# DARTFORD AND GRAVESHAM NHS TRUST
## TRUST BOARD MEETING

**9.00am, Thursday, 4 July 2019**  
Boardroom, Level 4  
Darent Valley Hospital

## A G E N D A – PART 1

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   - Minutes of the meeting held on 16 May 2019  
   - Summary Report from the meeting held on 20 June 2019 | Quality and Safety Committee Chair | K  
   K1 |
| 7-17 | Finance Committee  
   - Minutes of the meeting held on 28 May 2019  
   - Summary Report from meeting held on 25 June 2019 | Finance Committee Chair | L  
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| 7-18 | Workforce Committee  
   - Minutes of the meeting held on 16 April 2019  
   - Summary report from the meeting held on 18 June 2019 | Workforce Committee Chair | M  
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| 7-19 | Charitable Funds Committee  
   - Minutes of the meeting held on 26 February 2019  
   - Summary report from the meeting held on 25 June 2019 | Charitable Funds Committee Chair | N  
   N1 |
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<td>7-20</td>
<td>Changes to the Corporate Governance</td>
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<td>Use of the Common Seal</td>
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<td><strong>Any Other Business</strong></td>
<td>Chair</td>
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<td>12.30</td>
<td>Serco Taster Session</td>
<td>Chris Cheel, Serco</td>
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<td><strong>QUESTIONS FROM MEMBERS OF THE PUBLIC</strong></td>
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<td>Notice of Motion: That members of the</td>
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<td>public and press be excluded from the</td>
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<td>confidential nature of the business to</td>
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<td><strong>DATES OF FUTURE MEETINGS:</strong></td>
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<td>• No Meeting in August</td>
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<td>• 5 September 2019</td>
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<td>• 7 November 2019</td>
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Peter Coles, Chairman
MINUTES

Dartford and Gravesham NHS Trust Board (Part 1)
Thursday 6 June 2019
Hockenden Ward, Queen Mary’s Hospital, Sidcup

Present:
Peter Coles Trust Chair (PC)
Louise Ashley Chief Executive (LA)
Siobhan Callanan Director of Nursing and Quality (SC)
Dr Steve Fenlon Medical Director/ Deputy Chief Executive (SF)
David Horne Acting Director of Operations (DH)
Louise Lester Director of Human Resources (LL)
Lorraine Mills Director of Finance (LM)
Leslieann Osborn Director of Strategy and Planning (LO)
Lynn Gladwell Non-Executive Director (Charitable Funds Chair) (LG)
Dr Gill Jenner Non-Executive Director (Workforce Committee Chair) (GJ)
Karen Taylor Non-Executive Director (Audit Committee Chair) (KT)
David Warwick Non-Executive Director (Finance Committee Chair) (DW)

In attendance:
Jane Burr Trust Secretary Minutes (JB)
AC Patient Item 6-8 (AC)
PB Patient Item 6-8 (PB)

6-1 Apologies for absence
Apologies received from:
Pam Dhesi Director of Operations represented by David Horne
Steve Wilmshurst Non-Executive Director (Quality and Safety Committee Chair)

6-2 Declarations of Interest
No declarations of interest from Board members on any of the matters on the agenda.

6-3 Questions from members of the public relating to agenda items
There were no members of the public in attendance.

6-4 Minutes of the meeting held 2 May 2019
The minutes of the Board meeting held on 2 May 2019 were approved as an accurate record of the meeting.

Pending the following changes:

Financial update: £17.2m deficit should read £17.2m deficit - £19.2m excluding PSF
The Board asked that the minute regarding equality included the concern that staff were not declaring their protected characteristics.

Board presentation: minute to include that the research had not been as positive as the outcomes on Palm Ward and that further work was required.
6-5 Minutes of the Extraordinary Board meeting held 24 May 2019
The minutes of the Extraordinary Board meeting held on 24 May 2019 were approved as an accurate record of the meeting but the month on the minutes heading should be changed from April to May.

6-6 Matters Arising and Action Log Review
Action Log
5-9 Presented as Agenda item 6-6
5-10 Closed - 20/05/19 Matter raised with Serco and other partners at Partnership Board for discussion outside of the meeting.
5-10 Closed – 20/5/19 Summary version with links shared in DGT news and team brief. Printed versions of the report will be available for the next EDIC meeting. LL reminded the Board of the specific duty to review the Trust’s WRES annually and the Trust’s equality objectives must be reviewed at least every 4 years. The Workforce Committee are in the process of refreshing the objectives and will be presented at the next meeting in two weeks’ time. If approved these would then go to the Equality, Diversity and Inclusion Committee (EDIC). The Board were reminded that the next EDIC was scheduled for 26 June 2019 at 3pm in the Philip Farrant Centre. One of the Trusts equality objectives is as per the current board KPI for making the Trust a great place to workforce for everyone – to increase the % of BAME staff in band 7 and above roles.

5-11 Scheduled to be presented to the 23 July Finance Committee
5-12 Scheduled to be discussed at July Patient Experience Committee
5-19 Closed – 20/5/19 draft notes shared with the Board via email.

Did Not Attend (DNA) snapshot Review
In response to action 5-9 raised at the May Trust Board DH provided a summary of DNA performance for relevant services for the month of April 2019.

The Board discussed the key points to noting that of the 29,796 Out Patient appointments offered in April of this year, 2183 patients Did Not Attend. This represents an overall 7.33% DNA rate. Although the departmental OPD DNA rate varied between 0% and 33.3%, both of these extremes reflect specialities with extremely low numbers of booked appointments.

DNA rates for elective procedures stood at 1.7% for the month. The Board considered whether the elective procedures issue had an impact on wasted theatre time and it was confirmed that it did for various reasons but not least because the Trust could not overbook a theatre list. The Board asked for a comparison with other Trusts or if possible a comparison against a national benchmark. DH agreed to circulate benchmarking data prior to the next Board.

ACTION: DH to circulate benchmarking data for DNA rates prior to the July Board.

6-7 Chief Executives Report
LA Presented the Chief Executive’s report, updating the Board on internal, regional and national events and matters regarding regulation and regulators.
The Board noted the two day unannounced CQC inspection on the 13th and 14th May, inspectors visited a number of areas and all reported that the inspection team were very respectful and positive and the inspectors said the same of the staff. Initial feedback has been positive and indicates a minimal number of issues which need discussion. The Trust has an opportunity to discuss these areas with the lead inspector prior to the publication of the report. Any areas of concern highlighted by the CQC team have already been rectified by the Trust. The Board noted that the Trust has also undergone its ‘Use of Resources’ inspection and that NHSI would also be involved in the Well Led inspection. LA informed that Board that the Trust has received an initial feedback letter and that she had responded to this and that this would be shared with the Board. The final CQC Report is anticipated in September.

**ACTION:** LA to share initial CQC feedback letter and the Trust’s response with the Board.

There have been multiple events in May which have helped to celebrate DGT staff and their hard work. The Celebrating Success Event was well attended and similar quarterly events are being planned for the future. International Nurses Day was celebrated over a week and National Operating Department Assistant Day was also celebrated. It is important the Trust recognises the contribution that all the staff makes and tries to mark such occasions.

LA also informed the Board that the CEO spring forums had commenced and had been well attended, ways to engage with staff groups had been discussed and feedback would be considered to ensure effective engagement of staff is implemented.

Finally LA conveyed her thanks to Sue Braysher, Director of System Transformation who moved to the CCG full time at the end of May, for her contribution to the Trust during her 18 months in post.

### 6-8 Women Children and Planned Care Patient Story

The Board welcomed two patients to the Board, accompanied by Bukky Olutade, Senior Sister QMH and Siva Kabilan, General Manager QMH. The two patients presented their very positive experiences as patients at Queen Marys Hospital, one from a gynaecology perspective and one from an orthopaedic perspective.

The only issue that was highlighted was to do with patients being accompanied before a procedure. The female patient informed the Board that when being admitted to the Board her husband was not permitted to stay with her. The patient was not unhappy about this but she was anxious about the surgery and had not been informed prior to arrival that this would be the case and therefore her anxiety levels had been heightened.

The Director of Nursing undertook to rectify this issue of not being informed prior to arrival that partners would not be able to stay. She was able to explain to the Board the rationale for why partners could not stay and acknowledged that accommodation allowing privacy and dignity was the issue and therefore partners were not permitted.

**ACTION:** Director of Nursing to review the information given to patients before arrival at QMH regarding partners waiting with patients prior to surgery.

PC thanked the two patients for sharing their experiences with the Board and he was pleased that it had been so positive and that they were recovering well from their respective surgeries.
6-9 **Quality Account**
SC presented the Quality Account, which reports on the quality of Trust services and is published annually. The document was shared with the Board following presentation to board Sub-Committees and inclusion of their comments and reflections. It was noted that this was not the final version.

The Quality Account is externally audited and the auditor’s report included in the report before publication, as are comments from the three stakeholders invited to review the document, these are the local Clinical Commissioning Group, Healthwatch and the Kent Health Overview and Scrutiny Committee.

SC highlighted the priorities from last year noting those that had been completely met and those that had been partially met. The Board discussed some of the issues and agreed the document, noting that there were still elements that were yet to be included. The Board agreed delegated authority for the Chair and Chief Executive to sign off the Quality Account on 25 June 2019.

**DECISION: Delegated authority given for the Chair and Chief Executive to sign of the final version of the Quality Account on 25 June 2019.**

The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS website by 30 June each year. The requirement is set out in the Health Act 2009.

The Board wishes to convey its thanks to Sue Craven, Assistant Director of Governance for her hard work in producing the report.

6-10 **Mortality Report**
The Trust is reporting a stable HSMR and acceptable SHMI. SF presented a report which contained details of the mortality review process at DGT for the last quarter. The document provides the mortality findings presented to monthly meetings of the Quality and Safety Committee and Patient Safety Committee and ensures that the Trust Board has oversight and understanding of the process and outcomes in addition to oversight of learning from deaths: Implications of palliative care coding and the processes in place. The Board discussed the coding and why the two figures were different. PC was able to confirm that this issue had been discussed in depth at Quality and Safety Committee and that the Committee were assured by the care given was appropriate.

The content of the paper was noted and accepted as presented.

6-11 **Board GIRFT Report**
The GIRFT programme began in 2015 as a clinically driven pilot looking at variation in outcomes and practice of orthopaedic surgery, linked to a review of benchmarking data drawn from Hospital Episode Statistics, the National Joint Registry and NHS Litigation Authority. The Board noted that there were now 40 GIRFT programmes, 9 of which the Trust was engaged with.

The Board discussed the principles of GIRFT and noted that best practice was as of today and did not take into account research. The Board were made aware of the current positioning of the Trust in these programmes and SF explained the process of assessment and re-assessment and how this fitted into the Trust’s assurance processes and how this would assist in the effective use of resources and quality of patient care and that the programme was clinically led.
ACTION: SF to add the frequency of reporting into the GIRFT flowchart.

The Board robustly discussed the proposal and concluded that it was in line with Board objectives regarding quality and formed part of the framework for quality improvement in the organisation. The Board asked for a clinical outcomes report to go to Quality and Safety Committee initially and then to the Board which gave assurance through the various routes that the Trust was doing the best for patients. Additionally it was agreed that GIRFT should be included in the Quality Account going forward.

SF concluded that the nine programmes had all shown that they were value for money and that there were no clinical concerns, which was very positive.

DECISION: Approval of the proposed governance framework for service GIRFT programmes was provided.

6-12 Board Members Quality Assurance Feedback
GJ reported that she had visited Cherry Ward during the previous month and had spoken to staff that had been very positive about the unannounced CQC visit. The staff were also positive about participation in the Nightingale project and although the staff were unsure of the benefits as yet they were keen to try. GJ has also spoken to a patient who had suffered developed an infection whilst on the ward but had been rapidly treated and was doing well. He was very happy about his treatment but was not so happy about the hospital food. The issue of Band 7 development had also been raised with her the Execs were able to cite the development that had been put in place but also agreed that more specific development may be required to help with the retention of staff at that level.

GJ also visited another of her link area, Outpatient Physio, and had been made very welcome. She was made aware of the team’s anxiety over potential staffing changes and changes of provider to some services.

GJ has also visited OPD Cardiology at QMS and that too had been a positive experience. She had spoken to the lead consult for Cardiology and was able to report that the team had managed to appoint permanently to the vacant consult post following the recent sad event. She spoke to one of the cardiac physiologists who was taking positive steps to encourage school age children to think about her job and show them how interesting it was.

Following a family member attending DVH, DW asked about Emergency Department (ED) waiting times and about how streaming initiatives were working. DH and SF explained the process and how patients were escalated and overseen by the various specialties within the Trust. The Board were keen to know what improvements had been made in ED and asked for the improvement plan to come to the next Board.

ACTION: Emergency Department action plan to the July Board.

PC had attended the Celebration Event during May which had been well attended and staff were enthusiastic about being part of it.

6-13 Integrated Performance Report – Month 1 2019/20
LO introduced the new style performance report and explained to the Board how the report worked in terms of timings of indicators and what data underpinned the figures and indicators shown. The data shown was for Month 1 but that it was a 12 month
rolling data set. The Board were informed that all the indicators that were showing red had an action plan to bring the performance back on track. The Board also noted that the quality scorecard was still in development but would be available for the July Board.

The Month 1 report was updated by SC, DH and LL who highlighted the key performance metrics and changes.

SC reported an SI in month which had been closed and informed that Board that the matter would be discussed at the next Quality and Safety Committee. She drew the Board’s attention to fall and pressure ulcers and confirmed that the areas that were showing as grey in the report would be reported to the Board on a monthly basis.

DH was pleased to report ‘green’ figures for 4 of the 6 operational KPIs. The Board were also made aware of the continued high attendances to the Emergency Department, which were averaging 330. There was a rapid improvement plan in place and the streaming standard operating procedure which had recently been put in place appeared to be working well. The Board enquired what the position looked like for May but as the figures were not validated at this point he was unable to confirm if the position had improved.

LL was able to report a slight improvement in figures for both appraisals and the Trust’s vacancy rate. She updated the Board on areas of note. She was pleased the Trust were able to work with Fawkham Manor to offer positions within the organisation to suitable staff that were affected by its closure. The Board considered the other issues that were associated with Fawkham Manor’s closure and LO was clear that these had already been considered and the Trust was very conscious of not taking on more work that it had the capacity to cope with.

6-14 Finance Report – Month 1 2019/20
LM Presented an update of the M1 position noting key points: The Trust is on plan, with a £1.4m deficit but overall pay costs were underspent in month. The agency spend was down on the previous month but LM was cautious about any predictions until she had been able to look at Month 2. Carnall Farrar have been appointed to support to the delivery of the QIPP plan to ensure delivery of the £10.9m target for 2019/20.

LM apologies that she was not able to report the income for the Trust as there had been an issue extracting the data from the national system. However, she was able to report that the run rate was in a healthy position.

LM outlined the timeline for the Trust’s withdrawal from Elm Court and updated the Board on the capacity issues that had been discussed with the CCG. She confirmed that capacity was a risk that appeared on the risk register.

6-15 Seven Day Service
SF presented a report which contained detail of the Trust performance against the criteria for seven day services. SF explained the reasoning behind the differences in the once daily and twice daily scores which were essentially attributed to HDU ITU. He advised the Board that the introduction of e-noting will assist.

6-16 CRR and BAF Report
The Board were provided a summary of current risks on the Corporate Risk Register (CRR). These risks were presented to both the Quality and Safety Committee and
the Audit Committee in May and were discussed in depth at the May Trust Risk Management meeting.

Additionally Board Assurance Framework (BAF) was the subject of a Board development session in April, since then work has been undertaken to refresh the BAF in line with the 2019/10 annual plan objectives.

The recommended changes were provided and the matter robustly discussed by the board, who concluded it was appropriate to accept the recommended changes to BAF Risks 2040, 2042, 2129, 2210, 2043, 2010, 2024, 2030, 2033, 2110, 2038, 2045, 2012.

Approval: The changes to the refreshed Board Assurance Framework risks were approved by the Board.

6-17 THC Compliance Statement
The THC Compliance Statement is a live document that is issued to Partnership Health and Safety and Partnership Group meetings for discussion and monitoring. Following presentation to the Partnership Board 20 May 2019 the 2018/19 Compliance Statement is presented to the Trust Board for assurance. The Board accepted that the document was issues at a point in time and although there appeared to be a number of sections that were noted as ‘amber’, no areas were showing as ‘red’. LG asked that the firm brought in to support the Estates team could give an update to the Board of their findings at the next meeting.

Action: P2G to give an update to the Board on their findings.

6-18 Terms of Reference
Following the request of the Trust Board at its March meeting the Terms of Reference for all established Trust Board Sub-Committees have been reviewed and a revised template developed. All Trust Board Sub-Committee Terms of Reference have now been assimilated on to a new format, this format allows for standardisation of presentation and ensures that relevant detail is contained and presented uniformly. There have been no material changes to the text or content of those Terms of Reference previously agreed by the respective Sub-Committees and subsequently ratified by the Trust Board.

The Terms of Reference for the Workforce Committee were submitted separately following review and amendment by the 16 April Workforce Committee as they require formal ratification of the changes.

The Board asked for the italics to be changed and for the wording regarding deputy chairs be the same as for the Finance Committee.

Approval: The Trust Board approved the Terms of reference as presented in the standardised format with the change to the wording regarding deputy chairs where appropriate.

6-19 Workforce Committee
The revised Terms of Reference were presented to the 16 April workforce committee following the inclusion of comments and requests noted at the February Meeting. Following their presentation committee members were satisfied with the content of the Terms of Reference and pending a minor typographical issue they were approved and recommended to the Trust board for final ratification. The Board requested that the revision history be restored to the document.
Action: The revision history to be restored to the Workforce Committee Terms of Reference.

Approval: The Workforce Committee Terms of Reference were formally ratified by the Board.

6-20 Quality and Safety Committee
The Quality and Safety Committee minutes of the meeting held on 18 April 2019, were received by the Board.

The summary of the Quality and Safety Committee meeting held on 16 May 2019 was received by the Board.

6-21 Finance Committee
The Part 1 Finance Committee minutes of the meeting held on 23 April 2019 were received by the Board.

A summary of the Part 1 Finance Committee meeting held on 28 May 2019 was given by DW. This included the extension to the current car parking contract, a discussion regarding space and cost at QMH and the shared procurement service.

6-22 Audit Committee
The Audit Committee minutes of the 15 March 2019 were received by the Board.

A summary of the meeting held 24 May was given by KT.

The Board received the Audit Committee Effectiveness Report and Annual Report for assurance and ratification following presentation to the 24 May Audit Committee. The Board considered the issue of partially completed spells of accruals and LM confirmed that sample testing was taking place and the belief was that this was a one off error. DW thought that this was likely to be a result of updating PAS retrospectively and LM agreed to take a report to both the Finance Committee and the Audit Committee to update the position.

Action: LM to take an update paper to both the Finance Committee and the Audit Committee on partially completed spells of accruals.

6-23 Stakeholder Council
The Stakeholder Council Minutes of the 6 February 2019 were received by the Board.

A summary report from the 8 May meeting was provided by PC, noting that the meeting agenda included notification of Trust Board changes, a comprehensive Trust position update, updates on A&E changes and improvements and the development of the DGT Patient Engagement strategy.

6-24 Remuneration Committee
KT provided a summary of the Remuneration Committee meeting held 2 May 2019 noting the agreement of the salary ranges for the two new executive directors and the starting salary for the newly appointed Director of Human Resources. The Committee also reviewed the salaries of the remaining director roles within the executive team.

6-25 Changes to the Corporate Governance Framework
The Board were advised of the necessary changes that had been made to the corporate governance framework.

In December 2018 the Corporate Governance Framework was reviewed and a number of amendments were made. Since then the Executive structure has been reviewed and it was therefore necessary to update the Corporate Governance Framework to reflect the changes.

The Trust no longer has a Director of System Transformation and therefore reference to this post needs to be removed. Additionally the Trust is in the process of advertising two new executive roles and it is anticipated that the CGF will require further updating in due course, however until these posts are filled it is proposed that changes are made on an 'as and when required' basis.

The Board were notified of changes to voting rights. Previously on a temporary basis voting rights were conferred upon the Director of Operations. Due to reasons of ill health the role is being fulfilled by the Deputy Director of Operations in an acting director capacity. Additionally one of the Trust’s Non-Executive Directors is currently unwell and unlikely to be available for an extended period, it was proposed that voting rights are not granted to the Acting Director of Operations and that voting rights for the two individuals who are off sick are held in abeyance thereby keeping the Board in balance regarding voting.

Decision: The Board agreed that the proposed approach to voting right was consistent and appropriate. Acting Director of Operations will not be conferred voting rights.

6-26 Use of the Common Seal
Since December 2018, the Trust’s Common Seal has been used 3 times in accordance with the Trust’s Standing Orders. The Board were asked to note the included detail.

No further questions were asked and the paper was accepted as presented.

6-27 Any Other Business
SC tabled one item of additional Business.

Safeguarding Declaration
The Board is required to publish an annual statement that documents it has received sufficient assurance with regards to effective safeguarding arrangements, systems and processes.

The Board must be assured in line with statutory requirements and Care Quality Commission (CQC) recommendations, to safeguard children, young people and adults accessing our services. The Statement confirms this assurance and the Board were asked to approve the publication of the statement on the Trust Website.

Decision: The Safeguarding declaration was approved for publication.

Action: Declaration to be published on the Trust Website.

6-28 Questions from Members of the Public
There were no items to cover under this agenda item.

6-29 Exclusion of the Public and Press
The notice of motion on the agenda was taken as read and the Board adopted it as its resolution, that members of the public and the press be excluded from the remainder of the meeting by reason of the confidential nature of the business to be transacted.
## TRUST BOARD – JULY 2019

LOG OF OUTSTANDING ACTIONS FROM THIS MEETING AND PREVIOUS MINUTES

### Actions ‘open’

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<th>Ref.</th>
<th>Action</th>
<th>Person responsible</th>
<th>Deadline</th>
<th>Progress</th>
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<tr>
<td>5-11</td>
<td>Proposal for extended/enhanced use of the QMH site by the Executive Leadership Team to be taken to Finance Committee in July 2019.</td>
<td>Director of Strategy and Planning</td>
<td>September 2019</td>
<td>This item is deferred from July to September and the responsible person moved to Director of Improvement.</td>
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<td>5-12</td>
<td>SC to ask the Patient Experience Committee for their suggestions regarding KPIs that patients and the general public would be interested in.</td>
<td>Director of Nursing and Quality</td>
<td>July 2019</td>
<td>Not yet due.</td>
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<td>6-6</td>
<td>DH to circulate benchmarking data for DNA rates prior to the July Board.</td>
<td>Acting Director of Operations</td>
<td>July 2019</td>
<td>Shared via email 26/06/19.</td>
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<td>6-7</td>
<td>LA to share initial CQC feedback letter and the Trust’s response with the Board.</td>
<td>Chief Executive</td>
<td>June 2019</td>
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<tr>
<td>6-8</td>
<td>Director of Nursing to review the information given to patients before arrival at QMH regarding partners waiting with patients prior to surgery.</td>
<td>Director of Nursing and Quality</td>
<td>July 2019</td>
<td></td>
</tr>
<tr>
<td>6-17</td>
<td>P2G to give an update to the Board on their findings</td>
<td>Director of Finance</td>
<td>July 2019</td>
<td></td>
</tr>
<tr>
<td>6-19</td>
<td>The revision history to be restored to the Workforce Committee Terms of Reference.</td>
<td>Trust Secretary</td>
<td>July 2019</td>
<td></td>
</tr>
<tr>
<td>6-22</td>
<td>LM to take an update paper to both Finance Committee and Audit Committee on partially completed spells of accruals.</td>
<td>Director of Finance</td>
<td>July 2019</td>
<td>Agenda items for both Finance Committee and Audit Committee</td>
</tr>
<tr>
<td>6-27</td>
<td>Safeguarding declaration to be published on the Trust website</td>
<td>Trust Secretary</td>
<td>June 2019</td>
<td>Completed 25/06/19</td>
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## TRUST BOARD – JULY 2019

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Chief Executive Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>To update the Trust Board on developments nationally and within DGT</td>
</tr>
</tbody>
</table>
| Key points for the Trust Board: | This report covers  
- internal Trust events and updates  
- matters regarding regulation and our regulators  
- national and regional updates |
| Consideration of public and patient involvement and communication: | Publish |
| Recommendations:  | For noting and discussion |

### Links to Board priorities, Board Assurance Framework, Trust Risk Register

<table>
<thead>
<tr>
<th>Organisational Priorities</th>
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</table>
| Maintain and improve the quality of services delivered by DGT  
| Make DGT a great place to work for everyone  
| Implement and embed the clinical and organisational strategy  
| Deliver the 2019/20 financial plan  
| Deliver all NHS constitutional and contractual standards |
| CQC Reference |  
| Safe  
| Effective  
| Caring  
| Responsive  
| Well-led |
| Board Assurance Framework/ Trust Risk Register |  
| BAF 2110 - Failure to establish and maintain effective relationships with key stakeholders at national, regional and local levels and thereby constraining the achievement of the Trust's strategic aims.  
| BAF 2037 - The Trust may not deliver excellent services currently and in the future as it does not have the right staff in the right place and at the right time.  
| BAF 2044 - Failure to achieve the Trust's Improvement Programme would impact on patient experience, increase expenditure, reduce income, increase financial deficit and impact on longer term transformational delivery |

### Committee/ Meetings at which this paper has been discussed/ approved

<table>
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### TRUST UPDATE

#### 1.1 CQC Visit
The Trust was very pleased to host the final part of our CQC assessment, a two day 'Well Led' assessment. The Trust welcomed 9 CQC inspectors, who were joined by 2 NHSI inspectors to carry out 23 interviews with the Executive Team, Non-Executive Directors and other key members of the Trust Leadership team. In addition to the ‘Well Led’ team, two other inspectors spent a full day in ED walking through processes and pathways, talking to managers, staff and patients and observing the service.

Overall the CQC assessment has been a positive experience with staff and CQC assessors alike commenting on the levels of mutual respect and transparency. I would like to extend my thanks to the whole Trust for their input during the inspection and their clear engagement in our journey to ‘outstanding’, there is still work to be done but I am confident we can achieve it.

Finally following this visit the CQC have notified the Trust that the CQC internal ratings panel will meet on 15 July, with a draft report expected 22 July. There is then a two week window for the Trust to review factual accuracy and the final report will be published by the end August.

#### 1.2 Leadership changes
The Trust has appointed a new Chief Operating Officer (COO), Julie Frake-Harris and a Director of Improvement, Bas Sadiq. These are not newly funded director roles but replace directors on the Board. Both Julie and Bas have varied experience across the NHS. Julie has most recently been COO in a Mental Health Trust and Bas has been an Operational Director in an Acute Trust and a Community Trust. Bas will take up post from the 1st July and Julie will take up post in October. As an interim solution Gavin Macdonald, an experienced COO is joining us for the next few months. I would like to take this opportunity to thank Leslieann Osborn, Director of Strategy and Planning who has acted up on the Board for 18 months. Leslieann will remain part of the Executive Leadership Team but Bas Sadiq will now represent strategy, planning, IT and estates on the Board. From the 1st July 2019, the performance team will come under the management of the COO.

I would also like to thank Dave Horne, who has acted up into the Director of Operations role for the last three months, for all his fantastic work. Dave will return to his deputy role and also take up the interim Divisional Director of Operations role for Medicine, Cancer and Emergency Care. This will support the clinical group to really get on top of the length of stay and Emergency Department issues.

I would also like to take this opportunity to thank Tina Bailey who has been the interim Associate Director Operations for medicine, cancer and ED. Tina will be moving over to become the Head of the North Kent Pathology Service.

#### 1.3 An Apple a day
I am pleased to announce that every Monday there will be a Fruit and Veg stall named ‘Five-a-Day’ located just outside the hospital's main entrance. This is a great opportunity for staff, patients and visitors to purchase fresh, local produce, fruit and vegetables on their way to/from the hospital and providing healthy snack alternatives.
### 1.4 Celebrations

It has been a busy month with lots to celebrate. The Occupational Therapy Department have submitted a nomination for the 2019 CAHPO Awards. The Chief Allied Health Professions Officer (CAHPO) Awards celebrate the contribution AHP’s make in supporting improvements in health, care and wellbeing and the impacts described by AHP’s in action. The Occupational Therapy’s project ‘to improve patient experience and outcome, inpatient flow and reduction in level of carer need on discharge from the acute hospital setting’ will be reviewed in the next few weeks! – Good Luck to the Team and Well Done

30 Ride4Life cyclists set off from Darent Valley Hospital for Amsterdam. 330 miles, across 4 countries in just 4 days! They were all raising money for 2 projects at the hospital; a 3D imagining tool to detect breast cancer, and the expansion of our SCBU. Despite bad weather and an extraordinary amount of punctures they all made it in one piece (minus one bike) and have reached their target raising over £50k.

The Research and Clinical Audit & Improvement Competition took place in the Lecture Hall in the Philip Farrant Centre and was attended by over 150 staff including nurses and pharmacists, junior doctors and consultants, and some of our CQC inspectors. The competition showcases the work that often goes unseen in the Trust but which can have a huge impact on the care we provide to our patients, from new treatments to improving standards of care.

Slightly new for this year was the addition of a poster presentation competition, with 16 entries being judged in groups of 4 by judging teams consisting of a clinician and nurse/AHP. The judges found it difficult to pick a winner in 2 of the groups resulting in 5 winners and one entry being ‘highly commended’ by judges.

Following the oral presentation of 3 research and 4 clinical audit & improvement projects, the judges again had a tough time picking the winners. All finalists received a certificate with vouchers also being awarded to the first and second place entries. The winning Research entry was Dr Anna Schumann with ‘Bedside Communication with Non-sedated Patients on Intensive Care Ward Rounds’. The winning Clinical Audit & Improvement entry was presented by Dr Colin Weekes for the project ‘Improvement in Mortality for Hip Fractures admitted to Darent Valley Hospital.’

Congratulations to everyone in the Trust who has achieved an award or been recognised by a colleague or patient, there are too many of you to mention, you are all what makes this organisation a great place to be.

### 1.5 What an Honour

Congratulations are extended to Shibu Chacko, Specialist Nurse Organ Donation who has been awarded an MBE in the Queen’s Birthday Honours as recognition for his work in Organ Donation especially within minority communities. Shibu started his role 5 years ago and was faced with the reality of a high number of organ donation declines from minority communities. He identified that there was a poor understanding of the importance of donation, plus a lack of information about how the donation is facilitated, peoples fear of mutilation, along with cultural and religious reasons. Shibu then experienced several declines from his own South Asian community, so he...
decided to do something to address this issue by spreading the message of how important organ donation is. He used presentations, teachings, leaflets and social media to encourage people to sign up to become donors and had discussions among community members. His initial responses was disappointing so he persevered and became an active educator and campaigner using leaflets in regional languages and spent lots of time clarifying people’s concerns. Once his campaigns gained acceptance within the community, he formed a voluntary group and over the last 5 years has achieved over 3000 new registrations to the NHS Organ Donation register.

Congratulations to Dianne Garland, a midwife who works on our Staff Bank who has received a prestigious RCM Fellowship. This is an honour given to just a handful of midwives each year. The Fellowship recognises Dianne’s contributions in many areas. It particularly focuses on her pioneering work in research, clinical practice and education around water birth.

<table>
<thead>
<tr>
<th>1.6</th>
<th><strong>Cancer Waits – Simply the 7th Best</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dartford and Gravesham NHS Trust has been placed 7th best in the country for cancer wait times, this is an achievement to be proud of and congratulations to our cancer staff who work hard to achieve this.</td>
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</tbody>
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<table>
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<tr>
<th>1.7</th>
<th><strong>Emergency Surgical Clinic Launch</strong></th>
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<tr>
<td></td>
<td>The Emergency Surgical Clinic was launched on Tuesday 24th June 2019 and it is based in the Outpatient’s Department. This service will provide rapid assessment and treatment for patients requiring acute hospital care, but for whom an overnight stay is not clinically necessary; and centralised comprehensive specialist assessment for surgical patients with complex needs who are identified as meeting the pathway requirements. Patients will be streamed directly to this clinic from the Emergency Department (ED) and General Practitioners (GPs) via the Surgical Nurse Practitioner and will be reviewed by a dedicated Surgical Registrar. This will divert surgical patients away from the current service provided in the Ambulatory Emergency Care Unit and ED to improve capacity and flow.</td>
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</tbody>
</table>
1.8 Ward Accreditation
The ward accreditation scheme is now being rolled out across the Trust as part of the Nightingale project to improve patient safety and standardise practice. The accreditation visit involves a team looking at the ward area and answering 152 questions to gain an in-depth view of the quality and care delivered on the ward. Wards will be re-audited on a quarterly basis with the aim of wards reaching the exemplar status of platinum through team working and focus on the areas for improvement. Rowan is the latest ward to progress through the ward accreditation scheme and is first in the Trust to be awarded Silver in the programme, closely followed by Spruce Ward.

1.9 Exercise Barrel
This week, Exercise Barrel took place at DVH. It was a Chemical, Biological, Radiological and Nuclear (CBRN) exercise facilitated by EPRR Students. Our thanks to Kent Fire and the DIM Officer for their support.

2.1 NHS National Chief Operating Officer announced
NHS England and NHS Improvement have their national chief operating officer, effectively the deputy chief executive of the NHS. Amanda Pritchard, currently Guy’s and St Thomas’ Foundation Trust chief executive, will take up the role. The seven new regional directors of NHSE are expected to report to this new role. The moves take place as NHSE seek to form joint leadership. She will take up the post on 31 July and will oversee “NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS long-term plan”, according to NHSE and I. We have all worked closely with Amanda through our healthcare Alliance and we wish her every success in this very challenging role.

2.2 Clinical Director for Violence Reduction in London
The NHS has also appointed its first clinical director for violence reduction to help prevent stabbings and other violent crime.
Martin Griffiths, a lead surgeon at Barts Health NHS Trust in London, has spent the past decade visiting schools to lecture on the dangers of carrying weapons as well as saving lives on the operating table. His appointment is as Clinical Director for Violence Reduction in London.


### REGIONAL AND NATIONAL HEADLINES AND REPORTS

#### 3.1 NHS Interim People Plan

NHS Improvement has published its interim NHS people plan which sets the national strategic framework for the workforce over the next five years.

The plan was ordered as part of the NHS Long Term Plan and drawn up under NHSI Chair Dido Harding, and Senior Responsible Officer Julian Hartley, CEO of Leeds Teaching Hospital NHS Trust. A national steering group was engaged extensively with stakeholders, including NHS Providers, to ensure a wide range of views fed into the document.

The on the day briefing provides full analysis of the interim people plan. Stating that in development of the plan NHSI has discussed key initiatives including consultations on a “new offer” to NHS staff; a pension’s policy proposal; and a new “leadership compact”. It also proposes measures to significantly grow the nursing workforce; review HR/OD best practice in NHS trusts; and devolve workforce planning to regions, systems and local NHS organisations.

Andrew Foster, chief executive of Wrightington, Wigan and Leigh Foundation Trust, who contributed to the work on making the NHS the best place to work, said: “Delivering great patient care depends on highly motivated staff who feel able to deliver the high quality care their patients expect. This plan rightly highlights the need for trusts to do more to keep and nurture their staff. Making the NHS a great place to work is key to that.”

https://nhsproviders.cmail19.com/t/t-l-bbpll-crkjhjik-k/

#### 3.2 Designing Integrated care systems (ICS) in England

During June NHS Providers published a newsletter which provided a description of the possible functions of partnerships at different levels of population within an ICS and emerging regional and national arrangements to support and oversee systems. It also included a new maturity matrix intended to help system leaders to assess their own progress and a chart of the proposed freedoms and flexibilities that NHS England/Improvement plan to award to mature systems.


### DGT STAFF CHANGES

#### 4.1

I would like to welcome the 36 people who joined the Trust in May. This number included 4 Clerical staff, 1 Consultant, 1 Doctor, 7 Nurses, 9 Healthcare Assistants and support workers, 4 Healthcare Science Practitioner and assistants, 1 Trainee Scientist, 1 Midwife, 1 Occupational Therapist, 1 Pharmacist, 1 Pharmacy Storeman, 2 Clinical Coding Analysts and 3 Managers.

#### 4.2

On behalf of the Board, I would like to thank and wish farewell to the 41 staff that left us in May for their loyalty, contribution and commitment to the work of our Trust. We wish them every success in the future. In particular I would like the Board to note the following retirements and the long service that these individuals have given to the Trust:
- Michelle Purver – 15 years 9 months (Flexi Retirement)
- Veronica Mohideen – 6 years 11 months
- Thayanayaki Littlewood – 6 years 8 months
- Melanie Sell – 7 years 8 months

Louise Ashley  
Chief Executive  
30 June 2019
## Nursing Establishment Review – Inpatient Wards

### Subject:
Nursing Establishment Review – Inpatient Wards

### Author:
Deputy Director of Nursing and Quality

### Presented by:
Director of Nursing and Quality

### Purpose of paper:
For information and Assurance

### Key points for the Trust Board:
A Safer staffing review is undertaken in line with the NICE endorsed Shelford Safer Nursing Care Tool Guidance on a six monthly basis.

The previous review was conducted in September 2018 and some wards received amendments/uplifts to their establishment in line with the findings of the previous review.

This review has been presented to both the Quality and Safety Committee and Workforce Committee in June for discussion and it provides assurance as to which wards currently have sufficient budgeted establishment to meet the safety and quality of care needs for their relevant patient cohort as well as some areas that require a review of key metrics in the next six months.

### Consideration of public and patient involvement and communication:
Not for Publication

### Recommendations:
For information, discussion, assurance, decision

### Links to Board priorities, Board Assurance Framework, Trust Risk Register

#### Organisational Priorities
- Maintain and improve the quality of services delivered by DGT
- Make DGT a great place to work for everyone
- Implement and embed the clinical and organisational strategy
- Deliver the 2019/20 financial plan
- Deliver all NHS constitutional and contractual standards

#### CQC Reference
- Safe
- Effective
- Caring
- Responsive
- Well-led

#### Board Assurance Framework/ Trust Risk Register
All Quality BAF Risks

### Committee/ Meetings at which this paper has been discussed/ approved

<table>
<thead>
<tr>
<th>Committee/ Meetings</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Safety Committee</td>
<td>20.06.19</td>
</tr>
<tr>
<td>Workforce Committee</td>
<td>18.06.19</td>
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</tbody>
</table>
SUMMARY OF REPORT

The purpose of this report is to inform the board of the outcomes of the February 2019 assessment of staffing levels using the Safer Nursing Care Tool\(^1\) (SNCT), and other methodologies (Hurst 2003)\(^2\) to triangulate the results and give an indication of the Trust’s position in relation to the guidance published by the Royal College of Nursing\(^3\) (RCN 2010). The RCN suggests that to determine appropriate levels of staffing, best practice is to triangulate the results of different methodologies and to evaluate these regularly against patient outcome data.

The models currently used within the Trust are SNCT, Professional Judgement and care hours per patient day (CHPPD) for general inpatient wards. For Critical Care there is nationally recommended guidance on staffing levels which are incorporated into the Critical Care Standards.

The patient outcomes measured in the SNCT are infection rates, medication errors, falls, pressure sores, and complaints, collectively known as Nurse Sensitive Indicators (NSIs).

Following the publication of the National Quality Board\(^4\) report on nursing and midwifery staffing in 2013, Trusts are now mandated to report on staffing capacity and capability every six months at their public Board meetings. This report is expected to:

- Draw on expert professional opinion and insight into local clinical need and context
- Make recommendations to the Board which are considered and discussed
- Be presented to and discussed at the public Board meeting
- Prompt agreement of actions which are recorded and followed up on
- Be posted on the Trust’s public website along with all the other public Board papers

ACTION REQUIRED

The Board is asked to:

Note the work undertaken in relation to assurance of safe staffing across the wards as identified in the review.

Significant progress continues to be made to ensure that data gathered to measure the Safer Nursing Care of patients within DGT are accurate, reliable, valid and timely. The committee/board is therefore asked to support the recommendations made within review.

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\(^1\) Shelford Group (2013). Safer Nursing Care Tool. Implementation Resource Guide
\(^3\) RCN (2010) Guidance on safe nurse staffing levels in the UK. London. Royal College of Nursing
\(^4\) National Quality Board. (2013) How to ensure the right people, with the right skills, are in the right place at the right time, A guide to Nursing and Midwifery and care staffing Capacity and Capability. NHS England.
HOW TO ENSURE THE RIGHT PEOPLE, WITH THE RIGHT SKILLS, ARE IN THE RIGHT PLACE AT THE RIGHT TIME

The National Quality Board document entitled “How to ensure the right people, with the right skills, are in the right place at the right time; a guide to nursing, midwifery and care staffing capacity and capability” sets out ten expectations for NHS providers and commissioners in relation to nursing and midwifery staffing.

The guide states that Boards should ensure that there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

The guide also states that Boards should be actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made.

The Care Quality Commission (CQC) are using this guide in its new approach to monitoring, inspecting and rating providers. The expectations set out in the guide will be used to inform their judgements and ratings for providers.

Following the publication of the National Quality Board guidance and Hard Truths: The Journey to Putting Patients First (2014)\(^5\), Jane Cummings, Chief Nursing Officer England, NHS England and Mike Richards, Chief Inspector of Hospitals, Care Quality Commission wrote to all Trusts and Foundation Trusts to give clear guidance on the delivery of commitments associated with publishing staffing data regarding nursing, midwifery and care staff.

They set out a number of milestones for the first phase, which focused on all inpatient areas; including acute, community, mental health, maternity and learning disability. The commitments were to publish staffing data in the following ways:

- Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. This report will be presented to the Board every six months.
- Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level.
- A Board report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month. This report will be presented to the Board every month.
- The monthly report must also be published on the Trust’s website.

The Trust meets all of these milestones.

NICE GUIDANCE - SAFE STAFFING FOR NURSING IN ADULT INPATIENT WARDS IN ACUTE HOSPITALS

In July 2014 the National Institute for Health and Care Excellence (NICE) published the first of a planned series of guidelines on safe staffing; adult inpatient wards. This guideline recommends a systematic approach at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. This guidance describes the factors that should be taken into consideration when determining ward establishments as well as those that may affect staffing requirements on a day-by-day, shift-by-shift basis. These could be patient, staff or environmental factors which will support the professional judgement method of calculating nurse staffing requirements. A series of outcome measures are identified together with nursing ‘Red Flags’. These ‘Red Flags’ are events which indicate the need to escalate concerns about the staffing level on a ward, for example, a 30 minute delay in administering pain relief.

The guideline identifies organisational and managerial factors that are required to support safe staffing for nursing, and makes recommendations for monitoring and acting if there are not enough nursing staff available to meet the nursing needs of patients on the ward.

NICE endorsed the SNCT as a nurse staffing decision support toolkit to be used alongside its guideline on safe staffing for nursing in acute hospitals in October 2014.

CARE HOURS PER PATIENT DAY (CHPPD)

CHPPD can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by the number of inpatients at 23:59 hours.

CHPPD should not be used in isolation and should be used alongside other data which includes skill mix, nurse to bed ratio, the Safer Nursing Care tool outputs, Royal College recommendations and the nationally accepted professional judgement model. The table above identifies a number of areas which demonstrate below national benchmark for CHPPD and when triangulated with the other metrics correlate with the professional judgement view.

SAFER NURSING CARE TOOL

The SNCT was originally developed in conjunction with the Association of UK University Hospitals (AUKUH) and has subsequently been reviewed and updated in 2015.

The tool comprises 2 parts:

- An Acuity and Dependency Tool which has been developed to help acute NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.
- The tool sets out how to measure the acuity (how ill a patient is) and dependency (how dependent a patient is to have their normal needs met, such as moving, eating and drinking, going to the toilet) of patients in a ward, what rules to follow to ensure that data are captured accurately and how to use this information to calculate the optimal level of

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staff needed in a particular ward using nursing multipliers to ensure the delivery of safe patient care.

DGT currently have processes in place for undertaking bi-annual assessments of the nursing establishments of inpatient care areas across the Trust over a four week period.

The ward manager submits a month of daily assessments of patients’ acuity and dependency using the criteria below. Each level of care has an assigned multiplier which represents the number of nursing staff required to provide care to the patient over a 24 hour period according to their level of acuity or dependency.

Nurses, Midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties; therefore staffing establishments should take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles.

In addition when planning the staffing of wards there is a need for an allowance to be made for periods of leave to ensure that there are sufficient nurses available to provide the planned level of nurse staffing. Sickness and paternity or “other leave” this is shown in the review section by Trust, Site and Directorate.

At DGT the level of cover built into ward establishments is 22% per Whole Time Equivalent (WTE) Staff Member this is in line with the SCNT guidance.

The tables at Appendix 1 show the multipliers used.

The scores for every patient are then added together to calculate the nursing establishment required to provide the required level of care to each patient and collectively, for the inpatient area concerned. Comparisons are drawn between this information and the whole time equivalent establishment (WTE) for each ward which is adjusted to reflect the number of nurses who provide direct care to patients. Housekeepers, ward clerks; support workers to junior doctors are not included in the calculation as they do not provide direct nursing care to patients.

Nurse Sensitive Indicators (NSIs) which have been identified as quality indicators of care with specific sensitivity to nursing intervention. They can be used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. The SNCT demonstrates how NSI outcome data can be used alongside acuity and dependency information to monitor the relationship between ward staffing and nursing outcomes.

It is acknowledged that SNCT data should not be acted upon in isolation and quality aspects of patient care, particularly outcomes must also be taken into account. Nationally this is undertaken by means of Nurse Sensitive Indicators (NSIs). These are infection rates (hospital acquired MRSA infection and colonisations and C.Difficile rates); formal complaints related to nursing care, falls, medication errors and pressure sore rates.

At DGT the collection and reporting of NSIs is undertaken monthly not just during the SNCT data collection months and is reported, discussed and actions agreed at the Clinical Group performance meetings.
Comparison with previous positions over the past six months is illustrated in the tables above. The trend position reflects the acuity and dependency of patients has increased/decreased in number of patients with a higher dependency. Of particular note, there has been a great improvement in the volume of acuity data captured.

The reported increase in Level 2 patients on the QMH site is suggestive of inaccurate scoring as there are no HDU facilities at the QMH site and transfers from QMH to DVH due to patient acuity are rare - action has been taken to address this.

Red Flag Events

NICE Safe Standards for nursing in adult inpatient wards in acute hospitals recommends that the occurrence of any of the following red flag events be monitored over each 24 hour period.

The Trust captures red flag events via the SafeCare module with in the Healthroster system which in turn prompts an automatic immediate escalation requiring a mitigation response i.e. an appropriate response may be to allocate additional nursing staff to the ward.

Details of red flag events can be found at Appendix 3.

3. PROFESSIONAL JUDGEMENT

Allied to the use of the SNCT and other tools used at DGT is the use of Professional Judgement to confirm appropriate nurse staffing levels. The professional judgement model is a bottom up approach used to determine ward staffing requirements and is based on the judgement of experienced nurses to agree the number and band of staff required to provide care on a specific ward.

The standard formula used to calculate the whole time equivalents (WTEs) required to staff the ward is:

No. of nurses x No. of days x shift length + 22% ÷ 37.5 = no. of whole time equivalents

As well as considering the acuity and dependency of the patients normally cared for by the ward speciality, other factors which can affect staffing requirements include:

- The layout and design of the ward, wards with multiple single rooms or bays may require higher staffing capacity and capability
- The number of housekeepers and other support staff available, employing ward clerks and housekeepers on wards can assist nurses, midwives and care staff by undertaking tasks not directly related to patient care
- Patient throughput, with a high throughput ward needing more staff to help maintain patient flow.

4. SKILL MIX

The minimum skill mix recommended by the RCN is a ratio of 65/35 registered nurses/healthcare assistants and the target agreed within DGT is that there should be an average ratio of 60/40 registered nurses/healthcare assistants across all inpatient areas,
(this changes depending on the speciality of the ward - the average skill mix is shown the tables below).

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Ward</th>
<th>Recommended Registered Nurse %</th>
<th>Recommended Unregistered %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Medicine</strong></td>
<td>AMU</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Beech</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Chestnut</td>
<td>60%</td>
<td>40%</td>
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<tr>
<td></td>
<td>Ebony</td>
<td>60%</td>
<td>40%</td>
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<tr>
<td></td>
<td>Laurel</td>
<td>70%</td>
<td>30%</td>
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<td></td>
<td>Linden</td>
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<td>Oak</td>
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<td>Spruce</td>
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<td>40%</td>
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<td>Mulberry</td>
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<td>40%</td>
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<tr>
<td><strong>Surgery</strong></td>
<td>Juniper</td>
<td>65%</td>
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<tr>
<td></td>
<td>Rowan</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Critical Care</strong></td>
<td>Acer</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Urology Nephrology</strong></td>
<td>Redwood</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>Rosewood</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Paediatrics</strong></td>
<td>Willow</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Orthopaedics</strong></td>
<td>Cherry</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Maple</td>
<td>65%</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Additional Duties Feb 19**

In January 2019 a revised Enhanced Observation Policy published with the inclusion of an Enhanced Observation Risk Assessment tool to guide staff.

A table of the additional duties requested by ward for the month of February 2019 can be found at Appendix 4.
REVIEW FINDINGS

Dartford and Gravesham NHS Trust inpatient staffing data is benchmarked against information collected in the same way in similar wards elsewhere in the UK.

Patients are assessed at least twice per day by ward staff who know the patients and are placed into four categories ranging from low- (Lev. 0) to high- (Lev. 3) dependency/acuity.

Occupancy, dependency/acuity and staffing data from DGT adult inpatient wards were entered via the Healthroster SafeCare software. Consequently, patient dependency/acuity levels, funded, actual, temporary (bank & agency) and recommended staffing are compared and benchmarked.

Data By Ward (WTE)

<table>
<thead>
<tr>
<th>Feb-19</th>
<th>Funded Establishment</th>
<th>Skill Mix</th>
<th>Vacancy</th>
<th>Sick Leave</th>
<th>Other Leave</th>
<th>Total Leave</th>
<th>No of Bank/agency</th>
<th>No of Bank HCA's used</th>
<th>Average CHPPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Acute Medical Unit</td>
<td>52.54</td>
<td>55:45:00</td>
<td>7.31</td>
<td>1.16</td>
<td>0.52</td>
<td>7.54</td>
<td>8.18</td>
<td>4.03</td>
<td>6.49</td>
</tr>
<tr>
<td>**Acer</td>
<td>37.22</td>
<td>-</td>
<td>6.3</td>
<td>0.43</td>
<td>0.16</td>
<td>4.67</td>
<td>3.59</td>
<td>2.94</td>
<td>4.67</td>
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<tr>
<td>Beech</td>
<td>34.77</td>
<td>50:50:00</td>
<td>4.34</td>
<td>0.23</td>
<td>0.02</td>
<td>4.34</td>
<td>3.76</td>
<td>6.28</td>
<td>5.72</td>
</tr>
<tr>
<td>Cherry</td>
<td>32.69</td>
<td>49:51:00</td>
<td>0.62</td>
<td>2.36</td>
<td>0.76</td>
<td>7.7</td>
<td>2.33</td>
<td>3.79</td>
<td>5.7</td>
</tr>
<tr>
<td>Chestnut</td>
<td>32.87</td>
<td>58:42:00</td>
<td>-0.09</td>
<td>2.11</td>
<td>1.17</td>
<td>8.1</td>
<td>4.37</td>
<td>3.05</td>
<td>6.18</td>
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<td>43:57:00</td>
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<td>0.25</td>
<td>5.16</td>
<td>6.43</td>
<td>6.06</td>
<td>5.33</td>
</tr>
<tr>
<td>Juniper</td>
<td>36.79</td>
<td>52:48:00</td>
<td>7.31</td>
<td>4.65</td>
<td>0.54</td>
<td>8.95</td>
<td>5.27</td>
<td>5.09</td>
<td>5.43</td>
</tr>
<tr>
<td>Laurel</td>
<td>23.92</td>
<td>73:27:00</td>
<td>2.35</td>
<td>0.86</td>
<td>0.08</td>
<td>3.44</td>
<td>2.55</td>
<td>0.84</td>
<td>9.98</td>
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<tr>
<td>Linden</td>
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<td>0.04</td>
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<td>8.36</td>
<td>8.89</td>
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</tr>
<tr>
<td>Maple</td>
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<td>0.23</td>
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<tr>
<td>Mulberry</td>
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<td>0.66</td>
<td>0.08</td>
<td>2.24</td>
<td>7.9</td>
<td>9.88</td>
<td>7.17</td>
</tr>
<tr>
<td>Oak</td>
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<td>1.94</td>
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<td>8.14</td>
<td>4.91</td>
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<td>6.5</td>
</tr>
<tr>
<td>Palm</td>
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<td>1.4</td>
<td>0.46</td>
<td>8.96</td>
<td>3.67</td>
<td>3.29</td>
<td>6.27</td>
</tr>
<tr>
<td>***QMH</td>
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<td>2.87</td>
<td>0.31</td>
<td>8.33</td>
<td>0.46</td>
<td>0.54</td>
<td>14.25</td>
</tr>
<tr>
<td>Redwood</td>
<td>24.02</td>
<td>58:42:00</td>
<td>0.91</td>
<td>2.18</td>
<td>0.08</td>
<td>6.4</td>
<td>0.69</td>
<td>1.82</td>
<td>6.64</td>
</tr>
<tr>
<td>Rosewood</td>
<td>41.12</td>
<td>51:49:00</td>
<td>5.77</td>
<td>2.3</td>
<td>0</td>
<td>8.92</td>
<td>4.84</td>
<td>3.76</td>
<td>5.94</td>
</tr>
<tr>
<td>Rowan</td>
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<td>2.23</td>
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<td>0.17</td>
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<td>6.92</td>
<td>4.12</td>
<td>6.05</td>
</tr>
<tr>
<td>***Spruce</td>
<td>40.53</td>
<td>52:48:00</td>
<td>7.06</td>
<td>2.85</td>
<td>0.23</td>
<td>10.42</td>
<td>4.52</td>
<td>4.67</td>
<td>6.4</td>
</tr>
<tr>
<td>****Willow</td>
<td>43.86</td>
<td>70:30:00</td>
<td>0.44</td>
<td>2.34</td>
<td>1.09</td>
<td>9.7</td>
<td>3.72</td>
<td>1.1</td>
<td>7.85</td>
</tr>
</tbody>
</table>

* AMU Clinical Judgement applied in relation to high patient throughput deems the establishment appropriate

** Acer & QMH Budget includes admissions & day care staffing (these include day case activity which will not be acuity scored)

***Spruce Budget includes the Thrombolysis nurse, who attends all Stroke calls in ED

**** Willow Budget includes PAU (this includes day case/outpatient activity which will not be acuity scored) - Clinical Judgement applied in relation to high patient throughput deems the establishment appropriate
Summary Highlights:

The funded establishments for the following wards accurately reflects the requirements in line with the methodology used and have been reviewed with the Associate Director of Nursing, DDoN and DoN in order to agree the wards remain appropriately funded:

Acute Medical Unit – budgeted establishment continues to accurately reflect the requirements of the ward in line with review methodology.

Cherry – received amended staffing following previous safe staffing review, funded establishment now accurately reflecting in line with review methodology.

Chestnut – budgeted establishment continues to accurately reflect the requirements of the ward in line with review methodology (acute cardiac/ITU step down ward). However, it should be noted that there is currently no funded establishment for the emergency cardiac nurse responder who is required to attend cardiac arrest calls at the DVH site. This role is allocated from within the Chestnut ward budget and as such currently presents a cost pressure.

Ebony – budgeted establishment continues to accurately reflect the requirements of the ward in line with review methodology.

Juniper – received amended staffing following previous safe staffing review, funded establishment now accurately reflecting the requirements of the ward in line with review methodology.

Laurel – budgeted establishment continues to be considered appropriate and accurately reflecting the requirements of the ward in line with review methodology (acute respiratory/ITU step down ward).

Maple – received amended staffing following the previous safe staffing review, funded establishment now accurately reflecting the requirements of the ward in line with review methodology.

Palm – budgeted establishment continues to be considered appropriate and accurately reflecting the requirements of the ward in line with review methodology.

Redwood – budgeted establishment continues to be considered appropriate and accurately reflecting the requirements of the ward in line with review methodology (urology/renal dialysis)

Areas Requiring More Detailed Review:

Beech – The review has concluded that this ward has a regular requirement for one additional HCA at night following assessment of patients in line with the trust Enhanced Care Policy. It is therefore recommended that the above findings be re-evaluated following the autumn safe staffing review to establish whether there is consistent demand.
Linden – Despite receiving an establishment uplift in the previous safer staffing review to provide one additional RN at night (from two per shift to three), this review has concluded that this ward has a regular requirement for one additional HCA at night following assessment of patients in line with the trust Enhanced Care Policy. It is therefore recommended that the above findings be re-evaluated following the autumn safe staffing review to establish whether there is consistent demand.

Mulberry & Oak – These wards have recently combined their patient cohorts with the closure of Oak in April 2019 and the staffing profile adjusted accordingly. Therefore it is recommended that the review findings be noted, but reviewed again in six months to determine whether the revised funded establishment and ward staffing profile is meeting the acuity and dependency needs of patients.

Rosewood - This ward would benefit from further consideration of an uplifted establishment in relation to the skill mix, namely the number of Band 6 nurses with a skill set that includes the ability to give chemotherapy and/or complex medications.

Rowan – Following the safe staffing review in 2018 and in line with clinical judgement the skill mix was amended for day shifts from four RN’s and four HCA’s to five RN’s and three HCA’s without the requirement for further investment (cost neutral change). The wards continues to manage high acuity patients and the consistency of the enhanced care needs on this ward will be reviewed as part of our autumn review.

A further review of the inpatient ward acuity versus establishment will be undertaken in the Autumn, and will therefore reflect the benefit of the inter-rater reliability training which has been delivered by NHSI colleagues at the beginning of June 2019. The training was delivered on a train the trainer basis to Ward Managers and Matrons and is intended to improve the accuracy of acuity scoring, which in turn will decrease the risk of variation in scoring across the organisation which can have quite an impact on the accuracy of outcome data.

It is therefore recommended that the above findings be re-evaluated following the autumn safe staffing review.

It is further recommended that ward profiles take into consideration the potential contribution of new emerging roles in order to support the delivery of quality care, successful recruitment and retention, and career pathways e.g. Nursing Associates, Pharmacy Technicians.

RECOMMENDATIONS AND FURTHER WORK

Significant progress continues to be made to ensure that data gathered to measure the Safer Nursing Care of patients within DGT are accurate, reliable, valid and timely. As a result of this it is clear that a number of issues need to be addressed:

• Note the work undertaken in relation to assurance of safe staffing across the inpatient wards as identified in the review.
• It should be noted that there is a number of challenges in relation to the vacancy position and on-going recruitment, parenting leave and high levels of sickness which continue to impact on the nursing workforce.

• Associate Nurse Directors are required to use the information from this review to feed into the workforce plans. This will be discussed and agreed within the Clinical Group/Directorates and approved by the Director of Nursing.

• A review of nursing establishments is carried out bi-annually and this will consider skill mix ratios for individual wards to ensure that they remain relevant, reflect service changes, national guidance and are within the parameters agreed with the Director of Nursing. The Ward Establishment Review Template found at Appendix 5 will be used for the Autumn review.

• Work should continue to reduce the levels of sickness/absence seen across the Trust.

• For consistency, the Trust should use the NICE endorsed Shelford Safer Nursing Care Tools for all inpatient ward areas across the Trust.

• A further review will be carried out to provide assurance that critical care areas (ITU & Walnut) have appropriate budgeted establishment.

• A review of the Emergency Department (ED) staffing is in progress in line with the ED rapid improvement project.

• The next Safe staffing review should also consider any further recommendations set out in the recently published National Institute for Health Research Themed Review – Staffing on Wards (March, 2019).
### Appendix 1

**Shelford tool**

<table>
<thead>
<tr>
<th>Level</th>
<th>Level Descriptor</th>
<th>Multiplier (Generic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal patients who can be cared for on a general ward</td>
<td>0.99</td>
</tr>
<tr>
<td>1a</td>
<td>Acutely ill patients who can be cared for on a general ward</td>
<td>1.39</td>
</tr>
<tr>
<td>1b</td>
<td>Stable patients with an increased dependency on nurses</td>
<td>1.72</td>
</tr>
<tr>
<td>2</td>
<td>Patients in ward areas awaiting transfer to High Dependency care</td>
<td>1.97</td>
</tr>
<tr>
<td>3</td>
<td>Patients in ward areas awaiting transfer to Intensive Care</td>
<td>5.96</td>
</tr>
</tbody>
</table>

**Hurst model – are levels for long stay elderly care wards**

<table>
<thead>
<tr>
<th>Level</th>
<th>Level Descriptor</th>
<th>Multiplier (Generic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low dependency - Normal patients who can be cared for on an elderly ward</td>
<td>0.94</td>
</tr>
<tr>
<td>2</td>
<td>Medium dependency – Patient in poor health who can only be cared for on an elderly care ward</td>
<td>1.11</td>
</tr>
<tr>
<td>3</td>
<td>Higher dependency – Patients with higher acuity who can me managed in an elderly care ward and may require additional security related supervision</td>
<td>1.34</td>
</tr>
<tr>
<td>4a</td>
<td>Higher dependency – Patient has major physical and or mental issues</td>
<td>1.52</td>
</tr>
<tr>
<td>4b</td>
<td>Patient requires one to one care</td>
<td>6.02</td>
</tr>
</tbody>
</table>

**QMH Inpatients - Admissions and Assessment**

<table>
<thead>
<tr>
<th>Level</th>
<th>Level Descriptor</th>
<th>Multiplier (Generic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient requires hospitalisation. Needs met by providing 'normal' ward care</td>
<td>1.28</td>
</tr>
<tr>
<td>1a</td>
<td>Patients requiring intervention or those who are instable with a greater potential to deteriorate.</td>
<td>1.67</td>
</tr>
<tr>
<td>1b</td>
<td>Patient is stable but is dependent on nursing care to meet most or all daily living activities</td>
<td>2.10</td>
</tr>
<tr>
<td>2</td>
<td>Maybe managed within clearly identified, designated beds and resources with the required expertise</td>
<td>2.28</td>
</tr>
</tbody>
</table>
### Willow – Paediatric Acuity Tool

<table>
<thead>
<tr>
<th>Level</th>
<th>Level Descriptor</th>
<th>Multiplier (Generic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Basic care</td>
<td>1.42</td>
</tr>
<tr>
<td>1</td>
<td>Increased acuity care</td>
<td>1.9</td>
</tr>
<tr>
<td>2</td>
<td>Highly dependent on nursing time and support</td>
<td>2.73</td>
</tr>
<tr>
<td>3</td>
<td>Requiring intensive and continuous nursing time/support</td>
<td>5.69</td>
</tr>
<tr>
<td>4</td>
<td>Requiring 1 nurse or more for intensive nursing for &gt;6 hours in 12 hours care (Intensive Care)</td>
<td>5.69</td>
</tr>
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</table>
Appendix 2 - Trend Analysis of Acuity across the Trust

Darent Valley Hospital (excluding Critical Care)

**Shelford Tool (Inpatient wards excluding Elderly Care):**

<table>
<thead>
<tr>
<th></th>
<th>Sep 2018</th>
<th>February 2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients Assessed</td>
<td>16636</td>
<td>20364</td>
<td></td>
</tr>
<tr>
<td>Total 0</td>
<td>2740</td>
<td>2947</td>
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</tr>
<tr>
<td>Total 1a</td>
<td>5962</td>
<td>7177</td>
<td></td>
</tr>
<tr>
<td>Total 1b</td>
<td>5526</td>
<td>8789</td>
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</tr>
<tr>
<td>Total 2</td>
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</table>

**Hurst Model (Elderly Care Wards):**

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<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients Assessed</td>
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<td>4709</td>
<td></td>
</tr>
<tr>
<td>Total 1</td>
<td>87</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total 2</td>
<td>0</td>
<td>1104</td>
<td></td>
</tr>
<tr>
<td>Total 3</td>
<td>0</td>
<td>1955</td>
<td></td>
</tr>
<tr>
<td>Total 4a</td>
<td>0</td>
<td>695</td>
<td></td>
</tr>
<tr>
<td>Total 4b</td>
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<td>955</td>
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</table>

**1:1 Patients (separated but 1b equivalent):**

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<th>February 2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients Assessed</td>
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<td>882</td>
<td></td>
</tr>
<tr>
<td>1:1</td>
<td>828</td>
<td>882</td>
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**Willow (Paediatrics):**

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</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients</td>
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<td>1705</td>
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</table>
## Queen Mary’s Hospital:

<table>
<thead>
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<th>February 2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 0</td>
<td>417</td>
<td>390</td>
<td>↓</td>
</tr>
<tr>
<td>Total 1a</td>
<td>125</td>
<td>90</td>
<td>↓</td>
</tr>
<tr>
<td>Total 1b</td>
<td>220</td>
<td>143</td>
<td>↓</td>
</tr>
<tr>
<td>Total 2</td>
<td>0</td>
<td>111</td>
<td>↑</td>
</tr>
</tbody>
</table>
Appendix 3 – Red Flag Events

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach.
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.
### Appendix 4 – Additional Duties February 2019

<table>
<thead>
<tr>
<th>Department</th>
<th>Extra Activity</th>
<th>High Acuity (RN)</th>
<th>High Risk (HCA)</th>
<th>High Risk (RMN)</th>
<th>Preceptor</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acer Unit</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38</td>
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<tr>
<td>Cherry Ward</td>
<td>1</td>
<td>1</td>
<td>32</td>
<td></td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Chestnut</td>
<td>3</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td>19</td>
</tr>
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<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Ebony</td>
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<td>2</td>
<td>33</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Juniper Ward</td>
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<td>1</td>
<td>21</td>
<td>8</td>
<td>1</td>
<td>37</td>
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<tr>
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<td>1</td>
<td>11</td>
<td></td>
<td></td>
<td>13</td>
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<tr>
<td>Linden</td>
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<td>1</td>
<td>16</td>
<td></td>
<td></td>
<td>17</td>
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Appendix 5 – Ward Staffing Review Template

Ward Establishment Review Meeting

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Review team:

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<tbody>
<tr>
<td>Siobhan Callanan</td>
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<tr>
<td>Helen Mencia</td>
<td>Deputy Director of Nursing</td>
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Budgeted Establishment :

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<td>Band 4</td>
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<td>Band 2</td>
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Ward Clerk
(Days, hours and WTE)

Current Vacancies

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Shift Profile:

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Long Days

Long Nights

Further detail if different shift pattern

Finance confirmation:
Does Budget = Shift Profile?

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### Ratios:

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### Safe Staffing Acuity & Dependency (SNCT) requirements:

Activity/Turnover of patients (admits/discharges/escorts average per day – should be included in Acuity & Dependency)

Turnover rate

### Nurse sensitive indicators/risks:

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### Any other items for further discussion:

- Carter metrics (David Waterhouse)

### Conclusion/recommendation:
**TRUST BOARD – JULY 2019**

<table>
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<tr>
<th>Subject:</th>
<th>Chaplaincy Report</th>
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<td>Author:</td>
<td>Trust Chaplain</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Director of Nursing and Quality</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>For information and Assurance</td>
</tr>
<tr>
<td>Key points for the Trust Board:</td>
<td>The purpose of the Chaplaincy is to ensure that the pastoral, spiritual, religious and cultural needs of patients, relatives and staff are met during their time in the Trust’s care. The chaplains and volunteers are also available to offer specialist multi-cultural advice on religious practices and customs to staff. This paper provides a review of the service that has been offered to staff and patients between May 2018 and April 2019. The Board is asked to note the papers content and be assured that the service is appropriate and effective.</td>
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<td>Consideration of public and patient involvement and communication:</td>
<td>For publication</td>
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<td>Recommendations:</td>
<td>The Board id asked to discuss and content of the paper and take assurance that the service being provided within the Trust is appropriate and effective.</td>
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**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

| Organisational Priorities | • Maintain and improve the quality of services delivered by DGT  
                           | • Make DGT a great place to work for everyone |
|---------------------------|----------------------------------------------------------|
| CQC Reference             | • Safe  
                           | • Effective  
                           | • Caring  
                           | • Responsive  
                           | • Well-led |
| Board Assurance Framework/ Trust Risk Register | N/A |

**Committee/ Meetings at which this paper has been discussed/ approved**

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<thead>
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2018/19
CHAPLAINCY REPORT

Caring for Everyone
May 2018 – April 2019
<table>
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<tr>
<th>CONTENTS</th>
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<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>The Chaplaincy Team</td>
<td>3</td>
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<tr>
<td>The Chapel/Multi-Faith Prayer &amp; Quiet Room</td>
<td>4</td>
</tr>
<tr>
<td>Supporting patients, relatives and staff.</td>
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<tr>
<td>Proactive and Reactive Support</td>
<td>5</td>
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<td>Supporting staff</td>
<td>6</td>
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<tr>
<td>Chaplaincy Team examples of support</td>
<td>7</td>
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<tr>
<td>Senior Chaplain Engagement</td>
<td>9</td>
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<tr>
<td>Statistical Figures</td>
<td>10</td>
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<tr>
<td>Connecting the Chaplaincy to the local community</td>
<td>12</td>
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<td>Conclusion</td>
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Introduction

The purpose of the Chaplaincy is to ensure that the pastoral, spiritual, religious and cultural needs of patients, relatives and staff are met during their time in the Trust’s care. The chaplains and volunteers are also available to offer specialist multi-cultural advice on religious practices and customs to staff.

Spirituality is defined as that which gives meaning, purpose and value to life. It may or may not include reference to a supreme being. It is at the heart of every religion but may be experienced without a formal structure. It is nourished through prayer or meditation, stillness and action and finds its expression in the development of moral character and in the service of others.

The Chaplaincy Team

2018 was a time of change for the Chaplaincy Team as the Senior Chaplain, Revd Martin Kelly, retired after 14 years of faithful service to the Trust. His successor was the Revd Tony Green, who was appointed to the role of Senior Chaplain and took up this post in August 2018.

Tony had a background in engineering before training for Ordination in the 1990s. His parish ministry has included chaplaincy since 2003 at Queen Mary’s Hospital, Sidcup and Oxleas Trust, Bexley. Tony has been part of the Chaplaincy Team at DVH since 2014.

The current Chaplaincy Team consists of the Revd Tony Green, Fr Pat and a number of volunteers with an array of life and work experience. Currently, most Team members belong to local faith communities and one is a humanist (who is willing to subscribe to the definition of spirituality outlined in the Introduction). All are valued, gifted and bring a deep desire to offer appropriate pastoral and spiritual support to all who request this.

The Chaplaincy Team Ethos

For a team to be effective the relationships in it need to be authentic. Care has been taken therefore to encourage an atmosphere of openness where each may be honest about their feelings towards their work, including reflecting on experiences which went less well. Pastoral care is an integral part of this and is offered and reciprocated by all.

As pastoral and spiritual care is often emotionally demanding, it is essential that the day begins with the discipline of quiet reflection. For many of our volunteers this will take the shape of Morning Prayer, in order to still the mind and heart in preparation for the work ahead. Or, as is appropriate, one of our volunteer’s begins the morning with a ‘Focusing Exercise’; again, in order to focus the mind and heart for the work ahead.

At the conclusion of the pastoral visiting, all are encouraged to reflect on their experiences, in whatever manner is appropriate, before leaving. If the experience
has been particularly challenging pastoral support is offered by the Senior chaplain and/or other Team members.

The Team endeavours to meet throughout the year for training and reflection. This may include a shared meal or a visit to a place of interest. In general morale may be considered high.

**The Chapel/Multi-Faith Prayer Room & Quiet Room**

This space is used by people of faith and by those who have no formal faith but whom, nevertheless, need space and time for prayer, stillness and quiet reflection.

Morning Prayer takes place daily. At the Holy Communion Service, celebrated on Sundays and Thursdays any Christian is permitted to receive Holy Communion. At the Roman Catholic Mass on Fridays and holy days of obligation, only Catholics may do so. This is in line with the different Eucharistic disciplines of the respective churches and is therefore as ‘appropriate’ as it is possible to be.

The services in the Chapel/MFPR are usually attended by Chaplaincy Team members but are open to all. On occasions, patients, staff or relatives attend and find them hugely beneficial. Importantly, however, many in the hospital use this space at all times for quiet reflection or prayer. And, during periods of personal distress, many people find the Chapel/MFPR to be a place of peace and leave better able to face the future.

There is a ‘Prayer Tree’ made out of driftwood on one its walls with a number of blank cards. All visitors have the opportunity to write their personal prayers and attach them to the tree knowing that their prayers will be remembered by others during the course of the week. The Prayer Tree is well used by relatives and friends of patients’, members of staff and patients alike.

Each afternoon and evening, the Chapel/MFPR & Quiet Room is used at various intervals by Muslim staff and visitors alike. On Fridays, usually around 1.15 p.m. Muslim Congregational Prayer (Jumu’ah) takes place in both areas. This is always very well attended.

The Ablutions Room, adjacent to the Chapel/ MFPR & Quiet Room has recently been updated. This has been appreciated by Muslim staff in preparation for prayer.

The feedback received from those members of different faith communities and those who do not profess to be 'religious', is that the Chapel/MFPR & Quiet Room is a very special place in the hospital. It is so it seems, because of the sense of peace that many discover there. It has been described as an ‘oasis where I find refreshment’ enabling me to continue.

In a demanding environment the off-loading of stress is relatively common and the Chaplaincy performs an important function in being able to ‘receive’ and ‘contain’ this, enabling the person involved to feel that they and their concerns are
acknowledged. Often, this is all that is needed. However, there are occasions when more support is needed and so more structured time may be offered. Where appropriate, the member of staff may agree to be referred to colleagues, who offer specialist formal support. To be trusted to listen to the concerns, difficulties, joy and pain of others is always a privilege and never taken for granted.

Supporting patients, relatives and staff

Person–centred care is at the heart of the work of the Chaplaincy. This is broken down into: ‘proactive support’, through new patient visiting and regular patient visiting, and ‘reactive support’, through responding to requests for chaplaincy and to emergency call-outs. Statistics demonstrating the volume of this work is included in this report. However, the value of such work is difficult to quantify as its significance lies in the dynamics of personal encounters: that is, others are better able to manage their situation because of the support of chaplaincy.

Proactive support

The Chaplaincy Team’s supportive work varies enormously. It includes the following.

An attempt is made to visit each new patient each weekday. Patients are not seen if asleep, with the doctor or nurse, or away from their beds for any reason. Nor are they visited during protected meal-times.

The purpose of these visits is to offer pastoral and spiritual support through careful, active listening, which requires time. It is also to assess the spiritual needs of each new patient and to act as a referral service for deeper work if it is required. For example, bedside communion and anointing are given to those patients or their families who request it. Or, should the patient request this, contact with a non-religious Chaplaincy volunteer is arranged.

Prayers are said daily for all patients and staff in wards and departments according to a 30-day cycle. Individual requests for prayer are honoured each morning. Holy Communion is taken daily to some Catholic patients during their stay in hospital, while for other Christians it is usually, but not exclusively, taken on Sunday. When requested, praying with patients of any faith or none, is a frequent occurrence during the ward visits. Outpatients too have been known to receive this support.

At other times the Chaplaincy support staff in practical ways; for example, by sitting with a bereaved family, thereby freeing up nurses to attend to other patients.

The Chaplaincy also supports the institution through helping to build a sense of community by blessing people and memorials; by taking part in, or organising and leading seasonal celebration services such as Christmas Carols; or by being a visible reminder of the spiritual dimension of life simply through its presence in the hospital.
Reactive support

Emergency call-outs are almost always around end-of-life support. Space does not permit me to document every case, so I include some as examples of the support that I am engaged in.

The Senior Chaplain has offered pastoral and spiritual support to a young couple and their family in the event of the unexpected death of their six-month old daughter in the A&E Department. He has attended the Delivery Suite on a number of occasions offering appropriate support to those who have experienced miscarriages, stillbirths or neonatal deaths. This usually takes the form of naming and commending the hoped-for baby to God and prayer for the family in their distress.

The Senior Chaplain has also been alongside a number of families in different wards during the day and night, offering appropriate pastoral and spiritual support as their loved ones’ are dying or have died. He has supported families in ICU, as they have faced the sudden loss or impending death of loved ones’. He has remained with family members, long into the evening, when they have experienced unexpected loss and have instinctively sought out the Chapel/MFPR as a place of refuge. He has made an evening home visit to a young couple offering support and assisting them in the planning of the funeral service for their hoped-for child (The pregnancy was terminated, after much agonizing reflection, because a scan revealed catastrophic abnormalities in the unborn baby’s brain).

All of these encounters require great sensitivity and skill, as the shock and early grief of experiencing loss, whether unexpected or anticipated, can be compounded by complicated family dynamics and sometimes conflicting worldviews.

The Chaplaincy has a 24 hour, 365 days-a-year emergency call-out service. The Senior Chaplain is responsible for organising this service, which includes local clergy and the Roman Catholic Chaplain, Fr Pat. He is effectively on-call 24 hours per day 365 days a year for Roman Catholic patients who request his services but always offers support to all who request it.

Supporting staff

The Chaplaincy’s work with staff, again although difficult to quantify, is nevertheless significant. It consists of being a ‘compassionate companion’, listening, empathising and supporting in whatever way is appropriate, when invited to do so.

One of the most important aspects of chaplaincy is that the Chaplaincy Team, made up of ordained and volunteer members is outside the normal management structure of the hospital. This may enable staff to open up in confidence to someone who is neutral and who is there to listen carefully to their concerns. Often, this is all that is needed and the member of staff returns to their department in a better frame of mind. When appropriate, the member of staff may be offered more support in perhaps a more structured way. Occasionally, a member of staff is referred to someone more able to offer appropriate support.
The following quotations from team members illustrate the value that can be added to the patient experience by visits from the Chaplaincy.

- Patient “X” has been in and out of DVH on a number of occasions over the last three or four years and had a number of operations. I visited her regularly when she was in and as a result we have become friends. She is a practicing Christian and her faith is very important to her. She is always pleased to see me and receive Holy Communion. I am amazed how she has accepted her condition and when we speak she always asks about my family. She not only cheers up when she sees me but also cheers me up in the process. Without doubt she would find her stays in hospital more difficult without the chaplaincy visits.

- I came across a very troubled young man who was in hospital following an attempted suicide. He had recently turned to alcohol as a means of numbing the pain he felt following the death of his twin and two other family members. He told me that he had been brought up as a Catholic, but had lost his faith due to the tragedies he had suffered. He chatted for a long time and revealed that he had recently had a visit from the Catholic priest. At the end of my visit he was happy for me to pray with him and just as I was leaving, asked me for the address and contact number for St Vincent’s church.

- I first met the patient following her surgery the previous day. She was sitting in her chair by the side of the bed, obviously in some discomfort. The patient was not concerned with her own problems, but with that of her middle aged son who was now living with her. It transpired that his brother, her eldest son, had died in a tragic accident when he was 17. The son had taken this very badly and he lost his job due to depression, his marriage had collapsed, and his daughter and granddaughter do not visit. The patient was greatly distressed that her only living son was in a her words, "was a recluse," he sees nobody, does not go outside the house, has no friends or outside contacts, does not work, will not "sign" on, has no money and will not seek social or medical help. To compound the issue the patient’s husband died just before Christmas, so they are living on her pension only! The following words really brought home the reason the team visit the wards "I have never told anybody this before, I am so pleased you sat and listened to me"

Who would even guess that this lady following routine surgery, sitting
by the side of her bed was in such anguish. Comfort and prayers were offered and accepted. For follow up visit.

- I was at the bedside of an elderly gentleman. He reached out for my hand and held it for 20 minutes, saying nothing, just looking into my eyes. His thoughts he kept to himself but in those 20 minutes on a busy ward I think he found peace in the silence as we shared concern through human touch. He let go of my hand and said “I am so glad you came”. I gave him a hug. There was no need for words. I left the ward wondering how long it had been since someone had shown him they cared. We come alongside patients listening and offering support to them, showing them that we care.

- The patient was a 51 year old man who initially gave no indication he wished to talk. He wanted to know which church I was from why I had arrived at his bedside and nodded when I explained my role and that I am a non-religious volunteer. Slowly he began to recount his recent history and in particular how he had acquired a dependence on alcohol. He described in painful detail the recent break-up with his partner and that he had lost touch with the 14 year-old stepson with whom he had previously enjoyed a close and loving relationship. The four days he had spent in hospital had provided the opportunity for reflection and he had developed a sense of deep and anguished despair at his situation made worse by the self-inflicted illness (his words) recently diagnosed. He became silent and tearful. He said that he had never admitted to himself or anyone else that he had a problem and this was the first time he had spoken about it. He offered his hand and we shook. It was strange he said but he felt so much better for having this conversation. He mouthed a silent ‘thankyou’ and I wished him well.

- I met the patient on a short-stay ward where she had already been some time. I asked about her family and it transpired she has some older children, and also a baby of a few months. She told me she had decided not to let the baby come and see her so that she didn’t pick up the anxiety. The anxiety? I said. And waited. The patient then talked about how worried she was as she had not yet had a diagnosis and wondered what was wrong with her, and whether she'd ever get home to her family. I enquired if she had a religious faith at all, and it transpired she is basically C of E but hasn't time to go to church. I said I wasn't surprised, and injected the idea that Christianity is not so much about rules and regulations and going to church, but about a relationship with
God. I offered to pray with her which she accepted, and at the end she seemed to be more at peace.

- We received a message from a ward as a patient had requested to receive Holy Communion. The Senior Chaplain was on holiday but we had been given permission, as chaplaincy team members’, to offer this as the elements required for Holy Communion had been duly consecrated. Accompanied by the student member of the team, who happened to be Nigerian, we made our way to the ward. We were greeted by the patient, still articulate at this point, and his wife and daughter, who happened to be Nigerian and wished to be included in this bedside service. So there was a lovely shared connection. Those who shared in this simple service were all moved to tears; it was a very special moment.

As we got ready to leave, the patient thanked us and we comforted his wife and left. It was such a powerfully emotional experience that myself and our student volunteer paused outside the ward in order to prepare ourselves for our next patient.

The post-script to this encounter: Sadly, the patient died several days after our visit but we knew we had made a difference to him and his family.

- I first saw the lady sitting quietly in the chapel, visibly upset. I asked gently whether she wanted time to be alone, adding, ‘If I can help in any way, please ask.’ A few minutes later she asked if she could talk. It transpired that her spouse had cancer and the prognosis was not good. He had always been a complicated man with his own challenges, but she loved him. However, the way in which he was trying to manage this was damaging their relationship as he was so aggressive and critical. She felt increasingly unable to cope, was ‘unravelling’ and it was frightening. The future, too, was very frightening. More detail was shared over the next 20 minutes or so, punctuated with tears.

As our time concluded, this lady before me was far more composed, felt that she was able to ‘breathe again’ and was able to face what lay ahead. She thanked me for giving her time to talk in this way, adding, ‘I’ve not been able to tell anyone else how I really feel – thank you!’
Senior Chaplain Engagement

The following are some examples of the work the Senior Chaplain has undertaken.

The Senior Chaplain is currently studying for a qualification in Counselling at Birkbeck College, London.

He has joined the End of Life Steering Group and Health & Wellbeing Group. He attends the Supportive Care MDT Group meetings weekly and joins the ‘staff huddles’ on ICU as often as possible.

He continues to offer monthly ‘pastoral supervision & support’ to staff in Pine Therapy and has facilitated a number of ‘Schwartz-like’ de-brief sessions for staff on Rosewood and Palliative Care Team. Unlike clinical rounds, the focus here is on the care of staff and the aim is to provide a space where they can safely express their feelings and reflect on the value – and sometimes the cost – of the work they do.

The Senior Chaplain led a short period of reflection for staff members on Chestnut Ward who had been affected by the unexpected death of a colleague but were unable to attend the family funeral service.

He has lectured on the spiritual aspects of a cancer diagnosis to students at Greenwich University. He has also led several training sessions for staff on ICU, explaining the role of Chaplaincy, and how this service is accessed. This was part of staff development training in ICU.

The Senior Chaplain has arranged four emergency marriages for patients on various wards.

In October, the Senior Chaplain was the guest speaker at the annual service for the Dartford Nurses League, a retired nurses’ association, at St. Anselm’s Roman Catholic Church, Dartford.

In December, 42 people attended the Carol Service in the Lecture Hall, accompanied by the Salvation Army Band, led by the Senior Chaplain.

In January 2019 the Senior Chaplain took on responsibility for conducting the monthly Communal Service for Non-viable Foetuses. This was previously undertaken by a ‘Licensed’ member of the chaplaincy team.

Earlier this year the Senior Chaplain visited the Greenwich & Bexley Hospice, in the hope of strengthening the link between the two organisations. He also visited Littlebrook Hospital, Dartford for the same reason.

During this academic year the Senior Chaplain has supervised a theological student from Spurgeon’s College, London as he completed a short placement at DVH to gain experience of NHS chaplaincy.
### Statistical Figures

#### No. of communions in the Chapel/Multi-Faith Prayer Room

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#### The Current Composition of the Chaplaincy Team

The Chaplaincy team:

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<td>Muslim</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sikh</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15</td>
<td>18</td>
<td>20</td>
</tr>
</tbody>
</table>

#### Ward visiting

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient visits</td>
<td>8,790</td>
<td>9,276</td>
<td>9,699</td>
</tr>
<tr>
<td>Relatives visited</td>
<td>1,188</td>
<td>948</td>
<td>1,164</td>
</tr>
<tr>
<td>Prayer at bedside</td>
<td>912</td>
<td>936</td>
<td>*</td>
</tr>
<tr>
<td>C/E Holy Communion at bedside</td>
<td>396</td>
<td>372</td>
<td>403</td>
</tr>
<tr>
<td>RC Holy Communion at bedside</td>
<td>*</td>
<td>*</td>
<td>1338</td>
</tr>
<tr>
<td>Anointing</td>
<td>180(1)</td>
<td>144</td>
<td>131</td>
</tr>
<tr>
<td>Parallel funeral</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Information not available

(1) The figure for 2018/19 also includes blessings
Funerals

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby</td>
<td>13</td>
<td>*</td>
<td>25</td>
</tr>
<tr>
<td>Adult</td>
<td>9</td>
<td>*</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>*</td>
<td>32</td>
</tr>
</tbody>
</table>

* Information not available

An annual Baby Memorial Service is held for parents of children who have died at Darent Valley, or its predecessor hospitals. **27 people attended this service in May 2018.**

In July a Memorial Service was held for the families of the local Air Ambulance Service marking the 20th anniversary of the crash. The crew, consisting of the pilot and two paramedics died in the crash. Almost 100 people attended the service.

The provision of 24 hour emergency on-call cover remains a challenge. This is shared by the Senior Chaplain, the Catholic Priest, Fr Pat and local clergy. These clergy are under no obligation to respond to call-outs and are not paid to do so. It should be stressed that they are not coming in to the hospital to see their own parishioners but are responding to emergency call-outs often from people with no religious affiliation, but clear spiritual need.

The Senior Chaplain also received pastoral referrals for patients receiving chemotherapy in the adjacent Pine Therapy Unit.

The majority of calls, whether in or out of hours, are requests for the pastoral care of patients. Often they will include spiritual care as the context in which a rite of passage is asked for, for example the blessing of a dead foetus, enabling the parents to leave the hospital feeling that the right thing has been done to mark the event. Sometimes, however, requests are more explicitly religious, as the following accounts testify.

Out of hours call-outs

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church of England / Other</td>
<td>21</td>
<td>*</td>
<td>31</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>*</td>
<td>*</td>
<td>84</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>115</td>
<td></td>
</tr>
</tbody>
</table>

* Information currently not available
Increasing the profile of the chaplaincy

The ‘Before you come into hospital’ information leaflet contains a section on the Chaplaincy service. Patientline TV carries an advert for the Chaplaincy. Each bedside locker contains a Gideon’s New Testament and Psalms with a laminated leaflet about the Multi-Faith Chaplaincy tucked into it, which is restocked annually. Each ward will have a new ‘How to contact a chaplain’ notice in the corridor and Chaplaincy cards in the magazine racks shortly. A screen saver reminds people of how to contact the Chaplaincy and information about the service has been distributed by email.

There is a comprehensive set of web pages for the Chaplaincy, including information about birth customs, hygiene, dietary requirements etc for all the major world faiths. For staff these pages include information about customs surrounding death also and can be found at www.dvh.nhs.uk/homepage/directorates-departments/chaplaincy.

For the general public all other information is available at www.dvh.nhs.uk/page.asp?node=246&sec=Chaplaincy.

The main Chapel/MFPR & Quiet room/Counselling room and office comprise a welcoming and flexible space which is used by people from various faith communities, by those who have non-religious beliefs and by those who no particular belief but nonetheless are seeking a refuge from the hospital environment.

Most important of all, there is the daily presence of Chaplaincy team members on the wards. However, there is still considerable competition in getting out information and it is therefore a challenge to make sure that Chaplaincy information remains visible and available.

Connecting the chaplaincy to the local community

Team members live and worship in Dartford, Bexley, Crayford, Meopham, Gravesend, Greenhithe, Hartley and Ashford. The Trust Chaplain has taken services in local churches and participated in local church groups. Local clergy share the hospital’s on-call provision. Referrals of parishioners in need of pastoral care and/or the sacraments from local clergy are common.

Over the course of the year, the Senior Chaplain has offered supervision to two theological students and one Minister-in-Training.

Conclusion

The Chaplaincy service could not run effectively without our volunteers. Most are drawn from the ranks of the retired and it is the nature of the case that, eventually, these will have to retire too from their voluntary duties at the hospital. This year we said goodbye and sincere thanks to Mrs Marilyn Manning for her service to the chaplaincy and Darent Valley Hospital.
In March 2019, Father Pat, our Catholic chaplain, celebrated his Golden Jubilee since Ordination at St Vincents, his parish church. He has been with the Trust a little over 25 years, having worked first at Joyce Green and now at Darent Valley Hospital. His kindness has been a blessing to a generation of patients and staff. We join with them in expressing our gratitude.

**Senior Chaplain**

Revd Tony Green            April 2019.
CHAPLAINCY
Pastoral Care for Everyone
(Religious and non-religious)

Caring for the whole person
### TRUST BOARD – JULY 2019

<table>
<thead>
<tr>
<th><strong>Subject:</strong></th>
<th>Quality Account</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Author:</strong></td>
<td>Assistant Trust Secretary</td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
<td>Trust Secretary</td>
</tr>
<tr>
<td><strong>Purpose of paper:</strong></td>
<td>To notify the Board that activity given delegated authority has been carried out</td>
</tr>
<tr>
<td><strong>Key points for the Trust Board:</strong></td>
<td>The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS website by June 30 each year. The requirement is set out in the Health Act 2009. Following delegated authority from the Board the Quality Account was signed on 25 June 2019 by Dr Steve Fenlon, Deputy Chief Executive/Medical Director and Peter Coles, Trust Chair in line with this requirement.</td>
</tr>
</tbody>
</table>

**Consideration of public and patient involvement and communication:** For publication

**Recommendations:** The Board are asked to note the content.

### Links to Board priorities, Board Assurance Framework, Trust Risk Register

| **Organisational Priorities** | • Maintain and improve the quality of services delivered by DGT  
• Make DGT a great place to work for everyone  
• Implement and embed the clinical and organisational strategy  
• Deliver the 2019/20 financial plan  
• Deliver all NHS constitutional and contractual standards |
|-------------------------------|---------------------------------|
| **CQC Reference** | • Safe  
• Effective  
• Caring  
• Responsive  
• Well-led |
| **Board Assurance Framework/ Trust Risk Register** | All BAF Risks |

<table>
<thead>
<tr>
<th><strong>Committee/ Meetings at which this paper has been discussed/ approved</strong></th>
<th><strong>Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
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**TRUST BOARD – JULY 2019**

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Strategic Integrated Performance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Deputy Director Performance and BI</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Executive Directors</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>For Discussion and Assurance</td>
</tr>
<tr>
<td><strong>Key points for the Trust Board:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This is the second of the new style Performance Report with revised Board KPIs as agreed by Trust Board in May 2019. The KPI targets and RAG methodology have been reviewed and signed off by the relevant Sub-Committee Chairs and Executive Leads before being approved by the Finance Committee on 28th May.</td>
</tr>
<tr>
<td></td>
<td>The new report is aligned to the Trust Priorities:</td>
</tr>
</tbody>
</table>
|                           | • Quality  
|                           | • Workforce  
|                           | • Strategy  
|                           | • Finance  
|                           | • Operations  |
|                           | New quarterly indicators for 19/20 that do not have data available in M2 are shown in grey for M1 report. |
|                           | Statistical Process Control Charts have been used where appropriate and controls are set at a rolling 12 month period as per NHSI best practice templates. The controls therefore rebase on a monthly basis. |
|                           | Where the target is not within the statistical controls, it indicates that additional interventions made be required to reach the targets. As interventions deliver, the monthly rebase of controls will then move to gradually include the target. |
|                           | The Finance Dashboard is included as in Appendix 1 as agreed at Trust Board in May 2019. |
|                           | The Interim Quality Scorecard is attached as Appendix 2 and is being developed through the Quality and Safety Committee. |
|                           | Appendix 3 sets out the RAG Key and full scoreboard of charts for all KPIs. |
|                           | In this report the following KPI's flagged as Red with exception reports included: |
|                           | • Vacancy Level  
|                           | • Staff Appraisal  
|                           | • Agency Usage  
|                           | • QIPP Delivered  
|                           | • A&E 4 Hr Wait  |
| **Consideration of public and patient involvement and** | For publication |
**Recommendations:**
The Board are asked to review and discuss the Board KPIs for M2

### Links to Board priorities, Board Assurance Framework, Trust Risk Register

| Organisational Priorities | • Maintain and improve the quality of services delivered by DGT  
|                          | • Make DGT a great place to work for everyone  
|                          | • Implement and embed the clinical and organisational strategy  
|                          | • Deliver the 2019/20 financial plan  
|                          | • Deliver all NHS constitutional and contractual standards  
| CQC Reference            | • Safe  
|                          | • Effective  
|                          | • Caring  
|                          | • Responsive  
|                          | • Well-led  

### Board Assurance Framework/ Trust Risk Register
The report provides further assurance against:

- Risk 1353 – Imbalance between admissions and discharges
- Risk 1376 – Risk of insufficient nursing numbers and skill mix
- BAF 2012 – Insufficient focus on key areas of patient safety could result in avoidable harm and negatively impact on mortality rates
- BAF1815 – Failure to meet targets to improve access to and reporting in diagnostics may impact on patient safety, experience and the effective use of resources
- BAF 1816 – Inability to maintain an appropriate level of admissions and discharges will mean that the Trust cannot operate effectively and patient experience might be negatively impacted
- BAF 2044 – Risk of delivering financial plan

### Committee/ Meetings at which this paper has been discussed/ approved

<table>
<thead>
<tr>
<th>Committee/ Meetings</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance Committee</td>
<td>June 2019</td>
</tr>
</tbody>
</table>
**Reporting Periods:**
This is a M2 report, relating to the performance in May 2019. Where data is either reported in arrears or is updated quarterly, this is indicated on the graph and in any exception reports.

**New Indicators:**
New quarterly indicators for 19/20 that do not have historic data available (i.e. reported quarterly) remain grey for the M2 report.

**Statistical Controls:**
Statistical controls are set at a rolling 12 month period as per NHSI best practice templates. The controls therefore rebase each month. Where the target is not within the statistical controls, it indicates that additional interventions made be required to reach the targets.

**Governance:**
The interim quality dashboard that is included in the appendices is in development with the Director of Nursing and Quality and will remain an interim report until it has been signed off by the Quality and Safety Committee.
Executive Dashboard

Quality
- Proportion of Clinical Incidents that Cause Harm
- Friends and Family Test
- Mortality HSMR (12 month rolling)
- Mortality SHMI (12 month rolling)
- Complaints Response
- Performance Against National Benchmarks for Clinical Outcomes
- Staff Recommending DGT for

Workforce
- Vacancy Level
- Staff Appraisal
- BAME at 7 or above
- Agency Usage
- Staff Engagement

Finance
- QIPP Delivered Against Target YTD
- Income and Expenditure YTD
- Income and Expenditure FOT
- Cash Balance Performance
- Underlying Runrate

Operations
- 18 Week RTT Performance
- A&E 4 Hour Wait
- Cancer 62 Day
- Diagnostic 6 Week Wait
- Delayed Transfers of Care
- Cyber Security

RAG criteria used
- In Month target met, YTD and Forecast on track
- In Month target met, YTD and/or Forecast not on track
- In Month target breached
- No data available
Issue: This metric is RAG rated RED having not met the <9% in month (green) target.

Risk: High vacancy rates in Pathology (15.09%), Planned Care (16.99%) and A&E (16.29%).

Action: Following the closure of Oak ward, staff have been redeployed to posts across adult medicine, which has supported a reduction in vacancies. From 1st July 2019 staff formerly based at Elm Court will also move into roles within adult medicine.

A workforce review within Pathology has recently been completed to ensure optimum structure and skill mix and the directorate has clear recruitment plans with rolling adverts on NHS Jobs. The June 2019 recruitment pipeline includes 16 externally recruited candidates for posts in Pathology across roles such as biomedical scientists (4 scientists and 1 senior scientist) and medical laboratory assistants (8).

Planned care have recently interviewed and offered a number of staff following the Fawkham Manor private facility closure and transitioned some long term agency staff to bank roles supported by the change to Trust bank rates from 1st June 2019.

June Workforce Committee was provided with an overview of workforce modelling for Registered Nursing and plans to reduce the RN vacancy rate across the 19/20 financial year from 16.2% at the end of April 2019 (165 WTE) to 7.9% and 79 WTE vacancies by end of March 2020. Plans include increasing nurse recruitment open events from 2 to 3 across the year, a focused return to practice campaign with clinical education colleagues, increased attraction of operating department practitioner roles to theatre posts, and review and amendment of skill mix within existing establishment to increase attraction. The Trust interviewed in June 19 for the first cohort of trainee Nursing Associates and offered 9 candidates training roles which will start in September 2019. The Trust will also advertise for qualified Nursing Associates with a view to September start dates alongside the training cohort.
Issue: This metric is RAG rated RED having not met the 85% in month (green) target. The reported appraisal rate now includes both Agenda for Change (AfC) and Medical staff. Reporting AfC and medical staff appraisal rate as a combined total gives a more complete view of appraisal compliance and support and development of staff across the organisation. The appraisal rate of 83.1% in May compares to an appraisal rate for both AfC and medical staff of 84.6% in April and on comparable terms is a reduction of 1.5%. While there has been a reduction in appraisal rates in May overall, a number of areas have seen an increase including A&E with an appraisal rate of 82% (the highest rate reported in A&E since March 2018).

Risk: Poor staff support and development should appraisals not be done.

Action: Appraisal rates continue to be reviewed at Executive Performance Review Boards, and recovery plans monitored and managed. Corporate and local clinical group staff survey action plans also include actions related to improving quality of appraisals e.g. appraisal audits in areas including pharmacy.
**Issue:** This metric is RAG rated RED having not met the M2 target. The spend on Agency staff in Month 2 was £385k taking the overall agency spend at M2 over the cumulative target of £1079k. Expenditure increased by £183k between April and May mainly due to a £96k spend in A&E and £51k in Pathology. As this is the second of a 12 month plan, there is not sufficient data to statistically predict future trends, however the current position shows a deterioration from plan.

**Risk:** Agency overspend could impact on the Trust financial position against plan.

**Action:** The under delivery will be escalated through the Zero Agency Group for consideration and further actions. The zero agency group is focusing on a number of actions including: roll out of capped hours to support ward and service leads manage resource in budget including temporary spend; timely sign off of rosters within 6 week deadlines to ensure agency requirements are reduced; supporting transition of agency to bank following revision of RN bank rates; working closely with the STP on developing joint commissioning arrangements for medical agency; reviewing temporary staffing infrastructure to support delivery of savings.

Re A&E: middle grade recruitment is on plan, with pipeline candidates against all vacancies; a review is ongoing to determine the appropriate middle grade establishment for the service. Interim additional support is in place for over night cover. Nurse recruitment continues effectively.
Issue: This metric is RAG rated RED having not met the M2 target. Savings achieved YTD are £96k below the target of £741k. As this is the second of a 12 month plan, there is not sufficient data to statistically predict future trends.

Risk: Non delivery of the £11.0m in total could impact on the Trust financial position against plan and therefore not receive the additional funding available. The risk is included in the BAF as Risk 2044.

Action: The under delivery will be escalated through FRP for consideration and further actions. External support continues within the Trust to deliver the £11.0m savings target by working with the Clinical groups to reduce risk in current schemes, develop detailed plans to deliver the workforce, Outpatient transformation and Length of Stay boulders and identify new schemes to close the current gap.
**Issue:**
This metric is RAG rated RED having not met the recovery trajectory agreed with regulators. Whilst the trajectory still lies within the control limits, the controls are broad and current performance remains towards the lower control limit, indicating additional interventions will be required to reach trajectory and establish better control.

**Risk:**
BAF 1816 – Inability to maintain an appropriate level of admissions and discharges.

**Action:**
The Trust has joined national intensive support programme for ED performance, developing a Rapid Improvement Plan of high impact items which are overseen by the CEO through weekly meetings. Key areas of focus are the move towards a zero tolerance breach culture in minors, establishing rapid admission pathways into medical and surgical areas, including review of AMU and establishment of SAU and a rapid program of work to reduce occupancy levels, including regular MADE events. The plan also covers continued improvements to streaming options and demand alignment within ED.
Appendices

- Change Control Log

<table>
<thead>
<tr>
<th>Version</th>
<th>Change Made</th>
<th>Approved by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>First formal version issued.</td>
<td>Trust Board</td>
<td>2/5/19</td>
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- Finance Dashboard
- Interim Quality Scorecard
- RAG Key and Full Scorecard

End of Report
### Appendix 1 – Finance Dashboard

#### 2018/19 RAG rating included as reported last year - Green on plan or better, Amber < 2% off plan, Red > 2% off plan. 2019/20 based on KPI targets and RAG paper.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>YTD</th>
<th>RAG Rating</th>
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<tbody>
<tr>
<td>Income Plan</td>
<td>22,163</td>
<td>22,549</td>
<td>22,156</td>
<td>22,519</td>
<td>23,005</td>
<td>23,374</td>
<td>22,482</td>
<td>22,688</td>
<td>22,083</td>
<td>23,863</td>
<td>22,611</td>
<td>24,822</td>
<td>47,433</td>
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<tr>
<td>Income Actual</td>
<td>22,170</td>
<td>23,024</td>
<td>21,959</td>
<td>20,576</td>
<td>22,553</td>
<td>23,502</td>
<td>22,272</td>
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<td>22,524</td>
<td>23,601</td>
<td>46,125</td>
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</tr>
<tr>
<td>Cumulative Income Variance</td>
<td>(126)</td>
<td>-601</td>
<td>405</td>
<td>(1,538)</td>
<td>(1,996)</td>
<td>(1,861)</td>
<td>(2,071)</td>
<td>(2,502)</td>
<td>(2,671)</td>
<td>(2,559)</td>
<td>(2,87)</td>
<td>(1,221)</td>
<td>(2.8%)</td>
<td></td>
</tr>
<tr>
<td>Spend Plan</td>
<td>(22,923)</td>
<td>(23,205)</td>
<td>(23,425)</td>
<td>(23,328)</td>
<td>(22,660)</td>
<td>(22,280)</td>
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<td>(25,052)</td>
<td>(49,020)</td>
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<td>Cumulative Spend Variance</td>
<td>(100)</td>
<td>(596)</td>
<td>(604)</td>
<td>(556)</td>
<td>(1,311)</td>
<td>(1,849)</td>
<td>(3,230)</td>
<td>(4,599)</td>
<td>(7,639)</td>
<td>(9,028)</td>
<td>89</td>
<td>1,239</td>
<td>2.7%</td>
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<tr>
<td>Surplus/(Deficit) Breakeven Duty Plan</td>
<td>(761)</td>
<td>(656)</td>
<td>(1,269)</td>
<td>(806)</td>
<td>345</td>
<td>404</td>
<td>201</td>
<td>369</td>
<td>(189)</td>
<td>711</td>
<td>(1,357)</td>
<td>(230)</td>
<td>(1,587)</td>
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<td>Surplus/(Deficit) Breakeven Duty Actual</td>
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<td>(676)</td>
<td>(1,474)</td>
<td>(2,705)</td>
<td>(861)</td>
<td>(105)</td>
<td>(1,289)</td>
<td>(1,432)</td>
<td>(3,397)</td>
<td>(1,067)</td>
<td>(1,355)</td>
<td>(212)</td>
<td>(1,567)</td>
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<td>Cumulative Surplus/(Deficit) Variance</td>
<td>26</td>
<td>5</td>
<td>(109)</td>
<td>(2,095)</td>
<td>(3,301)</td>
<td>(3,810)</td>
<td>(3,991)</td>
<td>(7,101)</td>
<td>(10,306)</td>
<td>(12,087)</td>
<td>2</td>
<td>18</td>
<td>1.3%</td>
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<tr>
<td>PSF, FRF, MRET Plan</td>
<td>770</td>
<td>342</td>
<td>342</td>
<td>343</td>
<td>514</td>
<td>514</td>
<td>513</td>
<td>599</td>
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<td>599</td>
<td>702</td>
<td>702</td>
<td>1,404</td>
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<tr>
<td>PSF, FRF, MRET Actual</td>
<td>770</td>
<td>342</td>
<td>137</td>
<td>(479)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>1,919</td>
<td>702</td>
<td>702</td>
<td>1,404</td>
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<tr>
<td>PSF, FRF, MRET Cumulative Variance</td>
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<td>0</td>
<td>(205)</td>
<td>(1,027)</td>
<td>(1,541)</td>
<td>(2,055)</td>
<td>(2,568)</td>
<td>(3,167)</td>
<td>(3,766)</td>
<td>(4,446)</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td>Outturn Risk Assessment pre PSF, FRF, MRET</td>
<td>(9,600)</td>
<td>(11,000)</td>
<td>(11,125)</td>
<td>(10,083)</td>
<td>(10,065)</td>
<td>(1,065)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12,090</td>
<td>(11,590)</td>
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<tr>
<td>QIPP NHSI plan exc FYE</td>
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<td>785</td>
<td>804</td>
<td>826</td>
<td>1,494</td>
<td>1,619</td>
<td>1,634</td>
<td>1,634</td>
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<td>318</td>
<td>442</td>
<td>760</td>
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<tr>
<td>QIPP actual</td>
<td>708</td>
<td>789</td>
<td>603</td>
<td>1,099</td>
<td>896</td>
<td>828</td>
<td>1,592</td>
<td>781</td>
<td>787</td>
<td>598</td>
<td>246</td>
<td>399</td>
<td>645</td>
<td></td>
</tr>
<tr>
<td>Cumulative QIPP Variance</td>
<td>52</td>
<td>58</td>
<td>(145)</td>
<td>128</td>
<td>(470)</td>
<td>(1,261)</td>
<td>(1,303)</td>
<td>(2,156)</td>
<td>(3,003)</td>
<td>(4,042)</td>
<td>(72)</td>
<td>(115)</td>
<td>(15.1%)</td>
<td></td>
</tr>
<tr>
<td>Cash Plan</td>
<td>3,672</td>
<td>3,480</td>
<td>4,514</td>
<td>4,943</td>
<td>3,368</td>
<td>3,628</td>
<td>5,075</td>
<td>4,792</td>
<td>4,787</td>
<td>3,791</td>
<td>7,991</td>
<td>7,769</td>
<td>16,952</td>
<td></td>
</tr>
<tr>
<td>Cash Actuals</td>
<td>6,363</td>
<td>6,322</td>
<td>4,561</td>
<td>4,858</td>
<td>7,084</td>
<td>6,654</td>
<td>9,021</td>
<td>7,586</td>
<td>10,034</td>
<td>8,150</td>
<td>19,075</td>
<td>16,952</td>
<td>16,952</td>
<td></td>
</tr>
<tr>
<td>Cash Variance</td>
<td>2,691</td>
<td>2,842</td>
<td>47</td>
<td>15</td>
<td>3,716</td>
<td>3,026</td>
<td>3,946</td>
<td>2,794</td>
<td>5,247</td>
<td>4,359</td>
<td>11,084</td>
<td>9,183</td>
<td>118.2%</td>
<td></td>
</tr>
<tr>
<td>Capital Plan Approved (NHSI Plan)</td>
<td>1,262</td>
<td>1,059</td>
<td>627</td>
<td>662</td>
<td>756</td>
<td>1,318</td>
<td>742</td>
<td>237</td>
<td>505</td>
<td>357</td>
<td>179</td>
<td>181</td>
<td>369</td>
<td></td>
</tr>
<tr>
<td>Capital Actuals</td>
<td>140</td>
<td>919</td>
<td>59</td>
<td>427</td>
<td>304</td>
<td>287</td>
<td>303</td>
<td>397</td>
<td>886</td>
<td>1,743</td>
<td>206</td>
<td>126</td>
<td>332</td>
<td></td>
</tr>
<tr>
<td>Cumulative Capital Variance</td>
<td>(1,857)</td>
<td>(1,997)</td>
<td>(2,565)</td>
<td>(2,800)</td>
<td>(3,252)</td>
<td>(4,283)</td>
<td>(4,722)</td>
<td>(4,562)</td>
<td>(4,181)</td>
<td>(2,795)</td>
<td>(27)</td>
<td>55</td>
<td>(7.8%)</td>
<td></td>
</tr>
</tbody>
</table>

All figures in £’000s
### Appendix 2 – Interim Quality Scorecard

#### Quality Scorecard

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Latest Available Position</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Clinical Incidents that Cause Harm (12 Month Rolling)</td>
<td>5%</td>
<td>1.97%</td>
<td>Green</td>
</tr>
<tr>
<td>Friends &amp; Family Recommends - Inpatients</td>
<td>95%</td>
<td>97.0%</td>
<td>Green</td>
</tr>
<tr>
<td>Friends &amp; Family Response Rate - Inpatients</td>
<td>10.5%</td>
<td></td>
<td>Red</td>
</tr>
<tr>
<td>Friends &amp; Family Recommends - Outpatients</td>
<td>95%</td>
<td>96.9%</td>
<td>Green</td>
</tr>
<tr>
<td>Friends &amp; Family Response Rate - Outpatients</td>
<td>3.3%</td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td>Friends &amp; Family Recommends - A&amp;E</td>
<td>95%</td>
<td>94.4%</td>
<td>Red</td>
</tr>
<tr>
<td>Friends &amp; Family Response Rate - A&amp;E</td>
<td>0.4%</td>
<td></td>
<td>Red</td>
</tr>
<tr>
<td>Friends &amp; Family Recommends - Maternity</td>
<td>95%</td>
<td>97.5%</td>
<td>Green</td>
</tr>
<tr>
<td>Friends &amp; Family Response Rate - Maternity</td>
<td>11.3%</td>
<td></td>
<td>Red</td>
</tr>
<tr>
<td>Friends &amp; Family Recommends - Staff</td>
<td>71%</td>
<td>82.6%</td>
<td>Green</td>
</tr>
<tr>
<td>Mortality HSMR (12 Month Rolling)</td>
<td>Within normal range</td>
<td>92.5</td>
<td>Green</td>
</tr>
<tr>
<td>Mortality SHMI (12 Month Rolling)</td>
<td>Within normal range</td>
<td>1.1</td>
<td>Green</td>
</tr>
<tr>
<td>Complaints</td>
<td>31</td>
<td></td>
<td>Green</td>
</tr>
<tr>
<td>Complaints Response within 25 Days</td>
<td>35%</td>
<td>38%</td>
<td>Green</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme, number of measures achieved against national average (Annual)</td>
<td>56%</td>
<td>30%</td>
<td>Red</td>
</tr>
<tr>
<td>Stroke Direct Admissions</td>
<td>90%</td>
<td>83.7%</td>
<td>Red</td>
</tr>
<tr>
<td>Stroke 90% Stay</td>
<td>80%</td>
<td>86.2%</td>
<td>Green</td>
</tr>
<tr>
<td>TIA Assessed within 24 Hours</td>
<td>60%</td>
<td>75.0%</td>
<td>Green</td>
</tr>
</tbody>
</table>

#### Additional Metrics in Development

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Latest Available Position</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI - MRSA bacteraemia</td>
<td>0</td>
<td>0</td>
<td>Green</td>
</tr>
<tr>
<td>HCAI - Cdiff</td>
<td>5</td>
<td>2</td>
<td>Green</td>
</tr>
<tr>
<td>HCAI - E.Coli</td>
<td>0</td>
<td>1</td>
<td>Red</td>
</tr>
<tr>
<td>HCAI - MSSA</td>
<td>0</td>
<td>2</td>
<td>Red</td>
</tr>
<tr>
<td>Falls/1,000 Bed Days</td>
<td>5.5</td>
<td>5.7</td>
<td>Red</td>
</tr>
<tr>
<td>Falls (resulting in fracture)</td>
<td></td>
<td>4</td>
<td>Red</td>
</tr>
<tr>
<td>Falls (resulting in fracture)/1,000 Bed Days</td>
<td></td>
<td>0.2</td>
<td>Red</td>
</tr>
<tr>
<td>HA Pressure Ulcers (HCAI Grade 2,3,4)/1,000 Bed Days</td>
<td></td>
<td>1.5</td>
<td>Red</td>
</tr>
<tr>
<td>HA Pressure Ulcers - Unstageable</td>
<td></td>
<td>3</td>
<td>Red</td>
</tr>
<tr>
<td>STEIS Total number open</td>
<td></td>
<td>26</td>
<td>Red</td>
</tr>
<tr>
<td>STEIS Total number new this month</td>
<td></td>
<td>6</td>
<td>Red</td>
</tr>
<tr>
<td>STEIS Total number closed this month</td>
<td></td>
<td>2</td>
<td>Red</td>
</tr>
<tr>
<td>SI's Declared</td>
<td></td>
<td>6</td>
<td>Red</td>
</tr>
<tr>
<td>VTE Risk Assessment</td>
<td>95%</td>
<td>95.5%</td>
<td>Red</td>
</tr>
<tr>
<td>Dementia Screening</td>
<td>90%</td>
<td>95.8%</td>
<td>Red</td>
</tr>
<tr>
<td>#NoF BPT</td>
<td>72%</td>
<td>76.92%</td>
<td>Green</td>
</tr>
<tr>
<td>Single Sex Accommodation Breaches</td>
<td>18</td>
<td>15</td>
<td>Red</td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>0</td>
<td>Green</td>
</tr>
<tr>
<td>Safer Staffing (Avg Fill Rate)</td>
<td>95%</td>
<td>95.5%</td>
<td>Green</td>
</tr>
</tbody>
</table>

#### New Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Latest Available Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>HA VTE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3 – Full Scorecard & RAG Key

### Quality

<table>
<thead>
<tr>
<th>Ref</th>
<th>Metric</th>
<th>May-19</th>
<th>Latest Available</th>
<th>Targets</th>
<th>RAG</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Proportion of Clinical Incidents that Cause Harm (moderate to catastrophic categories)</td>
<td></td>
<td>1.97%</td>
<td>&lt; 5%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Friends and Family Test - percentage of people that would recommend the services</td>
<td></td>
<td>97.0%</td>
<td>&gt; 95%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>1.3a</td>
<td>Mortality HSMR (12 month rolling) - Latest available</td>
<td></td>
<td>92.5</td>
<td>Within normal range</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>1.3b</td>
<td>Mortality SHMI (12 month rolling) - Latest available</td>
<td></td>
<td>1.07</td>
<td>Within normal range</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Complaints Response</td>
<td></td>
<td>38%</td>
<td>&gt; 90%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>Performance Against National Benchmarks for Clinical Outcomes</td>
<td></td>
<td>NEW</td>
<td>&gt; 50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>1.6</td>
<td>Staff Recommending DGT for Treatment</td>
<td></td>
<td>82.6%</td>
<td>&gt; 71%</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>1.7</td>
<td>Vacancy Level</td>
<td></td>
<td>9.8%</td>
<td>&lt; 9%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>1.8</td>
<td>Staff Appraisal (excluding medical staff)</td>
<td></td>
<td>83%</td>
<td>&gt; 85%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>1.9</td>
<td>BAME at 7 or above</td>
<td></td>
<td>18.5%</td>
<td>&gt; 17.5%</td>
<td>17.5%</td>
<td></td>
</tr>
<tr>
<td>1.10</td>
<td>Agency Usage</td>
<td></td>
<td>-£385,000.00</td>
<td>zero adverse variance against plan</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1.11</td>
<td>Staff Engagement</td>
<td></td>
<td>68.84%</td>
<td>&gt; 66%</td>
<td>66%</td>
<td></td>
</tr>
</tbody>
</table>

### Finance

<table>
<thead>
<tr>
<th>Ref</th>
<th>Metric</th>
<th>May-19</th>
<th>Latest Available</th>
<th>Targets</th>
<th>RAG</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>QIPP Delivered Against Target</td>
<td></td>
<td>-£96,000</td>
<td>96,000.00</td>
<td>zero adverse variance against plan</td>
<td>0</td>
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<tr>
<td>2.2</td>
<td>Income and Expenditure YTD</td>
<td></td>
<td>£20,000</td>
<td>20,000</td>
<td>zero adverse variance against plan</td>
<td>0</td>
</tr>
<tr>
<td>2.3</td>
<td>Income and Expenditure FOT</td>
<td></td>
<td>£0</td>
<td>zero adverse variance against plan</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>Cash Balance Performance</td>
<td></td>
<td>£9,183.00</td>
<td>9,183.00</td>
<td>zero adverse variance against plan</td>
<td>0</td>
</tr>
<tr>
<td>2.5</td>
<td>Underlying Runrate</td>
<td></td>
<td>0</td>
<td>zero adverse variance against plan</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>18 Week RIT Performance</td>
<td></td>
<td>92.04%</td>
<td>92.04%</td>
<td>&gt; 92%</td>
<td>92%</td>
</tr>
<tr>
<td>2.7</td>
<td>A&amp;E 4 Hour Wait</td>
<td></td>
<td>82.25%</td>
<td>82.25%</td>
<td>&gt; 95%</td>
<td>95%</td>
</tr>
<tr>
<td>2.8</td>
<td>Cancer 62 Day (with 38 day compliance from April19)</td>
<td></td>
<td>89.6%</td>
<td>&gt; 85%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>2.9</td>
<td>Diagnostic 6 Week Wait</td>
<td></td>
<td>0.53%</td>
<td>&lt; 1%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>2.10</td>
<td>Delayed Transfers of Care</td>
<td></td>
<td>2.85%</td>
<td>&lt; 3.5%</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>2.11</td>
<td>Cyber Security</td>
<td></td>
<td>94.00%</td>
<td>zero adverse variance against plan</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>2.12</td>
<td>No impact to patients or services from a cyber attack</td>
<td></td>
<td>94%</td>
<td>zero adverse variance against plan</td>
<td>75%</td>
<td></td>
</tr>
</tbody>
</table>
Quality SPC / Graphs

Line Graph - Complaints Response Within 25 Days

New measure as of April 2019
Measured two months in arrears
Interim staggered trajectory beginning April 19:
Q1 50%
Q2 60%
Q3 75%
Q4 90%
(to be confirmed at Q&S Committee)

Line Graph - Staff Recommending DGT for Treatment

SPC - Proportion of Clinical Incidents that Cause Harm - starting 01/04/18

SPC - Trust Friends & Family - starting 01/01/18
Workforce SPC / Graphs

**Line Graph - Staff Recommending DGT as a Place to Work**

- % Recommends
- Target
- Mean

**Line Graph - BAME at 7 or above**

- BAME at 7 or above
- Target

**SPC - Appraisal Rate-Non-Medical starting 01/04/17**

- Mean
- Process limits - 3σ
- High or low point
- Special cause - improvement
- Special cause - concern
- % Appraisals

- 1 year
Workforce SPC / Graphs Continued
Finance SPC / Graphs

Line Graph - QIPP Delivered Against Target YTD

Line Graph - Income and Expenditure YTD

Line Graph - Cash Balance Performance (month end)

Line Graph - Underlying Run Rate
Operations SPC / Graphs
Operations SPC / Graphs continued
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Financial position as at month two 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Deputy operational finance director</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Deputy operational finance director</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>To inform the committee of financial performance in the period to May 2019.</td>
</tr>
</tbody>
</table>

**Key points for the Finance Committee:**

- **Deficit** of £0.2m in month two [£1.6m in the period to 31<sup>st</sup> May] which is on plan, albeit that the quarter one QIPP target is low.

- **Normalised run rate** has deteriorated in month to a £0.7m deficit from break even last month, driven by clinical income and pay cost month on month movements.

- **Forecast** remains to deliver the approved plan. A full reforecast and appraisal of risks to the outturn position informed by activity patterns and QIPP delivery forecast (incorporating a Carnall Farrar view) will be conducted after quarter one.

- **QIPP** delivery was £0.4m in month [£0.6m YTD] £0.1m adverse [£0.3m adv]. Phasing differences mean adverse to NHSI plan £0.1m. Carnall Farrar pump priming support commenced in month.

- **Income** was £23.6m in month [£46.1m YTD] £1.2m adverse [£1.3m adv]. The driver is £1.3m less clinical income from a lower than expected level of non-elective activity in month.

- **Pay** costs of £13.5m in month [£27.2m YTD] £0.1m favourable [£0.2m fav]. Medical pay is over budget in month and year to date driven by temporary staffing usage.

- **Agency** costs of £0.8m in month [£1.4m YTD] £0.6m adverse [£1.0m adv] marginally worse than the NHSI ceiling of £1.4m YTD driven by a shift from bank to agency medical shifts, particularly in A&E, and a one-off correction to the accrual.

- **Non-pay** costs of £8.2m in month [£16.4m YTD] £0.2m adverse [£0.4m adverse] caused by non-recurrent medical & surgical supplies & equipment spend and recognition of consultancy costs.

- **Cash** at month end of £17.0m [£19.1m at previous month end] versus £7.8m planned [£8.0m]. Capital invoices accrued not received, PFI support cash received in advance and NHS invoices awaiting approval drive this.

- **Capital expenditure** was £0.3m through month end [£0.2m one month ago] marginally behind plan and a low proportion of the £11.9m programme for the year.

- **Liquidity** is minus 15.1 days at month end [minus 15.4 days last month] against the plan of minus 8.7 days. (Explained in the report).

- **Better payments practice code** 95.1% paid on time by value, 94.4% by volume for non-NHS suppliers versus the 95% target.
**Financial risk rating** remains a “3” against a plan of “3” (“1” best ➔ “4” worst)

| Consideration of public and patient involvement and communication: | For publication |
| Recommendations: | The Finance Committee are asked to note, discuss and agree the month 2 financial position |

**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

| Organisational Priorities | Deliver financial sustainability and efficiency  
<table>
<thead>
<tr>
<th></th>
<th>Strengthen operational efficiency and effectiveness</th>
</tr>
</thead>
</table>
| CQC Reference              | Safe  
|                            | Effective  
|                            | Responsive  
|                            | Well-led  |
| Board Assurance Framework/ Trust Risk Register | BAF Risks 2040 - 2045 |

**Committee/ Meetings at which this paper has been discussed/ approved** | Date
--- | ---
Finance Committee | 28/05/2019
1. **Summary of the Financial Position**

The Trust reported a month two deficit of (£2.9m) before central additional funding in line with plan. The table below summarises the financial position.

<table>
<thead>
<tr>
<th></th>
<th>Month 2 2019/20</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £’000</td>
<td>Actual £’000</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from Patient Care Activities</td>
<td>21,367</td>
<td>20,077</td>
</tr>
<tr>
<td>Revenue from Patient Care Activities - Non NHS</td>
<td>222</td>
<td>272</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>3,234</td>
<td>3,253</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>24,822</td>
<td>23,601</td>
</tr>
<tr>
<td><strong>Operating Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Costs</td>
<td>(13,615)</td>
<td>(13,537)</td>
</tr>
<tr>
<td>Non Pay Costs</td>
<td>(8,011)</td>
<td>(8,218)</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>(21,625)</td>
<td>(21,755)</td>
</tr>
<tr>
<td>Reserves</td>
<td>(1,437)</td>
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</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>1,760</td>
<td>1,846</td>
</tr>
<tr>
<td>Profit/Loss on Disposal</td>
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<td>5</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(608)</td>
<td>(656)</td>
</tr>
<tr>
<td>Interest Receivable</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Interest Payable</td>
<td>(72)</td>
<td>(72)</td>
</tr>
<tr>
<td>Other Finance Costs</td>
<td>(1,267)</td>
<td>(1,273)</td>
</tr>
<tr>
<td>Public Dividends Payable</td>
<td>(73)</td>
<td>(73)</td>
</tr>
<tr>
<td>Other Finance Costs Total</td>
<td>(2,017)</td>
<td>(2,060)</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit) pre Technical Adjustment</strong></td>
<td>(257)</td>
<td>(215)</td>
</tr>
<tr>
<td>Technical Adjustments to Surplus/(Deficit)</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit)</strong></td>
<td>(230)</td>
<td>(212)</td>
</tr>
<tr>
<td>Additional Funding included above</td>
<td>702</td>
<td>702</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit) excl. PSF</strong></td>
<td>(932)</td>
<td>(914)</td>
</tr>
</tbody>
</table>

This performance delivers the financial control total year to date and so additional funding (PSF, FRF and MRET) of £1.4m has been recognised improving the reported deficit to (£1.6)m. The Trust needs to deliver its financial control total at the quarter end to secure the PSF and FRF elements of the income.

2. **Directorate Performance**

**Clinical Directorates:**

Only one directorate was more than 2% overspent at month two:
Accident and Emergency reported an overspend year to date of £182k, there are a number of vacancies for both Medical (7) and Nursing (9), these are covered by temporary staffing, interviews have been arranged to reduce the reliance on temporary cover.

3. Income

Total income underperformed by (£1.2m) against the budget of £24.8m in month. Clinical Income variance is primarily driven by Non Elective income which is £1m under plan year to date. Critical Care, Chemotherapy and Antenatal make up the balance.

4. Expenditure

The key issues are as follows:

- Pay expenditure was underspent by £0.2m at month two, against the budget of £27.4m. The variance in month remained similar to last month.
  - Medical Staff overspent by (£0.1m) – Adult Medicine and A&E are the drivers of this overspend.
  - Nursing underspent by £0.1m – Adult Medicine, closure of Oak ward and the redistribution of staff to cover vacancies in other areas
  - STT staff underspent by £0.1m with no major underspends in any one Directorate.
  - A&C Staff underspent by £0.1m, mainly in Corporate areas.

Total Agency Spend Ceiling

- The Trust a target for total agency spend of £5.1m in 2019/20, the same as last year’s ceiling. The Trust has spent £1.46m against the ceiling and NHSI plan of £1.44m. The plan however reduces significant from month 4 onwards.

Non Pay

- Non-pay was overspent by (£0.2m) to date, mainly on Supplies and Services, Clinical & Drugs – (£0.1m)

5. Normalised Run Rate

- The Normalised run rate for pay shows an increase on Month one costs, however remains below the twelve month rolling average cost.
- The Normalised run rate for non pay shows an increase on month one (£58k), and is above the rolling average run rate (£70k)
6. Capital

- The Trust has spent £0.3m on the capital programme to Month 2, which is marginally behind the NHSI plan, however the capital programme will be managed over the remaining months and this is not due to a slippage against a project just a small difference in the phasing. The plan includes £1.5m carry forward and an additional £2.2m loan requirement along with £1.9m of PDC for EPMA which we are awaiting confirmation.

7. Cash

- The cash balance at the end of Month 1 was £16.9m against a plan of £7.8m. The Trust received cash support of £1.5m based on the planned year to date deficit in Month 2. The cash position is better than plan due to the full receipt of PFI support in April of £4.5m, capital creditors that have not been paid as yet and year end agreements with Commissioners which would normally still to be agreed pending final Month 12 coding of activity.
**TRUST BOARD – JULY 2019**

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Interim NHS People Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Louise Lester, Director of Human Resources</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Louise Lester, Director of Human Resources</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>To provide the Board with an overview of the Interim NHS People Plan</td>
</tr>
</tbody>
</table>

**Key points for the Board:**

*Briefly summarise the main points and key issues*

An overview is given of the key elements of the interim plan.

The paper identifies the next stages in the development of the Final People Plan expected later in 2019.

The paper highlights the initial actions the Trust is taking in response to the interim NHS People Plans publication and key themes within it.

**Consideration of public and patient involvement and communication:**

n/a

**Recommendations:**

For information

---

**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

| Organisational Priorities | • Maintain and improve the quality of services delivered by DGT  
|                          | • Make DGT a great place to work for everyone  
|                          | • Implement and embed the clinical and organisational strategy  
|                          | • Deliver the 2019/20 financial plan  
|                          | • Deliver all NHS constitutional and contractual standards |

**CQC Reference**

• Safe  
• Effective  
• Caring  
• Responsive  
• Well-led

**Board Assurance Framework/ Trust Risk Register**

2038 The Trust does not provide high quality patient care and experience as staff are not in the right place and at the right time or they have not been appraised or received mandatory core skills.

---

**Committee/ Meetings at which this paper has been discussed/ approved**

<table>
<thead>
<tr>
<th>Committee/ Meetings</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Committee</td>
<td>18/06/2019</td>
</tr>
</tbody>
</table>
1. Introduction

The interim NHS People Plan was published on 3rd June 2019. The plan sets the national strategic framework for the NHS workforce for the next 5 years. It identifies that the NHS needs more staff, and must become a better place to work in order to address workforce challenges. There is also a focus on changing the leadership culture across the health service and training a workforce equipped for the future.

The plan seeks to create a unity of purpose on the workforce agenda. The inclusive way in which the plan was developed via the Talking Health and Care engagement platform has supported this.

The below paper provides an overview for the Board of the key elements of the interim NHS People Plan, identifies the next stages in the development of the Final People Plan, and highlights the initial actions the Trust is taking in response.

2. Key proposals:

The plan is structured into themes, with each theme having a number of actions that need to be taken by NHS organisations to enable the people who work in the NHS to deliver the NHS Long Term Plan. The themes are outlined below.

2.1 Workforce supply and prioritising urgent action on nursing shortages

This includes supporting and retaining existing nurses while attracting nurses from abroad and ensuring we make the most of the nurses we already have within the NHS.

There is a focus on delivering a rapid expansion programme to increase clinical placement capacity by 5,000 for September 2019 intake, working with Trusts to assess organisational readiness and providing targeted support and resource to develop the infrastructure required to increase placement capacity. The Trust has indicated an increase of 33% student nurse places could be accommodated however this would require investment from HEKSS in a practice development nurse role at the Trust.

A series of initiatives outlined in the interim plan will further aim to recruit an additional 40,000 nurses to the NHS in the next 5 years, including coordinating and consolidating national recruitment campaigns with a focus on learning disability and mental health nurses, as well as highlighting the realities of a career in modern nursing. The plan acknowledges that the 40,000 is to keep pace with rising demand and states that further action will be needed in the final People Plan to hit a vacancy rate target of 5% by 2028 (currently 11% nationally). The full people plan will focus on concerted action in areas of nursing with the greatest shortages including mental health, learning disability and primary and community nursing.

The plan states that the Department of Health and Social Care (DHSC) will work to improve awareness and effectiveness of financial support programs for trainee nurses through the Leadership Support Fund (LSF).

The plan identifies new entry routes as a priority, proposing that the final People Plan explores the potential for a blended learning nursing degree programme with an online theoretical component. The plan also proposes the development of a clear model that sets out the different routes into nursing and their benefits, and an expanded pilot programme for nursing associates wishing to continue their studies to registered nurse level. Finally the plan proposes consideration of job guarantees at system level to maximise opportunities for nurses using the blended entry route to qualify.
NHS England will develop a new procurement framework for approved international recruitment agencies while STPs and ICSs will implement lead recruiter arrangements for staff coming from overseas as part of delivering 5 year workforce plans. This will be discussed at the next Kent and Medway HR Directors meeting to determine how this will be taken forward locally. NHS England has committed to working with the DHSC and progression regulators to streamline the regulatory process on international recruitment.

A review will be undertaken of levels of NHS undergraduate medical school places with potential to expand beyond the recent addition of 1500 places, and a national conversation will be launched on what patients and the public require of 21st century medical graduates.

A new internal medicine training model for junior doctors (initiating August 2019) aims to increase generalist expertise. The Trust has 7 junior doctors joining the Trust in August 2019 on the IMT program.

2.2 Improve our leadership culture

This theme seeks to address how the health service needs to develop and spread a positive inclusive person-centered leadership culture across the NHS, with a clear focus on improvement and advancing equality of opportunity. The plan signals a system-wide engagement on a new NHS leadership compact that will establish the cultural values and leadership behaviors expected from NHS leaders together with the support and development leaders should expect in return.

As part of delivering the compact, the regulatory oversight framework will be reviewed and it is anticipated that there will be contractual requirements for Trusts in future to meet in relation to areas including creating a healthy and compassionate culture, a focus on equality and diversity, and eliminating bullying and harassment. The expected additions to the NHS oversight framework will also inform future CQC well led assessments.

There will be a local, regional and national talent program and an expansion of the NHS Graduate Management Training Scheme.

In line with the Kark review recommendations, there will be greater oversight and governance of director roles including the creation of a central data base of directors, and their qualifications/skills sets to support quality assurance of director level post holders and to ensure Board members meet specified measures of competence.

2.3 Culture and making the NHS the best place to work

A new offer to NHS staff will be developed through consultation this summer to ensure the NHS rapidly becomes a better place to work. All local NHS systems and organisations are also expected to set out plans to make the NHS the best place to work (to be updated to reflect the people offer published as part of the full People Plan later in 2019).

An independent review of HR/OD best practice in the NHS will be carried out later in 2019.

The national NHS Improvement retention program will be expanded to all Trusts. A focus on boosting the numbers of nurses with lapsed registration to return to practice is also noted, and a campaign announced working with Mumsnet to launch a new marketing campaign to inspire nurses to enroll in return to practice courses and make them aware of opportunities and support available.
2.4 Developing a new operating model for workforce

The interim plan identifies a new operating model for increased workforce devolution to regions, ICSs and local organisations to be developed, using an ICS maturity matrix to benchmark workforce planning capabilities. The maturity framework will also inform decisions on the pace and scale of devolution of workforce activities.

2.5 Developing a workforce to deliver 21st century care

This focuses on support to local health systems (STPs/ICSs) to develop five-year workforce plans, as an integral part of service and financial plans, enabling us to understand better the number and mix of roles needed to deliver the NHS Long Term Plan and inform national workforce planning.

Other elements of the plan focused on supporting cross disciplinary and 21st century working include creating career paths that enable people to change and move into different roles and work in a more agile way. The plan therefore calls for a “transformed workforce with a more varied and rich skill mix” to support the move towards new care models. Specific proposals around workforce transformation include:

- Recruitment of an additional 7500 nursing associate trainees by December 2019.
- Work with the GMC and medical colleges to roll out credentialing.
- Support for every STP/ICS to put in place a collaborative approach to apprenticeships and maximise the levy.
- Training to ensure a core level of digital ability for all non-technical NHS staff.

2.6 NHS Pension Scheme

As part of the theme of making the NHS the best place to work, the government is bringing forward a consultation on pension flexibility for senior clinicians. The proposal would give senior clinicians the option to halve the rate at which their NHS pension grows, in exchange for halving their contributions to the scheme. This is a response to the concerns staff and employers have raised around the impact of lifetime and annual pension allowances.

Nationally, the impact of NHS pension allowances and tax charges is becoming an increasing issue, as high earners including consultants and other senior clinicians, look to ways of mitigating the potential impact including by considering requesting reduced hours, reducing additional activity including extra duty/waiting list initiative activity (supporting performance) and early retirement.

The current proposal is focused only on senior clinicians and does not include other staff. It is not yet clear how this proposal will be received and the impact it may have. The Trust will continue to monitor the impact of pension annual and lifetime allowances on operational activity and will seek advice and guidance including from other Trusts and legal advice on how best to respond.

3.0 Final People Plan

NHS Improvement is continuing to work with all partners to further develop the final People Plan which is scheduled for release later this year.

Nationally the next steps will include:

- Consultations highlighted on pension reform, leadership behaviours and HR and OD practice and system maturity.
- A summer of engagement led by the Chief People Officer Prerana Issar to develop the “offer” of the health service that will ensure the NHS becomes the best place to work.
- A new People Board, Chaired by Prerana Issar, and its advisory group, will oversee the development of the full People Plan later in 2019/20.

The significance of the upcoming spending review in supporting the final plan is indicated - including in relation to funding for CPD, financial support for international recruitment, and flexibility/ revisions related to the apprentice levy in order for this to be maximised across systems.

4.0 Trust actions in response to the plan include

- Assessing placement capacity to support a local increase in student nurse placements. A 33% increase could potentially be accommodated with funded practice development nurse support from HEKSS.
- In line with the aim to increase Trainee Nursing Associates the Trust has recruited a cohort of TNAs for September 2019 and a further cohort will be recruited in Spring 2020.
- Action is underway at STP level to develop a 5 year workforce plan for Kent and Medway STP.
- In line with developing a 21st century workforce, the Trust plans to extend e-rostering and e-job planning to all front line clinicians by 2020/21 and assessment of e-rostering and e-job planning systems is underway. The Trust is awaiting details of a national capital bidding process for funding associated with this role out and will also work with STP colleagues on developing a streamlined solution.
- The Trust will engage in developing a local plan and offer that supports developing the NHS as the best place to work. The Deputy Directors of HR and Nursing and Quality attended the NHS Improvement retention program masterclass in early June 2019 and the learning from the event will support the development of future plans.

5.0 Board action

The Board is asked to note the above paper.

Louise Lester
HR Director
June 2019
# TRUST BOARD – JULY 2019

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<th>Subject:</th>
<th>NHS Resolution Maternity Incentive Scheme 2019 (Year 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authors:</td>
<td>Michele Ahluwalia- Director of Midwifery&lt;br&gt;Valerie Elderkin – Interim Maternity Incentive Scheme Midwife</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Michele Ahluwalia- Director of Midwifery</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>To demonstrate evidence of Trust and Maternity Services compliance/progress against the ten safety priorities identified by NHS Resolution for 2019. The Maternity Incentive Scheme (MIS) was introduced last year to encourage Trust compliance against the ten ‘Safety Actions’. Each Safety Action contributes to safe, high quality care for women and families accessing the maternity service. Trusts are rewarded for compliance with a significant rebate on their annual CNST contribution. This year the ten themes are identical although the requirements are more stringent. For last year’s scheme, the paper was submitted in June 2018. Dartford &amp; Gravesham Trust was deemed to be compliant on all ten safety actions and received a total rebate of over £1 million. This paper provides details of our compliance/progress against the Year 2 formulations of the Safety Actions. There is an outline of the evidence provided within the shared drive to accompany this document.</td>
</tr>
<tr>
<td>Key points for the Trust Board:</td>
<td>Trust Board are required to feel assured that the evidence provided demonstrates compliance with the ten maternity safety actions meets the required standards as formulated by NHS Resolution in the Maternity Incentive Scheme Year 2 guidance document, and that self-certification is accurate. The content of this report has been shared with the commissioner of the Trust’s Maternity Services</td>
</tr>
<tr>
<td>Consideration of public and patient involvement and communication:</td>
<td>This document has been shared with North Kent Maternity Voice Partnership.</td>
</tr>
<tr>
<td>Recommendations:</td>
<td>The Trust Board are invited to consider this report and the accompanying shared drive evidence folder</td>
</tr>
<tr>
<td>Links to Board priorities, Board Assurance Framework, Trust Risk Register</td>
<td>Organisational Priorities&lt;br&gt;- Provide high quality, safe patient services&lt;br&gt;- Deliver financial sustainability and efficiency&lt;br&gt;- Strengthen operational efficiency and effectiveness&lt;br&gt;- Promote excellent education and personal development&lt;br&gt;- Proactive partner engagement&lt;br&gt;CQC Reference&lt;br&gt;Applicable to all five domains: safe, effective, caring, responsive and well-led.&lt;br&gt;Board Assurance Framework/ Trust Risk Register&lt;br&gt;Not applicable</td>
</tr>
<tr>
<td>Committee/ Meetings at which this paper will be discussed/ approved</td>
<td>Date</td>
</tr>
<tr>
<td>Obs &amp; Gynae Clinical Governance, Audit and Shared Learning Meeting</td>
<td>10.04.2019</td>
</tr>
<tr>
<td>Local Maternity System Executive Committee Meeting</td>
<td>15.04.2019</td>
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<tr>
<td>Trust Quality and Safety Committee</td>
<td>16.05.2019</td>
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<tr>
<td>June Executive Leadership Team</td>
<td>26.6.19</td>
</tr>
<tr>
<td>Trust Board Meeting</td>
<td>04.04.2019 &amp; 02.07.2019</td>
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<tr>
<td>Safety Action 1 Validation process:</td>
<td>8</td>
</tr>
<tr>
<td>Safety Action 1 Support Available:</td>
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<td>Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</td>
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<tr>
<td>Safety Action 2 Primary Evidence</td>
<td>9</td>
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<tr>
<td>Safety Action 2 Secondary Evidence</td>
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<td>Dartford &amp; Gravesham submissions to the NHS Digital Maternity Services Data Set:</td>
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<tr>
<td>Safety Action 2 Action points:</td>
<td>14</td>
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<tr>
<td>Safety Action 2 Validation process:</td>
<td>14</td>
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<td>Safety Action 2 Support available:</td>
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<td>Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?</td>
<td>15</td>
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<tr>
<td>Safety Action 3 Primary Evidence</td>
<td>15</td>
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<tr>
<td>Safety Action 3 Secondary Evidence</td>
<td>16</td>
</tr>
<tr>
<td>Linking evidence to standards:</td>
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</table>
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<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust’s progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Action 1: Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?</td>
<td>Required Standards:</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>a) 95% of NPMRT reviews started within 4 months of the death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) 50% of neonatal death reports in draft within 4 months of the death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Parents correctly involved in 95% of neonatal deaths</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Quarterly reporting to the Trust Board including details of all the deaths reviewed and consequent action plans.</td>
<td></td>
</tr>
</tbody>
</table>

**Linking evidence to standards:**

**Starting NPMRT reviews within 4 months of death**

All reviews at Darent Valley Hospital are commenced well inside the deadline of 4 months from the birth. The timings of registering the loss via the National Perinatal Review online tool are shown in evidence file *C. PMRT surveillance - completed cases Dec 2018 to June 2019*. The Maternity Governance midwife begins the review by populating the online tool with demographic details prior to the next monthly DVH Perinatal Review meeting.

**Multidisciplinary reviews complete and draft reports generated within 4 months of death**

All deaths at Darent Valley Hospital have been reviewed by the multidisciplinary team and draft reports produced with 4 months of death. *D. PMRT cases currently under review* shows that only the very recent cases remain under review in contrast with those commenced in *C. PMRT surveillance - completed cases May 2018 to March 2019*.

**Parents’ involvement in case reviews**

100% of affected families are contacted following a stillbirth or neonatal death within Dartford & Gravesham Trust. The Bereavement Midwife contacts women by phone initially. This is followed up with information about their choice to be involved or...
Quarterly reports via Quality and Safety Committee

Quarterly reports containing up to date information on all stillbirths and neonatal deaths are brought to the Quality and Safety Committee. This was agreed and minuted in April Quality and Safety Committee Minutes and will be reported every quarter from April 2019

Reporting on Perinatal Mortality at Dartford and Gravesham NHS Trust

Dartford and Gravesham NHS Trust registered for NPMRT on the 14th February 2018 and commenced using the system at the same time. The NPMRT tool has also been used to review cases that pre-date the launch. All reviews have been submitted and can be cross referenced by NHS England. See Tables 1 and 2 below, showing compliance data:-


<table>
<thead>
<tr>
<th>All Stillbirths/Non Registerable Deliveries</th>
<th>All babies that fit the criteria</th>
<th>All babies notified</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>36 Babies born</strong></td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Notifications made on stillbirths and non-registerable deliveries

<table>
<thead>
<tr>
<th>Babies Born (Breakdown)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscarriage ≤ 24 weeks gestation (Not notifiable)</td>
<td>14</td>
</tr>
</tbody>
</table>

| Termination of pregnancy (Not notifiable) | 12 |
Intrapartum Stillbirth & Neonatal deaths ≥ 22 weeks gestation (Notifiable)  

<table>
<thead>
<tr>
<th>Table 2: Breakdown of notifications made on stillbirths and non-registerable deliveries by category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early Neonatal Death ≤ 22 weeks gestation (Notifiable)</strong></td>
</tr>
<tr>
<td><strong>Intrapartum Stillbirth &amp; Neonatal deaths ≥ 22 weeks gestation (Notifiable)</strong></td>
</tr>
</tbody>
</table>

The named professional responsible for notifying perinatal deaths on the Maternity Unit and Special Care Baby Unit via this new system is the Clinical Governance Midwife.

The National Perinatal Mortality Review Tool (NPMRT) was launched by the Department of Health in February 2018. This is a bespoke web-based system which is fully integrated with the MBRRACE-UK perinatal mortality surveillance data collection system. This tool aims to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

It encourages:

- A review of all perinatal deaths.
- Investigations into the cause of death.
- Learning from incidents to shape and improve future care.
- Parent engagement in the process.
- Standardised approach to identifying themes in causes of death, targeting these areas to reduce rates.

**Perinatal death is defined as stillbirth or death in the first week of life. The perinatal period commences at 22 completed weeks of gestation, and ends seven completed days after birth.**

This type of review is not new for the Maternity Services. All perinatal deaths at Dartford and Gravesham NHS Trust have been
reviewed since 2011. Cases are presented, discussed and actioned at the Directorate Audit and Perinatal Meetings. An annual stillbirth report is produced.

At Dartford and Gravesham NHS Trust, all intrapartum stillbirths and early neonatal deaths from 37 weeks gestation (excluding terminations), are reported onto the Strategic Executive Information System (STEIS). This is in line with the NHS England National Framework for Reporting and Learning from Serious Incidents. This requires investigation (SIRI’s) with learning from serious incidents requiring investigation. All incidents are subject to a Root Cause Analysis (RCA), which is reported to the CCG, via the Trust Patient Safety Committee.

The Stillbirth Review Group, a multidisciplinary forum that meets monthly, discuss, analyse and review the clinical care provided in all perinatal death cases. This group commenced in April 2016 with the name changing in February 2018 to the Perinatal Mortality Review Meeting. This group reviews all antenatal intrapartum stillbirths and neonatal deaths, excluding terminations of pregnancy, from 22 weeks gestation. All cases since January 2018 have been systematically reviewed and reported using the NPMRT tool. Terms of reference, agendas and minutes of meetings are seen in the evidence template.

Prior to the start and completion of the RCA, parents are invited to send the author’s key questions that they require answers to. Parental engagement and feedback is further achieved through multidisciplinary meetings with the parents to debrief and/or discuss the findings of investigations. All RCA’s undertaken are shared with the parents, who receive a copy, and are offered the opportunity to discuss the findings.

As part of the Maternity Transformation Programme, a national ‘Stillbirth Information Hub’ has been created within the Promoting Safer Care Work stream. The Stillbirth Information Hub is a secure web platform for healthcare professionals to share tools and information about preventing avoidable stillbirth. Resources are made widely available including research evidence, innovative local practice around SBLCB, parent’s stories, and information on the perinatal mortality review and bereavement care. There are also discussion forums and events lists. The Hub is not public facing and will be refined over time in response to user feedback.

- Continue to use NPMRT to review all perinatal deaths in a timely way.
| Safety Action1 Action Points: | • Continue to share all learning raised from the meetings, or the RCA reports, and feedback to the staff via the monthly newsletter and follow-up presentations.  
• Continue to present and discuss all stillbirths at the Perinatal Mortality Review Meeting, imbedding lessons learned into clinical practice.  
• Continue to report quarterly to Quality and Safety Committee. |
| --- | --- |
NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15th August 2019. |
<p>| Safety Action1 Support Available: | None Specified. |</p>
<table>
<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust’s progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
</table>
| **Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** | **Required Standard:**  
NHS Digital issue a monthly Trust specific scorecard to data submitters (Trusts) which details compliance or non-compliance with submission requirements. The required score is 3/3 within the mandatory categories and 14/19 in the optional categories (see next page). | **YES – DGT has scored 3/3 (mandatory) and 15/19 (optional).** |
| **Safety Action 2 Primary Evidence** |  |  |
| **Safety Action 2 Secondary Evidence** |  |  |
|  | **• NHS Digital Dashboard 2018-19 [from Paul showing msds2 compliance]**  
  **• Maternity Services Data Set Model v2.0**  
  **• Maternity Services Data Set v1.5 Model for comparison**  
  **• Maternity Services Data Set v2.0 User Guide** |  |
<table>
<thead>
<tr>
<th>Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019</th>
</tr>
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<tbody>
<tr>
<td><strong>Mandatory categories 1-3 must be met to pass Safety action 2</strong></td>
</tr>
<tr>
<td>1</td>
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<td>21</td>
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<td>22</td>
</tr>
</tbody>
</table>
Linking evidence to standards:

As can be seen in the NHS Digital Scorecard Results (2018/19 scorecard) below, Dartford & Gravesham Trust are compliant with this safety action:

<table>
<thead>
<tr>
<th>Score</th>
<th>November 2018</th>
<th>December 2018</th>
<th>January 2019</th>
<th>February 2019</th>
<th>March 2019</th>
<th>April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory (out of 3):</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Optional (out of 19):</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 3: Maternity Services Data Set submission criteria met by month from NHS Digital

Successful compliance was achieved by:

- Quality of January 19 Data Submission measured against MSDS v1 criteria (see ‘Jan 19’ tab within NHS Digital Dashboard 2018-19 spreadsheet showing score of 15 for optional categories).

- Successful submission of MSDSv2 Data for April 2019 births and bookings by the June 2019 deadline (see ‘April 19’ tab within NHS Digital Dashboard 2018-19 spreadsheet showing score of 3 for mandatory categories).

Check that the reported results are accurate!
Dartford & Gravesham submissions to the NHS Digital Maternity Services Data Set:

The Maternity Services Data Set (MSDS) is a patient-level data set that captures key information at each stage of the maternity care pathway including mother’s demographics, booking appointments, admissions and re-admissions, screening tests, labour and delivery along with baby’s demographics, admissions, diagnoses and screening tests. As a secondary uses data set it re-uses clinical and operational data for purposes other than direct patient care. NHS Digital made Trust submission for the Maternity Services Data Set (MSDS v1.5) mandatory from 1st November 2014. Central submission commenced from June 2015 and Dartford and Gravesham NHS Trust commenced submission of maternity data on 1st June 2015. The launch of MSDS version 2.0 was planned for bookings and births data from April 2019 with first submissions in the window from 1st May to 30th June. MSDS v2.0 datasets are uploaded to a new web-based portal with 2-factor authentication (SDCS) making it more secure and versatile.

The MSDS v2.0 is designed to meet requirements that resulted from the National Maternity Review, which led to the publication of the Better Births report in February 2016. Better Births highlighted the need for Maternity Services in England to become safer, more personalised and to provide better access to information for pregnant women. The publication of Better Births resulted in the establishment of the Maternity Transformation Programme, and the updated version of the data set forms part of the ‘Sharing Data and Information’ workstream of the programme. The release of the MSDS v2.0 represents a significant change to the existing structure of the MSDS v1.5 and brings the MSDS into line with the core structures of other data sets maintained by NHS Digital, specifically the Community Services Data Set (CSDS) and the Mental Health Services Data Set (MHSDS).

Changes from MSDS v1.5 to MSDS v2.0

- Structural changes to the data set
- Removal of paper-based records exemption
- Introduction of clinical classifications and terminology, including SNOMED CT
- Capture more detailed diagnoses (using clinical terminology)
- Updated payment requirements (using clinical terminology)
- Capture more detailed procedures, observations and findings (using clinical
• Changes to the capture of smoking status
• Capture scored assessments during maternity care pathway (using clinical terminology)
• Capture data about continuity of carer
• Enable linkage to neonatal data
• Capture data about personalised care plans
• Capture intended and actual place of birth
• Capture data from existing data sets and collections, i.e. the CDS ‘maternity tail’ data set and other collections, to enable future retirement of overlapping collections
• Conformance with additional NICE guidelines and quality standards
• Additional data items, such as ‘overseas visitor status’
• Minor updates to the data set to remove redundant tables/items
### Safety Action 2 Action points:

- To work in collaboration between DVH maternity IT, DVH Business Intelligence Team and Wellbeing (Euroking) Software to ensure continuous improvement in the quality of the MSDS v2.0 data submission in anticipation of stricter criteria for Maternity Incentive Scheme Year 3.

### Safety Action 2 Validation process:

Self-certification report from CEO using electronic submission template from NHS Resolution (.xls file).

NHS Digital data will be used by NHS Resolution to cross-reference against Trusts’ self-certification.

### Safety Action 2 Support available:

Please see the general guidance available on the NHS Digital website.
<table>
<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust's progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
</table>
| **Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?** | **Required Standard:**  
   a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.  
   b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.  
   c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.  
   d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN. | **YES** |
| **Safety Action 3 Primary Evidence** | **Transitional Care Guideline and related Guidelines**  
   • WAC094 Neonatal Transitional Care Clinical and Operational Guideline 2019  
   • BAPM Framework Transitional Care Framework 2017  
   • NICE CG98 Neonatal Jaundice  
   • NICE CG149 Antibiotics for early onset sepsis  
   **Data submission compliance**  
   • Email from Badgernet re data submission compliance  
   • HRG activity comparison Jan-Apr 2019  
   • NCCMDS Neonatal HRGs and Reference Costs – A Guide for Clinicians |
<table>
<thead>
<tr>
<th>Safety Action 3 Secondary Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATAIN</strong></td>
</tr>
<tr>
<td>• Dartford Gravesham ATAIN Project Plan 2019-20</td>
</tr>
<tr>
<td>• RE: ATAIN at Darent Valley ODN and LMS acceptance of action plan</td>
</tr>
<tr>
<td>• South East Neonatal Network Governance Meeting Minutes 06-02-2019</td>
</tr>
<tr>
<td>• ATAIN update for the LMS 30-04-19</td>
</tr>
<tr>
<td>• ATAIN e-learning compliance 7-5-19</td>
</tr>
<tr>
<td>• ATAIN update for ODN 07-05-19</td>
</tr>
<tr>
<td>• LMS Quality and Safety Minutes 17.5.19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting Minutes and other related documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ATAIN Multidisciplinary Review Meetings 2019</td>
</tr>
<tr>
<td>• NIPE meetings with ATAIN discussions</td>
</tr>
<tr>
<td>• Perinatal meetings with ATAIN reviews</td>
</tr>
<tr>
<td>• Study Day 1 including thermoregulation</td>
</tr>
<tr>
<td>• Antibiotic Use for Early Onset Neonatal Infection in Transition Care</td>
</tr>
<tr>
<td>• Keeping_Mothers_and_Babies_Together_Pathway_GIRFT1</td>
</tr>
<tr>
<td>• NHS Improvement ATAIN Insights November 2018</td>
</tr>
<tr>
<td>• NHS Improvement findings and resources for ATAIN 2017</td>
</tr>
<tr>
<td>• Ratification of TC guideline 2019 – perinatal meeting May 2019, Labour ward forum June 2019</td>
</tr>
</tbody>
</table>
Linking evidence to standards:

a) Pathways of care for admission into and out of transitional care are detailed in the recently updated guideline ‘WAC094 Neonatal Transitional Care Clinical and Operational Guideline 2019’. This guideline was developed by the neonatal sister with input from the neonatal team. Section 5 outlines the responsibilities of both medical and neonatal staff and their involvement in decision making and care planning for all babies in transitional care. The guideline is based on the principles within the ‘BAPM Neonatal Transitional Care Framework 2017’ from the British Association of Perinatal Medicine.

b) Dartford & Gravesham Neonatal Unit uses Clevermed’s BadgerNet System which includes functionality to produce commissioner returns for Healthcare Resource Groups (HRG). This capability is evidenced in ‘Email from BadgerNet re data submission compliance’ from Clevermed’s Chief Operating Officer. As an example of this capability, document ‘HRG activity comparison Jan-Apr 2019’ shows the required information from DVH neonatal activity coded appropriately.

c) The ATAIN action plan - ‘Dartford Gravesham ATAIN Project Plan 2019-20’ - was accepted by the ODN on 7th March 2019 as evidenced in the email – ‘RE: ATAIN at Darent Valley ODN and LMS acceptance of action plan’.

d) Progress with the ATAIN action plan was shared with the Trust Board on 04.04.19 as minuted. The LMS was updated on 26th April 2019 at the Quality and Safety Work stream Meeting as per ‘LMS Quality and Safety Minutes 26-04-19’. The ODN Network Administrator was offered an update on 30th April but was unable to provide a point of contact in the absence of an ODN lead in post and unable to provide any future meeting dates. An alternative email address was provided for a senior contact at NHS England as per ‘ATAIN update for ODN 07-05-19’.

Transition Care Services at Darent Valley Hospital:

“There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.” - Michele Upton, Head of Maternity and Neonatal Transformation Programmes NHS Improvement, February 2018
Dartford and Gravesham NHS Trust have Transitional Care facilities in place since 2012. Transitional care is a model of care, in the maternity setting, where mothers are resident with their babies and providing care with the support of health care professionals such as midwives, neonatal nurses and paediatricians. The aim of Transitional Care is to keep the mother and baby together whenever possible to optimise their physical and mental health. Virtual Transition Care involves the care of mothers and babies by midwives on the postnatal ward with support and input from the neonatal team e.g. where the baby may require antibiotics or blood testing.

The Transitional Care admission criteria are based on ‘BAPM Neonatal Transitional Care Framework 2017’. This includes caring for babies with sepsis, prematurity, jaundice requiring phototherapy and Intrauterine Growth Restriction (IUGR) below 1.8kg. Agreed care pathways exist for each clinical concern. Management of babies with jaundice and early onset neonatal sepsis are based on ‘NICE CG98 Neonatal Jaundice’ and ‘NICE CG149 Antibiotics’ for early onset sepsis. The WAC094 Neonatal Transitional Care Clinical and Operational Guideline was updated in May 2019 and agreed by neonatal and maternity staff at the May Perinatal Meeting and June 2019 Labour ward forum.

Transitional Care babies are looked after in one of four dedicated rooms on Walnut Ward Neonatal Unit. Virtual Transitional Care babies are looked after on Cedar Ward (mixed antenatal and postnatal ward) and Aspen Ward (postnatal ward). The staffing ratio for these babies is 1:4 trained neonatal nurses to four babies. The trained nurse is assisted by a support worker. In addition, mothers of VTC babies can be supported by ward midwives to care for their babies according to neonatal team care plans. The staffing establishment is compliant with the 2017 BAPM framework.

Dartford & Gravesham Neonatal care data submissions using Badgernet software are sufficient to meet Neonatal Critical Care Minimum Dataset introduced by in 2007 and we currently submit data according to both NNCCMDS v1.0 and v2.0 (2016 version). The NNCCMDS 1.0 reporting will cease this year and it is an MIS requirement for Trusts to successfully report according to the v2.0 (2016) version from April 2020.
The ATAIN Project at Darent Valley Hospital:

The ‘Avoiding Term Admissions into Neonatal Units’ (ATAIN) project was introduced by NHS Improvement in early 2017 as part of Maternity Transformation Work stream 2: Promoting Good Practice for Safer Care. It focuses on four key clinical areas that present a significant amount of potentially avoidable harm to babies, including avoidable separation from their mothers:

- Hypoglycaemia
- Jaundice
- Respiratory conditions
- Asphyxia (Hypoxic-Ischemic Encephalopathy)

The aim of the project is to ensure that units are learning lessons from each term admission that could potentially have been avoided, and therefore driving down the term admission rate, reducing harm to babies and keeping mothers and babies together.

The project was rolled out nationally, and Dartford & Gravesham Trust formed an ATAIN Project Group in September 2017. Dartford & Gravesham Trust meet regional and national targets for avoiding unnecessary term admissions.

ATAIN project group initially met as part of the monthly Newborn Infant Physical Examination (NIPE) meetings. From April 2018, all term admissions to the SCBU, expected and unexpected, have been reported at the monthly perinatal meeting. There was some loss of momentum on the project during 2018 partly due to the appointed ATAIN midwife not being available for the role with no reassignment of the role until March 2019. As a result, opportunities were missed to learn from specific cases of term admissions.

The last ATAIN project group meeting within the NIPE meeting was in May 2018, although individual case reviews continued to be presented by maternity staff at the monthly Perinatal meeting. The 2019 ATAIN action plan was submitted to the local Operational Delivery Network and Local Maternity System prior to March 10th 2019. Within the plan, it was identified that there was a lack of joined-up working between the neonatal team and the maternity team. ATAIN case review meetings were re-introduced in April 2019 with representatives from the maternity and neonatal teams, including a new appointment into the role of lead midwife for ATAIN. Maternity and neonatal staff are now working collaboratively to review ATAIN cases and feed learning points into the ATAIN Action Plan as SMART goals.
ATAIN online training for all Maternity and Neonatal staff became mandatory at the Trust in January 2018. Staff completing maternity Study Day 2 are reminded to complete the ATAIN e-learning during the study day. Compliance for this training is monitored by the Lead Midwife for Clinical Education and currently stands at 58.6%.

An update on the ATAIN project plan was provided to the Trust Board on 04.04.19 at the Board Meeting, and updates for the LMS and ODN were provided on 26th April 2019 and 7th May 2019.

| Safety Action 3 Action points: | • Continue to provide and develop the Transitional Care facilities at Darent Valley Hospital.  
• Keep up momentum with the ATAIN Project as detailed on the 2019/20 Project Plan.  
• Implement actions arising from individual ATAIN case reviews  
• Increase ATAIN e-learning compliance for Maternity and Neonatal staff. |
|---|---|
NHS Resolution will cross-check the Trusts’ self-reporting with Neonatal Operational Delivery Networks to verify the Trust’s progress against this action. |
<table>
<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust’s progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
</table>
| **Safety Action 4: Can you demonstrate an effective system of medical workforce planning?** | **Required Standard:**  
   a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who ‘disagreed/strongly disagreed’ with the 2018 General Medical Council National Training Survey question: ‘In my current post, educational/training opportunities are rarely lost due to gaps in the rota. In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.  
   b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSafety Action) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. | **YES** |
| **Safety Action 4 Primary Evidence** | **GMC Trainee Survey Results:**  
   • DVH GMC National Training Survey Result 2018 for MIS  
   • DGT Latest News 30 Oct 2018 from Website  
   • Notes of the Clinical Executive Directors Committee - August 2018 - see 8.4.4 GMC Survey results presented  
   **DGT Medical Staffing Guidelines**  
   • WAC052 Staffing Levels (Obstetricians) Care v6 July 18  
   • WAC053 - Staffing Levels Anaesthetists v5 Aug 17  
   **ACSafety Action Standards at DGT:**  
   • Action Plan to meet standard 1.2.4.6 [Rebecca King?]  
   • Anaesthetic rota demonstrating 24-7 cover for epidural provision |
Safety Action 4 Secondary Evidence

- Confirmation of anaesthetic involvement in ward rounds
- GMC Survey Results 2018 presented 07-08-18 to Clinical Executive Directors Committee
- Royal College of Anaesthetists AC Safety Action standards 2018

Linking evidence to standards:

The Clinical Director for Women’s Services has confirmed that the Trust is compliant with Safety Action 4 for Maternity Incentive Scheme Year 2.

Dartford & Gravesham have been Highly Commended by the General Medical Council for our performance on the 2018 National Training Survey within Obstetrics and Gynaecology. Only one trainee out of eighteen disagreed with the statement that training opportunities are rarely lost. Full details of answers to this question are shown in the word document: ‘DVH GMC National Training Survey Result 2018 for MIS’. This information was presented at Board level, as evidenced in: ‘Notes of the Clinical Executive Directors Committee - August 2018 - see 8.4.4 GMC Survey results presented’. See image file: ‘DGT Latest News 30 Oct 2018 from Website’ for internal reporting on the accolade.

There is no action plan in place to meet AC Safety Action standards 2.6.5.1 or 2.6.5.6 as these standards are met at Darent Valley Hospital. The ‘Anaesthetic rotas demonstrating 24-7 cover for epidural provision’ (Primary Evidence file) provide evidence that standard 2.6.5.1 is met. Duty anaesthetists participate in labour ward rounds. Evidence for this is by way of an email from the Lead Anaesthetist for Delivery Suite, ‘Email confirmation of compliance with AC Safety Action 2.6.5.6’ in ‘confirmation of anaesthetic involvement in ward rounds’ file within the Primary Evidence file.

The team does not support a dedicated anaesthetist each week day to cover elective cases in obstetric theatre. An action plan has been escalated to Board level to increase anaesthetic staffing with a view to moving towards this standard [Rebecca King?, Kim Pennington?] (See Primary Evidence file). As the Trust Board has had sight of this action plan, we are compliant with the NHS Resolution Safety Action 4 part B.
General Medical Council National Training Survey 2018

Safe staffing is key to the provision of safe effective care. Short term safety is reliant on having enough clinical staff for the care of women and families according to acuity. Longer term safety is reliant on having enough staff for the everyday workload in addition to the learning and teaching activities which are just as essential to providing safe care. Nationally, there have been identified gaps in middle-grade rotas. These gaps are often filled by consultants or trainees who are moved from other clinical sessions. This compromises the safety and care of women in other areas and limits learning opportunities for trainees. Trainee Doctors’ responses to the General Medical Council National Training Survey provide an accurate if indirect measure of safety of medical staffing.

Dartford & Gravesham NHS Trust has won recognition from the RCOG for the high standard of training facilitated here as evidenced by trainee survey responses, and are therefore compliant on this strand with no action plan required.
Dartford & Gravesham meeting ACSafety Action labour ward staffing standards:

Dartford and Gravesham NHS Trust, has a single site for inpatient maternity care based at Darent Valley Hospital. Obstetric staff work between Delivery Suite, Antenatal Clinic, Tambootie Maternity Assessment Unit, Cedar Ward (mixed antenatal and postnatal) and Aspen Ward (postnatal). They will attend alongside Midwifery Led Unit (The Birth Centre) in response to an emergency call. Within the rota, Obstetric staff will also have responsibility for gynaecology patients’ care elsewhere in the hospital.

The Obstetric Directorate has 14 middle grade (registrar level) doctors and 10 Senior House Officers who provide 24 hour cover to the Delivery Suite on a rotational basis. This ensures 24-hour Middle Grade and SHO doctor cover in supporting the Consultant Obstetrician on call for Labour Ward.

The Clinical Director has the overall responsibility for ensuring appropriate obstetric staffing levels are maintained. The draft duty rotas are approved by the Clinical Director in order to identify areas of shortfall in advance. Appropriate action is taken to ensure safe staffing levels i.e. arrange for locum cover. Once approved, duties are not changed without the knowledge and authorisation of the Clinical Director. Staffing levels are reviewed by the Clinical Director and General Manager to ensure that targets contained in the ‘Safer Childbirth’ document (see Safety Action 5 evidence file) are met. Identified shortfalls are discussed at directorate meetings and business cases are produced as appropriate. Incident reporting is used to identify any shortfalls in staffing.

At Darent Valley Hospital, there has been investment of time and resources for the training and welfare of Speciality and Associate Specialist (Safety ActionS) doctors. All are supported and encouraged to complete their RCOG and ATSM exams. During the last financial year, one registrar has successfully completed the Certificate of Eligibility for Specialist Registration (CESR) and taken up a consultant post. The post was backfilled internally allowing opportunities for progression for one middle grade doctor and one trainee. Retention rates within the DGT maternity department over the last year for middle grade doctors have been 100%. This highlights the department’s commitment to valuing staff and developing excellence.

In the event of increased workload or unplanned sickness, the Clinical Director or deputy is informed. A consultant is identified to
cover Delivery Suite who does not have clinical (patient contact) sessions. Cover arrangements are made by coordinated contact across the consultant body.

Minimum Obstetric Staffing Levels:

- 1 Consultant present on the Delivery Suite: Monday – Sunday 8:30am – 9 pm (‘Hot week’)
- Outside these hours 1 Consultant is on-call (not resident).
- 1 middle grade / registrar is present on Delivery Suite at all times and 2 middle grades at night.
- 1 Consultant on call at night (off site)
- 1 SHO is present on Delivery Suite at all times.

Anaesthetic staff are present on Delivery suite 24/7 to cover the epidural service, respond to emergencies, and enable multi-disciplinary input into complex cases e.g. in the event of severe haemorrhage or sepsis.

A team of 3 anaesthetist operate Monday to Friday during the daytime:
Consultant anaesthetist
Middle-grade anaesthetist
Junior anaesthetist

Overnight and at weekends, two middle-grade anaesthetists are present and one consultant anaesthetist is on-call.

Anaesthetic staff participate in a ward round which commences with a board round and includes face to face assessments for all women requiring anaesthetic input. It is not appropriate for anaesthetic staff to routinely review all women admitted to delivery suite.

The team does not support a dedicated anaesthetist each week day to cover elective cases in obstetric theatre. An action plan has been escalated to Board level to increase anaesthetic staffing with a view to moving towards this standard [Rebecca King?, Kim Pennington?].
<table>
<thead>
<tr>
<th>Safety Action 4 Action points:</th>
<th>• To increase anaesthetic staffing to move towards meeting ACSafety Action standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Action 4 Support available:</td>
<td>None Specified.</td>
</tr>
<tr>
<td>Safety action – please see the guidance for the detail required for each action</td>
<td>Evidence of Trust’s progress</td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>
| **Safety Action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard? | **Required Standard:**  
  a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed.  
  b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service.  
  c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on).  
  d) A bi-annual report that covers staffing/safety issues is submitted to the Board  
  Information from any consecutive three month period between January and July 2019 can be considered for this safety action. January to March 19 data has been used. | YES |
| **Safety Action 5 Primary Evidence** | **Bi-annual Reporting to Trust Board**  
  - Midwifery Safe Staffing Review May 2018  
  - Maternity Response to BirthRate+ November 2018  
  - Midwifery Safe Staffing Review June 2019  
  **Midwife to Birth Ratio**  
  - Midwife to Birth Ratio – Methods of Counting Review 2017  
  - BirthRate+ Report October 2018  
  - Maternity Response to BirthRate+ November 2018  
  - Maternity Dashboard as at March 2019 – Core sheet | |
## Safety Action 5 Secondary Evidence

| • Midwife to Birth Ratios on Risk Register as at February 2019 |
| **Supernumerary status of Labour Ward Coordinators** |
| • Supernumerary status of labour ward coordinator survey results |
| **Monthly Maternity Dashboard** |
| • Monthly Maternity Indicators Dashboard at end March 19 – Core sheet |
| **One-to-one Care in Labour** |
| • One-to-one care in labour poll results |
| • One-to-one deliveries excluding BBAs |
| **Maternity Staffing Red Flag reporting** |
| • Maternity Dashboard as at March 2019 – Local sheet |
| • Safety Thermometer v25 with red flag questions |

## Background

| • National Maternity Workforce Strategy March 2019 |
| • DVH Midwifery Staffing Regional and National Perspective 2018 |
| • DVH Specialist Midwifery Team Contact with Women November 2017 |
| • DVH Maternity Annual Statistics April 2019 |

## Minutes

| • Combined Agenda and Papers Trust Board June 18 – see 6.5 B1 |
| • Combined Agenda and Papers Trust Board – see 1-14 J1 |
| • Combined Agenda and Papers Trust Board – see 1-8 E |
| • Combined Agenda and Papers Trust Board – see 1-8 in minutes |
| • **Minutes for presentation of safe staffing May/June 2019** |
| • Clinical Solutions Minutes April 2019 |
Additional items

- DVH maternity evidence no agency staff used 2018-19
- DVH maternity staff bank figures 2018-19
- Trust Safe Staffing Information January 2019
- Trust Safe Staffing Information February 2019

Guidelines

- WAC060 - Staffing Levels (Midwifery) Guideline (September 2017)
- WAC099 - Labour Ward Staffing Guideline (January 2017)
- WAC103 - Maternity Bleep Holder Guideline (September 2018)
- NICE Guideline Safe midwifery staffing in maternity settings 2015

Linking evidence to standards:

**Systematic, evidence-based process to calculate midwifery staffing establishment**

Dartford and Gravesham can demonstrate an effective system of midwifery workforce planning. BirthRate+ is a systematic, evidence-based process to calculate midwifery staffing establishment. The process was carried out during 2018 with extensive reporting to the Trust Board in January 18, June 18 and December 18 (via Workforce committee). The following files in the primary evidence folder provide details of the method and findings: *Midwife to Birth Ratio – Methods of Counting Review 2017, BirthRate+ Report October 2018*, and *Maternity Response to BirthRate+ November 2018*. The BirthRate Plus report suggests an establishment of 153.99 WTE midwives and 17.11 WTE support workers, in contrast with an agreed establishment of 147.33 WTE midwives and 10.89 WTE support workers. Analysis in response to the BirthRate Plus findings led the Directorate to conclude that the current funded establishment is sufficient. Key factors are the national decline in the birth rate of 2.5% and the Trust investment in 4.71 WTE scrub nurses who will release midwives from scrubbing in theatre to support acuity across the unit. This analysis was accepted by the Trust Board in November 2018. See Minutes file within Secondary Evidence file.

Scrub nurses are now covering the elective caesarean sections during working hours. An action plan is in place to increase the use of Trust scrub nurses in theatre and eventually exclude midwives from scrubbing in theatre to release them for more midwifery specific activity. The next stage of the project should be complete by July 31st and will result in one scrub nurse being available from 8am to 1pm Monday to Friday to cover the elective list, and another scrub nurse being available from 8am to 6pm...
seven days a week to cover emergency caesareans during these hours.

**Supernumerary Status of Labour Ward Co-ordinator**

Trust Policy demonstrates that as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status. The *WAC099 - Labour Ward Staffing Guideline (v4) Jan 17* policy in the secondary evidence folder supports this policy. A survey of labour ward co-ordinators was carried out to confirm that we are achieving this standard. Overall, 86% of DGT labour ward coordinators agree that they are supernumerary all or most of the time. See report: ‘Supernumerary status of labour ward coordinator survey results’.

**One-to-one Care in Labour**

Women receive one-to-one care in labour as set out in *WAC099 - Labour Ward Staffing Guideline (v4) Jan 17*. One-to-one care is where a woman in established labour receives care from a designated midwife for the whole of that labour, or the midwife’s whole shift whichever is the shorter. The midwife will be available to care for the woman 100% of the time. At the end of the shift, if necessary, care will be handed over to another designated midwife, who will continue one-to-one care of that woman. Midwives enter data into the E3 maternity system following each delivery as to whether the woman had one-to-one care in labour. The percentage of deliveries each month where the woman had one-to-one care are reported via the ‘core’ sheet of the monthly Maternity Dashboard. The *Monthly Maternity Indicators Dashboard at end March 19* shows the following figures for monthly one-to-one care in labour:

<table>
<thead>
<tr>
<th></th>
<th>Jan 2019</th>
<th>Feb 2019</th>
<th>Mar 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of deliveries where the woman received one-to-one care in labour</td>
<td>98.4%</td>
<td>95.1%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

*Table 4: One-to-one care in labour figures reported via E3*

These figures include BBAs – deliveries where the baby was born before the arrival of a qualified healthcare professional. BBAs can happen at home or en route to hospital, and have a small impact on the figures for one-to-one care in labour. The following table from *One-to-one deliveries excluding BBAs* shows the adjusted figures when BBAs are excluded on the assumption that
one-to-one care is impossible to provide in these cases:

<table>
<thead>
<tr>
<th>Percentage of deliveries (excluding BBAs) where the woman received one-to-one care in labour</th>
<th>Jan 2019</th>
<th>Feb 2019</th>
<th>Mar 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.7%</td>
<td>97.2%</td>
<td>98.9%</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: One-to-one care in labour figures adjusted to exclude ‘born before arrival of healthcare professional’ deliveries

**Workforce planning including safety of staffing is reported bi-annually at Trust Board level.**

The Maternity Safe Staffing review is reported bi-annually to the Trust Board. The *Maternity Safe Staffing Review May 2018* was followed by *Midwifery Services Workforce Planning and Decision Making November 2018* and the *Maternity Safe Staffing Review May 2019* (see primary evidence folder).

**Midwifery Workforce Planning at Darent Valley Hospital:**

Midwifery workforce planning at Darent Valley Hospital is underpinned by the principles of the following documents:

- RCM Guidance on Implementing the NICE Safe Staffing Guideline on Midwifery Staffing in Maternity Settings (2016).
- Maternity Transformation Workforce Report- Five Year Forward View for Maternity (March, 2019).
All women are entitled to receive appropriate and safe care where ever they choose to give birth. The Maternity Services at Dartford and Gravesham NHS Trust provides individualised packages of care, based on the woman’s choice. This includes home birth (1.15%), low risk birth in the Birth Centre (co-located midwifery led unit) (14.4%) and birth in the hospital consultant-led Delivery Suite and Theatre (>80%). Only 1.13% of women give birth unattended before they can reach the planned place of birth or be attended at home. Maternity staffing reflects the differing requirements between the care settings.

Local planning for staffing and skill mix reflects the local model of care, case load diversity and complexity, the needs of women, their families and service design. The Director of Midwifery has overall responsibility for maintaining a safe midwifery workforce across all areas and undertakes monthly staffing reviews. The findings of these reviews are reported as a Midwife to Birth Ratio on the Maternity Dashboard which is shared with the Directorate Managers, Executives, Finance and Human Resource Teams. A comprehensive account of the review of maternity staffing was presented to the Trust Workforce Committee by the previous Head of Midwifery in January 2018 and May 2018. The paper was also presented to the Trust Board in January 2018 and the May 2019 review of staffing was presented at Workforce Committee on 18th June 2019.

The Royal Colleges have highlighted the need for a ratio of midwives to births of 1.30 to achieve safe staffing levels for the expected birth rate. However, there are differing methods used to calculate midwife to birth ratios, and BirthRate Plus is now used by Dartford & Gravesham maternity service to provide a standardised methodology. The BirthRate Plus tool is used to benchmark existing establishments for midwifery and support staff at Dartford & Gravesham NHS Trust. This tool allows a mixed skill adjustment for the addition of Band 3 staff to support the midwifery role. Evidence of the calculation methodology can be found in the BirthRate Plus Report October 2018. The BirthRate Plus assessment in October 2018 calculated a target ratio at Dartford & Gravesham NHS Trust of 1:28.7 based on the case mix and the activity levels across all maternity care settings. The report suggested a shortfall in establishment of 6.66 WTE midwives and 6.22 WTE Band 3 Support Workers. The Maternity Department response, agreed with the Trust Board in November 2018, provided assurance that the current funded establishment supports the delivery of safe quality care in line with National Guidelines and national benchmarks.

Two key factors must be considered to support this response. Firstly, there was a national decline in the birth rate of 2.5% in from 2016 to 2017 and a decline in deliveries at Dartford & Gravesham Trust of 2.1% was seen in the same period. The decline appears to be stabilising with a drop of only 0.4% from 2017 to 2018. Secondly, the Trust invested in 4.71 WTE scrub nurses who can release
midwives from scrubbing in theatre to support acuity across the unit.

The original plan to remove midwives from scrubbing in obstetric theatres was set out in four phases. At a theatre action group set up to monitor and deliver the actions required to achieve this it was decided to amalgamate the 4 phases. So phase 1 and 2 are being worked on together with a completion date set for 31st July 2019:

- Phase 1 - provision of a scrub nurse from 08:00 – 13:00 on weekdays to cover the elective list
- Phase 2 – provision of a scrub nurse from 08:00 – 13:00 on weekdays and provision of a scrub nurse from 08:00 to 18:00 seven days a week to cover emergency cases.

At present a scrub nurse has been attending Delivery suite Monday 08:00 – 16:00 and Tuesday – Friday 08:00 – 18:00. This scrub nurse assists with emergency cases once the list is complete. However, midwives are still required to scrub for emergencies while the elective list is in progress and outside the scrub nurse work hours. The theatre group plan to meet monthly to review progress.

The BirthRate Plus adjusted calculation is reported monthly via the maternity dashboard and gives a current midwife to birth ratio of 1:29.7 (as at March 2019). The Director of Midwifery is evaluating options to address the suggested shortfall in support workers.

The Human Resources team provide additional monthly workforce data, regarding vacancy, turnover, sickness and appraisal rates. This assists with ongoing safe midwifery workforce planning. Workforce issues are discussed monthly at the Senior Midwifery Managers Meeting and the Maternity Operational Leads hold monthly rota meetings to identify staffing gaps and take the required actions.

The Maternity Services recognises the importance of retaining experienced staff as well as being proactive in future workforce planning and are active participants in the Trusts Working Longer Group. Data from this forum is utilised to map the age profile of the midwifery staffing group against the requirements for recruitment and student midwives in training. The Senior Management team are supportive of and have facilitated several flexible working and retirement options over that past 5 years to maintain a balanced skill mix across the unit and in the community setting.

Quarterly decisions are made on maternity workforce realignment and uplift by the collaborative Senior Management team. This includes the Clinical Director, Business Manager, Director of Midwifery and the Senior Midwifery Management team. It is also
important to note that no midwifery agency staff are used by the Maternity Unit. Shortfalls in staff are covered by an internal system of bank, drawn from existing substantive staff. This further supports safe staffing and the bank supply of staff is adequate for safe staffing requirements.

**Safe Midwifery Staffing Operations:**

A daily assessment and ongoing monitoring of staffing levels, capacity and acuity is undertaken by the Maternity Bleep Holder. This assessment is an effective method of maternity and neonatal workforce monitoring. Bleep cover is provided Monday-Sunday for a minimum of 8 hours during the day. Outside these hours, the Labour Ward Coordinator assumes the maternity bleep holder responsibilities. The bleep holder will make formal rounds of all areas, including SCBU, at least three times a day, at the start of the day, lunchtime and prior to handover to ensure:

- Staffing is adequate.
- Workload against staffing is adequate.
- Bed and cot capacity is available.
- Elective activity is possible.
- Acuity of women and babies in each area is known.
- The unit is safe to function.

In order to ensure safe and effective care within the Delivery Suite setting, there is always a supernumerary Band 7 midwife (or in their absence an experienced Band 6 midwife with no current caseload) coordinating each shift. There are situations when this is not possible, to ensure patient safety. However, as noted above, a recent survey of all labour ward coordinators, where 12 of the 14 coordinators responded (86%), indicated that supernumerary status is achieved at least 75% of the time.

Their role is to:

- Receive hand over from previous shift coordinator regarding patients on Delivery Suite and any concerns regarding other patients within the maternity unit.
- Liaise with the obstetric, anaesthetic and paediatric teams regarding women’s management and plans of care and report any concerns regarding medical care to the consultant on call.
- Ensure that there is appropriate allocation of staff to workload and re-deploy when necessary i.e. midwives with appropriate experience are allocated high risk cases and that midwives (including limited experienced staff) receive adequate leadership, supervision, support and advice when dealing with cases requiring a level of expertise above their experience.
- Ensure equipment, stock and facilities are available and ready for use. This can be delegated to staff i.e. checking of resuscitation units, theatre, delivery rooms and maintenance of adequate stock levels.
- Prioritise workload in conjunction with medical colleagues.
- Ensure staffing levels are appropriate for the following shifts and report any deficiencies to lead manager.
- Hold the maternity bleep in the absence of the midwifery bleep holding manager and on a rotational basis.
- Be an expert practitioner and competent in all aspects of midwifery care on Delivery Suite.

**Red Flags**

With the publication ‘Safe midwifery staffing in maternity settings, NICE Safe Staffing Guideline’ (February, 2015), NICE introduced the idea of Maternity Staffing Red Flags. These are events that should flag up concerns to the Bleep Holder, Coordinator or Midwives in Charge that there may be a problem with staffing necessitating a redeployment of existing acute staff or the need to call in support. Red flags include:

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
Each unit is free to choose the Staffing Red Flags which are most relevant to their workload. The Dartford & Gravesham maternity service has been reporting on the following red flags since June 2018:

1) Delay of 30 minutes or more administering requested pain relief
2) Service user considers that staff have become so busy that they feel neglected or unable to ask for things

Service users are surveyed monthly via additional questions to the pre-existing ‘Safety Thermometer Questionnaire’, and the results are reported on the Monthly Maternity Indicators Dashboard.

There is scope to improve and extend the use of staffing’ Red Flags’. Ideally, red flag events would be tracked in real time to facilitate the labour ward co-ordinator and bleep holder in deploying staff appropriately across the unit. Additional red flags have been identified which would be useful to track including delays in transfer to delivery suite during the induction of labour process of more than 6 hours, and delays in postnatal discharge once well and ready to leave of more than 4 hours.

<table>
<thead>
<tr>
<th>Safety Action 5 Action points:</th>
<th>• The Director of Midwifery will continue to present six monthly safe midwifery staffing reviews to the Trust Board. These reports will also now contain the completion of a desktop exercise using the BirthRate Plus. • Work will continue with the project to remove midwives from the role of scrub nurse in obstetric theatres. • Improvement in use of Red Flags – real time reporting, and including both induction delays and discharge delays.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Action 5 Support available:</td>
<td>None specified</td>
</tr>
<tr>
<td>Safety action – please see the guidance for the detail required for each action</td>
<td>Evidence of Trust’s progress</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Safety Action 6: Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle? | Required Standard:  
   a) Ability to demonstrate Board level consideration of the SBL care bundle (version 1 2016) in a way that supports the delivery of safer maternity services.  
   b) Each element of the SBL care bundle has been implemented or that an alternative intervention put in place to deliver against element(s).  
   Trusts should be evidencing the position as at end July 2019. |
| Safety Action 6 Primary Evidence | • Maternity incentive scheme year one results overview  
• Saving Babies’ Lives – NHS England  
• Combined Agenda and Papers Trust Board June 18 – see item 6.5 – attachment B1  
• Combined Agenda and Papers Trust Board July 18 minutes showing Year 1 compliance  
• SBL1 Reducing Smoking in Pregnancy  
• SBL 2 Risk Assessment and surveillance for fetal growth restriction  
• SBL 3 Raising awareness of reduced fetal movement  
• SBL 4 Effective Fetal Monitoring in Labour  
• Audit  
• Guidelines  
• Global Stillbirths country income and causes pie charts – BJOG 2017  
• NHS England saving babies’ Lives Care Bundle version Two | YES |
Linking evidence to standards:

This Safety Action has not changed from Maternity Incentive Scheme Year 1 requirements. Dartford & Gravesham NHS Trust achieved compliance in Year 1 along with 110 other Trusts nationwide (84% national compliance). See ‘Maternity-incentive-scheme-year-one-results-overview’ spreadsheet from NHS Resolution (link: https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-one-results-overview/). The Trust remains compliant and has continued to develop all aspects of the Saving Babies’ Lives Care Bundle. This document outlines the significant changes and improvements since detail of the Saving Babies’ Lives v1 Care Bundle was brought before the Trust Board as part of the Maternity Incentive Scheme report in June 2018.

It is worth noting that should the Maternity Incentive Scheme run into a third year, there is a strong possibility that Trusts will need to comply with Saving Babies Lives Care Bundle v2, details of which were published during March 2019 (see secondary evidence file for ‘NHS England saving-babies-lives-care-bundle-version-two’). There is an NHS England commitment to fully implement the second version of the care bundle by 30th March 2020.

Saving Babies’ Lives Care Bundle v1:

Stillbirth is a pervasive problem worldwide with 2.6 million babies were estimated to have died in utero in 2015. 98% of these deaths occur in developing countries. In high-income countries, rates are generally much lower, one in 113–769 pregnancies end in stillbirth after 28 weeks. The six-fold variation in the incidence of stillbirth in high income countries, suggests that a large proportion of stillbirths are possibly preventable (Norman et al. 2018, Lancet).

In November 2015 the then Secretary of State for Health announced a new ambition to reduce the rate of Stillbirths in England by 50% by 2030 and 20% by 2020. In November 2017, the ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the 50% stillbirth reduction was brought forward to 2025. In response to the extended ambition, SBLCB version two (SBLCBv2) additionally includes the aim to reduce preterm birth and improve outcomes when preterm birth is unavoidable to further decrease perinatal mortality. NHS England published ‘Saving Babies Lives- A care bundle for reducing stillbirth’. The aim of this care bundle is to bring together four research-based interventions, to make care safer for mothers and
babies:

1) Reducing smoking in pregnancy.
2) Risk assessment and monitoring of fetal growth restriction.
3) Raised awareness of reduced fetal movements.
4) Effective fetal monitoring during labour.

The stillbirth rate at DVH has been:

![DGT Stillbirth Rate by calendar year 2013 to 2018](image)
Trusts receive regional level feedback which is benchmarked against national performance, identifying areas for improvement in all 4 elements. The Maternity Services at Dartford and Gravesham NHS Trust adopted all four elements of the care bundle and submit detailed reporting to NHS England quarterly via the Saving Babies Lives Care Bundle Survey (commenced March 2016). This survey allows NHS England to track the success of the implementation across trusts and regions. It is clear from the November 2018 survey update, that although almost all trusts have now implemented all four elements of the care bundle, there is still work to ensure that
every aspect of each element has been implemented in every trust to ensure gold standard practice. [Insert image from survey results] With the commitment to implementing SBLCBv2, work will continue in every trust to improve quality and safety and drive down the stillbirth rate further. An evaluation of the effectiveness of SBLCBv1 shows that although stillbirth rates have fallen steadily since the introduction of the care bundle, there is no robust statistical evidence that this can be attributed to the SBLCB interventions. SBLVBv2 cautions the overuse of obstetric intervention in the absence of confirmed pathology.

Reducing Smoking in Pregnancy

Evidence-based research strongly suggests that reducing smoking in pregnancy significantly reduces the incidences of stillbirth and has a positive impact on premature birth, miscarriage, low birth-weight and Sudden Infant Death Syndrome (SIDS). The Kent and Medway Local Maternity System has funded a band 7 Smoking Cessation Midwife post at DGT since February 2018. The Smoking Cessation Midwife’s key mission is to oversee the full implementation Element 1 of the Saving Babies’ Lives Care Bundle and to meet the Government’s target to reduce pregnancy smoking prevalence to 6% by 2022.

The key strategic priorities for this role along with a detailed progress report are set out in ‘Smoking in Pregnancy Annual Report 2018’ in the Safety Action 6 secondary evidence folder. Headline achievements include a reduction in the percentage of smokers at time of delivery (Safety ActionTOD rate) from 11.6% to 9.6% in one year. This has been a multifactorial initiative with increased referrals to stop smoking services, increased use of carbon monoxide breath testers for pregnant women, and the introduction of a new stop smoking antenatal clinic. Work continues with a key next step to be improving assurance around the data quality of smoking status figures.
Risk assessment and monitoring of fetal growth restriction

Research based evidence suggests that fetal growth restriction presents the greatest risk for stillbirth. This view was supported by the MBBRACE report (2017) which found that sub-optimal screening for fetal growth disorders contributed to the death in 25% of stillbirth cases. It is vital to screen effectively as growth restricted babies are at much higher risk of morbidity and mortality. In severe cases of fetal growth restriction, the baby will need to be delivered as the risk of continuing the pregnancy would be unacceptably high. In less severe cases, the risk is managed with close fetal monitoring in labour.

The Perinatal Institute (PI) provides tools for assessment of fetal growth and birth weight by defining each pregnancy’s growth potential through the Gestation Related Optimal Weight (GROW) software. Dartford and Gravesham NHS Trust implemented the (GROW) programme in May 2016. The GROW programme allows us to accurately define each pregnancy’s growth potential through customised charts which then monitors and changes care plans as a pregnancy advances. The software package includes GROW chart, GROW centile and GROW services.
Since the introduction of the GROW Programme all pregnant women cared for at Dartford and Gravesham NHS Trust have:-

• A customised growth chart (where appropriate)
• A comprehensive booking risk assessment, utilising the RCOG Green Top Guideline stratification algorithm - this allows placement on the required care pathway.
• Fundal height measurements, as per regime, using a standardised technique and plotted on the GROW chart.
• A referral for ultrasound for a growth scan as per care pathway identified at booking or through ongoing antenatal surveillance of fetal growth and maternal health.
• Serial growth scans when increased risk of fetal growth restriction is identified during the pregnancy.

GROW training is part of the Maternity Induction Programme for new starters and part of the preceptorship programme for newly qualified midwives. Each midwife is given a competency document which has been developed to ensure clinicians’ knowledge, understanding and competence in evidence-based fetal growth surveillance. Following training, observation and supervised practice, the clinician is:

• Knowledgeable about the importance of fetal growth and the impact of fetal growth restriction on the fetus during pregnancy, labour, the postnatal period and on long term health.
• Knowledgeable about the assessment and recognition of risk factors before and during pregnancy.
• Competent in the assessment of fetal growth during pregnancy, it’s recording on customised charts and the indications for referral for further investigation.

A GROW pathway notes audit was carried out in September 2018. It was found that use of GROW charts was widespread (found in 97% of notes) and charts for women not requiring serial USS scans were generally filled out correctly (81%). However, women with minor risk factors were not being assigned to minor risk pathway (only 14%) and women with major risk factors were not always scanned 3 weekly as per guideline (only 43%). Worryingly, SFH measurements were not always triggering appropriate referral (only 63%).
In response to this audit, the GROW guideline was revised to move from the RCOG risk assessment algorithm to an algorithm founded on NHS England ‘Saving Babies’ Lives’ guidance which is ensures ultra-sound scanning resources are targeted for those women and babies that need them most. The algorithm is also less confusing for clinicians and therefore better compliance is expected. A re-audit is planned for August 2019, six months from the implementation of the revised GROW guideline (February 2019).

The audit also called for better ongoing collection of information to assess the effectiveness of the GROW program. Within the software is the capability to provide management information on our ability to correctly detect fetal growth restriction antenatally and to act appropriately. To collect this information, midwives entering birth information in the immediate postnatal period need to enter babies’ birthweights into the GROW software (accessed via Adagio) together with whether or not antenatal growth restriction was detected. This information has been requested since February 2019, and collection rates set to improve month on month.

### Submission Rates

#### (a) Number of Charts Produced¹

<table>
<thead>
<tr>
<th>Hospital / Trust</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
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<tr>
<td>Darent Valley Hospital</td>
<td>527</td>
<td>507</td>
<td>472</td>
<td>459</td>
<td>502</td>
<td>472</td>
<td>555</td>
<td>530</td>
<td>427</td>
<td>572</td>
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<tr>
<td>Dartford &amp; Gravesham NHS Trust</td>
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<td>507</td>
<td>472</td>
<td>459</td>
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<td>530</td>
<td>427</td>
<td>572</td>
<td>459</td>
<td>547</td>
</tr>
</tbody>
</table>

#### (b) Number of Centiles Produced²

<table>
<thead>
<tr>
<th>Hospital / Trust</th>
<th>Predicted No. of births per year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
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<td>7</td>
<td>2</td>
<td>4</td>
<td>1</td>
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</tbody>
</table>

**Notes**

1. Based on the date the GROW chart was produced
2. Based on baby date of birth
Raised awareness of reduced fetal movements.

Maternal perception of fetal movement is one of the first signs of fetal life and is regarded as a positive indicator of fetal wellbeing. Conversely, clinicians have long recommended that pregnant women pay attention to fetal movements so that they can use a change or reduction in fetal movements as a screening tool to seek healthcare assistance for the unborn baby. Some studies have suggested that increasing maternal awareness of the recommendation to report reduced fetal movements can lead to a reduction in stillbirths. Certainly, 30–55% of women whose pregnancies end in stillbirth retrospectively report having experienced RFM in the preceding week. However, a Cochrane review in 2012 found a lack of high quality research to support this view. More recently, the AFFIRM study (2018) using data from over 400,000 pregnancies across the UK failed to show a statistically significant reduction in stillbirth following initiatives to increase women’s reporting of reduced fetal movements to healthcare practitioners. Reporting of reduced fetal movements continues to be encouraged as part of the overall strategy to reduce stillbirth, and the Saving Babies’ Lives Care Bundle outlines the care pathway to be followed.

Dartford and Gravesham have a comprehensive Trust Policy WAC143 Fetal Monitoring (Antenatal) which includes management of reduced fetal movements. The guideline details the appropriate action required with an easy to follow flow chart (see Guidelines folder). The flow chart is displayed in both our Maternity Assessment Unit and Fetal Assessment Unit and is clearly visible for midwives and obstetricians to consult. Midwives are able to request growth scans which simplifies the process. The flowchart meets the Saving Babies’ Lives guidance, with all women (of 28 weeks gestation or more) presenting with Reduced Fetal Movements having a cardiotocograph for at least 30 minutes, and being referred to a middle-grade obstetrician if there are relevant risk factors for stillbirth. Obstetricians assess on an individual patient basis and refer for an urgent growth scan where appropriate. In addition, all women of appropriate gestation are referred for an urgent growth scan following a second attendance for reduced fetal movements.

Dartford and Gravesham NHS Trust originally developed a leaflet for pregnant women in 2005 ‘Reduced Fetal Movements Information for Pregnant Women’. This leaflet has been regularly updated, with the latest revision in 2017, in line with the recommendations of RCOG Green-Top Guideline No. 57. Additional information on reporting reduced fetal movements is printed in the maternity hand held notes booklet for ease of reference for women.
Women are strongly encouraged to contact Tambootie Maternity Assessment unit if they have any concerns about their babies’ movements. All women are asked about their baby’s movements at every antenatal appointment after 20 weeks, and encouraged to get to know their babies’ unique pattern of movements during the second trimester. They are made aware of the importance of reporting any change or reduction in babies’ movement during the third trimester. Women can also contact the unit for review if a change or reduction of movements at any gestation from 18 weeks onwards leaves them with concerns. The Maternity Assessment Unit’s telephone number is printed on the front of the maternity hand held notes and indicated to women during appointments.

DGT Maternity unit conducted in audit of Reduced Fetal Movements accessing scan reports from all women presenting with reduced fetal movements for the first time, with a gestation of 32 weeks or greater, over a 4 month period in late 2018. It was found.

Effective fetal monitoring during labour

The labour process can place stress on a fetus, and a healthy, well-grown fetus is physiologically adapted to cope with the demands. However, babies that are growth restricted, or unwell, or have other significant risk factors, will need to be monitored more closely during labour. The challenge to the fetus is the cessation of perfusion of the placenta during contractions leading to a natural hypoxaemia in the fetus. The assessment of fetal wellbeing through heart rate monitoring is a key component of intrapartum care and is essential in identifying fetal compromise. There are two commonly used methods of fetal heart rate monitoring in labour, continuous cardiotocograph (CTG) monitoring and intermittent auscultation with a handheld Doppler. If the fetal heart rate pattern is normal, it is virtually certain that the fetus is coping well with labour and is not suffering from hypoxia (negative predictive value for intrapartum hypoxia is 98-99%).

The method of fetal heart monitoring will be recommended by the midwife or obstetrician based on whether the women and fetus are deemed ‘high risk’ or ‘low risk’ for labour. There is a strong evidence base that ‘low risk’ women will have better outcomes with intermittent auscultation, as it is just as good at detecting fetal compromise for these babies, and less likely to lead to unnecessary medical intervention. CTG monitoring can prevent women adopting the instinctive body movements and positions of labour, which facilitate the physiological process. Furthermore, it is well known that CTG monitoring increases the risk of unnecessary intervention, as it has a positive predictive value for intrapartum hypoxia of only 40-60%.
**Cardiotocograph (CTG) monitoring during labour** is a well-established method of confirming fetal wellbeing and screening for fetal hypoxia during a high risk labour. Despite the drawbacks of CTG as a screening tool, it provides far more detailed information to the obstetrician than intermittent auscultation, and enables timely and life-saving intervention for many high-risk labours. In many situations such as administering epidural anaesthesia or artificial augmentation of labour, it would be unethical to do so in the absence of continuous monitoring.

The interpretation and classification of a CTG is a high level skill and is subject to variations that can potentially lead to inappropriate care planning and impact on perinatal outcomes.

Dartford and Gravesham NHS Trust base the Fetal Monitoring Guidelines on NICE guidance “Intrapartum care for healthy women and babies’ (2017). As a result of the findings and recommendation of the RCOG ‘Each Baby Counts’ Report (2015) the Trust have implemented:

- A rolling yearly mandatory, all day, training programme ‘CTG Master Class’ that includes CTG monitoring and interpretation, intermittent auscultation for all midwives and obstetricians. (Since 2015). A register of compliance is kept by the Practice Development Midwife.
- Updated Guidelines: WAC044 Fetal Monitoring - Continuous Electronic and Fetal Blood Sampling Guideline (December 2107) and WAC144 Intermittent Fetal Heart Rate Auscultation in Labour (April 2017). These include clear guidance on appropriate use of either electronic fetal monitoring or intermittent auscultation, management in situations where the CTG is abnormal and clear lines of communication when an abnormal CTG is suspected.
- K2 online mandatory training (since 2017) to further compliment and consolidate learning.
- A buddy system known as ‘Fresh Eyes’ to review CTG traces. All continuous CTGs are reviewed and interpreted by an additional midwife every two hours. The midwifery coordinator will also review each continuous CTG at intervals; this is documented in the notes, on CTG sticker and on the coordinators handover sheet. Since implementation, this practice has been widely accepted and welcomed by the midwifery and obstetric staff and is now an integrated part of every-day practice.
- A laminated copy of the NICE criteria to determine features (baseline fetal heart rate, baseline variability, presence or absence of decelerations, presence of accelerations) and categorisation, as recommended by NICE, is attached to each of the CTG machines on Delivery Suite, Maternity Triage and the Fetal Assessment Unit as a prompt/reminder to staff.
A pre-printed sticker for recording the CTG features, categorisation and overall review with plan of care. The stickers are completed hourly documenting the current features and the previous hours’ features alongside each other, thus giving a visible comparison which helps decide whether or not referral is required their roles.

An audit during 2017 gave reasonable assurance that intermittent auscultation is being carried out according to guidelines. Following from the audit, the training as part of the CTG masterclass days was updated to address the findings. Monitoring and improvement continues led by the operational lead for the Birth Centre were most low-risk labour care is provided.

During 2019, the CTG sticker has been redesigned to clarify the difference between CTG interpretation and CTG classification. Interpretation is the examination of the individual features of the CTG trace and the description of each feature as ‘reassuring’, ‘non-reassuring’ or ‘abnormal’. Classification is the overall assessment of the trace as ‘Normal’, ‘Suspicious’, or ‘Pathological’ taking into consideration each feature and it’s description. A pathological CTG necessitates an emergency response to deliver the baby by the quickest route.

Weekly drop-in CTG case review sessions were introduced early in 2019 by a consultant obstetrician with medico-legal expertise. All involved with fetal monitoring are invited to come and consolidate their CTG knowledge.

Further information, including data, regarding the Saving Babies’ Lives Care Bundle can be seen in the Maternity Annual Report.

**Action points:**

- Continue work to reduce the rate of smoking in pregnancy as per the Smoking in Pregnancy Annual Plan and meet the requirements of SBLCBv2 for reducing smoking.
- Nominate leads for GROW, Reduced Fetal Movements and CTG and reducing prematurity, to implement the requirements of SBLCBv2
- Re-audit the GROW programme (August 2019)
- Increase GROW postnatal data collection to >95% and introduce reporting on effectiveness of antenatal SGA detection
<table>
<thead>
<tr>
<th>Validation process:</th>
<th>Self-certification report from CEO using electronic submission template from NHS Resolution (.xls file).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety action – please see the guidance for the detail required for each action</td>
<td>Evidence of Trust’s progress</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **Safety Action 7 Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?** | Required Standard:  
User involvement has an impact on the development and/or improvement of maternity services.  
January 2019 to July 2019 | YES |

| Safety Action 7 Primary Evidence | Overview of Capturing Women’s Feedback in Maternity  
- Capturing Women’s Views a summary of approaches 2019  
Maternity Voices Partnerships:  
- MVP service user role description – NHS England template  
- Email follow-up from the Maternity Voices Partnership web seminar Dec 18  
CQC National Maternity Survey  
- CQC National Maternity Survey Results DVH September 2018  
- CQC National Maternity Survey DVH Action Plan 2018/19  
- Email confirming presentation dates for the DGT CQC Maternity Survey 2018  
Responding to women Phlebotomy example:  
- Phlebotomy Letter of Complaint |
| Safety Action 7 Secondary Evidence | Phlebotomy response to complaint  
|                                    | Email - Change in Clinic by deputy manager following a complaint  
| Responding to women Birth Centre example: | Email regarding listening to women in the Birth Centre  
| Additional evidence: | 15 Steps Findings 2019  
|                                    | Friends and Family results  
|                                    | STAR Awards  
|                                    | Birth Options Antenatal Care Pathway.  
|                                    | DGT CQC Maternity Survey Report 2017 Executive Summary  
|                                    | DGT Patient and Public Experience and Engagement Workshop Jan 19  
|                                    | Email – Difficulty of booking onto Parent Education courses May 18  
|                                    | Facebook feedback DVH Maternity 18-19  
|                                    | Email – Weekly Complaints Spreadsheets as of 14 Feb 2019  
|                                    | Your Views Matter Leaflet.  
|                                    | Your Views Shape the Maternity Services Poster.  
|                                    | Health watch online maternity survey  
|                                    | Making Maternity voice Partnerships Work – event dates - 2018  
|                                    | Maternity CQC engagement presentation – October 2018  
|                                    | Maternity Services Your Views Matter Leaflet  
|                                    | Microsite Site Map 1 Parent Ed design  
|                                    | NHSUK public website feedback 18-19  
|                                    | Parent Education Report 2019 containing class feedback  
|                                    | WAC076 Patient Information and Discussion Guideline v4 May 18  
|                                    | Your views shape the maternity services poster |
Linking evidence to standard:

Dartford and Gravesham NHS Trust Maternity Services have a wide range of patient feedback mechanisms. MIS compliance during Year 1 was demonstrated via reporting from the Women’s Experience Lead and Maternity Services Liaison Committee minutes, together with feedback via Friends and Family reports, social media, NHS Choices (now NHS.uk) the CQC National Maternity Survey, informal Trust surveys, Patient Advice and Liaison Service, Professional Midwifery Advocates, Parent education evaluation forms and emails.

Mechanisms for feedback are very similar in Year 2 and recent examples of feedback and responses to feedback are detailed below. However, Maternity Services Liaison Committees have been replaced by Maternity Voice Partnerships which has led to a drop in available feedback via this route during the last 12 months. Consequently, the establishment of strong Maternity Voice Partnerships (MVPs) is a key priority for the Dartford & Gravesham Maternity Service during 2019 in line with the Trust commitment to put the service user at the centre of care. New MVP Chairpersons have been appointed by the Local Maternity System, and the ‘MVP service user role description – NHS England template’ is available in the primary evidence folder. There are now four MVPs across Kent reflecting the four acute Trusts in our Local Maternity System area. At Dartford & Gravesham we will also link in with the London based MVP which provides a voice to service users from the Bexley area.

The CQC National Maternity Survey provides an overview on the strengths and weaknesses of the service in terms of the service-user experience. The results as outlined in ‘CQC National Maternity Survey Results DVH September 2018’ are good. The action ‘CQC National Maternity Survey DVH Action Plan 2018/19’ shows how the unit will use the survey to continue to improve the experience of women and families.

As an illustration of continuous service improvement in response to patient feedback, evidence is included from Antenatal Clinic where the phlebotomy service received a complaint. The service has since been improved to minimise inconvenience to a) needle phobic patients and b) to any patients who need to re-attend following an unsuccessful blood test. See ‘Phlebotomy Letter of Complaint’, ‘Phlebotomy response to complaint’, and email ‘Change in Clinic by deputy manager following a complaint’.

Another example comes from a women’s complaint that her concerns weren’t listened to by Birth Centre staff when she was advised to go and mobilise around the hospital following a diagnosis of latent phase of labour. She delivered her baby in a public area within the hospital after rapid progress left her unable to make her way back the Birth Centre. As a result of this incident, the Birth Centre Manager has introduced an emphasis at staff meetings on the policy of ‘listening to women’. Cases are discussed to
empower staff to weight women’s intuitions on their own labour progress more highly when making clinical assessments. See evidence within Primary Evidence file → Responding to Women Birth Centre example file.

**Patient feedback mechanisms at Dartford & Gravesham Maternity Service:**

Within the Maternity Department at Darent Valley Hospital we actively invite service-users and their families to evaluate and comment on their experience of the services they receive, to ensure continuous improvements in the maternity care provision. The Maternity Department has a Women’s Experience Lead Midwife, who coordinates the process of gathering, analysing and disseminating the views of women and their families back into the maternity services. A comprehensive overview of feedback mechanisms is set out in the updated Women’s Experience Report ‘Capturing Women’s Views, A Summary of Approaches, 2019’. Service-user experiences and opinions of the Maternity Services are extremely important in leading and developing individualised care pathways for women and their families in the Dartford, Gravesham and Bexley areas. Local opinion and needs shape the Maternity Services at Dartford and Gravesham NHS Trust.

**Maternity Voice Partnerships**

March 2017 saw the publication of NHS England’s ‘Implementing Better Births: A Resource Pack for Local Maternity Systems’. NHS England recommended the establishment of independent formal multidisciplinary committees to be called ‘Maternity Voices Partnerships’ or MVPs (with existing Maternity Service Liaison Committees to be renamed as MVPs). The aim of the MVPs is to influence and share in local decision-making. All women in each local area should be able to participate in an MVP by giving feedback via the group or becoming a member. Partners and families may also wish to give feedback or join a partnership. ‘MVP service user role description – NHS England template’ is available in the primary evidence folder.

The Kent & Medway Local Maternity System covers the same geographical area as the Kent and Medway STP, encompassing approximately 20,000 births annually. Four MVPs support the Local Maternity System: Maidstone and Tonbridge Wells MVP, East Kent MVP, North Kent MVP and Medway MVP. Dartford and Gravesham maternity service also has links with Bexley Maternity Voice Partnership as approximately 30% of women birthing at Darent Valley Hospital come from the Bexley area.

The aim of the MVPs (and previously the MSLCs) is to ensure that maternity services providers and commissioners take account of the views of women and families using the service, and that individual choices and needs of women, their partners and babies, are...
placed at the centre of our maternity services. MVPs are attended by service users, commissioners, a variety of health care providers and various members of the maternity team from Dartford and Gravesham NHS Trust. The local maternity system has funded a part-time chairperson for the North Kent MVP who was appointed in April 2019.

More recently, women have been attending the Kent and Medway LMS in order to give their views. The Director of Midwifery or her representative is always in attendance and maternity performance data, services and new incentives are presented. The collective group make decisions and recommendations that shape the Maternity Services as Better Births recommendations are implemented.

**Friends and Family Test Surveys (FFT)**

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It was rolled out from 2013 to 2015 and recommendations for improvements to the feedback mechanism are planned. In the maternity service, the aim is to collect Friends and Family Feedback at three points during the maternity journey: 36 week antenatal appointment (feedback about antenatal care), on leaving the postnatal ward (feedback about intrapartum care and postnatal ward care) and on discharge from community midwife to health visitor and GP (feedback about community postnatal care). The questions are expressed as ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment? A descriptive six-point response scale is used to answer the question: Extremely likely, Likely, Neither likely nor unlikely Unlikely, Extremely unlikely, or Don’t know

The FFT feedback can be given via paper forms distributed to women, or online via the Trust Intranet ‘ADAGIO’. All maternity antenatal patient hand held notes have a QR code on the front which can be scanned using a smart phone and contains the Friends and Family Questionnaire. This can be completed and submitted using this code. However, this is not being promoted at the present time and many midwives are unaware of this. Paper forms are not currently being provided for the antenatal period or for the community postnatal period. However, on the postnatal ward, paper FFT feedback forms are provided at discharge. Maternity staff encourage women to complete the related questionnaires and place in the boxes provided.

Responses are collected and analysed by the Trust Lead for FFT. Common themes and specific issues are addressed. The findings are regularly disseminated throughout the Trust and to the patient experience leads. They are also available in the public domain. This information is further cascaded throughout each clinical area within the Maternity Service addressing the positive and negative comments. Most importantly it will address actions taken to resolve identified issues. Each maternity clinical area has a white board which display the comments and action taken from the findings. In reality, our maternity service rarely receives negative comments.
almost all are very positive, positive or neutral, and for this reason the ‘You said, we did’ section usually remains unpopulated.

At the present time, FFT is not being effectively collected for the antenatal period or for the community postnatal period and this is an area for improvement.

**Facebook and Twitter**
The Trust has an active Facebook account where parents are invited to comment on their experience either positive or negative. All comments are fed back to the Head of Midwifery via the Communications Team. These comments are disseminated to the relevant areas and staff involved are also informed. The majority of the feedback is positive and complementary, from thankful families (see secondary evidence file).

**National Websites for NHS feedback**
There are two national websites for providing feedback; NHS.uk and Care Opinion:

* **NHS.uk (reviews by hospital)**

* **Care Opinion**
  [https://www.careopinion.org.uk/youropinion](https://www.careopinion.org.uk/youropinion)

Parents are informed of this portal to comment on their maternity experience. An example of feedback is shown below:

🌟🌟🌟🌟🌟 **Anonymous** gave Maternity services at Darent Valley Hospital a rating of 5 stars

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**magnificent Maternity Department**

I recently supported my daughter give birth to a beautiful girl. The whole experience was nothing more than brilliant. From the hypnobirthing course to the postnatal care, my daughter was treated with care, professionalism and encouragement. Although her stay was for 5 days and included 4 different wards, what impressed me most was the excellent teamwork shown by the midwives, doctors and support staff. In particular the midwives were outstanding midwives. Thanks to all of you, though, in a difficult climate for maternity units.
CQC Regular Inspections
Dartford and Gravesham NHS Trust was inspected by the CQC in November 2017 and their findings were published in March 2018. The inspection included a ‘deep-dive’ review of maternity. The inspection team spoke to women, families, staff and managers. The CQC Inspection rated the Maternity Services as ‘good’ overall.

Fifteen Steps
First impressions give us an initial feeling about any situation. On first arriving on a ward, it is possible to assess whether it inspires confidence in the care that women are about to receive. Key questions of the 15 steps challenge include:

- What makes us trust a care environment?
- What makes us feel that we will be safe and cared for?
- What are the first clues to high quality care?
- What does ‘good’ look, feel, sound and smell like?

The 15 Steps Challenge is a toolkit with a series of questions and prompts to guide on the first impressions of a ward. The Challenge will help gain an understanding of how patients feel about the care provided and how high levels of confidence can be built. This tool can also help Trusts understand and identify the key components of high quality care that are important to patients and carers from their first contact with a ward.

The Challenge is designed to help trusts on their continuous improvement journey. By enabling the patient’s voice to be heard clearly, the tool can be used to highlight what is working well and what might be done to increase patient confidence. It is conducted within the Trust with an alliance of staff and voluntary members of the public. 15 Steps strongly aligns with a range of strategic initiatives including supporting improvements to quality, safety and patient experience. It is sponsored by the Trust senior leaders and forms part of wider improvement activity.

The 15 Steps Challenge has recently been completed and results are positive and can be viewed in the Secondary Evidence file.

Patient Advice and Liaison Service (PALS)
PALS are a confidential service for people, who would like information, help or who wish to comment about any aspect of the services provided at the hospital. The PALS officer provides the opportunity for women to raise in confidence, any issues and
comments that they might have about the care and service received from staff. PALS act as a liaison between service users and the Maternity Department, ensuring that the concerns of women and their families are heard and acted upon. PALS plays an important role in service improvement.

**Ward Surveys/ Patient Satisfaction Questionnaire**
Women and their families are invited to comment on their hospital stay and care before transfer home. Women’s satisfaction surveys are undertaken within the Maternity Department when a common theme is expressed by parents. This might involve reviewing local facilities and services.

**Professional Midwifery Advocates (PMA)**
PMAs are practicing midwives with additional training. They protect the public through the support of safe midwifery practice. They provide guidance and information to women and families about the right type of care, in the right place. Their philosophy is ‘no decision about you without you’. PMA’s support women to safely achieve the birth outcomes they choose. During their one to one meetings women often provide valuable feedback regarding the care they receive. PMA’s disseminate this information to the relevant areas to facilitate and support service improvements.

**Health watch England and Health watch Bexley**
Health watch England is the national consumer champion in health and care. The organization have significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. Local Health watch organisations can undertake visits to the Maternity Unit, talking to parents and collating views. The last Health watch visit was in 2014. Health watch have currently launched a survey to gather women’s views on the maternity services.

**PLACE Inspection**
Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. The yearly PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. Dartford and Gravesham NHS Trust has participated in PLACE since its introduction in April 2013. The assessment is completed across various areas of the Trust. The assessments see local people go into wards and departments as part of teams to assess how the environment supports patient’s privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staffs are doing their job.
Charities and external advisors
The Maternity Services will actively invite external reviewers to gain valuable feedback that can be utilised to support quality care improvements. For example, following negative feedback from the Kent Stillbirth and Neonatal Death Charity Safety ActionNDs and maternity staff regarding the newly refurbished bereavement room, representatives from the charity were invited to work alongside maternity staff to pilot the new facility and make recommendations. Changes were made accordingly. Dartford and Gravesham Maternity Services continues to work alongside Safety ActionNDS and other bereavement charities to ensure the best possible care for bereaved families.

STAR Awards (Staff thank you and recognition awards)
These awards give patients and staff members a chance to say "thank you" to those who they feel have gone above and beyond expectations. STAR awards replace the previous staff recognition scheme: ‘Every Thank You Counts’. Two members of staff from the maternity service (one obstetrician and one midwife) were finalists for the Annual Staff Awards in 2018. The Dartford and Gravesham Bereavement Midwife recently won a STAR award following exceptional feedback from a service user (see secondary evidence file).

Parent Education Evaluations & Surveys
Evaluations of the parent education programme are important and help to provide feedback and modifications of the programme. This information is gathered using paper evaluation and there is an online survey. Qualitative and quantitative data is obtained from parent education evaluations. This data is reviewed and the findings help shape and refine not just the parent education services but also the Maternity Services.

General Feedback
Women can feedback to us directly or ask us a question by using a form provided on the DGT website.
https://www.dgt.nhs.uk/contact-or-visit-us/feedback/
This form states that we value feedback as it helps us to continue to improve the care we provide to our patients both in our hospitals and in the community. We would encourage women to tell us what they think - good or bad. The Trust wants to hear what women have to say. This helps us to ensure we continue to be the "Hospital of Choice" for local people.

Formal Complaints
Dartford and Gravesham NHS has a clear pathway for service users to either compliment or make a complaint regarding care and
treatment they received. The Trust leaflet ‘How to Make a Complaint’ clearly outlines the process and contains a contact telephone number and email address. Receiving compliments and complaints is important to ensuring good quality healthcare, helping us to find out more about what we’re getting right and where we can improve.

All responses are provided by the Chief Executive and there is the option to attend a local resolution meeting. The Trust website contains information to support service users to write a formal complaint and details of the Independent Complaints Advocacy Service (ICAS).

**Food Evaluation**
The Dietetics Department regularly undertake surveys throughout the Maternity Department in relation to the strengths and weaknesses of the meals provided. The surveys are analysed and acted upon and an example of the action taken is shown in the specific menus now available for women with gestational diabetes and ethnic minority women.

**Personal Feedback to Individual Professionals**
Staffs within the Maternity Services regularly receive women’s feedback in the form of letters, cards, Emails and verbal comments. These are reflected upon via the annual review meetings held with staff and at the revalidation meetings with the PMA.

| Safety Action 7 Action points: | • Support the Local Maternity System to build and maintain a thriving network of Maternity Voice Partnerships so that the service-user voice is at the centre of maternity service development and design.  
• Build links between staff and service users via the MVPs.  
• Improve collection of FFT responses for community midwifery for the antenatal and community postnatal periods, and in Antenatal Clinic.  
• Explore the use of the NHS Improvement, Patient Experience Development Framework. This self-assessment tool will further support the Patient Experience Lead to carry out an organisational diagnostic in order to establish the extent to which ‘Improving Patient Experience’ is embedded both within its culture, and its operational processes. |

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<table>
<thead>
<tr>
<th>Item 7-15. Attachment J - Maternity Incentive scheme July 19 Board MIS Submission Final V2</th>
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<tbody>
<tr>
<td>Continue work on the digital offering in maternity to ensure that women can easily book places in parent education classes</td>
</tr>
<tr>
<td>Continue work on the DGT maternity microsite following a survey of 119 members of the public.</td>
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</table>

**Safety Action 7 Validation process:**

- Self-certification report from CEO using electronic submission template from NHS Resolution (.xls file).

**Safety Action 7 Support available:**

- None Specified
<table>
<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust’s progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
</table>
| **Safety Action 8 Can you evidence that 90\% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?** | **Required Standard:**
Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands on workshops.

The training syllabus should be based on:
- Current evidence, national guidelines/recommendations.
- Relevant local audit findings.
- Risk issues and case review feedback.
- Include the use of local charts, emergency boxes, algorithms and pro-formas.

There should also be feedback on local maternal and neonatal outcomes.

**Maternity staff attendees should include 90\% of the following groups:**
- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota).
- Obstetric anaesthetic consultants
- All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota.
- Midwives (including midwifery managers and matrons, community midwives, birth centre midwives and bank/agency midwives).
- Maternity theatre and maternity critical care staff (including operating... | **YES** |
| Safety Action 8 Primary Evidence | 90% Compliance Calculations:  
|                                 | • Training Compliance Calculations for Maternity Incentive Scheme Year 2.xls |
| Safety Action 8 Secondary Evidence | CTG and Fetal Monitoring Training Content:  
|                                 | • Intermittent Auscultation presentation new 2018.ppt  
|                                 | • The DVH CTG Master Class Course.ppt  
|                                 | • CTG advanced fetal monitoring programme 2019.doc |
|                                 | MSWs Training content:  
|                                 | • MSW training day agenda March 2019.doc |
|                                 | Obstetric Anaesthetic Staff Emergency Training Content:  
|                                 | • Anaesthetic audit meeting 2018  
|                                 | • PCD029 – Resuscitation Policy v8 July 2018 |
| department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)  
| • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) |
| Evidence to have been provided to the board that the threshold of 90% has been met for each of the staff groups before Thursday 15\(^{th}\) August 2019. |
Obstetric Induction Training:
- OG Induction Programme

ODP Emergency Training
- PCD029 – Resuscitation Policy v8 July 2018

Study Day 1 Training:
- SD 1 Agenda April 2019
- Presentations:
  - Cord Prolapse
  - Maternal Cardiac Arrest
  - Neonatal Resus
  - Pre-eclampsia (PET)
  - PROMPT
  - Sepsis
  - Thermoregulation 2
- Maternity Training Skills-Drills Day 1 programme 2019

Training record from Clinical Practice Facilitator:
- Directorate Training Template 2016-2019 as at 30.06.19
- Reconciliation maternity and whole Trust mandatory training March 19

Linking evidence to standard:
At least 90% of each maternity unit staff group at Dartford and Gravesham NHS Trust have attended an ‘in-house’ multi-professional
maternity emergency training session in the last year, achieving compliance on this safety action point. Training is based on current evidence, national guidance and learning from local audits. See table 6 overleaf for compliance figures.

**Compliance achieved: As of 30th June 2019**

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<tr>
<th>Group</th>
<th>Training</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric Consultants</td>
<td>Study Day 1, CTG Master Class</td>
<td>92%</td>
</tr>
<tr>
<td>Other Obstetric doctors</td>
<td>OG Induction, Study Day 1, CTG Master Class</td>
<td>96%</td>
</tr>
<tr>
<td>Obstetric Anaesthetic Consultants</td>
<td>Resus Update</td>
<td>100%</td>
</tr>
<tr>
<td>Other Obstetric Anaesthetic doctors</td>
<td>Airway Day-Obstetric station Induction (CT2), Complex Courses in Obstetrics (CT3 and above)</td>
<td>92%</td>
</tr>
<tr>
<td>Midwives</td>
<td>Study Day 1, CTG Master Class</td>
<td>97%</td>
</tr>
<tr>
<td>Maternity theatre staff</td>
<td>Study Day 1</td>
<td>92%</td>
</tr>
<tr>
<td>Maternity Support Workers and Maternity Care Assistants</td>
<td>Study Day 1, MSW Study Day</td>
<td>97%</td>
</tr>
</tbody>
</table>

*Table 6: Compliance with Safety Action Point 8 by staff group*

*Midwives includes, hospital midwives, community midwives, birth centre midwives, midwifery managers and matrons.*  
*Obstetricians include consultants, Safety ActionS doctors and yearly rotational junior doctors.*

Calculations are set out in Safety Action 8 Primary Evidence file: ‘Training Compliance Calculations for Maternity Incentive Scheme Year 2.xls’. 
Compliance Calculations Methodology:

Midwife/Scrub Nurse compliance is calculated based on each member of staff attending one or more of these study days, Study Day 1, CTG Master Class and is evidenced as of 30th June 2019.

Obstetric Consultant compliance is calculated based on each obstetric consultant attending one or more of these study days: Study Day 1, CTG Master Class. This is evidenced as at 30th April 2019.

Other obstetric doctors’ compliance is based on attending one or more of: Study Day 1, CTG Master Class, OG Induction Day. OG Induction Day includes both skills drills and CTG training. This is evidenced as at 30th April 2019.

MSW/HCA compliance is calculated based on each member of staff attending Study Day 1. This is evidenced as at 30th June 2019 Further training in emergencies specific to the MCA/MSW roles is delivered in the MSW update day.

Anaesthetic compliance was based on a cohort of 13 consultants and 24 middle grade and junior staff who either regularly attend, or may be required to attend labour ward as part of their duties. All 13 consultants received in-house emergency adult life support as part of the anaesthetic audit meeting 10th October 2018, resulting in 100% compliance.

Twenty of the 24 Middle grade and junior anaesthetists have attended Trust mandatory emergency training within the last 12 months (calculated as at 9th May 2019). Two of the four remaining anaesthetists attended alternative training at a higher level (see ‘Training Compliance Calculations for Maternity Incentive Scheme Year 2.xls’) and one other attended Maternity Study Day 1 PROMPT training.

ODPs undertake intermediate level life support training in-house as a Trust Mandatory requirement. Twelve out of the thirteen ODPs who work within maternity have attended within the last 12 months see ‘Training Compliance Calculations for Maternity Incentive Scheme Year 2.xls’ as at 1st January 2019.

At the present time, one member of theatre staff (in addition to the above groups) is allocated to maternity on an ongoing basis. This registered nurse attended Maternity Study Day 1 PROMPT training on 11th October 2018. As the project to bring midwives out of the scrubbing role progresses, this team will grow.
The cohort of staff excludes any member of staff on maternity leave, or long term sick leave. All new starters have been included in calculations.

**DGT Fetal Monitoring and Obstetric Emergency Training:**

**Emergency Skills Drills**
The Safe Births report recommended the use of simulation-based training, which assesses clinical skills as well as communication and team working. Dartford and Gravesham NHS Trust have implemented Practical Obstetric Multi-Professional Training (PROMPT) in conjunction with other tools such as Modified Early Obstetric Warning Score (MEOWS) and simulation to create a more realistic representation of an emergency.

The monthly joint training programme has enhanced collaborative relationships between maternity, obstetrics, paediatrics and anaesthetics and provided a greater insight into professional cultures and pressures, in a non-threatening environment. Evaluative feedback demonstrates a positive trend towards learning through simulated scenarios.

The Maternity Department Training Group is developing ‘In-situ Simulation’ to increase the frequency of obstetric emergency training for clinicians and encourage more multi-disciplinary training. 20 staff members have been trained in debriefing In-situ Simulation sessions including all operation leads. The plan will be to carry out In-situ Simulation on a monthly or bi-monthly basis. These will be carried out according to capacity and acuity and as such cannot be firmly scheduled in advance. Scenarios will be created across different ward areas and to simulate a variety of emergencies including: PPH, shoulder dystocia, undiagnosed breech presentation, maternal collapse, septic shock, and Eclamptic fit. The Training Group plan to make use of the SimMom interactive training dummy, and to make the scenario as realistic as possible.

**Study Day 1**
The PROMPT Study Day 1 skills drills training day is mandatory and identified staff including midwives, MSWs and obstetricians must attend annually. All professionals involved in delivering care in the maternity setting are invited to attend. This PROMPT based programme contains various work stations and simulated training scenarios including obstetric emergencies such as:
- Cord Prolapse.
- Shoulder Dystocia.
- Vaginal Breech.
- Antepartum & Postpartum Haemorrhage.
- Eclampsia.
- Septic shock.
- Inverted uterus.
- Maternal collapse.
- Maternal and neonatal resuscitation training.

This Training day is delivered by a multi-professional team.

**CTG Master Class**

This study day is delivered primarily by one of the Obstetric Consultants. It is a mandatory requirement for obstetricians and midwives to attend annually. The agenda includes theory and case discussions regarding CTG interpretation and classification and subsequent management. The agenda includes intermittent auscultation and is co-facilitated by a lead Birth Centre midwife. K2 online training complements this master class (further supporting the enhancement and knowledge to accurately interpret CTG’s as required as part of the Better Births Care Bundle). The maternity department purchased 3-year access to the K2 training (2017 to 2019). Compliance was mandatory and tracked during 2018 reaching 89.2%. Midwives, student midwives and doctors continue to use the modules to refresh their knowledge and over 80 practitioners have accessed the online training package during 2019.

**MSW / MCA Study Day**

The MSW/ MCA study day is an annual mandatory training day that has been implemented following the introduction of the Care Certificate. The agenda development has been influenced by one of the Maternity Support Workers who has become a recognized representative stakeholder for the staff group and successfully promotes the “our voice” news slot in the maternity matters newsletter.
Anaesthetic Emergency Training

Information on the Trust Mandatory emergency life support training can be found in appendix 6 of DGT Resuscitation Policy PCD029 (previously CL001) v8 2018. All emergency training for anaesthetists has to adhere to standards for the profession.

Multi-disciplinary working

Year 2 compliance with Maternity Incentive Scheme Safety Action 8 is based around multi-professional ‘in-house’ training in obstetric emergencies where professionals carry out training in a group setting with other professionals. The NHS England vision set out in Better Births, however, puts an emphasis on the importance of multi-professional working in the sense of multi-disciplinary training. Evidence shows that adopting a multi-disciplinary approach to education and training has a positive impact on patient safety. The gold standard would be for all obstetric anaesthetic doctors and ODPs to attend simulations and PROMPT Study Day 1 training along with the obstetricians, midwives and support workers who currently attend. It is possible that this multi-disciplinary training will need to be in place if the standard for compliance with the safety action is raised. The successful implementation of in-situ simulations will contribute to improvement in this area.

<table>
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<th>Safety Action 8 Action Points:</th>
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<tr>
<td>• Introduction of monthly or bi-monthly in-situ simulation.</td>
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<tr>
<td>• Introduce mandatory attendance at PROMPT Study Day 1 training for all anaesthetic staff, maternity scrub nurses and ODPs.</td>
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<td>Safety action – please see the guidance for the detail required for each action</td>
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| **Safety Action 9 Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?** | **Required Standard:**  
  a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHC) is actively engaging with supporting quality and safety improvement activity within:  
  I. the Trust  
  II. the Local Learning System (LLS)  
  b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues.  
  c) The Board level safety champions have taken steps to address named safety concerns and that progress with auctioning these are visible to staff.  
  Trusts should be evidencing the position as at end April 2018. | YES |
| **Safety Action 9 Primary Evidence** | **Engagement with MNHSC - MatNeo:**  
  • one to one Director of Midwifery and Director of Nursing Jan 19.doc  
  • Email regarding Executive Sponsor National event attendance [email from Siobhan](#)  
  • Email regarding National Learning Set attendance  
  • Email regarding Local Learning Set attendance  
  • Combined Agenda and Papers DGT Trust Board 4 April 2019 - Part 1 - For publication.pdf |
### Monthly open maternity meetings:
- Perinatal Meeting example minutes
- Labour Ward Forum example agendas
- Clinical Solutions example minutes

### Monthly Incident Reports:
- Monthly incident reports for January to March 2019
- Board level updates on action plans from datix reporting and monthly meetings - Executive Performance Board minutes

### Governance structure
- Maternity and Gynaec Risk Management Structure
- WAC045 – Maternity Risk Management Strategy (v8) 2017
- Bi-monthly meetings with CD as at 15 03 2019
- Maternity CQC Update – Quality and Safety Committee – May 2018
- Q&S report April to Oct 2018
- TOR for bi weekly risk meetings

## Linking evidence to standards:

a) Our Executive Sponsor for the Maternity and Neonatal Health and Safety Collaborative (MNHSC or ‘MatNeo’), the Director of Nursing, is actively engaging with supporting quality and safety improvement activity with the maternity department, and the wider Local Learning System. Evidence that MatNeo was discussed with our Executive Sponsor prior to the January 27th 2019 deadline is provided via: ‘one to one Director of Midwifery and Director of Nursing Jan 19.doc’. The Executive Sponsor and the Director of Midwifery discuss progress during each of their monthly meetings. As a Wave 3 Trust within the MatNeo project, NHS Improvement will be supporting us during 2019 to enhance our capabilities in continuous quality improvement. Further evidence of Trust attendance at National learning set and Local learning system events is found as emails within the
primary evidence folder. ‘Combined Agenda and Papers DGT Trust Board 4 April 2019 - Part 1 - For publication.pdf’ provides evidence that the Trust Board had sight of our plan with regards the MatNeo programme albeit at a very early stage. The Maternity Transformation Programme Presentation given to the Board on that date is contained within the document.

b) Maternity and Neonatal staff can raise any safety concerns as ‘any other business’ at any of the open maternity forums: Labour Ward Forum, Clinical Solutions and Perinatal Meetings. Evidence is provided in the form of minutes from these meetings during a recent twelve month period, in the ‘Monthly Feedback Safety Issues Folder’.

c) Progress with actioning safety concerns is made visible to staff via Monthly Incident Reports (see evidence in ‘Monthly Incident Reports’ folder). These reports are made available in staff only areas across the unit by attaching the full printed report to staff noticeboards. Reports are displayed in all the separate ward areas across the unit.

**DVH Maternity Risk Governance Structures:**

The Maternity Services continues to work hard to strengthen the safety culture by maintaining robust governance systems. There is a strong focus on quality and experience within the department and with other Directorates where women access services. Our performance indicators demonstrate that our clinical services remain safe and that women experience a positive response to their care needs.

Trust obstetrician Maternity Safety Champions and midwife Maternity Safety Champions meet with the Board level Maternity Safety Champions at least every two months as part of the Maternity Governance and Trust Governance structures and escalate locally identified issues.

**Board Level Forums:**

The relevant points from local maternity forums (listed below) are presented by Maternity Services Safety Champions (Midwife and/or Obstetrician) to the Board Level Safety Champion at the following meetings and forums:

- Weekly Serious Incidents (SI) Declaration Group.
- Monthly Clinical Director Board Meeting.
• Monthly Trust Quality and Safety Committee (QSC).
• Monthly Trust Patient Safety Committee Meeting.
• Quarterly Trust Risk Register Review Committee.
• Directorate Business and Performance Meeting.
• Executive Performance Board Meetings.

A six monthly obstetric and gynaecology quality and safety report is produced and presented to the Quality and Safety Committee by the Director of Midwifery and Clinical Director. This report outlines the key locally identified issues, indicators and metrics. This includes: outcome measures; investigation and learning from serious incidents; ‘no assurance’ audits; most significant risks; complaints received with actions and learning from complaints. A summary of this report goes to the Trust Board. Maternity and Gynaecology Services have specific measurable objectives and these are included in the Maternity and Gynaecology Risk Management Strategy. This Strategy is reviewed every 2 years to ensure timely evaluation of the measurable objectives and to ensure that these objectives remain relevant to the service.

**Maternity Safety Champions:**

The Maternity Services follow the Trust process of participating fully in the NHS England National Reporting and Learning System (NRLS). There are formal mechanisms and various weekly and monthly forums in place. In line with the new NHS Maternity Safety Champions Guidance, the Trust has identified the following safety champions:

- Board Level Safety Champion – Director of Nursing
- Maternity Provider Safety Champion- Head of Midwifery
- Maternity Provider Safety Champion- Clinical Governance Midwifery Manager
- Maternity Provider Safety Champion-Obstetric Consultant and Clinical Director
- Maternity Provider Safety Champion-Obstetric Consultant

**Bi-monthly Maternity Risk Management Case Discussions: Attended by Maternity Services Safety Champions (Midwife and Obstetrician):**

- Review previous month’s incidents, to identify risk management issues.
• Review any case reviews or SI’s
• Make recommendations and facilitate investigations as necessary.
• Be responsible for providing on a monthly basis, a report to the Directorate Quality meetings and Obstetrics and Gynaecology Clinical Governance and Risk Meetings.
• Cascade incidents and actions to staff within the Directorate, and other Directorates where applicable.
• Keep the Clinical Director, Director of Nursing and Head of Midwifery informed of findings and areas of concern that need to be reported to the Quality and Safety Committee and the Patient Safety Committee.
• An action log is kept of cases discussed.

**Monthly Obstetrics and Gynaecology Clinical Governance and Risk Meetings: Attended by Maternity Services Safety Champions (Midwives x 2, Obstetrician/CD):**

• Assurance to the Trust committees that risks are being monitored and managed.
• Discuss adverse incidents, SI’s and near misses.
• Midwifery practice investigations.
• Monitor local issue, risks, claims and complaints reported in Obstetrics and Gynaecology Services.
• Review recommendations from national enquiries, reports and guidance.
• Receive feedback from other monthly service meetings.
• Identify issues that cannot be resolved at Directorate level and report these to the Patient Safety Committee /Quality and Safety Committee.

**Monthly Clinical Directors Board Meetings: Attended by Maternity Services Safety Champions (CD) (Obstetrician) to the Board Level Safety Champion:**

• System wide issues
• Highlight directorate key concerns between CD’s and executive team
• Discuss quality and safety themes that may impact on safe services across the Trust
• Discuss current finance and performance indicators with an interface to the relevant to executive.
Monthly Delivery Suite (Labour Ward) Multidisciplinary Forum: Attended by Maternity Services Safety Champions (Midwife x 2 and Obstetrician). These meetings are an open forum for all obstetric, midwifery, anaesthetic and neonatal staff:

- Review monthly Delivery Suite activity.
- Discuss areas of concern and actions from the Obstetrics and Gynaecology Clinical Governance and Risk Meetings.
- Review maternity standards and make recommendations for changes.
- Ensure that amended new local polices and guidelines are underpinned by national guidelines and standards.
- Review and agree maternity guidelines/polices due for updating.

Monthly Professional Midwifery Advocates (PMA) Meetings: Chaired by all PMA’s on a rotational basis. Attended by Maternity Services Safety Champions (Midwives x 2):

- Discuss midwifery practice issues, adverse incidents, patient safety risk issues and near misses.
- Disseminate national NMC and NHS England information.
- Discuss local issues regarding midwifery practice.
- Discuss women’s reported complaints or concerns.
- Discuss PMA involvement in service improvements.

Monthly Perinatal Meetings: Attended by Maternity Services Safety Champions (Midwives x 2 and Obstetrician). These meetings are an open forum for all obstetric, midwifery, neonatal staff and Ultra sonographers:

- Discuss any risk or adverse incidents and near misses.
- Discuss perinatal mortality (every quarter).
- Discuss interesting cases and other areas of interest.
- Ensure that amended new local polices and guidelines are underpinned by national guidelines and standards.
- Present perinatal audits.
- Present and agreed any perinatal guidelines (which are forwarded to the Labour Ward Forum for final agreement before being placed on the Trust intranet).
- Discuss and present high risk screening cases.
Monthly Directorate Audit and Shared Learning Meetings. Attended by Maternity Services Safety Champions (Midwives x 2 and Obstetrician):

- These meetings are an open forum for all obstetric, nursing and midwifery staff.
- Review Maternity and Gynaecology Services monthly statistics and trends.
- Review of RCOG and NICE guidance and any other relevant national reports.
- Discuss recommendations and learning outcomes from case presentations and audit.
- Report major findings and management response to issues identified by audit activity to the Trust Clinical Audit Committee who will cascade this information to the internal and external auditors and Trusts Clinical Audit Department (if appropriate) to optimize resources.
- Case presentations

Other monthly meetings: Attended on most occasions by a Maternity Services Safety Champions (Midwives x 1 or 2). Monthly meetings are held to ensure that all risks and incidents are discussed and monitored in order that new pathways can be implemented to reduce harm:

- Maternity Infection Control Excellence (MICE).
- Maternity Medicine Management Group.
- Clinical Solutions.
- Operational Lead Meetings.
- Perinatal Mortality Review group.
- Educational Meetings.
- Maternity Safeguarding Hub.

Quarterly Directorate Risk Register Meeting: Attended by Maternity Services Safety Champions (Midwives x 2). This meeting is with Head of Midwifery and Clinical Governance Midwife. Discussion with the Clinical Director also takes place.

| Safety Action 9 Action points: | • Encourage Executive level involvement with MatNeo initiative  
• Continue to ensure that Trust Safety Champions both obstetric and midwifery meet at least bi-monthly with the Board Level Champion to |
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<td>Evidence of Trust’s progress</td>
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| **Safety Action 10: Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?** | **Required Standard:**  
Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.  
Time period: 1<sup>st</sup> April 2018 to 31<sup>st</sup> March 2019 | YES |
| **Safety Action10 Primary Evidence** | • A. Each Baby Counts Data Submission Summary  
• B. Cases Registered with HSIB  
• C. Example of Early Notification form  
• D. Governance Spreadsheet  
• E. Example of Duty of Candour letter to family  
• F. HSIB Duty of Candour information leaflet (v1) |  |
| **Safety Action10 Secondary Evidence** | • NHSR Early Notification Acknowledgement Example Letter - 2019  
• CG007 - Being Open Trust Policy v7 Nov 17  
• HSIB letter regarding their delayed reports Feb 2019  
• DVH Legal Team Early Notification Record as at March 2019  
• Update of HSIB cases as of June 2019 |  |

**Linking evidence to standard:**

100% of qualifying incidents that occurred in the 2018/19 financial year have been reported to NHS Resolution under the Early Notification scheme.
Notification scheme. Evidence D. Governance Spreadsheet shows the NHSR reference number for each case.

A. Reported onto the RCOG Each Baby Counts database. There was 100% reporting for the relevant time period.

B. Reported onto the HSIB database via their portal. There was 100% reporting for the relevant time period.
C. Reported the Legal Department who then report to the NHS Early Notification scheme. There was 100% reporting for the relevant time period.

D. The spreadsheet shows the early notification NHSR reference number once the notification has been accepted. The spreadsheet also shows the date that the case was reported to the RCOG Each baby Counts database and HSIB.

E. This shows an example of Duty of candour letter that is sent to the parents along with the HSIB Duty of Candour leaflet (F)

**Dartford & Gravesham reporting of qualifying incidents to the NHS Resolution Early Notification Scheme:**

Dartford and Gravesham NHS Trust have reported 100% of all qualifying incidents under the NHS Resolution Early Notification Scheme since the Trust commenced the process of Early Notification to NHS Resolutions in January 2017. Root Cause Analysis Investigation (RCA) are undertaken and submitted for each case. Parents are informed as soon as practically possible that their care will be reviewed. They are given a contact name and email address so that they can ask questions and can be updated of any investigation made. This is followed up in writing (see E. Example of Duty of Candour letter to family) along with a maternity investigations information leaflet (F. HSIB Duty of Candour information leaflet (v1)). Parents are routinely offered a debriefing meeting with an Obstetric Consultant, Risk Midwife and Neonatal Consultant (if applicable) once the RCA has been completed.

Action plans are made following recommendations from the RCA, with learning from the RCA’s being shared at the Perinatal Meeting, Directorate Audit Meetings, Professional Midwifery Advocates, Directorate Risk Meetings and where applicable the Trust Patient Safety Committee. Any feedback to individual staff is also offered via their educational lead or PMA.

NHS Resolution (formerly NHSLA) requires Trusts to report within 30 days, any notifiable severe brain injury incident as defined by Royal College of Obstetricians and Gynaecologists’ Each Baby Counts criteria:-
A diagnosis of Grade III hypoxic ischaemic encephalopathy.
Therapeutic cooling.
Decreased central tone and comatose, with seizures.

NHS Resolution Early Notification asks for confirmation that the family have been advised that the relevant records and investigation documents will be shared with NHS Resolution and that the family agree with this. There is some overlap between the information requested by NHS Resolution and the information already being submitted to the RCOG ‘Each Baby Counts’ programme. Work is ongoing to streamline the process, but in the meantime it has been agreed that the following information is submitted:

- Data to the RCOG Each Baby Counts programme as usual (see evidence A. Each Baby Counts Data Submission Summary).
- Notification to the Trust Legal Services Department within 14 days that a notifiable severe brain injury incident under the early notification scheme has occurred, using the NHS Resolution form (see evidence C. Example of Early Notification form).
- The Trust Legal Services Department will then report the incident to NHS Resolution within 30 days of the incident.
- The aim of the Early Notification Scheme is to enable early investigation of incidents, with a view to:

  ✓ Providing support for staff involved in incidents, including peer support for those affected by traumatic circumstances and practical help with delivering candour.
  ✓ Offering answers, information and (where appropriate) an apology to families.
  ✓ Enabling learning in the NHS locally, regionally and nationally, by using anonymized data and real (but anonymized) examples of good and substandard practice.
  ✓ Providing a fair but quicker, less expensive alternative to litigation for investigating and resolving cases where legal liability is likely; ensuring preservation of evidence, encouraging early admissions(where appropriate) and providing interim payments of damages.

Hundreds of incidents from across the UK have been notified to NHS Resolutions. The Early Notification Scheme has a team of four lawyers and four clinicians, with midwifery and obstetric expertise. This team has reviewed all cases, capturing information regarding:
- Clinical outcomes.
- Root cause of incidents i.e. system failures, human factors.
- Methods used by Trusts to investigate incidents and how they liaise with families.
- Independent peer reviews undertaken.
- Evidence of Duty of Candour.
- Shared learning.
- Change in practice to prevent the incident reoccurring.

Data collection for RCOG’s Each Baby Counts began on the 1st January 2015, with Dartford and Gravesham initially commenced notification in February 2015. This remains in place to the present day. During the 2018/19 financial year, the Maternity Services notified HSIB of 7 eligible cases through the Early Resolution Scheme.

| Safety Action 10 Action points: | - Continue to report all qualifying cases to NHS Resolution.  
- Continue to improve and develop the pathways and processes for parents by acting on feedback.  
- Continue to learn from incidents and embed this learning into clinical practice. |
|-------------------------------|-------------------------------------------------------------------------------------------------|
NHS Resolution to cross reference Trust reporting against the National Neonatal Research Database (NRRD) number of qualifying incidents recorded for the Trust. |
| Safety Action 10 Support available: | ENTeam@resolution.nhs.uk |
SECTION B: Further action required:

*If the Trust is unable to demonstrate the required progress against any of the 10 maternity safety actions, please complete an action plan template for each safety action, setting out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering the plan. A completed action plan is required even where Trusts have already completed this section. However, if this section hasn’t been completed, the action plan template alone will be sufficient.*

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund.

The Trust has declared itself compliant on all 10 Maternity Safety Actions.

An action plan is therefore not required.
SECTION D: Appendices

To access the evidence, please follow instructions below.

1. Under ‘Computer’ access the Shared Drive
2. Scroll down to Maternity NHS.
3. Inside the folder there are ten item folders containing the evidence for each

**Please note the evidence should be provided to Trust Board only. Please do not send the individual appendices through to NHS Resolution as it will not be considered.**
**Subject:** Quality and Safety Committee Minutes  
**Author:** Assistant Trust secretary  
**Presented by:** Chair of the Quality and Safety Committee  
**Purpose of paper:** For Information

**Key points for the Trust Board:**  
The Minutes of the Quality and Safety Committee held on 16 May 2019 are presented to the Trust Board following agreement at the Committee held on 20 June 2019

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<td>Recommendations:</td>
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**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

**Organisational Priorities**
- Maintain and improve the quality of services delivered by DGT
- Make DGT a great place to work for everyone
- Implement and embed the clinical and organisational strategy
- Deliver the 2019/20 financial plan
- Deliver all NHS constitutional and contractual standards

**CQC Reference**
- Safe
- Effective
- Responsive
- Well-led

**Board Assurance Framework/ Trust Risk Register**
- All BAF Quality Risks

**Committee/ Meetings at which this paper has been discussed/ approved**

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QUALITY AND SAFETY COMMITTEE

MINUTES OF THE MEETING HELD 16 MAY 2019

Present:
Steve Wilmshurst  Non-Executive Director (Chair)  SW
Louise Ashley  Chief Executive Officer  LA
Peter Coles  Chairman  PC
Gill Jenner  Non-executive Director  GJ
Sue Craven  Associate Director Governance  Scr
Siobhan Callanan  Director of Nursing and Quality  SC
Steve Fenlon  Medical Director  SF
Debbie Weston  Director Infection and Prevention Control  DW
Helen Mencia  Deputy Director of Nursing and Quality  HM
Dave Horne  Deputy Director Operations  DH
Michelle Ahluwalia  Director of Midwifery  MA
Mr Farqar Anjum  Consultant, Urology  FA
In Attendance:
Jess Feldon  Adult Acute Lead for Dietetics  JF
Eileen Brookson  Head of Dietetics  EB
Deborah McAllion  Associate Director Organisational Development  DM
Victoria Moore  Minute Taker  VM

5.1 APOLOGIES
Apologies were received from Francoise Iossifidis, Pam Dhesi and Karen Slevin

5.2 MINUTES OF THE PREVIOUS MEETING
The minutes from the meeting held on 18 April were approved pending the following adjustments:

4.11 addition of “SW also raised concern that NKPS assurance board not met in March or April and was assured the meeting was now set up.”
4.16 “SW also requested additional clarity as to what was rated green and amber.”
4.13 Alteration of the phrasing of paragraph 2 to read “due to the inability to recruit Theatre scrub nurses.”
4.19 “The Q&SC agreed that the minutes should be presented to the Trust Board for ratification”

5.3 ACTIONS FROM THE PREVIOUS MEETING
Update on action points from previous meetings was provided:

Action point 280: Lockdown at Queen Mary’s Hospital (QMH), Sidcup – Oxleas lockdown policy has been amended following feedback. This will be devolved to Trust staff working at QMH and embedded with a test planned for midsummer. Dep Dir Ops will check that the DGT Emergency Resilience Manager has access to the QMH Estates and Facilities office which would be the Ops room in the event of an incident. CEO satisfied this is not a contractual issue. Update requested in two months.
Action point 309: Pressure ulcers (PU) in the community – DGT Tissue Viability Nurses (TVN) are involved in work with the CCG Head of Quality and the community provider Virgin Health. The agenda will be extended to include wound care in addition to PUs. An update is requested in three months.

Action point 356: Q&SC KPIs for Board: this is on the agenda for discussion.

Action point 360: Catheter associated infections – the Director of Infection Prevention and Control (DIPC) has reviewed reason for catheter associated urinary tract infection flagging in the recent audit. This is a documentation issue, catheters are routinely removed on schedule but if a catheter is to stay in it becomes a team decision which should be documented with reasons given. It is this latter part which can be missed. Q&SC agreed to close and requested that going forward this is reported in the DON Quality report.

Action point 364: Action plan from the urgent waiting list incident – The Medical Director confirmed that all outstanding cases have been reviewed for harm, no issues found. All cases are being managed with weekly review of lists. The Access Policy, which was being updated before incident, will also be amended to include provisions from the action plan (see also PSC report below).

Action point 368: Q&S Committee TOR - amendments received have been included in TOR on the agenda for this meeting.

5.4 QUALITY AND SAFETY ISSUES FROM TRUST COMMITTEES
From the Trust Board, four ongoing items (a) Q&SC to track progress of CQC action plan (duplicate request received from the Audit Committee 16/11/18); (b) gain assurance of the Trust fitness for implementation of requirements of GDPR – ongoing monitoring; (c) to receive an update on NKPS at each Q&SC meeting; (d) review of complaints process responding to complaints from carers.

5.5 ASSURANCE PAPERS TO BE RECEIVED
The following reports were presented for assurance and accepted as presented.
- 5.5a Q&SC Report to the Board for April
- 5.5b Q&S Committee Workplan

5.6 INFECTION CONTROL REPORT – DW
The report was presented by DW who stated that there had been zero cases of MRSA bacteraemia in April (trajectory is zero). There were four MRSA acquisitions in April and zero C-Difficile cases. There were five cases of E.coli bacteraemia (post-48 hours) in April. A Gram-negative reduction plan is in place and a meeting held with Public Health England to monitor progress.

March’s IP&C Level 2 Mandatory Training compliance overall is 86%.

The Operational IPC Committee has good engagement and met in April, as did the Vascular Access Devices Working Group.

Additionally the committee were informed that DW is now the Decontamination lead, SW asked if this was usual for someone in her role, yes it is. DW is now revising the policy to ensure it demonstrates a move towards good practice.
GJ noted that it was positive to have junior doctors and medical representation on the operational IP&C Committee and SW extended the thanks of the Committee and the Board for driving the changes and the engagement of the organisation.

5.7 INFECTION CONTROL ANNUAL PROGRAMME 2019/20 – DW
The Quality and Safety Committee were asked to note and approve the IP&C Annual Programme for 2019/20, the production of which is a requirement under the Health and Social Care Act 2008, *Code of Practice on the prevention and control of infections*. The Programme describes the planned programme of work for the Team for this financial year and covers:

- HCAI objectives
- MRSA and C.difficile reduction
- Gram-Negative and MSSA bacteraemia
- Antibiotic Management
- Surveillance of Alert Organisms
- National Surgical Site Infection Surveillance Scheme
- Audit
- Education
- IP&C Link Practitioner Programme
- Hand Hygiene Programme
- Policy Development and Review
- New / Ongoing Initiatives
- Legionella and Pseudomonas Management / Monitoring
- Hospital Hygiene
- New Builds and Development / Re-configuration of Clinical Services
- Working with the CCGs
- Day to Day IP&C Management
- Management of Outbreaks of Infection
- Response to Disease Threats.

The Committee noted the paper and approved it for implementation.  
**DECISION: Approved the IP&C Annual Programme for 2019/20**

5.8 INFECTION CONTROL KPI FOR CLINICAL CARE GROUPS – DW
The Quality and Safety Committee were asked to note and approve the KPIs for 2019/20, which are closely aligned to the IP&C Performance Dashboard and describe the actions to be taken by / responsibilities of the Clinical Care Groups as follows:

- IP&C mandatory training
- Aseptic Non-Touch Technique
- IP&C Audits
- Hand hygiene training / competency assessment
- Reduction in MRSA acquisitions and bacteraemia
- *C.difficile infection* – reduction in cases
- Screening for Carbapenem-Resistant Organisms
- Screening for Colonisation with Candida auris (NB: new Patient Risk Assessment and Policy to be launched in June)
- Antimicrobial Stewardship (including CQUINs for 2019/20)
- Surgical Site Infection Surveillance – Orthopaedics, Surgery and Women’s Health
• Gram-negative bacteraemia prevention / reduction
• Serco – compliance with National Standards for Cleanliness and mandatory training

SW noted the comprehensive plans and agreed that they would prove to be effective.

DECISION: Approved the IP&C KPI's for 2019/20

5.9 ANTIMICROBIAL REPORT – DW
The report was reviewed by the Committee; it was noted that the number of surgical site infections is lower and Antibiotic usage is a focus within the clinical groups.

5.10 PATIENT SAFETY COMMITTEE REPORT (PSC) – SF
The PSC reviewed a total of 26 incidents. Of the 26 open cases, 11 were within the internal 45-day target, 15 (58%) had breached the internal 45-day target. 14 cases were closed this month.

The PSC has oversight of the surgical waiting list delays case which has been reported on STEIS. The action plan is nearing completion and when done the Performance Group will be requested to monitor the escalation triggers.

The Trust held Adverse Incident Investigation training in April at Queen Mary’s Hospital which was well attended.

5.11 NEW INTERVENTIONAL PROCEDURES– FA
Percutaneous Nephrolithotomy:
The paper was presented by the Consultant Urological Surgeon who described the procedure and benefits for the patient. PCNL is an established procedure in the Trust with patients usually requiring a planned inpatient admission, typically three days. Advancements in the miniaturisation of equipment and improved optic systems with resultant modification of renal access have made it feasible to complete this procedure as a day case. The paper presented also included inclusion and exclusion criteria for the procedure; immediate follow-up arrangements post discharge and the patient information leaflet. The impact of same day discharge has not yet been communicated to the GPs and Q&SC requested this was done.

To manage operationally it was agreed to request that the surgical group ring-fenced one bed in case a patient required admission – DH indicated this would be possible.

PC sought confirmation that there would be no adverse financial impact of this procedure and it was confirmed that there were no implications expected. LA agreed that the procedure looked positive and asked for some additional detail around the patients’ helpline and whether the patient has direct access back without having to go through ED. It was confirmed the helpline will be to ACER and there will be direct access back.

The Q&SC supported the proposal and asked that SF reviewed the patient information and post-procedure contact arrangements prior to commencement.

Action: The Consultant Urological Surgeon is asked to forward the completed patient information to the Medical Director after the meeting, prior to commencement of use of the procedure. The Medical Director is asked to ensure the change in practice is
communicated to GPs and the Deputy Director of Ops is asked to ensure a ring-fenced bed is available in case of readmission.

5.12 MORTALITY REPORT - SF
The presented report contained data from the previous month’s mortality review. The Trust has an acceptable annualised Hospital Standardised Mortality Ratio (HSMR) of 92.5 and acceptable Summary Hospital Mortality Index (SHMI) of 1.07. Alerts from Dr Foster are noted and investigated as they arise. The Trust currently has two alerts; (a) other perinatal conditions – this has been investigated by the obstetric governance team and will be reported to PSC then QSC by June 2019; and (b) diagnostic endoscopic procedures, this alert reflects small numbers of cases but with high variability and is under investigation. There have been two structured judgement reviews (SJR) with no problems found in care of the patients.

The QSC discussed the impact of palliative care coding on the HSMR. The Trust is fortunate in having a very responsive palliative care team, seven days a week, and this is translated within Trust clinical coding giving a high number of palliative care codes. The Medical Director was clear that this represents the best care for the patient. The Trust is considering adopting coding parameters similar to the peer group of hospitals locally, to achieve a comparative benchmark for qualitative coding.

5.13 NKPS UPDATE – SF
A verbal update was provided. The new manager is working on a workforce review and governance plan. A new general manager will be recruited. There have been two incidents reported in the month and the harm review process is on-going. The QSC requested that the on-going monthly updates are continued.

5.14 NUTRITION STEERING GROUP - J
There were 54 nutrition related incidents reported in six months this is a 4% increase on the previous period. These were related mostly to the provision of Parenteral Nutrition (PN), nasogastric feeding tubes and a failure in the referral process.

The PN audit data collection is complete and awaiting final meetings with consultant surgeon before presenting to surgical directorate, in addition the PN policy and emergency resilience risk assessment has been updated and is on Adagio.

MUST audits are ongoing, data is sourced from GATHER. The metric is completion of MUST within 24hrs and was at 66.7% for April.

PC asked what proportion of the work is for outpatients as opposed to inpatients. Inpatients are the priority but each team member has one outpatient clinic a week.

5.15 KPI - SW
Each Board sub-committee has a scorecard and will be responsible for monitoring the associated KPIs each month. The six proposed KPIs for the Q&SC track; incident reporting, friends and family test, mortality, complaints response rate, national audits, and staff recommendation of the Trust. The Q&SC requested that the KPIs be referred to the executive directors to be worked up and then represented to Q&S for sign off.

The committee discussed Mortality KPI and the differences between HSMR and SHIMMI, concluding that the measure should not reflect a % measure rather that it is within
acceptable range. SW accepted the proposed targets and requested that other stretch targets are considered appreciating that the achievement of targets is essential but the stretch is the aim.

**Action:** the DON is asked to review the KPIs with the executive director group and then bring back to Q&SC.

**5.16 MATERNITY INCENTIVE SCHEME – MA**
The paper provided an update on Trust compliance with the NHS Resolution Maternity Incentive Scheme. Successful completion allows the Trust to claim a rebate on the CNST contribution paid by the Trust. This is ‘year two’ of the scheme and the trust is compliant in the 10 safety action points.

SW noted the good piece of work and noted he had already provided his feedback; the committee were assured that progress is being made and that there is a high likelihood of achievement of the rebate.

**5.17 DIRECTORATE REPORT – TRAUMA AND ORTHOPAEDICS**
This item was deferred to a future meeting

**5.18 DIRECTORATE REPORT - CANCER SERVICES**
This item was deferred to a future meeting

**5.19 DIRECTOR OF NURSING AND QUALITY – HM**
There has been an increase in grade 2 pressure ulcers in February but also a reduction in all other grades of pressure ulcer and deep tissue injury. The falls rate in April was 5.56 falls per 1,000 bed days; this is a decrease on the 5.82 in March.

The Nightingale project has been rolled out to the five wards that attended the simulation training at the beginning of April and they have been using the skills they learnt to improve patient care and their timeliness of handover. Ward accreditation feedback will be given in May; Healthwatch and some patient relatives have been helping with the accreditation process.

The number of mix sex accommodation breaches in April was 20 compared to 18 in March. All breaches are checked and validated to ensure the need was justified. An internal trajectory target of 20 or less breaches per month for April onwards has been proposed and is under discussion with the CCG.

SW noted the good work that has been done on pressure ulcers and falls and asked what the next steps are. Stage 3 pressure ulcers and the need to reduce the impact on deep tissue, wards need to have clear targets to achieve which are bespoke to each area taking into account the types of patients in each area. LA added that the SPC work will help see where we are against trajectories and where to target.

**5.20 CQC ACTION PLAN – DM**
The proposed report had been superseded by the CQC unannounced inspection on 14th and 15 May. Three core areas were inspected; surgery and theatres, medicine and A&E. This
followed the CQC staff focus group day on 7 May and precedes the well-led inspection on 12 and 13 June.

Committee members discussed the visits and the good engagement across the Trust and were informed that early indicators were positive with significant improvements in Medicine and Surgery. Members were assured that any queries raised to date were being responded to and resolved where possible. The final report is expected in September.

LA commended DM and the team noting the exceptional way the visit had been prepared and run on the day, staff had felt supported and the only disappointment had been that areas were not visited. LA added she was proud of the way the whole Trust had conducted itself.

5.21 QUALITY RISKS FROM THE BAF - JB
The Board has agreed reframing the BAF to focus more on the assurance received from the Board sub-committee reports presented which relate to BAF risks. It will become a function of the Board sub-committees to confirm assurance to the Board rather than via the Audit Committee. There are two questions which the Q&SC will ask; (a) ‘what information have we considered as part of today’s agenda that provides assurance related to this risk’; and (b) ‘on the basis of the information we have received as a committee, how assured are we that this risk is being managed appropriately?’ The QSC will make recommendations for changes that are needed and identify from the agenda which items identify with each quality risk.

5.22 DRAFT QUALITY ACCOUNT 2018/19 – SF/HM
The document was presented to the committee noting that initial feedback was taken and SW requested that any changes be notified to the SC by 23 May. The next stage is for the QA to be sent to stakeholders for consultation prior to publication on 30 June 2019.

LA asked that the photo on the document included all three sites.

5.23 RISK MANAGEMENT STRATEGY - SF
The paper was presented by SF and SW requested that any changes be notified to SC by 23 May.

GJ noted that the Workforce Committee ToR had been updated and the updated version should be included.

DW added that DIPC is not listed under key roles and responsibilities

SC thanked GJ and DW for their input and agreed those changes would be made.

5.24 NEW NATIONAL CONFIDENTIAL ENQUIRIES - SF
There were no new national confidential enquiries to notify the committee of.

5.25 ANY OTHER BUSINESS
There was no other business raised.
Subject: Report from Quality and Safety Committee

Author: AD Governance

Presented by: Chair of Quality and Safety Committee

Key points for the Quality and Safety Committee:

Briefly summarise the main points and key issues

This report summarises the main points and actions from reports considered by the Quality and Safety Committee at the meeting of 20th June 2019.

Reports received:
- Q&SC Report to Board
- Q&SC Workplan
- Infection Prevention and Control Report
- Antimicrobial Report
- Patient Safety Committee Report
- Annual Organ Donation Report
- Mortality Report
- NKPS Update
- Quality Impact Assessment Update and Guidance
- Annual Audit Leads Committee Report
- Directorate Report – Adult Medicine
- Directorate Report – Emergency Department
- Directorate Report – Cancer Services
- Annual Disabilities Coordinator Report
- DON Quality Report
- Annual Complaints Report
- Safe Staffing Report
- CQC Update

Agenda items
- New Guidances – none
- New National Confidential Enquiries – none

Recommendations: Reason for submission of report to Trust Board (information, assurance)

Links to Board priorities, Board Assurance Framework, Trust Risk Register

Organisational Priorities
- Maintain and improve the quality of services delivered by DGT
- Make DGT a great place to work for everyone
- Implement and embed the clinical and organisational strategy
- Deliver the 2019/20 financial plan
- Deliver all NHS constitutional and contractual standards

CQC Reference
- Safe
- Effective
- Caring
- Responsive
- Well-led

Link to Trust Risk Register
2214, 2215, 2217, 2218, 2227, 2228, 2231, 2243

Committee/ Meetings at which this paper has been discussed/ approved

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Key discussion points:
Action points from previous meetings:
Action point 313: A written update on the compliance with medication safety and CQC storage
requirements in wards and departments was provided to the meeting. Medicine safety checks are part
of the ward accreditation programme and has highlighted as a top 3 priority for wards. The new Wi-Fi
system will enable remote fridge temperature monitoring. Q&SC requested an update on the progress
with Wi-Fi in three months and requested the Medicines Management Committee to oversee a ‘cold
chain’ investigation for assurance that medicines are not being used if the safe range of fridge
temperature has not been maintained.
Action point 338: Safeguarding strategy awaiting discussion at safeguarding meeting, action deferred
to July.
Action point 357: A paper about safe staffing is on the agenda for the meeting.
Action point 366: The Deputy Medical Director has included action plans for closed cases, and a
narrative timeline for long running cases in the PSC report for the meeting and will continue to do this.
Action point 369: scrub nurses to replace midwives in theatres as scrub nurses – this action has also
been discussed at Workforce Committee and difficulty in recruitment due to availability of scrub nurses
noted.

Issues from Trust Board and Committees for the Q&S Committee:
From the Board: six ongoing
items (a) Q&SC to track progress of CQC action plan (duplicate request received from the Audit
Committee 16/11/18); (b) gain assurance of the Trust fitness for implementation of requirements of
GDPR – ongoing monitoring; (c) to receive an update on NKPS at each Q&SC meeting; (d) review of
complaints process responding to complaints from carers; From the Audit Committee: The DON is
asked to submit a proposal on the Quality Account (QA) indicators audit for the 2018/19 QA.

Assurance Reports: The following reports were presented for assurance.
- Q&SC Report to Board for May
- Q&S Committee Workplan

Infection Prevention and Control (IPC) Report: The report was presented by the Director of Infection
Prevention and Control who said there were zero cases of MRSA bacteraemia in May, however there
is one late attribution of a case to the Trust for 2018/19. There were two cases of C. difficile infection
and two cases of MSSA bacteraemia in April. There was one case of E.coli bacteraemia occurring 48
hours post-admission in May associated with a surgical wound; this is under investigation. Supportive
measures are in operation for two areas based on MRSA acquisitions. Trust compliance for the 5
“Saving Lives” Audits is included in the report, as per the new IP&C Dashboard (GATHER) for April
2019 - March 2020. The Q&SC agreed that this could be included by exception in future reports. IPC
Mandatory training is 86% across the Trust.

Action: The Q&SC requested exception reporting for the ‘saving lives’ report in future.

Antibiotic update report: The report was reviewed by the Committee; which noted that usage of
linezolid has been increasing since March and has been flagged by NHSI. The Q&SC noted that
linezolid is only ever used with advice from a microbiologist. The Medical Director said this would be
within the remit of the new Microbiologist as there is no national guidance. No ward scored ‘red’ on the
HAPPI audit.

Patient Safety Committee (PSC) Report: the report was given by the Deputy Medical Director who
said PSC reviewed a total of 33 incidents. Of the 33 open cases, 26 were within the internal 45-day
target, 7 (21%) had breached the internal 45-day target. 16 cases were closed this month. Additional
information was provided within the report to show the action plans from two closed cases. The
additional staff trained recently will support investigations and reduce pressure on the existing group.
The Trust has another training booked for September 2019.

**Annual Organ Donation Report:** The report was presented by the Consultant lead for organ donation who said that the Trust has performed well against the national key performance indicators. All eligible patients were referred to the NHS Blood and Transplant’s Organ Donation service (100% compliance). Consent/authorisation rate was 80% (national average 67%) from 4 consented donors the Trust facilitated 2 actual solid organ donors resulting in 4 patients receiving a life-saving or life-changing transplant. The Trust will participate in the national ED strategy for organ donation and be involved in local roll out of opt-out system which is due to come in to force from Spring 2020.

**Mortality Report:** The report was presented by the Medical Director who said the paper contains the overall mortality figures and charts allowing comparison to similar organisations. The Trust has an acceptable annualised HSMR of 92.5 and an acceptable SHMI of 1.07. The Dr Foster alerts are (a) rectal and anal conditions; (b) deficiency and other anaemias – which is being investigated via coding; (c) other perinatal conditions – a review of cases has been completed with no concerns. The perinatal team has met with Doctor Foster colleagues to better understand the data entry. Structured judgement reviews (SJR) of mandated cases has been completed and presented to the Mortality Review Group for wider learning. The effective of palliative care coding was discussed as the Trust has a proactive palliative care team, seven days a week which results in a greater number of palliative care reviews compared to peer organisations with a five day service.

**North Kent Pathology Service (NKPS) Update:** the report was presented by the Medical Director who said the workforce plan had been completed and agreed by both Trust Boards. The UKAS accreditations are up to date. The OrderComms roll-out for Medway GPs has begun with a pilot in two practices. The pilot will continue until the end of July. To support the management of NKPS incidents a comprehensive spreadsheet has been compiled. This tracks the number of reviews completed. Senior staff continue to monitor all telephone alerts against the agreed service standards to ensure harmonisation across NKPS after non-harmonisation was found to be the root cause of a serious incident investigation. The Trust Chairman will take up the Non Exec support for the NKPS.

**Quality Impact Assessment (QIA) Update:** the report was presented by the Associate Director of Improvement who said the Trust QIA process has been reviewed and good practice identified in the review of QIAs by the clinical executive. The current process is well managed and maintained with twice yearly reporting to the Q&SC. Documentation will be updated to support assessment and risk analysis against the CQC five domains and will include introduction of a stage 2 detailed assessment. The paper was accompanied by a draft QIA policy which will go to the Trust document review group for review and agreement by stakeholders. The QIAs will continue to be reviewed by the Q&SC six monthly.

**Action:** The AD Improvement is asked to guide the draft QIA policy through the Trust documentation group for agreement with stakeholders and bring it back to the Q&SC.

**Annual Audit Leads Committee Report:** the report was presented by Clinical Audit Manager who said there are currently 79 national audits in progress across the Trust from 2018/19 and previously (plus an additional 55 to be undertaken this financial year). Some of the audits are continuous ongoing audits which are re-registered annually to allow tracking of data collection and reporting. 14 ongoing nursing and IPC audits are being run through the GATHER system. Completed audits totalled 111 during the year two thirds of which gave significant or reasonable assurance on the quality of care reviewed. Seventeen of the twenty four re-audits assigned an assurance level in the year showed an improvement in the quality of care or demonstrated continued good practice. The annual clinical audit and research competition was held the preceding week and included a poster competition. The event was a success with the projects and work showcased being both innovative and informative.
**Directorate Report – Adult Medicine:** the report was presented by the Clinical Director who noted an improving series of metrics. The directorate is maintaining improvement in infection control and has achieved a significant reduction in mixed sex accommodation breaches. The report included learning from serious incidents and details of the most significant risks. Staff appraisal rates are lower that Trust target in some areas and this is an improvement focus for the next quarter.

**Directorate Report – Emergency Department:** the report was presented by the Clinical Director and discussed by Q&SC which focussed on two significant areas: actions from national audits and lockdown at the emergency doors at the ambulance entrance to the ED. The AD Governance will assist with RAG rating the achievement of metrics in the report. Mandatory Training and appraisal compliance have improved and the ED quality agenda is focussed on implementation of the ED Improvement plan and the new assessment tool to prevent pressure damage.

**Action:** (a) The AD Governance is asked to assist the ED team to RAG rate the sections of the report. (b) An immediate response was requested to the lock down issue – note that this was resolved the same day.

**Directorate Report – Cancer Services:** the report was presented by the Lead Nurse for cancer services who said that mandatory training rates were good, and that the team have a monthly governance meeting. The numbers of staff trained in mental capacity assessment and provisions for the deprivation of liberty has also improved and has led to more confident ward management and care of patients. The service has good working relationships with patient groups and MacMillan. The MDT room is being progressed and a Trust patient information video has been adopted by Prostate Cancer UK. The service will be working to meet the challenge of the faster diagnosis standard about to be introduced. The Q&SC congratulated the team on a good showing in the report.

**Annual Disabilities Coordinator Report:** The report was presented by the Safeguarding Lead who said the Learning Disability (LD) Liaison Nurse has provided support to patients with a learning disability in many areas across the Trust. There have been nine deaths subject to a Learning Disabilities Mortality Review (LeDeR) in that time. Two cases have been subject to external review and the Trust has received feedback on very good care. The Trust promotes awareness of the hospital passport and this resource is well-used in Surgery – a revised draft is in progress. Benchmarking standards have been created to improve NHS care for LD patients and the Trust has agreed to pilot these. The Q&SC requested feedback on Trust performance against the standards together with any resultant strategy.

**Action:** The safeguarding and LD team are requested to bring the outcome of the benchmarking against the new standards back to the Q&SC when results are known (Dec 19).

**Director of Nursing Quality Report:** the report was presented by the DON who said there have been zero grade three pressure ulcers in May and similar numbers of grade 2 pressure ulcers to last month with three unstageable ulcers. The number of deep tissue injuries is zero. The falls rate in March was 5.68 falls per 1,000 bed days; this is an increase on the 6.82 in May. The Trust is working with community colleagues to track patients with pressure ulcers between the community services and the Trust. A revised serious incident form has been introduce for PUs and for falls and is being introduced. Rowan ward has achieved ‘silver’ accreditation in the Nightingale scheme. The Q&SC noted that the Nightingale project has been rolled out to more areas and requested that the Q&S agenda be amended to include a 6 monthly project report.

**Action:** The DON is requested to facilitate a report of the Nightingale project six monthly to the Q&SC – starting October 2019.

**Annual Complaints Report:** the report was presented by the DON who said there were 284 complaints during 2018/19, including those received for the Queen Mary Sidcup site, Elm Court and Erith Hospital. This compares to 280 received in 2017/18. The Trust’s internal 25 day response rate for
2018/19 was 28% compared to last year’s performance of 36%. This reflects a personalised approach to the management of the more complex complaints. For cases identified early as likely to require more than 25 days the complainant is contacted and a likely timescale advised, therefore fewer cases from the total number of complaints received fall into the 25 day bracket.

PALS enquiries have also increased in 2018/19 to 2868, compared to 2514 for 2017/18.

There were 19 re-opened complaints in 2018/19 compared to 14 re-opened complaints in 2017/18.

The Complaints team are working hard to support the clinical groups in achieving prompt responses to complaints and offering local resolution meetings at an earlier stage.

**Safe Staffing Update:** the report was presented by the DON who said the Trust has used a recognised methodology and data standard. The report has been reviewed by the Workforce Committee and there were no additional questions.

**CQC Improvement Update:** the report was presented by the AD Organisational Development who noted the improvement plan from the 2017 review will be superceded by the current inspection report. The Trust has now participated in all six elements of the inspection process.

**Reports received:**
- Q&SC Report to Board
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- Directorate Report – Emergency Department
- Directorate Report – Cancer Services
- Annual Disabilities Coordinator Report
- DON Quality Report
- Annual Complaints Report
- Safe Staffing Report
- CQC Update

**Agenda items**
- New Guidances – none
- New National Confidential Enquiries – none

**Actions for the Board:** To note the report.
Subject: Finance Committee Minutes Part 1  
Author: Assistant Trust Secretary  
Presented by: Chair of the Finance Committee  
Purpose of paper: For Information  
Key points for the Trust Board: The Minutes of the Finance Committee held on 28 May 2019 are presented to the Trust Board following agreement at the Committee held on 26 June 2019  
Consideration of public and patient involvement and communication: For publication  
Recommendations: To note  
Links to Board priorities, Board Assurance Framework, Trust Risk Register  
Organisational Priorities  
• Maintain and improve the quality of services delivered by DGT  
• Implement and embed the clinical and organisational strategy  
• Deliver the 2019/20 financial plan  
• Deliver all NHS constitutional and contractual standards  
CQC Reference  
• Safe  
• Effective  
• Responsive  
• Well-led  
Board Assurance Framework/ Trust Risk Register  
BAF Risk 2040 - Failure to maintain financial control, deliver the activity plan, and achieve the £10.9m savings plan resulting in failure to deliver the 19-20 financial plan, leading to increased external scrutiny and the loss of the Trust’s ability to influence its future direction.  
BAF Risk 2042 - Capital resource not sufficient to meet Trust requirements resulting in loss of operational capacity and inability to meet strategic aims and priorities impacting on delivery of financial targets.  
BAF Risk 2043 - Capacity in the health economy is insufficient to maintain and improve patient flows resulting in higher than planned lengths of stay and the Trust being unable to undertake the required levels of activity.  
BAF Risk 2030 - If the Trust does not fully engage with Dartford, Gravesham and Swanley and Bexely IPCs and associated partners, patient pathways, capacity planning and joint financial planning recovery will be compromised.  
BAF Risk 2045 - Failure to invest in enabling technologies may hinder the release of the necessary efficiencies within the workforce and therefore prevent the increase of productivity that is necessary for enabling the Trust to deliver financial sustainability.
MINUTES
Dartford and Gravesham NHS Finance Committee (Part 1)
Tuesday 28th May 2019
Darent Valley Hospital, Dartford

Present:
David Warwick Non-Executive Director (Chair) DW
Lorraine Mills Director of Finance LM
Peter Coles Chairman PC
Steve Fenlon Medical Director SF
Gill Jenner Non-Executive Director GJ
David Horne Deputy Director of Operations DH
Louise Ashley Chief Executive LA
Leslieann Osborn Director of Strategy and Planning LO

In attendance:
Martin Chamberlain Deputy Director of Finance MC
Djafer Erdogan Assistant Director of Finance DE
Laurence Bunnett Director of Estates and Facilities LB
Mr Abhishek Gupta Clinical Director, Obstetrics and Gynaecology AG
Dr Siva Kabilan Associate Director of Operations, Women’s and Children’s services SK
Lisa Jones Director of Procurement LJ
Victoria Moore Assistant Trust Secretary, (Minutes) VM

1 Apologies for absence
Apologies were received from Pam Dhesi, Director of Operations, represented by David Horne, Siobhan Callanan, Director of Nursing and Lynn Gladwell, Non-Executive Director

2 Declarations of Interest
There were no declarations of interest.

3 Minutes of meeting held on 23rd April
The Minutes of the meeting held on 23 April 2019 were agreed as an accurate record.

Matters arising Action Log

4 Action Log
The Committee agreed that all appropriate actions from the log were on the agenda.

4a Obs and Gynaec Consultant Business Case Review – AG/SK

A post implementation review of two business cases approved in January 2017 was presented. The business cases were:
- Laparoscopic Consultant with obstetric input
- Consultant obstetrician with gynecology input.

Committee members were provided an overview of the original cases and the actual activity and income noting key highlights: The anticipated growth had not manifested, members were assured that this is not due to patients choosing not to use DVH but this is consistent
across the patch. Income has increased due to tariff changes and obstetric scanning is now carried out on site rather than patients travelling to GSTT.

Operational issues were discussed as these have had an impact on the results of the business case and assurance was provided that these issues have been remedied. During 2017 there was a shortage of consultants largely due to sickness, maternity leave, sabbaticals, all positions are now fully recruited and it is expected that activity will increase.

Finally members were made aware of quality and performance outcomes that these business cases have helped to deliver. There have been reduced referrals to GSTT by 117 patients, they have helped to deliver CQC consultant hours on Delivery Suite, influenced changes in pathways that have reduced unnecessary surgeries, this is reflected in OPD activity, now above planned levels. Choice of Laparoscopic Hysterectomy was limited at DGT, this has now greatly improved with the new consultant and the Trust now an accredited Endometriosis centre, only one of two in the South East

PC and LG thanked AG for the presentation but noted that it would have been useful to be clear about what the expected impact of the business case was. AG said this was difficult as the HRG4 changes in 2018 have since further impacted these expectations. LM agreed that this information could have been mapped on and that the finance team would help to do this.

PC asked about agency staffing and Locums during periods of staff absence. The directorate only use Locums when there is no other option as it is not cost effective; the teams try and manage the cover internally.

DW congratulated the team on the achievement of Endometriosis Centre Accreditation and asked if it had been part of the Business case. No it had not however the report from the Royal College of Surgeons in 2016 had noted insufficient choice for laparoscopic hysterectomy, and the business case enable patient choice. The addition of the skills has improved other pathways including endometriosis and allowed the pursuance of the accreditation. The intention is to continue to develop these skills and raise the profile of the organization in this specialty.

DW suggested that the finance team develop a template for Business case reviews to ensure that the information provided is consistent and measurable. LO agreed she was happy to assist with the development of a template.

➢ ACTION: Develop a Business Case Review Template

LA added that business cases should be agreed with clear gateways for review to enable clear decision making opportunities around their effectiveness. AG agreed the process had been beneficial and the opportunity to reflect and review was positive.

DW thanked AG and SK for a good presentation and no further questions were asked.

4b T&O Financial Deep Dive – LM/LJ

The Committee were provided with a paper that demonstrated the M12 finance position against the M8 Control total, the paper clearly demonstrated non-pay had the largest variance and this is largely attributed to prosthesis. QIPP plans had an anticipated reduction in spend of £40k per month due to renegotiated contracts from month 6, this did not come to
fruition.

LJ provided the procurement perspective but no one from the Directorate was able to attend to present the paper so it was not possible to fully resolve the committee’s questions. SF explained the differences with the prosthetics used and recommendations from GIRFT. DW was not assured there was sufficient grip on the issue but was assured that there was sufficient oversight from the Execs and support from Carnall Farrar to continue to drive forward.

- **ACTION:** Represent the Trauma and Orthopedics directorate review to the June Finance Committee to include GIRFT update and impact on financial position.

### Performance

#### 5a Financial Position M1

**Presented by LM**

The finance Committee were presented with the M1 financial position in the new combined format. In addition LM presented the simple cover sheet which demonstrates key points to note and is in line with the paper presented to the Trust Board noting key points: The Trust is on plan, pay costs were a £0.2m favourable variance, Agency costs were £0.6m slightly better than the NHSI plan and the ceiling set at £0.7m.

Cash was £19.1m against a plan of £8.0m this is due to Year-end capital invoices which have not yet materialised, PFI support cash received in advance and CCG year end agreements received which would not normally be settled as yet. QIPP delivery was £0.2m £0.1 m below plan, Carnall Farrar have been appointed to support to the delivery of the QIPP plan to ensure delivery of the £10.9m target for 19/20. PC sought clarity on the Liquidity 15.4 (negative) days against the plan of 8.7. This is due to the non-confirmation of the extension of a loan. Once the extension is confirmed this will no longer be an issue.

DW noted the improvement in the report style and presentation and the committee robustly discussed its content. LA noted that M1 agency is not as low as it should be but confirmed there is good clear engagement with driving this down and ownership of the budgets down to the Band 7s is clear. ZAG will continue to monitor and drive reductions.

#### 5b Month 12 IPR

**Presented by LO**

The M12 report comes to the Finance Committee retrospectively, having already been to Trust Board. The Board noted that the following KPIs should have a red RAG status: Cancelled Operations and Fractured Neck of Femur.

The Board requested that clearer methodologies for RAG status be applied to the new Board KPIs going forwards. Furthermore, KPI measures that set targets at whole numbers, rather than percentages, will be avoided for monitoring activity driven areas. Learning from this feedback has been applied to the development of the new Board KPIs, which will commence reporting M1 data in June.

The content of the paper was noted and accepted as presented.
5c **New Board KPI RAG rating proposal**  
*Presented by LO*

Following an action from Trust Board to support their formal agreement of the new Trust Board KPIs each Board Sub-Committee has been asked to agree the targets identified for each indicator, in addition the Finance Committee was asked to agree the rules that drive the RAG status and ensure Committee Chairs have confirmed indicator targets as above.

The recommended RAG methodology has been kept simple, to better support a strategic overview of performance. Whilst the rules will automatically generate the RAG rating, there is a supporting process to validate the final RAG status to recognise the need for subjective assessment of the forecast position. The Amber and Red RAG status will trigger exception reporting to the Board.

In order to ensure ongoing control of the KPIs, targets and RAG methodology that have been signed off within the appropriate governance, a simple change control process is also recommended that follows the same governance approvals for any changes.

The Finance Committee was asked to confirm that these requirements have been met, agree the RAG methodology, KPI Targets and change control mechanism.

SF noted SW opinion that mortality should not be reflected as a percentage but rather reflected as being within normal range.

Robust discussion of the Cyber Security KPI was held noting the standard but questioning the accurate reflection. If all patches were in place and we still suffered a cyber attack would the KPI be correct. Members agreed that there should be two KPIs, the one proposed and one that reflects 0 impact on services from cyber attacks, this would assure that what we are doing is working.

- **DECISION:** RAG Methodology agreed
- **DECISION:** KPI Targets Agreed pending cyber Security adjustment
- **ACTION:** Cyber Security KPI to be added to reflect 0 Impact from Cyber Attacks
- **DECISION:** Agreed Change Control mechanism

5d **Select significant business case/ and or directorate for review in future month**  
*Presented by LO*

Following discussion the committee concluded that as previously agreed it would like to receive a review of Emergency Medicine and A&E in June and then Surgery in July.

Additionally the Committee concluded it would like to receive the Gamma Camera Business Case Review in July.

**ACTION:** Medicine and A&E Directorate review in June  
**ACTION:** General Surgery Directorate Review in July  
**ACTION:** Gamma Camera Business Case Review in July

**Programme Updates**

6b **CQUIN Paper**  
*Presented by LO*

ELT received a paper in April 2019 with brief outline of schemes requesting nomination of exec sponsors and clinical operational leads; currently there remain some CQUINs where the operational lead role is likely to be overseen by the Exec Lead with additional resource to deliver the audit requirements that provide the evidence required.
Contracts are yet to be finalised with Commissioners; CQUIN has been added to Longstop. This is not unusual and a precedent has been set in prior years that Q1 payment is accepted given the delay in agreeing evidence required. The Trust would expect the same to be true for the current year, however changes to payment mechanisms means if the Trust is paid Q1 and then does not deliver by year end, the income from Q1 could still be lost. However, the counter is also true, representing an opportunity to improve performance should one quarter not deliver. This supports the Trust to agree up-front payment for Q1 with Commissioners and de-risks the delays in agreeing CQUIN in contracts.

2018/19 assessment of achievement was provided which evidences a delivery of 81%, it is therefore recommended that a similar level is adopted as the risk adjusted value for CQUIN forecasts at this stage of the year.

DW noted that historically the Trust have come to an agreement on CQUINs at the end of the year and asked how important they were at this stage. The NHS Accountability framework requires that CQUIN are delivered and they sit within the long term plan of what must be done. DW noted that nothing has gone to the Board, it was considered that this would be the case as it forms part of the Executives ‘Day Job’ it is what is done.

6c Procurement shared service
Presented by LJ
Overview was provided of the South East London STP Patient Centric Supply Chain workstream which was established following the award of £10.5m from the DHSC Wave 4 STP Estate Transformation fund and £3.5m allocated from the Health System Led Investment (HSLI) programme in December 2018.

The initiative is a joint project between the Our Healthier South East London STP Procurement and STP Pharmacy workstreams and includes Dartford and Gravesham, Guy’s and St Thomas’, King’s College Hospital, and Lewisham and Greenwich. The programme involves three elements: (1) Supply Chain Hub, to release on-site space and enable integrated on-site distribution; (2) Inventory Management Systems and a Performance Centre, to improve control of spend in high cost clinical areas and reduce the risk of errors throughout the medicine pathway; and (3) Asset Tracking, to reduce the risk of equipment loss.

From the combined capital award of £14.0m and subject to completion of Full Business Cases, £1.9m is allocated to the Trust with £1.0m provisioned for inventory systems and £0.9m for asset tracking systems.

A detailed presentation of the Supply Chain hub and opportunities was shared with members, noting that initial implementation of the services would be carried out by GSTT but noting the availability of space within the building and its proximity to the DGT site.

Finance Committee members discussed the reasons that they had not been part of the bid and it was established that the bid had been completed prior to the establishment of the Alliance.

It was widely supported and the opportunities were apparent, it was also agreed there was benefit to having one Trust to role out the service and work out the teething issues before rolling it out across others. La added that it was important to ensure that there is a plan for DGT to enable maximisation of opportunities quickly.
Further to this the committee sought assurance that the business case for the asset tracking system would follow the appropriate governance and have clear clinical engagement. This was confirmed as the case.

7b 19/20 Capital Plan Update
Presented by LO
The requested capital resubmission update was provided to committee members noting key highlights and next steps:

- NHS Improvement requested that Trusts with assumed external funding to support their 2019/20 capital programme look to reduce or eliminate.
- The Trust resubmitted the finance template on 15 May reducing the 19/20 external loan by £465k; £335k deferred to 20/21. This was approved by La and LM.
- Additional £0.7m cost for Stroke still requested.
- Trust still awaiting a decision around awarding £1.85m for Electronic Prescribing and Medicines Administration (EpMA).

Members were also notified that NHSI could still come back seeking further information / scrutiny of the Trust programme.

The paper was accepted as presented, no further questions were asked.

Items to be noted by the Committee

8a Aged Debtors and Creditors report M1
The Committee noted the content of the paper and no further questions were asked.

8b Proposal for Committee Date Change – LM
The presented proposal was robustly discussed exploring various options and concluded that a date change was not necessary. However to allow for availability of data to facilitate the performance report being presented to the finance Committee prior to the Trust Board it was agreed that this paper could be distributed on the Friday prior to the meeting as opposed to the Tuesday.

The Committee also discussed the proposed August break and concluded that it was necessary to hold a meeting in August.

- DECISION: Finance Committee to remain on the existing cycle
- DECISION: Integrated performance report to be distributed on the Friday prior to the committee meeting
- DECISION: Finance Committee will meet in August.

8b Finance Committee Work plan
Presented by LM
The Committee noted the content of the paper and no further questions were asked.

For Information

Any other Business
LM raised the concerns of the ELT that business cases of low value are being held up waiting for presentation to the Finance Committee as agreed in the SFI process. DW felt that it would be appropriate to present a business case plan for review by the committee who could then block agree the principle of such cases in advance. LA added that this plan should also map the review gateways and it needs to be a tight process.
Pc recognised the unusual position but agreed that the Finance Committee still needs to have an appropriate level of control.

- **ACTION:** Business Case plan to be presented to the finance Committee for review and agreement in principle of those cases with a small value.

Date of Next Meeting
25 June 2019, 2pm Boardroom, Level 4 Trust Headquarters.
The Minutes of the Workforce Committee held on 16 April 2019 are presented to the Trust Board following agreement at the Committee held on 18 June 2019.

For publication

To note

- Maintain and improve the quality of services delivered by DGT
- Make DGT a great place to work for everyone
- Implement and embed the clinical and organisational strategy
- Deliver the 2019/20 financial plan
- Deliver all NHS constitutional and contractual standards

- Safe
- Effective
- Responsive
- Well-led

All Workforce BAF Risks

<table>
<thead>
<tr>
<th>Committee/ Meetings at which this paper has been discussed/ approved</th>
<th>Date</th>
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<tr>
<td>Workforce Committee</td>
<td>18.06.19</td>
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MINUTES
Dartford and Gravesend NHS Workforce Committee
Tuesday 16th April 2019
Darent Valley Hospital, Dartford

Present:
Gill Jenner   Non-Executive Director (Chair)            GJ
Louise Lester Acting Director HR                     LL
Louise Ashley Chief Executive                       LA
Peter Coles   Chairman                               PC
Charlotte Bull HRBP                                  CB
Steve Fenlon  Medical Director                       SF
Francoise Iossifidis Deputy Medical Director         FI
Lynn Lane     Interim Deputy Director HR              LLa
Helen Lovelock Head workforce information planning and projects   HL
Helen Mencia  Deputy Director of Nursing and Quality HM
Lynn Gladwell Non-Executive Director                 LG

In attendance:
Victoria Moore Assistant Trust Secretary, (Minutes) VM

4-1 Apologies for absence
Apologies received from Siobhan Callanan, Director of Nursing. David Warwick, Non-Executive Director. Steve Wilmshurst, Non-Executive Director. Pam Dhesi, Director of Operations.

4-2 Declarations of Interest
There were no declarations of interest.

4-3 Minutes of meeting held 19 February 2019
The minutes of the meeting held on 19 February were agreed as an accurate record.

Matters arising Action Log

Members agreed that all appropriate actions were included on the agenda and further updates provided where required.

Action Log

10-3a Item Closed
10-3b Guideline confirmed as available and action closed
10-10 Item Closed
12-5 Item Closed
12-7 Item Closed
12-10 Item Closed
12-10 Item Closed
12-14 Item Closed
2-4 It was confirmed that the calculations had been presented to the Board and the item was agreed for closure
2-5 Information was provided and committee agreed action could be closed
2-12a Item Closed
2-12b Item Closed
**Action from the Board**

3-10 The committee discussed the CEA awards paper which outlined the action taken in 2018/19, and the proposed way forward for the 19/20 awards round. SF noted there had been confusion around payment and clarity had been provided; for the 18/19 awards round, the consultants had requested an equal split of CEA monies to consultants compliant with core skills training – this was agreed as a pragmatic way forward for the year, however the committee noted that the expectation for 19/20 was that CEAs returned to an application process and for allocation to be based on merit/demonstrated excellence.

GJ asked if consideration had been given to making awards for two years rather than one. LL and SF confirmed this was possible, and that discussions would now initiate with the Local Negotiating Committee to confirm the 19/20 approach as soon as possible. The committee noted the position and proposed approach to 2019/20 awards round.

4-4 **Annual Equality Report - CB**

The Trust is required to report and publish each year an overview of the Trust’s workforce by protected characteristic. The data provided is at end of January 2019. The format remains the same as previous years, and has been benchmarked against other Trusts to ensure appropriate content.

The focus is mainly on presenting data and trends identifying where actions related to equality, diversity and inclusion are captured and it will be triangulated with information from the staff survey 2018, WRES and gender pay gap data to inform corporate response, and will be shared with the Trust Equality, Diversity and Inclusion committee for review.

GJ noted the quality of the report which was easy to read and clear.

FI asked what the Trust’s approach is to the aging workforce and their management? LL stated that the Trust had a working longer group which no longer meets and this could be revisited if required, this group looked at work patterns and flexible working.

LA noted that the report stated there were no significant concerns, however the data demonstrated that the % of BAME staff and female staff in senior roles was not as high as would be expected in line with % of BAME and female staff in the overall workforce. LA stated that the conclusion should be revised to confirm the relevant issues and confirm where the relevant actions are being addressed e.g the Trust gender pay gap report and action plan, and the Trust Workforce Race Equality standard action plan.

Additionally the committee discussed sexual orientation noting that there are no benchmarks included and that we report a low number of staff stating that they are LGBTQ, with high numbers choosing not to disclose. CB agreed to look into benchmarking and update the report.

**ACTION:** CB to update the report with relevant benchmarking information.

The Workforce Committee were asked to note the report which will be published following the Committee meeting on the Trust’s public website as required by the duty. PC requested that the paper was presented to the Trust board prior to publishing.
**ACTION:** Annual Equality Report to be presented to the Trust Board prior to publishing.

PC also asked for consideration of what elements of the report should be shared at the Equality Diversity and Inclusion Committee (EDIC).

**ACTION:** Consider what elements of the Annual Equality Report should be presented to the EDIC.

### 4-5 Clinical Workforce Reports
#### Nursing – HM

The committee received an update on key issues outlined within the paper and this included:

- The new NMC standards were approved for use in Jan 2019, they will apply to the supervision and assessment of all student nurses, midwives and trainee nursing associates.
- Clinical placements for learners: The Trust currently has 110 Adult and Paediatric Nursing students on placements throughout April and May. In addition to these, placements for AHP, ODP, Paramedic and Return to Practice students are also provided. The Trust is currently responding to a request for information from HEE regarding capacity for additional placements. We currently work with Greenwich and Canterbury Universities and we have been responsive and flexible with our opportunities to provide a good experience for our students. The plan is to look to extend existing placements opportunities to support students.
- The Trust operating departments are now on eroster making it easier to ensure safe staffing levels for the departments and identify opportunities for efficiency.
- The Nightingale Project began in earnest on Wednesday the 3rd April 2019 with a day of simulation training for staff from four wards. The project aims to standardise safety huddles and introduce bedside handovers to improve communication and patient safety. The project also expects to see a boost to staff satisfaction and a positive impact on their health and wellbeing.

The Committee was also informed that The Trust has submitted a bid to HEE to support the development of three programmes: Healthcare assistant educational pathway, Advanced Clinical practice and Aspiring Nurse Leaders Programme.

LA stated that we need to be clear about how the Trust builds in nursing associates and GJ suggested that formal rotation into the community may be beneficial, it was noted that SC had been investigating the feasibility of this approach. LA requested that the alliance partnership with GSTT is utilised where possible as it is a valuable asset.

LA also asked about career ladders, it there a document available that shows progression routes, it was agreed that this is necessary and assurance provided that this is something that clinical education are revising.

**ACTION:** HM/SC to provide workforce committee with an update on information available to staff re clinical career progression routes.

**ACTION:** workforce committee also requested an over view of nursing requirements for the next 12 months + and plans to meet the requirements including use of the nurse associate role and other alternative roles to bridge the gap.
**Medical Staff – SF**

The paper provided set out some of the key operational and strategic issues in relation to consultant medical staff employed by DGT, the diversity of the workforce was described with clear analysis.

LLa asked if there is confidence that there is a robust system in place for tracking sickness and absence. SF and LL confirmed that there is a robust system. The data on sickness is drawn from the rotas and supported by the rota managers; also benchmarking is in line with other Trusts.

PC noted historic difficulties with rostering the consultant workforce and it was agreed this was the case, as there is not a consistent electronic system in place, and if there was this would enable better understanding, however the complexity of such a system was acknowledged and the importance of a suitable single system was acknowledged.

LA asked how we ensure we manage safer staffing against benchmarking data and ensure we have the correct amount of clinical time for the activity. SF stated that job planning does this with objective setting that is well described and prescriptive. It was noted however that specialty doctors and staff grades are not currently job planned. SF stated that specialty doctors would be the focus of a future committee’s report, and that there are opportunities within this staff group in terms of development plus increasing efficiency and productivity. For June’s committee, SF will provide an update on Junior Doctors and a clinical education update.

**National Staff Survey 2018 - LL**

The Trusts results are broadly in line with national average for acute Trusts. The Trust results compare favourably to the results of the other acute Trusts in the Kent and Medway area, with DGT reporting the best acute Trust staff survey results overall for the geography. However the 2018 results are less positive than the results from last year’s staff survey. The context at the time of the 2018 survey included transition in the Trust CEO.

The overall staff survey results have also been impacted by feedback from staff in challenged services, including the Pathology joint venture with Medway FT (where staff are hosted by the Trust). The results have been shared with Trust Board in early April 2018.

LG noted the clear action plan and asked for assurance about the provision of a safe environment whilst balancing risk to security guards. LL advised that security staff have been provided with body worn cameras and this has helped to deescalate some of the worst behaviour. Security staff are included in the managing challenging behaviour training to ensure common understanding and a violence and aggression reduction strategy is being developed.

LA requested that outcomes were added to the action plan to show where it is expected to be in 3, 6, 9 and 12 months’ time. It was agreed that this would be added.

Further robust discussion of bullying and harassment was held, the survey does not indicate that the Trust has significant issues compared to other trusts, including acute trusts, but it is essential that work continues with the JCC to look at high points and low points. LG suggested that areas with low reported issues should be looked at to use their best practice. This is something the HR Business Partners are working with Clinical Groups on (sharing best practice from other areas – within and outside groups).
4-7  **Workforce Performance Report - LL**  
The paper provided an overview of workforce performance and key performance indicators as at the end of February 2019.

Highlights included a reduction of 0.9% in the vacancy rate now RAG rated amber, a 4.5% increase in appraisal rates, 0.3% increase in mandatory training, 2.8% increase in Information Governance and 0.9% increase in core induction compliance rates, all of these metrics are RAG rated green.

Sickness Absence is red RAG rated and has seen a 0.49% increase.

The clear content of the paper was noted and accepted as presented.

**Statistical Process Control – HL**  
The Committee were provided with an overview of SPC charts for core workforce data including vacancy, turnover, sickness absence and appraisal and an explanation of SPC indicators, measures and trends for the respective KPIs was provided.

The committee noted the report and that use of SPC reporting was an aim of the Trust Board to enable better understanding of trends and where areas are within trajectory or outliers. It was acknowledged that a consistent approach was required regarding use of data points across all Board and Sub-Committees and that a Board development session is planned to conclude the ambition.

All members acknowledged the value of this type of reporting and VM will follow up and arrange the Board development session.

**ACTION:** VM to arrange SPC board development session.

The committee discussed the increasing turnover and that turnover remains black RAG rated. LL advised the committee that a deep dive assessment of turnover is being undertaken and that in there had been an increase in the number of leavers due to retirement. LL and SF highlighted to the committee that senior medical staff have raised their increasing concern about the potential impact of annual and life time allowances on their pensions/potential tax bills – and this is leading some medical staff to explore options including reducing PAs, retiring earlier than planned, etc.

**ACTION:** LL and SF advised the committee that they are assessing the impact of this national issue and exploring options available to support addressing this. An update will be provided to the June Workforce Committee.

4-8  **Workforce Plan - LL**  
An overview of the workforce plan was provided including changes by substantive, bank and agency staff. The changes were broken down to show drivers including WTE reduction linked to efficiency and increases related to quality investments.

The Workforce Committee were advised of the future approach for monitoring and managing workforce efficiencies and ongoing workforce plan development.

PC sought assurance that this reconciles with the Trust financial plans, QIPP and CIP. LL confirmed that this is the case.
4-9 Guardian for Safe Working quarterly report – SF
The paper was prepared by Dr Mathias Toth, Guardian for Safe Working hours and presented by SF. Key highlights of the paper included:

- The majority of exception reports are being raised by F1 doctors. In the main the exceptions relate to additional working hours (most commonly up to 1 extra hour per exception) and remedy is typically payment.
- A number of areas continue to have pockets of low clinical supervisor engagement with reviewing and closing exception reports e.g. O&G.
- There has been an increase in exceptions related to missed education opportunities, and although these exceptions are low, it is likely missed education opportunities will increase as the next intake of medical trainees will be required to attend additional outpatients clinics for curriculum requirements to be met.
- There continues to be low attendance at the junior doctor forum hosted by the Guardian of Safe Working. However there is good engagement by the junior doctor representatives with the Trust LNC, and recently agreement reached for the junior doctor representatives, Acting HR Director and Medical Director to sign the BMA fatigue and facilities charter, and work together on assessing current facilities status/identifying where improvements could be made.

Following receipt of the report an action plan has been drafted by the Medical Director and was presented to the committee. Actions will be discussed and agreed with the Guardian of Safe Working on return from leave. Members were also informed that the GOSW is now reporting into and being supported by a non-executive Director (Chair of Workforce Committee).

Following the presentation to the Workforce Committee the paper should be presented to the Trust Board. The Workforce Committee endorsed this request and approved it for presentation.

DECISION: Approved for presentation to the Trust Board.

4-10 Workforce Change - LL
An overview of workforce change within the Trust was presented noting Oak ward bed closures, NKPS Workforce Review, HASU preparation, the transfer in of Minor Injuries staff and the transfer out of orthodontics staff. Additionally members were made aware of Kent and Medway STP schemes including: Single pathology service, joint procurement of medical agency, development of regional talent board and joint application to NHS Leadership academy for NHS Graduate trainees.

The paper was accepted as presented and no further questions asked.

4-11 National Workforce Issues - LL
An overview of national workforce issues was provided noting the long term NHS plan, which is anticipated in April 2019, Leaving the EU, Apprentice Levy transfer, agenda for change refresh and pension changes coming into effect on 1st April 2019.

LA asked about EU staff, originally the Trust had agreed to pay for staff settlement scheme applications however the government has since removed the £65 and any staff member that paid this for early applications will have the £65 refunded – therefore the Trust will recoup this money as the fee is returned.
LL confirmed that advisory sessions continue to be provided to our EU staff on the settlement scheme process, supported by Capsticks solicitors.

4-12 Committee Terms of Reference – GJ

The Terms of Reference were presented to the committee for discussion and approval. The Committee reflected that they were fit for purpose and with the minor amendment to the following sentence they were approved as a final version to be presented to the Trust Board for ratification.

“The Trusts Health, Safety and Security Committee will report into the Workforce Committee, providing an overview of Committee meetings and an annual report on activity. Any issues related to Health, Safety and Security by exception will also be reviewed by the Workforce Committee.” (Amended to read Quality and Safety Committee)

DECISION: ToR Approved for submission to the Trust Board for ratification.

4-13 Committee Forward Planner - LL

The Committee received an overview of the proposed annual agenda., noting a number of new items which have been proposed based on recent committee effectiveness discussions and terms of reference review. This includes items on health and wellbeing, staff development and engagement, and regular committee focus on new ways of working.

A new standing agenda item was suggested, Clinical Workforce, this would be presented by the Medical Director and Director of Nursing and Quality each committee, and be focused on: education and professional development; leadership; productivity; future workforce.

Safer staffing reviews related to nursing have previously been presented to Workforce Committee in April and October bi annually. It is proposed this year safe staffing reviews will be received in June and October, to allow for the nursing review to be completed, and to incorporate additional front line clinical staff groups into the review process, in line with the requirements of Developing Workforce Safeguards.

It was also proposed that summaries/committee notes from the Joint Staff Consultative Committee, and Health, Safety and Security Committee are reviewed by Workforce Committee at each committee meeting to provide subcommittee oversight. In addition to the addition of the annual health, safety and security report, previously reviewed by Quality and Safety committee in December in line with the previous reporting schedule.

The Forward Planner was agreed by the Committee

DECISION: The Forward Planner was agreed by the Committee

CLCH Committee Feedback - GJ

Committee members were informed that this visit had been useful and has influenced some of the changes to the forward planner, noting that the CLCH Committee receive papers presented by others not just HR and suggested that this approach could be considered in the future.
4-14 **Board Assurance Framework - LL**
The two risks overseen by the Workforce Committee were updated as agreed by the Committee at its last meeting and were presented for further review and discussion. In addition the paper provided overview of the future structure of the Board Assurance Framework and the format for presentation. At the April 2019 Board meeting there was a development session regarding the Board Assurance Framework. A different approach and format were suggested and these are detailed in the report.

Committee members asked the two set questions and concluded

**WHAT INFORMATION HAVE WE CONSIDERED AS PART OF TODAY’S AGENDA THAT PROVIDES US WITH ASSURANCE RELATED TO THIS RISK?**

*Risk 2037* The agenda would benefit from additional work on modelling and safer staffing – this will be picked up via the June 2019 committee agenda.

*Risk 2038* There is sufficient inclusion on the agendas.

**ON THE BASIS OF THE INFORMATION WE HAVE RECEIVED AS A COMMITTEE, HOW ASSURED ARE WE THAT THIS RISK IS BEING MANAGED APPROPRIATELY?**

*Risk 2037* There is limited assurance; we are good at looking at now but need to be more forward thinking. However it was noted that there is assurance of good management. June workforce committee will including information on future nursing capacity requirements, and modelling/planning updates on how this demand will be met.

*Risk 2038* There is sufficient assurance available and evidenced by the appraisal KPI updates.

4-15 **Summary of Complex and Contentious Employee Relations Issues – LL**
An overview of employee relations issues that have potential clinical implications, potential reputational issues, financial impact or other components of relevance such as whistleblowing implications was provided to committee members and the paper was accepted as presented.

4-16 **Notes from the meeting of the Joint Staff Consultative Committee 28/02/2019**
These notes were provided for oversight and no further questions were asked.

4-17 **Summary of Health, Safety and Security Committee 27/03/2019**
These notes were provided for oversight and no further questions were asked. Pc asked that these minutes are presented to the Trust Board in the assurance section.

**ACTION:** Present the minutes of the Trust Health Safety and Security Committee to the Trust Board for Assurance.

**Any other Business**
No other business was raised.

Date of Next Meeting: 18th June, 10am Boardroom, Level 4 Trust Headquarters.
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Summary Report from Workforce Committee</th>
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<tbody>
<tr>
<td>Author:</td>
<td>Director of HR</td>
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<tr>
<td>Presented by:</td>
<td>Chair of the Workforce Committee</td>
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<tr>
<td>Purpose of paper</td>
<td>Summary update of the June Workforce Committee</td>
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<td>Key points for the Trust Board:</td>
<td>This report summarises the main points and actions from reports considered by the Workforce Committee at the meeting of 18 June 2019.</td>
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| Recommendations:        | Reason for submission of report to Trust Board (information, assurance)        |
|                        | For Information and Assurance                                                   |

**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

| Organisational Priorities | • Maintain and improve the quality of services delivered by DGT  |
|                          | • Make DGT a great place to work for everyone                          |
|                          | • Implement and embed the clinical and organisational strategy         |
|                          | • Deliver the 2019/20 financial plan                                   |
|                          | • Deliver all NHS constitutional and contractual standards             |

| CQC Reference           | • Safe                                           |
|                        | • Effective                                      |
|                        | • Caring                                         |
|                        | • Responsive                                     |
|                        | • Well-led                                       |

| Board Assurance Framework/Trust Risk Register | All Workforce Board Assurance risks. |

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Safer Staffing
Safer staffing for nursing, midwifery and medical was reviewed and discussed – this was the first time medical safer staffing had been presented to the committee in line with Developing Workforce Safeguards requirements for Boards to be assured of safer staffing across a broader remit than nursing as has traditionally been the case in Trusts. Non-Executive Director, David Warwick noted there had been a 40% increase in nursing since 2013, the Director of Nursing and Quality clarified this was spend including bank and agency and not establishment which is what is reviewed as part of safer staffing. The committee asked for a review of previous investment in nursing posts and the rationale for review at the October committee when the next safer staffing review is due to be presented.

The Director of HR and Director of Nursing and Quality presented a modelling tool to outline the projected RN vacancy rate across the year based on establishment changes pending, and previous recruitment and turnover trends. A plan was presented to increase nurse supply and reduce the vacancy rate to <9% by financial year end. As part of this non-eea international nurse recruitment was proposed for 20 nurses using learning from previous campaigns. It was noted a business case would be required. Non-Executive Director, David Warwick challenged that bank recruitment would be just as cost effective if bank rates are comparable to AfC, in response to this concern was raised that the extension of bank usage needed to ensure that staff wellbeing was not compromised, by asking then to work too many hours. Both the Director of Nursing and Quality and the HR Director advised that the business case would ensure there was clarity of options including bank fill and the benefits of the options.

Clinical Workforce Report – Clinical Education
Clinical education presented an update to the committee – this included progress on responding to the previous GMC survey (and a new survey is pending) as well as updating the committee on implementation of trainee nursing associates. The committee were advised 9 trainee nursing associates will start their training programme in September 2019. The committee were also advised that this financial year, the workforce development fund is very low at 120K for all staff (approx. £40 per head) and presents workforce development challenges. The Director of HR advised that the HRD group in Kent and Medway is reviewing the allocations across the locality to see if there are opportunities for collaboration that will be cost effective on the limited resource.

Staff Development and Engagement
The committee focused on the freedom to speak up guardian and strategy with the guardian present to brief the committee on the strategy and the recruitment and roll out of freedom to speak up ambassadors. The committee heard how the team currently work to support staff, and how themes and issues are escalated including via 6 monthly meetings with the Chair and NED for whistleblowing. The Director of HR reflected that in relation to learning lessons from people practices, a separate item on the agenda re how Trusts can better support staff in employee relations processes, the guardian and ambassadors will be invited to join the work on developing an action plan that puts people’s health and wellbeing in the centre of our people practices going forwards.
Learning Lessons from People Practices
A series of recommendations from NHSI following a tragic outcome to an employee relations case at a London Trust in recent years, the committee were provided with an overview of the recommendations, and a plan for how the HR directorate will respond. The complex and contentious employee relations cases paper was adapted this committee to provide greater oversight of case number and type currently being managed, decisions made on case management and rationale, a summary of impact on patients and/or staff within the cases, and any lessons learnt. This was in response to the recommendation for increased oversight of employee relations activity.

Workforce Performance
The committee reviewed workforce metrics and plans to address areas below green target. There was a discussion re NKPS vacancy rates and turnover. The Director of HR noted that a workforce review has recently been undertaken and the assurance board provided with a proposed workforce model that will support stabilisation of the service. Committee members asked for this to be shared.

Equality Delivery System (EDS) 2
The Director of Nursing and Quality and HR Director provided an updated Equality delivery system 2 self-assessment as this had not been reviewed since 2016. They also proposed revised equality objectives linked to the assessment. The committee requested that the revised EDS2 and objectives be shared with the Equality, Diversity and Inclusion Committee for review and input - this will be added to the agenda for the next meeting. The committee also noted that some self-assessment outcomes rated as partially achieving were possibly too low and should be reviewed to determine if outcome should be “achieving”, both the Director of Nursing and Quality and Director of HR will review this.

Interim People Plan
The committee were provided with an overview of the interim people plan by Director of HR this included main themes and next steps. The committee will be provided with further updates as they arise. There was a discussion re proposals on pension reform and a pending consultation for senior clinical staff to mitigate the impact of lifetime and annual pension allowances – however it is not clear whether this will mitigate the risk at local level and the Medical Director highlighted that there is an operational risk to the anaesthetics rota as consultants opt out of extra duties to reduce the risk of tax implications from additional pay that is pensionable. The Medical Director and Director of HR will continue to review this and seek legal advice/review what other Trusts are doing.

BAF
Due to the length of the agenda, it was not possible to review 2 new BAF risks assigned to the committee. The Committee Chair and Director of HR proposed that they review the BAF and circulate feedback to other members for comment. The committee also proposed the BAF is reviewed in totality at July Board.

Topol Review
An agenda item on the workforce implications of the Topol review will also roll to August so that there is more time for this to be discussed.
## TRUST BOARD - JULY 2019

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<tr>
<th>Subject:</th>
<th>Minutes from Charitable Funds Committee – Part 1</th>
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<tr>
<td>Author:</td>
<td>Assistant Trust Secretary</td>
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<tr>
<td>Presented by:</td>
<td>Chair of the Charitable Funds Committee</td>
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<tr>
<td>Purpose of paper</td>
<td>Minutes of the Part 1 Charitable Funds Committee</td>
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### Key points for the Trust Board:

**Briefly summarise the main points and key issues**

The Minutes of the Charitable Funds Committee held on 26 February 2019 are presented to the Trust Board following agreement at the Committee held on 26 June 2019.

### Recommendations:

For information

### Links to Board priorities, Board Assurance Framework, Trust Risk Register

| Organisational Priorities | • Maintain and improve the quality of services delivered by DGT |
|                          | • Implement and embed the clinical and organisational strategy |
|                          | • Deliver the 2019/20 financial plan |
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| CQC Reference | • Safe |
|               | • Effective |
|               | • Caring |
|               | • Responsive |
|               | • Well-led |

| Board Assurance Framework/Trust Risk Register | All BAF risks |

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<tr>
<td>Charitable Funds Committee</td>
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MINUTES
Dartford and Gravesham NHS Charitable Funds Committee (Part 1)
Tuesday 26th February 2019
Darent Valley Hospital, Dartford

Present:
Lynn Gladwell Non-Executive Director-Committee Chair LG
Francois Iossifidis Deputy Medical Director FO
Lorraine Mills Director of Finance LM
Djafer Erdogan Assistant Director of Finance DE
Kathy Peache Finance Manager KP
Sally George Fund Raising & Voluntary Services Manager SG
Jane Burr Trust Secretary JB

In attendance:
Victoria Moore Assistant Trust Secretary, (Minutes) VM

2.1 Apologies for absence
Apologies were received from Louise Ashley, Chief Executive

2.2 Declarations of Interest
There were no declarations of interest.

2.3 Minutes of meeting held on 16th October 2018
The minutes of the meeting held 16 October 2018 were agreed as an accurate record

Action Log
The Committee agreed that all appropriate actions from the log were on the agenda

6-5 - LM to follow up with Professor Madaan with regards to an update around new equipment to carry out procedures, costing £60k. This has been done and agreed appropriate for closure. CLOSED

10-5 - The accounts and letter of representation will be presented to the Trust Board at the next meeting. This was presented to the Trust Board 1 November 2018. CLOSED

10-13 - Terms of Reference to be presented to the Trust Board for ratification. These were presented to the November Trust Board – CLOSED

2.4 Finance Reports - KP
The Charity opened the financial year with fund balances of £547k as at 1 April 2018. During the reported period 1 April 2018 to 31 December 2018 the balance has decreased by a net movement of £10k resulting in a closing balance of £537k. To date a further £140k has been allocated resulting in funds available of £397k.

The Committee discussed individual special funds and their balances and any plans to spend the available funds.
Clarification was sought and provided that services belonging to the Trust at Queen Mary’s Hospital, Sidcup could access the DGT funds, but that no approaches had been made.
Additionally the Committee discussed possible applications for charitable funds that they felt might be appropriate and confirmed the date for the next Charity Management Board as the 13 March 2019 for any applications to be considered.

JB noted that ITU may make a request for Dyson fans for patients, De felt that this should be financed by the Trust as they are to help patients. Fi was concerned that this would not be a capital priority and asked if a special case could be made for ITU.

2.5 Charitable Banking Update - DE
The Committee was informed that, following Treasury approval the GBS account has now been set up. The account has online access to allow transfer of funds as required.

Clarification was provided that the existing Co-Op account will remain open to collect those donations already set up and that inter account transfers would be made monthly as appropriate.

2.6 Detailed scrutiny of funds
The proposed scrutiny of a particular fund was discussed and concluded that the next Committee would receive a transactional deep dive, to see additional detail of income and expenditure.

ACTION: The June Committee will receive a transactional deep dive, to see additional detail of income and expenditure.

2.7 Valley Hospital Charity Shop and Fundraising Hub Update
The update was provided under Part 2 of the meeting

2.8 Ride4Life
There are currently 29 Riders signed up for the event in June 2019, with a deadline for applications of the 1 April 2019.

The Committee were informed that a donation of £1000 for sponsorship of the jerseys had been received from a local FM provider and that they had put two riders forward to take part in the event.

2.9 Association of NHS Charities Update
Following the NHSBig7tea campaign last year, it was agreed that a future nationwide campaign would be beneficial and supported by NHS Charities. From November 2018 the activities of NHS Charities Together moved under the governance of the Association of NHS Charities. The Association is now providing the forum to collectively raise the profile of NHS Charities and further support fundraising through nationwide campaigns, with a Steering Group of Association members and NHS England leading this.

During 2019, the Association itself will rebrand as NHS Charities Together in order to:

- Raise the profile of the Association and its member NHS Charities nationally
- Increase the public’s understanding of the role of NHS Charities
- Raise income for the Association of NHS Charities and its members
- Lead the successful establishment of NHS Charities ‘Big Tea’ as an annual nationwide fundraising campaign
- Establish 5th July as ‘NHS Day’ nationally for NHS Charities
- Build a large-scale NHS Charities 75th NHS Birthday Campaign for 2023
Item 7-19. Attachment N – Minutes of 26 February 2019 Charitable Funds Committee - Part 1

- Resource and enable member charities to increase their income
- Resource and enable member charities to increase the services they support or deliver, including volunteering, in line with the ambitions of NHS long-term plan.

In addition to these plans discussion of safeguarding specifically in relation to volunteers raised some points that needed to be investigated further and addressed and work continues to resolve these issues.

LG agreed that it was a positive action to pull together and increase visibility.

2.10 Committee Forward Planner
The forward planner was presented and the need to carry out a review to ensure that the Charitable Funds Committee had met its objectives was accepted, this work will be done by the JB and circulated to members for feedback and comment.

Members were asked to review the forward planner and provide comment or requests to the JB as appropriate.

Members requested that Annual Report of Volunteers out of pocket expenses was removed as this is paid from a Trust Budget.

**ACTION:** Comments and feedback on the forward planner to be sent to JB

2.11 Committee Terms of Reference
The Terms of Reference were presented, amendments were discussed and the committee requested a specific entry in respect of permitting a part 2 meeting is added.

Pending the agreed addition the Terms of Reference were approved for ratification by the Trust Board.

**DECISION:** Terms of Reference approved by the Committee

**ACTION:** Submit Terms of Reference to the Trust Board for ratification

2.12 Minutes of the Charity Management Board
The Minutes were accepted as presented and the Committee extended its congratulations and thanks to the organisers of Stride4Life which raised £36k in 2018.

2.13 Requests to January
The paper presented provided detail of the requests received by the charitable fund between September 2018 and January 2019. The Charitable Funds Committee was asked to review and note the contents.

The Committee discussed Paxman Scalp Cooling Systems which are now 10 and 8 years old. These systems help reduce the hair loss/hair thinning of patients receiving chemotherapy and were originally purchased with a grant that included maintenance, the maintenance agreement is now out of date and the replacement system does not come with inclusive maintenance costs. Whilst the details are agreed the purchase has been put on hold. The Committee were clear about the importance of these items and concluded that costs and commitments should be agreed and that they were supportive of the planned purchase.

The Committee discussed the membership of the Charity Management Board and the suggestion that one meeting a year could be help jointly with the Management Board and committee. This proposal will be considered and discussed with feedback provided at the next meeting.
2.14 **Any other Business**

The Committee were presented with the following items for discussion:

**Draft Grants Policy**

Best practice guidance from the Association of NHS Charities suggests the introduction of a Grants Policy. The committee were provided a draft copy of the DGT policy which has been written using an approved template from the Association of NHS Charities, this will ensure that the Trust charity is in line with other NHS Trust charities and that key elements are sufficiently covered in the document.

The Committee were satisfied that the document was appropriate and comprehensive but asked that the spend flow chart was revisited and adjusted to clarify the current process.

**Grant for Medical School Volunteering**

The Committee were informed of a scheme run by the Pears Foundation that provides grants to facilitate prospective medical school applicants obtaining appropriate work experience. It was agreed that this year DGT is not in a position to bid for the funds but that it is something that should be pursued in the future, additionally it was felt that if it is a scheme we could implement partially prior to bidding it would put the Trust in a stronger position to secure the funds.

**Volunteers**

Following discussion of medical school volunteers the committee discussed the forums that the volunteers are discussed at. At present this is with the Director of Nursing and the Deputy Director of Nursing, it was concluded that the Director of Finance would discuss this with the Director of Nursing and add to the committee forward planner if appropriate.

**Date of Next Meeting**

25th June 2019, 11am CEO Office, Level 4 Trust Headquarters.
## TRUST BOARD - JULY 2019

| Subject: | Summary Report from Charitable Funds Committee – Part 1 |
| Author: | Assistant Trust Secretary |
| Presented by: | Chair of the Charitable Funds Committee |
| Purpose of paper | Summary update of the Part 1 June Charitable Funds Committee |

### Key points for the Trust Board:

*Briefly summarise the main points and key issues*

This report summarises the main points and actions from reports considered by the Charitable Funds Committee at the meeting of 25 June 2019.

### Recommendations:

For information

### Links to Board priorities, Board Assurance Framework, Trust Risk Register

#### Organisational Priorities

- Maintain and improve the quality of services delivered by DGT
- Implement and embed the clinical and organisational strategy
- Deliver the 2019/20 financial plan
- Deliver all NHS constitutional and contractual standards

#### CQC Reference

- Safe
- Effective
- Caring
- Responsive
- Well-led

#### Board Assurance Framework/Trust Risk Register

All BAF Risks

### Committee/ Meetings at which this paper has been discussed/ approved

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SUMMARY REPORT
Dartford and Gravesham NHS Charitable Funds Committee (Part 1)
Tuesday 25th June 2019
Darent Valley Hospital, Dartford

Finance Reports
2018/19
Details of fund movements with a focus on those balances that remain uncommitted was provided, noting that the Charity opened the financial year with fund balances of £547k as at 1 April 2018. During the reported period April 2018 to March 2019 the balance has increased by a net movement of £3k resulting in a closing balance of £550k. Further to this members were informed that £43k has been allocated resulting in funds available of £507k.

2019/20
Details of fund movements with a focus on those balances that remain uncommitted was provided, noting that the Charity opened the financial year with fund balances of £550k as at 1 April 2019. During the reported period April 2019 to May 2019 the balance has decreased by a net movement of £16k resulting in a closing balance of £534k. £107k has been allocated resulting in funds available of £427k. Additionally the Committee received analysis of special funds and was satisfied that the reserves balance conforms to the charitable funds reserves policy.

Charitable Banking Update
Charity now has an active GBS account that is fully operational. This account has a balance of £440k and the Co-Op account holds a balance of approximately £90k. All balances are managed by the finance teams and confirmation was provided that since the opening of the GBS account no charitable funds are held in Trust Accounts.

Detailed scrutiny of funds
Transactional Deep Dive
A Transactional deep dive was provided analysis of income and expenditure, over £5k however it was noted that the majority of transactions are under £5k, and that these small donations amount to £324k.

The committee concluded that the smaller donations did not need further oversight but felt that they would like some insight into the number of, and, value of donations made by direct debit and standing orders, historically this has been reported as £11k.

Identification of Fund for Scrutiny next time
The proposed scrutiny of a particular fund was discussed and concluded that the next Committee would receive the expenditure plans for the other funds held within the Trust.

Draft Grants Policy
Following presentation to the February Charitable Funds Committee where members were notified that Best practice guidance from the Association of NHS Charities suggests the introduction of a Grants Policy and the committee were provided a draft copy of the DGT policy which has been written using an approved template from the Association of NHS Charities, this will ensure that the Trust charity is in line with other NHS Trust charities and that key elements are sufficiently covered in the document.
Following discussion the February Committee were satisfied that the document was appropriate and comprehensive however they requested that the spend flow chart was revisited and adjusted to clarify the current process.

Members were presented with the updated approvals process flow chart and assured that it has been updated in line with the current SFI's. Approval was sought to present to the Trust Board for ratification and then formally implement the policy. The Committee approved the policy for submission to the board.

**Association of NHS Charities Update**

Association of NHS Charities will now be rebranded as NHS Charities Together.

The recent AGM and its agenda was discussed, this touched on the use of volunteering in the long term plan; but did not directly help with solving any of the local issues such as the length of time it takes to get volunteers in and ensuring that the volunteers have positive experiences. Further discussion of the length of time it takes to appoint volunteers was held and the reasons were provided: these delays are often linked to the complexity of checks and the issues regarding reference checks, especially for those without easily traceable recent employment references.

Confirmation of the NHS Tea event which will be held in July was provided, this directly follows the success of the 70th Birthday celebrations and will happen annually. It is hoped that following this year the Trust can continue to build on the event and use it as an opportunity to engage staff. Linden and Ebony are holding a tea party and there will be a stand in the main reception all week.

**Committee Forward Planner**

Following feedback on the forward plan at the February meeting the plan has been revised and was presented to members for review and approval. Members were reminded that the forward plan has been based on historic requirements to ensure that the Committee meets it legal obligations. The Committee reviewed the forward plan and approved it as appropriate and fit for purpose.

**Committee Terms of Reference - JB**

The Terms of Reference were presented in the revised format noting that no material changes had been made, and the committee was informed that due to other commitments the Chief Executive had asked to be removed from the membership of the committee as she was assured that the committee was being conducted in a well-managed manner. It was also proposed that the Chief Operating Officer be included in the membership to ensure Quorum could be achieved.

Committee members approved this request and the ToR should be updated accordingly and presented to the Trust Board for formal ratification.

**Minutes of the Charity Management Board 13 March 2019**

The minutes were presented for information; the Committee noted their content and accepted them as presented.

**Minutes of the Charity Management Board 29 May 2019**

The minutes were presented for information; the Committee noted their content and accepted them as presented.

**Requests January to March 2019 and March to May 2019 – Special Funds Only**

The paper presented provided detail of the requests received by the charitable fund between March 2019 and May 2019. The Charitable Funds Committee was asked to review and note the contents.
Any other Business
The committee aware that in recent times there have been ‘Awareness Day’ stalls in the main reception and although they have met the appropriate criteria and been vetted it has been noticed that collection tins that had not been agreed had appeared; these issues with the stall holders as appropriate.
Subject: Grants Policy

Author: Head of Fundraising and Voluntary Services

Presented by: Chair of Charitable Funds Committee

Purpose of paper: For information and ratification

Key points for the Trust Board:
Following best practice guidance from the Association of NHS Charities, the Valley Hospitals Charity wishes to introduce a Grants Policy. The policy has been written using an approved template from the Association of NHS Charities to ensure that the Trust charity is in line with other NHS Trust charities and that key elements are sufficiently covered in the document.

This policy was received by the Charitable Fund Committee who agreed its content was suitable and fit for purpose and is presented to the Board for ratification as the sole Trustee for the Charity.

Consideration of public and patient involvement and communication:
For publication

Recommendations: The Board is asked to note the policy and its endorsement by the charitable funds committee and its implementation

Links to Board priorities, Board Assurance Framework, Trust Risk Register

Organisational Priorities
• Maintain and improve the quality of services delivered by DGT
• Make DGT a great place to work for everyone
• Deliver all NHS constitutional and contractual standards

CQC Reference
• Effective
• Caring
• Responsive

Board Assurance Framework/ Trust Risk Register

Committee/ Meetings at which this paper has been discussed/ approved Date
Charitable Funds Committee 25.06.19
VALLEY HOSPITAL CHARITY

GRANTS POLICY

1. Background

This purpose of this policy is to set out the principles, criteria and processes that govern how the Charity makes grants across all fund types.

Grants are awarded using a robust procedure to ensure donations are spent in accordance with the charity’s charitable objects and supporters’ wishes, to the greatest benefit of patients, their families and others who support them.

The trustee(s) has/have three main routes to govern the Charity’s grant-making:

- **Grant-making principles which are driven by good governance practice**
  Even where there is donor or funding partner involvement, or recommendations have been received from the Charity’s beneficiary the Dartford and Gravesham NHS Trust, or restrictions have been placed on the donation’s use, decisions and grant awards are ultimately made by the trustee(s).

- **Grant-making criteria which provide the public statement of the activities the trustee(s) wish to support in furtherance of the Charity’s charitable objectives**
  The criteria may also include those activities which it/they do not currently wish to support because the trustee(s) does/do not consider them to be in line with the Charity’s purpose. The trustee(s) acknowledge(s) that it/they may on some occasions make grants outside the published criteria, but that in all such cases the activity supported will be charitable in law.

- **Grant-making processes** which transparently set out in broad terms how decision-making is carried out for different types of grants.

2. Definitions

A grant is defined as a financial award made by the Charity from its funds to support its charitable activities to the Dartford and Gravesham NHS Trust.

3. The law

3.1 The charity must ensure via suitable due diligence and grant conditions that grants made to the NHS body are for a specific charitable purpose that provides sufficient public benefit in accordance with Charity Commission guidance on grants to non-charities, which includes NHS bodies. While the activities of NHS bodies will ordinarily be within the charitable purposes of an NHS charity, these actions must be demonstrable.

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<td>Grants Policy</td>
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3.2 The charity must have systems in place to set its priorities and assess risks in relation to grants and, in particular, to monitor grants made.

3.3 As an NHS charity, the charity may use its charitable funds to supplement or subsidise public services as this is within their objects, in the interests of the charity and its beneficiaries, where there is clear justification for doing so. The charity will ensure that its decision-making processes are clear and well-documented and record the particular charitable need addressed.

4 Statement of Principles

4.1 The governance principles which underpin the trustee(s)’s governance of the Charity’s grant-making take into account the scale of grant-related activity and strike a balance between direct involvement in decisions, and efficient, responsive customer service for applicants and donors. The governance principles are as follows.

- The Board has ultimate responsibility for all grant-making decisions in line with the Charity’s charitable purposes and any restrictions agreed with donors and funding partners.
- The trustee(s) may give certain decision-making responsibilities to a Grants Committee, Board members or staff within its framework of delegation.
- The trustee(s) approves and understand(s) the Charity’s grant-making principles and processes and have opportunities to engage in and learn from grant-making activities.
- The trustee(s) reserve(s) the right not to approve any recommendation or nomination if, through its decision-making, it determines that the resulting grant would not be charitable, or would conflict with the Charity’s stated policies or damage its reputation.

4.2 Through its grants schemes the Charity funds clinical research, health initiatives and projects which improve patient care and those which support staff to deliver improved patient care, all with the aim of changing lives through extraordinary healthcare.

The trustee(s) understand(s) that sometimes the smallest changes can make the biggest difference to a patient’s time in hospital, be it a more relaxing waiting area, better equipment, activities to improve wellbeing or better access to information.

4.3 The trustee(s) set grant-making criteria, the aim of which is to provide clear information from the trustee(s) to those who want to apply for grants. Clear guidance on criteria for applications is set out at Appendix I. The Charitable Funds Committee will review these criteria from time to time and, if necessary, amend or update them.

4.4 Research projects must seek to answer important questions that will make an impact on patient care within the Trust, surrounding communities and the wider NHS.

5 Grants process

5.1 Grant application process
All applicants must hold an NHS employment contract, must currently deliver services and plan to undertake their proposed project for the benefit of patients at Dartford and Gravesham NHS Trust.

The first step is to complete a short online application form on Adagio summarising the proposal. https://www.dgt.nhs.uk/adagio/publications/forms/fundraising-request-form/ This outlines:

• details of the unmet need the project will address
• project aims
• project cost
• anticipated outcomes

Applications must clearly demonstrate how the project proposal meets the Charity’s strategic aims, fits the criteria and will improve patient care, services, experience or staff amenity. They must provide evidence that the project will make a measurable difference to patients.

Applications should state how the learning from the project might be disseminated and how this will be achieved. All projects should have the potential to share learning and good practice with others and be of good value to other NHS trusts, staff or organisations. This might include:

• Articles in NHS trust publications
• Articles in the Trust’s newsletter or website
• Publications in peer-reviewed journals
• Presentations or posters at conferences
• Evaluation of the project shared with other departments/wards, staff, Trusts
• Use of the project as a good practice case study in a national pilot or working group
• Promotion of any awards, prizes or other type of recognition gained by the project/project staff, including further funding
• Any publicity in local, national or specialist press

Applications can be submitted at any time. If the Charity considers the project is viable, the applicant may be invited to attend the next Charity Management Board Meeting to present their proposal.

All applications must be endorsed by the Senior Sister/ Head of Dept, and if over £5k they must have approval by Capital.

5.2 Application assessment

Applications are received by the Head of Fundraising and Voluntary Services.

Advice is sought as necessary from clinical specialists in the field, EBMA, IT etc. and if over £5k a Capital Bid Request Template (2 sides A4) needs to be completed and approval from Capital sought.

A list of applications is sent out with the papers for the Charity Management Board meetings. The CMB reviews each application with comments received and where available, invite a representative to present their application.

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Ward/Department recognises need - endorsed by Manager (could include implementing patient feedback)

Complete Fundraising Request Form on Adagio

All expenditure up to £5k must be approved by the CMB. If an item is under £2k this can be approved by the Head of Fundraising in between CMB Meetings, and ratified at the next CMB Meeting.

All expenditure over £5k needs to be approved by Charitable Funds Committee. If expenditure is Capital, then it needs approval at CIG. CIG ToR will apply.

Check with EBME and IT to see if desired equipment is supported at the Hospitals.

Circulate request with Charity Management Board Papers prior to meeting

Invite a staff representative to the Charity Management Board meeting to talk through the request

Discuss requests at bi-monthly Charity Management Board Meetings

Outcome of CMB decisions on requests shared with Chair of CFC and agreed.

Head of Fundraising & Voluntary Services to feedback decision or find out more information as required.

Funding Requests and Charity Management Board Meeting papers are shared with the Charitable Funds Committee.
The Charitable Funds Committee meets 3 times a year. The CFC is a sub-committee of the Trust Board. The Committee will oversee the governance of Dartford and Gravesham NHS Trust, in accordance with the duties and responsibilities of charitable Trustees. It will ensure that Valley Hospital Charity complies with its charitable objects, oversees the plans for expenditure of the ‘Directorate-based’ and ‘Separate funds’ to ensure expenditure is in accordance with the Trust’s Standing Financial Instructions and guidance on the expenditure of charitable fund monies. (refer to Terms of Reference for full remit and powers).

The Charity Management Board meets every 6 week. The CMB is a sub-committee of the Charitable Funds Committee, with delegated authority to manage the ‘Special Funds’ by executing plans, monitoring actions, and making decisions regarding expenditure, within the framework agreed by the Charitable Funds Committee. The CMB is made up of community volunteers with representation from medical staff and finance colleagues. (refer to Terms of Reference for full remit and powers).

The Capital Investment Committee meets each month. The Committee has the authority to approve Capital purchases to £100k.

5.3 Grant award

5.3.1 Grant outcome

The Head of Fundraising and Voluntary Services will advise applicants of the outcome of their application within five working days of the Charity Management Board where it was discussed.

5.3.2 Grant payment

Approved grants will need to be spent within three months of the date of approval. If you think there will be a delay for some reason please inform the Head of Fundraising and Voluntary Services.

If the grant is not spent within the three months then it will be assumed that the grant is no longer needed and the money will be re-allocated. A new application would then need to be submitted.

5.3.3 Procurement Process

Please follow Procurement guideline in Appendix II. If an successful applicant does not have access to Integra, nor a lead in Procurement, then please ask the Head of Fundraising and Voluntary Services for assistance in placing the order.

5.3.4 Impact Reporting

Reporting on the progress of each project is crucial. As well as allowing the Charity to see the positive changes made, it helps in communicating the impact of the projects it funds – vital in enabling supporters to see the difference it makes to patients’ lives.

5.3.5 Promotion
Impactful projects will be showcased through the Charity’s and Trust’s communications channels, including website, emails to supporters, newsletters, and social media. Case studies of examples of the impact the Charity’s funding makes is powerful, and encourages our supporters to give again. You can help raise more charitable funds by:

1. Acknowledging and letting people know that your item has been funded because of donations received (we do have small plaques that can be stuck on items for others to see).
2. Encouraging the sale of our Charity Draw tickets at Christmas and in the summer.
3. Donating yourself/signing up to our lottery/encourage your family and friends to support the Hospital Charity.
4. Taking part or supporting an event go to: [www.valleyhospitalcharity.org.uk/events](http://www.valleyhospitalcharity.org.uk/events)
5. Letting everyone know what a difference the charitable support has made to your work.

6. Special Funds v Directorate-based’ fund and ‘Separate’ funds

The Charity Management Board oversees 6 public facing donor-gifted ‘special funds’, each with a specific purpose to support a particular group of patients. Through the generosity of our donors this enables tailored funding opportunities to a wide range of Trust departments and services.

The Charity together with designated special fund advisors - who are made up of suitably qualified staff from within the Trust - identify ways to utilise the funds to make a real difference to the Trust’s work in line with donors’ wishes.

<table>
<thead>
<tr>
<th>Overseen by the Charity Management Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Special Funds’:</td>
</tr>
<tr>
<td>Little Buds Fund</td>
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<tr>
<td>Heartbeat Fund</td>
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<tr>
<td>Cancer Fighting Fund</td>
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<td>Lollipop Fund</td>
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<td>Silver Birch Fund</td>
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<tr>
<td>Friend Fund (Includes Brick and Lottery Fund)</td>
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</tbody>
</table>

‘Directorate –based’ funds and ‘Separate’ funds are overseen by the Charitable Funds Committee. Each Fund has a Fund Managers who has delegated authority to spend funds in line with their specific purpose and agreed priorities, without the need for formal applications on each occasion of use. Fund Managers are expected to be familiar with their Fund balance. Should the fund balance reach over £5k they will be asked to provide a spending plan to the Charitable Funds Committee. As a general principle Fund Managers are expected to allocate any available funding in a fair and transparent way that maximises patient benefit.

<table>
<thead>
<tr>
<th>Overseen by the Charitable Funds Committee</th>
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</thead>
<tbody>
<tr>
<td>‘Directorate-based’ fund:</td>
</tr>
<tr>
<td>Accident and Emergency Unit</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
</tbody>
</table>

Valley Hospital Charity | Version Number: Draft 1.2
Grants Policy | Published Date: 
Page | Review Date: 7
<table>
<thead>
<tr>
<th>Children’s Fund (incorporating Paediatrics and NICU)</th>
<th>Breast Care Library Trust Fund</th>
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<tbody>
<tr>
<td>Diagnostics</td>
<td>Cardiology Training Fund</td>
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<tr>
<td>Gynaecology</td>
<td>Diabetes Centre Education Fund</td>
</tr>
<tr>
<td>Medicine</td>
<td>Haematology Study Fund</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Intensive Therapy Unit Education and Training Fund</td>
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<tr>
<td>Surgery</td>
<td>Microbiology Education Fund</td>
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<td></td>
<td>Neurology Trust Fund</td>
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<td></td>
<td>Pharmacy Fund</td>
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<td></td>
<td>Physiotherapy Department Training Fund</td>
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<td>Resuscitation Fund</td>
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<td></td>
<td>Surgical Speciality Education Fund</td>
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<td></td>
<td>Training Income for Dieticians</td>
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<td></td>
<td>Urology Education Fund</td>
</tr>
</tbody>
</table>
APPENDIX I

Grant criteria

- Ideally grants will support areas where the Trust is already a centre of excellence, or should aim to bring it up to world class standard in certain key strategic areas or where the Trust wishes to become a recognised regional or national leader.
- Applications can only be submitted by members of staff at Dartford and Gravesham NHS Trust, who plan to undertake their proposed project for the benefit of patients at Dartford and Gravesham NHS Trust.
- Applications must clearly demonstrate how the funds will improve patient diagnosis, treatment, care, services, experience or support staff to improve these things.
- Applicants must have sought support from any appropriate Directorate-based fund, or Separate fund, and if over £5k then also seek funding from Capital before making an application for a Grant.
- Applicants must obtain approval for their project from their Line Manager, Head of Department before making the application.

Small project grants are for initiatives that:

- promote innovation, transformation and new service development.
- will provide improved diagnosis or treatment or a better experience for patients. This includes investment into education, research, equipment and patient care across wards, departments and clinics.
- help staff deliver front line patient care more effectively. Staff welfare is critical to ensuring the Trust can provide the very best of care for patients. Grant funding can be used for activities that support staff to keep well and to continue growing professionally eg. fund Trust staff to learn new skills and further their knowledge by enabling staff to attend conferences, or visit and learn from other healthcare organisations
- pilot/test/implement projects relating to research seeking to produce the necessary data to springboard onto successful third party funding bids for further study or quality improvement ideas
- are new initiatives and not top-ups for existing projects.
- Innovative equipment or a new initiative to improve patient care
- Projects to encourage better health in the communities the Trust serves

Grants will not be awarded to support:

- Any item or project that could be funded by a Directorate-based fund or Separate fund
- Any item or project that should be funded from NHS Trust departmental budgets or Capital
- Any item or project that has already been purchased (ie. no retrospective funding)
- Payments to individuals
- Staff hospitality, meetings, travel or entertainment expenses

<table>
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</tr>
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<tr>
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<td>Published Date:</td>
</tr>
<tr>
<td>Page</td>
<td>9</td>
</tr>
</tbody>
</table>
Appendix II

Procurement Process

Once a grant has been authorised please ensure the grant is claimed within 3 months, using the following steps:

Please now place your order via the Integra eProcurement System.

http://dvh-intl-web01.dvh.nhs.uk:8080/series/esr.elogin

You will need to raise a requisition through the Integra system which will be sent to the Head of Fundraising and Voluntary Services to authorise.

When raising your requisition please ensure that you select the relevant Trust Fund Requisitioning Point

Equipment for medical purposes, may be exempt from VAT, therefore a VAT exemption form should be sent to the supplier and VAT removed from the price if this is quoted

Although this is not guaranteed Suppliers will often remove VAT when a VAT exemption form is received

And also enter the Grant Number you have been assigned above into the ‘Charitable Grant Number’ field on Integra.

Please also ensure that the GL Code reads as follows when adding the item/s to your trolley.
Once you are ready to complete your requisition then please ensure that you select the ‘TRUST FUND ORDER’ option from the drop down box you’re presented with on checkout.

Your requisition will be sent to the Authoriser of the trust fund for approval.

PLEASE NOTE... Your grant will need to be spent within three months. If you think there will be a delay for some reason please email the Head of Fundraising and Voluntary Services detailing the reason for the delay. After 3 months it may be assumed that the grant is no longer needed and the money will be re-allocated. You would then need to re-apply.
**TRUST BOARD – JULY 2019**

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Terms of Reference</th>
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<tbody>
<tr>
<td>Author:</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>The Board is asked to ratify the Terms of Reference as proposed and agreed by the June Charitable Funds Committee.</td>
</tr>
</tbody>
</table>

**Key points for the Trust Board:**

- The Terms of Reference were presented to the 25 June Charitable Funds Committee for discussion and approval of the following amendments:
  - Removal of Chief Executive as committee member
  - Addition of the Chief Operating Officer/Deputy Chief Executive to membership
  - Amendment of the following statement to reflect the specific requirements of the Committee:
    - “If the Committee Chairman is absent from the meeting, another Non-Executive Director, as the members present shall choose, shall preside”

  The proposed amendment is:
  - “If the Committee Chair is absent from the meeting and this is known in advance, another Non-Executive Director should be asked to attend and preside. If this is not possible the meeting should be rescheduled to accommodate availability of the Chair.”

  The Committee agreed the changes which have been reflected in the terms of reference as presented. (The changes have been highlighted in yellow)

  The Trust Board is asked to formally ratify the terms of reference.

**Consideration of public and patient involvement and communication:**

- For publication

**Recommendations:**

- To Review and ratify the Charitable Funds committee terms of reference

**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

<table>
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<th>Organisational Priorities</th>
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<td>Well-led</td>
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<tr>
<td>Board Assurance Framework/ Trust Risk Register</td>
<td>All board assurance risks</td>
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<tr>
<td>-----------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Committee/ Meetings at which this paper has been discussed/ approved</td>
<td>Date</td>
</tr>
<tr>
<td>Charitable Funds Committee</td>
<td>25.06.19</td>
</tr>
</tbody>
</table>
# CHARITABLE FUNDS

**JUNE - 2019**

<table>
<thead>
<tr>
<th>Summary of Purpose</th>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee will act in line with current Trust Board Objectives and regulator key lines of enquiry appropriate to the committee’s purpose.</td>
<td>The Charitable Funds Committee is constituted as a standing order of the Trust Board and is subject to its standing orders. Its constitution and terms of reference shall be set out as below, subject to ratification at future Trust Board meetings</td>
</tr>
<tr>
<td>The Committee exists to oversee the governance of Dartford and Gravesham NHS Trust Charitable Fund on behalf of the Board of Dartford and Gravesham NHS Trust¹, in accordance with the duties and responsibilities of charitable Trustees.</td>
<td>The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee, including any requests to attend its meetings</td>
</tr>
<tr>
<td>The Committee also exists to ensure that the Dartford and Gravesham NHS Trust Charitable Fund complies with its charitable objects. The Charitable Fund should be applied to wherever Dartford and Gravesham NHS Trust provides its services.</td>
<td>The Committee is authorised by the Trust Board to obtain external legal or other independent professional advice and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.</td>
</tr>
</tbody>
</table>

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¹ Dartford and Gravesham NHS Trust is the sole corporate Trustee of Dartford and Gravesham NHS Trust Charitable Fund
but committees must refer the following types of issue to the Trust Board. Any matter which will:

- Change the strategic direction of the Trust.
- Conflict with statutory obligations.
- Contravene national policy decisions or governmental directives.
- Have significant revenue implications.
- Have significant governance implications.
- Be likely to arouse significant public or media interest.

### Membership

- One of the Non-Executive Director members of the Committee will be appointed chair of the Committee by the Trust Chairman

- The Committee Shall be composed of;
  - Non-Executive Director (Chair)
  - Chief Operating Officer/Deputy Chief Executive
  - Director of Finance
  - Deputy Director of Finance
  - Associate Director of Finance
  - Medical Director (to be represented by another Executive Director or Deputy Medical Director if unable to attend)
  - Assistant Director of Finance
  - Fundraising & Voluntary Services Manager
  - Finance Manager
  - Associate Director, Corporate Development (Trust Secretary)xxx (details of members to be listed)

  *If the Committee Chairman is absent from the meeting, another Non-Executive Director, as the members present shall choose, shall preside.*

  *If the Committee Chair is absent from the meeting and this is known in advance, another Non-Executive Director should be asked to attend and preside. If this is not possible the meeting should be rescheduled to accommodate availability of the Chair.*

- Other staff may be co-opted to attend meetings as considered appropriate by the committee on an ad hoc basis.

- Regular attendees to be invited to attend at the discretion of the Committee Chair.

- The names of the members of the Committee shall be published in the Trust's Annual Report.

- Member and attendees are required to fully participate and contribute to the meetings thereby enabling the Committee to comply with its Terms of Reference.

### Quorum

- The quorum will be three members, including at least one Non-Executive Director, and one Executive Director
### Attendance
- Members must attend a minimum of 75% of meetings across a 12 month period.
- An officer in attendance for an Executive Director may count towards the quorum at sub-committees of the Trust Board, if the Chair of the committee is advised and agrees at the commencement of the meeting. It will be recorded in the minutes of the meeting that the officer is deputising for the Executive Director and forms part of the committee’s quorum for that meeting only.
- The sub-committee chair will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board’s meetings and may change, alter or vary these terms and conditions as it deems fit.

### Frequency of Meetings
- The meeting will take place 3 times a year.
- At the discretion of the Committee Chairman, additional meetings may be convened to fulfil its main functions.

### Status of Meeting
- All sub-committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the chair of the committee. Minutes of the meeting will be reported to the public session of the Trust Board unless they contain information which relates to an individual patient or member of staff or that it is commercially sensitive.
- All sub-committees of the Trust Board will, where a matter is considered confidential, submit Part 2 minutes to the Trust Board.

### Responsibilities/Main Duties
- The Charitable Funds Committee will review the Board Assurance Framework and the Risks appropriate to the committee.
- The Charitable Funds Committee will execute those activities and functions detailed in the Terms of Reference.

### Items Specific to Charitable Funds Committee
The Committee has the following duties and functions:
- To approve and review annually, on behalf of the Trust Board, an investment and disbursement strategy for the Dartford and Gravesham NHS Trust Charitable Fund, which:
  - accords with the objectives of Dartford and Gravesham NHS Trust, but is managed separately from Dartford and Gravesham NHS Trust’s Exchequer funds; and
  - provides added value and benefit above those afforded by Exchequer funds;
- To monitor adherence to the agreed investment and disbursement
strategy for Dartford and Gravesham NHS Trust Charitable Fund;

- To review the Annual Accounts and Annual Report of Dartford and Gravesham NHS Trust Charitable Fund (and the auditors' report on the accounts), and recommend their approval to the Trust Board;

- To ensure a framework is in place to ensure compliance with appropriate legislation and best practice guidance in relation to the management of Dartford and Gravesham NHS Trust Charitable Fund;

- To authorise/agree the establishment of new funds and new charities, including subsidiary charities;

- To review relevant Standing Financial Instructions, as they relate to Dartford and Gravesham NHS Trust Charitable Fund, including the thresholds and criteria for individual spending decisions, and make recommendations to the Trust Board, as appropriate;

- To review and approve other policies and procedures relevant to the governance and management of Dartford and Gravesham NHS Trust Charitable Fund;

- To oversee the plans for expenditure of the Directorate-based and Separate funds, to ensure such expenditure is in accordance with the Trust’s Standing Financial Instructions and guidance on the expenditure of charitable fund monies. In the absence of a plan for such expenditure, the committee should direct the Fund Manager as to the subjects/areas the fund should be expended on;

- To monitor and manage the overall financial position of Dartford and Gravesham NHS Trust Charitable Fund.

- To monitor processes that give assurance that volunteers are recruited in line with Trust policies and procedures and that risk assessments are undertaken for volunteers which the Trust considers work with the most vulnerable patients to determine whether they should have a regular DBS check and to determine the time period. The Committee should ensure that these requirements are being complied with.

<table>
<thead>
<tr>
<th>Sub Committees Reporting Lines</th>
<th>Reporting In</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Charitable Funds Committee has one established Sub-Committee and will receive information and assurances from the Trusts Charity Management Board processes and meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Out</th>
<th>The Chairman of the Committee should provide an update at the next available meeting of the Trust Board on the key matters discussed at the last Charitable Funds Committee.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If the Committee wishes to make recommendations to the Trust Board, it should be prepared to supplement the Committee Chairman's verbal report with a written report, outlining the basis for its recommendations.</td>
</tr>
</tbody>
</table>
The need for such a written report should be determined by the Trust Board, but if necessary (due to timing), should be determined following discussion between the Committee Chairman and the Chairman of the Trust Board.

### Reporting and Review

- The minutes of the Meeting will be presented to the Trust Board for ratification following Committee review and will be published as part of the Trust’s Board papers.

- The Committee Annual Plan will be agreed by the Committee in Q4 to allow implementation from the first month of the new financial year.

- Terms of Reference will be reviewed at least annually or at a frequency deemed appropriate by the Committee Chair.

- Once agreed the Terms of Reference will be received by and ratified by the Trust Board.

- The Committee will carry out an Annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

- The Board can amend, change or dissolve the Committee in accordance with the Trust’s Standing Orders.

### Administration

- The Administration of the Committee will be provided by the Assistant Trust Secretary or appropriate deputy

- Agendas and papers to be distributed in advance of the meeting.

- The Committee members will approve the minutes of the previous meeting at the start of the next meeting.

### Revision History

Previous Format Revisions
- Approved at Trust Board, June 2010
- Agreed at the Charitable Funds Committee, October 2011
- Approved at Trust Board, October 2011
- Revised June 2012 at Trust Board, to reflect the Trust’s appointment of a Non-Executive Director (Designate)
- Revised at Charitable Funds Committee, September 2012 (to reflect transfer of duties from Charity Management Board)
- Approved at Trust Board, October 2012
- Revised at Charitable Funds Committee, October 2013 (to reflect the principle that the Charitable Fund should be applied to wherever Dartford and Gravesham NHS Trust provides its services i.e. in the light of developments at Elm Court, and Queen Mary’s and Erith & District Hospitals)
- Approved at Trust Board, October 2013
- Draft March 2016 to incorporate Savile recommendations taken up by the Trust.
- Revised October 2018
- Revised February 2019
- Revised format to the Trust Board March 2019
- Revised June 2019
### Corporate Governance Framework

**Trust Board – July 2019**

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Corporate Governance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Purpose of paper:</td>
<td>Advise the Board of changes to the Corporate Governance Framework (CGF)</td>
</tr>
</tbody>
</table>

**Key Points for the Trust Board:**

Last month the Board approved the removal of references to the Director of System Transformation post within the CGF. It was noted at the time that there would be two new Board Director posts which would need to be incorporated into the framework and with the successful recruitment to these posts the following amendments are submitted for approval:

- References to Director of Operations are removed as this are no longer Board level position
- References to Director of Strategy and Planning is temporarily removed whilst the substantive post holder is on secondment.
- Reference to Director of Improvement is incorporated
- The reference to Deputy Chief Executive also refers to Chief Operating Officer (COO) (as per the job description for this position)
- The reference to Director of Nursing is amended to read Director of Nursing and Quality/Chief Nursing Officer.

The Board also agreed last month that the status quo would be maintained regarding voting rights which are held in abeyance for the two individuals who are off sick thereby keeping the Board in balance regarding voting. As the Director of Operations is no longer a Board member it is recommended that the vote is returned to the role of Deputy Chief Executive/COO as per the CGF. Since the role of COO is being covered on an interim basis it is recommended that the vote remains in abeyance until the permanent incumbent is in post.

**Consideration of public and patient involvement and communication:**

For publication.

**Recommendations:**

The Board are asked to approve the changes to the CGF.

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**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

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<th>Organisational Priorities</th>
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<thead>
<tr>
<th>Board Assurance Framework/ Trust Risk Register</th>
<th>BAF Risk 2033</th>
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</table>
Proposed Changes to the Corporate Governance Framework

4.1 Composition of the Membership of the Trust Board

4.1.1 In accordance with the Membership and Procedure Regulations and the Trust’s Establishment Order, the composition of the Board shall be:

- The Chair of the Trust (appointed by NHS Improvement)
- 5 Non-Executive Directors (NEDs) (appointed by NHS Improvement)

4.1.2 As per The National Health Service Trusts (Membership and Procedure Regulations 1990 up to 5 Executive Directors (EDs) (but not exceeding the number of non-executive directors) including:

- The Chief Executive Officer (the Accountable Officer)
- The Director of Finance (the Chief Finance Officer)
- The Deputy Chief Executive/ Chief Operating Officer
- The Medical Director (who must be a medical practitioner)
- The Director of Nursing & Quality/ Chief Nursing Officer (who must be a registered nurse or registered midwife as defined in section 10(7) of the Nurses, Midwives and Health Visitors Act 1979(10))

4.1.3 Other non-voting Executive Directors as the Trust Board will determine (currently, Director of Human Resources, Director of Improvement) except for 4.1.4.

4.1.4 Where, for instance, an Executive Director with a voting role fulfils another role, either temporarily or permanently (e.g. if the Medical Director is also the Deputy Chief Executive), for the period of the arrangement or until the two roles are separated, the Board will designate another Executive Director to hold voting rights. This will be recorded in the minutes of the Board and this will only be deemed as a temporary arrangement for the previously non-voting Executive Director.

4.1.5 The Chair, at their discretion will allow other Trust officers to take part in Board meetings but these officers will not have voting rights. See 5.19 in respect of observers of the Trust Board meetings.

4.1.6 The Trust Secretary or their representative is required to attend all Board meetings.
# Use of the Trust’s Common Seal

**Subject:** Use of the Trust’s Common Seal  
**Author:** Assistant Trust Secretary  
**Presented by:** Trust Secretary  
**Purpose of paper:** For Information  
**Key points for the Trust Board:**  
Since June 2019, the Trust’s Common Seal has been used twice in accordance with the Trust's Standing Orders. The following is an extract from the Register of Sealing detailing the Seal's use.

---

**Consideration of public and patient involvement and communication:**  
For Publication

**Recommendations:**  
For noting by the Trust Board.

---

**Links to Board priorities, Board Assurance Framework, Trust Risk Register**

| Organisational Priorities | • Maintain and improve the quality of services delivered by DGT  
                          | • Make DGT a great place to work for everyone  
                          | • Implement and embed the clinical and organisational strategy  
                          | • Deliver the 2019/20 financial plan  
                          | • Deliver all NHS constitutional and contractual standards |
|---------------------------|---------------------------------------------------------------|
| CQC Reference             | • Effective                                                   |
| Board Assurance Framework/ Trust Risk Register | Not Applicable       |

**Committee/ Meetings at which this paper has been discussed/ approved**  
N/A  

**Date**  

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<table>
<thead>
<tr>
<th>Consecutive number</th>
<th>Date of sealing</th>
<th>Description of document sealed</th>
<th>Names of persons attesting sealing</th>
<th>How document disposed of</th>
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<tr>
<td>248</td>
<td>25.06.19</td>
<td>Minor works letter - Mobile Cath Lab Pre Construction - DADPDAR1800008</td>
<td>Signed by Dr Steve Fenlon (Medical Director/Deputy Chief Executive) and attested by Peter Coles (Chairman)</td>
<td>Document was handed to Avtar Verdee, Project Manager Radiology</td>
</tr>
<tr>
<td>249</td>
<td>27.06.19</td>
<td>Amendment to the ESCP Contract Period (extension until 31 July 2019)</td>
<td>Signed by Dr Steve Fenlon (Medical Director/Deputy Chief Executive) And attested by Siobhan Callanan (Director of Nursing and Quality)</td>
<td>Document was handed to Laurence Bunnett, Director of Estates and Facilities</td>
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