Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public
Date: Wednesday, 05 October 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				
1.5	Chief Executive's Update	Chief Executive	3	12:35	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous Meeting: 03 August 2022	Chair	7	12:45	Approve
2.2	Action Log and Matters Arising		17		Note
3.	**Board Assurance Framework**				
3.1	BAF Report	Chief People Officer	19	12:55	Note
4.	**Quality**				
4.1	Integrated Quality Performance Report	COO, CNO, CMO	25	13:05	Assure
4.2	Quality Assurance Committee Assurance Report: - 23 August 2022 - 27 September 2022	Chair of Committee/ Chief Nursing Officer	45 49	13:15	Assure
4.3	Emergency Planning, Resilience and Response: • Annual Assurance Report • Business Continuity Policy and Framework	Chief Operating Officer	53 79	13:25	Approve
4.4	Risk Register Review	Chief Nursing Officer	81	13:35	Note
4.5	Patient Experience update		97		Note
4.6	Medical Appraisal and Revalidation Board Report		119		Assure
4.7	Ockenden Assurance Report	Director of Midwifery	143	14:05	Assure
4.8	CNST Assurance Report		163		Assure
4.9	Maternity Workforce		181		Assure
5.	**Sustainability**				
5.1	Finance Report	Chief Finance Officer	195	14:25	Note

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5.2	Finance, Planning and Performance Committee Assurance Report	Chair of Committee/ Chief Finance Officer	211	14:35	Note
6.	**People**				
6.1	People Committee Assurance Report	Chief People Officer	213	14:55	Assure
7.	**Any Other Business**				
7.1	Council of Governors Update	Lead Governor	Verbal	15:05	Note
7.2	Questions from the Public	Chair	Verbal	15:15	Note
7.3	Any Other Business	Chair	Verbal	15:25	Note
	Date and time of next meeting: Wednesday, 02 November 2022 – Patient First Board Review				

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Chief Executive's Report – October 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.

Like everyone else in the country, I was saddened to hear of the death of Her Majesty Queen Elizabeth last month.

For most of us the Queen has been a constant presence in changing times, and many have found her to be an inspiration through her devotion to duty; may she rest in peace.

COVID-19 and seasonal flu

As winter approaches we are expecting to see a rise in cases of COVID-19 and seasonal flu in our community. We are offering the Covid booster vaccination and seasonal flu vaccination to our staff and encouraging them to take up this opportunity to protect their patients, themselves, and their loved ones. We would also urge members of our community to have their vaccinations when invited; this will not only help to protect their own health, but also help to protect our services during what is likely to be a very busy period.

Donate and take scheme

The Trust is working in partnership with Gillingham Street Angels to offer a 'donate and take' scheme for our community.

Located in the lobby area of the Chapel/Prayer Room at Medway Maritime Hospital (level 2, blue zone), the donation and collection point is open to patients, visitors and staff, to take and donate non-perishable every day essential items, especially items which can be used to make healthy meals.

Times are difficult at the moment and we know from the national media coverage that people across the country are struggling to afford to buy food and every day essentials. We wanted to do something to help those who may be struggling financially, and the 'donate and take' scheme is one way of us showing our support. We hope it will bring comfort to those who need to use it and that patients, visitors and staff will support it by donating items too

Patients benefitting from new MRI scanner

Hundreds of patients are benefitting from vital scans every month thanks to a new Magnetic Resonance Imaging (MRI) scanner that has been installed at Medway Maritime Hospital.

The new mobile scanner is helping patients to get their diagnostic appointments quicker and reducing the number of people waiting for scans, which has increased since the COVID-19 pandemic.

Annual Members' Members Meeting

The Annual Members' Meeting due to take place last month was postponed as a mark of respect during the national mourning period. The new date for the event will be Tuesday 18 October.

A special honour

Last month, I was delighted to present our Learning Disability Liaison Nurse Eloise Brett with a prestigious Cavell Star Award. Eloise won the prize for promoting equality in healthcare and ensuring a positive experience for our patients with learning disabilities and autism. This is fantastic recognition for all the incredible work Eloise has done since joining the Trust six years ago. Congratulations Eloise – we are all so proud of you!

Improving access to healthcare

I'm incredibly proud of the fantastic new 'one stop shop' initiative the Trust has launched for patients with learning disabilities and autism who require a medical procedure under a general anaesthetic.

The initiative, which aims to improve healthcare outcomes, allows patients to have a combination of important treatments such as dental and podiatry work, and endoscopies or colonoscopies, while they are sedated and following a best interest decision.

I'm incredibly proud of all colleagues who came together, including the Learning Disability Nursing Team, theatre staff and partners from Medway Community Healthcare, to launch this project for our patients with learning disabilities and autism. By having more access to these important treatments, it will ensure that patients have a better quality of life and improved outcomes.

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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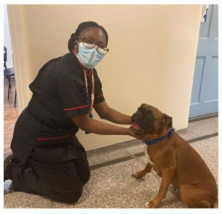
Communications update

October 2022

Photo gallery



53,000
total social media impressions

108
media mentions

Best of care
Best of people

NHS Medway NHS Foundation Trust

Minutes of the Trust Board PUBLIC Meeting

Wednesday, 03 August 2022 at 12:30 – 15:30

Meeting via TEAMS

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Alison Davies	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Jayne Black	Chief Executive (Interim)
	Leon Hinton	Chief People Officer
	Mandy Woodley	Chief Operations Officer (Interim)
	Mark Spragg	Non-Executive Director
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
Attendees:	Adebayo Da-Costa	Consultant Emergency Medicine
	Adrian Parsons	Medway Governor
	Alison Herron	Division Director of Midwifery
	Angela Harrison	Partner Governor
	Chee Fone-Chu	Consultant Anesthetist. Lead CPET
	David Brake	Lead Governor
	Emma Tench	Assistant Company Secretary (Minutes)
	Jignesh Patel	Public Governor
	Jordan Howard	Acacium Group
	Kate Nelson	Kent Online Medway
	Keith Lancaster	Consultant Anesthetist
	Linda Longley	Deputy Director of Strategy and Transformation
	Manisha Shah	Consultant Anesthetist. Lead Prehabilitation
	Michael Addley	Head of Communications
	Sam Black	Patient Information Lead RCOA
	Sam Lovage	Exercise Physiologist

	Sarah Hare	Consultant in Anaesthesia and Intensive Care Medicine, Clinical Director, Perioperative Medicine, Anaesthesia and Theatres
	Sarajane Poole	Deputy Nursing Officer
	Sue Plummer	Canterbury Christ Church University Medway Director
	Susan Plummer	Partner Governor
	Tracy Kelly	Deputy Head of Corporate Governance and Legal
	Vanessa Page	Culture and Workforce Engagement Manager
Apologies:	Evonne Hunt	Chief Nursing Officer
	Ewan Carmichael	Non-Executive Director
	Paula Tinniswood	Chief Strategy and Transformation Officer
	Penny Reid	Public Governor
	Rama Thirunamachandran	Academic Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

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

a) *Welcome to our August Board meeting. Normally at this time of year we would expect the hospital to be a little calmer, offering a chance to plan ahead and for colleagues to take their much-needed summer break. However, this year we have seen no let-up. The hospital has been incredibly busy throughout the spring and summer, and you will hear today how the Trust has been managing the demand and caring for patients despite the challenges.*

b) *Nonetheless, I am pleased to say that colleagues are taking their annual leave and teams are planning ahead for winter, with an earlier than ever start this year, so that the Trust is in the best possible position for what lies ahead in the winter months. In fact, some of that winter planning will have taken place on the hottest days of the year, last month, when we experienced some of the highest temperatures we have ever seen. I know that it was uncomfortable in parts of the hospital for patients and for colleagues, and I would like to thank you all for your understanding at such a time. Our colleagues were amazing, putting the comfort of patients first and foremost. The Executive Team ensured that cold bottled water and ice lollies were free available for patients and colleagues, and many more fans and some air conditioning units were purchased for areas where they could be used safely to help keep everyone cool.*

c) *In spite of all the challenges we face, I never cease to be impressed by the care and commitment we see every day, and by the outstanding work across the Trust. Whether it is in our award-winning teams, improvements to patient care such as the Accelerated Hip Fracture Pathway, or the heart-warming stories like the amazing compassionate care shown by our Learning Disability Team who provided support to a patient and her family, introducing a therapy dog to make a difference to that patient's experience in hospital – I hear of extraordinary work to put patients' needs at the centre of all we do.*

d) *Today we are going to hear about our Prehabilitation service, and I would like to welcome Dr Manisha Shah and Dr Chee Chu who are going to talk to us about the difference they are making to patients.*

e) *Before I hand over, I would like to take this opportunity to thank two of our Non-Executive Directors who are standing down this month.*

This is Tony Ullman's last Board meeting as he completes his time with the Trust next week. Tony joined the Trust in 2020 following a long career, largely in health and social care. He has chaired our Quality Assurance Board, and drawn on his experience to support the Trust's improvements in quality and safety. Thank you Tony for all you have done and we all wish you well for the future.
We are also saying farewell to Ewan Carmichael, who will shortly be completing his time as a Non-Executive Director. Ewan unfortunately could not join us today.
Ewan and I joined the Board at the same time as me in 2015. He has been involved in many committees and currently chairs our Charitable Funds Committee. Ewan has been a valued member of the Board, bringing wisdom, challenge and pragmatism to our discussions, and always with warmth and humour. Thank you Ewan for all you have done – we will all miss you.

1.2 Quorum

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

1.3 Conflicts of Interest

There were no conflicts of interest raised.

1.4 Chief Executive Update

Jayne Black, Chief Executive (Interim) gave an update to the Board:

a) Over last month there has been an increase in Covid cases, reflected nationally, causing some operational challenges. The situation is being monitored closely. Visitors have been asked to wear masks in clinical areas, wash their hands or use hand gel and not to enter the hospital with symptoms unless they require urgent medical care.
b) Thanks to all colleagues for their continued dedication is providing the best care to Medway and Swale.
c) CQC has noted significant improvements in the Emergency Care since their last inspection in December 2020 when the Trust was rated inadequate. The service is now rated good overall. Inspectors commended staff on managing infection control risk, assessing risks to patients and acting on them. Praise was given to planned care who are meeting the needs of the local people and individuals. Inspectors reported the staff felt respected, valued and supported, and their focus was on needs of the patients receiving care.
d) There have been a number of improvements made following the CQC inspection in December 2020; working with health partners on a collaborative approach, managing demand in the emergency department leading to reduction in patients waiting in ambulances for more than 60 minutes, identifying priorities in patients in ambulances and increased reviews of patients waiting to be admitted which reduces waiting times. The CQC recognised the significant improvements to the Trust. Thank you to colleagues for their hard work and commitment to deliver changes despite a challenging backdrop. The Trust remains committed to people of Medway and Swale.
e) The Trust Cancer team recently received the South East Regional winner at NHS Parliamentary award for Excellence in Health Care, nominated by our local MP. The award followed significant improvements including the Trust achieving the national standard in four key areas of cancer patients in December 2021, for the first time in the Trusts history. This demonstrates continued commitment to improving care to patients.
f) Patient First – introduced to improve care and services to people of Medway and Swale with targeted priorities. Gives colleagues the skills, tools and confidence to make small changes that matter the most.
g) There has been an improvement in care for patients with hip fractures. The Trust are delighted to announce improvements in care and outcomes for most vulnerable patients, who arrive in ED through the accelerated hip fracture pathway. The pathway was launched in 2016 receiving

national praise, the pathway has been reintroduced, which is an exciting development for the Trust.

h) Rainbow Day – In July 2022 local school and nurseries took part to raise money for Trust Charity; a big thank you for all involved who raised over £600.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 08 June 2022 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting.
TB/001/2022 – deferred to next meeting for update.
TB/002/2022 – On trajectory to complete within timeframe – Action Closed.

Patients

3.1 Clinical Presentation – Prehabilitation

Sarah Hare, Consultant in Anaesthesia and Intensive Care Medicine, Clinical Director, Perioperative Medicine, Anaesthesia and Theatres; presented the Prehabilitation presentation; outlining how the team contribute to care of patients who are undergoing major elective surgery. Demonstrating how the team collaborate with entire multi-disciplinary team, to support patients and keep patient centered care.

a) Sam Lovage, clinical exercise physiologist, presented a slide on tailored exercise in prehabilitation.
b) Dr. Keith Lancaster, consultant anesthetist, presented project in shared decision making.
c) Dr. Chee Fone-Chu, consultant anesthetist, and Dr Manisha Shah, consultant anesthetist, presented MeFit, supporting cancer patients from diagnosis to surgery and general recovery; support also to non-surgery patients.
d) Jo Palmer commented on the Trust being only 1 of 12 Prehabilitation clinics in the country, benefitting patients with reduced length of stay and post op recovery, but also benefitting patients with combatting loneliness and isolation, which has been seen in feedback.
e) The community service has an important role for those patients who do not have an operative intervention. The operative pathway offers the patient optimisation and familiarisation of the hospital. Colleagues at East Kent and Mid Kent are keen to work with us to develop their own prehab in their hospital services. Manisha Shah commented that the department are working with the CCG, to look at Kent wide services and funding.

Board Assurance Framework

4.1 BAF Report

Leon Hinton presented to the Board and informed them that the team are:

a) Reviewing Governance to ensure BAF is updated in a timely way. Chart showing residual risk target, a decrease over the last 3 months, on an upward trajectory since April 2021. Each Committee reviews their own risks. There are delays in updating the BAF that are being reviewed as part of the process.
b) Tony Ullman, at QAC risk 5c, emergency and elective access, was to be reduced to 12.
c) Annyes Laheurte for the Finance Committee risk to be changed – will review post Board meeting and adjust.
d) Sue Mackenzie, at People Committee, risk 4a was discussed to be set at 16. Leon confirmed this is highlighted within the People Committee paper.

Quality

5.1 Integrated Quality Performance Report

Mandy Woodley, Sarajane Poole and Alison Davis gave key highlights from the report, informing Board Members of the quality and operational performance across key performance indicators for the June 2022 reporting period.

a) Medway Infection Prevention and Control performance for June shows that the Trust is reporting 1 MRSA bacteraemia case and 11 hospital acquired C-diff cases against a threshold of 34 which is an increase of 4 in June.
b) HSMR for the reporting period of April 2021 - March 2022 is 101.9, weekend is 113.8 and weekday is 98.9; all within the 'as expected' banding.
c) MSA continues on a downward trajectory with 69 breaches recorded (against 162 in March reporting period).
d) The Friends and Family recommended rates for two areas remain above the national standard of 85% for this reporting period for Outpatients (88.4%) and Maternity (99.7%) whilst two areas remain below the national standard, Inpatients (77.4%) and ED (65.1%).
e) Pre-noon discharges are remaining above the lower levels seen before and during the high occupancy levels during the early periods of the pandemic sitting at 18% which is an increase from 16.9%. Work is on-going with our ward staff and system partners to continue to improve discharge information and metrics to support improvement and have confirmed this required improvement as one of our Patient First Breakthrough Objectives (40% of discharges prior to midday).
f) The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In May the RTT standard was 63.6% and the Trust recorded 158, 52 week breaches.
g) ED (Type 1) 4 hour performance has reduced since last reporting period moving to 58.5%. Additionally, the Trust saw a decrease in Ambulance Handover delays of +60mins decreasing to 136.
h) The DM01 Diagnostics performance decreased slightly to 75.7%.
i) See a continued improvement in 2 week waits on the cancer pathway, with 96.4% of patients seen within 2 weeks of their referrals into the cancer pathways.
j) Continue to see a stable position in appraisal rates, reporting 83.8%, which is an increase from 81% and the Trust has 83.5% compliance with statutory and mandatory training in period.

k) Jayne Black, thanked everyone, although the challenges have remained, the Trust is driven to improve patient experience and performance. Solutions around diagnostics are important.
l) Jo Palmer, acknowledged the submission of the Endoscopy proposal and asked when the Board can expect a response. Jayne Black advised there is no time-frame but will provide a weekly update to Executives.
m) Jo Palmer, VT risk assessments, is it time to do a quality assurance to support improvements. Alison Davis would be helpful to take through a Patient First route, to triangulate elements, then through QAC for review.

5.2 Quality Assurance Committee Assurance Report

5.2.1 28 June 2022

Tony Ullman highlighted from the June report:

a) Quality account has been signed off.
b) Work on structured judgement reviews, there have been improvements in processes. Work has been commended by NHSNI Better Tomorrow team.

5.2.2 26 July 2022

Tony Ullman highlighted from the July report:

a) New format for quality reporting. Dan Rennie-Hale has been driving overall assurance reporting to the Board.

5.3 Mortality and Learning from Death Annual Report 2021/22

Alison Davis highlighted the key from the paper providing the annual review of the Mortality and Learning from death data and performance for the period 01 April 2021 to 31 March 2022. At the time of writing this report, the most recent mortality indicator data was used

a) Hospital Standardisation Mortality Ratio (HSMR) for the reporting period of April 2021 – March 2022 is 101.9 which is within the 'expected range'
b) Standardisation Hospital-level Mortality Indicator (SHMI) for the reporting period of February 2021- January 2022 is 1.06 which is within the expected range.
c) Between April 2021 to March 2022, 141 deceased patients were subject to Structured Judgement Reviews (SJRs)
d) During period of April 2021 – March 2022, there has been a total of 141 SJRs completed. Reviews indicate that 67% of cases submitted to the panel, were scored good or excellent for overall care assessment. Ten (10) were categorised as deaths due to failings in care and are being investigated as Serious Incidents or High Level Investigation.
e) Jo Palmer, executive summary, total number of patients who died, a variation in data. Alison Davis advised this will be checked and reviewed.

5.4 NHSE Maternity Safety Self-Assessment Tool Gap Analysis

Alison Herron highlighted key points from the report providing an oversight and assurance to the Trust Board regarding Maternity Service's Self-Assessment against the NHSEI Safety Self-Assessment Tool.

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

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

a) Jayne Black, the red and amber from the assessment, are any of them a worry. Alison Herron confirmed, not a worry or a concern.
b) Mark Spragg, how often will self-assessment need to be completed, is there enough resource. Alison Herron, this does not have to, currently, be reported nationally; a tool for ourselves, no timeline. Will continue to triangulate against Ockenden and CNST. Will follow Patient First strategy.
c) Mark Spragg, how will bias be combated. Alison Herron, via review at QAC and Board, the LMNS will also review after restructure, for external oversight. The tool can be used for deep dive, to avoid buffering or bias.
d) Mark Spragg, suggest this should be reviewed annually at Board. Elements may be reviewed quarterly once final version is updated. **ACTION** TB/003/2022 – Annual review of NHSE Maternity Self-Assessment to be added to Board Planner (Assistant Co.Sec)

5.5 Perinatal Quality Surveillance Tool (Quarterly)

Alison Herron highlighted from key points from the report providing assurance to the Trust Board regarding Perinatal Quality and Safety in line with the expectation of the Perinatal Surveillance Quality model.

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

a) Mark Spragg, making lots of progress, thanks to Alison Herron. Attitudes of staff improving. Suggest engaging with medical staff for full picture.
b) Jo Palmer, smoking in pregnancy in terms of outcome. Alison Herron, seeing slow progress, mainly due to local population, will continue with information, forum and support.
c) Jo Palmer, maternity incidents, the biggest category is postpartum hemorrhage, how much is avoidable. Alison Herron, a deep dive of PPH has been requested, what could have been done to avoid, looking at every element. Program of work through Patient First, some crucial urgent actions in place, seeing reduction in delays of inductions. ACTION TB/004/2022 – Deep dive update into PPH (Alison Herron)
d) Alison Herron confirmed that there is correlation in complaints and categories of problems and it will be reported.

5.6 Complaints Report

Sarajane Poole highlighted Key points from the report:

a) Increase in complaints in PALS following Covid, a national picture.
b) Complaint handling, central complaints team contacting all complaints, working collaboratively with PALS. Increase in PALS, decrease in complaints.
c) Compliance, should be meeting 85%, in March at 20.83%, now at 61%.
d) Backlogs are reducing, processes changing. Complaints are reviewed by Directors.
e) Master action tracker, using Patient First approach. Learning from complaints.
f) Relocation of PALS office to front of hospital, for easy patient accessibility.
g) Compliments, to be built on over coming year, to be logged through Datix.
h) PHSO, detail complaint upheld.
i) Jayne Black, well done to team and divisions, dealing with backlog of complaints and learning.
j) Linda Longley, hearing Patient First language, demonstrating the embedding of the strategy.

Sustainability

6.1 Finance Report – p/e 31 May 2022

Alan Davis highlighted from the Month 3 Position report:

a) 1.4 million Deficit for 3 months to June 2022; in line with profile plan – to deliver break even position for this year. Positon includes 3 million of non-recurrent mitigation from within 8 million of non-recurrent mitigations within operating plan.
b) Key risks, efficiencies programme, year to date delivery reporting 0.9 million against target for first quarter, within annual planned target of 10.5 million. Shortfall due to length of stay scheme, constraints in medically fit to discharge patients and packages of care. Closed one of two isolation wards in efficiencies plan, struggling to close second ward. Through Patient First looking at processes, agreed actions at efficiencies group.
c) System level discussions with ICP for release of funding to mitigate impact of reduction to discharge to asses funding; to support Trust.
d) Opening of community beds in Sheppey, successful bid that will enable this capacity.
e) Theaters and outpatients, understanding and quantify risk of productivity opportunities that now should be seen. Identify improvements as financial benefit.
f) Overall programme, 10.4 million identified, following assessment 1 million will not deliver this year, now focusing on delivery and mitigating gaps. Mitigations to include car parking charges, and elective recovery plan – more efficiency deliver ERF targets.
g) ERF, Trust remunerated based on performance, the Trust is not performing to target, currently an income risk, notified by ICB will be mitigated nationally for first half of financial year, income risk now gone away, less clear on second half of the year. Focus to achieve 104% by end of the financial year.

h) 3.5 million Saving target linking to review of covid restrictions. Sub group established with ToR and action plan, will report end of August 2022.
i) Three Acute Trust: MTW reporting 5 million deficit, East Kent 6.5 million deficit, Dartford reporting balance.
j) Reporting at Finance Committee: Business planning, linking with Patient First. Report on Model hospital – linked to business planning. Drug spend – information on what's driving drug spend.
k) Annyes Laheurte, results of neighboring Trusts, do we know how they are performing against ERF targets. Alan Davies, most of them are behind other than Dartford.

6.2 Finance, Planning and Performance Committee Assurance Report

6.2.1 30 June 2022, and 29 July 2022

Annyes Laheurte highlighted from the report:

a) Approval of financial training policy and associated SoP
b) Reviewed and recommended Business case for Endoscopy bid application.
c) Reviewed hospital model.
d) Jo Palmer, getting greater clarity around financial position. Encouraging to see system programs. Alan Davies, still in deficit still need to see delivery of efficiency plans.
e) Jayne Black, getting granular programme of work, the system is a collective way for reviewing, understanding the impacts nationally and the impacts on Medway.

7.1 People Committee Assurance Report – 21 July 2022

Sue Mackenzie highlighted from the report:

a) BAF risk 4a, having enough staff to meet commitments, was 16 for mandatory vaccinations, then lowered to 12. Discussed within committee and agreed to raise to 16 due to staff sickness and issues around recruitment and retention. Leon Hinton, results on a monthly basis, turnover is increasing nationally. A risk for the future, unable to measure. Deep dive into driving forces including exit interviews, main reason for leaving remains retirement.
b) Appraisals, improving percentage now at 83.8% aim for 90%. Encourage all to complete appraisals.
c) Jo Palmer, international recruitment plans, are they broad enough, something for People Committee to consider.
d) Mark Spragg, concern around lack of suitable accommodation for overseas international staff. Leon Hinton, do have limited accommodation stock, and number of external units, remains a juggling act. Not preventing our international but is a regular management issue, including quality of accommodation.
e) Mark Spragg, could the Trust use student accommodation. Leon Hinton, it is stock the Trust have used through Covid; this is now diminishing as students return to accommodation.
f) Jo Palmer, the facilities manager was in conversation with the council regarding stock available. Leon Hinton, this will be followed up on. ACTION.
g) Alison Davis, appraisal metric being looked at through Patient First, including wellbeing checks.

Any Other Business

8.1 Council of Governor Update

Update not available at this meeting.

8.2 Questions from the Public

Angela Harrison asked the following questions:

a) Are patients being tested for Covid before they are discharged from hospital. Jayne Black, testing patients before they leave the hospital has been part of Medway's procedure.
b) What is your policy on mask wearing within the hospital. Jayne Black, Medway have not relaxed restrictions, continuously insisted masks are worn in all the clinical areas of the hospital by everyone, this is constantly under review.

c) Does Patient First also include families of patients. Jayne Black, Patient First will incorporate families and carers of patients. Sarajane Poole, looking at the patient holistically as a whole patient experience. Plans are very much around the family involvement and being part of the care conversation.

d) Does the hospital have enough anesthetists, ensuring the hospital is financially viable. Alan Davies, in terms of activity, Trusts have been incentivised to increase elective procedures through elective recovery fund, there is a target to deliver. Nationally Trusts are struggling to deliver targets. Challenges for Trust to hit targets. Alison Davis, chance to work with clinical colleagues to find savings and drug availability savings. Regarding recruitment and retention of medical staff, we have a large number retiring. Post graduate doctors have a flexible approach, seen more post covid. Medical efficiencies programme looking at focus on anesthetist staff; have a strong team to attract colleagues.

e) Is the hospital considering all aspects of drug spend to mitigate finances. Alan Davies, received detailed report at Finance Committee from deep dive, looking at trends, highlighted number of spend year on year with focused work. Departments to receive detailed spend of drugs. Need to look at trends elsewhere with other hospitals. An evolving piece of work.

f) Are there any other professions which are stopping the hospital receiving financial support. Jo Palmer, the People Committee review pinch points within the Trust, we are aware this is not all in our gift to resolve with national hospitals. An area the board is paying attention to through the Patient Tracking List meeting, looking at outstanding elective

8.3 Any Other Business

There were no matters of any other business

8.4 Date and time of next meeting

The next public meeting will be held on Wednesday, 05 October 2022.

The meeting closed at 15:22

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Wednesday, 03 August 2022

Signed …….. Date ……

Chair

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
08.06.2022	TB/001/2022	Review of how Patient First will continue for Board Review Meeting	03.08.2022	PT - Chief Strategy and Transformation Officer	On trajetory to deliver, will update at next meeting	White
03.08.2022	TB/003/2022	NHSE Maternity self assesment tool added to Board Planner	05.10.2022	Assistant Co.Sec	**Added to Planner**	Green
03.08.2022	TB/004/2022	Update on deep dive into PPH	05.10.2022	Alison Herron		White
03.08.2022	PTB/005/2022	Investigate risk of tax charge 'benefit in kind' car parking	05.10.2022	Alan Davies		White
03.08.2022	PTB/006/2022	Update BAF for accuracy	05.10.2022	Assistant Co.Sec	**New updates being made on new template**	Green
18.08.2022	ETB/001/2022	NT to invite PT to pathway meeting to review data on numbers to be cared for by new facility		Nikki Teesdale	**Reminder email sent, action closed**	Green
18.08.2022	ETB/002/2022	PK and PT to meet for business case review, join up initiatives in line with Patient First		Paul Kimber	**Reminder email sent, action closed**	Green
18.08.2022	ETB/003/2022	Glynis Alexander to communicate decision on funding to NEDs via weekly update		Glynis Alexander	**Reminder email sent, action closed**	Green
18.08.2022	ETB/004/2022	Glynis Alexander to communicate update on new facility to community and stakeholders, signposting investment		Glynis Alexander	Reminder email sent, action closed	Green

Meeting of the Public Trust Board
Wednesday, 05 October 2022

Title of Report	Board Assurance Framework (BAF)	Agenda Item	
Lead Director	Evonne Hunt, Chief Nursing Officer		
Report Author	Dan Rennie-Hale, Director of Quality & Patient Safety		
Executive Summary	The Trust has redesigned BAF in alignment to the revised Risk Management Framework. The current BAF contains the following Risks;		

Integrated Healthcare	**1a. Failure of System Integration**
Innovation	**2a. Future IT strategy**
	2b. Capacity and Capability
	2c. Funding for investment
Finance	**3a. Delivery of financial control total**
	3b. Capital Investment
	3c. Failure to achieve long term financial sustainability
	3d. Going concern
Workforce	**4a. Sufficient staffing of clinical areas**
	4b. Staff engagement
	4c. Best staff to deliver the best care
Quality	**5a. CQC Progress**
	5b. Failure to meet requirements of Health and Social Care Act
	5c. Patient flow – Capacity and demand

Of these this paper presents the current position for the Finance, Workforce and Quality Risks in the new format and acknowledges the further work to be completed to set KPIs for Workforce.

In line with Patient First, the Transformation team have also undertaken a piece of work to identify the top risks to the Trust True North Domains, which now need to be approved by the Executive and added into the BAF format for approval at a future committee.

Work is also required to review all risk on the Trust Risk Register scoring less than 15 which may impact on the True North Domains.

Committees or Groups at which the paper has been submitted	NIL

Resource Implications	NIL
Legal Implications/ Regulatory Requirements	Failure to implement an effective system of risk management will impact the Trust compliance to the Health and Social Care Act, as regulated by the Care Quality Commission.
Quality Impact Assessment	NA
Recommendation/ Actions required	The Committee is asked to approve the revised BAF template and recommendations for the inclusion of newly identified risks to the True North Domains.

Approval	Assurance	Discussion	Noting
☒	☒	☒	☒

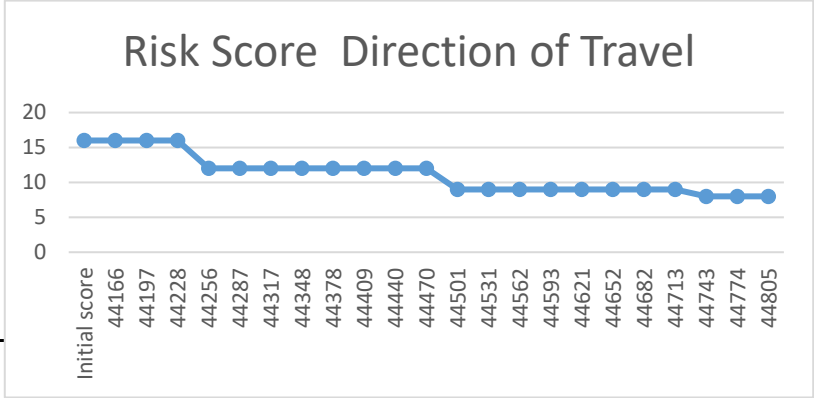
Appendices	Board Assurance Framework

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

Objective:	High Quality Care: We will consistently provide high quality care

Risk ID:	5a	**Principal Risk Name & Description:**	Failure to consistently demonstrate compliance with the Care Quality Commission Fundamental standards, and as such, to meet the statutory requirements of the Health and Social Care Act

Risk Rating & Analysis: (▲, —, ▼, N)	Likelihood	Consequence	Risk Score	Direction of Risk Score (since previous)
Initial Risk Score:	4	4	16	▼
Current Risk	2	4	8	▼
Target Risk Score:	3	4	12	—
Assurance	Medium /			
Adequacy of Controls	Adequate			



Context Summary

A number of quality performance metrics are below the required standard to provide assurance that we

Rationale for current score

A new Director of Quality and Patient Safety started in post in May 2022, and has developed a Quality In

Key Existing Controls:

1) Agreed Quality Strategy Priorities Year 2
2) Quality Report and Accounts with revised Quality Reporting and IQPR
3) Ward Accreditation
4) CQC Engagement Meetings
5) Quality Team Flash
6) Integrated Governance & Quality Consultation
7) NHSEI Independent Quality Governance review completed with recommendations accepted by the Executive

Gaps in controls and assurances:
(What additional controls and assurances should we seek?)

1.Implementation of the revised complaints & Feedback policy
2. Implementation of the revised Risk Management Framework
3. Implemnetation of the PSIRF, LFPSE and Revised Incident Management Policy
4. Deliver Integrated Governance & Quality Consultation
5. Deliver Ward accreditation across adult in-patient wards

Current performance / Progress:

1. Improvements required in the number of Breached Complaints

Date of last review:	27.09.22

d Assurance Framework

Executive Owner	Evonne Hunt Chief Nursing Officer	**Operational Owner**
Primary Risk Grouping: (Quality - QUL, Patient - PT, People - PPLE, Systems & Partnership - SP, Sustainabiity - SUS)	Quality and Patient Safety Governance, Compliance and Regulation	**CQC Domain:**

Relevant Key Performance Metrics:

Indicator: £m	Tar	Apr	May	Jun	Jul	Aug	Sep		Comments
Breached Serious Incident Reports	0		2	4	8	3		▼	
Breched formal Complaints	0								
NICE Guidance overdue for review				40	42	14		▼	
CQC Must Do Actions Open	0				0	0	0		
Ward Accreditation Complete	0								

are consistently meeting the CQC Fundamental Standards, and as such the requirements of the He

nprovement Plan to support the consistent delivery of the core components of the CQC Fundament

Assurances on Control:

1. Integrated Governance & Quality Meeting Structure with regular reporting
2. NHSE/I Ockenden Visit
3. NHSE/I Oversight

Mitigating actions to address gaps:

Action	Action Lead
Implement revised Complaints & Feedback Policy, systems and processes	Lyndsay Barrow
Implement revised IRG & SIRG Processes and develop trajectories for the	Kat Andrew
Delivery against the PSIRF Gap Analysis	Kat Andrew
Complete Integrated Governance & Quality Consultation	Dan Rennie-Hale
Deliver against Ward Accreditation Roll Out Plan	Ann Bushnell

	Additional Comments:	
	Operational Impact to Quality remains and issue	
Date of next review	Oct-22	**Relevant Committee/Group**

Dan Rennie-Hale Director of Quality & Integrated Governance
Well-led
alth and Social Care Act,
tal Standards. CQC Current
Action Due Date
Dec-22
Dec-22
Mar-23
Nov-22
Mar-23
Quality & Assurance Committee Audit and Risk Committee

Meeting of the Trust Board
Wednesday, 05 October 2022

Title of Report	**Operational Update for Trustboard**	Agenda Item	**4.1**
Lead Director	Mandy Woodley, Interim Chief Operating Officer Alison Davis, Chief Medical Officer Evonne Hunt, Chief Nursing Officer		
Report Author	Sunny Chada, Interim Deputy Chief Operating Officer		
Executive Summary	The attached slides provide a Performance Update for Medway Foundation NHS Trust (MFT) across the key business performance metrics. The purpose of the report is to provide assurance around performance, explain any key variances and also detail any key actions being taken to enhance performance where required.		
Committees or Groups at which the paper has been submitted	QAC People Commitee		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	N/A		
Recommendation/ Actions required			
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒
Appendices	N/A		

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance

Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement with timeline (where applicable), should be included in the report.	

1 Executive Overview

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: August 2022

How to...

NHS Medway NHS Foundation Trust

What is Statistical Process Control (SPC)?

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

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

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

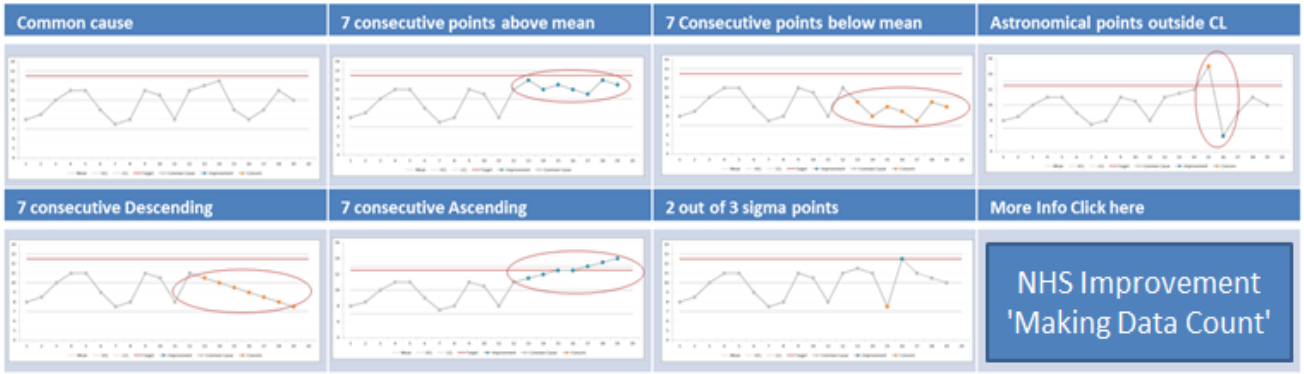
Key Facts about a SPC Chart:

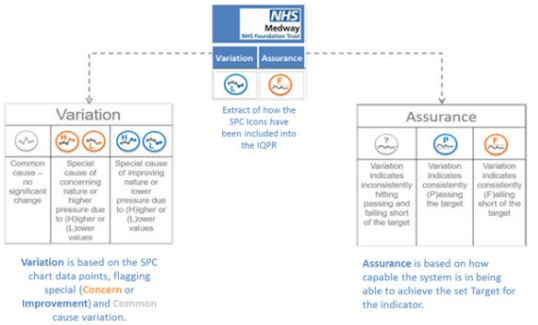
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

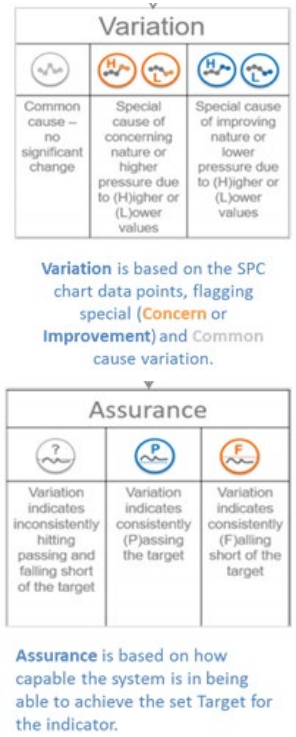
Contains a mean (the average), **lower and upper confidence levels**. 99% of all data will fall between the lower and upper confidence levels. If a data point falls outside these levels, an investigation would be triggered.

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

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







NHS
Medway
NHS Foundation Trust

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Cancer & Patient Flow improvement	• RTT & Emergency Pathways
Caring	• Maternity FFT % Recommended and Response Rates have shown significant statistical improvement • % Complaints responded to within target has improved	• High number of breaches in Mixed Sex Accommodation continues • Inpatient, Outpatient & ED FFT scores are showing sign of decline
Effective	• Discharges before Noon showing high statistical variation, and signs of improvement • 30 Day Readmission Rate showing improved statistical variation	• High statistical variance in C-Section rates evidenced • Fractured NOF significantly below target • VTE Risk Assessment % has dropped below lower confidence limit
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 • % SI's responded to within 60 days has improved	• 1 Never Event reported • 1 MRSA Case declared • E-Coli cases are above plan YTD and in month
Responsive	• Cancer Pathways continue to show stability & 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, with a high level of 52+ week waiters • 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

NHS Medway NHS Foundation Trust

Executive Summary

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

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	72		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	2	0			
S3	MRSA Bacteraemia (Trust Attributable)	0	1	5			
S4	E-coli (Trust Acquired) Infections	2	3	30			
S5	Falls Per 1000 Bed Days	6.63	4.27	6.63			
S6	Pressure Ulcer Incidence Per 1000 days (High Harm)	1.04	0.07	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	96.31	100	0.97		
S10	HSMR (Weekday)	100	92.94	100	0.94		
S11	HSMR (Weekend)	100	107.29	100	1.06		
S12	SHMI	1	1.05	-	25.30		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	140	0	3,072		
C2	Number of Complaints	41	45	-			
C3	% Complaints Responded to Within 30 Days	85.0%	35.6%	85.0%			
C4	% of EDNs Completed Within 24hrs	100.0%	71.4%	100.0%	68.6%		
C5	Inpatients Friends & Family Response Rate	22.0%	19.3%	22.0%	19.9%		
C6	Inpatients Friends & Family % Recommended	85.0%	75.6%	85.0%	80.4%		
C7	ED Friends & Family Response Rate	22.0%	15.0%	22.0%	14.6%		
C8	ED Friends & Family % Recommended	85.0%	52.6%	85.0%	77.6%		
C9	Maternity Friends & Family Response Rate	22.0%	26.0%	22.0%	25.5%		
C10	Maternity Friends & Family % Recommended	85.0%	100.0 %	85.0%	99.9%		
C11	Outpatients Friends & Family Response Rate	22.0%	8.2%	22.0%	9.2%		
C12	Outpatients Friends & Family % Recommended	85.0%	88.9%	85.0%	89.0%		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R1	Bed Occupancy Rate	85.0%	91.4%	85.0%	84.4%		
R2	Average Non-Elective Length of Stay	5	10.43	5	8.72		
R3	Average Elective Length of Stay	5	3.08	5	2.33		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	0.0%	4.0%	0.6%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	3.0%	7.0%	12.6%		
R6	ED 4 Hour Performance All Types	95.0%	76.4%	95.0%	77.6%		
R7	ED 4 Hour Performance Type 1	95.0%	57.3%	95.0%	67.6%		
R8	ED 12 hour DTA Breaches	0	148	0	1,171		
R9	Number of ED arrivals by Ambulance	-	3,062	-	92,660		
R10	60 Mins Ambulance Handover Delays	0	151	0	5,717		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	5.1%	5.0%	6.3%		
E2	30 Day Readmission Rate	10.0%	10.4%	10.0%	12.2%		
E3	Discharges Before Noon	25.0%	19.1%	25.0%	16.7%		
E4	Fractured NOF Within 36 Hours	100.0%	71.9%	100.0%	68.5%		
E5	VTE Risk Assessment % Completed	95.0%	89.4%	95.0%	94.7%		
E6	Elective C-Section Rate	13.0%	17.9%	13.0%	15.0%		
E7	Total C-Section Rate	28.0%	44.4%	28.0%	38.9%		
E8	Emergency C-Section Rate	15.0%	26.6%	15.0%	24.0%		
E9	12+6 Risk Assessment	90.0%	82.2%	90.0%	84.6%		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	68.7%	99.0%	78.2%		
R12	18 Weeks RTT Incomplete Performance	92.0%	61.9%	92.0%	64.3%		
R13	18 Weeks RTT Over 52 Week Breaches	0	383	0	6,442		
R14	Operations Cancelled By Hospital on Day	0	5	0	333		
R15	Cancelled Operations Not Rescheduled < 28 days	0	0	0	51		
R16	Cancer 2ww Performance	93.0%	95.0%	93.0%	95.8%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	93.1%	93.0%	90.9%		
R18	Cancer 31 Day First Treatment Performance	96.0%	97.2%	96.0%	97.6%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	84.0%	85.0%	77.8%		
R20	104 Day Cancer Waits	0	4	-	70		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	88.5%	-	83.8%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	0.0%	4.0%	4.5%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	20.9%	12.0%	13.5%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	85.1%	85.0%	88.3%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,841.76	-	122,215.72		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	3.5%	4.0%	2.9%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	13.4%	9.0%	13.1%		

Domain: Caring Dashboard

Executive Lead: Evonne Hunt
Operational Lead: N/A
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

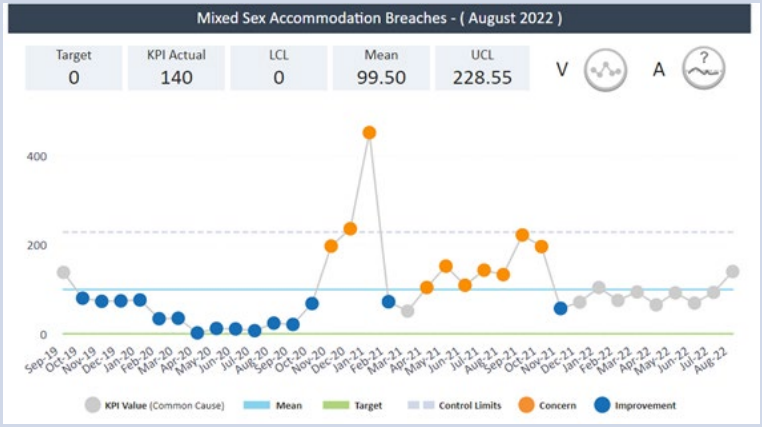
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Aug-22	100.0%	71.4%	62.9%	69.4%	75.9%		
		Inpatients Friends & Family % Recommended	Aug-22	85.0%	75.6%	69.7%	81.7%	93.7%		
		Inpatients Friends & Family Response Rate	Aug-22	22.0%	19.3%	16.1%	20.0%	23.8%		
		Mixed Sex Accommodation Breaches	Aug-22	0	140	0	99.50	228.55		
		MSA %	Aug-22	0.0%	0.0%	0.0%	0.6%	1.6%		
	ED Care	ED Friends & Family % Recommended	Aug-22	85.0%	52.6%	68.5%	78.3%	88.0%		
		ED Friends & Family Response Rate	Aug-22	22.0%	15.0%	12.7%	14.7%	16.7%		
	Maternity Care	Maternity Friends & Family % Recommended	Aug-22	85.0%	100.0%	99.3%	99.8%	100.4%		
		Maternity Friends & Family Response Rate	Aug-22	22.0%	26.0%	10.4%	24.1%	37.8%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Aug-22	85.0%	88.9%	87.3%	89.5%	91.7%		
		Outpatients Friends & Family Response Rate	Aug-22	22.0%	8.2%	8.7%	10.6%	12.4%		

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

Executive Lead: Evonne Hunt
Operational Lead: Sarajane Poole
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	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Arethus a/SAU								18				1	
Bronte		14				4		6					
Byron											6		
Critical Care Unit													
Dolphin Ward	2			1									11
Emerald Assessment Unit								19					
Emerald Short Stay Ward								2					
Intensive Care Unit	6	1	5	2	2	8	12	1	7	2	15	17	20
McCulloch Ward		3	15			1							
Harvey Ward													
Jade Ward			4	4		12			8				
Keats Ward		14						3					
Lawrence Ward	2	7											
Lister Assessment Unit		34	22					40					32
Nelson Ward		5	10										
Ocelot		29	32	1		5							
Pembroke Ward	15												1
Phoenix Ward												1	
Pre Op Care Unit													
Sapphire Ward	57	25	24									5	
SDEC													
Sunderland Day Case Centre		5	19							6			
Surgical Assessment Unit	7	20					3						
Theatre Intensive Care Unit													
Trafalgar Ward SHDU	33	86	65	46	69	74	60	73	50	84	48	69	70
Tennyson Ward													
Wakeley	5												
Victory	6												
Will Adams		8		4									6
Totals	133	251	196	58	71	104	75	162	65	92	69	93	140

What do the outcome measures show?

- MSA remains within common cause variation.
- Bed availability and patient flow remains challenging throughout the trust.
- Unjustified breaches recorded relate to the inability to step down patients within 4 hours from Critical care areas to level 1 ward based care.

What changes have been implemented and improvements made?

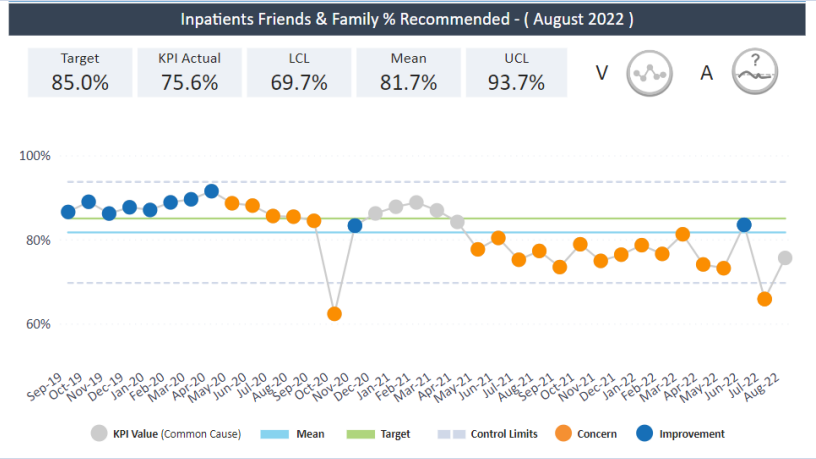
- Validation process for data is not defined. Process mapping exercise planned for 21/9/22.
- Working with BI to develop A3 thinking for MSA.
- Draft MSA policy being written.
- Continued monitoring of patient safety to ensure that where possible patients are informed and bed moves are prioritised and facilitated to correct any breaches.
- IPC, site team and the divisions continue to work together to minimise any unjustified mix sex accommodation breaches other than those areas with COVID positive patients or assessment areas.

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

Executive Lead: Evonne Hunt
Operational Lead: Sarajane Poole
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

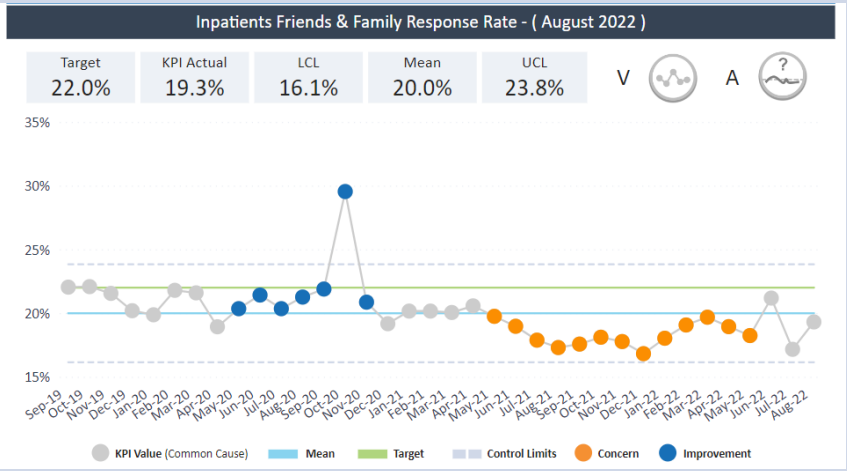
Outcome Measure: Inpatient Friends & Family % Recommended



What changes have been implemented and improvements made?

- The recommended rate for August has improved and moved above the lower control limit into common cause variation.
- 75.6% has been achieved.
- Critical Care, Ocelot, NICU, Dolphin, Trafalgar, Sunderland, McCulloch, CCU, Bronte all achieved 90% and above recommended rates.

Outcome Measure: Inpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

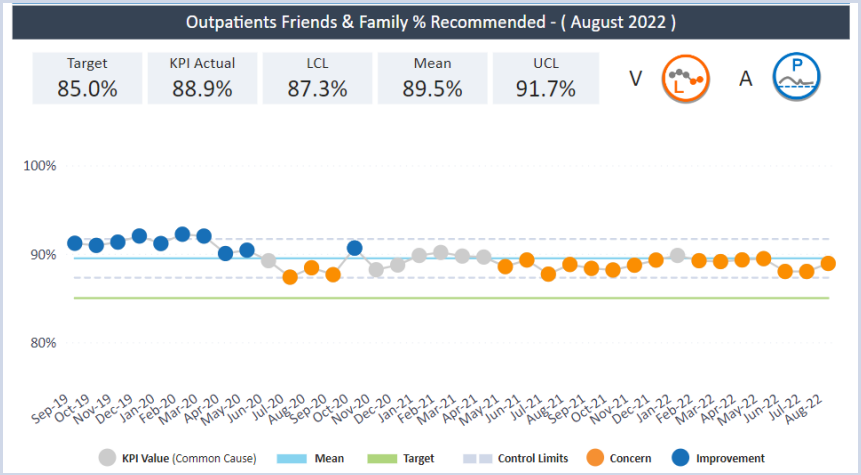
- Response rates remain within common cause variation, with August's data point just below the mean.
- Work has commenced with four ward areas to improve FFT response rates.
- Patient survey questions agreed.
- Each ward has developed A3 thinking in order to understand the blockers to FFT and are currently working through PDSA in order to trial and test ideas.

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

Executive Lead: Evonne Hunt
Operational Lead: Sarajane Poole
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

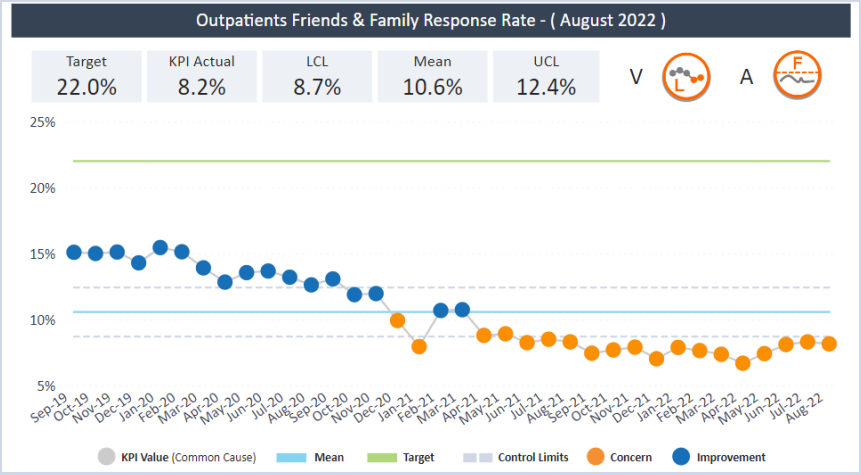
Outcome Measure: Outpatient Friends & Family % Recommended



What changes have been implemented and improvements made?

- Recommended rate remains consistent – 88%
- Feedback for Outpatients remains positive.

Outcome Measure: Outpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

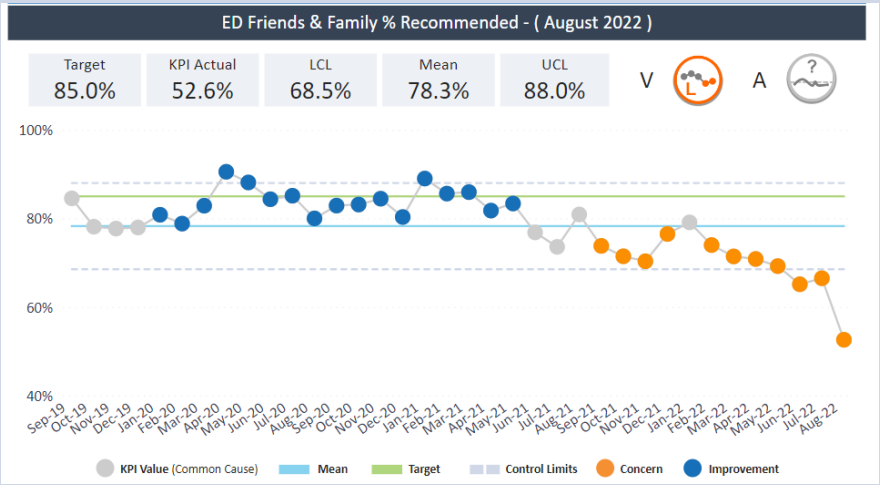
- Response rate continues to be poor within Outpatients.
- Response rate has hovered at 8% since April 2021.
- Outpatient team are working to improve the response rate.
- Outpatient team have previously used their own feedback survey, they are moving to using the agreed FFT questions.

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

Executive Lead: Evonne Hunt
Operational Lead: Sarajane Poole
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

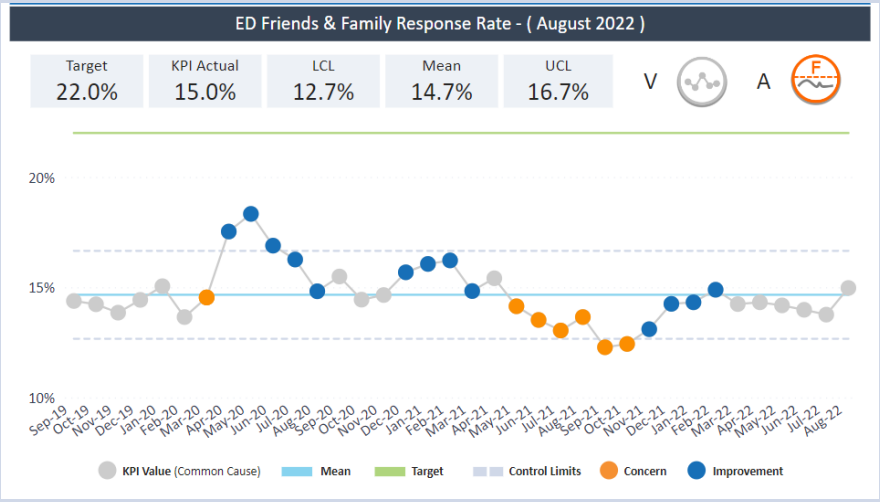
Outcome Measure: ED Friends & Family % Recommended



What changes have been implemented and improvements made?

- Percentage of patients recommending ED during August has reduced to 52%.
- August data shows special cause variation.
- ED has experienced pressures over August which has increased waits and possibly recommendations. Work to be undertaken with the ED team to understand the dip and also look at counter measures to bring the recommended rate up.

Outcome Measure: ED Friends & Family % Response Rate



What changes have been implemented and improvements made?

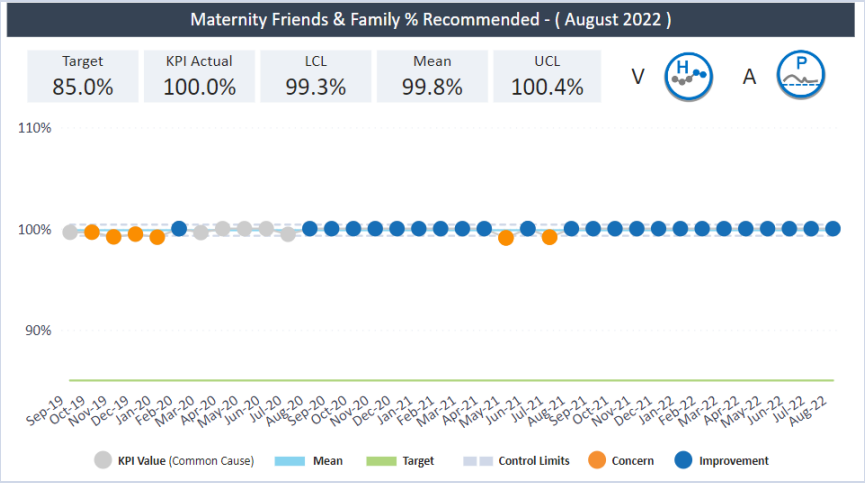
- Response rates remain within common cause variation and slightly above the mean.
- Response rates have remained hugging the mean since January 2022.
- Targeted work to begin with ED September to improve the response rate for feedback.

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Maternity Friends & Family % Recommended



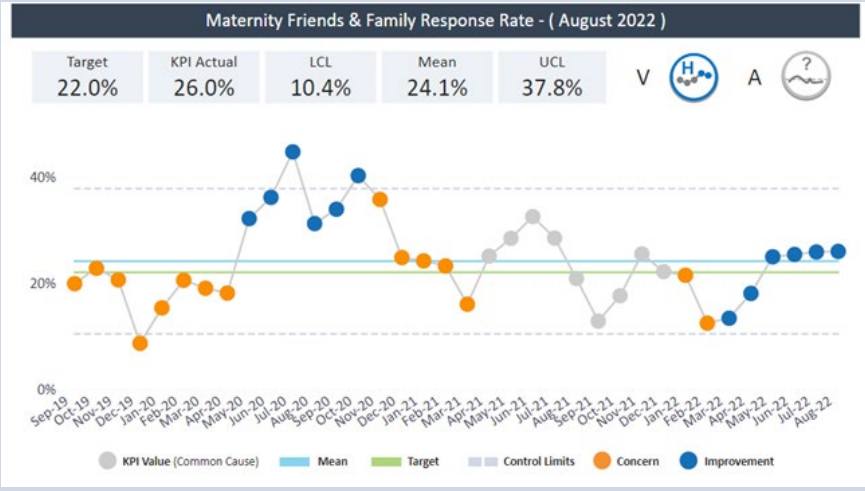
What changes have been implemented and improvements made?

Remains consistently above target and achieving 100% of women and birthing people recommending the maternity service.

A 15-steps challenge led by the MVP is planned for September 2022 following a mini 15 steps undertaken in July 2022.

Awaiting 15 steps challenge questions to be added to Gather, to aid data collection.

Outcome Measure: Maternity Friends & Family % Response Rate



What changes have been implemented and improvements made?

Although remains above target and the mean, there has been no increase in uptake in response rate in month, despite bespoke maternity FFT questions being uploaded to Gather and launch of QR code, with banner and posters on 16th August.

Information on use of QR code disseminated to staff through huddles, Friday news, handover and walkabout. Posters to be repositioned to ensure best visibility by parents.

Still awaiting IPADS to be configured with ICT, escalated to Dir ICT to resolve, as plan was to have these in place by end of August to assist in capturing feedback from women before discharge form the wards.

Postcards and a sticker with QR code are also being designed, and once approved and printed can be given to every woman.

Domain: Effective Dashboard

Executive Lead: Evonne Hunt
Alison Davis
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

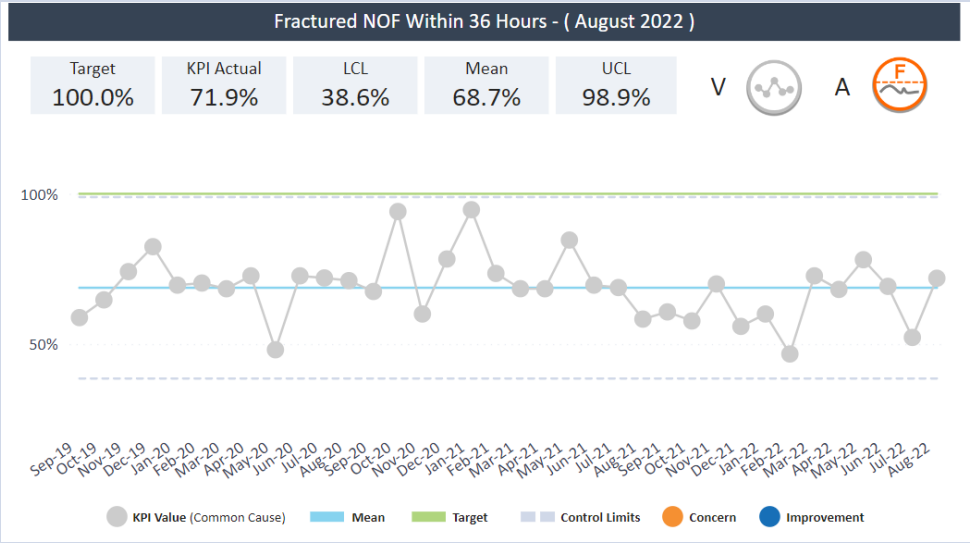
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Jul-22	10.0%	10.4%	9.7%	12.3%	15.0%		
		7 Day Readmission Rate	Jul-22	5.0%	5.1%	4.5%	6.4%	8.3%		
		Discharges Before Noon	Aug-22	25.0%	19.1%	13.0%	16.2%	19.4%		
		Fractured NOF Within 36 Hours	Aug-22	100.0%	71.9%	38.6%	68.7%	98.9%		
		VTE Risk Assessment % Completed	Aug-22	95.0%	89.4%	90.9%	94.8%	98.7%		
	Maternity	12+6 Risk Assessment	May-22	90.0%	82.2%	78.6%	84.1%	89.7%		
		Elective C-Section Rate	Aug-22	13.0%	17.9%	10.7%	14.8%	18.8%		
		Emergency C-Section Rate	Aug-22	15.0%	26.6%	17.2%	23.1%	29.0%		
		Total C-Section Rate	Aug-22	28.0%	44.4%	31.6%	37.9%	44.1%		

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

Executive Lead: Alison Davis
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?

The validated data show 32 hip fracture patients, 9 breaching 36 hours to surgery, 6 of which were due to medical optimisation… so 3 patients were delayed to list / theatre pressures… which is better, but still impacted by theatre staffing / anaesthetic resources.

What changes have been implemented and improvements made?

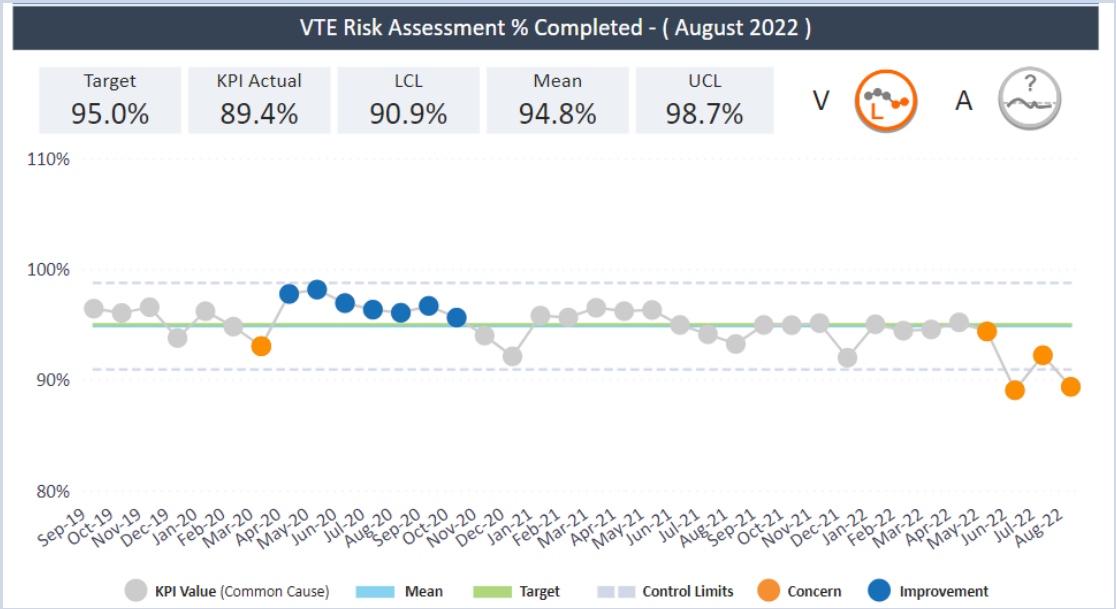
Corrections in coding / data entry will result in improvement in the wider metrics going forward.

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

Executive Lead: Alison Davis
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.

Month	Reported VTE data from PAS	Data following further drug chart review
Aug 22	85.39%	Review ongoing
Aug 21	84.21%	93.74%
Jul 22	88.97%	93.91%
Jun 22	88%	88.95%

What changes have been implemented and improvements made?

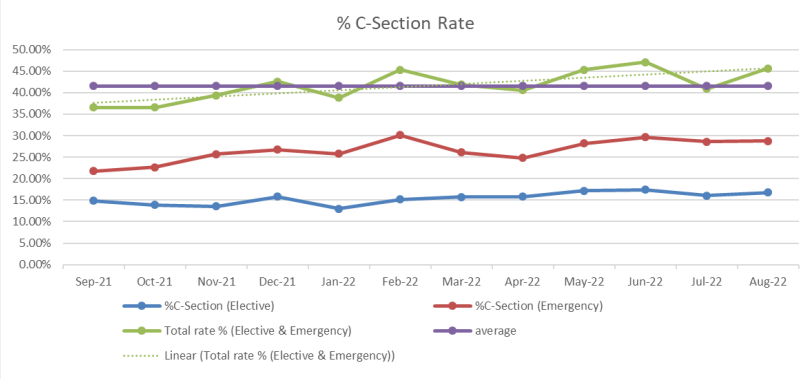
- With support from the Transformation Team and led by the Executive Lead, an improvement approach using Patient First A3 problem solving methodology is being utilised to understand the reduction in compliance.
- The VTE administration support leaves the service and will be covered by bank staff in the interim.
- VTE risk assessments are due to be added to EPR via the EPMA during September 2022.
- Audit questions have been trialled this month for Gthr and will be reviewed to ensure assurance reliability.

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

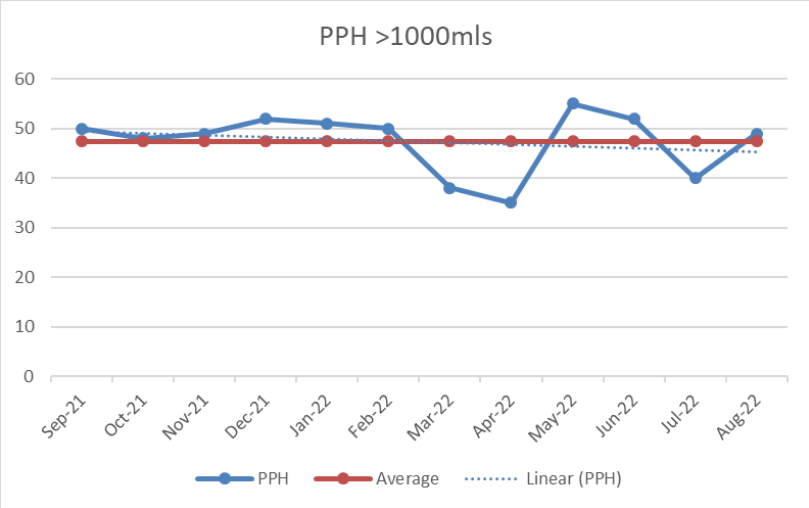
Executive Lead: Evonne Hunt
Operational Lead: Katherine Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: % C-Sections



Outcome Measure: Elective and Emergency C-Section Rate



What do the measures show?

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

Total rate has increased due to a rise in elective caesarean section in month

Delays in induction of labour are a potential contributor to caesarean section, this is a focus of quality improvement work through the Patient first methodology.

Evidence demonstrates that PPH can be reduced by avoiding unnecessary interventions, such as induction of labour/augmentation

What changes have been implemented and improvements made?

There is improved Consultant presence on delivery suite and with twice daily Consultant led ward rounds.

The daily caesarean section audit continues.

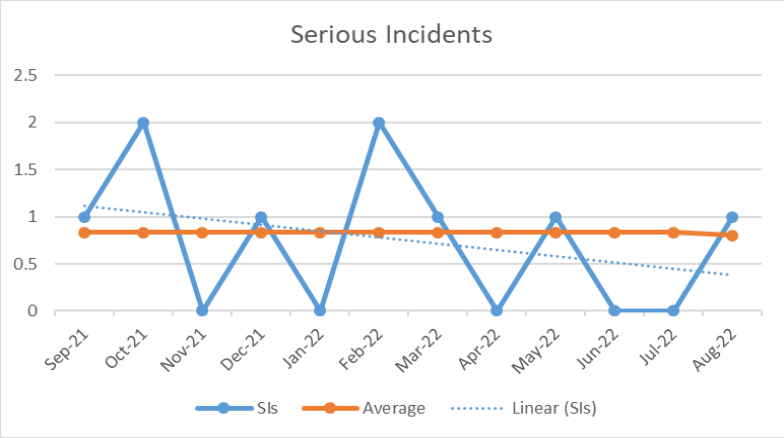
The Induction of labour QI project is progressing utilising A3 thinking. An immediate key change was implemented to perform ARM where appropriate on the ward with the intention of reducing the length of time women wait to move to delivery suite for ARM.
Audit of PPH including a retrospective review of antenatal and labour care being undertaken to ascertain whether PPH could have been avoided.

Safe: Maternity serious Incidents
Aim: Learning from adverse incidents
Latest Period: August 2022

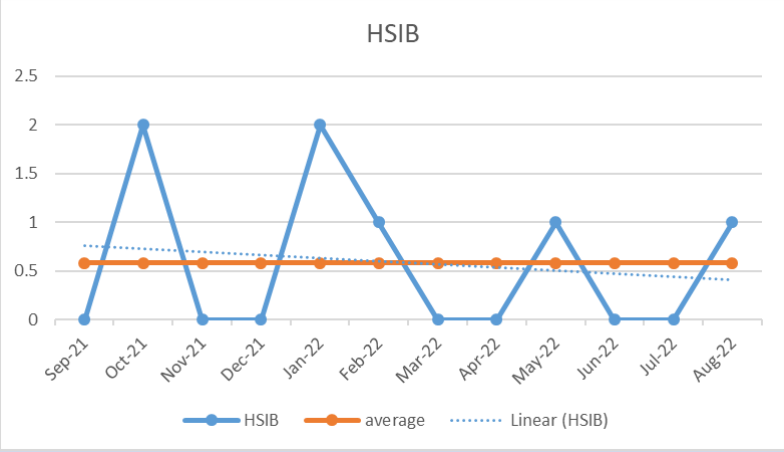
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Kate Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: % C-Sections



Outcome Measure: Elective and Emergency C-Section Rate



What do the measures show?

In August 2022 1 case of Neonatal Death was reported to HSIB and declared as an SI. Debriefs held with maternity and neonatal staff involved in this case.

Immediate learning disseminated across the services, including IOL pathway, interpretation of CTG and appropriate escalation and support/development given on a 1:1 basis where required for individual staff members.

What changes have been implemented and improvements made?

100% of eligible cases reported to HSIB and NHSR EN as required.

Bi-weekly shared learning meetings to support sharing the findings and recommendations from HSIB investigations.

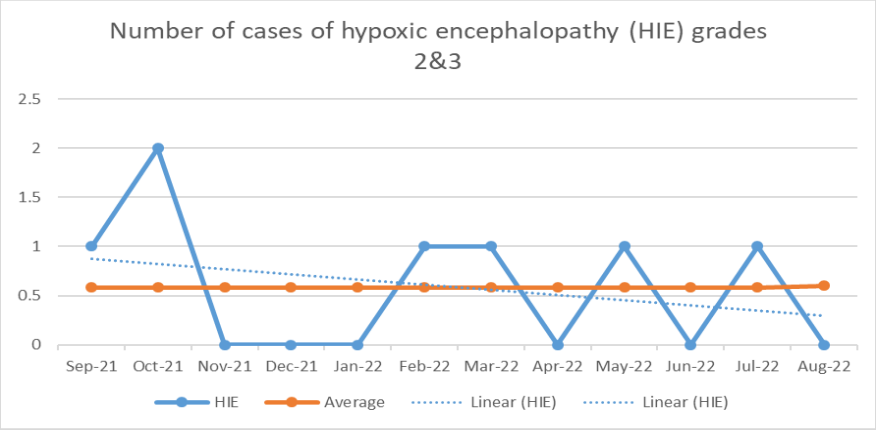
Learning also shared through Friday news and audit meetings.

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

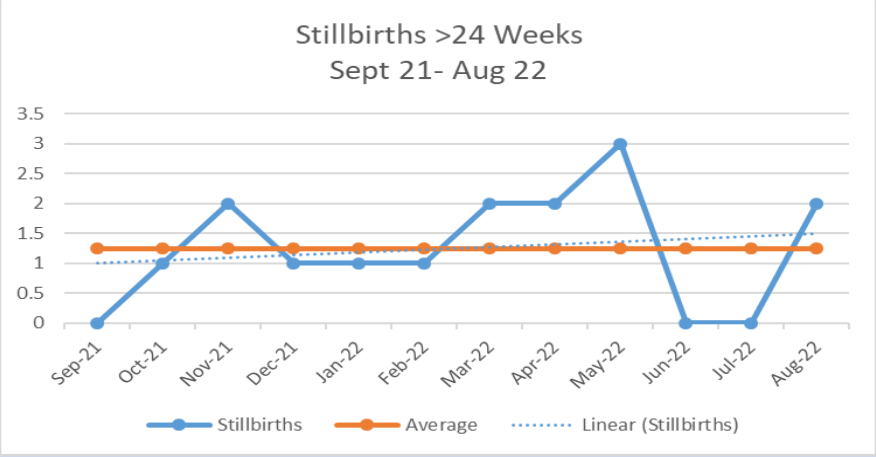
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Kate Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

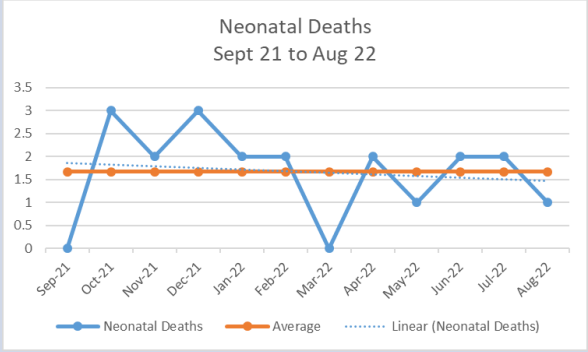
Outcome Measure: Number of cases of hypoxic encephalopathy (HIE) grades 2&3



Outcome Measure: Total Stillbirths >24 Weeks



Outcome measure: Neonatal deaths



What do these measures show?

2 Still births in August 2022 – Awaiting outcome of review

1 Neonatal death in August 2022 – referred to HSIB and coroner.

1 Neonatal Case reviewed August 2022 – known to fetal medicine due to fetal abnormalities, spontaneous delivery at home - Awaiting neonatal actions, No maternity actions.

What changes have been implemented and improvements made?

Increased numbers of HIE noted in past 12 months – prompted revision of Fetal Monitoring Training and move to Physiological Fetal Monitoring Training from October 2022 with guideline to launch January 2023.

Actions and recommendations from investigations incorporated in to training plans and shared learning meetings.

Domain: Safe Dashboard

Executive Lead: Evonne Hunt
Alison Davis
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

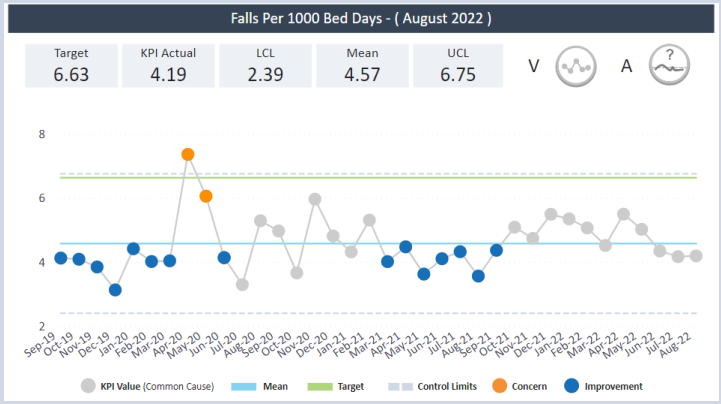
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Aug-22	6.63	4.27	2.39	4.57	6.76		
		Pressure Ulcer Incidence Per 1000 days (High Harm)	Aug-22	1.04	0.07	0	0.01	0.04		
	Incident Reporting	% of SIs Responded To In 60 Days	Aug-22		100.0%	0.0%	54.7%	116.0%		
		Never Events	Aug-22	0	1	0	0.17	0.85		
		No of SIs on STEIS	Aug-22	90	2	0	13.97	31.68		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Aug-22	43 [43]	2	0	2.39	8.39		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Aug-22		2	0	1.74	5.43		
		E-coli (Trust Acquired) Infections	Aug-22	0	3	0	3.14	6.98		
		MRSA Bacteraemia (Trust Attributable)	Aug-22	0	1	0	0.06	0.28		
	Mortality	Crude Mortality Rate	Aug-22	2.5%	1.4%	0.4%	1.9%	3.4%		
		HSMR (Weekday)	May-22	100	92.94		93.86			
		HSMR (Weekend)	May-22	100	107.29		107.53			
		SHMI	Mar-22	1	1.05	1.04	1.07	1.09		

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

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Kerry O'Neill
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days



What do the outcome measures show?

82% of falls occurred in Unplanned care (size of division and specialties and additional escalation beds), 89% of falls were unwitnessed
29% of falls were from bed/stretcher/ trolley (often whilst patient trying to get out bed independently), 10% of falls occurred between 10-11pm, 18% of falls across the Trust occurred on a Wednesday
The number of patients who have fallen previously on this admission increased from 9-14 this month

Month	Total Falls	No and low harm	Moderate harm	Severe harm/ Death
Aug-22	84	84	0	0
Aug- **21**	61	56	4	1
July - 22	79	77	1	0
June- 22	75	74	0	1

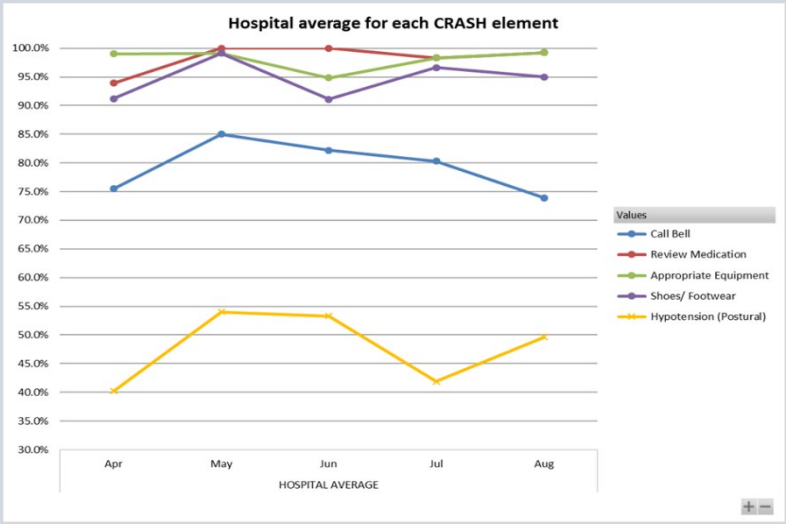
What do the process measures show?

The key consistent themes continue to be, call bell out of reach and lying and standing blood pressure recording

What changes have been implemented and improvements made?

To date, 14 wards have undergone data examination with A3 problem solving methodology to fully discover root causes in order to identify appropriate solutions. Currently 9 wards have quality improvement plans at the "do" stage of the PDSA cycle (Plan, Do Study, Act). Falls documentation audit was completed in July and results are available on Gthr. Results will be added to ward quality improvement plans and used to monitor progress in those wards who have already undergone deep dive. Working with Electronic Patient Record leads to improve risk assessment and associated documentation of interventions on daily records and care plan. This is due to go live September 2022. Acceptance testing has been completed on referral form to community falls team which is due to go live September 2022.

What do the process measures show?

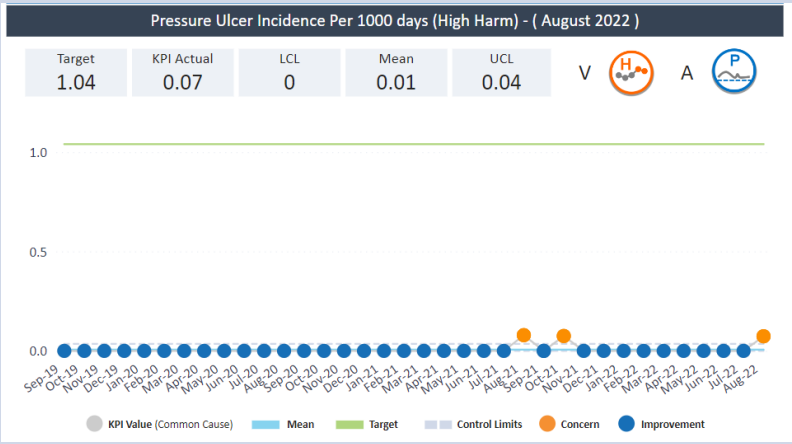


Safe: Pressure Damage Reduction
Aim: 10% Reduction in Hospital Acquired Pressure Ulcers
Latest Period: August 2022

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)



What do the outcome measures show?

58% of hospital acquired pressure ulcers were within Unplanned care while 42% of hospital acquired pressure ulcers were within Planned care
Milton, Victory and Will Adams ward had 2 or more HAPU's.

Hospital Acquired pressure ulcers HAPU

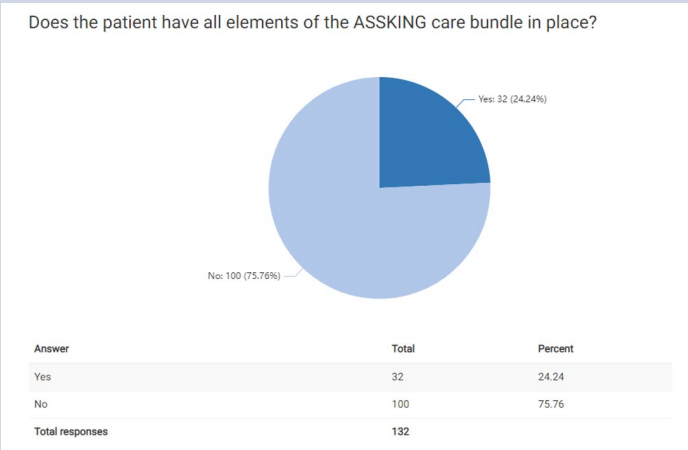
Month	Total HAPU	low harm	Moderate harm	Severe harm/ Death
August 2022	17	15	1	1
August 2021	19	18	0	1
July 2022	15	15	0	0
June 2022	15	15	0	0
May 2022	22	22	0	0
April 2022	25	24	1	

Category 2	Category 3	Category 4	DTI	Unstagable	Total
6	1	0	7	3	17

Pressure Ulcer's on admission (POA)

Category 1	Category 2	Category 3	Category 4	DTI	Unstagable	Total
4	93	11	0	9	10	128

Process Measures: ASSKING Bundle Reliability (Pilot Wards)



Answer	Total	Percent
Yes	32	24.24
No	100	75.76
Total responses	132	

What do the process measures show?

The Trust scored 76% in the ASSKING audit in August 2022, with 132 audits completed. This is up from 73% in July. This is due to further interrogation of the audits in particular the skin aspect of the ASSKING bundle. The tissue viability team now record the score as a negative if there is no skin assessment carried out daily by the RN

	June 2022	July 2022	August 2022
Assessment	92%	73%	83%
Skin	85%	62%	42%
Surface	86%	81%	78%
Keep Moving	80%	84%	55%
Incontinence	76%	84%	91%
Nutrition	93%	84%	86%
Giving Information	99%	100%	99%

What changes have been implemented and improvements made?

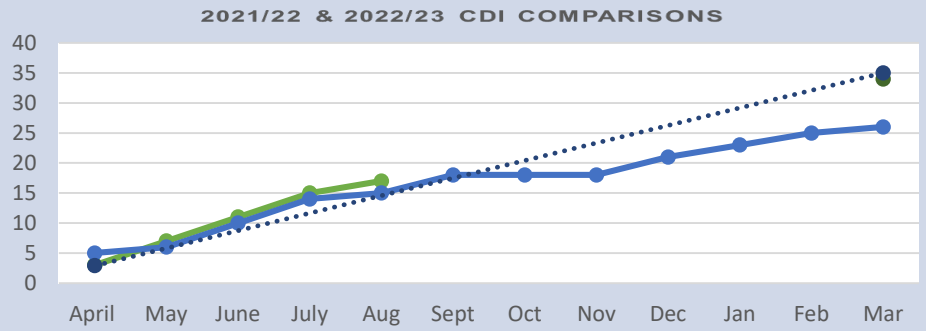
An improvement approach using an A3 problem solving methodology is being utilized across the Trust. Interrogation of data for each ward who acquire more than two pressure ulcer a month underway and will form a deep dive report for each area which will be presented at QAC.
Re-configuration of the documents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

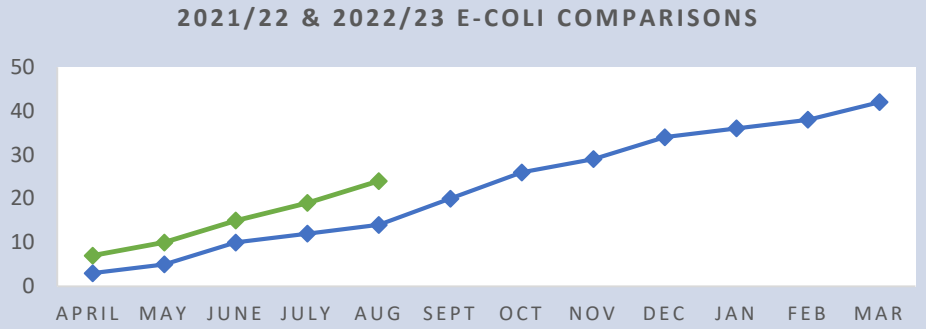
Safe: Improving Infection Control
Aim: Reduction in healthcare acquired infections.
Latest Period: August 2022

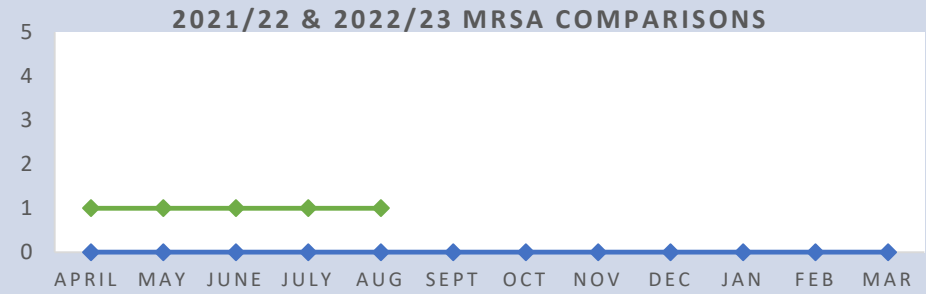
Executive Lead: Evonne Hunt
Operational Lead: Steph Gorman
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Infection Prevention Control measures







What do the outcome measures show?

- MFT continue to work to achieve their thresholds in 22/23. With the 1 MRSA Bacteremia MFT has breached that threshold. The below numbers are cumulative for the year.
- MRSA Bacteremia 1 HOHA with 0 new cases
- C.Difficile rates since 1st April 2022 is 17 HOHA's against a threshold of 34 which is an increase of 2 in August.
- E.Coli : 24 against a threshold of 77 which is an increase of 5 in August. This is above where we were last year.
- Klebsiella : 7 against a threshold of 37 with 1 cases in August which is below this time last year
- Pseudomonas : 2 against a threshold of 17 with 1 case in August which is below this time last year.

What do the process measures show?

C.Difficile is 1 above this point 21/22 by 2 cases but within trajectory. . E.coli is 10 above this point last year but Klebsiella and Pseudomonas are below.

What changes have been implemented and improvements made?

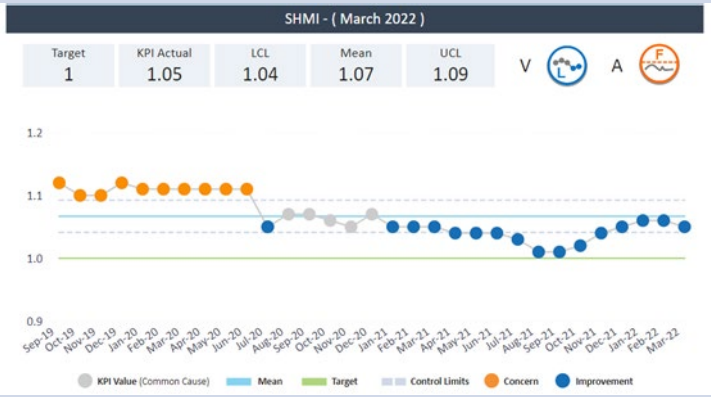
- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- IPC operational group involving SSR's, Matrons is ongoingand is reporting monthly to IPCG
- Commode cleanliness task and finish group is completed - agreed competency document, frequency of checks, initiating commode champions.
- Cleaning product trial to commence 3rd October for 1 month to move to a single product for both commodes and mattresses
- Different styles of commodes being viewed last week in September

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

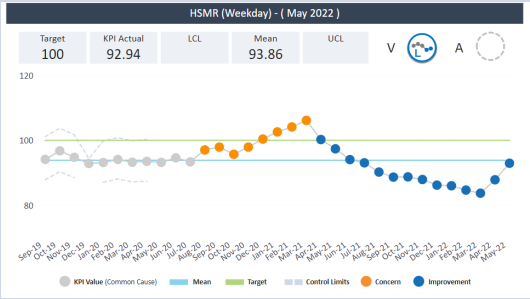
Executive Lead: Alison Davis, Chief Operating Officer
Operational Lead: Sofia Power
Sub Groups: Quality Assurance Committee

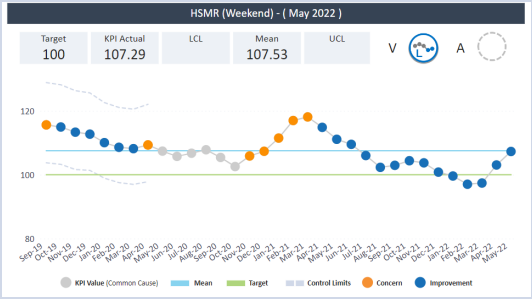
NHS Medway NHS Foundation Trust

Outcome Measure: SHMI Mortality



Outcome Measure: HSMR Weekend and Weekday Mortality





What do the measures show?

- HSMR- Within 'as expected' banding for overall HSMR (104.3), Emergency weekday (100.4), Emergency weekend (111.1) for the period of May 21- Apr 22. Increase in HSMR noted between March and April 22 which is being monitored.
- HSMR Weekend/Weekday both remain within expected range, but relative risk for each has risen. However, it is worth noting that this has also happened to national metrics too.

- SHMI is 1.05 and within the 'as expected' banding. Downward trend noted after a period of slight increase in SHMI. Analysis into the previous rise in SHMI showed that the percentage of deaths with palliative care coding was 48.0% compared to 40.0% nationally. A deep dive into Palliative care patients is being undertaken.
- SHMI highlights 10 diagnosis groups with the most patient activity. The Trust remains in the 'as expected' banding for all 10 diagnosis groups.

What changes have been implemented and improvements made?

- HSMR and SHMI continue to remain stable within expected banding and it is positive to see stability across a number of methodologies (SHMI, HSMR, SMR).
- Deep dives underway for Palliative care coded patients to investigate the slight rise in SHMI in previous months. An investigation into the proportion of spells where the primary diagnosis is different between the first and last episode of care is underway to monitor the rise as a continuous rise may put the Trust into the 'higher than expected' banding.
- Deep dives undertaken for the diagnosis groups showing as outliers for the Trust: **Cancer of the Liver and intrahepatic Bile Duct-** deep dive completed with no significant findings, **Genitourinary congenital anomalies-** Neonatology confirmed these cases have been reviewed with no issues in care identified**. Meningitis-** coding deep dive completed with no significant findings- clinical review underway**. Other perinatal conditions-** no major concerns and tends to alert due to the P95 (unspecified cause) linked to stillbirths**. Intestinal Obstruction without Hernia-** Coding found one case was coded erroneously. This was corrected and the individual was spoken to regarding the importance of coding correctly. The other cases are undergoing a clinical review with no significant findings.

Domain: Responsive – Non Elective Dashboard

Executive Lead: Mandy Woodley
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	Average Elective Length of Stay	Aug-22	5	3.08	1.46	2.37	3.28		
		Average Non-Elective Length of Stay	Aug-22	5	10.43	7.40	8.79	10.18		
		Bed Occupancy Rate	Aug-22	85.0%	91.4%	78.8%	85.2%	91.6%		
		Delayed Transfer of Care Point Prevalence in Month	Aug-22		0	0	133.42	285.72		
		Escalation Beds Open Point Prevalence in Month	Aug-22	0	0	0	0	0		
	Complaints Management	% Complaints Responded to Within 30 Days	Aug-22	85.0%	35.6%	0.0%	13.1%	33.8%		
		Number of Complaints	Aug-22	41	45	13.32	44.56	75.79		
	ED Access	30 Mins Ambulance Handover Delays	Aug-22	0	979	321.61	725.25	1,128.89		
		60 Mins Ambulance Handover Delays	Aug-22	0	151	0	178.42	396.76		
		ED 12 hour DTA Breaches	Aug-22	0	148	0	39.44	117.42		
		ED 4 Hour Performance All Types	Aug-22	95.0%	76.4%	70.8%	78.6%	86.4%		
		ED 4 Hour Performance Type 1	Aug-22	95.0%	57.3%	57.9%	68.7%	79.5%		
		Median Time to Ambulance Assessment (15mins)	Aug-22	15	38	12.44	20.72	29.01		
		Median Time to ED Clinician (60mins)	Aug-22	60	57	29.35	43.64	57.93		
		Number of ED arrivals by Ambulance	Aug-22		3,062	2,539.61	3,246.86	3,954.12		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

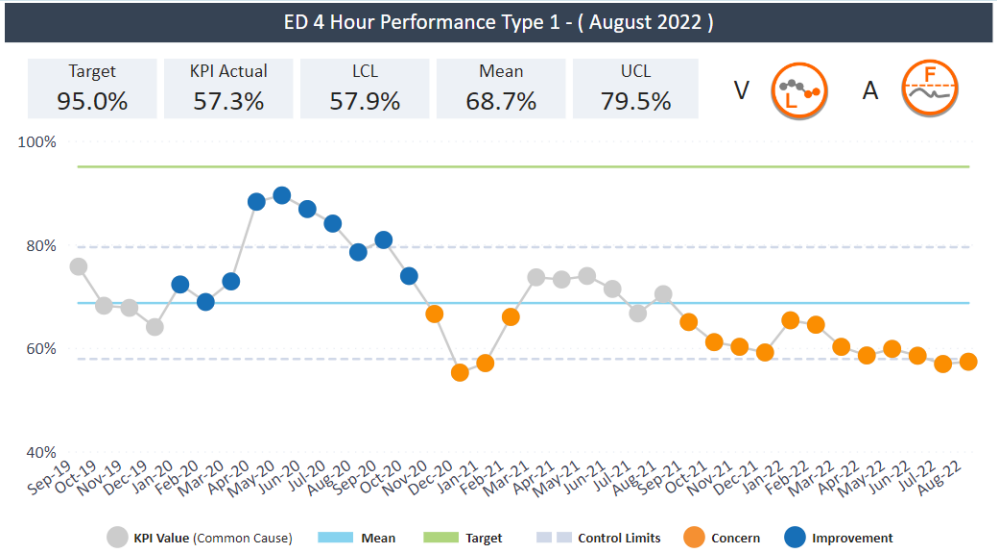
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	Jul-22	0	4	0	2	4.97		
		Cancer 28 Faster Diagnosis	Jul-22	75.0%	81.8%	51.0%	68.0%	85.1%		
		Cancer 28 Faster Diagnosis - Breast Symptomatic	Jul-22	75.0%	93.2%	32.5%	87.4%	142.2%		
		Cancer 28 Faster Diagnosis Screening	Jul-22	75.0%	40.5%	0.0%	45.3%	115.6%		
		Cancer 2ww Performance	Jul-22	93.0%	95.0%	92.5%	95.8%	99.1%		
		Cancer 2ww Performance - Breast Symptomatic	Jul-22	93.0%	93.1%	73.9%	91.3%	108.7%		
		Cancer 31 Day First Treatment Performance	Jul-22	96.0%	97.2%	92.4%	97.4%	102.4%		
		Cancer 31 Day Subsequent Treatments (Drugs)	Jul-22	98.0%	100.0%	89.4%	96.8%	104.3%		
		Cancer 31 Day Subsequent Treatments (Surgery)	Jul-22	94.0%	100.0%	70.5%	93.5%	116.4%		
		Cancer 62 Day Treatment - Cons Upgrades	Jul-22		47.4%	41.0%	71.5%	102.0%		
		Cancer 62 Day Treatment - GP Refs	Jul-22	85.0%	84.0%	58.7%	76.2%	93.7%		
		Cancer 62 Day Treatment - Screening Refs	Jul-22	90.0%	88.9%	20.5%	70.9%	121.3%		
	Diagnostic Access	DM01 Performance	Jul-22	99.0%	71.2%	68.5%	83.1%	97.6%		
	Elective Access	18 Weeks RTT Incomplete Performance	Jul-22	92.0%	61.7%	61.2%	68.0%	74.9%		
		18 Weeks RTT Over 52 Week Breaches	Jul-22	0	271	42.72	173.14	303.56		
		Daycase Rate	Aug-22	85.0%	67.1%	60.3%	67.2%	74.1%		
		DNA Rate	Aug-22	10.0%	8.6%	6.7%	7.9%	9.1%		
		First to Follow Up Ratio	Aug-22		2.26	2.15	2.62	3.08		
		PTL Size	Jul-22	22,477	32,675	22,978.66	24,410.60	25,842.54		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Aug-22	0	0	0	1.75	7.22		
		Operations Cancelled By Hospital on Day	Aug-22	0	5	0	14.11	34.18		
		Urgent Operations Cancelled for the 2nd Time	Aug-22	0	0	0	0.03	0.18		

Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley
Operational Lead: Sunny Chada
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



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

What the Chart is Telling Us:

The SPC data point is showing an plateau on performance in recent months.

Actions:

Specific project well underway to identify a new location for our mental health patients in partnership with system partners which will create the CDU space for use.

• A system wide ambulance offload improvement action plan is now in place, and managed through the fortnightly SECAmb & Medway meeting led by the DDO UIC. This repots into the AEC Steering group and LAEDB monthly meetings.

• A granular focus on performance is taken within ED supported by site management, Executive focus & new GM started in role in August.

Outcomes:

- Alternatives to hospital conveyance are
- utilised by SECAMB in particular through
- Meddoc.
- • An ED front door streaming nurse is in place
- and ambulances can be directed to UTC,
- MEDOC, EAU without the need for
- offloading into RAU if assessed and
- streamed.
- • HARIS project aims to further review
- appropriateness of arrivals and hence ease
- burden on ED.

Underlying issues and risks:

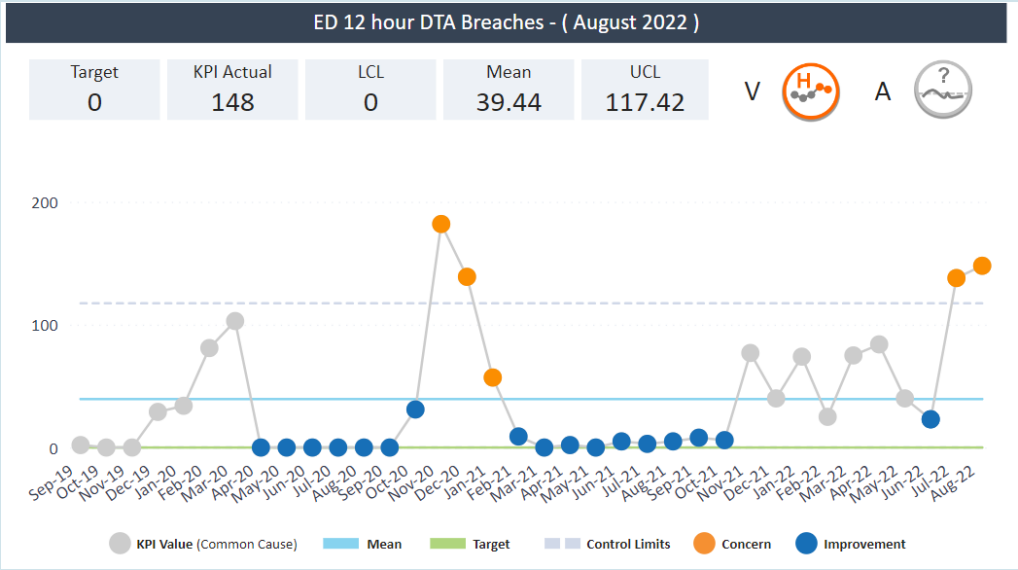
- Early morning bed availability remains a
- challenge and relates to the need to review
- wider site bed capacity.
- • Discharges before noon performance currently
- at 19.1%. Patient First programme focussed on
- plan to bring to 40% revolves around items
- such as EDN delays and golden discharges.
- Wards targeted as part of daily huddles on this
- issue.
- Executive Lead: Mandy Woodley

Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley
Operational Lead: Sunny Chada
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

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

What the Chart is Telling Us:

There has been a stark increase in breaches in the reporting period, with the position significantly worsened from July into August 2022.
Primarily due to peaks w/c 11th July, 1st August & 31st August related to the heatwave and bank holiday weekend.

Actions:

- Active use of escalation triggers managed via site team.
- Site Management attendance at ED sit reps.
- Implementation of new acute medical model planned for next week to improve ED flow.
- Protection of SAU to support enhanced flow.
- Discharge lounge de-escalated down to 5 patients and held since 4th September.
- Additional capacity for planned care expected from the end of November with move of Harvey to Minster.

Outcomes:

Use of inpatient PTL system to track confirmed and potential discharges, enabling the matching of demand and capacity

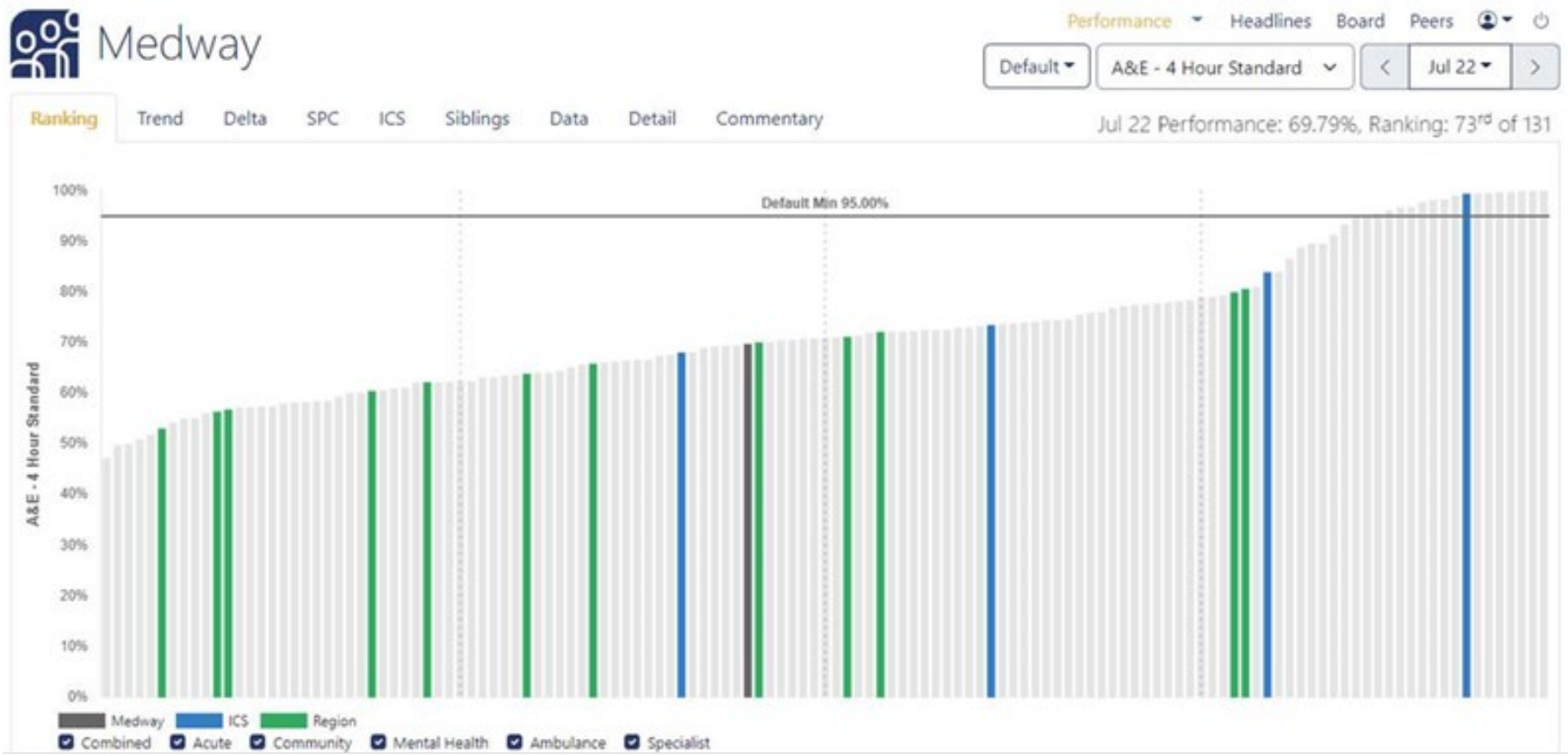
- Use of escalation areas to facilitate timely transfer into an appropriate bed and decongest ED
- Focus of HARIS project to ease ED flow and hence enhance bed capacity

Underlying issues and risks:

Underlying bed deficit,

- Use of escalation areas placing increased demands on medical, nursing and therapy workforce.
- High numbers of medically fit for discharge patients.
- System capacity constraints.

EC 4 Hour Benchmarking

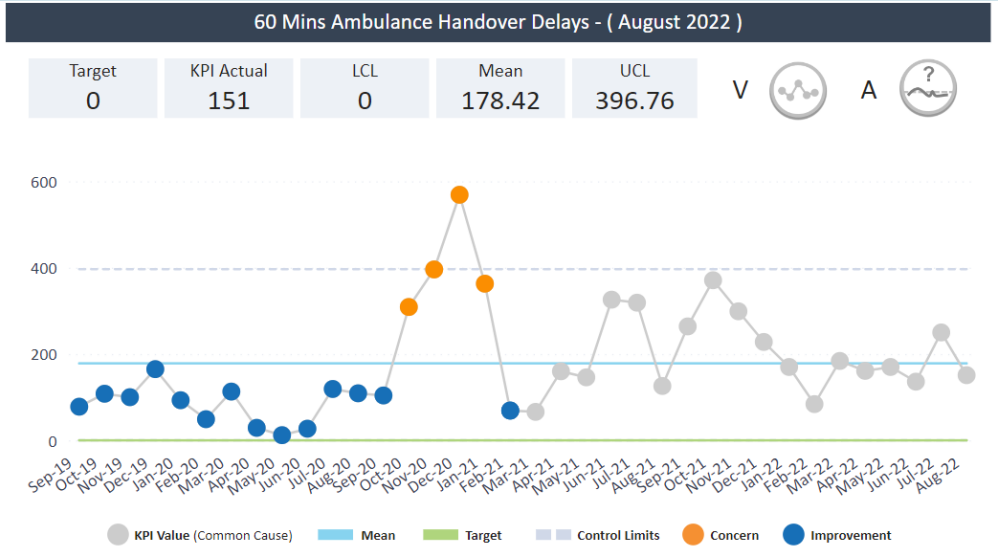


Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley
Operational Lead: Sunny Chada
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

A granular focus on performance is taken within ED supported by site management, Executive focus & new GM starting in August.
• Specific project well underway to identify a new location for our mental health patients in partnership with system partners which will create the CDU space for use.
• A system wide ambulance offload improvement action plan is in place, managed through the fortnightly SECAmb & Medway meeting led by the DDO UIC. Reporting into the AEC Steering group and LAEDB monthly meetings.

Outcomes:

- • Alternatives to hospital conveyance are
- utilised by SECAMB.
- • An ED front door streaming nurse is in place
- and ambulances can be directed to UTC,
- MEDOC, EAU without the need for
- offloading into RAU if assessed and
- streamed.
- • HARIS project aims to further review
- appropriateness of arrivals and hence ease
- burden on ED.

Underlying issues and risks:

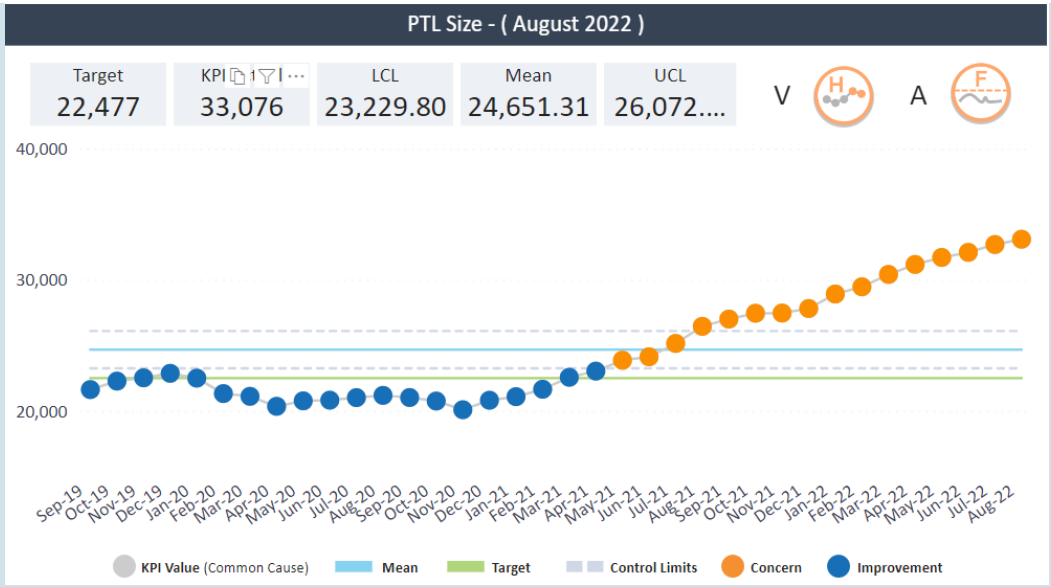
Early morning bed availability remains a challenge and relates to the need to review wider site bed capacity.
• Discharges before noon performance currently at 19.1%. Patient First programme focussed on plan to bring to 40% revolves around items such as EDN delays and golden discharges. Wards targeted as part of daily huddles on this issue.
• Inappropriate ambulance conveyances having not considered alternative pathways (60% actual).

Responsive: Elective Insights

Executive Lead: Mandy Woodley
Operational Lead: Benn Best
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: PTL Size



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature.

- The increase in PTL size is directly related to the pandemic which impacted elective capacity and has changed the referral profile from Primary Care

Actions:

Agree system-wide interventions i.e. controls for referral increases

- Local (MFT) pathway review groups for top 5 challenged specialities are aligned with Patient First groups
- Joint Commissioner/Trust groups have been started to support pathway reviews for challenged specialities
- Theatre and Outpatient efficiency projects have commenced
- Maximise current capacity, including Independent Sector to keep pace where possible with elective activity

Outcomes:

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

Underlying issues and risks:

Potential impact of further COVID waves resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.

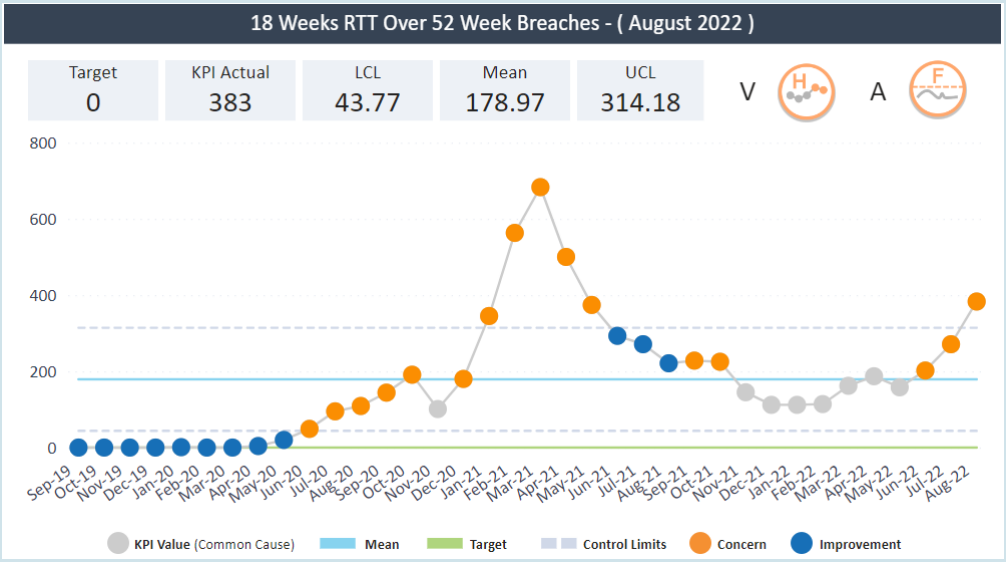
- Potential impact of Trust Business Continuity on Elective activity.
- Increased sickness absence driven by pressure of work and COVID related isolation or illness.

Responsive: Elective Insights

Executive Lead: Mandy Woodley
Operational Lead: Benn Best
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

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

What the Chart is Telling Us:

MFT improved in ranking this month to 18th in the country for 28 day for faster diagnosis on Public View.
• The 28 day is now part of the daily validations and PTL's.

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:

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.

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.

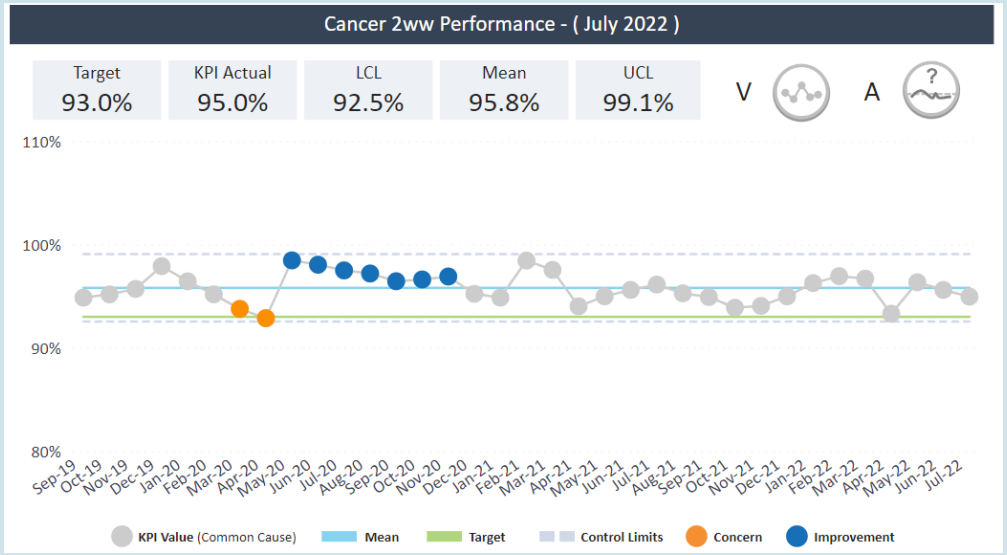
RTT Benchmarking

Responsive: Cancer Insights

Executive Lead: Mandy Woodley
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. Unfortunately in July the target was not met by UGI 87.88%, Breast 91.78% and Brain 84.62% due to diagnostic delays and patient choice.

What the Chart is Telling Us:

- Few concerns at present - continues to be compliant.
- **MFT were ranked 19th 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 and implemented within UGI. The STT/timed pathways are being agreed with the Cancer Alliance to enable patients having their tests before first outpatient appointment to allow the clinical team to have a more informed discussion and encourage a more timely pathway.
- We are working with the Alliance to implement the timed pathway across Lung, Lower GI, Upper GI and prostate which will be included in the 2022/23 CQUIN.

Outcomes:

- We continue to use the outpatient polling time report to monitor tumour groups on a daily basis.
- The Cancer Service Team are currently recruiting to all the FDS posts that have been funded by the Cancer Alliance to support the timed pathways and the new non specific symptom pathway.
- To support this we are working with Bi to provide a weekly report on diagnostic turnaround times (to be uploaded to BI portal) and review % booked within <7/7/8/9/10/>10 days.

Underlying issues and risks:

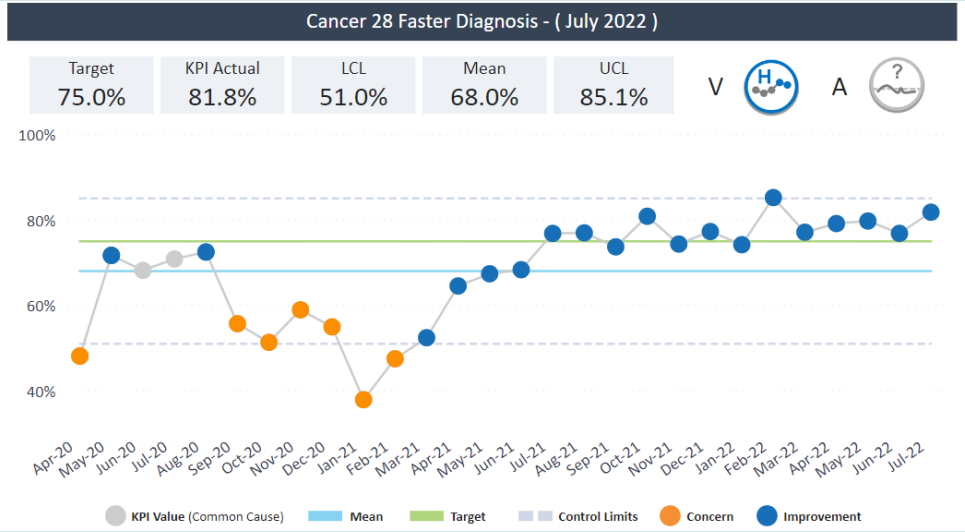
- The main challenges are volumes/fluctuations of referrals, particularly in some tumour sites, and patient choice.
- Currently we have set an internal target of 7 days for all 2 WW patients. We are currently booking 45.41% of patients within 7 days.

Responsive: Cancer Insights

Executive Lead: Mandy Woodley
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. We are maintaining performance with this metric and July performance was 81.82%

What the Chart is Telling Us:

- **MFT improved in ranking this month to 18th in the country for 28 day for faster diagnosis on Public View.**
- The 28 day is now part of the daily validations and PTL's.

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:

- 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.

Underlying issues and risks:

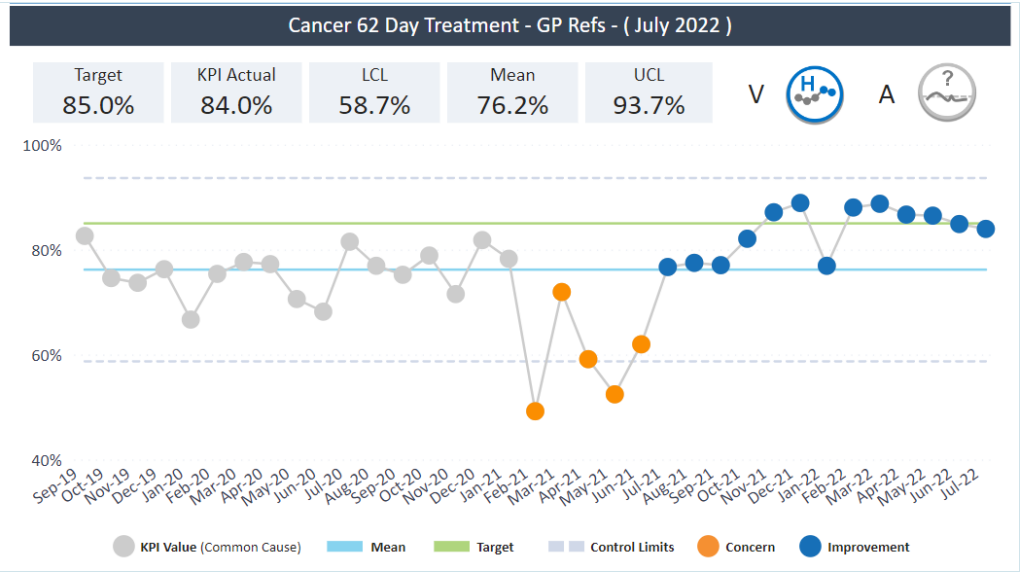
- Diagnostics capacity and turnaround remains the biggest issue to achieving compliance, particularly when affected by unplanned equipment failure or staffing capacity issues.
- Continue to improve our completeness data capture which is reflected in the performance
- Working with the Cancer Alliance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

Responsive: Cancer Insights

Executive Lead: Mandy Woodley
Operational Lead: Ellie Thomas
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

MFT achieved compliance against the 62D standard for the first time since June 2018 in November 2021. We were just short of meeting the 62 day standard for July achieving 82.10% in month

What the Chart is Telling Us:

MFT were ranked 15th in the country for 62 day treatment June performance on Public View.

Actions:

- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement Plan Meeting.
- Tumour Site Specific Improvements being taken through Cancer Board led by the Cancer Specialty Leads.
- Breach reports are completed fully and are analysed to identify themes and trends. All are signed off by clinical leads inline with the SOP
- 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

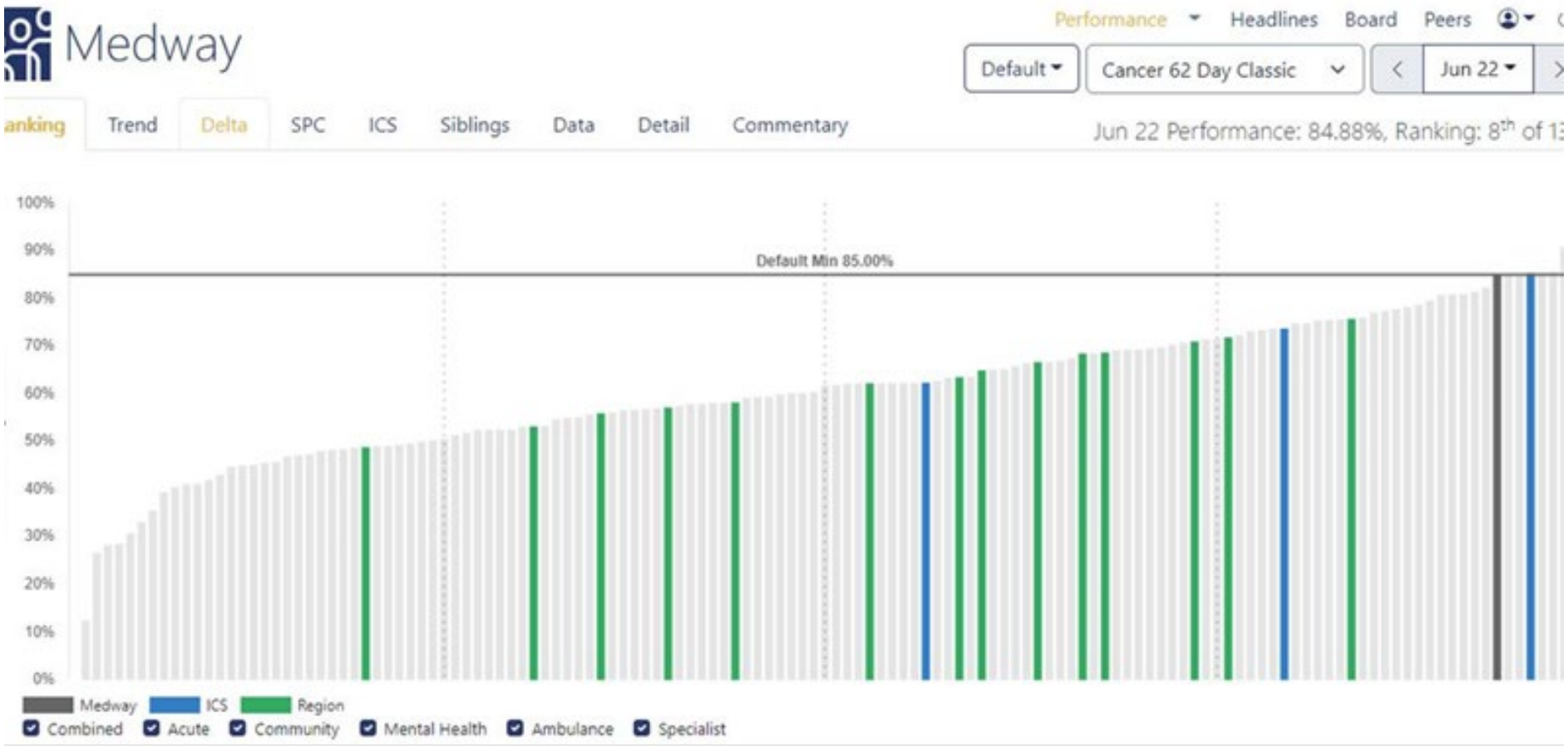
Outcomes:

- 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 three out of four key areas of cancer care June and we are working on improving performance to reach all four key areas going forward. This has meant that cancer patients in Medway and Swale have had an earlier diagnosis, faster treatment, a lower risk of complications, a better experience of care and improved outcomes.

Underlying issues and risks:

- 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. These posts have been included in the business plan.

Cancer 62day Benchmarking

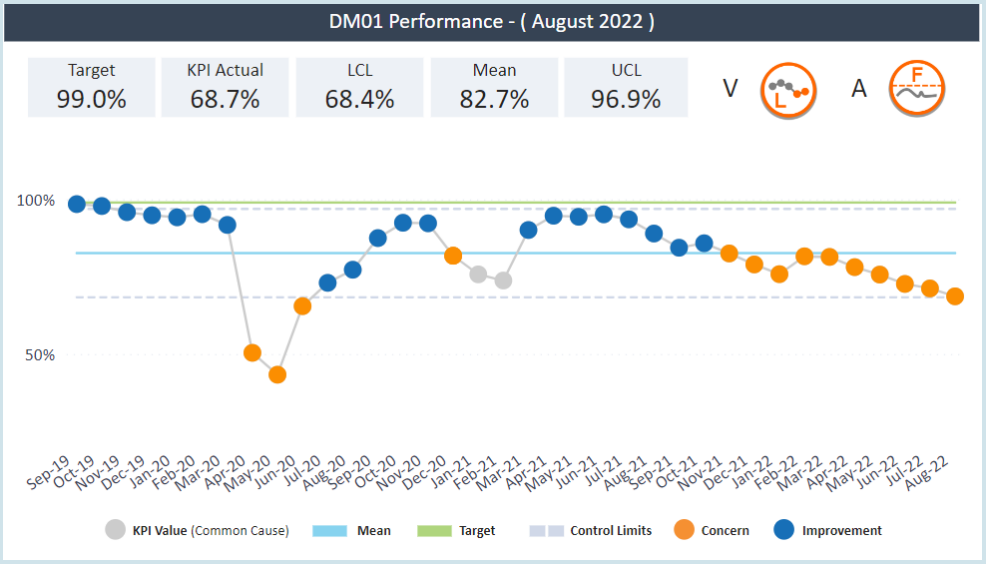


Responsive: Elective Insights

Executive Lead: Mandy Woodley
Operational Lead: Benn Best
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: DM01 Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

Triaging of patients on diagnostic waiting lists (D-code) by clinical team in line with national standard
• Use of Independent Sector for Endoscopy Insourcing (18WS) and Outsourcing (PPG) continues with good utilisation of lists
• Second mobile MRI onsite from August 2022
• Insourcing capacity is in place for Sleep Studies
• Echocardiography insourcing operational
• Trajectory to improve performance with 2nd MRI predicts improvement to above 75% in coming months.

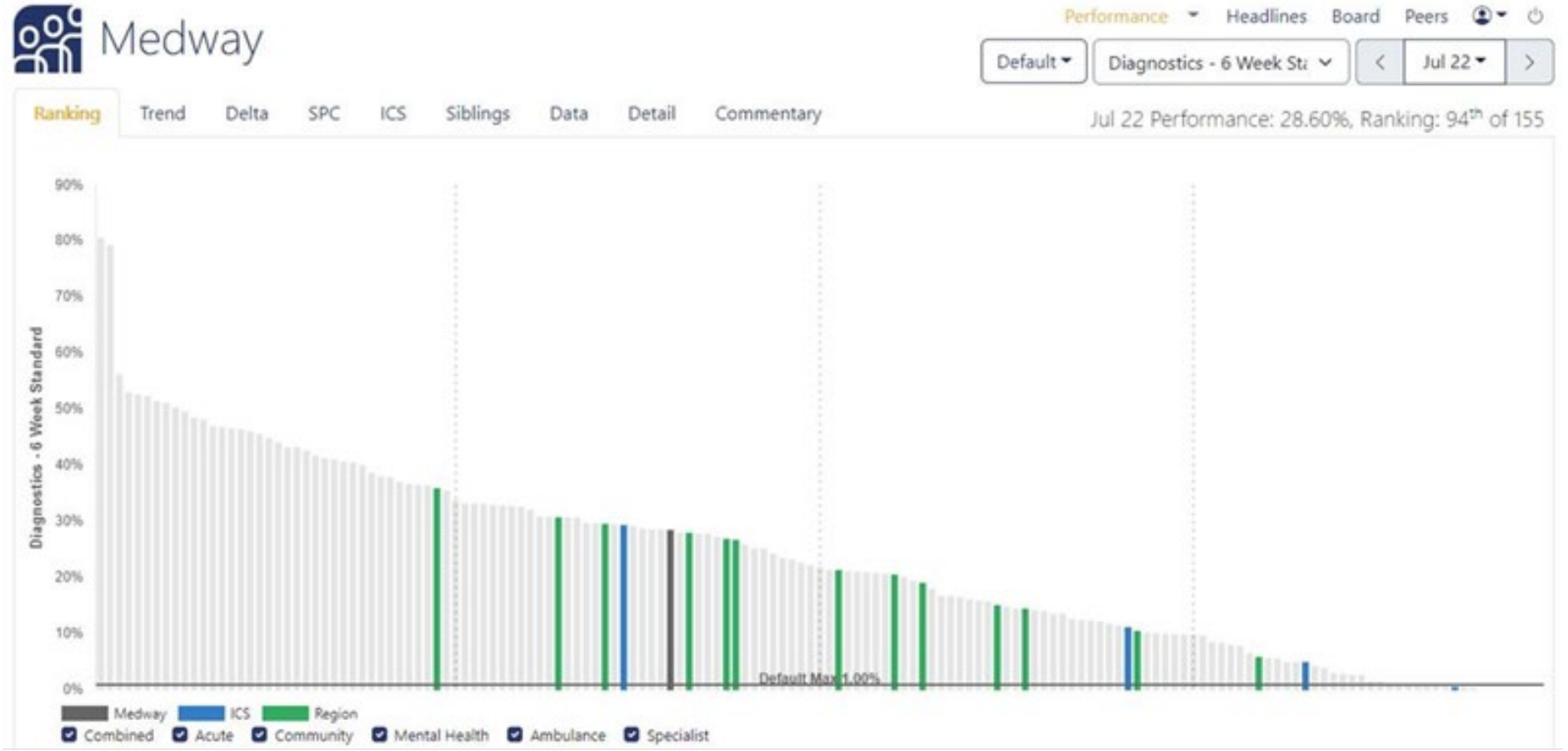
Outcomes:

Additional MRI capacity will support the backlog reduction for all specialities
• Insourcing and outsourcing of Endoscopy now focused on backlog as well.

Underlying issues and risks:

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

DM01 Benchmarking



Domain: Well Led – Dashboard

Executive Lead: Leon Hinton
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

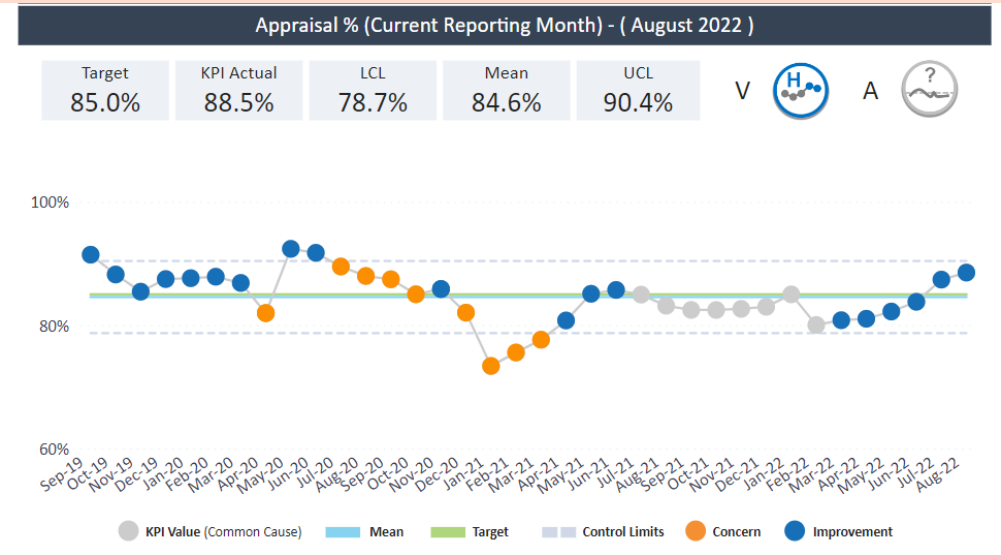
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Well Led	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Jul-22	4.0%	3.7%	1.0%	3.1%	5.2%		
		Agency Spend as % Paybill (Financial Year YTD)	Jul-22	4.0%	3.3%	2.7%	3.1%	3.6%		
		Appraisal % (Current Reporting Month)	Aug-22	85.0%	88.5%	78.7%	84.6%	90.4%		
		Bank Spend as % Paybill (Current Reporting Month)	Jul-22	9.0%	13.8%	8.1%	13.2%	18.3%		
		Bank Spend as % Paybill (Financial Year YTD)	Jul-22	9.0%	13.5%	11.6%	13.2%	14.8%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Jul-22		4,359.24	4,075.31	4,139.96	4,204.61		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Jul-22	2.5%	2.1%	1.5%	2.2%	2.9%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Jul-22	1.5%	3.7%	1.6%	2.2%	2.9%		
		Sickness Rate (Current Reporting Month, FTE%)	Jul-22	4.0%	5.8%	3.4%	4.5%	5.5%		
		StatMan Compliance (Current Reporting Month)	Jul-22	85.0%	85.1%	86.8%	89.2%	91.6%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Jun-22	75.0%	60.2%	51.1%	63.3%	75.5%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Jul-22	12.0%	16.9%	12.0%	12.9%	13.9%		

Well Led: Workforce - Insights

Executive Lead: Leon Hinton
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:

Underlying issues and risks:

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

Actions:

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

Outcomes:

3752 members of staff have an in-date appraisal
with objectives and personal development plan
outlined (from a total of 4238).

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month Baseline budget	In-month Actual	In-month Variance	YTD Baseline budget	YTD Actual	YTD Variance
Income	32,194	32,619	425	160,970	161,797	827
Pay	(20,422)	(21,910)	(1,488)	(102,392)	(102,489)	(97)
Total non-pay	(10,109)	(10,029)	80	(51,052)	(52,725)	(1,673)
Non-operating expense	(1,874)	(1,870)	4	(9,375)	(9,414)	(39)
Reported surplus/(deficit)	**(211)**	**(1,191)**	**(980)**	**(1,849)**	**(2,830)**	**(981)**
Donated Asset / DHSC Stock Adj.	13	8	(5)	67	62	(5)
Control total	**(198)**	**(1,182)**	**(985)**	**(1,782)**	**(2,768)**	**(985)**

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	978	705	(273)	3,237	2,630	(607)	10,482
Capital	(877)	(611)	266	(3,068)	(2,338)	730	(11,550)

Indicator Background:

The Trust reports a £1,191k deficit position for August; after removing adjustments for donated assets this reduces to £1,182k, which is £985k adverse to plan.

What the Chart is Telling Us:

The Trust has delivered £2.7m deficit year to date (YTD) for 2022/23, this is £1.0m adverse to the plan submitted to NHSE/I. The efficiency programme delivered in month £273k adverse to the £978k plan in month and £607k YTD. The capital programme is reporting £730k behind plan due to timing of the schemes completing.

Actions:

Financial performance is measured against the resubmitted plan to NHSE/I in June for 22/23, which is a planned breakeven position for the year. The plan contains a high level of risk including a £10.5m efficiency programme as well as £8m of non-recurrent mitigations. The Executive Team has agreed Executive Leads and actions to address each of the key financial risks, including divisional overspendings and efficiencies.

Outcomes:

The Trust is reporting a £1.0m adverse position to plan for August and is currently reporting a £1.0m deficit. This includes:

- Elective recovery fund income of £4.1m year to date. There is no risk of clawback of ERF income in the first half of the year.
- Non-recurrent release of accruals £7.0m to cover non-delivery of efficiencies, clinical supplies, increase in drugs costs, medical locums, escalation capacity remaining open and staff sickness.

Underlying issues and risks:

The current plan is a breakeven position for the year and includes the risk of delivering £8m of mitigations and the £9.6m efficiency programme, there is a further stretch target of £0.9m to add in the 2nd half of the financial year, to date £9.3m of schemes have been identified, £0.3m below the original target and £1.2m behind the stretch target. In month a further £1.5m of non-recurrent mitigations have been released into the position, mainly from a review of expenditure accruals. The 22/23 capital plan has been finalised.

Meeting of the Board of Directors in Public

Wednesday, 05 October 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	
Committee Chair:	Jo Palmer, Chair of Committee/Trust Chair		
Date of Meeting:	Tuesday 23rd August 2022		
Lead Director:	Evonne Hunt, Chief Nursing Officer		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headlines	**Assurance Level** (use appropriate colour code as above)
1. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report The Committee received the assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Thursday 18th August 2022. The Committee were assured by the excellent report which provided a really good summary of the discussions and provided a real essence of the things QPSSC are assured about and those that QPSSC are not assured of.	**Green**

The Committee noted the items where QPSSC have requested further assurance from; review of 2 child deaths and safeguarding Children's annual report, will be re-presented at QPSSC and then to this Committee. The Committee noted that a number of papers on the agenda for the quality assurance committee had been discussed at QPSSC.	
2. Quality performance report and IQPR The Committee received the quality performance report which provided progress updates detailing performance against the hospital's key quality metrics, including: • Patient Safety • Quality Assurance and Compliance • Clinical Effectiveness • Mortality and Morbidity • Risk & Policy Management • Legal and Information Governance The Committee were assured by the content of the quality performance report.	**Green**
3. Falls prevention The Committee received a Falls Prevention update following deeps dives into a rise in falls using A3 patient first methodology. The Committee were informed of the areas of work the deep dive has highlighted and the work being taken in these areas. The Committee were concerned about the reporting of moderate and severe harms and were advised that some of this could be attributed to those elderly and frail patients whom have become de-conditioned due to shielding during COVID and when they are admitted to hospital they were at a higher risk of falling. The Committee were informed of the work in the community to help those patients to prevent harms. The Committee were advised that the falls team are in the process of completing deep dives on all of the wards identified and a further update will be provided.	**Amber/Green**
4. Safeguarding Children quarter one report The Committee received the safeguarding children quarter one report which provided an update of the work of the safeguarding team. The Committee discussed the process of what happens when a child or other vulnerable person is 'not brought in' for an appointment and how this is flagged as a safeguarding concern and shared with local agencies. The Committee were advised that work is taking place to review the current process to ensure the Trust has a robust system in place. This work is being monitored by the Safeguarding Assurance Group.	**Amber/Green**
5. NHSEI Regional Team Ockenden Insight Assurance visit The Committee received an update following a visit to the Trust by the NHSEI regional Team for an Ockenden Insight Assurance visit on 16th August 2022. The	**Green**

team are visiting all maternity units to gain assurance against the 7 immediate actions from the Ockenden report which was published in 2020. The Committee were informed the visit was a huge success with great feedback received by the Trust from the visiting team. The Director of Midwifery has been approached to share the good work of the service by other Trusts.	
6. Adult in-patient Survey Results The Committee received the adult in-patient survey results paper which provided the trust position based on an adult in-patient survey which conducted in the early part of 2022 based on patients treated in November 2021. The report provide results this year and provided a comparison with the Trust's results from last year and also with the average scores of all 73 participating Trusts. The Committee were informed of the work taking place to improve friends and family test (FFT) response rate as part of a breakthrough objective within Patient First.	**Amber/Green**
7. Nutrition A3 The Committee were informed that A3 thinking methodology was used to look at the delays in NG tube feeding following a number of incidents that identified a delay in patient feeding. The process identified a number of areas for improvement and the Committee were informed of a difficulty in recruiting to a specialist nutrition post, which has led to thinking differently about how posts are covered. The post is being covered by a specialist dietician which is working well. The Committee were pleased to see this work being undertaken using A3 thinking and problem solving and suggested the data could be stratified in the targeted of where are the areas that require improvement and support. The Committee requested its thanks be passed to the team and made a recommendation for the team to present at Trust Board.	**Green**
8. CQC Action Plan Update The Committee were informed of the progress being made on the two should do actions that remain open following the 2020 CQC inspection. The Committee were informed these actions are on track for closure with evidence provided to support the action to be validated.	**Green**
Escalation to Board No items were identified for escalation to Board. The Committee inform the Board on the following points:- • The Committee were informed of a risk identified by quality and patient safety sub-committee relating to the NEWS2 electronic patient record (EPR) options paper. QPSS have an action for the Director of Quality and Patient Safety to meet with the project leads to discuss the governance arrangements for the EPR programme	

board. The Committee will receive an update from QPSSC at the meeting. • The Committee makes a recommendation for the Board to receive a presentation on the work taking place on nutrition and hydration.	

Meeting of the Board of Directors in Public

Wednesday, 05 October 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	4.2
Committee Chair:	Jo Palmer, Chair of Committee/Trust Chair		
Date of Meeting:	Tuesday 27th September 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**
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Key headlines and assurance level	
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1. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report The Committee received the assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Thursday 22nd September 2022. The Committee were assured by the report which provided a really good summary of the discussions and provided a real essence of the things QPSSC are assured about and those where further work is required.	**Green**

The Committee noted that a number of papers on the agenda for the quality assurance committee had been discussed at QPSSC.	
2. Quality performance report The Committee received the quality performance report which provided progress updates detailing performance against the hospital's key quality metrics, including: • Patient Safety • Quality Assurance and Compliance • Clinical Effectiveness • Mortality and Morbidity • Risk & Policy Management • Legal and Information Governance The Committee were assured by the content of the quality performance report. The Committee were advised of two never events, of which one was a near miss. The Committee whilst disappointed by the occurrence of a never event were comforted that both were quickly detected and colleagues had felt confident about speaking up.	**Green**
3. IQPR The Committee noted the IQPR and the data having been discussed via the quality and patient safety sub-committee assurance and escalation report and the quality performance report. The Committee were informed about the upcoming changes to the quality performance report and IQPR. The IQPR will be replaced by watch metrics and the quality performance report will move to quarterly reporting.	**Green**
4. Safeguarding adult annual report The Committee received and discussed the safeguarding adult annual report which provided an update on the activity of the adult safeguarding team for the period of 1 April 2020 to 31 March 2021. The Committee noted the content of the report and thanked the team for the work carried out.	**Green**
5. National review of 2 child deaths The Committee received and discussed the national review of 2 child deaths paper. The Committee informed that benchmarking exercise has been undertaken to evidence current practice, identify gaps in practice and identify mitigating actions to ensure the Trust is meeting its statutory duties to safeguard Children and young people as described within the Children Act 2004. The Committee were informed of a safeguarding risk as we migrate to EPR that the flags for children under child protection have not transferred across and work is underway to resolve this. The Committee have an action to track the progress of the work being taken to address this issue.	**Amber/Green**

6. Ockenden update The Committee received the Ockenden update report which included the actions from the second Ockenden report. The Committee were informed of the progress against the actions since the last report in June. The Director of Midwifery informed the Committee that the publication of the Kirkup report has been delayed to late October and the Trust will carry out a self-assessment once the report is available. The Committee approved the report for onward sharing with Trust Board.	**Green**
7. CNST update The Director of Midwifery presented the CNST compliance report to the Committee which provided an update on the Trusts compliance against the 10 CNST standards and actions which are on track for the reporting submission in January 2023. The Committee approved the report for onward sharing with Trust Board.	**Amber/Green**
8. Maternity workforce The Committee received the maternity workforce paper which is a requirement of CNST for maternity workforce to be presented the Trust Board twice a year. The Committee were informed that desk top exercise took place in June to assess the establishment of staffing in maternity to see we are where we are in acuity and activity. The outcome of the assessment was exactly the same ratio from the last formal assessment of 1.74 wte short. The Committee were informed by the Director of Midwifery that she will not be requesting any funding for the 1.74wte because there are 26 new members of staff joining the department. Their onboarding will be completed first and a further assessment taken in due course. The Committee were assured by the progress being made in maternity. The Committee approved the report for onward sharing with Trust Board.	**Green**
9. SOP – learning and recognising excellence The Committee approved the learning and recognising excellence SOP.	**Green**
10. Mix sex accommodation The Committee noted that that the mixed sex accommodation information had been reflected in agenda items 3.2 Quality Performance Report and 3.3 Quality IQPR. The Committee were informed that the new Associate Director for Patient Experience, Nikki Lewis, will be leading on mixed sex accommodation and one area of focus will be the validation of data.	**Amber/Green**
11. Private board paper – serious incident and multiple near misses involving patients with mental illness	**Amber/Green**

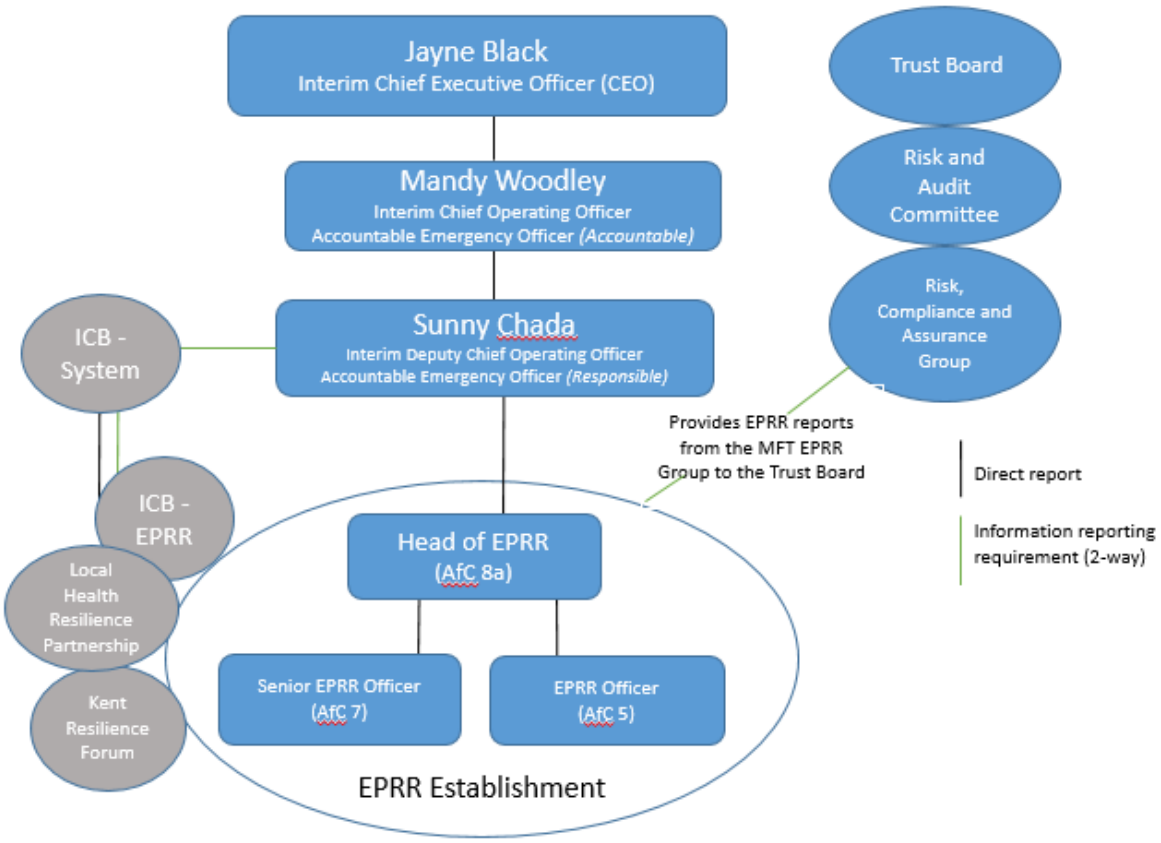
The Committee discussed the progress against actions identified following a serious incident relating to a patient self-harming in the car park and a number of other near misses relating to the car park. The Committee were informed of the decisions needed by the Capital Program and a paper relating to security that will be discussed at Trust Board.	
12. Revised terms of reference of the Quality and Patient Safety Sub-Committee The Committee approved the revised terms of reference for the Quality and Patient Safety Sub-Committee.	**Green**
13. Effectiveness review of the Quality Assurance Committee The Committee were advised this it is due to undertake a review of its effectiveness as part of good governance. The Committee will receive a QR code to access questions on how the committee is running. Once completed a summary paper will come back the Committee	**Green**
Escalation to Board The Committee approved the following papers for onward sharing with Trust Board:- • CNST update • Ockenden update • Maternity workforce The Committee inform the Board on the following points:- • two never events • upcoming change to the performance report and IQPR • safeguarding reports to be noted and the risk where child protection safeguarding flags have been removed as part of the migration to EPR, work is currently underway to resolve this. The Committee has an action to monitor this.	

Meeting of the Trust Board
Wednesday, 05 October 2022

Title of Report	**EPRR Annual Assurance Report 2022**	Agenda Item	X
Lead Director	Mandy Woodley, Chief Operating Officer		
Report Author	Sarah Garman, Head of Emergency Preparedness, Resilience and Response		
Executive Summary	This report provides the Trust Board with: • An update on EPRR work streams and issues related to its progress throughout 2022. • An overview and understanding of Trust compliance with the NHS EPRR Core Standards Assurance for 2022. • An Improvements plan, detailing actions required to enhance compliance for the EPRR Core Standards Assurance in 2023		
Committees or Groups at which the paper has been submitted	MFT Senior Leadership Group – 05th September 2022 Trust Management Board – 07th September 2022 Risk, Compliance Assurance Group – 09th September 2022 MFT EPRR Group – 29th September 2022		
Resource Implications	EPRR Resource required within its agreed Trust establishment – recruitment to one Band 5 and one Band 7 currently active.		
Legal Implications/ Regulatory Requirements	The Civil Contingencies Act 2004, CCA 2004(Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022. All acts place EPRR duties upon the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework (2022)		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	**The Board is asked to note and approve this Annual EPRR Core Standards Assurance Report 2022 and note its requirement to be public accessible, thereafter.**		
	Approval ☐	Assurance ☒	Discussion ☒	Noting ☒
Appendices	a) Letter from Director EPRR, NHS England, 29 July 2022 b) NHS England EPRR Annual Assurance Guide, July 2022 c) EPRR Assurance Improvements plan for 2023		

1.0 Trust EPRR Governance and Accountability

1.1 The current Trust EPRR establishment and accountability is represented below:



1.2 Since January and March 2022 respectively, 2 members of the Trust's EPRR team suddenly departed. This left 1 member of new staff in the team with no handover of information or annual work plan in place, to deliver the programme of EPRR and Business Continuity for the Trust. Due to these staff being on long term sick leave, recruitment to backfill the vacancies was unable to commence until later this year after they both resigned. The band 7 member was appointed to the 8a role in August after fair and open process and recruitment is now underway for the 2 vacant positions.

1.3 The previous governance for EPRR in the Trust has been recently reconfigured and now reflects in new reporting structures. There is a Trust 'EPRR group', chaired by the delegated AEO for the Trust and is established to assist the Trust Board in fulfilling organisational responsibilities in relation to the Civil Contingencies Act 2004. The Group has a new Terms of Reference, in keeping with the new reporting structures, membership and responsibility for maintenance and oversight of: all Trust EPRR plans, EPRR Risk register, EPRR Training and Exercising programme, Incident records management and retention and all lessons identified from debriefing post-exercises and incidents. The Group reports to the Risk, Compliance and Assurance Group.

2.0 NHS EPRR Core Standards – Annual Assurance process

2.1 The ability of the Trust to remain resilient and responsive to emergencies and incidents which disrupt day to day operations, over a sustained period, is due to our collective commitment to Emergency Preparedness, Resilience and Response (EPRR).

2.2 NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the EPRR annual assurance process with providers submitting a self-assessed view of compliance against a set of 68 Core standards: NHS England » Emergency preparedness, resilience and response: core standards

2.3 There are 64 NHS EPRR core standards for Acute Trusts to comply with, spanning 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

2.4 The 2022 assurance process aims to return to previous mechanisms, following amended 'light touch' processes, due to demands on the NHS during 2020 and 2021 (Covid).
As such, this year Medway NHS Foundation Trust is asked to comply with **64** of these Core standards and in addition, **13** standards relating to planning and response arrangements for 'Evacuation and Shelter' as part of a regional 'deep dive'. The complete Assurance assessment report, improvements plan and all sufficient evidence to **substantiate** this compliance, signed by the Trust AEO, is due by **12th September 2022.**

2.5 The overall EPRR assurance rating is based on the percentage of core standards the organisation assesses itself as being compliant with, from being non-Compliant through to Fully Compliant:

Overall EPRR assurance rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

100%	99-89%	88-77%	76% or less
Number of fully compliant core standards to achieve the percentage			
64	63-57	56-49	48

2.6 The organisation's EPRR self-assessment rating and all supporting evidence is shared with the Kent and Medway ICB and LHRP no later than **12th September 2022**. Along with granular pieces of evidence provided, this should also include the following, endorsed by the Trust Accountable Emergency Officer (AEO):

- self-assessed statement of compliance against individual core standards relevant to organisation type
- action plan to ensure full compliance with all core standards for the next year (2023)
- overall assurance rating and associated organisational Board Report detailing the outcome

2.7 The Kent and Medway ICB then review the evidence supplied, agree the rating and submit this to the NHS Regional head of EPRR. NHS England Regional heads of EPRR then submit the assurance ratings for each of their organisations and a description of their regional process to Stephen Groves, Director of Emergency Preparedness, Resilience and Response (NHS England) before Friday 30 December 2022.

2.8 Where an organisation considers itself less than fully compliant, ICBs are expected to investigate further, and support the development of any corrective actions by way of peer reviews and on-site visits.

3.0 Trust EPRR Core Standards Position Statement 2022

3.1 The Trust Board are asked to note the EPRR resource has been significantly depleted for almost the entire year. The work programmes which wrap around these 64 core standards and 13 in the deep dive, have been supported by 1 member of staff, which is only one third of the agreed required establishment and not near equivalent to the neighbouring Trusts, to lead and deliver this work.

3.2 The areas and levels of compliance, are detailed below. Where a standard is partially or non-compliant, there is an improvements plan to accompany this for enhancing the compliance outcome for 2023. See appendix c.

EPRR Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	6	3	0
CBRN	14	13	0	1
Total	**64**	**58**	**5**	**1**

3.3 The fully compliant scoring of **58**, means the Trust has a self-assessed compliance level of **'Substantial'** for the year 2022.

3.4 The Domains where improvements are required to achieve full compliance for 2023, are detailed in the table above and are addressed within the EPRR Core Standards Assurance Improvements plan 2022-23, in Appendix c.

3.5 Compliance towards this year's 'Deep dive' standards into Evacuation and sheltering plans, exercising, training and arrangements has been assessed as fully compliant with a partial rating for one standard noting the requirement to exercise an evacuation scenario in 2023 to inform a review of the Evacuation plan overall. Please note this **does not** count towards our official compliance with the annual EPRR Core Standards Assurance domains above.

3.6 The 'Deep dive' standards table and associated evidence required, has also been submitted along with the evidence collated for each standard, in the table below. Any non or partial compliance with these deep dive standards, will also be acknowledged in the improvements plan 2022 – 2023.

Deep Dive (all Evacuation and Shelter)	Total standards applicable	Fully compliant	Partially compliant	Non compliant
DD1. Up to date Plans	**13**	1		
DD2. Activation		1		
DD3. Incremental Planning		1		
DD4. Evacuation Patient Triage		1		

DD5. Patient movement		1		
DD6. Patient Transportation		1		
DD7. Patient Dispersal and Tracking		1		
DD8. Patient Receiving		1		
DD9. Community Evacuation		1		
DD10. Partnership Working		1		
DD11. Communications: Warning and Informing		1		
DD12. Equality and Health Inequalities		1		
DD13. Exercising		0	1	
Total	**13**	**12**	**1**	**0**

4.0 Summary of recent Incidents

4.1 The incidents below, required emergency responses to mitigate impacts to the safety and security of patients, staff and visitors in the Trust. Following each event, an Incident debrief in accordance with the NHS EPRR framework, was undertaken with staff involve, to identify lessons and improve response plans and processes for the 'next eventuality'.

4.2 The external incidents were monitored by the EPRR Lead for any impacts to the Trust, via links into the Kent Resilience Forum and Local Health Resilience Partnership colleagues and multi-agency meeting groups.

4.3 Internal incidents
Pager System outage 26.04.2022 and 11.05.2022
Level 4 Heat Health Response – July 2022
Foul Water leak, Sunderland Day care centre and patient evacuation – 17.08.2022
Foul Water leaks on Dolphin and Ocelot wards (no evacuations) 18.08.2022 and 21.08.2022

4.4 External Incidents - with potential impacts to the Trust
Isle of Sheppey Water outage 10-15.07.2022
Port of Dover major incident – 22.07.2022

5.0 Summary of 2022 EPRR Training, Exercising and meetings

5.1 Attendance to EPRR Training is currently managed by the EPRR lead by advertising training to appropriate staff, delivering the training and then recording on a central EPRR Training Register, linked to an EPRR Training needs analysis for Trust Staff. This has not historically linked to ESR for automation of booking attendance, compliance uptake or attendance recording; this will be progressed as part of the 2023 EPRR work plan.

5.2 EPRR Training compliance data is currently recorded by the EPRR team for the following modules**:**

Command Training – All SMoC and DoC staff (2 year refresher)
CBRN Response – ED staff, Heads of Nursing and Matrons across divisions and Site team staff
Initial Operating Response – frontline reception, security and admin staff
Loggist training – PA's, administrative staff, EPRR team, Site team staff
METHANE reporting training – all Site Team staff, switchboard operators and ED Resus/Majors staff
EPRR Group Meetings attendance – as per its Terms of Reference
LHRP Delivery and Executive Group meetings attendance – MFT Accountable Emergency Officer

5.3 Attendance and participation in EPRR Training, Exercises and relevant meeting groups are recorded for this year, as part of the schedule described below. The 2 areas of weakness currently are the CBRN

and Loggist training, both addressed in the Action Plan for 2023 with work already progressing this year to greatly improve current levels of compliance by end of 2022.

MFT EPRR Group Meetings

Date	Time	Location
27th January 2022	10 – 11:30am	MS Teams
Thursday 09th June 2022	10 – 11:30am	MS Teams
Thursday 14th July 2022	10 – 11.30am	cancelled
Thursday 15th September 2022	10 – 11:30am	MS Teams
Thursday 10th November 2022	10 – 11:30am	MS Teams
Thursday 12th January 2023	10 – 11.30am	MS Teams

Tabletop Exercises

Date	Time	Subject	Location
11th March 2022	09.30 – 12.30	Cyber Resilience Exercise	Res 13a, MFT

Live Exercises

The planning for undertaking a 'live exercise' this year was postponed due to 'real life' incident response for the Level 4 Heatwave which required Command, Control and Coordination establishment and replaced the formal requirement for a Live Exercise as part of the Assurance for 2022.

There is planning with ED staff underway to ensure we participate in a SELKaM Trauma Network exercise (Blue Circle) in Quarter 1 2023, testing Multi-agency, Mass Casualty response.

The foul water leak incidents in August 2022 contributed to our exercising of response plans and command, control and coordination structures and processes. The learning from which, has been captured in debrief reports and will inform quality improvements to mitigating risks, plans development, processes and staff training.

Communications Exercises

Date	Location	Subject
November 2021	MFT (Dory 3)	Comms cascade via ward ext numbers
24th June 2022	SECAmb, ICB, MFT (Ex Alert 2)	Testing the alerting for 'major incident notification' communications in and between organisations

We have fulfilled the requirement to undertake 2 x 6 monthly communications exercises. We have also proven our communications capabilities in 'real life' during 2 recent outages of the Pager system; utilising our back up plans and resources for continuation of urgent communications through other means (radios).

Multi-Agency Exercises

Date	Time	Location	Subject
16th – 20th May 2022	All week	ResilienceDirect	'Exercise Bird Call' - Business Continuity based on Power outage scenario

Loggist Training

Date	Time	Location
08th February 2022	09.30 – 11.30am	Gundulph meeting room, MFT
28th and 29th September	am / pm on each day	EPRR Office, MFT

There is currently a low uptake of staff wanting to do be trained in the Loggist role. There is a plan to issue a communications drive to encourage uptake and for training sessions to be made accessible for staff to attend.

Emergency Response CBRN Training (ED staff inc. CSWs)

Date	Time	Location
16.06.2022	09.00am – 4pm	East Kent, Canterbury Cricket ground
14.07.2022	09.00am – 4pm	Education Centre meeting room - MFT
01.09.2022	09.00am – 4pm	Education Centre meeting room - MFT
06.09.2022	09.00am – 4pm	Education Centre meeting room - MFT
15.09.2022	09.00am – 4pm	East Kent, Canterbury Cricket ground
26.09.2022	09.00am – 4pm	Education Centre meeting room - MFT
04.10.2022	09.00am – 4pm	East Kent, Canterbury Cricket ground
15.11.2022	09.00am – 4pm	Education Centre meeting room - MFT
24.11.2022	09.00am – 4pm	Education Centre meeting room - MFT

We have 140 staff on role for Emergency Department Staffing, suitable to undertake this training. There are currently 25% of ED staff competently trained, to respond to a CBRN incident.

There are 36 additional ED staff booked to attend courses up to and including November, which will elevate compliance to 50.7%. That leaves a deficit against the LHRP standards for CBRN training compliance, of 29.3% equating to 41 staff.

Several non-ED staff have also recently been trained and further staff are booked to attend future sessions, which elevates the % to the wider staffing groups who are able to support a CBRN response.

Overall: There are currently 35 ED staff and 7 non-ED staff fully competent in CBRN response. There are an additional 36 ED staff and 19 non-ED staff likely to be compliant with further training sessions taking place up until end of November 2022. We are required to train a further 41 ED staff, to reach full compliance with the Kent and Medway LHRP agreed standards for CBRN training; notwithstanding the additional resource (26 non-ED staff) who will be able to support a CBRN response.

Initial Operating Response Training – Front of house staff
NaCTSO ACT training – Front of house staff (and open to all)

Date	Time	Location
Online training sent to leads for ED admin team, Reception, Switchboard, Housekeeping, Security and Site team.	Available all year round for any new staff who join front of house roles.	Training Video, links to e-learning and hard copy materials made available via the EPRR office

METHANE Alerting and Escalation training

Date	Time	Location
Staff in ED Resus/Majors team, Switchboard and Site team.	Available all year round. Training provided to these teams in June 2022	In Person. Handouts of the METHANE form are provided

Incident Commander Training Programme for On Call staff

All new staff at Senior Manager and Director level, who are required to partake in the On Call rotas, have attended the Incident Commander training, as a requirement before undertaking such duties.

Incident Command – Sarah Garman	10.05.2022	12.30 - 2.30pm	EPRR office
Incident Command – Sarah Garman	17.06.2022	10am -1pm	EPRR office
Incident Command – Sarah Garman	20 and 21.06.2022	10am -1pm	EPRR office
Incident Command – Sarah Garman	21.10.2022	2.30 – 5.30pm	EPRR office
Incident Command – Sarah Garman	28.10.2022	1.30 – 4.30pm	EPRR office
Media Training – Glynis Alexander	29.06.2022	9am-1pm	
Media Training – Glynis Alexander	07.07.2022	1pm – 5pm	
Media Training – Glynis Alexander	15.07.2022	9am-1pm	
Media Training – Glynis Alexander	20.07.2022	1pm – 5pm	
Legal requirements of Incident management – Paul Mullane	30.06.2022	9.30 -10am	MS Teams
Legal requirements of Incident management – Paul Mullane	22.07.2022	10 -10.30am	MS Teams
Legal requirements of Incident management – Paul Mullane	29.09.2022	2.30- 5pm	MS Teams
Legal requirements of Incident management – Paul Mullane	24.11.2022	2.30 -5pm	MS Teams

6.0 Lessons Identified – Quality Improvements

6.1 Each Incident and/or Exercise that occurs in the Trust, requires a structured debrief with the staff involved, to ensure that lessons are identified and translated into recommended actions informing quality improvements to plans, processes, access to resources and identify training requirements. A tangible example of this would be the recent establishment of a Trust-wide Incident Response WhatsApp group following the foul water leaks incidents, which has improved the timely escalation and alerting and coordinated response to incidents on site.

6.2 This year, the following debrief reports have been developed and submitted to Trust Management Board and the Risk Compliance and Assurance Group for endorsement of actions.

- Cyber Resilience Exercise (March 2022)
- Level 4 Heatwave response (July 2022)

- Foul water leaks incidents (August 2022)

6.3 Other debrief reports have been developed following smaller scale incidents/exercises. The lessons and recommendations from all, are translated to the MFT Lessons Identified action log, overseen by the MFT EPRR Group. Progress of all actions towards quality improvements is regularly reported to the Trust Risk, Compliance and Assurance Group.

Exercise Dory 3 (Communications Exercise – November 2021)
Pager System outage debrief report (May 2022)
Exercise Alert 2 (Communications Exercise – June 2022)

7.0 EPRR Risks and process for management

7.1 The Trust EPRR risk register is managed by the Head of EPRR. This is representative of risks input into the DATIX system by staff across the Trust, which require appropriate management and ownership and risks which are identified through debriefs post incident and exercises.

7.2 Other external EPRR risks are included from the Kent Resilience Forum Community Risk Register as well as local risks reported via the Local Health Resilience Partnership, chaired by the Kent and Medway ICB.

7.3 EPRR risks are represented on the Trust Risk Register as they score appropriately according to the criteria. This coming year will see more intervention being requested to manage Climate Change and adaptation planning risks to the Buildings and infrastructure.

8.0 Next steps – Quality Improvements for 2023 Assurance compliance

8.1 The Action plan detailing improvements required against this year's EPRR Core Standards Compliance report 2022, can be found appended to this report. The actions directly relate to the domain areas in which the Trust were unable to provide substantial evidence to be 'fully compliant' with, this year.

8.2 The progress of this Improvements plan will be monitored by the MFT EPRR group and its members who will be allocated ownership of appropriate actions. This will be overseen by the Risk, Compliance and Assurance Group by way of regular KPIs reporting from the EPRR group chair. Completion of all actions within the Improvements plan is expected to ensure the Trust reaches 'Full compliance' with the NHS EPRR Core Standards Assurance for 2023.

ENDS

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Leads to the Report appendices aforementioned.

Appendix a)

Classification: Official

Publication reference: PAR1664_ii

NHS England

To:
- NHS accountable emergency officers
- NHS England regional directors, regional heads of EPRR, regional directors of performance and improvement, regional directors of performance
- LHRP co-chairs

cc.
- Mike Prentice, National Director for Emergency Planning and Incident Response
- NHS England Business Continuity Team
- CSU managing directors
- Clara Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, DHSC

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

29 July 2022

Dear colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2022/23

I thank you and your teams once again for your leadership and delivery of patient care during another exceptional year. The NHS continues to respond to a number of challenging events, as we recover from the COVID-19 pandemic and experience increased demands on our urgent and emergency care services.

The ability of the NHS to remain resilient and responsive over a sustained period is due to our collective commitment to emergency preparedness, resilience and response (EPRR).

NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

Due to the demands on the NHS, the 2020 and 2021 assurance processes were amended; however the 2022 EPRR process aims to return to many of the previous mechanisms.

With the introduction of the Health and Care Act 2022, this year's assurance process will reflect the establishment of integrated care boards (ICBs) as Category 1 responders and their local NHS leadership role. This includes: the requirement to undertake a self-assessment against the core standards; and lead the NHS locally to agree the process to gain confidence of organisational ratings.

This letter notifies you of the start of the 2022 EPRR assurance process and the initial actions for organisations to take.

Core standards

The NHS core standards for EPRR are the basis of the assurance process. This year the standards, including the interoperable capabilities standards, have undergone a triannual review in advance of the assurance process.

Domain 10-CBRN will be reviewed separately as part of the CBRN work programme. As such, for this year's assurance process, these specific standards remain unchanged. The new core standards are attached to this letter.

You are asked to undertake a self-assessment against the individual core standards relevant to your organisation type and rate your compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Following the publication of the updated Evacuation and shelter guidance for the NHS in England, and recent work driven by the heightened risk associated with reinforced autoclaved aerated concrete (RAAC), the 2022/23 EPRR annual deep dive will focus on local evacuation and shelter arrangements.

The deep dive questions are applicable to those organisations indicated in the NHS Core Standards for EPRR self assessment tool

The outcome of this process is used to identify areas of good practice and further development for future guidance. It should also guide individual organisations in the further development of their shelter and evacuation arrangements.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational ratin	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

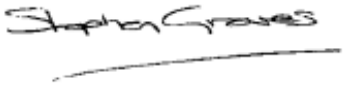
Action to take/next steps

- All NHS organisations should undertake a self-assessment against the 2022 updated core standards (attached) relevant to their organisation. These should then be taken to a public board or, for organisations that do not hold public boards, be published in their annual report.
- ICBs are required to work with their organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process should be agreed with the NHS England regional head of EPRR and their teams.

- NHS England regional heads of EPRR and their teams to work with ICBs to agree a process to obtain organisation-level assurance ratings and provide an environment that promotes the sharing of learning and good practice across their region.
- NHS England regional heads of EPRR to submit the assurance ratings for each of their organisations and a description of their regional process to myself before Friday 30 December 2022.

If you have any queries, please contact your regional head of EPRR or EPRR NHS system lead in the first instance.

Yours sincerely,



Stephen Groves
Director of Emergency Preparedness, Resilience and Response
NHS England

Appendix b)

Classification: Official

Publication reference: PAR1609_i

NHS England

NHS core standards for emergency preparedness, resilience and response guidance

Version 6.0, 29 July 2022

Contents

1. Purpose

The purpose of the NHS core standards for EPRR is to:

- enable health agencies across the country to share a common approach to EPRR
- allow co-ordination of EPRR activities according to the organisation's size and scope
- provide a consistent and cohesive framework for EPRR activities
- inform the organisation's annual EPRR work programme.

2. Relevant legislation and guidance

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

3. Relevant legislation and guidance

The NHS England Board has a statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care and the Secretary of State for Health and Social Care.

As the NHS core standards for EPRR provide a common reference point for all organisations, they are the basis of the EPRR annual assurance process.

Providers and commissioners of NHS-funded services complete an assurance self-assessment based on these core standards. This assurance process is led nationally and regionally by NHS England and locally by integrated care boards.

4. NHS core standards EPRR

The NHS core standards for EPRR cover 10 domains:

1. governance
2. duty to risk assess
3. duty to maintain plans
4. command and control
5. training and exercising
6. response
7. warning and informing
8. co-operation
9. business continuity
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

The applicability of each domain and core standard depends on the organisation's function and statutory requirements. Where organisations provide services across multiple organisation types, all the standards in all the applicable organisation types will apply; for example, an NHS111 service provider that also provides urgent treatment services (community) is required to comply with all the standards applicable to NHS111 services **and** community service providers.

An 11th domain is only applicable to NHS ambulance trusts and covers the 'interoperable capabilities' they must have in place.

4.1 Governance

An EPRR policy or statement of intent outlining the organisation's commitment to deliver EPRR must be in place. This statement should be supported by an annual EPRR work programme to ensure all NHS core standards for EPRR are delivered.

Organisations must have an appointed accountable emergency officer (AEO) who is a board-level director and responsible for EPRR in their organisation. Following a national review of non-executive director (NED) champions, the requirement for a non-executive board member to support the AEO has been removed, recognising

that the responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.

The AEO must provide reports to the public board on EPRR activity no less frequently than annually and must publicly state its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

Organisations that do not have a public board must instead publicly state their readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

4.2 Duty to risk assess

Organisations should have provision in place to regularly assess the risks to the population they serve. This process should consider the community and national risk registers.

A supporting risk management system must be in place to ensure a robust method of reporting, recording, monitoring, communicating and escalating EPRR risks internally and externally with partners.

4.3 Duty to maintain plans

Appropriate and up-to-date plans must set out how the organisation plans for, responds to and recovers from major incidents, critical incidents and business continuity incidents. These should be developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.

4.4 Command and control

A robust and dedicated EPRR on-call mechanism should be in place to receive notifications relating to EPRR. This facility should be 24 hours a day, seven days a week, and provide the ability to respond or escalate notifications to executive level.

Personnel performing the on-call function should be appropriately trained in major incident response.

4.5 Training and exercising

EPRR training should be carried out in line with a training needs analysis to ensure staff are competent in their role.

Arrangements must be exercised through, as a minimum, a:

- communications exercise every six months
- tabletop exercise once a year
- live exercise every three years
- command post exercise every three years.

4.6 Response

Staff trained in incident response should be available to respond to incidents from within an incident co-ordination centre (ICC). This includes having processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings. These arrangements should also include an alternative ICC, should the primary location be affected by the incident itself or be unavailable at the time of response.

4.7 Warning and informing

EPRR and communications planning activity should be co-ordinated to ensure communications align with organisational requirements during an incident. This includes ensuring access to trained communications support for senior leaders during an incident.

Communications plans should be tested alongside incident plans to support communication with partners and stakeholders, and warning and informing public and staff when responding to major incidents, critical incidents and business continuity incidents.

Organisations should also have appropriate media and social media strategies to enable communication with the public. This should include identification of, and access to, trained media spokespeople who can represent the organisation.

4.8 Co-operation

Arrangements should be in place to share appropriate information with stakeholders. This includes participation in local health resilience partnerships (LHRPs) and with local resilience forums (LRFs) and other multiagency planning forums to demonstrate engagement and co-operation with other responders.

4.9 Business continuity

Organisations must set out their intention and methods of undertaking business continuity in a policy and/or business continuity management system (BCMS).

The BCMS is part of the overall management system that establishes, implements, operates, monitors, reviews and improves business continuity.

The system allows organisations to identify prioritised/critical activities by undertaking a business impact analysis (BIA). In addition, it contributes to ensuring an organisation has business continuity plans in place to respond to business continuity incidents.

Each organisation should have in place a process to measure the effectiveness of the BCMS and take corrective action where necessary.

The BCMS should be in line with the International Standards for Organisations (ISO) 22301.

4.10 Chemical, biological, radiological, nuclear (CBRN) and hazardous materials (HAZMAT)

Acute, specialist, mental health and community healthcare providers are required to have planning arrangements in place for the management of CBRN incidents. NHS ambulance trusts also share this requirement and their specific responsibilities in relation to CBRN are set out in 'interoperable capabilities'.

4.11 Interoperable capabilities

NHS ambulance trusts in England are required to maintain a set of specialist capabilities. These capabilities are nationally specified under the NHS England EPRR Framework.

These capabilities are interoperable between services. They must be maintained according to strict national standards to ensure they can be combined safely to provide an effective national response to certain types of incidents.

The interoperable capabilities include:

- hazardous area response teams (HART)
- marauding terrorist firearms attack (MTFA)
- chemical biological radiological nuclear (CBRN)
- mass casualty vehicles (MCV)
- command and control
- joint emergency services interoperability principles (JESIP).

5. Climate adaptation planning

Under the adaptation reporting powers of the Climate Change Act, the Greener NHS programme has been invited by the Department for Environment, Food and Rural Affairs to produce the health and care adaptation reports on behalf of the sector.

The third health and care adaptation report includes the recommendation for adaptation planning to be considered for inclusion in the latest revision of the EPRR core standards to increase systematic scrutiny.

This has been reflected across several existing relevant domains and standards including:

- the consideration of reasonable worst-case scenario and extreme events for adverse weather as a core component of community risk registers
- adverse weather arrangements should be reflective of climate change risk assessments and cognisant of extreme events
- climate change adaption planning to be considered as a longer-term impact on an organisation as part of a business continuity policy statement.

As with all the core standards, it will be important for EPRR leads to engage with relevant local leads for the Greener NHS programme or climate adaptation planning, not only to seek local assurance of these relevant areas, but also to align longer-term planning arrangements.

6. Equality and health inequalities

In complying with the core standards for EPRR, organisations must ensure all EPRR arrangements and planning consider the needs of people with protected characteristics and vulnerable groups, particularly with regard to: access to information, services and premises; increased risk based on health factors; safeguarding implications; and the management of restoration of services.

Equality and health inequalities impact assessments (EHIAs) are tools that can be used to assess the impact of arrangements and plans on the communities and populations the organisation serves.

The use of EHIAs, and any subsequent recommendations made as a result of EHIAs, will assist organisations in developing EPRR plans and arrangements that improve the care and safety, health and wellbeing of all patients, staff, visitors and populations from protected characteristic groups. Their use contributes to the assurances that NHS organisations are meeting their legal duties around equalities and health inequalities under the Equality Act 2010 and the Health and Social Care Act 2012.

7. Reviews and updates

The NHS core standards for EPRR are subject to an annual review. This review includes minor amendments and updates according to recent learning and changes in legislation and/or guidance.

A full review of the core standards occurs every three years, involving consultation with a working group. This was last conducted in 2022. The working group for the 2022 review consisted of representatives from a variety of NHS organisations and independent providers of NHS services from across the country, including commissioners, acute, specialist, mental health, community, patient transport and NHS111 service providers.

Any amendments/recommendations to future NHS core standards for EPRR can be directed to: england.eprr@nhs.net

Appendix c)

EPRR Improvement Plan: Medway NHS Foundation Trust. AEO: Mandy Woodley
Version: 01.00

__Medway NHS Foundation Trust___ has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2022/2023. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to be completed**	**Lead name**	**Further comments**
5	Partially Compliant	Urgent recruitment to fill two thirds of the EPRR establishment as approved in the EPRR policy. Band 5 EPRR Officer and Band 7 Senior EPRR Officer, is required to fill posts vacant since March 2022	Both vacancies to be in post by 31st December 2022	Mandy Woodley / Sarah Garman	1 x Band 5 EPRR Officer is progressing through HR Recruitment process and 1 x Band 7 Senior EPRR officer post is out to advert currently.
24	Partially Compliant	Strategic oversight of Staff personal portfolios being maintained for continued EPRR training and exercising compliance. Establish a mechanism for staff to record their continued portfolio of EPRR training and be able to evidence this annually. Certificates to be provided after all Training and Exercising.	EPRR Training to be fully aligned to ESR by 30th April 2023	Mandy Woodley / Sarah Garman	Progress with internal work to align all EPRR Training to ESR – the Trust's online platform for all staff Training; access to courses and compliance maintenance.
46	Partially Compliant	Strategic Business Impact Analysis to be undertaken to fully identify the Trust's critical services and the impacts associated with the pre-identified Resilience risks, as per the NHS England Business Continuity Framework. Head of EPRR to form a strategic Task and Finish group with templates to facilitate discussion and outputs. This strategic BIA will inform the Trust	Strategic BIA and Corporate BC Plan completion by March 2023	Mandy Woodley / Sarah Garman	BIA Templates and Training have been developed in line with NHS England BC framework and the ISO 22301 guidance. Additional resource required in the EPRR establishment to lead the BC programme of work (Band 7 post).

		wide BC plan for all service level plans to feed from.			
47	Partially Compliant	100% of 97 service level Business Continuity Plans fully developed using new templates, aligned to the Trust Business Continuity Plan, NHS England Business Continuity Framework and ISO 22301. The newly recruited additional EPRR resource will be allocated to deliver the new Business Impact Analysis and BC Plan templates training, across the Trust, as well as formation and management of a Trust-wide BC Network.	All Trust BC Plans to be reviewed using new templates by August 2023	Mandy Woodley / Sarah Garman	Terms of Reference for the new Business Continuity network have been developed, under the new Trust BCMS Framework 2022 and reporting to the EPRR Group, as accountable. New BIA Template and BC Plan template developed and ready for roll out.
51	Partially Compliant	External / Internal Trust audits that are inclusive of Resilience planning, response to incidents or EPRR related risks, are to include the Head of EPRR, to ensure quality improvements to this work stream are being fed into from external audits and reviews, in future.	Provider peer review /External Audit to be undertaken by September 2023	Mandy Woodley / Sarah Garman	There was a KPMG audit of the EPRR and Business Continuity function – a report dated December 2021 gave several recommendations for improvements which were being progressed by the then new Band 7 staff member appointed in November 2021 however, progress with these actions stalled when the Band 7 became the only member of the EPRR team in place, from March 2022. No subsequent audits/reviews have taken place in 2022
58	Non-Compliant	Ensure the agreed Kent and Medway LHRP standard for compliance with CBRN training is fully met (80% ED staff) with members of clinical and non-clinical staff across the Divisions, included to provide support to that cohort of staff who will be required to front an initial decontamination response. Include a mix of day/night staff to ensure 24/7 rota's include an acceptable number of trained CBRN responders.	End of April 2023	Mandy Woodley / Sarah Garman	There are currently 35 ED staff and 7 non-ED staff fully competent in CBRN response. There are an additional 36 ED staff and 19 non-ED staff likely to be compliant with further training sessions taking place up until end of November 2022. ED and Site Team rotas will then be configured to reflect the CBRN requirement for 24/7 response capability for the Trust. EPRR team will make this training more accessible to wider cohorts of staff (clinical and non-clinical) across the Trust - need managers approval to attend this and for staff

					to be relinquished to support a CBRN incident, at short notice when needed.

Meeting of the Trust Public Board
Wednesday, 05 October 2022

Title of Report	**EPRR Business Continuity Policy and Framework 2022**	Agenda Item	**4.3**
Lead Director	Mandy Woodley, Chief Operating Officer		
Report Author	Sarah Garman, Head of Emergency Preparedness, Resilience and Response		
Executive Summary	This Policy document is a requirement for the Trust as a Category 1 responder organisation in England, under the Civil Contingencies Act 2004. Such requirements for the Trust are detailed within the NHS England EPRR Core Standards 2022 (NHS England » Emergency preparedness, resilience and response: core standards), referenced within the updated NHS England EPRR Framework 2022.(B0900_emergency-preparedness-resilience-and-response-framework.pdf (england.nhs.uk)) This Policy is a revision of the current version (EPRR and Business Continuity Policy 2020 v08.01) published to our public facing website and acts as a statement of commitment and intent from the Trust Board, on its delivery of Emergency Preparedness, Resilience and Response activities. This document is revised to align with reference to the updated NHS England EPRR Framework (2022), the new Health and Care Act 2022 *in place of the Health and Social Care Act 2012* and content alignment with the new Reporting and Accountability structures for EPRR and its establishment within the Trust. Documents attached: EPRR Policy and BCM Framework Click on paperclip icon to view attachement.		
Committees or Groups at which the paper has been submitted	Trust Public Board – 05th October 2022 Risk, Compliance Assurance Group – 29th September 2022 MFT EPRR Group – 29th September 2022		
Resource Implications	The delivery of this Policy requires additional recruitment to the current internal EPRR establishment. One vacant post is actively recruited to.		
Legal Implications/ Regulatory Requirements	The Civil Contingencies Act 2004, CCA 2004(Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022. All acts, place EPRR duties upon the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework (2022) which in turn outlines the requirement of annual compliance with the NHS England EPRR Core Standards Assurance.		

Quality Impact Assessment	N/A			
Recommendation/ Actions required	**The Board is asked to note and approve this Policy for publishing.**			
	Approval ☒	Assurance ☒	Discussion ☒	Noting ☒
Appendices	a) Medway NHS Foundation Trust Business Continuity Framework 2022			

Meeting of the Public Trust Board
Wednesday, 05 October 2022

Title of Report	**Trust Risk Register**	Agenda Item	
Lead Director	Evonne Hunt, Chief Nursing Officer		
Report Author	Evonne Hunt, Chief Nursing Officer & Dan Rennie-Hale, Director of Quality & Patient Safety		
Executive Summary	Medway NHS Foundation Trust (MFT) is committed to establishing and implementing a revised Risk Management Framework and Policy which minimises risk to its stakeholders' through a comprehensive system of internal controls. The Risk Management Framework encompasses strategic, financial, quality, reputational, compliance and health & safety risks. A new style Trust Risk Register (TRR) report has been introduced, this provides a direction of travel and comparison summary of all the extreme risks on a quarterly basis. Following a detailed review of the Trust Risk Register, there are now 17 (initially 43) extreme risks on the TRR. These are risks scored at 15 and above, escalated from other risk registers into the TRR. The detailed TRR review resulted in the following actions being taken: • Risk origins being identified. This identify which risk registers the risk has been escalated from • Risk title and description have been clearer to provide clarity on what the risk is • Risk type and group outlined • All risks aligned to the Trust's Patient First True North Domain and the CQC Domain • Key existing controls have been updated to reflect actual controls • Assurance on controls have been identified • All risk scores have been updated to ensure appropriately rated (initial, current and target risk score) • Risks updated to ensure where risks are identified as being Treated in terms of risk treatment, the gaps in control and or assurance are supported with mitigating actions, identification of action lead, action due date, action delivery progress and action RAG rating • Executive and Risk Leads have been updated Further detailed work is required to ensure the remaining 215 risks (less 17 TRR risks), across other risk registers in the Trust are updated In Q2 2022/23, all risks on the TRR are recorded as being treated. The gaps in controls, mitigating actions to address the risks can be found in appendix of this report.		

Committees or Groups at which the paper has been submitted	NIL
Resource Implications	NIL
Legal Implications/ Regulatory Requirements	Failure to implement an effective system of risk management will impact the Trust compliance to the Health and Social Care Act, as regulated by the Care Quality Commission.
Quality Impact Assessment	NA
Recommendation/ Actions required	The Committee is asked to receive the Trust Risk Register for discussion and approval of the new format reporting style and register.

Approval	Assurance	Discussion	Noting
☒	☒	☒	☒

Appendices	Trust Risk Register Report Trust Risk Register (Extreme Risks)

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

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Trust Risk Register Report

September 2022

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Executive Summary

Medway NHS Foundation Trust

Medway NHS Foundation Trust (MFT) is committed to establishing and implementing a revised Risk Management Framework and Policy which minimises risk to its stakeholders' through a comprehensive system of internal controls. The Risk Management Framework encompasses strategic, financial, quality, reputational, compliance and health & safety risks.

A new style Trust Risk Register (TRR) report has been introduced, this provides a direction of travel and comparison summary of all the extreme risks on a quarterly basis.

Following a detailed review of the Trust Risk Register, there are now 17 (initially 43) extreme risks on the TRR. These are risks scored at 15 and above, escalated from other risk registers into the TRR. The detailed TRR review resulted in the following actions being taken:

- Risk origins being identified. This identify which risk registers the risk has been escalated from
- Risk title and description have been clearer to provide clarity on what the risk is
- Risk type and group outlined
- All risks aligned to the Trust's Patient First True North Domain and the CQC Domain
- Key existing controls have been updated to reflect actual controls
- Assurance on controls have been identified
- All risk scores have been updated to ensure appropriately rated (initial, current and target risk score)
- Risks updated to ensure where risks are identified as being Treated in terms of risk treatment, the gaps in control and or assurance are supported with mitigating actions, identification of action lead, action due date, action delivery progress and action RAG rating
- Executive and Risk Leads have been updated

Further detailed work is required to ensure the remaining 215 risks (less 17 TRR risks), across other risk registers in the Trust are updated

In Q2 2022/23, all risks on the TRR are recorded as being treated. The gaps in controls, mitigating actions to address the risks can be found in appendix of this report.

Trust Risk Profile – 'Extreme' Risks Q2 2022/23 (Risks scored →15)
Quarter on Quarter Profile (Valid at 26/09/22)

NHS Medway NHS Foundation Trust

The table below shows the Trust's extreme risks for Q2 2022/23 with the changes in risk rating from quarter to quarter for the last year.

Key: 25 = Risk score = New risk → = Arrow indicates previous quarter change 4x5 = Risk rating shown as Likelihood x Consequence

Risk No	Principal Risk Title and Description	Q2 2022/23	Q3 2022/23	Q4/2022/23	Q1 2022/23
1	Financial loss to organisation: 2022/23 efficiency target. **Description**: The Trust is yet to identify the full value of efficiencies required as part of it's 2022/23 budget. A significant number of the schemes are currently identified with a RAG status of red.	16 → 4x4			
2	Care of inpatient in an unsuitable area. **Description**: ADL is being used as a bedded area for inpatient due to patient flow challenges which may result in patient harm and negative impact on discharges before noon breakthrough objective.	15 → 5x3			
3	CR Reader is outdated and results in the machine being faulty. **Description**: Due to their age, the CR readers used in General Imaging to process x-rays are unreliable and very prone to breaking down. The age of the equipment also means sourcing parts for the machines is becoming increasingly difficult. There is a risk that these concerns could lead to potential delays in care delivery, damage to Trust reputation and patient safety concerns through potential wrong information being given to patients or test result being wrong	15 → 3x5			
4	Delays in Induction of Labour. **Description**: The unit is currently unable to meet induction of labour demand due to capacity and staffing on a daily basis due to significant staff absence relating to C19.	15 ↑ 5x3			
5	Delays in responding to SARS requests due to staff shortages within the department. **Description**: Not responding to SARS request within statutory timeframe could lead to non-compliance of our data processing statutory obligations	15 → 5x3			
6	ENT Workforce: ageing workforce, inability to recruit an have a sustainable workforce. **Description**: Stability of the workforce for this specialty is fragile particularly at Consultant level which is below national standards . This is resulting in the increased of locums, bank and agency and Delays in patients not being seen in a timely manner	20 → 5x4			
7	Escalation Beds on Emerald Short Stay and Emerald Assessment Unit. **Description**: There is a potential risk to patient safety and patient experience due to: - Gaps in staffing as a result of the additional beds, - Lack of adequate privacy and dignity due to limited number of curtain rails, - Limited access to buzzers, - limited space for to manoeuvring patient equipment	15 → 5x3			
8	Gastroenterology backlog. **Description**: There is currently a huge backlog of patients waiting for a first outpatient appointment for the speciality. Currently patients are being offered their first appointment between 46 to 52 weeks, which is off the target of 18 weeks. A large number of patients (more than 20 pts per week) are breaching the 52 week target, due to increased demand and the numbers are expected to increase for 52 week breaches	20 → 5x4			
9	Immediate lack of capacity for Endoscopy due to contract issues. **Description**: Due to contractual issues with Practice Plus Group (PPG) requiring negotiations before the end of the current financial year to prevent inappropriate penalties, there will be a period where there will be substantially reduced capacity for endoscopy provision for MFT.	16 → 4x4			
10	Insufficient Midwifery Staffing. **Description**: Insufficient midwifery workforce to meet demand.	16 ↑ 4x4			
11	Lack of adequate critical care consultant to manage the critical care unit, **Description**: There is a risk that lack of adequate critical care consultant could lead to patients safety and experience concerns, including the closure of some critical care beds	20 ↑ 5x4			
12	Lack of Specialist Physiotherapist (Band 7) for Paediatrics and Neonates. **Description**: Due to the specialist nature of the post there is only one identified Specialist Physiotherapist (Band 7) for Paediatrics and Neonates. This means there is no adequate cover, this impacts on the ability to deliver physiotherapy to Paediatrics and Neonates	16 → 4x4			
13	Neurology back log of new referrals due to lack of consultant cover. **Description**: Consultant recruitment has been challenging due to national shortage of consultant neurologists. Leaving the Trust with only 1 consultant out of the 4 needed to see new referrals both inpatient and outpatient (all follow ups and [illegible] specialties are not covered such as MS and Parkinson's). This has led to a large backlog of new (1257) referrals not being seen within adequate timescales, with 586 of these being urgent.	16 → 4x4			

N.B. Full details of all risks are available on the Trust Risk Register.

Trust Risk Profile – 'Extreme' Risks Q2 2022/23 (Risks scored →15)
Quarter on Quarter Profile (Valid at 26/09/22)

NHS Medway NHS Foundation Trust

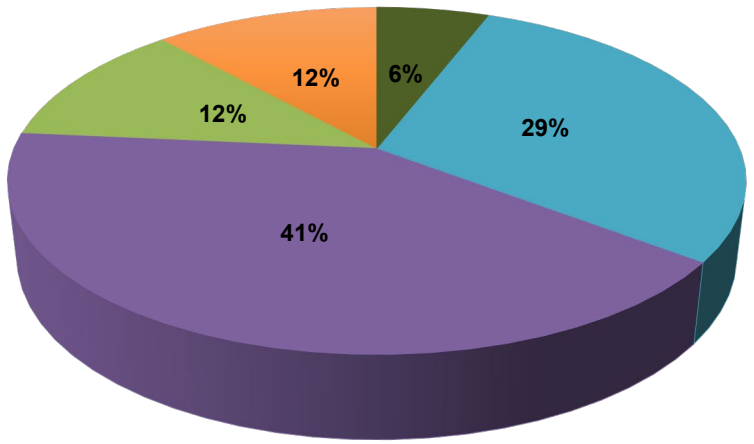
The table below shows the Trust's extreme risks for Q2 2022/23 with the changes in risk rating from quarter to quarter for the last year.

Key:

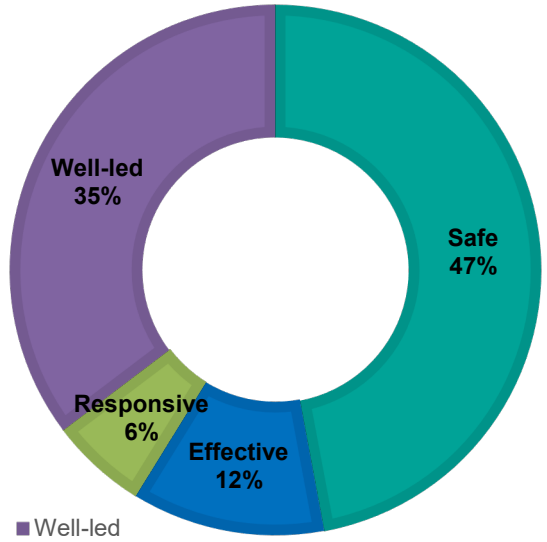
25 = Risk score **= New risk** **→ = Arrow indicates previous quarter change** **4x5 = Risk rating shown as Likelihood x Consequence**

Risk No	Principal Risk Title and Description	Q2 2022/23	Q3 2022/23	Q4/2022/23	Q1 2022/23
14	Trust wide Fire Safety Risks. **Description**: An Estates Fire Risk Assessment has identified a number of Trust Wide risks in relation to Fire Safety arrangements across the Trust. The risks identified are to patient and staff safety, breach of regulations, potential business interruption, reputational and financial risks. The individual risks identified are linked to this themed significant risk.	15 → 3x5			
15	Lack of robust and consistent approach for the managing patients with mental health needs. **Description**: The lack of a robust and consentient approach to the care and management of patients with mental health needs across the Trust could lead to - inadequate 1-2-1 supervision of this cohort of patients, - patients with mental health needs absconding or potential self-harm, - increased length of stay and harm in ED and across inpatient wards, - increased risk of violence and aggression towards self and others	15 N 5x3			
16	HSE Improvement notice issued to the Trust. **Description**: Following a planned inspection by the HSE in October 2021, the Trust has received an improvement notice in relation to the management of Violence and Aggression and Moving and Handling.	15 N 3x5			
17	Management of contractors and sub contractors. **Description**: Failure to manage contractors and their sub contractors leading to breaches in health and safety compliance on construction and engineering projects	15 N 5x3			

True North Domain



CQC DOMAIN



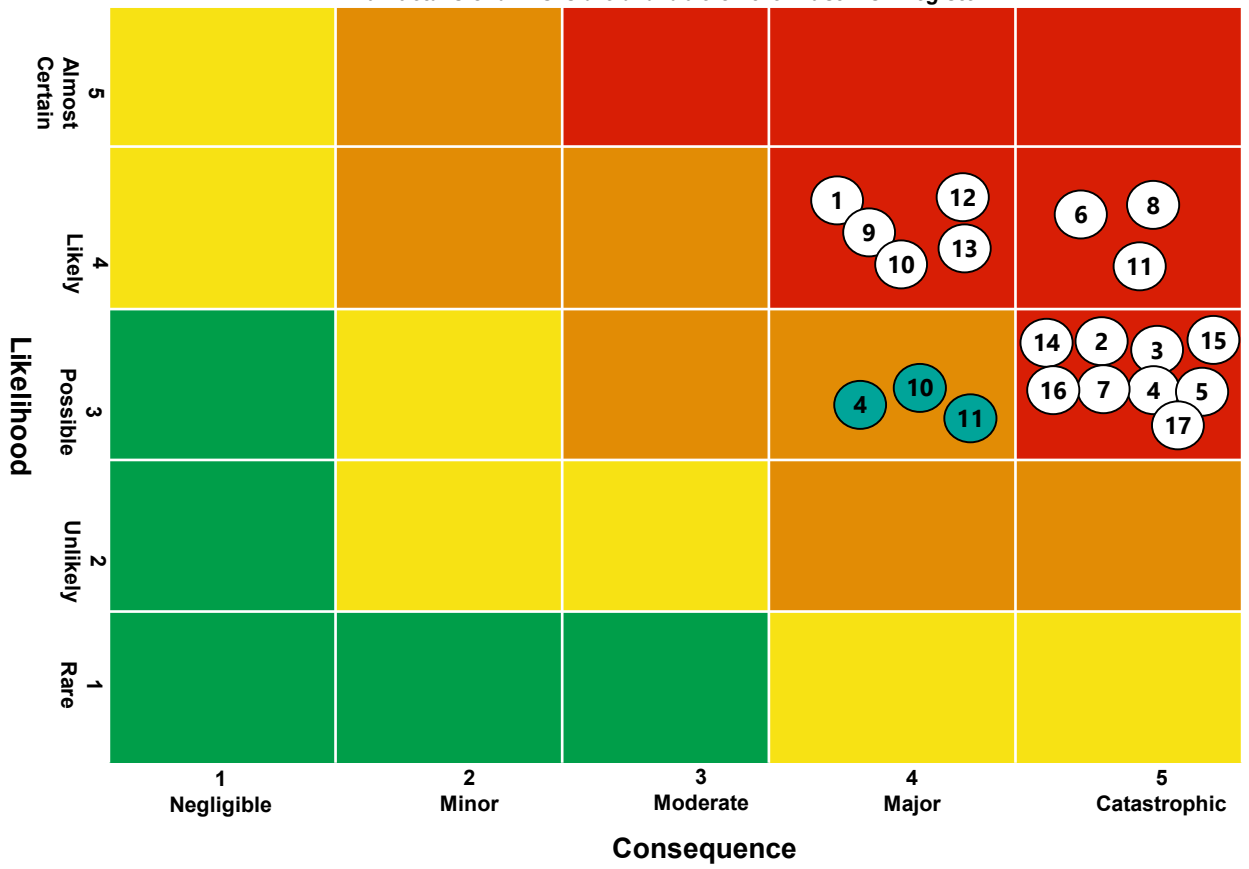
N.B. Full details of all risks are available on the Trust Risk Register.

Trust Risk Profile – 'Extreme' Risks Q2 2022/23 (Risks scored → 15)
Heat Map and Action Status Profile (Valid at 26/09/22)

Medway NHS Foundation Trust

This chart makes a comparison between the current risks score currently and previous quarters' score
The table to the right shows the Trust's extreme risks and the change since last quarter and action plan status

N.B. Full details of all risks are available on the Trust Risk Register.



The white dots represent the organisations' highest priority risks, scored as >15.
The black dots show their status in the previous quarter of the previous year.

= Current quarter risk score	Risk score in previous quarter	= Risk score in previous 2 quarter

On track	G/Green = All actions within timescale at point of last review	At risk	A/Amber = Some actions overdue at the point of last review	Overdue	R/Red = All actions identified overdue at the point of last review

Risk No	Principal Risk Title	Prev. Qtr Change	Action Status
1	Financial loss to organisation: 2022/23 efficiency target.	—	At risk
2	Care of inpatient in an unsuitable area.	—	On track
3	CR Reader is outdated and results in the machine being faulty.	—	On track
4	Delays in Induction of Labour.	▲	On track
5	Delays in responding to SARS requests due to staff shortages within the department.	—	On track
6	ENT Workforce: ageing workforce, inability to recruit an have a sustainable workforce.	—	On track
7	Escalation Beds on Emerald Short Stay and Emerald Assessment Unit.	—	On track
8	Gastroenterology backlog.	—	Overdue
9	Immediate lack of capacity for Endoscopy due to contract issues.	—	At risk
10	Insufficient Midwifery Staffing	▲	On track
11	Lack of adequate critical care consultant to manage the critical care unit,	▲	On track
12	Lack of Specialist Physiotherapist (Band 7) for Paediatrics and Neonates.	—	On track
13	Neurology back log of new referrals due to lack of consultant cover.	—	At risk
14	Trust wide Fire Safety Risks	—	On track
15	Lack of robust and consistent approach for the managing patients with mental health needs	N	On track
16	HSE Improvement notice issued to the Trust	N	On track
17	Management of contractors and sub contractors	N	On track

TRR Overview

The risk rating summary across the TRR:

Risk Group	Total	New	Adequacy of Controls				Current Risk Score			
			Ad	Pa	IN	Un	1-3	4-6	8-12	15-25
Clinical Performance and Medical Devices	2	0	1		1					2
Estates, Facilities and Non-Medical Equipment	1	0	1							1
Finance	1	0	1							1
Governance, Compliance and Regulation	3	2								3
Quality and Patient Safety	7	1	5	2						9
Workforce	3		1		2					3

The risk group area with the largest number of risks (7 of 17) is quality and patient safety, which includes risks owned by:

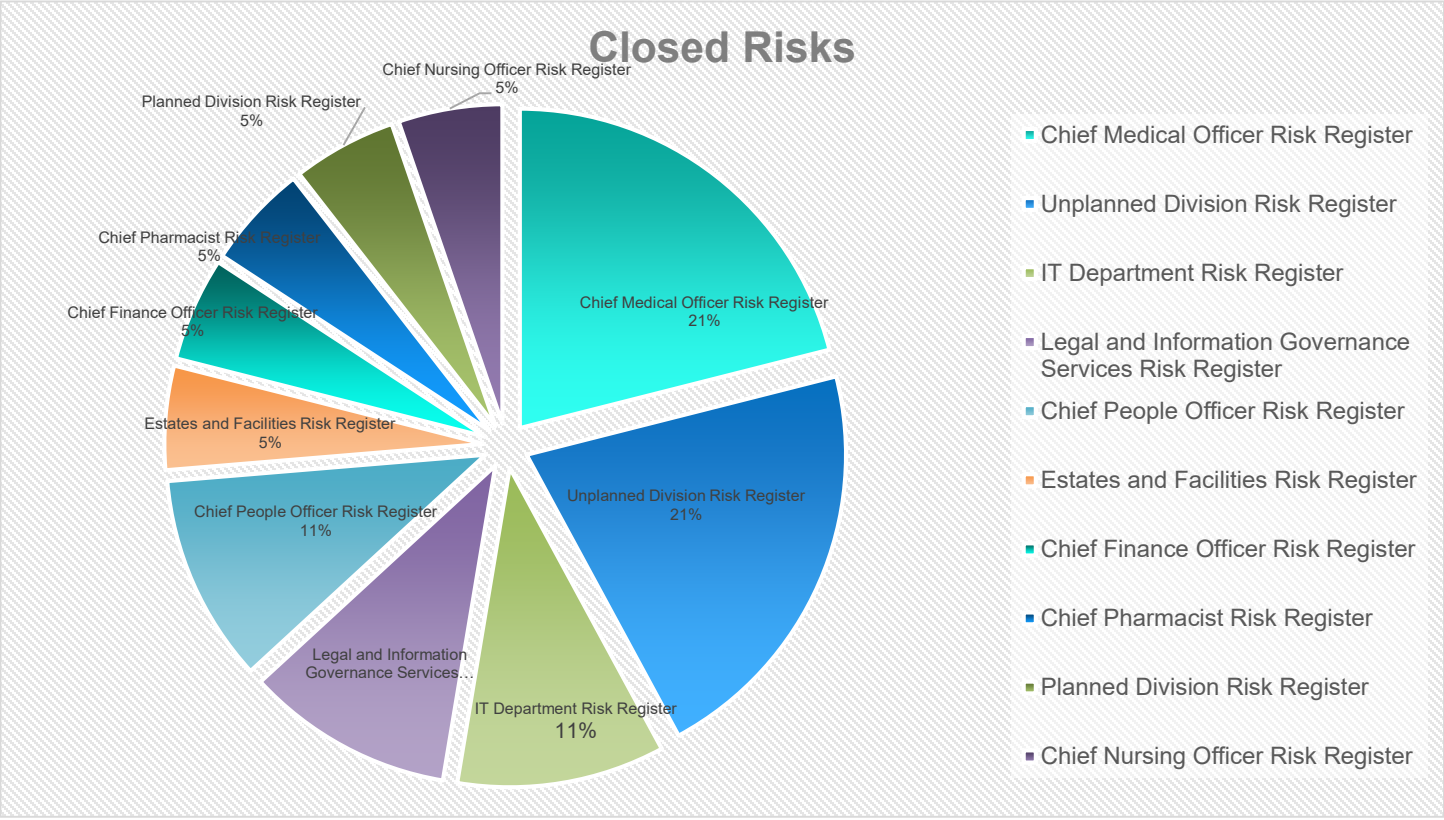
- Operational quality and safety relating to discharge, escalation beds, gastroenterology
- Workforce quality and safety relating ENT workforce
- Maternity quality and safety relating to delays in induction of labour
- Quality of care relating to neurology and mental health

Three new risks were escalated to the TRR. The risk title and description can be found in slide 4.

TRR Overview continues:

Following a detailed review of the TRR, a total of 26 risks were deescalated from the TRR back to the risk registers they originated from. These were:

Risk Origin	Total deescalated
Chief Medical Officer Risk Register	4
Unplanned Division Risk Register	4
IT Department Risk Register	2
Legal and Information Governance Services Risk Register	2
Chief People Officer Risk Register	2
Estates and Facilities Risk Register	1
Chief Finance Officer Risk Register	1
Chief Pharmacist Risk Register	1
Planned Division Risk Register	1
Chief Nursing Officer Risk Register	1



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Risk Management Framework

Implementation Plan

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Implementation Plan

Medway NHS Foundation Trust

Datix risk management module is being updated to reflect the updates to the risk registers and enable risk leads to be independent with the management of their risks. The below action descriptions will be developed into an action plan which will be monitored via the Risk & Compliance Assurance Group, Audit and Risk Committee and Update provided at Trust Board via the quarterly Risk Register Update Report.

Action Description
Risk Management Training
Review and update current expired Trust Risk framework and policy, including the implementation
Develop Risk Management awareness training to be delivered across the Trust, starting with senior managers. This will be reflected within the Trust's training needs analysis
Develop SOP 'How to Guidance' for risk managers, circulate and include in the risk awareness training
Establish what further support is required by corporate services, projects and divisional directors and senior managers to ensure robust identification, escalation and management of risks and risk registers in line with the new Trust Risk Policy.
Risk Management Governance and Data Quality
Revise the terms of reference of the Risk & Compliance Assurance Group terms of reference: requires approval at the Audit and Risk Committee
Identification of leads from divisional and corporate services with responsibility for management of risks
Ensure the TRR is reviewed by Executives every other week at the Weekly Executive Meeting and once a month at Trust Management Board
As part of the TRR detailed review, ensure all risks on all other risk registers have been reviewed and updated based on the outlined revised risk policy approach
Assess the Trust's risk and safety culture through the use of the Manchester Patient Safety Framework (MaPSaF). The findings of the MaPSaF will contribute towards the revision of the Trust's Quality Strategy
Development of an annual risk report which clearly illustrates progress made in 2022/23 in the management of risk within the Trust
Update and embed the understanding of the Board Assurance Framework ensuring its status as a key document in steering the focus of the Trust Board, Audit and Risk Committee, other Board Committee, groups and TRR with a clear audit trail of actions taken to recue Patient First True North Domain risk.
Datix Risk Module
Development of a new style risk register template which reflects the revised risk policy approach.
Ensure all gaps identified with the introduction of a new risk register template are updated
With the introduction of the national patient safety framework system (PSFS), review current Datix system to ensure its fir for purpose and can support PSFS

Trust Risk Register

Risk Identification																Risk Analysis								Risk Evaluation, Treatment, Monitoring and Control									
																Initial Risk			Current Risk Score										Target Risk				
No	Risk ID	Risk Added Date	Risk Origin	Risk Title	Risk Description	Risk Type	Risk Group	True North Domain	CQC Domain	Executive Owner	Risk Owner	Key Existing Controls (What are we currently doing about the risk?)	Assurance on Controls (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)	Adequacy of Controls	Assurance Strength	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Direction of Risk Score (since	Risk Treatment	Gaps in Control and or Assurance (What additional controls and assurances should we seek?)	Mitigating Action to Address Gaps (What more should we do to address gaps?)	Action Lead	Action Due Date	Action Plan Update	Action RAG	Likelihood	Consequence	Risk Score	Last Review Date	Next Review Date
1	1305	01/01/2021	Finance Risk Register	Financial loss to organisation: 2022/23 efficiency target	The Trust is yet to identify the full value of efficiencies required as part of it's 2022/23 budget. Delivery aganst identified schemes is behind plan so far in 22/23.	Trust wide	Finance	Sustainability	Well-led	Alan Davies	Paul Kimber	• Weekly divisional meetings with the PMO to identify, develop and implement efficiencies • Scrutiny and challenges at the Efficiencies Delivery Group • Appointment of a Financial Improvement Director • Added to the Executive Action Plan as a work stream	• Reporting to Efficiency Delivery Group and the Finance, Performance and Planning Committee • Reporting identified vs budget, togethe with delivered vs bugdet (in-month and YTD)	Inadequate	Low	**4**	**4**	**16**	**4**	**4**	**16**	—	**TREAT**	Executive action plan to be embedded	Follow the action plan and adhere to timescales	Paula Tinneswood	30/09/2022		**On track**	2	2	**4**	21/09/2022	30/09/2022
2	1345	08/03/2022	TOP Care Group Risk Register	Care of inpatient in an unsuitable area	ADL is being used as a bedded area for inpatient due to patient flow challenges which may result in patient harm and negative impact on discharges before noon breakthrough objective	Clinical	Quality & Patient Safety	Quality	Safe	Mandy Woodley	Beth Williams	• Daily staffing reviews to enable staff to support patients • Mobile screens in use • Matron oversight of the area • Set admission criteria: Low acuity, frailty patients • Only patients to be discharged in the next 24 hours are placed on the unit	• Care Group Huddle • Head of Nursing / DDON meetings • Divisional Governance meetings	Adequate	Medium	**5**	**3**	**15**	**5**	**3**	**15**	—	**TREAT**	Lack for structured LOS project which will minimise the use of ADL	• Delivery of LOS Project	Evonne Hunt Beth Williams	May-23	The LOS project meeting on a weekly basis	**On track**	1	3	**3**	21/09/2022	22/10/2022
3	1053 (Merged with Risk 1056: 22/09/22)	15/01/2020	Diagnostic and Clinical support service Risk Register	CR Reader is outdated and results in the machine being faulty	Due to their age, the CR readers used in General Imaging to process x-rays are unreliable and very prone to breaking down. The age of the equipment also means sourcing parts for the machines is becoming increasingly difficult. There is a risk that these concerns could lead to potential delays in care delivery, damage to Trust reputation and patient safety concerns through potential wrong information being given to patients or test result being wrong	Trust wide	Clinical Performance & Medical Devices	Systems and Partnership	Responsive	Mandy Woodley	Lorraine Becconsall	• Capacity going through the machine is regularly monitored and managed • Limited GP walk-in service • Inpatient x-ray room utilised to facilitate A&E patients and potentially some GP bookings • Sittingbourne and Sheppey hospitals can be utilised	• Imaging governance meeting • Diagnostic and Clinical support services governance meeting • Divisional governance Board	Adequate	Medium	**3**	**5**	**15**	**3**	**5**	**15**	—	**TREAT**	No CR reader has not been sourced	• Business plan to be developed	James Shaw	Oct-22	PID completed Decision to be made by the Care Group and Division in terms of the prioritisation	**On track**	1	5	**5**	22/09/2022	22/10/2022

Risk Identification																Risk Analysis								Risk Evaluation, Treatment, Monitoring and Control									
																Initial Risk			Current Risk Score										Target Risk				
No	Risk ID	Risk Added Date	Risk Origin	Risk Title	Risk Description	Risk Type	Risk Group	True North Domain	CQC Domain	Executive Owner	Risk Owner	Key Existing Controls (What are we currently doing about the risk?)	Assurance on Controls (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)	Adequacy of Controls	Assurance Strength	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Direction of Risk Score (since	Risk Treatment	Gaps in Control and or Assurance (What additional controls and assurances should we seek?)	Mitigating Action to Address Gaps (What more should we do to address gaps?)	Action Lead	Action Due Date	Action Plan Update	Action RAG	Likelihood	Consequence	Risk Score	Last Review Date	Next Review Date
4	1131	13/07/2021	Maternity Risk register	Delays in Induction of Labour	The unit is currently unable to meet induction of labour demand due to capacity and staffing on a daily basis due to significant staff absence relating to C19.	Clinical	Quality & Patient Safety	Quality	Safe	Evonne Hunt	Herron, Alison	• Attempts are made to distribute IOL activity across 7 day period to avoid pressures on capacity. • Consultant led daily review and prioritisation of IOL list. • Pre-induction clinic is attended by the majority of eligible women, which assesses maternal and fetal wellbeing and outlines expectations to women and their families. • Twice daily huddles between delivery suite coordinator and pearl ward to provide update on status for all outstanding inductions. • Movement of staff throughout the unit where possible	• QIA underway • Daily monitoring • Daily escalation monitoring • DATIX incidents - weekly case review Watch metrics	Adequate	High	**4**	**3**	**12**	**5**	**3**	**15**	▲	**TREAT**	Full establishment required Capacity demand and flow review	• Recruitment underway • Staff retention initiative to be rolled out	Alison Herron, Director of Midwifery	Dec-22	Good trajectory for recruitment, new staff to start by December 2022	**on track**	2	2	**4**	22/09/2022	22/10/2022
5	1324	01/03/2022	Legal and Information Governance Services Risk Register	Delays in responding to SARS requests due to staff shortages within the department	Not responding to SARS request within statutory timeframe could lead to non-compliance of our data processing statutory obligations	Non-Clinical	Governance, Compliance & Regulation	Quality	Well-led	Alison Davis	Molly Walsh-Keaney	• Temporary Bank staff utilised • SARS recovery plan • Data deep dive completed • Weekly monitoring of the data position • Director of Quality & Patient Safety: receives weekly update • Legal Services Manager • Weekly flash card • Departmental dashboard	• Information Governance Group meeting	Partial	Medium	**5**	**3**	**15**	**5**	**3**	**15**	—	**TREAT**	• No have adequate staff to cover SARS responsibilities	•Quality Team consultation underway	Dan Rennie-Hale, Director of Quality & Integrated Governance	30/10/2022	The consultation is underway	**On track**	3	3	**9**	21/09/2022	22/10/2022
6	1323	07/03/2022	Planned Division Risk Register	ENT Workforce: ageing workforce, inability to recruit an have a sustainable workforce	Stability of the workforce for this specialty is fragile particularly at Consultant level which is below national standards . This is resulting in the increased of locums, bank and agency and Delays in patients not being seen in a timely manner	Clinical	Quality & Patient Safety	People	Well-led	Leon Hinton	Howard Cottam	• Associated Specialist grades being developed to support consultant on-call	• Divisional Governance meetings • Care group governance meetings	Adequate	Medium	**5**	**4**	**20**	**5**	**4**	**20**	—	**TREAT**	Difficulty in recruiting into specialist areas	• Recruit in post	Howard Cottam	Oct-22	Recruitment has been completed and successful candidates waiting to start	**On track**	1	2	**2**	22/09/2022	22/10/2022
7	1343	08/03/2022	TOP Care Group Risk Register	Escalation Beds on Emerald Short Stay and Emerald Assessment Unit	There is a potential risk to patient safety and patient experience due to: - Gaps in staffing as a result of the additional beds - Lack of adequate privacy and dignity due to limited number of curtain rails - Limited access to buzzers - limited space for manoeuvring patient equipment	Clinical	Quality & Patient Safety	Quality	Safe	Mandy Woodley	Beth Williams	• Daily staffing reviews to enable staff to support patients • Mobile screens in use • Matron oversight of the area	• Care Group Huddle • Head of Nursing / DDON meetings • Divisional Governance meetings	Adequate	Medium	**5**	**3**	**15**	**5**	**3**	**15**	—	**TREAT**	Lack for structured LOS project which will minimise the use of ADL	• Delivery of LOS Project	Evonne Hunt Beth Williams	May-23	The LOS project meeting on a weekly basis	**On track**	1	3	**3**	21/09/2022	22/10/2022

Risk Identification																Risk Analysis								Risk Evaluation, Treatment, Monitoring and Control									
																Initial Risk			Current Risk Score										Target Risk				
No	Risk ID	Risk Added Date	Risk Origin	Risk Title	Risk Description	Risk Type	Risk Group	True North Domain	CQC Domain	Executive Owner	Risk Owner	Key Existing Controls (What are we currently doing about the risk?)	Assurance on Controls (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)	Adequacy of Controls	Assurance Strength	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Direction of Risk Score (since	Risk Treatment	Gaps in Control and or Assurance (What additional controls and assurances should we seek?)	Mitigating Action to Address Gaps (What more should we do to address gaps?)	Action Lead	Action Due Date	Action Plan Update	Action RAG	Likelihood	Consequence	Risk Score	Last Review Date	Next Review Date
8	1329	16/03/2022	Specialist Medicine Risk Register	Gastroenterology backlog	There is currently a huge backlog of patients waiting for a first outpatient appointment for the speciality. Currently patients are being offered their first appointment between 46 to 52 weeks, which is off the target of 18 weeks. A large number of patients (more than 20 pts per week) are breaching the 52 week target, due to increased demand	Clinical	Quality & Patient Safety	Quality	Safe	Mandy Woodley	Iram Ahmed	• Speciality are completing reviews of all new referrals to help prioritise urgent first. • Review of clinic utilisation is being completed weekly. • Currently working with procurement to identify providers to insource / outsource to help reduce the backlog. • The speciality is prioritising the 2 week cancer patients to avoid any 2 week waiting list breaches. • Additional adhoc clinics wherever capacity allows with current	• Consultants are job planned to clinical triage new referrals	Partial	Medium	**5**	**4**	**20**	**5**	**4**	**20**	—	**TREAT**	• There is no SOP for clinical referrals for all consultants to follow • Education of GPs to update algorithms to follow for referral, need to work with ICB • Funds not released need to be agreed at Exec level asap to enable tender process for outsourcing.	• PID to be submitted with options appraisals. • Implementation and training on SOP • Funding to be released asap	Dr Irfan Khan Divya Jinesh Alan Davies	Oct-22	PID approved at BCRG however funds not released	**On Track** **Overdue**	1	4	**4**	15/09/2022	15/10/2022
9	1337	20/04/2022	Specialist Medicine Risk Register	Immediate lack of capacity for Endoscopy due to contract issues	Due to contractual issues with Practice Plus Group (PPG) requiring negotiations before the end of the current financial year to prevent inappropriate penalties, there will be a period where there will be substantially reduced capacity for endoscopy provision for MFT.	Clinical	Clinical Performance & Medical Devices	Systems and Partnership	Effective	Mandy Woodley	Iram Ahmed	• Patient scheduling prioritisation on clinical need – urgent 2WW prioritised within MFT • General Manager • CCG and DDO in discussions with Practice Plus Group to negotiate contract	• Regular liaison with PPG to ensure recruitment process is on track for scheduler • Unplanned Divisional Governance Group meeting	Inadequate	Low	**4**	**4**	**16**	**4**	**4**	**16**	—	**TREAT**	Assurance that funding is approved for interim options of insourcing and outsourcing until the build is complete	• Executive approval	Alan Davis	Sep-22	• Contract with PPG has now been signed however awaiting for them to recruit a scheduler before the contract is activated. • PID submitted and approved at Trust Board and nationally for expansion of current unit by 2 rooms. Funding to be received nationally. PID presented at BCRG for approval to proceed to FBC and for approval of interim options for insourcing and outsourcing until the build is complete.	**At Risk**	1	4	**4**	15/09/2022	15/10/2022
10	1133	13/07/2021	Maternity Risk register	Insufficient Midwifery Staffing	Insufficient midwifery workforce to meet demand.	Clinical	Workforce	People	Well-led	Alison Herron	Kate Harris	• Enhanced Bank Rates: encourage staff • Weekly workforce meeting with senior sisters • Rolling recruitment to fill vacancies • Current 26 WTE vacancies recruited to – due to start between September and December and will need supernumerary support. • Mitigate risk by movement of staff across the unit based on acuity and capacity. • Senior Sisters, specialist midwives and matrons working clinically to support ward staff • Regular HOM Briefing to staff and Board Level Safety Champions walk around to support staff. • Support staff for	• Daily and weekly monitoring and escalation where required • Supporting staff for retention	Adequate	Medium	**3**	**4**	**12**	**4**	**4**	**16**	▲	**TREAT**	Staff retention and international recruitment options	• Recruitment underway • Staff retention initiative to be rolled out	Alison Herron, Director of Midwifery	Nov-22	Good trajectory for recruitment, new staff to start by December 2022	On track	2	4	**6**	22/09/2022	22/10/2022

Risk Identification																Risk Analysis								Risk Evaluation, Treatment, Monitoring and Control									
																Initial Risk			Current Risk Score										Target Risk				
No	Risk ID	Risk Added Date	Risk Origin	Risk Title	Risk Description	Risk Type	Risk Group	True North Domain	CQC Domain	Executive Owner	Risk Owner	Key Existing Controls (What are we currently doing about the risk?)	Assurance on Controls (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)	Adequacy of Controls	Assurance Strength	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Direction of Risk Score (since	Risk Treatment	Gaps in Control and or Assurance (What additional controls and assurances should we seek?)	Mitigating Action to Address Gaps (What more should we do to address gaps?)	Action Lead	Action Due Date	Action Plan Update	Action RAG	Likelihood	Consequence	Risk Score	Last Review Date	Next Review Date
11	1285	15/09/2021	Peri-operative and Critical Care Risk Register	Lack of adequate critical care consultant to manage the critical care unit	There is a risk that lack of adequate critical care consultant could lead to patients safety and experience concerns, including the closure of some critical care beds	Clinical	Workforce	People	Well-led	Alison Davis	Paul Hayden	• An approach of reduction of critical care beds based on staff availability • There are critical care consultants: albeit not enough • Chief Medical Officer	• Planned Divisional Governance Meeting • Chief Medical Officer Team meeting	Inadequate	Low	**5**	**3**	**15**	**5**	**4**	**20**	▲	**TREAT**	Staff morale is very low, needing an incentive for current workforce and advertisement agreement to enable competitive recruitment	• The team to create a contingency plan of restricting the number of critical care patients to 19: this will be manageable with the current critical care workforce short-term • Urgently recruit six consultants	Paul Hayden, Critical Care Clinical Director	Oct-22	Ongoing discussions between the Chief Medical Officer, Divisional Medical Director and Clinical Director. New job description approved by the Royal College of Anaesthetists and recruitment has commenced. Urgent recruitment of staff and need to offer a competitive package	**On track**	1	4	**1**	21/09/2022	22/10/2022
12	1346	08/03/2022	Therapies and Older Persons Risk Register	Lack of Specialist Physiotherapist (Band 7) for Paediatrics and Neonates	Due to the specialist nature of the post there is only one identified Specialist Physiotherapist (Band 7) for Paediatrics and Neonates. This means there is no adequate cover, this impacts on the ability to deliver physiotherapy to Paediatrics and Neonates	Clinical	Workforce	People	Well-led	Evonne Hunt	Beth Williams	• New in post band 6 physio for Paeds	• Divisional governance board • TOP Care Group Board	Inadequate	Low	**4**	**4**	**16**	**4**	**4**	**16**	—	**TREAT**	Not being able to recruit suitably trained individuals	• Recruitment process underway • Restructuring the role to increase the banding. This sits in line with the national recommendations	Laura Potter	Feb-23	recruitment underway	**On track**	2	4	**8**	21/09/2022	22/10/2022
13	1296 **(Merge with 1328 initially raised 12/11/21)**	16/03/2022	Specialist Medicine Risk Register	Neurology back log of new referrals due to lack of consultant cover	Consultant recruitment has been challenging due to national shortage of consultant neurologists. Leaving the Trust with only 1 consultant out of the 4 needed to see new referrals both inpatient and outpatient (all follow ups and the specific subspecialties are not covered such as MS and Parkinson's). This has led to a large backlog of new (1257) referrals not being seen within adequate timescales, with 586 of these being urgent.	Clinical	Quality & Patient Safety	Quality	Effective	Alison Davis	Iram Ahmed	• Harm reviews are being completed for all breaches • A review of clinic utilisation •Community Triage pathway • 3 Consultant neurologists in post due to additional recruitment of a locum consultant on 5 September 2022. • New consultant conducting 1st outpatient appointments only to address the backlog and 52 week breaches. • 4th consultant recruited starting 4 Jan 2023.	• Unplanned Divisional Governance Board	Partial	Low	**4**	**4**	**16**	**4**	**4**	**16**	—	**TREAT**	• Feasibility 18 weeks insourcing is yet to be completed • Alternative providers have not yet been sourced • Unable to secure capacity for new consultants to run the clinics - consultant unable to see require number of patients to reduce the backlog	• Team to review feasibility of 18 weeks insourcing to help reduce the current backlog of patients. • Team to work with procurement to identify alternative providers. • Liaising with HR with regards to progress of recruitment. Service manager monitoring clinic templates for outpatient activity. • In liaison with Head of Access • Looking to source 18 weeks insourcing support by December MTI Reg from respiratory who has an interest in neurology will support annual leave periods	Iram Ahmed, General Manager Mandy Woodley, Chief Operating Officer	**Dec-22**	• Discussions with CCG to be held regarding stopping incoming new referrals for a period of time. If this is not agreed then even with 18 weeks provision of capacity and continuing incoming referrals we will be in the same position in 6 months' time. • We are currently looking into the feasibility of 18 weeks insourcing to help reduce the current backlog of patients. However, they are not able to provide sufficient capacity over the next six months (due to lack of neurologists) and will only reduce the backlog by approx. 30%. • We are currently working with procurement to identify alternative providers. • Discussion with 5th locum consultant in progress for recruitment between Feb 2023 and May	**On track** **At risk**	1	4	**4**	21/09/2022	21/10/2022

Risk Identification																Risk Analysis								Risk Evaluation, Treatment, Monitoring and Control									
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14	1034	09/08/2017	Estates and Facilitates Risk Register	Trust wide Fire Safety Risks	An Estates Fire Risk Assessment has identified a number of Trust Wide risks in relation to Fire Safety arrangements across the Trust. The risks identified are to patient and staff safety, breach of regulations, potential business interruption, reputational and financial risks. The individual risks identified are linked to this themed significant risk.	Trust wide	Estates, facilities and Non-medical Equipment	Sustainability	Safe	Alan Davies	Richard Daniel	• A program for replacement of fire doors, site fire teams responsiveness (priority based) • Surveys and remedial works carried out in some areas • CCTV coverage to external areas • 2019-08-09 - Funding secured and investment is being made in fire related improvements across the estate. • Active fire safety monitoring by the fire safety team • Security and fire wardens maintains a level of vigilance against the causes of fire • Improved CCTV system • Fire alarm system is in operation. • Staff training in fire awareness	• Fire safety group • Capital project group • Estates and Facilities Senior Manager Group • Health, Safety and Security Group	Adequate	Medium	**3**	**5**	**15**	**3**	**5**	**15**	**—**	**TREAT**	• Access to clinical areas to undertake required works	• Liaising with clinical teams to assess risks	Richard Daniel	Dec-22	Work is underway	**On track**	2	5	**10**	22/09/2022	22/10/2022

Meeting of the Board of Directors in Public
Tuesday, 27 September 2022

Title of Report	Patient Experience Update	**Agenda Item**	4.5
Report Author	Evonne Hunt, Chief Nursing Officer and Nikki Lewis. Associate Director of Patient Experience		
Lead Director	Evonne Hunt, Chief Nursing Officer		
Executive Summary	The purpose of the report is to give an update summary for the work undertaken within patient experience. This report provides a quarterly update on patient experience. A report is routinely presented at the Patient Experience Group. The report focus on: • Patient First True North Domain Patient: FFT 95% of patients completing the friends and family test would recommend us as a place to receive care • Complaints, PALS and Compliment • Enhanced Care • Falls • Tissue Viability • Privacy and Dignity • Nutrition and Hydration • Mixed Sex Accommodation • End of Life Care • Voluntary services provision update • Chaplaincy • An update against the patient experience strategy delivery action plan The Associate Director of Patient Experience has very recently commenced in post. Once the induction period is complete, they are tasked to support the teams to build upon the work in progress and to drive the patient experience work plan going forward.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Patient Experience Group Date of approval:		
Executive Group Approval:	Date of Approval:		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state):		
Resource Implications	N/A		

Legal Implications/Regulatory Requirements	N/A			
Quality Impact Assessment	N/A]			
Recommendation/ Actions required	[PLEASE STATE WHAT IS REQUIRED OF THE BOARD – IE: REVIEW, APPROVE, NOTE.]			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☐
Appendices	N/A			

NHS
Medway
NHS Foundation Trust

Patient Experience Update Report

September 2022

Patient
FIRST

Executive Summary

This report provides a quarterly update on patient experience. A report is routinely presented at the Patient Experience Group. The report focus on:

- Patient First True North Domain Patient: FFT 95% of patients completing the friends and family test would recommend us as a place to receive care
- Complaints, PALS and Compliment
- Enhanced Care
- Falls
- Tissue Viability
- Privacy and Dignity
- Nutrition and Hydration
- Mixed Sex Accommodation
- End of Life Care
- Voluntary services provision update
- Chaplaincy
- An update against the patient experience strategy delivery action plan

The Associate Director of Patient Experience has very recently commenced in post. Once the induction period is complete, they are tasked to support the teams to build upon the work in progress and to drive the patient experience work plan going forward.

SIOR-

FFT: 95% of patients completing the friends and family test would recommend us as a place to receive

Successful Deliverables	Identified Challenges
• Patient first huddles are fully established and active • FFT questions drafted, approved and uploaded to Gthr for use on 4 top contributing areas • Maternity wards have implemented QR code survey capture which went live late August • System move for SMS text capture for FFT data	• Configuration of electronic devices for use in the trial areas • Consistent approach to FFT capture across services • Roll out of accurate QR codes from communications team • Full review of accurate themes and trends and triangulation piece
Opportunities	**Risks**
• Further review the survey questions as identified as an action from the huddle • ADPE to highlight the 'point of capture' for feedback opportunities in all areas • To develop a stand alone dashboard for oversight • Enhancement of Comms in SDEC areas	• Loss of data capture • Reduction in submission rates during the transition period • Reduced oversight in regards to themes and trends reported from patients

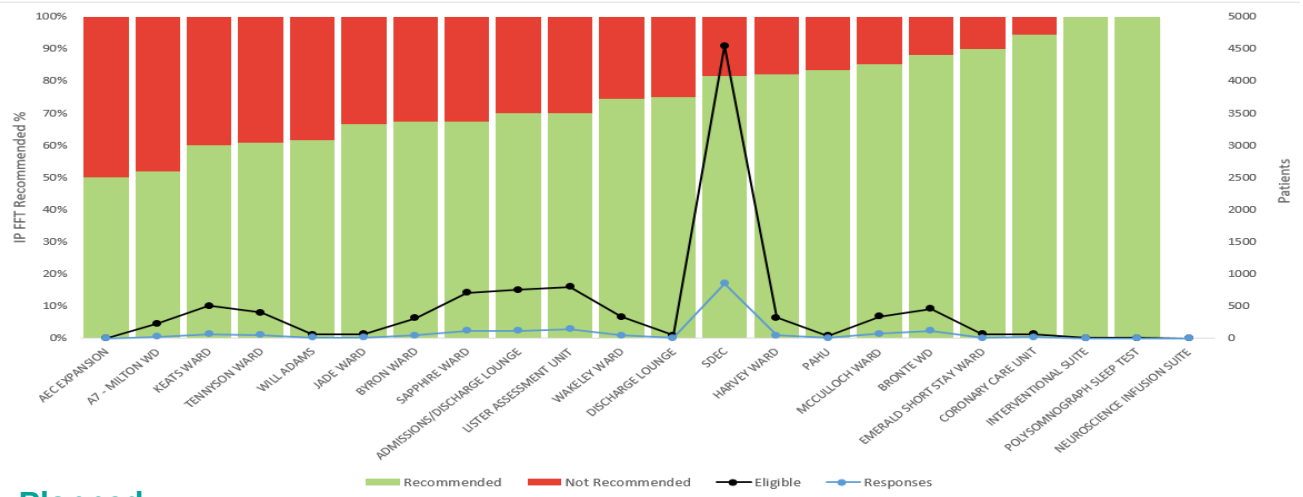
True North: Patients

Ambition: Providing outstanding, compassionate care for our patients and their families, every time

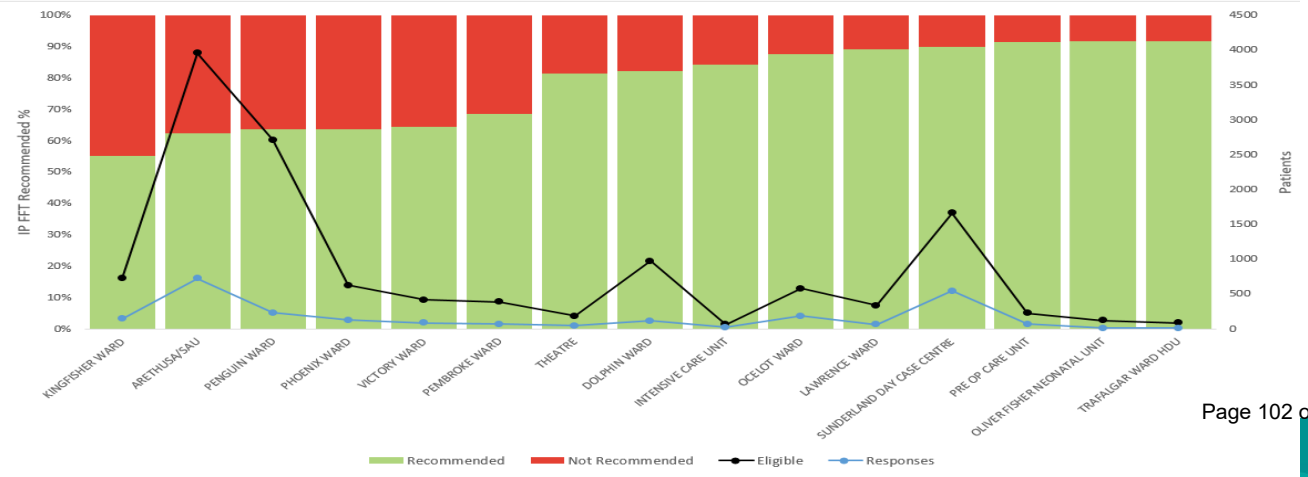
Goal: 95% of patient completing the FFT would recommend us as a place to receive care

NHS Medway NHS Foundation Trust

Unplanned



Planned



Key Messages:

- Patient first huddles commenced
- FFT surveys are live on Gthr

Issues, Concerns & Gaps:

- Deployment of electronic devices
- QR code use
- Consistent use of questions and submissions
- SMS switch over
- No standard approach to patient feedback

Actions & Improvements:

- Identify blockers in electronic device deployment
- Review QR codes in trial areas with comms
- Review SMS transition
- New Associate Director of Patient Experience taking the lead on the implementation of a consistent patient feedback approach

SIOR-

PALS & Complaints

NHS Medway

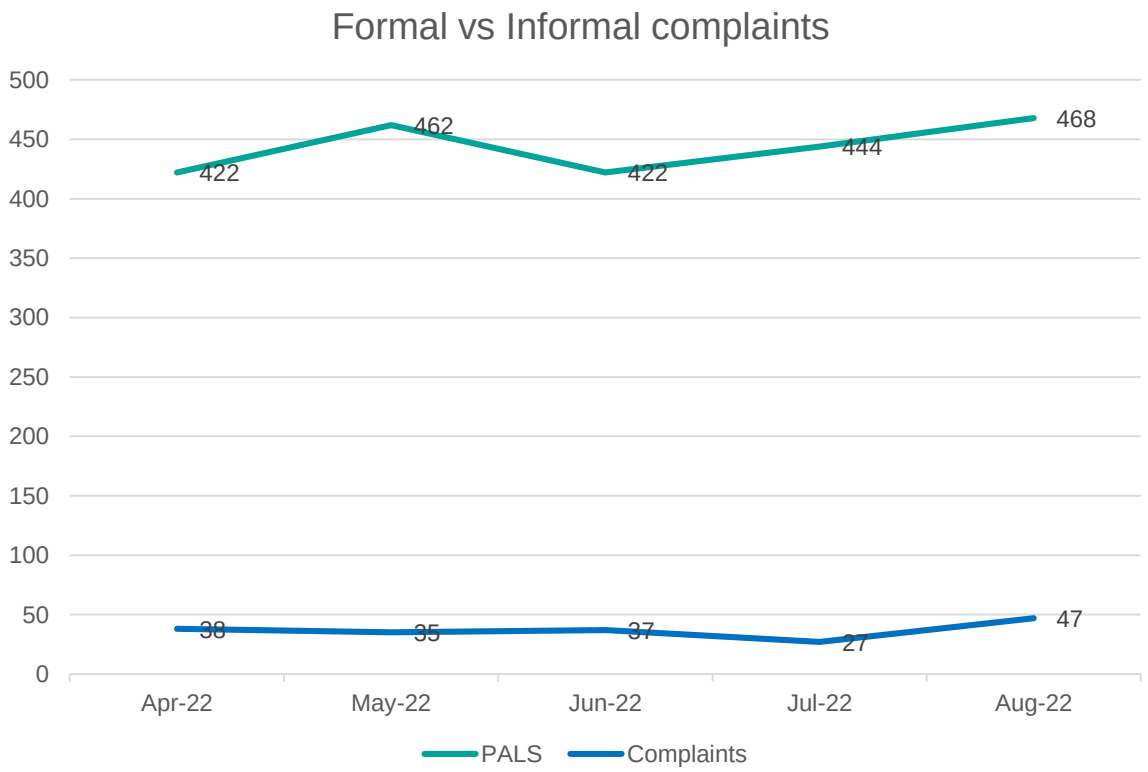
Successful Deliverables	Identified Challenges
• Reduction in overdue complaints backlog • Robust complaint handling policy endorsing a centralised process. • Introduction of a weekly complaints Flash report • Evidenced learning and improvement as a result of complaint investigations to support meaningful triangulation and thematic reporting. • Introduction of a Trust wide complaints training package concentrating on early resolution	• New staff still developing within team • Introducing a new process which is unfamiliar to the team who are inexperienced in complaint handling • Lack of Datix systems manager to facilitate the changes required
Opportunities	**Risks**
• Redesign of complaint handling module on Datix • Offering greater support, compassion and empathy for patients and families wanting to provide feedback and concerns about care.	• Datix System outdated and current configuration of complaints module is poorly presented which limits data entry and reporting opportunities. • Complaints policy in draft form and timescales for complaint responses currently not agreed. • Team restructure

True North: Quality

PALS & Complaints

Ambition: To offer early and swift resolution whenever possible.

Goal: To demonstrate a month on month increase in informal concerns to reduce the number of formal complaints



Key Messages:

- The complaints and PALS team are focussed on early resolution wherever possible to ensure complaints requiring investigation are registered and swift remedy is actioned wherever possible.
- There was an increase in both formal and informal complaints in August

Issues, Concerns & Gaps:

- Improved reporting functions on Datix have been identified
- Formal and informal reporting processes need to align to reduce the inaccuracies with data entry and offer a more robust approach to reportable data.

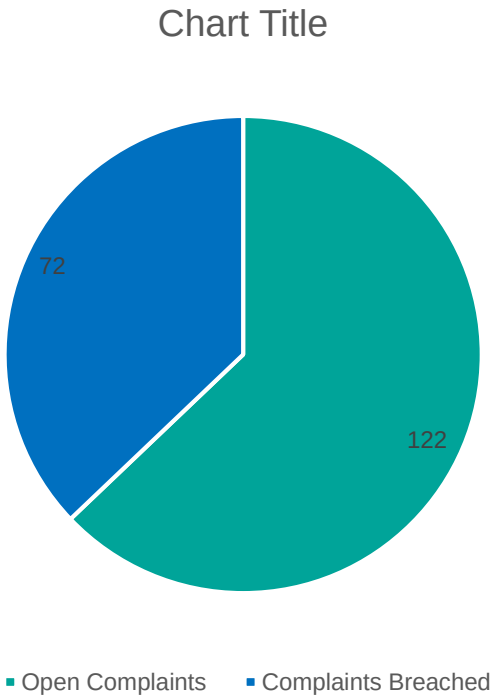
Actions & Improvements:

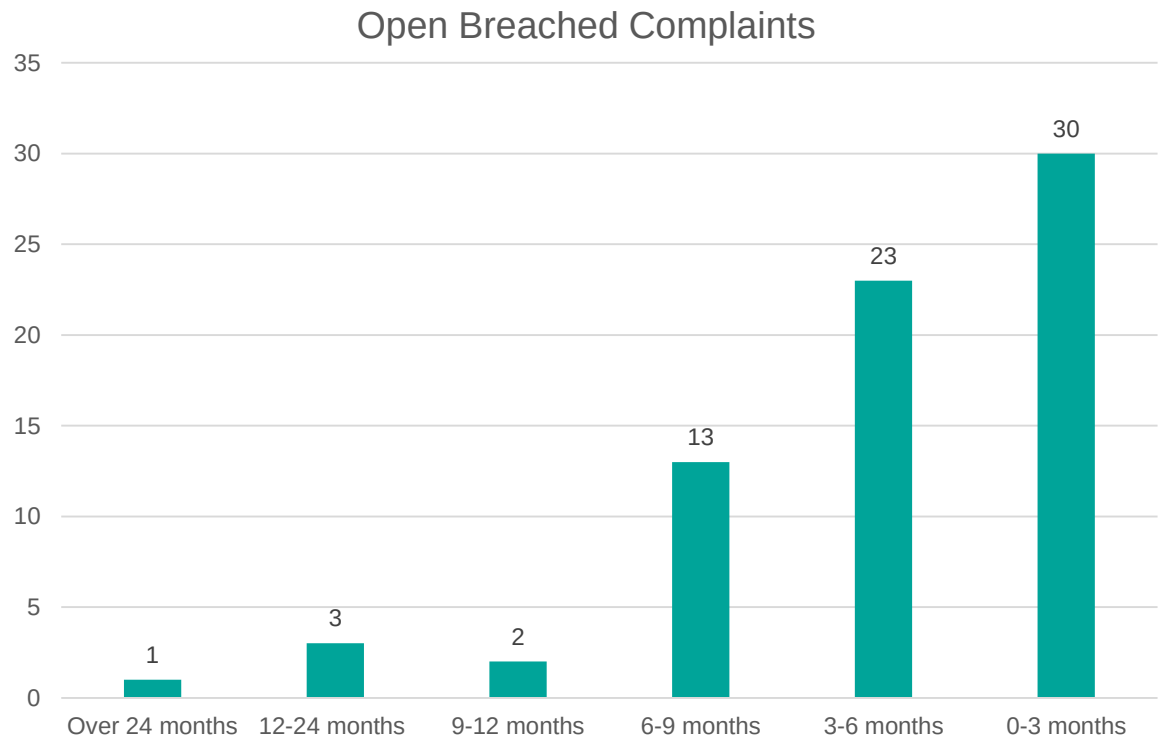
- Early resolution training has been arranged for the PALS and complaints team in September to enhance the strategies they currently use.
- This training and strategies will form part of the new training package which is being developed for Trust staff.

True North: Quality

PALS & Complaints

Ambition: To offer timely and complaint response letters
Goal: To demonstrate a reduction in open breached complaints month on month





True North: Patients

PALS & Complaints

Medway NHS Foundation Trust

Ambition: Supporting patients, families and carers to share their experiences of care.
Goal: Introduction of a robust complaint policy which reflects a centralised complaint handling model.

Complaints	Apr-22	May-22	Jun-22	Jul-22	Aug-22
New - Formal in month	38	35	37	27	45
New Re-open in month	0	1	3	1	0
Total open in month	38	36	40	28	45
Total closed in month	44	30	56	59	23
Total open at month end				111	122
Conversions from Formals to Informal's in month	0	1	0	33	25
Patient Advice & Liaison Service (PALS)	Apr-22	May-22	Jun-22	Jul-22	Aug 22
New in month	422	462	422	444	468
Closed in month	362	425	379	388	436
Compliments	30	51	35	52	37

Key Messages:

- The draft complaints policy, leaflet and SOP has been circulated for comment
- Work is underway to align PALS and Complaints data collection and reporting to ensure as much feedback is captured for triangulation as possible.
- More robust method of capturing and sharing compliments is needed.

Issues, Concerns & Gaps:

- Divisional teams working differently
- The large number of breached complaints
- Lack of learning and evidenced improvement
- Staff shortages in divisional teams
- Protracted sign off process delaying closing complaints

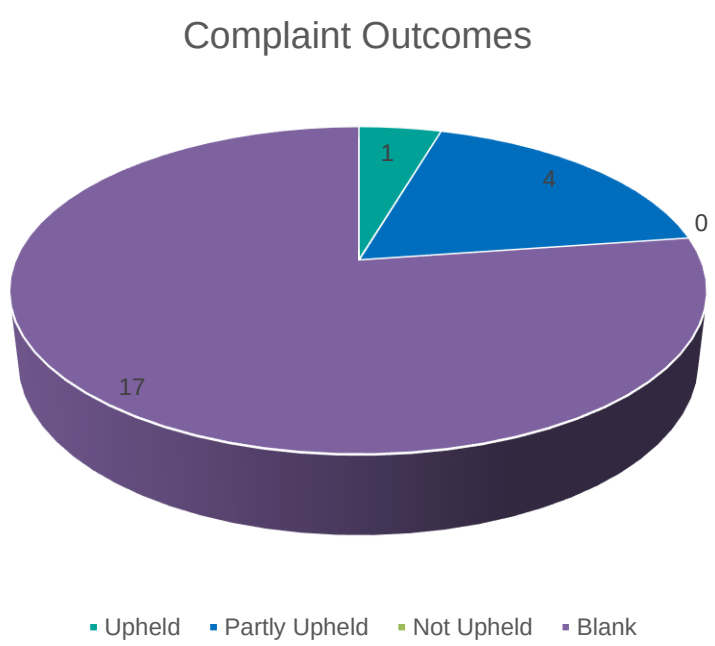
Actions & Improvements:

- More efficient sign off process detailed in the new policy
- Robust end to end process for complaint handling centrally.
- Improved data for triangulation and thematic analysis
- Training package being devised for Trust wide training using example cases.

True North: Systems and Partnerships

PALS & Complaints

Ambition: Delivering accurate and intelligent reports to identify and assist with triangulation and improvement.
Goal: Datix complaint handling module to be redesigned to enhance reporting ability. To accurately report upheld, not upheld and partially upheld complaints following investigation and reflect improvement and actions.



Key Messages:

- Most complaint outcomes are entered as being partially upheld or left blank.
- There is lack of evidenced learning and improvements following complaint investigation.
- The new complaint handling process will be focussed on evidencing learning and improvement.

Issues, Concerns & Gaps:

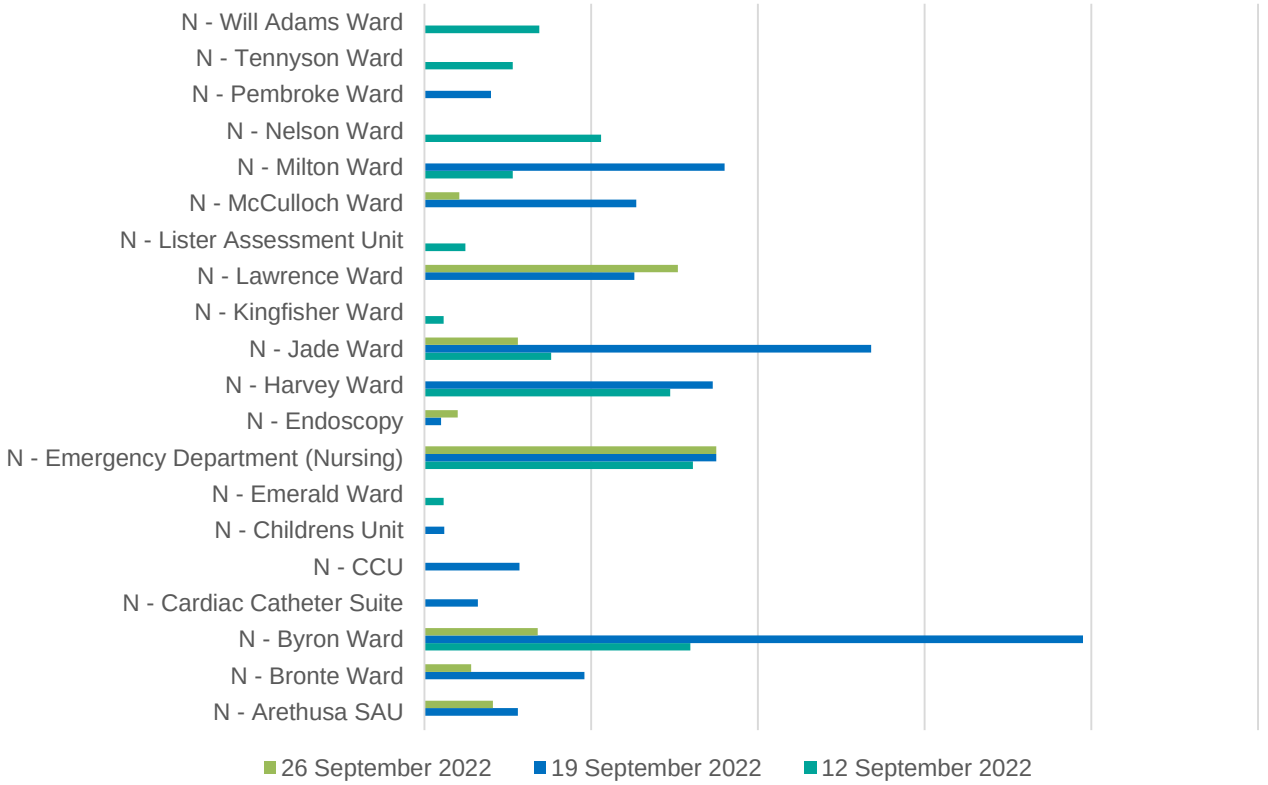
- Inconsistent data entry when closing complaints
- Lack of evidenced learning, preventing meaningful triangulation and thematic analysis.

Actions & Improvements:

- The new complaint handling process will be focussed on evidencing learning and improvement.
- Datix outcome box to be made a mandatory field so that outcomes are captured .
- All upheld complaints and partially upheld complaints where learning and improvement has occurred will be a key element within the quality teams
- triangulation work.

Enhanced Care

Enhanced Care requests in hours



Key Messages:

- Enhanced care policy approved
- Ongoing trial of the policy in the 5 highest requesting areas
- Reduction in enhanced care requests in comparison to the previous week for RN's
- Substantive reduction in requests for CSW's

Issues, Concerns & Gaps:

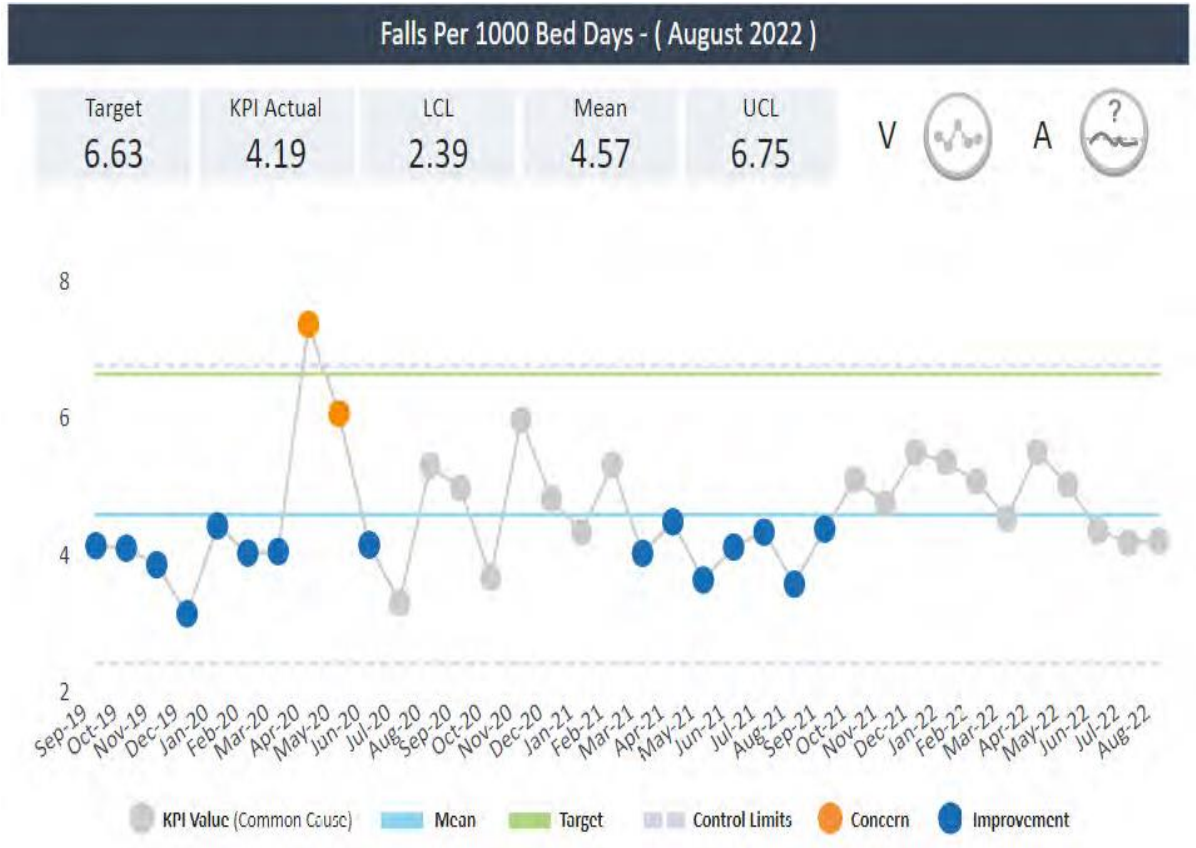
- High level requests remain evident for RN's in ED, Jade ward and over the weekends

Actions & Improvements:

- Continue to roll out and embed in the trial areas to see an impact in requests and for appropriate use of enhanced care cover
- Monitor and review appropriate use of policy in the target areas with assistance of Enhanced care lead and divisional Heads of Nursing

Falls

Ambition: Reduction in falls per 1000 bed days
Goal: 12% reduction in number of falls with harm



Key Messages:

- Well below the threshold for concern and within common cause variation
- Predominant causes for falls are call bell out of reach and hypotension
- 14 wards completed the A3 methodology to RCA causes
- Large percentage of patients have the top 3 elements of CRASH in place

Issues, Concerns & Gaps:

- Largest proportion of falls occur in unplanned care
- Failure to complete lying and standing blood pressures and accurately documenting these assessments

Actions & Improvements:

- Working with EPR to improve risk assessments on Sunrise
- Assessments will be live by the end of September

Tissue Viability

Ambition: Reduction in damage incidence in 1000 days
Goal: 10% reduction in hospital acquired pressure damage

Key Messages:

- Reduction in hospital acquired pressure ulcers (HAPU's) overall from 25 in April to 15 in July and a small rise to 19 in August
- Incidence of HAPU's 58% in unplanned care 42% in planned care
- Deep dives take place for any area who report 2 or more HAPU's. this month Milton, Will Adams and Victory declared 2 or more

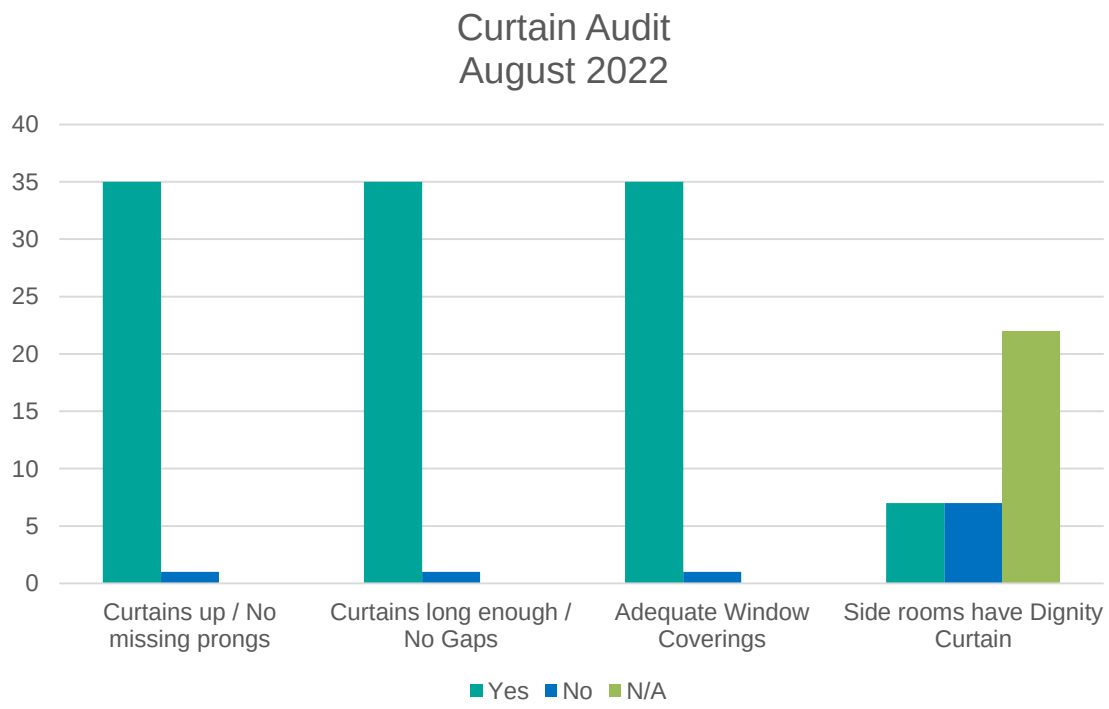
Issues, Concerns & Gaps:

- 76% of patients did not have the appropriate ASSKING bundle in place, however this is an improving picture from the previous audit in July

Actions & Improvements:

- To improve the reporting mechanism / SPC for the next update to break down incidence of HAPU's
- Team are working with wards to improve the ASSKING Bundle in place and documented appropriately

Privacy and Dignity



Key Messages:

- Clinical area curtain audit established and captured on Gather
- Visiting restrictions were relaxed in May with times agreed for all wards to be 14:00-16:00 and 18:00-20:00. this is working well
- Patient Charter to be co-produced to manage expectations

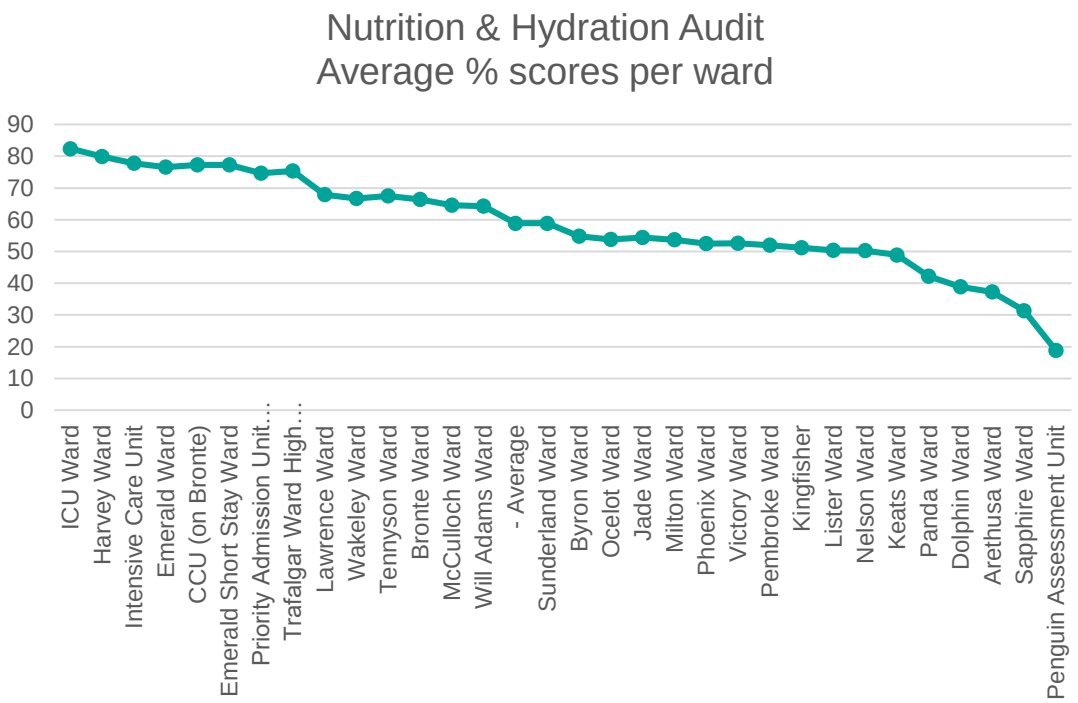
Issues, Concerns & Gaps:

- Visiting is restricted in 2 areas with outbreaks of Covid unless there are compassionate circumstances

Actions & Improvements:

- Key highlights for action and escalation to be shared utilising the A3 approach in relation to the curtain audit
- AD for IPC and Patient experience to reinforce the visiting decision tree and introduce visiting cards to support compassionate visiting
- SOP will continue to be reviewed on a 3 monthly basis or on outbreak notification

Nutrition and Hydration



Key Messages:

- Lead dietician is leading on the A3 work from a corporate perspective
- Associate Director who is new in post will be supporting this work going forward
- To work on central actions to reduce silo working in the Nutrition and Hydration group
- To pick up the feedback from the CQC in-patient survey in relation to nutrition and hydration

Issues, Concerns & Gaps:

- Similar themes and trends escalated across divisions
- Scoring from CQC in-patient survey was lower than expected
- Delays in NG feeding noted during A3 process

Actions & Improvements:

- Co-ordinated by the Associate Director of Patient Experience to lead on the inputs and outcomes of the cross divisional meeting
- To include all actions from the CQC in-Patient survey
- Staff competencies to be completed

Mixed Sex Accommodation

Key Messages:

- Validation process for data is not defined. •Draft MSA policy being written.
- Continued monitoring of patient safety to ensure that where possible patients are informed and bed moves are prioritised and facilitated to correct any breaches.
- MSA remains within common cause variation.
- Unjustified breaches recorded relate to the inability to step down patients within 4 hours from Critical care areas to level 1 ward based care.

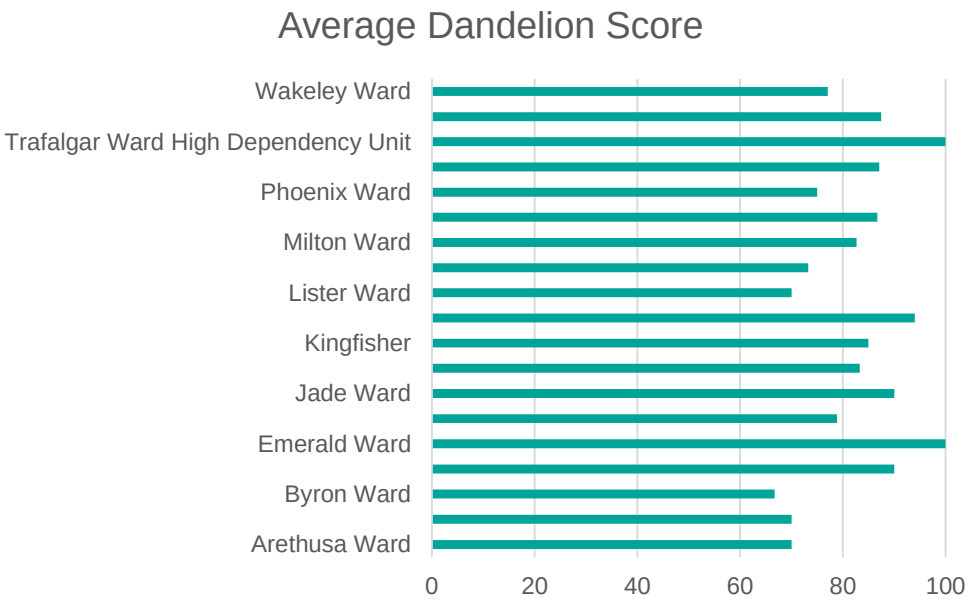
Issues, Concerns & Gaps:

- Bed availability and patient flow remains challenging throughout the trust.

Actions & Improvements:

- Process mapping exercise planned
- Working with BI to develop A3 thinking for MSA.
- IPC, site team and the divisions continue to work together to minimise any unjustified mix sex accommodation breaches other than those areas with COVID positive patients or assessment areas.

End of Life Care



Key Messages:

- Fine tuning processes for service integration between End of Life care and Palliative care
- Once integration complete, to co-ordinate a comms strategy for roll out

Issues, Concerns & Gaps:

- Lack of 7 day service for End of Life and Palliative care
- Lack of bereavement support service

Actions & Improvements:

- Service review finalisation
- To re direct monies to support a 7 day EoLC service

SIOR

Voluntary services provision update

NHS Medway NHS Foundation Trust

Successful Deliverables	Identified Challenges
• Successful application to HEE for the Volunteer to career programme for £25k to kick start the pathway • Identified areas for improvement to expand the service • Heightened opportunities for Volunteers; 189 actively working on site	• Expansion of support in all clinical areas • Recruitment process for new staff • Volunteer Passport • Volunteers to Career Programme roll out and funding
Opportunities	**Risks**
• To apply A3 methodology to improve the recruitment process in line with trust / HR policy • Lunch buddies • Out of hours working	• Full capture of staff recruited & Trained • Underutilising the volunteer workforce • Delay of Volunteer to career if unsuccessful in the tender process

SIOR-

Chaplaincy Update

NHS Medway NHS Foundation Trust

Successful Deliverables	Identified Challenges
In August we had chaplaincy encounters with a recorded 702 people. • In-patients: 495 • Staff: 50 • Event-attendees: 22 • Relatives: 111	• Recruitment through to start date for new recruits • Gaps in the on-call rota despite the utilisation of honorary Chaplains (Volunteers) • Implementing the Chaplaincy Guidance
Opportunities	**Risks**
• To plan a gap analysis to benchmark chaplaincy provision under the new guidance • Review of the service to build resilience	• Limited or no chaplaincy service during out of hours on call cover • Experience of pastoral care for patients, staff and family poorer

SIOR

Patient Experience Strategy Implementation Update

NHS Medway

Successful Deliverables

- Strong links with Health Watch team who attend the Patient experience group. AD for PE will be utilising these partners as a 'critical ally'
- PEG re-established and work ongoing to strengthen this
- Mixed Sex policy refreshed
- Pressure Ulcer and Falls improvement plan underway with evident improvements
- Patient Experience Academy work commenced
- EoLC and Palliative team have merged.
- Enhanced care policy written and being trialled in 5 areas
- Recognising excellence SOP drafted

Identified Challenges

- Roll out of End PJ paralysis in line with IPC and Covid measures
- Reduced capacity within the Chaplaincy team to enhance EoLC

Opportunities

- AD for PE will be implementing a SOP based on national framework and learning for 'stories to board'
- AD for PE to work with NHSE/I leads for new Patient experience Framework; to benchmark the organisation once complete
- AD for PE to commence reporting and escalation framework to update digital information with the Communications team
- Implementation of an AIS group to support items 1.9, 1.13, 2.1
- For the AD PE to work with Head of engagement to maximise opportunities for the patient voice to be the golden thread through all work plans

Risks

- Winter pressures and an increasing demand on front line staff

Meeting of the Board of Directors in Public
Wednesday, 05 October 2022

Title of Report	**Medical Appraisal and Revalidation Annual Report**	Agenda Item	X
Lead Director	Alison Davis, Chief Medical Officer and Responsible Officer		
Report Author	Jeremy Davis, Deputy Chief Medical Officer and Deputy Responsible Officer, Steve Houlihan, Head of Chief Medical Officer's Services, Rebecca Loates Revalidation Manager		
Executive Summary	In view of Covid-19 pandemic, appraisals and revalidation process for the doctors was put on hold completely by NHS England from Mid-March 2020. From June 2020, the appraisal and revalidation process was restarted as per choice of the individual organisations and MFT restarted the process in a phased manner taking into account the individual doctor's personal ability and circumstances to complete the appraisal. NHS England has stopped the requirement of sending the Annual Organisational Audit (AoA) report for this reporting year. As a result, no AoA has been submitted to NHSE for 2021-22 reporting year. We are still required to submit a statement of compliance to NHSE which is attached as Appendix 1– section 7. Medway NHS Foundation Trust has **454** doctors connected as on 31st March 2022. • **398(87.6%)** doctors completed an appraisal for the reporting year. • **54** doctors had an approved missed or incomplete appraisal out of which – 1. **39** doctors were working for less than 6 months and were new to UK and were not required to complete an appraisal before March 2022. 2. **2** doctors were on maternity leave. 3. **5** appraisals were closed due to sickness of the individual doctors. 4. **1** doctor held temporary covid-19 registration and retired very soon after this period ended. 5. **2** doctors had a career break during the appraisal window 6. **3** appraisals were late due to lack of time of the appraiser. 7. **2** doctors were late due to lack of time of the doctor • **2** doctors had unapproved or missed appraisals. Both Doctors met with Jeremy Davis, Deputy Chief Medical Officer and Deputy Responsible Officer, clear guidelines were given with dates in which the appraisal will need to be completed. Both Doctors followed the deadline dates given and submitted the appraisal late.		

	For the year ending 31 March 2022, A total of 116 revalidation recommendations were sent to the GMC during the reporting year. 24 deferral recommendations were sent with 5 doctors having a positive recommendation sent during the report period. • Following the retirements of David Sulch (Responsible Officer) and Kirtida Mukjerjee (Deputy Responsible Officer), Jeremy Davis took up the position of Responsible Officer in an interim role from December 1st 2021. • For clarity and information, although outside the period covered in this report, Alison Davis, CMO, took up the permanent position of Responsible Officer from 15th August 2022.
Committees or Groups at which the paper has been submitted	Presented to and approved by Trust Board on 05.10.2022 and by People Committee on 29.09.2022
Resource Implications	No new additional resources required
Legal Implications/ Regulatory Requirements	The purposes of this report are: • To provide assurance to the Board as part of the Responsible Officer's Regulations. • To seek approval of the statement of compliance confirming Medway NHS Foundation Trust is in compliance with the regulations.
Quality Impact Assessment	None
Recommendation/ Actions required	The Committee is asked to: state decision required i.e. review, approve, note. [For example: The Committee is asked to approve the Safeguarding Policy].

Approval	Assurance	Discussion	Noting
☒	☒	☐	☐

Appendices	State whether there are any appendices and list them. For example: Appendix 1: Board Assurance Framework Appendix 2: Corporate Risk Register

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 with timeline (where applicable), should be included in the report.

1 Executive Overview

This is the Trust Responsible Officer's (RO) annual report for 2021-22 reporting year. This report is a required item of assurance, and we are also required to submit a compliance statement, signed off by or on behalf of the Board.
We are able to positively respond to all assurance statements, as we are compliant with all regulatory requirements.

2 Background

The GMC's aims for medical revalidation are that it:

- is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession.
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body that monitors and assures their practice. MFT is a Designated Body for 454 doctors and this report is about them. This report does not cover the doctors in training grade as their designated body is Health Education England.

3 List of Attached Documents

Appendix 1 – Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2021-22.

This Framework is used across all designated bodies to enable a consistent approach for Boards to Quality Assure their appraisal and revalidation systems. Each section in the appendix relates to specific items set out in the Responsible Officer regulations 2010.

4 Conclusion and Next Steps

The overall appraisal rate at MFT remains high. A total of 405 Doctors were due an appraisal during the reporting period, 398 doctors completed on time, 5 doctors completed late and 2 doctors missed an appraisal during the reporting period. The Appraisals and Revalidation process was on hold from March 2020, and restarted in

a phased manner in June 2020. Some pandemic related restrictions continued into this reporting period.

We restarted recommendations for revalidation from July 2020. A total of 116 revalidation recommendations were sent to the GMC during the reporting year. 24 deferral recommendations were sent with 5 of these doctors subsequently having a positive recommendation sent during the report period.

The number of deferral recommendations are higher than previous years due to Covid restrictions on how Multisource feedback could be obtained, with the introduction of an electronic feedback system for patients. The response rate experienced by many doctors was very low and we have now been able to revert to a paper based system, resolving this issue. This has been resolved going forward.

General review of last year's actions

- **Completed Actions**:
  - To develop "help guides" on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document.
- **Actions partially completed:**
- **Incomplete Issues**
  - Audit of appraisal output summary and give one to one formative feedback to at least 20% appraisers on their appraiser performance.
- **Current Issues**:
  - To receive reports consistently from a centralised data base to check any SI/Complaints received for any individual doctor.
  - To work with our appraisal software supplier to adjust some fields and pages in the electronic appraisal document to reduce appraisals with errors which subsequently require further meetings or actions for the appraisee and appraiser.
- **New Actions**:
  - To provide training for new appraisers.

Overall conclusion:

- We have continued to strengthen our appraisal and revalidation process.
- There is overall good engagement from our doctors.

Appendix 1

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 7) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team of Medway NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has not been submitted as NHS England has cancelled the requirement for a 2020-2021 AOA report. A new format is due to be introduced in 2023.

Date of AOA submission: No submission

Action from last year: To submit the AOA as per NHS England directive.

Comments: **Not completed**

AoA for 2021-22 was not required to be submitted to NHS England due to Covid Pandemic.

Medway NHS Foundation Trust has **454** doctors connected as on 31st March 2022.

- **398(87.6%)** doctors completed an appraisal for the reporting year.
- **54 doctors** had an approved missed or incomplete appraisal out of which –

1. **39 doctors** were working for less than 6 months and were new to UK and were not required to complete an appraisal before March 2022.
2. **2 doctors** were on maternity leave.
3. **5 appraisals** were closed due to sickness of the individual doctors.
4. **1 doctor** held temporary covid-19 registration and retired very soon after this period ended.
5. **2 doctors** had a career break during the appraisal window
6. **3 appraisals** were late due to lack of time of the appraiser.
7. **2 doctors** were late due to lack of time of the doctor

- **2 doctors** had unapproved or missed appraisals. Both Doctors met with Jeremy Davis, Deputy Chief Medical Officer and Deputy Responsible Officer, clear guidelines were given with dates in which the appraisal will need to be completed. Both Doctors followed the deadline dates given and submitted the appraisal late.

Action for next year: None required as NHS England has stopped AoA submission for the year 2021-22.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: To appoint a new Responsible Officer from 1st December 2021 following David Sulch retiring. From December 2021 Jeremy Davis carried out the role of Responsible Officer for the rest of the reporting year (March 31st 2022). It has been approved that Alison Davis will take up the position of Responsible Officer with effect from 15 August 2022.

Comments: **Action Completed**

Jeremy Davis meets all the statutory requirements set out in the Medical Profession (Responsible Officer) Regulations 2010, namely he is a medical practitioner and has been continuously registered as medical practitioner for the previous 5 years.

Action for next year: Alison Davis will become Responsible Officer on 15 August 2022 in line with her appointment as Chief Medical Officer. Alison Davis meets all the statutory requirements set out in the Medical Profession (Responsible Officer) Regulations 2010, namely she is a medical practitioner and has been continuously registered as medical practitioner for the previous 5 years.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: New appraiser training was completed as planned alongside an appraiser refresher programme.

Comments: **Action Completed**

Designated body (MFT) provides sufficient funds and resources to carry out RO responsibilities. The Responsible Officer is supported by Deputy Responsible (Deputy Chief Medical Officer), a senior medical appraiser and an administrative team. The Trust has an electronic appraisal system in place (L2P).

New appraiser training did not take place during the year as there were sufficient trained appraisers, however a session is planned for September 2022.

An appraiser refresher course took place during the year providing a refresher course for 100 appraisers.

Action for next year: Funding will be available to complete a new appraiser training session in September 2022 to replace those who have retired or who wish to step down as an appraiser. We have 20 delegates booked for September 2022

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: The process is working well and effective relationship with medical staffing team are supporting the process.

Comments: **Action Completed**

The Human Resources Department/Medical Staffing provides the Chief Medical Officer's office with a weekly list of all new non-training grade doctors, together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC connection list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible.

When the monthly staff in post list is received, this is cross-checked with the Appraisal system to ensure that no Doctors have been missed.

Action for next year: None Identified

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None required

Comments: **Action Completed**

The Appraisal and Revalidation of Medical Staff policy is in date. However there have been changes to the revalidation and feedback cycle which means a review of policy will need to be carried out during 2022-2023 to ensure it is fit for purpose. The review will also need to build in mechanisms to improve the management of non-engagement,

Action for next year: Policy review as described in comments

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary by using an appraisal output quality tool.

Comments: **Not Completed**

MIAD reviewed the appraisal process in 2020 – a key recommendation was to carry out internal review of appraisers to give formative feedback. Due to ongoing challenges linked to the pandemic the loss of both David Sulch and Kirti Mukherjee this process could not be introduced during the reporting period.

Action for next year:

A review of this action by the Responsible Officer will take place during 2022-2023 to determine best practice moving forward.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Ongoing monitoring and review is taking place with no new issues identified..

Comments: **Action Completed**

The appraisal platform L2P has the relevant information to help completion of appraisal under the resources section.

Non-training grade Trust doctors and doctors working on MFT employment bank undertake an Annual appraisal. All doctors with a prescribed connection to MFT as Designated body are connected on GMC Connect and added to MFT appraisal system L2P.

New doctors are invited to the appraisal training and are sent all the necessary information for them to carry out an appraisal. Regular appraisee training sessions have been provided by Deputy Responsible Officer and 1:1 sessions if needed, to all doctors new to UK and any doctor who is new to the appraisal system. Revalidation team also offer all the support needed for completion of appraisals, including facilitating collection of patient and colleague feedback. The Revalidation administrator receives a monthly report of starters and leavers lists of doctors including any doctors who leave training and take up a non-training role.

For Agency doctors who are connected to their Agency RO - only agencies, where the trust has assurance of appraisal and revalidation processes, are used to source agency locum doctors.

All Doctors are encouraged to attend their own directorate governance meetings with attendance to be recorded within their CPD diaries. All short term placement doctors receive a Study Leave entitlement. All doctors are also encouraged to attend grand rounds, local tutorials/teaching sessions as appropriate.

MFT currently offer in house sessions “Welcome to UK practice” delivered by GMC’s *Regional Liaison Adviser (South East)* for those doctors who are new to UK practice and who did not attend this session during the GMC registration programme.

Action for next year: Reviews of appraisal have identified some new connected doctors do not always have robust appraisal history from previous organisations and sometimes key elements are not completed to the standards set at MFT. Further support is provided to these doctors through 1-1 coaching and mentoring and this will continue in 2022 -2023.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: The process for SI reports coming to the revalidation office is still a concern. Further action is being implemented to identify improved ways of receiving this information in a timely manner.

Comments: **Action Partially completed**

The Trust appraisal system, MyL2P enabled all of the relevant information to be stored and discussed during the appraisal process and includes access to HES data reports taken from Dr Foster to all Doctors, where available, for inclusion in their appraisal supporting documentation. At times, we have not received the list of all SIs and complaints in a timely fashion so that we can check the compliance as to their inclusion in the individual appraisal.

All Doctors are required to complete an appraisal every year containing supporting evidence on their full scope of work. If a doctor works outside MFT in any capacity as a medical doctor, the doctor is required to complete an Annual Declaration form duly signed and confirmed by RO/hospital Director from the Private Hospital or other organisations where they practice.

Action for next year: Review of existing process and agreement with appropriate governance teams for improving the process has been identified as a key improvement needed for 2022 -2023.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Full appraisal and management of non-engagement has been reintroduced following suspension during covid 19..

Comments: **Action Completed**

Following recovery from Covid during 2021 – 2022 the appraisal system is once again in place for all connected doctors. This included NHS England guidance to reintroduce measures for managing non-engagement including referrals to the GMC from February 2022 onwards.

Action for next year: SOP for late appraisals and non-engagement will be reviewed in 2022 in line with the overall policy review

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None identified.

Comments:

Medical Appraisal policy is up to date, however due to changes in the revalidation notice period and multi-source feedback the policy will need reviewing earlier than planned. This will also provide an opportunity to improve processes around quality assurance, postponement of appraisals and non-engagement.

Action for next year: Review policy in -2022-23

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: New Appraiser training.

Comments: **Action incomplete.**

The Trust had **113** trained appraisers on 31st March 2022.

In 2021 – 2022, a total of **4** appraisers from MFT ceased to be appraisers due to retirement, leaving the trust or stepping down from the role. There is a prediction that similar number of appraisers will be lost in 2022 – 2023. In order to mitigate this, new Appraisers will continue to be recruited.

In addition, Jeremy Davis, the Responsible Officer from December 2021 attended the Responsible Officer training during the year.

Action for next year: To provide New Appraiser Training in September for 20 doctors. The new Responsible Officer Alison Davis will attend the Responsible Officer training on 9 June 2022.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2021-22 year.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: **Not Complete**

Due to ongoing challenges linked to the pandemic the loss of both David Sulch and Kirti Mukherjee this process could not be introduced during the reporting period.

Action for next year: A review of this action by the Responsible Officer will take place during 2022-2023 to determine best practice moving forward.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: To continue presenting yearly report to Board for compliance.

Comments: **Action Completed**

Assurance of the Board and once ratified, the report is presented to the Trust Board.

Action for next year: To continue presenting yearly report to Board for compliance. It is anticipated that the revised policy will review the assurance process and implement a streamlined approach to improve quality and speed in the appraisal process.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Revalidation recommendations re-introduced as planned. Action Complete.

Comments: **Action Completed**

Revalidations restarted during 2021 – 2022.

For 2022 – 2023 changes to a 12 month notice period will be introduced, with an internal standard of 3 months for all information to be completed (e.g. appraisals, mandatory training) with feedback to be completed 3 years before revalidation. This change will result in an increase in administration for MSF feedbacks but it is anticipated that existing resource will be sufficient for the year.

Action for next year: To review policy to incorporate identified changes.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To continue with the correct processes in place to support Revalidation Recommendations.

Comments: **Action completed**

Doctors are supported with their revalidations and the evidence required by the Revalidation team – this particularly is relevant to Doctors new to the UK and doctors previously connected to locum agencies.

Action for next year: To continue with the correct processes in place to support Revalidation Recommendations.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: The Revalidation team will continue to monitor information on complaints/SIs for inclusion in medical appraisal.

Comments:

The revalidation team continues to monitor information on complaints/SIs for inclusion in medical appraisal.

Key aspects of clinical governance for the RO are the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems.

The Revalidation team continues to work with the Governance teams in the organisation to provide information on complaints, involvement in incidents and similar items for the medical appraisal process.

All Consultants, Specialty Doctors and doctors (not in a formal training programme) are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a regular basis by the Revalidation team to ensure that progress in meeting these deadlines is being maintained.

Action for next year: To continue to monitor the present system. .

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: We will strengthen the process of identifying early conduct and performance issues and monitor regularly in biweekly meeting with HR.

Comments: **Action completed**

There is a biweekly meeting of decision making group chaired by Chief Medical Officer and HR where any conduct or capability issues are triangulated from information received from HR processes, complaints/SIs/Never Events and regular weekly meetings of Chief Medical Officer with Deputy Chief Medical Officer and Divisional Medical Directors.

Upon connecting a Doctor to MFT, RO to RO references (MPIT) are requested which contain any relevant information to share. The team receives regular requests from Private Practices to complete Practicing Privileges references and share relevant information to the RO of the organisation where a doctor works.

All doctors are required to include reports of any SIs/Datix/Complaints in which they were involved during the appraisal year, with appropriate reflections and learning.

All doctors are required to undergo formal Multisource feedback both from Colleagues and Patients once in the 5 yearly revalidation cycle. All doctors are encouraged to share and reflect any compliments received (including thank you cards and feedback received from patient experience team) during every appraisal discussion.

Training grade Doctors have Postgraduate Dean at Health Education Kent, Surrey and Sussex (HEKSS) as their Responsible Officer. While they are working in MFT, the Doctors have regular work placed based assessments by their named Educational and Clinical supervisors and their performance discussed and documented in the quarterly Local Faculty Group and Local Academic Board meetings. Any identified concerns are flagged up to HEKSS via Director of Medical Education of MFT. They undergo Annual Review of Competency Progression (ARCP) in their respective School at HEKSS.

Action for next year: To continue biweekly decision making group meetings to discuss and action any conduct/capability issues of doctors. To update the terms of reference for the decision making group.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Identified

Comments: The Chief Medical Officer / Responsible Officer chairs the Decision Making Group, which meets bi-weekly to review all significant concerns and manages these under Maintaining High Professional Standards (MHPS) including liaising with NHS Resolution Service (formerly the National Clinical Assessment Service) and the GMC as required in each case. The Deputy Responsible Officer and a member from HR attend this meeting.

Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified, these are then managed under the appropriate Trust policy.

Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with the Trust policy.

The Trust has 18 trained Case Investigators and 8 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed.

All Case Investigations follow NHS Resolution Service best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance.

As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate.

Action for next year: Although there are a reasonable number of trained investigators and case managers, due to change in roles and time since last training, the Trust will be reviewing the quality and quantity of their Case Investigators and Managers and providing refreshers and training as required.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Nil

Comments: A senior team including the Chief Medical Officer (RO), Deputy Chief Medical Officer, Head of Employee Relations and Head of MD services meets on a biweekly basis to review concerns about doctors and decide on appropriate actions. Investigations where required, are undertaken under MHPS guidelines, using appropriately trained Case Manager and Case Investigators.

Doctors in training have their RO at the Health Education Kent, Surrey and Sussex (HEKSS) and any concerns are flagged up to RO at HEKSS via Director of Medical Education.

The following table outlines the number and outcome of cases reviewed by the Decision Making Group in the reporting year.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

	2022 – 2023 – issues managed within the Decision Making Group *(n.b. - Figures in brackets relate to the comparative figures for 2019 – 2020)*	White 28% (23%)	BAME 72% (77%)	Male 66% (66%)	Female 34% (34%)	**TOTAL**
Conduct/ Capability	Outcome					
01	Reviewed and no case to answer	0 (0)	1 (5)	1(4)	0 (1)	**21 5**
5	Reviewed and advice given regarding future conduct	1 (3)	4 (0)	3 (2)	2 (1)	**5 (2**
12	Reviewed and advice given regarding improving performance (capability)	1 (0)	1(1)	0 (0)	2(0)	**2 (1)**
3	Reviewed and managed by other HR policy (grievance, Dignity at work, sickness)	0 (1)	0 (2)	0 (3)	(0)	**00 (3)**
3	Formal MHPS investigation	1 (0)	2 (1)	2 (1)	1 (0)	**3 (1)**
	% Figures in brackets are the Proportion within protected characteristic	3 (4) (31%)	8 (9) (69%)	6 (11) (85%)	3 (2) (15%)	**12(13)**

Action for next year: To continue with the present format.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None identified.

Comments: Upon connecting a Doctor to the designated body, an RO to RO reference request is sent to the previous designated body. Dependent on the information shared, more details may be requested which can result in an RO to RO conversation to elaborate further.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

All doctors who work in other places are required yearly to produce a signed form from RO/Hospital Director of the other organisation (s) about their practice and any concerns regarding their practice. This form is uploaded to their medical appraisal every year.

For doctors connected elsewhere but working in MFT fall under two categories:

Training grade doctors who are regularly monitored by their educational supervisors and any concerns raised are dealt with through the Local faculty groups chaired by the specialty College Tutors and the Local Academic Board chaired by the Director of Medical Education and escalated to RO of HEKSS and the RO at MFT is updated immediately for any necessary actions.

Other groups of doctors who may work in MFT could be bank doctors or contracted through agencies and have their own RO. The Revalidation team would contact their designated body if any concern arises.

Action for next year: To continue with the current process set in place.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Nil

Comments: All processes for responding to concerns are managed according to our Trust Policy (Disciplinary and Capability Procedures for Medical and Dental Staff) which is consistent with MHPS. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced.

Action for next year: Nil

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None identified.

Comments: All doctors employed by MFT are subject to NHS mandatory recruitment pre-employment checks. To ensure compliance with pre-employment checks, a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT.

Action for next year: To continue to monitor compliance.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Overall, MFT achieved 87.6% appraisal completion for doctors A total of 116 revalidation recommendations were sent to the GMC during the reporting year. 24 deferral recommendations were sent with 5 doctors having a positive recommendation sent during the report period

Appraisals and Revalidation process was on hold from March 2020 but the appraisal and revalidation process was restarted in June 2020.

General review of last year's actions

o **Completed Actions:**

• To develop "help guides" on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document.

o **Actions partially completed:**

o **Incomplete Issues**

• Audit of appraisal output summary and give one to one formative feedback to at least 20% appraisers on their appraiser performance.

o **Current Issues:**

• To receive reports consistently from a centralised data base to check any SI/Complaints received for any individual doctor.

• To work with our appraisal software supplier to adjust some fields and pages in the electronic appraisal document to reduce appraisals with errors which subsequently require further meetings or actions for the appraisee and appraiser.

o **New Actions:**

• To provide training for new appraisers.

Overall conclusion:

• We have continued to strengthen our appraisal and revalidation process.

• There is overall good engagement from our doctors.

Section 7 – Statement of Compliance:

The Board / executive management team of ***Medway NHS Foundation Trust*** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Medway NHS Foundation Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS Medway NHS Foundation Trust

Trust Board Meeting
5 October 2022

Title of Report	Ockenden Assurance Report for Trust Board October 2022	Agenda Item	
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer		
Report Author	Alison Herron, Director of Midwifery		
Executive Summary	This report provides an update to the Quality and Patient Safety Sub-Committee and Quality Assurance Group on the Maternity Service's progress against compliance with the initial 7 Immediate and Essential Actions (IEAs) from the first Ockenden report (2020) along with the 15 IEAs from the second Ockenden report (2022). The report also provides a summary of the NHS England Insight Assurance Visit on 16 August 2022 to review MFT's compliance with the first Ockenden report 7 IEA's.		
Committees or Groups at which the paper has been submitted	Planned Care Group meeting Planned Care Divisional Governance Board Quality and Patient Safety Sub-Committee		
Resource Implications	No additional resource implications		
Legal Implications/ Regulatory Requirements	Compliance with Ockenden 1 and Ockenden 2 and CNST.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The committee is requested to approve the report for onward reporting to the Quality Assurance Group and Trust Board.		

Approval	Assurance	Discussion	Noting
☒	☒	☐	☒

Appendices	Appendix 1: Ockenden Assurance Report for Trust Board Oct 22

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

1 Appendix 1: CNST Assurance Report

Ockenden Assurance update report for Tru

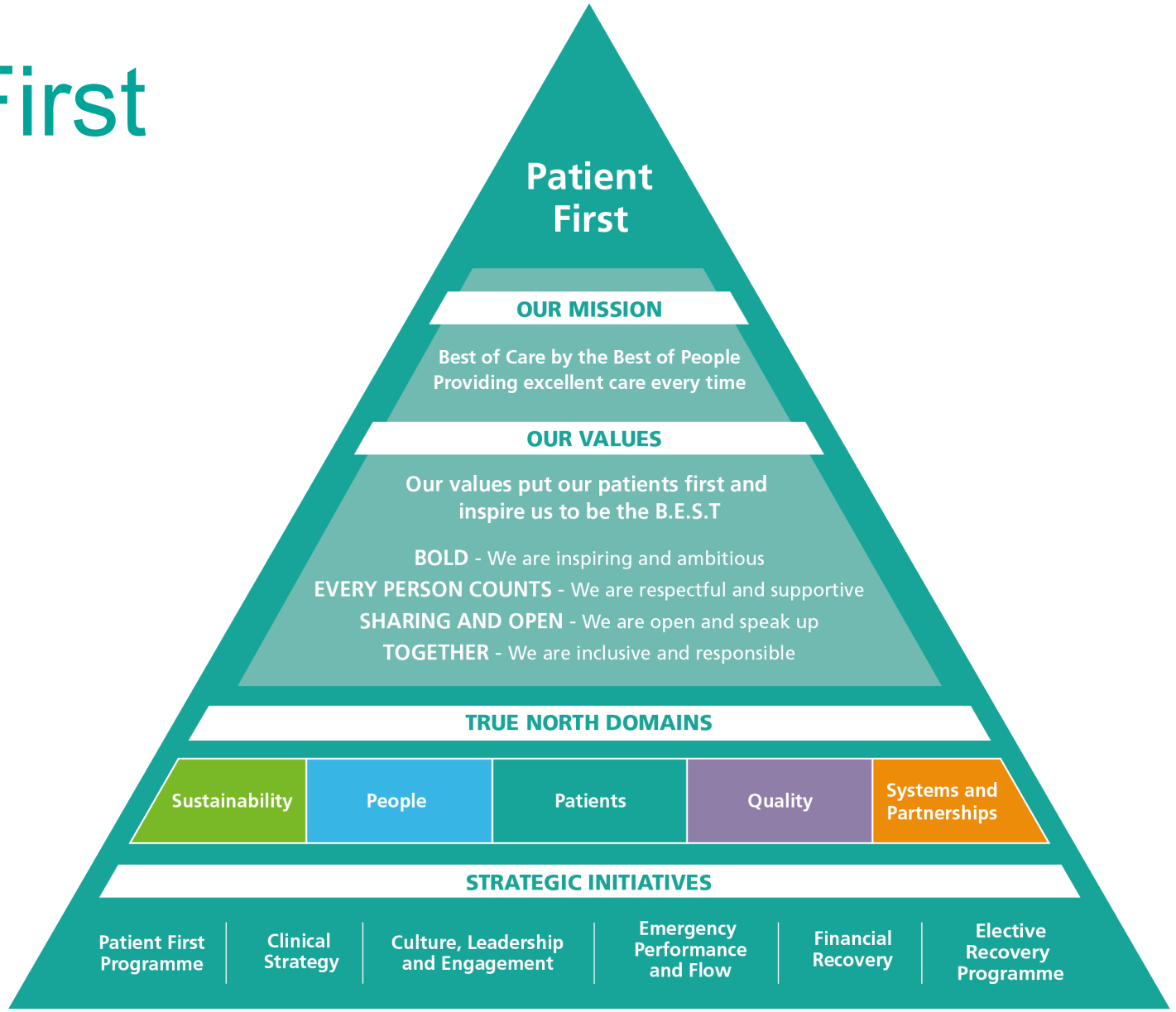
NHS
Medway
NHS Foundation Trust

Ockenden Assurance Update Report to Trust Board October 2022

Alison Herron, Director of Midwifery

Patient FIRST

Patient First



SIOR- Ockenden

Successful Deliverables

- Ockenden reporting established to assure and monitor compliance across all Ockenden IEA's.
- Position improved for Ockenden 1 since June 2022, with 3 completed IEAs, 6 IEAs on track and 0 off track or overdue.
- Key improvements in IEA 2 Listening to families, and in IEA 5 Risk assessment throughout pregnancy
- NED now member of MVP meetings and quarterly meetings commenced with MVP lead/NED/HOM/DOM
- Antenatal Clinic Pathway revised and will be ratified in September. Audit completed and actions identified to support improved recording of risk assessment at every contact
- All recommendations of Birthrate plus review 2020 recruited to (with exception of Consultant Midwife which is being interviewed for on 30th September)

Identified Challenges

- Maintaining training schedule and MDT attendance in face of staffing challenges.
- Launch of LMNS wide Personalised Care and Support plans (PSCP) delayed from October 2022 to January 2023
- Review of maternal death guideline delayed due to clinical pressures, revised date for completion end of September 2022 (Ockenden 2)
- Development of Midwifery led unit operational risk assessment tool delayed due to clinical pressures with plan now to review in labour ward forum in October 2022 (Ockenden 2)

Opportunities

- Opportunities to strengthen staff and service user feedback through staff engagement events and collaborative working with MVP.
- Good recruitment trajectory to full midwifery establishment by End of November 2022

Risks

- If staffing challenges continue longer term will pose a risk to education training schedule

Ockenden 1 Self-Assessment September 2022

NHS Medway st

True North	Immediate and Essential Action	RAG June 22	RAG Sept 22	Comments	Target Date
Quality	IEA 1: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMNS) oversight			All requirements of Ockenden met. To work with DOM to improve Board Reporting in line with Patient First methodology.	Nov 21
Patients	IEA 2: Listening to Women and their Families: Maternity services must ensure that women and their families are listened to with their voices heard.			NED now member of MVP meeting and additional quarterly meetings arranged with MVP/NED and HOM/DOM.. Continue to monitor MVP co-production/engagement via CNST Year 4 Safety Action 7	Oct 22
People	IEA3: Staff Training and Working Together: Staff who work together must train together			Achieved CNST Year 3 Training requirements and continue to monitor training compliance via CNST Year 4. Revised consultant job planning and rota in place allowing for AM and PM ward rounds. Audit ongoing demonstrating good compliance with ward rounds. LMNS review process commenced June 2022 with review of Training Needs Analysis and training figures. Action plan in place to support.	Nov 22
Quality	IEA4: Managing Complex Pregnancy: There must be robust pathways in place for managing women with complex pregnancies			Local maternal medicine SOP now in place. Working with LMNS to develop regional maternal medicine centre. Externally funded lead midwife for maternal medicine (8a) advertised September 2022.	Dec 22
Quality	IEA5: Risk Assessment Throughout Pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway			Risk assessment guidance was updated in 2021 and compliant for Ockenden. However, in light of revised antenatal clinic pathway this has been revised is due to be ratified through Governance in September 2022. Audit completed and actions identified to support improved recording of risk assessment at every contact. LMNS-wide, Personalised Care and Support plans (PSCP) being developed and planned launch delayed from October 2022 to January 2023.	Dec 22

Ockenden 1 -Self-Assessment September 2022

Medway NHS Foundation Trust

True North	Immediate and Essential Action	RAG June 22	RAG Sept 22	Comments	Target Date
Quality	IEA6: Monitoring Fetal Wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.			Appropriate fetal wellbeing leads in post (1.4 WTE midwives and obstetric lead).	Jan 22
Patients	IEA7: Informed Consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery			Action plan in place following MVP website review. LMNS PSCP will also support closing this action when implemented in January 2023.	Dec 22
People	Workforce			All recommendations of Birthrate Plus review 2020 recruited to (with exception of consultant midwife post, with interviews to take place in September 2022.) Director of Midwifery now in post.	Sep 22
Quality	NICE Guidance in Maternity			Process in place to monitor and review new NICE guidelines and ensure local guidance is appropriate and in date.	Sep 22

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
Off 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

Ockenden 2 – Self-Assessment Sept 22

True North	Immediate and Essential Action	RAG Jun 22	RAG Sept 22	Comments	Target date	Revised Target
Systems and Partnership	IEA 1: Workforce Planning and Sustainability : Financing a Safe Maternity Workforce			Workforce report for 2022 completed and to be presented to Trust Board in October 2022. Funding for full external workforce review to be requested for 2023.	Aug 2022	April 2023
Sustainability	IEA1: Workforce Planning and Sustainability: Training			Induction and preceptorship package strengthened. Community Induction pack approved and development of similar packs for all areas underway. Develop progression packages for staff to support advanced decision-making.	Dec 2022	N/A
People	IEA2: Safe Staffing			Enhanced Maternity Escalation plan now in place (June 2022). Develop formal mentorship programme for senior midwives.	Dec 2022	N/A
Quality	IEA3: Escalation and Accountability			Develop conflict of clinical opinion policy and ensure psychological safety amongst the workforce. Elements have been incorporated into new fetal monitoring training package due to launch in October.	Nov 2022	N/A
Quality	IEA4: Clinical Governance Leadership			NHSEI self-assessment refreshed and reported to Board Aug 2022. Awaiting further update from national team pending the Kirkup EKHUFT Report in September 2022. Formalise clinical responsibility for guidelines.	Dec 2022	N/A
Quality	IEA5: Clinical Governance – Incident investigations and complaints			Meetings established between governance and education teams to improve shared learning. Weekly MDT incident review group to be relaunched in October 2022 with in depth review. Continue to strengthen triangulation from clinical incidents and shared learning.	Dec 2022	N/A

Ockenden 2 – Self-Assessment Sept 22

True North	Immediate and Essential Action	RAG Jun 22	RAG Sept 22	Comments	Target date	Revised Target
Quality	IEA6: Learning from Maternal Deaths			Due to clinical pressures review of maternal death guideline delayed, to be completed by end of September. Awaiting national guidance on the allocation of maternal cases to expert pathologist in maternal physiology.	Aug 2022	October 2022
People	IEA7: Multidisciplinary Training			Updated TNA approved in line with core competency framework. LMNS training review process established. Implementation plan being developed to reinstate simulation sessions across the unit and closely monitor training compliance.	Jan 2023	N/A
Systems and Partnerships	IEA8: Complex Antenatal Care			Diabetes in pregnancy guidelines updated inline with current guidance. Review pre-conception care with Primary Care. Case note audit to confirm compliance with guidance for diabetes and hypertension.	Dec 2022	N/A
Quality	IEA9: Preterm Birth			Preterm birth guidelines due to be ratified in October 2022. “Prem7” antenatal optimisation bundle Quality Improvement project to be launched in October 2022 with ongoing audit throughout the project.	Dec 2022	N/A
Quality	IEA10: Labour and Birth			Development of Midwifery Led Unit operational risk assessment tool delayed due to clinical and staffing pressures. Plan to review through Labour Ward Forum October 2022.	Aug 2022	December 2022

Ockenden 2 – Self-Assessment Sept 22

True North	Immediate and Essential Action	RAG June 22	RAG Sept 22	Comments	Target date	Revised Target
Patients	IEA11: Obstetric Anaesthesia			Formalise postnatal anaesthetic follow-up for women and birthing people and review need for local guidelines for anaesthetic roles.	Dec 2022	N/A
Quality	IEA12: Postnatal Care			Audit required to confirm compliance with consultant ward rounds and review of postnatal readmissions.	Oct 2022	N/A
Patients	IEA13: Bereavement Care			Submitted EOI for national funding bid for workforce to move to 7 day service. Current workforce covering 7 days where possible. Call for staff to undertake Bereavement champion training to be launched in September 2022.	Nov 2022	N/A
Quality	IEA14: Neonatal Care			Ongoing Audit to confirm compliance with ODN requirements including born in appropriate location, outcomes of in-utero transfers.	Dec 2022	N/A
Patients	IEA15: Supporting Families			THRIVE midwife to support women with perinatal trauma recruited to. Audit to confirm compliance with mental health pathways deferred until revised guidelines ratified and implemented. Anticipated October 2022.	Aug 2022	December 2022

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
Off 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

NHS
Medway
NHS Foundation Trust

Ockenden Insight Visit

Summary Slides from Ockenden Insight Visit

16 August 2022

Patient FIRST

Regional CMO/NHSEI Ockenden Insight Visit

NHS Medway NHS Foundation Trust

- The Regional CMO/NHSEI teams Ockenden assurance visits are being held with every Trust to assess maternity services compliance against the recommendations and 7 Immediate and Essential Actions (IEA's), that were included in the preliminary findings Ockenden report 2020 (Ockenden 1).
- Medway Foundation NHS Trust visit held on 16th August 2022
- The visit incorporated a Trust maternity services presentation on the Ockenden action plan and progress. Focus groups with staff, care group triumvirate and DOM, maternity governance team and safety champions. Plus a review of the evidence in relation to the 7 IEA's, and a walkabout with the regional CMO in all maternity service clinical areas.
- Informal feedback given to the Trust Executive team of the key highlights and confirmation of next steps, with a report to follow in 6-8weeks.

IEA 1: Enhanced Safety

Complete


Classification: Official

NHS

Implementing a revised perinatal quality surveillance model

December 2020

Board Reporting in place – Nov 2021

LMNS Reporting – May 2021

Robust PMRT process in place with external reviewers

Next steps

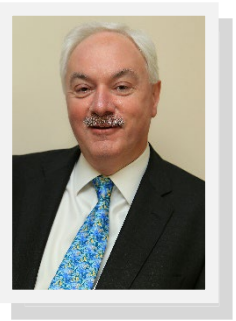
Continue with robust reporting to Board and LMNS

IEA 2: Listening to Women and Families

NHS Medway NHS Foundation Trust

Complete

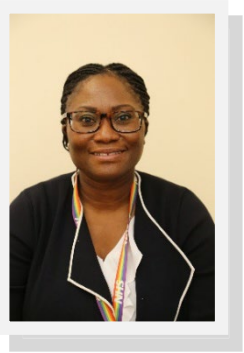
Non-Executive Director



Mark Spragg

Non-Executive Director

Board Level Safety Champion



Evonne Hunt
Chief Nursing Officer

Maternity and Neonatal Safety Champion Assurance Board

MEDWAY Maternity Voices

Working in partnership to improve maternity services

NED joined core membership of MVP meeting

Quarterly meeting between MVP, NED, HOM & DOM established

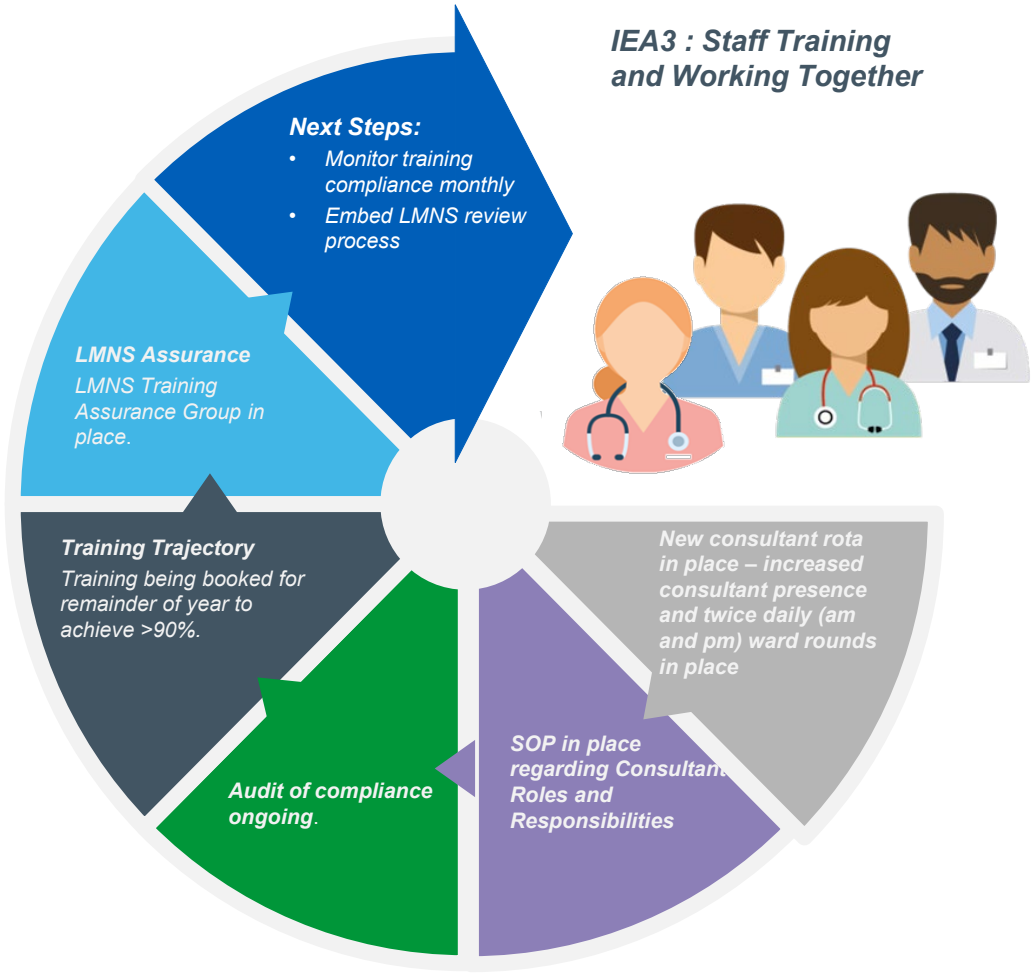
Next steps

Continue to work with MVP to co-produce – regional SOP and templates to be introduced

Continue to strengthen working relationship between MVP and NED

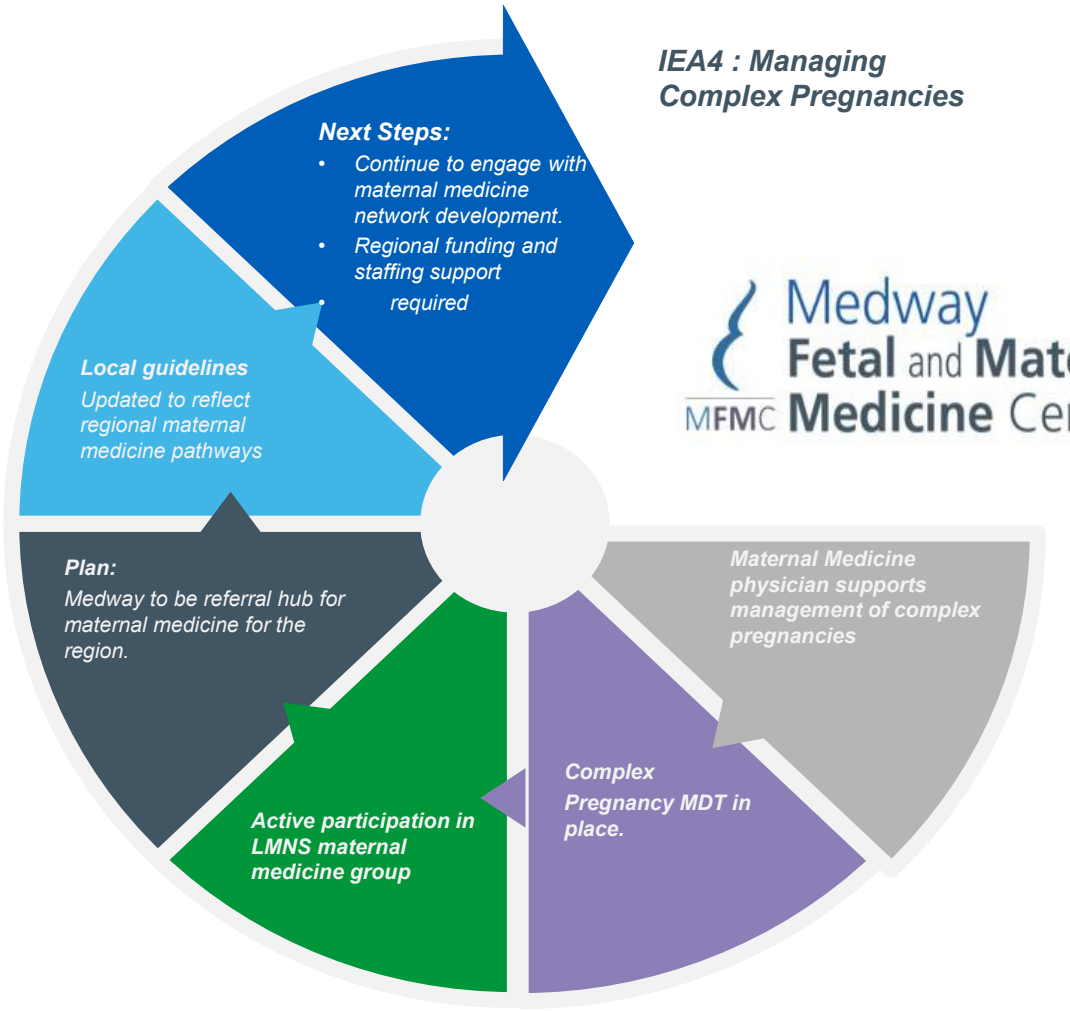
IEA 3: Staff Training and Working Together

On Track



IEA 4: Managing Complex Pregnancies

On Track



Medway Fetal and Maternal Medicine Centre

IEA 5: Risk Assessment Throughout Pregnancy

On track

- Local guidelines updated to ensure risk assessment at each contact
- Revised antenatal pathway – appropriate risk stratification
- Additional risk assessment questions on EuroKing –On-going audit
- Local personalisation and choice guidelines ratified

Next steps

- Embed personalisation and choice guidelines in to practice
- Working with LMNS to implement regional PSCP
- Streamline
  Audit and data collection from EuroKing
- Agree action plan to improve recording of risk assessment at every contact

IEA 6: Monitoring Fetal Wellbeing

Complete

- Fetal Wellbeing midwives – 1.4 WTE
- Obstetric CTG and Simulation Lead in post
- CTG Training
  Learning
  Investigations
- Regional Fetal Physiology guidelines
- Audit
  Quality Improvement
- Ongoing professional development and championing best practice
- Launch of Physiological Fetal Monitoring Training Oct 2022
- Local Fetal Physiology guideline to be launched Jan 2023

MCTG

NHS Medway NHS Foundation Trust

IEA7: Informed Consent

On Track

Maternity Services

Update of maternity website – national guidance, birth choices, inclusivity

MEDWAY Maternity Voices

Working in partnership to improve maternity services

On-going audit

Research project to support families with Learning Disabilities

MVP benchmarking of LMNS BBB website, Social medial and Leaflets

Local guidance for personalisation and additional guidance ratified– supporting informed consent

The Together Project

Next steps

MVP co-produced action plan in place to improve website and social media pages

Embed personalisation and additional guidance SOP/guideline into practice

Outside guidance and informed consent audit

NHS Medway NHS Foundation Trust

Midwifery Workforce

On Track

Next steps

Staffing Challenges – Recruitment to band 5 and 6 posts

Workforce group in place – refreshed rolling recruitment and engagment with students

Trajectory to be fully established by Q3 2022/23

Workforce review Local Birthrate + review completed

Board report and Business case to be compelted

Review safe staffing and MCoC

High Acuity and complexity Conintue to prioritise 1:1 care and safe staffing

Obstetric Workforce

On Track

Next steps

- Strengthen Collaborative MDT working
- Develop Maternal Medicine Staffing
- Faciliate organisational Learning
- Strengthen Obstetric Leadership Roles

NHS Medway NHS Foundation Trust

Informal Feedback to Trust Executive team

NHS Medway NHS Foundation Trust

- Fantastic day, awesome staff, positivity in every focus group, excellent staff engagement and discussions.
- Excellent presentation with clearly identified challenges
- Trust Self- Assessment and benchmark of Ockenden IEA's and level of compliance was accurate.
- Apparent that maternity is part of the trust and is heard at every level including at Trust Board.
- Collaborative working between obstetricians/midwives/neonatal staff/anaesthetists – exemplar for other maternity services to model.
- Staff very proud that bad behaviour is not tolerated and staff feel able to call this out when seen.
- Staff concerned re workforce challenges and filling vacant posts – NHSEI advised to keep the positive messaging going in staff focus groups on recruitment and what support is in place for existing staff and new starters.
- Keep wellbeing of staff a priority – staff awards/real time feedback/psychological safety, counselling support/time back for any online training undertaken in own time.
- Really good working with the MVP including being included in TOR for Maternity and Neonatal Safety Champion Assurance Board – ensure we involve MVP at every opportunity (at the beginning of any changes, pathway revisions or initiatives, ward/area improvements/decorations)
- Trust will receive the visit outcome report in 6-8 weeks.
- Regional CMO will be completing a regional benchmark and position, from the assessments undertaken at every Trust across the SE region and will offer support to Trusts to implement any outstanding IEA's

Next steps

- The report has provided an update to the Board on the progress in compliance to the Ockenden report recommendations and IEA's.
- The Board is requested to note the progress and the further actions required for compliance.
- The service will continue to monitor progress against compliance with a view to return to Board in February 2023.
- Once update to national reporting following Kirkup report in September 2022 if received, the maternity service will provide an update to the Board.

Public Trust Board Meeting
5 October 2022

Title of Report	**CNST Assurance Report**	Agenda Item	
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer		
Report Author	Alison Herron, Director of Midwifery		
Executive Summary	This report provides an update to the Quality and Patient Safety Sub-Committee and Quality Assurance Group on the Maternity Service's progress against compliance the 10 Safety Actions for CNST Year 4.		
Committees or Groups at which the paper has been submitted	Planned Care Group meeting Planned Care Divisional Governance Board Quality and Patient Safety Sub-Committee		
Resource Implications	No additional resource implications		
Legal Implications/ Regulatory Requirements	Compliance with CNST.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The committee is requested to approve the report for onward reporting to the Quality Assurance Group and Trust Board.		
	Approval ☒	Assurance ☒	Discussion ☐	Noting ☒
Appendices	Appendix 1: CNST Assurance Report Appendix 2: PMRT Action Plan Appendix 3: NICU Nursing QIS Action Plan Appendix 4: Supernumerary Action Plan		

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

1 Appendix 1: CNST Assurance Report

2 Appendix 2: PMRT Action Plan

2021-22. PMRT Action Plan.pdf

3 Appendix 3: NICU Nursing Qualified In Speciality (QIS) Action Plan

01. NICU Nursing QIS Action Plan Aug

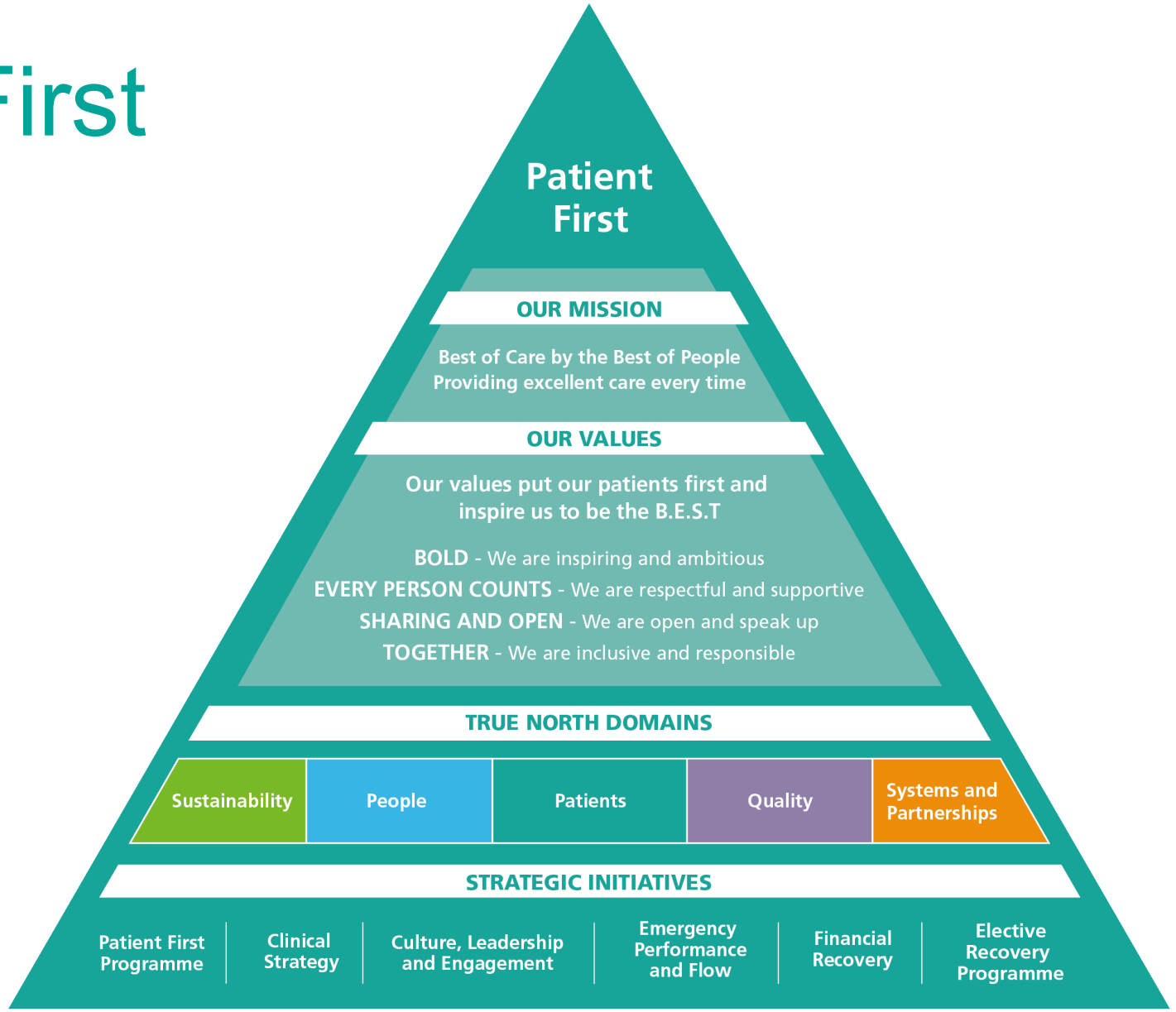
4 Appendix 4: Supernumerary Action Plan

04. 2021-22 Supernumerary Acti

CNST

Alison Herron, Director of Midwifery
Kate Harris, Head of Midwifery

Patient First



SIOR- CNST

Successful Deliverables

- CNST reporting established to ensure compliance across all Safety Actions.
- Position improved since June 2022, with 8 Safety Actions now on track and 2 remaining “off track with actions to deliver”.
- Obstetric staffing aligns with RCOG requirements and audit demonstrates 100% compliance with consultant attendance at required clinical emergencies/events whilst on-call.
- Full compliance with PMRT reporting requirements and processes in place to maintain compliance.
- Maternity Voice Partnership (MVP)meetings in place and required evidence available.
- Safety Action 5 (midwifery workforce) now on track due to completion of workforce report and planned presentation to Trust Board in October 2022

Identified Challenges

- Maintaining training schedule and MDT attendance in face of staffing challenges. (Regional Chief Midwifery Officer has requested the national CMO to request NHSR consider extending deadlines.)
- Data mapping errors in Maternity Information System identified and work ongoing to rectify to ensure compliance with Safety Action 2.

Opportunities

- Opportunities to strengthen staff and service user feedback through staff engagement events and collaborative working with MVP.
- With a robust MIS there is an opportunity to identify where our clinical risks and issues are and address in real time.
- Implemented audit tool of Neonatal ward attenders to support better understanding of workload.

Risks

- Non-compliance with data requirements of Safety Action 2 if data mapping errors cannot be rectified. (Included on risk register)
- Compliance with training in the face of staffing pressures.

Summary

NHS Medway NHS Foundation Trust

Safety Action	Description	RAG – June 2022	RAG – September 2022
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	**On Track**	**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**	**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**	**On Track**
Safety Action 4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	**On Track**	**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**	**On Track**
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	**On Track**	**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**	**On Track**
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**	**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**	**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**	**On Track**

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

True North: Quality

Safety Action 1: PMRT: On Track

Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

Key Messages:

- Safety Action remains on track and expected to achieve full compliance prior to Trust Board sign-off in December 2022.
- 100% of eligible cases notified to MBRRACE within second working days and surveillance completed within one month of death. (target 100%)
- 100% of cases had PMRT review commenced within 2 months of each death (target 95%).
- 100% of eligible cases reviewed by a multidisciplinary review team, with each review completed to draft within 4 months and published within 6 months. Appropriate process and trajectory in place to ensure continued compliance. (target 50%)
- Parents informed of review and their perspectives and questions incorporated into the review process for 100% of eligible cases. (target 95%).
- Quarterly reporting of all perinatal losses and action plans in place as part of the Perinatal Surveillance Tool reporting. Reports also discussed with the maternity and Board Level safety champions via Maternity and Neonatal Safety Champion Assurance Board. Details of perinatal losses also reported monthly via Quality Assurance Group IQPR slides.

Actions & Improvements:

- Funding agreed and SOP to ensure placental histology is carried out by specialist perinatal pathologist at Great Ormond Street to be ratified in September 2022. Education for relevant staff to commence in October to ensure correct pathways are followed for all eligible placentas.
- Neonatal SOP to support families taking baby home following a bereavement now in place.
- Service users being engaged to review bereavement information.
- Debrief checklist for neonatal staff in place along with Wellbeing Team and debrief pathway to support staff following any incident where staff require debrief or support.

Issues, Concerns & Gaps:

- Antibiotic prescription for preterm pre-labour rupture of membranes to be aligned with national guidelines and launched as part of QI project “Prem7” in October 2022.

True North: System & Partnership

Safety Action 2: MSDS: Off Track with actions to deliver

Ambition: Ensuring data submitted as part of Maternity System Data Set is robust and accurate and there is maternity digital strategy in place.

Goal: To ensure accurate data input and correct data mapping to achieve compliance with Safety Action 2.

Key Messages:

- Action remains off track with actions to delivery due to ongoing concerns regarding data quality/mapping.
- Maternity digital strategy completed and will be taken through the Trust reporting process by the Director for IT and DOM for approval and for onwards reporting to the LMNS.
- Primary goal of digital strategy to work with LMNS to procure a regional Maternity Information System to support safe and efficient patient care.
- Working closely with EuroKing provider to identify and correct data mapping errors – not currently achieving all data criteria (4/11 (May data) Care Quality Improvement Metrics (target 9/11))
- Awaiting feedback on June data via NHS Digital Scorecard to asses our position against the 11 CQIM and rest of CNST requirements. Scorecard anticipated end of September 2022.
- Improved processes in place to review, identify and rectify data errors. July data currently being reviewed and work with Digital Midwife, General Manger, BI and Wellbeing to ensure final data submission meets requirements by end of September 2022. (July data is the data solely used to assess CNST compliance)

Issues, Concerns & Gaps:

- Not achieving all MSDS data criteria in line with CNST requirements.

Actions & Improvements:

- Work ongoing with EuroKing provider to identify an correct data mapping errors to ensure compliance is achieved for July data in line with CNST requirements.
- Maternity Digital strategy has been developed will be taken through the Trust reporting process by the Director for IT and DOM for approval and for onwards reporting to the LMNS.
- Planning to implement a Digital and Data Review Group across the Care Group to incorporate all digital and data issues and ratification/approval of data prior to disseminating externally.

True North: Quality

Safety Action 3: ATAIN On Track

Medway NHS Foundation Trust

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

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

Key Messages:

- Safety Action remains on track and expected to achieve full compliance prior to Trust Board sign-off in December 2022.
- Number of admissions to the neonatal unit that would have met current Transitional Care (TC) admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. 0
- Number of babies that were admitted to, or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. 0
- Number of admissions deemed avoidable for other reasons. Q1 22/33 6 – (5 for respiratory symptoms that settled on admission/did not require respiratory support)
- Quarterly Audit of pathway into TC in place with reporting, including progress against action plan via Maternity and Neonatal Safety Champion Assurance Board (M&NSCAB) and LMNS Quality Assurance group as required.
- Appropriate data recording in place for all Neonatal Admissions to Transitional Care and Maternity Additional Care with onward reporting to the ODN as required.
- Appropriate data collection in place for ward attenders to the Neonatal Unit to support both understanding of Neonatal workload and pathways for babies requiring to attend the Neonatal unit from home.

Actions & Improvements:

- Data error regarding recording of place of care was identified and rectified which will support accurate reporting to ODN and reduce numbers of term admissions recorded.
- Electronic database for ward attenders to NICU in place from July 2022 to support compliance with CNST and to provide improved monitoring of workload on NNU.
- Weekly MDT review of all ATAIN cases to be commenced October 2022 to support real time learning and actions.
- Full ATAIN report to be presented to M&NSCAB in November 2022.

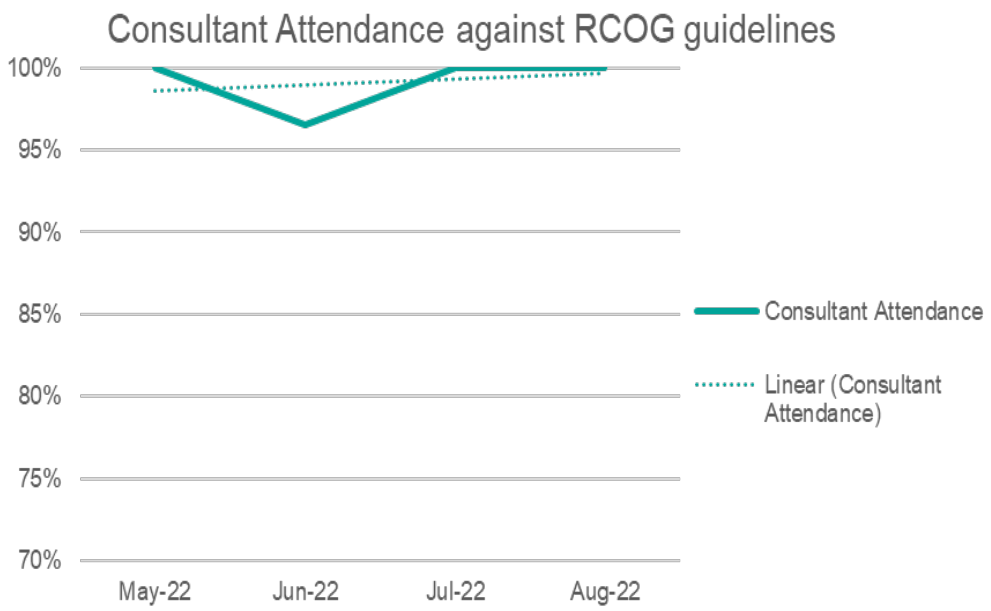
Issues, Concerns & Gaps:

- Data input issue identified regarding babies incorrectly being allocated to NNU rather than TC for part of admission, therefore increasing number of Term Admissions recorded. This has been rectified from Q1 22/23.

True North: People

Safety Action 4: Clinical Workforce On Track

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



Issues, Concerns & Gaps:

- Revised bed state to improve consultant attendance audit data recording. Also collecting data on consultant ward rounds. Working with clinical effectiveness team to capture bed state audit via Gthr.
- Current audit does not capture patient level detail or allow outcomes or themes to be easily monitored.
- NICU nursing workforce currently below 70% QIS requirement.

Key Messages:

- Safety Action remains on track and expected to achieve full compliance prior to Trust Board sign-off in December 2022.
- Audit of consultant attendance for RCOG required clinical events/emergencies commenced ahead of 29 July 2022 requirement. 100% compliance for July and August 2022 therefore fully compliant with CNST requirements.
- NICU junior medical staffing compliant with BAPM requirements.
- NICU Nursing staff <70% Qualified in Speciality (QIS) due to increase in QIS establishment (funded by HEE) by 16 WTE.
- NICU nursing staffing increased to 64.52% Qualified in Speciality (QIS). 5 new nurses due to commence course in September – Action plan in place. Request Board review and approval.
- Anaesthetic obstetric rota supports 24/7 anaesthetic availability for obstetric patients with clear lines of communication to a supervising anaesthetic consultant at all times.

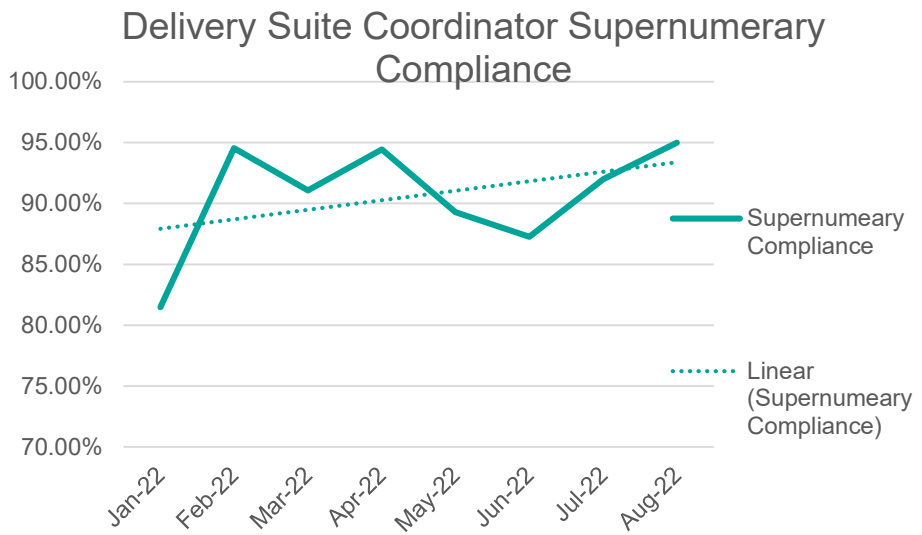
Actions & Improvements:

- Working with LMNS colleagues to consider adding workflow to Maternity information system to allow patient level audit directly from EuroKing which will support enhanced audit, improved data and allow outcomes and learning to be monitored.
- Ongoing audit and monitoring at local level as well as presenting to Trust Board as per CNST requirements.
- Action plan to address shortfall of NICU Nursing QIS requirement included as an appendix with this report for Trust Board approval and onward reporting to Royal College of Nursing as per CNST requirements.

True North: People

Safety Action 5: Midwifery Workforce On Track

Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard



Key Messages:

- Action now moved to on track due to completion of workforce report and plan to present to Trust Board in October 2022 inline with CNST reporting requirements.
- 100% compliance with 1:1 Care in Labour maintained.
- Improved compliance with Supernumerary status of Delivery Suite Coordinator – 92% for July 2022 and 95% for August 2022. Action plan in place with all appropriate mitigations to improve compliance.
- Fully recruited to Birthrate Plus 2020 recommendations (with exception of consultant midwife: interviews to take place 30th September 2022).
- 24.5 WTE Band 5/6 Midwives recruited to – anticipated start dates between August and December 2022.
- Local Birth-rate plus review completed.
- Ongoing work to improve recruitment and retention.

Issues, Concerns & Gaps:

- Large intake of newly qualified midwives will require additional support and preceptorship package.
- Next formal external Birth-rate plus audit to be commissioned for 2023. (Best practice is for every 3 years)
- Consideration to be given to increasing uplift to support safe staffing and additional training requirements of CNST and Ockenden as advised by NHSEI.

Actions & Improvements:

- Refreshed preceptorship package in place for newly qualified midwives.
- Recruitment and retention plan in place, including international recruitment and active engagement with students and open days.
- Workforce paper to Trust Board in October inline with CNST reporting requirements.
- PID to be completed October 2022 and submitted through internal governance processes for approval to commence external birth-rate plus audit.

True North: Quality

Safety Action 6: Saving Babies Lives Care Bundle v2 (SBLCB)

On Track

Medway NHS Foundation Trust

Ambition: Support positive clinical outcomes through compliance with SBLCBv2 requirements.
Goal: Ensure compliance with all 5 Elements of SBLCB v2

Key Messages:

- Safety action remains on track with all outstanding audits on appropriate trajectory to be completed prior to Trust Board sign-off in December 2022.
- Achieved >90% compliance for element 1 (CO monitoring) achieved (target >80%)– action plan in place to achieve >95%.
- Additional scanning pathway in place for women and birthing people with BMI >35.
- 96.96% compliance with providing information on Reduced Fetal Movements (RFM) by 28 weeks. (target 80%) Action plan not required.
- 100% compliance with computerised CTG for women and birthing people presenting with reduced fetal movements. (target 80%)
- Obstetric lead and fetal wellbeing midwives in post and well established as required by CNST and Ockenden.
- Fetal Monitoring training >90% with plan to launch new training programme for Physiological Fetal Monitoring in October 2022 and new guideline in January 2022.
- 55% compliance with full course of steroids for singleton births <34 weeks within 7 days of delivery – (target 80%) Action plan in place including introduction of bespoke steroid guidelines and launch of QI project “Prem 7” to support improved management of steroids.
- 96% compliant with Birth in Appropriate Location for singletons <27 weeks and multiples due <28 weeks due to level 3 neonatal unit (target 80%). 2 cases for 2021. No action plan required.
- Complaint with administration of magnesium sulphate for singleton births <30 weeks (>90%) (target 80%)
- Appropriate pre-term birth clinic in place, with cervical screening.
- Umbilical artery dopplers performed as routine for all scans.
- Multiple birth guidelines in place and in line with NICE guidelines.

Issues, Concerns & Gaps:

- Need to improve compliance with steroid administration. This will be supported by an update to pre-term birth guideline along with new bespoke steroid administration guideline.
- Need to improve compliance with additional scanning for BMI pathway.
- Manual audit of Smoking and CO monitoring due to Maternity information system data mapping errors.

Actions & Improvements:

- Action plan in place to be fully implemented.
- Revised pre-term guideline to support improvements in steroid administration compliance awaiting ratification.
- We have capacity for additional scanning for BMI pathway, however need to recruit to vacant midwife sonographer post to support this.
- Work with Maternity Information System to improve reporting and data mapping for Smoking/CO monitoring.

True North: Patients

Safety Action 7: Maternity Voices Partnership (MVP)

On Track

Ambition: Ensuring that the voices of women, birthing people and their families are heard within the service and that service users are involved in coproducing maternity services.

Goal: Mechanisms in place for gathering service user feedback, and work with service users, through the MVP to coproduce local maternity services.

Key Messages:

- Safety Action now on track due to re-establishment of MVP meetings, increased engagement between MVP and NED, increased co-production and sign-off of appropriate evidence.
- MVP Chair provides regular feedback to the service and supports the co-production of services, including action plans, reviewing guidelines, and attending governance meetings.
- Service user feedback is gathered through maternity specific friends and family tests, area and service specific service user feedback surveys and via the MVP.
- Informal 15 Steps Challenge held in July 2022 with service users, with MVP to undertake formal 15 Steps challenge in September 2022.
- Regional co-production SOP to be approved at MVP level along with co-production templates to support evidencing co-production.
- Non-Executive Director join MVP meeting.
- Schedule of MVP meetings now in place.

Issues, Concerns & Gaps:

- Limited capacity of MVP chair to meet demands of CNST and Ockenden.
- MVP Chair required to attend Maternity Governance meeting. Not yet established due to information governance concerns, working with Trust IG lead and LMNS to ensure confidential information can be shared securely.

Actions & Improvements:

- Schedule of MVP meetings now in place.
- Evidence required for CNST, including work plan, Terms of Reference and evidence of Co-production now available.
- Work with LMNS to consider additional regional MVP support and explore opportunities to increase local MVP involvement.
- Gthr to be utilised to support 15 Steps Challenge.
- MVP to be invited to join Board Level Safety Champion Walk-around.

True North: People

Safety Action 8: Multidisciplinary Training **Off Track with actions to deliver**

Ambition: All staff to attend annual multidisciplinary training, including obstetric emergency training, in line with the core competency framework.
Goal: >90% of all staff groups to have attended the relevant training within the CNST reporting period (Aug 2021-Jan 2023)

Staff Training Curriculum	Target	Compliance %	Trajectory %
Obstetric Emergency (PROMPT)			
Midwives	90%	77%	100%
Maternity Support Workers		64%	92.86%
Consultant Obstetricians		56%	100%
Doctors in Training (obstetric)		63%	96%
Consultant Anaesthetists		50%	100%
Doctors in Training (Anaesthetic)		67%	87.5%
Fetal Monitoring Training			
Midwives	90%	89%	100%
Consultant Obstetricians		94%	100%
Doctors in Training (obstetrics)		76%	100%
New Born Life Support			
Midwives	90%	91%	>90%
Maternity Support Workers		89%	>90%
Consultant Obstetricians		78%	>90%
Doctors in Training (obstetrics)		66%	>90%
Neonatal Nursing		81%	>90%
Consultant Neonatologist		100%	>90%
Doctors in Training (Neonatal)		100%	>90%
Advanced Neonatal Practitioners		100%	100%

Issues, Concerns & Gaps:

- Face to face MDT training threatened by clinical pressures and short staffing.
- Lead midwife for Education post vacant, interim appointed 9th September 2022, interview for substantive post 28th September 2022.

Key Messages:

- Action remains off track with actions to deliver, actions and trajectory in place to achieve compliance prior to Trust Board sign-off in December 2022.
- Trajectory in place to achieve >90% for all staff groups ahead of January 2023 deadline.
- Staff allocated training sessions on rota and e-learning used to support where required.
- New Physiological Fetal monitoring training to launch October 2022.
- Improvement noted in NBLS compliance for midwifery and neonatal staff.
- Drop in doctors in training compliance across all training due to August rotation.
- Non-Compliance escalated to relevant managerial/clinical lead and staff to be supported to complete training.
- Training Needs analysis updated and in line with core competency framework and CNST requirements.

Actions & Improvements:

- Training prioritised where clinically possible and concerns escalated to Clinical Director/ Head of Midwifery.
- Regular meetings established with all training leads to support compliance.
- All staff allocated training sessions. Removal of social distancing allows for greater capacity in face to face sessions.
- All maternity and neonatal staff encourage to attend maternity “pick and mix” sessions for NBLS compliance.
- All new starters will be allocated time for e-learning in first two weeks and face to face training within 6 months.
- Regional Chief Midwifery Officer raised training concerns in relation to compliance with CNST Safety action 8 to National CMO to raise with with NHSR to seek an extension to the deadline/revision of training requirements.

True North: Quality

Medway NHS Foundation Trust

Safety Action 9: Safety Champion

On Track

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

Key Messages:

- Action remains on track with all requirements in place.
- Board Level Safety Champion and Non-Executive Director undertake regular walk-arounds across the maternity and neonatal unit.
- Process for reporting maternity and neonatal safety and quality issues to Board is established and supported by Director of Midwifery and Chief Nursing Officer.
- Trajectory in place to achieve Continuity of Carer by April 2024 in line with CNST requirements and this has been shared with Board Level Safety Champion. Action plan in place with plan to implement first phase in Q1 2023/24
- Maternity and Neonatal Teams actively involved in MatNeoSIP programme and attending required events. Culture surveys being used to inform local quality improvement plans.
- Launch Culture Survey to further support Quality Improvement Plan

Issues, Concerns & Gaps:

- Ensuring Trust Board has appropriate oversight of all relevant maternity and neonatal quality and safety issues as required by CNST, Ockenden and the Perinatal Surveillance Model.
- Process for capturing staff feedback and resulting actions from walk-arounds/engagement sessions to be strengthened.

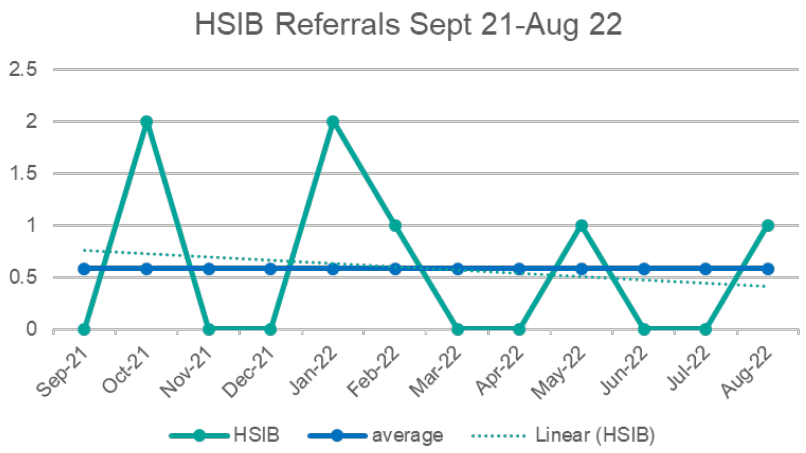
Actions & Improvements:

- Hold staff engagement events with Board Level Safety Champions to support more robust ward to Board feedback.
- Reporting via the Perinatal surveillance tool well established to Trust Board. Work ongoing to align to patient first methodology.
- Non-Executive Director and Board Level Safety Champion to join MVP meeting and MVP to support walk-arounds/staff engagement events.

True North: Quality

Safety Action 10: HSIB and NHSR EN reporting | On Track

Ambition: Ensure all eligible cases are investigated to the highest standard and receive appropriate external review.
Goal: Ensure all eligible cases are reported to Health Care Safety Investigation Branch (HSIB) and NHSR's Early notification scheme.



Key Messages:

- Action remains on track and expected to maintain compliance prior to Trust Board sign-off in December 2022.
- 100% of eligible cases reported to HSIB and NHSR EN as required.
- 100% of cases have had appropriate Duty of Candour.

Issues, Concerns & Gaps:

- Actions and recommendations to be incorporated in to training plan and shared learning meetings.

Actions & Improvements:

- Establish bi-weekly shared learning meetings to support sharing the findings and recommendations from HSIB investigations.

Next Steps

- Request report to be approved by QPSCC and QAC for Board Presentation in October 2022.
- Final CNST submission due 5th January 2023 to NHSR. Plan to report via QPSCC and QAC in November 2022 for DOM to present to Board and gain approval to submit in December 2022.
- Compliance will continued to be monitored via the Division.

NHS Medway NHS Foundation Trust

Public Trust Board
5 October 2022

Title of Report	**Maternity Workforce Oversight Report**	Agenda Item	X
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer		
Report Author	Alison Herron, Director of Midwifery		
Executive Summary	This report provides a Maternity Workforce Oversight report to the Quality and Patient Safety Sub-Committee and Quality Assurance Group in line with the requirements for Safety Action 5 for CNST Year 4.		
Committees or Groups at which the paper has been submitted	Planned Care Group meeting Planned Care Divisional Governance Board Quality and Patient Safety Sub-Committee		
Resource Implications	No additional resource implications		
Legal Implications/ Regulatory Requirements	Compliance with CNST.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The committee is requested to approve the report for onward reporting to the Quality Assurance Group and Trust Board.		

Approval	Assurance	Discussion	Noting
☒	☒	☐	☒

Appendices	Appendix 1: Maternity Workforce Oversight Report

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

1 Appendix 1: Maternity Workforce Oversight Report

Workforce 2022 -FINAL.pptx

NHS
Medway
NHS Foundation Trust

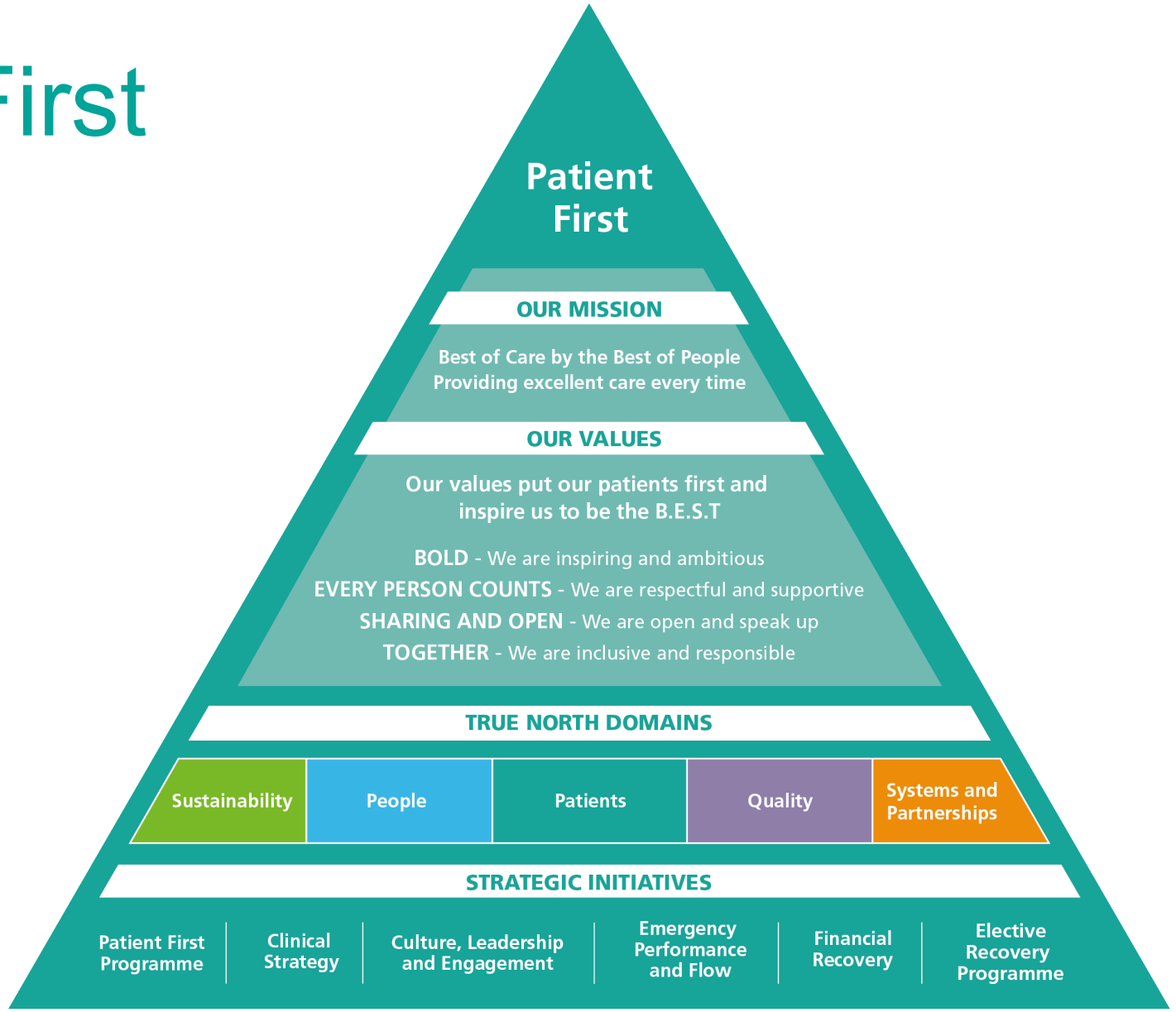
Maternity Workforce Report

Alison Herron- Director of Midwifery

September 2022

Patient FIRST

Patient First



SIOR- Workforce

NHS Medway NHS Foundation Trust

Successful Deliverables

- CNST Safety Action 5 asks Trusts to demonstrate an effective system of midwifery workforce planning to the required standard and six monthly oversight that covers staffing/safety issues during the maternity incentive scheme year four reporting period.
- Internal tabletop Birthrate plus review completed in June 2022 and identified 1:25 Midwife ratio required
- Monthly monitoring of workforce embedded into practice
- Current midwifery vacancy appointed to
- New Birthrate plus acuity tool implemented successfully on Delivery Suite

Identified Challenges

- Current vacancy of 27WTE Midwives
- Need to ensure robust support package for new recruits
- Movement of staff may create red flags
- Increasing complexity of women booking to deliver at MFT
- National Midwifery staff shortage

Opportunities

- To commission and undertake formal external Birth rate Plus audit in 2023
- Recruit to HEE funded Staff Nurse 18 month conversion course
- Launch ward based acuity tool in 2023

Risks

- Due to increased demands senior sisters and specialist roles having to work clinical impacts on their own workload priorities and ability to meet deadlines
- Strategic aspects of the Named Midwife roles are taking priority over the operational aspects
- Current vacant Lead Midwife for education role (interim appointed 9th September, substantive interviews 28th September)
- Delivery suite co-ordinator not supernumerary 100% of the time (action plan in place with all appropriate mitigations identified)

True North: People
Planned vs Actual Midwifery Staffing levels

Medway NHS Foundation Trust

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

		Month 2022						
Measure	Goal	JAN	FEB	MAR	APR	MAY	JUN	JUL
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio	1:25	01.33	01:33	01:34	01:30	01:30	01:31	01:33

Actions & Improvements:

- A staffing review is carried out on a weekly basis to identify any pinch points which impact and challenge the ability to maintain safe staffing.
- In response to the staffing gaps all Band 7 ward managers and specialist midwives have provided clinical care when acuity has been high.
- Improved preceptorship and induction packages in place to support new starters and improve retention.
- Although the vacancy has now been recruited to we still have a substantial 'not in post' figure as these members of staff join us throughout September to December 2022.
- A PID to be completed in October 2022 to request funding to commission a formal external Birthrate Plus audit in 2023.

Key Messages:

- A local internal tabletop Birthrate Plus workforce review was completed in June 2022
- Medway Foundation Trust (MFT) requires and are currently funded to a midwife to mother ratio of 1:25 based on a birth rate of 4821 deliveries to provide safe care.
- The staffing ratio is monitored on a monthly basis through the maternity dashboard.
- MFT have not achieved the recommended ratio due to absences caused by vacancy, staff absence and maternity leave. This issue has been compounded by the Covid pandemic.
- Staffing shortages in part mitigated by use of bank and agency (included in the actual worked ratio in table)

Issues, Concerns & Gaps:

- Birthrate Plus recommends a three-yearly review of midwifery safe staffing. (due in 2023)
- The last formal external review of midwifery staffing at MFT was in 2020.
- High vacancy and absence rate impacting on ability to fill substantive staffing shifts 24/7.

True North: People Recruitment

Medway NHS Foundation Trust

Ambition: To ensure that we recruit and retain the required workforce to deliver safe, high quality care to our service users
Goal: To ensure that MFT is a great place to work by prioritising staff support and wellbeing

	04.07.22	11.07.22	18.07.22	25.07.22	01.08.22	08.08.22	15.08.22	22.08.22	29.08.22	05.09.22
Midwives										
Establishment	191.69	191.69	191.69	191.69	191.69	191.69	191.69	191.69	191.69	191.69
Currently not in post	28.09	28.09	29.36	29.36	31.55	31.55	30.41	29.41	28.01	28.81
LTS	4.68	4.68	4.68	5.68	4.88	5.84	6.84	6.84	6.84	6.84
Mat leave*	12.27	13.27	13.63	13.63	13.63	13.63	13.63	13.63	12.63	13.59
Covid self isolation/sick	5.19	4.2	4.31	3.55	2.49	0.96	0	0.96	3.25	1.49
>28 wks pregnant	0	0	0	0	0	0	0	0	0	0
ECV - WFH	0	0	0	0.96	1.92	1.92	1.92	1.92	1.92	0
Career break	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91
Total off (WTE)	51.14	51.15	52.89	54.09	55.38	54.81	53.71	53.67	53.56	51.64
Total off (%)	26.68	26.68	27.59	28.22	28.89	28.59	28.02	28.00	27.94	26.94

Issues, Concerns & Gaps:

- Ensure that we deliver the required support and wellbeing to support new starters and international midwives through their preceptorship period
- National challenges with available number of midwives to recruit to and to therefore maintain a fully established workforce.

Key Messages:

- From August 2022 to December 2022 there will be 22.72 WTE new post registration midwives (Band 5) starting at MFT as well as 3.08 WTE experienced Band 6 midwives.
- The care group have maintained a rolling recruitment to utilise every opportunity to maintain staffing levels and use open days, attendances at universities and social media to recruit to vacant posts and involved in international recruitment.
- Exit interviews to be held by retention midwife to support thematic analysis of leavers.
- Band 8a Education Team Lead interim recruited to (9th September) with substantive interviews due to take place 28th September 2022. Role will have responsibility for strategic overview of recruitment and retention.

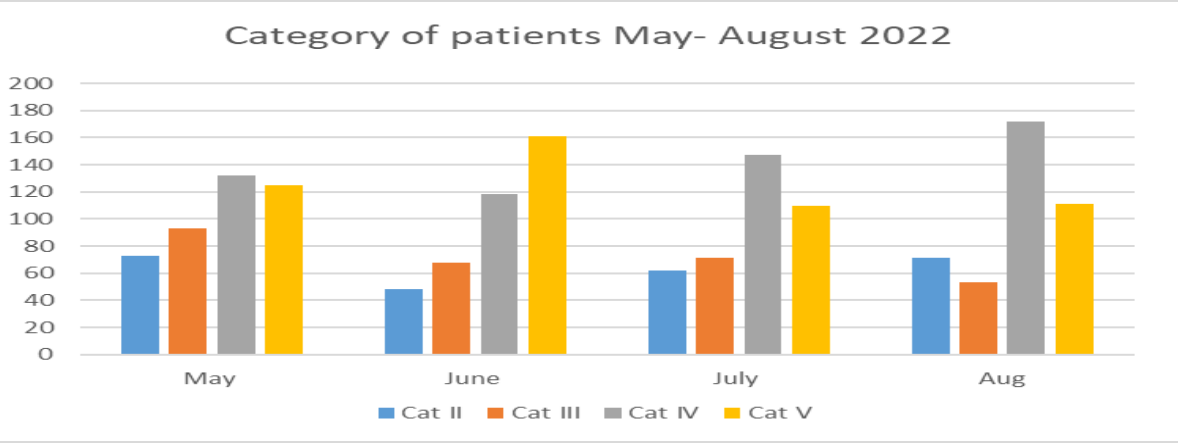
Actions & Improvements:

- Recruit to 18 month Midwifery programme for qualified nurses with HEE funding.
- Retention midwife in place until March 2023, to ensure that newly qualified midwives are fully supported and assist the unit to retain both post registration and experienced midwives.
- MFT are working with the LMNS on a collaborative bid for international recruitment Currently we have not recruited any midwives through the LMNS collaborative bid however we have carried out our own international recruitment where we have appointed 3 midwives.
- Consultant Midwife to be interviewed 30th September 2022.
- Opportunities for staff learning and development are being undertaken with a focus on wellbeing

True North: People
Birthrate Plus Acuity Tool (Delivery Suite)

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme



NB Category II are low complexity women, rising to category V for those that require a very high level of support and care.

Key Messages:

- Birthrate Plus is the only national tool currently available for calculating midwifery safe staffing levels
- The four hourly acuity tool is completed by the delivery suite coordinator to enable real time data on activity, acuity and safe staffing to be captured over a twenty four hour period. It calculates the complexity of cases on delivery suite versus the number of midwives available to provide care.
- Shortfalls are escalated as per the maternity escalation policy.
- Through four hourly acuity reporting it is evident that the majority of women on delivery suite are in the higher risk groups therefore requiring intensive care for longer periods of time in labour and the early post-natal period.
- The NICE quality statement for intrapartum one-to-one care in labour supports improved outcomes for families. Despite the challenges faced within the care group this metric has sat at 100% compliance consistently and is monitored via the maternity dashboard

Issues, Concerns & Gaps:

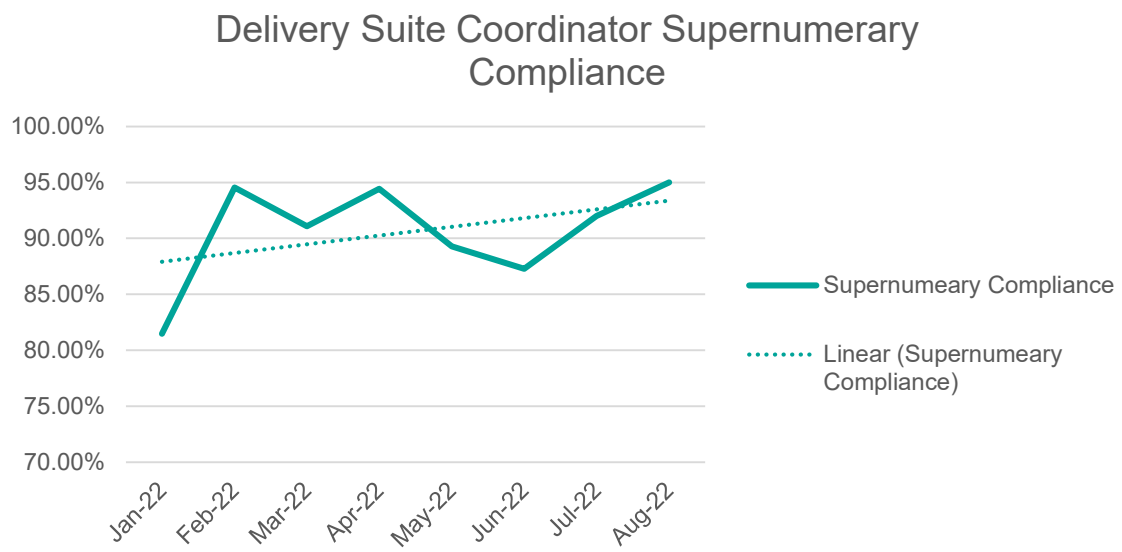
- Staff are moved from other areas to mitigate against the risk of staffing shortfalls however this can create red flags in other areas.
- Induction of labour has been significantly delayed. These delays have been due to significant staffing gaps created by staff absences and vacancy which means staffing on delivery suite is aligned to provision of one- to-one care in labour and the elective caesarean pathway as a priority, and therefore impacts on women awaiting induction of labour.

Actions & Improvements:

- The new web-based Birthrate Plus acuity tool was purchased and implemented by the Trust in March 2022.
- We monitor compliance to completing acuity tool to ensure robust data.
- The tool will further be rolled out in 2023 on the antenatal and postnatal wards supporting proactive assessment of women on the ward and matching them against the staff available.

True North: People
Delivery Suite Co-ordinator supernumerary status

Ambition: To ensure supernumerary status of the delivery suite co-ordinator.
Goal: To monitor compliance of supernumerary status and ensure there is an action plan in place of how the maternity service intends to achieve this .



Key Messages:

- A Delivery suite coordinator being supernumerary 100% of the time is a core element of achieving CNST Safety Action 5.
- The twice daily bed state in place reports the supernumerary status of the delivery suite co-ordinator to ensure Matrons, HOM and DOMs have oversight of any episodes that they have not been supernumerary to enable escalation and support.
- Supernumerary status is also captured via Birthrate Plus Acuity Tool.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status, this is escalated to the Midwifery Manager on call. Mitigation action is then taken to address the issue and the corresponding Red Flag is uploaded to the Birthrate Plus acuity tool.
- Auditing shows that Delivery Suite Coordinators cite the main reasons for inability to maintain supernumerary status is due to staff shortages, high acuity requiring them to carry out early labour assessments and care for labouring women for a short period of time, until requested staff members are redeployed in order to maintain one-to-one care in labour.

Actions & Improvements:

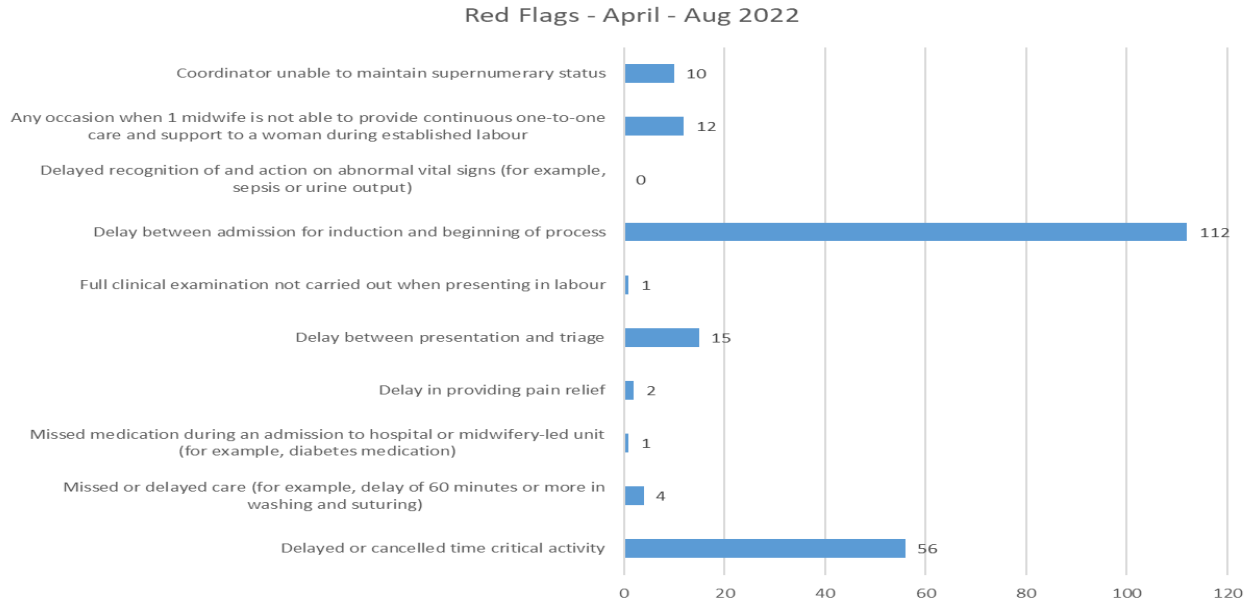
- To support mitigation of shortfalls the Trust has supported enhanced bank rates within maternity which is still in place which has had minimal positive impact due to bank staff being predominantly substantive staff.
- An action plan has been developed to mitigate and resolve the deteriorated position of supernumerary status inline with CNST recommendations.
- Monitor compliance to completion of bedstate and Birthrate Plus acuity tool to achieve robust data.

Issues, Concerns & Gaps:

- MFT are not currently achieving delivery suite coordinator supernumerary status 100% of the time. (95% for August – 3 instances) (92% for July – 4 instances)
- If delivery suite coordinator is not supernumerary they are unable to maintain effective oversight of acuity and activity across the unit.

True North: People
NICE Red Flags

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



Key Messages:

- The National Institute for Health and Care Excellent (NICE NG4) have drawn up a list of 'Red Flag Events' for maternity units. In order to comply with national recommendations, maternity units need to demonstrate compliance regarding red flag monitoring and management.
- The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) also requires ongoing audit of maternity red flags.
- Red flags are recorded on the live Birthrate plus acuity tool rather than the previous method of recording on a spreadsheet. The current method captures delivery suite red flags only but will incorporate the antenatal ward red flags once we implement the ward element of the live app.
- A "red flag" audit has been completed for the period 1 April 2022 to 31 July 2022.
- In the period 1 April 2022 to 31 August 2022 there were 213 red flags recorded.

Issues, Concerns & Gaps:

- The highest number of red flags related to induction of labour (IOL) delays, totalling 53% of all red flags. Staff shortages across the unit have meant that women have been experiencing long delays in being able to be transferred to the delivery suite to progress their IOL.
- 7% of red flags related to women having a delay between arriving on the on the unit and being see in obstetric triage.
- Data shows 6% red flags related to inability for 1 midwife to be able to provide continuous one-to-one care and support to a woman during established labour. However, more established data demonstrates 100% compliance with 1:1 care in labour. Deep dive into staff understanding of this red flag to discern whether this reporting is accurate and robust.

Actions & Improvements:

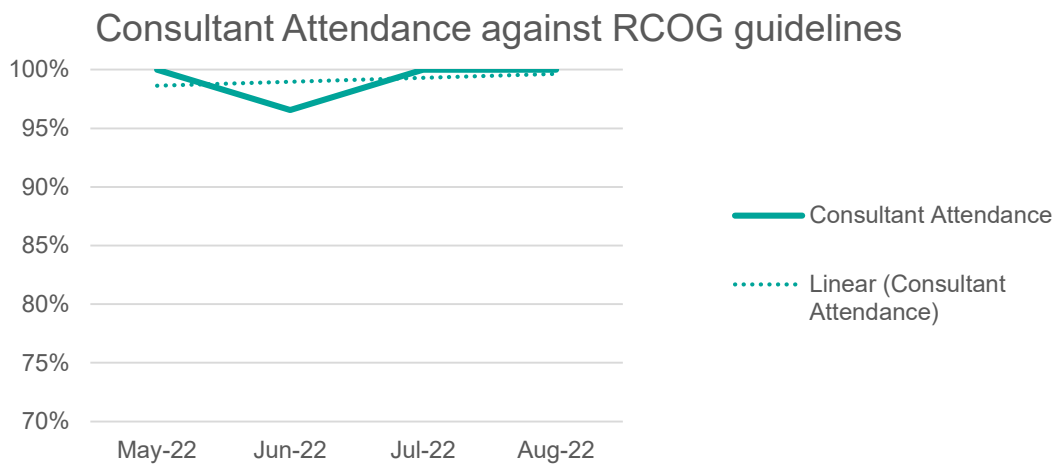
- An IOL Quality improvement Project has been commenced to review IOL pathway and delays.
- Maintain recruitment trajectory to reach full staffing establishment which will enable a reduction of red flags relating to the IOL pathway.
- An action plan to be developed to ensure appropriate escalation and monitoring of red flags inline with revised escalation guidance, with actions set to reduce and resolve red flags, which will include the highlighted issue of delay in review in obstetric triage.
- Deep dive into staff understanding of 1:1 care in labour red flag to discern whether this reporting is accurate and robust, benchmarked against the established data recording method which demonstrates 100% compliance.

True North: People

Clinical Workforce

Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care

Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard



Key Messages:

- Obstetric rota enhanced and SOP in place to support compliance with RCOG guidance for Obstetric Consultant roles and responsibilities.
- Audit of consultant attendance commenced ahead of 29 July 2022 deadline. 100% compliance for July 2022 and August. 1 occasion in June where consultant provided phone advice rather than attended in person.
- NICU junior medical staffing compliant with BAPM requirements.
- NICU Nursing staff <70% Qualified in Speciality (QIS) due to increase in QIS (funded by HEE) establishment by 16 WTE.
- NICU nursing staffing anticipating 64.52% Qualified in Speciality (QIS) by end of August 2022. 5 new nurses due to commence course in September – Action plan in place.
- Anaesthetic obstetric rota supports 24/7 anaesthetic availability for obstetric patients with clear lines of communication to a supervising anaesthetic consultant at all times.

Issues, Concerns & Gaps:

- Revised bed state to improve consultant attendance audit data recording. Also collecting data on consultant ward rounds.
- Working with clinical effectiveness team to capture bed state audit via Gthr.
- Current audit does not capture patient level detail or allow outcomes or themes to be easily monitored.
- NICU nursing workforce currently below 70% QIS requirement.

Actions & Improvements:

- Working with LMNS colleagues to consider adding workflow to Maternity information system to allow patient level audit directly from EuroKing which will support enhanced audit, improved data and allow outcomes and learning to be monitored.
- Ongoing audit and monitoring at local level as well as presenting to Trust Board as per CNST requirements.
- Action plan to address shortfall of NICU Nursing QIS requirement in place. 5 staff due to commence course in September 2022.

True North: People

Table top internal Birthrate Plus Review June 2022
Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

Medway NHS Foundation Trust

MEDWAY NHS TRUST

				Total births in service		4821	
CASEMIX	Cat I	Cat II	Cat III	Cat IV	Cat V		
DS Casemix	4.9	13.6	17.3	27.1	37.1		
Generic Casemix							
						Required WTE	
Delivery Suite				No.			
Delivery Suite Births				4688		63.45	63.45
Other DS Activity				No. Episodes of care	Hours		
Category X				3722	1.0	2.37	8.16
Category A1				678	4.0	1.72	
Category A2				441	7.0	1.96	
category R				293	6.0	1.12	
Escorted Transfers OUT				0	4.0	0.000	
Non-viables				100	15.5	0.99	
Alongside Midwife Unit							
Births				0			1.39
Unplanned Attenders				2190		1.39	
Additional PN Cases				Counted in PN care			
Transfers to D/S					within DVS wte		
Maternity Ward(s)							
Antenatal Care				No.			
Antenatal admissions				1428		4.54	6.58
Inductions				1283		2.04	
Postnatal Care				No.			
Postnatal women				4688		33.62	40.32
Postnatal Re-admissions				55		0.21	
Transitional Care Babies				500		3.50	
MAC babies				252		1.76	
NIPE				2578		1.23	
OUTPATIENT SERVICES							
Antenatal Clinics					Weekly hrs		
Antenatal Clinics					51.0	1.69	16.23
Fetal medicine						4.16	
Maternity Care Unit				8161	2.0	10.38	
COMMUNITY SERVICES							
				No.			
Home Births				133		1.44	57.30
Home birth NIPE				133		0.08	
Community Cases (full AN & PN Care)				4443		48.91	
Community Bookings ONLY				517		0.66	
Team Connect additional care				213		6.21	
						193.43	
CLINICAL MIDWIFERY WTE REQUIRED							193.43

The BR+ method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles and skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff. The table below outlines the comparison of Birthrate Plus® results for qualified midwives with current funded establishments based on the data reviewed.

The birthrate plus calculation takes into account the acuity of the women who access care at Medway NHS Trust. The highest proportion of women who receive care on the Delivery suite are in categories iv and v and therefore take up more midwifery hours than low risk women.

A comparison of staffing requirements from tabletop review vs current funded budget and midwife to birth ratio.

	WTE (qualified midwives)	**Ratio for 1:4821 women***
BR+ Internal Review June 2022	193.43	1:25
Budget	191.69	1:25

* Calculated as a prediction based on numbers of births in Q1 22/23 x by 4 for a full year

Internal Birthrate Plus review- Continued

Medway NHS Foundation Trust

Key Messages:

- The Ockenden Review sets a requirement for all NHS Trusts to provide assurance of maternity safe staffing.
- CNST requires annual review of maternity safe staffing with 6 monthly reporting to Trust Board.
- The Trust board supported investment of an additional 5.9 WTE Band 6 Midwives and 8 WTE Midwifery leadership and specialist roles in 2021.
- A maternity workforce gap analysis has been undertaken at MFT in June 2022 utilising Birthrate Plus methodology.
- The table top review maintained a requirement for a 1:25 ratio, which for 4821 births demonstrated a requirement for 193.61 WTE qualified staff to provide safe maternity care.
- 4821 births are calculated as a prediction based on numbers of births in Q1 22/23 x by 4 for a full year
- Current funded budget for midwifery staff is 191.69, a difference of 1.74 WTE from the table top review.
- Currently YTD actual working birth ratio is 1:31.

Issues, Concerns & Gaps:

- MFT is currently funded at a midwife to birth ratio of 1:25. Our actual worked ratio has been consistently below 1:25 in 2022 due to high staffing absence and vacancy.
- Current funded budget for midwifery staff is 191.69, a difference of 1.74 WTE from the table top review. This equates to a minimal difference and is based on an estimation from a predicted annual birth rate from Q1 data, therefore it is not felt that there is a major impact to safe staffing at this point.
- The maternity service currently has a 22% uplift to cover sickness and education. In view of the additional training requirements within maternity an uplift of 25% should be considered for future workforce reviews and planning.
- The annual turnover in maternity has increased from 7% in 2021/2022 to 9.03% currently and has been impacted by the number of midwives who have retired, impact of Covid and with nationally recognised burnout.

Actions & Improvements:

- Service is not currently requesting additional funding for midwifery staffing at this point, but will monitor the number of births against midwifery ratio to ensure safe staffing ratios are maintained alongside any increase in activity and escalate where required.
- A formal external Birthrate Plus audit is required in 2023 in line with guidance to undertake 3 yearly.
- PID to commission external Birthrate Plus review will be completed in October 2022 and taken through the appropriate governance processes for approval.
- Mapping of staffing age profile and exit interviews, with robust data is essential for longer term workforce planning. Care Group will work with HR business partners on data collection and review within Divisional Governance meetings.
- Service requires support and approval going forwards to agree an uplift to 25% to cover mandatory training and staff absence.

Next Steps

- Request report to be approved by QPSCC and QAC for Board Presentation in October 2022 to ensure compliance with CNST reporting requirements.
- Complete PID in October 2022 to request funding to commission full external Birthrate Plus Audit in 2023.
- Ongoing Divisional review and oversight of identified actions through governance with return to Trust Board at earliest April 2023.
- Service requires support and approval going forwards to agree an uplift to 25% to cover mandatory training and staff absence.

Meeting of the Board of Directors in Public
Wednesday, 05 October 2022

Title of Report	**Finance Report – Month 5**	Agenda Item	**6.1**
Lead Director	Alan Davies, Chief Finance Officer		
Report Author	Alan Davies, Chief Finance Officer Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director Income and Contracts Isla Fraser, Financial Controller		
Executive Summary	In month, the Trust reports a £1.2m deficit, this is £1.0m adverse to the June NHSE/I plan submission.		
Due Diligence	To give the Committee assurance, please complete the following:		
Executive Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	Use of resources as presented.		
Legal Implications/ Regulatory Requirements	None		
Quality Impact Assessment	Resources are not being starved to front line provision		
Recommendation/ Actions required	The Committee is asked to note this report.		

Approval ☐	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Noted on report cover page		

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

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Finance report

For the period ending 31 August 2022

Contents

1. Executive summary

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£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(211)	(1,191)	(980)	The Trust reports a £1,191k deficit position for August; reducing to £1,182k after making the technical adjustments for donated assets, this being £985k adverse to the submitted plan. The reported position includes Elective Services Recovery Funding (ESRF) income of £4.1m year to date; ESRF activity plans continue to not fully achieve however there is not be a requirement to repay ESRF income in H1. An assessment of goods received not invoiced (GRNI) accruals relating to previous years has released £1.5m into the position as an estimate of those accruals no longer needed. The non-recurrent benefit from general accruals released into the position year to date totals £7.0m. A further report on the financial risks is being presented to the September committee; this will address in more detail the root causes of overspending and implementing additional controls as one of the corporate objectives.
Donated Asset Depreciation	13	8	(5)	
Control Total	**(198)**	**(1,182)**	**(985)**	
Efficiencies Programme				
In-month	978	705	(272)	The delivered efficiency programme position of £2.6m includes £1.8m of the approved cross cutting themes and £0.2m full year effect of schemes continuing from 2021/22. The remaining efficiencies continue to be predominantly from the Corporate functions £0.2m as well as Facilities and Estates £0.3m.
YTD	3,237	2, 630	(607)	
Capital				
In-month		611	(459)	The Trust Capital Resource Limit (CRL) and plan has been set at £11,550k, to be funded from system capital, depreciation (£10,970k) and PDC (£580k). Since M4 a further £13,007k of PDC funding is in the pipeline mainly for diagnostic equipment, endoscopy expansion and EPR. This funding is highly likely but MOU's are yet to be issued as final confirmation. A detailed and prioritised capital plan for the £10,970k was agreed at the start of September along with approval for the PDC funding streams. The request from the operational and clinical teams was approx. £5m in excess of the funding available; this value of schemes of lower priority designation has therefore been deferred to future years or until further funding becomes available.
YTD	3,068	2,338	(730)	
System Annual	10,970	10,970	-	
Total Annual	11,550	24,659	13,109	
Cash				
Month end	32,892	41,067	8,175	The Trust cash balance is £8,175k higher than plan due to the implementation of cash maximisation strategy, which mainly involves reverting to paying HMRC, NHS Pensions and suppliers on contractual terms. During periods of excess cash and then mandated throughout COVID, these were paid as soon as invoices were approved and/or the cash was available.

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

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	27,846	27,622	(225)	139,231	139,619	388
High cost drugs	1,888	2,405	517	9,439	9,982	543
Other income	2,460	2,592	132	12,300	12,193	(107)
PSF/MRET/FRP	-	-	-	-	-	-
Donated Asset Adjustment	-	-	-	-	4	4
Total income	**32,194**	**32,619**	**425**	**160,970**	**161,797**	**827**
Nursing	(8,452)	(8,633)	(181)	(42,159)	(42,729)	(570)
Medical	(6,691)	(7,310)	(619)	(32,881)	(34,500)	(1,619)
Other	(5,280)	(5,967)	(688)	(27,353)	(25,260)	2,092
Total pay	**(20,422)**	**(21,910)**	**(1,488)**	**(102,392)**	**(102,489)**	**(97)**
Clinical supplies	(4,052)	(4,176)	(125)	(20,258)	(20,492)	(235)
Drugs	(632)	(1,099)	(467)	(3,160)	(4,899)	(1,739)
High cost drugs	(1,888)	(2,127)	(239)	(9,439)	(10,011)	(572)
Other	(3,538)	(2,628)	910	(18,195)	(17,323)	872
Total non-pay	**(10,109)**	**(10,029)**	**80**	**(51,052)**	**(52,725)**	**(1,673)**
EBITDA	**1,663**	**679**	**(984)**	**7,526**	**6,584**	**(942)**
Depreciation	(1,253)	(1,298)	(45)	(6,265)	(6,472)	(207)
Donated asset adjustment	(13)	(8)	5	(67)	(62)	5
Net finance income/(cost)	0	46	46	(3)	160	163
PDC dividend	(608)	(610)	(2)	(3,040)	(3,040)	0
Non-operating exp.	**(1,874)**	**(1,870)**	**4**	**(9,375)**	**(9,414)**	**(39)**
Reported surplus/(deficit)	**(211)**	**(1,191)**	**(980)**	**(1,849)**	**(2,830)**	**(981)**
Adj. to control total	13	8	(5)	67	62	(5)
Control total	**(198)**	**(1,182)**	**(985)**	**(1,782)**	**(2,768)**	**(986)**

1. Funding arrangements for the full year 2022/23 were agreed with the Kent & Medway CCG and included in the June plan submission.
2. Other income includes recharges for pass through clinical supplies costs and drugs, these costs are recorded in the relevant non-pay category. Also included are the NHS provider to provider contracts, car parking income, F&E retail income and medical education contribution to overheads.
3. The ESRF income year to date is included at £4.1m with an associated cost to the independent sector healthcare providers of £1.4m. The risk of the 75% clawback due to under performance against activity is being covered by NHSE/I and the ICB in H1.
4. Pay budgets are £0.1m adverse to plan YTD, however this includes £4.5m benefit from the non-recurrent release of accruals.
5. The nursing and medical pay categories are reporting a deficit position due to continuing premium costs for junior doctor to cover vacancies within the medical rota, sickness absence cover, maternity leave, reducing unfilled shifts, escalation capacity, nurse specialling, and the supernumerary costs from international nurse recruitment. There are reductions in the budget this month reflecting efficiency targets, however these are not delivering, mainly in outpatient clinics £0.1m and theatres utilisation £0.2m, as well as the closure of Jade ward £0.3m as part of the length of stay efficiency programme.
6. The length of stay efficiency scheme to close Nelson Ward has been delivered, however staff have been redeployed to vacant posts as well as utilised to reduce the number of unfilled shifts across the inpatient areas. The closure of Jade Ward is not on plan and impacting the budgets by £0.3m YTD.
7. Covid costs have increased slightly in month by £0.1m to £0.3m.

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3. SLA Activity and Income

	Planned care				Unplanned & Integrated Care				Totals			
POD Group	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s
A&E	-	-	-	-	16,635	7,262	7,931	668	16,635	7,262	7,931	668
Adult Critical Care	9,910	4,129	4,170	41	-	-	-	-	9,910	4,129	4,170	41
Block Contracts	1,704	707	707	-	1,365	567	567	-	3,069	1,274	1,274	-
Chemotherapy	2,022	803	873	70	1	0	50	50	2,023	803	923	119
CQUIN	-	-	-	-	-	-	-	-	3,339	1,400	1,330	(71)
Day Cases	15,025	6,427	5,752	(676)	7,896	3,436	2,577	(859)	22,921	9,864	8,329	(1,534)
Direct Access	1,288	567	244	(322)	8,507	3,612	4,548	936	9,796	4,179	4,792	614
Elective Inpatient	20,356	9,173	7,241	(1,932)	897	421	277	(144)	21,253	9,594	7,517	(2,077)
Excess Bed Days	1,257	524	467	(57)	2,165	730	1,574	844	3,422	1,254	2,041	787
Excluded Devices	428	178	97	(81)	1,742	763	711	(52)	2,170	940	808	(132)
HCD	6,571	2,557	2,684	128	16,082	6,592	7,297	705	22,653	9,149	9,982	832
Maternity Pathway	11,059	4,502	4,859	356	-	-	-	-	11,059	4,502	4,859	356
Neonatal Critical Care	10,194	4,170	5,003	834	-	-	-	-	10,194	4,170	5,003	834
Non Elective Inpatient	56,124	23,698	23,546	(151)	61,557	25,161	21,378	(3,782)	117,683	48,861	44,925	(3,936)
Other cost per case	2,712	1,167	1,059	(108)	1,349	559	352	(207)	4,061	1,726	1,411	(315)
Outpatients	27,252	11,164	11,762	598	23,214	9,714	8,064	(1,650)	50,466	20,878	19,826	(1,053)
Paediatric Critical Care	656	187	59	(128)	-	-	-	-	656	187	59	(128)
	166,559	69,953	68,523	(1,429)	141,409	58,818	55,326	(3,492)	311,310	130,173	125,179	(4,994)
Cancer Drug Fund									(1,675)	(807)	(647)	159
Block Adjustment K&M ICB									48,403	17,367	24,143	6,777
Block Adjustment SEL ICB									(20)	(51)	(141)	(90)
Block Adjustment Spec Comm									34	182	(82)	(264)
Block Adjustment NHSE Other									932	432	71	(362)
Block Adjustment LVA									(887)	(452)	(1,678)	(1,226)
Total Block Adjustments	-	-	-	-	-	-	-	-	46,787	16,672	21,666	4,994
Total Block Income	166,559	69,953	68,523	(1,429)	141,409	58,818	55,326	(3,492)	358,097	146,845	146,845	(0)

Providers continue to be funded on block contracts for 22/23 for most services except for elective patient care which is funded using the national tariff as part of the Elective Services Recovery Fund (ESRF).

The table sets out the income and activity performance for the Trust at point of delivery (POD) as at month 5.

- In 22/23 all clinical income has been devolved to divisions based on activity plans priced at national tariff (or local prices in the absence of a national tariff).
- Elective and Outpatient activity has been set to achieve the 104% of 19/20 value based on activity required to deliver ESRF.
- For Non-Elective, income plans are based on achieving 103% of activity the trust delivered in 19/20 priced at national tariff.
- All other PODs are based on delivering activity the trust delivered in 19/20.
- The differences between the value of income plans and actuals using national tariff compared to block funding is reported in central.
- The table shows that MFT has got a benefit of £46.8m in its annual budget if delivered the activity

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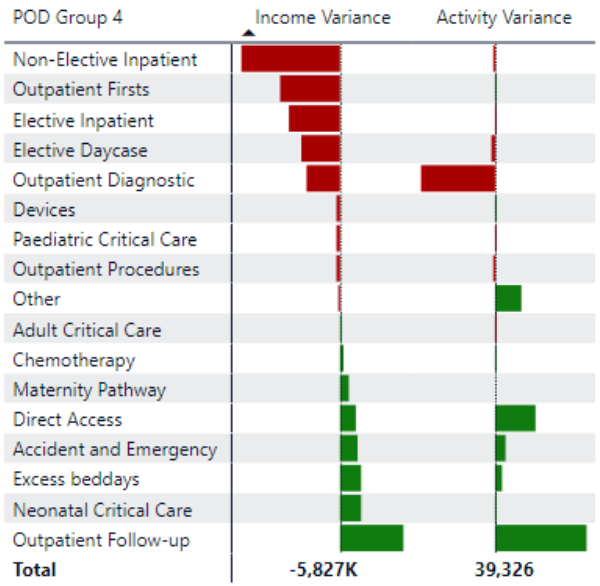
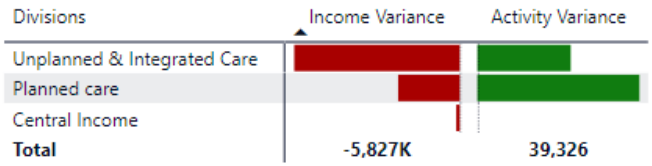
M5 Income and activity by POD (excl. HCD)

The estimated value of the underperformance in M5 for the SLA income based on national tariff is £5.8m YTD (excluding high cost drugs).



POD Group 4	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Non-Elective Inpatient	£48,692K	£44,714K	-3,978K	21189	19629	-1,560
Outpatient Firsts	£8,737K	£6,299K	-2,438K	41867	42333	466
Elective Inpatient	£9,594K	£7,517K	-2,077K	2337	1949	-388
Elective Daycase	£9,864K	£8,329K	-1,534K	11575	9692	-1,883
Outpatient Diagnostic	£3,390K	£2,042K	-1,348K	53312	20201	-33,111
Devices	£940K	£808K	-132K	30469	31084	615
Paediatric Critical Care	£187K	£59K	-128K	260	82	-178
Outpatient Procedures	£3,433K	£3,312K	-121K	17621	16251	-1,370
Other	£5,107K	£5,026K	-81K	32110	43517	11,407
Adult Critical Care	£4,129K	£4,170K	41K	3891	3583	-308
Chemotherapy	£803K	£923K	119K	5417	6004	587
Maternity Pathway	£3,883K	£4,222K	339K	2182	2161	-21
Direct Access	£4,179K	£4,792K	614K	1029298	1046787	17,489
Accident and Emergency	£7,262K	£7,931K	668K	37757	41854	4,097
Excess beddays	£1,423K	£2,252K	829K	4413	7100	2,687
Neonatal Critical Care	£4,170K	£5,003K	834K	4437	4875	438
Outpatient Follow-up	£5,231K	£7,797K	2,567K	50323	90680	40,357
Total	**£121,024K**	**£115,197K**	**-5,827K**	**1348456**	**1387782**	**39,326**



Divisions	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Unplanned & Integrated Care	£52,225K	£48,028K	-4,197K	1211457	1225769	14,311
Planned care	£67,396K	£65,839K	-1,557K	136994	162013	25,020
Central Income	£1,403K	£1,330K	-73K	5	0	-5
Total	**£121,024K**	**£115,197K**	**-5,827K**	**1348456**	**1387782**	**39,326**

Inpatient activity is driving the underperformance because services have not recovered to pre-pandemic activity levels of 19/20.

- The main underperformance is within elective, day cases, non-elective inpatients and outpatient first attendances.
- Non-elective is driven mainly by Stroke inpatient activity (£1m). Stroke services have moved to MTW and DVH but the activity and income remains within the budgets for MFT. The funding is covering costs in other areas, work will be done with commissioners to reallocate this funding to other services.
- Elective inpatients and day cases are £3.5m below plan and was mainly driven reduced surgical activity due to the lack of anaesthetists.
- Outpatient's income for first attendances is below plan of £2.4m YTD mainly driven by low activity in General Medicine and ENT.

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- Outpatient's income for follow up attendances is significantly above plan of £2.6m YTD mainly driven by high virtual activity in General Medicine. Coding for some of the FUP activity is being investigated and will be coded as Firsts for future months.
- Adult critical care bed days are above plan and creating a gain of £41k YTD.
- Chemotherapy treatments are above the activity and financial plan of £119k YTD.
- Neonatal cot days are above plan and resulting in a favourable income of £834k YTD.
- The underperformance is mainly offset by the over performance in outpatient follow-up. Unfortunately outpatient follow-up income is capped at 85% of the 2019/20 activity levels.

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Elective Services Recovery Fund (ESRF)

For 22/23 ESRF achievement will based on delivering 104% in value of 19/20 activity. Over performance above this threshold will be paid at 75%, underperformance will be deducted at 75% (although suspended in H1). All elective activity has been valued at 22/23 tariff (except OP Follow up which is fixed at 85% of the 19/20 baseline) as per the ESRF rules. Outpatient follow up activity is expected to reduce by 25% of 19/20 levels in 22/23

The table below shows the ESRF baseline provided by NHSE/I by month and POD and the actual performance for months 1 to 5.

Threshold at 104%

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,751	1,854	1,773	1,781	1,798	1,827	1,728	2,010	1,697	1,793	1,877	2,151	**22,038**
Elective Inpatient	1,705	1,840	1,852	1,728	1,704	1,716	1,489	1,866	1,472	1,475	1,836	2,203	**20,886**
OPFA	1,287	1,401	1,398	1,472	1,333	1,472	1,346	1,395	1,255	1,338	1,475	1,686	**16,858**
OPPROC	720	768	719	724	722	810	727	829	743	785	770	880	**9,196**
OPFU	1,254	1,347	1,280	1,282	1,252	1,374	1,308	1,424	1,139	1,366	1,251	1,429	**15,706**
Total	**6,716**	**7,210**	**7,021**	**6,988**	**6,808**	**7,200**	**6,597**	**7,523**	**6,305**	**6,758**	**7,210**	**8,349**	**84,684**

Actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,519	1,770	1,778	1,815	1,430								**8,312**
Elective Inpatient	1,520	1,662	1,572	1,558	1,279								**7,591**
OPFA	1,130	1,385	1,280	1,253	1,251								**6,299**
OPPROC	551	692	705	697	621								**3,266**
OPFU (fixed block)	1,025	1,101	1,046	1,048	1,023								**5,243**
OPFU actuals	1,531	1,830	1,647	1,439	1,351								**7,797**
Total	**6,252**	**7,339**	**6,982**	**6,761**	**5,932**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**33,266**
FUP activity not paid	(506)	(729)	(601)	(391)	(328)	-	-	-	-	-	-	-	(2,554)
Over/Underperfomance	(970)	(599)	(640)	(617)	(1,204)								(4,031)
RISK/ERF	**(728)**	**(449)**	**(480)**	**(463)**	**(903)**								(3,023)

At Month 5 the trust underperformed against the ESRF target by £4m. The financial risk of this is to the Trust is £3m, this being 75% of the underperformance. This has not been reflected in the financial position at M5 because it is been covered by NHSE/I and the ICB for the first half of the year

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The table below provides the performance in terms of activity achieved in M1 to M5 compared to the activity that plan the trust has set to achieve ESRF.

19-20 activity actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	2,203	2,236	2,139	2,283	2,031	2,015	2,200	2,225	2,050	2,234	2,132	1,744	**25,492**
Elective Inpatient	442	458	482	496	423	415	429	433	402	390	434	284	**5,088**
OPFA	5,744	5,880	5,846	6,730	5,277	5,956	6,291	5,678	5,330	5,882	5,922	4,930	**69,466**
OPPROC	3,784	3,895	3,646	4,068	3,387	3,844	3,962	4,006	3,634	4,165	3,849	2,973	**45,213**
OPFU	11,305	11,570	11,043	12,186	10,213	11,316	12,245	11,657	9,894	12,214	10,588	9,003	**133,234**
Totals	**23,478**	**24,039**	**23,156**	**25,763**	**21,331**	**23,546**	**25,127**	**23,999**	**21,310**	**24,885**	**22,925**	**18,934**	**278,493**

22-23 activity plan

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

22-23 activity actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,791	2,048	1,963	2,083	1,694	-	-	-	-	-	-	-	**9,579**
Elective Inpatient	447	476	465	425	363	-	-	-	-	-	-	-	**2,176**
OPFA	5,491	6,587	6,189	6,211	6,270	-	-	-	-	-	-	-	**30,748**
OPPROC	2,764	3,356	3,490	3,414	3,070	-	-	-	-	-	-	-	**16,094**
OPFU actuals	14,693	17,255	15,511	13,673	13,095	-	-	-	-	-	-	-	**74,227**
Totals	**25,186**	**29,722**	**27,618**	**25,806**	**24,492**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**132,824**

75% of 19-20 FUP	8,479	8,678	8,282	9,140	7,660	8,487	9,184	8,743	7,421	9,161	7,941	6,752	99,926
Excess OP FUP	(6,214)	(8,578)	(7,229)	(4,534)	(5,435)								(31,989)

Performance % against the Trust plan

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	78%	88%	88%	88%	81%	-	-	-	-	-	-	-	**85%**
Elective Inpatient	99%	102%	95%	85%	84%	-	-	-	-	-	-	-	**93%**
OPFA	65%	77%	73%	73%	74%	-	-	-	-	-	-	-	**72%**
OPPROC	78%	94%	98%	96%	86%	-	-	-	-	-	-	-	**90%**
OPFU actuals	126%	164%	140%	112%	128%	-	-	-	-	-	-	-	**134%**

Activity is below plan for all Pods within the scope for ESRF, which includes Day cases, Elective inpatients, Outpatient first attendances and Outpatient procedures. The average activity for M5 YTD for Day cases is 85% and 93% for elective inpatients of the trust plan set to achieve ESRF. This level of performance is below the average achieved last year for day cases and an improvement in elective inpatients. This is because Sunderland ward is yet to be converted to a day case suite which is required to increase day case activity. This is currently being worked on.

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Outpatient first attendances and Outpatient procedures are below plan having achieved 72% and 90% of the activity plan. This is because divisions are seeing a lot more follow up appointments because they make the majority of the waiting list because priority was given to first attendances during the covid pandemic.

Outpatient follow up attendances are significantly above plan at 134% of the plan at Month 5. Payment for this activity is fixed at 85% of 19-20 values and the excess activity will not be paid for and do not count towards the ESRF target.

Discussions are currently on going to improve performance on ESRF with weekly monitoring of activity and by-weekly performance review meetings now in place. Some of the key actions from the last ERF meeting included a review of the templates that the services use to schedule patients for clinics in order to increase the Out patients first attendances and reduce the follow ups. This would increase ESRF income because Follow attendances paid on block is in line with the national expectation to reduce follow up attendances over the next three years.

There were actions from the ESRF meeting to review the coding for Follow up activity within General medicines. Attendances following an emergency spell have been coded as follow instead of first attendances. This will be corrected and should reduce the FUP and increase the firsts.

Part of the reason for underperformance on Outpatient procedures discussed in the ESRF meeting was missing procedure codes for Pain injections which is being investigated and a further action was to check that this is the only area affected and that we are not losing income in other OP Procedures.

In order to address the underperformance in elective inpatients, there was an action for BI to model the impact on ESRF income of converting Harvey ward to an elective inpatient ward. Progress on this will be reported back to the group at the next meeting.

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4. Efficiency programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Cross Cutting Schemes	Sub-total Identified	Over Identified / (Unidentified)	Plan Target	YTD Plan	YTD Delivery	Variance
Planned care	10	735	84	0	1,593	2,422	(1,203)	3,625	703	260	**(443)**
UIC	144	613	0	321	3,000	4,078	847	3,231	1,421	988	**(433)**
E&F	89	598	0	0	0	687	1	686	298	301	**2**
Corporate	42	540	0	0	156	738	115	623	271	238	**(32)**
Central	0	0	0	0	1,419	1,419	(47)	1,466	545	843	**299**
Sub Total	**284**	**2,486**	**84**	**321**	**6,168**	**9,343**	**(288)**	**9,631**	**3,238**	**2,630**	**(607)**
Stretch target 0.5%						**0**	**(851)**	**851**			
Total for 22/23	**284**	**2,486**	**84**	**321**	**6,168**	**9,343**	**(1,139)**	**10,482**	**3,238**	**2,630**	**(607)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**978**	**705**	**(272)**	**3,237**	**2,630**	**(607)**	**10,482**	**10,482**	**-**

Process

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

The total efficiencies target for the financial year is £9.6m with a further £0.9m stretch target to be found in the second half of the year. Of the £9.6m, £9.3m of schemes have been identified; £8.9m of schemes have been rated as green or blue (including cross cutting schemes signed off by the executive team). The remaining gap and stretch of £0.9m is being focused on by the operational services with a view to achieving the plan.

The delivered efficiency programme position of £2.6m includes £1.7m from 8 of the cross cutting schemes; in addition, corporate functions have delivered a total of £0.2m and F&E £0.3m. The main schemes contributing to the £0.6m undelivered position include Jade Ward length of stay cross cutting efficiency £0.3m, outpatients including virtual clinics £0.1m, and theatres redesign following the review with independent consultants £0.2m.

To date £9.3m of schemes have been identified, of these £0.4m remain as schemes rated as amber or red with further actions ongoing to move these to the deliverable stage.

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

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5. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
240,295	**Non-current assets**	**237,686**	**(2,609)**
5,996	Inventory	6,215	219
13,889	Trade and other receivables	15,504	1,615
33,455	Cash	41,067	7,612
53,340	**Current assets**	**62,786**	**9,446**
(136)	Borrowings	(1,032)	(896)
(28,147))	Trade and other payables	(35,041)	(6,894)
(2,116)	Other liabilities	(3,358)	(1,242)
(30,399)	**Current liabilities**	**(39,431)**	**(9,032)**
(2,025)	Borrowings	(2,657)	(632)
(1,248)	Other liabilities	(1,248)	0
(3,273)	**Non-current liabilities**	**(3,899)**	**(626)**
259,963	**Net assets employed**	**257,136**	**(2,827)**
461,656	Public dividend capital	461,656	0
(245,218)	Retained earnings	(247,045)	(2,827)
43,525	Revaluation reserve	43,525	0
259,963	**Total taxpayers' equity**	**257,136**	**(2,827)**

Key messages:

1. Receivables have increased by £1.6m
   The current balance represents approximately 48% of one month's average turnover (£32.2m).

2. Cash balances are higher due to the implementation of a cash maximisation strategy to generate increased bank interest income whilst bank interest rates are increasing and minimise PDC dividend payments.

   Annual PDC Dividend payments are calculated on the following basis;

   Opening Relevant Net Assets + Closing Relevant Net Assets*
   Divided by 2 (Average Relevant Net Assets)

   Less: Average daily available GBS balance
   Multiply by: PDC Dividend rate 3.5%

   **Relevant Net Assets = Net assets adjusted for donated asset balances and national AUC schemes as agreed with DH*

   So in simple terms to minimise PDC Dividends the Trust needs to
   - Minimise 'Relevant Net Asset Value'
   - Maximise daily GBS Cash balance

3. Payables have increased by £6.9m from the prior year which is linked to the cash maximisation strategy and one rates invoice for £1.8m which was delayed for payment.
   Current payables balance represents 110% of one month's average turnover.

4. Total Trust borrowings are £3.7m, £1.6m higher than the prior month. This is due to the implementation of IFRS16 which has resulted in adding a £1.6m liability for the right of use asset lease creditors.

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6. Capital

2022/23 Capital Plan

After a series of meetings throughout August and September the draft 5 year capital plan was fully re-prioritised, reviewed and challenged leading to full approval by the Executive team on 5th September as below;

Proposed Funding	Trust Programme	2022/23	2023/24	2024/25	2025/26	2026/27
Internally Funded	Backlog Maintenance	2,721	12,909	7,485	6,403	8,653
	Emergency Department	74	0	0	0	0
	Fire Urgency Works	2,100	4,725	4,625	4,400	3,900
	Information Technology	1,220	4,389	3,550	2,900	4,650
	Medical and Surgical Equipment Programme	1,482	6,671	4,733	4,092	0
	Routine Maintenance	435	2,510	2,000	1,930	1,800
	Service Developments	2,938	12,225	1,325	1,325	1,325
Internally Funded Total (Depreciation/System Capital Allocation		**10,970**	**43,429**	**23,718**	**21,050**	**20,328**
Externally funded	Medical and Surgical Equipment Programme	5,937	3,400	0	0	0
	Service Developments	5,000	36,886	0	0	0
	Information Technology	2,650	2,011	1,379	2,299	1,000
Externally Funded Total (PDC agreements pending)		**13,587**	**42,297**	**1,379**	**2,299**	**1,000**
Charity donations	Medical and Surgical Equipment Programme	102	0	0	0	0
Charity donations Total (Agreement Pending)		**102**	**0**	**0**	**0**	**0**
Grand Total		**24,659**	**85,726**	**25,097**	**23,349**	**21,328**
Expected funding Shortfall*			**32,429**	**12,718**	**10,050**	**9,328**
Total Funding Risk (Pending Funding + expected shortfall)		**13,189**	**74,726**	**14,097**	**12,349**	**10,328**

** Based on £11m funding being allocated after any topslicing - Est £5m short of depreciation*

The funding for future years has not yet been agreed with the system, so the plan approved and shared with the ICS is based on recognised need. Once funding levels are confirmed each year the plan will be reviewed and re-prioritised accordingly.

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2022/23 Capital Expenditure Update

£'000	In-month			Year To Date			Annual				Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	NHSI Plan	Revised Trust Plan	Forecast	Var on revised Trust plan	Internal	PDC	OTHER
Backlog Maintenance	223	151	(72)	44	548	504	2,954	2,675	2,675	0	2,675	0	0
Emergency Department	6	4	(2)	0	(441)	(441)	0	74	74	0	74	0	0
Fire Urgency Works	175	72	(103)	20	124	104	0	2,100	2,100	0	2,100	0	0
Information Technology	102	138	36	227	253	27	2,619	1,220	1,220	0	1,220	0	0
Medical and Surgical Equipment Programme	79	(19)	(98)	7	(14)	(21)	1,086	1,394	1,394	0	1,394	0	0
Routine Maintenance	36	(5)	(41)	0	(10)	(10)	500	435	435	0	435	0	0
Service Developments	256	61	(195)	2,771	78	(2,693)	3,811	3,072	3,072	0	3,072	0	0
Total System Capital	**877**	**402**	**(475)**	**3,068**	**537**	**(2,531)**	**10,970**	**10,970**	**10,970**	**0**	**10,970**	**0**	**0**
UTC	0	1	1	0	93	93	500	500	500	0		500	
Unspecified PDC Schemes	0	0	0	0	0	0	80	0	0	0		0	
Total Planned Additional Capital	**0**	**1**	**1**	**0**	**93**	**93**	**580**	**500**	**500**	**0**	**0**	**500**	**0**
Total Planned Capital	**877**	**403**	**(474)**	**3,068**	**630**	**(2,438)**	**11,550**	**11,470**	**11,470**	**0**	**10,970**	**500**	**0**
EPR	0	208	208	0	1,708	1,708	0	2,650	2,650	0	0	2,650	0
Ultrasound	0	0	0	0	0	0	0	90	90	0	0	90	0
PACS/RIS	0	0	0	0	0	0	0	342	342	0	0	342	0
Endoscopy	0	0	0	0	0	0	0	4,500	4,500	0	0	4,500	0
CDC brokerage CR Uprades	0	0	0	0	0	0	0	1,275	1,275	0	0	1,275	0
CDC brokerage - Mobile MRI	0	0	0	0	0	0	0	1,530	1,530	0	0	1,530	0
CDC brokerage - Injector pumps	0	0	0	0	0	0	0	300	300	0	0	300	0
CDC brokerage - Gamma Camera	0	0	0	0	0	0	0	1,300	1,300	0	0	1,300	0
CDC brokerage - IR Suite	0	0	0	0	0	0	0	1,100	1,100	0	0	1,100	0
Defibrillators	0	0	0	0	0	0	0	102	102	0	0	0	102
Total Additional Capex	**0**	**208**	**208**	**0**	**1,708**	**1,708**	**0**	**13,189**	**13,189**	**0**	**0**	**13,087**	**102**
Total Capex	**877**	**611**	**(266)**	**3,068**	**2,338**	**(730)**	**11,550**	**24,659**	**24,659**	**0**	**10,970**	**13,587**	**102**

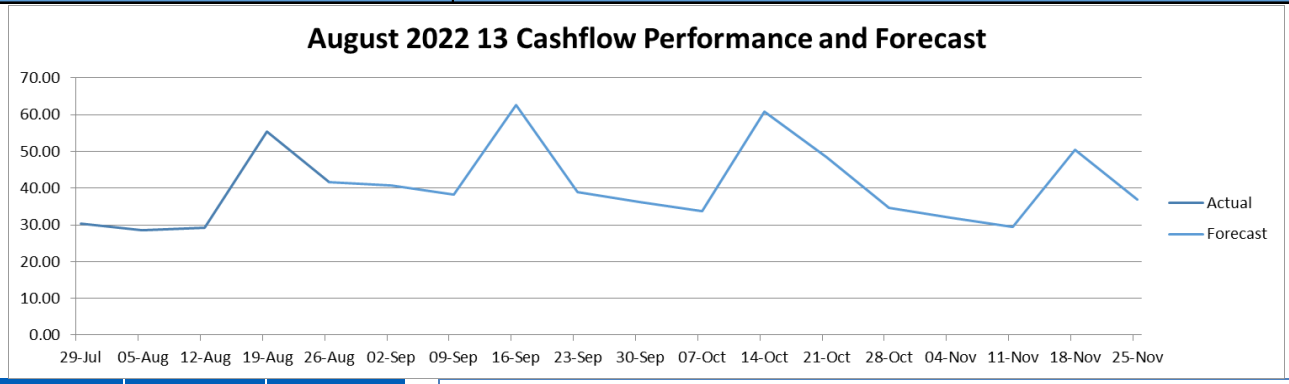
The table above reports performance against the approved plan, which is £730k behind YTD due to the delay in approval.

Only £500k (UTC) of the external funds have been fully approved; should the remaining funding not be approved the plan will need to be re-assessed and some further projects may need to be deferred. For this reason, whilst in the plan programme, leads had not yet been given authority to spend on these projects, with the exception of EPR, which is a contractual commitment and therefore a material total risk of £2.65m should funding not be made available.

7. Cash

13 Week Forecast w/e

£m	Actual 29/07/22	05/08/22	12/08/22	19/08/22	26/08/22	Forecast 02/09/22	09/09/22	16/09/22	23/09/22	30/09/22	07/10/22	14/10/22	21/10/22	28/10/22	04/11/22	11/11/22	18/11/22	25/11/22
BANK BALANCE B/FWD	**42.57**	**30.43**	**28.52**	**29.31**	**55.32**	**41.55**	**40.76**	**38.35**	**62.69**	**39.00**	**36.13**	**33.72**	**60.75**	**48.36**	**34.67**	**31.93**	**29.52**	**50.46**
Receipts																		
NHS Contract Income	0.00	0.00	0.00	29.59	0.26	0.06	0.00	32.74	0.00	0.00	0.00	31.35	0.00	0.00	0.00	0.00	31.35	0.00
Other	0.18	0.45	4.05	0.55	0.20	0.34	0.69	0.38	0.25	0.25	0.69	0.38	0.25	0.25	0.38	0.69	3.46	0.38
Total receipts	**0.18**	**0.45**	**4.05**	**30.14**	**0.46**	**0.40**	**0.69**	**33.12**	**0.25**	**0.25**	**0.69**	**31.73**	**0.25**	**0.25**	**0.38**	**0.69**	**34.81**	**0.38**
Payments																		
Pay Expenditure (excl. Agency)	(9.25)	(0.40)	(0.45)	(0.40)	(10.74)	(0.46)	(0.39)	(0.39)	(21.24)	(0.42)	(0.39)	(0.39)	(9.94)	(11.24)	(0.42)	(0.39)	(9.49)	(11.24)
Non Pay Expenditure	(2.81)	(1.95)	(2.77)	(3.56)	(3.33)	(0.73)	(2.46)	(4.07)	(2.47)	(2.47)	(2.47)	(4.07)	(2.47)	(2.47)	(2.47)	(2.47)	(4.07)	(2.47)
Capital Expenditure	(0.26)	(0.02)	(0.04)	(0.18)	(0.16)	0.00	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)	(0.24)
Total payments	**(12.32)**	**(2.36)**	**(3.26)**	**(4.13)**	**(14.23)**	**(1.19)**	**(3.09)**	**(4.69)**	**(23.94)**	**(3.12)**	**(3.09)**	**(4.69)**	**(12.64)**	**(13.94)**	**(3.12)**	**(3.09)**	**(13.79)**	**(13.94)**
Net Receipts/ (Payments)	**(12.14)**	**(1.91)**	**0.79**	**26.01**	**(13.77)**	**(0.79)**	**(2.41)**	**28.42**	**(23.69)**	**(2.87)**	**(2.41)**	**27.03**	**(12.39)**	**(13.69)**	**(2.74)**	**(2.41)**	**21.01**	**(13.56)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(4.09)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(4.09)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**
BANK BALANCE C/FWD	**30.43**	**28.52**	**29.31**	**55.32**	**41.55**	**40.76**	**38.35**	**62.69**	**39.00**	**36.13**	**33.72**	**60.75**	**48.36**	**34.67**	**31.93**	**29.52**	**50.46**	**36.89**



Prior year end	£'000	Month end actual	Var.
33,455	Cash	41,067	7,612

The overall cash balance has increased by £10.5m in August

£35.3m of cash was received in month

£29.7m NHS contract income for the month, £3.1m quarterly education funding £2.5m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£24.7m of cash was paid out by the Trust in month

£12.0m (49%) in direct salary costs to substantive and bank employees

£0.1m (%) employer costs to HMRC and NHSP- prepayment has stopped.

£13.0m (51%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

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8. Conclusions

The Finance Committee is asked to note the report and financial performance which is £1,182k deficit in-month, £2,768k year to date; this being £985k adverse to the plan submitted to NHSE/I and the Kent & Medway ICS in June 2022. The overall plan for the year is a breakeven position following discussions with the ICS and further support funding for inflationary costs, as well as identifying £8.0m of non-recurrent mitigations. To date £7.0m of non-recurrent mitigations have been released into the position. On a simple extrapolated basis, the current run-rate would result in a Trust overspend against its control total of c£15.5m; a more detailed forecast with mitigations plan is under development.

The current efficiency programme is £0.6m adverse to plan, with a delivery of £2.6m year to date. ESRF income of £4.1m has been included at a cost of £1.4m for activity delivered by the independent sector; the risk of repaying the ERF income will be mitigated by NHSE/I and the ICB for the first half of the year.

The Executive Team has agreed Executive Leads and actions to address each of the key financial risks, including divisional overspendings and efficiencies; this is discussed further in the financial risks paper.

Alan Davies
Chief Financial Officer
September 2022

Meeting of the Board of Directors in Public

Wednesday, 05 October 2022

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte		
Date of Meeting:	Thursday 22 September 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 3a "Delivery of Financial Control Total" due to the August position reporting off plan by £1.0m, it was agreed to increase the rating to 20. For 3b "Capital Investment", the capital plan has been finalised, an ongoing review of performance to plan will be reported back to subsequent committee meetings. For 3c "Financial Recovery Plan" increase rating to 20 as the first year of the recovery plan is aligned to the current year financial performance. The Trust has been informed it will remain in SOF4 until there is assurance over the in-year delivery and hence longer term plan.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
AGREED to increase 3a "Delivery of Financial Control Total" to 20, and 3c "Financial Recovery Plan" to 20.	
2. Corporate risk register The efficiency programme for 22/23 is £9.6m with a further stretch target of £0.9m in H2. Due to the under delivery of the efficiency programme and following a discussion by the committee regarding ongoing risks of delivering the plan, it was agreed to increase the risk rating to 20. **AGREED** to increase the risk score to 20	**Amber/Red**
3. Finance report – month 5 The Chief Financial Officer presented the report with the key highlights being: • The Trust is reporting a £1.2m deficit position in month and £2.8m year to date (YTD), this being £1.0m adverse to the final plan submitted to NHSE/I in June. • To date, £7.0m of the £8.0m identified non-recurrent mitigations have been released into the position. • The main drivers of the adverse position include medical staff pay pressures across the services including additional locums in the emergency department, premium cost of temporary staffing, escalation capacity remaining open, drugs & clinical supplies price and volume increases, unidentified and undelivered efficiencies. • Capital plans have been finalised and are reflected in the committee papers. • Covid costs remain at £0.2m. • Delivery of efficiencies is £0.6m behind plan, with efficiencies achieved YTD of £2.6m. • Cash sums remain in a stable position. **AGREED** to include a forecast position of efficiency delivery.	**Amber/Red**
4. Finance Risk 2022/23 A paper was submitted to the committee detailing the current drivers of the adverse position and risks to delivering the financial plan. The committee was briefed on the Executive actions and detailed project plans drawn up to mitigate any further overspending. These mitigating actions were discussed and progress will be reported back to future committee meetings. **AGREED** to quantify the actions included in the risk report.	**Amber/Red**
5. Performance report month 5 The performance report was presented to the committee, this included a comprehensive slide pack detailing performance across key business	**Amber/Green**

Meeting of the Board of Directors in Public

Wednesday, 05 October 2022

Assurance Report from Committees

Title of Committee:	**People Committee**	**Agenda Item**	**6.1**
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Thursday, 29 September 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 – People The Workforce risks were reviewed and assurances have been updated in order to provide further assurance for the mitigations and controls identified for each risk. No changes were made to the current risk score for the BAF items. Updates have been made to the current appraisal rate, a slightly improving turnover rate which does not mirror the deteriorating national turnover rate. The Committee **APPROVED** the BAF	**Amber/Green**
2. HEE Clinical Placement Provider Self-Assessment As part of the HEE (Health Education England) NHS Education Contract, the Trust completed an annual self-assessment as a process by which Trusts carry out their own quality evaluation against a set of standards. The relevant professional leads have reviewed the domain requirements and have provided a list of evidences to support the domain standards. Where further developments are required or gaps exist, the lead is responsible for developing and delivering an action plan (such as within Pharmacy in this case). There are no sub-domain questions that have been marked as non-compliant, however, there are areas of development listed throughout to demonstrate how the services are planned to improve. The Committee members **APPROVED** the HEE Clinical Placement Provider Self-Assessment	**Amber/Green**
3. IQPR The Committee reviewed the refreshed version of the IQPR in using Statistical Process Control charts to display the data. It reported on the HR performance across all key performance indicators for August 2022. A deep-dive was included demonstrating a regional picture of sustained and worsening turnover of all staff groups across the NHS, as it enters its third quarter and the actions put in place in the Trust. The Committee was asked to note the worsening of fire safety training compliance and	**Amber/Red**

MCA/DoLs. The Committee asked for more investigation into why this has happened. Retirement remains the third highest reason for leaving the organisation. The Committee raised concerns over the 27% report of Bullying, Harassment and Discrimination statement. Leon Hinton advised this matches with the staff survey, with the NHS as a whole report around 30%. The Committee noted the quantity of appraisals being completed as positive and the Trust must ensure quality of appraisals continues. The Committee suggested that fire safety training should be offered virtually, although understanding that a core skills training framework requirement for front facing patient cohorts to have face to face training. Colleagues are not being released for training and this will be addressed. The Committee **APPROVED** the Deep Dives regarding turnover of staff	
4. HR Resourcing Report Key highlights was information on; Nursing/Midwifery recruitment and Medical/Dental recruitment. Staffing into band 6 nursing has worsened due to elevated turnover; however, a significant number of band 6s are under offer. The planned band 5 to 6 development programme is designed to address this through nurse education. Nursing turnover has decreased overall opposed to a national pattern of elevated leavers through to April 2022. A significant number of AHP starters are also under offer including a higher number of international hires than previously achieved. The Committee **NOTED** the report.	**Amber/Red**
5. Medical Appraisal Report In view of Covid-19, appraisals and revalidation process for the doctors was put on hold completely by NHSE from Mid-March 2020. From June 2020, the appraisal and revalidation process was restarted as per choice of the individual organisations and MFT restarted the process in a phased manner taking into account the individual doctor's personal ability and circumstances to complete the appraisal. NHSE stopped the requirement of sending the Annual Organisational Audit (AoA) report for this reporting year. As a result, no AoA has been submitted to NHSE for 2021-22 reporting year. Trust is required to submit a statement of compliance to NHSE which was submitted to the Committee. Medway NHS Foundation Trust has 454 doctors connected as on 31 March 2022. For the year ending 31 March 2022, a total of 116 revalidation recommendations were sent to the GMC during the reporting year. 24 deferral recommendations were sent with 5 doctors having a positive recommendation sent during the report period. Following the retirements of David Sulch (Responsible Officer) and Kirtida Mukjerjee (Deputy Responsible Officer), Jeremy Davis took up the position of Responsible Officer in an interim role from 01 December 2021. Alison Davis, CMO, took the permanent position of Responsible Officer from 15 August 2022. The Committee **APPROVED** the Medical Appraisal Report.	**Amber/Green**

6. Health Care Worker Vaccination Self-Assessment The Committee reviewed a high level plan for the healthcare worker flu vaccination campaign for 2022/23 which will be in line with the best practice management checklist for public assurance via Trust boards. Healthcare workers with direct patient contact need to be vaccinated to ensure protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. The People Committee **APPROVED** the Health Care Worker Vaccination Self-Assessment (appendix I)	**Green**
7. Workforce Equity Data Report – WRES WDES The Committee received a report on the WDES and WRES data for 2022. A particular concern is that the staff perception data, measured by the Annual Staff Survey 2021, has largely deteriorated in terms of both race, although has largely improved regarding disability. Performance in terms of de-biasing recruitment has deteriorated, despite improvements made in recruitment policy, procedures and training. Combined with concerns about harassment (especially from patients and colleagues), this illustrates the need for a continued focus on cultural and behavioural change across the whole Trust. The WRES and WDES data were published by 30 August 2022, and the action plan(s) published by 30 October 2022. Further analysis of the workforce data will be brought to the Equality Steering Group (in October) and the People Committee (in November). The Committee **DELEGATED APPROVAL** of the Workforce Equity Data Report – WRES WDES to Equality Steering Group, in accordance with their Terms of Reference.	**Amber/Red**
Decisions made: 1) Chair asked for a review on the Bullying and Harassment allegations at the next meeting to gain a better understanding. Leon Hinton confirmed a draft report can be brought to the next meeting. 2) The Committee **DELEGATED APPROVAL** of the Workforce Equity Data Report – WRES WDES to Equality Steering Group, in accordance with their Terms of Reference.	
Further Risks Identified: None to report	
Escalations to the Board or other Committee: 1) Short-term sickness Deep Dive to be escalated to the Trust Board.	

NHS
Medway
NHS Foundation Trust

Appendix I: Healthcare worker flu vaccination best practice management checklist

A	Committed leadership	Trust self-
	(number in brackets relates to references listed below the table)	assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers (both clinical and non-clinical staff who have contact with patients)	
A2	Trust has ordered and provided a quadrivalent (QIV) influenza vaccine for healthcare workers	
A3	Board receive an evaluation of the influenza programme 2021 to 2022, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for influenza campaign	
A5	All board members receive influenza vaccination and publicise this	
A6	Influenza team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Influenza team to meet regularly from September 2022	
B	**Communications plan**	
B1	Rationale for the influenza vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Influenza vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters and social media	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	
C2	Schedule for easy access drop in clinics agreed	
C3	Schedule for 24 hour mobile vaccinations to be agreed	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	This will be as % increases