# Agenda

NHS Medway NHS Foundation Trust

## Trust Board Meeting in Public

**Tuesday, 10 September at 12:30 – 15:30 Trust Board Room, Gundulph Offices**

| Item | Subject | Presenter | Page | Time | Action |
|---|---|---|---|---|---|
| **1.** | **Preliminary Matters** | | | | |
| **1.1** | Chair's Introduction and Apologies | Chair | Verbal | 12:30 | Note |
| **1.2** | Quorum | | | | |
| **1.3** | Declarations of Interest | | | | |
| **2.** | **Minutes of last meeting and Action Log** | | | | |
| **2.1** | Minutes of 24 July 2024 | Chair | 3 | 12:35 | Approve |
| **2.2** | Action Log | | 13 | | Note |
| **3.** | **Opening Matters** | | | | |
| **3.1** | Chief Executive Update | Chief Executive | 14 | 12:40 | Note |
| **3.2** | Council of Governors Report (August 2024) | Lead Governor | 17 | 12:45 | Assurance |
| **3.3** | Governance Review - Board Designations | Company Secretary | 20 | 12:50 | Approve |
| **4.** | **Performance, Risk and Assurance** | | | | |
| **4.1** | Trust Risk Register* | Chief Nursing Officer | 30 | 13:00 | Assurance |
| **4.2** | Board Assurance Framework * | | 31 | 13:05 | Assurance |
| **4.3** | Integrated Quality Performance Report * | Chief Delivery Officer | 33 | 13:10 | Assurance |
| **5.** | **Board Story Presentation** | | | | |
| **5.1** | Physician Associates at Medway Maritime Hospital | Prof. Hasib Ahmed | 38 | 13:20 | Present |
| **6.** | **Board Assurance Reports** | | | | |
| **6.1** | Quality Assurance Committee (Aug 2024) | Chief Medical Officer, Chief Nursing Officer, Committee Chair | 43 | 13:30 | Assurance |
| **6.2** | People Committee (July 2024) | Chief People Officer, Committee Chair | 46 | 13:35 | Assurance |
| **6.3** | Finance, Planning and Performance Committee (July and Aug 2024) | Chief Finance Officer, Committee Chair | 50 | 13:40 | Assurance |

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|---|---|---|---|---|---|
| **7. Papers** | | | | | |
| **~ WELLBEING BREAK - 10 minutes ~** | | | | | |
| **7.1** | Finance Report (Month 4) * | Chief Financial Officer | 54 | 14:00 | Note |
| **7.2** | Financial Recovery Plan Report *<br>• Feedback from NHSE<br>• Breakeven recovery plan | | 56 | 14:15 | Note |
| **7.3** | Maternity CNST Compliance Assurance Report * | Director of Midwifery | 58 | 14:30 | Assurance |
| **7.4** | Perinatal Quality Surveillance Report * | | 61 | | Assurance |
| **7.5** | Perinatal Cultural Leadership Report * | | 64 | | Assurance |
| **7.6** | Maternity Claims, Incidents, Complaints Triangulation Report * | | 66 | | Assurance |
| **7.7** | Infected Blood Inquiry Report * | Chief Medical Officer | 68 | 14:50 | Assurance |
| **7.8** | Annual Reports:<br>a) Safeguarding *<br>b) IPC *<br>c) Medical Appraisal and Revalidation * | Chief Nursing Officer<br>Chief Nursing Officer<br>Chief Medical Officer | 73<br>75<br>77 | 14:55 | Note |
| **7.9** | Patient First Achievements * | Chief Delivery Officer | 103 | 15:05 | Assurance |
| **7.10** | Q1 Learning from Deaths * | Chief Medical Officer | 106 | 15:10 | |
| **8. Closing Matters** | | | | | |
| **8.1** | Questions from the Council of Governors and Public | Chair | Verbal | 15:15 | Note |
| **8.2** | Escalations to the Council of Governors | | | | |
| **8.3** | Any Other Business | | | | |
| **8.4** | Reflections | | | | |
| **8.5** | Date and time of next meeting: Wednesday, 13 November 2024 | | | | |

**Key – Patient First Domains** *** Appendices available in separate meeting paper pack.**

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|---|
| Quality |
| Patients |
| People |
| Sustainability |
| System and Partnership |

# Minutes of the Trust Board Meeting in Public

**Wednesday, 24 July 2024 12:30-15:30**

**Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY**

**And on MS Teams**

| PRESENT | | |
|---|---|---|
| | **Name:** | **Job Title:** |
| **Members:** | John Goulston | Trust Chair |
| | Alison Davis | Chief Medical Officer |
| | Annyes Laheurte | Non-Executive Director |
| | Gary Lupton | Non-Executive Director |
| | Gavin MacDonald | Chief Delivery Officer |
| | Jayne Black | Chief Executive |
| | Leon Hinton | Chief People Officer |
| | Nick Sinclair | Chief Operations Officer |
| | Sarah Vaux | Chief Nursing Officer (Interim) |
| | Paul Kimber | Chief Financial Officer (Interim) |
| **Attendees:** | Adrian Ward | Non-Executive Director (non-voting) |
| | Matt Capper | Company Secretary & Director of Strategy and Partnership |
| | Emma Tench | Assistant Company Secretary |
| | Andrea Maku | Member of the public |
| | Hari Aggarwal | Governor |
| | Steph Gorman | Deputy Director of Nursing |
| | David Brake | Lead Governor |
| | Karen Fegan | Staff Governor |
| | Simon Gilmore | National Recovery Support Team Chief Operating Officer's Directorate, NHS England |
| | Katherine Harris | Head of Midwifery |
| | Nikki Lewis | Associate Director of Patient Experience – agenda item 3.1 |
| | Rosie Chester | For Patient Story – agenda item 3.1 |
| | Roz Yates | For Patient Story – agenda item 3.1 |
| **Apologies:** | Mojgan Sani | Non-Executive Director |
| | Jenny Chong | Non-Executive Director |
| | Paulette Lewis | Non-Executive Director |
| | Alan Davies | Chief Financial Officer |

## 1. PRELIMINARY MATTERS

### 1.1 Chair's Welcome and Apologies

The Chair welcomed all present. Apologies for absence were noted as above. Introduction were made. The Chair noted the following:

a) Thank you to the Trust for a warm welcome, induction and tour of the site.
b) Attendance at the Patient First Conference, and the celebration of 25 years of Maternity and Neonatal at Medway NHS Foundation Trust (MFT), and the Rapid Improvement Week.
c) The importance of visibility of the Board around the hospital meeting staff and patients, to triangulate what is discussed in Board meetings.

### 1.2 Quorum

The meeting was confirmed as quorate.

### 1.3 Declarations of Interest

No new declarations of interest.

## 2. Minutes of the Last Meeting, Action Log and Governance

2.1 The minutes of the meeting held on 15 May 2024 were **APPROVED** as a true and accurate record

### 2.2 Action Log

No actions to review at this meeting.

### 2.3 Chief Executive Update

Jayne Black presented the report in line with the paper submitted. The following was highlighted:

a) Welcome to the Trust Chair, John Goulston; thanks to Mark Spragg for his service over the past seven years.
b) Welcome to new Trust Governors; thank you to those Governors who have completed their term of office.
c) Improving emergency performance, particularly in the Emergency Department, reducing overcrowding and waiting times. The progress is significant given the continued challenges.
d) Teletracking which provides real-time visibility of the bed available across the hospital. Since the introduction in September 2023 this has enabled faster movement of patients into beds on wards, releasing thousands of hours of nurse time to care for patients.
e) A Trust team has been nominated for the Urgent and Emergency Care Initiative of the Year at the annual Health Safety Journal (HSJ) Patient Safety Awards.
f) The new pharmacy robot, names 'Bert' and 'Ernie' is more efficient and reliable, and able to hold approximately 20,000 pack of medication, an increase from 12,000.
g) Macmillan Cancer Care Unit has received the Macmillan Quality Environment Mark award for the services it provides to help support people living with cancer and their families.
h) A new Patient Advice and Liaison Service (PALS) hub has been opened in the main reception.
i) The hospital celebrated the 25th anniversary of maternity services and the Oliver Fisher Neonatal Unit.
j) Medway Stars were celebrated at the awards ceremony on 13 June. Thank you to Mid Kent College for hosting.

Gavin MacDonald updated the Board on the Global Microsoft IT outage on Friday 19 July:

a) No clinical systems were impacted.
b) Staff Rostering and G4 were down for eight hours. G4 continuity plan worked well.
c) Concerns over possible impact at the 'front door' did not materialise.
d) A full debrief on Monday 22 July confirmed communication was good.
e) Lessons learnt – regular testing of continuity plans.
**ACTION TB/001/2024:** Regular lessons learnt from IT outage to test contingency on a regular basis.

2.4 **Council of Governors Report**

David Brake presented the report in line with the paper submitted. The following was highlighted:

a) Lead Governors attendance to 25-year anniversary and the Staff awards.
b) The final draft of the Annual Report and Accounts presented to Governors, with a period of question and answer before approval of both documents.
c) Presentation from the Associate Director of Patient Experience, on the process for raising complaints, Friends and Family Testing (FFT), enhanced care and the Trusts dementia buddy service.
d) Governor elections successfully completed.
e) Thanks to Mark Spragg and welcome to John Goulston.
f) Constitution refresh reviewed and approved by Governors.

The Board were **ASSURED** by the report.

2.5 **Constitution Amendments 2024**

Matt Capper presented the report in line with the paper submitted, providing the Board with details on amendments made in line with the Health and Care Act 2022. The Council of Governors have reviewed and approved the amendments.

The Board **APPROVED** and adopted the amended Constitution, subject to amendment. The Constitution to be presented to the Council of Governors on 14 August.

**3. Board Story Presentation**

3.1 **End of Life Care on Lister Ward – Dr Rosie Chester**

Nikki Lewis introduced Dr Rosie Chester. The presentation was delivered in line with the papers submitted.

a) Members of the Board thanked Rosie for her bravery in sharing her story, and relayed their sincere apologies and condolences. Alison Davis offered to meet with Rosie separately to discuss what can be done to ensure other families do not have the same experience.
**ACTION TB/002/2024:** Outcome of the meeting between the CMO and Rosie Chester to be updated to the Board.

b) Sarah Vaux: Work with integration and the palliative care team continues. Training and induction on wards will be reviewed to ensure this is embedded. HCP conversations on how the Trust address end of life will be taken forward. The Trust has a Namaste practitioner on site.
c) Jayne Black: In November 2023 the Trust discussed how to take forward end of life care during the Patient First Conference. We are taking this very seriously.

d) The Chair shared his personal experience, expressing his apologies of the failings. Positive stories are now being shared from patients regarding experiences, this should be the experience of every patient, every day.

**4. Board Assurance Reports**

4.1 **Quality Assurance Committee**

Alison Davis and Sarah Vaux presented the report in line with the submitted papers. Alison highlighted key areas from the reports from meetings held on 06 June 2024 and 04 July 2024. Highlighting:

a) Maternity and recruitment and risks around the introduction of new staff ensuring a safe service.
b) Improvement plans reviewed, to be escalated to Board.
c) Level 3 Safeguarding training remains a focus.
d) Mattresses remains a focus.
e) Patient Story 'end of life story' from a Governors was positive and relayed the ward.

The Board were **ASSURED** and **NOTED** the reports

4.2 **People Committee (May 2024)**

Leon Hinton presented the report in line with the submitted paper from the committee held on 30 May 2024. Escalations for the Board to note included:

a) Staff appraisal compliance
b) Training/StatMan: Safeguarding Adults level three, Moving and Handling Level 3.
c) Occupational Health resource capacity impacting recruitment, reporting and staff experience, the business case has been approved.
d) True North improvements with staff engagement, these need to move at pace.
e) Only metric for focus is sickness levels, a particular element to be reviewed.

The Board were **ASSURED** and **NOTED** the report

4.3 **Audit and Risk Committee**

Annyes Laheurte and Matt Capper, presented the report in line with the submitted paper from the committees held on 20 June 2024 and 04 July 2024. No risk or items were identified for escalation to the Board.

a) Annual Report and Accounts approved, external and internal audit reports received and reviewed.
b) Board Assurance Framework (BAF) reviewed for triangulation of objectives.
c) Noted changes in IQPR.
d) Financial compliance, and Single Tender Waivers, as well as internal/external audit action tracker reviewed. Action tracker needs to be implemented at pace.

The Board were **ASSURED** and **NOTED** the report

4.4 **Finance, Planning and Performance Committee**

Paul Kimber and Gary Lupton presented the reports in line with papers submitted. Highlights were given from the committee meetings held on 30 May 2024 and 27 June 2024

a) Benefits analysis of tele tracking, improvement in bed turnaround.
b) Work force report to come back to the committee next week.
c) Further assurance on 2-5 years for digital environment.
d) Pre-submission for National Cost Collection.

e) National resubmission of finance plans.
f) Finance improvement plan review.
g) Seek assurance form business planning process.
h) Focus around SIPS and pace of delivery.
i) Ongoing monitoring of cash flow, and bank/agency costs.
j) Business cases for review on future planning.

The Board were **ASSURED** and **NOTED** the reports

**5. Board Business in Public**

5.1 **Maternity Workforce Oversight Report**

Kate Harris presented the report in line with the submitted paper. The report highlighted the following:

a) Red flags and reasons for the red flags, completed 4-hourly, shared across the South East.
b) Accurate accounting of the current workforce status and update from recommendations with the paper presented to the Trust Board in January 2024
c) Gaps within the clinical midwifery workforce and mitigations in place.
d) Vacancy rate, trajectories in place for an anticipated full establishment.
e) Midwifery workforce risk (1133) rated 20. Score agreed by the CNO.
f) Ongoing compliance with 1:1 care in labour and supernumerary coordinator.
g) Full birth rate plus conducted in 2023, PID to support in completion.
h) Good compliance with Fetal Monitoring training and PROMPT for midwifery staff.

Check and Challenge

i) The Chair: Very encouraging to note retention stability at 90%.

The Board were **ASSURED** by the report.

5.2 **Maternity CNST Compliance Assurance Report – Updates and Actions**

Kate Harris presented the report in line with the submitted paper. The following was highlighted:

a) CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025
b) On track to declare compliance with all Safety Actions.
c) Monthly reporting via MNSCAG and to Trust Board until submission.
d) Review and presentation dates agreed with LMNS for key requirements

Check and Challenge

e) Sarah Vaux: The metric ID around stability indicates a compassionate team support by professional leaders, with an extremely good reputation, the Trust is very lucky to have them.
f) The Chair: The Director for Midwifery for the South East visited the Maternity department and was particularly impressed with inductions.

The Board were **ASSURED** by the report.

5.3 **Learning from Deaths – Quarterly Report**

Alison Davis gave the Board a verbal update on the quarterly report.

a) Between January 2024 and May 2024, the Trust recorded 694 inpatient adult deaths, 5 of whom were patients with learning difficulties who died in hospital and were highlighted for

Structured Judgment Reviews (SJR). One case was graded as 'poor' and has been escalated to the Incident Review Group.

b) 7.2% of deaths which were subject to SJR. Six cases highlighted as being possible/probable preventable deaths; all were escalated to the Incident Review Group.
c) Top five themes were noted.
d) First mortality newsletter sent out in May 2024.
e) Specialty Mortality and Morbidity meetings compliance showing little improvement in first five months.
f) A review of Learning from Deaths processes by NICHE, resulting in a refresh of A3 True North.
g) Standardised Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are published monthly, providing national benchmarking.
h) National data breeches in Hospital Episode Statistics (HES) dataset have resulted in patient ID's being duplicated, affecting the outlier/alerts values.

Check and Challenge

i) Jayne Black: What is happening to improve to bed capacity.
Alison Davis: A piece of work, looking at data, to ensure patients are allocated to the correct specialty at the correct place, ensuring flow through the hospital.
j) The Chair: In terms of triangulation, hospital standarised mortality rate, and the Board Assurance Framework (BAF) does the work align to ID 2a.
Matt Capper: The BAF contains strategic risks, the way this is articulated needs to be reviewed more explicitly.
**ACTION TB/003/2024:** The refreshed BAF to incorporate explicit updates to ensure alignment.

The Board were **ASSURED** by the update.

5.4 **Strategy Review and Summary**

Matt Capper presented the report in line with the submitted paper, outlining the current and on-going status of the strategy and partnerships portfolio.

a) Fully on target with progress, an excellent level of engagement.
b) Internal picture around system strategy, will include to see how this links and progressing.
c) In progress, number of areas progressing, the standing financial instructions, will support the financial governance and key item to drive towards financial stability.

Check and Challenge

d) Jayne Black: Bringing the strategies together and triangulating is important. Well done to the team for all the work and setting of the direction.
e) Gavin MacDonald: Should there be a procurement strategy.
Matt Capper: There is new legislation that will be picked up in SFI's, a mechanical process, on our sub list there is a business strategy, this may impact procurement.
f) Gary Lupton: Would be helpful to split procurement into two; a need to understand how we internally manage our procurement.
g) The Chair: A broader question; under the next refresh for system and partnership work with partner collaborative, what are the key areas.
Jayne Black: The new business planning cycle with review and refresh key areas.
**ACTION TB/004/2024**. Timing and refresh of system and partnership work with collaborative partners to be bought back to the Board for review.

The Board were **ASSURED** by the report.

**~ Wellbeing Break for 10 minutes ~**

5.5 **Finance Report (Month 2)**

Paul Kimber presented the report in line with the submitted paper, highlighting the following:

a) The Trust reports a deficit of £3.3m in month 2, and £6.9m year to date (YTD); this is on plan.
b) The efficiency programme has under delivered by £0.5m against the YTD plan of £1.5m.
c) The capital position is underspent as at month 2 due to the timing of schemes being delivered/awaiting approval of the full current year programme.
d) Cash at the end of May was £6.2m.

Check and Challenge

e) Jayne Black: Regarding the efficiencies programme, conscious they should be delivering, a gap that needs to be buttoned down. There is assurance they will be singed off; however, we are behind the curve and need to pick up pace in terms of delivery.
f) The Chair: For FPPC it is really important to be clear on the cost improvement programme and size of the gap and mitigations. Where are we precisely on reduction of bank/agency and financial consequent. What is the full year effect for 25/26. In terms of cost what the materials increase/decrease. Looking at run rate, currently we are over by £3million a month, our forecast for year is £25million, what is our confidence to reduce the run rate, down to £1million maximum per month in the last quarter. What is the scale against the risks, and rating, and what are the mitigations against risks. What is the residual impact. We need to be clear in September what is our forecast against the plan. A really important piece of work for FPPC to start on 31 July, to present at September board.
**ACTION TB/005/2024:** FPPC Board to align conversations to cover areas highlighted by the Trust Chair in agenda item 5.5f.

The Board **NOTED** the report

5.6 **Financial Recovery Plan Report**

Paul Kimber presented the report in line with the submitted paper, providing the Board with an update of development and submission of its Integrated Improvement Plan (IIP) to the ICB and NHSE.

Key areas of focus for the Trust to deliver against the exit criteria:

a) Delivery of the 2024/25 plan
b) Development of a medium-term financial plan alongside the ICS
c) Safe and sustainable clinical model
d) Affordable workforce plan
e) Transformation and efficiencies
f) Activity and income

The Trust will have monthly reporting across a range of financial and non-financial metrics to evidence delivery. The key and enabler workstreams have been fully mapped to the Financial Sustainability Strategy

Check and Challenge

g) Gary Lupton: What is the continuation of engagement with budget holders and clear ownership in terms of budget and SIPs.

Paul Kimber: Within Business Planning the budget holders are much more engaging.
**ACTION TB/006/2024:** Feedback from NHS, regarding the Financial Recovery Plan to be shared with the Board in August.

h) The Chair: Secondary issues align to the Financial Strategy, when is the break-even date.
**ACTION TB/007/2024:** A recovery plan, for break even, and how to sustain, to come to go to FPPC in August and Board in September.

i) Jayne Black: All actions are in place but need to be condensed. Additional support is in place from NHSE from the Senior Director and Senior Manager of Finance.

The Board **NOTED** the report

5.7 **Annual Report and Accounts**

Matt Capper presented the report in line with the submitted paper, covering the reporting period of April 2023 to March 2024. The Annual Accounts and Report were presented to the Audit and Risk Committee on 20 June 2024 and Approved, with delegation of authority from the Trust Board.
The document is in an accessible format apart from the accounts, due to the data layout. The summary report will be added to the website.
**ACTION TB/008/2024:** Annual Report and Accounts to be presented AMM on 11 September and submitted to House of Commons.

The Board **NOTED** the report

5.8 **Health and Safety Annual Report**

Sarah Vaux presented the report in line with the submitted paper, providing assurance on compliance with legislation and Trust policies to the Board. The report included statistical analysis and key information regarding Health & Safety (H&S) activity, audit programme and progress, training compliance, reported incidents, RIDDOR and investigation outcomes across MFT, together with monitoring and responding to the health and safety needs of the Trust. Of the 12 objectives set for 2023/24, 10 were achieved, as set out in Section 4 of the report

<u>Check and Challenge</u>

a) Gary Lupton: In terms of manual handling training, what impact has this had on sickness rates.
Sarah Vaux: No direct correlation, because it is not a simple line, one of the factors is training but there are other factors.
Leon Hinton: Sickness rates have increased, however there are no increase in referrals to occupational health; either managers are not referring or using the wrong codes to mark absence.

b) Gary Lupton: Assaults are up year on year, what can we do to support this, noting the five cases without prosecution from Kent Police.
Sarah Vaux: The increase is mainly due to the security team improving on reporting incidents. We need to encourage staff reporting, this may see a further increase in rates. The increase is a national picture. We cannot confirm if trust is an outlier, as reporting and demographics are different. The staff are recognizing the support that has been put into place. The police also have been responsive.
In terms of assault and 'serious' and 'no harm' we take all incidents seriously.

Jayne Black: This is an important aspect to tackle and take seriously, especially in ED. The issue is not just about physical harm. A conversation has been started with other CEO's to recognise best practice.

The Board were **APPROVED** by the report

## 6. Performance, Risk and Assurance

### 6.1 Integrated Quality Performance Report (IQPR)

Executives delivered updates on the submitted IQPR for June 2024
Sarah Vaux and Alison Davis highlighted the following:

a) Includes changes made to FTT, Changes to target recommend rate for ED, focusing on praise. Almost at target.
b) Mixed Sex accommodation, trying to sure where this happens the patients is receiving privacy and dignity. A national issue.
c) Complaints data, will be adjusting the target, from 25 days to 40 working days.
d) Reflects pressure ulcer data assessment framework, change in reporting, we remain on track for reductions in pressure ulcers.
e) No longer reporting SI's

**ACTION TB/009/2024:** Red drivers to be defined and included in the cover in order to triangulate with other reports and links to risks.

The Board **NOTED** the report

### 6.2 Risk Register

Matt Capper presented the report in line with the submitted paper, providing assurance on the current position of the Trust risk management system. The following was highlighted:

a) The Trust Risk Register has 237 approved risks in total, 25 risks are scoring 15 and above.
b) 25 new risks added, 22 risks have been closed.
c) Since the last review 16 risks have had their scored reduced, 5 risks have had their score increased, 9 risks have been rejected.
d) Process review and how these are challenged, this will feed in the Board Assurance Framework.

<u>Check and Challenge</u>

e) Gary Lupton: Is any support required for risk 2060 'Capital allocation vs requirements.
Matt Capper: Scoring is an area for review assessing if ratings are appropriate against risk issues.

The Board **NOTED** the report

### 6.3 Board Assurance Framework (BAF)

The Executives delivered updates on the submitted BAF, with 16 strategic risks aligned to each of the Trust's True North Domains.

a) The team are reviewing and starting to see movement.
b) Revised version to be reviewed at the next Audit and Risk and onto Board.

The Board were **ASSURED** and **NOTED** the report.

## 7. Closing Matters

### 7.1 Questions from the Council of Governors and Public

No questions received from Governors or Public

### 7.2 Escalations to Council of Governors

- Constitution

### 7.3 Reflection

Jayne Black: A useful meeting with fresh eyes coming in to check and challenge.

### 7.4 Any Other Business

The Board thanked Adrian Ward for his continued support since 2017 wishing him all the best for endeavors after Medway.
Annual Members Meeting on 11 September will include an external market place prior to the meeting.

### 7.5 Date of next meeting

Wednesday, 10 September 2024

7.6 The meeting closed at 14:55

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 24 July 2024

Signed by Chair …….. Date ……

# Public Trust Board
# 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 |
|---|---|---|---|---|---|---|
| 24.07.24 | TB/001/2024 | Regular lessons learnt from IT outage to test contingency on a regular basis. | On going | CDO | | |
| 24.07.24 | TB/002/2024 | Outcome of the meeting between the CMO and Rosie Chester to be updated to the Board. | ~~10.09.2024~~ 13.11.2024 | CMO | This meeting has been scheduled for Thursday, 19 September 2024 @ 11.00am on MS Teams | |
| 24.07.24 | TB/003/2024 | The refreshed BAF to incorporate explicit updates to ensure alignment. | 10.09.2024 | Director of Strategy and Partnership | | |
| 24.07.24 | TB/004/2024 | Timing and refresh of system and partnership work with collaborative partners to be bought back to the Board for review. | 10.09.2024 | Director of Strategy and Partnership | | |
| 24.07.24 | TB/005/2024 | FPPC Board to align conversations to cover areas highlighted by the Trust Chair in agenda item 5.5f. | 10.09.2024 | CFO and FPPC Chair | | |
| 24.07.24 | TB/006/2024 | Feedback from NHS, regarding the Financial Recovery Plan to be shared with the Board in Private in August. | 21.08.24 | CFO | | |
| 24.07.24 | TB/007/2024 | A recovery plan, for break even, and how to sustain, to come to go to FPPC in August and Board in September | 10.09.2024 | CFO | | |
| 24.07.24 | TB/008/2024 | Annual Report and Accounts to be presented AMM on 11 September and submitted to House of Commons. | 10.09.2024 | Director of Strategy and Partnership | To be presented at AMM on 11 Sept. | |
| 24.07.24 | TB/009/2024 | Red drivers to be defined and included in the cover in order to triangulate with other reports and links to risks | 10.09.2024 | Director of Strategy and Partnership | | |

# Chief Executive's report: September 2024

This report provides the 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.

## Emergency care improvements

I am pleased to report that in recent months we have made further improvements in urgent and emergency care by recording the shortest ambulance handover times in England this summer.

Figures released by NHS England show that the Trust was the best performer against the key metric in the country from April to July 2024, with an average ambulance handover time of 12 minutes and 19 seconds, against the national average of more than 31 minutes.

This is the result of a tremendous effort by hospital and ambulance staff to make sure patients are quickly and safely handed over to our Emergency Department team, freeing up ambulances to get back on the road quickly to help others.

This is one of a series of improvements in emergency and acute care that has been a focus of our Patient First improvement programme. We have introduced new models of care, including a Same Day Emergency Care (SDEC) for frail patients, and supporting systems, such as the TeleTracking bed management programme, that has helped reduce the time patients wait to be admitted.

We have seen a sustained improvement in emergency department performance, which is consistently exceeding the national four-hour emergency care standard – up from 65.6 per cent in December 2023 to almost 80 per cent last month (July 2024), against the 78 per cent target.

We are committed to making further improvements in this area, working with out-of-hospital partners, so that our patients get the care they need quickly, and to further reduce waiting times, particularly for patients who need to be admitted to a ward.

## New endoscopy unit

Key to reducing waiting times for patients is making sure that we have sufficient diagnostic capacity. Since the pandemic we have seen a significant increase in demand for endoscopy to diagnose and treat patients, and we have worked with NHS and independent sector partners to meet the demand.

I am pleased to report that we have just opened a new endoscopy unit at the hospital so that we can see approximately 400 extra patients a month which will help us treat more patients closer to home and bring down long waiting times for certain specialities.

## Improved patient feedback

Two recently published national surveys show improved feedback from patients in our care – the national Adult Inpatient Survey and the National Cancer Experience Survey. It is encouraging to see that the ongoing dedication of colleagues, coupled with Patient First, has helped us to score positively in many areas of both surveys.

Feedback from cancer patients showed improvements in 27 areas when compared to the previous year including involving and supporting patients' families and waiting times for clinic and day treatments. Scores in five other areas remained the same as last year and in 18 others scores were lower, showing a clear need for us to make further improvements.

Feedback from inpatients showed high or significantly improved scores in the following areas:

1. Patients being asked to give their views on the quality of care
2. Staff explaining reasons behind patients moving wards
3. Patients getting enough help from staff to eat meals
4. Hospital food being very or fairly good and patients being offered food that met dietary requirements
5. Patients being involved in decisions about care and treatment.

We also rated very well for treating patients with dignity and respect; giving patients enough information about care and treatment while on a virtual ward; nurses and doctors including patients in conversations; and rooms or wards being very or fairly clean.

Overall our inpatient survey results are lower when compared to other trusts so we have more to do to improve the experience of our inpatients. One clear area for improvement is reducing the time patients wait to be admitted to a ward which is a Patient First priority.

## Wellbeing improvements recognised

I'm pleased to report that we have achieved Platinum in the Healthy Workplace Programme provided by Medway Council. The programme supports businesses of all sizes and sectors to meet the health needs of their workplace.

To achieve this award, we took more than 30 pledges to work towards supporting the wellbeing of our colleagues. These included providing evidence to show: steps taken to support colleagues in times of poor mental health and/or stress, delivering training and one to one support, encouraging healthy eating, and looking after the environment around us and many more.

Achieving the Platinum award demonstrates continuous improvement of the wellbeing support available for colleagues.

## New home diabetes test for at-risk pregnant women

I am proud that we are now offering a new test that women can carry out in the comfort of their home to screen for gestational diabetes during pregnancy. The remote oral glucose tolerance testing kit, known as GTT@home, is offered to those who have been identified by their midwife as being at higher risk of developing the disease.

Undiagnosed or untreated, it can lead to complications during pregnancy including premature birth, preeclampsia (which causes high blood pressure) and increased growth of the baby but the risks are reduced if the condition is detected early and well managed so it's really important that we make testing as easy as possible for all at-risk women.

Home testing means pregnant women can carry out the test at a time that is convenient to them, without delay, and that treatment can be started earlier and managed if gestational diabetes is detected to help keep both mum and baby safe.

## Investing in a greener future

I am delighted to report that we are investing in a greener future by installing solar panels, replacing aging boilers with modern heat pumps, installing energy efficient LED lights and double glazing, thanks to more than £26 million in funding that will help us achieve our net zero commitment by 2040. The work to install the heat decarbonisation and energy efficiency measures will not only help us to reduce our carbon footprint, it will also help us save money, which both align to our Patient First sustainability priority.

## Nurses shortlisted for national award

Finally, congratulations to our Learning Disability Nurses for being shortlisted for a Nursing Times Award 2024 for introducing a 'one stop shop' service for patients with learning disabilities and autism who require medical procedures under a general anaesthetic.

They worked with anaesthetic colleagues to launch a pathway which allows patients to have a number of tests and treatments carried out while sedated, following a best interest decision. Usually these procedures are completed while a patient is awake but for some people with learning disabilities and autism, this can be traumatic and overwhelming without a general anaesthetic.

I'm incredibly proud of all colleagues who came together to launch this initiative which improves access to tests and treatments, so that patients have a better quality of life and better outcomes.

# The Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

| | | | |
|---|---|---|---|
| **Meeting** | Council of Governors Public Meeting – 14 August 2024 | | |
| **Title of Report** | **Assurance and Escalation Report** | Agenda Item | 3.2 |
| **Lead Director** | Matt Capper – Director of Strategy and Partnership and Company Secretary | | |
| **Report prepared by** | Emma Tench – Assistant Company Secretary | | |
| **Report Approved by** | | | |
| **Executive Summary** | This report is tendered by the Council of Governors. The report enables escalations from the Council of Governors to be directed to the Trust Board for review and comment.<br><br>The Council of Governors meeting covered the following items:<br>• The council were advised of the upcoming Lead Governor Elections with further information to be cascaded to Governors in due course. The Constitution to be refreshed to state a three-yearly election.<br>• The council were invited to express their interest in observing committees and becoming a member of the Council of Governors Nominations and Renumerations Committee.<br>• The council were given presentations from April Howard on Data Protection and Security, and Wayne Blowers on CQC Well-Led Preparations.<br>• The Annual Report and Accounts were presented to the Council of Governors for the reporting period April 2023 to March 2024. The council noted the contents in preparation for submission to Parliament.<br><br>There were no items for escalation to the Board at the meeting held 14 August 2024. | | |

| **Recommendation/ Actions required** | Approval ☐ | Assurance ☒ | Discussion ☐ | Noting ☐ |
|---|---|---|---|---|
| **Appendices** | None | | | |

***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 |

## ASSURANCE AND ESCALATION HIGHLIGHT REPORT

| Meeting | Meeting Date | Group Chairs |
|---|---|---|
| Council of Governors | 14.08.24 | **David Brake – Lead Governor** |

| Number of attendees | Number of apologies | Quorate | |
|---|---|---|---|
| | | Yes | No |
| 17 | 8 | x | |

**Declarations of Interest Made**

No declarations of interest received against any agenda item.

**Assurance received at the Group meeting**

1) The Governors were assured that the Lead Governor elections were proceeding as planned and would be completed in line with the election roadmap.

**Key actions**

Key actions from the meeting:
1) Constitution refresh.
2) PALS update
3) Governors invited to join committees
4) CQC presentation pack to be circulated to Governors
5) Deputy Lead Governor to be appointed
6) Governor handbook to be circulated
7) Facilitate NHSP training 'what does good look like'

**Highlights from sub-groups reporting into this group**

As per the Council of Governor Minutes

**Items to come back to the Group**

See Actions above

**Items referred to another Group, Subcommittee and or Committee for decision or action**

| Item | Group, Subcommittee, Committee | Date |
|---|---|---|
| Not at this meeting | | |

**Reports not received as per the annual workplan and action required**

None

**Items/risks/issues for escalation**

None

**Implications for the corporate risk register or Board Assurance Framework**

None

**Examples of outstanding practice or innovation**

1) Governors and Executives extended their thanks and appreciation to Mark Spragg and the Governors who have come to the end of their term of office.

# Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

| | | | |
|---|---|---|---|
| **Title of Report** | Board and committee membership and designations from 1st October 2024 | **Agenda Item** | 3.3 |
| **Author** | John Goulston - Chair | | |
| **Lead Executive Director** | N/A | | |
| **Executive Summary** | This paper provides an update on Non-Executive Director designations and Board Committee membership to take account of the changes of the Chair and Non-Executive Directors in 2024, which were approved by the Council of Governors. This report also includes the up to date position on Executive Director designations and Committee membership. | | |
| **Proposal and/or key recommendation:** | The Board is asked to approve:<br>• The Non-Executive and Executive Director membership of committees as set out in section 4, Table 3 effective from 1 October 2024.<br>• The changes to the Non-Executive directors' designations following the approval of the Council of Governors (see sections 5 and 6) covering;<br>  ○ The proposed appointment of deputy chairs to each Board Committee (see section 5, table 4)<br>  ○ The appointment of Jenny Chong as Senior Independent Director (SID)<br>  ○ The appointment of NED champions as detailed in section 6.2 | | |

| **Purpose of the report (Please mark with 'X' the box to indicate)** | | | | |
|---|---|---|---|---|
| | Assurance | | Approval | X |
| | Noting | | Discussion | |

| | | | | | |
|---|---|---|---|---|---|
| **Governance Process:**<br><br>**Committee/Group and Date of Submission/approval:** | Meeting: Council of Governors<br>Date: 14 August 2024 | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) X |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: | Effective: X | Caring: | Responsive: | Well-Led: X |
| **Identified Risks, issues and mitigations:** | Risk – Poor succession planning can pose several significant risks to an organisation:<br>• Sudden departures of key leaders can leave a vacuum, causing instability.<br>• Loss of Institutional Knowledge and experience may be lost when long-serving members leave. | | | | |

| | |
|---|---|
| | • Lack of diverse perspectives and fresh ideas can result in stagnation and poor strategic decisions.<br>• Reputation Damage through inconsistent leadership can harm the organisation's reputation with stakeholders<br><br>Effective succession planning ensures continuity, stability, and the long-term success of the organisation.<br>Mitigation – proposed in the attached paper.<br><br>Risk - Not having the required champion roles on an NHS Board can lead to several risks:<br>• Lack of Specialised Oversight - Champion roles, such as those for maternity safety or wellbeing, provide focused oversight on critical areas. Without these roles, important issues might not receive the attention they need.<br>• Without designated champions, there is a risk of false assurance among board members. They might assume that critical areas are being adequately managed when they are not.<br>• Champion roles help ensure accountability for specific areas. Without them, it can be challenging to hold individuals or committees accountable for outcomes in these areas.<br>• The absence of champions can lead to gaps in governance, as these roles often bring specialised knowledge and focus that contribute to effective decision-making.<br>• Increased Risk of Non-Compliance as certain champion roles are essential for ensuring compliance with regulatory and safety standards. Without them, the board may struggle to meet these requirements.<br><br>Ensuring that all required champion roles are filled is crucial for maintaining high standards of care, governance, and compliance within the NHS well-led framework. |
| **Resource implications:** | The approval of recruiting an additional Non-Executive will carry an additional revenue burden for the duration of their term. |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☒ Not applicable |
| **Legal and Regulatory implications:** | The recommendations contained within this report support requirements by NHS regulators or are recommended as part of a system of good governance. |
| **Appendices:** | • Board and committee membership and designations from 1st October 2024 paper. |
| **Freedom of Information (FOI) status:** | Tick either:<br><br>☒ This paper is disclosable under the FOI Act |

| | | | |
|---|---|---|---|
| **For further information please contact:** | Name: Matthew Capper<br>Job Title: Director of Strategy and Partnerships & Company Secretary<br>Email: m.capper@nhs.net | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | | Assurance minor improvements needed. |
| | Significant Assurance | X | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

**BOARD OF DIRECTORS –**
**BOARD AND COMMITTEE MEMBERSHIP AND DESIGNATIONS**
**From 1 October 2024**

## 1. Introduction and purpose of the report

The Constitution of Medway NHS Foundation Trust (the Trust) sets out the composition and makeup of the Board of Directors (the Board) both in terms of Executive and Non-Executive Directors roles. In addition, there are several other roles which are either required by NHS regulators or recommended as part of a system of good governance.

This paper provides an update on Non-Executive Director designations and Board Committee membership to take account of the changes of the Chair and Non-Executive Directors in 2024, which were approved by the Council of Governors. This report also includes the up to date position on Executive Director designations and Committee membership.

## 2. Non-Executive Director Terms of Office

The appointment of Non-Executive Directors are the responsibility of the Council of Governors. The Council of Governors established the Nominations Committee to consider the appointment and re-appointment of the Chair and Non-Executive Directors and make recommendations to the Council.

The Trust Constitution sets out that "In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence, the Deputy Chair), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors. The Constitution also states that there shall be a majority of NEDs including the Chair.

During 2024, two Non-Executive Directors, Sue Mackenzie and Mark Spragg have left the Board and Adrian Ward, a non-voting Non-Executive Director has also finished his term and left the Board.

The terms of office for the Non-Executive Directors, as at 1 September 2024, are detailed in table 1 below.

**Table 1 - terms of office for the Non-Executive Directors**

| First name | Surname | Start date | (Re) Appointment to the Board | Period of appointment | End date appointment |
|---|---|---|---|---|---|
| John | Goulston | 1/06/2024 | | 3 years | 31/05/2027 |
| Annyes | Laheurte | 1/04/2021 | 1/04/2024 | 3 years | 31/03/2027 |
| Paulette | Lewis | 1/11/2022 | | 3 years | 31/10/2025 |
| Jenny | Chong | 1/01/2024 | | 3 years | 31/12/2027 |
| Mojgan | Sani | 1/09/2023 | | 3 years | 31/08/2026 |
| Gary | Lupton | 1/09/2023 | | 3 years | 31/08/2026 |



Notes
•R – reappointed to the Board of Directors by the Council of Governors for a second term of 3 years.

From September 2023, with the refreshed Code of Governance for NHS Foundation Trusts, only in exceptional circumstances can the Chair or Non-Executive Directors stand for more than two, 3-year terms of office (more than 6 years) and be offered up to further years by the Council of Governors. This has to be agreed by NHS England. The maximum term for a NED is 9 years.

## 3. Board Membership

The Constitution sets out that the Board is made up of a Non-Executive Chair, up to a maximum of six Non-Executive Directors (NEDs) and up to a maximum of six Executive Directors. Table 2 demonstrates that we currently have 5 NEDs plus the Chair and 5 voting Executives (including the Chief Executive).

This means under the Trust's constitution, we have the opportunity to increase the number of NEDs from 5 to 6. Taking account of the skills and experience of the NEDs and the fact that the Trust has a significant deficit and challenging financial environment, the Chair is recommending to the Council of Governors via the Nominations Committee that the Trust urgently recruits a NED with a financial background in complex organisations who has the ability to Chair either the Finance, Performance and Planning Committee or the Audit and Risk Committee.

In order to enable succession planning, the Chair is also recommending to the Council that the Trust appoints an Associate NED with a financial background that can hopefully develop and succeed Annyes Laheurte as NED when her second term finishes on 31 March 2027.

The Board also has an Associate NED nominated by the University of Canterbury Christ Church University. Prof. Chris Burton is standing down on 30 September 2024 following his appointment to the University of East Anglia. The University's, Vice Chancellor has nominated Prof. Jane Perry, Dean of the faculty of Medicine, Health and Social Care to succeed Chris from 1 October 2024. Associate NEDs are non-voting members of the Board.

At the point when an additional NED joins the Board, the Chief Executive has the opportunity to change the voting membership of the Executive Directors by moving both the Chief Operating Officer, Nick Sinclair and the Chief People Officer, Leon Hinton from sharing a vote to each being a full voting member of the Board. This recommendation requires the approval of the Board.

**Table 2 Board Composition**

| **Non-Executive Directors** (As at 1 October 2024) | **Executive Directors** (As at 1 October 2024) |
|---|---|
| John Goulston, Chair | |
| 1. Annyes Laheurte | Jayne Black, CEO |
| 2. Paulette Lewis | Alison Davis, CMO |
| 3. Jenny Chong | Sarah Vaux, Acting CNO |
| 4. Mojgan Sani | Alan Davies, CFO |

| | |
|---|---|
| 5. Gary Lupton | *Nick Sinclair, COO (1/2 vote)* |
| 6. vacant | *Leon Hinton, CPO (1/2 vote)* |
| | Non-voting board members |
| Associate NED - Jane Perry (nominated by Canterbury Christ Church University) | Gavin MacDonald, CDO |
| | Matthew Capper, Director of Strategy, Partnerships and Governance |

The Director of Communications and Engagement, Glynis Alexander reports to the Chief Executive and attends Board meetings.

## 4. Membership of Board Committees

From 1 October 2024, the membership of Board Committees is set out in table 3 below.

**Table 3 - Membership of Board Committees from 1 October 2024**

| **Board member** | **Audit & Risk Committee** *(2 NEDs required for quoracy)* | **Charitable Funds Committee** *(1 NED required for quoracy)* | **Finance Performance & Planning Committee** *(2 NEDs required for quoracy)* | **Quality Assurance Committee** *(2 NEDs required for quoracy)* | **People Committee** *(2 NEDs required for quoracy)* | **Remuneration and Terms of Service Committee** |
|---|---|---|---|---|---|---|
| John Goulston, | | Member | | | | **Chair** |
| Annyes Laheurte | **Chair** | **Chair** | Member | | | Member |
| Paulette Lewis | | Member | | **Chair** | Member | Member |
| Jenny Chong | | Member | Member | | **Chair** | Member |
| Mojgan Sani | Member | Member | | Member | | Member |
| Gary Lupton | Member | Member | **Chair** | | | Member |
| Jayne Black | | Member | Attendance | Attendance | Attendance | |
| Alison Davis | | Member | Attendance | Member | Member | |
| Sarah Vaux | Attendance | Member | | Member | Member | |
| Alan Davies | Attendance | Member | Member | | | |
| Nick Sinclair | | Member | Member | Attendance | Attendance | |
| Leon Hinton | | Member | Attendance | | Member | |
| Gavin MacDonald | | Member | Member | | | |
| Matt Capper | Attendance | Member | Attendance | Attendance | | |

Executive directors will utilise their deputies where necessary to ensure attendance and use specific expertise. As part of good governance, the Chair and the Chief Executive are not members of any of the Board's assurance Committees, however, they may attend Board committee meetings. All Board members including the Chair and the Chief Executive are encouraged to attend at least one meeting per year of the Board's Assurance Committees that they are not formal members of.

## 5. Chairs and Deputies of Board Committees

As detailed in Table 4 each of the Board committees has a chair. In the interests of good governance, each committee should also have a deputy chair. Table 4 proposes the deputy chair for each Board committee. This will be reviewed on the appointment of a sixth NED and then at least on an annual basis in order to ensure that we take account of succession planning.

**Table 4 - Chairs and Deputy Chairs of Board Committees**

| Committee | Chair | Deputy Chair |
|---|---|---|
| Audit and Risk | Annyes Laheurte | Mojgan Sani |
| Quality Assurance | Paulette Lewis | Mojgan Sani |
| Finance Performance and Planning | Gary Lupton | Annyes Laheurte |
| People | Jenny Chong | Paulette Lewis |
| Charitable Funds | Annyes Laheurte | Gary Lupton |
| Remuneration | John Goulston | Jenny Chong |

The Remuneration Committee will be chaired by the Chair of the Trust with the Senior Independent Director as the Deputy Chair of the Committee. Where the Chair proposes an agenda item to the Committee concerning the Chief Executive e.g. a salary change or the appraisal of the Chief Executive, the Deputy Chair of the Committee will chair the relevant item.

## 6. Other Non-Executive Board Leadership responsibilities

### 6.1 Deputy Chair and Senior Independent Director

Paragraph 24.2 of the Trust's Constitution states that "The Council of Governors at a general meeting of the Council of Governors shall appoint the Chair of the Trust and the other Non-Executive Directors, Associate Non-Executive Directors, by approval of a majority of those present."

Deputy Chair means the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties in accordance with paragraph 13.2 of the Constitution if the Chair is absent for any reason.

*The Chair is in discussion with a NED regarding being nominated to the Council of Governors as Deputy Chair of the Trust.*

The Senior Independent Director (SID) is appointed by the Board of Directors (Paragraph 2.11.1). The NHS England code of conduct for NHS providers recommends that the SID should not be the Chair of the Audit and Risk Committee. As a short-term measure, the Acting Chair asked Annyes Laheurte, Chair of the Audit and Risk Committee to also undertake the SID role. This update recommends that Jenny Chong, Chair of the People Committee should become the SID. Appendix 1 provides an overview of the SID role.

### 6.2 Non-Executive Director Champion roles

In addition to the responsibilities in section 6.1 and table 4; there are the following assigned NED champion / lead roles and responsibilities:

- Maternity – Paulette Lewis
- Staff Health & Wellbeing – Jenny Chong
- Freedom to Speak Up – Mojgan Sani
- Security Management – Gary Lupton

In addition, under the 2003 'Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS' and the associated Directions on Disciplinary Procedures 2005, there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only. Medway NHS Foundation Trust follows the framework and will appoint a NED on a case by case basis to fulfil this role.

The above arrangements reflect the guidance issued by the NHS in December 2021 on NED champion roles ("A new approach to Non-Executive director champion roles" December 2021 - https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf). This guidance sets out the approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures. It also describes which roles should be retained (see above) and provides further sources of information on each issue. Table 5 sets out the Board Committees that will champion / lead on these roles.

**Table 5 – Committee leadership roles**

| Role | MFT Committee | Guide suggests |
|---|---|---|
| Hip fractures, falls and dementia | Quality | Quality |
| Palliative and end of life care | Quality | Quality |
| Resuscitation | Quality | Quality |
| Learning from deaths | Quality | Quality |
| Health and safety | Audit and Risk | Quality |
| Safeguarding | Quality | Quality |
| Safety and risk | Audit and Risk | Quality |
| Lead for children and young people | Quality | Quality |
| Counter fraud | Audit and Risk | Audit and Risk |
| Emergency preparedness | Audit and Risk | Audit and Risk |
| Procurement | Finance, Performance & Planning | Finance |
| Cyber security | Executive | Finance/ Board |
| Security management – violence and aggression | People | Workforce |

Health and Safety and safety and risk are led by the Audit and Risk Committee, which has an effective link to the corporate assurance management and corporate and quality compliance arrangements. It is not therefore proposed to change this arrangement.

Similarly, cyber security is effectively overseen by the Executive Management Committee and whilst the Finance, Business and Investment Committee oversees digital, the risk component sits best with Executive.

## 7. Recommendations

The Board is asked to approve:

7.1. The Non-Executive and Executive Director membership of committees as set out in section 4, Table 3 effective from 1 October 2024.

7.2. The changes to the Non-Executive directors' designations following the approval of the Council of Governors (see sections 5 and 6) covering;

7.2.1. The proposed appointment of deputy chairs to each Board Committee (see section 5, table 4)

7.2.2. The appointment of Jenny Chong as Senior Independent Director

7.2.3. The appointment of NED champions as detailed in section 6.2

## 8. Next steps

The Board is asked to note:

8.1. The composition of the Board and its voting membership as set out in section 3.

8.2. This report will be forwarded to the Council of Governors meeting on 20 November 2024 for the Council to note the updated Board designations and Committee membership.

8.3. The Chair will propose to the Nominations Committee of the Council of Governors the appointment of a Deputy Chair of the Trust.

**30 August 2024**

**Chair, John Goulston**

**Medway NHS Foundation Trust**

**APPENDIX 1**

## The role of the Senior Independent Director

The senior independent director has a key role in supporting the chair in leading the board of directors and alongside the deputy chair, acting as a sounding board and source of advice for the chair. The senior independent director also has a role in supporting the chair as chair of the council of governors.

### 1.1 Role Description

The senior independent director is a non-executive director appointed by the board of directors as a whole in consultation with the council of governors to undertake the role described below. NHSE best practice guidance states that the senior independent director should not be the deputy chair or the chair of the Audit Committee of the board of directors.

The senior independent director will be available to members of the foundation trust and to governors, if they have concerns which contact through the usual channels of chair, chief executive, finance director and company secretary has failed to resolve or where it would be inappropriate to use such channels. The senior independent director should liaise with the lead governor in the areas where their roles are complementary. The senior independent director also has a role in supporting the chair as chair of the council of governors. The senior independent director should hold a meeting with the other non-executive directors in the absence of the chair at least annually as part of the appraisal process. There may be other circumstances where such meetings are appropriate. Examples might include informing the re-appointment process for the chair, where governors have expressed concern regarding the chair or when the board is experiencing a period of stress. While the council of governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair.

The senior independent director should also be available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example. In rare cases where there are concerns about the performance of the chair, the senior independent director should provide support and guidance to the council of governors in seeking to resolve concerns or, in the absence of a resolution, in taking formal action. The senior independent director should liaise with the lead governor in such circumstances.

In exceptional circumstances where the board is undergoing a period of great stress, the senior independent director has a vital role in intervening to resolve issues of significant concern. These exceptional circumstances might include unresolved concerns on the part of the council of governors regarding the chair's performance; where the relationship between the chair and chief executive is either too close or not sufficiently harmonious; where the trust's strategy is not supported by the whole board; where key decisions are being made without reference to the board or where succession planning is being ignored.

In the circumstances outlined above, the senior independent director will work with the chair, deputy chair, other directors and/or governors, to resolve significant issues. Boards of directors and councils of governors need to have a clear understanding of the circumstances when the senior independent director might intervene so that the senior independent director's intervention is not sought in respect of trivial or inappropriate matters.

# Meeting of the Trust Board
## 10 September 2024

| | | | |
|---|---|---|---|
| **Title of Report** | **Trust Risk Register Report** | Agenda Item | 4.1 |
| **Lead Director** | Sarah Vaux, Interim Chief Nursing Officer | | |
| **Report Author** | Louise Furlong; Head of Quality & Safety | | |
| **Executive Summary** | The risk register report is intended to give the members of the Trust Board assurance as to the current position of the Trusts risks management system.<br>The report also responds to the regulatory and statutory duties such as those overseen by the Care Quality Commission (CQC), Ofsted and Health & Safety Executive to implement effective risk management systems. It also reflects the NHS Foundation Trust Code of Governance, and the Compliance Framework.<br>The data provided in this report was current as of the 28th August 2024 | | |
| **Committees or Groups at which the paper has been submitted** | Risk and Compliance Sub-Committee | | |
| **Resource Implications** | NIL | | |
| **Legal Implications/ Regulatory Requirements** | NA | | |
| **Quality Impact Assessment** | NA | | |
| **Recommendation/ Actions required** | | | |
| | Approval ☐ | Assurance ☒ | Discussion ☐ | Noting ☐ |
| **Appendices** | Trust Risk Register Report (including deep dive into Cancer & Access) | | |

| ***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 |

# Meeting of the Trust Board
# Tuesday, 10 September 2024

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Board Assurance Framework | | **Agenda Item** | 4.2 |
| **Author** | Integrated Governance Practitioner | | | |
| **Lead Executive Director** | Chief Financial Officer, Sustainability<br>Chief Medical Officer, Quality<br>Chief Nursing Officer, Patient<br>Chief Operating Officer, Systems & Partnerships<br>Chief People Officer, People | | | |
| **Executive Summary** | The Board Assurance Framework is the Board level register of risks which may affect the achievement of the Trust's strategic objectives. Risks on the BAF are owned and monitored by the Trust Board of Directors and managed through the Executive Board.<br>The Board Assurance Framework (BAF) consists of 18 strategic risks aligned to each of the Trust's True North Domains. | | | |
| **Proposal and/or key recommendation:** | The Trust Board is asked to note the report for assurance and discussion. | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | ✓ | Approval | |
| | Noting | ✓ | Discussion | ✓ |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | N/A | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | | |
| | Priority 1: (Sustainability) ✓ | Priority 2: (People) ✓ | Priority 3: (Patients) ✓ | Priority 4: (Quality) ✓ | Priority 5: (Systems) ✓ |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: ✓ | Effective: ✓ | Caring: ✓ | Responsive:✓ | Well-Led: ✓ |

| | |
|---|---|
| **Identified Risks, issues and mitigations:** | As outlined in the relevant sections of the Board Assurance Framework. |
| **Resource implications:** | N/A |

| | | | |
|---|---|---|---|
| **Sustainability and /or Public and patient engagement considerations:** | N/A | | |
| **Integrated Impact assessment:** | N/A | | |
| **Legal and Regulatory implications:** | There are regulatory requirements on the Trust to have effective systems and processes for the identification and management of risk. | | |
| **Appendices:** | Board Assurance Framework (PDF) | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | |
| **For further information or any enquires relating to this paper please contact:** | Integrated Governance Team<br>medwayft.integratedgovernance@nhs.net | | |
| **Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | ✓ | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board (Public and Private)
# Tuesday, 10 September 2024

| | | | |
|---|---|---|---|
| **Title of Report** | Integrated Quality and Performance Report for Month 4: 2024 | **Agenda Item** | 4.3 |
| **Author** | Gemma Brignell, Director of Planning and Operational Performance | | |
| **Lead Executive Director** | Gavin MacDonald (Chief Delivery Officer) | | |
| **Executive Summary** | This Report relates to the Month 4: 2024 and provides te Board with an update of performance against the Trusts Strategic Priorities.<br><br>**Overall summary:**<br><br>• The People domain continues to show the highest volume in metrics improving for Statistical Variance, however the Patients domain shows the highest % of statistical improvement metrics (~58% of all metrics)<br>• The Systems & Partnerships domain is showing the highest number of variances that are statistically showing concern, with 41% of all metrics flagging<br>• Both Quality and Sustainability domains show that the majority of their metrics are not showing any significant statistical change and as such are showing common variation.<br>• Overall, 69 metrics are now showing improved statistical variance (-2 from last month) against 34 which are showing concern (+2 from last month).<br><br>Key areas of improvement are identified with actions and mitigations being taken by operational teams which are contained in the report<br><br>**Domain summary:**<br><br>***Patients***<br>• Patients recommending the hospital has reached 91.1% overall which is the highest achieved to date<br>• Response rate has doubled overall in 23-24 since 22-23 with 60k responses from patients in the last year.<br>• A reduction has been seen overall in the number of negative responses by theme however clinical treatment remains the highest contributor<br>• Issues remain with patients reporting difficulties being able to contact someone from their medical team in regards to appointments / results. This information correlates with PALS enquiries<br>• Whilst FFT, Patient experience and Complaints have triggered business rules, these are all an improving position except Emergency care who saw a 1.9% decrease in the recommend rate<br>• Mixed sex breaches have significantly reduced as a consequence of the admission and discharge lounge closing overnight and not used as a bedded facility. The top contributors are ICU and Trafalgar patients who require a step down to a ward bed<br>• Complaints position remains stable with 31 cases open at month end | | |

- 4 complaints re-opened – Higher than average but anticipated due to the complexity of the cases
- Breached complaints position is improving at 6.7%
- 1 upheld Ombudsman case – the first to be upheld or partially upheld for 9 months

***Quality***

- Hospital Standardised Mortality Ratio (HSMR) (Apr 23- Mar 24) 113.7 'higher than expected'. Despite a recent improvement in crude rate, expected rate continues to deteriorate.
- Summary Hospital Level Mortality (SHMI) (Mar 23- Feb 24) 1.18 'higher than expected'. In-hospital deaths have increased over time, while out of hospital deaths have decreased. This is the highest value the Trust has seen.
- Patients with a primary diagnosis on admission as 'COPD & Bronchiectasis' remains a concern. This diagnosis group has continued to alert as having an increased observed death rate for over a year.
- Clinical incidents with harm as moderate or above have decreased by 41.6% compared to June.
- 98.9% of all incidents reported resulted in low or no harm.
- 7 incidents in July caused moderate harm or above
- 1 maternal death, not thought to be caused by omissions in care.
- Reduction in falls overall and no falls resulting in moderate or severe harm in July.

***System and Partnerships***

- Emergency care Consistently over achieving against the 78% threshold in July at 78.7%
- The hospital has 61.6 overnight admissions per year to each bed whereas the average for England is 55 overnight admissions per year to each bed. To put this in another way, the hospital has 548 beds but a hospital with its workload would normally have 593 beds.
- Number of patients >12 hours in department continues to be a challenge – July 6.7%
- Ongoing delays with endoscopy contributing to poor RTT performance and over 65 week waits within gastro and colorectal – the on-site mobile unit will support improvement with an additional 392 units of capacity and PPG will provide a further 200 units from September.
- Collaborative review of booking processes between MFT and PPG to provide a further 200 units of capacity.
- ENT have improved their position and majority of over 65 week waits now have a TCI.
- Rheumatology locum to provide additional clinics to eliminate any patient waiting over 65 weeks at the Fleet site
- Cardiology are in conversation with an insourcing company to provide additional weekend clinics and to ensure no patient waits over 65 weeks to be seen and treated.
- Cancer performance continues to be low in June across breast and total however this is in line with recovery trajectories and a significant improvement is reported for July

***People***

- The breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% with July 2024 reporting significantly off target

| | |
|---|---|
| | in month. The majority of leavers had stay conversations as part of the new intention to leave process<br>• Absence remains above target with an improvement for July; however, this remains higher than normal for July. Reasons for sickness remain high for musculoskeletal-related absences, cold/flu and pregnancy-related. Triangulation meetings for employee relations, wellbeing and occupational health now underway for root cause determination and countermeasures.<br>• Medical staffing time to hire is now on target at 42.6 days. Successful recruitment to difficult to appoint roles including consultant anaesthetists.<br>• Appraisals remain off target but improving. Focus on the corporate areas performance (off track) is focus for July and August.<br>• Continued improvements to nursing bank fill rate for demand at 84.9%.<br><br>***Sustainability***<br>• The Trust reports on plan for the month and £0.5m adverse YTD, driven by over £0.5m of industrial action costs incurred in June.<br>• We await further guidance nationally on whether these will be funded, treated as an "allowable miss" or if the Trust will be expected to absorb the cost within plan.<br>• Efficiency program has identified £16.1m of budget out/ income efficiencies with an additional £2.5m of run rate efficiencies identified<br>• The full year effect of budget out/income schemes is £18.3m (excluding Run rate and operational efficiency initiatives) £14.2m is budget out and £4.1m is income<br>• Delivery has been corrected to the months delivered and show the trust has over performed months 1-4 against submitted plan and under delivery is due to reporting issues<br>• HR data currently demonstrates a reduction of 144 WTE up to 12/08/24 with a remaining 256 to be identified to hit target<br>• There are a number of contractual assumptions between the Trust and the commissioner that are not aligned and present a potential risk to the financial performance. |
| **Proposal and/or key recommendation:** | The Board is asked to review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive Director to undertake. |

| **Purpose of the report (tick box to indicate)** | | | | |
|---|---|---|---|---|
| | Assurance | X | Approval | |
| | Noting | X | Discussion | |

| **(If appropriate) state reason for submission to Private section of Board:** | | | | |
|---|---|---|---|---|
| | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |

| | |
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| **Committee/Group at which the paper has been submitted:** | This has been requested in response to Trust Chair / NED feedback from regulatory preparations |

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|---|---|---|---|---|---|
| | | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | | |
| | Priority 1: (Sustainability) √ | Priority 2: (People) √ | Priority 3: (Patients) √ | Priority 4: (Quality) √ | Priority 5: (Systems) √ |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: | Effective: | Caring: | Responsive: | Well-Led: √ |
| **Identified Risks, issues and mitigations:** | No recommendations being made. Summary position document for 2022-23 and 2023-24 | | | | |
| **Resource implications:** | None | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | This is a summary paper which states current position on delivery against planned priorities | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☐ **Not applicable (*please indicate why an equality assessment was not required). This is not a recommendations paper/*** | | | | |
| **Legal and Regulatory implications:** | N/A – this is not a recommendations paper | | | | |
| **Appendices:** | Summary paper only – Patient First in Action (2 year review) | | | | |
| **Freedom of Information (FOI) status:** | State either:<br><br>**This paper is disclosable under the FOI Act**, or<br><br>This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | | | |
| **For further information or any enquires relating to this paper please contact:** | Gavin MacDonald (Chief Delivery Officer) gavin.macdonald3@nhs.net | | | | |

| | | |
|---|---|---|
| **Reports require an assurance rating to guide the discussion:** | No Assurance | There are significant gaps in assurance or actions |
| | Partial Assurance | There are gaps in assurance |
| | **Assurance** | Assurance with minor improvements needed. |
| | Significant Assurance | There are no gaps in assurance |
| | Not Applicable | No assurance required. |

NHS
Medway
NHS Foundation Trust

# Physician Associates at Medway Maritime Hospital

Professor Hasib Ahmed
MBBS(Lond) FRCOG MSc Adv Gyn Endosc
Consultant Obstetrician and Gynaecological Surgeon
PA Lead Medway NHS FT

Patient FIRST

# Introduction
# What is a PA

Brief history and development of the role

Supervision and scope of practice

Importance in the healthcare system

Value in secondary care

BMJ Open

What is the contribution of physician associates in hospital care in England? A mixed methods, multiple case study Vari M Drennan,1 Mary Halter,1 Carly Wheeler,1 Laura Nice,2 Sally Brearley,3 James Ennis,2 Jonathan Gabe,4 Heather Gage,5 Ros Levenson,6 Simon de Lusignan,7 Phil Begg,8 James Parle2

Contribution of physician assistants/ associates to secondary care: a systematic review Mary Halter,1 Carly Wheeler,1 Ferruccio Pelone,2 Heather Gage,3 Simon de Lusignan,4 Jim Parle,5 Robert Grant,1 Jonathan Gabe,6 Laura Nice,5 Vari M Drennan1

# Roles and Responsibilities

Taking medical histories and conducting examinations

Diagnosis, differential and proposing management plans

Performing diagnostic and therapeutic procedures

Providing health promotion and disease prevention advice

# Limitations

**MUST** work under clinical supervision of specialist

**CANNOT** prescribe

**CANNOT** order investigations involving ionising radiation

**BESPOKE** career development in collaboration with supervisor

# Training and Education

Biomedical Degree

Postgraduate training programme – Masters

Clinical placements

Hands-on experience

Continuing Professional Development

Regulation – MVA  GMC from 131224

Eighth cohort of students currently

Increasing numbers of students with no placements

# Working Environment and Impact

Primary or secondary care
Supervised by doctors
Collaboration with wider healthcare team
Continuity
Future prospects and career development

Part of workforce at Medway
ED 4
Surgery 2
Neonatology 1

# Meeting of the Trust Board in Public
# 10 September 2024

| | | | |
|---|---|---|---|
| **Meeting** | Quality Assurance Committee | | |
| **Title of Report** | **Assurance and Escalation Report** | Agenda Item | 6.1 |
| **Lead Director** | Alison Davis / Sarah Vaux | | |
| **Report prepared by** | Sarah Vaux | | |
| **Report Approved by** | Paulette Lewis | | |
| **Executive Summary** | The Committee received a number of reports for assurance and to note progress. No new areas of risk were identified. | | |
| **Committees or Groups at which the paper has been submitted** | n/a | | |
| **Resource Implications** | n/a | | |
| **Legal Implications/ Regulatory Requirements** | n/a | | |
| **Quality Impact Assessment** | none | | |
| **Recommendation/ Actions required** | | | |
| | Approval ☐ | Assurance ☒ | Discussion ☐ | Noting ☐ |
| **Appendices** | Nil | | |

***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 |

NHS Medway NHS Foundation Trust

# ASSURANCE AND ESCALATION HIGHLIGHT REPORT

| Meeting | Meeting Date | Group Chairs |
|---|---|---|
| QAC | 08/08/2024 | **Paulette Lewis** |

| Number of attendees | Number of apologies | Quorate | |
|---|---|---|---|
| | | Yes | No |
| 11 | 1 | X | |

## Declarations of Interest Made

Nil in addition to DoI register

## Assurance received at the Group meeting

*(overview of key points/issues/matters on the agenda discussed at the Group meeting, including anywhere the group was unable to obtain assurance or there may be an adverse impact for the Trust (e.g. potential impact on: strategic progress, compliance or patient safety). Consider whether the agenda was fit for purpose – e.g. linked to the terms of reference and the work plan for that month)*

The Committee received:

- the quality and safety risk register and the Board Assurance Framework (BAF) and discussed the content. The revised approach to BAF reporting was discussed. Members confirmed approval of risks and noted the reports.
- The Maternity CQC Picker report which included an update on the actions an the trajectory to complete the final few remaining. The Committee were assured by the report.
- The Mortality Review and Action log. The trust had developed an improvement plan in response to the recommendations made in the report and the implementation at Trust and divisional level was discussed. The Committee noted the report.
- The Mortality and Morbidity Assurance and Escalation Report was discussed. The activity in relation to reviewing deaths wads outlined as well as the process for learning. The Committee noted the report.
- The Quality Strategy Implementation Update which included progress against the key areas of focus which are either on track or completed. The Committee approved the report.
- The Integrated Quality Performance Report was reviewed and the links to Truse North and Strategic Objectives were discussed. The Committee noted the report.

## Key actions

Learning from deaths report will come to the Committee monthly.

## Highlights from sub-groups reporting into this group

*(Short description of any key successes / risks highlighted by the sub-groups. Outline any key projects delegated, e.g. task and finish exercises on a specific issue)*

The Committee received the report from QPSSC and discussed the content. Of particular note were:

- Issues regarding uptake of mandatory training were reviewed with particular reference to difficulties experienced by some staff groups in engaging.
- Update on ED quality week and improvement plan.
- Approach to support for divisions in relation to pharmacy and quality.
- Divisional mortality and morbidity meetings taking place monthly within divisions and feeding into divisional governance boards.

The Committee were assured by the report.

## Items to come back to the Group

*(Items the Group is keeping an eye on outside its routine business cycle)*

The meeting will receive reports on Antimicrobial stewardship and mattresses in September.

## Items referred to another Group, Subcommittee and or Committee for decision or action

| Item | Group, Subcommittee, Committee | Date |
|---|---|---|
| Nil | | |

## Reports not received as per the annual workplan and action required

Nil

## Items/risks/issues for escalation

*(Describe the reason for the item being escalated, where it has been escalated to and what action the group needs to take as a result. This may be include for example outstanding action where limited progress has been made)*

**Issues and or Risks to note:**
Nil identified

**Reflection:**
The agenda was more manageable in the time allocated which allowed for fuller discussion.

## Implications for the corporate risk register or Board Assurance Framework

Nil

## Examples of outstanding practice or innovation

Nil

# Meeting of the Board of Directors in Public
# Tuesday, 10 September 2024

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Assurance report – People Committee 31 July 2024 | | **Agenda Item** | 6.2 |
| **Author** | Leon Hinton, Chief People Officer | | | |
| **Committee Chair** | Jenny Chong, Chair of Committee/NED | | | |
| **Executive Summary** | Assurance report to the Trust Board from the People Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee. | | | |
| **Proposal and/or key recommendation:** | Not applicable | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | ✓ | Approval | |
| | Noting | | Discussion | |
| **Committee/Group at which the paper has been submitted:** | People Committee, 31 July 2024 | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) ✓ | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | |
| | Safe: | Effective: | Caring: | Responsive: | Well-Led: ✓ |
| **Integrated Impact assessment:** | Where applicable, Individual considerations are provided at the People Committee. | | | |
| **Legal and Regulatory implications:** | Individual legal and regulatory implications are provided at the People Committee. | | | |
| **Appendices:** | None | | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act. | | | |
| **For further information or any enquires relating to this paper please contact:** | Leon Hinton, leon.hinton@nhs.net | | | |
| **Reports require an assurance rating to guide the discussion:** | No Assurance | There are significant gaps in assurance or actions | | |
| | Partial Assurance | There are gaps in assurance | | |
| | Assurance | Assurance with minor improvements needed. | | |

| | | |
|---|---|---|
| | Significant Assurance | There are no gaps in assurance |
| | Not Applicable | No assurance required. |

## ASSURANCE AND ESCALATION HIGHLIGHT REPORT

| Number of Member Attendees | Number of apologies | Quorate | |
|---|---|---|---|
| | | Yes | No |
| 4 | 1 | x | |

**Declarations of Interest Made**

None

**Items referred to another Group, Subcommittee and or Committee for decision or action**

| Item | Group, Subcommittee, Committee | Date |
|---|---|---|
| None | | |

**Reports not received as per the annual workplan and action required**

| | | |
|---|---|---|
| People Promise update report deferred to September due to time | September Committee | |
| | | |
| | | |
| | | |

**Items/risks/issues for escalation**

**Issues and or Risks to note:** (1) Recommend to Board to approve the Medical Appraisal and Revalidation Annual Report; (2) Freedom to Speak Up items of concern to be highlighted with the assurance report.
**Reflection:** Future meetings to address (1) quality of appraisals; (2) improving moving and handling level 2 compliance; (3) BAME doctors revalidation data; (4) improving freedom to speak up psychological safety; (5) improving safeguarding level 3 compliance; (6) improving the culture; (7) reducing agenda for more discussion time.

**Implications for the corporate risk register or Board Assurance Framework**

None recorded

| Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below. | Assurance Level |
|---|---|
| **1. IQPR**<br>The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for April 2024. The Committee were **ASSURED** by the report:<br>• True North (Staff Engagement) – [6.65, 0.02 improvement, 0.28 below target] third successive increase; however, ranked score has worsened with the Trust remaining in the further quartile for staff engagement nationally;<br>• Breakthrough (turnover) – [0.9%, 0.1% deterioration, on target];<br>• Staff appraisal – [87.8%, -0.8% deterioration, 2.2% off target] progress remains low; backlog of appraisals has been resolved; corporate areas targeted for improvement. Appraisal quality audits will be included in future People Committee reports;<br>• Vacancy rate – [7.7%, no change, on target]. | Assurance |

| | |
|---|---|
| • Voluntary turnover – [8.7%, -0.1% improvement, 0.7% off target] continues to improve along with stability and reduced vacancies. No significant outliers to improving position by staff group.<br>• Staff fill rates – improving position for achieving required staffing versus planned staffing and increased care hours per patient day (CHPPD) and now near CHPPD target of 9.5;<br>• Sickness absence – [5%, +0.3% deterioration, 1% off target] improvement to long-term sickness however worsening short-term sickness. OH business case being implemented to support meeting target and improve health and wellbeing of staff;<br>• StatMan – [89%, +0.2% improvement, on target] improvements across the majority of areas including face-to-face. Particular work with moving and handling training to change delivery method to improve compliance and retain compliance to CSTF standards; however delayed due to absence. This is also a national project to rationalise the increasing demands for StatMand training requirements for staff with the aim of improving standards whilst decrease the training time. | |
| **2. People Strategy 2024-2027 implementation plan and status update**<br>The Committee **NOTED** the update on the People Strategy implementation plan, the detailed actions underway and informed that there were no immediate barriers to implementation. No new risks nor issues were raised. In the future, the Committee is to receive a status update report evidencing impact on agreed KPIs. Of the 42 activities, 40 were green rated (from 38) out of 42 activities. The Committee reviewed the four pillars of i) Becoming an employer of choice; ii) growing our talent; iii) keeping our people thriving at work; iv) delivering new ways of working. | Not Applicable |
| **3. Board Assurance Framework (BAF) and Risk Register**<br>The Committee discussed the revised People BAF items, mitigations, actions and gaps in control for items 3d, 3e and 3f. No changes were made to the scoring. The Committee discussed the risk register and requested review of the risk associated with workforce growth. The Committee were **ASSURED** and **NOTED** the report. | Assurance |
| **4. Policies for approval**<br>The Committee **APPROVED** the following policies following comment:<br>• On-call policy. | Not Applicable |
| **5. Health and Wellbeing Guardian Assurance Report Q1 2024/25**<br>The Committee received a report providing an update of the wellbeing dashboard metrics and a migration based on the new guidance; this reported against the newly updated 12 key responsibilities. 32 listening ear events were held, and information triangulated with freedom to speak up and bullying and harassment. A weekly perimeter walk and talk session now has 25 participants.<br>The Committee were **ASSURED** by the report. | Assurance |
| 6. **Anti-Bullying and Harassment Group**<br>The Committee received an assurance report covering triangulation of WRES reporting and employee relations cases representing improvements to band 5 to band 6 but issues remained for diversity to a higher level along with deterioration of BAME colleagues entering into disciplinary investigations. Triangulation of information sources has resulted in the group identifying areas for targeted support. The Committee **NOTED** the report. | Partial Assurance |

| | |
|---|---|
| **7. HR and OD Performance**<br>The Committee were **ASSURED** of HR and OD performance against workplan. | Partial Assurance |
| **8. Medical Appraisal and Revalidation Annual Report**<br>The Committee received the annual report demonstrating the compliance of 592 doctors and five dentists connected to the Trust as at 31 March 2024 along with recommendations for the forthcoming year. The Committee asked for further work in relation to proportion of BAME doctors and cases raised. The Committee were **ASSURED** by the report. | Assurance |
| **9. Industrial Action**<br>The Committee **NOTED** an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations, tactical command group structure, redeployment, national EPRR exercises and communicating with staff. The Committee **NOTED** the report. | Assurance |
| **10. Freedom to Speak Up Report Q4 2023/24 and Q1 2024/25**<br>The Committee received two quarterly reports from the Lead Freedom to Speak Up Guardian highlighting resource concern for the role, which is to be addressed in the new model from September. A year-on-year increase of cases was reported and the associated actions and learning. Cases raised anonymously had increased in quarters two and three. The Committee were **ASSURED** by the report. | Partial Assurance |
| **11. Mandated Equality Data Reports**<br>The Committee received three mandated data reports for Equality, Diversity and Inclusion: the Gender Pay Gap 2023/24, the Workforce Disability and Race Equality Standard (WDES and WRES respectively). The report highlighted particular concern of the medical pay gay, although improving still contributes to the overall gap of 27.9% mean. In addition the Committee discussed the overrepresentation of BAME/GM staff in formal disciplinary procedures. The Committee **APPROVED** the report. | Partial Assurance |
| **12. Staff Survey**<br>The Committee received a report highlighting steps to improve take up and learning from the 2023 staff survey through further moves to online surveys, development work for the staff survey reporting dashboard and research into incentives to support survey completion. The Committee **NOTED** the report. | Assurance |

# Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

| | | | |
|---|---|---|---|
| **Title of Report** | Finance Planning and Performance Committee Assurance Report – 29 August 2024 | **Agenda Item** | 6.3 |
| **Author** | Paul Kimber, Deputy Chief Financial Officer | | |
| **Committee Chair** | Gary Lupton, Non-Executive Director | | |
| **Reports require an assurance rating to guide the discussion:** | No Assurance | There are significant gaps in assurance or actions | |
| | Partial Assurance | There are gaps in assurance | |
| | Assurance | Assurance with minor improvements needed. | |
| | Significant Assurance | There are no gaps in assurance | |
| | Not Applicable | No assurance required. | |

**Key headline and assurance level**

| Key headline | Assurance Level |
|---|---|
| **1. Corporate Risk Register**<br>The reports for Sustainability and Systems and Partnership were reviewed. Further assurance was required in respect of the actions and ownership of the high scoring risks.<br>The Committee **NOTED** the reports. | Partial assurance |
| **2. Board Assurance Framework (BAF)**<br>The reports for Sustainability and Systems and Partnership were presented. Further consideration to the scoring of Sustainability risks was considered necessary for next month.<br>The Committee **NOTED** the reports. | Partial assurance |
| **3. Forecast outturn**<br>The Chief Financial Officer presented the report, outlining the potential risks and associated mitigations in the forecast against control total, together with the actions and governance by which this was being managed.<br>It was noted that a paper is due to the Trust Board on this topic, giving confidence in the forecast outturn.<br>The Committee **NOTED** the report. | Partial assurance |
| **4. Elective Hub update** | Not applicable |

| | |
|---|---|
| Progress and next steps for an offsite elective hub were discussed, including consideration of alternative options.<br>The Committee **NOTED** the update. | |
| **5. Cash position**<br>The current cash constraints, cash support draw downs and options for management of cash reserves was discussed. Supplier relationships were noted as a critical part of the Trust being able to do business.<br>The Committee **NOTED** the update. | Partial assurance |
| **6. Operational efficiencies**<br>The basis of the target, progress to date and areas of opportunity to drive improved delivery were discussed.<br>The Committee **NOTED** the update. | Partial assurance |
| **7. Finance Report M4**<br>The Committee received the paper for Month 4/July 2024, reporting a YTD deficit of £12.2m, being £0.5m adverse to control total. Discussion was held in respect of the process by which divisional performance is managed.<br>The position on capital expenditure and expectations around capitalisation of lease costs was also considered.<br>The Committee **NOTED** the report, with some gaps in assurance. | Partial assurance |
| **8. Activity Report**<br>The Director of Planning and Performance presented the report, outlining key activity variances from plan, the drivers and the constitutional standards performance.<br>The Committee **NOTED** the report. | Assurance |
| **9. Emergency Department analysis report**<br>A report considering the ED activity compared to cost was presented and discussed, giving rise to conversations on safer staffing, inflation, block contract funding, operational performance and productivity.<br>The Committee **NOTED** the update. | Partial assurance |
| **10. No Criteria To Reside**<br>This paper presented the cost and impact of c120 beds at the Trust being occupied. Further work was noted as being necessary, including working with HaCP partners.<br>The Committee **NOTED** the update. | Partial assurance |
| **11. Reducing waste programme** | Partial assurance |

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| | The latest position on both the waste reduction efficiencies, operational efficiencies and run-rate improvement opportunities was presented and discussed by the Committee.<br>The Committee **NOTED** the report. | |
| | **12. Integrated Quality Performance Report (IQPR)**<br>The Committee **NOTED** the report. | Partial assurance |

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| **Proposal and/or key recommendation:** | None other than business as usual. | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | ✓ | Approval | |
| | Noting | | Discussion | |
| **Committee/Group at which the paper has been submitted:** | Finance, Performance and Planning Committee – 29 August 2024 | | | |

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| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | | |
| | Priority 1: (Sustainability) ✓ | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) ✓ |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: | Effective: ✓ | Caring: | Responsive: | Well-Led: ✓ |
| **Identified Risks, issues and mitigations:** | All risk, issues and mitigations are referenced in the Corporate Risk Register and Board Assurance Framework items. | | | | |
| **Resource implications:** | Individual resource considerations are provided at the Finance, Planning and Performance Committee | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | Individual considerations are provided at the Finance, Planning and Performance Committee | | | | |
| **Integrated Impact assessment:** | Where applicable, individual considerations are provided at the Finance, Planning and Performance Committee | | | | |

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| **Legal and Regulatory implications:** | Individual legal and regulatory implications are provided at the Finance, Planning and Performance Committee |
| **Appendices:** | None |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act |
| **For further information or any enquires relating to this paper please contact:** | Alan Davies, alan.davies@nhs.net |

# Meeting of the Trust Board
# Tuesday, 10 September 2024

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| **Title of Report** | Finance Report – month 4 | **Agenda Item** | 7.1 |
| **Author** | Dan Thompson, Finance Business Partner<br>Cleo Chella, Associate Director Income & Contracts<br>Isla Fraser, Financial Controller | | |
| **Lead Executive Director** | Alan Davies, Chief Finance Officer | | |
| **Executive Summary** | • The Trust reports a deficit of £2.3m in month 4, and £12.2m year to date (YTD); the YTD performance is adverse to plan by £0.5m, mainly due to unbudgeted costs of £0.5m arising from industrial action.<br>• The efficiency programme has under delivered by £0.4m against the YTD plan of £4.5m.<br>• The capital position is underspent as at month 4 due to the timing of schemes being delivered (principally CDC leases being signed)/awaiting approval of the full current year programme.<br>• Cash at the end of June was £9.6m. The Trust continues to draw down its deficit support funding – the cash position overall continues to be a concern and will require careful management and solutions. This could impact on performance against the Better Payment Practice Code to ensure we have sufficient monies to pay staff and creditors. | | |
| **Proposal and/or key recommendation:** | The committee is asked to note this report. | | |

| **Purpose of the report (Please mark with 'X' the box to indicate)** | | | | |
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| | Assurance | | Approval | |
| | Noting | ✓ | Discussion | |

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| **Committee/Group submitted:**<br><br>**Date of Submission:** | Meeting: Finance, Planning and Performance Committee<br>Date: 29 August 2024 |

| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
|---|---|---|---|---|---|
| | Priority 1: (Sustainability) ✓ | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |

| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
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| | Safe: | Effective: | Caring: | Responsive: | Well-Led: ✓ |

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| **Identified Risks, issues and mitigations:** | Non-delivery of the breakeven control total.<br>Careful cash management. |

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| **Resource implications:** | The report sets out the financial resources /performance / position of the Trust | | |
| **Sustainability and /or Public and patient engagement considerations:** | N/A | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☑ Not applicable (*please indicate why an equality assessment was not required)* | | |
| **Legal and Regulatory implications:** | Achieving breakeven is a statutory duty | | |
| **Appendices:** | N/A | | |
| **Freedom of Information (FOI) status:** | Tick either:<br>☑ This paper is disclosable under the FOI Act<br>☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | |
| **For further information please contact:** | Name: Alan Davies<br>Job Title: Chief Finance Officer<br>Email: Alan.Davies13@nhs.net | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | ✓ | No assurance required. |

# Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

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| **Title of Report** | Forecast outturn and mitigations | | **Agenda Item** | 7.2 |
| **Author** | Paul Kimber, Deputy Chief Financial Officer | | | |
| **Lead Executive Director** | Alan Davies, Chief Financial Officer | | | |
| **Executive Summary** | The Trust is forecasting a draft unmitigated deficit of £38.6m, being £10.8m adverse to its control total of £27.8m. The Trust **must** identify mitigating actions to address this projected risk/overspend.<br><br>21 different lines have been identified, with each unmitigated overspend assigned to an executive lead to ensure full understanding, agreement and mitigation of the pressure. An Executive lead Task and Finish Group has been establised, chaired by the Chair of the Finance, Planning and Performance Committee, to oversee this work. | | | |
| **Proposal and/or key recommendation:** | The Board is asked to note this report. | | | |
| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | | Approval | |
| | Noting | X | Discussion | |
| **Committee/Group submitted:**<br><br>**Date of Submission:** | Finance T&F Group<br>Weekly meetings since 5th August 2024<br>Trust Executive Committee<br>Finance, Planning and Performance Committee – 29th August 2024 | | | |

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| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) X | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: | Effective: | Caring: | Responsive: | Well-Led: X |

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| **Identified Risks, issues and mitigations:** | There is a risk that the Trust does not meet its control total in 2024/25. |
| **Resource implications:** | This paper considers the Trust's use of resources. |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |

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| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☒ Not applicable - any individual actions arising as mitigation may be subject to a QIA | | |
| **Legal and Regulatory implications:** | The Trust has a statutory duty to breakeven. | | |
| **Appendices:** | Unfunded services | | |
| **Freedom of Information (FOI) status:** | Tick either:<br><br>☒ This paper is disclosable under the FOI Act<br><br>☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | |
| **For further information please contact:** | Name: Alan Davies<br>Job Title: Chief Financial Officer<br>Email: paul.kimber1@nhs.net | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | X | There are gaps in assurance |
| | Assurance | | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board in Public
# 10 September 2024

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|---|---|---|---|
| **Title of Report** | Maternity CNST 10 Safety Actions Compliance Report | **Agenda Item** | 7.3 |
| **Author** | Ali Herron, Director of Midwifery<br>Kate Harris, Associate Director of Midwifery<br>Ellen Salmon, Maternity CNST & Compliance Manager | | |
| **Lead Executive Director** | Sarah Vaux, Interim Chief Nursing Officer | | |
| **Executive Summary** | • CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025<br>• Anticipate declaring compliance with all 10 Safety Actions within the required reporting period.<br>• Safety Action 8 currently off-track due to compliance figures <90% for some staff groups. This has been escalated appropriately and actions are in place to mitigate this risk. It is anticipated that compliance >90% will be achieved for all staff groups.<br>• Monthly reporting via MNSCAG and reporting to each Trust Board until submission.<br>• Review and presentation dates agreed with LMNS for key requirements prior to submission of compliance to MFT Trust Board in January 2025.<br><br>Formal Request of Trust Board required for:<br>• Trust Board requested to formally note NICU medical and Nursing staffing position (noted within Safety Action 4 slides) in Trust Board minutes that service is BAPM compliant for NICU Medical Staff and NICU Nursing and Qualified in Speciality (QIS) =59% with NICU nursing vacancy reduced to 2.69 WTE across all bandings. QIS percentage reduced in line with reduction in vacancy.<br>• NICU Nursing action plan in place, Trust Board requested to formally approve action plan (noted within Safety Action 4 slides) so this can be shared with the LMNS and ODN as per CNST requirements.<br>• Safety Action 9 - Trust Board requested to confirm in minutes that The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.<br>• Safety Action 9 - Update on SCORE survey presented as part of separate full Perinatal Leadership report and Trust Board requested to minute progress and monitoring of actions. | | |
| **Proposal and/or key recommendation:** | Direct reporting to Trust Board from MNSCAG as per Corporate Governance Structure<br><br>Formal Request of Trust Board required for:<br>• Trust Board requested to formally note NICU medical and Nursing staffing position (noted within Safety Action 4 slides) in Trust Board minutes that service is BAPM compliant for NICU Medical Staff and NICU Nursing and Qualified in Speciality (QIS) =59% with NICU nursing vacancy reduced to 2.69 WTE across all bandings. QIS percentage reduced in line with reduction in vacancy. | | |

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| | • NICU Nursing action plan in place, Trust Board requested to formally approve action plan (noted within Safety Action 4 slides) so this can be shared with the LMNS and ODN as per CNST requirements.<br>• Safety Action 9 - Trust Board requested to confirm in minutes that The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.<br>• Safety Action 9 - Update on SCORE survey presented as part of separate full Perinatal Leadership report and Trust Board requested to minute progress and monitoring of actions. |

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| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | X | Approval | |
| | Noting | X | Discussion | |

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| **Committee/Group submitted:**<br><br>**Date of Submission:** | • Maternity and Neonatal Safety Champion Assurance Group - 9 August 2024<br><br>• QAC 5 September 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report |

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| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) X | Priority 3: (Patients) X | Priority 4: (Quality) X | Priority 5: (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: X | Effective: X | Caring: X | Responsive: X | Well-Led: X |

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| **Identified Risks, issues and mitigations:** | N/A |
| **Resource implications:** | N/A |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |
| **Integrated Impact assessment:** | Not applicable |
| **Legal and Regulatory implications:** | Compliance with CNST Year 6 |
| **Appendices:** | N/A |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act |
| **For further information please contact:** | Name: Alison Herron<br>Job Title: Director of Midwifery |

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| | Email: Alison.herron2@nhs.net | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | X | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

NHS Medway NHS Foundation Trust

# Meeting of the Trust Board in Public
# 10 September 2024

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| **Title of Report** | **Perinatal Quality Surveillance Quarterly Report, Q1 2024/25** | **Agenda Item** | 7.4 |
| **Author** | Alison Herron, Director of Midwifery<br>Kate Harris, Associate Director of Midwifery<br>Ellen Salmon, Maternity CNST & Compliance Manager | | |
| **Lead Executive Director** | Sarah Vaux, Interim Chief Nursing Officer | | |
| **Executive Summary** | • CNST Year 6 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9)<br>• Monthly updates aligned with the minimum dataset of the PQSM are submitted monthly to QPSCC and QAC (within IQPR) along with a detailed report to every Trust Board.<br>• This report provides quarterly oversight for Q1 2024/25 and includes the following:<br>➢ Incidents - Increase in number of incidents reported in this quarter maternity =353 (335 in Q4) with 99% of incidents reported as no or low harm and 4 incidents reported as Moderate Harm or above and NICU 47 reported (34 in Q4) with 100% of incidents reported as no or low harm.<br>➢ Investigations – 1 MNSI referral, 1 MNSI investigation closed with action to review risk assessments in telephone triage, 1 postpartum (7 months) maternal death in the community (March 2024) but Trust not informed until June 2024. PSIRF/LFPSE events relating to 3/4$^{th}$ degree tear and PPH greater than 1litre with audits and actions in place to address these.<br>➢ PMRT - 9 MBRRACE reportable cases in Q1, 36 actions currently open relating to PMRT cases with Communication and documentation being the most common themes.<br>➢ Risks - Currently 13 risks in maternity and 2 in Neonatology, with highest risk of 20 related to midwifery workforce challenges and 2 scored 15 relating to MIS.<br>➢ Workforce/Staffing - Midwifery staffing remains a challenge with true vacancy rate remaining high across the quarter, with continued high levels of maternity leave. Positive midwifery workforce retention rates with below average leavers per month over quarter. Trajectory in place with new staff joining each month and main influx of newly qualified staff arriving in Jan-Feb 2025. NICU Nursing vacancy rate reduced from 8.03WTE in Q4 to 2.69 across all bands.<br>➢ Training - Overall compliance for Maternity and Neonatal Staff for mandatory training has increased to 92.63% (NICU) 86.51% (Maternity and Obstetrics), Fetal monitoring training >90% for all staff groups, Midwives, MSWs and Theatre staff >90% for PROMPT training with Anaesthetic and obstetric doctors <85% with actions in place to address, Increase in compliance with ABLS, NBLS training and | | |

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| | Safeguarding adults Level 3 increased to 78% for midwifery staff (71% in Q4), with trajectory in place to achieve Trust target.<br>➢ Staff and Service User Feedback - Strong working relationship with Maternity and Neonatal Voices Partnership, Overall improvement in FFT response rate and recommend rate across the quarter, peaking in April with 49% response rate and 99% recommend. Positive staff feedback regarding newly established Maternity & Neonatal Collaborative Hour (MNCH) – forum for sharing and learning.<br>➢ Safeguarding - Ongoing effective partnership working with outside agencies, Improvements noted in non-CP case holder supervision compliance. Information has been sent to all staff to complete the Adults Level 3 and Children Level 3 training to achieve compliance targets. |
| **Proposal and/or key recommendation:** | Direct reporting to Trust Board from MNSCAG as per Corporate Governance Structure |

| **Purpose of the report (Please mark with 'X' the box to indicate)** | | | | |
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| | Assurance | X | Approval | |
| | Noting | X | Discussion | |

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| **Committee/Group submitted:**<br><br>**Date of Submission:** | • Maternity and Neonatal Safety Champion Assurance Group - 9 August 2024<br><br>• QAC 5 September 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report |

| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
|---|---|---|---|---|---|
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |
| | | X | X | X | |

| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
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| | Safe: | Effective: | Caring: | Responsive: | Well-Led: |
| | X | X | X | X | x |

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| **Identified Risks, issues and mitigations:** | N/A |
| **Resource implications:** | N/A |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |
| **Integrated Impact assessment:** | Not applicable |
| **Legal and Regulatory implications:** | Compliance with CNST Year 6 |

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| **Appendices:** | N/A | | |
| **Freedom of Information (FOI) status:** | Tick either:<br><br>This paper is disclosable under the FOI Act | | |
| **For further information please contact:** | Name: Alison Herron<br>Job Title: Director of Midwifery<br>Email: Alison.herron2@nhs.net | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | X | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board in Public
# 10 September 2024

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| **Title of Report** | **Perinatal Culture and Leadership Quarterly Report** | **Agenda Item** | 7.5 |
| **Author** | Ali Herron, Director of Midwifery<br>Kate Harris, Associate Director of Midwifery | | |
| **Lead Executive Director** | Sarah Vaux, Interim Chief Nursing Officer | | |
| **Executive Summary** | • Goal of the perinatal culture and leadership programme is to improve the safety and quality of care delivered to women, birthing people and babies by enabling those with specific responsibility for safety in maternity and neonatal units to understand the relationship between leadership, safety improvement and safety culture in order in enable change.<br>• Three year delivery plan committed to provide the perinatal culture and leadership programme to all maternity and neonatal quadrumvirates by April 2024. This is now complete.<br>• The QUAD completed the programme in April 2024.<br>• The national network of Patient Safety Collaboratives (PSCs) have been commissioned to offer support to sustainably support the leadership capacity, capability and improvement relating to safety culture within maternity and neonatal units and as part of local systems, building on the progress made during Phases 1-3 of the PCLP.<br>• Working closely with the PSCs to ensure that any ongoing support aligns with the principles of the PCLP and to identify any potential challenges or opportunities.<br>• New QUAD has been shared with PSC and meeting arranged for August 2024.<br><br>Trust Board are requested to minute the progress against the SCORE Survey Action plan and that it is being monitored and appropriate support is being sought to complete actions and implement recommendations. | | |
| **Proposal and/or key recommendation:** | • Reporting to Trust Board as per the requirements of CNST Year 6 and the Perinatal Surveillance Model.<br><br>• Trust Board are requested to minute the progress against the SCORE Survey Action plan and that it is being monitored and appropriate support is being sought to complete actions and implement recommendations. | | |

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| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | X | Approval | |
| | Noting | X | Discussion | |
| **Committee/Group submitted:** | | | | |

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| **Date of Submission:** | • Maternity and Neonatal Safety Champion Assurance Group - 9 August 2024<br>• QAC 5 September 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) X | Priority 3: (Patients) X | Priority 4: (Quality) X | Priority 5: (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: X | Effective: X | Caring: X | Responsive: X | Well-Led: X |
| **Identified Risks, issues and mitigations:** | N/A | | | | |
| **Resource implications:** | N/A | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | N/A | | | | |
| **Integrated Impact assessment:** | Has the quality and equality assessment been undertaken?<br>Yes | | | | |
| **Legal and Regulatory implications:** | Compliance with CNST Year 6 | | | | |
| **Appendices:** | N/A | | | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | | | |
| **For further information please contact:** | Name: Alison Herron<br>Job Title: Director of Midwifery<br>Email:Alison.herron2@nhs.net | | | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions | | |
| | Partial Assurance | | There are gaps in assurance | | |
| | Assurance | | Assurance minor improvements needed. | | |
| | Significant Assurance | X | There are no gaps in assurance | | |
| | Not Applicable | | No assurance required. | | |

# Meeting of the Trust Board in Public
# 10 September 2024

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| **Title of Report** | **Maternity Claims, Incidents and Complaints Triangulation Report** | **Agenda Item** | 7.6 |
| **Author** | Ali Herron, Director of Midwifery | | |
| **Lead Executive Director** | Sarah Vaux, Interim Chief Nurse | | |
| **Executive Summary** | • NHSR Claims scorecard published annually in September with data for the previous 10 years.<br>• MFT have had 55 Obstetric claims in the 10 year period from 2013/14 to 2022/23.<br>• Of these claims, 11 are currently open with 1 incident ongoing. 43 have been closed, 20 of which have been settled with damages.<br>• CNST Year 6 requires Trust Boards to have a quarterly oversight of obstetric claims data triangulated with data from incidents and complaints.<br>• This report reviews the NHSR Claims scorecard along with incidents and complaints from 2023/2024 to provide thematic analysis and identify areas for improvement and areas where improvements have been made following past incidents and claims. The report will review under the following headings:<br>  • Yearly breakdown of claims by incident date and claim date.<br>  • Progress/status of current claims<br>  • Review of claims outcomes against current MSNI/PSIRF/SI outcomes<br>  • Review of claims against current datix incidents and complaints<br>  • Review of claim closed with damages awarded with review of learning and current practice. | | |
| **Proposal and/or key recommendation:** | Trust Board reporting to meet requirements of CNST year 6 | | |
| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | X | Approval | |
| | Noting | X | Discussion | |
| **Committee/Group submitted:**<br><br>**Date of Submission:** | • Maternity and Neonatal Safety Champion Assurance Group - 9 August 2024<br><br>• QAC 5 September 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report | | |
| **Patient First Domain/True North** | *Please mark with 'X' the priorities the report aims to support:* | | |
| | Priority 1: | Priority 2: | Priority 3: | Priority 4: | Priority 5: |

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| **priorities (tick box to indicate):** | (Sustainability) | (People) | (Patients) X | (Quality) X | (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: X | Effective: X | Caring: X | Responsive: X | Well-Led: X |
| **Identified Risks, issues and mitigations:** | N/A | | | | |
| **Resource implications:** | N/A | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | N/A | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>Yes | | | | |
| **Legal and Regulatory implications:** | Compliance with CNST Year 6 | | | | |
| **Appendices:** | N/A | | | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | | | |
| **For further information please contact:** | Name: Alison Herron<br>Job Title: Director of Midwifery<br>Email:Alison.herron2@nhs.net | | | | |

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| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | X | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

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| **Title of Report** | **Infected Blood Inquiry and Blood donor surveillance (NHSBT)** | **Agenda Item** | 7.7 |
| **Author** | Nicola Cooper, Divisional Director of Operations for Cancer and Core Clinical Services | | |
| **Lead Executive Director** | Alison Davis, Chief Medical Officer | | |
| **Executive Summary** | On 20 May 2024, Amada Pritchard released a letter to NHS Organisations attaching the Infected Blood Inquiry Report. In Summary the report identified the following:<br><br>• Patients have received blood or blood products from the NHS since it began in 1948. Many of those treated with them, particularly between 1970 and 1998, died or suffered as a result of the treatment the patients received rather than as a direct result of their underlying condition or illness.<br><br>• It was identified that a catalogue of failures caused this to happened that that it could largely, though not entirely, have been avoided.<br><br>• It was reported that systemic, collective and individual failures to deal ethically, appropriately, and quickly, with the risk of infections being transmitted in blood, with the infections when the risk materialised, and with the consequences for thousands of families,<br><br>• There were around 4,000 to 6,000 people with bleeding disorders in the UK at any one time. Around 1,250 were infected with HIV. The best estimate is that this included 380 children. Almost all infected with HIV were also infected with Hepatitis C and some with Hepatitis B and Hepatitis D as well. Three quarters of these 1,250 adults and children have died. A larger number still (between 2,400 and 5,000 people with bleeding disorders) who were not infected by HIV received blood products infected with one or more hepatitis viruses, and developed chronic Hepatitis C.<br><br>• People who were infected by transfusions, rather than by blood products, were infected in even greater numbers. Between 80 and 100 were infected with HIV after a blood transfusion. Approximately 26,800 were infected with Hepatitis C after a blood transfusion, often linked with childbirth or surgery, but also from transfusions to treat thalassemia, sickle disease, or leukaemia, or tissue transfer. It has not been possible to estimate the number of people infected with chronic Hepatitis B due to limited data.<br><br>• The report states that there were multiple factors that lead to death, illness and suffering due to needless infections. | | |

| Proposal and/or key recommendation: | Medway Foundation Trust Rule 9 Request issued by the Infected Blood Inquiry. No patients were identified through our investigations relevant to the inquiry as having received contaminated blood products at Medway. We are aware of a concern raised that a patient, who had received contaminated blood products at another Trust, felt they had not been treated and cared for equitably whilst at Medway. Although there was a delay in the patient being given a side room, there was no evidence to confirm their claim. We work very hard to ensure that all our patients are treated with dignity and respect as part of our Patient First Strategy and our Trust values.<br><br>As a result of the letter from Amanda Pritchard, Medway NHS Foundation Trust have reviewed practices within the blood transfusion service to ensure that the following safety measures are in place(further detail is provided in appendix 1):<br><br>• Blood transfusion is highly regulated. Blood Establishments (NHSBT Tooting , supplier) and Blood Bank (Medway Blood Transfusion) must comply with the Good Manufacturing Practice (GMP) and Blood Safety and Quality Regulations 2005 (BSQR 2005 ) are regularly audited by internal and external inspectors i.e. Medicines and Healthcare Products Regulatory Authority (MHRA)<br>• Blood Compliance Report is submitted to MHRA on an annual basis. Last MHRA inspection was in April 2023 – no critical deficiency found. Other findings accepted, actions completed and submitted to MHRA with no further actions.<br>• National blood donation is voluntary in the UK.<br>• National improved donor selection by the use of donor selection guidelines and confidential donor questioning.<br>• Local robust IT system for documentation with built-in algorithm that complies with BSQR,GMP, ISO 15189:2022, NICE guidance, BSH guidelines and has passed rigorous validation and verification. Regular review process also in place to provide continued assurance with frequency determined by national and local policies.<br>• Improved donation testing methodologies e.g.use of Nucleic Acid-PCR techniques<br>• National quarantining of donations process in place<br>• Product processing methodologies such as leucodepletion using commercial filter containing polyester fibres to remove white blood cells believed to be associated with the agent responsible for the transmission of vCJD.<br>• National mandatory testing on every donation in the UK – ABO and Rh, antibody screen, Hep B surface antigen, antibody to HIV (anti-HIV1/2), antibody to Hep C Virus (anti-HCV), antibody to syphilis. In addition, all donations are tested for presence of HCV RNA using a NAT and antibody to Human T-cell Leukaemia Virus (HTLV 1 and 2)<br>• National discretionary testing include malaria, West Nile Virus, T. Cruzi,<br>• Piercers e.g. body piercing, tattoos, acupuncture, donation deferral after 6 months and undergo anti-HBc testing –details on the transfusion guidelines found in JPAC website<br>• National post donation reporting – donor to report symptoms within 14 days post donation<br>• Deferral procedure and ‘Permanent Exclusion’ procedures in place for reactive donors |
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| | • Viral inactivation process used in the manufacture of fractionated plasma products such as coagulation factors (Factor VII, Anti-Thrombin III,etc), Albumin products, Immunoglobulin products (prophylactic anti-D,ect)<br>• Recall procedures in place – Internal and External<br>• Batch Pre-Acceptance Testing process in place for reagents, kits to ensure no performance deterioration in transit and storage.<br>• Cold Chain maintenance of temperature-controlled storage equipment –blood fridges, platelet incubator, plasma freezer. Evidence of service, maintenance, calibration, mapping and revalidation of equipment completed on a regular basis depending on the required schedule.<br>• Electronic vein-to-vein transfusion software that traces the donor to the receiving patient. Supports electronic positive patient identification, electronic pre-transfusion checklist, electronic documentation of collection, arrival of unit to the ward, begin and end of transfusion, and document transfusion reaction. System used at Medway is BloodTrack.<br>• Robust Quality Management System that provides assurance and customer confidence that Medway has systems and procedures in place to produce high quality service/product as stated in the Blood Transfusion Quality Manual and Blood Transfusion policies and SOPs.<br>• Incident Management, reporting to Haemovigilance Scheme such as SABRE/SHOT<br>• Document retention process in place in compliance to RCPATH 'Retention and Storage of Pathological records and specimens 2015'<br>• Continued compliance to NICE, BSH, Patient Safety Alerts, SHOT recommendations<br>• Internal MFT Governance - Hospital Transfusion Team and Hospital Transfusion and Thrombosis Group meet quarterly and the transfusion team lead by Kathleen Sharp presents formally with a written update to Patient Safety Group quarterly and provides informal verbal updates to the PSG on a monthly basis as well as escalation through the NKPS governance meetings. Regular Meetings to escalate any issues relating to Blood Transfusion for discussion and Action. No issues related to blood borne viruses have been escalated through the above groups. Any historical escalations have gone through this group into the care group board and up through to divisional board and through NKPS governance routes.<br>• Haematology Consultant and BMS advice and support available 24/7<br>• BMS Empowerment to challenge inappropriate requests<br>• Availability of alternatives to transfusion e.g. IV Iron, Tranexamic acid, Vit B12, Folate, EPO, Cell Salvage machine in theatres<br><br>Details for the above is covered in the attached document for your information. Extracts are taken from JPAC website and Blood Transfusion Policies and Procedure |

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| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | x | Approval | |
| | Noting | | Discussion | |
| **Committee/Group submitted:** | Meeting: Private Trust Board<br>Date 24 July 2024 | | | |

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| **Date of Submission:** | | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) x | Priority 4: (Quality) x | Priority 5: (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: x | Effective: x | Caring: x | Responsive: x | Well-Led: x |
| **Identified Risks, issues and mitigations:** | Currently blood and blood components are prescribed using a paper system and are not currently on EPMA (Risk 2102). Patient consent and Transfusion Associated Circulatory Overload (TACO) documentation required to be uploaded onto EPMA (TACO is currently a CAS alert, for resolution by September 2024). | | | | |
| **Resource implications:** | Not applicable | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | Not applicable | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☐ Not applicable (*please indicate why an equality assessment was not required) x* | | | | |
| **Legal and Regulatory implications:** | Not applicable | | | | |
| **Appendices:** | Not applicable | | | | |
| **Freedom of Information (FOI) status:** | Tick either:<br>☐ This paper is disclosable under the FOI Act x<br>☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | | | |
| **For further information please contact:** | Name: Nicola Cooper<br>Job Title: Divisional Director of Operations<br>Email: Nicola.cooper4@nhs.net | | | | |
| **Please mark with 'X' - Reports require an** | No Assurance | | | There are significant gaps in assurance or actions | |
| | Partial Assurance | | | There are gaps in assurance | |

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| **assurance rating to guide the discussion:** | Assurance | | Assurance minor improvements needed. |
| | Significant Assurance | X | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board
# Tuesday, 10 September 2024

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|---|---|---|---|
| **Title of Report** | Safeguarding Annual Report (2023-2024) | **Agenda Item** | 7.8a |
| **Author** | Bridget Fordham, Head of Safeguarding | | |
| **Lead Executive Director** | Sarah Vaux, Interim Chief Nursing Officer | | |
| **Executive Summary** | The report sets out the arrangements that the Trust has in place to ensure that it complies with statutory safeguarding guidance, as well as to work collaboratively with multi agency partners and across the Medway and Swale and wider Kent and Medway system. In addition, the arrangements in place to support patients with Learning Disability are described.<br><br>The report details safeguarding activity undertaken staff to assist staff in meeting safeguarding duties and requirements. The report also includes activity undertaken collaboratively under the Kent and Medway Safeguarding Board and Partnership arrangements, including publication of practice review.<br><br>Of note the challenge of responding to the needs of children and young people with mental health/ behavioural and emotional health concerns is identified.<br><br>During the year there has been a focus on training compliance and this remains a priority for the year ahead. | | |
| **Proposal and/or key recommendation:** | Discuss and agree the report | | |

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| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | X | Approval | |
| | Noting | | Discussion | |
| **Governance Process:**<br><br>**Committee/Group and Date of Submission/approval:** | Meeting: Quality Assurance Committee<br>Date 4th July<br>Approved | | | |

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| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality)<br>x | Priority 5: (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe:<br>x | Effective: | Caring: | Responsive: | Well-Led: |
| **Identified Risks, issues and mitigations:** | | | | | |

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| **Resource implications:** | N/A | | |
| **Sustainability and /or Public and patient engagement considerations:** | What engagements with patients and the public has been undertaken or planned in connection with the paper. | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☒ Not applicable | | |
| **Legal and Regulatory implications:** | Sets out Trust compliance with statutory guidance and NHS Accountability and Assurance Framework. | | |
| **Appendices:** | N/A | | |
| **Freedom of Information (FOI) status:** | Tick either:<br>☒ This paper is disclosable under the FOI Act<br>☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | |
| **For further information please contact:** | Name: Sarah Vaux<br>Job Title: Interim Chief Nursing Officer<br>Email: sarah.vaux3@nhs.net | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | x | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

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| **Title of Report** | Infection Prevention and Control (IPC) annual report 2023/24 | **Agenda Item** | 7.8b |
| **Author** | Rod Harford -Rothwell – Acting Head of IPC | | |
| **Lead Executive Director** | Sarah Vaux – Interim Chief Nursing Officer and Director of IPC | | |
| **Executive Summary** | The IPC annual report focus on the activities from 2023/24. The report measures IPC practices against the 10 criterion based on Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.<br><br>The annual report details the IPC team structure, detailing the training of the team. It also measures improvement against the IPC board assurance framework.<br><br>All of the organisms that form part of mandatory surveillance are included in this report and measures the Trusts position against thresholds, learning from Post Infection Reviews (PIR's) and the split of infections across Divisions, care groups and ward areas.<br><br>This year's report is inclusive of winter respiratory viruses, FIT testing, surgical site infection surveillance, link practitioners, decontamination, hospital cleanliness, commode audit outcomes, and estates work with the addition of the new simulation training created by the IPC team to support wards with repeated hospital acquired infections. | | |
| **Proposal and/or key recommendation:** | This report is for information and discussion | | |

| **Purpose of the report (Please mark with 'X' the box to indicate)** | | | | |
|---|---|---|---|---|
| | Assurance | | Approval | |
| | Noting | √ | Discussion | √ |

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| **Governance Process:**<br><br>**Committee/Group and Date of Submission/approval:** | Meeting: IPC Strategic Assurance Group<br>Date 13th June<br><br>Meeting: Quality Assurance Commitee<br>Date: 4th July 2024 |

| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
|---|---|---|---|---|---|
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) √ | Priority 5: (Systems) |

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| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* |

| | Safe: √ | Effective: | Caring: | Responsive: | Well-Led: |
|---|---|---|---|---|---|
| **Identified Risks, issues and mitigations:** | NA | | | | |
| **Resource implications:** | NA | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | NA | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Not applicable | | | | |
| **Legal and Regulatory implications:** | The mandatory surveillance has a regulatory implication. No penalties for breaching last year and thresholds have been reset. | | | | |
| **Appendices:** | NA | | | | |
| **Freedom of Information (FOI) status:** | Tick either:<br>☐ This paper is disclosable under the FOI Act | | | | |
| **For further information please contact:** | Name: Rod Harford-Rothwell<br>Job Title: Head of IPC<br>Email: Medwayft.infectioncontrol@nhs.net | | | | |

| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | | | |
|---|---|---|---|
| | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | √ | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board in Public
# 10 September 2024

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|---|---|---|---|
| **Title of Report** | Medical Appraisal and Revalidation Annual Report | **Agenda Item** | 7.8c |
| **Author** | Jeremy Davis, Deputy Responsible Officer<br>Stephen Houlihan, Head of Medical Director Services<br>Rebecca Loates, Medical Revalidation Manager<br>Janet Bradford, Interim Revalidation Manager | | |
| **Lead Executive Director** | Alison Davis, Chief Medical Officer and Responsible Officer | | |
| **Executive Summary** | Medway NHS Foundation Trust has 592 doctors connected as on 31st March 2024. There are 5 Dentists also on the L2P appraisal system.<br><br>For the year ending - 31 March 2024, there were a total of 88 revalidation submissions of which 77 positive recommendations to revalidate were sent to the GMC during the reporting year. 11 deferral recommendations were sent, and of these we were able to make a subsequent positive revalidation recommendation for 4 doctors during the report period with a rolling deferral rate of 9.3% for 2023/24.<br><br>This report provides a summary of previous actions, updates and new actions for the current Trust year.<br><br>The report details the provision of resources to ensure that the appraisal and revalidation processes are conducted in a professionally safe way adhering to Responsible Officer (RO) regulations 2010 amended 2013<br><br>The report provides details regarding medical appraisal compliance and a brief summary of revalidation recommendations for the 2023-2024 Trust year. | | |
| **Proposal and/or key recommendation:** | The Board / executive management team of ***Medway NHS Foundation Trust*** is required to review content of this report in order to confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). | | |

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| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | X | Approval | |
| | Noting | X | Discussion | X |

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| **Committee/Group submitted:**<br>**Date of Submission:** | Meeting: People Committee<br>Date 31 July 2024 | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People)<br>X | Priority 3: (Patients)<br>X | Priority 4: (Quality)<br>X | Priority 5: (Systems)<br>X |

| | | | | | |
|---|---|---|---|---|---|
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe:<br>X | Effective:<br>X | Caring:<br>X | Responsive:<br>X | Well-Led:<br>X |
| **Identified Risks, issues and mitigations:** | No risks have been identified. | | | | |
| **Resource implications:** | No additional resources required. | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | Outline how the proposal aligns with the MFT green plan and sustainability strategy or whether any communications or medical issues have been considered (and describe these).<br>N/A<br><br>What engagements with patients and the public has been undertaken or planned in connection with the paper.<br>None | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ NO<br>☒ X Not applicable This is an annual report. Medical Appraisal and Revalidation processes already have impact assessments embedded. | | | | |
| **Legal and Regulatory implications:** | None | | | | |
| **Appendices:** | Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2023 - 24 | | | | |
| **Freedom of Information (FOI) status:** | Tick either:<br>☒ YES, this paper is disclosable under the FOI Act<br>☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | | | |
| **For further information please contact:** | Name: Janet Bradford<br>Job Title: Interim Revalidation Manager<br>Email: janet.bradford|3@nhs.net | | | | |
| **Please mark with 'X' - Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions | | |
| | Partial Assurance | | There are gaps in assurance | | |
| | Assurance | X | Assurance minor improvements needed. | | |
| | Significant Assurance | | There are no gaps in assurance | | |
| | Not Applicable | | No assurance required. | | |

## 1 Executive Overview

This is the Trust Responsible Officer's (RO) annual report for 2023-2024 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 circa 600 doctors (currently 602) 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 2023 - 24. 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 stable. 599 doctors were potentially due to complete an appraisal during the reporting period, and of that 446 were completed on time and 142 doctors had approved delayed appraisals (this category covers doctors who it was agreed would not undertake an appraisal in this year due to long term leave (mat leave, ill health) and also doctors who either joined in this year but were not due their first appraisal at MFT until 24/25, or left MFT before their annual appraisal was due. 11 doctors had unapproved missed appraisal during the reporting period. In two cases of these cases they were recorded in this category for administrative reasons that will be corrected. In the other nine cases appraisals were not completed in the year to 31st March 2024. In some cases the Dr had left MFT without completing their planned appraisal, in other cases the appraisals have either been completed late in the current financial year, or are still being worked on.

For the year ending 31 March 2024, a total of 88 revalidation submissions were made, out of which 77 positive revalidation recommendations were sent to the GMC during the reporting year. 11 deferral recommendations were sent, and of these we were able to make a subsequent positive revalidation recommendation for 4 doctors during the report period.

**General review of last year's actions**

**Completed Actions: The following actions were completed from the Board Report 2022-2023**

- A successful PID was approved in 2023 to provide funding for additional resources to increase the administrative team establishment with the recruitment of a B4 full time administrator from April 2024
- Funding has been made available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser.
- The Policy has been reviewed and approved in November 2023
- SOP for late appraisals and non-engagement was reviewed in 2023 in line with the overall policy review.
- Reviews of appraisals 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 2024 -2025.
- To provide New Appraiser Training in September for 20 doctors.
- 14 Case Investigators for Maintaining High Professional Standards (MHPS) were trained during 2023

**Incomplete Issues**

- A peer review to be undertaken of the organisation's appraisal and revalidation process. This was not undertaken due to insufficient capacity for this in the appraisal team resulting from a change of Senior Appraisers, administrative resourcing impact from sickness absence and maternity leave, and the need for a second DCMO.
- 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 2024-2025 year. This was not undertaken due to the capacity issues described above.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

**Current Staffing:**

- The Medical Revalidation Manager started maternity leave from April 2024
- A B6 Interim Manager who has been in the team since February 2023 will cover for up to 24 hours per week
- A B4 full time Medical Appraisal Support Administrator was recruited and joined the team in April 2024 primarily for appraisal and revalidation but also offering support for the CMO office
- Support and training for 2 Senior Appraiser's has been delivered, with one started in 23/24 and one in early 24/25.

**Actions Carried Forward:**

- A peer review to be undertaken of the organisation's appraisal and revalidation process, subject to sufficient capacity in the appraisal team. If there is an external HLRO review during the year, the peer review will not be required.
- Deputy Responsible Officer and Senior Appraisers 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 2024-2025 year.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

**New Actions**:

- To provide training for new appraisers – September 2024
- Provide appraiser refresher training for existing appraisers (circa 50 appraisers per year)
- Ongoing monitoring and review of resources to be regularly undertaken.

- Work further ahead with Revalidation preparation, ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by the GMC.
- To create an escalation process for MPITs not received to ensure no issues with Drs connecting with MFT at their previous trusts.
- The number of Case Investigators is now sufficient (20) for MHPS Investigations but we need more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS organisations.
- To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations, working with the Trust secretary re this. Once new NED's have been identified, we will provide appropriate training.
- As part of the implementation of the policy, the Joint Local Negotiation Committee have agreed to review the implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics.
- To review the ROAG and CMO team HR processes to ensure that there is assurance that these are free from bias and discrimination.
- Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances eg maternity leave).

**Overall conclusion:**

We have continued to strengthen our appraisal and revalidation process, and the governance of medical staff.

There is overall good engagement from our doctors.

## Appendix 1

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

1A – General The board/executive management team of Medway NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

| | |
|---|---|
| Action from last year: | **Appoint two new Lead Appraisers** |
| Comments: | Alison Davis remains as Responsible Officer with Jeremy Davis remaining as Deputy Responsible officer. Both are trained licensed medical practitioners.<br><br>In July 2023, following previous incumbent leaving the Trust, a Consultant Obstetrician, was appointed as Senior Appraiser. A second senior appraiser, a Consultant Gastroenterologist was appointed as a senior appraiser and started April 2024. They have both attended external (Miad Healthcare) Appraisal Lead courses and also the NHSE Responsible Officer programme. They received a local induction by the Deputy Responsible Officer, and their decisions regarding appraisals were initially monitored for a period of four weeks by the Deputy RO. The deputy RO provides ongoing advice and support when needed. |
| Action for next year: | To provide ongoing support and review |

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

| | |
|---|---|
| Yes | |
| Action from last year: | To provide 50 current appraisers with Refresher training, this will be delivered by e-learning modules to ensure that the Appraisers can complete the modules at a time convenient for them.<br><br>To ensure that the administrative team is optimally resourced to manage the increased demands/task associated with the increase in the number of prescribed connections (600+) |
| Comments: | **Completed:** |

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| | Despite Industrial Action occurrences and activity pressures of the hospital the New Appraiser Training sessions were moved and re arranged a number of times. However, two New Appraiser Training sessions took place in September 2023 with 18 Doctors Trained and another session in November 2023 with 13 Doctors trained.<br><br>An Appraiser Refresher Training session took place in October 2023 and January 2024, with a total 57 appraisers receiving an updated training.<br><br>A business case was successfully approved in 2023 and a B4 administrator full time was recruited from 01/04/2024. A B6 interim manager is in post for 22.50 hours per week (as maternity leave cover). In addition, resource was approved to provide a further Lead Appraiser from April 2024. This has been pivotal in ensuring safe systems are in place to manage revalidation and appraisal, |
| Action for next year: | To provide 50 current appraisers with Refresher training, this will be delivered by e-learning modules to ensure that the Appraisers can complete the modules at a time convenient for them.<br><br>Funding will be available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser. |

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

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| Action from last year: | None Identified |
| Comments: | 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.<br><br>Doctor's in training do not have a prescribed connection with MFT.<br><br>When the weekly 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: | To continue as before. |

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

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| Action from last year: | Policy review |
| Comments: | **Completed**<br>Policy approved by the Trust Executive Board in November 2023 and now active. |
| Action for next year: | To ensure any changes to NHS England/General Medical Council (GMC) guidance remain pertinent to the current policy |

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

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| Action from last year: | A review of this action by the Responsible Officer will take place during 2023-2024 to determine best practice moving forward. |
| Comments: | Not Completed:<br>• A peer review to be undertaken of the organisation's appraisal and revalidation process. Completion, subject to sufficient capacity in the appraisal team. If there is an external HLRO review during the year, the peer review will not be required. |
| Action for next year: | We are anticipating a possible HLRO review in the year 2024 – 2025 in which processes will be reviewed. If this does not take place we will undertake a peer review, subject to resource. |

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

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| Action from last year: | Ongoing monitoring and review of resources to be regularly undertaken. |
| Comments: | **Completed:**<br><br>The appraisal platform L2P has the relevant information to help completion of appraisal under the resources section.<br><br>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.<br><br>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, Senior Appraiser and Revalidation team including one to one coaching, 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 |

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| | facilitating collection of patient and colleague feedback. The Revalidation Team receives a weekly report of starters and leavers lists of doctors including any doctors who leave training and take up a non-training role. |
| Action for next year | Ongoing. |

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, 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.

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| Action from last year: | Review of existing process and agreement to identify which Doctors are associated with specific SI's, with appropriate governance teams for improving the process has been identified as a key improvement needed for 2023 - 2024. MFT Governance team are introducing a new DATIX Style system which may help assist with appraisal complaints. |
| Comments: | **Partially completed:**<br><br>The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.<br><br>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: | The process for identifying doctors in SI reports and those involved in legal claims and passing this information to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal. |

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

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| Action from last year | SOP for late appraisals and non-engagement will be reviewed in 2023 in line with the overall policy review. |
| Comments: | **Completed:**<br><br>Appraisal policy including SOP for late appraisals and non-engagement approved November 2023 |
| Action for next year: | None |

1B(iii) 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).

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| Action from last year: | Review policy in 2022-23 |
| Comments: | **Completed:**<br><br>Policy approved by the Trust Executive Board in November 2023 and now active |
| Action for next year: | Ensure it remains relevant to current practice and NHSE/GMC guidance |

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

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| Action from last year: | To provide New Appraiser Training in September and November for 40 doctors. |
| Comments: | **Completed**<br><br>The Trust had 163 trained appraisers on 31st March 2024. Not all are job planned to undertake appraisals, and of those that are the majority of our appraisers complete 5 appraisals on a rolling annual basis and generally no more than one per month<br><br>In 2023 - 2024, No appraisers left or retired. There is a prediction that small number of appraisers will be lost in 2024 - 2025. In order to mitigate this, new Appraisers will continue to be recruited, and a review of those who have undertaken few or no appraisal will be carried out to rationalise the appraiser list. |
| Actions for next year: | 1) To provide two dates of New Appraiser training for 20 doctors each session. (September 2024 and January 2025). |

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

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| | 2) Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances eg maternity leave). |

1B(v) 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 or equivalent).

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| 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 2023-2024 year. |
| Comments: | **Not Completed:**<br><br>This was reliant on a fully resourced team will being in post. The Revalidation Manager (RL) had long-term sickness absence and is now on maternity leave which impacted on delivery of this item. The team is now fully resourced with an interim B6 manager and a newly recruited B4 administrator. In addition, two Lead Appraisers are now in post<br><br>The Lead Appraisers are trained at Responsible Officer training events to garner a full understanding of their role. The RO, Deputy RO and managerial support team attend regional appraisal network events at least once per year. |
| Action for next 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 2023-2024 year. |

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

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| Action from last year: | To continue presenting yearly report to Board for compliance. |
| Comments: | **Completed:**<br><br>There is an ongoing process to support revalidation including the Responsible Officer Advisory Group meetings and the HR Decision Making process to ensure appraisal and revalidation is operationally supported throughout the year. The Trust Policy has been reviewed to ensure it is following best practice.<br><br>There is an annual report which goes to the People Committee and then the Board to provide assurance that revalidation processes are safe and effective. |

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| Action for next year: | To continue presenting yearly report to Board for compliance. |

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

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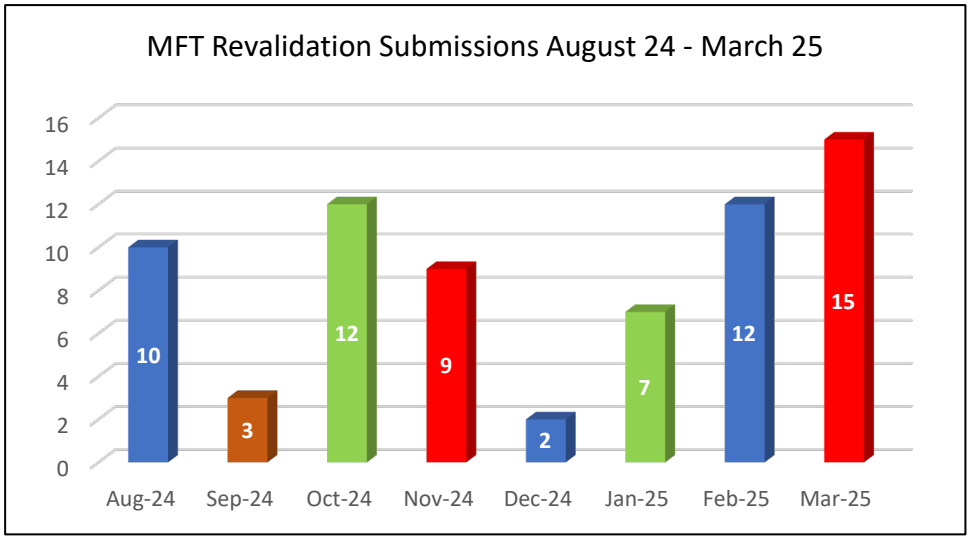
| Action from last year: | To review policy to incorporate identified changes. |
| Comments: | **Completed:**<br><br>For 2024 – 205 we continue to adhere to the changes (2022) for under notice period for Recommendations, monthly Responsible Officer Advisory Groups (ROAG) meetings have taken place, in which Doctors under notice are reviewed to ensure GMC requirements are adhered to. |
| Action for next year: | Work further ahead with Revalidation preparation ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by GMC. Please refer to the table below which outlines projected revalidation submissions from August 2024 – March 2025 inclusive<br><br>  |

1C(ii) 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, or where this does not happen, the reasons are recorded and understood.

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| Action from last year: | To continue with the correct processes in place to support Revalidation Recommendations. |
| Comments: | **Completed**<br>The Responsible Officer Advisory Group (ROAG) provides a structure for reviewing all revalidation recommendations and ensures all recommendations and deferral recommendations are complete in good time. |

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

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

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| Action from last year: | The Revalidation team will continue to monitor information on complaints/SIs for inclusion in medical appraisal. |
| Comments: | **Partially Completed:**<br><br>The revalidation team continues to monitor information on complaints/SIs for inclusion in medical appraisal.<br><br>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.<br><br>The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.<br><br>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: | The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal. |

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

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| Action from last 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. |
| Comments: | **Completed:** |

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| | Conduct and performance issues are reviewed at the biweekly Decision-Making Group. This includes triangulating 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.<br>Upon connecting a Doctor to MFT, RO to RO references (MPIT) are requested which contain any relevant information to share. This is monitored and there is an escalation process to ensure MPIT references are received and reviewed. 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.<br>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.<br>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.<br><br>Training grade Doctors have a Postgraduate Dean at NHSE KSS Deanery (Kent, Surrey and Sussex) 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 NHSE KSS via Director of Medical Education of MFT. They undergo Annual Review of Competency Progression (ARCP) in their respective School at NHSE KSS. |
| Action for next year: | No Action Required. |

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

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| Action from last year: | None required as ongoing. |
| Comments: | We have used L2P appraisal system since 2012 and are able to ensure the system incorporates any requested updates to comply with Good Medical Practice 2024 or any local requests to ensure the system is user friendly. |
| Action for next year: | Ongoing. |

1D(iv) There is a process established for responding to concerns about a medical practitioner's 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.

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| Action from last year: | The number of Case Investigators is insufficient for MHPS Investigations.<br>**Completed** -14 Case Investigators were trained during 2023. |
| Comments: | **Action Completed**<br><br>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, Head of Medical Director Services and a member from HR attend this meeting.<br><br>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.<br><br>Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with the Trust policy.<br><br>The Trust now has 20 trained Case Investigators and 3 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.<br><br>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.<br><br>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: | The Trust will train three more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS organisations. |

1D(v) 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 and country of primary medical qualification.

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| 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.<br>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.<br><br>The following table outlines the number and outcome of cases reviewed by the Decision-Making Group in the reporting year. |
| Action for next year: | To continue with the present format. |

| 2023 – 2024 – issues managed within the Decision-Making Group | White | BAME | Male | Female | |
|---|---|---|---|---|---|
| Outcome | | | | | |
| Reviewed and no case to answer | 0 (0) | 9 (3) | 9 (3) | 0 (0) | **9 (3)** |
| Reviewed and advice given regarding future conduct | 2 (2) | 3 (4) | 5 (5) | 0 (1) | **5 (6)** |
| Reviewed and advice given regarding improving performance (capability) | 0 (0) | 0 (0) | 0 (0) | 0 (0) | **0 (0)** |
| Reviewed and managed by other HR policy (grievance, Dignity at work, sickness) | 5 (2) | 8 (3) | 11 (5) | 2 (0) | **13 (5)** |
| Formal MHPS investigation | 0 (1) | 2 (2) | 2 (2) | 0 (1) | **2 (3)** |
| Total | 7 (5) | 22 (12) | 27 (15) | 2 (2) | **29 (17)** |

% Figures in brackets relate to 2022-2023

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1D(vi) 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 our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

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| Action from last year: | To continue with the current process set in place. |
| Comments: | Upon connecting a Doctor to the designated body, a 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 a RO to RO conversation to elaborate further.<br><br>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.<br><br>For doctors connected elsewhere but working in MFT fall under two categories:<br><br>Training grade doctors 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.<br><br>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. |

1D(vii) 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).

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| Action from last year: | Nil |
| Comments: | All processes for responding to concerns are managed according to our Trust Policy Maintaining High Professional Standards Policy. This policy was renewed in 2024 and included specific assurance that the Case Manager will use The NHS England 'Just Culture Guide' as part of the decision-making process where the concern relates to a patient safety incident.<br><br>The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events should be conducted where needed to clarify whether causes are more broadly based and can be |

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| | attributed to systems or organisational failures or demonstrate that there were untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each incident will require appropriate investigation and remedial actions. The Trust actively promotes an open and fair culture, which encourages practitioners and other NHS staff to report adverse incidents and other near misses.<br><br>To support case managers the Trust has trained Case Investigators to ensure appropriate processes. Whilst care is taken to avoid potential bias and discrimination when cases are considered by our Senior Team, it is recognised this process could be strengthened. Historically there was NED involvement in the ROAG process, but that has lapsed. |
| Action for next year: | Review of the ROAG and biweekly CMO HR processes to strengthen assurance that processes are free from potential bias and discrimination |

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

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| Action from last year: | Nil. |
| Comments: | The Trust has a robust educational infrastructure in place including weekly Grand Rounds. Appraisers are supported in ensuring that Personal Development Plan (PDP's) are relevant, challenging and specific.<br><br>Quality Improvement Activities (QIA) remain an integral part of the appraisal process and reviewing external and national data encouraged.<br><br>Doctors are encouraged to provide clinical performance evidence for various external facilities such as Dr Fosters or similar.<br><br>The Trust operates a Patient First philosophy which is fundamental to the Trust strategy/culture and is reflected in appraisal discussions/outputs. |
| Action for next year: | Ongoing. |

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

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| Action from last year: | Nil. |
| Comments: | 1. *Targeted interventions on collaborative leadership and organisational values* |

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| | Applying our *Bold* Trust values with *Patient First* principles the organisation leadership teams work collaboratively and actively to demonstrate this with a variety of interventions open to all staff such as monthly briefings and weekly Spotlight huddles.<br><br>2. *Positive equality, diversity and inclusion (EDI) action*<br><br>Equal opportunities and diversity are fundamental not just in the statutory training programmes but embedded in all Trust events and forums. There are a variety of active staff network programmes including: BAME, Women, Armed Forces, LGBTQA+<br><br>3. *Consistent management standards delivered through accredited training*<br><br>The Trust runs a variety of multi-disciplinary leadership programmes many aligned to our local university which has an extensive healthcare and management portfolio. (Canterbury Christ Church University)<br><br>4. *A simplified, standard appraisal system for the NHS*<br><br>The Trust has a very robust generic appraisal system for non-medical/dental staff. This is monitored Trust wide on a weekly basis with relevant follow ups as required.<br><br>The Trust appraisal dashboard incorporates medical and dental appraisal metrics.<br><br>5. *A new career and talent management function for managers*<br><br>There are structured and informal management and leadership development opportunities in all areas of the Trust. This can be demonstrated by the positive retention of key staff who have transitioned into more senior roles and sometimes through training/development into different areas.<br><br>6. *Effective recruitment and development of non-executive directors (NEDs)*<br><br>The Trust has a full complement of Non-Executive Directors (NEDs) from a range of backgrounds with regular review/renewal processes.<br><br>7. *Encouraging top talent into challenged parts of the system*<br><br>This is ongoing but there have been several new operational initiatives during 2023/24 that have required different people structures and new roles. |

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| Action for next year: | To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations, working with the Trust secretary re this. Once new NED's have been identified, we will provide appropriate training. |

1E – Employment Checks

1E(i) 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.

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| Action from last year: | To continue to monitor compliance. |
| 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 and liaise actively with the medical and temporary staffing teams as appropriate. |

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

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| Action from last year: | Nil. |
| Comments: | The Trust has been engaged in Patient First since 2022. This is interlinked with the Trust strategy and all non-clinical and clinical process are aligned to an all-inclusive culture for patients and staff. |
| Action for next year: | Ongoing. |

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

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| Action from last year: | Nil |
| Comments: | There are monthly staff briefings both face to face or Teams and all staff are encouraged to attend. At every event the right to 'Speak Up' is supportively emphasised.<br><br>The Trust has Human Resources /People teams with a range of roles that openly supports fairness and mutual respect. Diversity underpins all Trust polices. Trust values reflect this. |

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| Action for next year: | Ongoing. |

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistle-blowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

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| Action from last year: | Nil |
| Comments: | There is an active Whistle blowing policy in place that is regularly reviewed.<br><br>There is a in depth and proactive safeguarding system in place that is supportive of both staff and patients with robust training programmes. |
| Action for next year: | Ongoing |

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

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| Action from last year: | Nil |
| Comments: | The Trust has an active staff survey and outcomes are communicated at staff briefings with relevant action plans as required.<br><br>Opportunity for feedback from /with medical and dental staff is actively encouraged and supported through the Junior Doctor forum and Local Negotiating Committee as well as more informal routes.<br><br>The Trust adheres to an MHPS/Grievance/Complaints and disciplinary procedures |
| Action for next year: | Ongoing |

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

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| Action from last year: | Nil |
| Comments: | The Trust actively employs International Medical Graduates (IMG's) though robust recruitment processes. The Trust runs regular 'Welcome to UK Practice' face to face/team sessions bi-annually (January and September)<br><br>The MHPS and investigative processes are managed through the Chief Medical Officer's (CMO) service in conjunction with HR teams. The processes are non-discriminatory and monitored to ensure parity. |
| Action for next year: | As part of the implementation of the new MHPS policy, the Joint Local Negotiation Committee have agreed to review the |

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| | implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics. |

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

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| Action from last year: | Nil |
| Comments: | The CMO/RO and revalidation administrative teams regularly attend on the HLRO meetings and workshops and participate in a local peer group forum for informal feedback and discussion. This is about process and the sharing of best practice and not about individual doctors or cases. |
| Action for next year: | HLRO review/Peer review. |

- **Section 2 – metrics**

Year covered by this report and statement: 1 April 2023 - 31March 2024 . All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

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|---|---|
| Total number of doctors with a prescribed connection on 31 March | 592 |

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

| | |
|---|---|
| Total number of appraisals completed | 446 |
| Total number of appraisals approved missed | 142 |
| Total number of unapproved missed | 11 |

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

| | |
|---|---|
| Total number of recommendations made | 88 |
| Total number of late recommendations | 0 |
| Total number of positive recommendations | 76 |

| | |
|---|---|
| Total number of deferrals made | 12 |
| Total number of non-engagement referrals | 0 |
| Total number of doctors who did not revalidate | 512 |

| | GP | Specialist | GP & Specialist | Other | Total |
|---|---|---|---|---|---|
| Defer - insufficient evidence | 0 | 4 | 0 | 6 | **10** |
| Defer - subject to ongoing process | 0 | 1 | 0 | 0 | **1** |
| Revalidate | 0 | 39 | 0 | 38 | **77** |
| Non-engagement | 0 | 0 | 0 | 0 | **0** |
| **Total** | **0** | **44** | **0** | **44** | **88** |

*Source GMC Connect MFT*

2D – Governance

| | |
|---|---|
| Total number of trained case investigators | 20 |
| Total number of trained case managers | 3 |
| Total number of new concerns registered | 29 |
| Total number of concerns processes completed | 27 |
| Longest duration of concerns process of those open on 31 March | 4 months |
| Median duration of concerns processes closed | 1 month |
| Total number of doctors excluded/suspended | 1 |
| Total number of doctors referred to GMC | 0 |

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

| | |
|---|---|
| Total number of new doctors joining the organisation | 84 |
| Number of new employment checks completed before commencement of employment | 84 |

2F Organisational culture

| | |
|---|---|
| Total number claims made to employment tribunals by doctors | 1 |
| Number of these claims upheld | Not yet complete |
| Total number of appeals against the designated body's professional standards processes made by doctors | 0 |
| Number of these appeals upheld | Not Applicable |

**Section 3 – Summary and overall commentary**

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

**Completed Actions: The following actions were completed from the Board Report 2022-2023**

- A successful PID was approved in 2023 to provide funding for additional resources to increase the administrative team establishment with the recruitment of a B4 full time administrator from April 2024
- Funding has been made available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser.
- The Policy has been reviewed and approved in November 2023
- SOP for late appraisals and non-engagement was reviewed in 2023 in line with the overall policy review.
- Reviews of appraisals 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 2024 -2025.
- To provide New Appraiser Training in September for 20 doctors.
- 14 Case Investigators for Maintaining High Professional Standards (MHPS) were trained during 2023

**Incomplete Issues**

- A peer review to be undertaken of the organisation's appraisal and revalidation process. This was not undertaken due to insufficient capacity for this in the appraisal team resulting from a change of Senior Appraisers, administrative resourcing impact from sickness absence and maternity leave, and the need for a second DCMO.
- 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 2024-2025 year. This was not undertaken due to the capacity issues described above.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

**Current Staffing:**

- The Medical Revalidation Manager started maternity leave from April 2024
- A B6 Interim Manager who has been in the team since February 2023 will cover for up to 24 hours per week
- A B4 full time Medical Appraisal Support Administrator was recruited and joined the team in April 2024 primarily for appraisal and revalidation but also offering support for the CMO office
- Support and training for 2 Senior Appraiser's has been delivered

**Actions Carried Forward:**

- A peer review to be undertaken of the organisation's appraisal and revalidation process, subject to sufficient capacity in the appraisal team. If there is an external HLRO review during the year, the peer review will not be required.

- 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 2024-2025 year.
- The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2024/25 to allow an A3 process to pursue this goal.

**New Actions**:

- To provide training for new appraisers – September 2024
- Provide appraiser refresher training for existing appraisers (circa 50 appraisers per year)
- We are anticipating a possible Higher-Level Responsible Officer (HLRO) review in the year 2024 – 2025 in which processes will be reviewed.
- Ongoing monitoring and review of resources to be regularly undertaken.
- Review of existing process and agreement to identify which Doctors are associated with specific SI's, with appropriate governance teams for improving the process has been identified as a key improvement needed for 2023 - 2024. MFT Governance team are introducing a new DATIX Style system which may help assist with appraisal complaints.
- Work further ahead with Revalidation preparation, ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by the GMC.
- To create an escalation process for MPITs not received to ensure no issues with Drs connecting with MFT at their previous trusts.
- The number of Case Investigators is now sufficient (20) for MHPS Investigations but we need more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS
  organisations.
- To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations. To provide appropriate training which is via the Trust Secretary.
- As part of the implementation of the new MHPS policy, the Joint Local Negotiation Committee have agreed to review the implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics.
- To review the ROAG and CMO team HR processes to ensure that there is assurance that these are free from bias and discrimination.
- Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances eg maternity leave).

**Overall conclusion:**

We have continued to strengthen our appraisal and revalidation process, and the governance of medical staff.

There is overall good engagement from our doctors.

- **Section 4 – Statement of Compliance**

The Board/executive management team have 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 the designated body: | Medway NHS Foundation Trust |

| | |
|---|---|
| Name: | |
| Role: | |
| Signed: | |
| Date: | 2024 |

NHS Medway NHS Foundation Trust

# Meeting of the Trust Board in Public
# Tuesday, 10 September 2024

| | | | |
|---|---|---|---|
| **Title of Report** | Patient First in Action (2 year review) | **Agenda Item** | 7.9 |
| **Author** | Jacqui Leslie (Head of Transformation) | | |
| **Lead Executive Director** | Gavin MacDonald (Chief Delivery Officer) | | |
| **Executive Summary** | This paper sets out an overview of the Patient First Improvement and Operational Management System called Patient First and provides examples of adoption and positive impact across the organisation. Described in the paper are key achievements against our priorities for the years 2022-23, 2023-24 and 2024 year to date.<br><br>Each of the five True North (TN) strategic areas are profiled with a summary of our Ambition and Vision. It states the supporting Strategic Initiatives, Corporate Projects and other key linked activities, as well as our outcomes against our annual breakthrough objectives (BO). Key achievements in each domain are evidenced.<br><br>Work is underway and due to complete in Q4 to developed the 2025/ 2028 Patient First Strategy which will set out how the organisation will further build on clinical and patient engagement with Patient First. | | |
| **Proposal and/or key recommendation:** | Note this summary content as a position of our achievements to date, using the Trust's adopted improvement and operational excellence methodology.<br><br>Link this to other supporting content for Non-Executive / Board members. | | |

| | | | | |
|---|---|---|---|---|
| **Purpose of the report (tick box to indicate)** | Assurance | x | Approval | |
| | Noting | x | Discussion | |

| | | | | |
|---|---|---|---|---|
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |

| | | | | | |
|---|---|---|---|---|---|
| **Committee/Group at which the paper has been submitted:** | This has been requested in response to Trust Chair / NED feedback from regulatory preparations | | | | |
| **Patient First Domain/True North** | Tick the priorities the report aims to support: | | | | |
| | Priority 1: | Priority 2: | Priority 3: | Priority 4: | Priority 5: |

| | | | | | |
|---|---|---|---|---|---|
| **priorities (tick box to indicate):** | (Sustainability) √ | (People) √ | (Patients) √ | (Quality) √ | (Systems) √ |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: | Effective: | Caring: | Responsive: | Well-Led: √ |
| **Identified Risks, issues and mitigations:** | No recommendations being made. Summary position document for 2022-23 and 2023-24 | | | | |
| **Resource implications:** | None | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | This is a summary paper which states current position on delivery against planned priorities | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☐ **Not applicable (*please indicate why an equality assessment was not required). This is not a recommendations paper/*** | | | | |
| **Legal and Regulatory implications:** | N/A – this is not a recommendations paper | | | | |
| **Appendices:** | Summary paper only – Patient First in Action (2 year review) | | | | |
| **Freedom of Information (FOI) status:** | State either:<br><br>**This paper is disclosable under the FOI Act**, or<br><br>This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | | | |
| **For further information or any enquires relating to this paper please contact:** | Gavin MacDonald (Chief Delivery Officer) gavin.macdonald3@nhs.net | | | | |
| **Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions | | |
| | Partial Assurance | | There are gaps in assurance | | |

| | | |
|---|---|---|
| | **Assurance** | Assurance with minor improvements needed. |
| | Significant Assurance | There are no gaps in assurance |
| | Not Applicable | No assurance required. |

# Trust Board in Public
# Tuesday, 10 September 2024

| | | | |
|---|---|---|---|
| **Title of Report** | Learning from Deaths Quarter 1 (24/25) update | **Agenda Item** | 7.10 |
| **Author** | Sofia Power – Learning from Deaths Manager<br>Wayne Blowers – Interim Director for Quality and Safety<br>James Alegbeleye – Medical Director for Quality and Safety | | |
| **Lead Executive Director** | Alison Davis Chief Medical Officer | | |
| **Executive Summary** | Between April 2024 to June 2024, the Trust recorded 363 inpatient adult deaths. 3 patients with learning difficulties died in hospital during this time and all three were subject to SJR.<br><br>The Medical Examiner Office has highlighted the following concerns up to June 2024:<br><br>• Delays in receipt of proposed cause of death. 9% of proposal received more than 5 calendar days after death.<br>• Families continue to highlight concerns about waits in ED and being cared for in corridor environment<br>• Continued issues with quality of ward round documentation, specifically the use of copy and paste<br>• Difficult to identify the responsible consultant leading to lack of consultant involvement in proposed causes of death.<br><br>The Trust achieved 6.1% of deaths which were subject to Structured Judgement Reviews (SJR) over the period of April 2024- June 2024. During this time, four cases were highlighted as being possibly/probably preventable and all four cases were escalated to the Incident Review Group for further investigation under the PSIRF framework.<br><br>Three Learning Disability cases were highlighted for SJR and all three were completed within this time. For the majority of the cases reviewed, the patient received good care. For one case, the care was graded as 'poor' overall and has been escalated to the Incident Review Group for further investigation and is currently awaiting presentation.<br><br>The top five themes noted through SJR are:<br><br>• Problems in documentation which often related to copy and paste. | | |

- Problems with communication between clinical teams where ownership of patients is not clear.
- Problems with communication with families and carers where end of life care decisions could have been discussed with families sooner.
- Delays in treatment where policies for anticoagulation reversal has not been followed.
- Issues with bed capacity and delays in treatment.

SJRs are regularly shared with the appropriate speciality to reflect and share on learning highlighted.

All Learning Disability cases were escalated to LeDeR. The Learning Disability Liaison Nurse will be attending the MMSG in September 2024 to report on learning for the Trust from the Kent and Medway annual report.

The new SJR process will move from a panel of SJR reviewers to single reviewers. There has been expressions of interested from a number of nursing staff who want to be involved in the Learning from Deaths process. The new SJRplus app is currently going through the procurement process and is a system specifically designed to support the new process, designed to better support the learning from the reviews. Some of the new elements of the process include a quality assurance process by which each review will be graded in terms of comprehensiveness and feedback will be provided to clinicians to create a cycle of positivity and drive an improved culture around SJRs. Each quarter, a select sample of cases that were not progressed to the Stage 2 panel will be peer reviewed. Feedback from the peer reviews will be included in quarterly reporting.

The quality of some of the speciality Mortality and Morbidity meeting (M&M) has improved. Reports from Elderly care, Respiratory, Cardiology and Acute Paediatrics and Acute Medicine were shared. Concerns were raised in relation to ED M&M minutes where there is learning and lessons from cases presented but it is not clear how actions are monitored to evidence improvements. General Surgery submitted M&M minutes but there was no clear learning or actions from the meetings. In June, cases discussed at the Cardiology and Respiratory M&M were escalated for SJR review.

The Mortality A3 refresh work is currently ongoing which focuses on:

- Care continuity and specialty review for patients on emergency admission pathways
- Recording of episodes of care
- Variability in the SJR process
- Ensuring the learning from deaths process is in line with best practice
- Variability in the end of life care process
- Medical Examiner process.

A working group with key stakeholder will be occurring each week. The focus for the meetings will be to establish a measurable breakthrough objective to monitor improvement on a weekly basis.

The action plan for the NICHE recommendations will be monitored weekly. The NICHE recommendations focuses on 12 areas:

- Board Leadership on learning from death
- 'line of sight' to leanring from death agenda
- Specialty reporting
- Care review and SJR activity
- Reporting to the Board
- Shift from a focus on SHMI and HSMR as main vehicle for assurance on quality of care relating to deaths.
- SJR proces moving to a multi-professional approach
- Team working
- Ethnicity and other protected characteristics
- Referrals for SJR in line with Trust policy
- Thematic analysis and links to PSIRF and the patient profile
- Family feedback loop

The national data breech issues experienced by both Telstra Health and NHS Digital have been resolved. As a result, new data has been released for both of the indicators.

For the period of April 23- March 24 the Trusts HSMR is 113.7 and 'higher than expected'. The HSMR value is lower than 12 months ago however, it is marginal in comparison to the 22/23 financial year, and relatively, the rolling 12 month HSMR trend is flat across the last financial year. The reason for the 'higher than expected' values is because the crude rate remains higher than the expected rate, despite crude rate improving over the last year. The expected rate has also fallen. The expected rate for the financial year of 23/24 is the lowest it has been across five years. Furthermore, Medway performs in line when compared nationally to other Trusts for metrics most associated with quality of documentation (coding).

The average depth of coding and average Charlson comorbidity score metrics have both seen an improvement in the data provided up to April 2024. Data is showing that the average Charlson comorbidity score in subsequent Finished Consultant Episodes (FCE) improves.

SHMI for the period of February 23- January 24 is 1.16 and 'higher than expected'. COPD and Bronchiectasis continues to be an outlier on both mortality metrics.

Next steps include:

- Understanding why the high value months occurred and why for both April 23 and January 24 from HSMR and what impact the industrial actions had on these months.
- Exploring potential factors into the expected death rate. Could there be potential changes in the patient case mix seen at Medway compared to the last 5 years.
- Understanding A&E attendances versus emergency admissions. HSMR will take into account previous non-elective admissions but does not adjust for previous A&E attendances. Why has there been an increase in patients who have had previous A&E attendances but a decrease in emergency admissions? Expected rates of mortality will increase for those who have had multiple emergency admissions.
- A further look into documentation. Selecting a sample of non-elective patients who report as having zero comorbidity scoring.

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

| **Proposal and/or key recommendation:** | | | | |
|---|---|---|---|---|
| **Purpose of the report (Please mark with 'X' the box to indicate)** | Assurance | x | Approval | |
| | Noting | x | Discussion | |

NHS Medway NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Committee/Group submitted:**<br><br>**Date of Submission:** | Meeting: Mortality and Morbidity Surveillance Group (MMSG)<br>Date : 23/06/2024 | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | *Please mark with 'X' the priorities the report aims to support:* | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) x | Priority 4: (Quality) x | Priority 5: (Systems) |
| **Relevant CQC Domain:** | *Please mark with 'X' the CQC domain the report aims to support:* | | | | |
| | Safe: x | Effective: x | Caring: | Responsive: | Well-Led: |
| **Identified Risks, issues and mitigations:** | | | | | |
| **Resource implications:** | | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Not applicable (*please indicate why an equality assessment was not required)* | | | | |
| **Legal and Regulatory implications:** | | | | | |
| **Appendices:** | | | | | |
| **Freedom of Information (FOI) status:** | Tick either:<br><br>☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper. | | | | |
| **For further information please contact:** | Name: Sofia Power<br>Job Title: Learning from Death Manager<br>Email: sofia.power@nhs.net | | | | |
| **Please mark with 'X' - Reports require an** | No Assurance | | There are significant gaps in assurance or actions | | |
| | Partial Assurance | | There are gaps in assurance | | |

| | | | |
|---|---|---|---|
| **assurance rating to guide the discussion:** | Assurance | | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

## Learning from Deaths

Between April 24- June 24, for quarter 1 of the financial year 2024/2025, the Trust recorded 363 inpatient adult deaths. 3 patients with learning difficulties died in hospital during this time.

An overview of the Trust's current position with regards to the mortality is presented below. Deaths on each ward are reviewed at specialty Mortality and Morbidity Surveillance Group (MMSG). In April 2024, there were more deaths noted on Emerald ward. As a result, MMSG instructed a review of these deaths. The Matron for Emerald Ward reviewed 8 of the 10 deaths and confirmed these were expected deaths and the patients were on end of life care pathway. Two of the deaths were reviewed by the Clinical Learning from Deaths Lead who confirmed that in view of prognosis on admission and extensive comorbidities of the patients, both of these were expected and there were no failings in care identified.

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
|---|---|---|---|---|---|---|---|---|---|---|
| Total no. of adult inpatient deaths | 121 | 118 | 124 | | | | | | | 363 |
| No. Referred to Coroner | 29 | 23 | 26 | | | | | | | 78 |
| Learning Disabilities | 1 | 2 | 0 | | | | | | | 3 |
| Total number of deaths reviewed by SJR | 13 | 6 | 13 | | | | | | | 22 |
| % of deaths reviewed by SJR. | 10.1% | 5.1% | 10.4% | | | | | | | 6.1% |
| Total number judged as possibly/probably preventable | 2 | 0 | 2 | | | | | | | 4 |
| Total number of LD deaths reviewed | 1 | 2 | 0 | | | | | | | 3 |
| Total number of LD deaths judged as possibly/probably preventable | 0 | 0 | 0 | | | | | | | 0 |

### Medical Examiner Office

In June 2023, the Medical Examiner Office presented the following figures at the Mortality and Morbidity Surveillance Group for timeliness of completion for the Medical Certificate of Cause of Death (MCCD).

- 100% of cases were scrutinised by the Medical Examiner within 2 calendar days of death
- 52% of MCCDs completed by the clinical team within 3 calendar days of death
- 57% of coroner referrals completed by the clinical team within 3 calendar days of death

The date for statutory implementation of the Medical Examiner service has been announced as the 9th September 2024. The general election has impacted on ability for Civil Service to share information regarding implementation. The ME Office will continue to share updates as they are received.

The Medical Examiner Office have raised the following observation and concerns noted during scrutiny of the notes:

- Delays in receipt of proposed cause of death. 9% of proposal received more than 5 calendar days after death.
- Families continue to highlight concerns about waits in ED and being cared for in corridor environment
- Continued issues with quality of ward round documentation, specifically the use of copy and paste
- Difficult to identify the responsible consultant leading to lack of consultant involvement in proposed causes of death.

Cases where there has been excessive use of copy and paste noted during Structured Judgement Reviews (SJR) have been forwarded to the ePR team. Due to the up and coming Junior Doctor rotations, Clinical Coding and the Learning from Deaths Managers are re-starting presentations to the specialities on the importance of documentation and the impact this has on clinical coding and mortality.

**Structured Judgement Reviews (SJR)**

A total of 6.1% of deaths were subject to SJR review over quarter 4 (23/24). This was a lower percentage due to the bank holidays in May whereby the SJR panels that are held on a Monday were postponed. Four of these deaths were judged as either possibly or probably preventable. Any cases which are judged as such, or have an overall care score as ‘poor’ or ‘very poor’, are escalated to the Incident Reviews Group (IRG) for a panel decision into further investigation under the PSIRF framework.

The top five themes identified from SJR for quarter 4 are:

| Theme | Issues identified | Actions |
|---|---|---|
| Problems with communication between clinical teams | Ongoing ‘not my patient’ issue and ownership of patient not clear. Lack of communication with EOLC team. No clear reasons why tests were requested. | Issue highlighted by Medical Director for Quality and Safety and forms part of improvement work for the move from ‘it’s not my patient’ to ‘this is our Medway patient’. |
| Problems with documentation | Copy and paste on ePR<br>Documentation not completed re bleeping doctors | Examples of copy and paste sent to ePR team.<br>Learning included as key message in weekly datix flash. |

| | | |
|---|---|---|
| | Notes not updated in a timely manner- difficult to follow the patient story.<br>Medication prescribed or patient not documented – patient history not documented. | SJR themes discussed at CMO Grand Round<br>More education work on documentation being delivered by Coding and LfD with the new Jnr Doctor rotation. |
| Problems with communication with families and carers | Incorrect prognosis relayed back to family. Family concerns around lack of communication or explanation given by doctors.<br>EOLC decisions not always communicated well with families. | This message is relayed at speciality M&Ms. Elderly care presented one of these cases at the M&M and doctors were reminded to have EOLC discussions with families early. |
| Bed Capacity | Patients not suitable for ED corridor treatment need to be highlighted<br>Often linked to long stayed in ED<br>Lack of beds due to patient flow means privacy for EOLC patients cannot always be met. | Zero tolerance for treatment in corridors implemented. |
| Delays with imaging | Gaps in CT scan system and delays; patients not rescheduled.<br>Delays in reporting scan results<br>CT scans booked as urgent need to be discussed with radiologist<br>Delay in VQ scans. | Representative of imaging attends the SJR panels.<br>Issue was highlighted to Head of Imaging<br>Issue highlighted to Operational Director of CCCS. |
| Delays in treatment | Policy of reversal of anticoagulation not followed and resulted in treatment delays.<br>Delay in stroke escalation pathway | Cases forwarded to speciality M&M |

A summary of the four deaths that were judged as slight possibility and strong possibility of avoidably and escalated to the IRG are listed below.

Three of these cases have been closed. One case remains open as an ongoing Patient Safety Incident Investigation (PSII) under the Patient Safety Incident Response Framework (PSIRF).

| Month of review | SJR identified themes | Outcome |
|---|---|---|
| April 2024 | Delays in referral to Palliative/EOLC.<br>Delays in treatment.<br>Failure to recognise deteriorating patient.<br>Issues with Infection management.<br>Did not follow policy re reversal of anticoagulation.<br>Referrals for outpatient tests without any instruction to the patient.<br>Over anticoagulated - medication error.<br>Problems with communication between clinical teams - no clear reason why test was requested | Ongoing improvement work in pharmacy regarding Troponin and chest pain and the importance of checking worklist manager.<br>Discussed at Elderly Care M&M.<br>Lack of early intervention for sepsis infection.<br>Links to ongoing improvement work around sepsis treatment delay and identification of sepsis.<br>Learning to be discussed at Respiratory M&M. |

| | | |
|---|---|---|
| June 2024 | Lumbar puncture or CTACTVA should be considered for repeat headache attendances to hospital to rule out aneurysm<br>Accuracy and completion of recording of GCS<br>No second opinion from ICU or HDU.<br>Incorrect NEWS scoring did not trigger to ART team.<br>No discussion with poisons unit.<br>No involvement with ICU | Improvement work for training to be provided for NEWS scoring.<br>Learning to be undertaken for Nurses to appropriately document level of consciousness |

## Learning Disability

Every patient with a learning disability and autism is subject to an SJR. SJRs are forwarded to the Learning from Lives and Deaths of people with a Learning Disability and Autism for LeDeR review. Over quarter 1, there were a total of 3 SJRs for patients with learning disabilities. A member of the Learning Disabilities Team attends the SJR panel where LD patients are discussed to provide input into the care given to the patients and to highlight any concerns.

| Quarter of Review | SJR themes | Actions |
|---|---|---|
| April – June (Q1) | TEP and DNAR form completion<br>Good input from SALT and Palliative Care Team<br>No surgical opinion being sought for necrotising fasciitis.<br>Prompt administration of antibiotics | All cases forwarded to LeDeR<br>1 patient discussed at the Gastro M&M and 1 patient discussed at the Trust's Incident Review Group |

In the last financial year, the Kent and Medway LeDeR review highlighted issues with DNACPR/TEP issues at Medway. Education to Medical teams was provided by the Learning Disability Liaison Nurses to ensure these were completed appropriately for patients with Learning Disabilities. This still remains an issue for the Trust. Other issues identified for Medway are:

- Communication from Medical teams to families/carers regarding the care and treatment.
- Mental Capacity assessments/best interest decisions regarding invasive procedures and treatments.

The Learning Disability Liaison Nurse is presenting at the September 2024 Mortality and Morbidity Surveillance Group (MMSG) on any learning for the Trust and themes and trends from LeDeR reviews and the National Kent and Medway Annual LeDeR report (2022).

## Shared learning

All cases discussed at SJR panel are included in the weekly Datix Flash which is shared Trust wide to disseminate learning across the Trust. The flash includes positive learning identified from reviews and highlights learning and issues identified. All cases for speciality M&M discussion are forwarded to speciality leads to discuss at their M&M meeting. Cases identified as having significant problems in care are highlighted to the Incident Review Group and under the new PSIRF framework, will be verbally agreed as to the appropriate investigation pathway.

The mortality newsletter includes a case study to highlight learning actions and improvements each month. The Mortality Team has released newsletters each month since March 2024. The Learning Disability team are working with the Mortality Team to include educational

Themes from SJRs are shared in the quarterly CLIPS report which triangulates themes from other departments including those from the legal team. The new SJR process will look specifically at how the Trust addresses these themes with actions focused on improvement around the themes identified.

## Next steps

- To implement the new SJR process which will move from a weekly panel to single SJR reviewers. Target date to implement new process is September 2024. Target date to review the process is October 2024.

- To complete the procurement process for the new SJR+ app, the reporting dashboard and the training for new and existing reviewers. The new app and dashboard is specially designed to support the new process and will better support highlighting learning from reviews.

- New SOP for the SJR process to be approved at August 2024 MMSG.

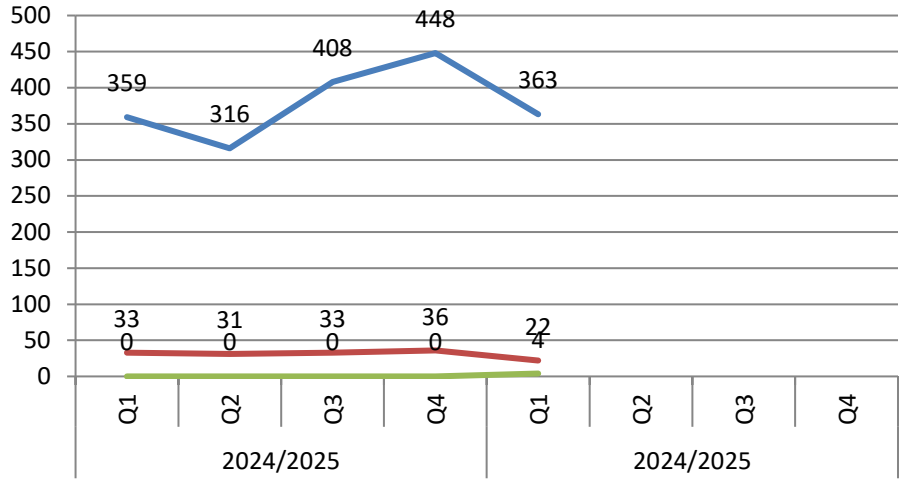
# Medway NHS Foundation Trust: Learning from Deaths Dashboard: Apr – Jun 2024

## Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

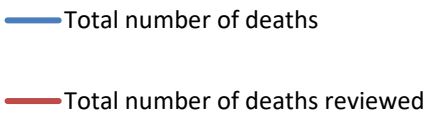
**Total number of deaths, deaths reviewed and deaths deemed more likely than not due to problems in care**
(does not include patients with identified learning disabilities)

| 2024/2025 | Total number of adult deaths | Total number of deaths reviewed | Total number of deaths judged more likely than not to be due to problems in care |
|---|---|---|---|
| 01/04/2024 | 121 | 13 | <5 |
| 01/05/2024 | 118 | 6 | 0 |
| 01/06/2024 | 124 | 13 | <5 |
| **Total Q1** | **363** | **22** | **<5** |
| | | | |
| **Year to Date** | **363** | **22** | **<5** |

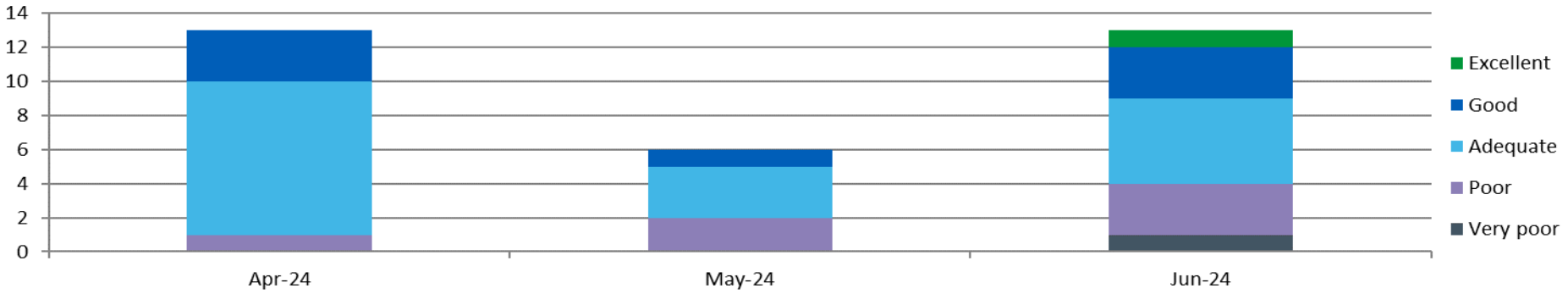
Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care




**Total deaths reviewed, categoris**




**Total deaths reviewed, categorised by Overall Care Score**



## Specialty Mortality and Morbidity Meetings

Specialty M&M meeting are monitored each month by the Mortality Team. There have been a number of challenges in relation to specialty M&Ms and the process of M&M will be a focus point for the mortality A3 improvement work.

The main issues highlighted from specialty M&Ms are:

- No reporting structure. National guidance recommends that each specialty has a dedicated lead who will have overall responsibility of actions/improvements and that these are reported to the Trust Mortality and Morbidity Surveillance Group

- M&M are sometimes poorly attended, poor engagement, no clear specialty lead- physiotherapist for cardiology and pathway coordinator for Urology submit minutes/reports. Meetings often cancelled.

- No clear action log from reviews. LfD contacted a number of specialties but there is no central action log to monitor actions discussed to evidence improvement.

- Mortality reporting system is currently very basic- no facility for reviews to be completed and submitted electronically (similar for SJRs- these are manually created by the LfD team raising an incident for each review which is time consuming and will be significantly impacted if the number of SJRs are increased).

- No standardised format to reviews. M&M review process are highly variable across the Trust.

**From SJR to M&M**

For Quarter 1, a total of 11 cases were discussed at Specialty M&Ms after SJR. Some of the highlights of the learning shared at M&M were:

- Junior Doctors need to ensure they chase urgent scans. Process of recognition of neurological observations to be relayed back to Junior Doctors.
- Patient did not have RESPECT form from previous admission. These are vital for patients who are discharged for care in the community.
- Miscommunication with family wasn't helped by discrepancy between CT/MRU diagnoses. Case will be put forward for UGI MDT and Radiology for further learning.
- Poor documentation, delayed referral and delayed observations noted at M&M and learning was shared amongst the team as an example.
- Doctors reminded to be cautious around the use of opioids with patients with CKD 3 and above.
- Although the care was adequate, specialist input needs to be acknowledge earlier and breaking bad news to families needs to be done sooner. Doctors were reminded that patients facing cancer may re-evaluate either lives and further stress or anxiety could be caused if they cannot ask questions around Hospice transfer.
- Medical team take over was delayed, despite good care. No paired ward for Victory ward- this has been raised with the Divisional Medical Director.

**Learning from Mortality and Morbidity Meetings – Quarter 1 24/25**

| Specialty | Number of cases discussed | Themes identified |
|---|---|---|
| **Acute Medicine** | 2 x mortality cases<br>1x morbidity cases | Communication between clinical teams<br>Decision making |
| **Acute Pediatrics** | 3x mortality<br>3x morbidity | Challenges with adults vs child admitted to MFT transition not established within Peadiatrics.<br>Confusion over 18 yr olds with LD/complex needs needing admission. Parents confused |
| **Cardiology** | 9x Mortality cases | Documentation<br>Decision making- inappropriate ward transfer<br>Delays in treatment |
| **Frailty** | 7 x mortality cases | Communication with families/carers<br>Documentation- copy and paste on ePR |
| **Respiratory** | 5X mortality | Lack of senior oversight/ weekend handover<br>Poor communication between clinical teams |

## Actions

There was a marked improvement for some of the specialty reviews: Cardiology, Respiratory, Frailty, Acute Pediatrics and Acute Medicine have clear learning and actions from M&M. Cardiology and Respiratory have both referred cases from M&M to SJR for a further review.

Issues highlighted to the Mortality and Morbidity Surveillance Group (MMSG) regarding M&Ms were:

- ED have been reminded to make sure they are discussing SJR cases referred to them at their M&Ms. Although there is learning discussed at M&M, it is not clear how actions are monitored and how they are able to evidence any improvement.

- General Surgery have been approached re the quality of reviews. Although the discussion of the case is minuted, there are no learning points or no actions. LfD manager is attending Divisional Governance Board of Surgery and Anesthetics to support.

- Cases discussed at the Urology M&M are difficult to identify. Learning from reviews tends be very limited in detail. This was raised with Urology consultants who acknowledged this and are working towards clearer M&M reviews. Examples of good practice and template suggestions have been sent to these teams.

- The lack of critical care meetings was highlighted at the MMSG and this was raised with the clinical lead.

- Each division has been asked to provide an update re M&M meetings in their QPSSC escalation and assurance reports.

- Specialty M&Ms are part of the focus for the Mortality A3 refresh. A Mortality and Morbidity Reviews Group will give the specialty teams an opportunity to discuss learning from M&M and will provide a reporting route for escalations to the MMSG.

Clinical Coding and Learning from Deaths will be presenting to the new Junior Doctors on the importance of documentation and the impact this has on coding and mortality metrics.

## M&M tracker of minutes received

| Speciality 2024/2025 | Quarter 1 | | |
|---|---|---|---|
| | Apr | May | Jun |
| Acute Medicine | Meeting Canc | 15th | 7th |
| Acute Paediatrics | 4th | 2nd | 6th & 20th |
| Cardiology | 23rd | 28th | 25th |
| Critical Care - ICU/HDU | No Meeting | No Meeting | No Meeting |
| Diabetes and Endocrinology | 17th | No Meeting held | No meeting held |
| ED | 24th | 22nd | 26th |
| Elderly Care | 25th | 23rd | 20th |
| ENT **LOW MORTALITY GROUP | | 9th | 24th |
| Gastroenterology | 22nd | 20th | |
| General Surgery | | 9th | No meeting held |
| Haematology **LOW MORTALITY GROUP | 19th | 24th | |
| Neonatology | | 28th | |
| Maternity/still births | | | |
| Gynaecology ** LOW MORTALITY GROUP | 26th | | 7th |
| Trauma & Orthopaedics | | | No meeting held |
| Respiratory | 19th | 17th | 21st |
| Urology | 17th | 9th | |

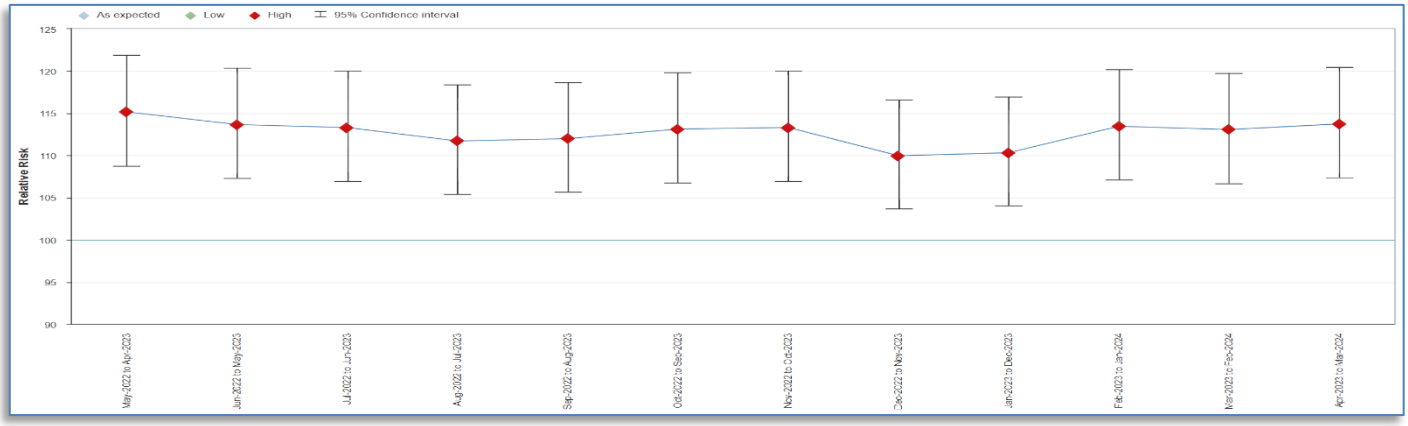
# Mortality

## Hospital Standardised Mortality Ratio (HSMR)

The National data breeches affecting both HSMR and SHMI has now been resolved and Telstra Health have been able to provide updated data in relation to HSMR.

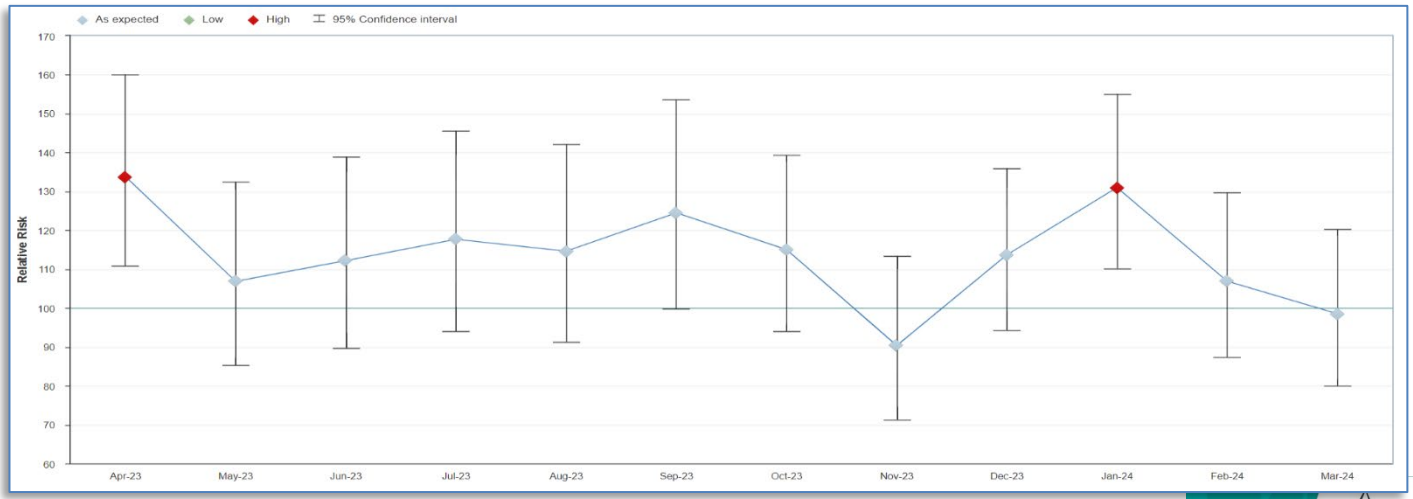
For the period of April 23- March 24 overall HSMR reported as 113.7 and remains 'higher than expected'. HSMR for 23/24 has made minimal improvements compared to last year and furthermore, remains far higher than the previous three financial years.

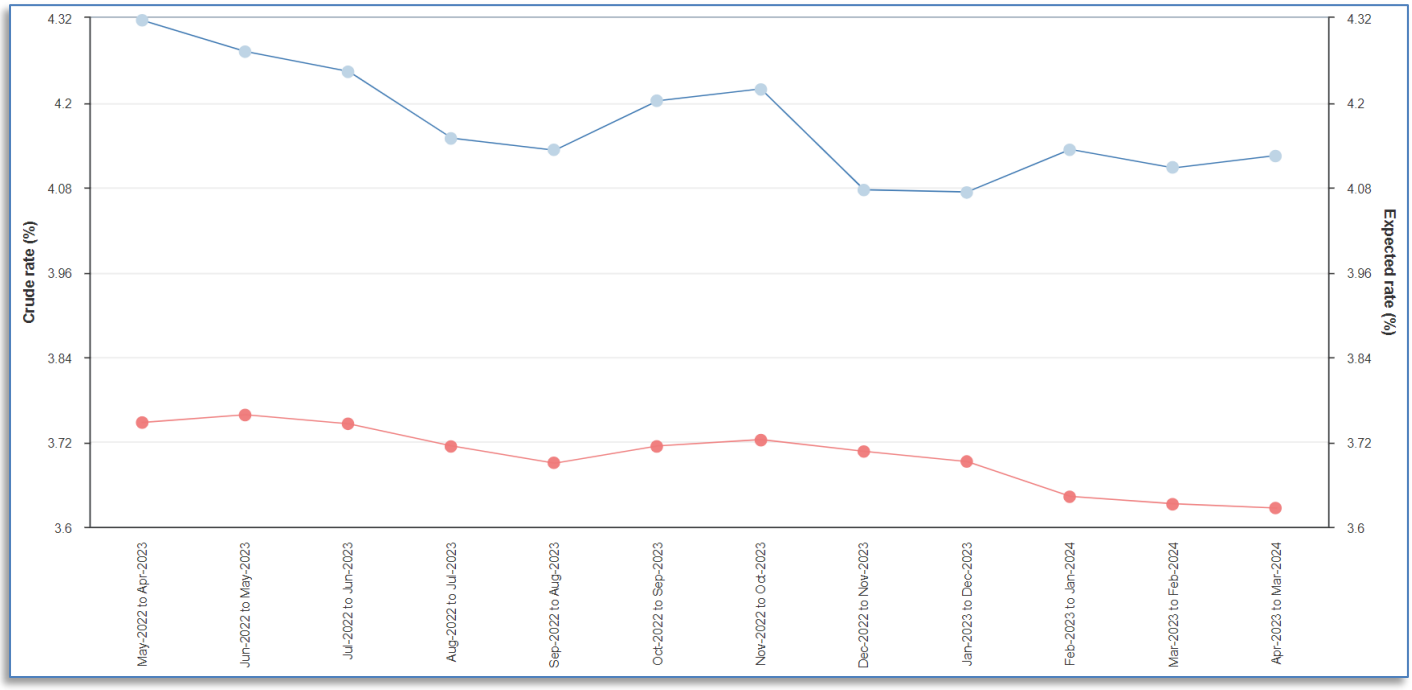
**HMSR 12 month rolling trend**




The general trend throughout the financial year 23/24 have been HSMR values that sit above the "100" benchmark; and on two occasions, they have been 'higher than expected values". On a single month trend, January 24 shows as 'higher than expected', whilst March 24 is the second occasion a month has returned a below "100" value. Further investigation into the potential reasons for the high values seen in both April 23 and January 24 will be explored at the MMSG. Both of these months experience industrial action and thus, further investigation will look into what potential impact this had on mortality at the time, and shortly after the strikes.

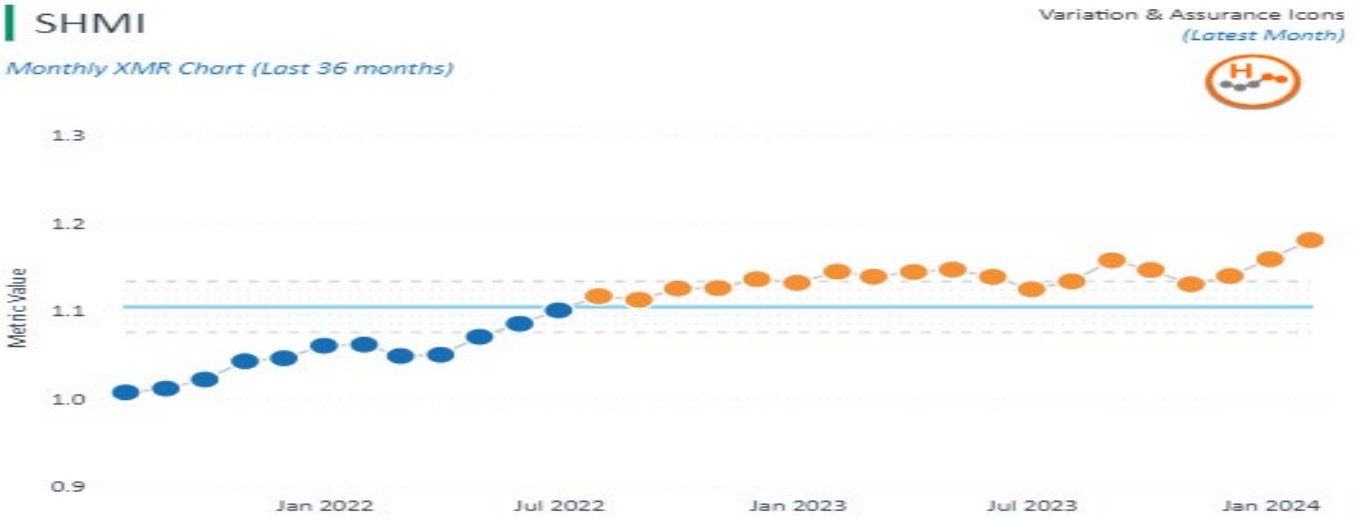
**HMSR 12 month single month trend.**





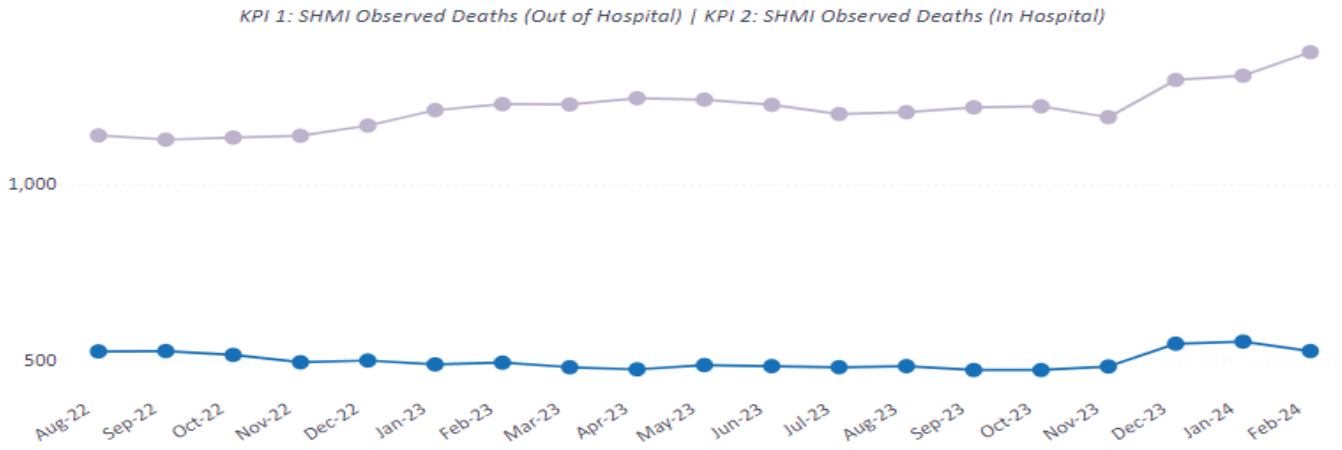

## Summary Hospital Level Mortality Indicator (SHMI)

The latest SHMI data was for the period of February 23- January 24 and the value was 1.16 and 'higher than expected'.




**S**HMI has continued to deteriorate after the brief improvement seen in December 2023. One contributing factor for the increase in SHMI value is the increase in-hospital deaths, and the decrease in out of hospital deaths. As these values has increased and decrease, the SHMI has deteriorated.

**SHMI observed deaths out of hospital (blue) Vs in hospital deaths (purple)**




## Next Steps

- Understanding why the high value months occurred and why for both April 23 and January 24 from HSMR and what impact the industrial actions had on these months.
- Exploring potential factors into the expected death rate. Could there be potential changes in the patient case mix seen at Medway compared to the last 5 years.
- Understanding A&E attendances versus emergency admissions. HSMR will take into account previous non-elective admissions but does not adjust for previous A&E attendances. Why has there been an increase in patients who have had previous A&E attendances but a decrease in emergency admissions? Expected rates of mortality will increase for those who have had multiple emergency admissions.
- A further look into documentation. Selecting a sample of non-elective patients who report as having zero comorbidity scoring.

**Patient First – True North Mortality A3 Refresh**

The focus of the Mortality A3 refresh will look into root causes for the increase in mortality indicators and focus on countermeasures to improve the mortality metrics and Learning from deaths process. The A3 will focus on the following areas:

- Care continuity and specialty review for patients on emergency admission pathways
- Review of outlier groups
- Recording of episodes of care
- Variability in the SJR process
- Ensuring the learning from deaths process is in line with best practice
- Variability in the end of life care process
- Validation of deaths to ensure data accuracy

Key stakeholders meet weekly to discuss contributing factors to each of these focus areas.

The next steps of the A3 are:

- To establish a suitable measurable breakthrough objective metric to monitor weekly progress.
- Continued weekly sessions to update on actions.
- Procurement process for RIP validation (5xPA). This process will ensure accurate clinical documentation is recorded and has been a contributing factor to improvement work with mortality indicators for other Trusts who have experienced high mortality indicators.
- Procurement process for SJR app, new SJR dashboard and training for new and existing reviewers from Aqua. The app is designed to support the new SJR process for single reviewers and has a Stage 2 panel function built in. The dashboard will extract the learning from the reviews and present trends in SPC format, which will better support the new process and drive improvement focused actions from SJRs.

**NICHE action log meeting**

Weekly sessions will be held to progress through the tweleve reccomendations made by NICHE to improve the learning from deaths process. Each week, key stakeholders will update the action log with progress on each of the reccomendations. The areas of focus from the NICHE report are:

- Board Leadership on learning from death
- 'line of sight' to leanring from death agenda
- Specialty reporting
- Care review and SJR activity
- Reporting to the Board
- Shift from a focus on SHMI and HSMR as main vehicle for assurance on quality of care relating to deaths.
- SJR proces moving to a multi-professional approach
- Team working
- Ethnicity and other protected characteristics
- Referrals for SJR in line with Trust policy
- Thematic analysis and links to PSIRF and the patient profile
- Family feedback loop

## Next steps

Many of the actions included in the NICHE reccomendations are in progress and most actions have a target completion date within the next few months, no later than December 2024. Some of the immediate next steps that will address the reccomendations are:

- Board training on learning from deaths process currently going through procurement.
- A lot of the actions related to SJR are in progress and will be resolved once the new SJR app, training and dashboard is provided. The target date to start the new process is

September 2024. The new process will be introduced slowly and will run alongside the current SJR panel process until assurance can be provided on the quality of the SJRs from the single reviewers.

- Target date of October 24 to set up the Mortality and Morbidity Review Group which will give specialites the opportunity to report Mortality and Morbidity activity, themes and trends and will report into the MMSG.