Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public
Date: Wednesday, 03 August 2022 at 12:30 – 15:30
MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
1.4	Register of Interest		3	12:33	Note
1.5	Chief Executive's Update	Interim Chief Executive	7	12:35	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous Meeting: 08 June 2022	Chair	11	12:45	Approve
2.2	Action Log and Matters Arising		17		Note
3.	**Patients**				
3.1	Clinical Presentation – Prehabilitation	Chief Medical Officer	Present-ation	13:00	Note
4.	**Board Assurance Framework**				
4.1	BAF Report	Chief People Officer	29	13:30	Note
5.	**Quality**				
5.1	Integrated Quality Performance Report	COO, CNO, CMO	33	13:40	Assure
5.2	Quality Assurance Committee Assurance Report - 28 June 2022 - 26 July 2022	Chair of Committee/ Chief Nursing Officer	101	13:50	Assure
5.3	Mortality and Learning from Death Annual Report 2021/22	Chief Medical Officer	111	14:00	Note
5.4	NHSE Maternity Safety Self-Assessment Tool Gap Analysis	Director of Midwifery	131	14:10	Note
5.5	Perinatal Quality Surveillance Tool (Quarterly)	Director of Midwifery	143	14:20	Note
5.6	Complaints Report	Chief Nursing Officer	167	14:30	Note
6.	**Sustainability**				
6.1	Finance Report – p/e 31 May 2022	Chief Finance Officer	189	14:50	Note
6.2	Finance, Planning and Performance Committee Assurance Report	Chair of Committee/ Chief Finance Officer	190	15:00	Note

	- 30 June 2022 - 29 July 2022				
7.	**People**				
7.1	People Committee Assurance Report - 21 July 2022	Chief People Officer	211	15:10	Assure
8.	**Any Other Business**				
8.1	Council of Governors Update	Lead Governor	Verbal	15:25	Note
8.2	Questions from the Public	Chair	Verbal		Note
8.3	Any Other Business	Chair	Verbal		Note
	Date and time of next meeting: Wednesday, 05 October 2022				

Meeting of the Board of Directors in Public
Wednesday, 03 August 2022

Title of Report	Register of Directors' Interests – update	**Agenda Item**	1.4
Report Author	David Seabrooke, Company Secretary		
Lead Director	Leon Hinton, Chief People Officer		
Executive Summary	This update to the register reflects recent changes to the composition of the Trust Board.		
National Guidelines compliance:	Required under paragraph 34.1 of the Trust's Constitution, Paragraph 18B of Schedule 7 to the NHS Act 2006 (as amended) and the new draft Code of Governance, the register sets out directors' declared interests.		
Resource Implications	None		
Legal Implications/Regulatory Requirements	Yes – the Act requires Boards to avoid conflicts of interests. The draft Code of Governance requires directors to identify and manage such conflicts so as not to override independent judgement.		
Quality Impact Assessment	None		
Recommendation/ Actions required	To note		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Register of interests – August 2022		

MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS
AUGUST 2022

Name	Position	Organisation	Nature of Interest
Jo Palmer	**Chair**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		Sutton Valence School	Governor
		B & CE Ltd	Chief Operating Officer
Ewan Carmichael	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Charitable Funds Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Mark Spragg	**Non-Executive Director**	Marcela Trust	Trustee
		Sisi and Savita Charitable Trust	Trustee
		Mark Spragg Limited	Director
		Faculty of Medical Leadership and Management	Lay Trustee/ Director
		Medway NHS Foundation Trust	Chair Integrated Audit Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Adrian Ward	**Non-Executive Director**	Award Veterinary Sciences Limited	Director
		Nursing and Midwifery Council	Chair Fitness to Practise Panel
		RCVS Preliminary Investigation Committee	Member
		BSAVA Scientific Committee	Member
		Institute of Chartered Accountants in England and Wales – Investigation Committee	Member
		Medway NHS Foundation Trust	Member of the Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Tony Ullman	**Non-Executive Director**	Age UK Canterbury	Trustee
		Medway NHS Foundation Trust	Chair Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
		East Kent Carers Support	Trustee
		CT5 People's Forum	Trustee
Sue Mackenzie	**Non-Executive Director**	Medway NHS Foundation Trust	Chair People Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		BMT Global Ltd	Non-Executive Director
		Logistics UK	Non-Executive Director
		Port of London Authority	Non-Executive Director
		Women's Royal Army Corps Association	Trustee
		National Army Museum	Council Member (pending)
Annyes Laheurte	**Non-Executive Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		Medway NHS Foundation Trust	Chair of Finance Committee
		Finance Committee for the British Association for Music Therapy	Trustee and Chair
		Brakes	Head of Finance (Controls) from 20th July – 19th Oct 2022
Rama Thirunamachandran	**Academic Non-Executive Director**	Canterbury Christchurch University	Vice-Chancellor and Principal Director and Trustee
		Universities UK	Director and Trustee
		Kent Lieutenancy	Deputy Lieutenant
		Million Plus (Lobby Group for HE)	Chair
Jenny Chong	**Associate Non-Executive Director**	Knightingale Consulting	Managing Partner
		KogoPay	Head of Innovation and Data Analytics
		Imperial College London	Advisor to IVMS (Imperial Venture Mentoring Service) and ITES (Imperial Technology Experts Service)
		The Design Museum	Co-opted Member of the Finance and Operations Committee
		Lightning Social Ventures	Advisor
		NHS Innovation Accelerator	Mentor and Panel Assessor
		Egypt Exploration Society	Trustee
		Business of Data	Global Advisory Board Member
Alison Davis	**Chief Medical Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Chief People Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Alan Davies	**Chief Finance Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Evonne Hunt	**Chief Nursing Officer**	Kent and Medway ICS	Husband is Project Lead for EDI
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jayne Black	**Interim Chief Executive**	Nil Declaration	Nil Declaration
Paula Tinniswood	**Chief Strategy and Transformation Officer**	Airglove	Inventor

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – August 2022

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

COVID-19

Over the last month we have continued to see a rise in COVID-19 cases in the hospital which reflects of the situation both in our community and nationally.

Although the increasing number of cases has presented some operational challenges, mainly around isolation of patients and staff sickness levels, we have not seen a significant impact on our services as a result. We continue to monitor the situation very closely and will bring in further restrictions if required.

We continue to ask that our visitors observe the following important measures while they are on our site:

- Wearing a mask in clinical areas
- Washing their hands regularly, or using hand gel
- Not entering the hospital if they have COVID-19 symptoms, unless they require urgent medical care.

Thank you to our staff

It has been a period of extended pressure for our staff, with increased demand for our services, rising COVID-19 cases and periods of very hot weather. I would like to thank them for their continued dedication to providing the very best care to the people of Medway and Swale.

Urgent and emergency care rated 'Good' by Care Quality Commission

In a recent report, the CQC noted significant improvements since its previous inspection in December 2020 and rated the service as 'Good' overall. The service had previously been rated as 'Inadequate'.

Inspectors commended staff for managing infection control risks, assessing risks to patients, and acting upon them. They praised the way care was planned to meet the needs of local people and the individual needs of patients. They also reported that staff felt respected, valued, and supported and that they were focused on the needs of patients receiving care.

A number of improvements were made following the CQC inspection of the Emergency Department in December 2020, including:

- Working with health partners on a collaborative approach to managing demand in the Emergency Department, leading to a reduction in the number of patients waiting in ambulances for longer than 60 minutes
- Putting processes in place to quickly identify patients who are deteriorating in ambulances so they can be prioritised
- Increasing reviews of patients waiting to be admitted resulting in greatly reduced waiting times

- Opening an additional 20 beds in order to cope with demand
- Instigating a multi-agency approach to increase timely discharge for patients who do not need to be in the hospital
- Introducing a tailored development programme to improve leadership and culture.

I am delighted that the CQC has recognised the significant improvements that have been made to the way emergency care is provided at the Trust.
I would like to thank colleagues for their hard work and commitment to delivering these improvements despite a very challenging backdrop of increased demand for services and the COVID-19 pandemic.

Thanks to their efforts we are now providing more timely and consistent care for patients coming into the Emergency Department.

We know there is still more that we can do to improve, and we remain committed to providing the outstanding service that the people of Medway and Swale expect and deserve.

Cancer team lands major award after significant improvements
Our Cancer Services Team has been named South East regional winner at the NHS Parliamentary Awards 2022 in the 'Excellence in Healthcare' category.

The team scooped the award after being nominated by local MP Rehman Chishti. It followed significant improvements which saw the Trust achieve the national standard in four key areas of cancer care in December 2021 (two-week wait, 31-day wait, 62-day GP referral and 28-day faster diagnosis) for the first time in its history.

To receive this award in recognition of this hard work means so much to the team and all our colleagues across the Trust who they work so closely with. It is a fantastic news for Medway, but more so for our patients as it demonstrates our continuing effort to provide the best possible patient care

Patient First
We continue to make great progress with 'Patient First', our new approach to providing excellent care, every time. We are introducing 'Patient First' to help us improve the care and services we provide to the people of Medway and Swale.

This new improvement system means we focus on fewer, more targeted priorities that can have a big impact quickly. With this approach, we can deliver real and lasting change over time.

'Patient First' gives our staff the skills, tools and confidence to make small changes that matter most. All colleagues play their part, whether they are out on the wards, in other clinical areas or providing essential support services.

We know that patients receive better care and have better experiences, when staff feel they are able to make a difference. That is why the Trust is investing in 'Patient First'.

Improving care for patients with hip fractures
I am delighted to say we are improving the experience and outcome for some of our most vulnerable patients who arrive at our Emergency Department (ED), through our relaunched Accelerated Hip Fracture Pathway

Hip fractures bring a significant risk of both morbidity and mortality. The average age of patients with the condition is 84, and these types of fractures are frequently a sign of overall physical decline, which can result in the patient losing independence and having to be placed into care.

The pathway was originally launched by our ED Team in 2016 with great success, and received national praise due to its innovative approach and significant improvements. We are now in a position to reintroduce this pathway and start offering the best possible care to our patients once again.

The pathway commences from the patient's home with the ambulance service informing our Associate Practitioners in ED; colleagues will know the patient's name on arrival and take them through the pathway, ensuring all best practice indicators are met.

A key part of this is having the availability of two specialist orthopaedic beds at short notice these will enable patients to be checked for serious illness or other life-threatening injuries; if none are present the patient can be 'accelerated' into the direct care of the specialist orthopaedic team.

This is a really exciting development for the Trust, and I look forward to sharing our progress in the coming months. Thank you to all colleagues who have worked so hard to get the pathway back up and running

Rainbow Day
Twenty organisations, including schools and nurseries, took part in Rainbow Day in July to raise money for The Medway Hospital Charity.

Our mascot Tedway visited four schools to meet some of the children taking part. The aim of the day was to dress up in rainbow-themed clothes and I would like to say a big thank you to everyone who got involved and raised more than £600.

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

Minutes of the Trust Board PUBLIC Meeting

Wednesday, 08 June 2022 at 12:30 to 14:30

MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Alan Davies	Chief Finance Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Evonne Hunt	Chief Nursing Officer
	Ewan Carmichael	Non-Executive Director
	Jayne Black	Interim Chief Executive
	Leon Hinton	Chief People Officer
	Mark Spragg	Deputy Chair/Senior Independent Director/NED
	Paula Tinniswood	Chief Strategy and Transformation Officer
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	Alison Herron	Director of Maternity
	Dan West	Patient Story
	David Brake	Lead Governor
	David Seabrooke	Company Secretary (Minutes)
	Ian Chappell	Public Governor
	James Chespy	Public Governor
	Suzy Dolby	Patient Story
Apologies:	Adrian Ward	Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and apologies were given as listed above. Chair continued with the following update:

The organisation had come together to mark Her Majesty's Platinum Jubilee with a tree planting and celebratory cupcakes given out to staff. She congratulated Her Majesty on this incredible milestone and thank her for her dedication to public service.

She welcomed Jayne Black to her first board meeting as Interim Chief Executive. Jayne has clinical experience as a nurse, along with her leadership experience across both acute and community sectors and also operating at system level.

On Covid over the last month she said we have seen a continuing reduction in the number of patients in the hospital with COVID and we've been able to cautiously remove some of the restrictions in place like social distancing. Chair thanked the public, patients and visitors and colleagues for their continued support in helping the Trust to keep our patients safe and following the existing infection control measures while they are here on the hospital site.

1.2 Quorum

The meeting was declared quorate with at least one-third of Directors present.

1.3 Declarations of Interest

There were no new declarations of interest in the business coming to the board today.

1.4 Chief Executive Update

The Chair invited the Interim Chief Executive to provide her update. The Board noted the report.

Jayne Black said she was incredibly proud to have been appointed as the interim chief executive.

Since joining the trust in 2021, she had had the opportunity to see the first hand, compassion and dedication of our staff. She echoed the Chair's earlier points about Covid and reminded people that using hand gel and not entering the hospital if they have Covid-19 symptoms unless they require urgent medical care remained important.

She highlighted the opening of the Changing Places toilet facility for people with significant learning and physical disabilities, making us the first acute trust in Kent and Medway to offer this. The new facility is located in the Atrium, Level 2, Green Zone. It can be accessed by patients, carers, visitors as well as staff who have a Radar key. She recognised that the Trust was fortunate to receive generous support from the Medway League of Friends. Their donations make a huge difference to our patients and colleagues.

2 Minutes of the previous meeting and matters arising

2.1 The draft minutes of the Public Board meeting, held on 11 May 2022 were circulated for approval.

The board **APPROVED** the draft minutes as a correct record.

2.2 Matters arising and actions from the last meeting:
There were no actions or matters arising.

3.0 Patients

3.1 Patient Story – Baby Willow

The Chair welcomed Dan West and Suzy Dolby to deliver the patient story, as part of the new Patient Experience Academy, set up under the Patient Experience Strategy. The story described an instance where some staff had not met the Trust's standards for interactions with patients. The Chair offered the Trust's apologies to the family for what had happened.

3.2 Patient First

Chief Strategy and Transformation Officer, Paula Tinniswood showed slides setting out progress with the implementation of the Patient First Improvement System. A glossary was included. The slides indicated that the initiative was on track and set out the roadmap for further stages as the Trust increasingly took over running the initiative from improvement partners KPMG. Year 1 Breakthrough Objectives are agreed and work was underway with the two divisions to develop local scorecards.

In discussion and questions, the following principal points were made:

a) Management's communication of Patient First needed to be clear and staff would need to have a clear understanding how the initiative affected them and how they could take part.
b) The initiative should lead to an improvement in performance and to patient experience
c) The initiative was long-term and work on it would continue at the next board seminar session for further discussion

4.0 Quality

4.1 Integrated Quality Performance Report

The Board received the Integrated Quality Performance report for April 2022. The Chair invited Evonne Hunt, Alison Davis and Jayne Black to provide highlights and updates for their areas.

The following principal points were noted:

a) The high numbers of Covid patients had been reducing in April
b) Emergency Department attendances including by ambulance had reduced slightly but acuity was often high – the performance against the 4 hour target was 72%, 12 hour breaches had reduced
c) There had been an increase in attendances by patients with mental health problems
d) The Trust's waiting list, its PTL remained at around 30,000, often waiting a first outpatient appointment. Jayne Black undertook to provide an update on the current position
e) There was good performance around two week cancer waits
f) Improving the rate of early discharges was a breakthrough objective
g) Mixed sex accommodation breaches continued to be an area of focus; issues often arose where patients were stepping down from intensive care
h) Work around collecting patient feedback and raising satisfaction rates continued
i) HSMR and SHMI were within expected ranges but there was an outlier alert for a particular set of conditions that was being reviewed

In response to a question at the last meeting regarding VTE assessments; it was noted that there were not expected to be contractual penalties in 2022/23. The data collection arrangements were being reviewed.

4.2 Quality Assurance Committee assurance report - 24 May 2022

The Board received the report from the committee. Tony Ullman highlighted that the committee had challenged data assurances and that the committee had also received information about meeting the needs of patients attending the hospital with complex needs and challenging behaviours.

4.3 CNST Quality Actions

The Chair welcomed Alison Herron the new Director of Maternity to the meeting and asked the Chief Nursing Officer to introduce the circulated report. Evonne Hunt advised that a detailed gap analysis against Ockenden 2 had been completed and there would be regular updates to the Board and Quality Assurance Committee.

Alison Herron informed the Board that the final submission on the safety actions was due in January 2023. Four actions were currently showing as off-track. There were some concerns about the processing of data that she was discussing with the Trust's Director of Business Intelligence. She believed that Action 5 on workforce planning was close to turning to green as appointments in the team were progressing over the summer. Work was also progressing around improving patient feedback.

Mark Spragg suggested that the Trust should consider some external review of its data in support of this important certification by the board.

4.4 Ockenden 2 (March 2022) Report Oversight and assurance

The Board received the report providing it with oversight and assurance on the Maternity Services' gap analysis against the recommendations raised by Ockenden 2.

The report described the range of 15 Immediate and Essential Actions (IEAs) arising from the report. 88 individual actions had been identified and 79 were on track, seven completed and two required national action.

4.5 Infection Prevention and Control Board Assurance Framework

The Board received the report on progress with the Infection Prevention and Control Board Assurance Framework (IPC BAF). It was noted that MFT had been stepped out of national surveillance and was now overseen by the Kent and Medway CCG. A number of trust improvement plans had been consolidated. Although over 50 actions were shown as overdue, this due to a temporary staff absence and work had resumed to address these by end of June 2022.

Actions signalled nationally under Living with Covid had been completed in March and April – this included stepping down isolation periods, changes to visiting and social distancing.

5 Financial Sustainability

5.1 Finance Report – Month 1

The Board received the month 1 finance report. A deficit of £0.5m was reported which was in line with the profile the Trust had submitted to NHS England. In terms of efficiencies, the Trust had a target of 2.83% (£9.6m) with a further stretch of £900k. Savings plans were in place for £5.8m and work continued to close the gap.

In its second draft operating plan, the Trust had submitted a £6.5m deficit position relating to unfunded inflationary pressures. Dialogue with NHS England had seen that reduced to £3.1m so the Trust was currently carrying a £3.4m risk. Executives would continue to monitor the situation.

5.2 Finance Committee Assurance Report Meeting: 28 April and 26 May 2022

The Board received the reports from the Finance, Planning and Performance Committee. Annyes Laheurte reminded the Board that the requirement under the Elective Recovery Fund was to achieve 104% of 2019/20 activity.

The BAF had been reviewed at both meetings and scores remained as;
Risk 3a Financial Control Total – 12, 3b capital investment – 12, 3c financial recovery plan – 16.

The committee had reviewed the business plan and financial recovery plan which were APPROVED by the Board.

6 People

6.1 Report of People Committee – 26 May 2022

The Board received the report of the People Committee. BAF risk 4a (clinical staffing) remained at 12. The committee had discussed the results of the latest Staff Survey which would continue at the 21 July meeting. It was noted that a reported spike in agency spend was largely an accounting feature, but there were concerns about increasing staff turnover which would be discussed at the July meeting.

It was noted that Patient First would be focusing on improving appraisal compliance.

7 Council of Governors Update

7.1 Cllr Brake gave an update from the Council of Governors. He advised that two new public governors for Swale would be joining on 01 July and that voting had started in a Staff Governor by-election. There were also elections in Medway constituency and for Rest of England and Wales.

Governors had attended the Dementia Action Week in May at the Pentagon Shopping Centre. There was a public event on Patient First on 05 July and a networking even on 12 July at the Sheppey Healthy Living Centre.

7.2 Questions from the Public

There were no questions received from the public.

Governor James Chespy placed a question in the meeting chat around the Trust's financial settlement for 2022/23. Alan Davies commented that the trust was receiving Elective Recovery Funding, but also faced an efficiency challenge. Financial support for Covid was being withdrawn. The Chair added that the Trust should aim to treat patients as close to home as possible and Alison Davis said improving the quality of services linked to achieving efficiency.

7.3 Any Other Business

There being no further business, the Chair closed the meeting.

Date of the next meeting: 03 August 2022, 12:30

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Wednesday, 08 June 2022

Signed …….. Date ……

Chair

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
08.06.22	TB/001/2022	Review of how Patient First will continue for Board Review Meeting	03.08.2022	PT - Chief Strategy and Transformation Officer	To update Board on 03 August 2022	
08.06.22	TB/002/2022	Safety Actions submission due Jan 2023, update on four actions showing 'off-track'	03.08.2022	AH - Directory of Midwifery	To update Board on 03 August 2022	

MeFit

NHS Medway NHS Foundation Trust

The Medway Prehabilitation Service

Patient Centered Multidisciplinary Integrated Care

Anaesthesia and Perioperative Care Group

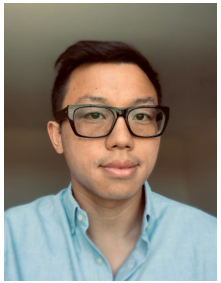
Dr Manisha Shah and Dr Chee Chu

Best of care Best of people

Our Medway

TEAM

Dr Manisha Shah – Lead Prehabilitation



Dr Chee Chu – Lead CPET

Dr Pavol Palcovic

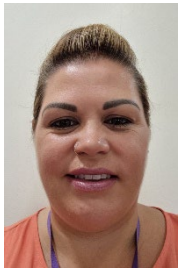
Dr Sam Black – Patient Information Lead RCOA

Dr Katina Damaskindou – Consultant Psychiatrist

Mr Sam Lovage – Exercise Physiologist

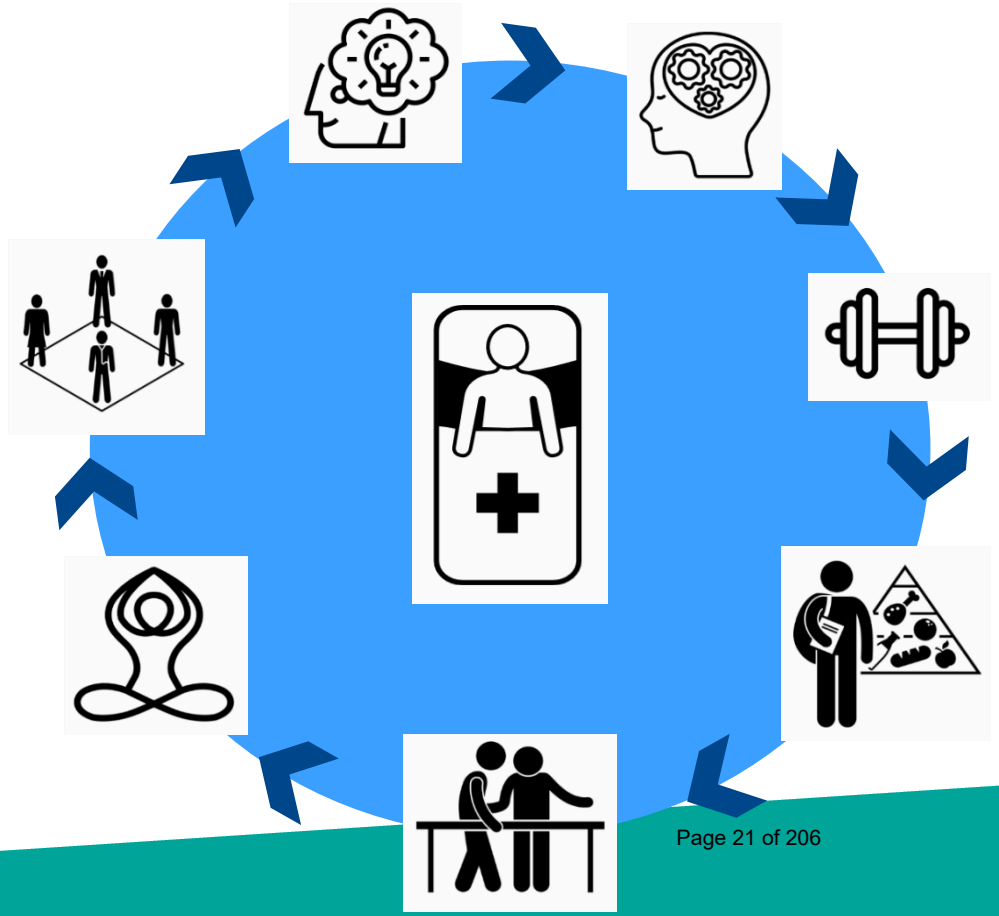
Dr Arthur Bossi (PhD) – Senior Exercise Physiologist

Mr Samuel Pierce – Prehabilitation Dietician



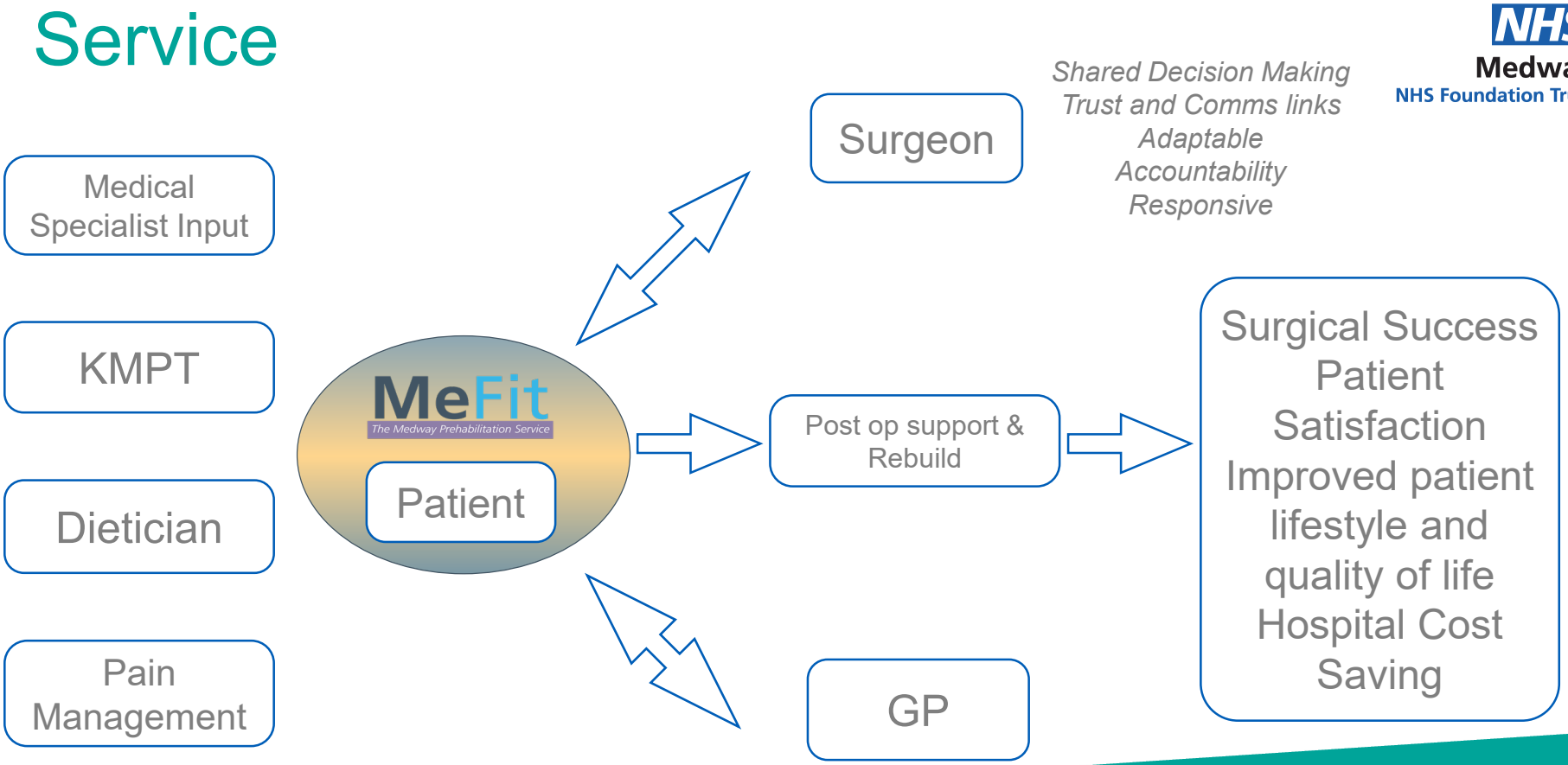
Ms Nadine Nihill

What is MeFit?



- **Patient FIRST**
- **GIRFT**
- **Medway's BEST**

Service



How can we help achieve 104% target?

- Reducing same day cancellations for major surgery (1.9% prehab to 5% no prehab).
- Reducing the length of stay after major surgery (6.45 days rehab to 7.15 days no prehab).
- Reducing readmissions following major surgery on sicker patients.

Help high risk patient choose the less risky treatment for them.

NHS Medway NHS Foundation Trust

- 28.35% of our patients were supported to have discussions about best treatment for them.
- 75.8% of high risk cancer patients then, chose less invasive surgery, non surgical option or no treatment.

Other benefits of this service – Patient satisfaction

NHS Medway NHS Foundation Trust

- 98% of the patients felt that this service help them prepare physically and mentally for major surgery.
- 95.4% of patient agreed that MeFit has made them feel in control of their treatment.

Other benefits of this service

NHS Medway NHS Foundation Trust

- Participation in national, local research.
- Collaboration with Kent and Medway partnership trust and University of Kent.
- Being the only hospital in Kent to provide this service.
- Finalist in HSJ value awards in 2021.

Feedback

NHS Medway NHS Foundation Trust

“I was treated not only as a body to be tested and sampled but as a person who had fears, questions and needed help on how to best help myself to prepare for what was to come. Whilst I was reasonably active and mobile, I was overweight with high blood pressure, resulting from a poor diet of processed meals/sweet snacks and drinks with my only exercise being walking. That changed in February, and I was physically in a better place come the operation. That was the first goal obviously, but having made such a commitment to myself and to Arthur, with his continued direction, I have continued the same approach, losing weight positively since through complete healthy eating practices, with a normal blood pressure level and continued varied exercises. “Life changing” is an over-used phrase, but for me, changing my bad habits of 50 years plus, is a reality.”

“I have been treated as an intelligent, honest person who is trying her best on the programme, not just as someone on a list who has to be processed, as has happened at other stages in my recent meetings with NHS professionals.”

Feedback

NHS Medway NHS Foundation Trust

“Furthermore, in a time when patients are more likely to encounter a series faceless bureaucratic walls and, although I understand the need for budget control, continued underfunding is causing more apathetic and delayed responses. As a patient, I often feel stuck between departments, opposing methodologies (and understandings) or both. Finding someone prepared to listen, yet adhere to the rules, and to take time to understand, yet know the limitations of the service they are responsible to, is priceless. Quite simply this team is the sweet filing in what is usually a rather bland sandwich. Thank you again.”

“I underwent major surgery, a Radicle Cystectomy to start with but during the operation the cancer had spread to the sigmoid Colon which was also removed. After such surgery I was, of course, unwell and unable to manage much at all. However, the dedication and encouragement of Sam certainly 'got me going'. I realised I needed to put the work in to get back to any 'normal' sort of way of life. He visited whist I was in hospital and encouraged me to do 'circuits' of the ward.

Upon discharge I received invaluable advice and information via telephone and emails which would include examples of safe exercises. Also, as I have, unexpectedly 2 stomas, he went above and beyond to provide online information, recommending suitable materials I could access at home via the internet. This was most helpful for me to be able to build up my strength and fitness safely at home. I have to admit that the were often days when I didn't feel like doing anything. However, if I noticed I was due a call it would make me 'get on with it' which I needed at the beginning.”

Meeting of the Public Board
Wednesday, 03 August 2022

<table>
<tr><td>Title of Report</td><td colspan="2">Board Assurance Framework (BAF)</td><td>Agenda Item</td><td>4.1</td></tr>
<tr><td>Report Author</td><td colspan="4">David Seabrooke, Company Secretary</td></tr>
<tr><td>Lead Director</td><td colspan="4">Leon Hinton, Chief People Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="4">A summary of the BAF in May/June 2022 is presented in this paper.

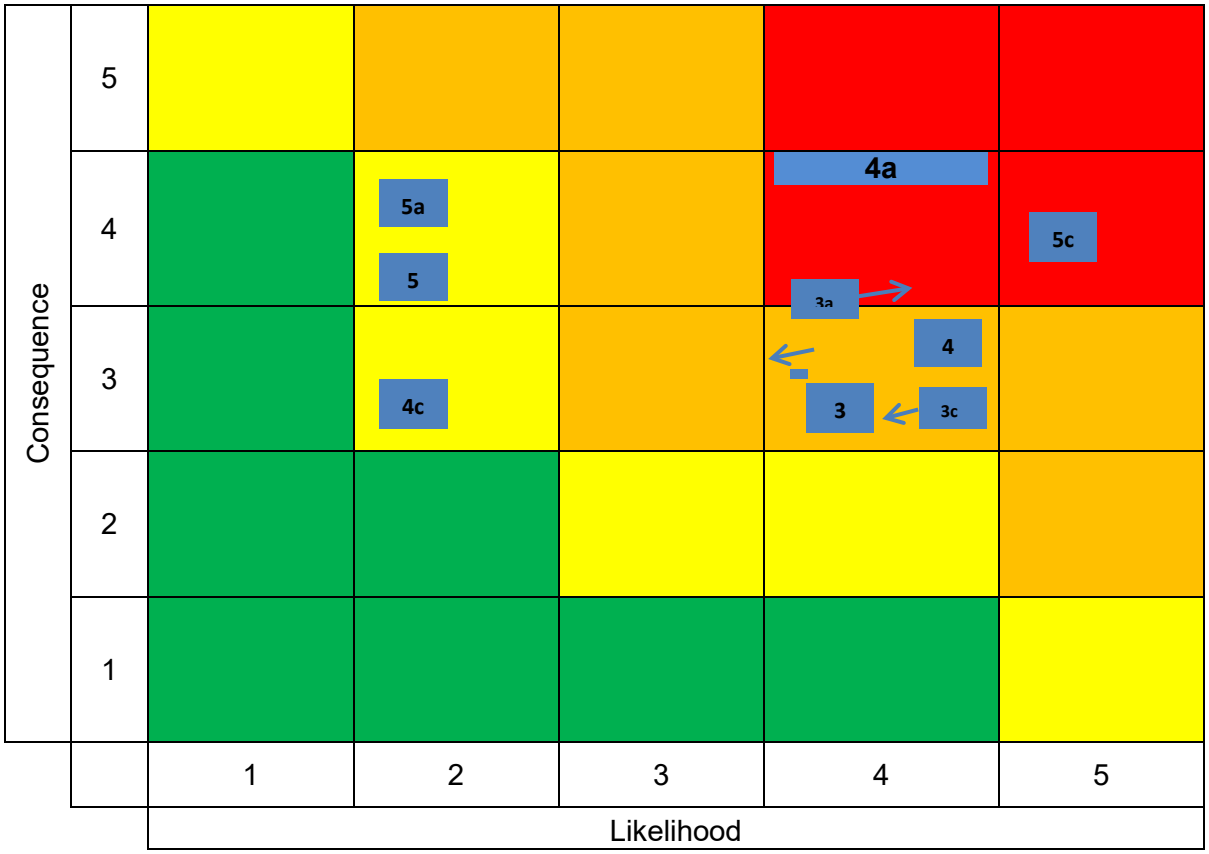
The Trust's two principal risks are currently:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>May 22</th></tr>
<tr><td>A risk that the Trust is unable to meet the constitutional standards for emergency and elective access</td><td>6</td><td>16</td><td>20</td></tr>
<tr><td>Delivery of Financial Control Total</td><td>4</td><td>16</td><td>16</td></tr>
</table>
</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="4">The Board last reviewed the BAF at its 11 May 2022 meeting.

The Finance Planning and Performance Committee reviews its section of BAF at every monthly meeting, so assessments are available for May and June.
The Quality Assurance Committee reviewed its BAF in May. The recommendation from the QAC July review is described in the committee's report.
The People Committee reviews its BAF at every bi-monthly meeting - assessments are available for May.</td></tr>
<tr><td>Resource Implications</td><td colspan="4">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="4">N/A</td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="4">N/A</td></tr>
<tr><td>Recommendation/ Actions required</td><td colspan="4">The Board is asked to NOTE the report for assurance regarding the processes in place around risk management.
<table>
<tr><th>Approval</th><th>Assurance</th><th>Discussion</th><th>Noting</th></tr>
<tr><td>☐</td><td>☒</td><td>☐</td><td>☒</td></tr>
</table>
</td></tr>
</table>

1 Board Assurance Framework – summary of movement

Detailed below is the overview of BAF risk movement for this period.



1-4	Very Low
5-8	Low
9-15	Moderate
16-25	High

Residual Risk to Target

BAF Risk tracker

May is the latest month where full information is available. Scores for QAC (4) and People (5) have been rolled forward from May.

	Target Score	Initial Score	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Apr-22	May-22	Jun-22
1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12			
2a. Future IT strategy	6	16	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9			
2b. Capacity and Capability		9	12	12	12	12	12	6	6	6	6	6	6	6	6	6	6	6	6	6	6						
2c. Funding for investment		9	9	9	9	9	9	6	6	6	6	6	6	6	6	6	6	6	6	6	6						
3a. Delivery of financial control total	9	16	6	9	9	9	9	9	16	16	16	8	8	16	16	16	16	16	16	16	16	16	16	12	12	12	16
3b. Capital Investment	12	16	20	20	20	20	20	20	12	12	12	12	12	16	16	16	16	16	16	16	16	12	12	12	12	12	12
3c. Failure to achieve long term financial sustainability	4	16	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	16	16	12
3d. Going concern		12	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4							
4a. Sufficient staffing of clinical areas	6	16	12	12	12	12	12	12	12	12	12	12	15	15	15	15	15	15	15	15	15	15	16	16	12	12	12
4b. Staff engagement	6	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
4c. Best staff to deliver the best care	6	12	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
5a. CQC Progress	4	16	16	16	16	12	12	12	12	12	12	12	12	9	9	9	9	9	9	9	9	8	8	8	8	8	8
5b. Failure to meet requirements of Health and Social Care Act	4	16	16	16	16	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	8	8	8	8	8	8
5c. Patient flow – Capacity and demand	8	12	12	12	12	12	12	9	9	16	16	16	16	9	9	12	12	16	16	20	20	20	20	20	20	20	20
Total Risk Score	71	242	174	173	173	165	165	153	152	175	175	167	139	141	141	144	144	148	148	152	148	130	131	127	106	106	
Residual Risk to Target Gap			77	76	76	64	64	52	51	70	70	62	65	36	36	39	39	43	43	47	45	60	57	51	52	49	

Meeting of the Board of Directors in Public
Wednesday, 03 August 2022

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	5.1
Report Author	Evonne Hunt, Chief Nursing Officer Alison Davis, Chief Medical Officer Mandy Woodley, Chief Operating Officer Alan Davies, Chief Financial Officer Leon Hinton, Chief People Officer		
Lead Director	Paula Tinniswood, Chief Strategy and Transformation Officer		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators for the June 2022 reporting period. **Safe** Our Infection Prevention and Control performance for June shows that the Trust is reporting 1 MRSA bacteraemia case and 11 hospital acquired C-diff cases against a threshold of 34 which is an increase of 4 in June. HSMR for the reporting period of April 2021 - March 2022 is 101.9, weekend is 113.8 and weekday is 98.9; all within the 'as expected' banding. **Caring** MSA continues on a downward trajectory with 69 breaches recorded (against 162 in March reporting period). The Friends and Family recommended rates for two areas remain above the national standard of 85% for this reporting period for Outpatients (88.4%) and Maternity (99.7%) whilst two areas remain below the national standard, Inpatients (77.4%) and ED (65.1%). **Effective** Pre-noon discharges are remaining above the lower levels seen before and during the high occupancy levels during the early periods of the pandemic sitting at 18% which is an increase from 16.9%. Work is on-going with our ward staff and system partners to continue to improve discharge information and metrics to support improvement and have confirmed this required improvement as one of our Patient First Breakthrough Objectives (40% of discharges prior to midday). **Responsive** The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In May the RTT standard was 63.6% and the Trust recorded 158, 52 week breaches. ED (Type 1) 4 hour performance has reduced since last reporting period moving to 58.5%. Additionally, the Trust saw a decrease in Ambulance Handover delays of +60mins decreasing to 136. The DM01 Diagnostics performance decreased slightly to 75.7%.		

	We also see a continued improvement in 2 week waits on the cancer pathway, with 96.4% of patients seen within 2 weeks of their referrals into the cancer pathways. **Well Led** We continue to see a stable position in appraisal rates, reporting 83.8%, which is an increase from 81% and the Trust has 83.5% compliance with statutory and mandatory training in this reporting period.
Resource Implications	None
Legal Implications/Regulatory Requirements	All indicators are monitored by CQC.
Quality Impact Assessment	Not required.
Recommendation/ Actions required	The Board is asked to NOTE the discussions that have taken place and discuss any further changes required.

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	Appendix 1 – IQPR June 2022

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: June 2022

NHS Medway NHS Foundation Trust

What is Statistical Process Control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

The IQPR incorporates the use of SPC charts to identify **Common Cause** and **Special Cause** variation and NHS Improvement SPC Icons, which replaces the traditional RAG rating format in favour of Icons to show SPC **variation (trend)** and **assurance (target)** to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using Statistical Process Control (SPC) charts is to understand what is **different** and what is **normal** to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether KPIs are improving.

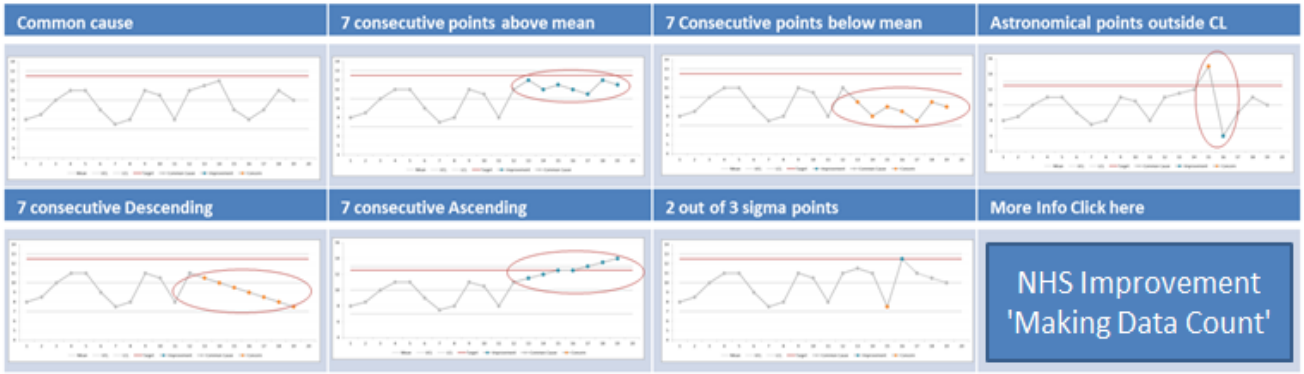
Key Facts about a SPC Chart:

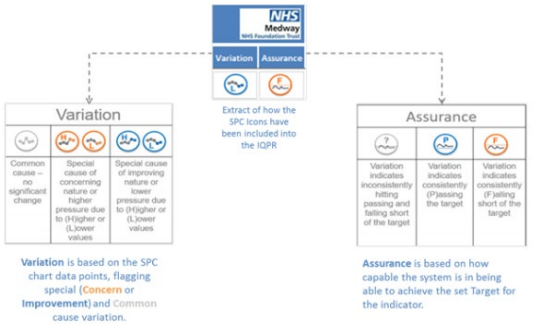
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

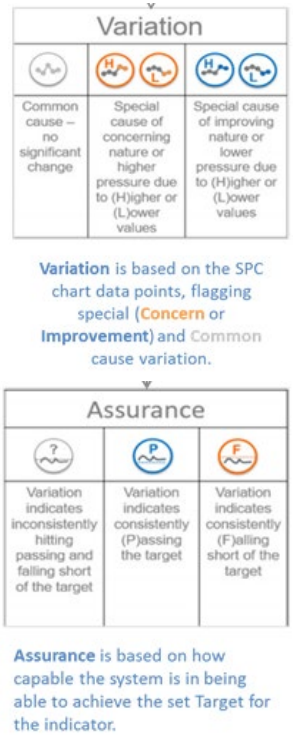
Contains a mean (the average), **lower and upper confidence levels**. 99% of all data will fall between the lower and upper confidence levels. If a data point falls outside these levels, an investigation would be triggered.

Contains two types of trend variation: Special Cause (Concern or Improvement) and Common Cause.

Below are examples of SPC trends that define common or special variation which will support understanding the variation Icons:







NHS Medway NHS Foundation Trust

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Cancer & Patient Flow improvement	• RTT & Emergency Pathways
Caring	• Both Maternity & Outpatients FFT % Recommended is over target • The number of Complaints received is consistently achieving under plan	• High number of breaches in Mixed Sex Accommodation continues (although the last 7 data points is under Mean) • % Complaints responded to within target has declined • Inpatient & ED FFT scores are showing sign of decline
Effective	• Discharges before Noon showing high statistical variation, and signs of improvement • 7 Day Readmission Rate showing improved statistical variation	• High statistical variance in C-Section rates evidenced • Fractured NOF significantly below target • VTE Risk Assessment % has dropped below lower confidence limit
Safe	• PU Incidence continuously passes (achieves under) the target set & Falls per 1,000 Bed Days under target • 0 Never Events reported • Both HSMR and SHMI have all shown a statistically significant improvement	• E-Coli cases and C-Diff acquisitions are above plan YTD and in month
Responsive	• Cancer Pathways continue to show improvement • DToC levels & Elective LoS show continued signs of improvement	• ED % Target has declined together with number of 12hr breaches increasing • RTT Incomplete Performance consistent • Bed Occupancy showing high statistical variance
Well Led	• Maintained compliance with Trust target for StatMan Compliance YTD • Agency staff spend is below plan	• Turnover Rate shows an increase in statistical variance • Bank spend has stabilised but is still over plan • Sickness Rates have also stabilised but above plan

NHS Medway NHS Foundation Trust

Executive Summary

TRUST

CQC Domain	CQC Sub Domain	Variation					Assurance			
			L	H	L	H	P	F	?	
Caring	Admitted Care	2	2	0	1	0	0	1	4	0
	ED Care	1	1	0	0	0	0	1	1	0
	Maternity Care	2	0	0	0	0	1	0	1	0
	Outpatients Care	1	1	0	0	0	1	1	0	0
Effective	Best Practice	3	1	0	1	0	0	2	3	0
	Maternity	1	0	3	0	0	0	2	2	0
Responsive	Bed Management	1	0	2	1	0	2	2	0	0
	Cancer Access	4	0	0	0	1	0	0	5	0
	Diagnostic Access	0	1	0	0	0	0	1	0	0
	ED Access	2	2	0	0	0	0	2	2	0
	Elective Access	1	1	1	0	0	0	3	0	0
	Theatres & Critical Care	2	0	0	0	0	0	0	2	0
Safe	Infection Control	1	0	0	0	0	1	0	0	0
	Mortality	1	0	0	4	0	0	1	1	3
Well Led	Workforce	4	2	1	0	1	1	0	6	1

Variation

Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Variation is based on the SPC chart data points, flagging special (**Concern** or **Improvement**) and Common cause variation.

Assurance

Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Assurance is based on how capable the system is in being able to achieve the set Target for the indicator.

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
S1	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	3	4	43	66		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	4	0			
S3	MRSA Bacteraemia (Trust Attributable)	0	0	5			
S4	E-coli (Trust Acquired) Infections	2	5	30			
S5	Falls Per 1000 Bed Days	6.63	4.33	6.63			
S6	Pressure Ulcer Incidence Per 1000 days (High Harm)	1.04	0	1.04			
S7	Never Events	0	0	0			
S8	% of SIs Responded To In 60 Days	100.0%	100.0 %	100.0%			
S9	HSMR (All)	100	92.70	100	0.97		
S10	HSMR (Weekday)	100	89.94	100	0.94		
S11	HSMR (Weekend)	100	101.42	100	1.05		
S12	SHMI	1	1.06	-	23.19		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R2	Average Non-Elective Length of Stay	5	9.45	5	8.63		
R3	Average Elective Length of Stay	5	2.74	5	2.33		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	0.0%	4.0%	0.6%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	17.3%	7.0%	13.0%		
R6	ED 4 Hour Performance All Types	95.0%	68.6%	95.0%	78.1%		
R7	ED 4 Hour Performance Type 1	95.0%	58.5%	95.0%	68.6%		
R8	ED 12 hour DTA Breaches	0	23	0	885		
R9	Number of ED arrivals by Ambulance	-	3,066	-	86,550		
R10	60 Mins Ambulance Handover Delays	0	136	0	5,316		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	72.7%	99.0%	79.1%		
R12	18 Weeks RTT Incomplete Performance	92.0%	62.6%	92.0%	64.5%		
R13	18 Weeks RTT Over 52 Week Breaches	0	202	0	5,788		
R14	Operations Cancelled By Hospital on Day	0	5	0	307		
R15	Cancelled Operations Not Rescheduled < 28 days	0	1	0	50		
R16	Cancer 2ww Performance	93.0%	96.4%	93.0%	95.8%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	93.2%	93.0%	90.9%		
R18	Cancer 31 Day First Treatment Performance	96.0%	100.0 %	96.0%	97.6%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	86.5%	85.0%	77.1%		
R20	104 Day Cancer Waits	0	1	-	64		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	69	0	2,839		
C2	Number of Complaints	41	37	-			
C3	% Complaints Responded to Within 30 Days	85.0%	13.5%	85.0%			
C4	% of EDNs Completed Within 24hrs	100.0%	70.8%	100.0%	68.7%		
C5	Inpatients Friends & Family Response Rate	22.0%	18.6%	22.0%	18.6%		
C6	Inpatients Friends & Family % Recommended	85.0%	77.4%	85.0%	79.1%		
C7	ED Friends & Family Response Rate	22.0%	14.0%	22.0%	14.6%		
C8	ED Friends & Family % Recommended	85.0%	65.1%	85.0%	78.8%		
C9	Maternity Friends & Family Response Rate	22.0%	25.4%	22.0%	25.5%		
C10	Maternity Friends & Family % Recommended	85.0%	99.7%	85.0%	99.7%		
C11	Outpatients Friends & Family Response Rate	22.0%	8.1%	22.0%	9.3%		
C12	Outpatients Friends & Family % Recommended	85.0%	88.4%	85.0%	89.0%		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	5.7%	5.0%	6.4%		
E2	30 Day Readmission Rate	10.0%	10.8%	10.0%	12.4%		
E3	Discharges Before Noon	25.0%	18.0%	25.0%	16.6%		
E4	Fractured NOF Within 36 Hours	100.0%	69.2%	100.0%	69.0%		
E5	VTE Risk Assessment % Completed	95.0%	88.2%	95.0%	94.9%		
E6	Elective C-Section Rate	13.0%	17.3%	13.0%	14.9%		
E7	Total C-Section Rate	28.0%	46.7%	28.0%	38.5%		
E8	Emergency C-Section Rate	15.0%	29.4%	15.0%	23.7%		
E9	12+6 Risk Assessment	90.0%	85.3%	90.0%	84.8%		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	83.8%	-	83.6%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	4.5%	4.0%	4.9%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	16.0%	12.0%	13.1%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	83.5%	85.0%	88.6%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,405	-	113,278.16		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	2.6%	4.0%	2.9%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	16.6%	9.0%	13.1%		

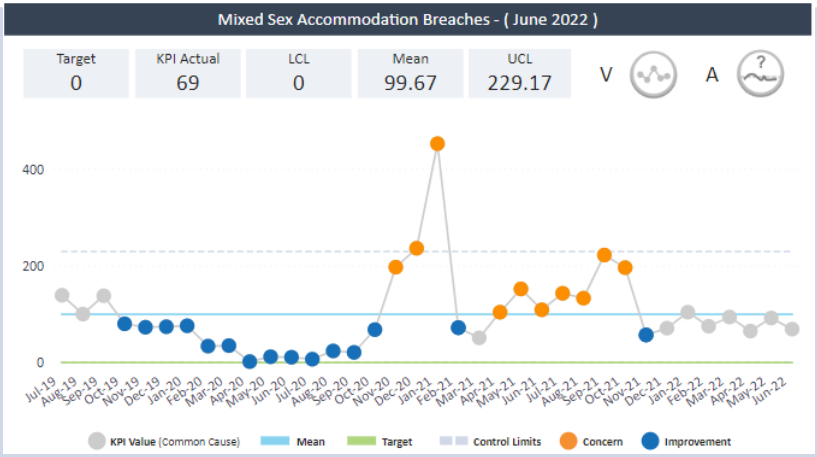
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Jun-22	100.0%	70.8%	63.8%	69.7%	75.7%		
		Inpatients Friends & Family % Recommended	Jun-22	85.0%	77.4%	74.3%	81.1%	87.8%		
		Inpatients Friends & Family Response Rate	Jun-22	22.0%	18.6%	15.8%	19.3%	22.8%		
		Mixed Sex Accommodation Breaches	Jun-22	0	69	0	99.67	229.17		
		MSA %	Jun-22	0.0%	0.0%	0.0%	0.6%	1.6%		
	ED Care	ED Friends & Family % Recommended	Jun-22	85.0%	65.1%	69.7%	79.2%	88.6%		
		ED Friends & Family Response Rate	Jun-22	22.0%	14.0%	12.5%	14.6%	16.8%		
	Maternity Care	Maternity Friends & Family % Recommended	Jun-22	85.0%	99.7%	98.8%	99.6%	100.5%		
		Maternity Friends & Family Response Rate	Jun-22	22.0%	25.4%	9.7%	23.8%	38.0%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Jun-22	85.0%	88.4%	87.4%	89.6%	91.9%		
		Outpatients Friends & Family Response Rate	Jun-22	22.0%	8.1%	8.9%	10.9%	12.9%		

Safe: Mixed Sex Accommodation (MSA)
Aim: Reduction in mixed sex accommodation
Latest Period: June 2022

Executive Lead: Evonne Hunt
Operational Lead: Heidi Jeffrey/Dan West
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Mixed Sex Accommodation Breaches



Outcome Measure: Mixed Sex Accommodation Breaches By Ward

Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Arethusa/SAU											18			
Bronte		4	7		14				4		6			
Byron														6
Critical Care Unit														
Dolphin Ward		4	4	2			1							
Emerald Assessment Unit											19			
Emerald Short Stay Ward											2			
Intensive Care Unit	20	11	3	6	1	5	2	2	8	12	1	7	2	15
McCulloch Ward	7		19		3	15			1					
Harvey Ward														
Jade Ward						4	4		12			8		
Keats Ward		3			14						3			
Lawrence Ward	2			2	7									
Lister Assessment Unit	12	16	43		34	22					40			
Nelson Ward	8		6		5	10								
Ocelot					29	32	1		5					
Pembroke Ward			7	15										
Phoenix Ward														
Pre Op Care Unit														
Sapphire Ward	2	9	3	57	25	24								
SDEC		2	2											
Sunderland Day Case Centre					5	19							6	
Surgical Assessment Unit		12		7	20					3				
Theatre Intensive Care Unit														
Trafalgar Ward SHDU	45	47	46	33	86	65	46	69	74	60	73	50	84	48
Tennyson Ward														
Wakeley		1		5										
Victory				6										
Will Adams	7		3		8		4							
Totals	103	109	143	133	251	196	58	71	104	75	162	65	92	69

What do the outcome measures show?

The SPC data point is showing special cause variation of a low improving nature. Bed availability and patient flow continue to be challenging throughout the Trust.

The unjustified breaches of MSA recorded relate to the inability to step down patients within four hours from Critical Care areas to Level 1 ward based care.

In June on Byron ward the DDON agreed a breach for a terminally ill patient (husband and wife both patients in the Trust) to be nursed together with partner for end of life care

What changes have been implemented and improvements made?

There is continual monitoring of patient safety to ensure that where possible patients are informed and bed moves are prioritised and facilitated to correct any breaches.

There is continued collaborative working within the divisions, site team and IPC to minimise any unjustified mix sex accommodation breaches other than areas with covid patients and assessment areas within the Trust.

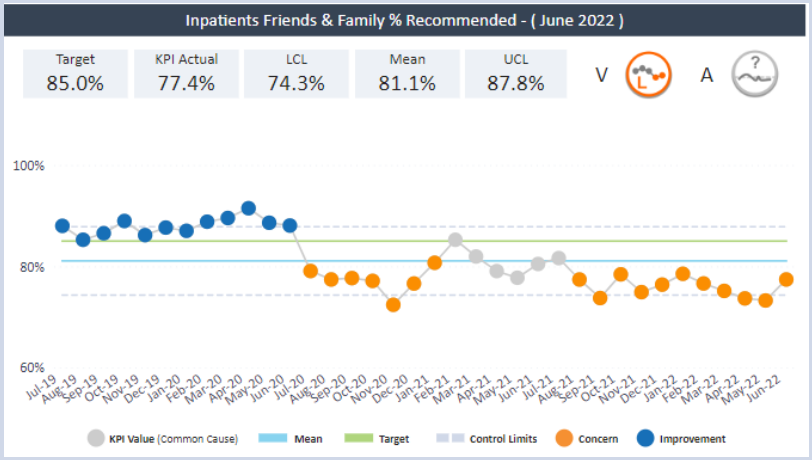
Discussion continues with BI team to improve the accuracy of reporting and reduce the burden of validation as the Trust transitions from Extramed platform to EPR

Patient Centred: IP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt
Operational Lead: Heidi Jeffrey
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Inpatient Friends & Family % Recommended

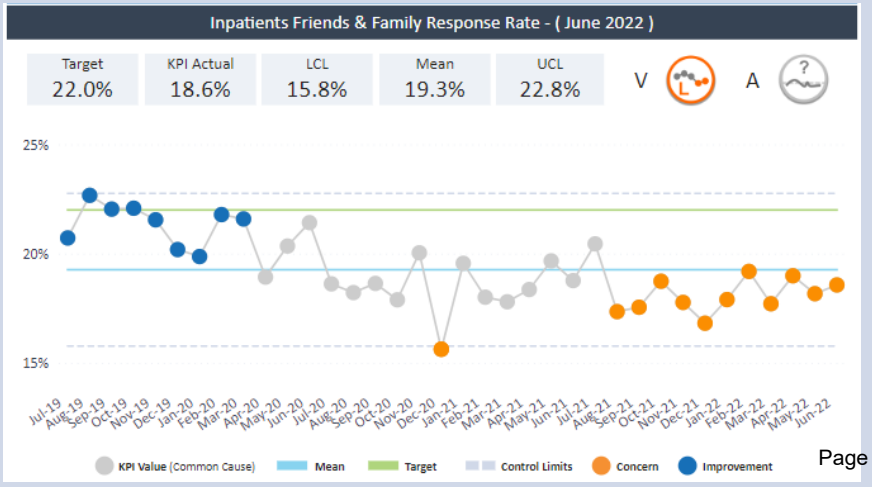


What changes have been implemented and improvements made?

The recommend rate is for May is similar to that of April at 18.15% which is below the national average. The following areas have receive above average recommend rates; Bronte 100%, Harvey 100%, McCulloch 90% and Ocelot

The following areas are showing an improved recommend rate; Emerald 83.33% and Sunderland Day Case 91.67%

Outcome Measure: Inpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate for May for inpatients is very similar to the last reporting month; April 22. Overall the response rate is 18.15% which is below the national average. High scoring areas include Bronte 24%, Lister 20.25% and Nelson 20%, the following areas have shown an improvement from last month; Keats has increased from 15.79% to 17.65 and Wakeley has increased from 9.80% to 28.57%.

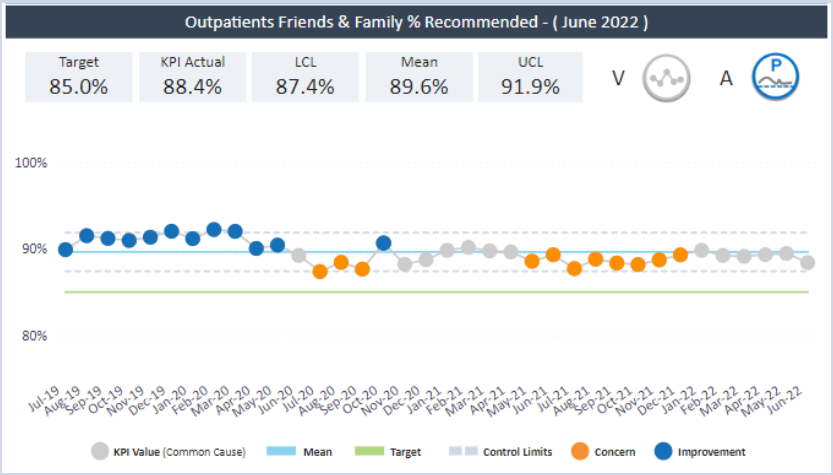
The following areas have shown a marked decreased in their response rate; Tennyson, Pembroke and Milton

Patient Centred: OP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt
Operational Lead: Heidi Jeffrey
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

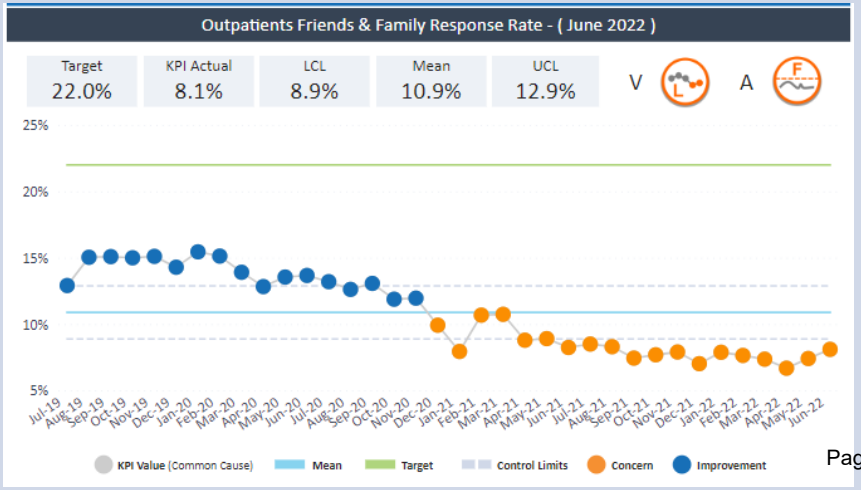
Outcome Measure: Outpatient Friends & Family % Recommended



What changes have been implemented and improvements made?

The outpatient recommend rate is consistently above 89% which demonstrates that many patients are happy with their outpatient experience.

Outcome Measure: Outpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate has been poor at less than 8%. The department has been issuing their own paper feedback survey for patients who attend their appointment and this may reflect the lower response rate as patients may not wish to give their feedback twice.

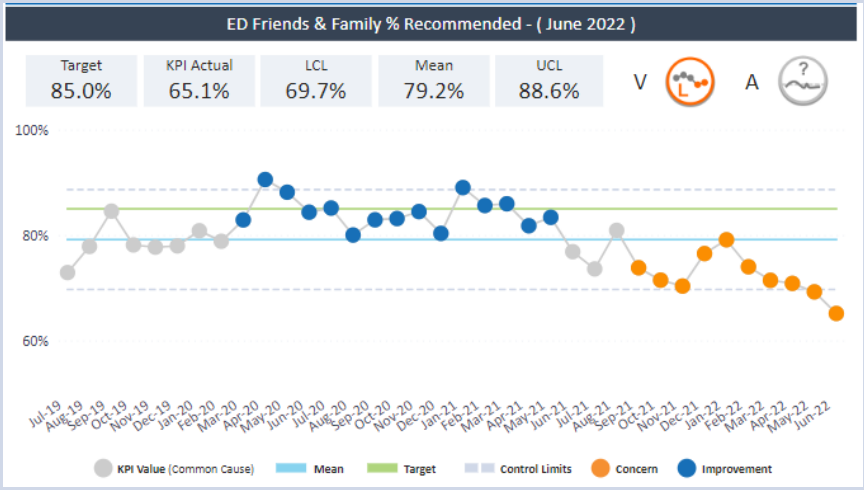
The recommendation is to channel as much feedback as possible through the Friends and Family Test.

Patient Centred: ED Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt
Operational Lead: Heidi Jeffrey
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: ED Friends & Family % Recommended

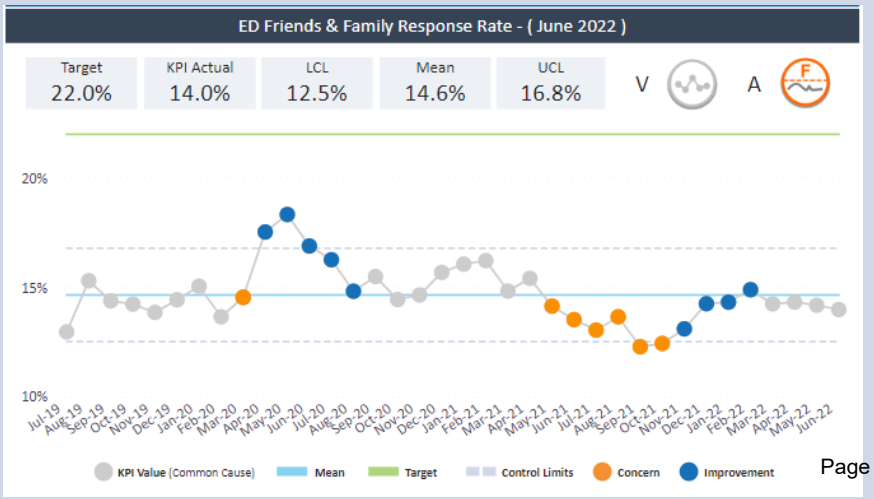


What changes have been implemented and improvements made?

The recommend rated for ED is 69.24% which is similar to the previous month. The rate has fallen slowly over a period of time since early 2021, with the exception in January and February this year.

The newly appointed Head of Nursing has been keen to engage patient feedback and the patient experience team will work with him to explore ways of robustly capturing it.

Outcome Measure: ED Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate for ED is consistently around 14% which is higher than the national average. Some patients who visit the department frequently will be excluded from the survey due to survey fatigue.

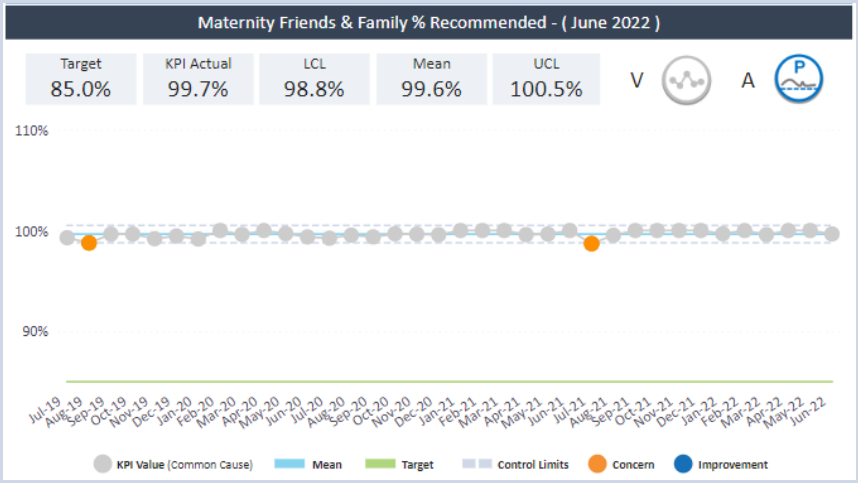
Having a system in ED which patients can use before they leave the department would be beneficial for this group of patients and this will be explored.

Patient Centred: Mat Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt
Operational Lead: Heidi Jeffrey
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

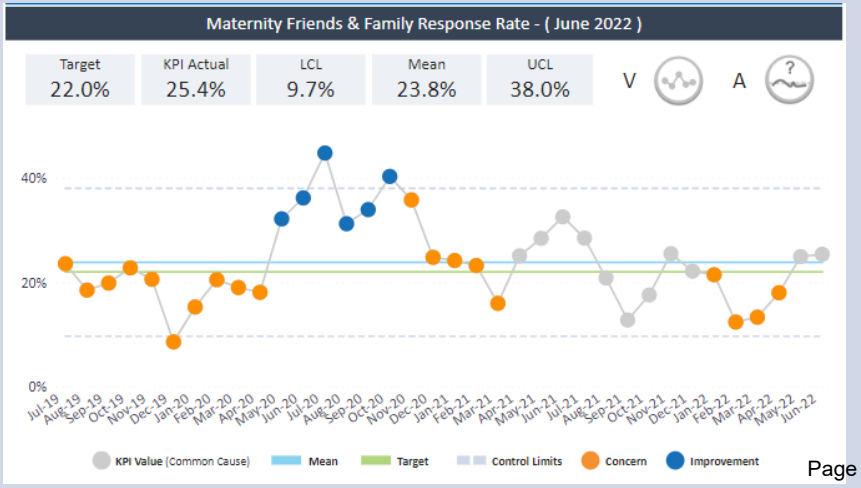
Outcome Measure: Maternity Friends & Family % Recommended



What changes have been implemented and improvements made?

Above target and very positive result of 100% of women and birthing people recommending the maternity service in month.

Outcome Measure: Maternity Friends & Family % Response Rate



What changes have been implemented and improvements made?

Increase of 6% in response rates from 18.02% up to 24.94% in May taking us above the mean

Bespoke maternity FFT questions confirmed and will be implemented once DOM approval has been given (currently reviewing).

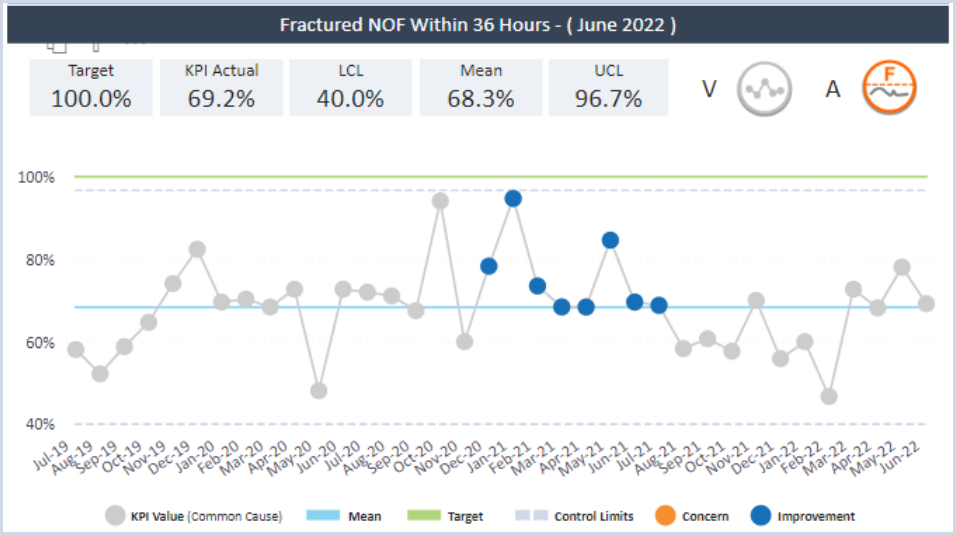
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	May-22	10.0%	10.8%	9.6%	12.3%	15.0%		
		7 Day Readmission Rate	May-22	5.0%	5.7%	4.4%	6.4%	8.4%		
		Discharges Before Noon	Jun-22	25.0%	18.0%	12.9%	16.0%	19.2%		
		Fractured NOF Within 36 Hours	Jun-22	100.0%	69.2%	40.0%	68.3%	96.7%		
		VTE Risk Assessment % Completed	Jun-22	95.0%	88.2%	91.3%	95.0%	98.7%		
	Maternity	12+6 Risk Assessment	Mar-22	90.0%	85.3%	78.6%	84.3%	90.1%		
		Elective C-Section Rate	Jun-22	13.0%	17.3%	10.6%	14.6%	18.7%		
		Emergency C-Section Rate	Jun-22	15.0%	29.4%	16.9%	22.6%	28.3%		
		Total C-Section Rate	Jun-22	28.0%	46.7%	30.9%	37.2%	43.5%		

Effective: Fracture NOF Within 36 Hours
Aim: TBC
Latest Period: June 2022

Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Howard Cottam
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Process Measure: Fractured NOF Within 36 Hours



What do the outcome measures show?

All breaches in the time to theatre this month were due to the need for medical optimisation prior to surgery.

What changes have been implemented and improvements made?

Hip fracture group met again on Friday (17th June), with agreement to formally relaunch the hip fracture pathway. Of note, SECAmb will reinstate mechanisms so that crew will dial in directly to into ED practitioner to alert and commence pathway; and the dedicated 'red' beds have been reinstated and will be protected, facilitating flow through ED.

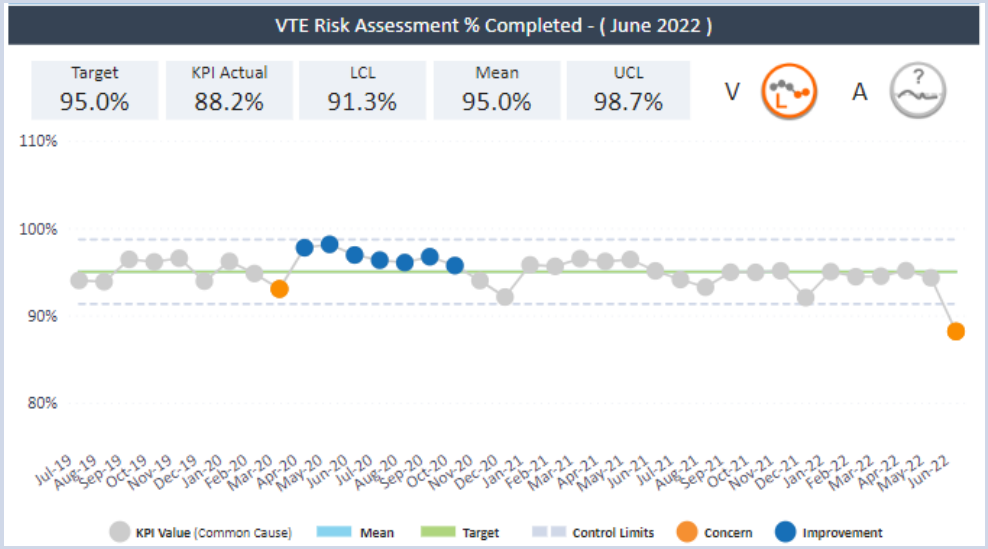
The process will be monitored and audited for compliance. Most pleasing, is the positive engagement between the departments in facilitating this clinical pathway, and ultimately care for this patient group.

Effective: VTE Risk Assessments
Aim: TBC
Latest Period: June 2022

Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: VTE Risk Assessments Completed



What does the measure show?

The venous thromboembolism (VTE) risk assessment data collection is used to inform a national quality requirement in the NHS Standard Contract, which sets an operational standard of 95% of inpatients (aged 16 and over at the time of admission) undergoing risk assessments each month.
Since December the VTE team have worked hard to achieve the 95% target. The chart shows that we haven't quite met the target in March and April, but the actual figures for each month are 95.04% and 95.60%. May currently sits at 93.70%, drug charts are being looked at every day to bring the percentage up to 95%. Various challenges we have encountered this month are, PAHU not having any sort of admin, so it has been solely the responsibility of the VTE team to manage this area, also, Arethusa/SAU have had a change in admin staff and they now seem to be struggling to enter their data, again relying on the VTE team. As a team we struggle to get data entered in a timely manner due the two team members only being part time.

What changes have been implemented and improvements made?

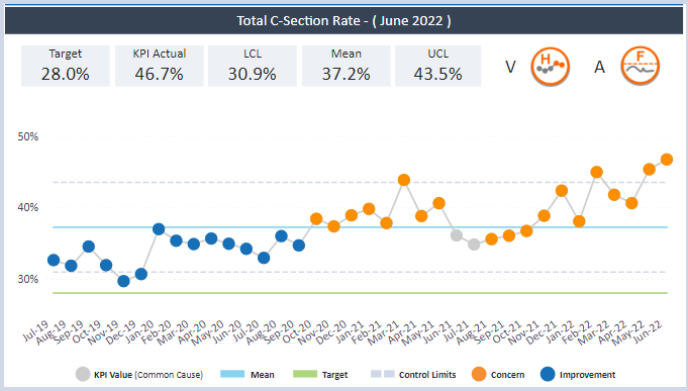
- Continuing to send regular VTE reports to the care groups who have wards
- We have recently been introduced to Gather, this will enable other modalities to see their own VTE data and take action against non-compliance
- An imminent change in management will hopefully provide more support to the VTE service
- VTE risk assessments will be included in the next rollout of EPR making the entering of risk assessments easier to track
- The use of EPR will encourage a better use of the VTE risk assessment, so clinicians will find it harder to skip the process

Effective: Maternity
Aim: TBC – Currently Under Development
Latest Period: June 2022

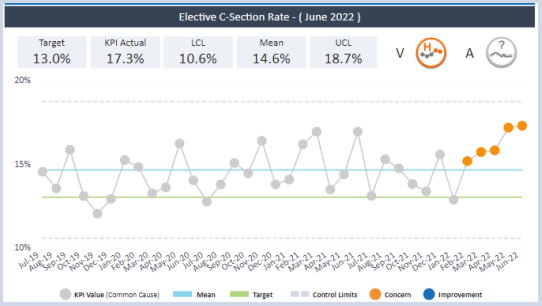
Executive Lead: Evonne Hunt
Operational Lead: Katherine Harris
Sub Groups: Quality Assurance Committee

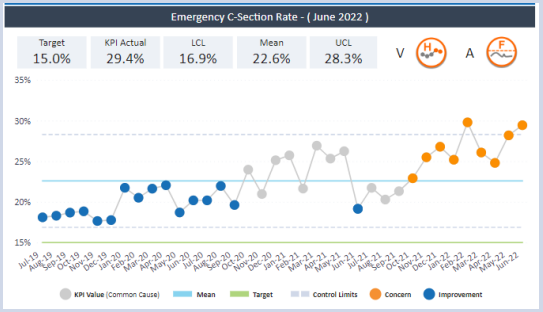
NHS Medway NHS Foundation Trust

Outcome Measure: Total Elective & Emergency C-Section Rate



Outcome Measure: Elective and Emergency C-Section Rate





What does the measure show?

The total caesarean section rate has increased slightly from last month to 45.34% which is just above the higher confidence level. The total caesarean rate is influenced by an increase in both emergency and elective rates. Elective caesarean rates are under the higher confidence level and there is a 3 year strategy in place to address the number of emergency caesarean sections. Robson group 2a (Nulliparous, singleton, cephalic, ≥37 weeks gestation, induced labour) and Robson group 5 (previous CS, singleton, cephalic, ≥37 weeks gestation) are the highest contributor to the caesarean section rate. Audit will focus in this area and an induction of labour review has been commissioned by DOM/CD with a task and finish group commencing in July 22

What changes have been implemented and improvements made?

There is increased Consultant presence on delivery suite to supervise doctors in training, and have oversight and expertise in decision making, and to enable instrumental delivery rather than caesarean section where appropriate.

Twice daily (morning and evening) Consultant led MDT ward round on delivery suite

The daily caesarean section audit continues, awaiting the preliminary results.

Audit of IOL pathway, capacity and demand, task commencing July 22.

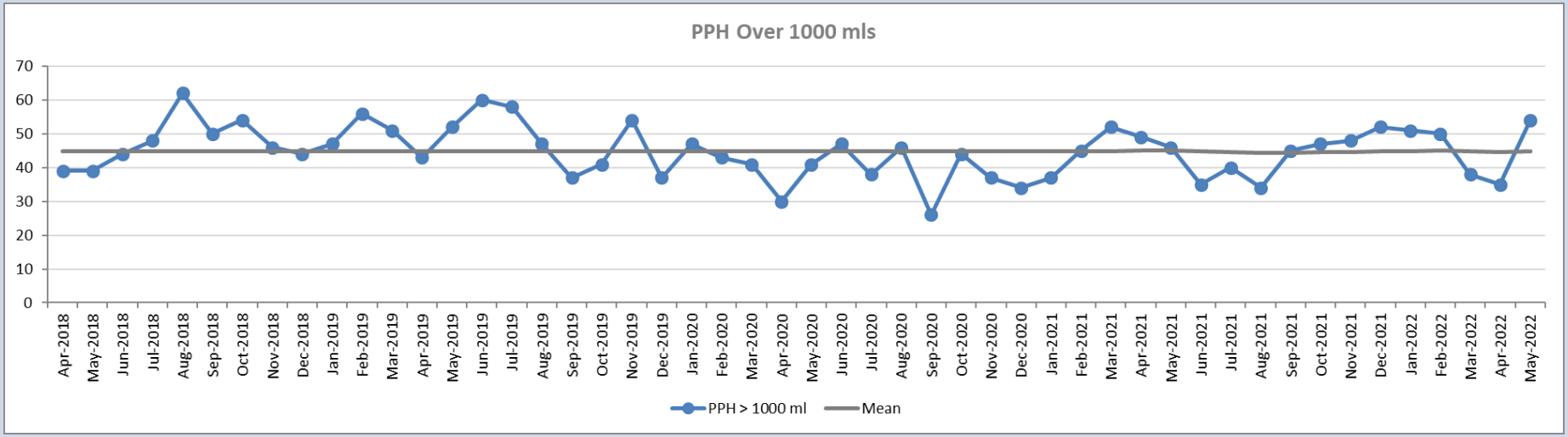
A review of the birth place criteria and pathway will be undertaken alongside the IOL review.

Effective: Maternity
Aim: TBC – Currently Under Development
Latest Period: May 2022

Executive Lead: Evonne Hunt
Operational Lead: Katherine Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: PPH Over 1000 mls



What changes have been implemented and improvements made?

Evidence demonstrates that PPH can be reduced by avoiding unnecessary inductions/augmentations of labour - a review of the IOL pathway, capacity and demand has been commissioned by the DOM/CD and induction of labour task and finish group to commence in July 22

Labour Ward lead obstetrician and Lead pharmacist for Women's planning a trial to implement carbetocin at elective caesarean sections to see if it reduces blood loss, date of commencement to be confirmed.

Domain: Safe Dashboard

Executive Lead: Evonne Hunt–Chief Nursing Officer
Alison Davis – Chief Medical Officer
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

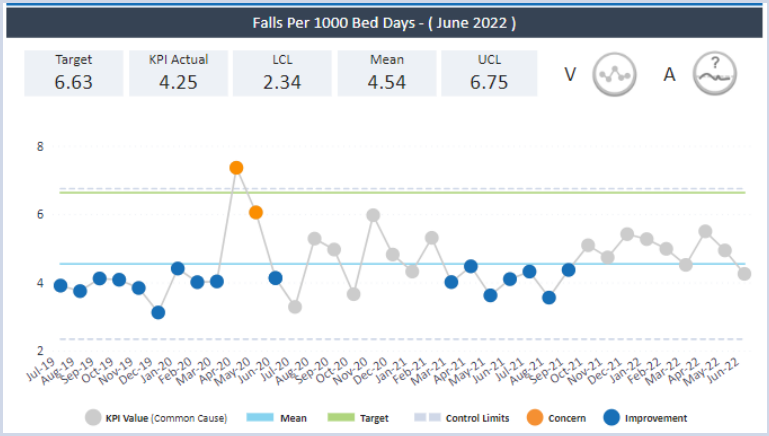
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Jun-22	6.63	4.33	2.35	4.55	6.76		
		Pressure Ulcer Incidence Per 1000 days (High Harm)	Jun-22	1.04	0	0	0	0.03		
	Incident Reporting	% of SIs Responded To In 60 Days	May-22		100.0%	3.7%	59.5%	115.3%		
		Never Events	Jun-22	0	0	0	0.17	0.93		
		No of SIs on STEIS	Jun-22	90	0	0	14.28	31.91		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	May-22	43 [43]	4	0	2.46	8.17		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Jun-22		4	0	2.33	6.63		
		E-coli (Trust Acquired) Infections	Jun-22	0	5	0	3.23	6.75		
		MRSA Bacteraemia (Trust Attributable)	Jun-22	0	0	0	0.03	0.18		
	Mortality	Crude Mortality Rate	Jun-22	2.5%	1.5%	0.4%	1.9%	3.4%		
		HSMR (All)	Mar-22	100	92.70		98.06			
		HSMR (Weekday)	Mar-22	100	89.94		94.60			
		HSMR (Weekend)	Mar-22	100	101.42		107.74			
		SHMI	Jan-22	1	1.06	1.04	1.07	1.10		

Safe: Falls management and reduction
Aim: 12% reduction in number of falls with harm
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days

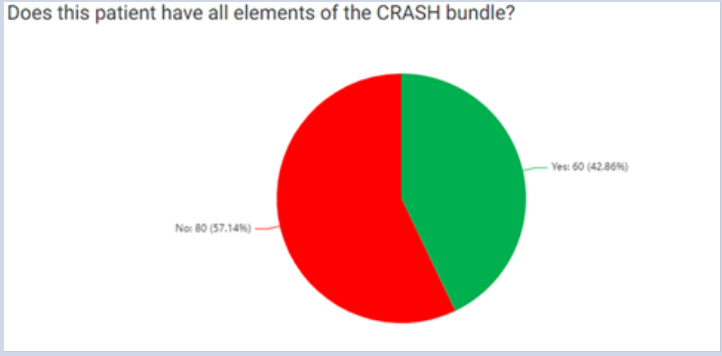


What do the outcome measures show?

80% of falls occurred in Unplanned care (size of division and specialties and additional escalation beds),
83% of falls were unwitnessed
29% of falls were on level ground (predominantly whilst patient walking)
12% of falls occurred between 7-8pm and 9% between 12-1pm.
21% of falls across the Trust occurred on a Monday
The number of patients who have fallen previously on this admission increased from 7-13 this month

Month	Total Falls	No and low harm	Moderate harm	Severe harm/ Death
June- 22	75	74	0	1
June -21	65	65	0	0
May-22	79	79	0	0
Apr-22	95	92	1	1

Process measure: 95% Crash Bundle Reliability (Pilot wards)



What do the process measures show?

43% of patients had all elements of the CRASH Bundle being completed compared to 45% in May.
Pie chart to demonstrate the number of patients who have received all elements of the CRASH Bundle.
The key consistent themes continue to be, call bell out of reach and lying and standing blood pressure recording, although improvement has been demonstrated, results remain unchanged this month.

What changes have been implemented and improvements made?

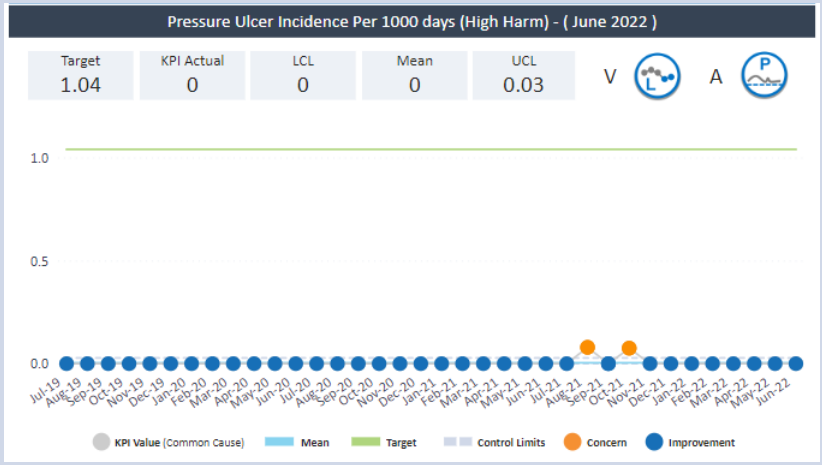
To date, 14 wards and the Emergency Department have undergone data examination with A3 problem solving methodology to fully discover root causes in order to identify appropriate solutions.
Currently 9 wards have quality improvement plans at the “do” stage of the PDSA cycle (Plan, Do Study, Act).
An update on progress and achievement will be presented to QAC in September

Safe: Pressure Damage Reduction
Aim: 10% Reduction in Hospital Acquired Pressure Ulcers
Latest Period: June 2022

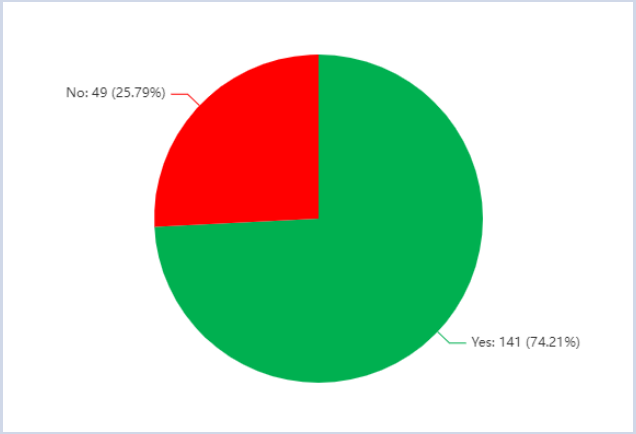
Executive Lead: Evonne Hunt
Operational Lead: Hayley Jones
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Pressure Ulcer Incidence Per 1000 days (High Harm)



Process Measures: ASSKING Bundle Reliability (Pilot Wards)



What do the outcome measures show?

60% of hospital acquired pressure ulcers were within Unplanned care
40% of hospital acquired pressure ulcers were within Planned care
Tennyson, Pembroke, and Will Adams ward had 2 or more HAPU's.

Hospital Acquired pressure ulcers HAPU

Month	Total HAPU	low harm	Moderate harm	Severe harm/ Death
June 2022	15	15		
june 2021	17	17		
may 22	25	25		
April - 22	24	23	1	

Category 2	Category 3	Category 4	DTI	Unstagable	Total
5			6	4	15

Pressure Ulcer's on admission (POA)

Category 1	Category 2	Category 3	Category 4	DTI	Unstagable	Total
2	121	6	1	11	20	161

What do the process measures show?

The Trust scored 85.6% in the ASSKING audit in June 2022, with 168 audits completed. Improvement seen in;

	June 2022	March 2022
Skin	85.1	52%
Incontinence	76.2	53%

What changes have been implemented and improvements made?

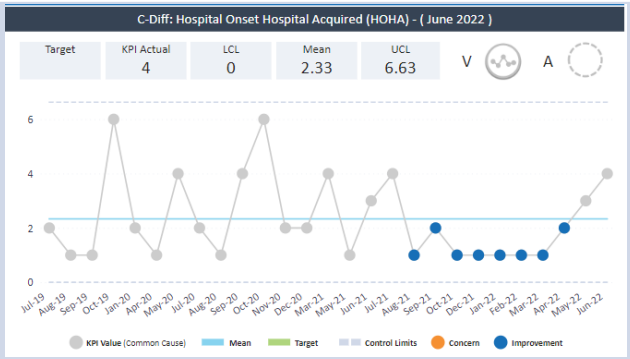
5 wards are undergoing an improvement approach using an A3 problem solving methodology. is being utilized across the Trust. Interrogation of data for each ward who acquire more than two pressure ulcer a month underway and will form a deep dive report for each area which will be presented at QAC

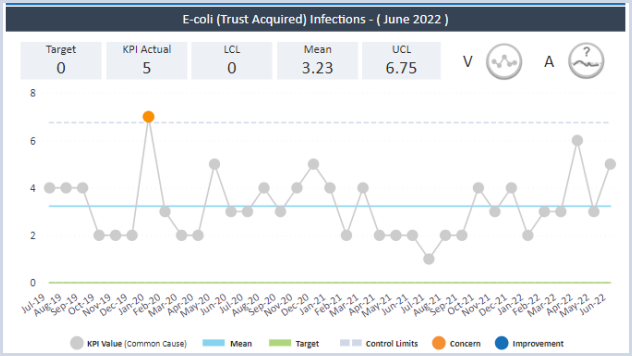
Safe: Improving Infection Control
Aim: Reduction in healthcare acquired infections.
Latest Period: June 2022

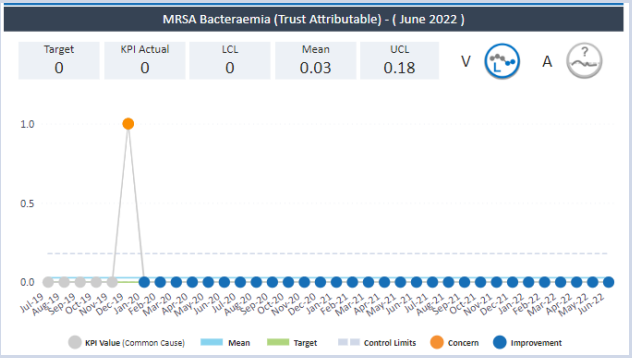
Executive Lead: Evonne Hunt
Operational Lead: Steph Gorman
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Infection Prevention Control measures







What do the outcome measures show?

MFT continue to work to achieve their thresholds in 22/23. With the 1 MRSA Bacteremia MFT has breached that threshold. The below numbers are cumulative for the year.
MRSA Bacteremia 1 HOHA with 0 new cases in May
C.Difficile rates since 1st April 2022 is 11 HOHA's against a threshold of 34 which is an increase of 4 in June.
E.Coli : 15 against a threshold of 77 which is an increase of 5 in June.
Klebsiella : 3 against a threshold of 37 with 0 cases in June.
Pseudomonas : 1 against a threshold of 17 0 cases in June

What do the process measures show?

C.Difficile is 1 above this point 21/22. E.coli is 5 above this point last year but Klebsiella and Pseudomonas are below

What changes have been implemented and improvements made?

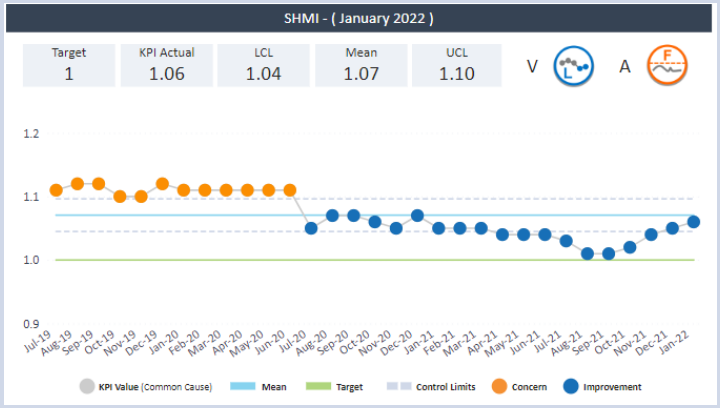
- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- IPC operational group involving SSR's, Matrons have now had 3 meetings and is reporting monthly to IPCG
- ANTT competency assessments are to be added to the core assessment skills for new nurses
- Commode cleanliness task and finish group has met for 3 weeks – agreed competency document, frequency of checks, initiating commode champions. Still to confirm is type of commode, frequency of competency assessments, type of cleaning product and video on how to clean

Effective: Mortality
Aim: TBC
Latest Period: SHMI Reporting Period: Jan-22
HSMR Reporting Period: Mar-22

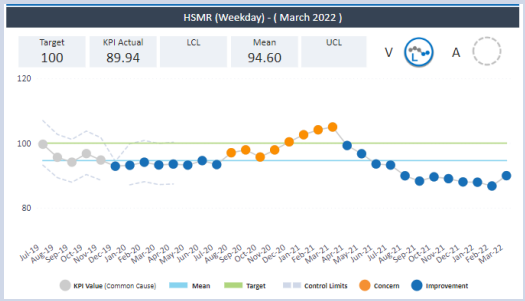
Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

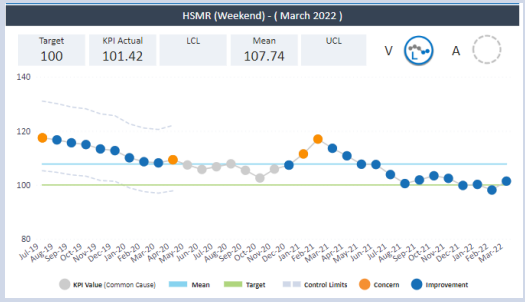
NHS Medway NHS Foundation Trust

Outcome Measure: SHMI Mortality



Outcome Measure: HSMR Weekend and Weekday Mortality





What do the measures show?

The trust's SHMI for December 20 – November 21 is 1.04, and is within the 'as expected' range for the reporting period of May 2022. The trust remains within the 'as expected' range for all 10 diagnosis groups indicated of the trusts performance.
The trust's weekend HSMR is 112.2 and weekday HSMR 98.2, both within the 'as expected' range.

What changes have been implemented and improvements made?

The mortality team recently worked with Dr Foster to get an insight into the weekend HSMR, these are a summary of the findings:

- Medway admit a higher proportion of spells at the weekend for elder patients (65+); with higher comorbidity scores (20+); palliative; and ultimately, higher risk of mortality.
- Conversely, midweek(and particularly Wednesday) is associated with the opposing picture: younger, less comorbid, more non-palliative, and lower risks of mortality.
- As a result, there is evidence to suggest that the quality of documentation at the weekend is good –but crucially, that there is clear evidence of more complex care required over the weekend
- Day of admission (and by extension weekend/weekday admissions) is not a factor adjusted for within the HSMR model, resulting in it possible to have higher relative risk for the weekend
- Therefore, while key to note weekend HSMR, we can say with some confidence that it is anticipated HSMR will and should be higher at the weekend because of more complex, unplanned admissions
- Moreover, trends in weekend HSMR are downwards; Medway are well within national control limits, and report as 'within expected' and ultimately, these should continue to be monitored but current performance does not raise alarm bells

Domain: Responsive – Non Elective Dashboard

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Bed Management	% Medically Fit For Discharge Point Prevalence in Month	Jun-22	7.0%	17.3%	11.7%	14.7%	17.7%		
		% of Delayed Transfer of Care Point Prevalence in Month	Jun-22	3.5%	0.0%	0.0%	1.0%	2.0%		
		Average Elective Length of Stay	Jun-22	5	2.74	1.45	2.36	3.28		
		Average Non-Elective Length of Stay	Jun-22	5	9.45	7.38	8.70	10.02		
		Delayed Transfer of Care Point Prevalence in Month	Jun-22		0	0	152.44	315.01		
		Escalation Beds Open Point Prevalence in Month	Jun-22	0	0	0	0	0		
		Medically Fit For Discharge Point Prevalence in Month	Jun-22		2,997	1,700.74	2,268.31	2,835.87		
	Complaints Management	% Complaints Responded to Within 30 Days	Jun-22	85.0%	13.5%	0.0%	12.8%	32.1%		
		Number of Complaints	Jun-22	41	37	16.27	46.44	76.62		
	ED Access	30 Mins Ambulance Handover Delays	Jun-22	0	935	289.50	694.81	1,100.11		
		60 Mins Ambulance Handover Delays	Jun-22	0	136	0	171.61	376.51		
		ED 12 hour DTA Breaches	Jun-22	0	23	0	31.64	100.42		
		ED 4 Hour Performance All Types	Jun-22	95.0%	68.6%	71.3%	79.0%	86.6%		
		ED 4 Hour Performance Type 1	Jun-22	95.0%	58.5%	58.7%	69.6%	80.5%		
		Median Time to Ambulance Assessment (15mins)	Jun-22	15	44	11.34	19.01	26.69		
		Median Time to ED Clinician (60mins)	Jun-22	60	78	28.06	41.67	55.27		
		Number of ED arrivals by Ambulance	Jun-22		3,066	2,526.93	3,264.67	4,002.40		

Domain: Responsive – Elective Dashboard

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

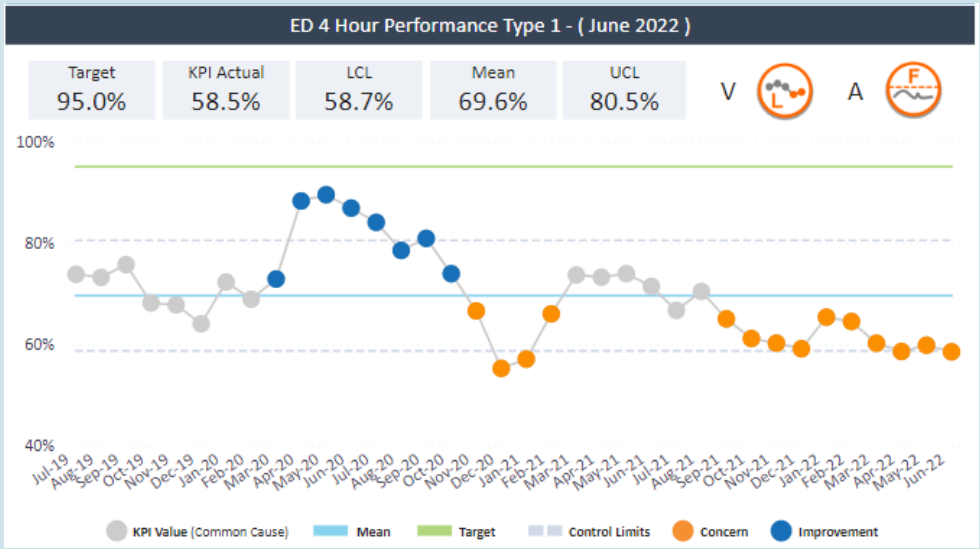
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	May-22	0	1	0	1.83	4.57		
		Cancer 28 Faster Diagnosis	May-22	75.0%	79.8%	49.6%	67.2%	84.7%		
		Cancer 28 Faster Diagnosis - Breast Symptomatic	May-22	75.0%	98.1%	28.2%	86.8%	145.5%		
		Cancer 28 Faster Diagnosis Screening	May-22	75.0%	65.9%	0.0%	44.4%	116.0%		
		Cancer 2ww Performance	May-22	93.0%	96.4%	92.3%	95.7%	99.1%		
		Cancer 2ww Performance - Breast Symptomatic	May-22	93.0%	93.2%	71.5%	90.4%	109.4%		
		Cancer 31 Day First Treatment Performance	May-22	96.0%	100.0%	92.2%	97.4%	102.6%		
		Cancer 31 Day Subsequent Treatments (Drugs)	May-22	98.0%	100.0%	88.1%	96.4%	104.8%		
		Cancer 31 Day Subsequent Treatments (Surgery)	May-22	94.0%	100.0%	69.8%	93.3%	116.7%		
		Cancer 62 Day Treatment - Cons Upgrades	May-22		60.0%	43.5%	73.4%	103.2%		
		Cancer 62 Day Treatment - GP Refs	May-22	85.0%	86.5%	57.9%	75.9%	93.9%		
		Cancer 62 Day Treatment - Screening Refs	May-22	90.0%	85.0%	16.8%	70.5%	124.1%		
	Diagnostic Access	DM01 Performance	Jun-22	99.0%	72.7%	69.9%	84.2%	98.4%		
	Elective Access	18 Weeks RTT Incomplete Performance	Jun-22	92.0%	62.6%	62.3%	69.0%	75.6%		
		18 Weeks RTT Over 52 Week Breaches	Jun-22	0	202	39.24	160.92	282.59		
		Daycase Rate	Jun-22	85.0%	64.0%	60.2%	67.3%	74.4%		
		DNA Rate	Jun-22	10.0%	8.8%	6.7%	7.8%	9.0%		
		First to Follow Up Ratio	Jun-22		2.56	2.14	2.59	3.04		
		PTL Size	Jun-22	22,477	32,075	22,501.86	23,960.83	25,419.81		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	May-22	0	1	0	1.80	7.28		
		Operations Cancelled By Hospital on Day	Jun-22	0	5	0	14.42	33.95		
		Urgent Operations Cancelled for the 2nd Time	Jun-22	0	0	0	0.03	0.18		

Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Dawn Sullivan
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

The proportion of Accident & Emergency (A&E) attendances that are admitted, transferred or discharged within 4 hours of arrival.

What the Chart is Telling Us:

Whilst the recent 4 hour performance is still cause for concern, it has stabilised in recent months

Actions:

- Focus on 4 hour performance now a formal part of site agenda.
- Predict, Escalate and Prevent overarching ED flow model is in place.
- HARIS review completed to target enhanced performance
- Patient First metrics agreed which will support front door flow
- Review ECIST recommendations and strategise into workable actions and solutions
- Employment of full senior operational team

Outcomes:

- Rapid Assessment Unit – ambulance offload area swapping out policy is in place and enacted proactively to prevent ambulance offload delays.
- 4hr ED standard is being enforced with daily breach validation analysis carried out

Underlying issues and risks:

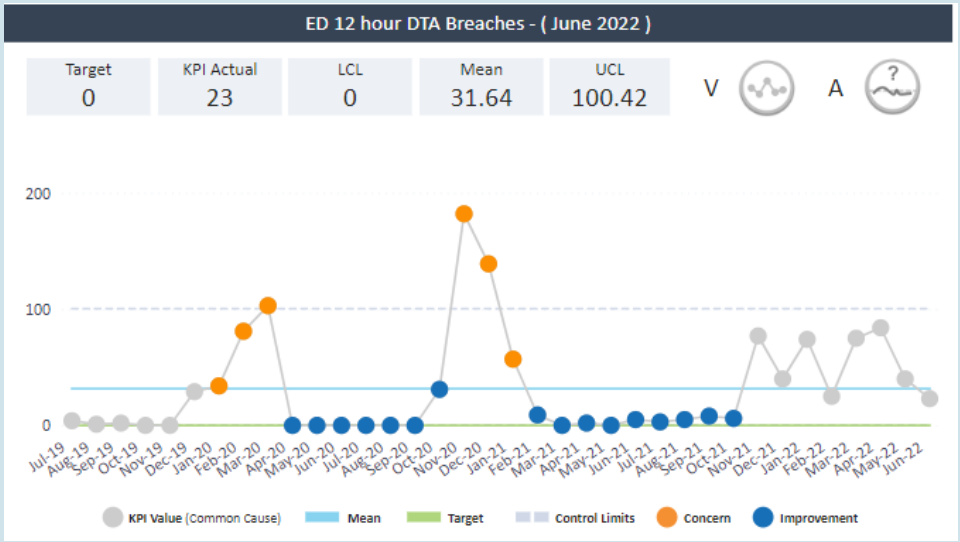
- Underlying bed deficit, and use of escalation areas places increased demands on medical, nursing and therapy workforce.
- Lack of operational team to monitor and support flow, with a preventative overview and direct liaison with stakeholders

Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Sunny Chada (DCOO)
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

The proportion of Accident & Emergency (A&E) attendances that are admitted, transferred or discharged within 12 hours of arrival.

What the Chart is Telling Us:

There has been a reduction in 12 hour breaches in the reporting period, with the position significantly improved from April 2022

Actions:

- Active use of escalation triggers managed via site team.
- Site Management attendance at ED sit reps.
- Identification of patients clinically ready to proceed.
- Protection of SAU and PAHU to support enhanced flow.

Outcomes:

- Use of inpatient PTL system to track confirmed and potential discharges, enabling the matching of demand and capacity
- Use of escalation areas to facilitate timely transfer into an appropriate bed and decongest ED
- Focus of HARIS project to ease ED flow and hence enhance bed capacity

Underlying issues and risks:

- Underlying bed deficit,
- Use of escalation areas placing increased demands on medical, nursing and therapy workforce.
- Blocking of assessment areas due to capacity constraints
- High numbers of medically fit for discharge patients.
- Diagnostic equipment issues causing delays in clinical decision making, discharge planning and LOS

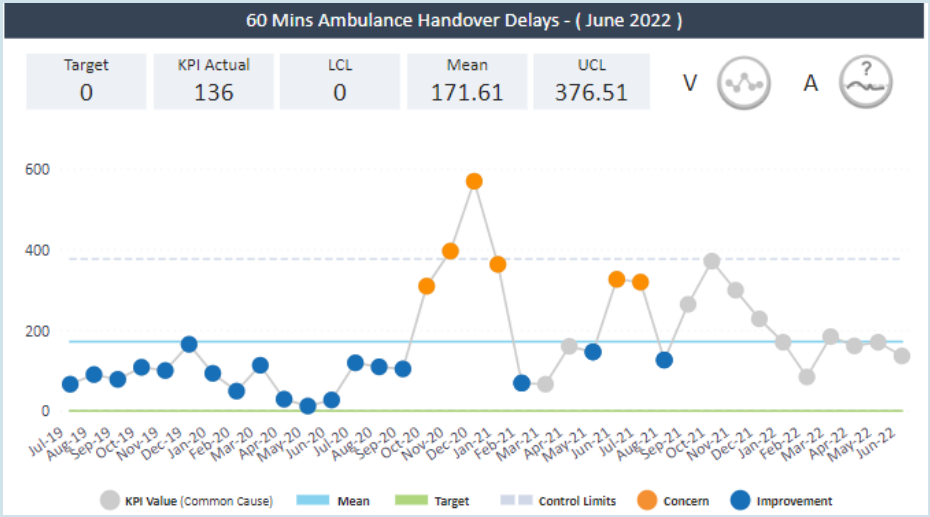
EC 4 Hour Benchmarking

Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Dawn Sullivan
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

The total number of Accident & Emergency (A&E) attendances where the patient is not offloaded within 60 minutes of arrival

What the Chart is Telling Us:

The SPC data point is showing an stark improvement on recent months, but is still above the target of zero instances.

Actions:

- A granular focus on performance is taken within ED supported by site management and Executive focus.
- Specific focus is now required on evening and early morning breaches.
- A system wide ambulance offload improvement action plan is in place, managed through the fortnightly SECAmb & Medway meeting led by the DDO UIC. Reporting into the AEC Steering group and LAEDB monthly meetings.

Outcomes:

- Rapid Assessment Unit - ambulance offload area and 'Ready to Proceed' patients identified and in place (from Majors).
- Alternatives to hospital conveyance are utilised.
- An ED front door streaming nurse is in place and ambulances can be directed to UTC, MEDOC, EAU without the need for offloading into RAU if assessed and streamed.
- HARIS project aims to further review appropriateness of arrivals and hence ease burden on ED

Underlying issues and risks:

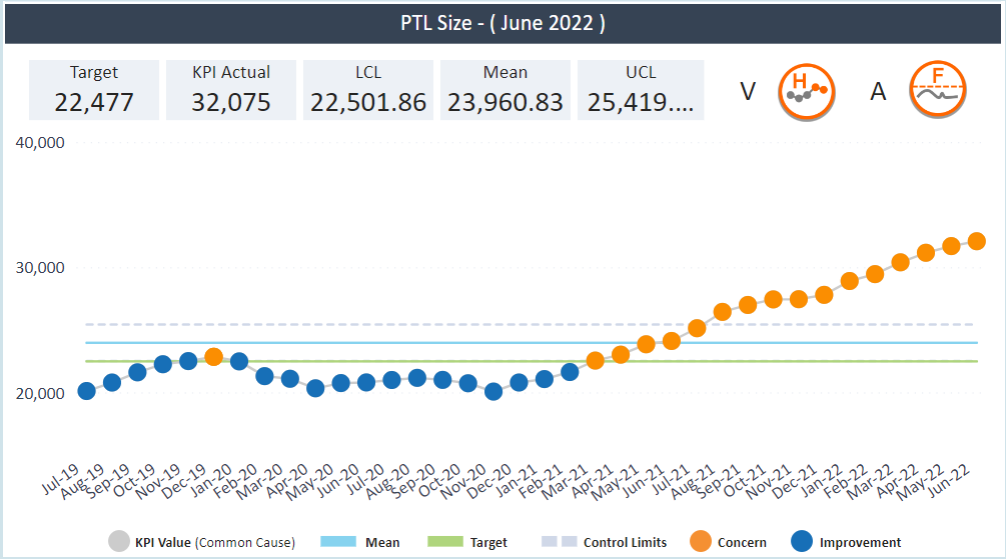
- Early morning bed availability remains a challenge and relates to the need to review wider site bed capacity.
- Inappropriate ambulance conveyances having not considered alternative pathways (60% actual 70% assumed)
- Inappropriate ambulance conveyances of T3 patients who are streamed to MEDDOC (P50% A71%)

Responsive: Elective Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Benn Best – Director of Operations Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: PTL Size



Indicator Background:

The total number of patients on a Referral to Treatment (RTT) pathway that are currently listed on the Trusts waiting list (Patient Tracking List or PTL)

What the Chart is Telling Us:

- The SPC data point is showing special cause variation of a low concerning nature.
- The increase in PTL size is directly related to the pandemic which impacted elective capacity and has changed the referral profile from Primary Care

Actions:

- System-wide Outpatient transformation meetings have commenced
- Agree system-wide interventions re controls for referral increases
- Joint Commissioner/Trust groups have been started to support pathway reviews for challenged specialities
- Theatre and Outpatient efficiency projects have commenced
- Maximise current capacity, including Independent Sector to keep pace where possible with elective activity

Outcomes:

- Plans being developed for referral avoidance and referral reduction with local commissioners
- Reductions in inappropriate referrals
- Trust Outpatients and Theatre Efficiency plans will improve the utilisation and productivity of Outpatient and Theatre activity

Underlying issues and risks:

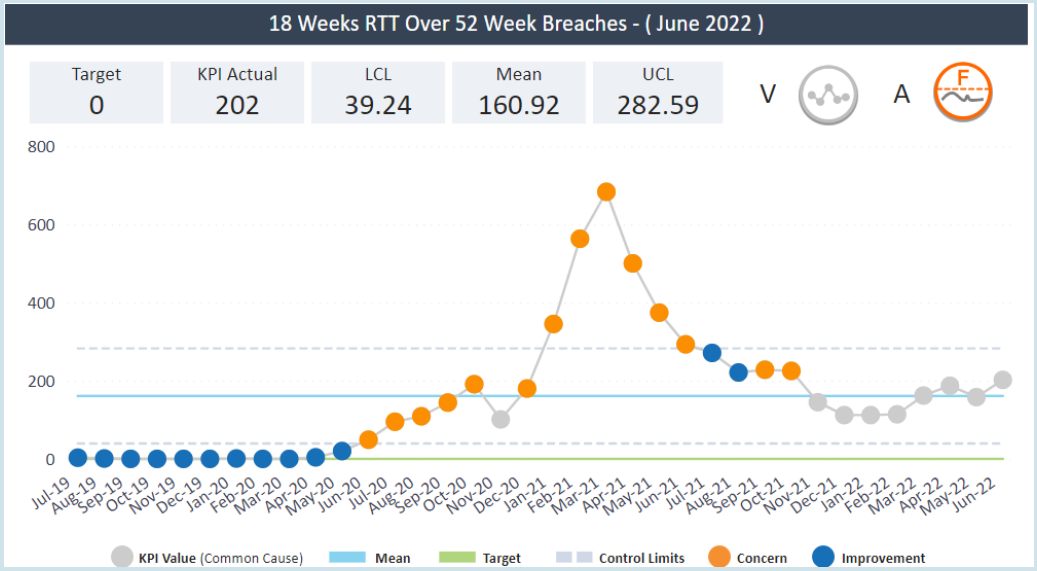
- Impact of further COVID waves resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Potential impact of Trust Business Continuity on Elective activity.
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

Responsive: Elective Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Benn Best – Director of Operations Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for more than 52 weeks from referral.

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature. The increase in 52 week waits is directly related to the pandemic and a reduction has been consistent since restarting elective activity .

Actions:

- Activity plans in place for all specialties reflecting the standards and targets for all elective activity and performance trajectories.
- All patients on the waiting list have an identified priority category (P) which is reviewed and updated regularly.
- Continuous validation of patients with long waiting times and harm review process established.
- Independent Sector capacity used where available to manage waiting times and increase volumes of activity

Outcomes:

- Elective capacity and activity monitored with weekly PTL and revised scheduling meetings for Theatres and Outpatients
- Clarity on patients and treatment in accordance with clinical priority (all patients will have a designated P category)
- All elective patients will be managed via the current IPC guidance

Underlying issues and risks:

- Impact of further COVID waves resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Potential impact of Trust Business Continuity on Elective activity.
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

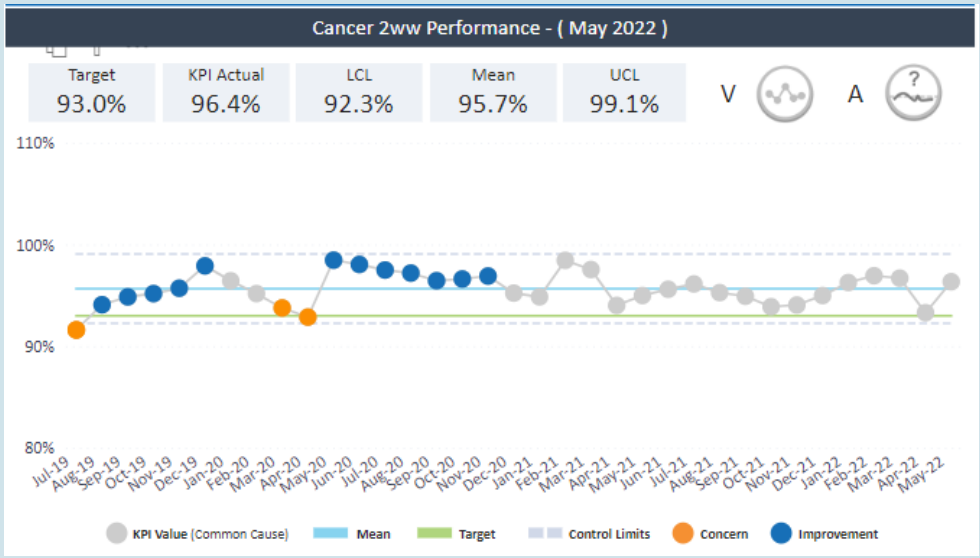
RTT Benchmarking

Responsive: Cancer Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Ellie Thomas
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

The proportion of patients urgently referred by GPs/GDPs for suspected cancer and who should be seen within 14 days from referral. 2WW performance has been maintained since May 2019. January is the first month this financial year that the 93% target has been met across all Tumour Groups.

What the Chart is Telling Us:

- Few concerns at present - continues to be compliant at 96.35% in May.
- **MFT were ranked 14th in the country for 2 week wait on Public View.**
- The Trust has remained compliant with this KPI since August 2019.

Actions:

- Straight to Test Nurses have been recruited in February to be implemented within UGI and LGI. The STT pathways are being agreed with the Cancer Alliance to enable patients having their tests before first outpatient appointment to allow the clinical team to have a more informed discussion and encourage a more timely pathway.
- We are working with the Alliance to implement the timed pathway across Lung, Lower GI, Upper GI and prostate which will be included in the 2022/23 CQUIN.

Outcomes:

- We continue to use the outpatient polling time report to monitor tumour groups on a daily basis.
- The Cancer Service Team are working with Imaging to implement one-stops for prostate cancer, H&N, lung and any other tumour sites when identified as feasible and beneficial. To support this we are working with Bi to provide a weekly report on diagnostic turnaround times (to be uploaded to BI portal) and review % booked within <7/7/8/9/10/>10 days.

Underlying issues and risks:

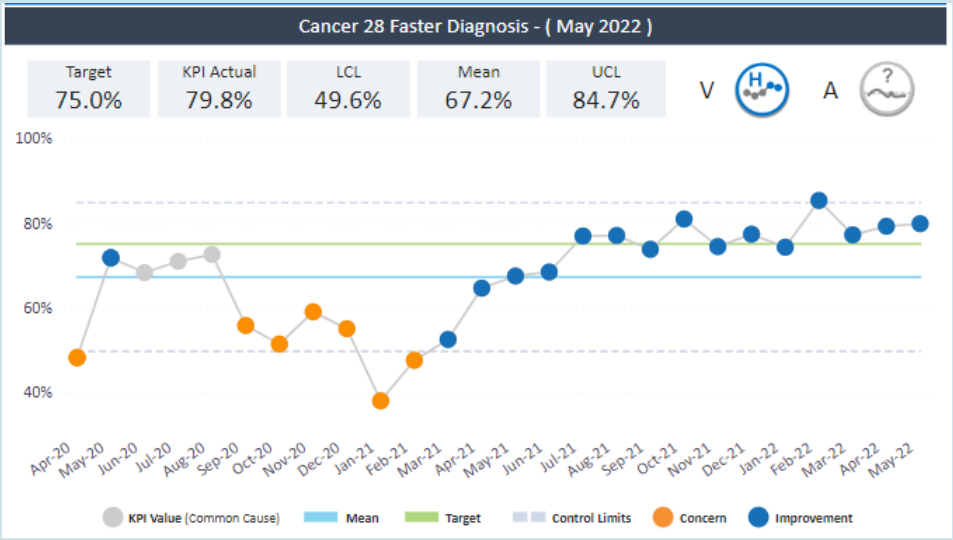
- The main challenges are volumes/fluctuations of referrals, particularly in some tumour sites, and patient choice.
- Currently we have set an internal target of 7 days for all 2 WW patients. We are currently booking 34% of patients within 7 days.

Responsive: Cancer Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Ellie Thomas
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 28 Faster Diagnosis



Indicator Background:

28 Day Faster Diagnosis Standard The new Faster Diagnosis Standard will ensure that all patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.

What the Chart is Telling Us:

- Few concerns at present - continues to be compliant at 79.76% in May.
- **MFT were ranked 21st in the country for 28 day for faster diagnosis on Public View.**

Actions:

- The introduction of Cancer Navigators has meant faster tracking of patients. Their roles are to help support Clinicians in ensuring patients are aware of their Cancer diagnosis within 28 days.
- Introduction of one stop shops and straight to test pathways will support improvement of the 28 day faster diagnosis (implemented in October 2021 as a standard). Working with the Alliance to implement the timed pathway across Lung, Lower GI, Upper GI and prostate which will be included in the 2022/23 CQUIN.

Outcomes:

- Overall performance hides a large variation in performance and data completeness by tumour group.
- We are working to identify the tumour groups which need additional support/help to achieved the targets.

Underlying issues and risks:

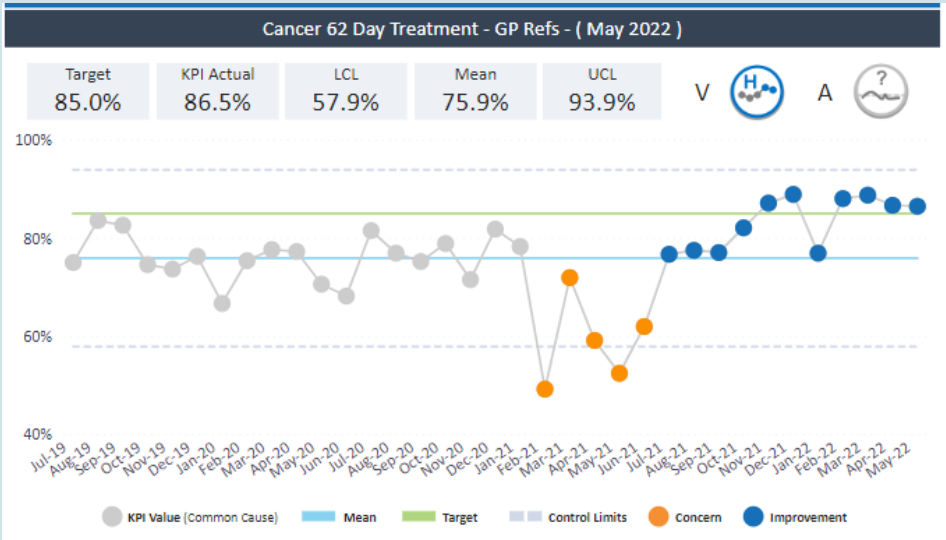
- Diagnostics capacity and turnaround remains the biggest issue to achieving compliance, particularly when affected by unplanned equipment failure or staffing capacity issues.
- Continue to improve our completeness data capture which is reflected in the performance
- Working with the Cancer Alliance to understand how we can better capture this data.

Responsive: Cancer Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Ellie Thomas
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

The proportion of patients urgently referred by GPs/GDPs for suspected cancer and receive their first treatment within 62 days of referral. MFT achieved compliance against the 62D standard for the first time since June 2018 in November 2021 and met the standard again in December 2021, we did not meet the target in January (as forecasted) but are on track to deliver in February.

What the Chart is Telling Us:

MFT achieved 88.02% and were ranked 6th in the country for 62 day treatment for May performance on Public View.

Actions:

- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement Plan Meeting.
- Tumour Site Specific Improvements being taken through Cancer Board led by the Cancer Specialty Leads.
- Daily PTLs taking place where necessary.
- Tumour Groups with the highest backlogs have clinically led PTLs in place.
- Inter-provider SOP has been drafted by the Cancer Alliance to streamline and improve inter-provider pathways

Outcomes:

- Cancer patients at Medway NHS Foundation Trust are receiving some of the fastest access to cancer treatment in the UK.
- The Trust achieved the national standard in four key areas of cancer care for the second time in February. This has meant that cancer patients in Medway and Swale have had an earlier diagnosis, faster treatment, a lower risk of complications, a better experience of care and improved outcomes.

Underlying issues and risks:

- We are forecasting our performance will decrease over the coming months due to imaging and diagnostic challenges.
- There is currently a consultation on the next version of Cancer Waiting Times guidance (V12) which could affect our ability to meet this standard moving forward.
- There are a number of posts that the Cancer Alliance has funded in the last financial year. These staff are on fixed term contracts, if the Trust chooses not to adopt these posts then we are at risk of not being able to continue to maintain our current performance

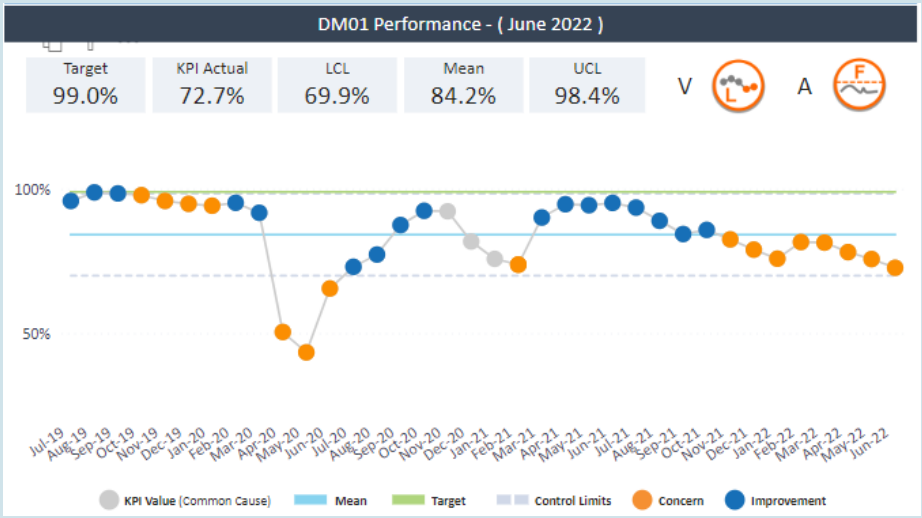
Cancer 62day Benchmarking

Responsive: Elective Insights

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Benn Best – Director of Operations Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: DM01 Performance



Indicator Background:

The proportion of patients that are currently waiting for a diagnostic test for less than 6 weeks from referral.

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature. Assurance indicates that the KPI is inconsistently achieving target.

Actions:

- Endoscopy task & finish group implemented
- Triaging of patients on diagnostic waiting lists (D-code) by clinical team in line with national standard
- Use of Independent Sector for Endoscopy Insourcing (18WS) and Outsourcing (PPG) continues with good utilisation of lists
- Insourcing capacity is in place for Sleep Studies
- Echocardiography insourcing now operational
- Plan to use IS capacity for Audiology is being developed

Outcomes:

- Endoscopy recovery plan implemented
- Additional capacity will support the reduction in backlogs across a number of diagnostic modalities
- Additional Audiology capacity would provide Medway patients with more choice of Diagnostic provider

Underlying issues and risks:

- Impact of third COVID wave resulting in increased NEL demand impacting on ability to continue same levels of diagnostic work.
- Insufficient internal Endoscopy capacity means that outsourcing continues to be required
- More insourced MRI capacity required
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

DM01 Benchmarking

Domain: Well Led – Dashboard

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

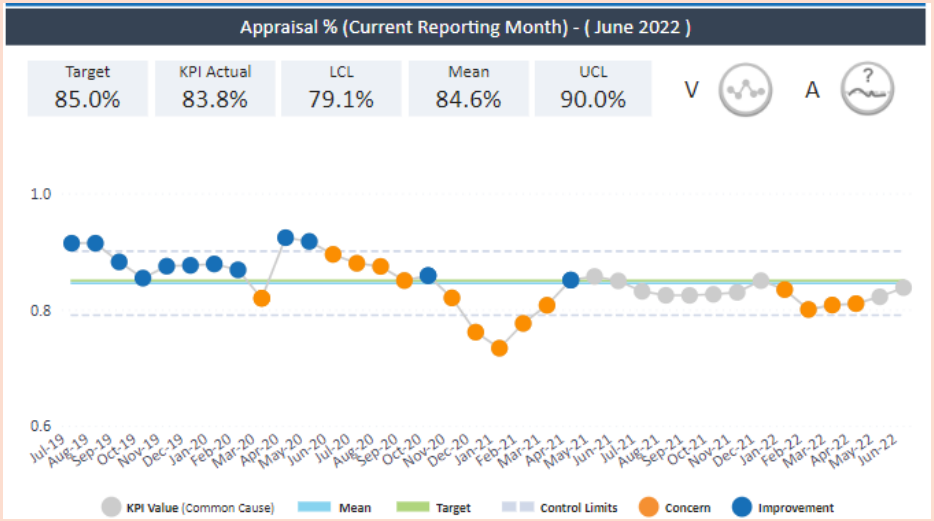
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Well Led	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Jun-22	4.0%	2.6%	0.4%	2.9%	5.3%		
		Agency Spend as % Paybill (Financial Year YTD)	Jun-22	4.0%	3.2%	1.9%	3.1%	4.3%		
		Appraisal % (Current Reporting Month)	Jun-22	85.0%	83.8%	79.1%	84.6%	90.0%		
		Bank Spend as % Paybill (Current Reporting Month)	Jun-22	9.0%	16.6%	7.4%	13.3%	19.1%		
		Bank Spend as % Paybill (Financial Year YTD)	Jun-22	9.0%	13.5%	6.2%	10.7%	15.3%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Jun-22		4,405	4,069.56	4,130.31	4,191.07		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Jun-22	2.5%	1.8%	1.6%	2.3%	3.0%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Jun-22	1.5%	2.7%	1.6%	2.2%	2.9%		
		Sickness Rate (Current Reporting Month, FTE%)	Jun-22	4.0%	4.5%	3.2%	4.7%	6.3%		
		StatMan Compliance (Current Reporting Month)	Jun-22	85.0%	83.5%	87.1%	89.3%	91.5%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Jun-22	75.0%	60.2%	52.2%	63.9%	75.6%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Jun-22	12.0%	16.0%	12.0%	12.8%	13.7%		

Well Led: Workforce - Insights

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: James Kendall
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The percentage of staff who have had an appraisal in the last 12-months compared to the total number of staff.

What the Chart is Telling Us:

Variation is: 'special cause of concerning nature' or 'higher pressure due to lower values'.

Assurance variation indicates inconsistently hitting 'passing' and falling short of targets.

Underlying issues and risks:

- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Recent increase in sickness levels across the Trust has had a negative impact on compliance
- Failure to appraise staff timely reduces the opportunity to identify skills requirement for development, succession planning and talent management. Low appraisal rate are linked to high turnover of staff, low staff engagement and low team-working. Appraisal is also an indicator to ensure health and wellbeing conversations are occurring between staff and their line manager, low compliance gives little assurance that such conversations are occurring regularly.

Actions:

- Identified as a breakthrough objective under Patient First.
- Weekly reporting in place with automated reminders in place;
- Weekly and monthly progress to form actions with
- care group leaders in place;
- Matrons, senior sisters and line managers required to build appraisal trajectory to correct current position (recovery plans);
- Appraisal workshops provided with good uptake;
- Pay progression policy linked to appraisal completion in place
- HR Business Partners continue to work with their respective Divisions to produce improvement plans

Outcomes:

3531 members of staff have an in-date appraisal
with objectives and personal development plan
outlined (from a total of 4295).

Domain: Well Led - Financial Position

Executive Lead: Alan Davies – Chief Financial Officer
Operational Lead: Paul Kimber – Deputy Chief Financial Officer
Sub Groups : Finance Committee

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month Baseline budget	In-month Actual	In-month Variance	YTD Baseline budget	YTD Actual	YTD Variance
Income	32,810	31,952	(858)	96,582	96,708	126
Pay	(20,486)	(19,850)	636	(61,548)	(60,485)	1,063
Total non-pay	(10,847)	(10,770)	77	(30,875)	(32,345)	(1,470)
Non-operating expense	(1,904)	(1,758)	146	(5,585)	(5,303)	282
Reported surplus/(deficit)	**(427)**	**(426)**	**0**	**(1,426)**	**(1,425)**	**1**
Donated Asset / DHSC Stock Adj.	13	12	(1)	40	51	11
Control total	**(413)**	**(414)**	**(1)**	**(1,386)**	**(1,375)**	**12**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	627	396	(231)	1,312	929	(383)	10,484
Capital	(438)	(126)	312	(1,314)	(1,310)	4	(11,550)

Indicator Background:

The Trust reports a £426k deficit position for June; after adjusting for donated asset income and depreciation this reduces to £414k, this being £1K favourable to plan.

What the Chart is Telling Us:

The Trust has delivered the planned £1.4m deficit year to date (YTD) for 2022/23. The efficiency programme delivered in month £231k adverse to the £627k plan in month and £383k YTD. The capital programme is reporting £4k under the planned spend and forecast will be on plan for the year.

Actions:

Financial performance is measured against the resubmitted plan to NHSE/I in June for 22/23. This was a 3rd submission for the year and reduces the £3.1m deficit to an overall breakeven position for the financial year, following agreement for additional inflationary funding. The plan contains a high level of risk including a £10.5m efficiency programme as well as £8m of non-recurrent mitigations, £3.5m of this is still yet to be identified.

Outcomes:

The Trust has met its control total for June 22/23, this includes:

- Elective recovery fund income of £2.5m year to date. This income is at risk as the Trust and K&M System are not delivering ERF activity targets.
- Non-recurrent release of accruals £3.4m to cover non-delivery of efficiencies, clinical supplies, medical locums and staff sickness.
- Pay costs include the 1.25% relating to the Health & Social Care Levy increase

Underlying issues and risks:

The current plan is a breakeven position for the year and includes the risk of delivering £8m of mitigations and the £9.6m efficiency programme, there is a further stretch target of £0.9m to add in the 2nd half of the financial year. To date, £10.4m of schemes have been identified, of this £1.1m will not be implemented so added to next year's plan, this brings the in year total to £9.3m, £0.3m below the original target and £1.2m behind the stretch target. The 22/23 capital plan continues to be developed, this is currently c.£11.5m.

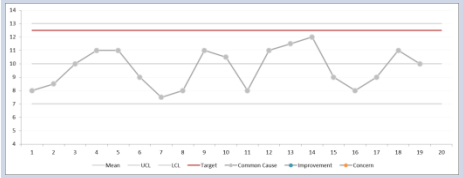
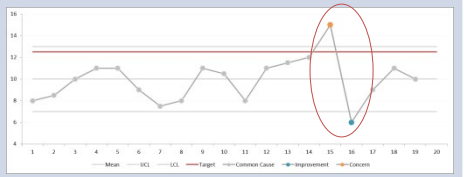
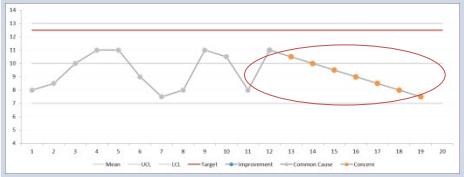
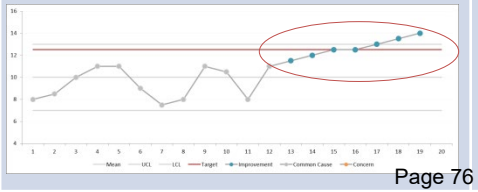
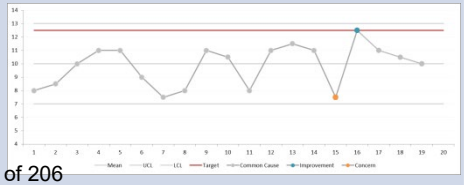
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

The IQPR incorporates the use of SPC charts to identify **Common Cause** and **Special Cause** variation and introduces NHS Improvement SPC Icons into a dashboard format to show trend **variation** and **assurance** in key performance indicators (KPIs) ability to achieve the targets set for each KPI.

The main aims of using Statistical Process Control (SPC) charts is to understand what is **different** and what is **normal** to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether KPIs are improving.

NHS Improvement have published two documents on '**Making Data Count**' which will provide further information on SPC. Please click on the More Info box in the bottom right hand corner to access the documents.

Below are examples of SPC trends that define common or special variation which will support understanding the variation Icons:

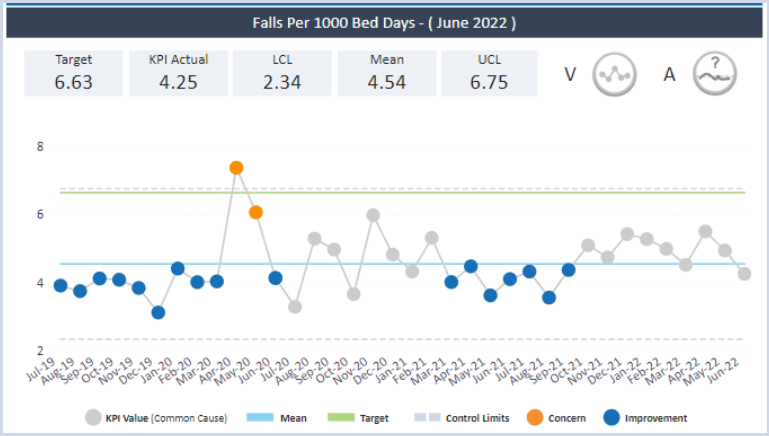
Common cause	7 consecutive points above mean	7 Consecutive points below mean	Astronomical points outside CL
			
5 consecutive Descending	**5 consecutive Ascending**	**2 out of 3 sigma points**	**More Info Click here**
			**NHS Improvement 'Making data count'**

Safe: Falls management and reduction
Aim: 12% reduction in number of falls with harm
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days

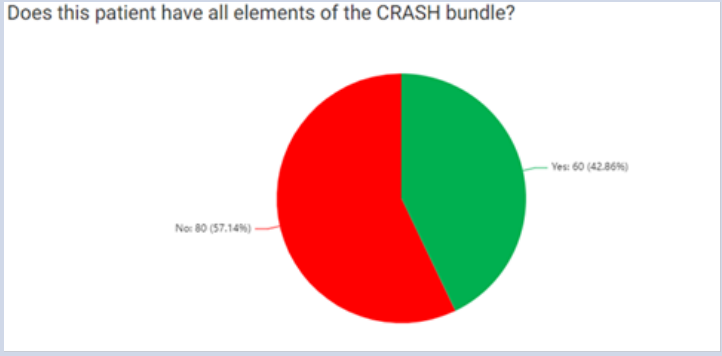


What do the outcome measures show?

80% of falls occurred in Unplanned care (size of division and specialties and additional escalation beds),
83% of falls were unwitnessed
29% of falls were on level ground (predominantly whilst patient walking)
12% of falls occurred between 7-8pm and 9% between 12-1pm.
21% of falls across the Trust occurred on a Monday
The number of patients who have fallen previously on this admission increased from 7-13 this month

Month	Total Falls	No and low harm	Moderate harm	Severe harm/ Death
June- 22	75	74	0	1
June -21	65	65	0	0
May-22	79	79	0	0
Apr-22	95	92	1	1

Process measure: 95% Crash Bundle Reliability (Pilot wards)



What do the process measures show?

43% of patients had all elements of the CRASH Bundle being completed compared to 45% in May.
Pie chart to demonstrate the number of patients who have received all elements of the CRASH Bundle.
The key consistent themes continue to be, call bell out of reach and lying and standing blood pressure recording, although improvement has been demonstrated, results remain unchanged this month.

What changes have been implemented and improvements made?

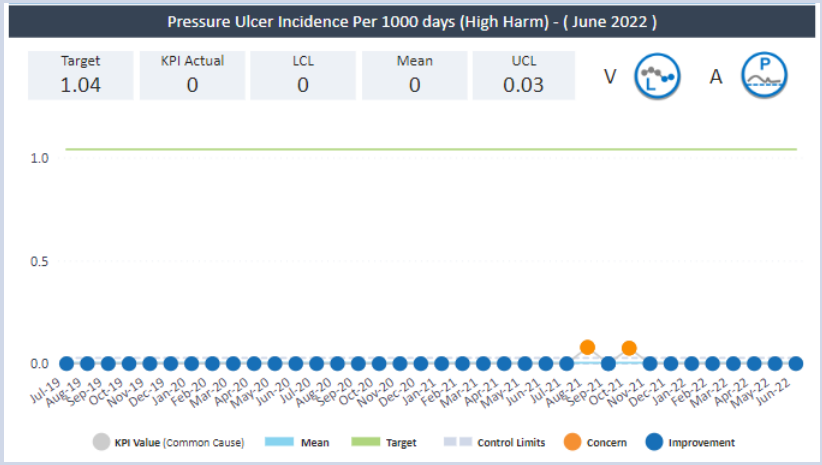
To date, 14 wards and the Emergency Department have undergone data examination with A3 problem solving methodology to fully discover root causes in order to identify appropriate solutions.
Currently 9 wards have quality improvement plans at the “do” stage of the PDSA cycle (Plan, Do Study, Act).
An update on progress and achievement will be presented to QAC in September

Safe: Pressure Damage Reduction
Aim: 10% Reduction in Hospital Acquired Pressure Ulcers
Latest Period: June 2022

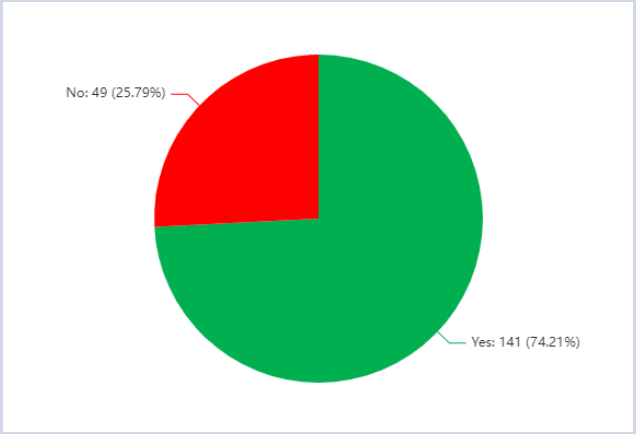
Executive Lead: Evonne Hunt
Operational Lead: Hayley Jones
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Pressure Ulcer Incidence Per 1000 days (High Harm)



Process Measures: ASSKING Bundle Reliability (Pilot Wards)



What do the outcome measures show?

60% of hospital acquired pressure ulcers were within Unplanned care
40% of hospital acquired pressure ulcers were within Planned care
Tennyson, Pembroke, and Will Adams ward had 2 or more HAPU's.

Hospital Acquired pressure ulcers HAPU

Month	Total HAPU	low harm	Moderate harm	Severe harm/ Death
June 2022	15	15		
june 2021	17	17		
may 22	25	25		
April - 22	24	23	1	

Category 2	Category 3	Category 4	DTI	Unstagable	Total
5			6	4	15

Pressure Ulcer's on admission (POA)

Category 1	Category 2	Category 3	Category 4	DTI	Unstagable	Total
2	121	6	1	11	20	161

What do the process measures show?

The Trust scored 85.6% in the ASSKING audit in June 2022, with 168 audits completed. Improvement seen in;

	June 2022	March 2022
Skin	85.1	52%
Incontinence	76.2	53%

What changes have been implemented and improvements made?

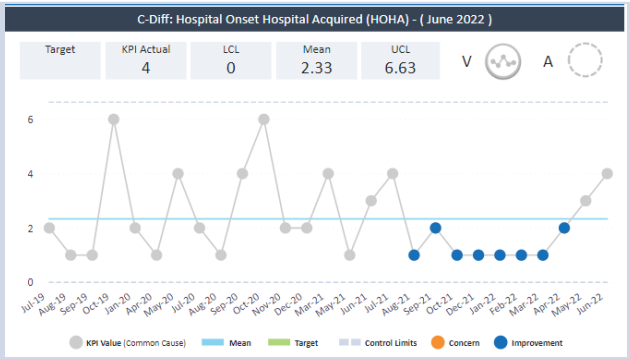
5 wards are undergoing an improvement approach using an A3 problem solving methodology is being utilised across the Trust. Interrogation of data for each ward who acquire more than two pressure ulcer a month underway and will form a deep dive report for each area which will be presented at QAC

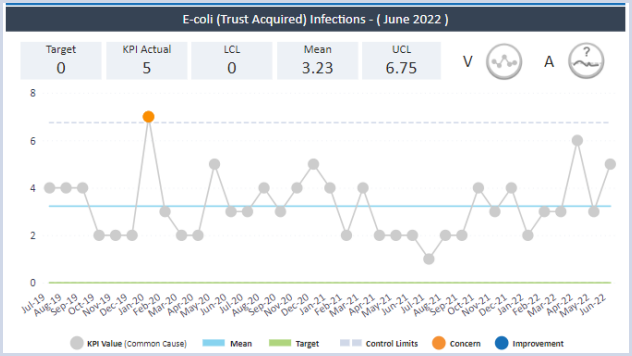
Safe: Improving Infection Control
Aim: Reduction in healthcare acquired infections.
Latest Period: June 2022

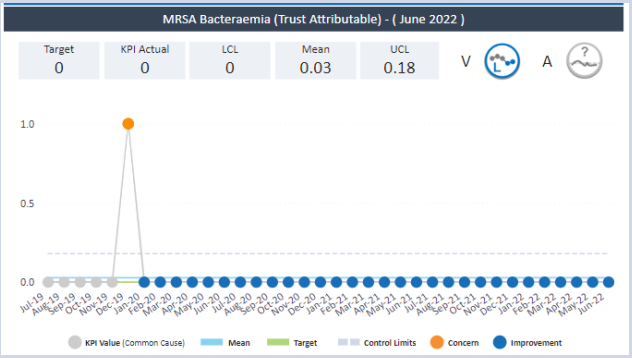
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Steph Gorman
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Infection Prevention Control measures







What do the outcome measures show?

MFT continue to work to achieve their thresholds in 22/23. With the 1 MRSA Bacteremia MFT has breached that threshold. The below numbers are cumulative for the year.
MRSA Bacteremia 1 HOHA with 0 new cases in May
C.Difficile rates since 1st April 2022 is 11 HOHA's against a threshold of 34 which is an increase of 4 in June.
E.Coli : 15 against a threshold of 77 which is an increase of 5 in June.
Klebsiella : 3 against a threshold of 37 with 0 cases in June.
Pseudomonas : 1 against a threshold of 17 0 cases in June

What do the process measures show?

C.Difficile is 1 above this point 21/22. E.coli is 5 above this point last year but Klebsiella and Pseudomonas are below

What changes have been implemented and improvements made?

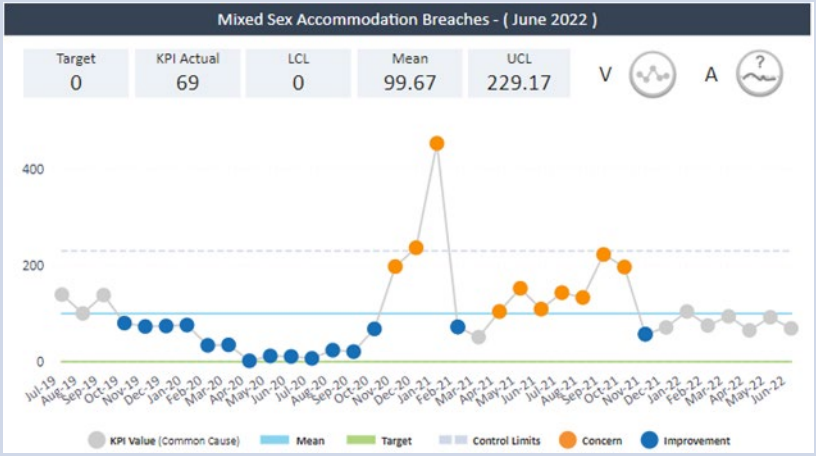
- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- IPC operational group involving SSR's, Matrons have now had 3 meetings and is reporting monthly to IPCG
- ANTT competency assessments are to be added to the core assessment skills for new nurses
- Commode cleanliness task and finish group has met for 3 weeks – agreed competency document, frequency of checks, initiating commode champions. Still to confirm is type of commode, frequency of competency assessments, type of cleaning product and video on how to clean

Safe: Mixed Sex Accommodation (MSA)
Aim: Reduction in mixed sex accommodation
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Dan West
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Mixed Sex Accommodation Breaches



What do the outcome measures show?

The SPC data point is showing special cause variation of a low improving nature. Bed availability and patient flow continue to be challenging throughout the Trust.

The unjustified breaches of MSA recorded largely relate to the inability to step down patients within four hours from Critical Care areas to Level 1 ward based care.

In June on Byron ward the DDON agreed a breach for a terminally ill patient (husband and wife both patients in the Trust) to be nursed together with partner for end of life care

Outcome Measure: Mixed Sex Accommodation Breaches By Ward

Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Arethusa/SAU											18			
Bronte		4	7		14				4		6			
Byron														6
Critical Care Unit														
Dolphin Ward		4	4	2			1							
Emerald Assessment Unit											19			
Emerald Short Stay Ward											2			
Intensive Care Unit	20	11	3	6	1	5	2	2	8	12	1	7	2	15
McCulloch Ward	7		19		3	15			1					
Harvey Ward														
Jade Ward						4	4		12			8		
Keats Ward		3			14						3			
Lawrence Ward	2			2	7									
Lister Assessment Unit	12	16	43		34	22					40			
Nelson Ward	8		6		5	10								
Ocelot					29	32	1		5					
Pembroke Ward			7	15										
Phoenix Ward														
Pre Op Care Unit														
Sapphire Ward	2	9	3	57	25	24								
SDEC		2	2											
Sunderland Day Case Centre					5	19							6	
Surgical Assessment Unit		12		7	20					3				
Theatre Intensive Care Unit														
Trafalgar Ward SHDU	45	47	46	33	86	65	46	69	74	60	73	50	84	48
Tennyson Ward														
Wakeley		1		5										
Victory				6										
Will Adams	7		3		8		4							
Totals	103	109	143	133	251	196	58	71	104	75	162	65	92	69

What changes have been implemented and improvements made?

There is continual monitoring of patient safety to ensure that where possible patients are informed and bed moves are prioritised and facilitated to correct any breaches.

There is continued collaborative working within the divisions, site team and IPC to minimise any unjustified mix sex accommodation breaches other than areas with Covid patients and assessment areas within the Trust.

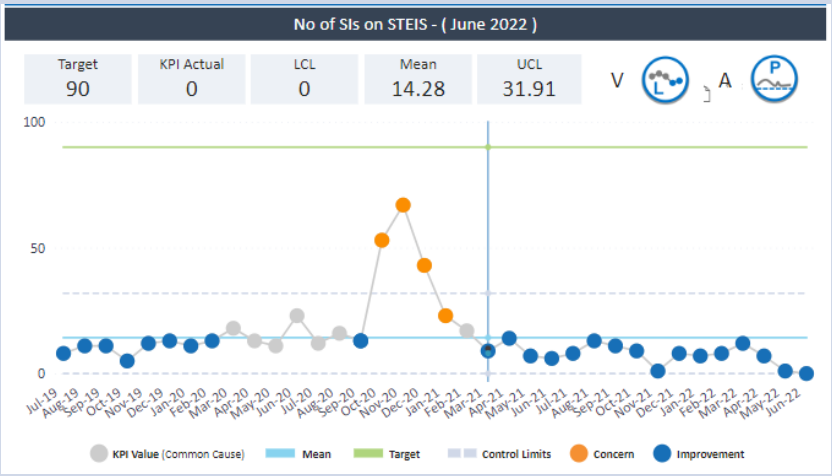
Discussion continues with BI team to improve the accuracy of reporting and reduce the burden of validation as the Trust transitions from Extramed platform to EPR

Safe: Incident Reporting
Aim: Safety and learning culture
Latest Period: June 2022

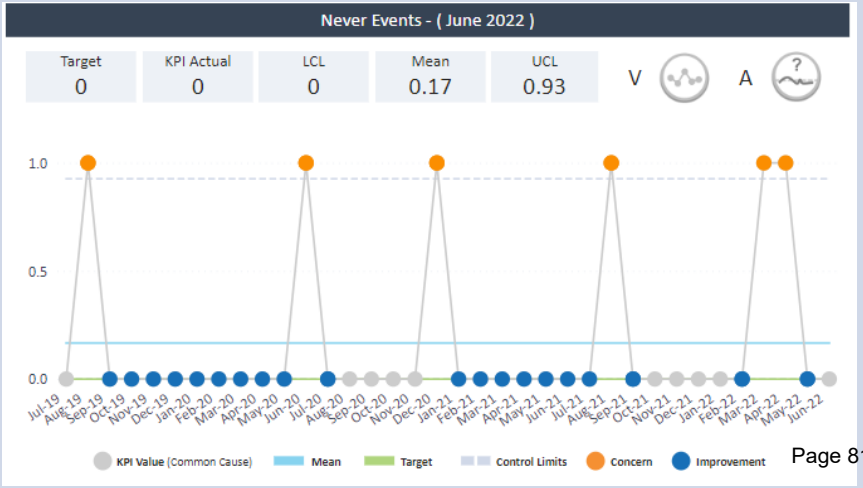
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Kat Andrew
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: No. Of Serious Incidences



Outcome Measure: Never Events



What do the outcome measures show?

The number of serious incidents reported this month has dropped to 3.

1 Medication Incident
1 Treatment delay meeting SI criteria
1 Maternity Incident

10 incidents closed by CCG in the month

There are currently 66 SIs open across the Trust. 11 of these have breached their CCG deadlines.

Of the 12 SIs due within the next month, 2 are closed, 3 are with the CCG, 7 remain open.

What changes have been implemented and improvements made?

In The Month of June, no never events were declared.

The never event declared in April has been closed by the CCG.

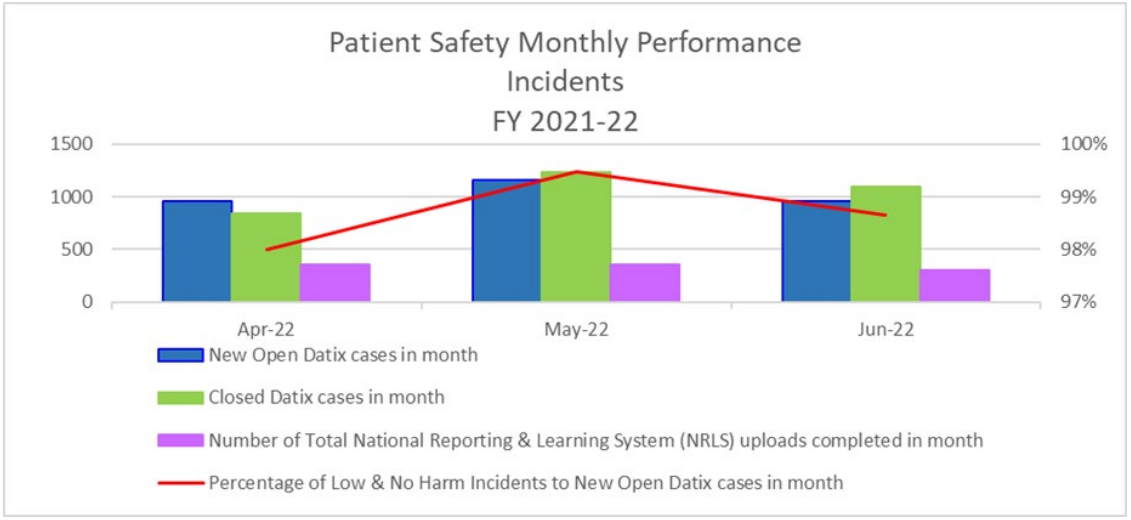
The never event declared in March required an extension request which the CCG have agreed to. This allows further time to ensure the robustness of the report.

Safe: Datix Incident Reporting (excluding No Harm)
Aim: Safety and learning culture
Latest Period: May 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Kat Andrew
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Category	Patient or Other Clinical	Patient or Other Clinical - non attributable to MFT	Staff (non clinical incidents)	Trust or other party (including Tiny Tugs Nursery)	Visitors, Contractors or the Public
Abusive, violent, disruptive or self-harming behaviour	45	1	15	1	2
Access, Appointment, Admission, Transfer, Discharge	134	6		5	1
Accident that may result in personal injury	89		13		
Clinical assessment (investigations, images and lab tests)	28	5	1	2	
Consent, Confidentiality or Communication	19	1	4	7	
Diagnosis, failed or delayed	15	3		2	
Financial loss			1		
Implementation of care or ongoing monitoring/review	320	22	4		1
Infrastructure or resources (staffing, facilities, environment)	41	1	11	12	
Labour or Delivery	67	5	1		
Medical device/equipment	19	1	1	6	
Medication	75	7	3	2	
Other - please specify in description	65	5	7	9	
Patient Information (records, documents, test results, scans)	30	3	4	1	
Security			1	7	
Treatment, procedure	21	4	2		



What does the table show?

Harm free care:
959 incidents reported in month of May:
99% resulted in No or Low harm
No harm incidents: 761
Low harm incidents: 185
Moderate harm incidents: 9
Severe harm incidents: 3
Death caused by the incident: 1

Themes:
Top 3 events declared excluding pressure on admission:
Other - please specify in description - 75
Implementation & ongoing monitoring/review – other - 54
Simple complication of treatment – 41

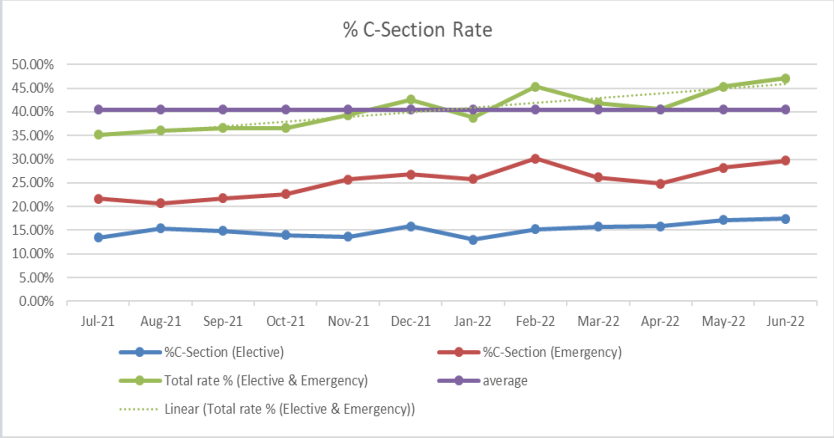
Overdue incidents
Overdue Incidents has seen a month on month decrease.
Total Overdue in Holding Area - 0
Total Overdue in Being Reviewed - 29
Total Overdue in Awaiting final approval - 88

Safe: Maternity
Aim: Ensure maternity services are fit for purpose, safe, and offer a high-quality of care
Latest Period: June 2022

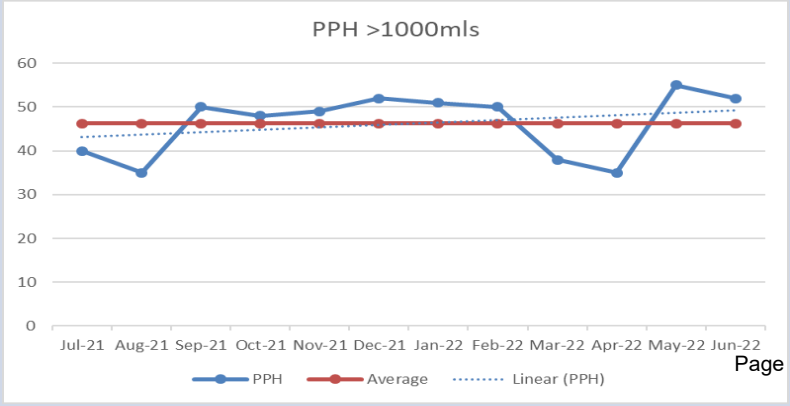
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Katharine Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: % C-Sections



Outcome Measure: PPH >1000mls



What do these measures show?

CS targets have been removed from reporting, in line with Health Social Care Select Committee (HSCSC) guidance 2022.

The total caesarean section rate has increased slightly from last month to 47.06%. This is influenced by an increase predominately in emergency rates.

Primagravida women undergoing induction of labour (IOL) are a key contributor group through our high caesarean section rate and will be the focus of quality improvement work following the DOM and CD commissioned IOL Deep Dive and audit.

What changes have been implemented and improvements made?

There is improved Consultant presence on delivery suite to supervise doctors in training and increase instrumental delivery rate, and ensure compliance with twice daily ward rounds.

The daily caesarean section audit continues and will be reported as soon as results are available.

Intrapartum Matron is leading on a "Time in Motion" audit of sections to provide assurance effective flow and time management which will feed into ongoing DOM and CD commissioned review of capacity and demand.

What do these measures show?
What changes have been implemented and improvements made?

Evidence demonstrates that PPH can be reduced by avoiding unnecessary inductions/augmentations of labour - a review of the IOL pathway, capacity and demand has been commissioned by the DOM/CD and induction of labour task and finish group to commence in July 22.

Key changes to the induction of Labour pathway were implemented on 18th July 2022 with the intention of reducing the length of time women and birthing people are administered syntocinon. It is anticipated that this will reduce volume of PPH experienced.

Effective: Maternity Aim: Ensure maternity services are fit for purpose, safe, and offer a high-quality of care **Latest Period**: June 2022	**Executive Lead:** Evonne Hunt, Chief Nursing Officer **Operational Lead:** Alison Herron/Katharine Harris **Sub Groups:** Quality Assurance Committee

NHS Medway NHS Foundation Trust

Maternity Transformation

Update on maternity transformation programme work, including National, Local Maternity and Neonatal System (LMNS) wide and internal service quality improvement projects.

LMNS Personalised Care and Support Plans (PSCP)

- Participation in LMNS PSCP Task and Finish Group
- Plan to launch regional PSCP in October 2022
- Local guidelines to support personalised care and choice have been reviewed and revised where necessary have been ratified at July 2022 Care Group and Divisional Board.
- Once Regional PSCP launched, education of staff and communication with women and birthing people will be undertaken, with appropriate guidance put in place.

Maternal Medicine Network

- A regional Maternal Medicine Network is currently under development.
- MFT to be commissioned as a sub-hub for Kent, within the Southeast Maternal Medicine Network.
- Referral pathways and processes are being developed and resource and funding requirements under discussion with the Clinical Director, MFT contracting team, and Commissioners.
- Anticipated launch Quarter 3 2022/23.
- Job Description for externally funded 8a 0.6WTE Lead Midwife for Maternal Medicine has been completed. Awaiting VCP approval July 2022.

Antenatal/Newborn Optimisation

- Focused project being undertaken by Infant Feeding midwife to improve rates of skin to skin following emergency caesarean section. Infant feeding midwife is engaging the delivery suite coordinator, who are present at all emergency section births, and theatre team to support families with this.
- Monthly audit ongoing and reporting to Intrapartum Matron and HOM to identify any further actions required.
- Delayed cord clamping for at least 30 seconds at birth improves the outcomes for neonates. "Delay the Clamp" campaign launched promoting the benefits of delayed cord clamping including a teaching session for all staff and audit presentation.

Induction of Labour (IOL)

- **Local IOL Pathway Review**
  - Ongoing delays for women booked for and awaiting IOL, current risk rated at 15.
  - June 2022 DOM and CD commissioned a local review of IOL clinical pathway, to include a review of capacity, demand and staffing model.
  - Initial meeting of Task and finish group held 15th July 2022 with good MDT attendance and actions identified.
- **LMNS IOL T&F Group**
  - Review of IOL processes and guidelines in light of revised NICE guidance which states to offer IOL for all women and birthing people from 40+7. Decision to be made on whether to accept new NICE guidance as the agreed pathway or to implement local guidance.
  - Review information given to women and birthing people to support personalisation and choice. System-wide sharing of information underway and plans in place to implement locally.

Fetal Physiology

- MFT Training programme has been revised and agreed in line with physiological approach to Fetal monitoring assessment and interpretation. MDT training to commence in Q3 2022.
- Plan to launch new local Physiological Fetal Monitoring Guideline in January 2023 once training for all staff is completed. Guideline is currently being written and anticipated to be circulated for comment in August 2022 and approved through Governance processes in October 2022. This will be a detailed guideline in response to local incidents and learning to support improved outcomes.
- Working with LMNS as part of the Fetal Physiology Group to develop regional guidelines for Fetal Monitoring to support local practice.

Digital

- The Maternity Service supports the procurement of a fit for purpose MIS, as the current system (EuroKing) does not provide a digital intrapartum module and therefore the current notes system is hybrid, which poses a risk to a robust communication process of clinical information between MDT professionals.
- Maternity digital strategy currently being developed in line with requirements of CNST Year 4. This will be presented to the Trust Board in October 2022.
- Ongoing work to improve community connectivity for community midwives through multi-network sim and hard-wiring in community bases to be completed by December 2022.
- Scoping exercised underway for digital handover on labour ward being undertaken by lead obstetrician to be completed by December 2022.
- Fetal Wellbeing team are working to get MSOS on consultant laptops to support remote review of CTGs by consultants on call and support the ability to provide advice overnight. Due to be completed by November 2022.

Continuity of Care (CoC)

- CoC is currently paused following the publication of the Ockenden Final report (March 2022) until assurance of safe staffing levels in line with the funded Birthrate Plus establishment.
- Review of future plans for CoC completed with DOM and revised trajectory submitted to the LMNS on the 14th June 2022, with a view to recommencing the roll out of case loading teams from April 2023, and an aim to achieve the full offer of CoC by April 2024.
- Implementation plan has been updated with revised dates for staff consultation, procurement and securing estates in line with revised trajectory.

Diabetes Blood Glucose Monitoring in the Community

- A business case for smart phone technology to support the monitoring of blood glucose levels in the community was approved at DMB in July 2022.
- This will support improved service user experience, reducing the need for onsite attendance and optimising the management of blood glucose for women and birthing people on the diabetic pathway.

Perinatal Mental Health - THRIVE

- LMNS have funded a post to support women and birthing people psychologically with birth trauma and loss.
- 0.6wte (22.5 hours) Band 7 to be recruited to join the perinatal mental health team to deliver this service.
- Role has been advertised and interviews anticipated in August 2022.

Conclusion and Next Steps for all programmes

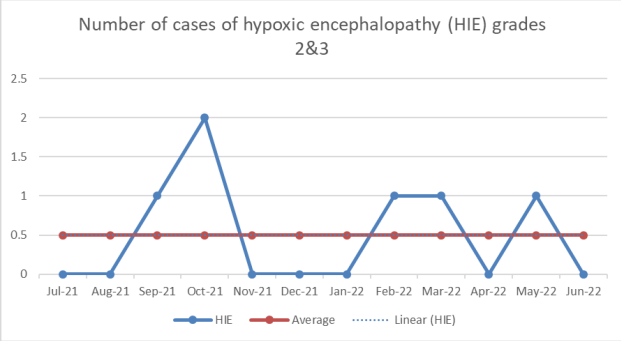
- Continue to engage in National maternity programmes as well as local improvement projects to ensure maternity services are fit for purpose, safe, and offer a high-quality of care for all women and birthing people accessing our services.
- To monitor compliance to any targets set.
- Review and audit services following implementation of any new pathways and practice.

Safe: Maternity
Aim: To reduce the number of HIE, stillbirths and neonatal deaths and improve outcomes for all babies
Latest Period: May 2022

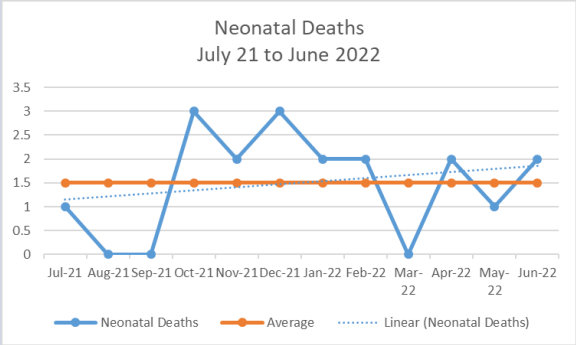
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Katharine Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

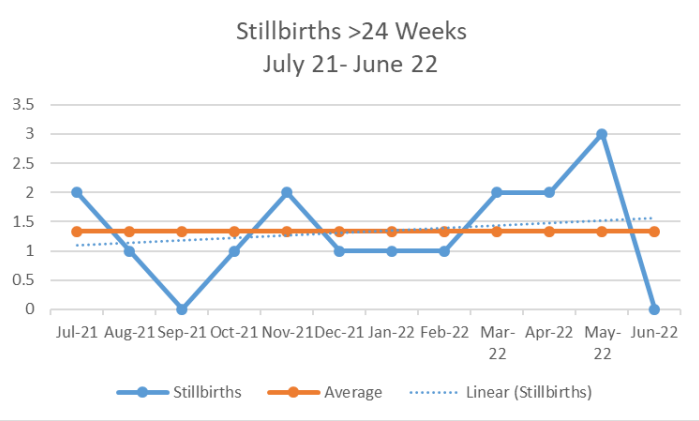
Outcome Measure: Number of cases of hypoxic encephalopathy (HIE) grades 2&3



Outcome Measure: Total Neonatal Deaths



Outcome Measure: Total Stillbirths >24 Weeks



What do these measures show?

In June 2023 there were 0 cases of HIE and 0 stillbirths.

There were 2 Neonatal deaths, both deaths were expected and no care failings have been identified.

An anomaly identified in March data has now been rectified, confirming 2 stillbirths for March 2022.

What changes have been implemented and improvements made?

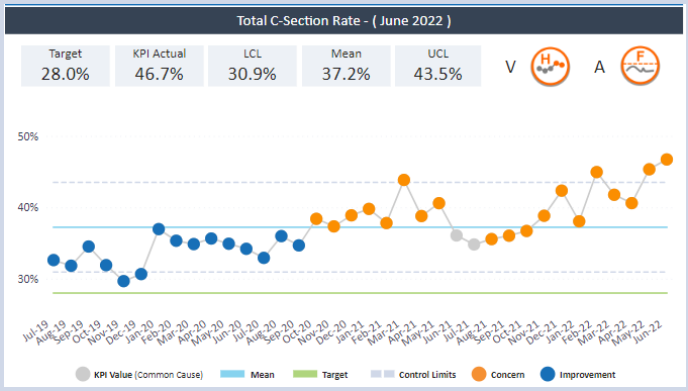
The service plans to introduce a fetal physiological monitoring guideline with a revised multidisciplinary training package incorporating a human factors element to support reduction in HIE. Training planned to commence in quarter 3.

Effective: Maternity
Aim: TBC – Currently Under Development
Latest Period: June 2022

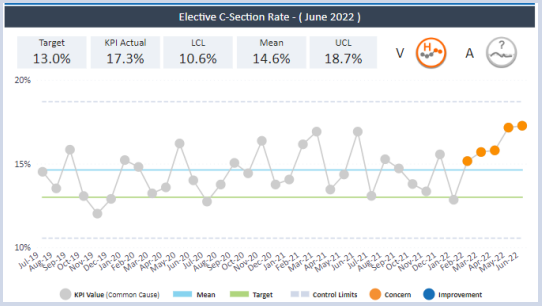
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Ali Herron/Katherine Harris
Sub Groups: Quality Assurance Committee

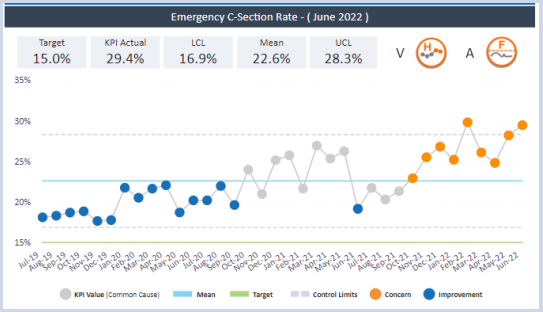
NHS Medway NHS Foundation Trust

Outcome Measure: Total Elective & Emergency C-Section Rate



Outcome Measure: Elective and Emergency C-Section Rate





What does the measure show?

The total caesarean section rate has increased slightly from last month to 45.34% which is just above the higher confidence level. The total caesarean rate is influenced by an increase in both emergency and elective rates. Elective caesarean rates are under the higher confidence level and there is a 3 year strategy in place to address the number of emergency caesarean sections. Robson group 2a (Nulliparous, singleton, cephalic, ≥37 weeks gestation, induced labour) and Robson group 5 (previous CS, singleton, cephalic, ≥37 weeks gestation) are the highest contributor to the caesarean section rate. Audit will focus in this area and an induction of labour review has been commissioned by DOM/CD with a task and finish group commencing in July 22

What changes have been implemented and improvements made?

There is increased Consultant presence on delivery suite to supervise doctors in training, and have oversight and expertise in decision making, and to enable instrumental delivery rather than caesarean section where appropriate.

Twice daily (morning and evening) Consultant led MDT ward round on delivery suite

The daily caesarean section audit continues, awaiting the preliminary results.

Audit of IOL pathway, capacity and demand, task commencing July 22.

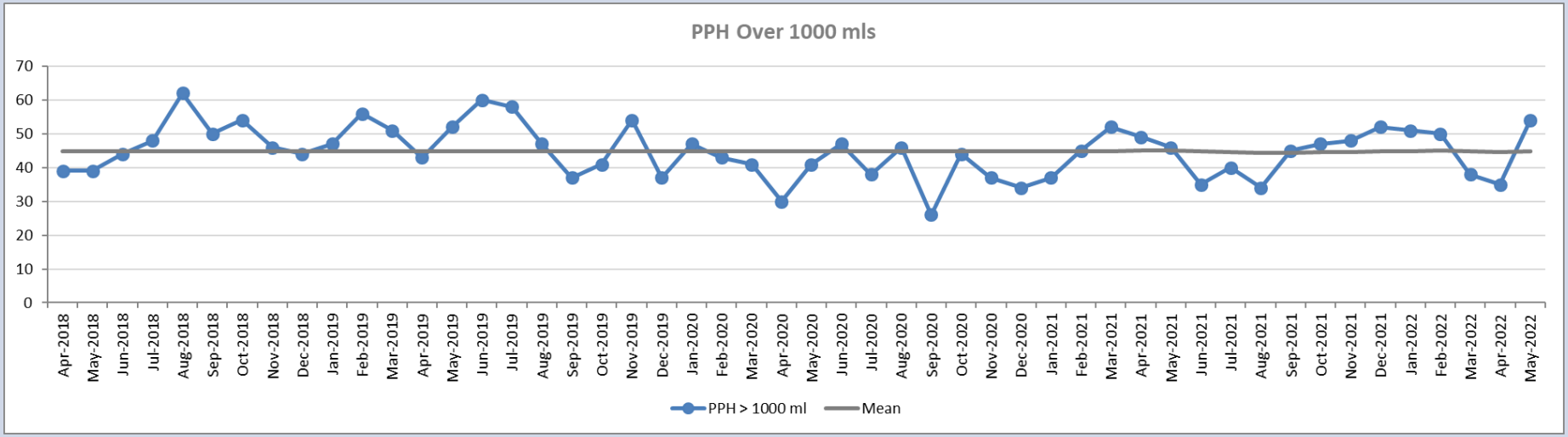
A review of the birth place criteria and pathway will be undertaken alongside the IOL review.

Effective: Maternity
Aim: TBC – Currently Under Development
Latest Period: May 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Ali Herron/Katherine Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: PPH Over 1000 mls



What changes have been implemented and improvements made?

Evidence demonstrates that PPH can be reduced by avoiding unnecessary inductions/augmentations of labour - a review of the IOL pathway, capacity and demand has been commissioned by the DOM/CD and induction of labour task and finish group to commence in July 22

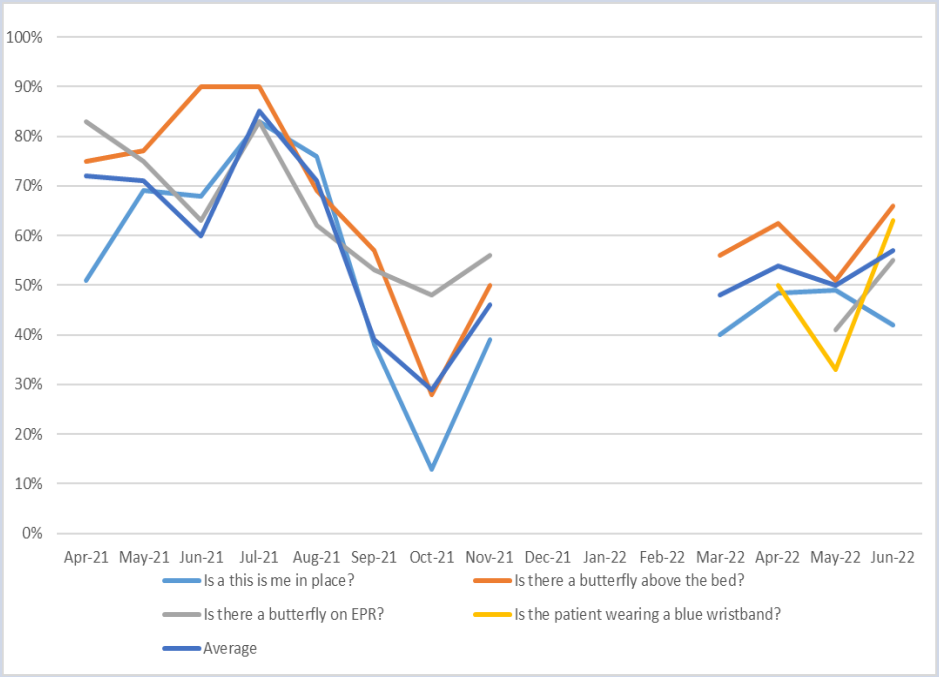
Labour Ward lead obstetrician and Lead pharmacist for Women's planning a trial to implement carbetocin at elective caesarean sections to see if it reduces blood loss, date of commencement to be confirmed.

Patient Centred: Dementia Management
Aim: TBC – Currently Under Development
Latest Period: May 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Joanne Dron
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Dementia Measures:



What do the outcome measures show?

The Dementia Care Bundle should be implemented for all patients admitted with dementia with a target of 95% reliability. This consists of a This-is-Me document, a Butterfly symbol above the bed, and on EPR, and a Blue Wristband worn by the patient (or a recording that the patient / carer has refused).

What do the process measures show?

The dementia care bundle audit is a point prevalence survey of all patients with dementia in-patient on the day of the audit. National average for compliance with This-is-Me (or similar documentation) is around 50% according to the National Audit of Dementia, which makes our target of 95% unrealistic.

What changes have been implemented and improvements made?

The Dementia Buddy co-ordinators are available to assist with completing This-is-Me documents.
An on-line This-is-Me has been created, which can be accessed externally via the Trust website and submitted directly to the DaD Team.

<u>Next steps</u>

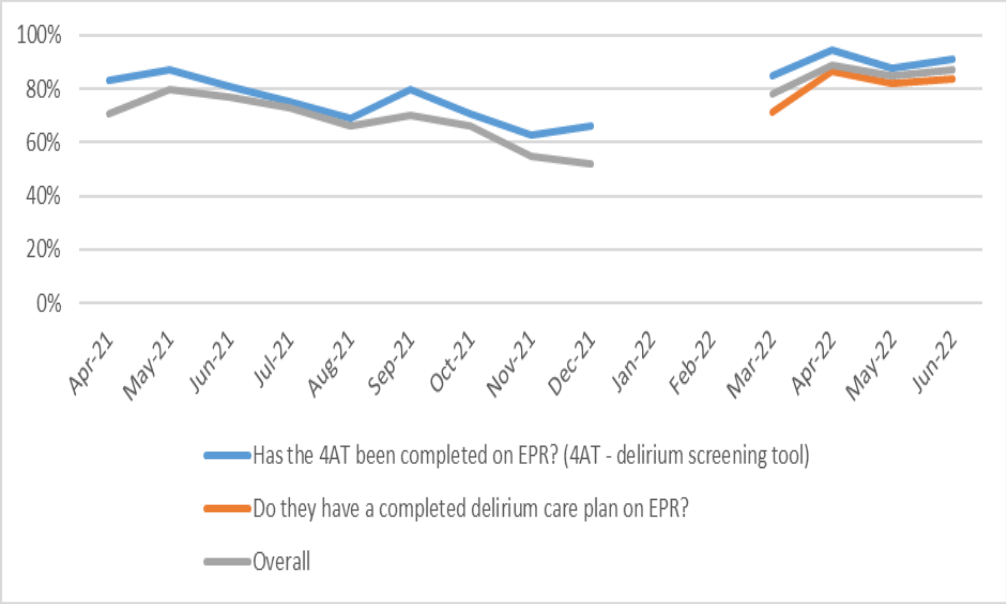
CNL Enhanced Care to explore the possibility of Dementia care awareness training to be mandatory for Nurses on Adult wards, as part of an Enhanced Care Training package.
Reconsidering target % for This-is-Me to be explored with Executive and Quality Teams
Day long Enhanced care training to commence on 1st September 2022
Butterfly Champions Day TBA

Patient Centred: Delirium Management
Aim: TBC – Currently Under Development
Latest Period: May 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Joanne Dron
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Delirium Measures:



What do the outcome measures show?

The Delirium Bundle consists of a 4AT delirium screening tool on EPR and a completed delirium care plan for patients scoring 4 or above. The 4AT should be completed for patients aged 65 and over with a target of 95% reliability

What do the process measures show?

The delirium care bundle audit is completed using digital records of 10 patients aged 65 and over each month on each adult inpatient ward (excluding high dependency units).
Compliance is high thanks to the accessibility of the 4AT on EPR.
Overall % is reduced mainly due to completion of the delirium care plan, which unlike the previous Extramed system, it does not generate the care plan checklist automatically when the patient scores 4 or above on 4AT. The electronic care plan has found to be faulty which means it cannot be completed fully

What changes have been implemented and improvements made?

Delirium flag / alert symbol populates the EPR dashboard when the patient scores 4 or above on EPR

Next steps

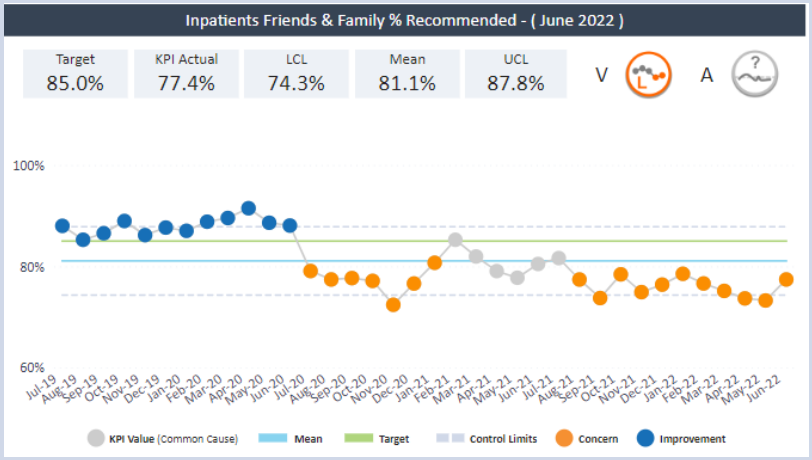
- The care plan on EPR is being rectified and made more accessible
- The audit will be divided, so care plan compliance will be on a separate audit which focusses more on the quality of compliance with the care plan. 4AT data will be pulled from EPR

Patient Centred: IP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Sarajane Poole, Deputy Chief Nurse
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Inpatient Friends & Family % Recommended

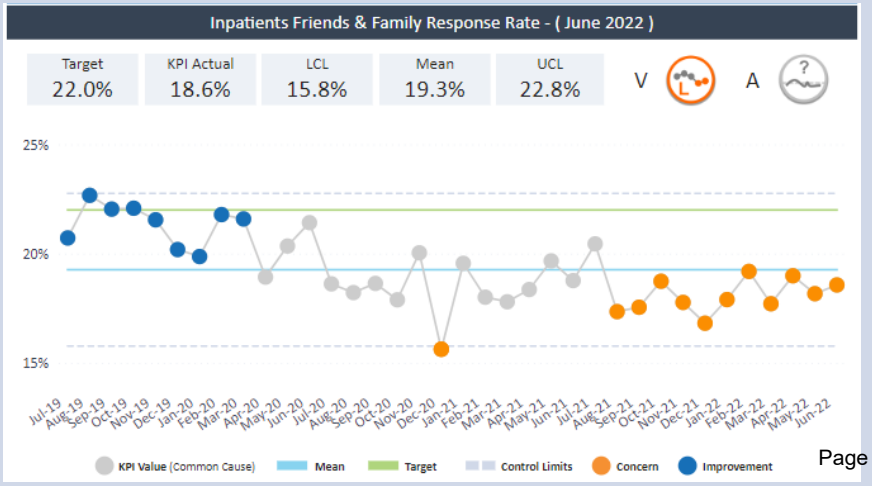


What changes have been implemented and improvements made?

The recommend rate is for May is similar to that of April at 18.15% which is below the national average. The following areas have receive above average recommend rates; Bronte 100%, Harvey 100%, McCulloch 90% and Ocelot

The following areas are showing an improved recommend rate; Emerald 83.33% and Sunderland Day Case 91.67%

Outcome Measure: Inpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate for May for inpatients is very similar to the last reporting month; April 22. Overall the response rate is 18.15% which is below the national average. High scoring areas include Bronte 24%, Lister 20.25% and Nelson 20%, the following areas have shown an improvement from last month; Keats has increased from 15.79% to 17.65 and Wakeley has increased from 9.80% to 28.57%.

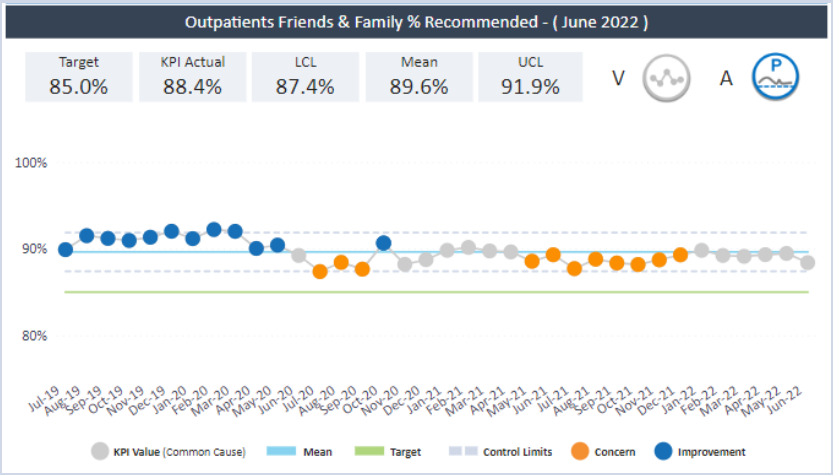
The following areas have shown a marked decreased in their response rate; Tennyson, Pembroke and Milton

Patient Centred: OP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Sarajane Poole, Deputy Chief Nurse
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

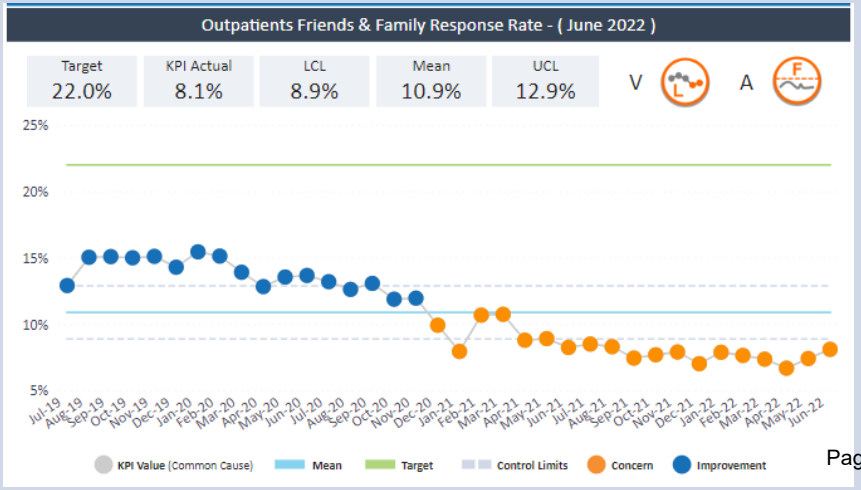
Outcome Measure: Outpatient Friends & Family % Recommended



What changes have been implemented and improvements made?

The outpatient recommend rate is consistently above 89% which demonstrates that many patients are happy with their outpatient experience.

Outcome Measure: Outpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate has been poor at less than 8%. The department has been issuing their own paper feedback survey for patients who attend their appointment and this may reflect the lower response rate as patients may not wish to give their feedback twice.

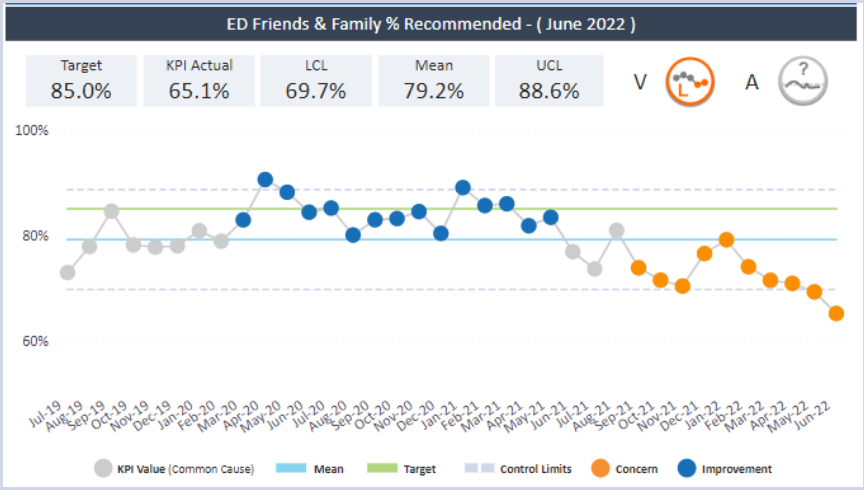
The recommendation is to channel as much feedback as possible through the Friends and Family Test.

Patient Centred: ED Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Sarajane Poole, Deputy Chief Nurse
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: ED Friends & Family % Recommended

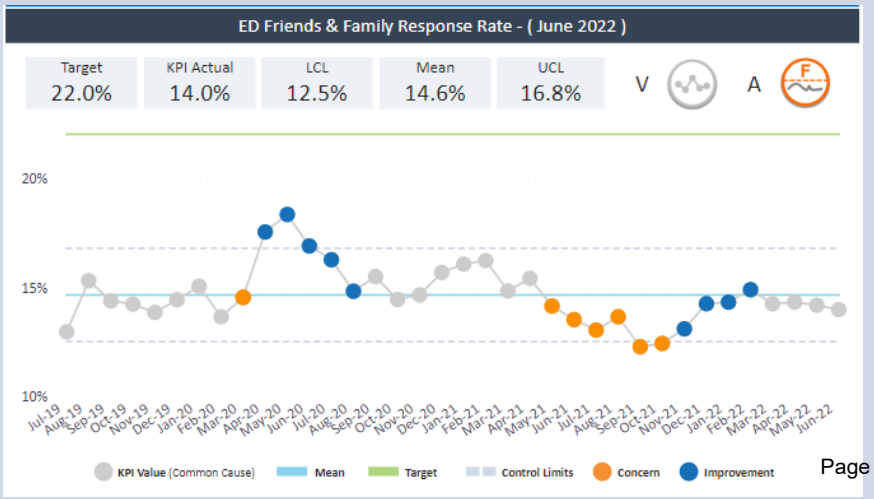


What changes have been implemented and improvements made?

The recommend rated for ED is 69.24% which is similar to the previous month. The rate has fallen slowly over a period of time since early 2021, with the exception in January and February this year.

The newly appointed Head of Nursing has been keen to engage patient feedback and the patient experience team will work with him to explore ways of robustly capturing it.

Outcome Measure: ED Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate for ED is consistently around 14% which is higher than the national average. Some patients who visit the department frequently will be excluded from the survey due to survey fatigue.

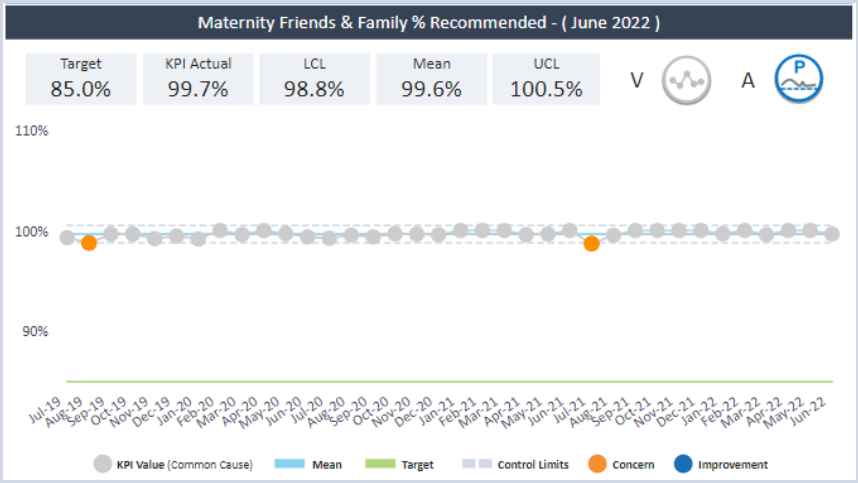
Having a system in ED which patients can use before they leave the department would be beneficial for this group of patients and this will be explored.

Patient Centred: Mat Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: June 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Sarajane Poole, Deputy Chief Nurse
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

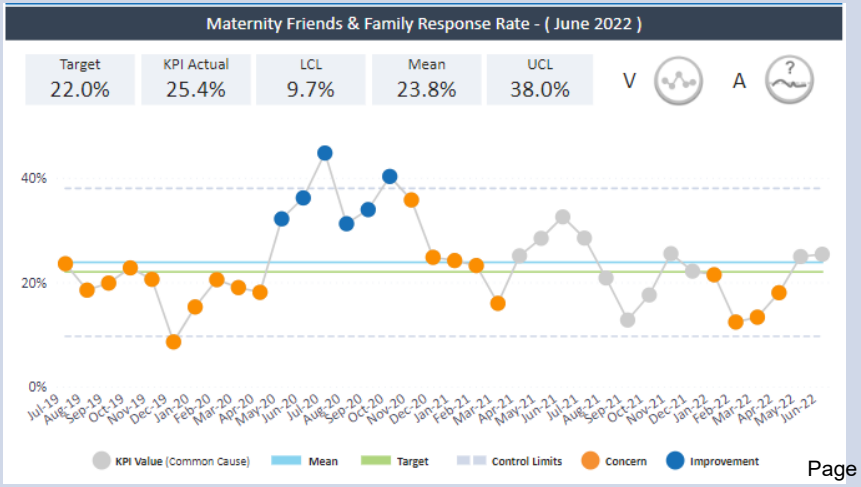
Outcome Measure: Maternity Friends & Family % Recommended



What changes have been implemented and improvements made?

Above target and very positive result of 100% of women and birthing people recommending the maternity service in month.

Outcome Measure: Maternity Friends & Family % Response Rate



What changes have been implemented and improvements made?

Increase of 6% in response rates from 18.02% up to 24.94% in May taking us above the mean

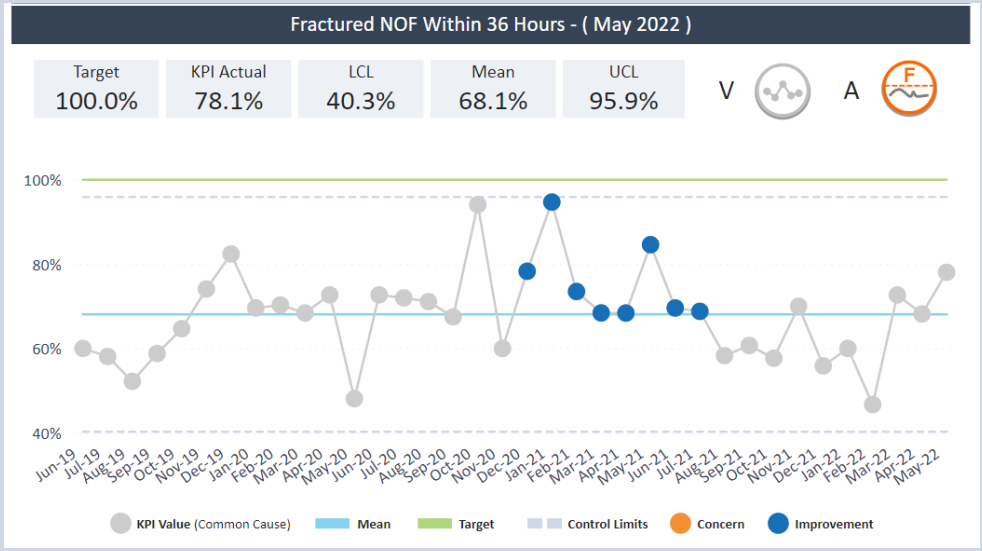
Bespoke maternity FFT questions confirmed and will be implemented once DOM approval has been given (currently reviewing).

Effective: Fracture NOF Within 36 Hours
Aim: TBC
Latest Period: May 2022

Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Howard Cottam
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Process Measure: Fractured NOF Within 36 Hours



What do the outcome measures show?

39 hip fracture patients; 10 breaching 36-hour time to theatre target; with four delayed for medical optimisation and six for lack of theatre availability (predominantly due to Covid-related theatre staffing issues).

The multidisciplinary hip fracture group is now established and will continue to meet monthly. There is agreement from site, with executive support, to protect the 'red bed' and prioritise the accelerated pathway (business continuity willing).

What changes have been implemented and improvements made?

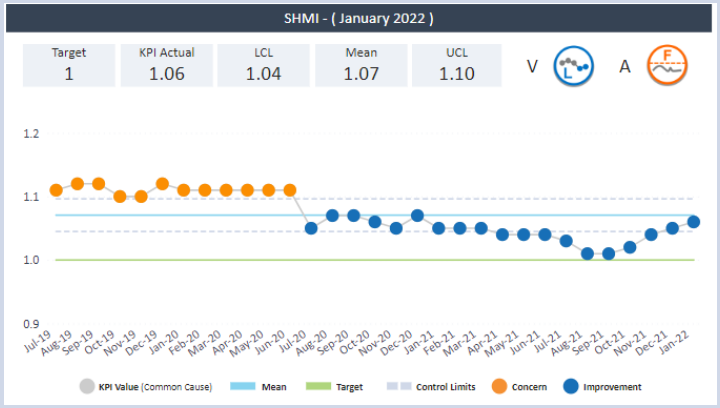
Focusing upon the KPI performance, 'admitted to specialist ward', both the destination and time to the destination feature in this target, with the majority of patients admitted to the specialist ward in an average time of 6.5 hours (target 6h). The performance should improve in line with the adherence to the 'red bed' accelerated pathway.

Effective: Mortality
Aim: TBC
Latest Period: SHMI Reporting Period: Jan-22
HSMR Reporting Period: Mar-22

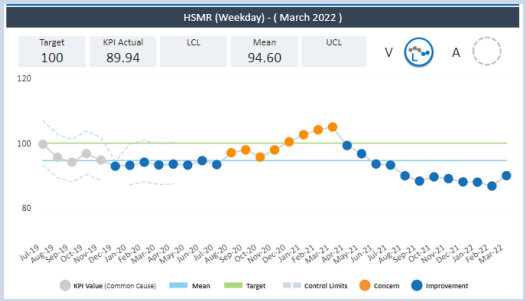
Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

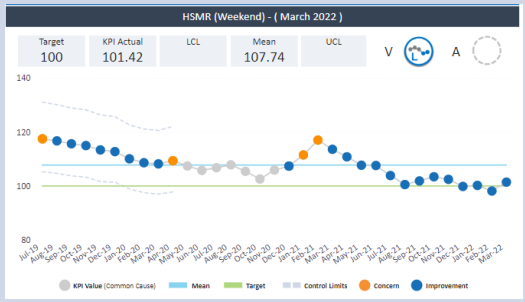
NHS Medway NHS Foundation Trust

Outcome Measure: SHMI Mortality



Outcome Measure: HSMR Weekend and Weekday Mortality





What do the measures show?

The Trust's SHMI for February 2021 – January 2022 is 1.06, and is within the 'as expected' range for the reporting period. The trust remains within the 'as expected' range for all 10 diagnosis groups. The slight increase noted in the SHMI can be due to a number of reasons, including seasonality. When data is compared to the HSMR (which considers in hospital deaths only), the trend follows a similar pattern, which indicates its more likely the out of hospital deaths causing a slight increase. Dr Foster are going to analyse this in more detail when the new model for yearly data is recalculated after July.

HSMR for the reporting period of April 2021- March 2022 is 101.9, weekend is 113.8 and weekday is 98.9; all within the 'as expected' banding.

What changes have been implemented and improvements made?

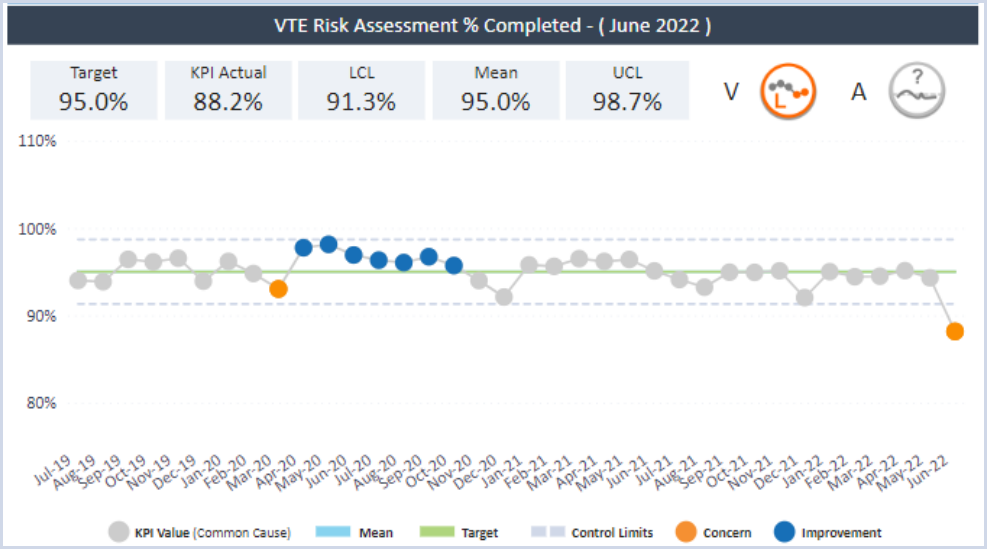
- The most recent data from Dr Foster indicated that there are no new outlier groups. The weekend HSMR is currently on a downward trend for the third consecutive month.
- At the recent Mortality and Morbidity Surveillance Group, the new deep dive process was agreed amongst the group with a view to pilot this process on the existing outlying diagnosis groups.
- Dr Grimes and Dr Ogburn completed a deep dive for the diagnosis group 'Cancer of the liver and intrahepatic Bile duct' and this showed no significant findings or failings in care.
- Dr Sulch completed an initial deep dive into stroke patients and concluded there were no significant concerns. Dr Sulch is going to complete a further review, focusing on two key patient groups ; patients discharged from Medway with a diagnosis of Stroke and patients treated at Maidstone Hospital (which include the majority of Medway and Swale patients).

Effective: VTE Risk Assessments
Aim: TBC
Latest Period: June 2022

Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Paul Oldak, VTE Nurse Specialist
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: VTE Risk Assessments Completed



What does the measure show?

The venous thromboembolism (VTE) risk assessment data collection is used to inform a national quality requirement in the NHS Standard Contract, which sets an operational standard of 95% of inpatients (aged 16 and over at the time of admission) undergoing risk assessments each month.

Month	Reported VTE data from PAS	Data following further drug chart review
June 22	88%	Drug chart review ongoing
June **21**	84.18%	94.84%
May 22	93.7%	95.9%
April 22	90.01%	95.6%

The reduction of VTE assessment in June is due to VTE assessments not being recorded promptly on the Patient Administr5ation System (PAS) by ward

What changes have been implemented and improvements made?

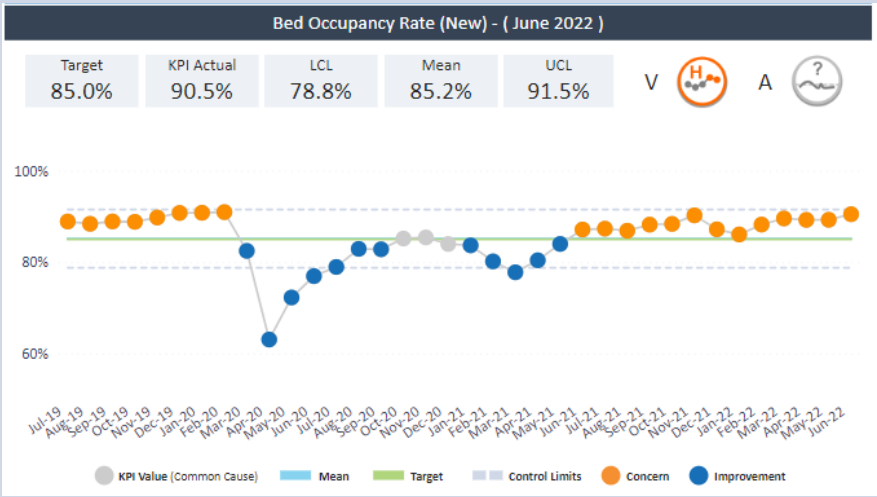
- The VTE team (1WTE) have to bridge the gap in recording VTE assessment on PAS for wards that do not have ward clerks reducing timely upload.
- This process will be improved once VTE risk assessments are added to Electronic Patient records (EPR) in November 2022.
- VTE prevention compliance audit has been added to Gthr. The regime for the next 3 months involves auditing 5 patients on 3 random wards weekly until assurance that the audit questions are formatted correctly. The audit will then be rolled out Trust Wide.
- The audit will inform education focus provided by VTE CNS to improve VTE assessment and prevention.

Operational Standards: Bed Occupancy Rate
Aim: TBC
Latest Period: June 2022

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Not applicable
Sub Groups: TBC

NHS Medway NHS Foundation Trust

Outcome Measure: Bed Occupancy Rate



What does the measure show?

The measure describes the trust as consistently performing above the target occupancy of 85% since July 2021.

This metric in part is expected to be challenged during the winter months and this was somewhat heightened in March due to the rising COVID patient numbers and associated contact beds.

However over April & May the position is slightly improved due to COVID numbers gently declining (around 17 average in late May) but rising once more to 70 per day in June.

What changes have been implemented and improvements made?

During the period of June there have been many improvement programmes developed to enhance our bed occupancy. Namely: -

- An agreement to protect the trust's surgical assessment unit to ensure steady flow for surgical admissions.
- A granular focus on early discharge across all care groups via "live" estimated day of discharge reporting (EDD) managed through the site teams.
- Haris project to review admission avoidance has commenced in March. Initial feedback was provided on 12th May with the full report presented on 24th May.

There has also been a decision in May to close Nelson ward as one of our escalation areas which was successful in June.

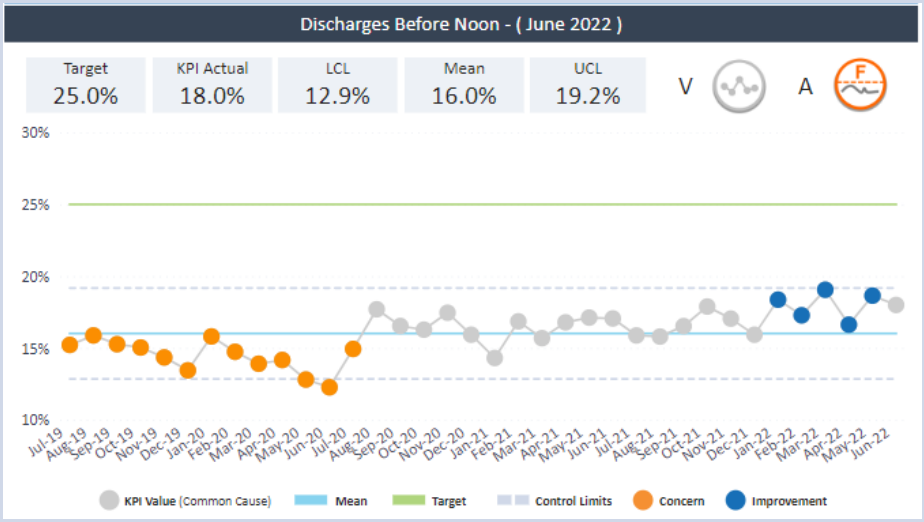
Future strategies to reduce bed occupancy include the midday discharges project which is championed by the COO and forms a core part of the breakthrough objectives for Patient First programme alongside the implementation of the new medical-acute model which starts in August 2022.

Effective: Discharges Before Noon
Aim: TBC
Latest Period: June 2022

Executive Lead: Mandy Woodley, Chief Operating Officer
Operational Lead: Tracey Stocker
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Process Measure: Discharges Before Noon



What do the outcome measures show?

Pre-noon discharges are remaining above the lower levels seen before and during the high occupancy levels during the early periods of the pandemic.

Work is on-going with our ward staff and system partners to continue to improve discharge information and metrics to support improvement. We are working with clinical, operational and BI colleagues to base line pre-noon for all adult G&A wards and set trajectories for improvement milestones.

What changes have been implemented and improvements made?

Implementation and use of the PTL and operational pressure report which pulls a summary of the potential and definite discharges through, this report also shows the status of eDN for these patients. This is providing operational, clinical and site oversight of our discharge levels, EDD's and associated eDN numbers which are reviewed throughout the day.

Under the Patient First Strategy, discharges before noon is one of the 5 Breakthrough objectives for the trust and we are currently in the process of defining the Care Group level driver metrics for this area.

Changes to the start-times for consultants to ensure early morning patient reviews has recently started following a consultation period and we will be monitoring the impact of these changes through our divisional SDR's.

Meeting of the Board of Directors in Public

Wednesday, 03 August 2022

Quality Assurance Committee Assurance Report

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	5.2
Committee Chair:	Tony Ullman, Chair of Committee		
Date of Meeting:	Tuesday, 28 June 2022		
Lead Director:	Evonne Hunt, Chief Nursing Officer		
Report Author:	Joanne Adams, Business Support Manager		

The key headlines and levels of assurance are set out below, and are graded as follows:	
Assurance Level	**Colour to use in 'assurance level' column below**
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headlines	**Assurance Level**
1. Quality account 2021/22 for approval The Committee received, reviewed and discussed the quality account 2021/22. The Committee were informed about a couple of proposed changes to the proposed priorities and how they are monitored. A spelling mistake was highlighted. The statement from the Chair of Medway Council's Health and Social Care Oversight Committee needs to be included within the account. The signed quality account will be uploaded to the Trust website, NHS England and shared with Trust Board. The Committee **APPROVED** the quality account subject to the proposed amendments.	**Green**
2. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report The Committee received the assurance and escalation report from the quality and patient safety sub-committee. The Committee were informed that QPSSC	**Green**

took place over two meetings (23 June and 24 June) due to the robust discussions and assurances on the agenda items. The Committee were ASSURED by the robust discussions taking place at QPSSC and the detail provided within the report. The Committee NOTED the need extend the QPSSC meetings to allow for the discussions on the papers. The Committee also NOTED the ongoing work to align meetings to ensure flow of information and reporting.	
3. Quality, safety and risks report The Committee received the quality, safety and risks report which provided an update for the reporting month of May 2022 on incidents reporting and current position, CQC information requests, Quality Assurance visits, implementation of Gather, safety update, quality risks, clinical effectiveness and mortality and morbidity. The Committee were pleased to note the feedback from the Better Tomorrow team at NHSE/I on their review of the Trusts processes for structured judgement reviews. Better Tomorrow have requested the Trust's approach be used as a case study for other trusts to learn from. The Committee were pleased to NOTE the improvement to compliance of duty of candour in both divisions.	**Amber\Green**
4. Infection prevention and control update and IPC BAF The Committee received the infection prevention and control update paper which provided progress on mandatory surveillance against national targets for Hospital Acquired Infections, measurement of the Trust's current management of SARS-COV2 virus (COVID-19) including changes to social distancing and visiting and the living with COVID paper. The report also provided an update on hand hygiene audit results, training compliance and national and regional updates. The Committee was informed about the results from an audit of cleanliness of commodes, which highlighted a number of commodes were broken and not fit for purpose. The Committee were assured to hear that a task and finish group has been established to competencies for staffing in cleaning commodes, spot checks taking place and handover of cleaning at each shift. The Committee as informed of the plans to replace the broken and out of date commodes. The Committee were informed about the outstanding actions on the IPC BAF for the month and the plans in place to bring these back on track. The Committee were assured by these plans. The Committee discussed Monkey Pox and were informed that there have been no cases at the Trust.	**Green**
5. Quality IQPR The Committee received and noted the Quality IQPR which provided an update on key performance indicators and quality metrics for the reporting month of May 2022. The Committee were informed of the work taking place with KPMG and the Business Intelligence team to update the IQPR which will be based on Patient First breakthrough objectives, the watch metrics and will include performance against other quality metrics.	**Green**

The Committee noted the inclusion of additional slides within the IQPR relating to maternity performance and transformation work. The Committee were informed about the improved 4 hour ED performance, the closure of an escalation ward and improved ambulance handover performance.	
6. End of Life Care quarter 4 report The Committee received the end of life care quarter 4 report which provided an update of the work of the end of life care team for the reporting period. The Committee were informed of the increase to end of life care education and training along with a training programme which provides end of life care and palliative care training to medical students. The Committee were informed that the end of life care service and palliative care service are combining to provide a collaborative joined up approach to providing end of life care to our patients. The Committee were pleased to NOTE the Trust is above national average benchmarking in the national audit of care at the end of life (NACEL). This is a comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community and mental health inpatient provides.	**Green**
7. Regulation 28 The Committee received a report and action plan in relation to a Regulation 28 issued to the trust by HM Coroner. The response and action plan have been submitted to the Coroner ahead of the deadline date. The Committee discussed the actions within the action plan as they were keen to understand how the actions are closed. The Committee requested the action plan be taken to the mortality and morbidity group for review and monitoring and the group will feedback progress to the Committee in a few month's time.	**Amber/Green**
Escalation to Board No items identified for escalation to Board. The Committee inform the Board on the following points: • No items for escalation to the Board • Discussion on risk and reporting • Amendment to quality account on how quality priorities are described and monitored • End of life care infographics on the NACEL audit which shows the trust above the national average in benchmarking for communication and decision making	

Meeting of the Board of Directors in Public

Wednesday, 03 August 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday 26th July 2022		
Lead Director:	Evonne Hunt, Chief Nursing Officer		
Report Author:	Joanne Adams, Business Support Manager		

The key headlines and levels of assurance are set out below, and are graded as follows:	
Assurance Level	**Colour to use in 'assurance level' column below**
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headlines	**Assurance Level** (use appropriate colour code as above)
1. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report The Committee received the assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Friday 22nd July 2022. The Committee were assured by the robust discussions taking place at QPSSC and the detail provided within the report. The Committee noted that a number of papers on the agenda for the quality assurance committee had been discussed at QPSSC.	**Green**

The Committee also noted the ongoing work to align meetings to ensure flow of information and reporting.	
2. Quality performance report The Committee received the revised quality performance report noting this had been presented and well received at Trust Management Board and Quality and Patient Safety Sub-Committee. The report provided progress updates detailing performance against the hospital's key quality metrics, including: • Patient Safety • Quality Assurance and Compliance • Clinical Effectiveness • Mortality and Morbidity • Risk & Policy Management • Legal and Information Governance The Committee were assured by the content of the quality performance report and welcomed the revised and thorough report.	**Green**
3. Quality IQPR The Committee received and noted the Quality IQPR which provided an update on key performance indicators and quality metrics for the reporting month of June 2022. The Committee were advised that the IQPR is being revised using the format of the new Quality Performance Report and will focus on Patient First break through objectives, true north domain and watch dashboard. There will be a spot light on 4 month reporting period which will highlight were improvements are required and the detail of what the improvement is.	**Green**
4. Safeguarding self-assessment The Committee received the safeguarding self-assessment framework (SAF) – thematic review tool which has been submitted to the Kent and Medway Adult Safeguarding Board (KMASB). The Committee were informed the KMASB have a statutory responsibility to review the quality of the safeguarding arrangements in its area and the SAF is the tool they use. The Committee were advised that since submitting the SAF a peer review of the evidence has taken place with KMASB who recommended that 3 of the 5 amber rated actions should be green as they felt there was sufficient evidence to support a green rating. The Committee were assured by the clear assessment provided and the clarity on the improvements that are needed. The Committee were informed that the Safeguarding team has consolidated all improvement plans into the one document. The Committee commended the work of the safeguarding team.	**Green**
5. Stroke update	**Green**

Dr David Sulch, consultant physician (Dartford) and medical examiner (MFT) provided an update to the Committee on the review of stroke services that he has undertaken. The purpose of the review was to determine if Medway patients have been disadvantaged since the move of stroke services to the hyper acute stroke unit (HASU). • The review has determined:- o Medway patients sent to Dartford HASU are not disadvantaged with regard to the care they receive o Stroke patients that are not sent to Dartford HASU and die at MFT all had low GCS scores, were very sick and were brought to the nearest hospital. Dr Sulch advised the Committee that he is now reviewing Swale patients that are sent to Maidstone HASU and patients at Medway that have survived a stroke and have been discharged and time taken by ambulance to get to the HASU. The outcome of this review will shared at the clinical effectiveness and outcomes group and then with the Committee.	
6. Mortality and Learning from death annual report 2021/22 The Committee received a robust mortality and learning from death annual report 2021/22 and approved the report for onward sharing with Trust Board.	**Green**
7. HARIS update The Committee received an update from the HARIS steering group that are working on 3 workstreams: • Virtual Ward • Acute Medical model • Frailty Weekly meetings are taking place with the national team to ensure the trust can do all it can to improve ambulance hand overs and the wider patient journey into hospital, and to find admission alternatives wherever possible. The Committee will receive regular updates on the HARIS project.	**Green**
8. Maternity self-assessment tool The Committee received the NHSEI maternity self-assessment tool which was developed in response to national review findings, and recommendations for good safety principles within maternity services. The current self-assessment was completed in May and June 2022 and reflects the following position of 8 red, 49 amber and 97 green. An action plan is being developed to deal with the areas requiring improvement. The Committee approved the Maternity self-assessment tool for onward sharing with Trust Board.	**Green**
9. Perinatal surveillance quality report The Committee received the perinatal surveillance quality report which has combined all aspects of quality and safety in maternity including Ockenden and CNST requirements. Going forward the report will be presented in the format of the new quality performance report.	**Green**

10. Maternity and Neonatal Safety Champions Assurance Board Terms of reference The Committee approved the terms of reference for the maternity and neonatal safety champions assurance board. The terms of reference will be presented to Trust Board for sign off.	**Green**
11. Complaints annual report The Committee received the complaints annual report which provided a summary of complaints from 1 April 2021 to 31 March 2022, referencing the main issues raised by patients and their families, including trends and triangulation work, performance against agreed response targets and complaints that progress to second stage by the Parliamentary and Health Service Ombudsman. The Committee were informed that focus has been given to providing early and swift resolution at every opportunity by the PALS team and the data provided in the report reflected this approach. The Committee approved the report for onward sharing with Trust Board.	**Green**
12. BAF – quality risks The Committee were informed that a review of the gaps in assurance/control has taken place to provide assurance that the BAF –quality risks are appropriately managed and any identified gaps in control does not create further risk exposure for service delivery. The Committee noted the proposed change in risk rating score of Risk 5c reducing from a risk rating score of 20 to a risk rating score of 12. The Committee recommended the proposed change to Risk 5c be discussed at Trust Board.	**Amber/Green**
13. Commissioning for Quality and Innovation (CQUIN's) 2022/23 The Committee were informed that Swale & Medway CCG have agreed on the following 5 CQUINS: • CCG1: Staff flu vaccinations • CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions • CCG4: Compliance with timed diagnostic pathways for cancer services • CCG5: Treatment of community acquired pneumonia in line with BTS care bundle • CCG7: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service In addition to the CQUINs the trust will be delivering the following specialized services scheme (PSS scheme) • PSS1: Achievement of revascularisation standards for lower limb Ischaemia • PSS2: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery • PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines	**Green**

Progress against CQUIN targets will be monitored through the establishment of a CQUIN Monitoring Group, chaired by the Director of Quality and Patient Safety. This group will report into the Clinical Effectiveness and Outcomes Group.	
14. CQC insight report The Committee received the CQC insight report which provided a review of data published in the CQC May's release of its Insight Report for Acute NHS Trusts published on 8th June, 2022. The reporting period covered: February 2021 to January 2022. • For Medway, Intelligence from this insight report indicates that o Overall performance for this trust is about the same o Caring performance is improving o Effective, Responsive, Safe, Well led performance is stable o Urgent and emergency care performance is declining(current positions now inspected as good) o Critical care, Children and young people, o Maternity and gynaecology, Medical care, Outpatients, Surgery performance is stable The Committee were asked to note that the data within the report covers the period February 2021 to January 2022 and since publication mitigations and improvements are in place for the red rated areas and progress is monitored via the IQPR metrics.	**Amber / Green**
Escalation to Board No items were identified for escalation to Board. The Committee inform the Board on the following points: o A number of reports were approved for onward sharing with Trust Board, these being:- o Mortality and Learning from death annual report 2021/22 o Maternity self-assessment tool o Perinatal surveillance quality report o Maternity and Neonatal Safety Champions Assurance Board Terms of reference o Complaints annual report o BAF – quality change to risk rating for risk 5c • The Committee commend the improved formatting of the quality performance report.	

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 03 August 2022

Title of Report	**Mortality and Learning from Death Annual Report 2021/22**	**Agenda Item**	5.3
Report Author	Sofia Power, Mortality and Bereavement Manager		
Lead Director	Alison Davis, Chief Medical Officer		
Executive Summary	This paper provides the annual review of the Mortality and Learning from death data and performance for the period 01 April 2021 to 31 March 2022. At the time of writing this report, the most recent mortality indicator data was used • Hospital Standardised Mortality Ratio (HSMR) for the reporting period of April 2021- March 2022 is 101.9 which is within the 'as expected' range. • Standardised Hospital-level Mortality Indicator (SHMI) for the reporting period of February 2021- January 2022 is 1.06 which is within the 'as expected' range. • Between April 2021 to March 2022, 141 deceased patients were subject to Structured Judgement Reviews (SJRs). • During the period of April 2021- March 2022, there has been a total of 141 SJRs completed. Reviews indicate that 67% of cases submitted to the panel, were scored good or excellent for overall care assessment. Ten (10) were categorised as deaths due to failings in care and are being investigated as Serious Incidents or High Level Investigation. • During this period, 1398 patients died, inclusive of 23 early neonatal deaths and 9 child deaths. Of these, 11 were identified as having a learning disability.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Quality Assurance Committee. Date of approval: July 2022		
Executive Group Approval:	Date of Approval: No		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state):		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	The Trust is required to be compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.		
Quality Impact Assessment	None		

Recommendation/ Actions required	The Trust Board are asked to NOTE the report for ASSURANCE as to the current performance and learning from deaths			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	Annual Report			

Medway NHS Foundation Trust
Mortality and Learning from Death
Annual report 2021/22

Report Author: Sofia Power, Mortality and Bereavement Manager

Lead Director: Alison Davis, Chief Medical Officer

Contents

1. Executive summary

At the time of writing this report, the most recent mortality indicator data was used

- Hospital Standardised Mortality Ratio (HSMR) for the reporting period of April 2021- March 2022 is 101.9 which is within the 'as expected' range.
- Standardised Hospital-level Mortality Indicator (SHMI) for the reporting period of February 2021-January 2022 is 1.06 which is within the 'as expected' range.
- Between April 2021 to March 2022, 141 deceased patients were subject to Structured Judgement Reviews (SJRs).
- During the period of April 2021- March 2022, there has been a total of 141 SJRs completed. Reviews indicate that 67% of cases submitted to the panel, were scored good or excellent for overall care assessment. Ten (10) were categorised as deaths due to failings in care and are being investigated as Serious Incidents or High Level Investigation.
- During this period, 1398 patients died, inclusive of 23 early neonatal deaths and 9 child deaths. Of these, 11 were identified as having a learning disability.

2. Introduction

In March 2017, the National Quality Board published guidance based on the recommendations from the Care Quality Commission (CQC) report 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.'

The Standardised Hospital-level Mortality Indicator (SHMI) produced by NHS Digital, published monthly. The Hospital Standardised Mortality Ratio (HSMR) produced by Telstra Health (Dr Foster) Intelligence and is published monthly, are the two mortality indicators the Trust uses for monitoring mortality. Both are expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

Both mortality indicators use slightly different methodology to arrive at the indicator value and aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR) to ascertain whether a trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'. To be 'higher than expected', the Trust must have a HSMR above 100 and the lower confidence interval must be above 100. To be low, the Trust must have a HSMR below 100 and the upper confidence interval must be below 100

It important to note that whilst mortality indictors are a good way of detecting and learning from adverse events, they should not be used in isolation or as a measure of Trust performance in terms of quality of care.

This report provides a summary of the Trust's mortality metrics and activity over a twelve month period for 01 April 2021 to 31 March 2022.

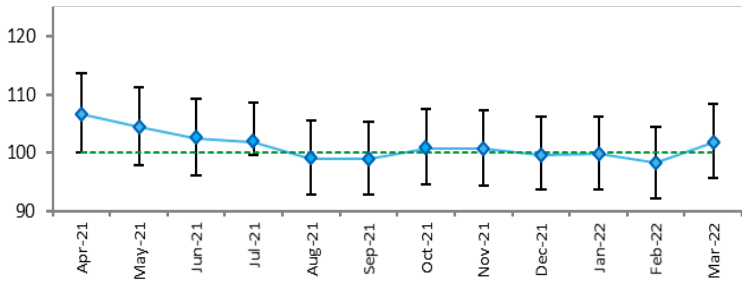
3. Hospital Standardised Mortality Ratio (HSMR)

Telstra Heath UK (Dr Foster) is used to collate the Trust's Hospital Standardised Mortality Ratio (HSMR) data. HSMR data is published monthly, three months in arrears.

The Trust's HSMR for the reporting period of April 2021 – March 2022 is 101.9 and within the 'as expected' band. HSMR for Emergency weekday admission is 98.0 and for weekend admission, the Trust's HSMR is 109.8; both are within the 'as expected' band.

12 months to:	Crude %	HSMR overall
Apr-21	4.00%	106.7
May-21	3.80%	104.4
Jun-21	3.80%	102.5
Jul-21	3.80%	101.9
Aug-21	3.70%	99
Sep-21	3.70%	98.9
Oct-21	3.70%	100.8
Nov-21	3.70%	100.7
Dec-21	3.70%	99.7
Jan-22	3.70%	99.8
Feb-22	3.60%	98.2
Mar-22	3.70%	101.9

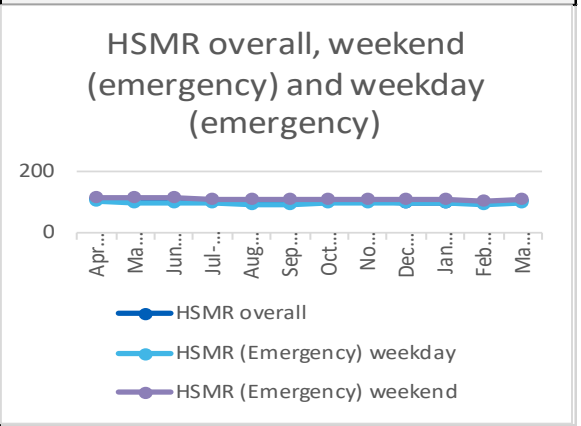
Trend



Weekend and weekday HSMR remain within the 'as expected' banding. When investigating HSMR by day of admission, a common approach is to narrow the methodology to just 'emergency' admission (excluding elective, transfers and maternity). This is because HSMR will then better reflect how the day of the week impacts outcomes form unplanned events. The Trust emergency HSMR follows the same trend as HSMR, but with more stability over the last 36 months. Emergency weekend HSMR is 105.9, Emergency weekday HSMR is 94.2.

12 months to:	HSMR overall	HSMR (Emergency) weekday	HSMR (Emergency) weekend
Apr-21	106.7	101.4	115.2
May-21	104.4	99.4	112.3
Jun-21	102.5	96.6	112.8
Jul-21	101.9	97.1	109.5
Aug-21	99	94	106.5
Sep-21	98.9	93.7	108.1
Oct-21	100.8	95.2	110.8
Nov-21	100.7	95.5	109.7
Dec-21	99.7	95.2	107.2
Jan-22	99.8	94.9	107.9
Feb-22	98.2	93.6	106.1
Mar-22	101.9	98	109.8

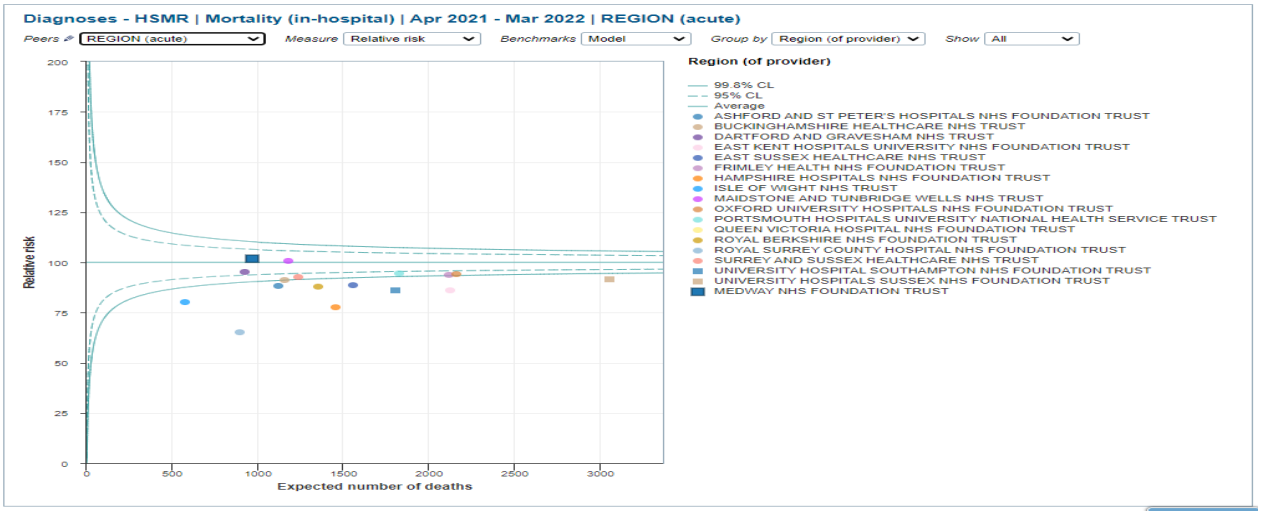
Trend



Analysis of trends in HSMR should be held with some caution.

- Firstly, the second wave of COVID is beginning to move out the 12 month rolling period and Medway in particular were hit harder and earlier in the second wave of COVID than many other Trusts nationally. Therefore, when Dec 20 drops out of the 12 month rolling period, Medway are more affected in terms of HSMR.

- Secondly, HSMR uses the year of discharge data as a model for HSMR. The most recent year of discharges between Nov 20 - Oct 21 include the second wave of COVID months; therefore, the model is calculating risk of death by including COVID.



Peer comparison: South region (acute)

Outlier and Cumulative Sum (CUSUM) Alerts

Dr Foster monitor and highlight diagnosis groups that are outliers and CUSUM alerts on a monthly basis. CUSUM alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold. The alert is triggered when a CUSUM statistic passes a national benchmark. They act as an alarm bell for potential further investigation, should the number of deaths increase .

It is important to note that diagnosis groups that trigger an alert do not always mean there is an immediate need to investigate. Dr Foster recommends that a sample of patients is used for deep dive reviews. This is inclusive of monitoring identified diagnosis groups and the number of observed deaths within that group on a month-by-month basis. The outlying diagnosis groups highlighted for the most recent data set are:

- Cancer of the Liver and intrahepatic Bile duct.- *Deep dive completed with no significant findings. One case referred for High Level Investigation due to nutrition issues.*
- Intestinal Obstruction without Hernia
- Genitourinary congenital anomalies
- Other perinatal conditions: *Other perinatal conditions and genitourinary congenital anomalies are diagnosis groups are monitored via the well-established Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) programme, as well as through the*

National Neonatal Audit Programme. Dr Foster have confirmed that HSMR is not a good measure of performance and risk for this cohort and advise that crude numbers are reviewed rather than focus on outlier status.

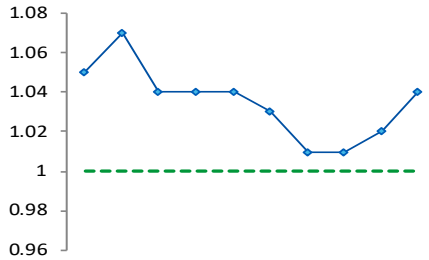
The Better Tomorrow Team at NHS England and Improvement are working with the Mortality Team to co-produce a process for review and management of outlier groups and determining which require deep dives and how they should be conducted and reported. The process will be agreed at the Mortality and Morbidity Surveillance Group (MMSG) and the process will be trialled at Medway with a view of making it accessible nationally.

4. Standardised Hospital-level Mortality Ratio (SHMI)

SHMI reports on mortality at trust level across all NHS Trusts in England and is produced and published monthly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there. SHMI differs from other mortality indicators as it includes all deaths outside of hospital, within 30 days of discharge, as well as all hospital deaths.

COVID-19 activity is excluded from SHMI as it is not designed for this type of pandemic activity. The model used to calculate SHMI might not be robust enough if such activity were included. Therefore, SHMI is not exposed to the same levels of volatility as HSMR is, which does include COVID-19 activity.

12 months to:	SHMI	Crude %	In-Hospital	Post discharge	Expected	Trend
Feb-21	1.05	3.02	900	505	1332.81	
Mar-21	1.07	2.91	877	495	1280.19	
Apr-21	1.04	2.74	836	512	1292.92	
May-21	1.04	2.71	852	520	1317.95	
Jun-21	1.04	2.67	855	528	1327.68	
Jul-21	1.03	2.63	863	514	1334.58	
Aug-21	1.01	2.55	839	504	1333.47	
Sep-21	1.01	2.56	847	506	1337.56	
Oct-21	1.02	2.58	869	498	1337.8	
Nov-21	1.04	2.69	934	513	1387.87	
Dec-21	1.05	2.78	999	538	1469.36	
Jan-22	1.06	2.83	1050	557	1515.66	



The Trusts SHMI value for the most recent reporting period of February 2021- January 202 is 1.06. This has remained consistent within the 'as expected' range for year 2021. SHMI is composed of 142 diagnosis groups and it highlights the ten (10) diagnosis groups that have the most observed deaths in order to indicate performance of these groups. The Trust is within the 'as expected' band for all ten (10) groups.

Outliers identified for the most recent data set are:

- Acute Cerebrovascular Disease- An initial deep dive completed by the one of the Trust Medical Examiners concluded that there were no significant concerns over the management of patients from Medway and Swale who were treated at Darent Valley Hospital or those who were conveyed to Medway and subsequently died. Dr Sulch is continuing to review two key patient groups with a focus on patients discharged from Medway with a diagnosis of stroke to enable a prospective review of care provided and patients who were treated at Maidstone hospital which includes the majority of Swale patients.
- Other connective Tissue Disease
- Deficiency and other anaemia, acute post-haemorrhagic anaemia

5. Learning from Death

In March 2017, the National Quality Board published its guidance based on the recommendations from the Care Quality Commission (CQC) report 'Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.' The national guidance provided a framework for NHS Trusts to identify, report, investigate and learn from deaths in care and required all Trusts to put in place a policy setting out their approach to mortality reviews. This approach was embedded in a revised Medway NHS Foundation Trust mortality review process during April 21- March 22.

Between 01 April 2021 and 31 March 2022, for Quarter 1,2, 3 and 4, the Trust recorded 1364 inpatient deaths; inclusive of 23 early neonatal and 9 child deaths. During this timeframe, 11 patients with learning disabilities died in hospital. Patients who die with a Learning Disability are flagged for Structured Judgement Review and are also referred to the Learning Disabilities Mortality Review (LeDer) panel.
An overview of the Trust's current position with regard to the Mortality Review Process is presented below.

Early neonatal and child deaths
Any child who dies before their 18th birthday is subject to the Child Death Review Process, which involves a multi-agency review of the child's care and is coordinated by Kent and Medway Child Death Review (CDR) Team. In addition, the Trust's neonatology and acute paediatric teams hold specialty mortality and morbidity meetings to discuss the care of these patients. Child deaths and neonatal deaths are discussed and well monitored at the monthly Acute Paediatrics Mortality and morbidity meetings and via the Perinatal mortality Review Tool (PMRT).

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Total
Total number of deaths	88	87	82	108	101	114	131	154	140	153	111	129	1398
Neonatal Deaths	4	1	1	4	1	0	4	0	1	3	1	3	23
Child Deaths	1	1	0	1	1	0	2	1	1	1	0	0	9
Learning Disability Deaths	1	0	1	1	2	0	0	0	2	1	1	2	11
% of SJRs Requested (from number of deaths)	7%	5%	11%	7%	10%	5%	3%	7%	4%	8%	10%	12%	7%
SJR Review Completed	0	8	8	11	26	5	14	16	14	17	11	11	141
Coroner Referrals - Form B (Post Mortem) and Inquests	12	15	14	27	14	17	15	19	13	21	14	16	197

Medical Examiner Service

The Medical Examiner Service was implemented in the Trust in July 2020. The Trust has three Medical Examiners and a Lead Medical Examiner. Medical Examiners are independent from the Trust and accountable to the National Medical Examiner. The purpose of the Medical Examiner Service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.
- Improve the quality of death certificate
- Improve the quality of mortality data.

The Medical Examiners (ME) are supported by Medical Examiner Officers (MEOs) who provide administrative support with ensuring accuracy of any medical certificate or cause of death (MCCD). The MEO's lead in liaising with families/ next of kin of the deceased to discuss cause of death establish if there are any concerns with hospital provided care prior to death. They also act as a medical advice resource for the local coroner. Working in collaboration with the mortality team, MEOs inform of potential cases flagged for structured judgement reviews.

The Medical Examiner Office is required to report to NHS England on the number of MCCDs not completed within three calendar days of death. Calendar days take no account of bank holidays or weekends. An escalation process is in place to mitigate any delays that may arise from non-completion of death certificates following medical examiner scrutiny.

The Medical Examiner's Office annual statistics indicate that the majority of MCCD's are completed within the 5 calendar days.

	Acute deaths scrutinised by Medical Examiner	Scrutiny by next working day	Scrutinised deaths referred to coroner	Deaths notified to coroner and taken for investigation (Post mortem / inquest)	% of cases not completed within 3 days	Time to Completion		
						Within 2 working days	Within 3 calendar days	Within 5 calendar days
Apr-21	88	93%	17	12	73%	86%	73%	95%
May-21	87	91%	21	15	64%	78%	64%	94%
Jun-21	82	79%	22	14	66%	77%	66%	88%
Quarter 1	**257**	**88%**	**60**	**41**	**68%**	**81%**	**68%**	**93%**
Jul-21	108	92%	29	27	62%	70%	62%	85%
Aug-21	101	96%	16	14	75%	84%	75%	96%
Sep-21	114	95%	22	17	67%	81%	67%	96%
Quarter 2	**323**	**94%**	**67**	**58**	**68%**	**78%**	**68%**	**92%**
Oct-21	131	98%	26	15	72%	82%	72%	95%

Nov-21	154	95%	27	19	76%	83%	76%	96%
Dec-21	140	92%	23	13	53%	71%	53%	86%
Quarter 3	**425**	**95%**	**76**	**47**	**67%**	**79%**	**67%**	**92%**
Jan-22	153	98%	27	21	63%	65%	63%	94%
Feb-22	111	75%	19	14	51%	63%	51%	94%
Mar-22	129	78%	30	16	57%	62%	57%	90%
Quarter 4	**393**	**85%**	**76**	**51**	**58%**	**64%**	**58%**	**93%**
	1398	**91%**	**279**	**197**	**65%**	**75%**	**65%**	**92%**

It has been announced that Medical Examiner scrutiny of non-coronial deaths will become statutory from April 2023. The office has also been tasked by NHS England to prioritise rolling the service out to the community. The ME Office are taking a number of steps to facilitate the roll out, including ensuring staffing levels in the team are sufficient by April 2023, communication with local GP to access to their electronic referral system (ERS) to streamline patient information sharing process. The statutory system will also require all neonatal and paediatric deaths to be subject to scrutiny and the MEs are currently liaising with the relevant individuals in the Trust to discuss the process to begin scrutiny as soon as possible.

Structured Judgement Reviews (SJR)

The Structured Judgement Review process blends traditional, clinical-judgement based mortality review methods with a standard format. This approach requires reviews to make safety and quality judgements over phases of care, where the reviewer/s can make explicit comments about each phase of care and score the care in order to establish if the care was satisfactory or identify any suboptimal care. This in turn allows learning and support for the development of quality improvement initiatives when problems in care are identified. The standardised format of reviews allows analysis to identify themes and trends of learning identified or areas of particularly excellent care where positive learning can be shared.

In December 2021, the Trust introduced the Structured Judgement Review panel. This is a multi-disciplinary, multi-professional meeting consisting of consultant patient safety leads form a number of different specialities across the hospital, nursing staff, governance representation from both divisions, representation form end of life care and Resus teams. Consultants who looked after each patient are also invited as required. The cases reviewed are triggered for SJR either by the Medical Examiner during scrutiny or as highlighted to the mortality team by staff if there are staff concerns. The panel also review a randomly selected case for quality assurance each week. Since the introduction of the SJR panel, SJRs are completed more regularly and consistently with the panel reviewing the most recent deaths. The panel meets each Monday to review 3-4 cases with issues and actions agreed. The process has greatly improved as a results of the implementation and use of the Trust's electronic patient record (EPR) system.

Between April 2021 to March 2022, 141 cases have been reviewed. Of these,

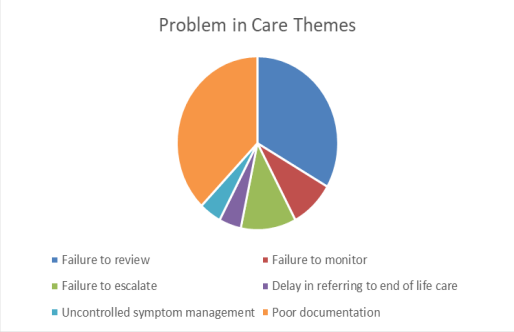
- 53 cases were highlighted for further review
- 32 cases remain open and awaiting outcomes from a further review within the specialist area

- 21 cases closed with cases reviewed by specialty consultants to distribute learning to the teams.

  Of the 53 cases requiring a further review following SJR.
- 43 cases identified problems in care.
- 10 cases fell within the 'death due to failing in care' category:
  - Seven met the serious incident (SI) criteria
  - One case was downgraded from an SI and closed
  - One case is being investigated as a High Level Incident
  - Once case was highlighted to Specialties for discussion at Mortality & Morbidity meetings

The following themes were identified:

- Failure to review
- Failure to monitor
- Poor documentation
- Uncontrolled symptom management
- Failure to escalate
- Delay in referring to end of life care



All actions for completion sit with the Divisions and are monitored through divisional specialty mortality meetings. In addition the Quality domain of the Trust Patient First Strategy will focus on reducing the number of avoidable 2222 calls.

Going forward, the Morality team are exploring a number of different reporting options for SJRs which will include a more in-depth review of the care provided, allowing for more detailed analysis around themes and trends, drilling down specifically where the problems in care arise more frequently amongst the specialties.

Of the 141 cases Structured Judgement Reviews completed, 67% cases were rated good/excellent for overall care.

75% of cases were rated good or excellent care for Admission & Initial Management	Increase	
68% of cases were rated good or excellent care for ongoing care	Increase	
69% of cases were rated good or excellent care for final days	Increase	
67% cases rated good or excellent care for overall assessment	No change	

March 2022: month on month trend compared to February 2022 data

Positive themes from SJRs:

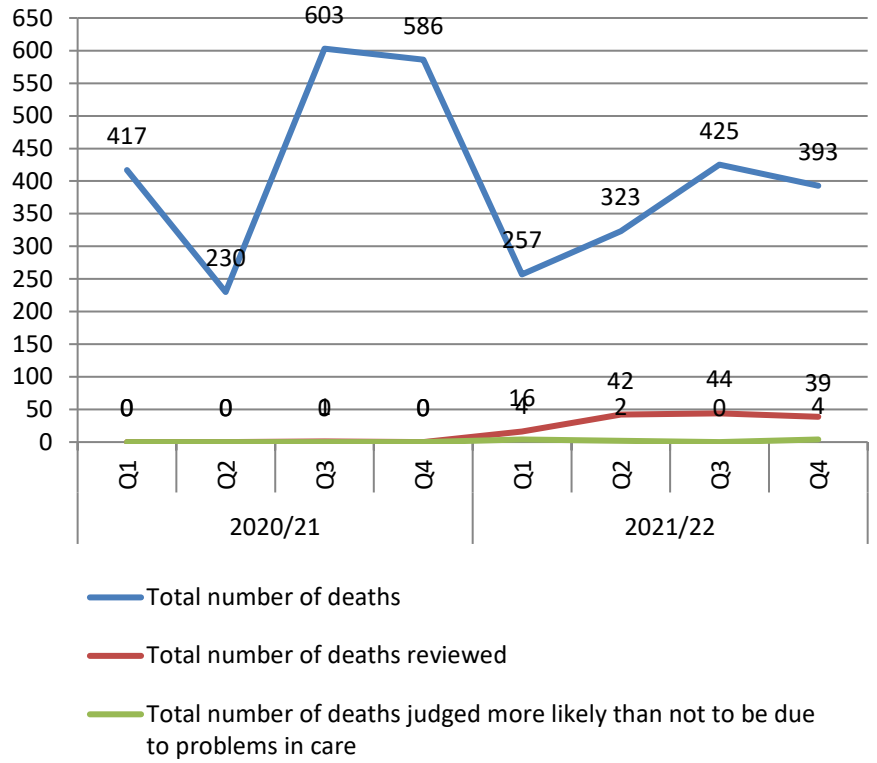
- Good, timely end of life care
- Good communication with families
- Rapid review
- Rapid diagnosis
- Appropriate escalation

All cases that undergo an SJR are recorded on Datix. If a case does not require further review, the Patient Safety Team are notified and the case is closed. If the case requires further review, this is escalated via Datix to the appropriate team to investigate. This is a new process that was introduced this year to simplify tracking actions, outcomes and lessons learnt which are reported back to the mortality team and highlighted at the Mortality and Morbidity Surveillance Group (MMSG). Deaths due to failings in care are escalated to the Incident Review Group for High Level or Serious Incident investigation.

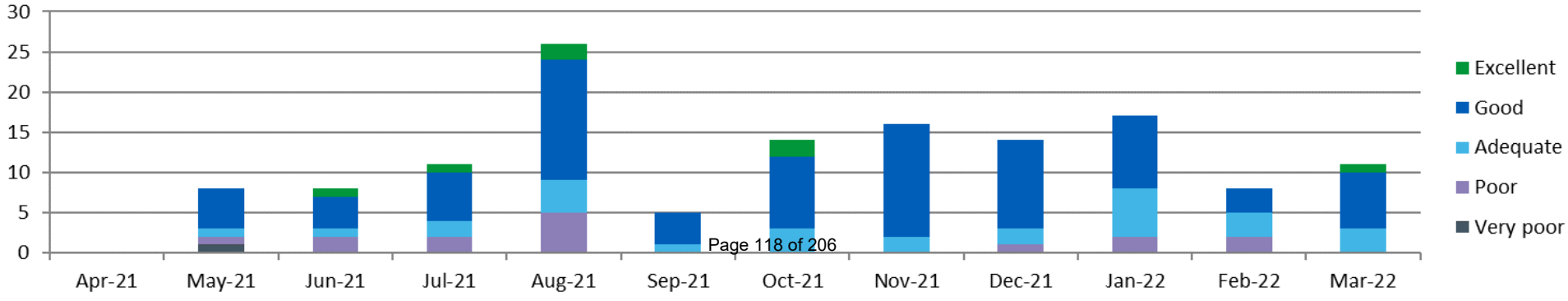
0 2021/22	Total number of adult deaths	Total number of deaths reviewed	Total number of deaths judged more likely than not to be due to problems in care
01/04/2021	88	0	0
01/05/2021	87	8	2
01/06/2021	82	8	2
Total Q1	**257**	**16**	**4**
01/07/2021	108	11	1
01/08/2021	101	26	1
01/09/2021	114	5	0
Total Q2	**323**	**42**	**2**
01/10/2021	131	14	0
01/11/2021	154	16	0
01/12/2021	140	14	0
Total Q3	**425**	**44**	**0**
01/01/2022	151	17	1
01/02/2022	111	11	3
01/03/2022	129	11	0
Total Q4	**393**	**39**	**4**
Year to Date	**1398**	**141**	**10**

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care

(Note: Changes in recording or review practice may make comparison over time invalid)



Total deaths reviewed, categorised by Overall Care Score



Patient First

Patient First is the Trust strategy and within the quality domain the break through objective has been agreed to be mortality with a the vision / goal for Medway Hospital to be amongst the top 25% nationally for having low mortality rates at the weekend and during the week (against current baseline).

The vision for the Trust by March 2023 is be amongst the top 25% nationally for having low mortality rates at the weekend and during the week (against current baseline) and to reduce avoidable 2222 calls to below 50% of total calls. As an improvement measurable, the Trust aims to;

- Ensure compliance with training (Resus/NEWS 2.0)
- Look into capacity and demand modelling
- Cross check Dr foster data by Speciality for weekday vs weekday admission data.

Mortality and Morbidity Meetings (M&M)

Specialties hold monthly Mortality and Morbidity (M&M) meetings to discuss cases demonstrating both learning points and highlighting good practice. Some specialties struggled to facilitate meetings due to staffing issues and lack of admin support particularly after wave 2 of the Covid-19 pandemic. The Mortality team supported these specialties initially by minute taking at the meetings and provided all specialties with a standardised template. Acute Medicine, Elderly Care and Diabetes departments have made a marked improvement in the regularity of meetings. The quality of minutes taken has also improved amongst the specialities.

Since Quarter 3 and 4 of 2021/2022, a total of 108 meetings should have taken place (based on each specialty holding one meeting per month as required):

- 31 meetings were cancelled due to staffing issues
- 17 meetings are tracked as providing no update to the Mortality team or submitting any minutes.
- 60 sets of minutes provided between October 21- March 22 (Q3 and Q4).

Following discussion at the meetings, if further investigation is required then cases may be referred to other specialties for a second opinion, or referred to the Indecent Review group for Serious Incident or High Level Investigation. Specialties can also refer cases to the Mortality Team for SJR, if there are concerns raised during the review.

Themes identified at the SJR panel, can also be seen to occur at Specialty M&M meetings;

1. **Patient First**

Patient First is the Trust strategy and within the quality domain the break through objective has been agreed to be mortality with a the vision / goal for Medway Hospital to be amongst the top 25% nationally for having the lowest mortality rates at the weekend and during the week (against current baseline).

2. **Copy and paste on Electronic Patient Record (EPR).**
   This year, the Trust moved over to EPR from paper patient notes. It was noted during SJRs that Doctors were copying highlighted the difficulty in ascertain true timeline of events that occurred in the care of the patient. Elderly Care M&M noted that a similar trend has been observed.

   This issue has been escalated to the clinical effectiveness and outcomes group (CEOG) and the Chief Medical Officer is escalating this issue to the EPR board. An exploration with the EPR team to disable the copy and paste function on the system is also being explored, and what impact this would have on the system if this was to happen. This will be monitored via the CEOG.

3. **Poor documentation**
   22% of SJRs completed found that there was poor documentation in patient notes amongst the majority of specialties and is the most common occurring theme. This includes not being able to read signatures on notes, incorrect NEWS scores documented and missing past medical history information. These issues are monitored via the SJR panel and findings are fed back through the bi-monthly Mortality and Morbidity Surveillance Group, for actions to be agreed and fed back to the Divisions. Themes and trends highlighted at SJR are also reported via the Divisional mortality reports, which are sent to the Divisional Governance teams every month, to escalate the issues identified during reviews of cases for each Division.

   This theme was noted within Emergency Department (ED) M&M discussions during Quarter 2, highlighting key omissions in patient care and history documentation as per standard operating procedures. The staff have been reminded the importance of documenting discussions of managements of unwell patients with ED senior team and documenting the important discussions with families. ED are having ongoing session within ED doctors meeting around 'improving ED documentation' and at local teaching for middle grade doctors. Poor documentation will continue to be monitored via SJR panel, and findings highlighted to the bi monthly Mortality and Morbidity Surveillance Group, for actions to be agreed and fed back to the Divisions.

4. **Poor communication between medical teams**.
   Acute Medicine noted during their M&M discussions that post take ward rounds were not documented correctly and the patient was not handed over well to the next shift Doctors. It was recognised that there needs to be more of a robust handover between shifts and teams, as well as earlier identification of NEWS scores. Acute Medicine as also looking into weekend patient handover notification on EPR. Poor communication between medical teams will to be monitored via the SJR panel, and findings highlighted to the bi monthly Mortality and Morbidity Surveillance Group, for actions to be agreed and fed back to the Divisions. The issue of a more robust weekend hand between teams has been escalated to colleagues by the Associate Medical Director of Patient Safety.

6. Mortality and Morbidity Surveillance Group (MMSG)

The Trust Mortality and Morbidity Surveillance Group (MMSG) provides Executive led scrutiny of mortality and morbidity surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review and learning from death. It currently meets bi-monthly and is chaired by the Chief Medical Officer and attended by representatives from the Divisions as well as key stakeholders including a consultant representative from Telstra Health UK (Dr Foster) and Medway and Swale CCG.

Telstra Health UK looked into the Trusts weekend and weekday analysis to ascertain why the HSMR for weekend tends to be higher and what type of patients are presenting at MFT for emergency admissions. In summary;

- Medway admit a higher proportions of spells at the weekend for older patients (65+); with higher comorbidity scores (20+); palliative and ultimately higher risk of mortality
- There is evidence to suggest that the quality of documentation at the weekend is good- crucially there is clear evidence of more complex care required over the weekend.
- While key to note weekend HSMR, we can say with some confidence that it is anticipated HSMR will and should be higher at the weekend because of more complex, unplanned admissions.
- Moreover, trends in weekend HSMR are downwards; Medway are well within national control limits, and report as 'within expected' and ultimately, these should continue to be monitored but current performance does not raise concerns.

For the reporting period of 2021- 2022, MMSG actions include;

Date of meeting	Action	Owner	Progress	Status
September 2021	Work through the backlog of SJRs. As of September 2021,there were 152 cases that required SJR.	Mortality team/clinical reviewers	With the help of the introduction of the SJR panel and a huge effort from clinical staff, the backlog was cleared by January 2022.	Closed
September 2021	Reinstate Divisional mortality reporting	Mortality Team	Divisional reports that highlight Trust mortality metrics and SJR outcomes were reinstated and are now sent out monthly to disseminate learning and outcomes of cases reviewed under the divisions.	Closed
November 2021	Create a standard template for Specialty mortality and morbidity meetings to help improve the quality of minutes received and track progress within the divisions through tracker.	Mortality team	A template was sent out to all specialities and the Mortality team continue to track progress within the divisions. An improvement has been noted and most specialities are using the standard template.	Open-ongoing
January 2022	Terms of reference (ToRs) to for Structured Judgement Reviews to be agreed for sign off	Mortality manager, Head of Clinical Effectiveness and Associate Director for Patient Safety	ToRs or SJR were agreed and signed off in March 2022	Closed
January 2022	Consider other reporting pathways to be reported into MMSG	Learning Disability Nurse, Legal Services, Divisional Governance Lead, Neonatology, Mortality manager	This will form part of the desktop review which will be provided by NHSE/I which will look at ways to incorporate leaning form death from a number of different investigation tools such as MMBRACE, Regulation 28 and LeDeR reviews	Ongoing

March 2022	Define deep dive process for diagnosis groups that flag alerts on HSMR and SHMI.	Head of Clinical Effectiveness, Associate Director for Patient Safety and Mortality Manager	Work is ongoing with the Better Tomorrow Team at NHSE/I who are supporting the Trust in building a robust process on how and when to undertake deep dive reviews.	Open-ongoing

7. NHS England and Improvement- Better Tomorrow

The Better Tomorrow team at NHS England and Improvement will be assisting the Trust's Mortality Team in building robust processes in place in terms of mortality receive and learning from death processes. The Better Tomorrow team will complete a desktop review of the mortality and learning from death processes. The purpose of the review is to present findings of a review of systems and processes for learning from deaths at Medway NHS Foundation Trust. The report will include a review of key documents and meetings with Trust leads to clarify understanding. The areas to be assessed are:

1. Strategy and leadership
2. Systems and processes
3. Training and resources
4. Data and information
5. Governance
6. Learning from deaths

The Better Tomorrow team are also assisting the Trust in developing a robust process for deep dive reviews by revising recommendations on when and how to undertake deep dive reviews. A sustainability survey has been shared amongst divisional leads, management and other staff both clinical and non-clinical with involvement in mortality reviews. The survey captures an indicative baseline of the sustainability of the Trust's ongoing mortality programme effort. The Better Tomorrow Team will review the results and produce a report to indicate areas of improvement and where further support is needed.

8. Conclusion and next steps

The Trust continues to monitor the HSMR and SHMI indicators and recent data shows that the Trust is starting to return to pre-pandemic levels across both indicators.

During the course of the year, the completion of mortality reviews has greatly improved following the COVID 19 pandemic. It should be noted that Medway were hit particularly hard in terms of the effect of the pandemic in comparison to other Trusts regionally. As a result of staff sickness and staffing levels across the Trust, the mortality review process was particularly affected with the majority of 2020 and the beginning of Quarter 1 having no reviews completed. In September 2021, the Mortality team was fully staffed and with a huge effort from clinical staff, the backlog of cases requiring SJRs was cleared by January 2022.

The successful implementation of the SJR panel has meant cases are now reviewed more regularly, allowing the Trust to act on further reviews and investigations quicker so that learning is relevant and can be implemented sooner to support the delivering the best quality of care for patients. 67% of cases review at SJHR were rated good or excellent for overall care.

To use the Trust Patient First strategy to enable Medway Hospital to be amongst the top 25% nationally for having low mortality rates at the weekend and during the week.

Going forward, the Mortality Team's focus for 2022/2023 is;

- To implement the recommendations received from the desktop review from the Better Tomorrow team
- To establish deep dive process and have a robust process for monitoring, reviewing and investigation alerts highlighted by Dr Foster and NHS Digital

- To continue to monitor the Specialty M&M and track progress with the aim of all specialties regularly providing evidence of discussion, with clear learning and outcomes.
- To finalise reporting systems used for death notifications and SJRs. The Trust is currently working on a new system for reporting deaths using the Formic database and working with the Better Tomorrow Team around SJR Plus platform which will capture more patient information allowing us to make even more detailed judgements of care.
- To continue to develop the MMSG and include other investigation reporting for learning from death. For example Regulation 28, MMBRACE, LeDeR as well as including morbidity as a standing agenda item for the group so that Specialties are given the opportunity to raise issues.
- To use the Trust Patient First strategy to enable Medway Hospital to be amongst the top 25% nationally for having low mortality rates at the weekend and during the week.

Meeting of the Board of Directors in Public
Wednesday, 03 August 2022

Title of Report	NHSEI Maternity Safety Self-Assessment Tool	**Agenda Item**	5.4
Report Author	Alison Herron, Director of Midwifery		
Lead Director	Evonne Hunt, Chief Nursing Officer		
Executive Summary	This report provides oversight and assurance to the Trust Board regarding the Maternity Service's Self-Assessment against the NHSEI Safety Self-Assessment Tool. The NHSEI/CMO virtual Maternity Safety Executive meeting was held on the 28th June 2022, this is being held with every Trust and incorporated an NHSEI presentation on safety in maternity, and advised that the self-assessment tool will be amended following the publication of the East Kent/Kirkup Report in autumn 2022. The Maternity Service has triangulated the Self-Assessment with the other national reports of Ockenden and CNST.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Quality Assurance Committee Date of approval: 26 July 2022		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	N/A		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	Compliance with Ockenden, CNST and CQC		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE the contents of the report for assurance.		
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	Appendix 1: NHSEI Maternity Self-Assessment Tool		

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement, should be included in the report.	

1 Executive Overview

1.1 This report provides oversight and assurance to the Quality Assurance Committee regarding the Maternity Service's Self-Assessment against the NHSEI Safety Self-Assessment Tool.

1.2 The NHSEI/CMO virtual Maternity Safety Executive meeting was held on the 28 June 2022, this is being held with every Trust and incorporated an NHSEI presentation on safety in maternity, and advised that the self-assessment tool will be amended following the publication of the East Kent/Kirkup Report in autumn 2022.

1.3 The Maternity Service has triangulated the Self-Assessment with the other national reports of Ockenden and CNST.

1.4 NHSEI have not assessed the Trust's position, but rather devolved the responsibility of assessment and monitoring compliance to the Trust Board and Executive Team.

2 NHSEI Maternity Safety Self-Assessment Tool

Amber / Green

2.1 First published in 2020, the Maternity Safety Self-assessment tool was for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

2.2 The tool was in response to national review findings, and recommendations for good safety principles within maternity services. The Tool was updated in September 2021, influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

2.3 Medway Maternity Services initially self-assessed against the Tool in December 2020 and revised the self-assessment in September 2021. The current self-assessment was completed in May and June 2022 and reflects the following position:

Self-Assessment Summary	
Red	7

Amber	49
Green	96

2.4 No National timescales are currently in place for achieving the recommendations of the Self-Assessment Tool.

2.5 The Key areas for improvement at Medway are:

- Strengthening Multidisciplinary engagement with the Maternity Voices Partnership
- Relaunch of Quality and Safety Summits, both internally and Trust-Wide
- Development of a Maternity Equity strategy
- Development of a Maternity Risk Strategy aligned to the Board Assurance Framework
- Strengthening governance and reporting processes from Ward to Board
- Strengthening how learning is shared with all staff and how we close the loop following incidents.
- Finalise Maternity Strategy and review Maternity Safety Strategy

3 Conclusion and Next Steps

3.1 NHSEI and advised that the self-assessment tool will be amended following the publication of the East Kent/Kirkup Report in Autumn 2022. Following this update the Maternity Service will:

- Refresh their Self-Assessment against the revised tool.
- Agree actions, timescales and appropriate operational and managerial leads.
- Incorporate actions and requirements into the Maternity Board Assurance Framework Quality Improvement Plan.
- Monitor and report progress against the Self-Assessment Tool requirements to Quality and Patient Safety Sub-Committee, Quality Assurance Committee and Trust Board as required.
- Develop robust evidence archive to support compliance and provide assurance.

4 Appendix 1: NHSEI Maternity Safety Self-Assessment Tool

2022.07 NHSEI maternity Safety Self

Self Assessment Summary	
Red	7
Amber	47
Green	98

NHS Improvement - Maternity Self-assessment tool
Medway Maritime Hospital May 2022

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
Directorate/care group/infastructure and leadership	**Clinically-Led triumvirate**	**N/A**	**Workforce**	**IEA4**	Trust and service organograms showing clinically-led directorates/care groups	Green	Trust Organogram				
					Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	Amber	Terms of Reference for Divisional and Care Group Board meetings	Audit required to demonstrate 75% clinical lead attendance at key meetings. Terms of reference review and update in progress.	Audit of clinician attendance compliance	Dec-22	
	Director of Midwifery (DoM) in post	**N/A**	**Workforce**	**IEA4**	DoM job description and person specification clearly defined.	Green	DOM in post 23/5/22				
					Agenda for change banded at 8D or 9	Green	See JD - Band 9				
					In Post	Green	in post 23/5/22				
	Direct line of sight to the Trust Board	**N/A**	**Workforce**	**IEA4**	Lines of professional accountability to executive board member for each member of triumvirate	Green					
					Clinical director to executive medical director	Green	Clinical Director reports to Divisional Medical Director and Medical director				
					DOM to executive director of nursing	Green	DOM to report to Chief Nursing Officer and COO				
					General manager to executive chief operating officer.	Green	Reporting to Divisional Director of Operations who has direct line to COO				
		SA1, SA3, SA9	**IEA1**	**IEA4, IEA5**	Maternity services standing item on trust board agenda as a minimum three- monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockenden learning actions	Green	SOP in place to reflect requirements of perinatal surveillance tool. Reporting bi-monthly to trust board in private since November 2021.	Proposed ongoing maternity assurance reporting to Trust Board to include Ockenden.			
		SA1, SA3, SA9	**IEA1**	**IEA4, IEA5**	Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	Green	SOP in place - bimonthly reporting. Formal Trust Board now only occurs bi-monthly. Reported through local governance monthly and escalated to QAC if required.	Now included in IPQR			
		N/A	**N/A**	**IEA4**	There should be a minimum of three PAs allocated to clinical director to execute their role	Amber	Clinical director currently has 2 PAs to execute role.	PA allocated does not meet recommendation.	Review PA allocation and propose recommendations to meet compliance	Nov-22	
	Collaborative leadership at all levels in the directorate/care group		**Workforce**	**IEA4**	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team.	Green	Midwifery structure Trust Organogram	Refresh midwifery structure chart.			
		N/A	**N/A**	**N/A**	Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	Amber		Awaiting substantive HR BP		Nov-22	
		N/A	**N/A**	**N/A**	Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	Green	Financial manager supports triumvirate and directorate.				
		N/A	**N/A**	**N/A**	Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	Amber	Currently meets with Band 8 and above	Does not meet with band 7 ward managers.	Review finance meeting schedule when Finance BP new appointment made	Jan-22	
		N/A	**N/A**	**N/A**	Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	Green	additional leadership roles now in place, including additional matron and specialist roles.				
		N/A	**N/A**	**IEA4**	From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	Amber	Need to strengthen MDT decision making and review of clinical incidents.	Current process does not provide assurance of full MDT review	DoM review of case review to be completed	Nov-22	
		N/A	**N/A**	**IEA4**	Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly	Green					

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
		N/A	N/A	IEA4	Leadership culture reflects the principles of the '7 Features of Safety'.	Green	Reflected across all aspects of the unit - training, governance, shared learning, unit culture, PROMPT and Simulation training, Safety systems e.g.. Fresh eyes, CTG, MEOWS etc.				
	Leadership development opportunities	N/A	N/A	IEA1	In-house or externally supported clinical leadership development programme in place	Green	In-house and external leadership development programmes available	to incorporate in succession planning strategy			
					Leadership and development programme for potential future talent (talent pipeline programme).	Green	Trust Leadership Programme in place	to incorporate in succession planning strategy			
					Credible organisations provide bespoke leadership development for clinicians/frontline staff and other recognised programmes, including coaching and mentorship.	Green	Trust Coaching and Mentoring Website				https://intranet.medway.nhs.uk/directorates-and-departments/human-resources/organisational-development/coaching-and-mentoring/
	Accountability framework	N/A	N/A	IEA4	Organisation organogram clearly defines lines of accountability, not hierarchy.	Green	Trust Organogram	Get current organogram			
					Organisational vision and values in place and known by all staff.	Green	Part of annual appraisal process				
					Organisation's behavioural standards framework in place.	Green	Trust Visions and Values				
	Maternity strategy, vision and values	N/A	N/A	N/A	Maternity strategy in place for a minimum of 3-5 years	Amber	Strategy under development. Service user engagement events taken place.	Ensure all maternity policies align and are included within Trust strategy	Strategy to be finalised and linked to Trust Clinical Strategy	Dec-22	
					Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	Amber		Ensure all maternity policies align and are included within Trust strategy	Strategy to be finalised and linked to Trust Clinical Strategy	Dec-22	
					Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	Green	Strategy under development. Service user/staff engagement events taken place.				
					Strategy shared with wider community, LMNS and all key stakeholders	Amber	Strategy under development. Service user/staff engagement events taken place.	Awaiting development	Share with LMNS and wider once draft completed and approved	Jan-23	
	Non-executive maternity Safety Champion	SA9	IEA2	N/A	Non-executive director appointed as named maternity safety champion.	Green	Dedicated NED in post - attending Maternity and Neonatal Safety Champion Assurance Board and staff engagement events.	Work plan for NED not agreed.			
		SA9	IEA2	N/A	Maternity and neonatal safety champions to attend key directorate meetings.	Green	TOR and Minutes for Governance meetings & Forums	Refresh Safety Champion SOP and finalise M&NSCAB TOR once DOM in post.			
		SA9	IEA2	N/A	Safety champions lead quality reviews, e.g.. 15 steps.	Green	Safety Champions lead on Mateno/ATAIN/QI projects.				
		SA9	IEA1, IEA2	IEA4	Trust Board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services.	Green	Check and Challenge occurs at Maternity Transformation and Assurance Board and NED and Board Level Champion attend Board and provide comment. Formal reporting process to Trust board in place to allow check and challenge				
		SA9	IEA1, IEA2	N/A	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	Green	Pathway in place.	Refresh SOP for Safety Champions and poster with relevant staff.			
Multiprofessional team dynamics					Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, i.e.. Quarterly audit days.	Amber	Audit sessions in place. Not chaired by members of the triumvirate. Staff Focus groups chaired by DOM/HOM	Quality and Safety Summits reinstated - September one postponed due to clinical pressures.	When appropriate clinical audit to be added to GTHR	Nov-22	KM for agenda & record of attendance
					Record of attendance by professional group and individual.	Green	Audit Register and recordings available.	Where possible audit to be completed on GTHR			

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
	Multi-professional engagement workshops	**N/A**	**N/A**	**IEA7**	Recorded in every staff member's learning and development record.	Amber	Staff undertake annual Multiprofessional training sessions including PROMPT, Human Factors etc. Staff can choose to attend and can be raised at appraisal/revalidation if further professional development needed	Attendance at Audit is not recorded as part of annual appraisal.	Audit sessions included and supported through appraisal process	Jan-23	
	Multi-professional training programme	**SA8**	**IEA3**	**IEA1, IEA7**	Annual schedule of maternity specific training and education days published and accessible for all relevant staff to see.	Green	Essential skills training allocated on rota. Pick and mix and any other additional training advertised on ward/via Friday news/education newsletter.	Update TNA/Matrix in line with core competency framework.			
					Full record of staff attendance for last 3 years.	Green	Clinical education team to provide.	refresh for 2022			2 years saved in Ockenden - ask for additional year.
					Record of planned staff attendance in current year	Green	Clinical education team to provide.	refresh for 2022			
					Clear policy for training needs analysis in place and in date for all staff groups.	Green	Specialist training matrix outlines requirements for each staff group including medical staff	Update TNA/Matrix in line with core competency framework.			
					Time allocated from contracted hours for all training requirements.	Green	Training is built into WTE uplift.	Reviewing uplift in current workforce report to consider additional time for training.			
					Compliance monitored against training needs policy and recorded on roster system or equivalent.	Green	Midwifery training recorded on e-roster and medical staff training allocated on rota.				
					Education and training compliance a standing agenda item of divisional governance and management meetings.	Green	Statutory Mandatory training discussed at Divisional meeting. PROMPT and Fetal Monitoring training shared via CNST/Ockenden updates.	LMNS reporting system for training to commence in June 2022 and will provide oversight/assurance for all training - to be reported through Care Group and Divisional Governance			
					Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	Green	MDT training i.e. PROMPT, CTG, Resus - Simulation - aware of roles and responsibilities.				
					Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	Green					
		N/A	**N/A**	**N/A**	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation.	Amber		Some JDs do not include reporting lines	Review and refresh JDs to ensure that reporting/responsible to is the line manager who would be responsible for appraisal.	Jan-23	
					Compliance with annual appraisal for every individual.	Amber	Workforce reports	Appraisal for all staff groups currently <90%	review and refresh trajectory of compliance	Nov-22	
					Professional validation of all relevant staff support by internal system and email alerts.	Green	Managed centrally by workforce				
					Staff supported to ensure they fulfil their roles and responsibilities.	Green	All midwifery staff have a PMA and clinical staff have a clinical supervisor to support revalidation. Appraisals and supportive 1:1s available to all staff.				
	Multi-professional clinical forums	**N/A**	**N/A**	**IEA4, IEA5**	Schedule of clinical forums published annually, e.g., labour ward forum, safety summit	Amber	Meetings in place but dates are not published	Establish calendar of meeting dates.	Create 2023 diary	Nov-22	
				N/A	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups.	Green	HR policy reflects this.				
					Organisational values-based recruitment in place.	Green	Value based questions in interview.				
	Multi-professional				Multiprofessional inclusion in clinical HR investigations, complaint and compliment procedures.	Green	HR investigations are conducted within nursing and medical specific groups.				

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
	Multi-professional inclusion for recruitment and HR processes.	**N/A**	**N/A**	**IEA7**	Standard operating procedures provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints.	Amber	Complex postnatal clinic now in place. PMA debrief process in place - SOP to be drafted. Hot debrief held for staff following complex cases.	Include in maternity safety strategy.	Ensure maternity safety strategy aligns and is included in Trust safety strategy	Nov-22	
				IEA7	Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	Green	Debrief sessions held for staff following complex/unusual cases				
				IEA7	Schedule of attendance from multiprofessional group members available	Green	Attendance at debrief sessions kept.				
	Multi-professional membership/representation at Maternity Voices Partnership forums	**SA7**	**IEA2**	**N/A**	Schedule of attendance from multiprofessional group members available.	Red		TOR requires review to ensure appropriate MDT representation.	Review MVP TOR to ensure appropriate MDT representation.	Nov-22	
					Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	Red		Review MVP TOR to ensure appropriate MDT representation.	Review MVP TOR to ensure appropriate MDT representation.	Nov-22	
				IEA5	Maternity Voice Partnership involvement in service development, recruitment and business planning.	Amber	MVP currently involved in co-production and service development.	MVP doesn't participate in recruitment.	Review MVP TOR to ensure appropriate MDT representation.	Nov-22	
	Collaborative multi-professional input to service development and improvement	**SA9**	**N/A**	**N/A**	Quality improvement plan (QIP) developed and visible to all staff as well as Maternity Voice Partnership/service users	Amber	BAF QIP in place/being developed to incorporate all national guidelines - to share with staff (via Friday news) and MVP/Service users (via M&NSCAB)	BAF currently not shared with wider team	DoM / HoM to share as part of weekly focus groups	Dec-22	
					Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility.	Green	Implementation lead clearly defined on BAF QIP				
					Clearly defined and agreed measurable outcomes in QIP	Green	BAF approved at QAC/Board				
					Identification of the source of evidence to enable provision of assurance to all key stakeholders	Green	Evidence listed on BAF - available for execs on shared drive				
					The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	Green	CNST and Ockenden evidence appropriately archived on Shared drive with access to key stakeholders.				
					Clear communication and engagement strategy for sharing with key staff groups	Amber	Need to consider how the BAF QIP will be shared with staff	BAF currently not shared with wider team	DoM / HoM to share as part of weekly focus groups	Dec-22	
					QIP aligned to national agendas, standards and national maternity dataset.	Amber	BAF/QIP working to incorporate all relevant national standards	BAF requires review to ensure alignment with national standards	DoM/ HoM to review BAF ensure standards are included from national agendas	Dec-22	
		N/A	**IEA1**	**IEA4, IEA5**	Weekly/monthly scheduled multiprofessional safety incident review meetings	Amber	Weekly incident review meeting (CRIG) with MDT attendance. IRG trust-wide meeting, IQPR slides to QPSCC	Current process does not provide assurance of full MDT review	DoM review of case review to be completed	Feb-23	
	Multi-professional approach to positive safety culture	**N/A**	**IEA1**	**IEA4, IEA5**	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Red	All safety incidents shared at LMNS QAG meeting and key incidents shared at audit.	Schedule not currently in place. LMNS Quality & Safety meeting is establishing quarterly reporting.			
					Weekly/monthly scheduled multiprofessional safety summits	Green	Monthly forums and governance meetings, monthly audit meeting with all with a focus on safety. Fortnightly Matneo meetings (MDT) held across Neonatal/Maternity. Trust Wide-incident review group (IRG) to review all SIs/Rapid Reviews Reporting monthly to QPSSC, QAC, Board, LMS QAG monthly Weekly CRIG				

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
		SA9	IEA1	IEA4,IEA5, IEA7	Positive and constructive feedback communication in varying forms.	Green	Reflective discussions with clinicians following near misses. PMA team support restorative clinical supervision. Family and Friends Greatix Appraisal Revalidation process. Feedback from service users is shared with named staff members. CRIG meeting identifies staff members where positive and constructive feedback is recommended as an action. Complaints, Compliments and PALS shared and managed.				
		N/A	N/A	IEA4,IEA5, IEA7	Debrief sessions for cases of unusual or good outcomes	Green	Debrief sessions held for staff following complex/unusual cases				
		N/A	N/A	IEA4,IEA5, IEA7	Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	Green	PMA 1:1 reflective Debrief, SWARMs (MDT), Hot Debrief for Complex cases.				
	Clearly defined behavioural standards	N/A	N/A	N/A	Schedule of focus for behavioural standards framework across the organisation	Green	Trust Visions and Values in place appraisal process				
					Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month.	Amber	Behavioural standards underpin all Trusts meetings	To be included within TOR for key meetings	Revise and refresh TOR	Oct-23	
Governance infrastructure and ward-to-board accountability		N/A	N/A	N/A	All policies and procedures aligned with the Trust Board's assurance framework (BAF)	Green	All Trust policies follow review, approval and sign-off as per document control policy.				
		SA9	IEA1, IEA2	IEA4,IEA5	Governance framework in place that supports and promotes proactive risk management and good governance.	Green					
	System and process clearly defined and aligned with national standards	N/A	N/A	IEA4, IEA5	Staff across services can articulate the key principles (golden thread of learning and safety.	Amber	Principles embedded as part of work.	Include in maternity strategy paper Risk midwives have updated Governance Training Package from May 2022	SCORE survey update to be completed	Nov-23	
		SA9	IEA3	IEA7	Staff describe a positive, supportive, safe learning culture.	Amber	2021 SCORE survey and PMA survey identified further work required on staff culture 2022 Culture survey to launch July 2022	CCG Patient safety review - going to complete survey with staff and undertake "see it, read it, do it" approach to Safety strategy	SCORE survey update to be completed	Nov-23	
	Maternity governance structure within the directorate	N/A	IEA1	IEA4, IEA5	Robust maternity governance team structure with key roles identified and clearly defined links to corporate governance teams	Green	Recruited 1 WTE additional risk and governance midwife to support governance structure				
		N/A	IEA1	IEA4, IEA5	Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	Green	JD in place for Risk midwives and Patient Safety Leads				
		N/A	IEA1	IEA4, IEA5	Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales.	Green	Team works with Governance team to ensure investigations completed in required timescales.				
	Maternity-specific risk management strategy	N/A	N/A	IEA4, IEA5	In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	Red		Risk midwives to draft risk management strategy linked or included in Trust management strategy			
	Clear ward-to-board framework aligned to BAF				Clearly defined in date trust-wide BAF	Green					
					Standardised reporting in place from ward to board	Amber	Ward to board reporting via M&NSCAB and QPSCC/QAC/Board - Trust reviewing reporting structure with a view to streamline.		Work being undertaken by Quality Director to review reporting processes	Nov-23	
		SA9	IEA3	IEA4, IEA5, IEA6, IEA7	Mechanism in place for trust-wide learning to improve communications	Amber	Global Safety Messages Dissemination of Alerts Friday News Risk Midwives Grand rounds in place.	Work with Comms to ensure maternity learning is shared Trust-wide	Work with Director of quality to Ensure Trust and Maternity learning is interlinked and shared.	Nov-23	

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
	Proactive shared learning across directorate	**SA9**	**IEA3**	**IEA4, IEA5, IEA6, IEA7**	Mechanism in place for specific maternity and neonatal learning to improve communication	Amber	Governance Snapshot Shared learning and Care Group Board Shared investigation of SIs across directorate Friday News disseminates learning from incidents Top 5 messages Risk Midwife delivers Mandatory training focusing on SI/Near miss Daily Huddles x2 with Neonatal team where key issues are shared Neonatal Grand round and audit Meeting. Staff Focus Groups Increased workforce in risk and governance midwifery team to support learning. Learning from incidents to be aligned to Training plan and reviewed by LMNS Audit, CTG meetings and education sessions recorded and shared via Vimeo for staff to review.	As part of Maternity Patient Safety Review concerns identified re. sharing of learning and information following incidents - review of this is underway. Consider how to link with Medway 5 pillars of learning	Ensure linked to MFT 5 Pillars of learning	Nov-23	
					Governance communication boards	Green	Boards are in place and updated regularly.				
					Publicly visible quality and safety board's outside each clinical area.	Green					
		SA3, SA9	**IEA1, IEA2, IEA3**	**IEA4, IEA5, IEA6, IEA7**	Learning shared across local maternity system and regional networks.	Green	LMNS Quality Assurance Group well established with learning from all trusts in region - Training assurance group also in place to share learning.	Perinatal mortality review tool implemented - sharing of learning still being embedded			
		SA3, SA9	**IEA1, IEA2, IEA3**	**IEA4, IEA5, IEA6, IEA7**	Engagement of external stakeholders in learning to improve, e.g. CCG, strategic clinical network, regional Director/Heads of Midwifery groups	Green	LMNS, Regional & National HOMS and DOMS				
Application of national standards and guidance	**Maternity specification in place for commissioned services**	**N/A**	**N/A**	**IEA1**	Multi-agency input evident in the development of the maternity specification.	Amber	Check with Glenn Page	Require assurance of MDT collaborative working between service users and maternity	Need to ensure co-productions of maternity specification	Feb-23	
					Approved through the relevant governance process	Amber		Require assurance of MDT collaborative working between service users and maternity specification	Need to ensure co-productions of maternity specification	Feb-23	
					In date and reflective of local maternity system plan	Amber		Require assurance of MDT collaborative working between service users and maternity specification	Need to ensure co-productions of maternity specification	Feb-23	
	Application of CNST 10 Steps	**ALL**	**ALL**	**ALL**	Full Compliance with all current 10 standards submitted	Green	Declared fully compliant with year 3	Workforce requirements now met			
					A SMART action plan in place if not fully compliant that is appropriately financially resourced.	Green	Declared fully compliant with year 3				
					Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	Green	Formal sign-off with CCG and Trust Board				
	Clinical guidance in date and aligned to the national standards	**N/A**	**NICE**	**N/A**	Clear process for multiprofessional review and ratification of all clinical guidelines.	Green	Developed in forums, signed off at Women's Governance, through care group to DMB				
					All guidance NICE compliant where appropriate for commissioned services.	Green	Work in progress to review all outstanding guidelines				
					All clinical guidance and quality standards reviewed and updated in compliance with NICE.	Green	All new NICE guidelines and quality standards have been reviewed and compliance/gap analysis completed				
	Saving Babies Lives care bundle implemented	**SA6**	**IEA6**	**IEA9**	All five elements implemented in line with most updated version	Green	Quarterly Bundle Survey CNST				
					SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	Amber	FWB team to review and put action plan in place.		Action plan to be shared via care group board	Feb-23	

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
	Application of the four key action points to reduce inequality for BAME women and families	**SA9**	**N/A**	**N/A**	Trajectory for improvement to meet national ambition identified as part of maternity safety plan.	Amber	Maternity Safety Strategy in place due for review July 2022 but does not include a trajectory for national ambition.		Action plan to be shared via care group board	Feb-23	
					All four key actions in place and consistently embedded	Amber	Need to determine 4 key actions and ensure embedded across service		Action plan to be shared via care group board	Feb-23	
					Application of equity strategy recommendations and identified within local equity strategy	Red	No equity strategy				
	Implementation of 7 essential learning actions from the Ockenden first report	**ALL**	**ALL**	**ALL**	All actions implemented, embedded and sustainable	Amber			Review of completed actions and assurance	Feb-23	
		SA6			Fetal Surveillance midwife appointed as a minimum 0.4 WTE	Green	1.4 WTE in post				
					Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 Pas	Green	Obstetric lead in post - allocated 1PA				
	A-EQUIP	**N/A**	**N/A**	**IEA7**	Plan in place for implementation and roll out of A-EQUIP	Green	PMA strategy and annual report PMA supports all restorative supervision conversations Underpin all revalidations All meetings with supervisees All reflective clinical practice discussions.				PMA presentation for RCM
					Clear plan for model of delivery for A-EQUIP	Green	PMA strategy and annual report PMA supports all restorative supervision conversations Underpin all revalidations All meetings with supervisees All reflective clinical practice discussions.				
					Training plan for transition courses and succession plan for new Professional Midwifery Advocate (PMA) A-EQUIP model in place and being delivered.	Green	Funding for PMA training requested annually for and supported by the HOM and at least 1 staff member per year supported through the course (2 this year) funded by HEE				
	Maternity bereavement services and support available	**IEA1**	**N/A**	**IEA13**	Service provision and guidance aligned to national standards	Green	Follow national bereavement pathway - one of the first adopter sites. Policies and SOPS align to national recommendations.				
					Bereavement midwife in post	Green	Bereavement Midwife and support Bereavement Midwife in post				
					Information available 24/7	Green	Call the Midwife and via sign-posting to appropriate charities and external organisations. Moving to 7 day service and increasing training to ensure 1 bereavement champion per shift				
					Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	Green	Bespoke designed bereavement suite away from the obstetric unit, and a dedicated bereavement room on Delivery suite which were co-designed with bereavement support groups and charities.				
					Quality improvement leads in place	Amber	Maternity and Neonatal Safety Champions appointed	QI projects currently lead by existing workforce, vision to recruit dedicated midwifery QI lead to drive improvement and change - to be part of consultant midwife role	QI projects to encompass A3 methodology	Feb-23	
					QIP that defines all key areas for improvement as well as proactive innovation	Amber	BAF QIP in place - to include all improvement measures.	Need to formalise strategy and QIP with a need to clearly outline all QIP in one place.	QI projects to encompass A3 methodology	Feb-23	

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
	Quality Improvement structure applied	**SA9**	**N/A**	**N/A**	Recognised and approved quality improvement tools and frameworks widely used to support services.	Green	Matneo leads have completed substantial QI training - utilising driver diagrams and PDSA cycles				
					Established quality improvement hub, virtual or otherwise.	Green	Medway Innovation Institute established and projects are undertaken as part of this scheme.				
					Listening into action or similar concept implemented across the trust.	Amber	Safety Champion Ward to Board feedback in place. Listening to staff via psychological safety work being undertaken. Staff focus groups in place		Review of safety champion walkabout and incorporate staff focus groups	Mar-23	
Positive Safety culture across the directorate and trust	**MatNeoSip embedded in service delivery**	**SA9**	**N/A**	**N/A**	Continue to build on the work of the MatNeoSip culture survey outputs/findings.	Amber	Ongoing culture surveys and working with staff to understand concerns and take appropriate action Staff Focus Groups		Complete SCORE survey	Feb-23	
	Maternity Transformation Programme (MTP) in place		**N/A**	**N/A**	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	Amber	To be included in safety strategy		Strategy to be finalised and linked to Trust Clinical Strategy	Dec-22	
	Maternity safety improvement plan in place	**N/A**	**N/A**	**N/A**	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	Amber	Safety Strategy in place - due to be refreshed July 22		Strategy to be finalised and linked to Trust Clinical Strategy	Dec-22	
					Standing agenda item on key directorate meetings and trust committees	Amber	Currently remapping all maternity reporting to ensure appropriate reporting at key meetings		Strategy to be finalised and linked to Trust Clinical Strategy	Dec-22	
	Freedom to Speak Up (FTSU) guardians in post	**N/A**	**N/A**	**N/A**	FTSU guardian in post, with time dedicated to the role.	Green					
	Human factors training available	**SA6, SA8**	**IEA3**	**IEA1, IEA4**	Human factors training lead in post	Green	Jenna Thompson				
					Human factors training part of trust essential training requirements	Green					
					Human factors training a key component of clinical skills drills	Green					
					Human factors a key area of focus in clinical investigations and formal complaint responses.	Green					
	Safety huddles	**SA4**	**IEA3**	**IEA7**	Daily safety huddles in all clinical areas	Green	Daily huddles in place and well embedded in practice.				
					Guideline or standard operating procedure describing process and frequency in place and in date.	Amber	Part of escalation guideline and consultant SOP	Safety huddles in place - formal SOP required.	Undertake SOP audit	Jan-23	
					Audit of compliance against above	Amber	Intrapartum Matron to complete	Audits previously taken place - re-audit once SOP implemented.	Undertake SOP audit	Jan-23	
	Schwartz rounds	**N/A**	**N/A**	**IEA7**	Annual schedule for Swartz rounds in place	Green	Trust wide Schwartz rounds - paused during Covid-19	Grand rounds now in place which encompass Schwartz methodology			Medway Foundation Trust - Grand Rounds
					Multiprofessional attendance recorded and supported as part of working time	Green	Staff supported to attend Available on intranet	Further work to be done to encourage staff to attend			
					Broad range of specialities leading sessions	Green	Grand round lead ensure MDT presenting roster is created.				
	Trust-wide safety and learning events	**N/A**	**IEA1, IEA2**	**IEA4, IEA5, IEA6, IEA7**	Trust-wide weekly patient safety summit led by medical director or executive chief nurse	Green	Weekly incident review meeting (CRIG) with MDT attendance. IRG trust-wide meeting, IQPR slides to QPSCC				
					Robust process for reporting back to divisions for safety summit	Green	Attendance from key members of division to report back and share learning/themes				
					Annual or biannual trust-wide learning to improve events or patient safety conference forum	Green	Trust-wide audit held				
					Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes.	Green	Not Maternity Specific but maternity cases are presented prorata				

Area for Improvement	Description	Link to CNST Safety Action	Link to Ockenden 1 IEA	Link to Ockenden 2 IEA	Evidence	Self-assessed compliance (RAG)	Evidence for RAG Rating	Gaps in assurance	Improvement action	By when	Evidence Links for RAG rating
Comprehension of business/contingency plans impact on quality (i.e. maternity transformation plan, neonatal review, maternity safety plan and local maternity system plan)	**Business plan in place for 12 months prospectively**				In date business plan in place	Green	Business plan approved	Sam Chapman			
					Meets annual planning guidance	Green					
					Business plan supports and drives quality improvement and safety as key priority	Amber		Business Plan to be reviewed ensure meets service needs for 23/24	Review business plan and ensure encapsulates national and regional agendas	Feb-23	
		SA4, SA5	**Workforce**	**IEA1, IEA2**	Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	Green					
		SA4	**IEA3**	**IEA1, IEA2**	Consultant job plans in place and meet service needs in relation to capacity and demand	Green	Consultant job planning completed December 2021 with additional consultants to support more consultant cover.				
		N/A	**IEA3, IEA6**	**IEA1, IEA2, IEA4**	All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	Green	Consultant job planning completed December 2021 with additional consultants to support more consultant cover.				
		N/A	**N/A**	**IEA1, IEA2**	Business plan ensures all developments and improvements meet national standards and guidance	Amber		Business Plan to be reviewed ensure meets service needs for 23/24	Review business plan and ensure encapsulates national and regional agendas	Feb-23	
		N/A	**N/A**	**IEA1, IEA2**	Business plan is aligned to the NHS 10-year plan, specific national initiatives and agendas	Amber	Sam Chapman - ask for copy	Business Plan to be reviewed ensure meets service needs for 23/24	Review business plan and ensure encapsulates national and regional agendas	Feb-23	
		N/A	**N/A**	**IEA1, IEA2**	Business plans include dedicated time for clinicians leading on innovation, QI and Research	Amber		Business Plan to be reviewed ensure meets service needs for 23/24	Review business plan and ensure encapsulates national and regional agendas	Feb-23	
		N/A	**N/A**	**IEA1, IEA2**	That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	Amber		Business Plan to be reviewed ensure meets service needs for 23/24	Review business plan and ensure encapsulates national and regional agendas	Feb-23	
Meeting the requirements of equality and inequality and diversity legislation and guidance	**Employment policies and clinical guidance meet the publication requirements of equity and diversity legislation**	**SA9**	**IEA7**	**IEA15**	The service plans and operational delivery meets the maternity objectives of the NHS Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the maternity and neonatal plans on pages 12 and 13	Amber	Trust Strategy reflects the NHS Long Term Plan	Maternity strategy to be aligned to Trust strategy and NHS Long Term Plan New Service Delivery Plan needs to be developed.	Maternity strategy to aligns and be included within Trust Strategy	Jan-23	
					Assess Service ambitions against the Midwifery 2020: Delivery expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the document	Red		Need to map against Midwifery 2020	2020 delivery expectations to form part of strategy	Jan-23	
					Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health (2017). Utilise the Stepping up to the Public Health Model, Table 10 as a template	Red		To incorporate public health priorities into Maternity Strategy and Delivery Plan and every contact with our service users.	Maternity strategy to aligns and be included within Trust Strategy	Jan-23	

Meeting of the Board of Directors in Public
Wednesday, 03 August 2022

Title of Report	Perinatal Surveillance Quality Report	**Agenda Item**	5.5
Report Author	Alison Herron, Director of Midwifery		
Lead Director	Evonne Hunt, Chief Nursing Officer		
Executive Summary	This report provides assurance to the Trust Board regarding Perinatal Quality and Safety in line with the expectations of the Perinatal Surveillance Quality model. The report complies with the requirements of CNST and Ockenden to ensure that the Trust Board has oversight of all perinatal incidents, risks and actions relating to maternity quality and safety		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Quality Assurance Committee Date of approval: 26 July 2022		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	N/A		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	Compliance with Ockenden, CNST and CQC		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE the contents of the report for ASSURANCE.		
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	N/A		

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement, should be included in the report.	

1 Executive Overview

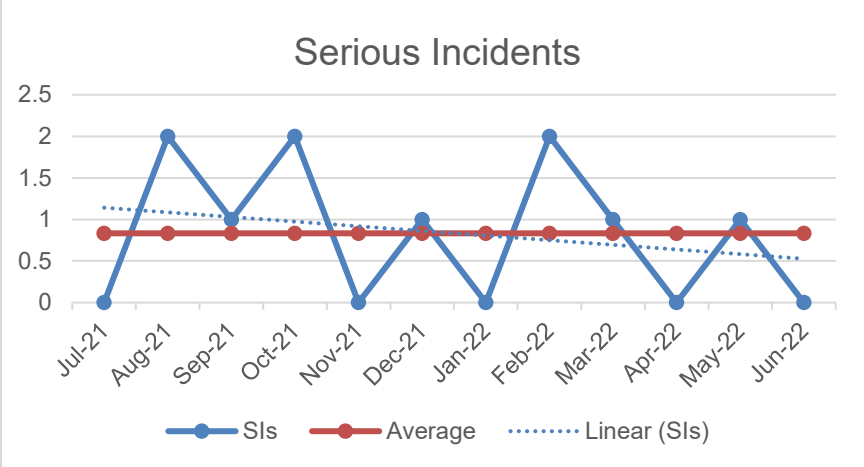
1.1 This report provides assurance to the Trust Board regarding Perinatal Quality and Safety in line with the expectations of the Perinatal Surveillance Quality model.

1.2 The report complies with the requirements of CNST and Ockenden to ensure that the Trust Board has oversight of all perinatal incidents, risks and actions relating to maternity quality and safety

2 Incidents

White

Serious Incidents (SIs) Q1 2023/24	**Number**
Number declared this reporting quarter	1
Number submitted this reporting quarter	0
Number past CCG deadline	0
Number closed this reporting quarter	2
Number of Healthcare Safety Investigation branch (HSIB) investigations	1
% of qualifying cases report to HSIB and NHS R Early Notification	100%



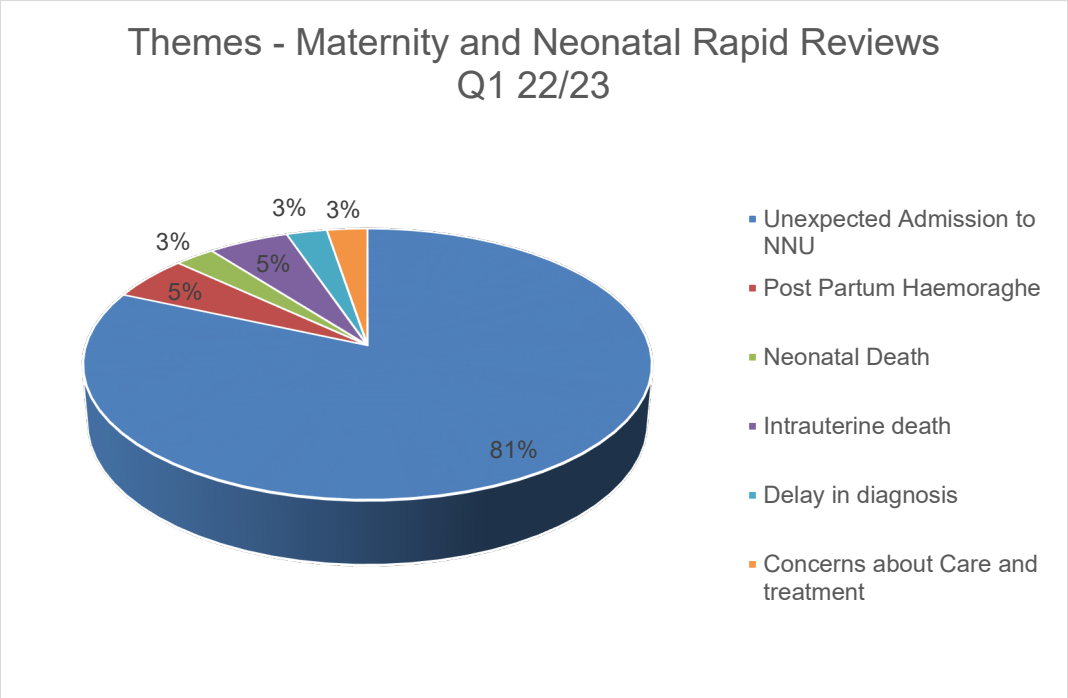
SIs – Opened Q1 2022/23				
Datix	**Summary**	**Learning Points**	**Actions**	**Completed/Target**
WEB119275	1 SI in Q1 which was referred to HSIB for neonatal collapse (6 hours post birth) with subsequent diagnosis of HIE. Preliminary findings suggested that the positioning of the baby during skin to skin contact may have contributed to the sudden, unexpected neonatal collapse.	Importance of ensuring parents have appropriate information regarding safe skin to skin in the post natal period.	1. Carers now provided at birth to all families regarding "keep me safe", "see my nose" within one week of the incident. 2. Cards now routinely distributed at 36 week birth choices appointment and following birth.	Completed June 2022

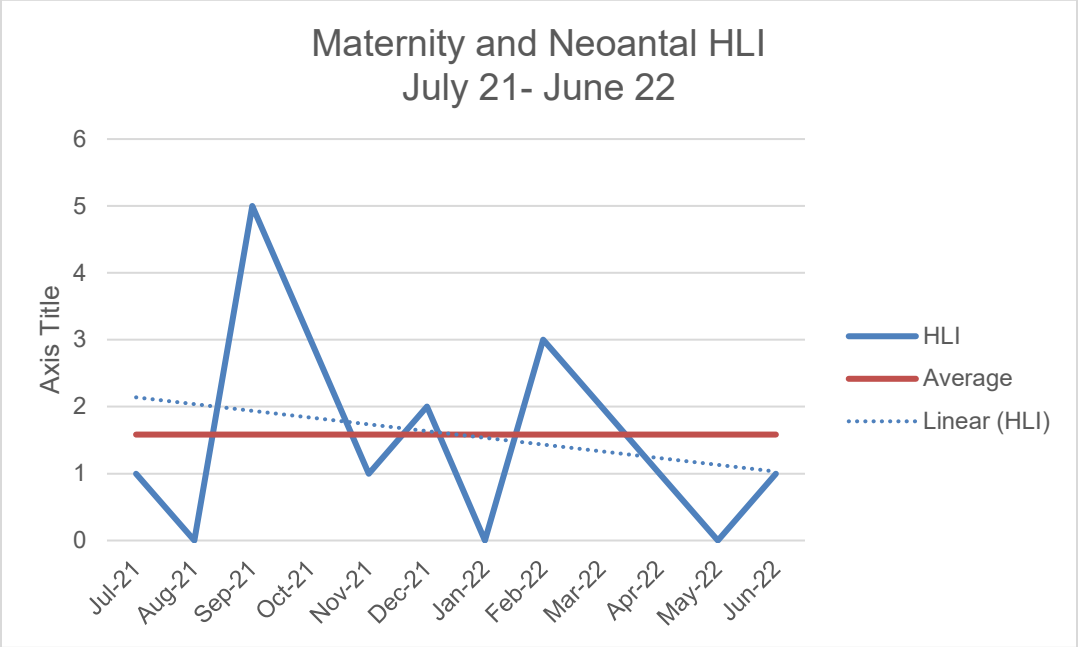
SIs – Closed Q1 2022/23				
Datix	**Summary**	**Learning Points**	**Actions**	**Completed/Target**
WEB111845 HSIB MI-004516	Unexpected admission to the Neonatal Unit	• Placentas should be sent for pathological examination including histology in line with national guidance (RCPath, 2019) • Differential maternal and fetal heartrates must always be recorded/documented. • Maternal observations must always be recorded on a MEOWS chart in order to alert any areas of abnormality • A PCR should always be taken and sent in the presence of proteinuria	1. The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (RCPath, 2019). 2. For staff to always recorded maternal pulse on the CTG trace. 3. For staff to plot maternal observations on a MEOWS chart. 4. For staff to send a PCR in the presence of antenatal proteinuria.	Approval of business planning for Placental histology – SOP to be updated – Due to launch September 2022. Actions and expectations shared with staff – audit to be completed by October 2022

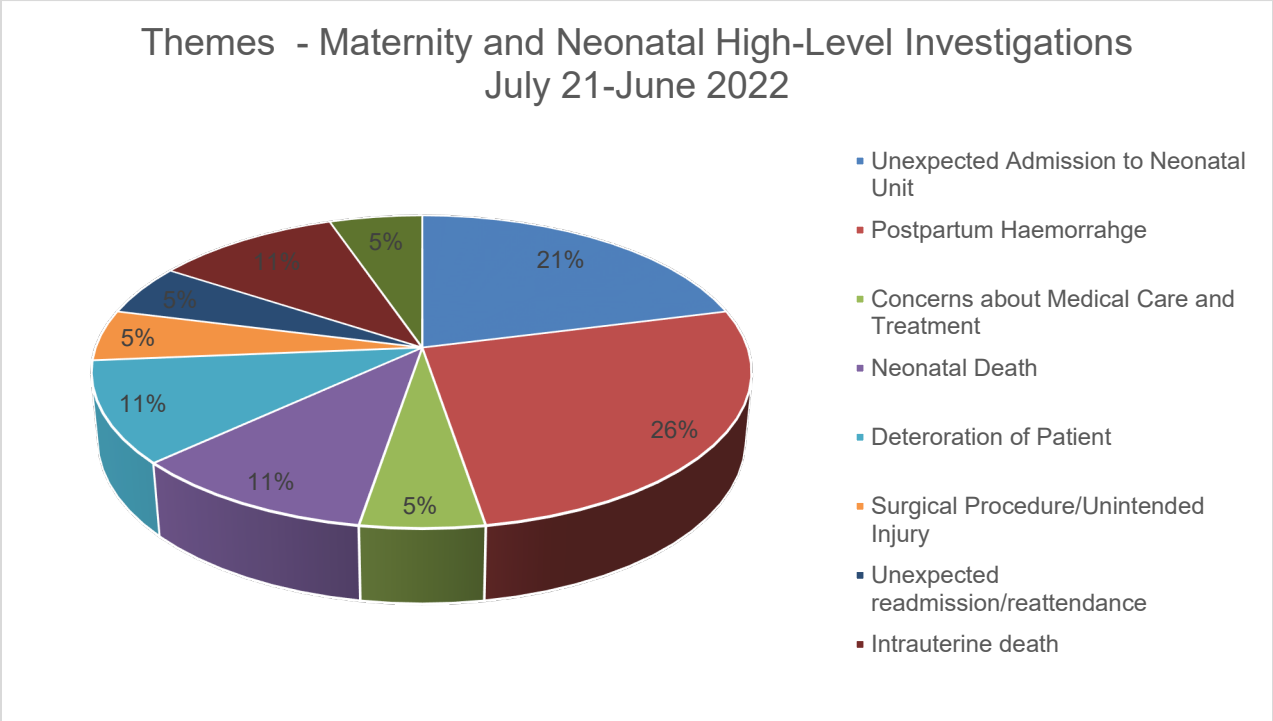
Near Misses Q1 2022/23				
Datix	**Theme**	**Recommendations**	**Actions**	**Completed/Target**
WEB120065	Delayed diagnosis of deep vein thrombosis	Specialist Registrar to be available in Maternity Care Unit/Obstetric Triage to provide senior obstetric review. Daily availability of ultrasound scans to rule out DVT/Pulmonary Embolism.	1. Memo to all doctors regarding need to follow VTE policy. 2. Present case at next audit meeting to raise awareness of near-miss 3. Case presentation/VTE update in Fridays News.	June 2022 August 2022 July 2022

Rapid Reviews and High Level Investigations

- 41 Rapid reviews (RR) completed in Q1 2022/23.
- 2 High-Level Investigations (HLI) for Q1 2022/23.
    - Eclamptic Fit
    - Fractured humerus in neonate
- Conversion of RR to HLI or SI for Q1 2022/23 – 7.3%
- Rapid review required for all unexpected admissions to neonatal unit.
- Neonatal deaths (1) and intrauterine death (2) not escalated to High-Level Investigation or SI but fully reviewed and investigated through the Perinatal Mortality Review Tool (PMRT) process.

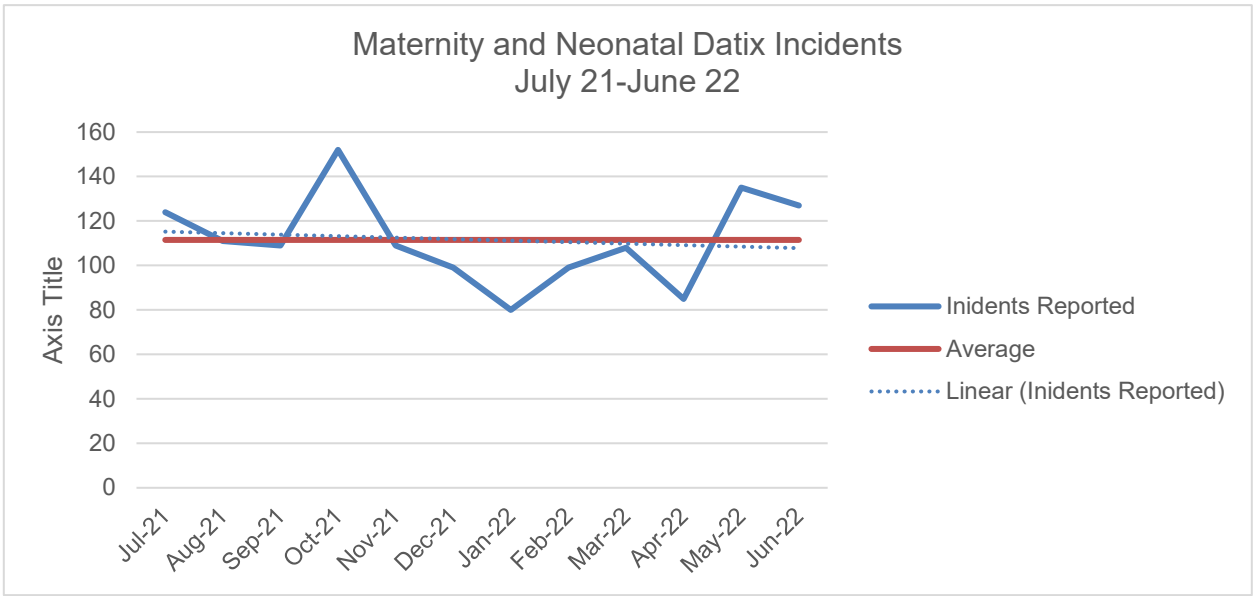

Themes - Maternity and Neonatal Rapid Reviews
Q1 22/23
3%
3%
3%
5%
5%
81%
Unexpected Admission to NNU
Post Partum Haemoraghe
Neonatal Death
Intrauterine death
Delay in diagnosis
Concerns about Care and treatment

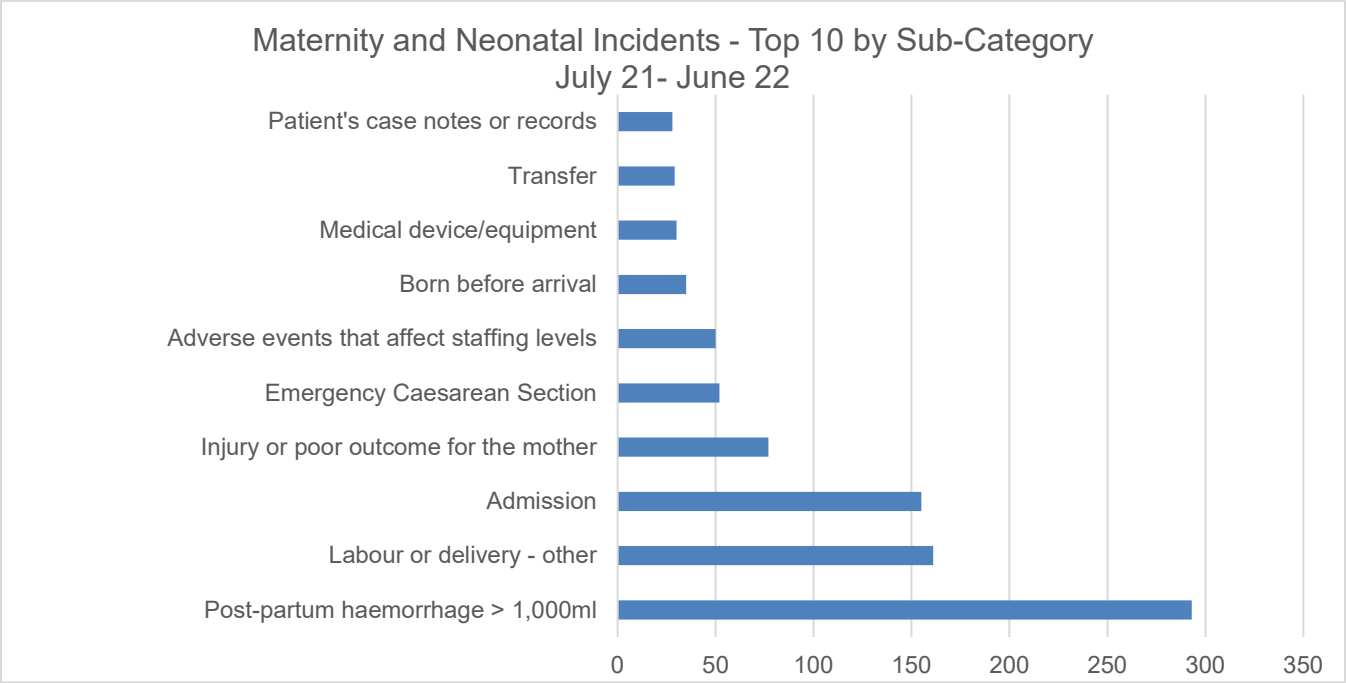

Maternity and Neoantal HLI
July 21- June 22
Axis Title
6
5
4
3
2
1
0
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
HLI
Average
Linear (HLI)



Datix Incidents

- 1362 incidents reported for Maternity and Neonatal from July 2021 to June 2022.
- Average of 111 per month
- PPH >1000mls highest reported incident

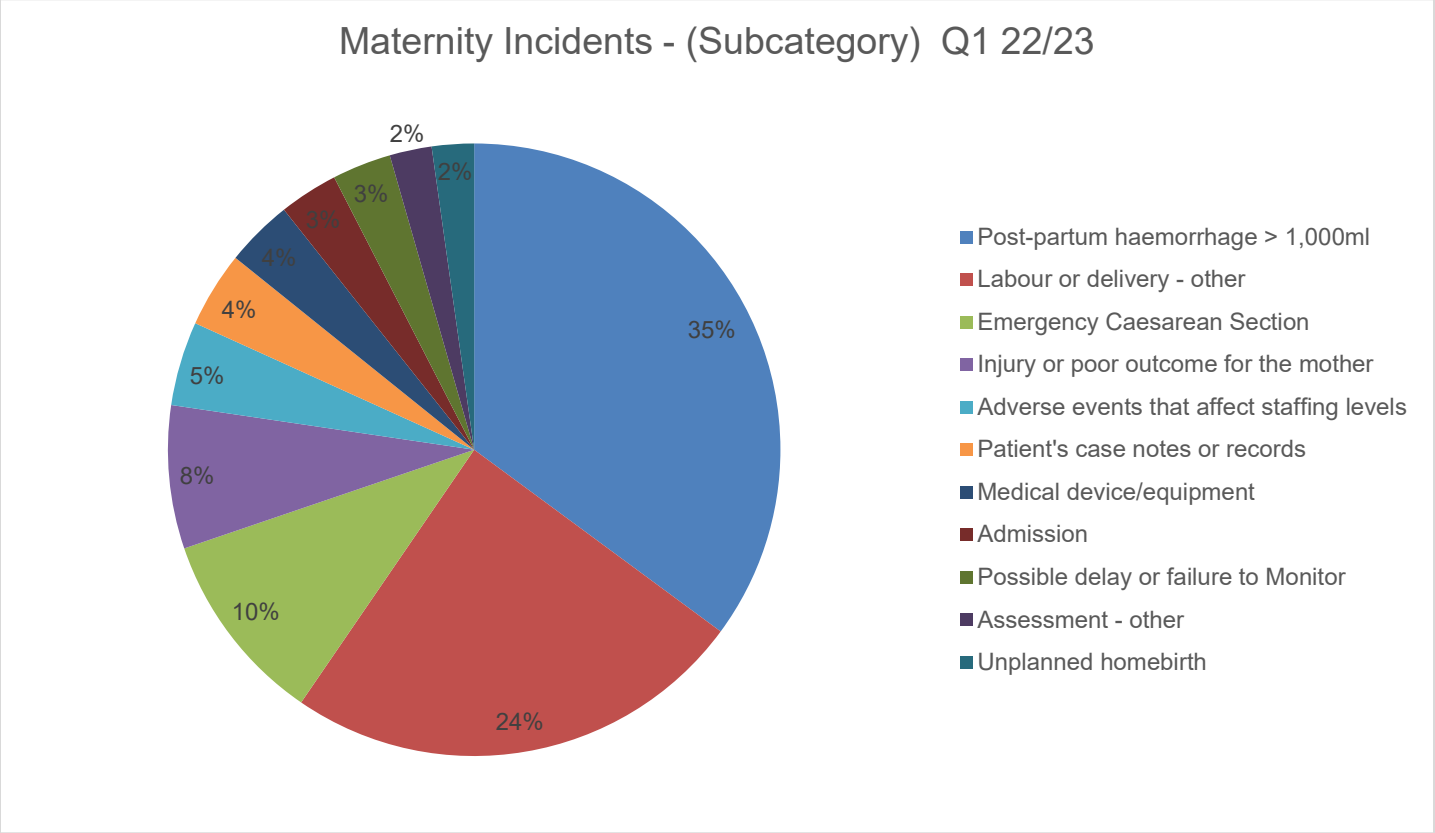




- 347 Maternity and Neonatal incidents reported in Q1 2022/23

Q1 2022/23 Incident Top 3 themes	Number	Actions and Learning	Completed/Target
Post Partum Haemorrhage	79	• Following the CRIG meeting the learning from the cases were shared with staff via the **TOP 5** and the **Governance Snap Shot** to use the PPH pro-forma in real time. The Senior Sisters have ensured that the forms are readily available in every Delivery Room. • Audit of PPH ongoing and to include use of Pro-forma going forward • Encouraged staff to continue to Datix all PPH >1L • Anecdotal evidence suggests that there may be a correlation between Induction of labour and increased PPH cases. A review of the IOL pathway and delays in IOL has been commissioned by DOM/CD – first task and finish group meeting in July 22. • Clinical leads engaged in the LMNS wide work on IOL.	Completed June 2022 September 2022 Completed June 2022 Commenced July 2022
Term/Unexpected Admissions to Neonatal Unit	39	• Quarterly review of term admissions is currently being completed. RDS appears to be the largest cause for admission which is in line with	August 2022

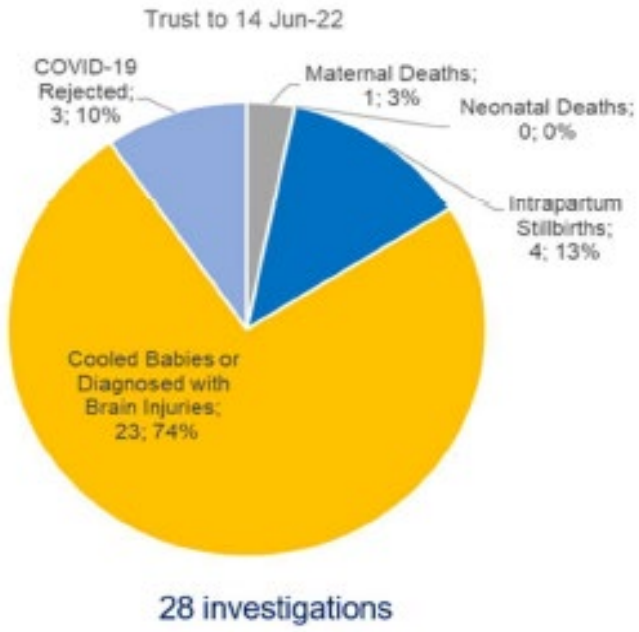
		previous ATAIN (Avoiding Term admissions to NNU) audits. • A weekly MDT review meeting is being implemented in August 22, previously the meeting was monthly, to review all term unexpected admissions to NNU, capture immediate learning, implement actions in real time and share the learning.	Due to commence August 2022
Maternal Readmissions	18	• On initial review there has been a trend in maternal readmissions with infections, retained products or severe abdominal pain. Further deep dive of cases being undertaken to identify any common factors. Pending outcome quality improvement measures will be implemented and monitored for sustained improvements	September 2022

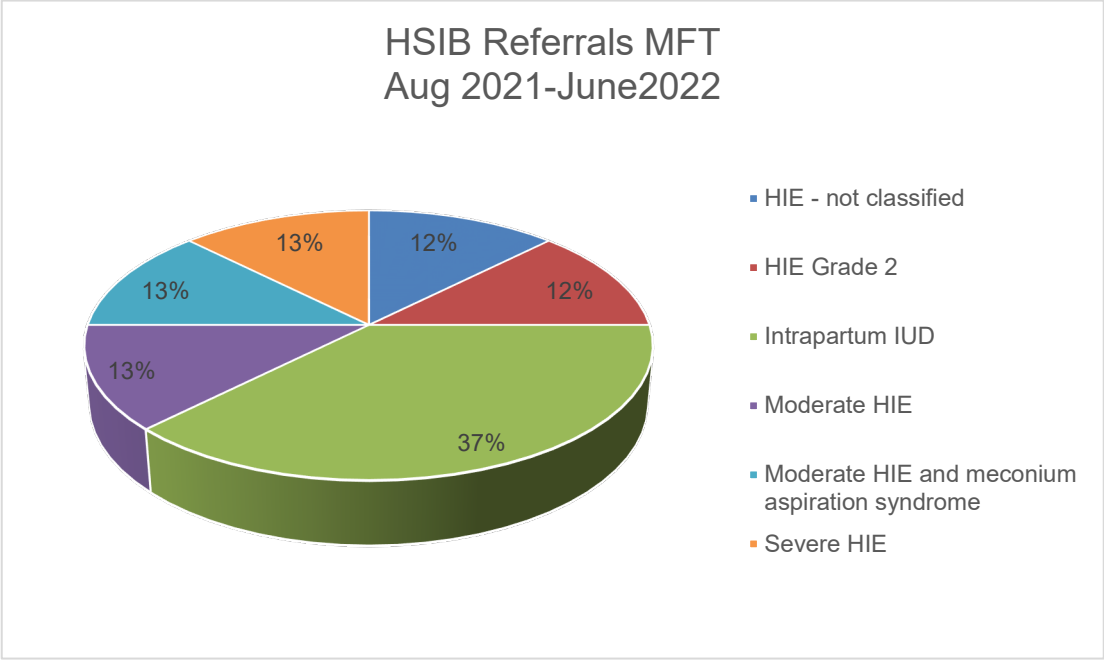


Healthcare Safety Investigation Branch (HSIB)

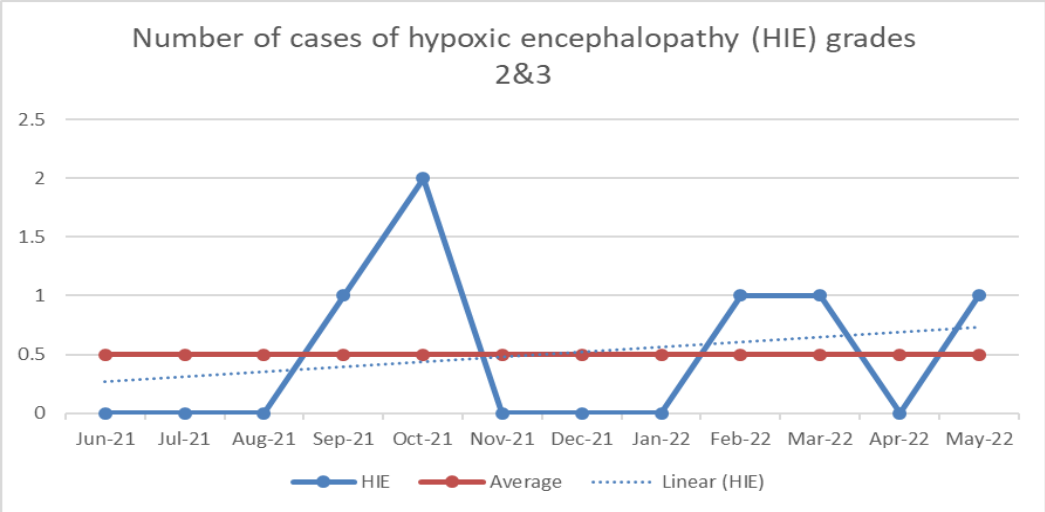
- No Letters of recommendation received in quarter.
- Since 2018/19 the Trust has made 34 referrals to HSIB and 28 of these were accepted. 23 of these related to Hypoxic ischemic encephalopathy (HIE). 5 cases of HIE have been reported in the period July 2021 to June 2022.
- Recommendations have been made for 23 reports. 5 received no recommendations.

- 8 cases have been referred to HSIB since August 2021.





HSIB Top 5 Recommendations - MFT	Number	Recommendations	Completed/Target
Guidance	21	• All Placentas for neonatal admissions to be sent for pathological examination (11) • BMI guideline to be updated • Small for Gestational Age guideline to be reviewed (2) • Vaginal birth after caesarean section guideline to be reviewed (1)	December 2022
Fetal Monitoring	9	• The Trust to support staff in the use of formal CTG categorisation alongside consideration of intrapartum risk factors to support accurate assessment, identification, and communication of fetal heart rate concerns	New physiological fetal monitoring training to launch October 2022 with new guideline in place for January 2023.
Risk Assessment	6	• The Trust to ensure that there is a robust risk assessment process in place to optimise a mother's care pathway during telephone conversations.	Remote 24/7 call the midwife service introduced November 2021.
Escalation	6	• The trust to ensure that staff are supported to escalate CTG concerns in line with local guidance	New physiological fetal monitoring training and guideline will support improved escalation. (Jan 23) Conflict of clinical opinion guideline underdevelopment in line with Ockenden 2 recommendations (Dec 2022)
Communication	5	• The Trust to ensure that a clear systematic approach exists for communication of the urgency of a delivery to staff involved in the preparations for the delivery.	Attending registrar/consultant indicates and documents timeframe for delivery for all cases including instrumentals to ensure timely delivery as required.



- Due to an upward trend in HIE in the previous 12 months, the service plans to introduce a fetal physiological monitoring guideline with a revised multidisciplinary training package incorporating a human factors element. Training planned to commence in quarter 3 2022/23

Safeguarding Incidents			
Incident	**Good Practice**	**Missed Opportunities**	**Actions/learning**
Child Death – 3 months	• Commencement of DNA policy • Appropriate sign-posting • Community midwife in contact with safeguarding team • Liaison with Health Visitor regarding non-engagement in postnatal period.	• Exploration of previous alcohol and drug misuse • Information from policy/children's services not shared with midwifery. • Contact with children's services not actioned on DNA checklist • Lack of safeguarding management oversight.	• Alcohol/substance misuse to be added as a question to all contacts. (June 22) • Reiterate DNA checklist (May 2022) • Safeguarding management to be added to risk register. Meeting held with HOM and DOM and staffing reviewed and agreed restricting current staffing in post to mitigate. (September 2022)

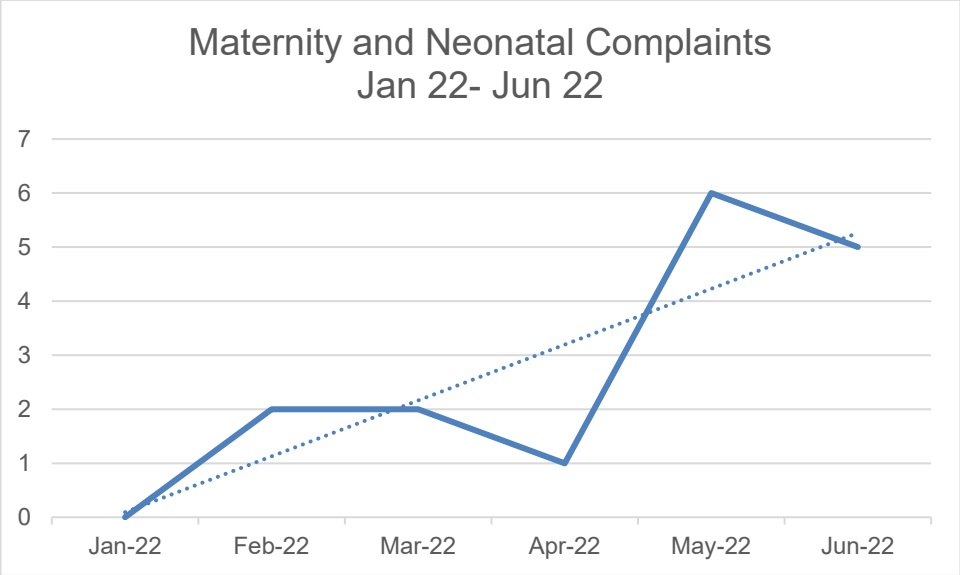
3 External Reviews

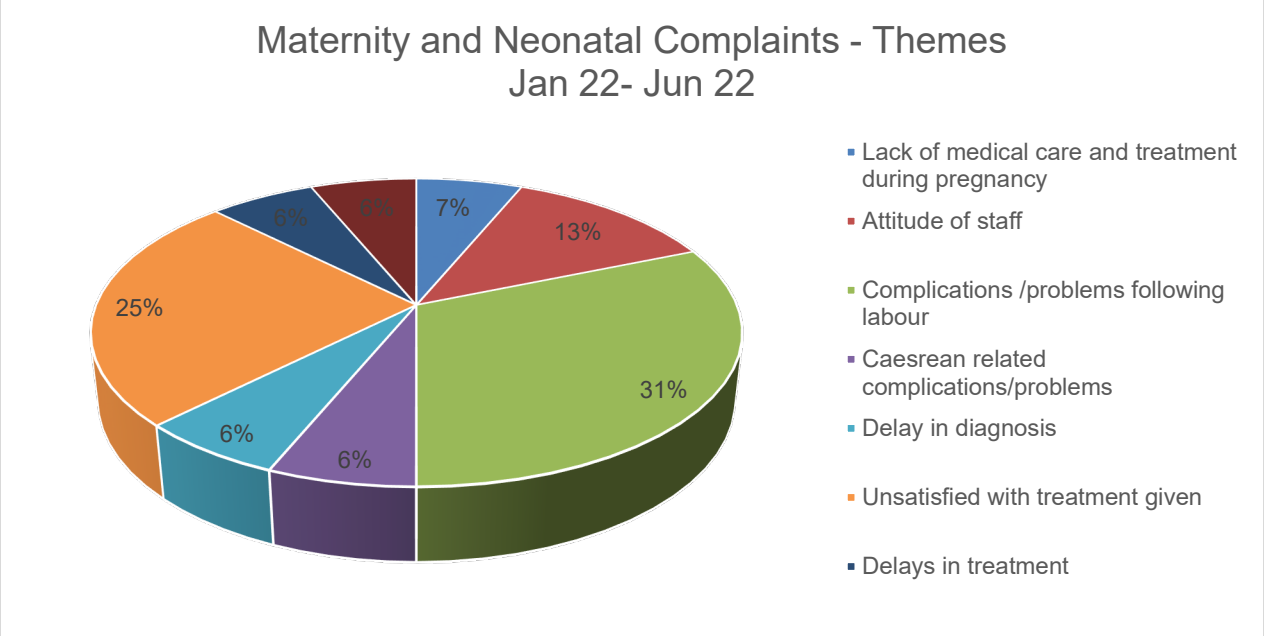
White

External Reviews
• No external reviews taken place in quarter.
• NHSEI/CMO Ockenden Insight Visit planned for 16th August 2022
• Maternity Voice Partnership 15 Steps Challenge Planned for September 2022

4 Complaints

White


Maternity and Neonatal Complaints
Jan 22- Jun 22
7
6
5
4
3
2
1
0
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22


Maternity and Neonatal Complaints - Themes
Jan 22- Jun 22
7%
13%
31%
6%
6%
25%
6%
Lack of medical care and treatment during pregnancy
Attitude of staff
Complications /problems following labour
Caesrean related complications/problems
Delay in diagnosis
Unsatisfied with treatment given
Delays in treatment

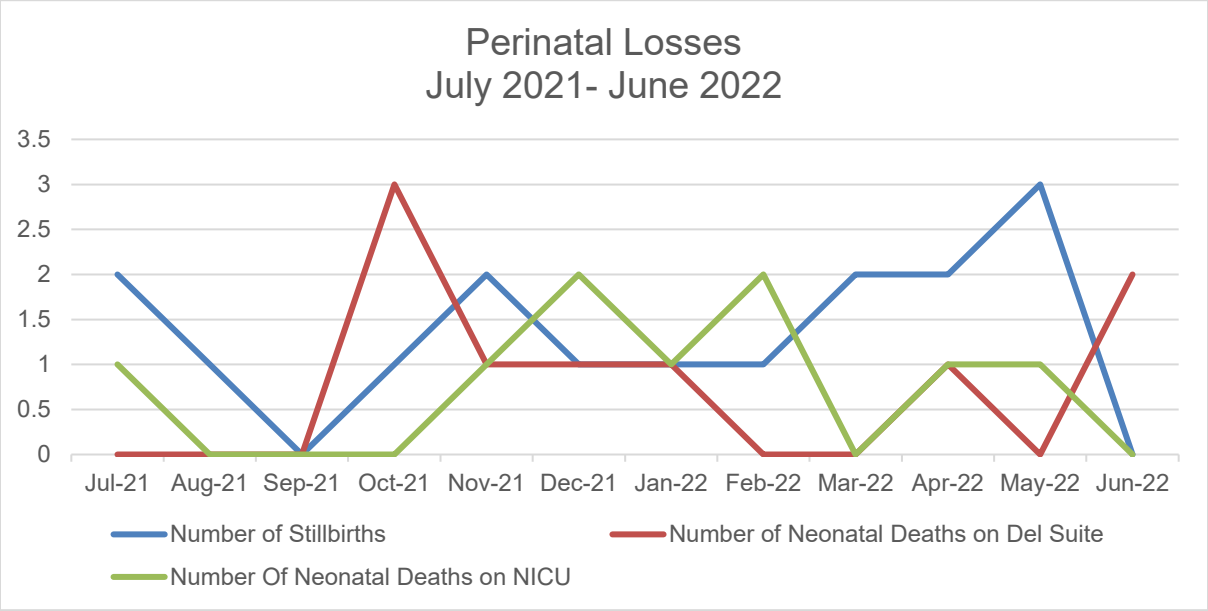
Closed Complains Q1 2022/23		
Area	**Theme**	**Actions/Recommendations**
Obstetrics & Maternity (O&M)	Delay in Diagnosis	•Staff reflection •Highlight in education and training sessions.
O&M	Complications following labour/delivery	• Importance of documenting all care given in postnatal period.
Neonatal (x2)	Unsatisfied with treatment given	• Complaint shared to remind staff to be professional in their attitude at all times • Treatment appropriate based on clinical presentation
O&M	Complications following labour/delivery	All staff to: •Be reminded to listen to women. •Gain consent for all procedures. •Inform women so that they are able to make decisions about their care. •Offer a debrief following delivery if appropriate. •Review the induction of labour decision-making process for large for date's babies.
O&M	Unsatisfied with treatment given	•Staff to be reminded to ensure all maternal and neonatal observations are explained to parents to allow them to make informed decisions about care.
O&M	Unsatisfied with treatment given	• Rapid review completed and actions in place as per near miss.
O&M	Attitude of staff	• Staff Reflection

5 Perinatal Mortality Review Tool

White

Perinatal Mortality Review Tool (PMRT) Summary			
Eligible cases Q1 2022/23	**Still Births**	**Neonatal Deaths on Delivery Suite**	**Neonatal Deaths**
Reported	5	3	2
MBRRACE notified within 7 working days	100%	100%	100%
Cases published in quarter	0	0	4
Summary of cases reviewed Q1 2022/23	• Extreme prematurity • Unexplained stillbirth • Placental abruption	• Extreme prematurity • Expected death due to abnormalities	• Extreme prematurity • Expected death due to abnormalities
Themes for those reviewed in quarter	• Late Maternal Booking		N/A

	• Following appropriate pathway from booking (eg. Appropriate testing for BMI) • Grading of Care		
Actions/learning/timescale	• Encourage all returning families to book subsequent pregnancy early – ongoing • Community midwives reminded of importance of identifying and acting on appropriate pathway from booking. – Completed June 2022 • Care grading reviewed with MBRRACE and advised to be based against local policy.- Completed July 2022		N/A
Themes for those published in quarter	No reports published in quarter.	No reports published in quarter.	• Ex-utero transfers for intensive care at MFT • Extreme prematurity
Actions/learning/timescale	N/A	N/A	• No actions identified for MFT



Top Themes PMRT 2021/2022			
Theme	**Learning**	**Action**	**Target/Complete**
Pathway from Booking	Need to ensure that women are on the correct pathway from booking and receive appropriate testing (eg. BMI) and receive appropriate medication (eg. Aspirin)	Communicate with teams and introduce written communication to patients to support pathway.	Completed June 2022

Communication	Ensure that families, including those with additional learning needs, are communicated with appropriately during pregnancy and following a loss.	Service user review of all parental communications to ensure information provided is appropriate and conveys appropriate information Work with research and learning disabilities team to develop maternity hospital passport following Together Project research trial which supported families with learning disabilities.	Target September 2022 Target December 2022
Placental Histology	Placental histology should be carried about by a perinatal/paediatric pathologist.	Included in business planning for 2022/23 and approved. SOP drafted.	SOP to be updated to include placental histology for neonatal admissions and plan to launch pathway in September 2022.

6 Staff and Service User Feedback

White

Safety champion Feedback		
• Monthly Walkabouts in quarter with Board Level Safety Champion (Chief Nursing Officer) and Non-Executive Director(NED). • Meeting set up with NED and Maternity Voices Partnership lead to review further engagement with women's and families.		
Feedback and Actions from Walkabout		
Theme	**Action**	**Target/Completed**
Updates required to Boards in Ward areas	• Staff notice Boards to be updated in line with Trust Structure • Governance Boards and quality Boards to be updated in line with current leadership. • DOM to work with Director of Quality to review quality indicators reported on governance boards.	• September 2022 • Completed July 2022 • October 2022

Ward Environment	• Review patient information and posters on display • Consider adapting The Birth Place (TBP) method for displaying birth numbers on delivery suite • Utilisation of space and patient flow requires review – DOM and HOM to review as part of larger piece of work on capacity and demand across the service	• Completed July 2022 • September 2022 • December 2022
Pathways of Care	• Review of pathways and staffing on TBP to reduce the number of occasions when TBP needs to close – review of TBP criteria is currently underway.	• December 2022

Staff Focus Groups

- Weekly staff focus groups held with Director of Midwifery (DOM) and Head of Midwifery (HOM) throughout June and July to support staff in preparation for upcoming Ockenden visit.
- Staff given opportunity to discuss progress against Ockenden recommendations as well as discuss any concerns regarding quality and safety.

Feedback and Actions from Staff Focus Groups

Theme	Recommendation	Action/Target/Completed
Fetal Monitoring Training	• Meeting to be arranged with senior management team to agree new Fetal Monitoring Training plan to support implementation of Fetal Physiological Monitoring Guidance	• Training plan agreed and due to launch in October 2022 ahead of new guideline launch in January 2023.
Digital	• Need for improved Maternity Information System to support recording and auditing key indicators eg. Risk assessment at every contact. • Need for Maternity Digital Strategy • Community Connectivity	• Digital Midwife supporting improvements to the current system and working with provider to improve reporting. • LMNS working to procure region-wide Maternity Information System. • Digital Strategy focus groups with staff being held in July 2022 to support development of digital strategy. • Community Connectivity being addressed by enabling community teams to connect via hard wiring
MDT Training	• Need to improve MDT engagement with training and closing the loop	• Monthly meetings with training teams established to escalate concerns (July 2022)

	following incidents by sharing learning with training.	• Quarterly MDT Training Review meeting to be established August 2022 to review training plans and incidents to ensure learning is incorporated into training programme. • Education Team and Obstetric Lead for CTG and Simulation to work together to improve staff engagement and reintroduce simulations- September 2022
Equipment Availability	• Need to improve availability and turn around of equipment that is sent for service.	• Director of Midwifery to meet with Head of E&F Performance and Clinical Engineering to address staff concerns

Service User Feedback	
Friends and Family Test	100% recommend rate. New bespoke FFT to be implemented. Gathering service user feedback through a range of area and service specific surveys facilitated through QR codes.
Professional Midwifery Advocate Debrief Service	24 Debriefs were offered in Q1 2022/23. 13 of these related to women and birthing people wishing to understand their delivery. 3 raised communication as a concern 22 were happy explanation of events 2 discussed birth choices for future deliveries and advice was given. 7 actions were identified, including feedback to senior sisters on postnatal ward regarding care and treatment given, discussing with community team regarding including different scenarios in antenatal classes and sharing learning on Fridays News.

CQC Patient Survey Report actions			
5 actions were identified following the 2021 CQC Patient Survey			
Recommendation	**Action**	**Progress**	**Target/Completed**
Partners or someone else involved in the mother's care being able to stay with them as much as the mother	• Review in line with Trust visiting policy/Covid-19 restrictions with a view to return to overnight visiting	• Visiting restrictions eased in line with Trust guidance allowing 2 birthing partners and 2 visitors during inpatient	• Ongoing in line with national and Trust guidance.

wanted during their stay in the hospital.	on postnatal ward as soon as possible.	stay. Overnight visiting has not resumed.	
Mothers being offered a choice about where to have their baby during their antenatal care.	• Draft Personalisation and Choice guideline for staff to support women in making choices • Working with LMNS to develop a regional PSCP for all women.	• Personalisation and Choice guideline due for final ratification July 2022. • Work with LMNS continues with anticipated launch of PSCP in Q3 2021/2022	• August 2022 • October 2022
During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.	• Draft Personalisation and Choice guideline for staff to support women in making choices • Working with LMNS to develop a regional PSCP for all women. • Choice of place of Birth Leaflet to be added to PHR alongside choice of place of birth information on website • Review EuroKing reports for "Choice of Place of Birth" review at each appointment/Ockenden Audit to determine compliance with review • Audit of 36 week appointment to determine place of birth discussion.	• Personalisation and Choice guideline due for final ratification July 2022. • Work with LMNS continues with anticipated launch of PSCP in Q3 2021/2022 • Choice of place of birth audit ongoing due to complete July 2022 • Audit of 36 week appointment to commence September 2022	• August 2022 • October 2022
The midwife or midwifery team appearing to be aware of the medical history of the mother and baby during care after birth.	• Audit of handover to ensure all relevant details/history is shared • Audit midwife to lead on piece of work to share learning from survey to educate staff on how they communicate with patients and ensure they communicate that they have reviewed their notes.	• Audits delayed due to clinical pressures. Due to commence September 2022	• December 2022
The midwife or health visitor asking about mothers' mental health during their care after birth.	• Share finding with health visiting team • Re-energise daily postnatal checklist on postnatal ward to ensure it captures psychological wellbeing. • Audit of patients on postnatal ward to check if they have been asked	• Audits delayed due to clinical pressures. Due to commence September 2022	• December 2022

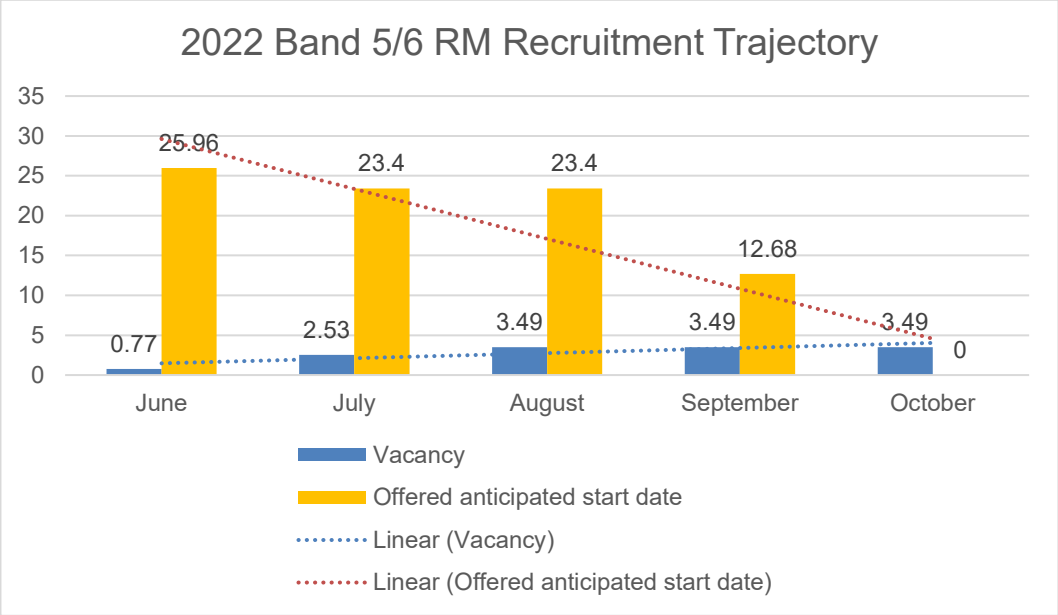
	about their mental wellbeing. • Include postnatal mental health in the documentation audit. • Audit "Emotional State" questions on postnatal checks.		

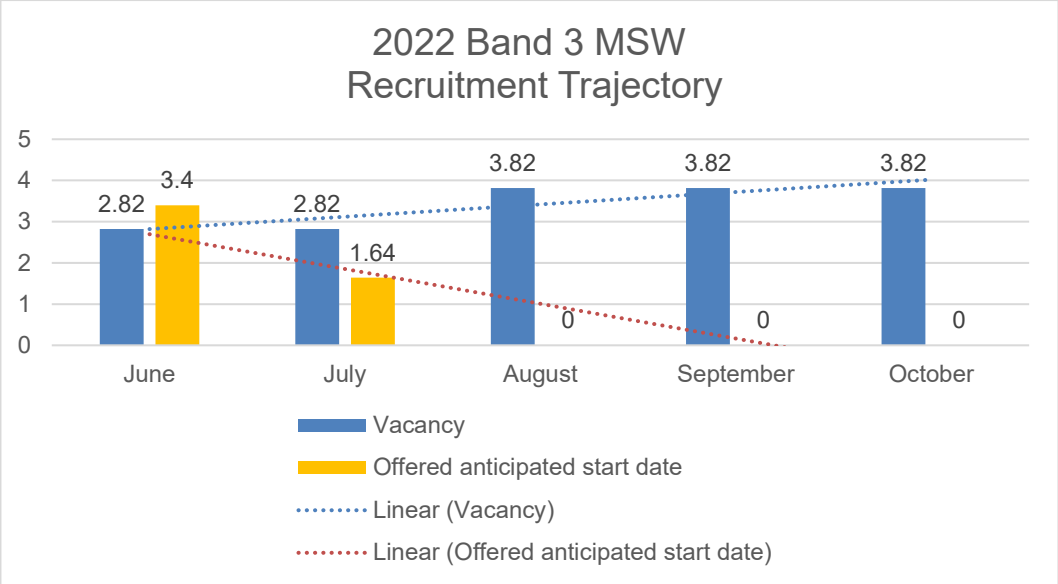
Maternity Voices Partnership (MVP) 15 steps challenge
• Informal 15 Steps Challenge to be held 18 July 2022 • MVP lead 15 Steps Challenge to be held September 2022 • 15 Steps Challenge questions entered onto Gather to support efficient reporting.

7 Staffing and Recruitment

Amber / Green

Workforce WTE	**Midwives**	**Maternity Support Workers**
Vacancies	2.53 WTE	2.82 WTE
Offered but not yet started	23.4 WTE	1.64 WTE
Sickness	4.61%	4.91%





Recruitment Plans
• Open rolling recruitment advertisement on NHS Jobs for midwives and staff nurses • Ongoing and active involvement with the LMNS International midwifery recruitment plan • Independent International recruitment campaign • Recruitment day for midwives planned on 29 July 2022 • Attendance at nursing open day • Education team attend Universities to recruit Band 5's • Social media campaign planned with merchandise purchased • Band 7 Education post advertised • Band 2/3 MSW posts advertised

8 Training

Amber / Green

Staff Training Curriculum	Target	Compliance %	Trajectory %	Action plan in place
Obstetric Emergency (PROMPT)				
Midwives	90%	78%	100%	• All Staff allocated to training session and time given on rota • E-learning utilised to support non-attendance • Medical attendance escalated to Obstetric education lead and CD to support compliance.
Maternity Support Workers		64%	92.86%	
Consultant Obstetricians		50%	100%	
Doctors in Training (obstetric)		67%	94%	
Consultant Anaesthetists		50%	100%	

Doctors in Training (Anaesthetic)		67%	87%	• Working with anaesthetic lead to support compliance
Fetal Monitoring Training				
Midwives	90%	94%	100%	• New MDT Fetal monitoring training plan has been agreed and will commence October 2022. • Will maintain compliance at >90% with the support of e-learning prior to commencing new training. • New 'Physiological Fetal Monitoring Guideline' will be launched in January 2023.
Consultant Obstetricians		95%	100%	
Doctors in Training (obstetrics)		95%	100%	
New Born Life Support				
Midwives	90%	88%	>90%	• Work to validate staff training data ongoing as CNST requires specific staffing groups which cannot be extracted from ESR. Errors in mapping rotational staff noted on ESR. • All line managers contacted regarding non-compliance and staff encouraged to attend training. • Maternity offer Pick and Mix Sessions to support NBLS Training. • NICU due to commence local training to support compliance.
Maternity Support Workers		93%	>90%	
Consultant Obstetricians		55%	>90%	
Doctors in Training (obstetrics)		56%	>90%	
Neonatal Nursing		72%	>90%	
Consultant Neonatologist		86%	>90%	
Doctors in Training (Neonatal)		82%	>90%	
Advanced Neonatal Practitioners		100%	100%	
Safeguarding Children Level 3				
Midwives	90%	90%	N/A	• Obstetric compliance to be escalated to Clinical Director and College Tutor to support compliance.
Consultants and Doctors in Training (Obstetric)		75%		
Safeguarding Adults Level 2				
Midwives	90%	94%	N/A	• Obstetric compliance to be escalated to Clinical Director and College Tutor to support compliance.
Consultants and Doctors in Training (Obstetric)		82%		

9 CNST

Amber / Green

Maternity incentive Scheme Non-Compliance
• Full CNST report was last presented to the Board in June 2022 and is due to be presented to the Trust Board again in October 2022, and December 2022 for final approval prior to submission. • On track to achieve compliance for all Safety Actions.

- Safety Action 2 (Maternity Dataset) has been raised as a risk on the risk register. Work ongoing with Maternity Information System provider to rectify data mapping issues.

10 Ockenden 1

Amber / Green

Ockenden
• Full Ockenden report presented to Trust Board in June 2022 and is due to be presented to the Trust Board again in October 2022. • On track to achieve compliance with all 7 Immediate and Essential Actions by December 2022. • One IEA (Risk Assessment Throughout Pregnancy) has been self-assessed as Amber, but is on track for completion following the ratification of revised antenatal risk-assessment guidance and personalisation and choice guidance in July 2022 and the implementation of a regional Personalised Care and Support Plan from October 2022.

11 Saving Babies Lives Care Bundle

Amber / Green

Saving babies Lives Care Bundle Compliance			
Element	**Update**	**Actions**	**Completed/Target**
1. Reducing smoking in pregnancy	• 95% compliance with CO monitoring at booking. • 90% compliance with CO monitoring at 36 weeks	• Action plan in place to achieve >95% for both indicators including Smoking in pregnancy midwife attending Team meetings and work with digital midwife to ensure data is accurate and supporting reporting.	• August 2022
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)	• Audit completed for raised BMI pathway • Quarterly audit of babies born <3rd centile ongoing.	• Audits to be completed by September 2022 for local review and sign-off before presentation to the Board.	• December 2022
3. Raising awareness of reduced fetal movements (RFM)	• Audit showed 100% compliance with computerised CTG for women attending with RFM • Audit showed 100% compliance with providing information regarding FRM by 28 weeks.	• Repeat audit for RFM by 28 weeks to be undertaken	• September 2022

4. Effective fetal monitoring in labour	• Consultants: 95% • Doctors in training: 95% • Midwives: 94% • New MDT Fetal monitoring training plan has been agreed and will commence October 2022.	• Finalise revised 'Physiological Fetal Monitoring Guideline' and submit to governance for ratification.	• December 2022
5. Reducing preterm birth	• Audits regarding administration of corticosteroids ongoing. • MDT Obstetric and Midwifery Quality Improvement Project (QIP) for the Prem 7 Antenatal Optimisation Bundle to launch in August 2022.	• Audits to be completed by September 2022 for local review and sign-off before presentation to the Board. • Launch QI project and audit outcomes.	• December 2022 • December 2022

12 CQC

CQC actions for sharing and learning
No recent CQC inspections for Maternity. Maternity included in the Ward Accreditation programme and bespoke questions have been agreed and Clinical Effectiveness Team to enter onto Gather.

13 Conclusion and Next Steps

13.1 Continue to monitor local and report to Trust Board Quarterly.

13.2 Report perinatal surveillance to the LMNS, who in turn report to NHSE. LMNS have revised the reporting template, which will be implemented for the next reporting quarter.

NHS Medway NHS Foundation Trust

Public Trust Board
Date of meeting: 3 August 2022

Title of Report	**Annual Complaints Report**	Agenda Item	**5.6**
Lead Director	Evonne Hunt, Chief Nursing Officer		
Report Author	Dan Rennie-Hale, Director of Quality Lyndsay Barrow, PALS and Complaints Lead		
Executive Summary	The report provides a summary of complaints from 01 April 2021 to 31 March 2022, referencing the main issues raised by patients and their families, including trends and triangulation work. This report also reviews our performance against agreed response targets and includes complaints that progress to the second stage of the complaints process including assessment and investigation by the Parliamentary and Health Service Ombudsman. Focus has been given to providing early and swift resolution at every opportunity by the PALS team and the data provided in this report reflects this approach. Key findings are: • 486 complaints were received, which is just 2% more than the number recorded the previous year. • 98% of complaints were acknowledged within 3 working days. • Overall performance was 40.26% against the 85% performance target for amber complaints. • 23 complaints were re-opened where it was felt that further resolution would be helpful • Five cases were referred to the Parliamentary and Health Service Ombudsman for assessment and closed within this reporting period. • 362 compliments were received, registered and shared. • 4602 enquiries were raised with the Patient Advice and Liaison Service. This marks a significant increase in comparison with the previous year of 3056 enquiries.		
Committees or Groups the paper has been submitted	Quality and Patient Safety Sub Committee Nursing, Midwifery and Allied Health Professional Board		
Resource Implications	None		
Legal Implications	None		
QIA	None		
Recommendation/ Actions required	The Board is asked to NOTE this paper.		

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	- Annual Complaints Report - PALS and Complaints Annual Summary

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Contents

1 EXECUTIVE SUMMARY

In accordance with NHS complaint regulations (2009), this report sets out detailed information relating to complaints received by Medway NHS Foundation Trust during 1 April 2021 to 31 March 2022

It is widely accepted that effective patient complaint management systems constitute a crucial component of well-performing health systems. Listening and responding to feedback from patients, relatives and carers provides our Trust with a vital source of insight about people's experiences of healthcare and provide vital information on how our services might be improved.

The Trust follows the Department of Health guidance and legislation (The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) ('the regulations')

Effective complaint handling remains a priority for the organisation. We actively encourage patients, families and visitors to feedback on their experience of visiting or receiving care in our organisation, and use their feedback to improve the experience of patients. Our organisation recognises that complaints matter to individuals, staff, and to our community. They matter to people who use the services, who deserve an explanation when things go wrong and want to know that actions have been taken to prevent reoccurrence and that evidenced learning has taken place.

This reporting year has continued to be challenging for our organisation and for the NHS in general because of the after effects and additional work following the Covid19 Pandemic. The number of PALS and complaints contacts from patients and their families has risen and this has undoubtedly had an impact on the organisation's ability to respond to complaints within the timeframes it aspires to.

This report provides a summary of complaints, referencing the main issues raised by patients and their families, including trends and triangulation work. This report also reviews our performance against agreed response targets and includes complaints that progress to the second stage of the complaints process including assessment and investigation by the Parliamentary and Health Service Ombudsman.

The PALS team carry out signposting, provide information, advice or reassurance and manage issues that can be resolved quickly, assisting patients' and relatives who need time to discuss concerns and operate a triage service for telephone and face to face enquiries . The complaints team manage more complex and serious concerns that require a formal investigation about past events.

Focus has been given to providing early and swift resolution at every opportunity by the PALS team and the data provided in this report reflects this approach.

Key findings are:

- 486 complaints were received, which is just 2% more than the number recorded the previous year.
- 98% of complaints were acknowledged within 3 working days.

- Overall performance was 40.26% against the 85% performance target for amber complaints.
- 23 complaints were re-opened where it was felt that further resolution would be helpful
- Five cases were referred to the Parliamentary and Health Service Ombudsman for assessment and closed within this reporting period.
- 362 compliments were received, registered and shared.
- 4602 enquiries were raised with the Patient Advice and Liaison Service. This marks a significant increase in comparison with the previous year of 3056 enquiries.

2 COMPLAINT HANDLING

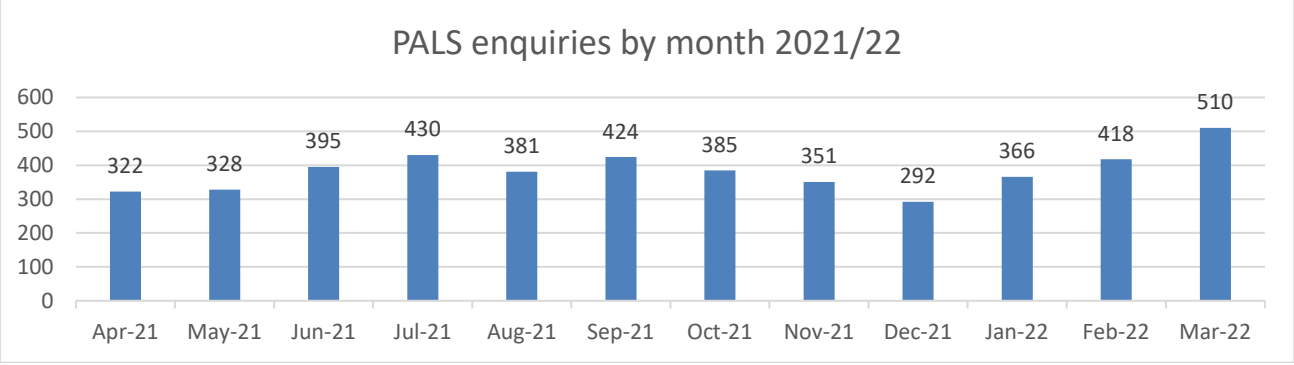
Since April 2017, a de-centralised model of complaints management has been in place. Each complaint is assessed and early resolution via the Patient Advice and Liaison Service (PALS) is offered wherever possible. In cases where this is not possible the central complaints team take responsibility for assessing and registering the complaint before divisional governance teams investigate the complaint and draft a complaint response letter.

One of the elements that has worked well is the 'scope of investigation', which was introduced in early 2021. A member of the central team speaks with the complainant to identify the main points of the complaints, their anticipated outcome and helps to manage their expectations of complaint handling. Anecdotal feedback from patients tells us that this initial call is very welcomed by complainants, who comment that hearing a human voice and having someone listen and empathise at the beginning of the complaint helps them to feel confident that their concerns are understood and will be taken seriously.

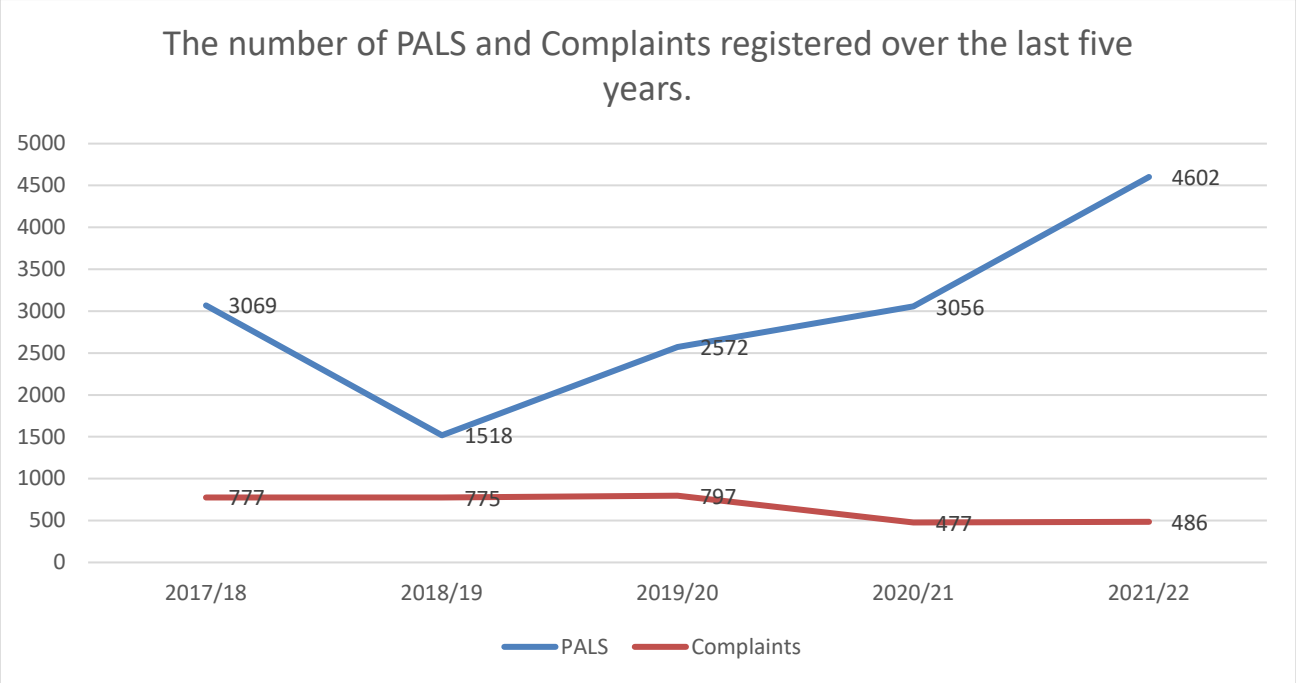
The complaints and PALS team consists of 4.6 WTE band five complaints officers, a 0.6 WTE band six team leader and 1.0 WTE eight (a) PALS and complaints lead.

3 SUMMARY OF PALS

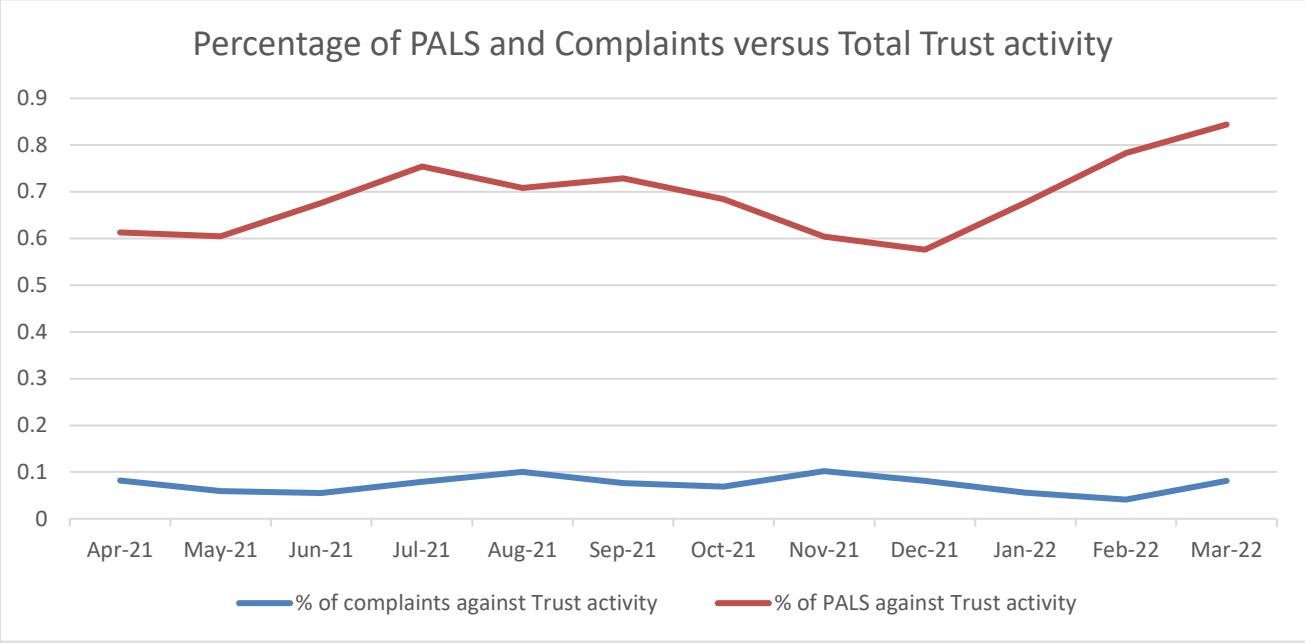
The Patient Advice and Liaison Service received 4602 enquiries, an average of 384 enquiries each month, with quarter 4 being the busiest totalling 431 enquiries each month.



The PALS and central complaints teams (CCT) have been working in a more collaborative way to identify early opportunities to facilitate and provide swift remedy and resolution. This welcomed approach by patients and families has led to an increase in PALS concerns and decrease in formal complaints as demonstrated in the graph below:



The graph below demonstrates the number of complaints and PALS concerns/enquiries measured against total Trust activity. Both PALS can complaints registered fall below 1% of all Trust activity, which includes inpatients, Emergency Department, Outpatients



4. SUMMARY OF COMPLAINTS

A total of 486 formal complaints were registered, this is an average of 40 complaints per month and is a similar figure to the 477 complaints registered last year.

Of the 486 complaints registered, 16 (3.2%) of these related to complaints that are being led by other organisations.

The number of PALS enquiries which progress to a formal complaint has not previously been measured and therefore there is no data is available. This metric has been added from April 2022 and will be featured in future reporting.

When complaints are received, they are assessed and categorised as below:

Code	Category	Response timeframe	Percentage received 2021/22
Amber	Less complex complaints	30 working days	92.5%
Blue	Less complex complaints supported or made by an Member of Parliament (MP)	30 working days	3.2%
Red	More complex complaints – multi-organisational, multi divisional, multiple attendances and or linked to a serious incident.	60 working days	4.11%

The Trust is organised into two clinical divisions; planned care (PC) and unplanned and integrated care (UIC). Other complaints, which are not clinical will be categorised within the corporate division.

The table below represent complaints received in 2020/21 categorised by division in comparison with the previous two years.

Division	Number of formal complaints 19/20	Number of formal complaints 20/21	Number of formal complaints 21/22
Planned Care	325 (40.7%)	198 (41.5%)	222 (45.6%)
Unplanned & Integrated Care	464 (58.2%)	261 (54.7%)	252 (51.8%)
Corporate	8 (1%)	18 (3.77%)	12 (2.4%)
Total	797	477	486

The table below represents complaints categorised into care groups for 2021/22 along with comparison data over a five year period. Surgical Services, and Specialist Medicine Care group are historically the highest scoring care groups with a number of high activity specialities including trauma and orthopaedics, urology, general surgery, ear nose and throat, respiratory, cardiology, neurology and rheumatology.

Care Group	Number of complaints received 2017/18 (242)	Number of complaints received 2018/19 (774)	Number of complaints received 2019/20 (797)	Number of complaints received 2020/21 (477)	Number of complaints received 2021/22 (486)
Surgical Services Programme	59 (24.3%)	218 (28.1%)	233 (29.2%)	116 (24.3%)	140 (28.8%)
Urgent and Emergency Care	65 (26.8%)	236 (30.4%)	193 (24.2%)	108 (22.6%)	107 (22.01%)
Specialist Medicine Programme	50 (20.6%)	144 (18.6%)	169 (21.2%)	79 (16.5%)	81 (16.6%)
Women & Children's Programme	37 (15.2%)	81 (10.4%)	63 (7.9%)	63 (13.2%)	68 (13.9%)
Therapies and Older Person's Programme	-	4 (0.51%)	63 (7.9%)	57 (11.9%)	47 (9.6%)
Diagnostics & Clinical Support Services	2 (0.8%)	1 (0.1%)	29 (3.6%)	14 (2.9%)	15 (3.8%)
Corporate	4 (1.6%)	20 (2.5%)	16 (2.0%)	22 (4.6%)	12 (2.4%)
Peri-operative & Critical Care Programme	9 (3.7%)	11 (1.4%)	26 (3.2%)	12 (2.5%)	11 (2.2%)
Cancer Services	16 (6.6%)	59 (7.6%)	5 (0.6%)	6 (1.2%)	5 (1.2%)
Total	242	774	797	477	486

Urgent and Emergency Care also historically receive a high number of complaints as an area of high activity. They also receive a high number of compliments.

5. COMPLAINT PERFORMANCE

In accordance with the 'Regulations' all complaints are required to be acknowledged within 3 working days. During 2021-22, 98% of all complaints were acknowledged within this timeframe.

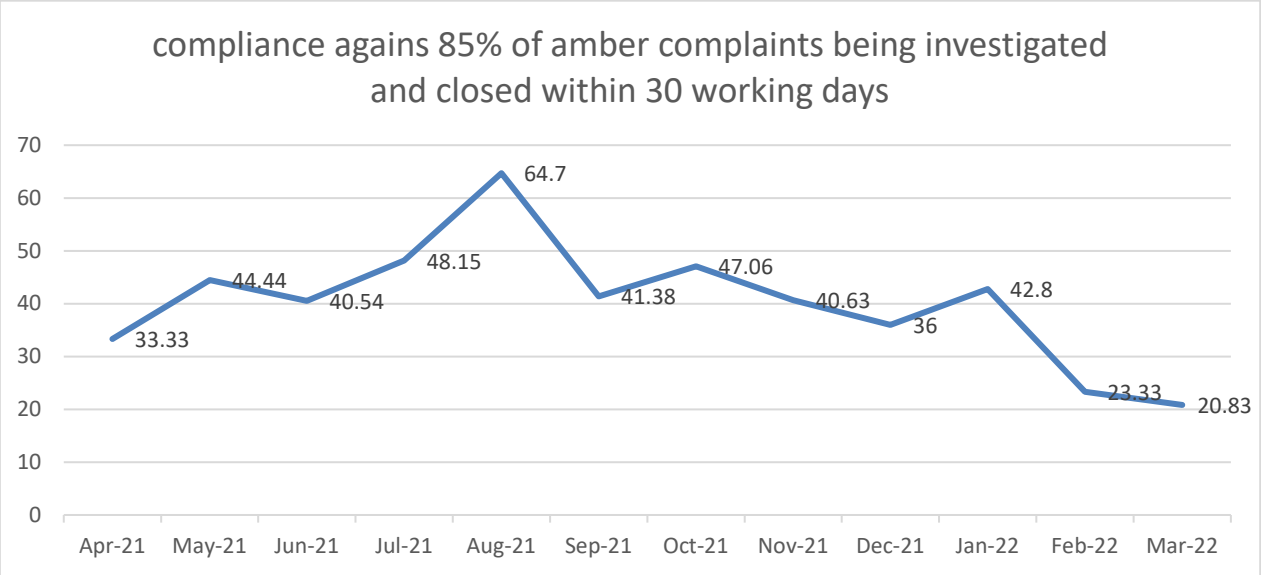
The organisational complaints compliance metrics are:

- The number of complaints received
- 95% of complaints acknowledged within 3 working days.
- 85% of amber complaints are responded to within 30 working days.

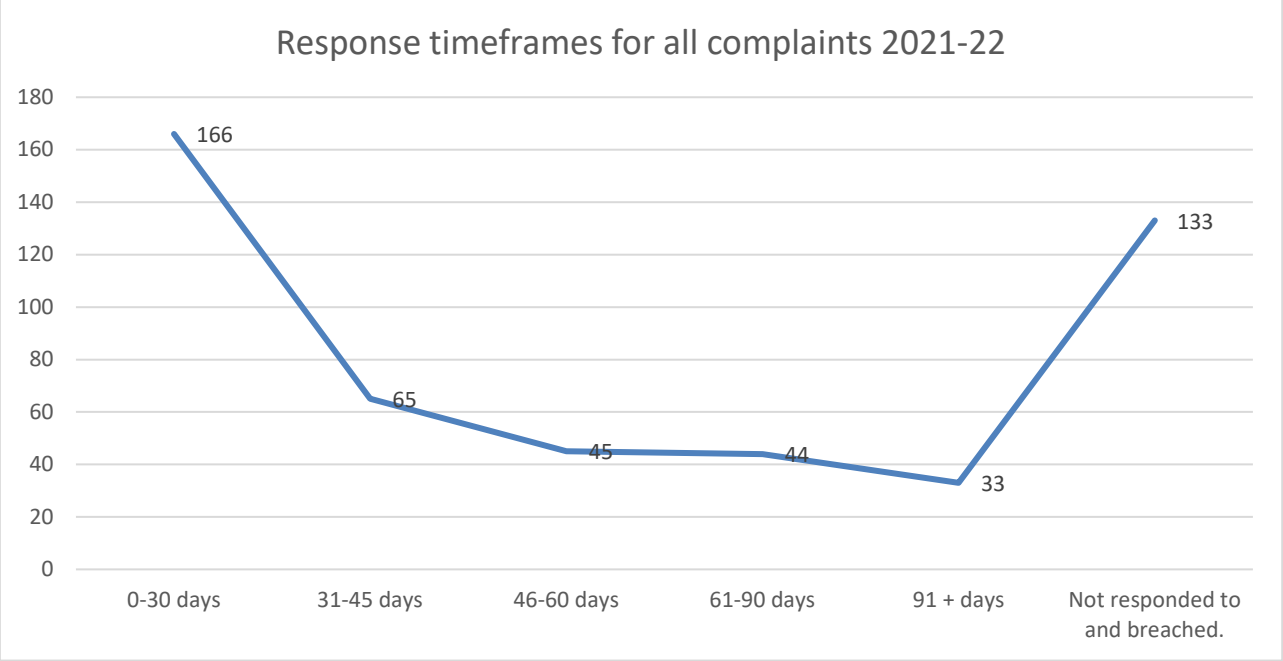
In relation to the above metrics:

- 486 complaints were registered, this is an increase of just 1.8% from 2020/21 and a decrease of 39% from 2019/20
- 98% of complaints were acknowledged within 3 working days
- There were zero months where the KPI of responding to 85% of amber complaints within 30 working days was met. An average of 40.2% complaints met this key performance indicator.

The graph below reflects monthly compliance with the KPI of responding to 85% of amber complaints within 30 working days.

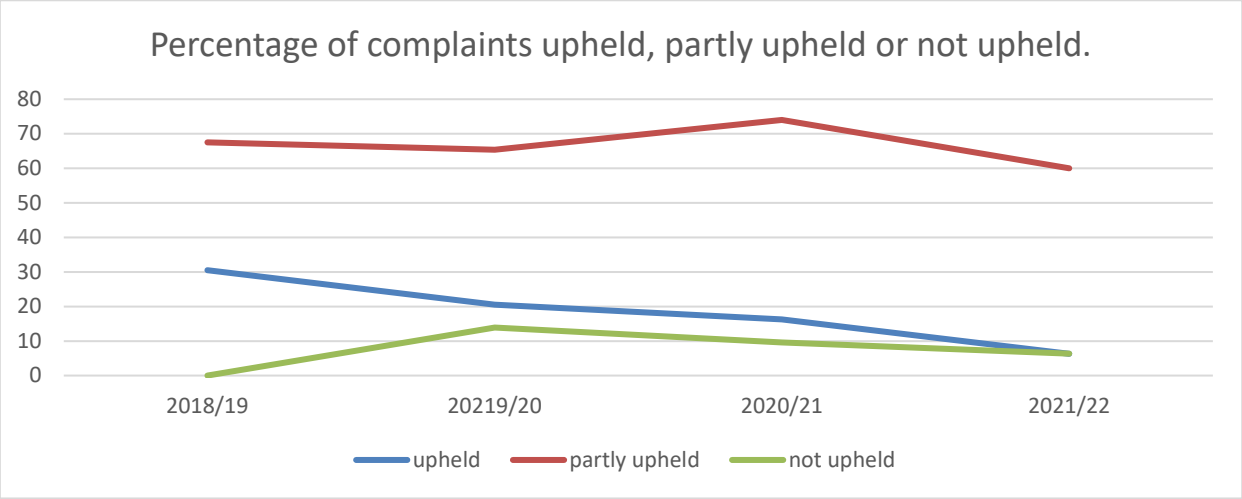


The table below reflects timeframes in which the complaints registered in 2021-22 were responded



Upon completion of the investigation, complaints are categorised by outcome in the following ways, upheld (all aspects of the complaint are upheld), partially upheld (some aspects of the complaint are upheld) or not upheld (no aspect of the complaint is upheld). Complaints which are partially or fully upheld are likely to include examples of improvement and learning which is used for shared learning across the organisation. Matters of importance are escalated and brought to the attention of senior managers for discussion. Important issues are also discussed with the patient safety team and/or the safeguarding team.

The graph below represents the percentage of complaints, which were upheld, partly upheld or not upheld following the complaint investigation in comparison with previous years.



23 complaints were re-opened for ongoing resolution where the complainant remained dissatisfied and there was further opportunity for resolution. This may have included a further letter or a resolution meeting.

The graph below reflects how this compares with previous years.

6. COMPLAINT THEMES

The Department of Health (DoH) classifies complaints into distinct categories by the subject of the complaint. Theming our complaints by subject allows us to identify whether any trends are developing.

Primary subject of complaint	2017/18	2018/19	2019/20	2020/21	2021/22
All aspects of clinical care and treatment	89 (36.77%)	299 (38.6%)	327 (41.1%)	255 (53.4%)	295 (60.6%)
Attitude of staff	39 (16.11%)	128 (16.5%)	97 (12.2%)	71 (14.8%)	51 (10.4%)
Failure to follow agreed procedures	1 (4.5%)	5 (0.6%)	2 (0.2%)	0	
Communication/Information	28 (11.5%)	58 (7.4%)	71 (8.9%)	43 (9.01%)	41 (8.4%)
Admission, discharge and transfer arrangement	15 (6.1%)	61 (7.8%)	67 (8.4%)	35 (7.3%)	36 (7.4%)
Appointments, delay/cancellation (outpatient incl. ED)	40 (16.5%)	116 (14.9%)	107 (13.4%)	22 (4.6%)	23 (4.7%)
Appointments, delay/cancellation (inpatient)	9 (3.71%)	28 (3.6%)	46 (5.7%)	13 (2.7%)	13 (2.6%)
Personal records	3 (12.5%)	15 (1.9%)	19 (3.1%)	7 (1.4%)	7 (1.4%)
Results	0	1 (0.1%)	6 (0.7%)	2 (0.4%)	5 (1%)
Other	5 (22.7%)	24 (3.1%)	12 (1.5%)	7 (1.4%)	4 (0.8%)
Patients' property and Expenses	8 (3.3%)	20 (2.5%)	18 (2.2%)	15 (3.1 %)	3 (0.6%)
Consent to treatment	0	1 (0.1%)	2 (0.2%)	1 (0.2%)	2 (0.4%)
Hotel Services	0	3 (0.3%)	3 (0.3%)	0	2 (0.4%)
Patients' privacy and dignity	2 (0.8%)	7 (0.9%)	7 (0.8%)	15 (3.1%)	2 (0.4%)
Aids and appliances, equipment, premises, access	2 (0.8%)	5 (0.6%)	9 (1.13%)	5 (1.04%)	2 (0.4%)
Information relating to other organisations	0	1 (0.1%)	0	0	0
Patient status and discrimination	0	1 (0.1%)	2 (0.2%)	0	0
Total:	242	774	795	477	486

The table below identifies the top five themes and trends from our complaints by subject during each quarter of 2021/22. The data is related to the primary subject raised within each complaint, using the DoH classifications.

The five most commonly identified complaints were:

- Clinical Care and Treatment (60.6%)
- Attitude of staff (10.4%)
- Communication and information (8.4%)
- Admission, Discharge and transfer arrangements (7.4%)
- Appointment delays/cancellation (outpatient) (4.7%)

A further breakdown of the top five areas by subject includes:

Clinical care and treatment – 295 (60.6%)		
	Dissatisfied with treatment	46 (15.5%)
	Lack of nursing care	41 (13.8%)
	Delay in diagnosis	34 (11.5%)
	Lack of medical care	33 (11.1%)
	Delay in treatment	31 (10.5%)
	Failure to diagnose	20 (6.7%)

Attitude of staff – 51 (10.4%)		
	Attitude of staff	44 (86.2%)
	Lack of compassion/empathy	7 (13.7%)

Communication and information – 41 (8.4%)		
	Verbal communication to relatives	18 (43.9%)
	Written communication to patient/family	9 (21.9%)
	Verbal communication to patient	7 (17%)

Admission, Discharge and Transfer – 36 (7.4%)		
	Appropriateness of discharge	23 (63.8%)
	Discharge other	4 (11.1%)

Appointment delays/cancellation (outpatient including ED) – 23 (4.7%)		
	Delay in outpatient appointment	7 (30.4%)
	Delay in outpatient scan, test etc.	5 (21.7%)
	Streaming process in the Emergency Department	4 (17.3%)

7. COMPLIMENTS

362 compliments were registered in this reporting period. Previously only the compliments recorded are those, which have been received by the PALS team. There are many more compliments received in the organisation that we can currently not evidence and therefore the true figure cannot be determined, however from April 2022 a focussed effort has been to capture more compliments, which will enable us to demonstrate a more balanced picture of patient satisfaction.

Ward sisters have access to Datix and can record any compliments they receive directly from patients and their families. Additionally, the PALS team also now registers compliments received via the following routes:

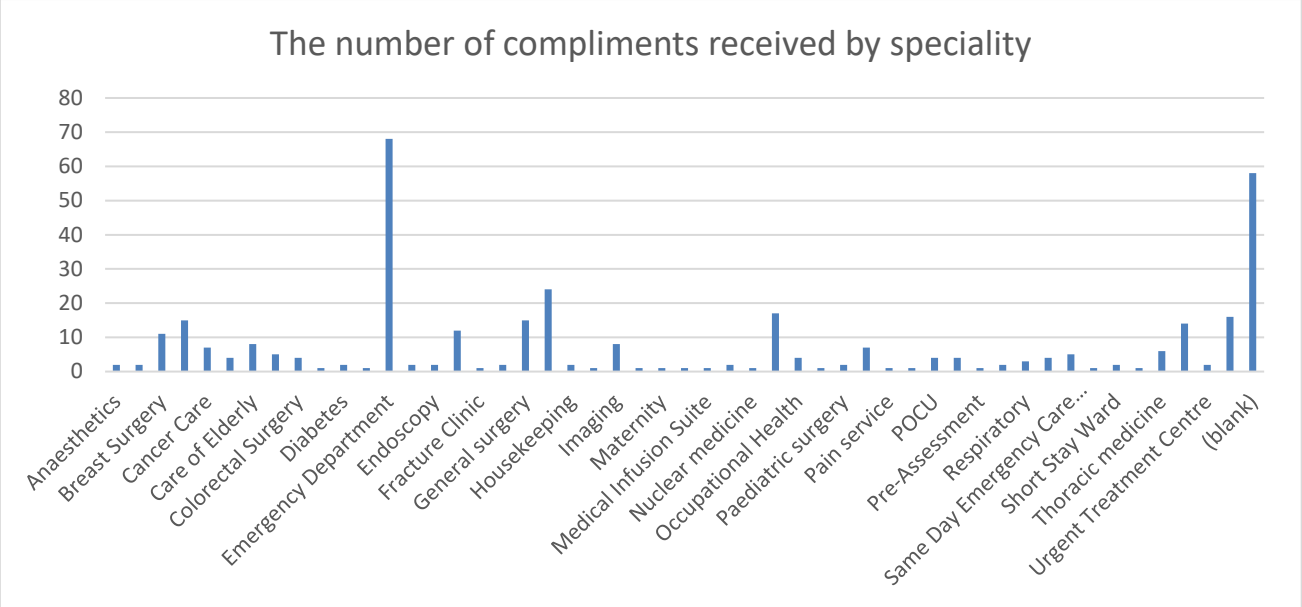
- Comments slips, situated in the main entrance
- 'Have Your Say' on the Trust website
- Those that are posted on NHS.UK and Care Opinion
- Those that are posted on social media and identified by the Communications Team.

From the compliments that were registered it is evident to see that patients, families and colleagues from neighbouring organisations are keen to show their appreciation whether it be because of a kind deed, recognising good care or kind and helpful staff.

A breakdown of the compliments received include:

- 79.3%% of the compliments registered were from patients and/or their families giving thanks for the care they received.
- 0.05% were from other professionals from other organisations paying a compliment to a team or team member.
- 20.1% were gifts such as chocolates, biscuits or sweets
- 31 families of patients who had received care in Galton Day Unit. donated £3,470.

The graph below represents the specialities receiving the compliments. The blank section is where a general compliment is given which cannot be attributed to a speciality.



Some examples of compliments received include:

Three years ago I had a very bad experience at this hospital and was worried but I have had a totally different experience this time (gynaecology)

A patient who observed a kind act from a member of staff made a compliment about the ENT Department. There was a kind clinical support worker in a grey uniform who helped a young patient feel at ease with being in Hospital.

The team from Demelza Children's hospice wanted to thank staff on Dolphin ward for being so welcoming.

Patient wanted to compliment member of covid vaccination team who assisted her and another patient to find the breast screening unit and even got them both a bottle of water as it was so hot.

8. QUALITY IMPROVEMENTS AND LEARNING FROM COMPLAINTS

The Trust values complaints as one way of listening to patients and hearing about their experience of our services. This in turn provides an opportunity to take action and make improvements to our services to benefit our patients.
The importance of shared learning and improvements from complaints is widely recognised and we continue to strive to demonstrate the changes that are made and to sustain the changes for long-term improvement.

Finding examples of learning from complaints using Datix is challenging. Complaints are often dealt with on a singular basis and any identified learning is within the complaint letter only. Although Learning and improvements are discussed at divisional programme review meetings, team huddles and within Trust wide and divisional communications, there is missed opportunity to look more broadly than a care group of division.

The Patient Experience Strategy and delivery plan was launched in April 2022 and contains a number of initiatives to improve and enhance the experience of patients, carers and families. The initiatives are led by feedback from patients and families from a number of sources including; focus groups, the Friends and Family Test feedback, complaints and concerns, suggestions for improvement, compliments, triangulated data resulting from incidents, risks and inquests, patient experience partners and governors and members.

In cases where it has been acknowledged that, something has gone wrong, processes and policies are reviewed and an apology is offered to the complainant, identifying the improvements that have been made.

Complaints and PALS data is shared with the patient experience and quality teams for discussion and to highlight and areas of concern which require additional focus. Complaints and pals data is also shared across the Trust at meeting such as; the nursing, midwifery and allied healthcare professionals board and the quality and patient safety sub-committee.

The table below gives some examples of improvement and action taken as a result of complaint investigations.

Issue	Improvement
Poor communication with families: A number of complaints centred around communication issues faced by families due to restricted visiting due to the pandemic	The 'I care to call' initiative was trialled and then rolled out across the organisation in quarter 4. Emerging findings are that PALS concerns about poor communication have decreased since the introduction of this initiative. Therapists, doctors and nurses will speak with family members when requested.

Appointments Issues relating to a delay or cancellation of an appointment.	An apology was given for each case and an appointment offered. This included sharing outstanding investigation results.
Medication: Issues relating to the administration of medication or delays with medication.	Administration competencies for staff. Reminder of Nursing and Midwifery Council (NMC) code of conduct in relation to drug administration.
Staff attitude: Poor attitude displayed by staff, which led to poor experience for patients.	Staff reflect on their role when feedback is negative. This can include how thy have been perceived, the impact of negative role modelling and the emotional impact on the patients and families when their expectations have not been met. Empathy training sessions were sourced for staff to attend. Over sixty staff have attended this training and feedback has been very positive in regard of the identified changes they would make to their personal communication style. Midwifery staff undergo clinical supervision where issues and concerns are discussed and explored within a formal framework.
Clinical Care and Treatment: The complainant describing delays with care and treatment	Practice Development nurses worked alongside nursing teams to role model and teach clinical skills and assessment of patients. Complaints were discussed as part of the revalidation process for registered staff, for example doctors, midwives and nurses. Advice was sought from manufacturers when an issue relating to equipment was raised. Additional training is available for staff who require it; this includes pressure ulcer care, nutritional and hydration, recognising a deteriorating patient.
Clinical Care and Treatment: Generalised poor care and treatment.	Women and/or their partners were offered the opportunity of a birth debrief with a senior midwife to discuss their care.

	Patients and families were offered a meeting to discuss their concerns and ask questions relating to their care and treatment. Complaints and the issues detailed within them were shared and discussed at ward and department meetings. Complex or serious issues formed part of a wider investigation and the information is shared within the organisation as learning when things have gone wrong. Pertinent issues from complaints were raised during morning' huddles' and in the Big 4 divisional message which is an internal communication channel

9. THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

Once the Trust has completed the complaint response, if a complainant remains dissatisfied they can progress to the next stage of the complaints process and refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) who will assess their complaint and decide whether to investigate further.

Five cases referred to the PHSO were closed with the following outcomes:

- Two complaints were closed with no action necessary
- Two complaints were returned for further local resolution following identification of minor aspects of the complaint, which could be resolved.
- One complaint was investigated and upheld as detailed below:

	Findings	Action required	Progress
Case 1 Upheld	The Trust did not keep appropriate records once it induced anaesthesia until it transferred the patient to ICU. This meant the Trust could not evidence how it monitored them in that time. Recognition that this caused the patient pain and distress.	A letter of apology to the patient. Produce an action plan detailing how it will ensure it records the observations, assessments, and actions it takes during and following intubation procedures, and explain how it will monitor this going forward	Complete Complete

SUMMARY

This year has continued to be challenging for patients, visitors and hospital staff with continued restrictions because of the Covid 19 pandemic. These have included

additional swabbing for patients, wearing facemasks for patients, staff and later visitors and additional personal protective equipment worn by staff.

Visiting restrictions have prevented families and visitors from giving compliments and raising issues with staff in the way they usually would whilst on site. Equally, restricting visitors to the hospital has prevented face-to-face resolution meetings, which is a well-recognised and successful way of listening, understanding, discussing and resolving issues to the complainants' satisfaction.

Despite these challenges, the Trust has remained committed to investigating, learning from, and introducing quality improvements as a direct result of complaints. This also includes suggestions for improvement and preventative measures based on poor experiences.

Heading into next year, the Trust will:

- Continue to monitor and review complaint handling compliance with the aim of achieving the key performance indicators.
- Ensure questions and concerns raised about the quality of care and care delivery are robustly investigated and responded to in an empathetic way.
- Continue to be committed to improving services and taking action where it is found that standards fall below the expected level.
- Use patient feedback to better inform us and identify changes, which will make a positive impact.
- Invite patients and/or their families to share their experience of care for the 'patient story' initiative. These 'stories' are shared at a various audiences including; the Executive Team, divisional meetings, patient experience group and grand rounds.
- Patients and their families will be invited to participate in focussed work with the Patient Experience Team to offer their unique perspective of care experiences and suggestions for improvement including collaborative work for the new patient experience strategy, the patient experience group and the complaint handling process.
- Triangulate data by looking at more than one source, for example from complaints, incident risks, serious incidents and inquests, to gain a wider understanding of key trends to help identify common themes to support change and learning. Introduction of a 'Quality Dashboard' will help to focus this work and provide an improved system to identify themes and trends.
- Work collaboratively with colleagues to review data from multiple sources including complaints, incidents and inquests and identify areas for focussed improvement.

- Capture and report on ethnicity and gender metrics. We will also capture and report specifically on the source of complaints.

- Work with the divisions to re-visit action plans, particularly in PHSO cases to ensure the learning identified has been completed and is sustained. The PHSO are more frequently asking for evidence of updates from action plans and this will help to ensure this work is given focus and the information is available.

- Ensure initiatives from the patient experience strategy delivery plan which have been identified to improve the experience for patients, carers and relative are embedded, these include:

  Improving the information available to patients admitted to hospital, including helpful information on who to contact when they leave hospital.

  A review of the information on the Trust website to allow patients, carers and visitors to access the services they require more easily

  'Every patient every day' and 'hello my name is' where patients are spoken to each day and asked for their views on their care and the introduction of privacy and dignity audits to highlight issues for resolution as a result of patient feedback.

Following a review of complaint handling a re-centralised model will be introduced, whereby the complaints team will manage the handling of complaints from start to finish. This will offer a person centred approach to complainants and offer more robust reporting mechanisms for learning and improvement

The complaints team will utilise the newly developed tools, which have been made available by the Parliamentary and Health Service Ombudsman to offer a standardised approach when responding to complaints.

There will be a strong focus on capturing learning as a result of complaints. Previously learning and improvement has been focussed on individual areas rather for the whole organisation and there has been challenges with accessing evidenced learning on Datix. Ensuring evidenced learning is a higher focus will help to influence the triangulation work with colleagues in patient safety and influence improvement initiatives with patient experience colleagues. Collaborative working, sharing data and identifying areas for improvement following complaint investigations will offer a robust approach to complaint handling and preventing poor experiences for future patients.

The patient experience strategy and delivery plan details a three year focussed approach to improvement following feedback from patients, some examples include:

- improving accessibility to the PALS team, including visibility in wards and clinical areas; responding to and acting to complaints as they happen
- encouraging more people to drop in and to raise concerns as they happen and seek advice from the PALS team

- recognising capturing and spreading good practice, teaching and role modelling how to resolve issues at a local level, meeting with patients, relatives and carers who have concerns

A training package to support staff with recognising and acting on concerns immediately, managing the expectations of complainants, the benefit of early resolution and remedy and customer care skill will be introduced across the organisation. Patient feedback and real life scenarios will be used.

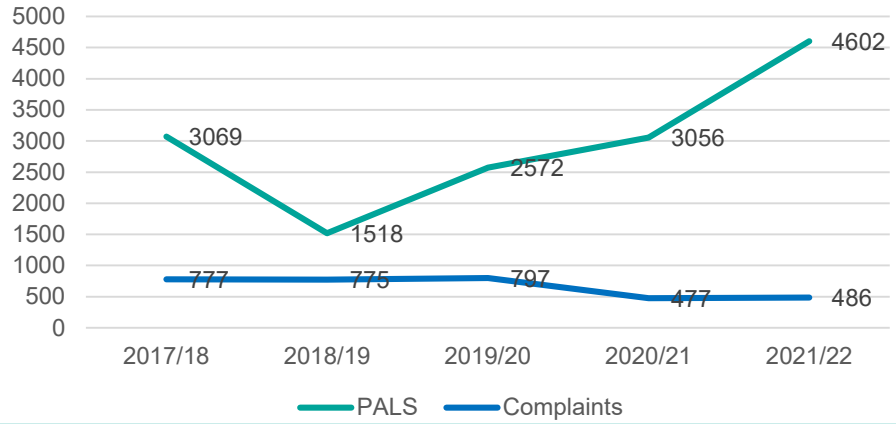
The Trust has introduced the Patient First programme, which puts the patient first in all decision-making and improvement within the hospital. This is a clear commitment that everything we do, no matter how big or small, should always contribute to improving outcomes and experiences for the people we care for. Encouraging patients to feed back on their care is a core objective and we will strive to gain the confidence and trust of patients to achieve the aim of 95% of patients who complete the Friends and Family test to recommend the organisation based on their safe, effective and caring experience.

Annual Complaints Report 21-22

Board Summary

Medway NHS Foundation Trust

The number of PALS and Complaints registered over the last five years.



Key Messages:

- The number of complaints has remained consistent, whilst PALS activity continues to increase
- 98% of complaints were acknowledged
- 23 complaints were re-opened (less than 5%)
- 5 cases referred to PHSO of which 2 closed with no further action, 2 returned for further local resolution and 1 was investigated and upheld

Issues, Concerns & Gaps:

- 40.26% against a target of 85% performance target for responding to amber complaints
- Clinical Care and Treatment accounts for 60.6% of reason for the complaint

Actions & Improvements:

- Review of Complaint Policy with improved systems and processes being implemented with a return to a centralised complaints process.
- Continue to monitor and review complaint handling compliance with the aim of achieving the key performance indicators.
- Ensure questions and concerns raised about the quality of care and care delivery are robustly investigated and responded to in an empathetic way.
- Patients and their families will be invited to participate in focussed work with the Patient Experience Team to offer their unique perspective of care experience.
- Triangulate data by looking at more than one source, for example from complaints, incident risks, serious incidents and inquests with the introduction of a ‘Quality Dashboard’ will help to focus this work and provide an improved system to identify themes and trends.
- Work with the divisions to re-visit action plans, particularly in PHSO cases to ensure the learning identified has been completed and is sustained.
- The Trust has introduced the Patient First programme, which puts the patient first in all decision-making and improvement within the hospital. Encouraging patients to feed back on their care is a core objective.
- Capture and report on ethnicity and gender metrics. We will also capture and report specifically on the source of complaints.
- Development of a Trust wide Master Action Data Base to improve learning from Complaints, Incidents, Inquests through focused quality improvement work.
- A training package to support staff with recognising and acting on concerns immediately, managing the expectations of complainants, the benefit of early resolution and remedy and customer care skill will be introduced across the organisation.

Meeting of the Board of Directors in Public
Wednesday, 03 August 2022

Title of Report	**Finance Report**	**Agenda Item**	6.1
Report Author	Alan Davies, Chief Financial Officer Isla Fraser, Financial Controller Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director of Income and Contracting		
Lead Director	Alan Davies, Chief Financial Officer		
Executive Summary	The Trust reports a £0.9m deficit, this is in line with the draft NHSE/I plan.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 30 June 2022		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance report		

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Finance report

For the period ending 31 May 2022

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(447)	(447)	0	The Trust reports a £447k deficit position for May; reducing to £434k after making the technical adjustments for donated assets. The reported position includes Elective Recovery Funding (ERF) income of £1.7m year to date, this is highlighted as a risk due to planned activity levels not being achieved and therefore underperformance is subject to a 75% clawback in the future. Depreciation and dividend costs are higher than 2021/22 as a consequence of the capital programme and assets that are now operational and no longer categorised as under construction. The annual leave accrual of £2.9m is included in the position, this being the same level as 2021/22. This month's pay expenditure has decreased by £0.2m to £22.2m due to a reduction in the need for temporary staffing; non-pay costs have increased by £1.4m mainly due to inflation, unfound efficiencies and activity pressures in drugs and clinical supplies.
Donated Asset Depreciation	13	12	(1)	
Control Total	**(434)**	**(434)**	**(1)**	
Efficiencies Programme				
In-month	332	235	(97)	The in-month position is reporting a £0.1m adverse to plan for May, and £0.2m adverse for the year to date. The delivered efficiency programme position of £0.4m includes £0.3m of the approved cross cutting themes and £0.1m full year effect of schemes continuing from 2021/22.
YTD	662	461	(201)	
Capital				
In-month	438	856	418	The Trust Capital Resource Limit (CRL) and plan has been set at £11,550k, to be funded from depreciation (£11,050k) and PDC (£500k). In May a high level plan was presented to the Executive to spend the internally generated allocation of £11,050k plus 20%, which was approved in principle. The value of projects provisionally agreed was £13,700k, i.e. an over-allocation of £2,150k against budget. The theory behind this is that in prior years there has been significant project slippage and late allocations of external capital funding which has been difficult to spend on the right priorities. This is of course a risky strategy, not least due to the revenue consequences of additional depreciation and PDC dividends. Detailed budgets are still being finalised which will need to include a 20% stretch target as the Trust is unable to report in excess of the £11,550k allocation. As detailed budgets have not yet been finalised reporting on capital is limited in this report. There is an expectation this work will be complete for Month 3 reporting.
YTD	876	1,184	308	
Annual plan/forecast	11,550	11,550	-	
Cash				
Month end	31,851	33,127	(328)	No matters of significance to note.

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2. Income and expenditure (reporting against NHSE/I plan)

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	27,538	28,334	795	55,076	55,828	752
High cost drugs	1,888	1,924	36	3,776	3,859	83
Other income	2,413	2,857	444	4,920	5,051	131
PSF/MRET/FRP	-	-	-	-	-	-
Donated Asset Adjustment	-	17	17	-	17	17
Total income	**31,839**	**33,131**	**1,292**	**63,772**	**64,756**	**984**
Nursing	(8,319)	(8,254)	65	(16,643)	(16,756)	(113)
Medical	(6,501)	(6,592)	(90)	(13,054)	(13,516)	(462)
Other	(5,678)	(5,403)	275	(11,365)	(10,363)	1,001
Total pay	**(20,498)**	**(20,248)**	**250**	**(41,062)**	**(40,635)**	**427**
Clinical supplies	(4,052)	(4,498)	(446)	(8,103)	(8,295)	(192)
Drugs	(632)	(1,007)	(375)	(1,264)	(1,905)	(641)
High cost drugs	(1,888)	(1,956)	(68)	(3,776)	(3,769)	7
Other	(3,376)	(4,044)	(669)	(6,885)	(7,606)	(721)
Total non-pay	**(9,947)**	**(11,505)**	**(1,558)**	**(20,028)**	**(21,575)**	**(1,547)**
EBITDA	**1,394**	**1,378**	**(15)**	**2,682**	**2,546**	**(136)**
Depreciation	(1,218)	(1,171)	48	(2,437)	(2,341)	95
Donated asset adjustment	(13)	(12)	1	(27)	(38)	(12)
Net finance income/(cost)	(1)	30	31	(2)	49	51
PDC dividend	(608)	(672)	(64)	(1,216)	(1,215)	1
Non-operating exp.	**(1,841)**	**(1,825)**	**16**	**(3,681)**	**(3,545)**	**136**
Reported surplus/(deficit)	**(447)**	**(447)**	**0**	**(999)**	**(999)**	**0**
Adj. to control total	13	12	(1)	27	38	12
Control total	**(434)**	**(434)**	**(1)**	**(973)**	**(961)**	**12**

1. Funding arrangements for the full year 2022/23 have been agreed with the Kent & Medway CCG and included in the April draft plan submission
2. Other income includes NHS provider to provider contracts, car parking income, medical education contribution to overheads, and drugs recharges offsetting overspending in clinical divisions.
3. The ERF income year to date is included at £1.7m, although this is at risk pending achieving the 104% activity plan as a system overall.
4. Pay budgets are £0.4m favourable to plan, however this includes £1.3m release from general accruals.
5. The Nursing and Medical pay categories are reporting a deficit position as these include efficiency targets that have not been attributed to specific schemes year to date, as well as premium rate rates for temporary staff. It is expected the pay position will improve as the services finalise and deliver efficiency schemes for reduced length of stay and medical productivity.
6. Escalation capacity has been fully budgeted and included within the final position, this also incorporates funding for the additional junior medical locum shifts that were a cost pressure during 2021/22. These costs are expected to reduce in month 3 with the closure of Nelson ward.
7. Increased costs to deliver ERF activity targets have been identified at £0.7m, the budget to cover these costs is held in central reserves and included in the position.
8. Covid costs have remained at a steady level c.£0.2m per month and not expected to rise significantly in the future months.

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3. SLA Activity and Income

The table below sets out the income and activity performance for the Trust at point of delivery (POD) as at month 2. The income has been calculated using 22/23 national tariff. Providers continue to be funded on block contracts for 22/23 for most services except for elective patient care which is funded using the national tariff as part of the Elective Services Recovery Fund (ESRF).

In 22/23 all clinical income has been devolved to divisions based on activity plans priced at national tariff (or local prices in the absence of a national tariff). Elective and Outpatient activity has been set to achieve the 104% of 19/20 value based activity required to deliver ESRF. For Non Elective, income plans are based on achieving 103% of activity the trust delivered in 19/20 priced at national tariff. All other PODs are based on delivering activity the trust delivered in 19/20. The differences between the value of income plans and actuals within the divisions compared to block funding is reported in central and provides an indication of benefit/ loss of being on a block contract.

The table below shows the performance on clinical income and High Cost Drugs at M2 by division and variance to block income by commissioner.

	Planned care				Unplanned & Integrated Care				Totals			
POD Group	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s
A&E	-	-	-	-	16,234	2,813	3,064	251	16,234	2,813	3,064	251
Adult Critical Care	9,843	1,640	1,619	(21)	-	-	-	-	9,843	1,640	1,619	(21)
Block Contracts	1,704	273	273	-	1,365	219	219	-	3,069	492	492	-
Chemotherapy	2,009	315	216	(99)	-	-	27	27	2,009	315	243	(72)
CQUIN	-	-	-	-	-	-	-	-	3,257	544	504	(40)
Day Cases	14,695	2,533	2,006	(527)	7,715	1,313	910	(403)	22,410	3,846	2,916	(930)
Direct Access	1,280	195	86	(109)	8,453	1,413	1,728	315	9,732	1,608	1,814	206
Elective Inpatient	19,892	3,596	2,784	(813)	873	109	90	(19)	20,765	3,705	2,873	(832)
Excess Bed Days	1,229	221	82	(139)	2,117	352	199	(153)	3,346	573	280	(293)
Excluded Devices	428	69	10	(59)	1,742	247	230	(17)	2,170	316	240	(75)
HCD	6,572	971	1,045	74	16,082	2,490	2,724	234	22,653	3,461	3,769	308
Maternity Pathway	10,983	1,799	1,918	120	-	-	-	-	10,983	1,799	1,918	120
Neonatal Critical Care	10,121	1,717	1,760	43	-	-	-	-	10,121	1,717	1,760	43
Non Elective Inpatient	54,852	9,548	9,333	(215)	60,171	9,324	8,423	(900)	115,023	18,871	17,756	(1,115)
Other cost per case	2,693	489	384	(105)	1,340	205	207	2	4,033	694	591	(103)
Outpatients	26,634	4,420	4,310	(110)	21,633	3,570	3,094	(476)	48,267	7,990	7,404	(586)
Paediatric Critical Care	651	76	-	(76)	-	-	-	-	651	76	-	(76)
	163,586	**27,862**	**25,826**	**(2,036)**	**137,724**	**22,054**	**20,915**	**(1,139)**	**304,568**	**50,460**	**47,245**	**(3,214)**
Block Adjustment K&M CCG									44,746	7,575	10,468	2,893
Block Adjustment SEL CCG									17	(1)	(34)	(32)
Block Adjustment Spec Comm									(1,650)	(75)	502	577
Block Adjustment NHSE Other									951	179	100	(79)
Block Adjustment LVA									(869)	(176)	(321)	(145)
Total Block Adjustments	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**43,196**	**7,501**	**10,715**	**3,214**
Total Block Income*	**163,586**	**27,862**	**25,826**	**(2,036)**	**137,724**	**22,054**	**20,915**	**(1,139)**	**347,763**	**57,961**	**57,961**	**-**

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The table above shows that MFT has got a benefit of £43.2m in its annual budget if delivered the activity, of which £44.7m is from Kent and Medway CCG offset by a cost pressure of £1.6m form NHSE Spec com.

The benefit of £44.7m from K&M is due to the top elements of the block of £53m plus Covid income of £8.4m included in the block. This is offset by a shortfall on the activity element of £15.9m. Insulin Pumps are paid outside the block.

Kent and Medway CCG (91Q)	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s
Cost and Volume Income	261,051	43,391	40,498	(2,893)
Block Adjustments:				
COVID Income	8,426	1,404	1,404	-
Top up	53,417	8,903	8,903	-
Insulin Pumps	(1,236)	(206)	(190)	16
C&V Block Adjustment	(15,862)	(2,526)	350	2,876
K&M Block Income	**305,797**	**50,966**	**50,966**	**(0)**

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M2 Income and activity performance (excl. HCD)

The estimated value of the underperformance in M2 for the SLA income based on national tariff is £3.5m YTD (excluding high cost drugs).

	In Month Movement £'000						YTD Month 2 £'000					
Pod	Price Plan	Price Actual	Price Var	Activity Plan	Activity Actual	Activity Var	PricePlan	Price Actual	Price Var	Activity Plan	Activity Actual	Activity var
A&E	1,426	1,616	190	7,596	8,798	1,202	2,813	3,064	251	14,980	16,618	1,638
Adult Critical Care	656	489	-167	618	434	-184	1,640	1,619	-21	1,556	1,470	-86
Block Contracts	245	245	0	268	232	-36	492	492	0	535	532	-3
Chemotherapy	160	242	82	1,086	1,389	303	315	243	-72	2,135	2,152	17
CQUIN	268	260	-9	0	0	0	544	504	-40	0	0	0
Day Cases	1,914	1,574	-340	2,368	1,990	-378	3,846	2,916	-930	4,680	3,592	-1,088
Direct Access	795	1,096	300	205,174	209,385	4,211	1,608	1,814	206	410,522	417,170	6,648
Elective Inpatient	1,871	1,553	-317	453	386	-67	3,705	2,873	-832	906	739	-167
Excess Bed Days	272	242	-30	854	796	-58	573	280	-293	1,833	924	-909
Excluded Devices	160	180	20	4,719	7,446	2,727	316	240	-75	9,169	10,489	1,320
Maternity Pathway	917	953	36	859	794	-65	1,799	1,918	120	1,643	1,605	-38
Neonatal Critical Care	868	904	37	902	836	-66	1,717	1,760	43	1,802	1,837	35
Non Elective Inpatient	9,385	8,703	-682	4,292	3,955	-337	18,871	17,756	-1,115	8,656	7,896	-760
Other cost per case	353	275	-78	5,744	4,067	-1,677	694	591	-103	11,306	12,307	1,001
Outpatients	3,747	4,182	436	31,808	39,056	7,248	7,990	7,404	-586	64,892	70,321	5,429
Paediatric Critical Care	43	-1	-44	60	3	-57	76	0	-76	106	5	-101
Grand Total	**23,079**	**22,514**	**(566)**	**266,801**	**279,568**	**12,767**	**46,999**	**43,476**	**(3,523)**	**534,723**	**547,657**	**12,934**

The estimated value of the underperformance in M2 for the SLA income based on national tariff is £3.5m YTD (excluding high cost drugs).

- The main underperformance is within elective, day cases and non-elective inpatients. Non-elective is driven mainly by Stroke inpatient activity (£455k). Stroke services have moved to MTW and DVH but the activity and income remains within the budgets for MFT. The funding is covering costs in other areas, work will be done with commissioners to reallocate this funding to other services.
- Adult critical care bed days are below plan and causing underperformance of £21k YTD
- Chemotherapy treatments are above the activity plan, but below plan financially causing an underperformance of £72k YTD due to delayed coding
- Neonatal cot days are above plan and resulting in a favourable income of £43k YTD
- Outpatient's income is below plan by £586k YTD mainly driven by high non face-to-face activity within follow-up, however overall activity is above plan due to high levels of radiology activity, which has a cheaper tariff.
- The underperformance is offset by the over performance on direct access in radiology of £206k and maternity pathway income of £120

Inpatient activity is driving the underperformance in both in-month and YTD because services have not recovered to pre-pandemic activity levels of 19-20.

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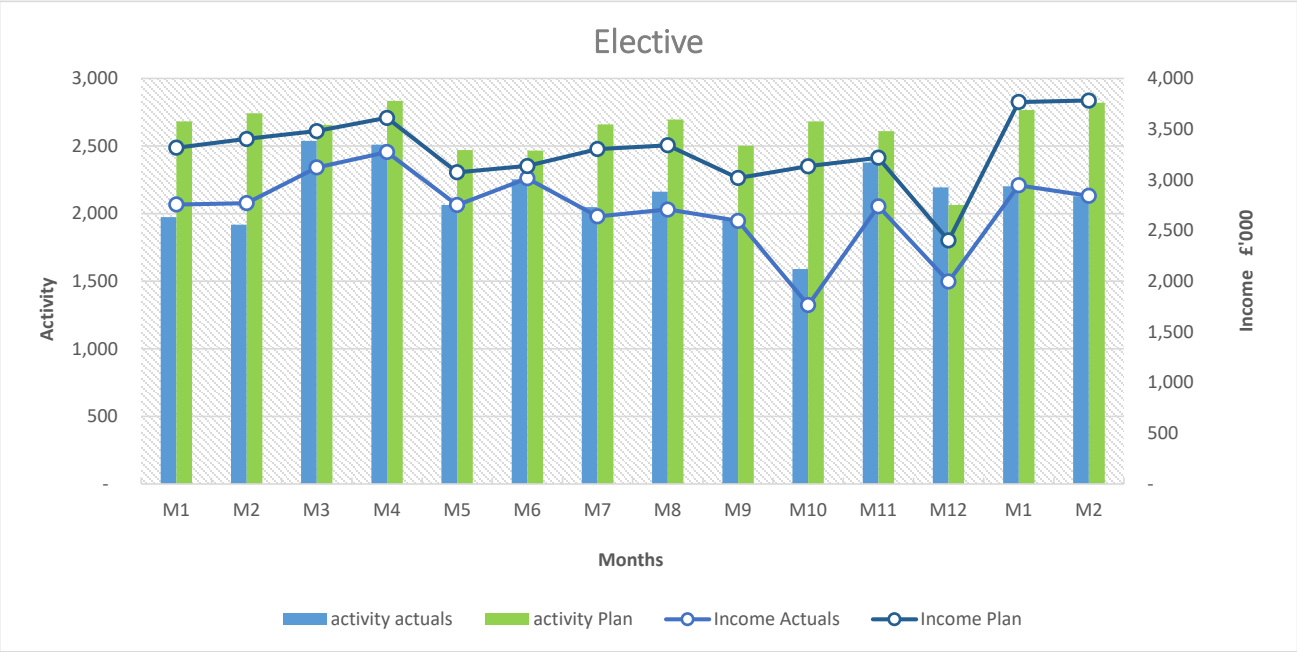
Elective activity and Income

Elective activity and income (Day cases and inpatients) remains below the pre pandemic levels of 19/20 as shown below with activity and income being the lowest during the winter months. The month 2 activity numbers continue to be below the activity and income levels pre pandemic and significantly from plan.

Graph below shows activity and income for 21/22 and 22/23.



The table below shows monthly activity performance for 21/22 and 22/23 compared to that delivered in 19/20.

2021-22												2022-23	
M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2
74%	70%	96%	89%	84%	91%	77%	80%	78%	59%	91%	106%	80%	75%

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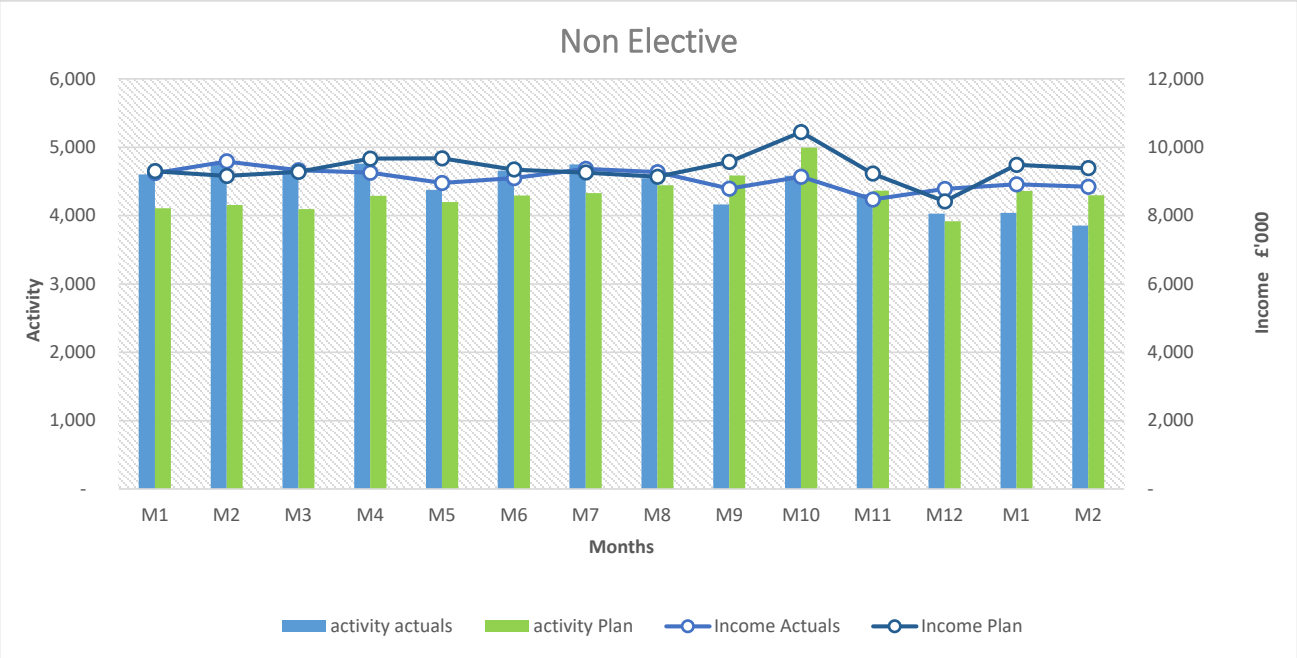
Non-elective activity and Income

Non-elective activity and income remains below plan for the first two months of 22/23. Nine months of 21/22 has exceeded the 19/20 levels. The increased activity has been observed for the first eight months (April to November) and again in the last month (March). Between December and February, the activity has remained below plan.



The table below shows monthly activity performance for 21/22 and 22/23 compared to that delivered in 19/20.

2021-22												2022-23	
M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2
112%	115%	115%	111%	104%	109%	110%	102%	91%	92%	99%	103%	93%	90%

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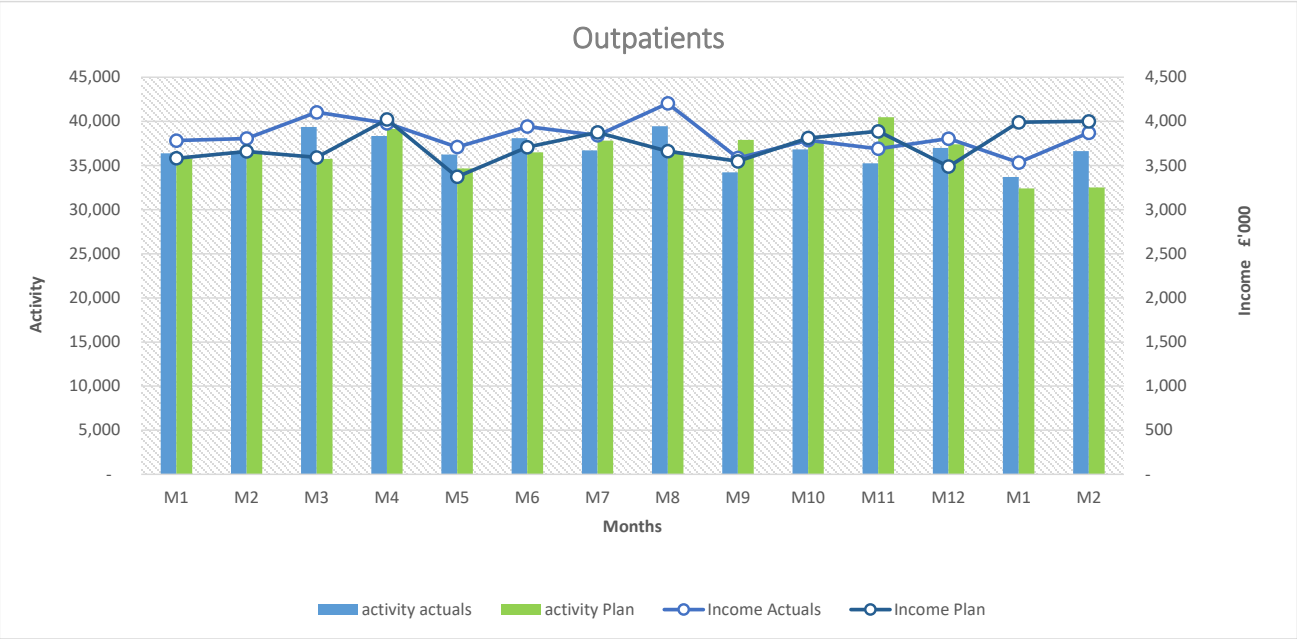
Outpatient income and activity

Outpatient activity has been higher than 19/20 level in most months of 21/22 and the first two months of this year as shown in the graph below. From December to March, the activity and income was reduced due to cancelation of clinics to cope with winter pressures. The over performance on outpatients was within follow-up clinics, offsetting the underperformance in first attendances and procedures.



The table below shows monthly activity performance for 21-22 and 22-23 compared to activity delivered in 19-20.

2021-22												2022-23	
M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2
102%	100%	110%	98%	105%	104%	97%	108%	90%	97%	87%	99%	104%	113%

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Elective Services Recovery Fund (ESRF)

For 22/23 ESRF achievement will based on delivering 104% in value of 19/20 activity. Over performance above this threshold will be paid at 75%, underperformance will be deducted at 75%. All elective activity has been valued at 22/23 tariff (except OP Follow up which is fixed at 85% of the 19/20 baseline) as per the ESRF rules. Outpatient follow up activity is expected to reduce by 25% of 19/20 levels in 22/23

The table below shows the ESRF baseline provided by NHSE/I by month and POD and the actual performance for month 1 and 2.

Threshold at 104%

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,716	1,808	1,740	1,746	1,757	1,788	1,690	1,972	1,664	1,753	1,836	2,099	**21,570**
Elective Inpatient	1,708	1,822	1,868	1,716	1,675	1,742	1,492	1,859	1,484	1,456	1,846	2,219	**20,885**
OPFA	1,220	1,313	1,318	1,395	1,244	1,394	1,281	1,331	1,207	1,293	1,363	1,560	**15,920**
OPPROC	706	741	710	711	701	791	710	809	729	762	752	859	**8,980**
OPFU	1,225	1,308	1,261	1,255	1,214	1,339	1,275	1,388	1,124	1,334	1,226	1,404	**15,352**
Total	**6,575**	**6,992**	**6,897**	**6,822**	**6,591**	**7,053**	**6,449**	**7,359**	**6,208**	**6,598**	**7,023**	**8,141**	**82,707**

Actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,474	1,422											**2,896**
Elective Inpatient	1,471	1,418											**2,889**
OPFA	1,105	1,291											**2,396**
OPPROC	536	556											**1,092**
OPFU (fixed block)	1,001	1,069											**2,070**
OPFU actuals	1,435	1,591											
Total	**5,588**	**5,755**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**11,343**
FUP activity not paid	(434)	(523)	-	-	-	-	-	-	-	-	-	-	(956)
Over/Underperfomance	(988)	(1,236)											(2,224)
RISK/ERF	**(741)**	**(927)**											(1,668)

At Month 2 the trust underperformed against the ESRF target by £2.2m. The financial risk of this is to the Trust is £1.7m, this being 75% of the underperformance. This has not been reflected in the financial position at M2 because the CCG is managing this risk at system level and is in discussion with NHSE/I.

The table below provides the performance in terms of activity achieved in M1 and M2 compared to the activity that plan the trust has set to achieve ESRF.

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22-23 activity plan

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	2,286	2,319	2,220	2,368	2,104	2,090	2,282	2,306	2,128	2,320	2,215	1,811	**26,449**
Elective Inpatient	449	467	488	500	432	423	436	444	408	398	442	288	**5,175**
OPFA	8,511	8,511	8,511	8,511	8,511	8,511	8,511	8,511	8,511	8,511	8,511	8,511	**102,127**
OPPROC	3,559	3,559	3,559	3,559	3,559	3,559	3,559	3,559	3,559	3,559	3,559	3,559	**42,713**
OPFU	11,693	10,500	9,940	11,098	9,274	10,256	10,921	10,654	9,016	10,895	9,569	7,979	**121,794**
Totals	**26,499**	**25,356**	**24,718**	**26,036**	**23,879**	**24,840**	**25,708**	**25,474**	**23,621**	**25,683**	**24,297**	**22,148**	**298,259**

22-23 activity actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,790	1,739											**3,529**
Elective Inpatient	405	381											**786**
OPFA	5,537	6,283											**11,820**
OPPROC	2,757	2,840											**5,597**
OPFU actuals	17,700	19,535											**37,235**
Totals	**28,189**	**30,778**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**58,967**

75% of 19-20 FUP	8,479	8,678	8,282	9,140	7,660	8,487	9,184	8,743	7,421	9,161	7,941	6,752	99,926
Excess OP FUP	(9,221)	(10,858)											(20,079)

Performance % against the Trust plan

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	78%	75%	-	-	-	-	-	-	-	-	-	-	**77%**
Elective Inpatient	90%	82%	-	-	-	-	-	-	-	-	-	-	**86%**
OPFA	65%	74%	-	-	-	-	-	-	-	-	-	-	**69%**
OPPROC	77%	80%	-	-	-	-	-	-	-	-	-	-	**79%**
OPFU actuals	151%	186%	-	-	-	-	-	-	-	-	-	-	**169%**

Activity is below plan for all Pods within the scope for ESRF, which includes Day cases, Elective inpatients, Outpatient first attendances and Outpatient procedures. The average activity for M2 YTD for Day cases is 77% and 86% for elective inpatients of the target set to achieve ESRF. This level of performance is below the average achieved last year for day cases and an improvement in elective inpatients. This is because Sanderland ward is yet to be converted to a day case suite which is required to increase day case activity. This is currently being worked on.

Outpatient first attendances and Outpatient procedures are below plan having achieved 69% and 79% of the activity plan. This is because divisions are seeing a lot more follow up appointments because they make the majority of the waiting list because priority was given to first attendances during the covid pandemic.

Outpatient follow up attendances are significantly above plan at 169% of the plan at Month 2. Payment for this activity is fixed at 85% of 19-20 values and the excess activity will not be paid for and do not count towards the ESRF target.

Discussions are currently on going to improve performance in Day cases and Elective inpatients with weekly monitoring of activity and by-weekly performance review meetings now in place.

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4. Efficiency programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Cross Cutting Schemes	Sub-total Identified	Over Identified / (Unidentified)	Plan Target	YTD Plan	YTD Delivery	Variance
Planned care	10	713	891	173	1,593	3,379	(246)	3,625	218	60	**(158)**
UIC	144	513	0	521	3,000	4,178	947	3,231	59	22	**(38)**
E&F	89	598	0	0	0	687	1	686	119	109	**(10)**
Corporate	42	328	8	183	156	718	95	623	70	70	**0**
Central	0	0	0	0	1,466	1,466	0	1,466	199	199	**0**
Sub Total	**284**	**2,152**	**899**	**877**	**6,215**	**10,427**	**796**	**9,631**	**666**	**461**	**(205)**
Stretch target 0.5%						**0**	**(851)**	**851**			
Total for 22/23	**284**	**2,152**	**899**	**877**	**6,215**	**10,427**	**(55)**	**10,482**	**666**	**461**	**(205)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**332**	**235**	**(97)**	**662**	**461**	**(201)**	**10,482**	**10,482**	**0**

Process

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

The total efficiencies target for the financial year are £9.6m with a further £0.9m stretch target to be found in the second half of the year. Of the £9.6m, £8.6m of schemes have been rated as green or blue (including cross cutting schemes signed off by the executive team), with the gap of £1.0m needing further detail and required governance scrutiny to move on to being implemented. The actual performance of delivery across the services is £0.5m as at the end of May, against a target of £0.7m, this is mainly from £0.3m of the trust wide cross cutting schemes and £0.1m of FYE schemes from 21/22.

The efficiency programme continues to be prioritised across all of the services with regular progress meetings and position reporting at the efficiency review group and efficiency delivery group meetings.

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5. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
240,295	**Non-current assets**	**239,113**	**(1,182)**
5,996	Inventory	6,123	127
13,889	Trade and other receivables	17,011	3,122
33,455	Cash	33,127	(328)
53,340	**Current assets**	**56,261**	**2,921**
(136)	Borrowings	(128)	8
(28,147))	Trade and other payables	(30,189)	(2,042)
(2,116)	Other liabilities	(2,881)	(765)
(30,399)	**Current liabilities**	**(33,198)**	**(2,799)**
(2,025)	Borrowings	(1,962)	63
(1,248)	Other liabilities	(4,521)	0
(3,273)	**Non-current liabilities**	**(3,210)**	**63**
259,963	**Net assets employed**	**258,966**	**(997)**
461,656	Public dividend capital	461,656	0
(245,218)	Retained earnings	(246,215)	997
43,525	Revaluation reserve	43,525	0
259,963	**Total taxpayers' equity**	**258,966**	**997**

Key messages:

1. Non-Current Assets, £2,366k depreciation net of £1,184k capital investment

2. Receivables have increased by £3.1m from the prior year to £17.0m and represent approximately 53% of 1 month's average turnover (£32m).

3. Payables have increased by £2.0m from the prior year

   Current payables balance represents 94% of 1 month's average turnover.

4. Total Trust borrowings are £2.1m and relate to long term capital loans issued by DHSC in a prior year.

6. Capital

2022/23 Capital Expenditure Summary

£'000

			High level Plan as submitted to NHSI													Trust Performance			
NHSI Ref	Scheme Category	Funding	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total	YTD Budget	YTD Expenditure	YTD Variance	% Complete
Capital Scheme 1	Routine (E&F general, H&S)	Internally Funded	20	20	20	40	40	40	45	45	45	50	60	75	500	40	0	(40)	0%
Capital Scheme 2	Backlog Maintenance	Internally Funded	118	118	118	236	236	236	266	266	266	296	355	443	2,954	236	0	(236)	0%
Capital Scheme 3	Information Technology	Internally Funded	105	105	105	209	209	209	236	236	236	262	314	393	2,619	210	921	711	35%
Capital Scheme 4	Medical and Surgical Equipment Programme (inc beds)	Internally Funded	43	43	43	87	87	87	98	98	98	109	130	163	1,086	86	0	(86)	0%
Capital Scheme 5	Service Developments /specific Business cases	Internally Funded	114	114	114	229	229	229	257	257	257	286	343	429	2,858	228	0	(228)	0%
Capital Scheme 6	Patient Experience	Internally Funded	38	38	38	76	76	76	86	86	86	95	115	143	953	76	0	(76)	0%
Capital Scheme 7	Patient Environment	PDC												500	500	0	97	97	19%
Capital Scheme 8	Forecast additional PDC for unknown schemes based on PY	PDC												80	80	0	0	0	0%
Capital Scheme 9	Unfunded schemes	Internally Funded														0	167	167	Not planned
Total 2022/23 Capital Programme			438	438	438	877	877	877	988	988	988	1,098	1,317	2,226	11,550	876	1,184	308	10%
Cumulative			438	876	1,314	2,191	3,068	3,945	4,933	5,921	6,909	8,007	9,324	11,550					
Cumulative 100%			4%	8%	11%	19%	27%	34%	43%	51%	60%	69%	81%	100%					

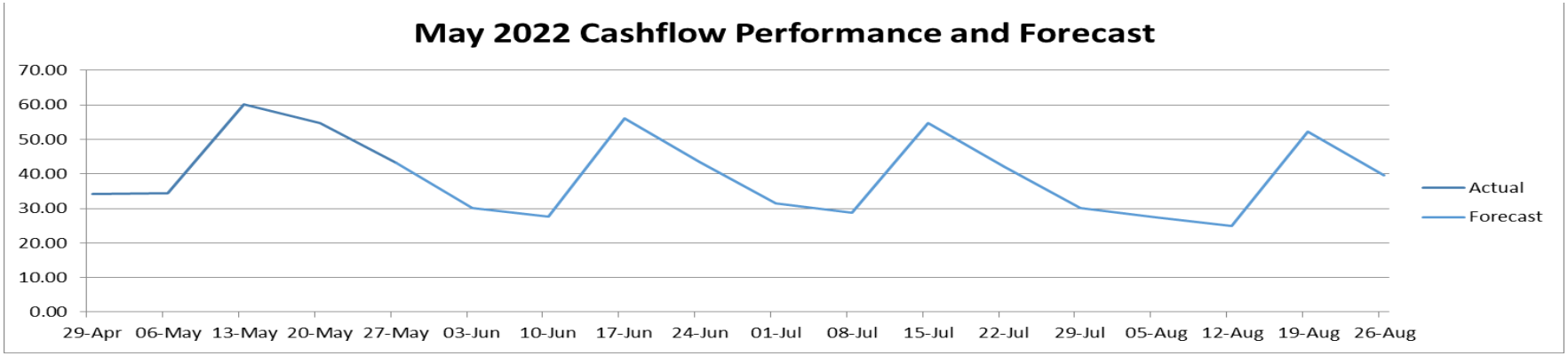
The table above details the overall progress against the Trust capital plan as agreed with NHSI at £11,550k.
Most of the expenditure to date relates to projects brought forward from the prior year, e.g. EPR in IT, and contains £1,831k of GRNI accruals; £899k relates to goods/services receipted in 2021/22 which are yet to be invoiced.

Finance is currently working with Programme Leads and the new Director of Estates & Facilities to align the NHSI agreed £11,550k and the over allocation of £2,150k against individual projects, after top slicing for PDC and order commitments from the prior year.
From month 3 when the detailed plan is finalised this report will highlight progress against the main programmes and monitor the over allocation of £2.150k.

7. Cash

13 Week Forecast w/e

£m	Actual 29/04/22	06/05/22	13/05/22	20/05/22	27/05/22	Forecast 03/06/22	10/06/22	17/06/22	24/06/22	01/07/22	08/07/22	15/07/22	22/07/22	29/07/22	05/08/22	12/08/22	19/08/22	26/08/22
BANK BALANCE B/FWD	**45.95**	**34.18**	**34.47**	**60.14**	**54.69**	**43.16**	**30.14**	**27.58**	**56.12**	**43.42**	**31.58**	**28.70**	**54.78**	**42.08**	**30.20**	**27.45**	**24.89**	**52.30**
Receipts																		
NHS Contract Income	0.10	0.04	29.87	0.08	0.00	0.10	0.00	30.16	0.00	0.00	0.00	30.16	0.00	0.00	0.00	0.00	30.16	0.00
Other	0.22	0.65	0.16	0.15	0.39	0.53	0.58	3.16	0.30	0.30	0.25	0.71	0.30	0.25	0.38	0.58	0.38	0.30
Total receipts	**0.31**	**0.69**	**30.03**	**0.23**	**0.39**	**0.63**	**0.58**	**33.32**	**0.30**	**0.30**	**0.25**	**30.87**	**0.30**	**0.25**	**0.38**	**0.58**	**30.54**	**0.30**
Payments																		
Pay Expenditure (excl. Agency)	(9.39)	(0.36)	(0.41)	(0.46)	(10.31)	(9.27)	(0.43)	(0.43)	(10.30)	(9.43)	(0.43)	(0.43)	(10.30)	(9.43)	(0.43)	(0.43)	(0.43)	(10.30)
Non Pay Expenditure	(2.55)	(0.03)	(3.91)	(5.04)	(1.56)	(3.88)	(2.20)	(3.85)	(2.20)	(2.20)	(2.20)	(3.85)	(2.20)	(2.20)	(2.20)	(2.20)	(2.20)	(2.20)
Capital Expenditure	(0.15)	0.00	(0.04)	(0.10)	(0.05)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)
Total payments	**(12.08)**	**(0.40)**	**(4.36)**	**(5.60)**	**(11.91)**	**(13.65)**	**(3.13)**	**(4.78)**	**(13.00)**	**(12.13)**	**(3.13)**	**(4.78)**	**(13.00)**	**(12.13)**	**(3.13)**	**(3.13)**	**(3.13)**	**(13.00)**
Net Receipts/ (Payments)	**(11.77)**	**0.29**	**25.67**	**(5.38)**	**(11.52)**	**(13.02)**	**(2.56)**	**28.53**	**(12.70)**	**(11.83)**	**(2.88)**	**26.08**	**(12.70)**	**(11.88)**	**(2.75)**	**(2.56)**	**27.41**	**(12.70)**
Funding Flows																		
DOH - FRF/Revenue 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
MRET	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
PSF	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
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**(0.08)**	**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**
BANK BALANCE C/FWD	**34.18**	**34.47**	**60.14**	**54.69**	**43.16**	**30.14**	**27.58**	**56.12**	**43.42**	**31.58**	**28.70**	**54.78**	**42.08**	**30.20**	**27.45**	**24.89**	**52.30**	**39.60**



Prior year end	£'000	Month end actual	Var.
33,455	Cash	33,127	(328)

£**32.6m of cash was received** in May
£30m NHS contract income for the month and £2.6m cash receipts in relation to trading activities and settlement of prior period sales invoices including provider to provider SLAs

£32.9m of cash was paid out by the Trust in May
£11.5m (36%) in direct salary costs to substantive and bank employees
£8.9m (28%) employer costs to HMRC and NHSP
£12.4 m (36%) in supplier payments, including NHSR, Agency staff, capital and revenue non pay.

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8. Conclusions

The Finance Committee is asked to note the report and financial performance which is £434k deficit in-month, £999k year to date; this being as per the plan submitted to the Kent & Medway ICS in April 2022.

The current efficiency programme is £0.2m adverse to plan, with a delivery of £0.4m year to date. ERF income of £1.7m has been included at a cost of £0.7m; the ERF income is at risk of a 75% clawback of the underperformance against the agreed activity plan. The annual leave accrual of £2.9m has been included.

Alan Davies
Chief Financial Officer
June 2022

Meeting of the Board of Directors in Public

Wednesday, 03 August 2022

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**6.2**
Committee Chair:	Annyes Laheurte		
Date of Meeting:	Thursday, 30 June 2022		
Lead Director:	Alan Davies, Chief Financial Officer		
Report Author:	Matthew Chapman, Head of Financial Management		

The key headlines and levels of assurance are set out below, and are graded as follows:	
Assurance Level	**Colour to use in 'assurance level' column below**
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headline	**Assurance Level**
1. BAF strategic risks 3a "Delivery of Financial Control Total" rating was increased from 12 to 16 following the national resubmission exercise in June 2022. This was on the basis of the scale of risk inherent within that plan. For 3b "Capital Investment", further work is ongoing to confirm the plan for 22/23. Rating 12 For 3c "Financial Recovery Plan" has been finalised with further work ongoing to deliver the plan. It was proposed to reduce the rating to 12 however due to risks associated with delivering the financial plan, it was **AGREED** to maintain the rating at 16.	**Amber/Red**
2. Corporate risk register The efficiency programme for 22/23 is £9.6m with a further stretch target of £0.9m in H2. Further progress has been made to identify and finalise schemes, however there is still risk to deliver the programme and therefore the risk rating score remains unchanged at 4 x 4 = 16.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level**
3. Finance report – month 2 The Chief Financial Officer tabled the report with the key highlights being: • The Trust is reporting a £0.4m deficit position in month and £0.9m year to date (YTD), this being in line with the draft plan submitted to NHSE/I in April. • Main pressures on pay budgets are from maternity cover, sickness cover and junior medical vacancies requiring temporary staffing cover. • Drugs spend is above plan, however more budgets have been moved to cover some of the overspending which are reflected in the revised June plan submission. Homecare provider drugs spend has increased by £0.1m in month; further analysis of drugs spend will be provided at the July committee meeting. • ERF Income of £1.7m was fully accrued YTD month, however it has been highlighted there is a risk of not meeting the 104% targets across the system. • Covid costs remain at £0.2m - £0.3m. • Delivery of efficiencies is £0.2m behind plan, with efficiencies achieved YTD of £0.4m. • Capital spend is £0.4m ahead of plan for the first 2 months but expected to be on plan as the year progresses with the timing of schemes being actioned. • Cash sums remain in a stable position. The Chief Operating Officer briefed the committee on current bed capacity changes and how this links into to delivering the 104% ERF activity targets. An **ACTION** was taken for a detailed ERF activity delivery plan to be submitted to the July meeting. An **ACTION** was taken to provide further analysis of drugs spend at the July meeting.	**Amber/Green**
4. Performance report month 2 The performance report was presented to the committee, this included a comprehensive slide pack detailing performance across key business performance metrics of emergency demand, patient flow, RTT, cancer and diagnostics. The report was discussed by the committee, in particular the high number of ambulance visits. No further actions were recommended.	**Amber/Green**
5. Efficiency programme update The Chief Financial Officer updated the committee on the latest plan for 22/23. A target of 2.83% has been applied in the operational plan which totals £9.6m, and an additional 0.5% stretch target adding a further £0.9m to the bring efficiency plan to £10.5m. An overview of the current programme was presented with focus on the £10.4m of efficiencies that have been identified, and a further £0.2m since the report was written. This position includes £6.2m of the 11 cross cutting schemes. There is risk that not all schemes will deliver so further work continues to bring the RAG rating from red to green.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
6. Operating Plan and FRP Update The Chief Finance Officer confirmed the Financial Recovery Plan had been approved and an update was provided with details of changes to the operating plan; this highlighted some of the key risks to deliver a revised breakeven position plan for 2022/23. There is further work ongoing to mitigate the risks within the plan and agree a trajectory of delivering ERF activity. Some of the key ongoing initiatives include delivering the efficiency plan, a business case review group, progress with the contract compendium, and implemented EPR. More detail programme of work to deliver the plan would be available by the end of August.	**Amber/Red**
7. Capital plan update. The Chief Finance Officer informed the committee there is further work is ongoing to finalise the capital plan, a more detailed report will be presented at the July committee meeting.	**Green**
8. CNST contributions The Deputy Chief Finance Officer presented a report detailing CNST contributions and the factors affecting the level of contribution required by the Trust. The report was discussed by the committee, this concluded that good clinical practice could reduce the claims and put the Trust in a better position of controlling the CNST premium.	**Green**
9. Financial Training Policy and Financial Training SOP The Deputy Chief Finance Officer briefed the committee of the updates to the Financial Training Policy and how this links into budget holder training as well as improving the financial awareness culture across the organisation. The policy and SOP were **APPROVED**.	**Green**
10. Corporate Governance Statement It was **RECOMMENDED** by the committee to submit this document for approval by the Board of Directors.	**Green**
Decisions made **AGREED** to maintain a rating of 16 for delivering the financial recovery plan. An **ACTION** for a detailed ERF activity delivery plan to be submitted to the July meeting. An **ACTION** to provide further analysis of drugs spend at the July meeting. The Financial Training Policy and its associate SOP were **APPROVED**. **RECOMMENDED** by the committee to submit the Corporate Governance Statement document for approval by the Board of Directors.	
Further Risks Identified No further risks were identified.	
Escalations to the Board or other Committee There were no further issues identified to escalate to the Board.	

Meeting of the Board of Directors in Public

Wednesday, 03 August 2022

Assurance Report from Committee

Title of Committee:	**People Committee**	**Agenda Item**	**7.1**
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Thursday, 21 July 2022		
Lead Director:	Leon Hinton, Chief People Officer		
Report Author:	Leon Hinton, Chief People Officer		

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Board Assurance Framework The Committee reviewed the updated BAF and following discussion of all papers APPROVED the risk rating to 4x4 (16) from 4x3 (12) of risk 4a highlighting an increased likelihood of the Trust being unable to staff clinical and corporate areas sufficiently to function as a result of sustained elevated turnover across the whole NHS.	**Amber/Red**
2. IQPR – People KPIs Key highlights were noted as follows: 1) Total Sickness (rolling) for June had slightly worsened, up to 5.21%, with a sustained decrease to long-term sickness but a sustained increase to short-term sickness. Usage of occupational health services remains high for anxiety and stress with additional service capacity added being scoped. 2) Turnover (12-month rolling) has decreased slightly; however, remains significantly higher than previous years and mirrors the national picture. Turnover is not an outlier against other Kent and Medway Trusts. A deep-dive into comparative turnover was presented to the committee. 3) Appraisal rates have improved significant to 83.8%; however, remain below the target of 90%, this is being monitored as a Patient First breakthrough objective. 4) Plans are being developed to recover a worsening fire safety compliance level following the move to classroom learning and MCA/DoLS compliance.	**Amber/Red**
3. HR Resourcing Dashboard Key highlights were noted as follows:	**Amber/Green**

1) International recruitment for nursing is on trajectory along with clinical support worker recruitment (above plan). Concerns have been raised in relation to capacity of suitable accommodation.	
4. OD Update and culture, leadership and engagement report. Key highlights were noted as follows: 1) The committee was updated in relation to the successes and lessons learnt through the Kick Start programme with a number of permanent offers made as a result. 2) The committee was updated in relation to the big six culture programmes and next steps including the recruiting of a new culture change team.	**Amber/Green**
5. Terms of reference The Committee APPROVED revised terms of reference adding in Patient First support to delivery and commissioning deep dives.	**Green**
6. Wellbeing Guardian Assurance Report (Q1, 2022/23) 1) The Committee noted the revised KPIs and measures following the revision of the national health and wellbeing framework and associated targets. The Trust is on target to achieve a 5% overall improvement score by the end of the year. 2) The Committee noted the results of the Fitness Hub survey with over a third of respondents giving it 10/10	**Amber/Red**
7. Freedom to Speak Up Lead Guardian's report – Q3 and Q4 2021/22 1) The Committee noted the comparative reviews of freedom to speak up insights across the West Suffolk NHS FT and the final Ockenden report and implications for the Trust's strategy. 2) The Committee noted the increase of freedom to speak up concerns in Q3 and Q4 back to pre-covid levels; the proportional decrease of cases with an element of patient safety/quality and similarly a decrease to the cases with an element of bullying harassment. Positively, it was reported, that the number of cases being reported anonymously had decreased proportionally. The report included a high-level breakdown of issues raised during the two quarters.	**Amber/Green**
Decisions made: None to report	
Further Risks Identified: None to report	
Escalations to the Board or other Committee: 1) None to escalate	