Trust Board Meeting ('Part 1') - Formal meeting, which is open to members of the public (to observe)

Thu 26 May 2022, 09:45 - 13:00

Virtually, via Webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ).

05-1
To receive apologies for absence

David Highton

05-2
To declare interests relevant to agenda items

David Highton

05-3
To approve the minutes of the 'Part 1' Trust Board meeting of 28th April 2022

David Highton

Board minutes, 28.04.22 (Part 1).pdf (10 pages)

05-4
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (1 pages)

05-5
Report from the Chair of the Trust Board

David Highton

N.B. This will be a verbal report.

05-6
Report from the Chief Executive

Miles Scott

Chief Executive's report May.pdf (4 pages)

Reports from Trust Board sub-committees

05-7
Quality Committee, 11/05/22 (incl. approval of the revised Terms of Reference (annual review))

Maureen Choong

Summary of Quality C'ttee, 11.05.22 (incl. revised ToR).pdf (6 pages)

05-8
Finance and Performance Committee, 24/05/22 (incl. approval of revised Terms of Reference)

David Morgan

Summary of Finance and Performance C'ttee 24.05.22.pdf (6 pages)

05-9
People and Organisational Development Committee, 19/05/22 (incl. quarterly report from the Guardian of Safe Working Hours)

Richard Finn

Summary of People and Organisational Development Cttee, 19.05.22 (Incl. Guardian of Safe Working Hours Annual report).pdf (5 pages)

05-10
Audit and Governance Committee, 16/05/22

David Morgan

Summary of Audit and Governance Committee, 16.05.22.pdf (2 pages)

Integrated Performance Report

05-11
Integrated Performance Report (IPR) for April 2022

Miles Scott and colleagues

Integrated Performance Report (IPR) for April 2022.pdf (39 pages)

Planning and strategy

05-12
Update on the Nursing and Midwifery staffing review

Joanna Haworth

Update on the Nursing and Midwifery staffing review.pdf (12 pages)

05-13
Update on 2022/23 planning

Bob Cook / Steve Orpin

N.B. This item will be scheduled for 11:35am.

Update on 202223 planning.pdf (9 pages)

05-14
Update on the development of the corporate objectives for 2022/23

Bob Cook and Steve Orpin

N.B. This item will be scheduled for 11:45am.

Update on the development of the corporate objectives for 202223.pdf (10 pages)

05-15
To approve the draft People and Culture Strategy, 2022 – 2025

Sue Steen

To approve the draft People and Culture Strategy, 2022 – 2025.pdf (29 pages)

Assurance and policy

05-16
NHS provider licence: Self-certification for 2021/22

Miles Scott

Provider Licence self-certification 2021-22.pdf (12 pages)

05-17
To consider any other business

David Highton

05-18
To respond to any questions from members of the public

David Highton

Questions should relate to one of the agenda items above, and be submitted in advance of the Trust Board meeting, to Kevin Rowan, Trust Secretary, via kevinrowan@nhs.net.

Members of the public should also take note that questions regarding an individuals patient's care and treatment are not appropriate for discussion at the Trust Board meeting, and should instead be directed to the Trust's Patient Advice and Liaison Service (PALS) (mtw-tr.palsoffice@nhs.net).

05-19
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960,representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 28th APRIL 2022, 9:45 AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director (except items 04-10 and 04-12)	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive (except items 04-14 and part of 04-13 – refer to the relevant minute for the specific details)	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Blanchard-Stow	Divisional Director of Midwifery, Nursing & Quality, Women's, Children's and Sexual Health (for item 04-11)	(SBS)
	Sarah Flint	Chief of Service, Women's Children's and Sexual Health (for item 04-11)	(SF)
	Natalie Hayward	Deputy Freedom to Speak Up Guardian (for item 04-13)	(NH)
	Christian Lippiatt	Freedom to Speak Up Guardian (for item 04-13)	(CL)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

[N.B. Some items were considered in a different order to that listed on the agenda]

DH firstly apologised for the fact that the YouTube livestream did not work for the Trust Board's meeting on 31st March 2022, but noted that the recording of that meeting had been uploaded to the Trust's website.

04-1 To receive apologies for absence

No apologies were received.

04-2 To declare interests relevant to agenda items

No interests were declared.

04-3 To approve the minutes of the meeting of 31st March 2022

The minutes of the meeting of 31st March 2022 were approved as a true and accurate record of the meeting.

04-4 To note progress with previous actions

The content of the submitted report was noted. DM then referred to action 03-13 ("Liaise with the Chair of the Charitable Funds Committee to explore the use of charitable funds to support the work to reduce patient falls") and noted that an offer had been made to an individual for the Fundraising Manager post. The point was acknowledged.

04-5 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted the following points:

- 28/04/22 was AJ's last day at the Trust, and it was hoped that the Kent and Medway Medical School (KMMS) accommodation project contract would be able to be signed later that day or on 29/04/22. The project was very important to support the initially 40, and eventually 120, medical students at the Trust.
- DH could not attend the anaesthetist Advisory Appointments Committee (AAC) panel on 29/03/22 as it clashed with the Finance and Performance Committee meeting. However, further panels had been held, to recruit a consultant paediatrician and three haematology consultants.

04-6 Report from the Chief Executive

MS referred to the submitted report and highlighted the following points:

- There were three themes to highlight: operational pressures, COVID-19, and staffing, and these would be discussed throughout the Trust Board meeting.
- The last month had been very challenging, with record levels of attendances and longer lengths of stay for inpatients, and that had placed the Trust under considerable strain. The situation had however improved over the past week, as the number of COVID-19 positive inpatients had reduced, and there had been some success from the "Improving flow" exercise. There had also been an increase in the use of the discharge lounge, among other things. However, the Trust needed to make progress on issues such as the development of virtual wards, which PM was leading on for the Trust in conjunction with colleagues in West Kent.
- The issue that was of most concern was the number of long length of stay (LOS) and medically optimised for discharge (MOFD) patients, and SB was working with colleagues in community and social care to try and address these.
- In relation to the 'new normal' post COVID-19 environment, a cautious approach was being taken to visiting, and the plan for the future was to maintain control over access to the Trust's sites, although the Trust wanted to support visiting for inpatients, and support patients to be appropriately accompanied. SM was leading the work on clinical protocols and establishing a post-COVID-19 'new normal', whereby the Trust would manage its level of COVID-19 inpatients, taking account of the new guidance from the UK Health Security Agency (UKHSA).
- Staffing continued to be the Trust's top priority, and JH and SS would discuss the steps being taken to improve staffing levels and retain existing staff later in the meeting. SS was also working with each Division to help develop their response to the latest NHS Staff Survey.

DH noted that patient flow would be discussed further during item 04-10, but highlighted that the Non-Executive Directors had been concerned about the number of MOFD patients i.e. those that did not meet the criteria to reside.

DH then noted that the Business Case for the new 'barn' theatre complex at Maidstone Hospital (MH) was expected to be considered by the Trust Board in May 2022, but work was taking place, including a new governance arrangements for the project. DH continued that it would therefore be helpful to hear how the Kent and Medway Integrated Care System (ICS) intended to align with the project, along with the workforce aspects, noting that these had been queried at the last People and Organisational Development Committee meeting. MS clarified that the work was a programme, not a project, and further details would be submitted in May 2022, although SB was the Senior Responsible Owner (SRO) for the work. MS then outlined the various workstreams within that programme, some of which were chaired by colleagues from the Clinical Commissioning Group. MS added that the staffing workstream was being led by JH, and it was clear that the recruitment to the barn theatre should extend beyond the staffing required for existing NHS recruitment i.e. there would need to be a net additional group of staff recruited across the ICS. DH asked if the workstream would recognise the staff that would work at the barn theatre who were employed by other NHS organisations. MS confirmed that would be the case, although most staff working at the theatre complex would be Maidstone and Tunbridge Wells NHS Trust employees. DH also acknowledged the governance-related issues associated with the arrangements.

Reports from Trust Board sub-committees

04-7 Quality Committee, 13/04/22

MC referred to the submitted report and highlighted the following points:

- The issues covered correlated with the issues raised by MS under item 04-6 i.e. the considerable pressure on staffing in all areas, and the impact on patient safety & staff wellbeing.
- The focus that had been applied to the issues was commended, although it was noted that the falls rate continued to be a concern. A further update on that would be given in June 2022.
- There had been an in-depth review of the lessons learned from patients with learning disabilities; while infection control issues had also been discussed, which again triangulated with MS' points.

04-8 Finance and Performance Committee, 26/04/22

NG referred to the submitted report and highlighted the following points:

- The meeting had been relatively straightforward, although the difficulties with patient flow had been discussed, and alternative ways of tackling the issues had been explored. Further information on such options would be submitted to the next meeting.
- The Friends and Family Test (FFT) metrics had been discussed and the need for a new approach had been recognised.
- It was agreed that some adjustments would be made to the Committee's functioning, in response to the latest Committee evaluation.

04-9 People and Organisational Development Committee, 22/04/22

EPM referred to the submitted report and highlighted the following points:

- Recruitment and retention had been discussed in depth. The focus being applied across the Trust was recognised, and the pressures acknowledged, including the high vacancy rates in some departments.
- A presentation on talent management had been given, and it was noted that the issues would be considered at the Executive Team Meeting (ETM).
- A report on equal pay had been considered, but more work was required, so a further report would be submitted to a future meeting.

Integrated Performance Report

04-10 Integrated Performance Report (IPR) for March 2022

MS firstly noted that the focus would be on the areas for escalation and the Counter Measure Summaries. SS then referred to the "People" strategic theme and reported the following points:

- The Trust's target for the "Climate Survey Responses" metric was to be within the top quartile of acute Trusts in England, but further work would be done in relation to achieving some staged trajectories in the first instance.
- The response rate for the most recent staff 'pulse' survey was not yet available, but it was expected to be low, as the survey had been issued at the same time as the national NHS staff survey, so the Trust's focus and communications had been on the latter survey.
- Staff vacancies and the turnover rate remained key priorities, but there were still some 'hot spot' areas, which were described in the report.
- The Trust had had a considerable presence on social media platforms over the last month, and had seen a lot of spread across Facebook, Twitter and LinkedIn.
- More work was required on staff retention, and SS now had two additional staff members to focus specifically on that aspect, which included proactive work on why staff were leaving. The Trust's 'retire and return' policy and process would also be changed. The position therefore remained challenging but staff were working hard to address the issues.
- The Trust sickness target had been changed to 4.5% but the change in performance would not be shown until next month.

DM referred to staff turnover, which had an accumulating trend, and asked whether any themes had emerged. DM also referred to the low climate survey response rate and queried whether the

Trust needed to pause and consider whether the target was still appropriate, or whether it should be suspended or replaced. SS replied that exit/moving on surveys had provided reasonable data on staff turnover, and turnover was related to promotion; work/life balance; and natural attrition, such as retirement, including premature retirement, and taking retirements that had been delayed by the COVID-19 pandemic. SS added that the importance of understanding the reasons for leaving before staff actually left had been recognised.

SS then referred to the climate survey and noted that the response rate was important as it indicated the level of engagement at the Trust, although it was recognised that survey fatigue was likely to be a factor, as was the Trust's response to the surveys and feedback to staff. SS therefore stated that further work was required on these issues but also acknowledged the need to consider whether the target should be slavishly pursued.

EPM referred to the statement on page 10 of 42 that "Kick start scheme for MTW is currently being advertised in connection with DWP", and asked what the expectations were in relation to working with the Department of Work and Pensions (DWP). SS explained that it was a new programme so expectations were quite low, although it was a positive development for the Trust.

JW asked about the role of One Team Runners (OTRs), and how that aligned with apprenticeships and the kick start scheme. JW also asked what was being done for the staff with caring responsibilities beyond childcare, such as those caring for older relatives. SS noted that the management of the OTR scheme had transferred to the temporary staffing team, to integrate it with the wider temporary staffing work, but it was acknowledged that OTRs had been critical to supporting wards, and several OTRs had acquired permanent employment at the Trust, so it was a good entry route. SS also stated that the Trust's flexible working policy did not differentiate between different caring responsibilities, although certain legal protections applied for childcare responsibilities. SS however acknowledged that it was a further area for the retention team to explore. JH welcomed that, given the reduction of support that had been seen, post COVID-19.

PM then referred to the "Patient Safety & Clinical Effectiveness" strategic theme and reported the following points:

- There had been concerns that the Hospital Standardised Mortality Ratio (HSMR) was rising, but that was now declining, and was now at 94.1, while the new Summary Hospital-level Mortality Indicator (SHMI) data published on 27/04/22 remained low, at 94. PM would speak more about the issues regarding clinical coding and mortality in the future, as a 'deep dive' had just been held with Telstra Health UK (formerly Dr Foster).
- For the harm Counter Measures Summary, seven data points had been observed, and the data suggested that the drivers were slips, trips, infection control and failure to monitor.
- The vast majority of the issues in the "Top Contributors" fishbone diagram on page 12 of 42 were under active management for the relative Divisions and departments, and much work was taking place, which included a new medic Chair of the Sepsis Committee.
- Further actions would be taken in relation to the "Fall Rate", following helpful comments by the Trust Board and the Quality Committee, and the Deputy Chief Nurse - Quality and Experience would take a more active role in the work. Interviews were also scheduled for a falls coordinator w/c 02/05/22, to support the existing falls team.

WW asked when the falls work described by PM was expected to have an impact. PM speculated that improvements could expect to be seen within three months, but sustained improvements would likely not be seen for a year. PM also noted that he had been spoken with DM about releasing funding from the charitable fund to support falls initiatives. KC asked whether any national data sets were available. PM confirmed there was a national benchmarking club, and most organisations had a target falls rate of circa 6.0 (per 1,000 Occupied Bed Days). KC stated that a demonstrable link between harm and workforce would be quite powerful. PM confirmed there was a relationship between staffing levels and harm. JH then pointed out that there was a national benchmark falls rate of circa 6.6, but organisations varied in their definitions of falls, as some recognised patients who were lowered to the floor as a fall, while some did not. PM added that he believed the reduction in harm metrics would improve before the falls metric.

SB then referred to the "Patient Access" strategic theme and highlighted the following points:

- The Trust continued to face significant pressures, but there had been an improvement in the patients waiting over 52 weeks, and the Diagnostics Waiting Times and Activity (DM01) standard. The 62-day cancer waiting time target had also been met for 31 successive months.
- The delivery of the Emergency Department (ED) 4-hour waiting time target had been incredibly challenging. 20/03/22 had been promising, as the Trust had been the third or fourth best performing in the country, but demand had continued to rise from that point, and activity was 25% higher than pre-COVID-19 demand. The Trust had 185 MOFD inpatients on 28/04/22. Modelling COVID-19 cases was becoming harder, so it had been accepted that the Trust would continue to see 'mini-waves' of COVID-19 among patients and staff. The past two to three weeks had been the most challenged hospital sites that SB had seen, but he had also felt his highest level of pride for the staff during that period. Effort would be required across the Trust to recover the position, and the 4-hour ED waiting time target performance on 27/04/22 was back at 85%, which was one of the best in the country. However, that had masked the significant pressures on staff, and the adverse impact being felt on clinical outcomes and quality.
- Work was taking place to address the issues affecting patient flow and there had been some small increases in community capacity, but much more capacity was needed. The Trust was fortunate that Kent Community Health NHS Foundation Trust (KCHFT) was willing to work with the Trust but social care problems persisted. There had been some minor improvements in relation to Pathway 1 capacity, with a new recruitment campaign, but there was still a significant problem, as the Trust had four to five wards of MOFD patients on its sites.

DH noted that community beds were now visible on the TeleTracking system and asked if a representative from KCHFT would join the Care Coordination Coordination (CCC). SB confirmed that was being explored, although the Discharge Manager, who was a joint appointment between the Trust and KCHFT, would sit in the CCC. SB acknowledged that the work referred to by DH was important in ensuring there was 'one version of the truth' among all partner organisations, and the Trust was seeking to have a representative from Social Services within the CCC.

JW asked about the division between patients on Pathways 1, 2 and 3. SB replied that there were 43 patients in Pathway 3, the care home pathway, although each patient had different needs, as six of those patients needed a dementia care home, for example. MS highlighted that complex care packages drove blockages in other parts of the system, and often the other delays were a consequence of Pathway 3 delays. The point was acknowledged.

WW commended SB and his colleagues for their work, and noted the likelihood of future COVID-19 waves, so asked whether such waves could be predicted, and whether anything had been learned from the latest phase, in relation to swift recovery. SB replied that the teams working across the Trust were taking the issues seriously and supporting the required work, via early senior clinical decision-making, focusing on discharge, having wards properly staffed by nurses etc., but it had been acknowledged that additional capacity would be required for the next winter, including via virtual wards. SB also acknowledged the need for improved prediction of short-term increases in COVID-19 cases and staff sickness absence, but highlighted the difficulties involved. WW opined that preparing people for a period of high intensity would likely help them have better resilience. SB agreed and noted the need for further liaison with SM and her colleagues.

JH then referred to the "Patient Experience" strategic theme, and highlighted the following points:
- The FFT response rate remained challenged, but there was a high positive rating across all areas from the limited number of responses received. The previous challenges with the FFT provider had now been resolved so there was increased visibility at service level. Staffing challenges had been a contributory factor in the low response rate, while the SMS text messaging service remained problematic.
- JH had mentioned at the last Trust Board meeting that she was reviewing the overall patient experience Strategy Deployment Review metrics, & that review had started. When considering the overall sources of patient feedback data, patients were dissatisfied with information & communication, so that would likely be the focus of a future Breakthrough Objective.

JH then reported the latest position in relation to the "Complaints" metric, which was that the target continued to be missed, due to staffing challenges in the central complaints team and operational

challenges in clinical areas. JH continued that additional resources would be brought in to the complaints team, which would help clear the complaints backlog, and a more detailed analysis of the backlog and process would be undertaken.

AJ then referred to the "Systems" strategic theme, and the "Reduction in non-elective bed days" metric, and reported that there had been an increase in non-elective bed days, and many of the actions required to address the situation were similar to the issues that had already been discussed at the meeting i.e. staffing and Pathway 3 capacity, as well as primary care capacity. AJ continued that the Trust was therefore working on such issues via the Health and Care Partnership, and the work that PM was leading on in relation to frailty care and virtual wards.

SO then reported the following points in relation to the "Sustainability" strategic theme:

- The Trust had ended 2021/22 with a £231k surplus, subject to audit, although the audit process had started.
- The Trust had spent £19m of capital funding in the last month, as a consequence of much capital funding only being received in the last three months of the year. A tremendous effort had been required to spend that money wisely, and swiftly, in accordance with the Trust's strategy and capital plan. The level of capital expenditure was one of the largest ever, given that the Trust's base capital was only £10m.

DH thanked SO and his team on behalf of the Trust Board for delivering the year-end surplus, given the Trust's circa £625m of annual turnover.

Quality items

04-11 <u>Assessment of the Trust's position against, and implications of, the final Ockenden report (the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust)</u>

JH firstly noted that an Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust had been taking place, led by Donna Ockenden, and the last Trust Board meeting had received a report on the first published report from that review. JH continued that the review's second report was published on 13/03/22, and that report focused on four key themes. SF then referred to the submitted report and highlighted the following points:

- The submitted report contained the high-level assessment that had been undertaken via the multidisciplinary team in maternity.
- At present, there were no specific objective measures for the majority of the recommendations within the review's report, so further detailed guidance and news about associated funding was awaited.
- The importance of everyone reading the review's report had been recognised, and the report had been discussed at the service's latest monthly clinical governance meeting.

SBS then highlighted the following points:

- The submitted report contained an immediate and high-level overview in response to the NHS England/Improvement (NHSE/I) letter received on 01/04/22.
- The review's second report contained 15 immediate and essential actions, which were in addition to the seven actions from the review's first report, which was considered by the Trust Board in March 2022. Four key pillars encompassed the actions.
- The preliminary assessment had not revealed any obvious concerns, although the Trust had an opportunity to apply for the £127m of funding that had been announced nationally. Staffing was a key issue, but a range of initiatives were in place, such as apprenticeships and international recruitment, in liaison with colleagues in the ICS, while the Trust was exploring opportunities related to work experience and return to practice midwives. A Recruitment and Retention Midwife had been recruited, who liaised with other recruitment staff in the Trust, and with the Local Maternity & Neonatal System (LMNS).
- The negative media coverage of the Ockenden review had caused low morale, but reassurance had been provided, and the Trust had reviewed the text within job advertisements.

SF added that the team was also ensuring that the content of the service's website, including the video content, contained appropriate messages and did not refer to 'normality' in terms of births.

DH asked how the current maternity staffing issues affected the aspirations regarding the Continuity of Carer work. SBS stated that the work had been paused for the Crowborough Birth Centre, but a risk assessment had been done in relation to the Phoenix team, and it had been agreed to retain that team, because of the valuable work they did with teenagers. SBS continued that a realistic assumption was that it would take seven years to achieve the Continuity of Care standard, although that could be reviewed. SBS however emphasised that although the service had a 25 Whole Time Equivalent (WTE) vacancy rate, the service was not unsafe. SF also added further details about the new Care Pathway Coordinator role, which had been very effective, and would be extended, as it would address many of the recommendations from the Ockenden review.

KC asked for additional assurance on how families were listened to, as well as learning from when things went wrong. SBS confirmed that the Trust had developed strong relationships with the Maternity Voices Partnership (MVP), while there was a well-established Complaints, Legal, Incidents, PALS and Audit (CLIPA) meeting. SBS also reported that a patient experience role had been trialled, and that role had won an award at the recent Healthwatch awards, so funding to continue that role would be sought via the aforementioned £127m of national funds. SBS continued that "DadPad" had also been launched, which focused on the support that could be offered to fathers, and "PartnerPad" would soon be introduced for the LGBT community and same-sex couples. SBS also highlighted the recent presentation the service had recently given to the Care Quality Commission which demonstrated the service's good work. SF added that when there was an adverse outcome with a baby, the Perinatal Mortality Review Tool (PMRT) was applied, which included engagement with, and listening to, the affected families.

MC commended the work of the Patient Experience Midwife, and in particular their contribution to the Patient Experience Committee, and confirmed her support for the continuation of that post, as well as the work done with the MVP. MC also highlighted the Division's executive safety walkarounds, which MC had been privileged to join over the past year, and commended SF and SBS for their leadership.

DH then thanked SF and SBS for their report and confirmed that further Ockenden review-related documents would be considered in due course, once the relevant templates had been issued. SBS however pointed out that the further work would likely be deferred until the publication of the report from the Independent Investigation into East Kent Maternity Services. The point was acknowledged.

Planning and strategy

04-12 <u>The final planning submissions for 2022/23</u>

AJ referred to the submitted report and highlighted the following points:

- The Trust Board had delegated the approval of the planning submissions to the Finance and Performance Committee meeting on 26/04/22, and the submission had been duly approved and submitted after that meeting, to ensure alignment with the Kent and Medway ICS submission.
- NHSE/I's assessment of the first Kent and Medway operational planning submission had concluded "partial assurance" with a rating of 30 out of 45. The key lines of enquiry identified by NHSE/I were financial affordability and health inequalities.
- It was likely that a further planning submission would need to be made in the near future, but that had but not been confirmed.
- The acceptance of the endoscopy activity baseline adjustments had still not been confirmed, but such confirmation was being pursued.
- Much work had been undertaken on workforce plans, and AJ & SS had met with all the Divisions. However, the workforce planning process needed to be developed to be more like the activity planning process, and reflect a more dynamic position.

SS referred to the latter point and added that the workforce plan contained some high estimations regarding the increase in recruitment, and reductions in temporary staffing, which was reliant on

activity and the Trust's ability to recruit staff. SS added that a regular review of the plan would be undertaken, including quarterly 'deep dives'.

SO then highlighted the following points in relation to the finance plan:

- There had been a slight amendment to the plan described in the submitted report, as the plan was now for a year-end deficit of £7.6m, not £9.7m, as some non-recurrent benefits had been identified.
- The £7.6m deficit was closely linked to additional inflationary pressures, which mainly related to energy, for which the Trust had signed a new contract at the end of 2021/22, and the PFI contract, which was linked to the Retail Prices Index (RPI). There was no expectation that the Trust would receive additional funding for such pressures.
- SO was content to provide an updated version of the submitted plan to either the Trust Board or Finance and Performance Committee.
- The Cost Improvement Programme (CIP) would be a key area of focus, and a challenging target had been set, particularly given the current context, and the fact that the Trust had not had a challenging CIP during the COVID-19 pandemic.
- The five year capital plan that had been submitted was not fixed, but the main elements were the KMMS accommodation, the further development of the Community Diagnostic Centre & the potential for further lease activity in the staff accommodation in Springwood Road, Maidstone.
- The transition to International Financial Reporting Standards (IFRS) 16 (leases) was not funded, so the specific impact of that transition was not yet known.

DH noted that the Finance and Performance Committee had already approved the planning submission, so the Trust Board just needed to note the submission, and the adjustments that had been described at the Trust Board meeting. The points were duly noted.

Assurance and policy

04-13 <u>Quarterly report from the Freedom to Speak Up Guardian</u>

DL welcomed CL and NH. CL explained that NH had joined as the Deputy Freedom to Speak Up Guardian (FTSUG) the previous week, to cover the substantive Deputy's maternity leave. CL thanked the substantive Deputy for her dedication and commitment to the role, then referred to the submitted report and highlighted the following points:

- The report represented a year-end position so offered the opportunity to reflect on the last three years of the FTUSG service.
- There was a clear relationship between the Trust's investment in the FTSUG agenda and the increase in staff engagement with the process.

[N.B. MS left the meeting at this point]

- Administrative and Clerical (A&C) and Allied Health Professional (AHP) staff had seen the largest increase in concerns, mainly relating to bullying and harassment.
- 18 concerns had been raised from staff satellite sites. There had been 18 separate concerns relating to the same issue, from the same site, and the staff were now receiving a multidisciplinary intervention. This was the first concern raised that had resulted in such a large and diverse support team being deployed.
- The Safe Space Champion programme continued to go from strength to strength, and it was intended to expand that team.
- The national NHS staff survey results showed that the Trust had improved on 'speaking up' aspects, although more work was required to be among the best performing organisations.

WW referred to the "Bullying/Harrassment" [sic] concerns in the January to March 2022 data, and asked whether any themes had emerged, such as pressure on staff to get the COVID-19 vaccination etc. CL confirmed that the issues mainly related to dignity and respect, and lack of support from managers, which had not necessarily been seen before. CL added that there may have been some impact from the stresses and pressures that staff had experienced during the COVID-19 pandemic. WW asked whether the issues were prevalent across all areas or just related

to certain sections of management. CL replied it was mainly related to A&C staff and AHPs, and tended to be related to more junior staff, up to and including shift leaders and supervisors.

EPM referred to the 31 Safe Space Champions and asked what the plan was to increase that number. CL confirmed there was a plan which involved targeting areas where there was no Champion in place, including the satellite locations and under-represented areas of the main hospital sites, to raise the profile and agenda of the FTSUG service, and recruit more Champions. EPM asked if there was a target number. CLK confirmed that no target had been set, but there was no cap on the overall number. CL added that persons in the role needed to be active however, so recruitment would be on the basis of ensuring that staff and their managers could be released to actively support the work.

EPM then noted that page 8 of 9 in the report showed the areas where the Trust needed to improve, so asked if CL had identified any areas where the Trust could do better. CL acknowledged that the data provided an opportunity to liaise with other, better performing, Trusts, and confirmed that would be the service's next phase of work. EPM invited CL to submit that work to a future People and Organisational Development Committee meeting, as she was interested in the outcome. CL agreed.

Action: Arrange for the Freedom to Speak Up Guardian to submit a report to the People and Organisational Development Committee on the work being done in response to the Trust's performance on the "Raising Concerns" questions in the latest NHS staff survey (including comparison with better-performing NHS Trusts) (Trust Secretary, April 2022 onwards)

DM referred to the survey data on page 8 and commented that the "Best" and "Worst" performing Trusts could be totally unrepresentative, so it was often better to select the ninth and first decile as more meaningful comparators. DM therefore queried whether CL was able to obtain that data, to enable the Trust's performance to be compared with the more relevant Trusts. CL acknowledged the need to be aware of the differences in, for example, specialists Trusts, so confirmed work would be done to try and compare the Trust against similar sized district general hospital acute Trusts. SS added that the team was working more closely to triangulate different data sets and identify proactive interventions, as well as responding to concerns raised via the FTSUG service.

RF stated that it was worrying that one satellite site had led to 18 separate concerns and asked for further details. CL stated that there had been some issues relating to dignity and respect, which was then reflected in the entire working environment, and the work taking place in that environment. CL therefore acknowledged the concerns, but stated that he hoped the case would be able to be used as an example of best practice. SM added that the area in question was a non-clinical area, so the issues had no impact on clinical care, and there was a long list of actions being taken. CL also pointed out that the concerns had also been prompted by proactive visits to the area by the FTSUG team, to promote the FTSUG service.

04-14 <u>Infection prevention and control board assurance framework</u>

SM referred to the submitted report and highlighted the following points:

- The Trust did not agree with all of the significant new guidance from the UKHSA, and the relevant aspects of disagreement were highlighted in the report.
- The new guidance stated that lateral flow COVID-19 testing, not PCR testing, should now only be used for staff, and only patient-facing staff (which included anyone who would attend a clinical area at any point) should be tested. Non-patient-facing staff should only test if they were symptomatic. Patient-facing staff and symptomatic non-patient facing staff could however request lateral flow tests from the national hub. The Trust had therefore withdrawn its staff PCT testing facility.
- The second major change related to household contacts, as staff who were household contacts could return to work after taking daily lateral flow tests for the ten-day contact quarantine period.
- The national guidance stated that patients should only now be isolated if they were symptomatic. However, the Trust was aware that patients could transmit COVID-19 up to 48 hours before they became symptomatic, so the Trust had decided to continue to isolate contacts of patients who had COVID-19 for the time being. The ten-day isolation period had

also been left in place, as 30% of contacts developed infection between 7 and 10 days after exposure. The position would however be closely monitored.

- For visiting, the Trust had made sure that lateral flow tests were available for parents in the neonatal unit, and the maternity service still allowed one birth partner to attend births. The Trust had also introduced some limited visiting to COVID-19 and quarantined patients, which included the use of air-powered respirators for visitors in the stroke unit, which had been successful.
- For elective patient testing, patients who were due to have a general anaesthetic would continue to have a PCR test, while the Trust would move to lateral flow tests for those not scheduled to have a general anaesthetic. However, although the national guidance just asked for one test to be taken three days prior to admission, the Trust would require tests for the three days prior to, and including, the day of admission, to ensure the Trust did not inadvertently admit a COVID-19 positive patient.
- The national guidance also stated that routine testing for patients, apart from the admission swab, should be done by lateral flow test. However there had been a general uproar among Infection Prevention and Control (IPC) colleagues when that had been announced, so PCR tests would continue to be used.
- The Trust had also been asked to establish some form of reporting system to collate data from lateral flow tests. However, this was a huge task, so the Trust would wait until East Kent Hospitals University NHS Foundation Trust (EKHUFT) had developed its response, as the Trust was already using EKHUFT's reporting portal for staff testing.
- The distancing applied in waiting areas had been reduced, although the use of face masks would be retained.
- COVID-19 positive staff could now return to work on day six if they tested negative on days five (when they started testing) and six i.e. when they had had two negative tests, 24 hours apart.
- As MS had stated earlier, the whole Trust arrangements were being reviewed through the IPC team, including moving away from the use of gloves and aprons, and just using Personal Protective Equipment (PPE) as per the pre-COVID-19 position.

DH noted that he had seen some coverage that the new national guidelines had not been universally supported so asked about the position at other local Trusts. SM noted that there were some slight differences of opinion across Kent and Medway, and an ICS meeting would be held w/c 02/05/22, to aim to come to a consensus, although there would likely still be some differences because of the different ward layouts at different Trusts etc.

DH then commented that even after the changes described by SM, the impact of COVID-19 on patient care was still significant, given the different pathways etc. SM agreed but noted that the position was improving, although the separation of respiratory and non-respiratory patients would need to remain in place for some time. SM also noted that information was being finalised to explain the position to patients.

04-15 To consider any other business

There was no other business.

04-16 To respond to questions from members of the public

KR confirmed that no questions had been received.

04-17 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

Log of outstanding actions from previous meetings **Chair of the Trust Board**

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
04-13	Arrange for the Freedom to Speak Up Guardian to submit a report to the People and Organisational Development Committee on the work being done in response to the Trust's performance on the "Raising Concerns" questions in the latest NHS staff survey (including comparison with better-performing NHS Trusts).	Trust Secretary	April 2022	A "Review of the Trust's response to the "Raising Concerns" questions in the latest NHS staff survey (including comparison with better-performing NHS Trusts)" item has been scheduled at the People and Organisational Development Committee 'deep dive' meeting in September 2022.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
N/A	N/A	N/A	N/A	N/A
				N/A

[1] Not started | On track | Issue / delay | Decision required

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chief Executive **Chief Executive**

I wish to draw the points detailed below to the attention of the Board:

- We are continuing to see high levels of pressure at our hospitals with large numbers of people coming into our Emergency Departments (ED). On Monday 16 May we saw our busiest ever day in our ED's, with 667 attendances across both our sites in a 24-hour period. It is worth noting that attendances in general have been 22% higher than the equivalent period in 2019. Despite this pressure, our colleagues have continued to go above and beyond to deliver outstanding care and make fantastic achievements to benefit our patients. This has included:
    - Our surgical colleagues continuing to make excellent progress in reducing our overall waiting lists
    - Our Emergency Departments are regularly the best performing trust in the region and within the top ten nationally
    - Expanding our diagnostic capacity with services such as our Community Diagnostic Centre near Maidstone Hospital, allowing patients quicker access, closer to home
    - Maintaining our cancer targets for some of our most vulnerable patients and increasing our outpatient activity
    - Recovering and opening new pathways in Women's and Children's services, including the re-establishment of services at Crowborough Birthing Centre and the recent opening of our Children's Emergency Department at Tunbridge Wells Hospital.

As mentioned in previous updates, our teams are also working proactively to help combat some of the pressure across our sites with a number of Quality Flow Improvement events. They're creating new and innovative ways of speeding up the discharge process for patients - making sure we get people home as quickly as possible or to the right place for their ongoing care. Our teams are working hard to reduce the number of patients who are medically fit for discharge. Our Integrated Discharge Team is working with partners in the community hospitals, Kent and Medway Clinical Commissioning Group (CCG) and social care services to expedite patient discharges. We are tracking our stranded patients* weekly and the team have made good progress with the reduction of the number of long-stay patients. * Stranded patients can be identified as those with a length of stay (LOS) of seven days or more.

We're also continuing to see a further drop in COVID-19 patients across our sites and are currently caring for 26 positive patients in our hospitals. Given the decrease in numbers over recent weeks we've extended our visiting policy to ensure patients are now able to have two visitors for two hours each day from 2pm-5.30pm and patients attending outpatient appointments are now able to also bring along someone to support them at our sites. Full details of visiting are available on our website. We have also returned to pre-pandemic physical distancing in all areas of our hospitals, but ensuring all patients, visitors and staff continue to practice good hand and respiratory hygiene, including the continued use of face masks. In the interim, there is a need to ensure that IPC practice returns to pre-pandemic standards wherever possible while retaining precautions for patients on the respiratory pathway and continuing to observe the remaining mandated Covid-19 precautions including universal mask wearing and routine swabbing for both inpatients and elective patients.

- Our Nursing and Midwifery teams have recently launched a recruitment campaign and have held the first two Open Days. The campaign is being promoted through number of platforms including local radio and social media channels. Our Clinical Support Worker Open Day on 7 May welcomed 25 potential candidates with 17 interviews held on the day. The Nursing and Midwifery Open Day saw 16 attendees with 9 interviewed. We have monthly events running for the remainder of the year including the Trust attending external recruitment events. Additionally, in terms of temporary staff usage, from the end of this month, Confirm & Support meetings are being introduced to support ward leaders with effective rostering and improve lead times.

- Following the issues raised by the David Fuller case, the Independent Inquiry, the Department for Health and Social Care and the Human Tissue Authority(HTA) issued progress statements last week (19 May). These detailed the actions taken to date, key themes, next steps and a revised publications date for phase one of the inquiry – which focuses on Fuller's activities in the Kent and Sussex and Tunbridge Wells hospitals.

Because the inquiry has received a larger amount of evidence than expected the initial report (phase one) is now expected to be published later in 2022, rather than in the middle of the year as previously anticipated.

Interviews with families and Trust staff have begun and analysis of material from organisations including the Trust and Mitie (Fuller's employer at the time of his arrest) is underway.

From the inquiry's engagement with witnesses so far, it has experienced a high degree of co-operation and expects this to continue. The Trust continues to support the work of the inquiry and we are providing them with all the documents, data and information they require. The inquiry team has begun work to further scope and plan for the second phase of the Inquiry, to look at the implications of Fuller's activities and the issues identified in phase one, for the country as a whole to ensure this activity cannot be repeated elsewhere. The HTA, whose remit includes regulating mortuaries, is engaging with stakeholders involved in mortuary oversight and reviewing HTA guidance.

- On Friday 13 May, the MP for Tunbridge Wells, the Rt Hon Greg Clark officially opened our Surgical Assessment Unit (SAU) at Tunbridge Wells Hospital. The event was also attended by MP for Chatham and Aylesford, Tracey Crouch and MP for Tonbridge and Malling, Tom Tugendhat. The SAU is open seven days a week and sees patients who have been referred by their GP or ED because a surgeon is required to assess their condition and treatment. During the visit, the MPs were also shown around the new Children's Emergency Department which opened last month at Tunbridge Wells Hospital, linking in directly with the current main ED and increasing capacity for the Trust's most urgent patients.

- The stroke Hyper-Acute Stroke Unit (HASU)/Acute Stroke Unit (ASU) development continues. The Clinical Effectiveness Group (CEG) for the Network Stroke Programme recommended that the original activity profile based on 2015/16, 2016/17 and 2017/8 needed reviewing as the judicial and independent review processes caused considerable delay and the stroke landscape changed after the closure of Tunbridge Wells Hospital and Medway NHS Foundation Trust stroke services. The latter has resulted in the flows settling and more activity than anticipated in the original business case being experienced. As a result, the activity from financial years of 2019, 2020 and 2021 has been used to model revised bed numbers. Added to this the national stroke bed model has been published and CEG recommended this also be used in the bed calculation. As a result of this the beds have been recalculated and the MTW requirement is now 16 HASU beds and 34 ASU beds (previously 11 and 27). This is being confirmed at the next CEG meeting and Network Stroke Programme Board. Positively MTW are planning to build sufficient beds as the original plan catered for 20 stroke rehabilitation beds. Stroke rehabilitation was moved into the community during COVID-19 and has been very successful, so will not be moved back into the hospital. The extra costs associated with this particularly related to staffing are being calculated.

Plans for the build have been reviewed and agreed with the clinical team. The process for confirming the build and tendering in the market is being implemented. In discussion with the Kent and Medway Clinical Commission Group (CCG) we will be providing this information by December 2022 to allow the full business case for the Trust to be submitted to NHS England and Improvement. The process is being developed with the estates team. The CCG have allocated £1.9m capital to the MTW stroke programme in 2022/23. MTW have made a requested to release that capital early and before the financial business case to allow the first stage of developing the former Acute Medical Unit to take place. We are waiting CCG feedback.

Plans for our Digestive Diseases Unit (DDU) continue apace. This specialist unit will provide expertise in both common and complex digestive conditions, encompassing a team-based approach that brings together experts from gastroenterology, hepatology, endoscopy, and surgery to provide informed, thorough care from the start. By enabling a more multidisciplinary approach, a DDU can improve the treatment for patients who suffer from a range of gastrointestinal conditions such as Crohn's disease, Pancreatitis and Reflux Disease. Gastro-centralisation at the Tunbridge Wells site is currently underway to facilitate the next steps in the development of the unit, this will be completed by the end of May. In parallel, development of Tier 4 bariatric service is continuing with the Kent and Medway Clinical Commissioning Group (CCG).

- Our staff networks continue to play a key role in supporting staff across MTW. At the end of last month our Cultural and Ethnic Minorities Network (CEMN) hosted a conversation between Steve Orpin, MTW's Deputy Chief Executive Officer and executive sponsor of the CEMN and Tafadzwa Mugwawa, Chief Operating Officer at Bradford District Care NHS Foundation Trust. Steve and Tafadzwa shared information about how they developed their careers in operations management and their thoughts on how we continue to improve on diversifying our workforce. WRES (Workforce Race Equality Standard) workshops have begun with Divisional leaders. Supported by the CEMN, Divisions are provided with the WRES data for their areas which shows the number of white and B.A.M.E. staff at each band including medical and dental staff and encouraged to consider how they can meet a national target of having 19% B.A.M.E. representation at each band by 2025. The NHS Rainbow Badge assessment continues with allies of the network promoting the importance of LGBT+ inclusion for both staff and patients by filming a Talking Heads video to share across our communication channels. All of the networks have been involved in the developing Equality, Diversity and Inclusion (EDI) strategy for the Trust which we plan to release in the coming weeks.

- At the end of last month, we ran a communications campaign internally to promote our Safe Space Champions (SSCs) to staff. SSCs are a group of staff members from different areas and roles within the Trust who provide a listening ear and safe space for staff to discuss any worries or concerns, in confidence, about themselves or patient care. The role of a Safe Space Champion has two parts: to be a listening ear to staff and to signpost to appropriate help if further support is needed, and to work with the Freedom To Speak up Guardians (FTSU) to promote speaking up across MTW and ensure that staff who speak up are listened to.

- The last few weeks we have been celebrating our staff with International Day of the Midwife (5 May), International Nurses' Day (12 May) and Operating Department Practitioners (ODP) Day (14 May) and highlighting the continued incredible work undertaken by these staff groups. You can read more about how we celebrated International Day of the Midwife here, International Nurses' Day here and you can view the ODP video we shared as part of the celebrations here: https://www.youtube.com/watch?v=yaMgbRucVF0

- Our Patient First magazine is now in an all new digital format. The e-magazine shares all the latest news and developments at MTW with people living in our local communities and partner organisations. The first edition was published on Friday 6 May and if you'd like a copy sent straight to your inbox you can sign up to our mailing list here.

- The West Kent Health and Care Partnership (HCP) continues to make great progress this month notably on working with partners to improve mental health support:

    - A data harmonisation tool developed by the Kent & Medway Clinical Commissioning Group Medicines Management Team is being rolled out by the HCP to all GP Surgeries in West Kent. The tool is uploaded into EMIS by the practice manager and identifies patients that do not have a dementia diagnosis but potentially could have dementia given a number of indicators in their care record. So far in West Kent 11 practices that have used the tool and 181 patients have been identified that will now be reviewed by a GP to determine whether a dementia diagnosis is appropriate.

    - The Severe Mental Illness (SMI) health check rate in West Kent has also improved since the HCP have been working with the team, moving from 18% in Quarter 3 2021-2022 to 32.5% in Quarter 4 2021-2022. A significant contributing factor has been improved engagement with GPs which has resulted in the Primary Care Mental Health Team having access to more practice SMI registers and an increased number of clinics being set up in GP surgeries across West Kent.

    - The HCP team are also working with partners to consider how to pilot a Multi-disciplinary team meeting at Primary Care Network level for patients with complex mental health needs. The partnership have identified a significant group of patients who are presenting repeatedly in practices but don't seem to be making any progress in their mental health, this initiative would aim to enhance the care and support they receive through a multi-agency response.

- Congratulations to the winner of the Trust's Employee of the Month scheme for April, Lianne Noble, PALs* Officer. Lianne is a dedicated PALS Officer who invests her time and energy in advocating for patients at all times. Lianne never shies away from a difficult conversation, and is known for conducting herself with professionalism to ensure all parties are heard and that mutual agreement can be reached. On behalf of the Trust Board I would like to say thank you to Lianne for her fantastic work to help support our colleagues and patients. (*Patient Advice and Liaison Service).

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performanc

Summary report from Quality Committee, 11/05/22 (incl. approval of revised Terms of Reference)	**Committee Chair (Non-Executive Director)**

The Quality Committee met on 11th May (a 'main' meeting), via virtual means.

1. The key matters considered at the meeting were as follows:

- The Committee agreed **revised Terms of Reference**, as part of the routine annual review. These are enclosed in Appendix 1, with the proposed changes shown as 'tracked', and the Trust Board is asked to approve the changes.
- The reports from the Committee's sub-committees (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; The Infection Prevention and Control Committee; The Drugs, Therapeutics and Medicines Management Committee; The Sepsis Committee; and the Health and Safety Committee) were considered and revised Terms of Reference were approved for the latter. It was agreed under the summary report from the Infection Prevention and Control Committee that the Director of Infection Prevention and Control should provide an update the challenges associated with the Domestic Hot Water System at Tunbridge Wells Hospital (TWH) to the July 2022 'Main' Quality Committee meeting. It was also agreed under the summary report from the Sepsis Committee that the Chief of Service for Medicine and Emergency Care should liaise with the Chair of the Sepsis Committee to ensure that the Terms of Reference for the Sepsis Committee were submitted to a future 'main' Quality Committee, for approval
- The issues raised from the **reports from the clinical Divisions** highlighted the challenges associated with staffing levels at the Trust; the impact of increased operational pressures; and the Committee's support for the revised Divisional Governance report template which had been developed by the Director of Quality Governance. It was agreed under the Diagnostic and Clinical Support Services Divisional Governance Report that the Deputy Divisional Director of Operations, Diagnostic and Clinical Support Services should ensure that the Diagnostic and Clinical Support Services Divisional report to the July 2022 'main' Quality Committee meeting included an update on the staffing challenges within the Aseptic Unit at TWH. The Women's, Children's and Sexual Health Divisional Governance report included an "Assessment of the Trust's position against, and implications of, the final Ockenden report (the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust)" report which was considered by the Trust Board in April 2022.
- The Referral to Treatment (RTT) Operational Lead attended for the latest **update on harm reviews for patients who have waited a long time** wherein it was agreed that it should be ensured that the report to the to the July 2022 'main' Quality Committee meeting should include details of the plan to prevent future deterioration of the Trust's long waiting patient position and, if feasible, details of the breakdown of long waiting patients by demographic.
- The Deputy Chief Nurse, Quality and Experience gave the latest **update on the work to achieve an 'Outstanding' CQC rating** and it was agreed that the "CQC Staff Guide" should be amended to reflect the feedback received at the May 2022 'main' Quality Committee meeting (i.e. to include details of the Freedom to Speak Up service; the support available from the Trust's Non-Executive Directors; and the provision of an Executive Summary).
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality**, wherein they agreed to liaise with the Head of Clinical Coding and PbR Assurance to investigate the root cause for the above average number of symptoms being recorded as a primary diagnosis.
- The latest **Serious Incidents (SIs)** were reported by the Director of Infection Prevention.
- The Deputy Chief Nurse, Quality and Experience provided the latest **update from the Enteral feeding and Nasogastric tube (NGT) placement working group** and it was agreed that the rationale for Paediatric Nasogastric tubes (NGT) being able to be maintained in a community setting when adult NGTs were required to be maintained in a hospital setting should be investigated.
- The Committee reviewed the **draft Quality Accounts for 2021/22** wherein the Committee recommended that the draft Quality Accounts for 2021/22 be submitted to the Extraordinary

'Part 1' Trust Board in June 2022, subject to Director of Quality Governance ensuring that the narrative associated with the "2021/22 Completed structured judgement review" graph in the draft Quality Accounts 2021/22 reflected that Structured Judgement Reviews (SJRs) were required for less than 10% of all deaths at the Trust.

- The Clinical Director, Pharmacy and Medicines Management lead a detailed **review of the report on safe use of medical oxygen training for staff across the Trust** it was agreed that an update on the progress to ensure compliance with safe use of medical oxygen training for Trust staff should be submitted to the July 2022 'main' Quality Committee meeting; at which point further discussions would be held in relation to reporting and monitoring arrangements for such training.
- The report from the last **Quality Committee 'deep dive' meeting** was noted.
- The **summary report from the Patient Experience Committee** meeting held on 03/03/22 was noted.
- Under **Any Other Business** it was agreed that the Assistant Trust Secretary should schedule a "Review of the management of health and safety at the Trust" at the June 2022 Quality Committee 'deep dive' meeting, having first discussed what, if any, item should be deferred with the Chair of the Quality Committee

2. **In addition to the agreements referred to above, the meeting agreed that:** N/A

The issues from the meeting that need to be drawn to the Board's attention are:

- The Committee's Terms of Reference were reviewed and the proposed changes were agreed. The revised Terms of Reference are enclosed in Appendix 1, for the Trust Board's approval

Which Committees have reviewed the information prior to Board submission? N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Appendix 1 – Revised Terms of Reference (for approval)

QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Quality Committee is constituted at the request of the Trust Board to:

a) Seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care
b) Oversee quality within the clinical divisions

2. Membership

- Non-Executive Director or Associate Non-Executive Director (Chair)*
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)*
- One other Non-Executive Director or Associate Non-Executive Director*
- Chief Operating Officer*
- Chief Nurse*
- Medical Director*
- Deputy Medical Director*
- Director of Infection Prevention & Control (if not represented via another role within the membership)
- ~~Deputy~~ Director of Quality Governance*
- The Chiefs of Service for the five clinical divisions
- The Divisional Directors of Nursing & Quality (DDNQs) (or equivalent) for the five clinical divisions
- The Clinical Director of Pharmacy & Medicines Optimisation (as Chair of the Drugs, Therapeutics and Medicines Management Committee)

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least four of the 'main' Quality Committee meetings per year (those who are also members of the 'deep dive' meeting will be required to attend at least three such meetings per year). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality Committee for action.

3. Quorum

The 'main' meeting of the Committee will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[2]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director)
- Three clinical divisional representatives (i.e. either the Chief of Service, DDNQ (or equivalent) or an appropriate deputy for either)

The 'deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director). Deputies representing members of the Executive Team will count towards the quorum.

4. Attendance

[2] For the purposes of quorum, the Chair of the Trust Board will be regarded as a Non-Executive Director

The following are invited to attend each 'main' meeting

- The Chief Nurse (or an appropriate deputy, as they determine) from NHS Kent and Medway Clinical Commissioning Group

Other staff may be invited to attend, as required, to meet the Committee's purpose and duties.

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and members of the Executive Team (i.e. apart from those listed in the "Membership") are welcome to attend all meetings of the Committee. The same applies to representatives from Internal Audit.

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will generally be a 'deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects. For clarity, the other meeting will be referred to as the 'main' Quality Committee.

Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To seek and obtain assurance on all aspects of the quality of care across the Trust, and if not assured, to oversee the appropriate action or escalate relevant issues to the Trust Board, for consideration

6.2 To oversee all aspects of quality within the clinical divisions, and to obtain assurance that an appropriate response is given

6.3 To seek and obtain assurance on the mitigations for significant risks relating to quality

6.4 To seek and obtain assurance that the Trust Risk Management Policy is implemented, in relation to quality issues

6.5 To seek and obtain assurance on compliance with relevant policies, procedures and clinical guidance

6.6 To receive details of the learning arising from complaints, claims, inquests, and Serious Incidents (SIs)

6.7 To seek and obtain assurance on the Trust's compliance with the Fundamental Standards (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and reflected in the Care Quality Commission's 5 domains)

7. Parent committees and reporting procedure

The Quality Committee is a sub-committee of the Trust Board. The Committee Chair will submit a written summary report to the next Trust Board meeting following each Quality Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported to the Quality Committee by the Committee Chair, as they deem necessary.

The Committee's relationship with the Patient Experience Committees is covered separately, below.

8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

1. The Cancer Services Divisional Clinical Governance Committee (or equivalent)
2. The Diagnostics & Clinical Support Divisional Clinical Governance Committee (or equivalent)

3. The Medicine & Emergency Care Divisional Clinical Governance Committee (or equivalent)
4. The Surgery Divisional Clinical Governance Committee (or equivalent)
5. The Women's, Children's & Sexual Health Divisional Clinical Governance Committee (or equivalent)
6. The Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group
7. The Infection Prevention and Control Committee
8. The Learning and Improvement (SI) Panel
9. The Joint Safeguarding Committee
10. The Drugs, Therapeutics and Medicines Management Committee
11. The Health and Safety Committee
12. The Sepsis Committee

A report from the Clinical Governance Committees (or equivalent forums) of the five clinical divisions will be submitted to each 'main' Quality Committee meeting, using a format approved by the Chair of the Quality Committee.

Reports from the Quality Committee's other sub-committees will be given after each sub-committee meeting (either via submission of the minutes of the meeting, a written summary report or a verbal report from the Chair).

The Quality Committee may establish fixed-term 'Task & Finish' Groups to assist it in meeting its duties as it, or the Trust Board, sees fit.

10. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

A summary report of the Patient Experience Committee will be submitted to the Quality Committee (the summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose).

11. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each meeting is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's forward programme, setting out the dates of key meetings and agenda items
- The meeting agenda
- The meeting minutes and the action log

12. Emergency powers and urgent decisions

The powers and authority of the Quality Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two of the Committee's members, one of whom should be a member of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next meeting of the Quality Committee, for formal ratification.

13. Review of Terms of Reference

These Terms of Reference will be agreed by the Quality Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Review history

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015
- Revised Terms of Reference agreed by the Quality Committee, 6th January 2016
- Revised Terms of Reference approved by the Trust Board, 27th January 2016
- Revised Terms of Reference agreed by the Quality Committee, 11th January 2017
- Revised Terms of Reference approved by the Trust Board, 25th January 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Revised Terms of Reference agreed by the Quality Committee, 10th January 2018
- Revised Terms of Reference approved by Trust Board, 25th January 2018
- Revised Terms of Reference agreed by the Quality Committee, 8th May 2019
- Revised Terms of Reference approved by Trust Board, 23rd May 2019
- Revised Terms of Reference agreed by the Quality Committee, 10th July 2019 (to add the Drugs, Therapeutics and Medicines Management Committee as sub-committee, and add the Clinical Director of Pharmacy & Medicines Optimisation as a member of the 'main' Quality Committee)
- Revised Terms of Reference approved by Trust Board, 25th July 2019
- Revised Terms of Reference agreed by the Quality Committee, 6th May 2020
- Revised Terms of Reference approved by the Trust Board, 21st May 2020
- Amendment approved by the Trust Board, 26th November 2020 (to add the Health and Safety Committee as sub-committee)
- Amendment approved by the Trust Board, 17th December 2020 (to enable deputies attending the Quality Committee 'deep dive' meeting for members of the Executive Team to count towards the quorum requirements)
- Revised Terms of Reference agreed by the Quality Committee, 12th May 2021
- Revised Terms of Reference approved by the Trust Board, 27th May 2021
- Amendment agreed by the Quality Committee, 12th January 2022 (to add the Sepsis Committee as a sub-committee)
- Revised Terms of Reference approved by the Trust Board, 27th January 2022
- Revised Terms of Reference agreed by the Quality Committee, 11th May 2022
- Revised Terms of Reference approved by the Trust Board, 26th May 2022

Summary report from the Finance and Performance Committee, 24/05/22	**Committee Chair (Non-Exec. Director)**

The Committee met on 24th May, via a webconference.

1. The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed, one of which was related to the Trust Board's previous decision that the Green Committee should be a sub-committee of the Finance and Performance Committee. The Committee agreed that the Green Committee should instead be a sub-committee of the Executive Team Meeting, to free the Finance and Performance Committee to have an assurance-seeking role. The Trust Board is therefore asked to approve the removal of references to the Green Committee from the Finance and Performance Committee's Terms of Reference (as shown in Appendix 1). The Committee also agreed that that it should receive an annual report on progress against the Trust's annual Green Plan, in addition to reviewing the Green Plan itself.
- The Chief Operating Officer presented **the actions being taken, and considered, to address the current patient flow-related challenges,** which led to a detailed discussion on the extent to which the Trust should expend funds to release acute beds that were occupied by patients who no longer had the right to reside. It was acknowledged that the Trust needed to work with partner organisations to solve the problem, rather than take unilateral action, and it was agreed that the Chief Operating Officer should submit an "Update on the development of the options to address the Trust's patient flow-related challenges" report to the Committee in June 2022.
- **The Patient Access strategic theme metrics** for month 1 were reviewed in detail, which included a discussion on the factors affecting the non-delivery of the Breakthrough Objective to ensure elective activity levels matched those pre-COVID-19.
- The **financial performance for month 1** was reviewed, which noted that although the Trust's overall position was on plan for that month (once the variances associated with income from the Elective Recovery Fund were excluded), there were concerns at the costs of medical staffing in certain specialties, and also at the plateau in the identification of additional Cost Improvement Programme schemes over the past five weeks.
- The details of the final finance **plan for 2022/23** that was submitted in April 2022 were formally noted, but it was confirmed that a re-submission of Trust Board-approved planning templates was required by 20/06/22, which would likely require the scheduling of an extraordinary Trust Board meeting in mid-June 2022.
- The Committee considered an optional appraisal report regarding **the future of the Trust's laundry service**, and gave its approval to develop the options appraisal into an Outline Business Case, for further consideration in the autumn of 2022.
- The Director of Estates attended for the **annual review the Trust's Green Plan**, prior to the Plan being submitted to the Trust Board, for approval, in June 2022. The Plan was supported as submitted, although the need for greater specificity in future versions was highlighted, to ensure that the 'mission critical' issues went beyond just a commitment.
- The Chief Operating Officer gave an update on **the development of the Business Case for additional orthopaedic elective capacity for Kent & Medway.**
- The Medical Director attended to provide an **update on the implementation of the Electronic Patient Record (EPR),** which focused on the forthcoming implementation of the Electronic Prescribing and Medicines Administration (EPMA) system. A useful discussion was held and the Medical Director agreed to ask the EPR team to develop a contingency plan, should the current 'go live' date for the implementation of the EPMA system not be met.
- The Director of IT attended to provide an **update on the development of the revised IT Strategy "What Good Looks Like framework"** which proposed that the Trust's IT Strategy should be combined with the Digital Transformation Strategy to produce a single Strategy. The Committee supported the proposed approach.
- The Trust Secretary notified the Committee **of the uses of the Trust Seal** since the last meeting.

2. **In addition to the agreements referred to above, the Committee agreed that:** N/A

3. The issues that need to be drawn to the attention of the Board are as follows:

- The Trust Board is asked to approve the removal of references to the Green Committee from the Finance and Performance Committee's Terms of Reference (as shown in Appendix 1).

Which Committees have reviewed the information prior to Board submission? N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)

1. Information and assurance
2. To approve the proposed changes to the Committee's Terms of Refence (see Appendix 1)

Appendix 1: Proposed revised Terms of Reference for the Finance and Performance Committee (for approval)

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- An objective assessment of performance-related issues affecting the key operational targets and the Trust's financial position
- Advice and recommendations on all key issues of financial management, financial performance and operational performance
- Assurance on Information Technology performance (and IT-related business continuity)

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- A further Non-Executive Director or Associate Non-Executive Director
- The Deputy Chief Executive/Chief Finance Officer *
- The Chief Operating Officer*
- The Chief Executive*

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director or Associate Non-Executive Director and two Members of the Executive Team (see * above) are present. If a member of the Executive Team cannot attend a meeting, they should aim to send a representative in their place.

For the purposes of being quorate, any Non-Executive Director or Associate Non-Executive Director (including the Chair of the Trust Board) may be present; and any two Members of the Executive Team may be present (including any of those not listed in the Membership). Deputies representing Members of the Executive Team will count towards the quorum.

4. Attendance

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors and Members of the Executive Team are entitled to attend any meeting of the Committee.

The Committee Chair may also invite others to attend, as required, to cover certain agenda items, and/or ensure the Committee meets its purpose and complies with its duties.

5. Frequency of meetings

The Committee shall, generally, meet each month, but the Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings)

6. Duties

The Committee has the following duties:

Financial Management

- To review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- To ensure a comprehensive budgetary control framework is in place and operating effectively

- To monitor financial performance against plan, and ensure corrective action is taken where appropriate
- To develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- To review and monitor the Trust's Cost Improvement Programme (CIP)
- To monitor the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations"), and subsequent related publications or national guidance.
- To ensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national initiatives

Treasury Management
- To review any significant (in the judgement of the Deputy Chief Executive/Chief Finance Officer) proposed changes to the Trust's treasury management policies, processes and controls
- To approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within the Committee's delegated authority), or to review such applications, and make a recommendation to the Trust Board if the value exceeds the Committee's delegated authority)
- To review the Trust's cash flow and balance sheet, to ensure effective cash management plans are in place

Capital Expenditure and Investment
- To review the Trust's capital plan ensuring its alignment to strategic priorities
- To review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- To approve Business Cases for capital and service development, within the financial limit set out in the Reservation of Powers and Scheme of Delegation
- To review Business Cases for capital and service development above the financial limit set out in the Reservation of Powers and Scheme of Delegation, and make a recommendation to the Trust Board regarding the approval of such Cases
- To receive assurance on the effectiveness of the Trust's investment appraisal and approval process (via consideration of post-project reviews)

Financial Governance, Reporting, Systems and Function
- To review and assess the arrangements for financial governance
- To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)
- To review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust
- To assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives
- To review and approve the Trust's approach to its National Cost Collection return/s

Procurement
- To monitor performance against the Trust's Procurement Strategy and Procurement Transformation Plan

Performance
- To monitor and review non-quality performance-related issues, particularly in relation to the key patient access targets
- To monitor and review the indicators within the Trust Integrated Performance Report (IPR) (and associated information) prior to review by the Trust Board
- To escalate performance-related issues to the Trust Board in the event of any concerns

Informatics (including Information Technology

- To review Information Technology strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- To review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to the financial implications and risks of the proposals

Assurance and Risk

- To assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

The Committee is a sub-committee of the Trust Board.

A summary report of each Committee meeting will be submitted to the Trust Board. The Chair of the Committee will present the Committee report to the next available Trust Board meeting

8. Sub-Committees and reporting procedure

~~The Committee has the following sub-committees:~~
~~- The Green Committee~~

~~Reports from the Committee's sub-committees will be given after each sub-committee meeting (either via submission of the minutes of the meeting, a written summary report or a verbal report from, or on behalf of, the sub-committee Chair).~~

The Committee has no standing sub-committees, but ~~The Committee~~ may ~~also~~ establish fixed-term working groups, as required, to support the Committee in meeting the purpose and/or duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Members of the Executive Team (see * in the above "Membership" section). The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee.

10. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015

- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2019
- Terms of Reference (revised) approved by the Trust Board, September 2019
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2020
- Terms of Reference (revised) approved by the Trust Board, September 2020
- Terms of Reference approved by the Trust Board, January 2021 (to address the anomaly regarding the listing of an “Associate Non-Executive Director” in the membership rather than a third Non-Executive Director)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2021 (annual review, but also to include formalising the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, September 2021
- Terms of Reference (revised) agreed by the Finance and Performance Committee, May 2022 (to remove the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, May 2022 (to remove the Green Committee as a sub-committee of the Finance and Performance Committee)

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 19/05/22 (Incl. Quarterly update from the Guardian of Safe Working Hours (covering January to March 2022))

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on the 19th May 2022 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The Committee reviewed the **actions from previous meetings** and it was agreed that the Assistant Trust Secretary should ensure that 'action owners' provided an estimated completion date for those actions which remained 'open' within the Committee's "Log of outstanding actions…".
- The Chief People Officer and Deputy Chief Executive / Chief Finance Officer presented a **Strategy Deployment – The People Strategic Theme** item which included a **review of the breakthrough objectives** and the Committee emphasised the importance of the provision of a robust leadership development programme for People Leaders on Agenda for Change (AfC) bands 5 to 7.
- The Committee reviewed the **monthly update on the latest People Key Performance Indicators (KPIs)** wherein it was agreed that the Head of Resourcing should ensure that the "update on recruitment and retention" report to the June 2022 People and Organisational Development Committee 'deep dive' meeting included an update on the challenges associated with Sonographer staffing vacancies. It was also agreed that the Chief People Officer should investigate what, if any, issues were concealed by the utilisation of overtime by Allied Health Professionals (e.g. whether there were significant staffing shortages). Furthermore, it was agreed that the Head of Resourcing should ensure the development of a Key Performance Indicator to illustrate the return on investment of the Trust's Bank staff engagement initiatives.
- The Head of Staff Engagement and Equality attend for an **update on recruitment and retention (which included a quarterly review of the findings from 'Moving On' survey)** which included the further work which was required to increase the response rate to the 'Moving On' survey to ensure the findings were statistically significant.
- The Chief People Officer provided assurance in relation to **Disclosure and Barring Service (DBS)** checks wherein it was agreed that the Chief People Officer should consider, and confirm to Committee members, whether the Trust should provide funding for high-risk staffing groups to be enrolled in the automated DBS update service.
- The Advanced Clinical Practitioner Project Lead attended for an in-depth **review of the findings from the Advanced Clinical Practitioner (ACP) workforce project** wherein the Committee acknowledged the long term strategic focus which was required in relation to the ACP workforce and it was agreed that the Assistant Trust Secretary should schedule an "Update on the findings from the Advanced Clinical Practitioner workforce project" item at the November 2022 People and Organisational Development Committee 'deep dive' meeting.
- The Deputy Chief People Officer, Organisational Development provided the latest **update on activity levels within the Trust's Networks** (which included an update on the Equality, Diversity and Inclusion (EDI) strategy) during which the importance of Executive sponsorship for each of the Trust's staff networks was highlighted and it was agreed that the Assistant Trust Secretary should schedule an "update on the Trust's Equality, Diversity and Inclusion (EDI) strategy (incl. any further support which was required)" item at the December 2022 'main' People and Organisational Development Committee meeting.
- The latest **quarterly review of internal communications** and **quarterly update from the Director of Medical Education** were noted.
- The Deputy Chief People Officer, People and Systems provided an **update on the latest 'MTW Climate survey' and national NHS staff survey 2021** which included a discussion on the Trust's future survey strategy; the reduced response rate and performance compared to the previous 'MTW Climate survey'; and the key area of focus which had been identified.
- The Interim Head of Learning and Development attended for a comprehensive **review of a**

proposal regarding the scope and reporting frequency for an update on learning and development wherein the Committee supported the proposed reporting schedule and noted the additional space allocation which was required at the Trust to support learning and development although noted the challenges associated with the provision of such space. However, the Committee encouraged the Deputy Chief People Officer, Organisational Development; and Interim Head of Learning and Development to find ways in which the difference between the Apprentice Levy and Trust's expenditure could be reduced.

- The latest **quarterly update from the Guardian of Safe Working Hours** (covering January to March 2022) was reviewed (and this is enclosed in Appendix 1, for information and assurance).
- The **Committee's forward programme** was noted.
- Under the **evaluation of the meeting** it was agreed that the Chief People Officer should ensure that presenters for reports to the Committee were briefed in relation to the Committee's expectations (i.e. that it should be assumed that Committee members had read reports and reviewed the presentation prior to the meeting to enable a full discussion on the topic and for the Committee to debate questions posed by the report's author).

In addition to the actions noted above, the Committee agreed that: N/A

The issues from the meeting that need to be drawn to the Board 's attention as follows: N/A

Which Committees have reviewed the information prior to Board submission? N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)[1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – MAY 2022

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (COVERING JANUARY TO MARCH 2022)	**GUARDIAN FOR SAFE WORKING HOURS**

The enclosed report covers the period January 2022 to March 2022:

- A total of 80 Exception Reports were raised during this period relating to extra hours worked.
- 8 reports were for educational opportunities missed.
- The majority were raised in General Medicine (38), 18 in General Surgery, 16 in Orthopaedics and 5 in paramedics
- 56 ERs were raised by FY1 and FY2 doctors in medicine /surgery,
- Exception reports were filed relating to excessive workload, staff shortages and lunch breaks missed.
- There is a current issue with ALLOCATE exception reporting system not taking resolved reports off the system. This issue is currently being reviewed.
- There has been an improvement in response time from supervisors in responding to ERs from their trainees.

Reason for circulation to People and Organisational Development Committee

Assurance

Reporting Period: Jan-March 2022

Exception Reports-table of results

Specialty	Grade	No. exceptions raised
Paediatrics	FY2	5
Orthopaedics	FY2	16
Haematology	CT2	1
General Medicine	FY1	28
General Medicine	FY2	9
General Medicine	CT2	1
General Surgery	FY2	18
Geriatric Medicine	FY2	1
Urology	FY2	1
Total		80

Missed educational opportunities

Specialty	Grade	No. exceptions raised
Paediatrics	FY2	5
Ophthalmology	ST1	1
General Medicine	FY1	2
Total		8

Report Commentary:

For the period Jan-March 22

During the three-month period there were 80 Exception Reports received. The 80 ERs were related to hours worked (individual workloads)

There were also 8 exceptions reports relating to missed educational opportunities..

As per previous reports the majority of ERs were generated by FY1 and FY2 doctors in medicine/surgery.

During this period reasons for ERs being raised included;

- Short staffing
- Complicated patients
- Missed lunch breaks
- Workload not finished on time
- An urgent procedure needed to be performed on a patient
- Excessive workload

During this period no fines or work schedule reviews were performed

As Guardian of Safe Working the main difficulty / challenge currently is the ALLOCATE system not updating ER outcomes in a timely manner, sometimes not at all.
The issue is that after a supervisor meets with their trainee regarding an ER raised and formulates either an outcome such as time off in lieu/payment agreed or decides no action is required the system does not update and remove the ER. This will then look like the clinical supervisors not responding in an appropriate timeframe (in line with the terms and conditions of the contract of trainee doctors).
I currently have to ask the medical staffing team to take these ERs off the system as I don't have privileges to do this as Guardian

The medical workforce team are currently looking at this glitch in the system and how it can be resolved without having to update manually.

Lastly I'm happy to report that during this period the clinical supervisors in general are responding to ERs in a more timely manner.

Audit and Governance Committee, 16/05/22 **Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met, virtually via web conference, on 16th May 2022.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were reviewed and it was agreed that the Deputy Chief Executive / Chief Finance Officer should liaise with the Senior Anti-Crime Manager Tiaa Ltd to ensure that future "Counter Fraud update" reports reflected the work which was undertaken by the Anti-Crime service in relation to Cyber Security.
   - The Risk and Compliance Manager attended for a **review of the Trust's red-rated risks** wherein it was agreed that liaison should be held the risk lead for risk ID2839 "Risk of nosocomial COVID -19 infection" to review and amend the "Rating (Target)" so that such a rating was no longer red. It was also agreed that it should be ensured that future "Review of the Trust's red-rated risks" reports reflect the comments received at the May 2022 Audit and Governance Committee meeting (i.e. confirmation of any in-depth discussions at other Trust Board sub-Committees; and the inclusion of the expected date, where applicable, that a mitigation was anticipated to have an impact on the risk rating).
   - The Committee received the **Internal Audit Annual Report for 2021/22 (incl. the draft Head of Internal Audit Opinion)** wherein the Trust received a rating of **"Reasonable Assurance"** for the draft Head of Internal Audit Opinion.
   - An **update on progress with actions from previous Internal Audit reviews** (incl. response to the Internal Audit survey findings) was reported which included details of Outstanding Audit Recommendations; wherein it was agreed that the Assistant Trust Secretary and Trust Secretary should ensure the Trust's Medical Director was invited to the July 2022 Committee meeting to provide assurance in relation to the findings of the Internal Audit review of "Consent". It was also agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should provide further clarification to Committee members as to why the assurance rating for the "Consent" Internal Audit review was "Reasonable" and not "Limited". Furthermore, it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should arrange for a further "Divisional Plans from Staff Surveys and Climate Surveys" review to be added to the draft Internal Audit plan for 2023/24. The list of recent Internal Audit reviews is shown below (in section 2).
   - The **findings from the review/survey of Internal Audit Service** were reviewed and it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should ensure that future "Update on progress with the Internal Audit plan for 2021/22 (incl. progress with actions from previous Internal Audit reviews)" reports explicitly highlighted areas of best practice which had been observed at other Trusts and provided additional root cause analysis of any identified weaknesses in internal controls.
   - The **Counter Fraud Annual Report for 2021/22**; the latest **Counter Fraud Update;** and the **Findings from the review/survey of Counter Fraud Service** were noted.
   - The **Informing the audit risk assessment for Maidstone and Tunbridge Wells NHS Trust 2021/22 – The Trust's response** report was noted with no areas of concern raised by External Audit.
   - The **"Audit Progress Report and Sector Update" from External Audit** was noted and the **Findings from the review/survey of External Audit service** were reviewed wherein it was agreed that the Director, Audit, Grant Thornton UK LLP should ensure that future ""Audit Progress Report and Sector Update" from External Audit" reports highlighted the seminars and publications which were available to Committee members
   - The **Draft Annual Report for 2021/22 (incl. the Governance Statement)** was reviewed wherein it was agreed that the Assistant Trust Secretary and Trust Secretary should amend the "The purpose and activities of Maidstone and Tunbridge Wells NHS Trust" section of the draft Annual Report 2021/22 to better illustrate the purpose of the Trust.
   - The **Draft Annual Accounts for 2021/22** (incl. latest losses & compensations data) was reviewed by the Committee.

- The Committee approved the **"Audit and Governance Committee Annual Report for 2021/22"** which will be submitted to the Extraordinary 'Part 1' Trust Board meeting in June 2022 as part of the assurances required, by the Trust Board, for approval of the Trust's Annual Report and Accounts for 2021/22.
- The **latest single tender / quote waivers data** was reviewed and the **details of gifts, hospitality and sponsorship** were noted.
- The Committee reviewed the **findings of the Committee's evaluation** wherein it was agreed that the Assistant Trust Secretary and Trust Secretary should ensure that the "Evaluation of the meeting" item at future Committee meetings provide an opportunity for Committee members to consider what, if any, "spotlight on…" items should be scheduled at the next Committee meeting.
- Under **Any Other Business** an in-depth discussion was held regarding whether the Committee; and additionally, the Trust Board; should return to face-to-face / in-person meetings wherein Committee members outlined both the advantages and disadvantages to each approach.
- The Committee undertook an **evaluation of the meeting**.

2. The Committee received details of the following completed Internal Audit reviews:
- "Payroll" (which received a "Reasonable Assurance" conclusion)
- "Divisional Plans from Staff Survey and Climate Surveys" (which received a "Reasonable Assurance" conclusion)
- "Consent" (which received a "Reasonable Assurance" conclusion)
- "Data Security and Protection Toolkit – Part 1" (which received an assurance opinion will be allocated for following completion of the Part 2 review in June 2022)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews: N/A

4. The Committee agreed that (in addition to any actions noted above): N/A

5. The issues that need to be drawn to the attention of the Board are as follows: N/A

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for April 2022	Chief Executive / Members of the Executive Team

The IPR for month 1, 2022/23, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 24/05/22, Finance and Performance Committee, 24/05/22

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Review and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

April 2022

MTW
exceptional people, outstanding care

Contents

Note: Detailed dashboards and a deep dive into each SDR and CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

Key to KPI Variation and Assurance Icons

Variation			Assurance					
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Consistent (P)assing of Target - Upper control limit is below the target line or Lower control limit is above the target line (depending on the nature of the metric)	Metric has (P)assed the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Inconsistent passing and failing of the target	Metric has (F)ailed to meet the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Consistent (F)ailing of Target - Lower control limit is below the target line or Upper control limit is above the target line (depending on the nature of the metric)	Data Currently Unavailable or insufficient data points to generate an SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Maidstone and Tunbridge Wells NHS Trust

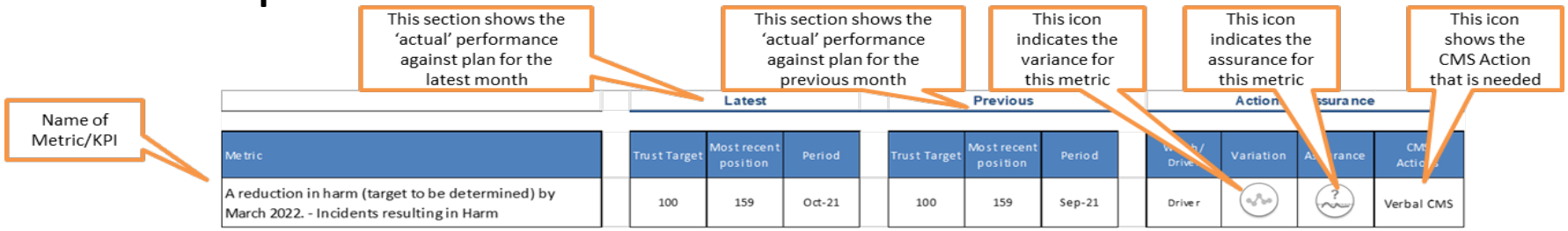
Escalation Rules:

Please see the Business Rules for the five areas of Assurance: Consistently Failing, Not achieving target >=6 months, Hit or Miss, Consistently Passing and Achieving target >=6 months (three slides in the last Appendix)

Escalation Pages:

SPC Charts that have been escalated as have triggered the Business Rule for Full Escalation have a Red Border

Scorecards explained



Further Reading / other resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

MTW exceptional people, outstanding care

Executive Summary

Executive Summary

This report has been developed further to incorporate the Trust Strategy Deployment Review (SDR) process which has been implemented during this highly challenging period of time. This process is in the early stages currently and therefore some of the processes are still being embedded. The full Counter Measure Summaries (CMSs) will therefore develop and improve once these processes are fully embedded across the Trust.

The Trust Vacancy Rate continues to consistently fail the target and is experiencing common cause variation. Agency use and spend is consistently failing the target. Sickness and Safe Staffing levels remain in escalation as have not achieved the target for more than six months which is impacting on key quality indicators.

The rate of inpatient falls continues to experience common cause variation. This indicator, along with the Hospital on-set of COVID indicator have not achieved the target for more than six months and have therefore been escalated. These indicators also impact the Incidents resulting in harm indicator which has also not achieved the target for more than six months.

Diagnostic Waiting Times remains in escalation as has been in Hit & Miss for more than six months. RTT performance is experiencing common cause variation has not achieved the trajectory target for more than six months. We continue to be a Trust with no 52 week waiters (one of the first Acute Trusts to have cleared these long waiters). Elective, first outpatient, MRI and NOUS activity levels have failed the trajectory target for the last six months. The high level of emergency admissions and delayed discharges continues to put pressure on the bed capacity.

A&E 4hr performance is experiencing common cause variation at 80.0% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers also remains in full escalation. The Trust continues to achieve both the National Cancer 62 Day Standard and the 2 Week Wait (2WW) Standard, reporting 85.3% and 94.2% respectively, however, achievement of the these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and the number of patients on the 62 day backlog.

The Trust's level of responses received from the Friends and Family (FFT) surveys remains low, with all areas currently not achieving the target and the complaints response rate has also experienced variable achievement of the target for more than six months.

Escalations by Strategic Theme:

People:
- Climate Survey Responses (P.8)
- Vacancy Rate (P.9)
- Sickness Rate (P.9)

Patient Safety & Clinical Effectiveness:
- Falls Rate (P.12)
- Safe Staffing (P.13)
- Incidents Resulting in Harm (P.11)
- Infection Control (P.13)

Patient Access:
- RTT Performance (P, 16)
- *Diagnostics <6 weeks (P.21)
- A&E Performance (P.22)
- Outpatient Calls answered <1 minute (P.23)
- Outpatient Clinic Utilisation (P.23)
- Ambulance Handovers >30 minutes (P.22)
- Super-Stranded Patients (P.22)
- % Emergency Admissions to Assessment Areas (P.22)
- Ensuring Activity Levels Match those Pre-Covid – Inpatients, Outpatients, MRI & NOUS (P.16-20)

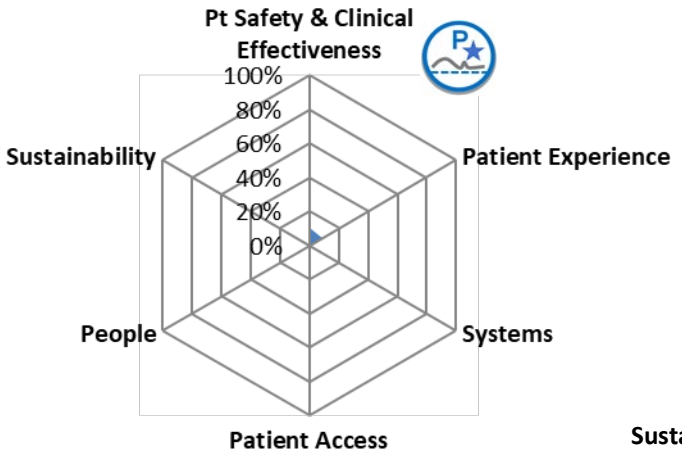
Patient Experience:
- Friends & Family Response Rates (P.25)
- *Complaints (P.26)

Systems:
- Reduction in non-elective bed days (P.28)

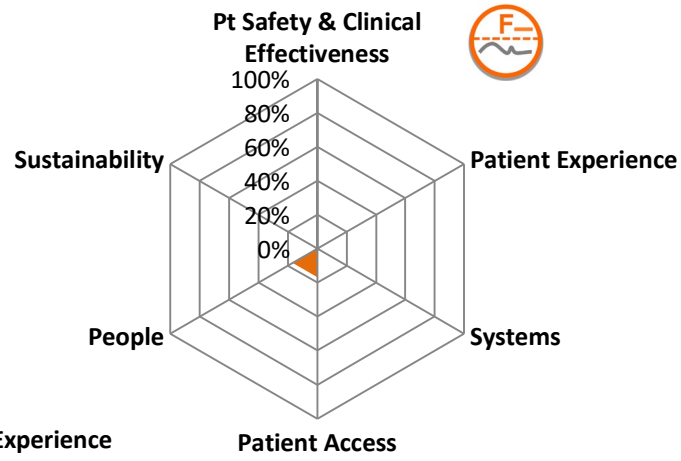
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

Assurance RADAR Charts by Strategic Theme

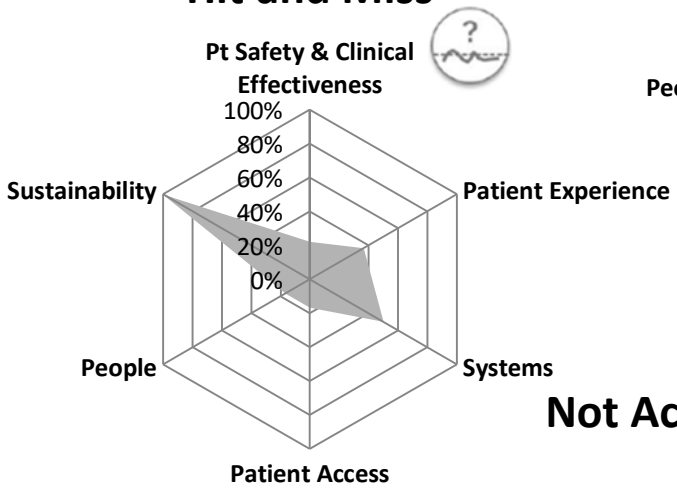
Consistently Passing



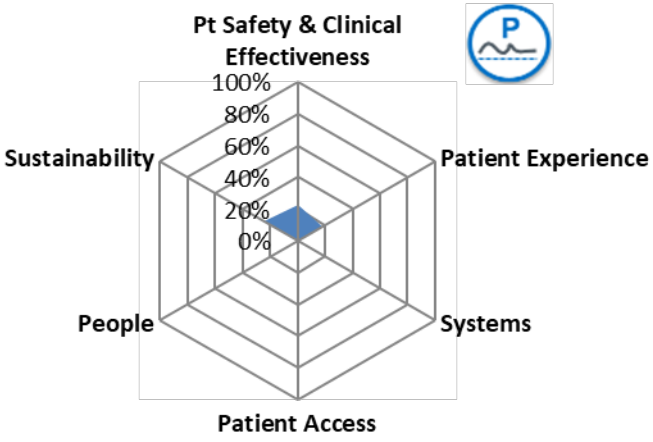
Consistently Failing



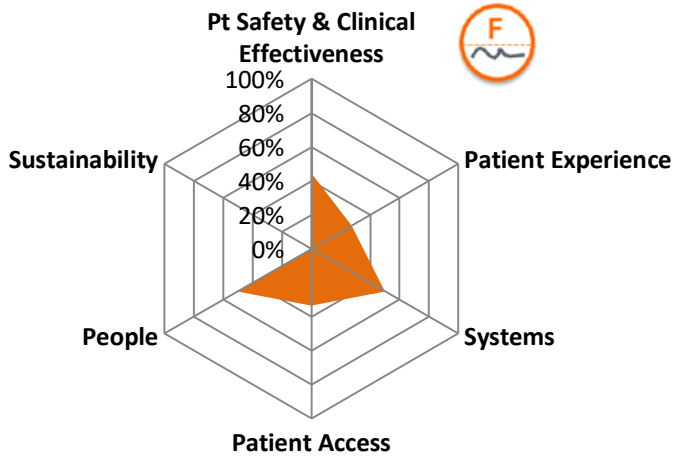
Hit and Miss



Achieved Target > 6 months



Not Achieved Target > 6 months



Matrix Summary

April 2022		Assurance				
		Pass★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement		RTT >52 wk Waiters Flow: % of Emergency Admissions that are zero LOS (SDEC), Maintain the National FFT positive response. Outpatients		Appraisal Completeness, Flow: % of Emergency Admissions into Assessment Areas	Transformation: CAU Calls answered <1 minute
	Common Cause		FFT positive response: Inpatients, FFT positive response: A&E, FFT positive response rate: Matenity, Never Events, Cancer 62 Day Standard Cancer - 2 Week Wait	Activity levels match those pre-Covid - Follow Ups & MRI, NOUS, CT Reduce average non-elective bed days relating to patients with high and very high AEC conditions by 10%, IC- Rate of C.Difficile IC - Number of Hospital acquired MRSA, Complaints Rate, Access to Diagnostics (<6weeks standard),	Achieve the RTT standard , Incidents resulting in Harm, Reduction in slips, trips and falls, Activity levels match those pre-Covid - Elective, OP New, Increase FFT response rates: Inpatients, Safe Staffing Levels, Sickness Absence, Hospital Acquired Covid, A&E 4 Hour Performance	Transformation: % OP Clinics Utilised (slots), Vacancy Rate, Flow: Ambulance Handover Delays >30mins
	Special Cause - Concern	Standardised Mortality HSMR, Statutory and Mandatory Training	Delivery of financial plan,including CIP	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Survey, Cash Balance (£k), Capital Expenditure, FFT Response Rate - Maternity, % complaints responded to within target, Agency Spend, VTE Risk Assessment	Increase Climate Survey response rates, Super Stranded Patients Reduction in Non-Elective Beddays,	FFT Response Rate: A&E & Outpatients

Strategic Theme: People

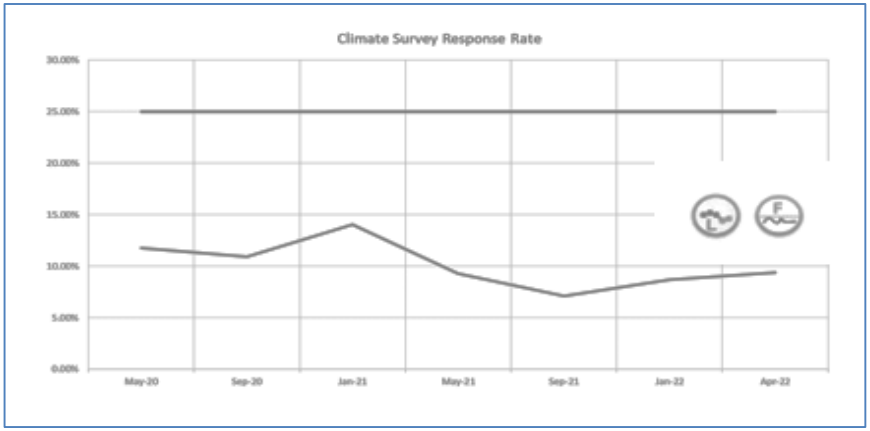
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Surveys	80%	60.3%	Apr-22	80%	64.4%	Jan-22	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Increase Climate Survey response rates to provide a larger sample base to be able to assess those that recommend MTW as a place to work.	25%	9.40%	Apr-22	25%	8.70%	Jan-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Vacancy Rate	9.0%	14.6%	Apr-22	9.0%	11.3%	Mar-22	Driver			Escalation
	Well Led	Sickness Absence	3.3%	5.3%	Mar-22	3.3%	4.3%	Feb-22	Driver			Escalation
	Well Led	Appraisal Completeness	95.0%	79.0%	Apr-22	95.0%	89.7%	Mar-22	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	82.8%	Apr-22	85.0%	79.9%	Mar-22	Driver			Not Escalated

Breakthrough Objective: Counter Measure Summary

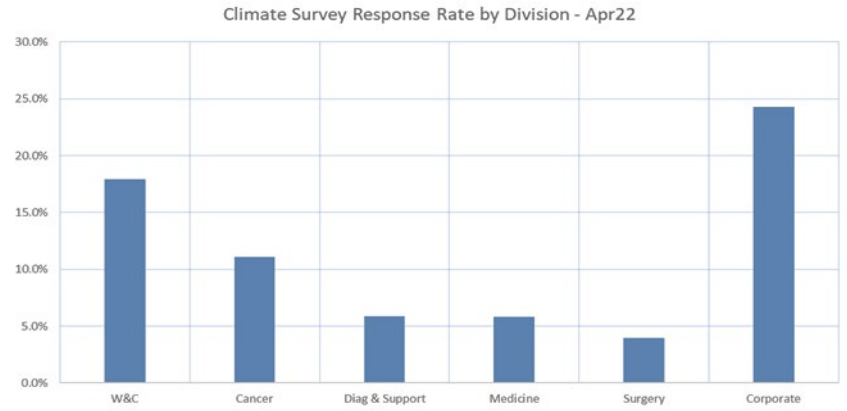
Metric Name – Increase Climate Survey Response to provide a larger sample base

Owner: Sue Steen
Metric: Climate Survey Responses
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



2. Stratified Data



4. Action Plan Updates – May 2022

Engagement Workshops

- Divisions / Directorates to develop action plans for the top 3 staff survey issues - by end of May 2022.
- WC&SH to pilot the workshop process - June 2022.
- Engagement targets in all Divisional SDR plans (ongoing)

Incivility

- Bullying, harassment, kindness and respect are areas that require a focus across the whole Trust.
- We are implementing various eLearning and training which includes:
  - ❖ Kindness into Action eLearning – July 2022.
  - ❖ Respectful Resolution – Training by A Kind Life – September 2022.
  - ❖ OD team development programmes in Divisions in response to key feedback from staff survey (ongoing)
  - ❖ Multi-team approach to support team diagnostics – FTSU/Wellbeing/HRBP/Occupational Health. (Ongoing)

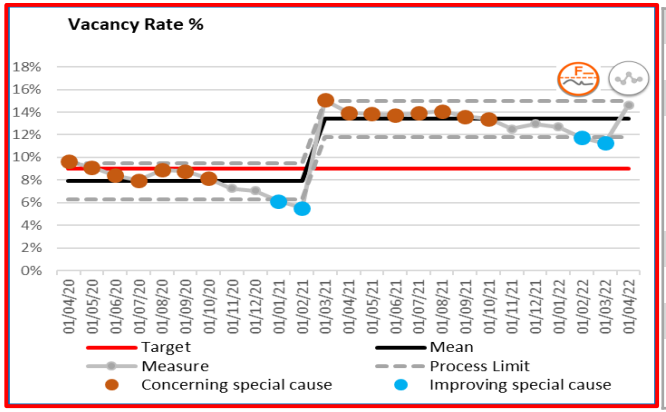
Exceptional Leaders

- Suite of leadership development for all people leaders to ensure clarity and communication
- Piloting - Affina Team Journey - tool to support Team Leaders. – June 2022
- L&D are reviewing and refreshing management skills training – August 2022.
- Full range of appraisal toolkits for people leaders available on MTW Learning – April 2022
- Focus on wellbeing and development/aspirations conversations-April 2022

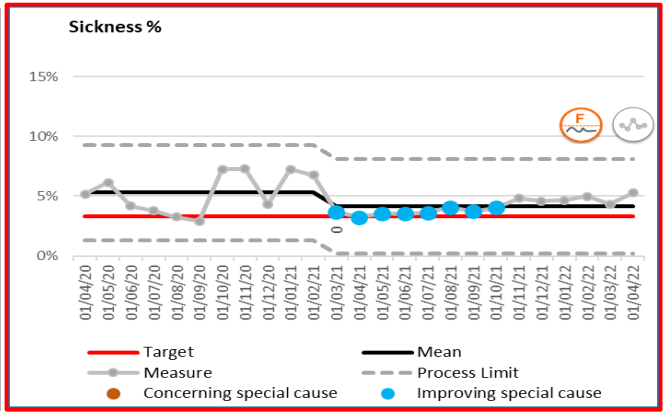
Personal and Career Development

- Developing a talent management approach which will de-bias access to CPD and link career development to appraisal. – July 2022
- Create talent pools, using TRAC to self promote skills, centralise the CPD process – June – December 2022.
- Talent management – December 2022
- Reviews of the pilots and programmes – January – June 2023
- Key driver from NHSEI is race equality, 19% BAME representation at all levels by 2025

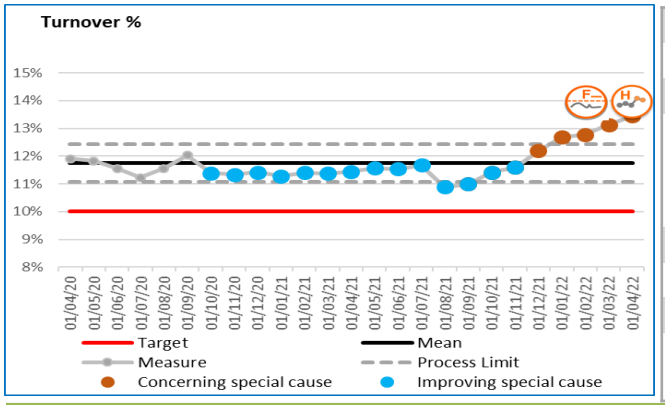
People – Workforce: CQC: Well-Led



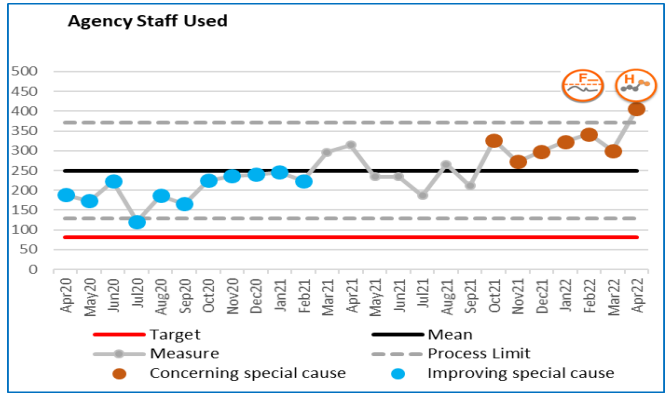
Apr-22
14.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and os consistently failing the target
Max Limit (Internal)
9%
Business Rule
Full Escalation



Mar-22
5.3%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and not achieving the target for > 6 months
Max Target (Internal)
4.5%
Business Rule
Full Escalation as not achieving the target > 6 months



Apr-22
13.9%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and is consistently failing the target
Max Limit (Internal)
10%
Business Rule
For Information as linked to Vacancy Rate



Apr-22
462
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
81
Business Rule
For Information as linked to Vacancy Rate

Summary:

Vacancy Rate % - This metric is experiencing Common Cause Variation and is consistently failing the target This indicator is being reviewed with regards to the way the impact of the new financial year is taken into account.

Sickness % - With a step change after wave 2 of Covid, this metric is experiencing Common Cause Variation and variable achievement of the target and has failed the target for more than six months. It has been agreed that the target will change to 4.5% from Apr-22 to reflect the impact of Covid on the new expected sickness absence rate.

Turnover: Shown for information as linked to Vacancy Rate and is consistently failing the target. The Therapies, Pathology, Imaging, Women's' Services and Acute Medicine + Geriatrics Directorates have the highest Turnover Rates.

Agency Staff Used: Shown for information as linked to Vacancy Rate and is consistently failing the target. The Medical and Emergency and ICT Directorates have the highest Agency Staff Used.

Actions:

Vacancy Rate: The new financial year has meant that some budgets have increased meaning that the current vacancy figure is 1061 WTE, with the largest proportion of vacancies being within Medical and Emergency care. Nursing and Midwifery remains our largest resourcing challenge- however we have a healthy pipeline of candidates joining the trust.

We currently have over 319WTE going through pre-employment checks or with start dates booked, with Nursing and Midwifery having the level of recruitment activity. There are currently only 130 vacancies currently advertised, which evidences that recruiting managers are not pro-actively advertising all there vacancies.

Sickness: Absence rate remains slightly above target, in part due to a combination of stress & anxiety, cold, flu-influenza and covid related absence (reflecting the national picture).

Turnover: interventions beginning to be put in place e.g. welfare support, and a retention lead now to be recruited following the approval of the business case for this. With positive recruitment pipeline numbers, turnover is the priority issue to address.

Assurance & Timescales for Improvement:

Vacancy Rate % - Recruitment pipeline shows high level of candidates at offer and check stages, we therefore expect the metric to continue to improve.

External marketing campaign is live and has already proven successful wit an increase in attendee's to two of our recruitment events held in May. Cardiology Nursing have a live campaign with currently over 30 applications. There are over 25 events booked this year which are a combination of recruitment, education and PR. The Trusts Job Description template is being re-designed to ensure that our adverts are appealing to future candidates.

Our student nurse recruitment campaign is already proving successful with 9 being allocated and a further 16 have expressed an interest.

Sickness % - Monitor and record sickness absence to understand the trends of sickness reasons. Continuous monitoring of covid-related absence. Investment and promotion of healthy living and positive work environment though the Occupational Health and Well-being Teams.

Strategic Theme: Patient Safety & Clinical Effectiveness

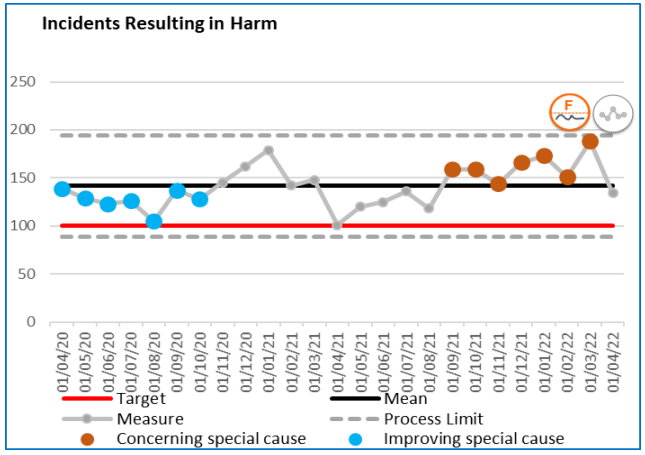
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	100	134	Apr-22	100	188	Mar-22	Driver		F	Full CMS
Breakthrough Objectives	Safe	Reduction in slips, trips and falls (Rate per 1,000 Occupied Beddays)	6.0	7.4	Apr-22	6.0	9.1	Mar-22	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	14	Apr-22	11	0	Mar-22	Driver		?	Not Escalated
	Safe	Standardised Mortality HSMR	100.0	94.1	Jan-22	100.0	97.8	Dec-21	Driver	H	P	Not Escalated
	Safe	Never Events	0	0	Apr-22	0	0	Feb-22	Driver		P	Not Escalated
	Safe	Safe Staffing Levels	93.5%	87.7%	Apr-22	93.5%	85.4%	Mar-22	Driver		F	Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	15	Apr-22	0	48	Mar-22	Driver		F	Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	15	Apr-22	22.7	34	Mar-22	Driver		?	Not Escalated
	Safe	IC - Number of Hospital acquired MRSA	0	0	Apr-22	0	0	Mar-22	Driver		?	Not Escalated

Breakthrough Objective: Counter Measure Summary (Hit & Miss >6 months)

Project/Metric Name – Reduction in harm : Incidents resulting in harm

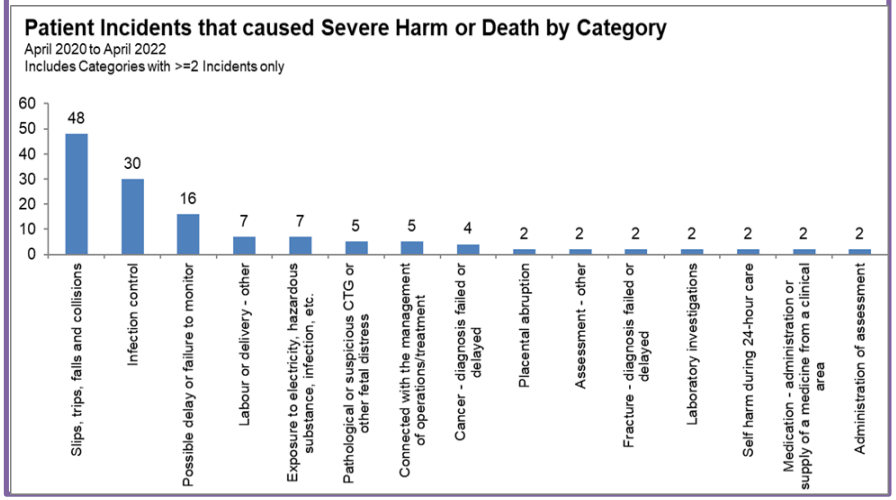
Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

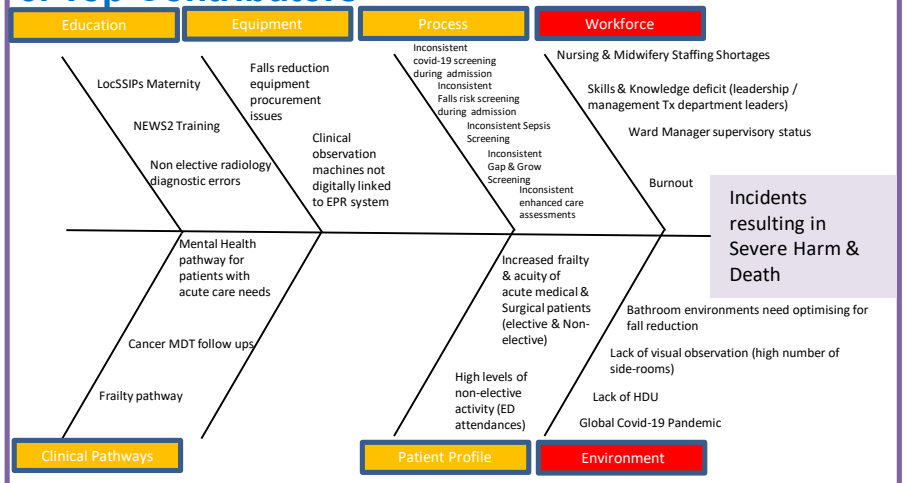


Apr-22
134
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for more than 6 months
Max Target (Internal)
100
Business Rule
Full Escalation as Hit or Miss > 6 months

2. Stratified Data



3. Top Contributors



4. Action Plan

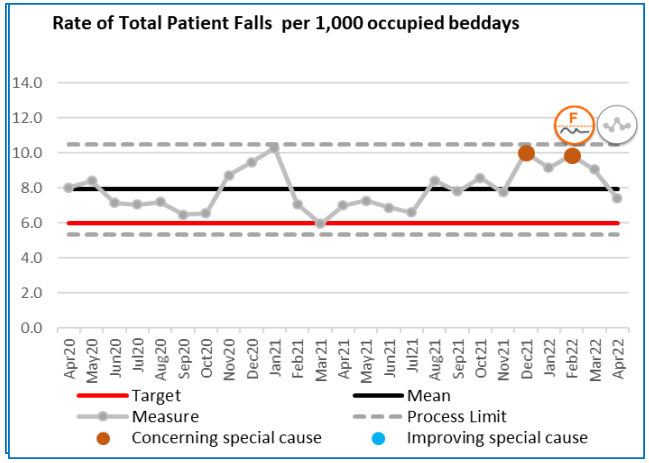
Contributor	Solution / Countermeasure	Owner	Due by?
Environment	Trust wide Falls QI workstream	Medical Director & Deputy CNO	Launched and Ongoing
	Options Appraisal HDU		
Workforce	Safer Staffing Review (drive to 95% fill rate substantive staff & assurance safe staffing models in place)	CNO	June 2022
	Wellbeing workstream	Chief People Officer	
	Leadership & OD Training Plan		

Breakthrough Objective: Counter Measure Summary (Hit & Miss >6 months)

Project/Metric Name – Reduction in slips, trips and falls (Rate per 1,000 Occupied Bed days)

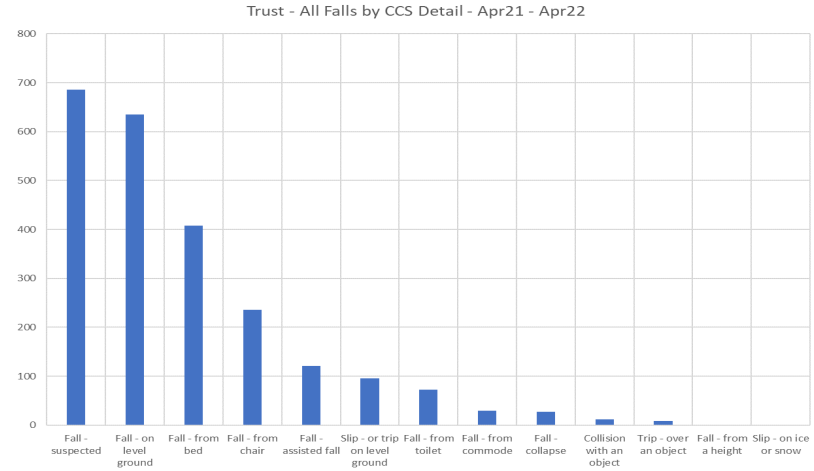
Owner: Peter Maskell
Metric: Falls Rate per 1,000 Occupied Beddays
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Apr-22
7.40
Variance / Assurance
Metric is currently experiencing common cause variation and has not achieved the target for more than 6 months
Max Target (Internal)
6.0
Business Rule
Full Escalation as not achieved target for > 6 months

2. Stratified Data



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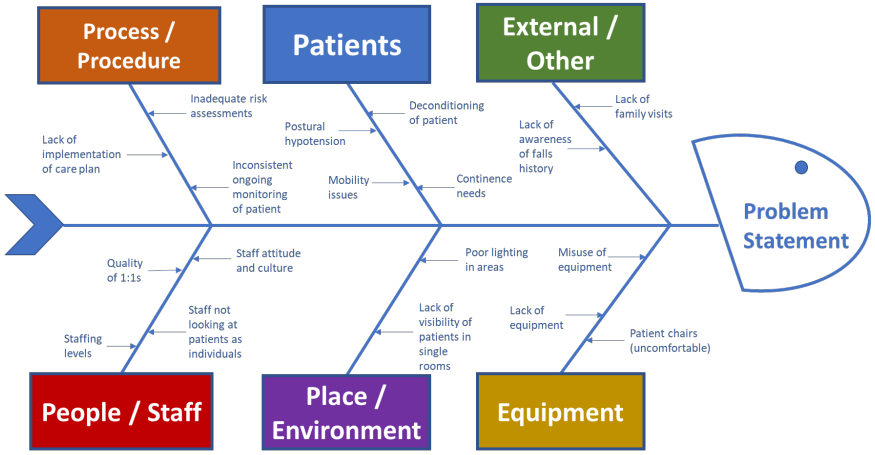
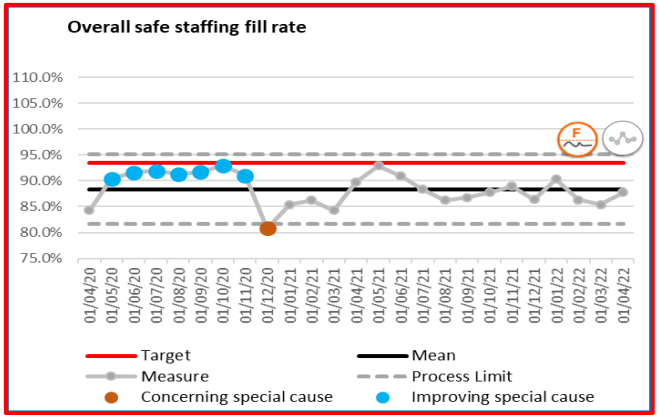


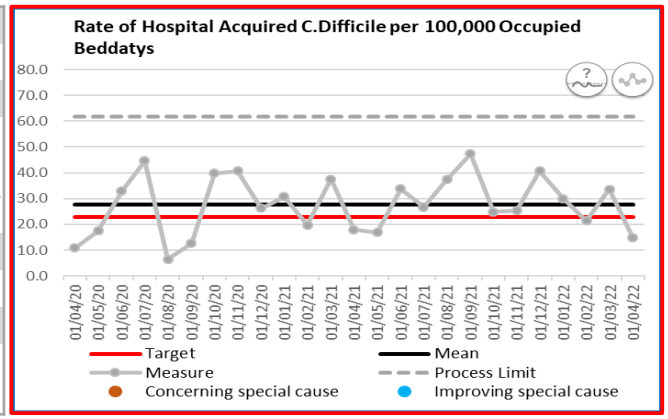
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Equipment-lack of / faulty / incorrect use	Resource/ Finance/ historical organizational working.	Leads on Working Group A has completed the ward equipment audit on the six target wards and results report to be produced.	Falls Working group A	18/05/22
Equipment-lack of / faulty / incorrect use	Resource/ Finance/ historical organizational working.	Falls Alarm monitor replacement- model identified and number of devices identified; funding identified through charitable fund. Business case to be submitted	Lead Nurse for Falls prevention	17/05/22
Inconsistent monitoring of patients	assessment not specific to ED	ED specific assessment documents being drawn up. Identification of patients at risk of falls through the 'Think Yellow' initiative.	ED Matrons /Falls Lead Nurse	28/05/22
Multiple ward moves/ inappropriate bed allocation	High risk patient and appropriate beds for high risk patient on wards not identified.	Implemented high risk falls room so the CCC can allocate the most appropriate patients into those rooms. Spread sheet to identify patient moves as currently TeleTracking not able to display information.	Working Group B	13/05/22
Lack of capacity to support and deliver services in the clinical setting	Finance and staff numbers/ workload	Recruitment for Falls Prevention Practitioner to support the falls prevention agenda and focus work. Interviews held and conditional offer made to the successful candidate.	Lead Nurse for Falls prevention	05/05/22

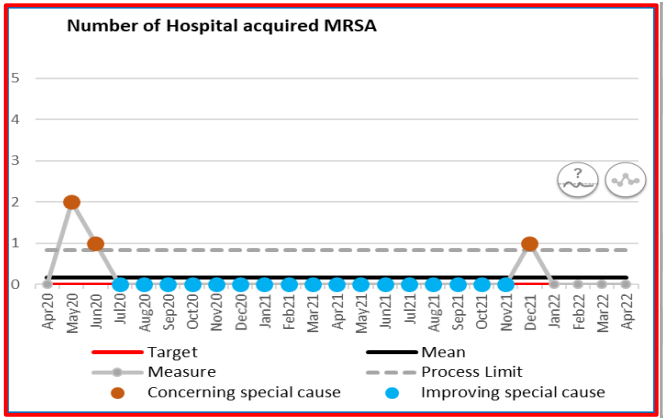
Patient Safety and Clinical Effectiveness: CQC: Safe



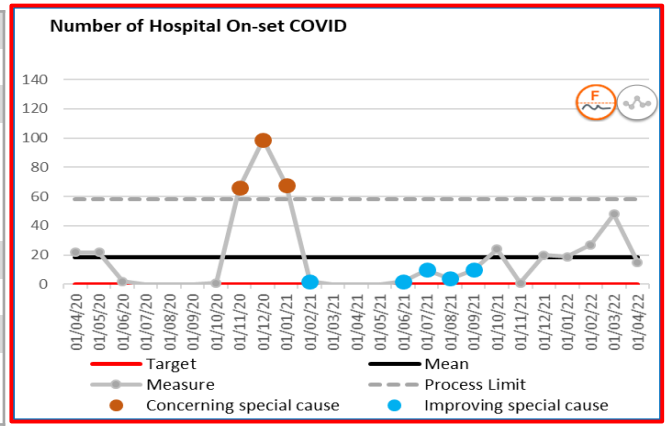
Apr-22
87.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Target (Internal)
93.3%
Business Rule
Full Escalation as has not achieved the target for > 6 months



Apr-22
14.7
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
22.7
Business Rule
Full Escalation as Hit or Miss > 6 months



Apr-22
0
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target
0
Business Rule
Full Escalation as Hit or Miss > 6 months



Apr-22
15
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6 months
Max Target (Intern
0
Business Rule
Full Escalation as has not achieved the target for > 6 months

Summary:

Safe Staffing Fill Rate: The level reported continues to experience common cause variation and has not achieved the standard for more than six months.

Rate of C.Difficile: continues to experience common cause variation and variable achievement of the target.

MRSA: The level of MRSA has stayed at o and is in common cause variation and variable achievement of the target

Hospital on-set COVID: This indicator is experiencing common cause variation and has failed to achieved the target of zero for more than six months.

Actions:

Safe Staffing Fill Rate: Daily staffing huddles review nursing and midwifery rosters. The temporary staffing team continue to attend site meetings. The Matrons afternoon staffing huddle are supported by the Bank team and Senior corporate nursing team. There is ongoing focus on Recruitment Activity, including International Recruitment. Retention Committee working groups have been formed and are focused on the reduction of Nursing, Midwifery and Clinical Support Workers (CSWs) turnover rates. Enhancements for temporary staffing have been negotiated until the 6th June 2022, with regular reporting for Divisions on bank and agency usage. Roster performance 'confirm and support' meetings are now scheduled. These will support effective rostering going forward.

Infection Control: The Trust has seen an increase in numbers of Trust attributable C.difficile cases, and has breached our 21/22 trajectory of 58 cases. A large proportion of were deemed to be unavoidable on RCA, those cases that were deemed to be avoidable were largely due to inappropriate antimicrobial prescribing which has been feedback to teams. We continue to drive the appropriate prescribing of antimicrobials and the completion of C.difficile risk assessments. During April the IPC team have undertaken rapid C.difficile RCA and table top reviews to support and release staff time on the wards. The Trust is experiencing a number of Covid outbreaks which has seen a fairly high transmission rate in bays where a Covid positive patient has been identified, this is reflective of increasing community Covid rates and staff positives. Outbreaks are managed through Trust wide outbreak meetings which identify areas for action.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Regular staffing huddles with Divisional leads and Staff Bank review substantive and temporary staffing requirements across all areas. All staffing levels are reviewed, with oversight and appropriate redeployment monitored by the Senior Nurse Leadership Team. Real time daily staffing data has been developed by the Senior Corporate Nursing and CCC team. Extension of incentive package implemented until 6th June 2022. Phase 1 of the SafeCare project is nearing completion, with all adult inpatient units live or at implementation stage. Phase 2 of the project is being confirmed. Recruitment activity continues to move at pace with a focus on International recruitment. National delays with Visa allocation and OSCE assessment availability has slowed the recruitment process. This has been escalated Regionally and Nationally by the Chief Nurse. Confirm and support meetings have been scheduled to provide oversight of rostering. These meetings will support effective rostering, the monitoring of skill mix, fill rate and staff un-availabilities.

Infection Control:: The Infection prevention team will continue to monitor and escalate where infection and nosocomial rates are rising, RCA scrutiny will continue for alert organisms including C.difficile.

Covid-19 outbreak management meetings continue to be a high priority in the Trust, and we continue with precautions to help minimise the spread of infection such as restricted visiting, patients screening and staff LFD testing. The IPC team are visiting all wards and departments to reinforce good IPC practice and monito compliance.

Strategic Theme: Patient Access

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	We will ensure no patient waits longer than 52 week for treatment by April 2022	0	0	Apr-22	0	0	Mar-22	Driver	L	P	Note Performance
	Responsive	We will achieve the RTT Submitted Trajectory	72.3%	69.8%	Apr-22	79.0%	70.8%	Mar-22	Driver		F	Full CMS
Breakthrough Objectives	Responsive	Ensure activity levels match those pre-Covid - Total Elective Activity (Plan and Actual) as a % of 1920 Activity	93.2%	91.3%	Apr-22	139.8%	135.4%	Mar-22	Driver		F	Full CMS
	Responsive	Ensure activity levels match those pre-Covid - Total First Outpatients Activity (Plan and Actual) as a % of 1920 Activity	109.3%	84.9%	Apr-22	132.1%	120.5%	Mar-22	Driver		F	Full CMS
	Responsive	Ensure activity levels match those pre-Covid - Total Follow Up Outpatients Activity (Plan and Actual) as a % of 1920 Activity	87%	94%	Apr-22	133%	128%	Mar-22	Driver		?	Verbal CMS
	Responsive	Ensure activity levels match those pre-Covid - Total MRI Activity (Plan and Actual) as a % of 1920 Activity	117%	111%	Apr-22	135%	103%	Mar-22	Driver		?	Verbal CMS
	Responsive	Ensure activity levels match those pre-Covid - Total CT Scan Activity (Plan and Actual) as a % of 1920 Activity	120%	131%	Apr-22	159%	153%	Mar-22	Driver		?	Verbal CMS
	Responsive	Ensure activity levels match those pre-Covid - Total NOUS Activity (Plan and Actual) as a % of 1920 Activity	93%	75%	Apr-22	130%	118%	Mar-22	Driver		?	Verbal CMS

Strategic Theme: Patient Access - continued

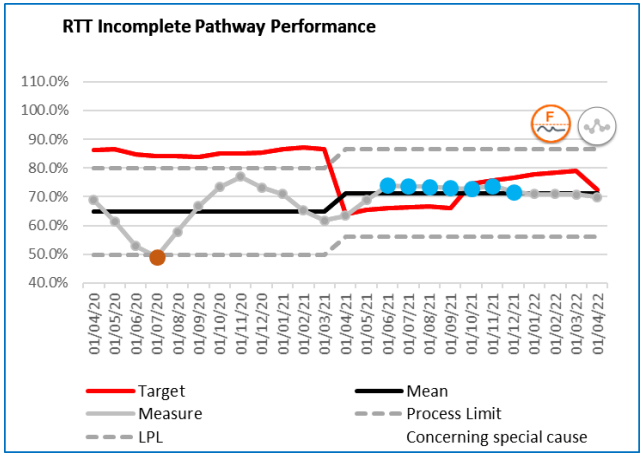
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	52.8%	Apr-22	85.0%	54.8%	Mar-22	Driver			Escalation
	Responsive	Access to Diagnostics (<6weeks standard)	87.0%	82.3%	Apr-22	75.5%	82.8%	Mar-22	Driver			Not Escalated
	Responsive	A&E 4 hr Performance	89.5%	79.7%	Apr-22	91.0%	82.2%	Mar-22	Driver			Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	94.2%	Mar-22	93.0%	94.3%	Feb-22	Driver			Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.3%	Mar-22	85.0%	85.8%	Mar-22	Driver			Not Escalated
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	2.6%	Apr-22	1.5%	2.9%	Mar-22	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	62.6%	Apr-22	90.0%	59.7%	Mar-22	Driver			Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	7.0%	10.5%	Apr-22	7.0%	13.4%	Mar-22	Driver			Escalation
	Effective	Flow: Super Stranded Patients	80	131	Apr-22	80	120	Mar-22	Driver			Escalation
	Effective	Flow: % of Emergency Admissions that are zero LOS (SDEC)	35.0%	44.8%	Apr-22	35.0%	43.5%	Mar-22	Driver			Not Escalated
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	59.1%	Apr-22	65.0%	59.2%	Mar-22	Driver			Escalation
	Effective	Patients not meeting the criteria to reside (MFFD)	TBC	166	Apr-22	TBC	110	Mar-22	Driver	No SPC	No SPC	
	Effective	Bed Days not meeting the criteria to reside (MFFD)	TBC	1324	Apr-22	TBC	707	Mar-22	Driver	No SPC	No SPC	

Vision: Counter Measure Summary

Project/Metric Name – By April 2022 we will achieved the RTT National Standard

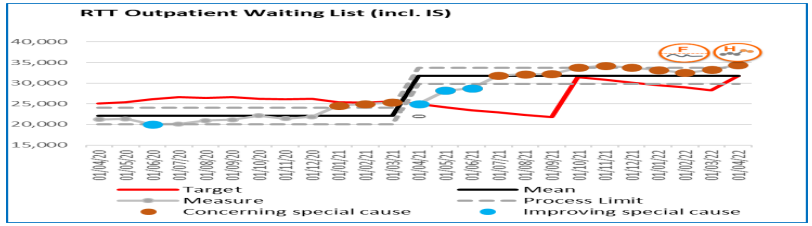
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

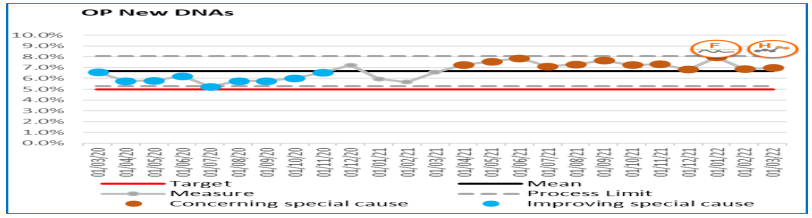
1. Historic Trend Data



Apr-22
69.8%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
72.3%
Target Achievement
Metric is consistently failing the target

2. Stratified Data





3. Top Contributors

Working group to be set up to undertake full analysis of data.

4. Action Plan

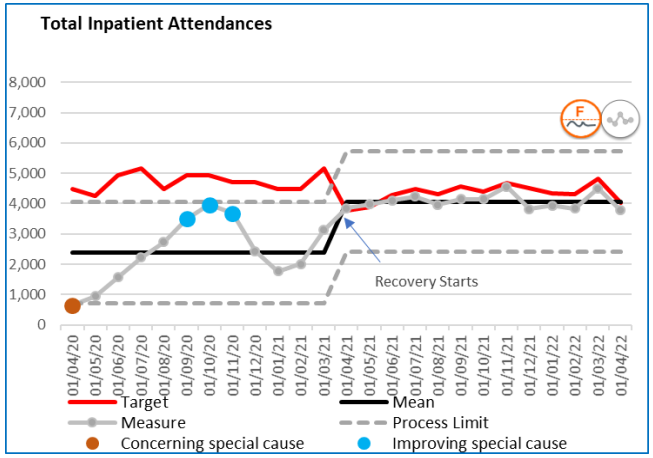
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
New Outpatient backlog	Reduced capacity due to pandemic	Implementing 110% activity targets Reduction in DNA's	DDO's, GM's	May 2022
Reduction in clinic utilisation (target 90%)	Increase in DNA rates	Directorates to review DNA rates and any over 10% to implement an improvement action plan	GM's	Ongoing
Booking process	Correct booking process not robustly being followed	Action to be agreed	GM's, DDO's RTT Training Team	May 2022
Hospital Flow	Increased LOS due to lack of Pathway 3 beds	Improving Flow week commencing 19/04/2022	Safer, Better Sooner	Ongoing
Internal activity below plan	Closure of 1 theatre at TW due to staffing and increased NEL demand	Activity monitored weekly and day case activity increased. Theatre plan to reopen after following the Improving Flow weeks at the beginning of May.	GM's	Ongoing

Breakthrough Objective: Counter Measure Summary

Project/Metric Name –Ensure Elective Activity Levels match those pre-Covid: Total Elective

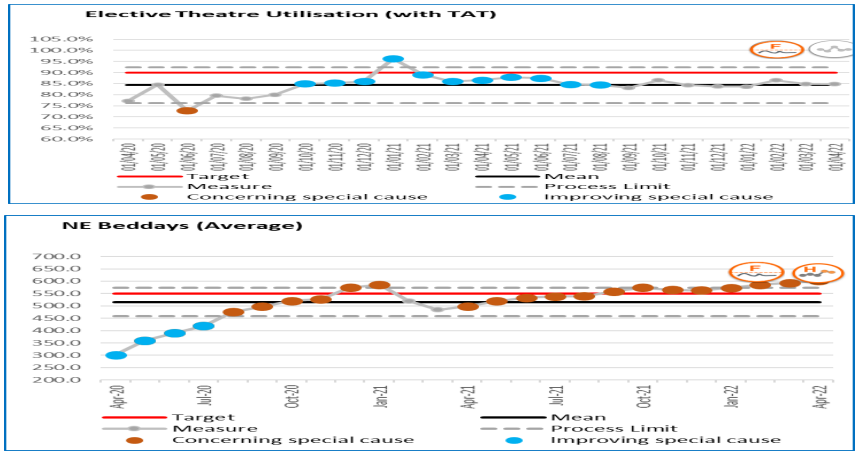
Owner: Sean Briggs
Metric: Elective Activity: Total Elective
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data

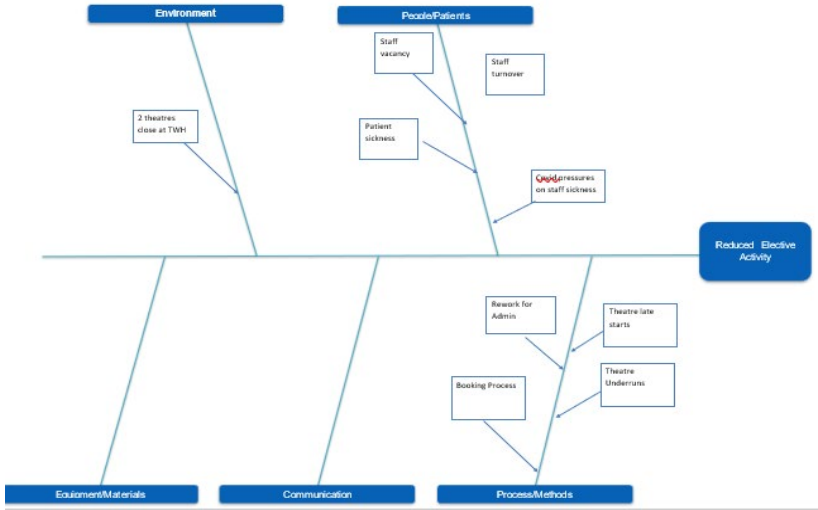


Apr-22
3779
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4020
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data



3. Top Contributors



4. Action Plan

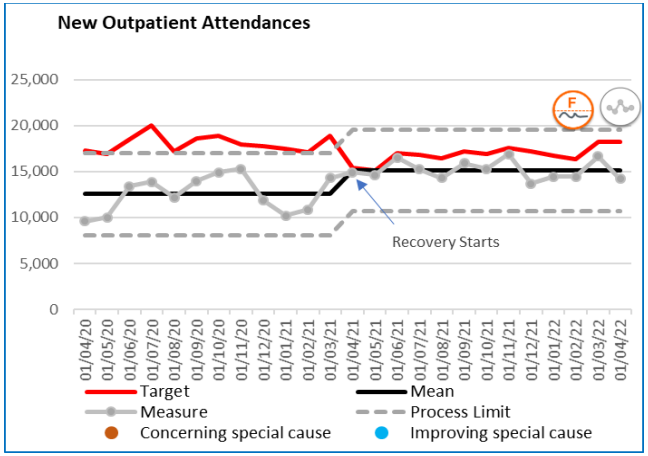
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Closure of 1 theatre at TW due to staffing and increased NEL demand	Activity monitored weekly and day case activity increased. Theatre plan to reopen after perfect weeks.	GM's	June 22
Outsource activity below plan	Lack of staff and capacity	Activity monitored weekly. Calls scheduled with IS Directors 17/01/22 – capacity made available, activity improving	SD/DR	On-going
Cancelled Operations	Increase in cancellations due to processes not being followed correctly	Monitored weekly at Directorate PTL and through theatre scheduling meetings	GM's/TL	In progress
		7 day call to check the patient is coming and is aware of their covid swab and pre-assessments is all signed off	CAU's	In progress
Theatre Utilisaton	Theatres not utilised to 85% trajectory without TAT	Monitored weeks at Directorate PTL Monitored at monthly TUB	GM's/PM	
List Under booked	Timings on NCR different to clinicians time	Fully book from NCR Adjust theatre times based on BI information	CAU's	In progress

Breakthrough Objective: Counter Measure Summary

Project/Metric Name – Ensure Elective Activity Levels match those pre-Covid: New Outpatients

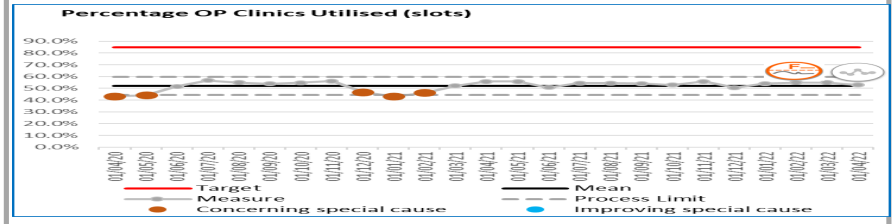
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

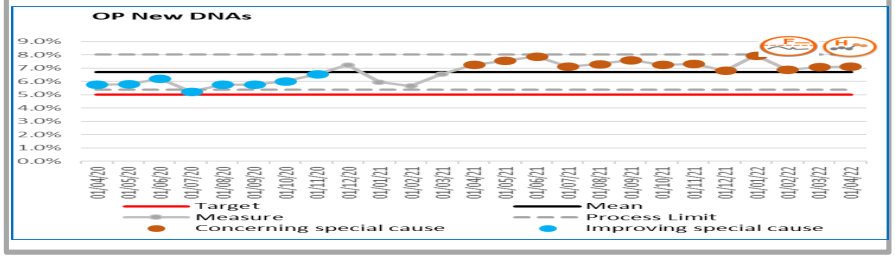
1. Historic Trend Data



Apr-22
14,212
Variance Type
Metric is currently experiencing Common Cause Variation
Target
18,283
Target Achievement
Metric is consistently failing the target

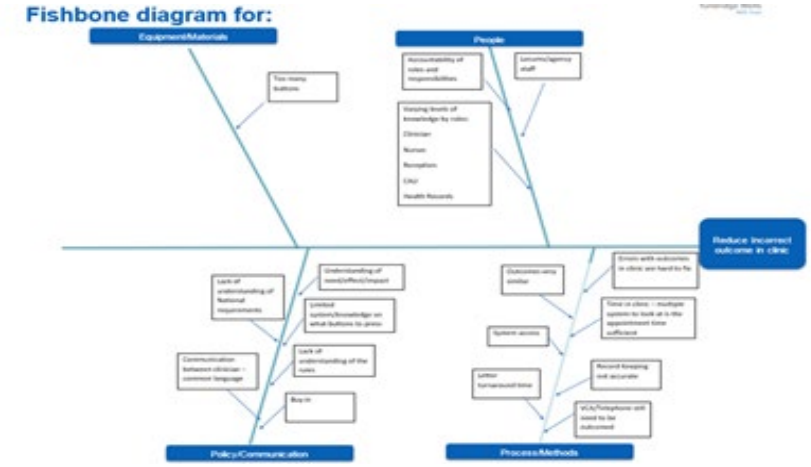
2. Stratified Data





3. Top Contributors

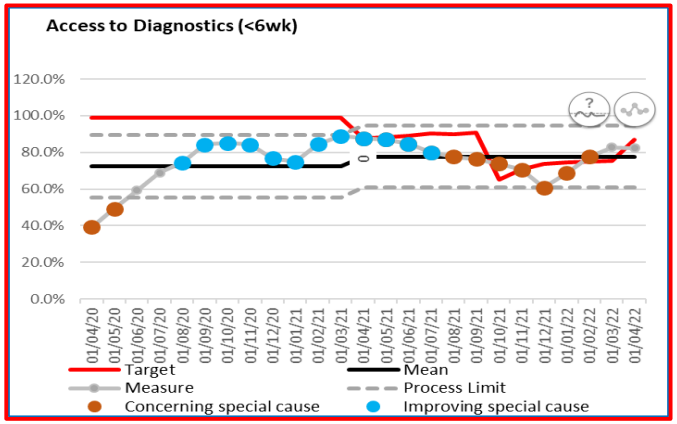
Working group to be set up to undertake full analysis of data.



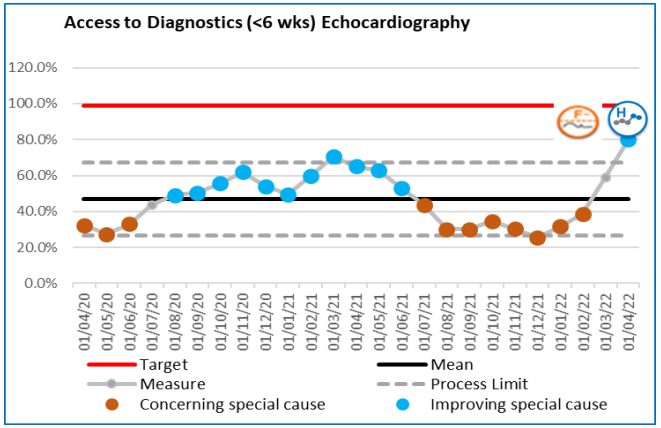
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Clinics not cancelled with 6 weeks notice if specialty cant utilise	Activity monitored weekly. Weekly OPA scheduling meeting.- including the 6-4-2 process Monitored weekly at Directorate PTL	GM's	In progress
Outsource activity below plan	Lack of capacity and reduction in workforce due to covid sickness	Activity monitored weekly. Weekly operational meetings with the IS	DDOO Surgery	In progress
Reduction in clinic utilsation (target 90%)	Increase in DNA rates	Directorates to review DNA rates and any over 10% to implement an improvement action plan	GM's/TL	In progress
DNA's	Communication	Review of wording on clinic letters	RTT Op Lead	Impleme nted

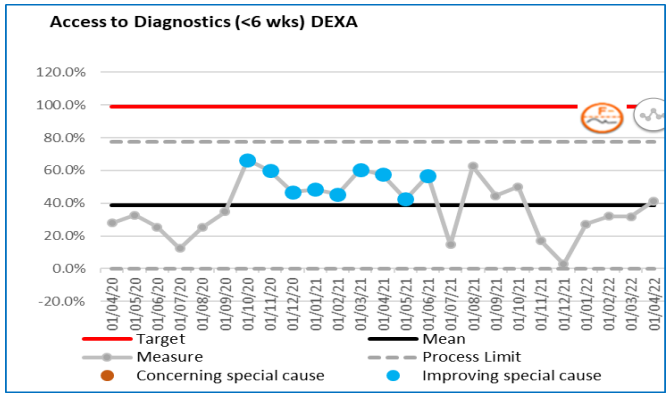
Patient Access – Diagnostics Waiting Times: CQC Responsive



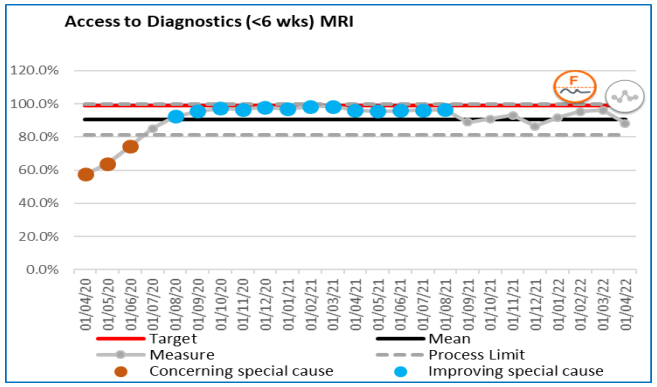
Apr-22
82.3%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target (Internal)
87.0%
Business Rule
Full Escalation as Hit or Miss > 6 months



Apr-22
80%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
99%
Business Rule
For Information as Contributor to Overall



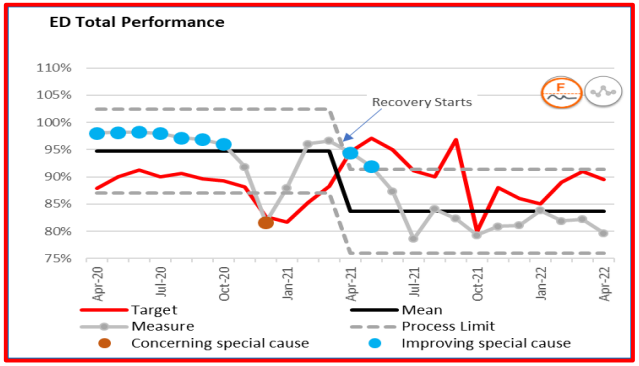
Apr22
41.3%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
99%
Business Rule
For Information as Contributor to Overall



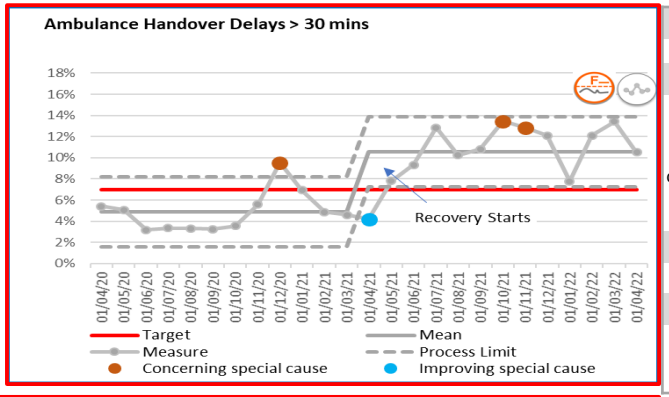
Apr-22
88.2%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for more than six months
Target (Internal)
99%
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Diagnostic Waiting Times: Performance continues to experience common cause variation and variable achievement of the target. This three biggest contributors to this are Echocardiography, DEXA and MRI. **MRI:** is experiencing common cause variation but has now failed the target for more than six months. **Echocardiography:** is experiencing special cause variation of an improving nature and consistently failing the target but has seen a significant increase in performance for April 22. **DEXA:** is experiencing common cause variation and consistently failing the target largely due to a lack of capacity.	**Echocardiography:** The cardiology team have implemented an improvement plan. **DEXA:** New DEXA in place at TWH and activity commenced. Additional outsourcing agreement with Medway agreed and implemented. **MRI:** Proposal for a second mobile MRI scanner at Hermitage Court, Maidstone agreed. Scanner arrived w/comm 14/03	**Echocardiography:** Insourcing has commenced to support the internal recovery plan. Plan is monitored weekly with DCOO. **DEXA:** Recovery plan in progress and is monitored weekly with DCOO. **MRI:** Scanner arrived w/comm 14/03/22 and is a managed service providing an additional 183 slots per week. The MRI service are on track to be DM01 compliant by July 22.

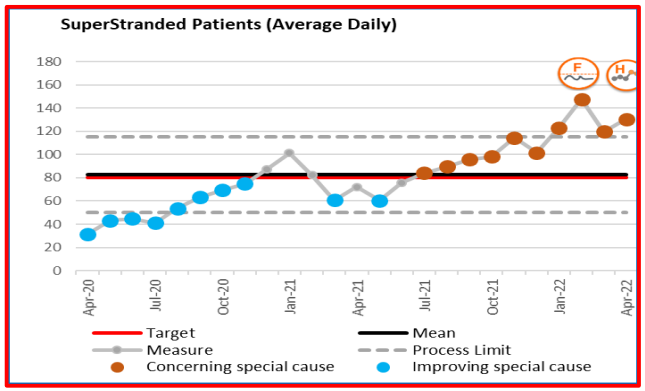
Patient Access – Hospital Flow: CQC: Responsive



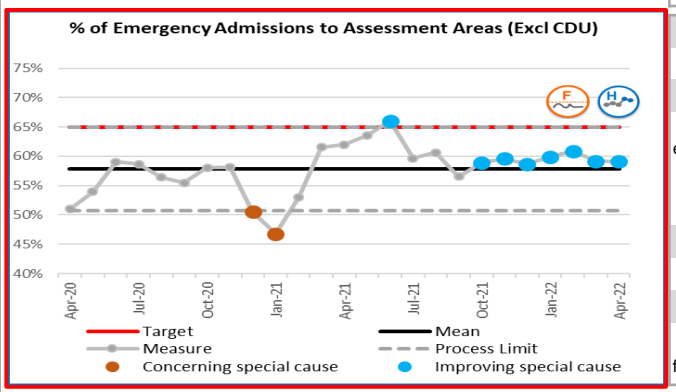
Apr-22
80.0%
Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months
Target (Internal)
89%
Business Rule
Full Escalation as has failed the target for > 6 months



Apr-22
10%
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months
Mas Limit (Internal)
7%
Business Rule
Full Escalation as has failed the target > 6 months



Apr-22
131
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months
Max Limit (Internal)
80
Business Rule
Full Escalation as has failed target for >6 months



Apr-22
59.1%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and has failed the target for >6 months
Target
65%
Business Rule
Full Escalation as has failed target for >6 months

Summary:

ED 4hr performance (inc MIU): This indicator is now experiencing common cause variation and has failed the target for more than six months

Ambulance Handover Delays of >30 minutes is experiencing common cause variation of a concerning nature and has failed the target for more than six months

Super Stranded Patients: is experiencing special cause variation of a concerning nature and has failed the target for more than six months

% of Emergency Admissions to Assessment Areas: is experiencing special cause variation of an improving nature but has failed the target for >6 months. SAU emergency admission rates have reduced due to site escalation restricting flow and lack of ability to open 24hours due to staffing constraints. Performance varies depending on escalation and complexity of patients in A&E.

Actions:

ED 4hr performance (inc MIU): The trust has maintained a strong position regionally and nationally. MEC have prioritised SDEC extension hours to build on previous improvement work and service has achieved 40% of medical take going through against a national target of 33%.

Ambulance handover delays: Ongoing task and finish meeting regularly to focus on cross organisation working to support improvements in handover times, process and elimination of 60 minute HO breaches. Long term strategy to deliver digital sign off, work on an interim solution to modify reception area to support sign off.

Super-Stranded Patients : Performance improved this month but this has not been maintained. The main discharge block is domiciliary care for LT packages of care. Slow down in nursing home admissions caused by covid.

% of Emergency Admissions to Assessment Areas: 4 suitable candidates arranged for interview in January in order to resume 24/7 opening hours. 3 x ACP's are training to help improve flow and length of stay.

Assurance & Timescales for Improvement:

ED 4hr performance (inc MIU): Action plan in place to focus on improving breach position at TWH during the evening.

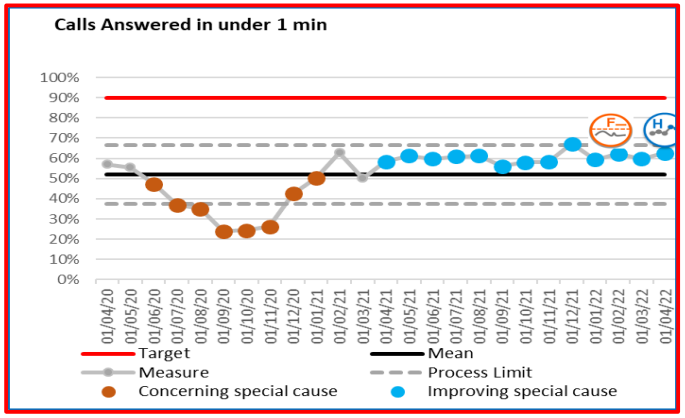
Ambulance handovers delays: Divisional weekly performance meeting in place

Super stranded patients:

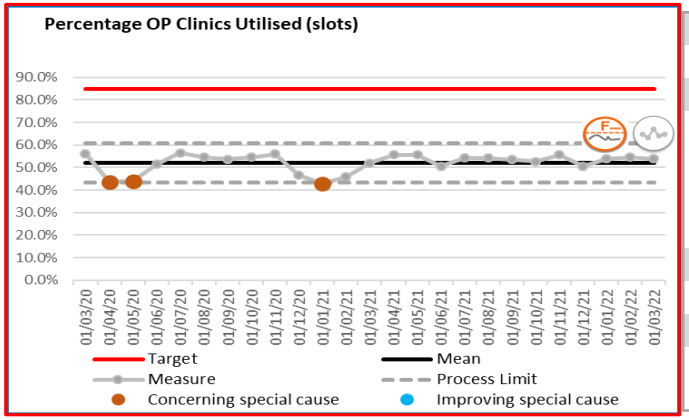
Monthly MADE events to bring an MDT approach. Improved understanding of pathways and introduction of resource packages.

% of Emergency Admissions to Assessment Areas: Ongoing recruitment programme and introduction of the Physicians Associate role to pull from A&E so patients are not placed in a ward beds before being assessed by the SAU team

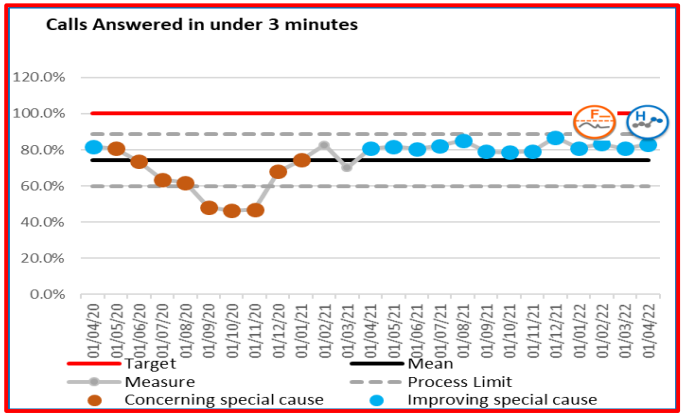
Patient Access – Transformation: Outpatients: CQC: Responsive



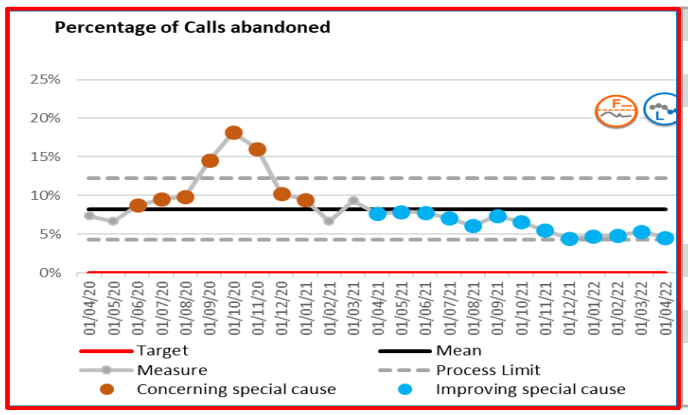
Apr-22
62.6%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Mar-22
59.3%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation



Apr-22
83.4%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
100%
Business Rule
For Information as linked to Calls <1min



Apr-22
4.5%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
0%
Business Rule
For Information as linked to Calls <1min

Summary:

Calls Answered: The number of calls answered in less than 1 minute is experiencing special cause variation of an improving nature and remains consistently failing the target.

Outpatient Utilisation: This indicator continues to experience common cause variation and consistently failing the target

Actions:

Calls Answered: Currently investigating spacing options in which to house call operatives for the outpatient communication centre pilot which will improve this. Continuous monitoring of the CAU's has helped to flag any long waiters.

Outpatient Utilisation: The Clinical System Development Managers have reviewed over 99% of the clinic templates on Allscripts, this includes viewing the individual micro session templates and removing any historic clinics that are no longer required to ensure that utilisation is a true reflection. Once complete the utilisation figures will be correct to do further analysis on how to improve this.

Assurance & Timescales for Improvement:

Weekly meeting with specialties are undertaken to go through all of our KPI's to understand areas for improvement and reasonings for poor performance. This includes calls, DNA's and Cancellations.

Outpatient Utilisation: Specialty clinic templates are being reviewed to ensure that all templates are correct and have received GM and CD sign off. Further analysis of utilisation is being completed to understand reasonings.

Strategic Theme: Patient Experience

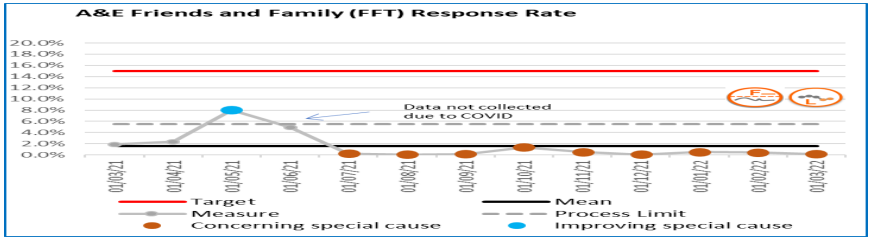
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	Maintain the National FFT positive response rate. Inpatients	95.0%	97.0%	Apr-22	95.0%	97.2%	Mar-22	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. A&E	87.0%	93.4%	Apr-22	87.0%	100.0%	Mar-22	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. Maternity	95.0%	98.3%	Apr-22	95.0%	98.3%	Mar-22	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. Outpatients	84.0%	89.9%	Apr-22	84.0%	91.3%	Mar-22	Driver	H	P	Note Performance
Breakthrough Objectives	Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target : Inpatients	25.0%	16.0%	Apr-22	25.0%	12.5%	Mar-22	Driver		?	Verbal CMS
	Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target A&E	15.0%	0.8%	Apr-22	15.0%	0.3%	Mar-22	Driver	L	F	Full CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Maternity	25.0%	12.7%	Apr-22	25.0%	13.5%	Mar-22	Driver	L	?	Verbal CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Outpatients	20.0%	2.6%	Apr-22	20.0%	2.2%	Mar-22	Driver	L	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	2.5	Apr-22	3.9	3	Mar-22	Driver		?	Not Escalated
	Caring	% complaints responded to within target	75.0%	22.7%	Apr-22	75.0%	40.3%	Mar-22	Driver	L	?	Not Escalated
	Caring	% VTE Risk Assessment (one month behind)	95.0%	96.1%	Mar-22	95.0%	96.4%	Feb-22	Driver		P★	Verbal CMS

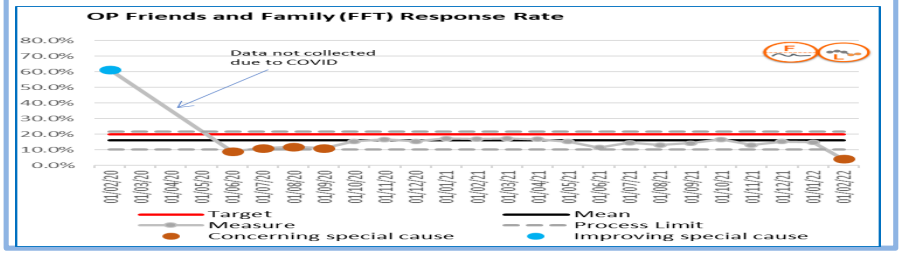
Breakthrough Objective: Counter Measure Summary

Metric Name – Increase Friends and Family Response Rates for A&E, Outpatients, Inpatients and Maternity

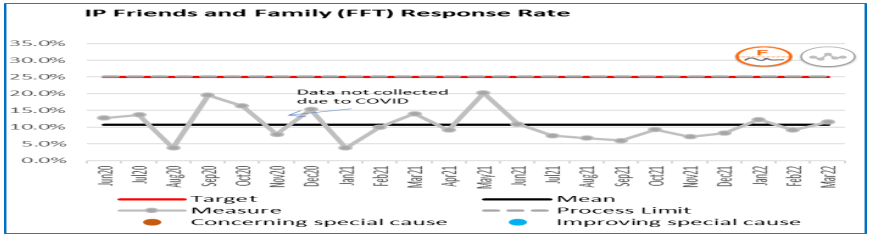
Owner: Joanna Haworth
Metric: FFT Response Rate – A&E, OP, IP, Mat
Desired Trend: 7 consecutive data points above the mean

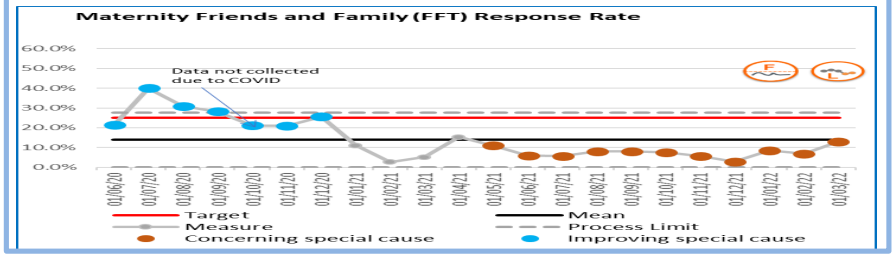
1. Historic Trend Data



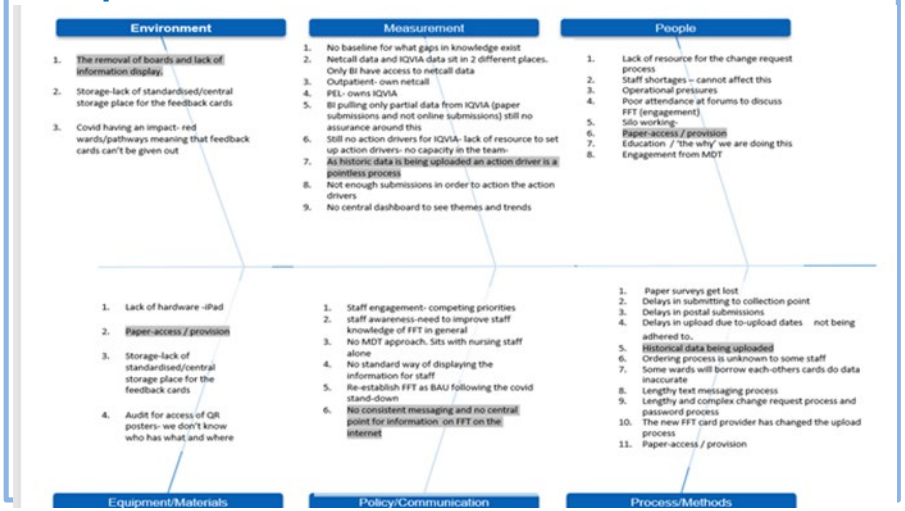


1. Historic Trend Data





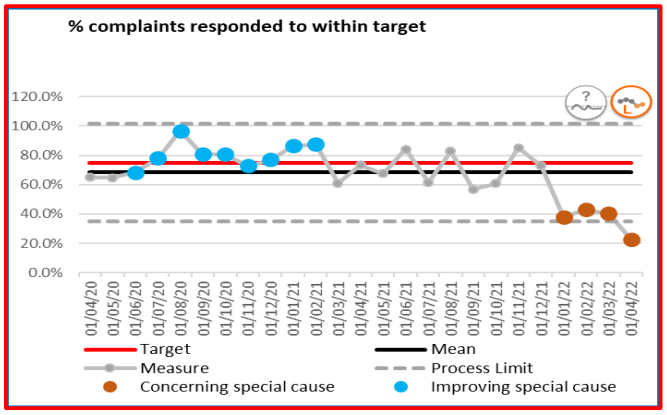
3. Top Contributors



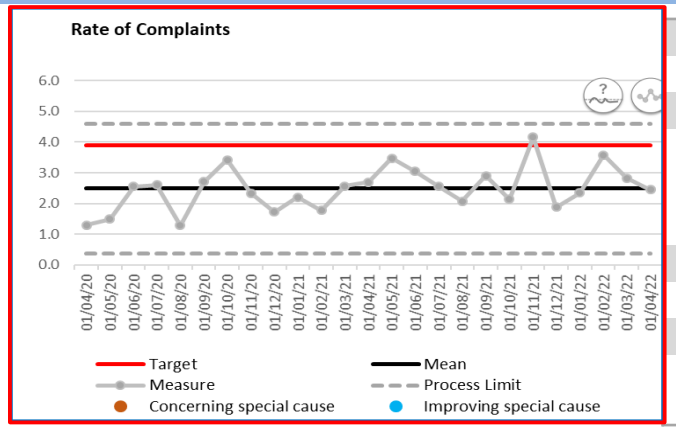
4. Action Plan

Contributor	Potential Root Cause	Solution/Countermeasure	Owner	Due by?
Reduction in Netcall OPD data	Patching did not resolve this issue	Comms ongoing with Netcall to resolve with OPD / IT	NL/SH / RS / CC /CM /JR	30.06.22
Poor responses in ED	Access to SMS text	Testing ongoing - support provided by SW in Med directorate Task and finish group to be set up between dept leads	NL/SW /MW / CM/JR	30.06.22
Service leads not accessing reports frequently	Push reporting not available / in correct format	NH creating action driver alert with IQVIA and requesting support from IQVIA to reformat reports	NL/NH	30.06.22

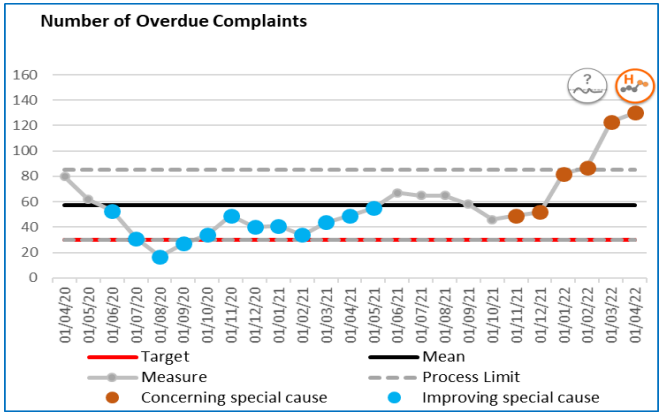
Patient Experience: CQC: Caring (Hit or Miss >6 months)



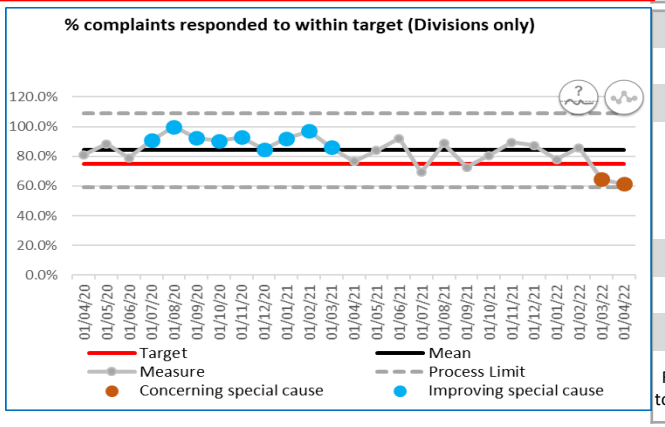
Apr-22
22.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Target (Internal)
75%
Business Rule
Full Escalation as Hit or Miss > 6 months



Apr-22
2.5
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
3.9
Business Rule
Full Escalation as Hit or Miss > 6 months



Apr-22
130
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Max Limit (Internal)
30
Business Rule
For Information as linked to % Complaint Responded



Apr-22
61.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
75%
Business Rule
For Information as linked to % Complaint Responded

Summary:

% Complaints responded to within Target: this indicator is now experiencing special cause variation of a concerning nature and has been experiencing variable achievement of the target (Hit & Miss) for more than six months.

Rate of Complaints: This indicator is experiencing common cause variation, but has been experiencing variable achievement of the target (Hit & Miss) for more than six months.

Actions:

% Complaints responded to within Target:
Complaints performance recovery and stabilisation actions include;

- Recovery plan presented to ETM May 2022
- Additional temporary resource in place for 6 more weeks
- Complaints leads have weekly meetings with directorates / divisions who have the biggest outstanding volume
- Divisional patient experience improvement plans to be developed
- Business case for revised complaints model (meeting new 2022 National framework) to be finalised by July 2022
- Briefing re: new national framework to be shared at Patient Experience Committee

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Expect upward shift in performance from June and achievement of target by mid September

Strategic Theme: Systems

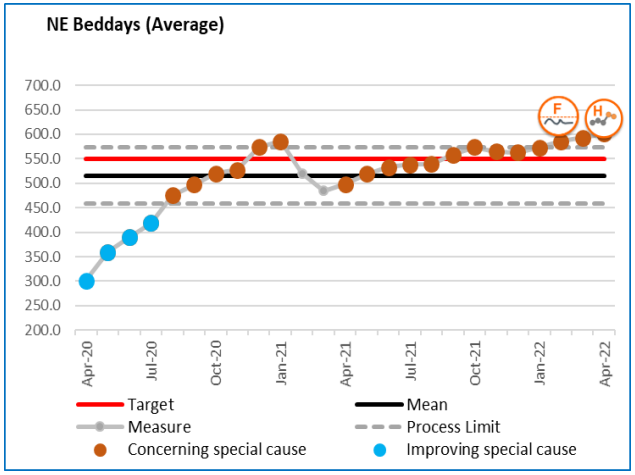
	CQC Domain	Metric	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions
Vision Goals / Targets	Effective	The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).	550	601	Apr-22	550	593	Mar-22	Driver			Full CMS
Breakthrough Objectives	Effective	The target is to reduce the average non-elective bed days relating to patients with high and very high AEC conditions by 10%	3.90	3.90	Mar-22	3.90	4.01	Feb-22	Driver			Verbal CMS

Vision: Counter Measure Summary

Project/Metric Name – To reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).

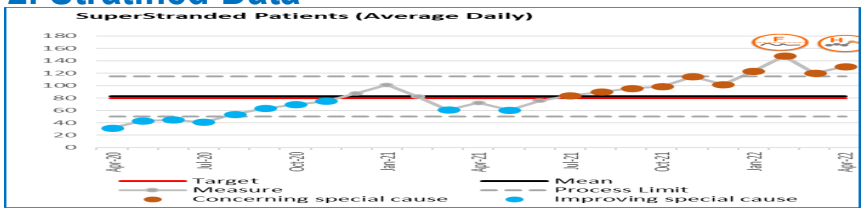
Owner: Robert Cook (Interim)
Metric: non-elective bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Apr-22
601
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
550
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data



3. Top Contributors

	Top Contributor
1.	Out of Hospital Capacity - Pathway 3 Social Services
2.	Full bed occupancy - Escalation of SDEC areas
3.	Critical Staffing/Sickness
4.	Increased ED Attendances

4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Lack of out of hospital capacity	Pathway 3 capacity	Daily system calls	DCOO	Ongoing
Full bed occupancy	Escalation of SDEC areas	Safer better sooner working on all elements of flow Earlier Discharges Increased HIT provision	DCOO	Ongoing
Critical Staffing Levels	Increased Sickness	Staffing data validated Twice daily staffing huddles in place Robust plan to close escalation	HT	
Increased ED Attendances	Lack of capacity in Primary Care	Increased ED hot clinics Improve hospital avoidance schemes (home treatment service)	RC	
Refreshing A3 to reflect the stratified data				

Strategic Theme: Sustainability

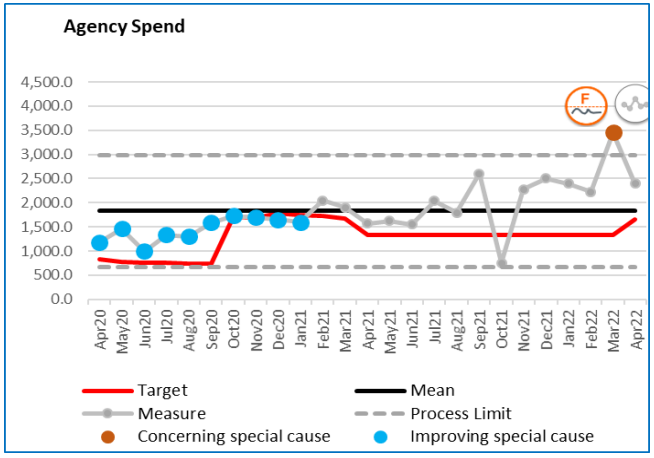
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	-1,528	-1,526	Apr-22	0	-128	Mar-22	Driver	L	P	Note Performance
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000	1654	2398	Apr-22	1333	3454	Mar-22	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	298	166	Apr-22	483	213	Mar-22	Driver	No SPC	No SPC	Not Escalated
	Well Led	Cash Balance (£k)	20995	22355	Apr-22	20995	11838	Mar-22	Driver		?	Not Escalated
	Well Led	Capital Expenditure (£k)	120	200	Apr-22	120	18991	Mar-22	Driver		?	Not Escalated

Vision: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000

Owner: Steve Orpin
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

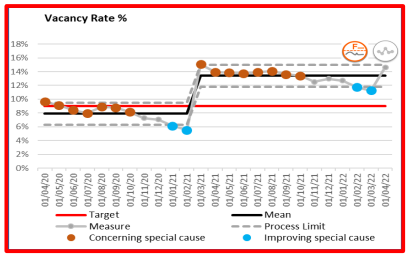
1. Historic Trend Data

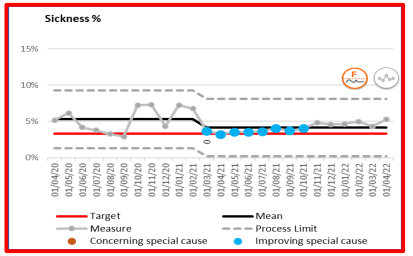


Apr-22
2,398
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
1,654
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data

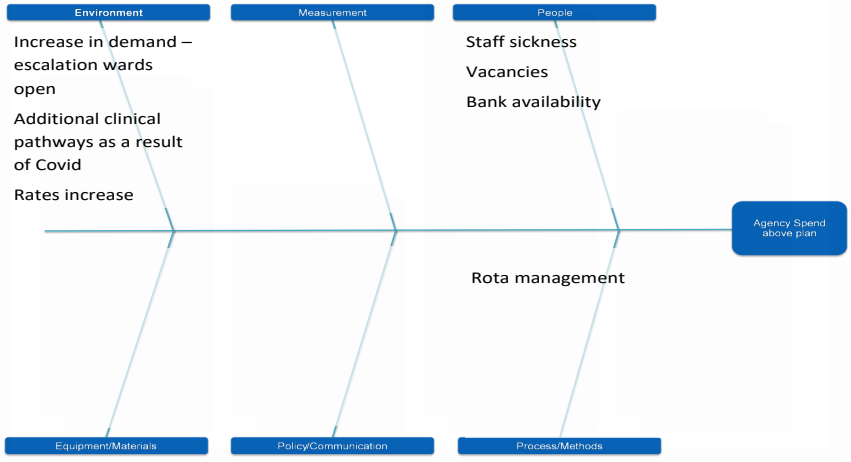
Reason	
Vacancy	48%
Back Filling	23%
Escalation / Demand	13%
COVID-19 Related	5%
Patient Special / Escort	5%
Other	4%
Sickness	3%





3. Top Contributors

Fishbone diagram for:



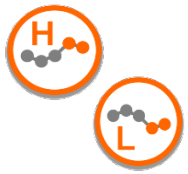
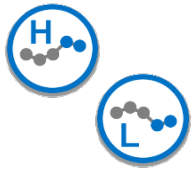
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Increase in demand	Root cause to be identified using data	MEC Division to create action plan to understand increase in bookings	MEC leadership team	16/6/22
Rota Management	Specialties not all on same roster system	Roll out of rostering for medical taking place, all specialties to be added by end of June 22	Nicky Sharpington	30/6/22
People	Root cause to be identified using data	More analysis required to understand impact of short notice sickness and bank availability	MEC leadership team	16/6/22
Rates Increase	Shortage in staff leads to higher rates from agencies	Work with other K&M providers to avoid artificial price increases. Improve recruitment to reduce demand		

Appendices

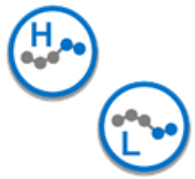
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is showing a Special Cause for Concern. A full CMS is required to support actions and delivery of a performance improvement. Consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is in Common Cause variation. A verbal CMS is required, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric

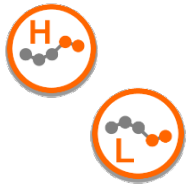
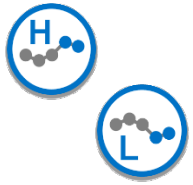
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance	Metric is in Common Cause, but is showing a Special Cause for Concern. **Note performance**, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is in Common Cause variation. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance	Metric is Hitting & Missing the Target and is in Common Cause variation. **Note performance**, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target and blue outline indicates this has continued for 6 months or more.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target, but is showing a Special Cause for Concern. A verbal CMS is required to support continued delivery of the target	Metric is Passing the Target, but is showing a Special Cause for Concern. Note performance, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is in Common Cause variation. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is in Common Cause variation. Note performance
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

The **upper** control limit **below** the target line for metrics that need to be **below the target**

The **lower** control limit **above** the target line for metrics that need to be **above the target**

A metric achieving the target for 6 months or more will be flagged as passing

Metrics that are **hit and miss** have:

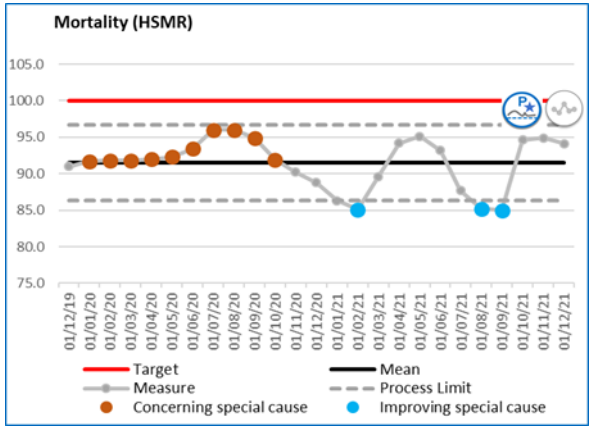
The **target** line **between** the **upper** and **lower** control limit for all metric types

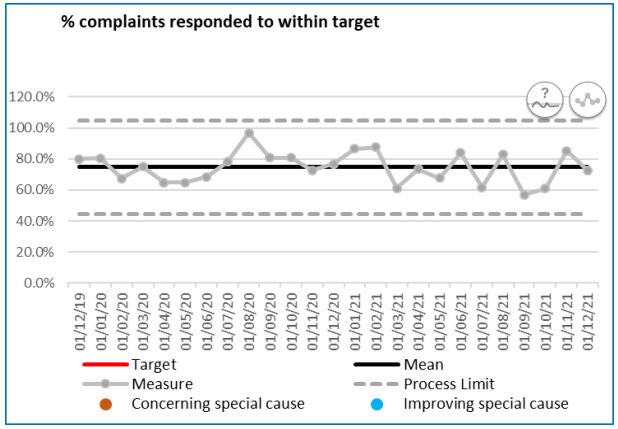
Metrics that consistently **fail** have:

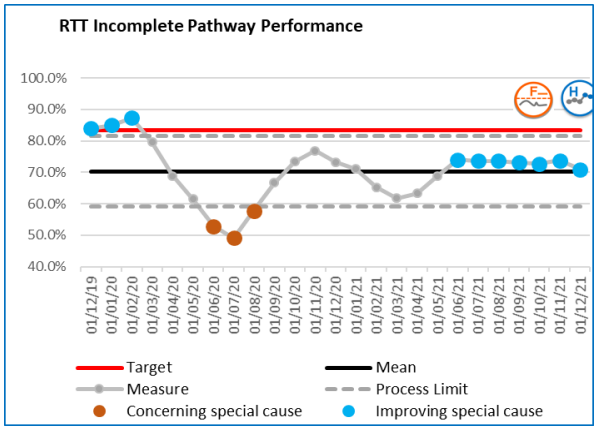
The **lower** control limit **above** the target line for metrics that need to be **below the target**

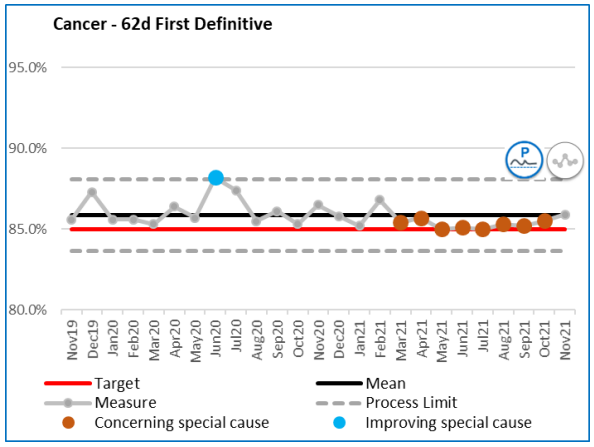
The **upper** control limit **below** the target line for metrics that need to be **above the target**

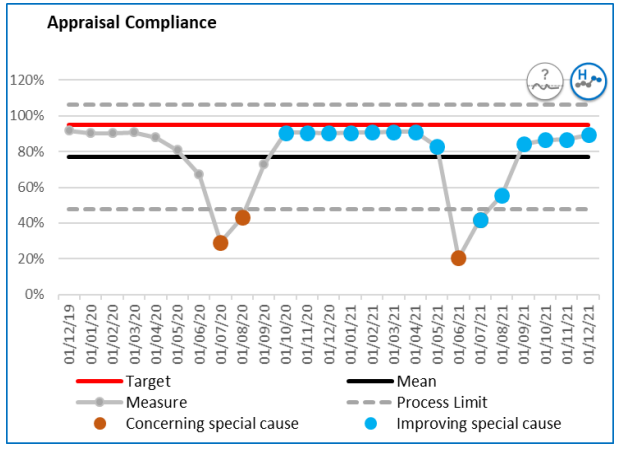
A metric not achieving the target for 6 months or more will be flagged as failing

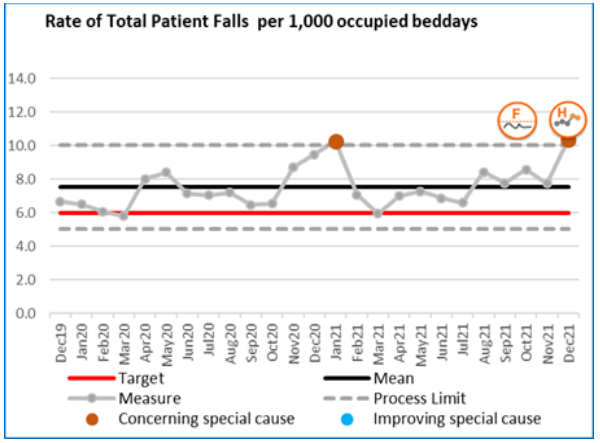












Current Months Financial Position

- The Trust generated a £1.5m deficit which was in line with plan.
- The Trust released 1/12th of the general contingency in the month (£0.2m) to offset the agreed continuation of enhanced bank rates.
- In line with NHSE/I guidance additional income (£0.5m) has been included in the position to offset additional costs for PCR swabbing and Rapid testing.
- The key year to date variances are as follows:
  - **Adverse Variances**
    - Pay budgets overspent (net of release of general contingency) by £0.7m. Medical staffing budgets overspent by £0.7m, of which £0.6m in Emergency Medicine and £0.1m in Women's Services directorate and Support staff pay budgets overspent by £0.3m which were within facilities. These pressures were partly offset by underspends within Nursing (£0.3m)
    - Cost Improvement Plans were £0.1m adverse to plan in month which mainly related to delay in oncology provider to provider contract arrangements.
  - **Favourable Variances**
    - Release 1/12th of Service development funding (£0.2m)
    - Release of 1/12th growth funding (£0.2m) to offset unfunded waiting list initiatives and pressures within pay budgets.
    - Reduction in doubtful debt (£0.2m)
    - Elective Activity was in April was below 104% of 2019/20 levels this therefore generated underspends within non pay budgets of (£0.3m).
  - **Risks**
    - Elective Activity in April was below 104% of 2019/20 levels which could result in an Elective Recovery Fund clawback of c£0.9m. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Therefore, the month 1 position does not assume any ERF clawback.

Cashflow

- The closing cash balance at the end of April 2022 was £22.3m which is an increase by £1.4m from the cash plan of £20.9m, the increase is primarily due to K&M CCG paying slightly more than the agreed SLA income value, this will be corrected from month 3.

Capital Position

- The Trust's capital plan, excluding IFRS 16 items, agreed with the ICS/STP for 2022/23 is £41.3m comprising:
- Net Internal funding (£8.6m):
  - £19.5m depreciation
  - less £2.5m in-year cash surplus (balancing to ICS control total)
  - less £8.4m of PFI finance and capital investment loan repayment
- **PFI lifecycle** per Project model of £1.3m - actual spend will be notified periodically by the Project Company.
- **Donated Assets** of £0.4m relating to forecast donations in year.
- **System PDC** of £1.95m for HASU (to be approved) and
- **National PDC** of £29m for Barn Theatre (to be approved)

- The Plan figure of £41.3m includes:
  - **Estates:** Enabling schemes include contractual commitments from 21/22 relating to enabling works for Linacs and SPECT CT equipment, as well as MRI enabling/build works at MGH and TWH (relating to In-Health proposed contract). Backlog schemes includes carry

forward spend from projects that commenced in 2021/22 e.g. Annexe and Oncology OPD. Works for ventilation systems and chiller units at MGH.
    - **ICT:** ICT schemes include EPMA costs relate to contractual commitments, IT for KMMS, iPro Anaesthetics, EPR infrastructure upgrade, eChemo prescribing, PACS replacement and devices replacement.
    - **Equipment:** Includes contractual commitments from 21/22 relating to schemes that could not be delivered by 31st March due to supplier issues. Other equipment schemes are now being re-prioritised.
    - **Externally Funded schemes: Estates:** Includes £1.9m for the HASU and £29m for the Barn Theatre (includes estates, ICT and equipment), both are waiting for the business cases to be approved.
- In April the Capital spend was £200k compared to the Plan of £120k. The majority of this relates to Estates Backlog carry forward spend from projects commenced in 2021/22 e.g. Annexe & Oncology OPD.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 1
2022/23

Maidstone and Tunbridge Wells NHS Trust

Dashboard

April 2022/23

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-through	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	51.5	51.8	(0.4)	(0.3)	(0.0)	51.5	51.8	(0.4)	(0.3)	(0.0)
Expenditure	(49.3)	(49.6)	0.3	0.3	(0.0)	(49.3)	(49.6)	0.3	0.3	(0.0)
EBITDA (Income less Expenditure)	2.2	2.2	(0.0)	0.0	(0.0)	2.2	2.2	(0.0)	0.0	(0.0)
Financing Costs	(3.8)	(3.8)	0.0	0.0	0.0	(3.8)	(3.8)	0.0	0.0	0.0
Technical Adjustments	0.1	0.1	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0
Net Surplus / Deficit (Incl Top Up funding support)	**(1.5)**	**(1.5)**	**0.0**	**0.0**	**0.0**	**(1.5)**	**(1.5)**	**0.0**	**0.0**	**0.0**
Cash Balance	22.4	21.0	1.4		1.4	22.4	21.0	1.4		1.4
Capital Expenditure (Incl Donated Assets)	0.2	0.1	(0.1)		(0.1)	0.2	0.1	0.1		0.1
Cost Improvement Plan (Internal £30m target)	0.2	0.3	(0.1)		(0.1)	0.2	0.3	(0.1)		(0.1)

Summary Current Month:

- The Trust delivered the plan in the month generating a £1.5m deficit.
- The Trust released 1/12th of the general contingency in the month (£0.2m) to offset the agreed continuation of enhanced bank rates
- The Trusts key variances to the plan are:

Adverse Variances:

- Pay budgets overspent (net of release of general contingency) by £0.7m. Medical staffing budgets overspent by £0.7m, of which £0.6m in Emergency medicine and £0.1m in Womens services directorate and Support staff pay budgets overspent by £0.3m which were within facilities. These pressures were partly offset by underspends within Nursing (£0.3m)
- Cost Improvement Plans were £0.1m adverse to plan in month which mainly related to delay in oncology provider to provider con tract arrangements.

Favourable Variances:

- Release 1/12th of Service development funding (£0.2m) and growth funding (£0.2m) to offset unfunded waiting list initiatives (£0.2m) and pressures within pay budgets. In April there was a reduction in doubtful debt of £0.2m.
- Elective Activity was in April was below 104% of 2019/20 levels this therefore generated underspends within non pay budgets of (£0.3m).

Risk

- Elective Activity in April was below 104% of 2019/20 levels which could result in an Elective Recovery Fund clawback of c£0.9m. However the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Therefore the month 1 position does not assume any ERF clawback

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2022/23 of £20m but a internal savings requirement of £30m. Against the £30m internal target the TRust has delivered £0.2m saving in the month compared to a £0.3 savings target.
- The CIP phasing increased to £1.5m from July and then increases further to £4.1m from October.

Apr-22		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	79.9%	80.2%	-	100.0%	98.7%	108.2%	-	-	3.2%	31.7%	308	21.88	107	6.1	14.1%	100.0%	11	3	318,042	291,510	26,533
MAIDSTONE	Cornwallis (M) - NS959	67.6%	75.4%	-	100.0%	110.5%	183.8%	-	-	5.1%	37.8%	155	10.96	50	5.8	-	-	3	0	93,557	91,971	1,586
MAIDSTONE	Culpepper Ward (M) - NS551	115.7%	80.0%	-	-	143.3%	185.9%	-	-	4.4%	32.0%	93	6.69	36	5.9	42.1%	100.0%	3	0	109,875	142,508	(32,633)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	108.3%	94.5%	-	-	114.0%	143.0%	-	-	4.4%	49.0%	217	15.64	70	5.8	-	-	5	0	197,705	186,627	11,078
MAIDSTONE	Intensive Care (M) - NA251	106.0%	97.8%	-	-	93.3%	74.1%	-	-	1.0%	1.3%	95	5.64	29	40.4	260.0%	100.0%	1	0	259,600	250,491	9,109
MAIDSTONE	Pye Oliver (Medical) - NK259	81.9%	92.7%	-	-	102.2%	98.9%	-	-	2.6%	36.2%	116	7.51	32	5.8	-	-	1	1	128,790	138,684	(9,894)
MAIDSTONE	Whatman Ward - NK959	111.5%	82.5%	-	-	152.0%	193.4%	-	-	7.8%	51.3%	224	15.79	42	6.9	-	-	17	1	105,390	152,247	(46,857)
MAIDSTONE	Lord North Ward (M) - NF651	86.6%	78.0%	-	-	86.6%	100.0%	-	-	0.7%	20.0%	47	3.38	26	8.1	34.5%	100.0%	3	0	111,138	97,443	13,695
MAIDSTONE	Mercer Ward (M) - NJ251	72.8%	71.0%	-	100.0%	114.2%	115.0%	-	-	3.7%	37.9%	130	9.36	51	4.9	9.1%	100.0%	4	2	108,840	132,869	(24,029)
MAIDSTONE	Edith Cavell - NS459	97.4%	78.8%	-	100.0%	102.0%	91.9%	-	100.0%	3.5%	27.6%	67	4.68	11	6.0	44.8%	100.0%	0	0	112,597	94,503	18,094
MAIDSTONE	Acute Medical Unit (M) - NG551	97.6%	89.5%	-	100.0%	149.4%	226.7%	-	-	3.1%	38.7%	134	9.40	48	9.3	-	100.0%	6	0	177,287	177,360	(73)
TWH	Ward 22 (TW) - NG332	73.3%	100.3%	-	-	102.5%	92.6%	-	-	3.3%	33.3%	159	11.42	87	5.2	23.5%	100.0%	11	0	139,368	127,539	11,829
TWH	Coronary Care Unit (TW) - NP301	74.7%	83.9%	-	-	70.0%	-	-	-	1.6%	30.0%	82	5.91	57	9.7	-	-	1	0	70,950	60,794	10,156
TWH	Ward 33 (Gynae) (TW) - ND302	87.3%	90.0%	-	-	78.4%	83.3%	-	-	3.2%	1.5%	78	5.05	27	5.7	31.7%	93.9%	1	0	116,618	111,454	5,164
TWH	Intensive Care (TW) - NA201	104.4%	107.5%	-	-	101.5%	95.0%	-	-	1.2%	0.0%	137	8.98	11	32.7	-	-	0	0	389,871	362,498	27,373
TWH	Acute Medical Unit (TW) - NA901	69.4%	53.1%	-	100.0%	71.8%	64.0%	-	100.0%	1.5%	26.5%	226	16.87	156	6.7	9.2%	100.0%	11	0	225,097	179,417	45,680
TWH	Surgical Assessment Unit (TW) - NE701	102.5%	149.2%	-	-	36.7%	86.7%	-	-	2.8%	11.4%	91	6.19	48	17.2	4.5%	93.8%	0	0	73,332	68,555	4,777
TWH	Ward 32 (TW) - NG130	82.1%	72.6%	-	100.0%	53.3%	81.1%	-	-	1.4%	14.5%	111	7.79	78	6.6	10.4%	100.0%	4	1	143,173	118,655	24,518
TWH	Ward 10 (TW) - NG131	76.7%	129.1%	-	100.0%	84.2%	152.3%	-	-	4.4%	27.7%	222	14.92	97	6.1	7.7%	100.0%	2	1	141,361	157,021	(15,660)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	73.3%	80.0%	-	-	107.8%	73.2%	-	-	6.5%	32.0%	256	16.97	100	5.2	-	-	12	1	125,301	117,892	7,409
TWH	Ward 12 (TW) - NG132	70.7%	86.0%	-	-	96.8%	89.5%	-	-	3.7%	29.7%	199	13.08	100	5.3	-	-	2	1	141,487	142,486	(999)
TWH	Ward 20 (TW) - NG230	68.7%	83.7%	-	-	101.1%	104.2%	-	-	1.9%	30.6%	136	9.34	85	5.8	-	-	16	1	166,313	156,847	9,466
TWH	Ward 21 (TW) - NG231	86.1%	103.4%	-	-	81.3%	113.3%	-	-	2.5%	35.5%	180	12.47	108	6.1	2.9%	100.0%	3	1	144,683	153,124	(8,441)
TWH	Ward 2 (TW) - NG442	67.8%	81.5%	-	100.0%	87.8%	119.1%	-	100.0%	3.2%	20.6%	138	8.62	96	5.6	68.2%	83.3%	11	0	181,176	153,803	27,373
TWH	Ward 30 (TW) - NG330	68.9%	100.4%	-	100.0%	78.8%	111.8%	-	-	3.2%	22.2%	182	12.00	110	5.4	9.3%	100.0%	10	0	121,432	136,251	(14,819)
TWH	Ward 31 (TW) - NG331	77.7%	91.4%	-	-	83.3%	128.2%	-	-	3.4%	29.4%	193	12.42	81	6.0	91.7%	90.9%	5	1	134,458	153,744	(19,286)
Crowborough	Crowborough Birth Centre (CBC) - NP775	67.7%	97.7%	-	-	50.0%	90.0%	-	-	0.8%	0.0%	23	1.32	0	171.4	157.1%	100.0%	0	0	140,259	76,911	63,348
TWH	Midwifery (multiple rosters)	75.3%	54.3%	-	-	78.8%	86.0%	-	-	1.7%	3.0%	807	46.19	262	12.1	48.6%	97.7%	0	0	757,510	842,937	(85,426)
TWH	Hedgehog Ward (TW) - ND702	100.0%	137.0%	-	-	127.5%	-	-	-	4.8%	70.5%	252	17.83	67	12.2	27.7%	94.7%	0	0	145,545	183,455	(37,910)
MAIDSTONE	Maidstone Birth Centre - NP751	97.4%	97.7%	-	-	100.5%	100.3%	-	-	2.7%	0.0%	42	2.51	0	49.5	96.4%	100.0%	0	0	72,788	98,643	(25,855)
TWH	SCBU (TW) - NA102	87.9%	-	-	100.0%	95.0%	-	-	-	2.3%	0.0%	101	5.85	1	13.4	25.0%	100.0%	0	0	194,672	200,715	(6,043)
TWH	Short Stay Surgical Unit (TW) - NE901	84.0%	61.8%	-	100.0%	55.0%	99.4%	-	100.0%	0.8%	3.0%	26	1.76	10	10.4	18.6%	95.2%	0	0	77,966	75,406	2,560
MAIDSTONE	Accident & Emergency (M) - NA351	94.4%	91.2%	-	100.0%	98.7%	90.9%	-	-	3.4%	40.8%	426	30.15	76		0.8%	90.0%	4	0	367,872	425,749	(57,877)
TWH	Accident & Emergency (TW) - NA301	95.6%	81.3%	-	100.0%	93.7%	84.4%	-	100.0%	4.1%	53.0%	552	38.62	85		0.8%	96.8%	5	0	394,618	476,419	(81,801)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	79.2%	86.8%	-	100.0%	85.0%	-	-	-	1.7%	0.0%	19	1.30	0	16.2	51.2%	100.0%	1	0	56,166	58,462	(2,296)
MAIDSTONE	Peale Ward COVID - ND451	78.8%	70.8%	-	100.0%	102.6%	106.7%	-	-	2.4%	41.6%	106	7.40	58	7.1	3.3%	100%	2	0	119,714	98,190	21,525
MAIDSTONE	Foster Clark - NS251	81.9%	79.2%	-	100.0%	103.3%	102.5%	-	-	2.1%	34.8%	129	8.85	65	6.6	62.7%	95.7%	2	0	150,466	164,567	(14,101)
MAIDSTONE	Foster Clarke Ward - NR359	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2,294	(2,294)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	87.8%	84.5%	-	-	81.3%	-	-	-	1.9%	15.4%	24	1.35	1	22.1	19.7%	98.2%	0	0	54,433	60,703	(6,270)
																Total Established Wards				6,569,450	6,720,746	(151,296)
																Additional Capacity beds	Cath Labs			89,997	40,015	49,982
																				0	0	0
																				0	0	0
																Other associated nursing costs				4,823,762	4,696,254	127,508
																				11,483,209	11,457,015	26,194

Under fill Overfill

Green: equal to or greater than 90% but less than 110%
Amber Less than 90% OR equal to or greater than 110%
Red Less than 80% OR equal to or greater than 130%

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the Nursing and Midwifery staffing review — Chief Nurse

The enclosed report provides information on:

- Progress against actions from November 2021 board report
- Current staffing position, vacancy rate and pipeline recruitment
- Outline of the establishment review process and annual cycle
- Outline Safe Staffing escalation process
- E-roster confirm and support process for effective rostering
- Outline of on-going actions and service considerations

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 24/05/22

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

1. Summary

Nursing establishment reviews are essential in ensuring the nursing workforce meets service demands and patient needs. NHS Trusts are expected to complete an annual establishment review to provide assurance to the Trust Board that staffing levels and staff/patient ratios are appropriate to deliver safe and effective patient care (National Quality Board, 2016). In addition, there should be a mid-point review at 6 months to ensure that safe staffing levels remain in place.
The last full establishment review was undertaken in April 2021 and a mid-point review was shared with the Trust Board in November 2021. Subsequently the Chief Nurse has recruited a Deputy Chief Nurse for Workforce & Education and a Head of Nursing (HoN) for Safe Staffing. The cycle for establishment reviews has been re-visited as a priority and the annual cycle is outlined in this report. Essentially the revised cycle is aligned with business planning and the next full establishment review will take place in October 2022.

2. Purpose

This report presents a mid-year review of nursing establishments with particular focus on safe staffing levels and progress made against the recommendations in the November 2021 report. The report will also outline the revised annual cycle for nursing establishment reviews and current actions in relation to nursing workforce.

Review of actions from November 2021 Board Report:
Working closely with HR colleagues the Executive Nursing team have made progress against the November 2021 actions as outlined below:

1. **Review of supervisory/Practice Development roles to support nursing teams:**
   - Business case approved for 12 wte additional Clinical Skills Facilitators (CSFs) to be recruited over the next 3 years. Recruitment currently underway for the first intake of the CSF.

2. **Development of recruitment pathways, recruitment campaigns, expansion of OSCE training, streamlining of Healthcare Support Worker (HCSW) pathways, and the building of financial resilience for overseas recruitment, return to practice and IET (International English Test)/OET (Occupational English Test) support for CSW's.**
   - Weekly recruitment meeting in place to review recruitment pathways with the establishment of rolling adverts and recruitment open days (2 events held).
   - Refreshed strategy for campaigns with an annual calendar of events.
   - Enhanced advertising including social media activity and local radio advertising.
   - OSCE training capacity has now increased from 9 to 18 candidates per month.
   - OSCE ready induction capacity has now increased from 12 to 20 candidates per month.
   - CSW pathway reviewed to welcome candidates new to care and meet and standardise Healthcare Support Worker role meeting national objectives.
   - Business case approval for 140 Internationally Educated Nurses (IEN's) per year for next 3 years.
   - Return to practice pathway embedded.
   - Supported 61 CSW through training for IET/OET with a total of 19 internal CSW's who have progressed to RN's. The remainder are currently undertaking the programme. Cohort 4 is being recruited to, with 13 CSW's undergoing benchmarking tests with the Training provided. 33 CSW's are on the waiting list for future cohorts.

3. **Review night time staffing levels**
   - In conjunction with business planning the night time nursing establishment has been increased on Wards 12, 20, 22 and 30 at the Tunbridge Wells site.

4. **Complete Winter 2021 preparedness assurance framework for nursing and midwifery staffing**
   - Complete with action plan identified for roll out.

5. **Develop a mechanism to highlight wards with red flag events, ensuring staffing is addressed in real time, from a Trust wide perspective.**
   - Staffing levels have been rag rated by the HoN for Safe Staffing and DDNQs, a trust wide process has been introduced to manage risks (Appendix 1). Red flag events are still in their infancy and not yet fully embedded but are in progress. SafeCare will facilitate the raising of Red Flags within the Clinical areas. Training on this process is rolling out within the clinical areas.

6. **Ongoing reviews of the eRoster system in conjunction with roster rebuilds. Develop robust accountability framework to ensure the Trust is compliant with NHSE guidance on roster management.**
   - Roster rebuilds have been completed.
   - Confirm & Support framework written with monthly support meetings established to ensure rostering is effective (Appendix 2).

7. **Matron for recruitment and retention will be appointed**
   - Funding for this role has been agreed on a temporary basis, recruitment completed and Matron in post as a secondment until July 2022.

8. **Simplification of recruitment and onboarding pathways, to ensure timely start dates are achieved post offer**
   - In progress

9. **Plan to substantively recruit to winter escalation inpatient clinical areas**
   - This is being addressed via the business planning process.

10. **Plans are being developed to recruit to turnover**
    - In progress in some areas, with the implementation of Divisional Nursing Workforce Trackers with starters and leavers in real time accurate recruitment to turnover will be fully embedded.

11. **SafeCare project on inpatient wards expected to be live by Mid-April 2022**
    - Phase 1 of the SafeCare project nearing completion with all Adult inpatient wards either live or implementing. Phase 2 of the project being finalised with a focus on elevation of compliance, the raising of Red Flags, and the operational embedding of SafeCare for BAU.

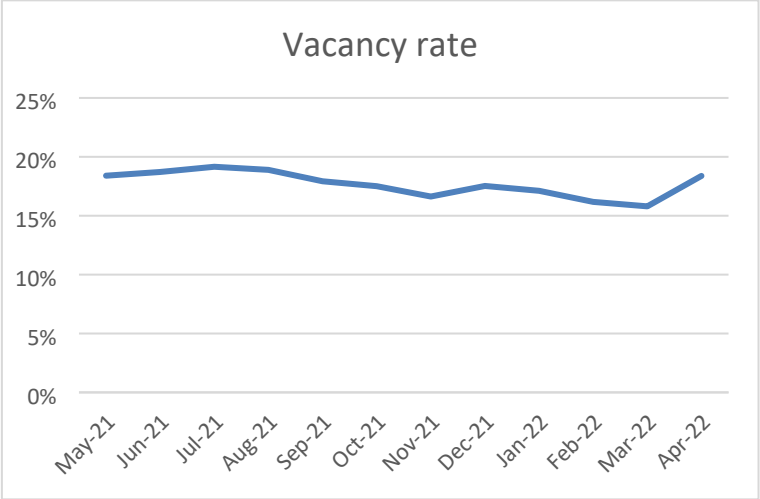
12. **Development of a Safe Staffing policy which defines nursing establishments for clinical areas, clear direction for escalation of staffing risks and process for establishment reviews**.
    - In draft (outstanding)

3. Current Staffing Position

Considerable staffing pressures were experienced within the Trust during the winter months with a high volume of escalation beds open and an increased level of Covid related absence. A slight improvement in the vacancy rate for registered nursing and midwifery staff was seen at the end of March 2022 (See Vacancy Rate Graph below). 1% reduction from November 2021 to March 2022.

However, from April 2022 budget setting there was an increase in establishment by 55 WTE resulting in the vacancy rate for registered staff increasing to 18.38%.

Registered Staff Bands 4-9	Total Budget	Total SIP	Total Vacancy	Vacancy %	Turnover %
Cancer Services	193.56	152.29	41.27	21.32%	13.70%
Corporate and Support	146.86	114.62	32.24	21.95%	11.92%
Diagnostic + Clinical Support	26.34	18.32	8.02	30.45%	5.53%
Medical + Emergency Care	751.69	568.01	183.68	24.44%	13.23%
Surgery	618.84	525.26	93.58	15.12%	11.64%
Women, Children and Sexual Health	405.88	370.74	35.14	8.66%	13.29%
Grand Total	**2143.17**	**1749.2**	**393.93**	**18.38%**	**12.64%**



*Source: April 2022 BI Recruitment Dashboard for Nursing Midwifery

Current recruitment pipeline for nursing

Registered Nurse Recruitment

To date, there are currently 170.9 WTE registered nurses being recruited to:

- 76 WTE candidates currently going through checks for nursing and midwifery roles (band 5 or higher).

International recruitment

- 65 WTE international nurses have start dates confirmed, with Divisional allocation as below:

Directorate	WTE
Acute & Geriatrics	23
Medical Specialities	14
Accident and Emergency	6
Surgery	6
Critical Care	8
Trauma & Ortho	5
Cancer	2
Women's and Children	1
Total	**65**

- 56 WTE International nurses are going through checks with the Divisional allocation as below;

Directorate	WTE
Acute & Geriatrics	13
Medical Specialities	1
Accident and Emergency	1
Surgery	7
Critical Care	5
Trauma & Ortho	5
Women's and Children	2
Total	**34**

- 34 WTE international nurses are in the pipeline

Healthcare Support Worker Recruitment

- 98.7 WTE HCSWs in pipeline:
- 56.1 WTE candidates currently going through checks for HCSW.

Data compiled by the recruitment team

Additional Recruitment Pipelines

Progress has been made on the development and incorporation of new roles and apprenticeships to support the recruitment, retention and development of the nursing staff at MTW. The second cohort of the Registered Nurse Degree Apprenticeship is in the recruitment phase following the successful roll out of the first cohort in September 2021. Currently recruitment for this programme is internal, with a forward vision of external recruitment. This will provide a recruitment stream to 'grow our own' RN's at MTW and moving forward, capitalise on external candidates keen to undertake nurse training at MTW.

- The Nursing Associate role is now embedded within nursing establishments and recruitment to the fifth TNA cohort is in progress. External recruitment for TNA's has been progressed, with four candidates joining MTW to undertake their TNA training. A two-year top up degree for NA's wanting to progress to RN's is currently being recruited to at Canterbury Christchurch University, and 6 NA's at MTW have been accepted for this course. **February**

The 'New to Care' recruitment pathway has been developed, and actively recruited into. This provides opportunities for candidates with no care experience to join the MTW. The apprenticeship route is also available, and facilitates career pathways for school leavers and those who want to develop academically.

Two candidates have been recruited into the new salaried return to practice pathway at MTW. Advanced Clinical practice within MTW continues to progress, with accreditation and workforce mapping currently a priority. Advanced Clinical Practice is being considered within service developments, with oversight provided by the Advanced Practice Assurance group.

Monitoring of Safe Staffing

Ensuring safety within the clinical areas is of paramount importance therefore a number of key staffing reviews are in place to support this. Staffing levels are closely monitored daily in real time at site meetings, daily staffing huddles, weekly bank and agency usage monitoring and weekly recruitment activity progress. A monthly report and publication return to NHSI/E indicating 'planned' and 'actual' nurse staffing by ward is submitted now with the inclusion of Trainee Nursing Associates

and Nursing Associates under development. The safe staffing paper is published monthly at Trust Board and shared with Divisional Nursing and Midwifery Leads.

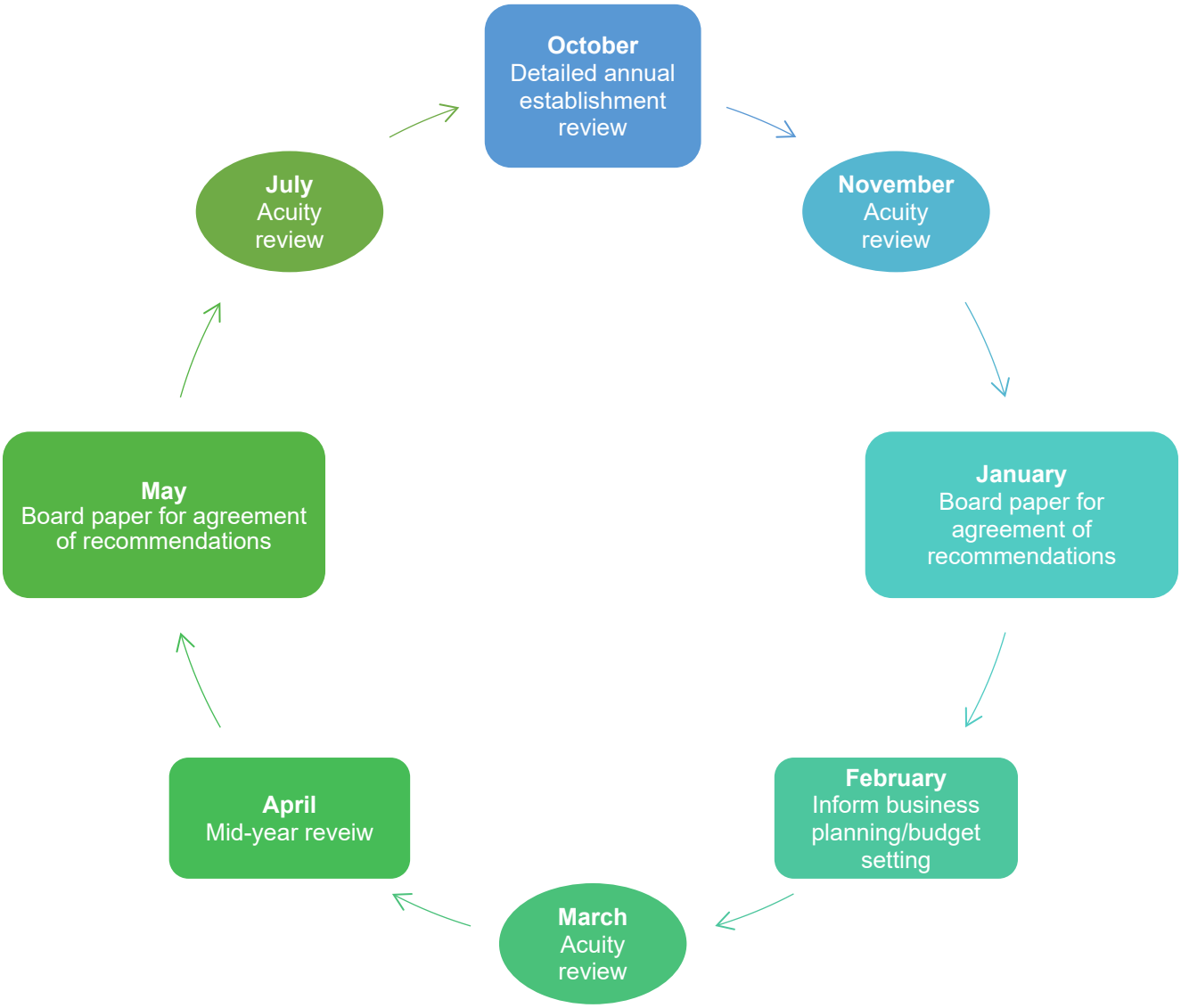
Recruitment activity is reported monthly in the Nurse Staffing (recruitment plan) paper presented to the Executive Team. To support recruitment activity in the divisions 2 WTE band 3 recruitment officers have been employed for the Medicine and Surgery Divisions. The Matron for Recruitment & Retention has developed a monthly newsletter to assist in communicating activity to staff groups.

Other on-going actions:

- Workforce planning group initiated to develop the Nursing & Midwifery workforce strategy for the next 3 years - output report from this group is expected to be completed by July 2022.
- Development of workforce recruitment trackers to closely monitor starters and leavers in order to recruit to turnover and improve allocation and on-boarding of new starters.
- Standardisation of job descriptions with rolling adverts and interviews – draft process currently being shared with divisions
- Implementation of values-based recruitment
- Development of policy and process for establishment reviews with the introduction of acuity reviews using the Safer Nursing Care Tool.
- Revision of the e-rostering policy (e-roster team)

4. Establishment Review Cycle

Annual Cycle



Action	Description
Acuity Review	Acuity of dependency data collection
Annual Establishment Review	Review meetings held with DCN, DDNQs, Matrons, Ward Managers, Finance & HR with full establishment review of each ward/department.
Mid-Year Review	Review meetings held with DCN, DDNQs, Matrons, Ward Managers, Finance & HR to access for any service changes and establishment requirements.

As outlined above the establishment review cycle has been revised to ensure alignment with the business planning cycle.

Reviews will be carried out using methodologies set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the Developing Workforce Safeguards: Using a triangulated approach to ensure the use of:

- Evidence based tools (where they exist):
- Professional Judgement: The Professional Judgement (Telford) model the National Audit Commission, endorsed by the RCN, supported by the NQB and NHSi Developing Workforce Standards. For ward areas the Carter Model was applied to include consideration of Care hours Per Patient Day (CHPPD).
- Outcomes of nurse sensitive indicators including; pressure ulcers, falls, infection prevention control, nursing care complaints and feedback
- Based on patients' needs, acuity, dependency and risks.

5. Other considerations

The establishment reviews planned for this year will take into consideration any service developments to include:

1. Barn theatres – preparing the workforce plan to the opening of additional theatres.
2. Stroke – meeting the demand in the increasing number of stroke beds

Ward 21 & John Day – ensuring the ward templates reflects the increased acuity as a result of COVID-19 with level 2 respiratory patients being placed in these wards.

Appendix 1 – Safe Staffing Escalation Action Card – All Adult areas

BLUE

Do you have additional staff over your nursing establishment? **If Yes, inform Matron or Clinical Site Team to review the need to support other clinical areas.**

GREEN

Do you have the right staff with the right skills to provide patient care and ensure staff can take breaks? **If Yes, No action required.**

AMBER

Do you have the right staff with the right skills to provide patient care and ensure staff can take breaks? **If No, please follow actions below and complete a datix and document actions taken**

In Corporate Working Hours
• Nurse in Charge to ensure staff absence is reported on SafeCare or HealthRoster • Nurse in Charge to ensure Ward Manager and Matron are aware • Matron to escalate to Senior Matron. • Contact temporary staffing to actively recruit into shift. • Nurse in Charge /Ward Manager to work in numbers • Matron to move staff from other areas within the Division • Contact CCC to escalate impact on bed availability/patient boarding. • Ensure the use of the Discharge Lounge is maximised • Matron to seek mutual aid from other Divisions within the Trust • Prioritise patient care and adjust workload throughout shift • Ensure continual review of staffing during shift and at Safety Huddles • Review clinical staff on non-clinical shifts, such as non-mandatory study days.
Out of Normal Working hours
• Inform CCC to escalate impact on bed availability/patient boarding • CCC to move staff across Divisions. • Maternity Services – Inform on-call Senior Midwife • Nurse in Charge to ensure staff absence is reported on SafeCare or HealthRoster. • CCC to move staff from other areas • CCC to review rosters and authorisation for bank to go out to agency • Prioritise patient care and adjust workload throughout the shift

RED

ENSURE ALL AMBER ACTION COMPLETE

Do you have the right staff with the right skills to provide patient care and ensure staff can take their breaks? **If No, please follow actions below and complete a datix and document actions taken**

In Corporate Working Hours
• Matron to inform DDNQ • DDNQ to seek mutual aid from other Divisions across sites • If no mutual aid from Divisions, Clinical site team to work with DDNQ to expedite discharges. • DDNQ to complete risk assessment for non-framework agency and send to temporary staffing • Redeploy off ward clinical staff (Clinical Nurse Specialists, Practice Development Nurses, Matrons and DDNQ's/HoN's) to work within clinical teams. • Huddle with CCC/ DDNQ's/HoN's/COO to determine if planned activity can be continued and make decision to cancel mandatory study days. • Inform Head of Nursing for Safe Staffing or Deputy Chief Nurse to review other staff groups in corporate teams to support. • Consider avoiding new admissions or boarding patients on the ward until resolved • In conjunction with the OPEL Escalation Triggers consider holding patients in the Emergency Department based on clinical risk • Liaise with Chief of Service/Clinical Director to consider a further ward round • Inform Chief Nurse/Chief Operating Officer
Out of Normal Hours
• Site Operations Team to inform Silver on call. • Silver on call to escalate to Executive on call.

Appendix 2

Nursing e-Roster Confirm and Support Meetings, KPI's and Performance Compliance Framework

The purpose of the 'Confirm and Support meetings', is to optimise nursing and midwifery rostering at MTW. Effective rostering supports teams to provide excellence in patient care, delivering the NHSEI guidance for staff with the 'right skills, right time and right place' within clinical areas.

Accountability for effective e-Rostering will sit within Divisional senior nursing teams in order to ensure safe rostering is achieved. Effective rostering ensures that clinical areas are safe, supporting excellence in patient care, and assisting with the recruitment and retention of registered nursing and midwifery staff within the Trust.

'Confirm and Support meetings', will take place monthly. These will be led by the Head of Nursing for Safe Staffing who will be supported by the Deputy Chief Nurse for Workforce and Education and Head of Nursing for Safe Staffing. Attendees to include Lead Matron and B7 from each area and a member of the e-rostering team.

Glossary and terminology

Terminology	Descriptor
% Unfilled Roster	How much of the roster (template shifts) is unfilled?
Shifts without charge cover	The number of shifts with no in charge capable staff (managers to check that all appropriate staff have 'Take charge' skill assigned)
Unused Hrs	Hours that staff are under rostered
Over contracted Hrs.	Additional hours that staff are working
Additional duties	Additional duties added above the template (there shouldn't be any in advance)
Annual leave %	should be between 14% and 17%
Other leave	Includes unpaid/paid absence/carers leave/compassionate leave
Study leave	Study leave should be checked for relevance and amount allocated to individual staff.
Working day	this includes roster creation/management days
Sickness	Only long-term sickness will show in advance
Parenting	maternity/paternity/parenting
Total unavailability	To use headroom/uplift as a guide. Total unavailability should be below 21% before the roster period starts

Nursing e-Roster Confirm and Support Meeting Procedure

Nursing rosters will be prospectively reviewed 4-5 weeks in advance of the roster start date by the DDNQ/senior matrons for the Directorate at the meeting.
Each roster is checked against the Key Performance Indicators listed below and an action plan created. Recommendations for improving rostering and practices are made.
Directorates are invited to the e-Roster confirm and Support meetings. Representation from the DDNQ, Matron and ward manager is required.
One week prior to Confirm and Support meeting, a performance report for clinical areas will be circulated.
Attendees should prepare and bring to the meeting:

- Any action plans currently in place for the clinical areas in relation to rostering.
- An overview of clinical areas with large numbers of net hours over or under.
- An overview of any staff within clinical areas who have poor compliance with high levels of un-booked leave or less that 25% leave booked per quarter.
- If any action points are not completed from the previous meeting, then they are invited to the next meeting.

Invites are circulated to DDNQ's, Matrons and ward managers at least a week in advance of the meetings. They are to be held virtually every four weeks.

Rostering Key Performance Indicators for Review:

- Roster laid down and complete
- Partial approval of rosters by 8 weeks, with a 6-week deadline for full approval.
- Net Hours concern, e.g. An increase in number of staff with net hours over 11.5hrs, or where there has not been improvement when plan in place
- Annual Leave within 14% -17% or concern
- Total unavailability below 21% prior to roster commencement
- Additional Shifts
- Working Day i.e. management days
- Missing Charge Cover
- Missing Skills
- Wrong grade types
- Staff without shifts
- Shift pattern concerns i.e. <5 LD or N shifts in a row
- Number of temporary staffing requests.
- Errors in practices e.g. using unavailabilities on shifts generating enhancements, time owing being recorded incorrectly
- General housekeeping reminders e.g. update staff working restrictions where warnings are generated
- Rules & restrictions
- Safe Care compliance will also be discussed.

Review framework for compliance against eRostering, quality and workforce standards
General

DDNQ's, Lead Matrons and Matrons need to highlight eRostering noncompliance and action plans in Directorate reporting, 1:1 meetings, ward meetings, etc.
Implementation of monthly directorate 'Confirm and Support Meetings' led DCN & HON and attended by DDNQ's, Matron, B7 from each area, ERoster manager, or nominated deputy.
Meetings need to be locked into diaries.
Assurance to be provided to DCN through 8-week compliance (eRostering) and through Allocate insight reporting.

ERoster – 'Confirm and Support Meetings

Action	Compliance	RAG status
Fully approved rosters being completed 8 weeks in advance	100% compliance	
Unused hours	Each individual to have no more than 11.5 unused hours at any time	
Spread of annual leave	14-17%	
Nurse in charge of all shifts	100% compliance	
Total unavailability i.e. annual, sick and study leave	NOT TO EXCEED 21% (this does not include maternity leave)	
% of unfilled roster (Releasing shifts to bank)	<25%	
Representation at 'Confirm and Support Meetings'	Attendance by Matron and B7 or a representative	

RAG status:
Green = Achieved Red = Not achieved

Compliance framework for eRostering

Number of actions not met	Action to be taken
If 8 week rostering not completed in month	Matron and B7 to review non-compliance of 8-week rostering period at Confirm and Support meetings
Three red actions for one month	B7 and Matron need to meet with HON for Safe Staffing to agree an action plan
Three red actions for 2 consecutive months	HON, Matron and B7 need to meet with DCN. Compulsory refresher session with the eRostering team
Three red actions for 3 consecutive months	DDNQ, HON, Matron and B7 need to meet with Chief Nurse.

NHS Maidstone and Tunbridge Wells NHS Trust

Update on 2022/23 planning	Deputy Director of Strategy, Planning & Partnerships and Chief Finance Officer / Deputy Chief Executive

The enclosed report provides information on 2022/23 Operational Planning round.

- There have been no changes to the activity and workforce submissions approved through the Finance and Performance Committee and Trust Board in April 2022.
- The Trust submitted a final financial plan for 2022/23 on 28th April 2022 with a deficit of £7.6m. This is part of the Kent and Medway System plan which is a deficit of £74.6m. These are an improvement on the draft submission of £2.1m for the Trust and £10.4m for the system. Please see attached finance pack for details of the movements.
- As of 18th May 2022 the trust has not received feedback from NHS E/I on our operational planning submission, as a result we have not yet received formal confirmation that the changes to baseline relating to endoscopy have been formally accepted.
- Nationally a re-submission of all planning templates has been requested, with a resubmission date of 20th June 2022. Whilst we awaiting guidance on the requirements for resubmission, we have re-instigated the trusts operational planning processes to respond accordingly.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 17/05/2022, Finance and Performance Committee, 24/05/2022

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Financial Plan 2022-23

Plan submitted 28th April 2022

2022/23 Final Plan I&E Summary

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 Annual Plan
Income from Patient Care Activities	47.7	47.7	47.7	47.7	47.7	47.7	47.7	47.7	47.7	47.7	47.7	47.7	**572.9**
Other Income	4.1	4.1	4.2	4.3	4.3	4.3	4.5	4.5	4.5	4.5	4.6	4.5	**52.4**
Total Income	**51.9**	**51.9**	**51.9**	**52.1**	**52.1**	**52.1**	**52.2**	**52.2**	**52.2**	**52.2**	**52.3**	**52.2**	**625.3**
Medical Staff	-9.2	-9.2	-9.2	-8.9	-9.0	-8.9	-8.4	-8.4	-8.4	-8.4	-8.4	-8.3	**-104.6**
Nursing	-9.1	-9.2	-9.3	-9.2	-9.2	-9.2	-8.7	-8.7	-8.7	-8.7	-8.7	-8.7	**-107.2**
Scientific Therap & Tech Staff	-3.9	-3.9	-4.0	-3.8	-3.9	-4.0	-3.7	-3.8	-3.8	-3.8	-3.8	-3.8	**-46.5**
Qualified Ambulance + Paramed	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	**-0.6**
Support to Clinical Staff	-5.1	-5.2	-5.2	-5.1	-5.1	-5.1	-4.8	-4.8	-4.8	-4.8	-4.8	-4.8	**-59.4**
Support Staff	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	**-17.1**
A&C/Sen Man Staff	-2.8	-2.9	-3.0	-3.0	-3.0	-2.9	-2.9	-2.9	-2.9	-2.9	-2.9	-2.9	**-35.1**
Apprenticeship Levy	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	**-1.3**
Total Pay	**-31.7**	**-32.0**	**-32.2**	**-31.6**	**-31.8**	**-31.7**	**-30.1**	**-30.1**	**-30.2**	**-30.2**	**-30.2**	**-30.1**	**-371.9**
Drugs & Medical Gases	-5.0	-5.0	-5.0	-4.9	-4.9	-4.9	-4.6	-4.6	-4.6	-4.6	-4.6	-4.6	**-57.7**
Clinical Negligence	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	**-19.4**
Premises	-2.6	-2.9	-2.6	-2.6	-2.6	-2.6	-2.5	-2.5	-2.5	-2.5	-2.5	-2.5	**-30.7**
Purch healthcare from non NHS	-2.2	-2.2	-2.2	-2.1	-2.1	-2.1	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	**-24.8**
Supplies and Services	-4.0	-4.3	-4.3	-4.3	-4.3	-4.3	-4.0	-4.0	-4.0	-4.0	-4.0	-4.0	**-49.7**
Other Non Pay	-2.6	-2.7	-2.7	-2.7	-2.7	-2.7	-2.6	-2.6	-2.6	-2.5	-2.5	-2.5	**-31.3**
Total Non Pay	**-18.0**	**-18.7**	**-18.5**	**-18.2**	**-18.2**	**-18.2**	**-17.4**	**-17.4**	**-17.4**	**-17.2**	**-17.2**	**-17.2**	**-213.5**
Depreciation	-2.0	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.2	**-25.4**
Other Finance Costs	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-2.4	**-17.6**
Public Dividends Payable	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	**-5.8**
Total Finance Costs	**-3.8**	**-3.8**	**-3.8**	**-3.9**	**-3.9**	**-3.9**	**-4.1**	**-4.1**	**-4.1**	**-4.1**	**-4.1**	**-5.1**	**-48.7**
Technical Adjustment	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	-0.1	1.0	**1.2**
Total Deficit (-) / Surplus (+)	**-1.5**	**-2.6**	**-2.6**	**-1.6**	**-1.7**	**-1.7**	**0.7**	**0.7**	**0.6**	**0.7**	**0.7**	**0.8**	**-7.6**

2022/23 Final Financial Plan

Draft Plan
The Trust submitted a final financial plan for 2022/23 on 28 April 2022 with a deficit of £7.6m. This is part of the Kent and Medway System plan which is a deficit of £74.6m. These are an improvement on the draft submission of £2.1m for the Trust and £10.4m for the system.

Key Assumptions
Contracts have not yet been signed with commissioners but the values in the plan are following discussions with commissioners and assumed to be the final value.

There is an uplift for growth at 0.8% and inflation at 2.8%. There is a national efficiency ask of 1.1% and a local system efficiency of 1.2%.

The Trust has an internal CIP target of £20m for 2022/23 plus £10m of undelivered CIP from 21/22.

The plan currently includes an additional £19.3m of expenditure to support growth (£2.9m), cost pressures (£10.7m) and service developments (£5.7m).

The plan assumes additional resource in winter and that current escalation wards remain open with current staffing levels.

The plan includes £16.8m of risk which is detailed on slide 6.

Key movements	£m
Draft plan submitted	-9.7
Finance Costs	-1.7
RPI increase	-0.3
Growth	1.8
Other changes	2.3
Final plan submitted	-7.6

Key movements
Finance Costs – Values revised following year end position, significantly the increase in valuation, higher cash balance and change in LINAX deprecation had the following impact; depreciation revised value £0.4m, IFRS16 £0.5m, PDC £0.8m

RPI – PFI value changed based on February RPI value £0.3m above previous estimate.

Growth – The remaining growth expenditure plan has reduced by £1.8m to support the increased changes

Other changes – Other revisions to the plan resulted in a £2.3m benefit.

2022/23 Cost Improvement Plan

Efficiency Plan Risk £000	Pay	Non Pay	Income	Plan
High Risk	6,161	4,077	1,343	**11,581**
Medium risk	52	1,220	924	**2,196**
Low Risk	264	5,327	647	**6,238**
Total Efficiencies	**6,477**	**10,624**	**2,914**	**20,015**

Efficiency Plan Status £000	Pay	Non Pay	Income	Total
Fully Developed	0	689	174	**863**
Plans in Progress	211	1,831	1,353	**3,395**
Opportunity	795	5,143	1,387	**7,325**
Unidentified	5,471	2,961	0	**8,432**
Total Efficiencies	**6,477**	**10,624**	**2,914**	**20,015**

Efficiency Profile £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Recurrent	326	348	398	671	670	713	1,978	1,985	2,085	1,989	1,990	1,963	15,116
Non Recurrent	54	54	46	41	57	59	760	760	760	772	769	767	4,899
Total Efficiencies	**380**	**402**	**444**	**712**	**727**	**772**	**2,738**	**2,745**	**2,845**	**2,761**	**2,759**	**2,730**	**20,015**

The 2022/23 CIP target is £20.0m, there is an additional £10.0m CIP from 21/22 but this is not reported externally. Around £4.3m of CIP is either fully developed or plans in progress. There is a further £7.3m of opportunities identified. This leaves £8.4m of unidentified schemes.

The plan does assume that the CIP target will be met by the end of the year but some of this will be non recurrent CIPs.

2022/23 Capital Plan

Capital Spend plans	2022/23	2023/24	2024/25	2025/26	2026/27
	£'000	£'000	£'000	£'000	£'000
Estates Projects - b/f commitments	1,672	0	0	0	0
Estates - Backlog maintenance	1,323	2,000	2,015	3,964	3,547
ICT - b/f commitments	1,431	0	0	0	0
ICT - Devices	300	500	500	1,000	1,199
ICT - Infrastructure	350	500	500	1,000	1,000
ICT- Clinical applications/EPR	850	1,345	1,435	2,000	1,500
Equipment projects - b/f commitments	1,550	0	0	0	0
Linear Accelerator replacements	0	3,000	3,000	0	0
Equipment - backlog replacement	1,156	1,933	1,828	4,376	3,826
Total internal funds	**8,632**	**9,278**	**9,278**	**12,340**	**11,072**
ICS capital - HASU stroke reconfiguration	**1,945**	**4,175**	**0**	**0**	**0**
National funded projects					
TWH PFI Lifecycle	1,325	1,378	1,412	2,105	2,775
Barn Theatre	28,989	0	0	0	0
Critical Medical Imaging	**0**	**0**	**2,300**	**0**	**0**
Maidstone Theatres	0	0	0	0	20,000
Total national funding/tech sources	**30,314**	**1,378**	**3,712**	**2,105**	**22,775**
IFRS 16 Leases - capital spend					
Cardiology equipment	1,501	0	0	0	0
KMMS Accommodation	14,674	0	0	0	0
Leased vans	353	0	0	0	0
Unit A CDC additional works	294	0	0	0	0
Springwood Rd Accommodation	9,119	0	0	0	0
Remeasurement of existing leases	1,874	0	0	0	0
Total IFRS 16 capital spend	**27,815**	**0**	**0**	**0**	**0**
Total Capital Spend Plans (excl donated)	**68,706**	**14,831**	**12,990**	**14,445**	**33,847**

- The Trust has prepared its five year capital plan for agreement with the K&M ICS, who manage the local system balancing, and with NHSEI.
- For 2022/23 the Trust has an ICS internal resource control total of £8.6m which is generated from Trust internal resources (depreciation less loan/PFI/Lease repayments) but capped at the control total level. This resource has to fund prioritised key projects for Estates backlog, ICT renewal and Equipment replacement. The final prioritisation of this limited resource will be undertaken by the capital budget holders with the Divisions, taking account of business planning submissions, and agreed with the Executive Team.
- The Trust has an initial allocation of ICS system capital for 2022/23 relating to the system stroke reconfiguration plans. This will need to be reviewed and confirmed as the costs and timelines for the project are finalised.
- The Trust has also included an assumption of national funding for the Barn Theatre project – this figure has been agreed for use in the plans with the ICS, but the FBC is in development, so final figures and timelines will need to be confirmed, and approval from NHSEI/DHSC obtained.
- 2022/23 sees the change in lease accounting, bringing leases, rentals, equipment use under MSC/MES arrangements previously funded from revenue budgets onto the balance sheet, and capitalising the costs. The Trust has included assumptions of new leases in its capital plans, including the planned KMMS accommodation at TWH.

Risks and Benefits

	Value £ m	Risk %	Risk Adjusted Value £ m
CIP Delivery 2022/23	20.0	25%	5
CIP Delivery 2021/22	10.0	75%	7.5
Net Inflation Pressure, additional 4% increase in all non pay	8.6	50%	4.3
Total Risks			**16.8**
COVID reduction	-2.0	50%	-1.0
Total benefits			-1.0
Total Risks and Benefits			**15.8**

The goal between now and the final plan submission will be to minimise these risks, and manage any impact on the plan that crystallises.

The plan assumes full delivery of CIP but there is a risk that this may not be fully delivered in 2022/23. Plans are being developed with Divisions with support from the PMO but the pause in CIP in the last 2 years means CIP programmes are at a less developed stage than in previous years.

The plan now includes increased contract values for contracts with embedded RPI increases. However there remains a further risk to general non pay price increases over and above the 2.8% funded for inflation. A 4% increase on all non pay would equate to an £8.6m cost pressure.

There is a potential benefit from a further reduction in COVID expenditure, this is being reviewed following changes to IPC. COVID expenditure is also being benchmarked across the system.

There is still further clarification required on the impact of underperformance against the elective activity target of 104%. However the latest activity plan shows 104% when costed at tariff so this minimises the risk.

Mitigations

	£ m
Workforce availability	3
Annual Leave accrual reduces	4
Non recurrent income in year	1
Reduce SD, CP or growth investments	4
Release of Contingency	2.2
Total Mitigations	**14.2**

In order to mitigate risks in the financial plan the Trust has identified the following potential mitigations, some of which require further development

- Workforce availability may limit recruitment ambitions
- Annual Leave accrual may reduce if staff are able to take their annual leave in full.
- Identify further non recurrent income support
- Reduce the level of investments in Service Developments and Cost Pressures.
- Release of contingency

Note the mitigations are lower than the risks.

Next Steps

There is still further work required before the final plan submission;
CCG Income – The final contract value has not yet been agreed with the CCG. The CCG will continue to negotiate for additional funding to support the current levels of activity, performance and quality. ERF funding and the risk of clawback is being reviewed at a system level.

Workforce Plan – Current plan includes recruitment assumptions that look ambitious. Further reviews with Divisions to ensure understanding. This won't reduce the gap but provide assurance that workforce will remain within core establishment.

Cost Pressures – List has been reviewed within finance, this will now be agreed at Executive Team Meeting. Alternative solutions and mitigations to be considered for any not funded.

Service Developments – Clinically Led Prioritisation will took place on 27 April. Divisions will need to consider alternative solutions and mitigations to be considered for any not funded.

CIPs – CIP plans to be developed

COVID expenditure – Covid related expenditure to be reviewed.

Growth – Allocation of growth funding to be agreed at Executive Team Meeting.

Alignment of plan to other workstreams, for example;

Trust – Cardiology, EPR, KMMS, Divisional Objectives
West Kent HCP – Urgent Care and Frailty, WKHCP priorities
Kent and Medway ICS – Pathology, RIS/PACs, CDC, Productivity

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Update on the development of the corporate objectives for 2022/23	Director of Strategy, Planning & Partnerships and Chief Finance Officer / Deputy Chief Executive

Please find enclosed the update on the development of the corporate objectives for 2022/23.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 17/05/22

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

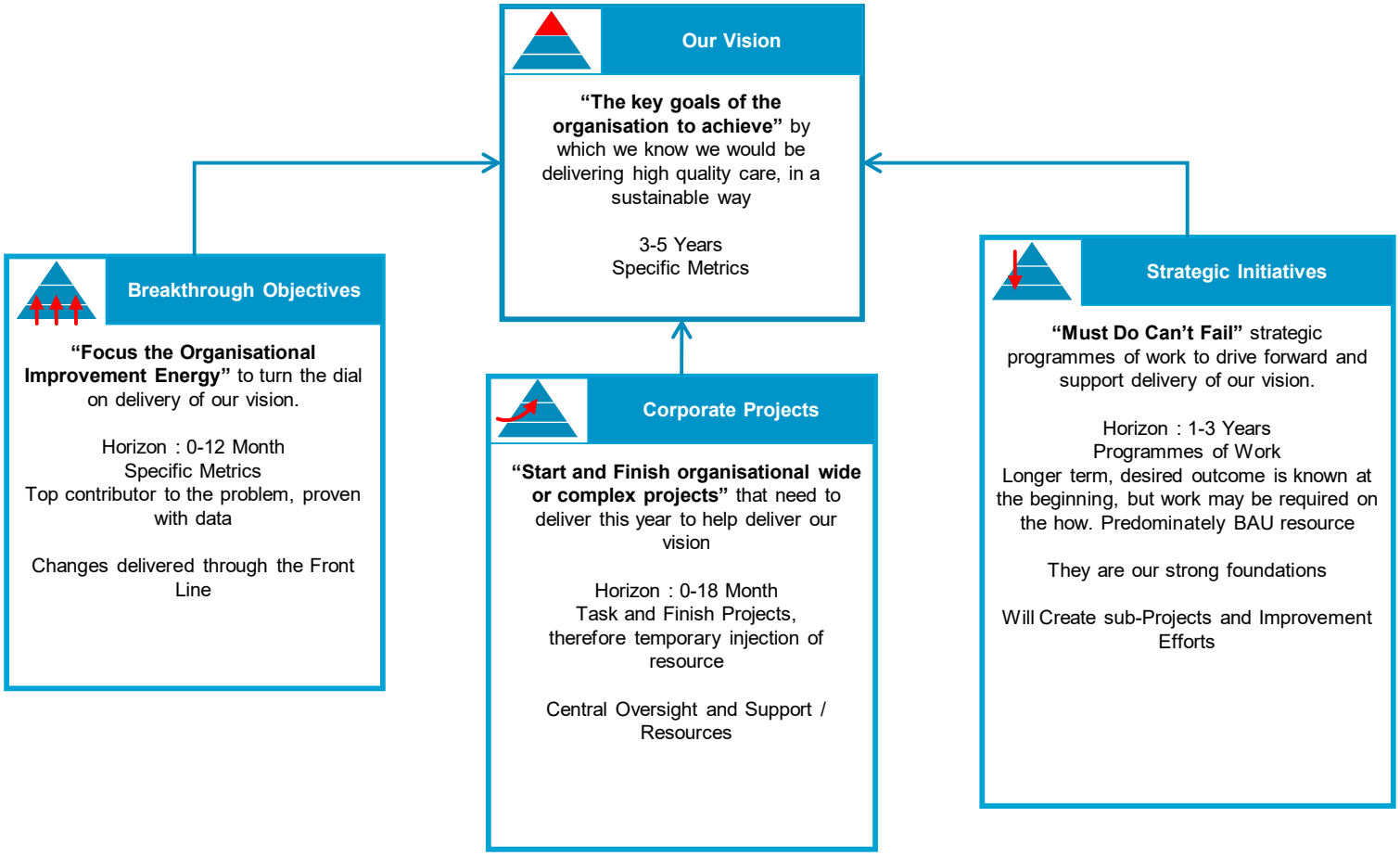
Objective Setting 22/23

May 2022

In 2020 we brought together our strategic ambitions into a single unified structure. Refreshing our corporate objectives will focus the continuous improvement capacity of the organisation on a limited number of important areas.

- We are planning to keep the same six strategic themes in 2022/23.
- Each strategic theme is being reviewed utilising our continuous improvement methodology to ensure the vision, goal and break through objectives reflect the most impactful change(s).
- This is an executive led, transformation team facilitated iterative approach.

In 2020 we launched the first part of our continuous improvement methodology, Strategy Deployment.



In setting our objectives for 22/23 we should **reflect** on the journey to date, and the current organisational challenges.

- Divisional SDR process is now in a significantly different place to 3-6 months ago
  - SDR and A3s were seen as a template to fill, not a method and thought process. This has begun to improve but is not uniform yet
  - A3s are brought to the divisional SDR have become progressively better (demonstrate A3 thinking)

- Some A3s are only now being worked upon. We need to reduce the number of schemes to increase turnaround of A3's and countermeasures to drive the pace of change

In the context of objective setting we are asking execs to focus on the overall expectations.

Overall	ETM SDR	Divisional SDR
• Accountable for the Strategic Theme including overall performance • Develop and refresh the Strategic Theme A3 as required • Develop the Breakthrough objective A3 • Monitor the Progress against the Goal and Target set • Provide guidance to divisions on key focus areas during Catchball scorecard development	• Reviewing Vision metric and breakthrough objective metric on Trust level scorecard in line with business rules • To produce Structured Verbal updates or Full Countermeasure summaries as required • Present to ETM SDR • Feed up any success against your theme from divisional SDR	• To coach the divisional driver metric owners in the development of their A3's • Provide challenge on continuous improvement performance • Celebrate their successes in supporting your theme • Support divisions with escalations against your theme

Reflection: Feedback from divisions on objective and corporate projects provides additional insight.

The high number of corporate projects is potentially diluting focus, some are not projects, others require sharpening in scope:

- *They are a critical enabler, particularly for a number of BTOs*
- *Would benefit from enhanced progress*
- *Due to their cross cutting nature enable better use of CI capacity if run in advance of the BTO*
- *Not visible to divisions*
- *Demonstrate executive commitment to SDR methodology*

Operational feedback on the most significant challenges aligns with escalation areas on the trust IPR and red risks on the trusts risk register

- Workforce recruitment and retention.
- Numbers of medically optimised for discharge patients
- Scale of elective recovery requirement including diagnostics

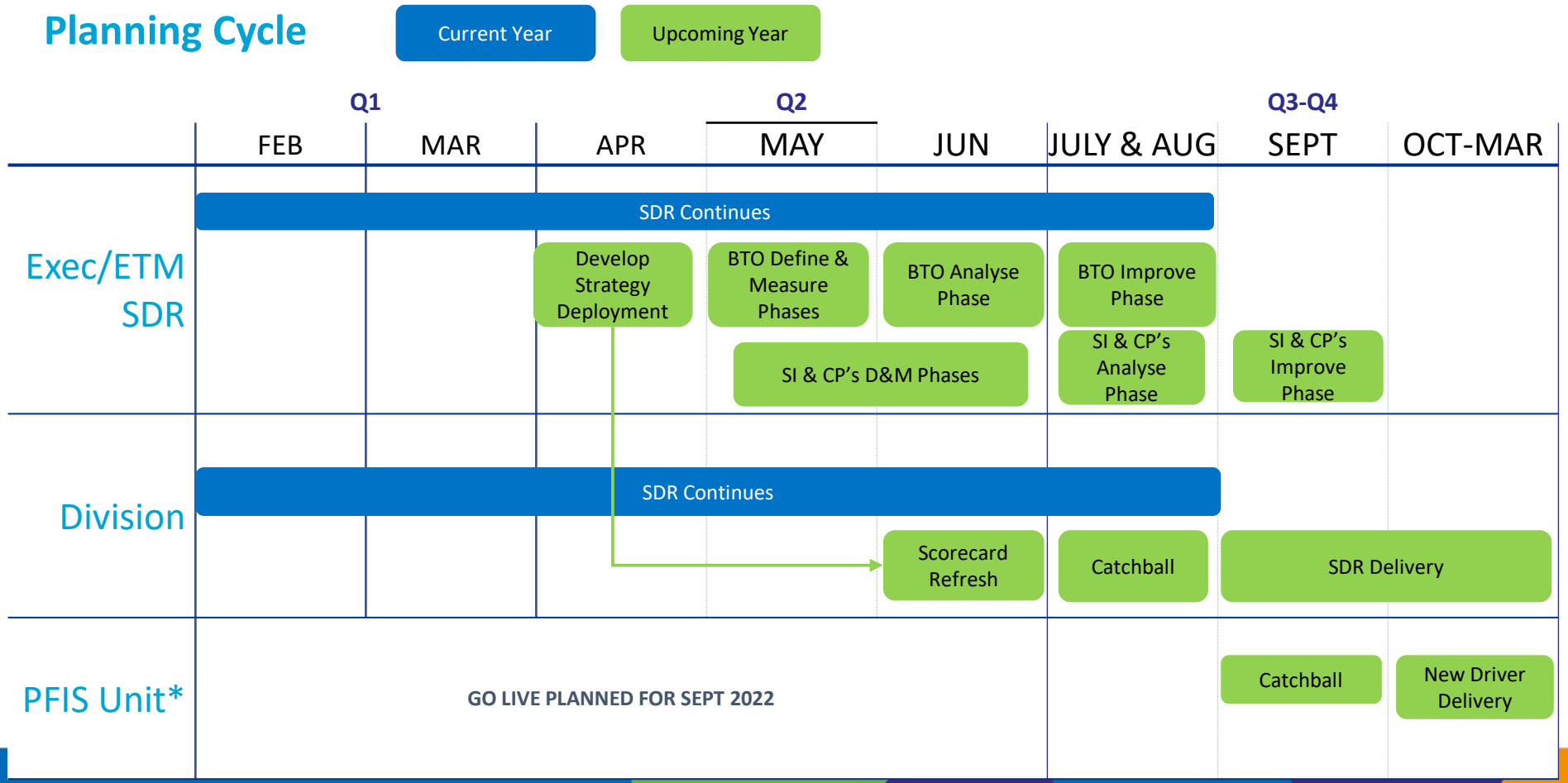
We are proposing two strategic themes & their BTOs remain the same as falls and premium workforce expenditure remain the dominant issues

Our Vision		Strategic Goal	Current Target	Breakthrough Objective	Breakthrough Update	Update on Strategic Theme
Patient Safety and Clinical effecti veness	Working together to put quality at the heart of all that we do. Achieving outstanding clinical outcomes with no avoidable harm.	Zero harm episodes	A reduction in harm	Reduction in slips, trips and falls	Falls increased during the extended winter period 21/22 and is now reducing but still above the target of 6.0 per 1000 occupied bed days.	Breakthrough objective A3 has identified corporate actions which are due for implementation
Sustain ability	Living within our means providing high quality services through optimising the use of our resources	Continued delivery of financial plan, with a modern and fit for purpose environment and infrastructure	Delivery of financial plan, including operational delivery of capital investment plan	Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022	Premium workforce has increased during 21/22	A3 is being refreshed to ensure breakthrough is not time limited and check focus.

Whilst the vision remains the same we are proposing changes to the BTO and/or goals for all remaining strategic themes

Our Vision		Strategic Goal	Current Target	Breakthrough Objective	Breakthrough Update	Update on Strategic Theme
Patient Experience	To meet our ambition of always providing outstanding healthcare quality we need people to have a positive experience of care and support.	We are consistently recognised by patients as outstanding through FFT positive response rates nationally.	Achieve the national FFT response rate target and maintain the positive response rate.	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target.	FFT Response rates have has failed the target for the last 6 months	A3 has been reworked to focus on a wider range of feedback sources (FFT, PALs, National Inpatient Survey). Themes emerging from these indicate and support the renewed focus which will be on all aspects of communications (understanding, feeling involved in care) and information provision.
Access	Ensuring all of our patients have access to the care they need to ensure they have the best chance of getting a good outcome	To ensure we are achieving all constitutional patient access standards	We will achieve a 50% reduction in 52 week breaches by September 2021 and by April 2022 we will achieve the RTT standard whilst also ensuring no patient waits longer than 52 weeks for treatment.	Ensure activity levels for theatres , diagnostics and outpatients match those pre-Covid	Due to pressures in NEL flow activity numbers in Theatres, OP have been impacted which have affected the RTT position.	52 week target has been achieved. RTT standard not achieved. A3 under review to agree next steps and identify effort for improvement e.g. achieve MTW RTT trajectory
Systems & Partnerships	Working with partners to provide the right care & support, in the right place, at the right time.	No patients who could be treated in our community are transferred to our hospital or who could be treated in West Kent are transferred out	The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction)	Decreasing the volume of high and very high AEC sensitive conditions being admitted to our bed base as NEL admissions	Achieved sustained reductions in AEC admissions to NEL bed base. However NE bed days have not reduced.	Plan is to refresh data and identify if breakthrough target should change, for example super stranded patients volumes.
People	Creating an inclusive, compassionate and high performing culture where our people can thrive and be their best self at work.	We will achieve continuous improvement to take MTW to the best place in the NHS Staff Survey amongst Acute Trusts	We will be amongst the top performing Acute Trusts for recommending MTW as a place to work.	Each department and team improves their 'recommendation as a place to work' proportionate to overall Trust performance	Under Revision	A3 is under complete revision and will now be centred on addressing inconsistent leadership behaviours with a view to creating development pathways for leaders.

Bringing it all together, this is how we implement



To approve the draft People and Culture Strategy, 2022 - 2025 **Chief People Officer**

I am so proud to be able to present the People and Culture Strategy 2022-25 for the Trust Board review and approval. Over the last 3-4 months as a People and OD function we have been in a process of consultation and engagement with many forums, groups and individuals across the Trust to understand what is important to our people and what they need, as well as the organisational objectives and ambitions which will support us to deliver on our exceptional people outstanding care vision.

This consultation has included many interested stakeholder groups including members of the Trust Board, the executive team, our representative groups, union and staff side colleagues, medical teams, front line clinical colleagues and members of the People and OD team.

This process of consultation and design has also taken account of a number of other key documents and strategies including the Trust Clinical Strategy, the Exceptional People Outstanding Care vision and strategic objectives, the NHS People Plan, and the Future of HR and OD programme launched across the NHS.

Other data sources have also fed into the development of the priorities including the extensive feedback our people have provided through the 2021 National Staff Survey.

In summary the strategic feedback has highlighted six key themes which collectively represents the ambitions for the period 2022-25. The three-year plan is outlined and the delivery will be reviewed through reporting to the Executive and the People and OD Committee. The strategy is owned at Trust Board level and has expectations and a framework of delivery for all members of the Trust. This is most specifically directed at people leaders who have the capacity to influence and create the lived experience of our people on a daily basis.

A number of 'enabling' strategies and operational plans are in development to ensure that all objectives are mapped into a programme of work and link to a scorecard of measurements to monitor and track delivery and impact. The additional investment into the capacity of the People and OD Team once fully onboarded will support the ability to deliver on this strategy.

Which Committees have reviewed the information prior to Board submission?

- People and Organisational Development Committee, 25/03/22, Executive Team Meeting, 29/03/22

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

For approval

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Our people and culture strategy 2022 - 2025

Creating a great place to work

Foreword

Maidstone and Tunbridge Wells NHS Trust (MTW) provides acute hospital services (both general hospital services and specialist complex care) to around 590,000 patients.

This can only be achieved through the dedication and commitment of our outstanding people many of whom are also patients and users of our services, and take a great pride in what they do. We thank each and every one who has been part of our journey so far.

We employ a team of over 6,000 full and part time staff across our sites, supported by a team of dedicated and committed volunteers, having significantly invested in the workforce numbers over the last 12 months. Every single one of our employees, whatever their role, contributes to the delivery of high quality care and experience for the communities we serve.

We recognise and value this contribution and have listened to our people in the development of this strategy, through focus groups and engagement sessions, to understand what matters most to them.

This strategy outlines our commitments over the next three years to deliver our strategic goal through continuous improvement to create an environment where our people can thrive and be their best self at work.

Sue Steen
Chief People Officer

This is a strategy for our people, by our people.

Our people and culture vision

Creating an inclusive, compassionate and high performing culture where our people can thrive and be their best self at work.

The achievement of this vision is everyone's responsibility and our culture is something our patients and other stakeholders experience when they visit or connect with our services and what our people see hear and feel when they come into work. With this in mind, this strategy has been developed and informed through engaging with and listening to our teams to understand what really matters to them and enables the delivery of outstanding care in a great place to work. This ensures we are focusing on the things that people want us to improve and resolve.

Our strategic goal is that:

We will achieve continuous improvement to take MTW to the best place in the NHS Staff Survey amongst Acute Trust.

To achieve this, our people identified six strategic priorities:

Staff engagement and growth

We will listen to, enable and strengthen the staff voice and help people to develop and grow.

Supportive team behaviours

There will be a consistent experience of the Trust values in our teams and we will reward the right things.

Recruitment and resourcing

Through workforce planning and clear career pathways we will create a sustainable productive workforce.

Collective and compassionate leadership

We value effective and compassionate leadership at all levels, learning from experience and seeking continuous improvement.

Equality, diversity and personalisation

We will continue to champion respect of difference, ensure equity of opportunity and enable people to bring their best selves to work.

Health and wellbeing

We will take a holistic and preventative approach to health and wellbeing in caring for our people.

The future health and social care challenges are to some extent unknown and there are likely to be changing circumstances and therefore we will review this strategy annually to keep the focus current and most meaningful for our people.

Strategic context and known challenges

Our people tell us that we are already doing great things, but this isn't a consistent experience by everyone and we have further ambitions to be better.

The Trust Clinical Strategy was published in 2019 and this is an ideal time to re-fresh and re-focus our People and Culture priorities to enable this.

The strategy is being written at a time when our teams have faced tough challenges in responding to a pandemic for nearly two years and they have done so marvellously and selflessly to continue to care for our patients. We predict that there will be ongoing challenges and service pressures ahead in this regard with future waves, undiagnosed conditions and patient waiting lists.

This period has further emphasised the importance of health and wellbeing and flexibility for our people in terms of their work life balance. It has also the inequalities that exist in health which need to be addressed.

Recruitment and resourcing will continue to be challenging to fill existing and emerging roles and to proactively create a pipeline of suitably skilled staff for the future. Recent changes to freedom of movement across Europe and other parts of the world has increased this challenge and the cost of living for people is influencing social choices of working in our sector. We will need to attract people to MTW across all ages and re-balance the demography and age profile through attracting school leavers, and apprentices at entry level whilst recognising that people will also be working longer in their careers.

This will require creativity and flexibility in the roles we create.

There are structural changes in the NHS which devolves funding at a system level. We will work in partnership as a system to develop a sustainable workforce for the future that is representative of the communities we work with.

How it all fits together

We have targeted our priorities for this strategy based on the feedback from our people, and as a Trust we also commit to supporting the plans of our local system and national plans and expectations from NHS England and Improvement.

The National People Plan and People Promise

The NHS is the largest employer within the UK and The National People Plan 'We are the NHS' was published in 2020 setting out expectations for all Provider Organisations, and focusing on developing a culture of belonging, keeping staff safe, health and wellbeing and creating the workforce of the future, including new ways of working and recruitment and retention.

We support the NHS People Promise as a Trust and this ambition will be delivered through our People and Culture strategy.

We support the NHS People Promise as a Trust and this ambition will be delivered through our People and Culture strategy.

Our NHS People Promise

Our system – Kent and Medway People Plan

Locally we are adopting a 'system first' approach to how services are planned and provider organisations are working more closely together in collaboration than ever before. This will mean some of our people working across organisational boundaries and in collaboratives, which is a new way of working and requires ongoing development of a spirit and ethos of partnership and patient centred care.

Our System People Plan highlights the following priorities:

- Health and wellbeing
- Equality, Diversion and Inclusion (ED&I)
- System leadership
- Recruitment
- Retention
- Temporary staffing
- Growing for the future
- Planning for the future
- Digitally enabled and ready workforce

The system plan of work will include recruitment campaigns, international recruitment, workforce planning as a system, a virtual academy, flexible working and rostering, bank staff harmonisation, a preventative wellbeing hub, ED&I strategy and a system approach to talent.

These priorities will cross map with our strategic priorities. The system has capacity and resource to drive key initiatives and our Trust will benefit in economies of scale, lack of duplication, knowledge sharing and increased workforce supply and capacity.

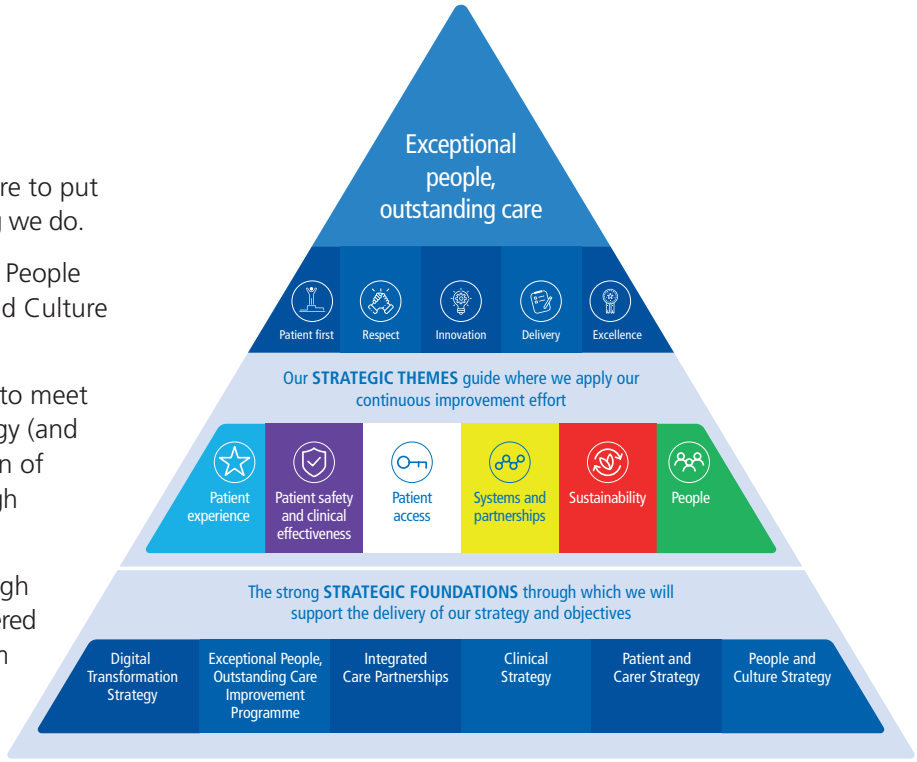
Our Trust

In 2018 we moved to a clinically-led structure to put our expert clinicians at the heart of everything we do.

Our Overarching Trust Strategy 'Exceptional People Outstanding Care' recognises the People and Culture Strategy as a key enabler for success.

We have cross referenced our people plans to meet the deliverables stated in the Clinical Strategy (and other Trust strategies) to ensure prioritisation of resources to achieve outstanding care through exceptional people.

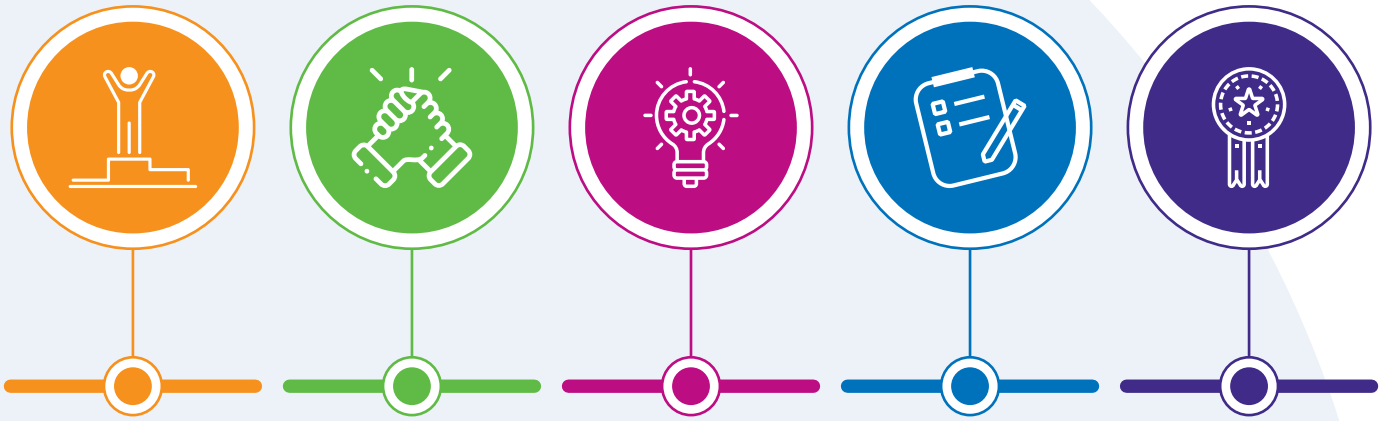
Previous work on culture assessments through culture change ambassadors has been considered in this re-fresh, along with feedback data from our national staff survey and quarterly climate surveys.



Our values

Our values are the things that we do not compromise on. They guide our decision making and set an expectation of the behaviours that our people exhibit (and experience) in the workplace.

These are implicit within the priorities identified and together, combined with our approach to systems and processes, create and define our culture.



Patient first

We always put the patient first.

Respect

We respect and value our patients, visitors and staff.

Innovation

We take every opportunity to improve services.

Delivery

We aim to deliver high standards of quality and efficiency in everything we do.

Excellence

We take every opportunity to enhance our reputation.

What our people are proud of and recognise

Our people tell us that we are already doing many things well and over 65% of our people who responded to the climate survey throughout 2021 said that they were likely or extremely likely to recommend MTW as a place to work.

We want to build on these successes to enable further development of our services and to proactively respond to the workforce challenges that we predict over the next three years.

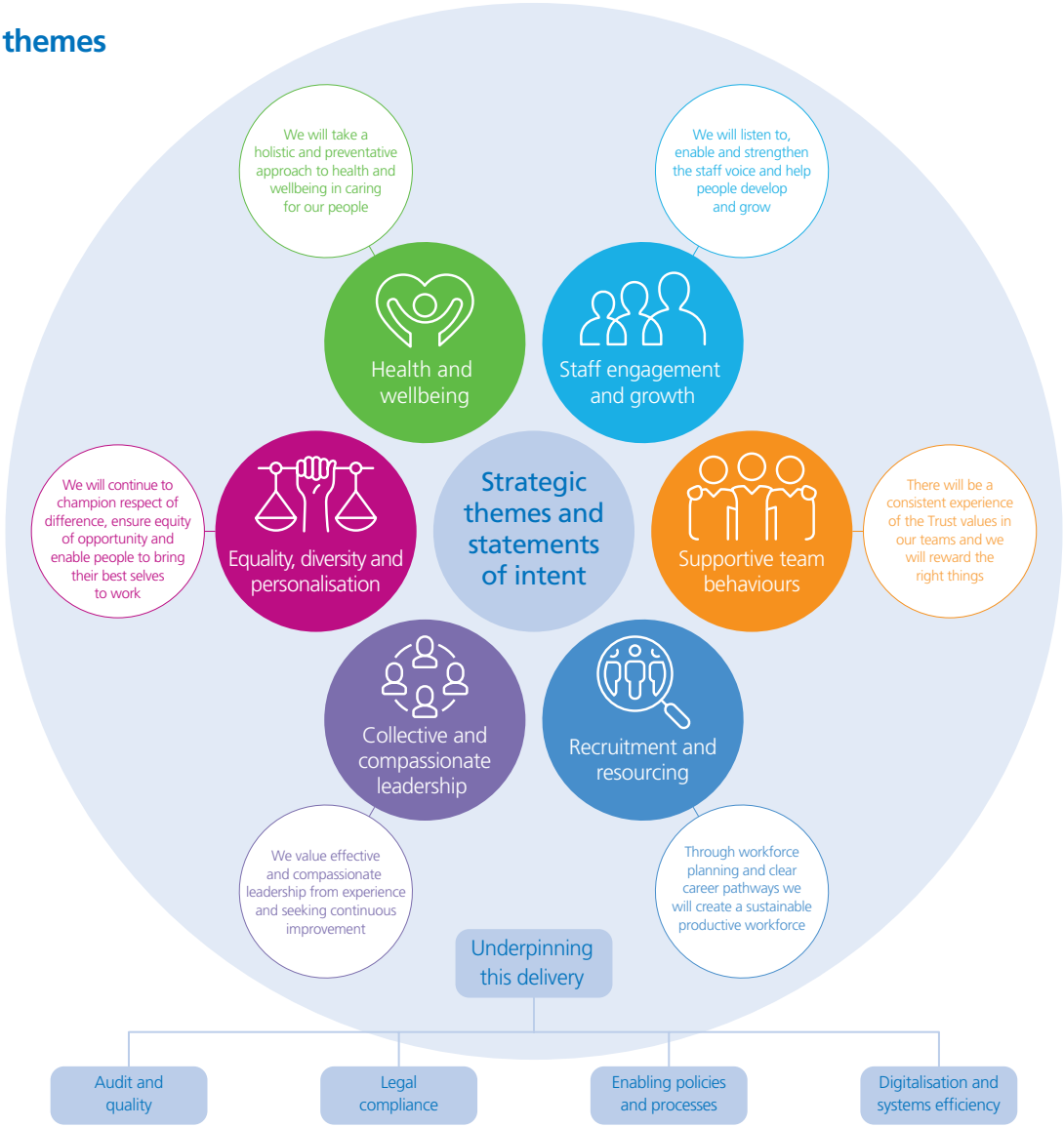
What we are proud of what we do well

Strategic themes for continuous improvement

To achieve our vision, we need to improve on the consistency of experience for our people and tackle areas (where individuals have a poorer experience than other colleagues) whilst recognising and learning from the good practice that exists.

Through engagement and feedback our people told us what they identify as the continuous improvement areas which have been grouped into the following key strategic themes (shown on next page). These are not stand alone and are interdependent with one another. When delivered collectively, they will take MTW to the best place in the NHS Staff Survey amongst Acute Trusts, creating a great place to work and further improve patient care.

Strategic themes



Each of these strategic themes will have an associated programme of work and be delivered through our operational teams.

Outcomes

Strategic goal

We will achieve continuous improvement to take MTW to the best place in the NHS Staff Survey amongst Acute Trusts.

Within each strategic theme, we have success markers and improvement outcomes which will be monitored through annual survey and quarterly climate surveys, heatmaps and workforce information data. A full workforce dashboard is outlined on page 24. The high impact improvement aims are:

- Be in the top quartile in our peer group in the national staff survey
- Improved retention levels and reduced voluntary turnover and vacancy levels ensuring sustainable services and safe staffing levels for our people and patients
- Improved engagement scores and effective team working (as measured by the staff and climate surveys)
- Consistency of experiences across our staff demographic groups and significant progress towards the WRES and WDES targets for our Trust
- Eradication of bullying and harassment creating an environment where people can deliver outstanding care and feel valued
- Reduced sickness absence through continuing to focus on health and wellbeing.

Staff engagement and growth

We will listen to, enable and strengthen the staff voice and help our people to develop and grow.

Our people tell us that they value the opportunity to make change happen, to innovative and share ideas and also the accessibility and availability of the Executive Team and Senior Leaders to share information in a meaningful way. This breadth and depth of knowledge and creativity will be facilitated further as an asset of MTW through a structured approach to staff engagement.

We define engagement as 'a positive relationship where staff are satisfied and enriched in their jobs and at the same time empowered and focused on the Trust goals'. This requires a clear vision and direction, support from line managers, aligned values and visibility of leadership.

The opportunity for job enrichment and personal development is also a significant factor in levels of engagement. As the Trust delivers the clinical strategy and develops innovative pathways of care, we will commit to continuing to invest in training and learning opportunities and continuing professional development, considering protected time and equal access for our people to participate.

The commitments we will make:

- Effective engagement is everyone's responsibility, but we will clearly define our expectations of roles and responsibilities in engagement
- We will implement annual engagement plans providing listening forums and all staff events to maintain dialogue and shared accountability for our Trust's Purpose
- We will provide feedback on how staff views have informed change and why (when appropriate) they can't be implemented
- We will create the capacity and improve accessibility to enable people to contribute to engagement whatever their roles (especially on the wards, remote workers and lack of IT access)
- We will support Divisions to use training needs analysis and effective development and delivery conversations to invest in the right personal development opportunities for growth
- We will work with the system to design and develop a Talent Management and Succession plan to strengthen internal and broader opportunities
- We will continue to provide resource so staff are confident and enabled with the 'freedom to speak up' with any concerns
- Offer extended roles and apprenticeship training to optimise the skill mix in our services.

We define engagement as 'a positive relationship where staff are satisfied and enriched in their jobs and at the same time empowered and focused on the Trust goals'.

Our three year plan

2022-23

- Implement a structured annual engagement plan.
- Use climate surveys to act quickly on feedback.
- Design and pilot inclusive talent management and a succession planning approach.
- Invest in additional advanced practitioner roles to support clinical service development.
- Review how we communicate with people across our organisation and across access including IT and language preferences.
- Design and pilot Executive Roadshows and open discussion forums for small staff groups.
- Increase uptake in surveys from under-represented groups.
- Scope and design appraisals into development and delivery conversations which focus on our values.
- Continue to build on the role of staff side and networks across the Trust.

2023-24

- Develop and roll out all staff listening events, leadership forums and co-production forums.
- Set and deliver local engagement forums.
- Continue to roll out talent management and succession planning.
- Build additional competency frameworks to the MTW portfolio to enable personal development pathways.
- Continue to develop executive roadshows.
- Widen access through use of learning technology and remote solutions.
- Back to the floor programme for Executive Team.
- Review and refine learning and development offer.
- Review of communication flows and team brief.

2024-25

- Continue all staff listening events and leadership forums.
- Rotational and development career pathways.
- Review and refine learning and development offer.
- Embed appraisals into development and delivery conversations and values based.
- Learning, Development and Education strategy developed.
- Strengthen staff voice through staff events.
- Pilot and review appraisals into development and delivery conversations and values based.
- Review and relaunch Trust values.

Our aims:

- → **Improved** perception of availability of learning and development.
- → **Improved** engagement scores: staff feeling listened to and valued; quality appraisals.
- → **Strong** career pathways and equitable access to promotion and development.

Supportive team behaviours

There will be a consistent experience of the Trust values in our teams and we will reward the right things.

Our people tell us how important effective team working and collaboration are for them (and increasingly so through the challenges of the last few years). Civility and mutual respect are fundamental to this. We spend a significant amount of time at work and we commit to focus on creating an environment where our staff can thrive and feel happy. This starts at a team level and involves all colleagues in the team as well as people leaders. Our core values provide a framework for the expectations of behaviours, but our people tell us that there isn't always a consistent experience across our teams.

Overall we are one team 'the MTW Team' but we recognise that within this there are sub teams, cross functional teams (and none are fully independent of each other). How collaboratively we work in and across our sub-teams directly impacts on the patient experience and outcomes, efficiency, and responsiveness of our services.

New system level teams will function to deliver care across organisational boundaries and we will provide organisational development to support staff working in this new way. There will be increasing levels of teams working in a blended way or working remotely and this will require new ways of working, communicating and developing collaborative cultures remotely to ensure staff don't feel excluded or isolated in their work.

Supportive behaviours are essential for a culture of safety, where decisions and actions are 'just' and staff feel safe to speak out about concerns.

The commitments we will make:

- To promote and reward behaviours aligned to our values without exception and hold people to account where there is a difference
- To provide focused team development in creating high performing teams and increase the level of team learning opportunities
- Ensure equity across team members including banding levels, site / location, professional groups and job roles
- Provide a programme of organisational and team development for system and place-based teams
- Recognise blended working will change the way some teams operate and provide guidance on how to ensure collaborative cultures remotely
- Identify connectivity lines for effective information sharing and set guidelines for effective meeting structures and communication in and across these 'streams'.

How collaboratively we work in and across our sub-teams directly impacts on the patient experience and outcomes, efficiency, and responsiveness of our services.

Our three year plan

2022-23

- Develop and pilot divisional OD plans for team development.
- Refresh our behavioural framework and summarise expectations of people leaders and civility within teams.
- Climate survey data to be integrated into the divisional performance management processes.
- High performing team development with Executive Team.
- Identify connectivity across teams and evaluate information flows and decision making.
- Review and design OD support for hybrid and remote teams.
- Review and pilot values-based recruitment.
- Onboarding of new HRBPs and introduction of new operating model.

2023-24

- Developed OD plans for team development across all divisions.
- Provide training for people leaders on developing cultures and managing remote / blended teams.
- Review staff reward and recognition schemes to re-enforce behavioural framework including awards.
- Review and develop schemes of delegation to enable local ownership of team ideas into action.
- Outline an effective teams' model as an internal diagnostic tool.
- Training for staff on teams and streams effectiveness.
- Monitor the speed of knowledge sharing and innovation spread through sub-teams.
- Review and develop 'one team runners'.
- Implement values-based recruitment across the Trust.

2024-25

- Introduce peer review scheme.
- Review team structures to improve productivity and staff acting to top of licence.
- Review and develop schemes of delegation to enable local ownership of team ideas into action.
- Review staff awards and recognition framework to introduce and champion team delivery.
- Continued delivery of high-performance teams development.

Our aims:

- → **OD programme** for each division.
- → **Reduction** in claims of bullying and harassment and improve the lived experience of our people.
- → **Improved** staff survey and climate score for team working and experience of organisational values.
- → **Aligned** staff awards to reward and recognise supportive behaviours and teamwork.
- → **Early** and informal conflict resolution.

Recruitment and resourcing

Through workforce planning and clear career pathways, we will create a sustainable productive workforce.

Our Clinical Strategy sets out clear ambitions for service development and new roles. We can be sustainable through proactive workforce planning, reviewing the skills, knowledge and job functions required and diligently building a pipeline of appropriate resources. Innovative pathways of care will require a transformation in the workforce including increased use of technology, a different skills mix and new roles.

We will work with the system to capitalise on building a strong employer brand for the area and the NHS and build on successful attraction campaigns promoting what MTW can offer. We know that the future of staffing will be competitive and difficult, so we will re-think partnerships with our local educators and other providers building on our existence as an anchor institution providing key employment opportunities to our local communities.

Through creating a great place to work, we are confident that retention levels will improve. To do this, we will seek feedback, monitor exit interviews and be increasingly flexible and personalised in the way that we contract with our people.

Our values will be implicit and embedded through our attraction and selection processes and appraisal, development and succession planning.

Our people highlight an opportunity to increase the availability of internal career pathways beyond the traditional hierarchies that exist. This will involve establishment reviews and consideration of new roles and skill mix. It will also consider not just recruiting for current vacancies but using data and trajectories and scenario planning to mitigate risks for the future.

The commitments we will make:

- Promote the Trust as a great place to work to ensure a healthy pipeline of people to meet our workforce needs
- Guide and participate in the system approach to developing an attraction campaign for the area
- Develop new career structures and pathways that provide greater flexible opportunities for existing staff enabling people to retrain and be re-deployed at different stages in their career
- Ensure equity across the whole employee lifecycle by monitoring protected characteristics and other EDI data setting aspirational goals for improvements
- Effective workforce planning and reporting annually for each Division
- Using the talent mapping and succession planning data to offer internal moves more easily and investment in development and qualifications for our people
- Define our brand as an anchor institution and offer increased entry and experience to the health service
- Increased flexibility in our contracts to provide opportunities for people at all stages of their careers
- Increase Divisional capacity and capability for analysis of workforce information making the right and timely choices for recruitment and resourcing.

Our values will be implicit and embedded through our attraction and selection processes and appraisal, development and succession planning.

Our three year plan

2022-23

- Develop and implement a workforce planning process and annual reporting cycle.
- Participate in system level recruitment drives and overseas recruitment.
- Increase social media presence and modernised recruitment and interview end to end processes.
- Resourcing incentives plans (e.g. retire and returners, referrals, flexible benefits, secondments, rotational posts).
- E-rostering roll out.
- System level agency agreements.
- Pilot and design values-based recruitment and widen training.

2023-24

- Rotational programmes developed for the system.
- Graduate, student and work experience programme expansion.
- Clinical and Non Clinical Career pathway reviews.
- Expand the 'one team runners' cohort of staff to improve flexible and responsive staffing cover.
- Open days, virtual hosting and cohort attraction campaigns.
- Divisional talent pools and succession planning / talent mapping to the next phase.
- Increased external local routes into the trust (apprentice and graduate schemes).
- Target and invest in internal sponsorship of professional qualifications (including apprenticeships).

2024-25

- Mapping roles for the future.
- Divisional workforce planning.
- System talent pool development.
- Flexible working pattern review and expansion.
- Explore automation and systems for managing rolling recruitment advertising.
- Shadow interviewing trials.
- Productivity review and job carving.

Our aims:

- → **100%** compliance against recruitment KPIs.
- → **Improved** experience of candidates and reduced time to hire.
- → **Reduced** vacancy levels.
- → **Reduced** bank and agency usage.
- → **Reduced** turnover and number of staff leaving within the first 12 months of employment.

Collective and compassionate leadership

We value effective and compassionate leadership at all levels, learning from experience and seeking continuous improvement.

Our people are passionate about leadership existing at all levels in their teams and this will be promoted through collective leadership principles. Collective leadership ensures empowerment of everyone in MTW to make decisions in their everyday work and levels of competence, to improve the experience for staff and patients. This requires an understanding and commitment from individuals to their Team and Trust goals so these will be communicated regularly and informed through engagement and co-production.

Inclusive and compassionate people leaders create the most conducive team culture and environment for people to thrive. They can seek to understand and improve reasons why some of our people have poorer experiences at work. We will provide training and guidance to embed these principles and broaden to consider virtual and hybrid teams. We will continue to take action where these attributes are not exhibited but ensure we provide the capacity for leaders to lead and grow.

It is through coaching and inclusion that we will encourage learning and continuous improvement, always seeking to drive change for the better. Our people recognise that there is the opportunity to do this and value this characteristic as being part of a great place to work. It is a leader's role not only to coach but to create an environment where coaching happens.

Through an inclusive and equitable approach to talent management, we will strengthen our pipeline of management and people leadership capability and define competencies required to be successful. We will also ensure that more senior roles are representative and unlock any career barriers some groups face and ensure fair access.

The commitments we will make:

- All managers/people leaders will undergo an induction to managing people at MTW so that expectations on them are clear
- Quality assure and monitor the competence of our managers and people leaders through a 360-degree feedback process (a skill review)
- Roll out the next phase of the exceptional leader's programme to facilitate consistency of experience across the organisation
- Making decisions about change efficient and responsive to encourage a climate of creativity and continuous improvements.

It is through coaching and inclusion that we will encourage learning and continuous improvement, always seeking to drive change for the better.

Our three year plan

2022-23

- Managers/people leaders' behavioural framework developed.
- Completion of the first level of exceptional leaders programme.
- Managers' induction programme developed.
- Outline the coaching culture required to deliver Exceptional People, Outstanding Care.
- Continuous improvement plans targeted training and processes.
- Internal coaching pool.
- Mediation training developed and rolled out.

2023-24

- All people managers to attend a development programme first cohort.
- 360-degree feedback process for managers first cohort.
- Managers' induction programme roll out.
- Increased graduate cohort intake.
- Review of non-clinical managerial posts, releasing time for care.
- Mentor programme pilot.
- Capacity planning for clinical managers.
- Provide skills needs assessment for innovation hubs and quality improvement initiatives.
- Ongoing Board and executive development.

2024-25

- All people managers to attend a development programme second cohort.
- 360-degree feedback process for managers second cohort.
- Training locally on QI methodology.
- Mentor programme roll out.

Our aims:

- → **A succession** plan and talent map for hard to fill posts and senior roles.
- → **Improved** survey score for support from line manager and manager taking care of wellbeing.
- → **Reduced** employee relations cases and more issues resolved informally through mediation and prevention.

Equality, diversity and personalisation

We will continue to champion respect of difference, ensure equity of opportunity and enable people to bring their best selves to work.

Diverse organisations deliver improved success and we are proud of the diversity we have in our Trust and our EDI strategy will address differentials in experience and inequalities where they exist. We have a proactive equality, diversity and inclusion agenda which we will build on over the next three years and add a focus on the concept of personalisation which recognises that whilst being equitable, fair and operating within the boundaries of UK employment law, there is opportunity to be flexible to an individual's circumstance and make person-centred decisions which are empathetic and inclusive.

This principle of respecting difference is implicit within our Trust Values and we want everyone to feel valued and respected. It also cuts across the other aims of this strategy and wider operational policy and process, creating an inclusive culture and one that enables our people to bring their best selves to work.

Through publishing and reporting on our Workforce Race and Disability Equality Standards and from our staff surveys and freedom to speak up information, we know some staff groups are more likely to be involved in disciplinary cases and investigations than others and we will seek to understand the reasons for this and reduce unwarranted and disproportionate sanctions across all protected characteristics. For some of our people, they report different experiences of workplace conflict, bullying and harassment and this strategy will continue to address this and not accept or tolerate these inequalities.

Our people tell us that they want to see increasing levels of respect from colleagues beyond protected characteristics for example banding levels, place of work professional groups and job roles, so that everyone feels valued and recognised as a contributor to patient outcomes and experience without negative bias or judgement.

We will educate and promote this through networks, mentors, engagement forums and learning and development programmes. We will evaluate and monitor our data to act swiftly on evidence that suggests otherwise.

The commitments we will make:

- Insist on a culture of equity and inclusion where all staff expect and respect difference
- Consider individual differences and experience as we make people-centred decisions at work
- Publish and deliver on our WRES and WDES and Gender Pay Gap action plans and monitor this at a divisional level
- Strengthen and promote our staff networks to strengthen their voice and improve knowledge and understanding about individuals' lived experience and different privileges
- Undertake equality impact assessments across all people policies and processes and demand equity of access and opportunity irrespective of difference and beyond protected characteristics
- Re-focus investigations and handling of conflict through early intervention and mediation.

This principle of respecting difference is implicit within our Trust Values and we want everyone to feel valued and respected.

Our three year plan

2022-23

- Set and Monitor WRES and WDES and gender pay gap data across Divisions.
- Invest in a network lead development programme.
- Include self-nomination in succession planning opportunities.
- Early intervention and mediation process.
- Widen work with kick start, Mind, Princes Trust, supported employment and disability confident standards.
- Ally programme expansion.
- Reverse mentoring programme expansion pilot.
- Interview skills for BAME and Disabled staff.
- Disability leave policy.
- Implementation of the Race code 2020.

2023-24

- Audit of objective assessments.
- Roll out disability confident and job carving training for hiring managers.
- Cultural awareness training in teams cohort one.
- Annual WRES and WDES and EDS Plan.
- Evaluate the central budget for reasonable adjustments.
- Continued implementation and review of the code requirements.
- Ethnicity pay gap reporting.
- Expansion of reverse mentoring programme.
- Implement WRES targets at divisional level.

2024-25

- Annual WRES and WDES and EDS Plan.
- Cultural awareness training in teams cohort two.
- Ethnicity pay gap reporting.

Our aims:

- → **Improved** WRES, WDES and gender pay gap targets.
- → **Reduced** levels of perceived difference in experience of our people and discrimination.
- → **Improved** perception of fairness in career progression.

Health and wellbeing

We will take a holistic and preventative approach to health and wellbeing in caring for our people.

We have a duty of care as an employer to ensure that our people are safe in the workplace and our aim is also to ensure that our people feel well (physically and psychologically) and are appropriately supported in their roles. In line with the national people plan, we have appointed a guardian and will ensure all staff have wellbeing conversations to promote early identification of potential concerns.

Demographically, there are shifting health issues presenting in people of working age (a factor which is also increasing). The impact of home and remote working will also play a part in the changing needs of our people in the timeline of this strategy. We will build on the evidence-based model that was introduced during previous Covid-19 surges using a stepped-care model helping staff develop self-awareness and self-care practices and ease of access to appropriate help and support.

We will take a holistic approach to wellbeing which starts with a collaborative and respectful team climate and compassionate and caring support from people leaders. They will be the custodians of the Trust Values and ensure that without exception they are creating the right environmental support. Alongside this, we will provide rapid access to occupational health and psychological support where needed and build in capacity for restorative supervision and building resilience.

We will improve the access and variety of preventative wellbeing activities that will refresh and re-energise staff and promote a sense of belonging and community spirit. This will be evaluated and re-developed annually, focused on the needs of our teams.

We recognise that with staffing pressures and vacancies, we need to undertake regular risk assessments and be realistic about the capacity in people's roles and ensure breaks, rest and annual leave are taken. We will continue to invest in the physical environment and availability of resources and equipment that enable people to deliver their roles to the best of their ability.

The commitments we will make:

- Listen to staff concerns around wellbeing and work pressures and consider this in the requests we make of people
- Improve accessibility to preventative wellbeing initiatives
- Proactively support staff to build self-awareness and self-care practice
- Train our people leaders in their role in health and wellbeing and develop these as expectations in the behavioural framework of our managers and leaders
- Provide team development and psychological support to build resilience and collaboration
- Ensure specialist occupational health services are readily available
- Promote and refine our employee assistance programme
- Create and nurture a sense of togetherness and community
- Promote psychological safety in the workplace so that our people feel safe to share their concerns.

We will take a holistic approach to wellbeing which starts with a collaborative and respectful team climate and compassionate and caring support from people leaders.

Our three year plan

2022-23

- Health and wellbeing annual programme.
- Activity and access to support and facilities through the wellbeing lounges.
- Schwartz rounds expanded.
- Support circle facilitation.
- Psychological support for teams (tier 1 – 4).
- Health and wellbeing conversations.
- Review of supervision trees.
- OH specialist nurse training programme.
- Review use of Mental health first aiders.
- Onlyhuman campaign rollout and evaluation.
- Review and scope use of health apps.
- Flexible working, leave and benefits packages scoped.
- Increased support and offering for team debrief following traumatic events.

2023-24

- Capacity and work level programme.
- Health and Wellbeing guardian programme.
- Estates plan to review rest rooms, hubs, prayer rooms and collaborative space.
- Implement actions from best practice review.
- Further development of wellbeing partners providing increased team services.
- NHSEI Wellbeing guide self-assessment and action plan, benchmarking.
- Flexible working, leave and benefits packages piloted.
- Clinical psychologist team providing post-pandemic recovery support.
- Roll out use of health apps.
- Review leave year to reduce pressure points in the year.

2024-25

- Evaluation of offer, including exploration of regional partnerships.
- Flexible working, leave and benefits packages embedded.
- EAP offer review.
- Annual risk assessments for staff.

Our aims:

- → **Increased** resilience.
- → **Reduction** in sickness absence and long term sick.
- → **Achieve** mandatory training target.
- → **Improved** score staff survey organisation taking concern for wellbeing.

Underpinning this strategy:
High quality, responsive People and OD service delivery

Although this strategy is organisationally owned, the People and OD Team will continue to develop their service offer to be responsive, effective, efficient and proactive in supporting its delivery.

The team exist to support clinical and corporate teams to deliver outstanding care.

The structure of the function will be informed by the 'NHS National Guidance on the Future of HR & OD' and also national best practice guidelines. This will include being appropriately resourced and structured to support clinical and corporate teams to deliver the best patient care, with ongoing development for the team including continuing professional development, legal updates and effective business partnering. This includes strong and effective relationship working with staff side and union/ professional bodies who represent employees through recognised unions.

Operating model

Our business partners will work closely with leadership and clinical teams to help build people capabilities, understand local aspirations and commission additional support, flexible to specific needs. This is achieved through developing meaningful relationships with key people and teams across the organisation, using data to inform priorities and delivering a portfolio of business relevant solutions that meet evolving needs.

People managers (line managers) resolve a large number of HR queries and have direct impact on staff satisfaction day to day. They have a high level of involvement in and accountability for people management and people risk mitigation by adhering to policies. This will increase with more self service functionality. Their needs shape the people priorities and service offer.

Operational services are customer focused considering timeliness, efficiency, operational excellence and continuous improvement. This includes key touchpoints across the whole employee lifecycle. Using data analysis, workforce information, automation and specialist knowledge to drive excellence.

Centres of expertise create workforce programmes and solutions based on user insights, research and best practice. They provide thought leadership and subject matter expertise (e.g. recruitment, learning and development, OD, reward, employee relations). Collaborate and integrate with business partners to develop relevant and desirable solutions to develop capacity to drive change and continuous improvement.

The team will have annual detailed operational delivery plans for:

- Health and Wellbeing
- Recruitment and Resourcing
- Education, Learning and Development (including induction and stat/man)
- Talent Management
- Staff Engagement
- Equality, Diversity, Inclusion and Personalisation
- OD (including culture, values and leadership)
- Reward and recognition
- Workforce Intelligence (including workforce planning)
- Digitalisation.

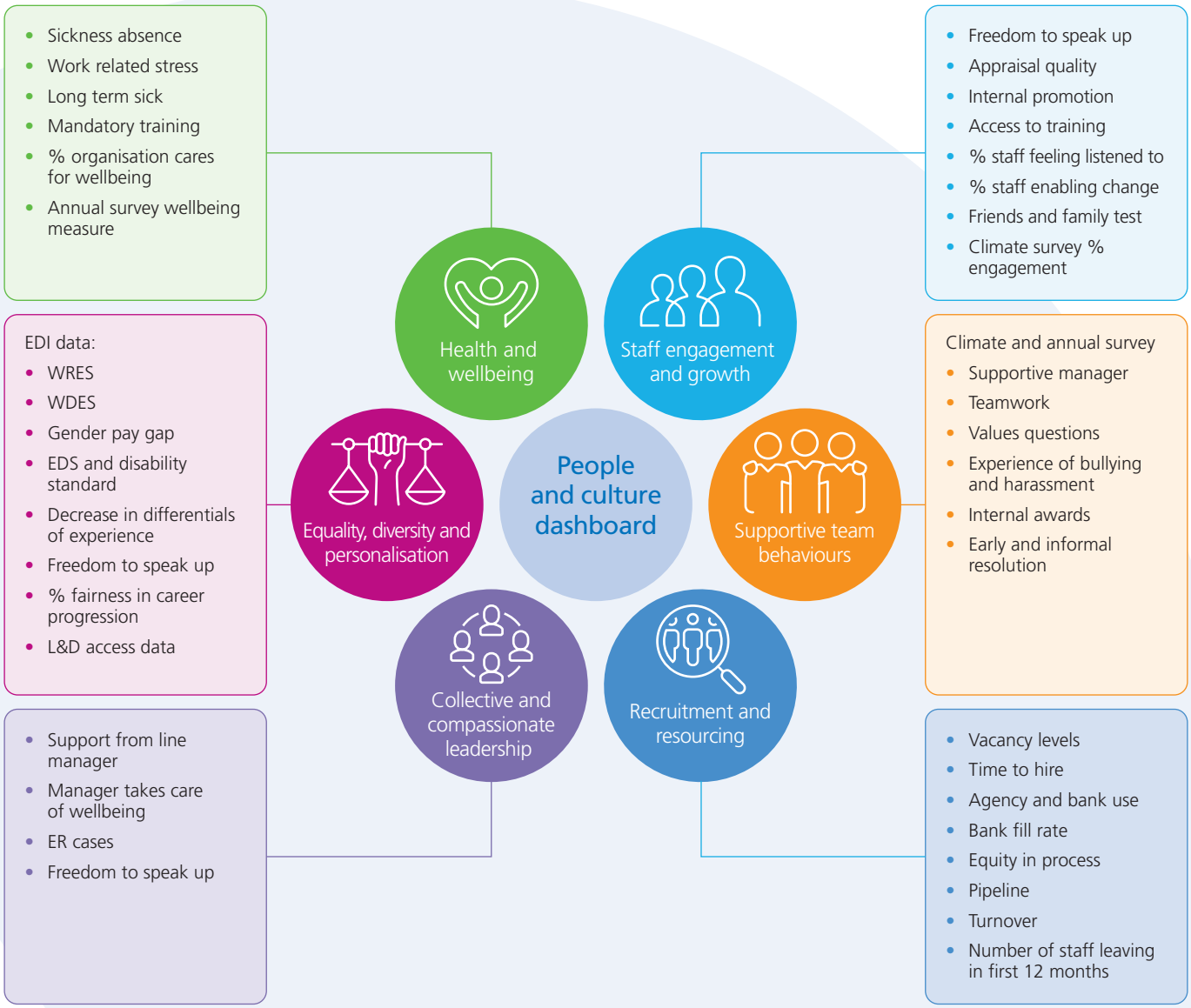
Through these plans, the vision for the People and OD Team is:

- To develop an employer brand and reward package that attracts, appoints and retains the best
- To develop effective and equitable resourcing informed through robust workforce planning and rostering to ensure sustainable services delivering outstanding care and fit for the future
- To ensure a focus on quality standards through expert advice, audit, risk management, regulatory requirements, data accuracy, responsive operational HR services, evaluations and quality improvement to enable teams to deliver the best for patients
- To embed an inclusive culture consistent with the Trust values where staff are engaged and leaders are developed as enablers of the strategy
- To offer clear career pathways, succession plans and opportunities for development and re-training to increase knowledge and capability in the organisation irrespective of an individual's role
- To improve the retention of staff through developing a great place to work where people feel valued listened to, safe to speak out and supported
- To focus on staff health and wellbeing at work and the effective and equitable management and advice for people policies
- To support clinical and corporate teams to deliver their business plans and transformation through high quality responsive provision and in partnership with trade unions
- To ensure decisions are informed and evaluated by accurate and timely analysis of workforce information
- Working in partnership with the system; develop a pipeline fit for the future ensuring sustainability of our clinical services.

These objectives will be monitored, evaluated and reported to the Executive Management Team; the People and OD Committee and the Trust Board as part of the Trust Governance/Leadership Structure. There will be additional workforce information available to inform annual priorities and review workforce trends. The team will produce an annual workforce report on this basis, making recommendations for the future investment priorities.

Governance and the people dashboard

The measures of success and progress on deliver will be measured through the people dashboard which will be reported through the People and OD Committee (a sub-committee of the Trust Board). There will also be key people measures within the Divisional Performance Dashboards.



Analysis of the data will enable proactive focus on 'hot spot areas' to facilitate corrective action at pace and to evaluate the success or learning from targeted interventions.

Conclusion

Delivering the People and Culture Strategy will improve working lives for everyone employed at MTW and improve the experience and outcomes of the patients and communities we provide care for.

The Strategy is trustwide and everyone has a part to play in making MTW a great place to work where people can thrive and be their best selves.

With support from everyone and through operational delivery plans we will:

Provide sustainable services and outstanding care through exceptional people.

Appendix: Cross-mapping Trust priorities with national and system level aims

	NHS strategic themes						
	Staff engagement and growth	Supportive team behaviours	Recruitment and resourcing	Collective and compassionate leadership	Equality, diversity and personalisation	Health and wellbeing	Underpinning Functional Operations
NHS people promise							
We are a team		✔					✔
We work flexibly			✔		✔		✔
We are always learning	✔			✔			✔
We are safe and healthy			✔			✔	✔
We have a voice that counts	✔						✔
We are recognised and rewarded		✔				✔	✔
We are compassionate and inclusive	✔			✔	✔		✔
System priorities							
Supporting developing people professionally							✔
Improvement, change and innovation	✔			✔			✔
Digital-enabled solutions							✔
Prioritising health and wellbeing						✔	✔
Ensuring inclusion and belonging	✔				✔		✔
Great employee experience	✔	✔	✔	✔	✔	✔	✔
Harnessing talents of all our people	✔			✔	✔		✔
Enable new ways of working and planning for the future	✔		✔				✔

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

05.2022 – 261-V3

NHS Provider licence: Self-certification for 2021/22 **Chief Executive**

The Health and Social Care Act 2012 introduced a licence for providers of NHS services. The NHS Provider Licence was subsequently introduced in February 2013 as the main tool with which providers of NHS services would be regulated. Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014. It was later confirmed that the Licence would *not* apply to NHS Trusts, but in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption from needing to hold the Licence, directions from the Secretary of State required NHSI to ensure that NHS Trusts comply with conditions equivalent to the Licence, as it deemed appropriate. As NHSI's Single Oversight Framework based its oversight on the Licence, NHS Trusts were legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

NHS Trusts were required to undertake self-certification for the first time in May 2017 (covering 2016/17), and have been required to self-certify each year since then. Specifically, NHS Trusts are asked to self-certify that they have:

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (licence condition G6(3));
- Complied with governance arrangements (licence condition FT4(8))

It is up to providers how they undertake their self-certification, but any process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance. NHS England/Improvement (NHSE/I) provide templates which Trusts can (but are not obliged to) use.

NHS providers must self-certify against condition G6 by 31/05/22 and against condition FT4(8) by 30/06/22. Providers must then publish their G6 self-certification by 30/06/22 (the publication is itself a licence condition). NHS Trusts are not required to submit their self-certification declarations to NHSE/I unless specifically requested to do so. NHSE/I usually retains the option of contacting a select number of NHS Trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off.

The proposed self-certification, which uses the template provided by NHSE/I, is enclosed. The Trust Board is asked to review, and approve, the content. Ordinarily, the Board would receive the Annual Report, which contains the Annual Governance Statement (AGS), at the same meeting it considered the self-certification (under a separate agenda item), and the Annual Report and AGS would usually provide sufficient information and supporting evidence to enable the Board to self-certify that the Trust has been compliant with all relevant licence conditions. However, as the timetable for the Annual Accounts was again delayed due to the COVID-19 pandemic, the Board will not see the draft Annual Report for 2021/22 until its meeting on 16/06/22. Ideally, the self-certification process would be deferred to that meeting, but as the self-certification timescale has not been changed, a draft version of the AGS has been included in this report, to support the proposal that the Trust Board self-certify that the Trust has been compliant with all relevant licence conditions. This same approach was taken for the self-certification for 2020/21, which the Trust Board approved in May 2021 (i.e. before it then approved the Annual Report for 2020/21 on 24/06/21).

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Review and approval of the proposed self-certification for 2021/22

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2021/22

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Refer to the content of the draft 2021/22 Annual Governance Statement for full details (see Appendix 1)
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Refer to the content of the draft 2021/22 Annual Governance Statement for full details (see Appendix 1)
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Refer to the content of the draft 2021/22 Annual Governance Statement for full details (see Appendix 1)
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Refer to the content of the draft 2021/22 Annual Governance Statement for full details (see Appendix 1)
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Refer to the content of the draft 2021/22 Annual Governance Statement for full details (see Appendix 1)
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Refer to the content of the draft 2021/22 Annual Governance Statement for full details (see Appendix 1)

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Miles Scott

Signature _____ **Name** David Highton

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A N/A

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2021/22

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	N/A

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account i particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	N/A

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available t it for the period of 12 months referred to in this certificate.	N/A

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

N/A - Maidstone and Tunbridge Wells NHS Trust is not a Foundation Trust.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Miles Scott	**Name**	David Highton
Capacity	Chief Executive	**Capacity**	Chair of the Trust Board
Date	26th May 2022	**Date**	26th May 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

Appendix 1: Annual Governance Statement (AGS) for 2021/22

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Maidstone and Tunbridge Wells NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Maidstone and Tunbridge Wells NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The ways in which leadership is given to the risk management process

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. The overall Executive Lead for risk management is the Chief Nurse, who is supported in this role by a range of staff, including the Trust Secretary and Risk and Compliance Manager. A number of specific risk-related roles are also held by Trust Board Members, as follows:

- The Chief Nurse is the Senior Information Risk Owner (SIRO).
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation).
- The Chief Executive is the Board Level Director (with fire safety responsibility)[1].
- The Chief Operating Officer is the Security Management Director[2] and the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[3].
- The Chair of the Audit and Governance Committee is the security management Non-Executive Director (NED) champion[2].
- The Chair of the Quality Committee is Maternity board safety champion.

The Trust has a Risk Register in place, which is subject to an annual review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2021/22 gave an overall assessment of TBC *[N.B. the outcome is not available at the time this Statement was drafted]*.

The ways in which staff are trained or equipped to manage risk in a way appropriate to their authority and duties (including the guidance provided to them and the ways in which the Trust seeks to learn from good practice)

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. In addition to the Trust's Risk Management Policy and Procedure, a comprehensive range of risk management policies and guidance is made available to staff. This includes the policies and procedures for risk assessment, incident reporting, managing complaints, investigation of incidents, health and safety, and 'being open' to staff and patients (to

[1] Required by "Firecode – fire safety in the NHS. Health Technical Memorandum 05-01: Managing healthcare fire safety"
[2] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"
[3] Required by The Health and Social Care Act 2012

support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Quality Governance department includes patient safety/clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); legal services; and research and development. The systems to oversee staff health and safety are managed via the Estates department, but there is close liaison with other relevant staff. In addition, Directorates and sub-specialities have clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialties.

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish) via a range of methods, including via the Freedom to Speak Up Guardian or their Deputy; being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling. Non-mandatory training is also available to staff on a wide range of issues relating to risk management, both general (e.g. risk assessment) and in response to specific risks (e.g. falls prevention), whilst in-house support and advice on risk management is also available (which includes advice relating to patient safety, health and safety, Emergency Planning & Response and information governance. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS).

The Trust's advisers on risk seek to learn from best practice from a variety of means, including continuing professional development and via networking with counterparts from other organisations.

The risk and control framework

The key elements of the Risk Management policy (including the way in which risk (or change in risk) is identified, evaluated, and controlled; and how risk appetites are determined)

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. Mitigations are aimed to be identified in advance (where appropriate), so that these can be applied should the identified risk materialise. Most risks are identified at local level and initially managed by department managers. Identified risks are added to the Risk Register and are then either managed locally or escalated through the Trust's management and/or committee structure. The Trust's competent persons (individuals with specialist skills, knowledge and qualifications that are assessed by external bodies who are able to advise managers and employees on all aspects of health, safety and risk) identify hazards within their area of expertise, and undertake Trust-wide risk assessments for hazards that affect multiple areas. Risks are identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents, which includes grading risks for their potential impact and likelihood of harm using a standard Risk Categorisation Matrix. The risk score determines the priority, response and level of management required to manage the risk. Risk appetite is the level of risk the Trust will accept for a particular type of risk. When a risk is assessed the uncontrolled risk score is determined, along with a target risk score, which indicates the risk rating that would be considered as satisfactory. This target risk score should be set as high as can be tolerated, and constitutes the risk appetite for that risk.

The key elements of the quality governance arrangements (including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with Care Quality Commission (CQC) registration requirements)

The Trust's Quality Governance arrangements are overseen via the Quality Committee, which receives a report from each Division whenever it meets in its 'main' form[4]. The Quality Committee then aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care (as well as oversee quality within the clinical divisions).

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Clinical Audit Overview Committee. The investigation of, and learning from, incidents are predominantly managed within Directorates and discussed at Divisional, Directorate and specialist clinical governance meetings. Serious Incidents (SIs) are discussed and monitored at a corporate level via the Learning and Improvement (SI) Panel, and an SI report is submitted to each 'main' Quality Committee.

Complaints are managed by the central complaints team in partnership with the relevant Directorates and Divisions. The rate of new complaints and percentage of complaints responded to within target are monitored monthly at the Trust Board, while detailed reports on Complaints and Patient Advice and Liaison Service (PALS) contacts are received by the 'main' Quality Committee and also the Patient Experience Committee.

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017 (which resulted in an overall assessment of "Requires Improvement"). However, regular engagement events have taken place with the CQC during 2021/22. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been covered by these events.

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's 'business as usual' quality improvement agenda, and overseen by a Quality Improvement Committee, which is accountable to the Executive Team Meeting (ETM) via the Chief Nurse. The ETM and 'main' Quality Committee receive regular reports on progress with the Trust's ambition to achieve an "Outstanding" rating by the CQC.

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the National Data Guardian's ten data security standards. That assessment is primarily done via the Data Security and Protection Toolkit, and the Trust made a "Standards Met" Toolkit submission for the 2020/21 year in June 2021. The Trust is required to make its submission for the 2021/22 Toolkit by the end of June 2022.

Brief description of the organisation's major risks (including how they are/will be managed and mitigated and how outcomes are/will be assessed)

The objectives for 2021/22 were approved by the Trust Board in April 2021, and were grouped under six "strategic themes": People; Patient Safety & Clinical Effectiveness; Patient Access; Patient Experience; Systems; and Sustainability. Each theme had a "Problem Statement", "Vision statement", and "Target and goal" (which later evolved into "Breakthrough objectives").

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the monthly Integrated Performance Report (IPR), the format of which underwent a significant transformation during 2021/22. In addition, a number of risks were rated as 'red' in 2021/22. Red-rated risks are reviewed and validated at the ETM (see

[4] The Quality Committee meets monthly, with each alternate month being a 'main' meeting (which involves a broad membership and discussion of a wide range of subjects) or a 'deep dive' (which involves a smaller membership and discussion of a small number of targeted subjects)

below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2021/22, and each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

Are the Trust's services well-led (under NHS Improvement's well-led framework)?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2022/23.

The principal risks to compliance with the NHS provider licence, condition 4, and actions identified to mitigate these risks

In May 2021, the Trust Board completed the required self-certification (for 2020/21) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement for 2020/21. The Trust Board will be asked to undertake the required self-certification for 2021/22 at its meeting in May 2022, and it will again be proposed that full compliance be confirmed.

The key ways in which risk management is embedded in the activity of the organisation

As noted earlier in this Statement, risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure, and a range of supporting systems and processes are in place to embed risk management activity. For example:

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling.
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Quality Governance department).
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning and Cost Improvement Programme (CIP) arrangements, via the Quality Impact Assessment (QIA) process.

The key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place (which assure the Trust Board that staffing processes are safe, sustainable and effective)

The Trust complies with the "Developing Workforce Safeguards"[5] recommendations via the following methods:

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[6] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHS England/Improvement (NHSE/I) along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission.
- The ETM received regular updates during 2021/22 on progress against the Trust's recruitment plan.

[5] "Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing" (NHS Improvement, October 2018)
[6] "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (National Quality Board, July 2016)

- Service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse.
- The Trust Board reviews workforce metrics on each month, via the IPR, to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.
- The Trust's People and Organisational Development Committee (a sub-committee of the Trust Board, which is chaired by a Non-Executive Director) meets every month. The Committee provides assurance to the Board in the areas of people development, planning, performance and employee engagement, and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success.

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the CQC.

Register of interests

The Trust has an established "Gifts, hospitality, sponsorship and interests policy and procedure". However, it has not yet implemented NHS England "Managing Conflicts of Interest in the NHS" guidance and has not therefore published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance. The Trust's Audit and Governance Committee (which receives reports of declarations made under the "Gifts, hospitality, sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, which the Trust intends to implement in full in 2022/23.

NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Obligations under equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has plans in place which take account of the "Delivering a Net Zero Health Service" report under the Greener NHS programme. This is primarily driven via the Trust's Green Plan, which was approved by the Trust Board in May 2021, and is scheduled to be approved next in June 2022.

Review of economy, efficiency and effectiveness of the use of resources

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the People and Organisational Development Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2021/22. The Trust's annual Internal Audit

plan for 2021/22 included a range of reviews relating to this area, including “Critical Financial Assurance – Financial Accounting and Non Pay Expenditure”, and “Critical Financial Assurance – Payroll”, which achieved overall assessment of “Reasonable Assurance”.

Information governance

The Trust had three serious incidents involving personal data that met the criteria for reporting to the Information Commissioner’s Office (ICO), as described within NHS Digital’s Data Security and Protection Toolkit, during 2021/22. All three were subject to an internal investigation and remedial action was taken. The ICO confirmed it was satisfied that appropriate measures were taken for all three incidents.

Data quality and governance

The controls in place to ensure the accuracy of data (including the quality and accuracy of elective waiting time data)

The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- The Trust has a Data Quality Steering Group, chaired by the Deputy Chief Executive/Chief Finance Officer.
- The Trust has a “Patient access to elective care policy”, which covers the management of waiting lists at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those relating to data quality.
- The Trust also has an “Information Lifecycle Management Policy and Procedure”, which describes the Trust’s general approach to data quality; and a Data Quality Strategy, which has been developed by the Data Quality Steering Group to ensure alignment with NHS Digital’s Provider Data Quality Assurance Framework.
- There is a validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data.

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of “Data Quality of Key Performance Indicators”, which forms part of the Internal Audit plan each year. The “Data Quality of Key Performance Indicators” that was undertaken as part of the 2020/21 Internal Audit plan (and which was issued in July 2021) covered clinic cancellations less than 6 weeks and 18 Weeks Referral to Treatment (RTT) incomplete pathway indicators, and gave an overall assessment of “Reasonable Assurance”.

In addition, the Trust’s contract with the Clinical Commissioning Group (CCG) includes a requirement to have a Data Quality Improvement Plan (DQIP). The governance processes defined in the contract mean that any data quality issues relating to our RTT or cancer waiting times can be raised and resolved via that route. The Trust’s commissioners receive copies of the Trust’s performance reports, as well as information provided to them via NHSE/I, to support the performance management of the Trust’s services (with the aim of ensuring the achievement of key targets such as the RTT and cancer waiting time standards). Any associated data quality issues are raised as part of this dialogue and are managed via the technical groups established under the contract and documented in the DQIP. Furthermore, all trusts now have to submit a weekly copy of their RTT waiting list (Patient Tracking List, or PTL) to NHSE/I and they have developed a Data Quality assurance report that is linked to this called “LUNA”. All Trusts had the target to reach an RTT PTL confidence level of 95% by December 2021. The Trust achieved this standard and at the end of 2021/22 the confidence level stands at 99.38%.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within

Maidstone and Tunbridge Wells NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit and Governance Committee and Quality Committee and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Head of Internal Audit Opinion for 2021/22 states that "TIAA is satisfied that, for the areas reviewed during the year, Maidstone and Tunbridge Wells NHS Trust has reasonable and effective risk management, control and governance processes in place. This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by Maidstone and Tunbridge Wells NHS Trust from its various sources of assurance".

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Trust Management Executive (TME), Finance and Performance Committee, People and Organisational Development Committee, and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2021/22 resulted in an overall 'Reasonable assurance' assessment, one led to an assessment of 'Limited assurance'. This related to Estates Procurement, and the Director of Estates and Facilities was invited to attend the Audit and Governance Committee meeting on 03/11/21 to respond to the review.

The role of the Trust Board in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting). All but one of Trust Board's meetings in 2021/22 were held 'virtually', as a result of the COVID-19 pandemic, and the requirement to meet in public was met via the Trust Board's meetings being broadcast live on the internet, via the Trust's YouTube channel. The agenda and reports for all 'Part 1' Trust Board meetings are available via the Trust's website.

The agenda for Trust Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key part of the information the Board receives at each meeting in public is an IPR, which contains up-to-date details of performance across a range of indicators.

The role of the Trust Board's sub-committees and other key forums in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board operates with the following sub-committees (which are listed alphabetically):

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control; oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a Non-Executive Director, and meets five times each year (including a

specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other Non-Executives Directors (apart from the Chair of the Trust Board) are members.

- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a Non-Executive Director, and usually meets three times per year, although it met five times during 2021/22.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, and meets monthly.
- The Patient Experience Committee. This considers the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations. The Committee is chaired by a Non-Executive Director, and meets quarterly. In addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.
- The People and Organisational Development Committee. This provides assurance to the Board in the areas of people development, planning, performance and employee engagement; and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success. The Committee is chaired by a Non-Executive Director and meets monthly.
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a Non-Executive Director and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of members of the Executive Team; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met three times during 2021/22).

Although not a Trust Board sub-committee, the ETM enables key clinical and managerial issues to be discussed, debated, developed, scrutinised, monitored and agreed and/or approved. The ETM meets every week, is chaired by the Chief Executive and its membership comprises all members of the Executive Team, the five Divisional Chiefs of Service, the Deputy Medical Director and the Director of Estates. The ETM is authorised to make decisions on any matter that is not reserved for the Trust Board or its sub-committees.

The TME, which meets quarterly, supports the delivery of robust risk management policies and processes and the identification and addressing of all key risk issues. The meeting is chaired by the Chief Executive and its membership comprises circa 50 senior clinical and managerial leaders from across the Trust.

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, an Infection Prevention and Control Committee; a Health and Safety Committee; a Drugs, Therapeutics and Medicines Management Committee; an Information Governance Committee; and a Joint Safeguarding Committee.

Significant internal control issues

The following significant internal control issues[7] have been identified in 2020/21:

1. Four "Never Events" were declared at the Trust in 2021/22. These related to a wrong side nerve block in theatres; a mis-placed nasogastric (NG) tube within Medicine and Emergency Care; a retained swab following a caesarean section in the delivery theatres; and a retained guide wire in surgery / Intensive Care Unit (ICU). The incidents were subject to scrutiny through the SI investigation process, and the Quality Committee, to aim to ensure that lessons were learnt to prevent recurrence.
2. In December 2021, HM Coroner issued the Trust with a Regulation 28 ("Report to Prevent Future Deaths") report, following the Inquest into the death (in October 2021) of one of the Trust's patients. HM Coroner identified some factors that they regarded as a "gross failure to provide basic medical care that would have prolonged but probably would not have saved [the patient's] life". The Trust duly wrote to HM Coroner in January 2021 to explain the actions that had been taken, and would be taken in the future, to learn from the incident, and prevent it from recurring.
3. On 15/12/20, Kent Police notified the Trust of their inquiries relating to a former Trust/Interserve/Mitie employee, David Fuller, committing offences under the Sexual Offences Act 2003 in the mortuary at Tunbridge Wells Hospital. Fuller subsequently pleaded guilty, on 08/10/21, to a range of offences against 78 identified deceased persons within the mortuaries at Tunbridge Wells Hospital and the now-closed Kent and Sussex Hospital. Fuller's mortuary-related offences were made public on 01/11/21 and on 08/11/21, in an Oral Statement to Parliament, the Secretary of State for Health and Social Care announced an independent inquiry into the issues raised by the actions of David Fuller. That Inquiry was formally launched on 18/01/22, and its Terms of Reference were published on 23/02/22. The Trust is cooperating fully with the Inquiry, and although a range of actions have been taken in response to Fuller's criminal activity, the Trust will respond to the Inquiry's findings once published.

Conclusion

The Trust has maintained a sound system of internal control during 2021/22, and has identified only three significant internal control issues during the year. These are described above, in the body of the Annual Governance Statement.

Miles Scott, Chief Executive

16th June 2022

[7] The Trust considered the following criteria when identifying if any significant internal control issues had occurred during 2021/22: Might the issue prejudice achievement of priorities? Could the issue undermine the integrity or reputation of the NHS? What view does the Audit and Governance Committee take on this point? What advice has internal or external audit given? Could delivery of the standards expected of the Accountable Officer be at risk? Has the issue made it harder to resist fraud or other misuse of resources? Did the issue divert resources from another significant aspect of the business? Could the issue have a material impact on the accounts? Might national or data security or integrity be put at risk?