Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public
Date: Wednesday, 8 June 2022 at 12:30 – 15:30
MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
1.4	Chief Executive's Update	Interim Chief Executive	3	12:35	Note
1.5	Patient Story	Chief Nursing Officer	7	12:50	Receive
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of previous meeting: 11 May 2022	Chair	13	13:20	Approve
2.2	Matters arising	Chair	Verbal		Discuss
3.	**Strategy and Resilience**				
3.1	Patient First Improvement Programme	Chief Strategy and Transformation Officer	21	13:30	Note
4.	**High Quality Care**				
4.1	Integrated Quality Performance Report	COO, CNO, CMO	37	13:45	Assure
4.2	Quality Assurance Committee Assurance Report - Meeting date: 24 May 2022	Chair of Committee/ Chief Nursing Officer	77	14:00	Assure
4.3	CNST Year 4 Oversight Report	Chief Nursing Officer	81	14:10	Note
4.4	Ockenden 2 (March 2022) Report Oversight and assurance	Chief Nursing Officer	97	14:25	Note
4.5	Infection Prevention & Control Board Assurance Framework	Chief Nursing Officer		14:40	Receive
5.	**Financial Sustainability**				
5.1	Finance Report - Month 1	Chief Finance Officer	111	14:50	Note
5.2	Finance, Planning and Performance Committee Assurance Report Meetings: 28 April, 26 May 2022 • Approval of Business Plan 2022/23 • Approval of Financial Recovery Plan	Chair of Committee/ Chief Finance Officer	119 123	15:00	Approve

Agenda

6.	**Our People**				
6.1	Health and Safety Annual Report	Chief Nursing Officer	withdrawn	15:10	Assure
6.2	Assurance Report of People Committee – 26 May 2022	Chief People Officer	131	15:20	Assure
7.	**Any Other Business**				
7.1	Council of Governors Update	Lead Governor	Verbal	15:30	Note
7.2	Questions from the Public	Chair	Verbal		Note
7.3	Any Other Business	Chair	Verbal	15:30	Note
	Date and time of next public board meeting: 3 August 2022, 12:30 – 15:30				

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Chief Executive's Report – June 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.

I am incredibly proud to have been appointed as Interim Chief Executive following Dr George Findlay's departure at the end of May; since joining the Trust in 2021 I have had ample opportunity to see first-hand the compassion and dedication of our staff.

I look forward to working with them, patients, their families and our local communities, as we build upon our successes, and continue on towards our goal of providing outstanding care for the people of Medway and Swale.

COVID-19

Over the last month, we have continued to see a decline in the number of cases of COVID-19 in our hospital. Following last month's lifting of some of our visiting restrictions, we have also now removed social distancing requirements from our Trust sites.

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

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

We have welcomed more visitors back into the hospital, and we know how important this is to our patients and their loved ones.

We are keeping our COVID-19 infection control measures under continual review, and we hope to be able to further lift the restrictions in the hospital in the coming weeks.

A brand-new facility for people with learning and physical disabilities

Last month we were proud to open our new Changing Places toilet for people with significant learning and physical disabilities, making us the first acute Trust in Kent and Medway to offer this facility.

Changing Places toilets, which are larger than a standard wheelchair accessible toilet, are specially equipped to ensure those who are unable to use a toilet independently, can use the bathroom with dignity and hygienically. Our facility has been fitted with a height-adjustable toilet and sink, an adult-sized changing bench, hoist, and colostomy bag shelf, and is big enough for a person and two carers to use comfortably.

Access to safe and suitable bathrooms is a human right. Changing Places toilets really are life changing as they give people with significant learning and physical disabilities and their carers the space and the equipment, they need to have the confidence to leave their homes and attend appointments or visit loved ones in hospital.

Located in the Atrium, Level 2, Green Zone, the new Changing Places toilet can be accessed by patients, carers and visitors, as well as staff, who have a radar key.

Getting by with a little help from our friends

We are very lucky to receive generous support from the Medway League of Friends; their donations make a huge difference to our patients and colleagues.

We've seen incredible generosity from the charity over the last year, with donations of more than £200,000 funding vital equipment.

These items have enhanced patient care across several areas including the Oliver Fisher Neonatal Unit, hepatology, the falls service and maternity.

Recent donations have included more than £25,000 for new 'Criticool Units' for Oliver Fisher. These are used to reduce the side effects of premature birth on poorly young babies and improve their chances of recovery.

We have also received £88,000 for a new 'Fibroscan' machine for our hepatology department. This is a non-invasive machine that performs simple, painless, real-time tests on a patient's liver. This helps staff to better understand the condition of the patient and allows treatment to be planned more efficiently.

Congratulations to David

I'm delighted to say that our Pharmacy Technician David Ellis-Adams won the Excellence in Hospital Pharmacy Award at the Clinical Pharmacy Congress for his

poster presentation ‘Pilot and scoping for the creation of an innovative rotational, cross sector, pharmacy technician workforce within Medway and Swale’.

The nomination recognises the work David completed as part of a Health Education England (HEE) project which involved him working at the hospital and a number of GP surgeries to develop an innovative cross-sector pharmacy technician role to improve integrated patient care in a nine-month secondment across Medway South Primary Care Network. This role increased patient safety following discharge by ensuring high quality, efficient medicines reconciliation (drug histories) and targeted interventions for high-risk patients addressing issues affecting ongoing care.

Additional benefits demonstrated improved collaboration, governance, and shared learning across the interface.

Trust nurse appears on Britain’s Got Talent

If you are a regular viewer of Britain's Got Talent you may have spotted our very own Critical Care Nurse, Emily Mann. Emily performed with The Frontline Singers, which received four 'yes' votes from the judges!

We couldn't be prouder of Emily and the group for their fantastic audition.

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.

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Communications Update

June 2022

Total social media impressions

76,000

Media mentions

120

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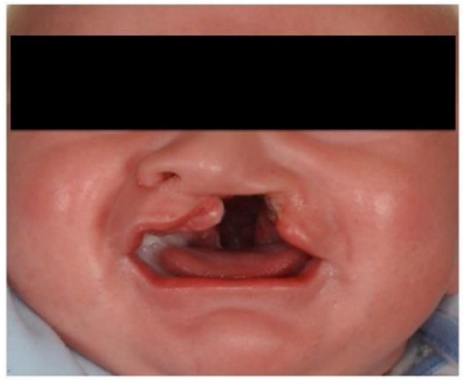
Baby Willow's story

Patient
FIRST

What happened

- Willow is a nine-day-old baby girl born with a cleft palate
- She was transferred to our children's Penguin Assessment Unit
- Parents overheard a nurse and a receptionist referring to Willow as "that cleft palate baby"
- Parents were unable to identify the individuals who made the comments



How Willow's parents felt

- Willow's parents felt "upset", "felt they were doing a bad job", "felt guilty", "felt it's the start of negative experience for Willow throughout her life"

- Willow's parents contacted PALS to discuss the negative impact

"*This made us feel really upset hearing staff not calling our baby by her name*."

Immediate learning

- The PALS team listened to Willow's parents and apologised for the family's poor experience of staff attitude and behaviours
- The feedback was escalated to the Ward Manager and Head of Nursing
- Urgent ward meeting was called to discuss poor staff attitudes / behaviours
- Staff expectations reset: aligned to Trust values

Patient Experience Strategy

- The Trust is committed to ensuring patients have a positive experience.

- Patient First / Patient Experience Strategy-
  - think Patient First
  - communicate to ensure patients (children), their families feel involved and listened to
  - be leaders of patient experience
  - create a positive culture (staff attitude and behaviour)
  - work with patients and their families.

- Patient Experience Academy: professional training and development programme

- National initiatives: Hello, my name is…, who's who,

- Equality, Diversity and Inclusion

NHS Medway NHS Foundation Trust

Minutes of the Trust Board PUBLIC Meeting

Wednesday 11 May 2022 at 12:30 to 14:25

MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Jayne Black	Chief Operating Officer
	Ewan Carmichael	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Alison Davis	Chief Medical Officer
	George Findlay	Chief Executive
	Leon Hinton	Chief People Officer
	Evonne Hunt	Chief Nursing Officer
	Annyes Laheurte	Non-Executive Director
	Sue Mackenzie	Non-Executive Director
	Mark Spragg	Deputy Chair/Senior Independent Director/NED
	Paula Tinniswood	Chief Strategy and Transformation Officer
	Tony Ullman	Non-Executive Director
	Adrian Ward	Non-Executive Director
Non-Voting:	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	David Brake	Lead Governor
	Kelly Ferris	Baxter
	Karen Breen	Chief Operating Officer, Sussex NHS Commissioners
	Dr Richard Patey and Vidya Pundit-Dermody	Clinical presentation

1.0 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present, including visitors.

Chair continued with the following update:

She thanked the 4,000 plus colleagues who make up our fantastic Trust. Their resilience and determination means the Trust has continued to provide safe and effective care to our community, despite the pressures we have seen in the last month.

She noted further progress against some of our key statutory targets, including in relation to cancer, infection control and the performance of our Emergency Department. These are improvements that our patients deserve, meaning they will have access to better and more efficient care. Thanks to the hard work of teams across the hospital for achieving this.

It was positive to see the number of COVID-19 cases falling within our Trust and in the community, however we rely on our staff, patients and visitors to remain vigilant and follow all the necessary infection control measures to stop the spread of the virus.

She thanked George Findlay as this will be his last board meeting before he departs Medway at the end of the month. Over the last year under George's excellent leadership, we have seen significant improvements to the experience of patients and staff, and we are in a far better position to continue improving thanks to the introduction of Patient First, which George has brought to the Trust. George leaves with our heartfelt thanks and we wish him all the very best for his new role in Sussex and for the future.

She announced that Jayne Black will be our interim chief executive from the end of May, while we complete the recruitment for the substantive position.

The interim CEO was selected by a panel of colleagues, including from the system and the region. Jayne brings to the role her clinical experience as a nurse along with her leadership experience across acute and community sectors and at a system level. She's also been involved in transforming services through the Patient First program at other trusts. This is the first time that we have appointed an interim CEO from within the organisation and that's a measure of the depth and breadth of experience that we've been building across, not just the leadership team, but at all levels of the organisation.

She recognised Gary Lupton, who will shortly be retiring as our Estates director. Gary has been with Medway for four years, and has done an amazing job of supporting us, not just through all of the capital works, especially on our fire safety program, but also through the pandemic. Tt was as a result of Gary's prompt response that we were so well placed, particularly at the start of the pandemic when equipment wasn't as available as readily as it was in the later stages. She said Gary was a credit to the hospital, and not just in his functional role, but his contribution to the leadership team. We wish you all the very best whatever you choose to do next.

Finally, protecting the health and wellbeing of NHS staff has never been more important and I'm very happy to see the Trust continuing to lead from the front in this area. Over the last month we have seen the opening of our beautiful new Reflection Garden, while we also welcomed the 'Project Wingman' health and wellbeing bus to the hospital for a week, which gave our colleagues access to free refreshments, therapy sessions and advice on all things wellbeing. The pressures on our colleagues remain, and we will continue to take care of them so that they can care for our patients.

1.2 Quorum

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

1.3 Declarations of Interest

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

1.4 Chief Executive's Update

The Chair invited the Chief Executive to provide his update. George Findlay commented as follows:

It is good to see that the numbers of inpatients in the hospital have been decreasing over the past number of weeks. But we still need to be vigilant and continue to ensure the right processes are in place to keep our patients, colleagues and visitors safe when learning to live with COVID. The Trust be able to lift some of our visiting restrictions: patients are now able to receive visits from two named visitors, instead of one. We ask visitors to observe some simple measures whilst they are on site. This includes wearing a mask at all times on site and social distance where possible, washing hands regularly or using hand gel.

I talk with passion about the importance of Patient First and how that is our strategy to sustainable improvement and we'll continue to make good progress with the rollout of Patient First. Our executive team met last month to agree the key objectives, what we call our breakthrough objectives, for the next 12 months.

Reducing the time that patients wait for their first appointment, increasing the number of patients that were discharged before midday each day, more prompt recognition of the deteriorating patient and reducing the number of avoidable cardiac arrest calls and increasing the number of patients who would recommend us as a place to receive care through the Friends and Family Test, and an increase in the number of staff receiving a quality appraisal with a well-being check. We have chosen those because we believe that they are five things that will move us more quickly towards our True North goals.

Sometimes, we think about statutory targets as management and management targets are numbers, but behind every number is a real person that might be waiting for treatment or waiting for a diagnosis. That's why I'm delighted to say that last month our 62 day cancer performance was at 88% which placed us fifth in the country and the highest performing district general hospital. Also we saw 92.5% of suspected cancer patients within two weeks and placing of 17th in the country. Our patients worried that they may have cancer diagnosis are getting prompt assessment and treatment if required.

The Trust is doing very well against some of our other targets, including emergency department performance, ambulance handovers, elective surgery and diagnostics and that will continue as we go forward through the year. The Trust is under its trajectory for C Diff infections, with just 26 cases against the trajectory of 35 and a significant reduction from the 45 of the previous year.

Finally, we were delighted to welcome the Mayor of Medway Councillor Jan Aldous, to open our reflection garden last month. This is a really important addition to our health and wellbeing offering. It's a paved garden with pergolas, raised beds, privacy screens and a stunning water feature and it was made possible thanks to the generous funding from the Medway Hospital charity and the Medway League of Friends.

2.0 Minutes of the previous meeting and matters arising

2.1 The draft minutes of the Public Board meeting, held on 9 March 2022 were circulated for approval

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

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

3.0 Clinical Presentation – Paediatrics

The Chair welcomed Dr Richard Patey and Vidya Pundit-Dermody to the meeting to present on the Paediatric service. Slides were shown in support of this.

The presentation included the following highlights:

- The relationship with other health care settings, public health and community provision
- A SWOT analysis of the service
- Good progress with internal nurse recruitment
- The current patient pathways for paediatrics from ED to the wards
- Good responses to emerging clinical standards over time
- The current inspection rating with CQC – amber ratings for effectiveness and responsiveness and actions around this
- The impending appointment of a paediatric research lead

The Chair thanked the speakers for the presentation.

4.0 Strategy and Resilience

4.1 Board Assurance Framework

The Board received the report on the Board Assurance Framework reviewed by Executives and by the People Committee, Finance Planning and Performance Committee and Quality Assurance Committee.

The report indicated that it was proposed to close the BAF risks relating to integration and to innovation. The top two risks were in relation to access for emergency and elective care and failure to deliver the financial recovery programme. The Company Secretary undertook to verify the past scores reported for the Finance risks.

The People Committee had reduced the risk level for safe clinical staffing, following the national change of approach to vaccine as a condition of deployment.

The board noted the report and approved the closing of the integration and innovation risks.

5.0 High Quality Care

5.1 Integrated Quality Performance Report

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

The following principal points were made:

- Improvements continued to be made in the emergency department to address ambulance handover delays
- There was an increase in the number of falls, but the majority were no harm or low harm
- Work with Medway Community Healthcare was continuing on community-acquired pressure ulcers
- There was a high number of mixed sex accommodation breaches and work continued with the site team to address this
- Bed occupancy continued to be high
- Work continued to reduce the number of patients that were medically fit for discharge
- The Patient Tracker list was around 30,000, predominantly outpatients; there were transformation programmes to address this
- A working group was reviewing the fractured neck of femur pathway
- The Trust was working within expectation for the mortality indicators SHMI and HSMR; an outlier report in relation to stroke was being followed up

Alison Davis undertook to review the position on VTE under the contract in relation to a question from Jenny Chong. Evonne Hunt highlighted the ward accreditation process in relation to a question from Mark Spragg about recognition of wards with periods without a patient fall.

The Chair passed on positive feedback from Region about the work to improve weekend discharge.

The Board noted the report.

5.2 Quality Assurance Committee assurance report - 22 March and 26 April 2022

The Board received the assurance reports from the Quality Assurance Committee. Committee chair Tony Ullman highlighted the role of the new structure reporting into QAC that was having a good effect on the operation of the committee in terms of the levels of assurance received. He also highlighted the multi-agency work on review of the waiting list by protected characteristics.

The Board noted the reports.

5.3 Patient Experience Report

The Board received the Patient Experience report, setting out progress with the implementation of the Patient Experience Strategy and the activity of the complaints and PALS service.

Evonne Hunt highlighted the pilot work being undertaken on a scheme of ward accreditation. Work was continuing to improve real-time feedback from patients.

There had been 40 complaints in the month; a more proactive approach was being taken with the PALS team speaking to patients to address potential complaint issues.

It was noted that the Trust had 95 volunteers and the board discussed how more could be recruited and their work celebrated.

5.4 Clinical Negligence Scheme for Trusts Maternity Incentive Scheme: Safety Actions 8, 9, and 10

The board received the report setting out assurance in relation to staff completion of the Core Competency Framework for Maternity, process for the provision of assurance on safety/quality issues and arrangements for reporting relevant cases to the Healthcare Safety Investigations Branch (HSIB).

Evonne Hunt informed the Board that the Lead Midwife for education was reviewing the position with the Core Competency Framework. Face to face training had been affected by the Covid pandemic, but plans were in place to get back above 75% compliance by 30 June.

She highlighted the role of the Maternity Safety Champion in supporting effective ward to board reporting. Feedback through the Friends and Family Test was positive. She noted that work on the gap analysis in relation to the requirements of the Ockendon Report requirements was continuing and would be reported to the Quality assurance Committee.

The Board noted the report.

6.0 Financial Sustainability

6.1 Finance Report: M12

The Board received the Finance Report to 31 March. The Chief Finance Officer informed the Board that the Trust met its 2021/22 target to break even on revenue and that it achieved the capital target of just under £23m.

In response to a question form Jenny Chong about Public Dividend Capital (PDC) Alan Davies informed the board that this was capital schemes externally funded by the Department of Health and there were one or two schemes where we slipped on in 21/22. As we cannot carry that funding forward into 22/23, three we have to balance this from within internally generated capital resources. In 21/22, we had utilized the underspending on PDC schemes to fund other projects. We have brought these projects forward to take up slippage, but it means we need to reimburse that slippage from our own program in 2022/23. He added that the new clinical strategy would better inform future capital spending decisions.

The board noted the report.

6.2 Finance, Planning and Performance Committee Assurance Report Meeting: 24 March 2022

The Board received the Assurance Report from the March meeting of Finance Planning and Performance Committee. Chair Annyes Laheurte informed the Board the committee had met in April, where the first draft financial statements for 2021/22 had been reviewed.

She expressed concern about the position on the Trust's efficiency programme 2022/23 at this stage in the year.

It was noted that the total requirement was for £9.6m, of which £7m had been so far identified. 11 of 13 cross-cutting schemes had been agreed and work was ongoing on scheme around medical staffing and length of stay - the realisation of which would get the Trust closer to the required target.

The Chief Executive assured the Board that financial sustainability was a key of objective for the Executive as the Trust emerged from the pandemic. He added that Medway had seen the least reduction in productivity and cost growth among the acute trusts in Kent. The Financial Recovery Plan was a significant piece of work that was aiming to set out a realistic plan to enable the Trust to live within its means in future.

The Board noted the report.

6.3 Approval of the Annual Report and Accounts 2021/22

The board confirmed that it would delegate the approval of the Annual Report and Accounts 2021/22 to the Audit & Risk Committee. It was noted the committee was meeting on 16 June to effect this.

7.0 Our People

7.1 Report of the People Committee – 24 March 2022

The Board received the report of the People Committee. Chair, Sue Mackenzie highlighted (i) the change to the risk in relation to safe staffing because of the change in policy on vaccine as a condition of deployment, as discussed earlier and (ii) as mentioned in the IQPR there was some progress on raising the rate of appraisals which had risen to 85%. However the Chief People

Officer confirmed that the latest position was 78% compliance. He also highlighted the sickness rate of 5% which was an improvement on 12 months ago and was around the norm comparatively in Kent.

8.0 Council of Governors Update

8.1 The Chair welcomed Councilor David Brake who presented on behalf of the Council of Governors.

He highlighted the Swale by election where there are two seats vacant with results will be declared in mid-June. For the staff governor by-election there was an information session on 27th April given by the Chair, with eight members of staff attending to find out more about the role.

One governor also joined us at the community hub in Walderslade, along with Eunice Norman from the hospital radio. Eunice spoke about her incredible 50 years of service. They've receiving an MBE from Prince William, recognising the great work that takes place at the hospital radio and the League of Friends.

We were also invited to the Parkinson's Awareness Week which was held at St. John's Church in Chatham. The aim of the week was to raise awareness and funds for a very worthy cause.

On 26th April, we had the governor introduction to Patient First led by our Chief Executive who presented a bespoke session to introduce this new improvement system.

We are also hoping to attend the Sheppey Health Healthy Living Centre for their Jubilee event in May and the Big Bash in August. Further details will be circulated once that is confirmed.

8.2 Questions from the Public

There were no questions received from the public.

8.3 Any Other Business

There being no further business the Chair closed the meeting.

Date of the next meeting is to be held on 8 June at 12:30pm.

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Wednesday 11 May 2022

Signed …….. Date ……

Chair

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Patient First

Trust Board Update

8th June 2022

Patient FIRST

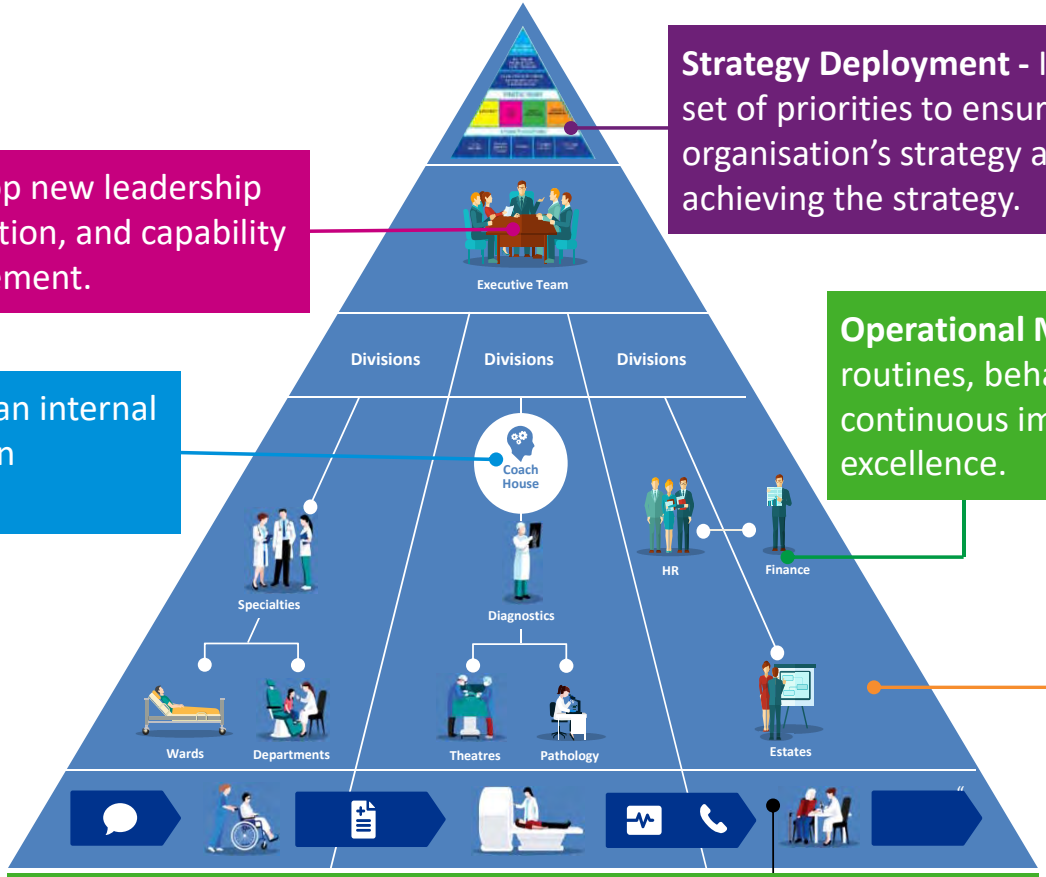
Building a culture of continuous improvement

Strategy Deployment - Identify and communicate a focused set of priorities to ensure the entire staff can align with the organisation's strategy and understand its contribution to achieving the strategy.

Leadership behaviours - Develop new leadership styles at the top of the organisation, and capability to cascade this through management.

Operational Management System – A system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence.

Centre of Excellence - Develop an internal capability to develop and sustain improvement journey



Transformational projects - Using improvement methodology to create step-change improvement

Communication and engagement - Providing an environment that values staff and engages them with the organisation

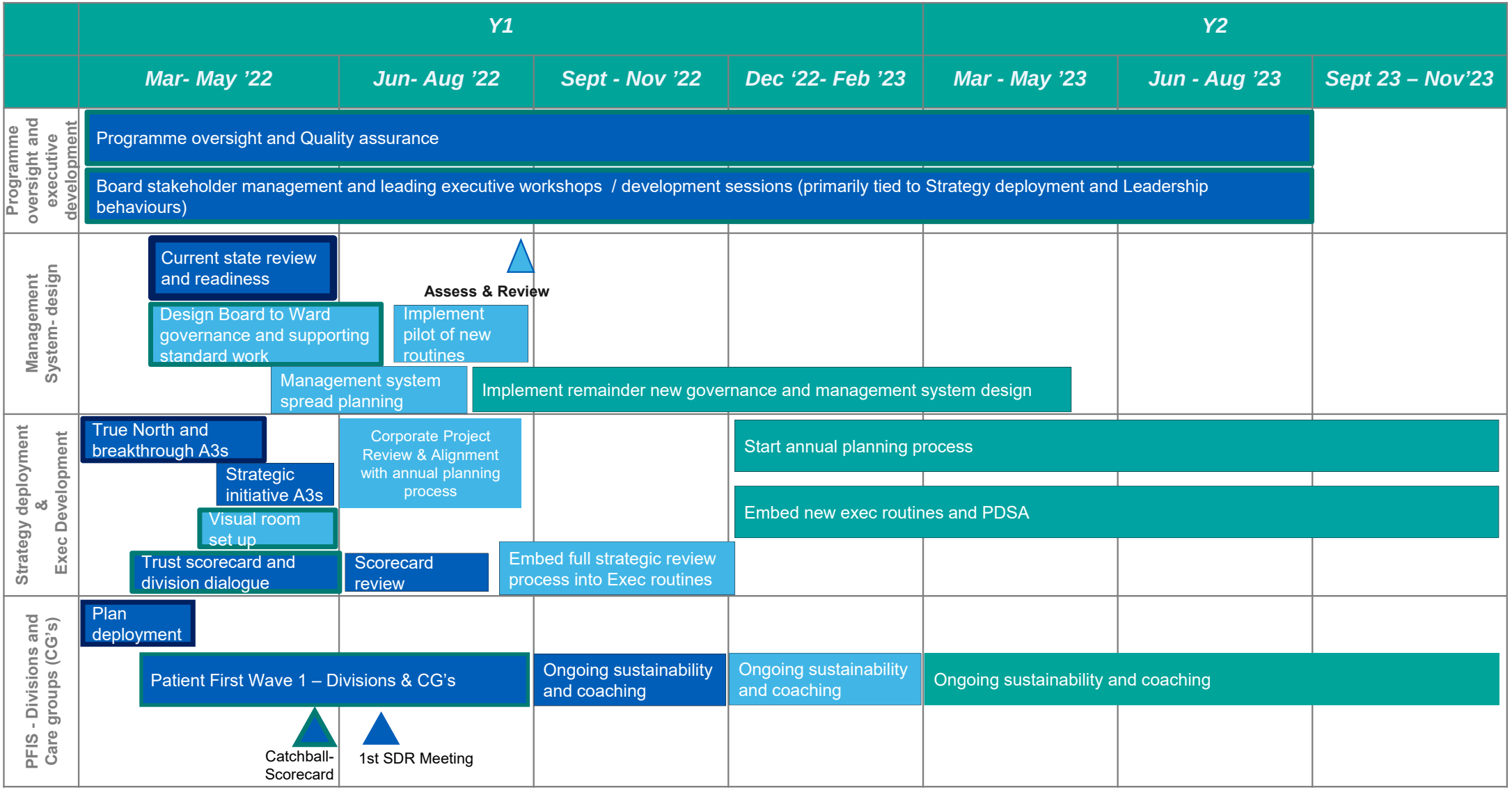
Patient First Health Check

NHS Medway NHS Foundation Trust

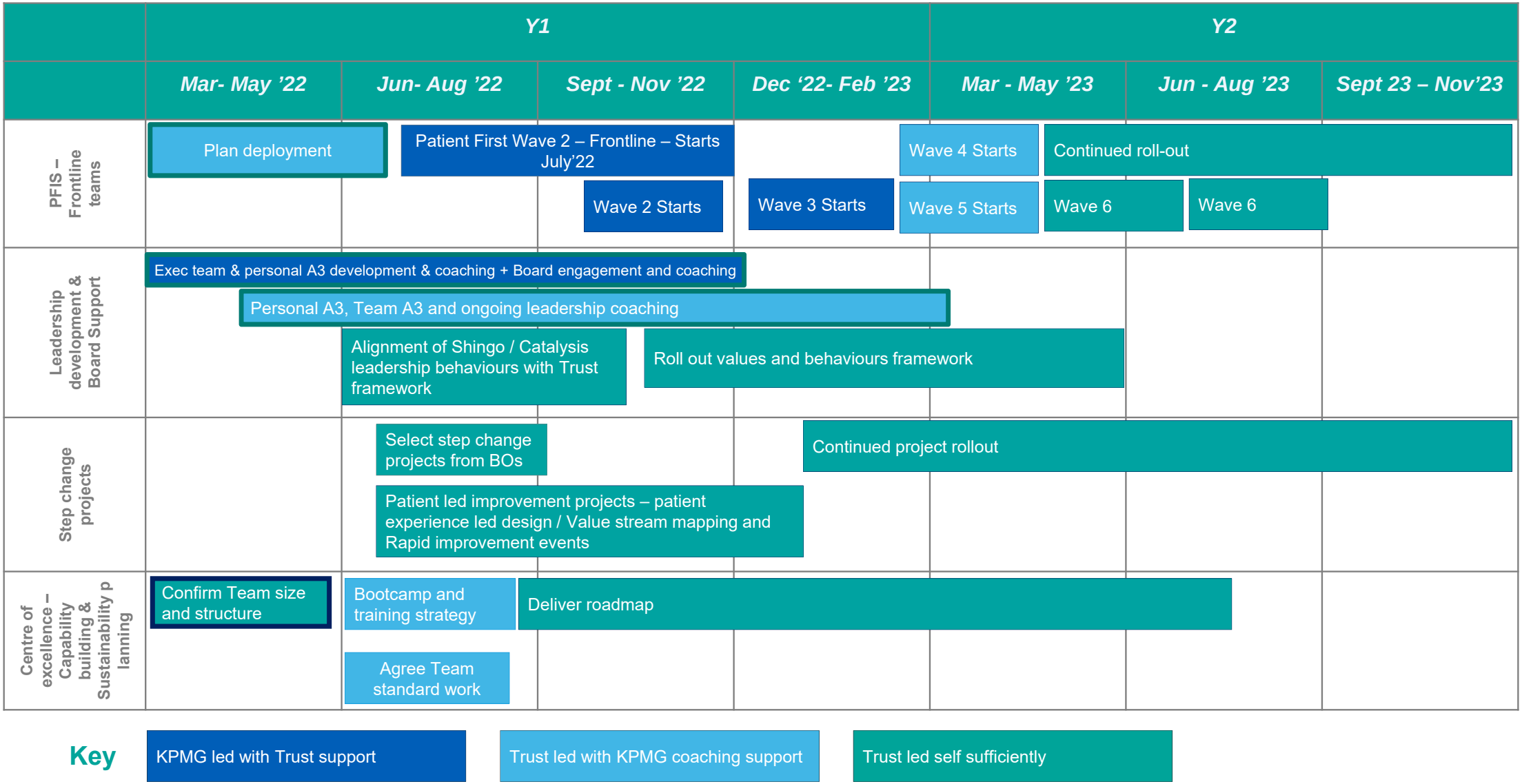
Phase(s): Strategic Deployment and Exec Development / Management System design / PFIS Divisions and Care Groups

Progress against Plan	• on track
Budget	• on track
Risks/Issues for escalation	• on track

MFT – Patient First Roadmap(1/2)



MFT – Patient First Roadmap(2/2)



Where are we with Patient First?

- Year 1 Breakthrough objectives have been agreed and targets have been largely finalised.
- Divisional leadership teams have agreed their metrics (Scorecards) to define and measure progress against the breakthrough objectives. Discussion and agreement sessions with Execs are taking place as we speak and will be finalised on 10th June.
- The first two module workshops have been held to introduce the Patient First Improvement System to Divisions and Care Group Leaders. We are now preparing for Frontline deployment in July;
- Management System design is underway and all current state reviews have been completed with Executive colleagues;
- The Strategy Deployment Hub has been established within the Executive area in preparation for the first Strategy Deployment Review (SDR) on 22nd June
- Centre of Excellence established and recruitment is now complete. The Centre of Excellence Hub will be ready for use at the end of June;
- Breakthrough A3's (structured problem solving approach) have commenced with Execs;

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GLOSSARY:

Your guide to the language of Patient First

Patient FIRST

Introduction

Patient First is the Trust's long-term approach to transform our services and enable us to provide excellent care every time.

The Patient First approach is centred around developing a culture of continuous improvement led by frontline staff empowered to initiate and lead positive change. It ensures that we are all focused on the same clear priorities that will make the greatest difference to the care we give our patients.

Patient First has specific terminology that you will hear frequently.

This guide has been produced to support your learning and understanding of Patient First at the start and throughout your journey.

You can use it to find out the meaning of a phrase or term that you are not familiar with in the context of Patient First.

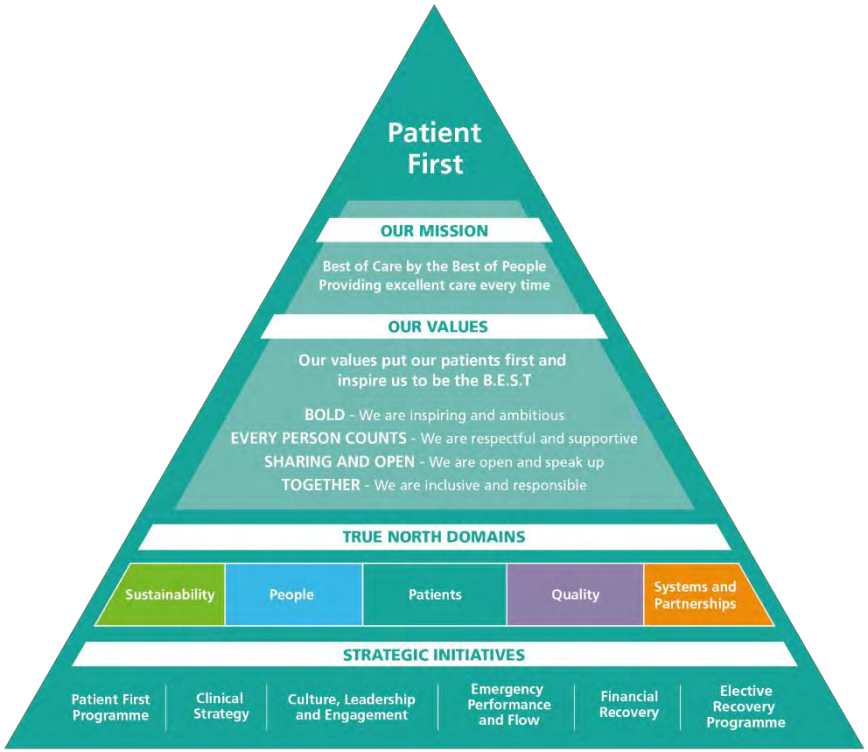
At a glance

These are the terms you are most likely to hear when talking about Patient First – explanations are on the following pages.

True North **Breakthrough Objectives** **Strategic Initiatives** **Corporate Projects**	**Performance Boards** **Improvement Boards** **Visual Management**
Strategic Deployment Review **Weekly Driver Meetings** **Daily Huddle** **Leader Standard Work** **Standard Work**	**Strategy Deployment** **Gemba 'Go and See'** **Catchball** **Scorecards** **Status Exchange** **A3** **Countermeasure Summary**

The Patient First triangle

We use the Patient First Triangle to explain how the approach works.



Key definitions:

True North: Describes our shared purpose to “Put our Patients First” through our mission of “providing excellent care every time” through “the best of people”. This describes what we should all be continually striving towards and is our long-term aspiration.

Our values: A statement of the healthcare provider we want to be and of the way we work together.

True North domains: The five areas that make up True North. The domains describe the key goals of the Trust, by which we know we would be providing excellent care in a sustainable way.

True North metrics: These are derived from the True North domains. They are outcome-focused measures we aim to achieve within the next three to five years and will help ensure that we are working towards our True North. The Trust has seven in total, balanced across the True North domains.

Breakthrough objectives: These are a set of objectives, derived from evidence-based analysis, that warrant most in-year improvement focus. They are typically achieved within 12 months, and are delivered by frontline teams, supported by senior management. The Trust has five breakthrough objectives.

Strategic initiatives: These are **l**ong-term transformational initiatives, likely to be enabling in nature – truly ‘must do, can’t fail.’ They enable long-term organisational sustainability and cut across multiple True North domains. They may take one to three years to achieve and are led by the Executive team. The Trust has six Strategic Initiatives, including the Patient First programme itself.

Corporate projects: These are Task and Finish Projects derived directly from strategic initiatives and breakthrough objectives, also statutory or regulatory mandates. They may take up to 18 months to achieve and are led with central oversight, delivered by corporate resources. The Trust currently has five Corporate Projects.

THE GLOSSARY

Your guide to phrases and terms used in Patient First, listed alphabetically

Phrase / term	Meaning
A3	A common structured problem-solving approach. The A3 format tells the whole story on one page (and A3 sheet) and serves as an excellent communication tool. Used as a reporting tool within the Patient First improvement system.
Business Rule	Business Rules provide guidelines concerning how scorecard items should be dealt with in strategy deployment meetings.
Catchball/scorecard agreement	Meaningful communication between two or more people. The purpose of Catchball is to reach agreement on Watch Metrics, tolerance levels, driver targets, 'how much by when' metrics not currently on scorecard and projects not currently listed as a corporate project or improvement project.
Countermeasure Summary (CMS)	A reporting tool within the Patient First improvement system. It is designed to report on under-performance within the performance meetings, and to briefly articulate a problem solving approach and progress (from an A3). It refers to the way a proposed action directly addresses a root cause. CMS communicates progress on driver metrics and is a working document in the Strategic Deployment Review. It includes a problem statement and four quadrants that communicate progress against the metric trend, current state, root cause analysis and countermeasures.
Driver Lane	Visual management tool displayed on the Performance Board, which breaks down the driver metric into four different sections; historical data, weekly/daily data/stratified data, root causes and Plan, Do, Study, Act (PDSA). The Driver Lane is discussed every day at the frontline improvement huddle and in more detail at Weekly Driver Meetings. The structure of a Driver Lane is the same as the structure of an A3 summary.
Driver Metric	Measures and targets that a division, ward or department chooses to focus on to drive improvements. Driver metrics are so called because they drive improvement to achieve the target for example : 'reduce 30 day admissions by 50 per cent ' or 'eliminate all avoidable surgical site infections.' Driver metrics are selected as areas that have the highest impact on True North.

Fishbone	The fishbone diagram is typically used in the Root Cause section of an A3. It is a quality tool that can be used to structure a brainstorming session aiming to identify the potential causes for an effect or a problem.
Gemba 'Go and See'	Gemba is a Japanese term meaning "the real or actual place." The main idea of the Gemba is the managers and leaders on every level take regular walks around the place where work is done and value is created for the patient, and respect workers by asking open-ended questions and seeking their inputs. A 'Gemba walk' connects the management to the frontline – the 'Board to Ward'. It's all about observing, engaging and improving.
Improvement Huddle	Short (10-15 minutes) daily, predominantly standing meetings involving all and any staff in a service team for staff to identify, prioritise and action daily improvement ideas linked to set priorities. Both Performance and Improvement Boards can be used as part of the Improvement Huddle.
Improvement Boards	A visual tool to track daily improvement activity. 1) Improvement activities will be identified when discussing the Driver Metric(s) on the Performance Board. 2) Daily operational activities can be identified in the huddles, morning handovers and ward rounds.
Leader Standard Work (LSW)	A tool within the Patient First improvement system used to set out the standard expectations of a leader and associated management best practices. Focus is on how we learn from behaviours, and how and what we spend our time on. A high-level schedule of daily activities to be completed in sequence by a leader in the Trust.
Metrics	Measurement of a ward or department's activities and performance against agreed standards.
Patient First Improvement System (PFIS)	A system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence.

Patient First Improvement System - Divisions	A way of working that enables the skills and techniques of the improvement system to be applied routinely across the Divisions. Key elements are: • To cascade the organisational priorities to Divisions and then frontline ensuring everyone understands their contribution • Embedding a new performance framework • A focus on problem-solving at Division and Care Group level, rather than waiting for solutions to be imposed from above Embedding coaching behaviours to help support and develop colleagues.
Patient First Improvement System - Frontline	A way of working that enables the skills and techniques of the improvement system to be applied as part of the individual wards, departments' and service area's daily work and routines. Key elements are: • A focus on problem-solving at a team, ward or department/service area level, rather than waiting for solutions to be imposed from above • Concentration on the 'True North' of the Trust's strategic initiatives and ensuring everyone understands their contribution • The use of visual management tools that allow us to see and track improvement areas for our key priorities at a glance
Performance Boards	A physical board that includes charts and graphs to document performance over time of key metrics. Typically, the board will also include a visual tracking system to collect, prioritise and track the implementation of improvement ideas.
P.I.C.K Chart	A visual tool with four quadrants: • Prioritise (usually quick wins) • Investigate (Plan, Do, Study, Act tickets) • Check (could the problem be broken down in more manageable chunks) and • Kibosh (do not implement unless no other improvement ideas). It is used in the Improvement Huddle and helps staff prioritise improvement tickets.
Plan, Do, Study, Act (PDSA)	Plan, Do, Study, Act describes the ongoing cycle of improvement. It is a structured problem solving approach and can be used to test different solutions:

	Plan: Plan the change to be implemented **Do:** Carry out the test or change **Study:** Use before and after data to measure change, reflect on the impact and what was learnt **Act:** React to the insights gained and plan the next change cycle or full implementation
Root cause analysis	A method of problem solving used for identifying the root causes of faults or problems. A Fishbone diagram, pareto charts and 5 why's are some of the tools used to facilitate and arrive at potential root causes – typically seen as a section in the A3.
Run Charts	A graphical display of data plotted as a line over time. It is used to understand how a metric changes over time. Used on Performance Boards as a visual management tool.
Scorecards	A visual tool within the Patient First improvement system comprised of a balanced set of Key Performance Indicators (KPIs) at Executive, Division/Corporate areas, Care Group, specialty and departmental/service area level that have come directly from True North metrics. The scorecard is made up of metrics that have been chosen for improvement and that are being monitored to ensure performance is maintained.
Standard Work	A tool within the Patient First improvement system to describe and implement the best way to do a process. A written set of step-by-step instructions for completing a task using the best-known methods. Examples include 'Standing orders', 'standard operating procedures' and' NeverEvents.
Status Exchange (Structured 1:1)	A regular structured conversation between a leader and team member. It lasts between 10 and 30 minutes depending on the frequency and uses a single page of focused questions to guide the dialogue to enable proactive planning and assist with removing and mitigating risk. Most questions are linked with True North and are open-ended questions to promote a coaching discussion. There is a linked chain of conversations up to the Exec team to enable knowledge sharing. Examples would be Nurse in Charge and Ward Manager (daily), Ward Manager and Service Manager (weekly) Service Manager and the Divisional Director (fortnightly). Divisional Director and Chief Operating Officer (Monthly).

Strategic Deployment	The sequence of steps followed to ensure that an effective strategy can be implemented through the Trust, ensuring projects, activities, processes and goals are aligned. This cascade gives a clear line of sight for individuals across the Trust, connecting what they do to what the Trust aims to achieve – sometimes referred to as 'The Golden Thread.'
Strategic Deployment Reviews (SDR)	Meetings to review the division's or frontline's scorecard, focusing on the progress of the Driver Metrics and projects that contribute to achieving the Trust's strategy.
Strategic Filter	A tool to support the alignment and prioritisation of new projects being selected.
Strategic Planning Framework	A framework that describes how the True North metrics, strategic initiatives, breakthrough objectives and corporate projects are aligned.
Tolerance level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits. A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level, the Divisions will continue watching the metric.
Watch Metric	Agreed metrics that will be monitored monthly. Using our Business Rules, we will watch for adverse trends in performance, at which time we may decide to actively work to improve it.
Weekly Driver Meetings	Meetings to review the Division/Corporate areas, Care Group, specialty and departmental/service area level's operational drivers that contribute to achieving the strategy (using the Performance Board to discuss each Driver). Driver meetings also enable efficient information flow. They are a way of checking progress against plan.

Meeting of the Board of Directors in Public
Wednesday, 08 June 2022

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.1
Report Author	Alison Davis – Chief Medical Officer Jayne Black – Chief Operating Officer Alan Davies – Chief Financial Officer Leon Hinton – Chief People Officer		
Lead Director	Paula Tinniswood, Chief Strategy & Transformation Officer		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators for the April 2022 reporting period. **Safe** Our Infection Prevention and Control performance for April shows that the Trust is reporting 1 MRSA bacteraemia cases and 3 hospital acquired C-diff cases. **Caring** MSA continues on a downward trajectory with 65 breaches recorded (against 162 in March reporting period). The Friends and Family recommended rates for two areas remain above the national standard of 85% for this reporting period for Outpatients (89.3%) and Maternity (100%) whilst two areas remain below the national standard, Inpatients (73.7%) and ED (70.9%). **Effective** Discharges before Noon, have decreased since last reporting period sitting at 16.9% but still lower than optimal. We continue to work on achieving a significant improvement on this and have confirmed this required improvement as one of our Patient First Breakthrough Objectives (40% of discharges prior to midday). **Responsive** The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In April the RTT standard was 62.3% (unchanged) and the Trust recorded 162 52 week breaches (no change from previous reporting period) ED (Type 1) 4 hour performance has reduced since last reporting period moving to 58.6%. Additionally, the Trust saw a decrease in Ambulance Handover delays of +60mins decreasing to 161. The DM01 Diagnostics performance decreased slightly to 78.1%. We also see a continued improvement in 2 week waits on the cancer pathway, with 96.7% of patients seen within 2 weeks of their referrals into the cancer pathways. **Well Led** Whilst a slight drop on last reporting period, we continue to see a stable position in appraisal rates, reporting 81% and the Trust has maintained		

	compliance statutory and mandatory training at 85% in this reporting period.			
Resource Implications	None			
Legal Implications/Regulatory Requirements	All indicators are monitored by CQC.			
Quality Impact Assessment	Not required.			
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.			
	Approval ☒	**Assurance** ☒	**Discussion** ☒	**Noting** ☒
Appendices	Appendix 1 – IQPR April 2022			

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: April 2022

What is Statistical Process Control (SPC)?

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

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

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

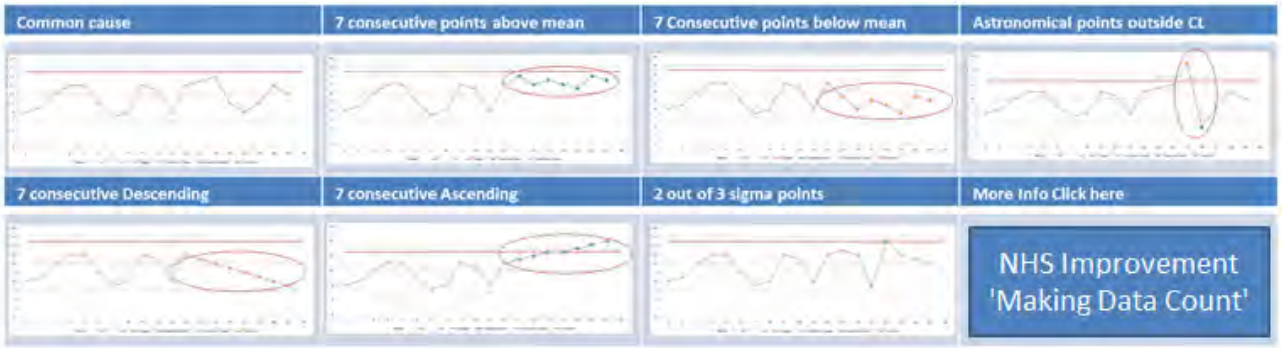
Key Facts about a SPC Chart:

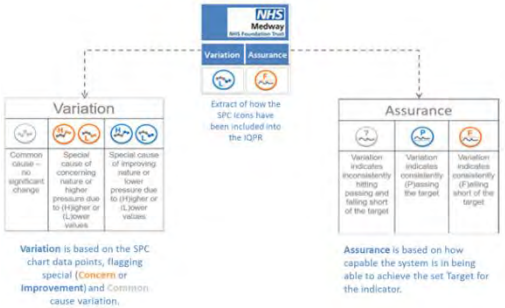
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

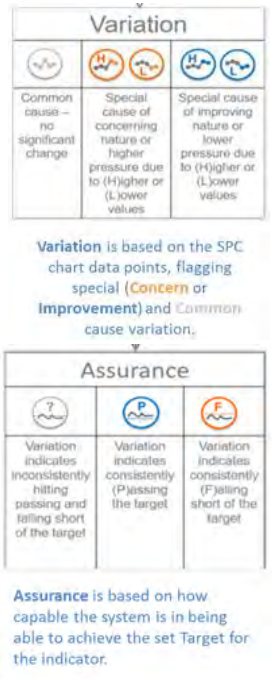
Contains a mean (the average), **lower and upper confidence levels**. 99% of all data will fall between the lower and upper confidence levels. If a data point falls outside these levels, an investigation would be triggered.

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

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







NHS
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Topic	Overview	Deep Dive
Executive Summary	4	5
Caring	7	8
Effective	13	14
Safe	18	19
Responsive	13	25
Well Led	38	39

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Cancer & Patient Flow improvement	• RTT & Emergency Pathways
Caring	• Both Maternity & Outpatients FFT % Recommended is over target • The number of Complaints received is consistently achieving under plan	• High number of breaches in Mixed Sex Accommodation continues • % Complaints responded to within target has declined • Inpatient & ED FFT scores are showing sign of decline
Effective	• Discharges before Noon showing high statistical variation, and signs of improvement • 30 Day Readmission Rate showing improved statistical variation	• High statistical variance in C-Section rates evidenced • Fractured NOF significantly below target
Safe	• PU Incidence continuously passes (achieves under) the target set • Falls per 1,000 Bed Days under target • Both HSMR and SHMI have all shown a statistically significant improvement	• 1 reported Never Event in month • E-Coli cases are above plan YTD and in month
Responsive	• Cancer Pathways continue to show improvement • DToC levels & Elective LoS show continued signs of improvement	• ED % Target has declined together with number of 12hr breaches increasing • RTT Incomplete Performance decreased • Bed Occupancy showing high statistical variance
Well Led	• Maintained compliance with Trust target for StatMan Compliance YTD • Agency staff spend is below plan	• Turnover Rate shows an increase in statistical variance • Bank spend has increased considerably • Sickness Rates have shown a statistically significant increase

Executive Summary

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

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
S1	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	3	2	43	59		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	3	0			
S3	MRSA Bacteraemia (Trust Attributable)	0	0	5			
S4	E-coli (Trust Acquired) Infections	2	6	30			
S5	Falls Per 1000 Bed Days	6.63	5.37	6.63			
S6	Pressure Ulcer Incidence Per 1000 days (High Harm)	1.04	0	1.04			
S7	Never Events	0	1	0			
S8	% of SIs Responded To In 60 Days	100.0%	100.0 %	100.0%			
S9	HSMR (All)	100	94.48	100	0.98		
S10	HSMR (Weekday)	100	91.41	100	0.95		
S11	HSMR (Weekend)	100	103.72	100	1.06		
S12	SHMI	1	1.04	-	21.08		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	65	0	2,678		
C2	Number of Complaints	41	37	-			
C3	% Complaints Responded to Within 30 Days	85.0%	27.0%	85.0%			
C4	% of EDNs Completed Within 24hrs	100.0%	71.2%	100.0%	68.7%		
C5	Inpatients Friends & Family Response Rate	22.0%	19.0%	22.0%	18.7%		
C6	Inpatients Friends & Family % Recommended	85.0%	73.7%	85.0%	79.5%		
C7	ED Friends & Family Response Rate	22.0%	14.3%	22.0%	14.6%		
C8	ED Friends & Family % Recommended	85.0%	70.9%	85.0%	79.8%		
C9	Maternity Friends & Family Response Rate	22.0%	18.0%	22.0%	25.5%		
C10	Maternity Friends & Family % Recommended	85.0%	100.0 %	85.0%	99.7%		
C11	Outpatients Friends & Family Response Rate	22.0%	6.7%	22.0%	9.6%		
C12	Outpatients Friends & Family % Recommended	85.0%	89.3%	85.0%	89.0%		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R1	Bed Occupancy Rate	85.0%	88.9%	85.0%	83.7%		
R2	Average Non-Elective Length of Stay	5	9.66	5	8.52		
R3	Average Elective Length of Stay	5	2.82	5	2.29		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	0.0%	4.0%	0.7%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	15.9%	7.0%	12.7%		
R6	ED 4 Hour Performance All Types	95.0%	70.6%	95.0%	79.0%		
R7	ED 4 Hour Performance Type 1	95.0%	58.6%	95.0%	69.5%		
R8	ED 12 hour DTA Breaches	0	84	0	822		
R9	Number of ED arrivals by Ambulance	-	3,085	-	80,108		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	4.8%	5.0%	6.4%		
E2	30 Day Readmission Rate	10.0%	10.5%	10.0%	12.5%		
E3	Discharges Before Noon	25.0%	16.9%	25.0%	16.4%		
E4	Fractured NOF Within 36 Hours	100.0%	68.2%	100.0%	68.6%		
E5	VTE Risk Assessment % Completed	95.0%	93.6%	95.0%	95.1%		
E6	Elective C-Section Rate	13.0%	15.8%	13.0%	14.7%		
E7	Total C-Section Rate	28.0%	40.6%	28.0%	38.0%		
E8	Emergency C-Section Rate	15.0%	24.8%	15.0%	23.3%		
E9	12+6 Risk Assessment	90.0%	77.9%	90.0%	84.8%		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	78.1%	99.0%	79.7%		
R12	18 Weeks RTT Incomplete Performance	92.0%	62.3%	92.0%	64.8%		
R13	18 Weeks RTT Over 52 Week Breaches	0	162	0	5,241		
R14	Operations Cancelled By Hospital on Day	0	10	0	296		
R15	Cancelled Operations Not Rescheduled < 28 days	0	0	0	48		
R16	Cancer 2ww Performance	93.0%	96.7%	93.0%	95.9%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	93.2%	93.0%	91.7%		
R18	Cancer 31 Day First Treatment Performance	96.0%	100.0 %	96.0%	97.4%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	88.7%	85.0%	75.9%		
R20	104 Day Cancer Waits	0	3	-	60		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	81.0%	-	83.6%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	4.7%	4.0%	5.0%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	15.7%	12.0%	12.8%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	84.3%	85.0%	88.8%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,354.90	-	104,496.20		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	3.3%	4.0%	2.8%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	14.0%	9.0%	13.0%		

Domain: Caring Dashboard

Executive Lead: Evonne Hunt–Chief Nursing Officer
Operational Lead: N/A
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

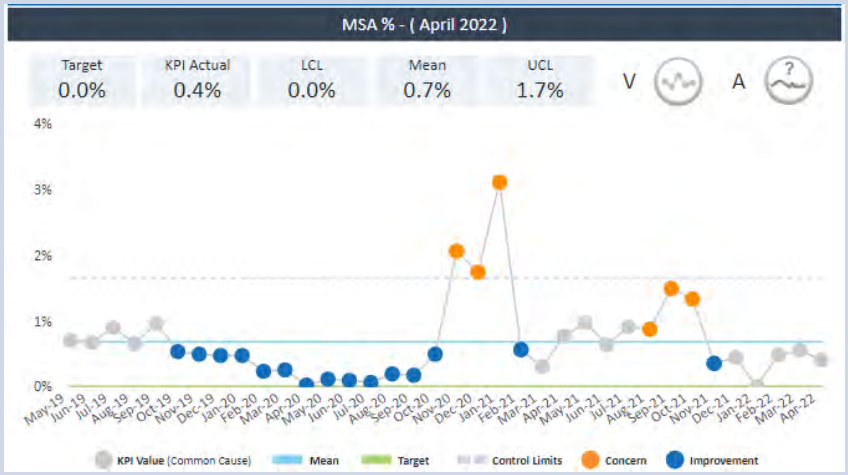
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Apr-22	100.0%	71.2%	63.8%	70.1%	76.4%		
		Inpatients Friends & Family % Recommended	Apr-22	85.0%	73.7%	74.8%	81.6%	88.4%		
		Inpatients Friends & Family Response Rate	Apr-22	22.0%	19.0%	15.8%	19.3%	22.9%		
		Mixed Sex Accommodation Breaches	Apr-22	0	65	0	100.86	230.52		
		MSA %	Apr-22	0.0%	0.4%	0.0%	0.7%	1.7%		
	ED Care	ED Friends & Family % Recommended	Apr-22	85.0%	70.9%	70.4%	79.5%	88.6%		
		ED Friends & Family Response Rate	Apr-22	22.0%	14.3%	12.4%	14.6%	16.8%		
	Maternity Care	Maternity Friends & Family % Recommended	Apr-22	85.0%	100.0%	98.8%	99.6%	100.5%		
		Maternity Friends & Family Response Rate	Apr-22	22.0%	18.0%	7.6%	23.5%	39.5%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Apr-22	85.0%	89.3%	87.5%	89.7%	91.9%		
		Outpatients Friends & Family Response Rate	Apr-22	22.0%	6.7%	9.6%	11.3%	13.0%		

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Mixed Sex Accommodation Breaches



Outcome Measure: Mixed Sex Accommodation Breaches By Ward

Ward	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Arethusa/SAU														18	
Bronte					4	7		14				4		6	
Critical Care Unit															
Dolphin Ward		2			4	4	2			1					
Emerald Assessment Unit														19	
Emerald Short Stay Ward														2	
Intensive Care Unit	6		18	20	11	3	6	1	5	2	2	8	12	1	7
McCulloch Ward		6	7	7		19		3	15			1			
Harvey Ward															
Jade Ward									4	4		12			8
Keats Ward	2				3			14						3	
Lawrence Ward				2			2	7							
Lister Assessment Unit	16			12	16	43		34	22					40	
Nelson Ward	11	5	24	8		6		5	10						
Ocelot								29	32	1		5			
Pembroke Ward						7	15								
Phoenix Ward	19	7													
Pre Op Care Unit	2	11													
Sapphire Ward				2	9	3	57	25	24						
SDEC					2	2									
Sunderland Day Case Centre								5	19						
Surgical Assessment Unit					12		7	20					3		
Theatre Intensive Care Unit	1														
Trafalgar Ward SHDU	11	19	55	45	47	46	33	86	65	46	69	74	60	73	50
Tennyson Ward															
Wakeley					1		5								
Victory							6								
Will Adams	4			7		3		8		4					
Totals	72	50	104	103	109	143	133	251	196	58	71	104	75	162	65

What do the outcome measures show?

Bed availability and patient flow has been challenging as expected due to winter pressure and SARS2 pandemic demand.

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

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

What changes have been implemented and improvements made?

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

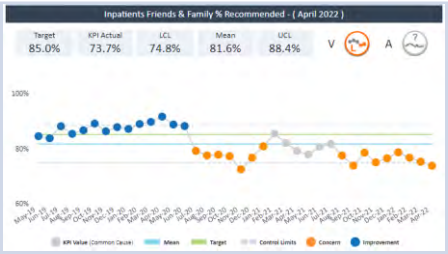
Collaborative working within the divisions, site team and the IPC team and utilising the Trust winter plan / surge plan has ensured patient safety and dignity during this process and has minimised the unjustified mixed sex accommodation breach outside of Covid management and assessment areas in the Trust.

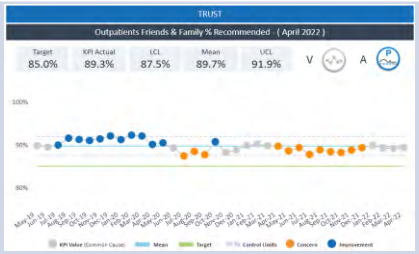
Patient Centred: IP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: April 2022

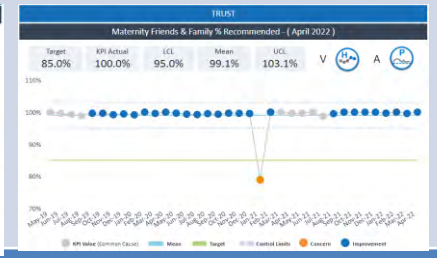
Executive Lead: Evonne Hunt
Operational Lead: Heidi Jeffrey
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Inpatient Friends & Family % Recommended



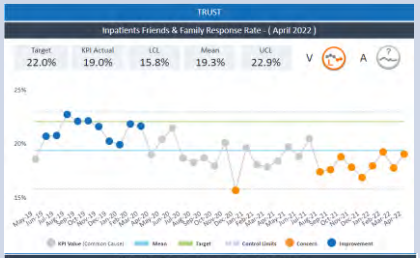


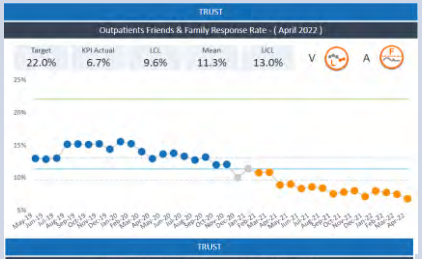


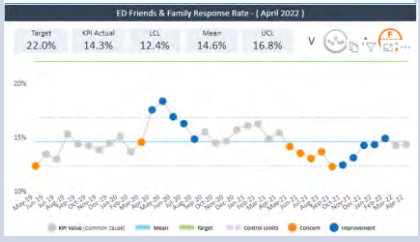
What changes have been implemented and improvements made?

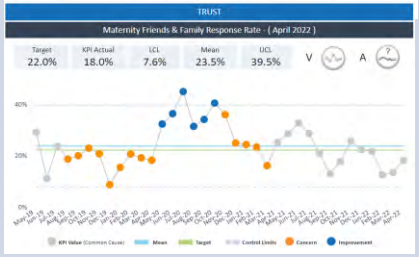
The inpatient recommend rate continues to fall below the Trust target of 85%. 100% of women and birthing people recommend our service.
Plans are progressing to add patient feedback onto the Gthr platform and additional questions have been written to gain a better understanding why patients recommend us to endorse good practice, and also why they might not recommend us to prioritise the poor aspects of their experience.
The Trust has agreed, under patient first, the true north objective is that 95% of patients would recommend us and are satisfied they have received very good or a good experience. As part of this, there has been a review into the methods of collecting feedback from patients. It is proposed that wards/departments will be using tablet computers with the support of volunteers as part of the discharge process. This will also provide the Trust with real-time data to make improvements.

Outcome Measure: Inpatient Friends & Family % Response Rate









What changes have been implemented and improvements made?

The inpatient response rate has increased slightly from last month but remains below the Trust target of 22%. The Trust is committed to gaining feedback from patients about their experience and it is hoped that the face to face engagement when using the questions to patients who are waiting for discharge will increase the amount of feedback we receive and improve the response rate.

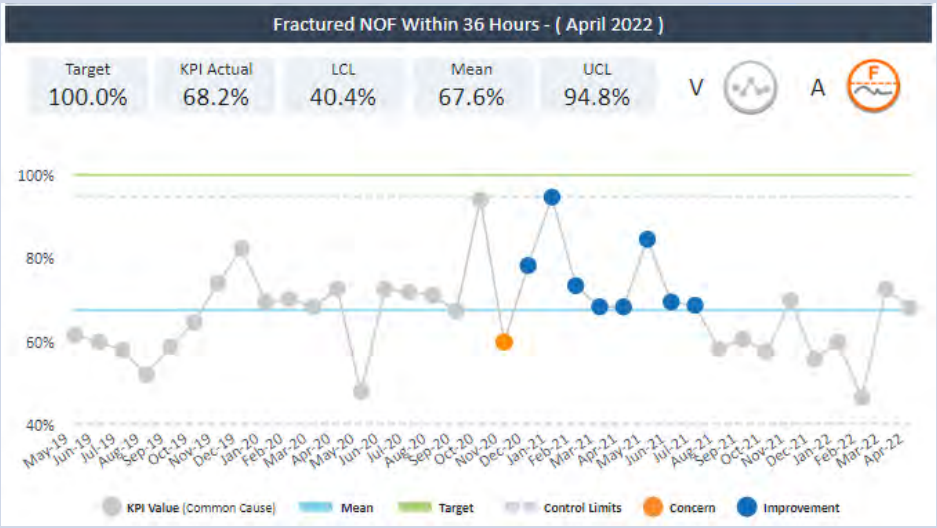
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Mar-22	10.0%	10.5%	9.7%	12.2%	14.8%		
		7 Day Readmission Rate	Mar-22	5.0%	4.8%	4.4%	6.3%	8.3%		
		Discharges Before Noon	Apr-22	25.0%	16.9%	12.8%	15.8%	18.8%		
		Fractured NOF Within 36 Hours	Apr-22	100.0%	68.2%	40.4%	67.6%	94.8%		
		VTE Risk Assessment % Completed	Apr-22	95.0%	93.6%	91.6%	95.0%	98.4%		
	Maternity	12+6 Risk Assessment	Jan-22	90.0%	77.9%	78.8%	84.2%	89.6%		
		Elective C-Section Rate	Apr-22	13.0%	15.8%	10.3%	14.4%	18.5%		
		Emergency C-Section Rate	Apr-22	15.0%	24.8%	16.4%	21.9%	27.5%		
		Total C-Section Rate	Apr-22	28.0%	40.6%	30.3%	36.4%	42.4%		

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

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

NHS Medway NHS Foundation Trust

Process Measure: Fractured NOF Within 36 Hours



What do the outcome measures show?

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

What changes have been implemented and improvements made?

Reinvigoration of the hip fracture pathway with multidisciplinary meeting occurred on 22nd April to establish solutions to existing barriers, with an acute awareness around unintended consequences – this working group continues to meet regularly.

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: VTE Risk Assessments Completed

What does the measure show?

The venous thromboembolism (VTE) risk assessment data collection is used to inform a national quality requirement in the NHS Standard Contract, which sets an operational standard of 95% of inpatients (aged 16 and over at the time of admission). undergoing risk assessments each month.
The VTE assessment was 93.6% and is an improvement compared to March 2022.
Work is ongoing to validate data for preceding months in order to ensure that all completed VTE assessments are entered in a timely manner onto PAS.
However, for VTE risk assessment our Trust's performance is above national average.

What changes have been implemented and improvements made?

- In order to support ward sisters VTE risk assessment is monitored via daily board rounds as standard work.
- A global message has been agreed with heads of nursing and distributed on the wards to share responsibility between nurses to check VTE Risk assessments during drug rounds and to remind doctors to complete it when needed.
- Additional support re the completion of VTE assessments ahs been provided for overseas nurses by the Trust VTE nurse.
- Regular VTE risk assessment compliance reports are sent to individual care groups
- VTE risk assessment has been raised with the divisional leadership teams

Effective: Maternity

Aim: TBC – Currently Under Development

Latest Period: April 2022

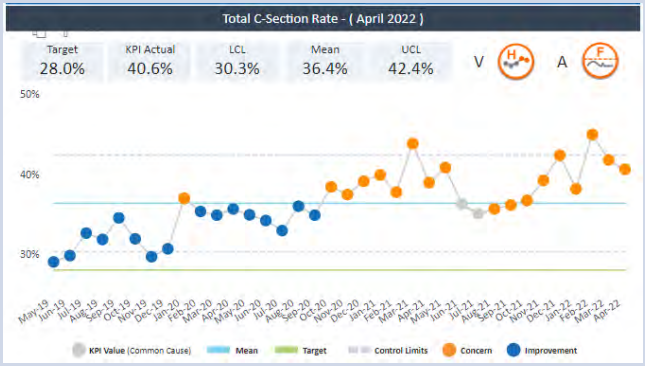
Executive Lead: Evonne Hunt

Operational Lead: Katherine Harris

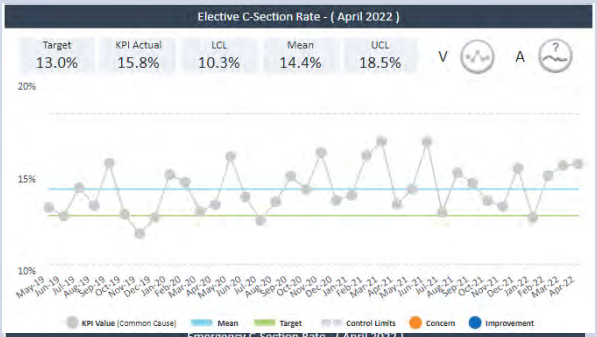
Sub Groups: Quality Assurance Committee

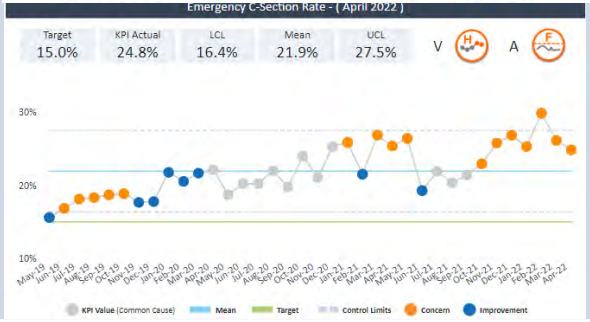
NHS Medway NHS Foundation Trust

Outcome Measure: Total Elective & Emergency C-Section Rate



Outcome Measure: Elective and Emergency C-Section Rate





What does the measure show?

- The Caesarean section rate has decreased slightly from last month 42% to 40.6% which is just below the upper confidence level.
- The total caesarean rate is influenced by an increase in both emergency and elective rates.
- Robson Group 2a (Nulliparous, singleton, cephalic, ≥37 weeks' gestation, induced labour) are the highest contributors to the Caesarean rate. Key audit focus will be in this area.

What changes have been implemented and improvements made?

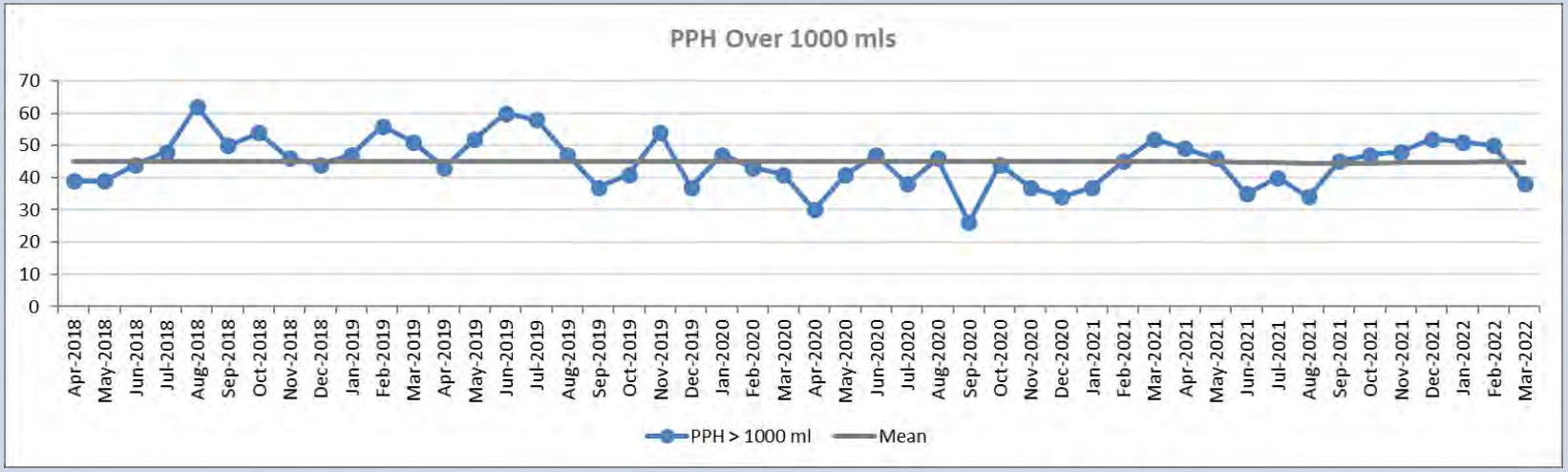
The daily caesarean section audit continues and will be reported next month
There is improved Consultant presence on delivery suite
Final Ockenden report published with recommendations to be mindful about terminology and communication used with service users. Gap analysis has been completed and is being discussed at the June Board.

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: PPH Over 1000 mls



What changes have been implemented and improvements made?

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

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

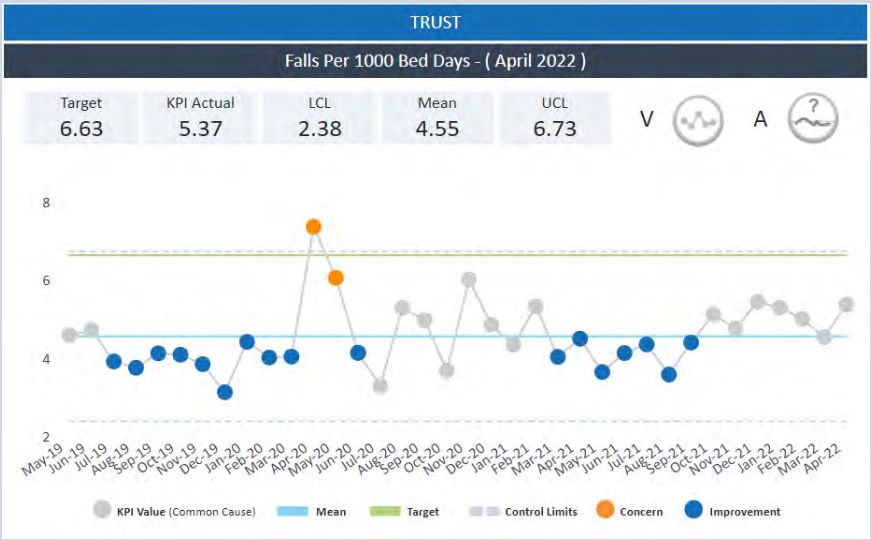
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Apr-22	6.63	5.37	2.38	4.55	6.73		
		Pressure Ulcer Incidence Per 1000 days (High Harm)	Apr-22	1.04	0	0	0	0.03		
	Incident Reporting	% of SIs Responded To In 60 Days	Apr-22		100.0%	7.6%	63.1%	118.6%		
		Never Events	Apr-22	0	1	0	0.22	1.06		
		No of SIs on STEIS	Apr-22	90	2	0	14.61	32.17		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Feb-22	3 [43]	2	0	2.59	8.55		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Apr-22		3	0	2.22	6.62		
		E-coli (Trust Acquired) Infections	Apr-22	0	6	0	3.26	7.01		
		MRSA Bacteraemia (Trust Attributable)	Apr-22	0	0	0	0.03	0.18		
	Mortality	Crude Mortality Rate	Mar-22	2.5%	1.4%	0.4%	1.9%	3.4%		
		HSMR (All)	Jan-22	100	94.48	94.42	98.77	103.11		
		HSMR (Weekday)	Jan-22	100	91.41		95.27			
		HSMR (Weekend)	Jan-22	100	103.72		108.54			
		SHMI	Nov-21	1	1.04	1.05	1.07	1.10		

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

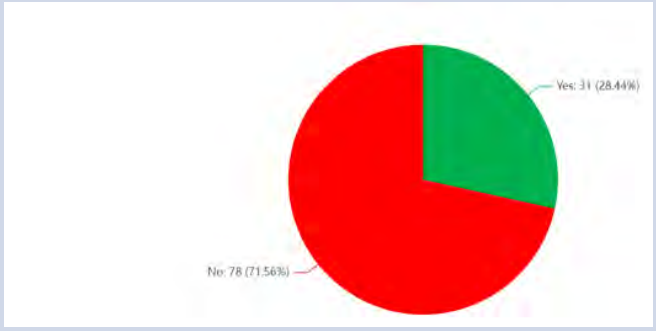
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days



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



What do the outcome measures show?

70% of falls occurred in Unplanned care (size of division and specialties and additional escalation beds),
83% of falls were unwitnessed
32% of falls were from the bed (predominantly whilst patient getting out of bed)
12% of falls across the Trust occurred on a Thursday
12% falls across the Trust occurred on a Saturday
The number of patients who have fallen previously on this admission reduced this month from 21- 16.

Month	Total Falls	No and low harm	Moderate harm	Severe harm/ Death
Apr-22	94	92	0	2
Apr- 21	65	64	0	1
Mar- 22	92	91	1	0
Feb- 22	85	80	3	2

What do the process measures show?

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

What changes have been implemented and improvements made?

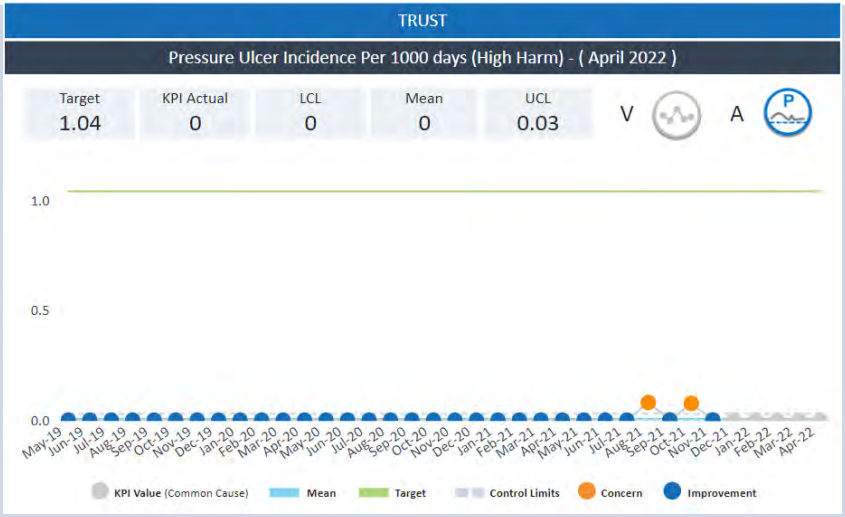
An interrogation of data has been conducted and meetings with ward teams underway to understand emerging themes and trends.
A3 problem solving methodology is being utilised to fully discover root causes in order to identify appropriate solutions and quality improvement plans. This quality improvement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

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

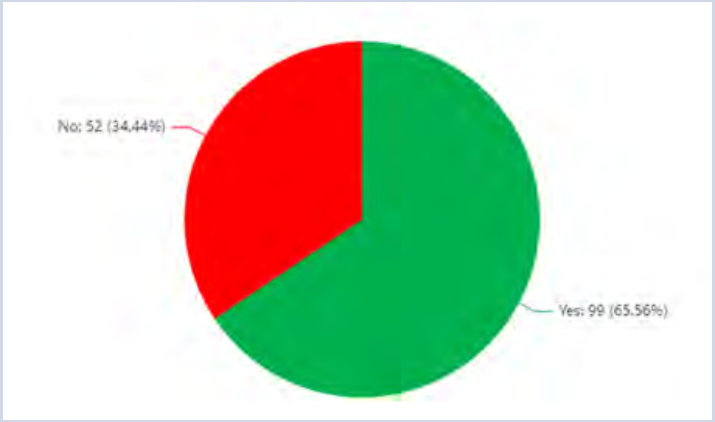
Executive Lead: Evonne Hunt
Operational Lead: Hayley Jones
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

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



Process Measures: ASSKING Bundle Reliability (Pilot Wards)



What do the outcome measures show?

64% of hospital acquired pressure ulcers were within Unplanned care
36% of hospital acquired pressure ulcers were within Planned care
Byron Harvey, Kingfisher, Lawrence, Milton, Pembroke and Wakeley ward 2 or more HAPU's.

Month	Total HAPU	low harm	Moderate harm	Severe harm/ Death
April- 22	25	24	1	
April- 21	10	10		
March- 22	11	11		
Feb- 22	20	20		

Category 2	Category 3	Category 4	DTI	Unstagable	Total
7			8	10	25

What do the process measures show?

The Trust scored 84% in the ASSKING audit in April 2022, with 151 audits completed. This is an increase from 77% in March

What changes have been implemented and improvements made?

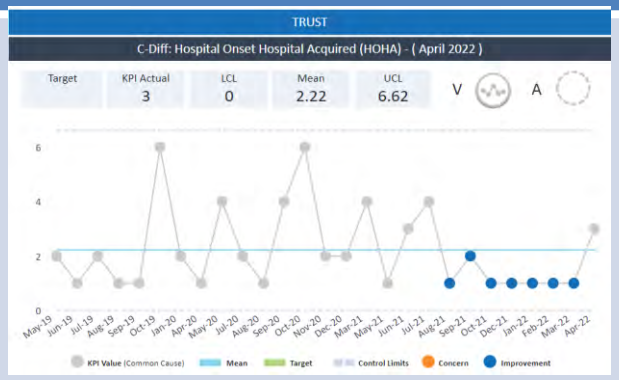
An improvement approach using an A3 problem solving methodology is being utilized across the Trust. Interrogation of data for each ward who acquire more than two pressure ulcer a month underway and will form a deep dive report for each area which will be presented at QAC.
There has been an increase in some elements of the ASSKING care bundle completed, 65% (99) of patients audited in April had all elements completed compared to 49% (71) in March
Re-configuration of the documents on EPR has taken place. The tissue viability team are currently working on providing education to all ward staff to ensure there is a consistent approach with all tissue viability documents on EPR.

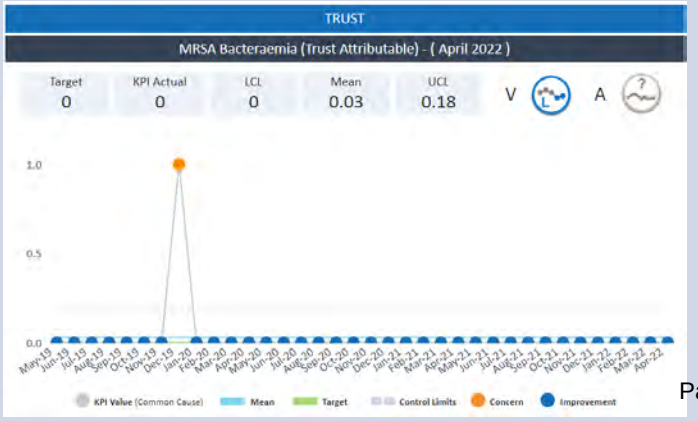
Safe: Improving Infection Control
Aim: Reduction in healthcare acquired infections.
Latest Period: April 2022

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

NHS Medway NHS Foundation Trust

Infection Prevention Control measures





What do the outcome measures show?

The NHS Standard Contract for 22/23 has set new thresholds for minimizing infections for the coming year. This is all healthcare associated infections so HOHA and COHA.
MRSA is not within the contract but there remains a zero tolerance.
MRSA Bacteremia 1 HOHA
C.Difficile rates since 1st April 2022 is 3 HOHAs against a threshold of 34
E.Coli : 7 against a threshold of 77
Klebsiella : 2 against a threshold of 37
Pseudomonas : 0 against a threshold of 17

What do the process measures show?

The infections in April enabled a quick identification around hand hygiene practices and commode cleanliness. Action plans have been drafted in areas of concern with the ward managers and Matrons.
IPC Focus for 2022/23 will be on 5% reduction for other hospital acquired infections looking at hydration, ANTT and catheter care as well as continuing to focus on commode cleanliness and hand hygiene practices.

What changes have been implemented and improvements made?

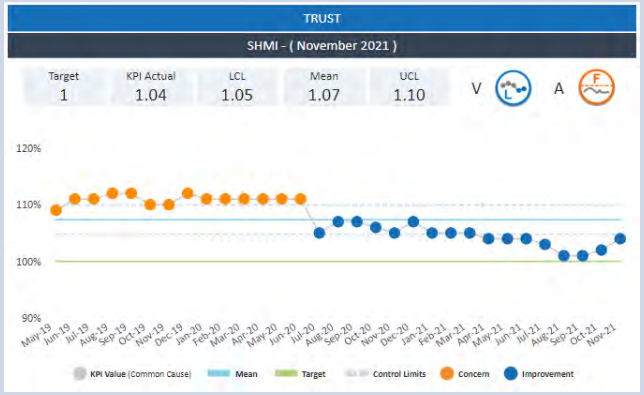
- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- IPC operational group involving SSR's Charge nurses and Matrons to review audit data, best practice and to support improvement has started and is monthly
- Work with PDN team to assess ANTT competency assessments
- Trust wide Commode integrity audit
- "8 is great" drink tracker launch to support hydration

Effective: Mortality
Aim: TBC
Latest Period: SHMI reporting period October 2020 to October 2021 – HSMR January 2022

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

NHS Medway NHS Foundation Trust

Outcome Measure: SHMI Mortality



Outcome Measure: HSMR Weekend and Weekday Mortality

What do the measures show?

The Trusts HSMR for the period of February 2021- January 2022 is 102.3, weekend HSMR is 99.0 and weekend is 112.2, all within the 'as expected' banding. Analysis on HSMR levels should be treated with some caution over the next coming months. Firstly, the second wave of covid is moving out of the 12 month rolling period, where Medway was hit particularly harder than many other Trusts nationally. Therefore, when December 20 drops out of the 12 month rolling period, Medway are more affected in terms of HSMR. Secondly, HSMR uses a year of discharge data as a model. The most recent year currently includes the second wave of covid; therefore, the model is likely to be 'over adjusting' for covid inappropriately and marking Feb 21- Jan 22 data is 'risker' for mortality outcomes than it actually is.
The Trusts SHMI for the reporting period of October 20- November 21 is 1.04 and within the 'as expected' band. Covid activity is excluded from SHMI data.

What changes have been implemented and improvements made?

Dr Foster has recently completed analysis over the Trust's weekend and weekday HSMR. When investigating HSMR by day of admission, a common approach is to narrow the methodology to just 'emergency' admissions as this better reflects the how the day of the week impacts outcomes from unplanned events. In summary, trends in weekend HSMR are downwards; Medway are well within the national control limits and report as 'within expected' and current data shows stability across a number of methodologies with no cause for concern. Outlier groups identified from SHMI and HSMR have been identified with more specific recommendations on cases for deep dive. The Better Tomorrow team at NHSE/I are assisting in reviewing current processes for deep dives.

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Bed Management	% Medically Fit For Discharge Point Prevalence in Month	Apr-22	7.0%	15.9%	11.9%	14.8%	17.8%		
		% of Delayed Transfer of Care Point Prevalence in Month	Apr-22	3.5%	0.0%	0.0%	1.1%	2.1%		
		Average Elective Length of Stay	Mar-22	5	2.82	1.43	2.35	3.28		
		Average Non-Elective Length of Stay	Mar-22	5	9.66	7.33	8.62	9.92		
		Bed Occupancy Rate	Apr-22	85.0%	88.9%	78.0%	85.9%	93.8%		
		Delayed Transfer of Care Point Prevalence in Month	Apr-22		0	0	169.89	342.03		
		Escalation Beds Open Point Prevalence in Month	Apr-22	0	0	0	0	0		
		Medically Fit For Discharge Point Prevalence in Month	Apr-22		2,716	1,685.66	2,270.86	2,856.06		
	Complaints Management	% Complaints Responded to Within 30 Days	Apr-22	85.0%	27.0%	0.0%	13.6%	34.1%		
		Number of Complaints	Apr-22	41	37	16.19	48.42	80.64		
	ED Access	30 Mins Ambulance Handover Delays	Apr-22	0	917	254.34	666.64	1,078.94		
		60 Mins Ambulance Handover Delays	Apr-22	0	161	0	168.83	374.41		
		ED 12 hour DTA Breaches	Apr-22	0	84	0	31.53	99.02		
		ED 4 Hour Performance All Types	Apr-22	95.0%	70.6%	71.7%	79.6%	87.5%		
		ED 4 Hour Performance Type 1	Apr-22	95.0%	58.6%	59.3%	70.2%	81.2%		
		Median Time to Ambulance Assessment (15mins)	Apr-22	15	42	10.07	17.29	24.51		
		Median Time to ED Clinician (60mins)	Apr-22	60	66	26.56	39.56	52.55		
		Number of ED arrivals by Ambulance	Apr-22		3,085	2,552.50	3,271.31	3,990.11		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	Mar-22	0	3	0	1.71	4.30		
		Cancer 28 Faster Diagnosis	Mar-22	75.0%	77.1%	47.4%	66.1%	84.9%		
		Cancer 28 Faster Diagnosis - Breast Symptomatic	Mar-22	75.0%	98.5%	22.6%	86.0%	149.4%		
		Cancer 28 Faster Diagnosis Screening	Mar-22	75.0%	20.0%	0.0%	43.2%	115.8%		
		Cancer 2ww Performance	Mar-22	93.0%	96.7%	92.2%	95.4%	98.5%		
		Cancer 2ww Performance - Breast Symptomatic	Mar-22	93.0%	93.2%	71.5%	90.5%	109.5%		
		Cancer 31 Day First Treatment Performance	Mar-22	96.0%	100.0%	91.4%	97.0%	102.7%		
		Cancer 31 Day Subsequent Treatments (Drugs)	Mar-22	98.0%	95.8%	88.1%	96.5%	104.8%		
		Cancer 31 Day Subsequent Treatments (Surgery)	Mar-22	94.0%	94.1%	67.0%	92.5%	118.1%		
		Cancer 62 Day Treatment - Cons Upgrades	Mar-22		63.2%	42.8%	74.1%	105.5%		
		Cancer 62 Day Treatment - GP Refs	Mar-22	85.0%	88.7%	56.2%	75.3%	94.4%		
Responsive	Cancer Access	Cancer 62 Day Treatment - Screening Refs	Mar-22	90.0%	97.1%	18.2%	71.2%	124.3%		
	Diagnostic Access	DM01 Performance	Mar-22	99.0%	81.4%	71.0%	85.4%	99.8%		
	Elective Access	18 Weeks RTT Incomplete Performance	Mar-22	92.0%	62.3%	63.7%	70.3%	76.9%		
		18 Weeks RTT Over 52 Week Breaches	Mar-22	0	162	32.37	150.11	267.86		
		Daycase Rate	Apr-22	85.0%	63.9%	60.3%	67.5%	74.7%		
		DNA Rate	Apr-22	10.0%	9.3%	6.7%	7.8%	8.9%		
		First to Follow Up Ratio	Apr-22		2.74	2.10	2.55	2.99		
		PTL Size	Mar-22	22,477	30,391	21,707.44	23,080.54	24,453.65		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Apr-22	0	0	0	1.94	7.49		
		Operations Cancelled By Hospital on Day	Apr-22	0	10	0	15.33	35.78		
		Urgent Operations Cancelled for the 2nd Time	Apr-22	0	0	0	0.03	0.18		

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1

Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Appointment of new DDO in place since March to enhance focus.
- Focus on 4 hour performance now a formal part of site agenda.
- Predict, Escalate and Prevent overarching ED flow model is in place.
- HARIS review underway to target enhanced performance
- Symphony discharges; Weekly emails are sent to the UTC/ED workforce managers. Meetings have now started to take place to encourage GIRFT

Outcomes:

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

Underlying issues and risks:

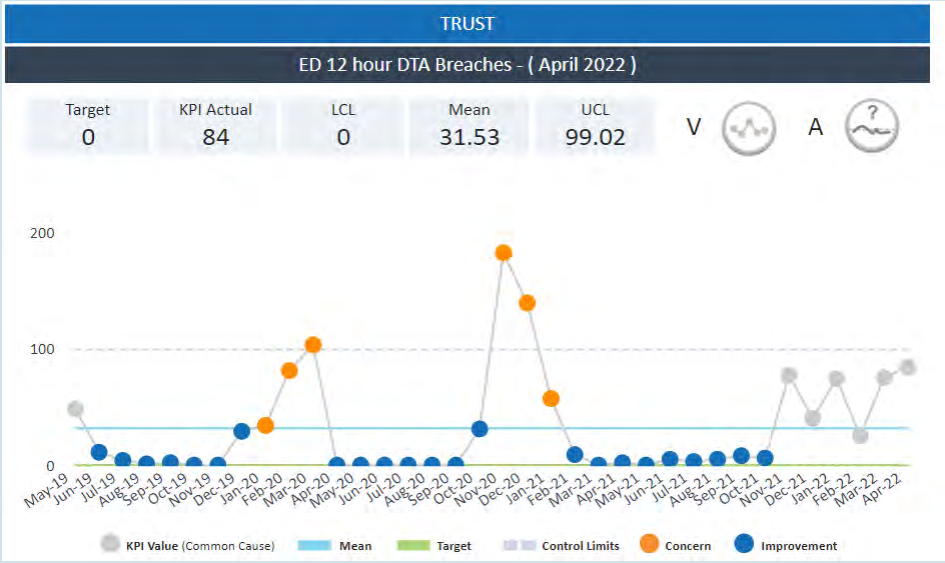
- Underlying bed deficit, COVID contact bed issues, delayed speciality review and use of escalation areas places increased demands on medical, nursing and therapy workforce.

Responsive: – Non Elective Insights

Executive Lead: Jayne Black–Chief Operating Officer
Operational Lead: Sunny Chada (DCOO)
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

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

What the Chart is Telling Us:

There has been an increase in 12 hour breaches in the reporting period, with the position around 50 per month on average since December 2021.

Actions:

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

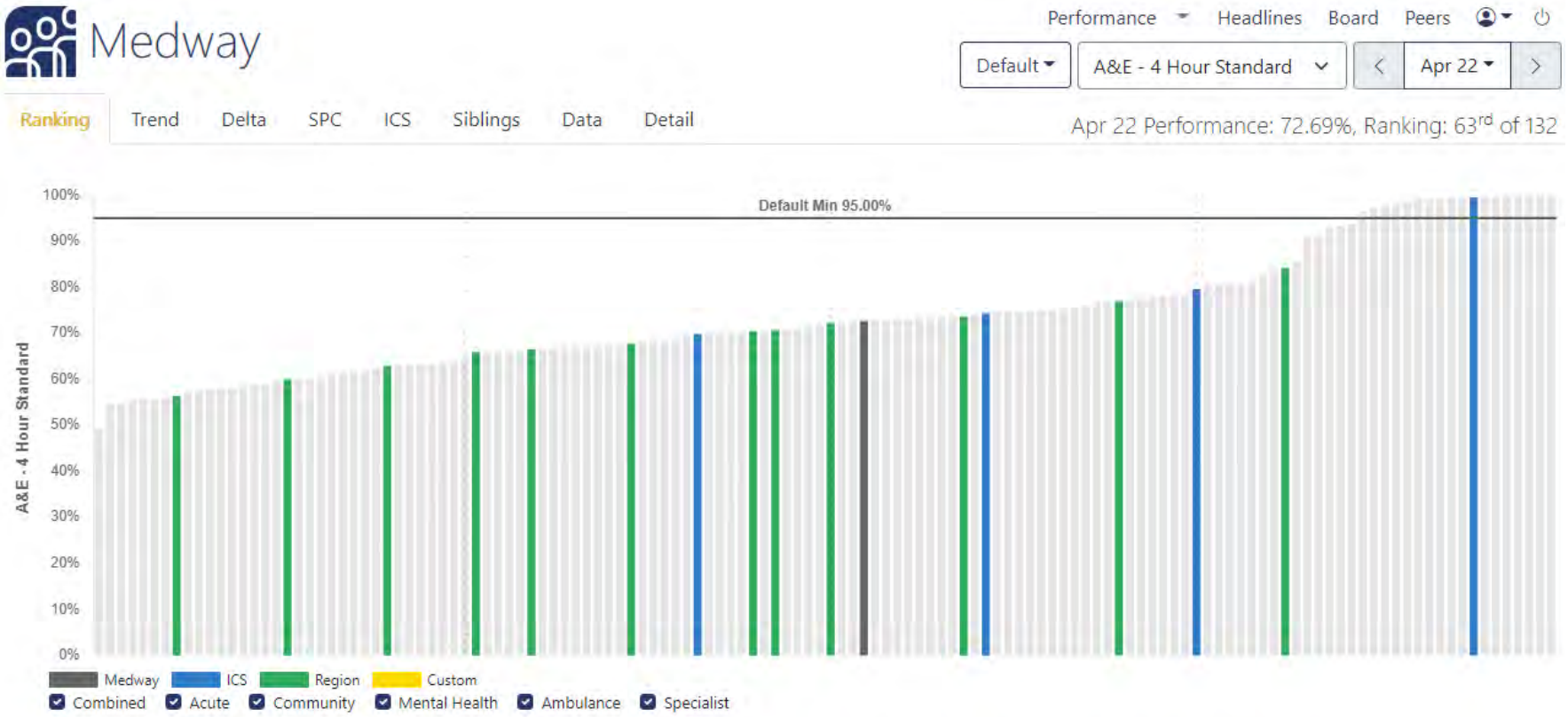
Outcomes:

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

Underlying issues and risks:

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

EC 4 Hour Benchmarking

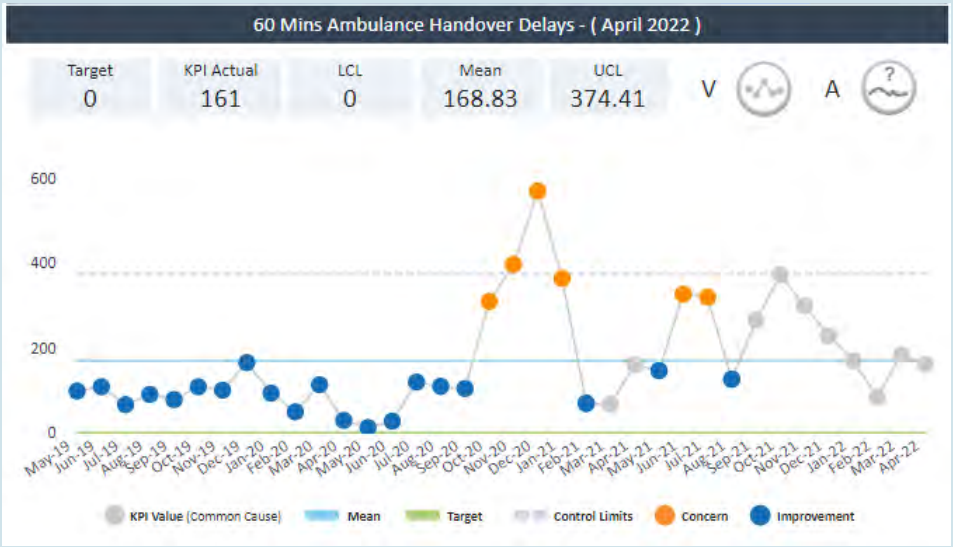


Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

What the Chart is Telling Us:

Actions:

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

Outcomes:

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

Underlying issues and risks:

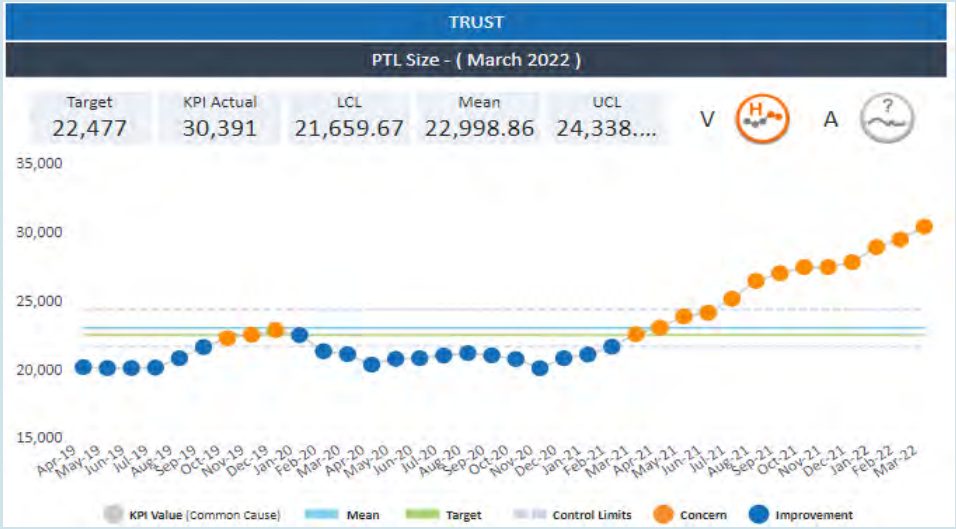
- Early morning bed availability remains a challenge and relates to the need to review wider site bed capacity.
- Rising COVID contact beds have challenged ED but the team should be commended on performance during this time as during this period the site was under periods of business continuity.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: PTL Size



Indicator Background:

What the Chart is Telling Us:

Actions:

- System-wide Outpatient transformation meetings have commenced
- Agree system-wide interventions re controls for referral increases.
- Theatre and Outpatient efficiency projects have commenced
- Maximise current capacity, including Independent Sector to keep pace where possible with elective activity.

Outcomes:

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

Underlying issues and risks:

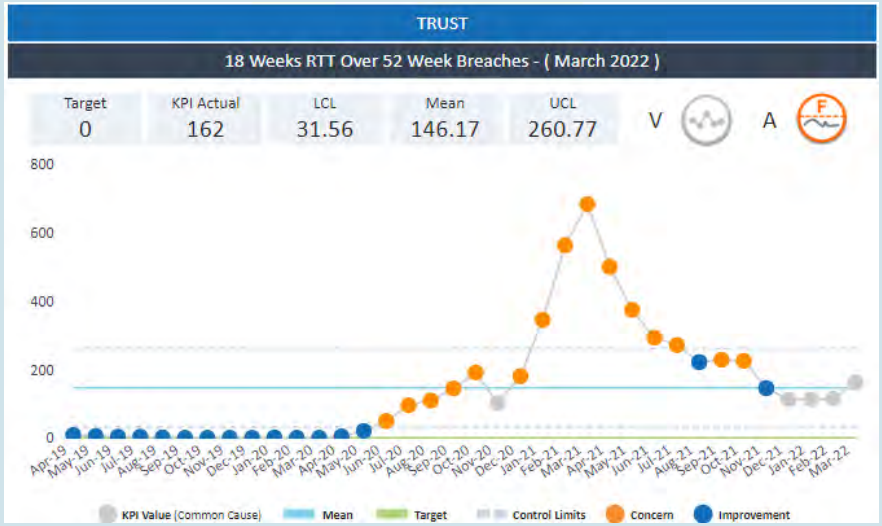
- Impact of further COVID waves resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Potential impact of Trust Business Continuity on Elective activity.
- Increased sickness absence driven by pressure of work and COVID related isolation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

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

What the Chart is Telling Us:

Actions:

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

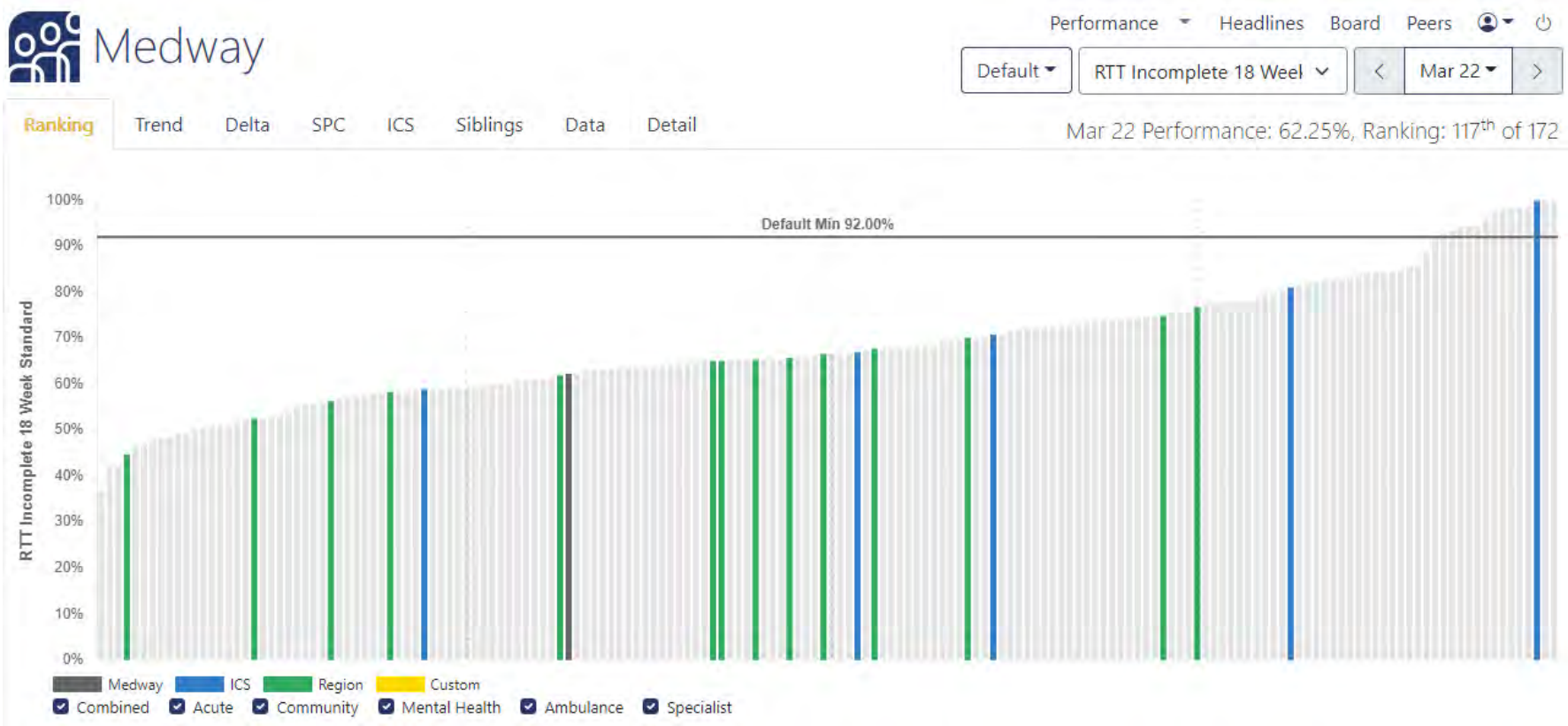
Outcomes:

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

Underlying issues and risks:

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

RTT Benchmarking

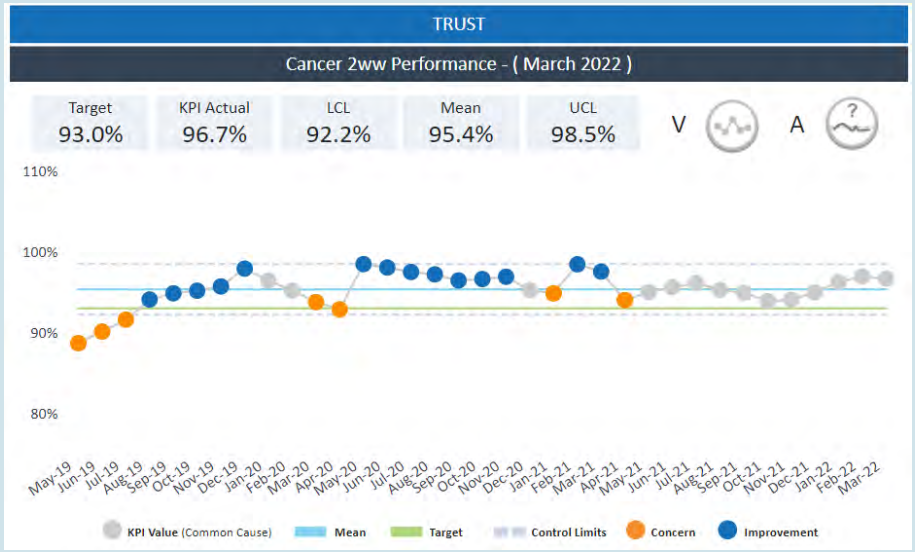


Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

- Few concerns at present - continues to be compliant.
- **MFT were ranked 16th in the country for 2 week wait on Public View.**
- The Trust has remained compliant with this KPI since August 2019.

Actions:

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

Outcomes:

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

Underlying issues and risks:

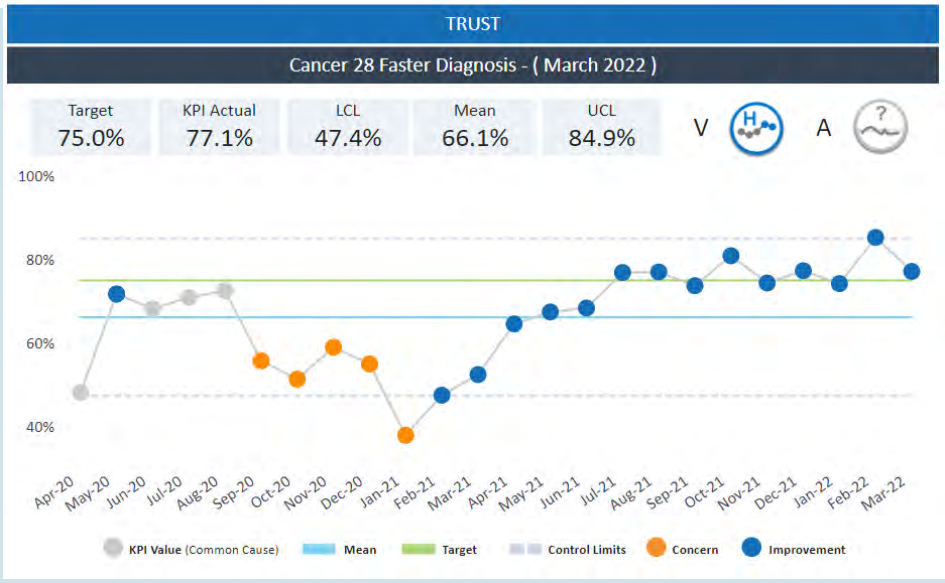
- Request form for the STT cancer CNS to be able to request imaging according to the SOP for the straight-to-test pathway has been waiting for sign off. In the meantime STT nurses not being optimised.
- Main challenges are volumes/fluctuations of referrals, particularly in some tumour sites, and patient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

Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 28 Faster Diagnosis



Indicator Background:

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

What the Chart is Telling Us:

- **MFT were ranked 45th in the country for 28 day for faster diagnosis on Public View.**
- No concerns at present and 28 day is now part of the daily validations and compliant.

Actions:

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

Outcomes:

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

Underlying issues and risks:

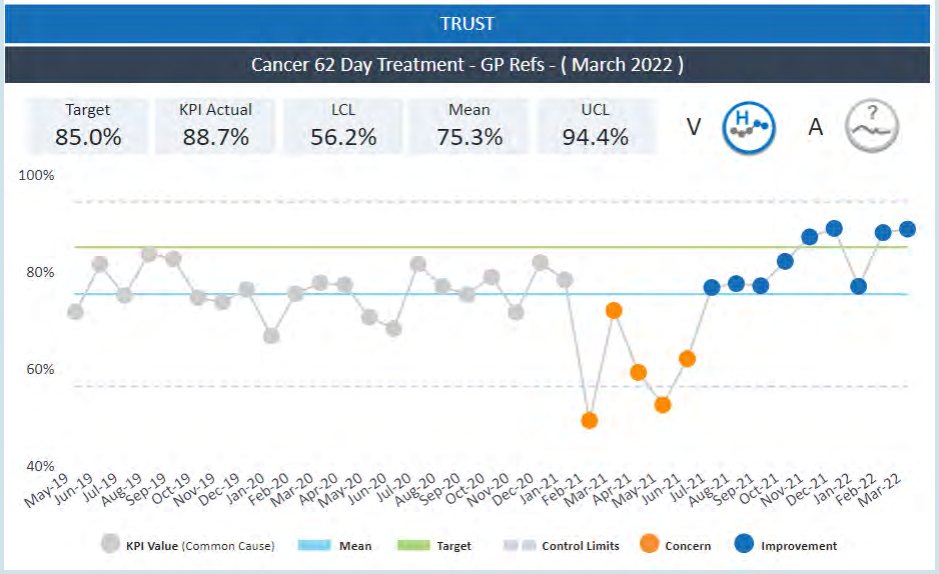
- Diagnostics capacity and turnaround remains the biggest issue to achieving compliance, particularly when affected by unplanned equipment failure or staffing capacity issues.
- Continue to improve our completeness data capture which is reflected in the performance
- Working with the Cancer Alliance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

Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

- **MFT were ranked 8th in the country for 62 day treatment February performance on Public View.**

Actions:

- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement 14 Point Action Plan Meeting.
- Tumour Site Specific Improvements being taken through Cancer Board led by the Cancer Specialty Leads.
- Daily PTLs taking place where necessary.
- Tumour Groups with the highest backlogs have clinically led PTLs in place.
- Inter-provider SOP has been drafted by the Cancer Alliance to streamline and improve inter-provider pathways

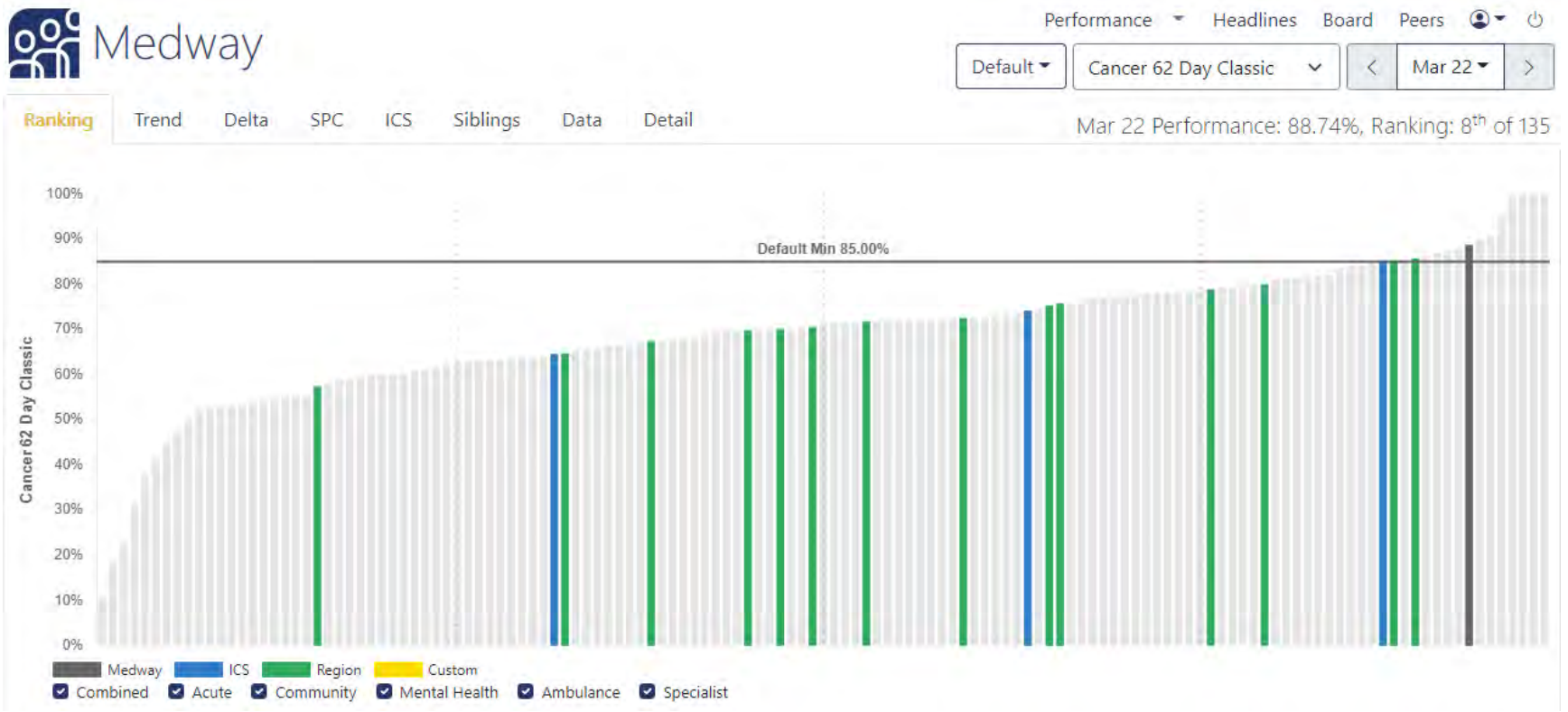
Outcomes:

- Cancer patients at Medway NHS Foundation Trust are receiving some of the fastest access to cancer treatment in the UK.
- The Trust achieved the national standard in four key areas of cancer care for the second time in February. This has meant that cancer patients in Medway and Swale have had an earlier diagnosis, faster treatment, a lower risk of complications, a better experience of care and improved outcomes.
- The Trust has now met the national 62-day cancer standard for three months in the last financial year.

Underlying issues and risks:

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

Cancer 62day Benchmarking

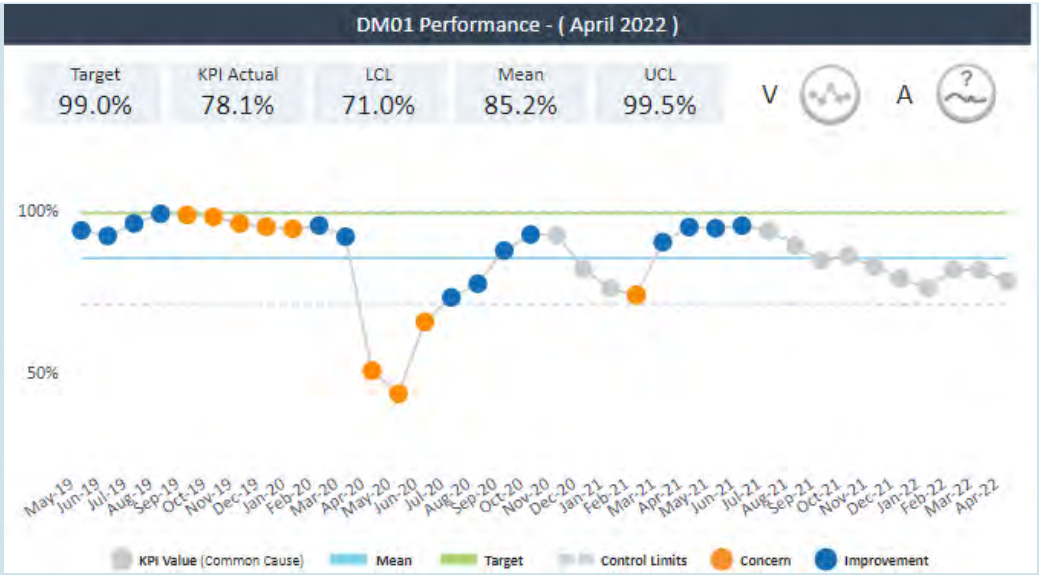


Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: DM01 Performance



Indicator Background:

What the Chart is Telling Us:

Actions:

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

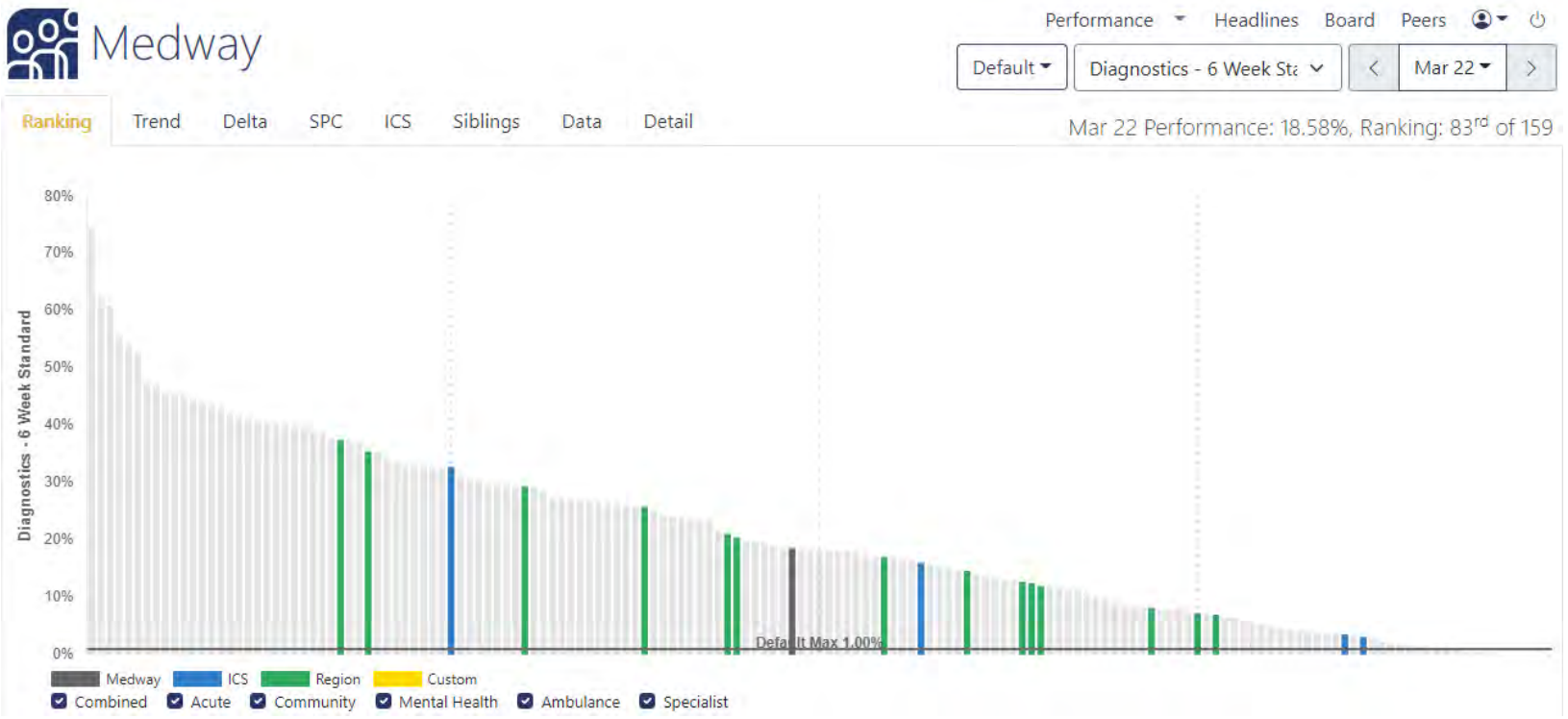
Outcomes:

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

Underlying issues and risks:

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

DM01 Benchmarking



Domain: Well Led – Dashboard

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

NHS Medway NHS Foundation Trust

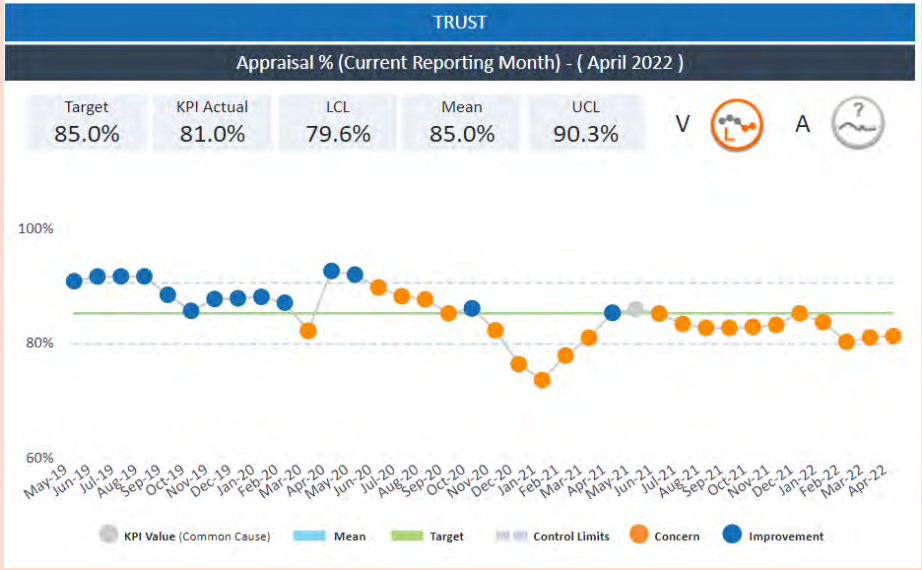
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Well Led	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Apr-22	4.0%	3.3%	0.5%	2.8%	5.2%		
		Agency Spend as % Paybill (Financial Year YTD)	Apr-22	4.0%	6.1%	2.0%	3.1%	4.2%		
		Appraisal % (Current Reporting Month)	Apr-22	85.0%	81.0%	79.6%	85.0%	90.3%		
		Bank Spend as % Paybill (Current Reporting Month)	Apr-22	9.0%	14.0%	8.0%	13.2%	18.3%		
		Bank Spend as % Paybill (Financial Year YTD)	Apr-22	9.0%	0.1%	7.1%	10.7%	14.3%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Apr-22		4,354.90	4,021.96	4,093.73	4,165.50		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Apr-22	2.5%	1.8%	1.7%	2.3%	3.0%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Apr-22	1.5%	2.9%	1.7%	2.2%	2.7%		
		Sickness Rate (Current Reporting Month, FTE%)	Apr-22	4.0%	4.7%	3.2%	4.7%	6.2%		
		StatMan Compliance (Current Reporting Month)	Apr-22	85.0%	84.3%	87.5%	89.4%	91.3%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Apr-22	75.0%	55.9%	52.7%	64.7%	76.6%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Apr-22	12.0%	15.7%	11.8%	12.6%	13.5%		

Well Led: Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

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

What the Chart is Telling Us:

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

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

Actions:

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

Outcomes:

3587 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 4411).

Underlying issues and risks:

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

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month Baseline budget	In-month Actual	In-month Variance	YTD Baseline budget	YTD Actual	YTD Variance
Income	31,933	31,625	(308)	31,933	31,625	(308)
Pay	(20,564)	(20,387)	177	(20,564)	(20,387)	177
Total non-pay	(10,081)	(10,070)	11	(10,081)	(10,070)	11
Non-operating expense	(1,841)	(1,720)	120	(1,841)	(1,720)	120
Reported surplus/(deficit)	**(552)**	**(553)**	**(0)**	**(552)**	**(553)**	**(0)**
Donated Asset / DHSC Stock Adj.	13	26	13	13	26	13
Control total	**(539)**	**(527)**	**12**	**(539)**	**(527)**	**13**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	318	311	(7)	318	311	(7)	9,631
Capital	(438)	(328)	110	(438)	(328)	110	11,550

Indicator Background:

The Trust reports a £553k deficit position for April; after adjusting for donated asset income and depreciation this reduces to £527k, this being £12k favourable to plan.

What the Chart is Telling Us:

The Trust has delivered the planned £0.5m deficit for April 2022/23. The efficiency programme delivered in month £7k adverse to the £318k plan. The capital programme is reporting £110k variance to plan although expected to recover as the financial year progresses.

Actions:

- The draft plan was submitted to NHSE/I for 22/23 in April, for a £3.1m deficit. The plan contains a high level of risk and mitigating actions.
- Further work is ongoing to develop the mitigations as well as the efficiency plan for 22/23.
- All 11 of the cross cutting efficiency schemes are signed off and are being implemented across the services.

Outcomes:

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

- Elective recovery fund income of £0.8m.
- Non-recurrent release of general accruals £0.8m.
- Pay costs include the 1.25% relating to the Health & Social Care Levy increase (N.I. cost increase).
- Continuation of increased capacity across the escalation areas in Unplanned Care.

Underlying issues and risks:

The financial position is monitored against the draft plan submitted to NHSE/I for 2022/23. There will be a 3rd and final planning submission on the 20th June following further confirmation of funding arrangements for inflationary pressures. The current plan includes the risk of identifying mitigations and delivering the efficiency programme, as well as managing Covid costs and delivering the activity plan to achieve Elective Recovery Funding.
The 22/23 capital plan continues to be developed, this is c.£11.5m.

Meeting of the Board of Directors in Public

Wednesday, 08 June 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	4.2
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday 24th May 2022		
Lead Director:	Evonne Hunt, Chief Nursing Officer		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headlines	**Assurance Level** (use appropriate colour code as above)
1. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report The Committee received the assurance and escalation report from the quality and patient safety sub-committee held on 19th May 2022 The report provided assurance to the Committee on the robust discussions, outcomes and decisions made at the QPSSC on the reports submitted. The Committee noted the need to align meetings to ensure flow of information and reporting.	**Green**

2. Quality, safety and risks report The Committee received the quality, safety and risks report which provided an update for the reporting month of April 2022 on incidents reporting and current position, delivery of the Trust's CQC action plans, CQC information requests, CQC unannounced inspection in February, journey to excellence, Quality Assurance visits, implementation of Gather, safety update, quality risks, clinical effectiveness and mortality and morbidity. The Committee were informed that the Must Do Should do CQC actions from the 2021 inspection have now all been closed.	**Amber\Green**
3. Infection prevention and control update and IPC BAF The Committee received the infection prevention and control update paper which provided progress on mandatory surveillance against national targets for Hospital Acquired Infections, measurement of the Trust's current management of SARS-COV2 virus (COVID-19) including changes to social distancing and visiting and the living with COVID paper. The report also provided an update on hand hygiene audit results, training compliance and national and regional updates. The Committee were informed about the outstanding actions on the IPC BAF for the month of March and the plans in place to bring these back on track and close by June. The Committee were assured by these plans. The Committee discussed Monkey Pox and were informed that the UK has 56 cases. The IPC team have been working with the emergency department on the management of patients that may arrive with suspected Monkey Pox through the department. The Associate Director of Infection Prevention and Control is attending a national webinar about Monkey Pox.	**Green**
4. Quality IQPR The Committee received and noted the Quality IQPR which provided an update on key performance indicators and quality metrics for the reporting month of April 2022. The Committee noted that some metrics had also been discussed as part of the other agenda items at the meeting. The Committee noted the timing of the IQPR data being published does not align with meetings and Committees.	**Green**
5. Incident Review of Never Events declared 2021/22 The Committee received the incident review of never events declared during 2021/22 paper which provided assurance on the investigations and learning from the 3 never events.	**Green**
6. Enhanced Care Update The Committee received an update about the newly formed enhanced care team which is made up by the dementia and delirium team and the clinical nurse specialist for mental health care. There are plans to recruit clinical support workers who will be trained in providing one to one care. The aim of the team is provide additional care a patient may require and reduce the cost of using agency and bank staff. The enhanced care provided will move towards providing a holistic care approach rather than a guarding approach.	**Green**

The Committee will received an update on the new team in 6 to 8 months times.	
7. Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Oversight Report The Committee received the Clinical Negligence Scheme for Trusts Maternity Incentive Year 4 oversight report. The report showed the areas where more work is required to close down actions. The Committee were informed about a business case to support a data assurance clerk who will ensure that data shared outside of the trust has been ratified and approved as correct. The actions are on track to be closed by the January 2023 deadline.	**Amber/Green**
8. Ockenden 1 Oversight Report The Committee received the Ockenden 1 Oversight report which provided assurance to the Committee on the plans to close down the final safety actions by June 2022. The Committee approved the paper for onward sharing with Trust board.	**Green**
9. Triangulation of Data for Organisational Learning and Development The Committee received the triangulation of data for organisational learning and development which provided an analysis of themes, identified risks and lessons learnt from the triangulation of data from serious incidents, claims, coroners' inquests and complaints to aid the identification of improvement and learning opportunities. The Committee will receive a further update in 6 months' time as part of the work plan.	**Green**
9. Quality Account The Quality Account was still in draft form and the Committee decided to hold an extra-ordinary quality assurance committee meeting week commencing 30th May to review the document before submission to Trust Board.	**Amber/Green**
10. BAF-quality risk The Committee were informed of a piece of work requested by the Quality and Patient Safety Sub-Committee to review the gaps in control relating to risks 5a and 5b and to ensure the BAF is triangulated with divisional risks, Board and patient first objectives. The Committee agreed to leave the risk rating for risk 5a at 12. The Committee will receive the reviewed and update BAF quality risks at the July meeting.	**Amber/Green**
Escalation to Board No items were identified for escalation to Board. The Committee inform the Board on the following points: • Quality of data • Enhanced care team update to the committee • Extra-ordinary QAC to consider the Ockenden report and Quality Account	

Meeting of the Board of Directors in Public
Wednesday, 08 June 2022

Title of Report	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Oversight Report**	**Agenda Item**	**4.3**
Report Author	Kate Harris, Interim Head of Midwifery		
Lead Director	Evonne Hunt, Chief Nursing Officer		
Executive Summary	This report provides the Trust Board with oversight and assurance with regards to progress against achieving compliance with the requirements of NHS Resolution Year Four Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The report will focus on the following Safety Actions: CNST year 4 has been paused since 23rd December 2021. On 6th May 2022 the scheme was relaunched with a revised submission deadline of 5th January 2023 (previously 30th June 2022). This report provides the Board with oversight and assurance against all 10 Safety Actions in light of the revised guidance.		
Link to strategic Objectives	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted	Women's and Children's Care Group Board, May 2022 Planned Care Divisional Board, May 2022 Maternity and Neonatal Safety Champion Assurance Board, June 2022 Patient Safety and Quality Sub Committee, May 2022 Quality Assurance Committee, May 2022		
Resource Implications	No additional resource implications		
Legal Implications/Regulatory	Compliance with CNST Year 4, Ockenden (2020)(2022) , CQC		

Requirements				
Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to: state decision required i.e. review, approve, note. [For example: The Board is asked to approve the Safeguarding Policy].			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices				

1 Executive Overview

1.1 This report provides 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:

1.2 CNST year 4 has been paused since 23rd December 2021. On 6th May 2022 the scheme was relaunched with a revised submission deadline of 5th January 2023 (previously 30th June 2022).

1.3 This report provides the Board with oversight and assurance against all 10 Safety Actions in light of the revised guidance.

1.4 Year 4 of the CNST MIS launched on the 8th August 2021. The maternity service has provided assurance reports to the Quality Assurance Committee and Trust Board.

1.5 The report assures the Board that work has been ongoing against the original CNST year 4 guidance during the period of pause, and that all mandatory reporting and activity has continued including:

- 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.

Safety Action	Description	RAG
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	**On Track**
Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	**Off Track with actions to deliver**
Safety Action 3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	**On Track**

Safety Action 4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	**On Track**
Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	**Off Track with actions to deliver**
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	**On Track**
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?	**Off track with actions to deliver**
Safety Action 8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	**Off track with actions to deliver**
Safety Action 9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	**On track**
Safety Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	**On Track**

1.6 Each individual Safety Action and sub-requirement were also reviewed and the following assessment was made.

	Position	Trust Position										
CNST Year 4	Description	Safety Action 1	Safety Action 2	Safety Action 3	Safety Action 4	Safety Action 5	Safety Action 6	Safety Action 7	Safety Action 8	Safety Action 9	Safety Action 10	Total Actions
Completed	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice	0	0	1	2	0	3	0	0	0	0	**6**
Overdue *	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.	0	0	0	0	0	0	0	0	0	0	**0**
Off Track with actions to deliver *	Action is off track and plans are being put in place to mitigate any delay	0	8	0	0	3	5	5	4	1	0	**21**
On Track *	Action is on track with progress noted and on trajectory	5	1	5	0	3	19	2	0	3	5	**35**
Total Number of actions		**5**	**9**	**6**	**2**	**6**	**27**	**7**	**4**	**4**	**5**	**62**
Percentage of actions completed/on track		100%	11%	100%	100%	50%	81%	29%	0%	75%	100%	66%

* Actions required to achieve compliance are noted in the narrative for each Safety Action.

2 Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

2.1 The report assures the Board that all processes are in place to meet the requirements of Safety Action 1.

2.2 The Maternity service has been providing regular reports on Safety Action 1 to Trust Board in Private, with the latest report being in May 2022, and the maternity service continues to meet all the targets for reporting. Reporting to MMBRACE-UK (Mothers and Babies: Reducing Risks through Audits and Confidential Enquires across the UK) continued throughout the pause period.

2.3 The revised guidance has amended the reporting period to 6th May 2022 to 5th December 2022 and the service is confident of achieving all the recommended targets.

2.4 The revised guidance also noted that quarterly reports should be submitted to Trust Board of all deaths reviewed and consequent action plans from 6th May 2022. This reporting has continued from November 2021. The guidance however indicates that the summaries, issues and action plans should be for those reports which have been published and may lag behind the current quarter by up to 6 months. The service is reviewing its reporting to Board and will ensure that the summaries and issues from published cases are clearly indicated in the reporting.

Significant Assurance	Green – There are no gaps in assurance

3 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

3.1 The maternity service has continued to review and submit data to the Maternity Services Data Set (MSDS) as required throughout the CNST Year 4 pause period. As previously reported to the Board, the maternity service and Business Intelligence (BI) Team have raised concerns with the maternity information system (EuroKing) provider, Wellbeing, regarding the accuracy of the data being submitted to the MSDS and compliance with Safety Action 2 has been included on the Women's and Children's risk register.

3.2 All data that has been flagged as invalid by the BI team has been reviewed by the maternity team, and it has found that the data entered into the front end of the system is 95% correct, and therefore does not reflect the number of invalid data returns that are being extracted from the system. This has been escalated to Wellbeing and the service and BI are awaiting the rollout of the new dataset, in line with the revised guidance, to assess the current position. The team have requested to be an early adopter of the new dataset to ensure adequate time to rectify any data extraction errors.

3.3 The revised guidance also requires the following:

- By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.

- Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022

- July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.

- July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.

- July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)

- July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

- Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:

    - Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.

    - Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.

    - At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.

3.4 The maternity service have identified the following actions required to achieve compliance:

- Work with Wellbeing to identify errors in the MSDS mapping and rectify data extraction, including data submitted to the National Maternity Dashboard to the CQIM – July 2022
- Maternity Senior Leadership team and Digital midwife to work with Director of IT to develop maternity digital strategy, aligned to Trust digital strategy. To be reported to Trust Board, LMNS and Integrated Care System (ICS) by October 2022.
- Review current front end reporting for BMI, complex social factors, ethnic category and antenatal care plan to ensure ongoing compliance and work with Wellbeing to ensure MSDS submission reflects this. – June 2022
- Seek clarification from NHS Resolution and NHS Digital regarding Continuity of Care (CoC) requirements in light of Ockenden 2022 report recommending pause of all CoC pathways until the model could be safely staffed. Medway currently are not running any CoC teams. – June 202

Partial Assurance	Amber/ Red - there are gaps in assurance

4 Safety Action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

4.1 The report assures the Board that all appropriate processes in place to achieve compliance with Safety Action 3:

- Pathways into Transitional Care (TC) and Maternity Assisted Care (MAC) are in place and have been approved jointly by maternity and neonatal teams.
- Audits are ongoing of the TC and MAC pathways and reported quarterly. All actions are recorded on the ATAIN action plan which has been shared through Care Group and Divisional Governance, along with Maternity and Neonatal Safety Champion Assurance Board, Quality Assurance Committee and Trust Board. There is an agreed reporting schedule to the LMNS and ICS to begin in July 2022.
- A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) is embedded.
- Reviews of all term admissions to the Neonatal Unit continue monthly, with quarterly reporting in place and a schedule to report externally to LMNS and ICS as required from July 2022.

- The Avoiding Term Admissions to the Neonatal Unit (ATAIN) action plan was shared with the Board Level Safety Champions and presented to and signed off by Trust Board on 11th January. This has met the revised requirement to have this signed off by Board by 29th July, and progress will be presented to the Trust Board in July 2022 and December 2022. Progress against the action plan will also be shared with the LMNS and ICS as part of the established reporting schedule.

Significant Assurance	Green – There are no gaps in assurance

5 Safety Action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard?

5.1 The report assures the Board that an appropriate and effective system of clinical workforce planning is in place for Obstetrics, Neonatal Medical Staffing, Neonatal Nursing and Obstetric Anaesthetic staffing. The following actions have been taken to achieve compliance:

- The service's position against the Royal College of Obstetrics and Gynaecology (RCOG) "Roles and Responsibilities for Obstetric and Gynaecology Consultants" was presented to Trust Board on 11th January 2022. This included confirmation that the consultant job plans and rota had been revised to ensure that consultant led ward rounds took place twice daily (morning and evening) 7 days per week. The report also confirmed that the service had an appropriate SOP in place to reflect the RCOG guidance and that plans to audit this, including attendance at the specified clinical situations outlined in the RCOG guidance were in place.

- The revised CNST guidance has changed the audit requirement to commence from 29th July 2022, and the report assures the Board that this has commenced and initial reporting is anticipated in July 2022.

- There is appropriate, dedicated, anaesthetic cover for obstetrics at all times, with appropriate lines of communication to a consultant at all times. 6 months of anaesthetic rota will be reviewed and supplied as evidence.

- The Neonatal unit meets the requirements of the British Association of Perinatal Medicine (BAPM) national standards for junior medical staffing. This was confirmed to Trust Board in January 2022 and a workforce oversight report was prepared by the Clinical Director for Children's Services and presented to M&NSCAB in March 2022 further confirming this position.

- The Neonatal Unit also meets the service specifications for nursing standards, with 71% of nurses qualified in speciality. It is anticipated that this number will increase as more staff are due to complete the course in the coming year. A workforce review has been completed by the Neonatal Matron and presented to M&NSCAB to meet the requirements of this action.

Significant Assurance	Green – There are no gaps in assurance

6 Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

6.1 The report assures the Board that the maternity service has identified the required actions ongoing audit and reporting requirements to achieve compliance with Safety Action 5.

- A full workforce review using Birth Rate plus methodology has been completed and reporting is anticipated in May 2022. A full workforce report to Trust Board, including request to fund any shortfall in staffing, will follow, and anticipated to be presented to Trust Board in August 2022.

- To be compliant with CNST year 4, at least one workforce report must be submitted to Trust Board between 6th May 2022 and 5th December 2022. Where Trusts are not compliant with a funded establishment based on Birth Rate Plus or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- An LMNS funded workforce review has been undertaken by NHSIE and the recommendations of this will support the recommendations of the formal workforce report.

- Supernumerary audit continues, with improvement noticed in compliance since January 2022. The Supernumerary action plan was presented to Trust Board on 9th of March 2022, and progress against this and the results of the ongoing audit will be presented to Board in July 2022 and again December 2022 prior to submission.

2022 Compliance with Supernumerary Status of Delivery Suite Coordinator	
Jan-22	81.48%
Feb-22	94.55%
Mar-22	91.07%
Apr-22	98.11%

- One to one care in labour has been maintained throughout the CNST Year 3 and CNST Year 4 reporting period, and therefore no action plan is required. This will continue to be audited.

- The maternity service's monitoring of red flags was also presented to Trust Board in March 2022. The service has introduced a live reporting Birth Rate Plus Acuity tool which allows the delivery suite coordinators to record acuity, staffing, red flags and any management actions or required escalations in real time. Data from this tool will be used to support the next red flag audit and this will be presented to Trust Board in July 2022 and also support the workforce oversight report and final pre-submission report in December 2022.

Assurance	Amber/ Green - Assurance with minor improvements required

7 Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

7.1 The report assures the Board that the maternity service has appropriate processes and actions in place to achieve compliance with the requirements of Safety Action 6.

7.2 The service has implemented all five elements of the Saving Babies Lives Care Bundle v2 (SBLCBv2) and has the following actions in place to achieve compliance.

- The completion of the quarterly care bundle survey had been paused until the relaunch of CNST in May 2022. The report assures the Board that this survey is being completed and evidence of completed surveys will be submitted to Trust Board in October 2022.
- In March 2022, the maternity service reported that for Element 1, Carbon Monoxide Monitoring, that the rates of CO readings at booking and 36 weeks was improving and it was anticipated that compliance with the 80% target would be reached. The service is now achieving >90% compliance for both indicators and an action plan is in place to support achieving >95% for both indicators.
- The revised CNST guidance requires Trusts to also record those who decline CO monitoring at booking and delivery. This is being reviewed by the smoking in pregnancy midwife and will be presented to Trust Board in October 2022.
- As per Safety Action 2, Safety Action 6, Element 1 requires Trusts to past the data quality rating for 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. This data is being routinely recorded by community midwives, but is not being extracted as part of the MSDS and fed to the National Maternity dashboard. This has been escalated to Wellbeing with a view that it will be actioned by July 2022.
- The remaining audits for Element 1 have been commenced by the smoking in pregnancy midwife and will be presented to Trust Board in October 2022.
- The report advises that for Element 2: Fetal Growth Restriction (FGR) that all audits are ongoing or scheduled for this element and will be presented to Trust Board in October 2022. The service confirmed to the Board in March 2022 the following:
    - Women with a BMI>35 kg/m2 are offered an ultrasound assessment of growth from 32 weeks as per local small for gestational age guidelines.

- All pregnancies, including all high-risk pregnancies have uterine artery Doppler flow velocimetry performed at all scans.
- There is an appropriate preterm birth lead in place
- The risk assessment and management of growth disorders in multiple pregnancies complies with NICE guidance.

- The report advises that for Element 3, Reduced Fetal Movements (RFM), as reported in March 2022:
  - 100% of cases audited received RFM information by 28+0 weeks. This was a manual audit of 20 cases as per the minimum requirements, and a review of the all 2021 bookings will be undertaken to ensure ongoing compliance and identify any required actions.
  - 100% of cases audited who attended with RFM received a computerised CTG.
- The report advises for Element 4, Fetal Monitoring, that supported by online training, a trajectory is in place to achieve 100% compliance by June 2022. The fetal wellbeing team will launch a new training programme in July 2022, in line with LMNS fetal physiology guidance, and a trajectory for achieving >90% compliance for all staff groups from August 2021 to January 2023 will be presented to Trust Board in October 2022.
- The report advises for Element 5, Preventing preterm birth:
  - All required audits regarding steroid administration are underway and anticipated to report to Trust Board in October 2022.
  - As reported in March 2022, 99.6% of babies for 2021 were born in appropriate location for gestation.
  - Compliance with the administration of Magnesium sulphate for neural protection in births <30+0 weeks remains very high, with >95% for singleton births, with any missed cases being the result of imminent delivery.
  - There is an appropriate obstetric consultant lead in place for preterm birth.
  - All women at risk of preterm birth have access to a preterm birth clinic where transvaginal assessment of cervical length is provided.

- An audit of risk assessment of preterm birth at booking at subsequent stratification of care is underway in line with locally agreed pathway.
- The risk assessment and management in multiple pregnancy guideline compliance with NICE guidance.

Significant Assurance	Green – There are no gaps in assurance

8 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?

8.1 The report assures the Board that the maternity service has identified the following actions required to achieve compliance with Safety Action 7:

- MVP Terms of reference and work programme for 2022/23 requested from MVP – August 2022
- Minutes of Medway MVP meetings saved as evidence and review ongoing to ensure they meet the evidential requirements. – August 2022
- MVP chair has provided written confirmation of remuneration for herself and service users as required, however this will need to be resubmitted in line with revised timescales in new guidance - August 2022
- Review and refresh evidence for how MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in high levels of deprivation. – August 2022
- The May 2022 guidance requires the MVP Chair be invited to attend maternity governance meetings. This will be arranged and the Terms of Reference of this meeting will be updated accordingly. – August 2022
- Work is ongoing with the LMNS to strengthen the process for co-production with the MVP for all Trusts and once this process has been approved by the MVP and LMNS it will be implemented at Medway.- September 2022

Assurance	Amber/ Green - Assurance with minor improvements required

9 Safety Action 8: Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

9.1 The maternity service provided a full report to the Trust Board regarding Safety Action 8 and training compliance in May 2022. At the time of reporting the revised guidance had not been released and the service reported that the current trajectory for Professional Obstetric Multidisciplinary Training (PROMPT) was below 90% up until June 2022.

9.2 The revised guidance now stipulates, in light of Covid-19 related pressures, that Trusts have from 8 August 2021 to 5 January 2023 to achieve 90% compliance with the training requirements for Safety Action 8 (PROMPT, Fetal Monitoring, New Born Life Support) by December 2022.

9.3 The maternity service assures the Board that this extended timeframe to achieve compliance will support achieving 90% across all staff groups. Work is ongoing with the training leads to plot their training trajectory for the remainder of the year.

9.4 Training compliance will continue to be reported to Trust Board in Private via the Perinatal Surveillance Tool report and also formally reported to Trust Board in Public in October 2022 and again in December 2022 prior to submission.

9.5 The report further assures the Board that the Training Needs Analysis/training plan reflecting the Core Competency Framework has been drafted and is going through the appropriate internal governance processes before being submitted to the LMNS. This training plan will be presented to Trust Board in October 2022.

Assurance	Amber/ Green - Assurance with minor improvements required

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

10.1 The report assures the Board that the maternity service has the appropriate processes in place to achieve compliance with Safety Action 9. A full report on Safety Action 9 was presented to Trust Board in May 2022.

10.2 The report assures the Board that progress against this Safety Action continued during the pause, including Board Level Safety Champion walkabouts/Engagement events and that this will continue. Sharing of learning and actions from these engagement sessions is being strengthened and will be presented to Trust Board in October 2022.

10.3 Safety Action 9 has not removed the requirement for a CoC Action plan, but has changed the date CoC should be offered as the default option for all women to March 2024. CNST requires this to be approved by the Board Level Safety Champion by 16th June 2022. This action plan will be presented at the M&NSCAB meeting in June 2022 and presented to Trust Board for oversight in October 2022.

Assurance	Amber/ Green - Assurance with minor improvements required

11 Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

11.1 The report assures the Board that the maternity service has the appropriate processes in place to achieve compliance with Safety Action 10. All eligible cases are reported as required and appropriate Duty of Candour applied.

11.2 Details of cases reported will be presented to Trust Board in October 2022 with compliance confirmed to Trust Board in December 2022 prior to submission.

Significant Assurance	Green – There are no gaps in assurance

12 Conclusion and Next Steps

12.1 The report advises the Board of that CNST Year 4 relaunched on 6th May 2022.

12.2 The maternity service has self-assessed as having 6 Safety Actions on track and 4 Safety Actions off track with actions to deliver. Appropriate actions have been identified for those Safety Actions rated as off track and the report has assured the Board that compliance with all 10 Safety Actions is achievable within the revised timeframe. All identified actions will be monitored via the CNST Safety Compliance Group and included on the Maternity Services Board Assurance Framework Quality Improvement Plan.

12.3 The report has proposed an ongoing reporting schedule to Trust Board.

12.4 The report requests the Trust Board:

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

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 08 June 2022

Title of Report	**Ockenden 2 (March 2022) Report Oversight and assurance**	Agenda Item	**4.4**
Lead Director	Evonne Hunt – Chief Nursing and Quality Officer		
Report Author	Alison Herron, Director of Midwifery Kate Harris, Head of Midwifery and Ambulatory Gynaecology		
Executive Summary	This report provides the Trust Board with oversight and assurance on the Maternity Services' gap analysis against the recommendations and 15 additional IEAs noted in the final Ockenden report published in March 2022. The maternity service has provided the Executive Group, Trust Management Board, QAC and Trust Board with regular updates and assurance regarding compliance with the seven Immediate and Essential Actions (IEAs) outlined in the Ockenden 1 preliminary findings December 2020 report and more recently, a report to Trust Management Board on 6th April 2022, in response to the final Ockenden report and a request by NHS England to provide assurance regarding Continuity of Care and safe staffing. The report advised and assured the Management Board that the Maternity Service have suspended their COC service and have paused plans for further roll-out until safe staffing levels have been achieved. This report provides the outcome of a service review, gap analysis and benchmarking against the recommendations and 15 IEAs outlined in the final Ockenden 2 report, March 2022.		
Committees or Groups at which the paper has been submitted	Quality and Patient Safety Group (QPSG May 2022)		
Resource Implications	No additional resource implications		
Legal Implications/ Regulatory Requirements	Non-compliance with Ockenden, Clinical Negligence Scheme for Trusts Maternity Incentive Scheme, CQC		

Quality Impact Assessment	N/A
Recommendation/ Actions required	The Board is asked to note the outcome of the review and gap analysis of the 15 IEAs from the final Ockenden 2 report.

Approval	Assurance	Discussion	Noting
☐	☒	☐	☒

Appendices	Appendix 1: Board Assurance Framework Maternity Quality Improvement Plan Ockenden 2

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

1 Executive Overview

1.1 This report provides the Trust Board with oversight and assurance on the Maternity Services' gap analysis against the recommendations and 15 additional IEAs noted in the final Ockenden report published in March 2022.

1.2 The maternity service has provided the Executive Group, Trust Management Board, QAC and Trust Board with regular updates and assurance regarding compliance with the seven Immediate and Essential Actions (IEAs) outlined in the Ockenden 1 preliminary findings December 2020 report and more recently, a report to Trust Management Board on 6th April 2022, in response to the final Ockenden report and a request by NHS England to provide assurance regarding Continuity of Care and safe staffing. The report advised and assured the Management Board that the Maternity Service have suspended their COC service and have paused plans for further roll-out until safe staffing levels have been achieved.

1.3 This report provides the outcome of a service review, gap analysis and benchmarking against the recommendations and 15 IEAs outlined in the final Ockenden 2 report, March 2022

1.4 The 15 IEAs incorporate a total of 88 actions

2 Ockenden 2 (March 2022) Benchmarking and gap analysis

Amber /Red

2.1 The final Ockenden report was published on 30 March 2022. The report provided findings, conclusions and a further 15 IEAs for Trusts providing Maternity Care as follows:

1. Workforce Planning and Sustainability
2. Safe Staffing
3. Escalation and Accountability
4. Clinical Governance Leadership
5. Clinical Governance – Incident investigations and complaints
6. Learning from Maternal Deaths
7. Multidisciplinary Training
8. Complex Antenatal Care
9. Preterm Birth
10. Labour and Birth
11. Obstetric Anaesthesia
12. Postnatal Care
11. Obstetric Anaesthesia
12. Postnatal Care
13. Bereavement Care
14. Neonatal Care
15. Supporting Families

2.2 The Interim Head of Midwifery attended a national webinar following the publication of the final report and the guidance from NHSE was that Trusts should continue progressing, with a view to closing, the initial 7 IEAs. NHSE also advised that they were awaiting the publication of the Kirkup report into East Kent Hospitals, anticipated in Autumn 2022, and following this a national set of actions would be drawn up for maternity services.

2.3 Whilst awaiting further guidance from NHSE, the maternity leadership have undertaken a full review, benchmarking and gap analysis to identify actions required to achieve compliance against the 15 IEAs within the final report. These actions will be included in and monitored via the Maternity Board Assurance Framework Quality Improvement Plan whilst awaiting the national recommendations (Appendix 1). The benchmarking has identified 84 actions for MFT with a breakdown of BRAG rating below:

Completed	**7**	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice
Overdue	**0**	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.
Off Track with actions to deliver	**0**	Action is off track and plans are being put in place to mitigate any delay
On Track	**79**	Action is on track with progress noted and on trajectory
National Action	**2**	National Action required prior to local implementation
Total Number of actions		88
Percentage of actions completed/on track		98% (Local actions on track 100%. 2 actions require national initiative in order to achieve 100% overall)

Immediate and Essential Action	RAG	Comments	Target date
IEA 1: Workforce Planning and Sustainability : Financing a Safe Maternity Workforce		Continue to review workforce and ensure staffing levels meet the acuity and complexity of women and birthing people.	Aug 2022
IEA1: Workforce Planning and Sustainability: Training		Develop robust induction and progression packages for staff to support advanced decision-making.	Dec 2022
IEA2: Safe Staffing		Develop formal mentorship programme for senior midwives and enhance escalation process to ensure regional approach to acuity challenges.	Dec 2022
IEA3: Escalation and Accountability		Develop conflict of clinical opinion policy and ensure psychological safety amongst the workforce.	Nov 2022
IEA4: Clinical Governance Leadership		Refresh NHSEI Self-assessment benchmarking and formalise clinical responsibility for guidelines.	Dec 2022
IEA5: Clinical Governance – Incident investigations and complaints		Need for improved triangulation from clinical incidents and shared learning.	Dec 2022

IEA6: Learning from Maternal Deaths		Review maternal death guideline in line with recommendations	Aug 2022
IEA7: Multidisciplinary Training		Reinstate Simulation sessions across the unit and closely monitor training compliance.	Jan 2023
IEA8: Complex Antenatal Care		Review pre-conception care with Primary Care. Case note audit to confirm compliance with guidance	Dec 2022
IEA9: Preterm Birth		Update current preterm birth guidelines and audit compliance with antenatal optimisation bundle.	Dec 2022
IEA10: Labour and Birth		Develop Midwifery Led Unit operational risk assessment tool and in situ simulation programme	Aug 2022
IEA11: Obstetric Anaesthesia		Formalise postnatal anaesthetic follow-up for women and birthing people and review need for local guidelines for anaesthetic roles.	Dec 2022
IEA12: Postnatal Care		Audit required to confirm compliance	Oct 2022
IEA13: Bereavement Care		Moving towards 7 day Bereavement Service and increasing staff training to ensure one bereavement champion per shift.	Nov 2022
IEA14: Neonatal Care		Ongoing Audit to confirm compliance	Dec 2022
IEA15: Supporting Families		Audit to confirm compliance	Aug 2022

2.4 In response to the publication of the report, NHSE also issued a letter to Trusts on 1st April 2022, asking Trusts to confirm their position against CoC. The Ockenden report advises the management Board to assure that the maternity service has made the following decision:

2.4.1 *3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.*

2.5 In response to this the maternity service have taken the following steps:

- Disbanding Team Connect (Safeguarding Team) as a Continuity Team from 28 March 2022, but who continue to provide antenatal, postnatal and safeguarding care for women on their caseload.
- That all plans for further roll out of CoC have been paused until safe staffing against the CoC model has been achieved. CoC requires an increase to the workforce to support a reduction in the number of women on each caseload. This cannot be achieved with current staffing levels, skill mix and vacancy.

2.6 This report assures the Board that safe staffing is currently being achieved, based on current caseload and working patterns. One to One care in labour is being maintained at

100% and any staff shortages are being mitigated by movement of staff across the unit in line with the escalation policy.

2.7 The report also assures the Board that work is ongoing to improve recruitment and retention across the unit. A workforce group is in place, and the following actions are being undertaken:

- Refreshed and reinstated the rolling recruitment programme
- Actively engaging with universities and students to promote recruitment of newly qualified midwives.
- Working closely with the communications team to promote Medway maternity as a place to work.
- Liaising with HR to understand exit interviews and working on ways to improve retention, including additional support for newly qualified staff

3 Conclusion and Next Steps

3.1 The report has provided the Board the outcome of a service review, gap analysis and benchmarking against the recommendations, 15 IEAs and 88 incorporated actions outlined in the final Ockenden report, March 2022.

3.2 The report requests the Board note the analysis, benchmarking and actions required for compliance.

4 Appendix 1

Board Assurance Framework Maternity Quality Improvement Plan: Ockenden 2

Maternity BAF
Quality Improvemen

Maternity Board Assurance Framework (BAF)
Quality & Improvement Plan
Ockenden 2 (2022)

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
			OCKENDEN 2 (2022)				
			1. Workforce Planning and Sustainability				
Essential action – financing a safe maternity workforce: The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.							
Q1	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	Annual workforce review and birthrate+ assessment undertaken and shortfall raised with Trust Board for additional funding. Support ongoing national investment and bid as appropriate. Obstetric workforce reviewed and increased in 2021 to support additional ward rounds/consultant presence. NICU workforce review annual - nursing staff meeting QIS requirements and medical workforce meets BAPM requirements. Workforce paper/business case completed in line with findings of Birthrate+ review and NHSEI workforce review.	Last formal Birthrate Plus review was completed in 2018. Local exercise being undertaken 2022. Completed report will be taken through Trust governance reporting process.	Workforce paper to be presented to Trust Board in August 2022. Review of obstetric staffing levels is required to ensure adequate consultant cover for acuity and complexity of caseload.	Aug-22	Director of Midwifery Clinical Director, Women's & Children's	
Q2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Establishment levels are in line with most recent birth rate plus. This has been repeated in May 2022 which anticipates further recommendations which will be included in the paper to the Trust Board.	LMNS only receive information on staffing levels. Birthrate plus includes these for Midwives. Obstetricians Neonatologists and Nurses	Team Connect works with vulnerable families and their caseload is reduced to allow them to provide additional support to these families. Any staffing and workforce concerns are reported through the Trust Governance processes and the LMNS.	Aug-22	Director of Midwifery	
Q3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Birthrate + Review and Report NHSEI Workforce review report Board report/Business Case 2021 Board report 2022	Current uplift based on previous Birthrate + review was calculated at 21%. Post Ockenden recommendations regarding enhanced maternity MDT training an increased uplift is required. LMNS funded workforce review (March 2022) recommended increasing uplift to 25% to cover leavers and mandatory training. This will be incorporated into the local staffing review.	Workforce paper to be presented to Trust Board in August 2022.	Aug-22	Director of Midwifery	
Q4.	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	The Birthrate+ tool is currently the only nationally recognised midwifery staffing tool.	Need for a national review of Birthrate+ and additional staffing tools available for maternity staffing.	Support national review of Birthrate plus and adopt methodology based on national recommendations	TBC as National initiative	TBC as National initiative	
Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.							
Q5.	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this	Preceptorship programme including supernumerary guidance in place Band 5 study day Band 5 Competencies National Working Group evidence	Preceptorship programme and Band 5 study day will be reviewed to incorporate and reflect the recommendations from Ockenden 2. Education lead is part of national group to standardise preceptorship across Trusts - actions/ambitions listed in actions.	Need to review preceptorship rotational schedule to ensure exposure to all areas of maternity. Need to review preceptorship to allow preceptees to reflect and revisit areas that they feel they need to meet competencies in before finishing the year preceptorship. Streamline transition process from student to preceptee - more teaching opportunities from clinical environment for students.	Dec-22	Intrapartum Matron	
Q6.	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Currently NQM may be transferred to community after 6 months in the hospital setting. All are signed off for appropriate competencies before being able to practice in the community.	Currently NQM may be transferred to community after 6 months in the hospital setting. All are signed off for appropriate competencies before being able to practice in the community.	Review deployment times of NQM into the community. Continue to work with HEI to ensure we get appropriate numbers and strong candidates as NQM and working towards reinstating twice yearly intake. Consider advertising for community specific band 6 midwives	Dec-22	Intrapartum Matron	
Q7.	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	* Coordinator competencies * Coordinator JD?	No current national course for coordinators. Aspiring coordinators currently do a period of acting up and get signed off on competencies prior to commencing the role which allows for succession planning.	Fully support this ambition and will seek support and funding for coordinators to attend national course once available.	Dec-22	Head of Midwifery	
Q8.	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Current competency pack is used to support orientation, but there is a need for a further bespoke package to be designed to encompass roles, responsibilities and personal and professional development opportunities.	A need for a further bespoke package to be designed to encompass roles, responsibilities and personal and professional development opportunities.	A need for a further bespoke package to be designed to encompass roles, responsibilities and personal and professional development opportunities. Work with LMNS colleagues to support best practice and professional development opportunities	Dec-22	Intrapartum Matron	
Q9.	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	RCM accredited Maternity Enhanced Care Course (used across LMNS) MECU training course figures Rota to demonstrate compliance	No gaps in assurance	Continued funding support for placement on course.	May-22	Director of Midwifery	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
Q10.	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Deputy team leader/Specialist JD Evidence of attendance on training/development programmes	Currently offer deputy roles within specialist midwifery roles to support career development and succession planning e.g.. risk, bereavement, diabetes, mental health, screening, infant feeding, deputy senior sisters in community. No formal succession planning strategy in place Trust offers manager development training which is open to all relevant staff and midwives are supported to attend if requested. Aspiring leaders are talent managed at appraisals and supported to set appropriate objectives to support their development. Staff supported to undertake NHS Leadership Academy Course where appropriate.	Develop robust succession planning strategy Gap analysis of all leadership roles	Dec-22	Director of Midwifery	
Q11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	LMNS regional Maternal Medicine Working party papers Board Reports Evidence of funding for sub-specialist trainee	Funding for maternal medicine centre has not been approved/finalised.	Working with the LMNS to develop maternal medicine network regionally - awaiting funding agreement and timescales from LMNS Successfully applied for national funding for sub-specialist trainee in maternal medicine - awaiting funding to be allocated	Dec-22	Clinical Director, Women's	
2. Safe Staffing: All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.							
Q12	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Regional Dashboard/Mutual Aid agreement Escalation Policy Maternity daily staffing is included within the daily Trust site staffing pressure report.	Local escalation processes in place which includes escalation to senior management team, obstetric lead. Need to formalise process to notify chief nurse medical director, safety champion and LMNS of escalation events.	Review escalation policy in line with mutual aid protocols Review escalation process to Chief Nursing Officer and MD Final stages of developing regional dashboard which will allow Trusts within the region to be aware of neighbouring trust's position and ability to offer mutual aid.	Dec-22	Head of Midwifery	
Q13	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Obstetric and Gynae rotas Job Planning If in escalation this would be reported to Site and SMOC and DOC would be advised.	No gaps in assurance	No gap in assurance but will continue to monitor compliance to 24/7 dedicated consultant rota	May-22	Clinical Director, Women's	
Q14	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Labour Ward Coordinator JD (to be revised)	JD currently in place - to be refreshed in light of Ockenden recommendations for training and development.	JD currently in place and being reviewed	Aug-22	Intrapartum Matron	
Q15	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain	MCoC Report/Trajectory Exec reports/Board Reports - pausing to MCoC reported to board April 2022	Need to get further guidance in line with CNST year 4 relaunch requiring COC by March 24 and LMNS pushing ahead with plans.	Current COC action plans are in place with appropriate role out trajectory based on safe staffing levels. This will now be paused pending further national guidance in light of Ockenden recommendations. Focus will now be shifted to recruitment and retention to ensure staffing built to maintain safe staffing across the community and hospital.	Dec-22	Director of Midwifery	
Q16	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction						
Q17	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	Rotas Job Planning TNA All consultants and locally employed doctors are allocated sufficient time for training outside of generic mandatory training. Junior doctors are also given protected time for training weekly on a Friday.	Study leave time is not always protected due to clinical pressures.	Review consultant study leave allocation Review TNA for doctors training to ensure in line with current recommendations.	Aug-22	Clinical Director, Women's	
Q18	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Education team rotas & JD/structure Team are supernumerary to workforce and work alongside NQM and new to Trust midwives to support orientation and preceptorship. Education team mirror shifts where possible to ensure additional staff available when more band 5s present on shift.	No gaps in assurance	Currently 1 band 7, 3 band 6, (plan to move to 2 Band 7 2 Band 6).	May-22	Intrapartum Matron	
Q19	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Maternity Structure/lines of reporting	No formal mentorship programme in place for new Band 7/8 staff, informal mentorship amongst existing staff.	Include mentoring programme as part of succession planning strategy.	Dec-22	Head of Midwifery	
Q20	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Daily Hospital/Community leaders meeting where cases of concern/high-risk are discussed and individualised care planning developed to ensure high-quality care and communication. EDN generated on discharge which communicates between hospital and community setting. Guidelines and pathways are developed collaboratively between hospital and community staff. EuroKing Electronic records allows all staff to have access to the maternity record across all locations.	Collaborative working is part of business as usual - Audit compliance with bi-directional pathways.	Audit Compliance with bi-directional pathways between hospital and community setting.	Sep-22	Intrapartum and Community Matrons	
Q21	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	General guidelines for New medical staff and locums Mainly use internal locums or doctors who have worked in our trust before. For all new locums (long term) HR follows due process for pre-employment checks . We arrange CTG and PROMPT course for new long term locums.	Guideline requires updating to reflect current staffing and escalation process (in line with consultant SOP)	Update guideline to reflect current staffing and escalation process (in line with consultant SOP)	Sep-22	Clinical Director, Women's	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
3. Escalation and Accountability: Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.							
Q22	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	Human factors training included in PROMPT training CTG training and CTG meetings highlight the process for escalating concerns regarding CTG readings and differing opinions. *Currently use SBAR as a means of escalating clinical concerns. Many maternity policies direct midwives to escalate to consultant if there are unresolved concerns.	Need to formalise conflict of clinical opinion policy.	Develop bespoke conflict of clinical opinion policy	Nov-22	Head of Midwifery	
Q23	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Obstetric clinician rota Consultant roles and responsibilities SOP. Consultant rota provides 24/7 advice and support to trainees and middle-grades, with SOP in place to support escalation and consultant attendance. Each shift where consultant is not physically present is managed by a senior registrar with appropriate seniority to manage the shift (Clinical Trust Fellow/ST5/ST6/ST7)	Update new doctor and locum guidance.	Update new doctor and locum guidance.	Aug-22	Clinical Director, Women's	
Q24	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Consultant roles and responsibilities SOP. Consultant rota provides 24/7 advice and support to trainees and middle-grades, with SOP in place to support escalation and consultant attendance.	Audit currently ongoing - awaiting results to determine compliance.	Link to annual audit programme	Aug-22	Clinical Director, Women's	
Q25	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Consultant Roles and responsibilities SOP Consultant Audit (from Aug 22) Rota in place from February 2022 - 8-8 consultant presence 7 days per week, with SOP in place to outline roles and responsibilities and requirements for attendance when on call.	Audit currently ongoing - awaiting results to determine compliance.	Link to annual audit programme	Aug-22	Clinical Director, Women's	
Q26	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Escalation guidelines Consultant roles and responsibilities SOP	Audit against escalation policy required	Audit compliance with Escalation guideline Escalation guideline provides clear details of when to escalate acuity on the unit to both the consultant on call and the midwifery manager on call.	Sep-22	Head of Midwifery	
4. Clinical Governance Leadership: Essential action Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.							
Q27	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Perinatal Surveillance Tool Reporting SOP Board Reports Perinatal Surveillance Tool	Need to formalise regular reporting of Ockenden to the Board and confirm CNST year 4 reporting schedule for remained of the year.	Formalise reporting schedule for Ockenden and CNST with Trust Board	Jun-22	Director of Midwifery	
Q28	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Benchmarking against the NHSI Self-Assessment tool completed in 2021 -	Need to refresh benchmarking for 2022, add actions to BAF and complete Board report	Refresh benchmarking against self-assessment tool and complete report for Trust Board by 30 June 2022.	Jun-22	Head of Midwifery	
Q29	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Risk Midwife JD Risk/Governance/audit midwife JD	Governance/audit midwife started in April 2022 - need to embed working practice.	Embed working practice of new audit/governance midwife.	Jul-22	Head of Midwifery	
Q30	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Job Plan Role descriptor Rota Clinical Governance Leads have 1 session per week - reflected in their job plans.	Leads are new in post and role and practice need to be embedded.	Embed working practice of new governance leads.	Aug-22	Clinical Director, Women's	
Q31	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	Governance leads are trained in human factors and RCA.	No formal family engagement training undertaken	Seek opportunities for family engagement training Ensure all current clinical governance leads have completed Human factors and RCA training.	Dec-22	Clinical Director, Women's	
Q32	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. Currently senior midwife/matron obstetrician reviews guidelines.	Guidelines are coproduced where required, with speciality/department leads write guidelines for their areas. All guidelines are reviewed by MDT team at Forums and governance meetings for sign-off.	No formal Consultant lead for guidelines/Consultant midwife not in post.	Appoint Consultant midwife and develop appropriate work plan. Once consultant midwife is appointed, there will be shared ownership of guidelines.	Aug-22	Head of Midwifery	
Q33	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Audit Lead JD Audit Midwife JD Consultant lead for audit in place and audit midwife in post.	Audit midwife new in role, need to embed working practice and audit schedule	Develop work plan for audit midwife and obstetric audit lead.	Aug-22	Intrapartum Matron	
5. Clinical Governance - Incident Investigation and Complaints: Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.							
Q34	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Currently explain terms in body of SI report.	Review glossary from HSIB and adapt and include as an appendix to all SIs	Review glossary from HSIB and adapt and include as an appendix to all SIs	Jul-22	Intrapartum Matron	
Q35	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Fetal wellbeing team use current cases for education, local cases also used for PROMPT. Work with LMNS to review and sign-off training plans	Need for improved triangulation from clinical incidents and shared learning. To be reviewed as part of LMNS Training Assurance Group.	Evidence database of cases presented for education Updated Training Plan.	Sep-22	Intrapartum Matron	
Q36	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Routinely include follow up audits in the action plan for all SIs -	Need for improved triangulation from clinical incidents and shared learning. To be reviewed as part of LMNS Training Assurance Group.	Audit programme against all SIs required	Sep-22	Intrapartum Matron	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
Q37	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Currently all SIs with immediate learning/actions are actioned ASAP e.g.. Stopping daws Redman for women with abdominal pain - evidence of communication to all staff, Friday News, change in guidelines.	Need to develop a robust audit programme against recommendations from SIs, including re-audit as required.	Improve process to ensure changes are implemented and evidenced within a timely way.	Sep-22	Intrapartum Matron	
Q38	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	The current process is when complaints are received they are assessed which includes checking against incidents and PALS. If the complaint is considered to be complex or higher risk they are categorised as Red and the divisional team are notified. The complaints team also regularly discuss / raise issues with the patient safety team (to determine if it's a current SI, or if there are other cases of similarity) and/or the safeguarding team. If the Red complaint is not found to be an existing SI the divisional governance and quality team and / or the DDON will consider if it should be one.	Complaints policy under review does. Does not formally state process for reviewing complaints and making them SIs if appropriate.	Complaints policy under review. To be provided as evidence once finalised.	Dec-22	Head of Midwifery	
Q39	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Trust has a central complaints process in place. Review and pilot of new Complaints process from Ombudsman underway - to include MVP in working Group Working party established to review process and introduce new pilot in Women's and Children's - MVP to be involved.	Current complaints process does not include service user representation.	Review complaints process/guideline with complaints manager and revise as appropriate following outcome of pilot which will include service user representation.	Dec-22	Head of Midwifery	
Q40	Complaints themes and trends must be monitored by the maternity governance team.	Monitored monthly via Governance Report Included on LMNS dashboard Perinatal Surveillance Tool	Need to improve process for sharing learning and themes with frontline staff.	Need to improve shared learning at ward level and understanding of themes and trends	Aug-22	Intrapartum Matron	
6. Learning from Maternal Deaths: Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.							
Q41	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	Maternal deaths are appointed to a pathologist by the coroner.	Awaiting national guidance.	Review maternal death guideline in line with recommendations. When coroner is notified of a maternal death, highlight the requirement for a expert perinatal pathologist.	Jul-22	Head of Midwifery	
Q42	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Review panel for all cases would take place. Need to ensure independent chair. Maternal deaths are investigated by the Coroner and HSIB and the Trust develop action plans in response to the reports.	Require independent chair for all maternal death cases for PMRT reviews.	Review maternal death guideline in line with recommendations.	Jul-22	Head of Midwifery	
Q43	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS	All Maternal deaths would be shared with LMNS and Trust Board via Perinatal Surveillance Tool.	Need to develop a robust audit programme against recommendations from SIs, including re-audit as required.	Process to be implement as above for SIs.	Aug-22	Head of Midwifery	
7. Multidisciplinary Training: Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training							
Q44	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Medical staff have audit time allocated in diary. The senior midwifery team attend audits as available.	Midwifery staff are not allocated time to attend audit.	When safe staffing levels are met, we will allocate clinical midwifery staff to attend audit and quality summits	Dec-22	Head of Midwifery	
Q45	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Local handover tools in place - SHARED stickers or Risk Assessment Tools on admission in labour - but not explicitly included in training. Getting attention of leader - escalation and SBAR/each baby count tools is included in PROMPT. Handover covered in band 5 study days. Neonatal resuscitation handover tool is included in NBLS training .	Need to ensure local handover tools are shared at midwifery and obstetric induction.	Review training schedules/plan and ensure handover is included.	Jul-22	Intrapartum Matron	
Q46	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Human factors is included in training and will be agreed with LMNS as part of training assurance group including civility working. Incivility training included in essential skills. Recent examples provided during training.	Awaiting LMNS approval of content	Ensure LMNS approves all content via Training Assurance Group.	Aug-22	Intrapartum Matron	
Q47	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Simulation is part of PROMPT training. Skills drills/simulations to be reinstated on the unit.	Need to increase Simulation/skills drills across the unit.	Reinstate skills drills/simulations - to be led by Fetal Wellbeing Team/Education Team/MIC Doctor allocated time to support simulation - review of job planning/rota required. Need to provide evidence of content covered Audit	Aug-22	Intrapartum Matron	
Q48	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Debriefs following complex incidents PMA support available - provide wellbeing support Culture survey being undertaken to understand psychological safety TRIM training for managers to support staff Trust focus on Wellbeing - "Wellbeing Wednesdays" THRIVE Training for managers to help support staff. Team Meetings	2022 SCORE survey to be undertaken and robust action plan put in place.	To include question on whether staff feel supported in Culture Survey	Jun-22	Head of Midwifery	
Q49	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	CTG training package/competencies/assessment Training allocation Training compliance figures/trajectory	Clinical pressures preventing attendance at training.	Training trajectory in place with ambition to achieve >90%. Training Needs Analysis reflects requirements for annual training.	Jan-23	Director of Midwifery Clinical Director, Women's	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
Q50	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	CTG training package/competencies/assessment Training allocation Training compliance figures/trajectory	Clinical pressures preventing attendance at training.	Training trajectory in place with ambition to achieve >90%. Training Needs Analysis reflects requirements for annual training.	Jan-23	Director of Midwifery Clinical Director, Women's	
8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy							
Q51	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Specialist clinics provided for pre-existing medical conditions e.g.. Diabetes, hypertension etc.	Do not currently provide pre-conception care.	Need to review pre-conception offer with primary care. Specialist clinics provided for pre-existing medical conditions e.g.. Diabetes, hypertension etc. Do not currently provide pre-conception care.	Dec-22	Director of Midwifery Clinical Director, Women's	
Q52	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Appropriate staffing, clinics and guidelines in place for multifetal pregnancies.	No gaps in assurance	Review guidance to ensure that it reflects the appropriate language	Aug-22	Intrapartum Lead	
Q53	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Local guidelines in place and reflect NICE 2020 guidelines.	No gaps in assurance	Review guidance to ensure that it reflects the appropriate language	Aug-22	Fetal Medicine Matron	
Q54	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Diabetes guideline supports decision making on when to deliver. PIL in place and PSC planning in place.	Audit required to confirm compliance	Case note audit to confirm compliance	Sep-22	Fetal Medicine Matron	
Q55	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Appropriate hypertension guideline.	Audit required to confirm compliance	Review guideline to ensure meetings Ockenden requirement.	Aug-22	Clinical Director, Women's	
9. Preterm Birth: The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)							
Q56	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Fetal medicine run preterm birth clinic. We are a tertiary referral unit for extreme prematurity and follow BAPM guidance ensuring that women receive joint obstetric and neonatal guidance from senior clinicians and management plans are documented.	Preterm birth guidelines due for review.	Preterm birth guidelines being updated	Jul-22	Clinical Director, Women's	
Q57	Women and their partners must receive expert advice about the most appropriate Fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Fetal monitoring guideline, intermittent auscultation guideline, pregnancy loss guideline., Risk assessment in labour guideline/assessment tool, Antenatal Optimisation Bundle	Need to ensure advice given is appropriate for monitoring of babies on the cusp of viability.	Review guideline to ensure appropriate advice for monitoring of babies on the cusp of viability.	Jul-22	Clinical Director, Women's	
Q58	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability	Pre-birth neonatal counselling for families as part of antenatal optimisation bundle.	Audit required to confirm compliance	Optimisation QI project underway. Re-audit compliance with optimisation bundle	Dec-22	Head of Midwifery	
Q59	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit	In utero transfers would not be made to unit that was not level 3 if level 3 care was required.	Audit required	Monitor any relevant cases to ensure appropriate level of NICU care/management for any in utero transfers.	Dec-22	Intrapartum Matron	
10. Labour and Birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units							
Q60	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Admission in labour tool allows for full assessment and appropriate discussions with women if chose place of birth is no longer recommended based on clinical presentation.	Audit required to confirm compliance	Re-Audit use of Risk Assessment Tool	Aug-22	Intrapartum Matron	
Q61	Midwifery-led units must complete yearly operational risk assessments.	N/A	Need to devise a MLU operational risk assessment tool.	Need to devise a MLU operational risk assessment tool	Aug-22	Community Matron	
Q62	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Video simulations recorded during Covid-19 - need to develop in person simulations on the birth place	Need to reinstate simulation/skills drills on the unit.	Develop in situ simulation programme on the birth place Education team/Fetal wellbeing team to develop Simulation programme.	Aug-22	Intrapartum Matron	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
Q63	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust. Transfer information updated in Homebirth guideline with times for ambulance response times included. Cannot include times from a woman's home but this could be considered in homebirth risk assessment	Homebirth policy.	Homebirth policy being revised and information leaflet being implemented for women. To be added to the homebirth risk assessment.	Revised homebirth guidance to be finalised and approved through appropriate governance meetings. Work with LMNS/Regional SECAMB to develop a regional information sheet.	Aug-22	Community Matron	
Q64	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	IOL guidelines in place.	Formal process for delayed IOLs needs to be implemented.	Revisit guideline to include daily CTG for delayed IOL and ensure appropriate mechanisms documented. Working on mutual aid guidance to formalise support from other Trusts.	Jul-22	Intrapartum Matron	
Q65	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Appropriate CTG guidelines in place.	Need to review centralised CTG system to ensure it is fit for purpose and meets the needs of transition to physiological interpretation.	Review Fetal monitoring guidelines to reflect Ockenden wording – ensure regional Fetal Wellbeing group revising guidance to include Fetal physiology reflect Ockenden requirements.	Aug-22	Fetal Wellbeing Leads	
11. Obstetric Anaesthesia: In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.							
Q66	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Currently would follow up anaesthetic complications such as puncture headache, need for more robust pathway to meet this requirement.	Currently would follow up anaesthetic complications such as puncture headache, need for more robust pathway to meet this requirement	Discuss with Obstetric Anaesthetic Lead to consider introducing pathway for postnatal anaesthetic follow-up.	Dec-22	Clinical Director, Women's	
Q67	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	All patients who have had anaesthetic intervention are reviewed following day by anaesthetics.	Need to formalise postnatal anaesthetic review process.	Discuss with Obstetric Anaesthetic Lead to consider introducing pathway. Need audit instances of complex anaesthetic cases to understand the predicted workload and consultant time required to meet needs of the postnatal anaesthetic pathway.	Dec-22	Clinical Director, Women's/ Anaesthetic Lead	
Q68	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Currently complex anaesthesia patients are debriefed in recovery post-delivery. Need for more robust pathway to ensure we capture all appropriate cases and offer outpatient support as required.	Audit to assess compliance	Audit of anaesthetic documentation	Dec-22	Clinical Director, Women's	
Q69	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	This is a requirement for the national anaesthetic professional bodies - presumably the Obstetric Anaesthetists' Association and the Royal College of Anaesthetists - to do. Not applicable for local units	Not applicable for local units	This is a requirement for the national anaesthetic professional bodies - presumably the Obstetric Anaesthetists' Association and the Royal College of Anaesthetists - to do. Not applicable for local units	TBC as National initiative	TBC as National initiative	
Q70	Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	No current guideline apparent on Qpulse - follow ACAS guidance - need to review and determine if local guidelines required.	No current guideline apparent on Qpulse - follow ACAS guidance - need to review and determine if local guidelines required	No current guideline apparent on Qpulse - follow ACAS guidance - need to review and determine if local guidelines required. Need to map staffing that it is in line with this recommendation.	Dec-22	Clinical Director, Planned Care	
12. Postnatal Care: Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times							
Q71	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	Roles and responsibilities of consultants SOP in place that indicates requirements for postnatal ward rounds.	Audit required to confirm compliance	Audit of compliance with consultant ward round	Sep-22	Intrapartum Matron	
Q72	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Roles and responsibilities of consultants SOP in place that indicates requirements for postnatal ward rounds.	Audit required to confirm compliance	Audit of compliance with consultant ward round	Sep-22	Intrapartum Matron	
Q73	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	All admissions are admitted via triage following obstetric review. They would then have daily review on postnatal ward or more urgently if required.	Audit required to confirm compliance	Audit of compliance	Sep-22	Intrapartum Matron	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
Q74	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Safe staffing has been agreed at 1:8 for the postnatal ward. There are occasions where this is not met due to staff shortages. Attempts are made to mitigate risks by deploying increased numbers of MSWs at these times.	Audit required to confirm compliance	Audit of staffing and patient on postnatal ward to determine compliance with safe staffing guidelines. Birth rate plus workforce review underway Awaiting ward module for Birthrate+ acuity tool	Oct-22	Intrapartum Matron	
13. Bereavement Care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services							
Q75	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Bereavement team currently staffed to 2 WTE midwives (6 and 7) plus administration support. Previously provided 5 day a week service, but in the process of transitioning to 7 day a week service.	Need to increase numbers of bereavement trained staff so that there is a champion on each shift.	Update Bereavement team SOP/guidelines to reflect 7 day a week working Audit of compliance	Nov-22	Fetal Medicine Matron	
Q76	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	A number of staff are trained to undertake PM consent - Bereavement midwife train the trainer. Flow chart in place to support timely consent.	Need to increase numbers of trained staff to ensure 1 per shift.	Review numbers of trained staff and undertaken training programme to increase numbers. – (Team Vilomah) – to ensure appropriately trained staff on every shift. Audit compliance with post-mortem counselling within 48 hours. Audit compliance with trained staff per shift once Team Vilomah reinstated.	Nov-22	Fetal Medicine Matron	
Q77	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome	Perinatal Loss Clinic in place	Audit to confirm compliance.	Review of guidelines to ensure details of follow up care offer included Audit all losses to determine compliance with follow up	Nov-22	Fetal Medicine Matron	
Q78	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Local guidelines/SOP/PIL are all underpinned by the NBCP	No gaps in assurance	No gaps in assurance	May-22	Head of Midwifery	
14. Neonatal Care: There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.							
Q79	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly	As level 3 unit MFT are not required to do exception reporting Agreed pathway is that if there is a preterm baby <27 weeks who are presenting to a 2 of 1, at best should be transferred to level 3 unit as in-utero transfer - monitored via network. MFT monitor in-utero requests - acceptance/decline.	Audit to confirm compliance	Audit of current in utero requests - acceptance/decline Audit of outcomes for any babies unable to be accepted into the unit due to capacity/staffing.	Aug-22	Clinical Director, Children's	
Q80	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Compliant 2021: 99.6%	Audit 2022 compliance	Audit 2022 compliance	Jan-23	Clinical Director Children's/Clinical Director Women's	
Q81	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Fully engaged with ODN activities, neonatal staff attend regular education sessions and also present and patriate in guidelines.	No gaps in assurance	No gaps in assurance	May-22	Clinical Director Children's	
Q82	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	Network action	No gaps in assurance	Regular peer reviews and GIRFT assessments are welcomed within ODN. The NNAP audit programme run in association with Badgernet and PMRT review process also add collaborative working oversight and continuous peer review within the national neonatal network.	May-22	Clinical Director, Children's	
Q83	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	100% compliant - contacted via switch - connected to resuscitation team connected via band 7 phone to provide live advice during resuscitation.	Audit to confirm compliance.	Audit to confirm compliance	Dec-22	Clinical Director Children's	
Q84	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	All neonatal staff, medical and nurses have passed NBLS training - core competencies Band 6 and band 7, all compliant with NLS training annual refresher Updated resuscitation guidelines	Places on national course are limited.	Review current compliance with local NBLS and resuscitation council training courses.	Aug-22	Clinical Director Children's	
Q85	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Appropriate staffing across all tiers as reflected in rota and workforce paper.	No current gaps in assurance.	Continue with annual workforce review.	May-22	Clinical Director Children's	

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	RAG
15. Supporting Families: Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care							
Q86	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	All women are asked questions pertaining to their psychological welfare at each appointment. Any concerns are signposted appropriately to the perinatal mental health team or other external agencies as required. Mental health guidelines in place to support pathway with clear referral process in place. Mental health training included in annual mandatory training.	Audit required	Audit required	Aug-22	Community Matron	
Q87	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Cases of concern are referred in a timely manner and reviewed by the perinatal mental health team.	Audit required	Audit required	Aug-22	Community Matron	
Q88	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Joint mental health clinic runs with appropriate psychological practitioner.	Audit required	Audit required	Aug-22	Community Matron	

Complete	Action has been completed and there is robust evidence to support that the action has been completed and where relevant, embedded practice
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address
Of track with actions to deliver	Action is off track and plan are being put in place to mitigate any delay
On track	Action is on track with progress noted and on trajectory
National Action	Action not deliverable for local Trusts

Meeting of the Board of Directors in Public
Wednesday, 08 June 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 £0.5m deficit, this is in line with the draft NHSE/I plan.		
Link to strategic Objectives	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance report		

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Finance report

For the period ending 30 April 2022

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(552)	(553)	(1)	The Trust reports a £0.5m deficit position for April, this is in line with the plan submitted to NHSE/I. after making the technical adjustments for donated assets depreciation. The reported position includes Elective Recovery Funding (ERF) income of £0.8m, and £0.8m release of accruals. Excluding non-recurrent year-end adjustments in month 12 relating mainly to increased pensions costs, CEA awards the annual leave accrual, this month's pay expenditure has increased by £0.2m which is predominantly the 1.25% impact of the Health and Social Care Levey N.I. rise. Covid costs excluding DoH stock adjustments have remained consistent compared to March as £0.4m.
Donated Asset Depreciation	13	26	13	
Control Total	**(539)**	**(527)**	**12**	
Efficiencies Programme				
In-month	318	311	(7)	The in-month position is reporting slightly adverse to plan to deliver £0.3m of efficiencies for April. Schemes are progressing with development and overall £9.8m of schemes have been identified against a target of £9.6m for 2022/23, included in this position £0.3m relates to the full year effect impact of schemes from 21/22.
Capital				
In-month	438	328	(110)	The ICS agreed capital allocation (CRL) for the Trust is currently £11,550k, £10,970k to be funded internally from depreciation; £500k funded by pre-approved PDC for the completion of the UTC project, £80k estimated PDC allocation for other yet to be confirmed schemes.
YTD	438	328	(110)	
Forecast	11,550	11,550	0	The Trust is finalising the detailed plan which will enable budgets to be set and monitored at an individual scheme level for 2022/23.

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Cash				
Month end	33,455	34,241	786	Cash balances are slightly higher in month 1 due to the Trusts main commissioner settling some long standing debt.

Activity is below draft budgeted levels as a result of Covid	Activity and income plans for M1 have not yet been finalised but will be finished in time for M2 reporting. Activity and income plans are based on 19-20 activity priced at 22/23 tariff, adjusted for growth for all areas except for elective and outpatients, which have been uplifted to achieve the 104% ERF target.

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

£'000	In-month		
	Plan	Actual	Var.
Clinical income	27,538	27,495	(43)
High cost drugs	1,888	1,935	48
Other income	2,507	2,195	(313)
PSF/MRET/FRP	0	0	0
Donated Asset Adjustment	0	0	0
Total income	**31,933**	**31,625**	**(308)**
Nursing	(8,325)	(8,502)	(177)
Medical	(6,553)	(6,924)	(371)
Other	(5,686)	(4,960)	726
Total pay	**(20,564)**	**(20,387)**	**177**
Clinical supplies	(4,052)	(3,797)	254
Drugs	(632)	(898)	(266)
High cost drugs	(1,888)	(1,813)	74
Other	(3,510)	(3,562)	(52)
Total non-pay	**(10,081)**	**(10,070)**	**11**
EBITDA	**1,288**	**1,168**	**(120)**
Depreciation	(1,218)	(1,171)	48
Donated asset adjustment	(13)	(26)	(13)
Net finance income/(cost)	(1)	20	21
PDC dividend	(608)	(544)	65
Non-operating exp.	**(1,841)**	**(1,720)**	**120**
Reported surplus/(deficit)	**(552)**	**(553)**	**(1)**
Adj. to control total	13	26	13
Control total	**(539)**	**(527)**	**12**

1. Funding arrangements for the full year 2022/23 have been agreed with the Kent & Medway CCG and included in the draft plan submission.
2. Other income planned figure includes an estimate of income to be recovered during the year to bring income to the same level as the outturn position for 2021/22. This is expected to recover as the year progresses from NHS provider to provider contracts, car parking income, additional out of envelope covid income to cover vaccination and quarantine costs, medical education contribution to overheads, and drugs recharges offsetting overspending in clinical divisions.
3. The ERF income for April is included, although this is at risk pending further coding of activity and meeting the 104% plan as a system overall.
4. Pay budgets are £0.2m favourable to plan, however this includes £0.8m release from contingency accruals.
5. The Nursing and Medical pay categories are reporting a deficit position as these include efficiency targets that have not been attributed to specific schemes in April. It is expected the pay position will improve as the services finalise and deliver these agreed schemes such as medical productivity and reduced length of stay.
6. Escalation capacity has been fully budgeted and included within the final position, this also incorporates funding for the additional junior medical locum shifts that were a cost pressure during 2021/22.
7. Increased costs to deliver ERF activity targets have been identified, the budget to cover these costs is held in central reserves and included in the position.
8. Depreciation and dividends are planned to increase by £3.7m for 2022/23 compared to the previous year, this being the impact of the capital programme and PDC drawn down for the last financial year.
9. Covid costs have reduced in month to £246k and it is expected the trend will continue to fall during the year in line with reduced covid infections.

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3. Balance sheet summary

Prior year end (DRAFT)	£'000	Month end actual	Var on PY.
240,295	**Non-current assets**	**239,440**	**(855)**
5,996	Inventory	6,066	70
13,633	Trade and other receivables	15,649	2,016
33,455	Cash	34,241	786
53,084	**Current assets**	**55,956**	**2,872**
(136)	Borrowings	(139)	(3)
(27,890))	Trade and other payables	(28,730)	(840)
(2,115)	Other liabilities	(3,841)	(1,726)
(30,141)	**Current liabilities**	**(32,710)**	**(2,569)**
(2,025)	Borrowings	(2,025)	0
(1,248)	Other liabilities	(1,248)	0
(3,273)	**Non-current liabilities**	**(3,273)**	**0**
259,965	**Net assets employed**	**259,413**	**(552)**
461,656	Public dividend capital	461,656	0
(245,216)	Retained earnings	(245,216)	(552)
43,525	Revaluation reserve	43,525	0
259,965	**Total taxpayers' equity**	**259,413**	**(552)**

Key messages:

1. Overall Net Assets = £259.4m, £0.5m reduction due to the in-month deficit.
2. Trade and Other receivables, £2.6m invoice raised to Health Education England for quarterly funding, excluding this receivables have reduced in month.
3. Other Liabilities increase, £1.7m due to an increase in deferred income.

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4. Conclusions

The Board is asked to note the report and financial performance which is £553k deficit in-month reducing to £527k deficit after removing the adjustments for donated asset depreciation; this is in line with the £0.5m in-month deficit plan submitted to NHSE/I.

This overall financial performance for the year is to achieve a £3.1m deficit, this will change following a final plan submisstion on the 20th June when more confirmation is received regarding fundinf for inflation.

The final efficiency programme is marginally adverse to plan for month 1, however there still remains a risk of delivering the £9.6m programme prior to the additional £0.9m strectch target being added. General accruals in month have been reduced by £0.8m, this has been released into the position for April.

Alan Davies
Chief Financial Officer
May 2022

Meeting of the Board of Directors in Public

Wednesday, 08 June 2022

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte		
Date of Meeting:	Thursday 28 April 2022		
Lead Director:	Alan Davies, Chief Financial Officer		
Report Author:	Matthew Chapman, Head of Financial Management		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF strategic risks It was proposed to retain the scores for all 3 risks at the current level: 3a "Delivery of Financial Control Total" of breakeven was achieved for 21/22; however, the trust is submitting a plan for 22/23 with significant risks, currently being a deficit position of £3.1m. Rating 12 For 3b "Capital Investment" plan was delivered for 21/22 with a £5k surplus; further work is ongoing to confirm the plan for 22/23. Rating 12 For 3c "Financial Recovery Plan" progresses with further work ongoing through to the middle of May. Rating 16	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
2. Corporate risk register The delivery of the efficiency programme target remains at 4 x 4 = 16 as the plan under delivered by £1.0m for 21/22, and there still remain risks in the current programme for 22/23. **ACTION** to update the description on the risk assessment to 2022/23	**Amber/Red**
3. Finance report – month 12 The Chief Financial Officer tabled the report with the key highlights being: • The Trust has met its control total of breakeven in month 12 and for the full year of 21/22. • Non-recurrent system support funding of £2.5m was received for the increased escalation capacity. • The carry forward annual leave provision was increased by £1.7m to £4.6m. • £9.2m for increased pension costs (6.3%) was invoiced at the year end, this is covered by additional income. • The final position includes the impact of the year end stock count adjustments. • ERF Income of £8.9m was received for 21/22. • The efficiencies delivered were £4.1m, this being £1.0m adverse to the £5.1m plan. • The capital plan was achieved with a small surplus of £5k. • Cash sums remain in a strong position.	**Green**
4. Draft Annual Accounts 2021/22 The draft annual accounts were presented to the committee. There is a small surplus of £53k on the SOCI, this is adjusted to breakeven after removing the impact of donated assets depreciation and impairments. A revaluation exercise had been completed by Montague Evans, this resulted in an upward revaluation of the estate by £14m and can be seen on the balance sheet. The draft accounts had been submitted on time, with a final submission date of the 22nd June following the ongoing external audit currently taking place. It was noted the amount of hard work and commitment by the Financial Services team to put together a set of accounts of such high quality.	**Green**
5. Performance report month 12 The performance report was presented to the committee, this included a comprehensive slide pack detailing performance across the clinical services. There was a follow up discussion regarding current performance across services in the Emergency Department, high number of ambulance	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
handovers, cancer services and the Trust being ranked 5th in the country for cancer treatment.	
6. Efficiency programme update The programme for 21/22 delivery efficiencies totalling £4.1m, this being £1.0m adverse to the £5.1m plan. The Chief Financial Officer updated the committee on the latest plan for 22/23 which is currently reporting a gap in the range of £1.2m - £2.5m. 9 of the 11 cross cutting schemes have been signed off and approved. The main focus for the transformation team is to finalise the length of stay scheme as well as medical productivity to close the current gap. Corporate schemes of £0.4m against a target of £0.6m have been confirmed. A target of 2.83% has been applied in the operational plan which totals £9.6m, and an additional 0.5% stretch target adding a further £0.9m to the bring efficiency plan to £10.5m.	**Amber/Red**
7. Operating plan update The Chief Finance Officer presented an update of the operational plan for 22/23. The main points included: • A draft deficit of £6.5m this being a marginal improvement from the first plan deficit of £7.3m. • Assumptions have been made for growth, inflation and efficiencies. • The main cost pressures relate to energy price increases, higher CNST costs, capital charges impact from the capital programme over the last couple of years, inflation and covid costs. • Recently prior to the finance committee meeting, it was agreed to mitigate the plan further by another £3.5m to a deficit of £3.0m. • The £6.5m position included £4.9m of mitigations yet to be identified in full. Adding a further £3.5m gives total mitigations required of £8.4m • In terms of identifying and delivering mitigations, the first target would be any balance sheet opportunities such as reassessment of provisions and accruals plus any non-recurrent items. • The plan includes ERF costs and income of £8.9m. To achieve this income requires delivery of 4% greater activity than the 19/20 baseline levels. • Non-pay inflation has been included at same levels included in the financial envelope; there is a risk this is not sufficient with current RPI being 6-7%. • Increased energy prices of £1m have been included (this is a national issue).	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
• A contingency of £2.2m has been included. The committee **AGREED** to submit the £3.0m deficit plan to the ICB and NHSE/I and noted the high level of risks included.	
8. Financial Recovery Plan ("FRP") The FRP Director updated the Committee on the latest Financial Recovery Plan document following the submission to NHSE/I and the feedback that followed. It is expected a final version of the plan would be tabled on or around the 12thMay ready for the FRP meeting on the 13th May, and would be in time for the next financial oversight meeting scheduled for the 16th May. The Trust will continue to work with Richard Winter from NHSE/I to focus on the underlying drivers of the deficit and some of the key areas of financial recovery.	**Amber/Green**
Decisions made **ACTION** to update the description on the risk assessment on the Corporate Risk Register to 2022/23. The committee **AGREED** to submit the £3.0m deficit plan to the ICB and NHSE/I and noted the high level of risks included.	
Further Risks Identified No further risks were identified.	
Escalations to the Board or other Committee There were no further issues identified to escalate to the Board.	

Meeting of the Board of Directors in Public

Wednesday, 08 June 2022

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte		
Date of Meeting:	Thursday 26 May 2022		
Lead Director:	Alan Davies, Chief Financial Officer		
Report Author:	Matthew Chapman, Head of Financial Management		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF strategic risks It was proposed to retain the scores for all 3 risks at the current level: 3a "Delivery of Financial Control Total" of £0.5m deficit was achieved for month 1. As the Trust has submitted a £3.1m deficit draft plan for 22/23 with significant risks, it is proposed the rating of 12 remains. For 3b "Capital Investment", further work is ongoing to confirm the plan for 22/23. Rating 12 For 3c "Financial Recovery Plan" has been finalised with further work ongoing to deliver the plan. Rating 16	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
2. Corporate risk register The efficiency programme for 22/23 is £9.6m with a further stretch target of £0.9m in H2. Further progress has been made to identify and finalise schemes, however there is still risk to deliver the programme. Score unchanged at 4 x 4 = 16. **ACTION** to update the description on the risk assessment to 2022/23	**Amber/Red**
3. Finance report – month 1 The Chief Financial Officer tabled the report with the key highlights being: • The Trust is reporting a £0.5m deficit position, this being in line with the draft plan submitted to NHSE/I. • Covid costs remain at £0.2m - £0.3m. • Delivery of efficiencies is on plan at £0.3m. • Capital spend is slightly less than plan for month 1 but expected to catch up during the year. • Cash sums remain in a stable position. • ERF Income of £0.8m was fully accrued in month, however there is a risk of not meeting the 104% targets across the system.	**Green**
4. Performance report month 1 The performance report was presented to the committee, this included a comprehensive slide pack detailing performance across key business performance metrics of emergency demand, patient flow, RTT, cancer and diagnostics. The report was discussed by the committee with no further actions recommended.	**Amber/Green**
5. Efficiency programme update The Chief Financial Officer updated the committee on the latest plan for 22/23. A target of 2.83% has been applied in the operational plan which totals £9.6m, and an additional 0.5% stretch target adding a further £0.9m to the bring efficiency plan to £10.5m. At the time of the committee meeting, £9.8m of efficiencies had been identified, this includes £6.2m of the 11 cross cutting schemes. There is risk that not all schemes will deliver so further work continues to bring the RAG rating from red to green.	**Amber/Red**
6. Elective Recovery Funding The detailed report of elective recovery funding (ERF) was presented to the committee. ERF funding is income received above the block contract income, and based on delivering 104% of 19/20 activity. Over performance against these targets with be funded at an additional 75% of tariff, however the risk lies with underperformance where there will be a 75% clawback of the income if targets are not achieved.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Aside the 104% target, all systems and providers will be monitored against the following key elective recovery performance priorities: • Over 10% more patients completing treatment than in 2019/20 • Eliminating waits over 104 weeks by July 2022, eliminating waits over 78 weeks by March 2023 and reducing waits over 52 weeks • Reducing cancer 62+-day waiting list size to pre-pandemic levels by March 2023 • 25% reduction in OPFUs by 2023 • Increasing diagnostic capacity to a minimum of 120% of pre-pandemic activity levels to meet local need and support elective recovery. Though the priorities above are important, they will not affect payment if a provider meets the 104% target.	
7. Operating plan update The Chief Finance Officer presented an update of the operational plan for 22/23. There is further work ongoing to plan the trajectory of delivering ERF activity, identifying and funding of cost pressures and reducing the risk in delivering the efficiency programme. There will be a third plan submission on the 20th June 2022.	**Amber/Red**
8. Capital – Lift refurbishment works. A paper was presented to the committee detailing the need for a further 2 lifts to be installed. The total cost of the project is £2.5m, this straddles 2 years, with £1.8m required in 2022/23. The paper has been previously discussed and approved as part of previous papers to Trust Board on “Fire” as well as being approved at the Fire Committee and supported by BB7 the Trust’s independent fire advisors.	**Green**
9. Financial Recovery Plan (“FRP”) The FRP Director updated the Committee on the final FRP document and detailed the main changes since the previous meeting. The report has been seen and discussed with the ICS, NHSE/I and is moving further into delivery mode, with a view to breakeven by 2027/28. It was **RECOMMENDED** the financial recovery plan is approved by the Trust Board.	**Green**
10. Budget Holder Guidelines The committee was informed that the budget holder guidelines document has been updated and now available to all staff in the Trust intranet.	**Green**
11. Corporate Governance Statement It was agreed to move this item to the June Finance Committee meeting.	**Green**
Decisions made **ACTION** to update the description on the risk assessment on the Corporate Risk Register to 2022/23. It was **RECOMMENDED** the financial recovery plan is approved by the Trust Board.	

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Further Risks Identified No further risks were identified.	
Escalations to the Board or other Committee There were no further issues identified to escalate to the Board.	

2022-23 Business Planning – latest planning position.

Executive Summary

This report provides an update following submission of operational plans to NHSEI on the 27th May.

Current position

Since the submission of the plan detailed below on 27th May, regulators have requested a further submission by the 20th June. This will be a full resubmission including finance, activity, and workforce.

2022/23 High Level Bridge

£'000	Outturn	FYE serv. devp.	Non-recurrent	21-22 Normalised Position	Growth	Inflation	Efficiency	Contingency	Net Covid	Cost pressures	Net income movements	ERF	2022-23 Plan (Excl.Serv Devs)	Mitigation	22/23 Start position (inc. mitigations	Service developments	22/23 Start position (inc. mitigations)
Income	(399,844.7)	(2,896.8)	13,962.5	(388,779.0)	(2,634.1)	(9,403.5)	7,966.2	0.0	10,567.6	0.0	(108.1)	(8,900.0)	(391,290.9)	0.0	(391,290.9)	0.0	(391,290.9)
Pay	256,129.5	3,231.7	(9,988.1)	249,373.1	0.0	6,426.1	(5,284.7)	2,200.0	(1,601.6)	2,909.1	0.0	3,348.8	257,370.7	(3,719.3)	253,651.5	16,525.6	270,177.1
Non Pay	125,468.4	1,744.5	(4,753.4)	122,459.5	0.0	1,905.4	(4,348.4)	0.0	(845.4)	1,121.1	0.0	5,359.3	125,651.4	(1,177.7)	124,473.8	2,670.4	127,144.2
Post EBITDA	18,192.9	0.0	0.0	18,192.9	0.0	0.0	0.0	0.0	0.0	1,465.3	0.0	0.0	19,658.2	0.0	19,658.2	0.0	19,658.2
(Surplus)/deficit	**(53.9)**	**2,079.3**	**(779.0)**	**1,246.5**	**(2,634.1)**	**(1,072.0)**	**(1,666.9)**	**2,200.0**	**8,120.6**	**5,495.4**	**(108.1)**	**(192.0)**	**11,389.4**	**(4,896.9)**	**6,492.5**	**19,196.0**	**25,688.5**

The final planning submission presented to board was as above, however it was agreed that for the final submission, taking in to account further mitigations linked to the relaxation of COVID restrictions and changes in IPC recommendations, the final agreed mitigated value was £3.25m deficit. This late mitigation clearly needs further work to review costs incurred for testing under the new protocols and infection control processes changes inline with the recommendations, as well as any productivity improvements this will realise. The Trust will also consider mitigation from acceleration of System wide schemes, as described in the Financial Recovery Plan. A report back on these opportunities and mitigation plans will be brought back to the next meeting.

As part of the resubmission NHSE has identified c£1.5bn in national funding to fund three areas of cost pressures identified in the planning process. These are:

- Inflationary pressures above those assumed in the national tariff uplifts
- Additional funding for commissioners to cover increases in social care cost linked to Better Care Fund and Funded Nursing Care
- Funding for Ambulance specific cost pressures including fuel and call handlers

This additional income for inflationary pressures for the Trust is expected to fund the remaining £3.25m deficit allowing the Trust to submit a balanced plan. This will be confirmed before the 20th June submission.

The national expectation is that all systems deliver a breakeven position, the full letter and appendices are included in Appendix 1.

As part of the system assurance process there is a peer review process underway with the Trust paired with Maidstone and Tunbridge Wells Trust.

Terms of Reference are being drafted but key lines of enquiry will be review of residual Covid expenditure, review of efficiency schemes, and review of cost pressures.

Bench marking data produced by the system shows income increasing by 42.6% in 21-22 against 19-20 due to the inclusion of Top-up funding (Previously PSF funded by NHSI), Covid Funding, Elective Recovery funding and TIF winter funding. This reduces to 40% comparing 22-23 and 19-20 due to the reductions in covid funding.

Cost pressures would appear to have been significantly better contained at MFT than at other providers, for example the Trusts pay cost increase between 19-20 and 21-22 was 12.9% other acute providers within the system ranged from increases of 19.2% to 20.7% over the same period.

Non pay costs again show an even more significant difference with the Trusts increase between 19-20 and 21-22 of 4.9% % other acute providers within the system ranged from increases of 20.5% to 27.8% over the same period.

The analysis is provided in full in Appendix 2.

Recommendations

The Committee is requested to note the above to deliver final business plans by the 20th June.

Appendix 2 – System Income and Cost Analysis over the last three years.

Trust	CCG Income 19/20	CCG Income 20/21	CCG Income 21/22	CCG Income 22/23	CCG Income Movement	CCG Income Movement %	CCG Increase 19/20 to 22/23	CCG Income 19/20 to 22/23 %	CCG Increase 19/20 to 21/22	CCG Income 19/20 to 20/21 %
MTW	349,459	382,002	463,017	476,780	13,763	3.0%	127,321	36.4%	113,558	32.5%
EKHUFT	467,198	552,175	648,136	639,468	(8,668)	-1.3%	172,270	36.9%	180,938	38.7%
DGH	213,943	253,567	299,927	305,114	5,187	1.7%	91,171	42.6%	85,984	40.2%
Medway	221,996	265,815	316,877	310,792	(6,085)	-1.9%	88,796	40.0%	94,881	42.7%
Total	**1,252,596**	**1,453,559**	**1,727,957**	**1,732,154**	**4,197**	**0.2%**	**479,558**	**38.3%**	**475,361**	**38.0%**

Trust	Pay 19/20	Pay 20/21	Pay 21/22	Pay 22/23	Pay Movement	Pay Movement %	Pay Movement 19/20 to 22/23	Pay Movement 19-20 to 22/23 %	Pay Movement 19/20 to 21/22	Pay 19/20 to 20/21 %
MTW	299,931	342,834	361,975	371,886	9,911	2.7%	71,955	24.0%	62,044	20.7%
EKHUFT	452,317	525,291	539,134	550,772	11,638	2.2%	98,455	21.8%	86,817	19.2%
DGH	174,587	203,291	208,729	222,077	13,348	6.4%	47,490	27.2%	34,142	19.6%
Medway	216,428	244,702	244,349	244,552	203	0.1%	28,124	13.0%	27,921	12.9%
Total	**1,143,263**	**1,316,118**	**1,354,187**	**1,389,287**	**35,100**	**2.6%**	**246,024**	**21.5%**	**210,924**	**18.4%**

Trust	Other Expenses 19/20	Other Expenses 20/21	Other Expenses 21/22	Other Expenses 22/23	Other Expenses Movement	Other Expenses Movement %	Other Expenses 19/20 to 22/23	Other Expenses 19/20to 22/23 %	Other Expenses 19/20 to 21/22	Other Expenses 19/20 to 20/21 %
MTW	189,169	202,767	228,678	238,901	10,223	4.5%	49,732	26.3%	39,509	20.9%
EKHUFT	235,714	269,181	284,097	295,752	11,655	4.1%	60,038	25.5%	48,383	20.5%
DGH	105,659	125,138	135,072	127,750	(7,322)	-5.4%	22,091	20.9%	29,413	27.8%
Medway	127,071	128,867	133,040	134,036	996	0.7%	6,965	5.5%	5,969	4.7%
Total	**657,613**	**725,953**	**780,887**	**796,439**	**15,552**	**2.0%**	**138,826**	**21.1%**	**123,274**	**18.7%**

Trust	Total Expenses 19/20	Total Expenses 20/21	Total Expenses 21/22	Total Expenses 22/23	Total Expenses Movement	Total Expenses Movement %	Total Expenses 19/20 to 22/23	Total Expenses 19/20 to 22/23 %	Total Expenses 19/20 to 21/22	Total Expenses 19/20 to 20/21 %
MTW	489,100	545,601	590,653	610,787	20,134	3.4%	121,687	24.9%	101,553	20.8%
EKHUFT	688,031	794,472	823,231	846,524	23,293	2.8%	158,493	23.0%	135,200	19.7%
DGH	280,246	328,429	343,801	349,827	6,026	1.8%	69,581	24.8%	63,555	22.7%
Medway	343,499	373,569	377,389	378,588	1,199	0.3%	35,089	10.2%	33,890	9.9%
Total	**1,800,876**	**2,042,071**	**2,135,074**	**2,185,726**	**50,652**	**2.4%**	**384,850**	**21.4%**	**334,198**	**18.6%**

Other expenses- excludes impairments

Meeting of the Board of Directors in Public

Wednesday, 08 June 2022

Assurance Report from Committees

Title of Committee:	**People Committee**	**Agenda Item**	6.2
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Thursday, 26 May 2022		
Lead Director:	Leon Hinton, Chief People Officer		
Report Author:	Leon Hinton, Chief People Officer		

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Board Assurance Framework The Committee APPROVED the recommendation to stabilise the BAF in relation to clinical staffing (4a) at 12 (medium) in view of progress with work around the culture and engagement and leadership through the management essentials training.	**Amber/Green**
2. IQPR – People KPIs The committee principally focused on the current rate of appraisal compliance as this was a PFIS breakthrough objective. It is also a factor on the People BAF. April compliance was 81%. There was also concern about a reported spike in temporary staffing covering sickness and vacancies and the potential impact on the efficiency programme if it did not reduce.	**Amber/Red**
3. Gender Pay Gap – 2022 report The committee reviewed the first draft of the 2022 gender pay gap, due to be reported in spring 2023 to the government equalities office. A further report will come to the next meeting of the committee.	**Amber/Green**

4. Integrated Care System response to National Priorities on Race Equality The committee received an update on progress with six priorities from the national heat map, including training and guidance and leadership/objectives.	**Amber/Green**
5. Resourcing Dashboard The Committee noted an overall stable position on nurse recruitment and progression. There was some concern about increased turnover. A bid for funding to support international nurses was noted.	**Amber/Green**
6. Wellbeing Guardian Assurance Report Q4 2021/22 The committee noted the report setting out progress against a range of staff well-being actions and initiatives mainly deriving from the staff survey (discussed below). An increase in the positive response to the question about the Trust's actions towards staff well-being was noted.	**Amber/Green**
7. OD update and Culture, Leadership and Engagement Report The committee noted progress on the Institute of Leadership and Management (ILM) training, and activity against the Apprenticeship Levy.	**Amber/Green**
8. Staff Survey 2021 – overview of results The committee received a summary of the staff survey results and noted the range of initiatives being undertaken to address the findings. The Trust was at or slightly below the category averages and was above average in respect of learning.	**Amber/Red**
Decisions made: None to report	
Further Risks Identified: None to report	
Escalations to the Board or other Committee: 1) Temporary staffing 2) Staff survey results	