Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public
Date: Wednesday, 11 May 2022 at 12:30 – 15:45
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	Chief Executive's Update	Chief Executive	1	12:35	Note
1.5	Clinical Presentation – Paediatrics	Chief Medical Officer	presentation	12:50	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of previous meeting: 9 March 2022	Chair	5	13:20	Approve
2.2	Matters arising	Chair	Verbal		Discuss
3.	**Strategy and Resilience**				
3.1	Board Assurance Framework	Company Secretary	11	13:30	
4.	**High Quality Care**				
4.1	Integrated Quality Performance Report	COO, CNO, CMO	15	13:40	Assure
4.2	Quality Assurance Committee Assurance Report - Meeting date: 22 March; 26 April 2022	Chair of Committee/ Chief Nursing Officer	57 61	14:00	Assure
4.3	Patient Experience Update	Chief Nursing Officer	65	14:10	Note
4.4	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Safety Action 8, 9, 10	Chief Nursing Officer	71	14:30	Assure
5.	**Financial Sustainability**				
5.1	Finance Report	Chief Finance Officer	83	14:50	Note
5.2	Finance, Policy and Performance Committee Assurance Report Meeting: 24 March	Chair of Committee/ Chief Finance Officer	99	15:05	Assure
5.3	Approval of Annual Report and Accounts 2021/22 by Audit & Risk Committee	Chair of Committee/ Chief Finance Officer	Verbal	15:15	Approve

Agenda

6.	**Our People**				
6.1	Report of People Committee – 24 March 2022	Chair of Committee/ Chief People Officer	103	15:20	Assure
7.	**Any Other Business**				
6.1	Council of Governors Update	Lead Governor	Verbal	15:30	Note
6.2	Questions from the Public	Chair	Verbal		Note
6.3	Any Other Business	Chair	Verbal		Note
	Date and time of next formal meeting: 8 June 2022, 12:30 – 15:30				

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – May 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, the Trust has seen a gradual decrease in the number of COVID-19 patients in the hospital and we continue to work hard to ensure that we have the right processes in place to keep our patients, colleagues and visitors safe while learning to live with Covid.

I'm pleased to say that we have been able to lift some of our restrictions on visiting, and patients are now able to receive visits from two named visitors instead of one. We will continue to keep the situation under review and will lift restrictions further when it is safe to do so.

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

- Wearing a mask while they are with us
- Keeping social distancing with other people where possible
- Washing their hands regularly, or using hand gel
- Walking on the left side of the corridor
- Not entering the hospital if they have COVID-19 symptoms, unless they require urgent medical care.

Patient First

We continue to make good progress in the development of our Patient First improvement system. Our Executive Team met last month to agree our key objectives for the first phase of the programme.

The main areas the objectives cover are around:

- Reducing the time patients wait for their first appointment
- Increasing the number of patients discharged before midday

- Recognising the deteriorating patient – reduction of avoidable cardiac arrest calls
- Increasing the number of patients recommending us as a place to receive care in the Friends and Family Test
- Increasing the number of staff receiving an appraisal, with a wellbeing check.

We will provide more information about Patient First in the coming weeks.

Our improvement continues

Our performance against statutory targets is really important because we know that meeting these targets is a clear indicator that we are providing the care that our patients deserve.

Behind every number and percentage point is a real person; a person who might be scared or in pain – a person waiting anxiously to have an important operation or to find out whether they have cancer. Receiving expert care in a timely manner, matters to our patients and it matters to our staff too.

That's why I am absolutely delighted to say that last month our 62-day cancer performance was at 88 per cent, which placed us fifth in the country and the highest performing district general hospital. In addition, we saw 92.5 per cent of suspected cancer patients within two weeks, placing us 17th in the country.

We are also doing well against some of our other targets including Emergency Department performance, ambulance handovers, elective surgery (known as Referral to Treatment) and diagnostics.

We have continued to see success as an organisation in how we effectively manage infection control. This has been thanks to the efforts of staff across the Trust, and in particular the leadership of our infection control team. Our latest data shows that we had no cases of MRSA in 2021/22, a significant drop from the six cases we recorded in 2019/20. We are also notably under our trajectory for C.diff infections, with just 26 cases for 2021/22 against a trajectory of 35, and a significant reduction from the 45 cases we had in the previous year.

I would like to say a big thank you to the teams who are working so hard to ensure that as a Trust we are providing safe and responsive care.

Celebrating our nurses, midwifes and ODPs

Every May we take a moment to celebrate our nurses, midwifes and operating department practitioners and the fantastic work that they do for our community.

They work around the clock, to provide care of the highest quality and we are incredibly proud of the difference they make to our patients' lives.

Our new Reflection Garden

Last month we were delighted to welcome the Mayor of Medway, Cllr Jan Aldous, to open our new Reflection Garden.

The fully blocked-paved Reflection Garden, which has pergolas, raised beds, privacy screens and a stunning water feature, was made possible thanks to generous funding from Medway NHS Foundation Trust, The Medway Hospital Charity and Medway League of Friends.

Garden and landscape designer Jo Jemmison, who won a Royal Horticultural Society (RHS) Silver Gilt Medal and a Best in Category award for a Metamorphosis Show Garden at BBC Gardeners' World Live 2014 for her first show garden, created the planting scheme.

The garden is an important addition to our hospital, and we hope it will enhance mental and physical wellbeing. The pandemic has been tough on colleagues and this garden recognises that people need a space to remember loved ones, who have lost their lives to COVID-19 or other illnesses. It has been designed as an uplifting area for relaxation, rejuvenation and reflection and we hope staff, patients and visitors will be able to take a break and make the most of this wonderful new resource.

Celebrating a special golden NHS anniversary

I want to pay tribute to our colleague Sue Meathrel, Senior Audiologist, who last month marked an incredible 50 years of working in the NHS, with 22 of those spent at Medway.

Sue began her NHS career on 4 April 1972 working in London, before she spent time at hospitals in Southampton, Berkshire, and finally with us here in Kent, where she helped setup the Trust's audiology service in 2000.

Sue has assisted countless patients to manage their hearing conditions and regain hearing through the use of audiology equipment such as hearing aids, and we are very thankful to her for the years of dedication she has shown to the Trust and the wider health service.

Award winners

Congratulations to our Communications and Engagement Team, and the Electronic Patient Record (EPR) Project Team, who won the Leading Healthcare Awards 2022 Excellence in Communication and Engagement award.

This was awarded for communications and engagement work for the launch of EPR. Well done to the EPR Project Team who were also shortlisted in the 'Best COVID-19 Project Team' category at the same awards.

Communicating with colleagues and the community

The graphic below gives a flavour of some of the work carried out to communicate with our staff and community over the last month.

Minutes of the Trust Board PUBLIC Meeting

Wednesday 9 March 2022 at 12:30 to 14:30

MS Teams

Members	Name	Job Title
Voting:	Mark Spragg	Deputy Chair/Senior Independent Director/NED
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Evonne Hunt	Chief Nursing Officer
	George Findlay	Chief Executive
	Gurjit Mahil	Deputy Chief Executive
	Tony Ullman	Non-Executive Director
	Sue Mackenzie	Non-Executive Director
Non-Voting:	Glynis Alexander	Director of Communications and Engagement
	Jayne Black	Chief Operating Officer
	Paula Tinniswood	Chief Strategy and Transformation Officer
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	David Brake	Lead Governor
	Alex Blackshaw	Pfizer
	Dawn Cowcher	Deputy Director of HR
	Lisa Webb	Associate Director of Organisational Development
Apologies:	Jo Palmer	Chair
	Ewan Carmichael	Non-Executive Director
	Leon Hinton	Chief People Officer
	Gary Lupton	Director of Estates and Facilities

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:

It is good to see noticeable improvements in performance and patient experience. Teams throughout the Hospital have worked very hard and it is pleasing to see waiting times reduced for Cancer patients and patients being seen more quickly in the Emergency Department. We are also attracting more staff to join the Trust including high caliber clinical staff. We have recently recognised 35 valued colleagues who have given long service at Medway with special awards.

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 Chief Executive to provide his update.

George Findlay observed that there had been a steady reduction in the impact of Covid. He highlighted the successful delivery of cancer standards at the Trust. He continued to express concern about instances of racist abuse coming from patients and relatives and stated that the Trust valued its diverse workforce and would not tolerate racism.

He congratulated Evonne Hunt on her appointment as the Chief Nursing Officer; Evonne had been appointed by the Trust in late November on an interim basis.

The CQC Maternity survey had seen some positive feedback for this service.

He gave a reminder that the Trust was open for nominations until 18 March 2022 for candidates to stand in the by-election being held in the Swale Constituency.

Finally, on a personal note he confirmed that he would be leaving the post of Chief Executive Officer in May to take up the role of Chief Executive of University Hospitals Sussex.

1.5 Integrated Care System

The Chair welcomed Mike Gilbert, Executive Director of Corporate affairs from Kent and Medway CCG who was leading on the configuration of the Kent and Medway Integrated Care Board and integrated partnerships.

Mike Gilbert outlined the aims nationally of the transition to integrated care systems and the core purposes. The integrated care board for Kent and Medway was expected to have committees focused on improving outcomes, reducing health inequalities, productivity and investment and remuneration/people as well as an audit and risk committee. The main board would be comprised of the Directors of the Integrated Care Board with representation from the providers, primary care and Local Authority. There would be an integrated care partnership comprising a range of health and social care stakeholders tasked with developing an integrated health and care strategy by early 2023.

In terms of the transition, shadow running of the board and partnership and some of the committees would start from May 2022, the board would be formally established in June with a transition date of 1 July 2022 to also entail the dissolution of the Kent and Medway CCG.

In response to questions from Board members he acknowledged the role in the partnership of education and training and noted that at present Prison health was commissioned by NHS England but it was possible that this would move to an integrated board later on. He also recognised the need to address system issues and challenges such as maternity workforce through strengthened joint working.

The Chair thanked Mike Gilbert for attending the meeting and suggested he should return for a further update as the implementation progressed.

2 Minutes of the previous meeting and matters arising

2.1 The draft minutes of the Public Board meeting, held on 9 February 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 matters arising.

Strategy and Resilience

3.1 Board Assurance Framework

The Board received the update from the Deputy Chief Executive on the Board Assurance Framework dated 28 February 2022. The report summarised the principal risks which were sufficient staffing of clinical areas (currently scored16) and patient flow (currently 20). It was noted that risk 4a had been raised due to the position around covid vaccines which would be reviewed at the March People committee.

The Chair reflected that it was good to see some movement and dynamism in the risks as shown by the summary in the report. In response to a question from Tony Ullman, the Chief Executive stated that plans would be made within the 2022/2023 planning cycle to reduce the risk around patient flow.

In response to a question from the Chair, Gurjit Mahil agreed that a risk that was not reducing could be due to mitigations not being sufficient or the risk being tolerated. The Chair also asked about comparison with other Trusts and the Chief Executive stated that there needed to be more clarity about the role of the different elements and levels of the health care partnership in assessing and mitigating system risk. Alan Davies added that the Chief Finance Officers were continuing to work together to review key risks in that area and so comparison was evolving.

The Board noted the Board Assurance Framework report.

3.2 Patient first improvement programme

The Board received a set of slides on progress with establishing patient first within the Trust. Paula Tinniswood stated that the approach to strategy development and review continued to be refined. George Findlay described the summary position set out in the slides as a roadmap for the coming 18 months and suggested that there should be a board development session to do further work on this.

In response to a question about the effectiveness of the Patient First Programme, George Findlay stated that there would be regular visibility or progress and a mechanism for the Board to monitor the programme itself.

The Board noted the report.

3.3 Annual Business Plan 2022/23 - progress

The Chair invited Alan Davies to update the Board on progress with the annual business plan. Alan Davies reported that the Trust's internal planning round had been commenced and first draft plans have been received from the Divisions, which were being reviewed. A separate plan from Estates and Facilities was also being reviewed. In terms of the financial envelope for 2022/23 there was a centrally set efficiency target of 2.8% and at present local efficiency targets valued at around ten million pounds which would in effect pay for inflationary uplifts. The funding that had been established for covid was being reduced.

The Chair thanked Alan Davies for the update.

4 High Quality Care

4.1 Integrated Quality Performance Report

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

Jayne Black highlighted that the Trust was in the middle of the pack nationally on its Emergency Department performance. The department had halved the number of ambulance handover delays compared to previous months. There had been an increase in the waiting list which currently comprised around twenty eight thousand patients. There were one hundred and twelve, fifty-two week waiters. The trust's compliance with the referral to treatment target was 63% and independent sector support was being used wherever possible. The compliance with the target for domestic diagnostic was 75.8%. In response to a question from Tony Ullman, Jayne Black said that work on length of stay was ongoing to address and improve the position on morning discharges.

George Findlay added that the Patient First approach would give individual wards ownership of issues such as morning discharge.

In response to a question from the Chair it was noted that the Trust continued to be challenged on Endoscopy capacity.

In relation to quality Evonne Hunt noted that the rate of patient falls was continuing and that in terms of maternity Medway was among the most improved Trusts in the region. The Trust continued to monitor incidents to ensure that no backlog developed. There were no infection prevention and control issues to report and no new events to report.

Alison Davis added that the Trusts mortality indicators were within the expected range.

On behalf of Leon Hinton, George Findlay reported that in terms of people there continued to be a focus on staff wellbeing, including involving appraisals developing into a wellbeing focused conversation. The rate of vacancies continued to reduce and international recruitment continued to progress.

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4.2 Quality Assurance committee assurance report- 22 February 2022

The Board received the assurance report from the Quality Assurance Committee. Tony Ullman highlighted the review the committee had done around Ockenden, and noted that through the IPC Board Assurance Framework the committee had greater visibility of progress in this area.

4.3 CNST Quality Actions

The Board received the report on the maternity incentive scheme, year 4 safety actions 5,6 & 7 in relation to midwifery workforce planning. Compliance with saving babies' lives and gathering feedback.

The report highlighted the progress that was being delivered in all of these areas.

The Board noted the progress towards achieving compliance and approved the action plan set out in appendix 1 of the report.

4.4 Ockenden Oversight Report

The Board received the report from the Chief Nursing and Quality Officer providing assurance and oversight on the progress towards achieving the 7 immediate and essential actions published in the Ockenden report in December 2020.

Evonne Hunt informed the Board that the Trust had self-assessed against the report that had been issued in December and the actions identified there-in would enable the Trust to respond to a request from NHS England/improvement for this report to be presented to the Board in public.

It was noted that a report would arise in respect of East Kent and a further update from Ockenden would be reviewed by Quality Assurance committee later this month.

The Board noted progress against compliance and actions required and recommended onward reporting to the LMNS and ICS.

It was noted that the detailed action plan had been reviewed by the Quality Assurance Committee and had been available to board members on request.

4.5 Infection Prevention & Control Board Assurance Framework

The Board received the report setting out the requirements of the IPC BAF and the Trusts' progress towards compliance. There were five recommendations in relation to meetings and communications, clarity of responsibility across the organisation, reporting to Board and Board oversight of IPC issues.

Evonne Hunt, as Director of Infection Prevention and Control, informed the Board that a number of action plans had been consolidated into a single action plan to ensure compliance with the requirements of the IPC BAF. The Quality Assurance Committee would continue to have oversight of the process.

It was also noted that ward visits around the 15 steps challenge were expected to be able to resume in the next few weeks

5 Financial Sustainability

5.1 Finance Report – Month 10

The Board received the finance report for January 2022. The Trust had reported a breakeven position for this month. It was expected to present a balanced position at the end of the financial year.

It was noted that cash balances had decreased in month by 2.1 million pounds which was within normal range of fluctuation. The cash balance was 6.6 million pounds adverse to that held on 31 March 2021, which was due to the late issue of public dividend capital in the prior year for capital schemes.

The Board noted the finance report.

5.2 Finance Committee Assurance Report Meeting: 24 February 2022

The Board received the Assurance Report from the Finance Committee. It was noted that the committee had reduced the BAF score for risk 3a (delivery of financial control total) to a 12.

It was also noted that the drivers of deficit paper had been approved.

6 Council of Governors Update

6.1 The Chair welcomed Councilor David Brake who presented on behalf of the Council of Governors. He highlighted his attendance at the visit earlier that day by a Government Minister and an ICS chair looking at the efforts made towards public health in the Medway area.

He also noted that the Swale by-election was ongoing with nominations currently open until 18 March and that the board and Council of Governors had approved an additional appointed Governor to represent Swale Borough Council on the Council of Governors. Finally, he mentioned a planned event for Governors focused on research due to take place on 27 April 2022.

6.2 Questions from the Public

There were no questions received from the public.

6.3 Any Other Business

There being no further business the Chair closed the meeting.

Date of the next meeting is to be held on 6 April 12:30pm.

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Wednesday 9 March 2022

Signed …….. Date ……

Chair

Meeting of the Public Board
Wednesday, 11 May 2022

<table>
<tr><td>Title of Report</td><td colspan="2">Board Assurance Framework</td><td>Agenda Item</td><td>3.1</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 as of 30 April 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>Dec 21</th><th>Jan 22</th><th>Feb 22</th><th>Mar 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><td>20</td><td>20</td><td>20</td></tr>
<tr><td>Failure to develop, approve and deliver against a Financial Recovery Plan ("FRP")</td><td>4</td><td>16</td><td>12</td><td>12</td><td>12</td><td>16</td></tr>
</table>
</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="4">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="4">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="4"></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>
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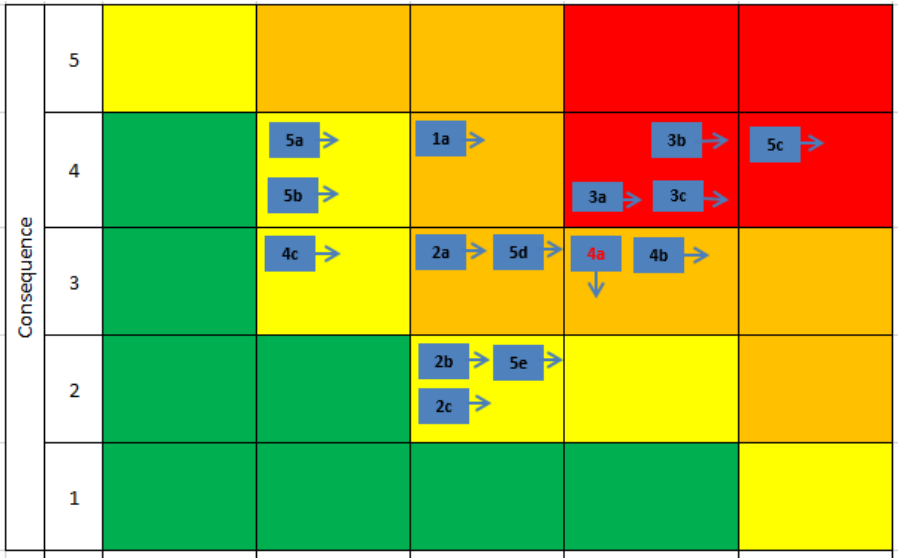
1. Proposed closure of BAF risks

It is proposed to close the BAF risks relating to Future IT strategy and to Integration. This would leave Quality, Finance and People as the main BAF themes.

2 Board Assurance Framework – summary of movement

Detailed below is the overview of BAF risk movement for this period. The risk relating vaccine deployment for staff has been reduced by the People Committee.



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

In the current. reporting period, the Trust has seen the reduction of one risk, safe staffing in clinical areas in the light of the repeal of the mandatory covid vaccination requirements. There are two principal risks that are rated as high: ability to meet constitutional targets and ability to generate efficiencies

Residual Risk to Target

	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
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

	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
Residual Risk to Target Gap	76	76	64	64	52	51	70	70	62	65	36	36	39	39	43	43	47	45	60	57	51	52

BAF Risk tracker

This chart reflects the proposed closure of risk relating to system integration and on future IT strategy.

	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
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	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	16
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
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
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
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
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
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
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
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	114
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

Meeting of the Board of Directors in Public
Wednesday, 11 May 2022

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.1
Report Author	Alison Davis – Chief Medical Officer Jayne Black – Chief Operating Officer Alan Davies – Chief Finance Officer Leon Hinton – Chief People Officer		
Lead Director	Paula Tinniswood, Chief Strategy & Transformation Officer		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators for the March 2022 reporting period. **Safe** Our Infection Prevention and Control performance for March shows that the Trust has continued to have 0 MRSA bacteraemia cases and 2 hospital acquired C-diff cases. **Caring** MSA continues on a downward trajectory with 94 breaches recorded (against 104 in January reporting period). The Friends and Family recommended rates for three areas, remain close or above the national standard of 85% for this reporting period (Inpatients: 75.2%, Maternity: 99.6%, Outpatients: 89.1%, ED: 71.4%). **Effective** Discharges before Noon, have increased slightly since last reporting period sitting at 19.3% but still lower than optimal. We continue to work on achieving a significant improvement on this 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 January the RTT standard was 62.3% and the Trust recorded 162 52 week breaches (an increase from previous reporting period of 50) ED (Type 1) 4 hour performance has reduced slightly since last reporting period moving from 65.3% in December to 60.3%. Additionally, the Trust saw an increase in Ambulance Handover delays of +60mins rising from 170 to 184. The DM01 Diagnostics performance is significantly improved rising from 75.1% in January to 81.4% now We also see a continued improvement in 2 week waits on the cancer pathway, with 96.9% of patients seen within 2 weeks of their referrals into the cancer pathways		

	Well Led Whilst a slight drop on last reporting period, we continue to see a stable position in appraisal rates, reporting 80.8% and the Trust has maintained compliance statutory and mandatory training at 88.7% in this reporting period. To note: • The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay. • The SHMI data reports in arrears – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR reports in arrears, this is reliant on Dr Foster and this is 3 to 4 months in arrears. • The bed occupancy includes all beds within the Trust including maternity and paediatrics. • Cancer data is reported a month in arrears.	
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Resource Implications	None	
Legal Implications/Regulatory Requirements	State whether there are any legal implications	
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 – March 2022

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: March 2022

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.

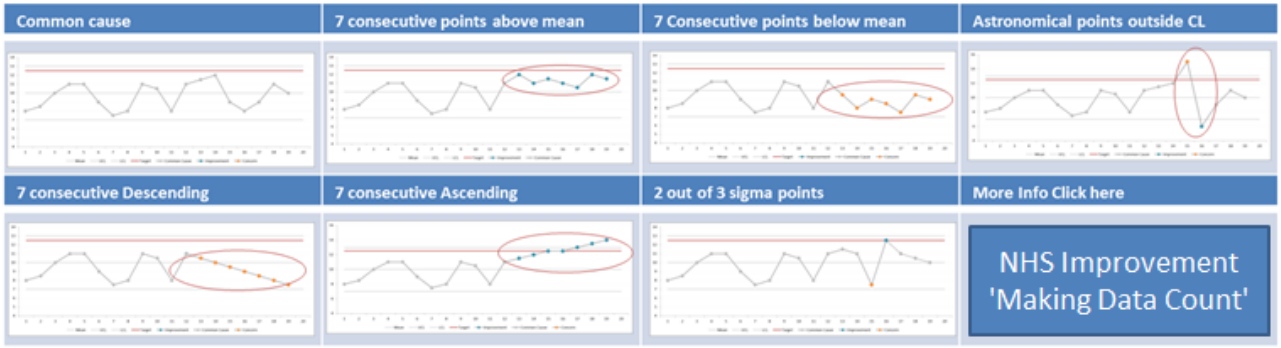
Key Facts about a SPC Chart:

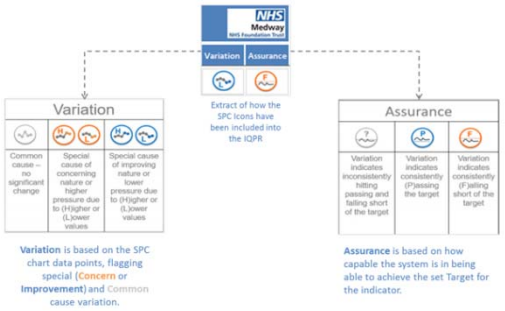
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

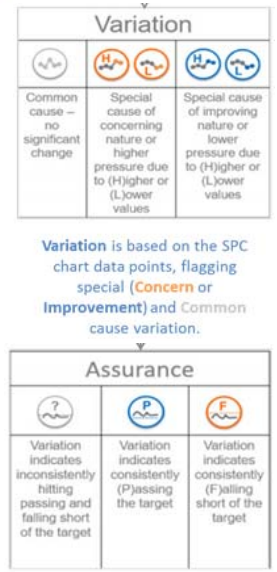
Contains a mean (the average), **lower and upper confidence levels**. 99% of all data will fall between the lower and upper confidence levels. If a data point falls outside these levels, an investigation would be triggered.

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:







Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Cancer & Mortality improvement	• RTT & Emergency Pathways
Caring	• Both Maternity & Outpatients FFT % Recommended is over target and showing signs of improvement • The number of Complaints received is consistently achieving between 4-50 per month, in line with expectation	• High number of breaches in Mixed Sex Accommodation continues • % 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 • 30 Day Readmission Rate showing improved statistical variation	• High statistical variance in C-Section rates evidenced • Fractured NOF significantly below target • VTE Risk Assessment % Rate below plan and showing low statistical variation
Safe	• PU Incidence continuously passes (achieves under) the target set • Falls per 1,000 Bed Days under target • Both HSMR and SHMI have all shown a statistically significant improvement	• 1 reported Never Event in month • E-Coli cases 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 decreased • Bed Occupancy showing high statistical variance
Well Led	• Maintained compliance with Trust target for StatMan Compliance • Agency staff spend has reduced	• Turnover Rate shows an increase in statistical variance • Bank spend has increased considerably • Sickness Rates have shown a statistically significant increase

Summary | Caring | Effective | Safe | Responsive | Well Led

Best of care Best of people

NHS Medway NHS Foundation Trust

Executive Summary

CQC Domain	CQC Sub Domain	TRUST Variation					TRUST Assurance			
Caring	Admitted Care	3	2	0	0	0	0	1	4	0
	ED Care	1	1	0	0	0	0	1	1	0
	Maternity Care	0	1	0	0	1	1	0	1	0
	Outpatients Care	1	1	0	0	0	1	1	0	0
Effective	Best Practice	2	1	0	1	1	0	2	3	0
	Maternity	2	0	2	0	0	0	3	1	0
Responsive	Bed Management	2	0	2	1	0	2	2	1	0
	Cancer Access	4	0	0	0	1	0	0	5	0
	Diagnostic Access	1	0	0	0	0	0	0	1	0
	ED Access	2	2	0	0	0	0	2	2	0
	Elective Access	1	1	1	0	0	0	2	1	0
	Theatres & Critical Care	2	0	0	0	0	0	0	2	0
Safe	Infection Control	1	0	0	0	0	0	0	1	0
	Mortality	1	0	0	4	0	0	1	2	2
Well Led	Workforce	3	2	2	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	2	43	59		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	1	0			
S3	MRSA Bacteraemia (Trust Attributable)	0	0	5			
S4	E-coli (Trust Acquired) Infections	2	3	30			
S5	Falls Per 1000 Bed Days	6.63	4.08	6.63			
S6	Pressure Ulcer Incidence Per 1000 days (High Harm)	1.04	0	1.04			
S7	Never Events	0	1	0			
S8	% of SIs Responded To In 60 Days	100.0%	100.0 %	100.0%			
S9	HSMR (All)	100	93.86	100	0.97		
S10	HSMR (Weekday)	100	90.75	100	0.95		
S11	HSMR (Weekend)	100	103.50	100	1.06		
S12	SHMI	1	1.02	-	20.04		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	94	0	2,613		
C2	Number of Complaints	41	48	-			
C3	% Complaints Responded to Within 30 Days	85.0%	29.2%	85.0%			
C4	% of EDNs Completed Within 24hrs	100.0%	70.1%	100.0%	68.7%		
C5	Inpatients Friends & Family Response Rate	22.0%	17.7%	22.0%	18.7%		
C6	Inpatients Friends & Family % Recommended	85.0%	75.2%	85.0%	79.7%		
C7	ED Friends & Family Response Rate	22.0%	14.2%	22.0%	14.7%		
C8	ED Friends & Family % Recommended	85.0%	71.4%	85.0%	80.2%		
C9	Maternity Friends & Family Response Rate	22.0%	13.3%	22.0%	25.8%		
C10	Maternity Friends & Family % Recommended	85.0%	99.6%	85.0%	98.5%		
C11	Outpatients Friends & Family Response Rate	22.0%	7.4%	22.0%	9.7%		
C12	Outpatients Friends & Family % Recommended	85.0%	89.1%	85.0%	89.0%		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R1	Bed Occupancy Rate	85.0%	89.2%	85.0%	83.5%		
R2	Average Non-Elective Length of Stay	5	9.78	5	8.53		
R3	Average Elective Length of Stay	5	2.92	5	2.30		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	0.0%	4.0%	0.7%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	16.7%	7.0%	12.5%		
R6	ED 4 Hour Performance All Types	95.0%	70.5%	95.0%	79.4%		
R7	ED 4 Hour Performance Type 1	95.0%	60.3%	95.0%	70.1%		
R8	ED 12 hour DTA Breaches	0	75	0	738		
R9	Number of ED arrivals by Ambulance	-	3,210	-	77,023		
R10	60 Mins Ambulance Handover Delays	0	184	0	4,849		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	5.2%	5.0%	6.5%		
E2	30 Day Readmission Rate	10.0%	10.4%	10.0%	12.6%		
E3	Discharges Before Noon	25.0%	19.3%	25.0%	16.4%		
E4	Fractured NOF Within 36 Hours	100.0%	72.7%	100.0%	68.6%		
E5	VTE Risk Assessment % Completed	95.0%	89.7%	95.0%	95.1%		
E6	Elective C-Section Rate	13.0%	15.7%	13.0%	14.7%		
E7	Total C-Section Rate	28.0%	41.8%	28.0%	37.9%		
E8	Emergency C-Section Rate	15.0%	26.1%	15.0%	23.2%		
E9	12+6 Risk Assessment	90.0%	81.4%	90.0%	85.2%		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	81.4%	99.0%	79.7%		
R12	18 Weeks RTT Incomplete Performance	92.0%	62.3%	92.0%	64.8%		
R13	18 Weeks RTT Over 52 Week Breaches	0	162	0	5,241		
R14	Operations Cancelled By Hospital on Day	0	6	0	286		
R15	Cancelled Operations Not Rescheduled < 28 days	0	0	0	49		
R16	Cancer 2ww Performance	93.0%	96.9%	93.0%	95.9%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	92.1%	93.0%	91.5%		
R18	Cancer 31 Day First Treatment Performance	96.0%	99.2%	96.0%	97.2%		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	80.8%	-	83.7%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	5.4%	4.0%	5.0%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	15.4%	12.0%	12.7%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	88.7%	85.0%	89.1%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,362.20	-	100,141.30		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	3.9%	4.0%	2.8%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	11.8%	9.0%	13.0%		

Domain: Caring Dashboard	**Executive Lead:** Evonne Hunt–Chief Nursing Officer **Operational Lead:** N/A **Sub Groups :** Quality Assurance Committee	NHS Medway NHS Foundation Trust

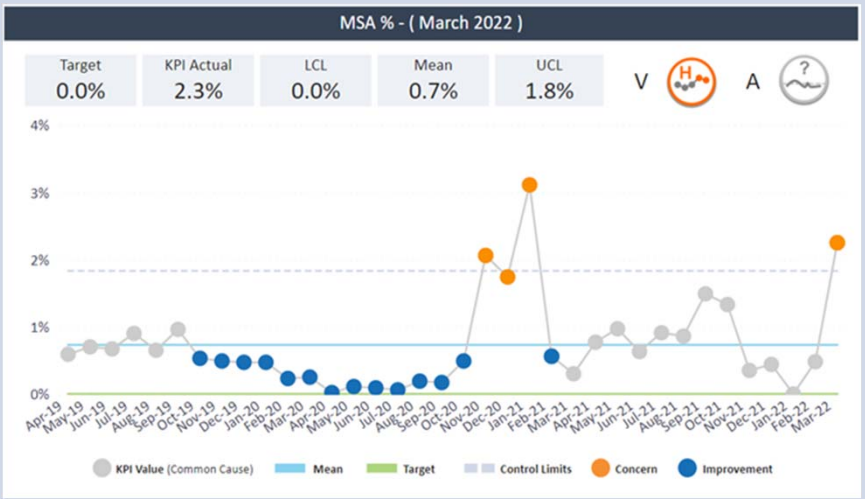
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Mar-22	100.0%	70.1%	64.3%	70.3%	76.4%		
		Inpatients Friends & Family % Recommended	Mar-22	85.0%	75.2%	75.1%	81.9%	88.7%		
		Inpatients Friends & Family Response Rate	Mar-22	22.0%	17.7%	15.6%	19.2%	22.9%		
		Mixed Sex Accommodation Breaches	Mar-22	0	94	0	101.42	230.54		
		MSA %	Mar-22	0.0%	0.6%	0.0%	0.7%	1.7%		
	ED Care	ED Friends & Family % Recommended	Mar-22	85.0%	71.4%	70.5%	79.5%	88.6%		
		ED Friends & Family Response Rate	Mar-22	22.0%	14.2%	12.1%	14.5%	16.8%		
	Maternity Care	Maternity Friends & Family % Recommended	Mar-22	85.0%	99.6%	95.1%	99.1%	103.1%		
		Maternity Friends & Family Response Rate	Mar-22	22.0%	13.3%	8.2%	23.9%	39.5%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Mar-22	85.0%	89.1%	87.4%	89.7%	92.0%		
		Outpatients Friends & Family Response Rate	Mar-22	22.0%	7.4%	9.5%	11.4%	13.2%		

Safe: Mixed Sex Accommodation (MSA)
Aim: Reduction in mixed sex accommodation
Latest Period: March 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	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	Mar-22
Arethusa/SAU														18
Bronte					4	7		14				4		6
Critical Care Unit														
Dolphin Ward		2			4	4	2			1				
Emerald Assessment Unit														19
Emerald Short Stay Ward														2
Intensive Care Unit	6		18	20	11	3	6	1	5	2	2	8	12	1
McCulloch Ward		6	7	7		19		3	15			1		
Harvey Ward														
Jade Ward									4	4		12		
Keats Ward	2				3			14						3
Lawrence Ward				2			2	7						
Lister Assessment Unit	16			12	16	43		34	22					40
Nelson Ward	11	5	24	8		6		5	10					
Ocelot								29	32	1		5		
Pembroke Ward						7	15							
Phoenix Ward	19	7												93
Pre Op Care Unit	2	11												
Sapphire Ward				2	9	3	57	25	24					132
SDEC					2	2								
Sunderland Day Case Centre								5	19					
Surgical Assessment Unit					12		7	20					3	
Theatre Intensive Care Unit	1													
Trafalgar Ward SHDU	11	19	55	45	47	46	33	86	65	46	69	74	60	73
Tennyson Ward														
Wakeley					1		5							
Victory							6							
Will Adams	4			7		3		8		4				
Totals	72	50	104	103	109	143	133	251	196	58	71	104	75	387

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 has been challenging as expected due to winter pressure and SARS2 pandemic demand.

Unjustified breaches of MSA recorded in relate to the inability to step down within 4hrs our patients from critical care into level 1 ward based care and the overnight bedding of the surgical assessment unit .

The use of escalation areas within Emerald ward has also triggered a short MSA breach in month.

What changes have been implemented and improvements made?

Continuous monitoring of patient safety and ensuring that where possible the patients are informed and bed moves prioritised and facilitated in a timely way to correct the breach.

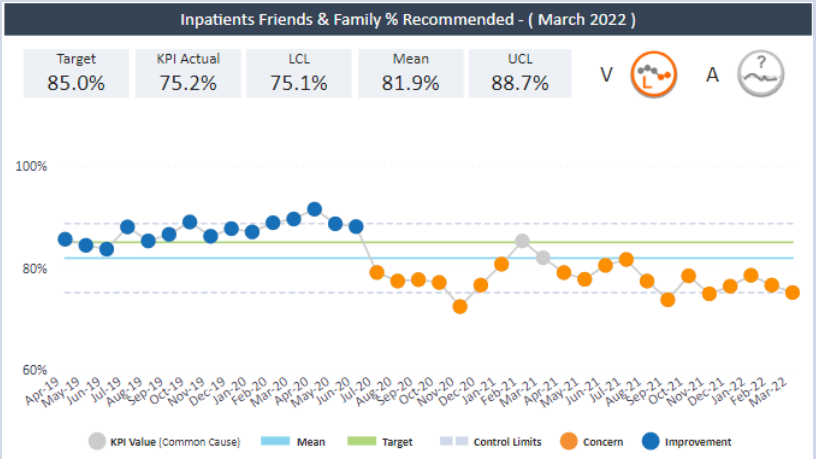
Collaborative working within the divisions, site team and the IPC team and utilising the Trust winter plan / surge plan has ensured patient safety and dignity during this process and has minimised the unjustified mixed sex accommodation breach outside of Covid management and assessment areas in the Trust.

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

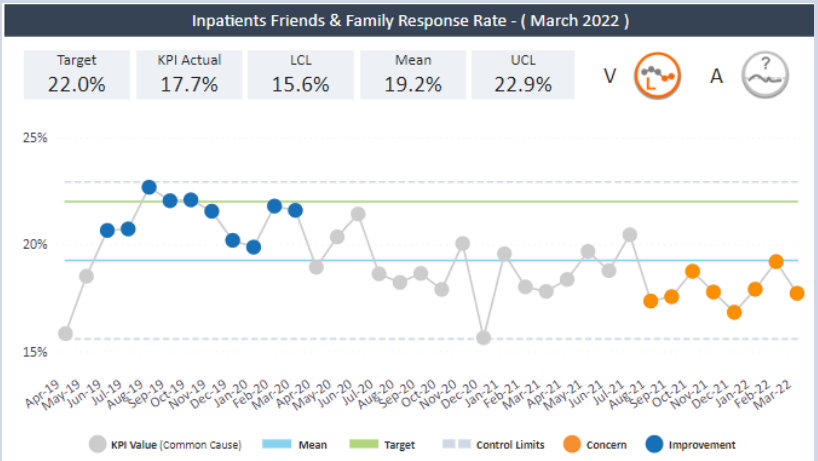
The inpatient would recommend rate continues to fall below the trust target of 85%.

The ambition to improve the would recommend score continues In March 11 departments had an increase in their scores one ward stayed the same and there was a decrease in 13 wards.

Call to call has been implemented in Planned care wards to improve the communication as this was a theme.

CCU has continually scored 100% would recommend in the last 12 months.

Outcome Measure: Inpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

The inpatient response rate continues to be below the trust target of 22%. However 10 areas did score above the target an increase of 1 from last month.

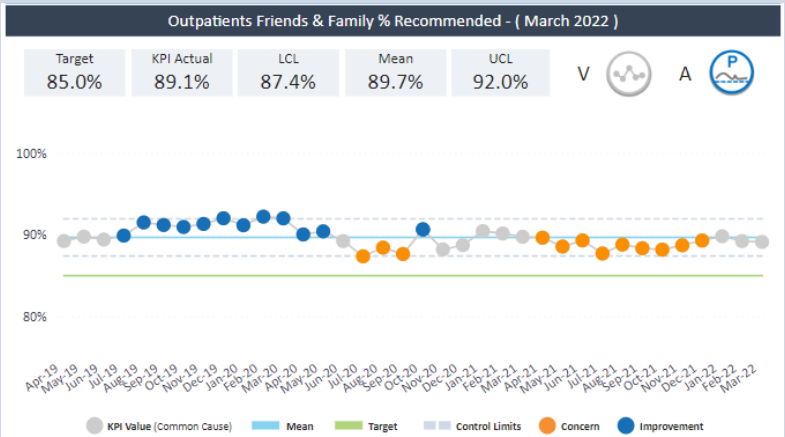
Staff are reminded to actively tell their patients on discharge they will be receiving a txt and the importance of completing this so improvement can be made- when the scores are reviewed weekly some weeks have a higher response rate, however a poor week reduces the score.

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



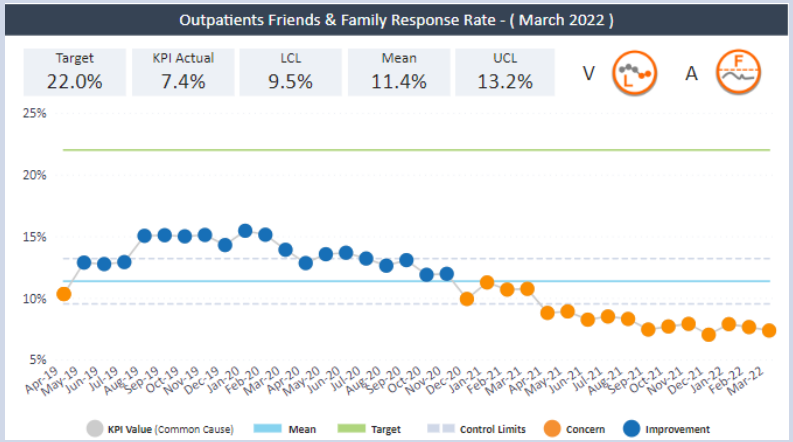
What changes have been implemented and improvements made?

The recommend rate remains consistently above the trust target of 85%. All comments are shared with staff.

Data continues to be looked at monthly for themes so this can be actioned.

Discussed with Matron the best area in outpatients to display family and friends data so the patients can see the changes made.

Outcome Measure: Outpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

The response rate has continued to drop since November 2020.

Staff to actively encourage feedback within their department.

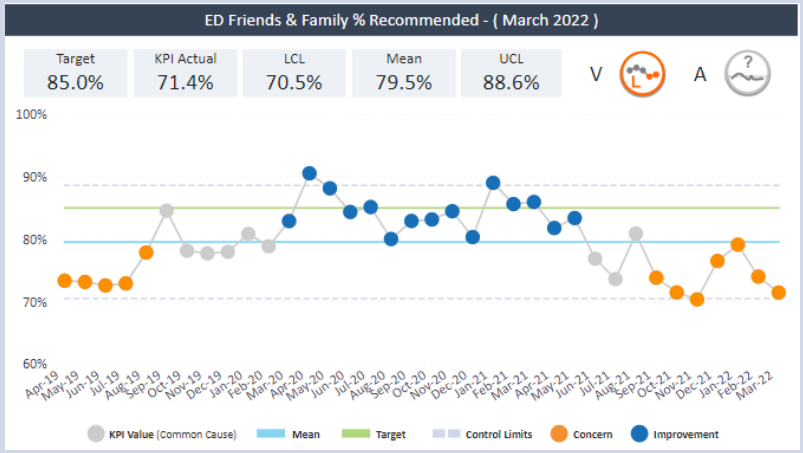
Outpatients have identified the 10 questions they would like asked for F+F to make there feedback more applicable to outpatients and to create a specific action plan.

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

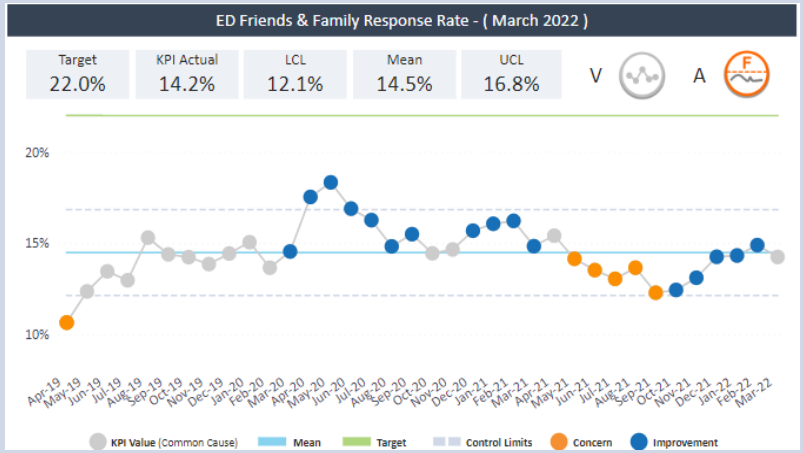


What changes have been implemented and improvements made?

We are currently Looking at the last 3 months data to see the themes, and meeting arranged with ED matrons to discuss and make action plan as required.

March had the highest number of people eligible to respond (8059) since April 2021.

Outcome Measure: ED Friends & Family % Response Rate



What changes have been implemented and improvements made?

Whilst the response rate remains below the trust target of 22% it has remained in the 14% since December.

From the 8059 people who where eligible to respond, 1148 people completed the survey.

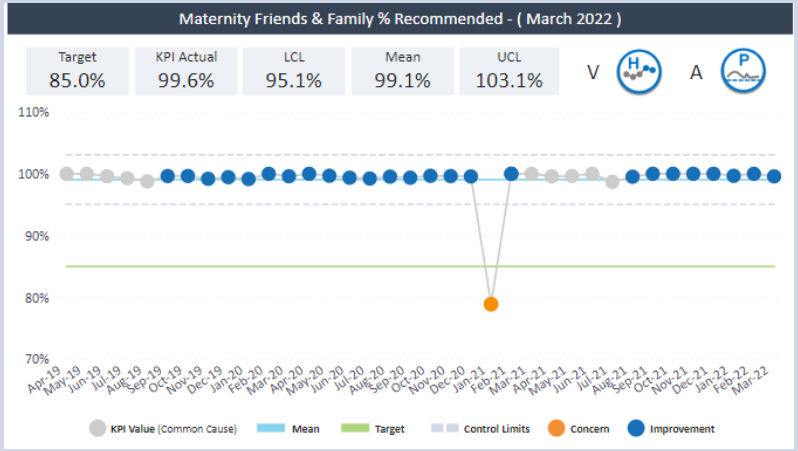
Discussion with the Matrons for them to disseminate with staff the importance of asking patients on discharge to complete survey.

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

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

NHS Medway NHS Foundation Trust

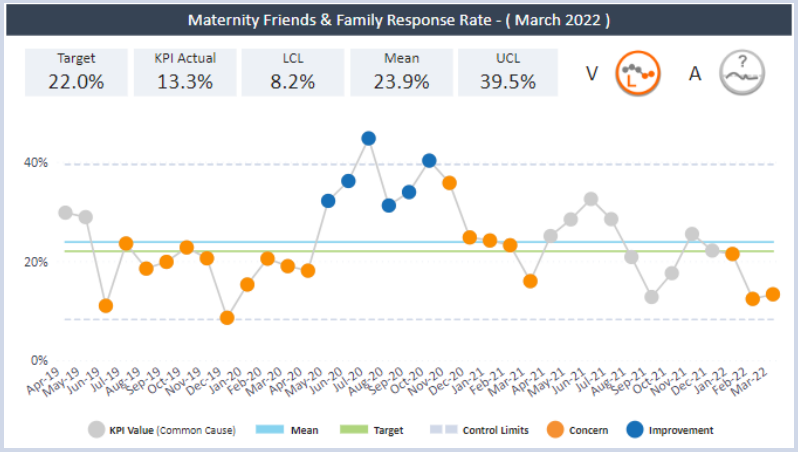
Outcome Measure: Maternity Friends & Family % Recommended



What changes have been implemented and improvements made?

100% of women and birthing people recommend our service.

Outcome Measure: Maternity Friends & Family % Response Rate



What changes have been implemented and improvements made?

No significant increase in response rates during March, partially due to closure of The Birth Place and staffing shortages.
FFT will be re-energised as a top topic at team meetings this month.

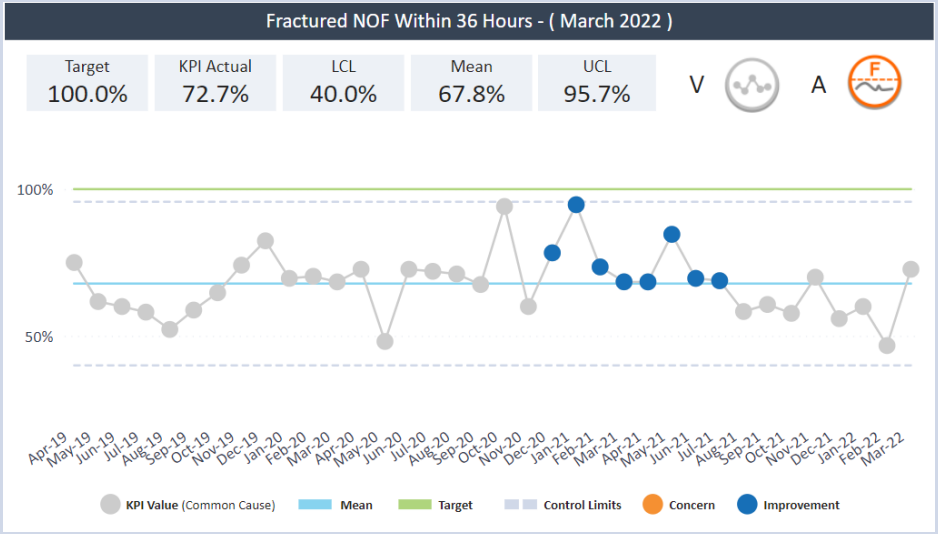
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Feb-22	10.0%	10.4%	9.6%	12.2%	14.8%		
		7 Day Readmission Rate	Feb-22	5.0%	5.2%	4.4%	6.3%	8.2%		
		Discharges Before Noon	Mar-22	25.0%	19.3%	12.8%	15.7%	18.6%		
		Fractured NOF Within 36 Hours	Mar-22	100.0%	72.7%	40.0%	67.8%	95.7%		
		VTE Risk Assessment % Completed	Mar-22	95.0%	89.7%	91.2%	95.0%	98.8%		
	Maternity	12+6 Risk Assessment	Dec-21	90.0%	81.4%	79.2%	84.4%	89.6%		
		Elective C-Section Rate	Mar-22	13.0%	15.7%	10.3%	14.4%	18.4%		
		Emergency C-Section Rate	Mar-22	15.0%	26.1%	16.2%	21.7%	27.2%		
		Total C-Section Rate	Mar-22	28.0%	41.8%	30.0%	36.1%	42.1%		

Effective: Fracture NOF Within 36 Hours
Aim: TBC
Latest Period: March 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?

Data shows 34 hip fractures, 9 breaching the 36h window for surgery, with four (9%) for logistical/capacity reasons and the others requiring medical optimisation.

What changes have been implemented and improvements made?

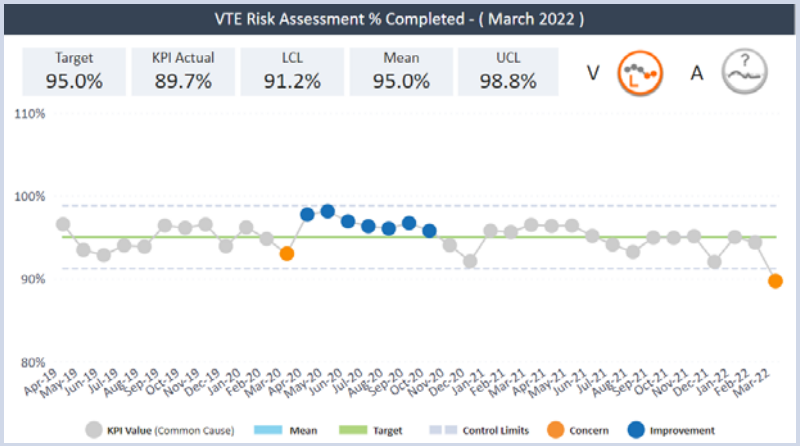
Reinvigoration of the hip fracture pathway with multidisciplinary meeting scheduled for 22nd April to establish solutions to existing barriers, with an acute awareness around unintended consequences.

Effective: VTE Risk Assessments
Aim: TBC
Latest Period: March 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. Unfortunately, reviewed period showed that in some months it was impossible to achieve the this target mainly due to unpredictable variables i.e. ward clerks sickness, ward changes with no ward clerk cover and holiday periods. It also has to be noted that the VTE admin, who supports the collection of the data, now only works 2 days per week due to change in post. Due to the VTE admin collecting the data retrospectively (waiting to see notes from discharged patients), March is still being worked on, so the percentage will improve daily.

What changes have been implemented and improvements made?

- Ward Clerks have been nominated to process VTE Risk Assessments data.
- Training for all ward Clerks has been provided by VTE nurse and regular meetings with ward clerks are being held.
- Ongoing presence of VTE service in clinical areas speaking to doctors and nurses about the importance of VTE compliance.
- VTE Nurse provides continues training for junior doctors on the wards.
- VTE column has been added to board round to encourage ward sisters to monitor VTE Risk Assessments
- VTE Nurse holds regular meetings with heads of nursing and clinical management.
- Global message has been recently agreed with heads of Nursing and distributed on the wards to share responsibility with nurses to check VTE Risk assessments during drug round and remind Doctors to complete it when needed.
- VTE CNS has been also approaching new oversee Nurses individually and explain their role in VTE care.
- VTE has been added as a discussion at Divisional level to raise awareness
- Regular VTE compliance reports sent to individual care groups

Effective: Maternity

Aim: TBC – Currently Under Development

Latest Period: March 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

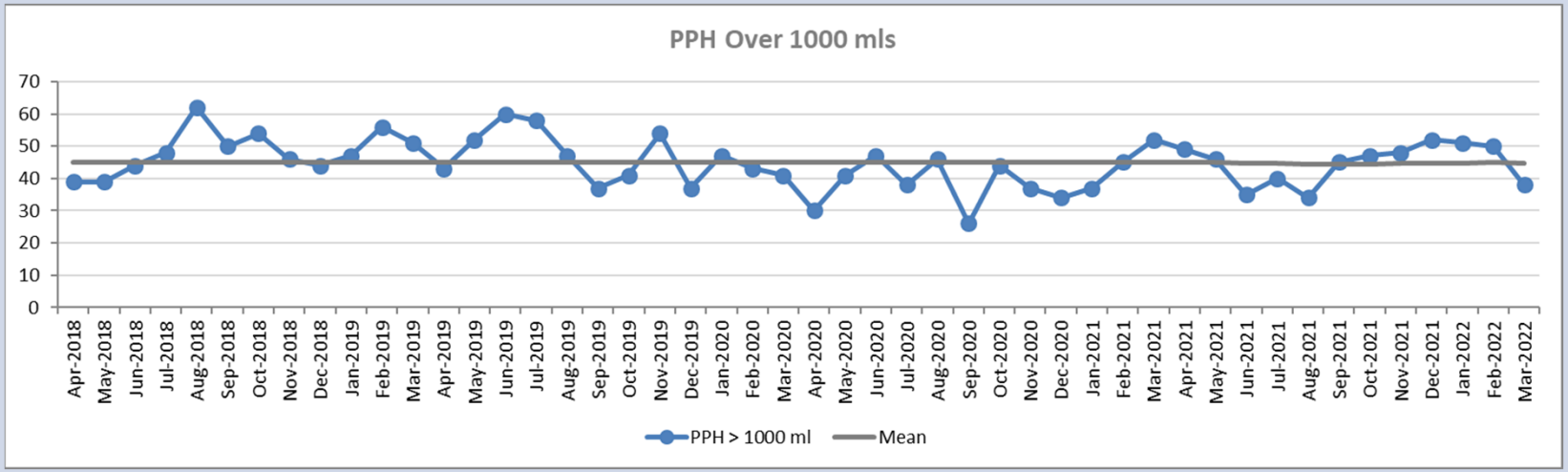
What does the measure show?

- The Caesarean section rate has decreased slightly from last month 45% to 42% which is just below the upper confidence level.
- The total caesarean rate is influenced by an increase in both emergency and elective rates.
- Robson Group 2a (Nulliparous, singleton, cephalic, ≥37 weeks' gestation, induced labour) are the highest contributors to the Caesarean rate. Key audit focus will be in this area.

What changes have been implemented and improvements made?

- The daily caesarean section audit continues and will be reported in 2 months
- There is improved Consultant presence on delivery suite
- Final Ockenden report published with recommendations to be mindful about terminology and communication used with service users.

Outcome Measure: PPH Over 1000 mls



What changes have been implemented and improvements made?

- Evidence demonstrates that PPH rates can be reduced by avoiding unnecessary inductions/augmentations of labour, risk factors assessment and active management of 3rd stage of labour. Further that early escalation and early resuscitation is critical to management. Caesarean section audit will focus on induction and augmentation cases.

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

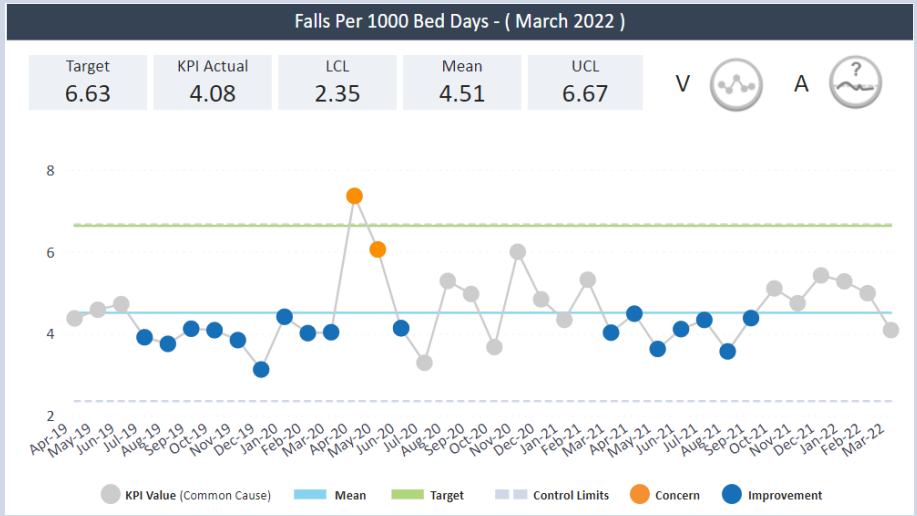
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Mar-22	6.63	4.08	2.35	4.51	6.67		
		Pressure Ulcer Incidence Per 1000 days (High Harm)	Mar-22	1.04	0	0	0.01	0.04		
	Incident Reporting	% of SIs Responded To In 60 Days	Mar-22		100.0%	9.4%	63.8%	118.2%		
		Never Events	Mar-22	0	1	0	0.19	1.18		
		No of SIs on STEIS	Mar-22	90	5	0	14.86	31.96		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Feb-22	3 [43]	2	0	2.60	8.47		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Mar-22		1	0	2.22	6.52		
		E-coli (Trust Acquired) Infections	Mar-22	0	3	0	3.26	7.09		
		MRSA Bacteraemia (Trust Attributable)	Mar-22	0	0	0	0.03	0.18		
	Mortality	Crude Mortality Rate	Mar-22	2.5%	1.4%	0.4%	1.9%	3.3%		
		HSMR (All)	Dec-21	100	93.86	94.76	98.90	103.05		
		HSMR (Weekday)	Dec-21	100	90.75		95.42			
		HSMR (Weekend)	Dec-21	100	103.50		108.63			
		SHMI	Oct-21	1	1.02	1.05	1.07	1.10		

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

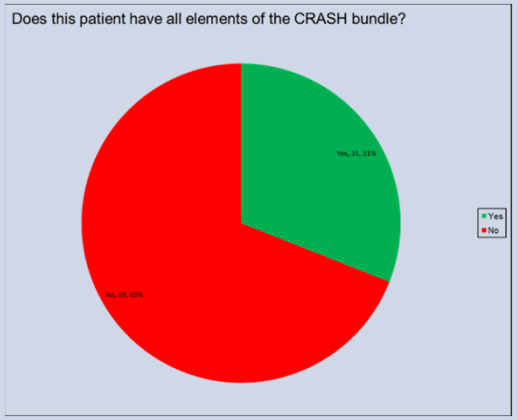
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days



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



What do the outcome measures show?

87% of falls occurred in Unplanned care (size of division and specialties), 65% of falls were unwitnessed
29% of falls were from level ground
16% of falls across the Trust occurred on a Wednesday
The number of patients who have fallen previously on this admission has begun to increase over the past 2 months from 11 (13%) in February to 21 (23%) in March

Month	Total Falls	No and low harm	Moderate harm	Severe harm/ Death
Mar- 22	92	91	1	0
Mar- 21	72	70	1	1
Feb- 22	85	80	3	2
Jan- 22	92	89	1	2

What do the process measures show?

The top 3 wards with the most falls had the most repeat fallers, primarily patients with certain circumstances and conditions relating to increased confusion and unpredictable behaviour such as Dementia, Delirium, mental health presentations and those on alcohol withdrawal regimes which also incorporate medications known to increase the risk of falls. There has been a 13% Trust wide increase in all elements of the CRASH Bundle being completed.

What changes have been implemented and improvements made?

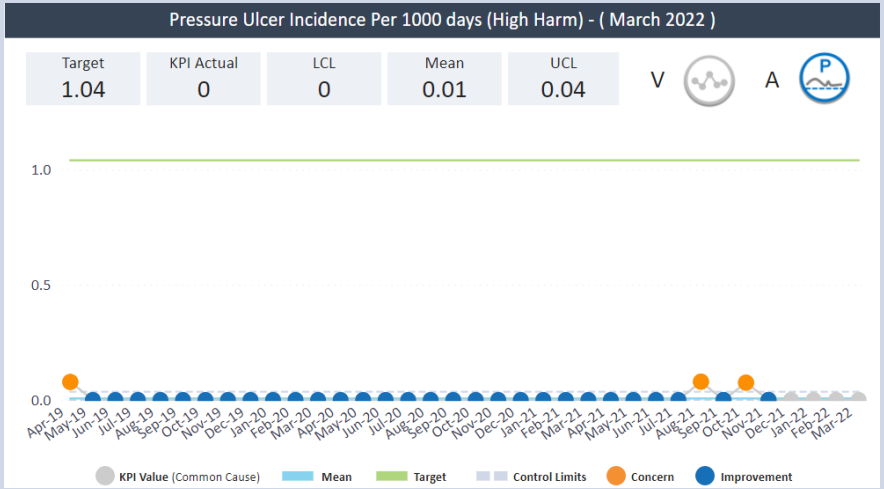
An interrogation of data has been conducted and meetings with ward teams underway to understand emerging themes and trends.
A3 problem solving methodology is being utilised to fully discover root causes in order to identify appropriate solutions and quality improvement plans. This quality improvement approach is part of the falls improvement work under the Patient First Programme strategic theme of quality and safety. Initial data findings were presented at QAC in March 2022 and an update will be provided in 6 months.

Safe: Pressure Damage Reduction
Aim: 10% Reduction in Hospital Acquired Pressure Ulcers
Latest Period: March 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?

90% of hospital acquired pressure ulcers were within Unplanned care
10% of hospital acquired pressure ulcers were within Planned care
Harvey, Jade and Saphire all acquired 2 or more HAPU's.

Month	Total HAPU	No Harm	Low Harm	Moderate Harm	Severe Harm/ Death
Mar-22	11		11		
Mar-21	25		25		
Feb-22	20		20		
Jan-22	14		14		

Category 2	Category 3	Category 4	DTI	Unstagable	Total
3			3	5	11

What do the process measures show?

The transition of moving all audits to Gther from Perfect ward has taken place. Duplicated questions have been asked to be removed to ensure the data is correct. There has been an increase in some elements of the ASSKING care bundle completed, 39% of patients audited in March had all elements completed compared to 21% in Febuary.

What changes have been implemented and improvements made?

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: March 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 were under their trajectory for hospital acquired infections in 2021/2022. There were some increases from the previous year 2020/2021 although remaining under trajectory some organisms did not achieve a 10% reduction on previous year.
MFT MRSA Bacteraemia 0 (since May 2020)
C.Difficile hospital acquired rates since 1st April 2021 is 26 against a target of 35
E.Coli : 42 against a threshold of 112 which was a 7% reduction
Klebsiella acquired: 27 against a threshold of 38 which was increase of 15%
Pseudomonas is 12 against a threshold of 33 which was a 25% increase

What do the process measures show?

Good changes becoming embedded for management of both C.Difficiles and MRSA.
IPC Focus for 2022/2023 will be on 10% reduction for other hospital acquired infections looking at hydration, ANTT and catheter care

What changes have been implemented and improvements made?

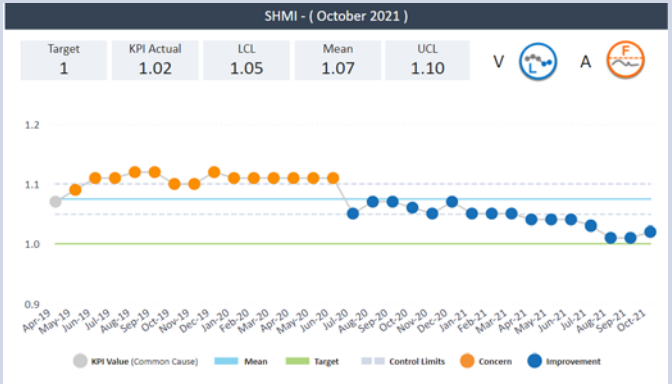
- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- Commencement of IPC operational group involving SSR's Charge nurses and Matrons to review audit data, best practice and to support improvement in low scoring areas first meeting 26th April 2022
- Participation in Kent and Medway hydration project
- Work with PDN team to assess ANTT competency assessments

Effective: Mortality
Aim: TBC
Latest Period: SHMI reporting period October 2020 to October 2021 – HSMR December 2021

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 SHMI reporting period of November 2020- October 2021 was published by NHS Digital on 10th March 22 as 1.02 which is within the 'as expected' range. SHMI highlight 10 diagnosis groups with the most patient activity and therefore most indicative of Trust performance. The Trust remains in the 'as expected' band for 9 of the diagnosis groups and is 'lower than expected' for the Urinary Tract Infections. The most recent reporting period for HSMR covers January 2021- December 2021. The Trusts HSMR for this period is 102.5 and within the 'as expected' band. HSMR for weekday is 99.2 and weekend is 112.9, both within the 'as expected' band.

What changes have been implemented and improvements made?

Since the last update, there are no new outliers or CUSUSM alerts for this reporting period from Dr Foster. Cases from alerts and outliers from last month are being selected for deep dive review. SHMI identified a new outlier group for this period- Acute Cerebrovascular Disease. These cases have been identified and are currently awaiting a deep dive review.

Whilst mortality metrics should not be used in isolation to determine Trust performance, it is positive to see that the Trusts remains stable and consistent within the 'as expected' banding across number of methodologies.

The mortality team are working with NSHE/I Better Tomorrow team to create a more robust mortality review and reporting processes with a focus on ways to effectively share lessons learnt throughout the Trust

Domain: Responsive – Non Elective Dashboard

Executive Lead: Jayne Black–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	Mar-22	7.0%	16.7%	11.9%	15.0%	18.2%		
		% of Delayed Transfer of Care Point Prevalence in Month	Mar-22	3.5%	0.0%	0.1%	1.2%	2.2%		
		Average Elective Length of Stay	Mar-22	5	2.92	1.43	2.36	3.29		
		Average Non-Elective Length of Stay	Mar-22	5	9.78	7.35	8.63	9.92		
		Bed Occupancy Rate	Mar-22	85.0%	89.2%	78.1%	86.0%	93.8%		
		Delayed Transfer of Care Point Prevalence in Month	Mar-22		0	6.13	180.25	354.37		
		Escalation Beds Open Point Prevalence in Month	Mar-22	0	0	0	0	0		
		Medically Fit For Discharge Point Prevalence in Month	Mar-22		2,939	1,696.97	2,289.08	2,881.20		
	Complaints Management	% Complaints Responded to Within 30 Days	Mar-22	85.0%	29.2%	0.0%	13.7%	33.9%		
		Number of Complaints	Mar-22	41	48	15.78	48.92	82.05		
	ED Access	30 Mins Ambulance Handover Delays	Mar-22	0	985	238.93	650.78	1,062.62		
		60 Mins Ambulance Handover Delays	Mar-22	0	184	0	167.28	371.64		
		ED 12 hour DTA Breaches	Mar-22	0	75	0	29.39	99.31		
		ED 4 Hour Performance All Types	Mar-22	95.0%	70.5%	71.9%	79.8%	87.8%		
		ED 4 Hour Performance Type 1	Mar-22	95.0%	60.3%	59.7%	70.6%	81.4%		
		Median Time to Ambulance Assessment (15mins)	Mar-22	15	35.50	9.70	16.43	23.16		
		Median Time to ED Clinician (60mins)	Mar-22	60	68	25.90	38.82	51.74		
		Number of ED arrivals by Ambulance	Mar-22		3,210	2,569.59	3,279.81	3,990.03		

Domain: Responsive – Elective Dashboard

Executive Lead: Jayne Black–Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

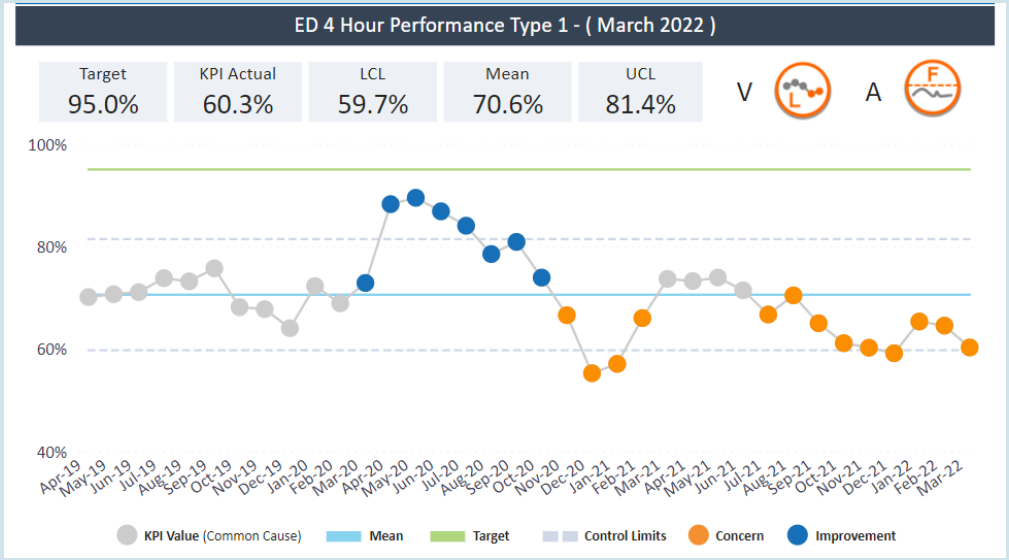
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	Feb-22	0	2	0	1.63	4.13		
		Cancer 28 Faster Diagnosis	Feb-22	75.0%	85.3%	47.0%	65.7%	84.3%		
		Cancer 28 Faster Diagnosis - Breast Symptomatic	Feb-22	75.0%	100.0%	19.3%	85.4%	151.5%		
		Cancer 28 Faster Diagnosis Screening	Feb-22	75.0%	56.3%	0.0%	44.2%	115.7%		
		Cancer 2ww Performance	Feb-22	93.0%	96.9%	91.4%	95.0%	98.5%		
		Cancer 2ww Performance - Breast Symptomatic	Feb-22	93.0%	92.1%	69.5%	89.9%	110.2%		
		Cancer 31 Day First Treatment Performance	Feb-22	96.0%	99.2%	91.3%	96.9%	102.4%		
		Cancer 31 Day Subsequent Treatments (Drugs)	Feb-22	98.0%	95.5%	88.3%	96.6%	104.9%		
		Cancer 31 Day Subsequent Treatments (Surgery)	Feb-22	94.0%	87.0%	66.5%	92.2%	117.9%		
		Cancer 62 Day Treatment - Cons Upgrades	Feb-22		30.0%	44.1%	74.4%	104.7%		
		Cancer 62 Day Treatment - GP Refs	Feb-22	85.0%	88.0%	55.4%	75.1%	94.8%		
		Cancer 62 Day Treatment - Screening Refs	Feb-22	90.0%	67.7%	20.0%	71.2%	122.4%		
	Diagnostic Access	DM01 Performance	Mar-22	99.0%	81.4%	71.6%	85.7%	99.8%		
	Elective Access	18 Weeks RTT Incomplete Performance	Mar-22	92.0%	62.3%	64.2%	70.7%	77.1%		
		18 Weeks RTT Over 52 Week Breaches	Mar-22	0	162	31.56	146.17	260.77		
		Daycase Rate	Mar-22	85.0%	63.4%	60.3%	67.6%	74.8%		
		DNA Rate	Mar-22	10.0%	9.2%	6.6%	7.7%	8.9%		
		First to Follow Up Ratio	Mar-22		2.77	2.08	2.52	2.97		
		PTL Size	Mar-22	22,477	30,391	21,659.67	22,998.86	24,338.06		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Mar-22	0	0	0	2.19	7.82		
		Operations Cancelled By Hospital on Day	Mar-22	0	6	0	16.19	38.31		
		Urgent Operations Cancelled for the 2nd Time	Mar-22	0	0	0	0.03	0.18		

Responsive: – Non Elective Insights

Executive Lead: Jayne Black–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:

- Appointment of new DDO in place since March to enhance focus.
- 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 underway to target enhanced performance
- Symphony discharges; Weekly emails are sent to the UTC/ED workforce managers. Meetings have now started to take place to encourage GIRFT

Outcomes:

- 4hr ED standard is being enforced with daily breach validation analysis carried out..
- ED Outflow: Surgical Admission Hospital Unit (SAU) protected since March 2022 so expect to see enhanced performance.

Underlying issues and risks:

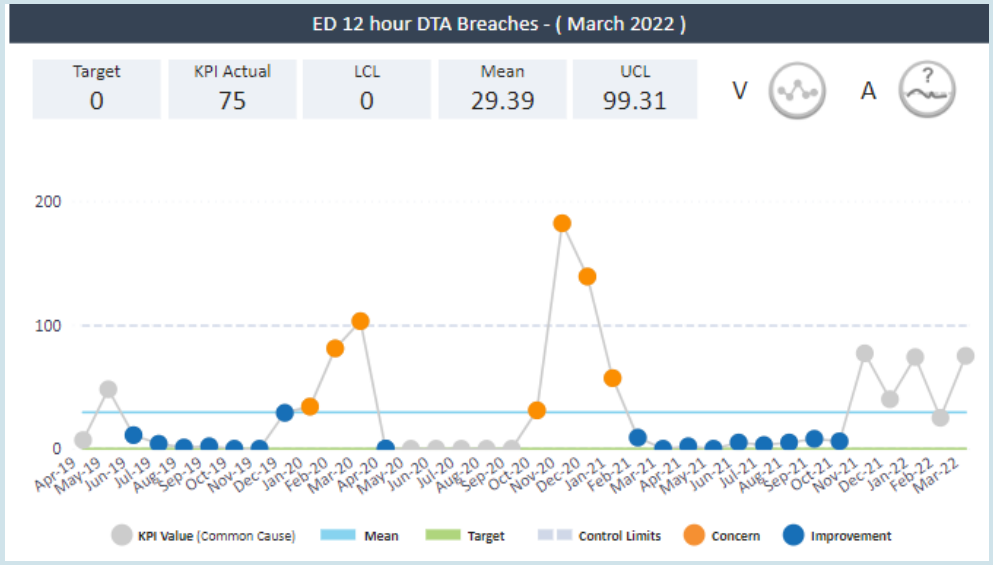
- Underlying bed deficit, COVID contact bed issues, delayed speciality review and use of escalation areas places increased demands on medical, nursing and therapy workforce.

Responsive: – Non Elective Insights

Executive Lead: Jayne Black–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 an increase in 12 hour breaches in the reporting period, with the position around 50 per month on average since December 2021.

Actions:

- Active use of escalation triggers managed via site team and implementation of site huddles to prevent breaches.
- Site Management attendance at ED sit reps.
- Identification of patients clinically ready to proceed.
- Protection of SAU in place to support enhanced flow.
- Will further work on protection of PAHU and ADL in April.

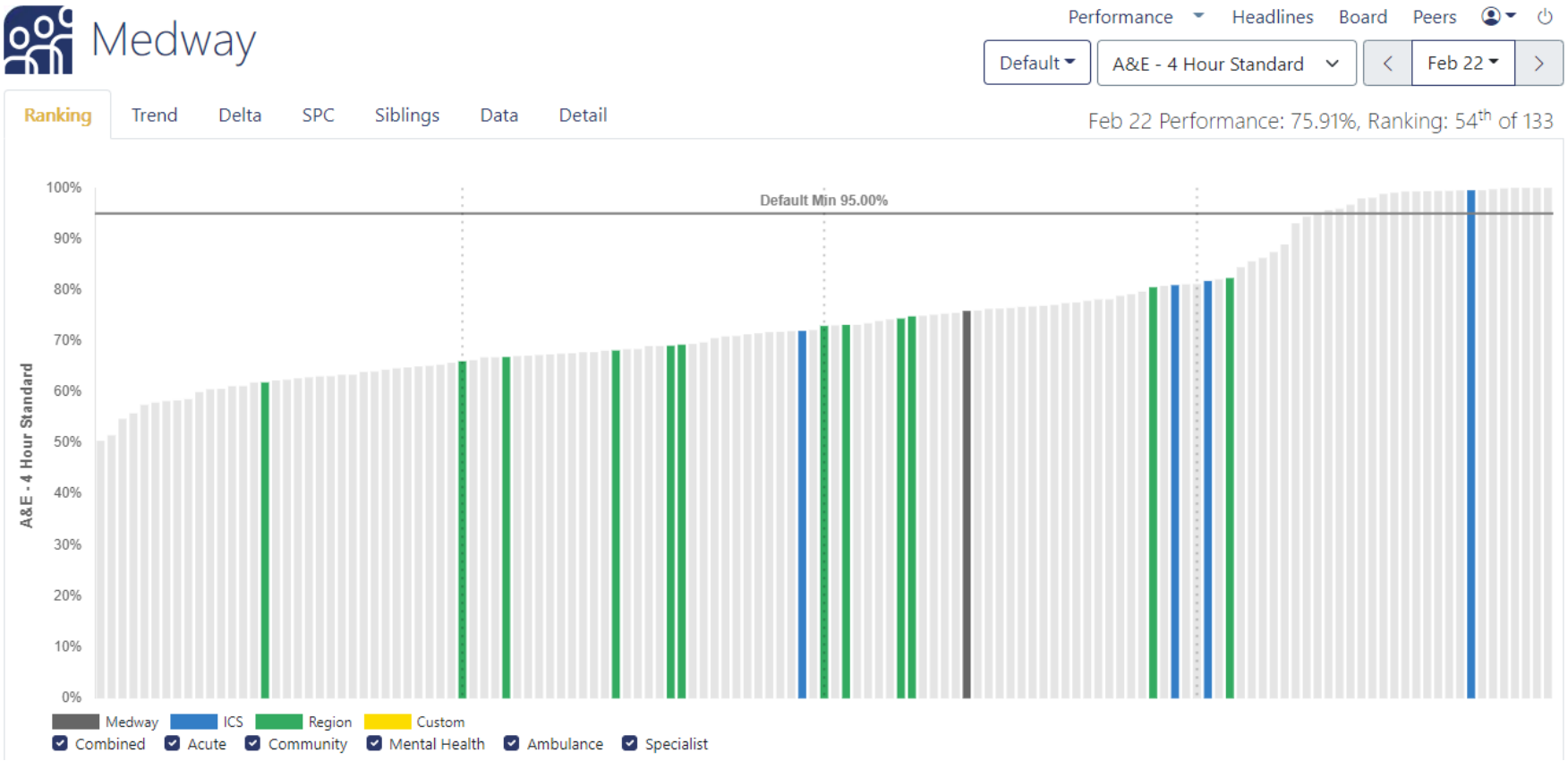
Outcomes:

- 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, COVID contact areas increased from 16 patients to a peak of 68 in March and as a result use of escalation areas placed increased demands on medical, nursing and therapy workforce.

EC 4 Hour Benchmarking

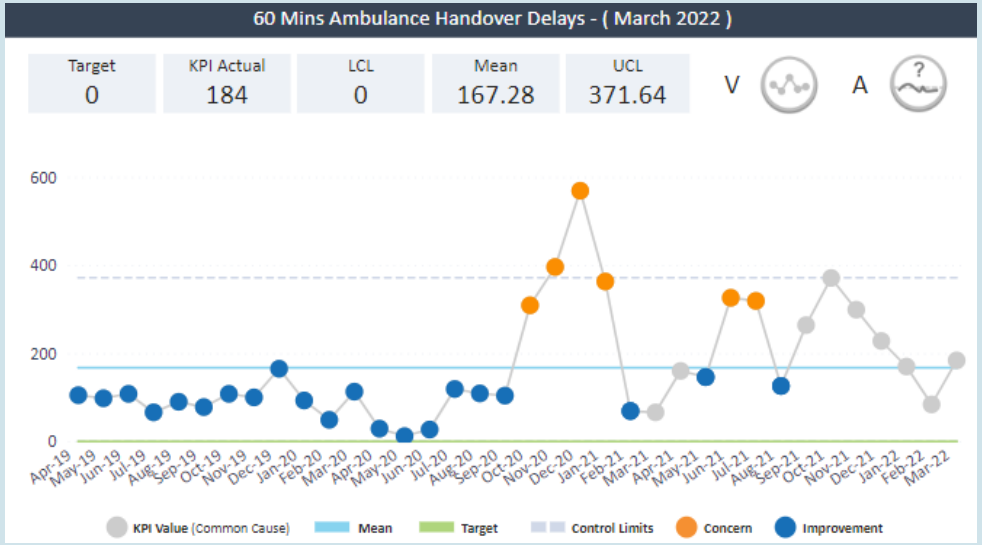


Responsive: – Non Elective Insights

Executive Lead: Jayne Black–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 with a slight increase in March.

Actions:

- A granular focus on performance is taken within ED supported by site management and Executive focus.
- Specfic focus is now required on evening and early morning breaches.
- HARIS project aims to further review appropriateness of arrivals and hence ease burden on ED
- Early escalation and breach management process to be put into place to mitigate breaches.

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.

Underlying issues and risks:

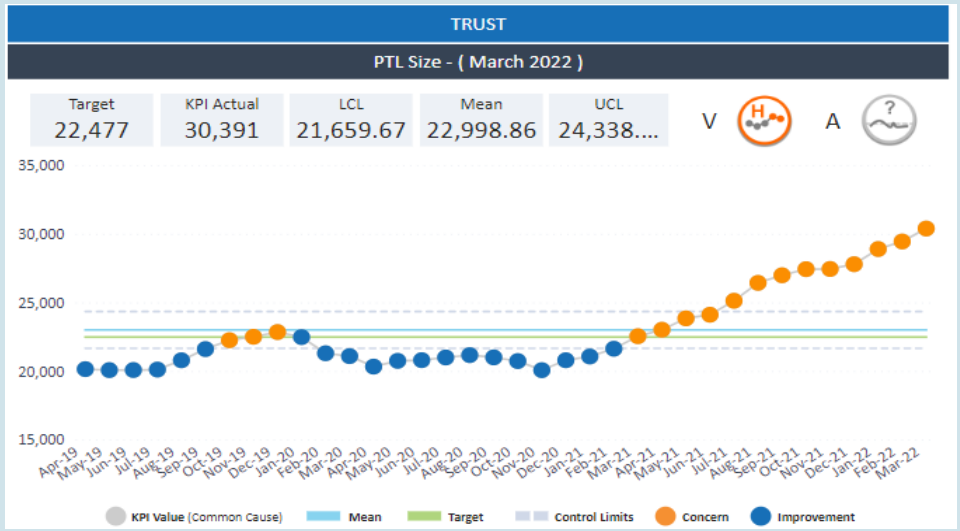
- Early morning bed availability remains a challenge and relates to the need to review wider site bed capacity.
- Rising COVID contact beds have challenged ED but the team should be commended on performance during this time as during this period the site was under periods of business continuity.

Responsive: Elective Insights

Executive Lead: Jayne Black–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:

What the Chart is Telling Us:

Actions:

- System-wide Outpatient transformation meetings have commenced
- Agree system-wide interventions re controls for referral increases.
- 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:

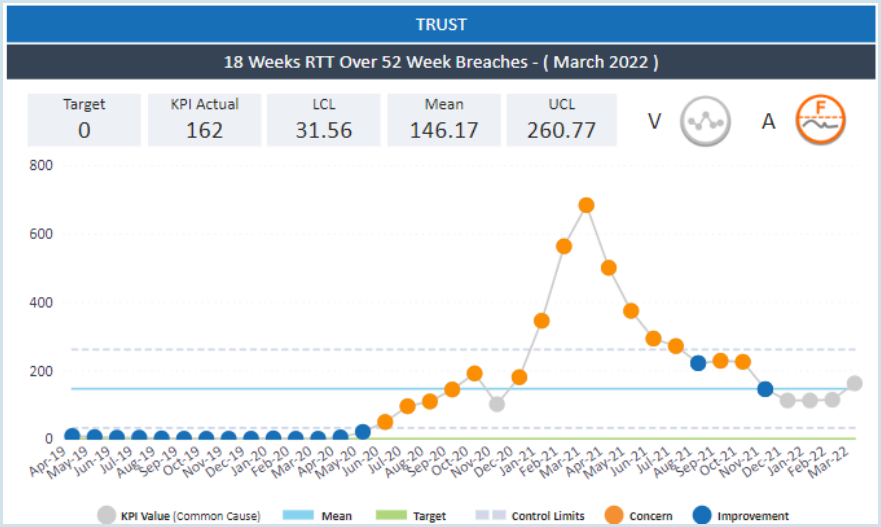
- Impact of further COVID waves resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Potential impact of Trust Business Continuity on Elective activity.
- Increased sickness absence driven by pressure of work and COVID related isolation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

Responsive: Elective Insights

Executive Lead: Jayne Black–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:

What the Chart is Telling Us:

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.

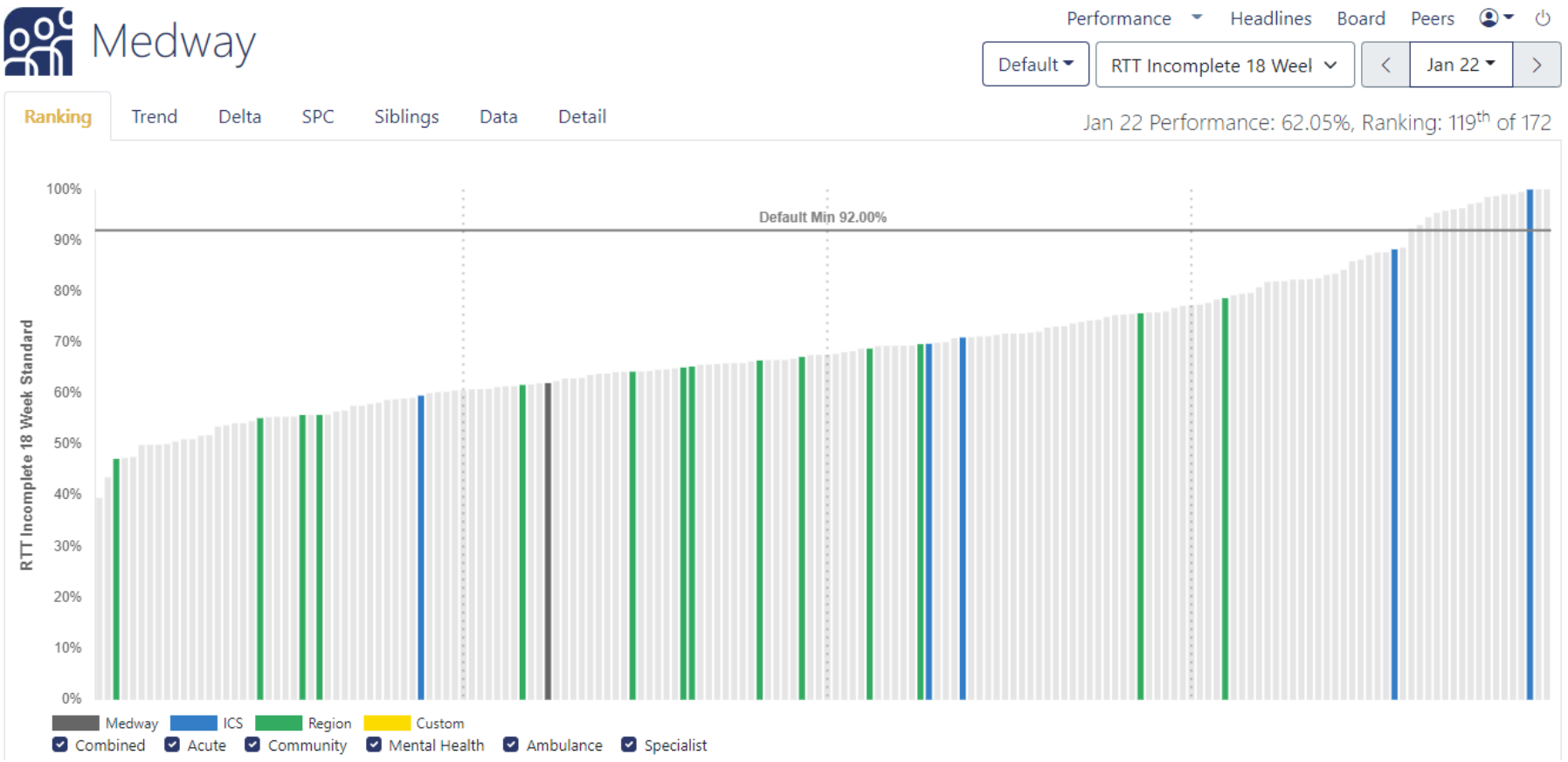
Outcomes:

- Elective capacity and activity monitored with weekly PTL and scheduling meetings
- 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 safe green pathway including appropriate isolation and pre-op swabbing (current IPC guidance)
- Elective capacity is now T

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

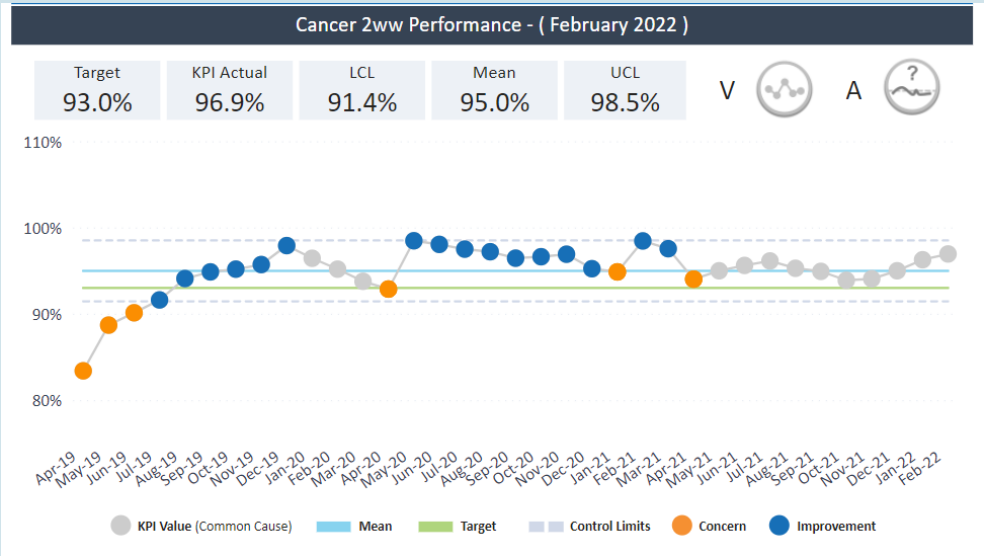


Responsive: Cancer Insights

Executive Lead: Jayne Black–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.
- **MFT were ranked 17th in the country for 2 week wait on Public View.**
- The Trust has remained compliant with this KPI since August 2019 and will remain compliant in March.

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. A Senior Referrals Officer has been recruited to oversee the reduction in polling times and is aiming for all tumour groups to poll at 7 days or under. 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:

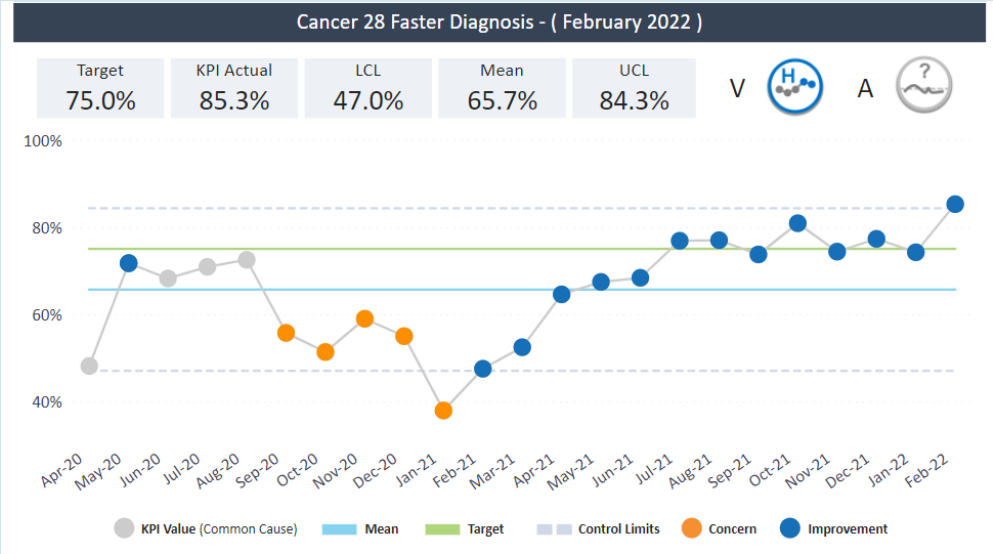
- Request form for the STT cancer CNS to be able to request imaging according to the SOP for the straight-to-test pathway has been waiting for sign off. In the meantime STT nurses not being optimised.
- Main challenges are volumes/fluctuations of referrals, particularly in some tumour sites, and patient choice.

Responsive: Cancer Insights

Executive Lead: Jayne Black–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:

- **MFT were ranked 15th in the country for 28 day for faster diagnosis on Public View.**
- No concerns at present and 28 day is now part of the daily validations and compliant.

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:

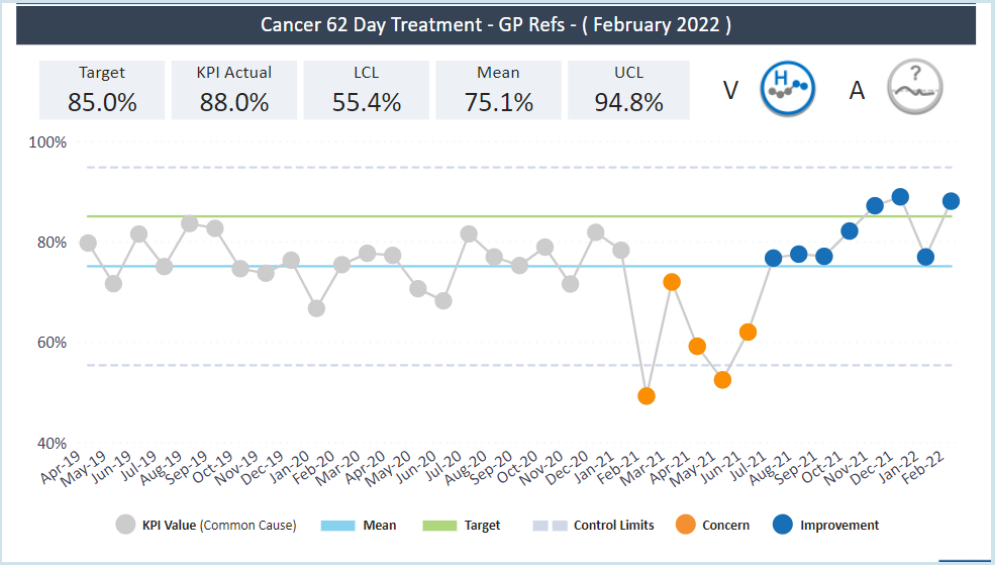
- Diagnostics capacity and turnaround remains the biggest issue to achieving compliance, particularly when affected by unplanned equipment failure or staffing capacity issues.
- Continue to improve our completeness data capture which is reflected in the performance
- Working with the Cancer Alliance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

Responsive: Cancer Insights

Executive Lead: Jayne Black–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 were ranked 5th in the country for 62 day treatment February performance on Public View.**
- January was a challenging month due to high number of breaches but February and March have improved. The Trust was compliant with this KPI in February and will remain compliant in March.

Actions:

- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement 14 Point Action 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

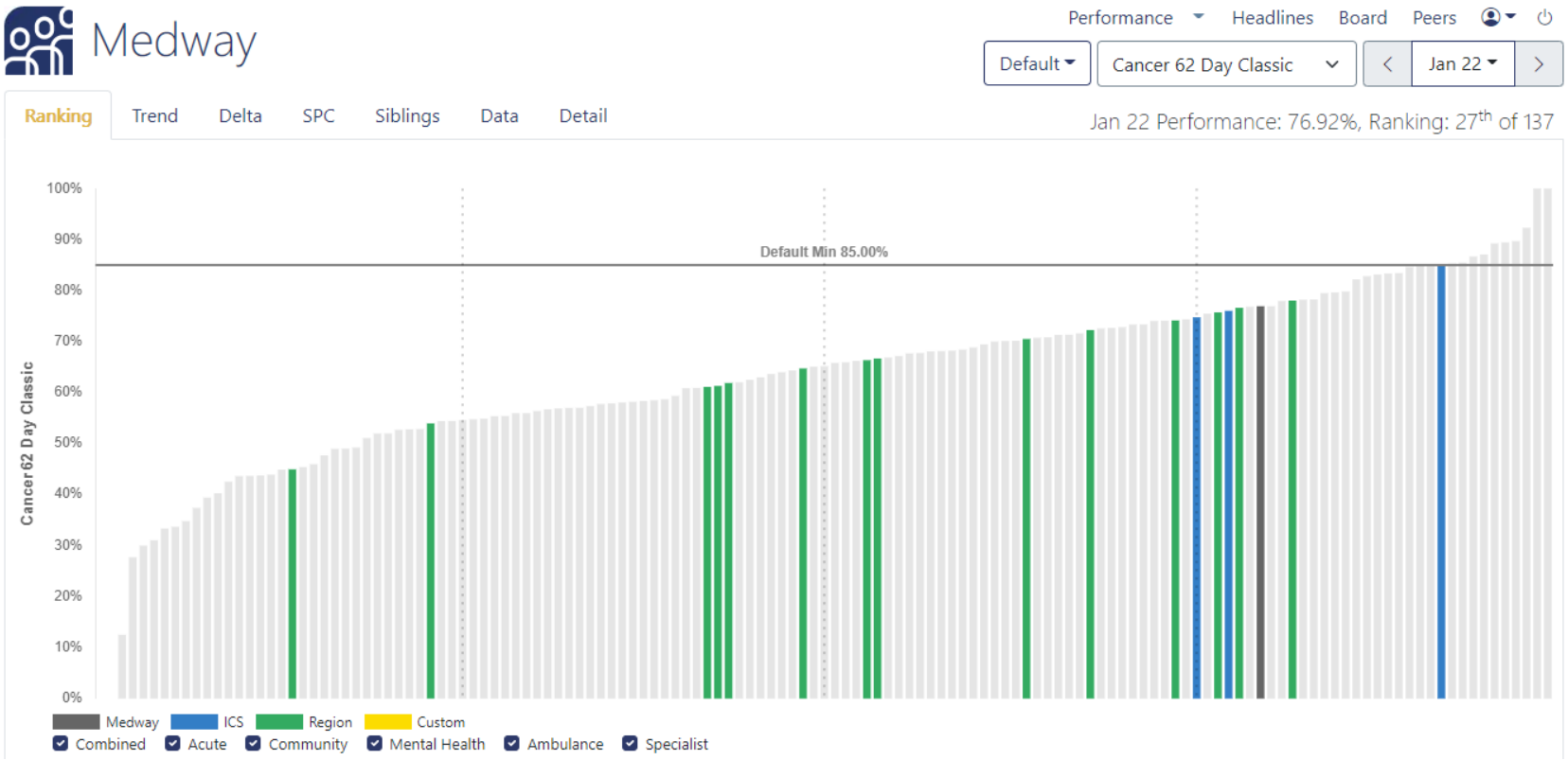
Outcomes:

- 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.
- The Trust has now met the national 62-day cancer standard for three months in the last financial year.

Underlying issues and risks:

- 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.
- 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.

Cancer 62day Benchmarking

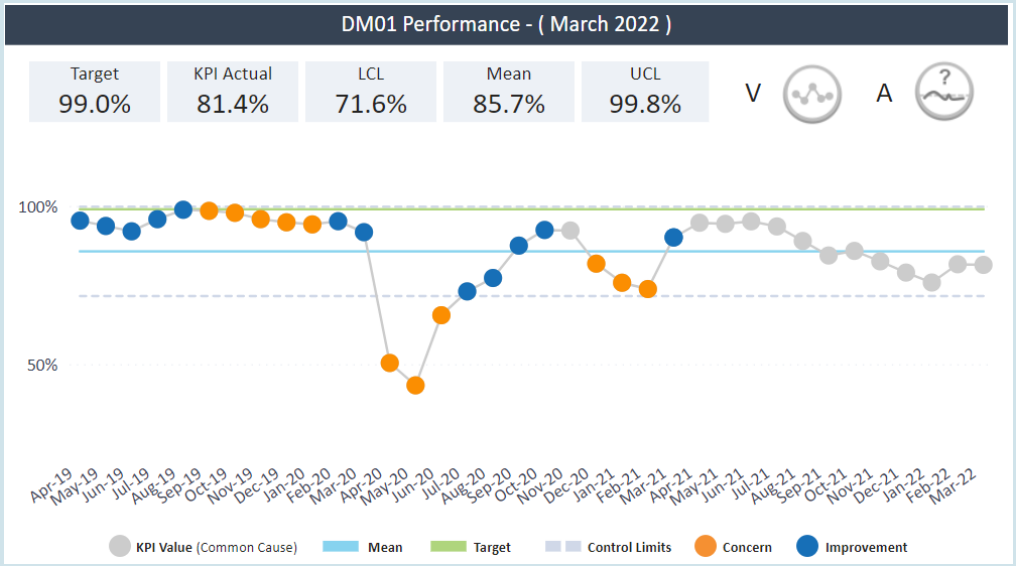


Responsive: Elective Insights

Executive Lead: Jayne Black – 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:

What the Chart is Telling Us:

Actions:

- Triaging of patients on diagnostic waiting lists (D-code) by clinical team in line with national standards
- Use of Independent Sector for Endoscopy Insourcing (18WS) and Outsourcing (PPG) continues
- Access to DVH endoscopy capacity is being developed
- Echocardiography insourcing now operational
- Outsourced capacity for MRI now operational
- Potential IS capacity for Audiology is being discussed with Commissioning teams

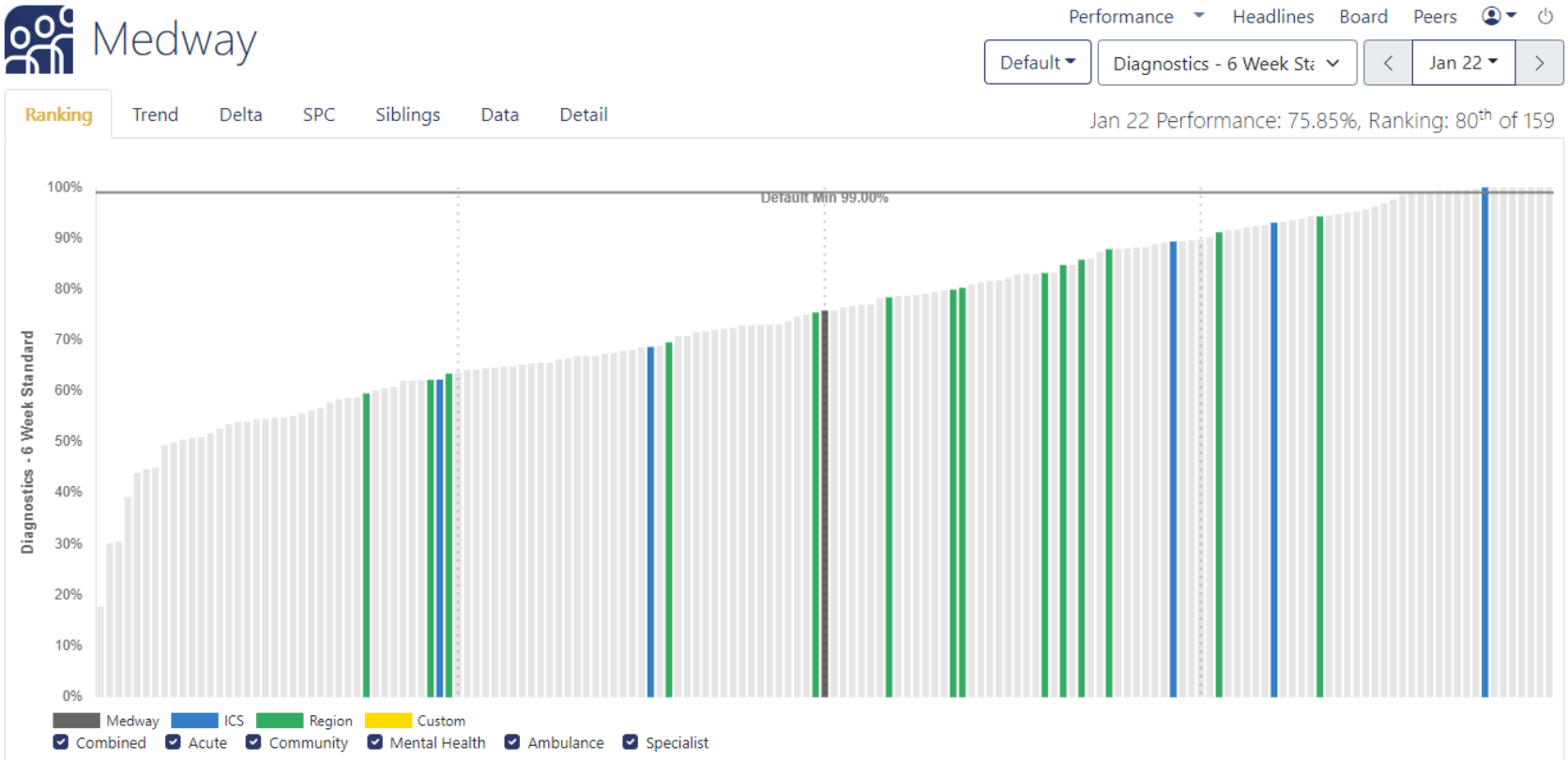
Outcomes:

- 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 a further COVID wave resulting in increased NEL demand impacting on ability to continue same levels of diagnostic work.
- Insufficient onsite Endoscopy and imaging capacity means that outsourcing continues to be 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

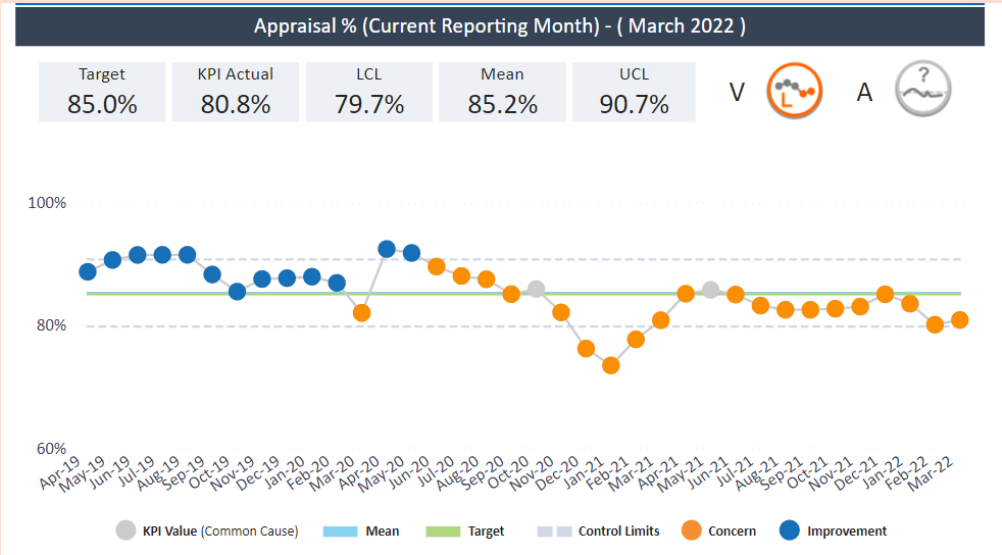
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Well Led	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Mar-22	4.0%	3.9%	0.5%	2.9%	5.3%		
		Agency Spend as % Paybill (Financial Year YTD)	Mar-22	4.0%	3.2%	2.2%	3.1%	4.0%		
		Appraisal % (Current Reporting Month)	Mar-22	85.0%	80.8%	79.7%	85.2%	90.7%		
		Bank Spend as % Paybill (Current Reporting Month)	Feb-22	9.0%	11.8%	8.3%	13.0%	17.8%		
		Bank Spend as % Paybill (Financial Year YTD)	Mar-22	9.0%	12.7%	8.4%	11.0%	13.7%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Mar-22		4,362.20	4,002.26	4,075.01	4,147.76		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Mar-22	2.5%	1.6%	1.7%	2.3%	3.0%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Mar-22	1.5%	3.8%	1.7%	2.2%	2.6%		
		Sickness Rate (Current Reporting Month, FTE%)	Mar-22	4.0%	5.4%	3.3%	4.7%	6.1%		
		StatMan Compliance (Current Reporting Month)	Mar-22	85.0%	88.7%	87.7%	89.4%	91.1%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Mar-22	75.0%	56.1%	53.1%	65.3%	77.5%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Mar-22	12.0%	15.4%	11.6%	12.5%	13.4%		

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.

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:

3410 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 4005).

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.

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	31,187	47,735	16,548	378,567	399,845	21,278
Pay	(19,682)	(32,150)	(12,468)	(236,304)	(256,113)	(19,808)
Total non-pay	(10,211)	(13,122)	(2,910)	(125,163)	(125,508)	(345)
Non-operating expense	(1,457)	(2,818)	(1,362)	(17,349)	(18,170)	(821)
Reported surplus/(deficit)	**(163)**	**(355)**	**(192)**	**(249)**	**54**	**303**
Donated Asset / DHSC Stock Adj.	163	355	192	249	(54)	(304)
Control total	**0**	**0**	**0**	**0**	**0**	**0**

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	502	395	(107)	5,171	4,143	(1,028)	5,171
Capital	(9,886)	(8,482)	1,404	(22,782)	(22,777)	5	(22,777)

Indicator Background:

The Trust reports a £355k deficit position for March; after adjusting for donated asset income and depreciation the Trust reports breakeven in line with the plan.

What the Chart is Telling Us:

The Trust has delivered the planned breakeven control total for the 2021/22 financial year. The efficiency programme under delivered by £1,028k, focus continues to close the gap in the 2022/23 plan. Capital plan was delivered with a small surplus of £5k.

Actions:

- The final plan has been submitted to NHSE/I for 22/23.
- The Trust is planning for a £3.1m deficit. The plan contains a high level of risk and mitigating actions.
- Further work is ongoing to develop the mitigations as well as the efficiency plan for 22/23.
- 9 out of the 11 cross cutting efficiency schemes are signed off and further work is ongoing to action these.

Outcomes:

The Trust has met its control total for 21/22, this includes:

- System support non-recurrent funding of £2.5m for the increased escalation capacity.
- Increased carry forward annual leave provision of £1.7m.
- £9.2m for 6.3% increased pension costs invoiced at the year end, this is covered by additional income.
- Year end stock count adjustments.

Underlying issues and risks:

The financial position is monitored against the plan submitted to NHSE/I for Oct-Mar (H2). The Trust delivered both the income and expenditure breakeven control total, as well as the capital plan for 21/22.
In 22/23 risks continue with closing the gap in the efficiency programme, as well as managing Covid costs within the financial envelope, increased escalation capacity, and delivering the activity plan to achieve Elective Recovery Funding.
The 22/23 capital plan continues to be developed, this is c.£11.5m.

Meeting of the Board of Directors in Public

Wednesday, 11 May 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	4.2a
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday 22 March 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, safety and risks report The Committee received the quality, safety and risks report which provided an update for the reporting month of February 2022 on incidents reporting and current position, delivery of the Trust's CQC action plans, CQC information requests, CQC unannounced inspection in February, journey to excellence, implementation of Gather, safety update, quality risks, clinical effectiveness and mortality and morbidity.	**Amber\Green**

2. 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) for January 2022 including outbreaks, hand hygiene audit results, training compliance and national and regional updates. The Committee noted the improvement to the infection control reports over the last few months which provide assurance to the Committee.	**Green**
3. Safeguarding quarter 3 reports – Children's and Adults The Committee received the quarter 3safeguarding reports for Children's and Adults. The reports provided the Committee with oversight of the work for the safeguarding teams for the quarter 3 period. The Committee were concerned to learn about 16 to 18 year olds being cared for on adult wards and were informed of a piece of work being undertaken to look at this issue. The Committee requested an update on this matter in 2 months' time.	**Amber/Green**
4. Quality and Patient Safety Sub-Committee (QPSSC) – assurance and escalation report The Committee received the assurance and escalation report from the first meeting of the Quality and Patient Safety Sub-Committee. The Committee were advised that there was good engagement at the meeting with outcomes, decisions and actions having been agreed. Risks and issues were also discussed and those reporting were encouraged to ensure risks are discussed at their respective care group meetings and within the divisions. The Committee noted the points for escalation, in particular the need to align meetings in the divisions and care groups to the QPSSC, QAC and Trust Board and the issue about 16 to 18 year olds being cared for on adult wards of which the Committee has already raised concern about in item 3 above.	**Green**
5. Deep Dive – pressure ulcers The Committee received the deep dive into pressure ulcers paper noting the findings from the deep dive. The Committee requested an update in 6 months' time on the impact of the improvements highlighted from the deep dive.	**Amber/Green**
6. Deep Dive - falls The Committee received the deep dive into falls paper noting the findings from the deep dive. The Committee requested an update in 6 months' time on the impact of the improvements highlighted from the deep dive.	**Amber/Green**
7. Medicines management quarterly report The Committee received the medicines management quarterly report which provided a summary of the actions of the Medicines Management Group for the months of July to December 2021 on policy review and approvals, patient group directives, updates from sub-groups, medication safety, controlled drugs and safety alerts.	**Green**

The Committee noted the content of the report. The Committee were advised that of the six meetings that have taken place only two were quorate. A change has been made to the terms of reference to the Chair of the meeting that should improve quoracy of future meetings.	
8. Report on the current Trust Patient Tracking List (PTL) size The Committee received a comprehensive update on the patient tracker list (PTL). The report explained how the elective waiting list has increased due to COVID and reduced elective capacity. This growth is in line with national and regional situation for elective procedures. The report explained the plans that are in place to address those patients on the waiting lists along with the processes in place to prioritise the patients and review any harms. The Committee were informed of the national capacity issues for ENT speciality and were advised that the ICS has a specific steering group looking at Kent and Medway ENT pathways which Jayne Black, Chief Operating Officer is leading on.	**Amber/Green**
9. Proposal for review of Structured Judgement Reviews and Mortality The Committee received a verbal update on the proposal to undertake a review the Structured Judgement Reviews (SJR) and mortality processes at the Trust. A table top exercise is being undertaken by the mortality team and then a review will be carried out by the Better Tomorrow programme which was a recommendation by Sheila Adam NHSE/I Intensive Support Improvement Director as a way of benchmarking our SJR process. The review will be carried out over a couple of months with updates to the Committee by way of the Mortality report.	**Green**
10. Quality IQPR The Committee received the Quality IQPR which provided an update on key performance indicators and quality metrics for the reporting month of February 2022.	**Green**
11. Review of the Quality Assurance Committee terms of reference The Committee reviewed the proposed changes its terms of reference. The Committee agreed to the changes proposed and will submit the updated terms of reference to Trust Board for approval.	**Green**
Escalation to Board No items were identified for escalation to Board.	

Meeting of the Board of Directors in Public

Wednesday, 11 May 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	4.2b
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday 26th April 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 held on 21st April 2022. The report provided assurance to the Committee on the robust discussions, outcomes and decisions made at the QPSSC on the reports submitted. The Committee noted the need to align meetings to ensure flow of information and reporting.	**Green**
2. Quality, safety and risks report	**Amber\Green**

The Committee received the quality, safety and risks report which provided an update for the reporting month of March 2022 on incidents reporting and current position, delivery of the Trust's CQC action plans, CQC information requests, CQC unannounced inspection in February, journey to excellence, Quality Assurance visits, implementation of Gather, safety update, quality risks, clinical effectiveness and mortality and morbidity.	
3. 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) for March 2022 including outbreaks, hand hygiene audit results, training compliance and national and regional updates. The Committee noted the improvement to the infection control reports over the last few months which provide assurance to the Committee.	**Green**
4. Responding to deaths report The Committee received the responding to deaths report noting that it picks up acute cerebrovascular disease as an outlier. The Committee were informed this issue forms part of the Stroke Services review currently being undertaken by Dr David Sulch of which an interim briefing paper was discussed at the Committee and a full report will be received in May. The trust is working with NHS England and their 'better tomorrow' program to review the structured judgement review process. Initial feedback is good and a meeting is taking place on 3rd May to discuss in more detail. The Committee noted Dr Foster is working with the trust to review weekend mortality rates and will receive further updates via the quality and patient safety sub-committee.	**Amber/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 March 2022.	**Green**
6. CNST maternity safety actions 8, 9 & 10 and perinatal surveillance tool CNST safety action 1 The Committee received comprehensive update papers on the compliance with actions against CNST maternity safety actions 8, 9 & 10 and perinatal surveillance tool safety action 1. The Committee were advised that following the publication of the Ockenden report on 30th March NHS guidance is to suspend continuity of care until further notice. The Trust has suspended this and awaits further instruction from NHSE. The Committee were informed of a challenge in meeting compliance with local training in that all staff are to attend a one day multi-disciplinary training. This has been a challenge due to staffing levels and COVID, and there are mitigations in place to achieve this compliance. The Committee noted the SPA time for consultants and doctors to complete training and requested the doctors prioritise this training in their SPA time.	**Green/Amber**
7. Stroke services review	**Amber/Red**

The Committee received an interim update report from Dr David Sulch, who is reviewing stroke services. The report shows that when the Medway patients get to Dartford or Maidstone they get good care. A concern is the high mortality rate for patients who stay at Medway; Dr Sulch is currently reviewing those cases and will present a full report at the 17th May Committee.	
8. Patient experience report The Committee received the patient experience report which had been discussed in detail at the quality and patient safety sub-committee. The report provided an update on the patient experience strategy, including care to call roll out across the trust; a privacy and dignity audit and noise at night audit; and a working group to explore the best way to ensure patients in ED are getting regular drinks as required. It also advised the Committee of work on the backlog of complaints, including the upskilling to the complaints and PALS team working collaboratively to address patient concerns resulting in a reduction of formal complaints, and work to improve friends and family response rates. The Committee will receive further updates as part of its annual work plan.	**Green**
9. Implementation of the learning framework The Committee received a comprehensive update report on the implementation of the learning framework paper. The report provided an update and assurance on a number of projects that have been implemented and some that are under development, such as serious incident training which will change with the implementation of PSIRF. The Committee will continue to receive updates are part of its work plan.	**Green**
10. MS PHM Ethnicity inequity WL report – March 2022 The Committee received a comprehensive update from Simon Bailey, Director of Business Intelligence, Planning and Performance on the Medway and Swale Health and Care Partnership – Localised analytical response to ethnicity inequity in waiting lists study report. The report provided the Committee with assurance following a HSJ report on ethnicity inequity in waiting lists in January 2022, that the trust is not witnessing level of inequity in Medway and Swale for its waiting lists. The Committee were informed of further analysis taking place and will receive a report at a future Committee meeting.	**Green**
11. Well Led Core Service CQC action plan The Committee noted the well led core service CQC action plan was included as part of the quality, safety and risk report and discussed under that agenda item.	**Amber/Green**
12. Quality and Patient Safety Sub-Committee terms of reference and work plan The Committee received the terms of reference and work plan for the quality and patient safety sub-committee for approval. The Committee approved the terms of reference and work plan.	**Green**
Escalation to Board No items were identified for escalation to Board.	

The Committee inform the Board on the following points: • Suspension of continuity of care in maternity • Quality and Patient Safety Sub-committee is providing QAC with improved assurance • Learning framework to be commended to the Board • Thanks to the Medway and Swale Health and Care Partnership Board – Localised analytical response to ethnicity inequity in waiting lists study report.	

Meeting of the Trust Board in Public – 11 May 2022

Title of Report	**Patient Experience**		**4.3**
Report Author	Heidi Jeffery Lyndsay Barrow		
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer		
Executive Summary	Person centred care lies at the centre of all that we do. Ensuring patients have a good experience is a key strategic priority for the Trust. Gaining a full understanding of patients' experienced of their care is a key component to successfully delivering high-quality care and services. It is widely known that a positive experience of care leads to positive clinical outcomes for patients and if a patient feels listened to and involved in their care they will respond better to medical, nursing and therapy interventions and manage their own journey of care. The Quality Assurance Committee received a paper in February 2022 outlining the development and pace of the patient experience strategy along with a range of other initiatives to support patient experience improvements. This report provides a summary update on the Trust's Patient Experience agenda.		
Resource Implications	Nil		
Legal Implications/ Regulatory Requirements	Nil		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	The Board is asked to note the report.		
	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒
Appendices	None		

1 INTRODUCTION

At Medway NHS Foundation Trust, putting our Patients First and ensuring they receive person centred care is at the heart of all we do. Ensuring patients have a good experience is a key strategic priority for the Trust. Gaining a full understanding of patients' experience of their care is a key component to successfully delivering high-quality care.
This report provides key update related to patient experience in February/March 2022 with further work underway to triangulate information from multiple sources to inform the patient experience strategy and support divisions with informing improvement work.

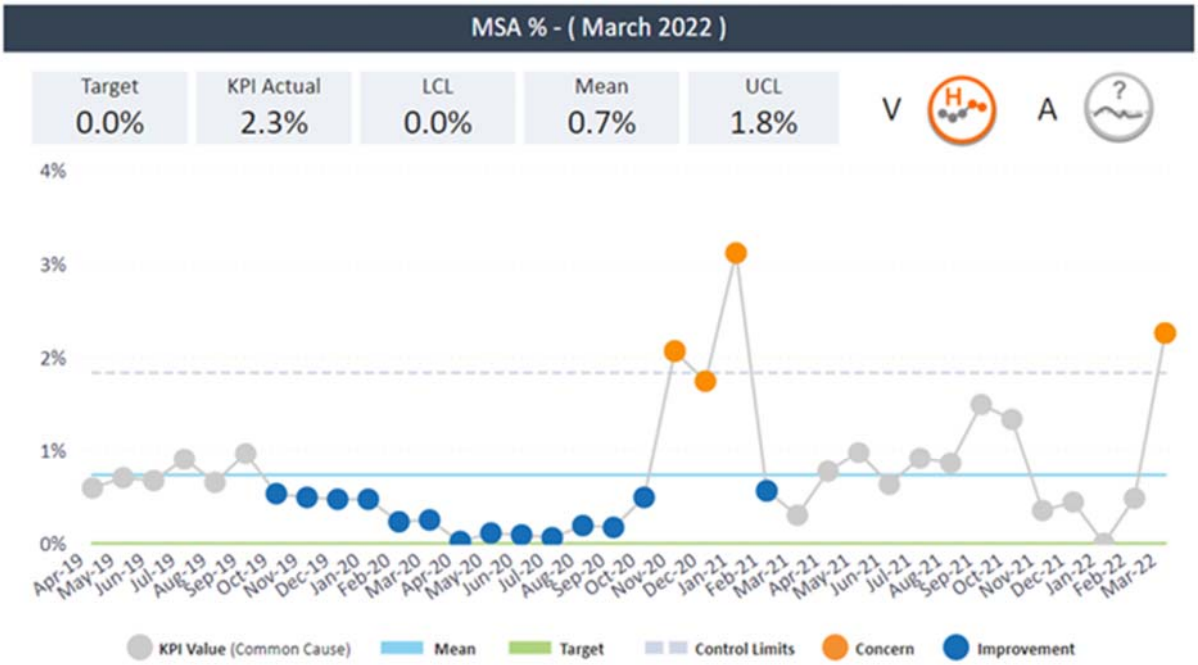
2 UPDATE IN RELATION TO PATIENT EXPERIENCE STRATEGY

Following the Board's approval of the Trust's Patient Experience Strategy and detailed delivery plan, this section provides an update on the delivery of the patient experience strategy implementation plan:

- **Action No 2.3:** *Ensure the following initiatives are fully embedded in the Trust - I care to call framework.*
  Update Summary: "I Care to call" is a campaign designed for our wards to call our patients' relatives, as required, on a daily basis, to ensure they are updated on how their loved one's care. This campaign was launched following feedback from relatives who faced problems reaching out for an update. After successfully piloting on the frailty wards it has now been rolled out across the Trust. United Lincolnshire Hospitals NHS Trust (ULHT) showed an interest in our work and we have shared information about the pilot with them. We now work with them collaboratively sharing successes, obstacles and best practice with this initiative.

- **Action No 1.13:** *Ensuring high standards of privacy and dignity for patients, relatives and carers.*
  Update Summary: A privacy and dignity audit has been newly introduced on the Trust's Gthr platform. This will be monthly peer review audit carried out by Ward Managers to identify issues with maintaining patient's privacy, especially when curtains are pulled around the bed space. The findings of the audit will be monitored through the divisions and the Trust's Patient Experience Group.

- **Action No 1.8:** *Review, revise and relaunch eliminating mixed sex accommodation policy, procedure and practice.*
  Update Summary: There have been a higher number of unjustified breaches in March. This has been due to operational bed pressures difficulties in stepping down patients from critical care to level one ward based care. Collaborative working within the divisions, site team, and the IPC team has ensured patient safety and dignity is maintained when a breech has occurred. Understanding the length of time each breach takes before being resolved, Ward Managers are ensuring that Datix incident is completed and investigated.



- **Action No 1.5:** *Improve the experience of patients with challenging behaviours such as mental ill-health, dementia, delirium.*
  Update Summary: The new Enhanced Care Service includes Dementia and Delirium and mental health under the heading of 'Enhanced Care Service'. The aim is to improve the quality of care and experience of challenging behaviour. The team will ensure patients with challenging behaviours are monitored therapeutically and effectively. Enhanced Care Support Workers (CSW) are currently being recruited into the team, working closely with the Kent and Medway NHS and Social Care Partnership Trust on the training requirements for the CSWs. The Clinical Nurse Specialist for Mental Health (CNS MH) has completed a review of all wards to better understanding the systems, processes and support available to patients with challenging behaviour to ensure they receive the best care. The findings/recommendations are currently being implemented.

- **Action No 2.2:** *Develop a range of options for obtaining real time feedback: on discharge, end of life, etc.*
  Update Summary: The Friends and Family Test (FFT) is a national survey designed to give the public an easy way to express their feedback. The Executive Team met to finalise and agree the Trust's five breakthrough objectives, a significant step forward with the Patient First programme. The key breakthrough objective linked to the patient experience strategy is '*95% of patients completing the friends and family test would recommend us as a place to receive care'.* This will see an increase in both the number of people responding to FFT and in those that would recommend us as a place to receive care.

	Jan 22	Feb 22	Mar 22
Inpatient (including daycase)			
Response rate	17.9%	19.1%	19.6%
% Recommend	78%	76%	81%
A&E			
Response rate	14.3%	14.8%	14.2%

% Recommend	79%	74%	71%
Inpatient (paediatrics)			
Response rate	10.1%	10.59%	9.6%
% Recommend	72%	69%	71%
Maternity overall			
Response rate	21.4%	12.4%	13.3%
% Recommend	99%	100%	99%
Response rate	7.8%	7.6%	7.3%
% Recommend	89%	89%	89%

A number of actions have been taken so far to improve the number of patients responding and increasing the number of patients who would recommend us:

- A review as part of the Patient First programme to understand the reasons for the low response rate and low recommendation rate. Work is underway to identify different ways of obtaining patient feedback
- The patient experience team and the Communication team are working together to develop the Trust's patient feedback survey questions.

- **Action No 3.3:** *Development of a volunteering and carers strategy*
- **Update Summary:** There are currently 95 volunteers in the Trust. A review is underway to understand how volunteers are currently utilised across the Trust with the aim of developing a strategy. A listening event is being organised to enable current volunteers in being involved in the development of the strategy. The volunteering job description is being revised, alongside setting out the principles for how the Trust will work with carers. A new therapy dog, Phoebe has been welcomed to the Trust and is currently working with the team to complete her assessment before she will become a regular member the team. Fred and Yazzy continue to be in popular demand across the Trust and have helped patients specifically in ward areas.

3 PATIENT ADVICE AND LIAISON (PALS) AND COMPLAINT SERVICE

For the month of March 2022, 417 contacted were registered by the PALS team. This is a significant increase on the 289 contacts that were registered in the same period last year, and continues to reflect the appetite of patients, families and staff for early resolution. The top themes for PALS concerns include, outpatient appointments, communication with relatives and patients, dissatisfaction with nursing or medical care and staff attitude.

In order to resolve issues and concerns swiftly and effectively, the PALS team work collaboratively with divisional, department and ward colleagues in many cases and rely on responsiveness and early action

Following assessment and individual remedy between 30–40 formal complaints are dealt with swiftly by PALS with a successful conclusion for the complainant.

Formal Complaints Performance

	Jan 22	Feb 22	Mar 22
No of new complaints	30	22	48
No of closed cases	17	14	11
No closed in 25 days (%)	33.3%		
Re-opened cases	1		

The main three types of complaints received were around:

- Aspects of clinical treatment
- Staff attitude
- Communication / information to patients

The management of complaints will be centralised as part of the corporate Quality team with close working with Divisions.

There were no new cases opened by the Parliamentary and Health Service Ombudsman and no cases closed. There is currently one case being investigated and seven cases under assessment. .

Actions include:

- Appointments being reviewed and brought forward if clinically indicated
- Apology for rudeness from a staff member or their manager.
- Calls to relatives or patients who require speaking to a pathway coordinator or nurse or doctor
- Issues relating to care expedited to the senior sister, matron or nurse in charge for swift remedy.

Compliments

Recognition of good care from patients and families is very much appreciated and there is currently more work being done to standardise how compliments are being received. An example of compliments received are:

I recently retired after 20 years of NHS service, the last 5 at Medway. During this time I have heard many comments relating to service provided.

My husband contracted covid and went downhill very suddenly. After speaking with 111 and Medocc I was advised to take him to A&E, where he was seen quickly and treated very well. He was admitted to Wakeley ward 3 hours later. He was diagnosed with Covid pneumonitis and T1RF.

We would like to thank the staff on the ward who were extremely caring which I understand from my husband was very difficult for them. He was treated with the utmost dignity at all times. Special thanks and our utmost gratitude go the FY2 ?????, who was absolutely excellent in the way he cared for my husband. He phoned me on several occasions so that I was kept up to date with my husband's progress and his treatment. He was aware that my husband was becoming depressed and he wasnt getting any sleep due to the condition of some of the patients on the ward. As his sats had improved my husband was allowed home.

??? is an excellent doctor and Medway should be very proud of him. He is a credit to the profession and we are truly thankful to him getting my husband well and on the road to a full recovery.

I was proud to work at Medway. People are quick to complain about the service but my husband received the best care for which we send our thanks

"Fast and friendly MRI scan★★★★★
Would like to thank staff at Ultrasound reception and MRI staff. Appointment on 13/2 was on time. Receptionist was friendly and MRI radiographers were efficient, friendly and carefully explained the procedure. They are all great ambassadors for the service."

4. CONCLUSION

Progress continue to made with clearing the backlog of complaints and ensuring a robust policy is in place will improve responsiveness to patients and their families and provide reassurance that their concerns have been taken seriously. It will also allow designated time to concentrate on identifying and introducing positive changes and improvements.

A combined incident and complaints new flash report will be introduced to keep complaint handling at the forefront of people's minds.

The Board is asked to note the paper.

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 11 May 2022

Title of Report	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Safety Action 8, 9, 10**	**Agenda Item**	**4.4**
Report Author	Evonne Hunt, Chief Nursing Officer		
Lead Director	Dot Smith, Head of Midwifery Kate Harris, Interim Head of Midwifery		
Executive Summary	This report provides the Trust Board with oversight and assurance with regards to progress against achieving compliance with the requirements of NHS Resolution Year Four Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The report will focus on the following Safety Actions: • Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? • In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4? • Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? • Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22? Year 4 of the CNST MIS launched on the 8th August 2021. The maternity service has provided assurance reports as follows: • Quality Assurance Committee (QAC) on the 19th October 2021 – Oversight report • Trust Board in Private 4th November 2021 – Oversight report and Perinatal Surveillance Tool • QAC on the 21st December 2021 – Safety Action 2, 3, 4 • Trust Board in Private 12th January 2022 – Safety Action 1 and Perinatal Surveillance Tool • Trust Board on the 13th January 2022 – Safety Action 2, 3, 4 • QAC on the 22nd February 2022 – Safety Action 5, 6, 7 • Trust Board in Private on the 9th March 2022, Safety Action 1 and Perinatal Surveillance Tool • Trust Board on the 9th March 2022, Safety Action 5, 6, 7		

	• QAC on the 26th April 2022, Perinatal Surveillance Tool and Safety Action 1 • QAC on the 26th April 2022 – Safety Action 8, 9 10 The report requests that the Board notes the detail of the report and progress against compliance.	
Link to strategic Objectives	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐
	Finance: We will deliver financial sustainability and create value in all we do	☐
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Women's and Children's Care Group Board, March 2022 Planned Care Divisional Board, March 2022 Maternity and Neonatal Safety Champion Assurance Board, March 2022 Patient Safety and Quality Sub Committee, April 2022 Quality Assurance Committee, April 2022	
Resource Implications	No additional resource implications	
Legal Implications/Regulatory Requirements	Compliance with CNST Year 4, Ockenden (2020)(2022) , CQC	
Quality Impact Assessment	N/A	
Recommendation/ Actions required	The Board is asked to: state decision required i.e. review, approve, note. [For example: The Board is asked to approve the Safeguarding Policy].	

Approval	Assurance	Discussion	Noting
☐	☒	☐	☒

Appendices	

1 Executive Overview

1.1 This report provides the Board with oversight and assurance with regards to progress against achieving compliance with the requirements of NHS Resolution Year Four Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The report will focus on the following Safety Actions:

- **Safety action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
  In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?
- **Safety Action 9:** Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
- **Safety Action 10:** Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

1.2 Year 4 of the CNST MIS launched on the 8th August 2021. The maternity service has provided assurance reports in line with the reporting schedule below:

Month	QAC	Private Board	Public Board
Oct-21	Overview		
Nov-21		Perinatal Surveillance Tool & Safety Action 1	Overview/Workforce
Dec-21	Safety Action 2,3 & 4		
Jan-22		Perinatal Surveillance Tool & Safety Action 1	Safety Action 2, 3 & 4
Feb-22	Safety Action 5, 6, 7		
Mar-22		Perinatal Surveillance Tool & Safety Action 1	Safety Action 5, 6 & 7
Apr-22	Safety Action 8, 9, 10		
May-22	Final Oversight Report	Perinatal Surveillance Tool & Safety Action 1	Safety Action 8, 9, 10/ Workforce
Jun-22			Final Oversight report

1.3 The report advises the Board that NHSR issued a pause letter for CNST in December 2021, in response to the challenges currently faced by the NHS and maternity services. This pause is for a minimum of 3 months, and further details regarding guidance and overall deadline will be made available following the meeting of the MIS Collaborative Advisory Group (CAG) in February 2022. At the time of submission of the report (April 2022) the scheme had not been relaunched, but this is anticipated imminently. Once the details of the guidelines are known the maternity service will provide an oversight report to the QAC and Trust Board and propose an ongoing reporting schedule to comply with the revised requirements and timescales.

1.4 NHSR have however, asked Trusts to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. NHSR advise that this should include:

- Undertaking midwifery workforce reviews
- Ensuring oversight provided by maternity, neonatal and board level safety champions continue
- Utilising on-line training resources
- Reporting to MBRRACE-UK and HSIB
- Make Maternity Services Data Set Submissions to NHS Digital.

1.5 The Maternity service therefore have continued with the approved reporting schedule and continue to progress all actions to achieve compliance with the 10 Safety Actions until further guidance is received.

1.6 The report requests that the Board:

- Notes the detail of the report and progress against compliance.

2 Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

2.1 The following training information is also included in the Perinatal Surveillance Tool report that is being presented to Trust Board in Private in May 2022. Both CNST Safety Action 8 and the perinatal surveillance tool require updates on training compliance as part of the reporting schedule.

2.2 In Year 4 CNST requires all Trusts to review their local training plan in line with the Core Competency Framework and ensure that the training plan incorporates all six core modules over the next 3 years. The lead midwife for education has reviewed the Core Competency Framework and undertaken a benchmarking against the requirements of the Core Competency Framework. The findings of this benchmarking reflected that the training already provided as part of Obstetric Emergency Training and Essential Skills Training covers much of the requirements of the core competency framework, with minor gaps identified. All specialists who deliver training have met with the lead midwife for education and are in the process of revising their training content to ensure it aligns to the requirements of the core competency framework, including personalised care and learning from local incidents. The local training plan has been drafted to align to the core competency framework and this will be circulated for comment and approval once the new CNST guidance is released to ensure it meets all the requirements of the new guidance.

2.3 Trusts are also required to evidence that all relevant staff groups have attended an 'in-house' one day multi-professional obstetric emergency training. The Maternity Service runs Practical Obstetric Multi-professional Training (PROMPT) annually for all relevant staff groups. This is face-to-face training, however due to Covid-19 and staffing pressures, this was paused in

February 2022 and March 2022 (3 sessions). Face-to-face training was reinstated in April 2022. To support compliance during the pause, and in line with CNST guidance the following actions have been implemented:

- E-learning has been sent to all staff booked for training in February and March 2022.
- Staff who have completed e-learning will be prioritised for face-to face training when the new training year starts in September 2022.
- Staff training booked for remainder of the training year, with a mapped trajectory (in line with current CNST deadline) as below.

Staff Group	Current YTD Compliance PROMPT	CNST Compliance TRAJECTORY (Compliant + Planned) PROMPT 6.8.21-30.6.22
Midwives	59.69%	94.24%
MSW	49.06%	90.57%
Obstetric Consultants	58.33%	83.33%
Obstetric Junior Doctors	50.00%	83.33%
Anaesthetic Consultants	44.44%	88.89%
Anaesthetic Junior Doctors	41.18%	82.35%

2.4 In order to improve PROMPT compliance across all staff groups, the following actions have been put in place:

- The education team are working closely with the Clinical Director from Women's Health and the obstetric anaesthetic lead to ensure compliance amongst these staff groups.
- All Anaesthetic and obstetric medical staff have training spots allocated to them on their rota.
- E-learning will be utilised to support compliance during periods of covid-19 related absence or clinical pressures preventing attendance.
- It is anticipated that the deadline for achieving 90% compliance will be extended beyond 30th June 2022, and therefore there will be additional time to allocate training sessions and achieve a trajectory and final compliance figure of >90% for all staff groups for CNST year 4.

2.5 The above actions have been captured on the Maternity Quality Improvement Plan and will continue to be monitored via CNST Safety Compliance Group, Women's and Children's Care Group Governance and Planned Care Governance meeting, with appropriate channels of escalation in place.

2.6 Safety Action 8, in repetition of Safety Action 6, also requires 90% of relevant staff to have attended an 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance. The report assures the Board that this training is in place and is run by the Fetal Wellbeing Midwives and Obstetric Lead for CTG and

simulation. All relevant staff participate in this training and are required to complete and pass an assessment.

2.7 The current compliance figures for Fetal Monitoring training are outlined in the table below, with a trajectory in place to achieve 100% before the current CNST submission deadline.

Staff Group	Current YTD Compliance Fetal Monitoring Training	CNST Compliance TRAJECTORY (Compliant + Planned/Online) Fetal Monitoring 6.8.21-30.6.22
Midwives	87%	100%
Obstetric Consultants	78%	100%
Obstetric Junior Doctors	78%	100%

2.8 The following actions are in place to support compliance:

- All staff allocated a training position and this is allocated on their rota.
- Face-to-face training has been continued until March 2022 when it was paused due to staffing and Covid-19 pressures.
- Fetal Wellbeing team have developed an e-learning module to support compliance, implementing this will see 100% compliance for all staff groups by May 2022.
- Training will then restart in June 2022 in line with new regional physiological guidance.

2.9 CNST also requires 90% compliance with NBLS training for relevant staff groups. Currently, all staff groups are below 90%. In order to support compliance with NBLS training the following actions are being completed:

Staff Group	Current YTD Compliance NBLS
Midwives	89.72%
Obstetric Consultants & Junior Doctors	58.33%
Neonatal Medical	85.71%
NICU Nursing	78.75%

- A local review of compliance is underway as CNST requires each individual staff group to achieve 90% (eg. Consultants and junior doctors) and ESR does not provide this breakdown and can also take sometime to update junior doctors when they rotate in or out of the service, adversely

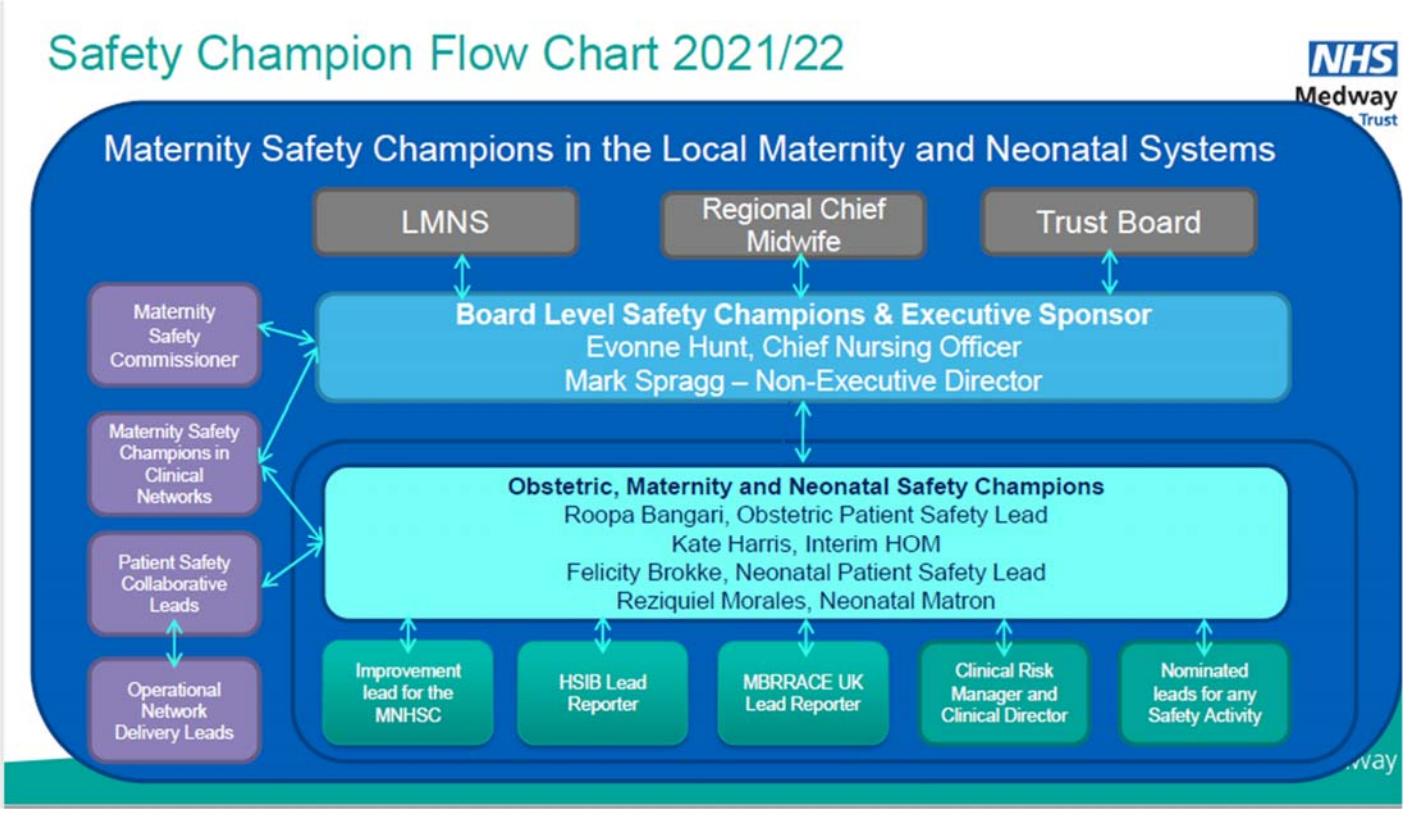
affecting compliance. This piece of work will be completed alongside the next rotation of junior doctors and be reported to QAC and Board in due course.

- The current compliance rate has been escalated to all relevant leads and will be monitored via CNST Safety Compliance Group and local governance meetings.

3 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

3.1 The report assures the Board that the Maternity and Neonatal Service have appropriate processes in place to meet the requirements of Safety Action 9.

3.2 CNST requires that an appropriate pathway is in place to describe how intelligence is shared from floor through Board, through Local Maternity and Neonatal Systems (LMNS) and the regional chief midwife. The report confirms that this pathway was revised in line with CNST year 4 requirements.



3.3 The report confirms that the names of all the Safety Champions are available to the Maternity and Neonatal staff via posters displayed in the clinical areas, along with flow charts outlining their roles and responsibilities. Monthly walk-arounds by the Board Level Safety Champion have

continued monthly, with the exception of January 2022. NHSR has asked that these continue during the pause and the Maternity and Neonatal Service will continue to welcome the Board Level Safety Champions onto the units to give the opportunity to provide feedback and express any safety concerns.

3.4 To support the work of the Safety Champions, there is a robust governance structure in place with reporting from speciality through Care Group, Division, Executive Level and Trust Board.

3.5 A SOP is now in place that outlines the process for reporting to Trust Board in line with Ockenden (2020) requirements and CNST Safety Action 9 (SOP0718). A report that meets the requirements of the perinatal surveillance tool is presented to the Maternity and Neonatal Safety Champion Assurance Board bi-monthly and to each Trust Board in Private. The reports to Trust Board in Private include the following:

- Details and immediate learning and actions from SIs declared in each quarter,
- Cases reviewed using the Perinatal Mortality Review Tool (PMRT)
- Cases referred to the Health Service Investigation Branch (HSIB)
- Staffing
- Training
- Staff and service user feedback
- Progress against the 10 Clinical Negligence Scheme for Trusts (CNST) Safety Actions.
- The accompanying report will include themes and trends from incidents, along with actions and mitigations in place.
- The report will also include a compliance and progress report against CNST Safety Action 1 which focuses on cases reviewed by PMRT.

3.6 The reporting schedule for the current CNST reporting period to Trust Board in Private outlined above in 1.2. It is expected, as outlined in the SOP, that this will continue beyond the current CNST reporting period to meet the quarterly reporting requirements.

3.7 CNST also requires that the Trust Claims scorecard be reviewed alongside serious incidents and complaints and this has been included in the report to Trust Board in Private on the 9th of March 2022.

3.8 CNST requires Board Level oversight of the plans to implement Continuity of Carer (CoC). An initial pilot team, Team Connect, has been in place since September 2021. This caseload for this team were women with complex social or safeguarding concerns, however whilst continuity of care is important in supporting good outcomes for these women, the shift to providing intrapartum continuity was having an adverse effect on the allocated midwife being able to attend safeguarding meetings has significantly reduced. Due to the critical nature of these meetings for making decisions and supporting the best outcomes for families, it was agreed that Team Connect would revert back to a traditional community model in order to best support their safeguarding work.

3.9 Since this paper was presented at the Maternity and Neonatal Safety Champion Assurance Board on 23rd March 2022, the second and final Ockenden report has been published on 30th March 2022. In this report, the recommendation was made for Trusts to immediately suspend current and future CoC unless safe staffing could be met. In response to this, the maternity service provided an assurance report to the Trust Management Board on 6th April 2022 to advise:

- That existing continuity team (Safeguarding team) had been disbanded as a continuity team in March 2022 due to concerns regarding the ability of staff to provide appropriate representation at Safeguarding case conferences whilst providing intrapartum care.

- That all plans for further roll out of CoC have been paused until safe staffing against the CoC model has been achieved. CoC requires an increase to the workforce to support a reduction in the number of women on each caseload. This cannot be achieved with current staffing levels, skill mix and vacancy.
- The report however assures the Board that safe staffing is currently being achieved, based on current caseload and working patterns. One to One care in labour is being maintained at 100% and any staff shortages are being mitigated by movement of staff across the unit in line with the escalation policy

3.10 In order to achieve safe staffing levels the maternity service have taken the following actions:

- Full workforce review using the Birth Rate Plus methodology completed. Recommendations and reporting to following in coming months.
- NHSIE review of workforce to support local Birth Rate Plus Review
- Supporting staff to undertake midwifery training through apprentice and nursing to midwifery courses
- Workforce working group in place, who have undertaken the following actions:
    - Refreshed and reinstated the rolling recruitment programme
    - Actively engaging in international recruitment, both locally and as part of a LMNS-wide programme.
    - Actively engaging with universities and students to promote recruitment of newly qualified midwives.
    - Working closely with the communications team to promote Medway maternity as a place to work.
    - Liaising with HR to understand exit interviews and working on ways to improve retention, including additional support for newly qualified staff

3.11 The service awaits further guidance from CNST as to the requirements for CoC in CNST year 4 and further national guidance on the expectations for how and when CoC can be reintroduced.

3.12 CNST requires that Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). The report assures the QAC that the maternity and neonatal safety champions have attended the required engagement events and are active participants in the MatNeoSIP programme. Current QI projects include the Covid-19 virtual clinic for pregnant women in the community who test positive with Covid-19. This service has been praised as a “gold-standard” by the Health Service Investigation Branch (HSIB) and was recently presented at the regional MatNeoSIP meeting and our local Maternity and Neonatal Safety Champion Assurance Board (M&NSCAB). Other QI projects include delayed cord clamping for pre-term infants and the implementation of an antenatal optimisation bundle. The work of the maternity

and neonatal safety champions is supported by the Board Level Safety Champions via the M&NSCAB meeting.

3.13 In line with the requirements to use insights from culture surveys to inform local quality improvement plans, the Maternity and Neonatal Safety Champions have worked with the Trust Staff Wellbeing team to develop a culture survey which is due to be launched in May 2022. The findings from this survey will form part of the Maternity Quality Improvement Plan.

4 Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22

4.1 As in Year 3, CNST requires maternity services report all eligible cases to HSIB and in turn NHS Resolution's Early Notification (NHSR EN) scheme.

4.2 The report assures the QAC that to date, all eligible cases have been reported to HSIB and duty of candour has been applied for all cases.

4.3 From April 2020, the responsibility for reporting to NHSR EN moved to HSIB, and to date, all eligible have been reported the NHSR EN. The report advised the QAC that a recent case which is eligible for reporting to NHSR EN has not yet been reported as the parents have declined the HSIB investigation. The Risk midwife is working with HSIB and the legal team to ensure that the case is still reported to NHSR EN as this is a separate process to a HSIB investigation and does not require the same level of parental consent.

4.4 The report advises the Board that from April 2022, the responsibility for reporting to NHSR EN has reverted back to Trusts. The report assures the Board that this change has been implemented with both the maternity and legal teams, and the SOP for reporting to HSIB and NHSR EN updated accordingly.

5 Conclusion and Next Steps

5.1 The report advises the Board of the ongoing pause to CNST year 4 as of the 23rd December 2021, and assures the Board that all actions and requirements will continue to be monitored until further guidance is received from NHSR. Once further guidance is received, an update and any proposed changes to the reporting schedule will be provided to the QAC and Trust Board.

5.2 The report has assured the Board that the Maternity Service is taking appropriate steps to achieve compliance with Safety Actions 8, 9 and 10. The report notes the challenges in achieving 90% compliance with training as per Safety Action 8, but assures the Board that appropriate mitigations are in place.

5.3 The report advises Board that in line with the recommendations of the Ockenden report published on 30th March 2022, all CoC teams have been suspended and future plans have been put on hold until safe staffing against the CoC model can be achieved.

Meeting of the Board of Directors in Public
Wednesday, 11 May 2022

Title of Report	**Finance report**	**Agenda Item**	5.1
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 breakeven against the NHSE/I control total.		
Link to strategic Objectives	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
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 March 2022

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(163)	(356)	(193)	The Trust reports a £356k deficit position for March; reducing to breakeven in month and year to date after making the technical adjustments for donated assets and impairments to report against control total. The reported position includes Elective Recovery Funding (ERF) income of £4.6m in H1 and £4.4m for year to date in H2, this covers the incremental costs of delivering ERF activity. Included in the year end position is £9.2m additional pension contribution, this is offset by additional income, a £1.5m increase in depreciation for assets that are now operational and no longer categorised as under construction, an increase in the annual leave accrual of £1.5m to £4.7m, and clinical excellence awards for 21/22 of £0.4m. Excluding these pressures, this month's pay expenditure has increased by £0.6m to £22.0m; non-pay costs have increased by £3.6m mainly due to year end stock adjustments, independent sector accruals and estates expenditure as forecast. The £1.3m contingency has been fully utilised to offset some of these major movements in March, as well as the £2.5m support funding agreed with the CCG.
Donated Asset Depreciation	163	356	193	
Control Total	**-**	**-**	**-**	
Efficiencies Programme				
In-month	502	395	(107)	The in-month position is reporting a £0.1m adverse to plan for March, and £1.0m adverse for the year, this represents the gap between identified schemes and the overall plan of £5.1m. The delivered efficiency programme position of £4.1m includes £0.3m of the full year effect of schemes continuing from 2020/21.
YTD	5,171	4,143	(1,028)	

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Capital				
In-month	9,886	8,482	(1,404)	The Trust Capital Resource Limit (CRL) and plan was set at £13,877k for 2021/22 by the ICS at the start of 2021/22.
Outturn	22,782	22,777	(5)	Throughout the year an additional £8,904k of spending capacity was granted to increase the capital. funding budget to £22,781k This was achieved via £631k charitable donations, £7,286k PDC, £987k additional ICS allocation (funded from Trust internal reserves). The Trust spent £22,777k which resulted in a £5k underspend for the year overall. However, whilst all capital funds have been spent many projects slipped against the original plan due to access restrictions, late funding allocations and in some cases a lack of forward planning. Contingency schemes were agreed to ensure maximum investment was achieved but not necessarily addressing Trust priorities. Notably PDC funded schemes underspent by £857k which is a breach of the funding agreement with DH which requires all funds to spent by 31st March on the specific outcomes being prioritised. Contingency expenditure has allowed the Trust to retain the funds under condition that the projects are internally funded for completion in 22/23. The 2022/23 capital plan is yet to be finalised which may have the same impact in the new financial year.

Cash				
Month end	49,184	33,455	(15,729)	Cash balances have decreased in month by £8.9m mainly due to the CCG advance made in 2019/20 being reclaimed in March, and bi annual payment of PDC dividends.

Activity is below draft budgeted levels as a result of Covid	Clinical income based on the 21/22 consultation tariff would have reported a year to date position of £260.1m, this being £6.6m lower than income in the same period of 19/20. In month performance excluding high cost drugs is £29.0m, which is £9.4m higher compared to M11 reported figure.Most of this over performance is due to correction of a bug in the system which affected the pricing of Non elective activity in previous months. Section 3. (below) is included within the main body of the report, in order to provide Members with a better understanding of the patient activity position and how it impacts on the income and expenditure position.

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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	27,326	31,336	4,010	334,232	338,697	4,466
High cost drugs	1,817	2,055	238	21,951	22,414	462
Other income	2,044	12,899	10,855	22,384	37,021	14,637
PSF/MRET/FRP	0	0	0	0	0	0
Donated Asset Adjustment	0	1,445	1,445	0	1,713	1,713
Total income	**31,187**	**47,735**	**16,548**	**378,567**	**399,845**	**21,278**
Nursing	(8,088)	(8,854)	(765)	(96,103)	(98,871)	(2,768)
Medical	(6,347)	(9,662)	(3,315)	(76,278)	(81,289)	(5,011)
Other	(5,247)	(13,634)	(8,388)	(63,923)	(75,952)	(12,029)
Total pay	**(19,682)**	**(32,150)**	**(12,468)**	**(236,304)**	**(256,113)**	**(19,808)**
Clinical supplies	(3,836)	(5,837)	(2,001)	(46,604)	(50,593)	(3,989)
Drugs	(545)	(803)	(258)	(6,859)	(10,333)	(3,474)
High cost drugs	(1,817)	(2,029)	(211)	(21,994)	(22,478)	(484)
Other	(4,013)	(4,453)	(440)	(49,706)	(42,103)	7,602
Total non-pay	**(10,211)**	**(13,122)**	**(2,910)**	**(125,163)**	**(125,508)**	**(345)**
EBITDA	**1,294**	**2,464**	**1,170**	**17,100**	**18,224**	**1,124**
Depreciation	(905)	(1,900)	(995)	(10,741)	(11,677)	(936)
Donated asset adjustment	(8)	60	68	(96)	470	566
Net finance income/(cost)	2	17	15	20	12	(8)
PDC dividend	(545)	(997)	(451)	(6,533)	(6,976)	(443)
Non-operating exp.	**(1,457)**	**(2,819)**	**(1,363)**	**(17,350)**	**(18,193)**	**(820)**
Reported surplus/(deficit)	**(163)**	**(356)**	**(193)**	**(250)**	**54**	**304**
Adj. to control total	163	356	193	250	(54)	(304)
Control total	-	-	-	-	-	-

1. Funding arrangements for the full year 2021/22 have been agreed with the Kent & Medway CCG.
2. The clinical income YTD variance includes Targeted Investment Funding (TIF) £0.9m, support funding from the CCG £2.5m, income for medical devices £1.0m that are excluded from the block income payment; the actual cost of these devices is included in clinical supplies.
3. Other income favourable position includes over performance on P2P contracts, additional out of envelope covid income to cover vaccination and quarantine costs £0.5m, medical education contribution to overheads of £0.3m, drugs recharges offsetting overspending in clinical divisions, and £9.2m of funding for 6.3% increased pension costs; these are offset with cost included in other pay.
4. The final ERF income for 21/22 included is £8.9m.
5. Pay budgets continue to overspend due to additional escalation and activity pressures in the Unplanned Care division, this is partially offset by some areas of underspend including Covid and reserves.
6. Other pay includes £9.2m of additional pension costs, the funding is included in other income, as well as £1.8m increase in the annual leave accrual. The remaining balance includes the impact of reserve adjustments.
7. Medical staffing adverse variance is due to unfunded locum junior doctor shifts arising from increased escalation capacity as well as patient flow.
8. The adverse position in nursing is driven by the £0.5m vacancy factor budget held by the Planned Care division as well as higher bank staff to cover the unbudgeted escalation beds in UIC.
9. The £1.3m contingency included in the position in February has been fully utilised to deliver the breakeven control total for 2021/22.
10. Total Covid spend in-month is £0.5m, this excludes £1.6m of DoH year end stock adjustments that are offset with income.

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3. SLA Activity and Income

Clinical Income by Point of Delivery (POD)

The table below sets out the income and activity performance for the Trust at point of delivery (POD) as at month 12. The income has been calculated using 21/22 national tariff. The plan is based on 19/20 activity priced at 21/22 national tariff.

Providers continue to be funded on block contracts for the second half of 21/22 due to the Covid-19 pandemic.

M12 Income and activity performance (excl. HCD)

	In Month Movement £'000						YTD Month 12 £'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	940	1,443	504	5,613	8,652	3,039	14,505	15,684	1,178	86,656	91,609	4,953
Adult Critical Care	753	497	-256	726	574	-152	9,803	8,583	-1,220	9,456	7,777	-1,679
Block Contracts	246	246	0	-14	2	16	2,954	2,954	0	-321	-225	96
Chemotherapy	130	273	143	1,015	1,651	636	1,642	1,692	50	12,845	13,453	608
CQUIN	226	336	111	0	0	0	3,073	3,000	-72	0	0	0
Day Cases	1,344	2,051	707	1,772	2,261	489	20,256	17,338	-2,917	25,939	21,433	-4,506
Direct Access	751	998	247	202,602	205,678	3,076	11,005	10,769	-236	2,481,800	2,458,323	-23,477
Elective Inpatient	1,057	1,289	232	291	399	108	18,191	14,799	-3,392	5,128	4,161	-967
Excess Bed Days	376	1,448	1,072	1,319	1,455	136	2,155	3,252	1,097	7,435	11,177	3,742
Excluded Devices	36	129	93	32	6,415	6,383	863	1,848	984	818	68,113	67,295
Maternity Pathway	955	1,093	138	874	908	34	10,800	11,792	992	10,145	10,217	72
Neonatal Critical Care	790	688	-102	838	769	-69	9,955	8,346	-1,608	10,857	9,897	-960
Non Elective Inpatient	8,414	13,999	5,585	3,918	4,519	601	112,466	109,259	-3,208	51,781	54,259	2,478
Other cost per case	260	313	53	6,127	8,153	2,026	4,174	3,915	-259	72,827	76,067	3,240
Outpatients	3,489	4,272	783	37,390	39,704	2,314	44,204	46,230	2,025	446,417	444,273	-2,144
Paediatric Critical Care	58	-1	-59	82	-2	-84	734	684	-51	1,047	975	-72
Grand Total	**19,824**	**29,075**	**9,251**	**262,586**	**281,138**	**18,552**	**266,782**	**260,146**	**(6,636)**	**3,222,830**	**3,271,509**	**48,679**

The estimated value of the underperformance in M12 for the SLA income based on national tariff is £6.6m YTD (excluding high cost drugs), and over performance of £9.2m in the month. Most of this over performance is due to correction of a bug by Civica which affected the pricing of Non elective activity in previous months.

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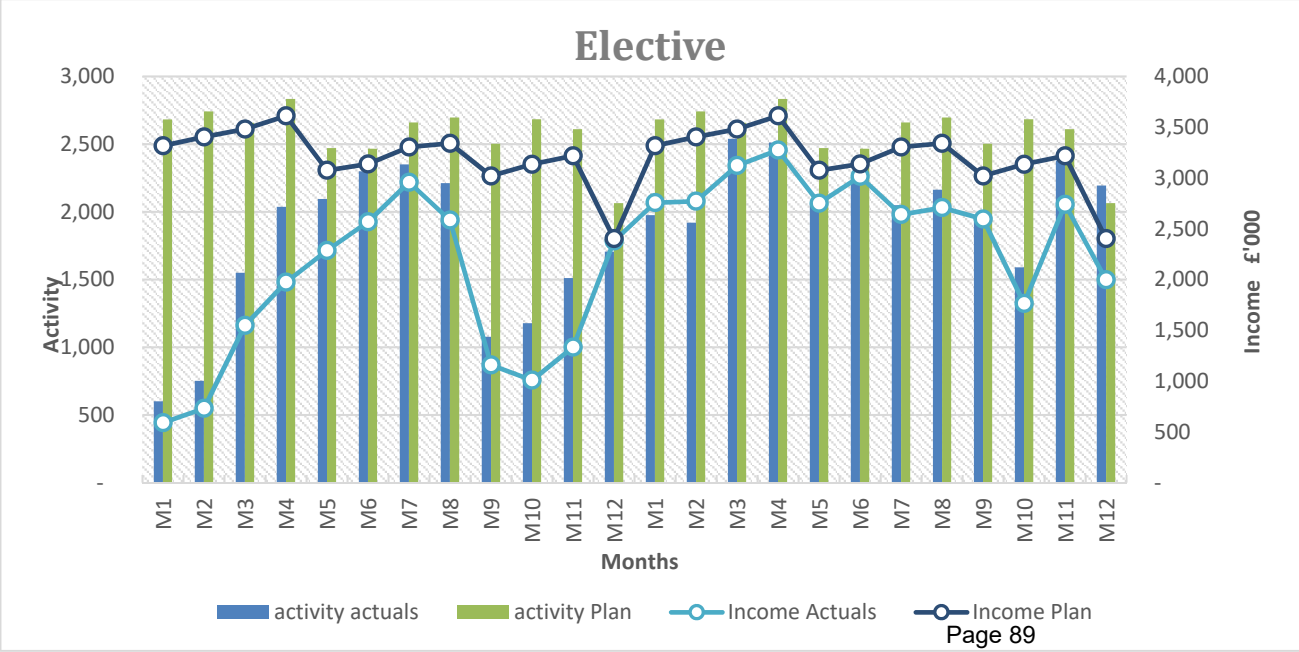
- The underperformance is within elective, day cases and non-elective inpatients. Non-elective is driven mainly by Stroke inpatient activity. Stroke services have moved to MTW and DVH but the activity and income remains within the budgets for MFT. Covid activity has a zero tariff in the national tariff and thus is diluting the case mix for Non-elective inpatients. Activity is above plan YTD but income is below plan as per the table above.
- Elective and day cases underperformance was mainly driven by the closure of surgical services to adapt to the surge in COVID patients and winter emergency activity
- Adult critical care bed days are below plan in month and YTD causing underperformance of £1.2m YTD
- Neonatal cot days are below plan and resulting in under delivery of income of £1.6m YTD
- Outpatient's income is above plan by £2.0m YTD mainly driven by high non face-to-face activity within follow-up, however overall activity is below plan due to low levels of radiology activity, which has a cheaper tariff.

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.

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 peak of the pandemic and during winter months. Month 12 is showing signs of improvement as the activity numbers have exceeded the planned activity.

Graph below shows activity and income for 20-21 and 21-22, income for 20-21 has been adjusted for comparability using 21-22 tariff.



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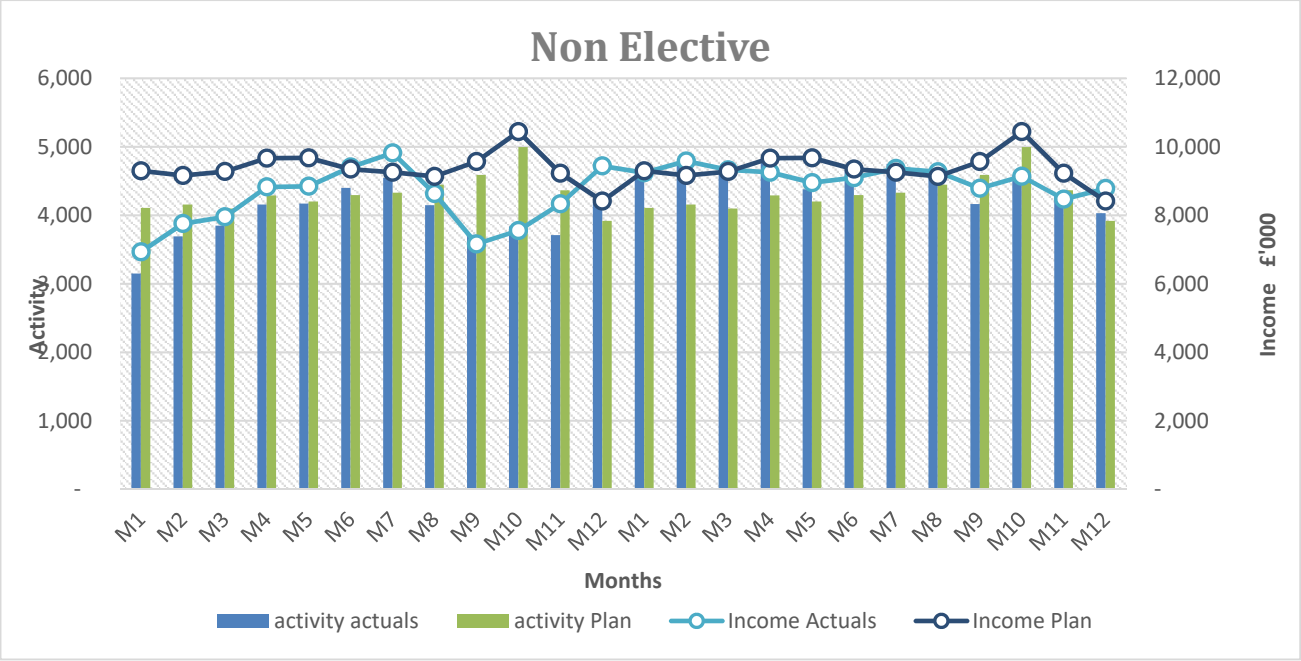
The table below shows monthly activity performance for 20-21 and 21-22 compared to that delivered in 19-20.

2020-21												2021-22											
M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
23%	29%	56%	71%	79%	83%	84%	82%	39%	44%	59%	59%	74%	70%	96%	89%	84%	91%	77%	80%	78%	59%	91%	106%

Non-elective activity and Income

Non-elective activity has been exceeding 19-20 levels for nine months of this year. 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.

Activity and income for 20-21 has been adjusted for comparability using 21-22 tariff.



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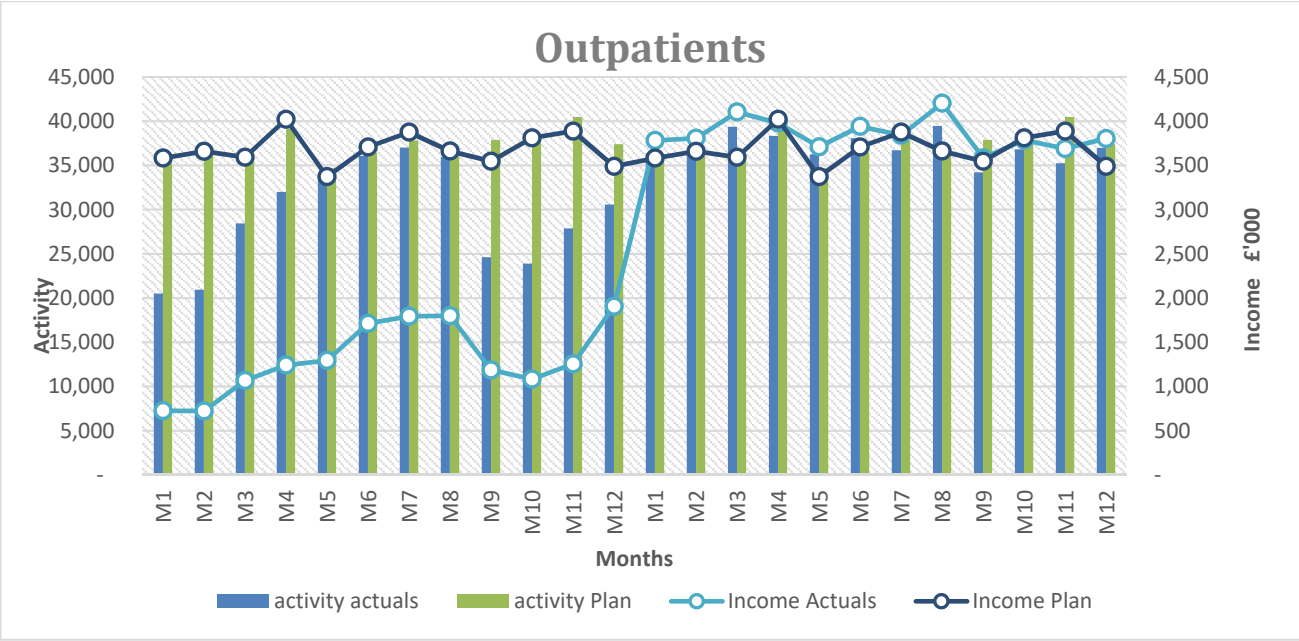
The table below shows monthly activity performance for 20-21 and 21-22 compared to that delivered in 19-20.

2020-21												2021-22											
M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
75%	88%	87%	90%	97%	99%	101%	96%	84%	89%	91%	91%	112%	115%	115%	111%	104%	109%	110%	102%	91%	92%	99%	103%

Outpatient income and activity

Outpatient activity has been higher than 19-20 level in most months of this year as shown in the graph below but it has reduced since December due to cancelation of clinics to cope with winter pressures.

Activity and income for 20-21 has been adjusted for comparability using 21-22 tariff.



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

2020-21												2021-22											
M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
64%	66%	84%	91%	104%	107%	108%	109%	74%	73%	90%	87%	102%	100%	110%	98%	105%	104%	97%	108%	90%	97%	87%	99%

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4. Efficiency programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Unidentified	YTD Plan	YTD Delivery	Variance
Planned care	70	1,347	53	0	1,470	**2,132**	(662)	2,132	1,430	**(703)**
UIC	179	1,457	0	0	1,636	**2,190**	(554)	2,190	1,935	**(255)**
E&F	21	407	0	0	428	**382**	46	382	420	**38**
Corporate	73	367	0	0	440	**467**	(27)	467	359	**(108)**
Total	**343**	**3,579**	**53**	**0**	**3,975**	**5,171**	**(1,197)**	**5,171**	**4,143**	**(1,028)**
Previous Month	343	3,579	53	0	3,975	5,171	(1,197)	4,669	3,806	(368)
Monthly Movement	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**502**	**338**	**(660)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**502**	**395**	**(107)**	**5,171**	**4,143**	**(1,028)**	**5,171**	**4,143**	**(1,028)**

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 is £5.1m including the full year effect (FYE) schemes from 20/21, which total £0.3m. Included in the year to date budget position are £4.0m of planned efficiencies and £1.1m schemes not identified, the actual performance of delivery across the services is £3.8m for 21/22 and an additional £0.3m for FYE schemes from 20/21.

This position has not changed significantly during H2 with efficiencies delivering approximately £0.3m per month; as forecast and noted to the committee previously, the £1.1m gap was not significantly closed with the final reported delivery of efficiencies being £4.1m, with a variance to plan of £1.0m.

The crosscutting efficiency schemes continue to be prioritised across all of the services with regular progress meetings and position reporting at the efficiency delivery group meetings.

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5. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
221,951	**Non-current assets**	**240,295**	**18,344**
6,962	Inventory	5,996	(966)
16,216	Trade and other receivables	13,633	(2,583)
49,184	Cash	33,455	(15,729)
72,362	**Current assets**	**53,084**	**(19,278)**
(137)	Borrowings	(136)	1
(37,101))	Trade and other payables	(27,890)	9,211
(8,839)	Other liabilities	(2,115)	6,724
(46,077)	**Current liabilities**	**(30,141)**	**15,936**
(2,151)	Borrowings	(2,025)	126
(1,424)	Other liabilities	(4,521)	176
(3,575)	**Non-current liabilities**	**(3,273)**	**302**
244,661	**Net assets employed**	**259,965**	**15,304**
453,870	Public dividend capital	461,656	7,786
(245,271)	Retained earnings	(245,216)	55
36,062	Revaluation reserve	43,525	7,463
244,661	**Total taxpayers' equity**	**259,965**	**15,304**

Key messages:

1. Non-Current Assets, £18.4m increase due to £11m capital investment in excess of depreciation and a £7.5m revaluation.

   This has a positive impact on the overall net assets of the Trust but comes with an additional £0.6m PDC dividend charge in I&E.

2. Inventory, All areas excluding pharmacy only hold stock counts at year end hence a decrease in stock balances in March whilst mainly static throughout the year, material movements are;
   - £485k PPE stock donated by DHSC in 2020/21 consumed in year
   - £440k theatre stock reduction due to improved stock management

3. Receivables have decreased by £2.6m from the prior year to £13.6m and represent approximately 42% of 1 month's average turnover (£32m).

4. Payables have decreased by £9.2m from the prior year due to the receipt and payment of material capital invoices; this balance includes £2.1m accrual for PDC dividend.

   Current payables balance represents 87% of 1 month's average turnover.

5. Other liabilities have decreased by £6.7m mainly due to the unwinding of an advance cash payment made by the main commissioner in 2019/20.

6. Total Trust borrowings are £2.2m and relate to long term capital loans issued by DHSC in a prior year.

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6. Capital

2021/22 Capital Expenditure Summary

£'000	In-month			2021/22 Final Position			FUNDING (CRL)				
	Plan	Actual	Var.	Plan	Actual	Var.	ICS	PDC	OTHER	TOTAL	PDC Variance
Backlog Maintenance	640	712	72	3,751	3,942	191	3,942	0	0	3,942	
Fire Urgency Works	362	1,010	648	2,581	2,749	168	2,749	0	0	2,749	
Emergency Department	46	187	141	1,257	187	(1,070)	0	0	0	0	
Information Technology	949	1,666	716	4,223	4,220	(3)	4,220	0	0	4,220	
Medical and Surgical Equipment Programme	922	692	(230)	1,133	995	(138)	995	0	0	995	
Service Developments	(1,389)	928	2,317	(80)	1,825	1,905	921	0	0	921	
Routine Maintenance	136	129	(7)	246	203	(43)	203	0	0	203	
Specific Business cases pending UTC	331	336	5	500	490	(10)	0	500	0	500	(10)
Total Planned Capex	**1,998**	**5,660**	**3,663**	**13,611**	**14,611**	**1,000**	**13,030**	**500**	**0**	**13,530**	**(10)**
Unfunded	(455)	(28)	427	0	(170)	(170)	0	0	0	0	
Capital Donation -schemes	0	0	0	557	631	74	0	0	631	631	
ICS Emergency Department	1,500	0	(1,500)	1,500	1,494	(6)	0	1,500	0	1,500	(6)
ICS KLS	600	282	(318)	300	342	42	0	300	0	300	42
Diagnostics CR/DR	440	463	23	440	463	23	20	420	0	440	43
UTF Cyber	155	152	(3)	155	152	(3)	0	155	0	155	(3)
UTF EPR	2,230	0	(2,230)	2,230	2,250	20	0	2,230	0	2,230	20
UTF Infrastructure	450	0	(450)	450	450	0	0	450	0	450	0
UTF Diagnostics	26	0	(26)	26	0	(26)	0	26	0	26	(26)
UTF Maternity	100	97	(3)	100	97	(3)	0	100	0	100	(3)
ICS Dolphin Ward	508	228	(280)	508	599	91	508	0	0	508	
ICS TMT to TVT	300	147	(153)	300	297	(3)	300	0	0	300	
ICS Site Generators	500	370	(130)	500	370	(130)	500	0	0	500	
SDEC - additional non-elective bed capacity**	(30)	67	97	541	138	(403)	0	541	0	541	(403)
virtual hub	100	122	22	100	122	22	0	100	0	100	22
day case trauma (2 rooms Phoenix)	30	0	(30)	30	0	(30)	0	30	0	30	(30)
Sunderland day case capacity**	20	20	0	20	20	0	0	20	0	20	0
MRI upgrade	198	0	(198)	198	0	(198)	0	198	0	198	(198)
Pre and intra operative digital solution/Safersleep	500	265	(235)	500	273	(227)	0	500	0	500	(227)
Video consultation platform	82	91	9	82	91	9	0	82	0	82	9
Digital Diagnostics irefer**	175	182	7	175	182	7	0	175	0	175	7
Digital Diagnostics home reporting	309	249	(60)	309	251	(58)	0	309	0	309	(58)
Imaging and Endoscopy Academies	16	0	(16)	16	0	(16)	0	16	0	16	(16)
Advice/Referal Optimisation	134	114	(20)	134	114	(20)	0	134	0	134	(20)
Total Additional Capex	**7,888**	**2,822**	**(5,067)**	**9,171**	**8,166**	**(1,005)**	**1,328**	**7,286**	**631**	**9,245**	**(847)**
Contingency											
Total Capex	**9,886**	**8,482**	**(1,404)**	**22,782**	**22,777**	**(5)**	**14,358**	**7,786**	**631**	**22,775**	**(857)**

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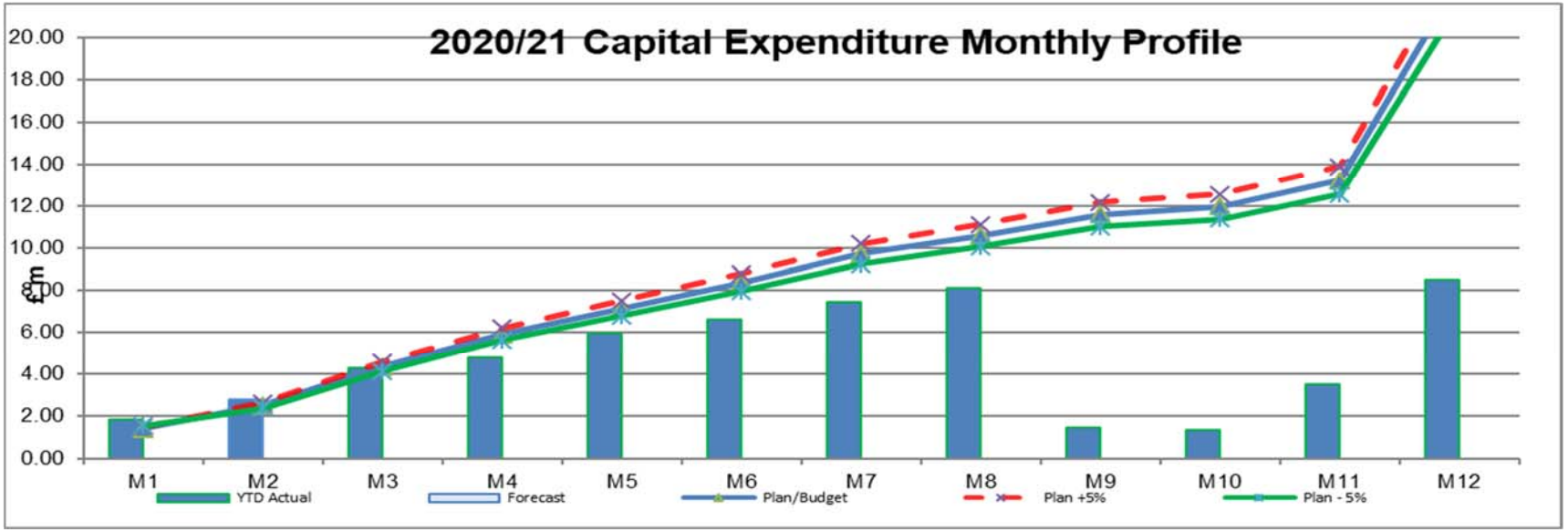

Despite the late issue of PDC funding in quarter 3 the Trust has utilised materially all capital investment, returning only a £5k outturn underspend. However, as in prior years it has been necessary to approve material levels of contingency schemes in the last quarter to achieve this outcome due to slippage across many individual projects. This means that the Trust has not necessarily maximised its impact with the investment.
Slippage has mainly occurred due to;

- limited contractor access as a result of COVID restrictions and excess capacity, affecting both the scoping and delivery of work.
- lack of clear clinical strategy which has delayed and/or changed plans and investment priorities from month to month, something which is also delaying the development of the 2022/23 5 year capital plan.

PDC scheme slippage of £857k should be particularly noted as under the terms of the funding the Trust had committed to fully utilise the funding by 31st March on outcomes specifically targeted by the allocations. The main reasons for slippage on these projects are

- late allocation of the funding by NHSI/DHSC
- ICS bidding for capital investment on behalf of the Trust without consultation key stakeholders who can confirm what is achievable

example ; *£198k MRI upgrade, a bid led by the ICS which could never have been delivered by the supplier by 31st March but was not made clear to the Trust when it accepted the drawdown*.

It should also be noted that PDC funding is not 'free' cash to the Trust, each allocation attracts additional depreciation as well as a PDC dividend charge of 3.5%.
For 2021/22 alone the Trust has incurred costs of £30k in year for monies it could not spend on the required outcome; £280k on all PDC funded schemes. Depreciation charges have also increased by over £1,000k in month where 2020/21 and 2021/22 funded projects have been capitalised in March but back dated to when the assets were assumed/confirmed ready for use. A lack of project sign off throughout the year resulted in this drive across February and March to capitalise AUC balances, an issue that has been flagged by both Finance and Audit in previous years.
If capital investment is kept within existing depreciation limits the impact on depreciation will be minimal however over the last 3 years £48,198k additional capital investment has increased the Trust asset base materially some of which on IT investment which has relatively short assets lives and returns no real benefit in capitalising.

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As the Trust has breached the agreements to accept the PDC it will be required to complete all PDC projects in 2022/23 from within internal funds.

- **Next Year 2022/23**

As outlined above there has been some delay in the development of a capital plan to the level of the previously forecast depreciation of approx. £11,000k. As a result budgets have therefore not yet been allocated to project managers to start work which could cause delays in delivery of the work once agreed. The delay in development relates to emerging and changing clinical strategies which has left the Board unable to approve the priorities with the limited funds.

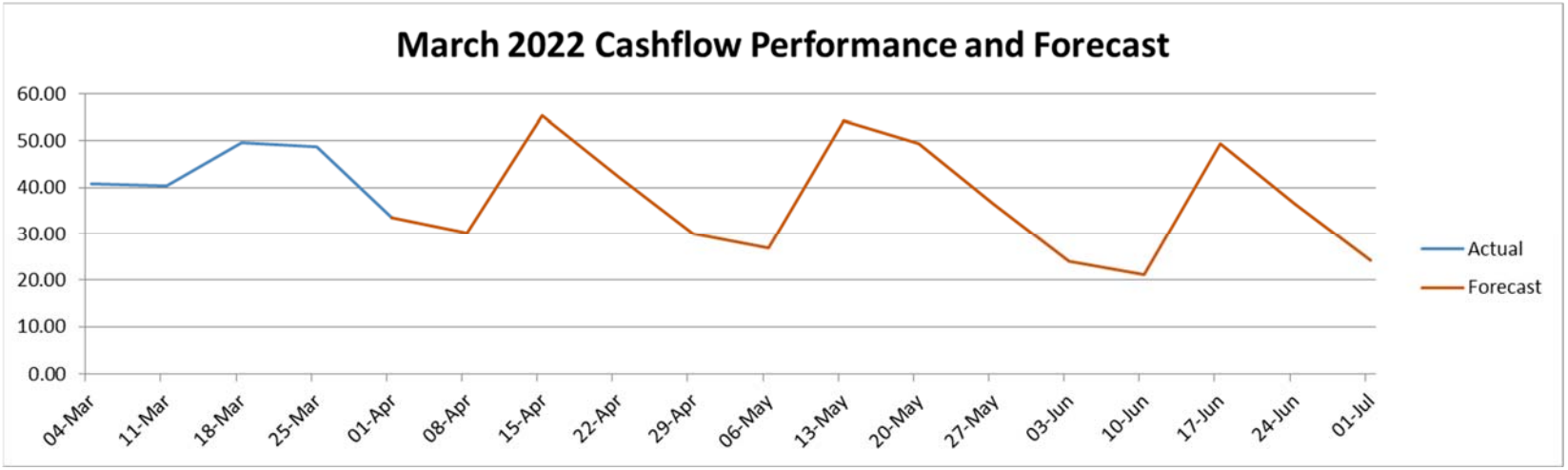
In 2022/23 the Trust also needs to consider the following;

- Increased depreciation levels to £14,000-£15,000k would have enabled additional capital investment, under the new ICS regime it is unclear whether this will be the case.
- ICS led/PDC bids should be support by a PID/business case, reviewed and approved by the relevant group and/or CFO before submission to NHSI in accordance with Trust SFIs. This has been raised with the ICS capital lead but also needs to be fully communicated to Trust staff who are part of ICS network groups who agree without a full understanding of the financial impact on the Trust.
- Project leads need to be accountable for real time project sign off and AUC regularly reported through the Trust Capital Group to provide an awareness of work still deemed in progress and the forecast financial impact.

7. Cash

13 Week Forecast w/e

£m	Actual 04/03/22	11/03/22	18/03/22	25/03/22	01/04/22	Forecast 08/04/22	15/04/22	22/04/22	29/04/22	06/05/22	13/05/22	20/05/22	27/05/22	03/06/22	10/06/22	17/06/22	24/06/22	01/07/22
BANK BALANCE B/FWD	**52.65**	**40.76**	**40.29**	**49.58**	**48.80**	**33.60**	**30.29**	**55.34**	**42.33**	**30.10**	**26.92**	**54.32**	**49.33**	**36.37**	**24.14**	**21.28**	**49.50**	**36.46**
Receipts																		
NHS Contract Income	0.15	0.16	13.62	10.62	0.14	0.55	29.66	0.00	0.00	0.00	30.15	0.00	0.00	0.00	0.00	30.15	0.00	0.00
Other	0.49	0.33	0.32	3.08	0.36	0.29	0.46	0.25	0.25	0.25	0.69	0.25	0.25	0.25	0.58	3.16	0.25	0.25
Total receipts	**0.64**	**0.49**	**13.94**	**13.71**	**0.50**	**0.83**	**30.12**	**0.25**	**0.25**	**0.25**	**30.84**	**0.25**	**0.25**	**0.25**	**0.58**	**33.31**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(9.48)	(0.44)	(0.45)	(10.55)	(9.28)	(0.46)	(0.41)	(10.26)	(9.48)	(0.43)	(0.43)	(0.51)	(10.21)	(9.48)	(0.43)	(0.43)	(10.30)	(9.46)
Non Pay Expenditure	(2.33)	(3.22)	(2.70)	(3.07)	(5.34)	(2.11)	(4.33)	(2.91)	(2.50)	(2.50)	(2.50)	(4.15)	(2.50)	(2.50)	(2.50)	(4.15)	(2.50)	(2.50)
Capital Expenditure	(0.71)	(0.42)	(1.10)	(2.67)	(1.08)	(1.58)	(0.32)	(0.09)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)
Total payments	**(12.53)**	**(4.08)**	**(4.25)**	**(16.29)**	**(15.70)**	**(4.15)**	**(5.07)**	**(13.26)**	**(12.48)**	**(3.43)**	**(3.43)**	**(5.16)**	**(13.21)**	**(12.48)**	**(3.43)**	**(5.08)**	**(13.30)**	**(12.46)**
Net Receipts/ (Payments)	**(11.89)**	**(3.59)**	**9.69**	**(2.58)**	**(15.20)**	**(3.31)**	**25.05**	**(13.01)**	**(12.23)**	**(3.18)**	**27.41**	**(4.91)**	**(12.96)**	**(12.23)**	**(2.86)**	**28.22**	**(13.05)**	**(12.21)**
Funding Flows																		
PDC Capital	0.00	3.13	2.86	1.80	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	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	(3.27)	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**	**3.13**	**(0.41)**	**1.80**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**40.76**	**40.29**	**49.58**	**48.80**	**33.60**	**30.29**	**55.34**	**42.33**	**30.10**	**26.92**	**54.32**	**49.33**	**36.37**	**24.14**	**21.28**	**49.50**	**36.46**	**24.25**



Prior year end	£'000	Month end actual	Var.
49,184	Cash	35,455	(15,729)

Month 11 cash balance was £42.4m therefore total net utilisation in month was £8.9m
Notable Outflows;
- £6m cash advance reclaimed by CCG
- £3.3m PDC dividend paid
- £13m of invoices issued and paid in March – approx. £4m higher than a normal month due to high capital expenditure.

Notable Inflows
- £7.8m PDC cash received

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8. Conclusions

The Finance Committee is asked to note the report and financial performance which is £53k surplus in-month reducing to breakeven year to date after removing the adjustments for donated asset depreciation and income as well as impairments.

This overall financial performance for the year is breakeven as per the plan submitted to the Kent & Medway ICS, this is in line with the control total.

The final efficiency programme is £1.0m adverse to plan, with a delivery of £4.1m year to date. ERF income of £8.9m has been included; £4.6m of this has been paid by the CCG relating to H1, the remaining £4.3m in H2, this being the agreed amount to cover the incremental cost of delivering ERF activity. The annual leave accrual of £2.9m has increased by £1.8m to £4.7m following a year-end review of annual leave carried forward, this increase has been offset by the £2.5m support funding from the CCG.

Alan Davies
Chief Financial Officer
April 2022

Meeting of the Board of Directors in Public

Wednesday, 11 May 2022

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte		
Date of Meeting:	Thursday 24 March 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** **(use appropriate colour code as above)**
1. BAF strategic risks It was proposed to reduce the risk rating for BAF item 3c "Failure to develop, approve and deliver against a Financial Recovery Plan ("FRP")" to a score of 12. The other 2 risks remain unchanged. This was **AGREED** by the committee.	**Amber/Red**
2. Corporate risk register The delivery of the efficiency programme target remains at 4 x 4 = 16 and RAG rated red as there is no reduction in the efficiency plan gap.	**Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
There was a discussion to potentially reduce the risk score as the impact / consequence of the efficiency gap has been mitigated mainly from non-recurrent measures, however it was agreed to remain unchanged.	
3. Finance report – month 11 The Chief Financial Officer tabled the report with the key highlights being: • The Trust has met its control total of breakeven in month 11 and for the year to date. • ERF+ Income of £3.6m had been accrued into the position, this being 5 months of the agreed £4.4m for H2. • The in-month position includes non-recurrent release of accruals for independent sector costs over estimated. A contingency of £1.3m is included, this is expected to be fully utilised in March to deliver the breakeven control total for the year. • The efficiencies delivered are £107k lower than budgeted for February and £863k year to date. • The capital spend in month is £2.4m, and year to date are £1.1m ahead of the £14.3m plan due to timing of various schemes completing ahead of schedule. The revised capital programme is now £22.5m and the forecast is to achieve plan. • Cash sums remain in a strong position. • The forecast outturn position 2021/22 is to breakeven, this has reduced from £2.3m deficit in the previous month due to lower costs than anticipated for the escalation beds and a reduction to junior medical locum spend. The position has been managed from existing resources without the need for additional support from the ICS. • Clinical income is £9m lower when comparing to 19/20 activity levels. • Mitigations have been factored into the position from the Covid underspend, reserves, TIF, and Covid out of envelope income.	**Amber/Green**
4. Performance report month 11 The performance report was presented to the committee as well as a discussion regarding current performance across services in the Emergency Department, ambulance handovers, referral to treatment performance, cancer services and continued work towards reducing waiting lists. The committee discussed the impact of the additional escalation capacity and development of a de-escalation plan; it was noted that funding for the hospital discharge programme will end at the end of the current financial year.	**Amber/Green**
5. Efficiency programme update	**Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
The Chief Financial Officer updated the committee on the latest position with the efficiency programme. It was noted the gap in the £5.1m programme continues, and current forecast is £4.1m to be delivered. The main focus for the transformation team working with the services is to continue the work on the 9 cross cutting schemes identified and finalise a robust deliverable efficiency programme for 2022/23. A target of 2.83% has been applied in the operational plan which totals £9.6m. Efficiencies totalling £5.4m – £7.2m have been identified within the cross cutting schemes; including directorate schemes the total efficiencies identified is £8.0m - £9.9m.	
6. Facilities and Estates Model Hospital update The Director of Facilities & Estates presented a report using information from the Model Hospital. Key comments included the benefits of using model hospital and the time spent to understand the opportunities to work more efficiently as well as areas of focus for the services. The slide pack presented added more detail to areas of opportunities as well as areas where costs had increased / decreased.	**Green**
7. Operating plan update The Chief Finance Officer presented the draft operational plan for 22/23. The main points included: • Current timetable main dates - 8-Apr Exec review of divisional plans, 13-Apr Exec Committee, 21-Apr FPP Committee and 22-Apr final business plans and budgets. • Current financial gap for the Trust is £7.3m – and for the ICS £85m. • ERF income and expenditure has been excluded. Further work is continuing to assess the impact of delivering the 104% activity target. • Plan excludes unfunded new service developments. • Current budget underspends have been excluded; however assumed to partially continue as a mitigation. • Assumptions have been made for growth, inflation and efficiencies. • Increased energy prices of £2m have been included (this is a national issue). • A £4m contingency is included with a proposal to reduce to £2.2m. • Reduction in Covid income of £11m and costs of £4.5m. • Increased capital charges due to the higher levels of capital spend.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
• Discussion of further mitigations to reduce the gap.	
8. Financial Recovery Plan ("FRP") The FRP Director updated the Committee on the latest Financial Recovery Plan document; this included the purpose of the FRP and some of the main drivers of the deficit across the Trust. An update was given on the latest financial modelling work that has taken place as well as some of the key assumptions included and scenarios modelled; the time period of the modelling work covered is 2022/23 – 2028/29. Further work is ongoing prior to the plan being finalised by the 31st March, and shared with colleagues when available. This includes further analysis of growth and the cost base during the pandemic, finalising the efficiency programme as well as aligning the FRP to the operating plan. The committee agreed they were assured by the process and the progress to date.	**Amber/Green**
9. Re-naming of the Finance Committee ToR The Company Secretary summarised the renaming of the terms of reference. It was agreed to amend the quorum to 2 non-executive directors. With the amendment above added, the document was **APPROVED.**	**Green**
10. Procurement of Picture Archiving and Communication System Prior to the Committee meeting the report was issued to the members and taken as read. The procurement process and financial impact was presented to the Committee, along with some of the key risks being addressed by the proposal. A question arose regarding the impact of IFRS16, this would be investigated further and clarified, initial estimates anticipated £15k pa impact. The full business case was recommended for approval by the Trust Board.	**Green**
Decisions made It was **AGREED** to reduce the score of BAF item 3c "Failure to develop, approve and deliver against a Financial Recovery Plan ("FRP")" to 12. It was **RECOMMENDED** the Procurement of Picture Archiving and Communication System full business case is approved by the Trust Board.	
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, 11 May 2022

Assurance Report from Committees

Title of Committee:	**People Committee**	**Agenda Item**	**6.1**
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Thursday, 24 March 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 APPROVED the recommendation to reduce the BAF risk 4a, sufficient availability of staff to deliver services, to a medium risk (12, 4x3) following the repeal of the mandatory covid vaccination. A series of mitigating actions were highlighted and updated for all People BAF items.	**Amber/Green**
2. IQPR – People KPIs Key highlights were noted as follows: 1) Total Sickness (rolling) for February had slightly worsened, up to 5.07%, but remains significantly better than the same period in 2021. Usage of occupational health services remains high for anxiety and stress with additional service capacity added being scoped. 2) Turnover (12-month rolling) continued to increase and was expected to continue to rise through to April 22 due to elevated monthly turnover in quarter 4 2020/21. 3) Appraisal rates continued to remain significantly below target (at 80.03%) below the target of 85%, a backlog of medical appraisals is currently being entered on to the report. 4) A plan to recover the resus statman training compliance had been developed by the division and is being implemented.	**Amber/Green**
3. HR Resourcing Dashboard Key highlights were noted as follows: 1) International recruitment for nursing is on trajectory (albeit with a delay into May for some cohorts) along with clinical support worker recruitment (above plan). Concerns have been raised nationally for lack of OSCE capacity. 2) There are six consultants in offer stage across specialties.	**Amber/Green**

4. OD Update and culture, leadership and engagement report. Key highlights were noted as follows: 1) ILM centre has had positive external verifier assessment. Apprenticeships remain in a positive position across the Trust along with go-live for the Kick Start programme and Bemix. 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. 3) Staff survey results show an increase in the response rate from 35% to 40% against a Trust target of 50% and a national response rate of 46%. The staff engagement score for the Trust decreased by 0.1 versus a national mean decrease in score of 0.2. The morale score decreased by 0.1 versus a national mean decrease of 0.3. Further breakdowns are being developed with actions using patient first methodologies.	**Amber/Green**
5. Terms of reference The Committee APPROVED revised terms of reference adding in Patient First support to delivery and commissioning deep dives.	**Amber/Green**
6. Healthcare support workers (HCSW) update The Committee noted a 16.9% reduction to the Trust's HCSW vacancy level with a pipeline of 59 FTE additional hires against the current vacancies; however, the vacancy rate remains above the county average.	**Amber/Red**
Decisions made: None to report	
Further Risks Identified: None to report	
Escalations to the Board or other Committee: 1) Continued focus on appraisals to reach target, particularly across corporate areas with a challenge to improve corporates rates to over 90%.	