APPENDICES - Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 13 November at 13:00 – 15:00

Item	Subject	Presenter	Page	Time	Action
1.	Preliminary Matters				
1.1	Chair's Introduction and Apologies	Chair			
1.2	Quorum				
1.3	Declarations of Interest				
2.	Minutes of last meeting and Action Log				
2.1	Minutes of 10 September 2024	Chair			
2.2	Action Log				
3.	Opening Matters				
3.1	Chief Executive Update	Chief Executive			
3.2	Council of Governors Report – no update from August 2024	Lead Governor			
	Board Story Presentation				
3.3	Breast Feeding Story	Associate Director of Patient Experience			
4.	Performance, Risk and Assurance				
4.1	Trust Risk Register	Company Secretary			
	Board Assurance Framework				
4.2	Emergency Preparedness, Resilience and Response – Annual Assurance Rating	Chief Operating Officer			
4.3	**APPENDIX 1: Integrated Quality Performance Report**	**Chief Delivery Officer**	**3**	**13:35**	**Assurance**
5.	Board Assurance Reports				
5.1	Quality Assurance Committee	CNO/CMO/Committee Chair			
5.2	People Committee	Chief People Officer, Committee Chair			
5.3	Finance, Planning and Performance Committee	Chief Finance Officer, Committee Chair			
6.	Papers				
6.1	**APPENDIX 2: Finance Report (Month 6)**	**Chief Financial Officer, Chief Delivery Officer**	**55**	**14:05**	**Note**

Best of care Best of people Patient FIRST

APPENDICES - Agenda

6.2	ED Recovery	Chief Delivery Officer			
6.3	**Maternity Services Reports:** **a) APPENDIX 3: Claims, Complaints and Incidents - Triangulation** **b) APPENDIX 4: CNST Compliance - Update** **c) APPENDIX 5: Perinatal Culture Leadership** **d) APPENDIX 6: Perinatal Quality Surveillance**	**Director of Midwifery**	**63**	**14:25**	**Assurance**
6.4	**APPENDICES 7, 8, 9, 10: Kent and Medway NHS Strategy 2024/25 – 2029/30**	**Chief Delivery Officer**	**135**	**14:30**	**Approve**
6.5	Strategy Review and Summary	Director of Strategy and Partnership			
6.6	In Patient Survey Results - Update	Associate Director of Patient Experience			
6.7	Medical Education Annual Report	Chief Medical Officer			

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Integrated Quality & Performance Report

September - 2024

Patient FIRST

Executive Summary

Jayne Black
Chief Executive

True North

	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
People	23	28	4	17	15	16
Quality	51	13	12	13	5	3
Systems & Partnerships	14	9	14	17	4	5
Patients	9	16	1	3	0	5
Sustainability	7	3	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, (28), however the Patients domain shows the highest % of statistical improvement metrics (~62% of all metrics)
- The Systems & Partnerships domain is showing the highest number of metrics statistically showing concern, with 38% of all metrics flagging
- The Sustainability Domain has shown an improvement since last month and 3 (25%) of the metrics are now showing as improving statistically
- The majority of the metrics in the Quality domain continue to show no significant statistical variation and as such are showing common variation.
- Overall, 72 metrics are now showing improved statistical variance (+3 from last month) against 33 which are showing concern (no change from last month).

Issues, Concerns & Gaps

- An emerging theme from patient feedback has been around food choice, access to food and issues with parking.
- Inconsistency with clinical education, VTE prescribing against the VTE assessment, limited assurance in relation to the number of HAT incidents
- RTT - The Trust are continuing to focus on the over 65 week position and is working hard to clear the number of patients waiting over 65 weeks
- Continued high percentage of patients in ED department over 12 hours
- High level of sickness short notice for Medics impacting staffing levels increased bank spend. CPO, HRBPs and rota team involved in work supporting divisions understand their position, stratified data, and approach;
- Following a review of the forecast outturn at Month 5 the risk assessed forecast has deteriorated by £9.3m, to £15.1m adverse to Plan.

Actions & Improvements

- Work is underway to standardise the information provided to patients about parking on site and managing expectations around delays
- A VTE clinical champion has been appointed from the medical team and will work very closely with the VTE nursing team to compete the identified countermeasures in the A3 group. A VTE dashboard is being developed which will go live when the Datix reporting is accurate, this will be complete by early November 2024
- RTT - Daily reviews/validation of all patients over 65 weeks
- ED - New Front Door Streaming model PDSA in place – review to be presented end of October
- Executive Review meetings with S&A and MEC Divisions

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	6	4	0	5	0	1
FFT	11	24	4	12	0	12
PALS	4	2	1	1	0	0
Patient Experience	0	2	0	2	0	0
PHSO	3	3	0	1	0	0

Patient FIRST

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

Committees:
Quality Assurance Committee (QAC)

Patients

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FFT

Total FFT Recommend %

Type	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	95.0%	H	F	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%

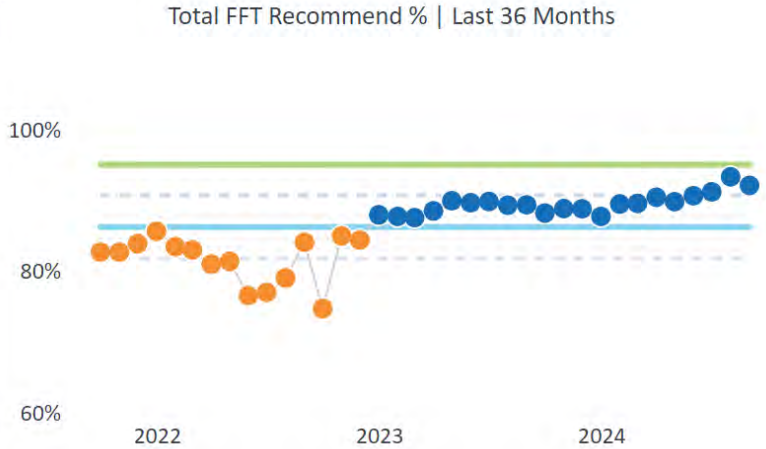
True North Domain: **Patients**

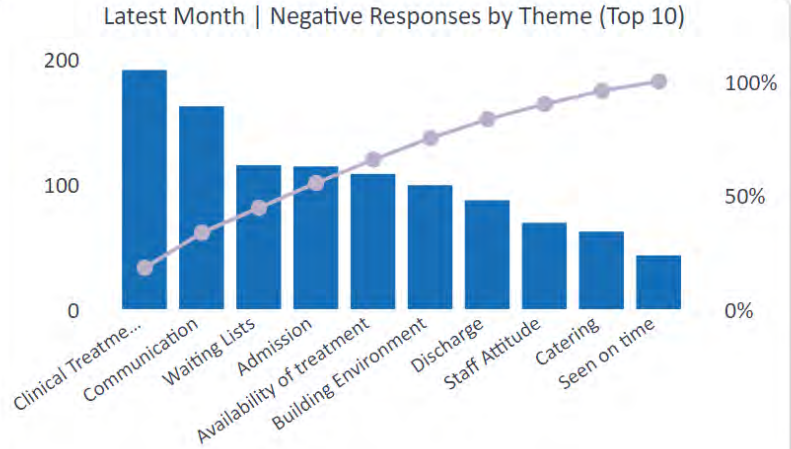
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

	L	H	L	H
2	1	0	0	7





Key Messages

- Trust wide positive experiences of care has remained off target
- Inpatient positive experiences of care is above target for the second consecutive month
- Focus has been on celebrating staff who have gone above and beyond and exceptional care practices
- Response rate has improved month on month in all areas
- An engagement event was held by the Maternity team to understand top themes / issues that could be improved when families are in out care

Issues, Concerns & Gaps

- Clinical treatment remains as the highest contributor to negative feedback
- An emerging theme from patient feedback has been around food choice, access to food and issues with parking. These have been discussed in the weekly breakthrough huddles

Actions & Improvements

- The facilities team generated a specific survey for patients to understand where to focus their improvements and next steps. This is to be used as a focus during the weekly FFT huddles
- Work is underway to standardise the information provided to patients about parking on site and managing expectations around delays
- The estates team to be included in weekly breakthrough huddles to address issues raised by patients around parking

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Patients	FFT			Emergency Care FFT Recommend %	85.0%		F	Watch is red for 4 reporting periods	77.1%	70.2%	74.9%	73.0%	79.9%	74.0%
				Outpatient FFT Recommend %	95.0%	H	F	Watch is red for 4 reporting periods	91.3%	92.7%	92.6%	93.0%	94.7%	92.8%
				Maternity FFT Recommend %	95.0%		?	Watch is red for 4 reporting periods	99.4%	96.5%	92.6%	88.0%	92.6%	94.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	Watch is red for 4 reporting periods	110	108	89	26	12	12

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%
				Total FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	16.2%	15.1%	15.5%	15.3%	17.0%	16.4%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.2%	92.6%	93.3%	94.5%	95.3%	95.6%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	50.8%	47.0%	50.6%	51.8%	51.7%	51.2%
				Outpatient FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.3%	92.7%	92.6%	93.0%	94.7%	92.8%
				Outpatient FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	9.9%	9.7%	9.6%	9.8%	11.3%	10.8%
				Maternity FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	49.2%	47.6%	39.0%	34.2%	42.3%	70.6%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	Special cause of improving nature or lower pressure due to (L)ower values	110	108	89	26	12	12
	Complaints			Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	28	23	27	21	30	21
				Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	91	66	55	34	44	34
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	60.7%	34.5%	21.4%	6.7%	0.0%	30.8%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	107	132	121	77	94	76

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Patients	PALS			PALS Converted to Complaints	-		Special cause of improving nature or lower pressure due to (L)ower values	0	1	0	0	1	0
	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 remain very low. The top contributors remain stepping patients down from ICU and HDU onto the ward.
- 100% acknowledgement for complaints
- 1 new PHSO investigation
- 0 PALS converted to complaints

Issues, Concerns & Gaps

- Accurate reporting mixed sex breaches automatically on teletracking remain a national issue
- The process for managing patients who identify as non-binary or trans has not been ratified
- 30.8% breached complaint status – this is due to a delay with comments from staff being on leave in August/September when comments were required from staff.
- 5 complaints re-opened – relating to deceased patients (3), multi-organisation complaint (1), Complex discharge (1).

Actions & Improvements

- MFT & MTW are working together with teletracking to resolve the reporting issues
- The MSA policy has been drafted, the EDI process for caring for trans and non-binary process is to be added and circulated. This will be complete by early November 2024
- All files robustly reviewed prior to decision to re-open
- Response timeframe aligned to NHSE complaint handing policy on 1 September – increasing from 40 working days from 25

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Patients	FFT			Total FFT Recommend %	95.0%	H	F	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%
				Total FFT Response Rate %	-	H		12.9%	13.9%	12.0%	12.4%	14.7%	14.0%	16.2%	15.1%	15.5%	15.3%	17.0%	16.4%
				Inpatients FFT Recommend %	95.0%	H	F	90.7%	92.2%	93.3%	92.3%	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%	95.3%	95.6%
				Inpatients FFT Response Rate %	-	H		36.8%	45.5%	38.0%	36.0%	40.9%	44.2%	50.8%	47.0%	50.6%	51.8%	51.7%	51.2%
				Emergency Care FFT Recommend %	85.0%		F	75.2%	67.9%	69.2%	64.7%	68.9%	71.6%	77.1%	70.2%	74.9%	73.0%	79.9%	74.0%
				Emergency Care FFT Response Rate %	-	L		9.9%	8.8%	7.6%	8.3%	9.9%	7.6%	10.2%	8.9%	9.1%	9.6%	10.0%	8.8%
				Outpatient FFT Recommend %	95.0%	H	F	91.1%	92.4%	91.9%	91.5%	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%	94.7%	92.8%
				Outpatient FFT Response Rate %	-	H		8.5%	8.8%	7.6%	8.7%	10.0%	9.2%	9.9%	9.7%	9.6%	9.8%	11.3%	10.8%
				Maternity FFT Recommend %	95.0%		?	92.5%	90.5%	82.7%	88.5%	85.8%	88.8%	99.4%	96.5%	92.6%	88.0%	92.6%	94.8%
				Maternity FFT Response Rate %	-	H		33.5%	26.1%	14.5%	30.9%	38.7%	30.6%	49.2%	47.6%	39.0%	34.2%	42.3%	70.6%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?				486	278	90	110	108	89	26	12	12
	Complaints			Complaints	-	L		28	32	19	20	25	29	28	23	27	21	30	21
				Complaints Closed	-			35	38	30	22	20	25	28	48	38	42	20	31

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Patients	Complaints			Complaints Open - Month End	-	L		100	95	84	82	87	91	91	66	55	34	44	34
				Complaints Re-Opened	-			1	2	2	2	1	6	1	3	2	4	1	5
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	42.9%	41.2%	40.6%	62.5%	55.6%	82.8%	60.7%	34.5%	21.4%	6.7%	0.0%	30.8%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			416	528	428	496	463	417	480	428	446	499	421	521
				PALS Closed	-			383	549	485	708	460	418	458	403	457	543	404	539
				PALS Open - Month End	-	L		369	351	294	83	86	85	107	132	121	77	94	76
				PALS Converted to Complaints	-	L		0	0	0	0	0	0	0	1	0	0	1	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			0	0	1	0	0	0	1	0	2	2	2	0
				PHSO Cases Closed - Partially Upheld	-	L		1	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Upheld	-			0	0	0	0	1	0	0	0	0	1	0	0
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-			0	0	0	0	1	4	0	0	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	13	14	11	7	3	7
IPC	7	1	1	1	2	0
Medicines	5	0	0	2	1	0
Mortality	16	3	3	14	1	2
Pressure Ulcer	3	2	2	2	1	0
Falls	15	0	0	11	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	2	1	0	0	0	0
Maternity	16	0	0	2	0	2
Risk & Policy	4	0	0	0	0	0
Surgical	0	1	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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	95.0%		P	99.3%	99.0%	99.6%	99.0%	98.9%	99.5%	98.7%	99.2%	98.6%	99.1%	98.8%	98.9%

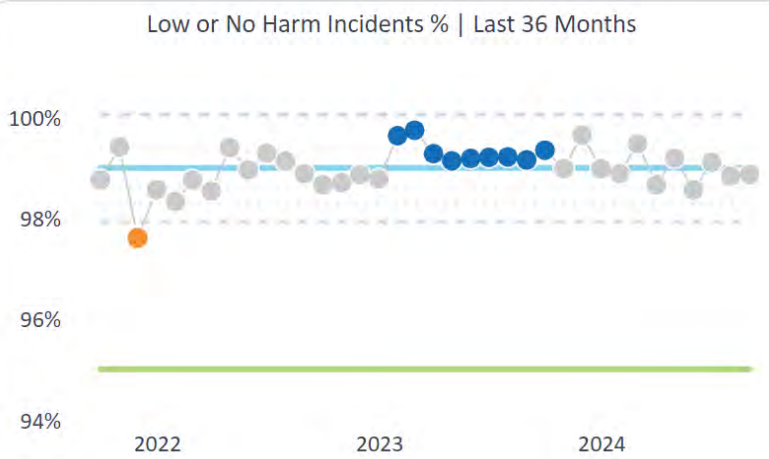
True North Domain: Quality

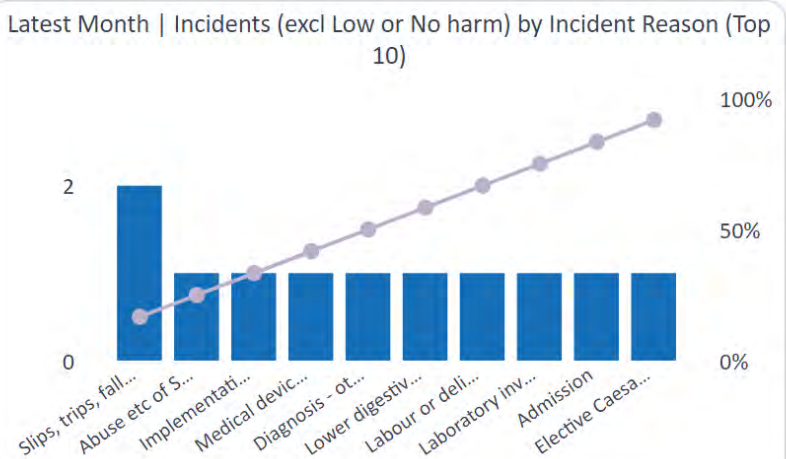
KPI Threshold: 95.0%

Sub Domain KPIs: 21

Variation Summary:

	L	H	L	H
8	0	7	1	5





Key Messages

- 98.9% of all incidents reported resulted in low or no harm. Clinical incidents with harm as moderate or above has remained stable.
- 11 incidents in September caused moderate harm or above.
- 6 Incidents caused moderate harm
- 5 Incidents caused severe harm

Issues, Concerns & Gaps

- Transfer of care concern from MCH
- Correct use of oxygen
- Thrombus and falls potential learning.
- Potential missed diagnosis.
- Ongoing review of 2222 calls

Actions & Improvements

- Improvement actions for falls, pressure ulcers and infections 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.
- Breakthrough objective has soon a significant reduction in avoidable 2222 calls. This work is now being transferred to the resuscitation and deteriorating patient working group.
- Sepsis improvement work has taken place and more planned, in line with updated NICE guidance.
- Coroner investigation.

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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	1.30%			1.53%	1.19%	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%	1.35%	1.28%

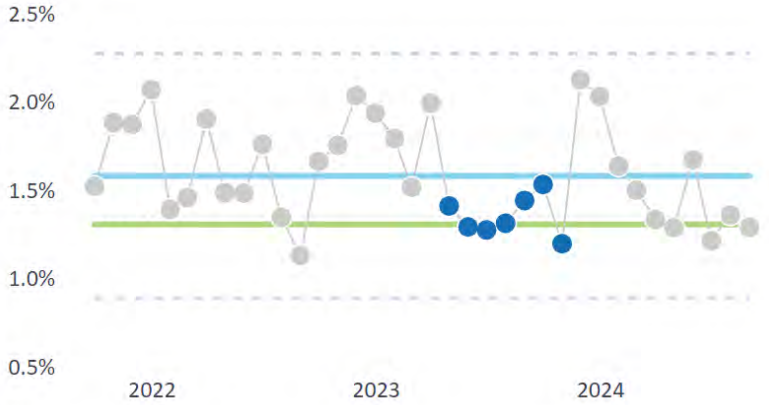
True North Domain: Quality

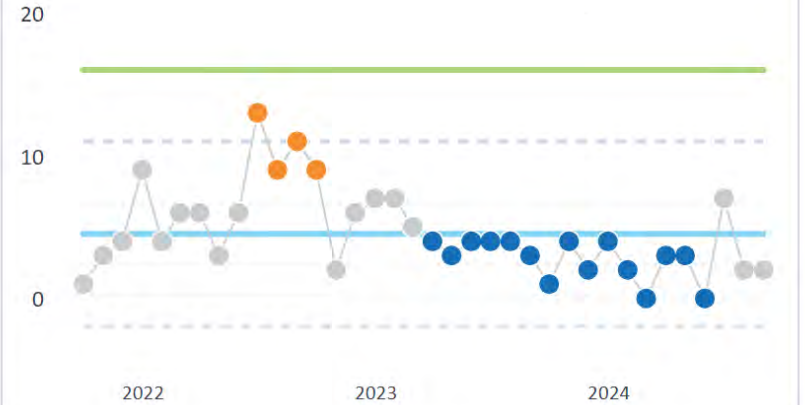
KPI Threshold: 1.30%

Sub Domain KPIs: 13

Variation Summary:

10	0	2	1	0





Key Messages

- HMSR for the period of June 2023- May 2024 is 111.05 and 'higher than expected'.
- SHMI for the period of June 2023- May 2024 is 1.18 and 'higher than expected'.
- 15.5% of deaths were subject to SJR reviews- this increase was due to the new SJR single reviewer process which runs alongside the current SJR panel process
- One case was highlighted to the Incident Review Group for further investigation due to abnormalities in a chest X-ray not reviewed, resulting in the patient being readmitted with a missed pneumothorax.
- 12/17 specialities submitted M&M minutes.

Issues, Concerns & Gaps

- Patients admitted with a respiratory diagnosis remain an outlier and when removing this from the HMSR and SHMI data, an improvement is seen in both indicators which indicates that this cohort of patients are having a negative impact on the overall mortality performance for the Trust.
- Both SHMI and HSMR remain higher than expected.

Actions & Improvements

- The new SJR single review process has resulted in an increase in the number of cases reviewed.
- SJR and Learning from Deaths training will be delivered to the Trust on the 6th November.
- A3 mortality improvement work ongoing with a focus on root causes into the higher than expected mortality indicators .
- Support to specialties for their M&Ms is being provided by the Learning from Deaths team by sharing best practice and supporting teams with the M&M process.
- Coding and Learning from deaths continue to deliver presentations on the importance of documentation and the impact this is having on coding, finance and mortality indicators.
- NICHE action log is monitored weekly with many actions on track and in progress or completed.

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0			Watch is red for 4 reporting periods	9	5	12	5	11	11
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	77.5%	80.3%	78.4%	81.5%	83.1%	81.5%
	Mortality			HSMR (All)	100	H	F	Watch is red for 4 reporting periods	109.82	110.74				
				SHMI	1	H	F	Watch is red for 4 reporting periods	1.19	1.18				
				Fractured NOF Within 36 Hours	92.0%			Watch is red for 4 reporting periods	60.0%	51.5%	52.5%	56.5%	74.1%	

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Incident Management			Patient Safety Incident Investigations (PSII) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	0	0	0	0	1	1
				After Action Review (AAR) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	1	4	2	2	3	2
				Never Events	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				EDNs Completed Within 24hrs %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	77.5%	80.3%	78.4%	81.5%	83.1%	81.5%
	Pressure Ulcer			Pressure Ulcers per 1,000 Bed Days (Reportable)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0.96	0.99	1.24	1.18	1.43	1.40
	IPC			MRSA Cases - Hospital Acquired	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	Mortality			Expected Death Rate %	-	L	Special cause of improving nature or lower pressure due to (L)ower values	3.6%	3.6%				
	VTE			VTE Risk Assessment Completed %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	99.1%	99.4%	99.5%	99.8%	99.0%	99.0%
	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	83.1%	83.0%	83.8%	83.6%	83.6%	82.9%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	84.0%	84.9%	85.1%	85.6%	86.6%	85.5%
	Legal & Information Governance			Regulation 28 Reports	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

FNoF

- The number of patients with hip fractures who had surgery within 36 hours, has shown significant improvement to 74.1% in August, from 56.5% in July.
- We are doing root cause analysis (RCA) for all breaches - first multi-disciplinary RCA was done on the 3rd October 2024. Lessons learnt have been shared.
- We are adding the breach times for all patients with hip fractures on e-trauma and the trauma list, so that the orthopaedic, anaesthetic and the theatre team are aware of the timelines.

Falls

- 143 staff attended falls prevention documentation training sessions.
- Falls documentation sessions very well evaluated
- Throne Project- all toilets and bathrooms audited. Recommendations currently being grouped for action.

VTE

- CNS specialist post is vacant, recruitment underway, which has been identified as a risk

HAPU

- Currently building purpose t on EPR for paediatrics
- Proposal will be shared at TIG to approve funding for a full replacement of all mattresses and pressure relieving equipment

Issues, Concerns & Gaps

FNoF

- Many patients with hip fractures have multiple co-morbidities which require optimisation to ensure safe anaesthesia and surgery. This often results in delay for surgery. Three of the seven patients (42%) who breached in August, needed medical optimisation.
- Many patients are also on anti-coagulants which preclude early surgery, as the guidelines suggest waiting 24-48 hours to reduce the risk of bleeding. Two of the seven patients were on anti-coagulants and hence did not meet the 36-hour target.
- Lack of theatre time and image intensifier continues to pose a challenge.

Falls

- Issues remain with the process of monitoring and managing equipment.
- Staffing in the falls team remains a risk, there are significant gaps within the team
- Mandatory training for falls and e-learning training is still waiting approval #

VTE

- Inconsistency with clinical education, VTE prescribing against the VTE assessment, limited assurance in relation to the number of HAT incidents

HAPU

- Mattress storage and space to store bariatric equipment remains limited
- Availability of equipment especially out of hours
- Purpose T roll out has been limited due to the change freeze on EPR. Therefore a risk has been raised to highlight the compliance against the national requirements

Actions & Improvements

FNoF

- We are working closely with the anaesthetists and ortho-geriatricians and making multi-disciplinary decisions regarding medically unwell patients, to ensure early and safe surgery.
- We are presenting the RCA summary for all patients who breached in our M&M meetings so that any lessons learnt are shared with the wider team. The first of such M&M presentation will be done on 9th October 2024.
- We have organised a MDT meeting today (8th October) with haematologist, anaesthetist, OG and orthopaedics to update the anti-coagulation pathway and have uniform consensus regarding management plan for these patients to avoid delays to surgery.

Falls

- A working group has been established to assess the process of equipment, facilitated by the senior team
- The Falls team PID was approved and recruitment is ongoing
- The OD team will approve the mandatory training as soon as possible

VTE

- The A3 working group is well attended by all stakeholders. A VTE clinical champion has been appointed from the medical team and will work very closely with the VTE nursing team to compete the identified countermeasures in the A3 group. A VTE dashboard is being developed which will go live when the Datix reporting is accurate, this will be complete by early November 2024

HAPU

- A working group has been established to assess the process of equipment, facilitated by the senior team
- Trafalgar and ICU rolled out purpose T with good results, Maternity is the next area of focus

Maternity

Key Messages

Perinatal Quality – Incidents September 2024: 2 Incidents Moderate Harm or above; IUD following presentation with RFM at 38+4 – AAR to be undertaken; Neonatal femur fracture following birth by ELCS; 0 MSNI referrals in month;
151 incidents reported in Maternity, 24 low harm. >30 Incidents relating to Bleep system; 16 incidents reported in Neonatal, 1 low harm. **Perinatal Quality – PMRT – September 2024**: 4 MBRRACE reportable deaths- all reported within required timeframe; 35+0 Neonatal Death– baby with known congenital anomalies; 22 +4 Miscarriage – unexplained; 39+3 Stillbirth – unexplained; 39+0 Stillbirth – unexplained; 4 PMRT reviews in September (3 maternity, 1 Neonatal) **Staffing:** Midwifery B5 &6 vacancy for August 15.48 WTE(↓) 11.63 recruited; Maternity Leave – 9.64 WTE (↑); Band 3 MSW vacancy 2.14 (-) WTE with 2.7 awaiting start date. **Training – September 2024:** 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 Nursery Nurses; NICU Nursing QIS on trajectory to achieve 90% for external NLS course by October 2024. **Listening to Women and Families – Service Users and MNVP – September 2024:** Positive neonatal patient story shared regarding NGT at home pathway; Neonatal FFT 95% recommend rate with increasing response rate; Positive feedback for IOL pathway; Service user engagement event to be held early October; 15 Steps challenge to be led by MNVP in December 2024.
Co-produced Benchmarking against national Birth-trauma report completed. To be shared at MNCAG in November. **Staff Feedback - September 2024:** Teams talk held in September 2024 positive feedback received from staff in attendance; 8 MSWs achieved awards; 1 MSW appointed to regional LMNS-led MSW framework review; PMA team working with LMNS to develop bespoke training package for Labour Ward coordinators in line with LWC framework and 3 year delivery plan. **External – September 2024:** No Regulation 28 notices, HSIB/NHSR/CQC requests for action; Q1 24/25 SBL submitted – (94%) – LMNS validation 11/10/24; Continue to progress actions to achieve compliance against CNST Year 6 10 Safety actions – LMNS assurance visit 3/12/24; On track for all actions, with exception of Safety Action 8 which has appropriate actions in place to mitigate risk; SA2 scorecard demonstrates compliance with all requirements for July 2024 data; All reporting for CNST on track with reporting to Trust Board in November 2024 and January 2025 prior to submission in March 2025.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: AAR to review management of patient who suffered IUD. Issues with bleep system poses potential risk to maternity & neonatal patients in emergency situation; 3rd and 4th degree tears continue as a theme of incident reporting. **Perinatal Quality - PMRT:** Patients with baby booked on a palliative care pathway booked for IOL without relevant specialist teams being involved; Care plans for palliative babies not available for maternity and neonatal staff at time of admission; Patrograms not routinely being used for cases over 22 weeks. **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 15/12; IOL Risk (1131) – Score reduced to 9 (Previously12); 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; Postnatal Care and informed consent continue to be themes of FFT and complaints. **Staff Feedback:** Need to relaunch frontline Safety Champions following changes in staff and leadership roles. **External:** Outstanding actions for SBL identified; Funding for Diabetes Nurse and Dietician awaiting Trust approval (To be presented at TIG October 2024). PID in place to be supported by CNST Year 5 monies.

Actions & Improvements

Perinatal Quality – Incidents: AAR to be held following IUD – review of diabetic pathway for IOL; Risk relating to bleep system added to Divisional Risk register for approval due to potential for harm if requests for clinical support via bleep system are not responded to; Launch of OASI-2 bundle across unit 30 September 2024. "Trolley dashes" by education team to achieve 80% staff compliance by end of October with practical elements. Theory an further training to be included in essential skills by OASI-2 champions. **Perinatal Quality – PMRT:** Flow chart being developed to be added to IOL and Elective section SOP to ensure specialist teams are informed of known palliative cases prior to admission.
Work with birthing people and families to ensure voice heard in care planning; Learning shared via handover key messages to be shared via Maternity Matters. **Staffing:** Table top birth-rate + to take place in October; Supernumerary review completed and approved by Trust Education lead; 2 final positions from BR+2023 presented to VCP in September. **Training:** Booked trajectory for PROMPT and Fetal monitoring training brings all non-compliant groups to >90%; All out of date NBLS staff to be contacted by line managers to ensure attendance at training; Midwifery staff non-complaint with Safeguarding training identified and booked onto course. **Risk:** Business case for EuroKing approved in Division, to be presented to Execs.in October. Score reduced from 15 to 12 as PID completed, but not downgraded further due to complexities and expense of procurement. **Listening to Women and Families – Service Users and MNVP:** Neurodiversity working group commenced September – positive meeting with key workstreams identified; Deep dive into ethnicity, deprivation and demographics being used to help inform service improvements; Postnatal Care and communication to be key focus areas for service user engagement event in October; LMNS approved additional resource for MNVP including 3 additional days/month for engagement and a dedicated governance lead to meet CNST year 6 requirements. **Staff Feedback:** Safety Champion Feedback form to be launched alongside of poster and other staff comms to reinvigorate the role with updates to be shared in staff news letter "Maternity Matters"; SCORE survey to be re-launched in October for all WCYP staff.
Managers engaged with Trust Staff Survey and supporting all staff to complete survey; Improvement huddle boards now in place across the units. Further work identified to emend the process and senior staff undertaking training to support all colleagues to utilise Boards successfully. **External:** QI work identified within SBL bundle and to be presented to LMNS with next submission in September 2024. Smoking Cessation, Preterm pathway and Preterm optimisation included in projects to be shared with LMNS; Sharing progress with LMNS via formal meetings and peer assurance process; Compliance with RCOG consultant Roles & Responsibilities shared at local audit meeting for discussion and learning. – audit of Q1 24/25 shows continued compliance at 99%, with positive levels of attendance noted for consultants in excess of the "Must" attend criteria.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.3%	99.0%	99.6%	99.0%	98.9%	99.5%	98.7%	99.2%	98.6%	99.1%	98.8%	98.9%
				Total Incidents Reported	-			1,984	2,155	1,686	1,366	1,337	1,329	1,191	1,228	1,179	1,229	1,199	1,055
				Clinical Incidents with Harm (Moderate and above)	0		?	11	16	6	9	9	5	9	5	12	5	11	11
				Incidents Open - Month End	-	H		2,157	2,415	2,981	2,773	2,737	2,776	2,729	1,620	1,666	1,765	1,925	1,925
				Incidents Overdue - Month End	-	H		479	702	1,143	1,655	1,774	1,735	1,799	657	730	816	972	968
				Patient Safety Incident Investigations (PSII) Declared	-			0	0	0	0	0	0	2	0	1	0	0	0
				Patient Safety Incident Investigations (PSII) Closed	-	H		0	0	0	0	0	0	0	0	0	0	1	1
				Patient Safety Incident Investigations (PSII) Open - Month End	-	H		0	0	0	0	0	0	2	2	3	3	2	1
				After Action Review (AAR) Declared	-	H		0	0	1	1	7	2	1	5	3	2	0	4
				After Action Review (AAR) Closed	-	H		0	0	0	0	1	6	1	4	2	2	3	2
				After Action Review (AAR) Open - Month End	-	H		0	0	1	2	8	4	4	5	6	6	3	5
				Never Events	0	L	?	0	1	0	1	2	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Incident Management			Duty of Candour Compliance Stage 2 %	-	H		83.3%	100.0%	100.0%	71.4%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				RIDDOR Incidents	-			2	0	0	4	5	2	2	2	0	1	0	3
				RIDDOR Compliance %	-			0.0%	-	-	75.0%	40.0%	100.0%	100.0%	100.0%	-	100.0%	-	66.7%
				Health & Safety Incidents	-			96	108	85	119	151	115	128	97	85	97	55	44
				Sharps Injuries	-	H		5	4	8	5	11	6	2	6	7	12	13	10
				EDNs Completed Within 24hrs %	90.0%	H	F	77.9%	77.6%	74.4%	75.4%	78.5%	77.9%	77.5%	80.3%	78.4%	81.5%	83.1%	81.5%
				Violence & Aggression Incidents	-	H		127	138	176	193	252	173	204	166	174	157	139	108
				Assaults - Patient on Staff	-			55	64	60	64	99	78	108	70	76	71	60	40
	Falls			Low or No Harm Falls %	95.0%		?	97.4%	95.9%	98.9%	100.0%	97.9%	100.0%	94.6%	98.8%	99.0%	100.0%	98.8%	97.8%
				Falls - Total	-			78	74	88	77	94	80	74	85	102	93	82	93
				Falls - Low Harm	-			23	11	30	24	22	17	15	19	23	29	22	31
				Falls - Moderate Harm	-			2	1	0	0	0	0	2	1	1	0	0	1
				Falls - Severe Harm	0		?	0	1	1	0	2	0	2	0	0	0	0	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Falls			Falls Resulting in Death	0		?	0	1	0	0	0	0	0	0	0	0	1	0
				Falls per 1,000 Bed days	-			4.87	4.67	5.47	4.67	6.23	4.88	4.73	5.25	6.65	5.77	5.10	5.91
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	25	30	20	23	25	24	15	16	19	19	23	22
				Pressure Ulcers - Grade 2	-	H		3	6	3	5	8	5	8	8	6	8	18	15
				Pressure Ulcers - Grade 3	-	H		0	1	0	0	2	3	7	8	13	10	4	7
				Pressure Ulcers - Grade 4	-			3	1	2	0	0	0	0	0	0	1	1	0
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-	L		1.56	1.89	1.24	1.39	1.66	1.46	0.96	0.99	1.24	1.18	1.43	1.40
	Medicines			Medicine Errors - Total	-			87	97	70	63	90	81	88	61	68	99	94	68
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%
	IPC			IPC Incidents	-			56	39	53	35	45	50	38	54	31	66	108	49
				C-Diff Cases - Hospital Acquired Total	-	H		3	3	5	3	4	8	4	4	2	4	7	11
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			33	36	41	44	48	56	4	8	10	14	21	32
				C-Diff Cases - Hospital Acquired (HOHA)	-			3	3	3	1	3	6	2	3	2	4	4	4

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	IPC			E.coli Cases - Hospital Acquired	-			9	5	8	2	6	4	6	3	5	6	9	2
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			41	46	54	56	62	66	6	9	14	20	29	31
				MRSA Cases - Hospital Acquired	0	L	?	1	1	0	0	0	0	0	0	0	0	0	0
				MSSA Cases - Hospital Acquired	-			4	3	1	4	3	2	4	1	0	0	3	4
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			21	24	25	29	32	34	4	5	5	5	8	12
	Mortality			Crude Mortality Rate %	1.30%		?	1.53%	1.19%	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%	1.35%	1.28%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	1	2	2	1	0	0	1	2	0	2	0	0
				Avoidable 2222 Calls – Peri-Arrests	3		?	0	2	0	3	2	0	1	1	0	4	2	2
				Avoidable 2222 Calls	16		P	1	4	2	4	2	0	3	3	0	7	2	2
				HSMR (All)	100	H	F	113.08	109.69	110.01	113.24	112.89	113.57	109.82	110.74				
				Expected Death Rate %	-	L		3.7%	3.7%	3.7%	3.7%	3.6%	3.6%	3.6%	3.6%				
				SHMI	1	H	F	1.15	1.13	1.14	1.16	1.18	1.19	1.19	1.18				
				Fractured NOF Within 36 Hours	92.0%		?	52.1%	71.9%	50.0%	71.4%	73.7%	60.0%	60.0%	51.5%	52.5%	56.5%	74.1%	
				Number of Deaths Reviewed via SJR	-			12	13	8	13	12	11	13	6	13	13	5	16

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Mortality			SJRs Completed %	12.5%			7.8%	9.7%	4.3%	6.5%	7.3%	6.8%	9.2%	4.5%	9.2%	11.1%	4.1%	13.1%
				Total Number of Deaths Due to Failings in Care	-			0	0	0	1	0	0	1	0	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			1	1	0	1	1	1	1	2	0	1	0	0
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%			98.9%	99.5%	99.0%	99.4%	99.2%	99.7%	99.1%	99.4%	99.5%	99.8%	99.0%	99.0%
	Maternity			Caesarean Section %	-			46.7%	51.6%	48.8%	49.6%	52.0%	44.2%	43.5%	44.2%	50.5%	42.5%	49.4%	49.2%
				Elective C-Section %	-			21.0%	21.5%	17.6%	19.8%	19.6%	19.2%	21.0%	17.2%	19.8%	17.3%	20.0%	19.4%
				Emergency C-Section %	-			25.6%	30.0%	31.2%	29.8%	32.3%	24.9%	22.5%	27.0%	30.7%	25.2%	29.4%	29.8%
				PPH greater than or equal to 1500mls	-			17	22	15	19	15	23	12	18	14	12	20	12
				Total Number of Still Births Greater Than 24 weeks Gestation	-			2	3	0	1	3	0	0	3	2	0	1	2
				Neonatal Deaths	-			0	1	4	1	2	3	0	1	0	2	2	0
				Maternity Serious Incidents	-			0	0	1	2	2	1	0	0	0	0	0	0
				Maternity HSIB Referrals	-			0	0	1	2	2	1	0	0	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Quality	Maternity			Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	1	2	1	1	0	0	0	0	1	1	1
	Risk & Policy			Risks Open - Low (Month End Snapshot)	-								6	4	6	4	2	1	1
				Risks Open - Moderate (Month End Snapshot)	-								55	57	55	50	53	46	50
				Risks Open - High (Month End Snapshot)	-								171	160	162	159	175	150	148
				Risks Open - Extreme (Month End Snapshot)	-								33	30	26	25	24	27	27
	Health & Safety			Resuscitation Training Compliance %	-	H		81.3%	81.6%	81.2%	82.2%	82.4%	83.8%	83.1%	83.0%	83.8%	83.6%	83.6%	82.9%
				Mental Capacity Act Training Compliance %	-	H		80.3%	80.6%	81.5%	81.4%	81.7%	83.1%	84.0%	84.9%	85.1%	85.6%	86.6%	85.5%
	Legal & Information Governance			Inquests Received	-			6	8	21	15	14	8	14	13	10	15	10	7
				Inquest Hearings	-			7	12	3	6	10	9	8	6	5	10	11	3
				Regulation 28 Reports	-	L		0	0	0	0	0	0	0	0	0	0	0	0

Systems & Partnerships

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

NHS Medway NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	32	12	24	32	7	18
Emergency Care	5	9	2	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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	54.0%	L	P	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%

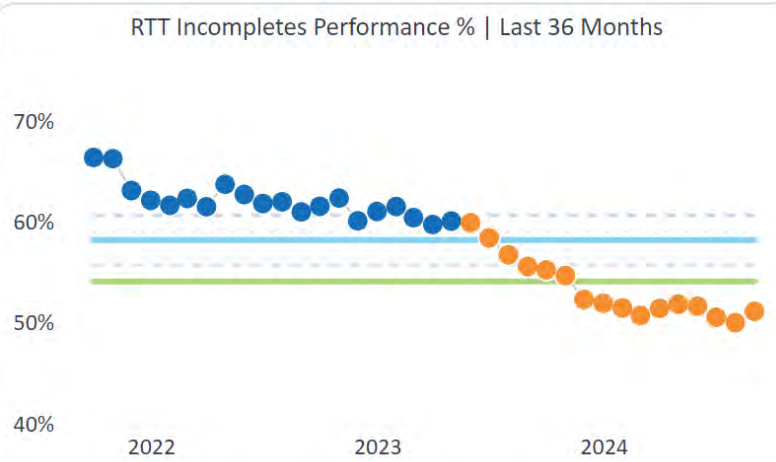
True North Domain: **Systems & Partnerships**

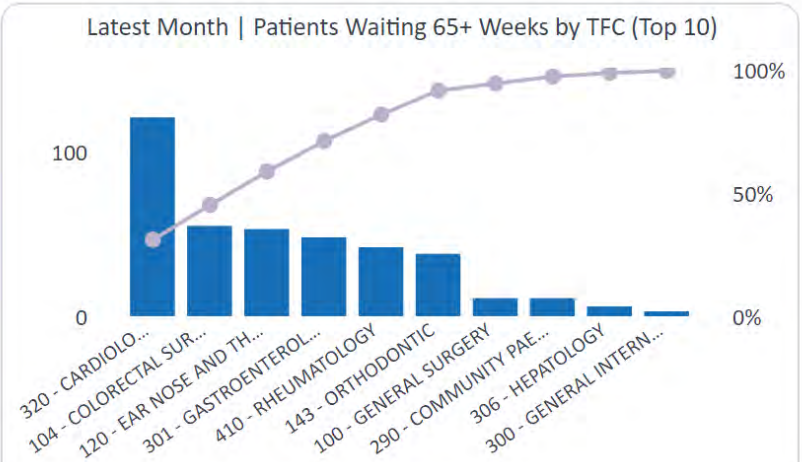
KPI Threshold: 54.0%

Sub Domain KPIs: 26

Variation Summary:

	L	H	L	H
11	5	7	2	1





Key Messages

- RTT - The Trust has seen a slight increase in the RTT position in September
- Cancer - USC Performance at 93.5%; 28 day performance 75.8%

Issues, Concerns & Gaps

- RTT - The Trust are continuing to focus on the over 65 week position and is working hard to clear the number of patients waiting over 65 weeks
- RTT - Cardiology, Colorectal, ENT and Gastro remain the top contributors to the over 65 week position
- Head and Neck (DVH) and Lung performance

Actions & Improvements

- Daily reviews/validation of all patients over 65 weeks
- Maintaining breast performance
- Reduction of backlog (related to breast and endoscopy)
- Lung Optimisation work
- H&N Task and finish group in place

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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	78.0%	H	?	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%

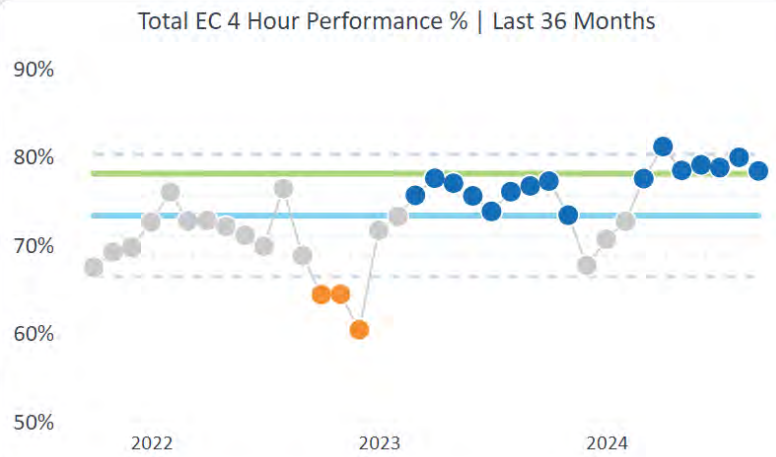
True North Domain: Systems & Partnerships

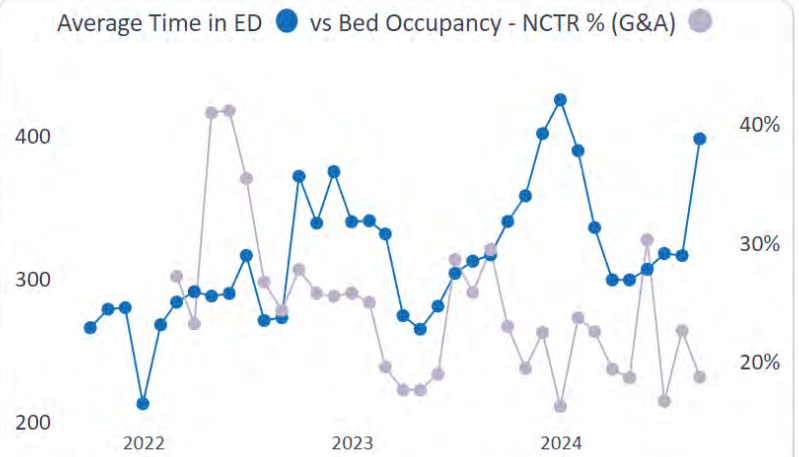
KPI Threshold: 78.0%

Sub Domain KPIs: 11

Variation Summary:

	L	H	L	H
3	0	2	3	3





Key Messages

ED performance 78.3%

Admitted Performance – 3.6%
Non-Admitted Performance – 82.7%

LOS >12 hours - 8.2%

Issues, Concerns & Gaps

Continued high percentage of patients in ED department over 12 hours – New A3 being commenced to drill down into the detail and understanding of top contributors

High number of NCTR patients impacting flow from ED

Actions & Improvements

New Front Door Streaming model PDSA in place – review to be presented end of October

A3s commenced for >12 hours

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	H	F	Driver is red for 2 reporting periods	284	404	549	630	542	390
				RTT 52 Week Breaches	1,250	H	?	Watch is red for 4 reporting periods	2,360	2,610	2,834	2,922	2,687	2,362
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	106.89	104.63	108.92	103.55	108.40	117.21
				Operations Cancelled by Hospital on Day	0		?	Watch is red for 4 reporting periods	14	17	14	19	20	14
				Cancer USC Performance %	93.0%	L	?	Watch is red for 4 reporting periods	73.4%	70.1%	68.7%	70.6%	72.7%	
				Cancer USC Performance - Breast Symptomatic %	93.0%	L	?	Watch is red for 4 reporting periods	2.9%	0.0%	9.9%	9.7%	38.6%	
				Cancer 31 Day First Treatment Performance %	98.2%		?	Watch is red for 4 reporting periods	94.9%	98.1%	97.2%	96.4%	96.2%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	Watch is red for 4 reporting periods	67.4%	67.6%	68.2%	67.7%	67.2%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	Watch is red for 4 reporting periods	77.6%	84.2%	80.0%	84.6%	66.7%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	Watch is red for 4 reporting periods	56.5%	53.7%	52.3%	67.9%	76.4%	
				DM01 Performance %	73.1%	L	?	Watch is red for 4 reporting periods	65.4%	67.1%	67.4%	67.6%	63.6%	68.4%
	Emergency Care			Type 1 EC 4 Hour Performance %	75.0%	H	F	Watch is red for 4 reporting periods	69.5%	70.6%	68.8%	68.5%	67.6%	64.9%
				Total EC 12 Hour DTAs	0	H	F	Watch is red for 4 reporting periods	521	588	618	663	577	644

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Systems & Partnerships	Emergency Care			Average Time in EC Department - Excl. Type 5 (mins)	240	H	F	Watch is red for 4 reporting periods	298.57	298.57	305.99	317.03	315.64	397.38
				Ambulance Handover Delays (> 60 mins)	0	L	?	Watch is red for 4 reporting periods	3	3	2	2	1	5

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Systems & Partnerships	Access			Outpatient DNA Rate %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	6.2%	6.4%	6.3%	6.3%	6.2%	6.4%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.89	1.77	1.77	1.83	1.71	1.77
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	71.4%	71.4%	81.6%	85.7%	79.2%	
	Emergency Care			Total EC 4 Hour Performance %	78.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	86.9%	84.0%	84.6%	84.1%	85.8%	82.7%
				Type 1 EC 4 Hour Performance %	75.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	69.5%	70.6%	68.8%	68.5%	67.6%	64.9%
				Ambulance Handover Delays (> 30 mins)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	67	49	73	59	46	77
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	3	3	2	2	1	5
				30 Day Readmission Rate	13.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	9.9%	10.4%	8.7%	8.5%	8.6%	6.8%

Access

Key Messages

RTT - The Trust has seen a slight increase in the RTT position in September

Cancer - USC Performance at 93.5%; 28 day performance 75.8%

Issues, Concerns & Gaps

- RTT - The Trust are continuing to focus on the over 65 week position and is working hard to clear the number of patients waiting over 65 weeks
- RTT - Cardiology, Colorectal, ENT and Gastro remain the top contributors to the over 65 week position
- Head and Neck (DVH) and Lung performance

Actions & Improvements

- Daily reviews/validation of all patients over 65 weeks
- Maintaining breast performance
- Reduction of backlog (related to breast and endoscopy)
- Lung Optimisation work
- H&N Task and finish group in place .

Emergency Care

Key Messages

ED performance 78.3%

Admitted Performance – 3.6%
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Continued high percentage of patients in ED department over 12 hours – New A3 being commenced to drill down into the detail and understanding of top contributors

High number of NCTR patients impacting flow from ED

Actions & Improvements

New Front Door Streaming model PDSA in place – review to be presented end of October

A3s commenced for >12 hours

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	L	P	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%
				RTT 65+ Week Waiters	0	H	F	246	217	237	257	286	235	284	404	549	630	542	390
				RTT 40+ Week Waiters	-	H		4,395	4,523	5,311	5,569	5,927	6,296	6,434	6,627	6,662	6,736	6,778	6,274
				RTT Waiting List Size	-	H		41,150	41,562	42,487	43,133	43,716	44,646	44,751	44,491	44,528	44,477	44,130	43,248
				RTT 52 Week Breaches	1,250	H	?	1,291	1,441	1,439	1,659	1,886	2,159	2,360	2,610	2,834	2,922	2,687	2,362
				OP Average Time to First Appointment (days)	60	H	F	98.43	98.37	94.85	98.84	104.02	103.54	106.89	104.63	108.92	103.55	108.40	117.21
				Outpatient DNA Rate %	10.0%	L	P	7.5%	7.0%	7.5%	6.3%	6.2%	6.2%	6.2%	6.4%	6.3%	6.3%	6.2%	6.4%
				OP First to Follow Up Ratio	-	L		2.03	1.89	1.95	1.96	1.87	1.84	1.89	1.77	1.77	1.83	1.71	1.77
				Operations Cancelled by Hospital on Day	0		?	9	18	12	14	6	10	14	17	14	19	20	14
				Cancelled Operations Not Rescheduled < 28 Days %	-	H		22.2%	66.7%	75.0%	50.0%	33.3%	50.0%	42.9%	64.7%	71.4%	63.2%	55.0%	50.0%
				Urgent Operations Cancelled for 2nd Time	0		?	1	3	2	0	2	1	2	5	1	0	1	0
				Day Case Rate %	-			87.0%	85.9%	86.2%	87.9%	87.3%	86.1%	85.9%	85.4%	84.9%	84.3%	83.7%	85.3%
				Average Elective Length of Stay (days)	3		?	3.32	3	2.79	2.54	2.55	3.21	2.93	3.44	2.83	2.74	2.29	2.59

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10	H	P	4.83	4.79	4.81	4.66	4.63	4.28	4.51	4.50	5.37	6.06	6.10	6.17
				104 Day Cancer Waits	-			17	17	7	13	12	14	16	9	17	17	14	
				Cancer USC Performance %	93.0%	L	?	90.2%	85.8%	92.7%	84.9%	73.0%	72.8%	73.4%	70.1%	68.7%	70.6%	72.7%	
				Cancer USC Performance - Breast Symptomatic %	93.0%	L	?	80.0%	63.5%	69.4%	58.4%	38.4%	4.2%	2.9%	0.0%	9.9%	9.7%	38.6%	
				Cancer 31 Day First Treatment Performance %	98.2%		?	98.1%	93.6%	99.2%	97.0%	98.7%	98.4%	94.9%	98.1%	97.2%	96.4%	96.2%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%		?	97.5%	100.0%	100.0%	91.2%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%		?	93.9%	93.8%	100.0%	81.3%	86.4%	92.6%	75.0%	94.6%	92.6%	96.4%	100.0%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	65.6%	68.1%	79.0%	72.5%	68.1%	68.2%	67.4%	67.6%	68.2%	67.7%	67.2%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%	H	?	81.3%	81.6%	78.4%	80.3%	72.2%	90.0%	71.4%	71.4%	81.6%	85.7%	79.2%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	72.4%	85.2%	74.1%	73.3%	47.6%	95.7%	77.6%	84.2%	80.0%	84.6%	66.7%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	66.6%	65.2%	69.8%	63.1%	73.0%	66.0%	56.5%	53.7%	52.3%	67.9%	76.4%	
				Cancer 28 Day Faster Diagnosis Screening %	-			68.5%	74.1%	76.7%	47.7%	79.3%	76.5%	72.2%	76.7%	74.5%	62.9%	45.5%	
				DM01 Performance %	73.1%	L	?	61.3%	62.1%	56.6%	59.5%	66.7%	66.9%	65.4%	67.1%	67.4%	67.6%	63.6%	68.4%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	78.0%	H	?	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	82.6%	78.7%	73.8%	75.7%	77.9%	83.0%	86.9%	84.0%	84.6%	84.1%	85.8%	82.7%
				IP Discharged Before Noon % (Inc transfers to ADL)	-			16.7%	17.3%	15.0%	14.1%	14.3%	12.6%	12.6%	13.8%	12.1%	16.6%	17.0%	18.4%
				Type 1 EC 4 Hour Performance %	75.0%	H	F	65.2%	62.0%	52.9%	59.1%	63.5%	69.3%	69.5%	70.6%	68.8%	68.5%	67.6%	64.9%
				Total EC 12 Hour DTAs	0	H	F	742	766	785	953	798	798	521	588	618	663	577	644
				Average Time in EC Department - Excl. Type 5 (mins)	240	H	F	339.48	357.44	401.11	424.67	389.04	335.25	298.57	298.57	305.99	317.03	315.64	397.38
				Number of ED Arrivals by Ambulance	-			3,107	3,137	3,167	3,281	2,956	3,173	2,981	2,993	2,869	2,919	2,820	2,887
				Ambulance Handover Delays (> 30 mins)	-	L		73	85	177	161	90	103	67	49	73	59	46	77
				Ambulance Handover Delays (> 60 mins)	0	L	?	1	3	10	9	5	6	3	3	2	2	1	5
				Bed Occupancy - NCTR % (G&A)	-			22.9%	19.6%	22.4%	16.2%	23.7%	22.5%	19.3%	18.6%	30.2%	16.6%	22.6%	18.7%
				30 Day Readmission Rate	13.0%	L	P	10.1%	9.7%	10.1%	9.2%	10.0%	9.8%	9.9%	10.4%	8.7%	8.5%	8.6%	6.8%

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	11	21	3	9	15	11
Compliance	1	0	1	1	0	1
Diversity	0	2	0	0	0	0
Safe Staffing	1	7	0	5	0	1
Workforce	35	9	3	37	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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	6.93	H	F	6.65	6.65	6.65	6.65	6.65	6.65

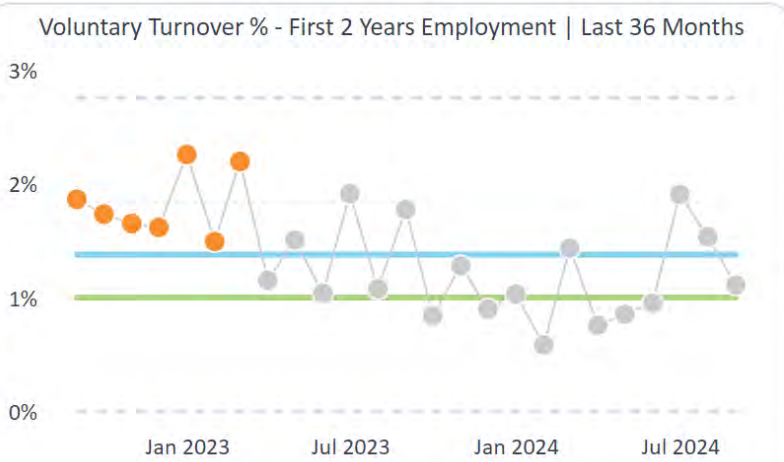
True North Domain: People

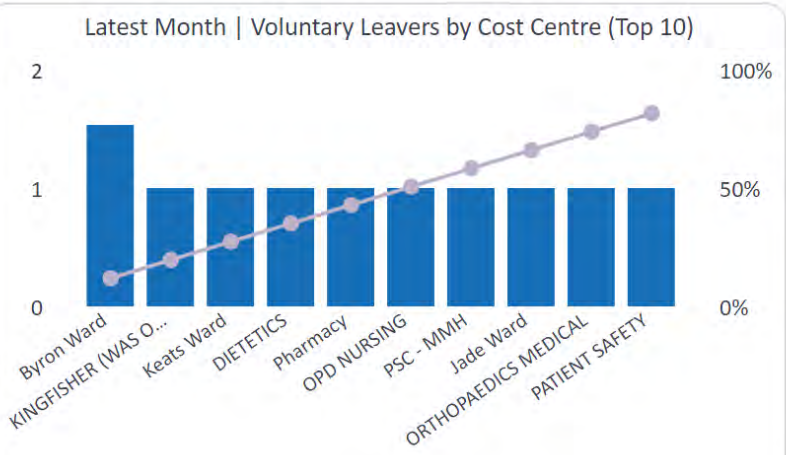
KPI Threshold: 6.93

Sub Domain KPIs: 16

Variation Summary:

	L	H	L	H
11	0	0	2	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% September 2024 reporting off target in month but two successive improvements. Overall metric shows a near 50% reduction in 12-months overall. 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 following divisional plans;
- Review of flexible-working recording/self-service via the People Promise;
- Appraisal quality reporting is now in place;
- Refresh of True North and breakthrough for people domain at catchball stage

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	Workforce			Voluntary Turnover % - First 2 Years Employment	1.00%			Driver is red for 2 reporting periods	0.8%	0.9%	1.0%	1.9%	1.5%	1.1%
				Staff Appraisal Rate %	90.0%	H		Watch is red for 4 reporting periods	89.6%	89.0%	88.8%	89.7%	89.7%	88.4%
				Voluntary Turnover %	8.0%	L	F	Watch is red for 4 reporting periods	9.1%	8.8%	8.7%	8.7%	8.9%	8.5%
				Sickness Absence Rate - Total %	4.0%			Watch is red for 4 reporting periods	4.4%	4.7%	5.1%	5.0%	4.8%	5.2%
				Sickness Absence Rate - Long Term %	2.0%			Watch is red for 4 reporting periods	2.2%	2.5%	2.7%	2.8%	3.0%	2.6%
				Time to Hire - AfC	42		F	Watch is red for 4 reporting periods	61.10	55.30	47.90	54	55.90	56
				Bank Spend %	10.0%			Watch is red for 4 reporting periods	11.1%	10.2%	10.4%	12.1%	10.2%	10.5%
	Safe Staffing			Care Hours per Patient Day (CHPPD)	9.50	H	F	Watch is red for 4 reporting periods	9.82	9.98	9.49	9.40	9.43	9.36
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%		F	Watch is red for 4 reporting periods	79.6%	80.4%	79.9%	79.8%	79.7%	79.9%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%		F	Watch is red for 4 reporting periods	43.4%	43.9%	46.7%	48.0%	49.7%	50.2%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	65.8%	66.3%	68.7%	72.6%	76.5%	76.6%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	L	F	Watch is red for 4 reporting periods	77.2%	79.3%	80.5%	81.9%	81.4%	80.6%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	80.9%	81.1%	82.1%	81.9%	82.3%	81.0%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	StatMan			StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	85.6%	83.0%	80.9%	80.5%	80.0%	78.6%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	77.3%	80.0%	81.4%	81.7%	80.8%	80.5%
				StatMan: New Born Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	82.0%	80.2%	80.8%	79.9%	78.7%	75.9%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	78.4%	78.4%	79.7%	78.0%	77.8%	77.4%
	Compliance			DBS Compliance %	100.0%	L	F	Watch is red for 4 reporting periods	99.8%	99.8%	99.8%	99.8%	99.4%	99.5%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	Workforce			Staff Appraisal Rate %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.6%	89.0%	88.8%	89.7%	89.7%	88.4%
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,036.99	5,029.83	5,028.97	5,030.13	5,076.44	5,059.99
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	9.1%	8.8%	8.7%	8.7%	8.9%	8.5%
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	2.1%	2.4%	1.5%	1.7%	1.9%	2.2%
	Safe Staffing			Staff Fill Rate - Total %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.1%	94.7%	94.6%	94.8%	86.9%	85.9%
				Staff Fill Rate % (Total) - Registered Nurse	-	H	Special cause of improving nature or lower pressure due to (H)igher values	91.7%	90.7%	90.1%	90.2%	89.2%	90.1%
				Care Hours per Patient Day (CHPPD)	9.50	H	Special cause of improving nature or lower pressure due to (H)igher values	9.82	9.98	9.49	9.40	9.43	9.36
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	41.1%	41.5%	42.0%	42.0%	42.2%	42.2%
				Diversity of Board %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	20.0%	18.2%	23.1%	21.4%	25.0%	25.0%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	88.1%	88.8%	89.0%	89.2%	89.6%	89.0%
				StatMan: Conflict Resolution Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.9%	95.2%	95.0%	95.0%	95.4%	94.9%
				StatMan: EDI Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.6%	95.9%	96.0%	95.9%	96.2%	95.8%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	StatMan			StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.3%	94.8%	95.4%	95.4%	96.0%	95.9%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.1%	91.2%	92.7%	92.2%	93.4%	94.2%
				StatMan: Health Safety and Welfare Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	88.9%	88.9%	90.1%	90.8%	91.6%	91.1%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.4%	92.3%	93.1%	93.2%	94.2%	94.3%
				StatMan: Basic Prevent Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	97.1%	97.3%	97.6%	96.0%	95.8%	95.6%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.7%	96.9%	97.3%	96.2%	95.7%	95.3%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	65.8%	66.3%	68.7%	72.6%	76.5%	76.6%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.6%	97.0%	97.4%	96.4%	96.3%	96.4%
				StatMan: Advanced Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	79.1%	83.7%	85.4%	85.1%	83.9%	87.2%
				StatMan: Adult Basic Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	80.9%	81.1%	82.1%	81.9%	82.3%	81.0%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	85.6%	83.0%	80.9%	80.5%	80.0%	78.6%
				StatMan: Anaphylaxis Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	90.3%	89.7%	89.9%	90.8%	91.7%	91.9%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	72.4%	68.3%	83.9%	85.9%	80.6%	81.1%

People

Key Messages

- The Trust's breakthrough objective to reduce voluntary turnover for individuals with less than 24 months service reports off target but improving for two successive months; however, the overall voluntary turnover rate has improved and nearing target.
- The Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative. No further agency within estates and facilities.
- Appraisals remain off target and slight deterioration. Corporate areas remain the most off-track with continued escalation reports to Executives on a fortnightly basis.
- Cultural transformation programme is now live within the Trust with the steering group having met twice with KPIs in development and benchmarking to be completed by the end of October.
- Trust has engaged a new freedom to speak up service, in place since 30 September
- Flu vaccination programme underway with c.700 vaccinations completed.
- Staff survey underway, current completion rate is 29.9% for substantive and 9.9% for bank staff – midway through our survey cycle.
- Celebrated World Mental Health day and World Menopause day in October.
- Leadership competency framework launched, updating mappings to individuals.

Issues, Concerns & Gaps

- High level of sickness short notice for Medics impacting staffing levels increased bank spend. CPO, HRBPs and rota team involved in work supporting divisions understand their position, stratified data, and approach;
- Delay to course mandatory process due to inaccurate people managers data/record –sent comms out for managers to update records via ESR.
- Worked FTE (substantive bank and agency) is greater than budgeted establishment by 50 FTE in September; however, patient first approach to stratifying the over budget areas to address;
- Worker Protection Act (amendment to the Equality Act to protect staff from sexual violence) due to late issuance of national training. Mitigations: revision of relevant HR&OD policies (complete), communications plan (23 October), and policy statement (jointly with Safeguarding).

Actions & Improvements

- Meetings set up to improve collaborative working between OH, ER, EDI and Employee Experience and Wellbeing;
- Flu comms campaign continuing;
- Addressing training elements to ensure we meet the requirements of the Worker Protection Act
- Review the Employee Relations KPIs to address timeliness of cases;
- Review of the Pre-Disciplinary Panel to ensure parity of cases and of protected characteristics.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	Workforce			National Staff Engagement Score	6.93	H	F	6.65	6.65	6.65	6.65	6.65	6.65						
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	0.8%	1.3%	0.9%	1.0%	0.6%	1.4%	0.8%	0.9%	1.0%	1.9%	1.5%	1.1%
				Staff Appraisal Rate %	90.0%	H	?	89.9%	89.9%	89.2%	89.1%	89.1%	89.7%	89.6%	89.0%	88.8%	89.7%	89.7%	88.4%
				Staff in Post (FTE)	-	H		4,869.78	4,905.26	4,933.95	4,955.16	5,001.04	5,029.27	5,036.99	5,029.83	5,028.97	5,030.13	5,076.44	5,059.99
				Staff Leavers (FTE)	-			65.89	57.12	46.85	39.76	35.66	53.55	37.79	44.65	42.21	62.65	140.58	62.37
				Staff Starters (FTE)	-			133.28	78.48	45.43	86.30	68.08	46.99	53.41	21.66	34.77	55.36	131.18	92.78
				Vacancy Rate %	9.0%		?	5.1%	5.2%	4.7%	4.3%	3.4%	3.0%	8.1%	7.8%	7.7%	7.9%	7.1%	7.4%
				Voluntary Turnover %	8.0%	L	F	10.9%	10.9%	10.7%	10.2%	9.7%	9.4%	9.1%	8.8%	8.7%	8.7%	8.9%	8.5%
				Voluntary Turnover (ICS) %	-			0.9%	1.2%	1.0%	0.8%	0.7%	1.0%	0.6%	0.9%	0.9%	1.2%	1.3%	0.9%
				Sickness Absence Rate - Total %	4.0%		?	4.9%	4.5%	5.1%	5.5%	4.9%	4.3%	4.4%	4.7%	5.1%	5.0%	4.8%	5.2%
				Sickness Absence Rate - Short Term %	2.0%		?	2.4%	2.2%	2.9%	3.2%	2.4%	2.0%	2.2%	2.2%	2.4%	2.2%	1.8%	2.5%
				Sickness Absence Rate - Long Term %	2.0%		?	2.5%	2.3%	2.2%	2.3%	2.5%	2.3%	2.2%	2.5%	2.7%	2.8%	3.0%	2.6%
				Time to Hire - AfC	42		F	66.70	62.10	60.40	88.10	60	66.10	61.10	55.30	47.90	54	55.90	56

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	Workforce			Time to Hire - Medical	70			89.60	65.30	147.70	107	76	54.90	91.30	66.70	58.90	42.60	86.50	51
				Agency Spend %	3.7%	L		2.6%	3.5%	2.7%	2.0%	2.7%	1.1%	2.1%	2.4%	1.5%	1.7%	1.9%	2.2%
				Bank Spend %	10.0%			12.2%	10.9%	11.0%	13.1%	11.7%	8.6%	11.1%	10.2%	10.4%	12.1%	10.2%	10.5%
	Safe Staffing			Staff Fill Rate - Total %	85.0%	H		89.5%	92.8%	90.0%	91.1%	91.6%	92.3%	95.1%	94.7%	94.6%	94.8%	86.9%	85.9%
				Staff Fill Rate % (Total) - Registered Nurse	-	H		87.7%	89.3%	88.2%	88.8%	90.0%	89.9%	91.7%	90.7%	90.1%	90.2%	89.2%	90.1%
				Care Hours per Patient Day (CHPPD)	9.50	H	F	9.05	9.18	9.06	9.10	9.20	9.05	9.82	9.98	9.49	9.40	9.43	9.36
	Diversity			Diversity of Workforce %	-	H		39.2%	39.7%	40.0%	40.3%	40.5%	40.8%	41.1%	41.5%	42.0%	42.0%	42.2%	42.2%
				Diversity of Board %	-	H		9.1%	18.2%	18.2%	18.2%	16.7%	16.7%	20.0%	18.2%	23.1%	21.4%	25.0%	25.0%
	StatMan			StatMan Training Compliance %	85.0%	H		86.1%	86.7%	87.5%	87.4%	87.9%	87.7%	88.1%	88.8%	89.0%	89.2%	89.6%	89.0%
				StatMan: Conflict Resolution Compliance %	85.0%	H	P	92.7%	93.5%	94.0%	93.5%	94.1%	94.5%	94.9%	95.2%	95.0%	95.0%	95.4%	94.9%
				StatMan: EDI Compliance %	85.0%	H	P	94.3%	95.0%	95.5%	95.4%	95.4%	95.4%	95.6%	95.9%	96.0%	95.9%	96.2%	95.8%
				StatMan: Fire Safety Compliance %	85.0%			83.1%	82.5%	82.1%	81.7%	82.9%	81.2%	84.2%	85.9%	84.5%	85.6%	84.5%	83.8%
				StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	90.5%	91.7%	92.7%	93.0%	93.6%	94.0%	94.3%	94.8%	95.4%	95.4%	96.0%	95.9%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	StatMan			StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	79.4%	82.4%	83.7%	86.8%	87.2%	88.0%	89.1%	91.2%	92.7%	92.2%	93.4%	94.2%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	86.7%	86.7%	89.8%	89.3%	89.6%	89.2%	88.9%	88.9%	90.1%	90.8%	91.6%	91.1%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	94.8%	95.8%	95.6%	96.3%	96.9%	97.5%	97.0%	97.1%	97.6%	96.7%	96.1%	95.6%
				StatMan: Infection Prevention L2 Compliance %	85.0%		P	89.1%	89.0%	89.6%	88.8%	88.7%	88.5%	89.7%	89.6%	89.1%	88.6%	89.5%	89.0%
				StatMan: Information Governance Compliance %	85.0%		P	90.8%	90.7%	90.9%	90.4%	91.0%	90.8%	91.6%	91.8%	91.1%	89.9%	90.9%	90.4%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	77.9%	83.2%	85.8%	87.4%	89.0%	90.1%	91.4%	92.3%	93.1%	93.2%	94.2%	94.3%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	80.6%	80.7%	81.2%	79.2%	78.9%	78.9%	79.6%	80.4%	79.9%	79.8%	79.7%	79.9%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%		F	44.1%	44.9%	45.1%	45.0%	44.5%	43.7%	43.4%	43.9%	46.7%	48.0%	49.7%	50.2%
				StatMan: Patient Safety L1 Compliance %	85.0%		P	94.3%	94.5%	95.1%	95.3%	95.4%	88.6%	87.7%	90.3%	91.7%	91.3%	91.7%	90.7%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	93.7%	94.9%	96.1%	94.6%	96.0%	97.0%	97.1%	97.3%	97.6%	96.0%	95.8%	95.6%
				StatMan: Prevent WRAP Compliance %	85.0%		P	87.3%	87.3%	87.6%	86.9%	87.2%	87.8%	88.3%	89.1%	88.3%	89.0%	89.7%	89.1%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	94.0%	95.0%	96.0%	95.8%	96.4%	97.3%	96.7%	96.9%	97.3%	96.2%	95.7%	95.3%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	StatMan			StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	L	P	93.1%	93.2%	94.0%	92.0%	91.8%	91.1%	91.3%	92.3%	92.5%	91.8%	91.7%	90.1%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	48.2%	54.5%	57.2%	59.6%	63.6%	66.9%	65.8%	66.3%	68.7%	72.6%	76.5%	76.6%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%	H	P	94.2%	94.6%	95.5%	96.0%	96.4%	97.0%	96.6%	97.0%	97.4%	96.4%	96.3%	96.4%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	85.7%	84.6%	84.4%	82.8%	83.2%	82.9%	84.5%	86.0%	86.2%	87.2%	87.2%	85.8%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	L	F	80.9%	82.0%	80.0%	79.9%	77.6%	76.7%	77.2%	79.3%	80.5%	81.9%	81.4%	80.6%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	77.7%	76.6%	74.5%	74.5%	71.8%	75.2%	79.1%	83.7%	85.4%	85.1%	83.9%	87.2%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	82.7%	82.4%	81.4%	82.0%	80.9%	82.1%	80.9%	81.1%	82.1%	81.9%	82.3%	81.0%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	74.3%	74.4%	75.1%	76.3%	80.2%	80.2%	85.6%	83.0%	80.9%	80.5%	80.0%	78.6%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	87.7%	90.2%	90.1%	91.1%	91.8%	91.7%	90.3%	89.7%	89.9%	90.8%	91.7%	91.9%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	80.4%	81.8%	81.5%	76.4%	65.5%	74.1%	72.4%	68.3%	83.9%	85.9%	80.6%	81.1%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	68.0%	66.3%	70.7%	71.7%	71.2%	77.8%	77.3%	80.0%	81.4%	81.7%	80.8%	80.5%
				StatMan: New Born Life Support Compliance %	85.0%		F	77.3%	77.5%	71.7%	73.4%	78.5%	82.9%	82.0%	80.2%	80.8%	79.9%	78.7%	75.9%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	77.7%	77.7%	78.2%	79.3%	77.6%	79.1%	78.4%	78.4%	79.7%	78.0%	77.8%	77.4%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
People	StatMan			StatMan: Paediatric Immediate Life Support Compliance %	85.0%			68.9%	64.1%	70.7%	76.1%	87.7%	83.4%	83.5%	84.1%	85.5%	85.9%	80.8%	77.7%
	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%	100.0%
				DBS Compliance %	100.0%			99.7%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.4%	99.5%

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	16	7	5	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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	£0.00m			-3.04m	-2.98m	-1.75m	-3.33m	2.56m	-2.76m	-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m

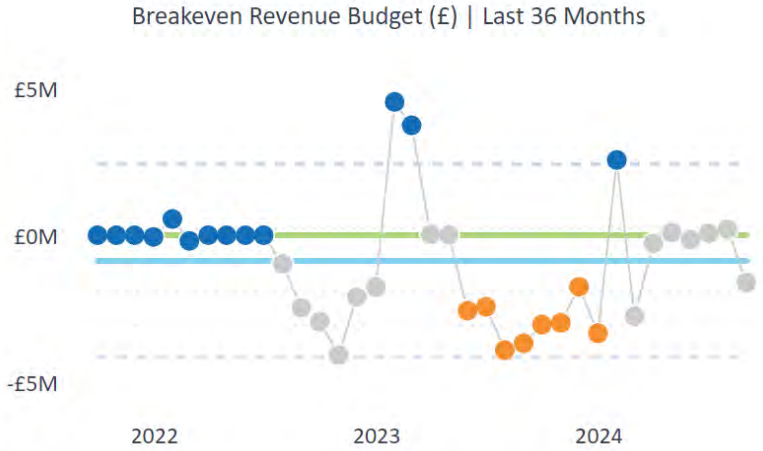
True North Domain: **Sustainability**

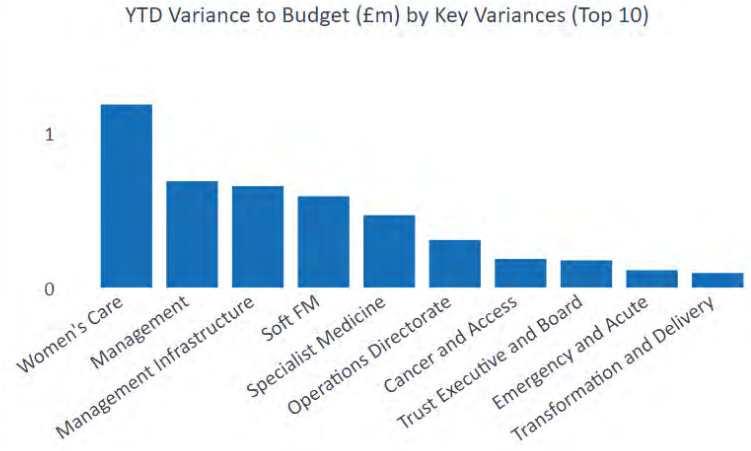
KPI Threshold: £0.00m

Sub Domain KPIs: 12

Variation Summary:

7	0	2	1	2





Key Messages

The Trust is reporting a month 6 adverse variance to plan of £1.4m and a YTD adverse variance of £1.9m.

In month 6 the Trust has received £0.5m of funding to support the unbudgeted Industrial Action costs.

In addition, deficit support funding from NHSE has been distributed to systems; the Trust will receive £25.4m in equal twelfths (cash-backed) and hence the annual plan has been adjusted for these monies, meaning our new control total is a deficit of £2.4m.

Issues, Concerns & Gaps

After adjusting for the non-recurrent funding received in month 6, the underlying run-rate has deteriorated by c£0.3m compared to month 5. Whilst there has been reduced spend across medical staffing and an improvement in ERF delivery, additional spend in respect of enhanced care, endoscopy and depreciation has had an adverse impact.

Unless expenditure is robustly controlled whilst maintaining income levels, the Trust could be at risk of not meeting its control total in 2024/25.

Actions & Improvements

Further mitigations against potential forecast overspend to be developed, particularly within S&A and MEC divisions.

Executive review meetings to be held with divisions.

Funding issues (Ruby Ward and High Cost Drugs) to be resolved with commissioners.

Grip and control actions/compliance to be reviewed.

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Sustainability	Financial Position			Total Financial Overspend (£)	£0.00m			Driver is red for 2 reporting periods	1.56m	0.61m	1.62m	1.37m	2.74m	3.87m
				Total Pay Spend (£) vs Budget	£0.00m			Watch is red for 4 reporting periods	-0.46m	-0.05m	0.76m	0.03m	2.64m	1.29m
				Actual Worked FTE vs Budget	0			Watch is red for 4 reporting periods	-27.32	-17.51	7.26	50.36	5.09	50.05

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Sustainability	Financial Position			(Surplus) / Deficit (£)	£0.00m	H	Special cause of improving nature or lower pressure due to (H)igher values	-3.57m	-3.33m	-2.85m	-2.31m	-1.81m	11.24m
				Agency Spend (£)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0.55m	0.61m	0.40m	0.44m	0.50m	0.57m
				Actual Worked FTE	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,475	5,452.75	5,470.54	5,531.73	5,480.86	5,528.07

Sustainability

Key Messages

- In month 6 there is an overspend of £1.4m; however, this includes £0.5m of funding for Industrial Action (costs in M1-5), therefore there is an underlying overspend of £1.9m.
- The Trust received deficit support funding of £14.2m in month, which is reflected in the bottom line position (both actual and budget). Without this funding the bottom line position in M6 was a £3.2m deficit, increasing to a £3.8m deficit excluding the £0.5m income for IA (effectively the underlying deficit in the month).
- This in month deficit represents a £0.3m adverse movement from the M5 underlying run rate deficit.

Issues, Concerns & Gaps

- Following a review of the forecast outturn at Month 5 the risk assessed forecast has deteriorated by £9.3m, to £15.1m adverse to Plan.
- The most material movements relate to: the Surgery and Anaesthetics and Medicine & Emergency Care Divisions (£7.1m – primarily increase in run rate spend and non-delivery of run rate assumptions made in M3); increase in enhanced care spend; Radiology additional sessions, and; reduction in medical education income
- Included within the forecast are three mitigations from month 3 of £5.0m that had previously moved the Trust towards breakeven as part of the earlier exercise, in relation to ERF and counting/capture income stretch and efficiencies improvement.
- Further mitigations of £7m, in respect of Operational efficiencies and funding for Ruby and High Cost drugs could improve the forecast variance to £8m deficit.
- There are further risks to the position which are not included within the forecast outturn but will require management/mitigation.

Actions & Improvements

Work through further mitigations in relation to forecast overspend, including;

- Surgery and Anaesthetics – including recruitment to mitigate agency/additional sessions, further reductions in B&A, ERF income to mitigate growth in non-pay
- MEC – mitigations to medical overspend including GIM rota, rostering controls
- Enhanced Care – further controls & mitigations including NCTRs and RMNs
- Radiology – fixed term locum posts to mitigate need for additional sessions
- Med education – liaison with medical education team and HEE to mitigate reduction in income and increased spend

Exec Review meetings with S&A and MEC Divisions

Resolve funding issues re Ruby & HC Drugs. NB recent indications from NHSE more positive – Year 1 funding confirmed

Complete review of grip and control actions / compliance with L3+/L4 controls

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m			-3.04m	-2.98m	-1.75m	-3.33m	2.56m	-2.76m	-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m
				Total Financial Overspend (£)	£0.00m			5.43m	5.17m	5.79m	6.32m	6.02m	19.01m	1.56m	0.61m	1.62m	1.37m	2.74m	3.87m
				(Surplus) / Deficit (£)	£0.00m			-3.84m	-3.78m	-2.55m	-4.13m	15.51m	-2.47m	-3.57m	-3.33m	-2.85m	-2.31m	-1.81m	11.24m
				Agency Spend (£)	-			0.65m	0.88m	0.68m	0.54m	0.71m	0.42m	0.55m	0.61m	0.40m	0.44m	0.50m	0.57m
				Income (£)	-			35.74m	36.63m	39.02m	38.07m	56.72m	52.27m	37.37m	37.52m	37.02m	39.81m	38.21m	52.45m
				Income (£) vs Budget	£0.00m			1.18m	2.07m	4.45m	3.49m	8.38m	16.46m	-0.50m	-0.33m	-0.85m	0.93m	1.27m	1.40m
				Total Pay Spend (£)	-			25.24m	24.93m	25.00m	26.71m	25.99m	37.01m	25.67m	25.86m	26.29m	26.13m	26.22m	26.23m
				Total Pay Spend (£) vs Budget	£0.00m			3.25m	3.70m	3.17m	4.85m	4.10m	14.99m	-0.46m	-0.05m	0.76m	0.03m	2.64m	1.29m
				Total Non-Pay Spend (£)	-			12.22m	13.18m	14.42m	13.35m	13.09m	15.22m	12.96m	12.65m	11.48m	13.56m	11.91m	12.47m
				Total Non-Pay Spend (£) vs Budget	£0.00m			0.97m	1.17m	3.01m	1.95m	1.72m	3.85m	0.30m	-0.33m	-1.26m	0.91m	-1.06m	1.22m
				Actual Worked FTE	-			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	5,480.86	5,528.07
				Actual Worked FTE vs Budget	0			284.50	204.96	264.97	332.87	347.90	361.66	-27.32	-17.51	7.26	50.36	5.09	50.05

Finance report

For the period ending 30 September 2024

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	12,846	11,241	(1,605)	The Trust is reporting a £3.2m deficit year to date (YTD), this being £1.9m adverse to the control total. In month the Trust has received £14.2m of deficit support funding and the control total has been adjusted accordingly; it has also received £0.5m of industrial action funding. The full year deficit funding – to be recognised as equal twelfths each month, is £25.4m; consequently, the Trust's control total for the year reduces from a deficit of £27.8m to a deficit of £2.4m.
Donated asset depreciation	(477)	(275)	202	
In-month total	**12,369**	**10,696**	**(1,403)**	
YTD total	**(1,338)**	**(3,236)**	**(1,898)**	
Efficiencies Programme				
In-month	2,235	1,550	(685)	The efficiency programme has under achieved in-month by £0.7m and by £0.6m YTD. There remains a balance of £2.1m unidentified budget out efficiencies against the in-year plan; this continues to be focused on by all services, as well as implementing operational controls to reduce expenditure.
YTD	9.278	8,670	(608)	
Cash				
Month end	9,918	5,155	(4,763)	The cash balance is £4.8m adverse to plan due to non delivery of cash releasing efficiencies expected. The additional revenue support payment from the ICB in month 7 will bring cash back into forecast.
Capital				
YTD				All capital funding for 2024/25 has now been allocated to projects. The only increase in funding since month 5 is £0.05m of additional charitable contributions. The programme is £14.8m (76%) behind plan due to late approval of the plan, legal complexities with CDC projects delaying lease approval and the continuation of physical work. The CDC issues have now been resolved in principle but are expected to impact completion in 2024/25. The projects are under review to agree timescale/financial slippage into 2025/26. Any financial slippage will require internal brokerage between financial years.
Capex	13,779	4,494	(9,285)	
Leases	5,500	0	(5,500)	
Total	**19,279**	**4,494**	**(14,785)**	
Annual Forecast	**31,476**	**31,476**	0	

2. Income and expenditure

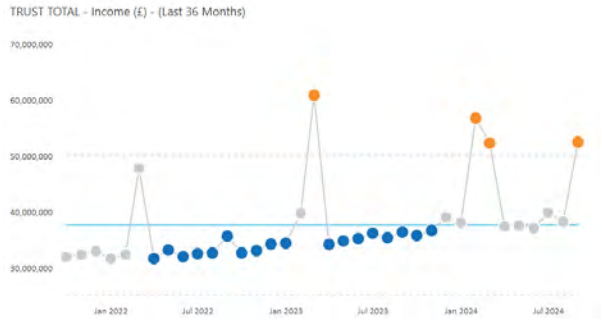
£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	47,362	47,168	(194)	213,614	210,364	(3,250)
High cost drugs	2,125	1,916	(209)	12,962	13,849	886
Other income	1,565	3,363	1,798	13,892	18,168	4,276
Donated Asset Adjustment	-	-	-	-	-	-
Total income	**51,051**	**52,446**	**1,395**	**240,469**	**242,382**	**1,913**
Nursing	(10,273)	(10,780)	(506)	(61,854)	(63,272)	(1,418)
Medical	(8,068)	(8,286)	(218)	(49,254)	(50,667)	(1,413)
Other	(7,879)	(7,165)	714	(45,783)	(42,461)	3,322
Unidentified efficiencies	1,285	-	(1,285)	4,698	-	(4,698)
Total pay	**(24,935)**	**(26,230)**	**(1,295)**	**(152,192)**	**(156,400)**	**(4,208)**
Clinical supplies	(4,823)	(5,061)	(238)	(30,039)	(29,873)	166
Drugs	(1,143)	(1,260)	(117)	(6,868)	(6,967)	(99)
High cost drugs	(1,994)	(1,853)	141	(12,832)	(13,849)	(1,017)
Other	(3,893)	(4,291)	(398)	(28,259)	(24,342)	3,917
Unidentified efficiencies	604	-	(604)	2,740	-	(2,740)
Total non-pay	**(11,249)**	**(12,465)**	**(1,217)**	**(75,258)**	**(75,030)**	**228**
EBITDA	**14,867**	**13,751**	**(1,116)**	**13,019**	**10,952**	**(2,067)**
Non-operating exp.	**(2,021)**	**(2,510)**	**(489)**	**(13,994)**	**(13,582)**	**412**
Reported surplus/(deficit)	**12,846**	**11,241**	**(1,605)**	**(975)**	**(2,630)**	**(1,655)**
Adj. to control total	**(477)**	**(275)**	**202**	**(363)**	**(605)**	**(242)**
Control total	**12,369**	**10,966**	**(1,403)**	**(1,338)**	**(3,236)**	**(1,898)**

1. Clinical income reports adverse performance of £3.3m YTD; this is due to centrally held items from planning that have not yet materialised, including the mobile endoscopy funding/activity (offset by expenditure not incurred in this respect) which started in-month (later than the assumption in the original plan), under delivery of ERF stretch income targets and funding of Ruby ward. High cost drugs favourable income is offset with expenditure reported in non-pay, however c£0.7m YTD of income related to HCD from the ICB is not expected to be paid and is reflected in the clinical income variance. The plan and actuals include the adjustment of £14.2m deficit support funding in-month and YTD.
2. The 'other income' favourable variance is mainly due to medical education income (£1.8m YTD) following an updated schedule from NHS England (Workforce, Training and Education), estates and facilities income above plan (£0.5m), Provider to Provider contracts (for imaging, pathology and radio-pharmacy) within CCCS (£0.7m), £0.2m funding for the Targeted Enhanced Recruitment Scheme (TERS), £0.5m funding towards Industrial action costs and £0.1m Recovery Support Programme Funding.
3. The September pay run-rate has remained in line with August, although medical pay has increased as a result of the rotation and additional sessions in month. The total staffing increase in-month is 46 WTE due to high acuity patients requiring significant enhanced care, sickness and to avoid dropping theatre sessions.
4. The overall pay variance is adverse by £4.2m YTD, being a deterioration of £1.3m from month 5, primarily due to the unidentified efficiencies budget (see point 7 below). Temporary staff numbers have increased overall by 37 WTE due to the continued requirement to cover vacancies and sickness; there remains a focus for the services to challenge all bookings.
5. Nursing staff report an adverse performance of £0.5m in-month and £1.4m YTD. This continues to be from pressures in emergency and acute care (£0.7m) as well as Frailty (£0.5m). Furthermore, month 6 has seen an increase of £0.3m in RMNs and enhanced care. The YTD medical overspend arises due to £0.6m industrial action costs (now funded), safe staffing/over-establishment in ED and £0.2m Targeted Enhanced Recruitment Scheme (TERS) funded costs.
6. The 'clinical supplies' favourable variance includes reserves held centrally for the Endoscopy mobile unit (and offsets the associated adverse income noted above) 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. These will be transacted in month 7 and may adjust the budget lines against which this should sit.

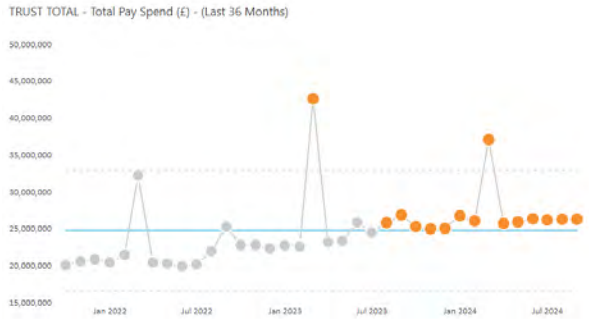
3. Run-rate

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.

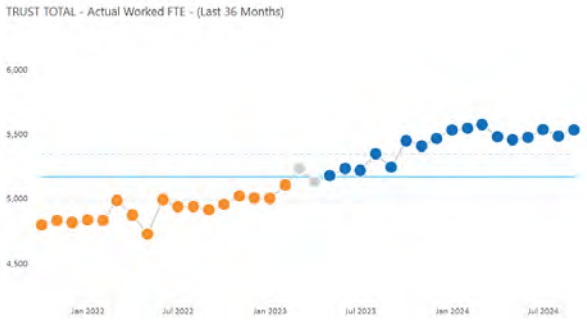
Income



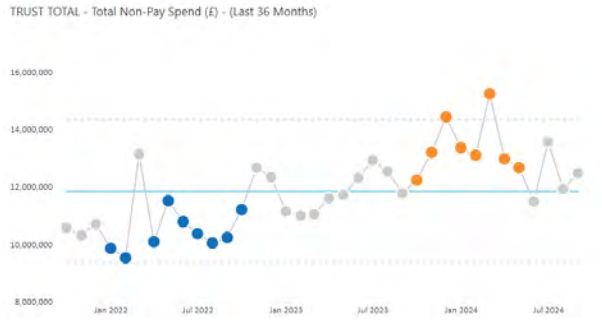
Pay



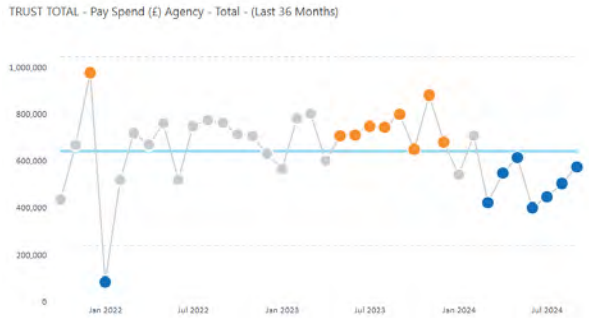
Full Time Equivalents worked



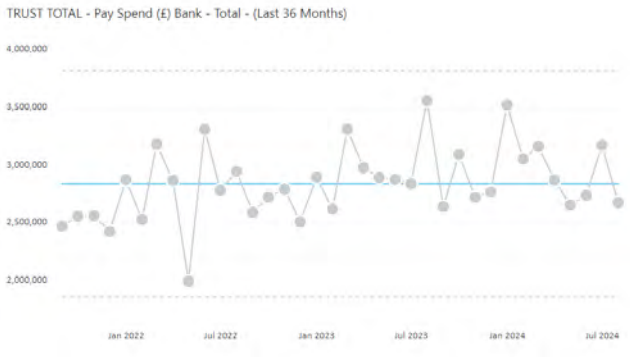
Non-pay



Agency

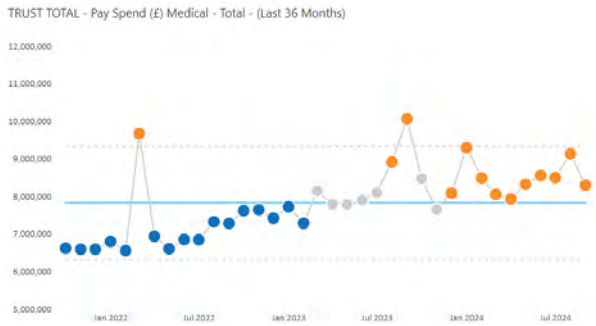


Bank

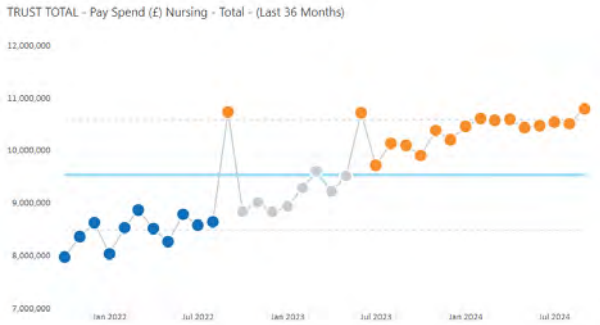


The pay spend results for March in each of the three years include the impact of the additional 6.3% pension costs, for which there is a corresponding increase to income as represented in the first chart. The total spend includes the impact of the pay awards, industrial action and the gradual growth 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 number of temporary FTE to March, there has been a reduction of c100 FTE - this results from tighter controls over rostering and bank bookings that continues to be prioritised across all divisions. This has manifested in a general plateauing of worked FTEs rather than a continual growth as previously experienced.

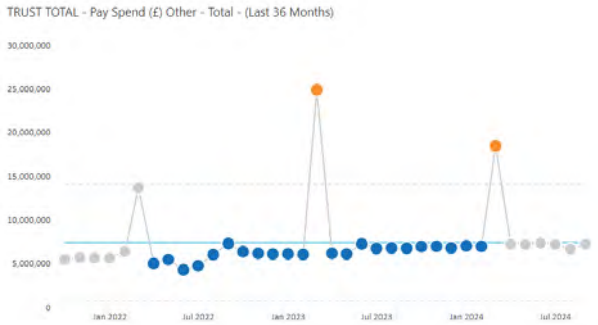
Medical pay total



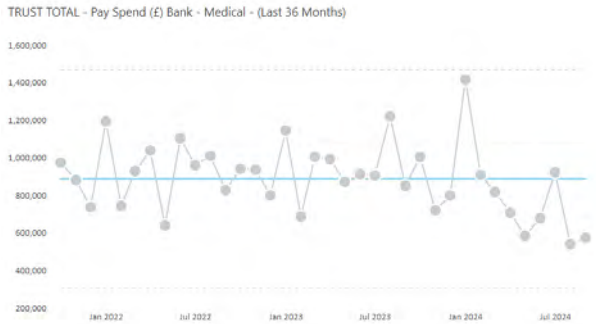
Nursing pay total



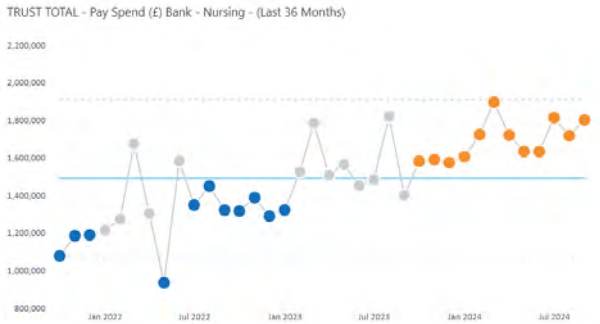
Other staff pay



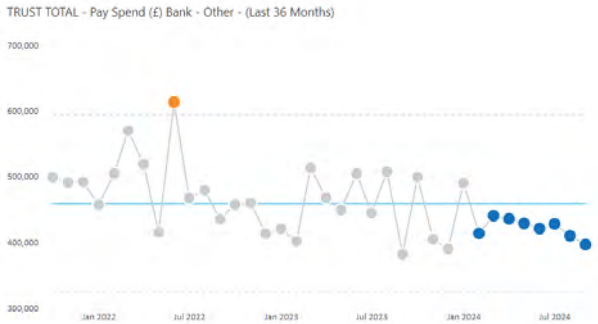
Medical bank



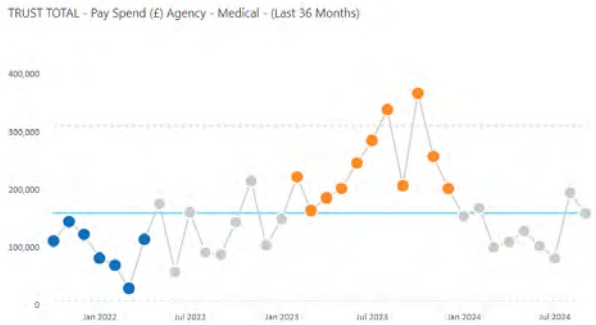
Nursing bank



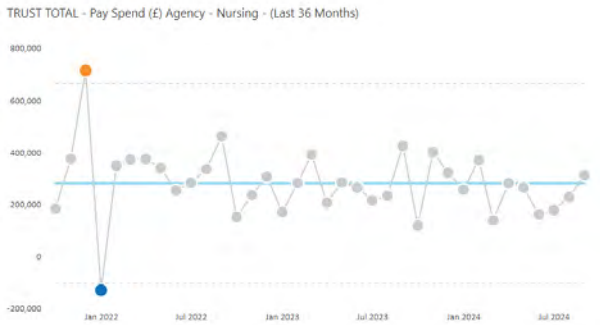
Other Staff bank



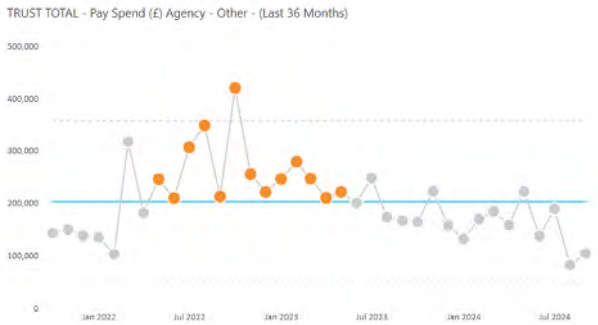
Medical agency



Nursing agency



Other Staff agency



Medical pay costs increase in May includes the pay award and backdated costs for April'24, The costs include industrial action of £0.4m in June and £0.1m in July. Medical temporary staff usage has remained in line with August albeit a reduction in agency offset by an increase in bank. Substantive pay has reduced by £0.8m with £40.4m in MEC.

Nursing temporary staff expenditure in-month has increased by £0.15m split equally across bank and agency from August levels.

Other agency staff has remained in line with August with a £0.02m increase in agency offset by £0.01 decrease in bank.

4. Statement of Financial Position

Prior year end	£'000	Month end actual	Var on PY.
281,888	**Non-current assets**	**276,722**	**(5,166)**
6,556	Inventory	6,863	307
29,573	Trade and other receivables	57,648	28,075
21,042	Cash	5,155	(15,887)
57,171	**Current assets**	**69,666**	**12,495**
(357)	Borrowings	(309)	48
(57,536)	Trade and other payables	(49,854)	7,682
(1,166)	Other liabilities	(2,678)	(1,512)
(59,059)	**Current liabilities**	**(52,841)**	**6,218**
(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**	**289,231**	**13,611**
489,836	Public dividend capital	506,079	16,243
(275,397)	Retained earnings	(278,029)	(2,631)
61,181	Revaluation reserve	61,181	0
275,620	**Total taxpayers' equity**	**289,231**	**13,611**

Key messages:

1. **Non-current assets** are £5.2m lower than year end, being the net impact of investment expenditure of £4.5m and £9.7m depreciation

2. In month 6 the Trust has net current assets of £16.8m, a £14.6m increase on month 5 due to income accruals for the additional ICB deficit support which is expected to be paid in month 7.

3. **Trade and other receivables** are £57.6m (152% of one month's income); £16.4m (28%) relates to invoices raised and awaiting payment. As above, the increase in non-invoiced receivables relates to the additional ICB payment expected in month 7; invoices are no longer raised for commissioner block income.

4. **Cash** has decreased by £15.9m since the year end due to payment of prior year capital creditors (approx. £9.4m) and the I&E deficit. The month 7 additional income will improve the cash position in the short term.

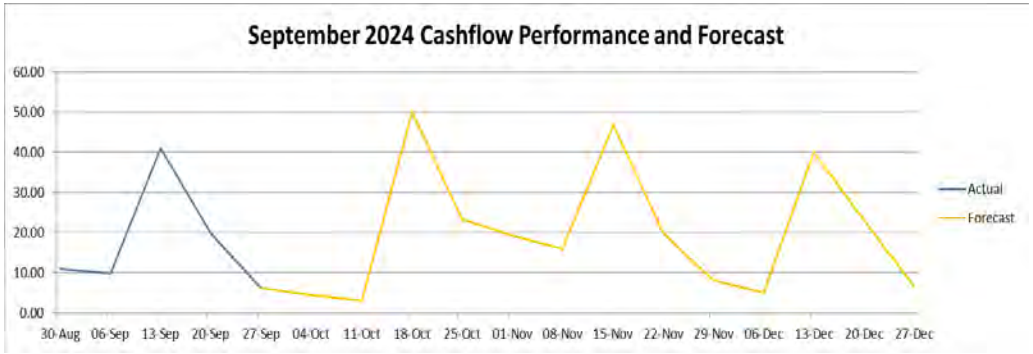
5. **Trade and other payables** are £49.9m (132% of one month's expenditure); £30.7m (62%) relates to invoices received and awaiting payment.

6. **Public Dividend Capital** has increased by £16.2m due to cash support drawn from NHSE in 24/25. No further support cash is available unless the I&E forecast changes.

5. Cash

13-week cash forecast

£m	w/e Actual 30/08/24	06/09/24	13/09/24	20/09/24	27/09/24	Forecast 04/10/24	11/10/24	18/10/24	25/10/24	01/11/24	08/11/24	15/11/24	22/11/24	29/11/24	06/12/24	13/12/24	20/12/24	27/12/24
BANK BALANCE B/FWD	**14.99**	**10.92**	**9.75**	**40.91**	**19.72**	**6.06**	**4.34**	**3.16**	**50.04**	**23.17**	**19.21**	**15.89**	**46.69**	**19.71**	**8.09**	**4.93**	**39.95**	**23.01**
Receipts																		
NHS Contract Income	0.65	0.05	33.69	0.03	0.16	0.55	0.01	58.73	0.00	0.00	0.00	36.50	0.00	0.00	0.00	38.04	0.00	0.00
Other	0.30	0.16	0.23	0.11	0.14	0.20	0.53	0.47	0.25	0.54	0.32	0.47	0.25	0.54	0.32	0.47	0.25	0.44
Total receipts	**0.95**	**0.21**	**33.92**	**0.14**	**0.30**	**0.75**	**0.54**	**59.20**	**0.25**	**0.54**	**0.32**	**36.97**	**0.25**	**0.54**	**0.32**	**38.51**	**0.25**	**0.44**
Payments																		
Pay Expenditure (excl. Agency)	(0.47)	(0.48)	(0.49)	(11.00)	(13.75)	(0.45)	(0.49)	(3.92)	(24.12)	(0.51)	(0.49)	(0.49)	(28.39)	(0.51)	(0.49)	(0.49)	(11.65)	(14.31)
Non Pay Expenditure	(4.10)	(0.90)	(2.26)	(5.44)	(1.70)	(1.99)	(0.81)	(7.14)	(3.00)	(4.00)	(3.15)	(5.69)	(2.15)	(9.65)	(3.00)	(3.00)	(4.54)	(1.30)
Capital Expenditure	(0.45)	0.00	(0.00)	(0.03)	(0.51)	(0.02)	(0.42)	(1.50)	0.00	0.00	0.00	0.00	(1.00)	(2.00)	0.00	0.00	(1.00)	(1.50)
Total payments	**(5.02)**	**(1.38)**	**(2.76)**	**(16.48)**	**(15.96)**	**(2.47)**	**(1.72)**	**(12.56)**	**(27.12)**	**(4.51)**	**(3.63)**	**(6.18)**	**(31.54)**	**(12.16)**	**(3.49)**	**(3.49)**	**(17.19)**	**(17.11)**
Net Receipts/ (Payments)	**(4.07)**	**(1.17)**	**31.16**	**(16.34)**	**(15.66)**	**(1.72)**	**(1.18)**	**46.64**	**(26.87)**	**(3.97)**	**(3.32)**	**30.80**	**(31.29)**	**(11.62)**	**(3.17)**	**35.03**	**(16.94)**	**(16.67)**
Funding Flows																		
DH Revenue Support	0.00	0.00	0.00	0.00	2.00	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
Working Capital Support	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
PDC Capital	0.00	0.00	0.00	0.19	0.00	0.00	0.00	0.25	0.00	0.00	0.00	0.00	4.39	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	(5.05)	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
Total Funding	**0.00**	**0.00**	**0.00**	**(4.86)**	**2.00**	**0.00**	**0.00**	**0.25**	**0.00**	**0.00**	**0.00**	**0.00**	**4.32**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**10.92**	**9.75**	**40.91**	**19.72**	**6.06**	**4.34**	**3.16**	**50.04**	**23.17**	**19.21**	**15.89**	**46.69**	**19.71**	**8.09**	**4.93**	**39.95**	**23.01**	**6.34**



The overall cash balance has increased by £5.8m in September.

£36.8m of cash was received in month

£33.9m NHS contract income for the month, £2m Revenue Support funding, £0.2m PDC drawdown and £0.7m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£42.6m of cash was paid out by the Trust in month

£15.2m (36%) in direct salary costs to substantive and bank employees.
£10.5m (25%) employer costs to HMRC and NHSP.
£11.9m (28%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.
£5.0m((11%) PDC dividend payment, paid in M6 and M12

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. A separate report has been prepared on the forecast.

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 £11.0m surplus in-month and £3.2m deficit YTD, this being £1.9m adverse to the latest plan submitted to NHSE. The main driver of the in month surplus is the receipt of £14.7m deficit support funding, for which the control total has been amended. The adverse variance is driven by £0.9m of pay costs across S&A and MEC, £0.5m Non pay cost pressures across MEC and WCYP, £0.8m of funding issues including Ruby Ward and High Cost Drugs.

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 revised £2.4m 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.

Alan Davies
Chief Financial Officer
October 2024

Maternity Claims Scorecard: Thematic Review Q2 2024/25

Trust Board 13 November 2024

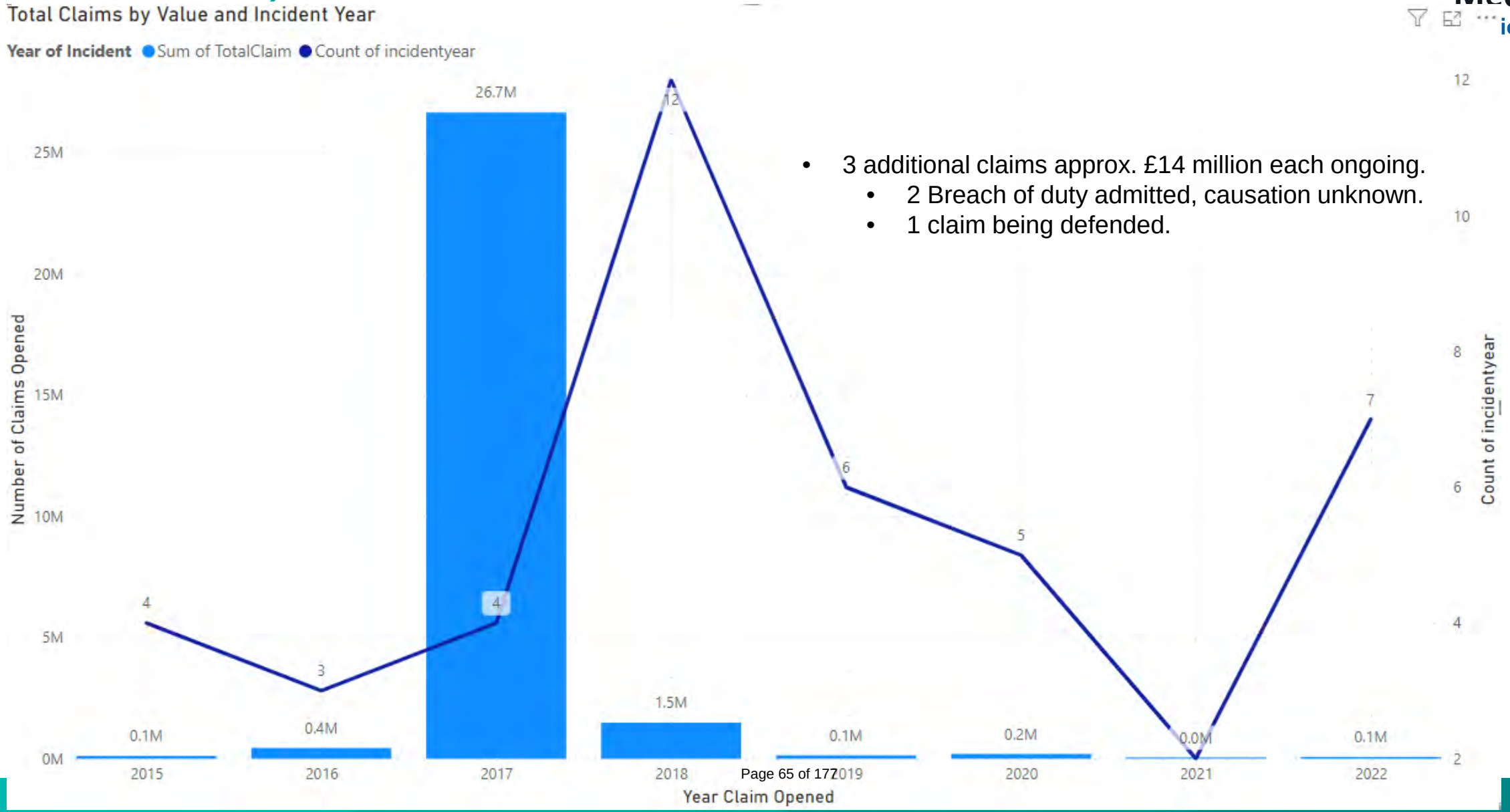
Overview

- NHSR Claims scorecard published annually in September with data for the previous 10 years.
- Latest scorecard has just been published in September but awaiting claim level data via legal department to review for quarterly report, therefore this report will use the scorecard from 2013-2023.
- 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 reviewed the claims scorecard for 2013-2023 alongside incidents and complaints for 2023/24. This included a review by ethnicity of service users.
- The report also reviewed all claims to identify if they were known to the Trust.
- For Incidents reviewed at CRIG in 2024 – 14.8% of incidents related to service users from Black backgrounds – compared to 9% of the 2023/24 birth rate. (17% of ATAIN cases and 20% of Postpartum haemorrhage - PPH)
- For Complaints from 2023/24 – 15% (3) of complaints received were from Asian families compared to 6% of birth rate. No complaints were received from black families.
- For Claims – 45/49 claims were able to be identified and Asian families accounted for 17.5% of claims from 2013-2023. 0 claims received from black families.
- 39/45 claims were known to the Trust prior to the claim being issued.
- 62.5% of these were investigated beyond the initial datix report with 25% being SIs, 15% MNSIs and 10% Patient Safety Case Review (prior to the SI framework)

Actions identified:

- Undertake a case review of current PPH for black ethnicities to identify any themes/learning.
- Undertake a case review of ATAIN babies for black ethnicities with fetal wellbeing midwives/NICU ATAIN leads to identify any themes/learning.
- Undertake a review of complaints and other service user feedback, including CQC Picker, to see if there is a broader theme from Asian families raising concerns regarding communication and care.
- Share the above at future audit meeting, once completed.
- Continue to do a deep dive of claims quarterly with new scorecard once released.

Claims – Yearly Breakdown (by incident year and total claim value)



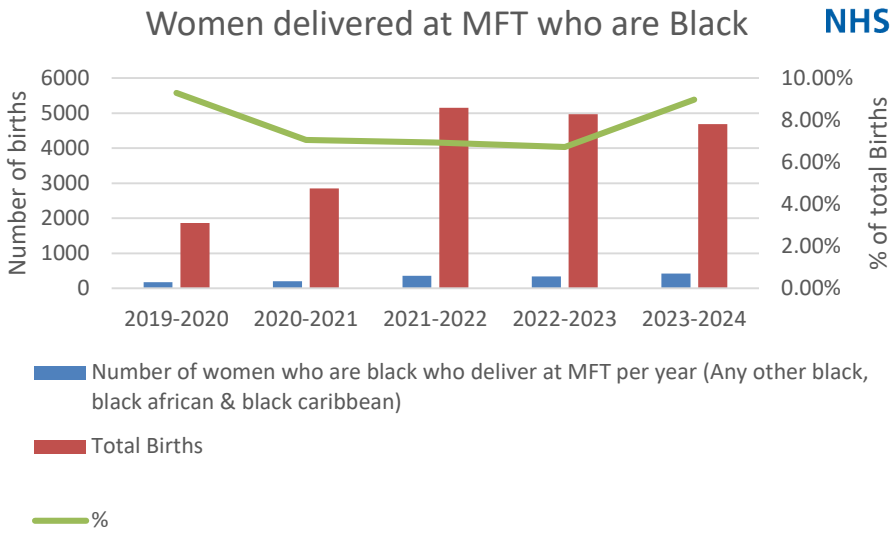
- 3 additional claims approx. £14 million each ongoing.
  - 2 Breach of duty admitted, causation unknown.
  - 1 claim being defended.

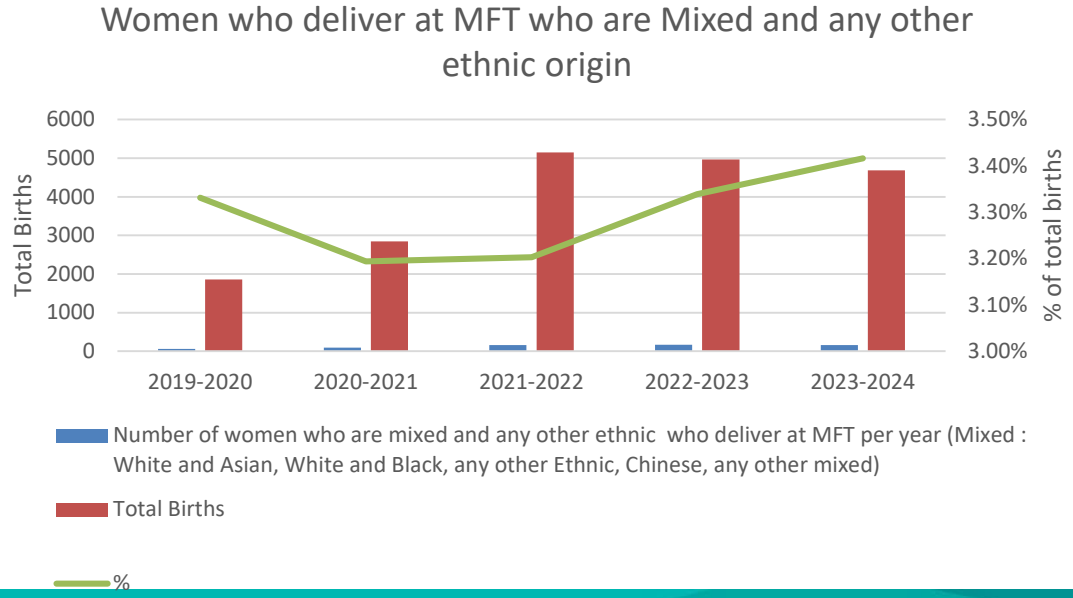
Births per Year/Ethnicity

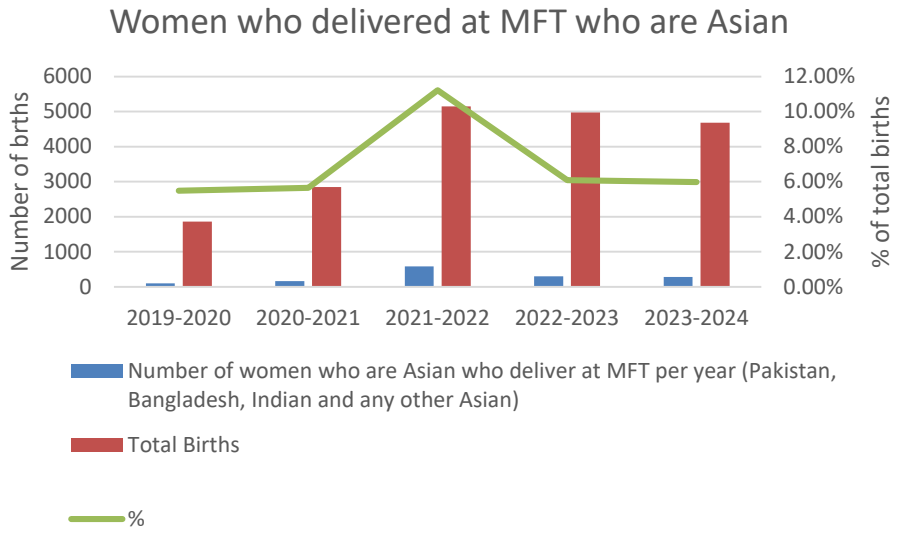
Medway NHS Foundation Trust

Key Messages:

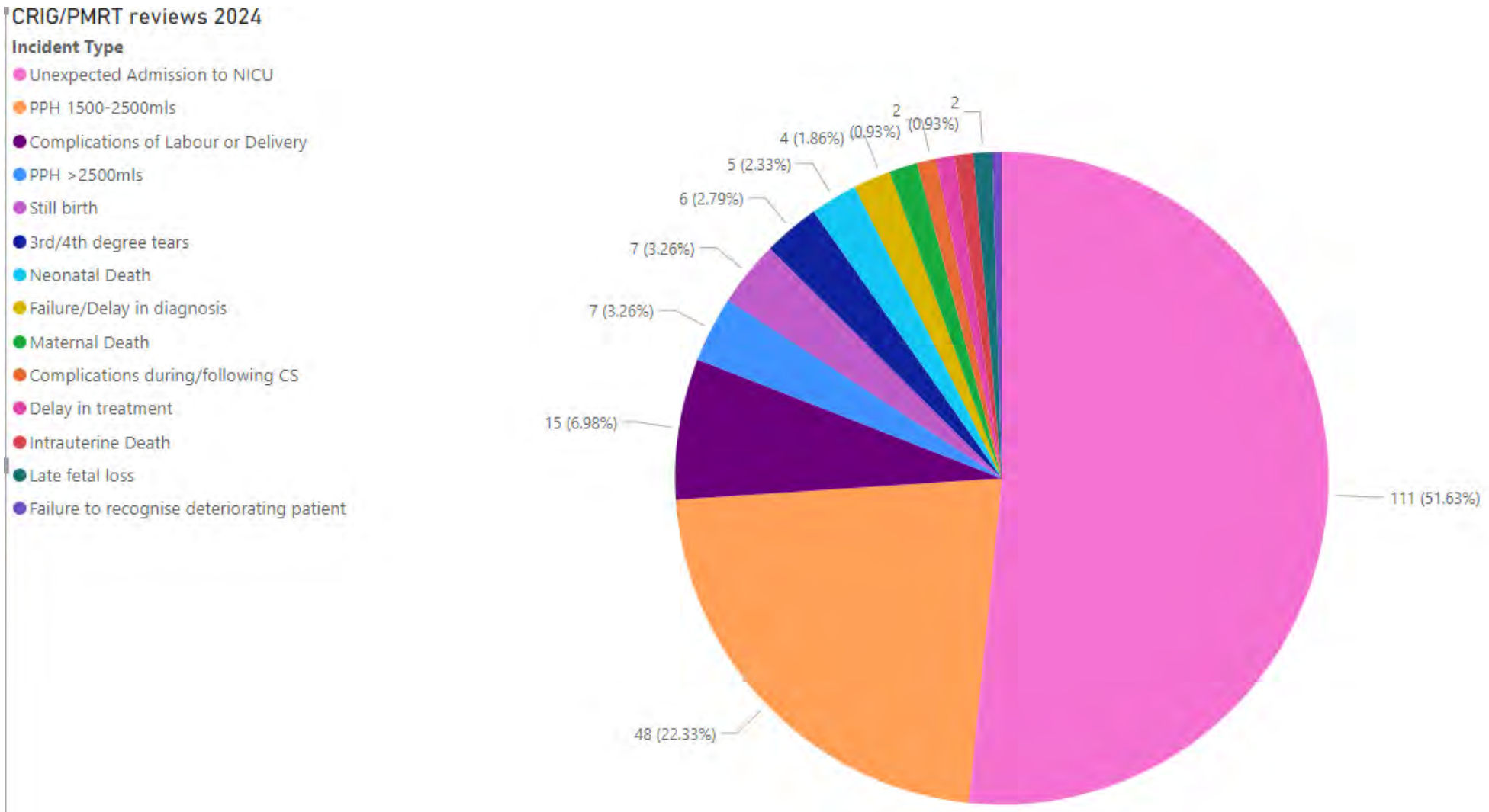
- On review of deliveries from BAME mothers from 2019 to 2024 the percentage of black women delivering has increased throughout the period and currently accounts for 9% of all deliveries at MFT in 2023/24.
- The total percentage of mixed and other ethnic origin has also increased across the period, accounting for 3.4% of total deliveries.
- Women from Asian backgrounds currently account for 6% of deliveries.
- Total % for 2023/24 of deliveries from BAME women is 18.36%
- *(Data provided by Doreen Hambe-Manu)*



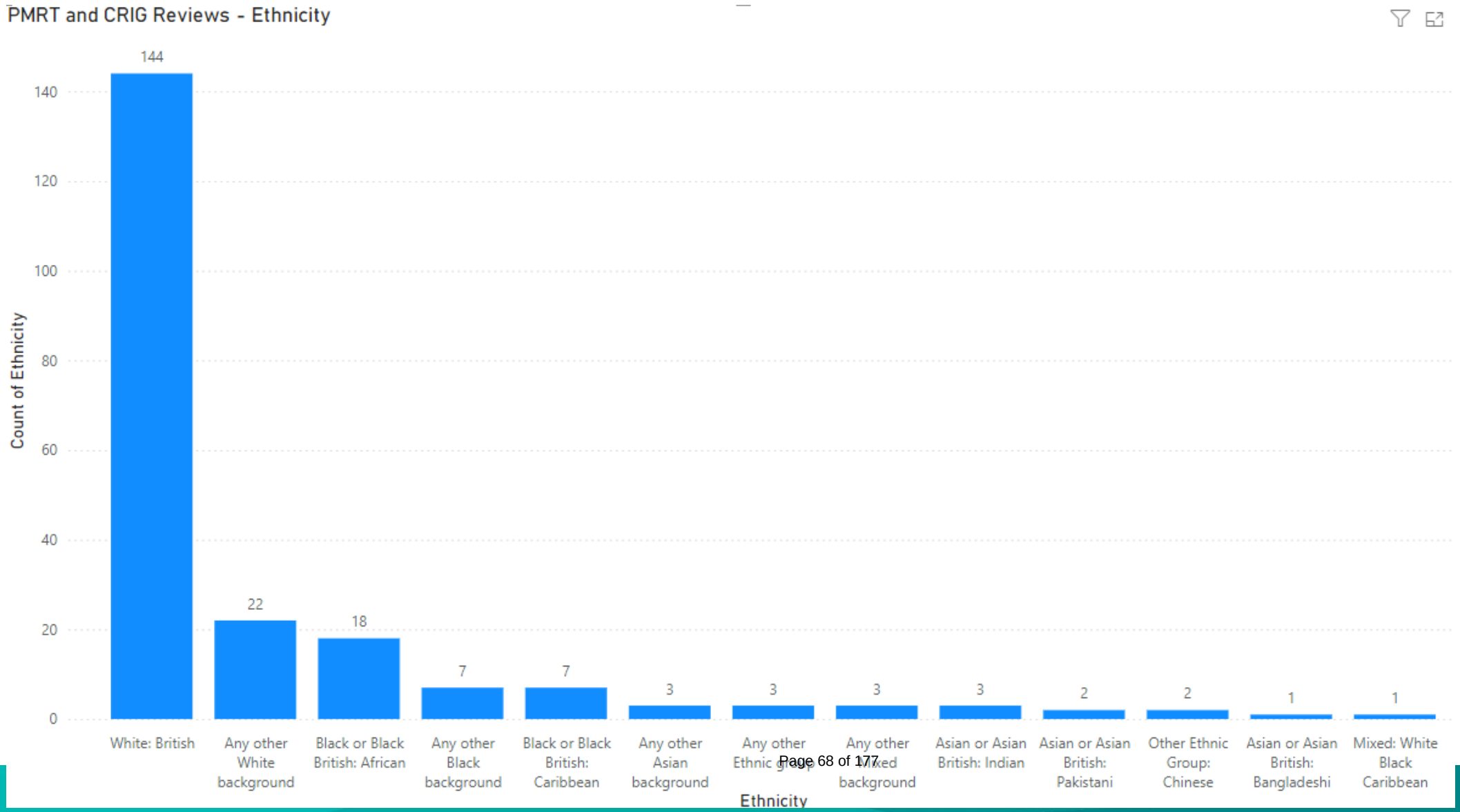




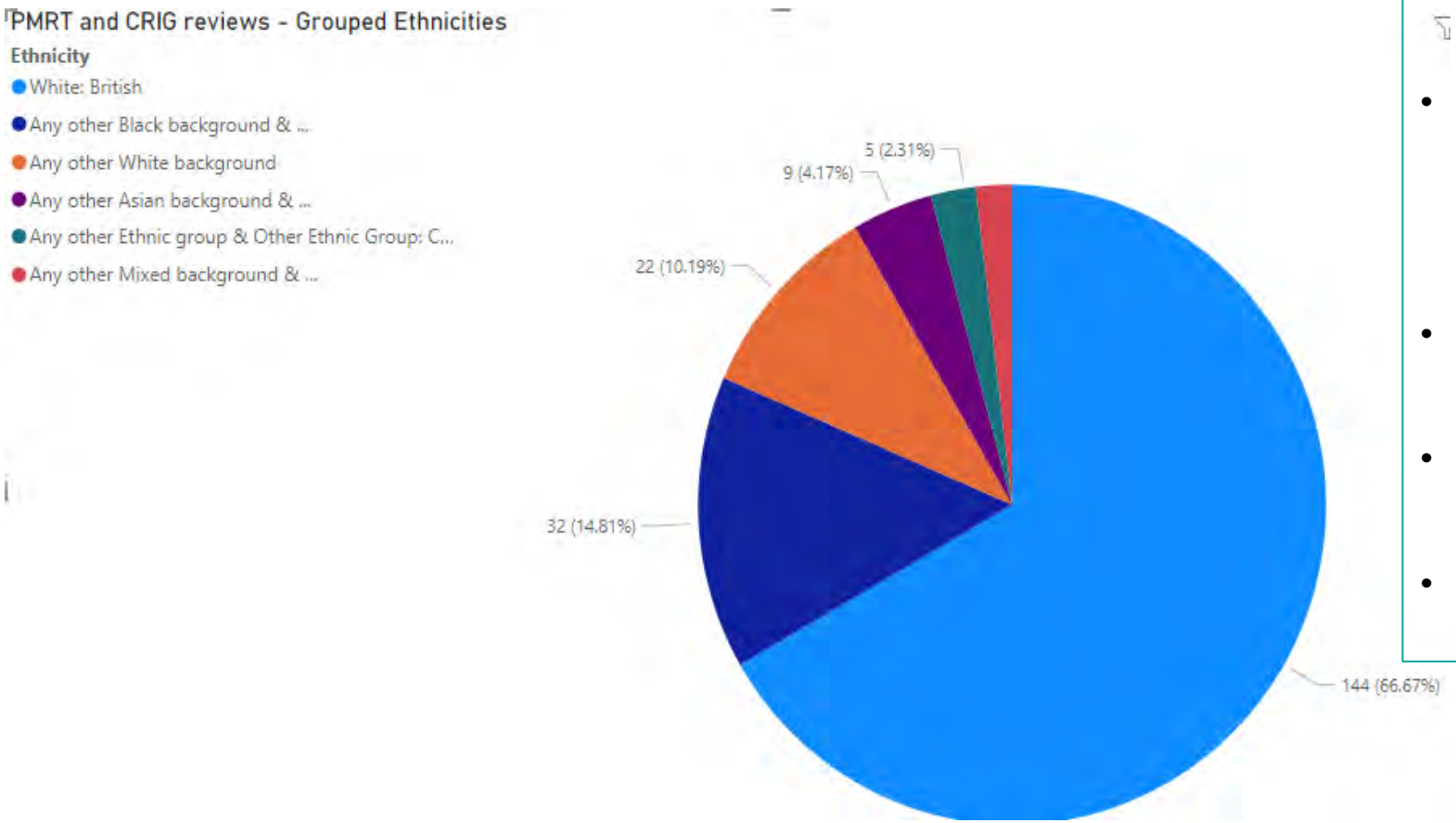
Incidents – CRIG/PMRT Review 2024



Incidents – CRIG/PMRT Review 2024



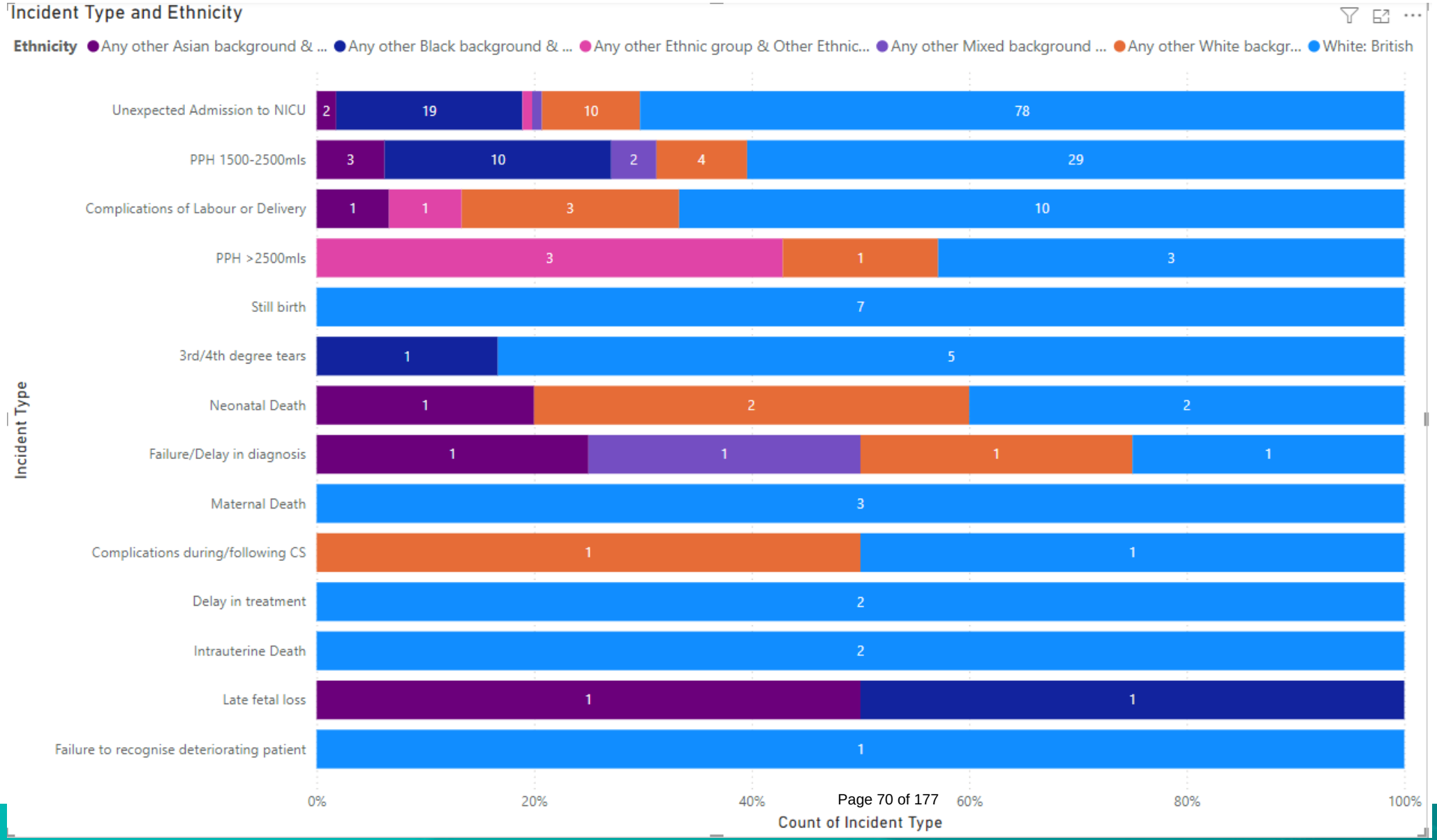
Incidents – CRIG/PMRT Review 2024



Key Messages:

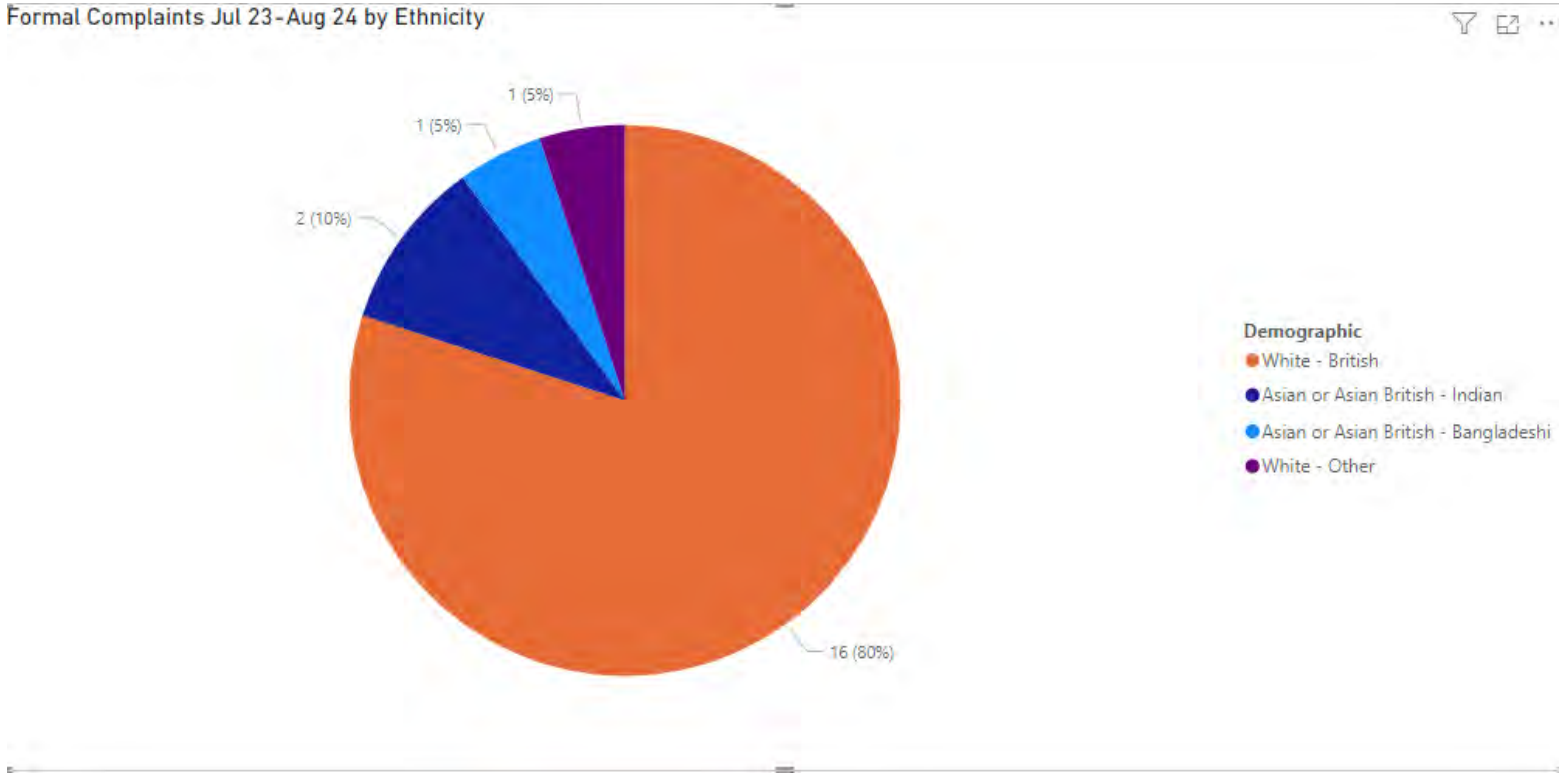
- All black ethnicities account for 14.8% of incidents reviewed at CRIG/by PMRT in 2024. The same group accounted for 9% of births in 2023/24.
- All black ethnicities accounted for:
  - 17% of Unexpected admissions to NICU
  - 20% of all PPHs (1500-2500mls)
  - 0% of PPH > 2500mls
  - 16% of 3rd and 4th degree tears reviewed at CRIG (1)
  - 50% of late fetal losses (1)
- Mixed and other ethnic origin accounted for 2.3% of CRIG/PMRT reviews, and accounted for 3.4% of total deliveries.
- Women from Asian backgrounds accounted for 4.17% of CRIG/PMRT reviews and currently account for 6% of deliveries.
- Total % for 2023/24 of deliveries from BAME women is 18.36%

Incidents – CRIG/PMRT Review 2024*



- Numbers in columns are numbers of incidents by ethnicity.
- Coloured bars represent % of each incident by each ethnicity.

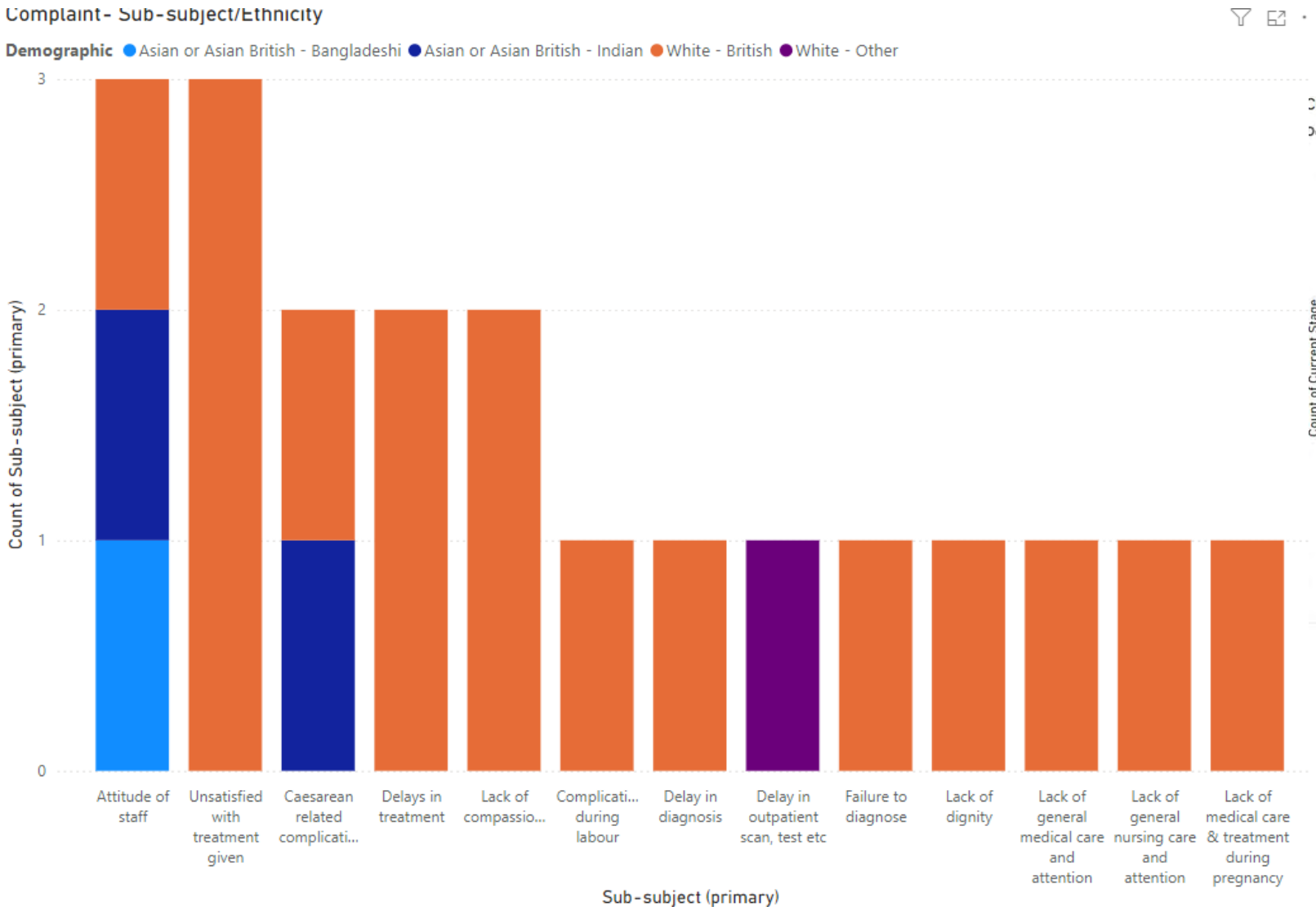
Complaints July 2023-Aug 2024

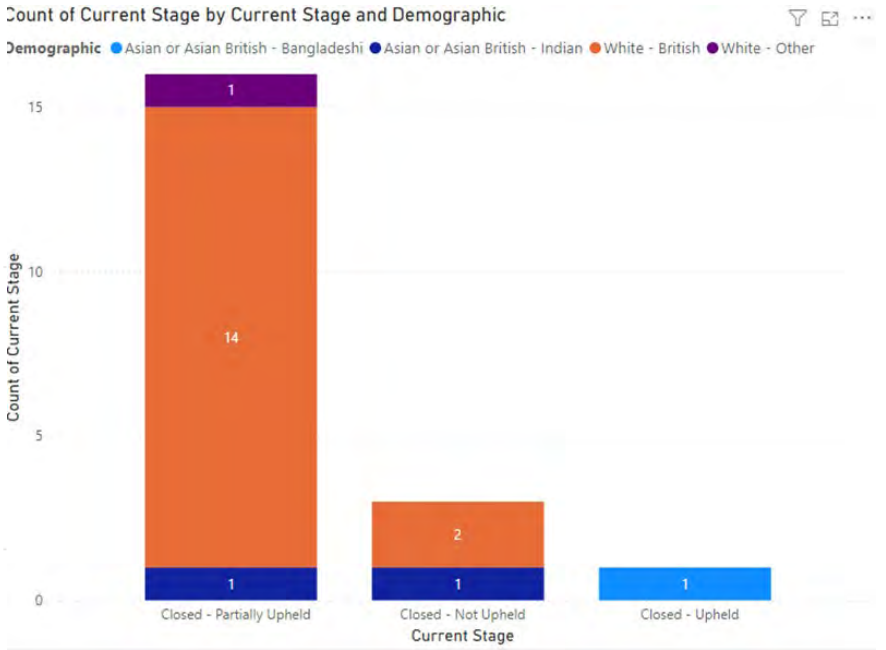


Key Messages:

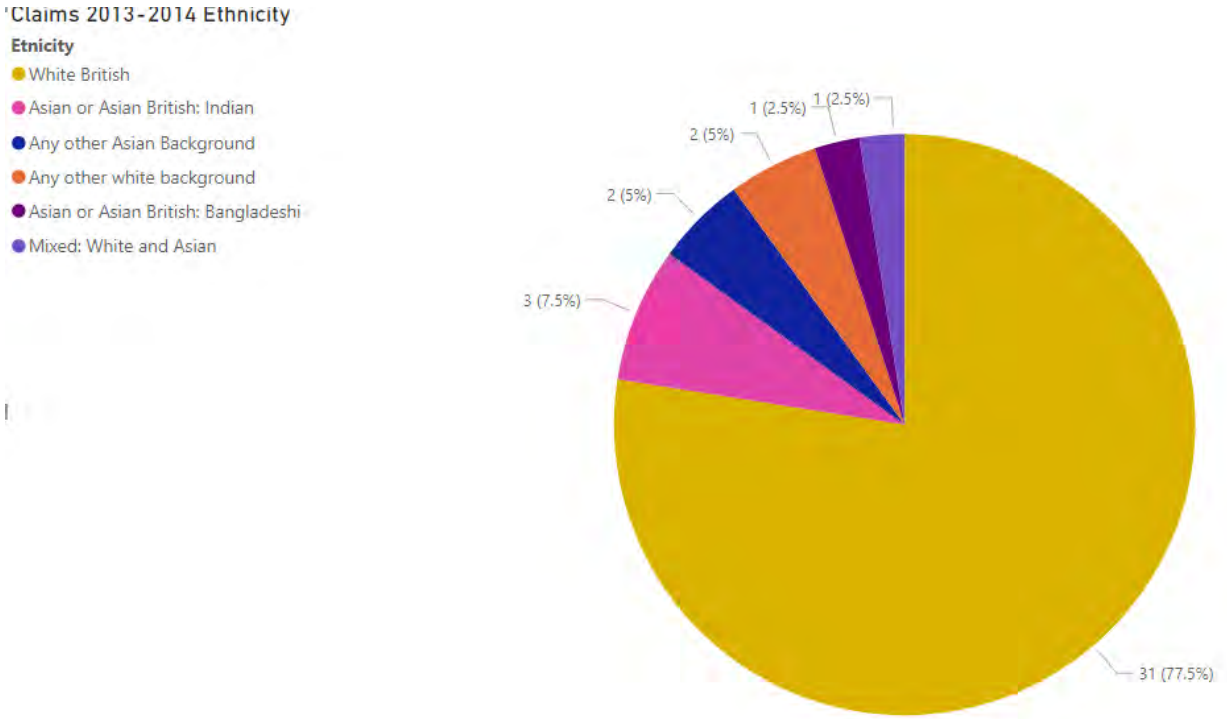
- Women from Asian backgrounds accounted for 6% of deliveries in 2023/34 but account for 15% (3) of the formal complaints received from July 2023-August 2023
  - 2 relating to attitude of staff
    - 1 upheld – (Attitude of staff during scan)
    - 1 partially upheld (attitude of staff, lack of communication/information during scan)
  - 1 relating to caesarean –(not upheld) from 2021 with view to make a claim – out of timescale for complaint. (communication and feeling listened to a theme of complaint)
- No trends identified in terms of upholding/not upholding complaints on based on ethnicities.
- 0 complaints received from Black families.

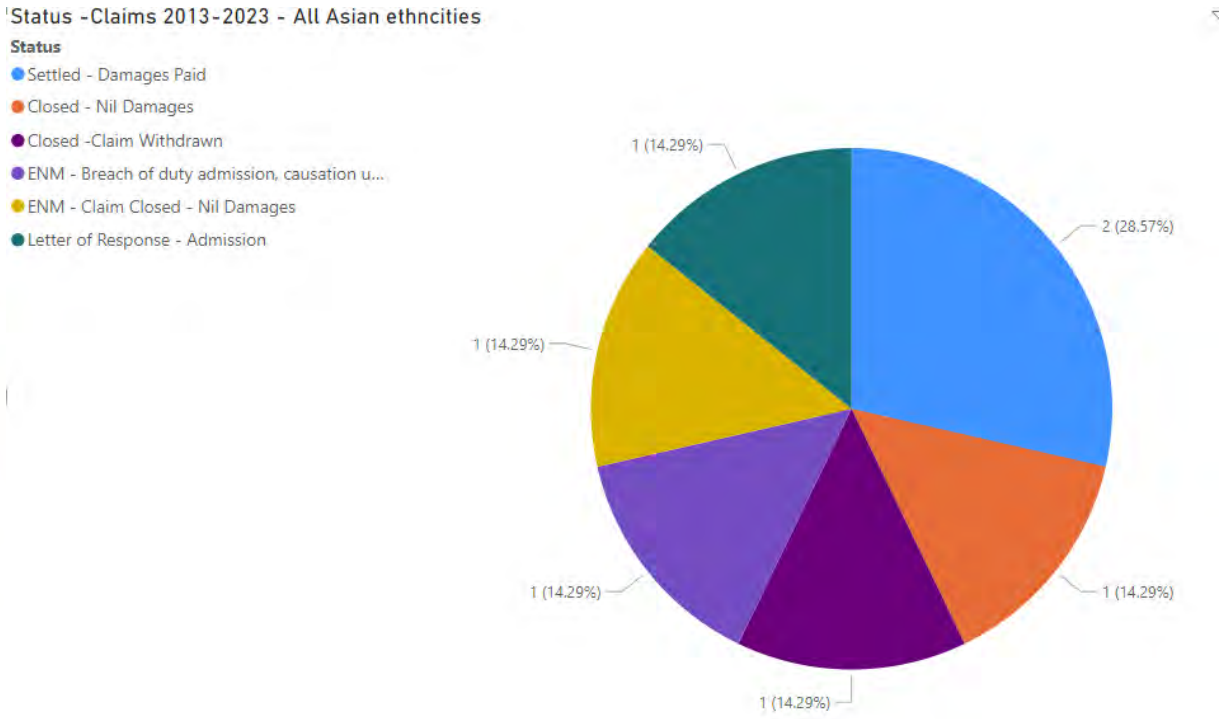
Complaints July 2023-Aug 2024





Claims 2013-2023





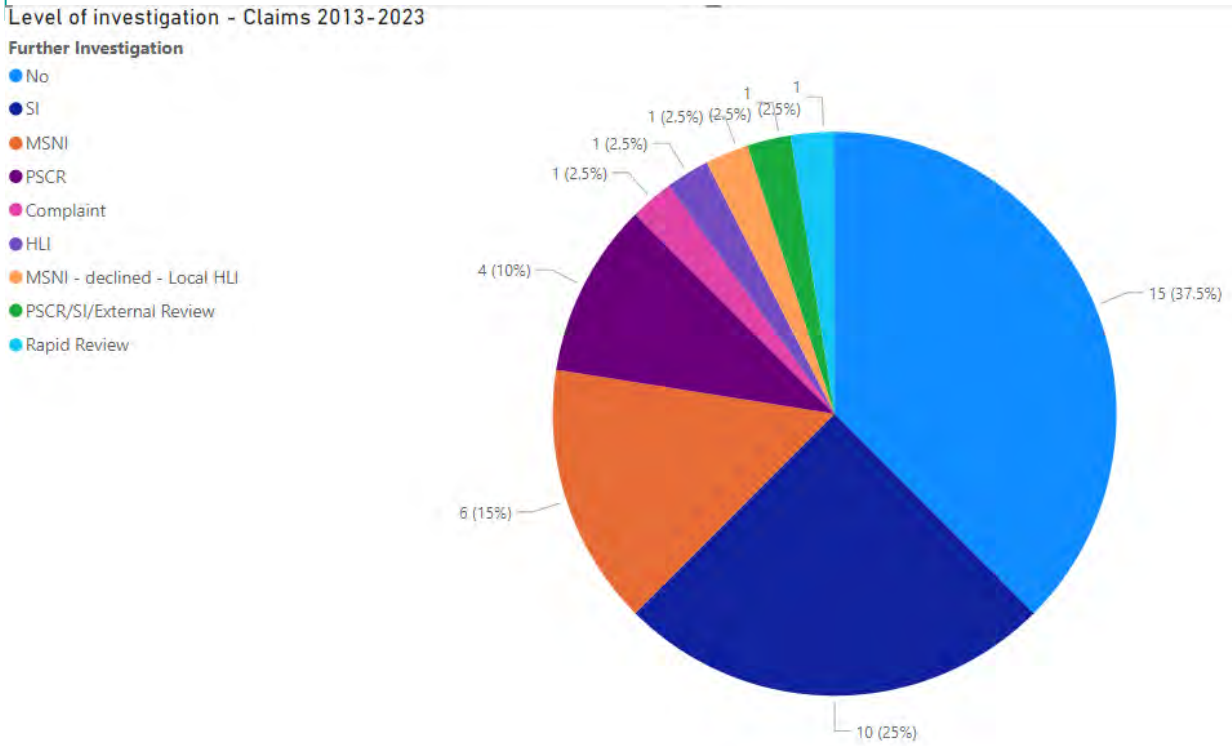
Key Messages:

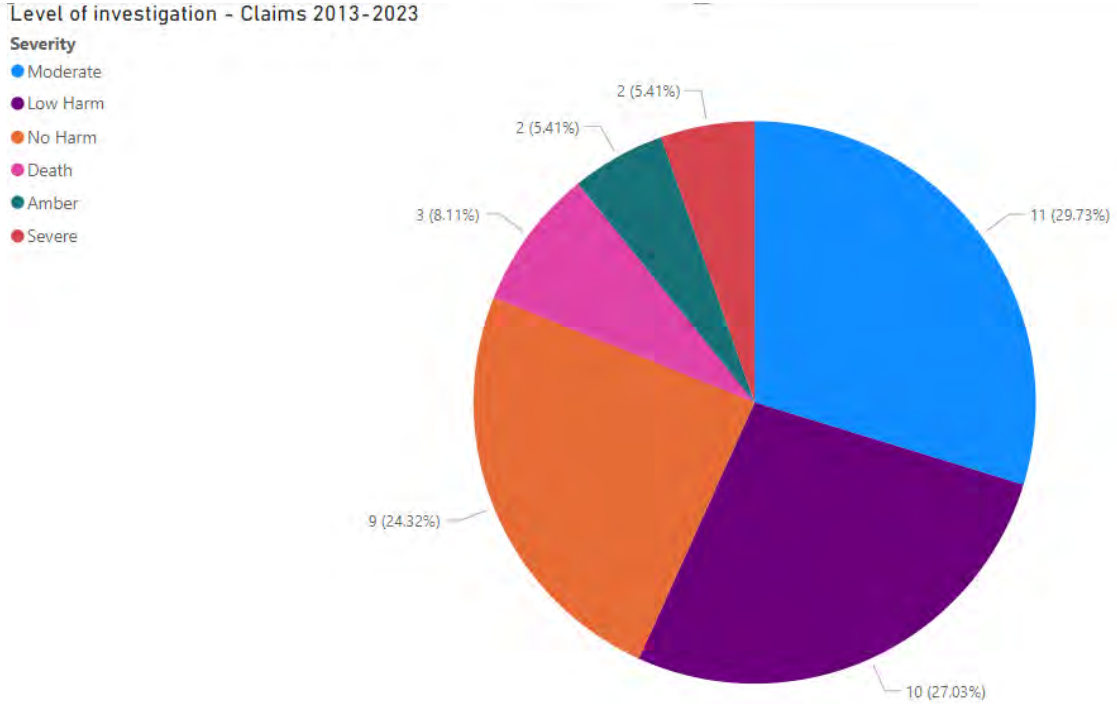
- 55 claims on scorecard for 2013-2023, 6 of these related to gynae cases so have been excluded.
- 45 of these 49 claims were able to be identified on datix and ethnicity and case details determined.
- Women from Asian backgrounds accounted for 6% of deliveries in 2023/34 but account for 17.5% of claims received from 2013-2023.
    - 29% of these claims have been settled with damages paid.
- Of the 45 claims identified, none were from families of any black ethnicities.

Claims 2013-2023

Key Messages:

- 8 of the identified claims were not known to the Trust via an incident report/SI or complaint.
- 39 of these were known to the Trust prior to the claim being issued via a datix report, further investigation or complaint.
  - 62.5% of these were investigated beyond the initial datix report with 25% being SIs, 15% MSNIs and 10% Patient Safety Case Review (prior to SI framework)
    - Of these, 30% were classed as moderate harm
    - 51% being classed as no or low harm.



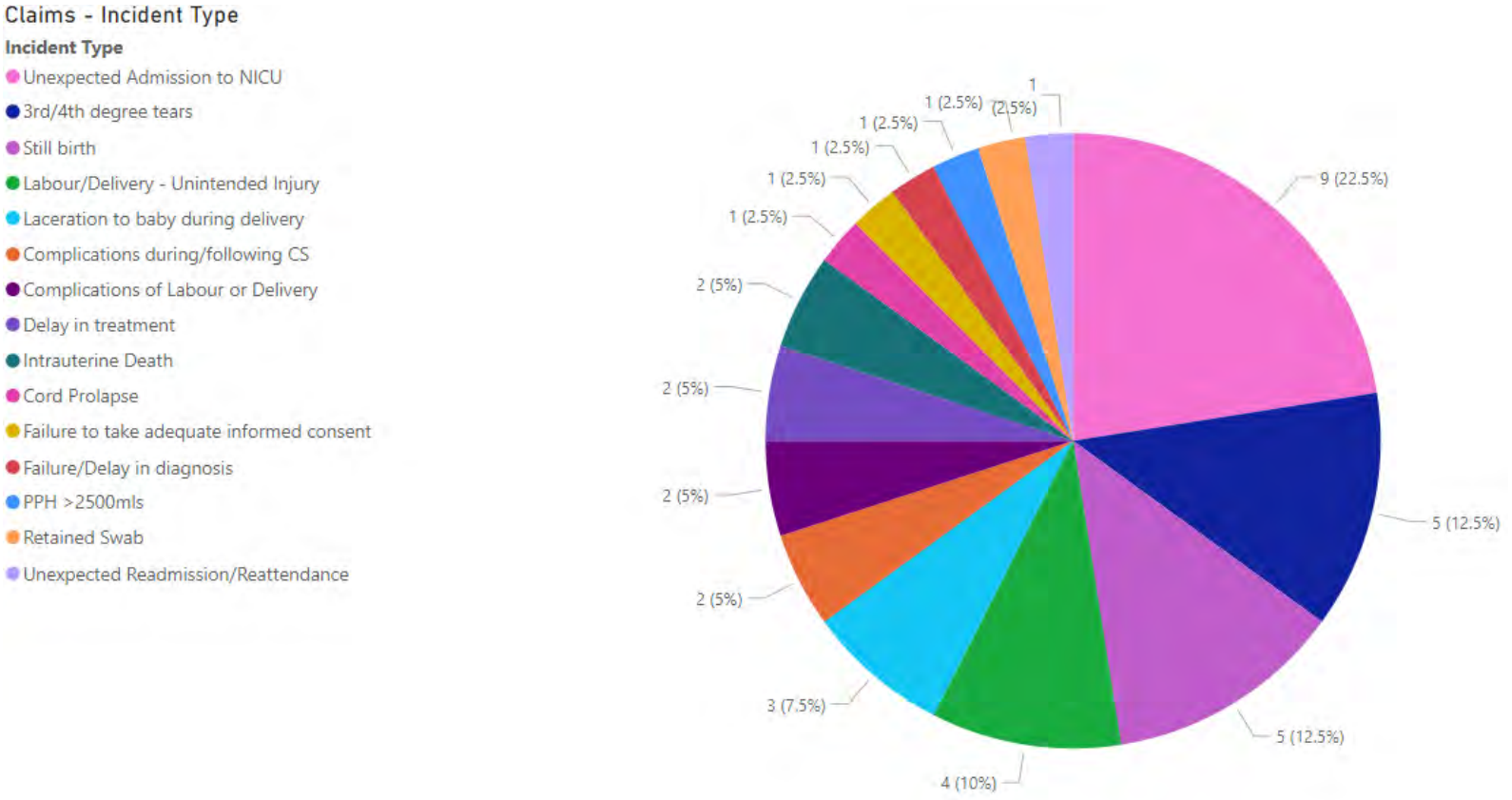


Claims 2013-2023

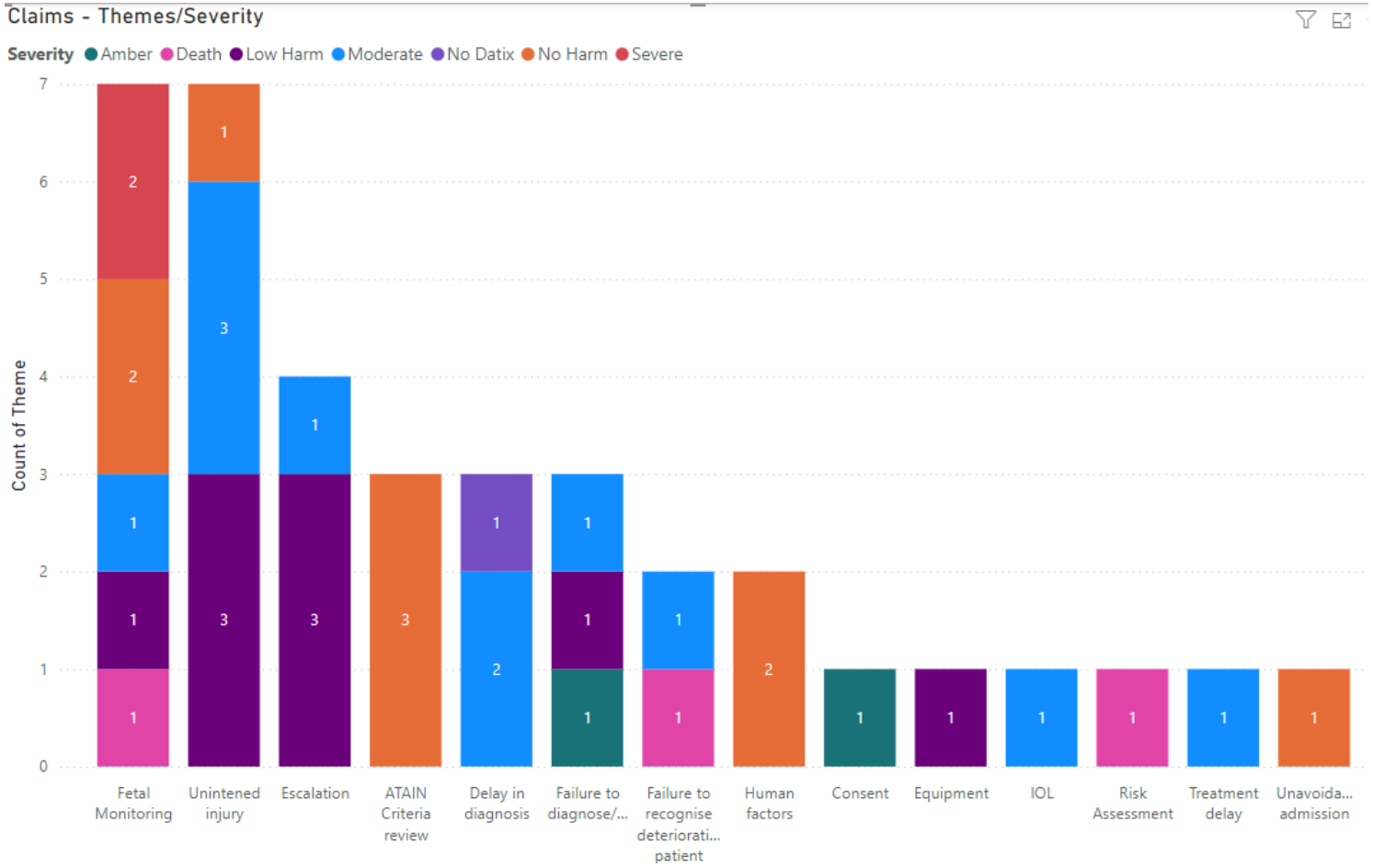
Medway NHS Foundation Trust

Key Messages:

- The identified claims were coded against the classifications of incidents we currently use in our MDT CRIG meeting and the three highest categories were:
  - Unexpected admissions to NICU (including all the MSNI cases referred for therapeutic cooling)
  - 3rd or 4th degree tears – complications/delay/failure to diagnose.
  - Stillbirths/IUD



Claims 2013-2023



NHS Medway NHS Foundation Trust

Key Messages:

- The identified claims were coded against the themes we currently use to categories incidents via our MDT CRIG meeting.
- The highest categories identified were:
  - Fetal Monitoring (7 Claims), Unintended injury (including injury to baby/mother – 7 claims)
  - Escalation was also noted in incidents to be a theme (4) cases, however 8 cases were also noted to have positive and appropriate escalation noted.
  - Failure/delay to diagnose is also a theme of claims with 6 being the main them and 9 a sub-theme. This continues to be a theme and sub theme of current incidents with 9 cases identified.

- On review of current incidents:
  - The recurring theme of issues with CTG interpretation and fetal monitoring noted in the claims of the past 10 years has not been seen in the themes of incidents reviewed in 2024, with no incidents reported as having fetal monitoring as a theme or sub-theme.
  - A number of these case relate to diagnosis/misdiagnosis of 3rd/4th degree tears and this is being addressed with the launch of the OASI2 bundle which will support staff in prevention and detection of 3rd and 4th degree tears. Trust guidelines now also indicate that a consultant or appropriately senior doctor be present for all 3rd and 4th degree tear repairs.

Claims -2013-2023 – Learning Themes - Highlights

Learning Identified	Changes Made
Failure to monitor/interpret CTG	Robust full day Fetal Monitoring training, Lead midwives and obstetrician for fetal monitoring, Development of physiological guidance and supporting LMNS to roll out across region.
Consultant attendance required for complex cases/specific scenarios including 3rd and 4th degree tears, c-section for >BMI	RCOG guidelines implemented to support consultant attendance at key clinical incidents. MFT has 98.7% compliance with this requirement.
Education and Training	Learning from cases are routinely fed into PROMPT and Essential Skills training.
Women and families did not understand the process of IOL or did not have time to consider their options.	Improvement of co-produced patient information, around informed choice, in particular IOL. Consultant midwives developed tools to support community staff to provide service users with the relevant information to make informed choices and outside guidance pathways available.
Fresh eyes, risk assessment and escalation.	Compliant with the SBL requirement for fresh eyes and risk assessment in labour. Ongoing work by FWB midwives to strengthen this. Core team on TBP suitably trained and escalation of deteriorating patient from TBP is included in PROMPT and SIM.
Need to improve detection and repair of 3rd and 4th degree tears	Identified as an ongoing theme in current incidents. Additional training being held by Perineal consultant and OASI-2 bundle being introduced across unit.
Senior clinician oversight required for complex patients	Senior doctor now required to review any medication changes for complex patients. Daily consultant review of patients on IOL list for risk assessment and prioritisation based on clinical need.
Failure to act on adverse test results	Theme identified in recent datix incidents regarding investigation log not being followed up. No harm identified but new process in place including dedicated obstetric cover to review and matron spot-check of process.

Findings

- Disproportionately high representation of black ethnicities in current incidents. Underrepresentation in complaints and claims (0%)
- Disproportionately high representation of Asian ethnicities in complaints and claims.
- Deep dive into claims identified that the majority of claims were known to the Trust via datix or complaint prior to the claim being raised, although 50% of these were rated as low harm.
- Key themes from claims, in particular fetal monitoring, are not themes of current incidents.
- 3rd and 4th degree tears and complications arising from these are a theme of both claims and current incidents – this is being addressed by the introduction OASI2 bundle and education.
- Communication, including taking informed consent, is a theme that has been seen recently in service user feedback.
  - Additional sessions on consent have been run by the Associate Director of Legal at Women's audit meeting in July and October 2024.
  - Work ongoing to improve patient facing information and supporting staff to have conversations with service users to support informed consent.

Recommendations/Actions

- Case review of current PPH for black ethnicities to identify any themes/learning.
- Case review of ATAIN babies for black ethnicities with fetal wellbeing midwives and NICU ATAIN leads to identify any themes/learning.
- Review of complaints & other service feedback, including CQC Picker, to see if broader theme from Asian families raising concerns regarding communication and care.
- Share at audit along with case review of high-value claim to share learning with clinical staff.
- Continue with deep dive of claims quarterly with new score card (released September 2024 – not yet received in department)

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

Trust Board 13 November 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.
- Safety Action 2 Complete – fully compliant.
- Safety Action 6 – SBL – good improvement in last few months to achieve current self-assessment of 94%, which was validated by LMNS on 11 October 2024.
- Monthly reporting via MNSCAG and reporting to each Trust Board until submission.
- LMNS Assurance Visit booked for 3 December 2024 to review evidence and discuss with the LMNS the key requirements, prior to submission of compliance to MFT Trust Board in January 2025.

CNST Year 6 Self-Assessment

True North	Safety Action	Description	May 2024	June 2024	July 2024	Aug 2024	Sep 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

CNST Year 6 Actions – Sept 2024

Completed	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice	12
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.	0
Off Track with actions to deliver	Action is off track and plans are being put in place to mitigate any delay	1
On Track	Action is on track with progress noted and on trajectory	70
Total Number of actions		84
Percentage of actions completed/on track		99%

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 November 2024 detailing losses and PMRT findings and actions as required.

Issues, Concerns, Gaps:

- No current caps in reporting process or compliance.

Actions and Improvements:

- 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.
- Funding for Neonatal Nursing Bereavement roles included in PID utilising CNST year 5 monies. To be presented to TIG in October.

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

Date of death	Date reported	Gestation at birth (weeks)	Birthweight (grams)	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
14/01/2024	15/01/2024	25	450	Surveillance complete	21/01/2024	Review complete	21/01/2024	13/03/2024	15/04/2024	0	< 1	Yes	Yes	< 1	< 2	< 4
01/02/2024	02/02/2024	31	620	Surveillance complete	12/02/2024	Review complete	12/02/2024	17/04/2024	08/05/2024	1	< 1	Yes	Yes	< 1	< 3	< 4
04/02/2024	04/02/2024	32	1720	Surveillance complete	12/02/2024	Review complete	12/02/2024	24/05/2024	25/06/2024	0	< 1	Yes	Yes	< 1	< 4	< 5
16/02/2024	18/02/2024	38	3620	Surveillance complete	01/03/2024	Review complete	05/03/2024	24/05/2024	14/06/2024	0	< 1	Yes	Yes	< 1	< 4	< 4
18/02/2024	18/02/2024	26	760	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
19/02/2024	20/02/2024	27	615	Surveillance complete	01/03/2024	Review complete	13/03/2024	11/06/2024	14/06/2024	1	< 1	Yes	Yes	< 1	< 4	< 4
25/02/2024	28/02/2024	22	265	Surveillance complete	04/03/2024	Review complete	22/04/2024	11/06/2024	14/06/2024	2	< 1	Yes	Yes	< 2	< 4	< 4
19/03/2024	21/03/2024	23	592	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
22/03/2024	21/03/2024	23	625	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
07/04/2024	08/04/2024	23	414	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
16/05/2024	20/05/2024	30	1085	Surveillance complete	20/05/2024	Writing report	20/05/2024	12/09/2024	Not set	2	< 1	Yes	Yes	< 1	< 4	Review report not published
18/05/2024	20/05/2024	39	3175	Surveillance complete	20/05/2024	Writing report	20/05/2024	12/09/2024	Not set	0	< 1	Yes	Yes	< 1	< 4	Review report not published
19/05/2024	20/05/2024	39	3705	Surveillance complete	20/05/2024	Writing report	11/06/2024	01/10/2024	Not set	0	< 1	Yes	Yes	< 1	< 5	Review report not published
25/06/2024	26/06/2024	32	1670	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

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

Date of death	Date reported	Gestation at birth (weeks)	Birthweight (grams)	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
09/07/2024	10/07/2024	Not known/not set	860	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
17/07/2024	18/07/2024	24	788	Surveillance complete	06/08/2024	Reviewing	06/08/2024	Not set	Not set		1< 1	Yes	Yes	< 1	Draft report not published	Review report not published
02/08/2024	04/08/2024	35	3245	Surveillance complete	06/08/2024	Reviewing	06/08/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published
04/08/2024	04/08/2024	23	590	Surveillance complete	09/08/2024	Reviewing	09/08/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published
18/08/2024	19/08/2024	35	2385	Surveillance complete	19/08/2024	Reviewing	19/08/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published
09/09/2024	09/09/2024	39	2965	Surveillance complete	09/09/2024	Reviewing	09/09/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published
21/09/2024	23/09/2024	39	3330	Surveillance complete	01/10/2024	Reviewing	01/10/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published
21/09/2024	23/09/2024	22	271	Surveillance complete	01/10/2024	Reviewing	01/10/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published
21/09/2024	23/09/2024	35	2155	Surveillance complete	30/09/2024	Reviewing	30/09/2024	Not set	Not set		0< 1	Yes	Yes	< 1	Draft report not published	Review report not published

True North: System & Partnership

Medway NHS Foundation Trust

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?				Completed
	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 & June 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	Compliance with requirement: May 2024 98.8% June 2024 97.7% July 2024 100%	

Key Messages:

- All requirements passed for July Data.

Issues, Concerns, Gaps:

- No gaps currently identified.

Actions & Improvements:

- Continue to work with provider, BI and digital midwife to improve back copy and data quality.

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

Organisation Name: MEDWAY NHS FOUNDATION TRUST

Reporting Period: July 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	370			Passed
CQIMDQ14	405	375	108.0		Passed
CQIMDQ15	395	400	98.8		Passed
CQIMDQ16	370	395	93.7		Passed
CQIMDQ24	370	370	100.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	245	410	59.8	Passed
CQIMDQ08	410	410	100.0	Passed
CQIMDQ09	405	375	108.0	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	405	375	108.0		Passed
CQIMDQ11	180	405	44.4		Passed
CQIMDQ12	15	405	3.7		Passed
CQIMPPH	10	405		30	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	405	375	108.0		Passed
CQIMDQ22	395	400	98.8		Passed
CQIMDQ23	370	400	92.5		Passed
CQIMPreterm	25	395		58	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	405	375	108.0		Passed
CQIMDQ15	395	400	98.8		Passed
CQIMDQ16	370	395	93.7		Passed
CQIMDQ18	230	395	58.2		Passed
CQIMDQ20	15	215	7.0		Passed
CQIMTears	15	215		60	Passed

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.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	405	375	108.0	Passed
CQIMDQ15	395	400	98.8	Passed
CQIMDQ16	370	395	93.7	Passed
CQIMDQ18	230	395	58.2	Passed
CQIMDQ26	395	400	98.8	Passed
CQIMDQ27	440	440	100.0	Passed
CQIMDQ28	205	440	46.6	Passed
CQIMVBAC	5	55	9.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	405	375	108.0	Passed
CQIMDQ31	410	410	100.0	Passed
CQIMDQ32	370	410	90.2	Passed
CQIMDQ33	410	410	100.0	Passed
CQIMDQ34	230	410	56.1	Passed
CQIMDQ36	405	405	100.0	Passed
CQIMDQ37	175	405	43.2	Passed
CQIMDQ38	410	410	100.0	Passed
CQIMDQ39	355	405	87.7	Passed
CQIMRobson01	10	70	14.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	40	60	66.7	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	60	65	92.3	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	440	375	117.3	Passed
CQIMDQ04	440	440	100.0	Passed
CQIMDQ05	65	440	14.8	Passed
CQIMSmokingBooking	65	440	14.8	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	405	405	100.0	Passed
CQIMSmokingDelivery	45	405	11.1	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	440	440	100.0	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 November 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 underway.

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 – progress report to MNSCAG and LMNS in November 2024.
- Further audit/review of admission rates prior to RCOG updated in counselling to be conducted.
- Launch of additional Prem Pack for all admissions for planned or suspected premature birth <37+0 weeks gestation.
- ATAIN Q1 2024/25 audit completed and summary report included for Board oversight.

True North: Quality

ATAIN Q1 2024/25

Ambition: Preventing avoidable admissions to the Neonatal Unit by supporting mothers and babies on the Transitional Care Pathway.

Goal: Ensure robust review of all Term Admissions to identify opportunities for learning and preventing avoidable admissions.

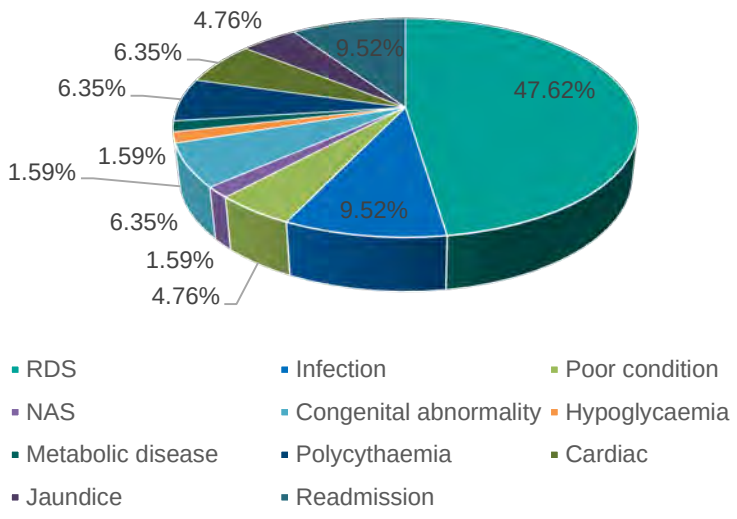
Medway NHS Foundation Trust

RDS	Infection	Poor condition	NAS	Congenital abnormality	Metabolic disease	Hypoglycaemia	Polycythaemia	Cardiac	Jaundice	Readmission
48% (30)	10% (6)	5% (5)	2% (1)	10% (6)	2% (1)	2% (1)	6% (4)	3% (2)	5% (3)	10% (6)

Key Messages: Q1 2024/25

- Number of Term admission from Q4 to Q1 increased from 5.1 to 5.7% (above KSS average 4.9%)
- 1 of the 60 admissions was deemed avoidable. All other admissions were determined to be unavoidable with no concerns in care received
- 48% of all term admissions were for Respiratory Distress Syndrome (RDS).
- 53% of those babies were born by caesarean section, with 75% EMCS in labour 25% ELCS
- Most prevalent antenatal risk factors identified in the term RDS admissions was RFM and GDM
- Most prevalent intrapartum risk factor for RDS admissions was meconium and chorioamnionitis
- Babies admitted for RDS received an average of 43 hours of respiratory support, with an average separation of mother and baby of 5.4 days
- Q1 saw an increase in babies being admitted for treatment of polycythaemia, 4 with a primary diagnosis and 4 with jaundice who were also treated for the condition
- There was also an increase in planned admissions for congenital abnormality

Percentage of reasons for all term admissions Q5 23/24



Issues, Concerns & Gaps:

- Admission rate has increased since the last quarter
- Deep dive of RDS admissions showed consistency in type of birth when compared to the previous quarters
- One avoidable admission infection where baby was then ready to transfer to TC but could not due to cot capacity
- Readmissions are directly admitted to NNU, where as other units in the KSS admit to their paediatric wards
- 60% births that were eligible for steroids declined to receive or were not offered
- Increase in the number of babies admitted from the postnatal wards with jaundice and polycythaemia

Actions & Improvements:

- ATAIN action plan ongoing and collating evidence continues
- Current review of RDS pathway by ATAIN Lead Neonatal Consultant
- Case reviews led by neonatal team for all polycythaemia cases – also replicated across the LMNS network
- FWB and NN ATAIN leads are launching a QIP for antenatal steroid patient information prior to no labour caesarean

True North: People

Safety Action 4: Clinical Workforce
Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard

Medway NHS Foundation Trust

Key Messages: 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.
- 99% compliance with RCOG Must/Should attend guidance.
- NICU nursing vacancy reduced to 2.8 WTE Band 6.
- NICU QIS 67.7%
- 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.

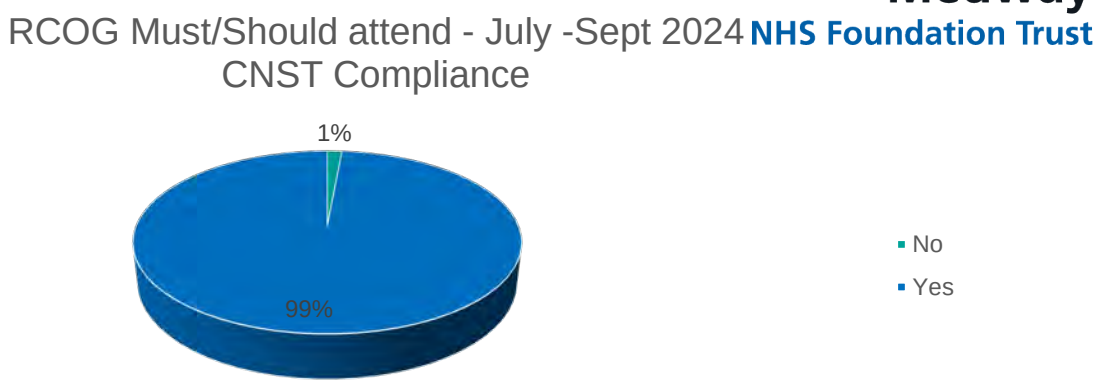
Actions & Improvements

- 6 NICU nurses qualified in speciality in September 2024 with a further 6 commencing the course.
- Action approved by Trust Board in September 2024.

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.
- Q4 2023/24 showed 99% compliance with CNST.
- Q1 2024/25 also demonstrated 99% compliance with CNST requirements with 204/207 cases meeting CNST requirements.
- Cases meeting the Must Attend requirement were 11% of the total cases, however consultants attended for 66% of all cases, with a senior doctor attending the remaining 44%.
- 49% of cases met the "should attend criteria", and MFT was 100% compliant with attendance at these incidents.
- Of the 207 cases reviewed, 136 (66%) met the Must or Should attend criteria, however MFT exceeded this requirement by attending 99% of all cases.
- An improvement was noted in this audit, with only 1 case of PPH >2L identified as not having a consultant attendance. (3 in last audit) This case was well managed and reviewed at CRIG, with a total EBL of 2.1L, therefore on the cusp of requiring consultant attendance.
- 2 cases of Caesarean birth for placenta praevia/invasive placenta (must attend) were not completed by the consultant. Both were elective sections without active bleeding.



Total Cases - 207	Consultant Attended	MeetsMust Attend Criteria	Meets Should attend Criteria	CNST Complaint
No	71	188	98	3
Yes	136	19	109	204
%	66%	12%	54%	99%

Issues, concerns & Gaps

- Consultant attendance for placenta praevia/invasive placenta

Actions & Improvements

- Reduction in the number of incidents on cusp of >2L PPH that were not escalated to consultant.
- No incidents relating to repair of 3rd or 4th degree tear – all perineal injuries were repaired by the appropriate level doctor or more senior.
- Findings of initial audit shared with Trust Board, LMNS, Labour Ward Forum and Women's Audit meeting.
- Share findings from current audit at audit and labour ward forum for review of non-compliant cases and any

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	BRAG September 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					

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

Key Messages: On Track

- Self-assessed 94% overall compliance across the 6 elements, with 3 elements now at 100% for Quarter 5. Await LMNS validation early October.
- 3 quarterly meetings to be held in CNST Year 6 period to meet requirements.
- Planned dates for learning and sharing forums with all Trusts in LMNS
- Action plan in place to achieve 100% for all elements
- 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.
- Consistent use of Partosure.

Actions & Improvements:

- Funding for diabetic nurse and dietician being considered from CNST funds. PID to go to TIG in October
- Swap to Stop programme now running to support smokers to quit. SIP midwife demonstrated improved quit rates amongst engaged service users.
- Spot check audit of partosure completed – actions identified to improve use including education and training.
- Sustained compliance with CGM use in diabetic patients and 100% compliance for HbA1c readings at start of 3rd trimester, push to ensure all readings are from laboratory readings.
- LMNS assessment of MFT as having well-embedded processes with robust monitoring & good awareness of our position and areas for improvement.
- Launch of Prem Pack for all admissions for planned or suspected premature birth < 37+0 weeks gestation to support compliance with element 5. Pre-made packs include:
    - Neonatal Yellow Card
    - Prep for Prem Tool (updated version)
    - Neonatal Team Parent Discussion form (green) to be completed by the neonatal team and placed in the maternal notes
    - LMNS Premature Labour and Birth patient leaflet
    - Milk as Medicine colostrum harvesting pack

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

- LMNS have supported the MNVP to increase offer to support the requirements of CNST Year 6. This includes:
  - Dedicated MNVP band 7 Governance Lead to support attendance at Core Governance meetings across the LMNS and be link role to support learning and thematic review across region.
  - Existing MNVPs to be given an additional 3 hours per month to support engagement work.
- Progress against Maternity CQC Survey shared at Maternity Board with Safety Champions (July) and at LMNS Board (October 2024)

Issues, Concerns, Gaps:

- Maternity CQC Picker Survey 2024 under embargo and free text not received. .

Actions & Improvements:

- Co-production and engagement work continues, including work on supporting patients with neurodiversity, benchmarking against Birth Trauma report and developing an action plan to improve service offered, patient facing information and MCU/Triage project.
- Results of Picker Survey received in September 2024 and plan to review with MNVP to coproduce action plan based on results and free text once the latter is available. This will be reported to the LMNS, MNSCAG and Patient Experience Group.
- Service user engagement event to be held with support of MNVP in October 2024.
- 15 Steps Challenge to be held in January 2025.
- Finalise 2022/2023 Picker CQC Action plan by October 2024.

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)

Key Messages: Off Track with Actions to Deliver

- Compliance for PROPT 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%
- CNST updated guidance to allow for lower compliance for new starters/rotational staff from July 2024.

Issues, Concerns, Gaps:

- <90% for PROMPT training for medical groups.
- <90% for NBLS Training for MSWs and Midwives and ANNP
- Support required from anaesthetic lead to secure anaesthetic consultant attendance.

Actions & Improvements:

- All PROMPT sessions booked with anticipated >90% for all groups by 4 November 2024.
- Obstetric consultants to achieve >90% in October for Fetal Monitoring Training and Assessment.
- 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.
- Trajectory for PROMPT and Fetal Monitoring Training included in next slides.
- NBLS training – MSW and Midwifery staff to attend Pick N Mix Sessions to increase compliance. Requested all staff complete by end of October.
- ANNP to complete NBLS training and future plan for next expiration date as all need to be compliant to achieve >90%

True North: People

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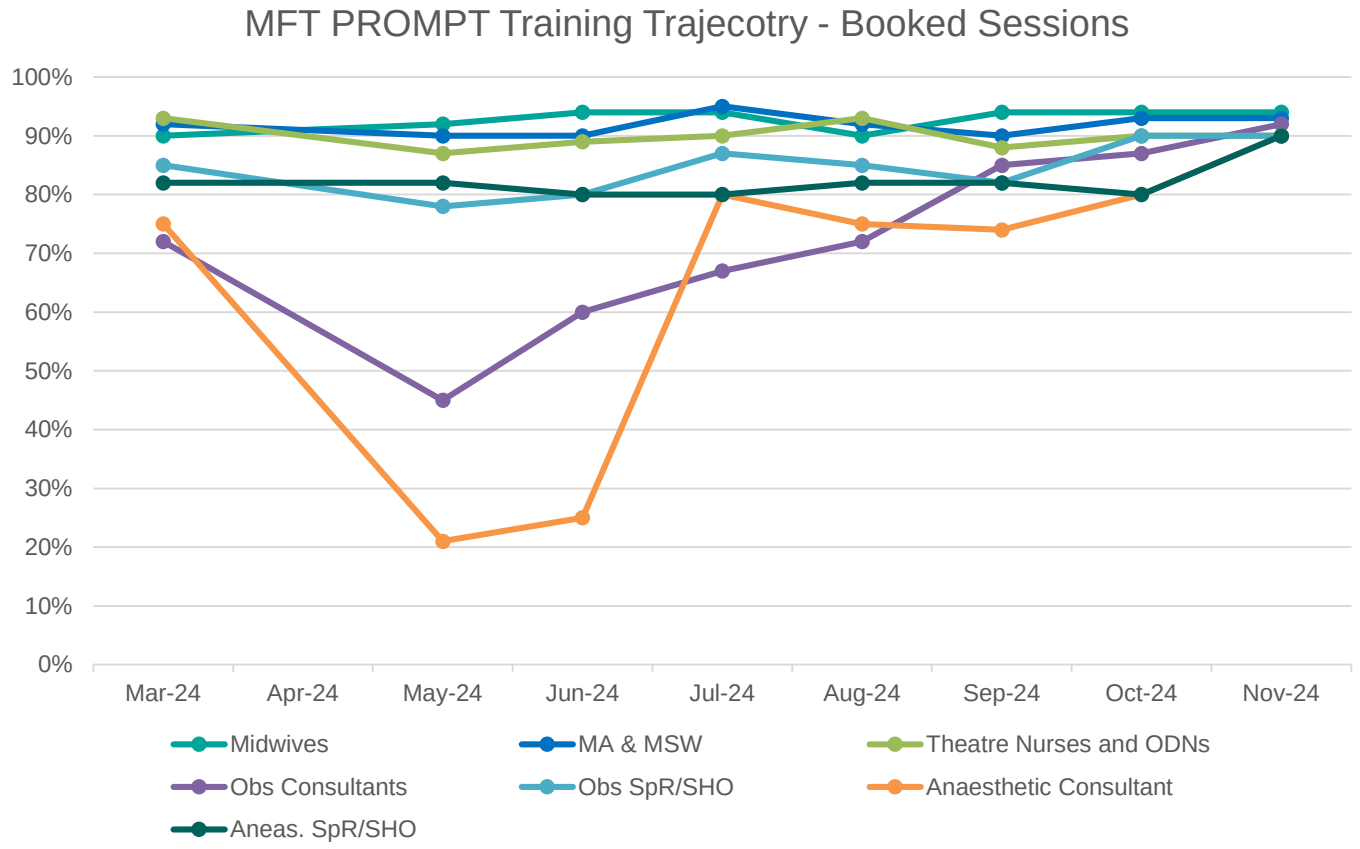
PROMPT training30						
	March 2024	**May 2024**	**June 2024**	**July 2024**	**Aug 2024**	**Sep 2024**
Midwives	90%	92%	94%	94%	**90%**	**94%**
MA & MSW	92%	90%	90%	95%	**92%**	**90%**
Theatre Nurses and ODNs	93%	87%	89%	90%	**93%**	**88%**
Obs Consultants	72%	45%	60%	67%	**72%**	**85%**
Obs SpR/SHO	85%	78%	80%	87%	**85%**	**82%**
Anaesthetic Consultant	75%	21%	25%	80%	**75%**	**74%**
Aneas. SpR/SHO	82%	82%	80%	80%	**82%**	**82%**



True North: People

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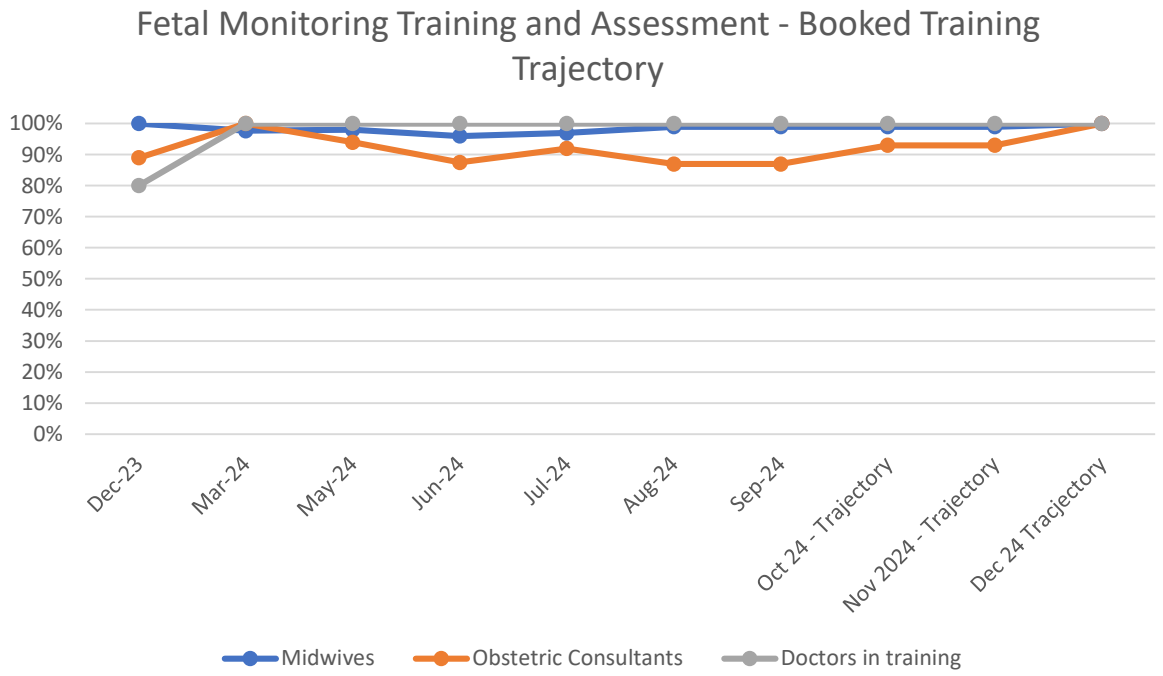
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

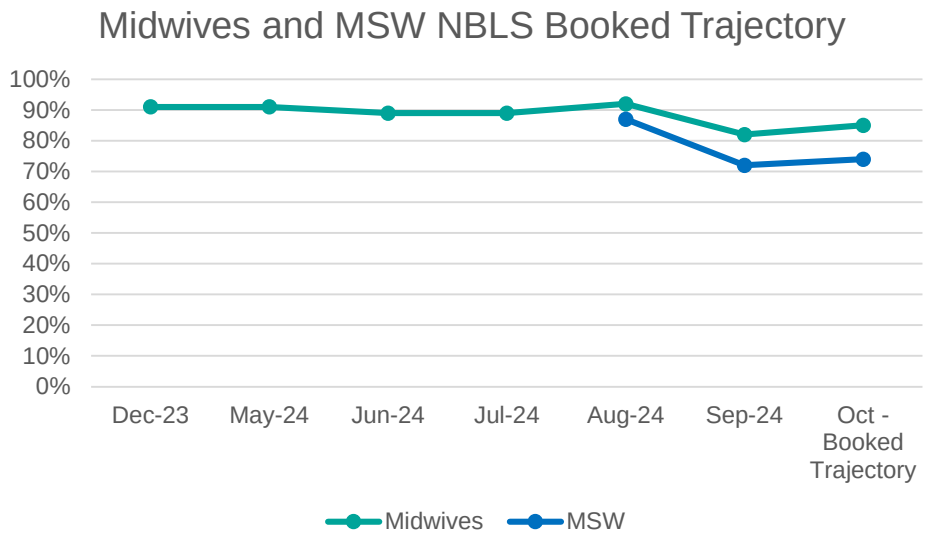
Fetal Monitoring Training and Assessment	Dec 2023	March 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024
Midwives	100%	97.7%	98%	96%	97%	**99%**	**99%**
Obstetric Consultants	89%	100%	94%	87.5%	92%	**87%**	**87%**
Doctors in training	80%	100%	100%	100%	100%	**100%**	**100%**



True North: People

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)

Neonatal Basic Life Support Training						
	Dec 2023	**May 2024**	**June 2024**	**July 2024**	**Aug 24**	**Sep 2024**
Midwives	91%	91%	89%	89%	**92%**	**83%**
MSW					**87%**	**72.3%**
NICU Nurses	89%	94%	93%	94%	**90%**	**91%**
NICU Nursery Nurses					**100%**	**100%**
Neonatal Consultants	90%	92%	84%	86%	**86%**	**93%**
Neonatal doctors	94%	90%	90%	90%	**100%**	**94%**
ANNP	100%	100%	100%	100%	**100%**	**67%**



True North: Quality

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

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

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

Key Messages:

- The Trust has embedded the perinatal quality surveillance model (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.
- 4 Actions outstanding from 2023 SCORE Survey

Actions & Improvements :

- PQSM report to be presented to Divisional Board monthly.
- Trust IQPR data now reflects PSIRF categories.
- 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.
- Strong working relationships with Board Level Safety Champions, supportive in escalating 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).
- DOM working with NED to strive for outstanding.

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:

Medway NHS Foundation Trust

Actions and Next Steps:

- Monthly reporting to MNSCAG with Bi-monthly reporting to Trust Board until submission.
- September Report to be presented to Public Trust Board in November.
- 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 – arranged for 3 December 2024.
- Collate evidence archive and make available to Executives via Shared Drive as per CNST Year 6.

Perinatal Culture and leadership Programme (PCLP) & SCORE survey

Trust Board 13 November 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.
- The quad will continue 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 preliminary meeting held. Follow up face to face meeting to be arranged.
- SCORE survey to be repeated in Autumn 2024, to include all of Women's, Children and Young People Division.
- 13 actions completed, 3 on track. 2 actions overdue and 1 action off track

Perinatal Culture and Leadership Q2

NHS Medway NHS Foundation Trust

Key Messages:

- Participated in re-launch meeting with Patient Safety Collaborative. Face to face meeting to be arranged to agree best way to support leadership team and service as a whole.
- 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.
- Trust Freedom to Speak Up guardian now appointed – 24/7 over.
- 13 actions completed, 3 on track. 2 actions overdue and 1 action off track
- "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	**15**
Overdue	**0**
Off Track with actions to deliver	**1**
On Track	**3**
Total Number of actions	19
Percentage of actions completed/on track	84%

Perinatal Culture and Leadership Q2

NHS Medway NHS Foundation Trust

Issues, Gaps and Concerns:

- Trust sign-off for Hardwiring in community premises PID, along with Maternity Information System PID.

Actions and Improvements:

- Breaks audit completed and actions being reviewed.
- “Re-briefs now included in escalation policy.
- SCORE survey to be launched October 2024, to include all of WCYP.
- Encourage all staff to complete Trust Staff Survey.
- Maternity and Neonatal Engagement with Trust Culture lead
- 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 from Board Level Safety Champions and NED to complete actions and implement recommendations.
- Additional Supportive roles now in post including:
    - EDI and PE Midwife
    - Education Team – to Support newly qualified.
    - PMA team supporting Labour Ward Cooridnators to achieve standards in Labour Ward Coordinator Framework
    - PMA team participating in developing regional PMA strategy.
- Positive retention figures noted across unit, particularly MSW groups.
- Reduction in vacancies and communication with staff reflected in improved staff morale.

Perinatal Culture and Leadership Q2 – Staff engagement and feedback

Key Messages:

- Board Level Safety Champion Engagement Session held in month. Staff concerns included:
  - Triage waiting room
  - IPC issues
  - Heat and Ventilation

- Staff Survey 2024 launched – all staff encouraged to participate.
- Local Maternity & Neonatal SCORE Survey to take place in October.

- Teams talk held monthly – updates provided to all staff from DOM and staff given opportunity to discuss concerns and provide updates on work. Updates included:
  - Success of T-Levels
  - Success of New to Care placements in maternity
  - Completion of Antenatal New-born Screening Action plan.
  - MSW awards – 8 received.
  - MSW participating in LMNS development of MSW framework.

Issues, concerns, gaps:

- Bespoke training for Labour Ward Coordinators
- Lack of local RN to RM conversion course.

Actions and improvements

- Actions to address staff feedback
  - Estates footprint for maternity triage being reviewed as part of MCU/Triage QI project.
  - IPC concerns being addressed by senior sisters and matrons.
  - Fans and open windows being used to assist with heat and ventilation concerns.
- Trust Freedom to speak up guardian is now provided by external company and provides 24/7 phone advice.
- Safety Champion Re-launch planned for October.
- Improved overall retention and low-levels of work-related stress reported reflect positive culture.
- PE and EDI midwife working with International Nurses and Midwives to understand their needs and what support can be offered.
- Additional member of staff in Education team to facilitate additional preceptorship and support for new starters/newly qualified staff.
- Education team completed away day to plan and develop enhanced preceptorship for newly qualified staff.
- Working with CCCU to re-instate midwifery course.
- Working with Greenwich university to ensure involvement in recruitment of student midwives.
- Working with local universities to develop RN to RM conversion course.
- Improvements made to IOL pathway shared at audit meeting and recruitment to permanent IOL midwife underway.
- Recruitment video launched September 2024- promoting MFT and midwifery.
- PMAs working with LMNS to develop bespoke training day for Labour ward Coordinators in line with national framework and individual feedback from staff and regional benchmarking. Plan to launch January 2025.

Next Steps

- Complete all actions from 2023/24 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.

Perinatal Surveillance – Quarterly Report Q2 24-25

Trust Board – 13 November 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 along with to every Trust Board.
- This report provides quarterly oversight for Q2 2024/25 and includes the following:
  - Incidents - Increase in number of incidents reported in maternity this quarter = 454 (353 in Q1) with 4 incidents reported as Moderate Harm or above and NICU 42 reported (47 in Q1).
  - 4 incidents moderate harm or above:
  - Maternal death (MNSI)
  - Unexpected Neonatal Admission, therapeutically cooled (MNSI)
  - Intrauterine Death 38+6 following RFM (AAR)
  - Neonatal Femur fracture at ELCS for breech presentation (ATAIN Review)
  - Investigations – 3 MNSI investigations closed. 40 ATAIN (Avoiding term admissions to Neonatal unit) reviews, 39 CRIG (Clinical Incident review group) reviews, 1 AAR (After Action review)
  - PMRT - 8 MBRRACE reportable cases in Q2. 38 actions open relating to PMRT - Communication and documentation being the most common themes.
  - Risks - Currently 11 risks in maternity and 2 in Neonatology, with highest risk of 20 related to midwifery workforce challenges and 1 scored 15 relating to MIS.
  - Workforce/Staffing - Midwifery staffing remains a challenge with contractual vacancy numbers remaining high across the quarter, plus high levels of maternity leave. Positive workforce retention rates, in particular with MSW's who were previously at risk group. Trajectory for midwives has been refreshed with a view to reach full establishment/rostered in post by end of May 2025. 3 RN's working on the postnatal ward are commencing the RM conversion course in September 24
  - Continuous service user feedback and coproduction work supported by MNVP. Positive FFT response rate 71% with a 95% recommend rate for month of September.
  - Positive staff feedback within FFT free text and 10 MSW's received the highly regarded National CMO recognition award and badges.

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.

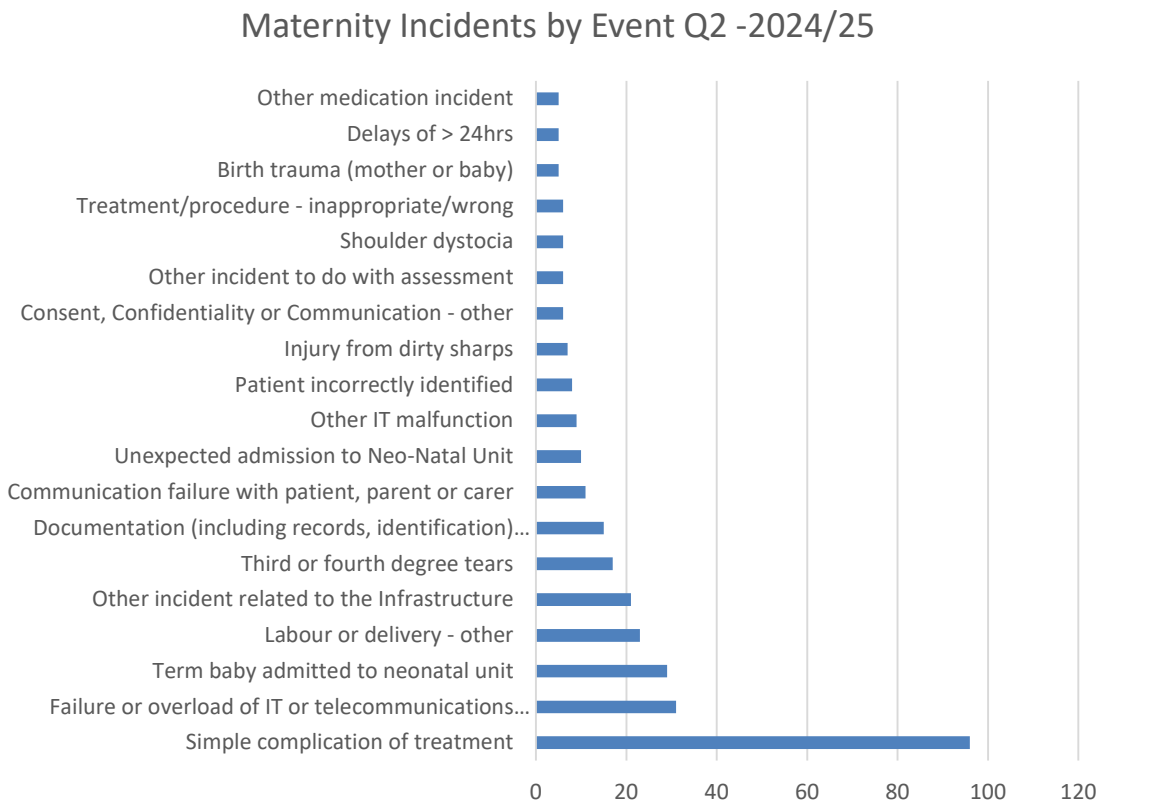
NHS Medway NHS Foundation Trust

Key Messages:

- Increase in number of incidents reported in quarter 454 (353 in Q1)
- 99% of incidents reported are no or low harm.
- 4 incidents reported as Moderate Harm or above
    - Maternal Death (inpatient)
    - Unexpected Neonatal Admission – Therapeutically cooled (MSNI)
    - Intrauterine Death 38+6 following reduced Fetal Movements – AAR
    - Neonatal Femur Fracture at ELCS delivery for Breech presentation – ATAIN Review

Actions & Improvements:

- Risk relating to failure of bleep system reflected in datix. Added to Care Group risk register – to be linked to Trust-wide risk.
- QIPs underway for PPH and 3rd and 4th Degree tear.
- Launch of OASI-2 bundle 30 September 2024.
- Clinical assessment (investigations, images and lab tests) accounted for 29 incidents in Q1 due to issues with investigations being followed up – this has reduced to 24, none of which relate to investigations log.



Top Three themes in maternity incidents for (sub-category) for Q2:

- Labour or Delivery (81) ↑
- PPH > 1L (74) -
- Information technology (50)

Top Three Maternity Incidents by event for Q2 :

- Simple complication of treatment (96) ↑
- Failure or overload of IT or telecommunication system (31)
- Term baby admitted to Neonatal Unit (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

Key Messages:

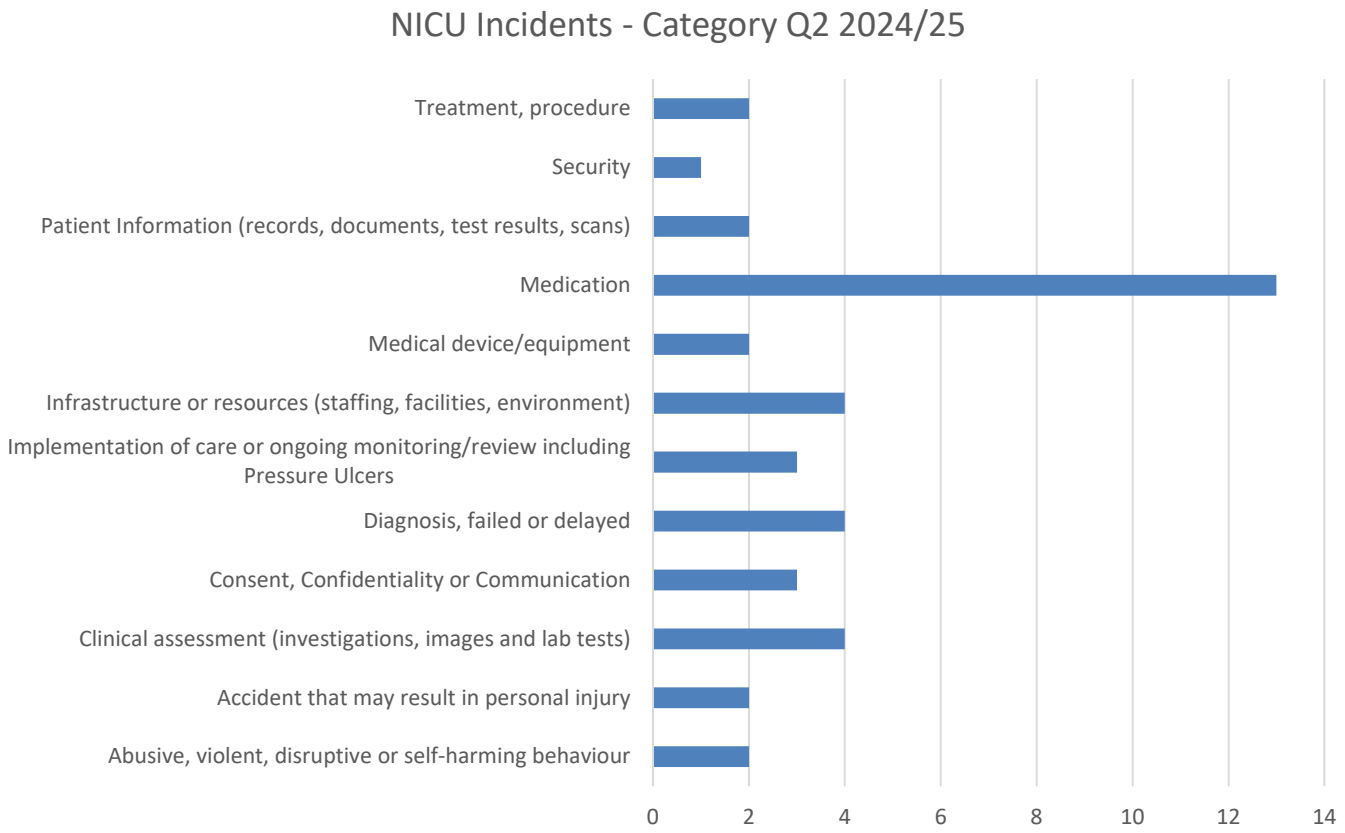
- Decrease in incidents reported in Q2 with 42 reported (47 in Q1)
- 100% of incidents reported are no or low harm.
- Medication incidents include errors/delays in administering milk to babies.
- 0 SIs or HLIs in Q2

Top 3 NICU Incidents by Category

- Medication (13) ↑
- Infrastructure or resources (4) ↓
- Clinical assessment (investigations, images and lab tests (4) ↓

Actions and Improvements

- Working with pharmacy to update monographs
- Working with POCT
- Documentation teaching sessions for staff
- Doctors teaching session re: medicolegal issues



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.

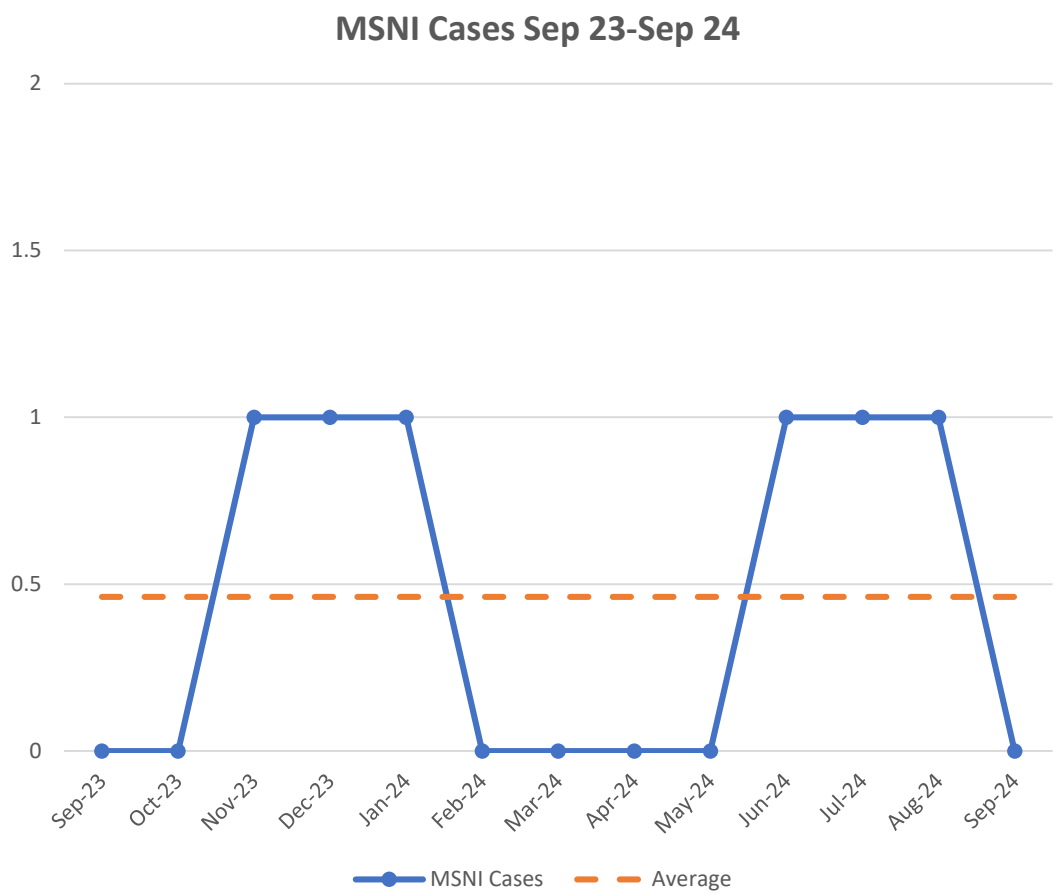
NHS Medway NHS Foundation Trust

Key Messages:

- 2 MSNI Referrals in Q2
  - Maternal death whilst an inpatient – currently unexplained. Awaiting coroner's findings. Support given to staff and family.
  - Unexpected admission to Neonatal Unit – Therapeutically Cooled – HIE
- 3 MSNI cases closed in Q2 - key actions identified below.

Actions and Improvements .

- Introduction of NORA to provide continuous risk assessment for babies and to support keeping mums and babies together.
- Prem Pack developed by fetal wellbeing midwives including Yellow Card for neonatal information – including specific box to highlight cord gas values.
- Identification and management of neonatal hypoglycaemia guideline developed.
- SOP for text message communication between community midwives and service users developed – awaiting governance sign-off
- Working to develop patient facing information to support text message SOP.



True North: Quality

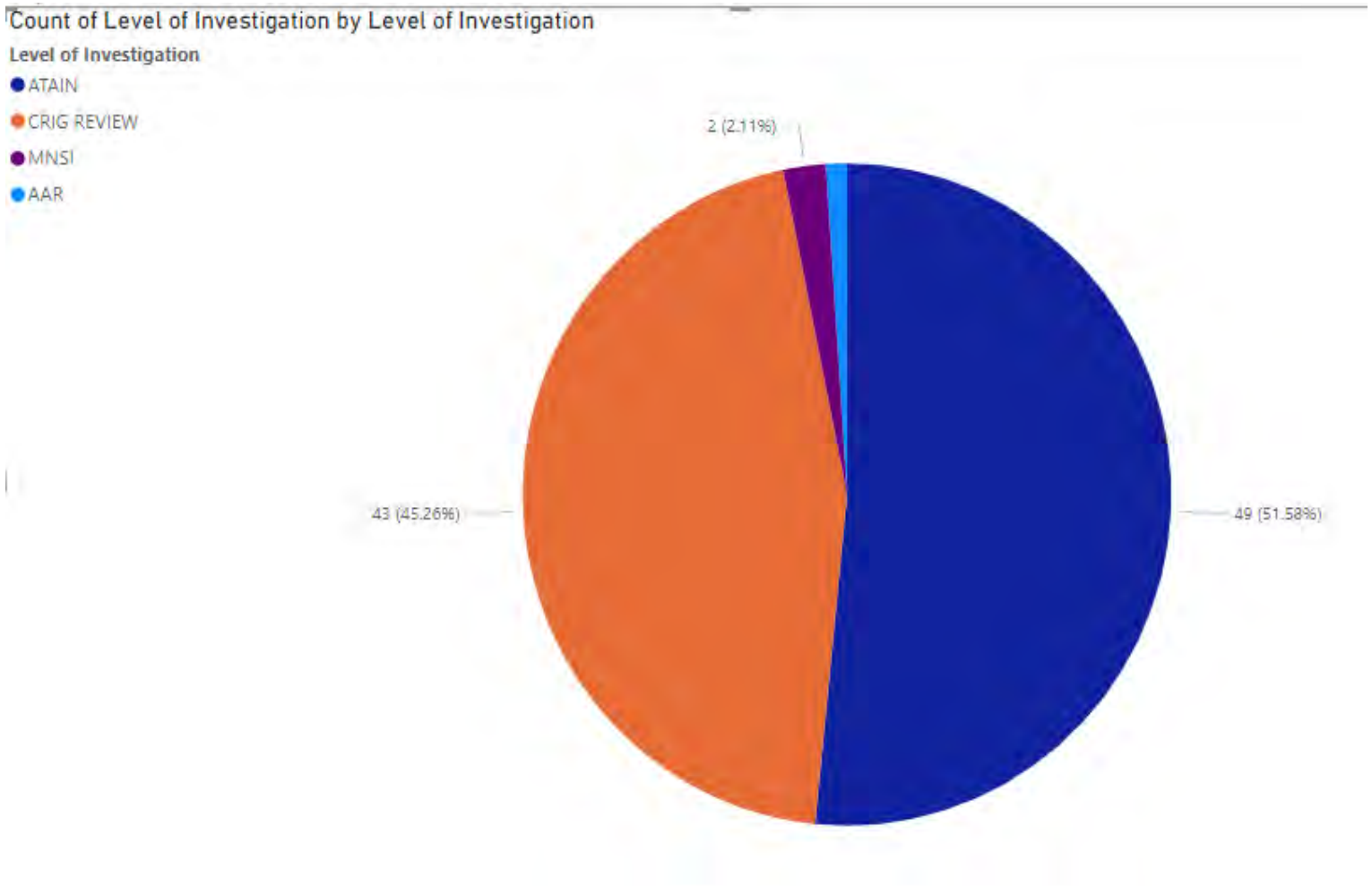
Perinatal Surveillance Tool Data Q1– PSIRF

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 :

- 80 cases reviewed at MDT CRIG meeting in Q2 ↓
  - 40 ATAIN Reviews ↓
  - 39 CRIG Reviews ↓
  - 1 AAR

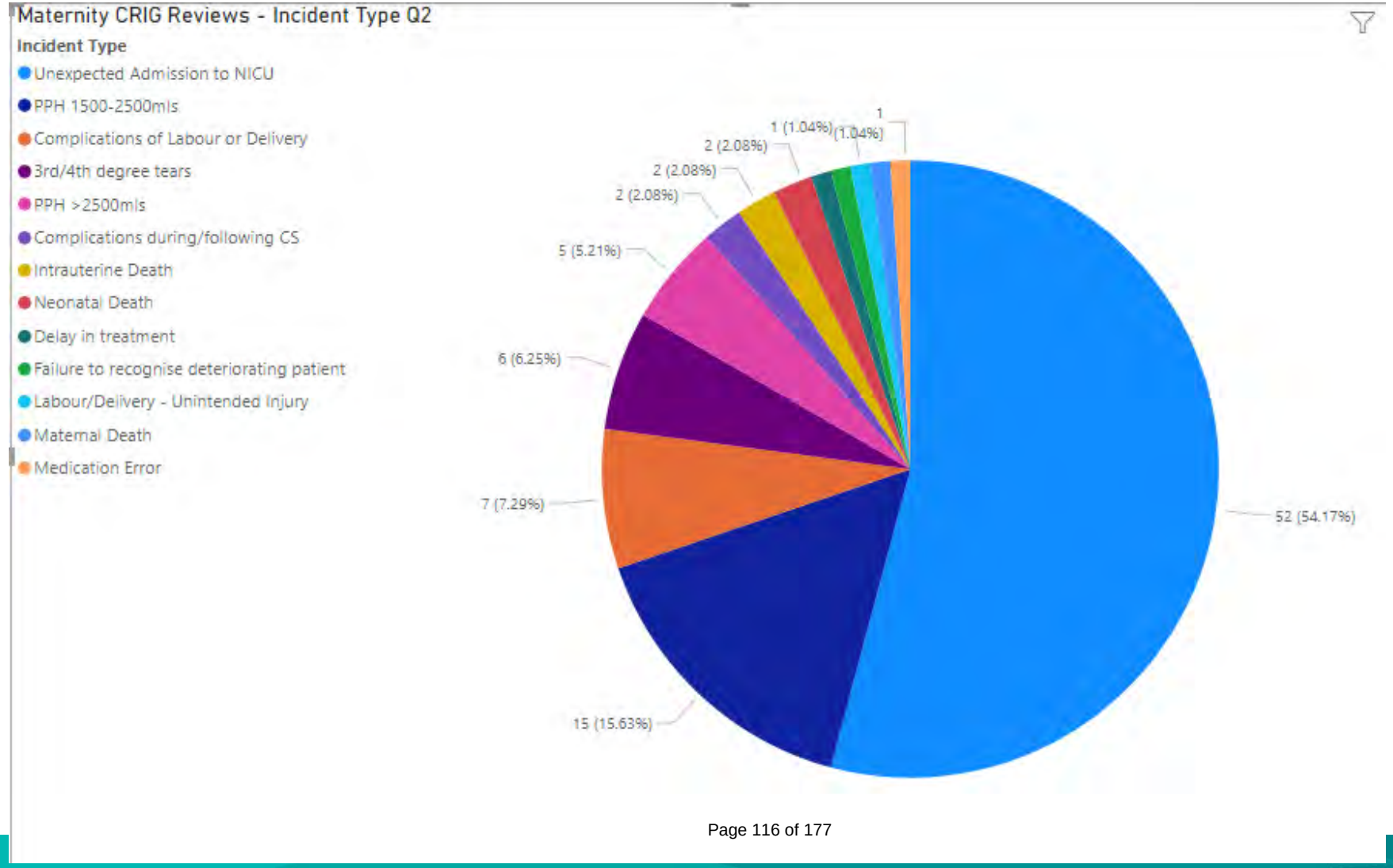


True North: Quality

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.

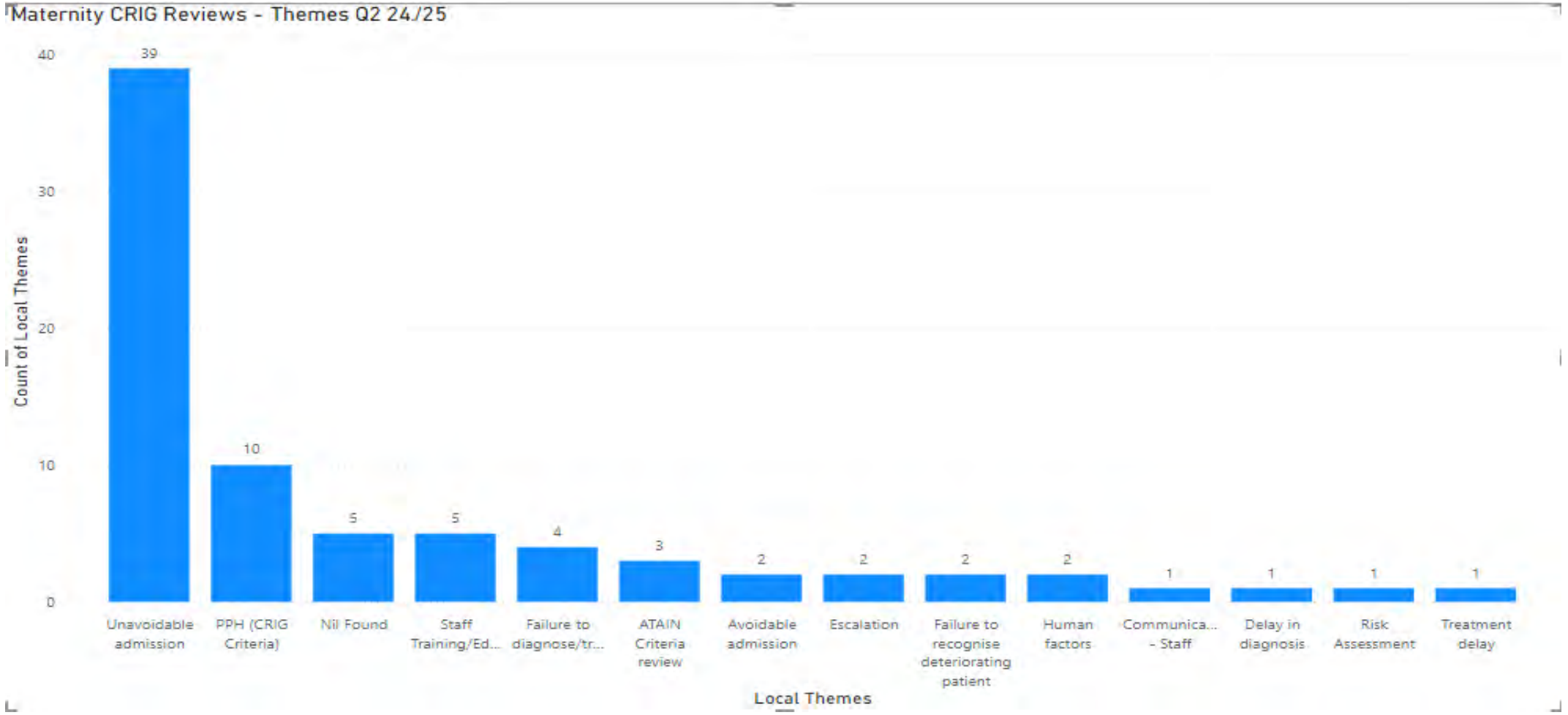


True North: Quality

Perinatal Surveillance Tool Data 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 Q1– PSIRF

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

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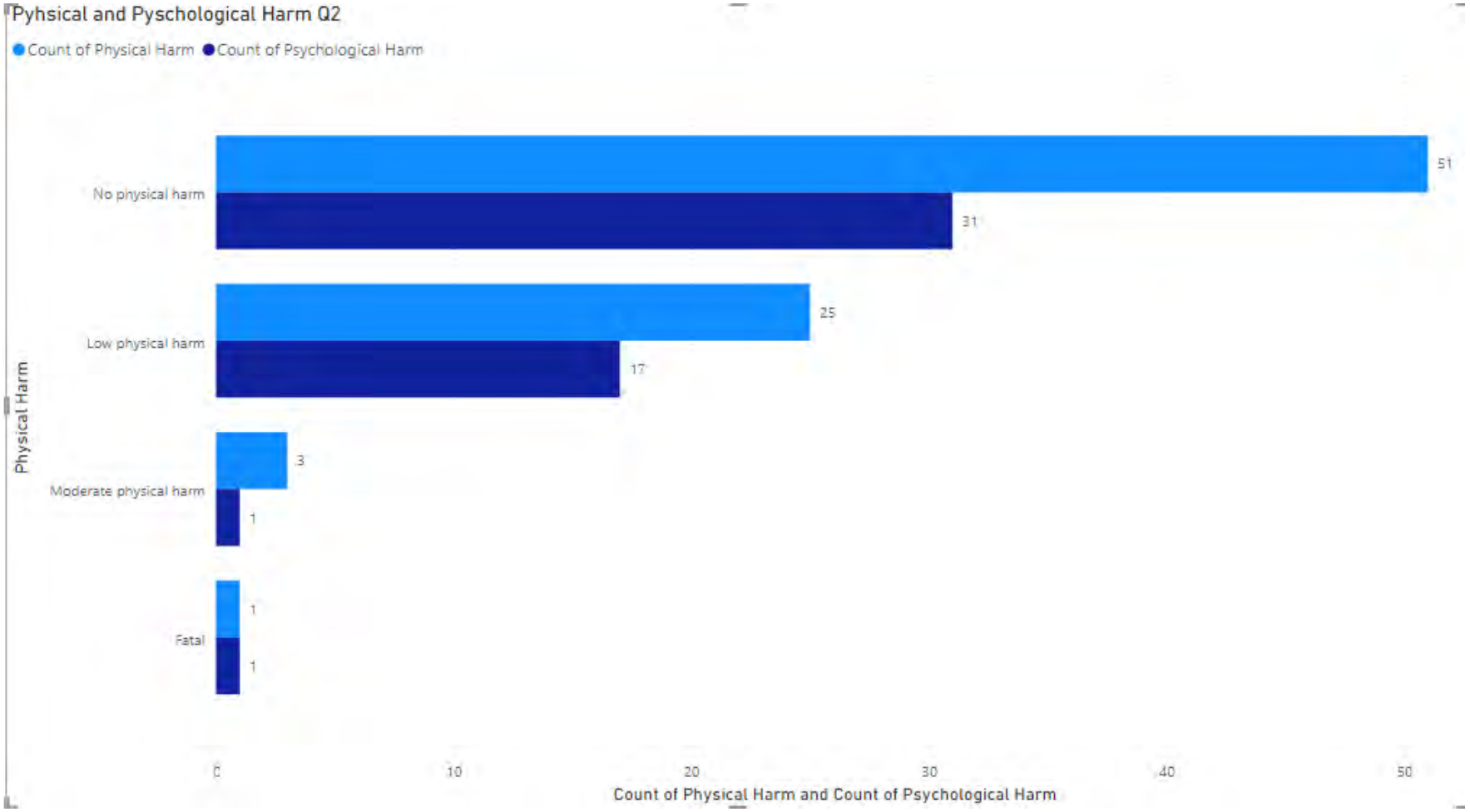
Medway NHS Foundation Trust



Key Messages :

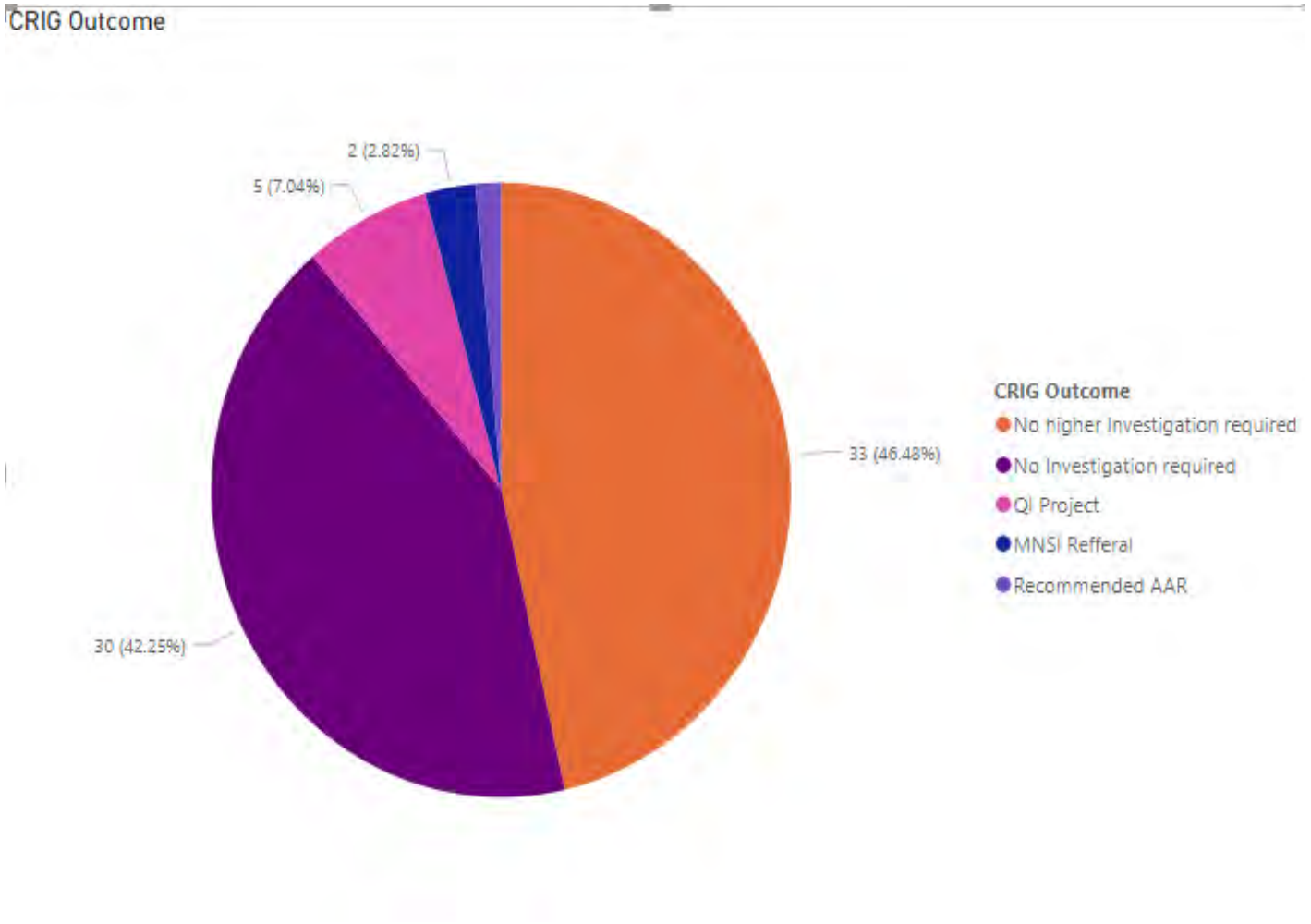
- All moderate harm/above investigated as MNSI or ATAIN.

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

- 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.

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

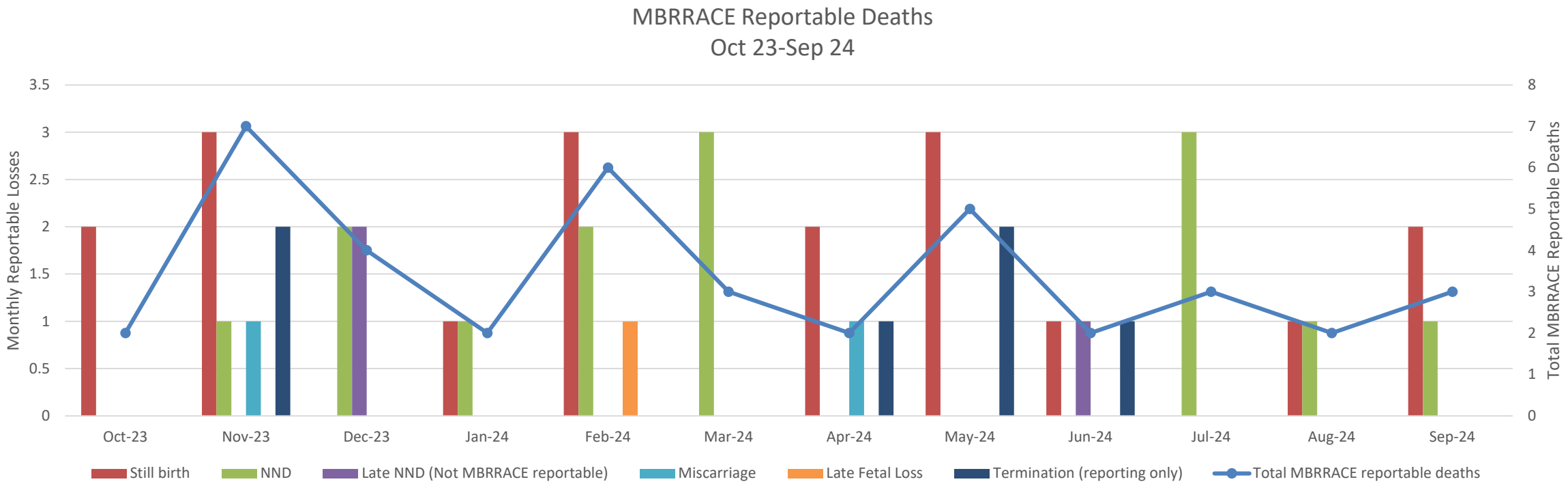
Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

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

Medway NHS Foundation Trust

Key Messages :

- 8 MBRRACE reportable cases in Q2
- All cases reported within CNST/MBRRACE timeframes
- 3 PMRT reviews completed in Q2.
- 38 actions currently open relating to PMRT cases – Communication and documentation being the most common themes

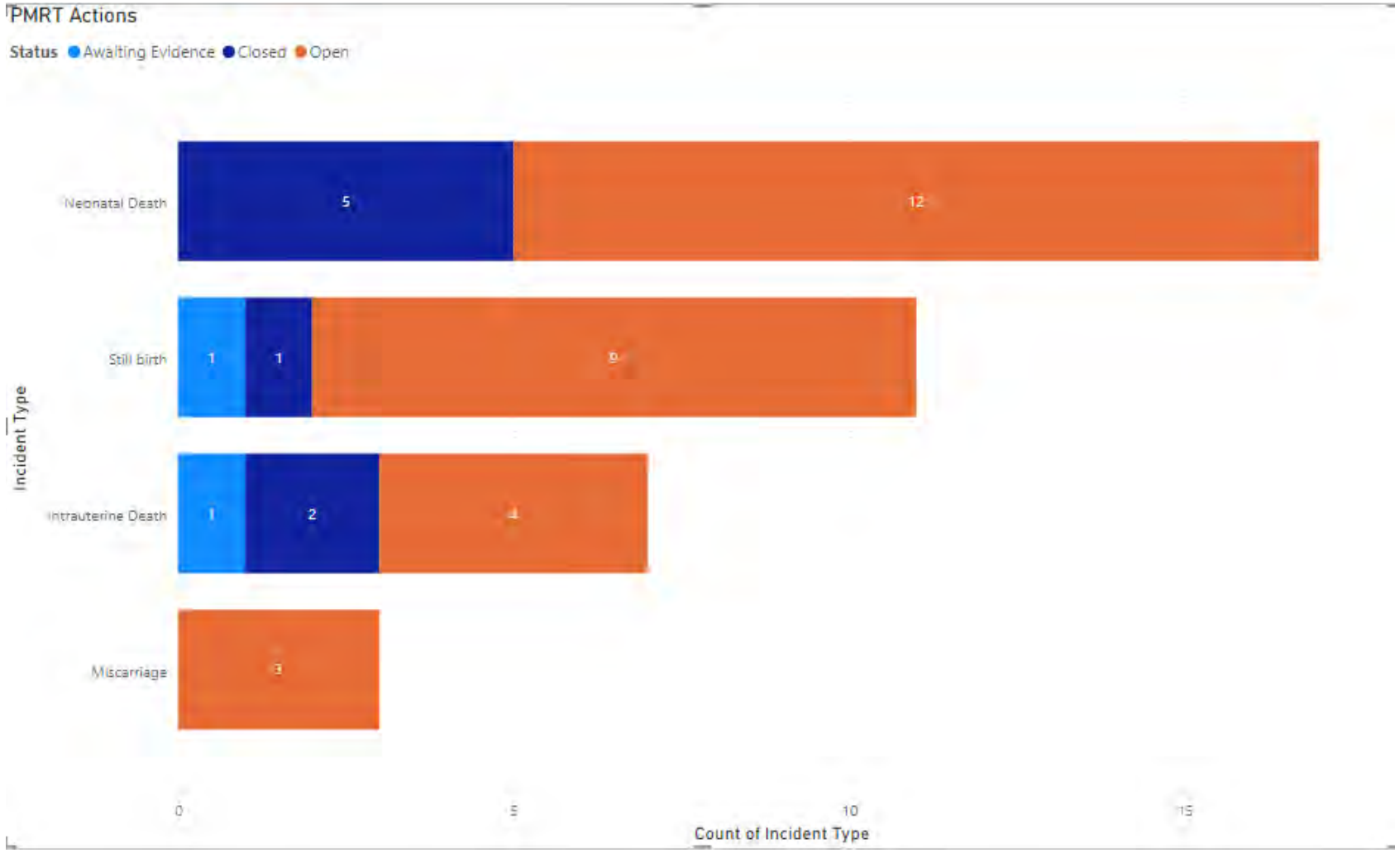


Perinatal Surveillance Tool Q1 2024/25– Perinatal Mortality Review Tool

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



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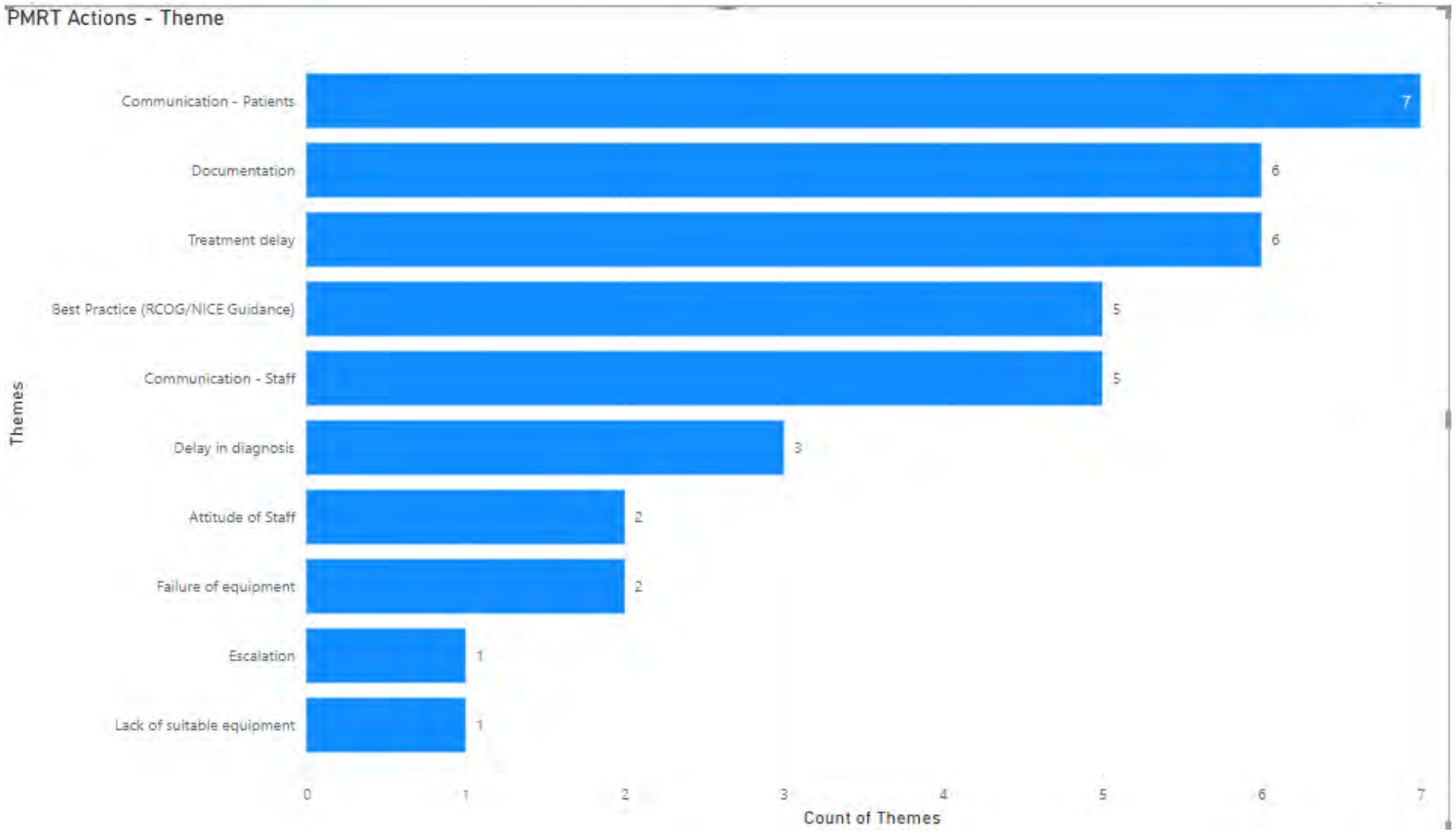


MBRRACE Reportable Loses Q1

Medway NHS Foundation Trust

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	N/A
1	3	Termination	22+3	Fetal Abnormality	MBRRACE Reportable only	N/A
1	4	Termination	22+5	Fetal Abnormality	MBRRACE Reportable only	N/A
1	5	Stillbirth	30+2	Unexplained	PMRT	A, A - Unexplained
1	6	Stillbirth	39+2	Fetal Abnormality	PMRT	B, A - Expected death acrania (communication of antenatal pathway, Booking of IOL)
1	7	Stillbirth	39+2	Unexplained	PMRT	A,C - Unexplained, actions being developed in response to parent feedback.
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	N/A
1	10	Stillbirth	32+4	Unexplained	PMRT	PMRT to be held in October

MBRRACE Reportable Loses Q2

Medway NHS Foundation Trust

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
2	1	Neonatal death	25+6	TBC	PMRT	To be finalised
2	2	Neonatal death	24+0 (approx - Ubooked)	Unbooked pregnancy delivered at home - awaiting coroner	PMRT & Coroner	PMRT due for October
2	3	Neonatal death	23+5	Extreme prematurity	PMRT	PMRT to be held
2	4	Neonatal death	35+0	Fetal Abmormality	PMRT (care Plan) Expected	PMRT due for November
2	5	Stillbirth	35+3	Fetal Abmormality	PMRT (expected)	PMRT due for November
2	6	Stillbirth	39+0	Unexplained	PMRT	PMRT due for December
2	7	Neonatal death	35+0	Fetal Abmormality	PMRt (expected)	PMRT to be held January
2	8	Stillbirth	39+3	Unexplained	PMRT	PMRT to be held January

Issues, Concerns, Gaps:

- Expected bereavement cases not flagged to Bereavement and specialist team when booked for IOL/Section.
- Care plans for palliative/expected losses not available on admission for delivery

Actions & Improvements:

- Reminder to all staff to ensure any expected bereavement cases are flagged with the bereavement team and fetal medicine when patient attends for delivery to ensure appropriate support is offered.
- SOP being developed to support this on the IOL, elective section pathway and for Labour Ward Coordinators.
- Working with tertiary centres, fetal medicine and neonatal teams to ensure care plans and neonatal alerts are immediately available via EuroKing .

Maternity Risks

NHS Medway NHS Foundation Trust

Patient FIRST

Executive Summary – Risks

- Currently 11 risks in maternity, 2 NICU
- 2 risks with scores 15 to 20 (Maternity).
- 2 risks proposed for closure
  - 1406 – Band 5 midwives in community – Closed Sept 2024
  - 1741 – Lone worker devices – Closed Sept 2024
- Highest risk remains midwifery workforce challenges
- All mitigations and scores have been reviewed within required timeframes

Maternity and Neonatal Risks

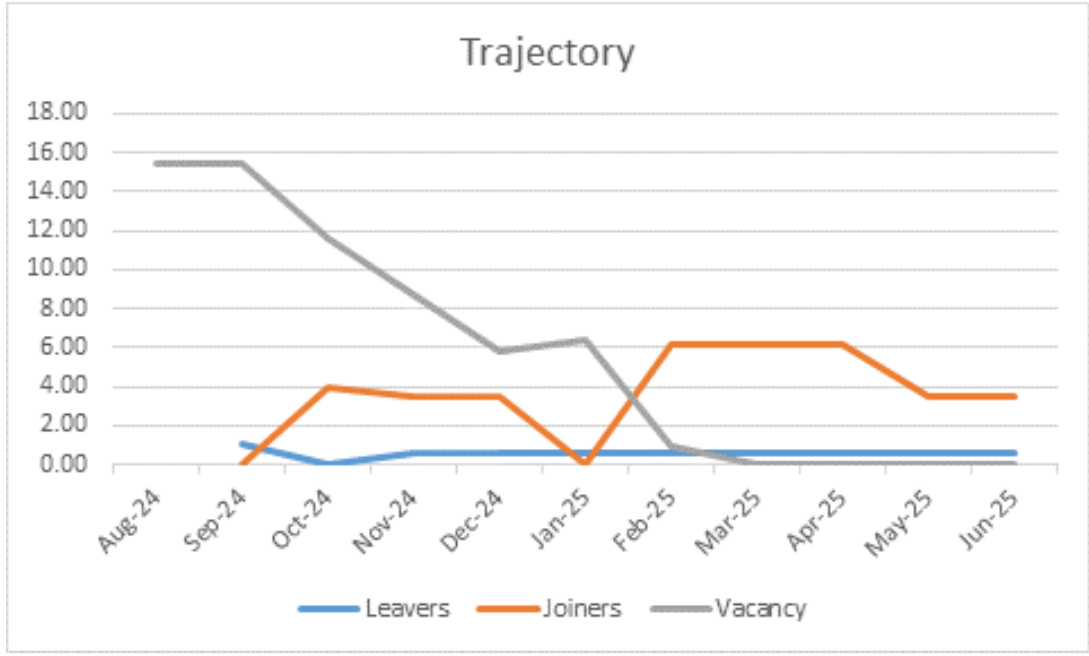
Risk ID	Maternity Risk	Mar-24	July 24	Sep 24
1133	Insufficient Midwifery Staffing impacting the ability to provide patient care.	20	20	20
1864	Maternity Information System coming to end of contract	15	15	12
1025	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	15	15	15
2078	Inability to provide timely fetal medicine service due to failing equipment/out of date	-	12	
1131	Delays in IOL	12	12	9
1128	Community Midwifery Premises	6	6	6
1300	Unable to access patient records at community antenatal clinics	9	9	9
1737	Inconsistent and inaccurate data being shared outside the organisation	6	6	6
1302	Movement of staff to support acuity on Delivery Suite creates red flags in other areas	6	6	3
2044	Insufficient Transcutaneous Bilirubinometer (TCB) Monitors in Community Midwifery	5	5	5
2079	Glucose meters not suitable for neonatal use -	-	6	6

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

Workforce – Midwifery/Nursing clinical safe staffing

Executive Summary- Maternity Workforce

- Midwifery vacancy 15.48 WTE
- Supernumerary review undertaken and adjustments made to provision for new starters to support onboarding and cost efficiency. Shared with Trust Education lead and approved.
- Positive retention figures noted – in particular with MSWs (previously at risk group)
- Safe staffing as per Birthrate + recommendations now in budget for 2024/25 – two final posts to be submitted to VCP in September.
- Table top Birthrate+ exercise in October 2024 – to feed into Trust-wide safe staffing report in November and inform Maternity workforce paper to MNSCAG in December and Trust Board in January.
- Trajectory for registered midwives completed with view to reach establishment in May 2025.
- PE & EDI midwife to lead meetings with IEM/N to identify any additional support needs.
- 3 RN from postnatal ward to commenced RM conversion course in September.
- Ongoing engagement with CCCU with DOM and Education lead regarding re-establishment of midwifery course at CCCU.
- 1 MSWs successfully appointed to take part in national MSW Framework review.
- New to care MSW interviews taking place October 2024.
- Meeting held with NHSE to discuss PWR and ongoing improvement work to ensure accurate workforce data.



True North: People
Planned vs Actual Midwifery Staffing levels

Medway NHS Foundation Trust

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

Measure	Goal	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	0:125	01:25	01:25
Actual Worked ratio		01:33	01:33	01:34	1:30	1:31	1:32	01:29	01:29	01:32

	Establishment	In post	Recruited to but not in post	On secondment	Contractual Vacancy
Clinical Band 7 Midwives	21.48	20.44	1.00	0	0.04
Clinical Band 5/6 Midwives	161.41	132.06	11.63	2.24	15.48
MSW's Band 3	35.76	27.64	2.7	3.28	2.14
Total	218.65	180.14	15.33	5.52	17.66

Key Messages:

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

Issues, Concerns & Gaps:

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

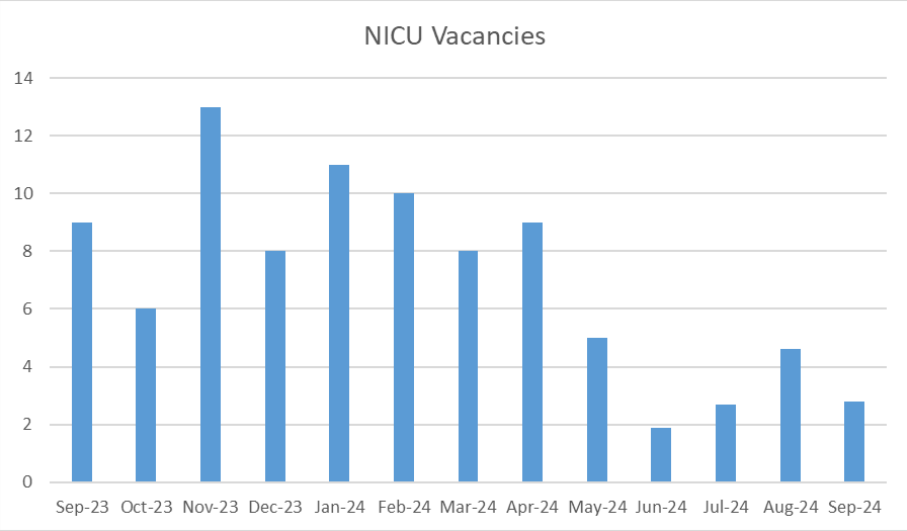
Actions & Improvements:

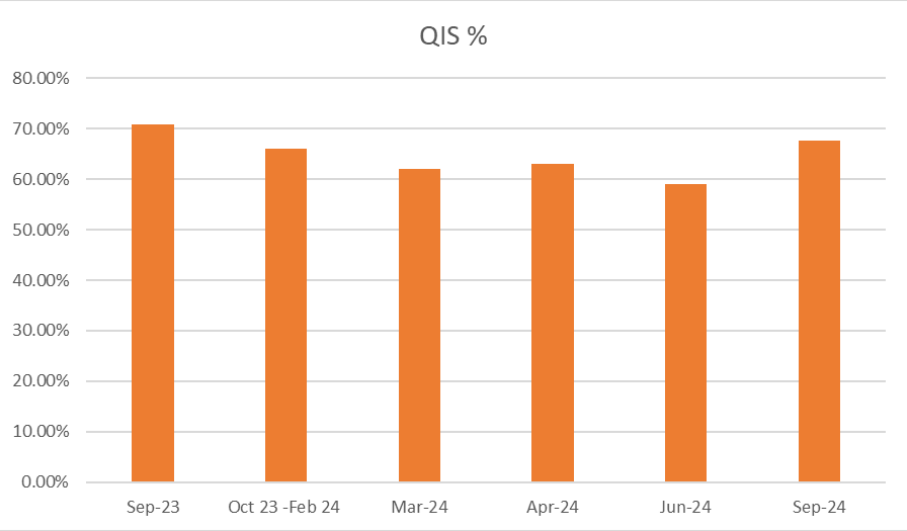
- EDI Lead role now in post support promoting MCOC for those families from BAME groups and those experiencing other social inequalities – to present at November MNSCAG.
- Two final posts from Birth-rate+ recommendations to be presented to VCP in September.
- Positive ongoing work with LMNS workforce lead to identify issues with PWR data.
- SCORE survey questions reviewed and staff to re-survey in Autumn.

True North: People
NICU Staffing levels

Medway NHS Foundation Trust

Ambition: Reduce NICU vacancy rate. Achieve 70% nursing staff QIS
Goal: To highlight gaps in service and showcase achievements





Key Messages:

- No current leavers
- QIS currently 67.7%

ROLLING TRAINING OF NURSES EACH YEAR CONTINUES

Actions & Improvements:

- Retain staff
- Recruit staff
- At least 6 members of staff complete training each year – recurring each September

Issues, Concerns & Gaps:

- Aim for 70% compliance

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.

NHS Medway

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
  - Supporting Neurodiversity Working Group to improve pathway for service users with Neurodiversity.
  - Supporting interviews as part of stakeholder groups
- MNVP lead on MNSCAB bi-monthly for service user feedback update.
- Overall improvement in FFT response rate and recommend rate across the quarter, peaking in September with 71% response rate and 95% recommend.
- Patient stories/service user feedback now embedded into MNSCAC.
- 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	April	May	June	July	Aug	Sept
Recommend Rate	99.4%	96.5%	92.6%	88%	92.6%	94.8%
Response Rate	49.1%	47.6%	39.0%	34.1%	42.3%	70.6%

Issues, concerns, gaps:

- Ongoing challenges to engage with service users, particularly those from minority groups.
- Capacity of MNVP lead to meet national requirements
- Dissatisfaction with postnatal care.

Actions and improvements

- Service user engagement event 5 October 2024.
- 15 Steps Challenge by January 2025
- ADOM attended LMNS Co-production away day.
- 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 approved new MNVP structure/additional funding to include 3 additional days per month for each MNVP and LMNS-wide MNVP governance lead to support.
- EDI & PE midwife working closely with MNVP to engage and support service users.

Perinatal Surveillance Tool Data Q2 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:
    - Triage waiting room
    - IPC issues
    - Heat and Ventilation
- Staff Survey 2024 launched – all staff encouraged to participate.
- Local Maternity & Neonatal SCORE Survey to take place in October.
- Teams talk held monthly – updates provided to all staff from DOM and staff given opportunity to discuss concerns and provide updates on work. Updates included:
    - Success of T-Levels
    - Success of New to Care placements in maternity
    - Completion of Antenatal New-born Screening Action plan.
    - MSW awards – 8 received.
    - MSW participating in LMNS development of MSW framework.

Issues, concerns, gaps:

- Bespoke training for Labour Ward Coordinators
- Lack of local RN to RM conversion course.

Actions and improvements

- Actions to address staff feedback
    - Estates footprint for maternity triage being reviewed as part of MCU/Triage QI project.
    - IPC concerns being addressed by senior sisters and matrons.
    - Fans and open windows being used to assist with heat and ventilation concerns.
- Trust Freedom to speak up guardian is now provided by external company and provides 24/7 phone advice.
- Safety Champion Re-launch planned for October.
- Improved overall retention and low-levels of work-related stress reported reflect positive culture.
- PE and EDI midwife working with International Nurses and Midwives to understand their needs and what support can be offered.
- Additional member of staff in Education team to facilitate additional preceptorship and support for new starters/newly qualified staff.
- Education team completed away day to plan and develop enhanced preceptorship for newly qualified staff.
- Working with CCCU to re-instate midwifery course.
- Working with Greenwich university to ensure involvement in recruitment of student midwives.
- Working with local universities to develop RN to RM conversion course.
- Improvements made to IOL pathway shared at audit meeting and recruitment to permanent IOL midwife underway.
- Recruitment video launched September 2024- promoting MFT and midwifery.
- PMAs working with LMNS to develop bespoke training day for Labour ward Coordinators in line with national framework and individual feedback from staff and regional benchmarking. Plan to launch January 2025.

Kent and Medway NHS Strategy 2024/25 – 2029/30

Version 9.1
8 October 2024

Contents

Foreword

Responsive, sustainable healthcare with equity of access and outstanding patient experience and outcomes for everyone in Kent and Medway.

This is our shared ambition for the NHS system in Kent and Medway.

The NHS in Kent and Medway provides healthcare services to our 2 million population. In 2023/24, we offered almost 11 million GP appointments, provided day case and inpatient surgery for 189,000 people, and supported over 18,000 births. We are proud of the care that we provide but recognise that we do not always get it right.

We are clear that we need to work together and differently. While we provide excellent healthcare across Kent and Medway, there is variation in access, experience and outcomes for patients. We cannot meet existing demand, and this will grow in future years. Our services are not sustainable. We also increasingly spend more than we receive.

These challenges cannot be overcome by sovereign organisations working separately. Acting together, Primary Care, NHS providers and NHS Kent and Medway ICB have produced this strategy. We have used data and feedback from our patients, the public and our stakeholders to identify four strategic themes.

This strategy will guide our way to equitable, sustainable and responsive healthcare.

Paul Bentley
NHS Kent and Medway, the Integrated Care Board

Mairead McCormick
Kent Community Health NHS Foundation Trust; Chair of Primary & Community Provider Collaborative; SRO for East Kent Health & Care Partnership

Jayne Black
Medway NHS Foundation Trust; Chair of Acute Care Provider Collaborative

Miles Scott
Maidstone and Tunbridge Wells NHS Trust; SRO for West Kent Health & Care Partnership

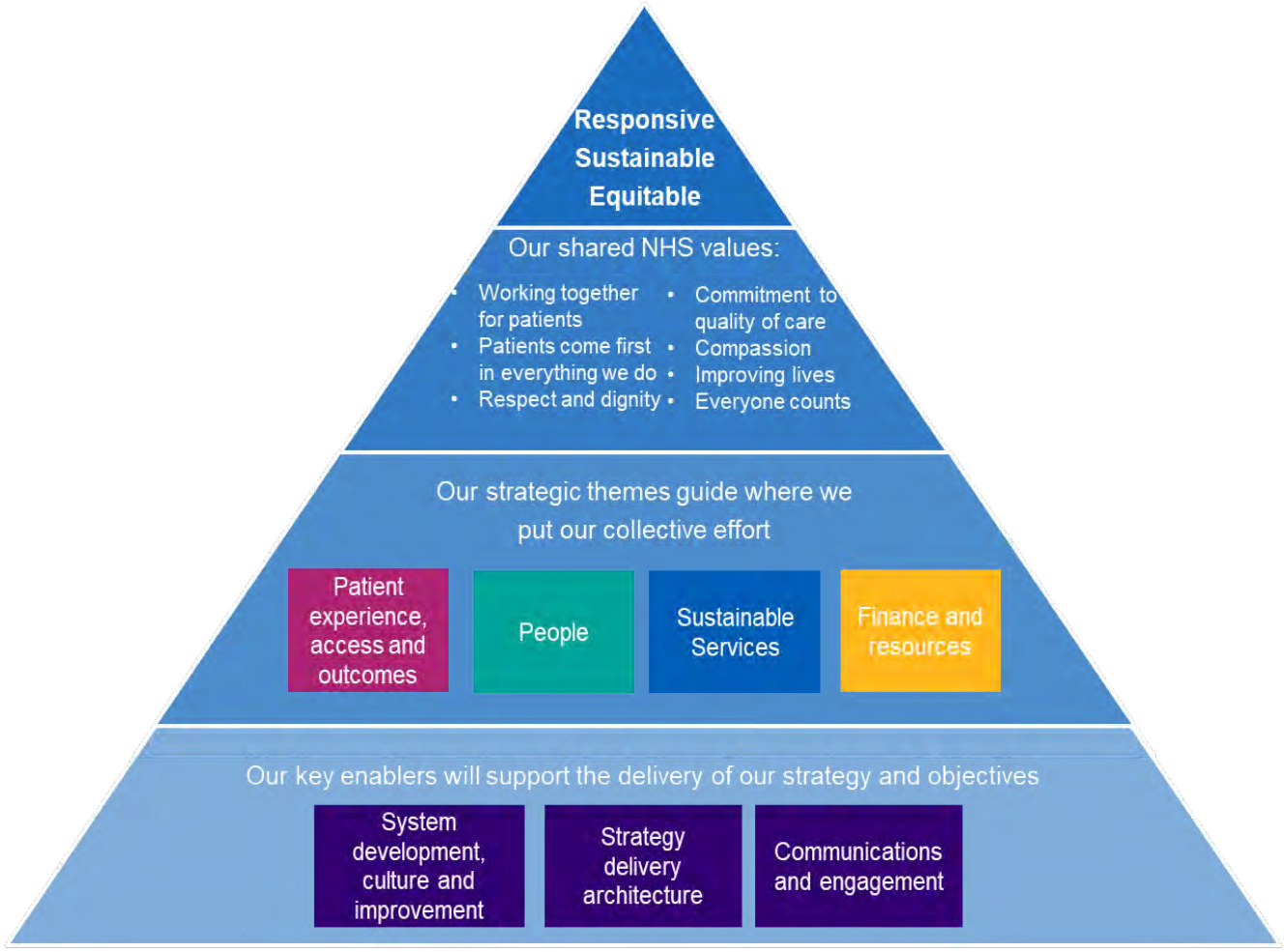
Dr Jonathan Bryant
GP Partner Member, NHS Kent and Medway

Sheila Stenson
Kent and Medway NHS and Social Care Partnership Trust; SRO for Provider Collaboratives and Chair of Mental Health, Learning Disabilities & Autism Provider Collaborative

Tracey Fletcher
East Kent Hospitals University NHS Foundation Trust

Jonathan Wade
Dartford and Gravesham NHS Trust; SRO for Dartford, Gravesham and Swanley Health & Care Partnership

Executive Summary



In each of our strategic themes we will achieve:

	Our Vision	Year One
Patient experience, access and outcomes	Patients in Kent and Medway will experience good, comparable outcomes, irrespective of where they live or what their background is. They will be partners with the NHS in their healthcare and we will support them with high quality, timely and accessible services.	Reduce variation in access to circulatory disease pathways, particularly for vulnerable groups. Focus on Making Every Contact Count.

People	We will have a skilled, healthy, engaged, productive and affordable workforce who are reflective of our local population that can meet the operating model and patient need. We will develop the right workforce for the long-term Kent and Medway model through workforce planning, enabling digital and by working as a single NHS team across the area, including primary care. Staff will move easily between organisations feeling safe and valued. Our workforce will be digitally capable, aided by common systems across our organisations and always seeking to use technology to free time to care.	Design an affordable system workforce plan which supports the needs of the clinical operating model. Develop our Health and Care Academy and work with our local medical school to develop our future workforce. Focus on the digital ability of our workforce.
Sustainable Services	We will provide sustainable, resilient healthcare that allows people to live, age and die well. We will empower people to self-manage where they can and deliver timely proactive services enabling care at home for our older population.	Focus on identifying vulnerable people who have the greatest need for unplanned care using risk stratification at local level. Each of these people will have a comprehensive assessment and tailored plan for their care in an emergency.
Financial Sustainability	We will have a financially sustainable system with sector-leading levels of productivity. Services will be supported by adequate resources, and funds will be directed towards their intended purpose and be able to support the other strategic themes. The approach to this will be developed in alignment with the themes of the Darzi review most applicable to financial recovery: re-engage staff and patients, shift care closer to home in a neighbourhood NHS, drive productivity and tilt towards technology. We will create a financial environment that enables future investment, both revenue and capital, in prevention and service provision.	Deliver year one of our agreed Financial Recovery Programme.

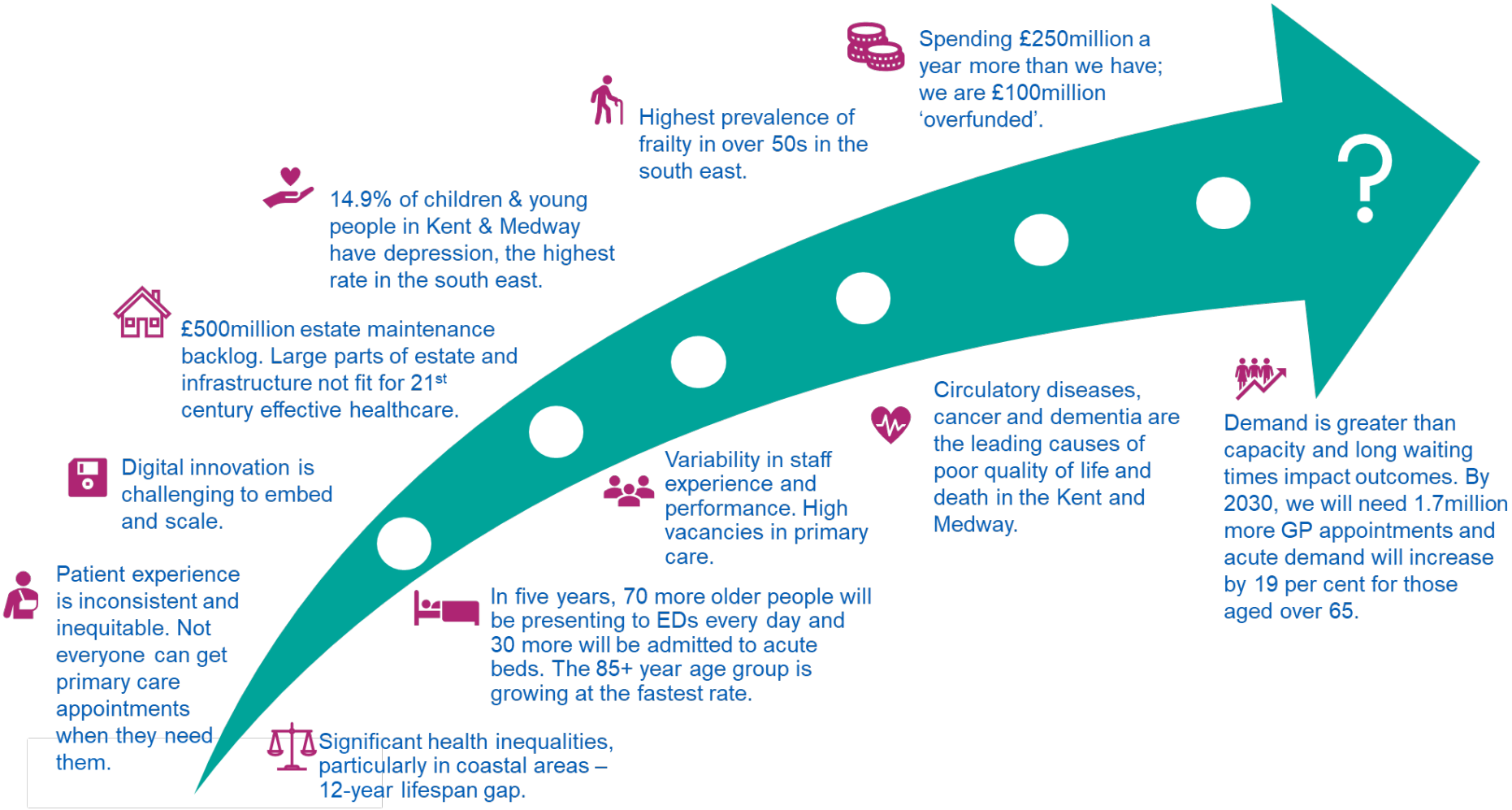
Where are we now?

About us – key facts

2 million people	Over **40,000** people working in the NHS	**6** NHS provider trusts and **1** integrated care board
11 million appointments in GP surgeries, **2.1 million** outpatient appointments	**164,000** day case and **25,000** inpatient surgeries	**Over 18,000** births
Over **£4.2** billion spent in 2023/24	**4** Health and Care Partnerships	**3** provider collaboratives
Over **2,000** mental health service users are treated in hospitals, and **54,000** in the community	**325** pharmacies, offering more than just prescriptions	Over **2.2 million** community care contacts
407 dental practices, **800,000** patients treated	**149** optometrists	**185** GP practices in **42** primary care networks

Why we need to work differently together

Some of our key challenges now and into the future are:



Where do we want to get to?

Almost all our patients will start a healthcare journey with an appointment in primary care, whether that's general practice, dentistry, pharmacy or optometry. For the overwhelming majority, there will be no need to go anywhere else. As the NHS changes to meet future challenges, more conditions will be treated in primary care or the community.

Our strategy is focused on improving the health outcomes of our population and shifting care from hospitals to primary and community care. This will require changes in our services, our workforce and how our funding flows. For each of our strategic themes this document describes our vision, our goals and how we plan to reach these.

Theme 1: Patient Experience, Access and Outcomes

Vision	Goals
Patients in Kent and Medway will experience good, comparable outcomes, irrespective of where they live or what their background is. They will be partners with the NHS in their healthcare and we will support them with high quality, timely and accessible services.	To reduce unwarranted variation against national measures, and within Kent and Medway, of: • patient outcomes • patient experience • patient access

Across Kent and Medway some people have a lower life expectancy; some wait longer than others; some receive poorer care; and for some their experience is poor. We will work together to reduce waiting times and raise outcomes to match the best in the region. We will initially focus on circulatory disease, which in Kent and Medway is increasing at a faster rate than the national average and is a leading cause of the life expectancy gap.

From primary care to referral to very specialist centres, all parts of the NHS play a critical role in the diagnosis and management of circulatory disease.

We will focus on circulatory disease because:

- It is the leading cause of the life expectancy gap in the South-East Region, and Kent and Medway has a higher prevalence of key risk factors than the national average.
- We can be better at every level of the health service from GP to specialist.
- Risk factors and access issues are similar for other health conditions, which will increase our impact.

We will: improve diagnosis rates, reduce admission rates, improve disease management, and work with patients to co-design our approach across public health, primary, community and acute care.

Theme 2: People

Vision

We will have a skilled, healthy, engaged, productive and affordable workforce who are reflective of our local population that can meet the operating model and patient need.

We will develop the right workforce for the long-term Kent and Medway model through workforce planning, enabling digital and by working as a single NHS team across the area, including primary care. Staff will move easily between organisations feeling safe and valued. Our workforce will be digitally capable, aided by common systems across our organisations and always seeking to use technology to free time to care.

Goals

- To be recognised as anti-discrimination employers.
- To have an attraction and retention strategy that targets key roles, making them a career of choice.
- To deliver the NHS workforce across the system within the agreed cost, improving workforce productivity and eliminating duplication.
- To maximise training and development opportunities for a range of routes including apprenticeships and through our Health and Care Academy.
- To develop a shared workforce that supports new operating models, including a shift to primary and community care.
- To realise a year-on-year improvement in the levels of staff engagement, staff survey results and inclusivity.

Our people, leadership and organisations work in silos. People often have different experiences of work and inequity of opportunity. This is particularly true for colleagues with protected characteristics. There is variation across Kent and Medway in the availability of some skills, leading to unsustainable services. The current workforce model is unaffordable and therefore we need a smaller workforce with more targeted skills.

We will plan for a workforce that is affordable. To do this, we will make the NHS a career of choice in Kent and Medway where a shared workforce targets particular skills. We will reduce duplication and improve productivity while training and developing our staff for the roles of the future. This will include increasing our digital capabilities and needing more staff in primary and community care, and fewer in secondary care.

Our national staff survey and quarterly pulse survey results will provide us with the measurements we need to target changes and track our improvements. We will focus on improving staff engagement, promoting a good work life balance and being an anti-discrimination system.

In the first year of our strategy, we will design an affordable system workforce plan, which supports priorities identified through the ‘Patient, Access and Outcomes’, ‘Sustainable Services’ and ‘Finance and Resources’ themes.

Theme 3: Sustainable Services

Vision	Goals
We will provide sustainable, resilient healthcare that allows people to live, age and die well. We will empower people to self-manage where they can and deliver timely proactive services enabling care at home for our older population.	We will make services sustainable by: • Promoting self-care which is digital-first and supported by integrated neighbourhood teams or wider multidisciplinary teams in primary care and communities. Focusing on optimal care for long term conditions. • Supporting children's mental wellbeing • Only admitting to hospital people whose needs cannot be met elsewhere and who we will discharge as soon as they could be treated somewhere else. • Co-ordinating clinical pathways across providers, removing duplication of clinical activity and allowing more patients to be seen quicker and less often. • Having a shared responsibility to plan for the end of life that allows people to die with dignity and comfort in their preferred place of death. • Working with the 'Financial Sustainability' theme to ensure our changes make financial sustainability possible.

The way we currently work does not meet demand, now or into the future. The population of Kent and Medway is increasing, with the over 85year age group growing at the fastest rate. Frailty, dementia, ageing well and long-term conditions are the areas with greatest demand on our services. 56% of the population registered with a GP has at least one long-term condition, which is the highest across the South-East Region.

We will provide sustainable services by promoting self-care and using digital technologies. We will focus on optimal management of long term conditions, working with people to prevent deterioration of health equitably, informed by Core20PLUS5. We will only admit to hospital people whose needs cannot be met elsewhere, and we will discharge them as soon as they could be treated somewhere else. Across our services we will seek to reduce the duplication we know exists.

Our key areas of focus will be: children who are obese, children's mental wellbeing; self-management and secondary prevention for people with long term conditions; keeping people that call 999 out of hospital; and maximising care in the community.

In the first year we will focus on identifying vulnerable people who have the greatest need for unplanned care using risk stratification at local level. Each of these people will have a comprehensive assessment and tailored plan for their care in an emergency.

Theme 4: Financial Sustainability

Vision

We will have a financially sustainable system with sector-leading levels of productivity. Services will be supported by adequate resources, and funds will be directed towards their intended purpose and be able to support the other strategic themes. The approach to this will be developed in alignment with the themes of the Darzi review most applicable to financial recovery: re-engage staff and patients, shift care closer to home in a neighbourhood NHS, drive productivity and tilt towards technology.

We will create a financial environment that enables future investment, both revenue and capital, in prevention and service provision.

Goals

- The system and all partners are in recurrent financial balance, having reduced the cost base by £300million, creating headroom to invest in prevention and service transformation (including strategic capital investment)
- Improved productivity across all services, including the reduction in waste and duplication not just doing more for the same cost.
- Equitable services that all improve outcomes.
- An engaged population that take personal responsibility for health prevention and self management of long term conditions, reducing health service interventions and treatments
- A digitally enabled and transformed effective operating model that supports a system-wide recurrent balance whilst improving quality and operational performance.
- Early prevention and intervention to reduce reactive and resource-intensive health interventions.
- Integrated commissioning with Local Authorities to reduce overall health and care costs.

Despite ambitious efficiency plans, we continue to spend more money than we have available, and the position is deteriorating. In addition, the current operating model doesn't achieve equitable access, outcomes and experience, resulting in health inequalities and poor workforce morale.

We will change our operating model to focus on value, prevention and empowering the population to manage their own health. By improving our productivity and reducing late, reactive and resource-intensive health interventions, we will bring our NHS system into financial balance and reduce the cost base.

In the next year we will: identify 75% of our Cost Improvement Plans for 2025/26 before the end of 2024, review the viability of our least value-adding services by March 2025 and ensure wherever services are available patients are treated in Kent and Medway rather than other areas, review how we provide back-office services, develop plans for a secondary care estate supported by a plan to prioritise delivery of care out of hospital and deliver our environmental sustainability targets, review our approach to interoperability for our electronic patient records, and work with the 'Sustainable services' theme to identify how a shift in funding from acute to primary, community and preventative care, along with the above plans, achieves financial sustainability.

How will we get there?

We recognise and welcome the role of the sovereign organisations in all parts of our NHS system. This strategy is focused on the additional effort that we can collectively achieve to go further and faster in tackling our shared challenges and meet the health needs of our population.

To deliver our strategy we will:

- recognise the value in our organisations and NHS system, using existing governance arrangements, rather than creating additional layers. For example, our Health and Care Partnerships, Provider Collaboratives and transformation programme boards such as Urgent and Emergency Care, Elective, Diagnostics etc.
- use our current Chief Executives' Group as an overarching Programme Board.
- continue to look to our Chief Executive Senior Reponsible Officers (SRO) to lead the implementation of our plans in each theme.
- resource a programme management office to co-ordinate planning and deliver a standardised process for reporting against delivery

We have taken a continuous improvement approach to the development of this strategy and will continue to use improvement tools in the delivery. But improvement does not stop there. We need to be a self-improving system. A system that learns from what works well and shares that rapidly and widely, as well as a system that learns from what does not work well to adapt and try again.

We will use an agreed set of principles and behaviours to support our work which will align with NHS Impact best practice.

Appendices

Strategic theme A3s and enabler proposals

The following appendices are the outputs of the continuous improvement methodology we have used to co-produce our strategy. They have been developed and approved by the SROs and the executive teams dedicated to each strategic theme and enabler. As we develop our countermeasures, or implementation plans, they will remain live documents which we will share with each other regularly to achieve the aims of our strategy.

Appendix – Strategic Theme A3s and enabler proposals

The following appendices are the outputs of the continuous improvement methodology we have used to co-produce our strategy. They have been developed and approved by the SROs and the executive teams dedicated to each strategic theme and enabler. As we develop our countermeasures, or implementation plans, they will remain live documents which we will share regularly to achieve the aims of our strategy.

Strategic Theme 1: Patient Access, Outcomes & Experience

Background

Patient satisfaction with NHS care is not only based on how effective treatment is, but on how it feels whilst our patients are receiving their care.

Pathways of care are often fragmented which means that there are large differences in what, where and how each organisation provides services across our area. Patients also report a lack of communication between services and a lack of digital accessibility.

This means that our patients are much less able to choose and access the care that's right for them, at a time they want to simply because of where they live. This has a significant impact on experience and outcomes.

Therefore the people of Kent and Medway are living in ill health, and have a lower life expectancy than other parts of the country.

In, and within, Kent & Medway, cancer, dementia and common diseases such as atrial fibrillation, coronary heart disease, high blood pressure, stroke and diabetes, show significant variation in morbidity and mortality rates, when compared to the rest of the country. Several of these circulatory conditions are revisable, and others changeable, which means we have an opportunity as Kent and Medway health partners to work together to provide our citizens the best possible services that support them to live in good health and with a high quality of life.

Problem statement

The people of Kent & Medway have a lower life expectancy than other parts of the country and there is variation in access to healthcare, positive patient outcomes and in how our patients experience the care they receive. There is a life expectancy gap of 12 years in the county.

Vision Statement:

Patients in Kent and Medway will experience comparable good outcomes, irrespective of where they live or what their background is. They will be partners with the NHS in their healthcare and we will support them with high quality, timely and accessible services.

Current state data:

Full data pack available, key points:

- Circulatory diseases are the leading cause for the life expectancy gap in the SE Region, and are growing faster than nationally.
- K&M has a higher prevalence of AF and hypertension than the national average.
- Qualitative patient experience feedback focuses on waiting times, access to primary care, communication between services, mental health service access, digital (but not always), patient centred care. Triangulated through national and local surveys at all service levels, Healthwatch data, population health (JSNA) outputs.
- Data collated for provider collaborative work programmes support the rational for focussing on Circulatory Diseases as a comorbidity.

Root cause analysis:

See attached Fish Bone analyses which identify the key root causes

Strategic Theme 1: Patient Access, Outcomes & Experience continued

Goals

To reduce unwarranted variation against national measures, and within Kent and Medway, of:

- patient outcomes
- patient experience
- patient access

Targets

- To improve patient experience against national measures, and within Kent and Medway
- To improve patient access against national measures, and within Kent and Medway
- To focus on circulatory disease for the following reasons:
    - It is a leading cause of the life expectancy gap in Kent and Medway.
    - Improvement actions can be applied at every tier of the health and care system.
    - Risk factors and access issues are similar for other leading causes and:
- To:
    - improve diagnosis rates
    - reduce admission rates
    - manage to target
    - co-design public health, primary, community and acute solutions

Breakthrough objectives

Access – Identification and reduction of variation in the cardiovascular pathway for vulnerable groups, levelling up to the best performance with a particular focus on primary care access.

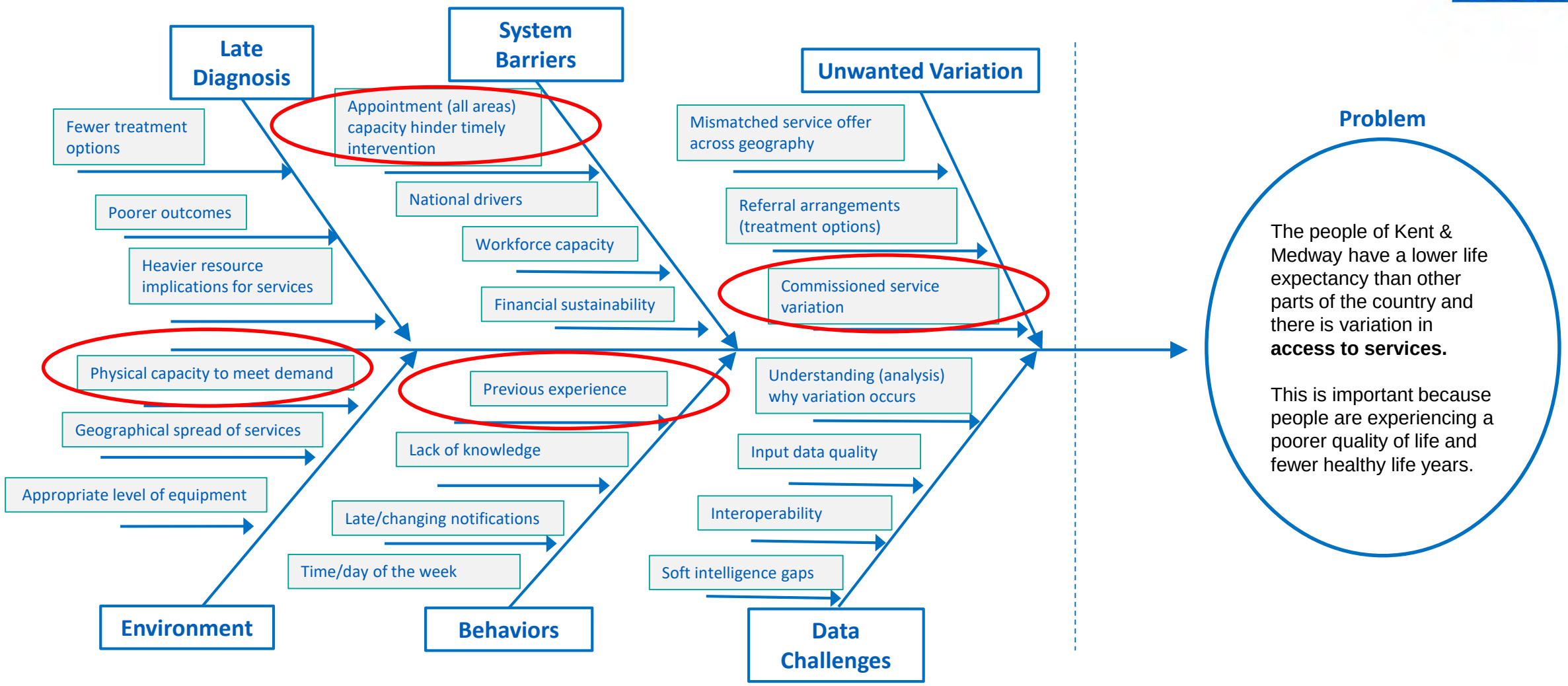
Experience – Identify areas of disjointed care in the cardiovascular pathway for patients and identify solutions with patients, families and advocates recognising the conversation is often initiated in primary care.

Outcomes – risk stratification of all patients on a holistic basis with a focus on psychological health – Making Every Contact Count

Implementation plan

Through Provider Collaboratives

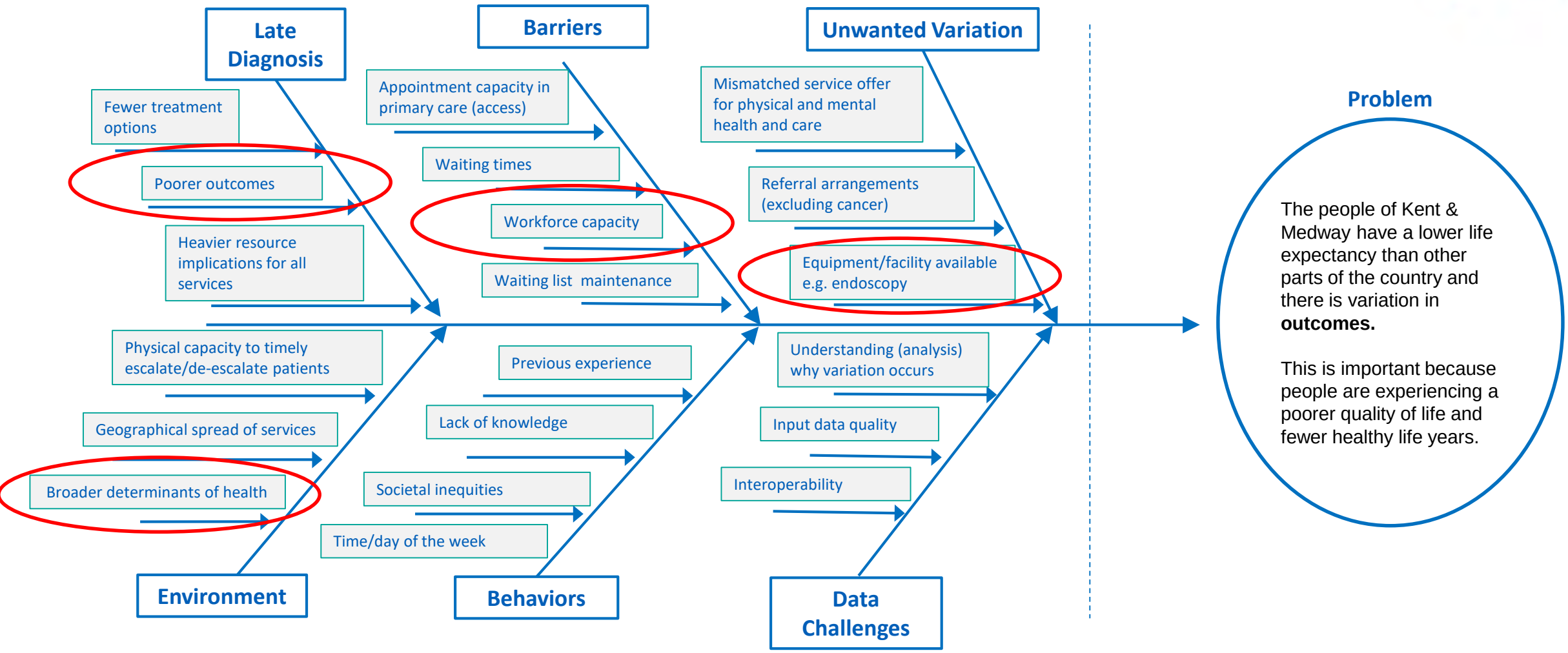
Patient Access – key contributing factors to the identified problem



Key: red circles are the top contributors

Together, we can

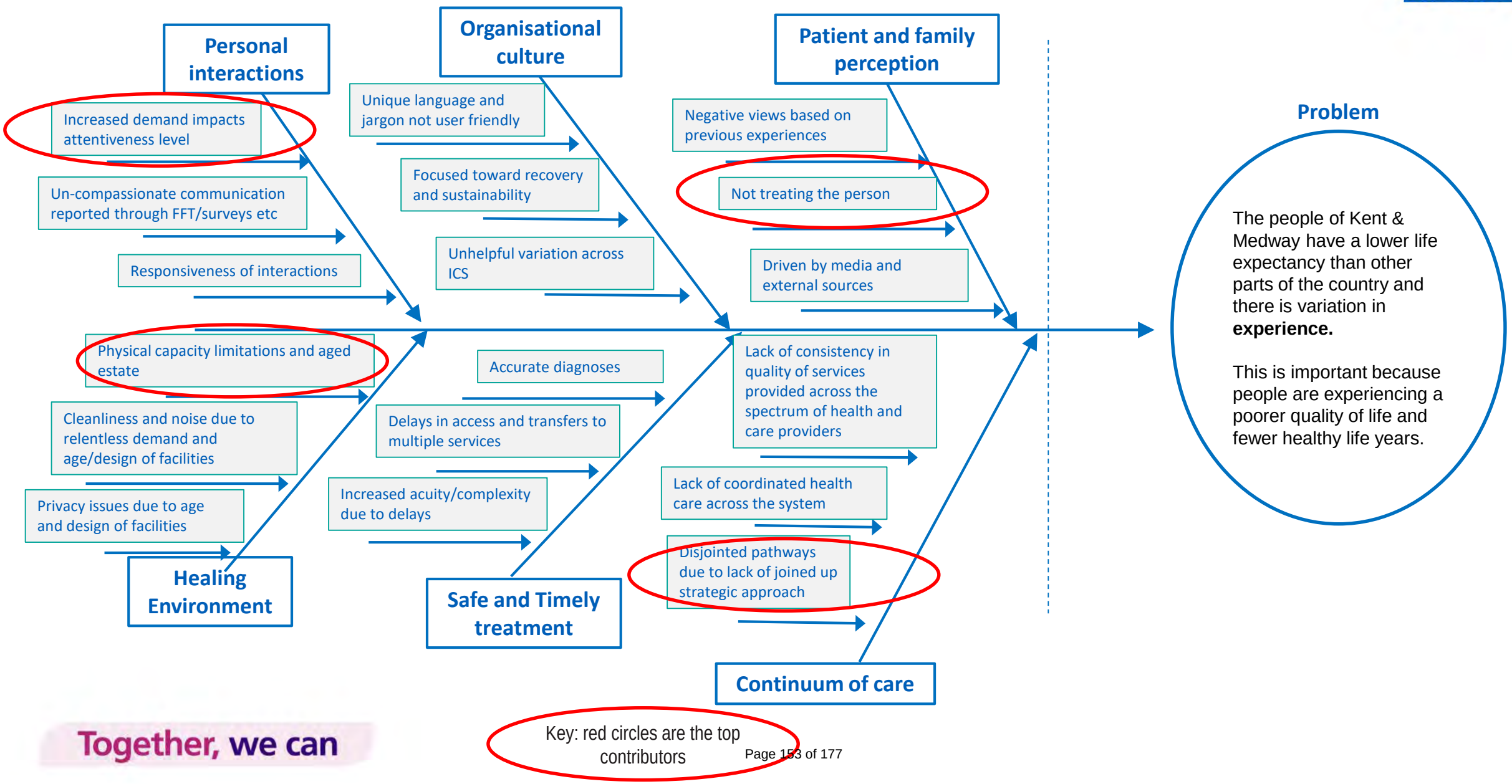
Patient outcomes - key contributing factors to the identified problem



Key: red circles are the top contributors

Together, we can

Patient experience - key contributing factors to the identified problem



Key: red circles are the top contributors

Together, we can

Strategic Theme 2: People

Background

Our organisations, leadership and colleagues work in silos. To deliver our new models of care and ways of working, our workforce and skills may be in the wrong place and need to move across organisational boundaries to match skills to strategic ambitions for primary and secondary care. Our colleagues have different experiences of work and have inequity of opportunities. This is particularly true for colleagues with protected characteristics. Colleague's experiences of work are directly impacted by our leaders who also receive differing development and well-being support across our organisations. Colleagues leave through their own attrition and rotate through our organisations in an unplanned way.

Our local workforce pipeline is limited and does not reflect the diversity of our population and needs to grow to address future demand. Our training and development of colleagues is procured, delivered and received in silos with a missed opportunity for system working, targeting and developing the pipeline for the Long-Term Workforce Plan, including growth in places at the Kent and Medway Medical School and areas of occupational shortage and high demand.

Individual Trusts and the ICB have their own People strategies aligned to the national People Plan and other national priorities.

Problem statement

Organisational boundaries create legal, cultural, policy and statutory obstacles to working in a collegiate way. Education and workforce planning is disconnected / abstract and removed from operating model development / clinical pathways. It is not targeted or sufficiently specific to meet anticipated demands. We are not established to address the shift to prevention nor to enhancing community care. Without a joined up, clinical, operational and workforce model incorporating primary care, we cannot deliver an affordable workforce that is appropriately trained, skilled, engaged and valued for the future.

Vision Statement:

We will have a skilled, healthy, engaged, productive and affordable workforce who are reflective of our local population and that can meet the operating model and patient need
We will develop the right workforce for the long-term Kent and Medway model through workforce planning, using digital as an enabler and by working as a single NHS team across the area, including primary care. Staff will move easily between organisations feeling safe and valued. Our workforce will be digitally capable, aided by common systems across our organisations and always seeking to use technology to free time to care.

Current state data:

Full data pack available, key points:

- Full data available from National Staff Survey results
- Overall colleagues with protected characteristics have a worse experience of work
- Too many healthcare workers feel stressed, work extra hours and do not look forward to coming to work
- Over half the organisations in K&M have seen a fall in staff engagement and people feeling they have a voice that counts
- Most organisations have seen an improvement in the theme of working flexibly and feeling they are a team
- Vacancy rates are up to 10%, but are improving
- 24% of GPs are aged 55 of over
- More generalist workforce skilled at manging complex care for multiple conditions required – ageing population increases complexity and multimorbidity

Strategic Theme 2: People continued

Goal:

- To be recognised by our staff as anti-discrimination employers and a system that will not tolerate this behaviour
- To have a Kent and Medway attraction and retention strategy that targets roles that support our future operating model across the care system as a career of choice in Kent and Medway
- To deliver a total workforce within system planned FTE and cost, improving workforce productivity and eliminating duplication
- To maximise the opportunities presented through apprenticeships and other training and development routes delivered by the system Health and Care Academy and HEE institutions including KMMS and CCCU
- To develop an approach to enable a shared workforce, which is digitally enabled within a suitable legal framework that supports new operating models
- To realise a year-on-year improvement in the levels of staff engagement identified through key domains within the quarterly pulse survey and National Staff Survey

Targets:

- Skills supply: system contractual vacancy level less than 7% with reduction in vacancy in hard to recruit roles and key posts.
- Realise year on year improvement in levels of staff engagement increasing advocacy scores specifically in 'recommend the organisation as a place to work and as a place to be treated'. Target score to achieve the upper quartile of 7.03.
- Effective provision of a system Health and Care Academy that will optimise the provision of local apprenticeships, development programmes and opportunities for local people to support reductions in health inequalities and widening participation (Increase in Levy spend). Specifically focusing on nursing and midwifery, therapies and theatre staff thereby reducing our reliance on international recruitment.

Targets (continued):

- Undertake an assessment of General practice vacancy and skill gaps testing plans against the trajectories and devising effective responses
- Employers of choice, a great place to live and work. Includes flexible working, good work life balance and delivery of the people promise with a focus on being non-discriminatory employers. System turnover (losses outside of the system) is less than planned monthly average for 24/25, 37,106 FTE and £179m cost.

Breakthrough objectives

- System workforce plan including primary care designed to address the gaps in support of the clinical operating model and the identified key health inequalities, in particular arising from strategic themes 1 &3.
- Develop system Health and Care Academy with focus on activity to support workforce aspirations for domain 1&3.
- Extend and enhance digital capabilities of our workforce.
- One offer to work in Kent and Medway supported by a shared people service.
- Work with our local medical school to develop a plan for expansion and support to the strategic themes.

Implementation Plan:

Through K&M CPO group

Strategic Theme 3: Sustainable Services

Background:

Our population is increasing, with the over 85yr age group growing at the fastest rate. As this cohort are the highest users of healthcare services, we know demand is going to continue to increase, particularly for frailty, dementia, ageing well and long-term conditions. 56% of the population registered with a GP have at least one long-term condition, which is the highest across the SE Region. We also have the highest prevalence of frailty in the over 50's age group in the SE Region with coastal areas most affected. Childhood obesity rates are increasing and childhood depression is the highest in the SE Region.

Only 2% of spend in Kent and Medway is allocated to preventing ill-health, meaning that our current model of care is focused on 'repair and recover', where, by definition, our patients will have already been negatively impacted by their healthcare concerns at the point as which they access our services. Kent & Medway (K&M) have the highest A&E attendance across SE Region when comparing 2022/23 with 2019/20 activity levels. 11,605 patients out of 2 million population are generating 52,136 ED attendances, 1.1 million GP encounters and 47,330 emergency admissions. There are consistently 550+ patients occupying acute beds that do not require acute care and at further risk of harm from long length of stay decreasing their potential to return to independent living.

Those living in the most deprived areas of K&M have the shortest life expectancy and the most health needs. However, services are not always accessible to those most in need for a wide variety of complex reasons – not all within the sole influence of the NHS. We know that timely access to services is a determining factor in health outcomes.

The model of care in the UK is over reliant on acute care. This model of care, with the increase in demand and limited workforce, means some services are unsustainable and others will become unsustainable in the future. An inconsistent and siloed approach to pathway/care design and delivery leads to further variation in outcomes for our population.

Problem Statement:

Our current ways of working and our infrastructure do not meet demand now or into the future. Through inefficiency and duplication, we contribute to some of this demand, leading to "waste" of our valuable and limited health resources. Services are not sustainably delivered for patients or for the system. Collectively, this results in adverse impact on the health and wellbeing of our population.

Vision Statement:

We will provide sustainable, resilient healthcare that allows people to live, age and die well. We will empower people to self-manage where they can and deliver timely proactive services enabling care at home for our older population.

Current state data:

Risk stratification data sets by PCN population
Health inequalities data
Primary care activity
NCTR
SPOA and ambulance conveyance data sets
Health insights and palliative and end of life care data

Root cause analysis:

Lightfoot analysis and algorithms to support paradigm shift

Strategic Theme 3: Sustainable Services continued

Goal:
To have improved the sustainability of services by:

- Promoting self-care for children and adults through education and access to expertise which is digital-first and supported by integrated neighbourhood teams and/or wider multidisciplinary teams in the community where people live. Focusing on optimal care for long term conditions.
- Supporting children's mental wellbeing
- Admitting people to hospital who require clinical management that can only be delivered in this environment and will only remain in this environment for essential care that cannot be delivered in the community.
- Co-ordination of Clinical pathways across providers which removes duplication of clinical activity, providing a holistic service that allows more patients to be seen quicker and less often
- A shared responsibility to plan for the end of life, that allows people to die with dignity and comfort, in their preferred place of death.
- Working with the 'Financial Sustainability' theme to ensure our changes make financial sustainability possible.

Targets:

Short term

- Children who are obese or at risk of obesity have a proactive plan delivered at a neighbourhood level that supports return to a healthy weight.
- Children's mental wellbeing supported
- People with long term conditions have a plan to self manage supported by the integrated neighbourhood teams, and with a focus on secondary prevention
- All care and residential home patients have a proactive care plan with RESPECT completed and accessible
- All PCN populations are risk stratified and those utilising the highest resource have a proactive plan that halves their utilisation of unplanned pathways.
- Each HCP to deliver a 15% reduction of conveyance to hospital for unplanned care from 22/23 baseline
- Reduction of 25% NCTR patients in acute, community and mental health hospitals

Long term

- People will only attend an acute hospital for care that cannot be delivered or supported in the community

Breakthrough objectives:
CGA/ACP/RESPECT for all vulnerable cohort at PCN level identified through risk stratification

Implementation Plan:
Ageing well programme and Community and provider collaborative programmes

Strategic Theme 4: Financial Sustainability

Background:

The 2024/25 NHS system has a planned deficit of £120m, which assumes stretching efficiencies of £400m which represent 10% of the system allocation. If we continue with the current service models, we won't have the resources to respond to expected patient needs now and in the future. We do not commission based on population need. Our operational model is to react to demand rather than targeted at long-term solutions that reduce/re-direct demand and does not allow us to deliver our constitutional requirements. The NHS financial pressures are mirrored in our local government partners and across the non NHS and VCSE provider landscape.

There are a lack of shared incentives which creates duplication and can lead to poor patient experience and outcomes. There is not a culture of "a single NHS pound", instead each team/organisation focus on their budget, resulting in missed opportunities to improve care and productivity. There is a lack of robust contract management and duplication of contracts impacting value for money.

Spend on agency varies between organisations, efficiency plans are being underachieved, procurement costs vary, increases in cost due to patient need (1:1 care) and drivers of the deficit show elective, better use of beds, workforce, primary care and community and commissioning savings as the biggest areas of opportunity.

Digital and AI are not progressing as a system and productivity is not as good as it would otherwise be. K&M is the least digitally mature system in the South East Region and is ranked 32 out of 42 ICS. £500m (and growing) estate maintenance backlog meaning large parts of estate and infrastructure are not fit for 21st century effective healthcare. Our estate is not aligned to demand reducing access to services.

Problem Statement:

i) The ICS is planning a deficit of £120m in 2024/25 and 10% efficiencies.
ii) Our modelling shows that continuing the current service models will result in a higher deficit which will likely result in poorer outcomes for patients.
iii) There is a resource gap to delivering constitutional standards, demand and capacity requirements consistently across ICS.
iv) Material parts of the ICS estate and equipment are not fit for purpose. There is insufficient capital to deliver backlog maintenance, asset renewal and essential developments to match service plans;
v) There has been a reduction in productivity in aggregate since 2019/20, with a particular growth in pay costs.
vi) Demand and capacity pressures and market sustainability in primary and social care are detrimentally impacting spend in acute, mental health and community care. These are drivers of poorer productivity and outcomes.
vii) There is significant variation in financial systems, capacity and expertise across the system. There is also variation in financial performance across the system and inconsistent ownership of the system financial gap.

Vision Statement:

We will have a financially sustainable system with sector-leading levels of productivity. Services will be supported by adequate resources and funds will be directed towards their indented purpose and be able to support the other strategic themes. The approach to this will be developed in alignment with the themes of the Darzi review most applicable to financial recovery:

- *re-engage staff and re-engage patients;*
- *lock in the shift of care closer to home*;
- *simplify and innovate care delivery for a neighbourhood NHS;*
- *drive productivity in hospitals; and,*
- *tilt towards technology.*

We will create a financial environment that enables future investment, both revenue and capital, in prevention and service provision.

Strategic Theme 4: Financial Sustainability continued

Goals

- The system and all partners are in recurrent financial balance, creating headroom to invest in prevention and service transformation (including strategic capital investment)
- Improved productivity across all services, including the reduction in waste and duplication not just doing more for the same cost (cost per weighted activity unit, reference costs, workforce productivity metrics s outlined by NHSE benchmarks)
- We stop providing services which are not delivering improved outcomes and reduces inequalities for patients to enable us to focus on delivery of equitable services which deliver the right (efficient) service in the right place at the right time.
- We have an engaged population that take personal responsibility for health prevention and self management of long term conditions reducing health service interventions and treatments
- A digital enabled and transformed effective operating model that supports a system-wide recurrent balance (model approved by all ICS Boards) whilst improving quality and operational performance.
- Demonstrable up-streaming of service provision, reducing reactive and resource-intensive health interventions.
- Integrated commissioning with Local Authorities to reduce overall health and care costs, driving the BCF to transform services

Targets:

- Achieve annual control total and develop bridging schemes as a system,
- Develop the framework and baseline assessment for a multi-year financial plan to 2029/30 by October 2024. This will be based on an understanding of cost drivers & productivity, include system efficiency & income plans, have identified SROs, delivery dates, scheduled savings plans and specific targets on pay.

Targets (continued):

- System and partners deliver financial balance in 2024/25.
- 75% of 2025/26 CIP plans identified before end of December 2024 and at least 75% of schemes recurrent.
- Delivery of improvement trajectory of key productivity measures (as outlined in FRP)
- Assess viability of services and decommission least value-adding and inequitable services by March 2025.
- Define and implement effective system operating model by Autumn 2024.
- By March 2025 develop a plan to move to single back-office services.
- Develop a plan for the strategic rationalisation of the secondary care estate by September 2025, supported by a plan to up-stream the delivery of care out of hospital and meet our environmental sustainability targets.
- Develop governance and implement approach for EPR convergence and interoperability to enable efficiency by the end of 2024

Break Through Objectives:

Alongside this A3 the workstream have developed a supporting Financial Recovery Plan (FRP) this plan includes a number of breakthrough objectives and targets in organisations and and the system. The key breakthrough objective identified therefore is delivery of year one of the FRP and progress on year tow as per the timetable in the FRP

Implementation Plan:

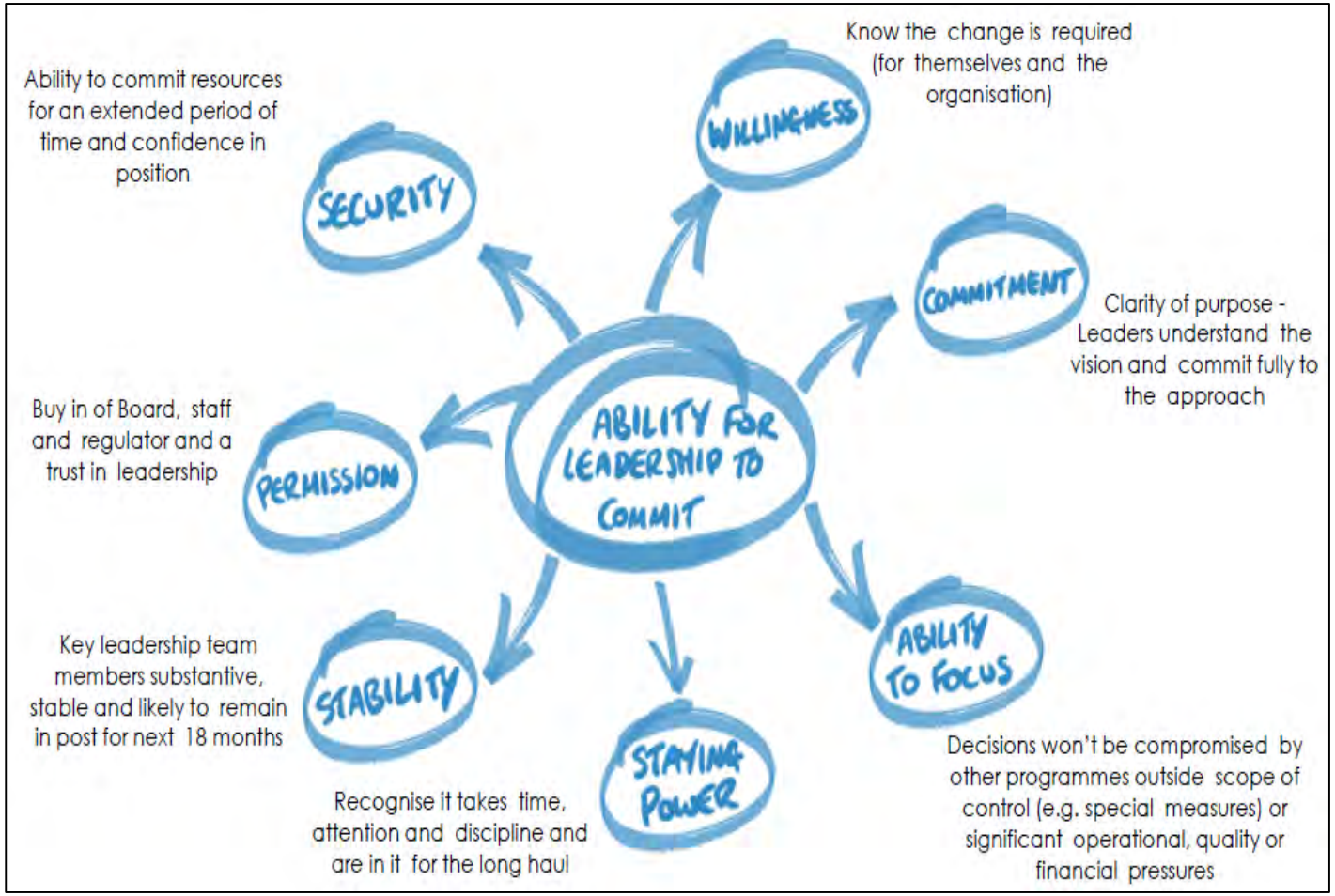
The ICS has developed a financial recovery plan framework through multi—disciplinary executive level system workshops. This will then be developed into a detailed financial recovery plan to return to a financially sustainable position by 2026/27.

Enabler 1: System development, culture and improvement

Workstream aim

- Assess the readiness of the system to undertake improvement work
- Define a set of principles at provider, place/ collaborative and ICB
- Agree and implement a set of behaviours across the system to support continuous improvement
- Align improvement work to NHS Impact, Improving Care Together best practice
- Define, secure and allocate improvement support for the system
- What is the single biggest priority we should focus on in each of the Places and Provider Collaboratives?
  - Identify what data is required
  - Which Provider will be Lead Provider for each of these priorities (sharing method with other providers)
- Ongoing work to prioritise schemes for this year. Kent workforce, single recruitment and leadership development are key focus for discussion

Readiness to start change



- Building of existing work
- Using existing groups where possible for this work
- Governance though existing committees

Focus on ICB and Provider Collaboratives

Focus for ICB:

For NHS IMPACT Strategy (Alignment) and governance (enable) underpinned by robust system wide data

Focus for Provider collaboratives / Place (improve) Improvement to models of care

	[principles]	[leadership]	[management]	[front-line]
ALIGN	Create value for the patient Create constancy of purpose Think systemically	**Establish Direction** **Develop** a vision and strategies to achieve that vision. **Set** high but reasonable targets. **Communicate** the direction on a regular basis.	**Organizing & Translating** **Establish** a structure to achieve the plan. **Organize** and **allocate** resources. **Monitor** structure to ensure consistency and alignment to plan.	**Setting & Achieving Goals** **Identify** meaningful goals that can be accomplished in their area that directly affect the overall vision and strategy. Daily **report** on status and needed support.
ENABLE	Lead with humility Respect every individual	**Motivate, Mentor, Inspire** **Energize** people to develop and overcome barriers to change. Daily **be in** the work area to **listen** to understand. **Embrace** failure; **celebrate** success.	**Empower, Involve & Coach** **Empower** authority within parameters of area to improve and solve problems. **Break-down** silos by **involving** cross-functional teams to solve value stream issues. **Coach** problem solving daily.	**Develop & Share** Be a self-developer. **Find** opportunities to grow and develop to better support the organization. **Share** with others what is working and what is not working.
IMPROVE	Focus on process Embrace scientific thinking Flow & pull value Understand & manage variation Assure quality at the source Seek perfection	**Break-through Thinking** Continuously **learn** by listening, seeing and translating observations. Support new models of care delivery developed by front line.	**Monitor & Maintain Predictability** **Monitor** the outputs of each system to ensure stability and a standard outcome. Continuously **challenge** the process to identify areas of improvement.	**Adapt & Adjust** **Adapt** the tools by making incremental adjustments that all shifts agree with. **Treat** tools as a countermeasure not a solution. Structurally **solve** area problems daily.

Source: Collaboration with Institute for Enterprise Excellence and Catalysis, 2013

Best Practice

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

Together, we can

What could our improvement framework include?

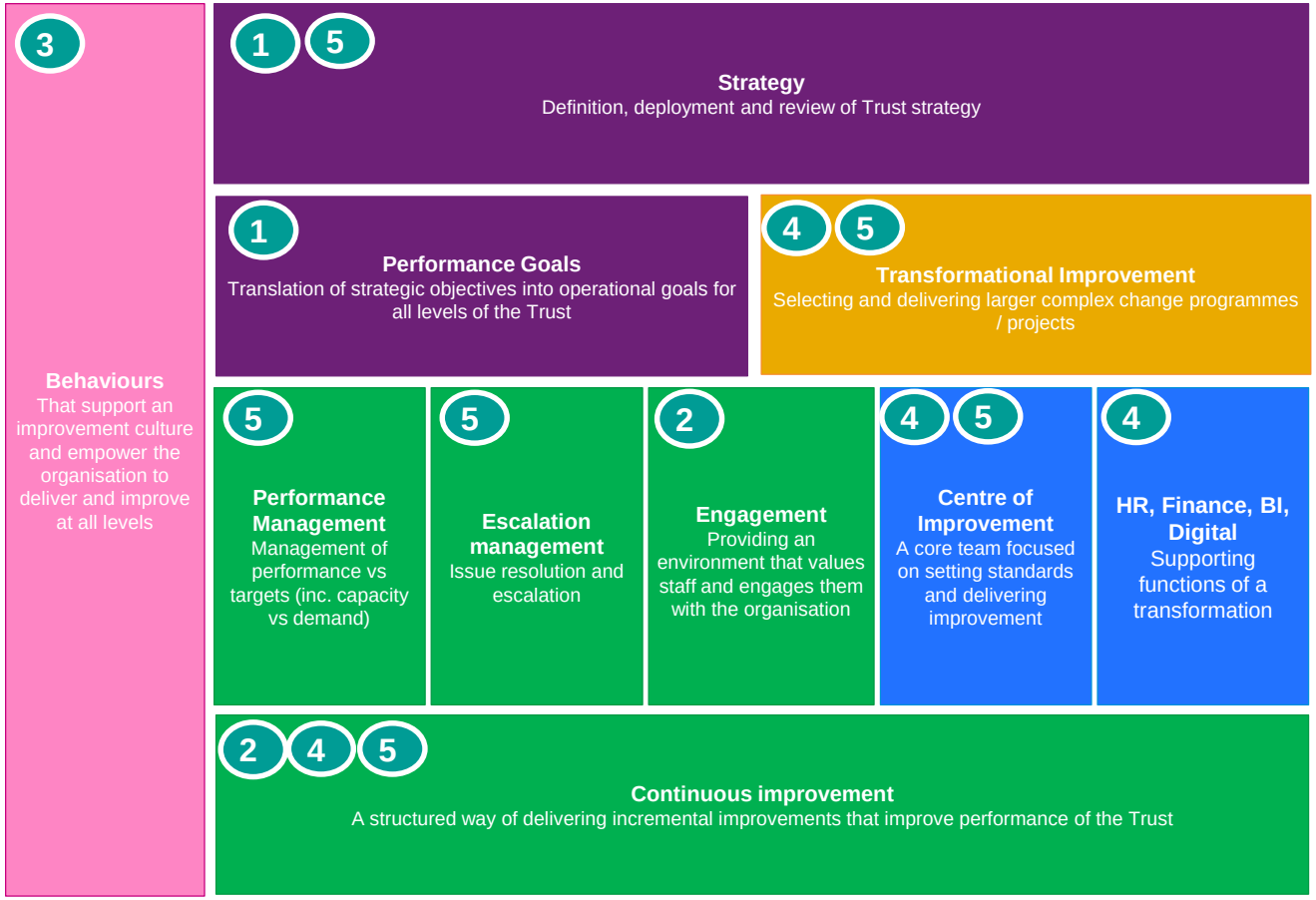
Key: Behavours | Strategy | Projects | Support | CI

Together, we can

Aligned to NHS IMPACT

NHS IMPACT
Improving Patient Care Together

1. **Building a shared purpose and vision**
2. **Investing in people and culture**
3. **Developing leadership behaviours**
4. **Building improvement capability and capacity**
5. **Embedding improvement into management systems and processes**



Together, we can

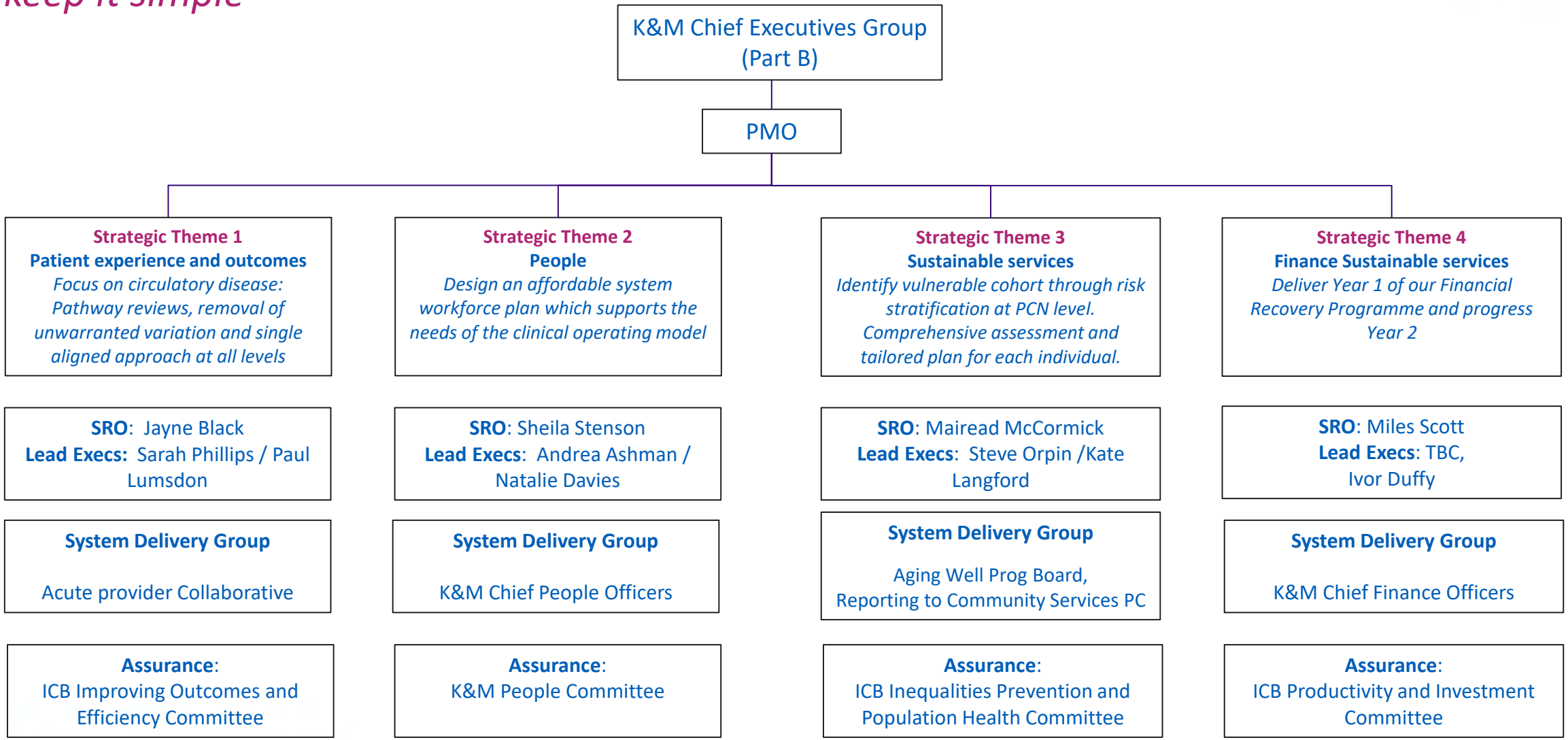
Enabler 2 - Strategy delivery architecture

Roles and Responsibilities

- Use existing governance and architecture arrangements, rather than create additional layers.
- Propose to extend existing Chief Executives Group as overarching Programme Board (suggest a Part B to existing meeting, with PMO and other execs in attendance as appropriate).
- Subject to confirmation of specific programmes of work from each strategic theme, existing delivery partnership arrangements are to be utilised, i.e.
    - Provider collaboratives
    - Transformation programme Boards such as UEC, elective, diagnostics, cardiovascular, etc
    - Existing professional groups, such as CFOs and CPOs
- NHS Providers and Health and Care Partnerships will be foundation delivery vehicles to the above
- Primary care to be enhanced in the above groups if not already established
- Programme Management Office to be established to co-ordinate planning and deliver a standardised process for reporting against delivery

Strategy delivery architecture

'keep it simple'



Together, we can

Appendix

Why do we need an NHS strategy?

The strategy describes the key challenges we face as an NHS system. We know we can achieve more collectively, rather than individually, to improve the health of the people of Kent and Medway. Producing this strategy has brought NHS provider organisations, primary care and NHS Kent and Medway together to consider how they best deliver the improvements needed to meet the health needs of our population.

Why doesn't this strategy include all of our statutory responsibilities?

NHS organisations have a range of statutory responsibilities, with regulation, to ensure their delivery. These will always be a focus for individual boards; however, this strategy focuses on what we will be doing jointly to tackle our collective challenges and achieve our shared ambition.

How does this strategy fit alongside existing work?

This strategy sets a framework for the NHS system to work together to deliver greater improvements than can be individually achieved. It does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships. It is supported by a range of subject specific strategies and plans, for example the Primary Care Strategy, NHS Estates Strategy and financial recovery plans.

How will you learn from others?

Q Health published a framework for improving health and care across systems (available here: Improving across health and care systems: a framework | Q Community). We have and will continue to use this to shape how we deliver the strategy. We will continue to look to learn from other integrated care boards and health economies as well as NHS England (through initiatives, such as NHS Impact).

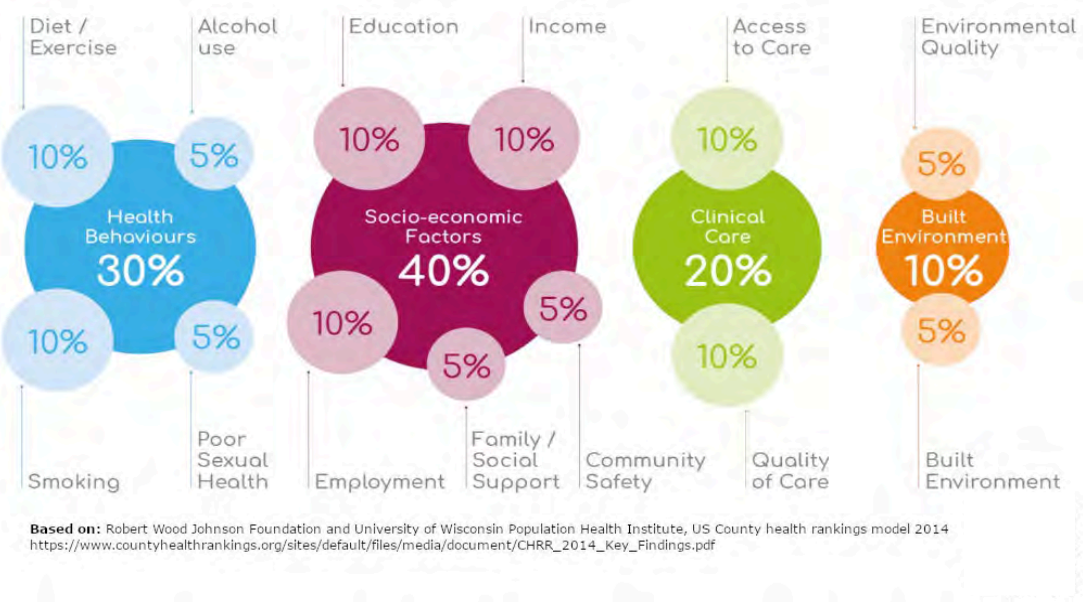
How does this align to our individual organisational or partnership strategies?

This strategy does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships. We recognise some challenges cannot be tackled by one organisation and this strategy sets out areas of focus for us as an NHS system to deliver greater improvements than can be individually achieved.

How is this different to our integrated care strategy?

Kent and Medway's Integrated Care Strategy was developed with a broad range of partners, and focuses on the wider, social determinants of health such as education, housing, environment, transport, employment and community safety. As demonstrated

by the Robert Wood Johnson model, these account for 80 per cent of the variation in health outcomes. This strategy focuses only on healthcare and the impact that has on our health outcomes. It is a strategy for the NHS partners in Kent and Medway.



How will this strategy be delivered?

Producing this strategy is the first stage of our partnership work. We are continuing to work together to agree how we achieve our stated goals, identifying specific programmes of work that will deliver our targets in the first 12 to 18 months of our strategy.

Who is this strategy for?

This strategy is for NHS providers, primary care and NHS Kent and Medway. It is for our people and our population, to demonstrate how we are setting our ambition and vision for NHS services of the future.

Equality, Diversity and Inclusion Impact Assessment

NHS
Kent and Medway

Stage 1

Section 1: Policy, Function or Service Development Details
This section requires the basic details of the policy, function or service to be reviewed, amended or introduced.

Section 2: Assessing Impact
This section asks the author to consider potential differential impacts the policy, function or service could have on each of protected groups. There is a separate section for each characteristic, and each should be considered individually.

Authors should refer to relevant evidence to inform the assessment, and to understand the likely demographics of the patient population who will be impacted by the policy, function or service. For example, findings from the Joint Strategic Needs Assessment (JSNA). It may be that no evidence is available locally. In this case, relevant national, regional or county-wide data should be referred to.

Authors must consider what action they will take to mitigate any negative outcomes identified and what actions they will take to ensure positive impacts are realized.

A link is provided to the legal definition for each of the protected characteristic groups.

Section 3: Equality Act 2010
This section asks the ICB's equality, diversity and inclusion lead to consider compliance to the Equality Act (2010). Within the Equality Act, NHS Kent and Medway as a public authority has a legal requirement to promote equality and set out how we plan to meet the "general" and "specific" duties specified in Section 149 (1) of the Public Sector Equality Duty.

As a public authority NHS Kent and Medway is required to pay "due regard" to the three aims of the general equality duty to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having "due regard" for advancing equality involves:

- Removing or minimising disadvantages people encounter due to their protected

characteristics

- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people

- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

NHS Kent and Medway are legally bound to demonstrate that we are taking action to promote equality in relation to policy making, development of policies and procedural documents, alongside the delivery of services, service developments and employment.

Within the Act, we also have a legal duty to show that we have given due regard to the nine protected characteristics below:

- Sex
- Ethnicity
- Gender
- Disability
- Religion / belief
- Sexual orientation
- Gender reassignment
- Marriage or civil partnership • Pregnancy / maternity
- Age.

The Human Rights Act

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. The Act sets human rights in a series of 'Articles' and each Article deals with a different right. There are 16 Articles; details of which are at: www.equalityhumanrights.com/en/human-rights/human-rights-act.

Article 14: Right to freedom from discrimination (which in effect means protection from discrimination for any other reason that is not one of the protected characteristics e.g. socio-economic status).

Section 4: Conclusions & Recommendations

Now the impact has been assessed, the reviewing panel is asked to consider whether, based on the findings, they agree with the findings and any mitigating actions.

Section 5: Planning Ahead

It is the responsibility of the Senior Responsible Officer accountable for the Strategy, Policy, Function of Service to sign-off your EIA, which should be through the governance arrangements/committees/Boards for the programme/area of work it supports.

Section 1: Policy, Function or Service Development Details (to be completed by the author)

Division: Strategy
Directorate: System Strategy
Senior Officer responsible for assessment: Rachel Hewett, Director of System Strategy
Date of assessment: 15th August 2024
Is this a (please confirm): New assessment

Defining what is being assessed:

What is the title of the policy, function or service this impact assessment applies to?
Kent and Medway NHS Strategy 2024/25 – 2029/30

Please briefly describe the purpose and objectives of this policy, function or service
NHS provider organisations, primary care and NHS Kent and Medway have come together to produce the NHS Strategy 2024/25-2029/30. We know we can achieve more collectively, rather than individually, to meet the health needs of our population and this strategy outlines our ambition and vision for NHS services of the future. It is focused around 4 strategic themes: Patient experience, access and outcomes, People, Sustainable Services and Finance and resources.

Who is intended to benefit and in what way?
It is intended to improve the health outcomes of all the Kent and Medway population by NHS organisations working collectively on issues that cannot be addressed by individual organisations.

What is the intended outcome of this policy, function or service?
The following outcomes are hoped to be achieved by this service.

The strategy will be used to agree new work, and extend current work, to tackle the challenges we have identified together. These challenges include increasing demand, a growing and ageing population, the need to stay within our financial means, a siloed workforce with inequity of experience and inequity of patient experience, access and outcomes.

Who are the main stakeholders in this piece of work?
The NHS Strategy has been developed and will be implemented by the ICB, NHS providers and primary care. We have used feedback from patients and the public and will continue to engage as we develop our delivery plans.

Who is responsible for implementing this change to policy, function or service? (Please provide contact details).
The Chief Executive Officers across Kent and Medway are each leading a theme or enabler of the NHS Strategy and will be responsible for delivery.

What factors may contribute to the outcomes of this policy, function or service? Identifying these will help you to design any public-facing communications to support your initiatives
We will need to continue ensuring the voices of patients and the public are included as we develop our strategy and implementation plans.
Partnership working, including through system structures such as the Provider Collaboratives, will be key.
Each of the strategic theme areas is interdependent on the others, for example ensuring a workforce model that delivers the changes required to make services sustainable.

What factors may detract from the outcomes of this policy, function or service? Identifying these will help you to design any public-facing communications to support your initiatives
Some of the factors identified above as contributing to the outcomes make also detract from them, for example challenging finances, workforce shortages and the need for enhanced partnership

working.

Section 2: Assessing Impact (to be completed by the author)

When completing this section please give consideration to the fact that a differential impact may be positive or negative.

1. Could there be a differential impact due to *racial/ethnic groups*?	Yes	
What evidence exists for this? The implementation plans are yet to be confirmed, however the strategy aims to reduce health inequalities by considering the needs of local populations and using population health data to identify those at risk of inequity. The vision for the Patient access, experience and outcome theme includes ensuring patients "experience good comparable outcomes, irrespective of where they live or what their background is". In addition the People theme champions an inclusive workforce which is "reflective of our local population" and our aim to become an anti-discrimination system.		

2. Could there be a differential impact due to *disability*?	Yes	
It is recognised that people with some disabilities are more likely to require healthcare services and so are more likely to be impacted by this strategy. The strategy should have a positive impact as it looks to reduce health inequalities, particularly in the Patient access, experience and outcomes theme. The People theme is focused on ensuring all staff feel "safe and valued" and recognises that experience for staff with protected characteristics is currently inequitable as evidenced in our staff survey results. One of the goals is to improve these results, particularly in relation to engagement and inclusivity.		

3. Could there be a differential impact due to *gender*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

4. Could there be a differential impact due to *sexual orientation*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

5. Could there be a differential impact due to *religion or belief*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

6. Could there be a differential impact due to people's *age*?	Yes	
The strategy addresses the needs of the whole population, of all ages. The Sustainable services theme has a focus on children's mental health and wellbeing as well as childhood obesity. It also promotes a shared		

responsibility for improvements in end of life care.

7. Could there be a differential impact due to *marital/civil partnership status*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

8. Could there be a differential impact due to a person being *trans-gendered or transsexual*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

9. Could there be a differential impact due to a person being *pregnant or having just had a baby*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care. There is a recognition that prevention of poor health and future good health outcomes start from the earliest years of life and reducing childhood obesity is a goal for the Sustainable Services theme.		
10. Are there any *other* groups that may be impacted by this proposed policy, function or service (e.g. speakers of other languages; people with carers, those with an offending past, or people living in rural areas, homeless or war veterans) but are not recognised as protected characteristics under the Equality Act 2010?	Yes	
The scope of the Strategy is very broad and has the ability to impact on all of the population of Kent and Medway. It aims to tackle health inequalities, increase local community and primary care, improve self-management of long term conditions and improve the productivity of services.		

NB: Remember to reference the evidence (i.e. documents and data sources) used

Section 3: The Equality Act 2010 (to be completed by the Senior Responsible Officer for the Policy, Function or Service Development Details)

Under The Equality Act 2010, the ICB is required to meet its Public Sector Equality Duty. Does this impact assessment demonstrate that this policy, function or service meets this duty as per the questions below?

A 'no' response or lack of evidence will result in the assessment not being signed off.

11. The need to eliminate discrimination, harassment and victimisation	Yes	
The content included in Section 2 of this report and the accompanying actions identified in Section 4 demonstrate that the NHS organisations in Kent and Medway have given due regard to the local communities		

that they serve in a way that meets obligations under the Public Sector Equality Duty. The strategy seeks to improve services and highlight and reduce inequalities thereby providing responsive, sustainable and equitable care.		
12. Advance equality of opportunity between people who share a protected characteristic and those who do not	Yes	
The content included in Section 2 of this report and the accompanying actions identified in Section 4 demonstrate that the NHS organisations in Kent and Medway have given due regard to the local communities that they serve in a way that meets obligations under the Public Sector Equality Duty. The strategy seeks to improve services and highlight and reduce inequalities thereby providing responsive, sustainable and equitable care.		
13. Foster good relations between people who share a protected characteristic and those who do not	Yes	
The content included in Section 2 of this report and the accompanying actions identified in Section 4 demonstrate that the NHS organisations in Kent and Medway have given due regard to the local communities that they serve in a way that meets obligations under the Public Sector Equality Duty. The strategy seeks to improve services and highlight and reduce inequalities thereby providing responsive, sustainable and equitable care.		

NB: Remember to reference the evidence (i.e. documents and data sources) used

Section 4: Action Plan

The below action plan should be started at the point of completing the Impact Assessment (as impacts are identified), however, it is an ongoing action plan that should support the project throughout its lifespan and therefore, needs to be updated and directly linked to other action plans associated with the programme on a regular basis.

Potential Impact identified	Which Protected Characteristic group will be impacted upon?	Action required to mitigate against/support implementation of impact	Deadline	Who is responsible for this action (Provider/ICB- please include job title where possible)?	Update on actions (to be provided throughout project)	RAG rating
	All	Ensure that detailed equality analysis and mitigation is in place for specific service changes or projects that happen as a result of the strategy	Ongoing	CEO SRO for each strategic theme and enabler		

Key-
Red- Not started
Amber- Started but delayed
Green- On track
Blue- Completed
Please note this can be amended to reflect status as per any other action plan you may have linked to this work

Section 5: Sign Off (to be completed by author and the Senior Responsible Officer for the Policy, Function or Service)

Date of next review	When strategy is next updated	
Areas to consider at next review (e.g. any data gaps to be established)	See action plan	
Signed (Author) R Hewett	Date	15/08/24
Signed (Senior Responsible Officer for the Policy, Function or Service)	Date	