NHS
Medway
NHS Foundation Trust

APPENDIX 1

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

January - 2025

Patient FIRST

Executive Summary

Jayne Black
Chief Executive

True North

	Variation: Common	Variation: Improve	Variation: Concern	Assurance: Common	Assurance: Improve	Assurance: Concern
People	21	30	5	20	15	14
Quality	45	13	19	14	5	3
Systems & Partnerships	20	7	9	17	4	5
Patients	11	14	1	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 Patients domain is now showing the highest % volume in metrics improving for Statistical Variance (53.8%), with the People domain achieving 53.6% metric improvement
- The Sustainability domain is showing the highest number of metrics statistically showing concern (4), with 33.3% of all metrics flagging
- The Patients Domain is showing the least amount of metrics showing concern (1), with ~4% against all metrics flagging.
- The majority of the metrics (58%) in the Quality domain continue to show no significant statistical variation and as such are showing common variation.
- Overall, 66 metrics are now showing improved statistical variance (-5 from last month) against 38 which are showing concern (+3 from last month).

Issues, Concerns & Gaps

- Focus in Q4 remains on spend control whilst addressing service demands
- Continued operational deficits will place a pressure on the Trust's cash holding
- Awaiting contract for SpecCom for Cardiology – potential of additional activity at KIMS through ICB IS contract / No General Manager for Rheumatology and Neurology
- Total LOS >12 hours 8.2% and NCTR Average for January 122 (highest for a year)
- SHMI remains 'higher than expected' with no significant improvement and in hospital crude rate continues to rise
- Issues remain with managing expectations around waiting and treatment for patients in the Emergency department plus concerns around the building environment and parking have been noted from patient feedback
- Continue to make improvements to our WRES/WDES indicators to ensure our recruitment, promotion and development pathways are based on best practice.

Actions & Improvements

- A series of spend controls and income initiatives, identified by the Executive Team, are currently being validated. Additionally, a specific challenge has been set to identify a further 200 posts reduction with a focus on bank and agency spending.
- New corporate project encompassing reforming elective care for patients will replace outpatient optimisation project.
- Reviews requested from ED Care Group for days of poor performance and regular meetings with Care Group Triumvirate re: performance and planning for performance improvement
- Of the 29 Niche actions, regarding Mortality, two remained outstanding but will monitored through the existing governance processes, plus the Mortality A3 Refresh work is ongoing
- Feedback from patients relating to the building and parking will be included in the estates strategy going forwards.

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	9	27	4	18	0	10
PALS	5	3	0	1	0	0
Patient Experience	1	2	0	3	0	0
PHSO	4	2	0	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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
	95.0%			89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%

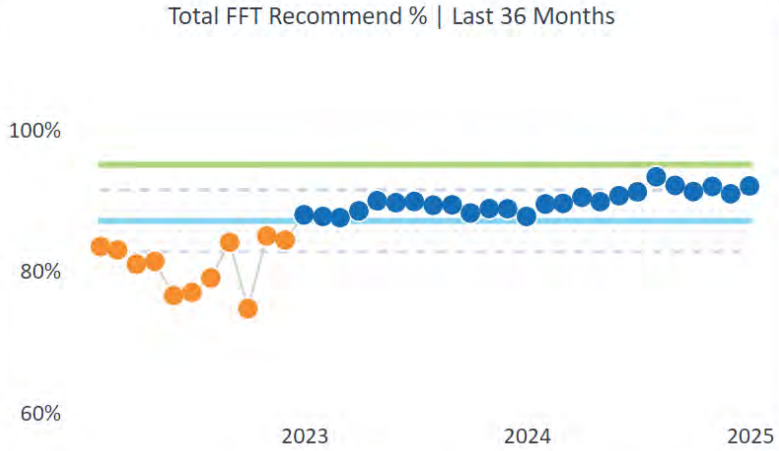
True North Domain: **Patients**

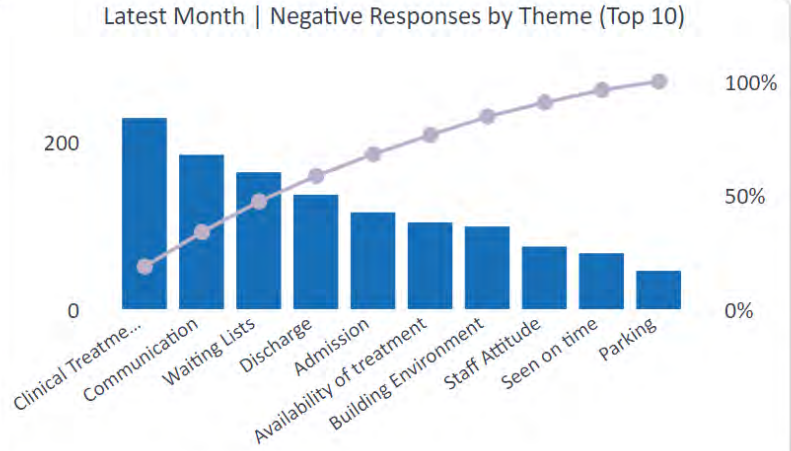
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

2	1	0	0	7





Key Messages

- There has been an overall improvement in positive experiences of care since the last reporting period
- To note that work has commenced to refresh the top contributors and root causes has commenced and will be complete by early March
- Maternity remain consistent with achieving above 95% positive experiences of care month on month

Issues, Concerns & Gaps

- Issues remain with managing expectations around waiting and treatment for patients in the Emergency department
- Concerns around the building environment and parking have been noted from patient feedback

Actions & Improvements

- A patient information leaflet has been approved for circulation in the ED for patients to understand why they are waiting. This is being reiterated with verbal messages to patients when staff are able.
- Feedback from patients relating to the building and parking will be included in the estates strategy going forwards. Parking solutions have been proposed and implemented in late 2025

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Patients	FFT			Emergency Care FFT Recommend %	85.0%		F	Watch is red for 4 reporting periods	79.9%	74.0%	72.8%	75.2%	71.1%	74.6%
				Outpatient FFT Recommend %	95.0%	H	F	Watch is red for 4 reporting periods	94.7%	92.8%	93.0%	93.1%	92.3%	93.3%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	Watch is red for 4 reporting periods	12	12	10	6	17	2
	Complaints			Complaints Breached %	5.0%	L	F	Watch is red for 4 reporting periods	0.0%	30.8%	20.0%	21.2%	14.6%	36.0%

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%
				Total FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	16.1%	15.3%	15.2%	13.7%	12.8%	13.4%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.3%	95.6%	93.9%	95.1%	94.7%	94.9%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	53.6%	53.2%	52.4%	48.1%	41.3%	43.5%
				Outpatient FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.7%	92.8%	93.0%	93.1%	92.3%	93.3%
				Outpatient FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	11.4%	10.6%	10.3%	9.5%	9.2%	9.9%
				Maternity FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	42.4%	70.6%	76.0%	70.1%	72.3%	71.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	Special cause of improving nature or lower pressure due to (L)ower values	12	12	10	6	17	2
	Complaints			Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	51	46	65	54	47	60
				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	0.0%	30.8%	20.0%	21.2%	14.6%	36.0%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	98	91	89	99	92	80
				PALS Converted to Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1	0	0	0	0	0

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
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

- Mixed Sex breaches remain low in all clinical areas, ITU and HDU are the top contributors
- 100% complaints acknowledged
- 0 PALS converted to complaints
- Complaint themes include, complications following/during operation, communication to patients/relatives, Delay with diagnosis/general dissatisfaction with care
- PALS themes include; appointments, results, delay/lack of communication during bereavement process/ communication with patients and families, information on access to records and SARs/chasing SARs application.
- No PHSO cases opened or closed
- 1 complaint re-opened for ongoing investigation

Issues, Concerns & Gaps

- Issues remain with reporting all MSA breaches on Teletracking, the module has not been updated to ensure accurate reporting when placing patients in clinical areas.
- 32% of complaints breached KPI – 26 complaints due for response. 8 breached (Frailty 4, Spec Med 2, Cancer and CCS 1, Surgical Services 1). All complaints required outstanding comments to be able to complete the complaint investigation. Frailty and Specialist Medicine had staff sickness and leave which impacted on their responding on time. Escalations were made to HON in both Care Groups. Additional support was provided in the approval stage to prevent additional breaches.

Actions & Improvements

- MFT and MTW have again escalated the concern around the MSA reporting element to the national teletracking team
- 'I care to call' has been promoted again with Emergency and Medicine with reminders to staff and promotion of posters/literature displayed
- Audits of NEWS2 compliance
- Motor Neurone disease and the specific needs of patients has been shared in the Emergency and Medicine's 'Big 4' communication tool
- The Trust has incorporated a question on personal care into the daily patient documentation audit.
- The communication teams have added a search term for interpretation / translation, which will take staff to the information page on the Trusts intranet
- posters are now displayed in the department on how to access translation / interpreter services.
- The communication teams have added a search term for interpretation / translation, which will take staff to the information page on the Trusts intranet
- Install voice message solution on all extensions associated with team Aurelia along with a standard operating procedure for message management (maternity only)

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Patients	FFT			Total FFT Recommend %	95.0%	H	F	89.4%	89.5%	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%
				Total FFT Response Rate %	-	H		14.8%	14.1%	16.2%	15.0%	15.2%	14.6%	16.1%	15.3%	15.2%	13.7%	12.8%	13.4%
				Inpatients FFT Recommend %	95.0%	H	?	94.2%	93.1%	93.2%	92.6%	93.3%	94.5%	95.3%	95.6%	93.9%	95.1%	94.7%	94.9%
				Inpatients FFT Response Rate %	-	H		42.0%	45.2%	52.2%	48.4%	52.3%	53.9%	53.6%	53.2%	52.4%	48.1%	41.3%	43.5%
				Emergency Care FFT Recommend %	85.0%		F	68.9%	71.6%	77.1%	70.2%	74.9%	73.0%	79.9%	74.0%	72.8%	75.2%	71.1%	74.6%
				Emergency Care FFT Response Rate %	-	L		10.0%	7.6%	10.1%	8.3%	7.9%	7.4%	7.4%	6.6%	7.5%	7.4%	6.8%	7.5%
				Outpatient FFT Recommend %	95.0%	H	F	91.9%	91.5%	91.3%	92.7%	92.6%	93.0%	94.7%	92.8%	93.0%	93.1%	92.3%	93.3%
				Outpatient FFT Response Rate %	-	H		10.1%	9.3%	9.9%	9.8%	9.7%	9.9%	11.4%	10.6%	10.3%	9.5%	9.2%	9.9%
				Maternity FFT Recommend %	95.0%		?	85.8%	88.8%	99.4%	96.5%	92.6%	88.0%	92.6%	94.8%	96.5%	98.3%	97.3%	97.9%
				Maternity FFT Response Rate %	-	H		38.7%	30.6%	49.2%	47.6%	39.1%	34.2%	42.4%	70.6%	76.0%	70.1%	72.3%	71.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	278	90	110	108	89	26	12	12	10	6	17	2
	Complaints			Complaints	-			25	29	28	23	26	21	30	22	43	19	20	38
				Complaints Closed	-			20	24	28	45	37	38	20	27	24	30	27	25

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Patients	Complaints			Complaints Open - Month End	-			86	91	91	69	58	41	51	46	65	54	47	60
				Complaints Re-Opened	-			1	5	1	3	1	4	1	4	10	2	2	1
				Complaints Acknowledged Within 3 Working Days %	95.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%			55.6%	82.8%	59.3%	34.5%	21.4%	3.6%	0.0%	30.8%	20.0%	21.2%	14.6%	36.0%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			463	417	480	428	446	499	421	521	439	515	463	470
				PALS Closed	-			461	418	457	402	458	540	402	528	441	505	470	482
				PALS Open - Month End	-			84	83	106	132	120	79	98	91	89	99	92	80
				PALS Converted to Complaints	-			0	0	0	1	0	0	1	0	0	0	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			0	0	1	0	2	2	2	0	0	0	0	0
				PHSO Cases Closed - Partially Upheld	-			0	0	0	0	0	0	0	0	1	1	1	0
				PHSO Cases Closed - Upheld	-			1	0	0	0	0	1	0	0	0	0	0	0
				PHSO Cases Closed - Not Upheld	-			0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-			1	4	0	0	0	0	0	0	1	1	0	0

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
Mortality	16	3	9	16	4	1
Incident Management	20	11	13	10	3	13
IPC	5	0	4	1	2	0
Medicines	6	0	0	3	1	0
Falls	15	2	2	15	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	2	1	0	0	0	0
Maternity	14	0	1	2	0	2
Pressure Ulcer	6	0	2	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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
	95.0%			98.9%	99.5%	98.8%	99.3%	98.6%	99.3%	99.2%	99.0%	99.1%	99.1%	98.7%	98.0%

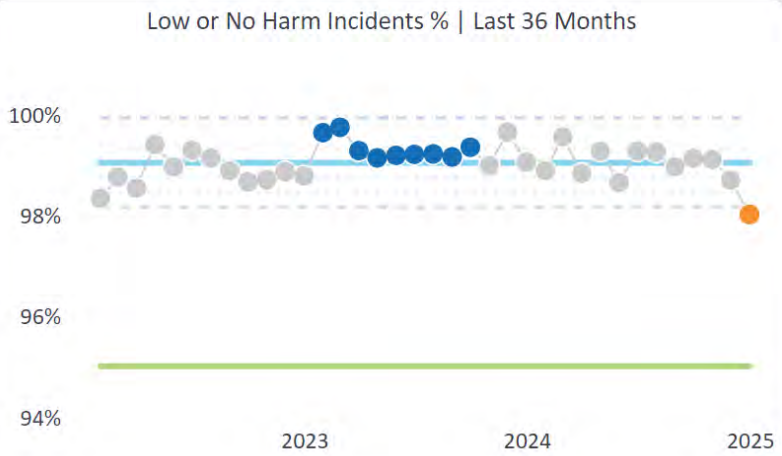
True North Domain: Quality

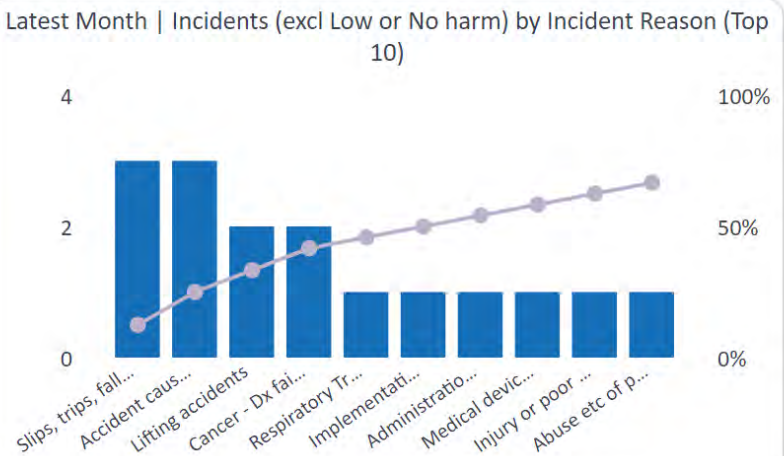
KPI Threshold: 95.0%

Sub Domain KPIs: 21

Variation Summary:

11	2	4	0	4





Key Messages

- 98.0% of all incidents reported resulted in low or no harm.
- 16 incidents in January caused moderate harm or above.
- 9 Incidents caused moderate harm: SSI; sigmoid perforation; post endoscopy injury resulting in ITU; fall; abnormal thyroid results not acted on resulting in ICU; 2 avoidable 2222 calls, same patient as treatments not given; lack of appropriate monitoring against medical plan and incorrect prescription of hypoglycaemia treatment; lack of bed pumps; Cat 4 PU.
- 5 Incidents caused severe harm: Possible delay in ICU referral/treatment with medicine contraindication; ENT delayed diagnosis; CT reporting delay for patient on 2ww; fall; IUD.
- 2 Incidents as death: Patient found dead by family. Maternal Death PE.
- Quarterly 12 hour breach harm reviews in place

Issues, Concerns & Gaps

- Clinical incidents with harm as moderate or above has increased by 33.3%.
- Post surgery issues: infection; sigmoid perforation.
- ICU referrals: abnormal thyroid results not acted; post endoscopy injury; PE resulting in maternal death.
- 2 avoidable 2222 calls for same patient as multiple medications missed and severe hypokalaemia not treated; lack of appropriate monitoring against medical plan and incorrect prescription of hypoglycaemia treatment;
- TVN: Lack of bed pumps; Cat 4 sacrum PU. • 2 falls
- Delays: ICU referral/treatment with medicine contraindication; ENT delayed diagnosis; CT reporting delay for patient on 2ww
- IUD - Patient found dead in bed, oxygen removed.
- 3 patients identified as potential harm following >12 hours stay in ED. Data validation lag for harm reviews due to coding issues

Actions & Improvements

- First quarterly QIP meeting took place to ensure progression. Providing support to create nutrition QIP and medications QIP.
- Supporting Trauma Director to increase funding and prevent removal of service.
- Business case is being developed to support the automated NEWS score recording and a NEWS Dashboard is being developed.
- TVN working with IPC on SSI reductions for emergency laparotomy.
- PS&IT set up DKA improvement group which is progressing to address pathways.
- Planning in place to implement Martha's rule for paediatrics.
- Harm review learning shared with immediate teams and will be shared with relevant specialty teams along with an MDT approach to conducting reviews going forward.

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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
	1.30%	H	?	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%	1.36%	1.30%	1.27%	1.52%	1.80%	2.39%

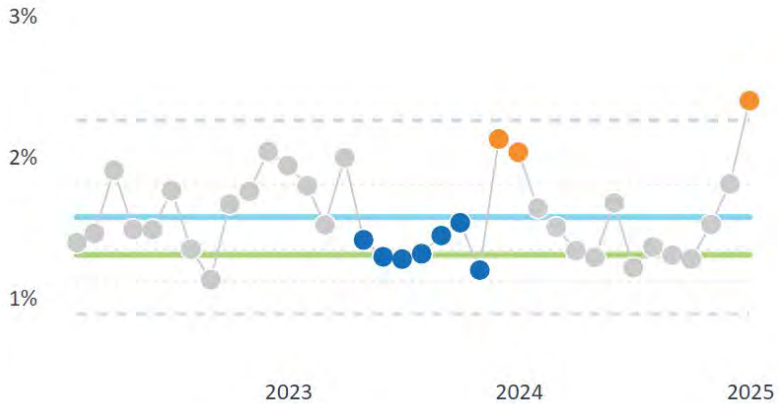
True North Domain: Quality

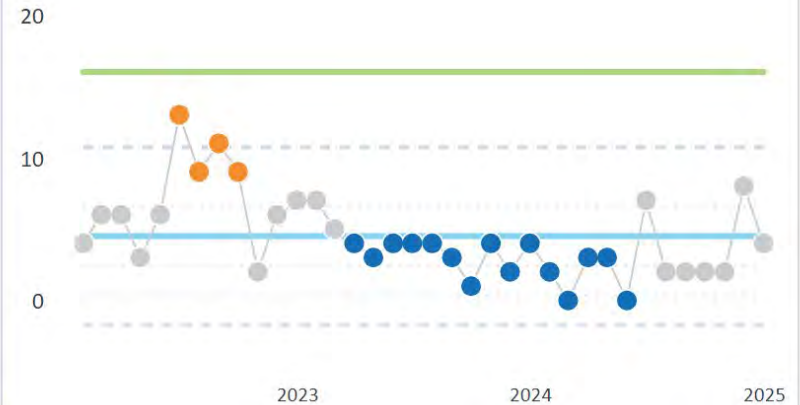
KPI Threshold: 1.30%

Sub Domain KPIs: 15

Variation Summary:

7	2	4	2	0





Key Messages

- HSMR for the period of Oct 23-Sept 24 is 98.6 and 'as expected'
- SHMI for the period of Sept 23- Aug 24 is 1.20 and 'higher than expected'
- SHMI in-hospital crude rate has hit an all time high this month.
- COPD and Other Connective Tissue Disease remain persistent outliers
- 6.1% deaths underwent stage 1 SJR reviews. The number of reviews has decreased due to annual leave, sick leave and capacity to complete against clinical pressures
- 13/20 specialties returned M&M minutes for January

Issues, Concerns & Gaps

- SHMI remains 'higher than expected' with no significant improvement
- In hospital crude rate continues to rise. The recommendation is to focus on palliative patients with long lengths of stays with advance care packages in place and to continue with plans for the validation of deaths process.
- Compliance with SJR stage 1 completion has decreased. The main reason for this is lack of time to complete the reviews due to clinical pressures

Actions & Improvements

- Mortality A3 Refresh work is ongoing
- Cases highlighted for SJR by the Medical Examiner are referred to the Divisional Medical Director as part of the Breakthrough Objective to expedite immediate actions and learning
- RIP validations process in progress with clinical coding Respiratory consultants
- Of the 29 Niche actions from the recommendations, four remained outstanding but will monitored through the governance process and the Mortality and Morbidity Surveillance Group . The working group has now been completed

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0		F	Watch is red for 4 reporting periods	6	10	9	8	9	16
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	84.1%	82.4%	84.4%	85.1%	84.7%	83.1%
	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	74.1%	66.6%	66.6%	76.2%	83.3%	70.7%
				SJRs Completed %	12.5%	L	?	Watch is red for 4 reporting periods	4.1%	13.0%	8.3%	0.0%	0.0%	0.0%

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Incident Management			After Action Review (AAR) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	3	2	2	1	3	2
				Duty of Candour Compliance Stage 1 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	90.0%	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	84.1%	82.4%	84.4%	85.1%	84.7%	83.1%
	Mortality			HSMR (12m)	100	L	Special cause of improving nature or lower pressure due to (L)ower values	98.58	98.60				
				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	99.0%	99.2%	99.7%	99.8%	99.0%	99.0%
	Risk & Policy			Risks Open - Moderate (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	24	23	22	20	20	22
				Risks Open - High (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	45	44	43	39	45	43
				Risks Open - Extreme (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	10	11	7	6	5	7
	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	83.6%	82.9%	82.9%	84.2%	84.5%	84.0%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.6%	85.5%	86.3%	87.0%	86.9%	86.1%
	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 41 patients with hip fractures were admitted in January 2025 . Of these, 12 patients underwent surgery after 36 hours, resulting in 70.7% compliance for prompt surgery. In December 2024, only 4 patients breached the 36 hours target with an 83.3% compliance. Over the last year there has been an overall upward trend in compliance for prompt surgery. In the 12 months up to December 2024, our compliance was higher at 63%, compared to 12 months up to December 2023 when our compliance was only 54.3%. The prompt surgery KPI on NHFD for Medway is 63%, which is above the national average of 58%.

VTE

- VTE CNS in post and is working at pace on the outstanding issues
- HAT data has been reported to the patent safety group in December and January, however this remains a manual process / The work to review the backlog of incidents has been agreed and will start late February

Falls

- Numbers of falls in the last reporting period has increased

HAPU

- There has been an increase in HAPU, this is in line with the increase in capacity, acuity and reduction in flow across the trust
- Positively there have been more than 7 wards who have remained harm free for more than 30 days and 5 areas over 6 months

Issues, Concerns & Gaps

FNoF: The primary challenge remains insufficient theatre capacity, which contributes to delays in timely surgery. This issue is particularly problematic on days with a high volume of admissions or when other urgent surgeries requiring timed operations are scheduled.

VTE

- The datix platform and information that is required to be populated remains inaccurate
- The team do not have a live / up to date dashboard to review all VTE related data

Falls

- Challenges remain an issue with staffing in the team
- Unwitnessed / unwitnessed falls at night remains off trajectory against the QIP

HAPU

- The top contributing wards remain within frailty and spec med
- Space utilisation for storing the new mattresses remains an issue

Actions & Improvements

FNoF: We have introduced the NAFF identification tool within our E-trauma system. This tool will enable accurate identification and tagging of patients, which is a critical first step in ensuring equitable care for this vulnerable patient group.

VTE

- Patient safety have prioritised the update to datix to ensure accuracy of reporting. This will be complete by late February
- The VTE team are working with BI to create a digital VTE dashboard for accurate data , this should be live early March

Falls

- Recruitment has commenced for the vacant band 6 and 7 in the team
- The clinical lead will be providing focused work on actions to improve unwitnessed falls and actions on the QIP
- Wards who contribute to the highest number of falls will be provided intensive support from the falls team

HAPU

- Intensive support has been provided to the top contributing wards
- The space utilisation team are supporting with mattress storage, this has been escalated to the Director for further assistance

Maternity

Key Messages

Perinatal Quality – Incidents January 2025: 2 Incidents in maternity rated Moderate harm or above, both to be investigated as MNSI cases and referred appropriately; Maternal Death at 5 weeks Postnatal following collapse at home. Referred to coroner, but case not accepted; IUD/Stillbirth– will also be reviewed by PMRT; 125 ↑ incidents reported in Maternity, 20 low harm.3 ↓Incidents relating to 3rd/4th degree tears, 13 ↑ relating to PPH; 18 ↓ Incidents in NICU, 1 low harm. **Perinatal Quality – PMRT**: 4 MBRRACE reportable deaths: Miscarriage 23+0, 2 Stillbirth, 30+2, 40+9, Neonatal death 23+0; 1 Maternity PMRT review (B,C), 1 Neonatal PMRT review (A,A,A); **Staffing**:Midwifery B5 &6 vacancy for Jan 25 12.51; WTE (↓) plus 11.88 WTE waiting to start Maternity Leave – 8.44 WTE (↑); Band 3 MSW vacancy 2.27(↑) WTE with 0.96 WTE awaiting start date; NICU QIS – 64.5% (-) (target 70%). Trajectory to achieve >70% in place with current staffing and training schedule. **Training:** PROMPT training recommenced in January with Fetal monitoring training to commence in February; Rolling training dates for 2025 in place for Fetal Monitoring and PROMPT to maintain compliance with CNST. Trajectory to be monitored monthly along with compliance figures; Midwifery staff 93% compliant with Safeguarding Adults level 3. **Listening to Women and Families – Service Users and MNVP:** MNVP lead continuing engagement work supported by the PE&EDI midwife including working with BAME groups; Action plan co-produced with MNVP and key stakeholders for the Picker 2024 CQC survey; Service user group held with MNVP to support review of birth after caesarean section pathway; FFT – 98% (↑) recommend rate, 72% response rate. (↑); 15 Steps challenge re-booked for February 2025. **Staff Feedback**: Team talks set monthly throughout 2025; Focused staff feedback session held with Internationally Educated Midwives. **External:** No Regulation 28 notices, MNSI/NHSR/CQC requests for action; CNST Declaration form approved at January Trust Board and both Trust CEO and ICB CEO have signed in prep for submission in next few weeks.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: Both incidents moderate harm and above reviewed at CRIG and referred to MNSI; IUD MNSI case did not pull onto IQPR dashboard as not presented at IRG until February 2025; PPH and 3rd and 4th degree tears continue to be an issue for concern and this is being addressed through QI projects and training; Medication errors continue to be a recurring theme in NICU **Perinatal Quality - PMRT:** Awareness for all staff of bereaved families on unit who may not be located in dedicated bereavement areas. **Staffing**: Uplift of some Band 2 MSWs to Band 3 will have an impact on Birth-rate+ calculations and potential disparity between tasks completed by staff of the same banding. **Training:** Safeguarding Children's – Midwifery staff – increased in month from 75% to 84%. Medical Staff 81% (↓); Safeguarding Adults Medical Staff – 71% (↑) **Risk & Issues:** Midwifery staffing risk now classed as an issue with rating of 4; Additional issues identified and awaiting approval regarding delivery suite floor requiring repair and lack of service contract for fetal medicine scanning machines. **Listening to Women and Families – Service Users and MNVP:** 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 postnatal experience **Staff Feedback**: IEM meeting identified areas for improvement. **External:** 1 case referred to coroner – case not accepted.

Actions & Improvements

Perinatal Quality: PPH audit presented at QAC in January and actions in place to better understand compliance with guidelines and appropriate management; Continue to engage with MNSI investigation and requests for information from coroner; Learning from MNSI case shared at audit meeting in January; OASI-2 training for midwifery staff via "trolley dash" in January with official launch date in February. OASI-2 champions trained; Ongoing QIP in place for medication errors on NICU with action plan to be shared at MNSCAG. **Perinatal Quality – PMRT**: Re-launch of "Bluebell" signs to be used on rooms when bereavement areas are not available. Ensure this is shared with all staff in clinical areas to ensure sensitive and appropriate communication with bereaved families; Updated and co-produced parent engagement information to be published in February 25; Bereavement team commenced monthly learning from PMRT item in staff newsletter. **Staffing**: Positive recruitment trajectory continues; No leavers expected in next 3 months. **Training:** Children's Safeguarding – E-learning or Face to Face for whole day; Adult Safeguarding training – remains face to face only – but moving to option 4 hourly workshop once per year from April 2025; DNA checklist video guide for staff developed. Due to launch in February to improve staff compliance with DNA checklist **Risks & Issues:** Business case for procurement of a suitable MIS system approved in principle, to be sent to ICB double lock process. Demo's of systems to be organised with staff. **Listening to Women and Families – Service Users and MNVP:** CQC Picker action plan to be shared with LMNS, QAC and PEG. Improving postnatal care and experience is a key drive of action plan; Service user and staff survey for Amenity rooms launched in February; Communication training video for staff to be co-produced with MNVP, Consultant Midwives and PE&EDI lead. **Staff Feedback:** Targeted work to support IEMs with action plan being developed with PE & EDI Midwife **External:** Ongoing audit of SBL compliance continues with next submission due to LMNS in March 2025; Anticipate SBL 3.2 in February/March 2025 with new implementation tool expected in April 2025.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Incident Management			Low or No Harm Incidents %	95.0%	L	P	98.9%	99.5%	98.8%	99.3%	98.6%	99.3%	99.2%	99.0%	99.1%	99.1%	98.7%	98.0%
				Total Incidents Reported	-	L		1,337	1,329	1,191	1,228	1,179	1,229	1,199	1,055	1,139	1,112	1,068	1,207
				Clinical Incidents with Harm (Moderate and above)	0		F	9	5	8	5	12	3	6	10	9	8	9	16
				Incidents Open - Month End	-	H		2,880	2,955	2,967	1,859	1,910	2,009	2,174	2,176	1,928	1,647	1,735	1,680
				Incidents Overdue - Month End	-	H		1,807	1,876	1,998	884	969	1,060	1,221	1,218	1,092	736	774	741
				Patient Safety Incident Investigations (PSII) Declared	-			0	0	2	0	1	0	0	0	2	0	0	1
				Patient Safety Incident Investigations (PSII) Closed	-			0	0	0	0	0	0	1	1	1	2	0	0
				Patient Safety Incident Investigations (PSII) Open - Month End	-			0	0	2	2	3	3	2	1	2	0	0	1
				After Action Review (AAR) Declared	-	H		6	2	1	5	3	2	0	4	0	7	2	6
				After Action Review (AAR) Closed	-	H		2	5	1	4	2	2	3	2	2	1	3	2
				After Action Review (AAR) Open - Month End	-	H		6	3	3	4	5	5	2	4	2	8	7	11
				Never Events	0		?	0	0	0	0	0	0	0	0	2	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Incident Management			Duty of Candour Compliance Stage 2 %	-	H		100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				RIDDOR Incidents	-			5	2	2	2	0	1	0	3	3	3	1	0
				RIDDOR Compliance %	-			40.0%	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	66.7%	100.0%	100.0%	-
				Health & Safety Incidents	-			151	115	128	97	85	97	55	43	64	54	45	54
				Sharps Injuries	-			11	6	2	6	7	12	13	10	6	14	7	9
				EDNs Completed Within 24hrs %	90.0%	H	F	80.0%	79.2%	78.8%	81.2%	79.6%	82.8%	84.1%	82.4%	84.4%	85.1%	84.7%	83.1%
				Violence & Aggression Incidents	126		?	252	173	204	166	174	157	139	108	119	99	123	116
				Assaults - Patient on Staff	-			99	78	108	70	76	71	60	40	62	35	53	57
	Falls			Low or No Harm Falls %	95.0%		?	97.9%	100.0%	94.6%	98.8%	99.0%	100.0%	98.8%	97.8%	98.0%	100.0%	100.0%	98.2%
				Falls - Total	-			94	80	74	85	102	93	82	92	102	74	83	114
				Falls - Low Harm	-			21	17	15	18	21	29	21	29	33	27	21	36
				Falls - Moderate Harm	-			0	0	2	1	1	0	0	1	2	0	0	1
				Falls - Severe Harm	0		?	2	0	2	0	0	0	0	1	0	0	0	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Falls			Falls Resulting in Death	0		?	0	0	0	0	0	0	1	0	0	0	0	0
				Falls per 1,000 Bed days	-			6.23	4.88	4.73	5.25	6.65	5.77	5.10	5.85	6.26	4.63	5.08	6.69
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	25	24	15	16	19	19	23	22	31	17	26	34
				Pressure Ulcers - Grade 2	-	H		8	5	8	8	6	8	18	15	24	9	15	21
				Pressure Ulcers - Grade 3	-	H		2	3	7	8	13	10	4	7	6	7	11	12
				Pressure Ulcers - Grade 4	-			0	0	0	0	0	1	1	0	1	1	0	1
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.66	1.46	0.96	0.99	1.24	1.18	1.43	1.40	1.90	1.06	1.59	1.99
	Medicines			Medicine Errors - Total	-			90	81	88	61	68	99	94	68	89	92	77	75
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	98.8%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	98.7%
	IPC			IPC Incidents	-	H		45	50	38	54	31	66	108	49	59	55	53	50
				C-Diff Cases - Hospital Acquired Total	-			4	8	4	4	2	4	7	11	5	6	5	6
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			48	56	4	8	10	14	21	32	37	43	48	54
				C-Diff Cases - Hospital Acquired (HOHA)	-			3	6	2	3	2	4	4	4	5	4	1	6

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	IPC			E.coli Cases - Hospital Acquired	-			6	4	6	3	5	6	9	2	5	8	2	2
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			62	66	6	9	14	20	29	31	36	44	46	48
				MRSA Cases - Hospital Acquired	0		?	0	0	0	0	0	0	0	0	0	0	2	0
				MSSA Cases - Hospital Acquired	-			3	2	4	1	0	0	3	4	1	1	3	2
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			32	34	4	5	5	5	8	12	13	14	17	19
	Mortality			Crude Mortality Rate %	1.30%	H	?	1.63%	1.49%	1.33%	1.28%	1.67%	1.21%	1.36%	1.30%	1.27%	1.52%	1.80%	2.39%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	0	0	1	2	0	2	0	0	0	0	2	1
				Avoidable 2222 Calls – Peri-Arrests	3		?	2	0	1	1	0	5	2	2	1	2	6	3
				Avoidable 2222 Calls	16		P	2	0	3	3	0	7	2	2	2	2	8	4
				HSMR (12m)	100	L	?	99.36	100.29	98.39	98.53	99.35	99.61	98.58	98.60				
				HSMR Expected Death Rate (12m)	-	H		5.2%	5.2%	5.1%	5.1%	5.1%	5.1%	5.2%	5.2%				
				HSMR Expected Death Rate (Month)	-			5.4%	5.4%	4.9%	4.7%	5.6%	4.9%	5.7%	5.1%				
				SHMI (12m)	1	H	F	1.18	1.19	1.19	1.18	1.20	1.20	1.20	1.20				
				SHMI Expected Death Rate (12m)	-	H		3.1%	3.0%	3.0%	3.0%	3.0%	3.1%	3.1%	3.1%				

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Mortality			Fractured NOF Within 36 Hours	92.0%		?	73.7%	60.0%	60.0%	51.5%	52.5%	56.5%	74.1%	66.6%	66.6%	76.2%	83.3%	70.7%
				Number of Deaths Reviewed via SJR	-	L		12	11	13	6	13	13	5	16	11	0	0	0
				SJRs Completed %	12.5%	L	?	7.3%	6.8%	9.2%	4.5%	9.2%	11.0%	4.1%	13.0%	8.3%	0.0%	0.0%	0.0%
				Total Number of Deaths Due to Failings in Care	-	L		0	0	1	0	0	0	0	0	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			1	1	1	2	0	1	0	0	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	?	99.2%	99.7%	99.1%	99.4%	99.5%	99.8%	99.0%	99.2%	99.7%	99.8%	99.0%	99.0%
	Maternity			Caesarean Section %	-			52.0%	44.2%	43.5%	44.2%	50.5%	42.5%	49.4%	49.2%	51.0%	48.6%	48.1%	46.5%
				Elective C-Section %	-			19.6%	19.2%	21.0%	17.2%	19.8%	17.3%	20.0%	19.4%	19.8%	19.4%	21.8%	19.8%
				Emergency C-Section %	-			32.3%	24.9%	22.5%	27.0%	30.7%	25.2%	29.4%	29.8%	31.1%	29.1%	26.3%	26.6%
				PPH greater than or equal to 1500mls	-			15	23	12	18	14	12	20	12	14	16	20	18
				Total Number of Still Births Greater Than 24 weeks Gestation	-			3	0	0	3	2	0	1	2	0	0	0	2
				Neonatal Deaths	-			2	3	0	1	0	2	2	1	0	2	2	3

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality	Maternity			Maternity and Newborn Safety Investigations (MNSI) Declared	-	H		2	1	0	0	0	0	0	0	1	0	0	2
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			1	0	0	0	0	1	1	1	0	0	1	0
	Risk & Policy			Risks Open - Low (Month End Snapshot)	-				4	3	5	4	1				1	1	1
				Risks Open - Moderate (Month End Snapshot)	-	L			38	41	38	32	33	24	23	22	20	20	22
				Risks Open - High (Month End Snapshot)	-	L			109	93	84	80	80	45	44	43	39	45	43
				Risks Open - Extreme (Month End Snapshot)	-	L			21	15	13	12	11	10	11	7	6	5	7
	Health & Safety			Resuscitation Training Compliance %	-	H		82.1%	83.5%	83.0%	83.1%	83.9%	83.6%	83.6%	82.9%	82.9%	84.2%	84.5%	84.0%
				Mental Capacity Act Training Compliance %	-	H		81.7%	83.1%	84.0%	84.9%	85.1%	85.6%	86.6%	85.5%	86.3%	87.0%	86.9%	86.1%
	Legal & Information Governance			Inquests Received	-			14	8	14	13	10	15	10	7	7	12	8	15
				Inquest Hearings	-			10	9	8	6	5	10	11	3	5	5	6	7
				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

Nick Sinclair
Chief Operating Officer

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	33	20	16	34	7	21
Emergency Care	12	5	1	9	1	4

Operational Leads:
Stewart Nisbet - *Director, Surgery and Anaesthetics*
Nicola Cooper - *Director, Medicine and Emergency Care*
Sam Chapman - *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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
	54.0%			51.4%	50.6%	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%	50.7%	50.4%	49.9%	50.1%

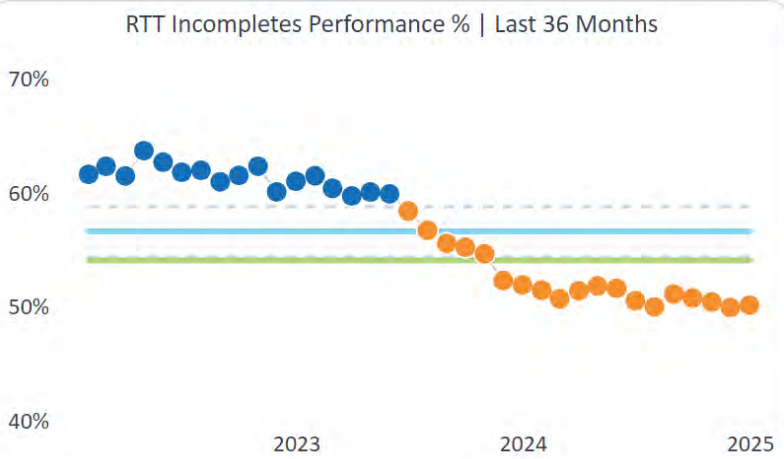
True North Domain: **Systems & Partnerships**

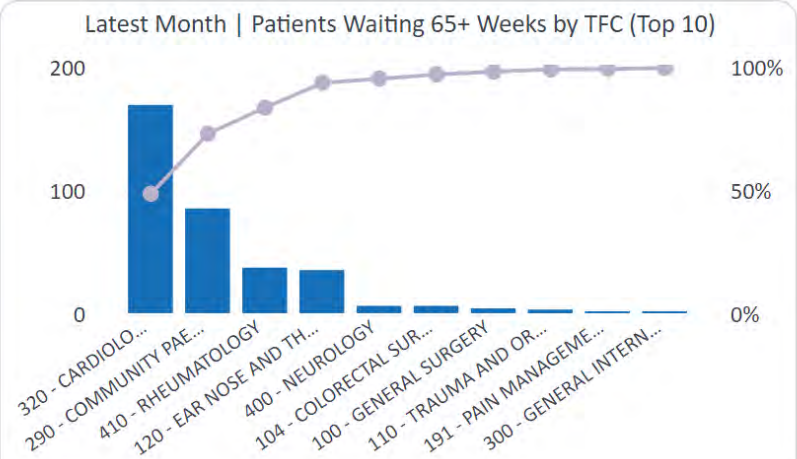
KPI Threshold: 54.0%

Sub Domain KPIs: 25

Variation Summary:

14	2	6	2	1





Key Messages

- Predicted position for 65 weeks at end of February is approximately 191. Due to unforeseen clinician leave/sickness in Cardiology and Rheumatology a number of job planned and additional clinics had to be stood down in December, January and February which has led to an increase in the number of patients waiting over 65 weeks.
- Fortnightly Tier 2 meetings in place with NHSE and ICB to monitor elective performance and provide any necessary support.

Issues, Concerns & Gaps

- Awaiting contract for Speccom for Cardiology – potential of additional activity at KIMS through ICB IS contract.
- 1 year wait for EEG (at King's) which significantly impacts on Neurology waiting times. All neurology patients first seen within 30 weeks, but still waiting due to long wait for EEG.
- No General Manager for Rheumatology and Neurology
- 1 Cardiology HMP patient currently waiting 79 weeks who have previously cancelled appointment 6 times
- ENT patients seen at DVH are sent to MFT at over 65 weeks which accounts for 80% - ongoing issues with visibility of PTL

Actions & Improvements

- Cardiology – Locum Consultant started in January to fill gap of retired Consultant who left in December.
- Cardiology locum due to start April, was planned for February however original candidate withdrew
- Rheumatology locum started in February as backfill to cover sickness
- New corporate project encompassing reforming elective care for patients will replace outpatient optimisation project.

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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
	78.0%			72.6%	77.4%	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%

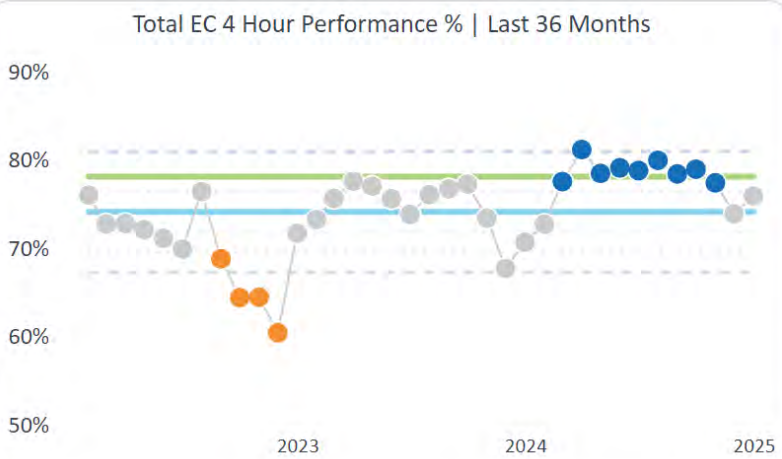
True North Domain: Systems & Partnerships

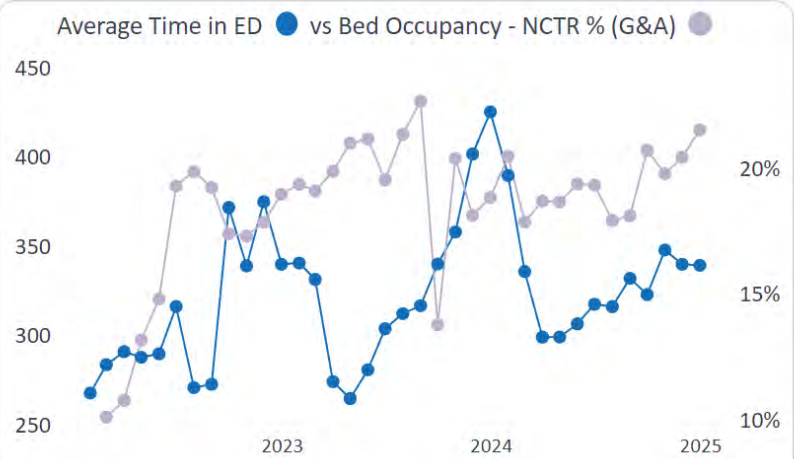
KPI Threshold: 78.0%

Sub Domain KPIs: 11

Variation Summary:

6	0	1	3	1





Key Messages

- Total ED Performance 75.8%
- Type 1 performance 61.2%
- Type 3 performance 91.4%

- Admitted performance 3.6%
- Non admitted performance 81.9%

- Whilst Ambulance handover delays increased Trust remained top in the country

Issues, Concerns & Gaps

- Total LOS >12 hours 8.2%

- HCP funding for SPOA model has been fully used. Funding stream required to continue model

- NCTR Average for January 122 (highest for a year)

Actions & Improvements

- Reviews requested from ED Care Group for days of poor performance to identify themes and trends as to why performance was low on specific days
- Regular meetings with Care Group Triumvirate around performance and planning for performance improvement
- Ongoing discussion around funding from ICB/HCP for continuation of SPOA as allocated initial funding of £100k has now been used – potential solution through use of MTW ACPs being finalised
- Flow and discharge fishbone ongoing

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	H	F	Driver is red for 2 reporting periods	542	390	348	229	248	349
				RTT 52 Week Breaches	1,250	H	?	Watch is red for 4 reporting periods	2,687	2,362	2,265	2,118	1,938	2,021
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	107.77	116.86	111.41	115.81	107.10	118.17
				Urgent Operations Cancelled for 2nd Time	0		?	Watch is red for 4 reporting periods	1	0	1	2	1	1
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	Watch is red for 4 reporting periods	67.2%	64.3%	58.1%	65.0%	63.7%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	Watch is red for 4 reporting periods	66.7%	90.6%	28.6%	84.2%	70.0%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	Watch is red for 4 reporting periods	76.4%	76.5%	76.1%	71.7%	70.5%	
	Emergency Care			Total EC 4 Hour Performance - Non-Admitted %	85.0%		?	Watch is red for 4 reporting periods	85.9%	83.9%	85.0%	82.3%	79.3%	81.9%
				Type 1 EC 4 Hour Performance %	75.0%		F	Watch is red for 4 reporting periods	67.6%	64.9%	67.8%	65.8%	58.3%	61.1%
				Total EC 12 Hour DTAs	0	H	F	Watch is red for 4 reporting periods	577	644	693	771	770	756
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	Watch is red for 4 reporting periods	315.59	331.41	322.37	347.30	339.30	338.72
				Ambulance Handover Delays (> 60 mins)	0	L	?	Watch is red for 4 reporting periods	1	5	2	6	10	8

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Systems & Partnerships	Access			Outpatient DNA Rate %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	6.2%	6.3%	6.1%	5.5%	6.4%	5.6%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.72	1.84	1.81	1.75	1.87	1.81
				DM01 Performance %	73.1%	H	Special cause of improving nature or lower pressure due to (H)igher values	63.6%	68.4%	72.3%	78.4%	78.3%	82.5%
	Emergency Care			IP Discharged Before Noon % (Inc transfers to ADL)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	17.1%	18.3%	20.6%	21.5%	17.6%	21.3%
				Ambulance Handover Delays (> 30 mins)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	46	77	77	76	145	137
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	1	5	2	6	10	8
				30 Day Readmission Rate	13.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	8.4%	7.4%	7.1%	7.5%	8.0%	7.0%

Access

Key Messages

- Predicted position for 65 weeks at end of February is approximately 191. Due to unforeseen clinician leave/sickness in Cardiology and Rheumatology a number of job planned and additional clinics had to be stood down in December, January and February which has led to an increase in the number of patients waiting over 65 weeks.
- Fortnightly Tier 2 meetings in place with NHSE and ICB to monitor elective performance and provide any necessary support.

Issues, Concerns & Gaps

- Awaiting contract for Speccom for Cardiology – potential of additional activity at KIMS through ICB IS contract.
- 1 year wait for EEG (at King's) which significantly impacts on Neurology waiting times. All neurology patients first seen within 30 weeks, but still waiting due to long wait for EEG.
- No General Manager for Rheumatology and Neurology
- 1 Cardiology HMP patient currently waiting 79 weeks who have previously cancelled appointment 6 times
- ENT patients seen at DVH are sent to MFT at over 65 weeks which accounts for 80% - ongoing issues with visibility of PTL

Actions & Improvements

- Cardiology – Locum Consultant started in January to fill gap of retired Consultant who left in December. Clinic template will be all new patients which will increase capacity.
-
- Cardiology locum due to start April, was planned for February however original candidate withdrew
- Rheumatology locum started in February as backfill to cover sickness
- New corporate project encompassing reforming elective care for patients will replace outpatient optimisation project.

Emergency Care

Key Messages

- Total ED Performance 75.8%
- Type 1 performance 61.2%
- Type 3 performance 91.4%

- Admitted performance 3.6%
- Non admitted performance 81.9%

- Whilst Ambulance handover delays increased Trust remained top in the country

Issues, Concerns & Gaps

- Total LOS >12 hours 8.2%

- HCP funding for SPOA model has been fully used. Funding stream required to continue model

- NCTR Average for January 122 (highest for a year)

Actions & Improvements

- Reviews requested from ED Care Group for days of poor performance to identify themes and trends as to why performance was low on specific days

- Regular meetings with Care Group Triumvirate around performance and planning for performance improvement

- Ongoing discussion around funding from ICB/HCP for continuation of SPOA as allocated initial funding of £100k has now been used – potential solution through use of MTW ACPs being finalised

- Flow and discharge fishbone ongoing

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	L	P	51.4%	50.6%	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%	50.7%	50.4%	49.9%	50.1%
				RTT 65+ Week Waiters	0	H	F	286	235	284	404	549	630	542	390	348	229	248	349
				RTT 40+ Week Waiters	-	H		5,927	6,296	6,434	6,627	6,662	6,736	6,778	6,274	5,917	5,777	5,982	5,843
				RTT Waiting List Size	-	H		43,716	44,646	44,751	44,491	44,528	44,477	44,130	43,248	42,912	42,165	41,518	40,726
				RTT 52 Week Breaches	1,250	H	?	1,886	2,159	2,360	2,610	2,834	2,922	2,687	2,362	2,265	2,118	1,938	2,021
				OP Average Time to First Appointment (days)	60	H	F	104.07	103.61	107.49	105.09	109.09	103.60	107.77	116.86	111.41	115.81	107.10	118.17
				Outpatient DNA Rate %	10.0%	L	P	6.2%	6.2%	6.2%	6.4%	6.3%	6.3%	6.2%	6.3%	6.1%	5.5%	6.4%	5.6%
				OP First to Follow Up Ratio	-	L		1.87	1.84	1.88	1.75	1.77	1.84	1.72	1.84	1.81	1.75	1.87	1.81
				Operations Cancelled by Hospital on Day	13		?	5	9	13	11	10	15	18	11	12	15	8	17
				Urgent Operations Cancelled for 2nd Time	0		?	2	1	2	5	1	0	1	0	1	2	1	1
				Day Case Rate %	-			87.2%	86.2%	86.0%	85.5%	85.0%	84.4%	83.9%	86.5%	86.0%	87.5%	88.7%	85.3%
				Average Elective Length of Stay (days)	3		?	2.54	3.22	2.93	3.43	2.84	2.73	2.31	2.65	2.62	2.21	2.86	2.62
				Average Non-Elective Length of Stay (days)	10	H	P	4.63	4.28	4.51	4.50	5.38	6.06	6.11	6.16	6.46	6.61	6.32	6.43

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Systems & Partnerships	Access			104 Day Cancer Waits	-			12	14	16	9	17	17	14	12	16	21	9	
				Cancer USC Performance %	93.0%			73.0%	72.8%	73.4%	70.1%	68.7%	70.6%	72.7%	93.6%	96.2%	94.9%	94.0%	
				Cancer USC Performance - Breast Symptomatic %	93.0%			38.4%	4.2%	2.9%	0.0%	9.9%	9.7%	38.6%	84.6%	97.9%	95.2%	90.6%	
				Cancer 31 Day First Treatment Performance %	98.2%			98.7%	98.4%	94.9%	98.1%	97.2%	96.4%	96.2%	97.2%	93.5%	96.5%	100.0%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%			100.0%	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	90.0%	94.7%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%			86.4%	92.6%	75.0%	94.6%	92.6%	96.4%	100.0%	93.9%	97.4%	100.0%	100.0%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L		68.1%	68.2%	67.4%	67.6%	68.2%	67.7%	67.2%	64.3%	58.1%	65.0%	63.7%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%			72.2%	90.0%	71.4%	71.4%	81.6%	85.7%	79.2%	87.2%	82.4%	79.4%	67.9%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%			47.6%	95.7%	77.6%	84.2%	80.0%	84.6%	66.7%	90.6%	28.6%	84.2%	70.0%	
				Cancer 28 Day Faster Diagnosis %	77.0%			73.0%	66.0%	56.5%	53.7%	52.3%	67.9%	76.4%	76.5%	76.1%	71.7%	70.5%	
				Cancer 28 Day Faster Diagnosis Screening %	-			79.3%	76.5%	72.2%	76.7%	74.5%	62.9%	45.5%	68.1%	65.3%	66.4%	50.5%	
				DM01 Performance %	73.1%	H		66.7%	66.9%	65.4%	67.1%	67.4%	67.6%	63.6%	68.4%	72.3%	78.4%	78.3%	82.5%
	Emergency Care			Total EC 4 Hour Performance %	78.0%			72.6%	77.4%	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance - Non-Admitted %	85.0%			77.9%	83.0%	86.9%	84.0%	84.6%	84.1%	85.9%	83.9%	85.0%	82.3%	79.3%	81.9%
				IP Discharged Before Noon % (Inc transfers to ADL)	-			14.3%	12.6%	12.7%	13.9%	12.1%	16.6%	17.1%	18.3%	20.6%	21.5%	17.6%	21.3%
				Type 1 EC 4 Hour Performance %	75.0%			63.5%	69.3%	69.5%	70.6%	68.8%	68.5%	67.6%	64.9%	67.8%	65.8%	58.3%	61.1%
				Total EC 12 Hour DTAs	0			798	798	521	588	618	663	577	644	693	771	770	756
				Average Time in EC Department - Excl. Type 5 (mins)	240			389.02	335.25	298.53	298.55	305.97	316.95	315.59	331.41	322.37	347.30	339.30	338.72
				Number of ED Arrivals by Ambulance	-			2,956	3,173	2,981	2,993	2,869	2,919	2,820	2,887	3,020	3,051	3,248	3,210
				Ambulance Handover Delays (> 30 mins)	-			90	103	67	49	73	59	46	77	77	76	145	137
				Ambulance Handover Delays (> 60 mins)	0			5	6	3	3	2	2	1	5	2	6	10	8
				Bed Occupancy - NCTR % (G&A)	-			20.4%	17.8%	18.7%	18.6%	19.3%	19.3%	17.9%	18.1%	20.7%	19.7%	20.4%	21.5%
				30 Day Readmission Rate	13.0%			10.0%	9.8%	9.9%	10.4%	8.7%	8.5%	8.4%	7.4%	7.1%	7.5%	8.0%	7.0%

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	23	2	11	15	10
Workforce	34	14	9	45	2	5
Compliance	0	1	1	1	0	1
Diversity	0	2	0	0	0	0
Safe Staffing	3	4	2	7	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	Feb-24	Mar-24
	6.93	H	F	6.65	6.65

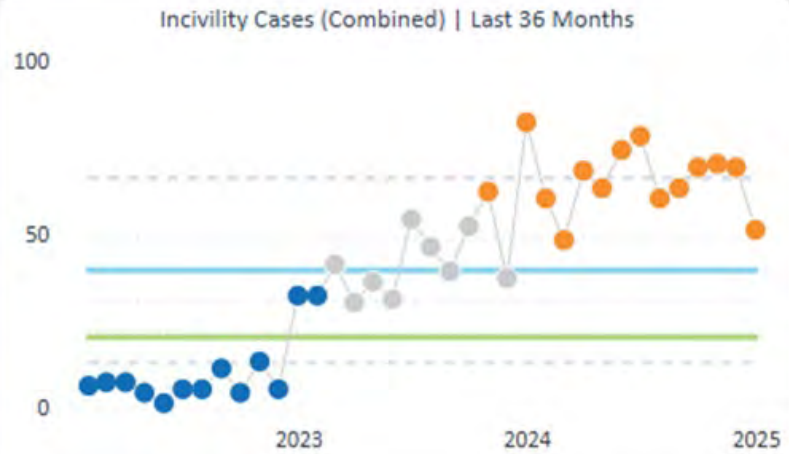
True North Domain: People

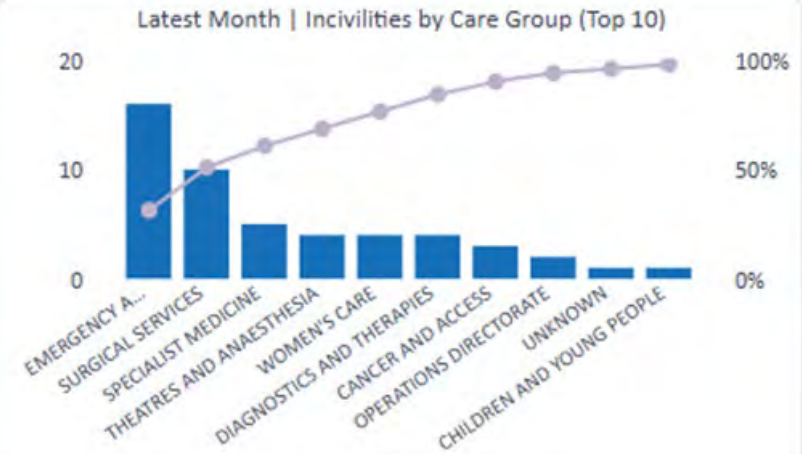
KPI Threshold: 6.93

Sub Domain KPIs: 17

Variation Summary:

8	0	2	4	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.
- As a weekly breakthrough objective with the aim of reducing reported incivilities by 50%, we are aiming to have concluded consolidation of all data source by March. Current developments include the overhaul of management essentials to ensure managers have the right skills to effectively lead and manager, this requirement has also been mandated.

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

- Catchball with divisions for a new breakthrough objective;
- Building into the reporting dashboard the additional sources;
- Continued development of the root causes via A3 methodology

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	Workforce			Incivility Cases (Combined)	20	H	?	Driver is red for 2 reporting periods	60	63	69	70	69	51
				Staff Appraisal Rate %	90.0%	H	?	Watch is red for 4 reporting periods	90.5%	89.8%	88.9%	88.7%	89.9%	89.4%
				Voluntary Turnover %	8.0%	L	F	Watch is red for 4 reporting periods	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%
				Sickness Absence Rate - Total %	4.0%	H	?	Watch is red for 4 reporting periods	4.9%	5.3%	5.3%	5.2%	5.3%	5.5%
				Sickness Absence Rate - Short Term %	2.0%		?	Watch is red for 4 reporting periods	1.8%	2.4%	2.5%	2.6%	2.7%	3.5%
				Sickness Absence Rate - Long Term %	2.0%	L	?	Watch is red for 4 reporting periods	3.1%	2.9%	2.8%	2.6%	2.6%	2.0%
				Time to Hire - AfC	42	L	?	Watch is red for 4 reporting periods	55.90	56	60	58.30	45.40	55.60
	Safe Staffing			Care Hours per Patient Day (CHPPD)	9.50		F	Watch is red for 4 reporting periods	8.95	8.51	9.09	8.55	8.80	8.21
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%		F	Watch is red for 4 reporting periods	79.7%	79.8%	80.7%	80.1%	79.4%	79.3%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	Watch is red for 4 reporting periods	49.7%	50.2%	50.6%	51.7%	51.5%	53.7%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	76.5%	76.6%	79.4%	81.3%	84.5%	84.8%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%		?	Watch is red for 4 reporting periods	81.5%	80.7%	82.2%	84.2%	80.3%	81.7%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	83.9%	87.2%	81.9%	83.3%	81.8%	82.1%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	StatMan			StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	82.3%	81.0%	81.2%	82.3%	83.0%	81.8%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	80.0%	78.6%	78.3%	76.7%	77.6%	78.1%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	80.6%	83.0%	76.3%	77.3%	79.7%	82.2%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	81.1%	80.6%	81.2%	84.2%	82.1%	83.8%
				StatMan: New Born Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	78.7%	75.9%	79.5%	83.3%	82.5%	79.2%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	77.9%	77.5%	75.9%	77.5%	78.5%	78.2%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	Watch is red for 4 reporting periods	80.8%	77.7%	78.4%	81.4%	79.1%	77.2%
	Compliance			DBS Compliance %	100.0%	L	F	Watch is red for 4 reporting periods	99.4%	99.5%	99.0%	98.9%	99.5%	99.3%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	Workforce			Staff Appraisal Rate %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	90.5%	89.8%	88.9%	88.7%	89.9%	89.4%
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,091.85	5,066.12	5,113.95	5,128.24	5,144.13	5,152.49
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%
				Sickness Absence Rate - Long Term %	2.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	3.1%	2.9%	2.8%	2.6%	2.6%	2.0%
				Time to Hire - AfC	42	L	Special cause of improving nature or lower pressure due to (L)ower values	55.90	56	60	58.30	45.40	55.60
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	1.9%	2.2%	1.5%	1.4%	1.2%	0.9%
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	42.2%	42.2%	42.7%	43.0%	43.3%	43.3%
				Diversity of Board %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	25.0%	25.0%	30.8%	30.8%	30.8%	28.6%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.6%	89.0%	87.2%	87.5%	87.9%	88.9%
				StatMan: Conflict Resolution Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.4%	94.9%	95.0%	95.2%	95.1%	94.9%
				StatMan: EDI Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	96.2%	95.8%	96.1%	96.2%	96.2%	96.0%
				StatMan: Fire Safety Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	84.5%	83.8%	85.7%	86.5%	87.7%	88.0%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	StatMan			StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.0%	95.9%	96.0%	96.2%	96.5%	96.6%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	93.4%	94.2%	94.3%	94.2%	95.2%	94.8%
				StatMan: Health Safety and Welfare Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.6%	91.1%	92.4%	92.6%	92.7%	92.3%
				StatMan: Information Governance Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	90.8%	90.3%	90.7%	90.9%	91.9%	91.4%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.2%	94.3%	94.8%	95.1%	95.4%	95.6%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	49.7%	50.2%	50.6%	51.7%	51.5%	53.7%
				StatMan: Patient Safety L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.7%	90.7%	91.3%	92.0%	92.6%	93.3%
				StatMan: Basic Prevent Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.8%	95.6%	96.1%	96.5%	96.7%	96.7%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.7%	95.3%	95.8%	95.7%	95.7%	95.9%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	76.5%	76.6%	79.4%	81.3%	84.5%	84.8%
				StatMan: Advanced Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	83.9%	87.2%	81.9%	83.3%	81.8%	82.1%
				StatMan: Adult Basic Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	82.3%	81.0%	81.2%	82.3%	83.0%	81.8%
				StatMan: Anaphylaxis Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.7%	91.8%	92.1%	93.2%	93.1%	93.5%

People

Key Messages

- New breakthrough objective for people domain now live – to reduce, by half, the number of reported incivilities – expect baselining by March;
- Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative. Spend improvement across maternity.
- New staff survey dashboard, developed with business intelligence, is now live.
- 188 mental health first aiders in place; 10 listening ear events conducted.
- Sickness rate, whilst static, shows a dramatic increase in the reduction of long-term sickness cases – however, a corresponding increase in short-term sickness cases. Targeting of reducing management referral times remain key priority through OH investment.

Issues, Concerns & Gaps

- Appraisal rate remains off track. Backlog of appraisal loading continues as a result of resourcing issues, potential underreporting of appraisal rate by 2-3%.
- National change of b2/b3 clinical support workers has significant implementation resource requirements requiring prioritisation for implementation.
- New triangulation of sickness triggers with occupational health data shows a number of long-term sickness cases are not being referred. This is being picked up across joint meetings between the two functions

Actions & Improvements

- Time to hire focus through improving the outcome notification from departments to initiate the employment checks. This delay is severely impacting on the speed to hire.
- Continued resourcing of the OH investment to address long-term sickness cases, triage times to decrease time to hire in recruitment.
- Project to move appraisals uploading directly into ESR in final testing stages.
- Testing of the workforce demographic dashboard version 2 in testing.
- Leadership development framework – final communications brochure to be completed in February.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	Workforce			National Staff Engagement Score	6.93	H	F	6.65	6.65										
				Incivility Cases (Combined)	20	H	?	60	48	68	63	74	78	60	63	69	70	69	51
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	0.6%	1.4%	0.8%	0.9%	1.0%	1.9%	1.6%	1.2%	1.1%	0.7%	0.8%	1.9%
				Staff Appraisal Rate %	90.0%	H	?	89.1%	89.8%	89.8%	89.3%	89.1%	90.2%	90.5%	89.8%	88.9%	88.7%	89.9%	89.4%
				Staff in Post (FTE)	-	H		5,000.86	5,029.08	5,037.19	5,029.92	5,027.71	5,030.78	5,091.85	5,066.12	5,113.95	5,128.24	5,144.13	5,152.49
				Staff Leavers (FTE)	-			35.66	53.55	37.79	44.65	42.21	62.65	145.58	67.67	70.68	49.26	38.32	47.84
				Staff Starters (FTE)	-			68.08	46.99	53.41	21.66	34.77	55.36	131.18	117.73	88.99	55.63	29.25	69.71
				Vacancy Rate %	9.0%		?	3.4%	3.0%	8.1%	7.8%	7.7%	7.8%	6.8%	7.3%	6.7%	6.5%	6.2%	7.1%
				Voluntary Turnover %	8.0%	L	F	9.7%	9.4%	9.1%	8.8%	8.7%	8.7%	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%
				Voluntary Turnover (ICS) %	-			0.7%	1.0%	0.6%	0.9%	0.9%	1.2%	1.4%	1.0%	0.9%	1.0%	0.7%	1.0%
				Sickness Absence Rate - Total %	4.0%	H	?	4.9%	4.4%	4.4%	4.7%	5.2%	5.0%	4.9%	5.3%	5.3%	5.2%	5.3%	5.5%
				Sickness Absence Rate - Short Term %	2.0%		?	2.4%	2.0%	2.2%	2.2%	2.4%	2.2%	1.8%	2.4%	2.5%	2.6%	2.7%	3.5%
				Sickness Absence Rate - Long Term %	2.0%	L	?	2.5%	2.3%	2.2%	2.5%	2.8%	2.8%	3.1%	2.9%	2.8%	2.6%	2.6%	2.0%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	Workforce			Time to Hire - AfC	42	L	?	60	66.10	61.10	55.30	47.90	54	55.90	56	60	58.30	45.40	55.60
				Time to Hire - Medical	70		?	76	54.90	91.30	66.70	58.90	42.60	86.50	51	78	69.90	60.90	61.70
				Agency Spend %	3.7%	L	?	2.7%	1.1%	2.1%	2.4%	1.5%	1.7%	1.9%	2.2%	1.5%	1.4%	1.2%	0.9%
				Bank Spend %	10.0%		?	11.7%	8.6%	11.1%	10.2%	10.4%	12.1%	10.2%	10.5%	9.0%	8.2%	9.6%	9.9%
	Safe Staffing			Staff Fill Rate - Total %	85.0%		?	93.0%	93.7%	96.3%	95.9%	95.8%	95.3%	87.2%	85.8%	86.3%	99.4%	85.2%	83.1%
				Staff Fill Rate % (Total) - Registered Nurse	-			91.5%	91.4%	92.9%	91.3%	90.5%	89.9%	89.3%	89.7%	91.1%	96.1%	88.1%	84.2%
				Care Hours per Patient Day (CHPPD)	9.50		F	8.63	8.47	9.47	9.45	9.03	8.86	8.95	8.51	9.09	8.55	8.80	8.21
	Diversity			Diversity of Workforce %	-	H		40.5%	40.8%	41.1%	41.5%	42.0%	42.0%	42.2%	42.2%	42.7%	43.0%	43.3%	43.3%
				Diversity of Board %	-	H		16.7%	16.7%	20.0%	18.2%	23.1%	21.4%	25.0%	25.0%	30.8%	30.8%	30.8%	28.6%
	StatMan			StatMan Training Compliance %	85.0%	H	?	87.9%	87.7%	88.1%	88.8%	89.0%	89.2%	89.6%	89.0%	87.2%	87.5%	87.9%	88.9%
				StatMan: Conflict Resolution Compliance %	85.0%	H	P	94.1%	94.5%	94.9%	95.2%	95.0%	95.0%	95.4%	94.9%	95.0%	95.2%	95.1%	94.9%
				StatMan: EDI Compliance %	85.0%	H	P	95.4%	95.4%	95.6%	95.9%	96.0%	95.9%	96.2%	95.8%	96.1%	96.2%	96.2%	96.0%
				StatMan: Fire Safety Compliance %	85.0%	H	?	82.9%	81.2%	84.2%	85.9%	84.5%	85.6%	84.5%	83.8%	85.7%	86.5%	87.7%	88.0%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	StatMan			StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	93.6%	94.0%	94.3%	94.8%	95.4%	95.4%	96.0%	95.9%	96.0%	96.2%	96.5%	96.6%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	87.2%	88.0%	89.1%	91.2%	92.7%	92.2%	93.4%	94.2%	94.3%	94.2%	95.2%	94.8%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	89.6%	89.2%	88.9%	88.9%	90.1%	90.8%	91.6%	91.1%	92.4%	92.6%	92.7%	92.3%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	96.9%	97.5%	97.0%	97.1%	97.6%	96.7%	96.1%	95.6%	96.0%	96.1%	96.1%	96.4%
				StatMan: Infection Prevention L2 Compliance %	85.0%		P	88.7%	88.5%	89.7%	89.6%	89.1%	88.6%	89.5%	88.9%	89.1%	90.3%	90.3%	89.7%
				StatMan: Information Governance Compliance %	85.0%	H	P	91.0%	90.8%	91.6%	91.8%	91.1%	89.9%	90.8%	90.3%	90.7%	90.9%	91.9%	91.4%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	89.0%	90.1%	91.4%	92.3%	93.1%	93.2%	94.2%	94.3%	94.8%	95.1%	95.4%	95.6%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	78.9%	78.9%	79.6%	80.4%	79.9%	79.8%	79.7%	79.8%	80.7%	80.1%	79.4%	79.3%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	44.5%	43.7%	43.4%	43.9%	46.7%	48.0%	49.7%	50.2%	50.6%	51.7%	51.5%	53.7%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	95.4%	88.6%	87.7%	90.3%	91.7%	91.3%	91.7%	90.7%	91.3%	92.0%	92.6%	93.3%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	96.0%	97.0%	97.1%	97.3%	97.6%	96.0%	95.8%	95.6%	96.1%	96.5%	96.7%	96.7%
				StatMan: Prevent WRAP Compliance %	85.0%		P	87.2%	87.8%	88.3%	89.1%	88.3%	89.0%	89.7%	89.1%	89.8%	90.2%	91.1%	90.5%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	StatMan			StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	96.4%	97.3%	96.7%	96.9%	97.3%	96.2%	95.7%	95.3%	95.8%	95.7%	95.7%	95.9%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	L	P	91.8%	91.1%	91.3%	92.3%	92.5%	91.8%	91.8%	90.2%	87.9%	88.5%	89.0%	88.1%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	63.6%	66.9%	65.8%	66.3%	68.7%	72.6%	76.5%	76.6%	79.4%	81.3%	84.5%	84.8%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		P	96.4%	97.0%	96.6%	97.0%	97.4%	96.4%	96.3%	96.4%	96.5%	96.5%	94.6%	95.5%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	83.2%	82.9%	84.5%	86.0%	86.2%	87.2%	87.2%	85.8%	86.1%	86.2%	85.3%	85.7%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%		?	77.6%	76.7%	77.2%	79.3%	80.5%	81.9%	81.5%	80.7%	82.2%	84.2%	80.3%	81.7%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	71.8%	75.2%	79.1%	83.7%	85.4%	85.1%	83.9%	87.2%	81.9%	83.3%	81.8%	82.1%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	80.9%	82.1%	80.9%	81.1%	82.1%	81.9%	82.3%	81.0%	81.2%	82.3%	83.0%	81.8%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		F	80.2%	80.2%	85.6%	83.0%	80.9%	80.5%	80.0%	78.6%	78.3%	76.7%	77.6%	78.1%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	91.8%	91.7%	90.3%	89.7%	89.9%	90.8%	91.7%	91.8%	92.1%	93.2%	93.1%	93.5%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	66.2%	70.5%	72.4%	68.3%	87.4%	85.9%	80.6%	83.0%	76.3%	77.3%	79.7%	82.2%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	71.1%	76.7%	76.5%	82.0%	82.6%	82.3%	81.1%	80.6%	81.2%	84.2%	82.1%	83.8%
				StatMan: New Born Life Support Compliance %	85.0%		F	78.5%	82.9%	82.0%	80.2%	80.8%	79.9%	78.7%	75.9%	79.5%	83.3%	82.5%	79.2%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
People	StatMan			StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	77.6%	79.1%	78.4%	78.4%	79.7%	78.0%	77.9%	77.5%	75.9%	77.5%	78.5%	78.2%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	87.7%	83.4%	83.5%	84.1%	85.5%	85.9%	80.8%	77.7%	78.4%	81.4%	79.1%	77.2%
	Compliance			Professional Registration Compliance %	100.0%	H	?	-	-	100.0%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%
				DBS Compliance %	100.0%	L	F	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.4%	99.5%	99.0%	98.9%	99.5%	99.3%

Sustainability

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

NHS Medway NHS Foundation Trust

Simon Wombwell
Chief Financial Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	16	8	7	24	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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
	£0.00m			2.56m	-2.76m	-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m	-1.86m	-5.41m	-1.98m	-5.62m

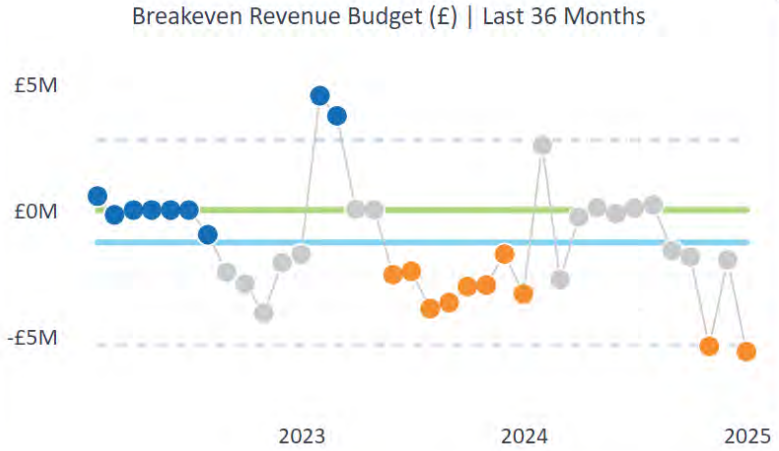
True North Domain: **Sustainability**

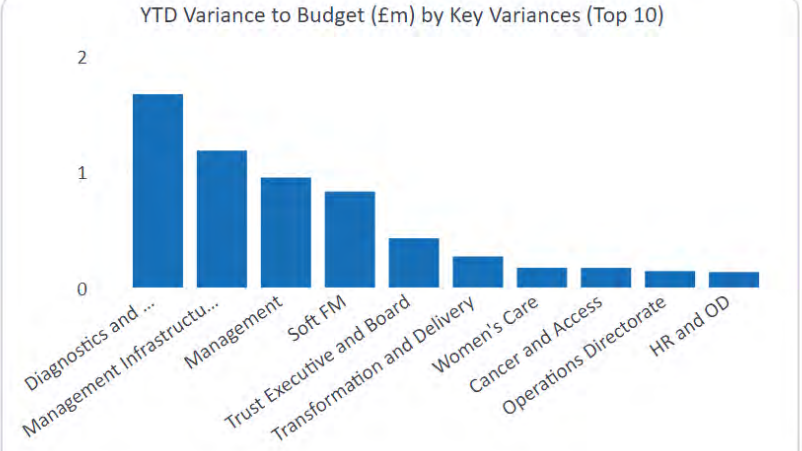
KPI Threshold: £0.00m

Sub Domain KPIs: 12

Variation Summary:

6	2	2	1	1





Key Messages

The headline position for January is a £4.9m deficit. This represents a worsening on last month's position, but this was largely predicted in the forecast. Disappointingly, the January number was again slightly worse than the forecast trajectory (by £343k).
Our overall deficit continues to reflect a mix of capacity and activity pressures driving spend levels, including maintaining our commitment to safe staffing levels. In specific areas (CDCs, endoscopy & respiratory) we have increased capacity to address demand pressures, but without full funding.

Issues, Concerns & Gaps

Focus in Q4 remains on spend control whilst addressing service demands. We are also seeking to increase activity to maximise our ERF earnings but activity in December and January was below expectations.

Continued operational deficits will place a pressure on the Trust's cash holding; this will need to be carefully managed and additional sources of cash identified. We have begun the process of seeking cash support in February.

Actions & Improvements

A series of initiatives have been identified by the Executive Team. This list of spend controls and income initiatives are currently being validated with an early estimate of opportunity to curtail the deficit by £2m.

A specific challenge has been set by the CEO to identify a further 200 posts reduction (as per targets agreed early this financial year) with a focus on bank and agency spending.

We also continue working with ICS colleagues through the I&I process, with the support of management consultants, Akeso.

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Sustainability	Financial Position			Total Financial Overspend (£)	£0.00m			Driver is red for 2 reporting periods	2.74m	3.87m	2.08m	6.22m	2.63m	3.00m
				(Surplus) / Deficit (£)	£0.00m			Watch is red for 4 reporting periods	-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m
				Total Pay Spend (£) vs Budget	£0.00m			Watch is red for 4 reporting periods	2.64m	1.29m	0.43m	3.81m	0.74m	1.68m
				Total Non-Pay Spend (£) vs Budget	£0.00m			Watch is red for 4 reporting periods	-1.06m	1.22m	2.19m	1.45m	2.60m	1.46m

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Sustainability	Financial Position			Agency Spend (£)	-		Special cause of improving nature or lower pressure due to (L)ower values	**0.50m**	**0.57m**	**0.50m**	**0.42m**	**0.32m**	**0.26m**
				Actual Worked FTE	-		Special cause of improving nature or lower pressure due to (H)igher values	**5,480.86**	**5,528.07**	**5,579.90**	**5,505.10**	**5,556.27**	**5,552.05**

Sustainability

Key Messages

- We are working to contain our deficit position to £22.9m by year end.
- Whilst this position represents £20.5m adverse to our Plan (£2.4m deficit), this has to be seen in the context of activity pressures, unfunded services and debt write-offs required in-year.
- We are currently working through 2025/26 planning proposals, with a view to balance outturn spending levels with an expected increase in activity to improve RTT and other performance targets.
- Medium term financial planning is being addressed by work to complete a Financial Recovery Plan (FRP).

Issues, Concerns & Gaps

- Activity in December and January was below expected levels, requiring a shift upwards to exceed levels reported in the autumn 2024.
- Pay pressures continue, including increased sickness following an increase in the 'flu in early to mid-January, and an emphasis on financial discipline to minimise unexpected costs

Actions & Improvements

- Business planning for 2025/26 to support clarity around targets and budgets; with improvement projects clearly identified.
- Greater financial discipline and understanding to support better understanding of position and actions required to achieve plan; accurate forecasting to inform corrective action planning.
- Medium term financial recovery plan to describe strategy for improvement.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m			2.56m	-2.76m	-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m	-1.86m	-5.41m	-1.98m	-5.62m
				Total Financial Overspend (£)	£0.00m			6.02m	19.01m	1.56m	0.61m	1.62m	1.37m	2.74m	3.87m	2.08m	6.22m	2.63m	3.00m
				(Surplus) / Deficit (£)	£0.00m			15.51m	-2.47m	-3.57m	-3.33m	-2.85m	-2.31m	-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m
				Agency Spend (£)	-			0.71m	0.42m	0.55m	0.61m	0.40m	0.44m	0.50m	0.57m	0.50m	0.42m	0.32m	0.26m
				Income (£)	-			56.72m	52.27m	37.37m	37.52m	37.02m	39.81m	38.21m	52.45m	47.61m	41.37m	41.38m	39.35m
				Income (£) vs Budget	£0.00m			8.38m	16.46m	-0.50m	-0.33m	-0.85m	0.93m	1.27m	1.40m	0.86m	-0.28m	0.18m	-1.73m
				Total Pay Spend (£)	-			25.99m	37.01m	25.67m	25.86m	26.29m	26.13m	26.22m	26.23m	32.75m	30.64m	27.20m	27.72m
				Total Pay Spend (£) vs Budget	£0.00m			4.10m	14.99m	-0.46m	-0.05m	0.76m	0.03m	2.64m	1.29m	0.43m	3.81m	0.74m	1.68m
				Total Non-Pay Spend (£)	-			13.09m	15.22m	12.96m	12.65m	11.48m	13.56m	11.91m	12.47m	14.29m	13.91m	15.04m	14.21m
				Total Non-Pay Spend (£) vs Budget	£0.00m			1.72m	3.85m	0.30m	-0.33m	-1.26m	0.91m	-1.06m	1.22m	2.19m	1.45m	2.60m	1.46m
				Actual Worked FTE	-			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	5,556.27	5,552.05
				Actual Worked FTE vs Budget	0			347.90	361.66	-27.32	-17.51	7.26	50.36	5.09	50.05	81.09	4.96	52.83	-1.98

NHS
Medway
NHS Foundation Trust

APPENDIX 2

Finance Report

For the period ending 31st January 2025 (Mth 10)

Contents

1. Executive Summary – Trust level

The financial results to January 2025 (Month 10) are set out below. Performance is measured against the Plan agreed with NHSE, and we continue to focus performance reporting against the £22.9m forecast I&E deficit. Work to improve upon the £22.9m deficit continues.

£'000	Budget	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month reported	271	(5,347)	(5,618)	The headline position for January is **£4.9m deficit**, whilst this is a deterioration from December (£2.9m deficit) this was largely predicted in our forecast due to debt write-offs. The adverse to forecast of £0.3m was the result of three factors: (i) an income correction (flex & freeze) being lower than the December prediction; (ii) an increase in sickness absence due to 'flu in early/mid January and (iii) unexpected costs in IT caused by an under accrual.
Tech. adjustments	(476)	424	900	
In-month vs **plan**	**(205)**	**(4,923)**	**(4,718)**	
In-month vs **forecast**	**(4,580)**	**(4,923)**	**(343)**	The overall deficit continues to reflect a mix of capacity and activity pressures driving spend levels, including maintaining our commitment to safe staffing levels; as well as write-off of the historic debts.
YTD total	**(2,112)**	**(18,473)**	**(16,361)**	
Forecast outturn	**(2,389)**	**(22,944)**	**(20,555)**	We continue to reflect no change to the forecast of £22.9m deficit, with active measures to address the in-month miss to forecast. Our biggest risk remains the outcome of the pathology charges by D&G.
Efficiencies Programme				
In-month	2,120	1,885	(235)	Our efficiency programmes continue to show progress towards the target. Our Reducing Waste weekly meeting includes an update against further rapid actions, including grip & control to achieve forecast.
YTD	17,295	15,735	(1,560)	
Cash				
Month end	14,448	7,060	(7,388)	Our cash level shows an in-month reduction of £2,334k in January. £7,388k adverse to plan. This is expected given the I&E deficit. An application to NHSE for additional cash support in March has been made, the outcome is pending.
Capital				
YTD				£5m (39%) of the YTD variance relates to IFRS16 intra-company leases for the CDC project, which will not be agreed until 2025/26. These are not part of the normal CRL of the Trust and thus capital limits are not expected to breach as a result, this will however impact the 2025/26 capital programme.
Capex	20,231	13,164	(7,067)	
Leases	5,750	0	(5,750)	The remaining underspend predominantly relates to schemes delayed for varying internal and external reasons. Of the £13.2m yet to be delivered £10.2m is forecast to deliver on plan. £3m will require deferral into 2025/26. Priorities from the 2025/26 programme have been brought forward for delivery in March to offset that impact and ensure full and effective utilisation of Trust operational CDEL.
Total	**25,981**	**13,164**	**(12,817)**	
FORECAST				
Forecast	**32,155**	**27,155**	**(5,000)**	

2a. Income and Expenditure (I&E) vs Plan

£'000	In-month			Year-to-date			Commentary
	Plan	Actual	Var.	Plan	Actual	Var.	
Clinical income	36,503	34,654	(1,849)	365,640	356,391	(9,250)	Clinical income remains adverse (£7.1m being clinical + HCD) as a result of the planning assumptions in respect of Ruby Ward funding, endoscopy mobile unit capacity in H1 and high cost drugs overperformance from the ICB (which has been fixed in contracts). Other income is favourable principally due to unplannd receipt of education monies, estates income, industrial action funding and favourable radio-pharmacy services to other providers.
High cost drugs	2,196	2,386	190	21,675	23,867	2,193	
Donated Asset Adjustment	500	(403)	(903)	2,500	2,510	10	
Other income	2,377	2,306	(71)	23,830	31,829	7,999	
Total income	**41,576**	**38,943**	**(2,633)**	**413,645**	**414,597**	**953**	
Nursing	(11,065)	(11,429)	(364)	(108,267)	(110,993)	(2,726)	ED staffing to meet demand safely, medical staffing in MEC and S&A to meet demand/address patient acuity/fill rota gaps, enhanced care requirements, CIP shortfalls and pay awards over and above national planning assumptions are all driving an adverse pay position. Overspending (4%) is a function of capacity demands.
Medical	(10,078)	(8,759)	1,318	(89,957)	(90,478)	(521)	
Other	(4,895)	(7,532)	(2,637)	(65,613)	(73,238)	(7,625)	
Total pay	**(26,037)**	**(27,721)**	**(1,683)**	**(263,837)**	**(274,708)**	**(10,872)**	
Clinical supplies	(5,323)	(5,307)	16	(49,682)	(52,425)	(2,743)	Consumable costs to meet demand, together with unplanned inflation cost pressures and some non-pay CIP under-delivery are the primary drivers of the 4% adverse to plan position. High cost drugs spend is offset by the income above; the true overspend on non-pay is £5.3m adv (£7.5m total less £2.2m HCD).
Drugs	(1,181)	(1,479)	(298)	(11,554)	(12,558)	(1,004)	
High cost drugs	(2,210)	(2,386)	(176)	(21,661)	(23,867)	(2,206)	
Other	(4,041)	(5,038)	(997)	(42,110)	(43,621)	(1,511)	
Total non-pay	**(12,755)**	**(14,210)**	**(1,456)**	**(125,008)**	**(132,472)**	**(7,464)**	
EBITDA	**2,784**	**(2,988)**	**(5,772)**	**24,800**	**7,417**	**(17,383)**	
Non-operating exp.	(2,513)	(2,359)	154	(24,640)	(23,779)	861	The favourable variance arises due to a lower than planned PDC dividend (due to higher cash balances to date) and delayed capitalisation generating lower depreciation charges.
Reported surplus/(deficit)	**271**	**(5,347)**	**(5,618)**	**160**	**(16,362)**	**(16,522)**	
Adj. to control total	(476)	424	900	(2,272)	(2,111)	161	Salix Grant (Decarbonisation Project) works delivery in advance of planned phasing. Expected to balance to plan by year-end.
Control total	**(205)**	**(4,923)**	**(4,718)**	**(2,112)**	**(18,473)**	**(16,361)**	The YTD deficit position is £16.36m. To deliver the control total, we would require a surplus in the final 2 months of c£14m.
Deficit Support Funding (incl. in Clinical Income)	(2,306)	(2,306)	-	(22,493)	(22,493)	-	
Performance against £27.8m deficit plan	**(2,396)**	**(7,114)**	**(4,718)**	**(24,605)**	**(40,966)**	**(16,361)**	The underlying position after removing Deficit Support Funding is a YTD deficit of £40.9m.

2b. In month Income and Expenditure (I&E) vs month 9 forecast

£'000	In-month			
	Plan	F/cast	Actual	Var. to F/cast
Clinical income	*36,503*	33,431	34,654	1,223
High cost drugs	*2,196*	2,380	2,386	6
Donated asset income	*500*	1,110	(403)	(1,513)
Other income	*2,377*	3,296	2,306	(990)
Total income	***41,576***	**40,217**	**38,943**	**(1,274)**
Nursing	*(11,065)*	(11,068)	(11,429)	(361)
Medical	*(10,078)*	(9,128)	(8,759)	369
Other	*(4,895)*	(8,196)	(7,532)	664
Total pay	***(26,037)***	**(28,392)**	**(27,721)**	**672**
Clinical supplies	*(5,323)*	(5,130)	(5,307)	(177)
Drugs	*(1,181)*	(1,218)	(1,479)	(261)
High cost drugs	*(2,210)*	(2,384)	(2,386)	(2)
Other	*(4,041)*	(4,187)	(5,038)	(851)
Total non-pay	***(12,755)***	**(12,920)**	**(14,210)**	**(1,290)**
EBITDA	***2,784***	**(1,096)**	**(2,988)**	**(1,892)**
Non-operating exp.	*(2,513)*	(2,396)	(2,359)	37
Reported surplus/(deficit)	***271***	**(3,491)**	**(5,347)**	**(1,856)**
Technical adjustments	*(476)*	(1,088)	424	1,512
Deficit vs Control Total	***(205)***	**(4,580)**	**(4,923)**	**(343)**

The overall performance **against Forecast** in January/M10 is adverse by £343k (being c0.9% of forecast income). However, within that overall position there are some notable variances, as follows.

Clinical income overperformance (favourable) is mainly due to £0.5m of £1.5m additional CDC income being brought into the M10. As per forecast we are now adjusting for the write back of unpaid prior year income assumptions. Clinical income performance is down in Dec and Jan – which increases the risk to the position over the final two months of the year (where we expect to increase activity to meet the ERF cap).

The donated asset income variance arises due to the timing of the works associated with the Salix Decarbonisation Grant, although this is removed to assess against the control total / Plan agreed with NHSE as a technical adjustment.

The forecast includes an estimate for staff growth as well as winter escalation capacity, this has been recognised in the higher run rate in-month. Sickness levels were high in January due to increase in 'flu (increasing bank costs in nursing). The pay favourable variance against Medical forecast, as stated last month, arises due to radiology additional sessions reported under non-pay (outsourced), also links to part of the adverse performance reported in clinical supplies. Underspending in Other is partly due to holding of vacancies, which is putting pressure on services, especially clinical admin.

Clinical supplies within non-pay is adverse to forecast, partially the result of the radiology sessions noted above, as well as activity driven clinical supplies costs. All non-pay costs continue to be monitored so they are offset by income/cost reductions elsewhere.

Other non-pay adverse variance to forecast includes costs that were not expected, mainly for unexpected and backdated IT contract costs included this month and winter non-pay related costs; expenditure for the mobile endoscopy unit are also included, as per the forecast.

3. Forecast

The forecast to 31 March of a **£22.9m deficit** remains unchanged; this position would be **£20.5m adverse to our agreed £2.4m deficit Plan / target**.

As highlighted above, we have recognised a proportion (£0.5m) of the additional CDC income (£1.5m) originally phased into M12/March. This compensates the in-month underperformance on clinical income – activity lower than expected in December and January. This increases the emphasis for increasing activity in February and March, where work is underway to meet the ERF cap. The income underperformance does signal a risk to the £22.9m forecast i.e. under-delivery in Feb and Mar could worsen the outturn vs forecast. We are actively looking at further mitigations to address the risk that December/January activity will not be recovered.

The table (right) includes our latest assessment of risks (-ve) and opportunities (+ve) to the income and expenditure extrapolations, adjusted following the M10 performance.

Our target remains to better this forecast and work is continuing to contain the risks, track and deliver the opportunities but given the heightened risks e.g. dampening of income, further mitigations may be required to hold the £22.9m deficit forecast.

Further measures and *Rapid Actions* being led by the Executives are focussing on discretionary spend in Q4, summarised as:

- Continued holding of vacancies / weekly vacancy panel.
- Minimise winter capacity / escalation.
- Discretionary spend controls / Procurement interception of reqs.
- Accelerate implementation and outputs of new medical model.
- Holding bank and agency to front line and critical posts only.
- Scrutiny of enhanced care spend.
- Scrutiny of capital spend charged to revenue.
- Actions to improve discharge.
- Unfunded services list.

We have also identified further risks not included in the £22.9m of £9m:

a) The dispute over MFT charges to MCH (expect to extend in 25/26).
b) Pathology charges from Dartford & Gravesham (host for KMPS)*.
c) Other outstanding debtors.

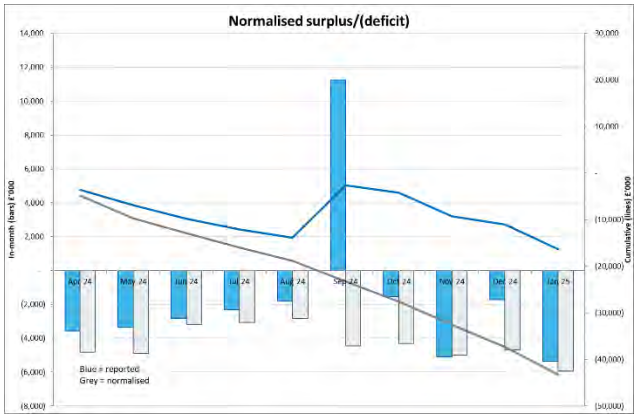
*This risk is our major concern with limited ability to mitigate.

£'000	M10 Forecast	M10 Actual	Var.	M10 FORECAST M11 Forecast	M12 Forecast	Total
Underlying Income	**41,447**	**40,556**	***(891)***	**40,245**	**40,723**	**495,658**
Risks & Opportunities						
CDC assumed in position	(750)	(750)	*0*	(750)	(750)	**(2,250)**
Coding & Counting - removed	(332)	(332)	*0*	(332)	(332)	**(996)**
Write backs from PY	(950)	(739)	*211*	(860)	(860)	**(2,458)**
Virtual Ward	(250)	(250)	*0*	(250)	(200)	**(700)**
Sheppy Frailty Unit (SFU)	(75)	(75)	*0*	(75)	(86)	**(236)**
Therapies	(200)	(200)	*0*	(200)	(200)	**(600)**
Ruby Ward	(133)	(133)	*0*	(133)	(134)	**(400)**
NHSE Aseptic Unit	0	0	*0*	0	(292)	**(292)**
Sub-total: risks	(2,690)	(2,479)	*211*	(2,600)	(2,854)	**(7,932)**
CDC expected to collect	0	500	*500*	500	500	**1,500**
Coding & Counting - lower target	250	286	*36*	250	214	**750**
PY - target to receive payment	0	100	*100*	100	800	**1,000**
ERF Stretch	100	0	*(100)*	100	200	**300**
ERF headroom to cap	0	0	*0*	850	850	**1,700**
System/national solution to class action	0	0	*0*	0	1,000	**1,000**
Winter discharge	0	0	*0*	0	(343)	**(343)**
22/23 support funding accrual	0	0	*0*	0	(206)	**(206)**
Sub-total: opportunities	350	886	*536*	1,800	3,015	**5,701**
Sub-total: risks and opportunities	**(2,340)**	**(1,593)**	***747***	**(800)**	**162**	**(2,231)**
Reported / Forecast Income	**39,107**	**38,963**	***(144)***	**39,446**	**40,885**	**493,427**
Reported Expenditure	**(42,686)**	**(43,697)**	***(1,011)***	**(42,686)**	**(42,686)**	**(515,567)**
Risks & Opportunities						
M7 & M8 Exp Growth continues into M9-12	(750)	(750)	*0*	(750)	(750)	**(2,250)**
Winter Ward	(250)	(250)	*0*	(250)	(250)	**(750)**
ERF headroom to cap - costs @40%	0	0	*0*	(340)	(340)	**(680)**
MCH VAT credit note	0	(70)	*(70)*	0	0	**(70)**
B2->B3 Class Action Back Pay	0	0	*0*	0	(1,075)	**(1,075)**
Sub-total: risks	(1,000)	(1,070)	*(70)*	(1,340)	(2,415)	**(4,825)**
Clin Division Mitigations	0	0	*0*	500	500	**1,000**
Non Clinical Mitigations	0	0	*0*	125	125	**250**
Salary overpayments	0	0	*0*	0	583	**583**
PDC dividend	0	157	*157*	22	22	**201**
Rev to cap	0	300	*300*	0	200	**500**
33 lines (other items)	0	0	*0*	0	100	**100**
Non-pay "holiday" - March	0	0	*0*	0	330	**330**
Interim/agency staffing "holiday" - March	0	0	*0*	0	100	**100**
Balance sheet	0	0	*0*	0	1,720	**1,720**
Sub-total: opportunities	0	457	*457*	647	3,680	**4,784**
Sub-total: risks and opportunities	**(1,000)**	**(613)**	***387***	**(693)**	**1,265**	**(41)**
Reported / Forecast Expenditure	**(43,686)**	**(44,310)**	***(624)***	**(43,379)**	**(41,421)**	**(515,608)**
Salix Grant removed	0	424	*424*	0	0	**(763)**
Net I&E Deficit	**(4,579)**	**(4,923)**	***(344)***	**(3,933)**	**(536)**	**(22,944)**
Cumulative Deficit	**(18,130)**	**(18,474)**	***(344)***	**(22,407)**	**(22,944)**	**(22,944)**

4. Normalised performance

The table below adjusts the reported I&E position for technical and other non-recurrent adjustments to give a 'normalised' view of the financial position i.e. the position we would expect to report operating on a normal, ongoing basis.

£'000	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Reported surplus/(deficit)	**15,507**	**1,622**	**(3,575)**	**(3,328)**	**(2,852)**	**(2,310)**	**(1,807)**	**11,241**	**(1,568)**	**(5,099)**	**(1,718)**	**(5,347)**
Technical adjustments	23	(464)	(15)	12	(173)	25	(178)	(275)	(267)	(475)	(1,188)	424
Control total surplus/(deficit)	**15,530**	**1,158**	**(3,590)**	**(3,316)**	**(3,025)**	**(2,285)**	**(1,985)**	**10,966**	**(1,835)**	**(5,574)**	**(2,906)**	**(4,923)**
Deficit support funding	(13,750)	(1,250)	-	-	-	-	-	(14,247)	(1,973)	(1,776)	(2,306)	(2,191)
Control total surplus/(deficit) before deficit support funding	**1,780**	**(92)**	**(3,590)**	**(3,316)**	**(3,025)**	**(2,285)**	**(1,985)**	**(3,281)**	**(3,808)**	**(7,350)**	**(5,212)**	**(7,115)**
Normalisation adjustments:												
Covid - income	(160)	(160)	(150)	(150)	(150)	(150)	(150)	(150)	(150)	(150)	(305)	(47)
Covid - incremental costs	4	40	-	1	3	-	-	1	-	1	-	(1)
Non-recurrent adjustments	-	(1,400)	(627)	(456)	(159)	(80)	(617)	(251)	510	293	806	1,231
Industrial action costs	590	-	-	-	447	130	-	-	-	-	-	-
Industrial action income	(2,167)	(167)	-	-	-	-	-	(542)	-	-	-	-
Annual leave accrual cost	-	130	-	-	-	-	(465)	-	-	-	-	-
Pension 6.3% Funding	-	10,929	-	-	-	-	-	-	-	-	-	-
Pension 6.3% Costs	-	(10,929)	-	-	-	-	-	-	-	-	-	-
Pay Award	(104)	83	(1,267)	(1,268)	(1,268)	(1,267)	(949)	(1,205)	5,239	3,109	-	-
Pay Award Income	94	94	960	960	960	960	961	961	(6,103)	(906)	-	-
NHS Property Services Credit Note	-	-	-	(667)	-	-	-	-	-	-	-	-
Additional Sessions Accrual	-	-	-	-	-	(379)	379	-	-	-	-	-
Recurrent surplus/(deficit)	**38**	**(1,472)**	**(4,823)**	**(4,896)**	**(3,191)**	**(3,071)**	**(2,827)**	**(4,469)**	**(4,312)**	**(5,003)**	**(4,711)**	**(5,932)**
Recurrent surplus/(deficit) - cumulative in-year	*(7,175)*	*(21,061)*	*(4,823)*	*(9,719)*	*(12,910)*	*(15,981)*	*(18,808)*	*(23,276)*	*(27,588)*	*(32,592)*	*(37,302)*	*(43,234)*



Commentary:

- The normalised/recurrent position removes technical items e.g. income and spend relating to charitable donations and one-off impacts e.g. industrial action.
- The normalised reporting in-month I&E position shows a worsening in our deficit by £1.2m. This is mainly due to income under performance, increased staff costs and I.T. contracts.
- As reported previously, the position throughout the year is caused by a combination of (i) under reporting of pay awards in earlier months and (ii) increased spending following increases in capacity e.g. CDCs, Ruby Ward, Endoscopy without a compensatory increase in our income.
- On a straight-line basis this indicates MFT has a ~£51.6m underlying gap to deliver a sustainability in its finances (£4.3m*12).
- This reinforces the actions to deliver spend reduction in the short term.

5. Statement of Financial Position

Prior Year 31.3.24	£'000	Month end Actual	Movement vs Prior Year
281,888	**Non-current assets**	**278,273**	**(3,615)**
6,556	Inventory	7,081	525
29,573	Trade and other receivables	47,218	17,645
21,042	Cash	7,060	(13,982)
57,171	**Current assets**	**61,359**	**4,188**
(357)	Borrowings	(284)	73
(57,536)	Trade and other payables	(56,054)	1,482
(1,166)	Other liabilities	(1,992)	(826)
(59,059)	**Current liabilities**	**(58,330)**	**729**
(3,073)	Borrowings	(2,817)	256
(1,307)	Other liabilities	(1,302)	5
(4,380)	**Non-current liabilities**	**(4,119)**	**261**
275,620	**Net assets employed**	**277,183**	**1,563**
489,836	Public dividend capital	507,969	18,133
(275,397)	Retained earnings	(291,761)	(16,364)
61,181	Revaluation reserve	60,975	(206)
275,620	**Total taxpayers' equity**	**277,183**	**1,563**

Key messages:

1. **Non-current assets** are £3.6m lower than year end, being the net impact of *£13.2m investment expenditure; £16.4m depreciation; £0.4m impairments.*

2. **Net Current Assets** (*Current Assets less Current Liabilities*). In January the Trust has net current assets of ~£3m, positive overall but a £3.7m decrease on December figures due largely to the deficit movement.

3. **Trade and other receivables** are £47.2m (115% of one month's income); £23.3m (49%) relates to invoices raised and awaiting payment.

4. **Cash** balance on 31 January is £7.1m just sufficient to cover weekly payroll and creditor payments until commissioner payments in mid-Feb. £16.5m of Revenue Support PDC has been drawn to date.

5. **Trade and other payables** are £56.1m (137% of one month's expenditure); £34.8m (62%) relates to invoices received and awaiting payment, £11.6m from prior years.

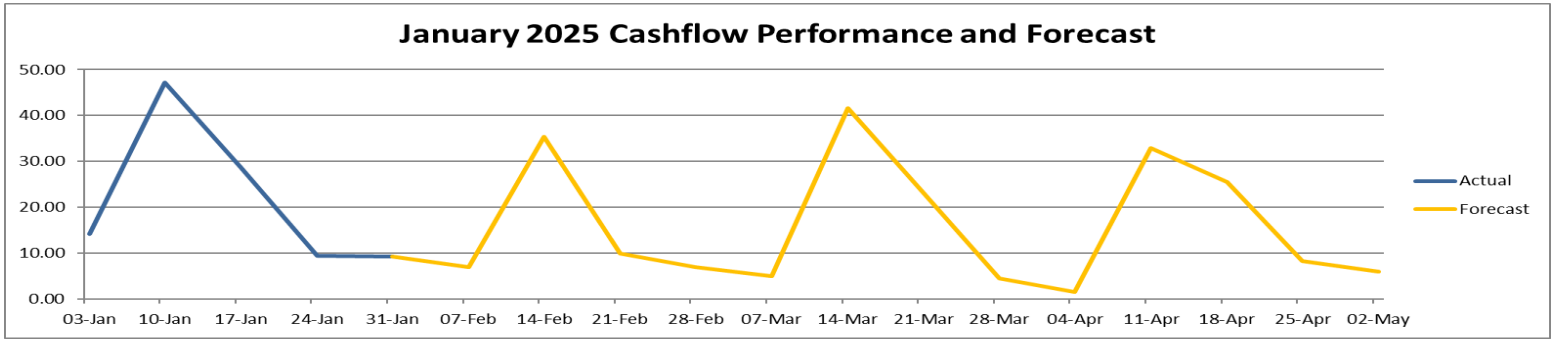
6. **Public Dividend Capital** £18.1m has been received YTD, £16.5m Revenue Support PDC and £1.9m Capital Support PDC for EPR.

7. **Revaluation Reserve** has decreased by £0.2m due to an impairment of off-site accommodation properties. No further changes are expected until M12 when the annual revaluation will be recognised.

6. Cash

13-week cash forecast

£m	w/e 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	07/03/25	14/03/25	21/03/25	28/03/25	04/04/25	11/04/25	18/04/25	25/04/25	02/05/25
	Actual					Forecast												
BANK BALANCE B/FWD	**15.61**	**14.17**	**47.13**	**28.57**	**9.32**	**9.27**	**6.86**	**35.37**	**9.95**	**7.01**	**4.91**	**41.66**	**23.17**	**4.54**	**1.57**	**32.83**	**25.46**	**8.24**
Receipts																		
NHS Contract Income	0.06	36.54	0.34	0.15	0.55	0.40	37.53	0.21	0.21	0.11	39.49	0.00	0.00	0.00	37.08	0.00	0.00	0.00
Other	0.16	0.42	0.45	0.16	0.07	0.42	0.26	0.58	0.18	0.18	0.45	0.25	0.54	0.32	0.63	0.21	0.44	0.30
Total receipts	**0.21**	**36.96**	**0.79**	**0.31**	**0.62**	**0.82**	**37.79**	**0.78**	**0.40**	**0.30**	**39.94**	**0.25**	**0.54**	**0.32**	**37.71**	**0.21**	**0.44**	**0.30**
Payments																		
Pay Expenditure (excl. Agency)	(0.45)	(0.55)	(13.38)	(14.30)	(0.65)	(0.42)	(4.29)	(22.21)	(0.46)	(0.52)	(0.49)	(11.79)	(14.67)	(0.49)	(0.49)	(11.78)	(14.65)	(0.52)
Non Pay Expenditure	(1.16)	(2.23)	(6.03)	(4.90)	(0.02)	(2.69)	(4.95)	(4.18)	(1.83)	(1.85)	(2.71)	(4.95)	(3.00)	(3.00)	(2.55)	(4.15)	(3.00)	(2.00)
Capital Expenditure	(0.04)	(1.21)	(0.30)	(0.36)	0.00	(0.12)	(0.05)	(1.71)	(1.22)	(0.02)	(0.11)	(2.00)	(1.50)	0.00	(1.45)	(1.96)	0.00	0.00
Total payments	**(1.65)**	**(4.00)**	**(19.72)**	**(19.56)**	**(0.67)**	**(3.22)**	**(9.28)**	**(28.09)**	**(3.51)**	**(2.39)**	**(3.30)**	**(18.74)**	**(19.17)**	**(3.49)**	**(4.49)**	**(17.89)**	**(17.65)**	**(2.52)**
Net Receipts/ (Payments)	**(1.44)**	**32.96**	**(18.93)**	**(19.24)**	**(0.05)**	**(2.40)**	**28.50**	**(27.31)**	**(3.12)**	**(2.10)**	**36.64**	**(18.49)**	**(18.63)**	**(3.18)**	**33.22**	**(17.68)**	**(17.21)**	**(2.22)**
Funding Flows																		
DH Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.26	0.00	0.00
Working Capital Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.36	0.00	0.00	0.00	0.00	1.89	0.17	0.00	0.11	0.00	0.00	0.20	2.57	4.06	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(4.53)	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.36**	**0.00**	**0.00**	**0.00**	**0.00**	**1.89**	**0.17**	**0.00**	**0.11**	**0.00**	**0.00**	**0.20**	**(1.96)**	**10.32**	**0.00**	**0.00**
BANK BALANCE C/FWD	**14.17**	**47.13**	**28.57**	**9.32**	**9.27**	**6.86**	**35.37**	**9.95**	**7.01**	**4.91**	**41.66**	**23.17**	**4.54**	**1.57**	**32.83**	**25.46**	**8.24**	**6.02**



- The overall cash balance has decreased by c£2m in January. Cash will naturally decrease as a result of the I&E deficit, so requires constant monitoring to ensure payroll and supplier payments are not compromised. The position has now reached a position that cash support will be required, the application has been instigated in February.
- The 13-week forecast assumes the Trust's current net cash [reducing] run-rate continues. We are seeking approval and drawdown of c£6m 'Revenue Support PDC; and £7m of the remaining £14m capital programme being paid in year with the remaining balance falling due in April. Creditors are assumed to be maintained at 30 days and there are no anticipated material cash settlements (payable or receivable).
- If we are unsuccessful in seeking cash support we will need to apply working capital management arrangements until a solution is agreed in the new financial year.

7. Conclusions

The Finance, Planning and Performance Committee is asked to note the report and financial performance, which is a £4.9m deficit in-month and £18.5m deficit YTD.

I&E: Disappointingly, the in-month performance was £0.4m worse than forecast. Whilst this is less than a 1% of the gross spend forecast for January, it is significant in terms of our bottom line. The 'miss' is partly a function of:

i. Lower income - activity in January was lower than projected, and we were forced to adjust to account for the December *flex and freeze* also being lower than our estimated figure;

ii. Some increased spending - notably, higher sickness levels and previously unreported IT costs.

The forecast outturn – £22.9m deficit - is not proposed to be adjusted at this time. The reduced levels of income in December and January do heighten the risk of missing the £22.9m deficit, but we are working to continue to build mitigations should income not be recovered in February and March.

We hold a small number of risks not included in the £22.9m – the most significant risk being the North Kent Pathology Service charges issued by Dartford and Gravesham. D&G are expected to issue charges of ~£3.5m above current payments in the current year. Investigation into the position is underway, together with discussion with D&G and the ICB have been informed about the differences in assumptions.

Balance Sheet / SOFP: The D&G position is characteristic of improvement required in the management both debtors and creditors. This will require further work and implementation of an action plan for improvement in the new financial year. In the absence of more detail, this does pose further risk in 2025/26.

Cash: Whilst the Trust currently has sufficient cash to continue its current business, as highlighted in December, we have now begun the process to seek cash support. The month-on-month deficit position is the primary driver for cash support.

Further, a number of risks, specifically around cash, will be carried into the early part of the new financial year without proactive management and recognition of support requirements in April and May.

Simon Wombwell
Chief Finance Officer
February 2025

NHS
Medway
NHS Foundation Trust

APPENDIX 3

Meeting of the Trust Board Public
Wednesday, 12 March 2025

Learning From Deaths – Quarterly Report

1. Excutive Summary

Reducing mortality and avoidable deaths remains one the Trust's key objectives. This quarterly report outlines the results of mortality improvement work, including regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual ongoing procceses throughout the Trust.

The report incoperates information and data mandatated under the National Learning from Deaths guidance which states that Trusts must collect and publish certain key data and informtaton reagrding deaths in their care via a quarterly public board report. A summary of the current report will be provided to the next public board meeting. More in-depth detail is provied in the following report for the benefit of the Mortality and Morbidity Surveillence Group (MMSG) and the Quality Assurance Committee (QAC).

2. Risks

The following represents the current key risks as detailed on the risk register, identified by the service:

Table 1: current risks

Risk/issue	Mitigations
The Trust's SHMI is higher than exepcted	HSMR+ is no longer a risk though this continues to be monitored by the Mortality and Morbditiy Surviellence Group (MMSG). Mortality A3 refresh work ongoing to look into root causes for the increase in SHMI value.

3. Learning from Deaths

Rich learning from deaths requires the triangulation of information from multiple sources, including mortality metrics, medical examiner scrutiny, structured judgement reviews (SJR), patient safety incident investigation outcomes, together with detail from Trust quality and governance processes. This report seeks to outline key relevant activity.

Between October 24 to December 24, for quarter 3 of the financial year 2024/2025, the Trust recorded 386 inpatient adult deaths. Three patients with learning difficulties died in hospital during this time. 10.9% of deaths were reviewed by Structured Judgement Review (SJR).

An overview of the Trust's current position with regards to the mortality is presented below. Deaths on each ward are reviewed at specialty Mortality and Morbidity Surveillance Group (MMSG).

Table 2: Q3 Deaths overview

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total no. of deaths (adult inpatient & ED)	121	113	124	98	100	104	107	132	147	1,046
Total number of deaths returned by SJR (stage 1)	13	6	13	13	5	16	14	21	9	108
% of deaths reviewed by SJR.	10.7 %	5.3 %	10.5%	13.3 %	5.0 %	15.4 %	10.3 %	14.4 %	6.1 %	10.3 %
Total number judged as possibly/probably preventable (>50:50)	2	0	2	0	0	1	0	0	0	4
Total number of LD deaths reviewed	1	2	0	1	0	0	0	3	0	6
Total number of LD deaths judged as possibly preventable (>50: 50)	0	0	0	1	0	0	0	0	0	1

Structured Judgement Reviews (SJR)

The start of Quarter 3 24/25 adopted the new SJR process, moving from a weekly panel reviews to align with national best practice and revert back to single SJR reviewers with a stage 2 process for escalating cases which require further review. In line with recommendations made by NICHE and their external review of the learning from deaths processes at Medway, the new process aimed to move away from an over reliance on the Medical Examiner Service to refer cases for SJR and consider incorporating a wider source of referrals for SJR, that can often capture the everyday care and can generate rich learning opportunities.

The new process also aimed to include a wider range of clinicians as reviewers, and move from a consultant led review panel to a more multidisciplinary team approach to reviews and to include nursing and Operating Department Practitioners (ODPs) as reviewers.

Aqua (Advancing Quality Alliance) and Better Tomorrow are an NHS health and care quality improvement organisation working across the NHS, care providers and local authorities to identify, refine and embed sustainable strategies for high-quality care and regulatory excellence. Following the NICHE review of learning from deaths, the Trust aimed to respond to the recommendations and refocus the systems and processes in this area. The Trust has worked with the Better Tomorrow team in the past and so a project was commissioned to assist with the improvement aims. Part of this work was the use of the Structured Judgement Review (SJR+) plus app, along with reporting

tool to better support the Trust in understanding the outcomes of the reviews. Some of the other projects covered by Aqua and Better Tomorrow are included in the NICHE recommendations action log, detailed later in this report.

As a result, SJR training was provided by Aqua to current and new reviewers who had expressed an interest in learning from deaths and SJRs reviews. The training was an open invitation trust wide, to share awareness around the learning from deaths process and improvement initiatives.

A total of 18 reviewers, both current and new, hold licences to the SJR+ app to complete SJR reviews. The list of reviewers are a mix of medical staff, nursing and ODPs. The new process was successfully implemented in November 2024 and incorporated the new Stage 2 process whereby cases that scored very poor or poor for overall care, if the death was judged in anyway to be possibly preventable or problems in care led to harm of patient, are reviewed at the multidisciplinary panel to agree on final scoring and escalation of the SJR.

There have been challenges along the way with the new process. The SJR review tool app and reporting dashboard only considers a review to be ‘complete’ once the stage 2 panel has been completed. This means that although a review may be completed for the month is was allocated to, the dashboard will only include this once the stage 2 review has been completed meaning that reviews can often roll over into the next month. This can lead to a misrepresentation of how many reviews are being completed per month. To mitigate this, a separate note is taken when a case has been allocated and returned within the same month, regardless if it requires a stage 2 reviews.

There have been delays in receiving SJRs back within the two weeks provided. Some clinicians reported issues accessing Metavision for ICU notes which has prevented them from completing the reviews allocated to them for that month.

Additional challenges have been faced with staff sickness and annual leave whereby some reviewers were unable to complete the reviews allocated to them within the month. They have requested to attend the training session in January 2025 before they complete the reviews. Aqua provides reviewers with SJR refresher courses every 6 months. The Learning form Deaths team has offered SJR drop in sessions to provide extra support to reviews where possible.

Three reviewers declined to continue with undertaking SJRs due to not having the capacity to complete the reviews and have therefore stepped down from the role. We were able to replace one of the licences with a Frailty consultant who attended the SJR training, but there are two licences which are currently unfulfilled from the Nurses in the pool of reviewers.

SJR plus

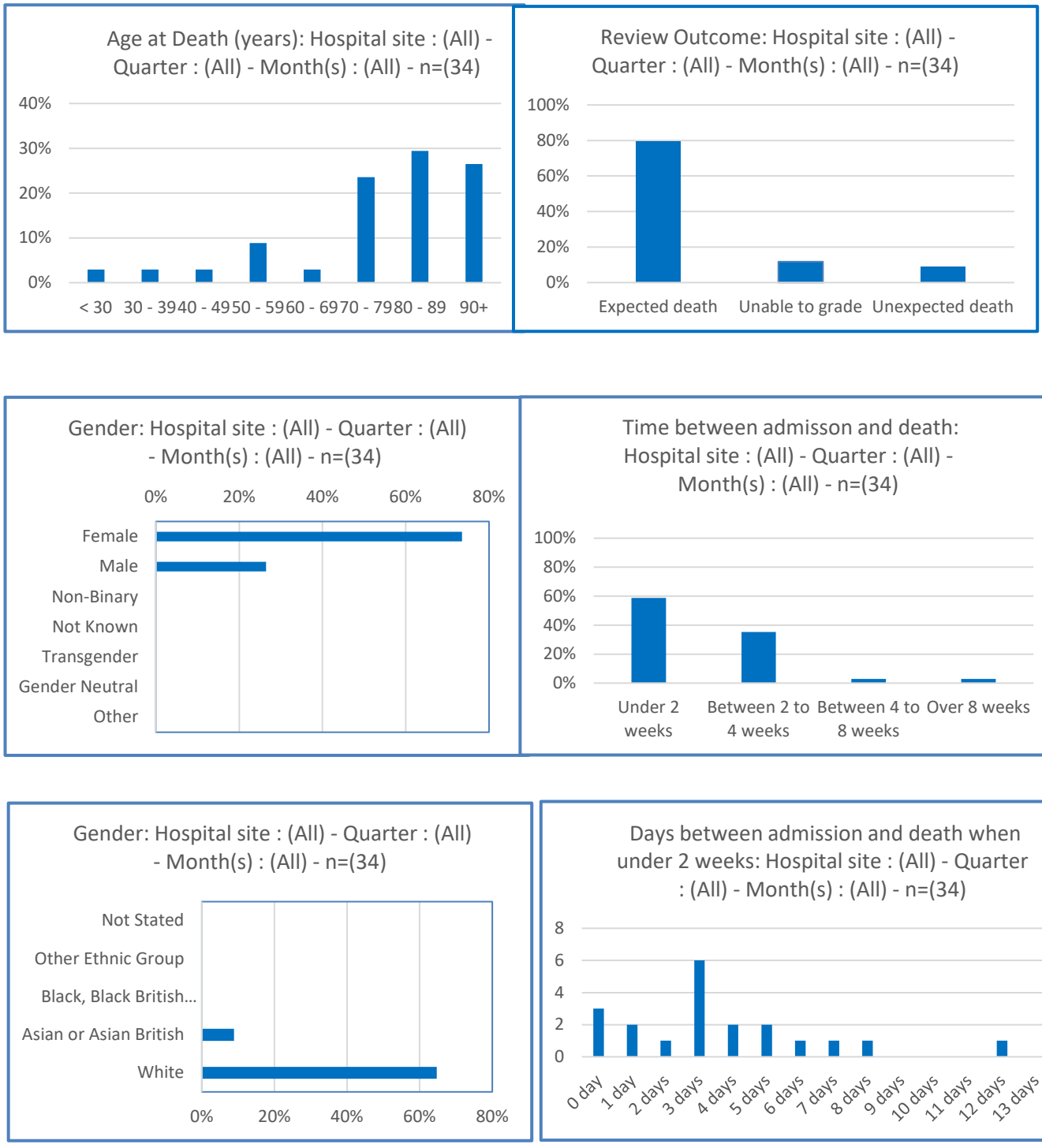
SJR plus is an e-review tool based on the SJR model created by Royal College of Physicians in 2016. Reviews are completed by our pool of trained reviewed. The focus of the review is on the final admission of care when the death occurs. If it is a readmission, the reviewer should also refer to the last admission, especially if thesis very recent.

Which sort of patients are we reviewing?

The new SJR plus tool is allowing a richer source of data from the SJR reviews and incorporates many patient factors which allows us to see which sorts of patients we are reviewing. From the data in quarter 3, we can see that:

- The majority of the patient we review are aged 70 and over and expected deaths (79.4%).
- The majority of patient are female and of white ethnicity.
- The majority of patients reviewed have a length of stay of between 1-6 days.

Figure 1: Q3 2024-25 deaths: SJR patient type data; age, expected deaths, gender, length of stay and day of death from admission.

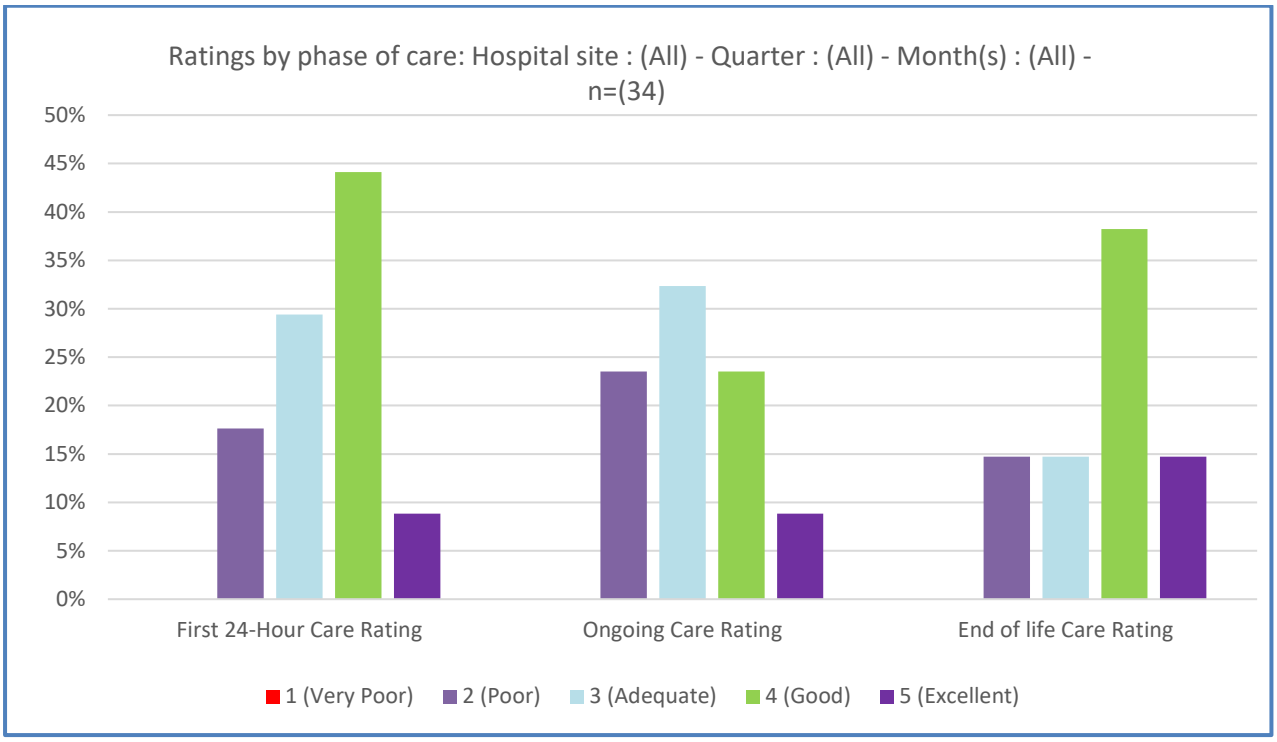


A total of 42 (10.9%) deaths were subject to SJR review over quarter 3 (24/25). Any cases which are judged as potentially avoidable, or have an overall care score as ‘poor’ or ‘very poor’, are escalated to the stage 2 SJR panel. If the panel agrees that the death was preventable (more that 50:50) these are escalated to the Incident Reviews Group (IRG) for a panel decision into further investigation under the PSIRF framework.

SJR phases of care scores

The SJR format allows reviewers to comment on each phase of care. The phases of care are the first 24 hours of admission, ongoing care, care during a procedure, final days and overall care. The reviewer is asked to score the phases from (i) very poor, (ii) poor, (iii) adequate (iv) good (v) excellent. This allows us to see where the poor or excellent care is during the admission. SJRs that have identified learning are shared with the specialities to discuss at the Mortality and Morbidity (M&M). The phases of care scores for quarter 3 are included in figure 2 below:

Figure 2 : Q3 2024-25 deaths: SJR phases of care



No cases were judges as very poor for any of the phases in care. Excellent care was most likely recognised in the end of life phases of care (14.8%). Excellent care in the end of life phase often related to:

- Excellent involvement with family, keeping them up to date
- Excellent consideration of families wishes
- Good end of life care team involvement
- Sensitive discussions with families to keep them updated on plans for end of life care

Poor care was most likely recognised in the ongoing care phase (23.5%). The poor care noted in ongoing care related to:

- Incorrectly calculated NEWS scores
- Delays in imaging
- Bleep issues/failures- lack of responding to bleeps or escalating

- Lack of review of bloods or repeated bloods
- Lack of escalation to ART
- Lack of continuity if care with multiple specialty involvement
- Poor communication between teams- Med SpR not aware of deterioration until days later
- Missed opportunities to act on deterioration
- Poor documentation with excessive use of copy and paste and not updating working diagnosis. Poor food chart documentation.

Learning from excellence and poor care

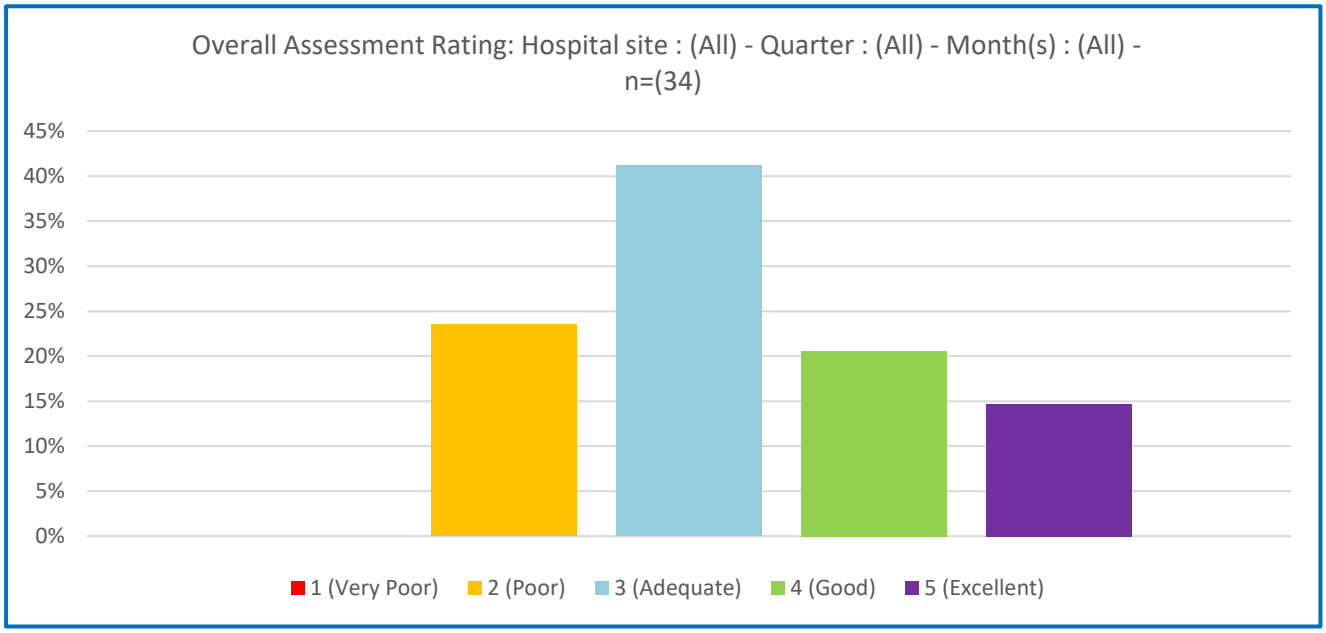
Figure below provides the overall assessment of care for Q3 deaths revived from October 24-December 24.

The SJR tool provides a balanced view of care, rather than focusing only on cases of poor or very poor care. It provides greater evidence to support learning from excellence.

23.5% (8) of cases were judged as poor for overall care and were escalated to the stage 2 review panel. No cases were judged as very poor for any of the phases of care.

35.3% (12) of cases were judged as good or excellent for overall care.

Figure 3: Q3 2024-25 deaths: SJR Overall Assessment of Care Rating



The reviews provide detail of both positive and negative lessons learned:

Table 3: Q3 2024-25 positive and negative lessons learned summary

	Positive lessons learned		Negative lessons learned	
	n.	%	n.	%
Yes	22	64.7%	29	85.3%
No	9	26.5%	2	5.9%
Total	**31**	**91.2%**	**31**	**91.2%**

Table 4 and 5 provides the details of positive and negative lessons identified regarding patient care. The positive lessons would rarely have been highlighted in our previous review process:

Table 4: Q3 2024-2025 deaths: SJR positive learning identified

DNAR and TEP forms completed
Excellent communication and involvement with family. Email of thanks sent from family complimenting the care.
Chaplin team input was excellent and respected the Islamic faith (turning bed to mecca and after death care, quick transfer to mortuary- very well done and respected.
Initial assessment in ED was well documented and there was a timely referral to the speciality made which was accepted. Patient was transferred to ward within 12 hours of admission.
Sensitive family discussions were held with the family, especially as one was dealing with a traumatic brain injury which was also very well documented.
Steps taken in ICU and patient's wishes were listened to
Good involvement from EOLC team.

Over the last few quarters, communication with families has often appeared as a common theme. Over the Q3, the positive comments from SJRs were around how well families were communicated with by clinical teams and how wishes of the patients and families were well respected during their stay and this area appears to have improved.

Communication with families is a learning point which is regularly shared with the teams from SJR to Mortality and Morbidity (M&M) meetings and ensuring the teams have early conversations around end of life care with patient and families so that they are better prepared for the enviable.

Table 5: Q3 2024-2025 deaths: SJR negative learning identified

Poor communication between clinical teams resulting in significant delays in treatment of a deteriorating patient between different wards. Ineffective communication systems have contributed to this- bleep system failures/ lack of bleep escalation being followed/phones not being answers/ referral systems for palliative care not effective.

Poor documentation - continued use of cut and paste through the notes. Lack of documentation around why or why not treatment plans have changed or haven't been followed. TEP forms not clear. Patient histories not including significant previous admissions and diagnosis, poor documentation around end of life care decisions. Lack of documentation to rationale for treatment or reason for not treating.
Appears to be no channel for communication if the discharge plans are not actions in the community. Patients who take medication home with them need to have the importance of compliance in taking the medication explained to them. Better patient education when giving EDN.
When a medication such as steroid is changed method (from IV to oral) this should be requested immediately and not wait until board rounds. Time critical medication neds to be highlighted to the prescriber in case they would prefer an alternative method until the medication is available.
Long stays in ED- some patients over 24/30 hours.
Unclear what treatment plans are- CT CAP indicated no cancer but no clear on the pleural effusion showing.
Sepsis 6 need to be done as soon as possible and sepsis recognised sooner. Sepsis 6 not completed
Lack of clarity in terms of communication and discussion of prognostic outcome with the patient and family

Opportunities to improve

The purpose of conducting SJRs is to identify concerns and opportunities to improve. In particular, there are three' triggers' within an SJR that lead to escalation to the stage 2 panel for consideration of a patient safety incident:

(i) Where overall care is considered poor/very poor,

(ii) Where a problem in care led to harm,

(iii) Where the reviewer considered there to be any evidence that the death may have been preventable. This approach ensures further scrutiny of these cases.

To maximise the use and value of the whole of the SJR dataset, all individual SJR with learning identified are discussed at the relevant Mortality and Morbidity (M&M) meeting for the teams to reflect on the learning and embed actions that are improvement driven where necessary.

Actions: From Quarter 3, a total of 42 SJRs were completed. 17 SJRs were referred to specialties to discuss at their M&M meeting.

An emerging theme was seen through SJR reviews during quarter 3 which was also a concerns raised by the Medical Examiner whereby frail, elderly patients who were clearly dying soon admission, were having longer stays in ED. All three of these cases that were highlighted for review occurred on the same day, which was also a day where ED had an increased number of deaths. All three cases were escalated to ED to review at their M&M. ED have confirmed that these cases will be looked at collectively at their M&M meeting in January 2025. The ED Matron is also going to review the deaths that occurred on that day and feedback any findings.

Another emerging theme was identified through the random SJRs that were selected from sepsis related deaths. Of the 7 SJRs completed, 4 of these identified issues with sepsis 6 pathway not being completed. The outcomes of the SJRs were forwarded to the Acute Response Team (ART) who are currently undertaking a sepsis audit with the view of finalising the policy for sepsis to support the A3 thinking work stream by the end of January 2025. Sepsis champions are being developed in all clinical areas with support with education and training which will disseminated in all clinical areas. By the end of January 2025, the policy will have been agreed by all key stakeholders and the audit will be complete to support the A3 work and move forward with countermeasures with a group of clinical staff in all areas who are focused on sepsis compliance and education.
SJRs where there have been significant issues with copy and paste have been shared with the specialties to discuss. Gastroenterology are focusing improvement work in this area with learning around not using copy and paste being shared at their M&M. Gastro report that through a review of cases, they have identified that this is commonly used among junior doctors. As a result, Gastro are implementing the following;

- This has been discussed with junior doctors who have been the main users of copy and paste and a decision has been made to include them in the M&M Meetings to enhance their learning.
- The type of information which is acceptable for copy and paste use was also highlighted and stated that it is not suitable in diagnostic and treatment plan documentation.
- It was highlighted how this has a negative impact on clinical coding.
- Consultant is showing doctors what errors have been made in the use of copy and paste.
- It was also discussed that Consultants check what junior doctors have written and check it is accurate.
- The Gastroenterology Team are working to improve teamwork to result in improving the note entries.

Preventable deaths

The SJR plus tool uses the terms ‘preventable’ rather than ‘avoidable’ as Aqua and Better Tomorrow agreed that a softer use of the term to describe deaths that may have been due to issues

in care would make the reviewer feel more confident in making a judgement if there had been suboptimal care.

Preventable deaths refers to deaths judged to have been more likely than not (>50:50) due to a problem in healthcare. This is the criterion for statutory reporting of preventable deaths in the Quality Account.

With the SJR approach, the preventability of death is assessed at the point of review. This provides a strong/clear steer for which cases should receive further robust investigation via our patient safety incident framework. In consultation with our patient safety team, it was decided that all cases judged as the following would be referred to the Incident Review Group (IRG) for further consideration:

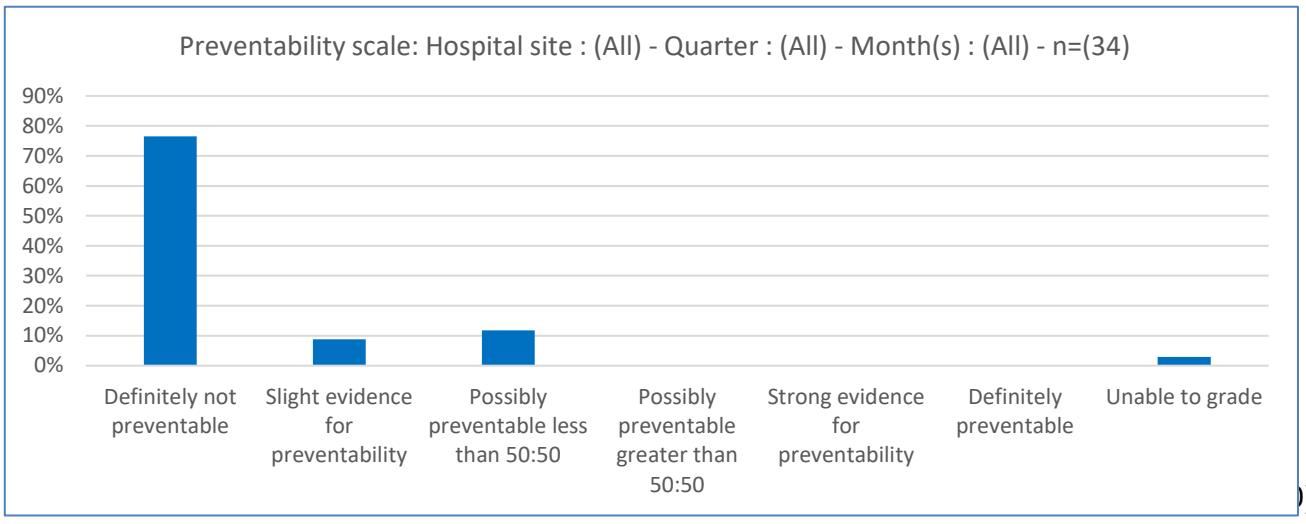
(i) Definitely preventable

(ii) Strong evidence of preventability

(iii) Possibly preventable (greater than 50:50).

It must be remembered that the question of the preventability of death is a subjective assessment of an individual reviewer on the basis of an SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in care (more than 50:50) provide invaluable, powerful indications that a further in-depth investigation of the case is required, using the Trust's Patient Safety incident process. It is important to note that SJRs are not an investigation tool.

Figure 4: Q3 2004-25 deaths: SJRs judged as possibly preventable



)), strong evidence of preventability or definitely preventable. 76.5% (26) of reviews were judged as definitely not avoidable.

Details of the cases that were judged as either slight evidence of preventability or possibly preventable (less than 50:50). As per the standard operating procedure, these cases underwent a further review at the Stage 2 panel to determine the outcome.

Thematic Analysis and escalations

Thematic reviews of SJRs are completed on a quarterly basis to allow sufficient data to review what issues are reoccurring. The table below gives an overview of the top five themes that were identified over quarter 3 2024-25, that is, issues that have been identified a number of times from different reviews. The table include the current status around ongoing improvement work.

Table 7: Q3 2024-25: SJR themes

Theme	Issues identified	Actions
Problems with communication between clinical teams	Lack of ownership of patients especially if patients are seen by teams a number of teams.	MD for Medicine and Emergency care has met with MD for Surgery and plans are ongoing. Acute care professional standards documented has been drafted and due to Medical Board for discussion. SJRs that identify the teams involved are sent to the teams for joint M&M meeting to reflect on learning.
Problems with documentation	Copy and paste on ePR	Do not use copy and Paste on epR is a regular message on speciality M&M meetings. This is also included in the coding and mortality presentation delivered to specialities. Gastro carried out a review of cases where this happens within their speciality and are implementing a number of actions to tackle this issue. LFD are in contact with EPR around the copy and paste of the working diagnosis issue.
Bleep issues and system failures to communicate	Difficulty in bleeps not being answered, no escalation if bleeps are not answered and lack of awareness around bleep escalation policy. When a ward attempts to bleep (e.g for deterioration) it says the bleep has been processed but the bleep holder does not receive the bleep. The ward does not know that the bleep hasn't gone through and keeps trying or tries another bleep number (with the same outcome). By which time, the patient continues to deteriorate until a 2222 call is required.	The issues was raised to the Chief Delivery Officer that this was becoming a regular theme from mortality reviews. He confirmed that a full replacement of the bleep system is in progress, not just for 2222 calls.
Long stays in the Emergency Department	Patients spending over 24 hours in ED, some over 30 hours.	Cases that have been reviewed at SJR have been sent to ED directly to discuss at their M&M meetings with a focus on elderly,

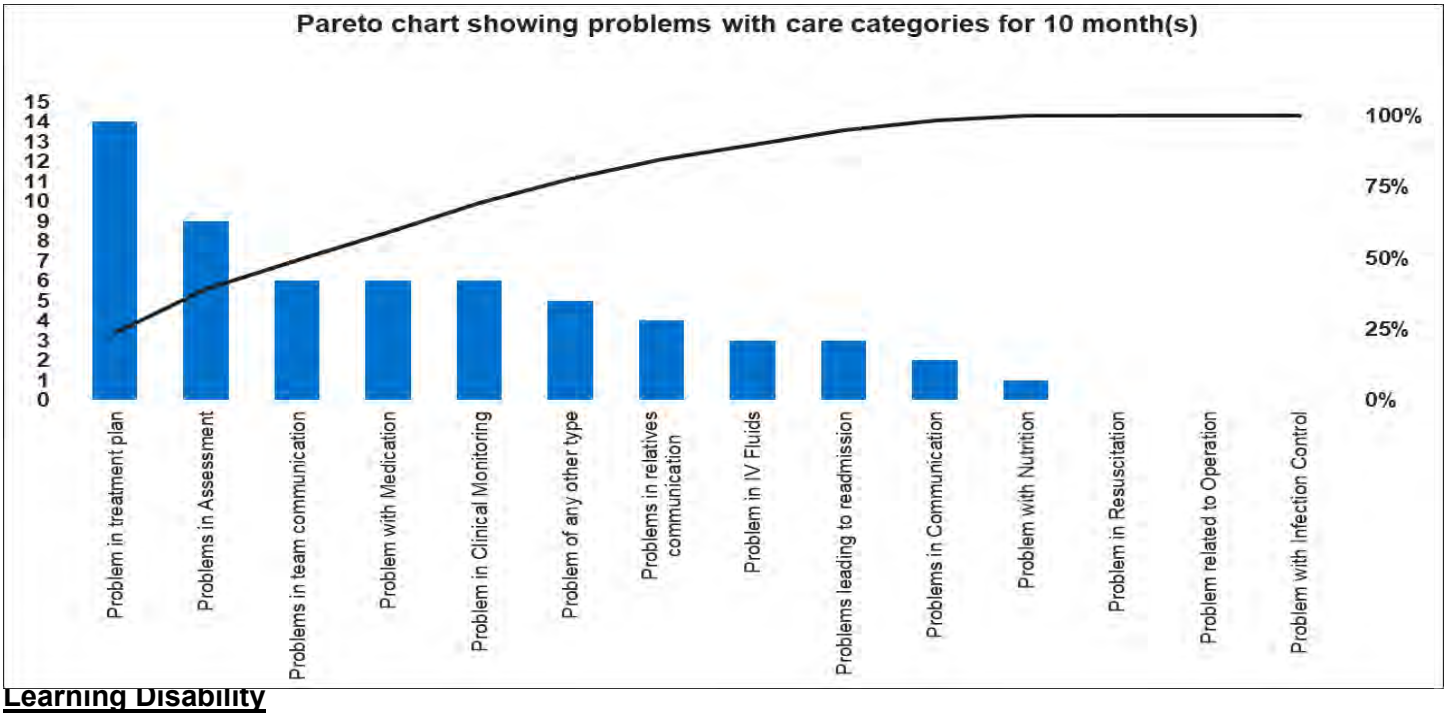
		frail patients or patients under DOLS who have long stays in ED. These cases are being discussed in the January ED M&M
Sepsis 6 pathway not followed	Sepsis 6 pathway not followed completely. This often relates to bloods and urine cultures	Cases were highlighted to ART. The work stream to this has commenced with the audit and sepsis policy currently in progress. Sepsis champions are being developed in all clinical areas with support with education and training which will disseminated in all clinical areas. By the end of January 2025, the policy will have been agreed by all key stakeholders and the audit will be complete to support the A3 work and move forward with countermeasures with a group of clinical staff in all areas who are focused on sepsis compliance and education.

Problems in care

The SJR format asks the reviewer to indicate if there has been in a problem in are and whether that problem lead to harm of the patient. This gives us an indication as to what the issues with the care are. For quarter 3, the top issues in care were. Figure 5 illustrates a pareto chart of the problems in care and how often these occur. This also allows us to triangulate the themes seen with problems in care and harm levels with patient safety incident themes:

- Problems in treatment plan
- Problems in assessment
- Problems in team communication
- Problems with medication
- Problems with clinical monitoring

Figure 5: Q3 2024-25: SJR problems in care categories



Learning Disability

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

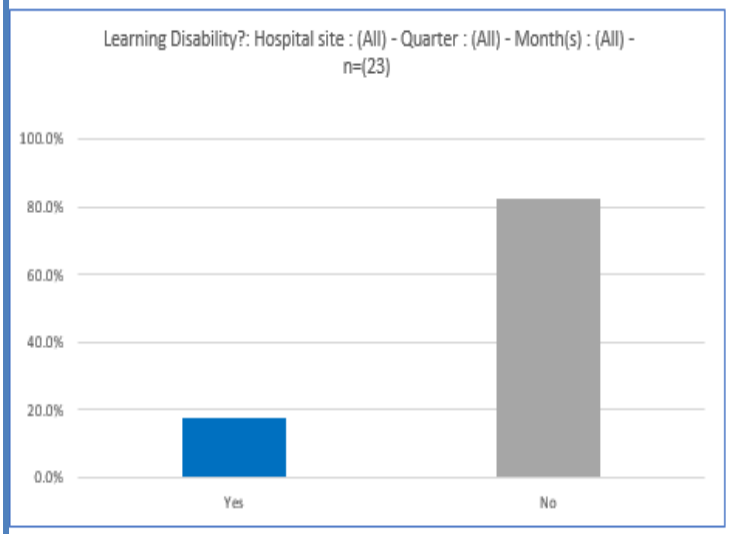
All four cases reviewed through SJR scored good or excellent care throughout the admission. There was good timely involvement with end of life care, TEP and DNAR forms were completed for all cases and there were examples of excellent multidisciplinary working between teams with sensitive involvement with families. A letter of thanks was received by one of the families for the care given to a patient. Feedback was shared to the teams involved to share as good news at their M&M meeting. The teams were grateful to receive positive feedback.

Some of the learning identified from the reviews were for teams to consider earlier involvement with the Learning Disability Nurses. There needs to be better collaboration with end of life care, community palliative care, SECAMB and paramedic to avoid hospital admissions for those on end of life care in the community. The Learning Disability Liaison Nurse is feeding back the learning from the reviews to the teams involved.

Figure 6: Q3 2024-25: SJRs for patients with learning disabilities

	n.	%
Yes	4	17.4%
No	19	82.6%
Grand Total	23	100.0%

*number of incomplete records 0



Overall care assessement rating for patients with learning disability

Patient with learning disability - overall assessment care rating
Learning Disability? Yes

Overall summary

	First 24-hour Care Rating	Ongoing Care Rating	End of Life Care Rating
1 (Very Poor)			
2 (Poor)			
3 (Adequate)			
4 (Good)	4	3	2
5 (Excellent)		1	2
Grand Total	4	4	4

Detailed summary

	First 24-hour Care Rating	Ongoing Care Rati	End of Life Care Rating
Patient 1	Good Care	Good Care	Excellent Care
Patient 2	Good Care	Excellent Care	Good Care
Patient 3	Good Care	Good Care	Excellent Care
Patient 4	Good Care	Good Care	Good Care

Specialty Mortality and Morbidity Meetings (M&M)

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

The main issues highlighted from specialty M&Ms are:

- No reporting structure. National guidance recommends that each specialty has a dedicated lead who will have overall responsibility of actions/improvements and that these are reported to the Trust Mortality and Morbidity Surveillance Group. This is currently being addressed through the new Mortality and Morbidity Review Group (MMRG) that is due to commence in February 2025.

- M&M are sometimes poorly attended, poor engagement, no clear specialty lead. A best practice guide has been shared with the teams which outline how M&Ms should be facilitate to maximise the effectiveness of these meetings. Surgery and Anesthetics Division turned the best practice guide into a standard operating procedure for the teams to follow.

- No clear action log from reviews. LfD contacted a number of specialties but there is no central action log to monitor actions discussed to evidence improvement. This element was included in the best practice guide and as result, some of the teams are improving their actions.

- No standardised format to reviews. M&M review process are highly variable across the Trust. A template has been shared with the teams and the majority of M&M now use the standard template.

From SJR to M&M

For Quarter 3, a summary of some of the learning discussed at specialties after SJR reviews is summarised below:

- General Surgery discussed a case presented at SJR whereby the reviewer felt that taking the age of the patient into consideration, operations should be avoided on very frail patients. Using the NELA grading will help with this. General Surgery reviewed the case and management of the patient was appropriate throughout the admission and there was good communication between the various teams.

- Gastroenterology discussed an SJR whereby the patient had a long stay in ED and spent 10 days on a medical ward before being transferred to Gastro. The Gastro team confirmed that this did not affect the care given to the patient and that the patient was being regularly reviewed by the Gastro team.

- Acute Medicine discussed a case whereby there was a delay in imaging due to an initial diagnosis of NSTEMI and whereby the SJR panel felt differential diagnosis should be considered sooner. Acute Medicine confirmed that the dissection was not suspected due to the absence of comorbidities causing ischaemic heart disease. Acute physicians requested a CT angiogram to confirmed this. Acute Medicine requested that this was is also discussed at the ED M&M.

Forward plans

The introduction of the Mortality and Morbidity Review Group (MMRG) will introduce a reporting and triangulation of data opportunity for the teams to share learning and improvement strategies within their teams with other specialties.

Themes and trends seen across all mortality reporting (from M&M meetings, Medical Examiner themes and trends and SJRs) will be shared with the teams. The group will place ownership and accountability of actions and improvements within the specialties, which in turn will be reported to the Mortality and Morbidity Surveillance Group and the Quality Assurance Committee in order to provide assurance that learning from deaths and improvements is a robust process within the specialties and Divisions.

Figure 7: Q3 2024-25: M&M tracker

Speciality 2024/2025	Quarter 1			Quarter 2			Quarter 3		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Acute Medicine	Meeting Canc	15th	7th	12th	30th	27-Sep	Meeting cancelled	29th	13th
Acute Paediatrics	4th	2nd	6th & 20th	18th	15th	5th	3rd & 17th	7th	Rescheduled to 23/01
Anaethetics					11th		9th		
Cardiology	23rd	28th	25th	30th		24th	meeting cancelled	26th	Meething cancelled
Critical Care - ICU/HDU	No Meeting	No Meeting	No Meeting	15th	21st	12th	23rd	13th	12th
Diabetes and Endocrinology	17th	No Meeting held	No meeting held	17th	No meeting held	Meeting cancelled	16th	20th	Meeting cancelled
ED	24th	22nd	26th	24th	28th	25th	23rd	27th	Meeting cancelled
Elderly Care	25th	23rd	20th		1st	26th	31st		Meeting cancelled
ENT **LOW MORTALITY GROUP		9th	24th	No meeting held	No meeting held		14th Nov	14th	Meeting- held awaiting minutes
Gastroenterology	22nd	20th	24th	29th	No meeting held	30th	28th	23rd Dec	13th Jan
General Medicine								held- awaiting minutes	Meeting cancelled
General Surgery		9th	No meeting held		No meeting held	11th	9th	14th	12th
Haematology **LOW MORTALITY GROUP	19th	24th			No meeting held		1st Nov	27th Dec	27th Dec
Neonatology		28th			No Merting held		8th		
Maternity/still births					No meeting held	chased 08/10			
Gynaecology ** LOW MORTALITY GROUP	26th		7th	5th	21st	26th	14th	18th	16th
Trauma & Orthopaedics			No meeting held	Meeting held. No M&M cases discussed	No meeting held	11th	9th	14th	12th
Respiratory	19th	17th	21st	No meeting held	No meeting held	20th	11th	22nd	20th
Urology	17th	9th	No update	9th	No meeting held	11th	9th	14th	12th

4. NICHE – you said, we did

NICHE consultancy were commissioned by the Trust to undertake an external, independent review of the Learning from Deaths processes at Medway. NICHE aim to support Trusts by supporting a better understanding of all aspects of mortality governance from reporting through to practice improvement by ensuring robust and effective processes are in place to learn from deaths.

A review of all current processes, policies and practices was undertaken. Weekly sessions were held thorughout last year to address reccomendations made by NICHE based on our current learning from deaths process. Reccomendations were made in order to ensure a robust leanring from deaths process by focusing on areas where improvement was required. 29 actions were identified from the following categories:

Board Leadership on learning from death

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

Actions:

- Training on Learning from deaths and structured judgement reviews was delivered to the Trust in November 2024 and to the Board in December 2024. The reporting structure for learning from deaths reports was revised. Learning from Deaths was previously far removed from QAC and the Board, but now learning from deaths and mortality is reported monthly to QAC and quarterly to the Board.

- Specialty reporting: Divisions are required to report on M&M activity to the Quality and Patient Safety sub committee (QPSSC). The new MMRG will also provide a forum for specialties to report their M&M activity and triangulate themes and trends with the SJR outcomes.

- SHMI and HSMR+ data is still included in learning from deaths reports but now follows the learning from deaths section, as opposed to being at the forefront of reports.

- SJR process was completely revised. The single SJR process of a stage 1 and stage 2 review is in line with national best practice. The new reviewers were selected from both medical and nursing to give a more MDT approach to reviews.

- SJR referrals include a wider source of referrals, moving from an over reliance on the Medical Examiners to highlight cases for review. Random cases and cases referred from specialty teams are now included to balance the referrals.

- The new SJR+ data base facilitates the capture of ethnicity with SJR reveiws.

- The process by which SJRs are escalated to IRG for cases that require further investigation in line with PSIRF is well embedded and the process is outlined in the new SOP.

Next steps

Many of the actions included in the NICHE reccomendations were completed by the target dates of December 2024. Some of the next reccomendations to be finalised are:

- Mortality and Morbidity Review Group to commence in Febraury 2025 and report into the Mortality and Morbidity Surviellnce Group.

- Family feedback loop for complaints raised to the Medcial Exmainer and Bereavement Office. The Bereavement Office is currently in the process of recruiting a lead Beravement Officer and this process will be incorperated into the role.

5. Mortality A3 thinking

Over quarter 3, work has continued to progress with the Mortality A3 thinking refresh. A3 thinking involves the practice of consolidating problems, analysis, countermeasures and action plan into a single sheet of paper, commonly A3 sized. The method of problem solving and improvement processes follows the ‘plan, do, study, act’ (PDSA) cycle and involves stages to assess the background, current situation, target, analysis, countermeasures, implementaiton plan and follow up.

Understanding the rise in the mortality indicators is multi-faceted. The mortality A3 thinking aims to target areas of impact from potential infulences on patient care pathways, end of life care processes

and the processes directly linked to learning from deaths such as the SJR process, Medical Examiner process and Speicalty M&M processes.

Weekly sessions are held with stakeholders to agree on target areas. One of the areas of focus for the Mortality A3 work is the validation of deaths process. The introduction of the process will be pivotal in ensuring deaths are accuratley documented to ensure the clinical coding reflects the acuity of the patient which will feed into the data provided for the Mortality Indicators. The vaidation of deaths work will target Respiratory related deaths which aligns with investigation reccomendations from the mortality indicators, where patient with a respiratory related conditions as primary diagnoses alert as persistent outliers for the Trust.

6. Mortality

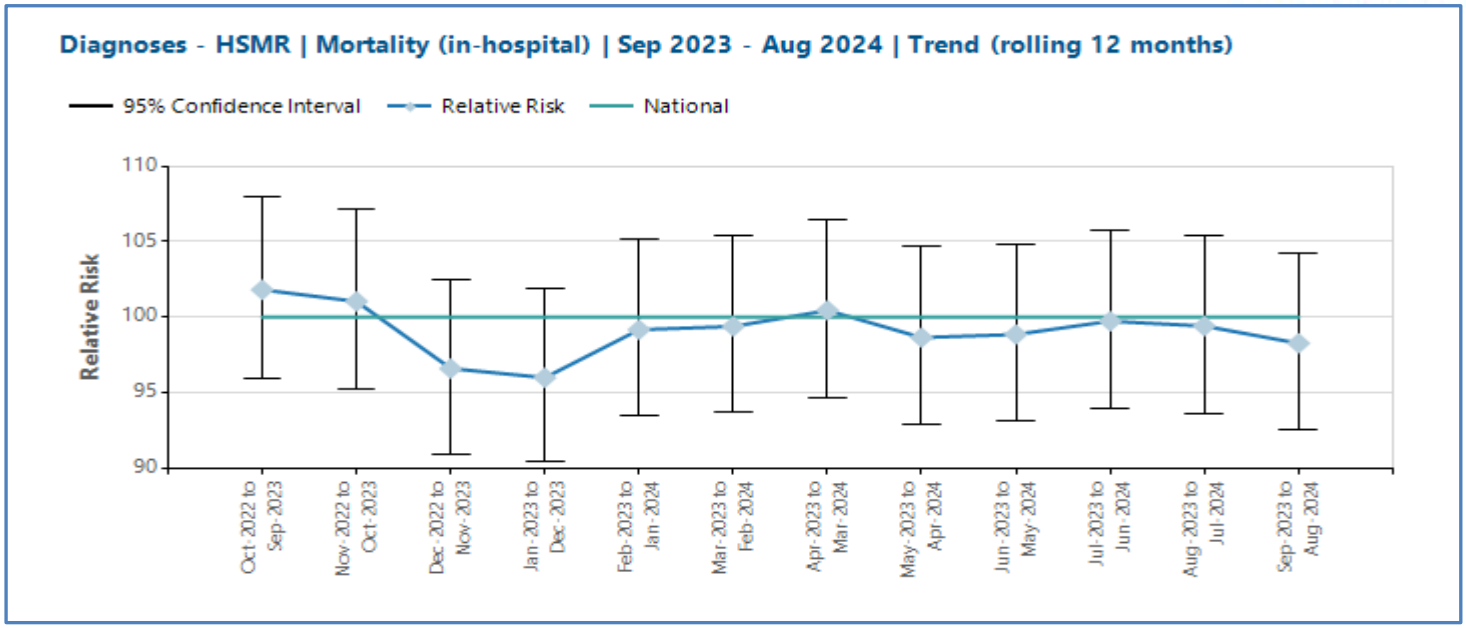
Hospital Standardised Mortlaity Ratio (HSMR)

In qaurter 3, Telstra Health UK (formally Dr Foster) announced the new HSMR+ which was replacing HSMR. The new model introduced a number of changes:

- 41 diagnosis groups (previously 56)- reflects mortality data more accurately from reducing to 41 groups, adding in the viral infections group which includes covid.
- Covid 19 inclusion- a new covid 19 sub group has been added within the viral infections diagnosis group, ensuring more specific risk adjustments for the pandemic's impact.
- Exclusion of stillbirths
- Deprivation metric update- deeper understanding of socio-economic factors
- Comorbidity index enhancement- moving from Charlson comorbidity index to Elixhauser-Bottle comorbidity index- a superior predictor of mortality, improving accuracy and considering a broader range of comorbidities
- Global frailty addition- accounts for frailty in the model by looking across seven groups of frailty syndrome. This is a significant predictor of mortality and adds depth to patients risk profiles
- Removal of palliative care addressing inconsistencies and potential biases

As a result of the updated methdology, and depsite the initial apprehension of the impact of the removal of palliative care as risk adjustment, Medway's HSMR value saw a signifcant improvement which was not mirrored nationally. The inclusion of frailty as a risk adjustment had a signficant impact of the Trust's overall HSMR position and as a result, the Trust returned to the 'as expected' banding.

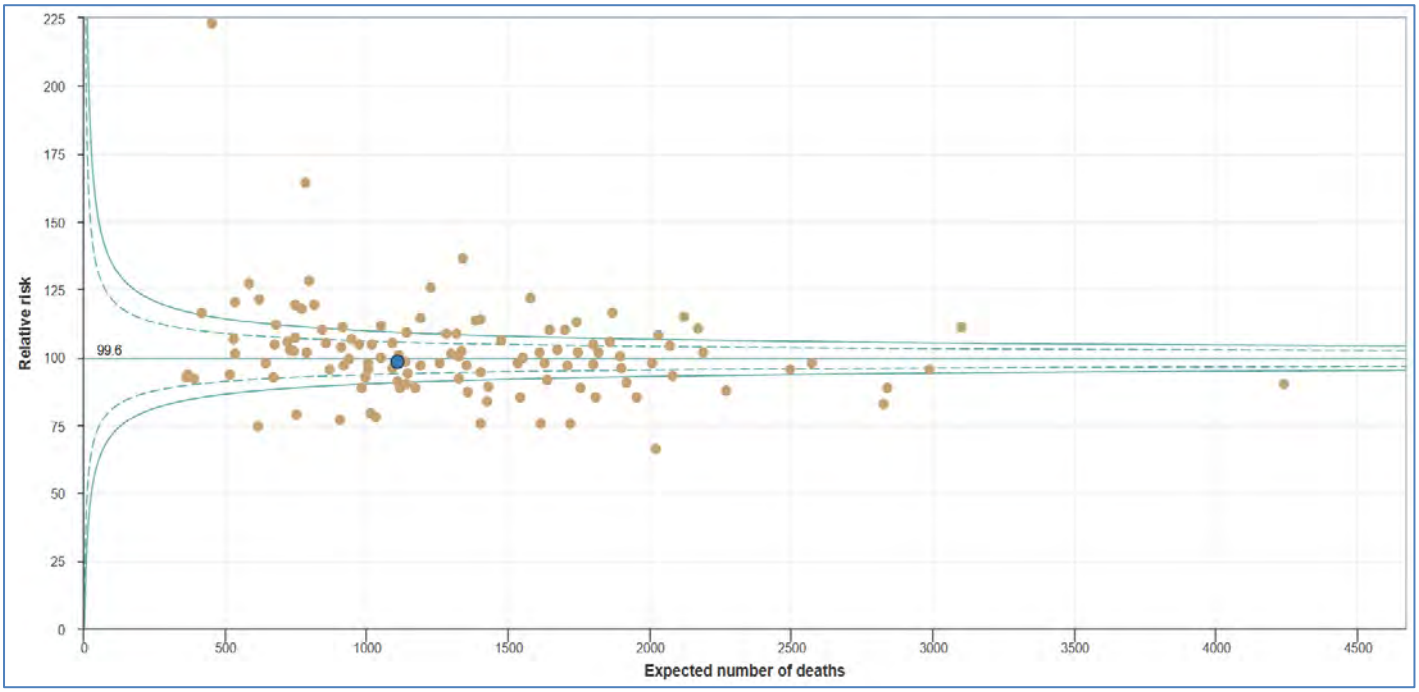
Figure 8 HSMR+ September 2023- August 2024 12 month rolling trend



HSMR+ for the period of Sepember 2023- August 2024 is 98.3 and ‘within expected’. The Trust are not statistically different to any of the national, regional or comparable Trust peer groups.

On a single month rolling trend, HSMR+ for August 2024 was 78.3 and ‘lower than expected’. This significant drop in HSMR+ value for the month of August has contributed to the overall HSMR+ value reaming with the ‘as expected’ badning.

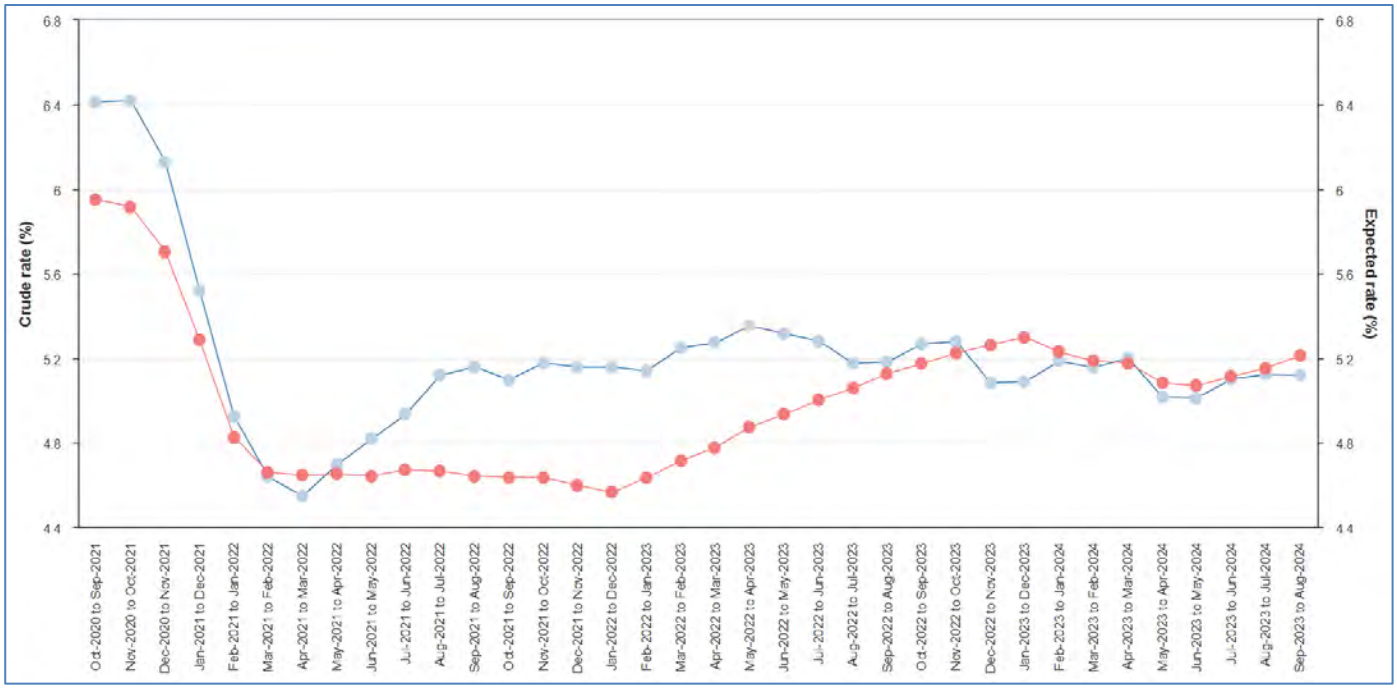
Figure 9: HSMR+ Medway (blue dot) funnel plot position against all other acute non specialist trusts



The reason for the improvement in overall HSMR+ vlaue is largely due to the improvement seen in the expected rate of mortality. Within the previous model, the expected rate was significantly lower than the

observed rate and the divergence between the two metrics was a contributing factor for the high HSMR value.

Figure 10: HSMR+ observed deaths (bue) vs expected deaths (red)- 36 month rolling trend



The introduction of the global frailty score as a risk adjustment within the HSMR+ model has had a positive impact for the Trust. Medway are seen to report above the the national average for for patients over 75 with a frailty condition. The new model calculates frailty similarly to the way comorbidites are scored as a risk adjustment. This adds another dynamic in understanding Medway's improved performace.

The introduction of deeper analysis of socio-economic factors and how deprivation impacts the risk of mortality revealed that the average patient at Medway is within the fourth most deprived deciles (with the 1st being most deprived and the 10th being least deprived).

The introduction of Elixhauser bottle comorbidity Index, includes a broader range of comorbidites when compared to the previously used Charlson comorbidiy index. Medway perform higher than the national average for fifteen of the thirty one comorbidities listed and is a contributing factor to the improved expected rate of mortality and overall HSMR+ value.

Summary Hospital- Level Mortality Indicator (SHMI)

SHMI for the period September 23 to August 24 is 1.20 and “higher-than-expected”. This is another slight deterioration on last month. There has been an increase in crude rate, and an increase in the difference between crude and expected rate.

Figure 11: Medway SHMI trend

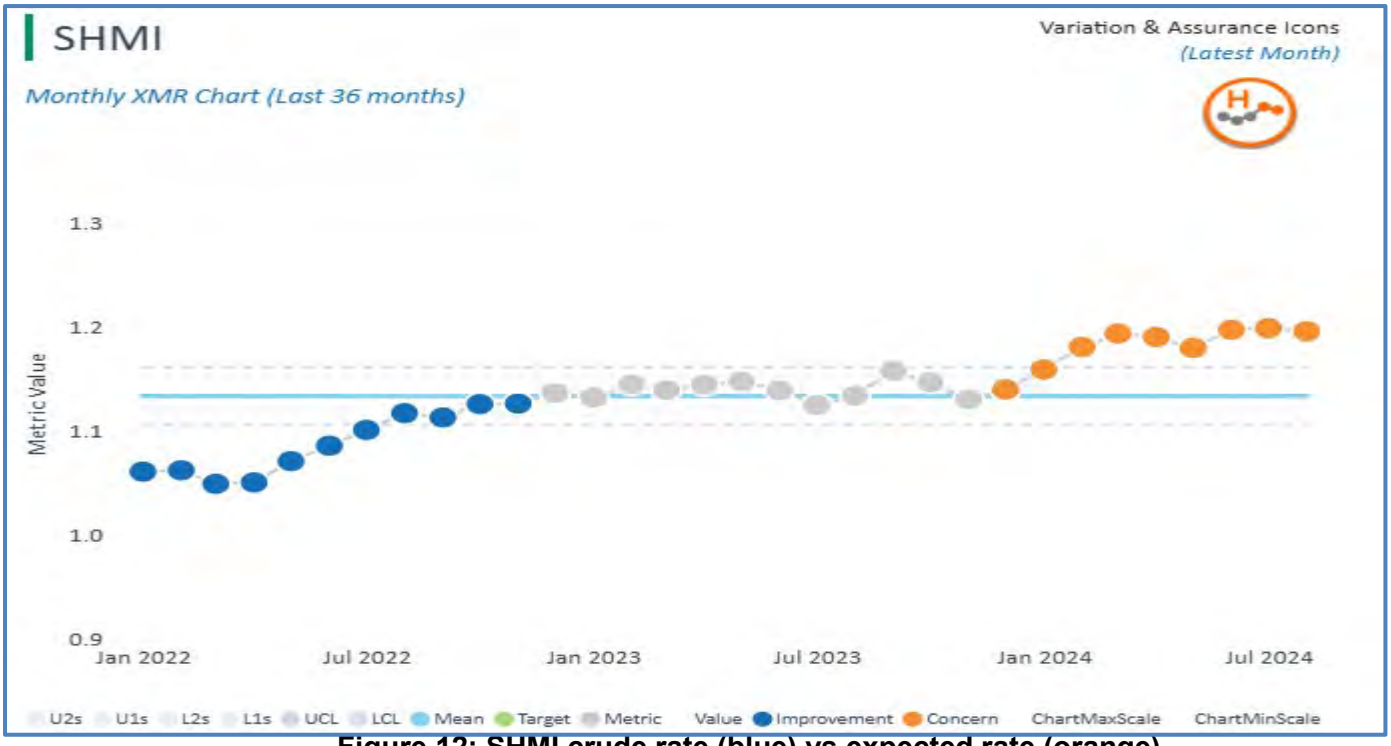
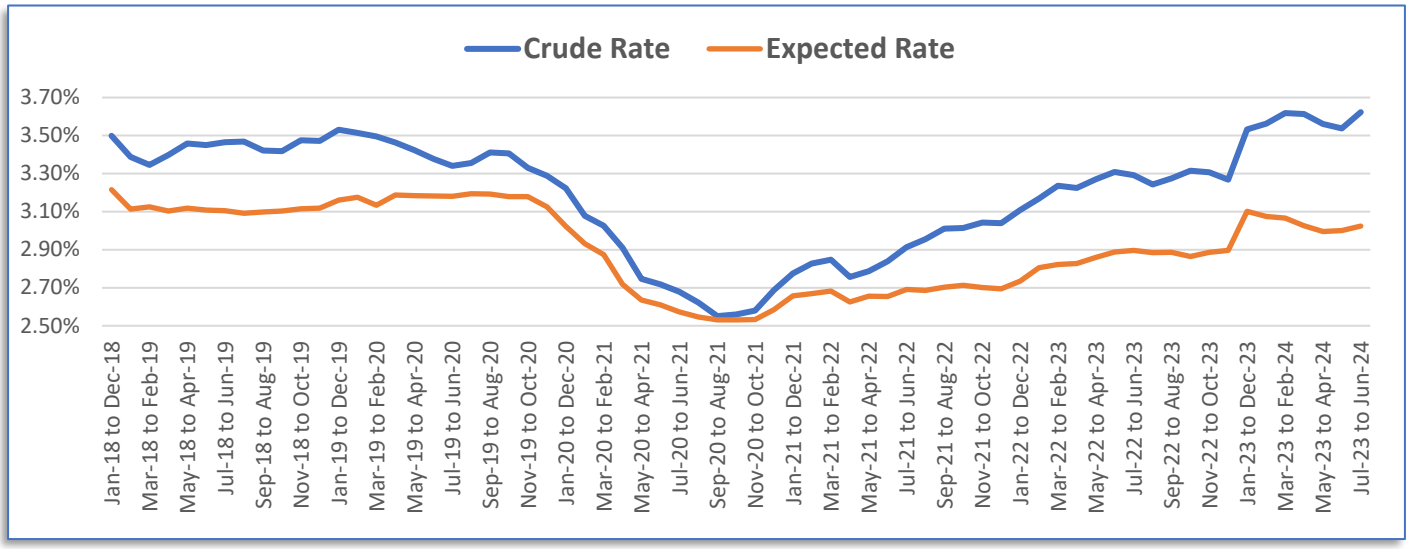
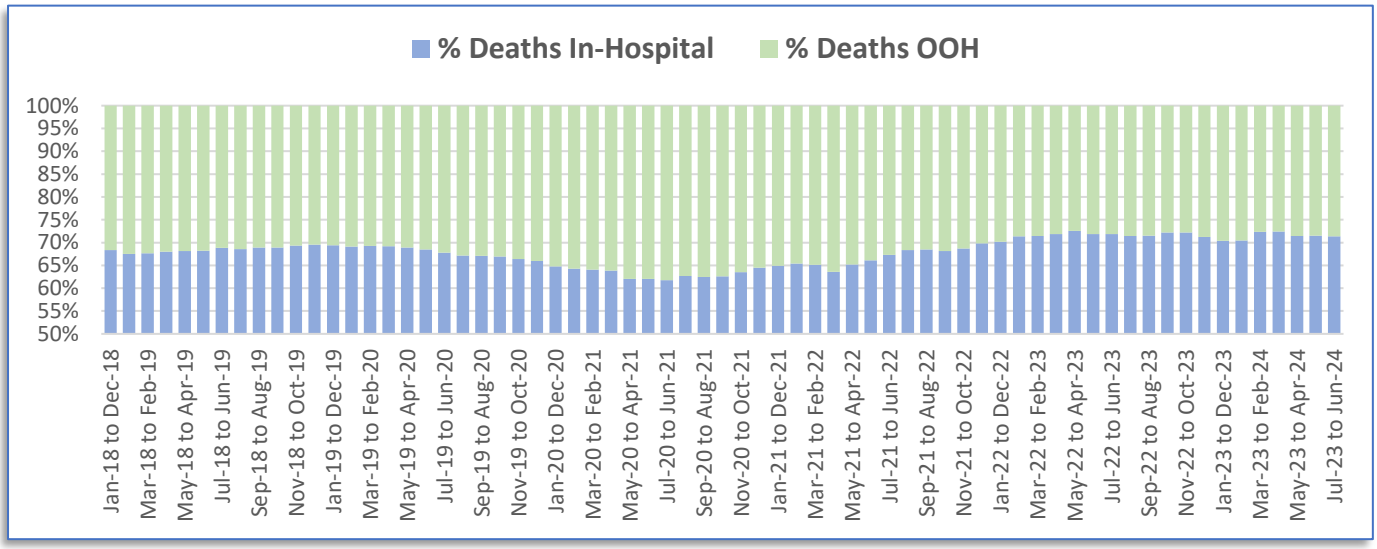


Figure 12: SHMI crude rate (blue) vs expected rate (orange)



In-hospital mortality continues to account for more than 70% of all deaths reported by the SHMI methodology; and in-hospital crude rate remains at an all-time high. Recommendations for the Trust continue to be (i) validation of respiratory deaths; and (ii) understanding the trends around long lengths of stay for elderly, and particularly, palliative patients, e.g. by reviewing levels of advanced care planning. It would make sense to target respiratory patients in this analysis in line with the persistent outlying diagnosis groups for Respiratory.

Figure 13: SHMI proportion of deaths in hospital (blue) vs out of hospital (green)



N.B please note this chart has a y-axis stating at 50%

Next steps

Along with the current ongoing A3 mortality workstream, aimed to address potential infleunces on the causes for the rise in SHMI, the Trust continue to address causes for outlying diagnosis groups.

A recent deep dive into ‘Acute Bronchitis’ was undertaken and findings concuded:

- Frequent documentation of diagnosis of ‘lower respiratory tract infectioon’ when ‘community acquired pneumonia’ or ‘exacerbation of (underlying lung disease) would have been more appropriate
- The majority of these cases were coded as J22X ‘unspecified acute lower respiratory infectioon’ failing under ‘Acute Bronchitis’.
- Coding may be failing to accurately reflect the expected rates of mortality as a result
- No obvious issues in care identified
- This represents a primary diagnoes documentation issues with lower respiratory tract infectioon being errneously appied as working diagnsis.

Another deep dive into patients who were highlighted as have a ‘zero’ comorbidity score (low risk of mortality) despite several previous A&E attendances, found that missing comorbidites in the clinical documentation resulted in patients who were at higher risk of mortality not being accurately reflected in the clinical documentation. These examples, along with regular presentations from the clinical coding department and the learning from deaths teams are delivered regulalry to specialities to evdience the importance of clinical documentation and the impact this has on coding, finance and mortality statistics for the Trust.

NHS
Medway
NHS Foundation Trust

APPENDIX 4a

Perinatal Quality Surveillance Q3 24-25 and Cultural Leadership Update report

Trust Board – 12 March 2025

Executive Summary

- CNST Year 6 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9). Plus updates aligned with the minimum dataset of the PQSM are submitted monthly via IQPR to QPSCC and QAC plus every Trust Board.
- This report provides quarterly oversight for Q3 2024/25 and includes the following:
- Increase of 15% for maternity reported incidents (datix) from last year – top categories of Medication, Clinical assessment, Infrastructure/resources, Medical Device/equipment, Treatment, procedure.
- 3 incidents reported as Moderate Harm or above: Maternal Collapse & Major Obstetric Haemorrhage at home following late referral from neighbouring Trust for Placenta praevia/accreta. Baby suffered HIE III and sadly demised. (MNSI referral)/ PPH >1000mls (TOP using misoprostol. 1.8L EBL – patient moved to theatre for EUA which was converted to hysterotomy. Total EBL 3L – postnatal care provided in MECU)/PPH>1000mls (PPH 1.5Ls at ELCS with placenta praevia. Further blood loss on postnatal ward and MECU. Return to theatre and required ICU admission).
- Q3 PSIRF - Database commenced March 2024 - 4 AAR declared in 2024/5 MNSI referrals/Proportionately small numbers of incidents requiring higher level investigation both locally and via MNSI and PMRT. Psychological harm is not captured on Datix and there is no clear guidance (national or local to assess level of psychological harm).
- 7 MBRRACE reportable cases in Q3 with all cases reported within CNST/MBRRACE timeframes. Communication and documentation being the most common themes of Perinatal Mortality Review Tool (PMRT) actions.
- FFT feedback consistently above 95% and above 70% response rate
- Re-launch of Safety Champions, with updated poster, feedback form, SOP and communication to staff.
- Safety Champion Engagement Session and Teams Talks held in quarter. Staff discussion points and concerns included: Community Broadband/Desk availability for Specialist staff/Damage to Equipment/Improved team morale and retention noted across service/Community Teams note positive reduction of on-call requirements following introduction of hospital on-call/uniform
- SCORE survey postponed due to ongoing cultural improvement work/surveys across the Trust. To utilise learning from Trust survey and consider further maternity/neonatal survey if required. Staff attending Culture and Inclusion Training.
- Leadership team working to ensure staff receive updates on key national initiatives including CNST by sharing newsletter via Maternity Matters. “You Said, We Listened Posters” displayed across the unit.
- Public Health England to visit MFT on 7th March 25 to celebrate our success with the maternal vaccination programme.
- Full year ‘Did Not Attend (DNA)’ audit completed and presented with action plan. Training video around completion of DNA checklist created and ready for launch.
- Increase in safeguarding adults and children level 3 and MCA training for midwifery and doctor staff groups with exception of children level 3 for maternity staffing due to additional staff being added to mapping for this instead of level 2.

Incidents, investigations and Perinatal Mortality Review Tool (PMRT)

NHS Medway NHS Foundation Trust

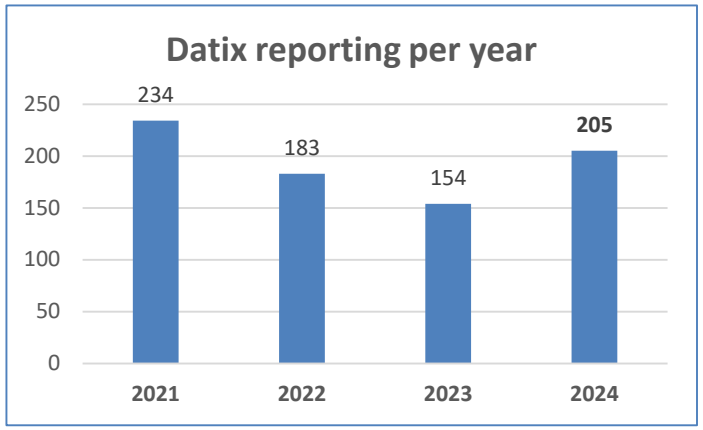
Patient FIRST

True North: Quality – Neonatal 2024 Overview

Medway NHS Foundation Trust

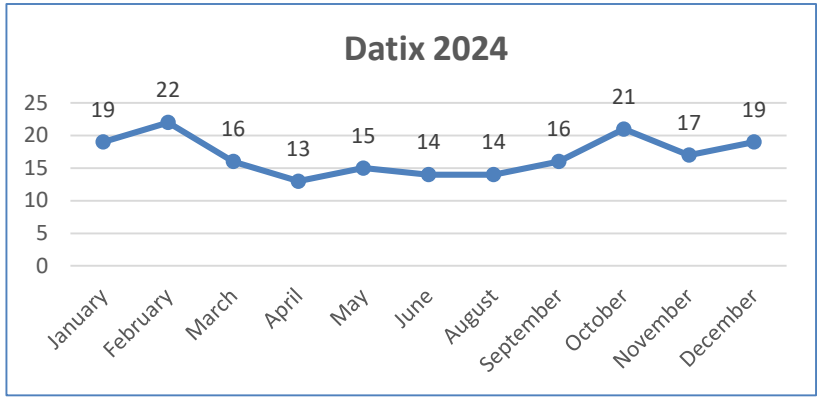
Key Messages: (2024)

- ↑15% of reported incidents (datix) from last year
- Average: 16 datix per month
- Top categories:
  - Medication
  - Clinical assessment
  - Infrastructure/resources
  - Medical Device/equipment
  - Treatment, procedure
- 5 formal learning response completed and submitted to PS Team
- 1 case went for inquest – learning and actions in place



Issues, Concerns, Gaps:

- Medication related incidents remain to be a problem
- ↑ incidents involving laboratory
- Equipment issues especially on the last quarter of the month- ventilators in EME for repair
- NICU governance has completed learning responses but have not submitted the reports to PS team
- NICU trigger list should be updated and should reflect in datix platform
- EOLAS app is now charging for use



Learning Responses for 2024	
Local SEIPS Review	1 – Changes embedded
Thematic Analysis	3
SWARM	1

Actions and Improvements

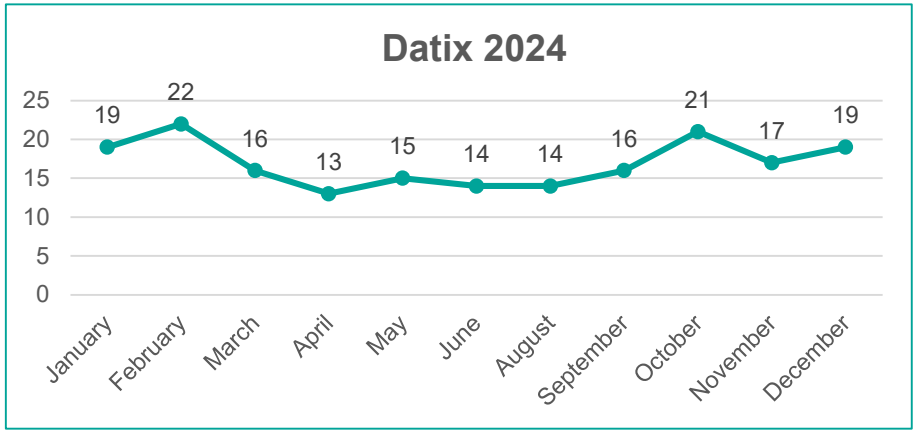
- Shared Learning sessions started with doctors and nurses
- Meeting held with PS Team. NICU Team to review trigger list and to update PS team.
- Discussion with Integrated Governance Team re- EOLAS app. Q-pulse being reviewed.
- Review of all medication incidents
- Meeting with Laboratory NKPS team to identify challenges and look into improvements

Quality: NICU Success and Challenges – Q3

Medway NHS Foundation Trust

Key Messages:

- 21 Datix in October
- 17 Datix in November
- 19 Datix in December
  - Main Category:
    - Medication Related Incidents
    - Clinical Assessment
    - Missed blood gas results
- 1 SWARM for wrong blood product transfused
- 2 Cases underwent of IRG review:
  - Perforation
  - UVC Extravasation
- 0 Duty of Candour
- 1 complaints
- 90% satisfaction rate FFT
- 9 Learning from Excellence
- ODN audit on unplanned extubation commencd
- Safety Alert:
  - BAPM – Reporting burns related to chlorhexidine use
  - BAPM – consultant cover across two different geographical sites of NNU
  - NHSE – Stop practice of warming feet for NBBS



Issues/Concerns/Gaps:

- Checking process of blood prior to transfusion needs to be improved
- UVC extravasation on a line that is in optimal postion
- Medication related incidents remain to be a problem
- ↑ incidents involving laboratory
- Issues with neonatal alerts
- Equipment issues especially on the last quarter of the month- ventilators in EME for repair
- Medication formulary requires updating

Actions/Improvements/ Next Steps:

- Independent double-checking in place for blood products
- Daily x-ray/POCUS for all UVC lines regardless of position
- Meeting with laboratory team
- Meeting with key people involve with neonatal alerts
- To launch gentamicin stickers
- To update monograph

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q3 24/25
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:

- Significant reduction in number of incidents reported in quarter 365 (454 in Q2))
- 99% of incidents reported are no or low harm.
- 3 incidents reported as Moderate Harm or above
    - Maternal Collapse & Major Obstetric Haemorrhage at home following late referral from neighbouring Trust for Placenta praevia/acreta. Baby suffered HIE III and sadly demised. (MNSI referral)
    - PPH >1000mls (TOP using misoprostol. 1.8L EBL – patient moved to theatre for EUA which was converted to hysterotomy. Total EBL 3L – postnatal care provided in MECU)
    - PPH>1000mls (PPH 1.5Ls at ELCS with placenta praevia. Further blood loss on postnatal ward and MECU. Return to theatre and required ICU admission)
- 14 incidents relating to laboratory investigations including rejected blood samples.
- 10 Incidents relating to Information technology, including 6 relating to failed bleeps and 4 relating to EuroKing connectivity.

Issues, concerns, gaps:

- Challenge of ensuring robust review under PSIRF model as cases that would previously have been escalated to full review are now only reviewed locally unless they fall within wider PSIRF themes/actions.
- Intermittent failure of bleep system added to issues log.

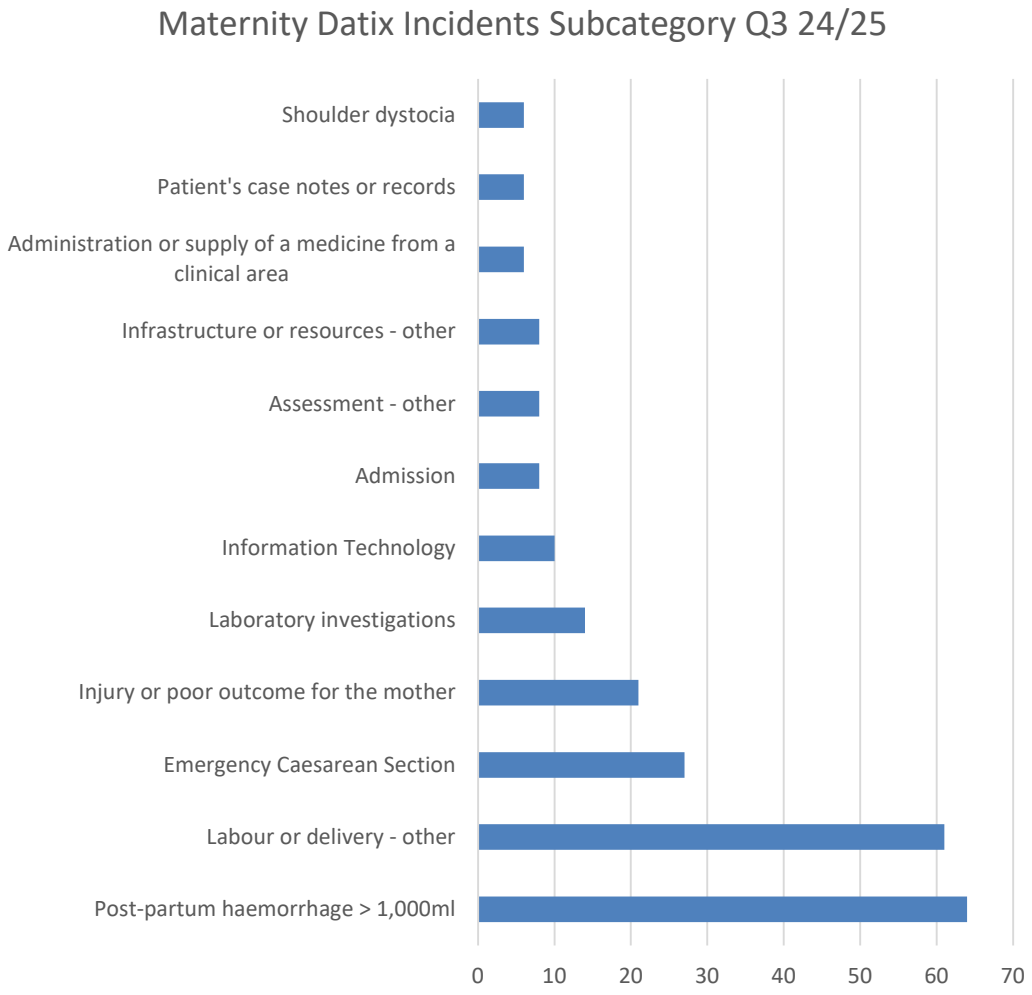
Actions & Improvements:

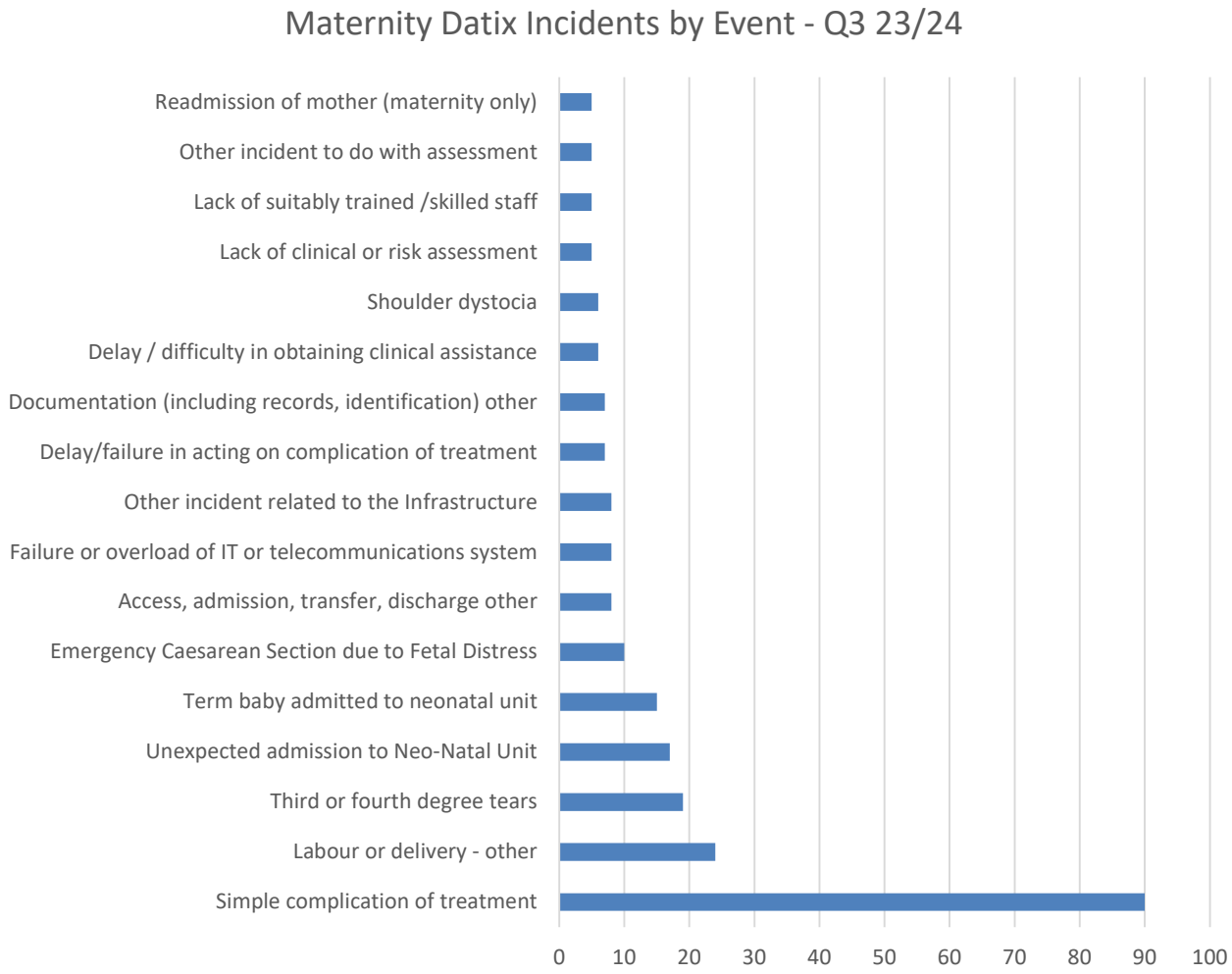
- 5 Mobile phones in place to support bleep system – further phones required.
- Maternity matrons attended stakeholder event regarding procurement of replacement bleep system.
- QIPs underway for PPH and 3rd and 4th Degree tear including launch of OASI-2 Bundle.
- Maternity engaged in QIP/A3 thinking supported by transformation team to support reduction in rejected blood samples.

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q3 24/25
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

Perinatal Surveillance Tool Data Q3– PSIRF

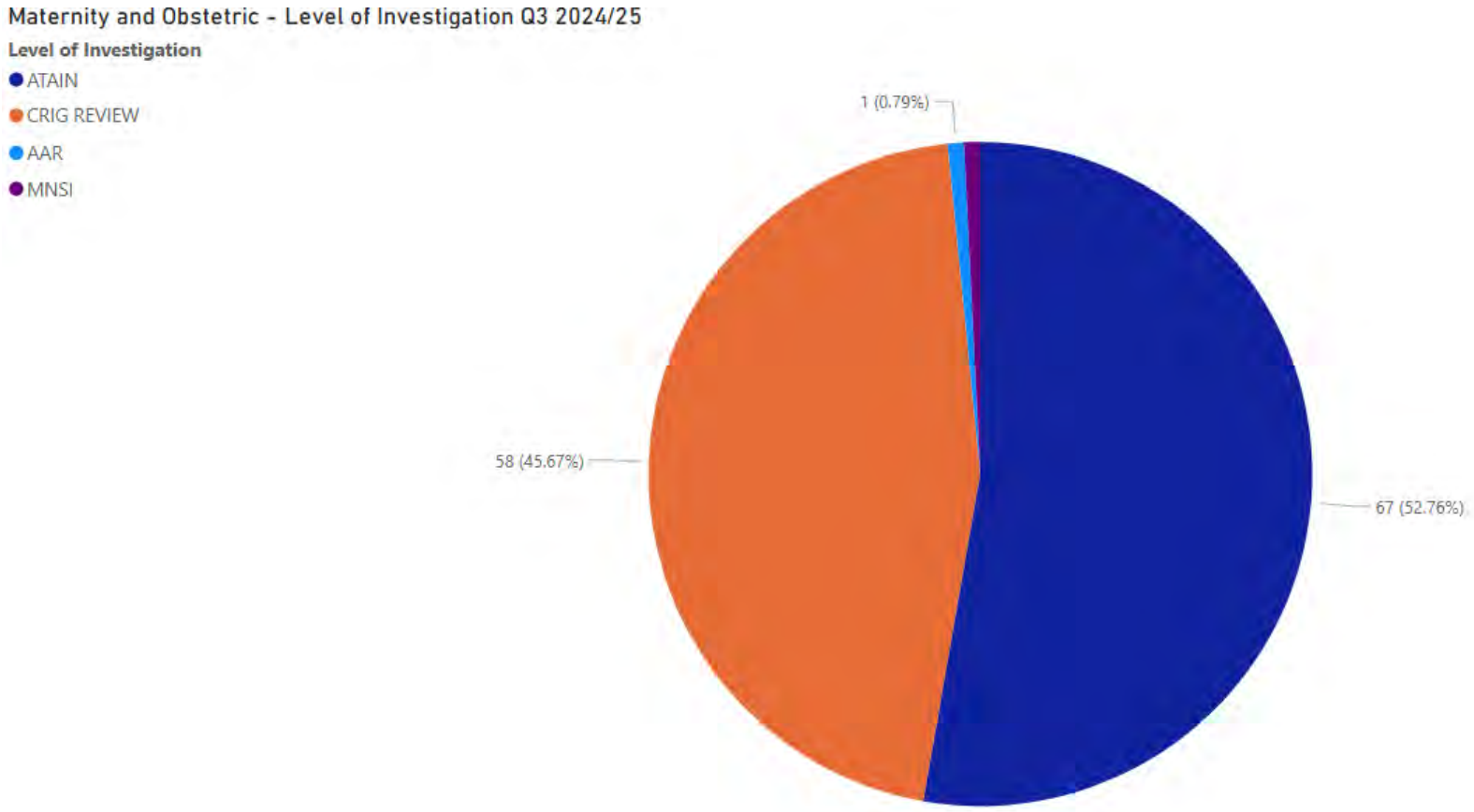
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.

Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages :

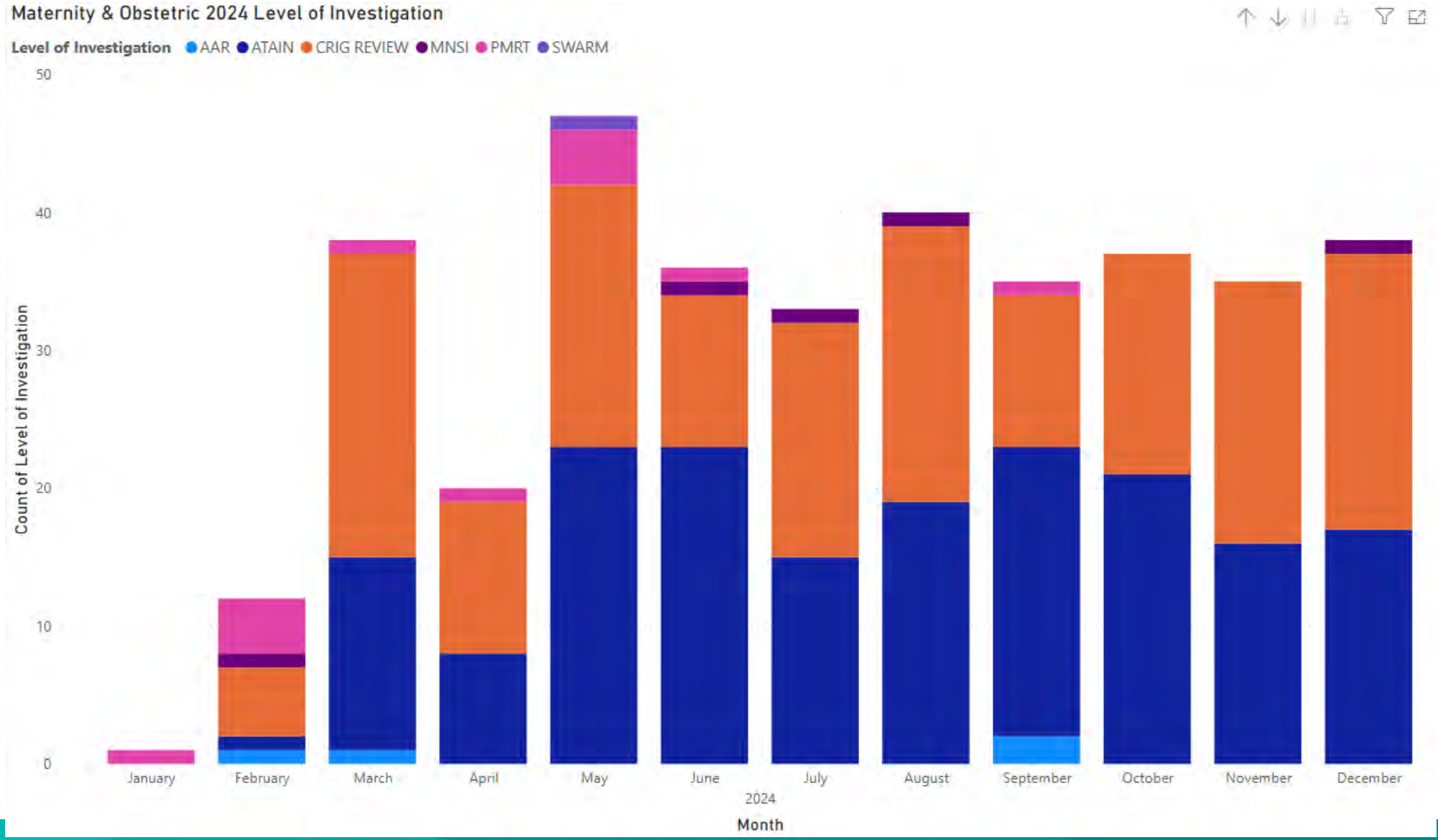
- 127 incidents occurring in Q3 required review at CRIG
  - 67 ATAIN Reviews (↑)
  - 58 CRIG Reviews (↑)
  - 1 AAR
  - 1 MNSI review



True North: Quality – Q3 PSIRF

Key Messages :

- Database commenced March 2024.
- 4 AAR declared in 2024.
- 5 MNSI referrals
- Proportionately small numbers of incidents requiring higher level investigation both locally and via MNSI and PMRT.
- PMRT reviews for Q3 losses have not been completed.



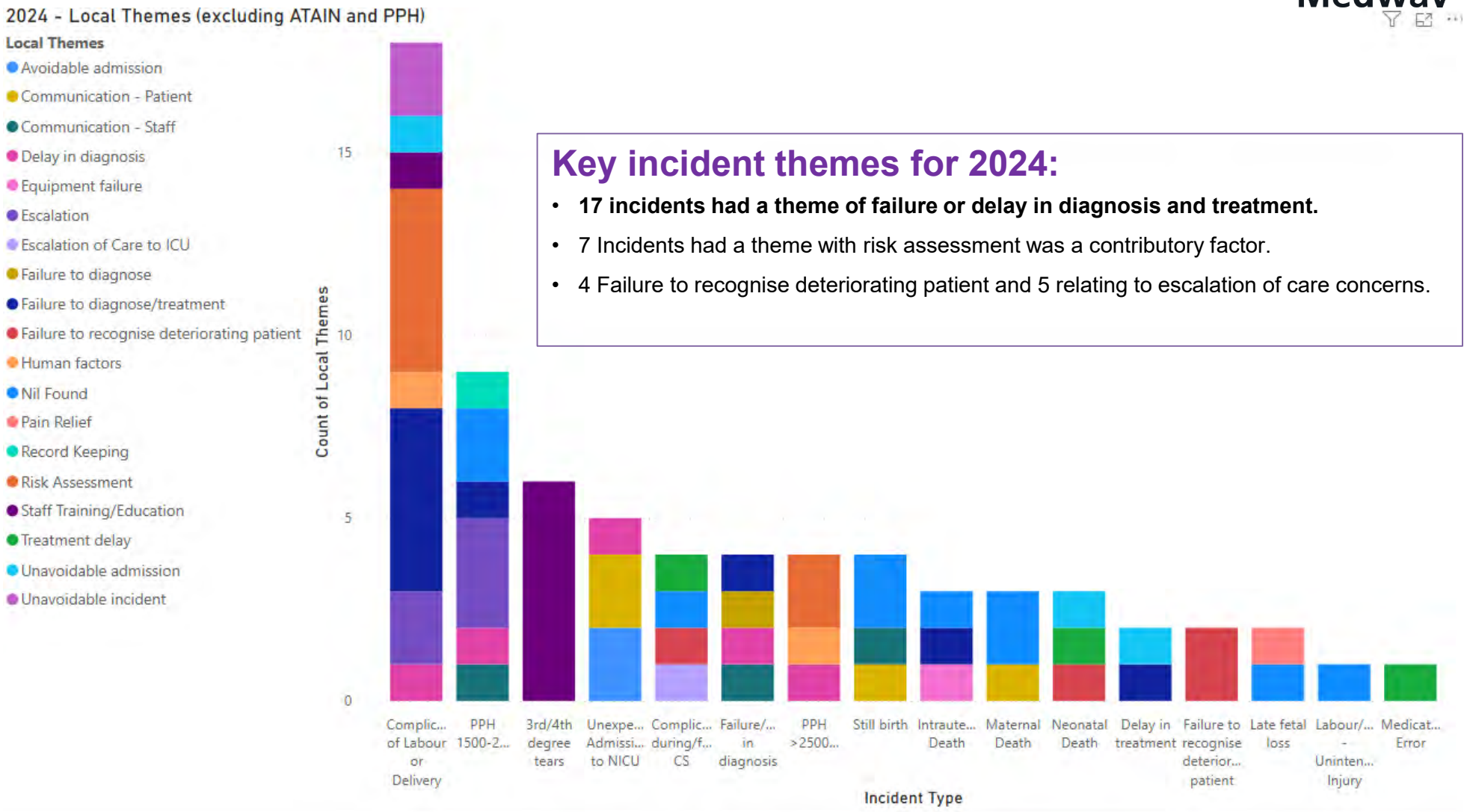
True North: Quality – Q3 PSIRF

Key Messages :

- Failure/delay in diagnosis and treatment most prominent theme for incidents (excluding ATAIN and PPH meeting CRIG criteria)

Recommendations :

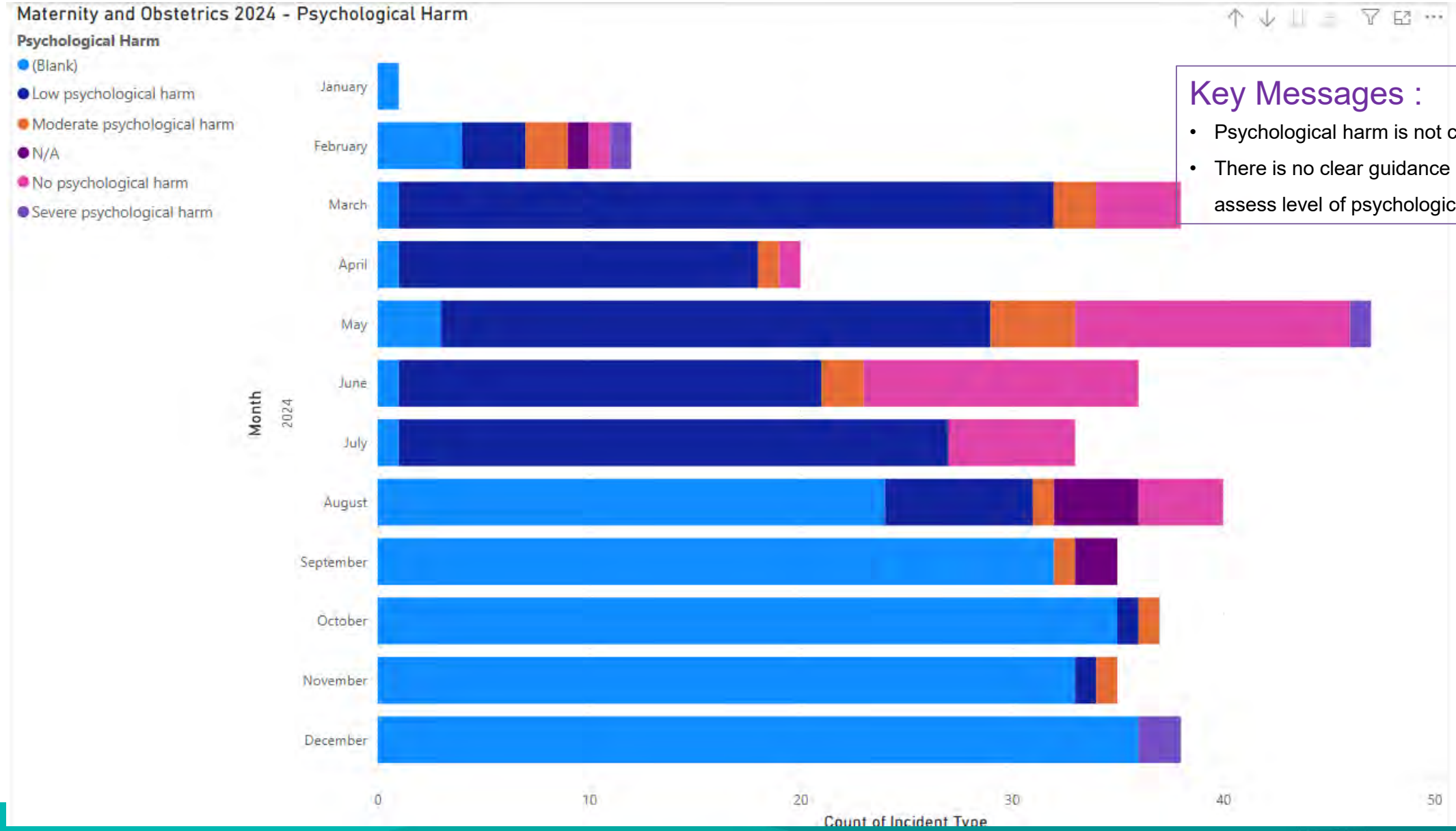
- Need to ensure themes from CRIG reviews are incorporated into PROMPT and Fetal Monitoring training and case reviews also shared at audit meetings.
- Align audit plan for 2025/26 and Maternity Patient Safety Incident Response Plan to key themes from 2024/2025 incidents.



Key incident themes for 2024:

- **17 incidents had a theme of failure or delay in diagnosis and treatment.**
- 7 Incidents had a theme with risk assessment was a contributory factor.
- 4 Failure to recognise deteriorating patient and 5 relating to escalation of care concerns.

True North: Quality – Q3 PSIRF



Key Messages :

- Psychological harm is not captured on Datix.
- There is no clear guidance (national or local to assess level of psychological harm)

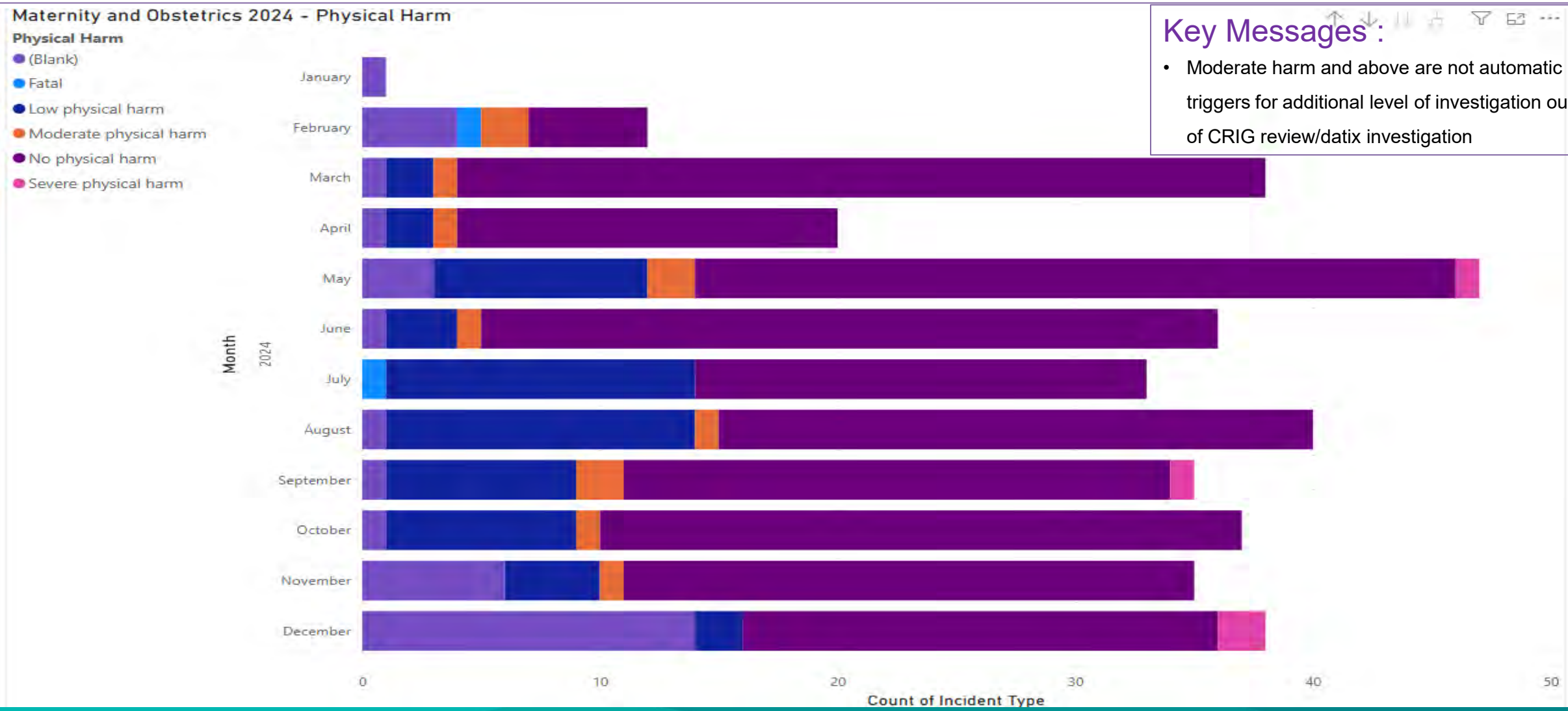
True North: Quality

Perinatal Surveillance Tool Data Q3– PSIRF

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.

Medway NHS Foundation Trust



Key Messages:

- Moderate harm and above are not automatic triggers for additional level of investigation outside of CRIG review/datix investigation

Perinatal Surveillance Tool Q3 2024/25– Perinatal Mortality Review Tool

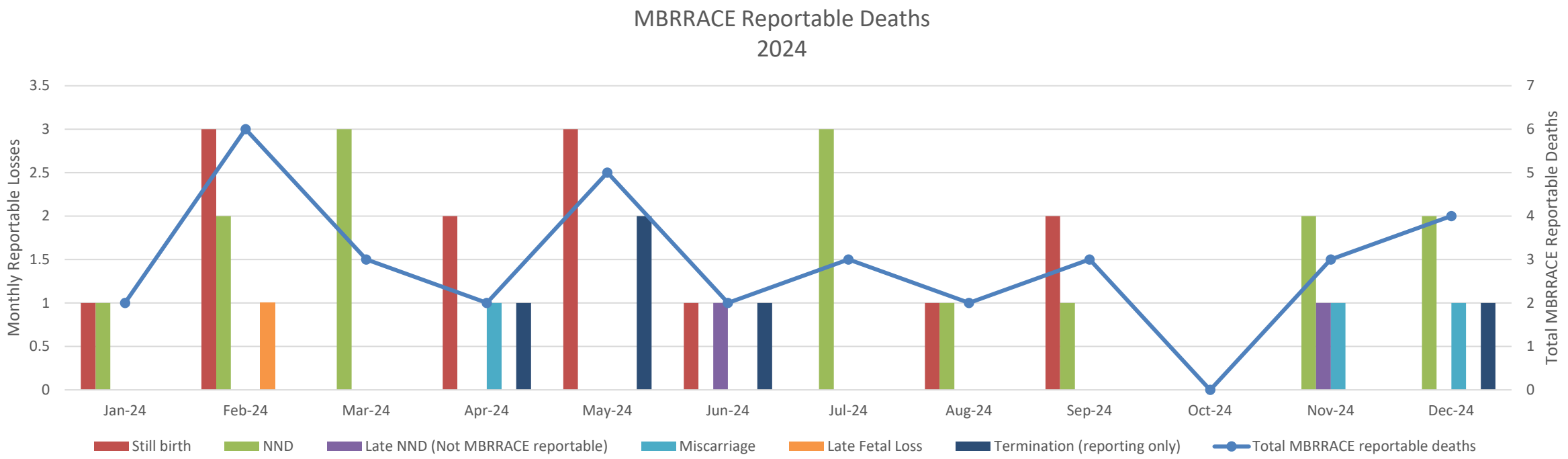
Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Key Messages :

- 7 MBRRACE reportable cases in Q3
- All cases reported within CNST/MBRRACE timeframes
- 7 PMRT reviews completed in Q3.
- Communication and documentation being the most common themes of PMRT actions

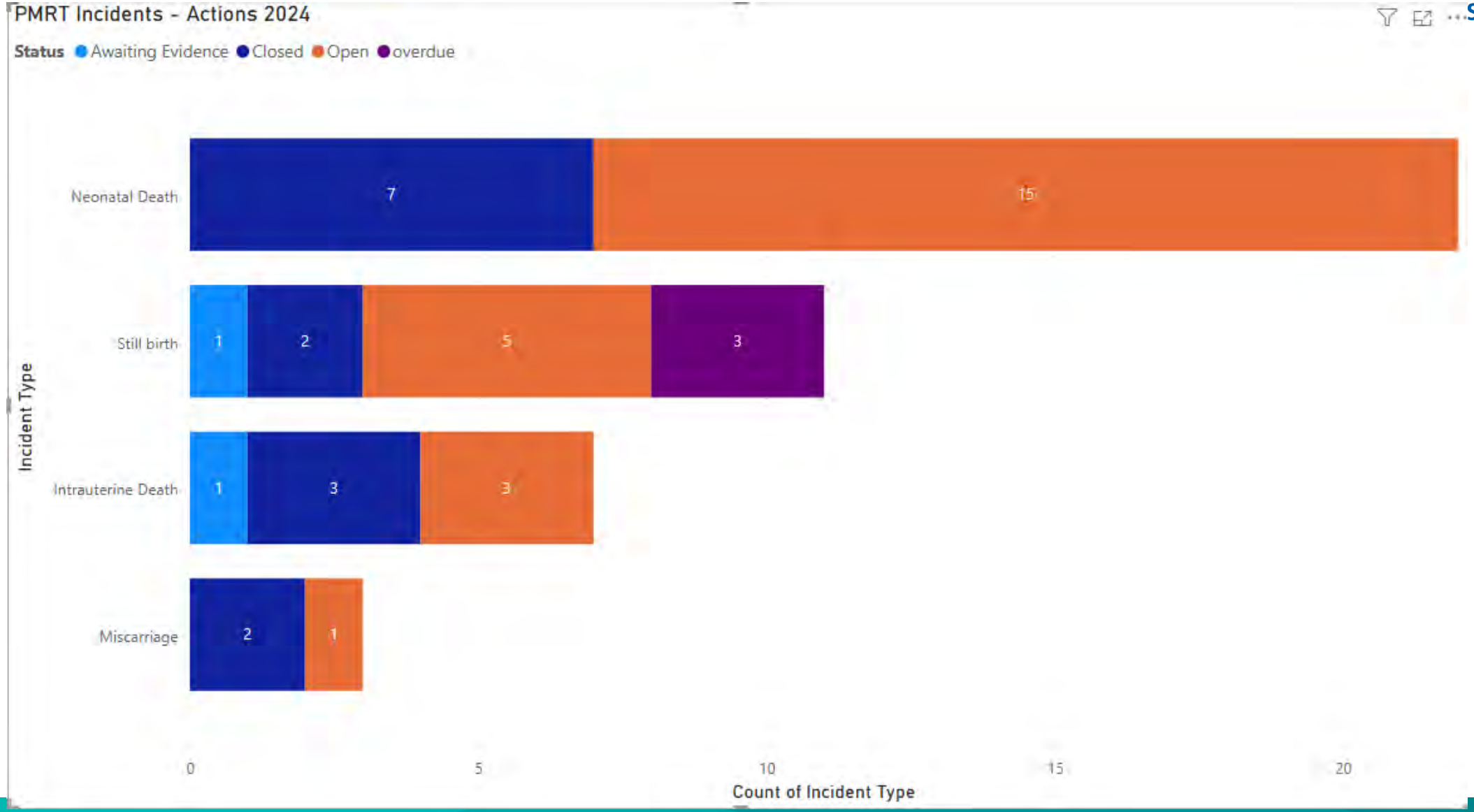


Perinatal Surveillance Tool Q3 2024/25– Perinatal Mortality Review Tool

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.

Medway ...S Foundation Trust

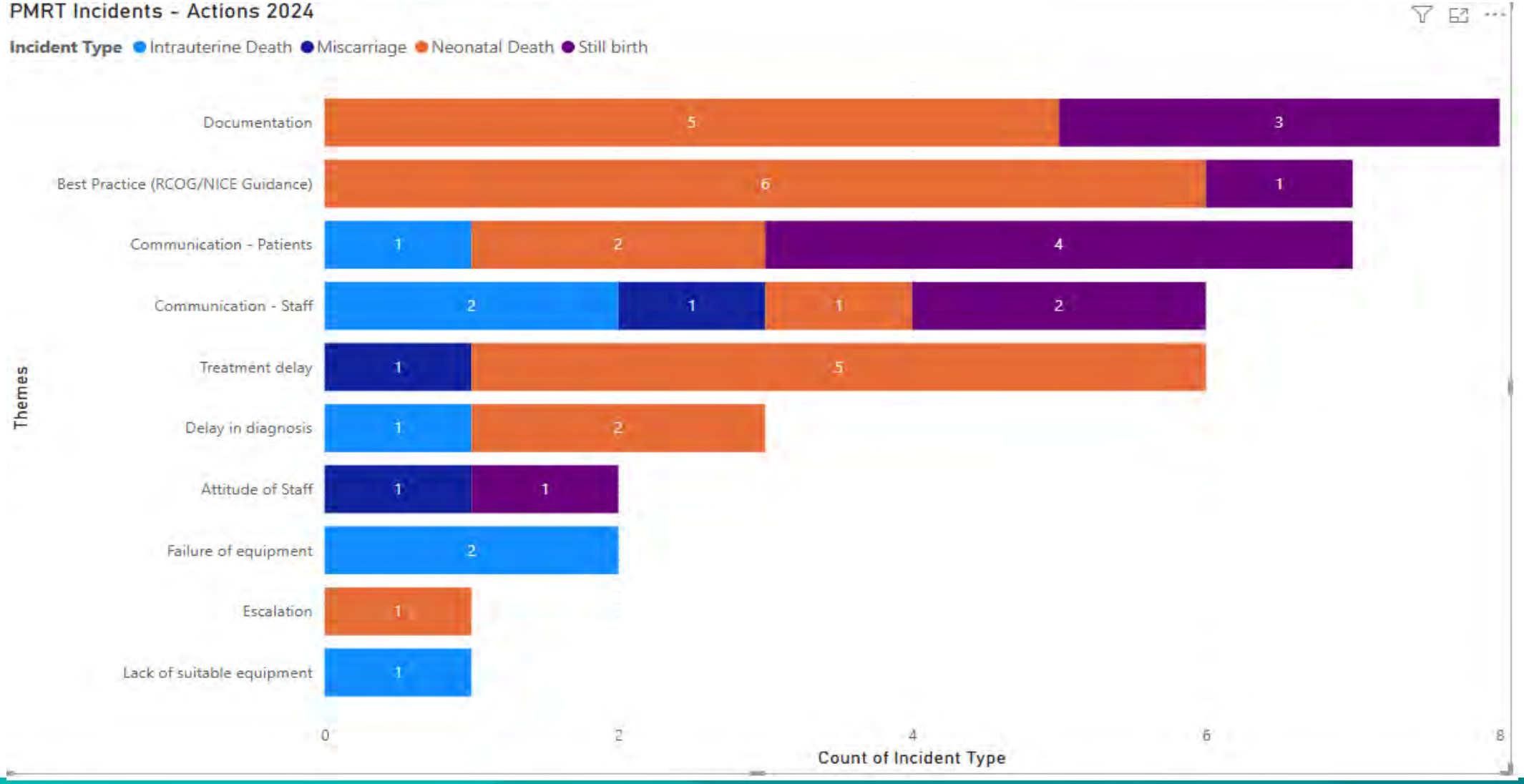


Perinatal Surveillance Tool Q1 2024/25– Perinatal Mortality Review Tool

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



MBRRACE Reportable Losses Q1

Medway NHS Foundation Trust

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
1	1	Miscarriage	23+5	Unexplained - despite all investigations	PMRT	B,C - Pain relief not managed appropriately, communication poor, failure to follow uniform policy
1	2	Termination	26+2	Fetal Abnormality	MBRRACE Reportable only	N/A
1	3	Termination	22+3	Fetal Abnormality	MBRRACE Reportable only	N/A
1	4	Termination	22+5	Fetal Abnormality	MBRRACE Reportable only	N/A
1	5	Stillbirth	30+2	Unexplained	PMRT	A, A - Unexplained
1	6	Stillbirth	39+2	Fetal Abnormality	PMRT	B, A - Expected death acrania (communication of antenatal pathway, Booking of IOL)
1	7	Stillbirth	39+2	Unexplained	PMRT	A,C - Unexplained, actions being developed in response to parent feedback.
1	8	Late Neonatal Death	Born 24 weeks - died 6 weeks post delivery	Extreme Prematurity	PMRT Only Not MBRRACE reportable	2 PMRT meetings held due to parents feedback. Additional feedback received on day of second meeting therefore this is still being finalised.
1	9	Termination	32+4	Fetal Abnormality	MBRRACE Reportable only	N/A
1	10	Stillbirth	32+4	Unexplained	PMRT	A, A, Unexplained. Baby transferred to GOSH for PM - no actions for action plan.

MBRRACE Reportable Losses Q2

NHS Medway NHS Foundation Trust

Q	Case		Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
	2	1	Neonatal death	25+6	TBC	PMRT	B,C,A Death e-coli sepsis and prematurity. Baby born at neighbouring Trust - actions identified for this Trust re. antenatal/delivery and missed opportunity for inutero transfer. Neonatal care - Issues identified - Communication due between birth Trust and MFT regarding results situational awareness problems.
	2	2	Neonatal death	24+0 (approx - Ubooked)	Unbooked pregnancy delivered at home - awaiting coroner	PMRT & Coroner	(antenatal ungraded as not booked), A, A - Developing a pathway for unbooked pregnancy losses to ensure appropriate escalation and communication within organisation/relevant external bodies
	2	3	Neonatal death	23+5	Extreme prematurity	PMRT	A,A,A, Issues for neonatal staff identified regarding memory making - action to ensure all memory making is offered and recorded.
	2	4	Neonatal death	35+0	Fetal Abmormality	PMRT (care Plan) Expected	A, A, A, Congenital cardiomyopathy and hydrops fetalis - no actions for action plans - family happy with care.
	2	5	Stillbirth	35+3	Fetal Abmormality	PMRT (expected)	A, A - Bilateral pulmonary hypoplasia secondary to multicystic dysplastic kidneys. Parents happy with care and that baby did not receive resus in accordance with wishes. For action plan - ensure pathway of communication of care plans for complex patients shared with relevant staff/teams. Neonatal alerts now sent at 24 weeks rather than 28 weeks and RA and HH Process now in place to ensure uploaded onto all systems eg. Viewpoint, EK, Badger.
	2	6	Stillbirth	39+0	Unexplained	PMRT/AAR	C, A, Issues with compliance with medication and missed opportunities to address this. Plan for diabetic team to review guidelines regarding virtual clinics.
	2	7	Neonatal death	35+0	Fetal Abmormality	PMRt (expected)	B,B, C, Neonatal alert not available at time of delivery.
	2	8	Stillbirth	39+3	Unexplained	PMRT	B,C, No soundproofed room available and inappropriate comments by staff - Actions - relaunched bluebell pictures for alternative rooms and ensure all staff are aware if bereavement families are in alternate rooms.

MBRRACE Reportable Losses Q3

NHS Medway NHS Foundation Trust

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
3	1	Miscarriage	22+4	Unexplained	PMRT	PMRT to be held February
3	2	Neonatal Death	23+4	Extreme prematurity	PMRT	Neoantal PMRT TBC (twin)
3	3	Neonatal death	26+5	Extreme prematurity tension pneumothorax	PMRT	Neonatal PMRT TBC (twin) - January
3	4	Post-neonatal death	26+0	Extreme prematruity	passed away at 53 days. Use PMRT tool for review - not for CNST.	PMRT February
3	5	Neonatal death	39+0	HIE - Maternal Abruption	MNSI, Coroner, PMRT	PMRT March
3	6	TOP	30+4	Fetal Abmormality	MBRRACE Reportable only	
3	7	Neonatal death	32+6	HIE - Maternal Abruption	PMRT	PMRT March
3	8	Miscarriage	23+6	Unexplained	PMRT	PMRT February

NHS
Medway
NHS Foundation Trust

Service User, MNVP and Staff Feedback Perinatal Cultural Leadership

Patient FIRST

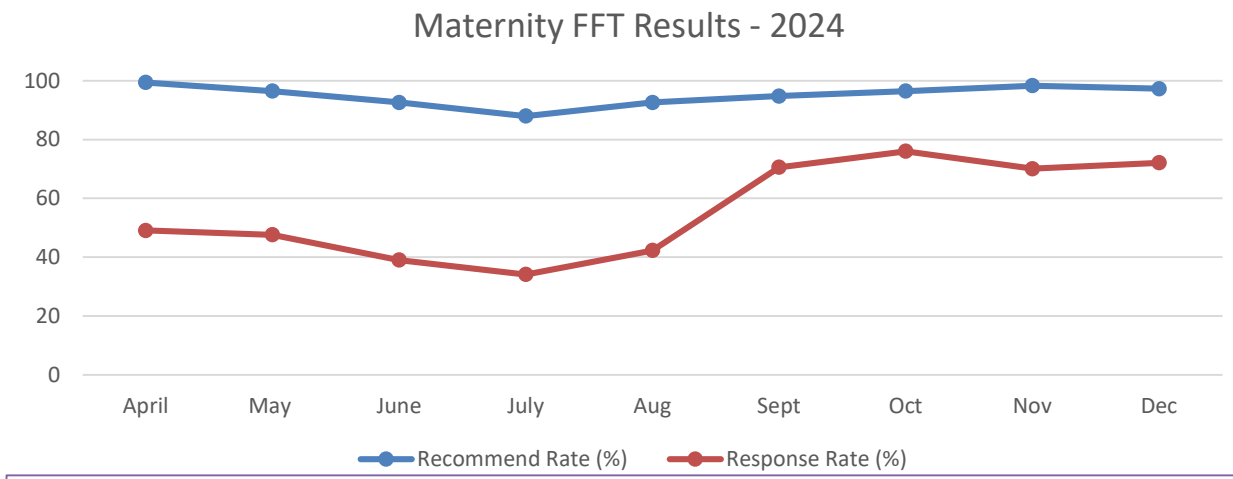
Perinatal Surveillance Tool Data Q3 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

Maternity FFT	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Recommend Rate (%)	99.4	96.5	92.6	88	92.6	94.8	96.5	98.3	97.3
Response Rate (%)	49.1	47.6	39.0	34.1	42.3	70.6	76.0	70.1	72.1

Key Messages:

- Strong working relationship with Maternity and Neonatal Voices Partnership Lead who provides service user feedback and works to support multiple co-production streams across the service including:
  - Maternity Triage/MCU QI Project
  - Co-production of CQC Picker Survey Action plan.
  - Supporting Neurodiversity Working Group to improve pathway for service users with Neurodiversity.
  - Working with EDI & PE Midwife to engage with BAME and other diverse service users.
- MNVP lead on MNSCAB bi-monthly for service user feedback update.
- Overall improvement in FFT response rate and recommend rate across the quarter, peaking in October with 76% response rate and November with 98% recommend.
- Positive service user feedback regarding VBAC at home. Felt supported and empowered by staff attending birth and supported to make a personalised care plan by the consultant midwives.



Issues, concerns, gaps:

- 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. Survey currently being undertaken with across service users and staff.

Perinatal Surveillance Tool Data Q3 2023/24– Service User Feedback

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

Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

Actions and improvements

- Service user engagement event held in October 2024. MNVP, MNISA and service users in attendance. Supported by Associate Director for Patient Experience, ADOM, DOM and maternity staff.
- Positive session with good discussion around whole pregnancy pathway, including postnatal care.
- Coffee morning listening session held for Black mothers in October with PE & EDI midwife and MNVP.
- 15 Steps Challenge re-booked for February 2024.
- Co-production of parent information for TC – including virtual tour antenatal counselling for high-risk groups.
- EDI & PE midwife working closely with MNVP to engage and support service users.
- Staff and service user developed following negative feedback regarding amenity rooms.
- Supporting development and pilot of immediate debrief service to be led by PMA team to support service users with complex labours/deliveries with a debrief prior to discharge.
- Focus group to be held for Previous C-Section mothers in January 2025 to support review and personalisation of care pathway.

Perinatal Surveillance Tool Data Q3 2024/2025– Staff Feedback & Perinatal Culture Leadership

Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.

Goal: To ensure staff feedback forms and integral part of service improvement

NHS Medway NHS Foundation Trust

Key Messages:

- Re-launch of Safety Champions, with updated poster, feedback form, SOP and communication to staff.
- Safety Champion Engagement Session and Teams Talks held in quarter. Staff discussion points and concerns included
    - Community Broadband.
    - Desk availability for Specialist staff.
    - Damage to Equipment
    - Improved team morale and retention noted across service.
    - Community Teams note reduction of on-call requirements following introduction of hospital on-call.
    - Uniform
- SCORE survey postponed due to ongoing cultural improvement work/surveys across the Trust. To utilise learning from Trust survey and consider further maternity/neonatal survey if required.
- Leadership team working to ensure staff receive updates on key national initiatives including CNST - sharing newsletter via Maternity Matters
- Culture and Inclusion Training for staff.

Issues, concerns, gaps:

- Lack of desk availability/estates footprint to support specialist staff .
- Guidelines continue to be difficult for staff to access across Q-pulse.
- Inconsistency in Band 2/Band 3 MSW roles.
- Damage to equipment requiring replacement and significant cost.
- Perinatal Cultural Leadership Modules complete, discussing next steps.

Perinatal Surveillance Tool Data Q3 2024/2025– Staff Feedback

Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.

Goal: To ensure staff feedback forms and integral part of service improvement

NHS Medway NHS Foundation Trust

Actions and improvements

- Actions to address staff feedback
  - ADOM to review hotdesking arrangements and support specialist staff to identify free desks. Review of estates with DOM to identify potential dedicated hot desk area.
  - Community Broadband due to launch early in 2025.
  - Financial and clinical cost of damaged equipment being highlighted to all staff in annual training days.
  - Staff supported to attend new uniform fitting sessions.
  - 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.
  - Working with patient safety collaborative to agree best use of resources following completion of perinatal leadership model. Consider utilising funds to for staff training and development.

Safeguarding

NHS
Medway
NHS Foundation Trust

Patient
FIRST

Safeguarding – Maternity

Medway NHS Foundation Trust

Key Messages:

-Full year 'Did Not Attend (DNA)' audit completed and presented to care group with action plan.
-Training video around completion of DNA checklist now created and ready for launch.
-Lone worker risk assessments created by security lead and community midwifery matron for all maternity teams who lone work with specificity around community centres each team works within.
-Increase in safeguarding adults and children level 3 and MCA training for midwifery and doctor staff groups with exception of children level 3 for maternity staffing. This is due to additional staff being added to mapping for this instead of level 2.
-Band 6 deputy named midwife now recruited to for secondment.

Issues, Concerns & Gaps:

- Completion of persistent DNA flow chart continues to be a challenge.
- Inconsistencies noted around 'safeguarding returns' completed by community midwifery.
- Safeguarding supervision for hospital based staff provision not yet in place.
- Complex case involving wide MDT input during December.
- Safe sleeping audit showed poor compliance around visualisation of sleep space during first postnatal home visit. Inconsistent compliance across all 5 teams in regards to SIDs prevention advice.
- Inconsistent compliance across inpatient areas for CP-IS review for all admissions.
- Antenatal toxicology data review outstanding from 2024

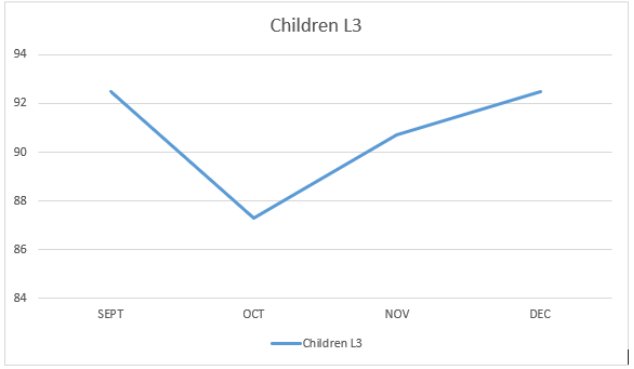
Actions/Improvements :

- New Medway pre-discharge planning documentation now complete with relevant stakeholder input-now completed and submitted for upload and launch with maternity staff
- Meeting to be planned to discuss how best to capture shift working colleagues to complete safeguarding supervision with senior sister/matron team.
- Updated/more user friendly safeguarding returns form now shared with all community midwifery teams- will capture both safeguarding cases and DNA checklists commenced- to allow closer oversight by senior sisters.
- Action plans in place for CP-IS and safe sleeping practices.

SIOR - Patients

Successful Deliverables

- 6 inpatients with safeguarding concerns (Dec)
- Safe guarding Level 3 staff statman compliance 92.47%
- Safeguarding documentation, Now on EPR
- Safeguarding guidelines all updated



Next Steps

SG L3 compliance:
SEPT 92.47%
OCT 87.31%
NOV 90.72%
DEC 92.47%

Identified Challenges

- Improved communication between NICUs within the Network is required to ensure seamless transfers of care
- Ensure guidelines are kept updated
- ESR, timely system updates

Next Steps

- Continue to work in partnership with NICUs within ODN
- Create a work schedule to ensure guideline are reviewed and updated as required

Opportunities

- New staff supported to complete mandatory training during their supernumery induction period
- Weekly meetings are face to face, ensuring positive information sharing
- Improved handover and communication between Maternity and NICU
- Safeguarding training available online
- Created Escalation Flowchart for NICU Clinical Band 7's to follow when Outreach out of office

Next Steps

- Continue to work closely with the multi professional team.
- Continue to support team to complete training

Risks

- Gaps with the information that is assumed Social Workers are informing families of in terms of Mother and Baby units and how these work, information around contact centres.
- Gaps in training for foster carers and Mother and Baby Units in terms of infant feeding advice once baby leaves the NICU.

Next Steps

- Ensure full and concise information sharing within the MDT
- Work with social workers as well as families as partners in care

Conclusions and Next Steps

The third quarter of the 2024-2025 has shown significant progress in several areas of neonatal and perinatal care, while also highlighting ongoing challenges that need to be addressed.

Incident Reporting and Management:

- There has been a notable reduction in the number of incidents reported, with the majority being of no or low harm. This indicates effective risk management and a proactive approach to patient safety.
- The implementation of independent double-checking for blood products and daily x-ray/POCUS for UVC lines has been a positive step towards improving clinical practices and patient outcomes.
- Positive strides in engaging with service users, particularly through the Maternity and Neonatal Voices Partnership (MNVP).
- High levels of satisfaction with VBAC at home and personalized care plans.
- Notable improvements in FFT response and recommend rates, indicating better service user engagement and satisfaction.
- Challenges remain, particularly regarding the funding for additional MNVP roles and negative feedback on Amenity Rooms.

Continued Focus on Learning and Improvement:

- Ongoing shared learning sessions and thematic analyses will continue to address recurring issues and promote a culture of continuous improvement.
- The launch of gentamicin stickers and updates to the medication formulary will enhance medication safety.

Addressing Equipment and Infrastructure Issues:

- Efforts will be made to ensure timely maintenance and availability of critical equipment, particularly ventilators, to support optimal patient care.

Enhancing Review and Reporting Processes:

- Aligning the audit plan for 2025/26 with key themes from 2024/2025 incidents will ensure a focused approach to quality and safety.
- Developing clear guidance for assessing psychological harm and ensuring it is captured in Datix will address current gaps in the reporting system.

Service User Engagement:

- Continue to strengthen collaboration with MNVP and other service user groups.
- Address negative feedback on Amenity Rooms through targeted surveys and improvement plans.
- Expand engagement efforts, including focus groups and listening sessions, to ensure diverse voices are heard and incorporated into service development.

Conclusions and Next Steps

Medway NHS Foundation Trust

Service User Feedback:

- Positive strides in engaging with service users, particularly through the Maternity and Neonatal Voices Partnership (MNVP).
- High levels of satisfaction with VBAC at home and personalized care plans.
- Notable improvements in FFT response and recommend rates, indicating better service user engagement and satisfaction.
- Challenges remain, particularly regarding the funding for additional MNVP roles and negative feedback on Amenity Rooms.

Staff Feedback & Perinatal Leadership:

- Successful re-launch of Safety Champions and engagement sessions, contributing to improved team morale and retention.
- Persistent issues with desk availability, access to guidelines, and equipment damage highlight areas needing attention.

Next Steps

Service User Engagement:

- Continue to strengthen collaboration with MNVP and other service user groups.
- Address negative feedback on Amenity Rooms through targeted surveys and improvement plans.
- Expand engagement efforts, including focus groups and listening sessions, to ensure diverse voices are heard and incorporated into service development.

Staff Engagement:

- Implement actions to address staff feedback, such as improving hotdesking arrangements and enhancing access to guidelines.
- Continue to support staff through training, development opportunities.
- Maintain momentum with Safety Champion initiatives and ensure ongoing communication and feedback loops.

NHS
Medway
NHS Foundation Trust

APPENDIX 4b

NHS
Medway
NHS Foundation Trust

Maternity Claims, Incidents and Complaints Triangulation Quarterly Report

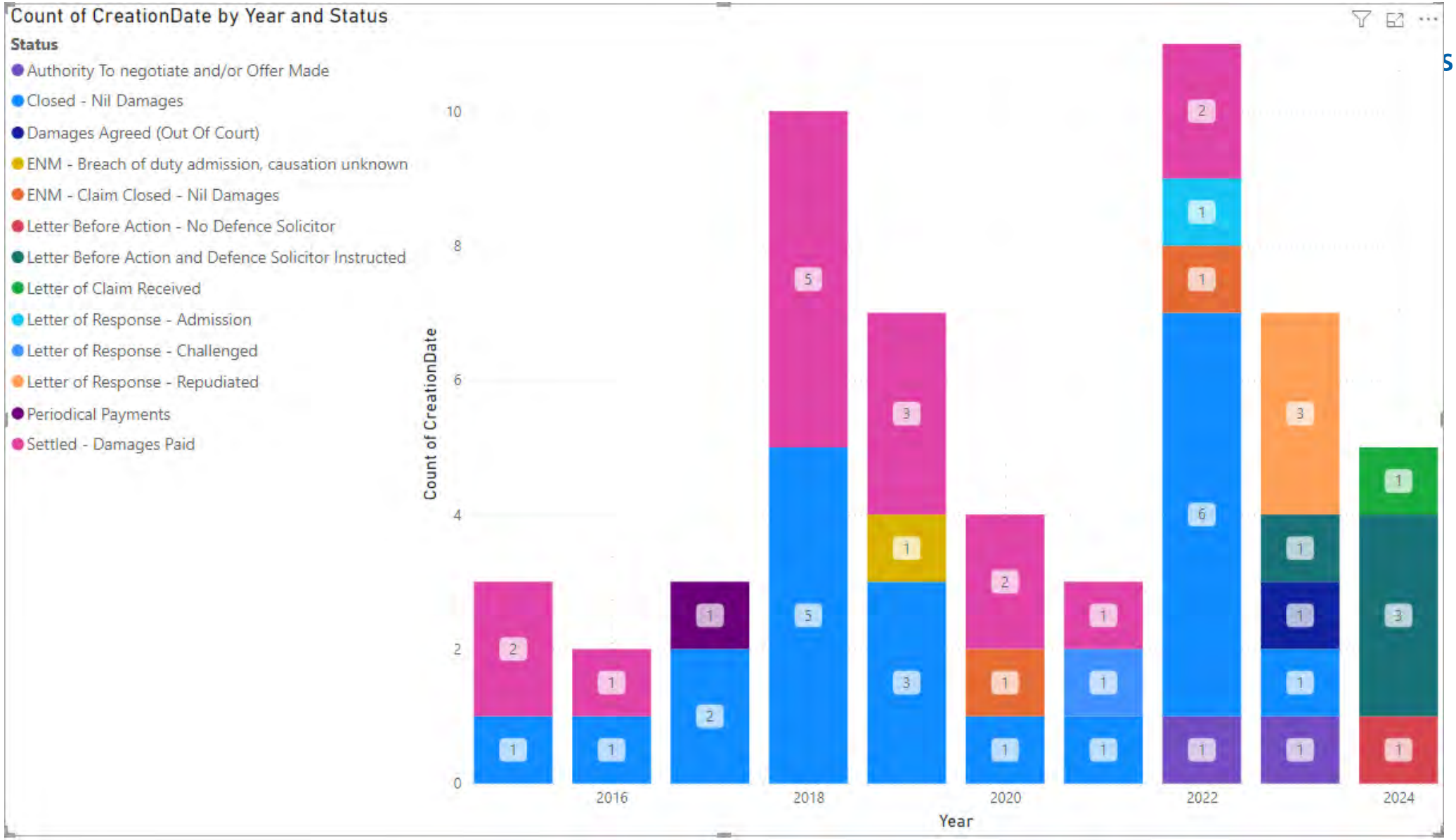
Trust Board 12 March 2025

Patient FIRST

Executive Summary

- The 2014-2024 Claims scorecard has been published in October 2024 – with total of 52 maternity claims, 36 closed, 12 open, 4 incidents
- A significant claim was settled in 2023, with total claim value >£26 million (periodic payments). This incident took place in 2017 and related to CTG interpretation. Significant learning and improvement has been made, including implementation of Fetal Wellbeing Team and regional physiological fetal monitoring training.
- Total claims paid in past 10 years £28.5 million (£46.5 million potential value) with 2 further high-value claims currently open: 2019, ENM – Breach of Duty, admission, causation unknown, hypoxia, £14.7 million – Medium probability and 2020, Letter of response – Admission, Fistula, £2.2 million – High probability
- 11 Claims received in 2022 - 7 Closed – Nil Damages, 1 letter of admission, 2 Settled damages paid, 1 authority to negotiate/offer made.
- 12 claims have been received in 2023/2024 - Highest predicted value £0.5 million, 1 certain, 3 High probability, 8 Medium probability, 3 repudiated, 1 damages agreed out of court, 1 authority to negotiate/offer made
- Trend of paid claims remains low, with exception of the above mentioned significant claim, with approximately £2 million across all other paid claims for the 10 year period.
- Based on 2017-2022 data, MFT is the second lowest for claim value within the South East Region, and the lowest within comparable Trusts with Level 3 NICU within the South East Region. NHSR have noted that premiums for all Trusts have increased in 2024/25.
- Report will review claims, alongside incidents reviewed at CRIG and complaint themes by Theme/Sub-Theme, Severity, Probability of Claim, Level of Harm, Level of Investigation
- The highest theme relates to fetal monitoring (9) claims, with delay in diagnosis, escalation, failure to recognise deteriorating patients, failure/delay to diagnose or treat accounting for 15 claims. This is aligned to the review of incidents for 2024 where this was also collectively a clear theme.
- Due to move to PSIRF, the numbers of higher level investigation has significantly reduced in Maternity, with the majority of further investigations undertaken by MNSI and PMRT. We may need to consider the impact this will have on our ability to identify and defend potential claims in the future.
- 18 (5%) incidents were rated moderate harm or above in 2024 on review at CRIG. Given that 41% of current claims were datixed at moderate or above, there is a potential for some of these incidents to convert to claims in coming years.
- Asian families continue to be over represented in claims (14% compared to 6% of birth rate), with Black families under represented in claims – 0 claims received, >7% of birth rate and 16.8% of incidents reviewed at CRIG.
- Maternity CNST rebates have successfully been reinvested in maternity and neonatal services to drive safety and quality improvements for women, birthing people and families. The importance of continuing to use maternity CNST rebates to improve outcomes for our families cannot be underestimated.

MFT Claims – Date opened/Status 2015-2024



NHS Medway S Foundation Trust

NHSR Data – 2022/23 and 2023/2024

NHS Medway NHS Foundation Trust

Contribution 2022/23 (£'s)

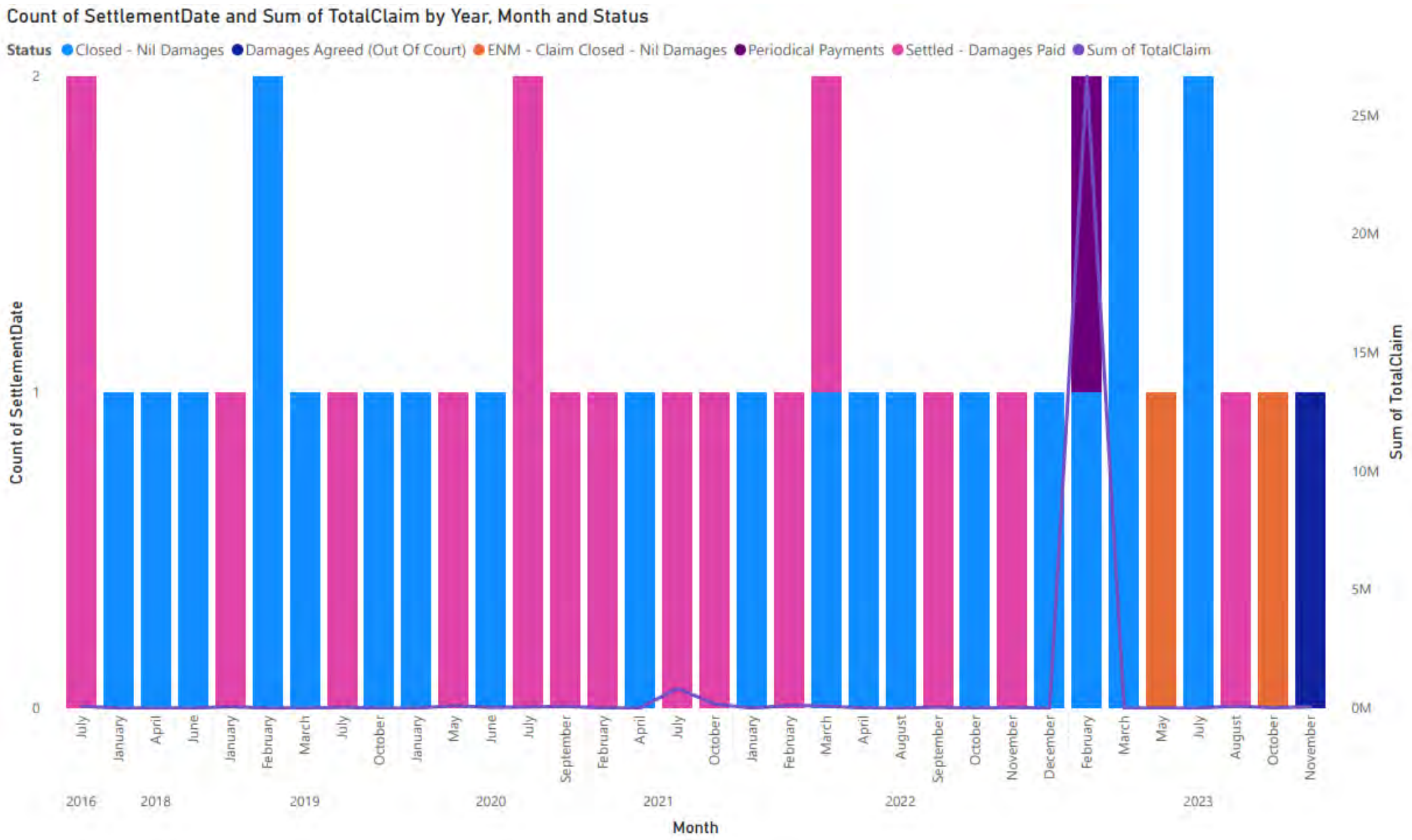
NHS Organisational Code	Member Code	Member Name	CNST Join Date	Trust offers labour ward services ?	CNST General	CNST Maternity	CNST Total	LTPS Join Date	LTPS	PES Join Date	PES	Grand Total
RN7	T139	Dartford and Gravesham NHS Trust	01/04/1995	Yes	6,474,944	7,908,603	14,383,547	01/09/2003	133,408	Not Applicable	0	**14,516,955**
RVV	T491	East Kent Hospitals University NHS Foundation Trust	01/04/1999	Yes	16,459,034	9,210,895	25,669,929	01/04/1999	385,836	01/04/1999	47,032	**26,102,797**
RWF	T571	Maidstone and Tunbridge Wells NHS Trust	01/04/2000	Yes	10,253,632	8,269,615	18,523,247	01/10/1999	470,625	01/10/1999	44,385	**19,038,257**
RPA	T035	Medway NHS Foundation Trust	01/04/1995	Yes	9,400,368	6,472,433	15,872,802	01/04/1999	111,437	01/04/1999	30,856	**16,015,095**

Contribution 2023/24 (£'s)

NHS Organisational Code	Member Code	Member Name	CNST Join Date	Trust offers labour ward services ?	CNST General	CNST Maternity	CNST Total	LTPS Join Date	LTPS	PES Join Date	PES	Grand Total
RN7	T139	Dartford and Gravesham NHS Trust	01/04/1995	Yes	7,369,046	10,180,462	17,549,508	01/09/2003	132,782	00/01/1900	0	**17,682,290**
RVV	T491	East Kent Hospitals University NHS Foundation Trust	01/04/1999	Yes	19,695,205	9,910,406	29,605,611	01/04/1999	364,373	01/04/1999	50,280	**30,020,264**
RWF	T571	Maidstone and Tunbridge Wells NHS Trust	01/04/2000	Yes	11,049,256	8,872,599	19,921,855	01/10/1999	381,254	01/10/1999	48,554	**20,351,663**
RPA	T035	Medway NHS Foundation Trust	01/04/1995	Yes	10,177,405	7,029,200	17,206,605	01/04/1999	126,022	01/04/1999	35,672	**17,368,299**

https://resolution.nhs.uk/resources/annual-statistics/

MFT Claims – Settlement date/Status



MFT Claims – Settlement date/Status

Medway NHS Foundation Trust

All Claims – Predicted and Settled Value

Status		2016	2018	2019	2020	2021	2022	2023	Total
Authority To negotiate and/or Offer Made	378,000.00								**378,000.00**
Closed - Nil Damages			5,276.67	5,205.00	30,290.91	1,010.00	23,858.50	6,984.60	**72,625.68**
Damages Agreed (Out Of Court)								54,500.00	**54,500.00**
ENM - Breach of duty admission, causation unknown	14,470,000.00								**14,470,000.00**
ENM - Claim Closed - Nil Damages								15,992.25	**15,992.25**
Letter Before Action - No Defence Solicitor	103,000.00								**103,000.00**
Letter Before Action and Defence Solicitor Instructed	493,000.00								**493,000.00**
Letter of Claim Received	107,500.00								**107,500.00**
Letter of Response - Admission	2,200,000.00								**2,200,000.00**
Letter of Response - Challenged	53,000.00								**53,000.00**
Letter of Response - Repudiated	560,000.00								**560,000.00**
Periodical Payments								26,637,518.00	**26,637,518.00**
Settled - Damages Paid		83,232.88		94,714.77	228,447.52	1,021,186.14	255,387.50	87,425.00	**1,770,393.81**
Total	**18,364,500.00**	**83,232.88**	**5,276.67**	**99,919.77**	**258,738.43**	**1,022,196.14**	**279,246.00**	**26,802,419.85**	**46,915,529.74**

Closed/Settled Claims

Status	2016	2018	2019	2020	2021	2022	2023	Total
Closed - Nil Damages		5,276.67	5,205.00	30,290.91	1,010.00	23,858.50	6,984.60	**72,625.68**
Damages Agreed (Out Of Court)							54,500.00	**54,500.00**
ENM - Claim Closed - Nil Damages							15,992.25	**15,992.25**
Periodical Payments							26,637,518.00	**26,637,518.00**
Settled - Damages Paid	83,232.88		94,714.77	228,447.52	1,021,186.14	255,387.50	87,425.00	**1,770,393.81**
Total	**83,232.88**	**5,276.67**	**99,919.77**	**258,738.43**	**1,022,196.14**	**279,246.00**	**26,802,419.85**	**28,551,029.74**

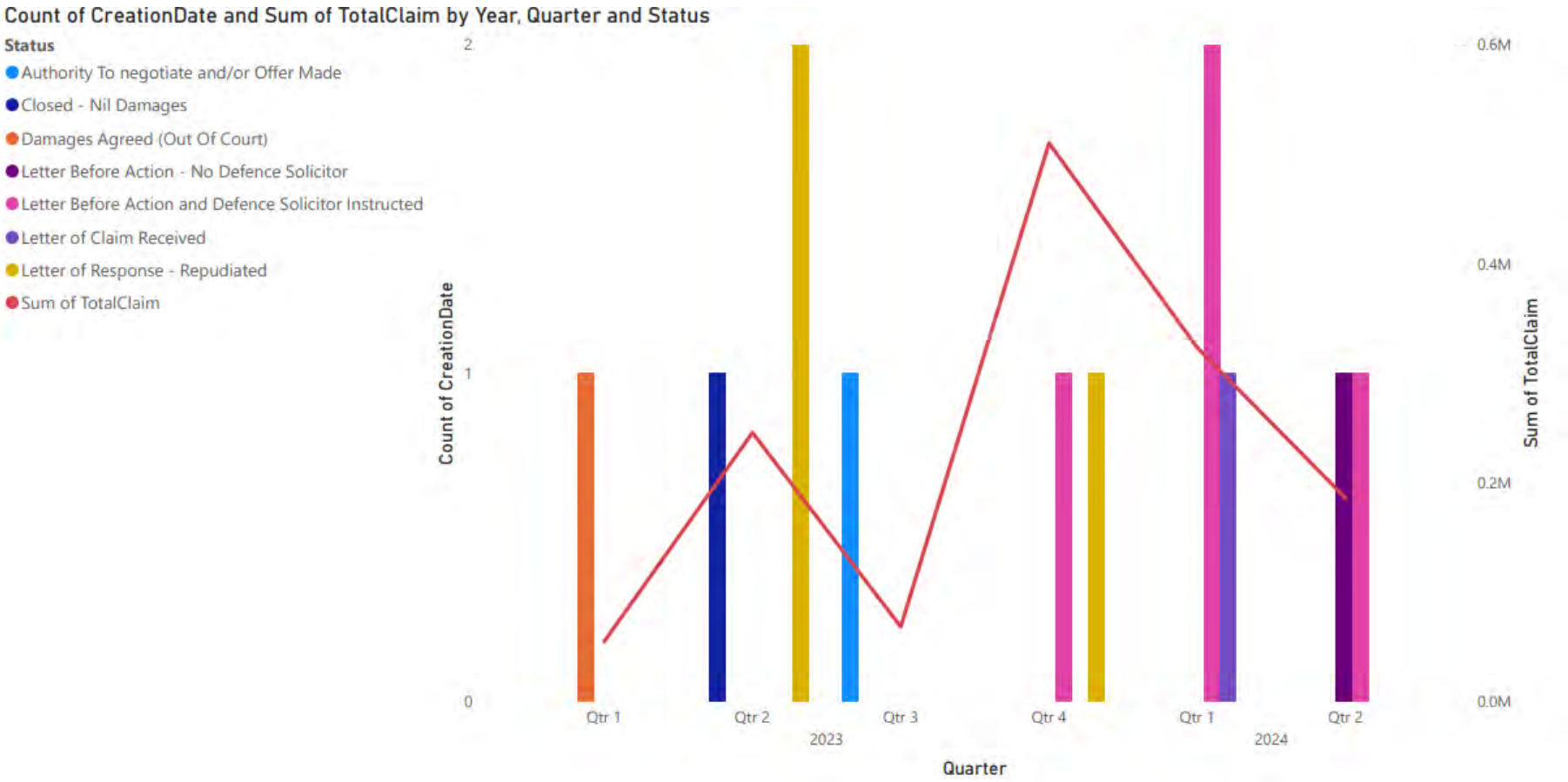
MFT Claims – Settled/closed claims – Total Claim Paid/Damages Paid

Row Labels	Sum of TotalClaim	Sum of DamagesPaid
Closed - Nil Damages	**72625.68**	**0**
Adtnl/unnecessary Operation(s)	2135	0
Advanced Stage Cancer	1730	0
Aneurysm	1010	0
Brain Damage	19788.5	0
Dislocation	30290.91	0
Erb's Palsy	2325	0
Failed Sterilization	1310	0
Fracture	1935	0
Hernia	0	0
Infection (bacterial)	337.5	0
Not Specified	0	0
Renal Damage/ Failure	2260	0
Rupture	457.1	0
Scarring	0	0
Stillborn	1000	0
Thrombosis/Embolism	2300	0
Unnecessary Pain	5746.67	0
Damages Agreed (Out Of Court)	**54500**	**35000**
Perforation	54500	35000
ENM - Claim Closed - Nil Damages	**15992.25**	**0**
Hypoxia	15992.25	0
Not Specified	0	0
Periodical Payments	**26637518**	**8600665**
Brain Damage	26637518	8600665
Settled - Damages Paid	**1770393.81**	**924164.49**
Adtnl/unnecessary Operation(s)	87425	44000
Fistula	834636.65	500000
Infertility	61428.07	45000
Loss Of Baby	75085	27500
Not Specified	9350	1000
Premature Onset Of Menopause	33286.7	25000
Psychiatric/Psychological Dmge	22500	11000
Stillborn	326107.4	149000
Unnecessary Pain	320574.99	121664.49
Grand Total	**28551029.74**	**9559829.49**

NHS Medway NHS Foundation Trust

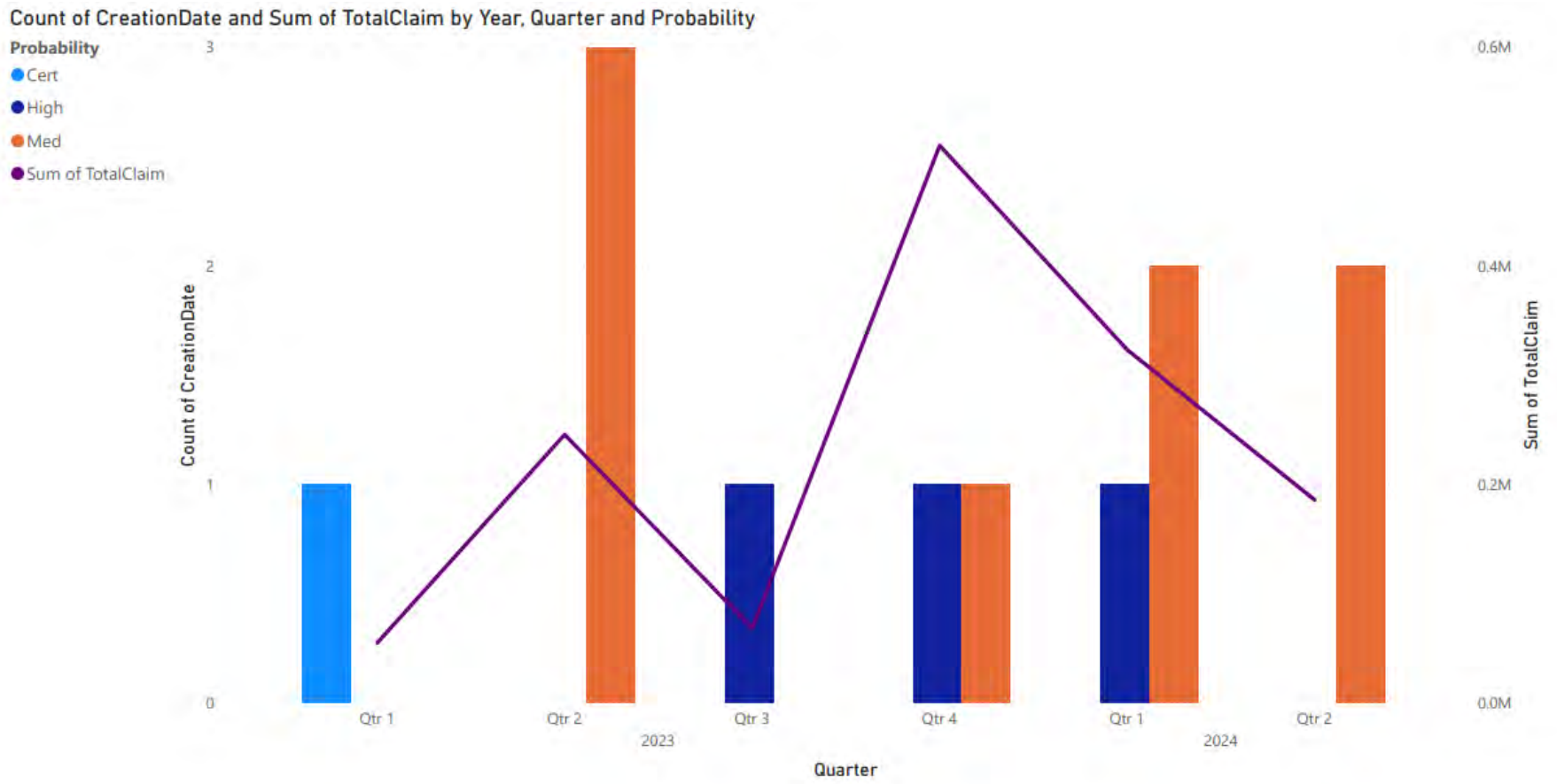
MFT Claims – 2023/2024 Status/Predicted Total Claim Value

Medway NHS Foundation Trust



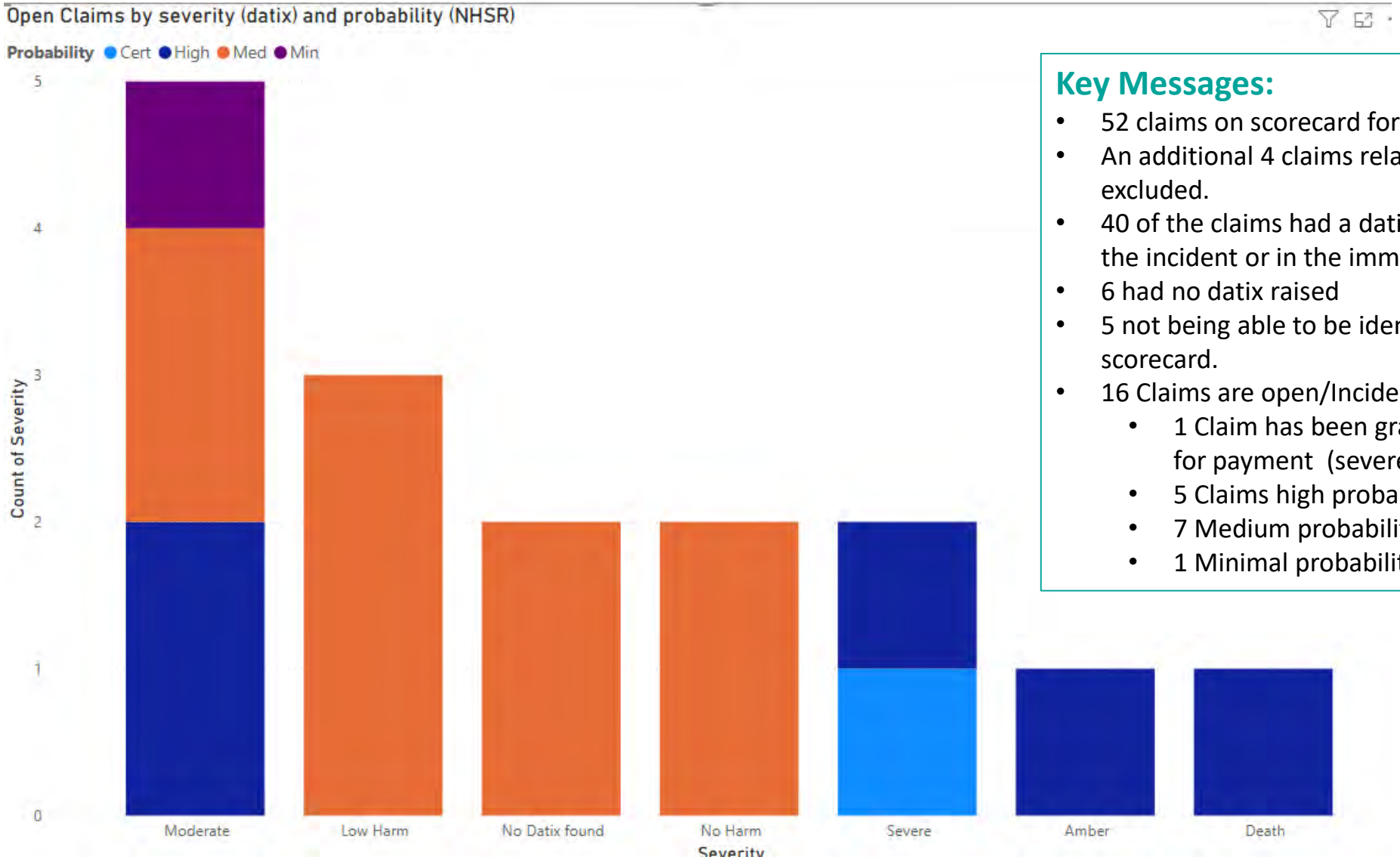
MFT Claims – 2023/2024 Probability/Predicted Total Claim Value

Medway NHS Foundation Trust



Claims -2014-2024 – Open Claims/Incidents

Medway NHS Foundation Trust



Key Messages:

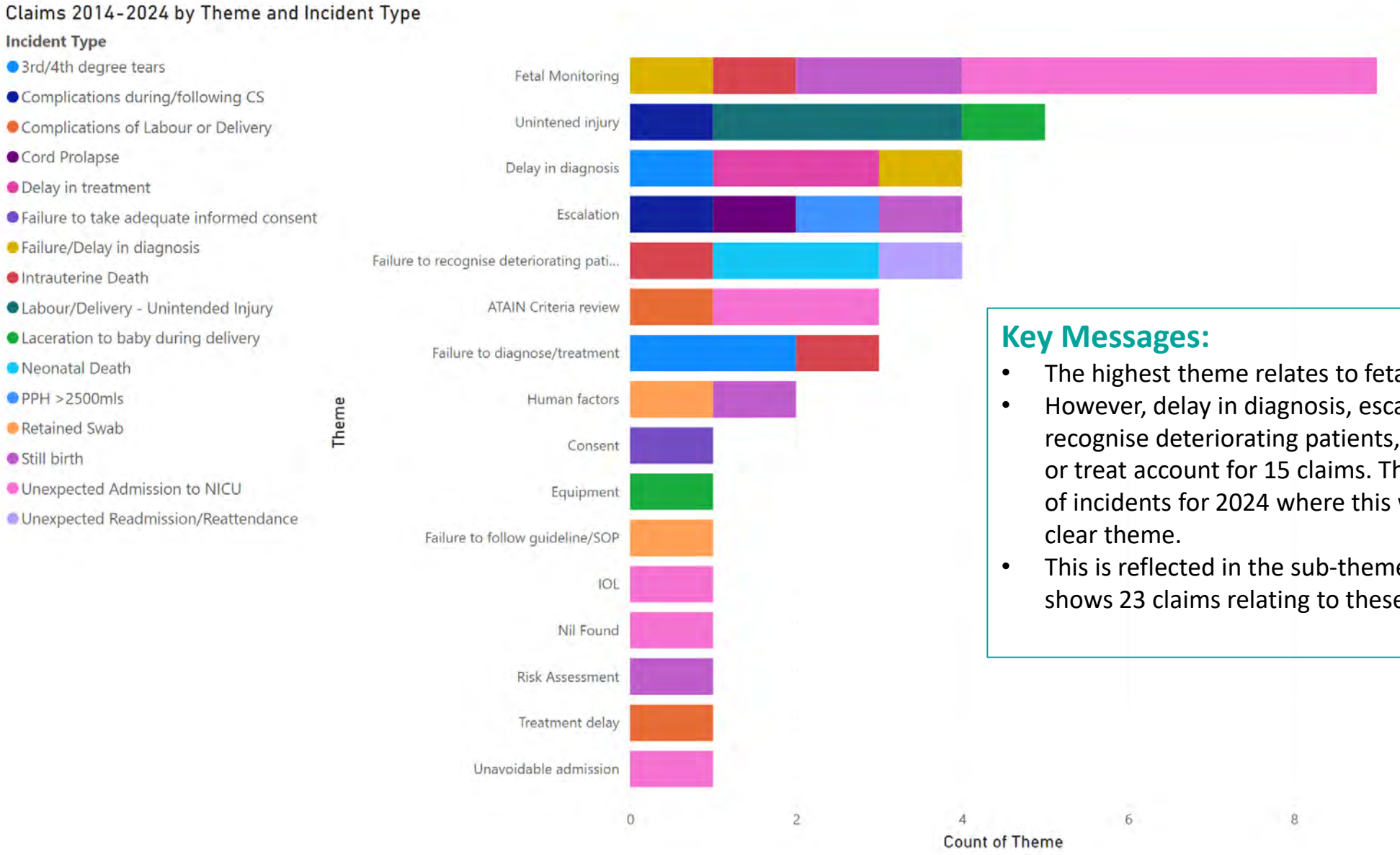
- 52 claims on scorecard for 2014-2024.
- An additional 4 claims related to gynae cases so have been excluded.
- 40 of the claims had a datix or a complaint raised at the time of the incident or in the immediate aftermath.
- 6 had no datix raised
- 5 not being able to be identified from the details on the scorecard.
- 16 Claims are open/Incident level
  - 1 Claim has been graded by NHSR as certain probability for payment (severe harm – ongoing periodic payments)
  - 5 Claims high probability
  - 7 Medium probability
  - 1 Minimal probability

Claims -2014-2024 – Summary of new claims

Medway
NHS Foundation Trust

Year	Status	Event	Further Investigation	Theme	Sub-Theme	Probability	Sum of TotalClaim
2023	Authority To negotiate and/or Offer Made	IUD or Stillbirth	SI	Fetal Monitoring	Delay in diagnosis	High	68,000.00
2023	Letter Before Action and Defence Solicitor Instructed	Neonatal Death	SI/HSIB/Coroner	Failure to recognise deteriorating patient	Risk Assessment	High	195,000.00
2023	Letter of Response - Repudiated	Uterine Rupture	HLI	Fetal Monitoring	Failure to diagnose/treatment	Med	315,000.00
2024	Letter Before Action and Defence Solicitor Instructed	Intra-operative Problems				Med	122,500.00
2024	Letter Before Action and Defence Solicitor Instructed	IUD or Stillbirth				Med	82,500.00
2024	Letter Before Action and Defence Solicitor Instructed	Neonatal Death	SI/Coroner	Failure to recognise deteriorating patient	Failure to diagnose/treatment	High	93,000.00
2024	Letter of Claim Received	Unexpected Admission to Neonatal Unit	No	Nil Found	ATAIN Criteria review	Med	107,500.00
Total							**983,500.00**

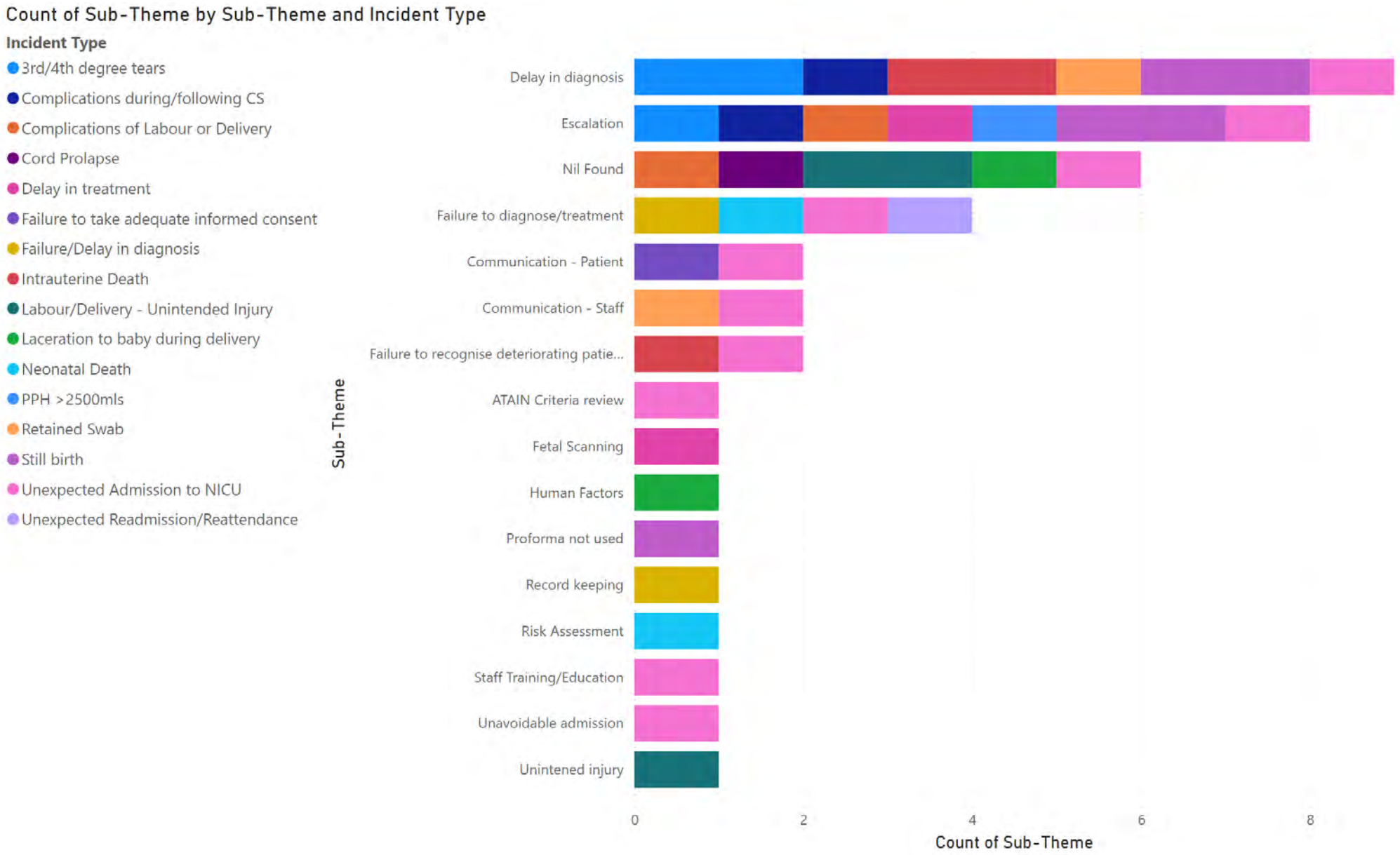
Claims -2014-2024 – Themes



Key Messages:

- The highest theme relates to fetal monitoring (9) claims.
- However, delay in diagnosis, escalation, failure to recognise deteriorating patients, failure/delay to diagnose or treat account for 15 claims. This is aligned to the review of incidents for 2024 where this was also collectively a clear theme.
- This is reflected in the sub-themes on the next slide which shows 23 claims relating to these areas.

Claims -2014-2024 – Themes



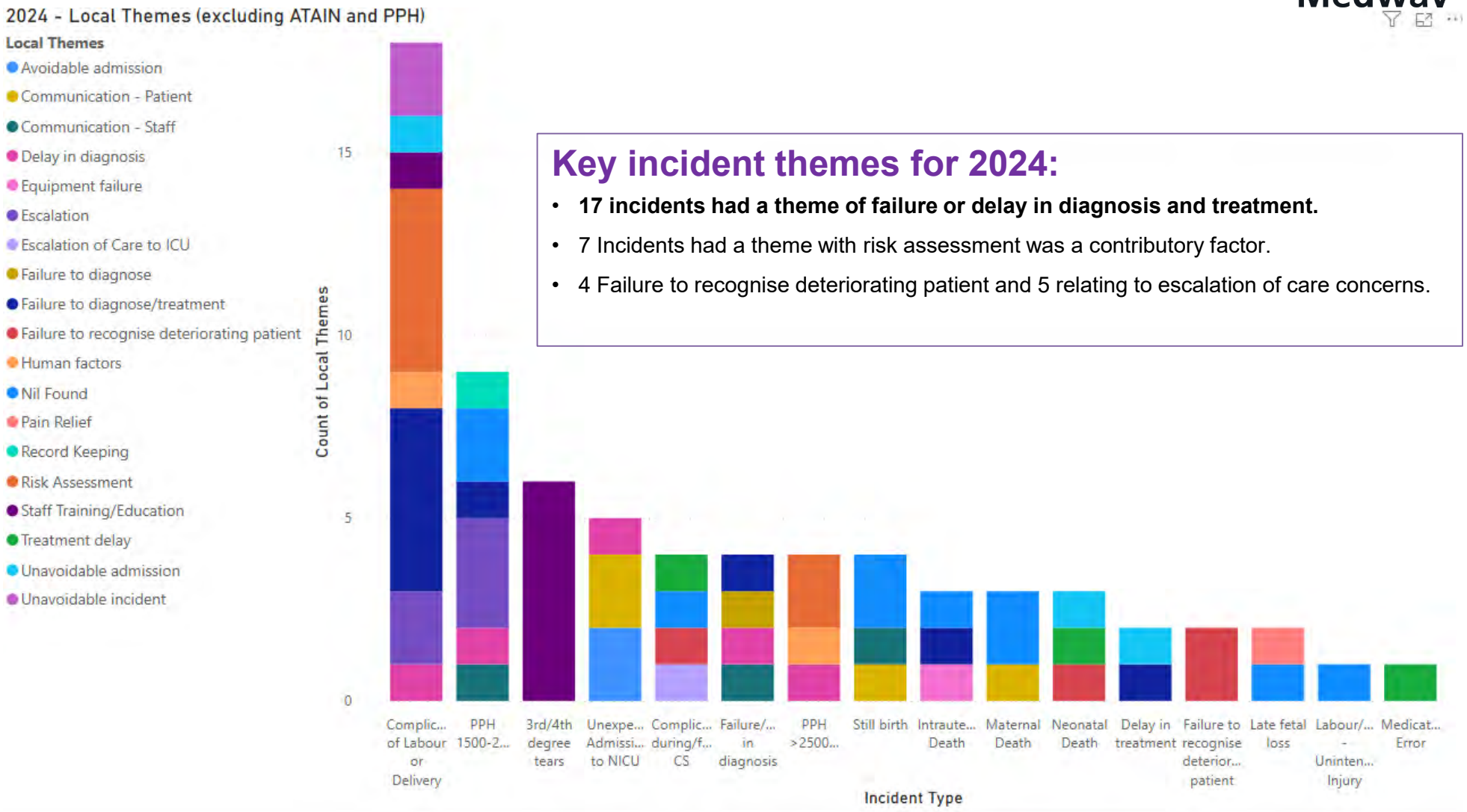
Maternity Incidents (CRIG) 2024 – Themes

Key Messages :

- Failure/delay in diagnosis and treatment most prominent theme for incidents (excluding ATAIN and PPH meeting CRIG criteria)

Recommendations :

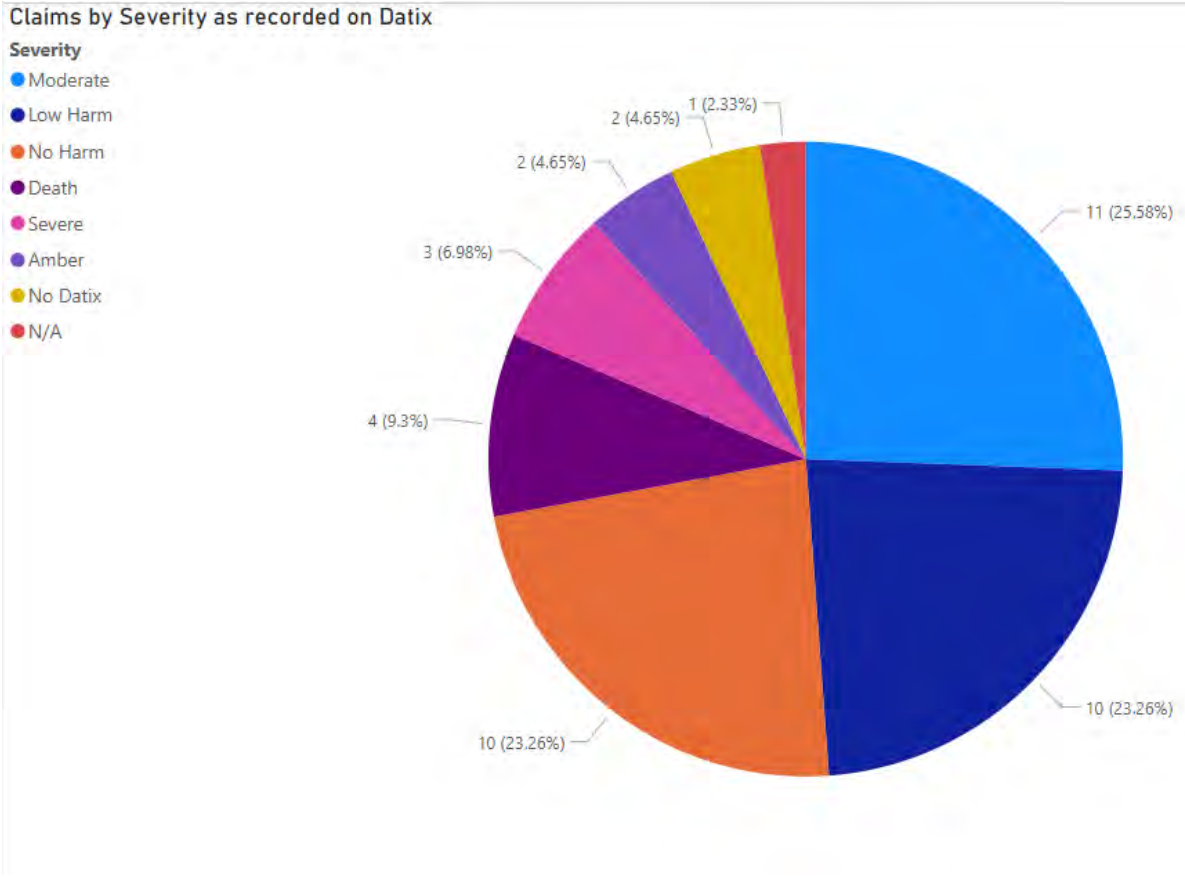
- Need to ensure themes from CRIG reviews are incorporated into PROMPT and Fetal Monitoring training and case reviews also shared at audit meetings.
- Align audit plan for 2025/26 and Maternity Patient Safety Incident Response Plan to key themes from 2024/2025 incidents.

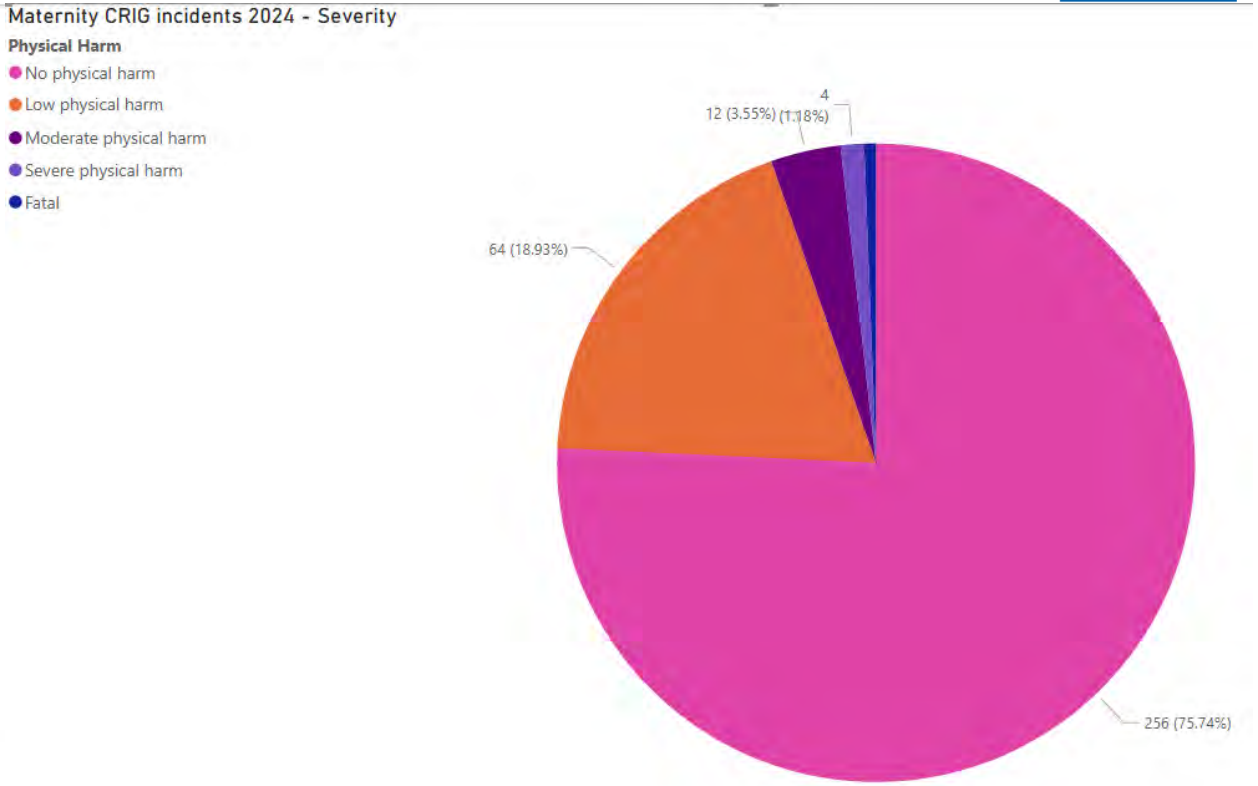


Key incident themes for 2024:

- **17 incidents had a theme of failure or delay in diagnosis and treatment.**
- 7 Incidents had a theme with risk assessment was a contributory factor.
- 4 Failure to recognise deteriorating patient and 5 relating to escalation of care concerns.

Claims -2014-2024/CRIG Incidents 2024 – Severity



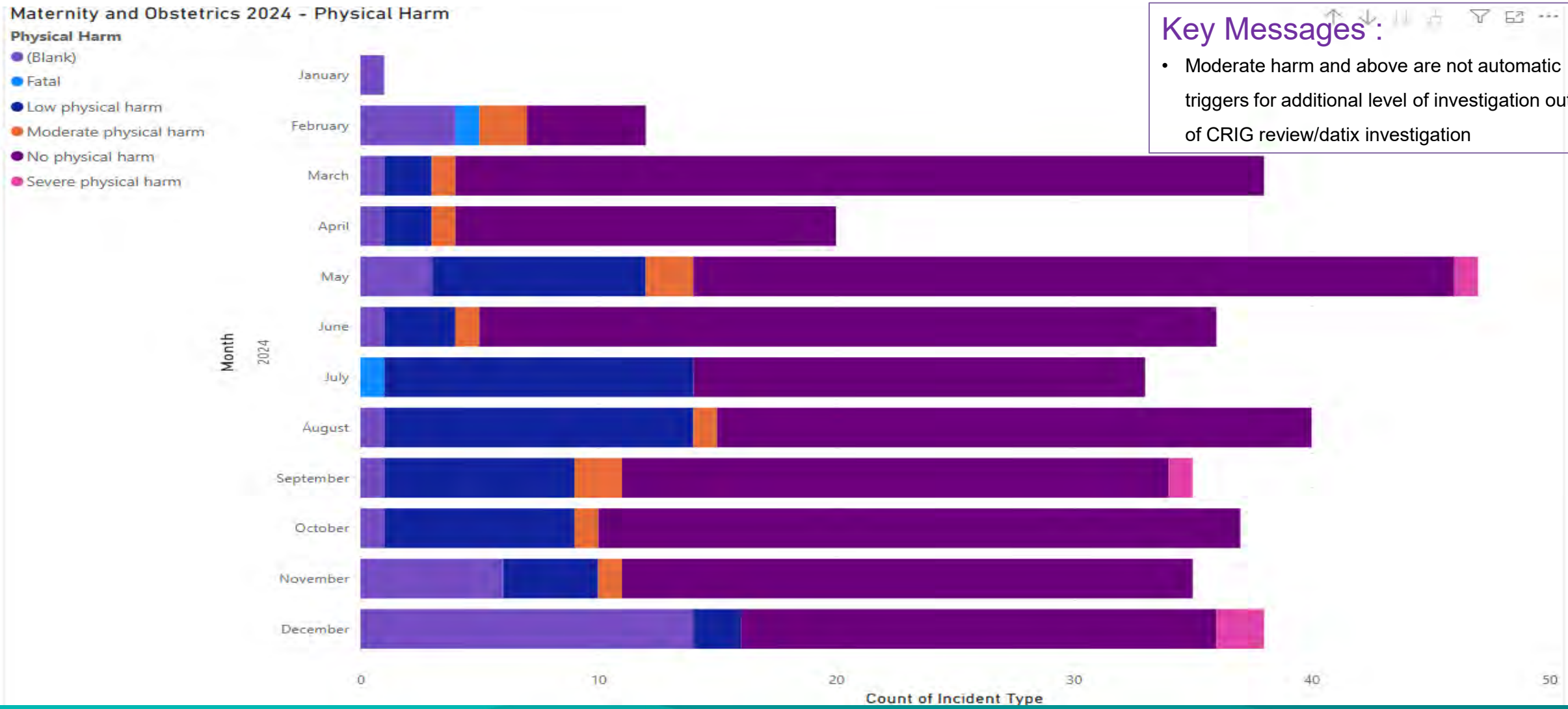


Key Messages:

- 41.4% of claims were datixed at moderate harm or above.
- 5.32% (18) of incidents reviewed at CRIG in 2024 were agreed as having moderate harm or above.

Maternity Incidents (CRIG) 2024 – Severity/Level of Investigation

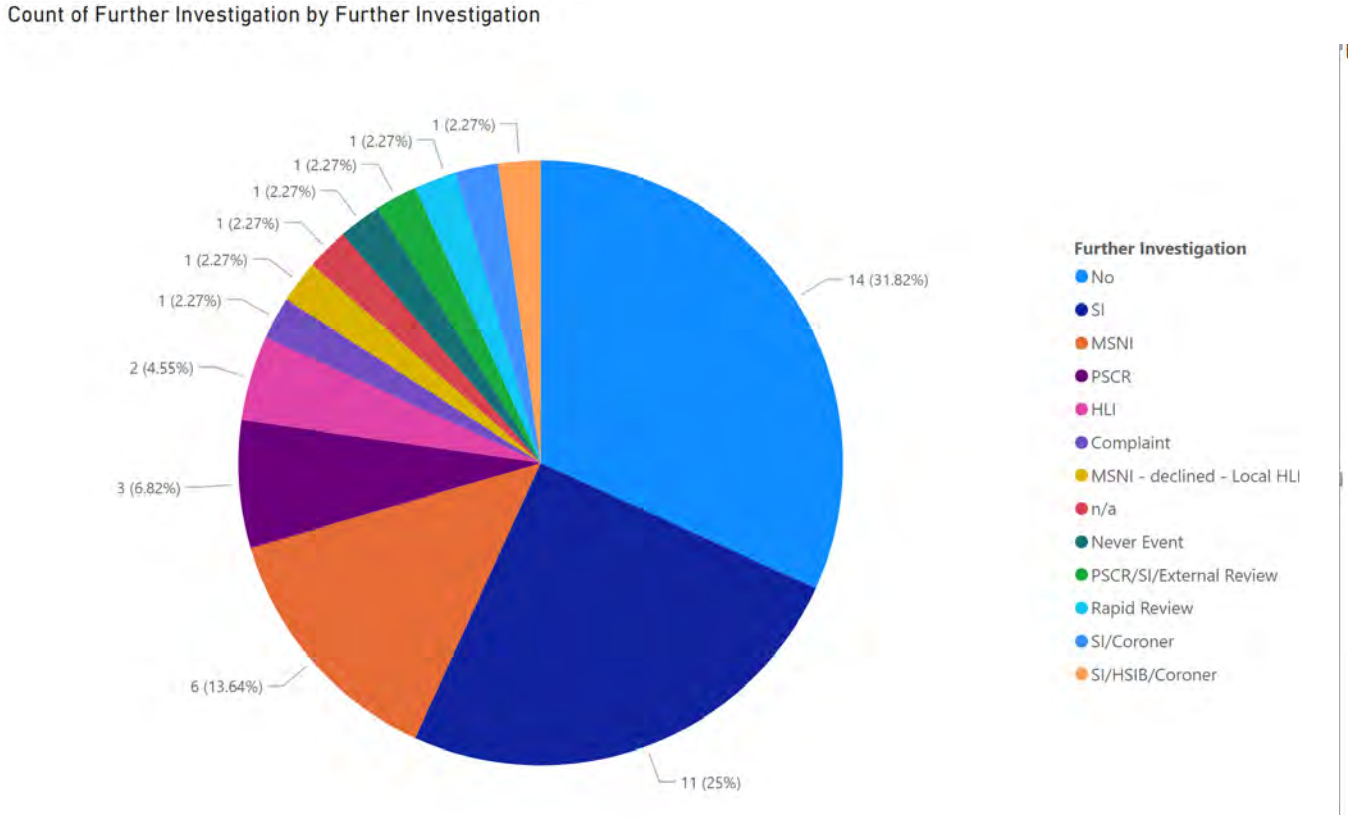
Medway NHS Foundation Trust

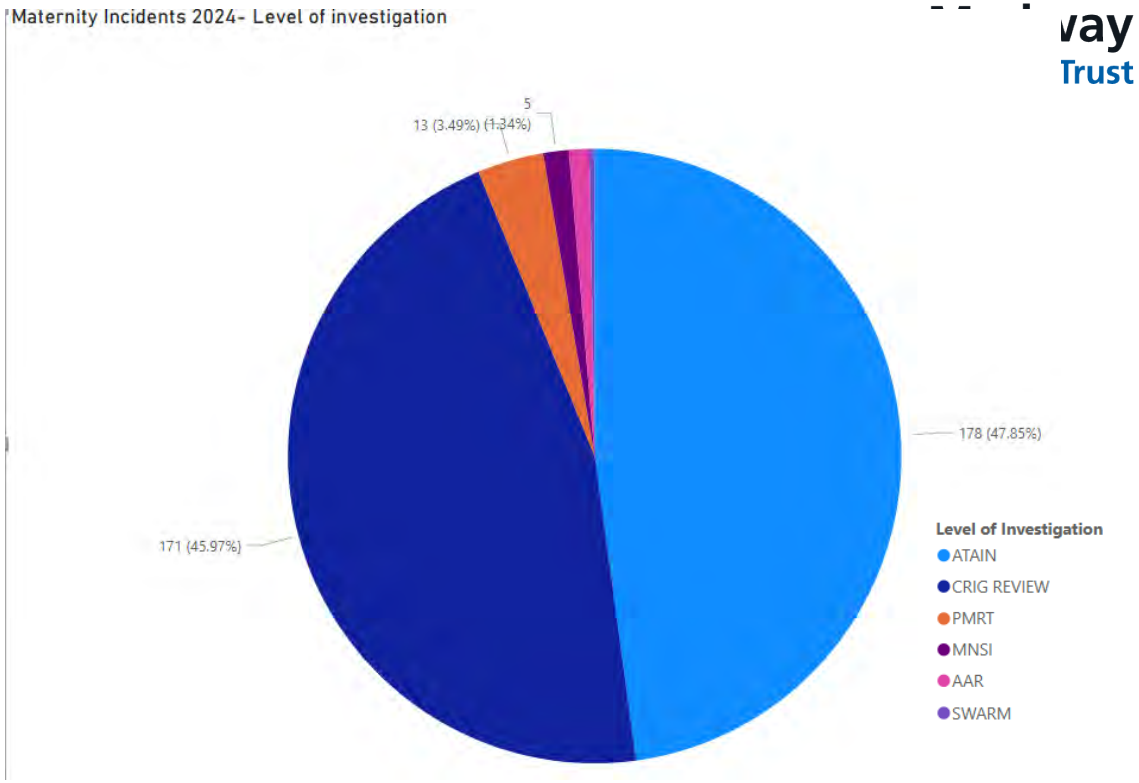


Key Messages:

- Moderate harm and above are not automatic triggers for additional level of investigation outside of CRIG review/datix investigation

Claims -2014-2024/CRIG 2024 –Level of Investigation

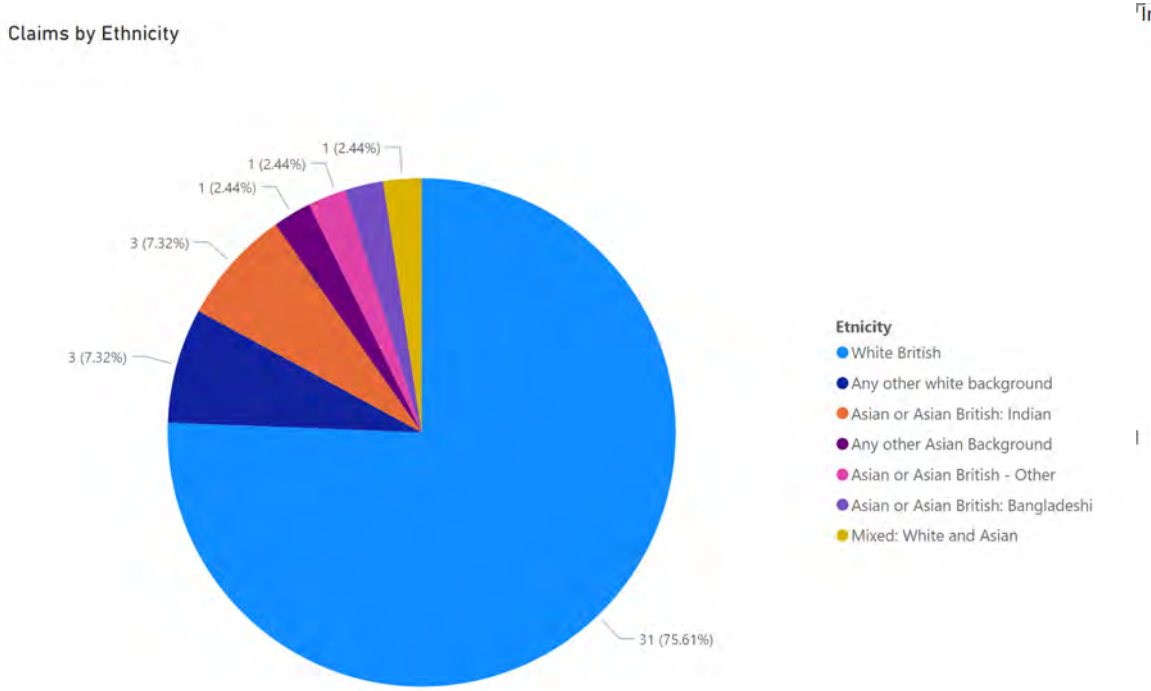


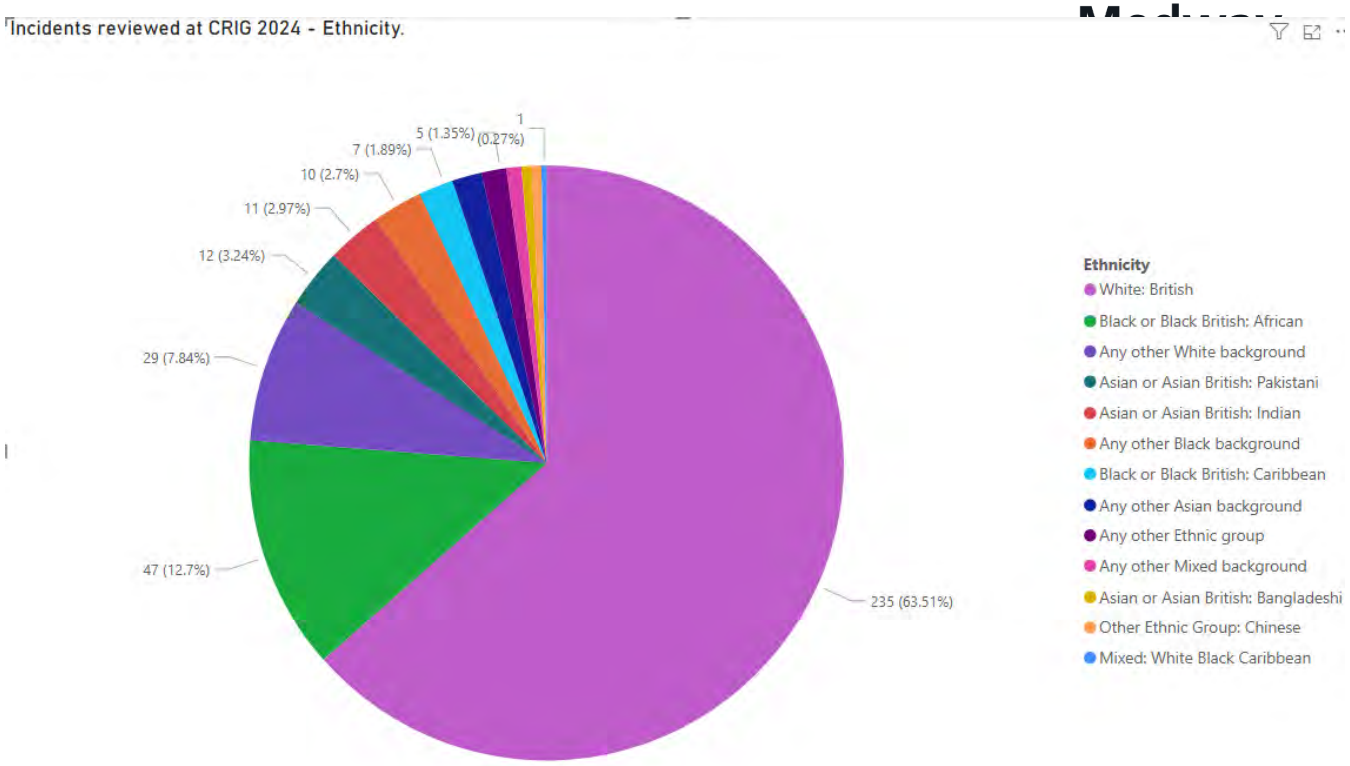


Key Messages:

- 63% of claims had a higher level of investigation.
  - >25% having an SI investigation
  - 18% were referred to MNSI/HSIB
- Only 3.77% of Maternity incidents reviewed at CRIG in 2024 received a higher level of investigation:
  - 1.34% MNSI (5)
  - 1.08% AAR (4)
  - 0.27% SWARM (1)
- 47.85% (178) had an MDT ATAIN review.
- 3.49% (13) had an MDT PRMT review.

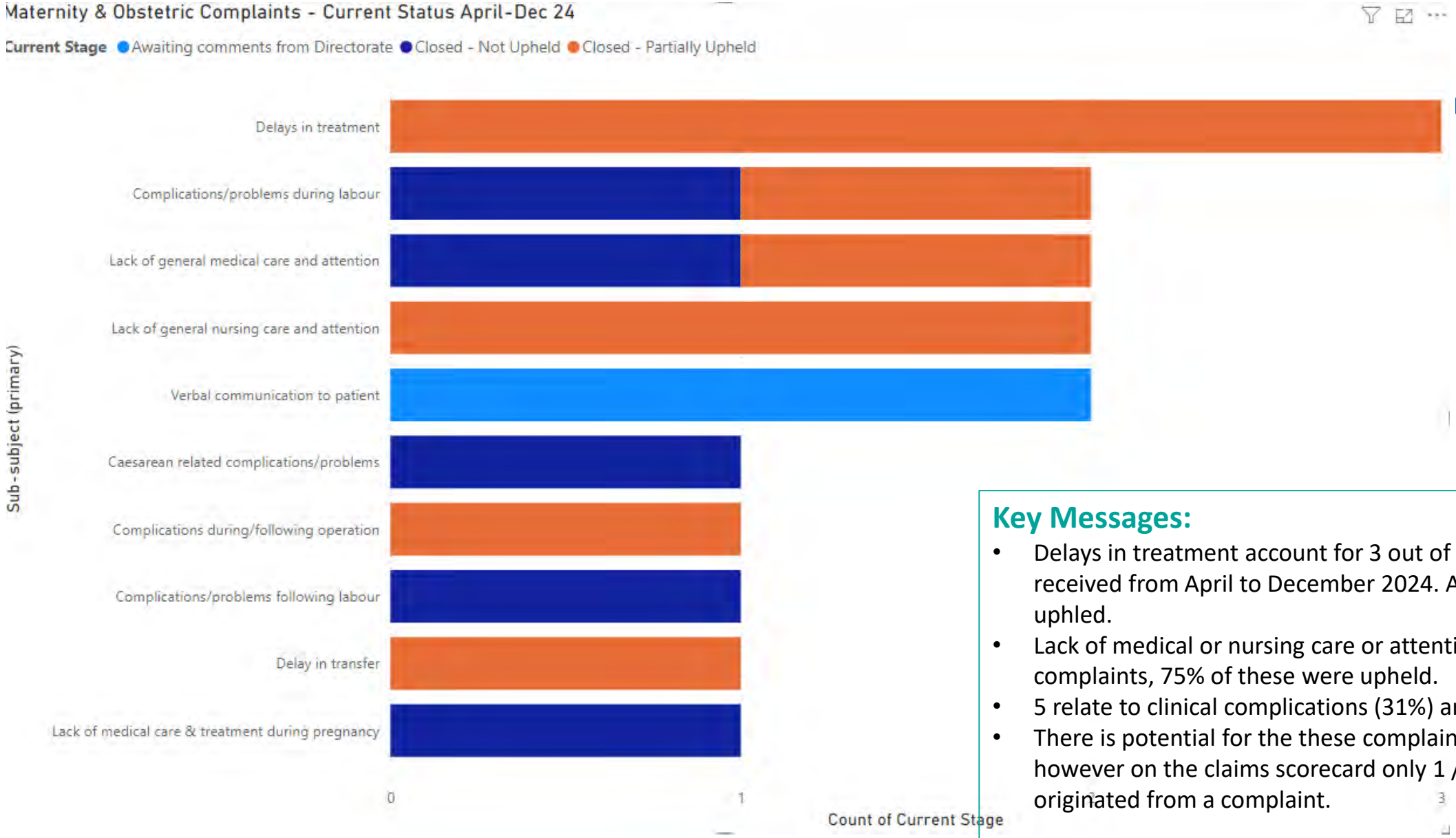
Claims -2014-2024/CRIG Incidents 2024 – Ethnicity





Key Messages:

- 75% of claims are from White British Families reduced from 77.5% for the 2013-2024 Scorecard. (65% of incidents reviewed at CRIG in 2024)
- 14.64 % of claims are from families of Asian background (reduced from 17.5%). This remains disproportionately high against the 6% of total births at MFT from Asian women. (8.37% of incidents reviewed at CRIG in 2024)
- 7.32% or 3 claims are from any other white background (7.84% of incidents reviewed at CRIG in 2024)
- 0 claims from Black families despite accounting for over 7% of the total births at MFT and 16.86% of incidents reviewed at CRIG in 2024



NHS
Medway
NHS Foundation Trust

Key Messages:

- Delays in treatment account for 3 out of 16 (18%) complaints received from April to December 2024. All 3 were partially uphled.
- Lack of medical or nursing care or attention accounts for 4 (25%) complaints, 75% of these were upheld.
- 5 relate to clinical complications (31%) and 2 (40%) were upheld.
- There is potential for the these complaints to become claims, however on the claims scorecard only 1 /52 (2%) of the claims originated from a complaint.

Summary and Findings

NHS Medway NHS Foundation Trust

- On thematic review of the 2014-2024 scorecard the highest single theme relates to fetal monitoring (9) claims.
- However, delay in diagnosis, escalation, failure to recognise deteriorating patients, failure/delay to diagnose or treat account for 15 claims. This is aligned to the review of incidents for 2024 where this was also collectively a clear theme.
- Due to move to PSIRF, the numbers of higher level investigation has significantly reduced in Maternity, with the majority of further investigations being due to mandated investigations such as MNSI and PMRT. We may need to consider the impact this will have on our ability to identify and defend potential claims in the future.
- 18 (5%) incidents were rated moderate harm or above in 2024 on review at CRIG. Given that 41% of current claims were datixed at moderate or above, there is a potential for some of these incidents to convert to claims in coming years.
- Asian families continue to be over represented in claims (14% compared to 6% of birth rate)
- Black families continue to be under represented in claims – 0 claims received, >7% of birth rate and 16.8% of incidents reviewed at CRIG.
- CNST rebates have successfully been reinvested in maternity and neonatal services to drive safety and quality improvements for women, birthing people and families. Overall claim values remain low. Improvements funded by CNST rebates, such as the introduction of Fetal Wellbeing Team, who in turn have introduced Physiology CTG monitoring and a robust local training programme, have seen a significant reduction in the number of HIEs and poor outcomes for our families. The importance of continuing to use CNST rebates to improve outcomes for our families cannot be underestimated.

Next Steps

- Continue to report Claims, Incidents and complaints Triangulation reports to MNSCAG and Trust Board quarterly in line with CNST requirements.
- Financial breakdown to be shared with Finance, Planning and Performance Committee annually.
- Work collaboratively with LMNS colleagues to identify themes and trends in claims/incidents/complaints across the region to support proactive quality improvement work.
- Findings of this report have influenced the work plan and objectives of the PE&EDI midwife which will be presented at the next MNSCAG meeting.
- Plan case review for the next quarterly report with a maternity/neonatal case to identify learning and improvements made.