidemiology Unit as newly tested and previously tested for the marker they are found positive for according to detailed information provided by blood centres about all or any previous donations in the UK. Data from Scotland is supplied on an annual basis.

The classification of infected donors as newly or previously tested is done by the NHSBT and UKHSA Epidemiology Unit:

1. a newly tested donor is one who has not been previously tested for the marker under consideration by the blood transfusion services included in this surveillance

2. a previously tested donor is one who has been previously tested for the marker under consideration by the blood transfusion services included in this surveillance.

Risk estimates for blood donors

The estimated risk that a donation entering the UK blood supply is potentially infectious, but not detected on screening because the donation is made during the infectious **'window period'**, is calculated annually for a rolling three-year period.

This statistical process combines information about tests in use by the UK blood services, the infection itself, and data on characteristics of blood donors and donations to produce a point estimate for each infection.

An infectious donation may **NOT** be detected if a blood donation is made during the infectious 'window period'. This is the period early in the course of infection when the tests in use will not detect the marker of infection.

It is also possible that a **false negative test** result may arise because of issues relating to assay sensitivity other than window period or a blood donation may be erroneously issued as negative due to a sampling, processing, or issuing error.

The contribution of these latter two elements is thought to be extremely small and is no longer estimated because of uncertainty around these values.

Transfusion Transmitted Infections

Blood centres in England, Wales and Northern Ireland report investigations of suspected transfusion transmitted infections (TTIs) to the NHSBT and UKHSA Epidemiology Unit. For each report, information on the recipient, the recipient's infection, the implicated transfusion, and findings of the investigation are provided using a detailed proforma. Blood centres in Scotland report all incidents to the Microbiology Reference Unit of the SNBTS, and the details and conclusion of each case are passed to the surveillance system annually. NHSBT and UKHSA Epidemiology Unit data is reconciled with the Serious Hazards of Transfusion (SHOT) and all blood service investigations with outcomes are included in the TTI chapter in the SHOT annual report.

Definition of a transfusion-transmitted Infection

A report of an infection suspected to be due to transfusion was classified as a TTI if the following criteria were met at the end of the investigation:

- the recipient(s) had evidence of infection following transfusion of blood components, and there was no evidence of infection prior to transfusion and no evidence of an alternative source of infection

and, either:

- at least one component received by the infected recipient was donated by a donor who had evidence of the same transmissible infection

or

- at least one component received by the infected recipient was shown to have been contaminated with the agent of infection

Cases that are reported for the SHOT annual report must meet the following inclusion criteria:

- an incident should be reported if receipt of the transfusion is confirmed
    - and either:
- the infection in the recipient had been confirmed by detection of antibody, antigen, RNA, DNA or culture as appropriate and there was no evidence that the recipient was infected prior to transfusion
    - or
- The recipient had acute clinical hepatitis of no known cause (including no evidence of acute hepatitis A virus (HAV), HBV, HCV, HEV, Epstein-Barr virus or CMV infection in posttransfusion samples to date).

TTIs may be identified as a result of infection in the patient where transfusion is the suspected source or alternatively via lookback investigations. A lookback investigation is carried out if a donation is found to be positive for infection and retrospective testing finds a previous donation to also be positive at low levels below the detection level of screening.

An incident should NOT be reported if:

- the incident involved HCV, HIV or HTLV in recipients who had received transfusions in the UK prior to routine testing (September 1991 for anti-HCV, October 1985 for anti-HIV, August 2002 for anti-HTLV)
- the incident involved HTLV in a recipient identified through the HTLV National Lookback
- the incident involved a transfusion outside UK
- the incident was identified as part of the HEV study

Please note:

1. the blood services are rarely able to conduct follow-up investigation of all untested donors implicated in post-transfusion HCV or HIV incidents, and these cases do not contribute to knowledge of the current infection transmission risks of blood transfusions
2. any post-transfusion HTLV infections identified through the HTLV National Lookback are excluded but will be collated, analysed, and published elsewhere, as was done previously with HCV 'lookback'

Data is published annually in the SHOT report, the UKHSA's Health Protection Report and in the NHSBT and UKHSA Epidemiology Unit annual review.

Reported TTIs to SHOT in 2022

Nationally, 124 Suspected TTIs reported for investigation

- Suspected Bacterial
    - 62 –post transfusion reactions, no evidence of bacteria on investigation
    - 52 – Not TTI
    - 1- Near Miss

    - Suspected Parasitic
    - 1 – Not TTI
- Suspected Viral
    - 7 – Not TTI
    - **1 –Confirmed TTI (Hepatitis B virus – 2 recipients)**

Deaths related to transfusion n=0

None of the patients with confirmed TTI were reported to have died after being transfused, following investigations in 2022

Major morbidity n=2

The recipient involved in the confirmed HBV TTI from an OBI (Occult Hepatitis B virus infection) donor had progressive kidney disease and underwent HBV testing following a liver function screen which revealed an increased ALT. The patient had extensive immunosuppression and therefore started antiviral treatment. A second recipient was diagnosed with a chronic HBV infection following a lookback investigation. They had moderate to severe fibrosis of the liver, which was multifactorial in origin and were also started on antiviral medication.

Viral TTI 1996-2022

The year of transfusion may be many years before the year in which the incident is investigated and reported to SHOT due to the chronic nature, and possible late recognition, of some viral infections.

Nationally, since 1996 there were:

- 43 confirmed TTI documented involving 35 donors
- 15 Hepatitis B virus
- 15 Hepatitis E virus

Reason:

Partly due to 'window period' where an infectious donation from a recently infected donor cannot be detected by the screening tests, is longer than for HCV or HIV, despite Nucleic Acid Testing (NAT) screening of blood donations

All except 2 of the 15 HEV transmissions were reported before the HEV RNA screening was introduced in April 2017 in the UK (Harvala et al. 2022). The rate of HEV RNA detected among donors is greater than other viral infections because it is generally acquired through food, and there is no specific donor selection to minimise donations from those infected

Lookback investigations

Lookback investigations are considered when the UK Blood Services identify markers of infection in a donation from a repeat donor. This may be due to seroconversion or the introduction of a new test. The archive sample of their most recent screen-negative donation is requested for retrospective re-testing and if identified as positive, a full clinical lookback will be instigated. This means the associated components are traced, recipients are identified, and advice is given regarding follow-up and testing. For lookbacks involving OBI donors, all previous donations available for retesting are considered regardless of the screening result. In NHSBT, samples of donations are stored for **three years.**

In England in 2022 there was:

- 1 HEV (apheresed platelet split to 2 packs. No transmission identified; both recipients died of unrelated caused)
- 4 syphilis (4 syphilis lookbacks involved 7 donations and 12 components: 5 recipients had died, 6 tested negative and 1 not transfused)
- 3 OBI (Occult Hep B Virus Infection) – 16 donations and 30 components had 6 associated components. Five components were transfused; one has follow-up in progress. Three recipients have testing results outstanding, one had died and one tested positive,

In Scotland there is one pending HBV lookback investigation

A HEV lookback investigation in Wales followed a donation positive for HEV RNA. The donor's most recent donation, made 6 weeks prior to the index donation, was found to contain HEV RNA on retrospective testing. This donation was a double apheresis platelet donation and manufactured into 8 neonatal platelet components. Fortunately, all neonatal components were time expired and not transfused to any patients. This case could have potentially led to adverse effects for several recipients of the donated components and has resulted in the **WBS commencing ID HEV NAT testing on all apheresis donations in November 2022**

Non-investigated reports

Some reports made to NHSBT are not investigated due to various biological and practical factors. Examples include:

- If a recipient tests positive only for antibodies to infection, it is possible that passive transfer of antibodies occurred. The presence of antibodies can reflect past infection. To clarify this NHSBT finds out if they received IVIg or blood transfusion, and if so, repeat the testing 4-6 weeks after the transfusion date. If it is the passive transfer of antibodies, then reactivity should resolve within this time, and they no longer have any evidence of infection

- In cases where only IgM antibodies are detected, reactivity for RNA/DNA and seroconversion (e.g., IgG) would also need to be confirmed before investigations commenced. This is because IgM assays are often cross-reactive and non-specific, so isolated IgM reactivity is not usually diagnostic

- In cases with evidence of a chronic infection, previous negative results are desired. This is to evidence transfusion as being the most likely source of infection • For older cases of possible TTI, year of transfusion should be provided for the implicated transfusions in addition to the unit numbers to enable effective investigation by the Blood Services

Residual risk of HBV, HCV, or HIV

The chance, or residual risk, of a potentially infectious HBV, HCV or HIV window period donation not being detected on testing in the UK is very low at less than 1 per million donations tested (Table 20.2) (JPAC 2021). The window period is the time very early in the course of infection when tests in use do not detect the virus but there may be a sufficient amount for transmission. The calculations are made annually, but for HBV only consider the risk of non-detection of acute infections and not the risk of non-detection of an OBI.

Table 20.2: The estimated residual risk (and 95% confidence interval) that a donation made in the HBV, HCV and HIV infectious window period related to acute infection is not detected on testing UK: 2019-2021

	HBV	HCV	HIV
Number per million donations	0.39	0.02	0.03
95% confidence interval	*(0.07-0.98)*	*(0.00-0.09)*	*(0.00-0.08)*
At 1.9 million donations per year, testing will miss a potentially infectious window period donation every:	1 year	35 years	18 years

Far fewer TTI are observed in practice than the estimated risks in Table 20.2 indicate, partly because the estimates have wide uncertainty and the model used to calculate risk is based on the risk in all donations tested. The model does not incorporate pack non-use, recipient susceptibility to infection, or under-ascertainment/under-reporting, for example due to recipients dying from an underlying medical condition before a chronic asymptomatic viral condition is identified, or, in the case of HBV, an asymptomatic acute infection.

Emerging infections

The EIAR produced by the NHSBT/UKHSA Epidemiology Unit is distributed monthly. This is reviewed by the SACTTI Horizon Scanning Team and may lead to further risk assessment and changes to the donor selection guidelines, or other blood safety measures, where necessary. Please see the horizon scanning position statement on the JPAC website: https://www.transfusionguidelines.org/documentlibrary/position-statements

In 2022, the monkey pox outbreak was monitored carefully to ensure that existing Blood Service safety measures were sufficient. Arbovirus outbreaks and spread, particularly within Europe, continued to be monitored carefully with a 28-day deferral implemented for donors visiting the areas in France affected by dengue outbreaks. There were no known cases of transfusion-transmitted SARS-CoV-2 infections reported to the Blood Services in 2022 and there is still no evidence that SARS-CoV-2 is a TTI.

Variant Creutzfeldt Jakob disease (vCJD) 2022

There were no vCJD investigations in 2022.

vCJD 1996-2022

Three vCJD incidents (Table 20.3) took place prior to the introduction of **leucodepletion** and other measures taken by the UK Blood Services to reduce the risk of vCJD transmission by blood, plasma and tissue products.

All these measures have been reviewed and endorsed by SaBTO (SaBTO 2013). One of these measures, the provision of imported plasma for individuals born on or after 1st January 1996, was withdrawn in September 2019.

This followed a recommendation by SaBTO based on evaluation of the risk of transmission of vCJD. Other risk-reduction measures, such as leucodepletion, remain in place (SaBTO 2019)

Surveillance continues to look for any evidence that vCJD or CJD could still be transmitted via the blood supply with no case of vCJD being identified for investigation since 2016 and no evidence of sporadic CJD being transmitted by the blood supply (TMER 2021).

In 2022 both the FDA in the United States and the Australian Red Cross Lifeblood announced the removal of their blood donor deferral for people who had spent time in the UK between 1980 and 1996 (AABB 2022) with the FDA also removing the deferral for people who have received a transfusion in the UK since 1980. Further review of CJD safety measures in the UK is planned (SaBTO 2022b)

Table 20.3: number of confirmed TTI incidents, by year of transfusion and infection in the UK, reported to SHOT between October 1996 and December 2022 (Scotland included from October 1998)

Year of transfusion	Bacteria	HAV	HBV	HCV	HEV	HIV	HTLV	Parvovirus (B19)	Malaria	vCJD or prion	Total
Pre 1996	0	0	1	0	0	0	2	0	0	0	3
1996	0	1	1	1	0	1(3)	0	0	0	1	5 (7)
1997	3	0	1	1	0	0	0	0	1	2	8
1998	4	0	1	0	0	0	0	0	0	0	5
1999	4	0	2 (3)	0	0	0	0	0	0	0 (1)	6 (8)
2000	7	1	1	0	0	0	0	0	0	0	9
2001	5	0	0	0	0	0	0	0	0	0	5
2002	1	0	1	0	0	1	0	0	0	0	3
2003	3	0	1	0	0	0	0	0	1	0	5
2004	0	0	0	0	1	0	0	0	0	0	1
2005	2	1	1	0	0	0	0	0	0	0	4
2006	2	0	0	0	0	0	0	0	0	0	2
2007	3	0	0	0	0	0	0	0	0	0	3
2008	4 (6)	0	0	0	0	0	0	0	0	0	4 (6)
2009	2 (3)	0	0	0	0	0	0	0	0	0	2 (3)
2010	0	0	0	0	0	0	0	0	0	0	0
2011	0	0	1 (2)	0	1 (2)	0	0	0	0	0	2 (4)
2012	0	0	0	0	2	0	0	1	0	0	3
2013	0	0	0	0	0	0	0	0	0	0	0
2014	0	0	0	0	1 (2)	0	0	0	0	0	1 (2)
2015	1	0	0	0	5 (6)	0	0	0	0	0	6 (7)
2016	0	0	0	0	0	0	0	0	0	0	0
2017	0	1	0	0	0	0	0	0	0	0	1
2018	0	0	0	0	1	0	0	0	0	0	1
2019	0	0	0	0	1	0	0	0	0	0	1
2020	0	0	0	0	0	0	0	0	0	0	0
2021	0	0	1 (2)	0	0	0	0	0	0	0	1 (2)
2022	0	0	0	0	0	0	0	0	0	0	0
Total number of incidents (recipients)	**41 (44)**	**4**	**12 (15)**	**2**	**12 (15)**	**2 (4)**	**2**	**1**	**2**	**3 (4)**	**81 (93)**

Year of transfusion	Red blood cells	Pooled platelets	Apheresis platelet	Fresh frozen plasma	Cryoprecipitate	Total
Pre 1996	3	0	0	0	0	3
1996	5	1	0	1	0	7
1997	6	1	1	0	0	8
1998	2	1	2	0	0	5
1999	5	3	0	0	0	8
2000	1	5	3	0	0	9
2001	0	4	1	0	0	5
2002	2	1	0	0	0	3
2003	1	1	3	0	0	5
2004	1	0	0	0	0	1
2005	1	3	0	0	0	4
2006	0	1	1	0	0	2
2007	2	1	0	0	0	3
2008	0	2	4	0	0	6
2009	1	0	2	0	0	3
2010	0	0	0	0	0	0
2011	2	0	0	2	0	4
2012	1	0	0	2	0	3
2013	0	0	0	0	0	0
2014	1	0	0	1	0	2
2015	1	3	1	1	1	7
2016	0	0	0	0	0	0
2017	0	0	1	0	0	1
2018	0	0	1	0	0	1
2019	0	0	1	0	0	1
2020	0	0	0	0	0	0
2021	1	0	0	1	0	2
2022	0	0	0	0	0	0
Total number of recipients	**36**	**27**	**21**	**8**	**1**	**93**

Table 20.4: Number and type of implicated components from confirmed TTI recipients, by year of transfusion in the UK, reported to SHOT between October 1996 and December 2022 (Scotland included from October 1998)

	Bacteria	HAV	HBV	HCV	HEV	HIV	HTLV I	Parvovirus (B19)	Malaria	vCJD or prion	Total
Outcomes											
Death due to, or contributed to, by TTI	11	0	0	0	2	0	0	0	1	3	**17**
Major morbidity	29	3	15	2	9	4	2	1	1	1	**67**
Minor morbidity	4	1	0	0	4	0	0	0	0	0	**9**
Implicated component types											
Red blood cells	7	1	11	2	4	2	2	1	2	4	**36**
Pooled platelets	21	2	1	0	2	1	0	0	0	0	**27**
Apheresis platelets	16	1	1	0	3	0	0	0	0	0	**21**
Fresh frozen plasma	0	0	2	0	5	1	0	0	0	0	**8**
Cryoprecipitate	0	0	0	0	1	0	0	0	0	0	**1**

Table 20.5: Outcome of confirmed TTI incidents and implicated components by infection in the UK, reported to SHOT between October 1996 and December 2022 (Scotland included from October 1998)

Accompanying notes for Table 20.3, 20.4 and 20.5

- Where applicable, number of recipients are included in bracket
- No blood donation screening has been ever in place for vCJD, HAV or parvovirus B19
- HTLV screening began in 2002
- HEV RNA screening began in April 2017 in the UK and was not in place at the time of the documented transmissions
- In both malaria transmissions, malaria antibody testing was not applicable at the time according to information supplied at donation
- HCV investigations where the transfusion was prior to screening are not included in the above figure
- The year of transfusion may be prior to year of report to SHOT due to delay in recognition of chronic infection • The 2 HIV incidents were associated with window period donations (anti-HIV negative/HIV RNA positive) before HIV NAT screening was in place. A third window period donation in 2002 was transfused to an elderly patient, who died soon after surgery. The recipient's HIV status was therefore not determined and not included
- In 2004 there was an incident involving contamination of a pooled platelet pack with Staphylococcus epidermidis, which did not meet the TTI definition because transmission to the recipient was not confirmed, but it would seem likely. This case was classified as 'not transfusion-transmitted'
- The vCJD case in 1999 was found to have the same blood donor as one of the 1997 transmissions and has therefore been counted as the same incident. Please note this was counted as two separate incidents in previous reports • A further patient with prion disease died but transfusion was not implicated as the cause of death. The outcome was assigned to major morbidity instead because although there was post-mortem evidence of abnormal prion proteins in the spleen the patient had died of a condition unrelated to vCJD and had shown no symptoms of vCJD prior to death

Bacterial screening of platelets

Platelets may be manufactured as pooled platelets from whole blood donors (a platelet pool from four donors) or as apheresis platelets where between 1 and 3 apheresis platelet packs may be manufactured from one component donor.

Testing of apheresis platelets by NHSBT began in February 2011 and testing of pooled platelets in June 2011. NHSBT was the last of the UK blood services to introduce bacterial screening of platelets. Bacterial screening was already in place in the other UK blood services. The BacTALERT culture system is used for bacterial screening across all four services but with slightly different sampling methods (see Table A). A surveillance system was put in place within NHSBT in 2011 to report the number of confirmed and indeterminate reactions each month and bacterial species on a quarterly basis.

NHSBT introduced the use of Platelet Additive Solution (PAS) for pooled platelets in 2015; by the end of June 2015 all pooled platelets were manufactured in PAS.

NHSBT produces and screens the largest number of platelets of the four services. Platelets are held for a minimum of 36 hours' post-donation before being sampled. An 8ml sample is inoculated into an aerobic and an anaerobic bottle and placed on the BacTALERT system. If samples are negative after a minimum six-hour incubation, the associated platelet donation can be released as negative-to-date. Platelets are released to stock with a seven-day shelf life since time of donation; prior to the introduction of bacterial screening platelets had a five-day shelf life. Table A shows the sampling volumes and incubation conditions used for the four UK blood services

Table A: Bacterial screening methods used by the UK blood services

UK Service	Time of sampling (hours)	Volume sampled (mls)	Apheresis sample	Time at release (hours)	Length of screening
NHSBT (NHS Blood and Transplant)	36	2 X 8	Post-split	6	Day 7
NIBTS (Northern Ireland Blood Transfusion Service)	36	2 X 8	Pre-split	6	Day 9
SNBTS (Scottish National Blood Transfusion Service)	36	2 X 8	Pre-split	6	Day 7
WBS (Welsh Blood Service)	36	2 X 8	Post-split	12	Day 7

Please note:

- Screening methods in Wales changed mid-2018 from testing on day 1 and day 4 to testing on day 2 only 15 BacTALERT uses a colourimetric system that detects change in pH. A decrease in pH results in an initial reactive report. In some cases, units will have already been transfused. All associated units will be recalled, and the BacTALERT bottle and any associated packs will be re-tested, and a final result released. Platelet donations are reported as confirmed positive if both the initial screen bottle and the index and or at least 1 associated pack is positive, and the same organism is identified in both. An indeterminate positive result is reported if bacteria are detected in only the initial screen bottle plus no index or associated packs are received or no index packs are received and there's no growth in any associated pack. For indeterminate negative packs, there is no growth from the initial reactive bottle, but a negative result cannot be confirmed because the index pack is not available. Units are confirmed negative if no organism is isolated from the initial reactive bottle and the index pack.

- Bacteria isolated from the pack and the bottle are identified to the species level and an assessment will be made of any significance to the donor's health. If a unit has been transfused the transfusion laboratory is notified and asked about any reaction in the recipient.

Tissue and cord blood donor surveillance

The NHSBT and UKHSA Epidemiology Unit tissue and cell donor scheme collects information on tissue and cord blood donations tested by NHSBT. Tissue donors include deceased and living donors who gave surgical bone. Corneas are donated by deceased donors, some of whom have also donated other tissues; those tested by NHSBT have been included in this scheme since 2012. Since 2013, deceased donors have been reported according to their type of donation for instance those who gave only corneas, those who gave multi-tissue donation including corneas and those who gave multi-tissue excluding corneas.

Donations tested by NHSBT

Data collection

Testing for the following mandatory markers of infection is carried out: on antibodies to HIV, HCV, HTLV and treponema; HBsAg and anti-HBc; HBV, HCV and HIV nucleic acid testing (NAT; singletons, triplex). Although not mandatory, blood donations are also tested for HEV RNA. Disaggregate data on the number of donations tested for mandatory markers of infection, as well as data on additional testing for malaria and T. cruzi, are extracted from PULSE (the NHSBT national donor database) on an annual basis. Donations are classified according to donor type (cord blood, living surgical bone or deceased donors [the latter including cornea donors]). The information extracted includes product or component type donated (for instance femoral head, left knee etc.) and gender and date of birth of the donors. Ethnicity of these donors is not currently recorded on PULSE and is therefore not available. In 2012 for the first time, the same data for cornea donors managed and tested by NHSBT were included in this scheme. Some data for stem cell and amnion donors are available but information is limited, thus these donors are not fully integrated into the surveillance scheme and are not reported upon.

Changes to testing

- there have been several changes to tissue and cord blood donor testing within NHSBT since surveillance began in 2001. HCV, HIV, HBV and HEV NAT (on single samples NOT pools) have been introduced for different donor types at different times

- Cord Blood Donors: HIV NAT and HCV NAT introduced in November 2003. HBV NAT since April 2009. HEV NAT since October 2017

- Deceased Donors: HIV NAT and HCV NAT since 2001. HBV NAT since September 2008. HEV NAT since October 2017 17

Surgical Bone Donors: Triplex HBV, HCV, HIV NAT since September 2008 (Note: A small number of surgical bone donors require two serology samples [initial and 6-month] where there is insufficient sample for NAT. Any follow-up samples are excluded from the count of number of donors tested, as they do not represent new donors). HEV NAT since October 2017

Anti-HBc testing has been mandatory for all tissue and cord blood donors since 2006 under EU Commission Directive 2006/17/EC.

Infected donors (Tissue and Cord blood)

Follow-up or risk exposure information is received for living surgical bone donors and, where possible, cord blood donors whose donations had markers of infection. As for blood donors, these donors are contacted and asked to telephone the blood centre to discuss their results. The post-test discussion commonly takes place over the telephone and, as for infected blood donors, a behaviour history is sought. For infections detected among deceased donors, an assessment is made to see if any family member or other individual is likely to be at risk before the donor's family is contacted. Risk exposures are not requested for deceased donors. These data are reported to the infected donor surveillance scheme by NHSBT clinicians using standard proformas.

Deceased organ donor surveillance

Data collection

Organ donor data are derived from the UK Transplant Registry (UKTR) and provided by NHSBT Organ Donation and Transplantation (ODT), and includes donor characteristics, cause of death, reactive test results, and a description of organs donated, and organs transplanted. This information is collected by the NHSBT and hospital staff and submitted to the UKTR either by paper or electronic form.

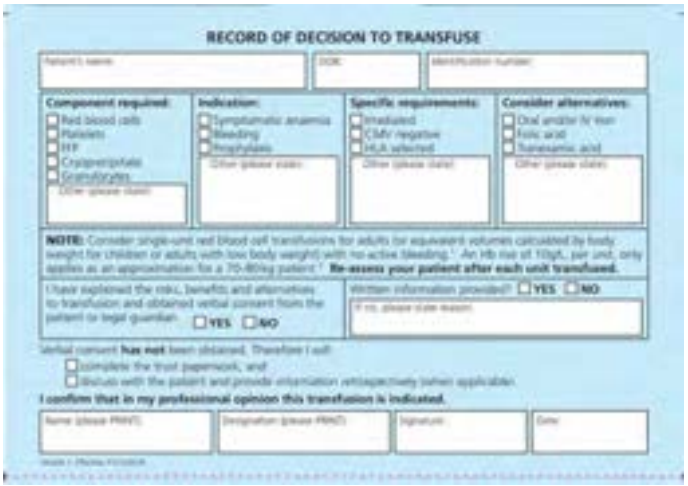
2. Blood Transfusion Procedures (Medway NHS Foundation Trust)

a. Decision to Transfuse and Consent

Before transfusion, the patient's doctor must provide verbal and written information to patients who may have or who have had transfusion, and their family members or carers (as appropriate), explaining:

- the reason for the transfusion
- the risks and benefits
- the transfusion process
- any transfusion needs specific to them
- any alternatives that are available, and how they might reduce their need for a transfusion
- that they are **NO** longer eligible to donate blood
- that they are encourages to ask questions

This is recorded on the NHSBT Consent sticker pad and attached to the patient's drug chart..


RECORD OF DECISION TO TRANSFUSE

Component required:
Red blood cells
Platelets
FFP
Cryoprecipitate
Granulocytes
Other (please state)

Indication:
Symptomatic anaemia
Bleeding
Prophylaxis
Other (please state)

Specific requirements:
Irradiated
CMV negative
HLA selected
Other (please state)

Consider alternatives:
Oral and/or IV iron
Folic acid
Tranexamic acid
Other (please state)

NOTE: Consider single-unit red blood cell transfusions for adults (or equivalent volumes calculated by body weight for children or adults with low body weight) with no active bleeding.* An Hb rise of 10g/L per unit, only applies as an approximation for a 70-80kg patient.* **Re-assess your patient after each unit transfused.**

I have explained the risks, benefits and alternatives to transfusion and obtained verbal consent from the patient or legal guardian: YES NO

Written information provided? YES NO
If no, please state reason

Verbal consent **has not** been obtained. Therefore I will:
complete the trust paperwork, and
discuss with the patient and provide information retrospectively (when applicable)

I confirm that in my professional opinion this transfusion is indicated.

Name (please PRINT) | Designation (please PRINT) | Signature | Date

Patients are also provided with patient information leaflet **'Receiving a Blood Transfusion'** as soon as possible prior to the transfusion commencing and this is documented on the 'consent sticker pad' provided or patient's notes (EPR).

Following an emergency situation the patient/guardian should be made aware that they have received a blood transfusion before their discharge. The information leaflet "Information for patients who have received an unexpected transfusion" should be used in this situation.

Where adult patients lack the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no one else can give consent on their behalf. However treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable Advanced Decision to Refuse Treatment.

Where patients decline blood components through religious beliefs or through fear of transfusion transmitted infection, administration errors or a misunderstanding of the risks and benefits, a trained practitioner will discuss the risks and consequences of such a refusal explained in full and document in 'Consent Form for the Refusal to Blood Transfusion form' – Refer to DITH-SOP-3 'Care and Management of Patient's Who Wish to Decline Blood Transfusion'

Provide the patient and their GP with copies of the discharge summary or other written communication that explains:

- the details of any transfusions they had
- the reason for the transfusion
- any adverse events
- that they are NO longer eligible to donate blood

Related documents: CORP-GRL-POL-5 ' Consent Policy and Decision Making Policy'

DITH-POL-17 'Blood Transfusion Policy'

DITH-SOP-3 'Care and Management of Patient's Who Wish to Decline Blood Transfusion'

b. Request

Transfusion tests should be requested via a pink blood transfusion paper request form or via EBOS (Electronic Blood Ordering System). We are also able to take requests over the telephone. The information on all request forms and accompanying specimen bottles must correspond and minimum acceptance criteria are set out in Blood Transfusion Policy.

Inadequately or incorrectly labelled samples and request NOT processed.

Related documents: DITH-POL-17 'Blood Transfusion Policy'

c. Sample Collection and Labelling

Samples are collected into EDTA containers (paediatric EDTA samples are acceptable for children or where difficulty is encountered in bleeding the patient). Identification of the patient is paramount.

In-patients must be identified with their request form using their wristband to confirm their full name, DOB and hospital number.

In addition, the patient must be asked verbally to give their full name and date of birth wherever possible. Out-patients' details must be confirmed verbally with the patient (in cases of language difficulties, young children or confused elderly patients' details may be confirmed with an accompanying relative).

Samples must be labelled using the BloodTrack System in all areas where BloodTrack is deployed. This will decrease the risk to patient safety through positive electronic identification of patients using wristband.

Samples without BloodTrack label will be rejected. All staff that do not use BloodTrack will be contacted before the sample is rejected.

d. Sample and Request Receipt

For safety reasons the laboratory has a **Zero Tolerance Policy** for mislabelled samples.

The patient identification on the request form and the sample (surname, forename, date of birth and hospital number/NHS number) must match exactly. Any sample which does not conform to these criteria will **NOT** be processed by the Transfusion Department.

Samples with PAS labels, overwritten patient details or two samples that appear to have been taken by the same person at the same time will also be rejected by the Transfusion Department

If a sample is rejected and blood is urgently required then group O blood will be issued pending a repeat sample

Requests that are rejected due to failing the acceptance criteria above will be reported via the DATIX system

Only staff who had completed and passed their eLearning on ESR and practical assessment can collect samples. Training is valid for 2 years, if not completed, BloodTrack will automatically disable their barcode**.**

Related documents: DITH-POL-17 'Blood Transfusion Policy'

MAN-PATH-7 'Blood Transfusion Handbook'

e. Pre-transfusion compatibility testing and component selection

Samples are run on the Ortho Vision Swift Analyser is designed to automate in vitro immunohaematology testing of human blood utilising the Ortho BioVue System cassette technology. It automates test processing functions including liquid pipetting, reagent handling, incubation, centrifugation, reaction grading and interpretation, and data management requirements using cassettes and digital image processing.

Tests performed are routine ABO and RhD grouping, Rh and K phenotyping, antibody screening and antibody panels, DAT and extended red cell phenotyping, using full automation with positive barcoded ID of samples and reagents and electronic transfer of results, via Ortho Connect middleware, to host LIMS

Preventative maintenance and equipment calibration is performed on an annual basis by a qualified Ortho field service engineer (FSE) to UKAS ISO:17025 accredited standard. Full reports, including engineer tool calibration certificates, are provided.

Ortho Confidence QC should be run after the analysers' maintenance procedures have been completed. QC is ordered through Ortho Connect. Any failed QC must be investigated and if the root cause is unknown, QC must be repeated and pass three times before patient samples are run.

Blood for transfusion is selected on the basis of ABO & RhD compatibility and either, the absence of any atypical antibodies of the major blood group systems in the patient or, the use of antigen negative blood if necessary.

Crossmatching cells from the donor units against the plasma of the recipient is the final test performed before issuing blood for transfusion to ensure that all blood issued for transfusion is compatible or suitable for the patient, whether via electronic issue or by detecting any incompatibilities between cells from donor units and plasma from a patient, when performing a serological crossmatch.

Internal Quality Controls are also run every 12 hours to ensure that reagents and cassettes are working as expected. Blood Transfusion also regular participates in External Quality Assurance schemes to benchmark analyser, reagent, method and staff competency performance.

In addition, BSH 'Guidelines for Pre-transfusion Compatibility Procedures in Blood Transfusion Laboratories' 2017 require that, in order to minimise the risk of 'wrong blood in tube' incidences, no group specific red cells should be issued on the basis of one group / save sample alone. A second independent group / save sample must be tested to confirm the initial blood group prior to issue of group specific red cells

Crossmatching / issue of blood & blood components are only undertaken by qualified HCPC registered BMSs. All BMSs performing crossmatching are required to participate in external NEQAS QC exercises each year

Related documents: SOP.BT.10 'Use and Maintenance or Ortho Analysers'

SOP.BT.MMH.20 'Crossmatching Techniques'

f. Component Collection

The BloodTrack system has been implemented to provide a robust audit of all movements of blood and blood components within the Trust, to ensure secure access to the blood issue fridge and ensure 100% traceability is upheld.

BloodTrack is fully validated and tested prior to implementation and is in compliance to the Blood Safety Quality Requirements 2005 and ISO 15189:2022 Medical Laboratories.

In order to use BloodTrack Courier, staff must be fully trained. After training a barcode will be added to the staff member's identification badge and activated to allow access to the blood fridge kiosks.

Unauthorised staff cannot access the Blood Transfusion blood fridges.

g. Prescription/Authorisation

Blood components/products can only be authorised/prescribed by a qualified medical practitioner with responsibility for care of the patient. Some components may require authorisation by a haematology consultant.

The prescription must contain

- the patient's core identifiers
- date & time of transfusion
- the blood component to be administered and any special requirements – see Appendix 4
- the quantity of units to be given. Blood products may be prescribed as "Units" in adult patients but should be expressed in millilitre (mL) for paediatric patients or where appropriate e.g. in smaller adults or those at risk of fluid overload.
- the duration of the transfusion (usually 2 - 4 hours for red cell transfusions and 30 minutes for a unit of platelets or FFP depending on volume)
- any medication required before or during the transfusion (e.g. diuretics).

Documentation in patient notes (EPR or paper notes) should also include:

- Current relevant blood results.
- TACO (Transfusion Associated Circulatory Overload) Assessment completed
- Date to be transfused.
- Component type and amount.
- The reason for the transfusion and the anticipated outcome.
- Any reported transfusion adverse events/reactions and their management.
- Review following the transfusion including how much blood has been transfused and whether the anticipated outcome has been achieved

Transfusions MUST only take place between the hours of **08.00 and 20.00** hours unless the patient is haemodiamically unstable. This is because it is harder to monitor a patient for transfusion reactions out of these

hours.When transfusions are given outside these hours the clinical indication must be documented in the patient's medical note

h. Administration, Monitoring of Reactions and Documentation

BloodTrack Tx is used to Administer Red Cells, FFP, Platelets, Cryoprecipitate and all other blood component/products – In routine and emergency transfusions.

BloodTrack Tx ensures electronically verifies the right blood is transfused to the right patient at the bedside. Enhances patient safety with positive patient identification through scanning of the 2D barcode on the patient's wristband, track time out of storage, document arrival at bedside and notify user when transfusion should be completed. It also lead users through site defined pre-transfusion checks and reminders which is in compliance to the blood transfusion policy.

The patient must be wearing a bar-code ID wristband containing a 2D barcode. No wristband, No transfusion. – This is trust policy.

Additional checks required are:

- The blood component must be checked to ensure it has not passed its expiry date/expiry time.
- Checked for any signs of discolouration, turbidity, haemolysis, large clots and the integrity of the pack by checking for leaks at the ports and seams.
- Baseline observations within 1 hour of transfusions
- Record time completion of transfusion on the Blood Transfusion Safety Critical tag

Monitoring of Reactions:

All patients should be transfused in clinical areas where they can be directly observed, and where staff are trained in the administration of blood components and the management of transfused patients, including the emergency treatment of anaphylaxis

Patients should be informed of the risk of transfusion reaction and consented to a transfusion. Patients should be encouraged to report any symptoms that occur within 24 hours of completion of a transfusion

If a patient develops new symptoms or signs during a transfusion, this should be stopped temporarily, but venous access maintained. Identification details should be checked between the patient, their identity band and the compatibility label of the blood component. Perform visual inspection of the component and assess the patient with standard observations.

All vital signs must be measured and recorded on the clinical observation record before the start of each unit of blood component or blood product, **within 15 minutes** of commencing the transfusion, at the hour and at the end of each transfusion episode:

- Respiratory Rate
- Oxygen Saturation
- Temperature
- Blood Pressure
- Pulse Rate

Management of Transfusion Reaction

For patients with mild reactions, such as pyrexia (temperature of ≥38°C AND rise of 1–2°C from baseline), and/or pruritus or rash but WITHOUT other features, the transfusion **may be continued with appropriate treatment and direct observation**

For moderate or severe reactions, where transfusion is considered to be the cause, take blood for full blood count, direct antiglobulin test, repeat cross match grouping and coagulation screen, blood cultures, Urea and Electrolytes and liver function tests. Return blood packs and giving set to transfusion laboratory with the samples and completed "Transfusion Reaction" form (see appendix 1 below) and telephone to inform them of the reaction

For all suspected transfusion reactions an DATIX form and an 'Investigation of a possible Transfusion Reaction' form should be completed. **DOC593 - Transfusion Reaction - TXR - Investigation Ward Form**

i. Fating of Unit

It is a legal requirement under the Blood Safety and Quality Regulations 2005 that positive evidence of transfusion of each component, including the unique donation number, is fully documented

At the end of the transfusion, document the stop date and time on the patient's chart or ICP and ensure the donation number is recorded.

Wherever it is deployed, BloodTrack should be used to record the end of the transfusion by selecting "end transfusion"

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - medical directors
  - chief nurses
  - chief operating officers
  - chief people officers
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - regional heads of nursing
  - regional heads of communications

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 May 2024

Dear colleagues,

Publication of the Infected Blood Inquiry final report

Earlier today, the Infected Blood Inquiry published its final report at: www.infectedbloodinquiry.org.uk/reports. The Prime Minister has subsequently issued an apology on behalf of successive Governments and the entire British state.

On behalf of the NHS in England, now and over previous decades, Amanda Pritchard issued a public apology, saying:

“Today’s report brings to an end a long fight for answers and understanding that those people who were infected and their families, should never have had to face.

“We owe it to all those affected by this scandal, and to the thorough work of the Inquiry team and those who have contributed, to take the necessary time now to fully understand the report’s conclusions and recommendations.

“However, what is already very clear is that tens of thousands of people put their trust in the care they got from the NHS over many years, and they were badly let down.

“I therefore offer my deepest and heartfelt apologies for the role the NHS played in the suffering and the loss of all those infected and affected.

“In particular, I want to say sorry not just for the actions which led to life-altering and life-limiting illness, but also for the failures to clearly communicate, investigate and mitigate risks to patients from transfusions and treatments; for a collective lack of openness and willingness to listen, that denied patients and families the answers and support they needed; and for the stigma that many experienced in the health service when they most needed support.

“I also want to recognise the pain that some of our staff will have experienced when it became clear that the blood products many of them used in good faith may have harmed people they cared for.

“I know that the apologies I can offer now do not begin to do justice to the scale of personal tragedy set out in this report, but we are committed to demonstrating this in our actions as we respond to its recommendations.”

The report is sobering reading, documenting failings over multiple decades, and making recommendations across a wide range of areas, including recognition, support and compensation; education and training; monitoring of and testing for Hepatitis C; the safety of blood transfusions; preventing future harm, via duty of candour and regulation; as well as giving patients a voice.

We write now to set out the initial steps we are taking in response.

Support for those affected

The Department of Health and Social Care is providing £19 million over five years to provide a bespoke Infected Blood Psychological Support Service which is expected to be rolled out later this summer.

We have listened to the experiences of those involved, including patients, their families and staff, and are working with them to design and develop this service, which will provide dedicated support for those affected, located around the country.

This service will include talking therapies, peer support, and psychosocial support, as well as access to other treatments or support for physical or mental health needs where appropriate.

In the interim, the existing England Infected Blood Support Service remains available here: www.nhsbsa.nhs.uk/england-infected-blood-support-scheme.

Further information about existing testing and support services, including those commissioned by the Government, can be found at: www.nhs.uk/infected-blood-support.

Supporting affected staff

It is important to also recognise that some of our colleagues may be affected by the publication of today's report in some way, whether through personal or professional connection to the issue.

Employers may therefore wish to increase promotion of their local health and wellbeing support for staff. Details of nationally-commissioned routes of support, including the 24/7 text helpline Shout and NHS Practitioner Health, can be found at NHS England - Support available for our NHS People.

Continuing to find and treat people with blood-borne viruses

Although it is likely that the majority of those who were directly affected have now been identified and started appropriate treatment given the time that has elapsed since the last use of infected blood products, there may be people who have not yet been identified, particularly where they are living with asymptomatic Hepatitis C.

We ask that systems continue to work with partners, including community groups and charities, as well as Hepatitis C Operational Delivery Networks, to promote local testing options for anyone at risk, or anyone who is concerned. This should include promotion of the new national service for at-home Hepatitis C self-testing kits, available via hepctest.nhs.uk.

For those who are concerned about the risk of HIV infection, further information can be found here: information on HIV diagnosis and the HIV testing services search tool.

Hepatitis B, another infection that can be linked to infected blood, usually clears up on its own without treatment; however, people concerned about Hepatitis B infection should be directed towards relevant hepatitis B information or their local sexual health clinic or GP practice.

Today's report highlights that in some cases those affected by infected blood products were told of their diagnosis in ways which were insensitive and inappropriate. We would therefore ask you to ensure that patients and their families are supported through the process of receiving test results – of whatever kind - in a compassionate and considerate way.

Ensuring patients can access the right information.

We recognise following the publication of this report, some patients may raise questions directly with their primary and/or secondary care teams, or through other points of contact with the NHS. We will be sharing materials with relevant service providers to ensure frontline clinicians and other colleagues in patient-facing roles are able to provide appropriate information or signposting.

We expect that this will be particularly relevant to:

- Providers of NHS 111 services
- GP practices and community pharmacies
- Trusts providing services where blood products are used
- Mental health providers

Maintaining confidence in current blood and blood products and related treatment

The infected blood and blood products that have been the subject of this Inquiry were withdrawn in 1991. In the intervening decades, comprehensive systems have been put in place to ensure the safety of both donors and recipients of blood and blood-derived products.

Today, blood and blood products are distributed to NHS hospitals by NHS Blood and Transplant (NHSBT), which was established in 2005 to provide a national blood and transplantation service to the NHS. NHSBT's services follow strict guidelines and testing to protect both donors and patients.

NHS Blood and Transplant has published clear information about these processes here: Infected Blood Inquiry - NHS Blood and Transplant (nhsbt.nhs.uk).

Nationally, NHS England will work with NHS Blood and Transplant and others to communicate the safety of current blood products.

Assessing further recommendations and next steps

As set out above, the final Inquiry report includes a number of important recommendations for the NHS. NHS England will be considering these in detail alongside the Department for Health and Social Care and other relevant bodies.

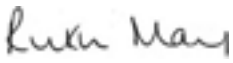
In addition, an Extraordinary Clinical Reference Group is being convened to inform any immediate actions which should be taken.

The next steps from this work will be shared as soon as possible, including through relevant clinical networks.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England



Dame Ruth May
Chief Nursing Officer England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Trust Safeguarding Annual Report

Head of Safeguarding

03 JUNE 2024

Contents

1 EXECUTIVE SUMMARY

1.1 Medway Foundation NHS Trust is committed to ensuring safeguarding is considered core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for collaborative working between partner agencies and professionals.

1.2 This report provides an update on safeguarding progress and achievements during 2023/24 and demonstrates assurance of the execution of our statutory duties. It aims to provide assurance of compliance with the local multi-agency guidelines for safeguarding adults and compliance with statutory and regulatory duties.

1.3 The monthly Safeguarding Operational Group (SOG) is responsible for sharing key information, highlighting risks and escalating key issues in a timely way to ensure that safeguarding is embedded into practice. This group reports into the Safeguarding Strategic Assurance Group (SSAG)

1.4 The Safeguarding Strategic Assurance Group provides scrutiny and challenge to the members of the group and safeguarding team and provides assurance to the Trust Board via the Quality Assurance Committee (QAC).

1.5 During 2023-2024 we have sustained and built on our external assurance via the Kent and Medway Safeguarding Adults Board and both the Medway Safeguarding Children's Partnership and the Kent Multi Agency Safeguarding Children's Partnership.

1.6 The focus has been on the returning to face to face training throughout the year to ensure that we have a workforce skilled enough to recognise and react appropriately to safeguarding concerns.

1.7 Children and Young People presenting with Mental Health concerns remains 3 times higher than pre-pandemic numbers, with the majority relating to behaviour and emotional concerns. It is likely that this is the related directly to the both the pandemic and the effects the current cost of living crisis is having on families.

1.8 Child Protection (CP)/Non-Accidental Injury (NAI) medicals saw an all-time high of 21 children referred for assessment by social care. There were concerns raised regarding the demand that this placed on the Consultant of the Week. Although the referrals have currently reduced to more manageable levels, a review of the processes is currently under by the paediatric team, with support from the safeguarding team and a new Standard Operating Procedure is expected in early 2024/25.

1.9 There has been one Local Safeguarding Children Practice Review published in 2023/24 under the pseudonym of 'Isabel'. There were actions identified for MFT and the action plan for this is held by Maternity Safeguarding.

1.10 The Maternity Safeguarding HUB, terms of reference and referral processes have been reviewed via joint working between the Named Midwife for Safeguarding, Local Authorities, the MSCP, and internal maternity staff. There has been a 118% increase in hub referrals heard for both Swale and Medway this year in comparison to 2022/2023. This report explores the reason for the increase and the adjustments made in line with recommendations from Local Children's Safeguarding Practice Reviews (LCSPR)

1.11 Deprivation of Liberty Safeguards (DoLS) applications in the Trust have reduced over the past 2 years however standard authorisations form the Local Authorities remain very low and leaves the Trust at risk of detaining patients without the correct authorisations to do so. The lack of local authority standard authorisations remains a risk on the risk register; however this remains a nationally recognised risk.

1.12 Safeguarding adult's level 3 and safeguarding children's level 3 remain below KPI, however remedial actions are in place to restore the compliance.

1.13 MCA training is just under the KPI of 85% which is the highest compliance for 2 years.

2 SAFEGUARDING CHILDREN

Child Protection Information Service (CP-IS)

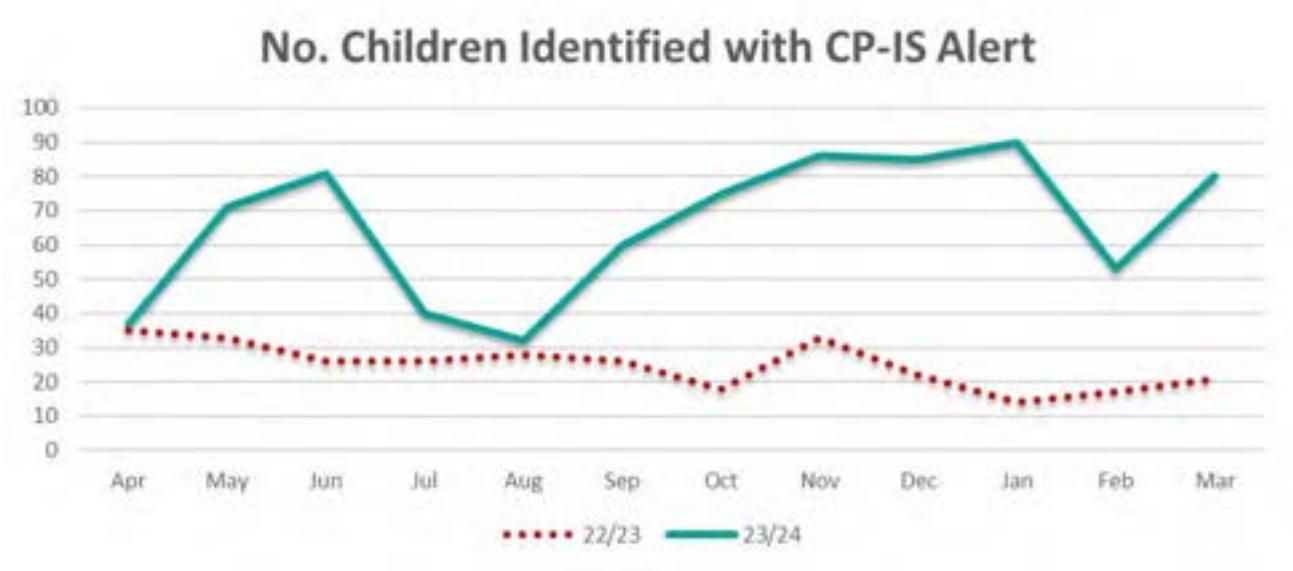
2.1 The CP-IS is a National system that helps health and social care professionals share information securely to identify children (including unborn babies) with a looked after status and those subject to a child protection plan. The system should be checked for all unplanned attendances for females aged 0-55 years and for males 0-19 years.

2.2 The attendance information on the Electronic Patient Record (EPR) has a mandatory CP-IS field that requires completion for all attendances, to identify if a child or unborn is a LAC or subject to a CP plan. The safeguarding team receive automatic notifications from EPR for patients where a CP-IS alert has been identified, or when CP-IS has been unable to be checked on attendance, for example a new staff member awaiting access. To mitigate the risk of an alert being missed where staff have been unable to check the system, the safeguarding team will complete this.

2.3 Historically, unplanned attendances to the Paediatric Assessment Unit (PAU) for children that do not attend via Children's ED (ChED), have not being checked against CP-IS. This was added to the Paediatric risk register 2023. Following the identification of this risk Smart Cards and CP-IS access was requested for all Band 7's, Band 6's and Admin staff to ensure that there is always a member of staff on shift that can access CP-IS.

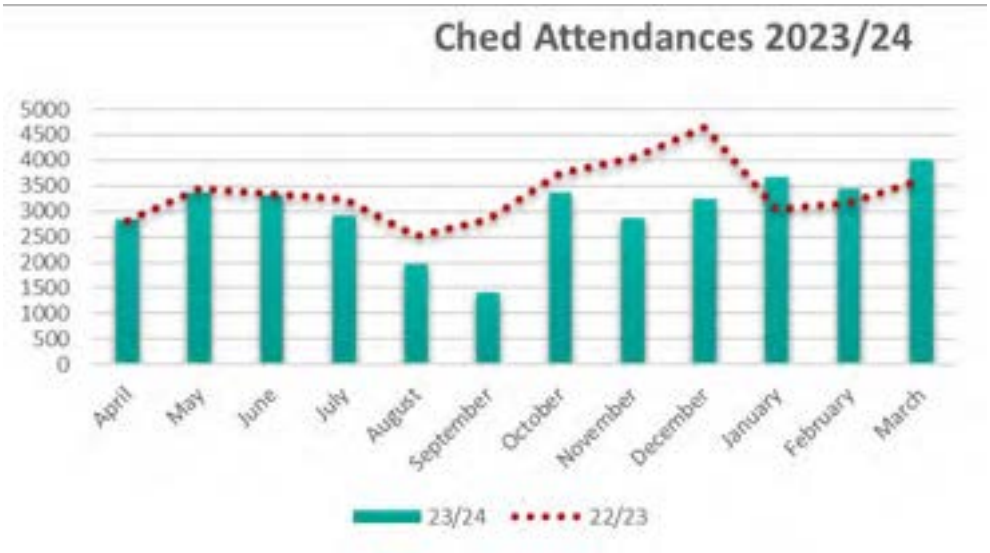
The result is that CP-IS checking is now live in all children's areas for all unplanned attendances.

2.4 In February 2024 it was identified that Maternity could not provide assurance that CP-IS is being checked for all unplanned attendances to the hospital. However, all new pregnancy bookings were being checked at initial contact in community and therefore most pregnancy people would have had been checked against CP-IS at least once in their pregnancy. To mitigate the risk for unbooked pregnancies and those accessing care directly with the hospital and not through the community teams, all Matrons and Midwives in Charge are being provided with smart cards and CP-IS access, this will bridge the gap until assurance is provided that all admin staff are accessing CP-IS as part of the routing admission process.



2.5 Overall the number of children attending MFT with CP-IS alert has been significantly higher than 2022/23, it is unclear why this is. There have been several children experiencing poor mental health that have had multiple attendances to the hospital and this may offer some explanation. However, this does not account for an increase of over 160% averaged across the year, with some months reflecting a 540% increase on the same period in 2022/23. What it does illustrate is the increased safeguarding activity related to safeguarding that both the safeguarding team and inpatient areas have been faced with across the year.

Children's Emergency Department (ChED)



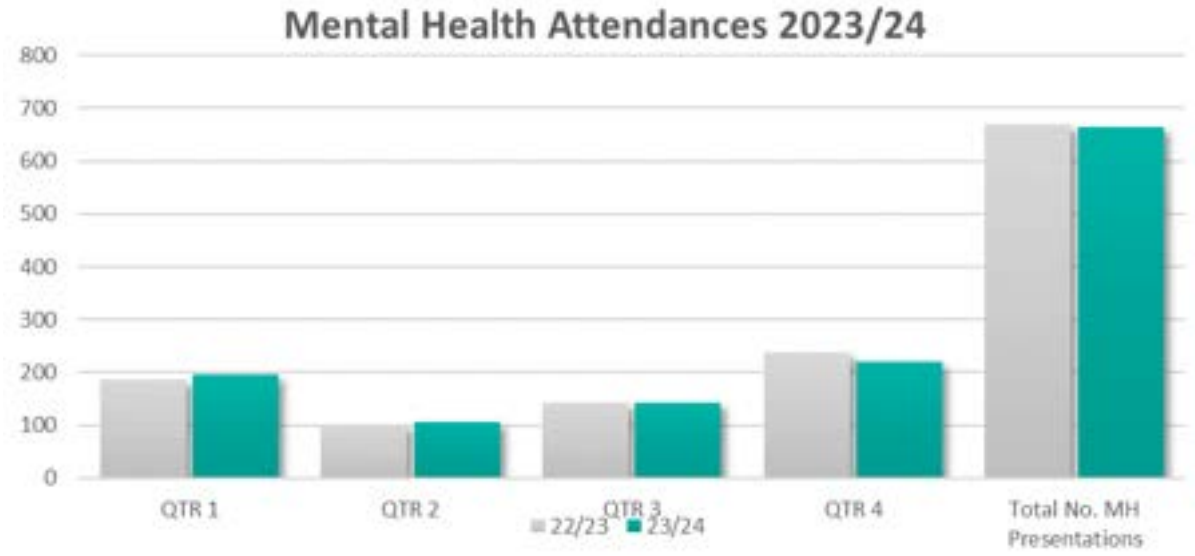
2.6 Throughout the year, ChED has seen an average of 104 children per day, with 93% under the age of 16 years. In comparison with other years, the trends appear to be similar, reflecting the seasonal demands. However, this year increased demand was noted January - March. On review of these attendances, they are not reflective in the number of safeguarding concerns raised and therefore likely linked to seasonal health issues.

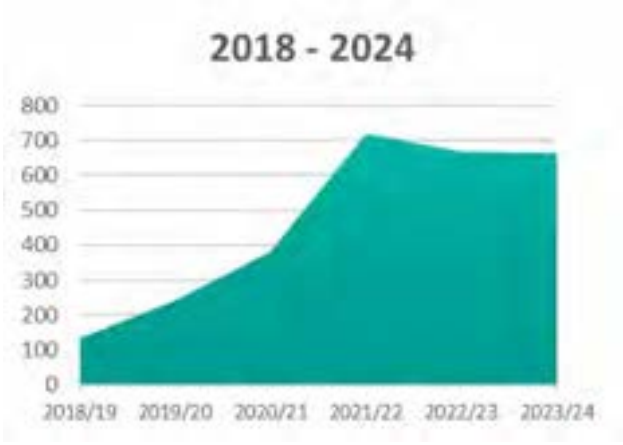
2.7 We have reviewed the way that relevant information is shared between our partner agencies to reduce time and free up capacity in the team allowing the focus to remain on priority attendances. This includes the sharing of information to health visitors and school nurses from both ED attendances and from paediatric admissions. From 1st April 2024, all EDN's are shared directly with the appropriate health agency electronically from the EDN system, in line with all other areas of the hospital.

Mental Health

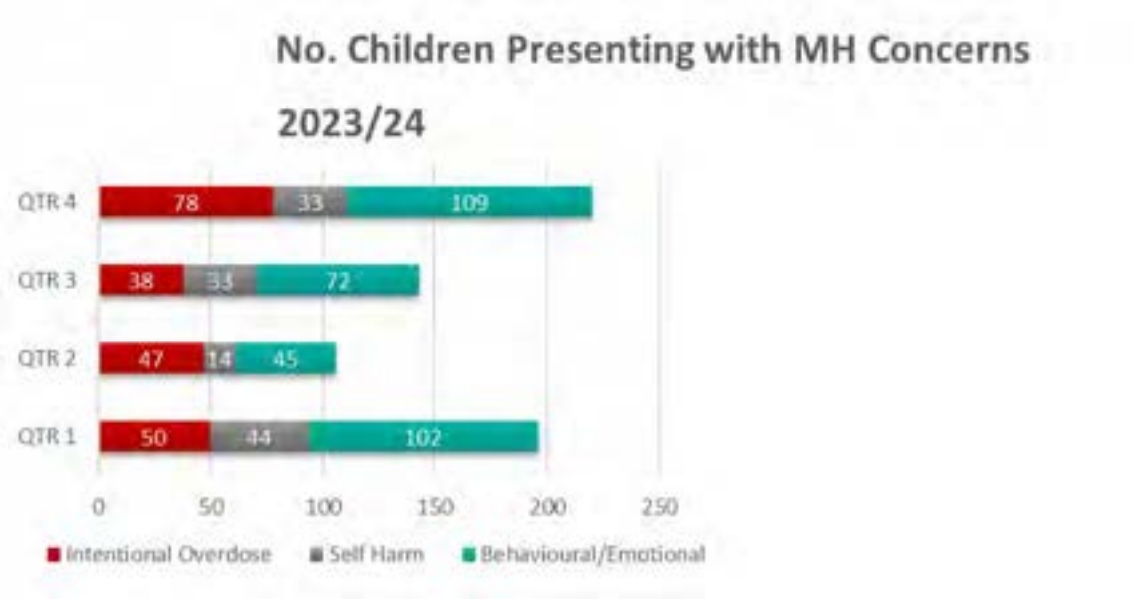
2.8 Overall the number of children and young people (CYP) presenting with mental health concerns has been consistent with the previous year 2022/23. However, it remains approximately 3 times higher than pre-pandemic numbers. It is likely that this is due to a combination of the effects of Covid on both CYP personally and the impact of parental behaviours on the family, resulting from the pandemic and the current cost of living crisis. Behavioural/emotional mental health concerns remain the highest presenting complaint for CYP.

2.9

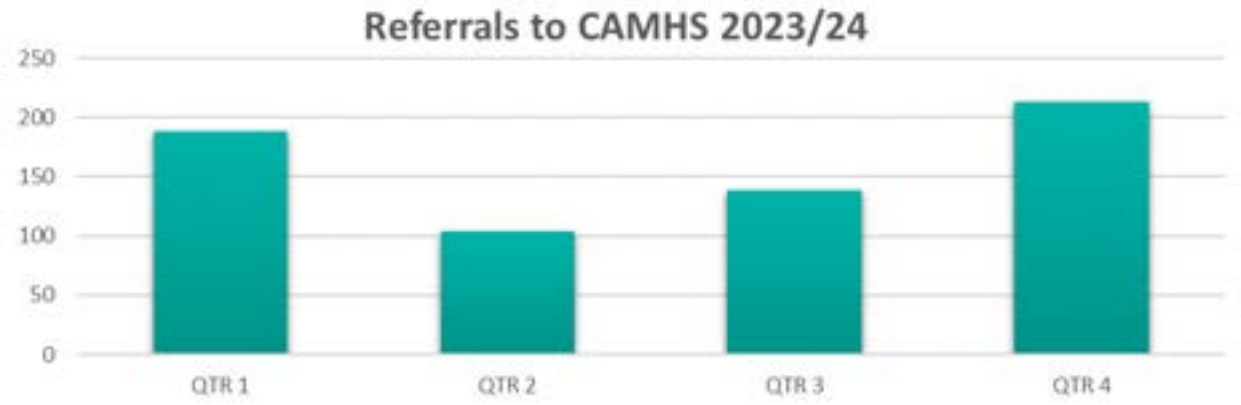




2.10 Overall the number of children and young people (CYP) presenting with mental health concerns has been consistent with the previous year 2022/23. However, it remains approximately 3 times higher than pre-pandemic numbers. It is likely that this is due to a combination of the effects of Covid on both CYP personally and the impact of parental behaviours on the family, resulting from the pandemic and the current cost of living crisis. Behavioural/emotional mental health concerns remain the highest presenting complaint for CYP.



2.11 Where appropriate, a referral to the Child and Adolescent Mental Health Service (CAMHS) was completed for all CYP presenting with poor mental health who were not already open to the service, with a total of 644 referrals completed. Several attendances related to CYP awaiting CAMHS assessments following referral, presenting with family members requesting support to help manage their child's mental health as both they and their child were feeling 'unheard' by community services. CAMHS have shared that work is ongoing to reduce the current wait time for assessments following referral. It is hoped that this will support a reduction in ChED attendances for CYP awaiting assessment.



Trust Safeguarding Notifications

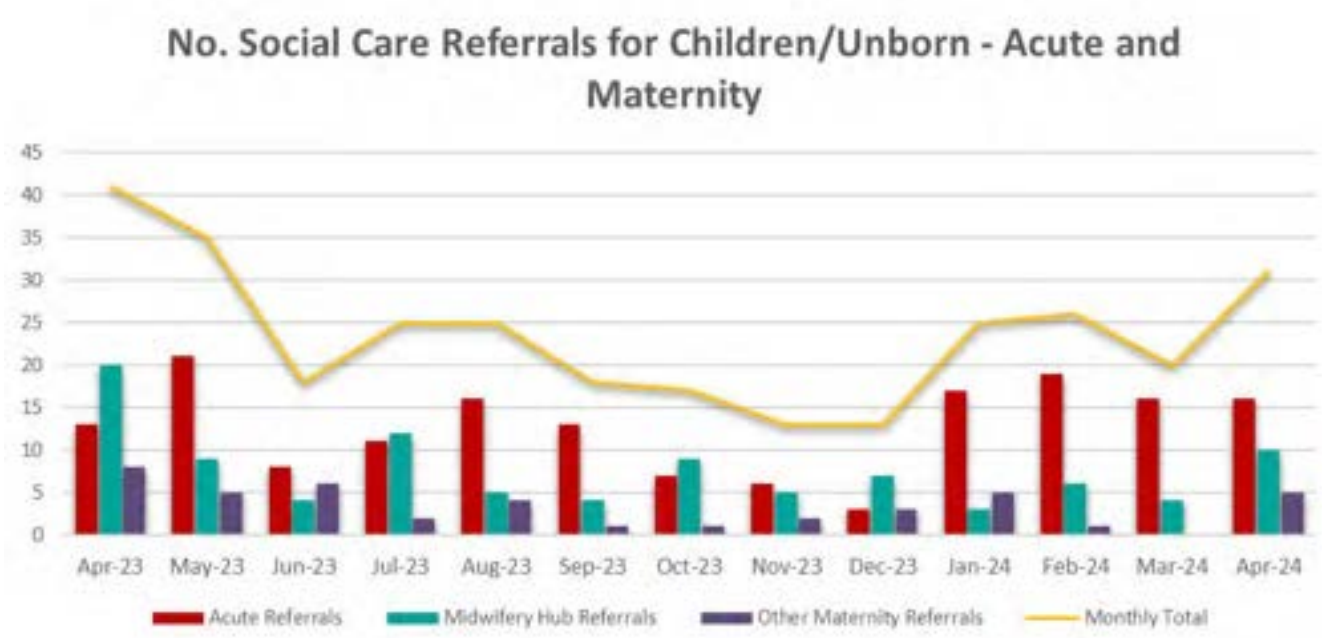
2.12 In July 2022 a safeguarding notification function for both adults and children was launched on the intranet. This system allows staff a quick and easy way to send a notification to the safeguarding team. Staff use this function to share non-urgent information with the team, confirm actions/referrals that have been completed or highlight concerns that have occurred out of hours that the safeguarding team are required to follow up

2.13 We have steadily seen the number of notifications received rise since this introduction with reduced numbers reflecting school holidays, when historically attendances to ChED tend to be fewer.

2.14 Following discussions with the EPR team in quarter 4 of 2022/23 regarding embedding the safeguarding notification within EPR, this has now been completed. The result of this is that staff no longer have search for the notification via the intranet, saving time. Furthermore, this notification is recorded as a document on EPR that staff can see, confirming what actions have been completed that that the concerns and attendance have been shared with the safeguarding team. In addition to this, this function supports triaging of the daily ChED attendances, aiding in improved information sharing with external agencies.

Referrals to Children's Social Care

2.15



2.16 With the exception of quarter 3, the increased safeguarding activity has been reflected within the number of referrals to Children's Social Care. In previous years 21/22 and 22/23, the number of referrals was relatively stable and mirrored each other. However, this has not been the case in 2023/24. There could be several reasons for this.

2.17 Firstly, historically the safeguarding team have not been made aware of most referrals and therefore the figures could reflect better reporting. Secondly, specifically quarter 4 could relate to improved staff awareness of the threshold guidance relating to mental health presentations, resulting in increased numbers of referrals, where historically these were not being completed. Thirdly, the safeguarding notification is now embedded within practice and staff are using this well to inform the safeguarding team of concerns.

2.18 This notification has a question relating to whether a referral has been completed, which aids in data collection. Finally, it may be due to the increase in safeguarding activity for the Trust. The likelihood is that is relates to all of these. However, the data is still only reflective of the referrals that the safeguarding team are aware of and therefore there is probability that some referrals have not been captured in the data.

Multi-Agency Safeguarding Hub (MASH)

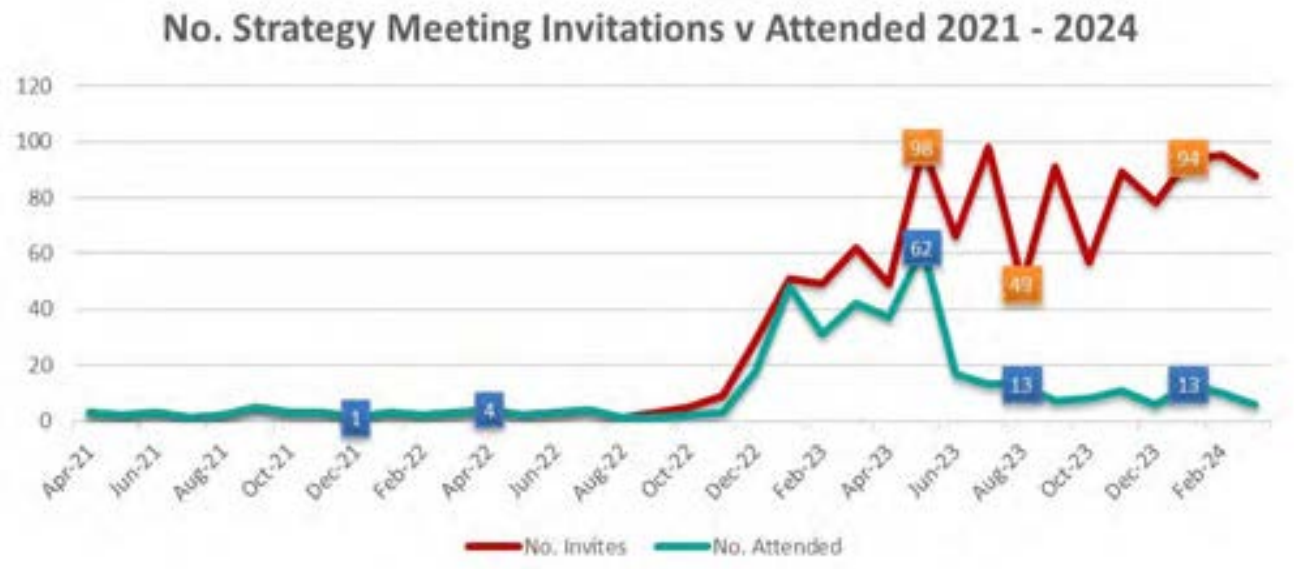
2.19 The Safeguarding team continue to work closely with our partner agencies within the local Multiagency Safeguarding Hub (MASH), providing data and analysis of attendances to our children and young people services. Attendance at both MASH operational and strategic boards by the Safeguarding Children's team, facilitates provision of assurance that the Trust are meeting our statutory duty to provide timely and proportionate information when a concern has been raised.

2.20 Over the last 3 years, the numbers of MASH requests have remained relatively stable. Quarter 1 of 2023/24 saw the largest number of MASH requests (423), with June alone recording 165 requests. The information that MFT hold is shared 100% of the time with the MASH team.

Strategy Meetings

2.21 The Safeguarding team act as a point of contact for all strategy meetings, where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. For the meeting to be quorate, there needs to be at least one member from the following agencies present: Social Work, Police and Health.

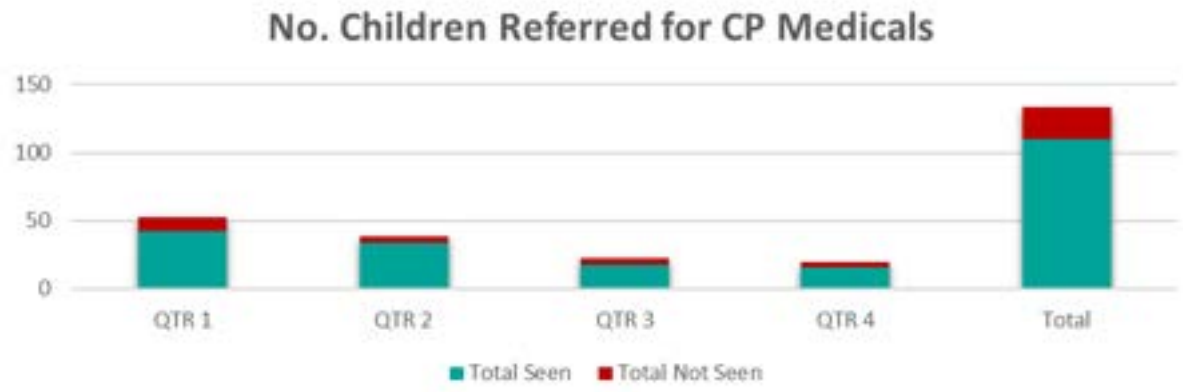
2.22 Following providing Health representation at strategy meetings in 2022/23 a vast increase in workload for the safeguarding team occurred, with numbers increasing from an average of 8 per quarter to 159 in quarter 4 (>1200% increase). This change in process illustrated that MFT hold a lot of information that other services do not, including identifying pregnant parents, family concerns relating to mental health, alcohol and drug dependence and regular attendances related to possible domestic abuse, or possible non-accidental injuries, etc. Feedback from Children's Social Care was shared across the partnership that this change in practice had been extremely positive, both with sharing of information and relationship building between agencies. However, this way of working and the demand on the safeguarding team was unsustainable and therefore in June 2023, the decision was made by the safeguarding team that MFT would only attend meetings where there was a recent attendance to the hospital.



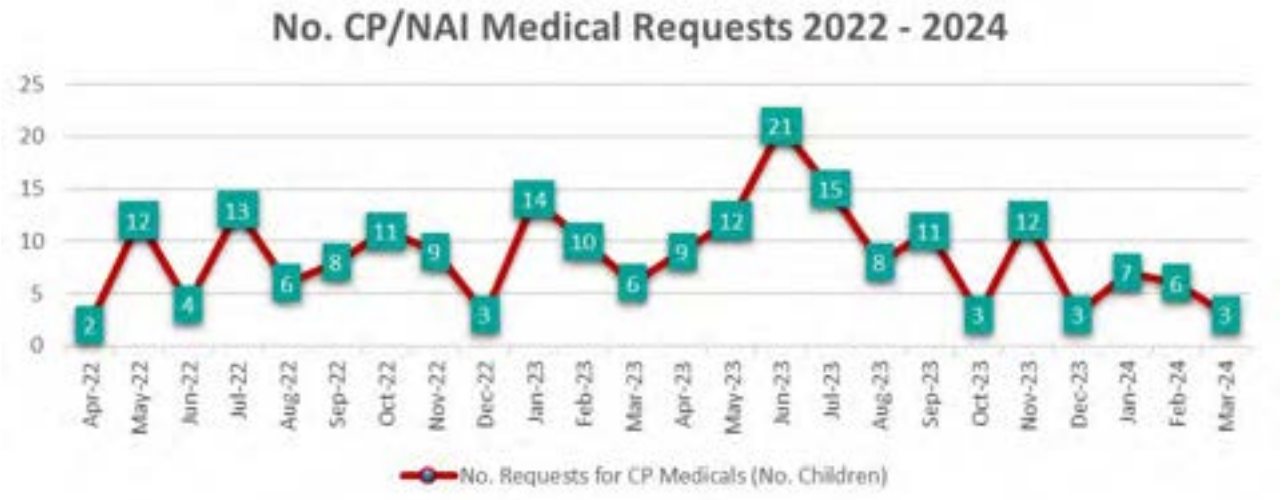
2.23 In November 2023 Medway Community Health implemented a strategy health team. Their role is to bridge to gap for health attendance at strategy meetings and co-ordinate health information from partner agencies. Following the launch of the team, MFT now only attend meetings for families that have had recent significant attendances to the hospital however research must be completed for all strategy meeting requests. Where there have been non-significant attendances, MCH are able to access discharge and outpatient letters via KMCR to share within the meeting. This change in process has resulted in MFT being able to triage the invitations and ensure that strategy meetings are only attended where recent significant information is held. This has significantly reduced the workload. However, the number of attendances remains 100-200% increased from historical data.

Non-Accidental Injury Assessments / Child Protection Medicals

2.24 The Number of CP Medical requests was the highest in Q1, with 42 requests and 31 children accepted by the Consultant of the Week (CoW) to be seen for assessment. The 12 that were not seen was due to: No parental consent (1), appointment not attended (1), referred to GP (1), no longer required (4) and no visible injuries noted (4).



2.25 The number of CP Medical requests has continued to increase year on year, although are currently illustrating a downwards trend following the peak in June 2023. The service is Paediatric lead, but supported by the safeguarding team. Throughout the year there have been challenges for the CoW to facilitate assessments, due to acuity on the wards. The process has been under review during 2023/24 and is currently awaiting final review and ratification.



Child Deaths

2.26 There have been 48 child deaths for children that were known to MFT in 2023/24. The majority have related to children that have either died in the neonatal period, or had complex health needs. However, there were 9 unexpected deaths for children residing with the hospital catchment area:

- Suicide x 2 (ages: 15yrs and 12yrs)
- Medical causes x 5 (ages: 13yrs, 15 months, 7yrs, 10yrs and 15 yrs)
- Sudden Unexplained Infant Death (SUDI) (ages: 20 days and 15 months)

2.27 Two of the deaths have been referred for a local safeguarding practice review (LSCPR); sudden infant death at 20 day old baby and a suicide by hanging for a 12 year old child.

Local Child Safeguarding Practice Reviews / Rapid Reviews

2.28 One LCSPR for a child that died in 2022 was published in September 2023. This was related to the death of a 3 month old child in March and was published under the pseudonym 'Isabel'. A video overview of the review can be accessed here: Case Review: Isabel and the full report can be accessed via the Medway Safeguarding Children's Partnership website.

2.29 The learning identified in within the review relates to missed opportunities for exploration of the lived experiences of the family and barriers to information sharing between agencies. Actions were identified for Maternity and these have either been completed or are in progress.

2.30 There have been 2 requests for LCSPR's for the death mentioned in 3.2. The first relating to the death of a 20 day old baby is currently in progress and awaiting the final report to be written and published. The second relating to the suicide of a 12 year old child is expected at the beginning of the year 2024/25.

2.31 The focus of service development in Maternity Safeguarding in 2023/2024 has been in relation to the most recent Local Child Safeguarding Practice reviews for RH, XW, and KH.

2.32 Themes raised from the reviews were improvements required in Professional Curiosity, DNA's, communication and information sharing, safe sleeping, and alcohol and substance misuse. Fourteen actions were suggested to Maternity and currently 10 have been completed to date.

Type of Review	Themes	Publication Date
LCSPR – Child Death (RH)	• Maternity Specific • Professional Curiosity • Non-Attendance • Information sharing • Substance/Alcohol use	Sept 2023 MSCP - 'Isabel' Case Review: Isabel – YouTube
Learning Lesson Review (XW)	• Professional curiosity • Information sharing • Substance misuse • Challenge and escalation	TBC
LCSPR – Child Death (KH)	• Safe Sleeping • Poor DNA checklist compliance • Communication / Information Sharing	TBC

3 MATERNITY SAFEGUARDING

3.1 The Maternity Safeguarding Service consists of one whole time equivalent (WTE) Band 7 Named Midwife for Safeguarding, and a Band 6 Deputy Named Midwife for Safeguarding (0.8 WTE). The responsibility of the Maternity Safeguarding Team is to provide oversight, co-ordination, and take responsibility of the day-to-day safeguarding of all unborn and new-born babies within the care of Medway NHS Foundation Trust (MFT), within both the hospital and community settings.

3.2 It was previously reported that the Named Midwife for Safeguarding role was becoming increasingly strategic in nature; there was a gap in succession planning, lack of robust cover for the role in periods of leave, and there was an increase in safeguarding activity adding to the demands of the role. With these

concerns highlighted, it was recognised that the maternity safeguarding service was not sustainable and was detrimental to the safety of service users.

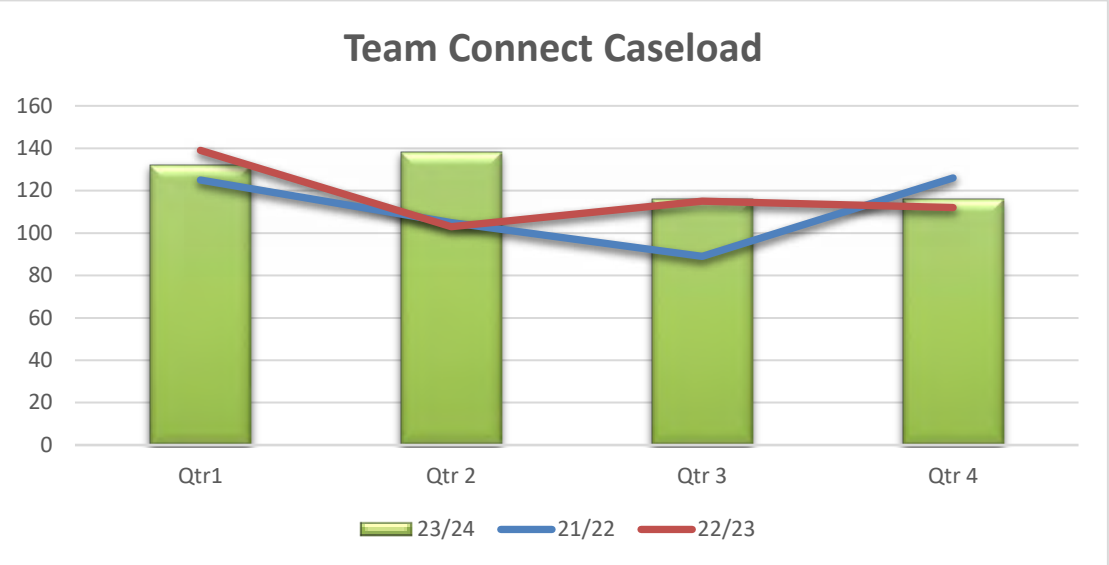
3.3 To ensure a more robust service and to comply with the recommendations from the Ockenden Maternity Review (Ockenden, 2022), a Deputy Named Midwife for Safeguarding secondment was implemented in quarter one with the successful applicant commencing the role in quarter two.

3.4 This allows the Named Midwife for Safeguarding to focus on the strategical elements of the role, developing the service, providing training and assurance; whilst the Deputy Named Midwife can focus on the operational aspects such as the day-to-day oversight of safeguarding, supporting families and the maternity workforce and increasing the visibility of the maternity safeguarding team. With the successful completion of the secondment and the improvements in the service being noted internally and externally, the Deputy Named Midwife role will become permanent in quarter one of 2024-25.

3.5 Team Connect provide holistic care to vulnerable families in the community, in both the antenatal and postnatal periods. In addition to providing maternity care, the team work closely with other health care providers, Children's services and agencies supporting the family. The Maternity Support Worker (MSW) for the team provides bespoke parent preparation visits for families, and undertakes appropriate clinical work to support the team and families

3.6 The Senior Sister for Team Connect works closely with the Named Midwife for Safeguarding for continued improvement of the service and increased oversight of the safeguarding practices within the team. There are elements of cross- cover between roles at a management level in times of leave to ensure there is always an identified person to escalate and have oversight of safeguarding.

3.7 Team Connect caseloads saw an increase between May – September 2023, however have remained under the maximum caseloads expected from the team; there has been a gradual decline in caseloads and now remains at the optimum level, FIG 2.6. The Swale area continues to be consistently high across the year as was the case in 2022-2023.



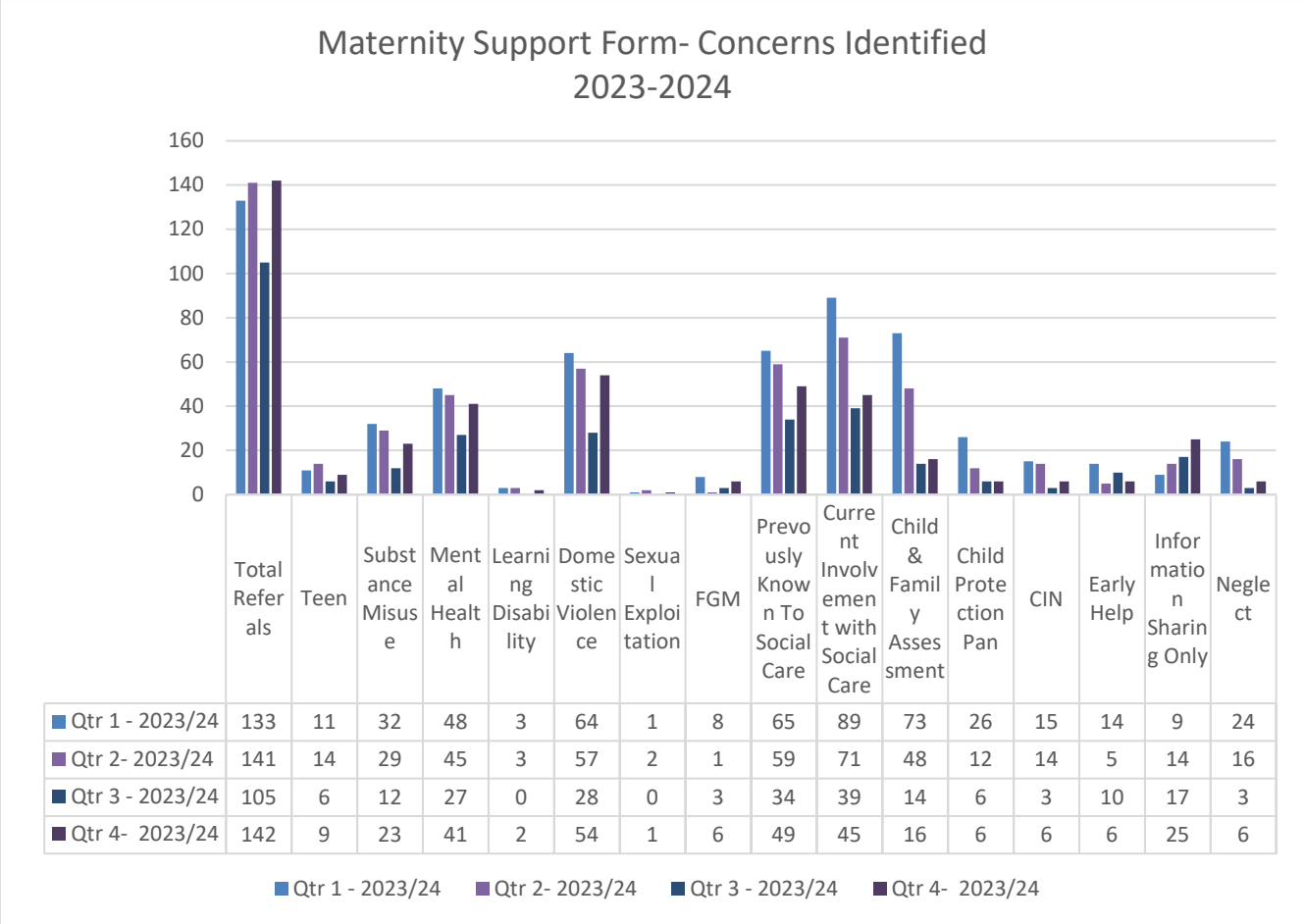
Maternity Safeguarding Activity

3.8 Maternity Support Forms (MSF), are used to clearly document safeguarding concerns or high-risk vulnerabilities, actions taken, and the plans agreed with the families and professionals.

3.9 MSF's are a communication tool between trust professionals, but also with external health agencies such as Health Visitors and General Practitioners (GP's).

3.10 The familiarity of the forms are also useful when sharing information between trusts if there is a transfer of care, for example. The forms allows for a reduction of delays in discharge due to clear plans being visible to staff to follow, it also ensures that professionals are aware of the concerns in all maternity areas to encourage professional curiosity and timely escalation of concerns. The forms allow data to be collected on the types of vulnerabilities we are supporting families with, and if there are any trends or significant areas of concerns to focus on.

3.11 The graph below shows the risks/concerns identified on MSF's over the period of 2023-2024 and is broken down into quarters for ease of comparison (please note that each individual MSF referred may have multiple concerns included):



	Total Referals	Teen	Substance Misuse	Mental Health	Learning Disability	Domestic Violence	Sexual Exploitation	FGM	Previously Known To Social Care	Current Involvement with Social Care	Child & Family Assesment	Child Protection Pan	CIN	Early Help	Information Sharing Only	Neglect
Qtr 1 - 2023/24	133	11	32	48	3	64	1	8	65	89	73	26	15	14	9	24
Qtr 2- 2023/24	141	14	29	45	3	57	2	1	59	71	48	12	14	5	14	16
Qtr 3 - 2023/24	105	6	12	27	0	28	0	3	34	39	14	6	3	10	17	3
Qtr 4- 2023/24	142	9	23	41	2	54	1	6	49	45	16	6	6	6	25	6

3.12 There have been 521 MSF's raised in 2023/2024, in comparison to 346 for the previous year, which is a 50.58% increase. The increase in MSF's could reflect the increase in safeguarding activity across maternity and / or an improvement in identifying concerns and understanding the purpose of the form.

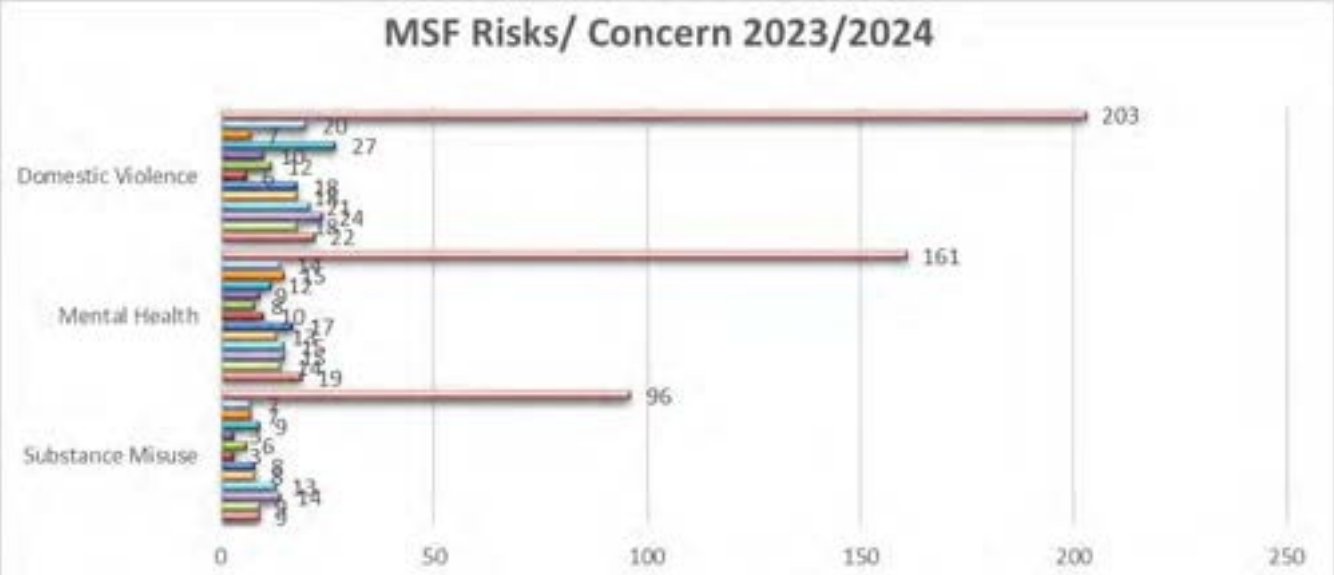
3.13 There has been additional training given to all community maternity teams who hold the responsibility of commencing and updating the MSF's, in relation to appropriate documentation and effective care planning.

3.14 The Named Midwife for Safeguarding has implemented a MSF Template for all midwives to use so that updates are unified in approach and are clearer to read and understand. It is worth noting that all MSF's are reviewed by the Maternity Safeguarding team to ensure that the MSF's are being used appropriately, as we do not want to lose the meaning of the form or its impact by having unnecessary forms raised.

3.15 The highest areas of concerns identified remains as:

- Family's previously known to social care,
- Current Involvement with Social care
- Child and Family assessment.

Outside of involvement with social services however, the three key areas of concern are Domestic Abuse, Mental Health concerns and Substance Misuse.



	Substance Misuse	Mental Health	Domestic Violence
Grand Total	96	161	203
Mar-24	7	14	20
Feb-24	7	15	7
Jan-24	9	12	27
Dec-23	3	9	10
Nov-23	6	8	12
Oct-23	3	10	6
Sep-23	8	17	18
Aug-23	8	13	18
Jul-23	13	15	21
Jun-23	14	15	24
May-23	9	14	18
Apr-23	9	19	22

Grand Total Mar-24 Feb-24 Jan-24 Dec-23 Nov-23 Oct-23
Sep-23 Aug-23 Jul-23 Jun-23 May-23 Apr-23

3.16 Kent and Medway have historically been known as a high prevalence area for Domestic Abuse; in the previous annual report, it was identified that Kent and Medway were second only to Staffordshire for the highest reported incidences of domestic abuse in the UK (Elkin, 2022). Unfortunately, due to an incomplete national data set for the period of 2023/24 comparative data is not available for the purpose of this report.

3.17 There have been 203 families identified with Domestic Abuse as a concern in 2023/24 in comparison to 165 families in 2022/23, which is a 23% increase. To ensure maternity staff are appropriately trained to identify, understand and support families where domestic abuse is a factor, it is included in both Adult and

Children Level 3 Mandatory Safeguarding Training, as well as essential skills maternity specific training. Maternity have a close working relationship with the Hospital Independent Domestic Violence advisors (HIDVA), who are able to support both staff and service users and have provided bespoke training and increased visibility to maternity staff both in the hospital and community settings. This level of training and support will need to continue to ensure a robust and safe service is provided, and to encourage multi-agency working.

3.18 In relation to mental health complexities, this could be for either parent, and not just for the pregnant person. This year has seen 161 families with mental health as a concerning factor which is an increase from last year's 141, this is a 14.18% increase. The specialist mental health maternity team, Team Lotus, take responsibility for the oversight of the care planning for families with mental health complexities and also attend the Maternity Safeguarding HUB's and Neonatal weekly safeguarding meeting to ensure specialist advice is shared with the Multi-disciplinary team to aid in care planning and improve communication between teams.

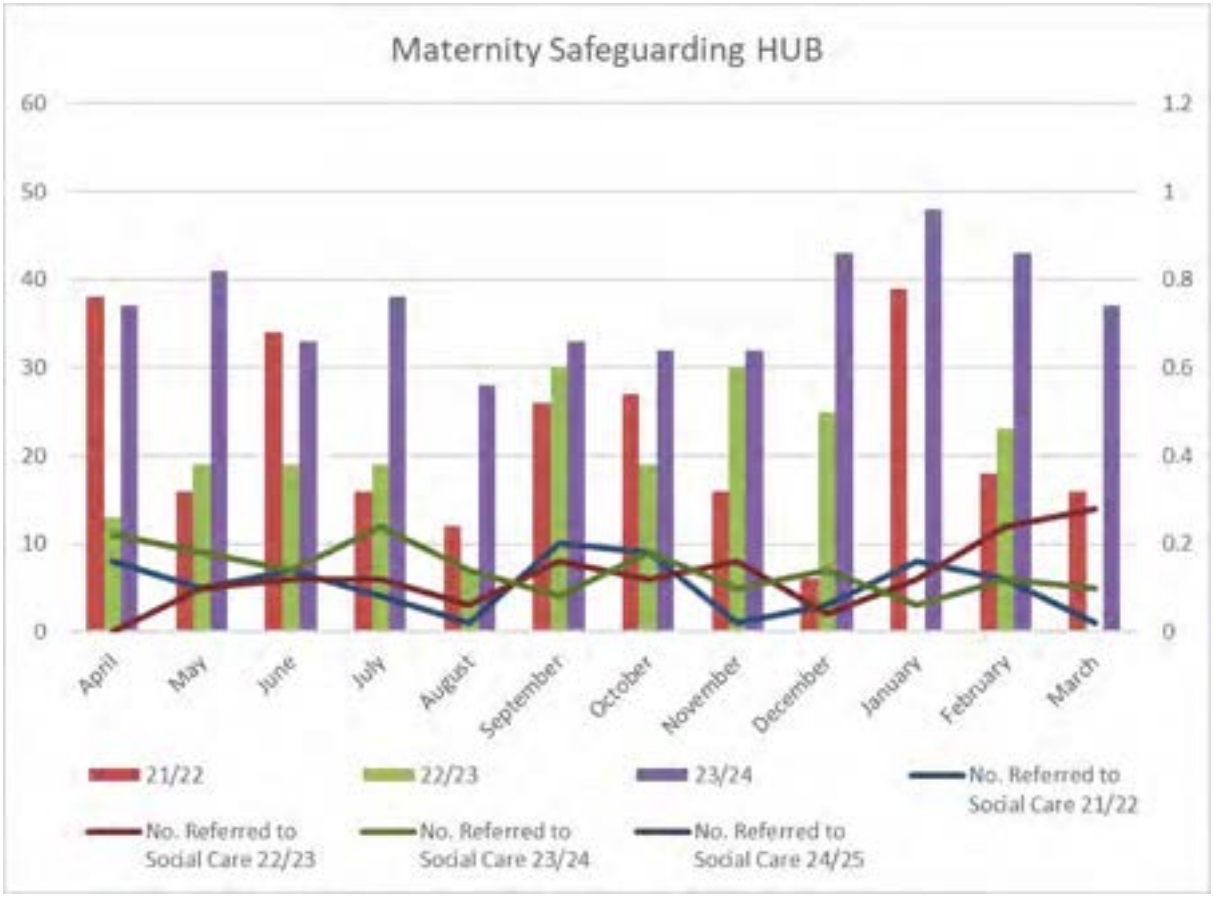
3.19 Joint working between the Maternity Safeguarding Team and Team Lotus is ongoing, and is crucial to ensure prompt and necessary early intervention and support.

Medway and Swale Maternity Safeguarding Hubs

3.20 The Named Midwife for Safeguarding chairs the monthly Safeguarding Hubs, and they are attended by: Social Care, Mental Health Specialist Midwives', Health Visiting, Early Help/Family Solutions, Domestic Abuse Services and Team Connect.

3.21 There have been 445 families referred to the Maternity Safeguarding HUB (including both Medway and Swale), in 2023/2024; In comparison to 204 heard the previous year. This is a 118% increase in families heard. The most likely reason for this is due to a process change following concerns raised from a Local Child Safeguarding Practice Review (LCSPR). It was highlighted that the Named Midwife for Safeguarding has historically triaged the referrals received from community midwives to see if they were appropriate to be heard in this forum however, there was no set criteria to follow for this, and rather relied on professional judgement and curiosity. As a temporary measure, it was agreed that all referrals to hub would be heard with the exception of:

- The Named Midwife for Safeguarding assesses it meets the threshold for a direct social care referral
- Current social care input, in which case contact is made directly with the allocated social worker.
- There is no consent from the parents for the HUB. Further exploration and planning will take place directly between the Named Midwife for Safeguarding and the allocated community midwife



3.22 Collaborative working has taken place between the Named Midwife for Safeguarding and the Service Manager Single Point of Access (SPA) & MASH at Medway Council to review the terms of reference and the referral processes for the maternity safeguarding hub. This process has had oversight from both Medway and Swale Hub members, the Medway Safeguarding Children Partnership, Matron for Community and Community Senior Sisters. For both Medway and Swale a senior social worker has attended to review the content of HUB and make suggestions for what is working well and any improvements. We are currently awaiting final sign off from governance for the new terms of reference and referral forms created; once this is in place there will be very clear guidelines to follow for all members of hub as well as community midwives.

Did Not Attend (DNA) processes and audit

3.23 Learning identified from a number of LCSPR's highlighted a concern that maternity were not appropriately following our defaulters guideline and due to this there has been missed opportunities for professional curiosity, early intervention, and safeguarding practices to be followed.

3.24 A full DNA audit was completed this year for the period of 01st October 2022 – 30th September 2023 to investigate areas of compliance, improvement required

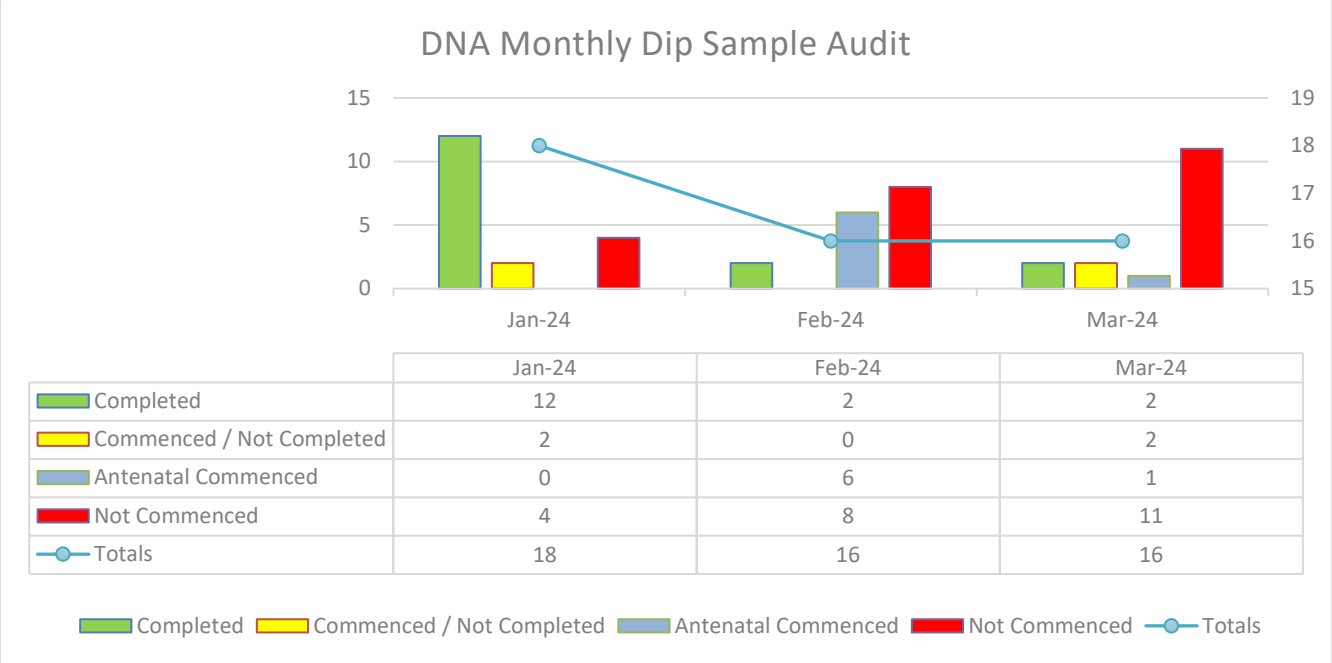
and ways to better support maternity staff to identify and support families who may need additional support.

3.25 The outcome of this audit demonstrated that that despite robust changes to the Defaulters Guideline and Missed contacts checklist during the audit period, compliance with this policy was still low with only 13% (of the 236) of services users requiring a Missed contacts checklist being completed in full, and 62% not commenced at all.

3.26 There were also concerns of the quality of documentation and the need for significant improvement in this area. Overall, it was identified that compliance with this policy was a practice issue rather than a process issue, and additional oversight from senior sisters and the maternity safeguarding team was required.

3.27 An action plan was created in agreement with senior maternity management. All actions have now been completed, there was a delay in the monthly audit due to high volumes of DNA's seen in maternity so a dip sample audit has been completed instead as this is more sustainable.

3.28 The last Q4 update showed that out of 50 service users requiring a Missed contact checklist, 46% had followed the Defaulters policy appropriately, 46% did not have the checklist commenced at all, and 8% had been commenced, but not completed at the point of discharge. There has been a marked improvement in the quality of documentation noted within the checklists and a slight increase in compliance with the policy; however, there is ongoing concern that these processes are not fully embedded in maternity practice yet and additional work and awareness is needed for the maternity teams.



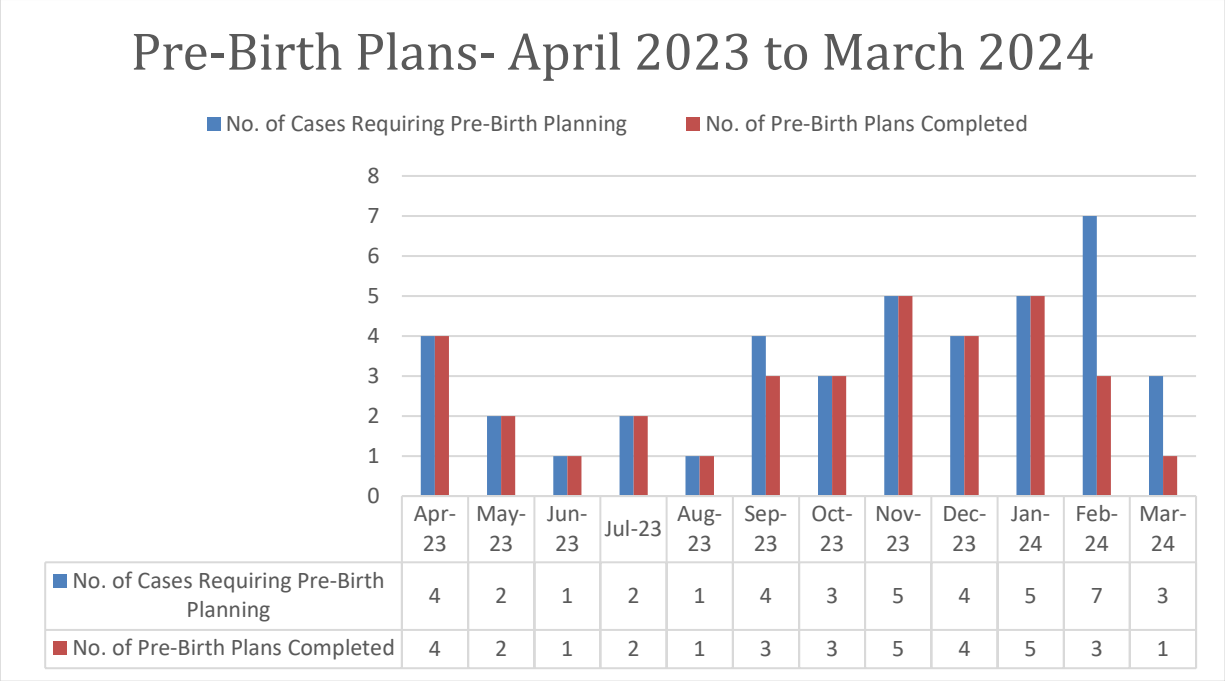
	Jan-24	Feb-24	Mar-24
Completed	12	2	2
Commenced / Not Completed	2	0	2
Antenatal Commenced	0	6	1
Not Commenced	4	8	11
Totals	18	16	16

Pre Birth Plans

3.29 Pre Birth planning is required for all CP cases within maternity. Pre Birth Planning Meetings are required to be held by 36 weeks gestation, or 34 weeks if they have factors for pre term delivery, and is led by the maternity teams.

3.30 In 2023/2024, 41 families required a pre-birth plan to be completed. The KPI for Pre Birth Plans is 100%, unfortunately there was only 82% compliance. Each month compliance is reviewed, and for any missed Pre-Births discussion is had with allocated Midwife and Senior sister. The reasons for those missed has been discussed with the teams involved- these include:

- Written safety plan and MSF update but no Pre Birth planning form used
- Delivery prior to 36 weeks
- Human error of not uploading the completed document
- Difficulties with contact with social care or social worker rearranging meeting date on multiple occasions
- One unborn was made subject to Child Protection Plan the day prior to delivery.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
No. of Cases Requiring Pre-Birth Planning	4	2	1	2	1	4	3	5	4	5	7	3
No. of Pre-Birth Plans Completed	4	2	1	2	1	3	3	5	4	5	3	1

Reduction in Length of Stay

3.31 Reduction in length of stay for Maternity Safeguarding remains a high priority. Following an audit on length of stay in 2018, it was identified that this was an area for concern for families with complex social needs and the implementation of Team Connect was to support in the reduction of this.

3.32 Following a re-audit in 2021, and implementation of Team Connect, the length of stay for these families has been reduced, with minimal delay for discharge. The audit in 2021 demonstrated that the average length of stay for CP/CIN cases had reduced to 2 days, and for those that were awaiting court the average length of stay was 4 days.

3.33 Although Reduction in Length of Stay has not been re-audit yet, it has been noted that due to working with multiple local authorities there can be times were there is a delay in discharge due to the local authorities not following the same processes or understanding the Trust's position on length of stay. To manage this the Named Midwife for Safeguarding has been working with a Team Leader within Kent Children's services to review the process so that a guideline can be agreed upon between services to improve the processes for both Maternity and the local authority supporting the family.

3.34 The aim is to reduce delays in discharge, improve service user experience, and reduce unnecessary anxiety or distress for families. The new guidance is due to be presented by the Named Midwife for Safeguarding at a regional local authority meeting for final consultation and feedback prior to being agreed within our trust governance processes. Once this is complete, the same process will be completed with Medway Children's services to ensure that the two local authorities are working similarly alongside us.

3.35 For families not on a child protection plan, clear discharge instructions are added to the maternity support form at 36 weeks gestation, which is reviewed by the Named Midwife for Safeguarding via supervision and upon receipt of the MSF. Length of stay is due to be re-audited in 2024.

4 LEARNING DISABILITIES

4.1 The role of the Learning Disability nurse service at Medway NHS Foundation Trust has developed over the years to support safe and high quality healthcare and treatment outcomes for people with learning disabilities accessing all Trust departments.

4.2 The issues around patients with learning disabilities in the secondary care setting and the adjustments that may be needed are often complex with regular input required from the learning disability/autism nurses to support high quality patient experiences.

4.3 Activity throughout the year has remained high. The table below represents the liaison time the nurses spend with patients in supporting the patient.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Number of Patients LD Nurse made aware of per month	21	51	56	56	46	63	38	40	36	32	39	41	**519**
How many Patient visits by LD Nurse	8	40	86	84	73	76	48	121	143	132	128	114	**1053**
Number of Patients Seen for the First Time by LD Nurse	9	28	25	22	18	17	15	15	16	8	18	18	**209**
Number of Patients seen without a Learning Disability	5	8	3	5	4	8	8	9	10	5	5	5	**75**
Time spent Liaising	34:30	82:15	132:15	141:45	125:00	141:30	76:30	130:15	145:20	145:00	120:55	112:55	**1388:10**

4.4 The Learning Disability nurses hold a caseload of inpatients as well as tracking those attending the Emergency Department with as required presence at outpatient appointments. We provide face-to-face assessment of a wide range of cognitive disabilities including genetic syndromes, dual diagnosis, physical disability, adapted communication and challenging behaviour management. We also support with best interests/decision making, advocacy support, mental capacity assessments, patient safeguarding, access to PALS/complaints and discharge planning/liaison with community services in coordination with the hospital Discharge Team.

Reason for Learning Disability Support	Total

Best Interest Meeting	**18**
Discharge Planning	**20**
Initial Review	**142**
Multidisciplinary Meeting	**1**
Other Meeting	**20**
Request for Advice	**48**
Request to attend – by carers	**4**
Request to attend – by family	**1**
Request to attend – by ward staff	**24**
Patient Review	**73**
Patient Support - Blood Test	**6**
Patient Support - Clinic Appointment	**55**
Patient Support - PALS/Complaint	**9**
Patient Support - Procedure	**50**
Patient Support - Reasonable Adjustments	**4**
Patient Support - Scan	**18**
Patient Support - Surgery	**7**
Total	**500**

4.5 Referrals are accepted via EPR, telephone or email. The Trusts **electronic patients records system** (EPR) has a digital flag (yellow warning symbol) which when clicked will display 'learning disability and/or autism spectrum'.

4.6 People with a learning disabilities and autistic spectrum needs experience significant health inequalities compared to the general population. These health inequalities are not associated with their learning disability or autism and can be addressed with reasonable adjustments to health services to enable equitable access, significantly improving their experience of care.

4.7 The **Oliver McGowan Mandatory Training** has been rolled out at pace in the Trust to raise awareness of health inequalities and adjustments among all NHS staff. Current completion across MFT stands at 3,700 for all staff grades and is increasing monthly. In addition, face to face LD/Autism awareness training is also presented to overseas new starter Nurses and for new medical cohort students.

4.8 '**Reasonable adjustments'** (Equality Act 2010) are expected to be made for patients with LD/Autism spectrum needs and their immediate family/carers when accessing Trust services.

4.9 In practice this will include paid and non-paid/family carers being allowed to stay in departments and wards as long as required including overnight. The Trust should provide bedside recliner chairs for rest/sleep, bedding, refreshments and carers cards allowing access to Trust hospitality services.

4.10 Carer cards were introduced April 2024 for food & drinks refreshments for parents/carers from the staff canteen if they miss the ward dining times.

4.11 Other reasonable adjustments used by Trust staff to support our patients this year have included extended out-patient clinic appointments, provision of side rooms and *Namaste* practitioner activities to support.

4.12 Learning Disability nursing in conjunction with the therapy dogs has helped to reduce anxiety. We have seen successful outcomes of procedures including scans, surgery, blood tests and preventing hospital admissions in the Emergency Department during the last year. The use of the dogs has enabled many patients with learning disabilities to successfully have procedures, tests or scans.

4.13 Theatres scheduling actively supports the provision of a '**1st on the list'** surgery approach as well as a **VIP** planning and treatment pathway for patients who require multiple procedures which can all be completed while under one sedation episode.

4.14 There have been a number of successful VIP patients this year who have undergone multiple procedures in one theatre under the same anaesthetic in order to reduce stress to the patient.

4.15 To prepare for such activity, often desensitising care is facilitated prior to the procedure. The LD nurses will liaise with the departments involved and the carers to arrange visits beforehand. At these visits supported by the LD nurses, they will be shown the area they will go to, meet some of the staff and become familiar with some of the equipment. In some cases the patient have been given some items to take home to get used to a mask over the face for example.

4.16 The imaging department and CT have been particularly supportive of such measures and have allowed the patient to spend time watching how the CT scanner works and therefore becoming calmer when the procedure is commenced.

4.17 Patient held **Learning Disability Hospital Passports** and Autism Passports are actively encouraged to be used as communications aids, these documents contain critical information including diagnoses, treatment protocols, behavioural guidelines, emergency medications, like/dislikes, eating/drinking/swallowing guidelines, seizure management, key contacts, care plans, medication lists etc. Hospital passports are widely recognised across the Trust as a means of evidencing recognised need.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Number of Patient's with Hospital Passport	13	32	30	35	32	45	22	22	18	18	17	14	**298**
Number of Patient's without Hospital Passport	8	17	20	21	13	14	13	17	16	13	15	21	**188**
Number of Patient's offered a Hospital Passport	0	2	0	1	0	0	1	3	3	3	2	6	**21**

4.18 Each patient is assessed as to whether one is already in existence or needs to be supported with one. These are available on the intranet for staff to print off as required.

Learning from Deaths.

4.19 The LeDeR programme is a national service improvement programme looking at the lives and deaths of people with a learning disability and autism. The programme aims to improve care, reduce health inequalities and prevent premature mortality.

4.20 Whenever a person with LD/Autism passes away a referral is made to the LeDeR programme by the hospital Learning Disability/Autism Nurses who will then participate in subsequent enquiries and reports by the LeDeR investigators.

4.21 Kent & Medway specific local LeDeR learnings include:

- GP's to complete annual health checks to a better quality.
- Cancer screening (Learning Disability nurses support with bowel screening & breast screening process at MFT)
- Improve documentation of TEP's/DNACPR (Learning Disability nurses have been completing audit on this subject to identify gaps, working with the deputy medical director & the resuscitation team to embed learnings)

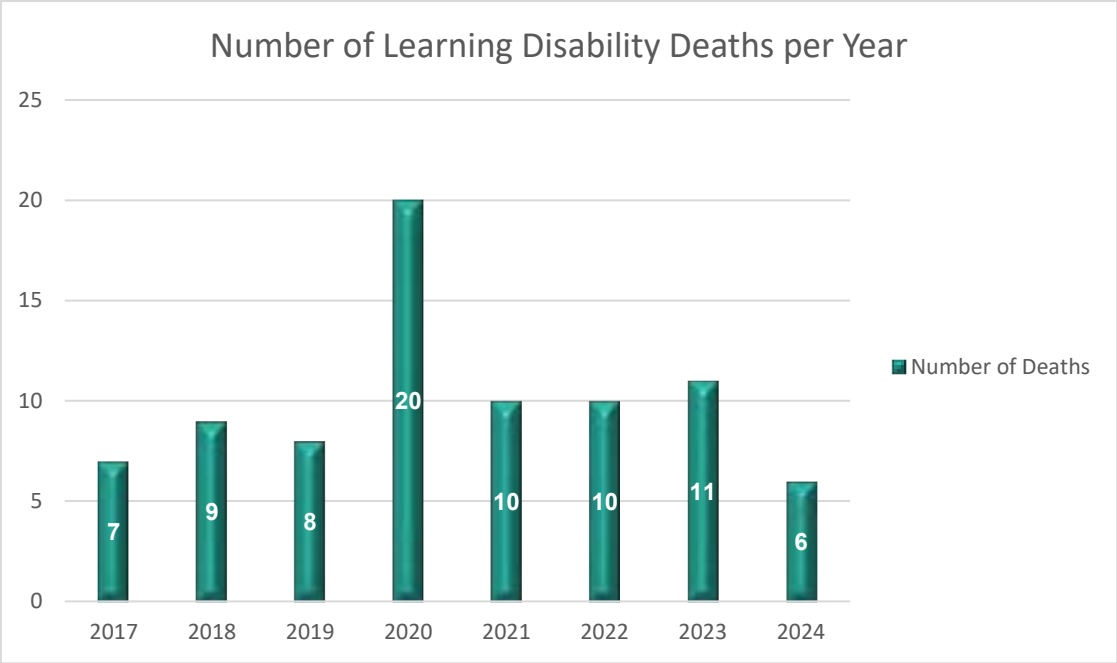
4.22 Some National learning outcomes of LeDeR reviews also include:

- Raising awareness regarding Stopping over medication of people with a learning disability autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the over medication of people with a learning disability, autism.
- Ask Listen Do complaints process – this is also highlighted in the national improvement standards audit.
- Reasonable adjustments through digital flagging.

4.23 An improvement plan is being developed to add the learning to the outcome of the national audit.

4.24 **Structured Judgement Reviews** are completed as an automatic procedure following the death of a learning disabled/autism spectrum patient. Such reviews with reflect on the 'patient journey' in order to highlight both strengths and weaknesses in the treatment pathway.

4.25 There have been 10 learning disability deaths in the past financial year the graph below demonstrates the annual numbers of LD deaths however this data is collated in calendar year.



4.26 The most common cause of death was pneumonia which accounted for 7 on these deaths. There were 2 aspiration pneumonia, 1 hospital acquired, 1 community acquired and 3 non specified pneumonia given as cause of death.

One patient had metastatic bowel cancer.

Audits

4.27 The improvement standards were launched in 2018 by NHS Improvement to ensure the provision of high quality, personalised and safe care from the NHS for the estimated 950,000 adults and 300,000 children with learning disabilities as well as the 440,000 adults and 120,000 children with autism across England. These standards were designed together with people with learning disabilities, autistic people, family members, carers and health professionals, to drive rapid and substantial improvements to patient experiences and equity of care. The NHS Long Term Plan, published in 2019, pledged that over the next five years, the national learning disability improvement standards will be implemented by all services funded by the NHS to ensure people with learning disabilities and/or autistic people can receive high quality, personalised and safe care when they use the NHS

4.28 The team participated in the 6th annual National NHS England Learning Disability Improvement Standards audit which commenced in October 2023 focussing on 2022-2023 data.

4.29 The Audit is undertaken in 3 parts

- Organisational data collection
- Staff Surveys
- Patient surveys

4.30 The four improvement standards against which trust performance is measured cover: 1. Respecting and protecting rights 2. Inclusion and engagement 3. Workforce 4. Specialist learning disability services

4.31 The audit closed at the end of January and is awaiting the reporting.

4.32 The National Team are now going to close the audit to LD providers and focus on Acute Hospital Trusts going forwards due to inconsistencies nationally in the standards being met.

4.33 The year 5 audit (2021-22 data) changed from the previous year in that it doubled the number of patent and staff surveys.

4.34 Trusts were supplied with 100 multiple choice paper surveys to distribute to service users, which could then be returned anonymously to a third-party provider via freepost. The staff survey was carried out online, with each trust receiving a unique URL link to distribute to up to 100 members of staff who had supported patients with a learning disability and/or autism.

4.35 200 organisations participated with 132 being Acute provider organisations.

4.36 Some of the standards we have not been able to meet across the 6 years of these audits are around Learning Disability specific data regarding waiting lists, complaints, incidents and Board oversight and monitoring of specific LD data. These will feature in the learning disability improvement plan going forwards.

5 MENTAL CAPACITY

Liberty protection Safeguards

5.1 On 5 April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, will be delayed “beyond the life of this Parliament” (therefore likely beyond Autumn 2024).

5.2 In the meantime, the Deprivation of Liberty Safeguards (DoLS) remain an important system for authorising deprivations of liberty, therefore, it is vital that the Trust continues to make applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack capacity are protected.

5.3 In order to identify and improve service and enhance care quality an MCA improvement plan was launched and is updated and reported through the safeguarding governance process.

5.4 There are x3 Risks on the Trust risk register in relation to MCA / DoLS that are updated on a monthly basis given their rating of risk level ‘high’. Those relating to the implementation of LPS have been closed for now.

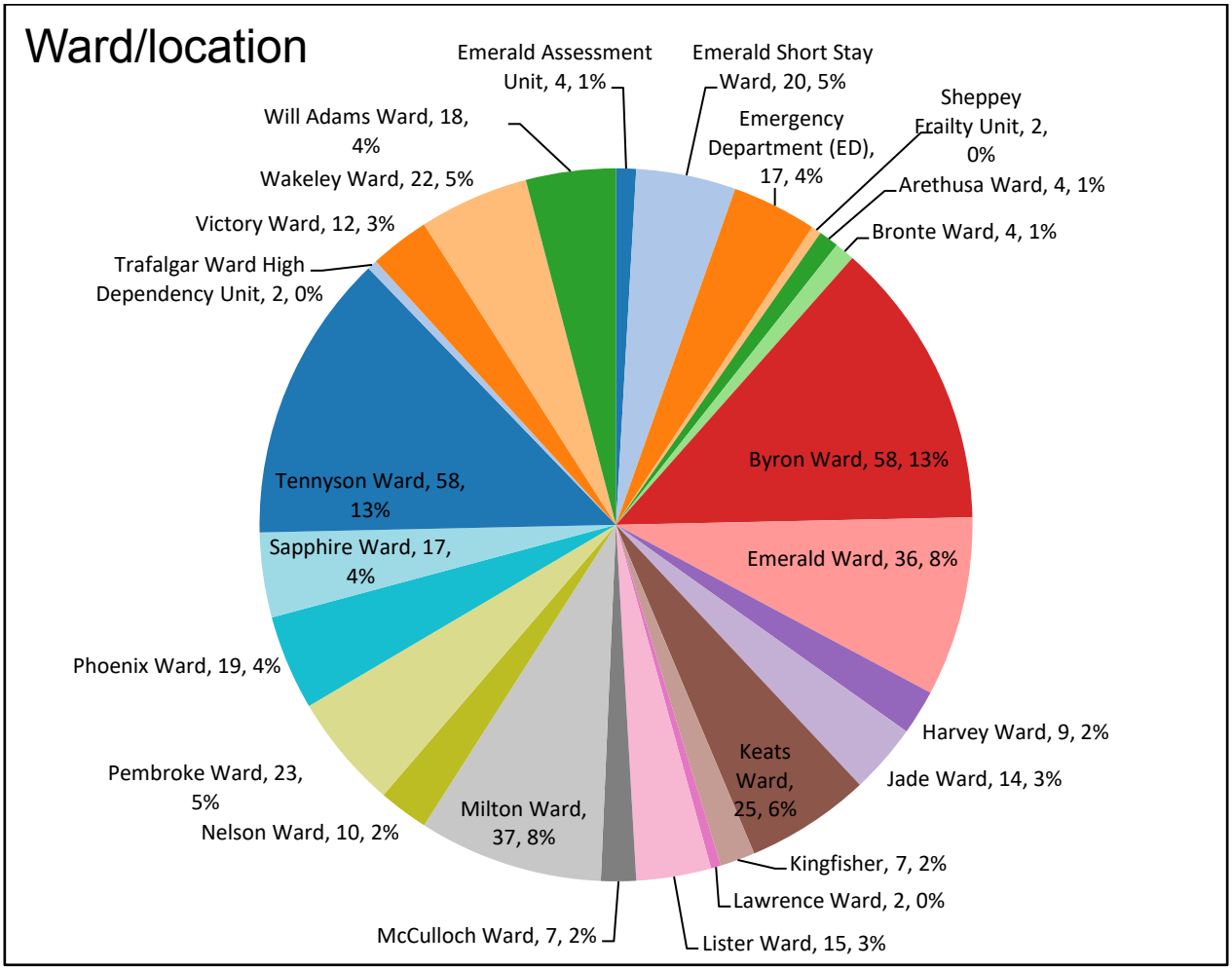
5.5 The MCA Policy (Ref:CORP-SAG-HANB-1) was updated to incorporate both policy and standard operating procedure in Quarter 3.

MCA Audits

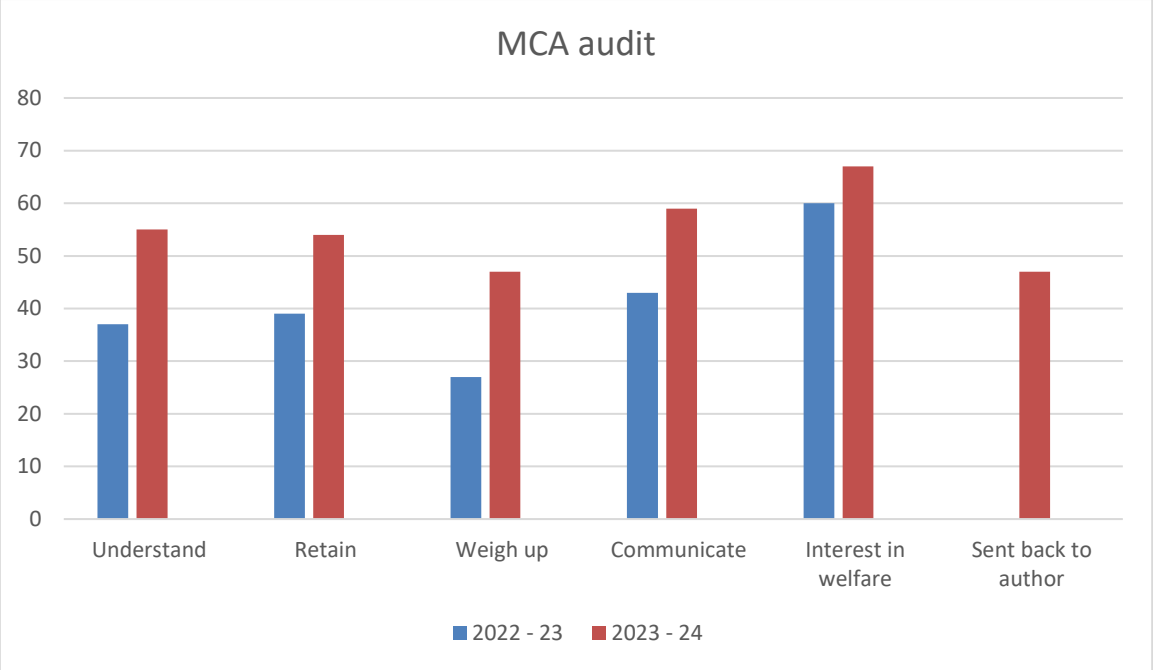
5.6 Approximately 50% of MCA assessments submitted in conjunction for Deprivation of Liberty Safeguards (DoLS) are audited for quality.

5.7 Given that the functional test serves to determine as to whether an individual has the ability to make a specific decision this area is scrutinised and sent back to authors for additional information as and when necessary. Authors are always given constructive feedback on how to improve their documentation going forwards, this field was added to the audit part way through the year therefore there is not yet a whole years' worth of data.

5.8 442 MCAAs were audited 2023 – 2024; a slight decrease on year 2022 – 2023 owing to a slight decrease in DoLS applications. The majority of these were from expected areas; frailty and elderly medicine.



5.9 Comparative data with 2022-23 and 2023-24 shows an increase in compliance around all aspects of the functional test, which demonstrates that the MCA is becoming further embedded within practice; it is a good measure of practice against standards.



5.10 There is still some evidence of practitioners using old toolkits that has not been captured by the audit, which is suggestive that toolkits are stored and copied and pasted to save time.

5.11 Whilst the MCA does not necessarily define best interests the best interest principle states that any action taken for a person that lacks capacity should be made in their best interest. This person is usually a person handling day to day decisions; it is therefore positive to see an increase on those with an interest in a person's welfare being contacted.

5.12 This increase in all areas of the audit can be attributed in part to the raised profile of the MCA lead nurse on the wards, attendance at ward and Band 7 meetings and supplementary workshops that are offered on a monthly basis throughout the Trust, which help professionals consolidate their learning from the mandatory training.

5.13 Competencies around undertaking MCA assessments are being considered in conjunction with the practice development nurses who have recently complied a nursing core competency booklet.

5.14 A better understanding of the Act could improve outcomes for those that lack capacity to make a decision therefore given the audit results and the mandatory training compliance the MCA lead nurse has introduced workshops that helps practitioners undertake an effective MCAA.

Independent Mental Capacity Advocate (IMCA)

5.15 The local IMCA service Libra, initiated a duty IMCA to be based at the hospital one day per week supported by the safeguarding team.

5.16 The aim of this support was to increase referrals for Long Term Accommodation decisions (LTA), Serious Medical Treatment decisions (SMT), Safeguarding referrals (Care Act) and those subject to a DoLS.

5.17 Furthermore this would upskill and support professionals, working collaboratively with Trust MCA Lead to create and maintain a 'visible' presence in the hospital.

5.18 She undertakes visits to identified wards, ICU and other areas to raise profile of IMCA service and supports referrals by signposting to the website/referral form and to alternatives if the referral is not appropriate.

5.19 The service provider did not start formally recording contacts until August 2023, however, whilst the number of enquiries remains relatively low with between 2 – 6 contacts monthly; 47 since August 2023, the networking and development opportunities for the placed advocate cannot be underestimated and the placement of the advocate results in a timely response to referrals.

MCA Training

5.20 The Trust workforce systems teams are responsible for maintaining employee service records: all training is uploaded to this system and reported on both internally and externally on a monthly basis by way of performance reports.

5.21 52 face-to-face training classes were undertaken throughout the year, some of which were bespoke at request. There is also an eLearning option available to staff.

5.22 From the 1898 spaces offered 1138 spaces were actually taken up equating to 60% uptake across the year. Most places were booked and therefore the DNA rate prevented others from booking. This is consistent with other training offered by the Trust.

5.23 Training spaces are booked up quickly but attendance can be problematic especially during times of the Trust being in business continuity. The clerical team have been supporting the MCA lead nurse by sending reminders to candidates 48 hours prior to training. This has had a positive impact given that training uptake was 55%-year end 2022 – 2023.

5.24 Given that the compliance remains lower than the KPI 85% this has been added to the Trust risk register: Reference number 1515 with the risk being reviewed on a monthly basis.

5.25 Supplementary monthly workshops are offered as a result of the audit and are advertised via ESR, paper flyers, email, social media and word of mouth. The MCA lead has identified areas requiring more support and offered bespoke workshops across the year.

5.26 The aim of the workshops is for staff to gain a clearer understanding of the MCA, to ensure that practitioners are working within legal guidelines and to be able to

confidently undertake assessment, apply the Acid Test and apply DoLS as appropriate.

5.27 Given that this is not mandatory training it can be hard to fill the places. From the 181 places offered throughout the year 121 spaces were taken up: 69%.

Deprivation of Liberty (DoLS)

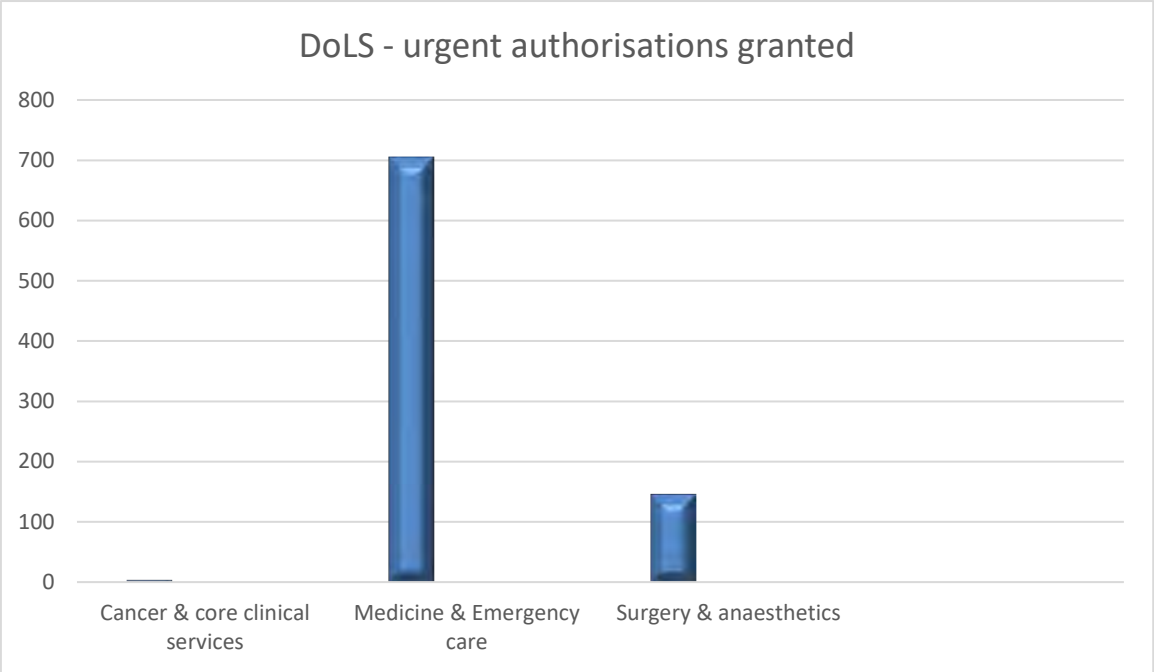
5.28 During 2023 – 2024 854 urgent DoLS authorisations were undertaken by the Trust, a slight decrease from 2022-23.

How Many DoLS Raised								
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Cancer and Core Clinical Services	0	3	8	6	4	4	0	4
Medicine and Emergency Care	243	339	389	553	831	996	738	708
Surgery and Anaesthetics	111	279	213	287	236	211	214	149
Total for All Divisions	354	621	610	846	1071	1211	952	861

5.29 Due to the unusual decrease in urgent authorisations and applications over the past 2 years, an audit in regards to the “Acid test”, arising from the Cheshire West judgement was introduced in July 2023. This is triangulated with the MCA implementation plan. Results for this period of time averaged out to 75% of those persons meeting the Acid test being safeguarded by a DoLS.

5.30 Results for this period of time averaged out to 75% of those persons meeting the Acid test were safeguarded by DoLS.

5.31 Due to ward moves and the restructure of the Divisions during the year it is difficult to provide a comparative table of data from the previous year.



5.32 Only six standard authorisations were granted by the relevant local authorities; a slight decrease from 9 year 2022 -23.

5.33 There were a total of 418 DoLS that breached the 14-day extension equating to 49% in the past year. This is a risk that is managed by both the Trust and the Local Authority and is reviewed month via the Trust risk register (Risk ID 1045).

5.34 One of the mechanisms in place to address this backlog is a triage type system employed by the local authorities as they allocate for standard authorisations on a weekly basis.

5.35 The MCA Lead nurse is in regular communication with both local authorities and will ask that they expedite standard authorisations for those patients that are unbefriended, those that are actively objecting to placement and those that are at risk of absconding.

5.36 To manage that risk at Trust level, a weekly report is sent to the wards; each one of those patients has an update on their electronic records informing all that are caring for them that the DoLS has breached, they do not need to renew it but need to continue to act in the patients best interests and inform the safeguarding team if the patients care or restrictions change.

Restraint

5.37 The team review all datix's daily to identify any incidents where restraints have taken place, this is to ensure the necessary safeguards are in place to protect the individual and to ensure the restraint applied

5.38 For the year end 23 -24 approximately 91 incidences of restraint in relation to 45 patients were identified. The majority of these incidences recorded were those whereby physical and or chemical restraint was used.

5.39 These may not be the only patients restrained as these are the case that security have reported via Datix and not clinical staff.

5.40 For any patient that lacks mental capacity where a restraint has been applied involving chemical sedation or where the patients has exhibited challenging behaviour a follow up telephone call is made to the ward and the information is then shared with the appropriate local authority to enable them to consider expediting the standard authorisation during their triage process.

5.41 Patient groups that are reflected on this database include those that are under the influence of alcohol and / or substances, those with mental health concerns and those that lack capacity owing to an impairment of the mind or brain.

Challenges

5.42 Winter pressures have an impact on both mandatory and supplementary training.

5.43 The current bed crisis has given rise to challenges around those patients that are deprived of their liberty but were not yet admitted to a ward, remaining in ED or under corridor care.

5.44 The length of time to assess and authorise DOLs applications by the local authorities creates risk of detaining patients at risk without a legal framework in which to do so.

5.45 Implementation of EPR leading to a culture of copying and pasting information onto documents.

5.46 Lack of clear visibility of safeguarding / MCA entries on the electronic patient records and professionals not reading this information available to them and not understanding risks.

6 SAFEGUARDING ADULTS

Safeguarding

6.1 In 2023/24 there were 88 safeguarding referrals raised about care and treatment provided at the Trust.

Raised Against Care Group	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Acute and Emergency Medicine	2	0	0	1	0	5	1	3	1	4	5	6	**28**
Cancer and Access	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Frailty	5	3	4	2	3	2	2	2	2	2	1	1	**29**
Specialist Medicine	2	0	0	1	1	1	6	4	1	0	0	1	**17**
Surgical Services	0	3	2	0	1	2	0	1	1	2	1	0	**13**
Theatres and Anaesthesia	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total	**9**	**6**	**7**	**4**	**5**	**10**	**9**	**10**	**5**	**8**	**7**	**8**	**88**

6.2 Of those referrals, 32 outcomes have been reached by the local authority. This equates to 86% of the closures were closed at referral, no case to answer, not substantiated or inconclusive, leaving 14% as substantiated.

6.3 The referrals received were made under the following categories.

Category of Abuse Raised Against Trust - by Date Received	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Discriminatory	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Domestic Violence or Abuse	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Financial or Material	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Modern Slavery	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Neglect or Acts of Omission	8	4	6	4	4	7	5	9	4	7	6	8	**72**
Organisational or Institutional	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Physical	0	2	1	0	1	2	3	0	1	1	1	0	**12**
Psychological or Emotional	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Self-Neglect	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Sexual	1	0	0	0	0	0	0	1	0	0	0	0	**2**
Total	**9**	**6**	**7**	**4**	**5**	**10**	**9**	**10**	**5**	**8**	**7**	**8**	**88**

6.4 Neglect / Acts of omission being the most common safeguarding category raised (72), followed by Physical abuse (12).

6.5 The Trust completed 29 of these safeguarding referrals relating to concerns about the treatment and care received by patients. Demonstrating an open and transparent culture. These were predominantly for the following reasons:

1 delayed treatment

7 harm caused (i.e. fall to fracture, bruising)

3 missing persons

1 delayed nutrition

8 staff allegations

3 transfer of care

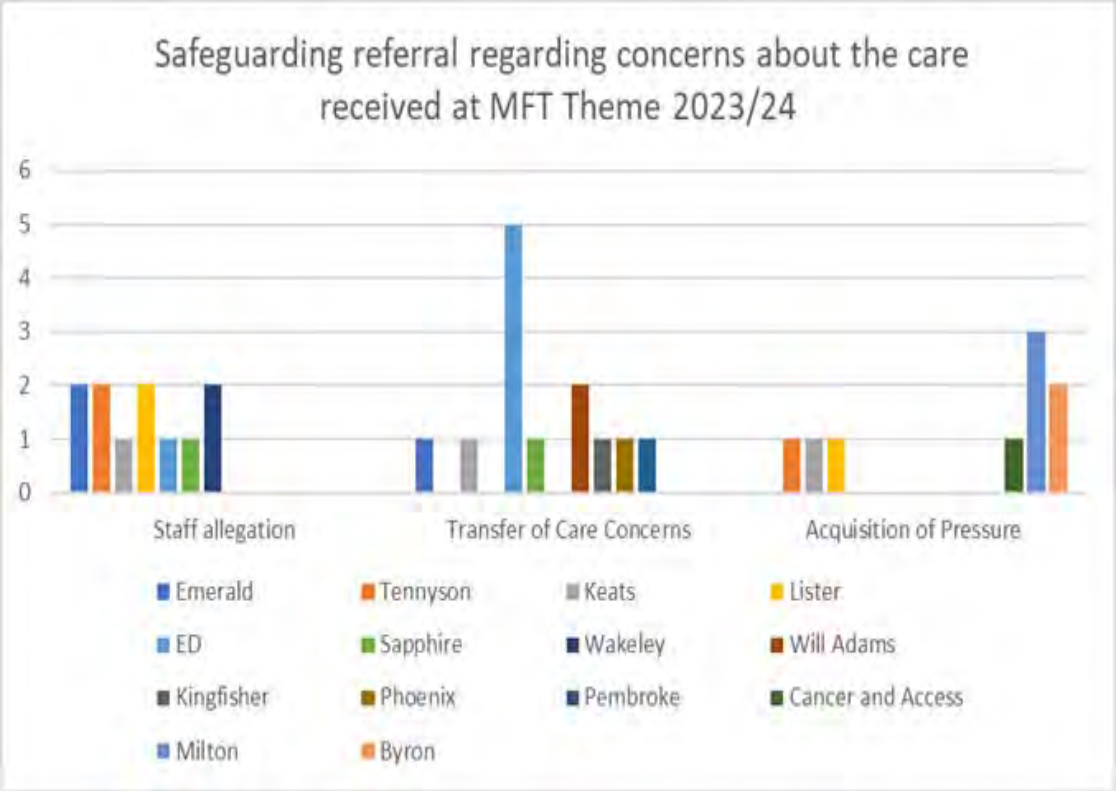
6.6 Outcomes and closures of safeguarding enquiries can take significant time for a number of reasons. Where a police investigation is ongoing the enquiry will remain open, when there is an internal investigation such as an SI or PSII the local authority will await the Trust sign off before reaching a conclusion and there is often drift and delay on both sides due to staffing continuity, competing priorities and volume of workload.

6.7 This has been recognised on both sides and as such a 6-8 weekly meeting is now held between the safeguarding team and the safeguarding lead at the local authority to reduce such delays.

Outcome - by Closure Date	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Closed at Referral	2	0	5	4	3	1	0	0	0	11	0	0	**26**
Inconclusive	1	0	1	0	1	0	3	0	0	2	0	0	**8**
No Case to Answer	1	0	0	0	0	0	0	0	0	0	0	3	**4**
Not Substantiated	0	0	5	4	0	1	3	0	0	4	0	0	**17**
Partially Substantiated	0	0	0	0	1	0	2	0	0	1	0	0	**4**
Substantiated	1	0	7	1	3	0	0	0	0	4	2	0	**18**
Total	**5**	**0**	**18**	**9**	**8**	**2**	**8**	**0**	**0**	**22**	**2**	**3**	**77**

It must be noted that the outcomes received above will not correspond with the concerns raised and may relate to safeguarding concerns from the previous year in many cases.

6.8 The three main identified themes for 2023/24 for safeguarding referrals made regarding care and treatment are staff allegation, transfer of care concerns and acquisition of pressure ulcers.



Transfer of Care Concerns

6.9 Of the 7 safeguarding concerns raised in relation to transfer of care concerns, this includes failed discharge, 3 were closed with no case to answers, 1 was substantiated and 3 remain open under investigation.

6.10 Safe discharge has been a theme in recent S44 Safeguarding Adult Reviews, “Brian” and “Thomas”, it was recognised that these individuals needed additional support for a safe discharge. They both has complex issues, mental health, drug misuse and homelessness. The team have connections with both Medway and Swale homelessness team. This is especially important when the patient is deemed to have capacity or leaving before treatment. If the patient leaves the department and there are concerns for safety the AWOL policy is followed and the police are contacted.

Safeguarding Allegations Against Staff

6.11 The Allegations policy was ratified in December 2023 and the policy is gradually becoming embedded across the organisation.

6.12 During 2023-24 there have been 13 staff allegations that reached the threshold for section 42 enquiry. Some of these are still under investigation with the police or professional bodies even if the staff no longer work at the Trust, others remain under our internal allegation process.

6.13 Some allegations against staff were raised about the conduct of agency staff working in the Trust which has led to us ensuring that the safer recruitment checks are robust with agencies used.

6.14 A deeper dive is currently being undertaken into safeguarding allegations against staff. This report will go through the safeguarding governance process for reporting once finalised.

Pressure Ulcers

6.15 Patients developing /acquiring pressure damage is often raised as Physical abuse and Neglect combined.

6.16 We have received 22 safeguarding referrals for patients that acquired pressure ulcers in our care. Of these 15 were raised by care homes on the patients discharge and 7 were raised internally.

6.17 2 of these have now been substantiated, 4 are awaiting social care decisions.

6.18 One patient had damage acquired due to lack of re-risk assessing which would have impacted on equipment provision and reposition schedule. There was a lack of documentation of repositions that also impacted the decline, alongside the patient deterioration in health.

6.19 The Pressure ulcers: safeguarding adults' protocol was withdrawn in June 2023 which Medway used as a reference to whether the pressure ulcer meets the safeguarding criteria. In the interim waiting for a new document the Tissue Viability Clinical Lead and safeguarding represented MFT at a multi-agency task and finish group for South East where they are designing new/revised toolkit. New government guidance has been now published Guidance: Pressure ulcers: how to safeguard adults (January 2024).

Safeguarding concerns raised about external care and support

6.20 There have been 2 dominant themes for safeguarding referrals raised externally to the Trust, these are Domestic Abuse and Self Neglect.

6.21 This supports that the staff have an awareness of self-neglect but the monthly audit of the safeguarding referral identified a lack of consultation with the hospital safeguarding team particularly where self-neglect referrals are being made.

6.22 Staff are referring directly into social care and the referral is closed as it is not necessary. In some cases when asked the patient accepts support and onward referrals, meaning an IDT referral is sufficient and a safeguarding referral is not required.

6.23 An audit of 13 referrals made by staff showed that 38.46% contained all of the relevant information required to meet the care act safeguarding criteria and only 30% of the referral identified if the patient could protect themselves from harm.

Domestic Abuse

6.24 We work closely with our Hospital Independent Domestic Violence Advisors to support staff and patients with concerns or disclosures made about domestic abuse. We recognise that domestic abuse impact the whole family and as such the team consider the victim, perpetrator, children and any vulnerable adults. The domestic abuse audit shows that staff are aware of their service and make referrals for their support.

6.25 We have requested data from Oasis Domestic Abuse Charity who are commissioned by the ICB to supply the domestic abuse service for the Trust. To date we have not received any data to demonstrate the value the HIDVA's make to supporting those experiencing domestic violence and abuse.

6.26 This missing data would provide a more comprehensive picture of the work the Trust is involved in on a daily basis as we work collaboratively with the HIDVA's. This has been escalated to the safeguarding designates at the ICB.

Domestic Homicide Reviews (DHR)

6.27 The safeguarding team have received 12 requests for research for Domestic Homicide Reviews during 2023-24.

6.28 Of these 1 was progressed to the Safeguarding Adults Board as a Section 44 Safeguarding Adults review (SAR), 3 Independent Management Reviews (IMR's) have been supplied as part of the reviews, 5 are being contributed to with 7 not known to the Trust.

6.29 A number of DHR's were already in progress from previous years, 2 of which are for publication early 2024-25.

6.30 DHR 38 will be published in June 2024 under the name of "Beth". This review began in 2020 which demonstrates the complexity of the process of these reviews. Actions for all agencies are:

- to provide guidance/training for staff regarding 'victim blaming' language, taking into account a trauma informed approach that seeks to understand the root of behaviours / distress and respond to the underlying trauma.
- to provide assurance (via a sample audit) that their staff are compliant with their most recent Domestic Abuse / Safeguarding policies
- to promote 'Making Safeguarding Personal' when working with service users and not looking at incidents in isolation; and that the potential for all types of domestic abuse is always explored when parents separate.

6.31 DHR 40 which commenced in 2021 was published in April 2024 known as Louise. Lessons identified in the review include:

- A different approach should be taken when dealing with alcohol dependent victims and perpetrators of domestic abuse, especially if they also have more complex needs such as mental health issues, general health issues or homelessness.
- Maintaining accurate and current records of information and intelligence is essential to inform decision making and to produce realistic risk assessments that deliver effective safeguarding measures.

6.32 DHR 39 commenced in 2020 and was published in January 2024 under the name Diana. This review identified 4 themes to learn from:

- Domestic Abuse and suicide link
- Multi agency working and information sharing

- Coercion and control (limits of physical barriers and risk of victim blaming.)
- Sub headings of Domestic Abuse – Economic abuse

Safeguarding Adult Reviews (SAR's) Section 44.

6.33 The team have raised 4 Section 44 SAR referrals to the Kent and Medway Safeguarding Adults Board this year. One of these did not progress to a SAR, one commenced as a discretionary SAR, one was progressed as a Health agency table top review and one awaits a decision by the SAR working group as to the type of review necessary.

6.34 We have received 23 requests for information for SAR's during the past year, this is in addition to a number of SAR's still in progress from 2022.

6.35 4 IMR's have been undertaken for the progression of some of these SAR's.

6.36 A number of SAR's have been published in the past 12 months, however the majority of those published did not involve MFT, however the identified learning is transferrable to other agencies and will form part of a new action plan of learning to be shared across the organisation.

Prevent

6.37 The Trust has raised 2 Prevent referrals in the past year.

6.38 The team have 63 had any requests for information from Dovetail (Channel panel) regarding young people and adults, which have been responded to in the time frame allocated.

6.39 We have ensured our quarterly returns to the Prevent duty data collection have been submitted in a timely way.

6.40 The current Prevent guideline has been re written to a Policy and is currently going through the governance process for approval.

7 SAFEGUARDING SUPERVISION

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6.1 Safeguarding supervision for staff that hold a Child Protection caseload is 100%. However, safeguarding supervision compliance for non-case holders has remained a challenge across the year. However, compliance in 2023/24 was 12%, in contrast to 35% currently. Although this is below the KPI of 85%, there has been ongoing work to support staff engagement, with supervision now included on the monthly paediatric training days. Furthermore, ChED staff are invited to attend these sessions to support compliance

6.2 Within the Neonatal Unit (NNU), the Neonatal Outreach team meet weekly with the Named Practitioner for Safeguarding Children and the Named Midwife for Safeguarding to discuss all babies who have been identified to have safeguarding concerns and are 100% compliant. However, the wider NNU members of staff have low compliance. There is currently liaison in progress regarding including supervision with the NNU training dates/team meetings

6.3 The weekly supervision meeting with the Children's Ward Matron, Managers and the Children's Mental Health Liaison Nurse, recommenced in May 2023. This is well attended and effective in providing supervision for children and young people that are on the ward. It also supports escalation and robust discharge planning.

6.4 In maternity safeguarding supervision is mandatory for all Child Protection case holders, with the statutory requirement of one session to be completed every quarter. The Named Midwife for Safeguarding completes supervision in maternity. Team Connect holds the majority of Child Protection cases, however there are some instances where the general community teams will have families open to a Child Protection plan due to concerns arising at a late gestation. In the year of 2023/2024, we have remained compliant with our statutory responsibility and achieved the KPI of 100% Safeguarding Supervision for all CP case holders

6.5 Due to the increase in safeguarding activity in maternity, the decision was made to increase supervision to two monthly, instead of three monthly. This increase in supervision allows for better oversight of complex cases, increased communication between the Named Midwife and Team Connect, and ensures compliance to our statutory requirements in periods of high activity.

6.6 We have seen recent changes to our Team Connect midwives, so to ensure additional support is provided new members of the team have monthly supervision for the first 6 months of their post.

6.7 For non-case holders in maternity, they are required to complete safeguarding supervision a minimum of twice per year, the uptake of this had been minimal and as such a targeted approach has been undertaken to focus on community midwifery teams.

6.8 There has now been an increase in compliance of over 50% of community senior sisters, midwives, and MSW's who have attended supervision

	Riverside	Castle	All Saints	Swale	Team Connect	Total
Non-Compliant	6	6	7	4	0	23
Compliant	8	9	7	10	6	40

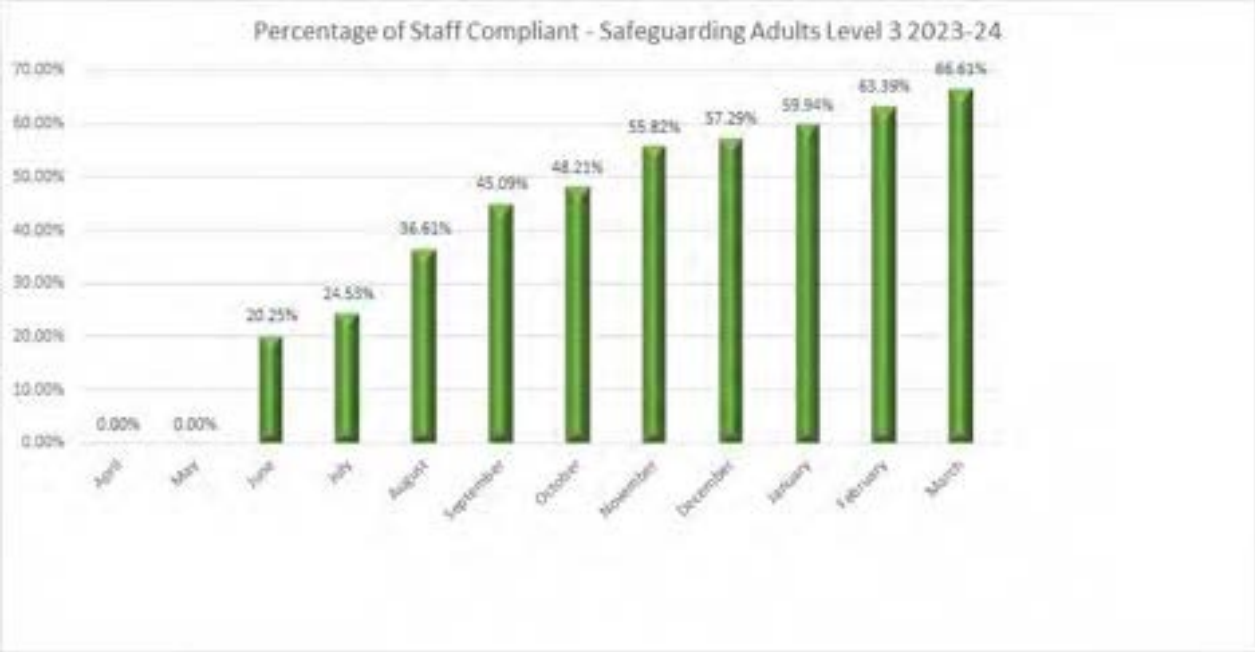
6.9 There have been a number of drop in sessions arranged for those who care for our adult patients. This has received a very poor attendance and participation. This has been stopped for the time being.

8 SAFEGUARDING TRAINING

8.1 The graph below shows the training subjects under safeguarding and Trust compliance by month. The red dotted line is the KPI of 85%

8.2 Following a Care Quality Commission (CQC) visit, it was identified that Maternity staff were not mapped to Adults Level 3 Safeguarding Training, as historically Maternity have been mapped to Children's Level 3 Safeguarding Training and only Level 2 for safeguarding adults training. It was explored that this would be beneficial for staff's understanding and for service user's safety that Midwives and Doctors were trained in both areas. Therefore, from March 2023 mapping was changed to reflect this.

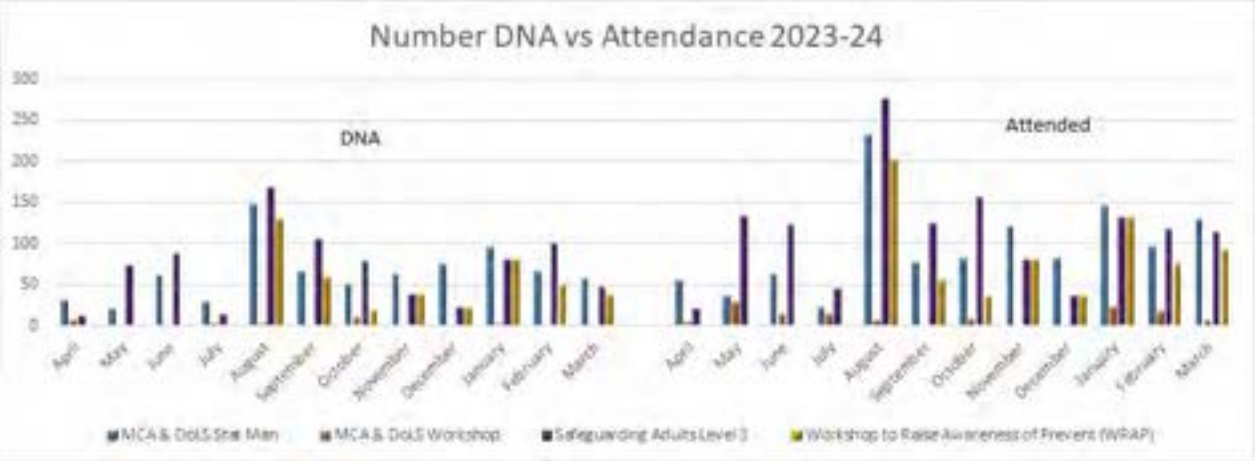
8.3 Safeguarding Adults level 3 compliance data was not available until June 2023 in workforce reports, however compliance has shown a steady increase.



8.4 All aspects of training compliance has posed a challenge within 2023/24. There have been several reasons that have compounded this. The main trigger for the downward trend in safeguarding children's level 3 has related to the remapping exercise undertaken by the safeguarding team with organisational development team. The mapping exercise identified that staff are mapped to a staff group and not a specific role. Therefore, it has been found that many staff have been mapped to levels that they do not require. Additionally, many staff remain mapped for more than one level.

8.5 Where a substantive staff member is also recruited in temporary staffing their overall compliance is affected to 2 different roles mapped.

8.6 Other challenges encountered by the team specifically relate to those staff who do not attend booked training. By booking and not cancelling other staff cannot book those spaces.



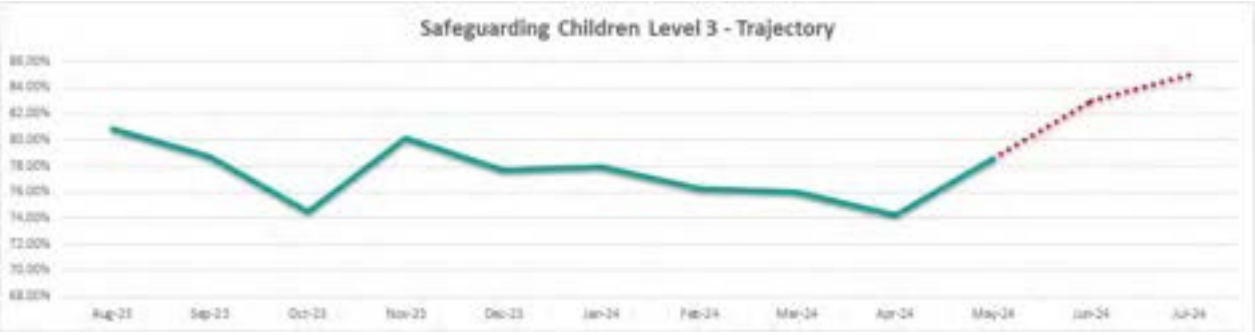
8.7 Mitigations in place now include reminders being sent to all those booked, managers being sent the list of booked staff in advance, all DNA's sent to managers following training.

8.8 Safeguarding children and safeguarding adult's level 1 and 2 are both on line as eLearning. Both level 3 subjects are face to face at present but can be completed partially on line. This is being reviewed for the coming year to see if there are other ways for staff to achieve compliance.

8.9 The down trend in safeguarding children level 3 compliance can be attributed to a number of factors. As a large cohort requiring level 3, Maternity have focused on compliance for safeguarding adults, which has meant that they have dropped from a historical compliance rate of approx. 95% to 81%. In addition to this the medics overall have low compliance, we believe that this is due to the return to full face to face training. Following the recent Children's HRG meeting, we have requested that the ESR team reinstate the e-learning for health online learning to support improved compliance. However, ChED are 100% compliant and the majority of our children's staff are above 85%.

8.10 The trajectory of 85% will be achieved by the end of July 2024. This is based on the current planned face to face training dates, including an average 30% DNA rate and the number of staff that are due to expire within that time frame. It does not include any online learning.

8.11 We have also identified a number of staff booked onto level 3 children's training that were not mapped. Following a review, over 100 staff members have been removed from 5 face to face sessions.



9 NEXT STEPS

8.1 To ensure that safeguarding training exceeds the KPI of 85% in all subjects by working with managers to support this.

8.2 Work with the EPR team to ensure that safeguarding and learning Disability notifications are highlighted to clinical staff accessing records.

8.3 Produce a Trust wide action plan of all learning identified in local reviews and work with the communications team on sharing the learning form reviews.

8.4 Share the learning through the safeguarding governance process from the National Learning Disability Standards audit.

8.5 Complete the 2024-25 Section 11 audit and the 2024-25 KMSAB Self-Assessment Framework identifying gaps on the Trust Safeguarding Board Assurance Framework.

8.6 Register for the 2024-25 Learning Disability National Learning Disability Standards Audit.

NHS
Medway
NHS Foundation Trust

Infection Prevention and Control Annual Report 2023-2024

Rod Harford-Rothwell
Head of IPC & Decontamination Lead

05 MAY 2023

Best of care
Best of people

Contents

Tables and figures

Glossary

Glossary Term	Meaning
IPC	Infection Prevention and Control
DIPC	Director of IPC
ADIPC	Associate Director of IPC
HoIPC	Head of IPC
IPCT	Infection Prevention and Control Team
BAF	Board Assurance Framework
DDoN	Divisional Director of Nursing
HoN	Head of Nursing
Gthr	Trust audit tool
PII	Period of increased incidence
POCC	Peri-op and Critical care
PIR	Post Infection Review
ICB	Integrated Care Board
AMS/AMR	Antimicrobial Stewardship/Resistance
AMSG	Antimicrobial Stewardship Group
GNBSI's	Gram negative bacteraemia Infections
PPE	Personal protective equipment
FFT	Friends and Family Test
RSV	Respiratory Syncytial Virus
SSIS	Surgical Site Infection Surveillance
SMART	Surgical, Medical and Acute Response Team
VHR	Very High Risk
HR	High Risk
UKHSA	United Kingdom Health Security Agency

1 DIRECTOR OF IPC INTRODUCTION

1.1 This annual report covers a summary record of all activities relating to practises in Infection Prevention and Control (IPC) at Medway NHS Foundation Trust during the period April 2023 – March 2024.

1.2 As Chief Nursing Officer and the Director of Infection Prevention and Control, it is a privilege and a proud moment to present Medway NHS Foundation Trust's Annual Infection Prevention and Control Report. The last year has continued to build on previous years improvements:

- Staff across the Trust work closely with the IPC Team to ensure that during the busy winter period IPC standards are consistently maintained to ensure patient safety and experience with clear processes for infection management embedded.
- Development of simulation training to support wards that have hospital acquired infections.
- Development of a MFT IPC Strategy.
- The first annual link practitioner showcase.
- Implementation of the National Standards of Healthcare Cleanliness across inpatient ward areas.
- Relaunching the FIT testing service managed by IPC team following a review of skill requirements
- The IPC team working as part of the Kent and Medway Hospital acquired Infection Collaborative

1.3 The report shows how the Trust continues to make improvements around IPC, and that it is still high on our agenda. Our challenges this year have been not meeting our targets around Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. diff). This was disappointing for us but we are comforted by the fact that a number of the infections, following thorough investigation, where identified as unavoidable. We continue to work hard to make sure we reduce infections which is a key part of keeping our patients safe and ensuring they have a positive experience while in our care.

Kind regards

Sarah

Sarah Vaux
Interim Chief Nursing Officer and Director of Infection Prevention and Control (IPC)
Medway NHS Foundation Trust

2 BACKGROUND

2.1 The code of practice for the prevention of infections, 2015 uses 10 criterion by which a registered provider will be monitored and judged on how it complies with the registration requirements placed upon them for cleanliness and infection control within an organisation.

2.2 The code, stipulates the importance of the Director of Infection Prevention and Control to regularly report to the board of directors. This includes the formation of an annual written report summarising the work undertaken by the IPCT over the year, reports on key IPC issues and progress around the Trust's annual Infection Prevention and Control (IPC) work programme.

2.3 The IPCT's annual work programme for 2023-24 was based on Health and Social Care Act 2008: *Code of Practice on the prevention and control of infections and related guidance* and would cover complete remit of the IPCT in controlling and managing infections throughout the Trust.

2.4 2023-24 was another challenging year for the Trust as we try to revert back to a business as usual model following the recent pandemic with the opening up of services, the stepping down the last remaining COVID restrictions and the re-education of staff

2.5 There was continued work on the IPC Board Assurance Framework (BAF) from last year which was then updated in May 2023 following an updated version being published.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Figure 1: Compliance Criterion of The Code of Practice on the prevention and control of infections and related guidance

3 THE IPC TEAM AND STRUCTURE

3.1 Delivery of Infection Prevention and Control sits within all departments and clinical services since it is fundamental to patient care. To enable this delivery, the Trust has an organisational structure which oversees required actions. These are outlined below in the trust governance structure and the IPC team reporting structure.

3.2

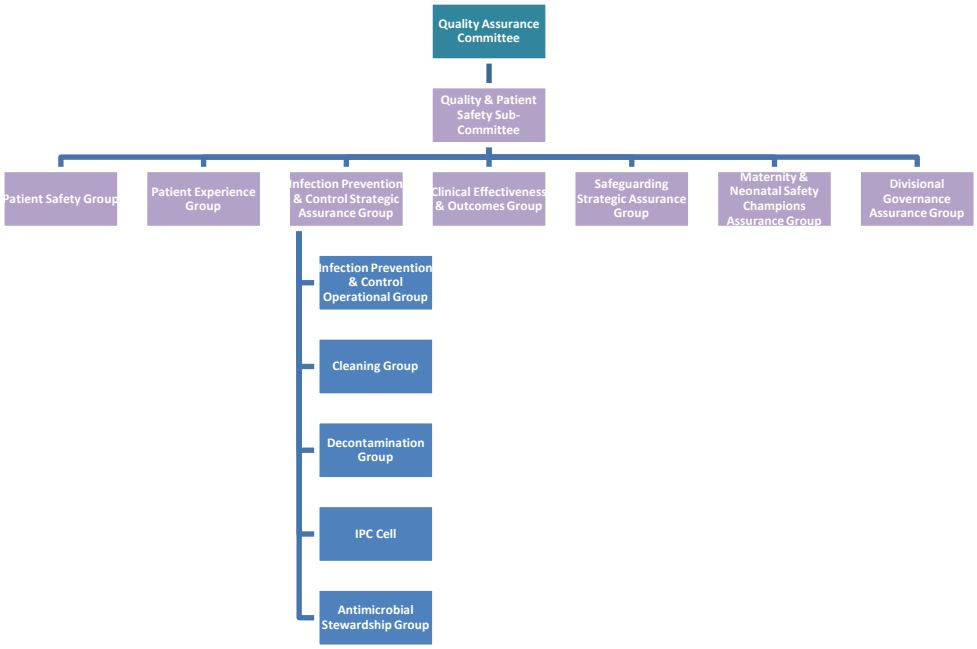


Figure 2 - Trust governance Structure

3.3

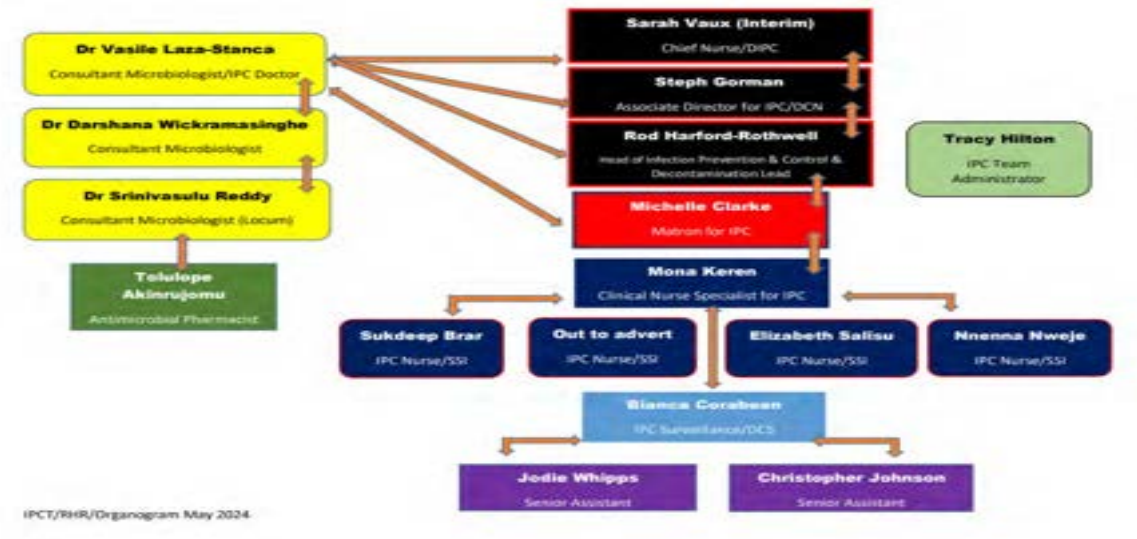


Figure 3 - The IPC team Structure

3.3 The team had been fully recruited into in early 2022-23 but following some internal promotions within the Trust opportunities presented for members of the team to act into more senior roles

3.4 With the promotion of the ADIPC to act as the Deputy Chief Nursing Officer in a dual role capacity created opportunities for some internal secondment placements. Firstly the previous Matron became the Head of Service, the IPCCNS to Matron, then IPC Nurse to IPCCNS with an outstanding vacancy currently out to advert.

3.5 IPC Team continued to expand and develop their knowledgebase by attending the courses listed below during 2023/24– Figure 4

Figure 4 – Continuous professional Development

Role	Course	Completion date
IPC Matron	Florence Nightingale Foundation IPC leadership	November 2023
	City & Guilds – Decontamination Leads Course	Completed 2023
IPC Clinical Specialist Practitioner	NHSE Fundamentals in IPC	Completed 2023
IPC Nurse	NHSE Fundamentals in IPC	Completed 2023
IPC Surveillance Nurse	MSc Infection Control	July 2024
IPC Nurses	IPC Conference – Birmingham	Completed 2023

3.6 The IPC Group (IPCG) name changed to become The IPC Strategic Assurance Group (IPCSAG) but continues to meet monthly with a slightly altered structure to reflect alternative reporting of full report or data reporting only. The change does not affect how it reports to the Quality and Patient Safety Sub-Committee (QPSS) chaired by the Chief Nursing Officer and the Chief Medical Officer. This then is reported to the Trust's Quality Assurance Committee (QAC).

3.7 Previously the IPC team had been split into two smaller teams to cover the different divisions within the Trust (Planned and Unplanned) but with the change in the organizational structure the team reunited offering the same level of support and guidance to all new 4 divisions.

3.8 Clinical audit of the care environment is a good indication of quality and all IPC audits are uploaded to the live data repository system, Gthr used by the Trust to capture and highlight good practice and where improvements are needed to help plan and guide additional resource. All wards have access to all their audit

information and reported on within their respective care groups and again at Trust level.

3.9 The IPC operational group (IPCOG) was developed from a need to have a better understanding of the issues facing ward leaders/|Matrons enabling them to understand their audit data better, identify themes and trends in an open forum sharing best practice through peer support helping to drive-up standards across the Trust to keep our patients safe whilst in our care. The IPCOG is always well attended and has proved a useful tool to engage staff. This group reports monthly to the IPCSAG.

3.10 The Antimicrobial Stewardship Group (AMSG) is chaired by a medical consultant and supported by a consultant microbiologist, the IPCT are frequent attenders and participants at these meetings but attendance not been consistent by care group members. A bi-monthly antimicrobial report presented at IPCSAG.

3.11 The decontamination group is chaired by the Head of IPC following successful completion of a City and Guilds Decontamination Leads course at Eastwood Park training centre. The Approved Engineer for Decontamination (AED) conducts annual audits on site offering assurance. The decontamination group was changed to reflect the incorporation of the cleaning group following implementation of the National Cleaning Standards of Healthcare Cleanliness and reports to the IPCSAG.

3.12 Following the relaunch of the water safety group a renewed focus on establishing all water safety requirements across the Trust and better reporting of issues has occurred. The appointment of an Approved Engineer for Water (AEW) has strengthened this group and reports back to the IPCSAG and the Health and Safety and Security Group (HSSG) and up to board level.

3.13 The relaunch of the Ventilation group has occurred following the need to re-look at the Trust's estate to ensure that current ventilation systems are adequate or where improvements can be made. Where no mechanical ventilation systems are in place the procurement of suitable air-flow systems can be discussed and effectively planned for. This group reports to the IPCSAG and the HSSG.

4 BOARD ASSURANCE FRAMEWORK

4.1 The Board Assurance Framework template was produced in June 2020 by NHSE/I to all NHS providers to help aid compliance with the Health and Social Care Act 2008, *Code of Practice* and compliance with the then national COVID-19 strategies, policies and guidelines.

4.2 Following several NHSE & Clinical Commissioning Group (CCG) now Integrated Care Board (ICB) visits in 2020/21 the DIPC had initiated and led on a collaborative discussion to combine the previous 4 previous improvement plans into one single plan aligning it to the BAF.

Originally 216 actions were identified within the Trust's 2021 IPC BAF improvement plan. This reduced to 145 actions by September 2023 and an action plan developed. 72% of the action plan is either completed or on track for completion and awaiting full implementation. There remains a continued improvement with closure of some outstanding actions. This leaves 24% overdue and 4% off-track.

Figure 5

4.3 The new improvement plan was agreed at IPCSAG and QPSS in May 2023 and an update report is presented bi-monthly at both of those groups as well as QAC..

4.4 The IPC Board Assurance Framework set the key lines of enquiry to measure compliance with the Health and Social Care Act 2008: the code of practice for prevention and control of infections.

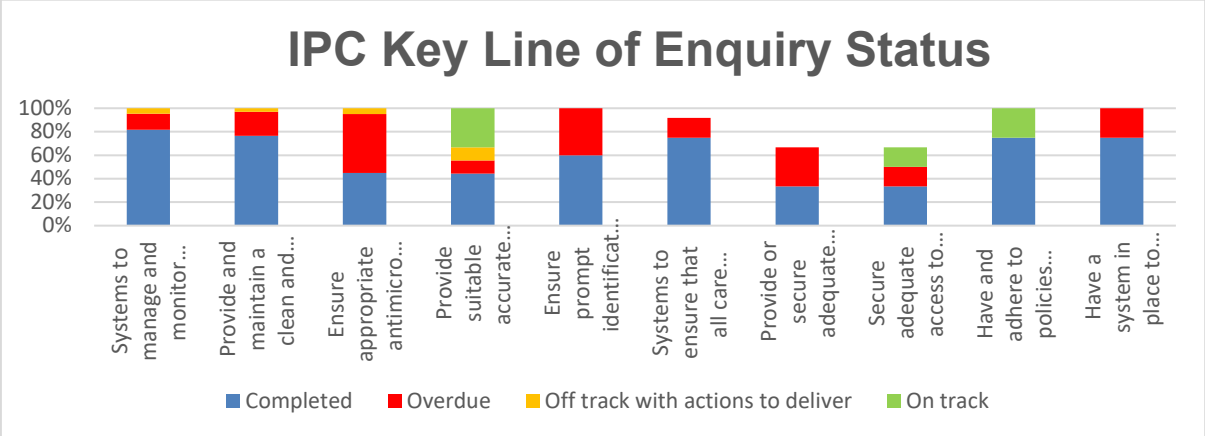


Figure 6

The report measures compliance against each of the 10 criterion which enables the action holders to see easily areas that need more focus to ensure completion. Figure 6

5 METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

5.1 Since April 2018, cases of MRSA bacteraemia have been reported by the time of infection onset versus the time of patient admission and apportioned by the UK Health and Safety Agency (UKHSA) HCAI Data Capture System (DCS)

- hospital-apportioned where the infection onset is >2 days after admission
- Community-apportioned where the infection onset / blood culture collection is < 2 days after admission

5.2 In 2023/2024 the Trust reported 4 cases of HOHA MRSA bacteraemia against a zero tolerance for any cases – figure 7. This was following 1 case the previous year.

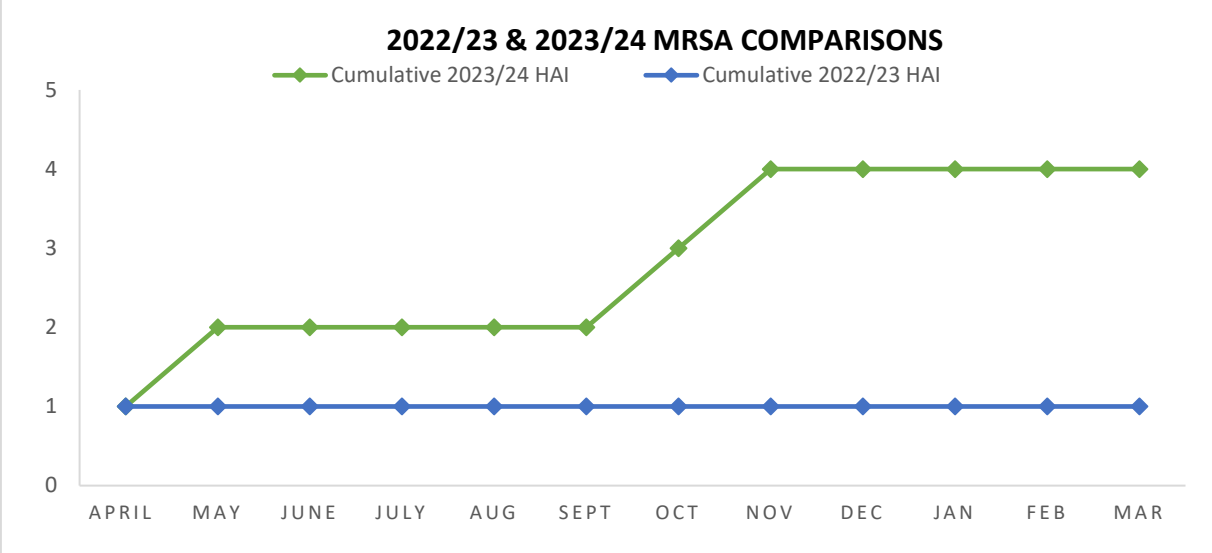


Figure 7

5.3 There was a COHA also reported in September 2023 which was difficult to determine attribution due to poor documentation in hospital for cannula management.

5.4 Root Cause Analysis (RCA) are in place for any MRSA bacteraemia to identify any gaps and lapses in care, any learning, good practice and understand the root cause identified to develop actions to mitigate repeat occurrences.

5.5 Contributory factors from the RCAs undertaken demonstrate that from the 4 cases factors were failure to check results; poor decolonisation therapy and 2 IV device related issues. All cases deemed avoidable and wards were placed on enhanced IPC interventions.

5.6 The IPC team have joined as part of the regional MRSA collaborative led by NHS England IPC team.

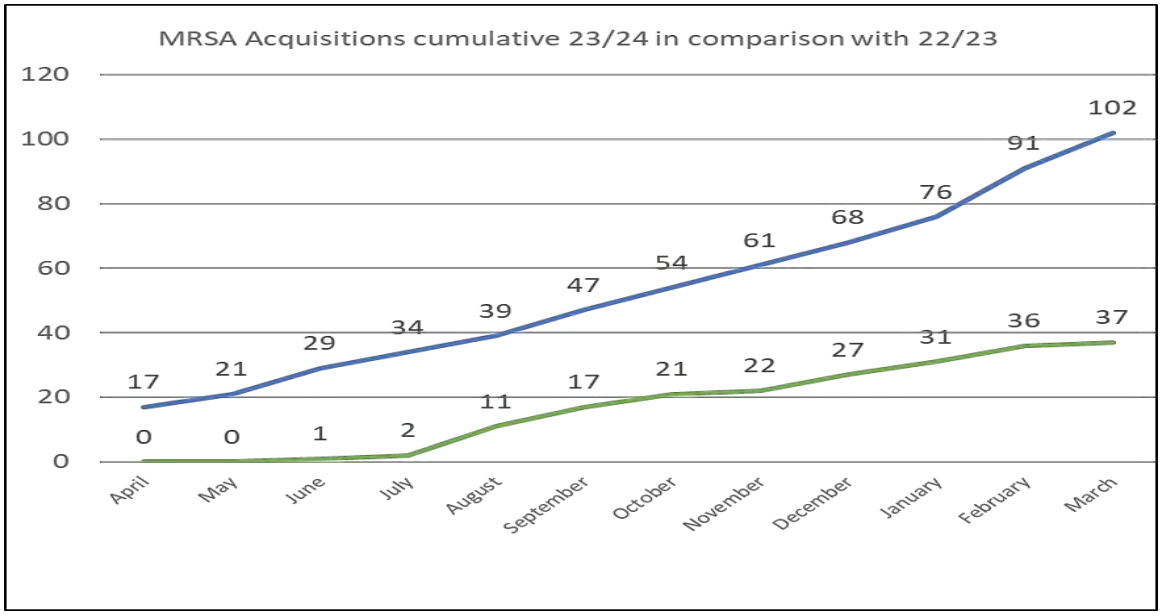
5.7 MRSA acquisitions, where MRSA is detected in patients on admission or through weekly screening, is recorded and overseen by the IPC team. Admission screening is usually swabbing of the nose and groin but should also include any wounds, cannula sites that look infected and pressure sores if identified at pre-assessment or triage in ED/SDEC. A urine sample should also be obtained from a catheter if also identified at time of admission.

5.8 There is no national reporting process regarding the acquisition of MRSA within the clinical areas therefore there is no national threshold set by NHSE.

5.9 MRSA acquisition equates to a near miss scenario for MRSA bacteraemias as acquisition increases the risk of developing a bacteraemia through poor hand hygiene compliance at the point of care (especially when managing invasive devices), incorrect use of Personal Protective Equipment (PPE) and cleanliness of equipment and the environment.

5.10 The Trust has not set any objectives for the reduction of MRSA acquisitions for 2023/24 but the IPC Team continue to monitor acquisition numbers and ward locations throughout the year.

5.11 The number of Hospital MRSA acquisitions has been collated across the year as cumulative – Figure 8



Data collected in 2023/24 will be compared in the forthcoming year to understand if any reductions can be made in acquisition or where increases in acquisition have been seen remedial actions undertaken. Wards that have 2 or more cases within a 28 rolling period will be placed on a Period of Increased Incidence (PII). This means that the clinical area is placed on enhanced monitoring with focused auditing and support from the IPC team with weekly visits and a targeted action plan developed.

5.12 The above table (figure 8) shows the increase in acquisitions 102 throughout the year and clearly surpassing 2022/23 levels at 37 cases. The majority of cases were found on routine nose and groin screening but the remainder for leg ulcer, conjunctiva and serous fluid collection.

5.11 The data collected has also enabled as to review the monitor the location of the acquisition as well as breaking it down for percentages by Division and then by care group. Figures 9, 10 and 11

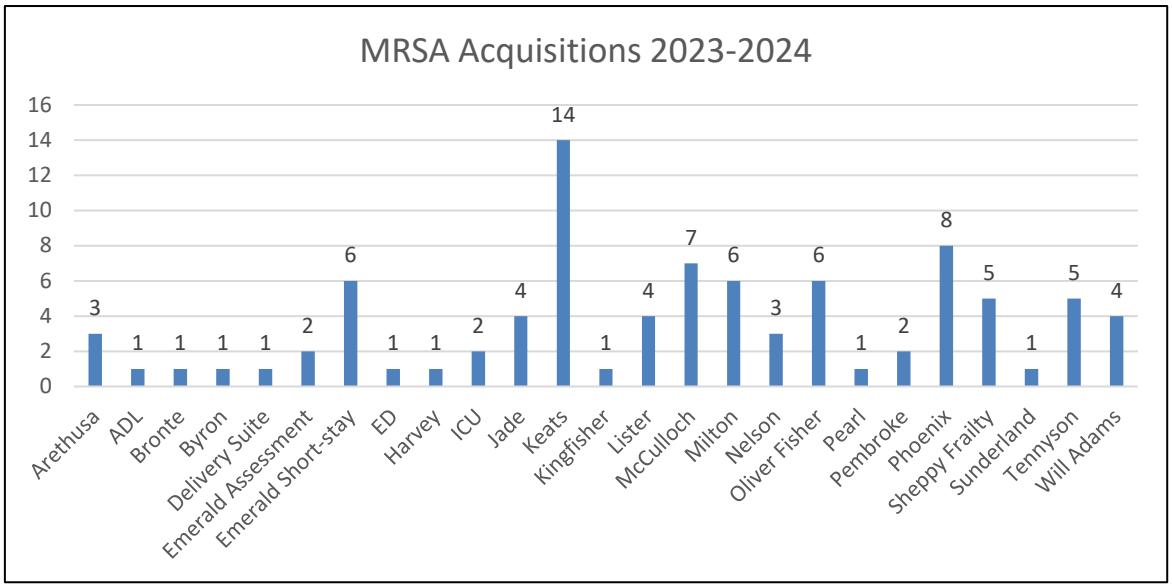
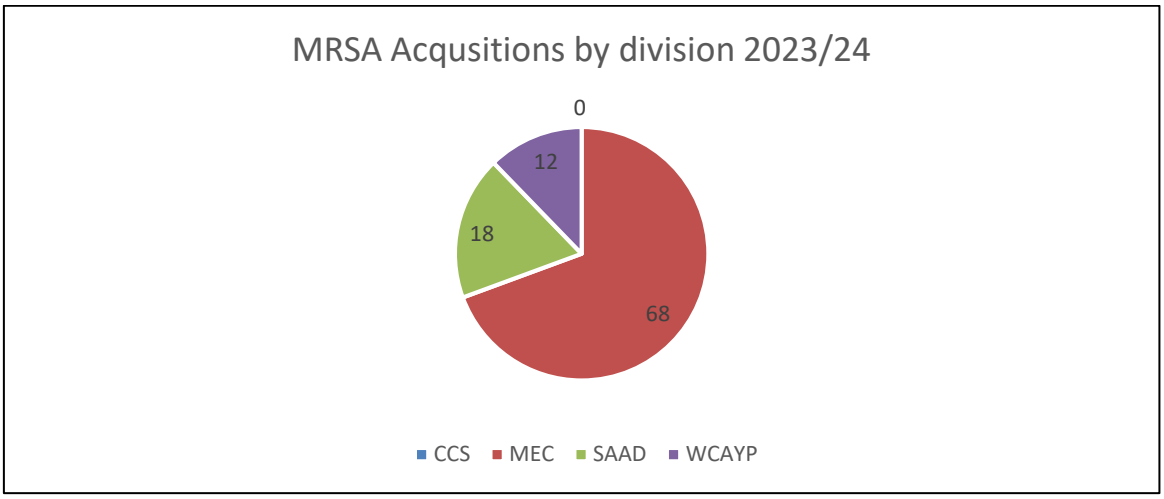


Figure 9 above shows the locations of the acquisitions by ward across the year 2023/24. The ward with the most acquisitions was Keats Ward and is related mainly to a period in April with multiple acquisitions which prompted an RCA. Learning from that review showed poor decolonisation therapy, a wandering patient who was positive who wasn't treated or isolated and general lack of understanding of management of MRSA acquisitions.

5.12 The table below (Figure 10) shows the percentage of acquisitions by divisions across the Trust



The highest number of acquisitions has occurred within the Medicine and Emergency Division (MEC) due nature of the services within that group Keats Ward and frailty bed base had the highest acquisition rate with no criteria to reside being cited and identified through weekly screening throughout their admission. The IPC team will continue to monitor the situation over the forthcoming year.

5.13 MRSA screening has been audited for the last year – All data is uploaded onto Gthr data repository system and discussed monthly at both IPC Operational group and IPCSAG meetings.

Below is the MRSA screening audit compliance for each division as compared to trust wide (figure 11). The new organisational structure was in place from October 2023

- **Cancer and Core Clinical Services (CCCS) - Division from October 2023**

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
-	-	-	-	-	-	No data	No data	71.6	No data	52.2	No data

- **Unplanned and Integrated Care/Medicine and Emergency Care (MEC)**

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
83.8	85.4	82.1	84.3	88.3	87.2	85.8	83	88.2	81.9	80.8	90.4

- **Planned Care/Surgery and Anaesthetics (SAA)**

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
81.7	71.8	70	88.1	86	86	79.1	81.6	74.7	83.6	90.4	84.2

- **Women, Children and Young People (WCYP)- Division from October 2023**

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
-	-	-	-	-	-	30	37.3	27.8	No data	30.8	38.5

- **Overall Trust Compliance Scores**

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
83.6	81.6	79.3	84.7	87.4	86.8	83.8	81	82.9	82.3	81.8	87.5

Throughout the year this 90% metric was not achieved until February by Surgery and Anaesthetics and March for Medicine and Emergency Care, but not met as a whole for overall Trust compliance. There is a review of the questions for WCYP division as they are non-compliant on questions about documentation and there is an action plan for CCCS to ensure completion of screening audit. The divisions continue to report to IPCSAG with an update on their data.

The IPC Operational Group continue to review the main issues for non-compliance around swabbing of wounds and IV devices. The IPC Team will further support continued education for all clinical areas assisted by IPC link practitioners.

6 METHICILLIN SENSITIVE STAPHYLOCOCCUS AUREUS (MSSA)

6.1 There is no national threshold for MSSA bacteraemias.

6.2 In 2023/24 the Trust reported 35 cases during this operational year. This was a increase of 5 cases on the previous year's total of 30 and the 2nd year of increase.

6.3 Figure 12 shows a comparison of MSSA infections for 2022/23 and 2023/24.

Year	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
22/23	2	8	9	10	12	16	17	20	26	27	29	30
23/24	2	5	12	14	15	17	20	24	25	29	32	35

6.4 A new review process for gram Negative Blood Stream Infections (GNBSI's) was introduced in November 2023 and this includes MSSA. This process is a rapid review of the case to identify themes, contributory factors and lesson for learning. This has then supported the development of the IPC Quality Improvement Plan which will be launched in 2024/25.

6.5 The IPC team expanded their PII process to include wards with any 2 acquisitions of a GNBSI including MSSA. This then generated intensive monitoring and further education through simulation training designed to cover the key themes and trends.

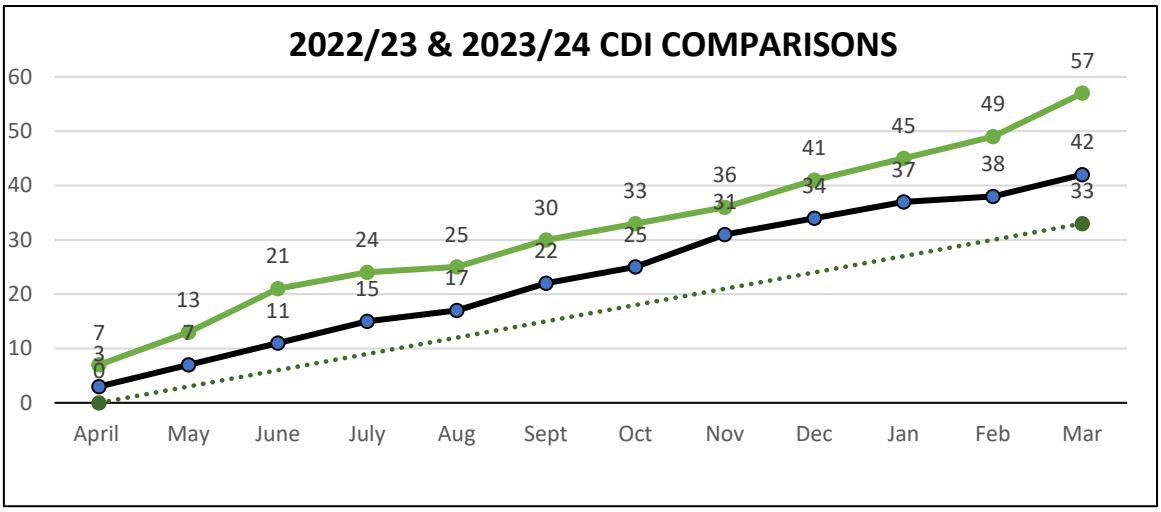
7 *CLOSTRIDIOIDES (CLOSTRIDIUM) DIFFICILE*

7.1 *Clostridioides.difficile* is classified under 3 headings.

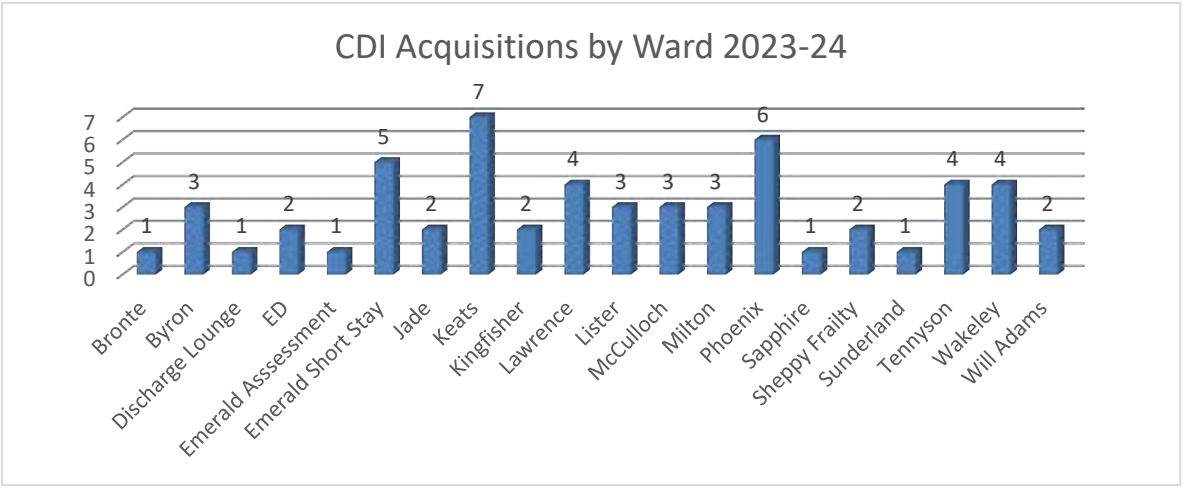
- **Hospital onset / healthcare associated (HOHA):** onset > 48 hours of admission. These cases are Trust-apportioned
- **Community onset / healthcare associated (COHA)**: cases that occur in the community (or within 2 days of admission) when the patient has been an in-patient in the previous 4 weeks. These cases are Trust-apportioned
- **Community onset, community associated (COCA)**: cases that occur in the community (or within 2 days of admission) when the patient has not been an inpatient in hospital in the previous 12 weeks. These cases are apportioned to the Integrated Care Board (ICB) formally the CCG.

7.2 From 2021/22 trust level thresholds include all healthcare associated cases (ie HOHA and COHA).

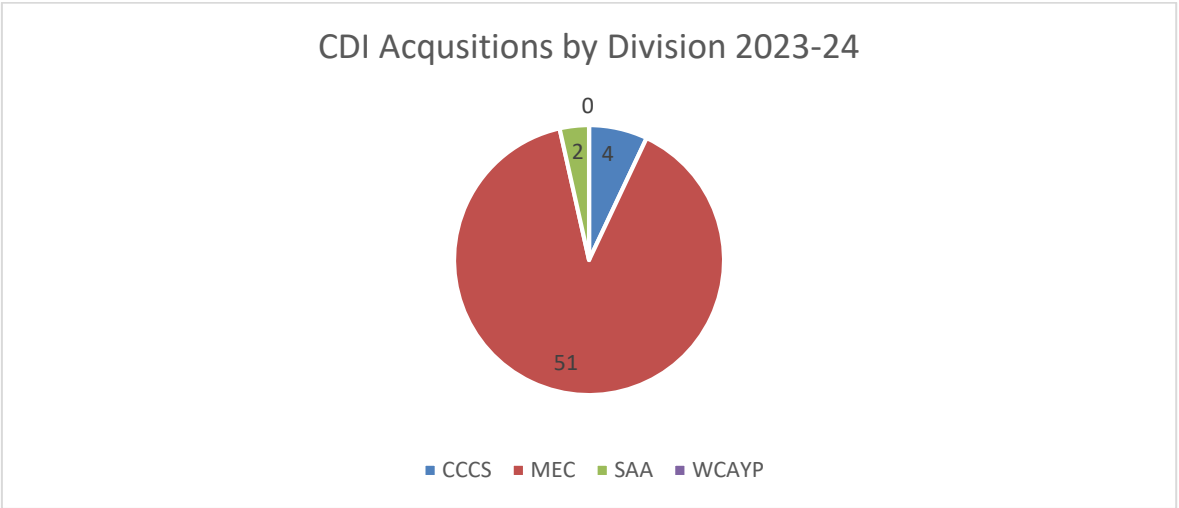
7.3 The Trusts tolerance for 2023/24 was 33 cases which was a reduction by 1 on the previous year. There has been a surge in hospital acquired infections in 2023/24 with many acute Trusts nationally breaching their thresholds. As you can see from the following graph the Trust breached the threshold in October 2023 – (figure 12)



7.4 Figure 13 shows the number of *C.difficile* by location.

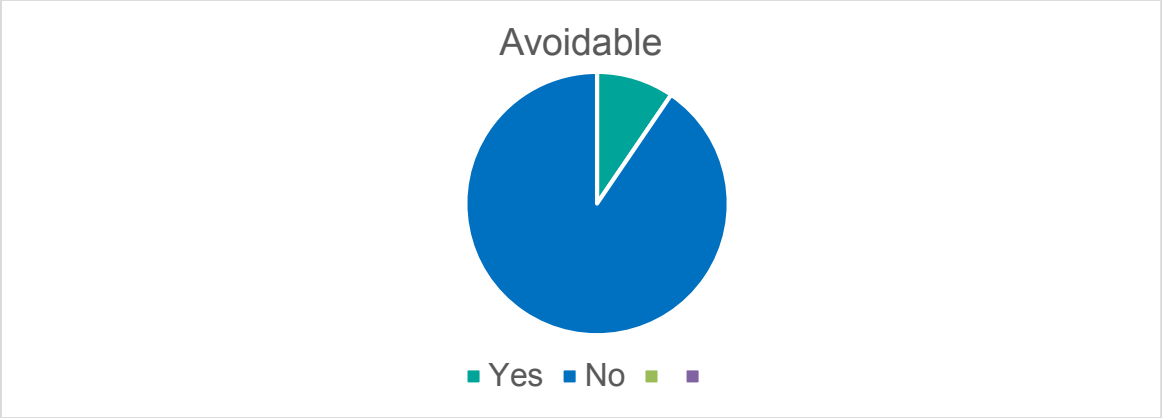


The table below (figure 14) shows the breakdown by division.



7.5 A Post Infection Review (PIR) is undertaken for all Trust apportioned *C.difficile* infections through a formal process. An invitation to attend the meeting goes to the ward manager, consultant overseeing the care, microbiology, matron, HoN, IPC team and ICB colleagues.

7.6 Following the completion of the PIR's for 23/24 only 4 of these cases were avoidable- Figure 15. This was due to inappropriate or incorrect antimicrobial use.



The remainder were unavoidable as these patients had complex medical or surgical issues with a need for antimicrobials.

7.7 Although the cases were largely unavoidable some lapses in care was established from case reviews which did not impact their positive result but will have led to discomfort, isolation and potentially extended lengths of stay. These have added to the actions within the IPC Quality Improvement Plan for 2024/25.

7.8 The most frequent lapses in care were to do with sampling, isolation, stool chart, treatment and antimicrobial duration or usage. With the exception of the 4 avoidable cases for inappropriate antimicrobial use the other issues were omissions in doses, not correct route or dose, no written indication on chart or not immediately available.

7.9 Actions taken in the year to improve on the previous year's results are

- Working with AMSG to ensure antimicrobial stewardship remains a top priority for the organisation
- Continue to hold *C.difficile* PIR's as a panel to insure learning is understood for any lapses of care and omissions led by ADIPC or HoIPC.
- Monthly IPCOG Gthr & PIR learning discussion: led by HON & HoIPC.
- Procurement of one standardized easy clean commode for inpatient areas.
- Commode cleaning competencies developed for all frontline staff
- Diarrhoea assessment tool (DAT) launched in April 2023
- Weekly *C.difficile* numbers & PIR outcomes to DIPC and DDoN's
- Implementation of C.difficiles ward rounds weekly with microbiologist and IPC team reviewing all cases of C.difficiles and new Glutamate dehydrogenase (GDH) positive result.

- Simulation training led by IPC team for wards on continuous PII.
- Relaunch of UVC cleaning for all red cleans with a relaunch of RAG rating for infectious cleans

7.10 Following the relaunch of UVC cleaning the IPC team and Housekeeping lead has developed a new 'what clean is required' and reworked to include UVC clean post infection and approved through cleaning group and IPCSAG.

7.11 The IPC team worked closely with system partners within Kent and Medway and are part of the CDI collaborative led by the ICB IPC team looking at actions from all Trusts to learn from each other. This led to a development of a MFT poster for toilets and bathrooms in ward areas to encourage ambulant patients to discuss their stool type with staff which was originally designed by Darent Valley Hospital. What was reassuring was that as a system we were reporting similar themes and trends and were doing many of the same initiatives

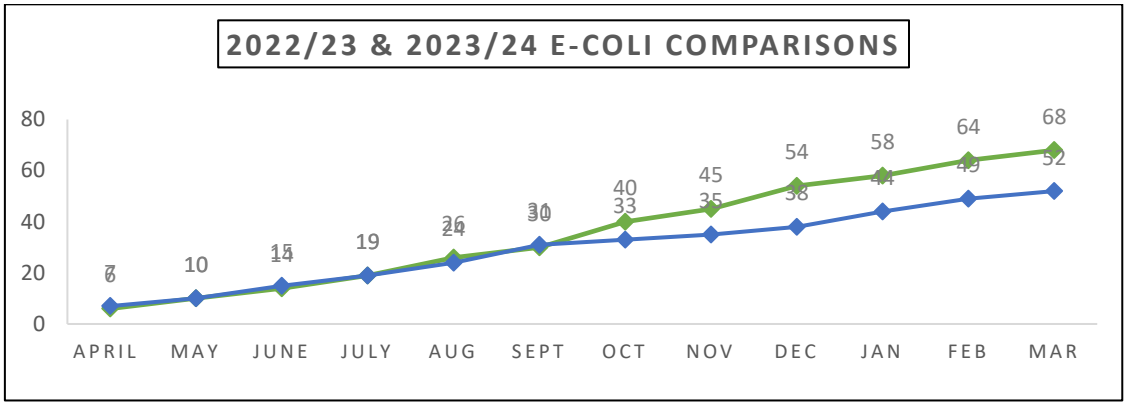
8 GRAM NEGATIVE BACTERAEMIA INFECTIONS (GNBI'S)

8.1 *Escherichia coli (E.coli),* Klebsiella and Pseudomonas are all gram negative bacteraemias and are now required to be reported nationally through the data capture system. All of these organisms have a significant impact on the health of the patient and also affect Kent and Medway Healthcare systems.

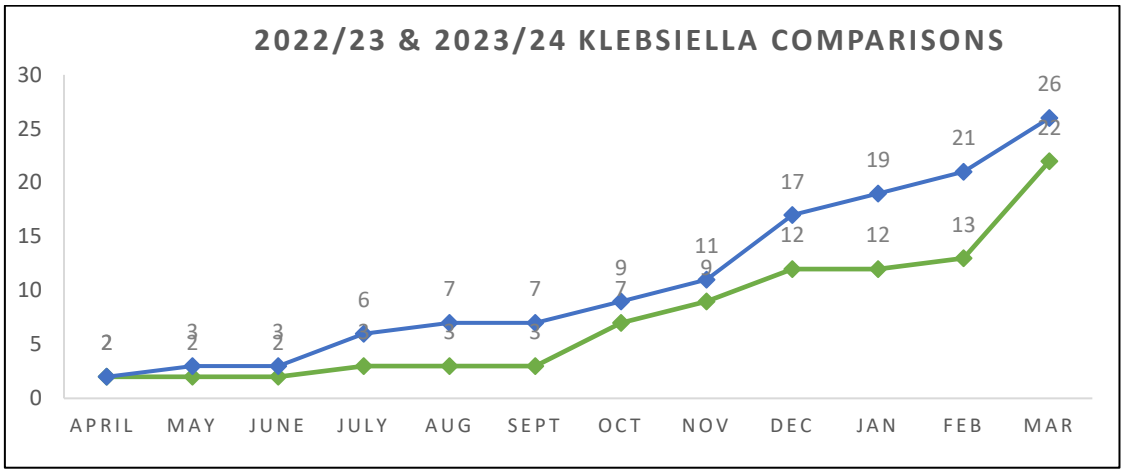
8.2 During 2023/24 the Care Groups completed the root cause analysis tools for all GNBI's which were shared with IPC team and added to Datix reports. This then changed in November 2023 with a structured rapid review by microbiologist and IPC nurses to understand root causes, source of infection and common themes and trends. This then supported the actions within the IPC Quality Improvement Plan

8.3 Of the 3 main GNBSI organisms only E.*coli* fell out of threshold and did not achieve a reduction on the previous year's total but both Klebsiella and Pseudomonas did.

E.coli – *(*figure 16) ended 2023/24 with 68 cases against a threshold of 52 cases work was underway to establish the reason for the increase and from a rapid review noted that most patients were elderly and often did not drink adequately or had a long term catheter.

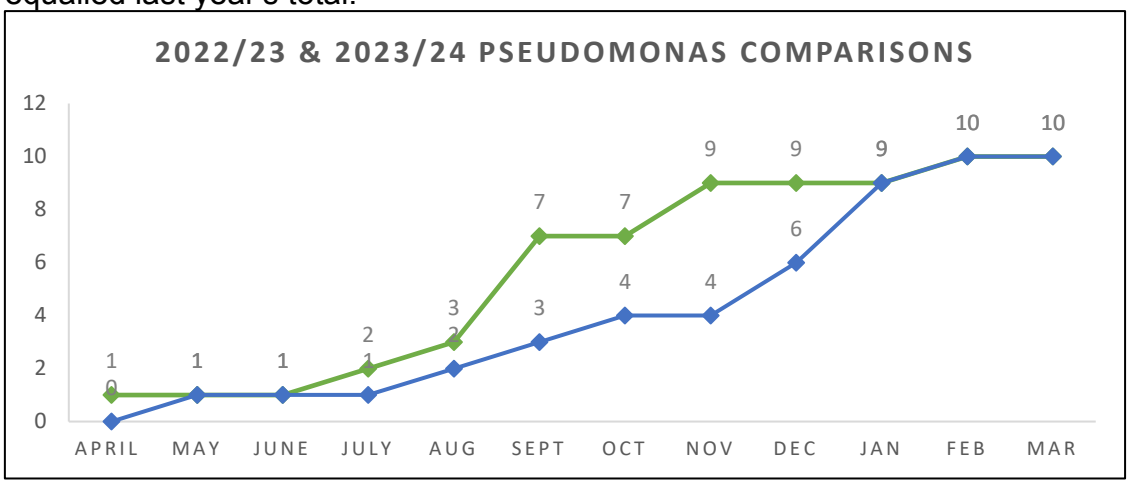


Klebsiella – figure 17 there was a total of 22 cases in 2023/24 against a threshold of 37 which is a 3% reduction against 2022/23.



8.4 Pseudomonas – figure 18 finished 2023/24 with 10 cases against a threshold of 17 cases. The Trust ambition for 2023/24 was

8.5 to reduce by 5% on last year's achievement unfortunately this was not met as we equalled last year's total.



8.6 The Trusts IPC strategy for has a measure for reduction of Hospital Acquired Infections. The year 1 deliverable was to maintain the status quo which was partially achieved with GNBSI's but was also to understand the lapses and the learning. The year 2 deliverable for 2024/25 is to reduce GNBSI's by 5% so the team will continue to work with the Quality Improvement Plan and the ward teams to achieve this goal.

8.7 There is a new process for monitoring GNBSI's for 2023/24. 2 or more cases within a 28 day period will require an immediate review by the IPC nurses to review and confirm source, any delays and to ensure appropriate management. These cases will also trigger a PII to support improvements.

9 SARS-COV-2 (COVID 19)

9.1 The novel coronavirus, SARS-CoV-2, had presented a significant challenge to the delivery of health services and Trust over the recent pandemic but as we return to a business as usual stance with the removal of all COVID restrictions following the publication of the Governments “Living with COVID – White Paper” in February 2023 but is anticipated to present to remain a challenge for some considerable time.

9.2 Most people infected with the COVID-19 virus will experience a mild to moderate respiratory illness and recover without requiring any medical intervention. Older people, unvaccinated people and those with underlying medical problems such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to go on to develop serious illness.

9.3 Current epidemiology suggests that the virus although still circulating in the community is now likely to be associated with less mortality and morbidity because of an increase immunity in the population following the mass vaccination programme and the development of therapeutic interventions.

9.4 The ability to use lateral flow tests in hospital was pivotal to supporting an early end to the isolation of COVID patients as well as an early return to work for staff.

9.5 Staff moved to using clinical judgement by using a symptom checker in identifying if a patient had developed COVID and can be effectively managed to prevent the disruption of vital services. Patients who were suspicious of having COVID were isolated in a timely manner whilst waiting for a result and remained isolated for 5 days if positive.

9.6 The system of command was stepped down in May 2022. The decision was made to continue with the operational IPC cell meetings to discuss and support any changes in guidance, further easing of restrictions and as a way of continually monitoring the numbers of COVID patients across the Trust and to re instigate the command meetings depending on escalation trigger level.

9.7 Determination of hospital acquired transmission was as below

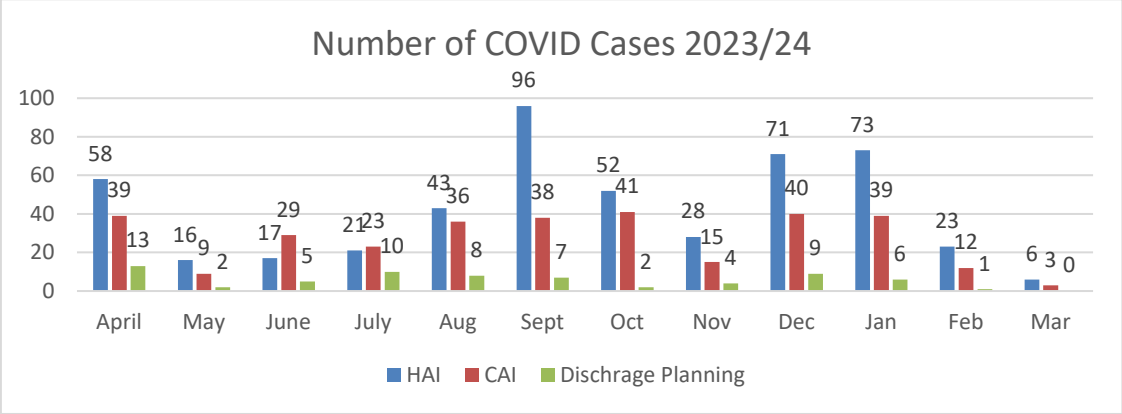
- **Hospital-onset probable healthcare-associated (HOPH)**– first positive specimen date 8-14 days after admission to the Trust
- **Hospital-onset definite healthcare-associated (HODH)**– first positive specimen date 15 or more days after admission to the Trust
- **Community acquired (CAI)-** first positive specimen less than 8 days after admission

9.8 COVID-19 comparison last four years figures – figure 19

Infection Control – COVID 19	2020-21	2021-22	2022/23	2023/24
Total number patients admitted with COVID	1963	710	1220	707

Total COVID cases	NA	1186	1853	827
Total number of deaths with COVID in part 1	571	96	170	30
Total number of HAIs	NA	224	650	325
Total number of outbreaks	17	22	22	3

9.9 Figure 20 below shows the total number of cases per month and demonstrates peaks in September, December and January for positive results and a clear reduction in March 2024.



Following on from the pause in asymptomatic testing an additional parameter for discharge planning was added. This is because many patients who tested positive for discharge to a care facility had been in the Trust for more than 8 days which is when a COVID infection is likely to become hospital acquired.

9.10 During this time the Trust had experienced periods of extreme pressure with an increase in hospital admissions and limited bed capacity often declaring business continuity to support flow through the hospital. But it is important to note that due to the lack of capacity at times positive patients were unable to move out of a bay into a side room or positive cohorted bay within the hour and could remain within a bay for much longer however this has not translated into an increase of outbreaks.

9.11 From August 2022 changes to the testing and isolation of patients within the trust the added symptom checker to Electronic Patients Records (EPR). Understanding when to test someone for COVID became an essential part of managing the virus and ensuring the correct patients were isolated and quickly. The compliance with this was audited from August – (Figure 21)

IPC Symptom Checker

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
80.2	85.5	89.2	89.3	88.8	90	89.8	90	92.2	84	89.7	89.7

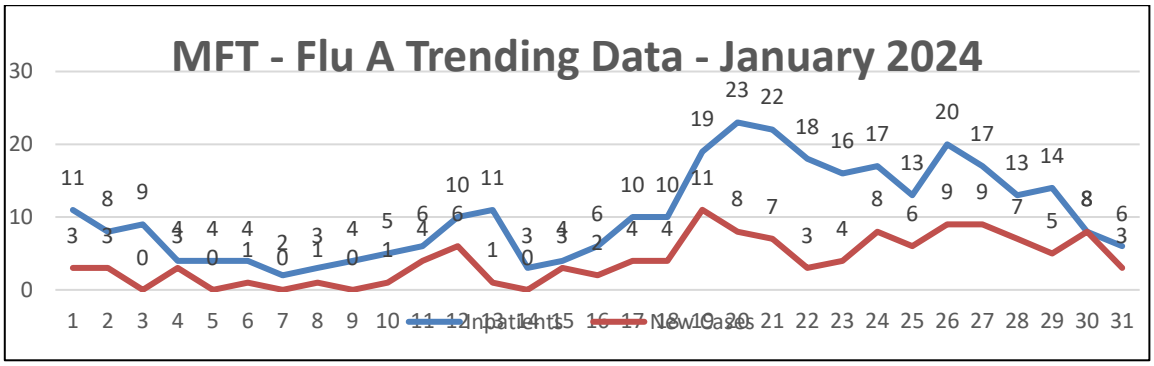
Compliance with the use of symptom checker remains inconsistent at times however this is the first year since its implementation there has been an over 90% compliance.

10 INFLUENZA/ RESPIRATORY SYNCYTIAL VIRUS (RSV)

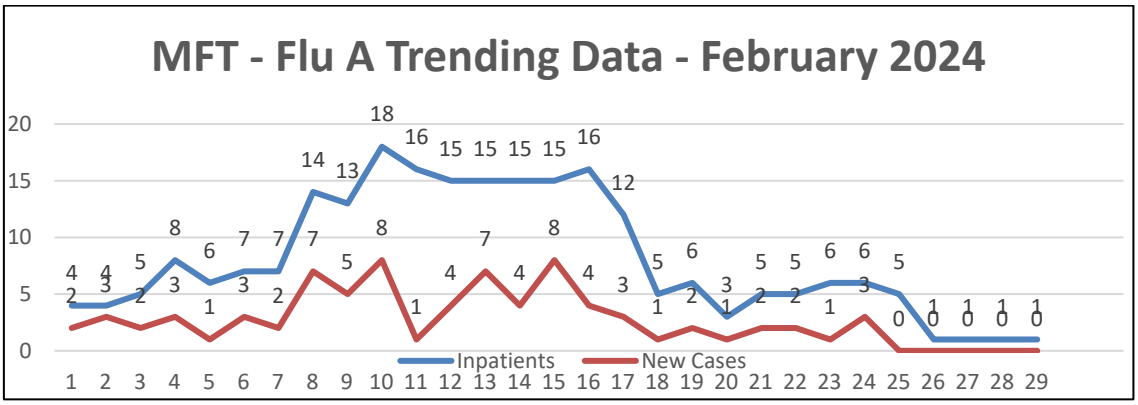
10.1 For Winter 2023/24 the Trust continued to use its established respiratory pathways for both paediatric and adult patients to ensure patient safety by correctly cohorting patients with respiratory symptoms and therefore reducing the risk of a nosocomial transmission and outbreaks.

10.2 The pathways are supported by the Rapid Testing Service who provided the Polymerase Chain Reaction (PCR) testing to identify four main respiratory infections, COVID-19, RSV (paediatrics), influenza A and influenza B

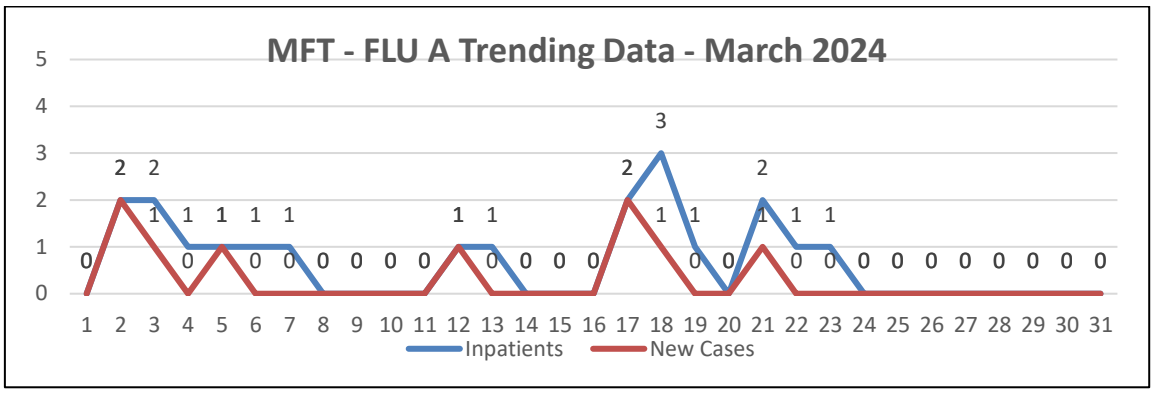
10.3 The Flu trend data was reviewed regularly at IPC cell meetings. Despite the late start in PCR testing the peak of Influenza admissions was towards the end of the first week of January 2024- (Figure 22) with no further increases. During this period there was only 1 patient admitted to critical care because of Influenza.



February started the month with low numbers but saw a further increase in cases from the 4th and steadily rose until 12th when numbers started to fall again.

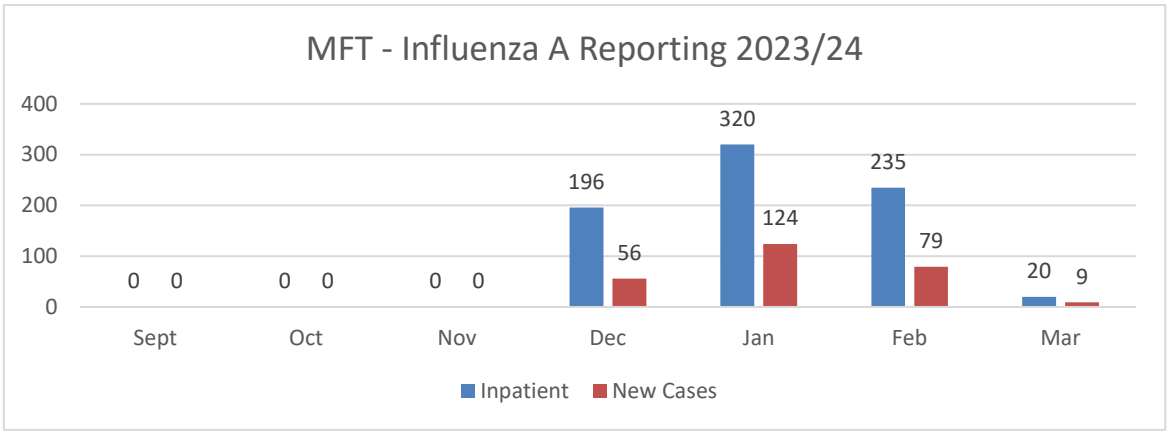


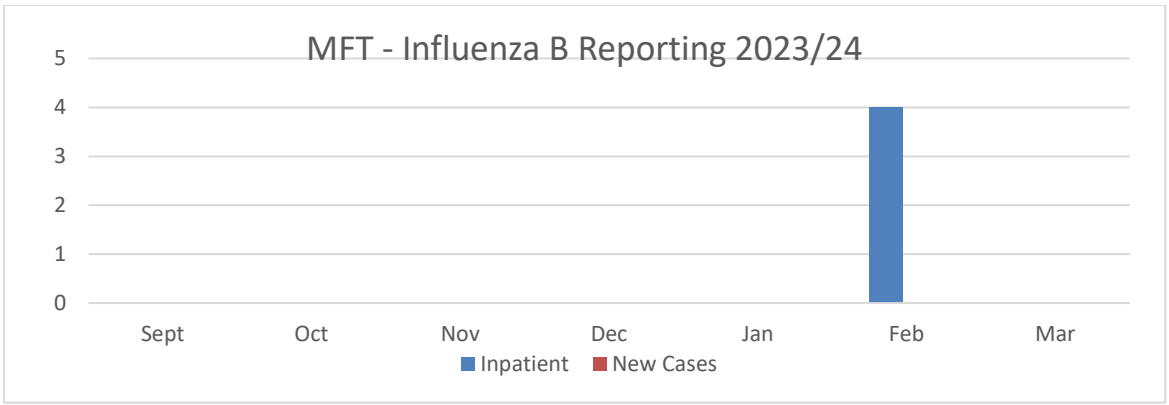
By March Flu numbers remained low throughout the month with the odd spike but not to the same level as the two previous months.

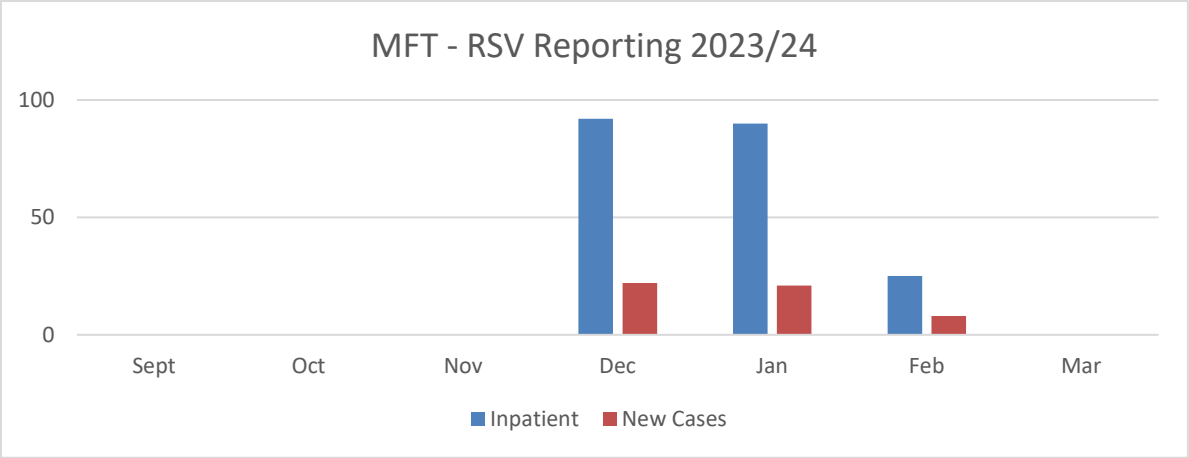


10.4 The usual process for RSV and Influenza screening using PCR also continued alongside the Rapid Samba testing.

10.5 IPCT monitoring of respiratory viruses started with the IPC Team monitoring cases daily and documenting each month all data is shared with the hospital site team to enable and facilitate effective management and placement of patients, the total number of cases is shown in (figures 23-25).







This data shows that both Influenza and RSV peaked in line with national data. This had an impact on the use of side rooms within the hospital over the winter period which at times restricted flow within the Trust. The IPC team supported the site team with appropriate use of side rooms and this was supported 7 days a week once the IPC team moved to 7 day working.

11 OUTBREAKS

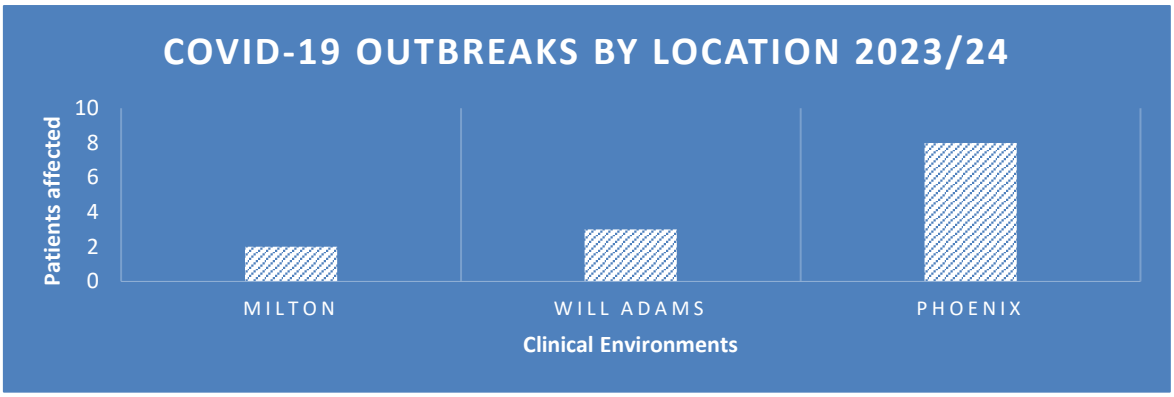
11.1 During 2023/24 there were 3 declared outbreaks for COVID-19 affecting 13 patients across the Trust.

11.2 Throughout Winter 2023/24 reporting period MFT was and remained under extreme pressure which saw most of that period escalating at Opel level 4 or entering into business continuity to support flow through the hospital.

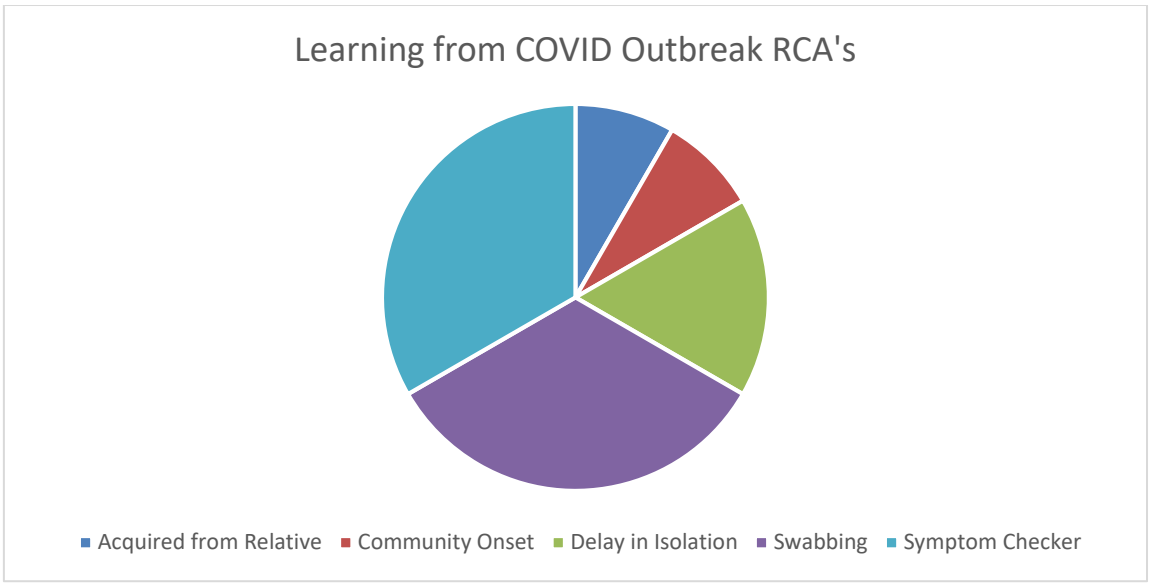
11.3 It is also important to note that due to the lack of capacity at times positive patients were unable to move out of a bay into a COVID bed within an hour and could remain there for longer. This then led to some reported exposure within bays resulting in an outbreak being declared.

11.4 Any ward where an outbreak was declared the IPC team instigated enhanced cleaning measures, a PII and an outbreak meeting was convened to identify learning and where improvements can be made.

11.5 COVID outbreaks by location – figure 26 shows the areas where the outbreaks occurred.



11.7 The key learning from the RCA meetings are in Figure 27



Many of the issues were regarding swabbing compliance as this was often non-compliant with delays in swabbing or the ward swabbing asymptomatic patients who might have been exposed which was non-compliant with Trust policy.

11.8 The next biggest learning was regarding symptom checker as this was not always being completed with the 3rd issue being delay in isolation due to the organisation being under extreme pressure with every attempt to find a suitable area to cohort cases when required.

11.9 Outbreak meetings were held with clinical team, IPC team, Microbiologist and ICB. These meetings reviewed the cases and considered causes and recommended actions.

11.15 Actions plan was devised and monitored through the outbreak meetings to reduce the effect outbreaks have on the patient, the clinical areas and also the organisation to aid flow.

11.17 In October 2023 there was a Norovirus outbreak on Emerald Short Stay affecting 12 patients but only 2 patients had confirmed Norovirus from PCR testing.

11.18 An Outbreak meeting was held with clinical teams, IPC team, microbiology, ICB, UKHSA and NHSE/I.

11.19 The outbreak was contained to the one ward with no staff involvement. Good practice was identified with quick escalation to IPCT, good stool chart documentation and appropriate sampling.

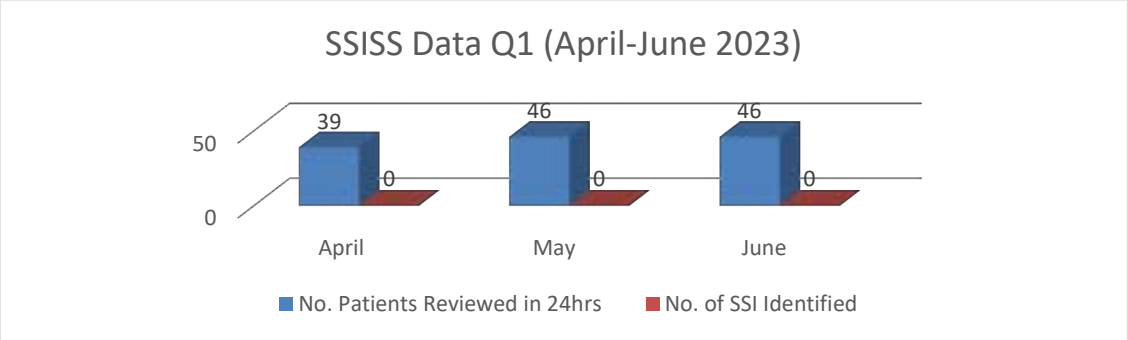
12 SURGICAL SITE INFECTION SURVEILLANCE (SSIS)

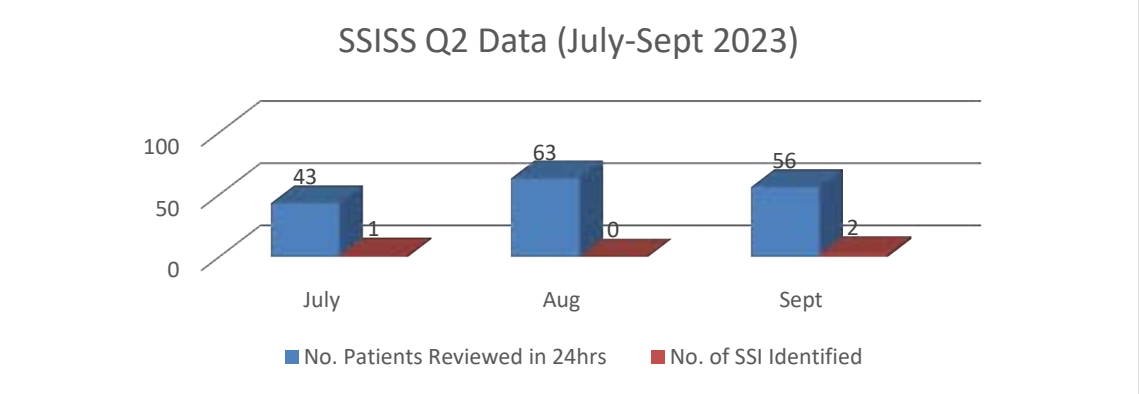
12.1 The IPC Team took over the administration of the mandatory SSI surveillance monitoring from the Surgical, Medical and Acute Response Team (SMART) in July 2022

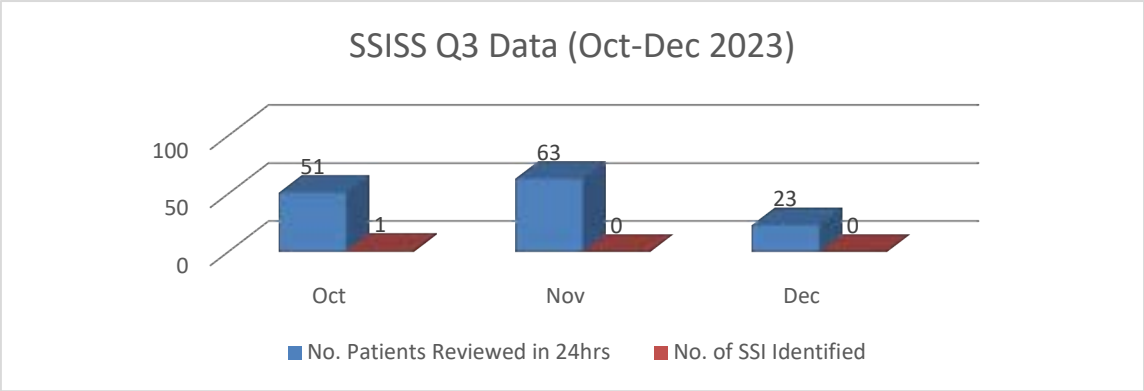
12.2 SSI data for mandatory hip and knee reporting is submitted once a quarter to the United Kingdom Health Security Agency (UKHSA) data capture system (DCS) and the minimum requirement is one submission per year. The original aim of the IPC Team was to continuously monitor hip and knee surveillance and report for the whole year has been achieved with 4 submissions a year.

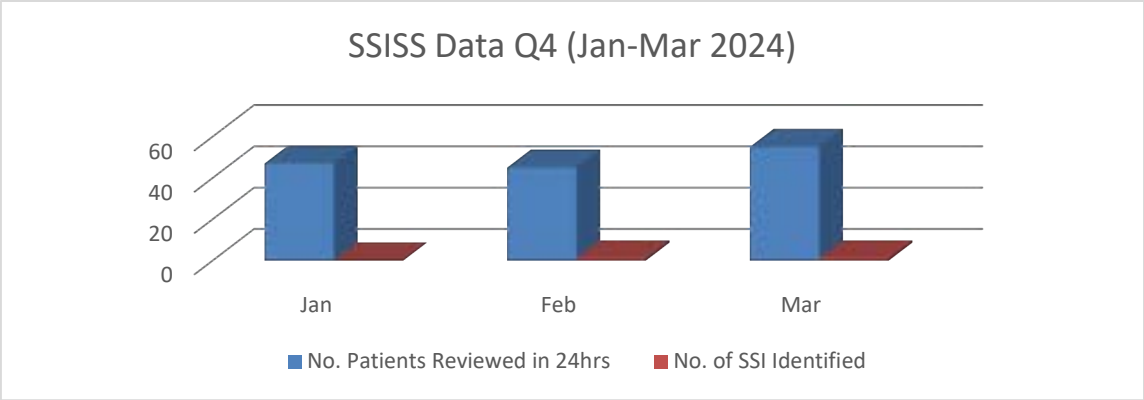
12.3 Although surveillance monitoring for all surgical sites is the focus for the team the initial focus was for elective hips and knee surgery and to build surveillance to cover the other domains.

12.4 Figures 28-31 shows the data for the number of patients reviewed at 24 hours and also the number of SSI's noted per quarter. There was not a site infection noted during any quarter.









12.5 Part of the surveillance programme is to contact patients at 30 days post procedure via telephone to determine if after discharge there was any infection at the surgical site.

12.6 Often there is a small drop in 30 day reviews this is partially due to no answer when called. There is no consistancy currently with the receiving of the theatre lists and the patient details may be incorrect. It would be better for the team to contact patients on the wards whilst still inpatients to confirm contact details and explain process for 30 day review to reduce the missed patient reviews.

12.7 In collaboration with the surgical services care group the IPC team have started to process map the pathway for elective hips and knees to ensure best practice and understand gaps and issues using patient first methodology. This started in January with the IPC team participating in some go and see sessions through the pathway. Once the process is completed best practice will then be rolled out across the pathways and then the IPC team will increase the pathways for SSI surveillance.

13 SIMULATION TRAINING TO SUPPORT PII PROCESS

13.1 Like many other NHS provider organisations Medway NHS Foundation Trust breached it's Clostridioides difficile threshold for 23/24 ending the year at 57 cases against a trajectory of 33 cases.

13.2 It had been clear from repeated RCA's and PII's highlighting that the same recurrent themes and issues had been occurring highlighting that learning from events did not seem to be disseminated and therefore a new approach was needed to help to reduce HCAI reduction.

13.3 The IPC team had devised a simulation training programme where wards that have acquired an HCAI infection and had been on PII for more than two weeks would be requested to attend a classroom-based training session based on their recent acquisition.

13.4 A pilot ward to test the simulation session was chosen and pre-and post training questionnaire's developed. Through the use of skill stations we had been able to test staff understanding and knowledge to see where there had been gaps in their knowledge and the simulation session should address this.

13.5 29 wards have been through the simulation style training programme with good success with only 1 clinical area having to repeat this process due to further acquisition. General feedback from staff had found this process useful and refreshed their level of knowledge and better equip staff to make the right choices or to seek help and clarification from their line manager or a member of the IPC team.

13.6 As simulation training had been proved a good medium to re-equip staff with the necessary refresher style training this has since been extended to include blood stream infections and urinary catheter infections.

13.7 This style of training was presented to the Kent and Medway Integrated Care Board (ICB) and has received good positive feedback and they have asked for an update on it's progress in September 2024.

14 IPC Gthr AUDITS

14.1 The Gthr repository system was adopted by the Trust to capture all audit data from February 2022 where wards can input see and access their results in real time whilst offering assurance on compliance to the board.

14.2 The IPC dash board on Gthr has allowed specific questions to be devised and tailored looking at the ward environment; hand hygiene; bare below the elbows and also includes the Friends and Family Test (FFT) cleanliness data.

14.3 Hand hygiene compliance scores have remained consistent over 2023/24 – Figure 32 and 33)

Figure 32 -Hand Hygiene Compliance Score (Trustwide).

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
95.5	95.4	94.8	94.6	93.8	95.1	94.8	94.1	94	94.7	94.3	100

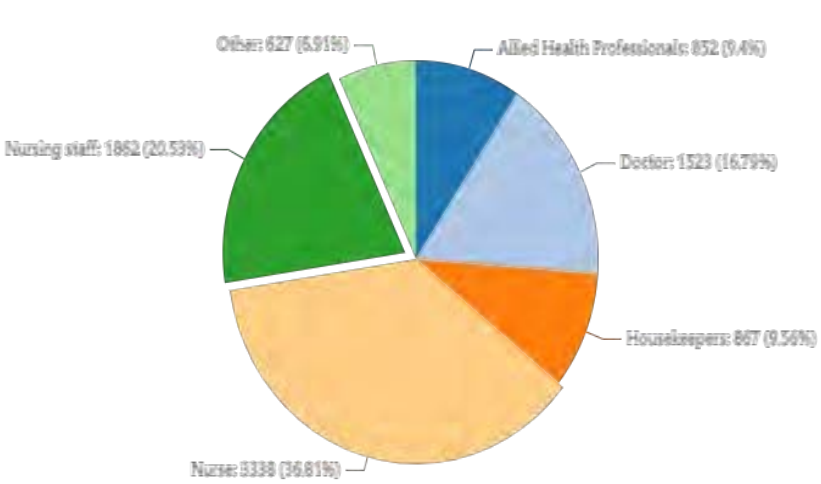
Figure 33 – Hand Hygiene Facilities Audit Compliance (Trustwide).

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar

97.8	98.2	98.8	99.1	99.4	98.1	97.6	95.3	98.2	96.4	96.2	97.5

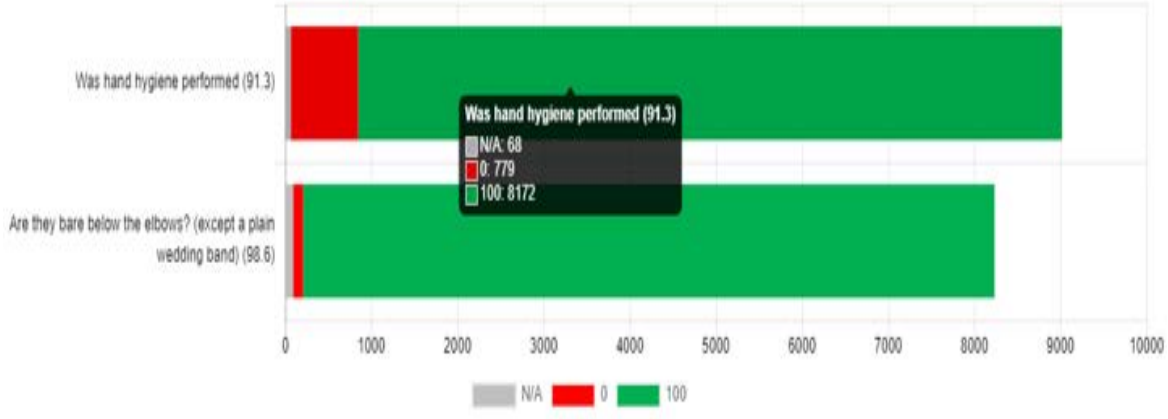
The information listed above in the two metrics show that hand hygiene compliance is good across the organisation generally but challenges still remain with some compliance around bare below the elbows within some clinical areas this is further examined in the bare below the elbows compliance section of this report.

14.4 The breakdown of staff observed for hand hygiene is in Figure 34



14.5 In addition to the data captured from assessing hand hygiene compliance bare below the elbows within the clinical environment is another key metric that has remained consistent throughout 2023/24 is the bare below the elbows – Figure 35

Figure 35 – Bare Below the Elbows Compliance Data (Trustwide)



14.6 The IPC team continues to challenge practice that falls below the standard expected when seen and offers support and guidance to staff so that they understand the importance complying with the hand hygiene and bare below the elbow's edict when in the care environment.

14.7 In 2023/24 The IPC team promoted world hand hygiene day by putting on some roadshows across the hospital including the staff canteen and foyer of the hospital by adopting some visual aids, handing out information, light box refresher sessions, using games and challenges to educate staff about the importance of hand hygiene in keeping patient's safe and reducing the risk of cross-contamination to others across the organisation by refocusing attention through a less formal route. These sessions are always well attended not only by staff but have helped to remind visitors to the Trust of the important part they also play in minimising infection.

14.8 Following the commode audit in 2023 the Trust has significantly invested in replacing it's varying commode types for one single 'easy clean' variant and have been rolling these out across the organisation, Unfortunately compliance remained poor until late 2023 early 2024 following with Commode cleanliness remained poor throughout 2022/23 – Figure 36-37

Figure 36 – Commode Observational Audit (Trustwide).

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
81	78.8	87.7	90.4	86.2	89	92.5	84.8	95.1	94.4	91.5	93.3

Figure 37 – Commode and Sluice Facilities Audit (Trustwide)

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
96.1	95.9	95.5	95.3	94.4	94.9	97.6	96.1	96.2	97.9	96.3	97

Following the two IPC team commode stock audits undertaken in May 2022 and March 2023 identified that 25 commodes were either condemned or damaged and broken requiring replacement parts under order. The urgent need to find a suitable 'easy to clean' and cost-effective replacement device was highlighted.

13.8 Peripheral cannula audits have been consistently under the Trust standard during 2023/24– Figure 41. From IPC audits it has demonstrated that some falls in compliance is down to not dating and labelling IV line devices post insertion and also not labelling giving sets administering medication to patients. The IPC Team have addressed these issues with the respective clinical areas to prevent re-occurrence.

Figure 38 – Peripheral Cannula Audits (Trustwide).

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
88.8	87.6	85.5	85.1	87.4	81.7	81.7	80.5	79.6	81.9	85.4	84.2

Also through auditing it showed that planned date for removal and lack of documentation on continued need for the cannula was missing. The IPC team continues to work with EPR team to resolve these issues.

14.9 Gthr has also become an integral part of the reporting by wards and departments to the IPC operational group. Wards have to present their areas of challenge to allow for discussion from other areas who have good practice. This is a forum for sharing ideas and solutions.

15 HOSPITAL CLEANLINESS

15.1 In April 2021 the NHS published the *National Standards of Healthcare Cleanliness* which would apply to all healthcare environments and replaced the *National specifications for cleanliness in the NHS* 2007

15.2 These standards have now been fully implemented as of 1st March 2023 across the Trust as healthcare providers must clearly demonstrate how and what standard should be achieved by setting out clear accountability and responsibilities for cleaning the clinical environment

15.3 Part of the agenda at IPCSAG requires a cleaning/housekeeping report to be presented for discussion and monitoring. This report is devised and presented by the housekeeping Lead.

15.4 The cleaning group was incorporated into the Decontamination group in September 2023 as the attendees were the same for both groups and the issue of cleaning fit comfortably here as part of criterion 2 under the *Health and Social Care act 2008: code of practice on the prevention and control of infections* and fed back to the IPCSAG.

15.5 The revised Decontamination and cleaning group purpose is to:

- Ensure the National Standards of cleaning are reviewed and updated as required.
- Monitor compliance and efficacy of cleaning in all areas.
- Provide a means to review that policies and SOPS are in place and are an accurate reflection of current practice.
- Provide a forum for housekeeping and departments to discuss practice and changes.
- Review audit data and actions.
- Ensure clear roles and responsibilities in place regarding cleaning environment, equipment etc.

15.6 The core membership of the group is chaired by the Head of IPC and includes housekeeping lead, facilities team, ward managers, Matron's, department managers and HoN's.

15.7 The Decontamination and cleaning group meets monthly and discusses the audit results for each clinical area, the participation scores for each area with ward staff supporting the audit alongside the housekeeping team and then any areas of concern.

15.8 Regular discussion at these meeting highlight that often the housekeeping auditors were completing the audits themselves with no participation from the wards. This meant that any issues or concerns raised were not challenged at the time. This has since changed and from September participation scores were also discussed at the meeting

15.9 The Friends and Family Test moved on to Gthr. One of the questions being asked is about how clean the patient found the location where they were being cared for. From April 2023 the results of this question pulled through to the IPC dashboard and will allow for the triangulation of data comparing the audit scores with participation percentages against the patient's scores. Figure 39.

Figure 39 – Friend and Family Test Cleanliness Scores (Trustwide).

April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
87.1	88.8	89.1	88.5	87.8	88.2	86.2	87	87.5	82.6	85.7	85

16 DECONTAMINATION

16.1 Following completion of the City & Guilds Decontamination Leads course at Eastwood Park training centre the Head of IPC took over the Decontamination Lead role and chair of the Decontamination group from the ADIPC in March 2024.

16.2 The ADIPC had previously relaunched the decontamination group and drafted a Terms of Reference (TOR) and reviewed its core membership. The purpose of the group is:

- To implement and monitor compliance with the decontamination policy as defined in Health Technical Memorandum (HTM) 0101 Management and decontamination of surgical instruments (medical devices) used in acute care (Part A: Management and Provision), and the Health and Social Care Act 2008.
- To ensure there are appropriate systems and processes in place for effective decontamination of patient environment and all patient equipment.
- To monitor compliance with assessing risks against the Health and Safety at Work regulations for Trust employees and service users.
- To ensure compliance with the Control of Substances Hazardous to Health (COSHH) regulations
- To action UKCA/EU directives regarding medical devices
- Review all audit data metric and actions in a timely manner

16.3 The Decontamination group meets monthly and is chaired by the HoIPC. It reports into the IPCSAG bi-monthly. The aim of the group is to move to bi-monthly meetings but after a prolonged period of monitoring to assure compliance.

16.4 Previously the ADIPC had completed a gap analysis to develop an action plan to be overseen by the group. The HoIPC has looked at this document and using this as a framework for service development and compliance purposes.

16.5 The Trust appointed an Approved Engineer for Decontamination (AED) who liaises closely with the Decontamination Lead and authorising engineer on all matters relating to testing and verification of results. The AED also conducts and

annual audit of the decontamination service to ensure it meets the required IHEEM standards.

16.6 A continued programme of audit is planned throughout the forthcoming year using an audit tool looking at standards of cleaning and sterilization of equipment used within the hospital. These audits will provide valuable data to be reviewed at the group.

17 COMMODE AUDITS

17.1 Audit provides assurance to the Trust on the cleanliness, suitability, safety and durability of the device being uploaded onto Gthr enables effective review of all data captured.

17.2 A Trustwide commode audit was completed by the IPC team in May 2022 which highlighted various issues and concerns around the six types of commode design currently being used across the organisation onhow they can be cleaned effectively.

17.3 One of the commodes in use manufactured by James Spencer had proved difficult to source replacement parts due to the company closing down had highlighted the need to look for a suitable alternative. The Trust following review purchased the 'Clinell easy-clean' commode following a trial process.

17.4 In addition to the new commode the following actions were recommended:

- All Ward/Department Managers must review commode cleanliness within their clinical areas to ensure that it *is* being undertaken thoroughly, and that staff are aware of the potential IP&C risks associated with soiled commodes.
- The development of at least two 'Commode Champions' who will receive practical commode training on the date(s) provided, with the expectation that they will then cascade the commode cleanliness training to all the staff on their wards.
- Replace all broken and damaged and aged commodes to the complete commode replacement of all commodes to ensure that the Trust has a standard commode that is easy to clean removing the potential for mis-management and the potential for faecal pathogen growth.
- Regular unannounced commode audit by IPC team.
- Ward / Department Managers must also:
  - ensure that the "Commode Cleaning: 10 Point Plan" poster is clearly displayed in the ward / department sluice(s)

17.5 The number of commodes in use across the Trust had reduced due to a review in 2023 but this did not negatively impact the wards while they awaited their replacement. Since June 2023 the commode cleanliness scores steadily increased following the interventions previously stated and repeated IPC support.

Figure 40 – Commode Cleanliness Audit (Trustwide)

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
81	78.8	87.7	90.4	86.2	89	92.5	84.8	95.1	94.4	91.5	93.3

18 EDUCATION AND TRAINING

18.1 The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

'that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients' care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection'.

18.2 Following a return to face-to-face training the IPC team revised it's training packages to refresh the information contained within staying current and up-to-date with developments within the IPC service, this included revised sharps disposal information and antimicrobial stewardship.

18.3 Level 1 training is e-learning is undertaken by non-clinical staff; Level 2 is undertaken by all clinical / patient-facing staff.

18.4 Training compliance for both levels was set at 90% by previous teams for IPC training although generally Trust compliance is at 85% for mandatory training.

18.5 Training compliance by division has been discussed at both IPCSAG and in the Divisional Governance Care Group meetings and included in the divisional reports. Figure 43

Column Labels	Compliant		Compliance (%)	
Staff Group / Subject	Yes	No	Yes	No
Add Prof Scientific and Technic	**122**	**14**	**89.71%**	**10.29%**
Infection Prevention L1	13	0	100.00%	0.00%
Infection Prevention L2	109	14	88.62%	11.38%
Additional Clinical Services	**890**	**42**	**95.49%**	**4.51%**
Infection Prevention L1	10	0	100.00%	0.00%
Infection Prevention L2	880	42	95.44%	4.56%
Administrative and Clerical	**970**	**44**	**95.66%**	**4.34%**
Infection Prevention L1	947	40	95.95%	4.05%
Infection Prevention L2	23	4	85.19%	14.81%
Allied Health Professionals	**240**	**14**	**94.49%**	**5.51%**
Infection Prevention L1	1	0	100.00%	0.00%
Infection Prevention L2	239	14	94.47%	5.53%
Estates and Ancillary	**466**	**3**	**99.36%**	**0.64%**
Infection Prevention L1	450	3	99.34%	0.66%

Infection Prevention L2	16	0	100.00%	0.00%
Healthcare Scientists	**2**	**3**	**40.00%**	**60.00%**
Infection Prevention L1	2	1	66.67%	33.33%
Infection Prevention L2	0	2	0.00%	100.00 %
Medical and Dental	**550**	**187**	**74.63%**	**25.37%**
Infection Prevention L1	1	0	100.00%	0.00%
Infection Prevention L2	549	187	74.59%	25.41%
Nursing and Midwifery Registered	**1413**	**99**	**93.45%**	**6.55%**
Infection Prevention L1	1	1	50.00%	50.00%
Infection Prevention L2	1412	98	93.51%	6.49%
OVERALL SUMMARY	**4653**	**406**	**91.97%**	**8.03%**

The above table demonstrates the compliance levels for all staff groups

18.9 The IPC team continue to take students for their nurse education in years 2 and 3. The placements range from 4-8 weeks and has proved a really useful placement in building their knowledge around infections and their overall management to keep and maintain hospital services.

18.10 The team continue to work hard in improving the experience for the students based on their feedback. An induction booklet was devised by the team and is sent out prior to their arrival including their hours of work, contact details for the team.

18.11 Students placed with the IPC Team are allotted time with various members of the team to understand the depth and wealth of the work undertaken including surveillance monitoring. During their placement the student is given an assignment to research on a subject relating to IPC and present this back to the team.

19 IPC LINK PRACTITIONERS

19.1 Link practitioner training was re-established in July 2022. IPC Link practitioners are required to attend regular updates provided by the IPC Team and be an active participant at these meetings.

19.2 Every ward and department has signed up to provide at minimum of one practitioner (Trained or Untrained) who will represent their respective clinical area when attending these sessions. IPC link meetings now run for a half day.

19.3 IPC Link sessions are chaired by the IPC Matron and some external speakers also provide content and support delivering additional updates on products being used or planned for introduction into the hospital.

19.4 Subjects covered can include but not limited to:

- Housekeeping and enhanced cleaning

- Nursing TB patients
- Hand hygiene scenarios and competency assessments
- PPE use scenarios
- Commode cleaning and competency assessments
- Sharps safety
- Swabbing for MRSA, CPE and GRE/VRE
- Infection control admission assessment
- C.*difficiles* update with learning from PIR's
- Stool assessment and stool chart on EPR

19.5 The Kent and Medway ICB IPC conference runs annually and affords places for links to attend in addition to the education session provided by the Trust.

19.6 In October 2023 the IPC team launched its first link practitioner showcase. This event was planned to conclude the annual IPC week. The links were asked to prepare a presentation of an improvement that they had implemented within their work area. The event was attended by 21 link practitioners with 10 wards presenting on the day. The presentations were judged by a panel of the Chief Nursing Officer and Director of IPC as well as a member of the NHSE IPC team.

19.7 Awards were given for

- 1st, 2nd, 3rd and highly commended for presentations demonstrating innovation and passion.
- The Ward with the Longest Infection Free Period.
- Most Improved Ward.
- Most Engaged Department.
- Long service as a link practitioner
- 2 extra awards for individuals outside of IPC

19.8 The day was well received by all including ward and care group teams who attended to support

19.9 The IPC team are planning to make this an annual event and have already started planning for this year

20 FIT TESTING

20.1 FFP 3 Fit-testing principles for Acute Hospital Trusts introduced in June 2021 became mandatory and forms part of EPRR Core standard 12 and being a legal requirement in August 2022. The Trust must have arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including high consequence infectious diseases (HCIDs).

20.2 Since the cessation of the national centrally funded fit-testing service by DHSC in March 2023 the IPC Team were left trying to find a way of delivering the requirement for fit-testing frontline healthcare workers and how this can be delivered. 4 proposals were put before the IPCSAG and Trust board. The proposals were:

- Remain with current provider (Ashfield Healthcare)
- Employ a fit-tester to run and manage service
- Train the IPC Team to provide the service
- Do nothing as service should be taken over by ICB

20.3 There were originally 3209 hospital workers who was required have FIT testing against their training profile during the pandemic, but following some relaxation of COVID guidance and dwindling COVID numbers a revision of the staff numbers was undertaken shrinking down the previous total to almost 1600.

20.4 In addition to the proposals the reduction of staff numbers was also included and agreed at Divisional Governance, IPCSAG and HSSG.

20.5 The IPC Team were chosen to continue to manage the mandatory fit-testing programme following Ashfield's departure from the Trust and the IPC Team were all re-trained to undertake qualitative fit testing using either a bitter or sweet fit testing solution. Face2fit undertook the training for all IPC team members and sessions were rostered for all staff identified following a staffing review.

20.6 The procurement team has worked alongside the IPC Team in the development of mask procurement to ensure that they are UK sourced and that the Trust has adequate stocks of all mask types within the clinical areas.

20.7 Currently staff are tested on 2 masks from the product range and where staff have failed due to altered facial features, beards for religious reasons and sensitivity to their use, the IPC Team are also trained on providing training on half masks to those staff members.

21 ESTATES/IPC/HOUSEKEEPING WALK ABOUTS

21.1 The joint IPC/Housekeeping and Facilities weekly walkabouts sought to address and remedy estates and cleaning issues, this programme began in June 2022 and consisted of representatives from Estates team (Director), ADIPC or IPC Matron, An estates team representative, Building, Electrical, Ventilation/water, Housekeeping/Hotel services, and then as needed Fire and Health and safety, Ward Manager/Matron

21.2 These walkabouts have been successful in highlighting and addressing the problems with the Trust's estate generating a lot of actions. Following the recent refurbishments of Keats (29th December 2022) and Harvey (January 2023) highlighted the need to look at fabric of the estate and seek to put right any issues or damage seen making the environment cleaner and safer for patients.

21.3 Following the extensive action list generated from the initial visits the visits were paused and then restarted in February 2023. In that time IPC developed an

annual audit programme and this visit now allows all areas to have this completed. This will be uploaded to Gthr.

21.4 After the focus on the inpatient area's March 2024 saw a change to assess and review all outpatient and other areas across the Trust.

22 CONCLUDING REMARKS

22.1 This year like most others have had it's challenges and the IPC Team have risen to the challenge by continuing to build and forge great links with all clinical teams across throughout the organisation including working well with estates and facilities make changes to both cleanliness and the fabric of the Trust's estate.

22.2 The IPC team have achieved a great deal in 2023/24 by further building and developing the FIT testing service so that it meet the needs of our regulatory responsibilities and the organisation as a whole, further expand the Surgical Site Surveillance programme to include colorectal surgeries with a plan to continue this in 2024/25 and the Head of IPC taking over the decontamination lead role following a period of study.

22.3 The team remain committed to delivering a robust and adaptable IPC service to the Trust and are fully integrated into the divisions and care groups with an IPC team member regularly in attendance at these meetings. We are also very visible within the clinical areas supporting, nurturing and advising all grades of staff working for the trust and for the benefit of our patients using our services.

22.4 The team are fully committed to working collaboratively incorporating facilities, clinical and procurement teams in trialling new products, reviewing practices and implementing new processes in the fight against infection.

22.5 The SSIS has continued to grow and has ensured closer working relationships with the surgical team in gathering information to ensure safer surgery in particular the orthopaedic team.

22.6 A successful and relaunched IPC link practitioner programme was devised and rolled out with good participation from staff around the Trust, this year we ended the year with a link practitioner showcase event to celebrate and reward the vital support work that they do. The showcase event also saw link practitioner present a subject that they were passionate about to their peers and colleagues and we had external stakeholders at this event where prizes were awarded to the most innovative subject. We thank Jackie Dalton from NHSE/I IPC team for their time and helping to judge this event.

22.7 Due to the increase in Clostridioides difficile cases nationally the IPC have devised a simulation training programme which is additional to our usual supportive processes which aims to make staff stop, think and focus on what measures should be taken, these sessions used the simulation training room to mock a scenario to focus minds on best practice thus trying to avoid needless

harm to patients and a disruption of our services. Primary feedback from teams proved encouraging and our progress is being followed by NHSE/I for possible national rollout.

22.8 This year saw the IPC service go 7 days to further support the vital work of our nursing and clinical colleagues. Since it's inception staff have really embraced this service and we hope to build on what we can offer the teams moving forward.

22.9 There were steps the team were hoping to implement this year but have now been planned for 2024/25 and are part of the annual programme. These are

- To implement PSIRF methodology for IPC hospital acquired infections using Swarms, After Action Reviews (AAR) and Patient Safety Investigations (PSII).
- To use the Quality Improvement Plan developed from key themes and trends from investigations in 2023/24 to drive improvements across the Trust and to support delivery of the IPC strategy.

22.10 Other areas for the IPCT to focus on in 2023/24 are

- To develop a plan for continued FIT testing within the Trust along with EPRR.
- Additional simulation IPC training to support wards that are challenged with HAI's and as part of level 2 training
- Continue to improve with hospital cleanliness and estates work looking at use of UVC and potentially HPV tools to support cleaning.
- Provide decontamination audit data which includes laundry, waste, endoscopy, theatres, mortuary and procurement.
- Improving the work of antimicrobial stewardship and supporting the antimicrobial pharmacist
- Developing an IPC web page with links to all of the surveillance data, organism of the month and key messages with learning from PIR's

ENDS.

1 Executive Overview

This is the Trust Responsible Officer's (RO) annual report for 2023-2024 reporting year. This report is a required item of assurance, and we are also required to submit a compliance statement, signed off by or on behalf of the Board.

We are able to positively respond to all assurance statements, as we are compliant with all regulatory requirements.

2 Background

The GMC's aims for medical revalidation are that it:

- is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession.
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body that monitors and assures their practice. MFT is a Designated Body for circa 600 doctors (currently 602) and this report is about them. This report does not cover the doctors in training grade as their designated body is Health Education England.

3 List of Attached Documents

Appendix 1 – Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2023 - 24. This Framework is used across all designated bodies to enable a consistent approach for Boards to Quality Assure their appraisal and revalidation systems. Each section in the appendix relates to specific items set out in the Responsible Officer regulations 2010.

4 Conclusion and Next Steps

The overall appraisal rate at MFT remains stable. 599 doctors were potentially due to complete an appraisal during the reporting period, and of that 446 were completed on time and 142 doctors had approved delayed appraisals (this category covers doctors who it was agreed would not undertake an appraisal in this year due to long term leave (mat leave, ill health) and also doctors who either joined in this year but were not due their first appraisal at MFT until 24/25, or left MFT before their annual appraisal was due. 11 doctors had unapproved missed appraisal during the reporting period. In two cases of these cases they were recorded in this category for administrative reasons that will be corrected. In the other nine cases appraisals were not completed in the year to 31st March 2024. In some cases the Dr had left MFT without completing their planned appraisal, in other cases the appraisals have either been completed late in the current financial year, or are still being worked on.

For the year ending 31 March 2024, a total of 88 revalidation submissions were made, out of which 77 positive revalidation recommendations were sent to the GMC during the reporting year. 11 deferral recommendations were sent, and of these we were able to make a subsequent positive revalidation recommendation for 4 doctors during the report period.

General review of last year's actions

Completed Actions: The following actions were completed from the Board Report 2022-2023

- A successful PID was approved in 2023 to provide funding for additional resources to increase the administrative team establishment with the recruitment of a B4 full time administrator from April 2024
- Funding has been made available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser.
- The Policy has been reviewed and approved in November 2023
- SOP for late appraisals and non-engagement was reviewed in 2023 in line with the overall policy review.
- Reviews of appraisals have identified some new connected doctors do not always have robust appraisal history from previous organisations and sometimes key elements are not completed to the standards set at MFT. Further support is provided to these doctors through 1-1 coaching and mentoring and this will continue in 2024 -2025.
- To provide New Appraiser Training in September for 20 doctors.
- 14 Case Investigators for Maintaining High Professional Standards (MHPS) were trained during 2023

Incomplete Issues

- A peer review to be undertaken of the organisation's appraisal and revalidation process. This was not undertaken due to insufficient capacity for this in the appraisal team resulting from a change of Senior Appraisers, administrative resourcing impact from sickness absence and maternity leave, and the need for a second DCMO.
- Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2024-2025 year. This was not undertaken due to the capacity issues described above.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

Current Staffing:

- The Medical Revalidation Manager started maternity leave from April 2024
- A B6 Interim Manager who has been in the team since February 2023 will cover for up to 24 hours per week
- A B4 full time Medical Appraisal Support Administrator was recruited and joined the team in April 2024 primarily for appraisal and revalidation but also offering support for the CMO office
- Support and training for 2 Senior Appraiser's has been delivered, with one started in 23/24 and one in early 24/25.

Actions Carried Forward:

- A peer review to be undertaken of the organisation's appraisal and revalidation process, subject to sufficient capacity in the appraisal team. If there is an external HLRO review during the year, the peer review will not be required.
- Deputy Responsible Officer and Senior Appraisers will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2024-2025 year.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

New Actions:

- To provide training for new appraisers – September 2024
- Provide appraiser refresher training for existing appraisers (circa 50 appraisers per year)
- Ongoing monitoring and review of resources to be regularly undertaken.
- Work further ahead with Revalidation preparation, ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by the GMC.
- To create an escalation process for MPITs not received to ensure no issues with Drs connecting with MFT at their previous trusts.
- The number of Case Investigators is now sufficient (20) for MHPS Investigations but we need more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS organisations.
- To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations, working with the Trust secretary re this. Once new NED's have been identified, we will provide appropriate training.
- As part of the implementation of the policy, the Joint Local Negotiation Committee have agreed to review the implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics.
- To review the ROAG and CMO team HR processes to ensure that there is assurance that these are free from bias and discrimination.
- Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances eg maternity leave).

Overall conclusion:

We have continued to strengthen our appraisal and revalidation process, and the governance of medical staff.

There is overall good engagement from our doctors.

Appendix 1

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

1A – General The board/executive management team of Medway NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	**Appoint two new Lead Appraisers**
Comments:	Alison Davis remains as Responsible Officer with Jeremy Davis remaining as Deputy Responsible officer. Both are trained licensed medical practitioners. In July 2023, following previous incumbent leaving the Trust, a Consultant Obstetrician, was appointed as Senior Appraiser. A second senior appraiser, a Consultant Gastroenterologist was appointed as a senior appraiser and started April 2024. They have both attended external (Miad Healthcare) Appraisal Lead courses and also the NHSE Responsible Officer programme. They received a local induction by the Deputy Responsible Officer, and their decisions regarding appraisals were initially monitored for a period of four weeks by the Deputy RO. The deputy RO provides ongoing advice and support when needed.
Action for next year:	To provide ongoing support and review

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes	
Action from last year:	To provide 50 current appraisers with Refresher training, this will be delivered by e-learning modules to ensure that the Appraisers can complete the modules at a time convenient for them. To ensure that the administrative team is optimally resourced to manage the increased demands/task associated with the increase in the number of prescribed connections (600+)
Comments:	**Completed:**

	Despite Industrial Action occurrences and activity pressures of the hospital the New Appraiser Training sessions were moved and re arranged a number of times. However, two New Appraiser Training sessions took place in September 2023 with 18 Doctors Trained and another session in November 2023 with 13 Doctors trained. An Appraiser Refresher Training session took place in October 2023 and January 2024, with a total 57 appraisers receiving an updated training. A business case was successfully approved in 2023 and a B4 administrator full time was recruited from 01/04/2024. A B6 interim manager is in post for 22.50 hours per week (as maternity leave cover). In addition, resource was approved to provide a further Lead Appraiser from April 2024. This has been pivotal in ensuring safe systems are in place to manage revalidation and appraisal,
Action for next year:	To provide 50 current appraisers with Refresher training, this will be delivered by e-learning modules to ensure that the Appraisers can complete the modules at a time convenient for them. Funding will be available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None Identified
Comments:	The Human Resources Department/Medical Staffing provides the Chief Medical Officer's office with a weekly list of all new non-training grade doctors, together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC connection list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible. Doctor's in training do not have a prescribed connection with MFT. When the weekly staff in post list is received, this is cross-checked with the Appraisal system to ensure that no Doctors have been missed.
Action for next year:	To continue as before.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Policy review
Comments:	**Completed** Policy approved by the Trust Executive Board in November 2023 and now active.
Action for next year:	To ensure any changes to NHS England/General Medical Council (GMC) guidance remain pertinent to the current policy

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	A review of this action by the Responsible Officer will take place during 2023-2024 to determine best practice moving forward.
Comments:	Not Completed: • A peer review to be undertaken of the organisation's appraisal and revalidation process. Completion, subject to sufficient capacity in the appraisal team. If there is an external HLRO review during the year, the peer review will not be required.
Action for next year:	We are anticipating a possible HLRO review in the year 2024 – 2025 in which processes will be reviewed. If this does not take place we will undertake a peer review, subject to resource.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Ongoing monitoring and review of resources to be regularly undertaken.
Comments:	**Completed:** The appraisal platform L2P has the relevant information to help completion of appraisal under the resources section. Non-training grade Trust doctors and doctors working on MFT employment bank undertake an Annual appraisal. All doctors with a prescribed connection to MFT as Designated body are connected on GMC Connect and added to MFT appraisal system L2P. New doctors are invited to the appraisal training and are sent all the necessary information for them to carry out an appraisal. Regular appraisee training sessions have been provided by Deputy Responsible Officer, Senior Appraiser and Revalidation team including one to one coaching, to all doctors new to UK and any doctor who is new to the appraisal system. Revalidation team also offer all the support needed for completion of appraisals, including

	facilitating collection of patient and colleague feedback. The Revalidation Team receives a weekly report of starters and leavers lists of doctors including any doctors who leave training and take up a non-training role.
Action for next year	Ongoing.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Review of existing process and agreement to identify which Doctors are associated with specific SI's, with appropriate governance teams for improving the process has been identified as a key improvement needed for 2023 - 2024. MFT Governance team are introducing a new DATIX Style system which may help assist with appraisal complaints.
Comments:	**Partially completed:** The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal. All Doctors are required to complete an appraisal every year containing supporting evidence on their full scope of work. If a doctor works outside MFT in any capacity as a medical doctor, the doctor is required to complete an Annual Declaration form duly signed and confirmed by RO/hospital Director from the Private Hospital or other organisations where they practice.
Action for next year:	The process for identifying doctors in SI reports and those involved in legal claims and passing this information to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	SOP for late appraisals and non-engagement will be reviewed in 2023 in line with the overall policy review.
Comments:	**Completed:** Appraisal policy including SOP for late appraisals and non-engagement approved November 2023
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Review policy in 2022-23
Comments:	**Completed:** Policy approved by the Trust Executive Board in November 2023 and now active
Action for next year:	Ensure it remains relevant to current practice and NHSE/GMC guidance

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	To provide New Appraiser Training in September and November for 40 doctors.
Comments:	**Completed** The Trust had 163 trained appraisers on 31st March 2024. Not all are job planned to undertake appraisals, and of those that are the majority of our appraisers complete 5 appraisals on a rolling annual basis and generally no more than one per month In 2023 - 2024, No appraisers left or retired. There is a prediction that small number of appraisers will be lost in 2024 - 2025. In order to mitigate this, new Appraisers will continue to be recruited, and a review of those who have undertaken few or no appraisal will be carried out to rationalise the appraiser list.
Actions for next year:	1) To provide two dates of New Appraiser training for 20 doctors each session. (September 2024 and January 2025).

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	2) Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances eg maternity leave).

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2023-2024 year.
Comments:	**Not Completed:** This was reliant on a fully resourced team will being in post. The Revalidation Manager (RL) had long-term sickness absence and is now on maternity leave which impacted on delivery of this item. The team is now fully resourced with an interim B6 manager and a newly recruited B4 administrator. In addition, two Lead Appraisers are now in post The Lead Appraisers are trained at Responsible Officer training events to garner a full understanding of their role. The RO, Deputy RO and managerial support team attend regional appraisal network events at least once per year.
Action for next year:	Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2023-2024 year.

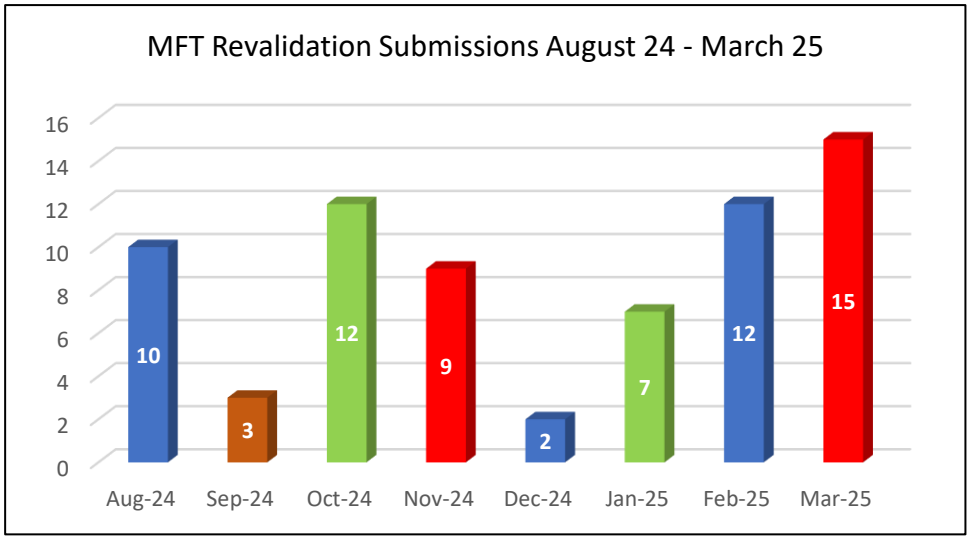
1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	To continue presenting yearly report to Board for compliance.
Comments:	**Completed:** There is an ongoing process to support revalidation including the Responsible Officer Advisory Group meetings and the HR Decision Making process to ensure appraisal and revalidation is operationally supported throughout the year. The Trust Policy has been reviewed to ensure it is following best practice. There is an annual report which goes to the People Committee and then the Board to provide assurance that revalidation processes are safe and effective.

Action for next year:	To continue presenting yearly report to Board for compliance.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	To review policy to incorporate identified changes.
Comments:	**Completed:** For 2024 – 205 we continue to adhere to the changes (2022) for under notice period for Recommendations, monthly Responsible Officer Advisory Groups (ROAG) meetings have taken place, in which Doctors under notice are reviewed to ensure GMC requirements are adhered to.
Action for next year:	Work further ahead with Revalidation preparation ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by GMC. Please refer to the table below which outlines projected revalidation submissions from August 2024 – March 2025 inclusive 

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	To continue with the correct processes in place to support Revalidation Recommendations.
Comments:	**Completed** The Responsible Officer Advisory Group (ROAG) provides a structure for reviewing all revalidation recommendations and ensures all recommendations and deferral recommendations are complete in good time.

Action for next year:	To continue with the correct processes in place to support Revalidation Recommendations.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	The Revalidation team will continue to monitor information on complaints/SIs for inclusion in medical appraisal.
Comments:	**Partially Completed:** The revalidation team continues to monitor information on complaints/SIs for inclusion in medical appraisal. Key aspects of clinical governance for the RO are the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems. The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal. All Consultants, Specialty Doctors and doctors (not in a formal training programme) are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a regular basis by the Revalidation team to ensure that progress in meeting these deadlines is being maintained.
Action for next year:	The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	To continue biweekly decision-making group meetings to discuss and action any conduct/capability issues of doctors. To update the terms of reference for the decision-making group.
Comments:	**Completed:**

	Conduct and performance issues are reviewed at the biweekly Decision-Making Group. This includes triangulating information received from HR processes, complaints/SIs/Never Events and regular weekly meetings of Chief Medical Officer with Deputy Chief Medical Officer and Divisional Medical Directors. Upon connecting a Doctor to MFT, RO to RO references (MPIT) are requested which contain any relevant information to share. This is monitored and there is an escalation process to ensure MPIT references are received and reviewed. The team receives regular requests from Private Practices to complete Practicing Privileges references and share relevant information to the RO of the organisation where a doctor works. All doctors are required to include reports of any SIs/Datix/Complaints in which they were involved during the appraisal year, with appropriate reflections and learning. All doctors are required to undergo formal Multisource feedback both from Colleagues and Patients once in the 5 yearly revalidation cycle. All doctors are encouraged to share and reflect any compliments received (including thank you cards and feedback received from patient experience team) during every appraisal discussion. Training grade Doctors have a Postgraduate Dean at NHSE KSS Deanery (Kent, Surrey and Sussex) as their Responsible Officer. While they are working in MFT, the Doctors have regular work placed based assessments by their named Educational and Clinical supervisors and their performance discussed and documented in the quarterly Local Faculty Group and Local Academic Board meetings. Any identified concerns are flagged up to NHSE KSS via Director of Medical Education of MFT. They undergo Annual Review of Competency Progression (ARCP) in their respective School at NHSE KSS.
Action for next year:	No Action Required.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None required as ongoing.
Comments:	We have used L2P appraisal system since 2012 and are able to ensure the system incorporates any requested updates to comply with Good Medical Practice 2024 or any local requests to ensure the system is user friendly.
Action for next year:	Ongoing.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that

includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	The number of Case Investigators is insufficient for MHPS Investigations. **Completed** -14 Case Investigators were trained during 2023.
Comments:	**Action Completed** The Chief Medical Officer / Responsible Officer chairs the Decision-Making Group, which meets bi-weekly to review all significant concerns and manages these under Maintaining High Professional Standards (MHPS) including liaising with NHS Resolution Service (formerly the National Clinical Assessment Service) and the GMC as required in each case. The Deputy Responsible Officer, Head of Medical Director Services and a member from HR attend this meeting. Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified, these are then managed under the appropriate Trust policy. Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with the Trust policy. The Trust now has 20 trained Case Investigators and 3 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed. All Case Investigations follow NHS Resolution Service best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance. As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate.
Action for next year:	The Trust will train three more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS organisations.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Nil
Comments:	A senior team including the Chief Medical Officer (RO), Deputy Chief Medical Officer, Head of Employee Relations and Head of MD services meets on a biweekly basis to review concerns about doctors and decide on appropriate actions. Investigations where required, are undertaken under MHPS guidelines, using appropriately trained Case Manager and Case Investigators. Doctors in training have their RO at the Health Education Kent, Surrey and Sussex (HEKSS) and any concerns are flagged up to RO at HEKSS via Director of Medical Education. The following table outlines the number and outcome of cases reviewed by the Decision-Making Group in the reporting year.
Action for next year:	To continue with the present format.

2023 – 2024 – issues managed within the Decision-Making Group	White	BAME	Male	Female	
Outcome					
Reviewed and no case to answer	0 (0)	9 (3)	9 (3)	0 (0)	**9 (3)**
Reviewed and advice given regarding future conduct	2 (2)	3 (4)	5 (5)	0 (1)	**5 (6)**
Reviewed and advice given regarding improving performance (capability)	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Reviewed and managed by other HR policy (grievance, Dignity at work, sickness)	5 (2)	8 (3)	11 (5)	2 (0)	**13 (5)**
Formal MHPS investigation	0 (1)	2 (2)	2 (2)	0 (1)	**2 (3)**
Total	7 (5)	22 (12)	27 (15)	2 (2)	**29 (17)**

% Figures in brackets relate to 2022-2023

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	To continue with the current process set in place.
Comments:	Upon connecting a Doctor to the designated body, a RO to RO reference request is sent to the previous designated body. Dependent on the information shared, more details may be requested which can result in a RO to RO conversation to elaborate further. All doctors who work in other places are required yearly to produce a signed form from RO/Hospital Director of the other organisation (s) about their practice and any concerns regarding their practice. This form is uploaded to their medical appraisal every year. For doctors connected elsewhere but working in MFT fall under two categories: Training grade doctors are regularly monitored by their educational supervisors and any concerns raised are dealt with through the Local faculty groups chaired by the specialty College Tutors and the Local Academic Board chaired by the Director of Medical Education and escalated to RO of HEKSS and the RO at MFT is updated immediately for any necessary actions. Other groups of doctors who may work in MFT could be bank doctors or contracted through agencies and have their own RO. The Revalidation team would contact their designated body if any concern arises.
Action for next year:	To continue with the current process set in place.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Nil
Comments:	All processes for responding to concerns are managed according to our Trust Policy Maintaining High Professional Standards Policy. This policy was renewed in 2024 and included specific assurance that the Case Manager will use The NHS England 'Just Culture Guide' as part of the decision-making process where the concern relates to a patient safety incident. The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events should be conducted where needed to clarify whether causes are more broadly based and can be

	attributed to systems or organisational failures or demonstrate that there were untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each incident will require appropriate investigation and remedial actions. The Trust actively promotes an open and fair culture, which encourages practitioners and other NHS staff to report adverse incidents and other near misses. To support case managers the Trust has trained Case Investigators to ensure appropriate processes. Whilst care is taken to avoid potential bias and discrimination when cases are considered by our Senior Team, it is recognised this process could be strengthened. Historically there was NED involvement in the ROAG process, but that has lapsed.
Action for next year:	Review of the ROAG and biweekly CMO HR processes to strengthen assurance that processes are free from potential bias and discrimination

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Nil.
Comments:	The Trust has a robust educational infrastructure in place including weekly Grand Rounds. Appraisers are supported in ensuring that Personal Development Plan (PDP's) are relevant, challenging and specific. Quality Improvement Activities (QIA) remain an integral part of the appraisal process and reviewing external and national data encouraged. Doctors are encouraged to provide clinical performance evidence for various external facilities such as Dr Fosters or similar. The Trust operates a Patient First philosophy which is fundamental to the Trust strategy/culture and is reflected in appraisal discussions/outputs.
Action for next year:	Ongoing.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Nil.
Comments:	1. *Targeted interventions on collaborative leadership and organisational values*

	Applying our *Bold* Trust values with *Patient First* principles the organisation leadership teams work collaboratively and actively to demonstrate this with a variety of interventions open to all staff such as monthly briefings and weekly Spotlight huddles. 2. *Positive equality, diversity and inclusion (EDI) action* Equal opportunities and diversity are fundamental not just in the statutory training programmes but embedded in all Trust events and forums. There are a variety of active staff network programmes including: BAME, Women, Armed Forces, LGBTQA+ 3. *Consistent management standards delivered through accredited training* The Trust runs a variety of multi-disciplinary leadership programmes many aligned to our local university which has an extensive healthcare and management portfolio. (Canterbury Christ Church University) 4. *A simplified, standard appraisal system for the NHS* The Trust has a very robust generic appraisal system for non-medical/dental staff. This is monitored Trust wide on a weekly basis with relevant follow ups as required. The Trust appraisal dashboard incorporates medical and dental appraisal metrics. 5. *A new career and talent management function for managers* There are structured and informal management and leadership development opportunities in all areas of the Trust. This can be demonstrated by the positive retention of key staff who have transitioned into more senior roles and sometimes through training/development into different areas. 6. *Effective recruitment and development of non-executive directors (NEDs)* The Trust has a full complement of Non-Executive Directors (NEDs) from a range of backgrounds with regular review/renewal processes. 7. *Encouraging top talent into challenged parts of the system* This is ongoing but there have been several new operational initiatives during 2023/24 that have required different people structures and new roles.

Action for next year:	To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations, working with the Trust secretary re this. Once new NED's have been identified, we will provide appropriate training.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	To continue to monitor compliance.
Comments:	All doctors employed by MFT are subject to NHS mandatory recruitment pre-employment checks. To ensure compliance with pre-employment checks, a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non-training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT.
Action for next year:	To continue to monitor compliance and liaise actively with the medical and temporary staffing teams as appropriate.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Nil.
Comments:	The Trust has been engaged in Patient First since 2022. This is interlinked with the Trust strategy and all non-clinical and clinical process are aligned to an all-inclusive culture for patients and staff.
Action for next year:	Ongoing.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Nil
Comments:	There are monthly staff briefings both face to face or Teams and all staff are encouraged to attend. At every event the right to 'Speak Up' is supportively emphasised. The Trust has Human Resources /People teams with a range of roles that openly supports fairness and mutual respect. Diversity underpins all Trust polices. Trust values reflect this.

Action for next year:	Ongoing.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistle-blowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Nil
Comments:	There is an active Whistle blowing policy in place that is regularly reviewed. There is a in depth and proactive safeguarding system in place that is supportive of both staff and patients with robust training programmes.
Action for next year:	Ongoing

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Nil
Comments:	The Trust has an active staff survey and outcomes are communicated at staff briefings with relevant action plans as required. Opportunity for feedback from /with medical and dental staff is actively encouraged and supported through the Junior Doctor forum and Local Negotiating Committee as well as more informal routes. The Trust adheres to an MHPS/Grievance/Complaints and disciplinary procedures
Action for next year:	Ongoing

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Nil
Comments:	The Trust actively employs International Medical Graduates (IMG's) though robust recruitment processes. The Trust runs regular 'Welcome to UK Practice' face to face/team sessions bi-annually (January and September) The MHPS and investigative processes are managed through the Chief Medical Officer's (CMO) service in conjunction with HR teams. The processes are non-discriminatory and monitored to ensure parity.
Action for next year:	As part of the implementation of the new MHPS policy, the Joint Local Negotiation Committee have agreed to review the

	implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Nil
Comments:	The CMO/RO and revalidation administrative teams regularly attend on the HLRO meetings and workshops and participate in a local peer group forum for informal feedback and discussion. This is about process and the sharing of best practice and not about individual doctors or cases.
Action for next year:	HLRO review/Peer review.

- **Section 2 – metrics**

Year covered by this report and statement: 1 April 2023 - 31March 2024 . All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	592

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	446
Total number of appraisals approved missed	142
Total number of unapproved missed	11

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	88
Total number of late recommendations	0
Total number of positive recommendations	76

Total number of deferrals made	12
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	512

	GP	Specialist	GP & Specialist	Other	Total
Defer - insufficient evidence	0	4	0	6	**10**
Defer - subject to ongoing process	0	1	0	0	**1**
Revalidate	0	39	0	38	**77**
Non-engagement	0	0	0	0	**0**
Total	**0**	**44**	**0**	**44**	**88**

Source GMC Connect MFT

2D – Governance

Total number of trained case investigators	20
Total number of trained case managers	3
Total number of new concerns registered	29
Total number of concerns processes completed	27
Longest duration of concerns process of those open on 31 March	4 months
Median duration of concerns processes closed	1 month
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	84
Number of new employment checks completed before commencement of employment	84

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	Not yet complete
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	Not Applicable

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

Completed Actions: The following actions were completed from the Board Report 2022-2023

- A successful PID was approved in 2023 to provide funding for additional resources to increase the administrative team establishment with the recruitment of a B4 full time administrator from April 2024
- Funding has been made available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser.
- The Policy has been reviewed and approved in November 2023
- SOP for late appraisals and non-engagement was reviewed in 2023 in line with the overall policy review.
- Reviews of appraisals have identified some new connected doctors do not always have robust appraisal history from previous organisations and sometimes key elements are not completed to the standards set at MFT. Further support is provided to these doctors through 1-1 coaching and mentoring and this will continue in 2024 -2025.
- To provide New Appraiser Training in September for 20 doctors.
- 14 Case Investigators for Maintaining High Professional Standards (MHPS) were trained during 2023

Incomplete Issues

- A peer review to be undertaken of the organisation's appraisal and revalidation process. This was not undertaken due to insufficient capacity for this in the appraisal team resulting from a change of Senior Appraisers, administrative resourcing impact from sickness absence and maternity leave, and the need for a second DCMO.
- Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2024-2025 year. This was not undertaken due to the capacity issues described above.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

Current Staffing:

- The Medical Revalidation Manager started maternity leave from April 2024
- A B6 Interim Manager who has been in the team since February 2023 will cover for up to 24 hours per week
- A B4 full time Medical Appraisal Support Administrator was recruited and joined the team in April 2024 primarily for appraisal and revalidation but also offering support for the CMO office
- Support and training for 2 Senior Appraiser's has been delivered

Actions Carried Forward:

- A peer review to be undertaken of the organisation's appraisal and revalidation process, subject to sufficient capacity in the appraisal team. If there is an external HLRO review during the year, the peer review will not be required.

- Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2024-2025 year.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

New Actions:

- To provide training for new appraisers – September 2024
- Provide appraiser refresher training for existing appraisers (circa 50 appraisers per year)
- We are anticipating a possible Higher-Level Responsible Officer (HLRO) review in the year 2024 – 2025 in which processes will be reviewed.
- Ongoing monitoring and review of resources to be regularly undertaken.
- Review of existing process and agreement to identify which Doctors are associated with specific SI's, with appropriate governance teams for improving the process has been identified as a key improvement needed for 2023 - 2024. MFT Governance team are introducing a new DATIX Style system which may help assist with appraisal complaints.
- Work further ahead with Revalidation preparation, ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by the GMC.
- To create an escalation process for MPITs not received to ensure no issues with Drs connecting with MFT at their previous trusts.
- The number of Case Investigators is now sufficient (20) for MHPS Investigations but we need more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS
  organisations.
- To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations. To provide appropriate training which is via the Trust Secretary.
- As part of the implementation of the new MHPS policy, the Joint Local Negotiation Committee have agreed to review the implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics.
- To review the ROAG and CMO team HR processes to ensure that there is assurance that these are free from bias and discrimination.
- Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances eg maternity leave).

Overall conclusion:

We have continued to strengthen our appraisal and revalidation process, and the governance of medical staff.

There is overall good engagement from our doctors.

- **Section 4 – Statement of Compliance**

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Medway NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	2024

NHS
Medway
NHS Foundation Trust

Patient First into Action Year 2 review

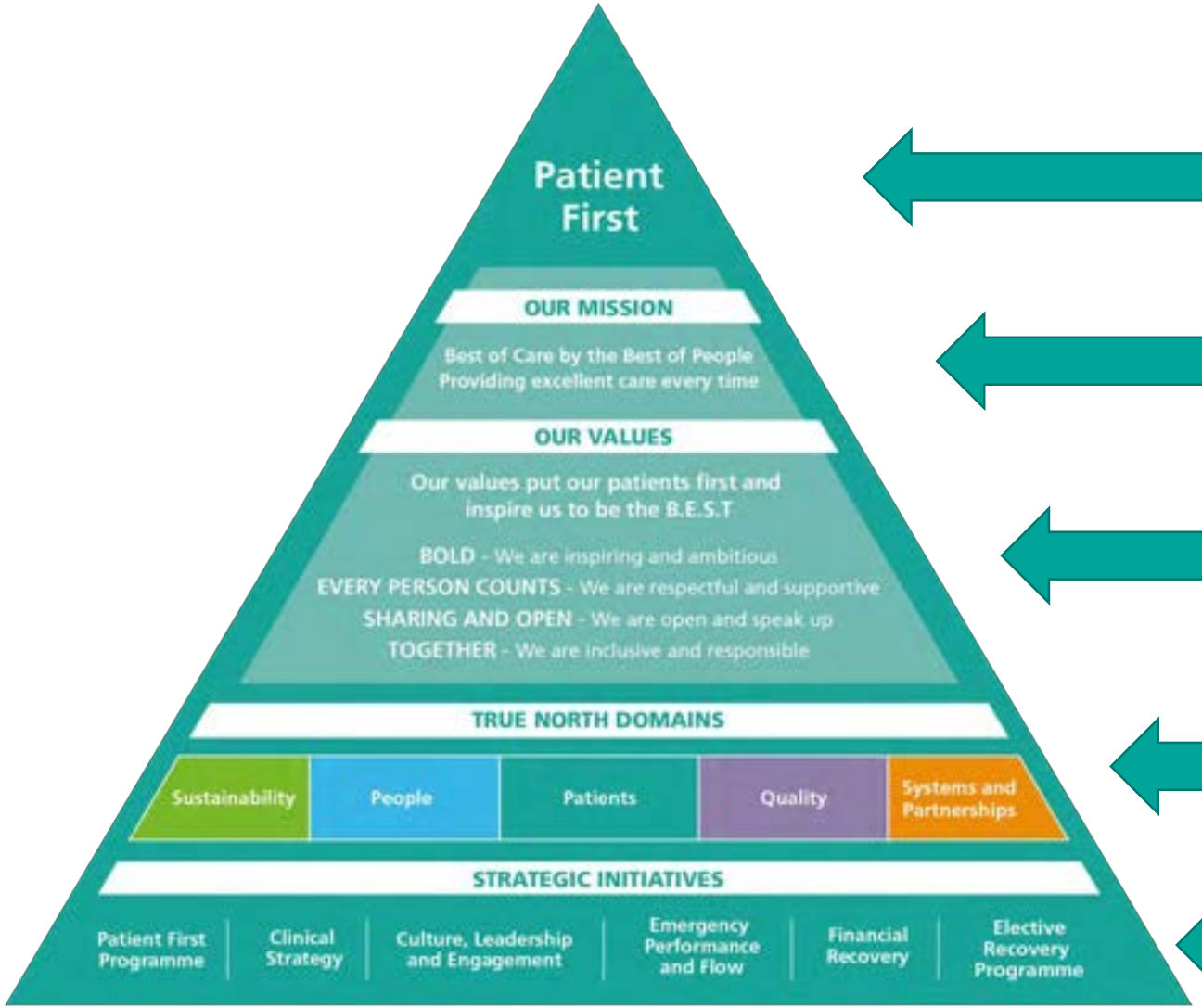
Best of Care by the Best of People; Providing excellent care, every time

Patient FIRST

version: v0.2

Patient First: Our shared vision, strategy and culture

Medway NHS Foundation Trust



Our True North – the organisational commitment to continue to put **Patients first** and foremost!

Our Mission states our vision of the standards we expect to achieve and an expectation that we do them consistently

Our Values are the Trust values we have invested in and describe, fundamentally, our approach and our behaviour

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12-Month Breakthrough Objectives

1	Reduction in Bank & Agency spending by 50%
2	To improve the experience of staff in order to retain them beyond the initial 24 months of their employment
3	Increase in FFT – percentage of Patients who would recommend us
5	Mortality – To reduce the number of avoidable 2222 cardiac arrest call to no more than 12/year (<1 / month) and the reduce the number of peri-arrest calls by 30% to 35 calls (<3 / month)
6	Improve overall ED 4 hour Performance to 76% consistently by Dec 2024
7	All patient referral to treatment (RTT) pathways to be completed within 65 weeks

Strategic Planning Framework

Medway NHS Foundation Trust

True North

Patient First

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

True North Domains

True North metrics

Sustainability | People | Patients | Quality | Systems and Partnerships

Key goals for the Trust to achieve. 3-5 year specific metrics that we will continuously measure to gauge improvement and to check that we are delivering of high quality care in a sustainable way.

1	Breakeven revenue budget
2	Top quartile of acute trusts for the national staff engagement score
3	Top quartile Friends and Family Test score
4	Harm – No hospital acquired harm
5	Mortality – Lowest quartile mortality rate
6	Medway NHS to have a Stable bed occupancy of 92% by 2028
7	To achieve 92% of patients seen or treated within 18 weeks for RTT

Strategic Initiatives (1-3 years)

- Exec Led "Must Do Can't Fail" strategic programmes
- Transformational in nature

1	Financial Recovery Plan
2	Culture, Engagement and Leadership
3	Patient First Improvement Programme
4	Clinical Strategy
6	Emergency Performance and Flow
7	Elective Recovery Programme

Corporate Projects

Mission Critical – 3

- Outpatient Optimisation
- Flow & Discharge
- Medical Productivity

Important – 1

- EDN Backlog

Wait - 4

- Frank Lloyd Centre Beds
- Patient Experience Academy
- R&I University Hospital Status

12-Month Breakthrough Objectives

1	Reduction in Bank & Agency spending by 50%
2	To improve the experience of staff in order to retain them beyond the initial 24 months of their employment
3	Increase in FFT – percentage of Patients who would recommend us
5	Mortality – To reduce the number of avoidable 2222 cardiac arrest call to no more than 12/year (<1 / month) and the reduce the number of peri-arrest calls by 30% to 35 calls (<3 / month)
6	Improve overall ED 4 hour Performance to 76% consistently by Dec 2024
7	All patient referral to treatment (RTT) pathways to be completed within 65 weeks

Patient First – Our systematic improvement approach

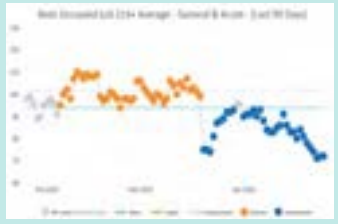
NHS Medway NHS Foundation Trust

Patient First Improvement and Operational Management System

A system of routines, behaviours and tools which ensure daily continuous improvement and support performance excellence.

Management System Design

Corporate Projects



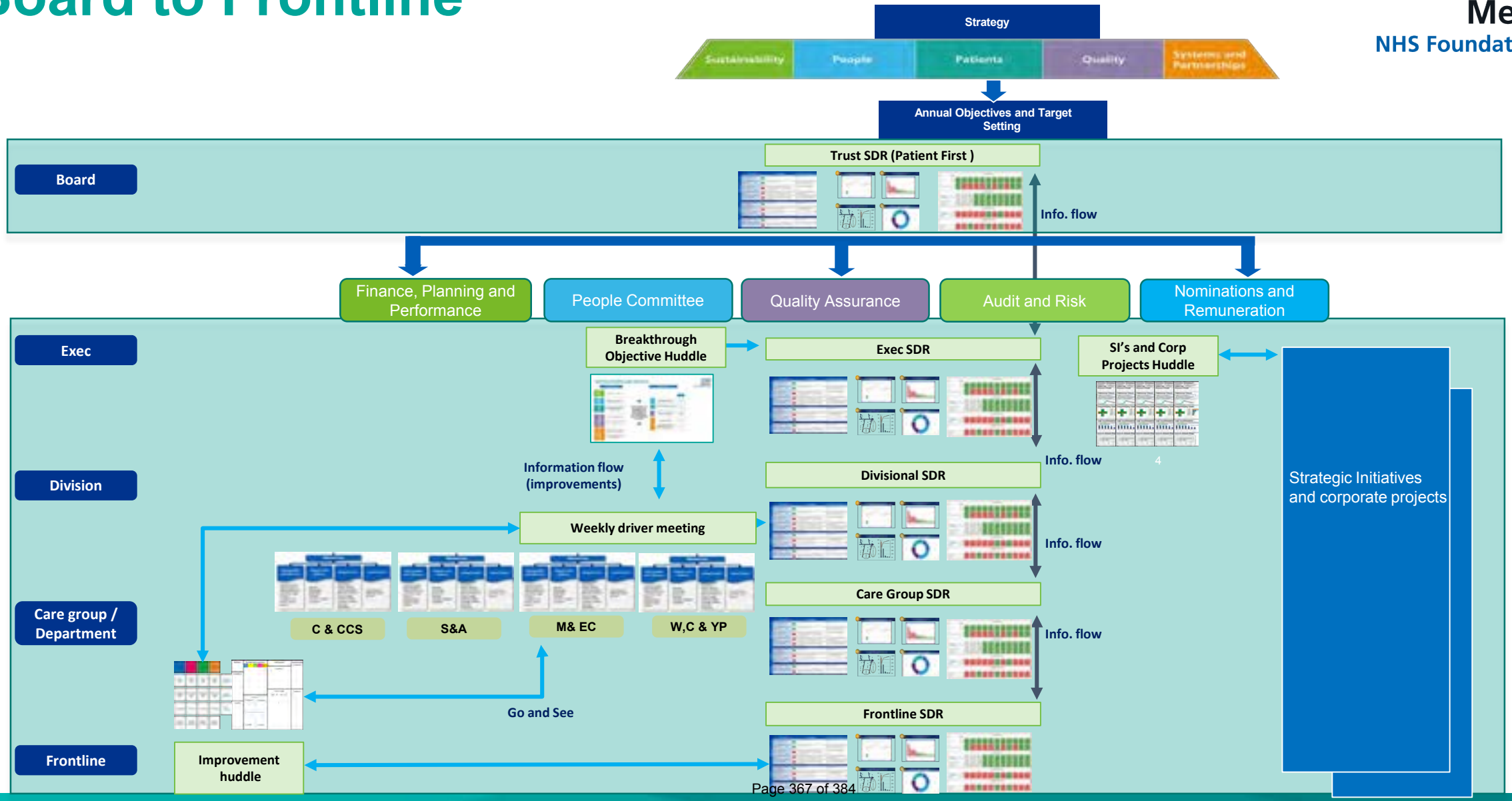
Clinical Strategy

Embedding Leadership Behaviours

Board to Ward Rollout

Patient First Operational Management System: Board to Frontline

Medway NHS Foundation Trust



Our approach to building a culture of continuous improvement

Medway NHS Foundation Trust

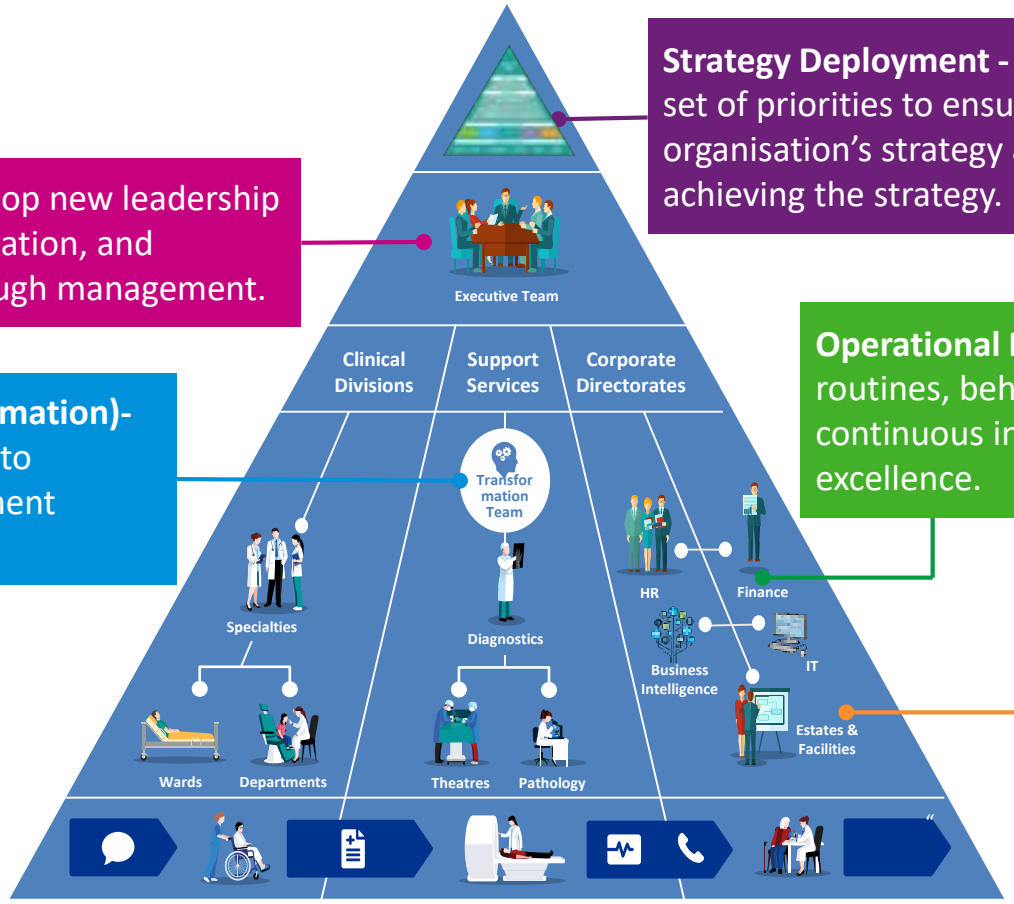
Strategy Deployment - Identify and communicate a focused set of priorities to ensure the entire staff can align with the organisation's strategy and understand its contribution to achieving the strategy.

Leadership behaviours - Develop new leadership styles at the top of the organisation, and capability to cascade this through management.

Operational Management System – A system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence.

Centre of Excellence (Transformation)- Develop an internal capability to develop and sustain improvement journey

Transformational projects - Using improvement methodology to create step-change improvement



Communication and engagement - Providing an environment that values staff and engages them with the organisation

Patient First – True North Domains

NHS Medway NHS Foundation Trust

Ambition:

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

Vision:

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

Ambition:

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

Vision:

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

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

Ambition:

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

Vision:

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

Ambition:

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

Vision:

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

Ambition:

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

Vision:

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

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

Patient First – Progress summaries

The next set of slides will detail the following for each Domain:

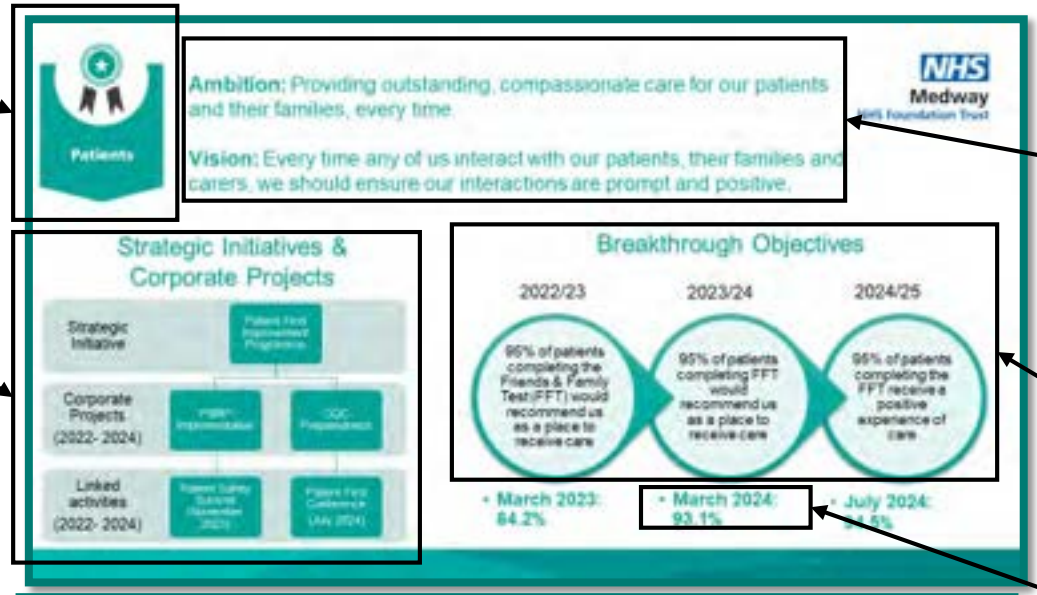
*The **'True North'** domain (or priority area), of the 5 key areas.*

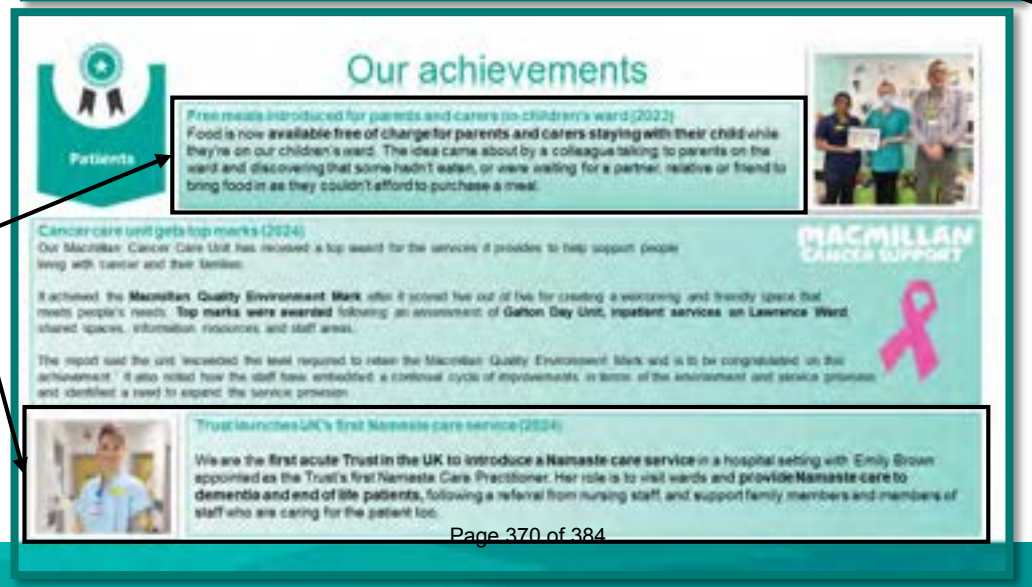
***The Strategic Initiatives** are our "must-do, can't fail" outcomes – all of which are underway, usually up to 3 year or so in duration. These support achieving the Vision*

*The **Corporate Projects** and **Linked Activities** are those targeted projects that make up or deliver part/s of the Strategic Initiative.*

*The **"Our achievements"** page denotes 3 – 4 key outcomes we have achieved in support of the 'True North' Vision. They are evidence of our successes.*

These are not exhaustive but represent some milestones we're proud of!





*The **'True North'** domain (or priority area), of the 5 key areas.*

*The '**Ambition' and 'Vision**' statements for this Domain indicate the long-term expectations we have (ambition) and a clear target we want to be able to show we have achieved (vision).*

*The ''**Breakthrough Objectives**' are specific annual metrics that we set, linked to addressing the root causes of issues that prevent us achieving our vision. They come from A3 Thinking processes.*

*The **end of year / in year position** states where we ended the year in terms of our progress against the objective.*

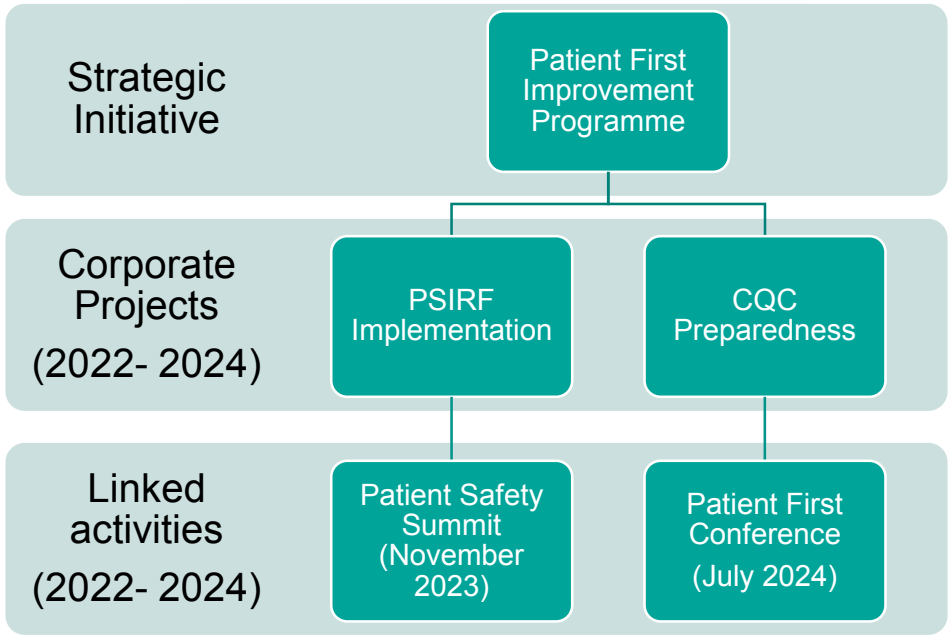
Patients

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

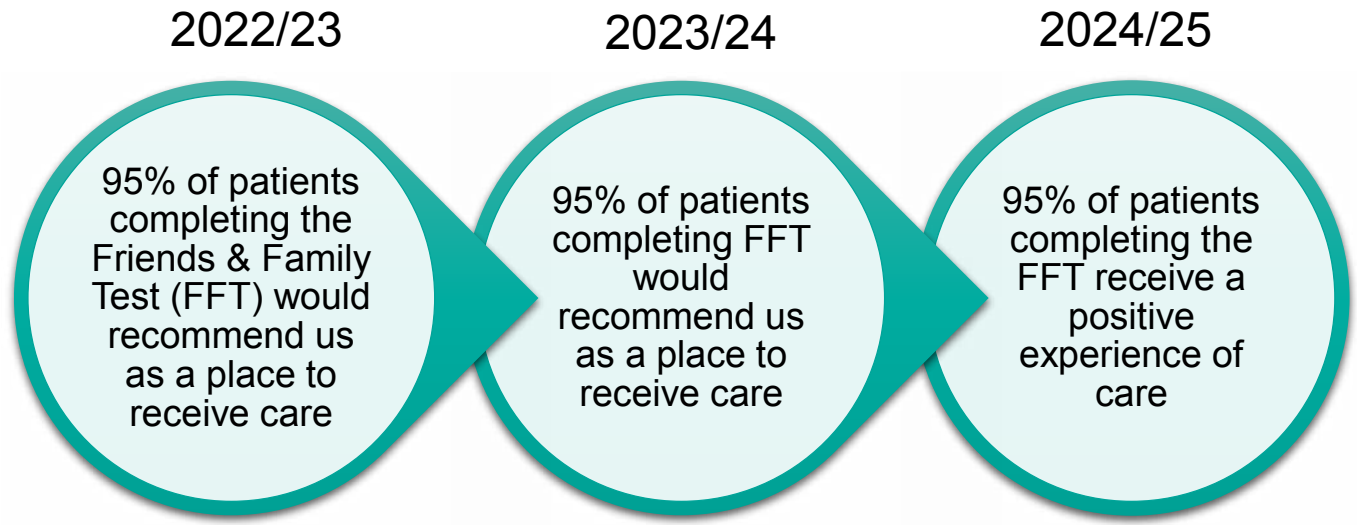
Vision: Every time any of us interact with our patients, their families and carers, we should ensure our interactions are prompt and positive.

NHS Medway NHS Foundation Trust

Strategic Initiatives & Corporate Projects



Breakthrough Objectives



- **March 2023: 84.2%**
- **March 2024: 93.1%**
- **July 2024: 94.5%**

Our achievements

Patients

Free meals introduced for parents and carers on children's ward (2023)

Food is now **available free of charge for parents and carers staying with their child** while they're on our children's ward. The idea came about by a colleague talking to parents on the ward and discovering that some hadn't eaten, or were waiting for a partner, relative or friend to bring food in as they couldn't afford to purchase a meal.

Cancer care unit gets top marks (2024)

Our Macmillan Cancer Care Unit has received a top 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 for creating a welcoming and friendly space that meets people's needs. **Top marks were awarded** following an assessment of **Galton Day Unit, inpatient services on Lawrence Ward**, shared spaces, information resources and staff areas.

The report said the unit 'exceeded the level required to retain the Macmillan Quality Environment Mark and is to be congratulated on this achievement.' It also noted how the staff have embedded a continual cycle of improvements in terms of the environment and service provision, and identified a need to expand the service provision.

Trust launches UK's first Namaste care service (2024)

We are the **first acute Trust in the UK to introduce a Namaste care service** in a hospital setting with Emily Brown appointed as the Trust's first Namaste Care Practitioner. Her role is to visit wards and **provide Namaste care to dementia and end of life patients,** following a referral from nursing staff, and support family members and members of staff who are caring for the patient too.

Systems and Partnerships

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

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

NHS Medway NHS Foundation Trust

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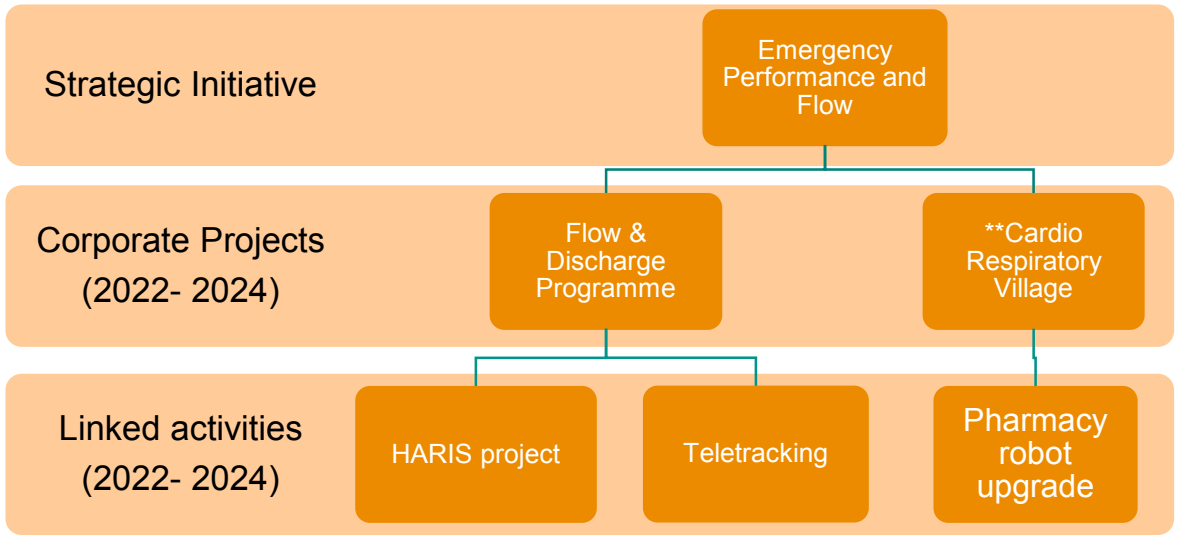

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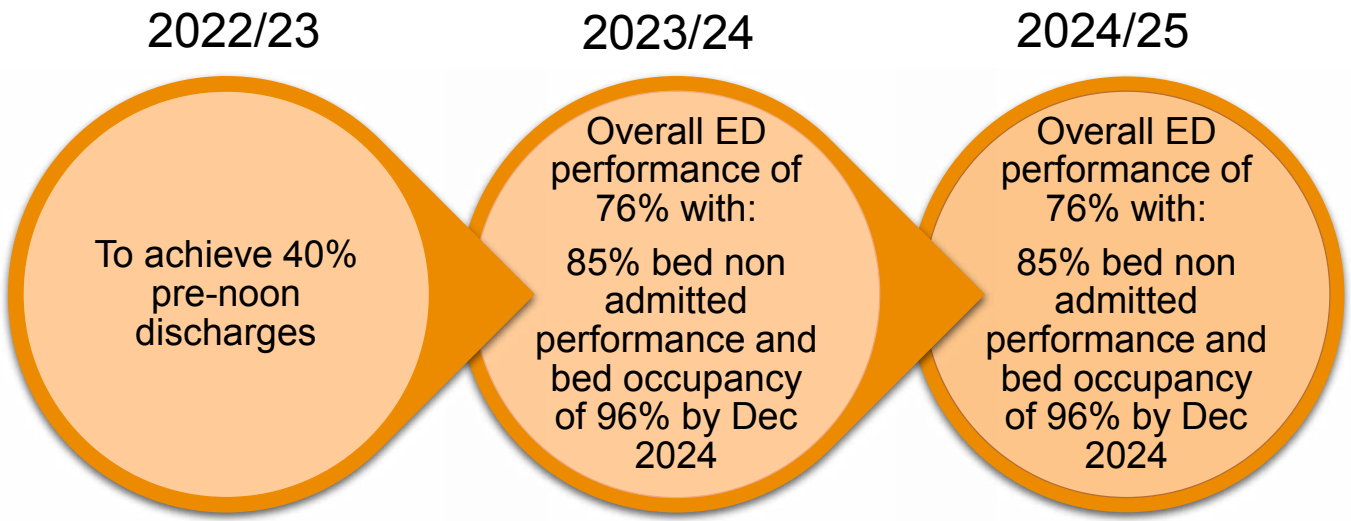


- **March 2023: 14.3%**
- **March 2024: 77.8%**
- **83% non-admitted performance**
- **July 2024:**
- **78.8%**
- **84.1% non-admitted**

Our achievements

Systems and Partnerships

Best Ambulance Handovers in the country (2024)

Thanks to the efforts of ED Staff and collaboration with hospital colleagues and external partners, national data shows that Medway was the **best performing trust for ambulance handovers in the country from April to July 2024**, with an average handover time of 12 minutes and 19 seconds, against the national average of more than 31 minutes.

*New bed management system (2023)

Patients are being moved into beds on wards faster, and thousands of hours have been freed up for nurses to care for them, thanks to our Teletracking bed management system which provides real-time visibility of the beds available across the hospital.

Patients wear an **electronic wristband on admission which allows Clinical Co-ordination Centre to see the bed the patient is occupying** and their care pathway. When the patient goes home, the wristband is placed in a drop box which then automatically updates on the discharge and notifies the centre that the bed is now ready to be cleaned ahead of the next patient being admitted on to the ward.

**New cardio respiratory ward opening (2024)

Our new cardio respiratory ward provides more than **30 new beds** and state-of-the-art facilities for patients with serious breathing or heart conditions.

The ward includes a **seven-bed Respiratory Support Unit (RSU),** which provides a higher level of monitoring for the sickest patients.

This is the first phase of a longer-term development of a *Cardio Respiratory Village, which will encompass a new cardiac catheterisation laboratory and better location of services – a priority under the Trust's Patient First improvement programme and Clinical Strategy.

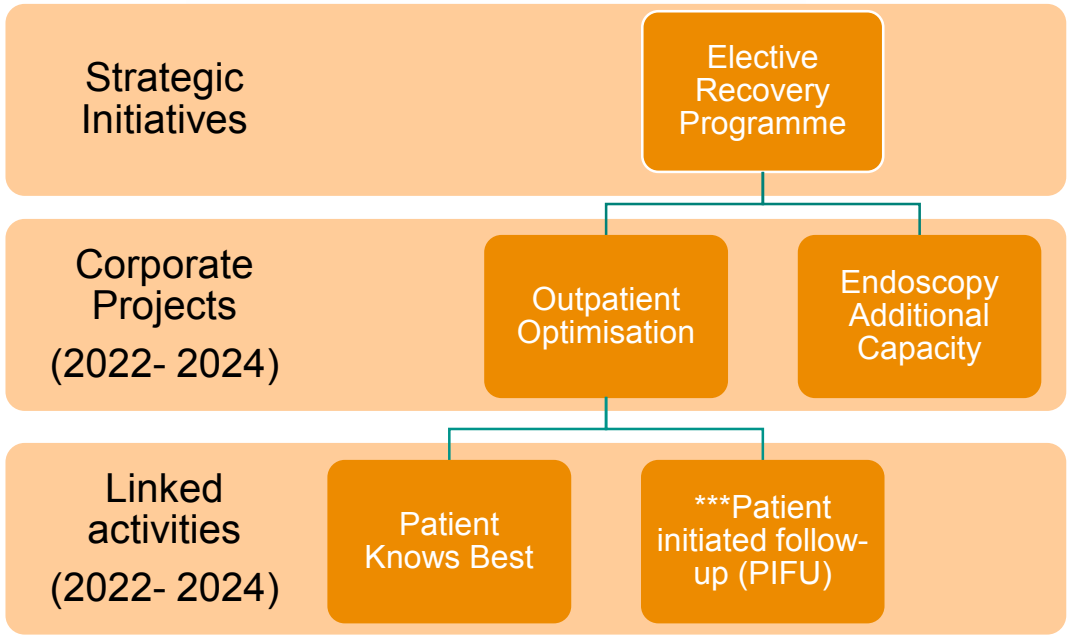
Systems and Partnerships

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

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

NHS Medway NHS Foundation Trust

Strategic Initiatives & Corporate Projects



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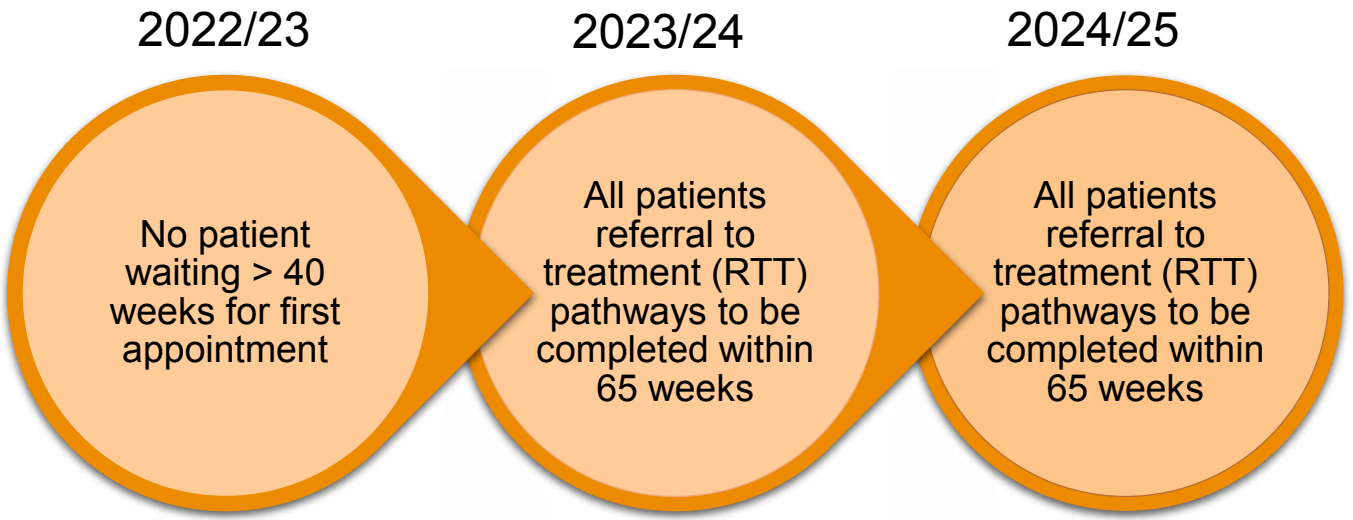


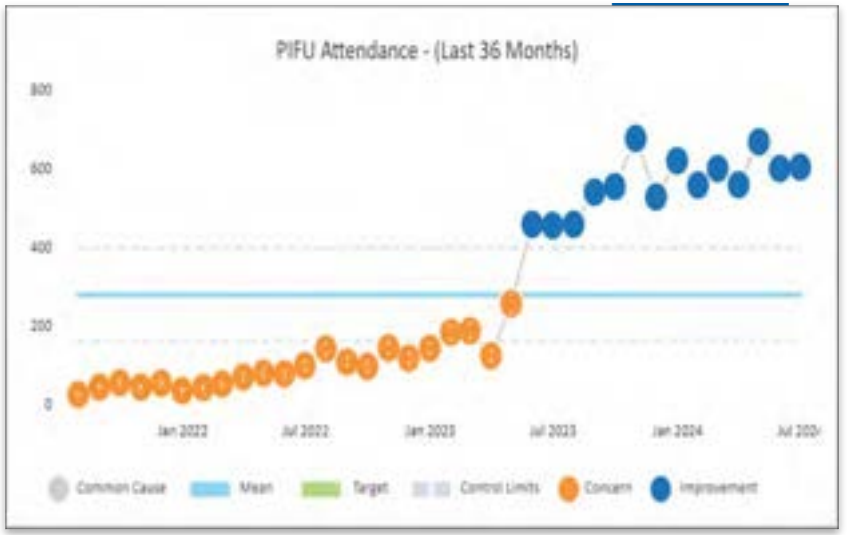
- **March 2023: 2500+ patients waiting >40 weeks for first appointment**
- **March 2024: 270+ patients waiting >65 weeks**
- **July 2024: 640+ patients waiting >65 weeks**

Systems and Partnerships

Our achievements

Putting patients in control of their outpatient appointment (2023 - 2024) ***

Patient Initiated Follow-Up (PIFU) appointments are being offered to many outpatients to give them more choice. Instead of attending regular follow-up appointments scheduled by the Trust, **PIFU puts patients in control of when they see a clinician as they can book an appointment when they need it most**, up to 12 months after the date of their outpatient appointment, before being discharged back to their GP.



Frailty unit opened (2023)

With the support of system partners and colleagues, **Sheppey Frailty Unit officially opened in Sheppey Community Hospital** in January 2023 to help us increase access to care for patients across Medway and Swale. This means patients in Sittingbourne and Sheppey will now be cared for closer to home and allow us to increase its capacity to treat more elective patients.

High Intensity Theatre (HIT) list (2023)

The ear, nose and throat (ENT) surgical team operated on 10 children on the same day, double the usual daily number, with eight of the children having both their tonsils and adenoids removed at the same time, as part of a High Intensity Theatre (HIT) list. The hospital's first adenotonsillectomy HIT list was inspired by a Getting It Right First Time GIRFT) publication.

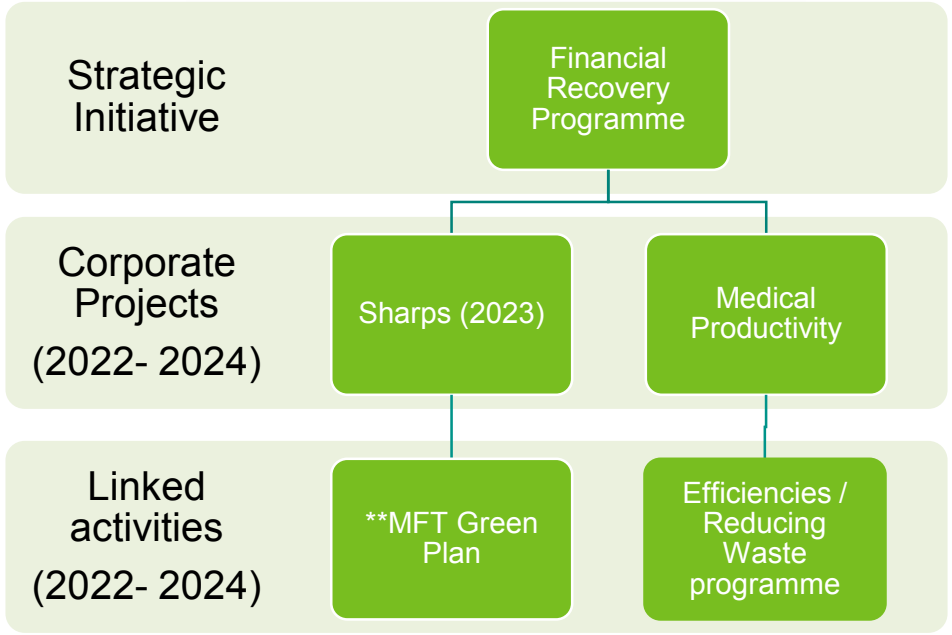
HIT lists need careful planning, bringing together clinical and non-clinical staff to select suitable patients, plan the order in which they are seen, and arrange all the equipment needed.

Sustainability

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

Vision: For Medway NHS to reach a sustainable underlying breakeven position within the next 5 years (by 2028/29 although now stretching to 2026/27).

Strategic Initiatives & Corporate Projects



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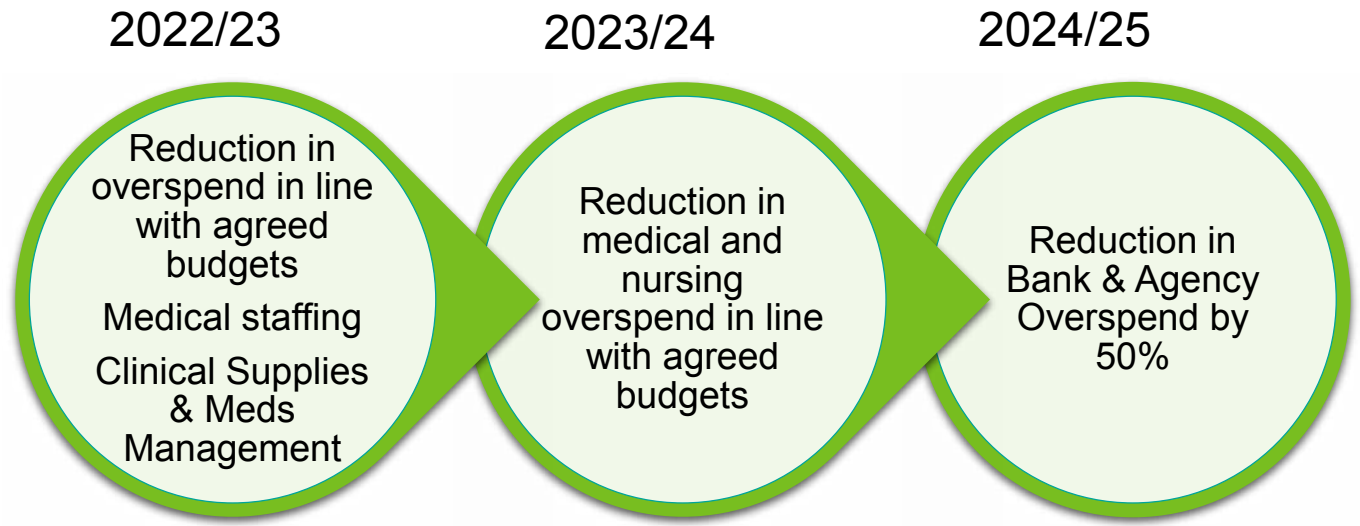


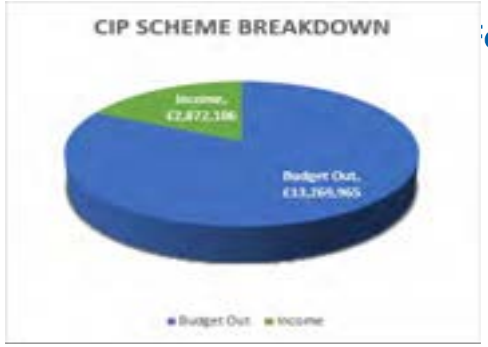
- **March 2023: forecast outturn delivered**
- **March 2024: forecast outturn delivered**
- **July 2024: average of c100-120 fewer worked FTEs per month vs March 2024**

Our achievements

Sustainability

Reducing waste programme:
A 4.24% efficiency cut was proposed by the Trust to the ICB, with an efficiency requirement by Division using proportion of expenditure as the basis.

Having defined targets in advance enables Divisional teams adequate planning time to initiate, plan and implement schemes that will set the Efficiency Programme 24/25 on the course for successful delivery.



NHS Medway Foundation Trust

Achievement Highlights

- A PMO Team has been stood up to support the Reducing Waste Programme and has been fully staffed from May 2024
- Weekly Check & Challenge Meetings are in place and chaired by an Executive. This meeting has introduced the rigour and governance to support the financial management of the programme
- The Reducing Waste programme for 2023/2024 saw delivery of £19.8M (against £27M target)
- The 2024/2025 programme is currently projected to deliver £16.1M in-year, budget out (including income, excluding operational efficiencies and run rate reduction)
- There has been notable progress in:
  - Job Planning progress (schemes signed off and delivering, unlike 2023/2024) and Medical Productivity in general
  - Outpatients AI/Teletracking/Faculty frontier and other transformational schemes (although non cash releasing)

Green Plan (2023-24)

As one of the largest employers in the area, and Kent's largest and busiest hospital site, our environmental impact needs to be addressed to improve the efficiency and resilience of the services we offer.

Our Green Plan aims to improve our organisational performance in this area by generating financial savings and environmental and social benefits.

We are investing in a greener future by Installing solar panels, replacing aging boilers with Modern heat pumps, installing energy efficient LED lights and double glazing, thanks to more than £26 million in funding to help reduce our carbon footprint and achieve our commitment to be net zero by 2040.

FOR A GREENER NHS

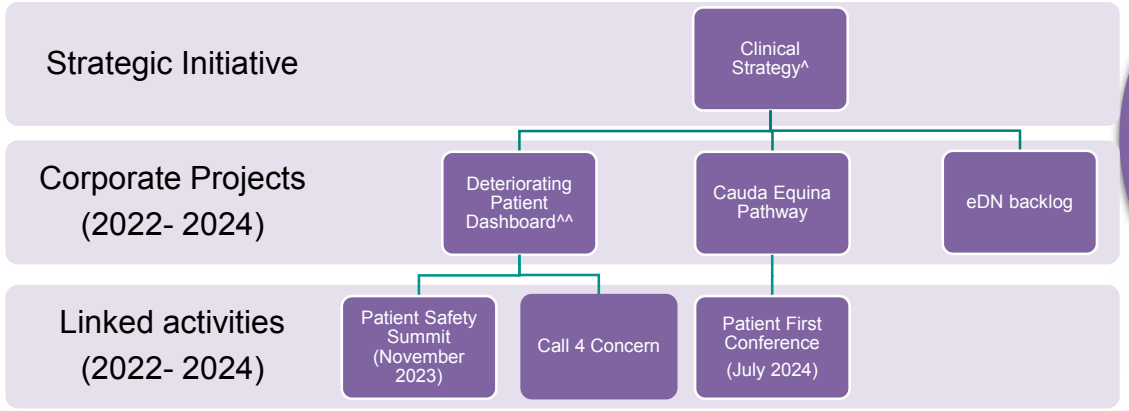
Quality

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

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

NHS Medway NHS Foundation Trust

Strategic Initiatives & Corporate Projects



Breakthrough Objectives

2022/23

50% reduction of avoidable cardiac arrest calls (2222) by March 2023

- **March 2023: = 89 (32 cardiac arrests, 50 peri-arrests; 7 pre-alerts)**

2023/24

Reduction of avoidable 2222 cardiac arrest calls to (<1 per month) and peri-arrest calls to (<3 per month by April 2024.

- **March 2024: 35 (13 cardiac; 22 peri-arrests)**

2024/25

Reduction of avoidable 2222 cardiac arrest calls to (<1 per month) and peri-arrest calls to (<3 per month)

****This is due to be updated In September 2024*

- **April - July 2024: 13 (5 cardiac, 6 peri-arrests & 2 pre-alerts)**

Our achievements

Quality

Clinical Strategy published^ (2024)

We published our Clinical Strategy 2024 - 2027, following extensive Patient, Public and Staff engagement activity. The Strategy sets out clearly how we intend to transform the services that we offer patients, using innovation and new technology, to deliver top quality healthcare.

The strategy defines our overall vision, and our aims and ambitions for each of our services and specialties over the next three, five and 10 years.

Sustaining our learning^^ (2023 – 24)

The Patient First Improvement System has supported us to foster a learning and safety culture.

As part of the Quality True North improvements, we are developing a trust and ward level “dashboard” to support teams to identify and monitor a number of key things that help to improve the care of our unwell or deteriorating patients.

The **Deteriorating Patient Dashboard** has been developed with frontline staff and our Business Intelligence Team to look at a number of key things which include the timeliness of patient observations, avoidable cardiac arrest calls and whether patients have had a Treatment Escalation Plan (TEP) completed on admission. This supports the wards to ensure that patients received timely care and that any changes in their condition is both recognised and responded to.

Patient safety initiative and Martha’s Rule (2023)

Our patient safety service **Call 4 Concern enables patients and families to call a dedicated number 24/7 for immediate help and advice directly from a member of our Acute Response Team** if they have ongoing concerns about their own or their loved ones changing condition, despite raising their concerns with the nurse in charge or doctor.

The Trust’s initiative was launched in January 2023 in advance of **NHS England’s commitment on the introduction of Martha’s Rule from April 2024.**

People

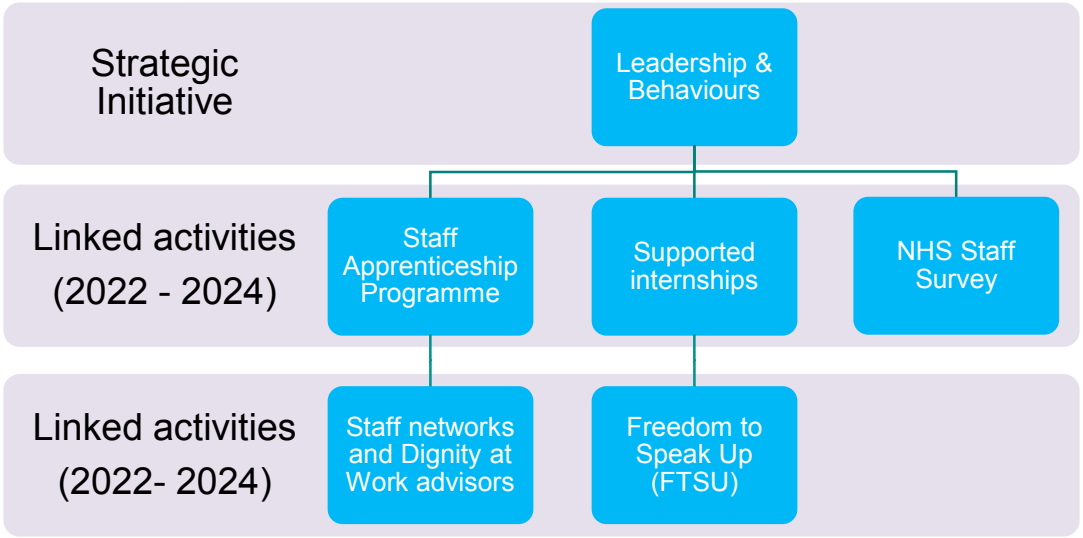
Ambition: To be the employer of choice and have the most highly engaged staff within the NHS.

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

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

NHS Medway NHS Foundation Trust

Strategic Initiatives & Corporate Projects



Breakthrough Objectives

- **March 2023: 91.7%**
- **March 2024: 1.4% (down from 2.2% in March 2023**
- **July 2024: 1.9%**
  (annualised position of <12% being reviewed as part of this year's Breakthrough Objective A3)

Our achievements

People

NHS Staff Survey – next steps (2024)

A total of 2,108 completed last year's survey, up from 2,023 the previous year. While we heard from more colleagues our overall response rate was down two per cent to 38 per cent, below the national average of 45 per cent. **Although our results have improved in most areas, it is clear we have more to do to improve the experience of working here**. We want to make Medway a great place to work and create a positive culture where our staff can thrive and our patients receive the best of care.

National recognition for support programme (2024)

We received the **National Preceptorship Interim Quality Mark for the support we provide to newly reg**istered healthcare professionals.

Preceptorship provides a period of guidance, support and structured learning to help newly registered healthcare professionals, to develop their knowledge and skills in their first year to ensure they can work as confident and competent practitioners as they transition from student to professional.

It's hoped the Quality Mark will attract early career nurses, midwives and AHPs to the hospital as it indicates that its preceptorship programme will provide them with a firm foundation for their career development.

Career conversation clinics (2023)

The Clinical Workforce Team launched Career Conversation Clinics which are hosted in different areas of the hospital throughout the year, **providing colleagues with an opportunity to find out about the exciting development opportunities that we have available right here at Medway.**

Trust receives NHS Pastoral Care Quality Award (2024)

We have been awarded the NHS Pastoral Care Quality Award in recognition of our work in international recruitment and the physical and emotional support we provide to overseas staff when they join us. Support offered includes in-house training and support for internationally educated nurses and midwives. We also offer support with flights, transport, and accommodation.

More than 90 different nationalities make up our multicultural workforce who work at different levels and in a variety of roles.

Patient FIRST

In the Spotlight

A weekly showcase in the Main Reception, learning taken from the visit to University Hospitals Coventry & Warwickshire in mid-2023 .

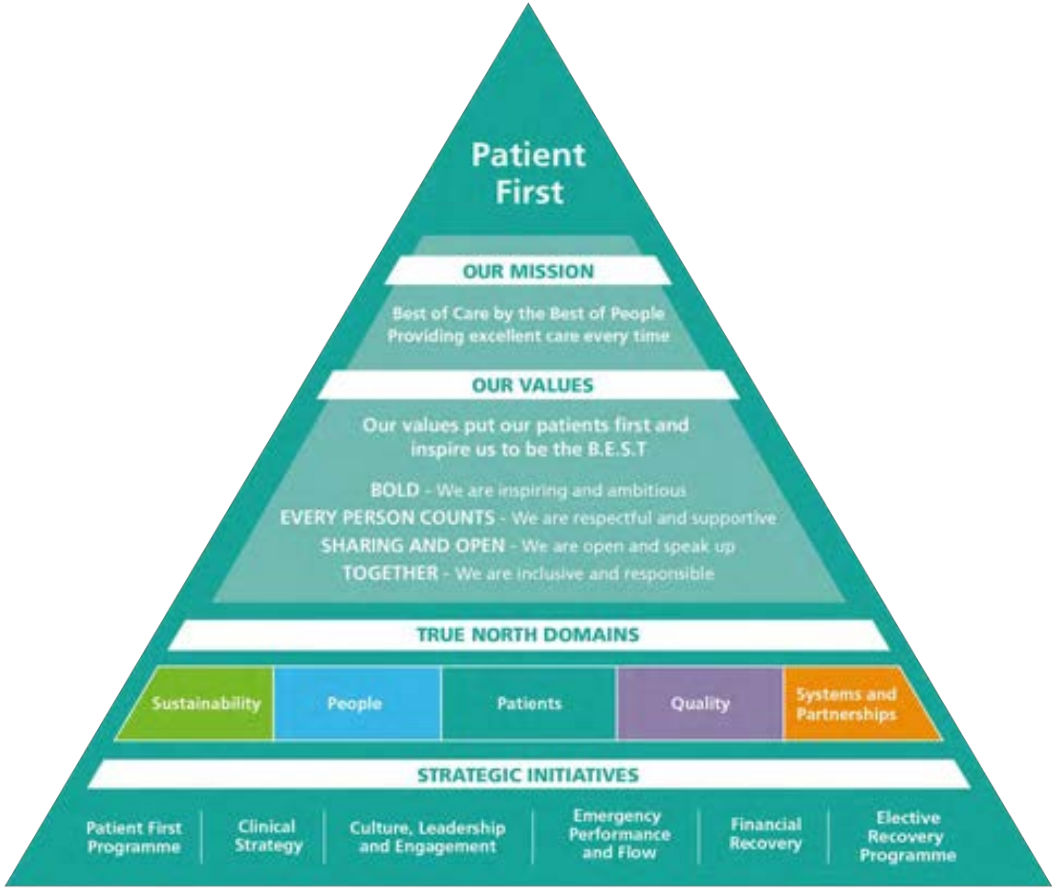
'Patient First… in the Spotlight' is a short stand-up session (15 minutes) in the main entrance where a team talks about improvements they have made to the care they are giving our patients. We encourage our staff, visitors and patients to attend.

Spotlight Activity has focused on a wide range of frontline improvements including:

- The establishment of Pressure Ulcer huddles in clinical areas;
- The use of Remote Patient Monitoring and elastomeric devices to improve patient recovery at home (SMART Team)
- The integration of our Hospital Palliative Care and Community End of Life Care teams to support our palliative care patients seamlessly onto and end of life pathway when it was needed.
- The introduction of day one post-discharge phone calls to remotely review day surgery and improve patient experience and surgical outcomes.

NHS Medway NHS Foundation Trust

Forward look



- Build on 2023/ 2024 Patient First Strategy
- Development of 2025/ 2028
- Patient First Strategy, likely to include:
    - Strengthening clinical engagement
    - Greater patient involvement
    - Greater spread of training for our staff
    - How we work with our partners
- Our 2nd Patient First Conference in summer 2025 aimed at out staff and partner organisations