

# Agenda

**Trust Board Meeting in Public**  
**Date: Wednesday, 9 March 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	Integrated Care System	Mike Gilbert, Kent & Medway CCG	Presentati on	12:50	
2. Minutes of the previous meeting and matters arising					
2.1	Minutes of previous meeting: 9 February 2022	Chair	5	13:20	Approve
2.2	Matters arising	Chair	Verbal		Discuss
3. Strategy and Resilience					
3.1	Board Assurance Framework	Deputy Chief Executive	13	13:30	Assure
3.2	Patient First Improvement Programme	Chief Strategy and Integration Officer	33	13:45	Note
3.3	Annual Business Plan 2022/23 - progress	Chief Finance Officer	Verbal	14:00	Note
4. High Quality Care					
4.1	Integrated Quality Performance Report	COO, CNO, CMO	39	14:10	Assure
4.2	Quality Assurance Committee Assurance Report - Meeting date: 22 February 2022	Chair of Committee/ Chief Nursing Officer	79	14:20	Assure
4.3	CNST Quality Actions	Chief Nursing Officer	85	14:30	Note
4.4	Ockenden Oversight Report	Chief Nursing Officer	103	14:40	Note
4.5	Infection Prevention & Control Board Assurance Framework	Chief Nursing Officer	123	14:40	Receive
5. Financial Sustainability					
5.1	Finance Report - Month 10	Chief Finance Officer	129	14:50	Note
5.2	Finance Committee Assurance Report Meeting: 24 February 2022	Chair of Committee/ Chief Finance Officer	145	15:05	Assure

# Agenda



Medway

NHS Foundation Trust

6. Any Other Business					
6.1	Council of Governors Update	Lead Governor	Verbal	15:15	Note
6.2	Questions from the Public	Chair	Verbal		Note
6.3	Any Other Business	Chair	Verbal	15:30	Note
Date and time of next formal meeting: 11 May 2022, 12:30 – 15:30; April date under preparation					

## **Chief Executive's Report – March 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.

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### **COVID-19**

The Trust has continued to see a reduction in the number of patients with COVID-19, which is obviously excellent news.

To ensure that we protect our patients, as well as visitors and staff, from the risks of COVID-19, appropriate infection prevention and control measures will remain in place at Medway Maritime Hospital for the immediate future. This is despite the lifting of COVID-19 restrictions across the UK from Thursday 24 February 2022.

We are asking our visitors to continue to 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
- 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.

To further protect patients, visitors and staff, limited visiting rules remain in place at Medway Maritime Hospital, although this will remain under constant review.

### **Trust makes history**

Cancer patients are receiving some of the fastest access to cancer treatment in the UK after the Trust achieved the national standard in four key areas of cancer care (two-week wait, 31 day wait, 62 day GP referral and 28 day faster diagnosis) for the first time in its history.

I am incredibly proud of all of the hard work of the cancer services team to improve the care that we provide for our local community. Receiving a cancer diagnosis is one of the most frightening things that can happen to someone, so making sure that treatment begins quickly doesn't just mean better clinical care – it means greater reassurance and peace of mind for patients and their families too.

Since the COVID-19 pandemic began, the Cancer Services Team has worked hard to improve the service provided for patients with cancer, or suspected cancer; this has included strengthening the leadership within the team and having a stronger focus on collaborative working with other departments in the Trust and with external partners, such as Macmillan.

The Trust also works closely with Kent and Medway Cancer Alliance to continually develop and improve cancer services. The Kent and Medway Cancer Alliance brings together clinicians and managers from health, social care and other services to transform the diagnosis, treatment and care for cancer patients.

### **Racism will not be tolerated**

I'm absolutely appalled by the racist abuse that some of our colleagues from diverse backgrounds have been receiving from patients and relatives.

I have often spoken of the considerable value that having a diverse workforce brings, and the care that we provide to our patients is greatly enriched by the experiences and skills of colleagues from many countries across the world. It is this diversity that makes us so special as an organisation.

We will not tolerate racism or any other forms of discrimination towards our staff and action will be taken against those guilty of these actions.

### **Chief Nursing Officer**

I'm delighted to announce that Evonne Hunt has been appointed as our new substantive Chief Nursing Officer. Evonne has had a considerable impact since she joined the Trust in October and will have a significant role to play as we continue to improve services for our community.

### **Maternity Patient Survey**

Last month saw the release of the findings of the Care Quality Commission Maternity Survey which captured the views of women who gave birth during February 2021, when the country was in the middle of a national COVID-19 lockdown. The survey asked those women about all aspects of their maternity care experience from the first time they saw a clinician or midwife, during labour and birth, through to the care provided at home in the weeks following the arrival of their baby.

I am really pleased to see that, despite the challenges of the pandemic, we continued to provide high quality care; our results showed that we were better than benchmarked trusts in four areas and the same in 43 other areas. We were not

worse in any of the areas. Thank you to the team for their dedication and passion and for continuing to deliver such great care throughout the worst of the pandemic.

### **An opportunity to make a difference**

I'm pleased to confirm that the Trust has opened applications for local people to apply to become a public Governor for Swale. This is a great chance to make a difference and represent your local hospital. To find out more about the role of Governors, please visit our Trust website.

### **Some personal news**

Last month the Trust announced that I will be leaving my role in the summer to take up a new appointment as Chief Executive of University Hospitals Sussex NHS Foundation Trust, where I was previously Deputy Chief Executive and Chief Medical Officer.

I've really enjoyed my time here at Medway and I have had the opportunity to work with some fantastic colleagues, so I am sad to be leaving; it was an incredibly difficult decision to make, but one that I feel was right for me and my family.

I'm so proud of the work that we have done in my time here and truly believe that we are now in a much better place than when I joined. We have clear plans for our future with the Patient First strategy about to get underway, and we now have a more stable and cohesive leadership team. As a result of the significant progress we have made against the delivery of constitutional standards, we are now providing better care for our patients.

The Trust is now working on the recruitment process to ensure we have a successor in place as soon as possible.

### **Communicating with colleagues and the community**

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

# Communications Update

## March 2022



Total social  
media impressions  
**65,000**



Media  
mentions  
**105**



**Minutes of the Trust Board PUBLIC Meeting**  
**Wednesday 9 February 2022 at 12:30 to 14:30**  
**MS Teams**

<b>Members</b>	<b>Name</b>	<b>Job Title</b>
<b>Voting:</b>	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Evonne Hunt	Chief Nursing and Quality Officer (Interim)
	Ewan Carmichael	Non-Executive Director
	George Findlay	Chief Executive
	Leon Hinton	Chief People Officer
	Mark Spragg	Deputy Chair/Senior Independent Director/NED
	Gurjit Mahil	Deputy Chief Executive
	Tony Ullman	Non-Executive Director
<b>Non-Voting:</b>	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Keith Soper	Deputy Chief Operating Officer
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
<b>Attendees:</b>	David Brake	Lead Governor
	David Seabrooke	Company Secretary
	Katie Nelson	Local Democracy Reporter
	Sheila Adam	NHSE/I Improvement Director
	Revd Ruth Bierbaum	Lead Chaplain
<b>Apologies:</b>	Sue Mackenzie	Non-Executive Director
	Jayne Black	Chief Operating Officer

## **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:

I want to thank our patients for their continuing support. Restrictions on visiting, requirements for mask wearing and other measures have caused some frustration for patients and their loved ones, but they've been necessary to help reduce the spread of infection. I also understand how distressing it is for patients waiting to have surgery, which has been delayed due to the pandemic. However, I'm pleased to say that we have ensured that cancer patients have been prioritised, and, as you'll hear later on the agenda, our teams can be proud of the achievements in this area.

Our colleagues are now working hard to further reduce the number of patients who are waiting for operations. I believe we're in a strong position to improve performance further across our services and offer the high-quality care that they've come to expect from us.

We acknowledge the decision to adjust the approach to mandatory vaccination of frontline colleagues. However, we still believe the safest way to protect yourself is through vaccination and we'd like to encourage anyone who has still not been vaccinated and would like to come forward.

We note the change to the implementation of legislation to give statutory powers to the integrated Care boards, and we welcome the new board members that have recently been appointed to the Kent and Medway System.

I'm particularly delighted that we have our patient experience strategy at the board today. I'd like to thank Evonne and her team for all of the hard work they put in throughout the winter period in finalising the strategy and building out the supporting plans to deliver the very best patient experience. I'm particularly pleased that Reverend Ruth Bierbaum will be with us later today to share her insights from spending time with patients and their families.

And with that thought in mind I'm also very pleased to be able to welcome one of our patients to the board today to share their story with us about their experiences of being cared for here in the hospital.

## **1.2 Patient Story – Jenny's story**

The Chair welcomed Jenny who was supported by Heidi Jeffrey.

Jenny shared the story of the care received by her son Liam, her concerns and the areas of improvement that she felt needed to be made. The details of Liam's history is known to the hospital, but is not included here to maintain patient confidentiality.

The head of nursing added that it was concerning and saddening to hear Jenny's story regarding Liam and that Jenny's experience is one that we are trying very hard to avoid, so things that have been done in order to ensure improvements.

The Chair and Chief Executive thanked Jenny for sharing her story and each apologised to her for the treatment described. An update was given on how Liam is progressing now and the Board wished him well.

## **1.3 Quorum**

The meeting was confirmed to be quorate with at least one-third of the whole number of the Directors (including at least one Executive Director and one Non-Executive Director) being present.

#### **1.4 Conflicts of Interest**

There were no conflicts of interest raised.

#### **1.5 Chief Executive Update**

George Findlay, Chief Executive gave an update to the Board providing an overview of matters on a range of strategic and operational issues. He echoed a number of points made by the Chair in relation to the handling of the Covid pandemic. The Board was asked to note the report and George gave the following key highlights:

The Trust has continued to see high levels patients at Medway with COVID related illness creating a significant pressure over the past few months. However, more recently we've seen evidence that we've probably passed the peak of the wave, which is good news, and the numbers are starting to reduce.

While the Trust continued to see a high level of patients attend with Covid related illness, the numbers were reducing as the peak of the wave passed. In response a number of clinical areas had been re-purposed to accommodate Covid patients and the Trust was gradually returning these to normal use. Some planned clinical activity had been paused and he apologised to patients for this.

There has been a considerable improvement in performance against a number of the constitutional standards, in particular the standard that requires that 95% of patients attending the emergency department should be transferred or discharged within 4 hours.

Some patients with cancer had a number of treatments paused through the 1st and 2nd wave. The Trust met the 85% standard for 62 day cancer standard in November and in October: that was the best performance against the standard for the past two years.

The trust was awarded the Kent & Medway Healthy Workplace Gold Award in recognition of ongoing achievement in promoting a healthy working environment for staff.

## **2 Minutes of the previous meeting and matters arising**

2.1 The minutes of the last meeting, held on 12 January 2022 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting: there was only one action, the Patient Experience Strategy which was on today's agenda.

## **High Quality Care**

### **3.1 Integrated Quality Performance Report**

The Board received the report; the paper was taken as read. The Chair invited Keith Soper to present the key highlights.

The 62 day cancer standard was achieved for the first time since June 2018, and the Trust continues to meet the two week wait standard and that level of performance has

progressed into December. It remains on track with our trajectory to continue above the 62 day standard.

The four hour performance was at just under 60%. The number of 60 minute handover delays reduced to 171 and that was almost 200 fewer than we experienced in January 2021.

We continue to see a marginal, but continued improvement in pre-noon discharges; we're still some way away from the 25% target. A number of actions to try to continue with flow that included increasing the level of medical nursing, therapy and operational support in place at the weekend are ongoing. We continue to see high levels of referrals, affecting our RTT position. There were no never events or CQC whistle-blowing alerts received in the last month.

We continue to monitor our falls and pressure ulcer incidents. The clinical lead nurse for falls and pressure ulcers is doing a problem-solving approach to try and understand what is driving the increase. Evonne Hunt added we saw that hospital acquired pressure ulcers decrease to 10 in January. For falls we had 99 in December and in January was 73.

The trust has recently consolidated all our infection prevention and control (IPC) action plans and several recommendations from the various reviews we've had into one IPC board assurance framework and improvement plan.

There has been no MSA cases and we continue to have no MRSA. Two new cases of C Diff were reported, bringing us to a total of 21 against the trajectory of 35 and our COVID cases continue to decrease. In January we had two outbreaks which have been managed and some of the findings from the RCA's have recently started.

Of the 18% of people who responded on the Friends and Family test, 82% of those would recommend us. Our Dr Foster data shows that our HSMR ratio is within the expected range.

The Chair noted that there remained a challenge with our C-section rates and the PTL was still growing.

It was noted that the rate of growth is definitely slowing, but it would be helpful to comment on the C-section rate and the overall PTL. It was pleasing to see the ambulance handover delays becoming more stable. The variation is much less pronounced and performance is more stable than it has been in the past. The team should be congratulated for all the work they've done in that area.

Analysis of C Sections shows that evening and out-of-hours procedures were a significant factor. Specialty colleagues have been re-modelling the workforce to provide extended consultant working on-site to provide more senior decision-making when it is required.

George Findlay reflected on the Trust's winter performance: the usual winter pressures layered on COVID pressures and staff absence due to Covid. Our planned care backlog

for patients over 52 weeks is continuing to come down. The ambulance handover performance has improved.

### **3.2 Quality Assurance Committee Assurance Report: 18.01.22**

The Board received the report from the Quality Assurance Committee.

Tony Ullman, Chair of Quality Assurance Committee informed the board that the committee had requested a review of the patient treatment list (PTL). The committee will be spending some time examining this in terms of our population and affected specialties.

He highlighted the national patient safety strategy where the committee is asking the board to agree that all board members undertake level one training on the national patient safety strategy. The Board agreed this recommendation.

### **3.3 Learning from Deaths**

Alison Davis, Chief Medical Officer presented this report.

HMSR is within the expected range for both weekday and weekend mortality. At the start of December 2021 we introduced a multi-specialty, multi professional weekly structured judgment review (SJR) group to ensure timely review of the cases and there has been a significant reduction in the backlog of SDR's: our total of 115 cases is down to 10 and work is ongoing to close these final cases

Next steps were to develop robust mortality governance and there will be meetings for all of our specialties to continue to review outlier diagnostics, groups and alerts. This structured judgement review process are looking at how we can assure the board that we are meeting the external standards. The Trust will work through our patient first and improvement methodology at how we work with bereaved families and carers. We know from the feedback we get that they value the bereavement service, but there is more that we can do to listen to the patient voice in that area to and share good practice.

### **3.4 Patient Experience Strategy**

Evonne Hunt, Chief Nursing and Quality Officer, presented to the Board for approval, the paper was taken as read. She offered the following highlights.

The strategy sits underneath the overarching Patient First strategy and puts patients at the centre of everything that the Trust does. Feedback from the patient survey had been considered. Similarly, the feedback from complaints and the Friends and Family test have also been included. Patient experience is everybody's business.

Engagement work has highlighted five key areas that the strategy needs to focus on: patient first, communication, leadership, making sure that we employ staff that really want to drive and improve the experience of our patients, developing a positive culture and finally aligning with our partners so our patients experience high quality care at all stages.

The Chair invited Revd Ruth Bierbaum, the Trust's Lead Chaplain to comment on her experiences of the hospital, and working with patients.

The chaplaincy respects the faith and beliefs of all people. Our remit is to make sure that we help, as far as we can, to make sure that the patient's spiritual and religious needs are met. When that happens it makes a huge difference to patient experience. She gave two examples of her work in this area and how this had supported patients and relatives.

Mark Spragg sought assurance around the ability for patients to raise issues while they were in the hospital's care.

The Chair thanked Revd Bierbaum for her contribution. The patient experience strategy was approved.

## **4 Financial Stability**

### **4.1 Finance Report - Month 9**

Alan Davies, Chief Finance Officer gave an update to the Board. The Trust reports a breakeven against the NHSE/I control total and the following highlights were noted:

For the month nine position, the trust was reporting break even again in the month and for the year. However, the month nine position itself was supported by some non-recurrent benefits in relation to reversal of accruals and provisions, so that the underlying position in month nine was effectively an overspend.

The Trust's position has been shared with the system and there was agreement to cover that risk within its overall position, so effectively from within the CCG's own financial position. In terms of capital we're showing a £2m underspend at month 9. Additional schemes were agreed in December to take up most of that opportunity, around £1.2 million. Cash remains in a strong position.

As regards the efficiency programme, there was a robust discussion at the Finance Committee around the delivery against the efficiency target for this year and putting into place plans to develop the program for next year. This was being accelerated to ensure that a plan for delivery from April was in place including new weekly executive review meetings, reporting into the monthly efficiencies delivery group.

Weekly meetings of each of the nine cross-cutting themes were established. The expectation is that by the end of February firm project plans for the cross cutting schemes will be in place. We will have a short list of the divisional schemes for review in March and deployment in April.

The system incorporates an efficiency target of around 2.8% for 22/23. However, that is in addition to a reduction in the level of COVID funding of around 55%, which is in line with the national planning guidance.

In terms of internal business planning guidance, a draft was considered by the Finance Committee. Divisions have an indicative target initially of 2.8%, which is consistent with the financial envelope, and is considered a reasonable, realistic, but probably stretching target for them to deliver. However, we also need a strategy to address the reduction in COVID funding. This will be picked up through the business planning process.

A final draft of the drivers of deficit document had been finalised. Drivers of deficit work was the first stage of the development of the recovery and efficiency plans for the next 3-5 years.

#### **4.2 Finance Committee Assurance Report: 20.01.22**

Annyes Laheurte, Chair of Committee presented to the Board, the paper was taken as read.

The position at month 10 is still a breakeven position, but it is worth emphasising that we are not on track for this year's efficiency targets. We wanted to have a strong position at the beginning of 22/23 with the efficiency programme and it's good to hear from Alan that this work is has started. The Finance Committee will review these activities at their next meeting.

### **5 Our People**

#### **5.1 Report of People Committee – 20.01.22**

In Sue Mackenzie's absence, Leon Hinton presented the report from the People Committee.

We have seen sickness increase through December to 5.98% in the month. However, that is an almost 2% decrease from same position we were in the year before.

Though this quarter will also be seeing the mental first aid trainer training come into place. The People Committee wants to escalate to the board the appraisal rate which stands at just over 85%. We've seen some slight improvements but performance requires further improvement.

#### **5.2 Vaccination as a Condition of Deployment (VCoD)**

It was noted that work on this had been put on hold as the Government had recently indicated that it was reviewing the regulations behind VCoD. Our colleagues have a number of questions and we've been able to provide a lot of well-being support to the organisation during this period of uncertainty.

### **6 Any Other Business**

#### **6.1 Council of Governors Update**

Cllr David Brake, Lead Governor presented to the Board, with the following highlights:

A quality priorities event with governors had taken place on 20 January 2022. Attendees took part in Group breakout sessions where each group discussed priorities corresponding to one of the three quality domains, safe, effective and caring.

On 27th January, we had the Council of Governors meeting. This was preceded by a pre meeting with our public and partner governors which was arranged as an opportunity to discuss future engagement ideas. Governors were encouraged to come forward with ideas for places to visit in the community and some good suggestions were made.

We also welcomed governors for Swale, James Chespy, and agreed to an amendment in the Constitution whereby a new partner governor seat would be offered to Swale Borough Council.

We are now looking at building these events up once again and a public event will be held in April and will be focusing on research. The date of meeting is yet to be confirmed and I'd like to thank the team and everyone at MFT for their help and support.

**6.2 Questions from the Public**

There were no questions from the public.

**6.3 Any Other Business**

There were no matters of any other business.

**6.4 Date and time of next meeting**

The next public meeting will be held on Wednesday, 09 March 2022.

The meeting closed at 14:30

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

Signed ..... Date .....

Chair

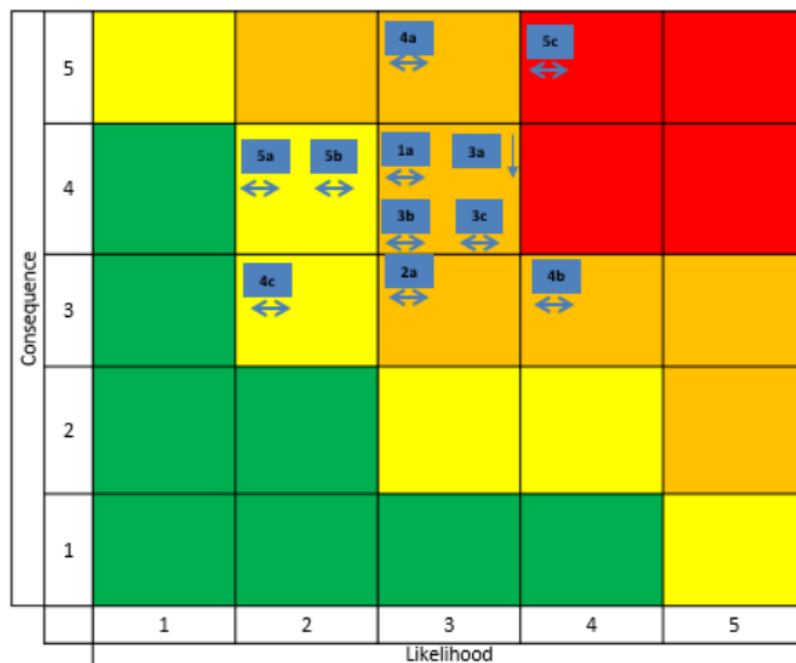
# Meeting of the Public Board

## Wednesday, 09 March 2022

Title of Report	Board Assurance Framework	Agenda Item	3.1																		
Report Author	Gurjit Mahil, Deputy Chief Executive																				
Lead Director	Gurjit Mahil, Deputy Chief Executive																				
Executive Summary	<p>A summary of the BAF as of the 28<sup>th</sup> of February 2022 is presented in this paper.</p> <p>The Trust’s principal risks are:</p> <table><tr><td>Risk</td><td>Target Score</td><td>Initial Score</td><td>Dec 21</td><td>Jan 22</td><td>Feb 22</td></tr><tr><td>4a – Sufficient staffing of clinical areas</td><td>6</td><td>16</td><td>15</td><td>16</td><td>16</td></tr><tr><td>5c – Patient Flow</td><td>6</td><td>16</td><td>20</td><td>20</td><td>20</td></tr></table> <p>4a – was raised due to the position around covid vaccinations – this will be reviewed in the next People Committee.</p>			Risk	Target Score	Initial Score	Dec 21	Jan 22	Feb 22	4a – Sufficient staffing of clinical areas	6	16	15	16	16	5c – Patient Flow	6	16	20	20	20
Risk	Target Score	Initial Score	Dec 21	Jan 22	Feb 22																
4a – Sufficient staffing of clinical areas	6	16	15	16	16																
5c – Patient Flow	6	16	20	20	20																
Committees or Groups at which the paper has been submitted	Board Sub Committees																				
Resource Implications	N/A																				
Legal Implications/Regulatory Requirements																					
Quality Impact Assessment	N/A																				
Recommendation/ Actions required	<p>The Board is asked to note the report for assurance regarding the processes in place around risk management.</p> <table><tr><td>Approval <input type="checkbox"/></td><td>Assurance <input type="checkbox"/></td><td>Discussion <input type="checkbox"/></td><td>Noting <input checked="" type="checkbox"/></td></tr></table>			Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Noting <input checked="" type="checkbox"/>														
Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Noting <input checked="" type="checkbox"/>																		

# 1 Board Assurance Framework

Integrated Healthcare	1a. Failure of system integration	↔
Innovation	2a. Future IT Strategy	↔
Finance	3a. Delivery of financial control total	↓
	3b. Capital investment	↔
	3c. Long term financial sustainability	↔
Workforce	4a. Sufficient staffing – clinical areas	↔
	4b. Staff engagement	↔
	4c. Best staff to deliver best care	↔
Quality	5a. CQC progress	↔
	5b. Health and Social Care Act requirements	↔
	5c. Patient flow	↔

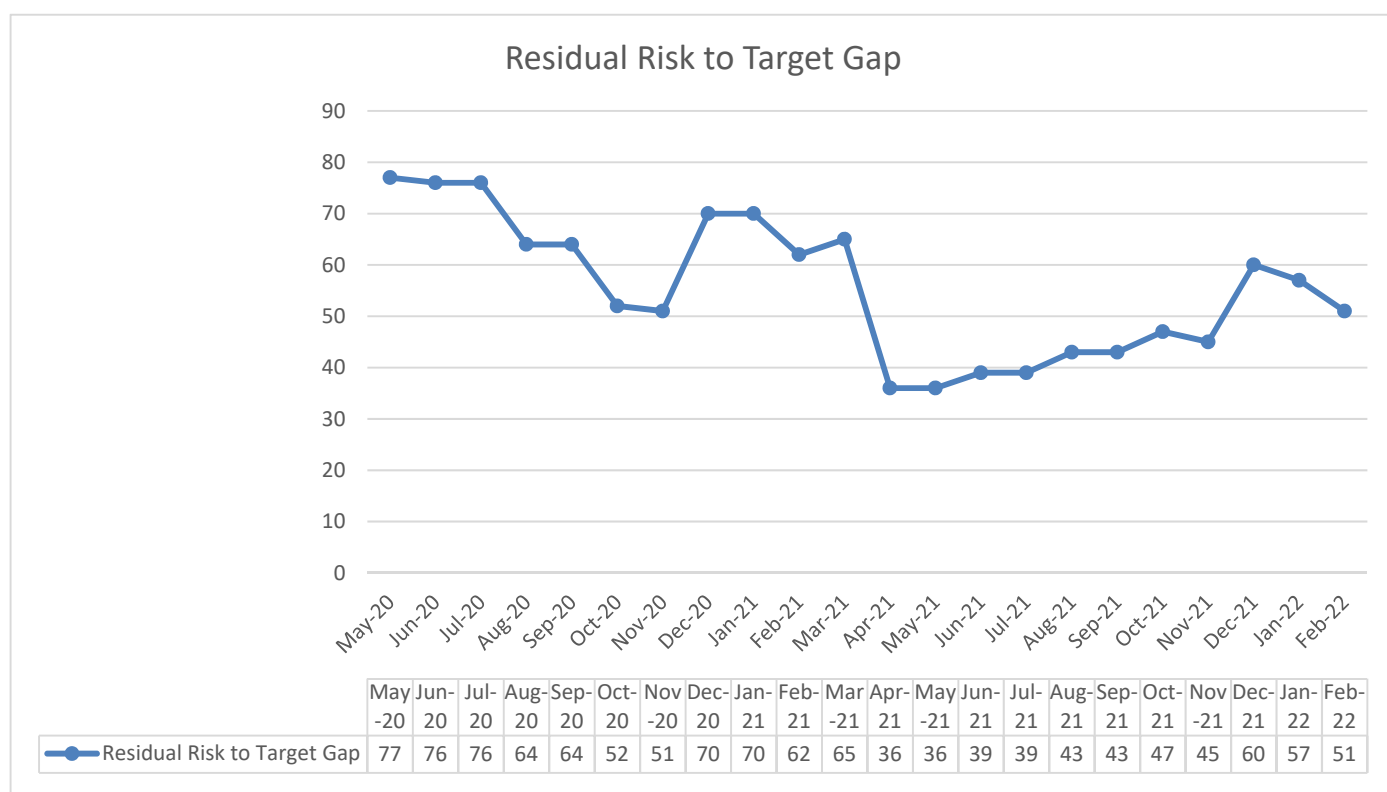


In the current reporting period the Trust has seen the decrease of 1 risk, 3a – delivery of financial control.

There are a two principal risks that are rated as high, 4a – sufficient staffing of clinical areas - this was based on the information at the time of the last People Committee around vaccinations, the position will be updated at the next People Committee in March 2022, and 5c – Patient flow, which is being managed through the clinical and operational teams.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1a. Failure of System Integration	12	12	12	12	12	12	12	12	12	12	12
2a. Future IT strategy	9	9	9	9	9	9	9	9	9	9	9
2b. Capacity and Capability	6	6	6	6	6	6	6	6			
2c. Funding for investment	6	6	6	6	6	6	6	6			
3a. Delivery of financial control total	16	16	16	16	16	16	16	16	16	16	12
3b. Capital Investment	16	16	16	16	16	16	16	16	12	12	12
3c. Failure to achieve long term financial sustainability	12	12	12	12	12	12	12	12	12	12	12
3d. Going concern	4	4	4	4	4	4	4				
4a. Sufficient staffing of clinical areas	15	15	15	15	15	15	15	15	15	16	16
4b. Staff engagement	12	12	12	12	12	12	12	12	12	12	12
4c. Best staff to deliver the best care	6	6	6	6	6	6	6	6	6	6	6
5a. CQC Progress	9	9	9	9	9	9	9	9	8	8	8
5b. Failure to meet requirements of Health and Social Care Act	9	9	9	9	9	9	9	9	8	8	8
5c. Patient flow – Capacity and demand	9	9	12	12	16	16	20	20	20	20	20

Table 1.1 – Summary of BAF



1.1

Figure 1.2: Residual risk to target gap

1.2 Figure 1.2 (above), shows the residual risk to target score gap. The target score is based on the trigger levels for each of the risk domains and the residual risk is based on the gap between the residual risk score and the target score.

1.3 The reduction in the residual gap between December 2021 and February 2022 was due to the reduction in the key financial risk – 3a.

COMPOSITE RISK: Integrated Healthcare										
EXECUTIVE LEAD: Chief of Staff										
LINKS TO STRATEGIC OBJECTIVE: Objective One - Integrated Health and Social Care: We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place										
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
<b>1a</b> There is a risk that the Medway and Swale system cannot enable true partnership working which designs a long term population based, integrated health and social care system with the patients at its centre. Thus leading to a failure to deliver systems integration, stability and better patient services via the enablement of clinically led patients centred system redesign.	The trust is unable to achieve its strategic objective of working within an Integrated Care System (ICS) and at a locality level within Medway and Swale that is based on a joint strategic needs assessment. We will therefore not leverage the ability to redesign the system for better quality of care to be provided to those we serve in the short and long term.	<b>3 x 4 = 12 Moderate</b>	<ol style="list-style-type: none"> <li>1. Systems wide strategic vision written in partnership with all organisations. Agreed Intergraded Care Partnership (ICP) model in place with systems partners actively working to mobilise key collaborative elements.</li> <li>2. The Trust now has senior representation at ICP and the ICS (the Chief Executive Officer and Chair) level across core governance structures and decision making groups.</li> <li>3. The Trust has aligned their clinical and quality strategy with the wider ICP quality strategy which ensures pathways and patient experience are central to the work of the Trust and the ICP.</li> </ol>	Governance arrangements for the Medway and Swale system agreed.  Weekly calls between all Partners and NHS I/E regarding MFFD patient pathways and mini MADE's taking place.  Attendance from the Trust at the ICP executive and the ICP partnership board.	Regular updates against milestones submitted to Executive and Board of Directors meetings.  Attendance at Population Health Management Groups.	Progress against system recovery and integration plans monitored independently via NHS England and Improvement.		<b>4 x 3 = 12 Moderate</b>	<b>3 x 2 = 6 Low</b>	Partial



COMPOSITE RISK: Innovation										
EXECUTIVE LEAD: Chief of Staff										
LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care										
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
<b>2a</b> There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP/ICS and the organisation's role therein.	Trust may slow down investment in digital innovation to keep to the pace with new technologies, other organisations locally and the ICP and ICS/STP.	4 x 4 = 16 <b>High</b>	1. Author a Digital Strategy that is well socialised across the region and well engaged with by teams internally. 2. Develop a roadmap to a single Electronic Patient Record. 3. Focus initially on key projects and investments to stabilise IT services (telephony, networks, end user devices, licenses, systems upgrades, service desk). This will provide a strong technology and information foundation to build upon: EPR, innovation, whole system analytics, specialist services. 4. Seek Regulator support for IT investments and longer-term Digital Strategy	Director of Transformation and Digital, CIO and Senior Digital Team  Weekly CIO call with all Kent & Medway provider Trusts	Reporting to the Executive Team  Reporting to the Innovation Board, Trust Improvement Board  Reporting to Finance Committee as part of Committee work plan	ICP Digital Strategy group (re-forming from October 2020)  ICS CIO  NHS E/I South East Digital team  NHS Digital (TSSM, Cyber)  NHS X	Formally publish Digital Strategy and EPR business case, ratified by Board  Participate well in ICP Digital Strategy Group  Form Digital First Team  Appoint CCIO  Re-launch Digital/IT team  Continue to work closely with Regulators	3 x 3 = 9 <b>Moderate</b>	3 x 2 = 6 <b>Low</b>	P

COMPOSITE RISK: Quality 2021/22											
EXECUTIVE LEAD: Chief Nursing and Quality Officer (5a and 5b) and Chief Operating Officer (5c)											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Gaps in Assurance/ Controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)					
5a Failure to consistently demonstrate compliance with the Care Quality Commission Fundamental standards, and as such, to meet the statutory requirements of the Health and Social Care Act	<b>Cause and Impact:</b> 1. Lack of effective governance systems and processes to routinely monitor compliance with the fundamental standards. 2. Lack of evidence to demonstrate compliance with NQB and NICE guidance (2015) Workforce Standards 3. Potential for regulatory action by CQC &/ or NHSI. 4. Loss of confidence in the Trust by the wider healthcare system e.g. CCG, patients and carers. 5. Poor staff morale and engagement. 6. Damage to patient experience and patient outcomes.	<b>12 Moderate 3(L) x4(C)</b>	1. Agreed Quality Strategy Priorities Year 2 2. Quality Report and Accounts 3. Agreed High Quality Care Programme Year 2 improvement priorities: monthly monitoring 4. Ward Quality & Safety Boards 5. Ward Gold 'stars' awards to recognise and celebrate patient high standard achievements. 6. CQC showcase events 7. CQC Engagement Meetings 8. Daily Trust wide safe staffing reviews: CNO & DDON escalation 9. Annual Safe Staffing reviews 10. Recruitment pipeline as per plan. 11. ED MD/ SD action plan following December 2020 unannounced CQC inspection now completed 12. NHSEI Independent Quality Governance review completed. Recommendations accepted by the Executive 13. Programme of Ward Quality Assurance Visits 14. Refreshed CQC MD SD action plan 15. CNST Maternity Incentive Scheme 16. Quality metrics monitored & reported via IQPR and divisional scorecards, Quarterly triangulation report on Claims, Complaints and Incidents to QAC 17. Audit review processes: Clinical Audit programme, Perfect Ward, NICE, NCEPOD & GIRFT providing enhanced assurance and oversight. 18. Quality Governance team, systems & processes 19. CCG CQR meeting 20. Quarterly report on clinical audit plan compliance to Q&PSG 21. Chief Medical Officer Grand Rounds 22. SI & IR Group meeting CQC action plan Must and Should Do with accountable executive and operational owners	CQC action plans are monitored through the biweekly Quality Panels. Following review of Quality Governance, CQC inspection will be monitored through Quality and Patient Safety Subcommittees going forward.  Our Journey to Excellence is part of Patient First programme and a priority for the organisation. CQC inspections is a part this priority.  A ward to board assurance framework has been developed which will support the organisation on its journey to excellence and full compliance with requirements of the Health and Social Care act.  Quality and Patient Safety Subcommittees meeting monthly.  CNST Task and Finish Group meeting fortnightly.  Care Group and Divisional Governance Boards meeting monthly	Monthly progress reports on divisional Quality Governance to Q&PSS, Executive Group, Quality Assurance Committee and Trust Board.  High Quality Care Programme Board provides monthly progress reports to the Trust Improvement Board.  Rolling programme of preparedness CQC care group showcase forums in place.  Quality Report and Accounts.  All actions on the ED MD/ SD action plan, following the unannounced CQC inspection of ED in December 2020, have now been completed and approved by the Quality Panel and incorporated into BAU.  CQC action plans are monitored through the central quality and compliance team with regular reporting to QPSS and QAC. Robust evidence is gathered through the biweekly quality panel.  CNST Maternity Incentive Scheme approved by the Trust Board and submitted to NHS Resolution in July.	Internal Audit and External Quality Audit.  QGR meetings with GCCG  CQC Engagement Meetings  Single Item Multi-Agency meetings	1. Divisional ownership and accountability for quality governance needs to be strengthened. 2. Embedding the new Governance Structure will take time and needs to be closely monitored	1. Organisational plan for moving Trust from good to outstanding in development led by Chief Strategy & Transformation Officer, CNO & AD QPS 2. Ward accreditation and CQC preparedness approach under review with the aim of combining the approach: self-assessment, assurance visit and showcase events 3. Monthly Matron & HON assurance monitoring meeting to discuss early warning quality assurance findings 4. Independent Quality Governance review structure implementation has been completed which has resulted in a new and improved way to monitor quality standards as well as ward to board flow of information. 5. a new Assurance and Escalation report has been developed which will be used to highlight risks as	<b>8 Low 2(L)x4(C)</b>	<b>4 Very Low 1(L)x4(C)</b>	Partial

			23. New approved Governance Structure					<p>well as learning going forward</p> <p>6. Review of safe staffing review approach underway</p> <p>7. There is now a Head of Patient Experience in post to support Driving PE agenda forward.</p> <p>8. Effectiveness &amp; Outcome Group has been reviewed following review of a more robust governance structure.</p> <p>9. Learning framework to articulate the Trust wide methodology for shared learning being developed</p> <p>10. Ward to Board Assurance Framework has been developed as part of the organisation's Journey to Excellence.</p> <p>New early warning tool (GTHERR) I currently being implemented to ensure timely review, monitoring and oversight of key quality data. This will also include Quality Assurance Visits as well as audits that will improve Trust wide insight into gaps and risks as well as areas of good practices across the organisation.</p>			
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Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Gaps in assurance / controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)					
<b>5b</b> Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	<b>Cause and Impact:</b> 1. Lack of effective IP&C governance systems and processes to routinely monitor and maintain compliance with the hygiene code 2. Potential for regulatory action by CQC &/ or NHSI. 3. Loss of confidence in the Trust by the wider healthcare system. 4. Poor staff morale and engagement. Damage to patient experience and patient outcomes.	<b>12</b> <b>Moderate</b> <b>3(L) x4(C)</b>	1. IPC Improvement plan 2. NHSEI & CCG IPC Intensive Support programme supporting the Trust 3. CNO is the DIPC 4. IPC Doctor is also Associate DIPC 5. Head of IPC is Deputy DIPC 6. IP&C Team structure and leadership 7. Improvement priority work through HQCP to reduce C- Diff Infections 8. IP&C Governance Review completed 9. Covid BAF reviewed and updated 10. MFT participation in Kent & Medway IPC Network 11. CNO IPC monthly blogs to communicated key messages 12. Mandatory IPC training compliance at over 95% for the majority of the last several months 13. Infection Prevention and Control Committee 14. Antimicrobial Stewardship Committee 15. Quality Assurance Committee 16. High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction 17. Decontamination included as part of IPC Committee 18. IPC Cell initiated as per COVID Plan	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual approach to be adopted, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan developed setting out short, medium and long term goals for delivery Mandatory IPC training compliance at over 95% for the majority of the last several months. Divisional and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Assurance Committee Quality Panel High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction Decontamination Group in place – IPC Cell initiated as per COVID Plan	IPAS (NHS I/E) meeting Oversight from system DIPC NHSE/I report CQC IP&C Inspection report	IPC policies currently undergoing review. PIRs not being completed in a timely way, therefore limited lessons learned and shared.	1. IPC policies, procedures and protocols being reviewed 2. CNO IPC monthly blog to be recommenced: Every Action Matters NHSEI initiative 3. Development of early warning quality assurance scorecard underway: will include IPC KPIs 4. Monthly Matron & HON assurance monitoring meeting to discuss early warning quality assurance findings 5. IPC Governance Review: implementation and improvement plan and update report to be presented at Exec, IPCC and QAC 6. Outbreak policy being updated	<b>8</b> <b>Low</b> <b>2(L) x 4(C)</b>	<b>4</b> <b>Very Low</b> <b>1(L)x4(C)</b>	Partial

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Gaps in assurance / controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
<b>5C</b> There is a risk that the Trust is unable to meet the constitutional standards for emergency and elective access	<b>Cause and Impact:</b> 1. Insufficient capacity to manage the totality of the emergency and elective demand over a 12 month period causing a deficit of bed on occasions leading to AMB hand over delays, long waits in ED and cancellation of elective activity 2. The demand for emergency care exceeds the expected levels for attendances and admissions	<b>16 High</b> <b>4(L)x4(C)</b>	1. Restart programme includes a refresh of demand and capacity across all specialties 2. Pathways reviewed to ensure patients receive care in most appropriate settings. 3. Emergency pathways further developed to include range of assessment options through frailty, acute assessment (medical and surgical) and Same Day Emergency Care (SDEC). 4. A priority admission unit (PAHU) has been set up to facilitate transfers out of ED once patients have a DTA. 5. Bed reconfiguration programme undertaken to profile the planned and unplanned beds based on expected demand, co-location of specific areas & full ring-fencing of elective capacity. 6. Renewed focus on length of stay to ensure patients get the most effective care as short a stay in hospital as is appropriate for their care (Patient First). 7. Covid and Winter Plan identified further interventions to expand capacity and maximise use of beds. 8. Elective, outpatients & cancer care modelling completed to ensure patients with a prolonged wait for treatment are appropriately prioritised and managed. 9. Recovery programme managed through System approach to ensure all out-of-hospital capacity and opportunities are highlighted and used appropriately. 10. Elective standards delivered as per the agreed trajectories (some ahead of trajectory). 11. NEL trajectories for the 4 hour standard, time spent in ED and ambulance handovers. 12. Action plan developed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A 13. ECIST 14. Patient First Programme:- focus is on 3 aspects of flow management: Acute Care Transfer, Flow and Discharge, Site Operations 15. SAFER principals taught ward by ward basis	Recovery plans including agreed trajectories for all constitutional standards  Patient Discharge & Flow Programme with focused clinically led work-streams.  Regular Mini-MADE events on targeted wards to highlight and manage delayed discharges for medically optimised patients.  Daily and Weekly operational performance reviews for elective, cancer and emergency activity  Daily check points for activity & flow  Trajectories for all constitutional standards in place.  Involvement of Matrons and Clinical Leads in Flow management  More clarity and targeted actions with system-partners on out of hospital capacity and responsiveness  Outputs and rapid changes from the Rapid Improvement Event held w/c 16	Reviews and updates discussed at Executive Group, TIB and Board.  Daily and weekly senior operational oversight.  National planning tools being used.  System calls in place to ensure escalations.  IQPR  PIRM  Progress against ED action plan will be overseen by Quality Panel	External reviews by NHS I/E  Single Item Multi-Agency meetings  Monthly checkpoint with SE Region  Monthly ICS Performance Reviews	1. Inability to fully mobilise the bed configuration and refurbishment plan 2. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22 3. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22.	1. Restart programme focused on Elective, Cancer and Diagnostics 2. Pathway interrogation to seek opportunities in accelerating frequent causes for delays (e.g., specialist beds prosthetic rehabilitation). Working with system partners to find care alternatives 3. SAFER, BR process and IDT work to improve discharge opportunities in back end wards and enable Assessment units to function 4. Revision and embedding of safer discharge principals 5. Regular Mini-MADE events on targeted wards to highlight and manage delayed discharges for medically	<b>20 High</b> <b>5(L)x4(C)</b>	<b>8 Low</b> <b>2(L)x4(C)</b>	Partial

			16. Recovery plans including agreed trajectories for all constitutional standards 17. Patient Discharge & Flow Programme with focused clinically led work-streams 18. Daily and weekly senior operational oversight 19. System calls 20. IQPR 21. PIRM 22. Monthly checkpoint with SE Region 23. Monthly ICS Performance Reviews 24. Weekly length of stay meetings with Matrons to focus on patients with LOS 14+, Intention to reflect this to patient 7days+ once numbers reduce	July 2021 being reviewed as to whether to adopt, adapt or discard any of the 'tests of change'.				optimised patients <b>6.</b> More engagement with Estates and Facilities re priorities for capacity configuration <b>7.</b> Full mobilisation of Frailty SDEC <b>8.</b> Inability to fully mobilise the bed configuration and refurbishment plan <b>9.</b> Roles and responsibilities review of IDT to ensure that MFT and MCH colleagues can work collaboratively to ensure that patient discharges are expedited <b>10.</b> Work with system partners to explore alternative options for intermediate resolution whilst care packages are extremely restricted (eg step down beds)			
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COMPOSITE RISK: Workforce										
EXECUTIVE LEAD: Chief People Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Four – We will enable our people to give their best and achieve their best										
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
<b>4a</b> There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety  Reduction in available staff following mandatory vaccination based on current vaccination rates.	<b>4 x 4 = 16 High</b>	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) ‘Our People’ programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) ‘Our People’ programme reviewed through the Trust Improvement Board (including NHS People Plan)  Wellbeing Guardian quarterly assurance report		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22]  Patient First to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Date TBC]  Delivery of equality action plans, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 22]	<b>4 x 4 = 16 High</b>	<b>3 x 2 = 6 Low</b>	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 10%. 2. Monthly Sickness rate 5% 3. Substantive workforce 85% Safe staffing report (twice yearly)					
			3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing.  Temporary staffing and daily pressure/gap report in operation.						
			4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	People Committee resourcing report – All staff groups recruitment					

			5. Temporary staffing delivery: <ul style="list-style-type: none"> <li>a. NHSI agency ceiling reporting to Board;</li> <li>b. Weekly breach report to NHSI;</li> <li>c. Reporting to Board of substantive to temporary staffing paybill.</li> </ul>		People Committee reporting <ul style="list-style-type: none"> <li>1. £6m favourable to ceiling;</li> <li>2. Averaging 30 breaches per week compared to c1000 in 2016</li> <li>3. Agency workforce 2%</li> <li>4. Bank workforce 13%</li> </ul>					
			6. Workforce redesign: <ul style="list-style-type: none"> <li>a. PRM review of hard to recruit posts and introduction of new roles;</li> <li>b. Reporting to Board apprenticeship levy and apprenticeships.</li> </ul>	OD Performance report 150 apprentices of 101 target	People Committee					
			7. Operational: <ul style="list-style-type: none"> <li>a. Operational KPIs for HR processes and teams reported monthly.</li> </ul>	HR & OD performance meeting 85% of operational HR KPIs met						
			8. Vaccination as a condition of deployment (VCOD) <ul style="list-style-type: none"> <li>a. VCOD policy approved and phase 1 process implemented;</li> <li>b. Signposting and information available including 1-2-1s with line managers.</li> </ul>	Covid tactical and strategic			Phase 2-4 VCOD national guidance pending			

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
<b>4b</b> Staff engagement  Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	<b>3 x 4 = 12 (Moderate)</b>	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan)		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22]	<b>3 x 4 = 12 (Moderate)</b>	<b>3 x 2 = 6 (Low)</b>	
			Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme.	1. You are the difference (YATD) embedded in induction 2. NHSEI Culture, Engagement and Leadership Programme Board	NED Wellbeing Guardian assurance report		Delivery of the Staff Health and Wellbeing strategy [Mar 22 milestone]			
			Staff Communications: <ul style="list-style-type: none"> <li>a. Weekly Chief Executive communications email;</li> <li>b. Monthly Chief Executive all staff session;</li> <li>c. Senior Team briefing pack monthly.</li> </ul>	Communications routes well-established in Trust.	Freedom to Speak Up strategy quarterly assurance report		Delivery of ILM level 3 leadership programme [Dec 21]			
			Staff Survey results: Annual report to Board demonstrating: <ul style="list-style-type: none"> <li>a. Trust scores across key domains;</li> <li>b. Comparative results from previous years and other organisations;</li> <li>c. Heat maps for targeted interventions.</li> <li>d. Local survey action plans to address key concerns.</li> </ul>	Survey 2020 staff engagement score, 6.6 – lower than average 7 (6.4 2018, 6.8 2019)	Wellbeing Guardian quarterly assurance report		Refresh of Dignity at Work policy and approach [Dec 21]			
			Leadership development programmes:	1. Trust has become an						

			<div>a. Implemented to ensure leadership skills and techniques in place.</div>	<div>ILM-accredited centre; 2. Programme in fifth year; 3. Henley Business School MA leadership programme launched in Q4 2018/19.</div>						
			<div>Policies, processes and staff committees in place:<div>a. Freedom To Speak Up Guardian route to Chief Executive;</div><div>b. Respect: countering bullying in the workplace policy;</div><div>c. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.</div></div>	<div>1. Freedom to speak up guardians in place; 2. Respect policy in place; 3. JSC and JLNC in place.</div>						
			<div>Well-being interventions in place:<div>a. Employee assistance programme and counselling;</div><div>b. Advice and health education programmes;</div><div>c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support.</div><div>d. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian</div></div>	<div>1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live. 3. Staff Health and Wellbeing strategy and delivery plan</div>						
			<div>Values embedded into the Trust and culture:<div>a. Values-based recruitment (VBR) in place for medical and non-medical positions;</div><div>b. Values-based appraisal in conjunction with performance.</div></div>	<div>1. VBR in place Qualitative and quantitative values-based appraisal</div>						
<div><b>4c</b> Best staff to deliver the best of care  Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover.  <b>IMPACT:</b> This may lead to an impact on patient experience, quality, safety and risk the Trust’s aim to be an employer of choice.</div>	<div>This may lead to an impact on patient experience, quality, safety and risk the Trust’s aim to be an employer of choice.</div>	<div><b>3 x 4 = 12 (Moderate)</b></div>	<div>Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the ‘Best Culture’.</div>	<div>2019-22 People Strategy in place with monitored delivery plans. (HR&amp;OD performance meeting) ‘Our People’ programme fortnightly review meeting which includes the NHS People Plan</div>	<div>2019-22 People Strategy in place with monitored delivery plans. (People Committee) ‘Our People’ programme reviewed through the Trust Improvement Board (including NHS People Plan)  Freedom to Speak Up strategy quarterly assurance report  Wellbeing Guardian quarterly assurance report</div>		<div>Delivery of ILM level 3 leadership programme [Dec 21]  Civility and Respect launch [Nov 21]  Appraisal rate below requirement (85%) [Dec 21]</div>	<div><b>3 x 2 = 6 (Low)</b></div>	<div><b>3 x 2 = 6 (Low)</b></div>	
			<div>Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency.  Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.</div>	<div>Competency profile in place for all positions. Competency compliance linked to incremental pay progression (policy implemented). 1. StatMan compliance &gt;89% 2. Appraisal rate &gt;82%</div>						
			<div>Right attitude and values:<div>a. Values-based recruitment (VBR) in place for medical and non-medical positions;</div><div>b. Values-based appraisal in conjunction with performance;</div><div>c. Civility and respect toolkit, actions and behaviours;</div><div>d. Respect – countering bullying in the workplace policy.</div>Triangulation between FTSU, Employee Relations, Legal and Equality and Inclusion.</div>	<div>1. VBR in place Qualitative and quantitative values-based appraisal in place; 2. Civility and respect toolkit (live Nov 2021) 3. Respect policy in place.</div>						
			<div>Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity:</div>	<div>1. Trust vacancy rate at 10%; 2. Substantive workforce 85% 3. Monthly PRM</div>						

			<div>a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and temporary staffing usage at PRMs; c. Reporting to Board of substantive to temporary staffing paybill.</div>	including discussion on workforce, vacancies, recruitment plan and temporary staffing;						
			Leadership development programmes implemented to ensure leadership skills and techniques in place.	<div>1. Trust has become an ILM-accredited centre; 2. Programme in fifth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.</div>						

COMPOSITE RISK: Finance (NB Changes from January Report in Track Changes)										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
<b>3a Delivery of Financial Control Total</b>	<p>If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact.</p> <p>Under 2021/22 contracting arrangements the ICS must meet its control total. Given the uncertainty of Covid, efficiency delivery risks and the system operating on a block income, there is significant uncertainty and a risk of the Trust not meeting its control total. This risk is exacerbated by significant activity / demand above planned levels, particularly emergency and non-elective demand, in particular through the winter months.</p>	<b>4 x 4 = 16 High</b>	1. Rebasing of divisional plans through robust business planning/budget setting. 2. Seek additional monies from third parties to support initiatives and/or the underlying financial position, including the Charity, ICS and national funding sources. 3. Work with NHSEI intensive support team. 4. Application of NHSEI “Grip and Control” actions to limit spending, at least on a temporary basis.	Internal accountability framework at programme level, i.e. budget holder meetings.	Monthly reporting and insight of actual v budget performance for review at care group boards, divisional boards, divisional IQPRMs, Finance Committee and the Trust Board.	Monthly Integrated Assurance Meetings with regulators.	Further assurance of monies available / awarded to the Trust in respect of Targeted Investment Fund and UEC national funding. Pursuit of Statistical Process Charts in understanding financial performance. The System has confirmed that the risk to the control total of c£3m as at M09, arising from winter pressures and COVID will be covered.	<b>4 x 3 = 12 Moderate</b>  (Previous risk rating: Jan 2022 4 x 4 = 16 High)	<b>3 x 3 = 9 Moderate</b>  (Previous target risk rating: Mar 2020 3 x 2 = 6 Low)	
			5. Programme Management Office: <ul style="list-style-type: none"> <li>a. Work with divisional teams to identify, develop, implement and track operational delivery and financial consequences of efficiency schemes.</li> <li>b. Delivery of efficiency showcase events.</li> </ul>	Chief Financial Officer and Chief of Staff.	Efficiency Delivery Group.		Progression of cross-cutting schemes to implementation. Rapid assessment of red schemes with no value. Progression of red and amber schemes through PID panel. Attend efficiency support session for divisions with NHSEI. Overall gap of c£1m against 21/22 Efficiencies target mitigated non-recurrently from reserves			
			6. Financial Training Policy and SOP approved, setting out the minimum levels of which staff awareness of financial matters and their responsibilities thereon.	Delivery of and attendance at training programmes for staff. Appraisals / objective setting.	Financial Stability Programme Board.		Financial training packages to be continually reviewed. Training dates diarised for next 18 months and first sessions delivered; finance induction leaflet issued. Global and targeted communication issued.			

COMPOSITE RISK: Finance (NB Changes from January Report in Track Changes)										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
			7. Activity pressures monitored as follows: a. Daily review of emergency flow data to inform new actions & interventions. b. x3 times per day site / flow meetings. c. Patient First Programme workstreams focused on improvements to: i. Discharge and Flow ii. Acute Care Transformation d. Public communication.	Chief Operating Officer	Weekly Senior Operations Meeting that reports via IQPR	Monthly IQPR meetings with NHSE/I	Agreement from Trust Executive Group as to which elements of the winter plan must be implemented irrespective of funding.			
			8. Escalation process to budget managers at care group level that monitor financial performance as well as efficiency delivery.	Chief Operating Officer	Monthly escalation reports sent to Directors and Service Managers.		Budget managers to provide a recovery plan and meet with the Chief Financial Officer to present this plan. Monthly Financial Escalation Process implemented from M09 – see report on Feb'22 Finance Committee Agenda			
3b Capital Investment	If there is insufficient resource to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan, patient safety and/or staff wellbeing.  Capital resource is allocated at a system level across the ICS and hence both national and local priorities (including top-slicing for ICS projects) could impact availability.	4 x 4 = 16 <b>High</b>	1. Governed entirely by the availability of capital resource, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the ICS and regulators unless affordable within the existing capital programme or through a revenue stream. 2. Project lead completion of prioritisation scoring matrix; Trust review to moderate and agree scores with highest priority projects being proposed as the in-year plan. Trust executive to review and agree the plan, including those items “below the line” in any given year. 3. Bid against/for additional capital sums released during the course of the year, whether that be from the ICS allocation or national funds for particular themes.	Trust business case governance process and templates	Project reviews by Finance Committee  Scrutiny of the overall capital programme by the Trust Capital Group, Business Case Review Group, Finance Committee and Board.	Sharing and scrutiny via the ICS capital planning group.	1. Trust clinical and divisional strategies to be developed by 31 March 2022.  2. Clarity and support from ICS where further funding is made available (ongoing/as applicable).  3. Capital plans / pipeline from divisional teams for 22/23 have been received. PIDs (and where required, business cases) to be written for approval in advance so schemes are “ready to go” as funds are known/awarded).  4. The trust plan will be submitted /	4 x 3 = 12 <b>Moderate</b>  (Previous risk rating: Oct 2021 4 x 4 = 16 <b>High</b> )	4 x 3 = 12 <b>Moderate</b>	

COMPOSITE RISK: Finance (NB Changes from January Report in Track Changes)										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Assurance			Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
				Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)				
							<p>reviewed at the ICS system capital plan meeting on the 25<sup>th</sup> January.</p> <p>Risk against delivery of 2021/22 capital target from slippage in schemes is being mitigated through implementation of additional schemes and reclassification of EPR project spend from revenue to capital (see Finance Report)</p> <p>5 Year Capital Programme being finalised, for final agreement with execs and with System – report back to March Finance Committee</p>			
<b>3c</b> <b>Failure to develop, approve and deliver against a Financial Recovery Plan (“FRP”)</b>	<p>If the Trust does not understand and agree with its partners the route(s) and impediments to financial sustainability, and then deliver against this, it will not exit the Recovery Support Programme, leading to reputational damage, further licence conditions and potential regulatory action.</p>	<p>4 x 4 = 16  <b>High</b></p>	<ol style="list-style-type: none"> <li>1. Financial sustainability has been agreed as one of the Trusts top corporate priorities following an executive director exercise. This is a strategic priority under “Patient First”.</li> <li>2. NHSE/I financial improvement/recovery group established including NHSE/I intensive support team collaboration.</li> <li>3. Work on the financial modelling has begun with sound collaboration and engagement across the ICP.</li> <li>4. A Financial Recovery Plan Director has been appointed to deliver this programme of work.</li> </ol>	<p>Development of long term financial model.</p> <p>Clinical service strategies in place and aligned to the Trust, ICP and ICS strategies.</p>	<p>Reporting of identified risks and pressures alongside efficiency and financial performance to Finance Committee regularly.</p> <p>Monitored at Financial Stability Programme Board.</p> <p>ICP working group and ICP steering groups.</p>	<p>NHSE/I-led steering committee of ICS partners.</p> <p>ICS currently responsible for managing system positions, with principle that all organisations achieve breakeven.</p>	<p>Agreement of activity growth/trajectories and associated financial modelling assumptions. Development of local and system interventions / efficiencies.</p> <p>Progress has been made since the January Finance Committee with:</p> <ol style="list-style-type: none"> <li>a. Completion of Final draft Drivers of Deficit (on agenda)</li> </ol>	<p>4 x 4 = 16  <b>High</b></p> <p>(Previous risk rating: Dec 2021 4 x 3 = 12 <b>Moderate</b>)</p>	<p>4 x 1 = 4  <b>Very low</b></p> <p>(Previous target risk rating: Mar 2020 4 x 3 = 12 <b>Moderate</b>)</p>	

<b>COMPOSITE RISK: Finance (NB Changes from January Report in Track Changes)</b>										
<b>EXECUTIVE LEAD: Chief Finance Officer</b>										
<b>LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do</b>										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
			5. The drivers of deficit work has been updated to January 2022.  6. Implementation of the grip and control actions, in particular the financial escalation process.				b. Implementation of Grip and Control actions and Financial Escalation Process  c. Strengthening of governance and processes for development of Efficiencies Programme at pace for 2022/23			

# Patient First

**Executive Lead:** Dr George Findlay

**SRO:** Paula Tinniswood

**Head of Transformation:** Jacqui Leslie

March 2022





# Patient First Health Check

## Phase: Strategic Deployment

Progress  
against Plan

• on track

Budget

• on track

Risks/Issues for  
escalation

• none



# Patient First Strategic Deployment Milestones

Week 1

## Kick-off - w/c 17 January

- Exec session on A3 development – Wednesday 19<sup>th</sup> 10am
- Preparatory work and scheduling of development sessions
- Expect three 90 minute sessions over the next 3 weeks

Week 3

## Deep dive - w/c 31 January

- 2<sup>nd</sup> development session: understand what the data is telling us and develop “countermeasures” / action plans

Week 5

## Refine - w/c 14 February

- 3<sup>rd</sup> / 4<sup>th</sup> (Refine) sessions with Quality, Patients and Systems & Partnerships True North domains, following on from People and Sustainability in w/c 7 Feb to review data and countermeasures.
- Patient Experience Strategy agreed at Trust Board in w/c 7 Feb

Week 6

## Refine continued / Finalise – w/c 21 February

- Final A3 sessions completed with Systems & Partnerships (Quality – 1st Mar)
- Coaching / support for completion of remaining True North domains
- Preparation started for PFIS: Divisions and Care Groups roll-out in mid-March

Week 7

## Finalise and complete Exec A3's / Share – w/c 28 Feb

- Exec presentations and A3 sign-off - 2 Mar
- Finalise logistics and complete Stakeholder mapping for Divisions and Care Groups roll-out. Communications to support roll-out phasing

## MFT – Patient First Roadmap(1/2)

	Y1				Y2		
	Feb- Apr '22	May- July '22	Aug- Oct '22	Nov '22- Jan '23	Feb- Apr '23	May- July '23	Aug 23 - Jan'24
Programme oversight and executive development	Programme oversight and Quality assurance						
	Board stakeholder management and leading executive workshops / development sessions (primarily tied to Strategy deployment and Leadership behaviours)						
Management System- design	Current state review and readiness	▲ Assess & Review					
	Design Board to Ward governance and supporting standard work	Implement pilot of new routines					
	Management system spread planning	Implement remainder new governance and management system design					
Strategy deployment & Exec Development	True north and breakthrough A3s	Corporate Project Review & Alignment with annual planning process		Start annual planning process			
	Visual room set up			Embed new exec routines and PDSA			
	Strategic initiative A3s	Embed full strategic review process into Exec routines					
	Trust scorecard and division dialogue	Scorecard review					
PFIS - Divisions and care groups	Plan deployment						
	Patient First Wave 1 – Divisions & Care Groups	Ongoing sustainability and coaching	Ongoing sustainability and coaching	Ongoing sustainability and coaching			
	▲ Catchball- Scorecard	▲ 1 <sup>st</sup> Improvement Meeting					
<div>Key</div> <div>KPMG led with Trust support</div> <div>Trust led with KPMG coaching support</div> <div>Trust led self sufficiently</div>							

## MFT – Patient First Roadmap(2/2)

	Y1				Y2			
	Feb- Apr '22	May- July '22	Aug- Oct '22	Nov '22- Jan '23	Feb- Apr '23	May- July '23	Aug- Oct '23	Nov '23- Jan '24
PFIS – Frontline teams	Patient First Wave 2 – Frontline – Starts April'22	Wave 4	Wave 6	Wave 8	Continued roll-out			
	Wave 3	Wave 5	Wave 7	Wave 9				
Leadership development & Board Support	Exec team & personal A3 development & coaching + Board engagement and coaching							
			Personal A3, Team A3 and ongoing leadership coaching					
			Alignment of Shingo / Catalysis leadership behaviours with Trust framework	Roll out values and behaviours framework				
Step change projects			Select step change projects from BOs		Continued project rollout			
			Patient led improvement projects – patient experience led design / Value stream mapping and Rapid improvement events					
Centre of excellence – Capability building & Sustainability planning	Confirm Team size and structure	Bootcamp and training strategy	Deliver roadmap					
		Agree Team standard work						
Key Strategy Delivery Timetable	Patient Experience Clinical Quality People	Digital Estates and Facilities Workforce	Finance Maternity Research and Innovation	Learning Disability Freedom to Speak Up Business Intelligence	Dementia Therapies Safeguarding	Staff Health and Wellbeing Information Governance	Health and Safety Business Continuity Management	Data Quality and Assurance Risk Management
<div> <div>Key</div> <div>KPMG led with Trust support</div> <div>Trust led with KPMG coaching support</div> <div>Trust led self sufficiently</div> </div>								



## Meeting of the Board of Directors in Public Wednesday, 09 March 2022

Title of Report	Integrated Quality and Performance Report (IQPR)	Agenda Item	4.1
Report Author	Evonne Hunt – Chief Nursing Officer Alison Davis – Medical Director Jayne Black – Chief Operating Officer		
Lead Director	Evonne Hunt – Chief Nursing Officer Alison Davis – Medical Director Jayne Black – Chief Operating Officer		
Executive Summary	<p>This report informs Board Members of the quality and operational performance across key performance indicators for the January 2022 reporting period.</p> <p><b>Safe</b> Our Infection Prevention and Control performance for January shows that the Trust has had 0 MRSA bacteraemia cases and 2 hospital acquired C-diff cases.</p> <p><b>Caring</b> MSA has shown improvement, January has seen that 104 breaches were recorded. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high.</p> <p>The Friends and Family recommended rates for three areas, remain close or above the national standard of 85% (Inpatients: 78.5%, Maternity: 99.7%, Outpatients: 89.8%, ED: 79.1%).</p> <p><b>Effective</b> Discharges before Noon, whilst close to the mean are still below at 18.4% and significantly below the Target of 25%, this is being reviewed through the rapid improvement work.</p> <p><b>Responsive</b> The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In January the RTT standard was 62.01% and the Trust recorded 112 52 week breaches which is lower than previous months.</p> <p>ED (Type 1) 4 hour performance as a result of site pressures reported 65.3% in December. Additionally, the Trust saw 170 Ambulance Handover delays of +60mins.</p> <p>The DM01 Diagnostics performance is at 75.1% for January 2022.</p> <p>In December 2021, 95% of patients were seen within 2 weeks of their referrals into the cancer pathways and 88.9% of patients were treated within 62 days.</p> <p><b>Well Led</b> We have seen a stable position in appraisal rates, reporting 83.5% and the Trust has maintained compliance statutory and mandatory training at 89.4%.</p>		

	<p>To note:</p> <ul style="list-style-type: none"> <li>• The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay.</li> <li>• The SHMI data is currently showing March – this is reliant on MHS I/E/D and is 3 to 4 months in arrears.</li> <li>• The HSMR is currently showing March data, this is reliant on Dr Foster and this is 3 to 4 months in arrears.</li> <li>• The bed occupancy includes all beds within the Trust including maternity and paediatrics.</li> <li>• IPC and cancer data is reported a month in arrears.</li> </ul>			
Link to strategic Objectives 2019/20	<b>Innovation:</b> We will embrace innovation and digital technology to support the best of care			<input checked="" type="checkbox"/>
	<b>Finance:</b> We will deliver financial sustainability and create value in all we do			<input checked="" type="checkbox"/>
	<b>People:</b> We will enable our people to give their best and achieve their best			<input checked="" type="checkbox"/>
	<b>Integrated Health Care:</b> We will work collaboratively with our system partners to establish an Integrated Care Partnership			<input checked="" type="checkbox"/>
	<b>High Quality Care:</b> We will consistently provide high quality care			<input checked="" type="checkbox"/>
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.			
	<b>Approval</b> <input checked="" type="checkbox"/>	<b>Assurance</b> <input checked="" type="checkbox"/>	<b>Discussion</b> <input checked="" type="checkbox"/>	<b>Noting</b> <input checked="" type="checkbox"/>
Appendices	Appendix 1 – IQPR – December 2021			

# Integrated Quality and Performance Report

Reporting Period: January 2022



## How to...

### 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.

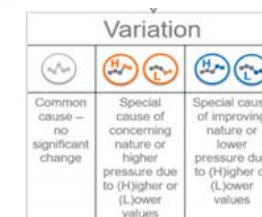
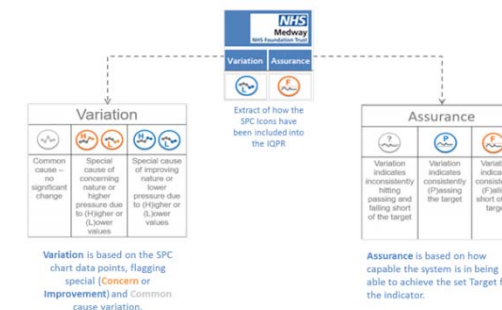
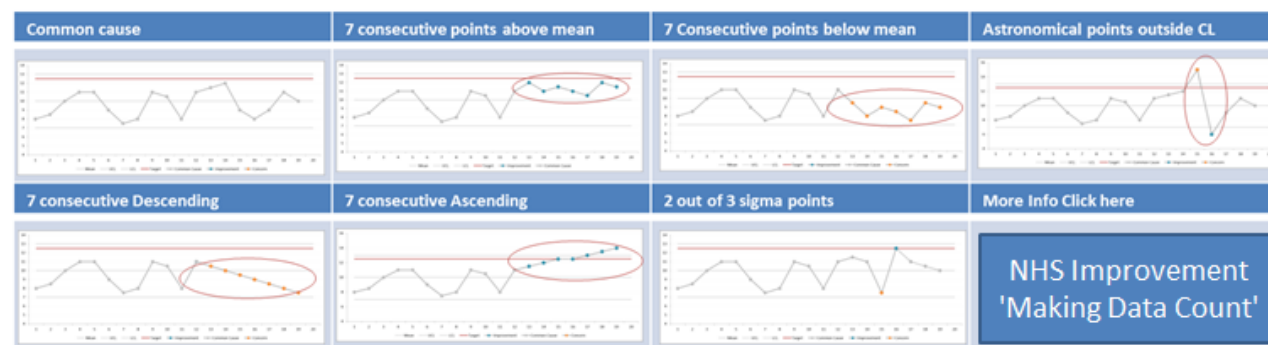
#### Key Facts about a SPC Chart:

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:



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



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

Topic	Overview	Deep Dive
Executive Summary	4	5
Caring	7	8
Effective	13	14
Safe	15	16
Responsive	20	22
Well Led	35	36

Executive Summary

	Success	Challenge
Trust	<ul style="list-style-type: none"> <li>Cancer &amp; Mortality improvement</li> </ul>	<ul style="list-style-type: none"> <li>Flow &amp; Emergency Pathways</li> </ul>
Caring	<ul style="list-style-type: none"> <li>EDNs completed within 24hrs is showing signs of improving</li> <li>The number of Complaints received is lower than that expected</li> </ul>	<ul style="list-style-type: none"> <li>High number of breaches in Mixed Sex Accommodation continues</li> <li>% Complaints responded to within target has declined</li> <li>FFT scores are showing sign of decline</li> </ul>
Effective	<ul style="list-style-type: none"> <li>Discharges before Noon and 30 day Readmission Rate are showing high statistical variation, and signs of improvement</li> </ul>	<ul style="list-style-type: none"> <li>High statistical variance in Emergency C-Section rates evidenced</li> <li>Fractured NOF significantly below target</li> <li>VTE Risk Assessment % Completed showing signs of deterioration</li> </ul>
Safe	<ul style="list-style-type: none"> <li>PU Incidence and Falls rate continuously passes (achieves under) the target set</li> <li>Both HSMR and SHMI have shown a statistically significant improvement</li> </ul>	<ul style="list-style-type: none"> <li>Cdiff (Trust Attributable) rates show a YTD position above plan</li> <li>E-Coli cases are above plan for month and YTD</li> </ul>
Responsive	<ul style="list-style-type: none"> <li>Cancer 62day standard, 2ww and 31day have achieved compliance in month and shown significant improvement</li> <li>DToc levels &amp; Elective LoS show continued signs of improvement</li> </ul>	<ul style="list-style-type: none"> <li>MFFD rate, ED 12hr DTAs and the ED % Target have deteriorated</li> <li>RTT Incomplete Performance decreased</li> </ul>
Well Led	<ul style="list-style-type: none"> <li>Maintained compliance with Trust target for StatMan Compliance</li> <li>Patient First initiative Launched</li> </ul>	<ul style="list-style-type: none"> <li>Turnover Rate shows an increase in statistical variance</li> <li>Bank spend has increased considerably</li> <li>Sickness Rates have shown a statistically significant increase</li> </ul>

Summary

Caring

Effective

Safe










Responsive




Well Led

Best of care  
Best of people



## Executive Summary

CQC Domain	CQC Sub Domain
Caring	Admitted Care
	ED Care
	Maternity Care
	Outpatients Care
Effective	Best Practice
	Maternity
Responsive	Bed Management
	Cancer Access
	Complaints Management
	Diagnostic Access
	ED Access
	Elective Access
	Theatres & Critical Care
	Harm Free Care
Safe	Incident Reporting
	Infection Control
	Mortality
Well Led	Workforce

TRUST									
Variation					Assurance				
									
4	1	0	0	0	0	1	4	0	
1	1	0	0	0	0	1	1	0	
2	0	0	0	0	1	0	1	0	
1	1	0	0	0	1	1	0	0	
2	1	0	1	1	0	2	3	0	
3	0	1	0	0	0	2	2	0	
2	0	2	1	0	2	2	1	0	
3	0	0	0	2	0	0	5	0	
1	1	0	0	0	0	0	2	0	
1	0	0	0	0	0	0	1	0	
1	2	1	0	0	0	2	2	0	
1	1	1	0	0	0	2	1	0	
2	0	0	0	0	0	0	2	0	
1	0	0	1	0	1	0	1	0	
3	0	0	0	0	1	0	1	1	
3	0	0	1	0	1	0	2	1	
1	0	0	4	0	0	1	2	2	
1	2	2	1	2	1	0	6	1	

Variation		
		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H) higher or (L) lower values	Special cause of improving nature or lower pressure due to (H) higher or (L) lower 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) passing the target	Variation indicates consistently (F) falling 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

Safe		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
S1	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	3	3	43	55		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	2	0	40		
S3	MRSA Bacteraemia (Trust Attributable)	0	0	5	0		
S4	E-coli (Trust Acquired) Infections	2	5	30	76		
S5	Falls Per 1000 Bed Days	6.63	5.27	6.63	4.88		
S6	Pressure Ulcer Incidence Per 1000 days (High Harm)	1.04	0	1.04	0.02		
S7	Never Events	0	0	0	3		
S8	% of SIs Responded To in 60 Days	100.0%	100.0%	100.0%	96.6%		
S9	HSMR (All)	100	92.69	100	0.98		
S10	HSMR (Weekday)	100	88.50	100	0.95		
S11	HSMR (Weekend)	100	101.99	100	1.05		
S12	SHMI	1	1.01	-	18.01		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R1	Bed Occupancy Rate	85.0%	86.7%	85.0%	82.9%		
R2	Average Non-Elective Length of Stay	5	9.56	5	8.41		
R3	Average Elective Length of Stay	5	2.91	5	2.28		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	0.1%	4.0%	0.8%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	17.6%	7.0%	12.1%		
R6	ED 4 Hour Performance All Types	95.0%	74.3%	95.0%	80.2%		
R7	ED 4 Hour Performance Type 1	95.0%	65.3%	95.0%	70.9%		
R8	ED 12 hour DTA Breaches	0	74	0	638		
R9	Number of ED arrivals by Ambulance	-	3,328	-	70,857		
R10	60 Mins Ambulance Handover Delays	0	170	0	4,581		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	75.8%	99.0%	79.5%		
R12	18 Weeks RTT Incomplete Performance	92.0%	62.1%	92.0%	65.2%		
R13	18 Weeks RTT Over 52 Week Breaches	0	112	0	4,965		
R14	Operations Cancelled By Hospital on Day	0	8	0	282		
R15	Cancelled Operations Not Rescheduled < 28 days	0	0	0	46		
R16	Cancer 2ww Performance	93.0%	95.0%	93.0%	95.8%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	90.6%	93.0%	91.7%		
R18	Cancer 31 Day First Treatment Performance	96.0%	97.1%	96.0%	97.1%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	88.9%	85.0%	74.4%		
R20	104 Day Cancer Waits	0	1	-	53		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	104	0	2,444		
C2	Number of Complaints	41	30	-	966		
C3	% Complaints Responded to Within 30 Days	85.0%	30.6%	85.0%	56.0%		
C4	% of EDNs Completed Within 24hrs	100.0%	70.7%	100.0%	68.7%		
C5	Inpatients Friends & Family Response Rate	22.0%	17.9%	22.0%	18.7%		
C6	Inpatients Friends & Family % Recommended	85.0%	78.5%	85.0%	80.1%		
C7	ED Friends & Family Response Rate	22.0%	14.3%	22.0%	14.7%		
C8	ED Friends & Family % Recommended	85.0%	79.1%	85.0%	81.0%		
C9	Maternity Friends & Family Response Rate	22.0%	21.4%	22.0%	27.0%		
C10	Maternity Friends & Family % Recommended	85.0%	99.7%	85.0%	98.4%		
C11	Outpatients Friends & Family Response Rate	22.0%	7.9%	22.0%	9.9%		
C12	Outpatients Friends & Family % Recommended	85.0%	89.8%	85.0%	89.0%		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	4.7%	5.0%	6.6%		
E2	30 Day Readmission Rate	10.0%	9.9%	10.0%	12.7%		
E3	Discharges Before Noon	25.0%	18.4%	25.0%	16.2%		
E4	Fractured NOF Within 36 Hours	100.0%	55.9%	100.0%	69.9%		
E5	VTE Risk Assessment % Completed	95.0%	91.1%	95.0%	95.1%		
E6	Elective C-Section Rate	13.0%	12.9%	13.0%	14.6%		
E7	Total C-Section Rate	28.0%	38.1%	28.0%	37.4%		
E8	Emergency C-Section Rate	15.0%	25.3%	15.0%	22.8%		
E9	12+6 Risk Assessment	90.0%	85.3%	90.0%	85.6%		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	83.5%	-	84.0%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	5.9%	4.0%	5.0%		
W5	Voluntary Turnover Rate - (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	14.0%	12.0%	12.5%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	89.4%	85.0%	89.1%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,307	-	91,456		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	0.4%	4.0%	2.8%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	14.0%	9.0%	12.7%		

## Domain: Caring Dashboard

**Executive Lead:** Evonne Hunt– Interim Chief Nursing & Quality Officer

**Operational Lead:** N/A

**Sub Groups :** Quality Assurance Committee



CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Jan-22	100.0%	70.7%	64.7%	70.8%	76.8%		
		Inpatients Friends & Family % Recommended	Jan-22	85.0%	78.5%	75.0%	82.2%	89.4%		
		Inpatients Friends & Family Response Rate	Jan-22	22.0%	17.9%	14.7%	19.1%	23.6%		
		Mixed Sex Accommodation Breaches	Jan-22	0	104	0	107.81	245.97		
		MSA %	Jan-22	0.0%	0.0%	0.0%	0.7%	1.7%		
	ED Care	ED Friends & Family % Recommended	Jan-22	85.0%	79.1%	70.7%	79.6%	88.5%		
		ED Friends & Family Response Rate	Jan-22	22.0%	14.3%	11.9%	14.4%	16.9%		
	Maternity Care	Maternity Friends & Family % Recommended	Jan-22	85.0%	99.7%	95.1%	99.0%	103.0%		
		Maternity Friends & Family Response Rate	Jan-22	22.0%	21.4%	9.6%	25.1%	40.7%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Jan-22	85.0%	89.8%	87.3%	89.7%	92.2%		
		Outpatients Friends & Family Response Rate	Jan-22	22.0%	7.9%	9.6%	11.7%	13.9%		

Summary

Caring

Effective

Safe

Responsive

Well Led



## Caring: Mixed Sex Accommodation (MSA)

**Aim:** Reduction in mixed sex accommodation

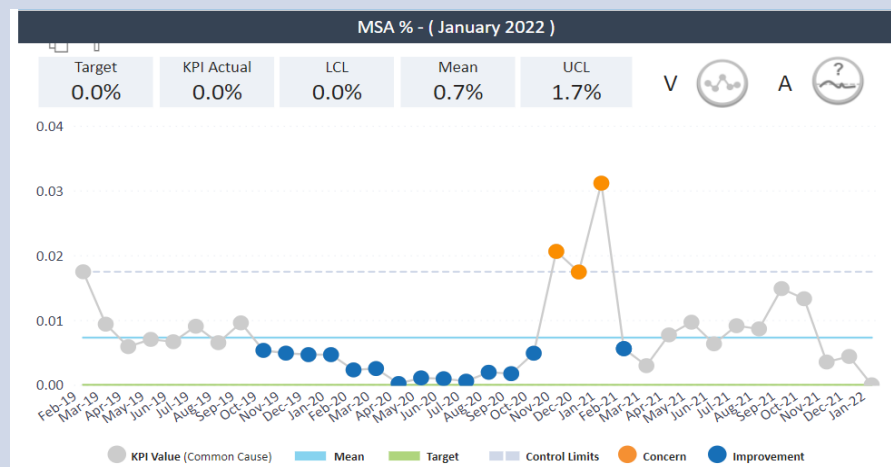
**Latest Period:** January 2022

**Executive Lead:** Evonne Hunt

**Operational Lead:** Not applicable

**Sub Groups:** Quality Assurance Committee

### Outcome Measure: Mixed Sex Accommodation Breaches



### What do the outcome measures show?

The number of patient breaches by day of mixed-sex accommodation (MSA)

Unjustified breaches of MSA recorded in January relate wholly to the inability to step down within 4hrs our patients from critical care into level 1 ward based care.  
Improved oversight from the critical care team in reporting 4 hour step down MSA breaches has increased the accuracy of reporting  
Average bed occupancy in Medway has been very high  
Assessment areas and same day care regularly used for overnight care and admitted patients  
Maintaining green and amber pathways for safety and the elective restart program within the SARS2 pandemic has care impacts on bed utility

### Outcome Measure: Mixed Sex Accommodation Breaches By Ward

Ward	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
Bronte						4	7		14				4
Critical Care Unit	2												
Dolphin Ward	1		2			4	4	2			1		
Intensive Care Unit	12	6		18	20	11	3	6	1	5	2	2	8
McCulloch Ward	1		6	7	7		19		3	15			1
Harvey Ward													
Jade Ward										4	4		12
Keats Ward		2				3			14				
Lawrence Ward					2			2	7				
Lister Assessment Unit	13	16			12	16	43		34	22			
Nelson Ward	14	11	5	24	8		6		5	10			
Ocelot	6								23	32	1		5
Pembroke Ward	1						7	15					
Phoenix Ward		19	7										
Pre Op Care Unit		2	11										
Sapphire Ward	33				2	9	3	57	25	24			
SDEC	312					2	2						
Sunderland Day Case Centre	6								5	19			
Surgical Assessment Unit	12					12		7	20				
Theatre Intensive Care Unit	8	1											
Trafalgar Ward SHDU	13	11	19	55	45	47	46	33	86	65	46	69	74
Tennyson Ward													
Wakeley						1		5					
Victory								6					
Will Adams	6	4			7		3		8		4		
<b>Totals</b>	<b>452</b>	<b>72</b>	<b>50</b>	<b>104</b>	<b>103</b>	<b>109</b>	<b>143</b>	<b>133</b>	<b>251</b>	<b>196</b>	<b>58</b>	<b>71</b>	<b>104</b>

### 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 and the IPC team and utilising the Trust winter plan / surge plan has ensured patient safety and dignity during this process

## Patient Centred: IP Friends & Family Test

**Aim:** TBC – Currently Under Development

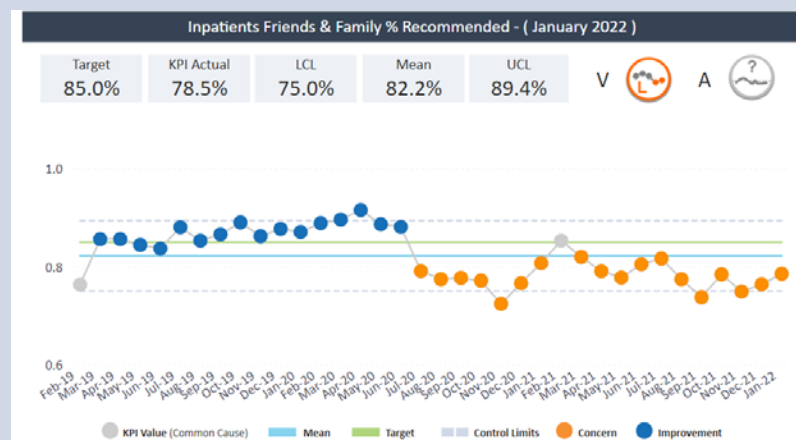
**Latest Period:** January 2022

**Executive Lead:** Evonne Hunt

**Operational Lead:** Not applicable

**Sub Groups:** Quality Assurance Committee

### Outcome Measure: Inpatient Friends & Family % Recommended



### What changes have been implemented and improvements made?

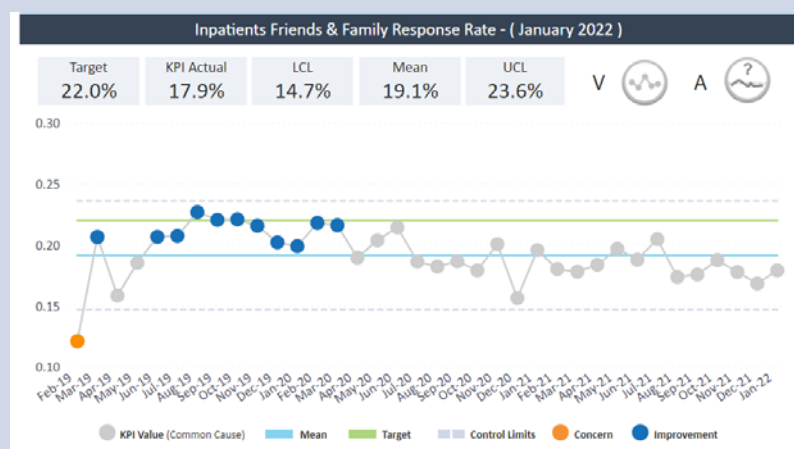
The inpatient would recommend rate continues to fall below the trust target of 85%

The ambition to improve the would recommend score continues. In January 15 wards/departments had an increase in there scores with 6 staying the same, whilst 10 wards/departments had a decrease.

Wards continue to access there family and friends data throughout the month to action feedback as required.

Wards continue to update there “You said We did” boards. The vision is to ensure we have 100% completion on these.

### Outcome Measure: Inpatient Friends & Family % Response Rate



The inpatient response rate continues to be below the trust target of 22%. The objective is to implement new ways of capturing the data-an example is I- pads to be used on discharge, alternatively I- pads to be placed at the exit of the wards so the survey can be answered as the patient leaves.

Staff to actively encourage feedback from their patients and explain the process and the importance of this happening..

## Patient Centred: OP Friends & Family Test

Aim: TBC – Currently Under Development

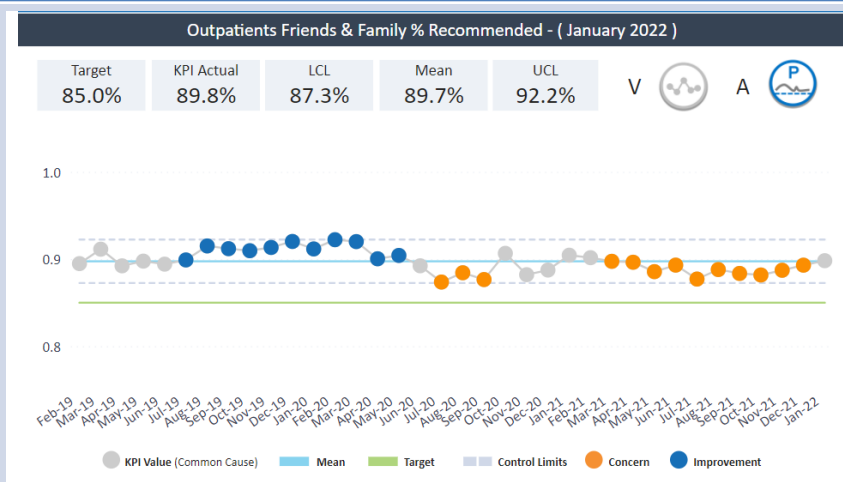
Latest Period: January 2022

Executive Lead: Evonne Hunt

Operational Lead: Not applicable

Sub Groups: Quality Assurance Committee

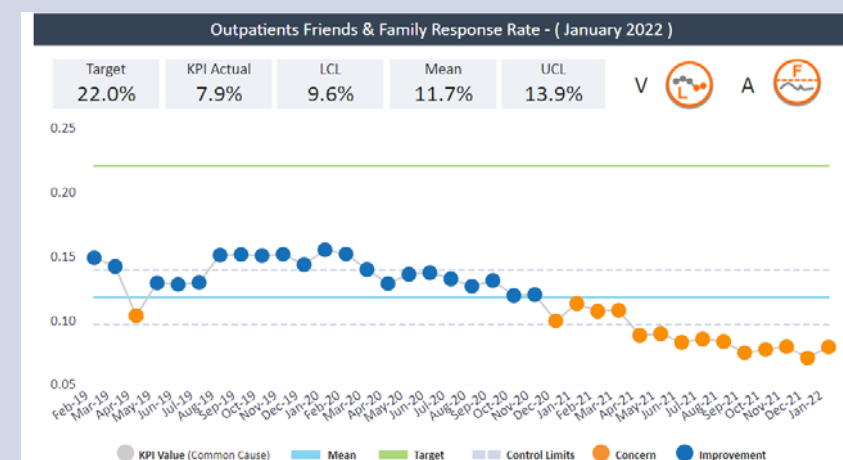
### Outcome Measure: Outpatient Friends & Family % Recommended



### 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, with recommendations made displayed on the "you said we did "boards for shared learning.

### Outcome Measure: Outpatient Friends & Family % Response Rate



### What changes have been implemented and improvements made?

The response rate for outpatients continues to be below the trust target of 22%

The rate has continued to drop since November 2020.

Staff to actively encourage feedback within their department.

After discussion with the Matron for outpatients we would like to implement the use of QR codes and posters to promote their use, so patients can complete the survey whilst waiting, this has been trialled in another trust and has proven to increase the numbers of patients responding.

## Patient Centred: ED Friends & Family Test

Aim: TBC – Currently Under Development

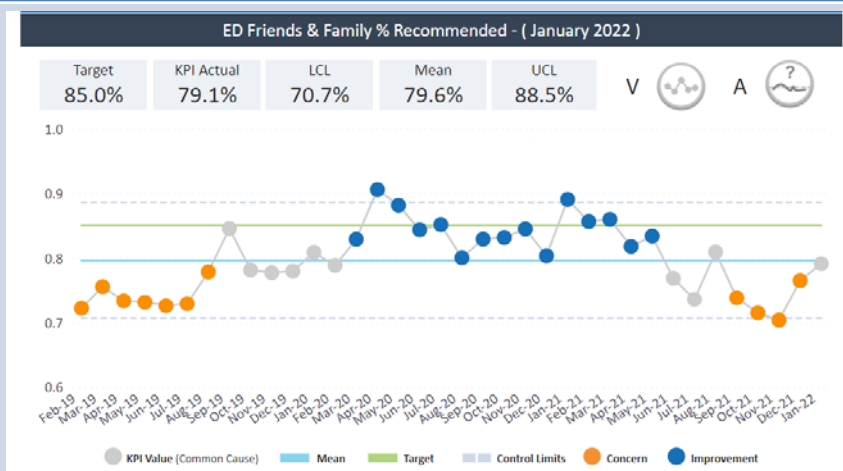
Latest Period: January 2022

Executive Lead: Evonne Hunt

Operational Lead: Not applicable

Sub Groups: Quality Assurance Committee

### Outcome Measure: ED Friends & Family % Recommended

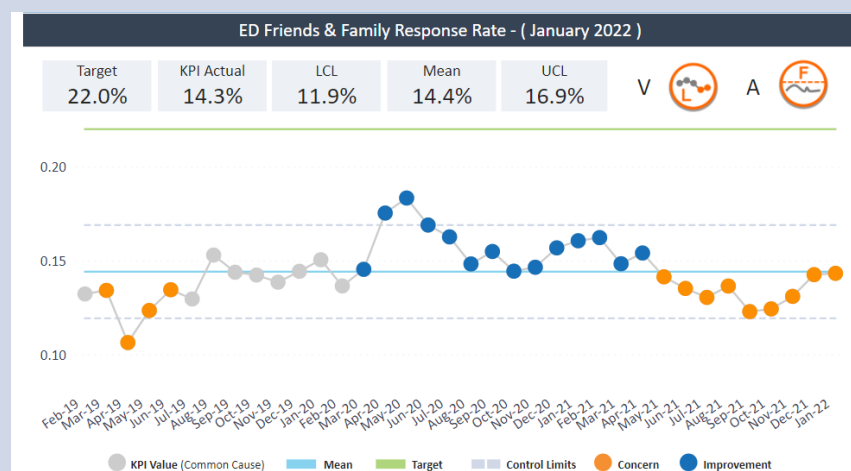


### What changes have been implemented and improvements made?

ED,s recommend rate remains below the trusts target of 85% , however have seen the biggest increase of patients that would recommend since September 2020.

The ED continue to share feedback comments with staff, and action as required using the “you said we did” boards

### 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 seen the highest response rate since September 2022.

The Head of Patient experience is to work alongside the department leads to explore and action key themes and trends .

There are plans to capture the patients response at each part of their journey and as they leave the department, to increase the response rate and to reflect the care they have received.

## Patient Centred: Mat Friends & Family Test

**Aim:** TBC – Currently Under Development

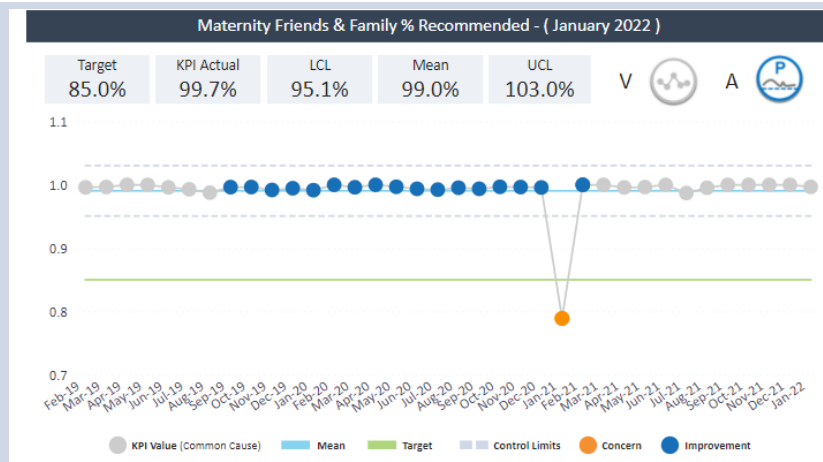
**Latest Period:** January 2022

**Executive Lead:** Evonne Hunt

**Operational Lead:** Not applicable

**Sub Groups:** Quality Assurance Committee

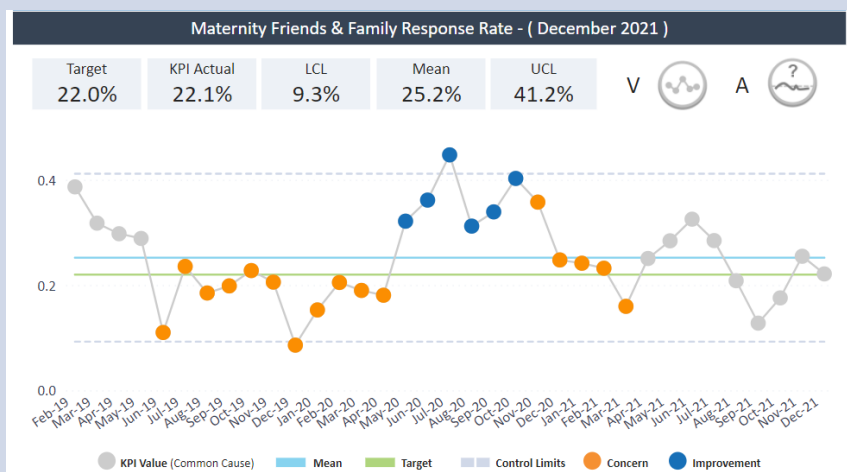
### Outcome Measure: Maternity Friends & Family % Recommended



### What changes have been implemented and improvements made?

The maternity service consistently performs above the target of 85% and has set at 100% of women and birthing people declaring that they would recommend the maternity service at MFT. All comments are shared with staff and where recommendations are made they are actioned and displayed on the “you said we did” boards.

### Outcome Measure: Maternity Friends & Family % Response Rate



### What changes have been implemented and improvements made?

The response rate in maternity for FTT meets the recommended target of 22% however the services has experienced a better performance previously which has been impacted on by staffing and ward managers working clinically. The limitations of FTT are well understood and therefore the service is developing a QR questionnaire which will be completed by women and birthing people at the point of discharge by the community midwife. This will commence in January 2022.

## Domain: Effective Dashboard

**Executive Lead:** Evonne Hunt– Interim Chief Nursing & Quality Officer

Alison Davis – Chief Medical Officer

**Sub Groups :** Quality Assurance Committee



CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Dec-21	10.0%	9.9%	9.9%	12.1%	14.3%		
		7 Day Readmission Rate	Dec-21	5.0%	4.7%	4.5%	6.3%	8.0%		
	Maternity	Discharges Before Noon	Jan-22	25.0%	18.4%	12.8%	15.6%	18.4%		
		Fractured NOF Within 36 Hours	Dec-21	100.0%	55.9%	41.9%	69.1%	96.4%		
		VTE Risk Assessment % Completed	Jan-22	95.0%	91.1%	91.1%	94.8%	98.6%		
		12+6 Risk Assessment	Oct-21	90.0%	85.3%	78.9%	84.6%	90.2%		
		Elective C-Section Rate	Jan-22	13.0%	12.9%	10.1%	14.2%	18.3%		
		Emergency C-Section Rate	Jan-22	15.0%	25.3%	16.1%	21.3%	26.6%		
		Total C-Section Rate	Jan-22	28.0%	38.1%	29.9%	35.5%	41.2%		

Summary

Caring

Effective

Safe

Responsive

Well Led



## Effective: Maternity

**Aim:** TBC – Currently Under Development

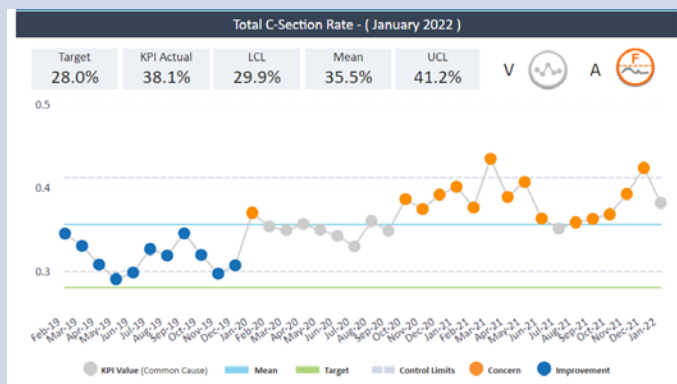
**Latest Period:** January 2022

**Executive Lead:** Dot Smith

**Operational Lead:** Not applicable

**Sub Groups:** Quality Assurance Committee

### Outcome Measure: Total Elective & Emergency C-Section Rate



#### What does the measure show?

- The target CS rate has not been updated and should be 30% to be at par with national rates of CS
- Our mean total CS rate is 35.5 %, which is marginally (5%) above the mean rate but still well within the confidence limits (30-41%).
- There is considerable variation over time and this may be due to several factors including workforce, Induction of Labour (IOL) rates but also an important factor could be the population COVID infection rates in the community.
- An audit has been completed using the “Robson Classification” which is due for presentation and demonstrates that the most significant contributors are first time mothers in particular those that undergo IOL.

### Outcome Measure: Elective and Emergency C-Section Rate



#### What changes have been implemented and improvements made?

- We have made improvements to consultant presence of delivery suite from 2 consultants providing a discontinuous 10 hour presence to a 1 consultant providing 13 hour cover. This new rota will commence in February 2022
- Previously the LW consultant would also cover wards and gynaecology but with the new model, the LW consultant does not cover any other service except LW.
- There is a separate clinical lead overseeing intrapartum fetal monitoring and obstetric emergencies simulation with introduction of human factors training
- We plan to conduct a daily audit of all emergency CS lead by the LW consultant when the new rota commences with quarterly audit reporting

## Domain: Safe Dashboard

**Executive Lead:** Evonne Hunt– Interim Chief Nursing & Quality Officer

Alison Davis – Chief Medical Officer

**Sub Groups :** Quality Assurance Committee



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	Jan-22	6.63	5.27	2.99	4.83	6.68		
		Pressure Ulcer Incidence Per 1000 days (High Harm)	Jan-22	1.04	0	0	0.03	0.14		
	Incident Reporting	% of SIs Responded To In 60 Days	Jan-22		100.0%	90.7%	97.8%	104.9%		
		Never Events	Jan-22	0	0	0	0.14	0.90		
		No of SIs on STEIS	Jan-22	90	5	0	13.22	28.50		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Dec-21	3 [43]	3	0	2.64	8.79		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Dec-21		2	0	1.76	6.16		
		E-coli (Trust Acquired) Infections	Dec-21	0	5	0	4.14	10.09		
		MRSA Bacteraemia (Trust Attributable)	Dec-21	1 [5]	0	0	0.17	0.80		
	Mortality	Crude Mortality Rate	Jan-22	2.5%	2.1%	0.4%	1.9%	3.3%		
		HSMR (All)	Oct-21	100	92.69	95.51	99.49	103.46		
		HSMR (Weekday)	Oct-21	100	88.50		95.67			
		HSMR (Weekend)	Oct-21	100	101.99		109.11			
		SHMI	Aug-21	1	1.01	1.05	1.08	1.11		

Summary

Caring

Effective

Safe

Responsive

Well Led



Best of care  
Best of people

## Safe: Falls management and reduction

**Aim:** 12% reduction in number of falls with harm

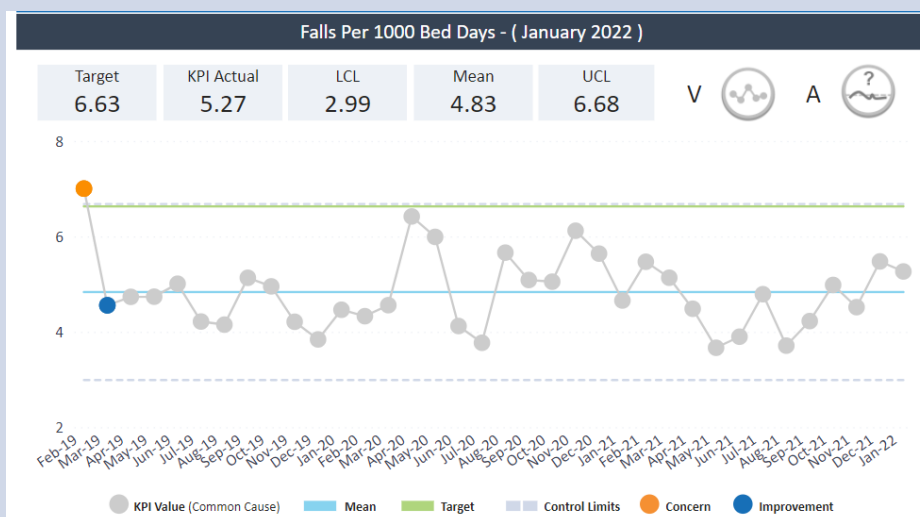
**Latest Period:** January 2022

**Executive Lead:** Evonne Hunt

**Operational Lead:** Not applicable

**Sub Groups:** Quality Assurance Committee

### Outcome Measure: Falls Per 1000 bed days



#### What do the outcome measures show?

The total number of falls in January is 92 compared to 94 last month and 71 in the same month last year.

Falls per Occupied Bed Days ( OBD) remain below the national average.

Of the 92 falls reported, 66 were no harm, 23, low harm, 1 moderate harm and 2 severe harm.

84% of falls occurred in Unplanned care (size of division and specialties),

16% of falls occurred in Planned care

27% of falls in each Division involved toileting

13% of falls involved patients living with Dementia (an independent risk factor for increased risk of falling)

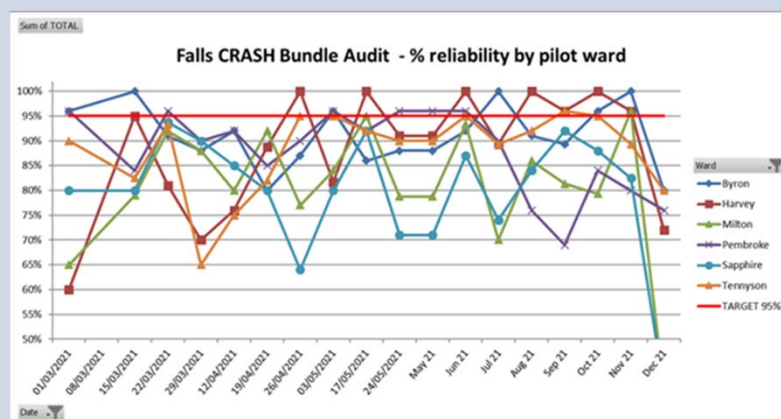
The majority of the types of falls were fall from a bed or level ground and both were mainly unwitnessed

#### What do the process measures show?

No audits were completed during January due to sick leave and requirements to support the wards clinically whilst the Trust faced the challenges of OPEL 4 status and the Omicron wave of Covid.

According to Datix field asking if patient had a lying and standing blood pressure recording prior to the fall, 52% had a positive answer.

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



#### What changes have been implemented and improvements made?

The Falls Team are working with Sunrise Team to ensure electronic falls documentation is fit for purpose and easy to navigate therefore improving consistency and accuracy of falls assessment and care planning recording Trust wide.

The team are currently exploring the use of Gait-Smart, a digital gait monitoring system in supporting current patient care pathways.

We have been working with one of the surgical matrons to improve lying and standing blood pressure competency assessments

## Safe: Pressure Damage Reduction

**Aim:** 10% Reduction in Hospital Acquired Pressure Ulcers

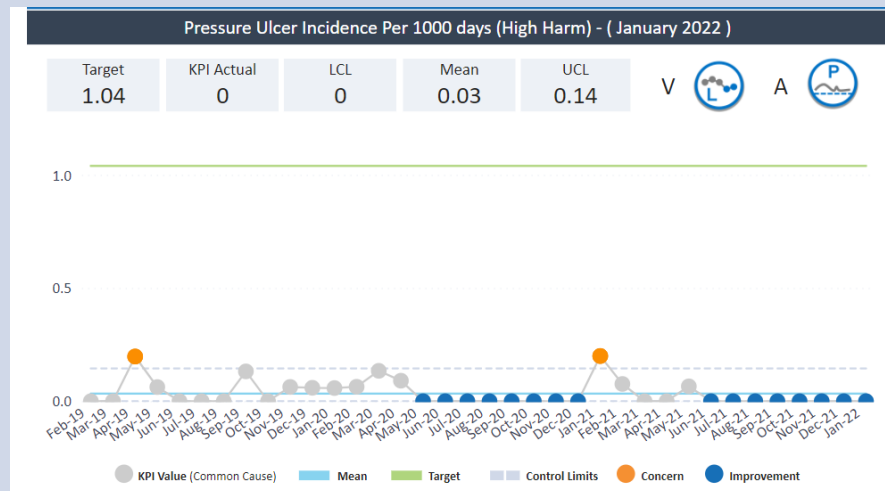
**Latest Period:** January 2022

**Executive Lead:** Evonne Hunt

**Operational Lead:** Not applicable

**Sub Groups:** Quality Assurance Committee

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



### What do the outcome measures show?

The Quality Strategy aim to reduce hospital acquired pressure ulcer (PU) incidents by 10% meaning no more than 181 hospital-acquired incidents by the end of March 2022. To date there have been 162 Hospital Acquired (HA) PU Incidents.

The total number of acquired PU in January is 14 compared to 28 in December 2021 and 22 in January 2021.

Planned Care HAPU = 4 category 1, 2x Category 2, 0 x Category 3, 0 x Category 4, 3x Unstageable, 1x Deep Tissue Injury, 1x category 2 device related. 1x unstageable device related.

Unplanned Care HAPU = 1x Category 1, 1x category 2, 0 x category 3, 0 x category 4, 3x Unstageable, 1x Deep Tissue Injury. 1x category 2 device related. Pressure Ulcers on admission (POA) total = 148. 2x Category 1, 110x Category 2, 3x Category 3, 2x Category 4, 21 x Unstageable, 10x Deep Tissue Injury

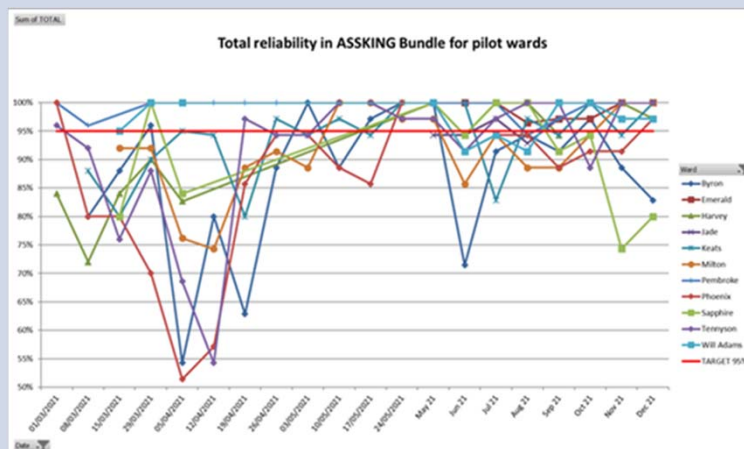
### What do the process measures show?

The process measure is achieving 95% reliability with the ASSKING care bundle audit. The Trust continues to show progress towards achievement with increasing days between PU in pilot wards and improvement with ASSKING reliability care bundle.

There were no audits carried out in January 2022

The introduction of Electronic Patient Records (EPR) may have affected some aspects of the audit and the location of recordings and documents.

### Process Measures: ASSKING Bundle Reliability (Pilot Wards)



### What changes have been implemented and improvements made?

It has been challenging to focus on quality improvement work due to requests to support the wards clinically with the Trust being in OPEL 4 status.

## Infection Prevention Control measures



## What do the outcome measures show?

MFT continues to present a lower level of all key hospital acquired infections, including MRSA bacteremia, C difficile & gram negative blood stream infections 21/22 compared to 20/21  
 MFT MRSA Bacteraemia 0 (since May 2020)  
 C.Diffi hospital acquired rates since 1st April 2021 is 23 against a target of 35.

### Other HAI since 1st April 2021 – January 2022:-

E.Coli : 36 against a threshold of 112  
 Klebsiella acquired: 17 against a threshold of 38

## What do the process measures show?

IPC processes in place continue to demonstrate low HAI

## What changes have been implemented and improvements made?

- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- DIPC Trust-wide IPC Blogs.
- Monthly hand hygiene audits commenced via Perfect Ward
- Monthly IPC audits ( including BBE and Saving Lives ,PV, Urinary catheter via Perfect Ward
- IPC Audit Schedule 2021/2022
- Review of COVID-19 Pathways and Screening Protocols
- Sharing & learning best practice IPC standards via IPC

Month	C-Diff	MRSA	E.Coli	MSSA	Klebsiella	Pseudomonas
Apr-21	5	0	3	1	0	1
May-21	1	0	2	2	3	1
Jun-21	4	0	5	5	2	1
Jul-21	4	0	2	1	1	2
Aug-21	1	0	2	1	3	0
Sep-21	3	0	6	3	2	3
Oct-21	0	0	6	1	4	0
Nov-21	0	0	3	2	2	0
Dec-21	3	0	4	0	4	0

## Safe: Mortality

Aim: TBC

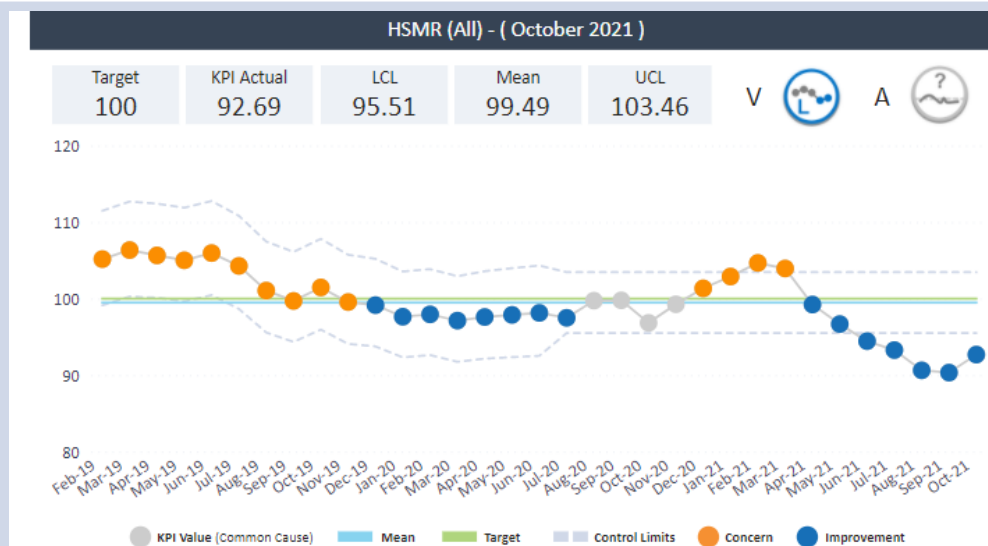
Latest Period: Oct– 2021

Executive Lead: Alison Davis - Chief Medical Officer

Operational Lead: Not applicable

Sub Groups: Quality Assurance Committee

### Outcome Measure: Mortality – HSMR All



### What do the measures show?

The Trust's HSMR for October 2020 to September 2021 is 100.0. The Trust has remained in the 'as expected' range over the past four months. Prior to that, the increase observed in HSMR is in line with the surge of deaths seen during Wave2 of the Covid-19 pandemic.

The Trust's SHMI for August 2020 – July 2021 is 1.03, and is within the 'as expected' range for the most recent reporting period. The figure below shows a reducing trend over the reporting period. These figures are inclusive of all ten diagnosis groups most indicative of the Trust performance.

### What changes have been implemented and improvements made?

The Structured Judgement Review(SJR) panel was introduced in December 2021 and is a multidisciplinary, multi-professional meeting consisting of consultant patient safety leads, from a number of different specialties across the hospital, nursing staff from both divisions, governance representation from both divisions, representation from the end of life care team and resuscitation teams. Consultants who looked after each patient are also invited as required.

The cases reviewed are triggered for SJR by the Medical Examiner during scrutiny as well as a randomly selected cases for quality assurance each week or any cases that have been highlighted from specialty mortality and morbidity meetings. This work continues to be embedded and consideration is being given as to how this work can be benchmarked with other providers and external standards

Crude mortality at the Trust has reduced from a peak of 4.30% in Feb 2021 to 3.70% in September 2021.

## Domain: Responsive – Non Elective Dashboard

**Executive Lead:** Jayne Black–Chief Operating Officer  
**Operational Lead:** N/A  
**Sub Groups :** N/A



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	Jan-22	7.0%	17.6%	12.4%	15.4%	18.4%		
		% of Delayed Transfer of Care Point Prevalence in Month	Jan-22	3.5%	0.1%	0.1%	1.3%	2.4%		
		Average Elective Length of Stay	Jan-22	5	2.91	1.50	2.35	3.20		
		Average Non-Elective Length of Stay	Jan-22	5	9.56	7.34	8.57	9.80		
		Bed Occupancy Rate	Jan-22	85.0%	86.7%	78.3%	86.3%	94.3%		
		Delayed Transfer of Care Point Prevalence in Month	Jan-22		19	13.36	195.92	378.47		
		Escalation Beds Open Point Prevalence in Month	Jan-22	0	0	0	0	0		
		Medically Fit For Discharge Point Prevalence in Month	Jan-22		3,082	1,764.27	2,331.31	2,898.34		
	Complaints Management	% Complaints Responded to Within 30 Days	Jan-22	85.0%	30.6%	37.2%	61.5%	85.8%		
		Number of Complaints	Jan-22	41	30	11.01	52.89	94.76		
	ED Access	30 Mins Ambulance Handover Delays	Jan-22	0	857	216.41	624.22	1,032.04		
		60 Mins Ambulance Handover Delays	Jan-22	0	170	0	169.42	367.78		
		ED 12 hour DTA Breaches	Jan-22	0	74	0	27.08	91.08		
		ED 4 Hour Performance All Types	Jan-22	95.0%	74.3%	72.2%	80.1%	87.9%		
		ED 4 Hour Performance Type 1	Jan-22	95.0%	65.3%	60.1%	70.8%	81.6%		
		Median Time to Ambulance Assessment (15mins)	Jan-22	15	27	8.99	15.22	21.45		
		Median Time to ED Clinician (60mins)	Jan-22	60	51	25.43	38.35	51.27		
		Number of ED arrivals by Ambulance	Jan-22		3,328	2,601.58	3,287.25	3,972.92		

Summary

Caring

Effective

Safe

Responsive

Well Led



**Best of care**  
**Best of people**

## Domain: Responsive – Elective Dashboard

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



CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	Dec-21	0	1	0	2	5.21		
		Cancer 28 Faster Diagnosis	Dec-21	75.0%	77.3%	45.7%	64.3%	82.9%		
		Cancer 28 Faster Diagnosis - Breast Symptomatic	Dec-21	75.0%	97.9%	11.7%	84.1%	156.6%		
		Cancer 28 Faster Diagnosis Screening	Dec-21	75.0%	22.7%	0.0%	44.9%	117.6%		
		Cancer 2ww Performance	Dec-21	93.0%	95.0%	87.3%	93.3%	99.3%		
		Cancer 2ww Performance - Breast Symptomatic	Dec-21	93.0%	90.6%	61.1%	86.1%	111.0%		
		Cancer 31 Day First Treatment Performance	Dec-21	96.0%	97.1%	90.4%	96.5%	102.6%		
		Cancer 31 Day Subsequent Treatments (Drugs)	Dec-21	98.0%	91.7%	88.9%	96.8%	104.8%		
		Cancer 31 Day Subsequent Treatments (Surgery)	Dec-21	94.0%	100.0%	65.7%	91.1%	116.5%		
		Cancer 62 Day Treatment - Cons Upgrades	Dec-21		60.0%	49.5%	75.9%	102.4%		
		Cancer 62 Day Treatment - GP Refs	Dec-21	85.0%	88.9%	55.6%	74.5%	93.3%		
		Cancer 62 Day Treatment - Screening Refs	Dec-21	90.0%	66.7%	19.3%	70.3%	121.2%		
	Diagnostic Access	DM01 Performance	Jan-22	99.0%	75.8%	72.7%	86.7%	100.6%		
	Elective Access	18 Weeks RTT Incomplete Performance	Jan-22	92.0%	62.1%	65.2%	71.7%	78.3%		
		18 Weeks RTT Over 52 Week Breaches	Jan-22	0	112	26.51	140.28	254.05		
		Daycase Rate	Jan-22	85.0%	62.6%	60.9%	67.7%	74.5%		
		DNA Rate	Jan-22	10.0%	8.8%	6.6%	7.7%	8.8%		
		First to Follow Up Ratio	Jan-22		2.89	2.02	2.47	2.92		
		PTL Size	Jan-22	22,477	28,897	21,183.04	22,580.53	23,978.02		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Jan-22	0	0	0	3.19	9.73		
		Operations Cancelled By Hospital on Day	Jan-22	0	8	0	17.89	44.11		
		Urgent Operations Cancelled for the 2nd Time	Jan-22	0	0	0	0.03	0.18		

Summary

Caring

Effective

Safe

Responsive

Well Led

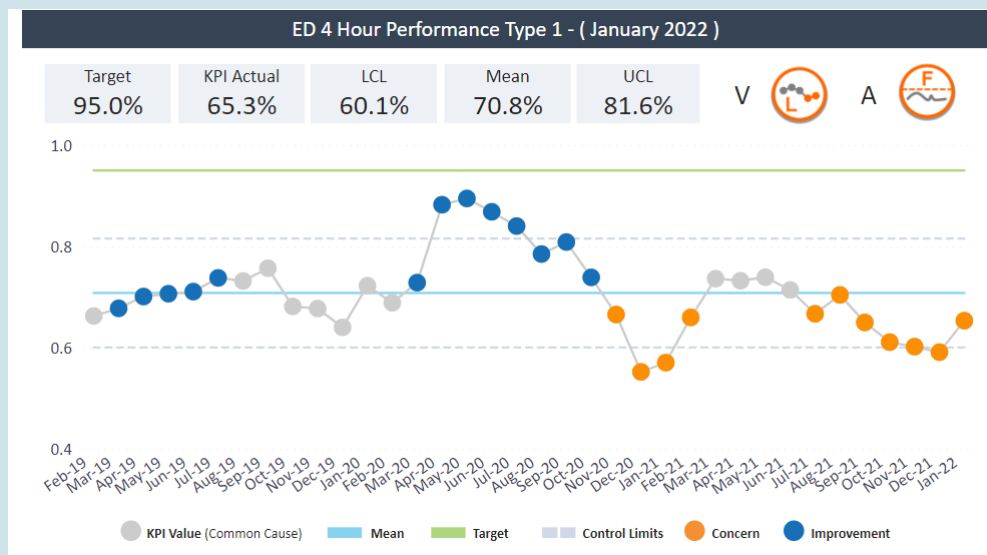


## Responsive: – Non Elective Insights

**Executive Lead:** Jayne Black–Chief Operating Officer  
**Operational Lead:** Shane Morrison-McCabe - Director of Operations, UIC  
**Sub Groups :** N/A



### 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:

- Winter ED Workforce redesign plan in place since November 2021 with a daily performance dashboard
- New ED & Acute Consultant Clinical Lead.
- Interim GM cover is now in place, substantive GM to commence in May 22..
- Predict, Escalate and Prevent overarching ED flow model is in place.

### Outcomes:

- Rapid Assessment Unit – ambulance offload area swapping out of clinically ready to proceed patients (CRTP) policy is in place and enacted proactively to prevent ambulance offload delays.
- 4hr ED standard is being enforced with daily breach validation analysis carried out. Fortnightly trust-wide breach panel is in place.
- ED Outflow: Priority Admission Hospital Unit (PAHU) is in place with 12 bed spaces.

### Underlying issues and risks:

- Underlying bed deficit and use of escalation areas places increased demands on medical, nursing and therapy workforce.

Summary

Caring

Effective

Safe

Responsive

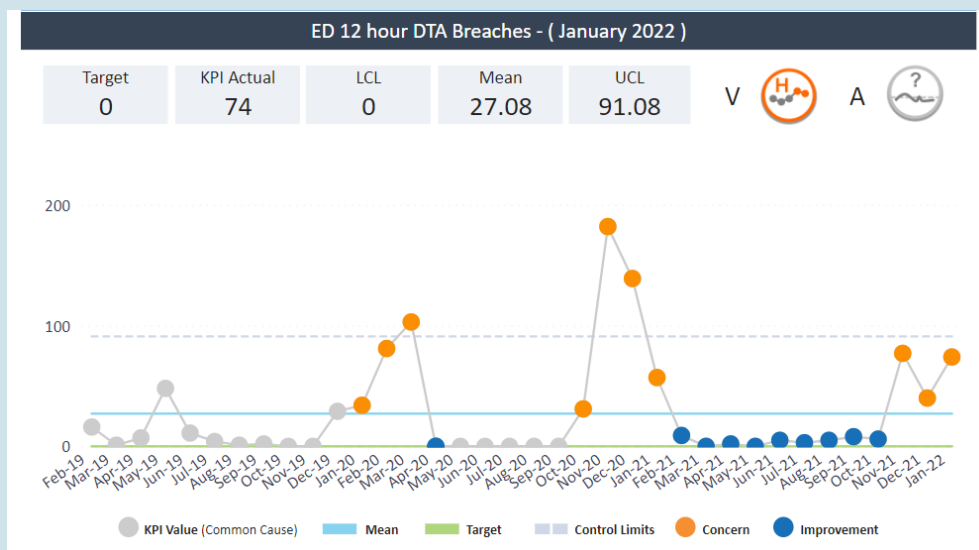
Well Led

## Responsive: – Non Elective Insights

**Executive Lead:** Jayne Black—Chief Operating Officer  
**Operational Lead:** Shane Morrison-McCabe - Director of Operations, UIC  
**Sub Groups :** N/A



### Indicator: ED 12 hour DTA Breaches



### Indicator Background:

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

### What the Chart is Telling Us:

There has been a reduction in 12 hour breaches in the reporting period, with the position significantly better than for the same period in 2020.

### Actions:

- Tracking of position against targets via Acute Care Transformation Board.
- Use of escalation triggers set out in Winter Plan.
- Site Management attendance at ED sit reps.
- Identification of patients clinically ready to proceed.
- A clear 12 hour monitoring and escalation process is in place with site ownership in and out of hours.

### Outcomes:

- Use of interim 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

### Underlying issues and risks:

- Underlying bed deficit and use of escalation areas places increased demands on medical, nursing and therapy workforce.
- Blocking of assessment areas due to capacity constraints and high numbers of medically fit for discharge patients.

Summary

Caring

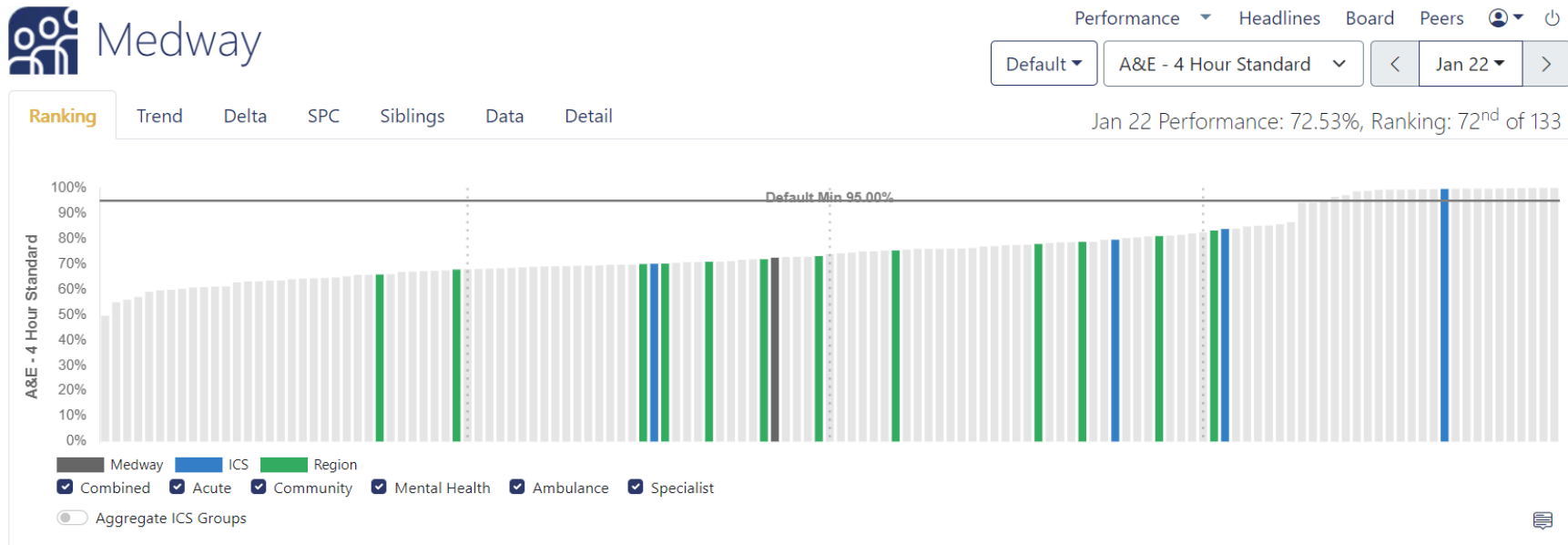
Effective

Safe

Responsive

Well Led

# EC 4 Hour Benchmarking

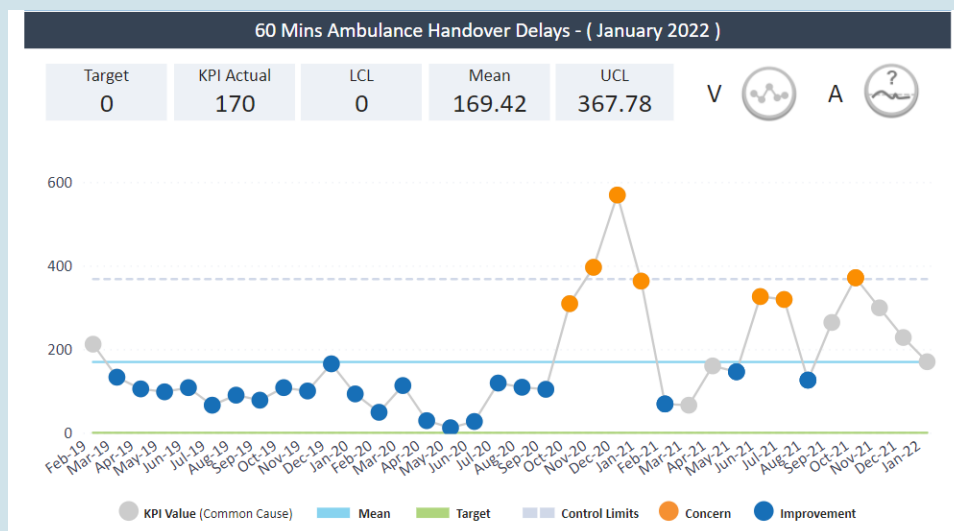


## Responsive: – Non Elective Insights

**Executive Lead:** Jayne Black–Chief Operating Officer  
**Operational Lead:** Shane Morrison-McCabe - Director of Operations, UIC  
**Sub Groups :** N/A



### Indicator: 60mins Ambulance Handover Delays



### 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:

The SPC data point is showing an improvement on recent months, but is still above the target of zero instances. There is improvement compared to same period in 2020.

### Actions:

- A system wide ambulance offload improvement action plan is in place, managed through the fortnightly SECamb & Medway meeting led by the DDO UIC. Reporting into the AEC Steering group and LAEDB monthly meetings.
- Pathways into SDEC are being explored with SECAMB as well as SECAMB Connect.
- Additional capacity has been opened as part of Winter Plan to enable decongestion of ED

### Outcomes:

- Rapid Assessment Unit - ambulance offload area and 'Ready to Proceed' patients identified and in place (from Majors) and enacted proactively to prevent ambulance offload delays.
- 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:

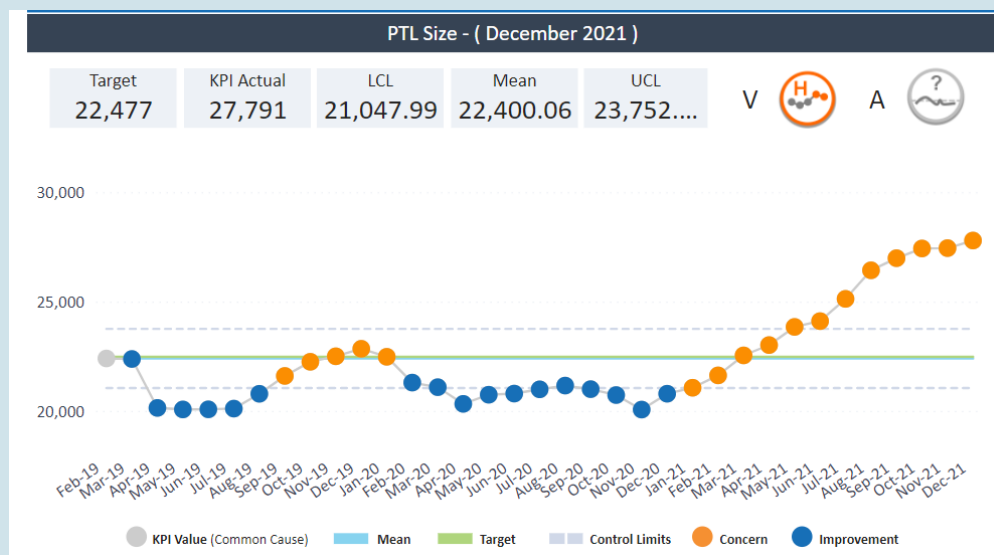
- Early morning bed availability remains a challenge

## Responsive: Elective Insights

**Executive Lead:** Jayne Black—Chief Operating Officer  
**Operational Lead:** Benn Best – Director of Operations Planned Care  
**Sub Groups :** N/A



### Indicator: PTL Size



### Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for less than 18 weeks from referral

### What the Chart is Telling Us:

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

### Actions:

- Review with ICP partners re referral assumptions and adjust trajectory accordingly.
- Agree system-wide interventions re controls for referral increases.
- Map impact of increased referrals on PTLs for Q4 and Q1 2022-23.
- Maximise current capacity, including Independent Sector to keep pace where possible with elective activity.

### Outcomes:

- Delivery of H2 planning performance targets (phase four guidance) and reduction in outpatient backlogs.
- Delivery of 104 and 52 week trajectories and reduction in admitted surgical backlogs.
- Delivery of DM01 trajectory and management of inpatient and 2ww waiting lists.

### Underlying issues and risks:

- Impact of third COVID wave has resulted in increased NEL demand therefore impacting on ability to continue same levels of elective work.
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

Summary

Caring

Effective

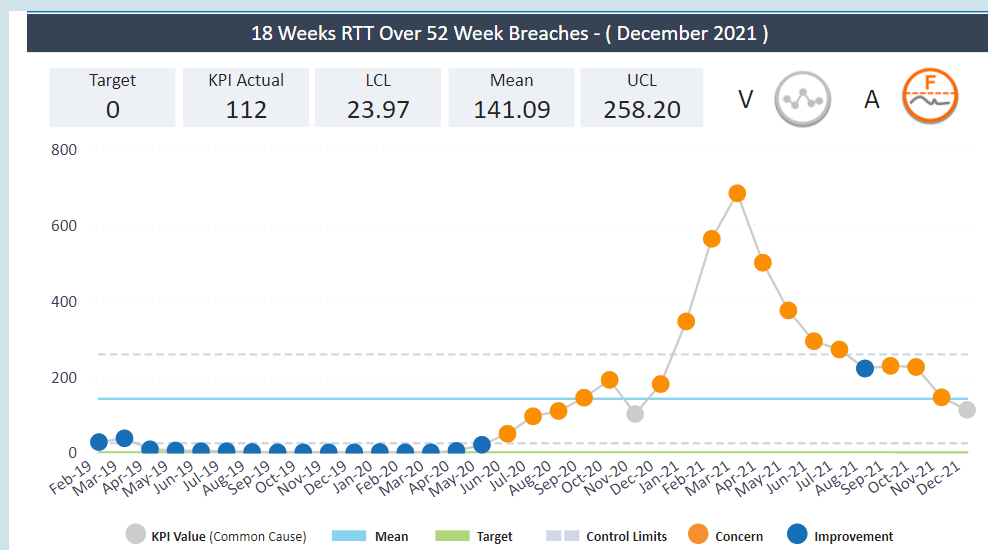
Safe

Responsive

Well Led



Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for less than 18 weeks from referral.

What the Chart is Telling Us:

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

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. This includes both insourcing and outsourcing of activity in a number of specialties.

Outcomes:

- Zero capacity related 104 and 52-week waiting patients by end of March 2022.
- 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.
- Elective capacity has been preserved for as long as possible within the winter and COVID-19 planning model.

Underlying issues and risks:

- Impact of third COVID wave resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Uncertainty regarding winter pressures impact on Elective activity.
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

# RTT Benchmarking



Medway

Performance ▾ Headlines Board Peers

Default ▾

RTT Incomplete 18 Week ▾

<

Dec 21 ▾

>

Ranking

Trend

Delta

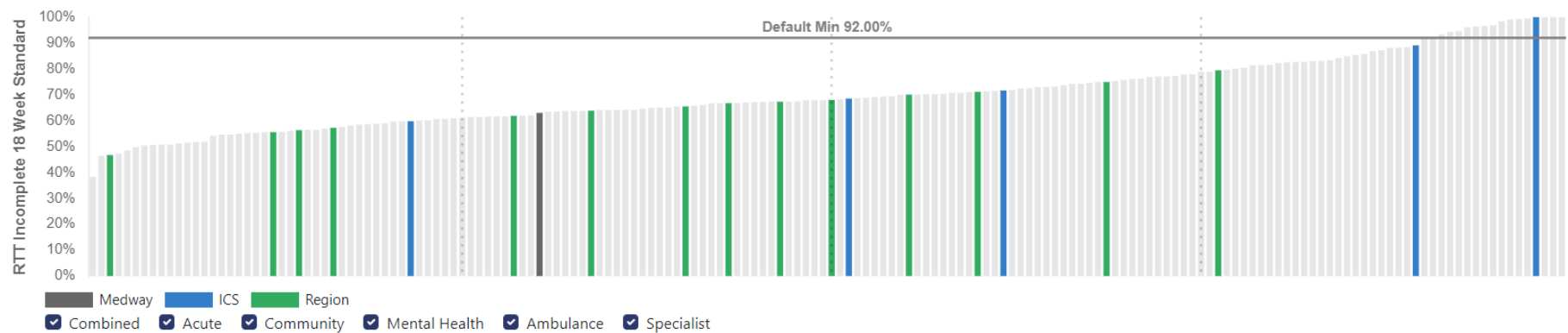
SPC

Siblings

Data

Detail

Dec 21 Performance: 63.02%, Ranking: 120<sup>th</sup> of 172

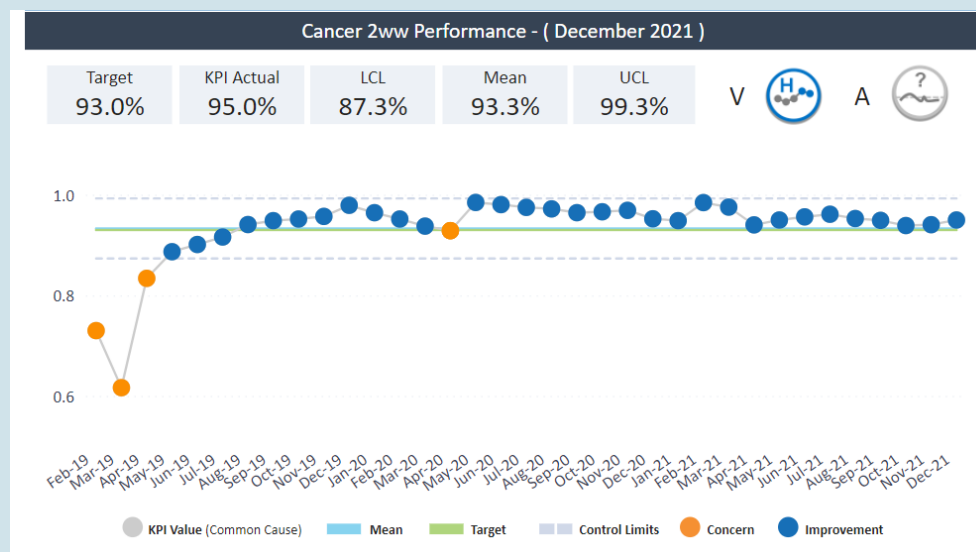


## Responsive: Cancer Insights

**Executive Lead:** Jayne Black—Chief Operating Officer  
**Operational Lead:** Benn Best – Director of Operations Planned Care  
**Sub Groups :** N/A



### 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.

### What the Chart is Telling Us:

2WW performance has been maintained since May 2019.

### Actions:

- Continue to use outpatient polling time report to monitor tumour groups on a daily basis
- Provide weekly report on diagnostic turnaround times (to be uploaded to BI portal) and review % booked within <7/7/8/9/10/>10 days
- Implement one-stops for prostate cancer, H&N, lung and any other tumour sites when identified as feasible and beneficial

### Outcomes:

- Breast T&F group continues to oversee activity an ensure not booking outside of 14 days.
- Recruit CRO Cancer Referrals Team Lead to liaise directly with Service Team to reduce polling times

### Underlying issues and risks:

- Not realising benefits of one stop clinics within tumour groups impacting 62D performance.
- Introduction of one stop shops will support achievement of the 28 day faster diagnosis (implemented in October 2021 as a standard) which was missed by 0.64% in November.

Summary

Caring

Effective

Safe

Responsive

Well Led

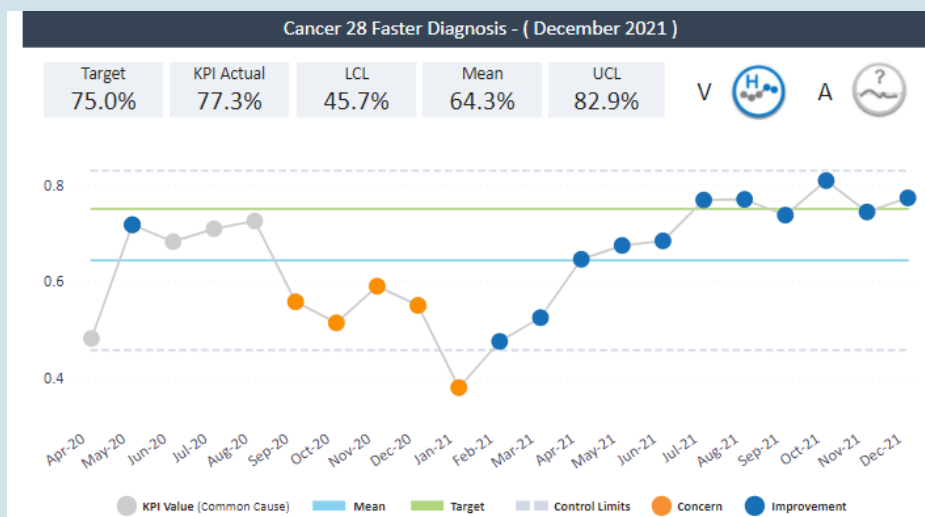


## Responsive: Cancer Insights

**Executive Lead:** Jayne Black—Chief Operating Officer  
**Operational Lead:** Benn Best – Director of Operations Planned Care  
**Sub Groups :** N/A



### Indicator: Cancer 28 Faster Diagnosis



### Indicator Background:

Patients diagnosed within 28 days of request

### What the Chart is Telling Us:

Trust is managing the 28 day target

### Actions:

- Continue to use PTL to monitor
- Provide weekly report on diagnostic turnaround times (to be uploaded to BI portal) and review % booked within <7/7/8/9/10/>10 days
- Implement one-stops for prostate cancer, H&N, lung and any other tumour sites when identified as feasible and beneficial

### Outcomes:

- Remain on trajectory and target

### Underlying issues and risks:

No risks at present

Summary

Caring

Effective

Safe

Responsive

Well Led

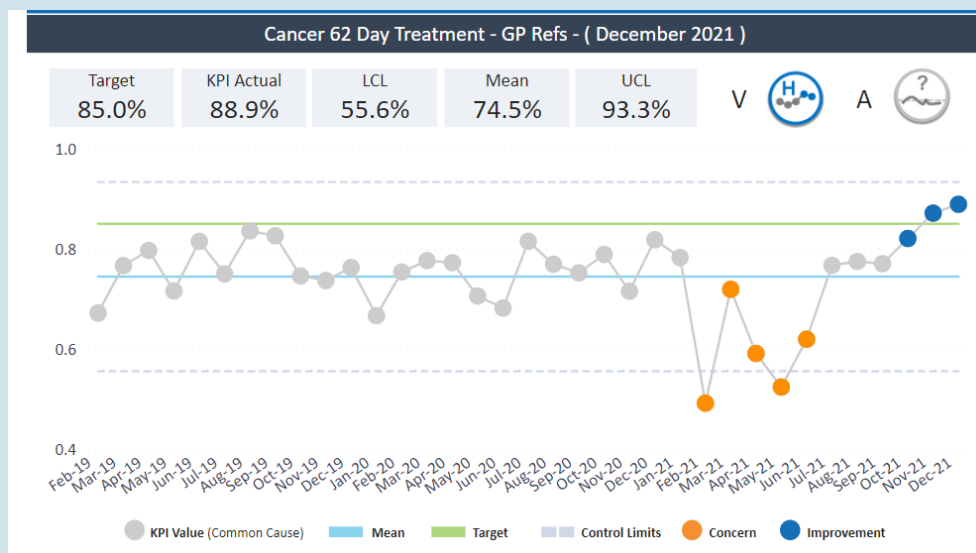


## Responsive: Cancer Insights

**Executive Lead:** Jayne Black—Chief Operating Officer  
**Operational Lead:** Benn Best – Director of Operations Planned Care  
**Sub Groups :** N/A



### 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.

### What the Chart is Telling Us:

MFT achieved compliance against the 62D standard for the first time since June 2018.  
 Ranked 13th in the country for achievement against the target.

### Actions:

- Tumour Site Specific Improvements being taken through Cancer Board led by the Cancer Specialty Leads.
- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement 14 Point Action Plan Meeting.

### Outcomes:

- MFT achieved compliance against the 62D standard for the first time since June 2018.
- MFT forecasting compliance in December 2021.
- K&M have the lowest percentage 62 day backlog in country @ 4.2% of the waiting list.

### Underlying issues and risks:

- Sustaining compliance against the standard.
- Diagnostic capacity to meet the 7 day polling target.
- Expansion of straight to test
- Improve GP referrals - working in line with the Integrated Care Partnership

Summary

Caring

Effective

Safe

Responsive

Well Led



# Cancer 62day Benchmarking



Medway

Performance ▾ Headlines Board Peers

Default ▾

Cancer 62 Day Classic ▾



Dec 21 ▾



Ranking

Trend

Delta

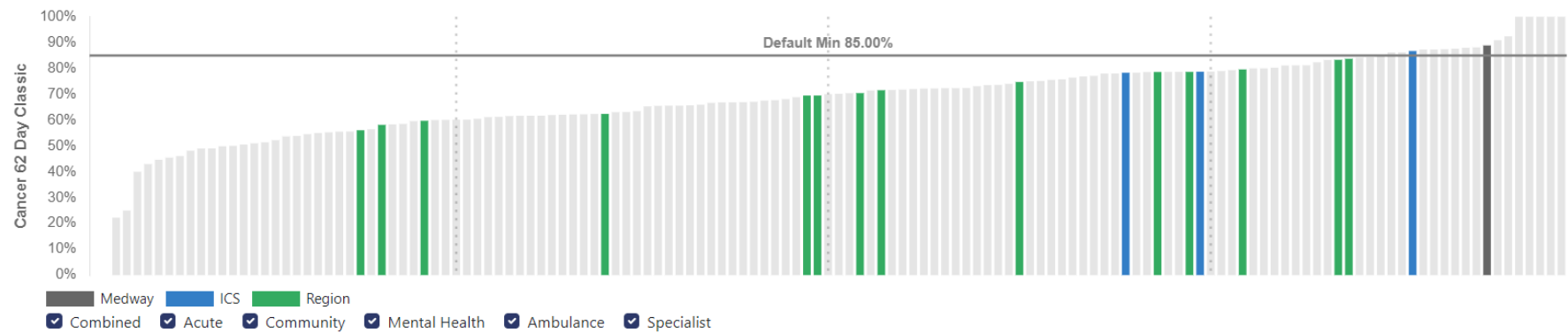
SPC

Siblings

Data

Detail

Dec 21 Performance: 88.89%, Ranking: 8<sup>th</sup> of 139

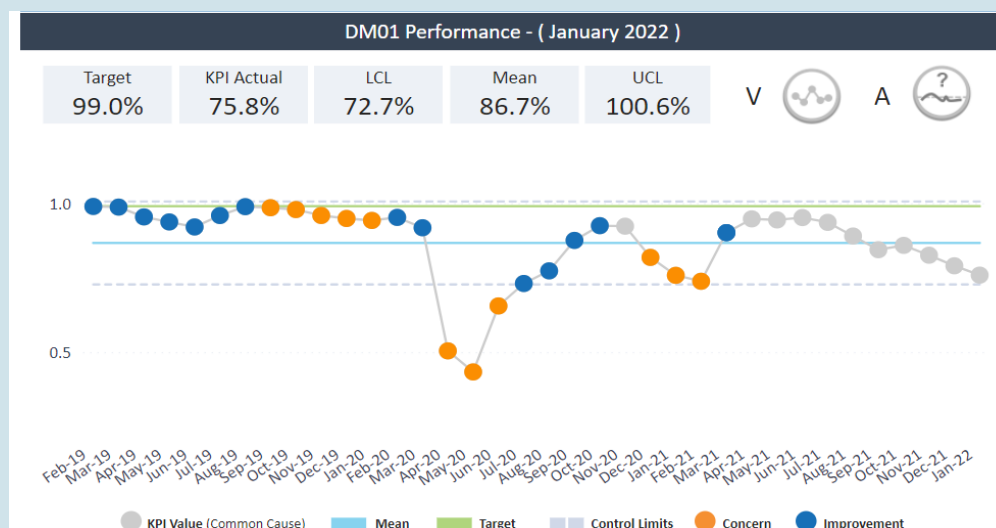


## Responsive: Elective Insights

**Executive Lead:** Jayne Black – Chief Operating Officer  
**Operational Lead:** Benn Best – Director of Operations Planned Care  
**Sub Groups :** N/A



### Indicator: DM01 Performance



### Indicator Background:

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

### What the Chart is Telling Us:

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

### Actions:

- Endoscopy task & finish group implemented
- Triaging of patients on diagnostic waiting lists (D-code) by clinical team in line with national standard
- Use of Independent Sector for Insourcing (18WS) and Outsourcing (PPG) continues with good utilisation of lists
- Insourcing capacity being developed for Sleep Studies and Echocardiography
- Outsourced capacity for MRI being negotiated
- 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 third COVID wave resulting in increased NEL demand impacting on ability to continue same levels of diagnostic work.
- Insufficient Endoscopy capacity means that outsourcing continues to be required
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

Summary

Caring

Effective

Safe

Responsive

Well Led



# DM01 Benchmarking



Performance ▾ Headlines Board Peers

Default ▾ Diagnostics - 6 Week Sta ▾ < Dec 21 ▾ >

Ranking

Trend

Delta

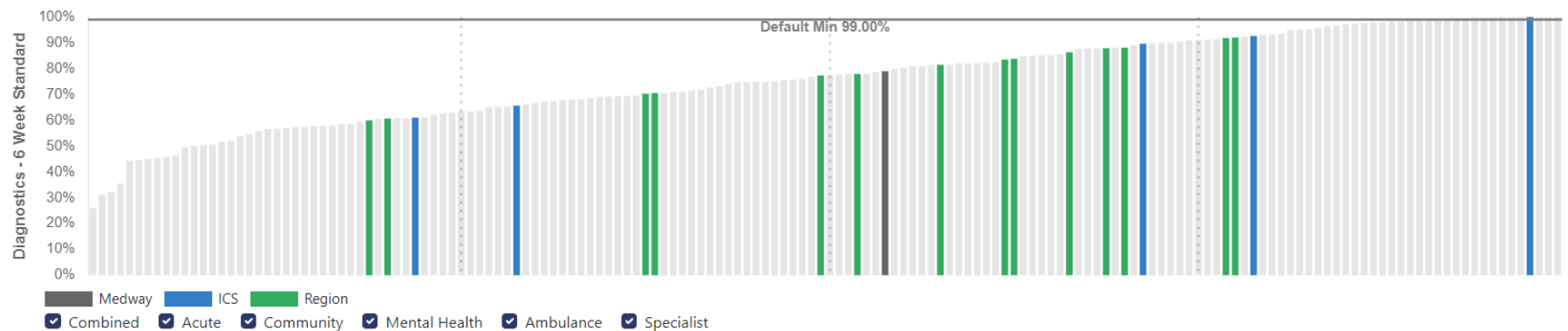
SPC

Siblings

Data

Detail

Dec 21 Performance: 78.99%, Ranking: 74<sup>th</sup> of 160



## Domain: Well Led – Dashboard

**Executive Lead:** Leon Hinton – Chief People Officer

**Operational Lead:** N/A

**Sub Groups :** N/A



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)	Jan-22	4.0%	0.4%	0.7%	2.9%	5.1%		
		Agency Spend as % Paybill (Financial Year YTD)	Jan-22	4.0%	3.2%	2.3%	3.2%	4.1%		
		Appraisal % (Current Reporting Month)	Jan-22	85.0%	83.5%	79.8%	85.4%	91.0%		
		Bank Spend as % Paybill (Current Reporting Month)	Jan-22	9.0%	14.0%	8.2%	13.0%	17.7%		
		Bank Spend as % Paybill (Financial Year YTD)	Jan-22	9.0%	12.4%	10.4%	12.4%	14.4%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Jan-22		4,307	3,967	4,044.45	4,121.90		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Jan-22	2.5%	2.5%	1.8%	2.3%	2.9%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Jan-22	1.5%	3.5%	1.7%	2.1%	2.5%		
		Sickness Rate (Current Reporting Month, FTE%)	Jan-22	4.0%	5.9%	3.3%	4.7%	6.0%		
		StatMan Compliance (Current Reporting Month)	Jan-22	85.0%	89.4%	87.2%	89.0%	90.9%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Jan-22	75.0%	51.8%	54.7%	66.6%	78.4%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Jan-22	12.0%	14.0%	11.5%	12.4%	13.2%		

Summary

Caring

Effective

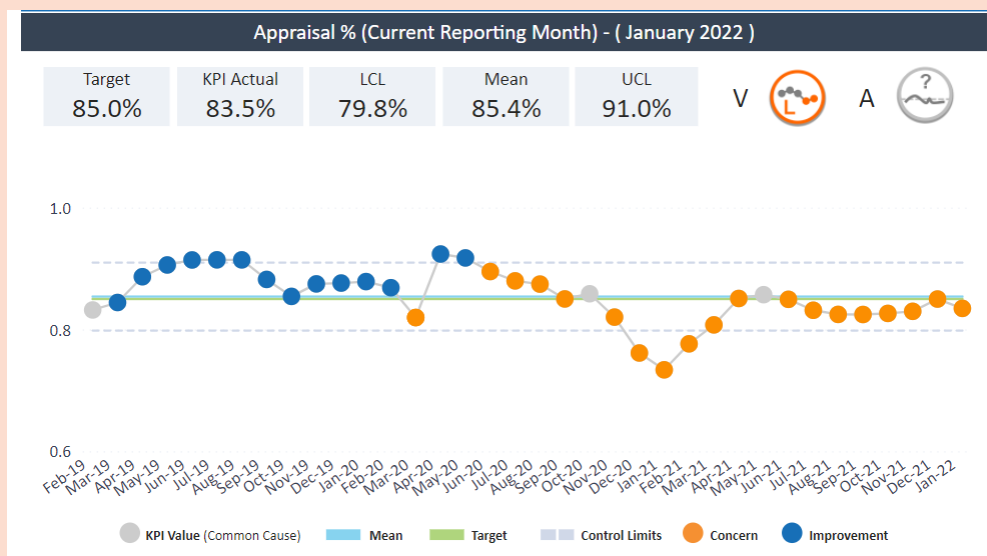
Safe

Responsive

Well Led



## 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:

The variation is special cause of concerning nature or higher pressure due to lower values. Assurance indicates inconsistently hitting passing and falling short of the target.

## Actions:

- Weekly reporting in place;
- 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:

3404 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 4005).

This data has been further refined to show those staff within their first 12m of employment as being compliant (rather than being ignored as was previously the case).

## Underlying issues and risks:

- Current COVID-19 is interrupting clinical area's capacity to carry out appraisals in a timely fashion.
- 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.

## Domain: Well Led - Financial Position

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



### Indicator: Financial Position

Income & Expenditure £k	In-month			YTD		
	Baseline budget	Actual	Variance	Baseline budget	Actual	Variance
Income	31,945	31,602	(343)	316,200	319,759	3,558
Pay	(19,679)	(20,375)	(695)	(196,937)	(202,553)	(5,616)
Total non-pay	(10,817)	(9,838)	979	(104,906)	(102,878)	2,029
Non-operating expense	(1,457)	(1,451)	5	(14,435)	(14,462)	(26)
<b>Reported surplus/(deficit)</b>	<b>(8)</b>	<b>(62)</b>	<b>(54)</b>	<b>(79)</b>	<b>(134)</b>	<b>(55)</b>
Donated Asset / DHSC Stock Adj.	8	62	54	79	134	55
<b>Control total</b>	<b>(0)</b>	<b>(0)</b>	<b>(0)</b>	<b>0</b>	<b>(0)</b>	<b>0</b>

Other financial stability work streams £k	In-month			YTD			Annual
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cost Improvement Programme	457	339	(118)	3,733	3,411	(322)	5,171
Capital	(703)	(1,323)	620	(11,962)	(11,889)	(73)	(21,797)

### Indicator Background:

The Trust reports a £62k deficit position for January; after adjusting for donated asset depreciation the Trust reports breakeven in line with the plan.

### What the Chart is Telling Us:

The Trust has reported breakeven for the year to date. The efficiency programme is £322k adverse to budget year to date, main schemes include ERF income, procurement, closing theatre 5, pharmacy and FYE of 20/21 schemes. Capital spend is marginally ahead of plan by £73k and expected to be on plan reduction by the end of 21/22

### Actions:

- Divisions have been working on the 22/23 business planning with a view to issuing a draft plan by the end of February.
- Discussions with the ICB regarding baseline funding for 22/23 are in progress although not finalised.
- Increased focus on the 9 cross cutting efficiency schemes is in progress.

### Outcomes:

The Trust has met its control total, however this includes:

- The non-recurrent benefit of £0.5m adjustment from agency nursing estimates reducing.
- Additional escalation beds from Winter planning actions and the Business Continuity response.
- Rise in covid costs by £0.1m in month.
- There is no contingency reserve included.

### Underlying issues and risks:

The financial position is monitored against the plan submitted to NHSE/I for Oct-Mar (H2). The risks identified with the financial position for the 2<sup>nd</sup> half of the financial year ahead include managing cost pressures from activity increases as well as elective recovery, delivery of efficiency schemes, and managing Covid costs within the financial envelope for H2, escalation capacity and PAHU, as well as winter pressures. The efficiency programme gap has increased by £0.1m to £1.1m against the £5.1m target.

Summary

Caring

Effective

Safe

Responsive

Well Led



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# Meeting of the Board of Directors in Public

Wednesday, 09 March 2022

## Assurance Report from Committees

<b>Title of Committee:</b>	<b>Quality Assurance Committee</b>	<b>Agenda Item</b>	<b>4.2</b>
<b>Committee Chair:</b>	Tony Ullman, Chair of Committee/NED		
<b>Date of Meeting:</b>	Tuesday 22 February 2022		
<b>Lead Director:</b>	Evonne Hunt, Chief Nursing and Quality Officer (interim)		
<b>Report Author:</b>	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
<b>No assurance</b>	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
<b>Partial assurance</b>	Amber/ Red - there are gaps in assurance
<b>Assurance</b>	Amber/ Green - Assurance with minor improvements required
<b>Significant Assurance</b>	Green – there are no gaps in assurance
<b>Not Applicable</b>	White - no assurance is required

### Key headlines and assurance level

Key headline	Assurance Level (use appropriate colour code as above)
<b>1. Quality, safety and risks report</b> The Committee received and discussed the quality, safety and risks report which provided an update for the reporting month of January 2022 on incidents reporting and current backlog position, delivery of the Trust's CQC action plans, CQC information requests, journey to excellence, implementation of Gather, safety issues, clinical effectiveness and mortality and morbidity.	<b>Amber\Green</b>

<p><b>2. Infection prevention and control update and IPC BAF</b></p> <p>The Committee received the infection prevention and control update paper which provided progress on mandatory surveillance of 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.</p> <p>The Committee were informed that the Trust remains on target for avoidable Onset Healthcare Associated Infections (COHA). The Trust now have had 23 CDiff cases Year to Date against annual ceiling of 35.</p> <p>The Committee were informed that stakeholders from IPCC met to review the IPC BAF which is now one document which combines all previous action plans.</p> <p>The Committee recommended the Board be sighted on the IPC BAF and the Committee will receive regular updates as part of its work plan.</p>	<p><b>Green</b></p>
<p><b>3. Themes from backlog of incidents</b></p> <p>The Committee received and discussed the themes from the backlog of incidents report which provided an update on the management of the Incident backlog, remedial action plans to continuously support the Trust's position on maintaining a positive position and the Quality improvements made through themed analysis of the incidents backlog.</p>	<p><b>Amber/Green</b></p>
<p><b>4. Quarter one and two Avoiding Term Admissions to the Neonatal Unit (Atain) report</b></p> <p>The Committee received a comprehensive report from Dr Ghada Ramadan, Consultant Neonatologist on avoiding term admissions to the neonatal unit.</p> <p>The report provided the Committee with oversight and assurance regarding the Trust's position in support of the national ambition to Avoid Term Admissions into Neonatal Units (ATAIN).</p> <p>The report also provided assurance from the findings of a deep dive into September 2021 Term Admissions as there had been an increase of the number of babies admitted to the unit.</p>	<p><b>Green</b></p>
<p><b>5. Patient Experience Strategy – delivery plan</b></p> <p>The Committee received the patient experience strategy delivery plan which was an update to the paper presented to the Committee last month.</p> <p>The delivery plan outlines all the different patient experience initiatives based on the 5 key themes and principles and will ensure the Trust is able to demonstrate the implementation of the Patient Experience Strategy. The delivery plan will be monitored by the patient experience group with regular updates to the Committee.</p> <p>The Committee approved the patient experience delivery plan.</p>	<p><b>Green</b></p>
<p><b>6. Clinical Negligence Scheme for Trust Maternity Incentive Scheme (CNST) Safety actions 5, 6 and 7</b></p> <p>The Committee received and discussed the CNST safety actions 5, 6 and 7 report which provided the Committee with oversight and assurance to progress against achieving compliance with the requirements of NHS Resolution Year 4 Clinical Negligence Scheme for Trust (CNST) maternity incentive scheme (MIS).</p> <p>The Committee were requested to note the detail of the report and progress against compliance, along with approving the Supernumerary Action Plan. The Committee were asked to approve the report for onward reporting to Trust Board.</p>	<p><b>Amber/Green</b></p>

<p>The Committee approved the report. The summary report has been provided to the Board; the detailed appendices reviewed by the QAC are available on request.</p>	
<p><b>7. CQC maternity survey</b></p> <p>The Head of Midwifery presented the results from the CQC maternity survey which is part of the NHS Patient Survey Programme (NPSP) commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.</p> <p>The maternity survey is split into three sections that ask questions about antenatal care, labour and birth, postnatal care. The survey demonstrated improvements after implementation of the action plan following the 2019 survey.</p> <p>An action plan from the 2021 survey will be agreed and implemented in order to progress further improvements. The Committee will receive the action plan once it has been agreed.</p>	<p><b>Amber/Green</b></p>
<p><b>8. Ockenden oversight report and maternity BAF</b></p> <p>The Committee received the Ockenden oversight report was requested by NHS England and NHS Improvement in their letter to the Chief Executive Officer on 25 January 2022. The expectation is that an Ockenden oversight report will be presented to Trust Board in public by 22 March 2022, with onward reporting to the Local Maternity and Neonatal System (Local Maternity and Neonatal System) and Integrated Clinical System (ICS) by 15 April 2022.</p> <p>The Committee were asked to note progress against compliance and identified actions to achieve full compliance, to note the maternity workforce plan and approve the report for onward reporting to the LMNS, ICS as required by NHSE/I and to Trust Board.</p> <p>The Committee approved the report.</p> <p>The summary report has been provided to the Board; the detailed appendices reviewed by the QAC are available on request.</p>	<p><b>Green</b></p>
<p><b>9. Caesarean section audit 2019/2021</b></p> <p>Professor Ranjit Akolekar, Consultant Fetal Medicine and Obstetrics presented a comprehensive update on C-section rates for the Trust which provided assurance that the rates have been reviewed to ensure they were carried out appropriately for the best outcomes for both mother and baby.</p> <p>Professor Akolekar explained the 4 categories for coding the C-sections at the Trust compared with 2 categories used by neighbouring Trusts, explaining that some category 3 C-sections have been coded as emergency when they are not.</p> <ul style="list-style-type: none"> <li>• Category 1 – immediate threat to life of the woman or fetus</li> <li>• Category 2 – maternal or fetal compromise which is not immediately life threatening</li> <li>• <b>Category 3 – no maternal or fetal compromise but needs early birth</b></li> <li>• <b>Category 4 – birth timed to suit woman or healthcare provider</b></li> </ul> <p>Professor Akolekar also explained that our Trust is a referral centre for fetal medicine which means mothers and babies that require specialist treatment are referred to Medway from our neighbouring Trusts and their babies are delivered here, this increases our rates.</p>	<p><b>Amber/Green</b></p>

Professor Akolekar will present back to the Committee in 4 months' time on the impact of the changes made to consultant cover in the department and the impact on the C-section rate and to provide assurance to the Board that the necessary people and resources are available to support the right outcomes for mothers and babies.	
<p><b>10. Revised discharge service model including the implementation of the inpatient PTL</b></p> <p>The Committee received a comprehensive report on the work being undertaken to revise the service model between acute and system partners for structure, roles, responsibilities and processes of the integrated discharge team and the implementation of the inpatient patient tracker list (PTL). The use of the PTL will facilitate improved board rounding and reporting of data related to discharge planning, pathways and re-admissions.</p>	
<p><b>11. End of Life Care quarterly report</b></p> <p>The committee received the quarterly end of life care report and noted its content.</p>	
<p><b>12. Quality IQPR</b></p> <p>The Committee received the Quality IQPR which provided an update on key performance indicators and quality metrics for the reporting month of January 2022.</p> <p>The Committee were informed of the work to be completed to align the IQPR with Patient First.</p>	<b>Green</b>
<p><b>13. Governance review and proposed Quality Assurance Committee reporting structure</b></p> <p>The Committee received the governance review paper and proposed reporting structure for Quality Assurance Committee. The governance review is a follow on from the review undertaken by NHSE/I. There is a recommendation for the introduction of a Quality and Patient Safety Sub-Committee (QPSS), with 5 sub-groups to be co-chaired by nursing and medical leadership with clear terms of reference and work plans. This will simplify the agenda for the Quality Assurance Committee who will receive assurance and escalation reports.</p>	<b>Green</b>
<p><b>14. BAF – quality risks</b></p> <p>The Committee received and discussed the BAF quality risks and were advised that there were no proposed changes to risk 5b and 5c.</p> <p>The Committee were informed of the proposed changes to risk 5a which related to flow of information and monitoring of CQC actions plans, standards and journey to excellence. The overall risk rating for 5a remains unchanged.</p> <p>The Committee accepted the proposed changes to risk 5a.</p>	<b>Green</b>
<p><b>15. Quality priorities 2022/23</b></p> <p>The Committee received and discussed the quality priorities 2022/23 paper which provided an update on:</p> <ul style="list-style-type: none"> <li>the process with identification of the 2022/23 quality priorities</li> <li>external stakeholder engagement session and themes from members event held on 20<sup>th</sup> January 2022.</li> <li>the rationale and process for identifying the quality priorities as part of the development of the Trust wide Quality Account</li> <li>update on progress made with our 2021/22 quality priorities</li> <li>draft 2022/23 quality priorities</li> <li>next steps</li> </ul>	<b>Green</b>

The Committee will receive the final report in April for approval.	
<p><b>15. Ward to Board Assurance Framework</b></p> <p>The Committee received the ward to board assurance framework which is designed to prepare wards and departments to be inspection ready by way of continuous assessment and monitoring of performance and evidence.</p> <p>The data from the self-assessments will be used by the central quality team for the quality assurance visits and ward accreditations.</p>	<b>Green</b>
<p><b>Escalation to Board</b></p> <p>The Committee escalates the following to Trust Board:-</p> <ul style="list-style-type: none"> <li>• IPC BAF</li> <li>• Ockenden oversight report and maternity BAF</li> </ul>	



## Meeting of the Board of Directors in Public

### Wednesday, 09 March 2022

Title of Report	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Safety Action 5, 6, 7	Agenda Item	4.3
Report Author	Dot Smith, Head of Midwifery		
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer (Interim)		
Executive Summary	<p>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:</p> <ul style="list-style-type: none"> <li>• <b>Safety Action 5:</b> Can you demonstrate an effective system of midwifery workforce planning to the required standard?</li> <li>• <b>Safety Action 6:</b> Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?</li> <li>• <b>Safety Action 7:</b> Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?</li> </ul> <p>Year 4 of the CNST MIS launched on the 8<sup>th</sup> August 2021. The maternity service has provided assurance reports as follows:</p> <ul style="list-style-type: none"> <li>• QAC on the 19<sup>th</sup> October 2021 – Oversight report</li> <li>• Trust Board in Private 4<sup>th</sup> November 2021 – Oversight report and Perinatal Surveillance Tool</li> <li>• QAC on the 21<sup>st</sup> December 2021 – Safety Action 2, 3, 4</li> <li>• Trust Board in Private 12<sup>th</sup> January 2021 – Safety Action 1 and Perinatal Surveillance Tool</li> <li>• Trust Board on the 13<sup>th</sup> January 2021 – Safety Action 2, 3, 4</li> <li>• QAC on the 22<sup>nd</sup> February 2022 – Safety Action 5, 6, 7</li> </ul> <p>The report requests that the Board notes the detail of the report and progress against compliance, along with approving the Supernumerary Action Plan in Appendix 1.</p>		
Link to strategic Objectives 2019/20	<b>Innovation:</b> We will embrace innovation and digital technology to support the best of care		<input type="checkbox"/>
<i>(Please mark X against the</i>	<b>Finance:</b> We will deliver financial sustainability and create value in all we do		<input type="checkbox"/>

<b>strategic goal(s)</b> <i>applicable to this paper - this could be more than one)</i>	<b>People:</b> We will enable our people to give their best and achieve their best			<input checked="" type="checkbox"/>
	<b>Integrated Health Care:</b> We will work collaboratively with our system partners to establish an Integrated Care Partnership			<input checked="" type="checkbox"/>
	<b>High Quality Care:</b> We will consistently provide high quality care			<input checked="" type="checkbox"/>
<b>Committees or Groups at which the paper has been submitted</b>	Women's and Children's Care Group Board Planned Care Divisional Board Maternity and Neonatal Safety Champion Assurance Board Quality Assurance Committee			
<b>Resource Implications</b>	No additional resource implications			
<b>Legal Implications/Regulatory Requirements</b>	Compliance with CNST Year 4, Ockenden (2020), CQC			
<b>Quality Impact Assessment</b>	N/A			
<b>Recommendation/ Actions required</b>	The Board is asked to note progress towards achieving compliance and approve the Action Plan in Appendix 1.			
	<b>Approval</b> <input checked="" type="checkbox"/>	<b>Assurance</b> <input checked="" type="checkbox"/>	<b>Discussion</b> <input type="checkbox"/>	<b>Noting</b> <input checked="" type="checkbox"/>
<b>Appendices</b>	Appendix 1: Supernumerary Action Plan			

# 1 Executive Overview

1.1 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 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- **Safety Action 6:** Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
- **Safety Action 7:** Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

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
<b>Oct-21</b>	Overview		
<b>Nov-21</b>		Perinatal Surveillance Tool & Safety Action 1	Overview/Workforce
<b>Dec-21</b>	Safety Action 2,3 & 4		
<b>Jan-22</b>		Perinatal Surveillance Tool & Safety Action 1	Safety Action 2, 3 & 4
<b>Feb-22</b>	Safety Action 5, 6, 7		
<b>Mar-22</b>		Perinatal Surveillance Tool & Safety Action 1	Safety Action 5, 6 & 7
<b>Apr-22</b>	Safety Action 8, 9, 10		
<b>May-22</b>	Final Oversight Report	Perinatal Surveillance Tool & Safety Action 1	Safety Action 8, 9, 10/ Workforce
<b>Jun-22</b>			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.

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 will maintain 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 was presented at QAC on the 22<sup>nd</sup> February 2022 and approved for onward reporting to the Trust Board.
- 1.7 The report requests that the Board:
  - Notes the detail of the report and progress against compliance, along with approving the Supernumerary Action Plan in Appendix 1.

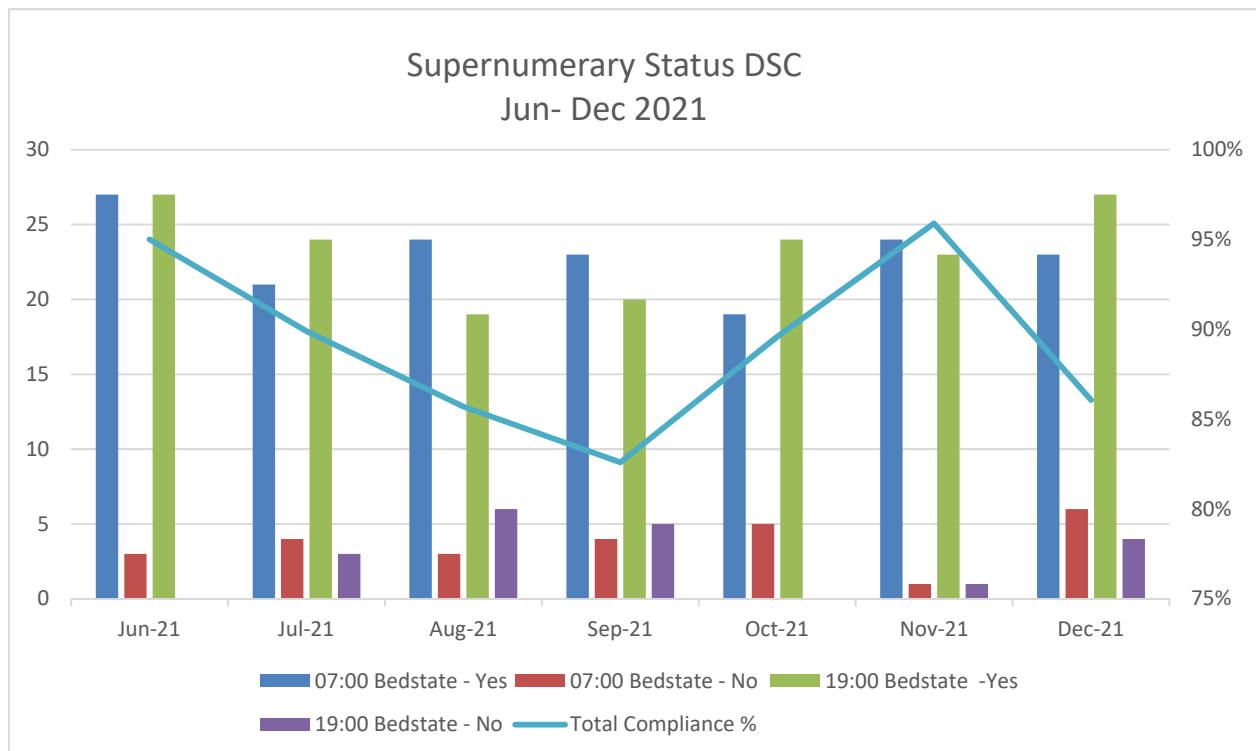
## 2 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- 2.1 In Year 4 CNST requires all Trusts undertake a systematic evidence-based process to calculate midwifery staffing establishment is completed, using BirthRate+ or equivalent. The Head of Midwifery completed a PID to undertake a full BirthRate+ assessment, based on current acuity and activity. The PID was rejected at Executive level and the Head of Midwifery is working with the General Manager for Women's and Children's and senior staff to undertake a local review using the methodology of BirthRate+. This review is currently underway and a full workforce report and action plan based on the recommendations of this review will be presented to the QAC in April 2022 and Trust Board in May 2022. This workforce report will comply with the requirements of CNST to present a midwifery workforce report to Trust Board every 6 months.
- 2.2 CNST requires Trusts to monitor the supernumerary status of the delivery suite coordinator (DSC), with the target being that this should be maintained 100% of the time. For units that are unable to maintain supernumerary status of the DSC, an action plan, signed off by the Trust Board, is required to achieve compliance.
- 2.3 Supernumerary status of the DSC is recorded twice daily on the Maternity Bedstate, and a minimum of 40 bed states per month are audited.

Month	Compliance
Oct-20	100.00%
Nov-20	100.00%
Dec-20	100.00%
Feb-21	100.00%
Mar-21	96.55%
Apr-21	100.00%
May-21	100.00%
Jun-21	95.00%
Jul-21	89.90%
Aug-21	85.74%
Sep-21	82.59%
Oct-21	89.58%

Nov-21	95.92%
Dec-21	86.07%
<b>Average</b>	<b>95.02%</b>

- 2.4 Supernumerary status has not been maintained at 100% since June 2021, due to significant staffing shortages during this time. Some improvement was seen in October and November 2021 following an influx of new starters, however December 2021 saw further decline in compliance as a result of covid-19 related staff sickness and absences.



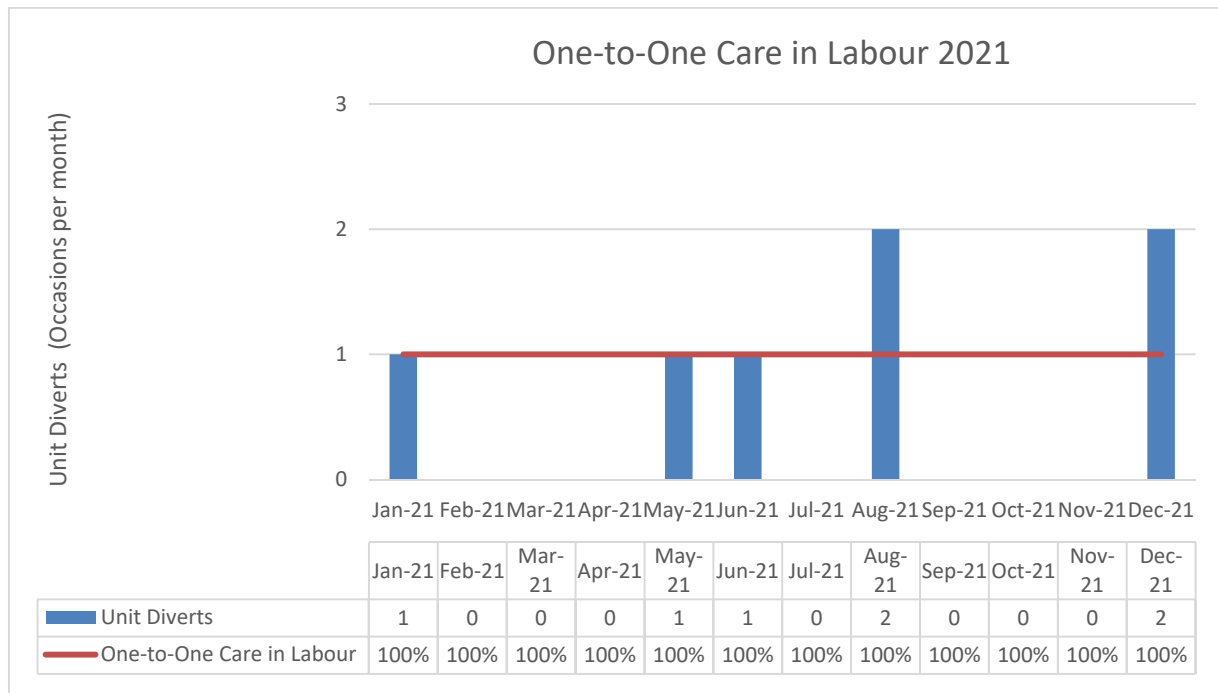
- 2.5 An action plan is in place to achieve supernumerary status and mitigations put in place to achieve compliance have included:

- Enhanced bank rates to support staffing shortages
- Rolling recruitment to vacancies with 20 WTE new starters in October and November 2021
- Managerial and Specialist Midwives working clinically.
- Update escalation policy to ensure threat to supernumerary status is escalated to manager on call.
- Workforce paper and business case to approve funding for additional midwives.
- Procurement of BirthRate+ four hourly acuity tool to support live reporting and data recording.
- Enhanced audit from January 2022 to triangulate supernumerary status with staffing, acuity and other activity.

2.6 The report requests that the Board:

- Review and approve the action plan included in Appendix 1

2.7 CNST also requires that all women in active labour receive one-to-one midwifery care. The report assures the QAC that the maternity service maintains 100% one-to-one midwifery care for women in labour. One-to-one care in labour is prioritised to provide safe maternity care and an inability to do so would trigger the escalation to close policy to enable divert of non-emergency cases:



2.8 One-to-One Care in Labour is monitored monthly via Labour Ward Forum and Care Group Governance Board, and reported to the CNST Safety Compliance Group. Should one-to-one care fall below 100%, this would be escalated to Divisional Board and Maternity and Neonatal Safety Champion Assurance Board and an action plan put in place to maintain compliance with CNST.

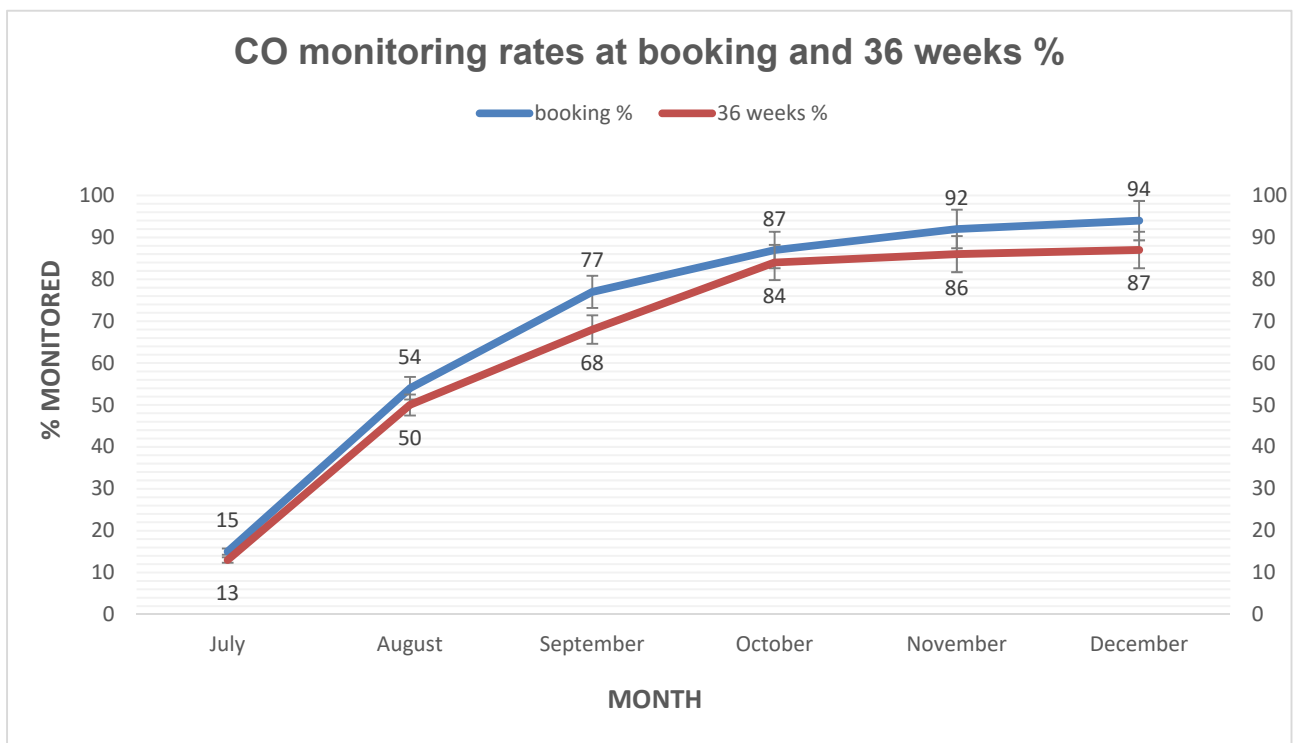
### 3 **Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?**

3.1 The report provides assurance to the QAC that the maternity service is on track to achieve compliance with all five elements of the Saving Babies' Lives Care Bundle version two (SBLCBv2) :

- Element 1: Carbon Monoxide Monitoring
- Element 2: Fetal Growth Restriction (FGR)
- Element 3: Reduced Fetal Movements (RFM)
- Element 4: Fetal Monitoring
- Element 5: Preventing Pre-term births

## 3.2 Element 1: Carbon Monoxide Monitoring

- 3.2.1 Element 1 requires Trusts to achieve a minimum of 80% compliance with carbon monoxide (CO) monitoring for women at booking and again at 36 weeks. The target for this element is 95% compliance with an action plan required for less than 95%.
- 3.2.2 In the report to QAC on the 19<sup>th</sup> of October the maternity service identified some concern regarding achieving this target due to the pause on CO monitoring during 2020 and 2021 due to Covid-19. Monitoring was recommenced in July 2021 and following some initial barriers to compliance, including equipment issues and data reporting from the maternity information system, the maternity service is now achieving >80% at booking and 36 weeks. Compliance is closely monitored and reported by the Smoking in Pregnancy Midwife and reported to the CNST Compliance Group.

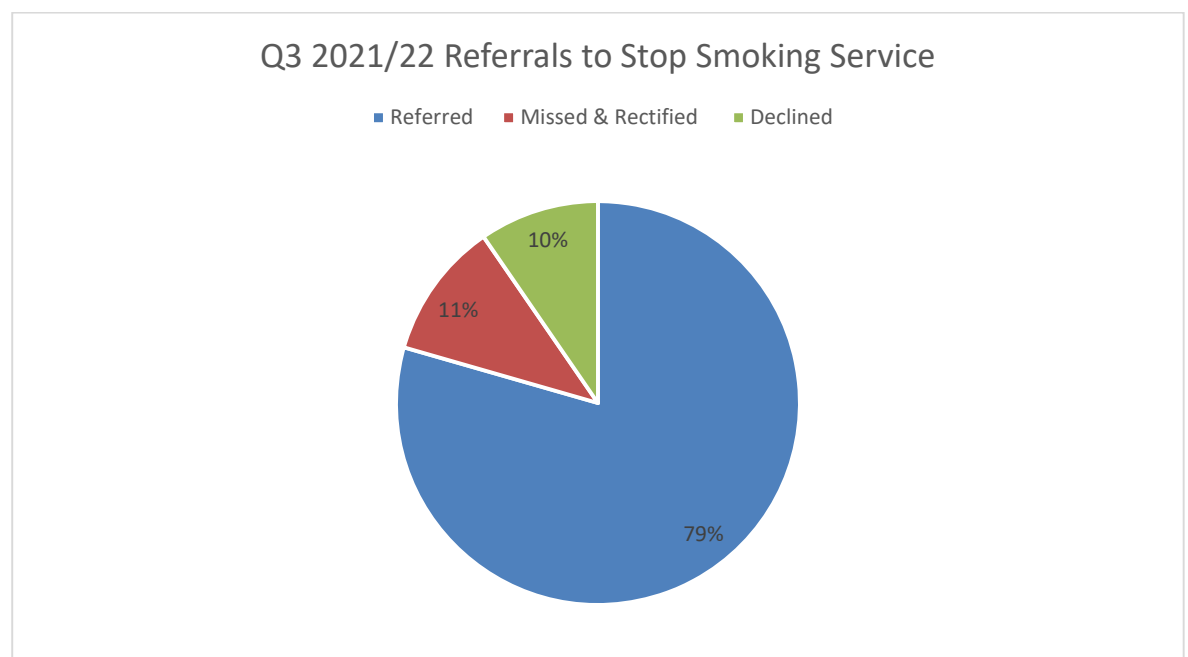


- 3.2.3 CNST requires Trusts to pass the data quality rating on the National Maternity dashboard for 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric (CQIM). This CQIM was not appropriately mapped by the Maternity Information System provider (Wellbeing) prior to September 2021 and therefore not showing on the National Maternity Dashboard. The maternity service has received assurance from Wellbeing that this data is now being mapped to the Maternity Services Data Set (MSDS) and will feed the dashboard from October 2021 onwards. Compliance with this requirement is being monitored by the CNST Safety Compliance Group and when October data is available on the National Maternity Dashboard this will be reviewed to ensure the data quality rating has passed.

3.2.4 A guideline is in place for smoking cessation in pregnancy (GUDMN262) and appropriate referral pathways to smoking cessation services for both Kent and Medway.

3.2.5 For Quarter 3 2021/22 219 women were eligible for referral to the Stop Smoking Service. Of these, 174 were referred and 21 declined. A further 24 referrals were initially missed, however all these referrals were completed by the Smoking in Pregnancy midwife who reviews and rectifies all missed referrals each month.

Quarter 3 Referrals to Stop Smoking Service				
Service	Referred	Missed & Rectified	Declined	Totals
October	62	5	11	78
November	59	6	6	71
December	53	13	4	70
Totals	174	24	21	219



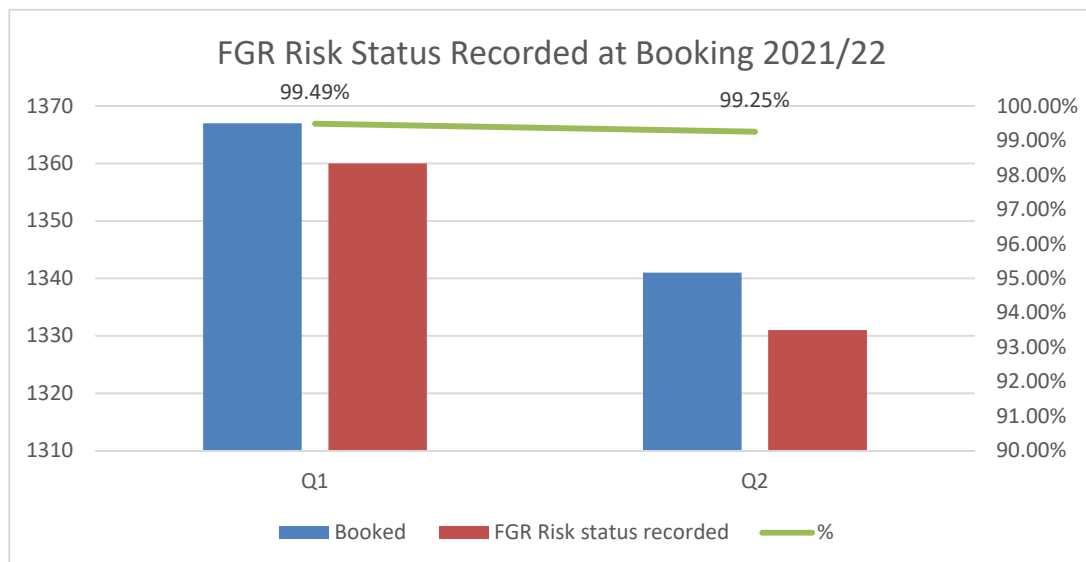
3.2.6 An audit plan is in place to review the following indicators from January to April 2022 as required by CNST. The outcome of this audit will be shared with the QAC and the Trust Board prior to submission.

- Percentage of women with a CO measurement  $\geq 4$ ppm at booking.
- Percentage of women with a CO measurement  $\geq 4$ ppm at 36 weeks.

- Percentage of women who have a CO level  $\geq 4$ ppm at booking who subsequently have a CO level  $< 4$ ppm at the 36 week appointment.

### 3.3 Element 2: Fetal Growth Restriction

- 3.3.1 CNST requires Trusts to achieve at least 80% compliance with recording risk status for Fetal Growth Restriction (FGR) at booking and at the 20 week scan. In year 3 CNST required Trusts to achieve 80% compliance with risk status recorded at booking and MFT achieved 97%.
- 3.3.2 This has been exceeded for Q1 and Q2 of 2021/22 with 99.49% and 99.25% achieved respectively. A review of all missed cases is being undertaken by the lead Midwife for Fetal Medicine to determine if there was an input error or other factors contributing to the missed cases.



- 3.3.3 The audit for FGR status at 20 week scan is ongoing and will be reported to the QAC and Trust Board prior to submission.
- 3.3.4 CNST requires the Trust Board to confirmed that women with a BMI  $> 35 \text{kg/m}^2$  are offered ultrasound assessment of growth from 32 weeks gestation onwards. This pathway reflected in Small for Gestational Age Fetus – Guideline for Management (GUDNM031) demonstrates that women with a raised BMI are offered additional scans at 32 and 40 weeks, in addition to the routine scan for all women at 36 weeks. Compliance with this pathway is currently being audited and the findings will be reported to the QAC and Board prior to submission.
- 3.3.5 As declared in CNST Year 3, all women, including those identified as high risk at booking have uterine artery Doppler flow velocimetry performed as standard at their 20-22 week scan as standard. Any women who returns a uterine artery doppler velocimetry reading  $> 95^{\text{th}}$  percentile will go on to be seen in the placental disorders clinic as outlined in the guideline GUDNM031 'Management of small for gestational age fetuses'.

- 3.3.6 Risk assessment and management of growth disorders in multiple pregnancies compliance with NICE guidance as reflected in the Guideline for Management of Multiple Pregnancies (GUDNM006) which outlines clear pathways of management for multiple pregnancies based on risk of growth restriction.
- 3.3.7 Element 2 also requires the following audits to be completed within the reporting period and the report assures the QAC that an audit plan is in place to undertake these and present at local audit and governance meetings, along with reporting to QAC and Trust Board:
- Quarterly audit of the percentage of babies born <3<sup>rd</sup> centile >37+6 weeks gestation.
  - Percentage of all Perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).
  - Quarterly review of a minimum of 10 cases born <3<sup>rd</sup> centile >37+6 weeks to identify themes of FGR not being detected.

### 3.4 Element 3: Reduced Fetal Movements

- 3.4.1 CNST requires Trusts to demonstrate a minimum of 80% compliance with the following requirements:
- Percentage of women booked for antenatal care who had received reduced fetal movements (RFM) information by 28+0 weeks of pregnancy.
  - Percentage of women who attend with RFM who have a computerised CTG.
- 3.4.2 The data for these requirements, whilst entered into the Maternity Information System by clinical staff have not been mapped to the MSDS and therefore require audit of a minimum of 20 cases to demonstrate compliance.
- 3.4.3 For CNST year 3, audit demonstrated 100% of women received RFM information by 28 weeks. A question has been added to the Maternity Information System, EuroKing, to allow midwives to record this information by the 28 week appointment. The maternity system is not able to feed this data to the MSDS therefore in line with CNST guidance an audit of 20 cases was completed demonstrating 100% compliance with discussion of RFM and signposting to appropriate information by 28 weeks.

Case	RFM Information shared by 28 weeks	Gestation RFM discussed	Case	RFM Information shared by 28 weeks	Gestation RFM discussed
1	Y	17+5	11	Y	17+6
2	Y	28+0	12	Y	19+6
3	Y	17+2	13	Y	20+1
4	Y	19+0	14	Y	16+1
5	Y	18+1	15	Y	17+6
6	Y	19+5	16	Y	18+6
7	Y	16+5	17	Y	18+6
8	Y	21+0	18	Y	19+5

9	Y	18+6	19	Y	19+4
10	Y	18+6	20	Y	27+1

3.4.4 Compliance with the use of computerised CTG for all women attending both the Maternity Care Unit and Obstetric Triage with RFM is maintained from year 3, with an audit demonstrating 100% compliance for both year 3 and year 4.

### 3.5 Element 4: Fetal Monitoring

3.5.1 CNST requires Trust Boards to confirm:

- 90% of eligible staff have attended local multi-professional fetal monitoring training annually.
- A dedicated Lead Midwife (0.4 WTE) and lead Obstetrician (0.1 WTE) have been appointed by the end of 2021.

3.5.2 Compliance with Fetal Monitoring training is as follows:

Fetal Monitoring Training Compliance	
Midwives	86%
Junior Doctors	90%
Consultants	62%

3.5.3 This position is a reflection of new midwifery starters and rotation of junior doctors. A trajectory is in place to have all midwives and outstanding consultants trained by March 2022.

3.5.4 A dedicated Fetal Wellbeing Midwife is currently in post (0.4WTE) with recruitment underway to increase this post to 1.4 WTE to support Fetal Monitoring Training and support the SBLCBv2 priorities. A lead obstetrician was appointed in 2021 (Simulation and CTG Lead) for 1 PA.

### 3.6 Element 5: Preventing Preterm Birth

3.6.1 CNST requires Trusts to achieve a minimum of 80% compliance with the following process indicators, with an action plan in place if 80% is not achieved:

- Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.
- Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.
- Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.
- Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

- 3.6.2 Audits are ongoing for steroid administration, both within seven days and more than seven days after birth and ongoing management of preterm birth is being supported by the revision of the preterm birth guideline. Findings of these audits will be shared at local audit and governance meeting and with QAC and the Trust Board prior to submission. If compliance falls below 80% an action plan will be put in place and form part of the Maternity Quality Improvement plan to support the service to achieve compliance.
- 3.6.3 The maternity service has a well embedded pathway to administer magnesium sulphate to all eligible mother threatening preterm birth. Compliance averages at 97% for singleton births, with any missed cases reviewed by the PReCePT (Prevention of Cerebral Palsy in preterm labour) midwife to assess whether there were any missed opportunities for administration of magnesium sulphate. Reviews to date have indicated that all eligible cases that did not receive magnesium sulphate were in cases where there was imminent delivery and therefore there was no opportunity to administer.
- 3.6.4 An audit of all births for 2021 was undertaken to determine the percentage of babies born in appropriate location. As Medway has a level 3 neonatal unit, only the following births would be considered outside of ODN guidance.
- Singleton births <27 weeks born outside the hospital
  - Multiple births <28 weeks born outside the hospital.
- 3.6.5 The audit demonstrated that 99.96% of babies were born in the appropriate location with only two instances of babies being born outside the hospital setting at <27 weeks gestation.
- 3.6.6 CNST requires Trust Boards to specially confirm that the following are in place:
- Dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention.
  - Women at high risk of preterm birth have accessed to specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided.
- 3.6.7 The report confirms that there is a dedicated lead consultant for preterm birth who is supported by a midwife sonographer.
- 3.6.8 There is an established pathway and guideline in place for the management of women at risk of preterm birth (GUDNM047) and the appropriate preterm clinic and transvaginal scanning for cervical length is in place.
- 3.6.9 CNST also requires an audit of 40 consecutive cases of women booking for antenatal care is completed to measure whether women are stratified to low, intermediate and high-risk pathways and the percentage of those assessed as at increased risk are referred to the appropriate preterm birth clinic and pathway. The audit for this requirement is ongoing, but the established pathway for preterm birth provides assurance that women who are assessed as being high-risk are placed on an

appropriate pathway, and all women receive appropriate and ongoing risk assessment throughout their pregnancy.

3.6.10 The multiple pregnancy guideline (GUDNM006) is in place and provides appropriate pathways for risk assessment and management for multiple pregnancies and preventing preterm birth.

#### **4 Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?**

- 4.1 As in Year 3, CNST requires maternity services to work with the Maternity Voices Partnership (MVP) to coproduce local services. In year 4 CNST requires the following evidence to demonstrate effective mechanisms and processes for gathering service user feedback via the MVP:
- Terms of Reference for MVP.
  - Minutes of MVP meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.
  - Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme.
  - The MVP's work programme, minutes of the MVP meeting which agreed it and the minutes of the Local Maternity and Neonatal System (LMNS) board that ratified it.
  - Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way.
  - Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds (BAME) and women living in high levels of deprivation.
- 4.2 The Medway MVP Terms of reference were reviewed in 2021 and a work plan/core offer was agreed with the LMNS in April 2021. The core offer is due for review in May 2022 and will be submitted to the Trust Board for evidence prior to submission.
- 4.3 Minutes of the MVP meeting reflect the joint working, co-production and prioritisation of BAME women and those living in high levels of deprivation. During the MVP meeting on the 29<sup>th</sup> November 2021, user feedback was provided and the common theme was communication:
- Closure of The Birth Place during the summer staffing challenge
  - Postnatal information inconsistent
  - Informed choice is not always perceived as welcome

- 4.4 In response to this feedback the maternity service have:
- Shared the feedback with all senior sisters
  - The Professional Midwifery Advocates (PMA) are working with midwives to improve their approach to personalisation and choice, which includes For all maternity staff to be able to deliver informed choice and give back control to women, people that birth and their families by providing a personalised care and support plan throughout their maternity journey
- 4.5 The MVP and the Maternity service are working collaboratively to ensure all language used in patient facing communications is inclusive and supportive of the LGBTQ+ community. A 15 Steps challenge was planned for January 2022, however this was deferred due to Covid-19 restrictions and is now scheduled for April. An action plan from this visit will be incorporated into the Maternity Improvement plan to support further coproduction and responsiveness to service user feedback.
- 4.6 The MVP chair has been proactive in recruiting new members, who in turn will support the development of the Maternity Service Strategy and will participate in the multi-stake holder meeting in February 2022.
- 4.7 The MVP chair is remunerated for her work and has confirmed this in writing, and discussions are ongoing with the LMNS to ensure the core offer and funding supports the work required of the chair by external reviews including Ockenden and CNST.
- 4.8 The Chair has also confirmed in writing that service user members are able to claim out of pocket expenses should this be required.






## 5 Conclusion and Next Steps





- 5.1 The report advises the Trust Board of the pause to CNST year 4 as of the 23<sup>rd</sup> December 2021 for a minimum of three months, 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 5, 6 and 7.
- 5.3 The report requests that the Board note progress against compliance and approve the report and supernumerary action plan in appendix 1 for onward reporting to the Trust Board in March 2022.
- 5.4 The maternity service will continue to progress audits for Safety Action 6 and ensure learning is disseminated via local audits and governance meetings prior to submission to the Trust Board.

## Appendix 1: Supernumerary Action Plan

**Accountable Lead: Dot Smith, Head of Midwifery**

**Action Plan Completion Date:** [Click here to enter a date.](#)

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Owner	Progress	Current position	Actual Date	Evidence Source
Monthly Audit of Supernumerary Status to demonstrate compliance.	Monthly Audit. Bi-Annual Report	Monthly Audit and Bi-Annual Report	31/01/2022	Intrapartum Matron	Supernumerary audit underway. Report to be completed July 2021 <b>Jan 2022:</b> Supernumerary Report for July to December 2021 to be completed in month.	On target	date	 2021.07.01 Supernumerary A
Timely escalation of barriers to supernumerary status	Update Escalation to Close Policy to include the requirement to raise a datix and inform Manager on Call if Supernumerary status not maintained for >1 hour.	Updated policy  Datix and escalation as required	30/06/2021	Intrapartum Matron	Escalation to close policy updated.	Complete	30/05/2021	 02. 2021.02 Escalation to Clo
Implement recommendations of Birthrate Plus	Funding for 13WTE midwives to meet Continuity of Carer and support staffing levels on unit.	Funding agreed.	30/07/2021	Head of Midwifery	<b>June 2021:</b> Report to Executive Group in April 2021 and Board in May 2021. Agreed in Principle.  <b>August 2021:</b> 7.1 approved and funded. Business case for remaining 6.9 with Executive	Complete	05/10/2021	 06. 2021.06.03 Tr Board Papers.p   04. May 2021 Maternity Staffin   03. 2021.04.21 Maternity Staffing R

					Group awaiting final approval. <b>5 October 2021:</b> Approved by Executive Group. Recruitment to begin.		 Midwifery workforce business  051021 BCRG Midwifery Workf
	Recruitment to additional 13WTE roles.	Staff recruited to posts	30/6/2022	Head of Midwifery	<b>January 2022:</b> Workforce plan to be conducted by Matron including: <ul style="list-style-type: none"> <li>• Review of JD</li> <li>• Review of Advert</li> <li>• Education offer</li> <li>• Succession planning</li> <li>• Retention and Retiring staff</li> <li>• Building dedicated Bank workforce.</li> </ul>		
Improve live reporting to provide timely escalation with non-compliance.	Purchase upgrade on four hourly birth rate+ acuity tool	Acuity in place and aligned to escalation policy.	31/1/2021	Intrapartum Matron	<b>January 2022:</b> Live reporting tool purchased and template completed.	Complete	 Set up form.ms  RE BR+ .msg

	Update process for completing bed state to improve communication of current status through live reporting.	Live reporting in place All staff trained to provide consistent reporting.	30/03/2022	Intrapartum Matron	<b>Jan 2022:</b> Staff training to take place February 2022 and Go-Live March 2022	On Target		
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Overdue

On target

Near

Complete



# Meeting of the Board of Directors in Public

## Wednesday, 09 March 2022

Title of Report	Ockenden Oversight Report	Agenda Item	11
Report Author	Dot Smith, Head of Midwifery		
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer		
Executive Summary	<p>This report provides the Trust Board with oversight and assurance on the Maternity Service's progress against achieving the seven Immediate and Essential Actions (IEAs) as published in Donna Ockenden's December 2020 report 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trusts'.</p> <p>This report has been requested by NHS England and NHS Improvement in their letter to the Chief Executive Officer on 25 January 2022. The expectation is that an Ockenden oversight report will be presented to Trust Board in public by 22 March 2022, with onward reporting to the Local Maternity and Neonatal System (Local Maternity and Neonatal System) and Integrated Clinical System (ICS) by 15 April 2022.</p> <p>As per NHSE, NHSI and LMNS requirements, the report includes:</p> <ul style="list-style-type: none"> <li>• Progress with the implementation of the 7 IEAS outlined in the Ockenden report and the plan to ensure full compliance.</li> <li>• Maternity services workforce plans.</li> <li>• Assurance regarding Morecombe Bay (2015) benchmarking</li> </ul> <p>The report requests the Board:</p> <ul style="list-style-type: none"> <li>• Notes progress against compliance and identified actions to achieve full compliance.</li> <li>• Notes the maternity workforce plan</li> <li>• Approves the report for onwards reporting to the LMNS and ICS as required by NHSEI.</li> </ul>		
<b>Link to strategic Objectives 2019/20</b>  <i>(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)</i>	<b>Innovation:</b> We will embrace innovation and digital technology to support the best of care		<input type="checkbox"/>
	<b>Finance:</b> We will deliver financial sustainability and create value in all we do		<input type="checkbox"/>
	<b>People:</b> We will enable our people to give their best and achieve their best		<input type="checkbox"/>

<b>one)</b>	<b>Integrated Health Care:</b> We will work collaboratively with our system partners to establish an Integrated Care Partnership	<input type="checkbox"/>	
	<b>High Quality Care:</b> We will consistently provide high quality care	<input checked="" type="checkbox"/>	
<b>Committees or Groups at which the paper has been submitted</b>	Women's and Children's Care Group Board Planned Care Divisional Governance Meeting Quality Assurance Committee		
<b>Resource Implications</b>	No additional resource implications		
<b>Legal Implications/Regulatory Requirements</b>	Non-compliance with Ockenden, Clinical Negligence Scheme for Trusts Maternity Incentive Scheme, CQC		
<b>Quality Impact Assessment</b>	Quality Impact Assessment Not required		
<b>Recommendation/ Actions required</b>	The Board is asked to note progress against compliance and actions required and recommend onward reporting to the LMNS and ICS.		
	<b>Approval</b> <input checked="" type="checkbox"/>	<b>Assurance</b> <input checked="" type="checkbox"/>	<b>Discussion</b> <input checked="" type="checkbox"/>
<b>Appendices</b>	<b>Noting</b> <input checked="" type="checkbox"/>		
	Appendix 1: Maternity Quality Improvement Plan - available on request		

## 1 Executive Overview

- 1.1 This report provides the Trust Board with oversight and assurance on the Maternity Service's progress against achieving the seven Immediate and Essential Actions (IEAs) as published in Donna Ockenden's December 2020 report 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trusts'.
- 1.2 This report has been requested by NHS England and NHS Improvement in their letter to the Chief Executive Officer on 25 January 2022. The expectation is that an Ockenden oversight report will be presented to Trust Board in public by 22 March 2022, with onward reporting to the Local Maternity and Neonatal System (Local Maternity and Neonatal System) and Integrated Clinical System (ICS) by 15 April 2022.
- 1.3 The report was presented to the Quality Assurance Committee on 22 February 2022 and was approved for onward reporting to Trust Board.
- 1.4 As per NHSE, NHSI and LMNS requirements, the report includes:
  - Progress with the implementation of the 7 IEAS outlined in the Ockenden report and the plan to ensure full compliance.
  - Maternity services workforce plans.
  - Assurance regarding Morecombe Bay (2015) benchmarking
- 1.5 The report requests the Board:
  - Notes progress against compliance and identified actions to achieve full compliance.
  - Notes the maternity workforce plan
  - Notes the position against the Morecombe Bay (2015) benchmarking
  - Approves the report for onwards reporting to the LMNS and ICS as required by NHSEI.

## 2 Overview

- 2.1 Following the publication of the Ockenden report in December 2020, the Maternity Services responded appropriately by completing the required review and benchmarking against the 7 IEAS on the assurance tool.
- 2.2 The service provided an oversight report to the Executive Group on the 28<sup>th</sup> January 2021, along with the completed assurance tool for review and support from that Group to enable the Chief Executive Officer to sign-off the submission of the assurance tool to NHSEI.
- 2.3 The maternity service identified some gaps in compliance and an action plan was put in place to achieve compliance, monitored by a monthly Ockenden Review Group, chaired by the Head of Midwifery and attended by senior members of the maternity team.

- 2.4 In June 2021 the Maternity service was required to submit evidence to support their declared position and this was completed, with an assurance and oversight report presented to the Executive Group on 7<sup>th</sup> July 2021 advising of the position against each IEA and identifying further actions required to achieve compliance.
- 2.5 The governance around the Ockenden self-assessment and review process was audited by KMPG as part of the Trust's internal annual audit programme. The findings of this audit were positive, with an overall rating of amber green, (significant assurance with minor improvement opportunities). The maternity service is working to implement these recommendations.
- 2.6 KMPG highlighted the following areas of good practice:

- Appropriate Action Plan and Action Tracker in place.
- Ockenden Review Group in place to monitor compliance, with appropriate minutes, actions and appropriate IEA leads in attendance.
- Periodical reporting to the Quality Assurance Committee and Maternity Transformation Assurance Board.
- Embedded sharing of perinatal surveillance tool with the LMNS.

2.6.2 The KMPG auditors identified the following key findings:

- Consultant and Audit Midwife: The Trust does not have capacity currently to conduct audits more frequently, or focus on research and service development:
- No action plan in place to assist the Trust in achieving the Trust target of 90% training compliance across all staff groups.
- Evidence has not yet been provided to demonstrate that the MVP action plan has been refreshed for 2021/22
- The standard operating procedure that is in place for Obstetric and Gynaecology Consultant Roles and responsibilities is in draft and not yet been finalised:

2.6.3 In response to the key findings the maternity service has taken the following actions:

- Recruit to audit midwife post (due to start February 2022).
- Plan to recruit to consultant midwife (approved funding following 2020 BirthRate+ assessment)
- Appoint Clinical Director and Divisional medical Director for Planned Care as responsible leads for training compliance. Actions to be incorporated into Maternity Improvement Plan.
- MVP core offer in place for 2021/22. Work plan to be formalised following 15 Steps Challenge (delayed due to Covid-19) with SMART actions to follow.
- SOP for Consultant roles and responsibilities approved at Divisional Level and presented to Trust Board in January 2022. Audit with compliance

against SOP will commence post-implementation of the new consultant rota on the 31<sup>st</sup> January 2022.

- 2.7 The Maternity service received feedback on evidence submitted in December 2021, which identified some areas where evidence submitted did not meet the requirements of NHSEI. The senior management team have undertaken a thorough review of all the evidence submitted and evidential requirements in light of this feedback and have identified some actions that will improve compliance. The report assures the Board that the missing evidence does not reflect a gap in service provision or safety, but rather existing guidelines or processes not meeting the prescriptive requirements of NHSEI. The Maternity Service await a peer review of the evidence to challenge the assessment of some pieces of evidence, and also to have an opportunity to better understand the evidential requirements and improve where required.

### **3 IEA1 Enhanced Safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMNS) oversight**

- 3.1 The report assures the Board that work is underway to achieve full compliance with the requirements of IEA 1. The IEA requires collaborative working with the Local Maternity and Neonatal System (LMNS) to ensure key safety information, including SIs are shared regionally, along with at Trust Board. As the processes for sharing this information at LMNS and Board Level are now embedded, the Maternity Service has improved its rating from amber/red in July 2021.
- 3.2 The following actions have been completed to support compliance with IEA1:
- Senior maternity and neonatal managers attend the Kent and Medway LMNS Maternity and Neonatal Quality Assurance Group. This meeting is a forum for sharing learning and themes for incidents.
  - MFT has shared information based on the Perinatal Surveillance Tool with the LMNS monthly since May 2021.
  - A SOP is now in place, which outlines the process for sharing information with the Trust Board and the LMNS.
  - Work is ongoing to strengthen the reports to Trust Board that supports the perinatal surveillance tool to ensure triangulation with incidents, learning, complaints and claims.
- 3.3 Actions required to achieve full compliance:
- Fully embedded process of reporting to Trust Board and LMNS, with robust analysis and identification of themes and learning.

### **4 IEA2: Listening to Women and their Families: Maternity services must ensure that women and their families are listened to with their voices heard.**

- 4.1 The report assures the Board that the Maternity service is taking appropriate steps to achieve full compliance with IEA 2.
- 4.2 The following Actions have been completed to support compliance with IEA 2:
- The Non-Executive Director Job Description has been approved and the Maternity and Neonatal Safety Champion Assurance Board is strengthening the work of the NED and Board Level Safety Champion by supporting ongoing dialogue between the MVP and the Board Level Safety Champion.
  - The MVP Chair is actively recruiting service user representatives to the MVP, and the MVP are directly involved in developing the Maternity Strategy through their involvement in a multi-stakeholder event due to take place in February 2022.
- 4.3 Actions required to achieve full compliance:
- The MVP 15 steps challenge has been postponed due to Covid-19 restrictions, however it is anticipated this will be rescheduled in March/April 2022 when restrictions allow.
  - The maternity service also plans to pilot some additional service user feedback surveys and will support the Trust Plans to introduce more robust, contemporaneous service user feedback across all areas.
  - IEA 2 requires an advocacy role for women and families to be established. This advocacy role is being developed at national level and Trusts are not required to meet this standard at this time.

## 5 **IEA3: Staff Training and Working Together: Staff who work together must train together**

- 5.1 The report assures the Board that the maternity service has taken significant steps to achieve compliance with IEA 3.
- 5.2 The following actions have been completed to support compliance with IEA 3:
- Revision of consultant job plans and rota to enable twice daily (day and night) ward rounds. New rota due to commence 31 January 2022.
  - SOP regarding Consultant Roles and Responsibilities now in place and audit against compliance will take place from January 2022 in line with CNST Safety Action 4 requirements.
  - Recruited to vacant middle grade posts to allow the uplift of senior registrars to Associate Specialist roles to support the consultant rota.
  - Trajectory for MDT training for obstetric emergencies (PROMPT) and Fetal Monitoring Training in place, with trajectory to achieve >90% compliance by June 2022.
  - Training compliance continues to be monitored monthly at local meetings.

- Education lead working with LMNS Workforce/Education Lead to ensure process in place for LMNS review and validation of Training Plans and compliance.
- Obstetric CTG and Simulation Lead appointed to support education.

5.3 Actions required to achieve full compliance:

- Launch of new rota on 31 January 2022.
- Audit of compliance with new SOP, including twice daily (day and night) ward rounds.
- Embed LMNS review process
- Achieve >90% compliance for training across all staff groups.

## 6 IEA4: Managing Complex Pregnancy: There must be robust pathways in place for managing women with complex pregnancies

6.1 The report assures Board that the service has identified and is making sufficient progress against required actions.

6.2 The following actions have been completed to support compliance against IEA4:

- Continued engagement of maternal medicine physician to support management of complex pregnancies.
- Complex Pregnancy MDT meeting embedded in practice.
- Referral pathways to tertiary centres in place and reflected in Clinical Risk Assessment in the Antenatal Period Guideline.
- Bespoke Maternal Medicine Pathways being developed. Work ongoing to link in with other services to agree pathways and referral criteria.
- Data collection underway to support LMNS development of regional maternal medicine centre.
- Funding for a subspecialist trainee in maternal medicine approved by the national team
- Planning with LMNS and the national team for Medway to be the Maternal medicine sub hub for Kent and Medway.

6.3 Actions required to achieve full compliance:

- Finalise bespoke maternal medicine pathway.
- SOP for maternal medicine referrals and complex pregnancies.
- Continue to work with LMNS and commissioners to develop regional maternal medicine centre.

## 7 **IEA5: Risk Assessment Throughout Pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.**

7.1 The report assures the Board that the maternity service has completed the appropriate actions to progress and maintain compliance with IEA 5.

7.2 The following actions have been completed to support compliance with IEA5:

- Revision of Antenatal pathway to establish additional risk assessment clinics at 12 and 28 weeks to support appropriate stratification of women and birthing people into low, moderate and high-risk categories.
- Ongoing audit in line with Ockenden evidential requirements, including prospective audit of women and birthing people who choose treatment outside of guidance.
- Clinical risk assessment in antenatal period guideline updated to meet Ockenden evidential requirements has been approved.
- Maternity information system updated to allow staff to confirm and record risk assessment completed at every contact.

7.3 Actions required to achieve full compliance:

- Launch and embed risk assessment clinic into practice.
- Guidelines/SOPs in place to support the new risk assessment clinics.
- Finalise 2021 audits and review audit template for 2022 in light of new clinics.
- SOP for risk assessment at every contact, review of place of birth and outside guidance pathway.
- Seek best practice for Personalised Care and Support Plans.

## 8 **IEA6: Monitoring Fetal Wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**

8.1 The report assures the Board that the service is on track to achieve full compliance with the requirements of IEA 6.

8.2 The following actions have been completed to support compliance with IEA 6:

- Obstetric CTG and Simulation Lead appointed and job planned. Dedicated time to be reflected on new rota from 31 January 2022.
- Recruitment underway to increase Fetal Wellbeing midwife to 1.4 WTE following successful Business case.
- Trajectory in place to achieve >90% compliance for fetal monitoring training by June 2022.

- Fetal Wellbeing leads engaging staff through training, supported by online platforms and hybrid teaching.
- Fetal Wellbeing leads continue to lead on investigations where issues with CTG interpretation are identified and continue to lead the Born in Poor Condition Review Group which reviews all term babies born in unexpectedly poor condition.

8.3 Actions required to achieve full compliance:

- Recruitment of additional Fetal Wellbeing midwife to support compliance with IEA 6/SBLCBv2 requirements.
- Consider introduction of STAN monitoring to improve CTG interpretation.
- Support Fetal Wellbeing Leads to establish a fetal wellbeing network to support best practice and learning.

## 9 **IEA7: Informed Consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery**

9.1 The report assures the Board that the service has taken appropriate steps to ensure compliance for IEA7 and continue to work on improving the way in which we communicate with women, birthing people and their families.

9.2 The following actions have been completed to support compliance with IEA 7:

- Maternity website reviewed to ensure birth choices and links to relevant national guidance is in place.
- Maternity website reviewed to ensure language is inclusive.
- Ongoing audit in line with Ockenden requirements.
- NHS Digital funding applied for successful.
- Trust participation in the Together Project, a research initiative to improve the way maternity services communicates with and supports parents to be with learning disabilities.

9.3 Actions required to achieve full compliance:

- System-wide MVP led review and benchmarking of maternity website using national template.
- Prospective audit of women and birthing people who choose care outside guidance and ongoing audit in line with Ockenden requirements.
- Work ongoing to ensure information is available in multiple languages/formats.

## 10 Workforce

- 10.1 The report advises the Board that compliance with workforce requirements has improved following the approval of the workforce paper and business case for funding for additional midwives and specialist staff.
- 10.2 The following actions have been completed to support compliance with Workforce requirements:
- Completion of Business Case and approval by Executives
  - Recruitment to specialist and managerial roles along with frontline midwifery posts.
- 10.3 Actions required to achieve full compliance:
- Full recruitment to all posts identified in 2020 Birthrate+ report.
  - Further workforce review using Birthrate+ methodology with appropriate actions identified. Provide assurance of safe staffing and the correct placement of staff.

## 11 Morcecombe Bay (2015)

- 11.1 In light of the expected publication of the Kirkup review for East Kent University Foundation Trust (EKUFT) in July 2022, Trusts are being asked to revisit their benchmarking against the recommendations, with evidence of this being discussed at Trust Board.
- 11.2 Following the publication of the Ockenden report in December 2020, NHSE also released an assurance template which included 18 recommendations from the Morecombe Bay report (2015). The maternity service used this template to refresh the gap analysis.
- 11.3 The recommendations, links to IEAs and CNST requirements are detailed below, along with steps taken to achieve compliance and identified actions to achieve full compliance.
- 11.4 *Admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but the length of time to bring to light the failures.*

### 11.4.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 1 , IEA 2
- Safety Action 1, Safety Action 10

### 11.4.2 The following actions have been completed to support compliance with this recommendation:

- Duty of Candour is in place and the service maintains 100% compliance with Duty of Candour requirements for all eligible cases.

- Reviews of all stillbirths and perinatal deaths using the Perinatal Mortality Review Tool (PMRT) is well established and all PMRT reviews involve the parents in the review and consider their questions and concerns.
- All eligible cases are reported to HSIB and NHSR Early Notification scheme. Parents are involved in all HSIB investigations and findings shared with them.
- Robust responses to all complaints, offering local resolution meetings if required.
- Debrief service offered by Professional Midwifery Advocates (PMAs) to support women and their families following a difficult, complicated or traumatic birth.
- All SIs reported to Trust Board and LMNS in line with the requirements of Ockenden and the Perinatal Surveillance Tool.
- Clinical review of all reported incidents to ensure appropriate level of investigation takes place and is shared with the patient if meets duty of candour criteria.

#### 11.4.3 Actions required to achieve full compliance:

- Improved audit of changes resulting from incidents and investigations.
- Improved thematic reporting of incidents, complaints and claims to support further learning and improvements.

11.5 *Review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.*

#### 11.5.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA3
- Safety Action 4
- Safety Action 8

#### 11.5.2 The following actions have been completed to support compliance with this recommendation:

- Maternity Critical Care Unit (MECU) in place, supported by anaesthetic team.
- MECU training course for midwifery staff in place.
- Escalation to Trust ITU or tertiary centres as required.
- Obstetric emergency training (PROMPT) in place.
- NICU staff meet Qualified in Speciality requirements.

- NICU medical staff meet BAPM requirements for junior doctor staffing.

#### 11.5.3 Actions required to achieve full compliance:

- Training needs analysis being revised in line with core competency framework
- Education/workforce lead to embed LMNS review process.

11.6 *Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice.*

#### 11.6.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA3
- Safety Action 8

#### 11.6.2 The following actions have been completed to support compliance with this recommendation:

- Appropriate training offered to staff in accordance with national guidelines and best practice, including human factors, personalised care and support planning, obstetric emergencies, bereavement, safeguarding, perinatal mental health.
- MATNEOSIP Quality Improvement projects support staff to develop and learn new skills.
- Secondments supported where appropriate.
- Supernumerary practice for all new starters.

#### 11.6.3 Actions required to achieve full compliance:

- Training needs analysis being revised in line with core competency framework
- Work with LMNS and other units to develop opportunities for staff to gain experience at other units by secondments and supernumerary practice when staffing and Covid-19 considerations allow.

11.7 *Identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation.*

#### 11.7.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 3, IEA 6
- Safety Action 6, Safety Action 8

#### 11.7.2 The following actions have been completed to support compliance with this recommendation:

- Essential skills programme in place
- Fetal Monitoring training in place, including interactive sessions and case reviews.
- PMA support individual staff for revalidation.

#### 11.7.3 Actions required to achieve full compliance:

- Training needs analysis being revised in line with core competency framework

11.8 *Identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities.*

#### 11.8.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 3, IEA 6
- Safety Action 6, Safety Action 8

#### 11.8.2 The following actions have been completed to support compliance with this recommendation:

- Obstetric Emergency Training (PROMPT) and fetal monitoring training are MDT (maternity, obstetric and anaesthetic staff (PROMPT only))
- Born in poor condition group established to undertake MDT (Obstetric, midwifery, neonatal) review of all unexpected term admissions to the neonatal unit.
- MatneoSIP projects encourage collaborative working across maternity and neonatal.
- Joint working to support the ambitions of the national programme, Avoiding Term Admissions to Neonatal Units (ATAIN) between maternity and neonatal teams.
- Collaborative working as part of Safety Champion agenda.
- Women's and Children's Care Group Governance and Management meeting supports shared learning and joint policy management.
- Collaborative working on shared policies and guidelines (e.g Transitional Care Guidelines).
- Participate in LMNS assurance activities including the LMNS Quality Surveillance Group and Investigation Bureau.

11.9 *Trust should draw up a protocol for risk assessment in maternity services around place of birth. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what*

*risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment.*

#### 11.9.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 3, IE5, IEA 7
- Safety Action 2

#### 11.9.2 The following actions have been completed to support compliance with this recommendation:

- Clinical Risk Assessment in Antenatal Period guideline revised in line with IEA4.
- Formal risk assessment at booking and 28 weeks, with ongoing risk assessment at every antenatal contact. Choice of place of birth reviewed at each contact and formally agreed at 36 week appointment.
- Maternity Information System (EuroKing) updated to allow staff to record risk assessment at every contact and review of choice of place of birth.
- Ockenden Risk Assessment Clinic launched to support appropriate stratification of women in to high, moderate or low risk categories.
- Fetal monitoring risk assessment stickers launched to support appropriate fetal monitoring in labour and timely escalation.
- Audit schedule in place for risk assessment and place of birth in line with Ockenden requirements.

#### 11.9.3 Actions required to achieve full compliance:

- Risk Assessment and place of birth review SOPS in line with Ockenden evidential requirements underway.
- Review of Low-risk guideline to ensure wording reflects Ockenden requirements and revised antenatal clinic pathway.
- Review of Clinical Risk Assessment in the Antenatal Period in line with revised antenatal clinic pathway.
- Work with BI and Digital midwife to improve reporting.

#### 11.10 *Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience.*

##### 11.10.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 3, Workforce
- Safety Action 4, Safety Action 5

##### 11.10.2 The following actions have been completed to support compliance with this recommendation:

- Annual workforce review and 6 monthly reporting in line with CNST requirements
- Birth Rate+ review 2020 prompted business case for additional staffing, including specialist and leadership roles. Recruitment underway.

11.10.3 Actions required to achieve full compliance:

- Birth Rate + full review underway (2022)
- Workforce review working group established to review recruitment and retention across the unit. Key actions identified.

11.11 *Developing better joint working between main hospital sites, including the development and operation of common policies, systems and standards.*

- Not applicable – single site

11.12 *Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances.*

11.12.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 1
- Safety Action 9

11.12.2 The following actions have been completed to support compliance with this recommendation:

- Active part of LMNS which provides opportunities for learning, mentoring and shared approach to problems.

11.12.3 Actions required to achieve full compliance:

- Explore approach to buddying system so that staff can have exposure to other specialist roles that are not in place locally once staffing and Covid-19 considerations allow.

11.13 *Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident.*

11.13.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA1, IEA2
- Safety Action 1, Safety Action 9

11.13.2 The following actions have been completed to support compliance with this recommendation:

- Trust SI process is followed for all serious incidents.
- Perinatal Surveillance Tool, sharing details of incidents and learning is established with reporting to Trust Board in Private and LMNS.
- Learning from incidents shared via Friday News, departmental audit meeting and included in PROMPT, fetal monitoring training, essential skills and CTG review meetings.
- Hot and cold debriefs held for staff following complex cases.
- Staff invited to participate in incident review meetings (SWARMs)
- Actions from SIs are monitored via the governance team and reported at Care Group Governance Meetings.
- Service level engagement with Health Service Investigation Branch (HSIB) and participation in review and quarterly summary meetings.

11.13.3 Actions required to achieve full compliance:

- Improve audit process following incidents to understand the impact of changes. Audit midwife due to start March 2022 to support this ambition.
- Improve processes for cascading learning from incidents to staff.

11.14 *Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee*

11.14.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 1, IEA 2
- Safety Action 1, Safety Action 7, Safety Action 9

11.14.2 The following actions have been completed to support compliance with this recommendation:

- Service follows Trust Complaints process, with local resolution meetings offered as requested.
- Duty of Candour and PMRT support the inclusion of patients and families in the investigation and reporting process
- PALS contacts reported at Care Group Governance meeting and on Perinatal Surveillance tool, response by senior team within 24 hours.
- Strong relationship with Maternity Voice Partnership (MVP) who supports with co-production and providing service user feedback.

- Well-established Birth Debrief service offered by PMAs to support women and their families to understand their birth experience and address any concerns they may have.

11.14.3 Actions required to achieve full compliance:

- Improve reporting and triangulation of themes and trends from complaints with incidents and claims as part of perinatal surveillance tool assurance reporting to Trust Board in Private.

11.15 *Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support.*

11.15.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA3, Workforce
- Safety Action 4, Safety Action 5

11.15.2 The following actions have been completed to support compliance with this recommendation:

- Birth rate + Assessment (2020) with resulting workforce paper and business case for additional midwifery staffing, including specialist and leadership roles.
- Review and refresh of consultant rota to allow for additional consultant presence and twice daily (morning and evening) ward rounds in line with Ockenden IEA 3.
- SOP in line with RCOG "Roles and Responsibilities for Obstetric Consultants" in place and commitment to the same declared to Trust Board in January 2022 in line with CNST year 4 guidance.
- Clinical Director for Women's and Clinical Director for Children's now in place.
- Additional leadership roles for consultants job planned as part of new rota, including CTG and Simulation Lead and Audit and Quality Improvement Lead.

11.15.3 Actions required to achieve full compliance

- Full Birth rate + review currently underway to support identification of appropriate staffing levels and skill mix.

11.16 *Trust should continue to prioritise the work commenced in response to the review of governance systems including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services.*

11.16.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 1, IEA 2
- Safety Action 1, Safety Action 9

11.16.2 The following actions have been completed to support compliance with this recommendation:

- Perinatal Surveillance Tool assurance reporting to Trust Board in Private in place.
- Robust reporting schedule in place to Quality Assurance Committee and Trust Board for CNST.
- Appropriate Governance structure within the Care Group and Division to support escalation.
- Maternity and Neonatal Safety Champion Assurance Board (M&NSCAB) (formerly Maternity Transformation and Assurance Board) in place and chaired by Chief Nursing and Quality Officer with reporting/escalation to QAC as required.

11.16.3 Actions required to achieve full compliance

- Review of Terms of Reference for speciality and Care Group Governance meetings to bring in line with current Trust requirements.

11.17 *Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality*

11.17.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 1, IEA 2
- Safety Action 9

11.17.2 The following actions have been completed to support compliance with this recommendation:

- Board Level Safety Champion Roles filled by Executive Director (Chief Nursing and Quality Officer) and Non-Executive Director.
- Local Role Descriptor approved for Non-Executive Director
- Board Level Safety Champion and Non-Executive Director members of M&NSCAB.
- HOM job description clearly articulates responsibilities with regards to quality and safety.

11.18 *Improve the physical environment of the delivery suite including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed.*

11.18.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 2, IEA 4, IEA 5, IEA 6, IEA 7
- Safety Action 7

11.18.2 The following actions have been completed to support compliance with this recommendation:

- Delivery suite appropriately located to allow access to theatres and allow staff to observe and respond to all women in labour.
- Appropriate ensuite facilities are in place
- Post-operative care for women is suitable.
- Participation in CQC Patient Satisfaction Surveys to understand women's experience of the environment.
- Required bathroom repairs on postnatal ward escalated to Chief Nursing and Quality Officer.

11.18.3 Actions required to achieve full compliance

- MVP 15 Steps challenge to identify any improvements that could be made from a service user perspective.
- Refurbish and refresh delivery suite as required to ensure all facilities are of appropriate standard.

11.19 *Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors.*

11.19.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 1, IEA 2, IEA 3, IEA 6
- Safety Action 4, Safety Action 5

11.19.2 The following actions have been completed to support compliance with this recommendation:

- Job descriptions and expectations in place in line with national guidelines for all clinical leads.
- Expectations of obstetric consultants outlined in "Consultants Roles and Responsibilities SOP" in line with RCOG recommendations.
- Fetal Wellbeing Midwife and CTG and Simulation Lead job description in place in line with Ockenden requirements.

11.20 *Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and nonexecutives.*

11.20.1 Links to Ockenden IEAs and CNST Safety Actions

- IEA 2
- Safety Action 9

11.20.2 The following actions have been completed to support compliance with this recommendation:

- Non-Executive Director Role Description in place.

- Expectations of roles and Responsibilities for Board Level and Local Safety Champions in place.
- Job descriptions in place for all managerial staff that reflect national standards and requirements.

## 12 Conclusion and Next Steps

- 12.1 The report has provided the Board with oversight and assurance as to the maternity services compliance with the Ockenden IEAs.
- 12.2 The report has provided:
- Progress with the implementation of the 7 IEAS outlined in the Ockenden report and the plan to ensure full compliance.
  - Maternity services workforce plans.
  - Oversight and assurance regarding the maternity service's position against the recommendations of the Morecombe Bay Report (2015)
- 12.3 The report requests the Board note compliance and actions required and approve the report for onward reporting to the LMNS and ICS.
- 12.4 The next Ockenden report is anticipated in April 2022 and the report requests the ongoing support of the Board to respond to the recommendations of this report and any Board level reporting requirements indicated by NHSEI.

## Meeting of the Trust Board - Public

### Wednesday, 09 March 2022

Title of Report	Infection Prevention and Control (IPC) Updated Board Assurance Framework (BAF) Assessment & Improvement Plan		Agenda Item	4.5
Lead Director	Evonne Hunt, Chief Nursing Officer			
Report Author	Evonne Hunt, Chief Nursing Officer Stephanie Gorman, Acting Head of Infection Prevention and Control			
Executive Summary	<p>The IPC BAF is based on PHE / UKHSA, NHSE/I and other COVID-19 related IP&amp;C guidance and requires evidence and assurance regarding the Trust's compliance with the Health and Social Care Act 2008, <i>Code of Practice on the prevention and control of infections and related guidance</i> (Hygiene Code), and compliance with COVID-19 strategies, policies and guidelines.</p> <p>NHSEI has further developed the BAF to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and other related infection prevention and control guidance to identify risks associated with Covid-19 and other seasonal respiratory viral infections. The general principles can be applied across all settings, in this case acute and specialist hospitals.</p>			
Committees or Groups at which the paper has been submitted	Infection Prevention and Control Committee Executive Group Quality Assurance Committee			
Resource Implications	NIL			
Legal Implications/Regulatory Requirements	Regular progress updates will be provided to the CQC on the improvement plans to address the survey results.			
Quality Impact Assessment	NA			
Recommendation/Actions required	The Trust Board is asked to receive this updated IPC BAF for discussion and assurance regarding compliance with the Code of Practice regarding Covid-19 and other healthcare associated infections.			
	Approval <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>	Discussion <input checked="" type="checkbox"/>	Noting <input checked="" type="checkbox"/>
Appendices	IPC BAF available on request			

*Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board*

The key headlines and levels of assurance are set out below:

<b>No assurance</b>	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
<b>Partial assurance</b>	Amber/ Red - there are gaps in assurance
<b>Assurance</b>	Amber/ Green - Assurance with minor improvements required
<b>Significant Assurance</b>	Green – there are no gaps in assurance
<b>Not Applicable</b>	White - no assurance is required

## IPC Board Assurance Framework Assessment and Improvement Plan Summary

The IPC BAF is based on PHE / UKHSA, NHSE/I and other COVID-19 related IP&C guidance and requires evidence and assurance regarding the Trust's compliance with the Health and Social Care Act 2008, *Code of Practice on the prevention and control of infections and related guidance* (Hygiene Code), and compliance with COVID-19 strategies, policies and guidelines.

NHSEI has further developed the BAF to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and other related infection prevention and control guidance to identify risks associated with Covid-19 and other seasonal respiratory viral infections. The general principles can be applied across all settings, in this case acute and specialist hospitals.

The framework is being used to assure the Board of Directors of the measures that have been taken in line with current guidance, ensuring that the Trust continues to maintain and strengthen its compliance and has mitigation in place to manage identified risks. As understanding of Covid-19 continues to develop, guidance on the required IPC measures has been published.

The IPC BAF assessment and improvement plan is monitored internally through the IPC group, newly established Quality & Patient Safety Subcommittee and the Quality Assurance Committee. It also provides external assurance to the CQC, NHSE/I, CCG, DHSc and HSE that quality standards in relation to IPC are being maintained.

Compliance with the Code of Practice is underpinned by ten criteria / key lines of enquiry (KLoE) which are individually sub-divided:

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

The adapted template for Medway NHS Foundation Trust (MFT) IPC BAF assessment and improvement plan enables each section, with the additional questions, which there are 125, to be rag-

rated Red, Amber or Green

**NB: The MFT IP&C BAF is a live document. It is regularly added to / updated and therefore subject to change.**

The IPC BAF assessment and improvement plan also takes into account Kent and Medway IPC surveillance visit output. MFT exited NHSEI IPC support improvement programme in June 2021. The criteria for exit agreed were for the CCG to:

- Remain attendees of MFT IPC group (oversight of improvement plan)
- Remain part of the PIR/Outbreak meetings (oversight of current issues and actions)
- Continue to receive assurance papers for the Trust Quality Assurance Committee (oversight of governance)
- Undertake focused IPC visits in conjunction with the Trust on a quarterly Enhanced CCG surveillance programme

As part of the IPC safety Support Improvement Programme exit plan for Medway Foundation Trust, it was the Kent and Medway Clinical Commissioning Group (KM CCG) recommendation that MFT exit the Infection Prevention & Control Safety Support (IPCSS) programme. The exit report which was issued on the 8<sup>th</sup> June 2021 forms part of Medway Foundation Trust exit strategy from the IPCSS programme and set out how the continued IPC improvement work will be taken forward

The IPC BAF assessment and improvement plan also takes into account the recommendations from IPC Governance Review completed on the 27<sup>th</sup> April 2021. The following recommendations are based on the review:

1. **Recommendation 1 - Trust Board:** going forward there is a need to ensure that:
  - The Board is well sighted on and seeks assurance regarding compliance against the IPC requirements of the Health and Social Care Act and other key policy areas
  - Risk and mitigations relating to IPC are regularly brought to the Board (not solely the Quality Committee), in addition to IPC data within the IQPR. The Code of Practice recommends quarterly;
  - There is regular horizon scanning by the Board of IPC implications from service reviews and capital developments
  - Accountability at Board level does not rest solely with the Chief Nursing and Quality Officer as the Executive Lead for IPC. Other named Executive functions also have specific responsibilities such as the Trust estate, antimicrobial prescribing and for staff attendance for annual IPC training as examples; therefore all Executives have been made aware of their specific accountability in relation to IPC by the DIPC and in writing
2. **Recommendation 2 – IPCC:** to support Board reporting the IPCC must meet monthly with approved terms of reference, a clear annual work plan, a standard agenda and standardised reporting against compliance with the ten criteria of the Health and Social Care Act 2008 and any risks and mitigations. The committee should hold and administer the IPC risk register which will be informed by appropriate review and reporting.
3. **Recommendation 3 – IPC responsibilities of care groups and divisions:** the IPC responsibilities of the care groups and divisions must be clearly outlined and delivered on. With the allocation of a lead clinician responsible for IPC per division, the lead clinician and Divisional

Director of Nursing should take joint responsibility for the oversight of IPC with the Divisional Director of Nursing being the named accountable person for monthly reporting to the IPCC and the same ownership and accountability model of Care Group level making the Head of Nursing / Midwifery the named accountable person. Divisions should be supported by an IPC team member attendance at their governance meetings. It is important that a multidisciplinary approach is taken across care groups and divisions with doctors, nurses / midwives and pharmacists all working together.

4. **Recommendation 4 – Weekly IPC review meetings:** the leadership of the IPC, initiated by the Chief Nursing and Quality Officer should continue to be strengthened with weekly review meetings between the DIPC, the IPC Doctor, the Deputy Chief Nurse and the interim Associate Director for IPC. The purpose for these meetings would be for monitoring the IPC Improvement Plan and Covid-19 BAF. These meetings would be time limited and be subject to review when all substantive posts have been recruited to. Ultimately these meeting should be used to inform annual reporting and annual planning / monitoring.
5. **Recommendation 5 – IPC communication list:** the organisation should consider a key list of personnel or groups that must be informed of any IPC related issue or report into or request of the organisation. The organisation must set up processes for horizon scanning and dissemination.



## Meeting of the Board of Directors in Public Wednesday, 09 March 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 2019/20  <i>(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)</i>	<b>Innovation:</b> We will embrace innovation and digital technology to support the best of care		<input type="checkbox"/>
	<b>Finance:</b> We will deliver financial sustainability and create value in all we do		<input checked="" type="checkbox"/>
	<b>People:</b> We will enable our people to give their best and achieve their best		<input type="checkbox"/>
	<b>Integrated Health Care:</b> We will work collaboratively with our system partners to establish an Integrated Care Partnership		<input type="checkbox"/>
	<b>High Quality Care:</b> We will consistently provide high quality care		<input type="checkbox"/>
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 24 February 2022		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
	The Board is asked to note this report.		

<b>Recommendation/ Actions required</b>	<b>Approval</b> <input type="checkbox"/>	<b>Assurance</b> <input type="checkbox"/>	<b>Discussion</b> <input type="checkbox"/>	<b>Noting</b> <input checked="" type="checkbox"/>
<b>Appendices</b>	Finance report			

# Finance report

For the period ending 31 January 2022

## Contents

1. Executive summary
2. Income and expenditure
3. Efficiency programme
4. Balance sheet summary
5. Capital
6. Cash
7. Risks and opportunities
8. Conclusions

## 1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(8)	(62)	(54)	The Trust reports a £62k deficit position for January; reducing to breakeven in month and year to date after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes Elective Recovery Funding (ERF) income of £4.6m in H1 and £2.9m for year to date in H2, this covers the incremental costs of delivering ERF activity. There is no contingency accrued into the position, however in month the benefit from £0.5m of non-recurrent items relating to agency invoices accrual reduction and VAT refund adjustment has been released into the position to achieve the control total. As a consequence of this, this month's pay expenditure has decreased by £0.4m to £20.4m; non-pay costs have decreased by £0.9m mainly in the Unplanned Care division as December reported increased independent sector costs of £0.4m and durgs costs due to activity pressures of £0.4m
Donated Asset Depreciation	8	62	54	
<b>Control Total</b>	<b>-</b>	<b>(0)</b>	<b>(0)</b>	
Efficiencies Programme				
In-month	457	339	(119)	The in-month position is reporting a £0.1m adverse to plan for January, and £0.7m adverse year to date. The position includes the impact of the current £1.1m gap between identified schemes and the overall plan of £5.1m for the full year. The delivered efficiency programme position of £3.1m includes £0.3m of the full year effect of schemes continuing from 2020/21.
YTD	3,733	3,068	(665)	

Capital				
In-month	703	1,323	620	The Trust Capital Resource Limit (CRL) and plan was set at £13,877k for 2021/22 by the ICS.
YTD	11,962	11,889	(73)	<p>Since M9 the additional capital funding has reduced by £1,471k due to MOU/bid Variations on TIF (£1,376k) and Cyber security (£95k)</p> <p>Total additional funding secured for 2021/22 is therefore £8,527k; £5,319k PDC, £3,128k additional system capital, £80k charitable donations.</p> <p>Total revised capital investment for 2021/22 is now £21,797k</p> <p>The year to date capital programme is £73k behind plan at month 10</p> <p>Based on the original plan of £13,877k the programme is 86% complete, although with the late additional funding planned to be spent in February and March the % is much lower at 55%. This seems like a significant task for M11 and 12 but as much of the funding is for IT projects which have a short lead time the risk is deemed to be low.</p> <p>Based on current forecasts from project managers total expenditure is likely to be £21,391k, which would result in £406k slippage. Contingency schemes to this value will need to be approved and completed by 31st March in order to ensure the maximum investment. The forecast reported assumes this happens.</p>
Annual (reported forecast)	21,797	21,797	0	

Cash				
Month end	49,184	42,634	(6,550)	<p>Cash balances have decreased in month by £2.1m, which is normal fluctuation in working capital balances.</p> <p>The cash balance is £6.6m adverse to the cash balance held on 31<sup>st</sup> March 2021, which the plan is set at. This is due to the late issue of PDC in the prior year for capital schemes. Since year-end capital expenditure associated with these schemes has been paid in cash resulting in a decreased cash balance, as debts are settled and current year PDC issues cash is expected to rise again.</p> <p>Cash balances are expected to be maintained at a similar level (£40m to £50m) throughout the year, however this is dependent on the approval of cash reserves being utilised for additional capital investment.</p>

Activity is below draft budgeted levels as a result of Covid	<p>Clinical income based on the 21/22 consultation tariff would have reported a year to date position of £191.8m, this being £9.2m lower than income in the same period of 19/20. In month performance excluding high cost drugs is £19.9m, which is £2.0m lower compared to M8 reported figure.</p>
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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	27,112	(214)	279,580	279,615	35
High cost drugs	1,817	1,876	58	18,317	18,467	150
Other income	2,802	2,614	(188)	18,303	21,438	3,134
PSF/MRET/FRP	0	0	0	0	0	0
Donated Asset Adjustment	0	0	0	0	239	239
<b>Total income</b>	<b>31,945</b>	<b>31,602</b>	<b>(343)</b>	<b>316,200</b>	<b>319,759</b>	<b>3,558</b>
Nursing	(8,104)	(8,023)	80	(79,918)	(81,498)	(1,580)
Medical	(6,365)	(6,787)	(421)	(63,621)	(65,084)	(1,463)
Other	(5,210)	(5,565)	(354)	(53,399)	(55,971)	(2,572)
<b>Total pay</b>	<b>(19,679)</b>	<b>(20,375)</b>	<b>(695)</b>	<b>(196,937)</b>	<b>(202,553)</b>	<b>(5,616)</b>
Clinical supplies	(3,834)	(3,480)	354	(38,930)	(41,540)	(2,610)
Drugs	(545)	(695)	(150)	(5,769)	(8,684)	(2,915)
High cost drugs	(1,817)	(1,889)	(72)	(18,359)	(18,481)	(121)
Other	(4,621)	(3,773)	848	(41,847)	(34,173)	7,675
<b>Total non-pay</b>	<b>(10,817)</b>	<b>(9,838)</b>	<b>979</b>	<b>(104,906)</b>	<b>(102,878)</b>	<b>2,029</b>
<b>EBITDA</b>	<b>1,448</b>	<b>1,389</b>	<b>(59)</b>	<b>14,357</b>	<b>14,328</b>	<b>(29)</b>
Depreciation	(905)	(851)	54	(8,931)	(8,876)	55
Donated asset adjustment	(8)	(62)	(54)	(80)	(134)	(54)
Net finance income/(cost)	2	4	2	17	(16)	(33)
PDC dividend	(545)	(544)	2	(5,443)	(5,436)	7
<b>Non-operating exp.</b>	<b>(1,457)</b>	<b>(1,452)</b>	<b>4</b>	<b>(14,436)</b>	<b>(14,462)</b>	<b>(25)</b>
<b>Reported surplus/(deficit)</b>	<b>(8)</b>	<b>(63)</b>	<b>(55)</b>	<b>(80)</b>	<b>(134)</b>	<b>(54)</b>
<b>Adj. to control total</b>	<b>8</b>	<b>62</b>	<b>54</b>	<b>80</b>	<b>134</b>	<b>54</b>
<b>Control total</b>	<b>0</b>	<b>(1)</b>	<b>(1)</b>	<b>0</b>	<b>0</b>	<b>0</b>

1. Funding arrangements for the full year 2021/22 have been agreed with the Kent & Medway CCG.
2. The clinical income YTD variance includes an adverse ERF position from H1 of £1.3m, this is offset Targeted Investment Funding (TIF) £0.5m as well as income for medical devices £0.8m that are excluded from the block income payment. These are offset by costs included in expenditure.
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 as well as drugs recharges offsetting overspending in clinical divisions.
4. YTD ERF income of £7.5m is included; this is further detailed as £4.6m for H1 and £2.9m for H2. This income is agreed for H2 and not dependent on delivery an agreed activity threshold as in H1.
5. Pay budgets are overspending due to additional escalation and activity pressures in Unplanned Care, and the vacancy factor held in the Planned Care division. Cost pressures are partially offset by some areas of underspend including Covid and reserves.
6. Medical staffing adverse variance is due to junior doctor shifts associated with a rise in Covid activity, increased escalation capacity £0.8m, as well as additional shifts to aid with patient flow £0.8m.
7. Nursing pay in month variance includes £0.5m non-recurrent agency invoices accrual reduction and VAT rebate. The year to date position includes £1.8m impact of the vacancy factor budget held by the Planned Care division. Substantive staff spend has increased by £0.2m with an increase of 10 WTE.
8. Non-pay category includes the contingency and reserves budgets not issued to divisions. ERF budgets have been issued to divisions for H2.
9. Total expenditure includes £0.4m of incremental Covid costs (£3.5m YTD).

### 3. 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	65	0	1,482	<b>2,132</b>	(650)	1,599	1,234	<b>(365)</b>
UIC	179	1,368	34	0	1,581	<b>2,190</b>	(609)	1,749	1,617	<b>(132)</b>
E&F	21	407	0	0	428	<b>382</b>	46	252	294	<b>42</b>
Corporate	73	367	0	0	440	<b>467</b>	(27)	133	266	<b>133</b>
<b>Total</b>	<b>343</b>	<b>3,489</b>	<b>99</b>	<b>0</b>	<b>3,931</b>	<b>5,171</b>	<b>(1,240)</b>	<b>3,733</b>	<b>3,411</b>	<b>(322)</b>
Previous Month	343	3,402	166	277	4,187	<b>5,171</b>	(984)	3,157	3,072	<b>(84)</b>
<b>Monthly Movement</b>	<b>0</b>	<b>88</b>	<b>(67)</b>	<b>(277)</b>	<b>(256)</b>	<b>0</b>	<b>(256)</b>	<b>576</b>	<b>339</b>	<b>(238)</b>

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	<b>457</b>	<b>339</b>	<b>(119)</b>	<b>3,733</b>	<b>3,411</b>	<b>(322)</b>	<b>5,171</b>	<b>4,094</b>	<b>(1,077)</b>

#### 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 £2.9m of planned efficiencies and £0.8m schemes not identified, the actual performance of delivery across the services is £3.1m for 21/22 schemes and an additional £0.3m for FYE schemes from 20/21.

The main schemes that have delivered include improved ERF contribution margin, cross cutting programme for procurement, closure of theatre 5 in the Planned Care division, Pharmacy procurement optimisation, patient meal costs and full year effect of 20/21 schemes. The overall gap in the identification of schemes has increased by £0.1m although the risk to delivery of initiatives has reduced with no schemes RAG rated as red.

The crosscutting efficiency schemes have been prioritised across all of the services; the Trust is committed to reducing the £1.1m gap in 21/22 and having a robust plan in place for the start of 2022/23 financial year.

## 4. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
<b>221,951</b>	<b>Non-current assets</b>	<b>223,774</b>	<b>1,823</b>
6,962	Inventory	6,904	(58)
16,216	Trade and other receivables	14,513	(1,703)
49,184	Cash	42,634	(6,550)
<b>72,362</b>	<b>Current assets</b>	<b>64,051</b>	<b>(8,311)</b>
(137)	Borrowings	(132)	5
(37,101)	Trade and other payables	(27,723)	9,378
(8,839)	Other liabilities	(11,993)	(3,154)
<b>(46,077)</b>	<b>Current liabilities</b>	<b>(39,848)</b>	<b>6,229</b>
(2,151)	Borrowings	(2,025)	126
(1,424)	Other liabilities	(1,424)	0
<b>(3,575)</b>	<b>Non-current liabilities</b>	<b>(3,449)</b>	<b>126</b>
<b>244,661</b>	<b>Net assets employed</b>	<b>244,528</b>	<b>(133)</b>
453,870	Public dividend capital	453,870	0
(245,271)	Retained earnings	(245,404)	(133)
36,062	Revaluation reserve	36,062	0
<b>244,661</b>	<b>Total taxpayers' equity</b>	<b>244,528</b>	<b>(133)</b>

### Key messages:

1. Receivables have decreased by £1.7m from the prior year to £14.5m and represent approximately 54% of 1 month's average turnover.
2. Payables have decreased by £8.3m 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 104% of 1 month's average turnover.
3. Other liabilities have increased by £3.2m from the prior year due to an increase in payments in advance from NHS Commissioners
4. Total Trust borrowings are £2.2m and relate to long term capital loans issued by DHSC in a prior year.

## 6. Capital

### 2021/22 Capital Expenditure Summary

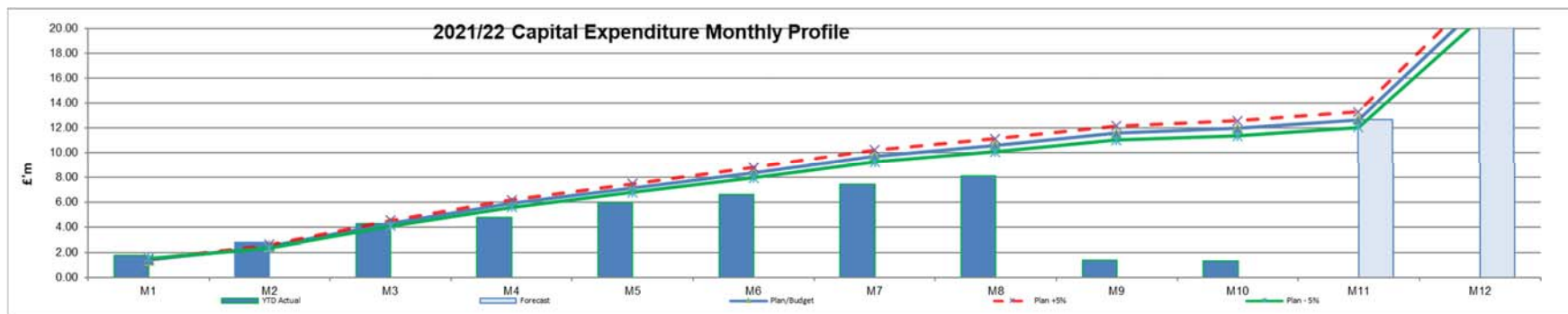
£'000	In-month			Year To Date					Annual					Funding (PLAN)		
	Plan	Actual	Var.	Plan	Actual	Var.	Offsets	Adjusted Var.	NHSI Plan	Revised Trust Plan	Forecast	Var on NHSI plan	Var on revised Trust plan	Internal	PDC	OTHER
Backlog Maintenance	74	197	123	3,033	3,073	40		40	3,014	3,551	4,072	1,058	521	3,205	0	0
Fire Urgency Works	112	457	345	2,107	1,364	(743)		(743)	2,331	2,581	2,525	194	(56)	2,331	0	0
Emergency Department**	0	(1,460)	(1,460)	1,211	0	(1,211)	1,211	0	1,211	1,257	0	(1,211)	(1,257)	1,257	0	0
Information Technology***	288	276	(12)	3,437	2,013	(1,424)	1,950	526	4,023	4,023	3,810	(213)	(213)	4,023	0	0
Medical and Surgical Equipment Programme	8	85	78	203	232	29		29	142	468	495	353	27	321	0	0
Service Developments	221	101	(120)	790	823	33		33	1,919	674	1,440	(479)	766	1,523	0	0
Routine Maintenance	0	0	0	110	70	(40)		(40)	130	216	191	61	(25)	110	0	0
Specific Business cases pending UTC	0	26	26	500	45	(455)		(455)	500	500	500	0	0	0	500	0
<b>Total Planned Capex</b>	<b>703</b>	<b>(317)</b>	<b>(1,020)</b>	<b>11,391</b>	<b>7,620</b>	<b>(3,771)</b>	<b>3,161</b>	<b>(610)</b>	<b>13,270</b>	<b>13,270</b>	<b>13,033</b>	<b>(237)</b>	<b>(237)</b>	<b>12,770</b>	<b>500</b>	<b>0</b>
Unfunded	0	(41)	(41)	0	(169)	(169)		(169)	0	0	0	(169)	(169)	0	0	0
Capital Donation -schemes	0	0	0	0	0	0		0	0	80	80	80	0	0	0	80
ICS Emergency Department**	0	1,488	1,488	0	1,488	1,488	(1,211)	277	0	1,500	1,500	1,500	0	1,500	0	0
ICS KLS	0	31	31	0	31	31		31	0	300	300	300	0	300	0	0
Diagnostics CR/DR	0	0	0	0	0	0		0	0	440	440	440	0	20	420	0
UTF Cyber	0	0	0	0	0	0		0	0	155	155	155	0	0	155	0
UTF EPR***	0	20	20	0	1,950	1,950	(1,950)	0	0	2,230	2,230	2,230	0	0	2,230	0
UTF Infrastructure	0	0	0	0	450	450		450	0	450	450	450	0	0	450	0
UTF Diagnostics	0	0	0	0	0	0		0	0	26	26	26	0	0	26	0
UTF Maternity	0	0	0	0	0	0		0	0	100	100	100	0	0	100	0
ICS Dolphin Ward	0	92	92	0	353	353		353	0	508	508	508	0	508	0	0
ICS TMT to TVT	0	34	34	0	146	146		146	0	300	300	300	0	300	0	0
ICS Site Generators	0	0	0	0	0	0		0	0	500	500	500	0	500	0	0
SDEC - additional non-elective bed capacity	0	15	15	571	20	(551)		(551)	0	541	541	541	0	0	541	0
virtual hub	0	0	0	0	0	0		0	0	100	100	100	0	0	100	0
day case trauma ( 2 rooms Phoenix)	0	0	0	0	0	0		0	0	30	30	30	0	0	30	0
Sunderland day case capacity**	0	0	0	0	0	0		0	0	20	20	20	0	0	20	0
MRI upgrade	0	0	0	0	0	0		0	0	165	165	165	0	0	165	0
Pre and intra operative digital solution/Safersleep	0	0	0	0	0	0		0	0	500	500	500	0	0	500	0
Video consultation platform	0	0	0	0	0	0		0	0	82	82	82	0	0	82	0
Digital Diagnostics irefer**	0	0	0	0	0	0		0	0	175	175	175	0	0	175	0
Digital Diagnostics home reporting	0	0	0	0	0	0		0	0	309	309	309	0	0	309	0
Imaging and Endoscopy Academies	0	0	0	0	0	0		0	0	16	16	16	0	0	16	0
<b>Total Additional Capex</b>	<b>0</b>	<b>1,640</b>	<b>1,640</b>	<b>571</b>	<b>4,269</b>	<b>3,698</b>	<b>(3,161)</b>	<b>537</b>	<b>0</b>	<b>8,527</b>	<b>8,358</b>	<b>8,358</b>	<b>(169)</b>	<b>3,128</b>	<b>5,319</b>	<b>80</b>
<b>Contingency</b>										<b>0</b>	<b>406</b>	<b>406</b>	<b>406</b>			
<b>Total Capex</b>	<b>703</b>	<b>1,323</b>	<b>620</b>	<b>11,962</b>	<b>11,889</b>	<b>(73)</b>	<b>0</b>	<b>(73)</b>	<b>13,270</b>	<b>21,797</b>	<b>21,797</b>	<b>8,527</b>	<b>0</b>	<b>15,898</b>	<b>5,819</b>	<b>80</b>

\*\* Emergency departments

\*\*\* IT

Additional funding in year released original budget

Additional funding in year for EPR released original budget



The planned capital programme is now on plan, and 89% complete based on the original programme. However as new monies have been issued late in the year there is now an additional £8.5m to spend over the last 2 months of the financial year. The budget for these projects has all been phased in month 12 when the Trust is expected to receive the cash.

Performance across the programme can be summarised as below;

- **Backlog Maintenance is currently on plan overall although there are schemes within the programme ahead and behind.**  
The programme is expected to overspend by £521k overall utilising slippage from other programmes.
- **Fire Urgency Works £743k behind plan, forecast for year is 56k underspent.**  
Main schemes generating this slippage are;
  - Compartmentation, £246k slippage, behind due to scoping delays earlier in the year, expected to complete by YE at £49k underspent
  - Fire Alarm, £150k slippage, access to certain areas within the Trust have resulted in works delays across both of these projects, as areas are now available work is back underway and still on course to complete this financial year at £102k underspent.
  - X Ray doors, £141k slippage. This project is now complete and awaiting QS approval to complete the payments. Once complete the project will be £20k underspent.
  - CSSD, £258k slippage, asbestos issues have caused a delay in scoping, these are now resolved and the work is to start imminently the project will catch up and complete in 2021/22 £60k overspent
- **Emergency Department, £1,211 underspent- adjusted to NIL**  
Please see ICS Emergency department line, expenditure on the internally funded project approved in the original plan has been rebadged against additional funding issued by the ICS. This releases the additional funding back into the Trust as slippage.
- **IT schemes £526k ahead of plan forecast for year is £1,257k underspent due to additional funding**  
£3.9m of the additional funding allocated to the Trust has been for IT schemes, some of which to fund projects originally planned from existing resources. This has released funds for use elsewhere.
- **Service Developments, is currently on plan, although forecast is £766k overspent, utilising slippage from other programmes**  
Ward refurbishments in the original plan have been deferred to 2021/22 and replaced by other projects to be completed over a different timescale.

Additional emergency projects such as bathroom refurbishments (£70k), Blue zone refurbishments (£115k), £1,162k of slippage schemes have been approved causing the forecast overspend, this overspend will be now be funded from other programme slippage as a result of the additional monies secured.

- **Routine Maintenance £40k behind plan, forecast £25k underspent.**

- **Unfunded, £169k credit, forecast £169k credit.**

The balance has been confirmed as VAT credits relating to PY projects, a genuine benefit to the current year position.

- **Additional Funding**

Currently the Trust has agreed additional funding of £8.5m as detailed in the capital table on the previous page.

£5,319k PDC funding (cash) which the Trust will be required to pay 3.5% PDC dividends on, £186k per annum from 2021/22 on reducing basis in line with the asset values. MOU's to the value of £2,690k for IT schemes are yet to be received

£3,128k additional system capital repurposed from EKHFT, the Trust received no additional cash transfer this is CRL only.

£80k of charitable donations.

Most of this additional funding will be spent across February and March.

- **Overall capital forecast is on plan**

In month 10 further slippage of £607k has been identified, contingency schemes have been approved at Trust capital group to best utilise before 31<sup>st</sup> March.

The position will be closely monitored on a weekly basis by Finance and TCG group members to ensure the target is achieved.

- **Next Year 2022/23**

As previously reported Capital funding for 2022/23 is expected to be lower, in line with depreciation of approx. £11m leaving the Trust up to £30m short of funding for identified schemes, over the next 5 years the Trust has a potential shortfall of over £100m. This shortfall is across the NHS as a whole and has been recognised at all levels.

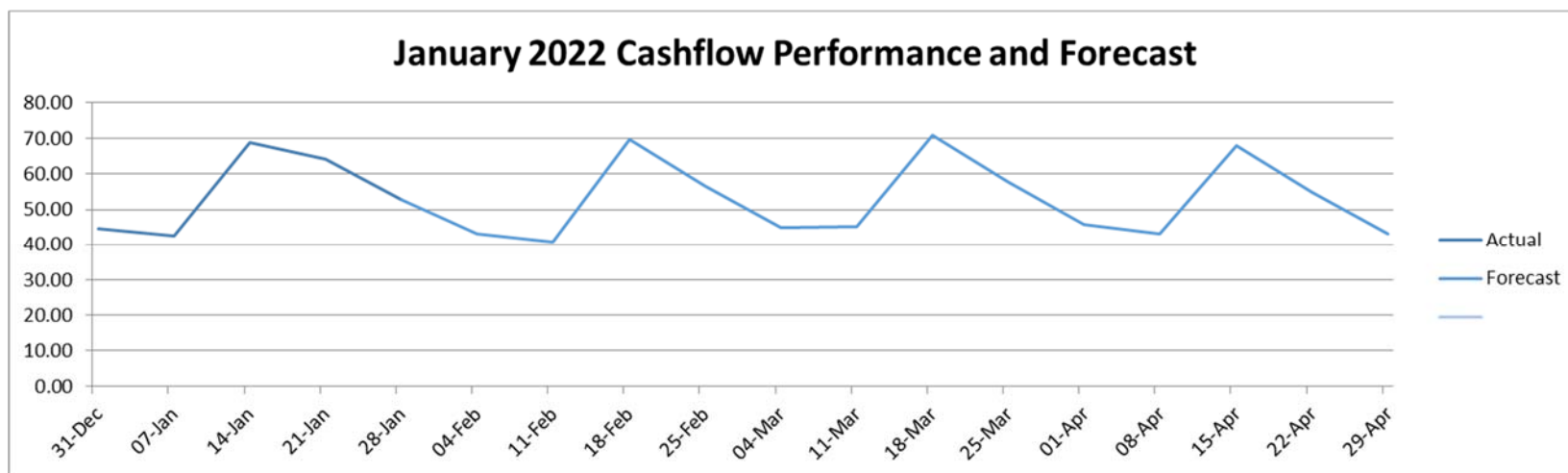
The capital envelope is now held by the ICS for allocation to Trusts, Trust plans have been submitted to them and are subject to a check and challenged before organisational CFOs approve final allocations.

## 6. Cash

### 13 Week Forecast

w/e

	Actual					Forecast													
£m	31/12/21	07/01/22	14/01/22	21/01/22	28/01/22	04/02/22	11/02/22	18/02/22	25/02/22	04/03/22	11/03/22	18/03/22	25/03/22	01/04/22	08/04/22	15/04/22	22/04/22	29/04/22	
BANK BALANCE B/FWD	51.71	44.72	42.65	68.84	64.22	52.67	43.03	40.79	69.84	56.70	44.97	45.27	70.88	57.65	45.92	43.10	68.07	54.91	
Receipts																			
NHS Contract Income	0.00	0.00	29.11	0.19	0.27	0.33	0.59	29.80	0.00	0.00	0.00	30.10	0.00	0.00	0.00	29.75	0.00	0.00	
Other	0.08	0.09	0.70	0.11	0.69	0.66	0.58	2.65	0.25	0.25	0.58	0.60	0.25	0.25	0.58	0.25	0.25	0.25	
Total receipts	0.08	0.09	29.81	0.30	0.96	0.99	1.16	32.45	0.25	0.25	0.58	30.70	0.25	0.25	0.58	30.00	0.25	0.25	
Payments																			
Pay Expenditure (excl. Agency)	(5.48)	(0.69)	(0.49)	(0.41)	(10.43)	(9.07)	(0.40)	(0.40)	(10.40)	(8.98)	(0.40)	(0.40)	(10.48)	(8.98)	(0.40)	(0.40)	(10.41)	(9.05)	
Non Pay Expenditure	(1.51)	(1.40)	(2.79)	(4.28)	(2.04)	(1.53)	(2.78)	(2.80)	(2.80)	(2.80)	(2.80)	(2.80)	(2.80)	(2.50)	(2.50)	(4.13)	(2.50)	(2.50)	
Capital Expenditure	(0.08)	(0.07)	(0.34)	(0.25)	(0.05)	(0.03)	(0.22)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	
Total payments	(7.07)	(2.16)	(3.62)	(4.93)	(12.51)	(10.63)	(3.40)	(3.40)	(13.40)	(11.98)	(3.40)	(3.40)	(13.48)	(11.98)	(3.40)	(5.03)	(13.41)	(12.05)	
Net Receipts/ (Payments)	(6.99)	(2.07)	26.20	(4.63)	(11.55)	(9.64)	(2.24)	29.05	(13.15)	(11.73)	(2.83)	27.30	(13.23)	(11.73)	(2.83)	24.97	(13.16)	(11.80)	
Funding Flows																			
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.13	1.57	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	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(3.26)	0.00	0.00	0.00	0.00	0.00	0.00	
Total Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.13	(1.70)	0.00	0.00	0.00	0.00	0.00	0.00	
BANK BALANCE C/FWD	44.72	42.65	68.84	64.22	52.67	43.03	40.79	69.84	56.70	44.97	45.27	70.88	57.65	45.92	43.10	68.07	54.91	43.11	



Prior year end	£'000	Month end actual	Var.
49,184	Cash	42,634	(6,550)

Cash balances have moved from the prior year due to

- £3.7m additional cash payments made in advance of contracts
- £9.3m reduction in trade payables, most of which will have been paid out in cash.

## 7. Risks and opportunities

Title	Risk description	RAG	£'000	Mitigation(s)	Lead(s)
Efficiencies	The Trust has not yet identified its target of 3% efficiencies (as communicated at the beginning of the year) for H2.		1,000+	Oversight from Efficiency Delivery Group to develop current schemes and identify more schemes. Red rated schemes with no value currently quantified.	Alan Davies
Winter	The Trust has compiled a winter plan with a number of interventions. The amount of funding agreed is currently £0.9m.		5,679	The unfunded element of the winter plan has been built in the overall revised forecast outturn (see below), which will be mitigated by the System.	Trust Executive
PAHU	Increased capacity on PAHU remains unfunded.		1,470	Built in to forecast outturn with overall risk to be mitigated by the System	Trust Executive
Covid	Covid activity has started to decrease however the impact on services as well as higher staff sickness levels requiring temporary staff cover remains a cost pressure.		Unknown	Estimated costs built in to forecast outturn with overall risk to be mitigated by the System..	Alan Davies

## 7. Risks and opportunities (continued)

### Trust Summary of Key Variances

(£m adverse / (favourable))

	Q1-Q3	Q4	Total
<b>Urgent &amp; Integrated Care (UIC)</b>			
Cost of increased escalation capacity:			
- Winter Plan (unfunded)	1.4	0.9	2.3
- Additional pressures from New Year	0.2	0.6	0.8
	1.6	1.5	3.1
Other cost pressures related to activity/acuity	2.7	1.6	4.3
Efficiencies gap	0.0	0.5	0.5
Other UIC	0.5	0.1	0.6
<b>Total UIC</b>	<b>4.8</b>	<b>3.7</b>	<b>8.5</b>
Planned Care	0.5	0.2	0.7
Estates & Facilities / Corporate	-1.2	-0.7	-1.9
Central income and reserves	-4.0	-0.9	-4.9
Other	-0.1	0.0	-0.1
<b>Grand Total</b>	<b>0.0</b>	<b>2.3</b>	<b>2.3</b>

The forecast risk as presented at the December committee identified a £3.3m risk to achieving breakeven for 2021/22, this was mainly due to unfunded costs for the additional escalation capacity and the unfunded element of the winter plan.

The position has been updated using the January position and incorporating any further risks that have been identified. The forecast position has reduced by £1.0m to a £2.3m deficit.

There has been a positive indication from the CCG that funding up to the level of £3.3m is available to the Trust to cover any risk to the achieving the control total.

## 8. Conclusions

The Finance Committee is asked to note the report and financial performance which is £63k deficit in-month reducing to breakeven year to date after removing the adjustment for donated asset depreciation and income. This financial performance is as per the plan submitted to the Kent & Medway STP and forecast to breakeven for the second half of the year in line with the control total. The year to date efficiency programme is £0.3m adverse to plan at £3.7m. ERF income of £7.5m has been included; £4.6m of this has been paid by the CCG relating to H1, the remaining £2.9m is an agreed amount to cover the incremental cost of delivering ERF activity. The wellbeing day accrual is being released into the position evenly over the period at approximately £60k per month, the annual leave accrual of £2.9m remains unchanged this financial year.

The risks identified with the financial position for the 2<sup>nd</sup> half of the financial year ahead include:

- Managing cost pressures, service developments and service charges within the financial envelope for H2.
- Delivery of efficiencies targets and reducing the £1.1m gap in the programme.
- Managing the incremental cost of elective recovery and covid costs within the financial envelope for H2.
- Escalation capacity, winter pressures and PAHU.
- Staff absences from annual leave and sickness with temporary staff covering the unfilled shifts.

Mitigations to reduce the risk:

- Continued development and implementation of the 9 crosscutting efficiency schemes.
- Use of benchmarking data including the Model Hospital to drive efficiencies.
- Agreement with the ICS to fund the additional costs identified above in relation to winter pressures and escalation capacity up to £3.3m

Alan Davies  
Chief Financial Officer  
February 2022



# Meeting of the Board of Directors in **Public**

Wednesday, 09 March 2022

## Assurance Report from Committees

<b>Title of Committee:</b>	<b>Finance Committee</b>	<b>Agenda Item</b>	<b>5.2</b>
<b>Committee Chair:</b>	Annyes Laheurte		
<b>Date of Meeting:</b>	Thursday 24 February 2022		
<b>Lead Director:</b>	Alan Davies, Chief Financial Officer		
<b>Report Author:</b>	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
<b>No assurance</b>	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
<b>Partial assurance</b>	Amber/ Red - there are gaps in assurance
<b>Assurance</b>	Amber/ Green - Assurance with minor improvements required
<b>Significant Assurance</b>	Green – there are no gaps in assurance
<b>Not Applicable</b>	White - no assurance is required

### Key headlines and assurance level

Key headline	Assurance Level (use appropriate colour code as above)
<b>1. BAF strategic risks</b> For the February update, the scores of the 3 risks identified on the BAF remain unchanged.  Following progress with the financial recovery plan and the a reassessment of the forecast position reducing by £1m, it was proposed to reduce the score for BAF item 3a "Delivery of Financial Control Total" to a 12 for next month. This was <b>AGREED</b> by the committee.	<b>Amber/Red</b>
<b>2. Corporate risk register</b>	<b>Red</b>

Key headlines and assurance level	
Key headline	Assurance Level (use appropriate colour code as above)
There has been no reduction in the efficiency plan gap, therefore the delivery of the efficiency programme target remains at 4 x 4 = 16 and RAG rated as red.	
<b>3. Finance report – month 10</b> <p>The Chief Financial Officer took the Committee through the report, with the key highlights being:</p> <ul style="list-style-type: none"> <li>• The Trust has met its control total of breakeven in month 10 and for the year to date.</li> <li>• ERF+ Income of £2.9m had been accrued into the position, this being 4 months of the agreed £4.4m for H2.</li> <li>• The in-month position includes non-recurrent release of agency accruals and a VAT rebate totalling £0.5m. There is no contingency carried forward to future months.</li> <li>• The efficiencies delivered are £119k lower than budgeted for January and £665k year to date.</li> <li>• The capital schemes year to date are £73k behind the £11.9m plan due to various schemes coming to completion. The revised capital programme is now £21.8m and the forecast is to achieve plan.</li> <li>• Cash sums remain in a strong position.</li> <li>• The forecast outturn position 2021/22 of £2.3m deficit, this has reduced by £1m from December due to £0.5m non-recurrent adjustment to agency accruals and lower insourcing costs than planned. The main driver continues to be the escalation capacity £3.3m that the ICS has advised there is further funding across the system to cover the financial risk.</li> <li>• Mitigations have been factored into the position from the Covid underspend, reserves, TIF, and Covid out of envelope income.</li> <li>• A de-escalation plan is being developed to review the use of escalation beds to support services following the business continuity response.</li> </ul>	Amber/Green
<b>4. Efficiency programme update</b> <p>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.</p> <p>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.</p> <p>It was <b>AGREED</b> further analysis of the current year efficiency programme to include the split between non-recurrent and recurrent schemes, and a review of the full year effect impact for the 22/23 programme.</p>	Red

Key headlines and assurance level	
Key headline	Assurance Level (use appropriate colour code as above)
<p><b>5. Grip &amp; Control High Priority Actions</b></p> <p>The FRP Director gave an update of the grip and control actions identified.</p> <p>An update was given regarding quantifying the actual benefit of the actions, some of these are non-financial, such as “Communication” but benefits would be realised by implementing this initiative. Also, it was discussed how some of the actions were now been linked with the cross cutting schemes, such as job planning being linked to demand management.</p> <p>It is intended to give actual values to some of the action points over the next 2-3 months as they are developed.</p>	<b>Amber/Green</b>
<p><b>6. Financial Escalation Process</b></p> <p>The financial escalation process is now in the 2<sup>nd</sup> month as part of the FRP. The general feedback is that engagement is good from the services and work is moving on the right direction to get towards the main issues driving the adverse variations, with a view to implementing mitigating actions. The general agreement is to learn from historical events but to promote a forward thinking ethos towards financial recovery.</p>	<b>Green</b>
<p><b>7. Drivers of Deficit</b></p> <p>The drivers of deficit paper was presented by the Financial Recovery Plan Director; this has also been presented to colleagues in the ICS as well as NHSE/I and updated on some of the issues raised at the last committee meeting and the next steps for the Trust.</p> <p>An action was taken for the FRP director to link up with Maidstone &amp; Tunbridge Wells Trust to discuss rising CNST costs and different levels of increase between MTW and MFT.</p> <p>The drivers of deficit paper was <b>APPROVED</b> by the members of the committee.</p>	<b>Green</b>
<p><b>6. Financial Recovery Plan (“FRP”)</b></p> <p>The FRP Director updated the Committee on the latest FRP developments. This main points included:</p> <ul style="list-style-type: none"> <li>Updating of items included in the FRP plan, including efficiency governance and some of the mitigations to achieve financial recovery.</li> <li>Appointment of an interim financial modeler to work on the system plan, with a draft plan due by 11<sup>th</sup> March.</li> <li>A further issue of the draft FRP document would be available by mid-March 2022, and available for the March Committee.</li> </ul>	<b>Amber/Green</b>
<p><b>7. Business Planning Update</b></p> <p>The Chief Finance Officer presented a slide pack to committee of the latest progress for business planning.</p>	<b>Green</b>

Key headlines and assurance level	
Key headline	Assurance Level (use appropriate colour code as above)
<p>The main changes to the guidance issued last month are:</p> <ul style="list-style-type: none"> <li>• Reduction to the efficiency requirement from 4% to 2.8%</li> <li>• Scope of cross cutting efficiency schemes had increase from 7 to 9 with the inclusion of Digital and EPR benefits realisation.</li> <li>• Removal of gain share by divisions for over delivery of efficiency plans.</li> </ul> <p>An overview of the current position indicated the current timetable has not changed and clinical services to present a draft business plan for the 1<sup>st</sup> of March with non-clinical by 7<sup>th</sup> March. A submission of first cut plans to the system is scheduled for the 17<sup>th</sup> March.</p> <p>Following Executive Team review there would be feedback to divisions with final plans due on the 25<sup>th</sup> March, and final plans submitted to the system by the 25<sup>th</sup> April.</p>	
<p><b>8. Re-naming of the Finance Committee ToR</b></p> <p>This item would be deferred to the March Committee meeting when the Company Secretary is available to present the paper.</p>	<b>Green</b>
<p><b>Decisions made</b></p> <p>It was <b>AGREED</b> to reduce the score for BAF item 3a “Delivery of Financial Control Total” to a 12 for next month.</p> <p>It was <b>AGREED</b> further analysis of the current year efficiency should be included to identify schemes that are non-recurrent and recurrent, as well as a review of the Full Year Effect impact for the 22/23 programme.</p> <p>The drivers of deficit paper was <b>APPROVED</b> by the members of the committee.</p>	
<p><b>Further Risks Identified</b></p> <p>No further risks were identified.</p>	
<p><b>Escalations to the Board or other Committee</b></p> <p>There were no further issues identified to escalate to the Board.</p>	