APPENDICES - Agenda

Trust Board Meeting in Public

Wednesday, 15 January at 13:00 – 15:00

Item	Subject	Presenter	Page	Time	Action
1.	Preliminary Matters				
1.1	Chair's Introduction and Apologies				
1.2	Quorum				
1.3	Declarations of Interest				
2.	Minutes of last meeting and Action Log				
2.1	Minutes of 13 November 2024				
2.2	Action Log				
3.	Opening Matters				
3.1	Chief Executive Update				
3.2	Council of Governors Report				
	Board Story Presentation				
3.3	Breast Feeding Story				
4.	Performance, Risk and Assurance				
4.1	Risk and Issue Register and Board Assurance Framework				
4.2	**APPENDIX 1: Integrated Quality Performance Report**	**Chief Delivery Officer**	**3**		**Assurance**
5.	Board Assurance Reports				
5.1	Quality Assurance Committee				
5.2	People Committee				
5.3	Finance, Planning, Performance				
6.	Papers				
6.1	**APPENDIX 2: Finance Report**	**Chief Financial Officer (Interim)**	**55**		**Note**

6.2	RSP, Financial Recovery and Integrated Improvement Plans update				
6.3	Strategy: Freedom to Speak Up				
6.4	**APPENDIX 3:** **Maternity Services Reports:** **a) Maternity Workforce Oversight Report** **b) Maternity CNST Compliance Assurance Report – Updates and Actions**	**Director of Midwifery**	**65**		**Assurance**

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

November - 2024

Patient FIRST

Executive Summary

Jayne Black
Chief Executive

True North

	Variation: Common	Variation: Improve	Variation: Concern	Assurance: Common	Assurance: Improve	Assurance: Concern
People	20	30	5	17	15	16
Quality	46	19	13	13	5	3
Systems & Partnerships	13	12	12	17	4	5
Patients	10	14	2	4	0	4
Sustainability	6	2	4	7	0	0

Variation icons:
Orange indicates concerning **special cause variation,** requiring action. Blue indicates where improvement appears to lie. **Grey** indicates no significant change (**common cause variation**).

Assurance icons:
Blue indicates that you would consistently expect to achieve a target. Orange indicates that you would consistently expect to miss the target. **Grey** tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Key Messages

- The People domain continues to show the highest volume in metrics improving for Statistical Variance (30), and shows the highest % of statistical improvement metrics (~55% of all metrics)
- The Sustainability domain is showing the highest number of metrics statistically showing concern, with 33% of all metrics flagging
- The Systems & Partnerships Domain is showing an equal distribution of metrics across all variations (both Improvement and Concern show 32%)
- The majority of the metrics (59%) in the Quality domain continue to show no significant statistical variation and as such are showing common variation.
- Overall, 77 metrics are now showing improved statistical variance (+7 from last month) against 36 which are showing concern (+3 from last month).

Issues, Concerns & Gaps

- Increase in concerns being received relating to delays receiving imaging results and noted increase in requests for financial recompense
- Cardiology capacity remains a risk, mutual aid has been sourced from MTW and DGH to support with clearance of >65 week waits
- Long waiting time in ED for beds once DTA given remains an issue. Total DTA was high at 771 compared to 693 previous month. Admitted ED performance for November at 3.7%
- High level of sickness short notice for Medics impacting staffing levels increased bank spend.
- Worked FTE (substantive bank and agency) is greater than budgeted establishment
- Identified insufficient mediators available; reviewing options for the service.

Actions & Improvements

- Further mitigations against potential forecast overspend to be developed.
- Task and finish group meetings agreed to continue on a weekly basis.
- Actions being taken across the Trust following complaints closed in November plus promotion of the 7 day IPC service for advice for ward staff, Utilising the 'Big 4' communication tool to highlight complaint themes.
- Cardiac physiology review underway by NHSE regarding capacity and processes within department and MTW agreed mutual aid to support >65 week waits in Cardiology
- New acute medical model due to commence at end of December once Pembroke works have been completed.
- Virtual Improvement Huddles rolled out within HR and OD teams
- Positive Action Policy moving to formal consultation;

Patients

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

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Complaints	8	4	0	7	0	1
FFT	11	24	5	15	0	10
PALS	5	3	0	1	0	0
Patient Experience	1	2	0	3	0	0
PHSO	3	2	1	1	0	0

Patient FIRST

Operational Leads:
Wayne Blowers - *Director of Quality & Patient Safety*
Nicola Lewis - *Associate Director of Patient Experience*

Committees:
Quality Assurance Committee (QAC)

Patients

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

FFT

Total FFT Recommend %

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	95.0%	H	F	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%

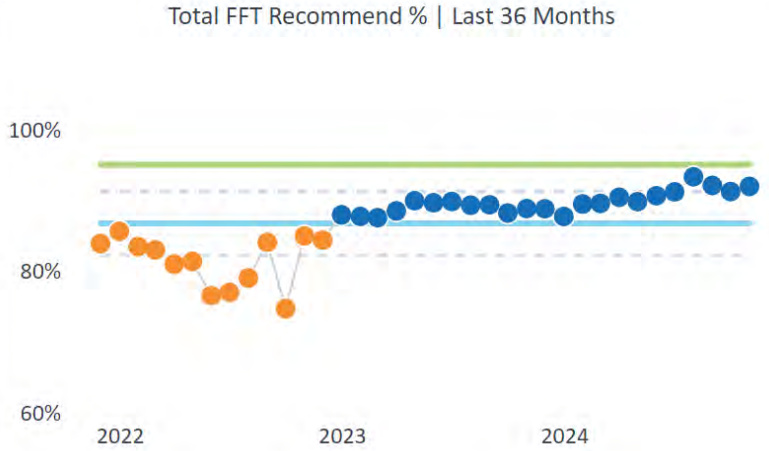
True North Domain: **Patients**

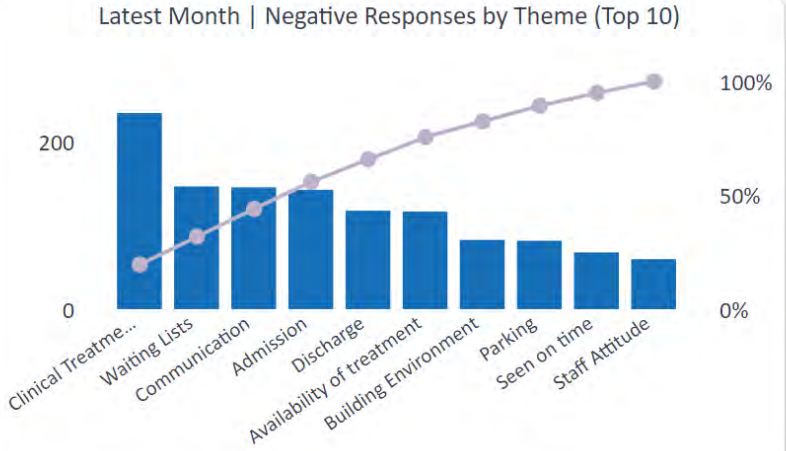
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

2	1	0	0	7





Key Messages

- Overall positive FFT and response rate remains static for this reporting period
- Maternity and inpatient areas remain above target for positive experiences of care
- ED has improved marginally since the last reporting period

Issues, Concerns & Gaps

- Issues with car parking features as a theme in weekly feedback
- Waiting/Waiting lists feature as a concern in monthly feedback

Actions & Improvements

- Estates and facilities team are attending the weekly FFT breakthrough huddles
- ANPR parking rolled out in early December to ease congestion
- The visiting policy is being refreshed, longer visiting hours will help avoid bottlenecks on site
- A review of clinical activity will be undertaken to ensure efficiency of outpatient appointments
- The catering feedback survey has gone live, to understand where we can focus improvements in clinical areas

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Patients	FFT			Emergency Care FFT Recommend %	85.0%		F	Watch is red for 4 reporting periods	74.9%	73.0%	79.9%	74.0%	72.8%	75.2%
				Outpatient FFT Recommend %	95.0%	H	F	Watch is red for 4 reporting periods	92.6%	93.0%	94.7%	92.8%	93.0%	93.1%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	Watch is red for 4 reporting periods	89	26	12	12	10	6

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%
				Total FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	15.1%	14.5%	16.0%	15.2%	15.2%	14.1%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.3%	94.5%	95.3%	95.6%	93.9%	95.1%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	51.4%	52.8%	52.7%	52.1%	51.5%	47.1%
				Outpatient FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	92.6%	93.0%	94.7%	92.8%	93.0%	93.1%
				Outpatient FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	9.6%	9.8%	11.3%	10.6%	10.4%	10.0%
				Maternity FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	39.1%	34.2%	42.4%	70.6%	76.0%	70.6%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	Special cause of improving nature or lower pressure due to (L)ower values	89	26	12	12	10	6
	Complaints			Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	56	39	49	44	63	52
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	21.4%	3.6%	0.0%	30.8%	20.0%	21.2%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	122	83	103	94	92	94
				PALS Converted to Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	1	0	0	0

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Patients	PHSO			PHSO Cases Closed - Not Upheld	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

Key Messages

- 100% complaints acknowledged within timeframe; 0 PALS converted to complaints
- Themes from complaints in November: delays in diagnosis, delays in treatment, discharge decision making
- Themes from PALS in November: appointment concerns, communication with patients and families, dissatisfaction with Care and Treatment, delays with results and delays with SAR responses.
- 2 PHSO cases closed: 1 partly upheld – recognised complex urology case with lack of discussion with family when discontinuing a urinary catheter in a frail patient. 1 no investigation necessary.
- Mixed sex breaches remain very low. The top contributors remain stepping patients down from ICU and HDU onto the ward.

Issues, Concerns & Gaps

- 21% of complaints breached target response time (n=6); 5 within Specialist Medicine Care Group
- 2 complaints re-opened – complex cases involving increased length of stay and complex discharge.
- Increase in concerns being received relating to delays receiving imaging results - known backlog in radiology reporting being rectified.
- Noted increase in requests for financial recompense
- Accurate reporting mixed sex breaches automatically on teletracking remain a national issue

Actions & Improvements

- Actions being taken across the Trust following complaints closed in November: Additional medication administration audits and spot checks, Promotion of protected mealtimes for families to assist patients, Promotion of the importance of utilising the ‘this is me’ board at the patient’s bedside, Promotion of the 7 day IPC service for advice for ward staff, Utilising the ‘Big 4’ communication tool to highlight complaint themes.
- MFT & MTW are working together with teletracking to resolve the reporting issues. An update was requested mid-December 202, however this is unlikely to be resolved until early 2025.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Patients	FFT			Total FFT Recommend %	95.0%	H	F	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%
				Total FFT Response Rate %	-	H		12.1%	12.5%	14.8%	14.1%	16.2%	14.9%	15.1%	14.5%	16.0%	15.2%	15.2%	14.1%
				Inpatients FFT Recommend %	95.0%	H	?	93.3%	92.3%	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%	95.3%	95.6%	93.9%	95.1%
				Inpatients FFT Response Rate %	-	H		38.4%	36.5%	41.5%	44.7%	51.5%	47.6%	51.4%	52.8%	52.7%	52.1%	51.5%	47.1%
				Emergency Care FFT Recommend %	85.0%		F	69.2%	64.7%	68.9%	71.6%	77.1%	70.2%	74.9%	73.0%	79.9%	74.0%	72.8%	75.2%
				Emergency Care FFT Response Rate %	-	L		7.6%	8.3%	9.9%	7.6%	10.1%	8.3%	7.9%	7.3%	7.4%	6.6%	7.5%	7.3%
				Outpatient FFT Recommend %	95.0%	H	F	91.9%	91.5%	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%	94.7%	92.8%	93.0%	93.1%
				Outpatient FFT Response Rate %	-	H		7.7%	8.7%	10.1%	9.3%	9.9%	9.8%	9.6%	9.8%	11.3%	10.6%	10.4%	10.0%
				Maternity FFT Recommend %	95.0%		?	82.7%	88.5%	85.8%	88.8%	99.4%	96.5%	92.6%	88.0%	92.6%	94.8%	96.5%	98.3%
				Maternity FFT Response Rate %	-	H		14.5%	30.9%	38.7%	30.6%	49.2%	47.6%	39.1%	34.2%	42.4%	70.6%	76.0%	70.6%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?		486	278	90	110	108	89	26	12	12	10	6
	Complaints			Complaints	-			19	19	25	29	28	23	26	21	30	22	43	19
				Complaints Closed	-			30	22	20	25	28	46	37	38	20	27	24	30

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Patients	Complaints			Complaints Open - Month End	-	L		84	81	86	90	90	67	56	39	49	44	63	52
				Complaints Re-Opened	-			2	2	1	5	1	3	1	4	1	4	10	2
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	40.6%	62.5%	55.6%	82.8%	59.3%	34.5%	21.4%	3.6%	0.0%	30.8%	20.0%	21.2%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			428	496	463	417	480	428	446	499	421	521	439	515
				PALS Closed	-			485	708	460	418	458	402	457	538	401	530	441	513
				PALS Open - Month End	-	L		294	83	86	85	107	133	122	83	103	94	92	94
				PALS Converted to Complaints	-	L		0	0	0	0	0	1	0	0	1	0	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			1	0	0	0	1	0	2	2	2	0	0	0
				PHSO Cases Closed - Partially Upheld	-	H		0	0	0	0	0	0	0	0	0	0	1	1
				PHSO Cases Closed - Upheld	-			0	0	1	0	0	0	0	1	0	0	0	0
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-			0	0	1	4	0	0	0	0	0	0	1	1

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Incident Management	18	12	12	7	3	11
Mortality	15	6	6	16	3	1
IPC	6	1	2	1	2	0
Medicines	6	0	0	3	1	0
Falls	16	3	0	15	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	2	1	0	0	0	0
Maternity	14	2	0	2	0	2
Pressure Ulcer	6	1	1	4	0	0
Risk & Policy	1	3	0	0	0	0
Surgical	1	0	0	0	0	1
VTE	0	1	0	1	0	0

Operational Leads:
Wayne Blowers - *Director of Quality & Patient Safety*
James Alegbeleye - *Medical Director for Quality & Safety*

Committees:
Quality Assurance Committee (QAC)

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	95.0%		P	99.6%	99.0%	98.9%	99.5%	98.8%	99.3%	98.6%	99.3%	99.2%	99.0%	99.1%	98.7%

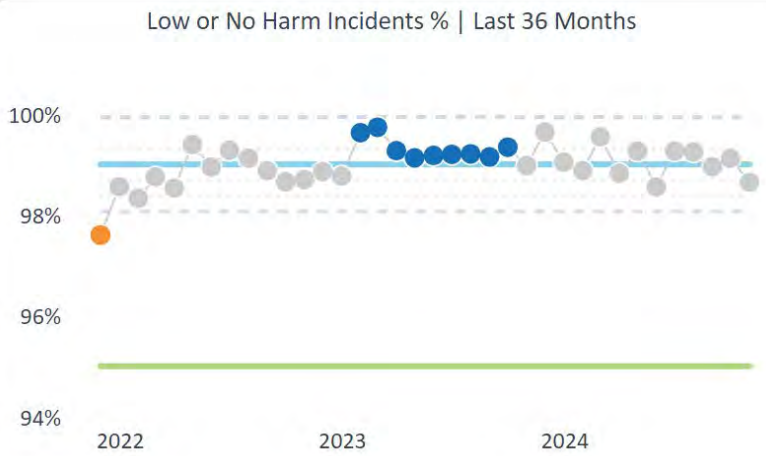
True North Domain: Quality

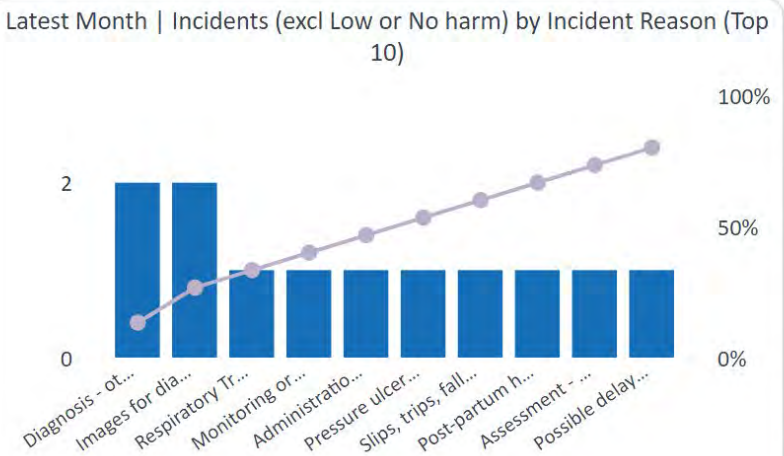
KPI Threshold: 95.0%

Sub Domain KPIs: 21

Variation Summary:

	L	H	L	H
9	1	5	1	5





Key Messages

- 98.7% of all incidents reported resulted in low or no harm.
- 13 incidents in November caused moderate harm or above – above average (unvalidated data until investigations into incidents complete).
- Events from >moderate harm incidents in November: delays in diagnosis, delays in monitoring and recognition of deterioration, sepsis management, poor EOL care, NIV and respiratory team involvement.

Issues, Concerns & Gaps

- Clinical incidents with harm as moderate or above have increased (unvalidated data)
- Specific issues from incidents include: recognition of when CT head referral is required, incorrect IV glucose management, clinic appointment delays for cancer diagnoses, reviews of lines e.g. UVC not being completed in line with guidance, competence in setting up syringe drivers, bereavement documentation and discussion.

Actions & Improvements

- Improvement actions for falls, pressure ulcers and infection prevention progressing (via QIPs).
- Business case for automated NEWS score recording
- NEWS compliance dashboard in use
- Electronic TEP in use from January
- Sepsis management (increasing training and digital proformas on EPR).
- DKA improvement group set up.
- Martha's rule roll out on track

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	1.30%			2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%	1.36%	1.30%	1.27%	1.51%

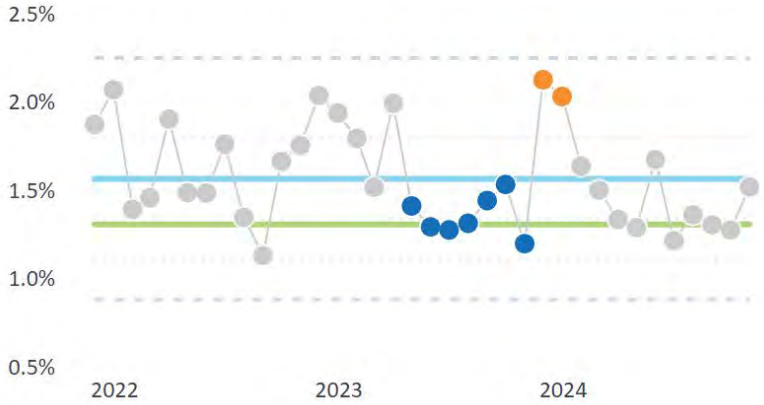
True North Domain: Quality

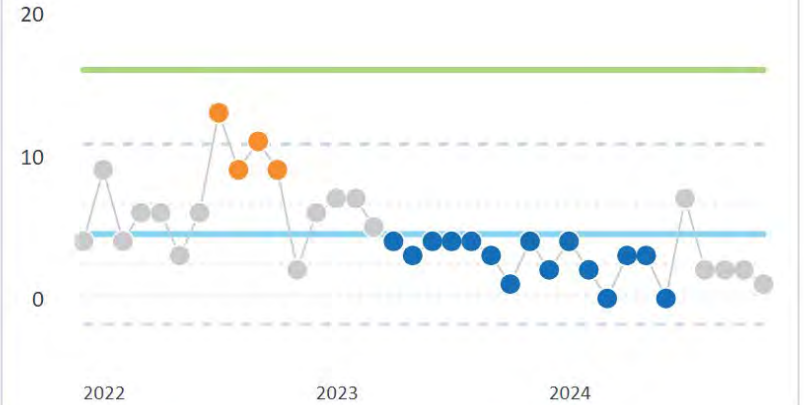
KPI Threshold: 1.30%

Sub Domain KPIs: 15

Variation Summary:

9	1	3	2	0





Key Messages

- HSMR+ for the period of Jun 23- July 24 is 99.2 and 'within expected'
- SHMI for the period of May 23- Jun 24 is 1.20 and 'higher than expected'
- 19 Deaths (14.7%) were subject to SJR. SJRs are now being completed on SJR+
- 14/17 specialities held M&M meetings in November

Issues, Concerns & Gaps

- SHMI has seen a further increase to a value of 1.20
- COPD and Bronchiectasis remain an outlying diagnosis group across SHMI and HSMR despite the changes in HSMR methodology
- Other connective tissue disease remains a persistent outlying diagnosis group across both SHMI and HMSR
- 3/17 specialties did not hold M&M meetings in November; issues with admin support and clinician availability for some meetings remains an issue.

Actions & Improvements

- New HSMR methodology has resulted in the Trust returning to the 'as expected' banding. This is due to the expected rate now coinciding with the observed rate and is largely due to the introduction of frailty as a risk adjustment, Elixhauser comorbidity index values which perform higher than the national average, and the inclusion of a more in-depth analysis of regional deprivation.
- 10 actions remain open from the NICHE mortality action log, majority of actions now complete following the introduction of the new SJR process.

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0		F	Watch is red for 4 reporting periods	12	3	6	10	9	13
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	78.4%	81.5%	83.2%	81.5%	83.2%	84.1%
	Mortality			SHMI (12m)	1	H	F	Watch is red for 4 reporting periods	1.20	1.20				
				Fractured NOF Within 36 Hours	92.0%		?	Watch is red for 4 reporting periods	52.5%	56.5%	74.1%	66.6%	66.6%	

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Incident Management			Patient Safety Incident Investigations (PSII) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	0	0	1	1	1	2
				Patient Safety Incident Investigations (PSII) Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	3	3	2	1	2	0
				After Action Review (AAR) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	2	2	3	2	2	1
				Duty of Candour Compliance Stage 1 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				EDNs Completed Within 24hrs %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	78.4%	81.5%	83.2%	81.5%	83.2%	84.1%
	Falls			Low or No Harm Falls %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	99.0%	100.0%	98.8%	97.8%	98.0%	100.0%
	IPC			MRSA Cases - Hospital Acquired	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	Mortality			HSMR (12m)	100	L	Special cause of improving nature or lower pressure due to (L)ower values	99.70	99.19				
				Total Number of Deaths Due to Failings in Care	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	99.5%	99.8%	99.0%	99.2%	99.7%	99.8%
	Maternity			Maternity Serious Incidents	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				Maternity HSIB Referrals	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Risk & Policy			Risks Open - Moderate (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	32	33	24	23	22	20
				Risks Open - High (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	80	81	46	45	44	40
				Risks Open - Extreme (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	12	11	10	11	7	6
	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	83.9%	83.6%	83.6%	82.9%	82.9%	84.2%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	85.1%	85.6%	86.6%	85.5%	86.3%	87.0%
	Legal & Information Governance			Regulation 28 Reports	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

- FNoF: A total of 39 patients with hip fractures were admitted, of which 11 underwent surgery beyond the 36-hour target, resulting in a compliance rate of 72.1%. Despite this, we have maintained an average compliance rate above 70% over the past three months (August: 76%, September: 74%).
- FNoF: Root Cause Analyses (RCA) continue to be conducted for each breach, positively influencing the prioritization of NOF patients by the orthopaedic and anaesthetic teams on the trauma list.The anticoagulation pathway is currently being updated in collaboration with haematologists, anaesthetists, orthogeriatricians, and orthopaedic specialists. The trauma list is reviewed daily by an MDT team comprising the NHFD Lead, Anaesthetic Trauma Lead, Orthogeriatrician, and Trauma Lead. This ensures NOF/NAFF patients are preoperatively reviewed, medically optimized, and prioritized on the trauma list, with extra capacity created when necessary.
- Falls - There has been an overall reduction in falls in comparison to the previous reporting period; There has been an increase in compliance with the CRASH bundle
- TVN - A reduction in overall HAPU noted in November; Roll out of Purpose T assessment continues in line with the QIP; A replacement programme of all pressure relieving equipment and mattresses has been approved which will commence in April 2025. this will mitigate risk number 1553
- VTE - VTE CNS has commenced in post full time; A3 working group has excellent engagement and the group are working on actions at pace.

Issues, Concerns & Gaps

- FNoF: Many hip fracture patients have multiple comorbidities requiring optimization before surgery. However, the number of breaches due to medical optimization has improved, with only three cases in October; Eight patients experienced delays despite being medically ready, primarily due to insufficient theatre capacity. This remains the most significant challenge, accounting for most breaches in October;
- Patients on anticoagulants face a mandatory 24-48 hour waiting period before surgery to minimize bleeding risks. However with the new anticoagulant pathway we expected to reduce he delay caused by this.
- Falls - Mandatory training for falls remains outstanding; Risk number 1556 - lost and broken equipment remains an issue
- TVN - Under target for ASKKING care bundles in December; Issues have been identified with storing the new equipment that will be replaced in April 2025
- VTE - Accurate dropdowns on Datix remains outstanding; VTE QIP remains outstanding

Actions & Improvements

- FNoF: NOF/NAFF patients are now prioritized on the main trauma list, with other trauma and TCI cases diverted to the green trauma pathway; Efforts to expand the green trauma list are ongoing to alleviate pressure on the main trauma list. However, additional capacity will be critical, particularly during the winter months; Learning points from each RCA are shared during T&O trauma meetings and with our anaesthetic colleagues; We are focusing on creating additional theatre capacity, especially for trauma cases, by improving Theatre utilization in SDCC.
- Falls - The mandatory training programme has been progressed with the head of OD. This will be live by the end of January 2025; The issues with equipment has been escalated to the Director of Estates and Facilitates and countermeasures have been proposed to mitigate the concerns. This will progress as an A3 working group.
- TVN - Byron, Emerald, Keats, Kingfisher have intensive support from the TVN team; Issues with capacity have been escalated to the ‘space’ team to
- VTE - Dropdowns on datix for VTE categorisation will be approved and live by the end of December 2024; QIP will be drafted by the new VTE CNS and approved by PSG early February 2025

Maternity

Key Messages

Perinatal Quality – Incidents November 2024: 1 Incident Moderate Harm or above in Maternity – Complications following TOP fetal anomaly – Examination Under Anaesthetic and Estimated Blood Loss 3L; 0 MNSI referrals in month; 117 incidents reported in Maternity, 27 low harm. 3 Incidents relating to Bleep system; 17 Incidents in NICU, 1 Moderate harm – UVC extravasation; Coroner's case for MNSI case of NND following cord prolapse – no concerns identified for the Trust. **Perinatal Quality – PMRT – November 2024:** 3 MBRRACE reportable deaths - 22+4 Miscarriage, 23+4 Neonatal Death, 26+5 Neonatal Death; 1 Maternity PMRT review/4 Neonatal PMRT review **Staffing:** Midwifery B5 &6 vacancy for Nov = 19.88 WTE(↑) plus 5.92 WTE waiting to start and 26.44 WTE graduate guarantees accepted who qualify Jan-May 2025; Maternity Leave – 7.76 WTE (-); Band 3 MSW vacancy 1.43(-) WTE with 0.64 WTE awaiting start date; NICU QIS – 67.7% (target 70%) **Training – November 2024:** Fetal Monitoring training >90% for all staff groups – CNST Compliant; PROMPT Training >90% for all staff groups – CNST Compliant; NBLS training >90% for all staff groups – CNST Complaint **Listening to Women and Families – Service Users and MNVP – November 2024:** Maternity CQC Picker Survey 2024 received with free text and initial findings shared with MNSCAG, PEG and QAC; Coffee morning and 1:1 meetings held with PE & EDI midwife and BAME service users with learning and actions identified. **Staff Feedback - November 2024:** Team talk held in November 2024 positive feedback received from staff in attendance; Improved team morale and retention noted across service; Community Teams note reduction of on-call requirements following introduction of hospital on-call. **External – November 2024:** No Regulation 28 notices, MNSI/NHSR/CQC requests for action; Q1 24/25 SBL (Saving Babies Lives bundle) - LMNS validated at 94% compliant; Q2 24/25 SBL maintaining compliance and QI work; **Proposing to declare to Trust Board in January 25 compliance with CNST Year 6 for all 10 Safety Actions. Once approved at Trust Board and Trust and ICB CEO's have signed off then on track for submission to NHSR in March 2025.**

Issues, Concerns & Gaps

Perinatal Quality – Incidents October 2024: Moderate harm reviewed at CRIG and actions agreed by clinical leads. No further formal investigation required; Intermittent connectivity issues with bleep system poses potential risk to maternity & neonatal patients in emergency situation as clinicians not receiving the alert/call to attend the emergency. **Perinatal Quality - PMRT – November 2024:** No bereavement or escalation pathway for unbooked pregnancies delivering at home; Communication of Care Planning **Staffing – November 2024:** Current uplift (22%) does not support all nationally and locally required training for midwives. **Training – November 2024:** Safeguarding Adults and Children's level 3 <85% with medical staff struggling to achieve compliance with face to face training. **Risk & Issues:** Midwifery staffing risk now classed as an issue with rating of 4; Remain non-compliant with National Patient Safety Alert relating to EuroKing System. **Listening to Women and Families – Service Users and MNVP – November 2024:** ICB currently unable to fund additional MNVP role (0.5WTE Band 7 Governance lead) to meet requirements of CNST Year 6 with regards to supporting MNVP quoracy at key Maternity and Neonatal Trust level meetings; Negative service user feedback received regarding Amenity Rooms on postnatal wards. **Staff Feedback – November 2024:** Guidelines continue to be difficult for staff to access across Q-pulse; Inconsistency in Band 2/Band 3 MSW roles. **External – November 2024:** Outstanding actions for SBL identified; Fixed term funding for Diabetes Nurse and Dietician approved and to go to recruitment.

Actions & Improvements

Perinatal Quality – Incidents October 2024: Trust-issued mobile phones in place to support intermittent bleep failure with appropriate process in place. Additional handsets required so all emergency bleep holders can be contacted. **Perinatal Quality – PMRT – October 2024:** Flow chart being developed to support escalation of un-booked pregnancy losses; Neonatal Alerts to be added across all relevant systems across maternity and Neonatal to ensure staff have access to care plans in event of unexpected admission/attendance. Staffing: Bi-Annual workforce report completed against BR+ table top exercise – recommend 25% uplift to support training requirements; Recruitment for final birth-rate plus posts underway; 6 leavers expected in next 3 months (leaving for promotion, childcare, personal reasons) **Training – November 2024:** Midwifery staff non-compliant with Safeguarding training identified and booked onto course dates; Medical Staff to be supported to complete e-learning for Safeguarding level 3 training to improve compliance; Training trajectory in place to achieve compliance **Risk:** Business case for procurement of a suitable MIS system approved at TIG on 11/11/24 and weekly Executive meeting on 10/12/24 – to go to Finance committee in January 25 followed by double lock process. Score reduced from 15 to 12 as BC completed, but not downgraded further due to complexities and requirements including cost for procuring a new system **Listening to Women and Families – Service Users and MNVP – November 2024:** DOM and Associate director of patient experience to support development of action plan based on service user feedback from engagement event held in October; MNVP to support co-production of action plan from 2024 CQC Picker Survey. This will support development of MNVP workplan; Formal escalation of MNVP funding issue to Trust Board required to maintain compliance with CNST year 6. **Staff Feedback – November 2024:** Safety Champion Feedback form launched alongside poster; "You Said, We Listened Posters" displayed across the unit; Public Health England to visit MFT to celebrate success of maternal vaccination programme; Piloting EOLAS Medical App to support staff access to key information and guidelines; Key word search terms now added to q-pulse – supported by consultant midwife – to support staff access; MFT MSWs supporting review of MSW framework and Trust wide-review underway. **External – November 2024:** QI work identified within SBL bundle and presented to LMNS including Smoking Cessation, Preterm pathway and Preterm optimisation; Action plan for CNST Safety Action 4 (NICU Nursing) submitted to LMNS and ODN as per requirements and therefore compliance can be achieved; CNST evidence peer assured by LMNS and reviewed at LMNS Assurance Visit on 3 December 2024. Available on shared drive for Executive review and oversight.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.6%	99.0%	98.9%	99.5%	98.8%	99.3%	98.6%	99.3%	99.2%	99.0%	99.1%	98.7%
				Total Incidents Reported	-	L		1,686	1,366	1,337	1,329	1,191	1,228	1,179	1,229	1,199	1,055	1,140	1,112
				Clinical Incidents with Harm (Moderate and above)	0		F	6	8	9	5	8	5	12	3	6	10	9	13
				Incidents Open - Month End	-	H		2,981	2,824	2,871	2,946	2,958	1,850	1,901	2,000	2,165	2,167	1,918	1,637
				Incidents Overdue - Month End	-	H		1,143	1,655	1,800	1,867	1,989	875	960	1,051	1,212	1,209	1,083	725
				Patient Safety Incident Investigations (PSII) Declared	-			0	0	0	0	2	0	1	0	0	0	2	0
				Patient Safety Incident Investigations (PSII) Closed	-	H		0	0	0	0	0	0	0	0	1	1	1	2
				Patient Safety Incident Investigations (PSII) Open - Month End	-	L		0	0	0	0	2	2	3	3	2	1	2	0
				After Action Review (AAR) Declared	-	H		1	1	6	2	1	5	3	2	0	4	0	5
				After Action Review (AAR) Closed	-	H		0	0	2	5	1	4	2	2	3	2	2	1
				After Action Review (AAR) Open - Month End	-	H		1	2	6	3	3	4	5	5	2	4	2	6
				Never Events	0		?	0	0	0	0	0	0	0	0	0	0	2	0
				Duty of Candour Compliance Stage 1 %	-	H		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Incident Management			Duty of Candour Compliance Stage 2 %	-	H		100.0%	71.4%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				RIDDOR Incidents	-			0	4	5	2	2	2	0	1	0	3	3	2
				RIDDOR Compliance %	-			-	75.0%	40.0%	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	66.7%	100.0%
				Health & Safety Incidents	-			85	119	151	115	128	97	85	97	55	43	64	54
				Sharps Injuries	-	H		8	5	11	6	2	6	7	12	13	10	6	14
				EDNs Completed Within 24hrs %	90.0%	H	F	74.4%	75.4%	78.4%	77.9%	77.6%	80.3%	78.4%	81.5%	83.2%	81.5%	83.2%	84.1%
				Violence & Aggression Incidents	-			176	193	252	173	204	166	174	157	139	108	119	99
				Assaults - Patient on Staff	-			60	64	99	78	108	70	76	71	60	40	62	35
	Falls			Low or No Harm Falls %	95.0%	H	?	98.9%	100.0%	97.9%	100.0%	94.6%	98.8%	99.0%	100.0%	98.8%	97.8%	98.0%	100.0%
				Falls - Total	-			88	77	94	80	74	85	102	93	82	92	102	74
				Falls - Low Harm	-			30	24	21	17	15	18	21	29	21	29	34	27
				Falls - Moderate Harm	-			0	0	0	0	2	1	1	0	0	1	2	0
				Falls - Severe Harm	0		?	1	0	2	0	2	0	0	0	0	1	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Falls			Falls Resulting in Death	0		?	0	0	0	0	0	0	0	0	1	0	0	0
				Falls per 1,000 Bed days	-			5.47	4.67	6.23	4.88	4.73	5.25	6.65	5.77	5.10	5.85	6.26	4.63
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	20	23	25	24	15	16	19	19	23	22	31	17
				Pressure Ulcers - Grade 2	-			3	5	8	5	8	8	6	8	18	15	24	9
				Pressure Ulcers - Grade 3	-	H		0	0	2	3	7	8	13	10	4	7	6	7
				Pressure Ulcers - Grade 4	-			2	0	0	0	0	0	0	1	1	0	1	1
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.24	1.39	1.66	1.46	0.96	0.99	1.24	1.18	1.43	1.40	1.90	1.06
	Medicines			Medicine Errors - Total	-			70	63	90	81	88	61	68	99	94	68	89	92
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	100.0%	100.0%	98.8%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.8%
	IPC			IPC Incidents	-			53	35	45	50	38	54	31	66	108	49	60	55
				C-Diff Cases - Hospital Acquired Total	-			5	3	4	8	4	4	2	4	7	11	5	6
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			41	44	48	56	4	8	10	14	21	32	37	43
				C-Diff Cases - Hospital Acquired (HOHA)	-			3	1	3	6	2	3	2	4	4	4	5	4

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	IPC			E.coli Cases - Hospital Acquired	-			8	2	6	4	6	3	5	6	9	2	5	8
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			54	56	62	66	6	9	14	20	29	31	36	44
				MRSA Cases - Hospital Acquired	0	L	?	0	0	0	0	0	0	0	0	0	0	0	0
				MSSA Cases - Hospital Acquired	-			1	4	3	2	4	1	0	0	3	4	1	1
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			25	29	32	34	4	5	5	5	8	12	13	14
	Mortality			Crude Mortality Rate %	1.30%		?	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%	1.36%	1.30%	1.27%	1.51%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	2	1	0	0	1	2	0	2	0	0	0	0
				Avoidable 2222 Calls – Peri-Arrests	3		?	0	3	2	0	1	1	0	5	2	2	1	1
				Avoidable 2222 Calls	16		P	2	4	2	0	3	3	0	7	2	2	2	1
				HSMR (12m)	100	L	?	96	99.23	99.48	100.50	98.58	98.80	99.70	99.19				
				HSMR Expected Death Rate (12m)	-	H		5.3%	5.2%	5.2%	5.2%	5.1%	5.1%	5.1%	5.1%				
				HSMR Expected Death Rate (Month)	-			5.8%	5.5%	5.4%	5.4%	4.9%	4.7%	5.6%	5.0%				
				SHMI (12m)	1	H	F	1.14	1.16	1.18	1.19	1.19	1.18	1.20	1.20				
				SHMI Expected Death Rate (12m)	-	H		3.1%	3.1%	3.1%	3.0%	3.0%	3.0%	3.0%	3.1%				

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Mortality			Fractured NOF Within 36 Hours	92.0%		?	50.0%	71.4%	73.7%	60.0%	60.0%	51.5%	52.5%	56.5%	74.1%	66.6%	66.6%	
				Number of Deaths Reviewed via SJR	-			8	13	12	11	13	6	13	13	5	16	11	0
				SJRs Completed %	12.5%	L	?	4.3%	6.5%	7.3%	6.8%	9.2%	4.5%	9.2%	11.1%	4.1%	13.0%	8.5%	0.0%
				Total Number of Deaths Due to Failings in Care	-	L		0	1	0	0	1	0	0	0	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	1	1	1	1	2	0	1	0	0	0	0
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	?	99.0%	99.4%	99.2%	99.7%	99.1%	99.4%	99.5%	99.8%	99.0%	99.2%	99.7%	99.8%
	Maternity			Caesarean Section %	-			48.8%	49.6%	52.0%	44.2%	43.5%	44.2%	50.5%	42.5%	49.4%	49.2%	51.0%	48.6%
				Elective C-Section %	-			17.6%	19.8%	19.6%	19.2%	21.0%	17.2%	19.8%	17.3%	20.0%	19.4%	19.8%	19.4%
				Emergency C-Section %	-			31.2%	29.8%	32.3%	24.9%	22.5%	27.0%	30.7%	25.2%	29.4%	29.8%	31.1%	29.1%
				PPH greater than or equal to 1500mls	-			15	19	15	23	12	18	14	12	20	12	14	16
				Total Number of Still Births Greater Than 24 weeks Gestation	-			0	1	3	0	0	3	2	0	1	2	0	0
				Neonatal Deaths	-			4	1	2	3	0	1	0	2	2	1	0	2

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality	Maternity			Maternity Serious Incidents	-	L		1	2	2	1	0	0	0	0	0	0	0	0
				Maternity HSIB Referrals	-	L		1	2	2	1	0	0	0	0	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			2	1	1	0	0	0	0	1	1	1	0	0
	Risk & Policy			Risks Open - Low (Month End Snapshot)	-						4	3	5	4	1				1
				Risks Open - Moderate (Month End Snapshot)	-	L					38	41	38	32	33	24	23	22	20
				Risks Open - High (Month End Snapshot)	-	L					109	93	84	80	81	46	45	44	40
				Risks Open - Extreme (Month End Snapshot)	-	L					21	15	13	12	11	10	11	7	6
	Health & Safety			Resuscitation Training Compliance %	-	H		81.1%	82.0%	82.1%	83.5%	83.0%	83.1%	83.9%	83.6%	83.6%	82.9%	82.9%	84.2%
				Mental Capacity Act Training Compliance %	-	H		81.5%	81.4%	81.7%	83.1%	84.0%	84.9%	85.1%	85.6%	86.6%	85.5%	86.3%	87.0%
	Legal & Information Governance			Inquests Received	-			21	15	14	8	14	13	10	15	10	7	7	12
				Inquest Hearings	-			3	6	10	9	8	6	5	10	11	3	5	6
				Regulation 28 Reports	-	L		0	0	0	0	0	0	0	0	0	0	0	0

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

NHS Medway NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	29	18	22	34	7	18
Emergency Care	5	10	1	7	1	3

Operational Leads:
Stewart Nisbet - *Director, Surgery and Anaesthetics*
Nicola Cooper - *Director, Medicine and Emergency Care*
Vacant - *Director, Cancer and Core Clinical Services*
Nadia Stevens - *Director, Women, Children and Young People*

Committees:
Finance & Performance Committee

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	54.0%	L	P	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%	50.7%	50.4%

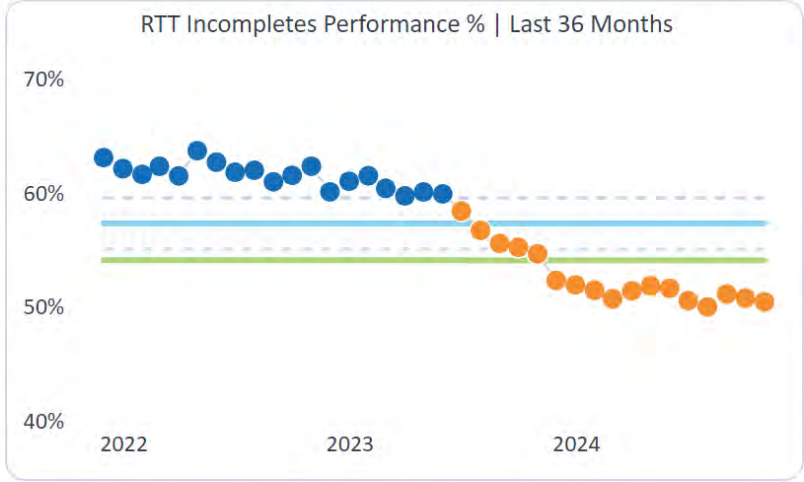
True North Domain: Systems & Partnerships

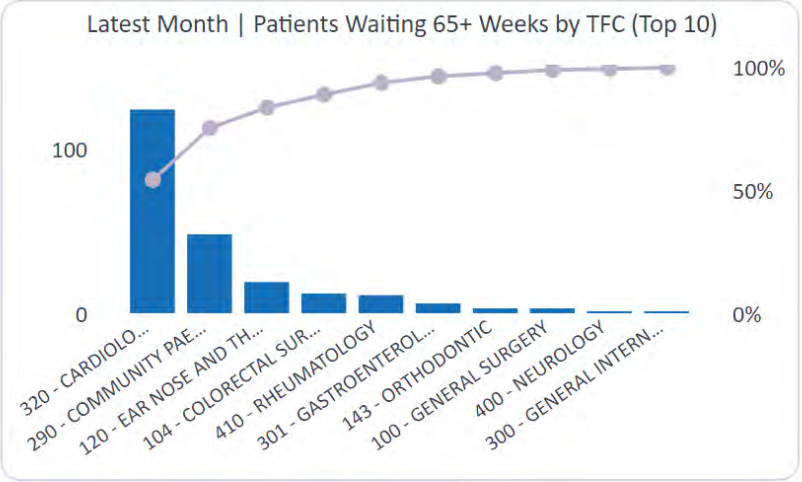
KPI Threshold: 54.0%

Sub Domain KPIs: 26

Variation Summary:

	L	H	L	H
10	4	7	2	3





Key Messages

Work ongoing to clear >65 week waits – 120 Cardiology patients remain a risk

Issues, Concerns & Gaps

Cardiology capacity remains a risk, mutual aid has been sourced from MTW and DGH to support with clearance of >65 week waits.

Awaiting dates for Cardio super clinics to be provided by NHSE

Awaiting Spec-Com agreement confirmation with ICB

Actions & Improvements

Cardiac physiology review underway by NHSE regarding capacity and processes within department

Awaiting dates for Cardio super clinics to be provided by NHSE

Awaiting Spec-Com agreement confirmation with ICB

MTW agreed mutual aid to support >65 week waits in Cardiology

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	78.0%	H	?	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%

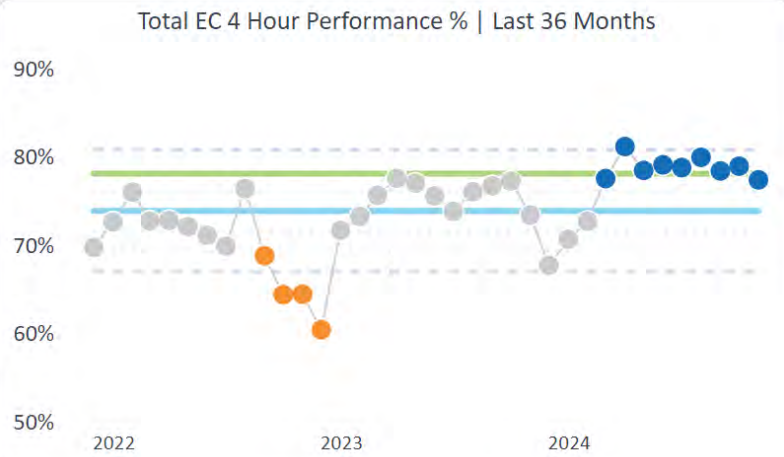
True North Domain: Systems & Partnerships

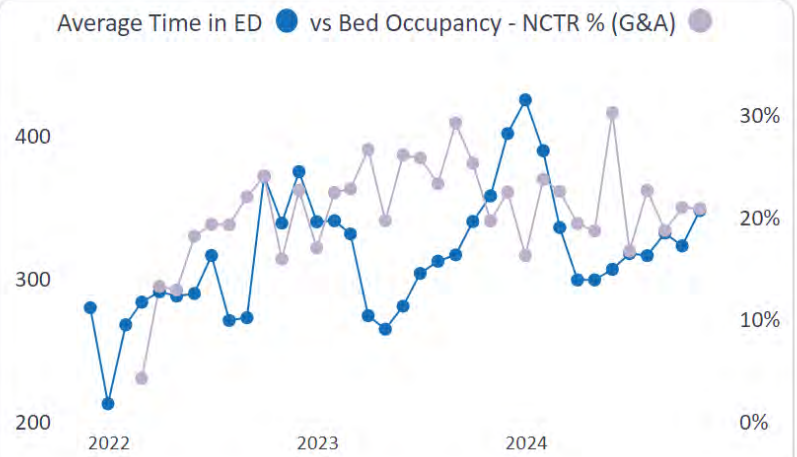
KPI Threshold: 78.0%

Sub Domain KPIs: 11

Variation Summary:

3	0	1	3	4





Key Messages

November position just under 78% target at 77.3%

Issues, Concerns & Gaps

Long waiting time in ED for beds once DTA given remains an issue. Total DTA was high at 771 compared to 693 previous month

Admitted performance for November at 3.7%

Non-admitted performance 82.4%

Actions & Improvements

New acute medical model due to commence at end of December once Pembroke works have been completed.

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	H	F	Driver is red for 2 reporting periods	549	630	542	390	348	229
				RTT 52 Week Breaches	1,250	H	?	Watch is red for 4 reporting periods	2,834	2,922	2,687	2,362	2,265	2,118
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	109.14	103.61	107.77	116.90	111.58	116.03
				Operations Cancelled by Hospital on Day	0	H	?	Watch is red for 4 reporting periods	14	19	20	14	13	17
				Cancer 31 Day First Treatment Performance %	98.2%	L	?	Watch is red for 4 reporting periods	97.2%	96.4%	96.2%	97.2%	93.5%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	Watch is red for 4 reporting periods	68.2%	67.7%	67.2%	64.3%	58.1%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%	L	?	Watch is red for 4 reporting periods	80.0%	84.6%	66.7%	90.6%	28.6%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	Watch is red for 4 reporting periods	52.3%	67.9%	76.4%	76.5%	76.1%	
	Emergency Care			Type 1 EC 4 Hour Performance %	75.0%	H	F	Watch is red for 4 reporting periods	68.8%	68.5%	67.6%	64.9%	67.8%	65.8%
				Total EC 12 Hour DTAs	0	H	F	Watch is red for 4 reporting periods	618	663	577	644	693	771
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	Watch is red for 4 reporting periods	306	317.02	315.64	331.42	322.44	347.20
				Ambulance Handover Delays (> 60 mins)	0	L	?	Watch is red for 4 reporting periods	2	2	1	5	2	6

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Systems & Partnerships	Access			Outpatient DNA Rate %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	6.3%	6.3%	6.2%	6.3%	6.1%	5.7%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.78	1.84	1.72	1.84	1.79	1.61
				Cancer USC Performance %	93.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	68.7%	70.6%	72.7%	93.6%	96.2%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	81.6%	85.7%	79.2%	87.2%	82.4%	
				DM01 Performance %	73.1%	H	Special cause of improving nature or lower pressure due to (H)igher values	67.4%	67.6%	63.6%	68.4%	72.3%	78.4%
	Emergency Care			Total EC 4 Hour Performance %	78.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	84.6%	84.1%	85.9%	83.9%	85.0%	82.3%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	12.1%	16.6%	17.1%	18.3%	20.6%	21.6%
				Type 1 EC 4 Hour Performance %	75.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	68.8%	68.5%	67.6%	64.9%	67.8%	65.8%
				Ambulance Handover Delays (> 30 mins)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	73	59	46	77	77	76
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	2	2	1	5	2	6
				30 Day Readmission Rate	13.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	8.7%	8.5%	8.4%	7.4%	7.2%	7.3%

Access

Key Messages

Work ongoing to clear >65 week waits – 120 Cardiology patients remain a risk

Issues, Concerns & Gaps

Cardiology capacity remains a risk, mutual aid has been sourced from MTW and DGH to support with clearance of >65 week waits.

Awaiting dates for Cardio super clinics to be provided by NHSE

Awaiting Spec-Com agreement confirmation with ICB

Actions & Improvements

Cardiac physiology review underway by NHSE regarding capacity and processes within department

Awaiting dates for Cardio super clinics to be provided by NHSE

Awaiting Spec-Com agreement confirmation with ICB

MTW agreed mutual aid to support >65 week waits in Cardiology

Emergency Care

Key Messages

November position just under 78% target at 77.3%

Issues, Concerns & Gaps

Long waiting time in ED for beds once DTA given remains an issue. Total DTA was high at 771 compared to 693 previous month

Admitted performance for November at 3.7%

Non-admitted performance 82.4%

Actions & Improvements

New acute medical model due to commence at end of December once Pembroke works have been completed.

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	L	P	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%	50.7%	50.4%
				RTT 65+ Week Waiters	0	H	F	237	257	286	235	284	404	549	630	542	390	348	229
				RTT 40+ Week Waiters	-	H		5,311	5,569	5,927	6,296	6,434	6,627	6,662	6,736	6,778	6,274	5,917	5,777
				RTT Waiting List Size	-	H		42,487	43,133	43,716	44,646	44,751	44,491	44,528	44,477	44,130	43,248	42,912	42,165
				RTT 52 Week Breaches	1,250	H	?	1,439	1,659	1,886	2,159	2,360	2,610	2,834	2,922	2,687	2,362	2,265	2,118
				OP Average Time to First Appointment (days)	60	H	F	94.82	98.95	104.07	103.63	108.25	104.93	109.14	103.61	107.77	116.90	111.58	116.03
				Outpatient DNA Rate %	10.0%	L	P	7.5%	6.3%	6.2%	6.2%	6.1%	6.4%	6.3%	6.3%	6.2%	6.3%	6.1%	5.7%
				OP First to Follow Up Ratio	-	L		1.95	1.96	1.87	1.84	1.91	1.78	1.78	1.84	1.72	1.84	1.79	1.61
				Operations Cancelled by Hospital on Day	0	H	?	12	14	6	10	14	17	14	19	20	14	13	17
				Cancelled Operations Not Rescheduled < 28 Days %	-			75.0%	50.0%	33.3%	50.0%	42.9%	64.7%	71.4%	63.2%	55.0%	50.0%	23.1%	11.8%
				Urgent Operations Cancelled for 2nd Time	0		?	2	0	2	1	2	5	1	0	1	0	1	2
				Day Case Rate %	-			86.2%	88.0%	87.2%	86.2%	86.0%	85.5%	85.0%	84.4%	83.9%	86.5%	86.0%	86.8%
				Average Elective Length of Stay (days)	3		?	2.79	2.51	2.54	3.22	2.93	3.43	2.84	2.73	2.31	2.65	2.62	2.21

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10	H	P	4.81	4.66	4.63	4.28	4.51	4.50	5.38	6.06	6.11	6.17	6.45	6.59
				104 Day Cancer Waits	-			7	13	12	14	16	9	17	17	14	12	16	
				Cancer USC Performance %	93.0%	H	?	92.7%	84.9%	73.0%	72.8%	73.4%	70.1%	68.7%	70.6%	72.7%	93.6%	96.2%	
				Cancer USC Performance - Breast Symptomatic %	93.0%		?	69.4%	58.4%	38.4%	4.2%	2.9%	0.0%	9.9%	9.7%	38.6%	84.6%	97.9%	
				Cancer 31 Day First Treatment Performance %	98.2%	L	?	99.2%	97.0%	98.7%	98.4%	94.9%	98.1%	97.2%	96.4%	96.2%	97.2%	93.5%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%		?	100.0%	91.2%	100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%		?	100.0%	81.3%	86.4%	92.6%	75.0%	94.6%	92.6%	96.4%	100.0%	93.9%	97.4%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	79.0%	72.5%	68.1%	68.2%	67.4%	67.6%	68.2%	67.7%	67.2%	64.3%	58.1%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%	H	?	78.4%	80.3%	72.2%	90.0%	71.4%	71.4%	81.6%	85.7%	79.2%	87.2%	82.4%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%	L	?	74.1%	73.3%	47.6%	95.7%	77.6%	84.2%	80.0%	84.6%	66.7%	90.6%	28.6%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	69.8%	63.1%	73.0%	66.0%	56.5%	53.7%	52.3%	67.9%	76.4%	76.5%	76.1%	
				Cancer 28 Day Faster Diagnosis Screening %	-			76.7%	47.7%	79.3%	76.5%	72.2%	76.7%	74.5%	62.9%	45.5%	68.1%	65.3%	
				DM01 Performance %	73.1%	H	?	56.6%	59.5%	66.7%	66.9%	65.4%	67.1%	67.4%	67.6%	63.6%	68.4%	72.3%	78.4%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	78.0%	H	?	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	73.8%	75.7%	77.9%	83.0%	86.9%	84.0%	84.6%	84.1%	85.9%	83.9%	85.0%	82.3%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H		15.0%	14.1%	14.3%	12.6%	12.7%	13.9%	12.1%	16.6%	17.1%	18.3%	20.6%	21.6%
				Type 1 EC 4 Hour Performance %	75.0%	H	F	52.9%	59.1%	63.5%	69.3%	69.5%	70.6%	68.8%	68.5%	67.6%	64.9%	67.8%	65.8%
				Total EC 12 Hour DTAs	0	H	F	785	953	798	798	521	588	618	663	577	644	693	771
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	401.10	424.67	389.04	335.25	298.60	298.57	306	317.02	315.64	331.42	322.44	347.20
				Number of ED Arrivals by Ambulance	-			3,167	3,281	2,956	3,173	2,981	2,993	2,869	2,919	2,820	2,887	3,020	3,051
				Ambulance Handover Delays (> 30 mins)	-	L		177	161	90	103	67	49	73	59	46	77	77	76
				Ambulance Handover Delays (> 60 mins)	0	L	?	10	9	5	6	3	3	2	2	1	5	2	6
				Bed Occupancy - NCTR % (G&A)	-			22.4%	16.2%	23.7%	22.5%	19.3%	18.6%	30.2%	16.6%	22.6%	18.7%	20.9%	20.8%
				30 Day Readmission Rate	13.0%	L	P	10.1%	9.2%	10.0%	9.8%	9.9%	10.4%	8.7%	8.5%	8.4%	7.4%	7.2%	7.3%

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

NHS Medway NHS Foundation Trust

Leon Hinton
Chief People Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	11	22	3	11	15	10
Workforce	37	9	7	42	1	6
Compliance	1	0	1	1	0	1
Diversity	0	2	0	0	0	0
Safe Staffing	2	7	0	6	0	1

Operational Leads:
Dominika Kimber - *Deputy Director of HR & Organisational Development*

Committees:
People Committee

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24
	6.93	H	F	6.65	6.65	6.65	6.65

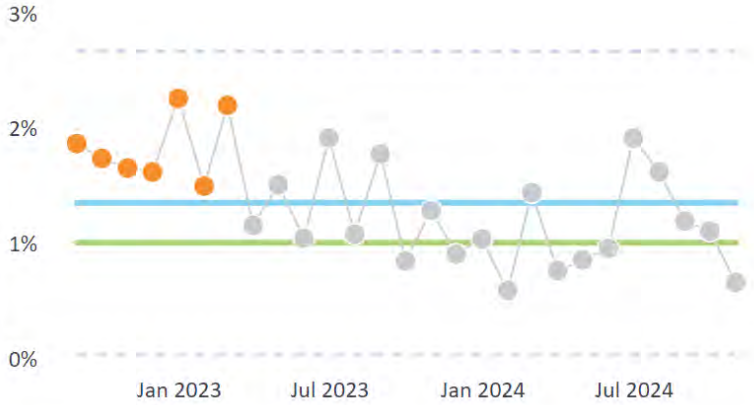
True North Domain: People

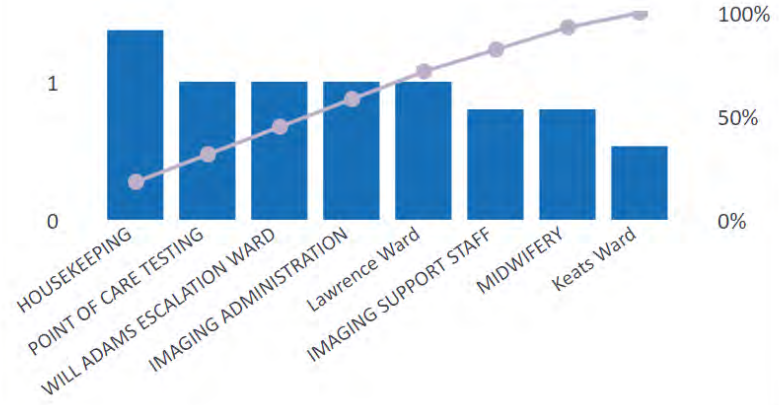
KPI Threshold: 6.93

Sub Domain KPIs: 16

Variation Summary:

	L	H	L	H
9	0	1	3	3





Key Messages

The Trust's True North objective is to be in the top 25% of Trusts nationally for staff engagement reported through the national staff survey.

The new breakthrough objective, to reduce by 50% the number of reported incivilities, continues to be developed with a new business intelligence dashboard in operation and development work to ensure robust reporting. Current development continues with root cause determination.

Issues, Concerns & Gaps

- Potential duplicate reporting of incivilities via multiple reporting routes;
- Lack of confidence in reporting processes;
- Continue to make improvements to our WRES/WDES indicators to ensure our recruitment, promotion and development pathways are based on best practice.

Actions & Improvements

- Catch-ball with the divisions for a new breakthrough objective to address incivilities in the organisation;
- Building into the dashboard reporting other elements manually;
- Continued development of the root causes.

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	Workforce			Voluntary Turnover %	8.0%	L	F	Watch is red for 4 reporting periods	8.7%	8.7%	9.0%	8.6%	8.7%	8.5%
				Sickness Absence Rate - Total %	4.0%		?	Watch is red for 4 reporting periods	5.1%	5.0%	4.9%	5.3%	5.3%	5.2%
				Sickness Absence Rate - Long Term %	2.0%	H	?	Watch is red for 4 reporting periods	2.7%	2.8%	3.1%	2.9%	2.8%	2.5%
				Time to Hire - AfC	42	L	F	Watch is red for 4 reporting periods	47.90	54	55.90	56	60	58.30
	Safe Staffing			Care Hours per Patient Day (CHPPD)	9.50	H	F	Watch is red for 4 reporting periods	9.03	8.86	8.95	8.51	9.09	8.93
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%		F	Watch is red for 4 reporting periods	79.9%	79.8%	79.7%	79.8%	80.7%	80.1%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	Watch is red for 4 reporting periods	46.7%	48.0%	49.7%	50.2%	50.6%	51.7%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	68.7%	72.6%	76.5%	76.6%	79.4%	81.3%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%		?	Watch is red for 4 reporting periods	80.5%	81.9%	81.5%	80.7%	82.2%	84.2%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	82.1%	81.9%	82.3%	81.0%	81.2%	82.3%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	L	F	Watch is red for 4 reporting periods	80.9%	80.5%	80.0%	78.6%	78.3%	76.7%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	87.4%	85.9%	80.6%	83.0%	76.3%	77.3%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	82.6%	82.3%	81.1%	80.6%	81.2%	84.2%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	StatMan			StatMan: New Born Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	80.8%	79.9%	78.7%	75.9%	79.5%	83.3%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	79.7%	78.0%	77.9%	77.5%	75.9%	77.5%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	Watch is red for 4 reporting periods	85.5%	85.9%	80.8%	77.7%	78.4%	81.4%
	Compliance			DBS Compliance %	100.0%	L	F	Watch is red for 4 reporting periods	99.8%	99.8%	99.4%	99.5%	99.0%	98.9%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	Workforce			Staff Appraisal Rate %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.1%	90.0%	90.3%	89.4%	88.3%	87.4%
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,027.67	5,029.74	5,091.82	5,066.86	5,115.41	5,133.76
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	8.7%	8.7%	9.0%	8.6%	8.7%	8.5%
				Time to Hire - AfC	42	L	Special cause of improving nature or lower pressure due to (L)ower values	47.90	54	55.90	56	60	58.30
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	1.5%	1.7%	1.9%	2.2%	1.5%	1.4%
	Safe Staffing			Staff Fill Rate - Total %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.8%	95.3%	87.2%	85.8%	86.3%	98.1%
				Staff Fill Rate % (Total) - Registered Nurse	-	H	Special cause of improving nature or lower pressure due to (H)igher values	90.5%	89.9%	89.3%	89.7%	91.1%	94.9%
				Care Hours per Patient Day (CHPPD)	9.50	H	Special cause of improving nature or lower pressure due to (H)igher values	9.03	8.86	8.95	8.51	9.09	8.93
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	42.0%	42.0%	42.2%	42.2%	42.7%	43.0%
				Diversity of Board %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	23.1%	21.4%	25.0%	25.0%	30.8%	30.8%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.0%	89.2%	89.6%	89.0%	87.2%	87.5%
				StatMan: Conflict Resolution Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.0%	95.0%	95.4%	94.9%	95.0%	95.2%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	StatMan			StatMan: EDI Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.0%	95.9%	96.2%	95.8%	96.1%	96.2%
				StatMan: Fire Safety Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	84.5%	85.6%	84.5%	83.8%	85.7%	86.5%
				StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.4%	95.4%	96.0%	95.9%	96.0%	96.2%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	92.7%	92.2%	93.4%	94.2%	94.3%	94.2%
				StatMan: Health Safety and Welfare Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	90.1%	90.8%	91.6%	91.1%	92.4%	92.6%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	93.1%	93.2%	94.2%	94.3%	94.8%	95.1%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	46.7%	48.0%	49.7%	50.2%	50.6%	51.7%
				StatMan: Patient Safety L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.7%	91.3%	91.7%	90.7%	91.3%	92.0%
				StatMan: Basic Prevent Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	97.6%	96.0%	95.8%	95.6%	96.1%	96.5%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	97.3%	96.2%	95.7%	95.3%	95.8%	95.7%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	68.7%	72.6%	76.5%	76.6%	79.4%	81.3%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	97.4%	96.4%	96.3%	96.4%	96.5%	96.5%
				StatMan: Advanced Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	85.4%	85.1%	83.9%	87.2%	81.9%	83.3%

People

Key Messages

- The Trust has a new breakthrough objective to reduce incivilities in the Trust which is going through catch-ball with the divisions.
- The Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative. No further agency within estates and facilities.
- Appraisals remain off target and deterioration. Exec SDR for corporate areas has been put into address the falling appraisal level;
- Cultural transformation programme is now live within the Trust; senior leadership cultural competency assessments underway;
- Staff survey has concluded, current completion rate is 45.9% for substantive (+8.4% from previous) and 18.3% for bank staff (+1%) – pending the outcome of the survey.
- Improvement to temporary staffing processes including stronger compliance controls in place (monitoring hours) and communicating cancelled shifts;
- Continued focus on sickness with additional 63 cases taken to formal stages in last month;
- Extended training dates now available for menopause training;
- MFT holds the most industry T-level placements for any one employer for science and Health. Successfully hosted T-level event on 5th Dec to promote and attract new hosts.

Issues, Concerns & Gaps

- High level of sickness short notice for Medics impacting staffing levels increased bank spend. CPO, HRBPs and rota team involved in work supporting divisions understand their position, stratified data, and approach;
- Worked FTE (substantive bank and agency) is greater than budgeted establishment by 5 FTE in November (significant improvement); however, patient first approach to stratifying the over budget areas to address;
- Identified insufficient mediators available; reviewing options for the service.

Actions & Improvements

- Virtual Improvement Huddles rolled out within HR and OD teams and the Senior HR Team and Heads of Services Flu comms campaign continuing;
- Positive Action Policy moving to formal consultation;
- Changes to the way appraisals are loaded into ESR to improvement efficiency and reporting timeliness.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	Workforce			National Staff Engagement Score	6.93	H	F	6.65	6.65	6.65	6.65								
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	0.9%	1.0%	0.6%	1.4%	0.8%	0.9%	1.0%	1.9%	1.6%	1.2%	1.1%	0.7%
				Staff Appraisal Rate %	90.0%	H	F	89.2%	89.1%	89.1%	89.8%	89.7%	89.2%	89.1%	90.0%	90.3%	89.4%	88.3%	87.4%
				Staff in Post (FTE)	-	H		4,934.78	4,955.99	5,000.86	5,029.08	5,036.96	5,029.74	5,027.67	5,029.74	5,091.82	5,066.86	5,115.41	5,133.76
				Staff Leavers (FTE)	-			46.85	39.76	35.66	53.55	37.79	44.65	42.21	62.65	145.58	66.57	69.68	47.42
				Staff Starters (FTE)	-			45.43	86.30	68.08	46.99	53.41	21.66	34.77	55.36	131.18	117.73	88.99	55.65
				Vacancy Rate %	9.0%		?	4.6%	4.2%	3.4%	3.0%	8.1%	7.8%	7.7%	7.9%	6.8%	7.2%	6.7%	6.4%
				Voluntary Turnover %	8.0%	L	F	10.7%	10.2%	9.7%	9.5%	9.1%	8.8%	8.7%	8.7%	9.0%	8.6%	8.7%	8.5%
				Voluntary Turnover (ICS) %	-			1.0%	0.8%	0.7%	1.0%	0.6%	0.9%	0.9%	1.2%	1.4%	1.0%	0.9%	0.9%
				Sickness Absence Rate - Total %	4.0%		?	5.1%	5.5%	4.9%	4.4%	4.4%	4.7%	5.1%	5.0%	4.9%	5.3%	5.3%	5.2%
				Sickness Absence Rate - Short Term %	2.0%		?	2.9%	3.2%	2.4%	2.0%	2.2%	2.2%	2.4%	2.2%	1.8%	2.4%	2.5%	2.7%
				Sickness Absence Rate - Long Term %	2.0%	H	?	2.2%	2.3%	2.5%	2.3%	2.2%	2.5%	2.7%	2.8%	3.1%	2.9%	2.8%	2.5%
				Time to Hire - AfC	42	L	F	60.40	88.10	60	66.10	61.10	55.30	47.90	54	55.90	56	60	58.30

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	Workforce			Time to Hire - Medical	70			147.70	107	76	54.90	91.30	66.70	58.90	42.60	86.50	51	78	69.90
				Agency Spend %	3.7%	L		2.7%	2.0%	2.7%	1.1%	2.1%	2.4%	1.5%	1.7%	1.9%	2.2%	1.5%	1.4%
				Bank Spend %	10.0%			11.0%	13.1%	11.7%	8.6%	11.1%	10.2%	10.4%	12.1%	10.2%	10.5%	9.0%	8.2%
	Safe Staffing			Staff Fill Rate - Total %	85.0%	H		91.0%	92.6%	93.0%	93.7%	96.3%	95.9%	95.8%	95.3%	87.2%	85.8%	86.3%	98.1%
				Staff Fill Rate % (Total) - Registered Nurse	-	H		89.5%	90.4%	91.5%	91.4%	92.9%	91.3%	90.5%	89.9%	89.3%	89.7%	91.1%	94.9%
				Care Hours per Patient Day (CHPPD)	9.50	H	F	8.51	8.48	8.63	8.47	9.47	9.45	9.03	8.86	8.95	8.51	9.09	8.93
	Diversity			Diversity of Workforce %	-	H		40.0%	40.3%	40.5%	40.8%	41.1%	41.5%	42.0%	42.0%	42.2%	42.2%	42.7%	43.0%
				Diversity of Board %	-	H		18.2%	18.2%	16.7%	16.7%	20.0%	18.2%	23.1%	21.4%	25.0%	25.0%	30.8%	30.8%
	StatMan			StatMan Training Compliance %	85.0%	H		87.5%	87.4%	87.9%	87.7%	88.1%	88.8%	89.0%	89.2%	89.6%	89.0%	87.2%	87.5%
				StatMan: Conflict Resolution Compliance %	85.0%	H	P	94.0%	93.5%	94.1%	94.5%	94.9%	95.2%	95.0%	95.0%	95.4%	94.9%	95.0%	95.2%
				StatMan: EDI Compliance %	85.0%	H	P	95.5%	95.4%	95.4%	95.4%	95.6%	95.9%	96.0%	95.9%	96.2%	95.8%	96.1%	96.2%
				StatMan: Fire Safety Compliance %	85.0%	H		82.1%	81.7%	82.9%	81.2%	84.2%	85.9%	84.5%	85.6%	84.5%	83.8%	85.7%	86.5%
				StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	92.7%	93.0%	93.6%	94.0%	94.3%	94.8%	95.4%	95.4%	96.0%	95.9%	96.0%	96.2%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	StatMan			StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	83.7%	86.8%	87.2%	88.0%	89.1%	91.2%	92.7%	92.2%	93.4%	94.2%	94.3%	94.2%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	89.8%	89.3%	89.6%	89.2%	88.9%	88.9%	90.1%	90.8%	91.6%	91.1%	92.4%	92.6%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	95.6%	96.3%	96.9%	97.5%	97.0%	97.1%	97.6%	96.7%	96.1%	95.6%	96.0%	96.1%
				StatMan: Infection Prevention L2 Compliance %	85.0%		P	89.6%	88.8%	88.7%	88.5%	89.7%	89.6%	89.1%	88.6%	89.5%	88.9%	89.1%	90.3%
				StatMan: Information Governance Compliance %	85.0%		P	90.9%	90.4%	91.0%	90.8%	91.6%	91.8%	91.1%	89.9%	90.8%	90.3%	90.7%	90.9%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	85.8%	87.4%	89.0%	90.1%	91.4%	92.3%	93.1%	93.2%	94.2%	94.3%	94.8%	95.1%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	81.2%	79.2%	78.9%	78.9%	79.6%	80.4%	79.9%	79.8%	79.7%	79.8%	80.7%	80.1%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	45.1%	45.0%	44.5%	43.7%	43.4%	43.9%	46.7%	48.0%	49.7%	50.2%	50.6%	51.7%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	95.1%	95.3%	95.4%	88.6%	87.7%	90.3%	91.7%	91.3%	91.7%	90.7%	91.3%	92.0%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	96.1%	94.6%	96.0%	97.0%	97.1%	97.3%	97.6%	96.0%	95.8%	95.6%	96.1%	96.5%
				StatMan: Prevent WRAP Compliance %	85.0%		P	87.6%	86.9%	87.2%	87.8%	88.3%	89.1%	88.3%	89.0%	89.7%	89.1%	89.8%	90.2%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	96.0%	95.8%	96.4%	97.3%	96.7%	96.9%	97.3%	96.2%	95.7%	95.3%	95.8%	95.7%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	StatMan			StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	L	P	94.0%	92.0%	91.8%	91.1%	91.3%	92.3%	92.5%	91.8%	91.8%	90.2%	87.9%	88.5%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	57.2%	59.6%	63.6%	66.9%	65.8%	66.3%	68.7%	72.6%	76.5%	76.6%	79.4%	81.3%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%	H	P	95.5%	96.0%	96.4%	97.0%	96.6%	97.0%	97.4%	96.4%	96.3%	96.4%	96.5%	96.5%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	84.4%	82.8%	83.2%	82.9%	84.5%	86.0%	86.2%	87.2%	87.2%	85.8%	86.1%	86.2%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%		?	80.0%	79.9%	77.6%	76.7%	77.2%	79.3%	80.5%	81.9%	81.5%	80.7%	82.2%	84.2%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	74.5%	74.5%	71.8%	75.2%	79.1%	83.7%	85.4%	85.1%	83.9%	87.2%	81.9%	83.3%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	81.4%	82.0%	80.9%	82.1%	80.9%	81.1%	82.1%	81.9%	82.3%	81.0%	81.2%	82.3%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	L	F	75.1%	76.3%	80.2%	80.2%	85.6%	83.0%	80.9%	80.5%	80.0%	78.6%	78.3%	76.7%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	90.1%	91.1%	91.8%	91.7%	90.3%	89.7%	89.9%	90.8%	91.7%	91.8%	92.1%	93.2%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%		F	84.4%	74.6%	66.2%	70.5%	72.4%	68.3%	87.4%	85.9%	80.6%	83.0%	76.3%	77.3%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	72.2%	72.6%	71.1%	76.7%	76.5%	82.0%	82.6%	82.3%	81.1%	80.6%	81.2%	84.2%
				StatMan: New Born Life Support Compliance %	85.0%		F	71.7%	73.4%	78.5%	82.9%	82.0%	80.2%	80.8%	79.9%	78.7%	75.9%	79.5%	83.3%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	78.2%	79.3%	77.6%	79.1%	78.4%	78.4%	79.7%	78.0%	77.9%	77.5%	75.9%	77.5%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
People	StatMan			StatMan: Paediatric Immediate Life Support Compliance %	85.0%			70.7%	76.1%	87.7%	83.4%	83.5%	84.1%	85.5%	85.9%	80.8%	77.7%	78.4%	81.4%
	Compliance			Professional Registration Compliance %	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				DBS Compliance %	100.0%			99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.4%	99.5%	99.0%	98.9%

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

NHS Medway NHS Foundation Trust

Alan Davies
Chief Financial Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	14	10	6	20	0	0

Operational Leads:
Paul Kimber - *Deputy Chief Financial Officer*

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Financial Position

Breakeven Revenue Budget (£)

Type	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	£0.00m	L	?	-1.75m	-3.33m	2.56m	-2.76m	-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m	-1.86m	-5.41m

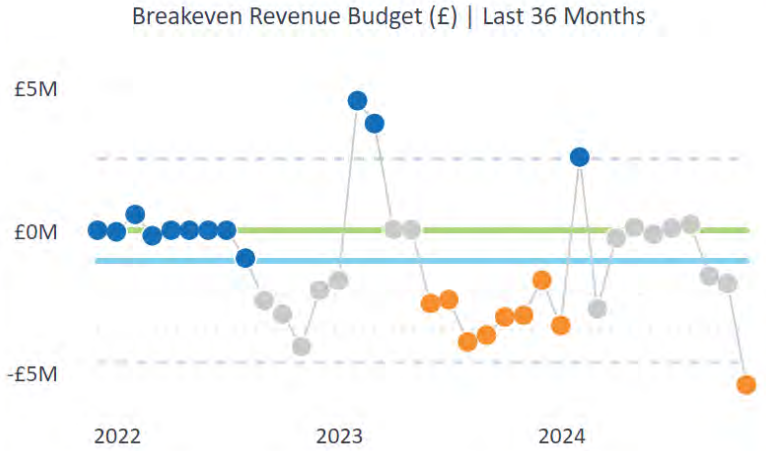
True North Domain: **Sustainability**

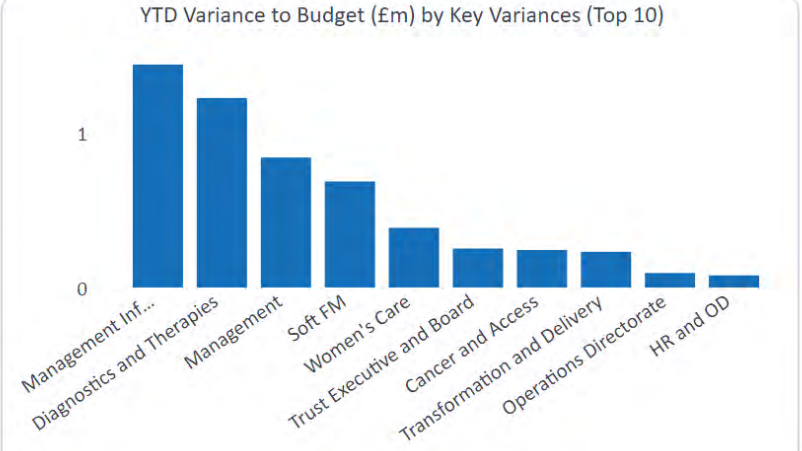
KPI Threshold: £0.00m

Sub Domain KPIs: 12

Variation Summary:

6	2	2	1	1





Key Messages

The Trust is reporting a month 8 deficit of £5.1m and YTD deficit of £9.3m
When adjusted for technical items this represents an adverse performance against control total of £5.4m and £8.95m respectively.
Those key pressures previously reported continue with no/little non-recurrent measures now available to offset; these include: ED safe staffing; medical staffing in MEC and S&A; enhanced care; Ruby ward and HCD funding. In addition, the YTD pay award expense and under-accrual versus income has given risen to a cost pressure in month of £2.5m.
After "normalising" the position, the underlying deficit showed a small deterioration in month.

Issues, Concerns & Gaps

Following the month 8 results the forecast outturn is under review – given the YTD performance there is some risk to the full year control total.

Actions & Improvements

Further mitigations against potential forecast overspend to be developed.
Task and finish group meetings agreed to continue on a weekly basis.

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Sustainability	Financial Position			Total Financial Overspend (£)	£0.00m			Driver is red for 2 reporting periods	1.62m	1.37m	2.74m	3.87m	2.08m	6.22m
				Total Pay Spend (£) vs Budget	£0.00m			Watch is red for 4 reporting periods	0.76m	0.03m	2.64m	1.29m	0.43m	3.81m
				Actual Worked FTE vs Budget	0			Watch is red for 4 reporting periods	7.26	50.36	5.09	50.05	81.09	4.96

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Sustainability	Financial Position			Agency Spend (£)	-		Special cause of improving nature or lower pressure due to (L)ower values	**0.40m**	**0.44m**	**0.50m**	**0.57m**	**0.50m**	**0.42m**
				Actual Worked FTE	-		Special cause of improving nature or lower pressure due to (H)igher values	**5,470.54**	**5,531.73**	**5,480.86**	**5,528.07**	**5,579.90**	**5,505.10**

Sustainability

Key Messages

The Trust is reporting a month 8 deficit of £5.1m and YTD deficit of £9.3m When adjusted for technical items this represents an adverse performance against control total of £5.4m and £8.95m respectively.
Those key pressures previously reported continue with no/little non-recurrent measures now available to offset; these include: ED safe staffing levels; medical staffing in MEC and S&A; enhanced care; Ruby ward and HCD funding. In addition, the YTD pay award expense and under-accrual versus income has given risen to a cost pressure in month of £2.5m. On a full year basis this is anticipated as c£3.4m cost pressure.
After "normalising" the position, the underlying deficit showed a small deterioration in month.

Issues, Concerns & Gaps

Following the month 8 results the forecast outturn is under review – given the YTD performance there is some risk to the full year control total.

Actions & Improvements

Further mitigations against potential forecast overspend to be developed.
Task and finish group meetings agreed to continue on a weekly basis.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m			-1.75m	-3.33m	2.56m	-2.76m	-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m	-1.86m	-5.41m
				Total Financial Overspend (£)	£0.00m			5.79m	6.32m	6.02m	19.01m	1.56m	0.61m	1.62m	1.37m	2.74m	3.87m	2.08m	6.22m
				(Surplus) / Deficit (£)	£0.00m			-2.55m	-4.13m	15.51m	-2.47m	-3.57m	-3.33m	-2.85m	-2.31m	-1.81m	11.24m	-1.57m	-5.10m
				Agency Spend (£)	-			0.68m	0.54m	0.71m	0.42m	0.55m	0.61m	0.40m	0.44m	0.50m	0.57m	0.50m	0.42m
				Income (£)	-			39.02m	38.07m	56.72m	52.27m	37.37m	37.52m	37.02m	39.81m	38.21m	52.45m	47.61m	41.37m
				Income (£) vs Budget	£0.00m			4.45m	3.49m	8.38m	16.46m	-0.50m	-0.33m	-0.85m	0.93m	1.27m	1.40m	0.86m	-0.28m
				Total Pay Spend (£)	-			25.00m	26.71m	25.99m	37.01m	25.67m	25.86m	26.29m	26.13m	26.22m	26.23m	32.75m	30.64m
				Total Pay Spend (£) vs Budget	£0.00m			3.17m	4.85m	4.10m	14.99m	-0.46m	-0.05m	0.76m	0.03m	2.64m	1.29m	0.43m	3.81m
				Total Non-Pay Spend (£)	-			14.42m	13.35m	13.09m	15.22m	12.96m	12.65m	11.48m	13.56m	11.91m	12.47m	14.29m	13.91m
				Total Non-Pay Spend (£) vs Budget	£0.00m			3.01m	1.95m	1.72m	3.85m	0.30m	-0.33m	-1.26m	0.91m	-1.06m	1.22m	2.19m	1.45m
				Actual Worked FTE	-			5,461.76	5,527.16	5,542.70	5,570.28	5,475	5,452.75	5,470.54	5,531.73	5,480.86	5,528.07	5,579.90	5,505.10
				Actual Worked FTE vs Budget	0			264.97	332.87	347.90	361.66	-27.32	-17.51	7.26	50.36	5.09	50.05	81.09	4.96

Month 8 Performance

£'000	In month (Oct'24)			In month (Nov'24)			Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	41,912	41,043	(869)	36,993	35,792	(1,201)	292,519	287,199	(5,321)
High cost drugs	2,196	2,730	534	2,125	2,463	338	17,283	19,042	1,759
Other income	2,640	3,835	1,195	2,532	3,114	582	19,064	25,118	6,053
Donated Asset Adjustment	-	-	-	-	-	-	-	-	-
Total income	**46,748**	**47,607**	**859**	**41,650**	**41,369**	**(281)**	**328,867**	**331,358**	**2,491**
Nursing	(13,518)	(14,161)	(644)	(10,928)	(11,114)	(187)	(86,299)	(88,548)	(2,248)
Medical	(10,299)	(10,201)	99	(11,077)	(12,157)	(1,080)	(70,630)	(73,025)	(2,395)
Other	(8,498)	(8,385)	113	(4,825)	(7,365)	(2,539)	(54,408)	(58,211)	(3,803)
Total pay	**(32,315)**	**(32,747)**	**(432)**	**(26,830)**	**(30,637)**	**(3,807)**	**(211,337)**	**(219,784)**	**(8,447)**
Clinical supplies	(4,980)	(5,545)	(565)	(4,451)	(5,620)	(1,169)	(39,470)	(41,038)	(1,568)
Drugs	(1,181)	(1,544)	(363)	(1,143)	(1,236)	(93)	(9,192)	(9,746)	(554)
High cost drugs	(2,201)	(2,730)	(529)	(2,158)	(2,497)	(339)	(17,191)	(19,076)	(1,885)
Other	(3,733)	(4,467)	(733)	(4,713)	(4,557)	155	(33,965)	(33,366)	600
Total non-pay	**(12,096)**	**(14,285)**	**(2,190)**	**(12,465)**	**(13,910)**	**(1,445)**	**(99,819)**	**(103,226)**	**(3,407)**
EBITDA	**2,337**	**574**	**(1,763)**	**2,355**	**(3,177)**	**(5,532)**	**17,711**	**8,348**	**(9,363)**
Depreciation	(1,745)	(1,653)	92	(1,745)	(1,646)	99	(13,184)	(12,828)	356
Donated Asset Adjustment	478	267	(211)	478	475	(3)	1,319	1,347	28
Net finance income/(cost)	69	90	21	69	95	26	521	589	68
PDC dividend	(846)	(846)	-	(846)	(846)	-	(6,738)	(6,753)	(15)
Non-operating exp.	**(2,044)**	**(2,142)**	**(98)**	**(2,044)**	**(1,922)**	**122**	**(18,082)**	**(17,646)**	**437**
Reported surplus/(deficit)	**293**	**(1,568)**	**(1,860)**	**311**	**(5,099)**	**(5,410)**	**(371)**	**(9,297)**	**(8,926)**
Remove Donated Assets Adjustment	(478)	(267)	211	(478)	(475)	3	(1,319)	(1,347)	(28)
Adjusted Reported surplus/(deficit)	**(185)**	**(1,835)**	**(1,649)**	**(167)**	**(5,574)**	**(5,407)**	**(1,690)**	**(10,644)**	**(8,954)**
Less: Deficit Support Funding		(1,973)			(1,776)				
Net deficit before support funding		**(3,808)**			**(7,350)**				
Non Recurrent flexibilities used		316			100				
Impact of YTD pay award in-month		(863)			2,203				
Underlying deficit		**(4,355)**			**(5,047)**				

The Trust reports an adverse position against plan in month 8 and for the YTD.

Previous cost pressures flagged continue to be drivers of the performance, with no/limited non-recurrent measures available to offset.

These pressures include:

- ED safe staffing (c£0.2m)
- Medical staffing – ED and S&A (c£0.6m)
- Ruby and HCD funding shortfalls (c£0.5m)
- Enhanced care incl. NCTR patients (c£0.2m)

Further deterioration in month 8 was the result of i) correction of an under accrual of Pay Awards ii) lower Clinical income and iii) increased expenditure, partly linked to CDC and Ruby Ward capacity, as well as increased cost of high cost drugs and clinical consumables (the latter partly linked to increased endoscopy).

Finance report

For the period ending 30 November 2024

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	311	(5,099)	(5,410)	The Trust is reporting a £10.6m deficit year to date (YTD), this being £9m adverse to the control total. The safe staffing (including enhanced care) and medical pay cost pressures, coupled with funding shortfalls for Ruby Ward, High Cost Drugs and the pay awards, continue to drive the adverse performance. In month 8 the impact of the pay award has adversely impacted by c£2.2m.
Donated Asset Adjustment	(478)	(475)	3	
In-month total	(167)	(5,574)	(5,407)	
YTD total	(1,690)	(10,644)	(8,954)	
Efficiencies Programme				
In-month	2,235	2,185	(50)	The efficiency programme has under achieved in-month by £0.05m and by £1.2m YTD. There remains a focus on stretching existing schemes and identifying new efficiencies by all services, as well as implementing operational controls to reduce expenditure.
YTD	13,748	12,591	(1,157)	
Cash				
Month end	14,565	15,700	1,135	The Trust cash position is marginally above the original plan but significantly lower than expected. The Trust has received to date both revenue support cash of £17m and deficit support PDC cash of £16.2m. The lower than expected balance is predominantly as a result of a lack of cash releasing efficiencies together with the cash payments run rate generally being higher than the I&E run rate.
Capital				
YTD				The annual capital budget has increased by £0.34m in month 8; £0.2m additional system funding is provided as a contribution to replace windows servers together with £0.14m additional charitable donations for equipment. £8.8m (28%) has been spent to date, which is £15.0m behind plan. This materially relates to leases (37%), CDC (36%) and MFT diagnostic projects (15%). Earlier reasons for delay have mostly been rectified but will cause some permanent slippage into 2025/26. This is estimated to be £4.4m across the whole programme for which £1.8m will be used to fund already approved pressures and £2.6m is being considered for reallocation at the time of writing. £3.9m of funding from the 2025/26 allocation will need to be ring fenced to complete the delayed 2024/25 projects.
Capex	17,267	8,837	(8,430)	
Leases	5,500	0	(5,500)	
Total	**22,767**	**8,837**	**(14,950)**	
Annual Forecast	**31,810**	**31,810**	0	

2. Income and expenditure

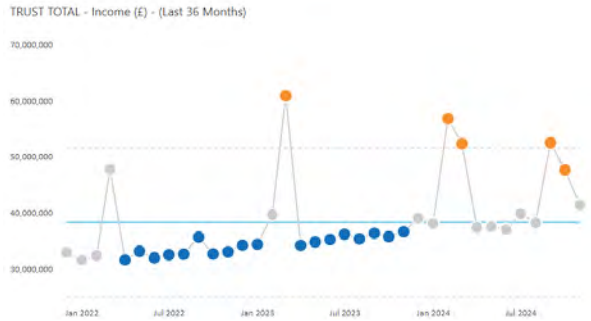
£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	36,993	35,792	(1,201)	292,519	287,199	(5,321)
High cost drugs	2,125	2,463	338	17,283	19,042	1,759
Other income	2,532	3,114	582	19,064	25,118	6,053
Donated Asset Adjustment						
Total income	41,650	41,369	(281)	328,867	331,358	2,491
Nursing	(10,928)	(11,114)	(187)	(86,299)	(88,548)	(2,248)
Medical	(11,077)	(12,157)	(1,080)	(70,630)	(73,025)	(2,395)
Other	(4,403)	(7,365)	(2,962)	(56,495)	(58,211)	(1,716)
Unidentified efficiencies	(422)	-	422	2,087	-	(2,087)
Total pay	(26,830)	(30,637)	(3,807)	(211,337)	(219,784)	(8,447)
Clinical supplies	(4,451)	(5,620)	(1,169)	(39,470)	(41,038)	(1,568)
Drugs	(1,143)	(1,236)	(93)	(9,192)	(9,746)	(554)
High cost drugs	(2,158)	(2,497)	(339)	(17,191)	(19,076)	(1,885)
Other	(4,398)	(4,557)	(160)	(35,779)	(33,366)	2,413
Unidentified efficiencies	(315)		315	1,813		(1,813)
Total non-pay	(12,465)	(13,910)	(1,445)	(99,819)	(103,226)	(3,407)
EBITDA	2,355	(3,177)	(5,532)	17,711	8,348	(9,363)
Non-operating exp.	(2,044)	(1,922)	122	(18,082)	(17,646)	437
Reported surplus/(deficit)	311	(5,099)	(5,410)	(371)	(9,297)	(8,926)
Adj. to control total	(478)	(475)	3	(1,319)	(1,347)	(28)
Control total	**(167)**	**(5,574)**	**(5,407)**	**(1,690)**	**(10,644)**	**(8,954)**
Deficit Support Funding (included in Clinical Income)	**(1,776)**	**(1,776)**	**-**	**(17,996)**	**(17,996)**	**-**
Performance against £27.8m deficit plan	**(1,943)**	**(7,350)**	**(5,407)**	**(19,686)**	**(28,640)**	**(8,954)**

1. Clinical income reports adverse performance of £5.3m YTD; this is due to centrally held items from planning that had a different phasing to that realised, including the mobile endoscopy funding/activity (offset by expenditure not incurred in this respect) which started in September, under delivery of ERF stretch income targets and funding of Ruby ward. High cost drugs favourable income is offset with expenditure reported in non-pay, however c£1.2m YTD of income related to HCD from the ICB is not expected to be paid (the underperformance of which is reported in the clinical income variance). The plan and actuals include the adjustment of £18m deficit support funding YTD, and £12.2m of pay award funding.
2. The 'other income' favourable variance is mainly due to medical education income (£3.5m YTD) based on the NHS England (Workforce, Training and Education) schedule, estates and facilities income (£0.6m), Provider to Provider contracts (for imaging, pathology and radio-pharmacy) within CCCS (£0.9m), £0.2m funding for the Targeted Enhanced Recruitment Scheme (TERS), £0.5m funding towards Industrial action costs and £0.1m RSP Programme Funding.
3. The November pay run-rate has decreased by £2.1m primarily as a result of the payment of the resident doctors pay awards including the associated back pay to April 23 being lower than the AfC and Consultant awards paid in October. The net in month pay award impact was a £2.2m pressure, bringing the YTD impact to a £0.7m pressure.
4. The overall pay variance is adverse by £8.4m YTD, being a deterioration of £3.8m from month 7, primarily due to the pay award, and part of the reserves from the original planning cycle being classified within non-pay.
5. Nursing staff report an adverse performance of £0.2m in-month and £2.2m YTD. This continues to be from pressures in emergency and acute care (£0.8m) as well as Frailty (£0.5m). Furthermore, month 8 has seen a further overspend of £0.2m in RMNs and enhanced care. The YTD medical overspend arises due to £0.6m industrial action costs (now funded), safe staffing/over-establishment in ED, £1.4m pressures in S&A and £0.2m (TERS) funded costs.
6. The unidentified efficiencies are a combination of the gap between devolved divisional targets and the identified schemes, as well approved schemes in progress that require budget holder approval before they can be actioned through the budgets, which may adjust the budget lines against which this should sit.

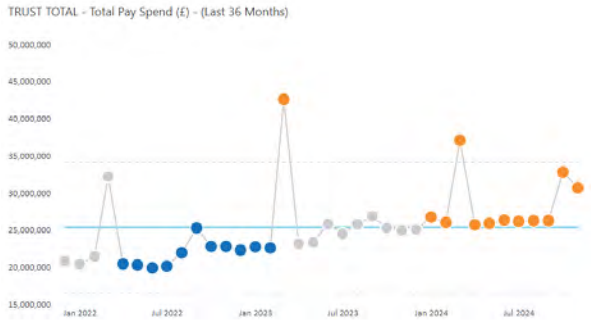
3. Run-rate

The charts below are examples of some of the statistical process control (SPC) charts available from the business intelligence platform; by analysing the changes in the run-rate over time, the divisions can understand different variations within particular areas of spend and whether results are as expected.

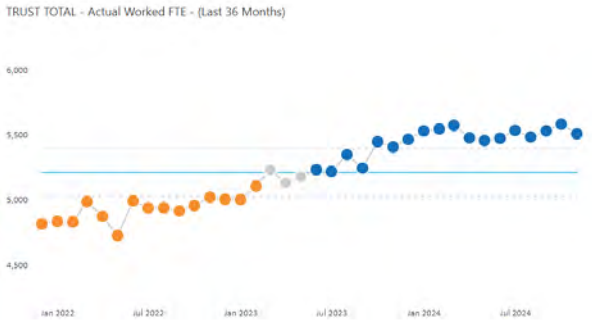
Income



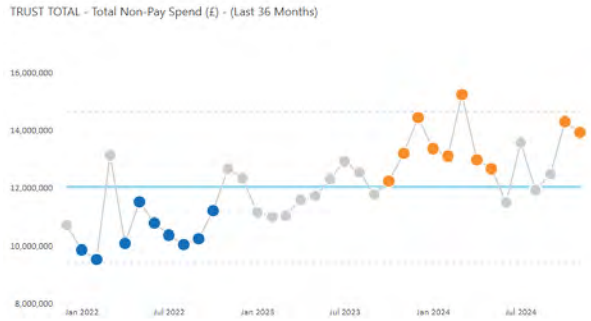
Pay



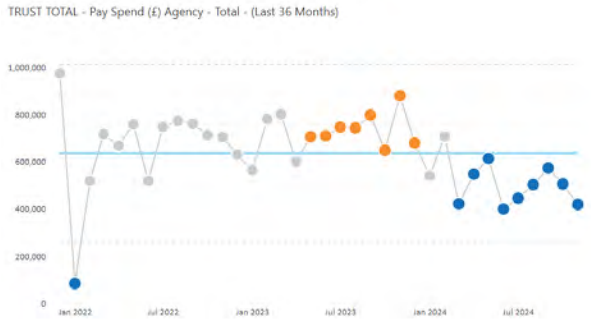
Full Time Equivalents worked



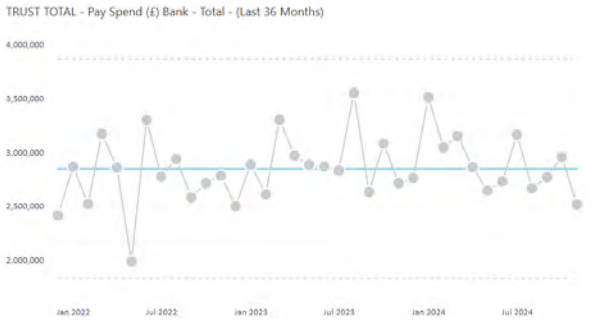
Non-pay



Agency

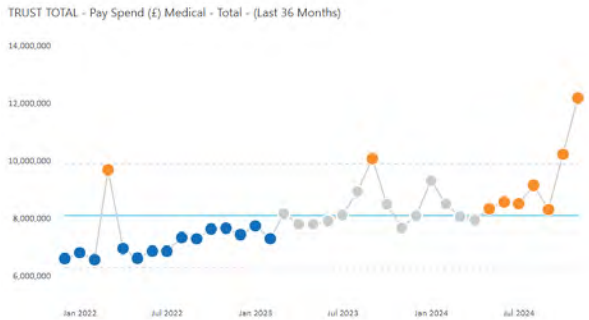


Bank

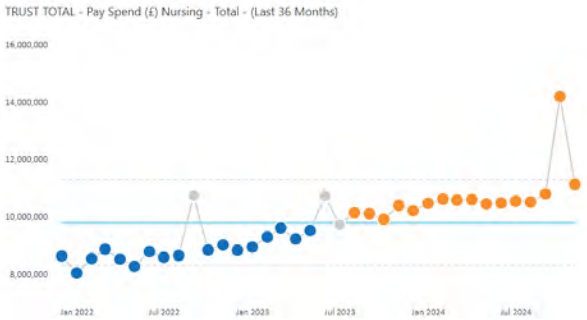


The pay spend results for March in each of the three years include the impact of the additional 6.3% pension costs, for which there is a corresponding increase to income as represented in the first chart. The total spend includes the impact of the pay awards, industrial action and the gradual growth in the workforce, for example increases for escalation capacity, service transformation, ERF activity and approved business cases (CDC, Virtual Wards, Teletracking, etc.), as well as unfunded cost pressures and areas of overspending which have been addressed through budget setting and the financial sustainability breakthrough objective.
When comparing the number of temporary FTE to March, there has been a reduction of c190 FTE - this results from substantive recruitment along with tighter controls over rostering and bank bookings that continues to be prioritised across all divisions.
The decrease of 74 WTE in month was spread across the Trust - 14 FTE Corporate, 23 FTE S&A, 15 FTE WC&YP, 13 FTE MEC and 5 FTE E&F.

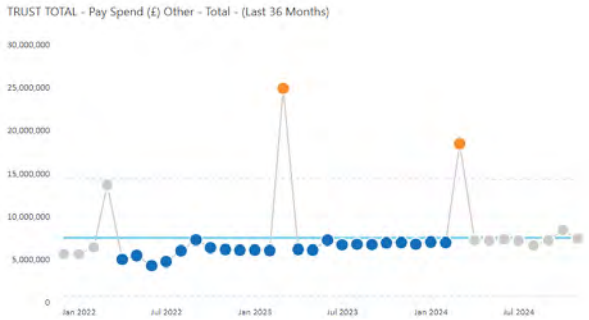
Medical pay total



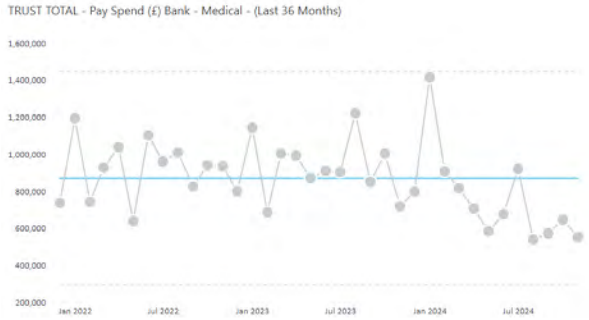
Nursing pay total



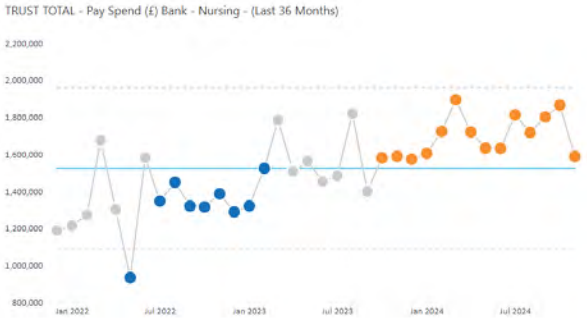
Other staff pay



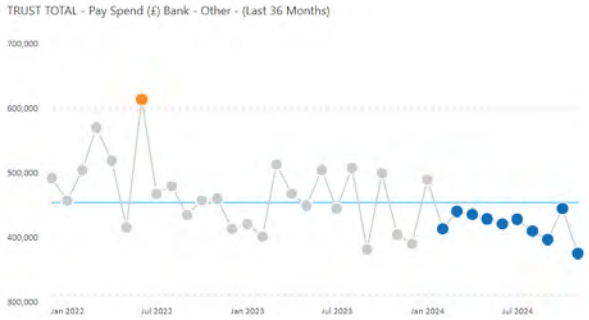
Medical bank



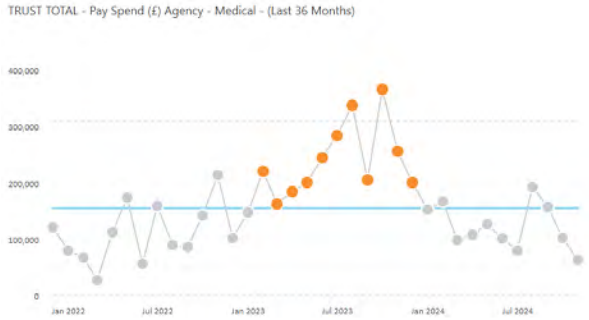
Nursing bank



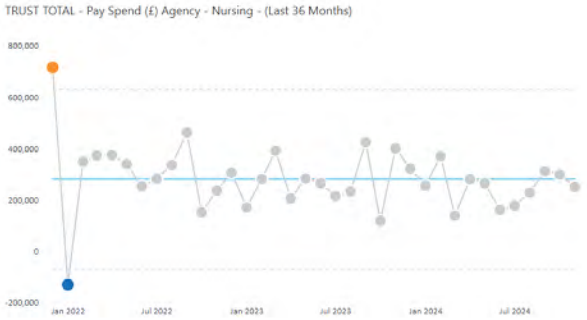
Other Staff bank



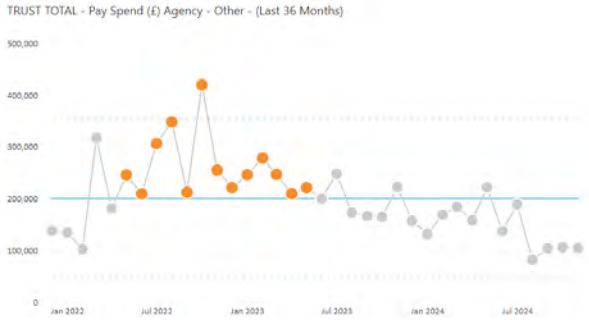
Medical agency



Nursing agency



Other Staff agency



Medical pay costs increase in November includes the pay award and backdated costs to April'23, The costs include industrial action of £0.4m in June and £0.1m in July. Medical temporary staff usage has reduced in month.

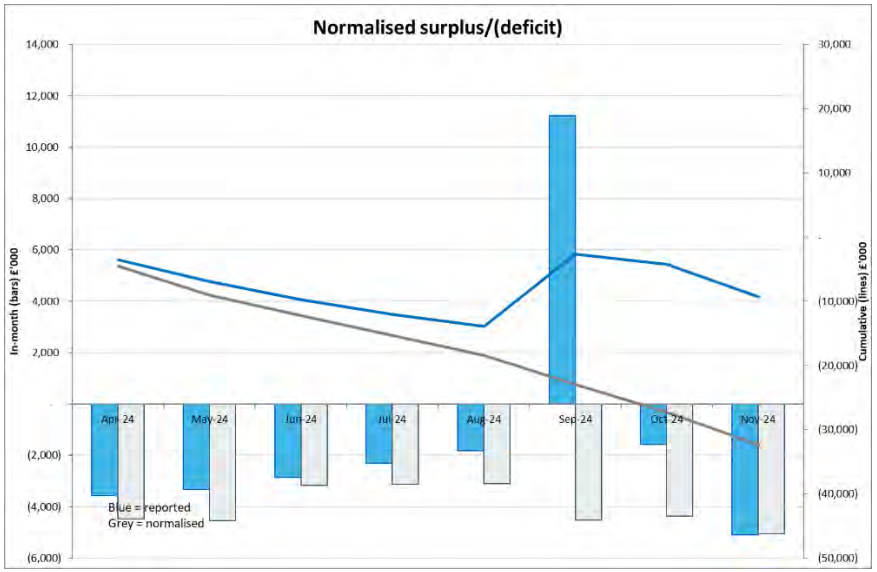
Nursing pay has decreased in month following the pay award and associated back pay in October.

Other agency staff has remained in line with October and bank staff have increased by £0.07m

4. Normalised performance

£'000	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Reported surplus/(deficit)	**(2,548)**	**(4,131)**	**15,507**	**1,622**	**(3,575)**	**(3,328)**	**(2,852)**	**(2,310)**	**(1,807)**	**11,241**	**(1,568)**	**(5,099)**
Support funding	-	-	(13,750)	(1,250)	-	-	-	-	-	(14,247)	(1,973)	(1,776)
Performance pre deficit support funding	**(2,548)**	**(4,131)**	**1,757**	**372**	**(3,575)**	**(3,328)**	**(2,852)**	**(2,310)**	**(1,807)**	**(3,006)**	**(3,541)**	**(6,875)**
Normalisation adjustments:												
Covid - income	(160)	(160)	(160)	(160)	(150)	(150)	(150)	(150)	(150)	(150)	(150)	(150)
Covid - incremental costs	23	1	4	40	-	1	3	-	-	1	-	1
Non-recurrent adjustments	365	(500)	-	(1,400)	(279)	(108)	(131)	(123)	(895)	(294)	466	250
Industrial action costs	807	1,352	590	-	-	-	447	130	-	-	-	-
Industrial action income	(167)	(167)	(2,167)	(167)	-	-	-	-	-	(542)	-	-
Annual leave accrual cost	-	-	-	130	-	-	-	-	(465)	-	-	-
Income Adjustments - capital charges	(1,042)	-	-	-	-	-	-	-	-	-	-	-
Pension 6.3% Funding	-	-	-	10,929	-	-	-	-	-	-	-	-
Pension 6.3% Costs	-	-	-	(10,929)	-	-	-	-	-	-	-	-
Pay Award	(104)	(104)	(104)	83	(1,267)	(1,268)	(1,268)	(1,267)	(949)	(1,205)	5,239	3,109
Pay Award Income	94	94	94	94	960	960	960	960	961	961	(6,103)	(906)
NHS Property Services Credit Note	-	-	-	-	-	(667)	-	-	-	-	-	-
Additional Sessions Accrual	-	-	-	-	-	-	-	(379)	379	-	-	-
Donated Assets/Impairment	25	23	23	(464)	(15)	12	(173)	25	(178)	(275)	(267)	(475)
Normalised surplus/(deficit)	**(2,707)**	**(3,591)**	**38**	**(1,472)**	**(4,475)**	**(4,548)**	**(3,163)**	**(3,114)**	**(3,105)**	**(4,512)**	**(4,355)**	**(5,047)**

£'000	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Reported surplus/(deficit)	(2,548)	(4,131)	15,507	1,622	(3,575)	(3,328)	(2,852)	(2,310)	(1,807)	11,241	(1,568)	(5,099)
Normalised surplus/(deficit)	(1,370)	(462)	2,608	(1,757)	(4,475)	(4,548)	(3,163)	(3,114)	(3,105)	(4,512)	(4,355)	(5,047)
Cumulative reported surplus/(deficit) 23/24	(20,569)	(22,152)	(7,175)	(21,061)								
Cumulative normalised surplus/(deficit) 23/24	**(21,698)**	**(20,790)**	**(22,306)**	**(26,671)**								
Cumulative reported surplus/(deficit) 24/25					(3,575)	(6,903)	(9,755)	(12,065)	(13,872)	(2,631)	(4,199)	(9,298)
Cumulative normalised surplus/(deficit) 24/25					**(4,475)**	**(9,023)**	**(12,187)**	**(15,301)**	**(18,406)**	**(22,918)**	**(27,273)**	**(32,320)**



5. Statement of Financial Position

Prior year end	£'000	Month end actual	Var on PY.
281,888	**Non-current assets**	**277,726**	**(4,162)**
6,556	Inventory	7,018	462
29,573	Trade and other receivables	45,185	15,612
21,042	Cash	15,700	(5,342)
57,171	**Current assets**	**67,903**	**10,732**
(357)	Borrowings	(234)	123
(57,536)	Trade and other payables	(54,047)	3,489
(1,166)	Other liabilities	(4,530)	(3,364)
(59,059)	**Current liabilities**	**(58,811)**	**248**
(3,073)	Borrowings	(2,946)	127
(1,307)	Other liabilities	(1,307)	0
(4,380)	**Non-current liabilities**	**(4,253)**	**127**
275,620	**Net assets employed**	**282,564**	**6,945**
489,836	Public dividend capital	506,079	16,243
(275,397)	Retained earnings	(284,695)	(9,298)
61,181	Revaluation reserve	61,181	0
275,620	**Total taxpayers' equity**	**282,564**	**6,945**

Key messages:

1. **Non-current assets** are £4.2m lower than year end, being the net impact of investment expenditure of £8.8m and £13m depreciation

2. In month 8 the Trust has net current assets of £9.1m, a £5.8m decrease on month 7 due largely to the deficit movement.

3. **Trade and other receivables** are £45.2m (113% of one month's income); £16.4m (36%) relates to invoices raised and awaiting payment.

4. **Cash** has decreased by £4.9m on month 7 and £5.3m on the prior year. This is an adverse position but also highlights a potentially significant cash risk. Additional cash support of £16.2m has been received from NHSE which should have allowed the Trust a more favourable balance on the prior year end; this is not the case - the cash run rate is much higher than the I&E run rate due to prepayments, non-cash releasing efficiencies and a higher than planned deficit.

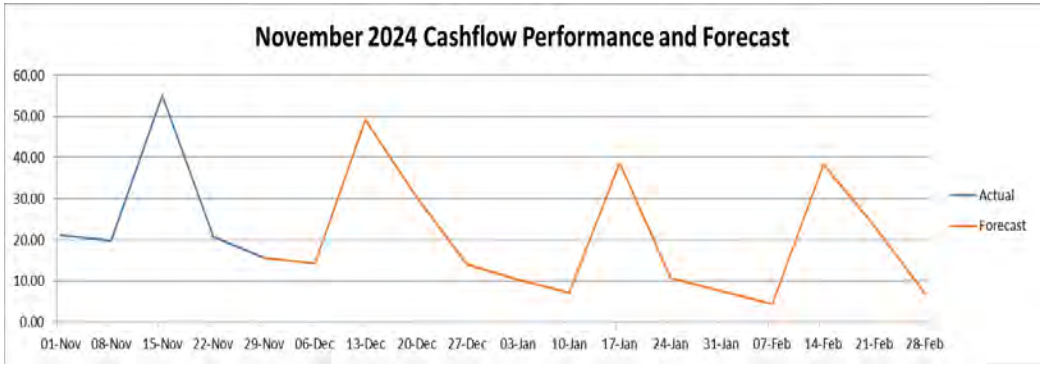
5. **Trade and other payables** are £54.1m (135% of one month's expenditure); £33.2m (61%) relates to invoices received and awaiting payment.

6. **Public Dividend Capital** has not changed since M7 when the last revenue cash support payment was made. Additional PDC of £4.4m for capital schemes is expected to be issued during Q4.

6. Cash

13-week cash forecast

£m	w/e 01/11/24	08/11/24	15/11/24	22/11/24	29/11/24	06/12/24	13/12/24	20/12/24	27/12/24	03/01/25	10/01/25	17/01/25	24/01/25	31/01/25	07/02/25	14/02/25	21/02/25	28/02/25
	Actual					Forecast												
BANK BALANCE B/FWD	**24.88**	**21.15**	**19.75**	**55.05**	**20.82**	**15.61**	**14.17**	**49.12**	**30.42**	**14.01**	**10.31**	**7.15**	**38.66**	**10.79**	**7.56**	**4.33**	**38.24**	**23.61**
Receipts																		
NHS Contract Income	0.89	0.14	39.52	0.10	0.38	0.06	38.04	0.00	0.00	0.00	0.00	40.68	0.00	0.00	0.00	36.84	0.00	0.00
Other	0.16	0.23	0.21	0.17	0.24	0.16	0.45	0.25	0.44	0.20	0.32	0.47	0.54	0.25	0.25	0.54	0.25	0.54
Total receipts	**1.05**	**0.37**	**39.73**	**0.27**	**0.62**	**0.21**	**38.49**	**0.25**	**0.44**	**0.20**	**0.32**	**41.15**	**0.54**	**0.25**	**0.25**	**37.38**	**0.25**	**0.54**
Payments																		
Pay Expenditure (excl. Agency)	(0.50)	(0.47)	(0.45)	(30.67)	(0.45)	(0.45)	(0.54)	(13.40)	(13.86)	(0.90)	(0.48)	(4.09)	(21.30)	(0.48)	(0.48)	(0.48)	(11.22)	(14.64)
Non Pay Expenditure	(3.84)	(1.30)	(3.95)	(3.57)	(4.61)	(1.16)	(2.40)	(3.10)	(1.50)	(3.00)	(3.00)	(5.54)	(10.50)	(2.00)	(3.00)	(1.50)	(1.65)	(1.00)
Capital Expenditure	(0.45)	(0.01)	(0.02)	(0.47)	(0.78)	(0.04)	(0.60)	(2.44)	(1.50)	0.00	0.00	0.00	(1.00)	(1.00)	0.00	(1.50)	(2.00)	(1.50)
Total payments	**(4.78)**	**(1.78)**	**(4.42)**	**(34.71)**	**(5.83)**	**(1.65)**	**(3.54)**	**(18.95)**	**(16.86)**	**(3.90)**	**(3.48)**	**(9.63)**	**(32.80)**	**(3.48)**	**(3.48)**	**(3.48)**	**(14.87)**	**(17.14)**
Net Receipts/ (Payments)	**(3.73)**	**(1.41)**	**35.31**	**(34.44)**	**(5.21)**	**(1.44)**	**34.95**	**(18.70)**	**(16.42)**	**(3.70)**	**(3.16)**	**31.51**	**(32.26)**	**(3.23)**	**(3.23)**	**33.91**	**(14.62)**	**(16.60)**
Funding Flows																		
PDC Capital	0.00	0.00	0.00	0.29	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.39	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.21**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**4.39**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**21.15**	**19.75**	**55.05**	**20.82**	**15.61**	**14.17**	**49.12**	**30.42**	**14.01**	**10.31**	**7.15**	**38.66**	**10.79**	**7.56**	**4.33**	**38.24**	**23.61**	**7.01**



The overall cash balance has decreased by £4.9m in November.

£42.0m of cash was received in month

£40.7m NHS contract income for the month including £2.1m deficit support funding and £1.3m pay award funding, £0.3m salix grant and £1.0m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£46.9m of cash was paid out by the Trust in month

£17.7m (38%) in direct salary costs to substantive and bank employees which includes this year pay award and arrears for AfC staff.
£14.3m (30%) employer costs to HMRC and NHSP.
£14.9m (32%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

7. Forecast, risks and mitigations

The Trust has established a Task and Finish Group, led by the Trust Executives and attended by the Committee Chair, to review and gain assurance over the forecast outturn.

The Trust continues to report delivery of its control total for 2024/25 to NHSE, however this is at significant risk given the recent financial performance.

8. Conclusions

The Finance, Planning and Performance Committee is asked to note the report and financial performance, which is a £5.6m deficit in-month and £10.6m deficit YTD, the latter being £9m adverse to the NHSE plan and control total.

For the remainder of this year (and beyond), the Trust must implement effective cost control processes to manage the run-rate, as well as identify further mitigations and waste reductions if it is to deliver the control total and a sustainable financial performance. In addition to the annual deficit, the Trust is targeting an exit run-rate for the year of a monthly deficit of no more than £1.5m (before deficit support funding) – cash-releasing improvements are therefore critical in achieving that performance.

Our cash position continues to be closely monitored. Delivery of the control total will be crucial in maintaining cash autonomy.

Alan Davies
Chief Financial Officer
December 2024

NHS
Medway
NHS Foundation Trust

Maternity Bi-Annual Workforce Report

Trust Board

15 January 2025

Patient FIRST

Executive Summary

- CNST Year 6 continues the requirement for a bi-annual midwifery workforce paper to be presented to Trust Board.
    - The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
    - This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
    - The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in January and July 2024.
    - Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
- A table top Birth-rate plus review was completed and reported to MNSCAG December 2024. No additional staffing required, on the basis of this assessment, due to low variance of -0.28wte. Report forwarded to Deputy CNO for inclusion in the Trust wide safer staffing report.
- Monthly monitoring of workforce embedded into practice
- New starter/preceptorship package is now in place
- HEE funded Staff Nurse 18 month conversion course in place
- Current vacancy of 19.88wte (November 2024) Band 5/6 Midwives
- The maternity service currently has a 22% uplift to cover sick leave, annual leave and mandatory training.
- In view of the additional training requirements within maternity including Labour Ward Coordinator training and additional requirements in the core competency framework v2, CNST and 3 Year delivery plan an uplift of 25% should be considered for future workforce reviews and planning. A PID will be prepared in 2025 to request Trust support for this.
- Incentivise return to work for midwives choosing to retire with flexible working and exemption from clinical on call rota.
- Focused work being undertaken to support staff with sickness absence for anxiety & stress.
- Midwifery retirement 5 year trajectory - 46.45wte currently aged between 51-70 who may plan to retire.
- Improvement in understanding reasons for staff absence, with “Unknown” reduced from 3rd highest reason to lowest reason due to work of senior sisters and matrons in recording absence data.
- The issue previously known as risk ID1133 in relation to midwifery staffing has been altered from a risk (score 15) to an issue (scoring 4) without care group consultation/Divisional understanding of the proposed changes to the risk register. This has been escalated through the Division to Execs.
- The Delivery Suite acuity tool data shows that the unit was adequately staffed 61%, which is an improvement on April 2023-March 2024 which showed 53%.
- The unit recorded negative acuity 39% of the time (down from 47% of the time). With 5% of the time being 2 or more MW’s short (down from 9%)

True North: People
Background to workforce report

Medway
NHS Foundation Trust

Ambition: To provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
Goal: To provide an accurate account of the current workforce status

Background:
The NHSR Maternity Incentive Scheme requires that MFT demonstrates an effective system of midwifery workforce planning to the required standard using the following standards prescribed within safety action 5 of the MIS:

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e)Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

True North: People
Planned vs Actual Midwifery Staffing levels

Medway NHS Foundation Trust

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

Key Messages:

- A table top Birthrate Plus workforce review was completed in November 2024
- Medway Foundation Trust (MFT) requires and are currently funded to a midwife to mother ratio of 1:25 based on a birth rate of 4618 deliveries to provide safe care.
- The staffing ratio is monitored on a monthly basis through the maternity dashboard.
- MFT have not achieved the recommended ratio due to absences caused by vacancy, staff sickness absence and maternity leave.
- Staffing shortages are in part mitigated by use of bank and agency (included in the actual worked ratio in table)
- A clinical on call system has been in place since 2023 providing access to 2 midwives who will provide hands on clinical help as part of the escalation policy.

Issues, Concerns & Gaps:

- Birthrate Plus recommends a formal three-yearly review of midwifery safe staffing. (Next due in 2026)
- Vacancy and absence rate impacting on ability to fill substantive staffing shifts 24/7.

Actions & Improvements:

- A staffing review is carried out on a weekly basis to identify any pinch points which impact and challenge the ability to maintain safe staffing.
- In response to the staffing gaps all Band 7 ward managers and specialist midwives have provided clinical care when acuity has been high.
- Improved preceptorship and induction packages in place to support new starters and improve retention.
- Although the vacancy has now been recruited to we still have a substantial ‘not in post’ figure as newly qualified band 5 midwives are expected to join between December 2024 and May 2025.

True North: People

Table top internal Birthrate Plus review November 2024

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus

Goal: Outline the findings from the internal Birth-rate Plus review

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

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

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

Birthrate Plus Formal Review July 2023 (22% Uplift) (B3-7 including specialist midwives proportion clinical time)	206.02wte
Table Top Birthrate Plus Review 2024 (22% Uplift) (B3-7)	209.30wte
Funded Establishment (B3-7 including extra specialist midwives proportion clinical time funded in 2024)	209.02wte
Variance	-0.28wte

** Total births calculated as a prediction based on numbers of births in Q1 24/25 x by 4 for a full year*

Medway NHS Foundation Trust

Anticipated Total births in service 2024/25: 4618

CASE MIX	Cat I	CatLL II	Cat III	Cat IV	Cat V
DS Casemix	3.8	9.1	15.2	32.8	39.1
Generic Casemix					

				Required WTE
Delivery Suite		No.		
Delivery Suite Births		4409	54.25	54.25
Other DS Activity		No. Episodes of care	Hours	
	Catergory X	3801	1 2.42	
	Catergory A1	714	4 2.15	
	Catergory A2		7 2.01	
	Catergory R		6 0.9	
	Escorted Transfers OUT		4 0	
	Non-viables		15.5 1.3	
				8.78
Alongside Midwifery Unit		No.		
	Births	209	10.85	
	Unplanned Attenders	2190	2.74	
	Additional PN Cases	Counted in PN care	13.59	
	Transfer to D/S	*within DS WTE*		13.59
Maternity Ward (s)				
Antenatal and Postnatal Care		No.		
	Antenatal Admissions	1532	5.62	
	Inductions	1501	3.21	
	Ward attenders (IOL assessment)	714	714 2.95	
	Re-Admissions (baby)	148	2690 5.43	
				17.21
	Postnatal women	4409	30.08	
	Postnatal Re-admissions (maternal)	66	0.34	
	Postnatal Ward Attenders	347	347 0.38	
	Transitional Care babies	465	3.36	
	MAC babies	301	2.04	
	NIPE		2.02	
				38.22
OUTPATIENT SERVICES				
Antenatal Clinics			Weekly hrs	
	Antenatal Clinics		51 1.69	
	Fetal medicine		5.16	
Maternity Care Unit		8882	2 11.96	
				18.81
COMMUITY SERVICES				
		No.		
	Home Births	156	1.51	
	Home Birth with NIPE	156	1.01	
	Community Cases (full AN & PN Care)	5301	47.05	
	Community Bookings ONLY	551	1.89	
	Team Connect additional care	250	6.98	
				58.44

CLINICAL WTE REQUIRED (Bands 3-7) at 22% uplift	209.3
Current funded establishment (Band 3-7)	209.02
Variance	-0.28

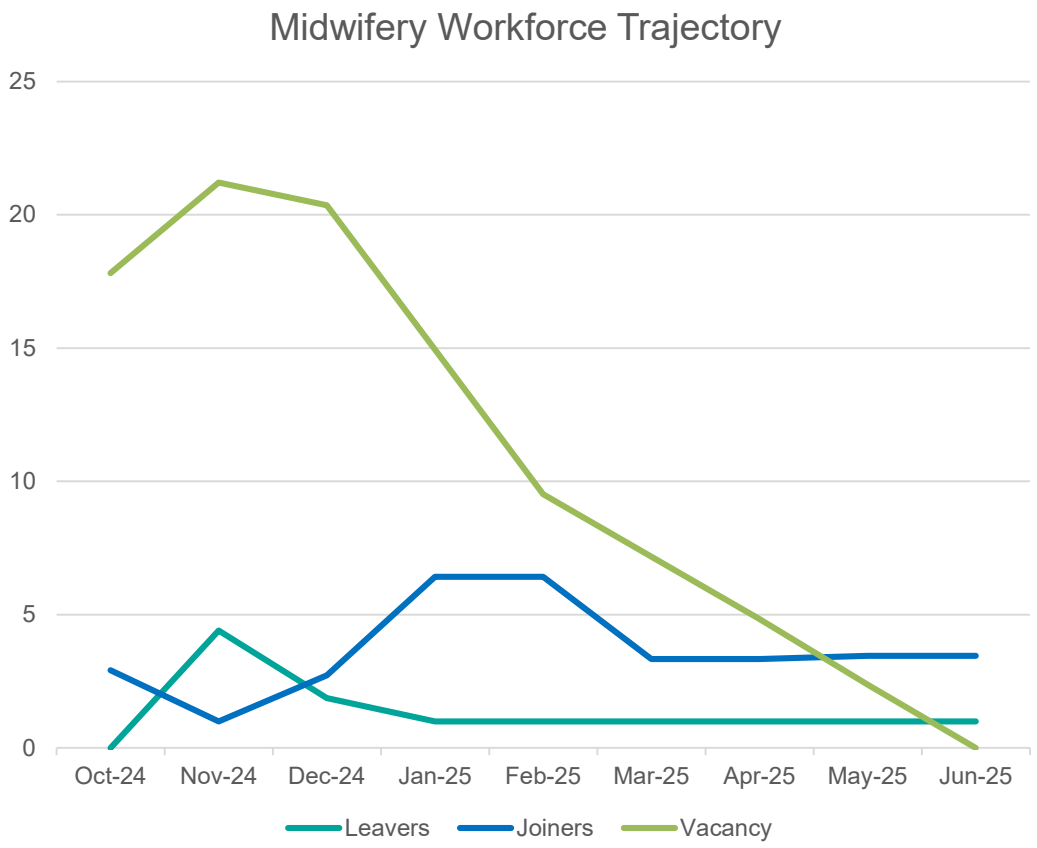
True North: People
Planned vs Actual Midwifery Staffing levels

NHS Medway NHS Foundation Trust

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

Measure	Goal	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	0:125	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio		01:33	01:33	01:34	1:30	1:31	1:32	01:29	01:29	01:32	1:31	1:29	1:30

	Establishment	In post	Recruited to but not in post	On secondment	Contractual Vacancy
Clinical Band 7 Midwives	21.48	21.27	0	0	0.21
Clinical Band 5 and 6 RM/RN	159.64	133.84	5.92	1.64	18.24
MSW's Band 3	33.76	29.41	0.64	2.28	1.43
Total	214.88	184.52	6.56	3.92	19.88



True North: People
Planned vs Actual Midwifery Staffing levels

NHS Medway NHS Foundation Trust

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

Key Messages:

- Table top BR+ exercise demonstrates a variance of -0.28wte from funded establishment.
- Based on the establishment, the mean midwife to birth ratio at MFT should be around 1:25 each month
- From Oct 24 to June 2025 there will be 33.08wte new starters, the majority of which will be newly qualified band 5mws which will impact on the skill mix across the service.
- In response to this, an additional clinical skills facilitator has been recruited to the education team to provide enhanced preceptorship and clinical support to newly qualified staff and mitigate risk and promote retention.
- Exit interviews demonstrate staff leaving for personal reasons or promotion and not due to work place dissatisfaction but service has overall good retention rates.

Issues, Concerns & Gaps:

- Ensure that we deliver the required support and wellbeing to support new starters and international midwives through their preceptorship period
- National challenges with available number of midwives to recruit to and to therefore maintain a fully established workforce.
- New training recommendation for Band 7 delivery suite coordinators
- Awaiting confirmation of NHSE/LMNS funding for retention midwife for 2025/26.

Actions & Improvements:

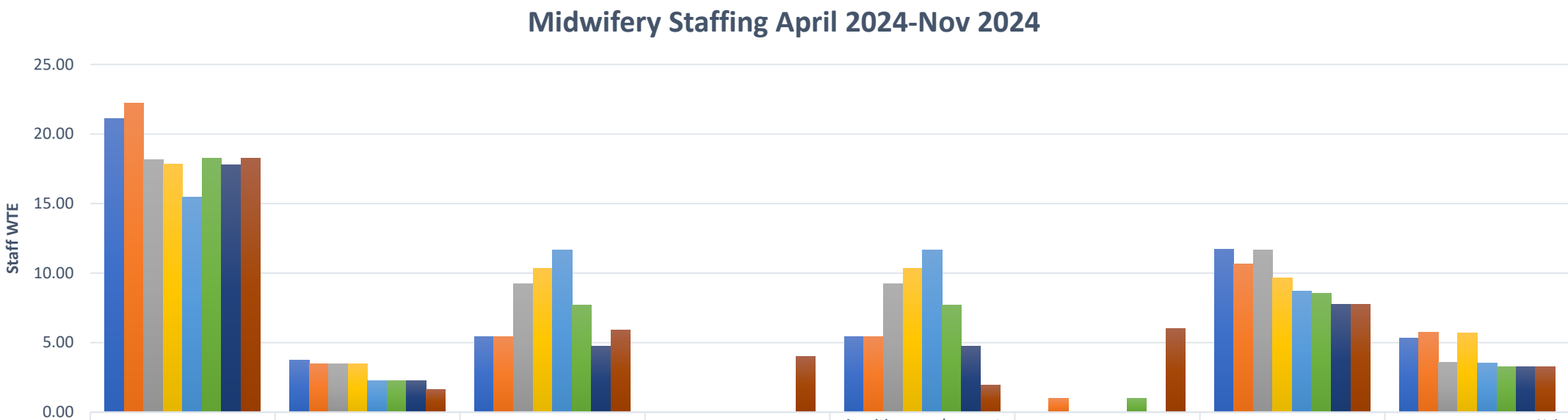
- NHSE/LMNS funding for retention midwife continues until March 2025, to ensure that newly qualified midwives are fully supported and assist the unit to retain both post registration and experienced midwives.
- Identifying mental health first-aiders within care group to complete training and be a source of support for staff absent with anxiety and stress.
- Consider formal Business planning/PID in 2025 to request increase uplift from 22% to 25% to support additional training requirements including additional enhanced Labour Ward Coordinator, additional requirements of the Core Competency Framework v2, Three Year Delivery plan and CNST requirements.

True North: People
Workforce Data October 2023 to March 2024

NHS Medway NHS Foundation Trust

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Apr-24	21.12	3.77	5.42	0.00	5.42	0.00	11.72	5.32
May-24	22.23	3.48	5.42	0	5.42	1	10.64	5.72
Jun-24	18.16	3.48	9.26	0	9.26	0	11.64	3.6
Jul-24	17.86	3.48	10.34	0	10.34	0	9.64	5.68
Aug-24	15.48	2.24	11.63	0	11.63	0	8.68	3.55
Sep-24	18.28	2.24	7.72	0	7.72	1	8.56	3.23
Oct-24	17.81	2.24	4.72	0	4.72	0	7.76	3.23
Nov-24	18.24	1.64	5.92	4	1.92	6	7.76	3.23

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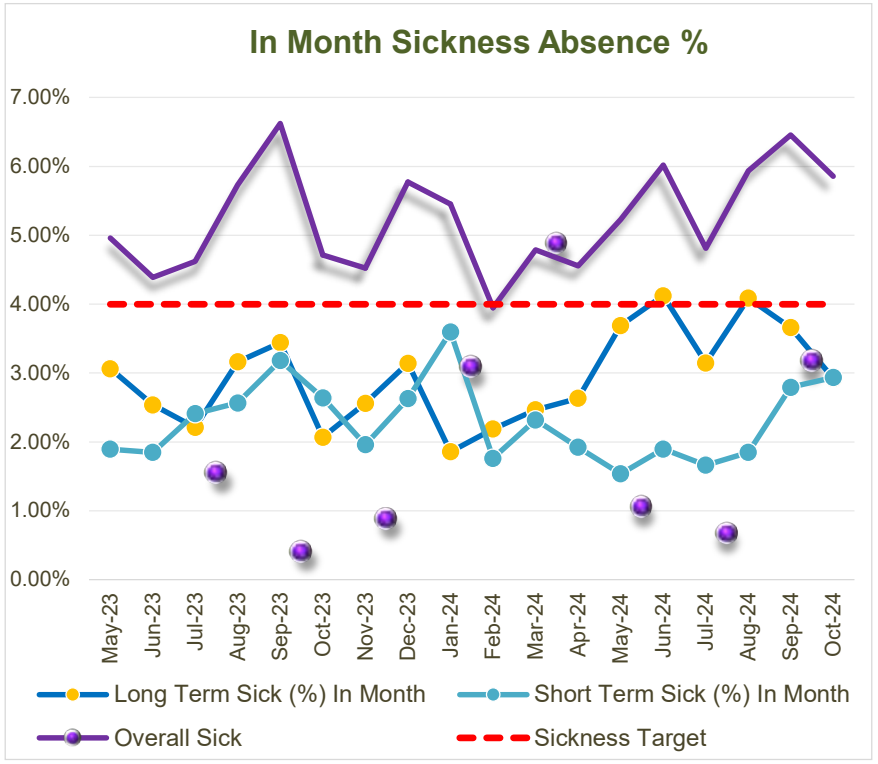

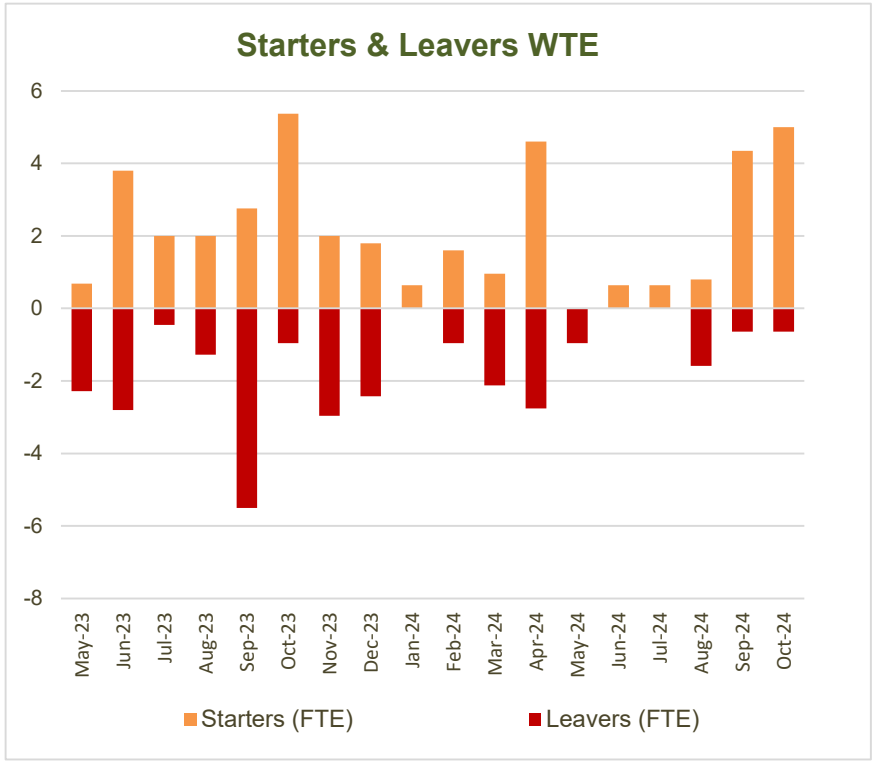

True North: People
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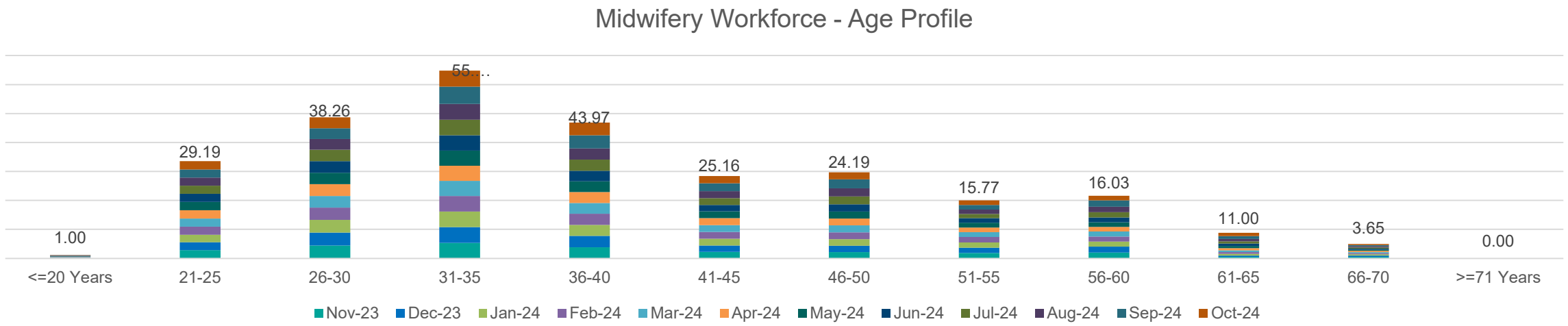

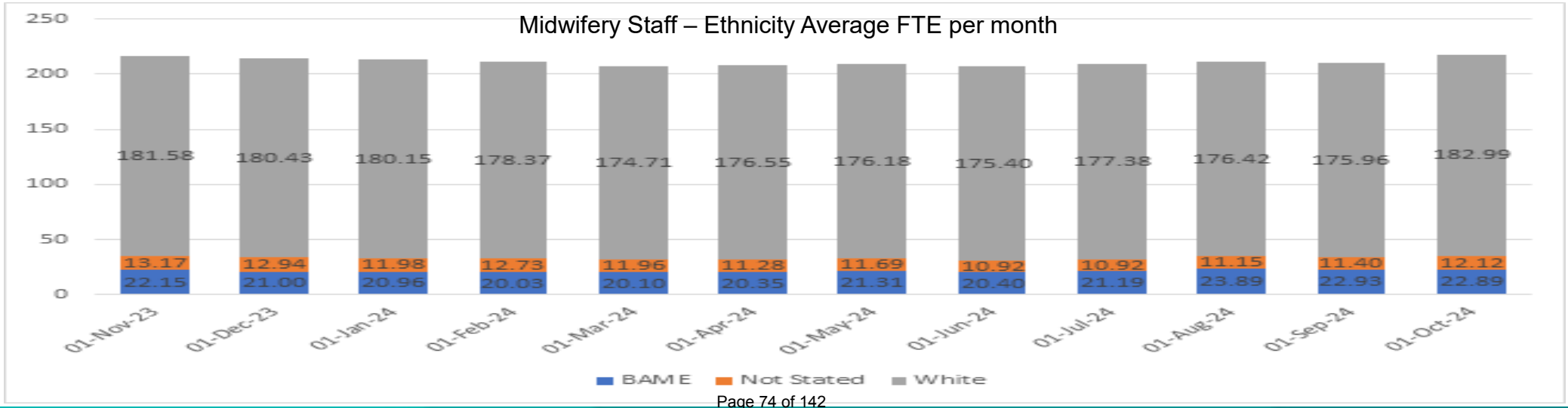

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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Absence FTE (In Month)	334.28	320.80	419.41	396.11	264.41	339.64	315.69	371.56	417.28	338.44	425.68	446.55	440.07
Absence FTE (Rolling)					3619.32	3958.96	4274.65	4296.79	4409.72	4411.95	4416.60	4389.85	4495.64
Absence % (In Month)	4.71%	4.52%	5.77%	5.45%	3.95%	4.79%	4.56%	5.23%	6.02%	4.81%	5.94%	6.45%	5.86%
Absence % (Rolling)					5.09%	5.06%	5.02%	5.04%	5.17%	5.19%	5.21%	5.19%	5.29%
ST Absence FTE (In Month)	187.41	139.08	191.03	261.24	117.95	164.69	133.17	109.21	131.48	117.03	132.57	193.35	220.43
LT Absence FTE (In Month)	146.87	181.72	228.39	134.87	146.47	174.95	182.52	262.35	285.80	221.41	293.11	253.20	219.64
ST Absence % (In Month)	2.64%	1.96%	2.63%	3.60%	1.76%	2.32%	1.92%	1.54%	1.90%	1.66%	1.85%	2.79%	2.93%
LT Absence % (In Month)	2.07%	2.56%	3.14%	1.86%	2.19%	2.47%	2.63%	3.69%	4.12%	3.15%	4.09%	3.66%	2.92%
ST Absence % (Rolling)					2.46%	2.45%	2.40%	2.37%	2.38%	2.32%	2.25%	2.22%	2.25%
LT Absence % (Rolling)					2.63%	2.61%	2.61%	2.67%	2.80%	2.88%	2.95%	2.97%	3.04%
Absence Instances	67	74	82	84	60	61	53	62	59	56	71	84	85
Estimated Cost of Absence	£39,508	£38,937	£46,319	£49,006	£26,858	£37,399	£36,552	£37,088	£50,151	£40,611	£45,774	£48,800	£49,070
Absence Days (Calendar)	451	449	542	504	378	432	387	464	536	456	560	571	565

True North: People
Workforce Data October 2023 to March 2024

NHS Medway NHS Foundation Trust

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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
S10 Anxiety/stress/depression/other psychiatric illnesses	14.56	2.48	0.00	58.60	58.24	127.84	139.12	181.55	154.63	71.95	102.09	91.64	129.51
S11 Back Problems	18.72	10.60	17.92	23.92	21.36	11.52	1.36	6.32	58.05	38.36	59.01	71.36	83.19
S12 Other musculoskeletal problems	45.20	47.23	32.76	31.60	27.20	28.32	21.12	16.60	25.81	29.44	24.80	23.84	12.80
S13 Cold, Cough, Flu - Influenza	34.35	33.99	72.61	68.28	40.69	33.77	17.40	17.96	16.96	3.24	10.16	20.47	37.34
S14 Asthma	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
S15 Chest & respiratory problems	8.64	6.80	0.00	0.00	3.41	16.64	25.64	23.00	0.00	7.00	4.00	23.92	0.00
S16 Headache / migraine	7.44	10.36	3.52	10.25	10.51	4.36	3.12	14.41	2.00	4.03	7.92	4.45	1.00
S17 Benign and malignant tumours, cancers	18.19	17.60	18.19	18.19	17.01	18.19	17.60	36.11	19.20	19.84	19.84	13.97	0.00
S18 Blood disorders	0.00	0.00	0.00	3.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.45	0.45
S19 Heart, cardiac & circulatory problems	19.84	0.00	0.00	1.44	0.00	2.88	0.95	0.00	0.00	0.00	13.89	12.00	12.75
S20 Burns, poisoning, frostbite, hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.24	10.88	0.00	0.00	0.00	0.00
S21 Ear, nose, throat (ENT)	0.80	1.95	0.00	14.32	1.00	14.68	0.00	2.60	0.80	25.96	31.00	9.75	3.00
S22 Dental and oral problems	0.80	2.40	2.13	5.79	0.00	1.28	3.84	0.00	0.00	0.00	1.49	2.68	0.00
S23 Eye problems	0.00	0.00	0.00	0.00	0.00	0.00	3.87	0.95	0.00	4.00	0.00	8.00	0.00
S24 Endocrine / glandular problems	0.00	0.80	1.28	0.00	0.96	1.92	0.00	0.00	0.00	1.92	0.00	2.88	0.00
S25 Gastrointestinal problems	14.44	17.52	26.24	9.85	4.04	16.96	19.32	12.41	16.61	33.87	45.61	32.61	29.49
S26 Genitourinary & gynaecological disorders	0.00	2.32	30.32	17.48	1.89	10.44	2.89	1.60	14.24	17.04	29.72	65.89	74.68
S27 Infectious diseases	38.40	12.12	33.08	33.16	8.64	10.56	10.84	13.49	35.60	35.15	21.08	14.68	17.45
S28 Injury, fracture	9.60	7.84	47.84	33.44	47.45	19.88	29.00	21.32	44.00	29.76	34.24	25.81	17.17
S29 Nervous system disorders	0.00	0.00	0.00	0.00	0.00	0.00	4.80	0.00	0.00	0.00	0.00	0.00	0.00
S30 Pregnancy related disorders	32.00	40.00	54.60	29.56	7.64	13.36	8.08	1.00	14.89	14.00	4.81	3.66	1.45
S31 Skin disorders	0.00	0.00	0.00	1.60	3.20	0.00	4.48	4.48	0.00	0.00	0.00	13.92	2.56
S98 Other known causes - not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
S99 Unknown causes / Not specified	71.31	106.80	78.92	35.23	11.16	7.04	2.27	5.52	3.60	2.89	16.00	4.56	17.23

True North: People
Workforce Data October 2023 to March 2024

Medway NHS Foundation Trust

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Midwifery Leaving Data April 2023-Aug 2024 (LMNS data)								
AGE GROUP								
KM LMNS Average	36.7	35.6	27.7	100				
MFT %	47.2	29.3	23.5	100				
WTE	9.47	5.88	4.72	20.07				
	<35	**35-54**	**55+**					
TENURE								
KM LMNS Average	7.5	15	41.2	11.5	11.3	13.6	100.1	
MFT %	9.8	10.4	40.6	19.1	8.2	12	100.1	
WTE	1.97	2.09	8.15	3.83	1.65	2.41	20.07	
	< 1 Year	**1-2 Years**	**2-5 Years**	**6-10 Years**	**10-20 Years**	**>20 Years**		
REASON 1								
KM LMNS Average	**33.2**	**22.8**	**21.3**	**18**	**1**	**3.8**	100.1	
MFT %	**40.7**	**20.3**	**18.9**	**20.1**	**0**	**0**	100	
WTE	8.17	4.07	3.79	4.03	0.00	0.00	20.07	
	Resign Destination Unknown	**Resign Move IN NHS/HC**	**Resign - Move out NHS**	**Retire**	**EoC/Redundancy/Dismissal**	**Unknown**		

True North: People
Workforce Data October 2023 to March 2024

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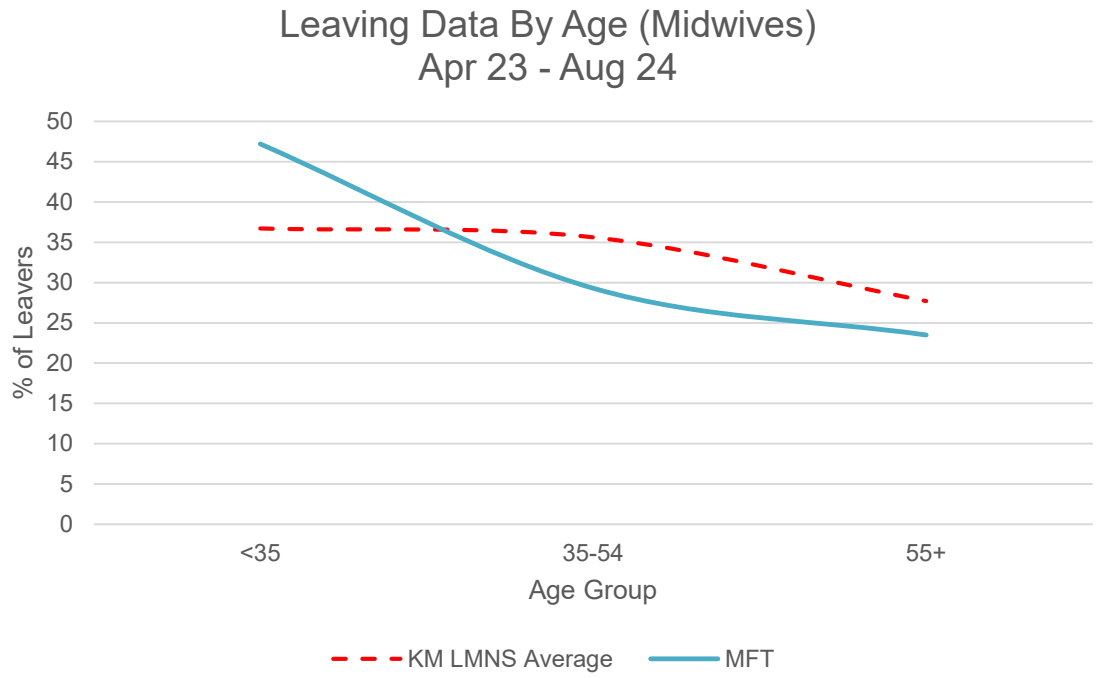
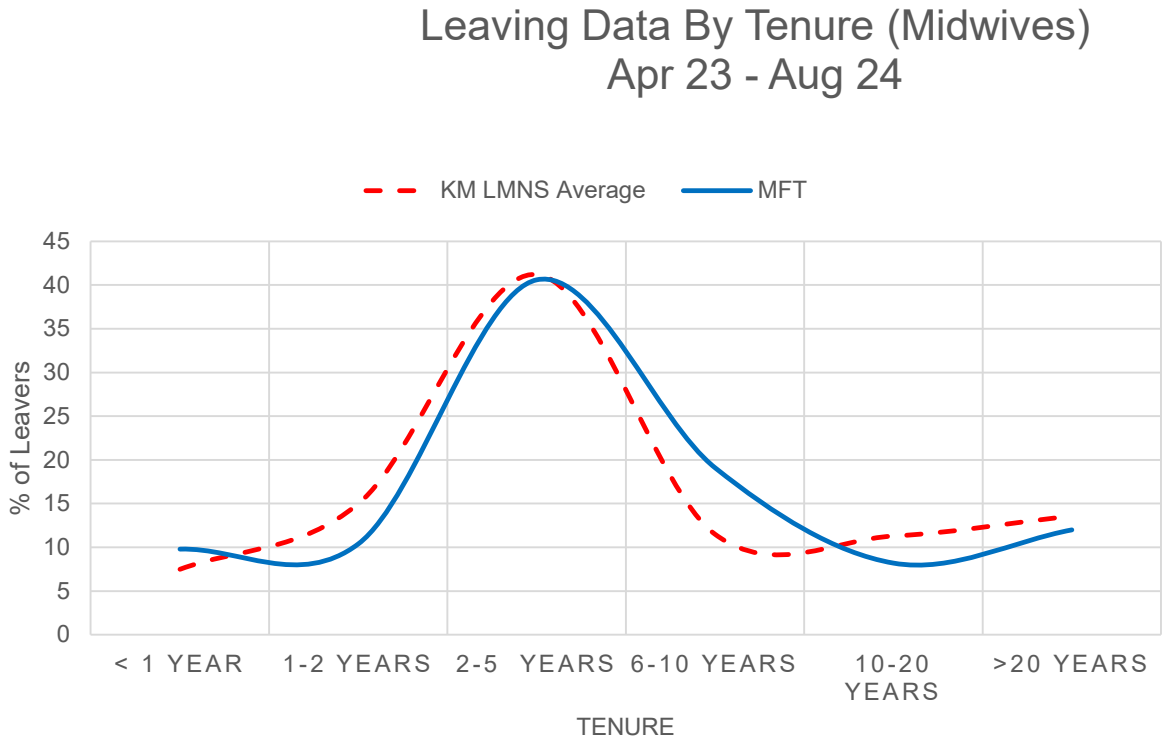
Medway NHS Foundation Trust





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Workforce Data October 2023 to March 2024

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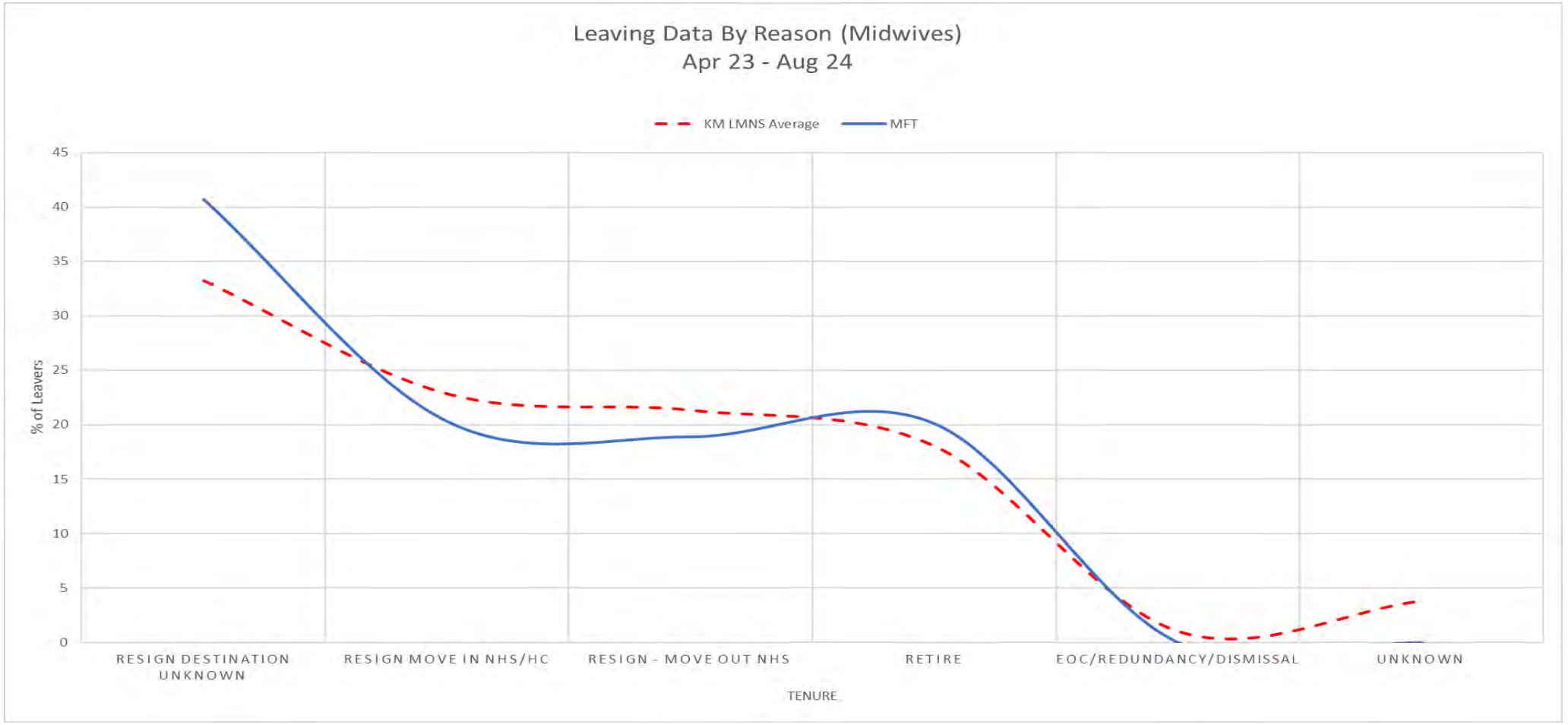

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Workforce Data October 2023 to March 2024

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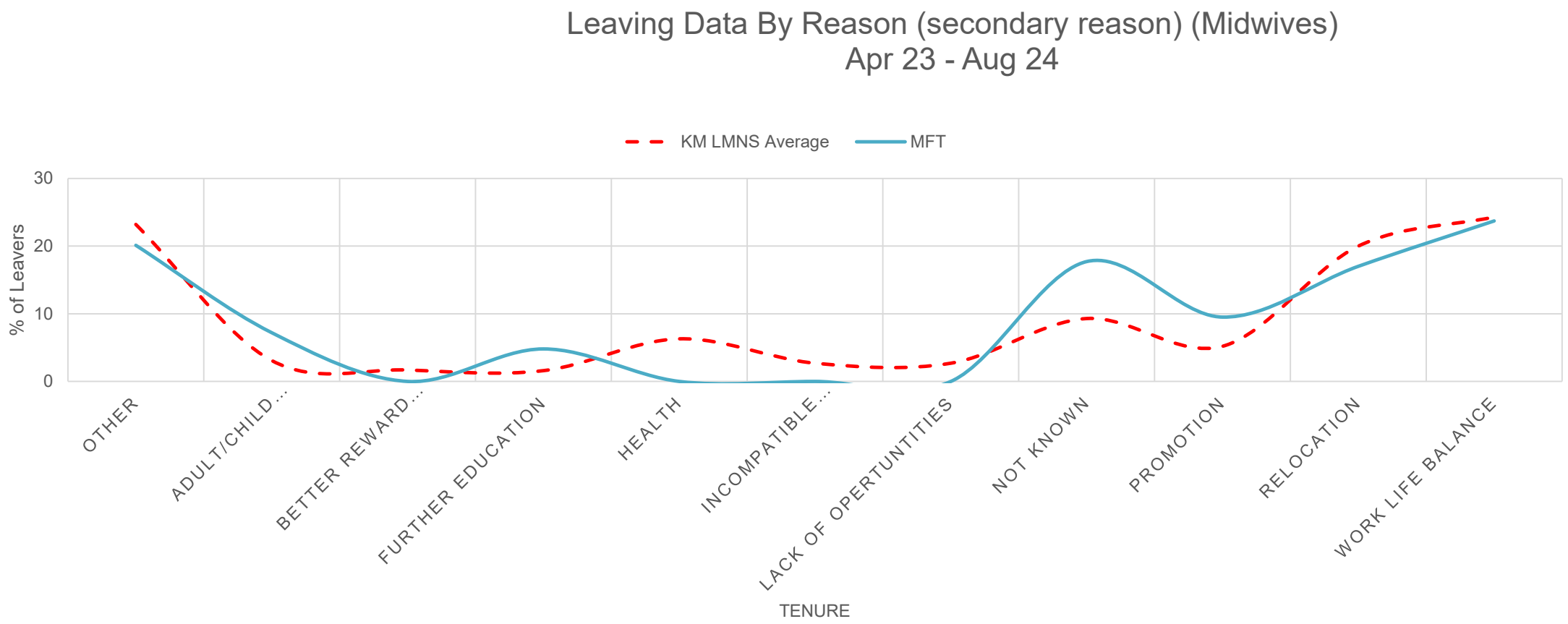

Recruitment and Retention

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

Medway NHS Foundation Trust

Key Messages:

- The maternity team continue to actively recruit to band 6 roles.
- Positive retention noted, with minimal leavers over past 6 months.
- The service is currently working with the HEE Midwifery Apprentice Programme and have 2 recently qualified and 3 ongoing apprentices with a further 2 due to commence in January 2025.
- MFT piloting T-Levels to support young people to complete health qualifications within the hospital setting with positive feedback from students and staff.
- SCORE survey planned for the New year
- To progress engagement in LMNS led staff-listening events and career opportunities including career cafes and shortened course.
- 1 RN on the RN to midwifery shortened course programme (18mth).
- Leaving data compared to Region based on age profiling, tenure and reasons (April 2023-Aug 24)
    - 47% of leavers (9.47 WTE) were <35
    - 40% (8.15 WTE) had a tenure of 2-5 years.
    - 20% leavers move within NHS, 19% move out of NHS, 20% retired.
- Midwifery retirement 5 year trajectory - 46.45 WTE currently aged between 51-70 may have a plan to retire
- 11% of midwifery workforce is BAME, continue to actively support applications from BAME midwives and work with EDI Midwife to in-reach into these communities to ensure our workforce is reflective of our population. (Total births from BAME families is 18.36% for 2023/24)

Issues, Concerns & Gaps:

- Sickness/absence is above Trust Target.
- Anxiety/stress/depression/other psychiatric illness highest reason for absence.
- Funding for recruitment and retention midwife continued for 2024/25. Waiting for confirmation of extension for 2025/26
- Formalise recording of actions from Board Level Safety Champions Walkabouts to ensure ongoing “You said, we listened” feedback to staff.
- 100% of the Midwifery workforce are female and over 80% of child-bearing age so maternity leave will, at times, be disproportionately higher than other workforce groups
- The issue previously known as risk ID1133 in relation to midwifery staffing has been altered from a risk (score 15) to an issue (scoring 4) without care group consultation/Divisional understanding of the proposed changes to the risk register. This has been escalated through the Division to Execs.
- Ongoing provision of midwifery pre registration education in the South-East remains reliant on one provider. Ongoing collaboration with CCCU regarding reaccreditation of midwifery degree programme.

Recruitment and Retention

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NHS Medway NHS Foundation Trust

Actions & Improvements:

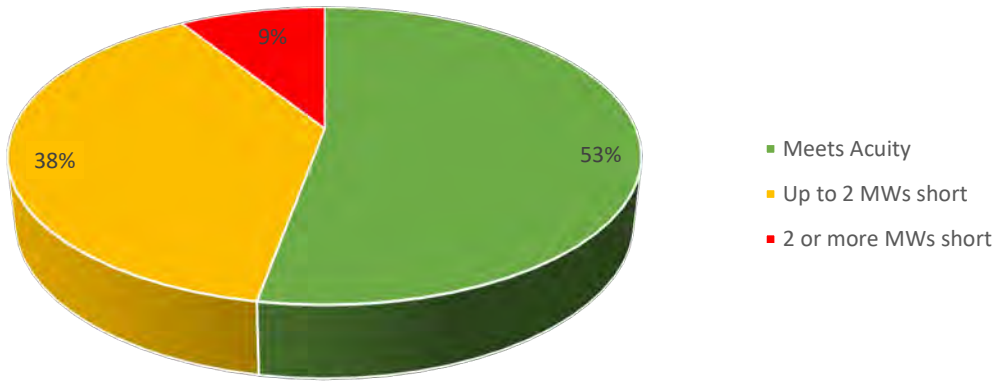
- Improvement in understanding reasons for staff absence, with “Unknown” reduced from 3rd highest reason to lowest reason due to work of senior sisters and matrons in recording absence data.
- Divisional and Care Group driver to reduce sickness/absence across WCYP. Working across care group to ensure compliance with absence guidance and management.
- Mental Heath First-Aiders identified across service to support staff with anxiety/stress.
- 2 members of staff (Labour Ward Coordinator and NICU Nurse) to attend Civility training and will support driving improvements in attitudes and behaviours in the clinical areas.
- Monthly Maternity forum chaired by the DoM to encourage speaking up
- Monthly safety walk rounds by Local and Board Level Safety Champions to talk to teams on shift, and anonymous safety champion feedback form now in place.
- Regular update for colleagues on progress around recruitment and actions taken as a result of the midwifery forum and safety walk arounds.
- Working with LMNS to cultivate local placements from alternative providers.
- All staff feedback collated on feedback log and actions allocated and outcomes fed back to staff. Actions to be grouped by theme and added to BAF to ensure appropriate oversight.
- Ongoing engagement with Trust and LMNS quality and diversity workstreams.
- Continue to publish EDI data in workforce reports.
- Continue to embed inclusive recruitment process for band 7 and above to ensure that our interview panels are diverse.
- Improve talent management and succession mapping.
- Work with LMNS and Trust to support staff to engage in career cafes.
- Continue apprenticeship scheme.
- Continue to support culture and improvement work, including recognising and celebrating staff achievements “Star of the Month!”

True North: People
Birthrate Plus 4- hourly acuity tool

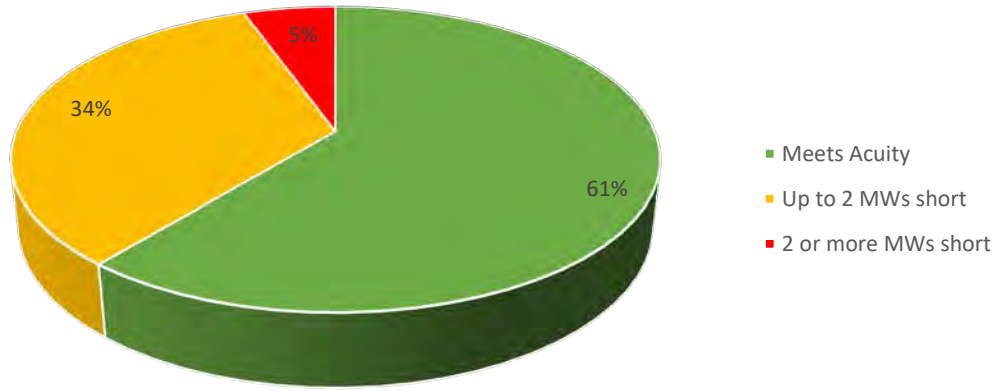
Medway NHS Foundation Trust

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

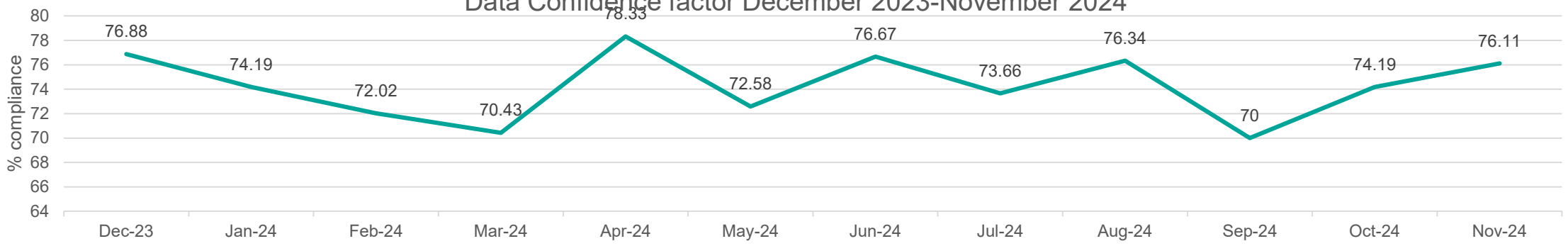
Delivery Suite Staffing/Acuity April to March 2024



Delivery Suite Staffing/Acuity Dec 2023-Nov 2024



Data Confidence factor December 2023-November 2024



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Birthrate Plus 4- hourly acuity tool

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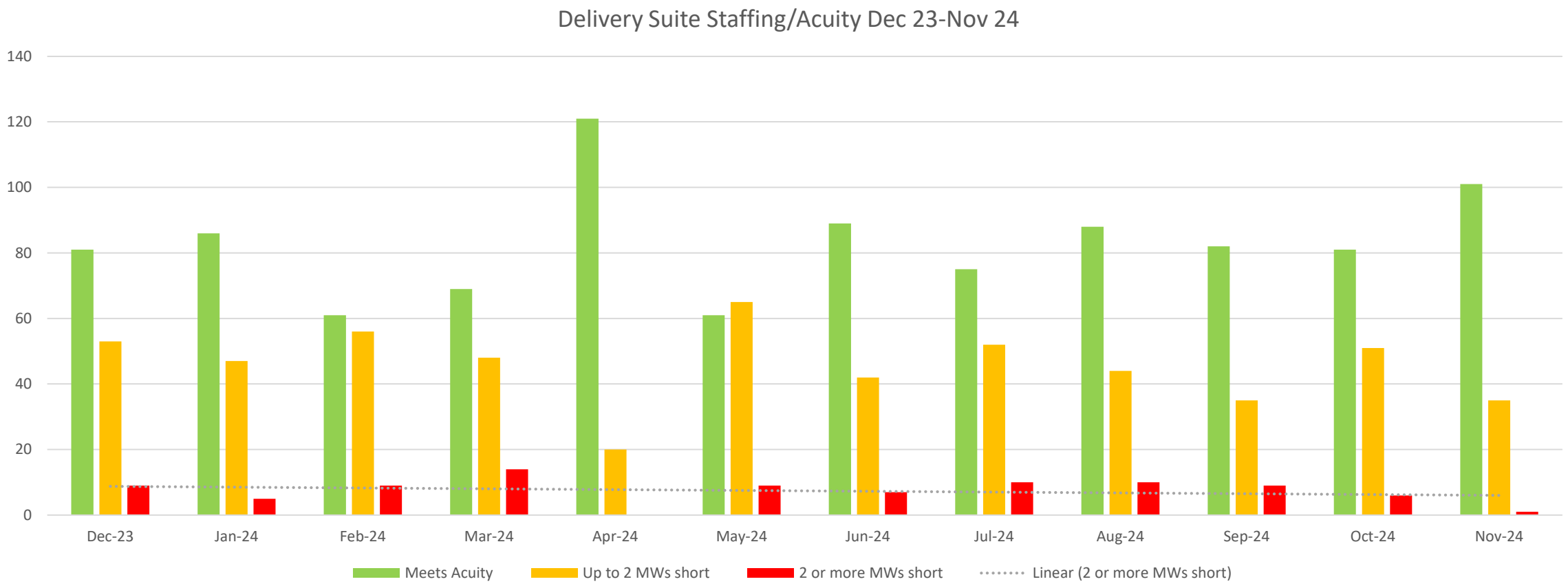

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Birthrate Plus 4- hourly acuity tool

Medway NHS Foundation Trust

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Key Messages:

- The pie chart shows Acuity RAG status for April 2023 to March 2024 and from December 2023 to November 2024.
- The Intrapartum tool currently uses Red, Amber, and Green as determinants of acuity.
- A target of 85% for Green, when there is an adequate number of midwives available to provide the clinical care required by the women depending upon their needs, is considered to be appropriate
- The Delivery Suite acuity tool data shows that unit was adequately staffed 61%, which is an improvement on April 2023-March 2024 which showed 53%.
- The unit recorded negative acuity 39% of the time (down from 47% of the time). With 5% of the time being 2 or more MW's short (down from 9%)
- Compliance with completion of the tool has fallen to 76% which is below the 85% standard recommended by BR+.

Issues, Concerns & Gaps:

- Staff are moved from other areas to mitigate against the risk of staffing shortfalls however this may create red flags in these areas
- Data entry to the acuity tool falls below the Birthrate Plus recommendations.
- Web-based acuity tool for antenatal and postnatal wards is still in testing due to technical issues from provider.

Actions & Improvements:

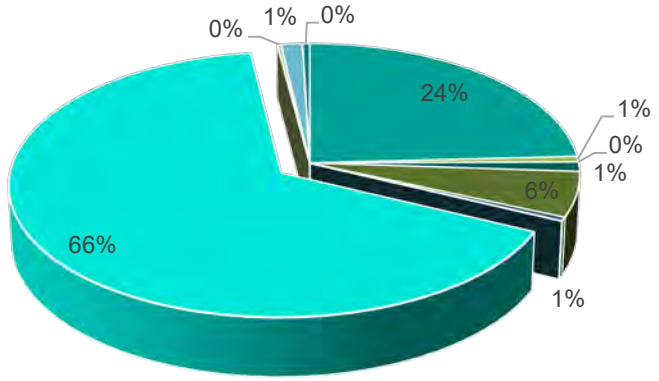
- Benchmarking against Labour Ward Coordinator framework completed since last workforce report. PMA team worked with all Labour Ward Coordinators to review skills and development opportunities. Engaging with LMNS working group to develop bespoke Labour Ward Coordinator Training to commence in 2025.
- A clear and robust escalation policy is in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored. Early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service
- Significant improvements have been made in recruitment and retention over the past 12 months and it is anticipated to be recruited to funded establishment by May 2025.

True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Medway NHS Foundation Trust

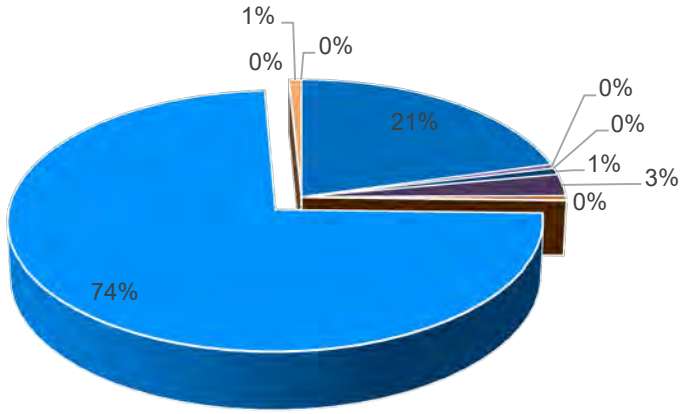
Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Maternity Red Flags Dec 23-May 24



- Delayed or cancelled time critical activity
- Missed or delayed care (for example delay of 60 minutes or more in washing and suturing
- Missed medication during admission to hospital or MLU
- Delay in providing pain relief
- Delay between presentation and triage
- full clinical examinaination not carried out when preseting in labour
- Delay between admission for induction and beginning of process
- delayed recognition of and action on abnormal vital signs.
- Any occasion where 1 midwife is not able to provide continuous 1:1 care during established labour
- Coordinator unable to maintain supernumerary status

Maternity Red Flags June -November 2024



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True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

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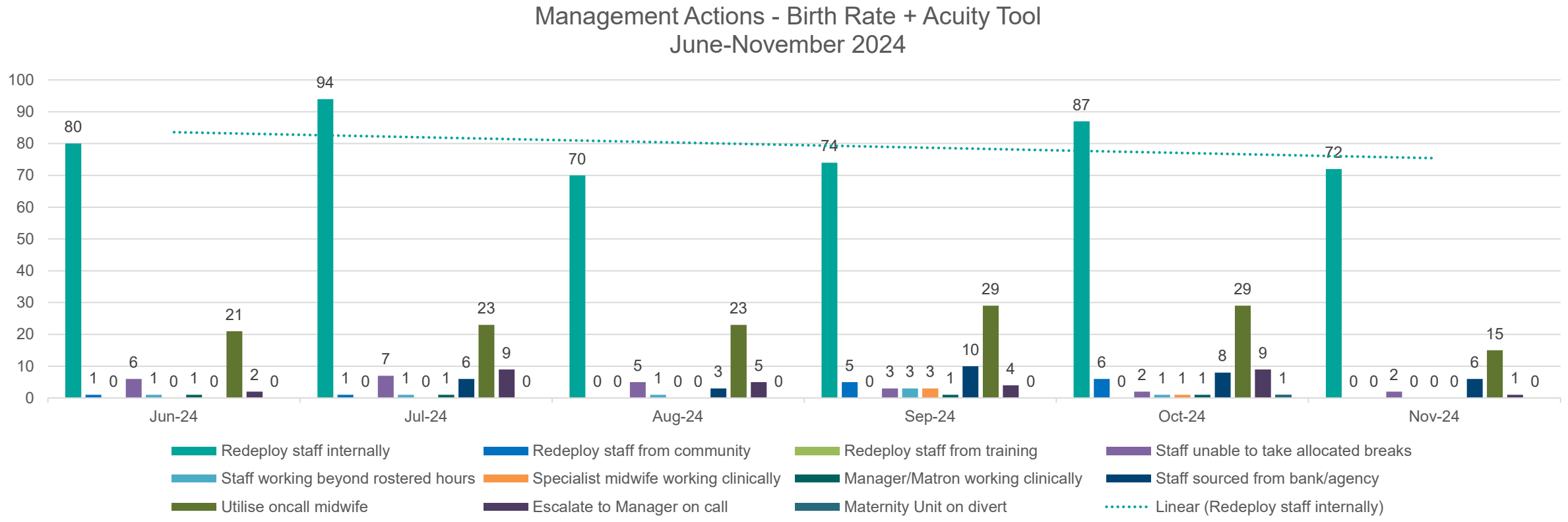

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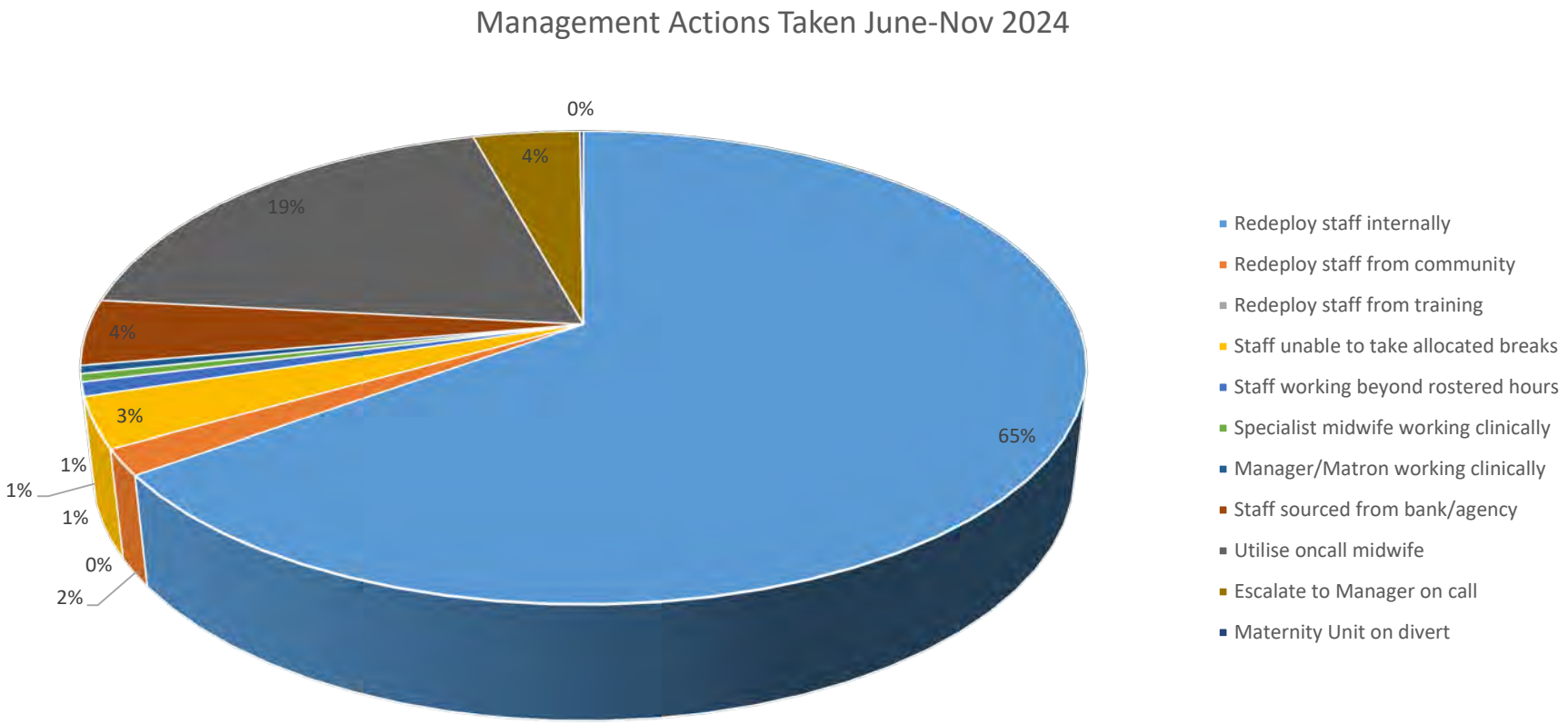

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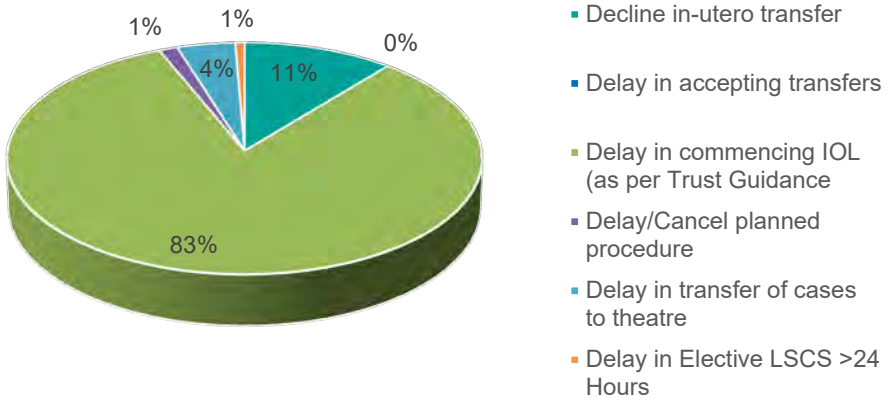
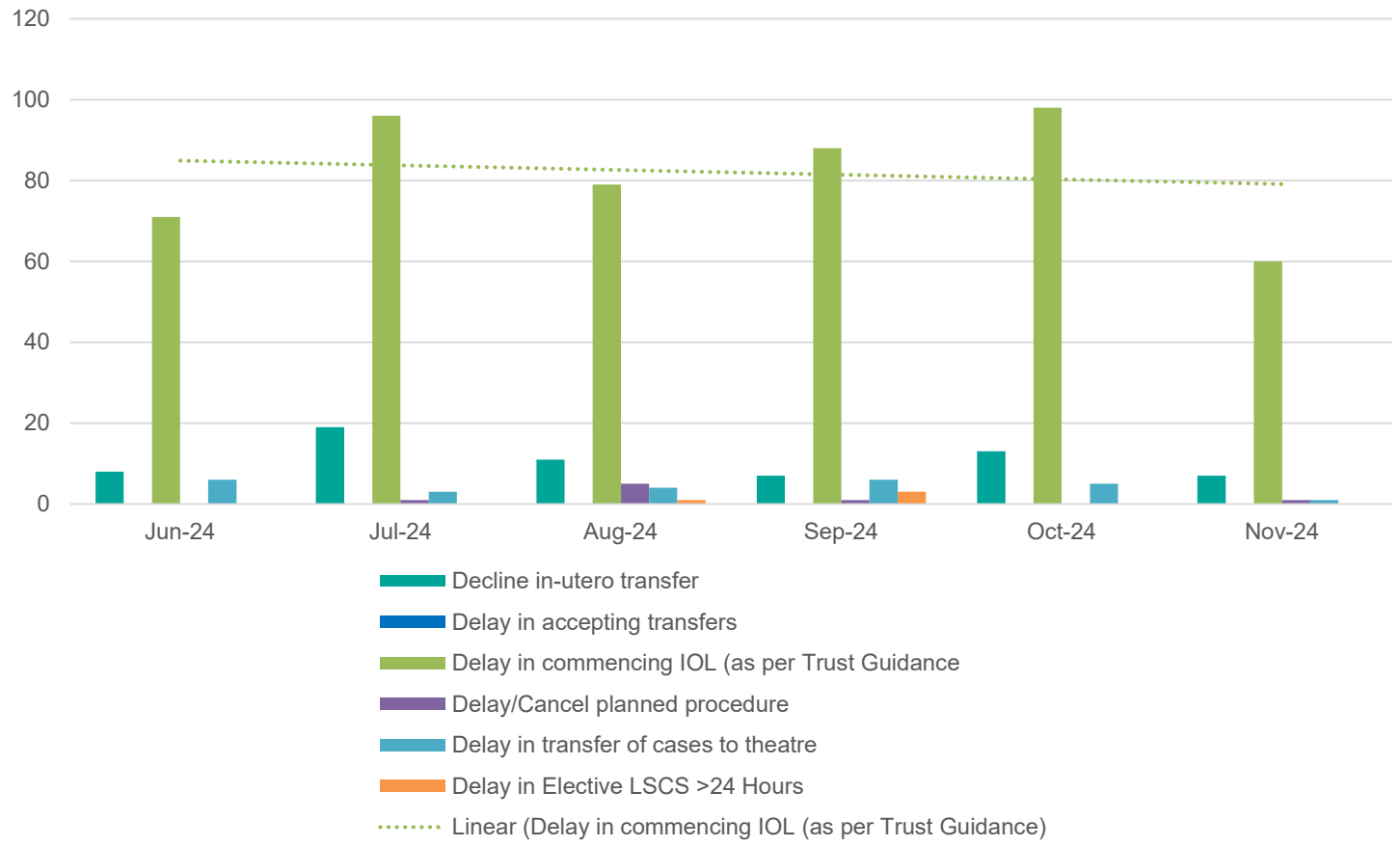
Medway NHS Foundation Trust

Clinical Actions Taken June-Nov 24



Clinical Actions Taken Jun- Nov 2024



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Birthrate Plus 4- hourly acuity tool – Red Flags

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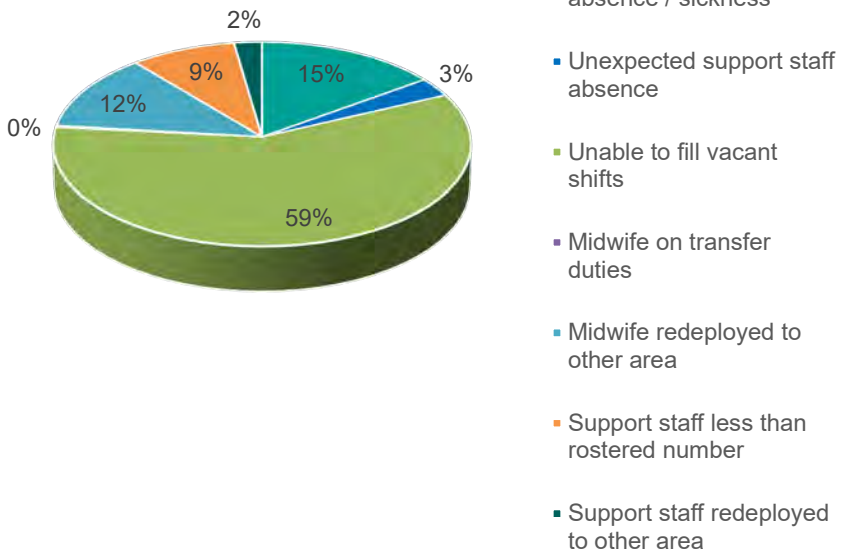
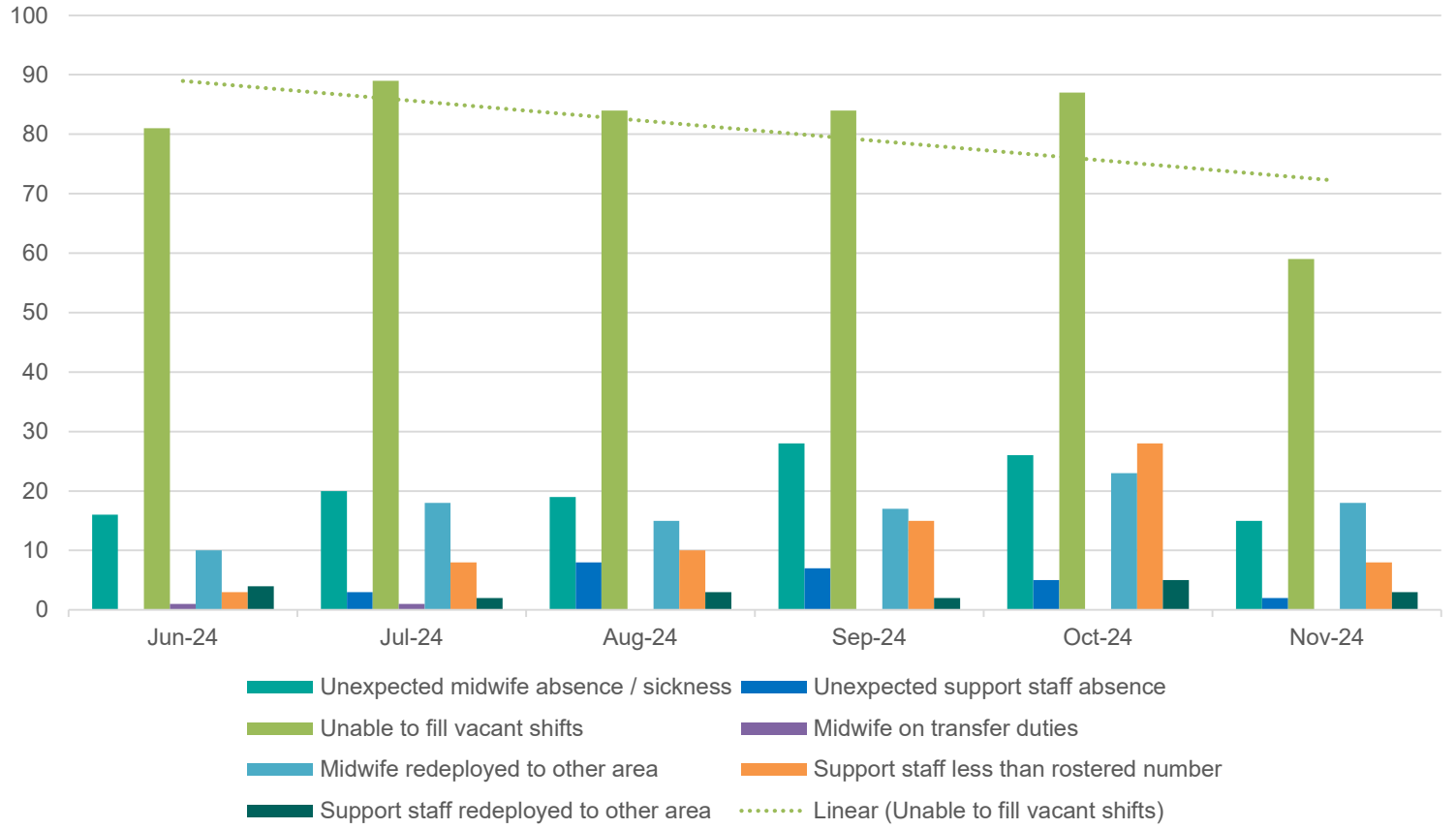
Medway NHS Foundation Trust

Staffing Factors - June - November



Staffing Factors Jun-Nov 2024



True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Medway NHS Foundation Trust

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Key Messages:

- Red flags are recorded every 4 hours by the delivery suite coordinator on the birth-rate plus acuity tool. The same red flag may be recorded multiple times per shift (eg. Delay in induction of labour).
- The pie chart shows that 66% (283) of red flags recorded from Dec 2023 to May 2024 were relating to delays in induction of labour, and that this has increased to 76% (270) for the current reporting period June to November 2024.
- 21% (76) of red flags relate to delay or cancelled time critical actives, down from 24% (104) in Dec 23-May 24.
- 3% indicated a delay between presentation and triage and 1% indicated a delay in pain relief.

Issues, Concerns & Gaps:

- Staffing factors also contribute to red flags and poor acuity with inability to fill vacant shifts accounting for 59% of staffing factors in the reporting period (down from 64% in previous period).

Actions & Improvements:

- To mitigate and resolve red flags and negative activity the coordinator records the following categories of action:
    - Staffing Actions
    - Clinical Actions
    - Management actions.
    - Details of these actions are included on the following slides.

True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

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Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- Delay in IOL accounts for 83% of clinical actions taken which aligns with the red flags raised for IOL delays across the 6 month reporting period. However, a downward trend in delays is noted. This aligns with the introduction of the revised IOL pathway and improved patient flow. This is continue to be supported by the recruitment of the Lead Midwife for IOL/Flow and phase 2 QI work on IOL.
- Decline in-utero transfer accounts for 11% (down from 13%) of clinical actions taken between June and November 2023, this is to ensure safety of patients already admitted into our maternity service.
- 65% (increased from 53%) of management actions taken were to redeploy staff across the unit, however, there is a downward trend noted in the need to redeploy staff across the unit.
- 19% saw the utilisation of the on-call midwife which is reflective of the on-call review document completed in August 2023 which calls the hospital on-call team in the first instance before the community team are called in.
- 59% of staffing factors are reported as inability to fill vacant shifts, however again there is a downward trend noted across the reporting period.

Issues, Concerns & Gaps:

- Inability to take staff breaks is recorded as 3% (reduced from 5%) of the time which is less than the reported occasions on which staff were unable to take breaks in our cultural survey and does not directly align to the breaks audit completed within the same reporting period.

Actions & Improvements:

- Breaks audit completed and actions identified, in particular PMA team to seek further staff feedback to understand blockers to taking breaks.
- Phase 2 QI work for IOL.
- Improved staffing position and positive trajectory.

True North: People
Delivery Suite Co-ordinator supernumerary status

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

	Compliance with Supernumerary status of coordinator as per CNST Guideance	Complaince with 1:1 Care in Labour as per CNST Guidance
Apr-24	100%	100%
May-24	100%	100%
Jun-24	100%	100%
Jul-24	100%	100%
Aug-24	100%	100%
Sep-24	100%	100%
Oct-24	100%	100%
Nov-24	100%	100%

Key Messages:

- Delivery suite supernumerary status is a core element of CNST Safety Action 5.
- In year 6, the requirement has changed to ensure that the coordinator is supernumerary on the rota and that the shift commences
- The twice daily bed state monitors the supernumerary status of the delivery suite co-ordinator to ensure that they have oversight of all activity within the service.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status for more than 1 hour, this is escalated to the Midwifery Manager on call
- All occasions of coordinator not supernumerary have been reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite, and therefore meet the requirements of CNST allowing the service to declare 100% compliance with supernumerary status.
- Compliance with 1:1 care in labour remains at 100%.

Issues, Concerns & Gaps:

- Back copy and data rules issues noted with maternity information system and BI which is showing scores of less than 100%.

Actions & Improvements:

- Digital midwife working with BI to ensure back copy/data exclusions eg. BBA (born before arrival) are in place for 1:1 care in labour compliance.

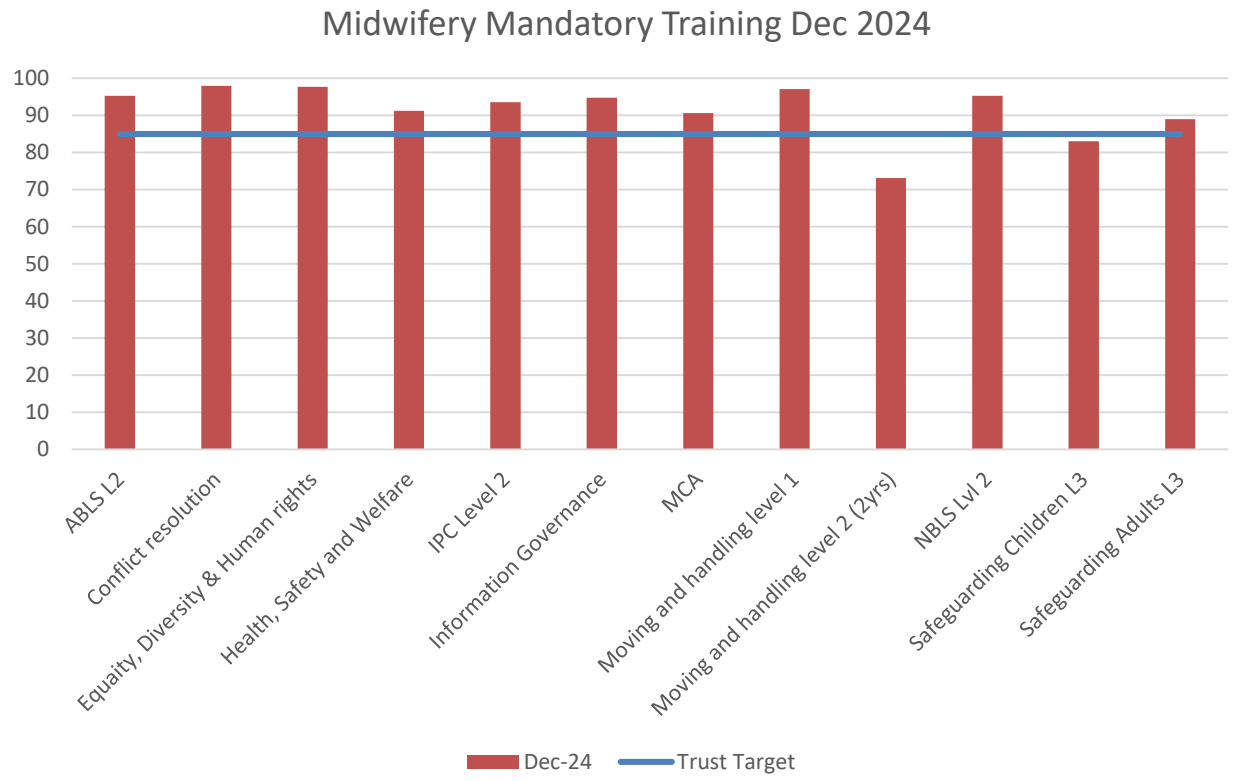
Perinatal Surveillance Tool Q3 2023/24 – Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust

PROMPT training	Sep 2024	Oct 2024	Nov 2024
Midwives	**94%**	**95%**	97%
MA & MSW	**90%**	**92%**	94%
Theatre Nurses and ODNs	**88%**	**93%**	90%
Obs Consultants	**85%**	**88%**	93%
Obs SpR/SHO	**82%**	**89%**	91%
Anaesthetic Consultant	**74%**	**82%**	91%
Aneas. SpR/SHO	**82%**	**90%**	90%

Fetal Monitoring Training and Assessment	Sep 2024	Oct 2024	Nov 2024	*Dec 2024 Booked*
Midwives	99%	97.4%	**96%**	*100%*
Obstetric Consultants	87%	93%	**94%**	*94%*
Doctors in training	100%	82%	**100%**	*100%*



Neonatal Basic Life Support Training	Sep 2024	Oct 2024	Nov 2024
Midwives	83%	**85%**	**95%**
NICU Nurses	91%	**93%**	**92%**
Neonatal Consultants	93%	**93%**	**100%**
Neonatal doctors	94%	**94%**	**100%**
ANNP	67%	**100%**	**100%**

Workforce Action Plan

Maternity Board Assurance Framework (BAF) Quality & Improvement Plan							
No	**Key lines of enquiry**	**Evidence Available**	**Gaps in Evidence/Assurance**	**Mitigating Actions /Comments**	**Action Due Date**	**Implementation Lead**	**BRAG**
Maternity Workforce Action Plan 2024/25							
The Primary focus of the Trusts and Kent and Medway LMNS is to establish a robust workforce pipleline and strategies to retain current staff.							
1	Support staff to raise concerns and have clear process of escalation to senior managers, locally and regionally.	Monthly Teams Talks by HOM/DOM Staff Engagement Sessions/Walk-abouts by Board Level Safety Champions monthly LMNS System Facilitated Listening Events	no gaps in assurance	Continue to actively seek staff feedback. Feedback and action log in place and actions to be collated monthly and added to BAF	Mar-25	Head of Midwifery	
2	Recruit to Birth-rate Plus 2023 recommendations following sucessful PID/Busines planning.			Awaiting VCP approval to advertise positions.	Sep-24	Head of Midwifery	
3	Ensure development of workforce pipeline by maintaining strong working relationships with local HEIs including Greenwich and Surrey	Lead midwife for Education partakes in monthly collaborative meetings with HEIs. HEIs attend Trust and teach on essential skills. Maximise capacity for student midwives within Trust Monthly student forum Trust Engaged in T-Levels and apprentiship scheme Support staff to undertake RN to RM shortened midwifery course	Capture student feedback onto staff feedback log.	Continue with monthly meetings and enagement sessions.	Mar-25	Lead Midwife for Education	
4	Seek feedback from staff via regular culture Surveys.			Repeat culture survey to be undertaken in September 2024	Mar-25	Inpatient Matron	
5	Promote recruitment and retention by making Medway Maternity an attractive place to work.	Monthly Engagement Sessions with HOM/DOM/Board Level Safety Champions		Support flexible working inline with Trust policy Continue to ensure staff have access to health and wellbeing support Support and strenghten leadership so staff feel "well-led" Continue to seek funding for CPD to support staff ongoing learning and development. Robust preceptorship and onboarding processes Engage with LMNS to produce recruitment video Engage with LMNS career cafes to attract potential recruits	Mar-25	Head of Midwifery	
6	Ensure labour ward coordinators are supported to develop the required skills and leadership qualities to effectively mangage labour ward.	PMA team undertaking benchmarking against National Labour Ward Coordinator Framework. Benchmarking completed and shared with LWC and LMNS. Action plan to be developed.		HOM to hold Q&A session with Coordinators	Jul-24	Head of Midwifery	

Workforce Action Plan

NHS Medway Trust

Maternity Board Assurance Framework (BAF) Quality & Improvement Plan							
No	**Key lines of enquiry**	**Evidence Available**	**Gaps in Evidence/Assurance**	**Mitigating Actions /Comments**	**Action Due Date**	**Implementation Lead**	**BRAG**
7	Ensure the service supports staff and service users from diverse backgrounds and promotes equality and equity in line with Three Year Delivery Plan.	Engaged in the LMNS Equalities and equities oversight group. Engaged with Trust Equality and diversity team EDI Midwife in post August 2024.			Sep-24	Head of Midwifery	
8	Support staff to develop their careers.	Staff supported to attend LMNS and Trust-level career cafes Aspiring leaders database maintained by Matrons to identify staff who are seeking development opportutines.			Mar-25	Head of Midwifery	
9	Demonstrate an effiective system of midwifery workforce planning to the required standard (CNST Year 6)	Bi-annual workforce reporting to Trust Board - July 2024 and Jan 2025. Monthly workforce reporting via MNSCAB.			Mar-25	Head of Midwifery	
10	Ensure the Quad leadership team demonstrate compassionate and inclusive leadership and develop a just learning culture where improvement methods can engage colleagues, patients and carers.	Quad open door sessions Monthly Engagement sessions Values based leadership A-EQUIP Model in place Enagement with Staff Survey Multi-professional learning through PROMPT, Fetal Monitoring and Mandatory Training Weekly MDT incident review meeting (CRIG) NEonatal and Maternity Collaborative Hour (MNCH)		Complete SCORE action plan SCORE survey June 2024 Quarterly reporting on progress against PCLP to MNSCAB and Trust Board Co-produce service developments using patient first methodology Support newly appointed CDs to engage with PCLP and quad	Mar-25	Quad	
11	Reduce sickness and absence across the service by management inline with Trust Policy and guidelines			Matrons to work with Senior sisters to ensure reasons for absence is recorded and staff absence is managed in line with Trust policy. Continue to review BI and local data to support Management	Mar-25	Matrons	
12	To improve the accuracy of maternity and neonatal Provider Workforce Return (PWR) to inform future workforce planning.			Engaging with LMNS workforce lead and Trust wokforce team to review data and ensure accuracy prior to external submission.	Sep-24	Head of Midwifery	

Next Steps:

- Continue to support staff development through apprenticeship schemes and RN to RM courses.
- Continue to monitor red flags and supernumerary and 1:1 care in labour.
- Continue to engage with LMNS workforce groups.
- Continue to seek staff feedback and provide staff with regular updates on outcomes following actions.
- Develop and strengthen preceptorship programme in anticipation of newly qualified starters in 2025.
- Incorporate recommendation for 25% uplift into Business Planning in 2025, PID to be completed .
- Request Board support for formal Birthrate+ establishment review in 2026 (3 yearly requirement), PID to be completed.
- Share report with Trust Board and LMNS in compliance with CNST Year 6 requirements.

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Maternity (and perinatal) Incentive Scheme – Year 6 Compliance Declaration Report

Trust Board
15 January 2025

Patient FIRST

Executive Summary

- CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025
- Maternity service declaring full compliance with all 10 Safety Actions, including previously off track Safety Action 8.
- All local and external reporting deadlines and targets met.
- All training targets met with >90% for all staff groups.
- 1 Action plan in place for Neonatal Nursing staff, presented and approved by Trust Board in September 2024, allowing us to declare compliance.
- All evidence available on shared drive and itemised list included in this report as appendix 1.
- K&M LMNS requested escalation to Trust Board for MNVP service provision:

  "At this time the ICB are unable to provide adequate MNVP Lead time to enable MNVP attendance as a quorate member at the required Trust assurance and Governance meetings as set out in year 6 CNST guidance. It had been agreed at LMNS board in July 2024 that a 0.5 band 7 MNVP system level governance lead would be recruited to fulfil this obligation. The role has been advertised, interviewed for and a suitable candidate has been identified. However, due to the recent financial restrictions placed on the ICB the role is awaiting executive sign off by Paul Bentley. All risks with not providing this much necessary resource to the MNVP have been clearly communicated throughout the LMNS and ICB and we continue to champion the need for this role."
- LMNS CNST peer review assurance visit completed 3 December 2024.
- CNST compliance report presented to MNSCAG 13 December 2024
- QAC – 9 January 2025 – noted as Appendix within MNSCAG Assurance and Escalation report
- Following approval at Trust Board 15 January 2025, DOM will ask Trust and ICB CEO to sign the declaration form that MFT are wishing to declare compliance to the CNST 10 safety standards.
- CEO signed declaration form to be submitted to NHSR by 28 February 2025.

CNST Year 6 Self-Assessment

True North	Safety Action	Description	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024
Quality	Safety Action 1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?							
Systems + Partnership	Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?							
Patients	Safety Action 3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?							
People	Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?							
People	Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?							
Quality	Safety Action 6	Can you demonstrate that you are on track to compliance with all the elements of saving Babies' Lives Care Bundle Version Three?							
Patients	Safety Action 7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users							
People	Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?							
Quality	Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?							
Quality	Safety Action 10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?							

Medway NHS Foundation Trust

CNST Year 6 Actions – Nov 2024

Completed	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice	84
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.	0
Off Track with actions to deliver	Action is off track and plans are being put in place to mitigate any delay	0
On Track	Action is on track with progress noted and on trajectory	0

Total Number of actions	84
Percentage of actions completed/on track	100%

CNST Year 6 Self-Assessment – Declaration Tool Summary Page

NHS Medway NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

True North: Quality

Safety Action 1: PMRT
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages:

- Currently meeting all reporting requirements for CNST year 6 with appropriate processes in place to maintain compliance.
- All eligible perinatal deaths reported within 1 day.
- Parents were informed of review and their perspectives sought and their questions and concerns were incorporated into the PMRT review process in 100% of eligible cases.
- 100% of reviews were commenced within 2 month of death.
- 94% (16/17) of reports were published within 6 months of death.
- All perinatal losses and actions are shared monthly with Maternity and Board level Safety Champions via MNSCAG.
- Quarterly reports have been discussed with Maternity Safety and Board level Safety champions in February, April, August and October 2024.
- Quarterly reports have been submitted to Trust Board in March, May, Sept and November 2024 with details of all losses and action plans included.

Safety action No. 1
Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Actions and Improvements:

- Share learning from PMRT cases via Maternal Compass Governance Newsletter where required. .
- Actions from PMRT reviews now incorporated into central Action Log for improved oversight and accountability.
- PMRT now added to incident spreadsheet to support thematic review in line with other incidents across the service.
- Supported across the LMNS for external obstetric cover for PMRT meetings.
- Supporting MNISA attendance at PMRT Meetings
- MNVP to join PMRT meetings once additional hours secured.
- PID for NICU bereavement lead nurse approved.

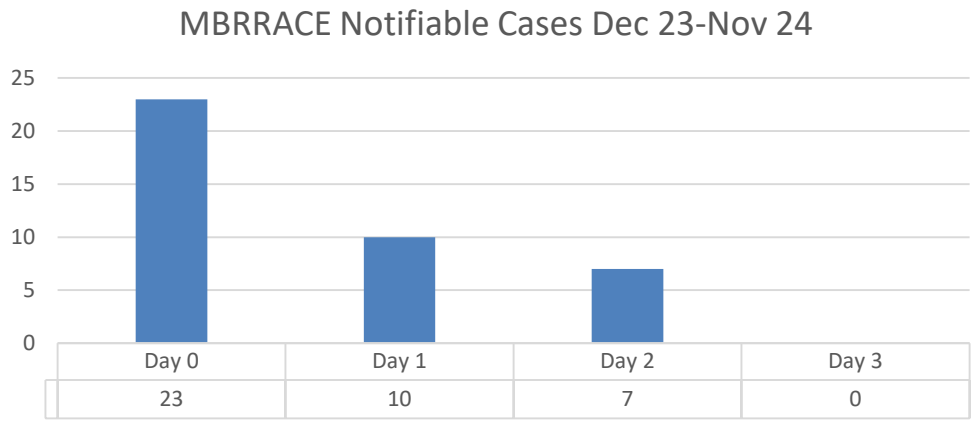
Issues, Concerns, Gaps:

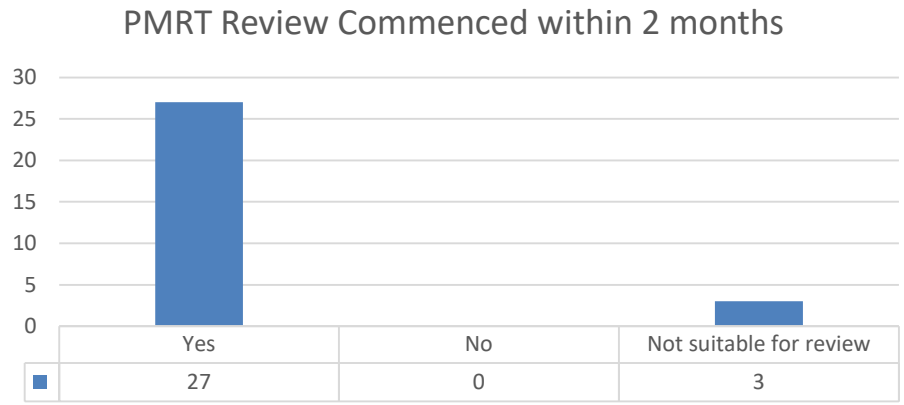
- NICU bereavement nurse post JD to be finalised before recruitment can commence.

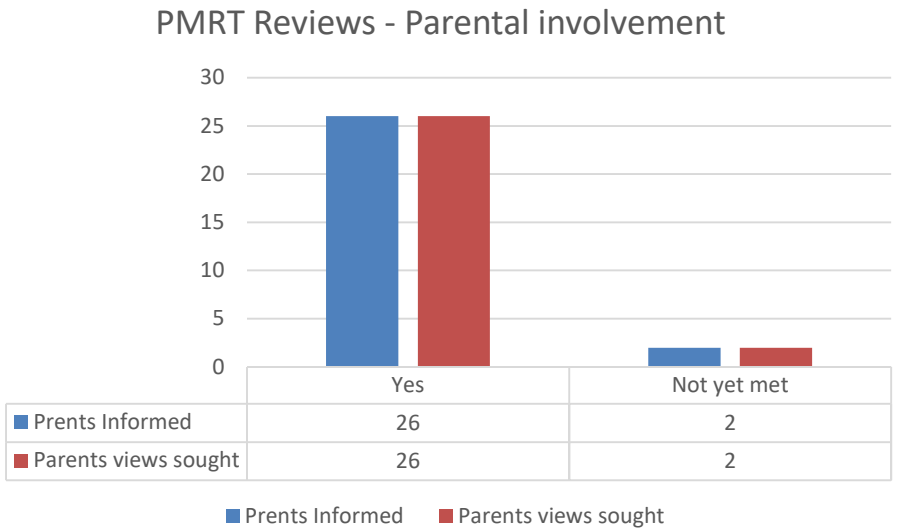
True North: Quality

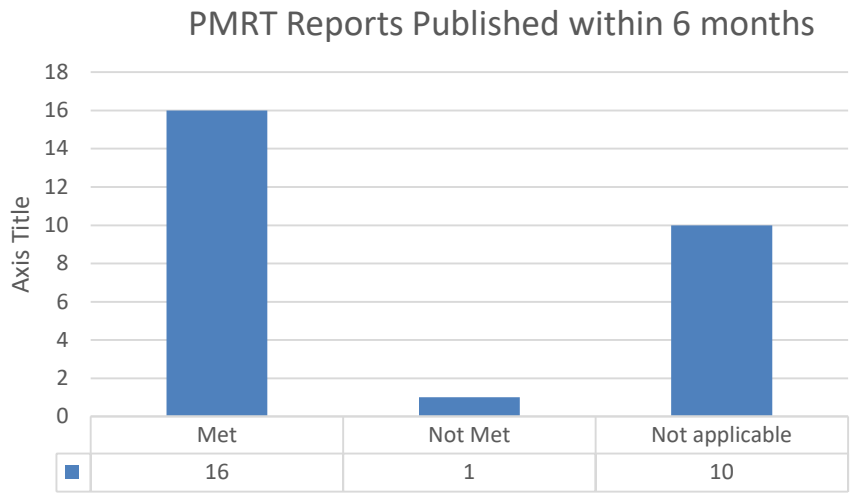
Safety Action 1: PMRT
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust





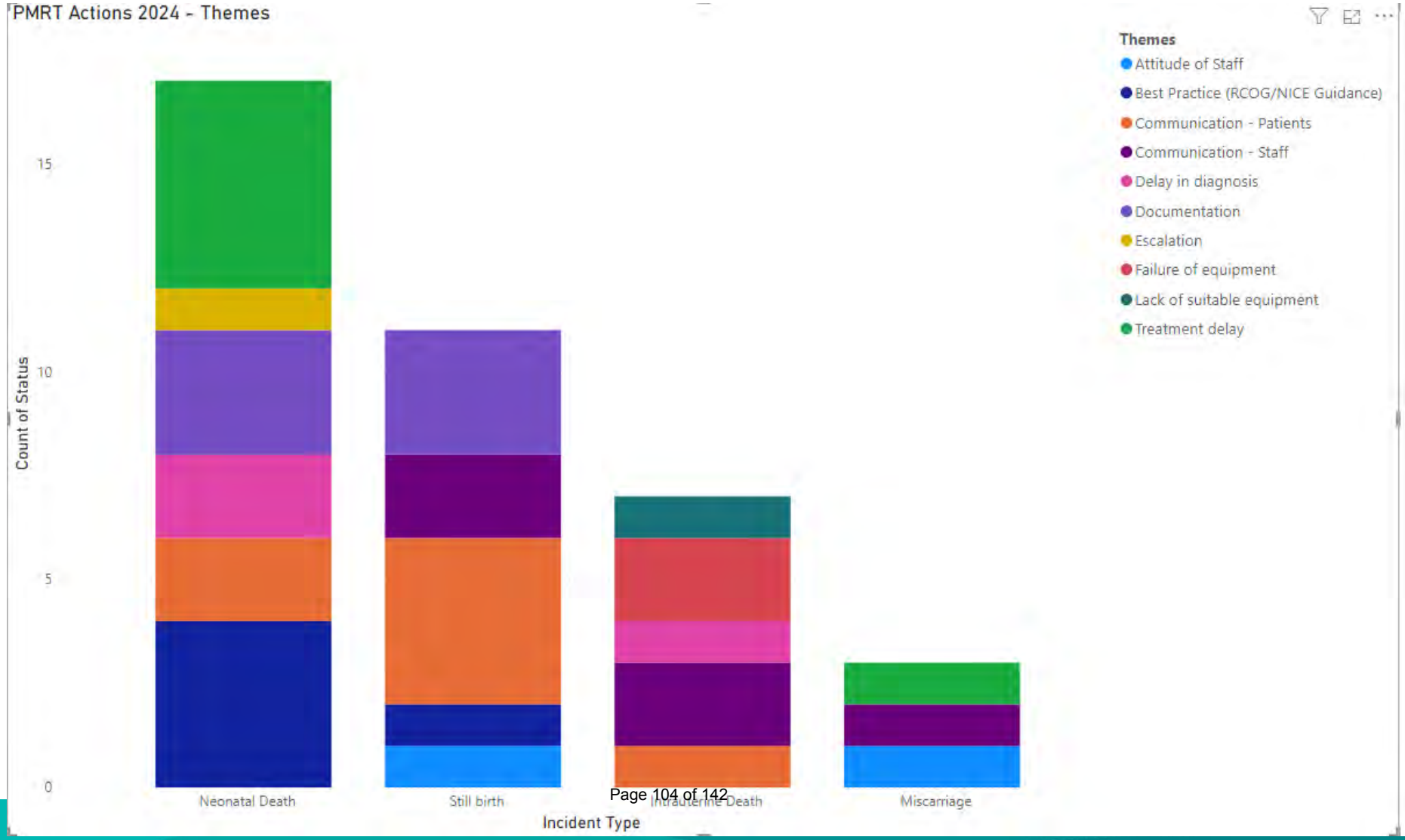




True North: Quality

Safety Action 1: PMRT
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust



True North: System & Partnership

Safety Action 2: MSDS

Ambition: Ensuring data submitted as part of Maternity System Data Set is robust and accurate

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

Safety action No. 2
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Key Messages:

- All requirements passed for July Data.

Issues, Concerns, Gaps:

- No gaps currently identified.

Actions & Improvements:

- Continue to work with provider, BI and digital midwife to improve back copy and data quality.

Safety Action 2: MSDS

Ambition: Ensuring data submitted as part of Maternity System Data Set is robust and accurate

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

Medway NHS Foundation Trust

NHS England

Organisation Name: MEDWAY NHS FOUNDATION TRUST

Reporting Period: July 2024

Notes: The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	375			Passed
CQIMDQ14	405	375	108.0		Passed
CQIMDQ15	400	400	100.0		Passed
CQIMDQ16	375	400	93.8		Passed
CQIMDQ24	375	375	100.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	245	410	59.8	Passed
CQIMDQ08	410	415	98.8	Passed
CQIMDQ09	405	375	108.0	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	405	375	108.0		Passed
CQIMDQ11	180	405	44.4		Passed
CQIMDQ12	15	405	3.7		Passed
CQIMPPH	10	405		29	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	405	375	108.0		Passed
CQIMDQ22	400	400	100.0		Passed
CQIMDQ23	375	400	93.8		Passed
CQIMPreterm	25	395		58	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	405	375	108.0		Passed
CQIMDQ15	400	400	100.0		Passed
CQIMDQ16	375	400	93.8		Passed
CQIMDQ18	230	395	58.2		Passed
CQIMDQ20	15	215	7.0		Passed
CQIMTears	15	215		60	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	405	375	108.0	Passed
CQIMDQ15	400	400	100.0	Passed
CQIMDQ16	375	400	93.8	Passed
CQIMDQ18	230	395	58.2	Passed
CQIMDQ26	395	400	98.8	Passed
CQIMDQ27	445	445	100.0	Passed
CQIMDQ28	205	445	46.1	Passed
CQIMVBAC	5	55	9.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	405	375	108.0	Passed
CQIMDQ31	410	415	98.8	Passed
CQIMDQ32	375	410	91.5	Passed
CQIMDQ33	410	415	98.8	Passed
CQIMDQ34	230	410	56.1	Passed
CQIMDQ36	405	405	100.0	Passed
CQIMDQ37	180	405	44.4	Passed
CQIMDQ38	410	415	98.8	Passed
CQIMDQ39	355	405	87.7	Passed
CQIMRobson01	10	70	14.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	40	60	66.7	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	60	65	92.3	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	445	375	118.7	Passed
CQIMDQ04	445	445	100.0	Passed
CQIMDQ05	65	445	14.6	Passed
CQIMSmokingBooking	65	445	14.6	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	405	405	100.0	Passed
CQIMSmokingDelivery	45	405	11.1	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	445	445	100.0	Passed

True North: Patients

Safety Action 3: Transitional Care and ATAIN
Ambition: Review the provision of transitional care pathway and ATAIN data to ensure admissions to NNU are unavoidable
Goal: To reduce unnecessary separation of mothers and babies

Medway NHS Foundation Trust

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Key Messages:

- Transitional Care (TC) service established since 2017.
- Neonatal team involved in decision making and care planning for all babies in TC.
- All term admissions to Neonatal Unit reviewed by an MDT including Neonatal Consultant ATAIN Lead, NICU Governance Lead, Fetal Wellbeing leads and Obstetric Lead.
- Quarterly audits ongoing.
- All findings reported via MNSCAG and shared with the LMNS via Neonatal Subgroup.
- Action plan in place for findings from ATAIN reviews
- Respiratory Distress is most common reason for admission at MFT, and 37% of these admissions were from no-labour CS. Therefore QI project focusing on reducing term admissions with revision of respiratory pathway and prenatal counselling for families underway.
- Project registered with Trust QI team. and presented to LMNS and Board Level Safety Champions in July 2024.
- Progress with the project shared with Safety Champions and LMNS in November 2024.

True North: Patients

Safety Action 3: Transitional Care and ATAIN
Ambition: Review the provision of transitional care pathway and ATAIN data to ensure admissions to NNU are unavoidable
Goal: To reduce unnecessary separation of mothers and babies

NHS Medway NHS Foundation Trust

Issues, Concerns, Gaps:

Patient information

- Lack of standardised information leaflet
- Lack of understanding– reading age, language,.
- Develop PIL reflective of MFT data collated from ATAIN audit in conjunction with the MNVP
- Incorporate RCOG national guidance

Counselling of patients

- Range of locations & level of qualifications who discuss options with patients
- Availability of information for patients to take home for further reflection
- Standardised counselling approach
- Education to all those involved in consenting patients for steroids

Timing of delivery

- Look at potential cohort of diabetic women to be delivered after 37+6
- Identify patients who deliver at 38 weeks gestation is within National & local guidance.

Actions, & Improvements:

- Respiratory pathway has been updated for all babies born after 34 weeks gestation. NICU will be auditing implementation.
- Fetal Wellbeing midwives continue to work with MNVP to complete 2nd draft of patient information leaflet for Antenatal steroids prior to planned CS
- FWB midwives have attended sessions with trainees to discuss ATAIN data

True North: People

Safety Action 4: Clinical Workforce

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

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

NHS Medway NHS Foundation Trust

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?
From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

True North: People

Safety Action 4: Clinical Workforce
Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard

NHS Medway NHS Foundation Trust

Key Messages:

The CNST criteria for employing short & long -term locum Doctors audited for 2024

- 100% compliant with RCOG guidance for short-term locums (including doctors who work exclusively on Bank)
- 100% compliant with RCOG guidance for long-term locums (RCOG guidance includes those directly engaged by Trusts for more than 2 weeks, but not on a substantive contract). All doctors on fixed term contracts have been through the appropriate employment and recruitment checks, undertake and have access to the appropriate systems and have appropriate clinical supervision.
- Ongoing compliance with compensatory rest for Consultants and Senior Specialist and Specialist doctors as reflected in obstetric rotas.
- 99% compliance with RCOG Must/Should attend guidance. Episodes when attendance has not been possible have been reviewed at the following unit level forums and actions identified, agreed and disseminated.
    - Women's Audit
    - Labour Ward Forum
    - Clinical Review Incident Group (CRIG)
- The position against RCOG Must/Should attend guidance has also been shared with:
    - Trust Board via CNST reports (September and November 2024)
    - LMNS CNST Peer Assurance Group (August and October 2024)
- NICU nursing vacancy reduced to 2.8 WTE Band 6.
- NICU QIS 67.7%
- NICU QIS action plan updated to include retention actions to support rolling programme of recruitment and training.
- Ongoing compliance with anaesthetist on-call with dedicated obstetric on-call rota.
- Ongoing compliance with BAPM requirements for neonatal medical staffing, submitted and noted by Trust Board.

Issues, Concerns & Gaps:

- NICU nursing staffing not meeting BAPM QIS standards.

Actions & Improvements

- 6 NICU nurses qualified in speciality in September 2024 with a further 6 commencing the course.
- Action plan approved by Trust Board and submitted to LMNS and ODN.

True North: People

Safety Action 4: Clinical Workforce
Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard

NHS Medway NHS Foundation Trust

Long-Term Locum Obstetric & Gynaecology Audit 2024

Doctor	Start Date	Locum doctor CV reviewed by consultant lead prior to appointment	Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	Departmental induction by consultant on commencement date	Access to all IT systems and guidelines and training completed on commencement date	Named consultant supervisor to support locum	Supernumerary clinical duties undertaken with appropriate direct supervision	Review of suitability for post and OOH working based on MDT feedback	Feedback to locum doctor and agency on performance
AK	14/03/2023	Yes	Yes	Yes	Yes	Mel Islam	Yes	Yes	Appraisal 29/12/23
PS	29/06/2023	Yes	Yes	Yes	Yes	Kandice Wong	Yes	Yes	Appraisal 07/07/2024
Psi	09/01/2023	Yes	Yes	Yes	Yes	Kandice Wong	Yes	Yes	Appraisal 19/9/2023

Short-Term Locum Obstetric & Gynaecology Audit 2024

Locum	Date substantive employment at MFT ended.	Grade worked at MFT	Short term locum passport completed	RCOG Certificate of Eligibility for Locums	Meets RCOG/CNST requirements
RM	Oct-21	Registrar	Bank	N/A	Y
MG	Aug-22	Registrar	Bank	N/A	Y
LK	Oct-19	Registrar	Bank	N/A	Y
MO	Oct-23	Registrar	Bank	N/A	Y
CA	Oct-19	Registrar	Bank	N/A	Y
CW	Oct-19	SHO	Bank	Yes	Y

True North: People

Safety Action 5: Midwifery Workforce
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

NHS Medway NHS Foundation Trust

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?
From 2 April 2024 until 30 November 2024

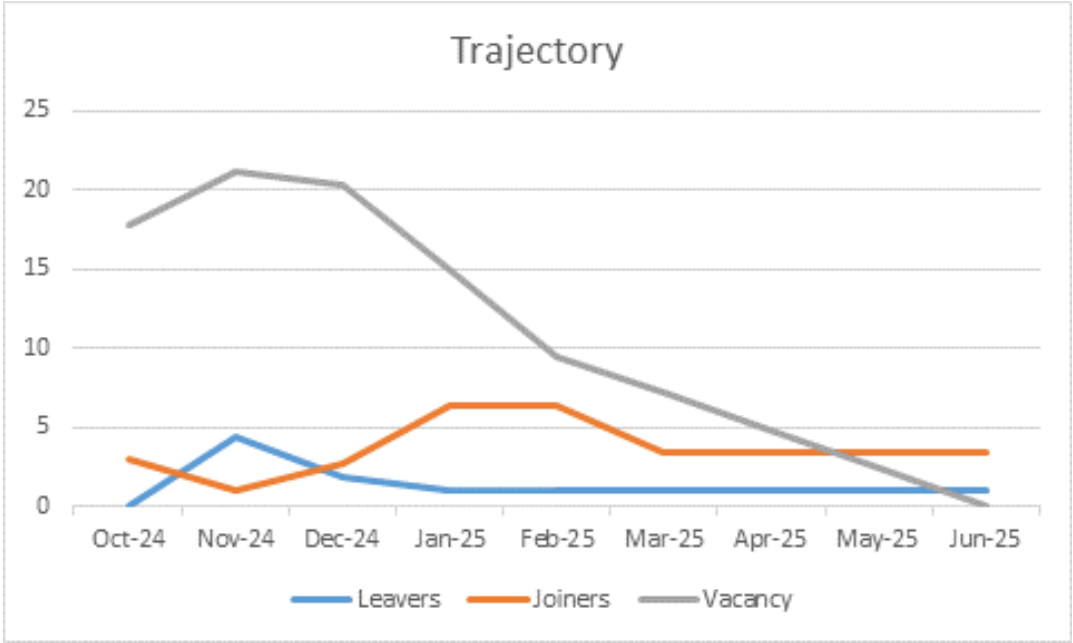
Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

True North: People

Safety Action 5: Midwifery Workforce
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Key Messages:

- Midwifery staffing oversight reports have been shared with the Trust Board Bi-Annual on an ongoing basis, with reports being shared in January and July 2024, with a further report planned for January 2025 and provided updates to the Trust Board on points required by CNST including:
  - Full Birth-rate Plus review conducted in 2023, with subsequent plans to meet the additional staffing requirements agreed by Trust Board and Executives. All positions from 2023 Birth Rate plus have now been recruited to or are in the recruitment process, including additional specialist roles.
  - Ongoing oversight of staffing levels and mitigations/action plans to improve recruitment and retention.
  - 100% compliance with Supernumerary Status of Labour Ward Coordinator at start of every shift, and throughout the shift.
  - 100% compliance with 1:1 Care in Labour.



Issues, Concerns & Gaps:

- Significant vacancy of Band 5 and 6 Midwifery Vacancy

Actions & Improvements

- Recruitment trajectory in place with graduate guarantees and current pipeline recruits set to bring staffing in line with establishment by May 2025.

CNST Year 6
Elements within Safety Action 6 - Saving Babies Lives Care Bundle 3

Medway NHS Foundation Trust

Safety action No. 6
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

CNST Year 6
Elements within Safety Action 6 - Saving Babies Lives Care Bundle 3

Medway NHS Foundation Trust

True North	Elements within Safety Action 6	Description	BRAG April 2024	BRAG May 2024	BRAG June 2024	BRAG July 2024	BRAG September 2024	BRAG October 2024	BRAG November 2024
Quality	Element 1	Reducing smoking in pregnancy							
	Element 2	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction							
	Element 3	Raising awareness of reduced fetal movement							
	Element 4	Effective fetal monitoring during labour							
	Element 5	Reducing preterm births							
	Element 6	Management of pre-existing Diabetes in Pregnancy							

Saving Babies Lives Care Bundle v. 3

Key Messages:

- LMNS validated and assessed 94% overall compliance across the 6 elements, with 3 elements now at 100% for Quarter 5.
- 3 quarterly QI meetings held within CNST Year 6 period to meet requirements.
  - LMNS confirmed sufficient progress made to implement bundle, with increase from 37% in Q1 to 94% in Quarter 5.
  - Stretch targets agreed with LMNS across the elements already achieving full compliance to original outcome measures to drive continued improvement.
  - Action plan in place to achieve 100% for all elements including QI projects to support service user engagement with stop smoking services and improving the diabetes MDT team.
  - SIP midwife, Pre-term leads and Fetal Wellbeing team all presented at LMNS learning and sharing forum to share continuous learning with the ICB and neighbouring Trusts.
- Focus on QI across all elements, with evidence of QI work to be included in submission for Q2 2024/25

Issues, Concerns & Gaps

- Quit date targets for element 1 remain challenging across the LMNS.
- Consistent use of Partosure.
- Not achieving compliance across all elements of pre-term optimisation in element 5
- Diabetic nurse and dietician not in post.

Actions & Improvements:

- Funding for diabetic nurse and dietician approved from CNST Monies at TIG in October. Expressions of interest sought from existing workforce – dietician interested in fixed term contract and member of midwifery staff dual qualifying as diabetic nurse in January – potential to offer diabetic nurse hours.
- “Think Partosure First” campaign in place to improve use of partosure for threatened pre-term birth.
- National Smoke-Free Pregnancy Incentive Scheme to be offered to service users alongside existing offer to support engagement and achieving smoke-free during pregnancy and post-partum. SIP midwife working with IG and Governance team to support roll-out.
- Audit of 35-36 week scan and evaluation of 39-40 week scan on FGR pathway.
- Audit of pregnancies at risk of placental insufficiency.
- Midwifery-led parent events planned for 2025 to support evaluation of preterm clinic services and develop improvements.
- Introduce parents paddles for high-risk families.
- Additional education for maternity staffing from preterm leads.
- Preterm and Fetal Medicine QI and audit activity to be shared at Women’s audit twice yearly.
- Using audits to drive improvement on the pre-term optimisation pathway including risk assessment and wholistic review.
- Collaborative working with neonatal colleagues to support preterm optimisation pathway and post-natal risk assessment.
- Working with LMNS to identify training gaps across region, including agency staff.
- Introduction of GTT at home to support testing for GDM.

True North: Patients

Safety Action 7: Maternity & Neonatal Voices Partnership (MNVP)

Ambition Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

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

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	Yes
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

True North: Patients

NHS Medway NHS Foundation Trust

Safety Action 7: Maternity & Neonatal Voices Partnership (MNVP)

Ambition Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

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

Key Messages:

- MNVP has engaged with local community groups and charities throughout CNST Year 6, prioritising hearing from those experiencing the worst outcomes. Engagement work has included:
    - Coffee morning with BAME service users, supported by the PE & EDI Midwife
    - Service user feedback meetings with PE & EDI midwife
    - Engagement work with Roma Community including visiting communities with specialist health visitor.
    - Service user engagement event with a focus on consent, communication, postnatal care and mental health.
    - Ongoing social media campaigns for feedback.
    - Work with service users to improve pathways, with direct line of communication to DOM/ADOM.
    - Supporting service users to join stakeholder panels at interviews.
    - Supporting clinical staff with benchmarking and developing subsequent action plans including work on neurodiversity and birth-trauma.
- MNVP is a listed member (non-voting) of MNSCAG which includes engagement with Safety Champions (front-line and Board Level), discussion of safety and incidents, workforce, PMRT, audit and compliance.
- MFT is committed to making the MNVP lead a quorate members of all meetings as outlined by CNST Year 6 requirements once the additional hours/post is in place to support this activity.
- Action plan from the 2023 Picker CQC Maternity survey, including free-text, was co-produced with the MNVP lead in December 2023 and progress against the plan was shared via MNSCAG and Maternity and Board Level Safety Champions as well as with the LMNS

Issues, Concerns, Gaps:

- MNVP Governance lead post has been recruited to but process paused due to financial restrictions. Awaiting approval.

Actions & Improvements:

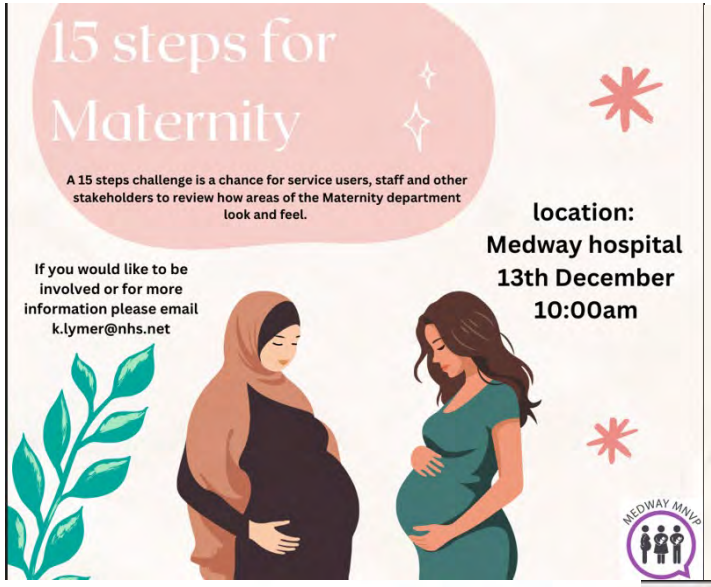
- Co-production and engagement work continues and is embedded in practice across Maternity & Neonatal Services .
- 15 Steps Challenge to be held in December 2024.
- Finalise 2022/2023 Picker CQC Action plan presented to LMNS executive group in line with CNST requirements.
- Picker CQC Maternity Survey now out of embargo. Meeting arranged to review with MNVP and key stakeholders and co-produce action plan.

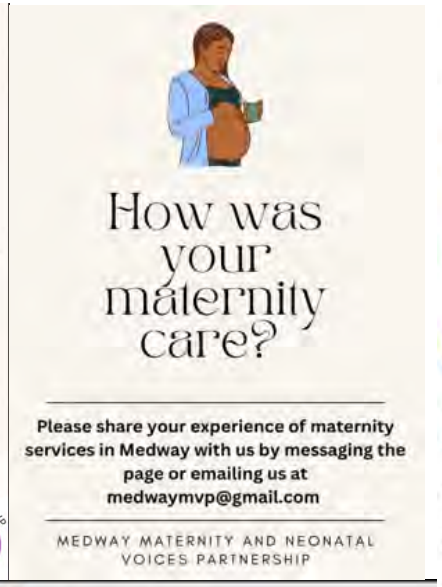
True North: Patients

Safety Action 7: Maternity & Neonatal Voices Partnership (MNVP)

Ambition Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

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





True North: People

Safety action No. 8
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

True North: People

NHS Medway NHS Foundation Trust

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

Key Messages: Complete

- >90% compliance for all staff groups including new starters from July 2024 for all required training
  - PROMPT
  - CTG
  - NBLS
- All neonatal medical staff are trained to the minimum required NLS training The British Association of Perinatal Medicine Neonatal Airway Safety Standard. As a level 3 until, this is covered in doctors induction, therefore currently 100% compliant with this requirement.

Issues, Concerns, Gaps:

- NLS extended course compliance figures not centrally available.
- Over-reliance on November training dates to achieve compliance with PROMPT and CTG training.

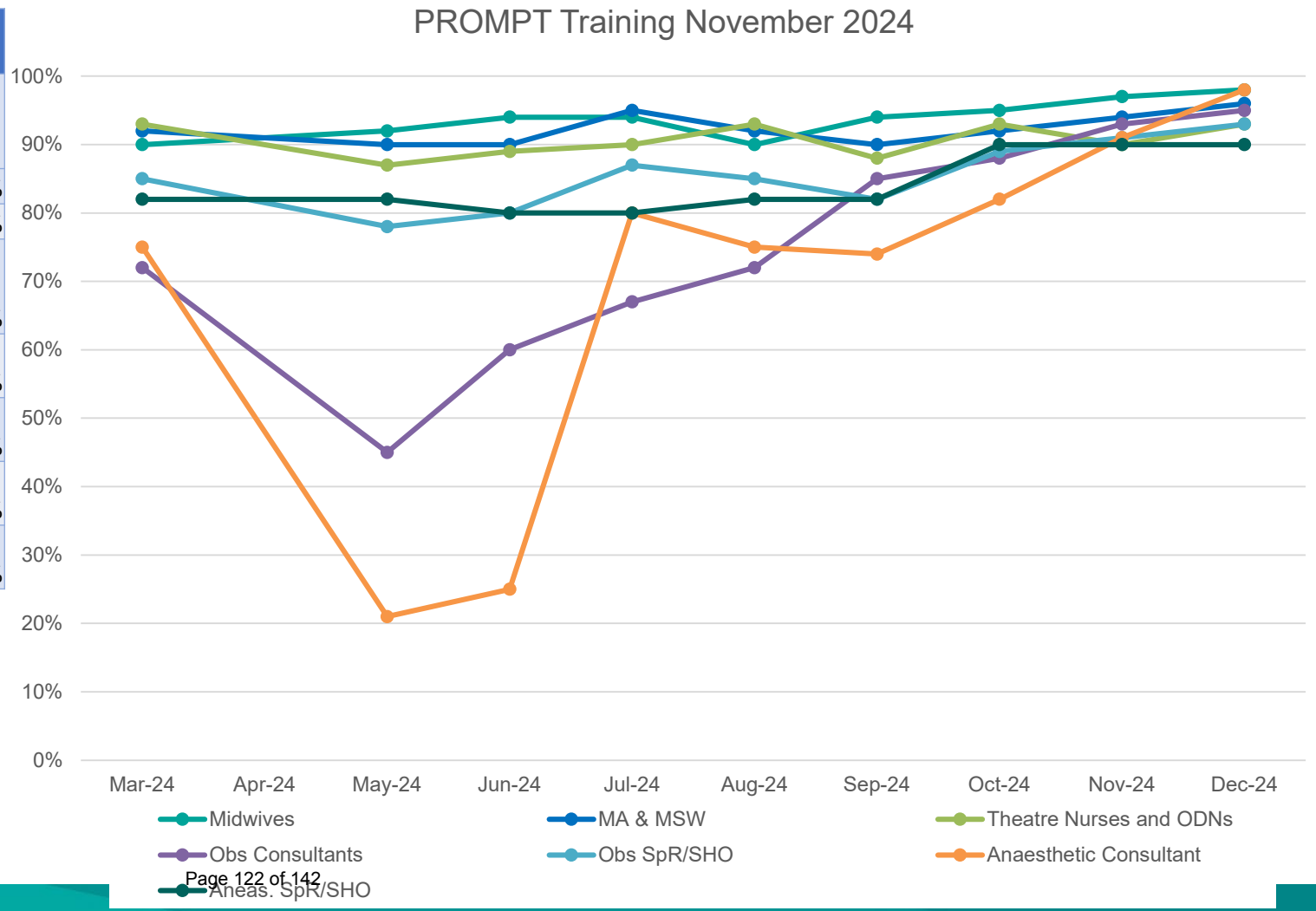
Actions & Improvements:

- Managerial oversight of all training spreadsheets and trajectories to reduce risk of cancellations impacting compliance close to submission.
- Continue to work with service managers to ensure all staff are allocated to training and appropriate study leave/cover is arranged for medical staff.
- Work with neonatal team to ensure advanced NLS course training dates are accessible centrally.
- Consider adding Fetal monitoring Training to ESR to support compliance.
-

True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

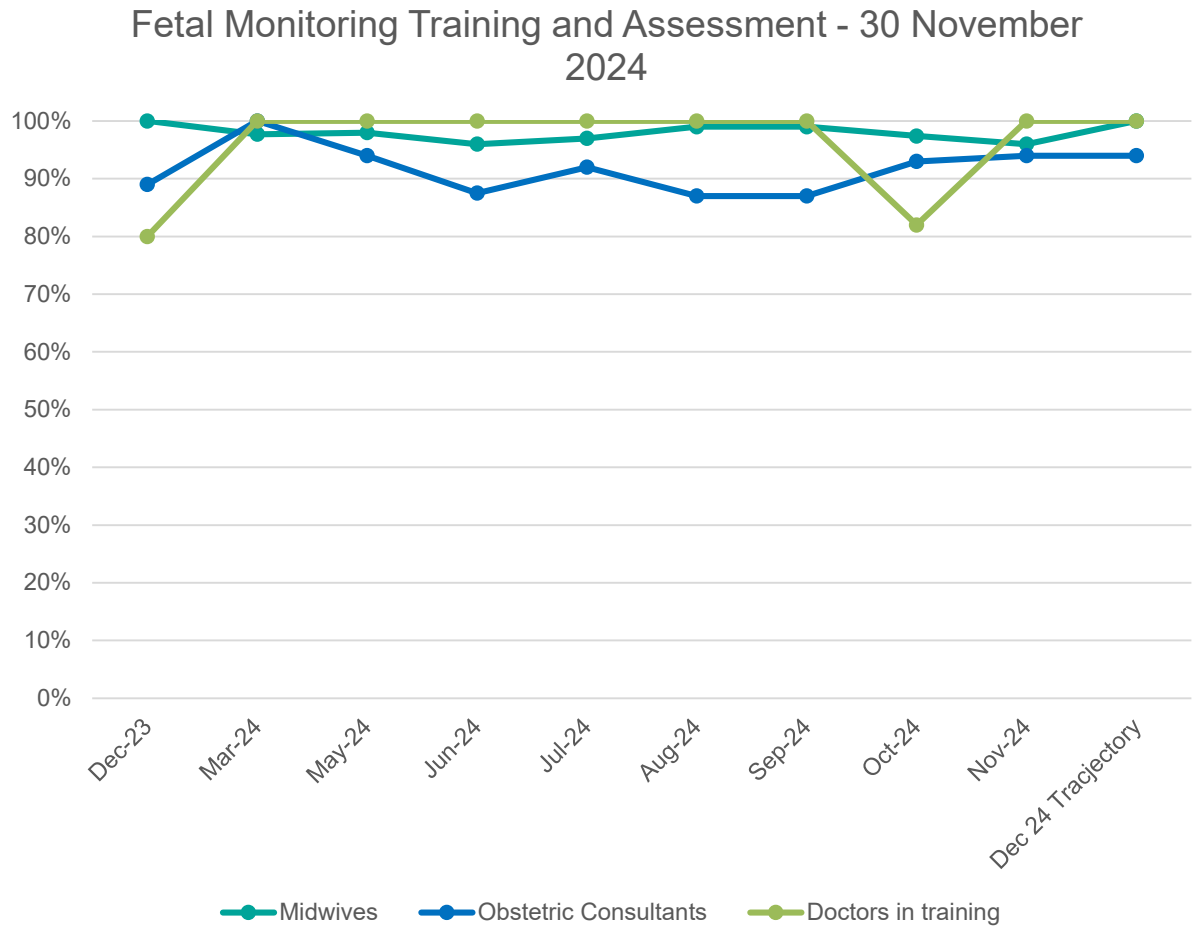
PROMPT training	March 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024
Midwives	90%	92%	94%	94%	**90%**	**94%**	**95%**	97%
MA & MSW	92%	90%	90%	95%	**92%**	**90%**	**92%**	94%
Theatre Nurses and ODNs	93%	87%	89%	90%	**93%**	**88%**	**93%**	90%
Obs Consultants	72%	45%	60%	67%	**72%**	**85%**	**88%**	93%
Obs SpR/SHO	85%	78%	80%	87%	**85%**	**82%**	**89%**	91%
Anaesthetic Consultant	75%	21%	25%	80%	**75%**	**74%**	**82%**	91%
Aneas. SpR/SHO	82%	82%	80%	80%	**82%**	**82%**	**90%**	90%



True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

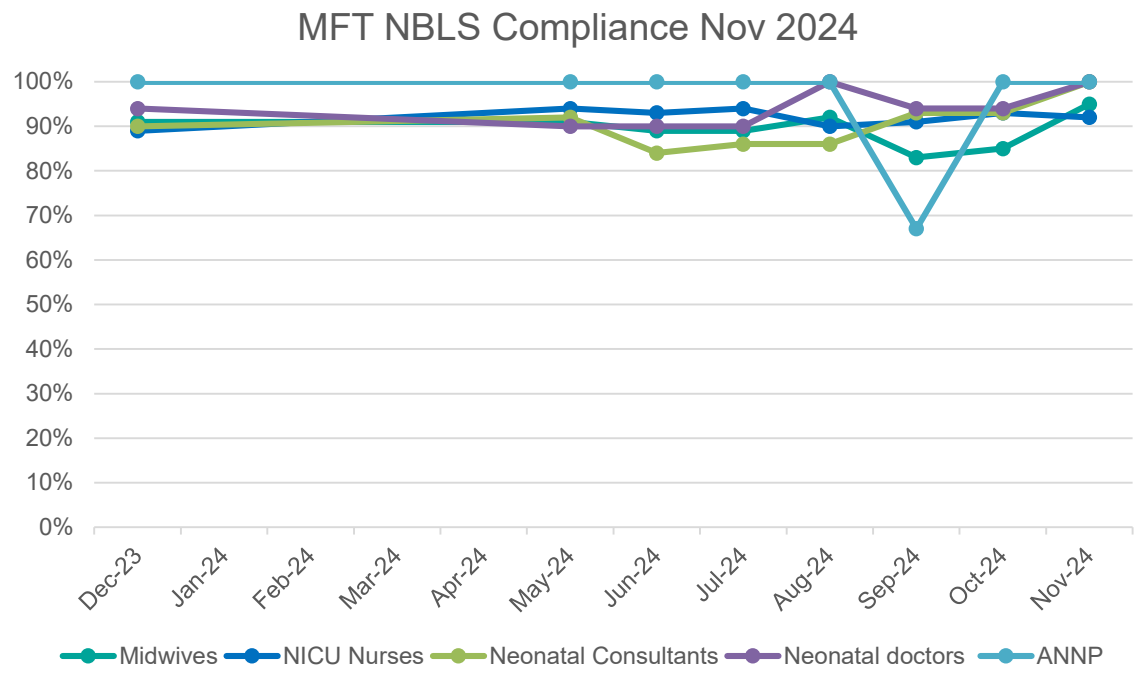
Fetal Monitoring Training and Assessment	Dec 2023	March 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	*Dec 2024 Booked*
Midwives	100%	97.7%	98%	96%	97%	99%	99%	97.4%	**96%**	*100%*
Obstetric Consultants	89%	100%	94%	87.5%	92%	87%	87%	93%	**94%**	*94%*
Doctors in training	80%	100%	100%	100%	100%	100%	100%	82%	**100%**	*100%*



True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

Neonatal Basic Life Support Training								
	Dec 2023	**May 2024**	**June 2024**	**July 2024**	**Aug 24**	**Sep 2024**	**Oct 2024**	**Nov 2024**
Midwives	91%	91%	89%	89%	92%	83%	**85%**	**95%**
NICU Nurses	89%	94%	93%	94%	90%	91%	**93%**	**92%**
Neonatal Consultants	90%	92%	84%	86%	86%	93%	**93%**	**100%**
Neonatal doctors	94%	90%	90%	90%	100%	94%	**94%**	**100%**
ANNP	100%	100%	100%	100%	100%	67%	**100%**	**100%**



True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

Total Staff	26
Compliant	24
Non-Compliant	2
%	92.31%

- **92.3% of Neonatal Medical Staff** (including ANNP covering neonatal registrar rota) are trained to the Advanced Certified NLS course.
- CNST does not require compliance with this standard for CNST Year 6, but requires Trusts have a plan to achieve this in year 7.
- All doctors rotating through or employed by the Trust have NLS as it is a training requirement as part of the RCPCH requirements for training doctors so no further action plan will be required to maintain this standard for CNST Year 7.
- 4 yearly advanced/certified NLS course is currently mapped to ST3 and above as part of Trust offer of certified course, along with QIS trained nurses and senior midwives/community midwives.

- QIS trained nurses are currently at 79% with a trajectory to achieve 93% at next NLS course in February 2025.
- As nursing staff achieve their QIS qualification they will be booked onto next NLS course to maintain high-levels of compliance for nursing staff.
- Local neonatal resus guidelines dictate first responder for required based on clinical picture:

1a Attendance at delivery- first attender is SHO supported by registrar as needed :

Emergency caesarean section for fetal distress (i.e. not solely maternal indications)
Instrumental deliveries for foetal distress, but not lift-outs
Breech deliveries
Premature deliveries (>32 weeks) and severe IUGR
Meconium stained liquor
SHO's who have not had experience in neonatal resuscitation will be accompanied by the registrar initially

1b Attendance at delivery- first attender is SHO and registrar together:

Deliveries of babies ≤32 weeks gestation
Deliveries where problems with resuscitation are anticipated as indicated by antenatal findings and agreed obstetric/ midwifery/ neonatal antenatal management plan

1c Attendance at delivery- full neonatal resuscitation team:

Preterm deliveries ≤ 30 weeks
Severe APH and cord prolapse
Shoulder dystocia
Multiple preterm births <34 weeks

True North: Quality

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Ambition: To provide assurance to the Board on maternity and neonatal safety and quality issues.

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

NHS Medway NHS Foundation Trust

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

True North: Quality

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Ambition: To provide assurance to the Board on maternity and neonatal safety and quality issues.

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

NHS Medway NHS Foundation Trust

Key Messages:

- The Trust has embedded the perinatal quality surveillance model (PQSM) with monthly reporting via MNSCAG and to every Trust Board.
- Detailed quarterly PQSM report to Trust Board to identify themes, trends and actions.
- Concerns raised by staff, service users and safety intelligence are reflected through MNSCAG and up to Trust Board
- The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.
- A Non-executive director (NED) is working with the Board safety champion and complete monthly staff engagement sessions (face to face and virtual)
- The Trust Claims scorecard is triangulated against incidents and complaints and this is reported via MNSCAG and onwards to Trust Board on a quarterly basis.
- SCORE Survey Completed and action plan in place with plans for local re-survey in Winter 2024 (delayed so as not to overlap with national Staff survey)
- Quad attended Perinatal Leadership Programme and quarterly reporting in place to MNSCAG and onwards to Trust Board.
- All required elements of SA9 minuted by Trust Board in September 2024 meeting.

Issues, Gaps & Concerns:

- Awaiting relaunch of Frontline Safety Champions.
- 4 Actions outstanding from 2023 SCORE Survey

Actions & Improvements :

- PQSM report to be presented to Divisional Board monthly.
- Trust IQPR data now reflects PSIRF categories.
- IQPR slides contain all PQSM information for Trust Board under appropriate headings and are supported by quarterly reports.
- Repeat SCORE survey in Winter 2024 for both maternity, neonatal and paediatrics.
- To continue to engage with the LMNS for regional shared learning via Quality Performance meeting and ensure reflective learning within MFT from other Trusts identified concerns/issues.
- Strong working relationships with Board Level Safety Champions, supportive in escalating risks and provide supportive challenge.
- Safety Champion SOP updated and information pack for Safety Champions Updated. Re-launch planned for Winter 2024.
- Claims triangulation report deep diving into ethnicity and aligning to Trust level investigation for each claim to support understanding and targeted work.
- Huddle Boards now in place to support “you said, we did” information for all staff, alongside established Teams Talks and Friday News (now Maternity Matters).
- DOM working with NED to strive for outstanding.
- Update Perinatal Surveillance Tool SOP required to reflect updated Trust reporting/governance structures.

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting
Ambition: Ensure all eligible cases are investigated to the highest standard and receive appropriate external review.
Goal: Ensure all eligible cases are reported to Maternity and Neonatal Safety Investigation (MNSI) and NHSR's Early notification scheme.

NHS Medway NHS Foundation Trust

Safety action No. 10
Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Key Messages:

- All eligible cases reported to MNSI and NHSR EN as required from 8 December 2024 to 30 November 2024.
- 100% of families received information regarding the role of MNSI and NHSR EN.
- 100% of cases had appropriate DOC.
- Trust Board have oversight of all MNSI cases via the monthly IQPR slides and quarterly PQSM report along with outcomes, learning and actions.
- 100% of cases had the appropriate field on claims wizard completed.
- All relevant information required to be presented to Trust Board is included in the next slide and this will be presented to Trust Board in January 2024.

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting

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

NHS Medway NHS Foundation Trust

HSIB & Early Resolution Form Database

Ref No	Date of incident	NHS ER Date Sent	MNSI Notified Date	MNSI Number	Family Information leaflet given	DoC	Verbal Duty of Candour
144899	28/11/2023	29/11/2023	29/11/2023	MI-036546	29/11/2023	Y	29/11/2023
146456	22/12/2023	28/12/2023	28/12/2023	MI-036662	27/12/2023	Y	29/11/2023
178586	15/01/2024	16/01/2024	16/01/2024	MI-036733	16/01/2024	Y	16/01/2024
148033	28/01/2024	29/01/2024	29/01/2024	MI-036768	30/01/2024	Y	30/01/2024
148740	12/02/2024	N/A	16/02/2024	MI-036836	13/02/2024	Y	13/02/2024
149374	02/02/2024	27/02/2024	04/03/2024	MI-036885	28/02/2024	Y	28/02/2024
153499	04/06/2024	01/07/2024	20/06/2024	MI-036545	05/06/2024	Y	05/06/2024
155039	14/07/2024	16/07/2024	15/07/2024	MI-037645	15/07/2024	Y	14/07/2024
155946	06/08/2024	14/08/2024	14/08/2024	MI-037938	07/08/2024	Y	07/08/2024

Next Steps

- Request Board approval for MFT CEO to sign declaration form.
- Request sign-off from ICB CEO.
- Submit completed declaration form to NHSR by 28 February 2025.

Safety Action 1

Element	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?		
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	MBRRACE Compliance Report	01. MBRRACE Compliance Report 28.11.24
			02. MBRRACE Compliance Report 30.09.24
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?		03. MBRRACE Compliance Slide November 2024
3	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?		
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.		
5	Were 60% of the reports published within 6 months of death?		
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	Quarterly Perinatal Surveillance Reports	Feb/March, April/May, Aug/Sept,
		Trust Board Papers	Jan, March, May, July, Sep, Nov 2024
		Monthly IQPR Slides	Jan-Oct 2024
		MNSCAG Papers	Jan - Nov 2024
		MNSCAG TOR	MNSCAG TOR Approved at QPSCC
		PMRT Action Plan	Dec 2023- November 2024

Safety Action 2

Element	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? Final data for July 2024 will be published during October 2024.	Safety Action 2	01. July 2024 NHSE Scorecard MFT 02. MNSCAG Papers Oct 2024
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)		

Safety Action 3

Element	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? **Evidence should include:** - Neonatal involvement in care planning - Admission criteria meets a minimum of at least one element of HRG XA04 - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards. - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	TC Guidelines	01. Admission of Infants to Transistional Care Guideline CYP-GUD-75 02. Advice for parents with a baby in Transitional Care
	Or Is there an action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.			
3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	ATAIN QI Project	01. 2024.07 ATAIN QI Project Registration Form 02. 2024.07 Refistered QI project local audit ref 2425_102
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	ATAIN Quarterly Reports	03. 2024.07.11 QIP ATAIN project, - presentation to LMNS 03.a 2024.07.11 CNST Peer Assurance Notes - Presnting QI project to LMNS 04. ATAIN Q6 presentation to Safety champs and LMNS 05. 2024.11.08 MNSCAG Minutes 06. CNST Peer Assurance Meeting 11.07.24 07. LMNS ATAIN QUIP Update 21.11.24

Safety Action 4

Element	Can you demonstrate an effective system of clinical workforce planning to the required standard?		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas			
4.1	Locum currently works in their unit on the tier 2 or 3 rota?	Locum Audit	01. MNSCAG Collated Papers 02.2 2024.10 CNST Short-Term Locum 04. Temporary Staffing Process 05. Recruitment and Secection policy 06. Recruitment process and kpis for non-training medical grade recruitment excluding consultants 07. Medway NHS Foundation Trust - Blank Compliance Form Sept 2020
4.2	OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)?		
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?		
Has the Trust ensured that the following criteria are met for employing long-term locum doctors in Obstetrics and Gynaecology.			
4.4	Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Locum Audit	03. 2024.10 CNST Year 6 Long-term locum audit 05. Recruitment and Secection policy 06. Recruitment process and kpis for non-training medical grade recruitment
RCOG compensatory rest (not reportable in MIS year 6)			
4.5	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Safety Action 4	On Call policy including compensatorary rest
4.6	OR Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?		
Consulant Attendance			
4.7	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?	RCOG Consultant Attendance Audit	01. Jan -June Consultant attendance Audit 02. 2024.08.09 MNSCAG Collated papers 02a. Labour Ward forum Agenda 15.08.24 03. 2024.08.11 Women's Group Audit Agenda 04. Consultant attendance audit June-Sept 05. Manternity CNST compliance update report for Trust Board 13 November 2024 05.a MAternity CNST Compliane report for Board 13 November 2024 (coversheet) 06. MNSCAG Papers OCt 2024 07. Labour Ward Forum Agenda 22.10.24 08. Consulant attendance audit - June to Sep - Email to Labour Ward Lead 08. Trust Board papers Public - nov 2024 09. Trust board papers- appendicies - Nov 24 11. 2024.10.04 MNSCAG Minutes 12a.Trust Board papesr Sept
4.8	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?		
4.9	Do you have evidence that the Trust position with the above has been shared with Trust Board?		
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?		
4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?		
Anaesthetic Workforce			
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Anaesthetic Rota	01. Anaesthetic Rota - Obs on Call 01.04.24-30.09.24 02. Anaesthetic Elective Rota - 01.04.23030.09.24 03. Anaesthethic oncall rota - Oct-Nov 2024
Neonatal Medical Workforce			
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Neonatal Workforce	01. Trust Board paers Nov 24 02. Trust Board papers - Sep 24 03. Trust Board papers - appendicies Sept 24 06. 2023.08.09 MNSCAG collated papers (127-133)
4.14	Is this formally recorded in Trust Board minutes?		
4.15	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.		

4.16	Was the above action plan shared with the LMNS?		
4.17	Was the above action plan shared with the ODN?		
Neonatal Nursing Workforce			
4.18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Neonatal Workforce	01. Trust Board paers Nov 24 02. Trust Board papers - Sep 24 03. Trust Board papers - appendicies Sept 24 04. NICU Nursing Action plan to LMNS and ODN 04a. Reciept of NICU Nursing Action plan 05. NICU Nursing Action Plan 06. 2023.08.09 MNSCAG collated papers (127-133
4.19	Is this formally recorded in Trust Board minutes?		
4.2	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.		
4.21	Was the above action plan shared with the LMNS?		
4.22	Was the above action plan shared with the ODN?		

Safety Action 5

Element	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?		
5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Bi-Annual Maternity Workforce Papers	01. Maternity workforce coversheet 02. Maternity workforce report May 204-Jul 2024 03. Trust Board papers - July 04. Trust Board papers - appendicies July 2024 05. Public Trust Board meetings papers - Sept 2024 06. 2024.07.30 CNST Peer Assruance Meeting
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.	Safety Action 5	01. Medaway NHS Birthrate Plus Report July 2023
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Safety Action 5	(Folder) Bi-Annual Mternity Workforce Papers (Folder) Monthly Workforce reports
5.4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift.	Safety Action 5	03. Bedstate Audit Presentation July-Sep 2024
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Safety Action 5	02. ANON one to one augSeptOct2024
5.6	A plan is in place for mitigation/escalation to cover any shortfalls in the two points above.	N/A	

Safety Action 6

Element	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
6.1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Implementation Tool	Implementation tool - March 2023-October 2024
		MNSCAG Papers	MNSCAG Papers includign SBL update - Jan 2024-Nov 24
		Trust Board Papers	Trust Board papers, inlcuding CNST/SBL updates from Jan-Nov 2024
		LMNS Review Meetings	MFT/LMNS review meetings - Q3, Q4, Q5, Q6 2024
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.	LMNS Review Meetings	MFT/LMNS review meetings - Q3, Q4, Q5, Q6 2024
6.3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.		
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.		
6.5	Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?		
6.6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	LMNS Learning and Sharing Forums	01. Learning and Sharing Meeting notes 10.10.24 02. QI Pre term lead midwife role - Oct 2024- LMNS presentation 03. Quality Safety Learning and Sharing Fourm QI SBL 08.08.24 03. 2024.08 LMNS Presentation (SIP) 04. maternity Matters 5 Aug 2024 06. Learning and Sharing Fourm Nov 2024 07. Making Audit Count Presentation

Safety Action 7

Element	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.		
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	MNVP Service User Engagement	01. Minutes and agendas from service user meetings . 02. Social media posts and posters
		MNVP JDs	01. MNVP Lead new job Spec 02. MNSCAG workplan revised July 2024 02. MNVP Proposal final sent 04. MNP Governance lead JD 05. MNVP Workplan Presentation 06. MNVP Work plan reviews - Sept 2024 07. MNSCAG TOR# 08. 2024.06.12 MFT Meetings for MNVP
		MNVP Meetings	MNVP Meeting minutes and TOR
		MNVP updates to MNSCAG	MNSCAG papers and minutes detailing MNVP updates
		Co-production charter	MNVP co-production charter presentation and postetr
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), such as: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	MNVP JDs	01. MNVP Lead new job Spec 02. MNSCAG workplan revised July 2024 02. MNVP Proposal final sent 04. MNP Governance lead JD 05. MNVP Workplan Presentation 06. MNVP Work plan reviews - Sept 2024 07. MNSCAG TOR# 08. 2024.06.12 MFT Meetings for MNVP
7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	MNVP JDs	01. MNVP Lead new job Spec 02. MNSCAG workplan revised July 2024 02. MNVP Proposal final sent 04. MNP Governance lead JD 05. MNVP Workplan Presentation 06. MNVP Work plan reviews - Sept 2024 07. MNSCAG TOR# 08. 2024.06.12 MFT Meetings for MNVP
7.4	If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.	CQC Picker Survey 23-24	Pickers survey presentations and action plans including : * MNSCAG * LMNS Local Meetings * LMNS Peformance and Quality * QAC
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis (if available), such as a coproduced action plan.		
7.6	Has progress on the coproduced action above been shared with Safety Champions?		
7.7	Has progress on the coproduced action above been shared with the LMNS?		
		CQC Picker 24-25	

Safety Action 8

Element	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024:			
Fetal monitoring and surveillance (in the antenatal and intrapartum period) training			
8.1	90% of obstetric consultants	Safety Action 8	01. MFT Training Compliance 30.11.24 02.2024 Maternity Mandatory Speciliast Training Policy (including skills drills and TNA) 02. Maternity Mandatory specialist training matrix 03. Annual Fetal Monitoring Training and Assessment Procedure 07. K&M LMNS Physiological Fetal Heart Rate Monitoring Guideline 08. 2024-25 CTG training day outline
8.2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)		
8.3	For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.4	90% of midwives (including midwifery managers and matrons), community midwives, birth		
Maternity emergencies and multiprofessional training			
8.5	90% of obstetric consultants	Safety Action 8	01. MFT Training Compliance 30.11.24 02.2024 Maternity Mandatory Speciliast Training Policy (including skills drills and TNA) 02. Maternity Mandatory specialist training matrix 06. PROMPT Agenda
8.6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota		
8.7	For rotational obstetric staff that commenced work on or after 1 July 2024 a lower compliance		
8.8	90% of midwives (including midwifery managers and matrons), community midwives, birth		
8.9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).		
8.1	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors		
8.11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.		
8.12	For rotational anaesthetic staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.13	Standard removed		
8.14	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?		
Neonatal basic life support			
8.15	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Safety Action 8	01. MFT Training Compliance 30.11.24 02.2024 Maternity Mandatory Speciliast Training Policy (including skills drills and TNA) 02. Maternity Mandatory specialist training matrix 04. MFT Resus training matrix 05. Resus training analysis 09. Junior Doctor induction March 2024 10. Neonatl Resus guideline (women's) 11. Neonatal resus guideline - 27 weeks to term 12. Neonatal Resus guideline - resus and perinatal managemnet up to 26+6 weeks
8.16	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births		
8.17	For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.18	90% of neonatal nurses (Band 5 and above who attend any births)		
8.19	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.		
8.2	90% of advanced Neonatal Nurse Practitioner (ANNP)		

8.21	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)		13. Neonatal Resus and stablisation 22+0-26+6 weeks 14. Neonatal Medical staff NLS certification.
8.21	In addition to the above Neonatal basic life support (NBLS) training, is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance by year 7 of MIS and ongoing?		

Safety Action 9

Element	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded (including the following)?	Safety Action 9	Folders: * IQPR Slides (Jan-Oct 2024) * LMNS PQSM Submsission (Jan-Oct 2024) * Quarterly Reports PQSM (2024) * Trust Board Papers * LMNS Performance and quality meeting - TOR, Minutes, Agendas, Reports * MNSCAG Papers & TOR * MFT Governance Structure
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Safety Action 9	* MNSCAG Papers & TOR * Safety Champions - Presentation,SOP and Poster, Feedback form
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.		* MNSCAG Papers & TOR * IQPR Slides (Jan-Oct 2024) * Quarterly reports (PQSM 2024) * Trust Board Papers
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.		Folders: * IQPR Slides (Jan-Oct 2024) * LMNS PQSM Submsission (Jan-Oct 2024) * Quarterly Reports PQSM (2024) * Trust Board Papers * LMNS Performance and quality meeting - TOR, Minutes, Agendas, Reports * MNSCAG Papers & TOR
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.		* LMNS Performance and Qualiyt meeting - TOR, Minutes, Agendas, Reports * MNSCAG TOR and Papers * LMNS PQSM Submission
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.		* MNSCAG TOR and Papers * Safety Champion - SOP, Poster, Presentation * Maternity Matters * Teams Talks Notes * Huddle Board Log * IQPR Slides/Trust Board Papers * You Said, We did Poster * Workforce poster April 24 & CNST Summary Newsletter
9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Claims, Incidents, Complaints Triangulation Reports	* Claims Incidents and Trainagulation Report (May Board, Sept Board, November Board) * MNSCAG TOR and Papers * Trust Board Papers
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	\\Safety Action 9	* MNSCAG TOR and Papers * MNSCAG Attendance Log
9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Perinatal Leadership Reports	* Trust Board Papers * MNSCAG Papers, TOR, Workplan * Perinatal Leadership reports (Trust Board - May, Sep, Nov)

Safety Action 10

Element	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI)		
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Safety Action 10	* HSIB & NHSR ER Database 2024 - ANON
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.		
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme		
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.		* HSIB & NHSR ER Database 2024 - ANON * IQPR Slides * Trust Board Papers * Quartery Perinatal Surveillance reports * Final CNST Paper (Jan 2024)
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?		
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?		
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.		