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

Thu 29 September 2022, 09:45 - 13:00

Virtually, via Webconference

NHS
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).

09-1
To receive apologies for absence

David Highton

09-2
To declare interests relevant to agenda items

David Highton

09-3
To approve the minutes of the 'Part 1' Trust Board meeting of 28th July 2022

David Highton

Board minutes, 28.07.22 (Part 1).pdf (12 pages)

09-4
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (2 pages)

09-5
Report from the Chair of the Trust Board

David Highton

Report from the Chair of the Trust Board.pdf (1 pages)

09-6
Report from the Chief Executive

Miles Scott

Chief Executive's report September 2022.pdf (3 pages)

Reports from Trust Board sub-committees

09-7
Quality Committee, 17/08/22 and 14/09/22

Maureen Choong

Summary of Quality C'ttee, 17.08.22.pdf (2 pages)
Summary of Quality C'ttee, 14.09.22.pdf (2 pages)

09-8
Finance and Performance Committee, 27/09/22 (incl. approval of revised Terms of Reference)

Neil Griffiths

Summary of Finance and Performance C'ttee 27.09.22.pdf (6 pages)

09-9
People and Organisational Development Committee, 23/09/22 (incl. an update on the 'Messenger review; and approval of revised Terms of Reference)

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 23.09.22 (incl. revised Terms of Reference; and messenger review).pdf (29 pages)

09-10
Patient Experience Committee, 01/09/22

Maureen Choong

Summary of Patient Experience Committee 01.09.22.pdf (1 pages)

Integrated Performance Report

09-11
Integrated Performance Report (IPR) for August 2022

Miles Scott and colleagues

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

Quality Items

09-12
Quarterly mortality data

Peter Maskell

Quarterly Mortality Data.pdf (23 pages)

09-13
Summary of the changes to the updated NHS Safeguarding accountability and assurance framework

Richard Gatune

N.B. The full "Safeguarding accountability and assurance framework" document can be accessed in the "Documents" section for the Board's information at "Trust Board/Documents/Trust Board Meetings (Part 1)/2022/09. 29.09.22/Safeguarding accountability and assurance framework"

Summary of the changes to the updated NHS Safeguarding accountability and assurance framework.pdf (12 pages)

Systems and Place

09-14
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the Kent and Medway Integrated Care Board (ICB) and West Kent Health and Care Partnership (HCP).pdf (11 pages)

Planning and strategy

09-15
To approve a Business Case for a Sunrise infrastructure upgrade

Steve Orpin

To approve a Business Case for a Sunrise infrastructure upgrade.pdf (8 pages)

09-16
The Kent and Medway Vascular Surgery Decision-Making Business Case

Rachel Jones

N.B. The full Business Case and appendices are available in the “Documents” section of Admincontrol for the Board’s information at “Trust Board/Documents/Trust Board Meetings (Part 1)/2022/09. 29.09.22/Kent and Medway Vascular Reconfiguration Decision Making Business Case and Appendices”

The Kent and Medway Vascular Surgery Decision-Making Business Case.pdf (7 pages)

Assurance and policy

09-17
Responsible Officer’s Annual Report 2021/22

Peter Maskell

Responsible Officer’s Annual Report 202122.pdf (27 pages)

09-18
To receive assurance regarding the confidentiality of patient information, in light of the ‘Approaching Standards’ submission on the Data Security and Protection Toolkit for 2021/22

Richard Gatune

To receive assurance regarding the confidentiality of patient information, in light of the ‘Approaching Standards’ submission on the Data Security .pdf (3 pages)

09-19
Health & Safety Annual Report, 2020/21 and agreement of the 2021/22 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

Rob Parsons

N.B. This item is scheduled for 12:15pm.

Health & Safety Annual Report, 202021 and agreement of the 202122 programme.pdf (40 pages)

09-20
Ratification of the revised Health & Safety Policy and Procedure

Rob Parsons

N.B. This item is scheduled for 12:25pm.

Ratification of the revised Health & Safety Policy and Procedure.pdf (27 pages)

09-21
Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

Sean Briggs

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment.pdf (3 pages)

09-22
Ratification of the revised policy and procedure for the production, approval

and ratification of Trust-wide policies (‘policy for policies’)

Kevin Rowan

N.B. The appendices are available in the “Documents” section of Admincontrol for the Board’s information at “Trust Board/Documents/Trust Board Meetings (Part 1)/2022/09. 29.09.22/Policy for policies appendices”

Revised policy for policies.pdf (40 pages)

09-23
Annual review of the Trust Board's Terms of Reference

David Highton

Revised Trust Board Terms of Reference.pdf (6 pages)

09-24
To consider any other business

David Highton

09-25
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).

09-26
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 JULY 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)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Bob Cook	Deputy Director of Strategy, Planning and Partnerships	(BC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Lynn Gray	Deputy Chief Operating Officer	(LG)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Natalie Hayward	Deputy Freedom to Speak Up Guardian (for part of item 07-19 – refer to minute for details)	(NH)
	Christian Lippiatt	Freedom to Speak Up Guardian (for part of item 07-19 – refer to minute for details)	(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]

07-1 To receive apologies for absence

Apologies were received from Sean Briggs (SB), Chief Operating Officer; and Peter Maskell (PM), Medical Director. It was also noted that Karen Cox (KC), Associate Non-Executive Director; and Rachel Jones (RJ), Director of Strategy, Planning and Partnerships would not be in attendance.

DH then welcomed BC and LG to the meeting.

07-2 To declare interests relevant to agenda items

No interests were declared.

07-3 To approve the minutes of the meeting of 30th June 2022

The minutes of the meeting of 30th June 2022 were approved as a true and accurate record of the meeting.

07-4 To note progress with previous actions

The content of the submitted report was noted and the following actions were discussed in detail:

- **Action 06-26 ("Arrange for the outcome of the further work on the Divisional Improvement Projects to be submitted to the Trust Board, when such work was completed").** DH noted that an update on the Divisional Improvement Projects was scheduled for consideration at the Trust Board meeting in September 2022.
- **Action 06-29 ("Provide the Trust Board with assurance regarding the confidentiality of patient information, in light of the 'Standards Not Met' submission on the Data Security and Protection Toolkit for 2021/22").** DH noted that an update would be provided to the 'Part 1' Trust Board meeting in September 2022.

07-5 Report from the Chair of the Trust Board

DH firstly thanked Trust staff for their continued response to significant operational pressures associated with the COVID-19 pandemic, patient flow challenges and the July 2022 heatwave. DH then referred to the submitted report and outlined the consultant appointments which had been made within the reporting period.

07-6 Report from the Chief Executive

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

- Significant planning had been required to support patients and Trust staff during the July 2022 heatwave and a lessons learned review would be implemented to improve the Trust's response in the future, as such adverse weather events were expected to increase in frequency.
- A Kent and Medway Integrated Care System (ICS) winter planning event had been held to investigate innovative approaches to address increased operational pressures; and the challenges associated with mental health presentations. Details of the increase in the severity of operational pressures compared to pre-COVID-19 attendance levels had been provided and the importance of planning to address an expected continued increase demand was highlighted. There had also been an increase in expressed demand within other service areas, such as cancer services, which had received referrals 130% above pre-pandemic levels, although such increased demand had been managed through alternative treatment approaches. However, it was acknowledged that all service areas would be required to consider what, if any, approaches could be adopted to address expressed demand.
- The importance of robust utilisation of the Trust's Same Day Emergency Care (SDEC) unit capacity to mitigate the increase in Emergency Department (ED) attendances; and the further winter planning which was required.
- The publication of the "Health and social care review: leadership for a collaborative and inclusive future" review by General Sir Gordon Messenger, the implications of which would be considered at the September 2022 People and Organisational Development Committee 'deep dive' meeting.
- Commendation of the Trust's Physiotherapy and Research Departments on the establishment of a new international stroke rehabilitation trial which was intended to identify best practice in reducing the incidents of disability after a stroke.
- As part of celebrations to mark the 74th birthday of the NHS the Trust officially opened the new Intensive Care Unit (ICU garden at Tunbridge Wells Hospital (TWH).

EPM queried whether the lessons learned review of the Trust's response to the July 2022 'heatwave' would incorporate any patient feedback which had been received. MS agreed to liaise with the Director of Emergency Planning and Response to ensure such feedback was duly incorporated.

Action: Liaise with the Director of Emergency Response and Planning to ensure that the lessons learned review of the Trust's response to the July 2022 'heatwave' incorporated any patient feedback which had been received (Chief Executive, July 2022 onwards)

EPM requested clarification regarding the intended meaning of the term "expressed demand". MS replied that "expressed demand" referred to the number of attendances at the Trust's Emergency Department and noted the rationale for the utilisation of the term. MS continued that the Trust's achievement to date, in relation to Urgent Care provisions and Cancer Performance Standards, were due to the ways in which such expressed demand was embraced and addressed; rather than focusing on measures to reduce such demand at the Trust. MS continued that although the number of ED attendances and cancer referrals had increased the number of serious injuries and confirmed cancer cases had not increased at a corresponding rate; therefore, it was important to ensure that the processes were in place to appropriate address each presentation as required.

DH acknowledged the importance of supporting the operational priorities within the Kent and Medway ICS; however, noted that prioritisation of those patients which presented to the Trust.

Reports from Trust Board sub-committees

07-7 Quality Committee, 13/07/22

MC referred to the submitted report and highlighted the key points therein, which included the intention to increase public awareness regarding the risks associated with the ingestion of button batteries; and the continued focus by the Trust's five Clinical Divisions to maintain a high standard of patient care, although, the impact of prolonged operational pressures on Trust staff was acknowledged.

07-8 Finance and Performance Committee, 26/07/22

DH referred to the submitted report and highlighted the key points therein, which included that the Committee had reviewed and recommended the Business Cases for Increasing Elective Orthopaedic Capacity; the development of a Community Diagnostic Centre (CDC) – Phase 2; and the establishment of a Tier 4 Bariatric Surgical Service; for approval by the Trust Board; and an in-depth discussion on the development of the options to address the Trust's patient flow-related challenges and the risks associated with increased length of stay.

DM noted the proposed amendments to Private Finance Initiative (PFI) contract at Tunbridge Wells Hospital due to the transition from the London Inter-Bank Offered Rate (LIBOR) to the Sterling Overnight Index Average (SONIA) interest rate.

07-9 People and Organisational Development Committee, 22/07/22 (incl. quarterly report from the Guardian of Safe Working Hours)

RF referred to the submitted report and highlighted the key points therein, which included details of the assurance provided by the People and Culture Function regarding the continued focus on recruitment and retention at the Trust and the further work which was required; an overview of the discussion which was held in relation to the Gender Pay Gap and the further support which was required from the Trust's Non-Executive Directors; that it had been agreed to increase the accessibility of the Trust's recruitment processes for candidates with disabilities and that further discussions should be held regarding the representation of individuals from Black, Asian and Minority Ethnic (BAME) backgrounds on the Trust Board; the reporting arrangements which had been agreed for the Wellbeing Committee; and that the Committee had thanked the Director of Medical Education (DME) for their significant contribution to the improvement of the quality of medical training during their tenure at the Trust.

DH acknowledged the resignation of the current DME and noted the importance of recording the Trust Board's thanks for their contributions during their tenure at the Trust. DH then asked MS whether a replacement DME had been agreed. MS replied that no such replacement had yet been agreed and stated that he would draft a letter of commendation, on behalf of DH, for the services provided by the DME during their tenure at the Trust.

Action: Draft a letter of commendation, on behalf of the Chair of the Trust Board, for the services provided by the Director of Medical Education during their tenure at the Trust (Chief Executive, July 2022 onwards)

07-10 Audit and Governance Committee, 20/07/22 (incl. the External Auditor's Annual Report for 2021/22)

DM referred to the submitted report and highlighted the key points therein, which included the final External Audit opinion which had been included within the External Auditor's Annual Report for 2021/22; commendation of the Trust's Finance Department for their work on the production of the Annual Accounts 2021/22; that an in-depth review of the Trust's red rated risks had been conducted and it had been agreed that Trust Board sub-committees would be commissioned to conduct 'deep dives' into longstanding risks; and that PM had attended to provide the Committee with additional assurance regarding the Internal Audit review of "Consent" wherein it was noted that eight of the nine instances where consent was not documented were related to Interventional Radiology which operated an alternative system that Internal Audit had been unable to be access. DM added that the Committee had been provided with a demonstration of the Trust's new eConsent system.

07-11 Charitable Funds Committee, 18/07/22

DM referred to the submitted report and highlighted the key points therein, which included the significant challenges associated with vacant Fundraising Manager post and the issues with the recruitment of a suitable candidate; the approval of the management and administration fee for 2022/23 although the impacts of the Fundraising Manager vacancy were acknowledged; commendation of the Director of Emergency Planning and Response on the management of the Trust's Charitable Fund in the absence of a Fundraising Manager; the charitable funding which had been provided for Falls Monitor Alarms; the proposed review of the Business Case process for charitable funding; and an update on the proposed partnership with Maggie's Centres, the Heads of Terms of which would be submitted to a future Trust Board meeting.

DH noted that Demelza House Children's Hospice had 7 vacant fundraising positions and outlined the recruitment difficulties which had been experienced due to the increased accessibility of roles within London based charities associated with the availability of working from home arrangements. DH noted that further discussions would be held with DM, external to the meeting, to facilitate discussions with representatives from Demelza House Children's Hospice. DM supported such discussions and emphasised the importance of the integration of charitable activities within the Trust's business as usual activities.

Integrated Performance Report

07-12 Integrated Performance Report (IPR) for June 2022

MS introduced the Integrated Performance Report for June 2022. SS referred to the "People" Strategic Theme and explained the latest position in relation to the "Appraisal Completeness" metric and reported the following points:

- Appraisal completeness had improved to 59% against a Trust-wide target of 95%; however, it had been agreed that the appraisal window should be extended for a further month to enable a further improvement in the Trust's position, and that the Human Resources Business Partners should support those areas with low compliance rates.
- A survey to investigate the Trust's flexible working offerings would be implemented, and improvement proposals developed, due to the impact on the Trust's turnover rate.
- The appraisal process for 2022 had been adapted to include a training needs analysis section, which would enable a coordinated approach to the identification of key training requirements for Trust staff and promote continued career development.

SS then referred to the "People –Workforce: CQC: Well-Led" section of the submitted report and explained the latest position in relation to the metrics contained therein and reported the following points:

- The Trust's vacancy rate had improved following a number of recruitment event and a data cleansing exercise which removed 60 Whole Time Equivalent (WTE) posts which had been introduced as part of the COVID-19 response.
- The key recruitment hotspots which had been identified for targeted support such as Nursing, Administrative and Clerical, Allied Health Professionals (AHPs), and Estates and Facilities.
- The challenges associated with recruitment to vacancies within lower Agenda for Change (AfC) pay banded roles due to the cost of living crisis.
- The three key factors impacting turnover rates were an increase in retirement rates following the COVID-19 pandemic; an enhanced focus on flexible working patterns; and the impact of the development of working from home practices which enabled staff to apply for national roles without relocating.
- The Trust's Turnover rate was 13.9% compared to 15.4% for the southeast region; which significantly impacted the ability of the Trust to reduce the vacancy rate and was therefore a key area of focus, with in-depth review of each Division to be conducted by the Recruitment and Retention Team to identify any turnover hotspots to enable the development of a robust action plan.

- Flexible working arrangements, or the lack thereof, were a key driver for the Trust's turnover rate, therefore a survey had been commissioned to examine the Trust's flexible working offerings and subsequently outline some proposed improvement recommendations based on the findings.
- A communication programme had been developed to inform Trust staff and potential candidates of the non-financial benefits of working for the NHS and the available development opportunities.
- There had been an improvement in the Trust's sickness absence rate which had reduced bank and agency expenditure and supported safe staffing levels.

WW outlined the discussions which had been held with a senior nurse at the Trust regarding the challenges associated with the required workload which had resulted in the aforementioned individual retiring and re-joining the Trust as a member of bank staff and asked what, if any, actions could be implemented in the short term to prevent regretted losses due to the current operational demands. SS replied that the workload due to operational pressures was a key concern across the NHS due to impact of the COVID-19 pandemic and staffing shortages and emphasised the importance of a robust 'Retire and Return Policy' to support the Trust's position and provide mentorship to more junior staff at the Trust. JH outlined the range of factors contributing to increased staff fatigue and diminished staff morale and emphasised the importance of the development of resilience training for Trust staff as operational pressures were expected to continue for the foreseeable future. JH then detailed the intention to deploy an 'itchy feet' programme to support retention at the Trust and acknowledged that flexibility working arrangements had been a key issue within nursing staff therefore an enhanced focus was required to support such arrangements. JH outlined the proposed 'legacy nurse' programme, whereby those nurses with sufficient expertise could provide mentoring and support to the incoming workforce, which would reduce the number of regretted losses incurred by the Trust.

NG highlighted the discussions which had been held at the Finance and Performance Committee as part of the "Medicine & Emergency Care Division 'deep dive'" item wherein the challenges associated with the timeline for the recruitment of Clinical Fellows were detailed and asked what, if any, actions could be implemented to expedite the recruitment timeline for such individuals. SS agreed to liaise with representatives from the Medicine and Emergency Care Division to investigate what, if any, actions could be implemented to expedite the recruitment process for Clinical Fellows. SS added that the other key challenge was the shortage of suitable candidates to fill certain vacancies and outlined the programme of work which had been implemented with the Surgery Division and Medicine and Emergency Care Division to examine bank and agency expenditure to enable the development of a consistent approach across the Kent and Medway ICS. SS then detailed the Key Performance Indicators (KPIs) which were associated with the recruitment process both for the recruiting manager and the Recruitment and Retention Team, and noted the further work required to improve the compliance with such KPIs. SS concluded by highlighting the monitoring process which had been implemented to investigate when candidates were lost from within the recruitment pipeline.

Action: Liaise with representatives from the Medicine and Emergency Care Division to investigate what, if any, actions could be implemented to expedite the recruitment process for Clinical Fellows (Chief People Officer, July 2022 onwards)

EPM requested that SS submit the findings of the survey to investigate the Trust's flexible working offerings and associated improvement recommendations to a future People and Organisational Development Committee meeting. This was agreed.

Action: Submit the findings of the survey to investigate the Trust's flexible working offerings and associated improvement recommendations to a future People and Organisational Development Committee meeting (Chief People Officer, July 2022 onwards)

DH asked whether the utilisation of the Trust's e-Rostering system had increased the provision of flexible working arrangements at a ward level. JH confirmed that was the case and noted that a further granular review was required to ensure that those staff that required flexible working arrangements were afforded the appropriate opportunities, and that discussions were held with those staff that no longer required such flexibility (e.g. those staff that were on a term time contract but their children were no longer of a school age).

SM explained the latest position in relation to the “Rate of Total Patient Falls per 1,000 occupied bed days” metric and reported the following points:

- There had been an improvement in the rate of patient falls at the Trust, with a further improvement trajectory predicted in response to the initiatives which had been implemented, including the ‘think yellow’ project, the impact of which would be reviewed in August 2022.
- A Falls Prevention Practitioner had been appointed to support the Lead Nurse for Falls Prevention.

SM then continued and explained the latest position in relation to the "Infection Control" metric and reported the following points:

- There had been an increase in the “rate of Hospital Acquired C. Difficile per 100,000 occupied bed days” metric, which reflected the challenge experienced by Trusts nationally, due to the increased acuity of patients and the challenges associated with the discharge of patients that no longer met the criteria to reside for inpatient care. However, an in-depth action plan had been developed to improve the Trust’s performance.
- The number of patients presenting due to COVID-19, and the associated number of COVID-19 inpatients], had continued to reduce.

JH referred to the “Patient Safety & Clinical Effectiveness” Strategic Theme and explained the latest position in relation to the “Safe Staffing” metric and reported the following points:

- The performance against the “overall safe staffing fill rate” metric may deteriorate once the data cleansing exercise had been completed.
- Healthcare Support Worker and Registered Nurse recruitment events had been scheduled to support the Trust’s staffing position.
- A recruitment event had been conducted in the Philippines and a further recruitment event was scheduled in the Caribbean to support the Trust’s nurse staffing levels.
- An in-depth training needs analysis had been implemented for nursing staff to promote retention and support career development.

LG referred to the “Patient Access” Strategic Theme and explained the latest position in relation to the “RTT Performance”, “Planned levels of new outpatients’ activity”, “A&E Performance”, “Outpatient Calls answered <1 minute”, “Outpatient Clinic Utilisation”, “Ambulance Handovers >30 minutes”, “% Emergency Admissions to Assessment Areas”, “Planned levels of Elective inpatients activity” and “Planned levels of Diagnostic activity” metrics and reported the following points:

- Despite continued demand within the Trust’s Emergency Departments performance against the “A&E 4 hr Performance” metric had been maintained, with the Trust achieving the 6th best performance nationally during the week commencing 18th July 2022.
- The continued achievement of the “Cancer - 2 Week Wait” and “Cancer - 62 Day” metrics.
- Performance against the “Access to Diagnostics (<6weeks standard)” metric had improved in the preceding two months and that the Trust was now aiming to achieve a 99% performance rate.
- The intention to reduce the number of patients waiting longer than 40 weeks for treatment to 0 by the end of July 2022.
- The Trust was on target to deliver the agreed elective treatment trajectory.

DH queried whether, in response to the “Letter on the next steps in the recovery of elective services” from NHS England (NHSE), the Trust would be encouraged to support neighbouring Trusts in the management of patients that had waited longer than 52 weeks prior to the reduction of the Trust’s patients that had waited longer than 40 weeks. MS replied that the Trust currently provided significant mutual aid to neighbouring Trusts and that the development of the Elective Orthopaedic Centre at Maidstone Hospital would support the reduction long waiting patients within the Kent and Medway ICS; although the Trust would continue to endeavour to maximise the delivery of elective activity prior to completion of the development.

WW asked what, if any, actions would be implemented to mitigate risks associated with the potential further increase in ED attendances during the Autumn and Winter period. LG replied that development of the Autumn and Winter plan had commenced, with an enhanced focus on the August 2022 Bank Holiday weekend. LG continued that discussions had been enacted with colleagues across the Kent and Medway ICS to understand the measures which could be implemented to

address system-wide patient flow challenges and outlined the potential solutions which had been proposed, which included an increased provision of Urgent Treatment Centre services. LG then noted the discussions which had been held with representatives from the South East Coast Ambulance (SECAmb) service to support the management of ambulance handovers.

WW noted the delays in ambulance handovers which had been experienced at Warrington and Halton Hospitals NHS Foundation Trust and emphasised the importance of providing assurance to stakeholders that such risks were mitigated at the Trust. MS provided assurance that ambulance handover times remained an operational priority for the Trust and noted that, on average, less than one ambulance a day took longer than an hour to handover, with the majority of ambulance handovers completed in less than thirty minutes.

JH referred to the "Patient Experience" Strategic Theme and explained the latest position in relation to the "Complaints responded within target" metric and reported the following points:

- The data issue which had been encounter in relation to the "To reduce the number of complaints and concerns where poor communication…" breakthrough objective, although such an issue was expected by resolved by the September 2022 Trust Board meeting.
- The rate at which complaints were received had stabilised compared to previously months, which was a trend reflected at other Trusts locally.
- Further work had been implemented to enable an improvement of the "% complaints responded to within target" metric, with additional staff allocated to the review of overview complaints with the intention to deliver a sustained improvement in relation to such complaints.
- A weekly complaints performance review had been initiated to ensure a robust focus on the improvement of complaints performance at the Trust in conjunction with weekly Divisional meetings with the relevant Complaints Lead.

EPM asked whether the mitigations, which had been implemented in JH's previous Trust, had been successful in improving complaints performance. JH replied that her previous Trust was in a similar position in terms of complaints performance and noted that, due to the complexity of some complaints, it was importance to ensure an effective review process. JH continued that the Trust would be focused on the implementation of the new NHS Complaint Standards Framework and noted the intention to develop a telephone de-escalation process for potential complaints.

JH then continued and explained the latest position in relation to the "FFT Response Rates – all areas" metric and reported the following points:

- The administrative issue which had impacted the Trust's Friends and Family Test (FFT) performance had been resolved.
- A significant improvement in performance was anticipated for Outpatients and the ED following the implementation of a text messaging service.
- As the number of responses received increase there may be a deterioration in the Trust's positive feedback; although, such feedback would enable to the continued improvement of the patient experience at the Trust.

BC referred to the "Systems" Strategic Theme and explained the latest position in relation to the "Discharge" metric and reported the following points:

- The Same Day Emergency Care (SDEC) scheme had transitioned to business as usual.
- Collaborative working had been implemented with partner organisations within the West Kent Health and Care Partnership (HCP) to support the delivery of the breakthrough objective.
- The Emergency Planning and Response Team had been invited to review the Trust's pathways to consider what, if any, amendments were required.

WW asked when the "Trust Target" would be developed for each of the breakthrough objectives. BC replied the target for the "To increase the number of patients leaving our hospitals by noon on the day of discharge" breakthrough objective had been agreed. However, further work was required with partner organisations within the West Kent Health and Care Partnership (HCP) to agree a target for the "to provide appropriate care capacity to enable timely discharge of patients to other settings" breakthrough objective.

SO referred to the "Sustainability" Strategic Theme and explained the latest position in relation to the "Agency Spend" metric and reported the following points:

- The Trust's financial plan for the year was to achieve a breakeven position through the delivery of Cost Improvement Programmes (CIPs).
- The financial forecast, as of month three of 2022/23, indicated delivery of the Trust's financial plan if the majority of CIPs were delivered.
- The CIP position was ahead of plan for the first quarter of 2022/23 and the number of confidently identified CIPs had increased; however, there were specific service areas which required an enhanced focus to ensure robust delivery of the associated CIPs
- The actions to reduce to reduce the amount of money the Trust spends on premium workforce spend had resulted in a degree of progress in June 2022, however further focus was required.
- The temporary staffing A3 was under development which would focus on two key targets, the first was 'hot spot' areas, the second was in relation to market management and agency caps which would be a key area for discussion with NHSE and partner organisations within the Kent and Medway ICS.

JW asked what proportion of the Trusts CIPs were recurrent and what proportion were non-recurrent. SO replied that approximately two thirds of CIPs were recurrent opposed to one third that were non-recurrent, and noted the enhanced focus on transformational programmes of work which, over a period of time, due to the associated benefits realisation would support cost efficiencies at the Trust. JW highlighted the challenges associated with the continued identification and delivery of recurrent CIPs. SO acknowledged the point and emphasised the impact of availability of time to progress the delivery of CIPs.

Quality Items

07-13 <u>Safeguarding update (Annual Report to Board, including Trust Board annual refresher training)</u>

JH referred to the submitted report and highlighted the key points therein, which included assurance that the Trust achieves its statutory duties in relation to safeguarding patients; further training would be provided to Trust Board members in September 2022, due to the update to the NHS Safeguarding accountability and assurance framework which had been issued on 21st July 2022; the Trust had been involved in four Serious Case Reviews / Child Safeguarding Practice Reviews within the reporting period; the risks associated with the lack of the provision of a Intendent Domestic Violence Advisor service, for which funding had been agreed with the Kent and Medway ICB; the further work required in regards to Level 3 Safeguarding Training compliance; the increase in children presenting with Mental Health concerns and associated challenges with the provision of tier 4 mental health beds; two applications had been made to the High Court for Deprivation of Liberty Safeguards (DOLS) orders for patients under the age of sixteen and that such cases had undergone an in-depth review due to the complexities involved; an update on the Self-Assessment Framework (SAF) which had been submitted to the Kent and Medway Safeguarding Adults Board; details of the Trust's safeguarding adults compliance and the rationale for the deterioration in the Trust's Mental Capacity Act training compliance; the feedback which had been submitted to the Liberty Protection Safeguards (LPS) consultation and the associated implications of the LPS; and the appointment of a New Learning Disability Liaison Nurse.

JH commented that the "Safeguarding accountability and assurance framework", which was issued on the 21st July 2022, could be circulated to Trust Board members for information, if required. DH supported such circulation and commended the quality of the submitted report.

Action: Circulate the "Safeguarding accountability and assurance framework", which was issued on the 21st July 2022, to Trust Board members for information (Chief Nurse, July 2022 onwards)

WW queried whether additional resources were required to address the increased prevalence of mental health presentations or whether the Trust had sufficient expertise to manage such demand. JH replied that a substantial piece of work was required to understand future demand and complexities associated with mental health presentations and subsequently ensure that staff had the appropriate skill set to enable care to be delivered confidently; which would be investigated via the

intended training needs analysis. JH continued that, within the Paediatrics Directorate, there were trained mental health Nurses and Clinical Support Workers (CSWs) to support the service and noted the additional support which was available for mental health presentations. JH added that further work was required to ensure that patients and staff received the appropriate support.

WW queried what, if any, further initiatives supported the improvement of the management of mental health presentations and whether such a programme of work was aligned to any existing workstreams. JH replied that the training needs analysis review was an ongoing programme of work that would require collaboration with educational providers to examine the available offerings for Trust staff. JH noted the work with representatives from the Kent and Medway ICS regarding mental health provisions; although, acknowledged that the challenges in relation to mental health provisions were reflected nationally and outlined the intention to develop an Enhanced Care Team at the Trust, but highlighted the significant time commitments required to ensure that the Enhanced Care Team was fit for purpose. JH then outlined the support for the programme of work from the Chief Nurse at Kent and Medway NHS and Social Care Partnership Trust (KMPT).

WW queried the rationale for the proposed reduction in the Trust's safeguarding adults training Compliance target from 95% to the Kent and Medway ICS target of 85% rather than encouraging other Trust's within the Kent and Medway ICS to increase such compliance rates. JH replied that a review of the benefits associated with a 95% compliance target compared to an 85% compliance target would be conducted to enable an informed decision-making process. JH continued that other Trust's would have improved compliance against target due to a lower target. WW emphasised the importance of ensuring that outstanding patient care was the key priority.

JW noted that it would be beneficial, at a future Quality Committee or Trust Board meeting, to receive a further update on the provision of Tier 4 Child and Adolescent Mental Health Service (CAMHS) capacity due to the associated challenges. JH provided assurance that Tier 4 CAMHS capacity was a key area of discussion within the Kent and Medway ICS and that a programme of work had been commissioned by the Kent and Medway ICB to investigate the provisions of such services, the outputs of which would be reported in due course once available.

07-14 <u>Quarterly Maternity Services report</u>

JH referred to the submitted report and highlighted the key points therein, which included that there had been five internal serious incidents declared within the reporting period; acknowledgement of the impact of Health Service Investigation Bureau (HSIB) case ref MI-008664 on Trust staff; details of the four cases which had been reported to the HSIB; the outputs of the comparison of Hypoxic Ischemic Encephalopathy (HIE) rates and the continued reduction in such rates; the further focus required in relation to Gap and Grow training; the feedback which had been received from the July 2022 Ockenden oversight visit; and details of the 'Listening Events' which had been implemented in response to the national concerns regarding morale within the Midwifery workforce.

DH noted that the Divisional Director of Midwifery, Nursing & Quality, for Women's, Children's & Sexual Health had attended the June 2022 Trust Board meeting for the approval of the Trust's long-term plan for Maternity Continuity of Carer and requested that future reports encompass such information. JH agreed and proposed that future reports also provide details of the actions in response to the final Ockenden Review; and, once available, the Trust's response to the Independent Investigation into East Kent Maternity Services. DH supported the proposal.

Action: Ensure that future "Quarterly Maternity Services report" reports included updates on the Trust's long-term plan for Maternity Continuity of Carer; the actions in response to the final Ockenden Review; and, once available, the Trust's response to the Independent Investigation into East Kent Maternity Services (the 'Kirkup review') (Chief Nurse, July 2022 onwards)

Systems and Place

07-15 <u>Update on the Kent and Medway Integrated Care Board (ICB) and West Kent Health and Care Partnership (HCP)</u>

BC referred to the submitted report and highlighted the key points therein, which included the key representatives within the Kent and Medway ICB; the alignment between the Kent and Medway ICB and the West Kent HCP; the agreements which required in relation to the delegation of functions and authority; the opportunity to develop new and innovation solutions for the provision of patient care; the development of an overarching Kent and Medway workforce action plan and place-based models for patient care; and the alignment with the needs of the local population.

RF asked whether there was any further update on the representation of Non-Executive Directors and Trust Board members on the West Kent HCP Board and the Kent and Medway ICB. DH replied that, in relation to the Kent and Medway ICB, there were two provider members, both of which were members of the Executive Teams from providers within the Kent and Medway ICS, as per the guidance for the establishment of ICBs, with one representing mental health and community services and the other representing acute services. DH continued that NG was a Non-Executive Director member of the West Kent HCP and that the Kent and Medway ICB had appointed an external consultant to consider the approach that should be adopted in relation to Non-Executive Director representation within the Provider Collaboratives and noted that some ICS' had included Non-Executive Directors within the membership of the ICB sub-committees. MS added that ICBs were statutory organisations, with the governance arrangements determined by NHSE, and noted that the key priority for the Trust was ensuring effective engagement. RF commented that further work was required to ensure that the Kent and Medway ICS reflected the best practice implemented by other ICS' in relation to the partnership aspect and noted that many of the key issues experienced by the Trust were system-wide issues which should be discussed at such a level. DH acknowledged the point and emphasised the importance of oversight of proposals in response to emerging issues. DH then provided assurance that he would continue to pursue discussions in relation to the improvement of oversight arrangements.

Planning and strategy

07-16 <u>To approve an updated Outline Business Case (OBC) for Increasing Elective Orthopaedic Capacity</u>

SO referred to the submitted report and highlighted the key points therein, which included the proposed development of a 3 Theatre, 14 Inpatient bed and 10 Day Case trolley facility at Maidstone Hospital to support the delivery of elective Orthopaedic capacity within the Kent and Medway ICS; details of the additional activity that would be supported; and the rationale of the revision from the initially proposed Business Case.SO then highlighted the additional funding challenges which remained and outlined the funding mechanisms which would be pursued.

JW query whether the design would enable the addition of an additional theatre in the future, if required. SO replied that the in-depth design work had not yet been completed for the three theatre option; however, the Director of Estates had been requested to investigate the potential for the design to enable such an expansion if required.

WW asked whether there would be further impacts on the total cost of the Business Case due to inflationary pressures and global supply chain issues. SO provided assurance that sufficient contingencies had been included within the Business Case to address any emerging risks associated with inflationary pressures and supply chain issues.

DH emphasised that further revisions were required prior to submission to NHSE and that the Trust Board was required to approve the Business Case to proceed to next stage of the development process. The Business Case was approved as submitted.

07-17 <u>To approve the Business Case for the development of a Community Diagnostic Centre (CDC) – Phase 2</u>

LG referred to the submitted report and highlighted the key points therein, which included details of the additional diagnostic capacity which would be provided by the Business Case; that there were no financial implications for the Trust; and that the Business Case required formal approval by NHSE.

DH noted the reduction in the availability of funding from NHSE for the further development of CDCs due to the NHS pay award for 2022/23. MS replied that Trusts had been encouraged to expedite the development of Business Cases to support the prioritisation of funding. SO added that NHSE funding would likely be prioritised for those CDC developments which had already been established. The Business Case was approved as submitted.

07-18 To approve a Business Case for the establishment of a Tier 4 Bariatric Surgical Service at MTW Trust

LG referred to the submitted report and highlighted the key points therein, which included the expected service demands; the financial implications for the Trust associated with the repatriation of patients from neighbouring counties; the implementation timeframes for the delivery of the service provisions; and that the service would be delivered within the Trust's current bed base.

DH queried what, if any, impact the establishment of a Tier 4 Bariatric Surgical Service at the Trust would have on the provision of plastic surgery for patients post bariatric surgery. LG agreed to check and confirm the potential impacts to Trust Board members. MS noted that the Business Case did not include that aspect of the treatment pathway therefore the potential impacts were likely limited.

Action: Check, and confirm to Trust Board members, what, if any, impact the establishment of a Tier 4 Bariatric Surgical Service at the Trust would have on the provision of plastic surgery for patients post bariatric surgery (Deputy Chief Operating Officer, July 2022 onwards)

The Business Case was approved as submitted.

Assurance and policy

07-19 Quarterly report from the Freedom to Speak Up Guardian

MC referred to the submitted report and highlighted the key points therein, which included details of the discussions which had been held with CL and NH prior to the meeting regarding to content of the report and the alignment with the findings from the Trust's various feedback mechanisms; and the approach which had been adopted to empower Trust staff to speak up and the further work which was planned with the Organisational Development Team. SS added that the Organisational Development Team had implemented 'listening events' to increase staff feedback. SS continued that discussions had been held with CL and NH regarding specific cases to ensure the appropriate interventions had been adopted. SS then detailed the measures which had been developed to address bullying and harassment at the Trust. MC concluded by noting that both herself and SS had acknowledged that an element of underreporting would continue to exist at the Trust and had recognised the impact of operational pressures on staff behaviour.

RF opined that the concerns raised only represented a proportion of total staff concerns and emphasised the importance of a continuing focus on the development of a culture which encouraged staff to speak up and report concerns at the Trust.

EPM referred to "Appendix B: Comparison of concerns logged and staff group" and noted the importance of continued monitoring of the concerns logged at Tunbridge Wells Hospital due to the increased frequency since 2020.

[CL and NH joined the meeting at this point]

WW highlighted the feedback which was received from Trust staff by the Trust's Chaplaincy Service and queried whether there was a method by which anonymised data sharing could be implemented in relation to staff concerns raised to the Chaplaincy Service. CL agreed to liaise with the Trust's Chaplaincy Service to investigate what, if any, anonymised data sharing could be implemented in relation to staff concerns raised to the Chaplaincy Service.

Action: Liaise with the Trust's Chaplaincy Service to investigate what, if any, anonymised data sharing could be implemented in relation to staff concerns raised to the Chaplaincy Service (Freedom to Speak Up Guardian, July 2022 onwards)

CL informed Trust Board members that a review had been conducted into the distribution of Safe Space Champions to ensure that all staffing areas and demographics were appropriately represented to increase accessibility. CL then outlined the various mechanisms which had been implemented, including 'listening events' to increase staff feedback. DH supported the importance of a broad range of feedback mechanisms, although acknowledged the challenges associated with the collection and comparison of the feedback received.

07-20 To consider any other business

There was no other business.

07-21 To respond to questions from members of the public

DJ confirmed that no questions had been received.

07-22 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]
06-26	Arrange for the outcome of the further work on the Divisional Improvement Projects to be submitted to the Trust Board, when such work was completed.	Director of Strategy, Planning and Partnerships	June 2022 onwards	A report has been scheduled for consideration at the Trust Board meeting in October 2022.
07-6	Liaise with the Director of Emergency Response and Planning to ensure that the lessons learned review of the Trust's response to the July 2022 'heatwave' incorporated any patient feedback which had been received.	Chief Executive	July 2022 onwards	The Director of Emergency Planning & Response has been commissioned to undertake the work, although the individual is away from work until the end of September, so it will be completed upon their return.
07-9	Draft a letter of commendation, on behalf of the Chair of the Trust Board, for the services provided by the Director of Medical Education during their tenure at the Trust.	Chief Executive	July 2022 onwards	A letter has been drafted, for review by the Chair of the Trust Board.
07-12a	Liaise with representatives from the Medicine and Emergency Care Division to investigate what, if any, actions could be implemented to expedite the recruitment process for Clinical Fellows.	Chief People Officer	July 2022 onwards	A verbal update will be given at the meeting.
07-19	Liaise with the Trust's Chaplaincy Service to investigate what, if any, anonymised data sharing could be implemented in relation to staff concerns raised to the Chaplaincy Service.	Freedom to Speak Up Guardian	July 2022 onwards	Liaison has occurred and options as to how/if anonymised contacts might be able to be captured are being explored.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
06-29	Provide the Trust Board with assurance regarding the confidentiality of patient	Chief Nurse	September 2022	A report has been submitted to the Trust Board meeting in

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	information, in light of the 'Standards Not Met' submission on the Data Security and Protection Toolkit for 2021/22.			September 2022.
07-12b	Submit the findings of the survey to investigate the Trust's flexible working offerings and associated improvement recommendations to a future People and Organisational Development Committee meeting.	Chief People Officer	September 2022	A "Review of the findings from the survey to investigate the Trust's flexible working offerings and associated improvement recommendations" item was considered at the People and Organisational Development Committee 'deep dive' meeting on 23/09/22.
07-13	Circulate the "Safeguarding accountability and assurance framework", which was issued on the 21st July 2022, to Trust Board members for information.	Chief Nurse	July 2022	The "Safeguarding accountability and assurance framework" was duly circulated to all Trust Board members on 29/07/2022.
07-14	Ensure that future "Quarterly Maternity Services report" reports included updates on the Trust's long-term plan for Maternity Continuity of Carer; the actions in response to the final Ockenden Review; and, once available, the Trust's response to the Independent Investigation into East Kent Maternity Services (the 'Kirkup review').	Chief Nurse	September 2022	The maternity service has been advised of the items that are required for future reports and these will be included in future reports (the next of which will be considered at the Trust Board in October 2022).
07-18	Check, and confirm to Trust Board members, what, if any, impact the establishment of a Tier 4 Bariatric Surgical Service at the Trust would have on the provision of plastic surgery for patients post bariatric surgery.	Deputy Chief Operating Officer	September 2022	The Surgery Division has confirmed that there is no likely discharge impact for patients post bariatric surgery.

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

Report from the Chair of the Trust Board **Chair of the Trust Board**

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants. The Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and two other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
19/07/22	Consultant Head and Neck	Nadine Louise	Caton	ENT	14/11/22	Replacement
26/08/22	Respiratory Consultant	Hussain Ahmad	Basheer	Respiratory	TBC	New
12/09/22	Consultant Chemical Pathologist	Ali	Al-Bahrani	Pathology	TBC	New
22/09/22	Consultant in Trauma & Orthopaedics Specialising in Paediatrics	Gavin Malcom	Spence	T&O	TBC	Replacement
22/09/22	Consultant in Trauma & Orthopaedics Specialising in Paediatrics	Gregory Bodley	Firth	T&O	TBC	Replacement
22/09/22	Consultant in Trauma & Orthopaedics Specialising in Paediatrics	Chun Hong	Tang	T&O	TBC	Replacement

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

[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

Report from the Chief Executive **Chief Executive**

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

- On behalf of the Trust Board I would like to express our deepest sympathies to the members of the Royal Family following the announcement of the death of Queen Elizabeth II. As our Queen, she served her country as sovereign for 70 years and was an inspiration to so many people. Her dedication to the hugely important role she played was second to none.

- Last week, Health and Social Care Secretary and Deputy Prime Minister, Thérèse Coffey, set out 'Our Plan for Patients' so patients receive easier access to NHS and social care this winter and next. A package of measures was unveiled across the priorities that matter most to patients – ambulances, backlogs, care, and doctors and dentists – and it also includes £500m of funding to support patient discharge from hospitals during the challenging winter period.

- We've hit our 62-day cancer standard for the third year in a row – one of only a handful of trusts in the country to do this and a fantastic achievement. Importantly, what this means for our patients is more than 85% of them receive their first treatment within 62 days of an urgent referral from their GP. Until August 2019, we had not hit the target at all for five years – so this really does mark a fantastic turnaround and one that has been made against a backdrop of record-breaking attendances at our hospitals and an increase in cancer referrals. This was only made possible by each and every member of Team MTW and we would like to pass on special thanks to all our oncology services at Canterbury, Maidstone and Tunbridge Wells.

- Patients in the Kent Oncology Centre are receiving some of the fastest treatment in the country, but now also with increased state-of-the-art equipment after the first patients were recently treated with the new Halcyon machine based at Maidstone Hospital. Only a small number of cancer treatment centres in England are using this new radiotherapy technology which halves treatment times and provides a much more comfortable experience for patients. Read the full story here.

- I wanted to provide an update on two areas of work we are progressing. Firstly, I'm really pleased to announce that this month work has started on phase 1 of our stroke service development plans at Maidstone Hospital. The first phase, which is expected to take three months, involves remodelling work in the old Acute Medical Unit to create stroke clinic rooms and an 18 bedded area which will become the Hyper Acute Stroke Unit, or HASU, once the whole programme of work is complete. This is part of a wider Kent and Medway system plan to change the way stroke services are delivered across the region. This was given the go ahead by the Secretary of State for Health and Social Care in November last year and will see three new HASUs created – at Maidstone, Dartford and Ashford. These will provide very specialist care to stroke patients in the immediate days after a stroke, helping to save lives and reduce disability. We are the first trust in the region to start work on a new HASU and I know once it is completed it will provide patients and staff with a much better environment to be both cared in and work in. Phase 2 and 3 will follow next year and includes the refurbishment of the current Acute Stroke Unit and Chaucer ward to create a new 35 bedded ASU. The aim is to deliver the completed HASU and ASU early in 2024.

- Secondly, I wanted to update you on the work to develop a new medical school and student accommodation building at Tunbridge Wells Hospital. Like many other building projects across the country we have seen some delays caused by the supply of building materials, but work is now progressing quickly and we expect the building to be finished in the spring. The modular accommodation units are being built and will arrive on site next month when we can look

forward to seeing them craned into place. A lot of preparation work is taking place, with the new building playing a really important role in the future of the Trust, not just benefitting MTW but also supporting the wider healthcare network for years to come by bringing more medical professionals into the area for their training. It is fantastic to see so many of these developments delivered during a time when our teams are still handling the impact of COVID – although we are currently only caring for 14 positive patients, the management of separate pathways still brings many challenges.

- The Trust has also secured funding to extend our Community Diagnostics Centre (CDC) based at Hermitage Court. The CDC has been running since September 2021 and provides increased MRI and CT capacity. As a direct result of this we have reduced the turnaround times from referral to scan from 17 to 9 days in CT and 19 days to 10.5 in MRI and supported the delivery of national diagnostic standards. Phase 2 will see the expansion of the CDC to provide additional clinical facilities - including 12 clinical rooms, 3 ultrasound rooms and 2 phlebotomy rooms.

- Last month we announced the expansion of our patient flow bed management digital platform – TeleTracking - into Kent Community Health NHS Foundation Trust's (KCHFT) four community hospitals. This is one of the UK's first examples of shared operational decision making and strategic capacity planning across acute hospital and community services. TeleTracking has enabled us to improve capacity management and better support staff. Together with KCHFT, we recognised the ability to manage patient flow more effectively was a model that could easily be extended into the 80 beds across their community hospitals. By adding further capacity and improving operational efficiency across the integrated health system, we are able to increase the number of timely discharges and reduce patients' length of stay, halve the time a hospital bed is empty and reduce the time it takes to get a patient from the Emergency Department to a bed. A huge well done to the teams involved with this integration which is yet another important step in a focus on the overall wellbeing of the region's population.

- Congratulations to Rantimi Ayodele, the Trust's Associate Chief of Surgery, Consultant Paediatric Trauma & Orthopaedic Surgeon and Chair of the Cultural and Ethnic Minorities Network (CEMN), who has been appointed Medical Director of the Princess Royal University Hospital (Bromley) and south sites, and Deputy Chief Medical Officer of Kings College Hospital. Rantimi will be leaving the Trust at the beginning of October. On behalf of the Trust I would like to personally thank Rantimi for all she has done for the Trust, the Division and the CEMN and wish Rantimi every success in her new role.

- This month we were asked by NHSE to focus on validating all patients from 78 weeks downwards and they named this validation month 'super September', with the outcome to reduce further long waiting patients waiting for elective care. Due to the fantastic work of our teams to reduce our long waiting patients, we have focussed on those waiting over 35+ weeks for treatment. I am pleased to report that over the last few weeks we have seen a decrease in those waiting over 40 weeks. Our teams are continuing to clinically validate the long waiting patients.

- I am delighted to report that our Endoscopy team has been shortlisted for the prestigious national Health Service Journal Awards. The Trust has been shortlisted in the new category of Performance Recovery Award. The COVID-19 pandemic presented huge challenges for the Endoscopy team but also provided an important opportunity to improve its services. By thinking differently, adapting to a changing environment and using cutting edge technology, the Endoscopy team at MTW has transformed the way it cares for its patients. The winners will be announced during the awards ceremony in London on 17 November.

- The annual national NHS survey has launched this month and it's an opportunity for our staff to have their say about what they like and don't like about working at MTW and use their voice to shape our Trust. We want MTW to be a workplace where staff have a healthy work/life balance,

are safe and respected and feel fulfilled. It's only by speaking out that we can collectively create change and make a difference. The results from the survey enable us to focus on improving the things that matter to our staff by identifying areas where we can do more to support. This year, once again the survey has been redeveloped to align with the NHS People Promise. A promise to each other to improve the experience of working in the NHS for everyone.

- During the current climate, with the rising cost of living leaving many with financial concerns, our Staff Health and Wellbeing Team has developed a booklet to offer advice on a range of financial services**.** The document covers support including information on grants, NHS discounts, childcare support and wellbeing offers. A range of support measures remain in place for staff including free bus travel to our hospitals and free fruit, tea and coffee for all staff.

- A new Mediation Service has been introduced across the Trust to encourage a positive culture of open and respectful conversations, where issues between staff can be mutually resolved. Mediation offers the opportunity to speak openly about issues in the event of a breakdown in communication between two colleagues, to help resolve any conflict and find a way forward. It also offers the opportunity to resolve these issues informally rather than it progressing into a formal HR process. Our network of specially trained and qualified MTW mediators are from different levels and areas of the Trust and can offer support to staff every step of the way to guide you through mediation process. They are there to create a supportive environment, ensure the communication is open and respectful and facilitate a joint discussion to reach a mutual resolution

- Last week (22 September), our Cultural and Ethnic Minorities Network (CEMN) held their Annual General Meeting (AGM) at Maidstone Hospital to celebrate their achievements and vote on the newest members of the committee. The CEMN is also gearing up to celebrate Black History Month in October, including an event with Kent and Medway groups (Tuesday 4 October) and a Power of Me event (Friday 21 October). The Trust has now received the report and action plan from the NHS Rainbow Badge Phase 2 Assessment Scheme, and an initial meeting is in place with the LGBT+ Network to discuss how we can best progress this area of work. Our Disability Network hosted its second Autism Working group this month, currently a key area of focus for this network. The Trust is planning to launch an Autism Health Passport for our patients and has also supported the Autism Reality Experience filming at Maidstone Hospital to help improve care for patients with learning disabilities or autism.

- Congratulations to the winners of the Trust's Employee of the Month scheme for July and August - Opal Bryan, Junior Sister, and Kathryn Duke, Registrar Trauma and Orthopaedics. Opal was recognised after staying on for three hours after her shift had finished to provide support for a two week old baby who required resuscitation. Opal really went the extra mile to support not only the baby, but her colleagues as well. Meanwhile Kathryn has been recognised for her dedication to her job, always putting the patient first and going above and beyond to ensure that a patient's family is kept up to date and supporting the junior doctors at the Trust - Kathryn is highly respected among the juniors and known for being compassionate and fair. On behalf of the Trust Board I would like to say thank you to both Opal and Kathryn for their fantastic work to help support our colleagues and patients.

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 performance

Summary report from Quality Committee, 17/08/22 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 17th August 2022 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted
   - The Director of Strategy, Planning and Partnerships and Business Intelligence Business Partner for Acute Medicine and Emergency Flow presented for a further **review of the health inequalities and equality of access to services on patient outcomes** (which included details of the approach by which the feedback received would be used to inform service developments) wherein the Committee were provided with a detailed background on the relationship between deprivation and health inequalities and a comprehensive breakdown of health inequalities by specific demographics within the West Kent Primary Care Networks. The following actions where then agreed:
     - That the Director of Strategy, Planning and Partnerships should investigate what, if any, health inequalities were experienced by full and part time carers within the Kent and Medway Integrated Care System and subsequently the West Kent Primary Care Networks
     - That the Assistant Trust Secretary should liaise with the Chair of the Quality Committee and the Director of Strategy, Planning and Partnerships to confirm the scheduling of a "Further review of the health inequalities and equality of access to services on patient outcomes" item at a future Quality Committee 'deep dive' meeting
     - That the Director of Strategy, Planning and Partnerships should circulate the Involve Kent presentation that was recently given to the West Kent Health and Care Partnership (HCP) to all Committee members, for information
     - That the Director of Strategy, Planning and Partnerships should ensure that any information regarding the national and local support that was available to reduce the impact of the cost of living crisis on staff and patients was publicised on both the Trust intranet and website
   - The Divisional Lead Matron for Governance, Medicine and Emergency Care and the Lead Matron, Emergency Medicine presented a **review of the risks associated with the management of mental health presentations within the Trust's Emergency Departments** which provided Committee members with details of the prevalence mental health presentations; the lessons which had been learned to improve the management of mental health presentations and the mechanisms which had been implemented to support staff safety and wellbeing. The Committee emphasised the importance of ensuring the provision of sufficient training for Trust staff and support the programme of work to reduce and mitigate ligature risks.
   - The Senior Sister, Critical Care Outreach Team attended for a **review of the progress with the improvement of the management of sepsis at the Trust**, wherein the Committee were informed of the significant challenges in terms of the progression of the programme of work and it was agreed that the Medical Director should liaise with the Chiefs of Service to escalate the issued outlined at the August 2022 Quality Committee 'deep dive' meeting regarding the management of sepsis at the Trust, including the lack of clinical engagement. It was also agreed that the Deputy Medical Director / Director of Infection Prevention and Control (DIPC) should ensure that a discussion was held at the Clinical Directors and Chiefs of Service meeting on the 7th September 2022 regarding the management of sepsis at the Trust and the importance of robust clinical engagement.
   - The **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings** were noted.

2. **In addition to the agreements referred to above, the meeting agreed that:** The Medical Director and Deputy Medical Director / DIPC should provide an update to the October 2022 Quality Committee 'deep dive' meeting on the progress to address the concerns raised at the July 2022 Quality Committee 'deep dive' meeting regarding the management of sepsis at the Trust.

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

Summary report from Quality Committee, 14/09/22	Committee Chair (Non-Executive Director)

The Quality Committee met on 14th September (a 'main' meeting), via virtual means.

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

- The r**eports from the Committee's sub-committees** (The Joint Safeguarding Committee; the Health and Safety Committee; and The Sepsis Committee) were considered, and the Terms of Reference were approved for the latter subject to the agreement that the Senior Sister, Critical Care Outreach Team should amend the Terms of Refence for the Sepsis Committee to reflect the feedback received at the July 2022 Quality Committee 'main' meeting (i.e. amend "Oncology" to "Cancer Services" within the "Membership" section; include the Associate Chief of Service for Surgery as an alternative Vice Chair within the "Membership" section; and consider whether the quoracy requirements should be amended so that only the Chair or Vice Chair need to be in attendance for quorum purposes). It was also agreed that the amended Terms of Reference for the Sepsis Committee should be circulated to Committee members, for information.
- It was agreed under the summary report from Sepsis Committee that the Divisional Director of Nursing and Quality, Cancer Services should Identify, and confirm to the Vice Chair of the Sepsis Committee, a representative from the Cancer Services Division to join the membership of the Sepsis Committee.
- The issues raised from the **reports from the clinical Divisions** highlighted the continued staffing challenges; the factors impacting the Trust's Cancer Services performance; an update on the COVID-19 vaccination programme; and that the Business Case for phase 2 of the Community Diagnostic Centre had been approved which provided additional Radiology capacity which would reduce the wait time for diagnostic investigations. The Women's, Children's and Sexual Health Divisional Governance report included the latest "Quarterly Maternity Services report" which has been scheduled for submission to the October 2022 'part 1' Trust Board meeting. It was agreed under the Cancer Services Divisional Governance report that the Divisional Director of Nursing and Quality, Cancer Services should Investigate the utilisation of a Play Specialist as an additional mitigation in response to the risks associated with children attending the adult Outpatient Department. It was also agreed under the Core Clinical Services Divisional Governance report that the Chief of Service, Core Clinical Services should ensure that future Core Clinical Services Divisional Governance reports included details of the mitigations which had been developed in response to risks within the Divisions, the expected implementation timeline for the mitigations, and what, if any, future support was required from the Committee.
- The Associate Chief of Service for Surgery provided the latest **update on harm reviews for patients who have waited a long time**, which included the intention to investigate whether there were any impacts from health inequalities within the harm review process.
- The General Manager for Outpatients provided a **further update on the Outpatients transformation programme** which included details of the improvement projects and the associated action plan to deliver such improvement projects and it was agreed that the General Manager for Outpatients should liaise with the Outpatients Management Team to consider the content of future "Update on the Outpatients transformation programme" reports to the Quality Committee 'main' meeting, to optimise the effectiveness of such reports, including ensuring that any additional support required from the Committee was highlighted. It was also agreed that the Assistant Trust Secretary should schedule an "Update on the Outpatients transformation programme" item at the November 2022 Quality Committee 'main' meeting and each 'main' meeting thereafter.
- The Deputy Chief Nurse for Quality and Experience gave the latest u**pdate on the work to achieve an 'Outstanding' CQC rating** wherein it was agreed that the Deputy Chief Nurse for Quality and Experience should consider how future "Update on the work to achieve an 'Outstanding' CQC rating" reports could be focused to reflect the discussion which was held at

the Executive Team Meeting (ETM) on 13th September 2022, and, if appropriate, ensure such reports included a summary of the key risks and associated mitigations.

- The latest **update on mortality** included details of the Trust Hospital Standardised Mortality Ratio (HSMR); the Cumulative Sum (CUSUM) alert which had been declared; and the latest Summary Hospital-level Mortality Indicator (SHMI) performance. It was agreed that the Associate Director of Business Intelligence should provide the Medical Director with further analysis of the root cause for the deterioration of the Trust's rolling twelve-month HSMR performance. It was also agreed that it should be ensured that the "Mortality update" report to the November 2022 Quality Committee 'main' meeting provided details of the root cause and Trust's response to the CUSUM alert for "Residual Codes"; and clarification regarding the issues associated with the Trust's depth of clinical coding for COVID-19 compared to Kent peers.
- The latest **Serious Incidents (SIs),** which included the report from the Learning and Improvement (SI) Panel, were reported by the Director of Infection Prevention and Control (DIPC), wherein it was agreed that the Chief Nurse and Deputy Medical Director / DPIC should ensure that the "Update on Serious Incidents (SIs)…" report to the November 2022 Quality Committee 'main' meeting included details of the discussions with the Kent and Medway Integrated Care Board regarding the closure of 'open' SIs and the associated lessons learned to improve the process.
- The Deputy Chief Nurse for Quality and Experience provided an **update from the Enteral feeding and Nasogastric tube (NGT) placement working group** wherein the Committee emphasised the importance of robust support for Trust staff during a HM Coroner's Inquest.
- The **recent findings from relevant Internal Audit reviews** and the report from the last **Quality Committee 'deep dive' meeting** held on 17/08/22 were noted.
- Under **Any Other Business** a discussion was held on the future format by which Committee meetings should be held and the Committee thanked the Associate Chief of Service for Surgery for their contribution to the Trust during their tenure.

2. **In addition to the agreements referred to above, the meeting agreed that:** The Lead Matron, Medicine and Emergency Care should ensure that the Medicine and Emergency Care Divisional Governance report to the November 2022 Quality Committee 'main' meeting included details of the progress made to reduce the number of outstanding complaints, and the measures to ensure the sustainability of such progress.

3. **The issues from the meeting that need to be drawn to the Board's attention are:** N/A

4. **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

Summary report from the Finance and Performance Committee, 27/09/22	Committee Chair (Non-Exec. Director)

The Committee met on 27th September 2022, via a webconference.

1. **The key matters considered at the meeting were as follows:**
   - The **updated Terms of Reference** were agreed, as part of their annual review, and these have been submitted for approval by the Trust Board (see Appendix 1, with changes 'tracked').
   - The divisional management team for the **Facilities Division**, attended to provide a **deep dive** into the financial position of the division, and assurance was given regarding the positive impact of increasing financial controls, reviewing procedures, and reducing agency and bank staff use
   - The Chief Operating Officer and Deputy Chief Operating Officer gave an **update on the plans to address the Trust's patient flow-related challenges for winter,** and it was noted that the options would be further discussed and included in the winter plan that would be submitted to the Committee and Board in October. There was a lengthy discussion about the involvement of the wider system and financial risk associated with the currently proposed schemes.
   - **The Patient Access strategic theme metrics for month 5** were reviewed, which noted that the Emergency Care Improvement Support Team (ECIST) had visited and had made some very positive comments regarding the Trust's culture and the 'can do' attitude of staff.
   - The report on **financial performance for month 5** highlighted that although the Trust had delivered the plan for the year to date; the significant slippage forecast against the year-end Cost Improvement Programme target posed a significant risk to the year-end plan. The Committee discussed the increasing level of concern regarding financial pressures and noted that additional work is being undertaken to develop additional actions.
   - The Committee supported the **self-assessment of the Healthcare Financial Management Association (HFMA) financial sustainability assessment**, which would now be submitted for a review by the Trust's Internal Auditors. It was also agreed to schedule a further item, once the outcome of the Internal Audit review was available.
   - The Head of Costing & SLR attended to provide the **latest information from the Costing Transformation Programme (CTP)** which included details of how the information had been used / was intending to be used at the Trust.
   - The committee received an update **on the Barn theatre programme,** which highlighted the regional and national process to approve the Business Case.
   - The Director of Strategy, Planning & Partnerships attended to provide the Committee with the **Project Initiation Document (PID) for Staff accommodation & ancillary benefit options for Tunbridge Wells Hospital**, the scope of which was supported by the Committee
   - The Head of the Programme Management Office presented **a further (closing) review of the update on the Business Cases that had been previously approved** by the Committee or Trust Board, which noted that the benefits assessment of the Sunrise Electronic Patient Record (EPR) would be completed in October 2022.
   - The latest position regarding the **laundry service project** was reported.
   - The **Business Case for a Sunrise infrastructure upgrade** was reviewed and recommended for approval by the Trust Board (the Case has been submitted under a separate agenda item).
   - The Programme Director for EPR (Sunrise) and Digital Transformation gave an **update on the implementation of the Electronic Patient Record (EPR)**, which noted that the 'go live' for the Electronic Prescribing and Medicines Administration (EPMA) system in Nov. was on track.
   - The **uses of the Trust Seal** since the last meeting were noted.

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 Committee agreed revised Terms of Reference, which have been submitted to the Trust Board for approval (see Appendix 1, with the proposed changes shown as 'tracked')).
   - The Committee recommended that the Trust Board approve the Business Case for a Sunrise infrastructure upgrade.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
1. To approve the Committee's revised Terms of Reference (see Appendix 1) 2. 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 the Finance and Performance Committee

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 delivery of the Trust's Cost Improvement Programme (CIP).
- To monitor the delivery of anythe recommendations arising from the 'model hospital' programmeof the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations"), and associated worksubsequent related publications or national guidance.
- To ensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national or local system-wide 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.

Green issues

- To provide oversight and scrutiny of the work of the Trust's Green Committee (via, as a minimum, receipt of the Green Committee's minutes).
- To receive an annual report on progress against the Trust's Green Plan.
- To review the Trust's Green Plan each year, prior to the Plan being submitted to the Trust Board, for approval.

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 no standing sub-committees, but may 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)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2022 (annual review, but also to include formalising the Committee’s role in relation to Green issues)
- Terms of Reference (revised) approved by the Trust Board, September 2022

Summary report from the People and Organisational Development Committee, 23/09/22 (incl. an update on the 'Messenger review'; and approval of revised Terms of Reference) | **Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 23rd September 2022 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were reviewed.
- The **Terms of Reference,** which were updated to reflected the additional of the Wellbeing Guardian Non-Executive Director to the Committee's "membership", were reviewed and agreed. The revised Terms of Reference are enclosed, in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Deputy Chief People Officer, People and Systems provided the latest **update on recruitment and retention** which included the latest position in relation to the Trust's vacancy rate; the challenges associated with the recruitment and retention of staff at Tunbridge Wells Hospital; and the disconnect between the Trust's vacancy rate and temporary staffing expenditure and it was agreed that the Chief Finance Officer should consider, and confirm to the Assistant Trust Secretary, the scheduling of a "Review of the Sustainability Strategic Theme and associated action plan" at a future People and Organisational Development Committee meeting. The following actions were then agreed for the Deputy Chief People Officer, People and Systems:
  - Ensure that the "Monthly update on the latest People Key Performance Indicators (KPIs)) (incl. an update on recruitment and retention)" item at the October 2022 'main' People and Organisational Development Committee meeting includes an overview of the return on investment from the Altadicta marketing campaign.
  - Inform Committee members of the measures being taken to ensure the timing of Estates recruitment takes into account the possibility that staff who will be TUPE transferred from the Trust to the new laundry service provider may choose to find new roles within the Trust's Estates team (and thereby adversely affect the current laundry service).
  - Ensure that future "Update on recruitment and retention" reports include metrics associated with the staffing requirements of the 'Barn Theatre' and the second phase of the Community Diagnostic Centre
- The Chief Nurse then provided an **update on the Staffing Assurance framework for winter 2022 preparedness** as part of the update on recruitment and retention report, wherein it was agreed that the Assistant Trust Secretary should liaise with the Deputy Chief Operating Officer and Chief Operating Officer to ensure that the "Review of the winter plan" item at the October 2022 Finance and Performance Committee meeting included consideration of all potential risks to service delivery during the winter period.
- The Chief People Officer presented an **update on the implementation of the actions arising from NHSE/I's "The Future of NHS Human Resources and Organisational Development" and the "Leadership for a collaborative and inclusive future" review by General Sir Gordon Messenger"** wherein the Committee emphasised the importance of maintaining a tailored approach to leadership development at the Trust and noted the implications of the reviews on the development of the Trust's Exceptional Leaders for all programme. The report is enclosed, under appendix 2, for the Trust Boards information.
- The Freedom to Speak Up Guardian, Deputy Freedom to Speak Up Guardian, and Patient Safety Manager attended for a **review of the Trust's response to the "Raising Concerns" questions in the latest NHS staff survey,** which included a comparison with better-performing NHS Trusts wherein a beneficial discussion was held, and it was agreed that the Chief Finance Officer should provide The Freedom to Speak Up Guardian and Deputy Chief People Officer, Organisational Development with details of the culture related concerns raised at the "Finance Department 'away day'" on the 22nd September 2022. It was also agreed that the Freedom to

Speak Up Guardian and Deputy Freedom to Speak Up Guardian should liaise with frontline to staff to check and confirm their understanding of the Freedom To Speak Up processes at the Trust.

- Due to time constraints it was agreed that the Assistant Trust Secretary should reschedule the "**Review of the findings from the survey to investigate the Trust's flexible working offerings and associated improvement recommendations**" item to the October 2022 'main' People and Organisational Development Committee meeting.
- The Committee conducted an **evaluation of the meeting** wherein the enhanced focus afforded by the executive summaries was commended, and members of the Executive Team were praised on the quality of their submitted reports, and the associated open and honest discussions on subjects that the Committee required assurance in relation to.

In addition to the actions noted above, the Committee agreed that: The Assistant Trust Secretary should liaise with the Chair of the People and Organisational Development Committee to confirm the scheduling of a "Further review of the Trust's response to the "Raising Concerns" questions in the latest NHS staff survey (incl. the actions to improve staff satisfaction in relation to the incident reporting process)" item at a future People and Organisational Development Committee meeting.

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

- The Committee's Terms of Reference are enclosed under Appendix 1, for approval

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

1. Information and assurance
2. To approve the Committee's revised Terms of Reference (see Appendix 1)
3. To receive an update on the 'Messenger review' (see Appendix 2)

[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

People and Organisational Development Committee

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

1 Purpose

The Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of people development, planning, performance and employee engagement.

The Committee will work 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.

2 Membership

- 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 Nurse*
- Chief People Officer*
- Deputy Chief Executive / Chief Finance Officer*
- Deputy Medical Director
- Director of Medical Education (DME)
- Wellbeing Guardian

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

Members can send an appropriate deputy if they are unable to be present at a Committee meeting.

3 Quorum

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

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

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

- The Chair or Vice Chair of the Committee and one other Non-Executive Director or Associate Non-Executive Director[1]
- One member of the Executive Team (i.e. Chief Nurse, Chief People Officer or Deputy Chief Executive/Chief Finance Officer). 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 (i.e. apart from those listed in the "Membership") are welcome to attend any meeting of the Committee.

Other staff, including members of the People and Culture Function, may be invited to attend, as required, to meet the Committee's purpose and duties.

5 Frequency of meetings

The Committee shall, generally, meet each month, but will operate under two different formats. The meeting held on alternate months will generally be a 'deep dive' meeting, which will enable

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

detailed scrutiny of a small number of issues/subjects. For clarity, the other meeting will be referred to as the 'main' People and Organisational Development Committee

The Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings).

6 Duties

To provide assurance to the Trust Board on:

- People planning and development, including alignment with business planning and development;
- Equality, Diversity and Inclusion (EDI) in the workforce;
- Employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes
- Occupational health and wellbeing in the workforce
- External developments, best practice and industry trends in employment practice;
- Staff recruitment, retention and satisfaction;
- Employee engagement
- Internal communications
- Terms and conditions of employment, including reward
- Organisational development, organisational change management and leadership development in the Trust;
- Training and development activity;
- Reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training)
- The Trust's Freedom to Speak Up Guardian (FTSUG) arrangements
- The Trust's wellbeing arrangements

To convene task & finish groups to undertake specific work identified by the Committee or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

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 Committee Chair will submit a written summary report to the next available Trust Board meeting.

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

8 Sub-committee and reporting procedure

The following Committee reports to the People and Organisational Development Committee through its chair or representatives following each meeting:

- Local Academic Board (LAB) (reporting to occur via the report from the DME)

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 Committee members who are members of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification

10 Administration

The Trust Secretary will ensure that each committee 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 & agenda items
- The Committee's pre-meeting discussion
- 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. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference agreed by Workforce Committee: 29th September 2016
- Terms of Reference approved by Trust Board: 19th October 2016
- Terms of Reference agreed by Workforce Committee: 30th October 2017
- Terms of Reference approved by Trust Board: 29th November 2017
- Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)
- Amended Terms of Reference approved by Trust Board: 1st March 2018
- Terms of Reference agreed by Workforce Committee: 28th March 2019
- Amended Terms of Reference approved by Trust Board: 25th April 2019
- Amended Terms of Reference approved by Trust Board, 31st October 2019 (to add the Health and Safety Committee as a sub-committee)
- Terms of Reference agreed by Workforce Committee: 26th March 2020 (as part of the annual review, and to include the Inclusion Committee as a sub-committee, to add the Deputy Medical Director as a member, and to reflect the agreement that members can send deputies if they are unable to be present)
- Terms of Reference approved by Trust Board: 30th April 2020 (as part of the annual review)
- Amended Terms of Reference agreed by Workforce Committee: 15th May 2020 (to withdrawn the membership of the Chief Operating Officer and to add the Chief Finance Officer as a member)
- Amended Terms of Reference approved by Trust Board: 21st May 2020
- Change approved by the Trust Board, 25th June 2020, to increase the frequency of meetings to monthly
- Change of the Committee's name and removal of the Inclusion Committee as a sub-committee, agreed by the Workforce Committee, 15th October 2020
- Change approved by the Trust Board, 22nd October 2020, to change the Committee's name (from the Workforce Committee to the People and Organisational Development Committee) and removal of the Inclusion Committee as a sub-committee.
- Terms of Reference agreed by the People and Organisational Development Committee: 23rd April 2021 (as part of the annual review, to remove the Health and Safety Committee as a sub-committee, to reflect the change of job title from Director of Workforce to Chief People Officer, to include the differentiation between the 'main' and 'deep dive' meeting and to more explicitly indicate the quorum requirements)
- Amended Terms of Reference approved by Trust Board: 29th April 2021
- Terms of Reference agreed by the People and Organisational Development Committee, 25th March 2022 (as part of the annual review)
- Amended Terms of Reference approved by Trust Board, 31st March 2022
- Terms of Reference agreed by the People and Organisational Development Committee, 23rd September 2022 (to include the Wellbeing Guardian within the Committee's membership)
- Amended Terms of Reference approved by Trust Board, 29th September 2022

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 'DEEP DIVE' - SEPTEMBER 2022

NHS Maidstone and Tunbridge Wells NHS Trust

UPDATE ON THE IMPLEMENTATION OF THE ACTIONS ARISING FROM NHSE/I'S "THE FUTURE OF NHS HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT" AND THE "LEADERSHIP FOR A COLLABORATIVE AND INCLUSIVE FUTURE" REVIEW BY GENERAL SIR GORDON MESSENGER"

CHIEF PEOPLE OFFICER

1. The Future of NHS Human Resources and Organisational Development (presentation attached)

Since the last update in March 2022 to the People and OD Committee there has been some developments and deliverables against the NHS Future of NHS Human Resources and OD.

Since the update in March 2022 a national programme structure and governance framework has been developed to take forward the key actions. As demonstrated in the attached presentation the eight vision themes have now been allocated vision theme champions and NHSE People Directorate Leads with a programme of work being developed.

It is fair to say there has been some rcent distraction with the national People Agenda as the NHS People Directorate are currently working through a significant restructuring to bring NHS England, Health Education England and NHS Digital together. The three organisations formally merged on 1 April 2023 which created the opportunity for all NHS data, digital services and workforce functions to be within the same organisation.

A new Workforce Training and Education Directorate has been developed and Em Wilkinson-Brice has been formally appointed as the Chief People Officer for the NHS. The Programme Director for the NHS People and OD Futures work is Claire Gore and it is expected that engagement with the regions will commence in Autumn.

Following the update from the presentation the People and OD Committee are to consider:

1.1 Are there any gaps or areas of the programme that the Committee would like further information/updates?
1.2 Does the Committee consider all the key areas contained in the review are covered?
1.3 What are the key areas of focus for MTW to engage in this programme of work?

2. "Leadership for a collaborative and inclusive future" review by General Sir Gordon Messenger

In October 2021 the government announced a review into leadership across health and social care, led by former Vice Chief of the Defence Staff General Sir Gordon Messenger and supported by Dame Linda Pollard, Chair of Leeds Teaching Hospital Trust.

On 8 June, the review of leadership in health and social care reported its findings and recommendations.

In the foreword from Sir Gordon Messenger he states "Of the many telling observations we have heard, two stand out as almost universal; firstly, the very real difference that first-rate leadership can make in health and social care, with many outstanding examples contributing directly to better service, yet; secondly, that the development of quality leadership and management is not adequately embedded or institutionalised in our health and care communities. We have consequently focused our findings on areas which improve awareness of the impact that good leadership can have, and which instil it as an instinctive characteristic in everyone, not just those with the word in their job title."

The review recognises the real difference that good leadership can make in health and social care and identifies many outstanding examples contributing directly to better service. However, it also found a lack of consistency and coordination in the way that leadership and management is trained, developed and valued.

Aimed at ensuring the right leadership is in place at all levels, the review lays out eight recommendations that seek to support services to deliver the best possible care while tackling the challenges the pandemic exposed across the country:

1. **Targeted interventions on collaborative leadership and organisational values**
   A new, national entry-level induction for all who join health and social care.
   A new, national mid-career programme for managers across health and social care.

2. **Positive equality, diversity and inclusion (EDI) action**
   Embed inclusive leadership practice as the responsibility of all leaders.
   Commit to promoting equal opportunity and fairness standards.
   More stringently enforce existing measures to improve equal opportunities and fairness.
   Enhance the Care Quality Commission's role in ensuring improvement in EDI outcomes.

3. **Consistent management standards delivered through accredited training**
   A single set of unified, core leadership and management standards for managers.
   Training and development bundles to meet these standards.

4. **A simplified, standard appraisal system for the NHS**
   A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

5. **A new career and talent management function for managers**
   Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

6. **More effective recruitment and development of non-executive directors**
   Establishment of an expanded, specialist non-executive talent and appointments team.

7. **Encouraging top talent into challenged parts of the system.**

8. **Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.**

There have been some developments following the review, however a lead for the NHS People function has only just been appointed and is not at this time of writing in post. At a system level the Kent and Medway ICB is being appointed to and the Chief People Officer has been recently appointed.

We continue to be a key influence at the Kent and Medway ICB level and also engage with the National Programme when this work commences shortly. As outlined in the Futures work we expect some of the elements of both programmes will be complementary.

Following the general update the People and OD Committee are to consider:

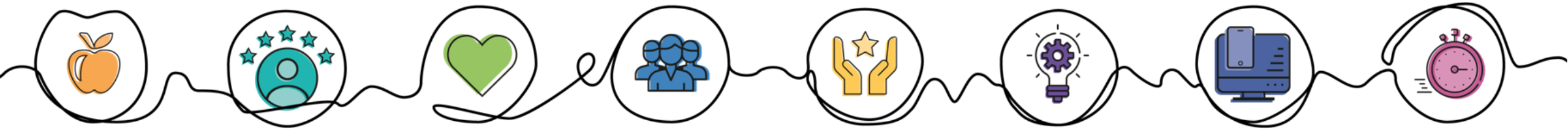
2.1 What areas of the report resonate with the Committee as areas for priority?
2.2 What influence can we bring about in the development of these actions going forward?
2.3 What wider influence can/should the Trust play across the system?

Key questions for discussion at the Committee
The key questions have been outlined above

Reason for submission to the People and Organisational Development Committee 'Deep Dive'
For discussion

The **future** of **NHS human resources** and **organisational development** 2030 vision

13th September 2022



Prioritising the **health** and **wellbeing** of all **our people**

Creating a **great employee experience**

Ensuring **inclusion** and **belonging** for all

Supporting and **developing** the **people profession**

Harnessing the **talents** of all our **people**

Leading **improvement, change** and **innovation**

Embedding **digitally** enabled **solutions**

Enabling new ways of **working** and **planning** for the **future**

What we found about NHS HR and OD

The people profession is key to creating an empowering and inclusive culture, supporting our people, and enabling workforce transformation.

The pandemic enabled the people profession to play a strong role, and demonstrate added value for organisations and our NHS people.

People service resources are heavily focused on transactional services – we can achieve more by simplifying, digitising and working at scale.

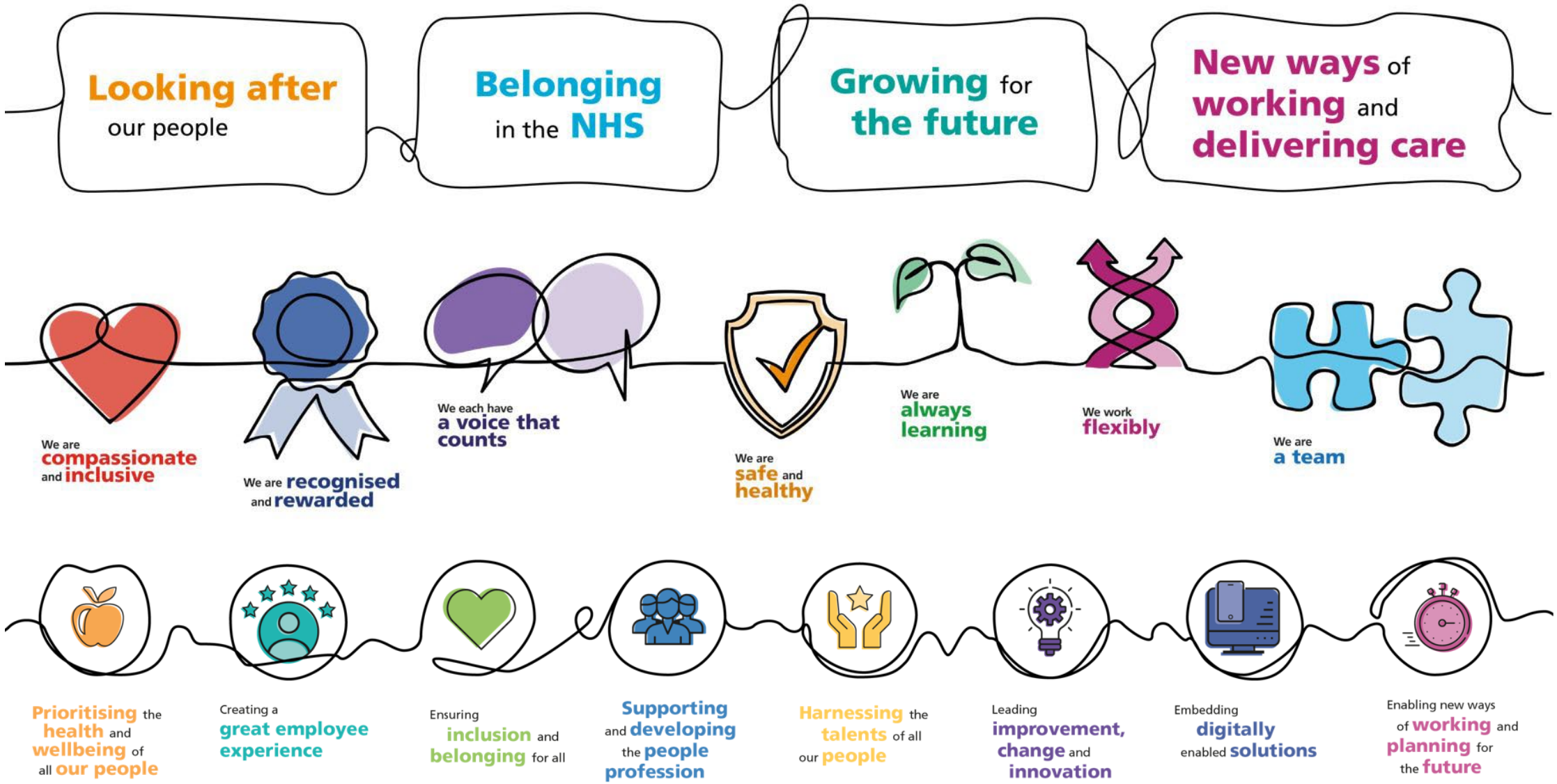
There are big opportunities to refocus people services on OD and workforce transformation.

Overall investment in NHS HR and OD is in the median range using global comparators – but investment in digital is below average.

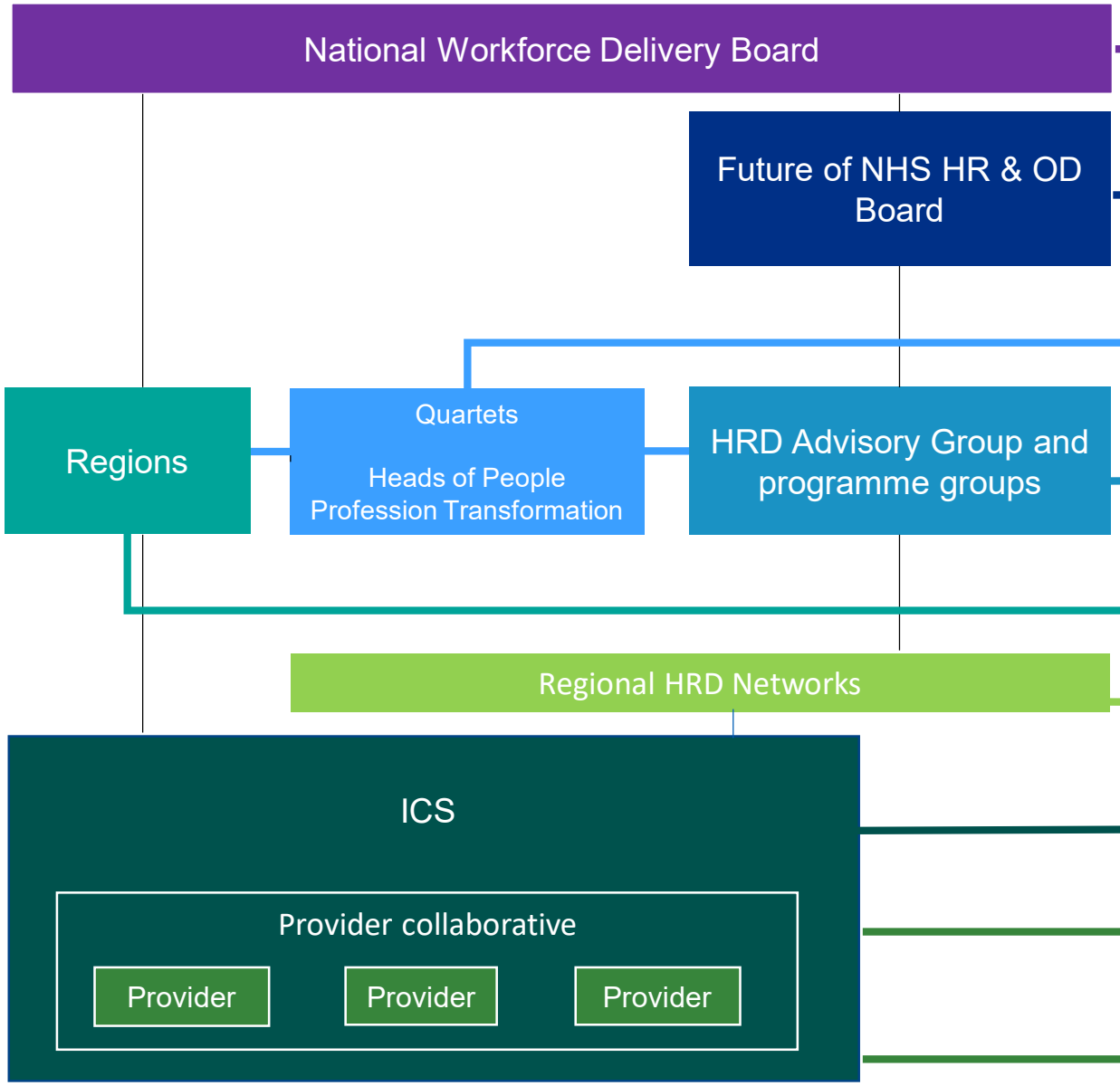
There are strong networks which could be used to scale best practice across the service.

Our customers were more positive about people services than the people profession – this was unique amongst sectors that have used the CIPD diagnostic.

People Plan, People Promise and NHS HR and OD vision



Programme structure: delivery of FHROD programme



National Workforce Delivery Board: oversight of the Future of NHS HR and OD programme by the Board to ensure alignment with People Plan. It is proposed that a report is provided every six months.

Future of NHS HR and OD Board will oversee the programme and provide assurance on progress. Membership of Board is proposed to include DHSC, HRDs, People Directorate SLT leads, HEE, CIPD, HPMA, NHS Employers, and staff side.

The Future of NHS HR and OD team: has a dedicated team in the HR Development and OD team, including PMO. Regionally aligned Heads of People Services Transformation will be key to regional quartets (with RDWOD, HRD Advisory Group member, and network chair(s)) and lead on specific national actions

HRD Advisory Group and programme Groups:. The programme will continue to be co-ordinated by the HRD Advisory Group who will oversee the work of task and finish groups and advisory boards to deliver national actions. The HRD Advisory Group will have HRD/CPOs for each region.

Regions: the Future of NHS HR and OD programme will liaise with the regions, primarily through the established regional quartet groups. Regional oversight of the implementation of the programme will be through Regional NHSE/I office – e.g. People Boards.

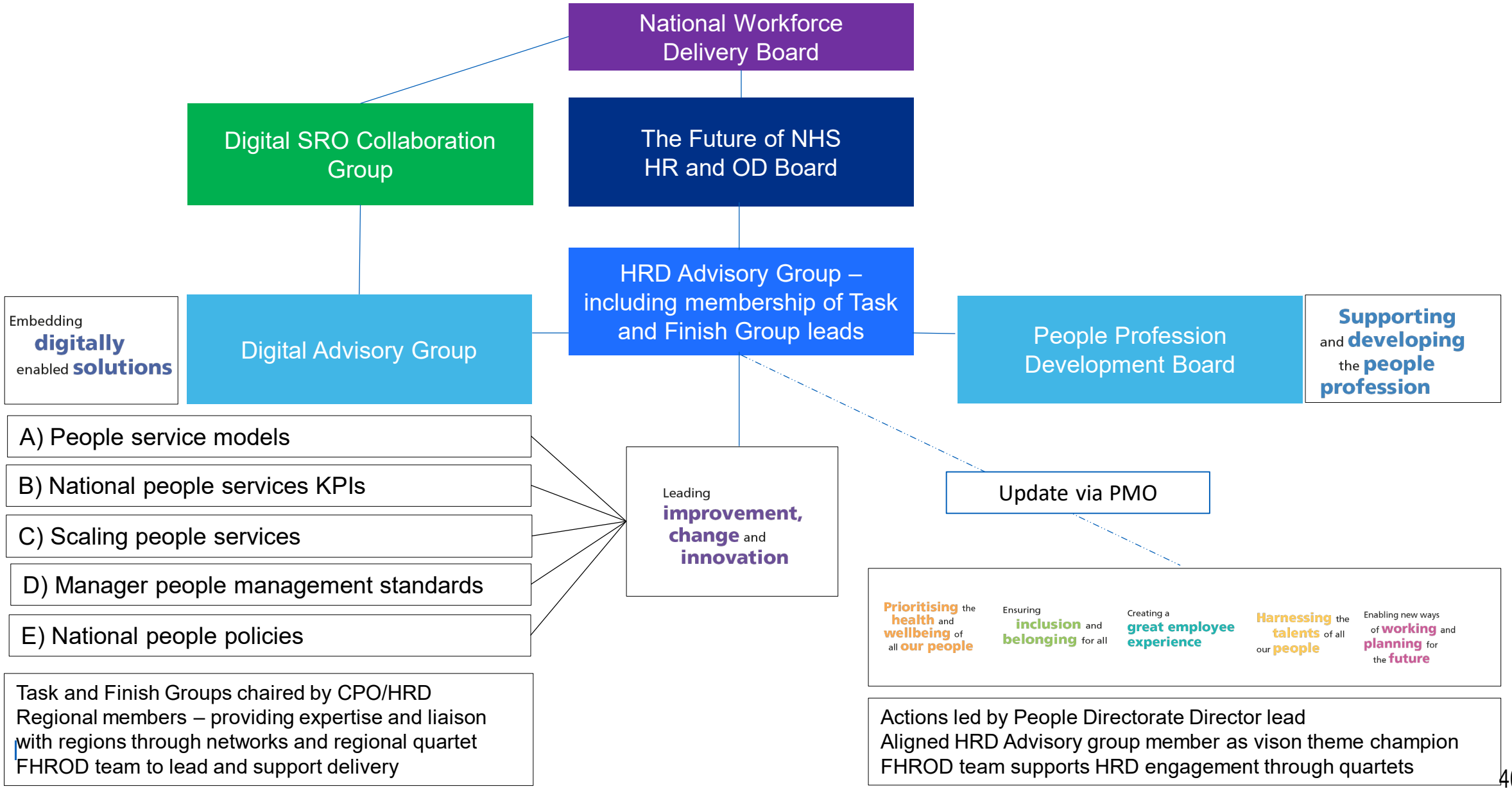
Regional HRD Networks: FHROD programme will continue to liaise with HRDs through regional networks. Links strengthened by regional membership in programme groups.

ICSs: accountable to regions for delivery of the ICS People Functions, workforce aspects of Long Term Plan, including the People Plan, and Future of NHS HR and OD actions for organisations at system level.

Provider collaboratives: some aspects of Future of NHS HR and OD programme delivery may most appropriately be delivered by provider collaboratives.

Providers: remain accountable for people management and people services provision, including delivery of the workforce aspects of Long Term Plan, including the People Plan, and Future of NHS HR and OD actions for organisations.

Programme structure: delivery of national actions



Vision Theme	FHROD national priorities to 2022/2023 – outputs for enabling themes
Supporting and **developing** the **people profession**	• NHS people profession standards tailored to the needs of the health and care sector • Infrastructure to support implementation – e.g. national people profession development board • Development programmes and tools to increase organisational development skills, capability and capacity – building on the 'Do OD' community resources • New model for the extensive use of apprenticeships to fund professional accreditation
Leading **improvement, change** and **innovation**	• frameworks to enable people services to assess alignment of resources with the national and local priorities (Task and Finish Group A) • range of new people function service models to support our vision for 2030 (T&F A) • central repository of best practice • national standards and KPIs for people services to support improvement (T&F B) • national toolkits and training that support the people profession to embed these standards (T&F B) • national guide for scaling people services (T&F C) • clear view on the expectations of managers in the service in relation to people practices (T&F D) • standard set of simplified national people policies (T&F E)
Embedding **digitally** enabled **solutions**	• strategic group that effectively prioritises, coordinates and agrees national digital people strategic initiatives • managed interdependencies between digital workforce programmes and the People Plan • data standards across multiple people digital systems to enable interoperability • benchmarked set of KPIs for people services, with a consistent reporting framework • Digital services procured with national technology standards and commercial digital frameworks

Programme update:
Leading Improvement, Change and Innovation

The Programme's overall delivery confidence is **Green**

People Service Models

- Developed a proposed set of people services models and a service model assessment tool
- Draft scaling playbook close to completion
- Joint working with Scaling People Services workgroup based upon the interdependencies between the two

National People Service KPIs

- Baseline Model Health System KPIs reviewed.
- In-person workshop held to develop people services KPI taxonomy and list of initial people services KPIs
- Will look at BSI and ISO HR and OD standards for potential adoption

Scaling People Services

- Deloitte led 5th workshop held and draft scaling playbook close to completion
- Begin socialising and gathering feedback in September
- Planning wider engagement via a Teams Topic or big conversation crowdsourcing event to introduce draft guide in October
- Identify pilot sites to test the implementation of the guide

Manager People Management Standards

- Gathering potential content in existence already
- Working closely with colleagues from Talent and Leadership Development in the People Directorate to develop standards

National People Policies

- Good policy development principles agreed and will create a policy development framework
- Two national policies will be developed in the initial tranche
- Engagement with National SPF and NHS Employers to propose establishment of working groups to include joint working with staff side colleagues and NHS Employers
- Group agreed to setting up stakeholder reference groups to test draft policies

People Profession – Actions

Action 1: The NHS People Professional Map

- introduce NHS people profession standards, to create a curriculum of development tailored to the needs of the health and care sector (by 2023)
- develop the infrastructure to support implementation, including a national people profession development board and strong links to the regional people boards (by 2023)
- deliver development programmes and tools to increase organisational development skills, capability and capacity – building on the 'Do OD' community resources (by 2023)
- ensure that systems, with support from the national team, adopt standard benchmarking tools, to help teams and organisations understand capability, and ensure tailored development (by 2025)
- ensure that employing organisations demonstrate they are meeting the professional standards set nationally

Action 2: National People Apprenticeship Programme

- undertake continuous professional development and appraisal processes that align to professional standards and incorporate customer feedback, to support development and continuous improvement
- have opportunities to enhance their skills, knowledge and experience through experiential and formal learning, to reach their full potential throughout their career journey
- access a high quality development support that covers the emerging skills and capabilities needed, such as workforce planning, organisation development, digital, equality, diversity and inclusion, transformational change, culture change and design and system thinking
- access apprenticeship programmes to enable CIPD accreditation at all stages of the career journey
- access professional support, such as coaching, mentoring, role modelling and senior sponsorship

Action 3: Representative of the communities we serve

- provide clear and inspiring pathways to address the underrepresentation of our NHS people with protected characteristics through improving development support, talent management, recruitment and promotion
- assess proactively the EDI development gaps in knowledge and upskill people professionals to be the catalysts for change and to positively disrupt the norms.
- collaborate with local communities – through multiple agencies, non-profit organisations and academic establishments – to improve the talent supply pipeline for the people profession
- advance the NHS people profession to be representative of the communities that our NHS people serve. Introduce new and comprehensive routes into and within the profession, including through apprenticeships
- create a vibrant and active succession planning framework within the people profession to ensure inclusive talent acquisition and management across systems and organisations
- recognise and sponsor all high-potential individuals from underrepresented backgrounds to enable them to fulfil potential and ambition. Use data and robust monitoring to understand the experience and outcomes of people professionals from underrepresented backgrounds, and take action where needed
- commit to professional accreditation, including apprenticeships, experience assessments and professional developmental pathways for all people professionals

Action 16: EDI Accreditation Programme

- Identify EDI standards and expertise as core competencies within the people profession, to be tested during recruitment, promotion and appraisal with support provided for development (by 2023)
- work in partnership with the CIPD to develop and accredit standards, competencies and skills in EDI (by 2023)

Action 7 & 11: Building Digital Capabilities Within the People Profession

- build digital workforce and business intelligence capability at national, ICS and provider level to support delivery of the People Plan and People Digital Strategy towards enabling improved efficiency and workforce planning (by 2025)
- use competencies, training and agreed standards to help build digital capability within the people profession, creating a supportive environment so that staff feel supported and skilled to embed the change to digitally-led services

Supporting and developing our people profession – update

NHS England

Professional Map (action 1)

- CPO/CIO sponsor sign off completed for all grouped standards
- Meeting with designers to discuss potential map design options
- Planning Teams Topic event to be launched in early winter 2022

Professional Development Board (action 1)

- Monthly board meetings scheduled until February 2023

EDI Accreditation (action 16)

- Programme outline completed
- Meeting with Equality and Inclusion team to discuss engagement (and support) with EDI leads

Partnership with HEE on the Delivery of Apprenticeships (action 2)

- Early Implementer Cohorts taking shape with eligibility checks and onboarding to national cohorts underway for new People Profession Apprentices
- Series of information and awareness sessions delivered for Early Implementors

Building Digital Capabilities within the People Profession (action 7 & 11)

- Build digital workforce and business intelligence capability at national, ICS and provider level to support delivery of the People Plan and People Digital Strategy towards enabling improved efficiency and workforce planning (by 2025)
- Use competencies, training and agreed standards to help build digital capability within the people profession, creating a supportive environment so that staff feel supported and skilled to embed the change to digitally-led services

Supporting and developing our people profession – what's next

NHS England

Action 2

- Development offer for the People Profession
- One point of access
- Access to apprenticeships

Action 3

- Partnering with HPMA to support organisations and ICS CPOs ensuring the PP is representing the communities they serve

Action 4

- Research and evidence-based practice ensure NHS part of CIPD policy and strategy construction

Action 4 and 11

- Repository of good practice and opportunities to share best practice

Action 11

- Build digital capability within the People Profession

What our people want…and how are we supporting them

Our people

- Frustrated when technology is not easy to navigate or when it does not work for them
- Fed up of repeating form filling, employment checks and statutory and mandatory training
- Feel their time is not valued
- Don't understand why the basics aren't there, systems are clunky, and not like systems I use on a day-to-day basis like my banking app, fitness app, Amazon and Facebook
- They want to help solve the problems

Our managers

- Too many workforce systems to learn, not intuitive. For example, erostering, ESR, occupational health, recruitment
- Too clunky – it takes too long to do what I need to
- Data is often wrong or out of date, so I end up chasing the wrong person
- Constantly being chased and chasing staff to do this and do that on the systems, why not the other way round?
- Want to see improvements but don't have the time to adopt new ways of working whilst under such pressure

Our leaders

- Difficult to help staff and managers if we don't know what is happening
- Too often have to rely on anecdotal evidence
- Data is inaccurate, slow to get and/or out of date, not easy to develop forward looking predictive analytics
- Only get part of the picture of what is really going on
- Starting to get some visibility and transparency of some areas, really want a fuller picture at our fingertips

People Teams

- 16,000 people professionals led by 200+ CPOs

Digital Teams

- 42,000 digital professionals led by 200+ CIOs

People Digital

Deliver a digitally enabled experience for our people, managers and leaders

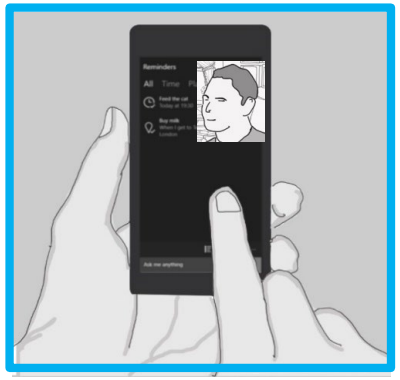
People Digital Vision: Digitally-enabled experience for NHS staff and managers

Easy for staff, managers and HR teams to complete tasks on the move to improve working lives

Managers and employers define staffing needs and publish vacancies / shifts

- Evidence-based workforce planning and insights to define staff and skills needed.
- Staff records full and up to date.
- Employers publish vacancies and unfilled shifts bookings.

Staff easily access information and activities on any device



- Staff use an app(s) to do basic tasks on the move like booking shifts, booking annual leave, viewing payslips etc.
- Carefully targeted notifications keep staff informed and engaged.

Managers and HR teams have intuitive workflow tools to complete tasks quickly

- Managers utilise workflow tools that enable seamless management of staff.
- HR teams manage workflow to recruit, shifts booking, managing absence, employee relations and more rapidly with confidence that all safeguards have been met.

Staff and managers present credentials as evidence and for access

- Staff control their data.
- Staff use an app(s) to hold their 'verified employment and skills credentials' securely.
- Staff able to access buildings and log into clinical systems.

Maximise staff time with patients

- Clinicians, managers and support teams feel their time is valued.
- Processes fast-tracked.
- Patients can rest assured that all safeguarding checks have been completed and are up to date.

People Digital Workstreams Readiness

Sub-programme	Status		Benefits	Current Status
ESR Self-service optimisation	**Live**	All Providers to rollout employee and managers self-service	Improves staff experience and data quality.	100+ Providers already have ESR self-service, others being encouraged to roll out asap. NHS BSA Optimisation team providing support, looking to scale up.
Erostering, ejob planning	**Live**	Optimise use of erostering and ejob planning	Improving workforce productivity and reducing agency spend.	82% of clinicians have eroster account and 8% have ejob plans. Average eroster Level of Attainment is 1.6 out of 4 maximum. Regional roadshows underway.
OH & LMS Interfaces	**Live**	All Learning Management and Occupation Health systems interface into ESR and Digital Staff Passport	Reduces HR admin and makes data available for passport to reduce duplication of checks and statman training.	13 pilots completed, 7 in testing, 52 funded and in progress. Gathering Expressions of Interest from Providers and designing service to support mass roll out.
RPA	**Live**	Automate as many HR processes as quickly as possible.	Improve staff experience, speed up HR processes, e.g. time to hire, and reduce HR admin.	HR processes have highest ROI. 6 ICSs leading RPA for clinical and corporate processes. Interested CPOs to join Community of Practice with CIOs.
NHS Digital Staff Passport	**Private Beta**	Starting with post-graduate doctors in training, secondments and honorary contracts then make available to all staff	Reduce duplication of unnecessary employment checks and statutory and mandatory training.	Covid Digital Staff Passport still live. New service for PGDiT and temp staff movements moving from alpha to private beta.
ICS Workforce Interoperability Hubs	**Early Alpha**	All workforce systems to be interoperable with each other	Better workforce information, better workflow, better experience for staff more accurate pay.	Proof of concepts for ICS Interoperability hubs completed with 4 x ICSs. Business case for these to become beta services being created.
NHS Staff App	**Discovery**	Enable staff to view their information, inc. payslips and undertake admin tasks on the move, e.g. booking annual leave, booking shifts or applying for new jobs in the NHS.	Improve staff engagement, save staff time, give staff more control over working lives.	Discovery work completed and validated with 20 Trusts. Market testing completed. Building team to design and procure partner to enter alpha and beta phases.
ICS People Digital Plans	**Support**	Each ICS to develop ICS People Digital plan to identify gaps, priorities and support needed to achieve the People Digital vision.	Ensure user needs and priorities from ICSs, Providers and service users are delivered as soon as practically possible and affordable.	First ICS People Digital Plans in development. Looking to align with ICS Digitalisation Planning.
People Digital Team	**Support**	Build small national People Digital team with regional People Digital leads.	Co-ordinate and align national programmes to minimise gaps and overlaps. Ensure priorities match ICS and user needs and ensure that benefits are monitored and realised.	Interim lead in place. Deputy lead due to start in September. Commercial lead being recruited.

Vision Theme	FHROD national priorities 2022/2023 – outputs for strategic vision themes
 **Prioritising** the **health** and **wellbeing** of all **our people**	• national direction on health and wellbeing through operational planning guidance • metrics to measure and track the health and wellbeing of our people • minimum standards for the physical work environment that supports good health and wellbeing
 Creating a **great employee experience**	• range of ways to measure employee experience that complement the staff survey • advice, guidance and support on how to promote the full range of careers in the NHS
 Ensuring **inclusion** and **belonging** for all	• EDI standards and expertise as core competencies within the people profession in partnership with the CIPD • regulator guidance on EDI and employee experience measures used to assess organisations • support the implementation of EDI elements of Director Leadership Competency Framework • resources for leaders and line managers to help them deliver compassionate and inclusive people practices
 **Harnessing** the **talents** of all our **people**	• standards and responsibilities, and practical support for organisations and systems for talent management
 Enabling new ways of **working** and **planning** for the **future**	• tools that support clinical, workforce and other specialist leaders, to plan for the workforce needs • training materials and a programme of development to support the people profession grow and evolve its skills and capacity in workforce planning

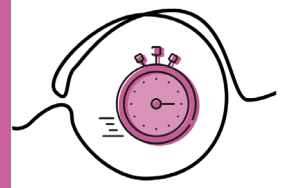
FHROD national priorities 2022/2023 – outputs for strategic vision themes

Creating a **great employee experience**

National key actions	Update on actions
• Establish regular ways to measure employee experience to complement the staff survey. • Advice, guidance, and support on how to promote the full range of careers in the NHS	• Quarterly Pulse surveys established

Harnessing & **Developing the Talents** of Our People

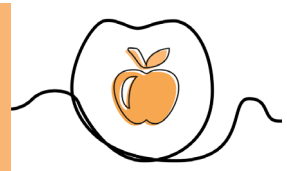
• Develop clear approach for talent management for all, including defined standards and support for organisations/ICSs.	• Finalised leadership competencies, pending final approval • Finalising consistent methodologies at aspiring CEO and Executive Director level linked to the competency framework • Developed the 'Scope for Growth' tool to support improved career conversations and inclusive identification of talent across all staff groups and seniority – 35 pilot sites and Q4 across 50% of people professionals



Enabling new ways of **working** & **planning** for the **future**

• Tools that support clinical, workforce and other specialist leaders to plan for the workforce needs • Training materials and a programme to support the people profession grow and evolve its skills and capacity in workforce planning	• Established a Workforce Planning Improvement Group to consider capacity, capability improvement requirements to enable effective workforce planning • Developing a repository and a network to develop sharing of good practice • Working with the People Profession team to develop competences around workforce planning.

FHROD national priorities 2022/2023 – outputs for strategic vision themes



Prioritising the health & wellbeing of all our people

National key actions

- National direction on health and well-being through operational planning guidance
- Metrics to measure and track the health and well-being of our people
- Minimum standards for the physical work environment that supports good health and well-being

Update on actions

- Health and Wellbeing tracked through the staff survey, aligned to the People promise and quarterly pulse surveys. Results published on Model Health System platform
- Guidance and toolkits on health and wellbeing developed for organisations
- Focus groups being held with key stakeholders to define standards for physical work environment in conjunction with colleagues in the estates and Health and well-being teams

Ensuring inclusion & belonging for all

- EDI standards and expertise as core competencies within the people profession in partnership with the CIPD
- Regulator guidance on EDI and employees experience measures used to assess organisations
- Support the implementation of EDI elements of Director Leadership Competency Framework
- Resources for leaders and line managers to help them deliver compassionate and inclusive people practices
- Overhaul recruitment processes to take into account EDI considerations
- Provide appropriate developmental support and pathways including coaching, mentoring for staff in under-represented groups
- Recruitment process contains evidence of candidates' impact on EDI
- High potential individuals from under-represented backgrounds have a clear development plan to help them reach their potential

- NHS People Profession Map defines EDI standards for all People Professionals, as well as define standards for EDI Experts
- Co-designing a global accreditation programme for EDI with CIPD to develop and accredit EDI experts based on defined standards, competencies, and skills
- Conversations have commenced with the CQC to include EDI and employee experience in organisational assessments
- EDI competencies incorporated into new My Leadership Way
- Resources being developed and rolled out to support leaders/managers develop their skills in managing compassionately
- Overhauling of recruitment programme has commenced with a number of sprints planned to commence in September aligned to each stage

Future of NHS HR and OD Programme Priorities for 2022/23 – Enabling Themes

Leading Improvement, Change and Innovation

National/Regional key actions	Update on progress
Develop a range of people service models to support our vision for 2030	A range of people service models have been developed by the Task and Finish Group and Deloitte to be included in the scaling guide Further focused work on going ahead of wider input from HRD Networks, SPF et al
Develop national KPIs for people services to support improvement	KPI Task and Finish Group review of baseline data, principles for development of KPIs and held a workshop in September to begin scoping KPIs. Working with colleagues in NHSE to streamline data collection, reporting and analysis
Develop a national guide for scaling people service	Deloitte creating a scaling guide in partnership with the Scaling Task and Finish Group Draft version shared with 35 CPOs/DCPOs for comments and feedback Plan to distribute via HRD Networks, SPF et al for further input Preparing for a crowdsourcing exercise targeted at Heads of Dept and above
Develop expected people management standards for managers for adoption across the service	People Management standards Task and Finish Group established and working with colleagues in leadership academy to align to Leadership Way and People Promise
Develop a standard set of simplified national people policies	Task and Finish Group established developing a national framework for policy development, engaging and working jointly with NHS Employers and Social Partnership forum

Future of NHS HR and OD Programme Priorities for 2022/23 – Enabling Themes
Supporting and Developing the People Profession

National/Regional key actions	Update on progress
Introduce NHS people profession standards and supporting development to increase the professionalisation and future contribution.	NHS People Profession Map developed in partnership with the CPO/HRD Community and the CIPD. Being presented to the People Profession Board for signoff in September and in preparation for engagement in Q3 and launch in Q4
Infrastructure to support implementation – Early Implementer Cohorts People Profession Development Board	People Profession Board established in August 2022 with representatives from HRDs/CPOs and key partners.
Develop comprehensive apprenticeship offer to increase the capability levels and professional accreditation within the profession.	Working in partnership with HEE to enhance the People Profession apprenticeship related offer and a national procurement framework

Future of NHS HR and OD Programme Priorities for 2022/23 – Enabling Themes
Embedding digitally enabled solutions

National/Regional key actions	Update on progress
Establish a strategy group that prioritises, co-ordinates and agrees people digital strategic initiatives	The People Digital SRO collaborative has been established and meeting monthly to manage the interdependencies between programmes and the People plan. Meets monthly.
Managed interdependencies between digital workforce programmes and the People Plan	People Digital Delivery Advisory Group established with membership from CIO and CNO communities to ensure people digital products to meet the needs of the people profession
Digital standards across multiple people digital systems to enable interoperability	Appointment made to lead the development of digital standards
Digital standards procured with national technology standards and commercial digital frameworks	Appointment made to lead the digital procurement standards programme

Future of NHS HR and OD Programme Priorities for 2022/23 – Strategic Themes

Theme	National/Regional key actions	Update on progress
Prioritising the health and wellbeing of all our people	National direction on health and well-being through operational planning guidance Metrics to measure and track the health and well-being of our people Minimum standards for the physical work environment that supports good health and well-being	Health and Wellbeing tracked through the staff survey, aligned to the People promise and quarterly pulse surveys. Results published on Model Health System platform Guidance and toolkits on health and wellbeing developed for organisations Focus groups being held with key stakeholders to define standards for physical work environment in conjunction with colleagues in the estates and Health and well-being teams
Harnessing the talents of all our people	Develop clear approach for talent management for all, including defined standards and support for organisations/ICSs.	Finalised leadership competencies, pending final approval Finalising consistent methodologies at aspiring CEO and Executive Director level linked to the competency framework Developed the 'Scope for Growth' tool to support improved career conversations and inclusive identification of talent across all staff groups and seniority – 35 pilot sites and Q4 across 50% of people professionals
Enabling new ways of working and planning for the future	Tools that support clinical, workforce and other specialist leaders to plan for the workforce needs Training materials and a programme to support the people profession grow and evolve its skills and capacity in workforce planning	Established a Workforce Planning Improvement Group to consider capacity, capability improvement requirements to enable effective workforce planning Developing a repository and a network to develop sharing of good practice Working with the People Profession team to develop competences around workforce planning

Future of NHS HR and OD Programme Priorities for 2022/23 – Strategic Themes

Theme	National/Regional key actions	Update on progress
Ensuring inclusion and belonging for all	EDI standards and expertise as core competencies within the people profession in partnership with the CIPD Regulator guidance on EDI and employees experience measures used to assess organisations Support the implementation of EDI elements of Director Leadership Competency Framework Provide appropriate developmental support and pathways including coaching, mentoring for staff in under-represented groups Resources for leaders and line managers to help them deliver compassionate and inclusive people practices High potential individuals from under-represented backgrounds have a clear development plan to help them reach their potential Overhaul recruitment processes to take into account EDI considerations Recruitment process contains evidence of candidates' impact on EDI	NHS People Profession Map defines EDI standards for all People Professionals, as well as define standards for EDI Experts Co-designing a global accreditation programme for EDI with CIPD to develop and accredit EDI experts based on defined standards, competencies, and skills Conversations have commenced with the CQC to include EDI and employee experience in organisational assessments EDI competencies incorporated into new My Leadership Way Resources being developed and rolled out to support leaders/managers develop their skills in managing compassionately Overhauling of recruitment programme has commenced with a number of sprints planned to commence in September aligned to each stage of the recruitment process. Steering Committee established which meets weekly

Future of NHS HR and OD Programme Priorities for 2022/23 – Strategic Themes

Theme	National/Regional key actions	Update on progress
Creating a great employee experience	Establish regular ways to measure employee experience to complement the staff survey.	NHS Staff Survey developed and aligned to the People Promise for 2021 to measure and improve employee experience through what our NHS people said is important to improve their working experience. A monthly Pulse Survey introduced– available free to all Trusts (currently 200 plus organisations have used Pulse). Quarterly Pulse surveys established and now in its 3rd quarter of providing data to track Employee Engagement Web based reporting to be enabled end Sept 2022, including non aggregated ICS view. All data currently available on Model Health System. Community of practice created to understand data and share the ways data is maximised for action and improvement. Currently 500 strong. Communication tools and assets developed nationally to support local comms. Organisations making a return Qtr 2 2022 at 187 Trusts submitting 127,021 responses From Sept – local and national driver analysis is available for the People Pulse.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 01/09/22	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 1st September 2022, virtually, via webconference

The key matters considered at the meeting were as follows:

- The Deputy Chief Nurse for Quality provided a **review of the revised Patient Experience Strategic Theme** which included the process by which the Vision Statement and Breakthrough Objectives would be achieved.
- The Patient Experience Lead and Quality & Technical Manager for Facilities provided a **review of the outputs from the Patient Led Assessment of the Care Environment (PLACE) 'lite' audits, including the methods to increase public representation** in which it was agreed that the Patient Experience Lead would liaise with the Valuing People Now District Worker for West Kent to investigate the provision of additional support for patients with disabilities within the Trust's bed base.
- The Patient Experience Lead and Deputy Chief Nurse for Quality provided an **update on the Patient Partner Programme and progress with increasing 'lay member' representation at the Committee's meetings** where it was agreed that the Patient Experience Lead should ensure that as part of the recruitment process for volunteers' additional support was provided to candidates, especially those candidates with protected characteristics.
- The Matron for Outpatients, General Manager for Outpatients, and Deputy General Manager for Outpatients attended for a **review of the findings of Cancer Services / Outpatients self assessment of the Care Quality Commission (CQC) 'Caring' domain and patient engagement work.**
- The General Manager for Facilities provided an **update on the progress with the Trust's response to the findings from the report of the Independent Review of NHS Hospital Food which included an in-depth update on the implementation of digital menus to increase accessibility for patients with disabilities** in which it was agreed that the Administration Assistant, Trust Secretary's Office should provide the General Manager for Facilities with the contact details of the Committee's 'lay members', to enable their involvement in the digital patient food ordering system task and finish group.
- The Chair of the Patient Experience Committee and the Deputy Chief Nurse for Quality **updated the Committee on their future plans** and it was agreed that the Director of Strategy, Planning and Partnerships and Deputy Chief Nurse for Quality liaise with the Patient Experience Lead for Maternity Services to investigate what, if any, lessons could be learned from the codesign approach utilised by the Maternity Voices Partnership to support the development of the Trust's patient experience strategy.
- Under **Any Other Business** it was agreed that the Patient Experience Lead should ensure that the Director of Strategy, Planning and Partnerships was provided with the feedback from the face to face / in-person reviews of the Community Diagnostic Centre.

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

The issues that need to be drawn to the attention of the Board: N/A

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 performance

NHS
Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 5, 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, 27/09/22, Finance and Performance Committee, 27/09/22

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

August 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

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)

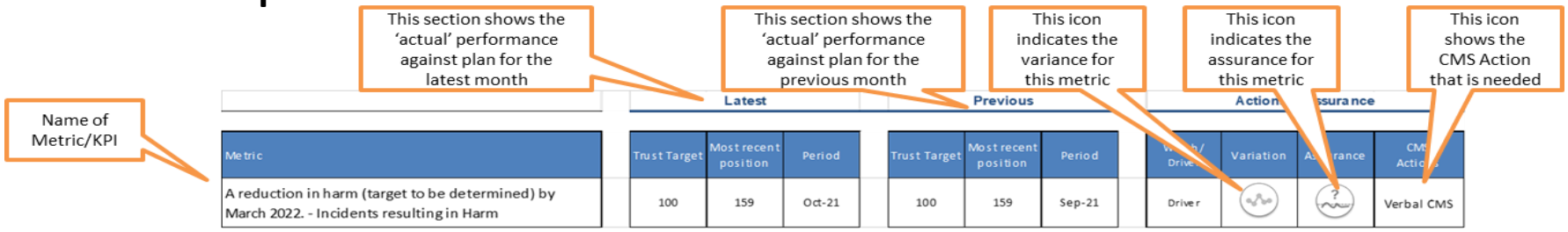
Escalation Pages:

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

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.

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

The Trust Turnover Rate is a new SDR metric and has failed the target for more than six months. It is in special cause variation of a concerning nature. Vacancy Rate is now experiencing special cause variation of a concerning nature and variable achievement of the target. Agency use and spend is consistently failing the target. Sickness is in variable achievement and Safe Staffing levels remain in escalation as has 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 and variable achievement of the target. Both the Hospital on-set of COVID and C.Difficile 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 is experiencing common cause variation and variable achievement of the target.

Diagnostic Waiting Times has seen a drop in performance this month and is now experiencing common cause variation at 89.7% for August 202, driven mainly by a drop in Echocardiography performance. RTT performance is experiencing special cause variation of a concerning nature and 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). First outpatient activity levels have failed the trajectory target for the last six months but were above 1920 levels for Quarter 1 and August 2022. Diagnostic Activity levels have not achieved the target for more than six months but remain consistently above 1920 levels. Elective activity achieved the plan for Quarter 1 overall as well as having achieved the plan for the months of June, July and August and is therefore above plan YTD.

A&E 4hr performance is experiencing common cause variation at 86.3% 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 the National Cancer 62 Day Standard (85.1%) and the national 2 Week Wait (2WW) Standard (95.0%) in July 2022. Achievement of 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.

Please note that some of Counter Measure Summaries (CMS)'s are still in development as the A3's are still in progress.

Escalations by Strategic Theme:

People:
- Turnover Rate (P.8)
- Sickness Rate (P.8)*

Patient Safety & Clinical Effectiveness:
- Safe Staffing (P.11)
- Infection Control (P.11)*

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

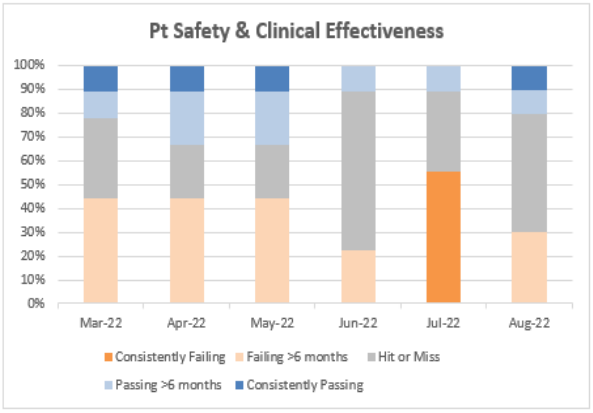
Patient Access:
- RTT Performance (P.13)
- Planned levels of new outpatients activity (P.14)
- A&E Performance (P.15)
- Outpatient Calls answered <1 minute (P.16)
- Outpatient Clinic Utilisation (P.16)
- Ambulance Handovers >30 minutes (P.15)
- Diagnostic Waiting Times (P.17)
- Planned levels of Diagnostics activity (P.18)

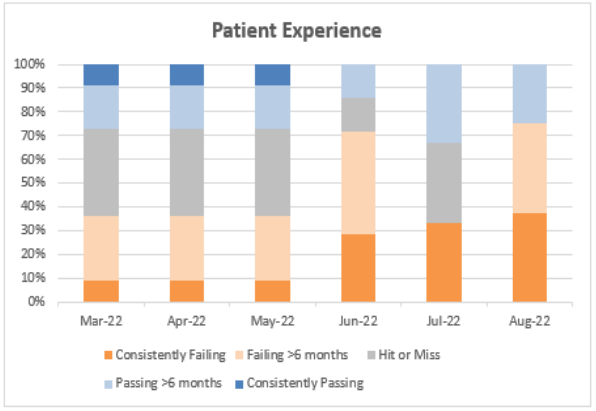
Patient Experience:
- Total Number of Complaints (P.20)
- Complaints responded within target (P.21)
- FFT Response Rates - all areas (P.22)

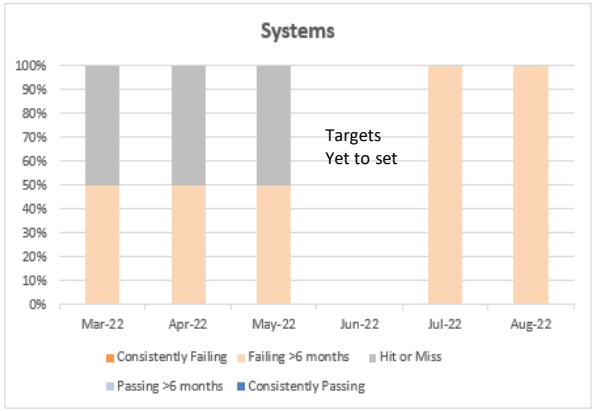
Systems:
- Discharges before Noon (P.24)

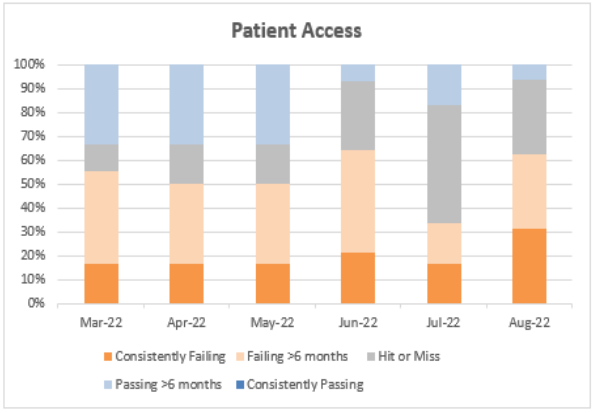
Sustainability
- Agency Spend (P.26)

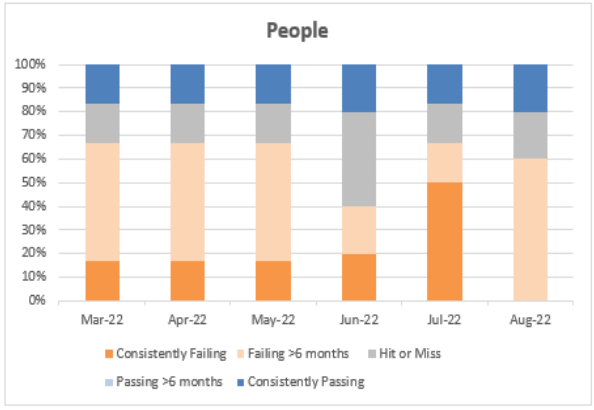
Assurance Stacked Bar Charts by Strategic Theme

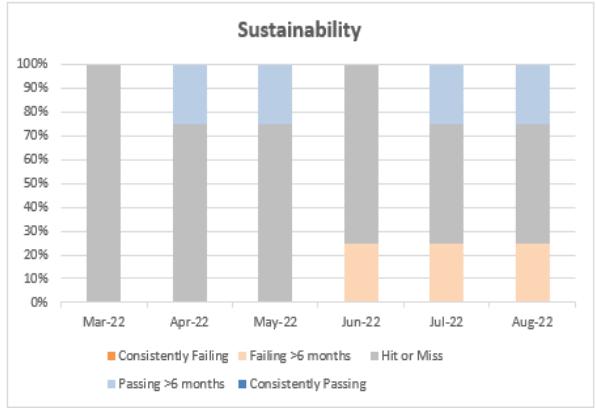












Matrix Summary

August 2022		Assurance				
		Pass ★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement		Never Events Flow: % of Emergency Admissions that are zero LOS (SDEC)	Flow: % of Emergency Admissions into Assessment Areas		To increase the number of patients leaving our hospitals by noon on the day of discharge Access to Diagnostics (<6weeks standard) Transformation: CAU Calls answered <1 minute
	Common Cause	Statutory and Mandatory Training	Cash Balance (£k) Complaints Rate % VTE Risk Assessment (one month behind) Cancer - 62 Day	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3 Reduction in incidents resulting in harm by 8.2% by March 2023 Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023 Ensure activity levels for theatres match those pre-Covid - Total Elective Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients Number of New SIs in month Cancer - 2 Week Wait Capital Expenditure (£k) Sickness Absence	To reduce the overall number of complaints or concerns each month To achieve the planned levels of new outpatients activity (shown as a % 19/20) To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. A&E 4 hr Performance Safe Staffing Levels Infection Control - Hospital Acquired Covid Appraisal Completeness % complaints responded to within target IC - Rate of Hospital C.Difficile per 100,000 occupied beddays Friends and Family (FFT) % Response Rate: Inpatients Vacancy Rate	Ensure activity levels for diagnostics match those pre-Covid - MRI Ensure activity levels for diagnostics match those pre-Covid - CT Ensure activity levels for diagnostics match those pre-Covid - NOUS Diagnostic Activity (MRI,NOUS,CT Combined) Transformation: % OP Clinics Utilised (slots) Flow: Ambulance Handover Delays >30mins Friends and Family (FFT) % Response Rate: A&E
	Special Cause - Concern	Summary Hospital-level Mortality Indicator (SHMI)		RTT Patients waiting longer than 40 weeks for treatment Delivery of financial plan, including operational delivery of capital investment plan. Standardised Mortality HSMR IC - Number of Hospital acquired MRSA	Achieve the Trust RTT Trajectory by March 2023 Reduce Turnover Rate to 12% by March 2023 Reduce the amount of money the Trusts spends on premium workforce spend Flow: Super Stranded Patients	

Strategic Theme: People

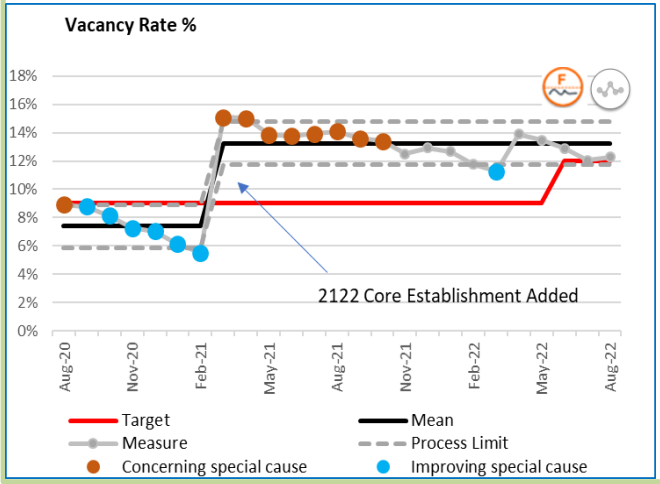
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	12%	12.3%	Aug-22	12%	12.0%	Jul-22	Driver			Full CMS
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12% by March 2023	12%	13.9%	Aug-22	12%	14.0%	Jul-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	5.0%	Jul-22	4.5%	4.1%	Jun-22	Driver			Not Escalated
	Well Led	Appraisal Completeness	95.0%	88.8%	Aug-22	95.0%	75.9%	Jul-22	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	86.3%	Aug-22	85.0%	86.6%	Jul-22	Driver			Not Escalated

Vision: Counter Measure Summary

Metric Name – Reduce the Trust-wide Vacancy Rate to 12% by the end of the financial year 2022/23

Owner: Sue Steen
Metric: Vacancy Rate
Desired Trend: 7 consecutive data points below the mean

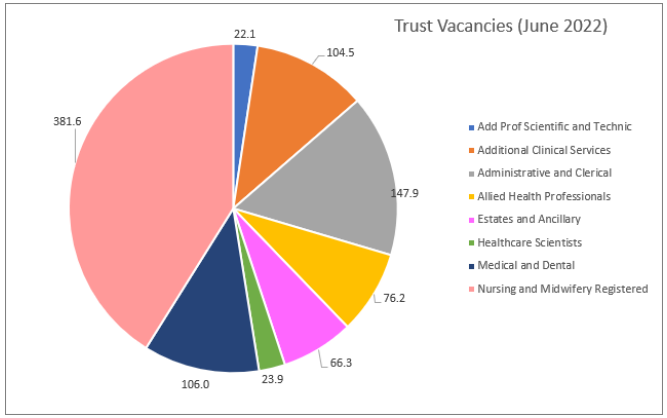
1. Historic Trend Data



Aug-22
12.29%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has not achieved the target for more than 6 months
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target for 6+ months

2. Stratified Data

Trust vacancies for June-22 show that almost half of all total vacancies were for nursing and midwifery posts.



3. Top Contributors

A3 stakeholder engagement event planned for Monday 26th September to explore all key contributors to the Workforce Supply Programme. Five working groups established: Attraction, Recruitment, Onboarding, Retention, and Flexible working.

Although above the 12% target, The Trust has a trend that is going the right direction with a healthy recruitment pipeline, so the expectation is that our recruitment continues to bring in more. The key factor determining vacancy rates remains retention of staff.

4. Action Plan

A new A3 is being developed, with countermeasures identified and to be implemented.

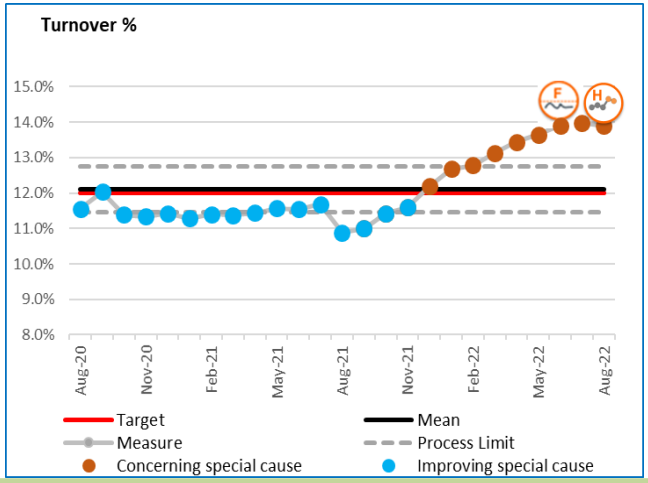
Define	Jul-Aug-22	Define objectives for Reduced Turnover	In progress
Measure	Jul-Aug-22	Review existing data	In progress
Analyse	Sep-22	Analyse data and define reduction trajectory	Not yet started
Improve	Sep-22-Mar-23	Working Groups reducing turnover rate with interventions	Not yet started
Control	Sep-22	Governance structure to encompass improvement framework	Not yet started

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12% by March 2023

Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

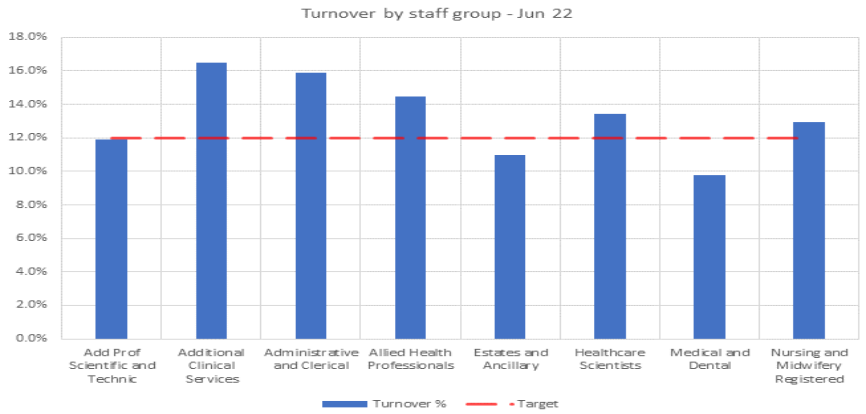
1. Historic Trend Data



Aug-22
13.9%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has not achieved the target for more than 6 months
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target for 6+ months

2. Stratified Data

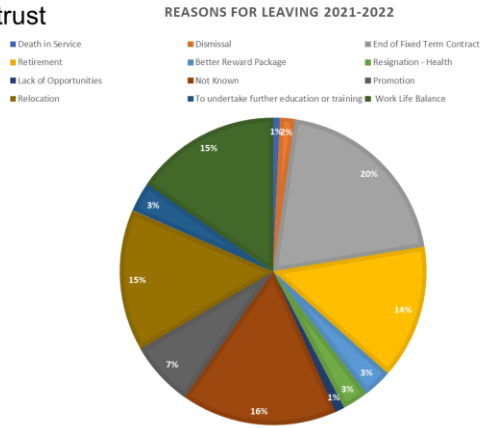
** This is an early view and further analysis will be undertaken



3. Top Contributors

** This early analysis has been undertaken as part of the A3. A deep dive session is scheduled for 26th September.

Reasons for leaving across the trust



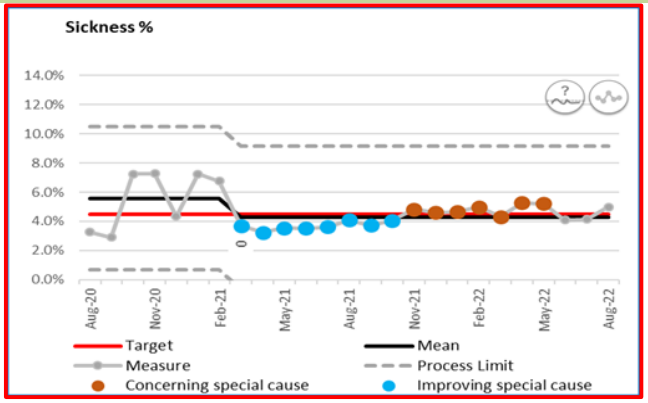
Aside from the reasons of 'End of FTC' (20%) , 'Unknown' (16%) and 'Retirement' (14%)
The most common reasons for leaving were 'Relocation' at 15% (It should be noted that Relocation has been used even for staff moving to neighbouring trusts) and 'Work Life Balance' also making up 15%. This value also includes staff that have left to support Adult or Child dependants.

4. Action Plan

A new A3 is being developed, with countermeasures identified and to be implemented.

Define	Jul-Aug-22	Define objectives for Reduced Turnover	Complete
Measure	Jul-Aug-22	Review existing data	Complete
Analyse	Sep-22	Analyse data and define reduction trajectory	In progress
Improve	Sep-22-Mar-23	Working Groups reducing turnover rate with interventions	In progress
Control	Sep-22	Governance structure to encompass improvement framework	In progress

People – Workforce: CQC: Well-Led



Jul-22

5.0%

Variance / Assurance

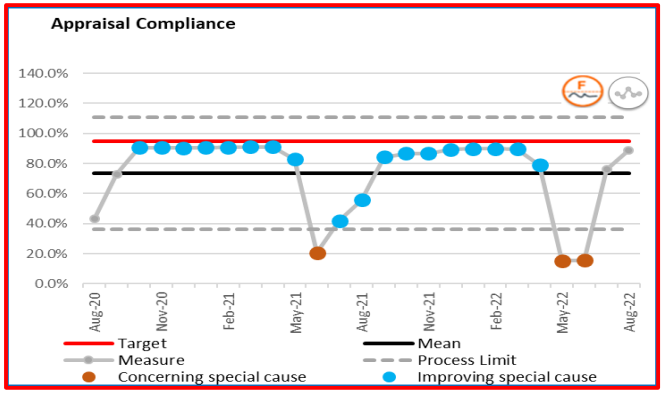
Metric is currently experiencing Common Cause Variation and variable achievement of the target

Max Target (Internal)

4.5%

Business Rule

Escalated as in Hit & Miss for >6months



Aug-22

88.8%

Variance / Assurance

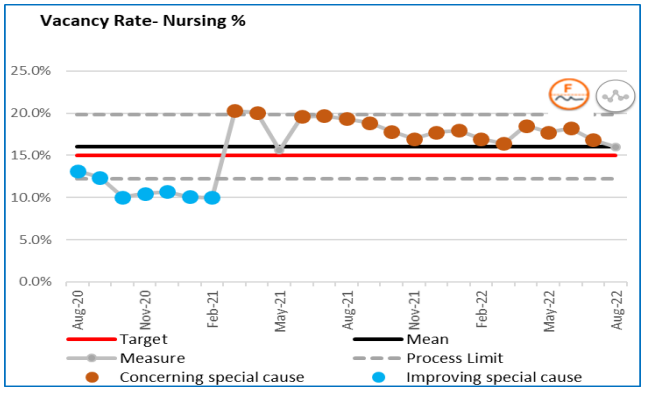
Metric is currently experiencing Common Cause Variation and failing the target for 6+ months

Max Target (Internal)

95%

Business Rule

Has failed the Target for 6+ Months



Aug-22

16.00%

Variance / Assurance

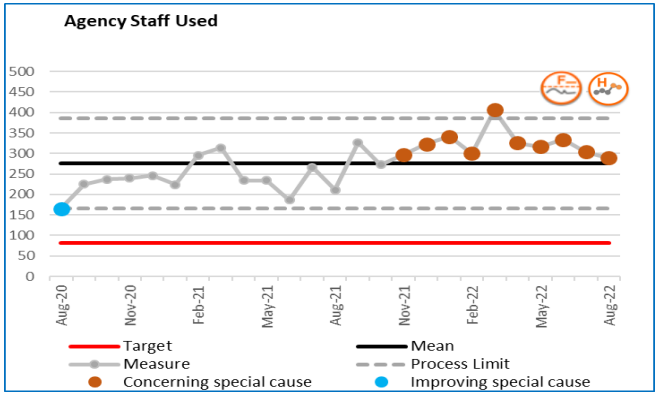
Metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months

Max Limit (Internal)

15%

Business Rule

For Information as linked to Vacancy Rate



Aug-22

289

Variance / Assurance

Metric is currently experiencing Special Cause Variation of a concerning and consistently failing the target

Target (Internal)

81

Business Rule

For Information as linked to Vacancy Rate

Summary:

Sickness % - This metric is experiencing Common Cause Variation and variable achievement of the Target

Appraisal Completeness - This metric is experiencing Common Cause Variation and failing the target for 6+ months

Nursing Vacancy Rate: Shown for information as linked to Vacancy Rate and has failed the target for more than six months.

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 Spend.

Actions:

Sickness: has risen above target for the first time in recent months. The cause of this was a doubling of absence due to Covid -19.

Appraisal Completeness: Implementing a programme of appraisal training for managers and staff to understand the process and the positive impact it can have. A trust wide survey and engagement survey to understand what worked well and where improvements can be made

Vacancy Rate: not reported here has slightly increased this month, which is out of line with the trend. The reason for this is late reporting by 1 month of the new doctor intake. The data for this affected period (June-August) has now caught up and does still show a net increase of 34WTE over this time. We expect next month's rate to drop again, due to continued high volume recruitment activity across all areas.

Agency staff: decrease in usage this month – we expect this to continue as divisions, working with HR and Finance colleagues look to reduce premium workforce spend further.

Turnover: not reported here, however a breakthrough objective with a target of 12% by 31 March 2023. August rate is 13.9%, a small decrease and the first we have seen since August 2021.

Assurance & Timescales for Improvement:

Sickness: As numbers of staff affected by covid-19 have dropped in recent weeks, we expect this trend to improve for next month.

Appraisal Compliance: Engagement with the areas which fell well-below the target to understand what the barriers for completion were and where additional support may be required is commencing and long with engagement with senior leaders within the organisation to ensure that the appraisal process is clearly understood and that leaders are modelling the behaviours being asked of the rest of the organisation

Vacancy Rate % - Recruitment pipeline shows high level of recruitment activity and due to the increase of recruitment activity with international recruitment, marketing campaign and events etc we expect this metric will continue to improve.

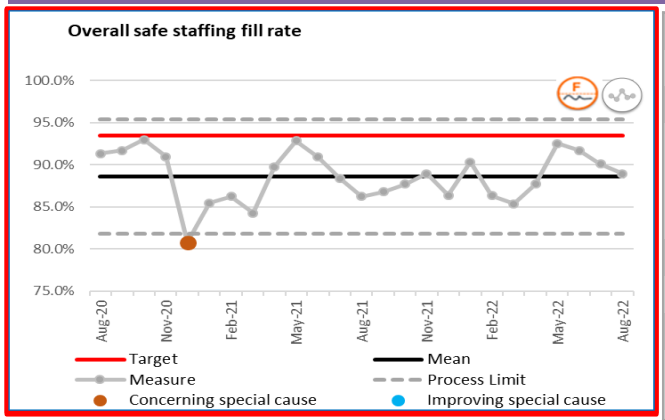
Agency Staff: Joint HR/Finance planning now to support sessions with divisions to take place in September and monthly from then on. This work will support the now live premium workforce group

Turnover: Workforce Supply programme has been launched, with working groups meeting in September to build on existing interventions regarding this target – we hope this will build on the reversal of the trend for the first time this month.

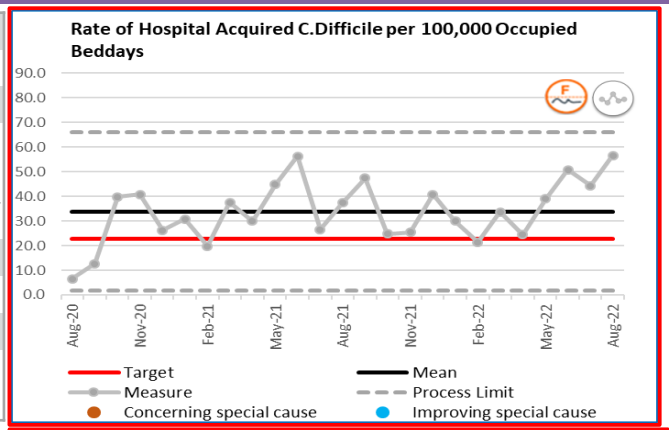
Strategic Theme: Patient Safety & Clinical Effectiveness

			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	Reduction in incidents resulting in harm by 8.2% by March 2023	130	195	Aug-22	131	168	Jul-22	Driver		?	Verbal CMS
Breakthrough Objectives	Safe	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	6.86	7.09	Aug-22	6.93	9.22	Jul-22	Driver		?	Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	8	Aug-22	11	9	Jul-22	Driver		?	Not Escalated
	Safe	Standardised Mortality HSMR	100.0	103.5	May-22	100.0	98.2	Apr-22	Driver	H	?	Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	98.6	Aug-22	100.0	96.8	Jul-22	Driver	H	P	Not Escalated
	Safe	Never Events	0	0	Aug-22	0	0	Jul-22	Driver	L	P	Not Escalated
	Safe	Safe Staffing Levels	93.5%	89.0%	Aug-22	93.5%	90.1%	Jul-22	Driver		F	Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	6	Aug-22	0	8	Jul-22	Driver		F	Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	56.5	Aug-22	22.7	44.4	Jul-22	Driver		F	Escalation
	Safe	IC - Number of Hospital acquired MRSA	0	1	Aug-22	0	0	Jul-22	Driver	H	?	Not Escalated

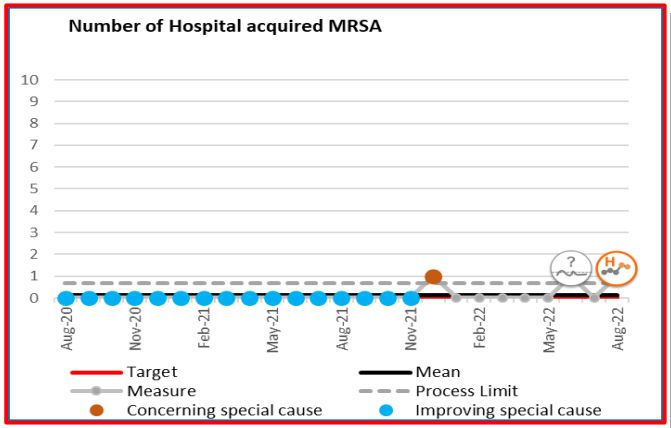
Patient Safety and Clinical Effectiveness: CQC: Safe



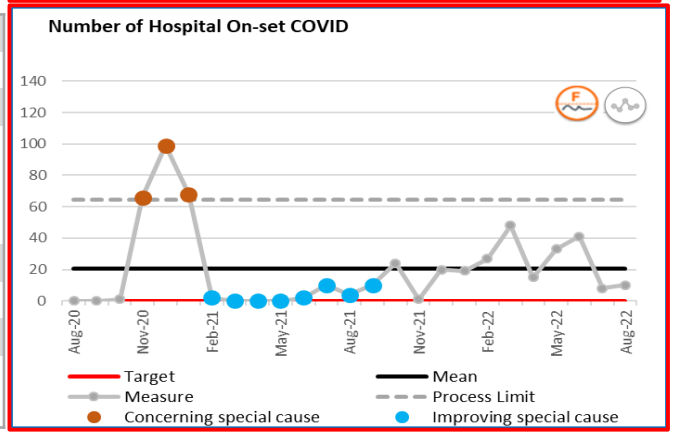
Aug-22
89.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Target (Internal)
93.3%
Business Rule
Full Escalation as has not achieved the target for > 6 months



Aug-22
56.5
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has failed the target for >6months
Max Target (Internal)
22.7
Business Rule
Full Escalation as Hit or Miss > 6 months



Aug-22
1
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a Concerning Nature and variable achievement of the target
Max Target
0
Business Rule
Full Escalation as Hit or Miss > 6 months



Jul-22
10
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 but has now failed the target for more than six months

MRSA: The level of MRSA has risen to 1 and is now in special cause variation of a concerning nature 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 huddles are supported by the Bank team to ensure the staffing allocations mitigate any safety risks. Rostering Confirm and Support meetings are now embedded, with a view to ensure effective rostering within clinical teams. Recruitment activity continues at pace and a focus is now on the retention of Registered Nurses/Midwives and Clinical Support Workers (CSWs) with a view to reduce turnover rates. Career roadshows will commence to support staff with CPD opportunity and career planning.

Infection Control: Due to the increased rates of C diff a Trust wide C.diff incident meeting was held in June to identify areas for improvement. The Infection prevention and Control Team has since provided ward based updates focusing on the management of patients with C diff, diarrhoea and antimicrobial stewardship. The Trust has a year end limit of 62 cases of CDI and continues to see an increase in numbers of Trust attributable *C.difficile* cases, with 32 cases at the end of July. This increased rate is also reflected regionally.
The Trust continues to see a number of Covid outbreaks which are mainly associated with Covid positive patients being identified in a bay resulting in subsequent transmission of infection. All Covid contacts are identified and quarantined. Weekly outbreak meeting are held to support the management of the outbreaks and identify areas for action.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. New processes for the redeployment of staff are now live, ensuring governance and reporting is in place to document staff moves. The Trust continues to roll out SafeCare, with Phase two of the project now live. Recruitment activity continues to move at pace with 68 IEN's recruited from the Caribbean. Increased OSCE training capacity is in place to support the numbers of IEN's joining MTW. Face to face recruitment events continue to have good attendance. The aim is to reduce the Nursing and Midwifery vacancy rate to 10% by December 2022.

Infection Control: The IPC team has provided addition IPC updates to all wards and department to promote the core IPC principles the return to standard Infection prevention and control precautions. All C diff samples are sent to the reference laboratory to assist in identify transmission of C diff infection and outbreaks. 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

Strategic Theme: Patient Access

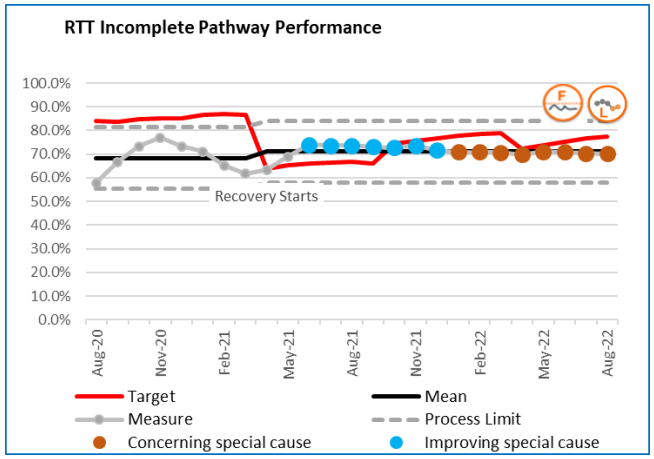
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory by March 2023	77.3%	70.1%	Aug-22	76.5%	70.4%	Jul-22	Driver	L	F	Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	131.9%	112.6%	Aug-22	104.9%	92.5%	Jul-22	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	505	899	Aug-22	517	858	Jul-22	Driver	H	?	Not Escalated
	Responsive	Access to Diagnostics (<6weeks standard)	95.7%	89.7%	Aug-22	91.5%	94.9%	Jul-22	Driver		F	Escalation
	Responsive	A&E 4 hr Performance	95.7%	86.3%	Aug-22	95.7%	84.0%	Jul-22	Driver		F	Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	95.0%	Jul-22	93.0%	93.0%	Jun-22	Driver		?	Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.1%	Jul-22	85.0%	85.3%	Jul-22	Driver		P	Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	59.0%	Aug-22	85.0%	58.0%	Jul-22	Driver		F	Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	1.0%	Aug-22	1.5%	1.9%	Jul-22	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	67.2%	Aug-22	90.0%	71.4%	Jul-22	Driver	H	F	Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	5.0%	9.1%	Aug-22	5.0%	8.8%	Jul-22	Driver		F	Escalation
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	65.8%	Aug-22	65.0%	62.7%	Jul-22	Driver	H	?	Not Escalated
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	111.0%	112.8%	Aug-22	97.8%	99.7%	Jul-22	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	105.9%	108.7%	Aug-22	93.0%	92.7%	Jul-22	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	200.2%	121.0%	Aug-22	190.4%	114.0%	Jul-22	Driver		F	Escalation

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT Trajectory by March 2023

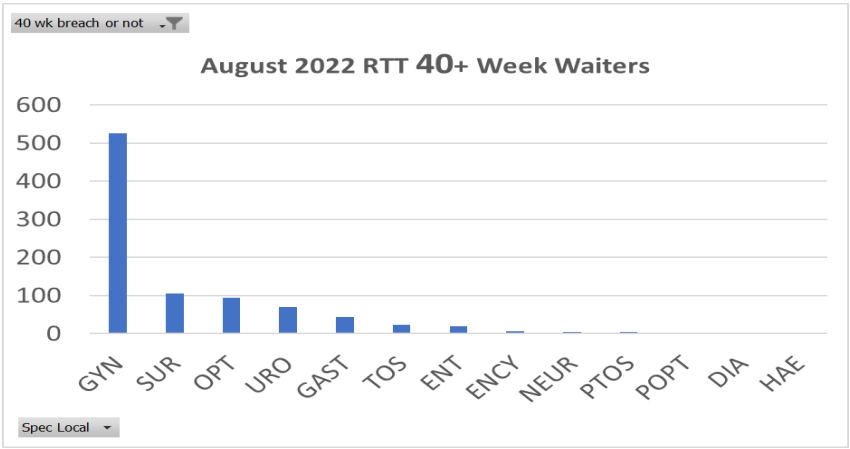
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Aug-22
70.1%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
77.3%
Target Achievement
Metric has failed the target for >6 months

2. Stratified Data



3. Top Contributors

- Close monitoring of all patients over 40 weeks via Tuesday PTL and Trust Performance meeting to ensure patients are treated before their 52 week breach date.
- Contacting patients over 40 weeks to ensure they still need to be on an active waiting list.
- Specialties with a smaller back log of patients are now focussing on over 35 weeks.
- Super September – validation of Waiting List down to 35 - 40 Weeks

- Gynaecology identified as biggest contributor. Divisional project commenced, analysis in progress

4. Action Plan

Breakthrough Objective delivered using Lean Six Sigma Improvement methodology and DMAIC framework

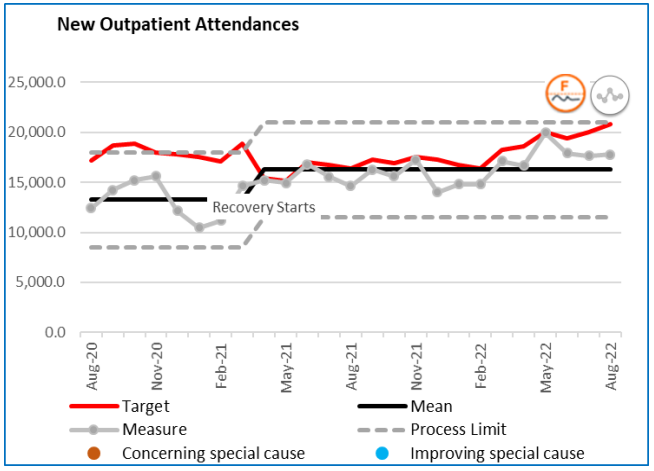
Action	Timeline	Progress
Define	July/August	In Progress
Measure	August/September	In Progress
Analyse	September	In Progress
Improve	TBC	
Control	TBC	

Breakthrough Objective: Counter Measure Summary

Project/Metric Name – To achieve the planned levels of New Outpatient Activity

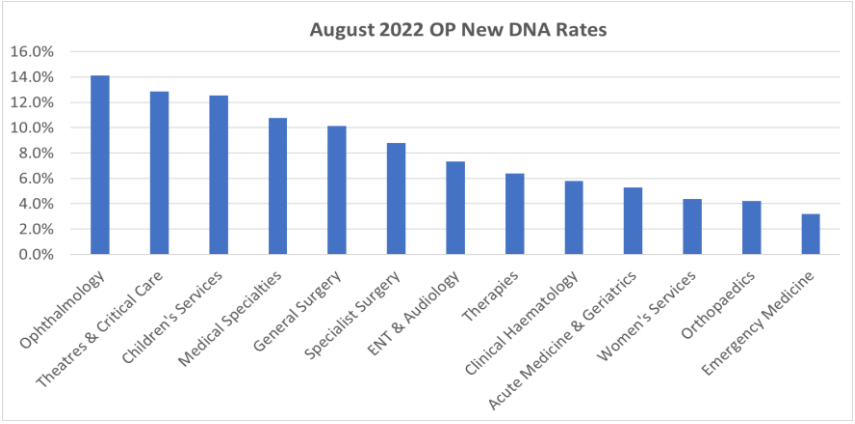
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



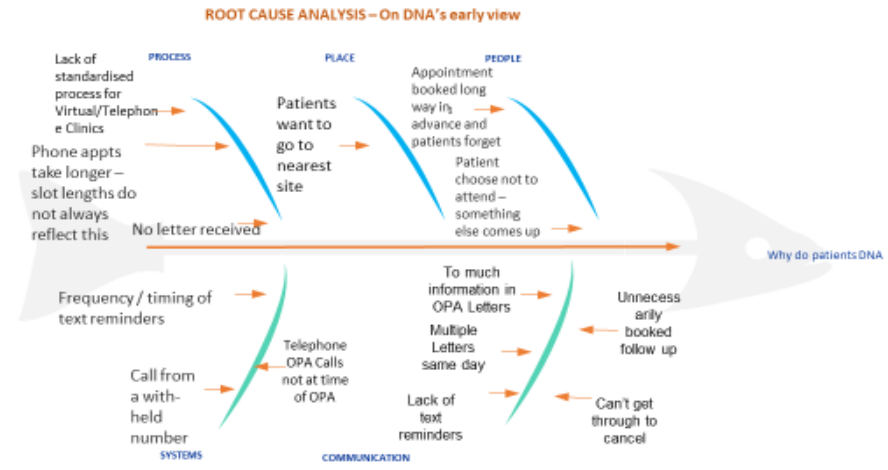
Aug-22
17,782
Variance Type
Metric is currently experiencing Common Cause Variation
Target
20,827
Target Achievement
Metric is consistently failing the target

2. Stratified Data



Although the Trust is near its 5% target the specialties that are not achieving activity levels have a DNA rate of 9% or above

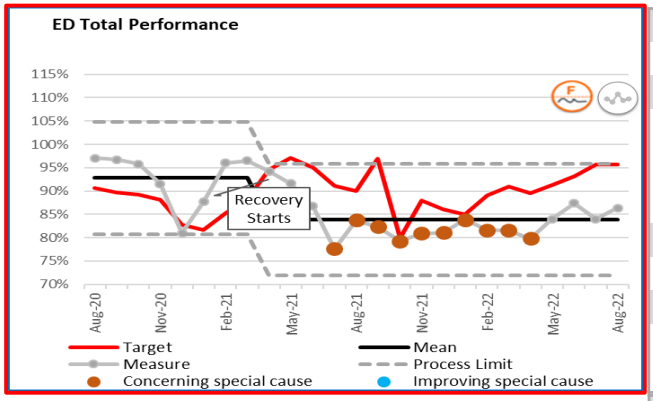
3. Top Contributors



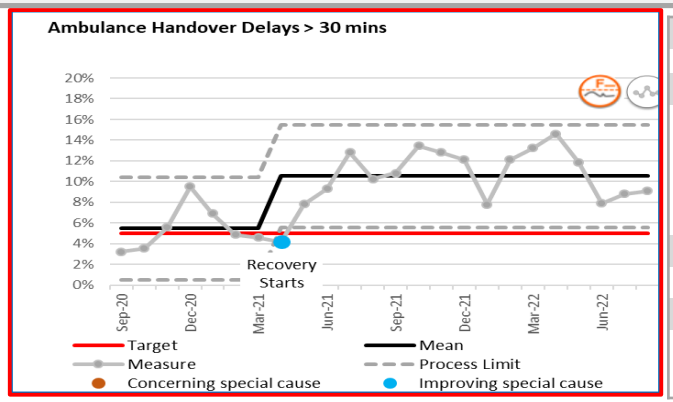
4. Action Plan

Countermeasures	Action	Who / By when	Complete (Y/N)
Review of Text reminder service	Speak to Clinical Systems and outpatients to review we are using all functionality	Project Team	Mid Oct
Provide alternative to patients to cancel appointments when phones are busy	Review if cancellation can be added to text reminder	Project Team	Mid Oct
Review of key OPA letters to see if all information is still required	Collate most used letters and review key information	Chris Caulton	End Oct
Due to split between telephone and virtual phones calls can be left to the end of clinic	Review of process, templates and letters to mitigate	Project Team	End Oct

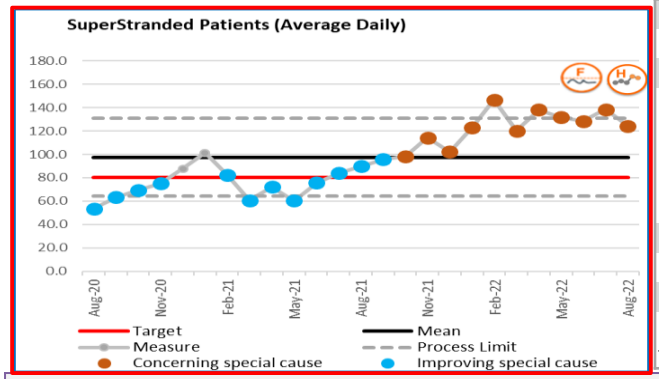
Patient Access – Hospital Flow: CQC: Responsive



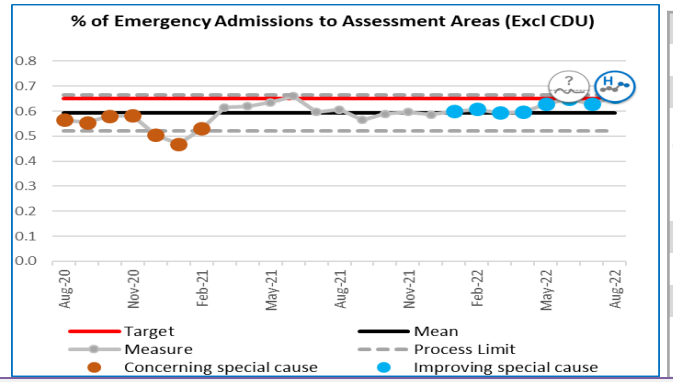
Aug-22
86.32%
Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months
Target (Internal)
95.7%
Business Rule
Full Escalation as has failed the target for > 6 months



Aug-22
9.1%
Variance / Assurance
Metric is currently experiencing Common Cause variation and is consistently failing the target
Max Limit (Internal)
7%
Business Rule
Full Escalation as is consistently failing the target



Aug-22
124
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



Aug-22
65.8%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and variable achievement of the target
Target
65%
Business Rule
Not Escalated

Summary:

ED 4hr performance (inc MIU): This indicator is now experiencing common cause variation and has failed the target for more than six months Despite this, the Trust is in the top 5 performing Trusts in the country during this time.

Ambulance Handover Delays of >30 minutes is experiencing common cause variation 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 and variable achievement of the target. . 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. Improved work in SDEC areas will support sustained improvement. Daily breach validation undertaken and clinic utilisation daily to improve performance.

Ambulance handover delays: Process of PIN entry now embedded , capacity issues remain in TW ED. Awaiting works on Ambulance window in reception

Super-Stranded Patients : 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: 3 x ACP's are training to help improve flow and length of stay.

Assurance & Timescales for Improvement:

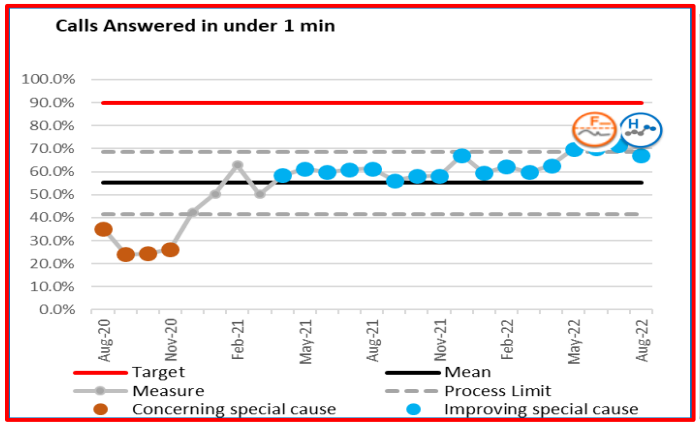
ED 4hr performance (inc MIU): Continue with ED improvement huddles. Daily monitoring of UTC utilisation to increase use of available resource.

Ambulance handovers delays: Maidstone performed at 94.5% and TW 88.7% for less than 30 minute handover times an improved picture at both Maidstone and Tunbridge Wells compared to last month. Daily review of breaches maintained.

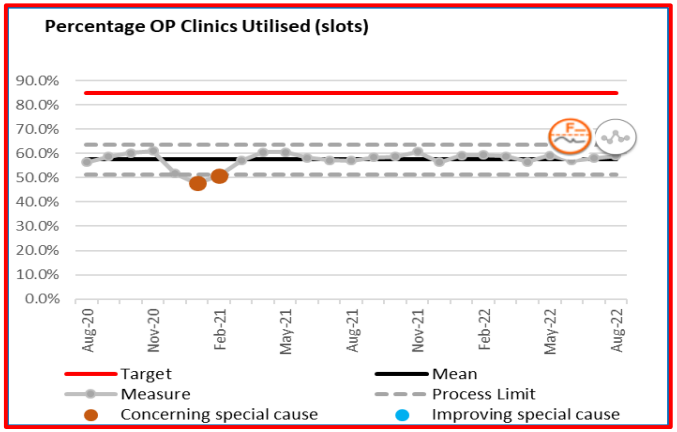
Super stranded patients:
Monthly MADE events to bring an MDT approach. Improved understanding of pathways and introduction of resource packages.

% 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

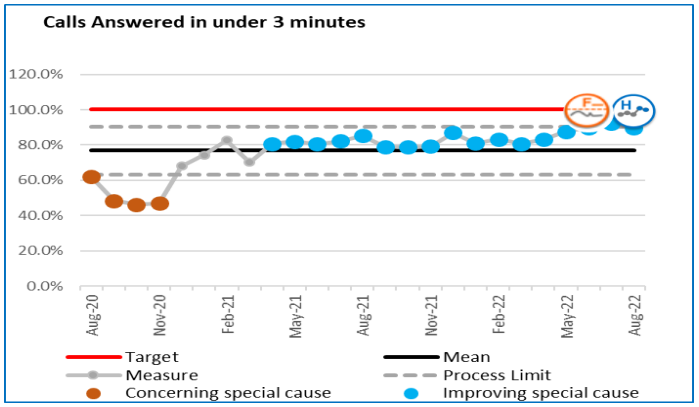
Patient Access – Transformation: Outpatients: CQC: Responsive



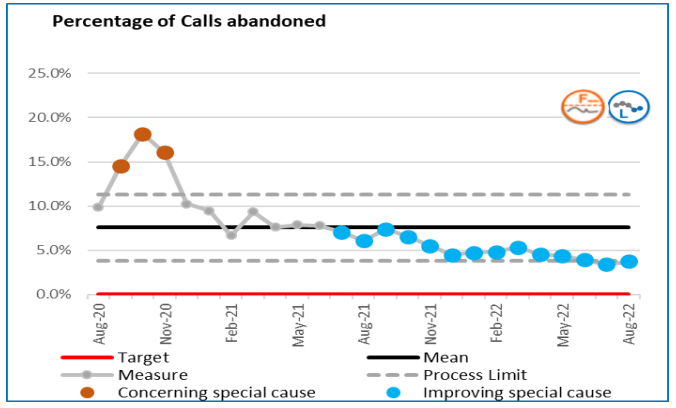
Aug-22
67.2%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Aug-22
59.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation



Aug-22
89.6%
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



Aug-22
3.8%
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: Screens have been installed in the Ophthalmology CAU office and are on order for T&O. These screens display call performance on the day in real time.
T&O recruited a bank member of staff to prioritise CAU telephone calls. This has been successful and is reflected in the call data. We have arranged similar support in Ophthalmology starting mid September.
Recruitment is underway for call operatives for the outpatient communication centre pilot. This centre will act as a centralist triage for all Outpatient calls.
Outpatient appointment re-booking/cancelling web page for appointments to be developed to reduce pressure on CAUs.

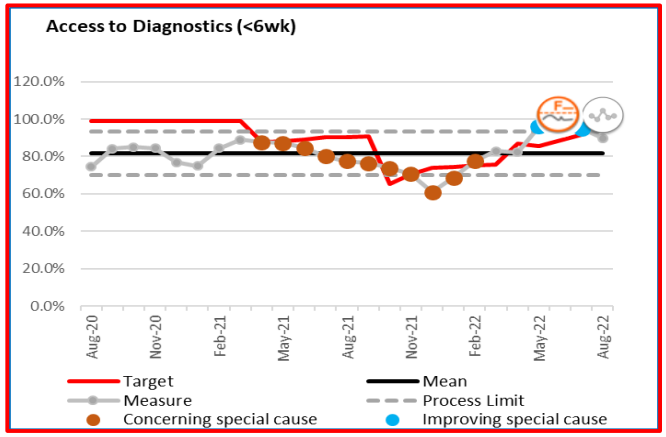
Outpatient Utilisation: Introduction of SOAP and Focal to the outpatient team to support management of utilisation of space.

Assurance & Timescales for Improvement:

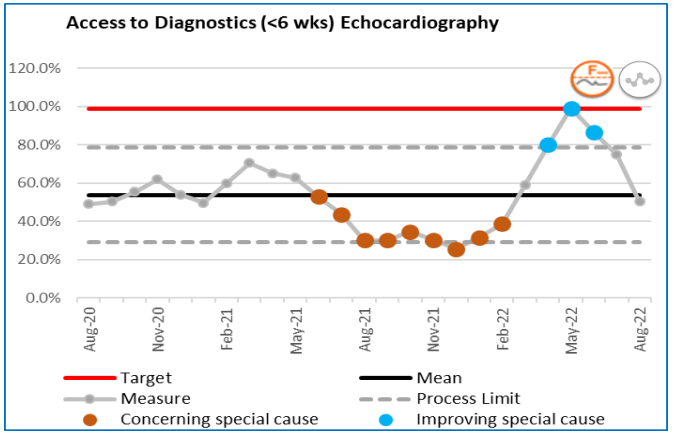
Calls Answered: Weekly meeting with specialties are undertaken to go through call KPIs to understand areas for improvement and reasonings for poor performance. Further actions are being progressed.

Outpatient Utilisation: Corporate Project on clinic templates

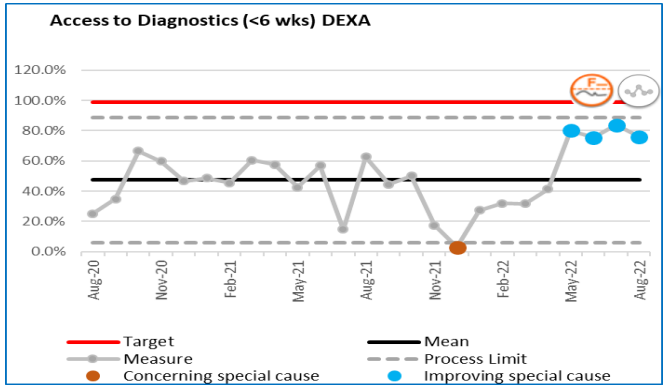
Patient Access – Diagnostics Waiting Times: CQC Responsive



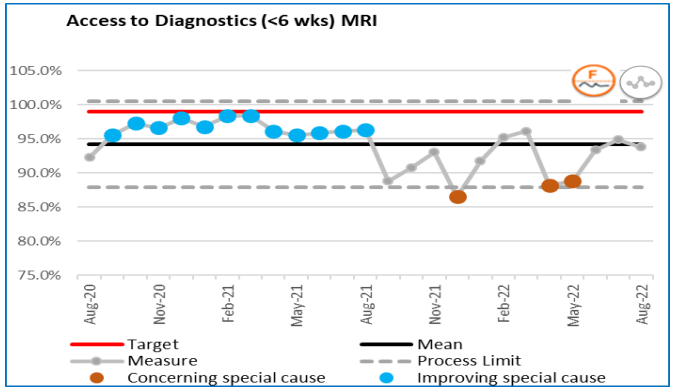
Aug-22
89.7%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
88.6%
Business Rule
Full Escalation



Aug-22
50.3%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



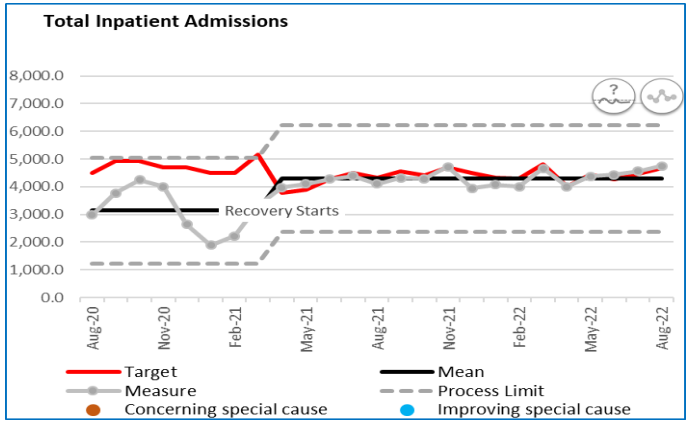
Aug-22
75.8%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



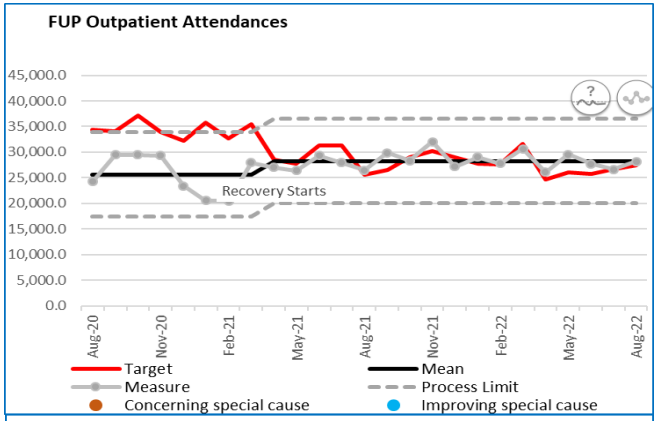
Jul-22
94.9%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for more than six months
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Diagnostic Waiting Times: Performance (measured via DM01) is experiencing common cause variation and consistently failing the target. The three biggest contributors to this are Echocardiography, DEXA and MRI. **Echocardiography:** is experiencing common cause variation and consistently failing the target. **DEXA:** is experiencing common cause variation and consistently failing the target largely due to a lack of capacity, but is starting to show signs of recovery. **MRI:** is experiencing common cause variation but has now failed the target for more than six months	**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:** Monitoring equipment was expected Mid August however the components are not available and unable to give estimated delivery date.	**Echocardiography:** Insourcing has commenced to support the internal recovery plan. The procurement of two Echocardiogram machines is in progress. **DEXA:** Recovery plan in progress and is monitored weekly with DCOO. The plan is on track to be DM01 compliant by the end of October 22. **MRI:** Discussions with Paediatric team for alternatives including diverting referrals to other providers as well as exploring previous methods such as Feed and Wrap. Overall DM01 Recovery Plan in progress.

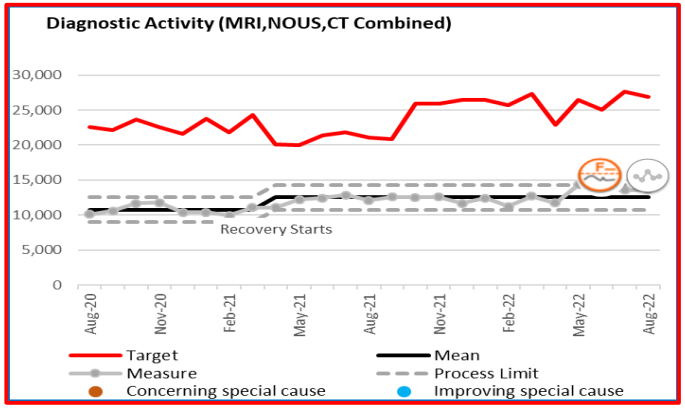
Patient Access –Activity Levels: CQC Responsive



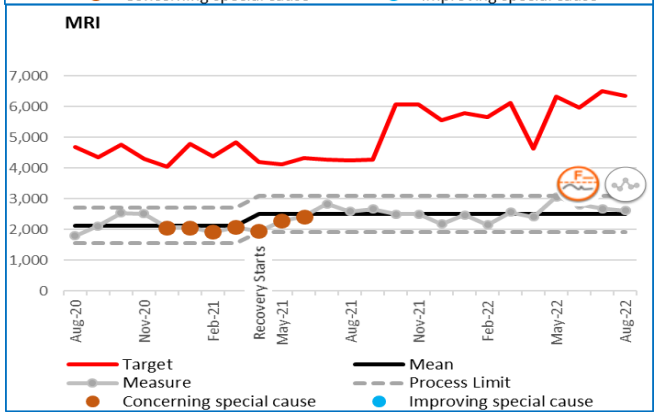
Aug-22
4746
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target
4688
Business Rule
Not Escalated



Aug-22
28,142
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and consistently failing the target
Target
27,426
Business Rule
Not Escalated



Aug-22
13,685
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target
26,906
Business Rule
Full Escalation as consistently failing the target



Aug-22
2620
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target
6364
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Elective Activity (DC/EL): This indicator is now experiencing common cause variation and variable achievement of the target Performance has been above plan for June and July and August 2022. Performance is therefore above plan and at the same level of activity as 1920 YTD. **OP Follow Up Activity:** The activity is experiencing common cause variation and variable achievement of the target. Activity levels for August 2022 were slightly higher than the plan and the 1920 levels. **Diagnostic Activity:** Activity levels are currently above 1920 levels for MRI, CT and NOUS but are experiencing common cause variation and consistently failing the target. **MRI:** is experiencing common cause variation and consistently failing the target (however MRI is above the 1920 levels).	**Elective Activity (DC/EL):** Activity continues to be monitored weekly which has assisted in developing a more robust forecasting plan. **Diagnostic :** Monitoring equipment was expected Mid August however the components are not available and unable to give estimated delivery date.. Work underway with Temporary staffing team and recruitment to support NOUS team.	**Elective Activity (DC/EL):** Weekly focus on submitted activity plans with the speciality and directorate teams. 6-4-2 scheduling meetings in place and any capacity identified continues to be offered to speciality teams. Weekly focus on theatre utilisation and productivity continues via trust performance meetings. Cancellation SOP in progress. **Diagnostic Activity:** Community Diagnostics Centre (CDC) business case has been approved and outputs of the business case are in progress.

Strategic Theme: Patient Experience

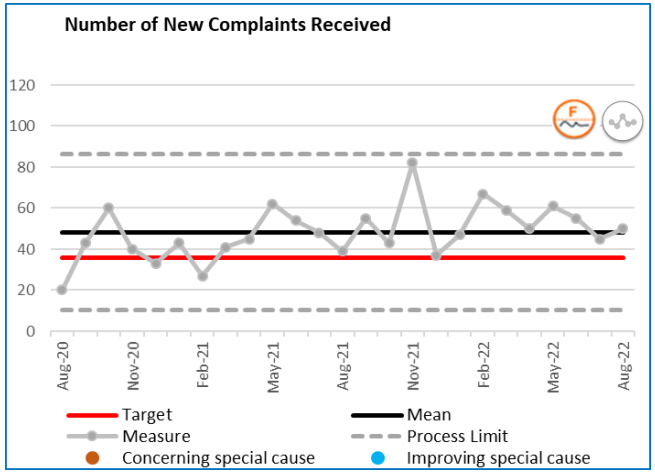
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month	36	50	Aug-22	36	45	Jul-22	Driver		F	Full CMS
Breakthrough Objectives	Caring	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	24	32	Aug-22	24	30	Jul-22	Driver	No SPC	No SPC	No SPC
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	2.6	Aug-22	3.9	2	Jul-22	Driver		P	Not Escalated
	Caring	% complaints responded to within target	75.0%	53.7%	Aug-22	75.0%	41.4%	Jul-22	Driver		F	Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	95.6%	Jul-22	95.0%	96.5%	Jun-22	Driver		P	Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	19.3%	Aug-22	25.0%	17.1%	Jul-22	Driver		F	Escalation
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	2.7%	Aug-22	15.0%	2.0%	Jul-22	Driver		F	Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	8.8%	Aug-22	25.0%	8.8%	Jul-22	Driver		F	Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	3.8%	Aug-22	20.0%	5.4%	Jul-22	Driver	L	F	Escalation

Vision: Counter Measure Summary

Metric Name – To reduce the overall number of complaints or concerns each month

Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Aug-22
50
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
36
Target Achievement
Metric has failed the target for >6months

1. Historic Trend Data

Historic trend data to be available from October now methodology agreed for data collection

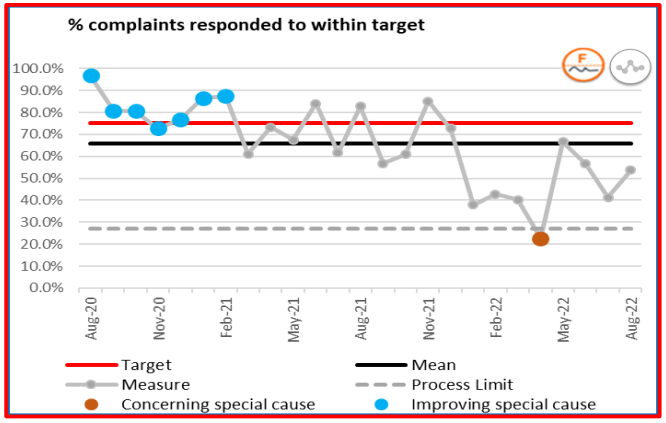
3. Top Contributors

A3 Thinking currently underway to understand the themes of complaints and concerns where poor communication is the main issue affecting patient experience

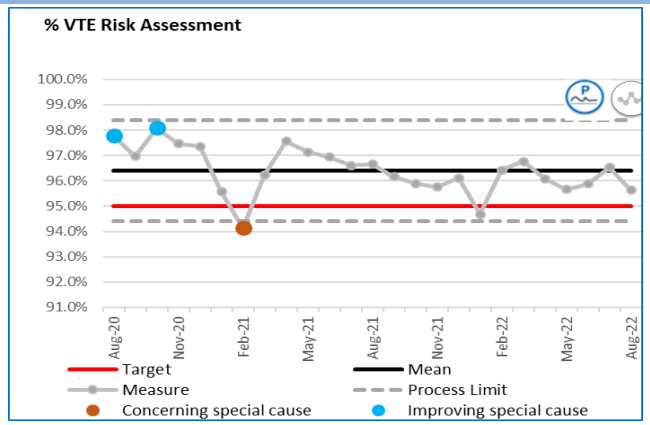
4. Action Plan

Action for A3	Timeline	Progress
Method to collect data from datix to be defined and agreed	August	Complete
Current condition being analysed	September	Complete
Audit of complaints to be completed	October	In Progress
Root Cause being identified	October	TBC

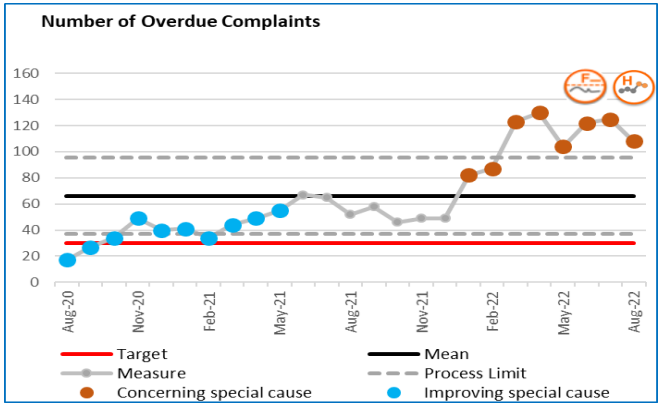
Patient Experience: CQC: Caring (Hit or Miss >6 months)



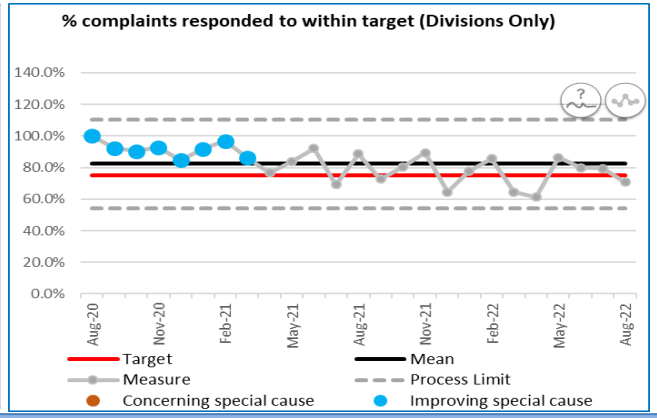
Aug-22
53.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Target (Internal)
75%
Business Rule
Full Escalation failed the target 6+ months



Jul-22 (month behind)
95.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has achieved the target for 6 months
Max Limit (Internal)
3.9
Business Rule
For info as changed back to Not Escalated



Aug-22
108
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and consistently failing the target
Max Limit (Internal)
30
Business Rule
For Information as linked to % Complaint Responded



Aug-22
70.7%
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 experiencing concerning cause variation and has failed the target for >6months, noting the target has not been met since November 2021

Number of Overdue Complaints: This indicator is experiencing special cause variation of a concerning nature and is consistently failing the target since October 2020.

%VTE Risk Assessment: This indicator is now experiencing common cause variation and has achieved the target for 6 months

Actions:

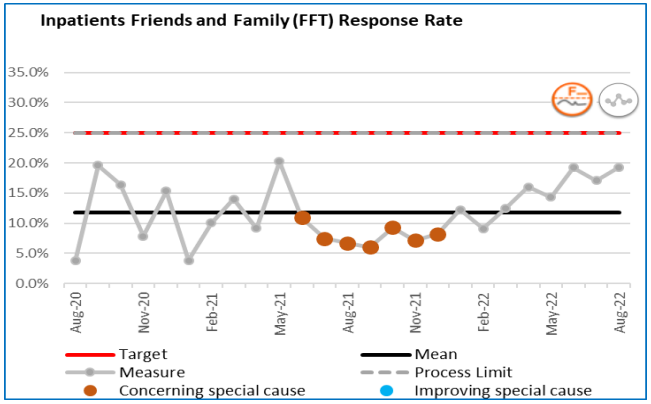
Weekly performance meetings taking place with DCQ and CN.
Recruitment to 12 month Complaints Lead post underway (interviews 23/9/22)
Extension agreed to temporary staff contracts for a further 2 months to support clearance of overdue complaints.
Weekly divisional meetings continue to target cases for closure
Targeted work plan in place to
Business case for revised complaints model (meeting new 2022 National framework) to be finalised by Feb 2023 *Not approved for business planning this year

Assurance & Timescales for Improvement:

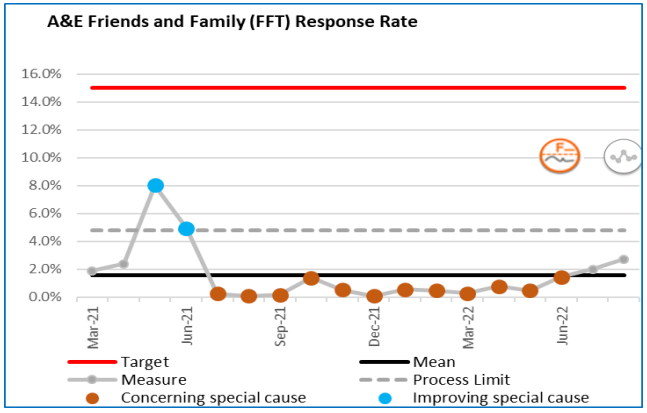
% Complaints responded to within Target:

- Expect stabilised performance from September 2022 (dependent on resourcing) *divisional performance has improved
- Number of open complaints continues to decrease steadily

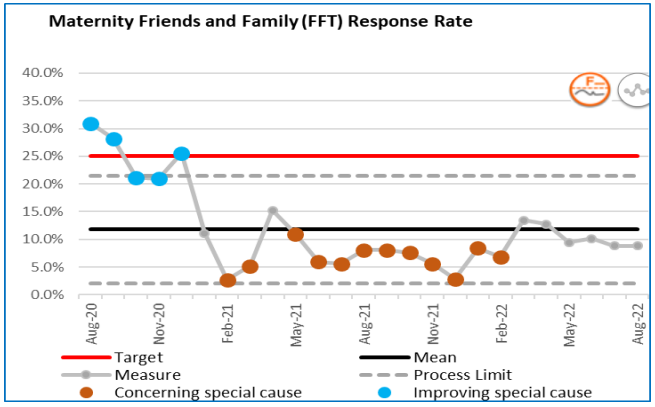
Patient Experience: CQC: Caring



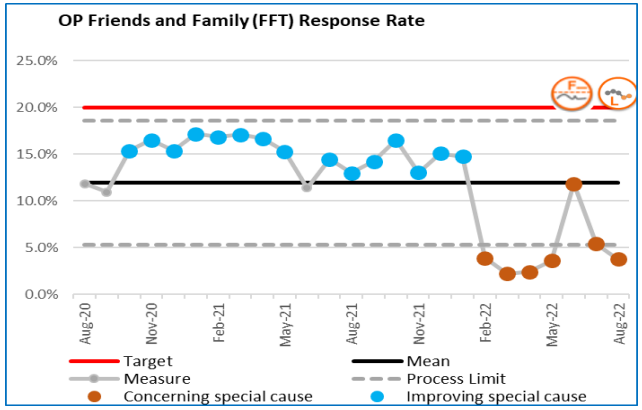
Aug-22
19.3%
Variance / Assurance
Metric is currently experiencing Common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation



Aug-22
2.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Aug-22
8.8%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as not achieved target for >6months



Aug-22
5.4%
Variance / Assurance
Metric is currently Special Cause Variation of a concerning nature and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

FFT Response Rate Inpatients: Metric is currently experiencing Common cause variation and has failed the target for >6 months

FFT Response Rate A&E: Metric is currently experiencing Common Cause Variation and is consistently failing the target

FTT Response Rate Maternity: Metric is currently experiencing common cause variation and is consistently failing the target

FFT Response Rate Outpatients: Metric is currently Special Cause Variation of a concerning nature and is consistently failing the target

Actions:

FFT Response Rate Inpatients: general incline in FFT submissions. Minor anomalies escalated and resolved with IQVIA.

FFT Response Rate A&E: SMS text messaging commenced on 5th July. The response rate had increased significantly. overall experience of care has dropped; themes and trends to be addressed by the ED Team.

FFT Response Rate Outpatients: SMS text messaging commenced on the 5th July, this has now replaced all phone call surveys. Overall numbers have dropped during the transition which we will continue to monitor. Imaging and diagnostics have gone live with SMS texts.

Assurance & Timescales for Improvement:

FFT Response Rate Inpatients: push reports have now been published to the respective departments

FFT Response Rate A&E: To continue to monitor data in response to the SMS campaign with the ED team.

FFT Response Rate Outpatients; Assurance reports requested for the Netcall / BI SMS data to complete a deep dive into all elements of the campaign upload to ensure full capture of all OPD patients.

Strategic Theme: Systems

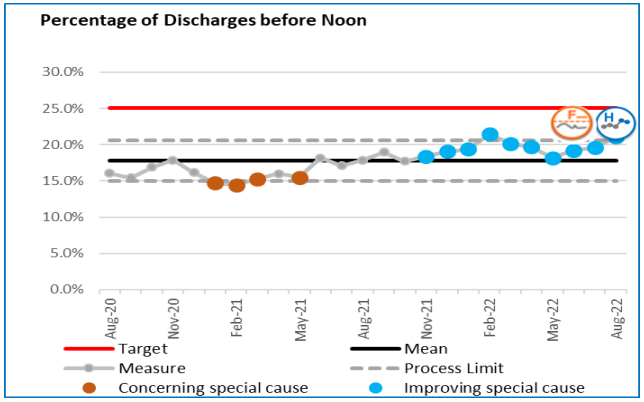
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	3.5	5.8	Aug-22	3.5	4.1	Jul-22	Driver	No SPC	No SPC	-
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge	25.0%	21.1%	Aug-22	25.0%	19.6%	Jul-22	Driver			Full CMS

Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

Owner: Rachel Jones
Metric: discharges before noon
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data

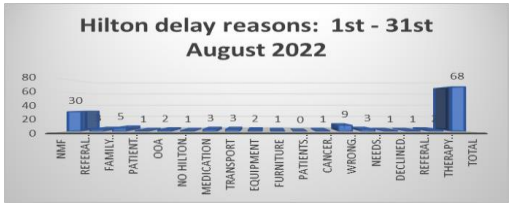


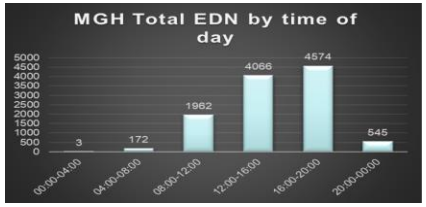
Aug-22
21.1%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

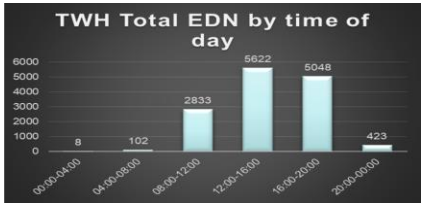
Target to be amended on graph at next IPR/ SDR.
Recent agreement to use TT for more accurate and timely data

2. Stratified Data

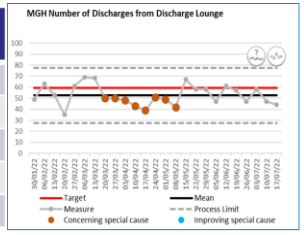
Discharge Year	Discharge Month	Count Spells	Count Nurse Led Discharge	Percentage
2021	11	2322	27	1.2
2021	12	3291	51	1.5
2022	1	3143	60	1.9
2022	2	3109	33	1.1
2022	3	3753	36	1.0
2022	4	3253	30	0.9
2022	5	2587	40	1.5
2022	6	2231	22	1.0
2022	7	2253	39	1.7
2022	8	2223	35	1.6
2022	9	363	4	1.1
Total		28528	377	1.3

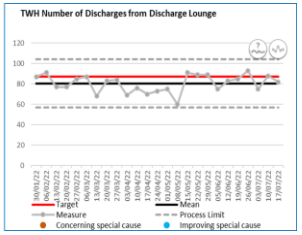






Pharmacy TTO Completion Time	MGH	TWH
08.00 – 11.00	4	6
11.00 – 12.00	5	1
12.00 – 13.00	1	4
13.00 – 16.00	13	14
16.00 – 20.00	30	57





3. Top Contributors

Area of Analysis	Considered a Top Contributor?
Hilton Pathway	The timeliness of this pathway due to the current process and mis-use of the service has deemed this to be a top contributor with 44% with a change in medically fit status after a referral has been made to Hilton results in patient not being accepted. There are specific wards that have higher levels of failed Hilton discharges and will be focussed on.
Sunrise team criteria led discharge usage	This is an area that is understood to be a top contributor as patients could be discharged from the ward earlier on in the day. Data shown that the NLD button on sunrise is used with 1.3% of all discharges however this may be inaccurate as button on sunrise may not have been being used.
EDN completion times	Yes EDN completion times is a top contributor to delays in discharge time. The Core Clinical Service MDT Programme Group is focussing on this – including providing digital solutions and CoS support for EDNs being completed during ward rounds. A report from the group will feed into this report.
Pharmacy TAT for Dossett's and TTOs / sent by couriers	Yes however EDN completion seems to be root cause for delays in this area. The Core Clinical Service MDT Programme Group is focussing on this - which will feed back into this report.
Discharge Lounge Usage	Although the discharge lounge is not utilised as fully as it can be, there is another project group looking at the discharge lounge of which a report will be included within this project stream. Business case in draft for discharge lounge – plans to increase establishment

Green to be carried forwards in the project. Amber to be observed from other programmes

4. Action Plan

Counter-measure	Action	Who	When	Complete
Hilton Pathway	Working group established. Looking at improving pathways	KC/ DH/ NP	Monthly	N
Nurse Led Discharge	Link with NHSE/I working group. Additional data collection req.	S Foy	TBC	N
EDN Completion	Working Group. EPMA actions, crib sheet, EDN during ward rounds	RG / C Chalmers	Bi-weekly	N
Pharmacy TAT	Working group established. Looking at pathway efficiencies, EPMA.	Abi Hill / FR/ NP	Bi-weekly	N
Discharge Lounge	Working group established. Looking at environment and usage	DH/ Sue	Monthly	N

Strategic Theme: Sustainability

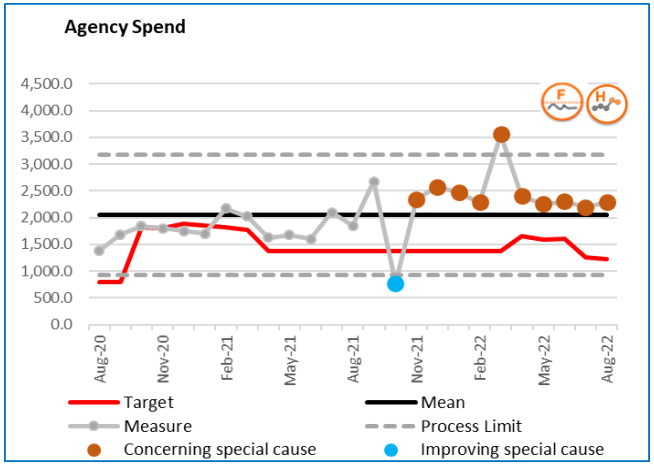
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	-510	-509	Aug-22	-407	-405	Jul-22	Driver	L	?	Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	1223	2288	Aug-22	1249	2191	Jul-22	Driver	H	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	1513	1069	Aug-22	1513	626	Jul-22	Driver	No SPC	No SPC	Not Escalated
	Well Led	Cash Balance (£k)	20175	33272	Aug-22	20175	28755	Jul-22	Driver		P	Not Escalated
	Well Led	Capital Expenditure (£k)	2404	7	Aug-22	2404	286	Jul-22	Driver		?	Not Escalated

Vision: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000

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

1. Historic Trend Data

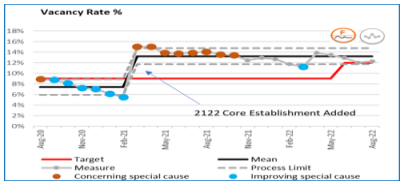


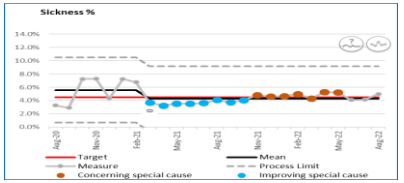
Aug-22
2,288
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
1,223
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data

** This is an early view and further analysis will be undertaken

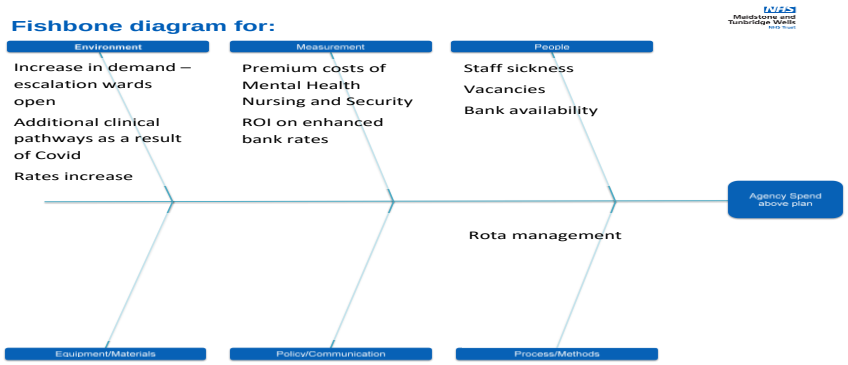
Reason	
Vacancy	48%
Back Filling	23%
Escalation / Demand	13%
COVID-19 Related	5%
Patient Special / Escort	5%
Other	4%
Sickness	3%





3. Top Contributors

** This is early analysis and full analysis will be undertaken shortly as part of the A3



4. Action Plan

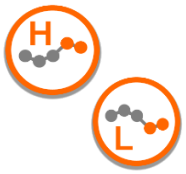
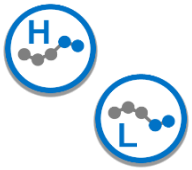
A new A3 is being developed, with countermeasures identified and to be implemented.
A steering group has been convened with fortnightly meetings, next meeting to review the data gathered to review top contributors and begin action planning.

Actions taken in support of other workstreams, particularly the People theme, will also support the planned reduction in premium temporary staffing. The Trust will also continue all of its ongoing business as usual actions that will have a bearing on this objective.

Appendices

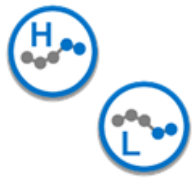
SDR Business Rules Driven by the SPC Icons

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

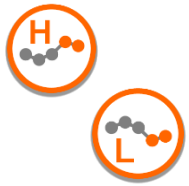
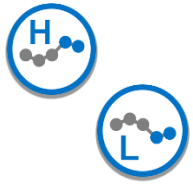
SDR Business Rules Driven by the SPC Icons

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:

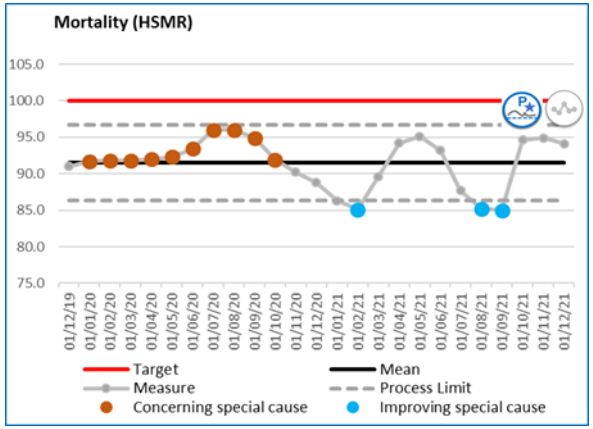
The **target** line **between** the **upper** and **lower** control limit for all metric types

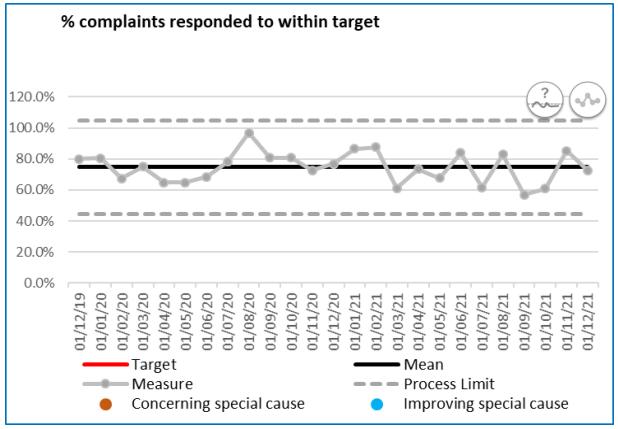
Metrics that consistently **fail** have:

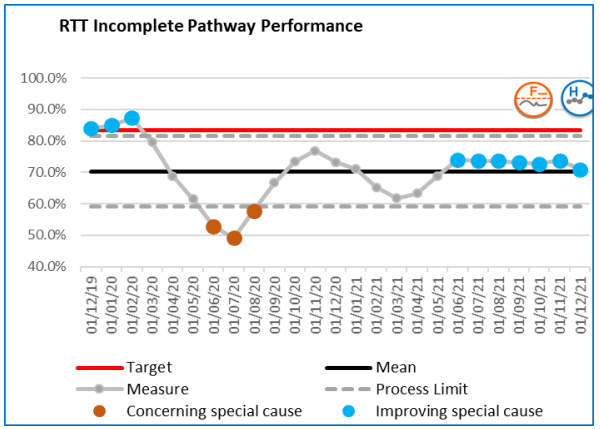
The **lower** control limit **above** the target line for metrics that need to be **below the target**

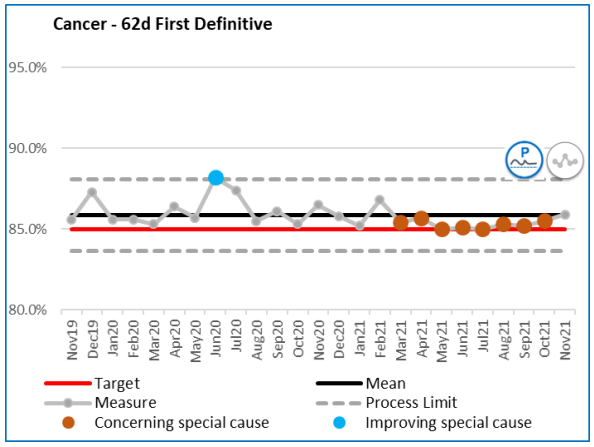
The **upper** control limit **below** the target line for metrics that need to be **above the target**

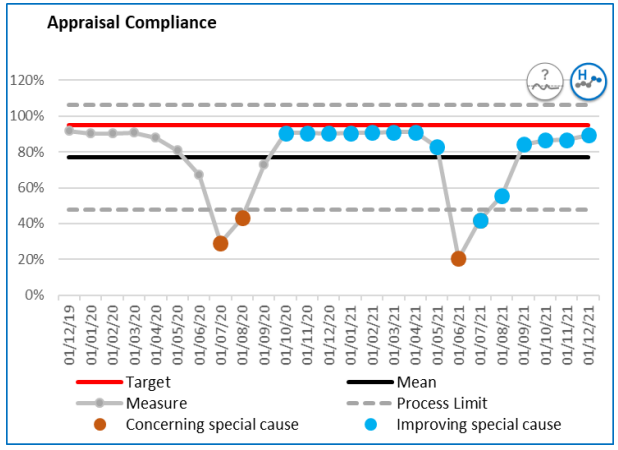
A metric not achieving the target for 6 months or more will be flagged as failing

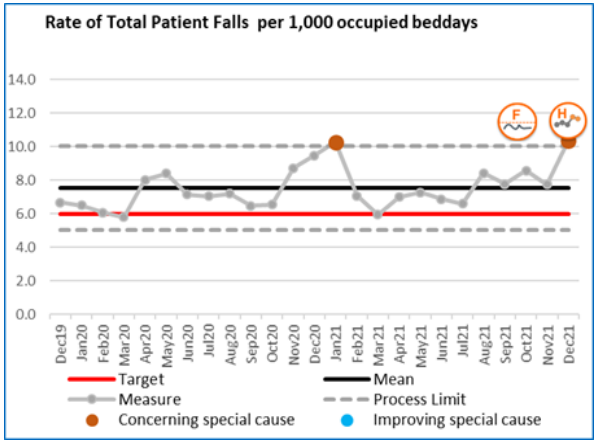












Executive Summary

- The Trust has delivered the August Plan and the Year to Date plan by delivering a deficit of £0.5m in month and £6.1m year to date.
- The key pressure is within pay budgets which are adverse to plan by £1.4m, this is driven by overspends within Emergency Medicine medical staffing (£2.5m) and facilities staffing (£1m) which are partly offset by underspends within Nursing (£1.4m). and support to clinical staff (£1m).
- The Trust has had to release £1.5m from reserves to help to part offset the pay pressures incurred.
- There is a risk of £5.2m associated with Elective Recovery Fund (ERF) clawback as the Elective Activity in April to August was below 104% of 2019/20 levels. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Early indications are that H1 (month 1-6) clawback will not be applied, confirmation is still to be received and further guidance on H2 (Oct to Mar) application should be forthcoming. Therefore, the month 5 position does not assume any ERF clawback.
- Cost Improvement Plans (CIP) are behind of plan with a year to date adverse position of £0.4m. The CIP plans are phased with stepped increases required from October.
- The Trust is forecasting to deliver a breakeven position however this requires full delivery of the CIP plan.

Year to Date Financial Position

- The Trust was on plan, generating a £6.1m deficit.
- The key year to date variances is as follows:
    - **Adverse Variances**
        - Pay budgets overspent by £1.4m. The main pressures continue to be within Emergency Medicine medical staffing (£2.5m) and facilities staffing (£1m). These pressures were partly offset by underspends within Nursing (£1.4m). and support to clinical staff (£1m).
        - Additional security costs (£0.3m)
        - Consultancy and professional fees (£0.3m)
        - Printing and postage pressures (£0.2m) which includes a 15% inflation increase for hybrid mail.
    - **Favourable Variances**
        - Release of £1.5m from reserves. The following reserves have been released: £0.7m from growth reserve to offset unfunded waiting list initiatives incurred, £0.4m from contingency to offset agreed extension to enhanced bank rates and £0.4m from service developments to part offset some of the YTD pay pressures.
        - Underspends within Clinical supplies (£0.5m) and Elective outsourcing due to Elective activity below budget (£0.3m)

Risk

- There is a risk of £5.2m associated with Elective Recovery Fund (ERF) clawback as the Elective Activity in April to August was below 104% of 2019/20 levels. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Early indications are that H1 (month 1-6) clawback will not be applied, confirmation is still to be received and further guidance on H2 (Oct to Mar) application should be forthcoming. Therefore, the month 5 position does not assume any ERF clawback.

Current Month Financial Position

- The Trust was on plan generating a £0.5m deficit in the month.
- The key current month variances are as follows:
  - Pay budgets (net of passthrough related costs) were £0.1m adverse to plan in the month. The level of pay spend in the month is consistent with previous months (£32.4m) the main pressures continue to be within Medical staffing (£1m) this pressure was partly offset by underspends within nursing (£0.5m), admin and clerical (£0.2m) and support to clinical staff (£0.2m). The Medicine and Emergency division continues to have the largest pay pressure and overspent by £1m on medical in the month, this is within Emergency Medicine (£0.6m) and Acute and Geriatrics (£0.4m).
  - Year to date catch-up of invoices relating to the hire of a mobile MRI scanner at Tunbridge Wells Hospital (£0.5m)
  - CIP slippage of £0.4m in the month.
  - Release of contingency reserves to help partly offset the above pressures (£0.6m)
  - Non-recurrent COS VAT rebate (£0.3m)

Cashflow

- The closing cash balance at the end of August 2022 was £33.3m which is higher by £13.1m compared with the revised plan resubmitted in June 2022. The increase between months is primarily due to the reimbursement of backlog costs by the funder of the development of accommodation for the Kent Medical School students following the contract being signed and capital spend is lower than plan, however orders are currently being placed so spend is expected to increase.
- The Trust is also working with its NHS colleagues to reduce all debtor/creditor balances. This also ensures the Trust is achieving the BPPC target of 95% that NHSE/I are reviewing regularly , the Trusts BPPC at the end of the August is - Trade in value is 93.7% and by quantity is 96.9%; for NHS by value is 96.6% and by quantity is 85.4%.

Capital Position

- The Trust's capital plan, excluding IFRS 16 items, agreed with the ICS 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 (now approved by ICB but awaiting confirmation of mechanism to access) and
- National PDC of £29m for Barn Theatre (to be approved)

- The Plan figure of £41.3m includes:
  - Estates: Estates Enabling and Backlog 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). They also include carry forward spend from projects that were planned for completion in 2021/22 but have overrun e.g. Annexe and Oncology OPD.
  - 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 have been prioritised and business cases are in development.
- Externally Funded schemes: 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. The CDC business case has been approved (£9.87m includes building, equipment and IT) and a Letter of Agreement has been received, MoU to follow.

- The Year to date spend on capital is £1.08m against the Plan of £3.7m. The majority of this spend relates to Estates and Equipment Backlog carry forward spend from projects commenced in 2021/22 e.g. Annexe & Oncology OPD and kitchen dishwasher. The month 5 position includes credits relating to VAT reclaims following a review carried out by the Trust VAT Advisors. The variance relates mostly to spend on the Barn project that was assumed in the plan to be continuing in the first quarter; currently it is on hold awaiting the BC approval.

Year-end Forecast

- The Trust is forecasting to deliver a breakeven position however this requires full delivery of the CIP plan.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 5
2022/23

Maidstone and Tunbridge Wells NHS Trust

August 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	52.7	52.1	0.6	0.0	0.6	262.4	261.0	1.4	(0.7)	2.1
Expenditure	(49.5)	(48.8)	(0.8)	(0.0)	(0.7)	(249.9)	(248.1)	(1.8)	0.7	(2.5)
EBITDA (Income less Expenditure)	3.2	3.4	(0.1)	0.0	(0.1)	12.5	12.9	(0.4)	0.0	(0.4)
Financing Costs	(3.8)	(3.9)	0.1	0.0	0.1	(18.9)	(19.3)	0.4	0.0	0.4
Technical Adjustments	0.1	0.1	(0.0)	0.0	(0.0)	0.3	0.3	(0.0)	0.0	(0.0)
Net Surplus / Deficit (Incl Top Up funding support)	**(0.5)**	**(0.5)**	**0.0**	**0.0**	**0.0**	**(6.1)**	**(6.1)**	**0.0**	**0.0**	**0.0**
Cash Balance	33.3	20.2	13.1		13.1	33.3	20.2	13.1		13.1
Capital Expenditure (Incl Donated Assets)	0.0	2.4	2.4		2.4	1.1	5.5	(4.4)		(4.4)
Cost Improvement Plan (Internal £30m target)	1.1	1.5	(0.4)		(0.4)	3.5	3.9	(0.4)		(0.4)

Summary Current Month:
- The Trust was on plan generating a £0.5m deficit in the month.

The Trusts key variances to the plan are:
- Pay budgets (net of passthrough related costs) were £0.1m adverse to plan in the month. The level of pay spend in the month is consistent with previous months (£32.4m) the main pressures continue to be within Medical staffing (£1m) this pressure was partly offset by underspends within nursing (£0.5m), admin and clerical (£0.2m) and support to clinical staff (£0.2m). The Medicine and Emergency division continues to have the largest pay pressure and overspent by £1m on medical in the month, this is within Emergency Medicine (£0.6m) and Acute and Geriatrics (£0.4m).
- Year to date catch-up of invoices relating to the hire of a mobile MRI scanner at Tunbridge Wells Hospital (£0.5m)
- CIP slippage of £0.4m in the month.
- The above pressures were offset by release of reserves (0.6m) and non recurrent VAT rebate (£0.3m)

Year to date overview:
- The Trust was on plan generating a £6.1m deficit year to date.
- The Trusts key variances to the plan are:

Adverse Variances:
- Pay budgets overspent by £1.4m. The main pressures continue to be within Emergency Medicine medical staffing (£2.5m) and faci lities staffing (£1m). These pressures were partly offset by underspends within Nursing (£1.4m). and support to clinical staff (£1m).
- Additional security costs (£0.3m), consultancy and professional fees (£0.3m) and printing and postage pressures (£0.2m) which includes 15% inflation pressure associated with Hybrid mail.

Favourable Variances:
- Release of £1.5m from reserves. The following reserves have been released: £0.7m from growth reserve to offset unfunded waitin g list initiatives incurred, £0.4m from contingency to offset agreed extension to enhanced bank rates and £0.4m from service developments to part offset some of the YTD pay pressures.
- Underspends within Clinical supplies (£0.5m) and Elective outsourcing due to Elective activity below budget (£0.3m)

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 £3.5m savings year to date which is £0.4m adverse to plan.

Risks
- ERF Clawback (£5.2m). The Trust has underperformance against the Elective Recovery Fund (ERF) baseline (104% of 19/20 activity) which equates to £6.3m. The Trust has not reflected this clawback in the YTD position because the baselines and methodology has not been confirmed or the interaction with the K&M ICS and NHSEI. Early indications are that H1 (month 1-6) clawback will not be applied, confirmation is still to be received and further guidance on H2 (Oct to Mar) application should be forthcoming.

Forecast
- The Trust is forecasting to deliver a breakeven position however this requires full delivery of the CIP plan.

Aug-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	92.9%	88.8%	-	100.0%	105.6%	94.3%	-	-	35.7%	33.5%	231	16.06	45	7.9	9.2%	100.0%	8	2	269,033	278,961	(9,928)
MAIDSTONE	Cornwallis (M) - NS959	69.5%	125.0%	-	100.0%	108.6%	221.7%	-	-	66.0%	26.5%	181	12.54	60	7.0	41.9%	92.3%	4	0	55,026	104,915	(49,889)
MAIDSTONE	Culpepper Ward (M) - NS551	109.1%	69.9%	-	-	124.2%	177.4%	-	-	44.7%	34.5%	52	3.62	10	5.5	20.0%	100.0%	1	0	276,499	137,399	139,100
MAIDSTONE	Foster Clark - NS251	81.3%	75.7%	-	-	92.7%	68.8%	-	-	16.4%	26.5%	85	5.98	36	6.6	1.8%	100.0%	2	0	161,173	142,894	18,279
MAIDSTONE	John Day Respiratory Ward (M) - NT151	87.3%	110.8%	-	-	103.2%	114.5%	-	-	46.0%	44.2%	195	13.95	50	6.3	-	-	3	1	178,335	162,570	15,765
MAIDSTONE	Intensive Care (M) - NA251	100.8%	86.7%	-	-	94.8%	87.6%	-	-	7.1%	5.0%	73	3.68	21	47.3	250.0%	100.0%	0	0	259,600	241,969	17,631
MAIDSTONE	Pye Oliver (Medical) - NK259	95.7%	103.7%	-	-	125.7%	109.7%	-	-	34.1%	51.5%	102	7.06	14	6.6	3.3%	100.0%	7	0	126,255	132,409	(6,154)
MAIDSTONE	Whatman Ward - NK959	104.9%	81.0%	-	-	120.5%	200.0%	-	-	82.2%	53.6%	199	13.87	30	6.6	14.3%	100.0%	9	0	122,199	132,189	(9,990)
MAIDSTONE	Lord North Ward (M) - NF651	83.4%	98.4%	-	-	98.8%	96.8%	-	-	20.7%	18.8%	74	5.43	19	6.7	50.0%	100.0%	2	0	111,138	112,511	(1,373)
MAIDSTONE	Mercer Ward (M) - NJ251	87.4%	95.6%	-	100.0%	118.0%	108.2%	-	100.0%	50.3%	45.7%	144	10.07	39	5.6	40.0%	100.0%	3	3	108,840	123,518	(14,678)
MAIDSTONE	Edith Cavell - NS459	78.0%	83.4%	-	100.0%	96.9%	91.9%	-	-	30.3%	31.2%	76	5.36	25	7.7	6.1%	100.0%	6	0	112,597	99,794	12,803
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	90.3%	92.6%	-	-	87.0%	-	-	-	21.7%	2.3%	29	1.79	9	21.7	-	-	0	0	54,433	55,893	(1,460)
TWH	Acute Medical Unit (M) - NG551	90.4%	87.4%	-	-	150.9%	222.6%	-	-	36.9%	44.0%	154	10.88	63	10.8	-	-	5	0	164,368	183,787	(19,419)
TWH	Ward 22 (TW) - NG332	79.5%	75.6%	-	-	123.9%	93.0%	-	-	40.1%	45.3%	141	10.32	56	5.3	28.3%	86.7%	18	1	139,368	151,382	(12,014)
TWH	Coronary Care Unit (TW) - NP301	81.8%	72.7%	-	-	76.1%	-	-	-	19.0%	22.4%	70	4.96	39	11.1	2.9%	100.0%	1	0	70,950	66,197	4,753
TWH	Ward 33 (Gynae) (TW) - ND302	93.7%	77.6%	-	-	77.4%	93.1%	-	-	30.7%	7.7%	61	3.87	20	7.5	0.9%	100.0%	0	0	95,808	93,225	2,583
TWH	Intensive Care (TW) - NA201	103.4%	115.1%	-	-	104.3%	88.7%	-	-	12.5%	0.0%	145	9.53	20	33.9	800.0%	100.0%	0	0	360,931	347,327	13,604
TWH	Acute Medical Unit (TW) - NA901	83.4%	50.2%	-	100.0%	87.1%	74.6%	-	100.0%	23.6%	33.5%	220	16.18	131	7.1	21.1%	87.5%	5	0	233,790	202,180	31,610
TWH	Surgical Assessment Unit (TW) - NE701	97.7%	125.8%	-	-	64.5%	96.8%	-	-	29.0%	10.6%	67	4.68	28	19.1	-	-	0	0	73,332	71,558	1,774
TWH	Ward 32 (TW) - NG130	85.9%	85.3%	-	100.0%	68.6%	66.7%	-	-	22.3%	30.1%	135	9.43	59	7.7	40.9%	94.4%	3	0	140,429	122,828	17,601
TWH	Ward 10 (TW) - NG131	95.8%	95.9%	-	-	87.0%	141.9%	-	-	38.0%	33.8%	156	10.56	38	6.1	6.0%	85.7%	2	1	138,874	147,400	(8,526)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	86.5%	60.3%	-	-	140.0%	75.7%	-	-	70.9%	37.2%	257	16.72	62	5.4	26.3%	90.0%	7	0	159,402	125,341	34,061
TWH	Ward 12 (TW) - NG132	88.6%	95.1%	-	100.0%	135.6%	80.6%	-	-	38.2%	49.9%	207	13.87	90	6.0	6.3%	66.7%	11	0	139,267	145,423	(6,156)
TWH	Ward 20 (TW) - NG230	101.5%	72.9%	-	-	174.2%	90.3%	-	-	42.7%	57.4%	219	15.56	72	6.9	4.2%	100.0%	16	1	164,050	166,760	(2,710)
TWH	Ward 21 (TW) - NG231	88.2%	94.6%	-	-	105.8%	114.5%	-	-	41.5%	61.7%	272	19.03	128	6.6	1.7%	100.0%	8	1	142,009	155,376	(13,367)
TWH	Ward 2 (TW) - NG442	69.5%	60.7%	-	100.0%	112.1%	119.3%	-	-	32.6%	39.2%	163	11.64	91	6.2	14.3%	100.0%	7	1	163,031	145,000	18,031
TWH	Ward 30 (TW) - NG330	83.7%	76.6%	-	100.0%	134.2%	127.8%	-	-	45.7%	46.7%	264	17.83	122	6.0	15.4%	87.5%	2	1	119,248	158,951	(39,703)
TWH	Ward 31 (TW) - NG331	86.4%	86.0%	-	-	130.8%	106.0%	-	-	33.6%	40.7%	171	11.43	60	6.1	39.7%	87.0%	3	1	132,279	150,860	(18,581)
Crowborough	Crowborough Birth Centre (CBC) - NP775	58.0%	92.9%	-	-	55.7%	70.8%	-	-	8.3%	0.0%	34	1.85	2	234.6	56.3%	100.0%	0	0	140,259	83,215	57,044
TWH	Midwifery (multiple rosters)	70.1%	69.5%	-	-	82.4%	87.8%	-	-	13.6%	5.2%	672	38.17	190	10.2	8.8%	100.0%	0	0	760,430	775,487	(15,057)
	Hedgehog Ward (TW) - ND702	75.8%	65.8%	-	-	76.9%	-	-	-	18.3%	33.4%	120	8.45	46	11.1	9.8%	100.0%	0	0	143,265	153,391	(10,126)
MAIDSTONE	Maidstone Birth Centre - NP751	94.8%	98.1%	-	-	99.9%	96.8%	-	-	12.8%	0.0%	26	1.23	0	54.1	92.0%	100.0%	0	0	72,788	81,625	(8,837)
TWH	SCBU (TW) - NA102	89.7%	69.4%	-	-	93.2%	75.0%	-	-	21.3%	3.3%	119	7.15	8	10.8	40.0%	100.0%	0	0	194,672	192,733	1,939
TWH	Short Stay Surgical Unit (TW) - NE901	73.1%	61.9%	-	100.0%	67.0%	97.1%	-	-	19.6%	27.0%	59	4.08	17	10	-	-	0	0	77,966	75,000	2,966
MAIDSTONE	Accident & Emergency (M) - NA351	96.5%	88.8%	-	100.0%	101.3%	74.2%	-	-	40.0%	41.5%	448	31.60	51		3.1%	92.5%	4	0	367,872	438,844	(70,972)
TWH	Accident & Emergency (TW) - NA301	91.8%	86.2%	-	100.0%	95.3%	93.0%	-	100.0%	38.1%	42.2%	454	31.95	73		2.3%	85.9%	7	0	394,618	484,232	(89,614)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	62.3%	77.3%	-	100.0%	77.4%	-	-	-	16.8%	0.0%	19	1.24	2	14.5	32.6%	100.0%	1	0	56,166	58,152	-1,986
MAIDSTONE	Peale Ward COVID - ND451	82.4%	103.1%	-	100.0%	103.3%	123.3%	-	-	23.5%	45.5%	74	5.45	30	8.8	35.7%	100.0%	3	0	119,714	93,376	26,338
TWH	Private Patient Unit (TW) - NR702	102.4%	73.4%	-	100.0%	54.8%	103.2%	-	-	19.1%	7.8%	57	4.08	28	8.5	-	-	0	0	73,445	69,852	3,593
																				Total Established Wards		
																				6,673,459	6,664,528	8,931
																				Additional Capacity beds Cath Labs		
																				54,288	39,077	15,211
																				0	0	0
																				Other associated nursing costs		
																				5,015,365	4,403,850	611,515
																				11,743,112	11,107,455	635,657

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 equal to or less than 80% OR equal to or greater than 130%

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points.

Which Committees have reviewed the information prior to Board submission?
- 'Main' Quality Committee, 14/09/22

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

Mortality Surveillance Group Report

August 2022

MTW
exceptional people, outstanding care

Contents

Maidstone and Tunbridge Wells NHS Trust

Note: Detailed analysis and a deep dive into specific areas are available on request - mtw-tr.informationdepartment@nhs.net

MTW exceptional people, outstanding care

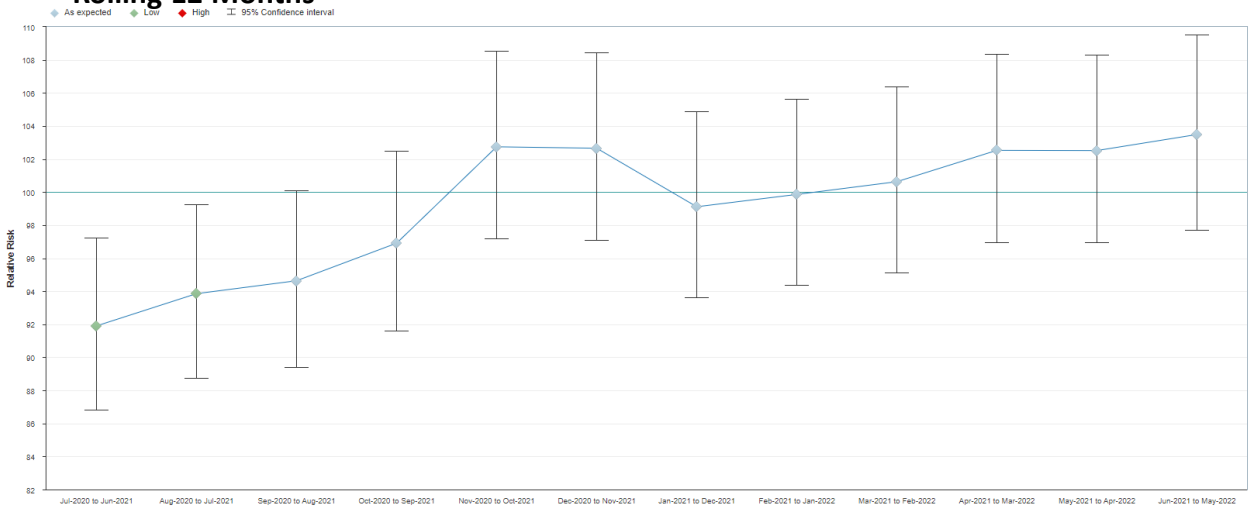
Executive Summary

- T Health (Dr Foster) have updated on schedule. Published data is up to **May 2022**.
- HSMR has risen from the previous period– Rolling HSMR currently at **103.5** and is performing well against the standard ratio of 100. We are in the "as expected" bracket.
- Monthly HSMR shows an decrease in February 22 (94.9), in the "as expected" bracket
- As a Trust we continue to perform well amongst our local peers as well as those trusts rated Good or Outstanding by the CQC
- The latest reporting month saw **one** CUSUM alert in Residual Codes, unclassified
- Weekend and Weekday HSMR are above the national average, but is in the "as expected" bracket. Further analysis suggests case mix and coding around Covid episodes are influencing the expected rate. Crude mortality is consistently below the national average.
- Deaths with no comorbidities on a rolling 12 month basis have decreased from the last published dataset. Those deaths with no comorbidities focussed on Geriatric and Respiratory Medicine
- Covid HSMR for the Trust is higher than our Kent peers, driven by depth of coding around Covid.
- Trust SHMI continues to perform in the green.

HSMR Overview

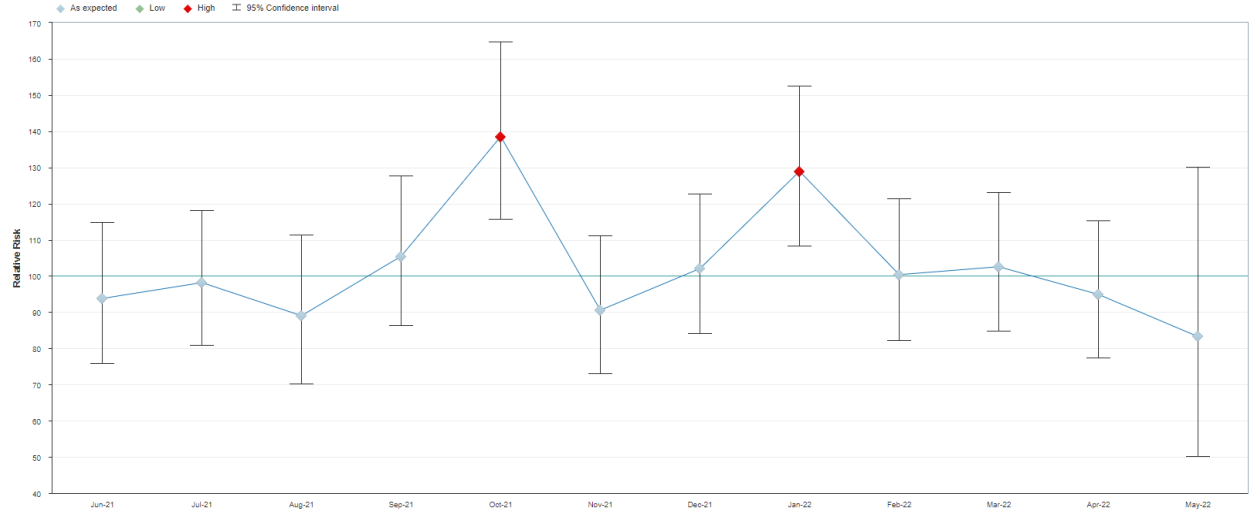
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Months



The 12 months **April 2021 to May 2022** show our HSMR to be **103.5**, an increase on last month's figure of **102.5**. The This places the Trust in the "as expected" bracket

Monthly View



The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so **April 2022** in this case, shows that the Trust's position has decreased to **94.9** from **102.9** in March 2022. The monthly view should be taken with caution, however, with a the rolling 12 month view a much more robust view of HSMR

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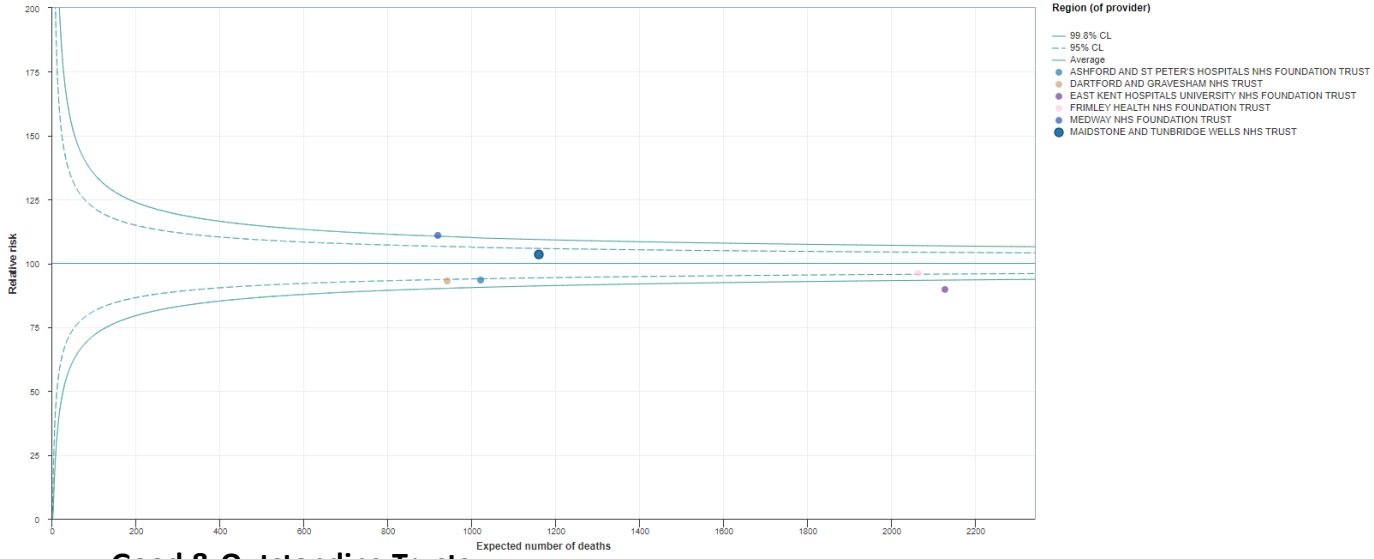
HSMR – Benchmarking

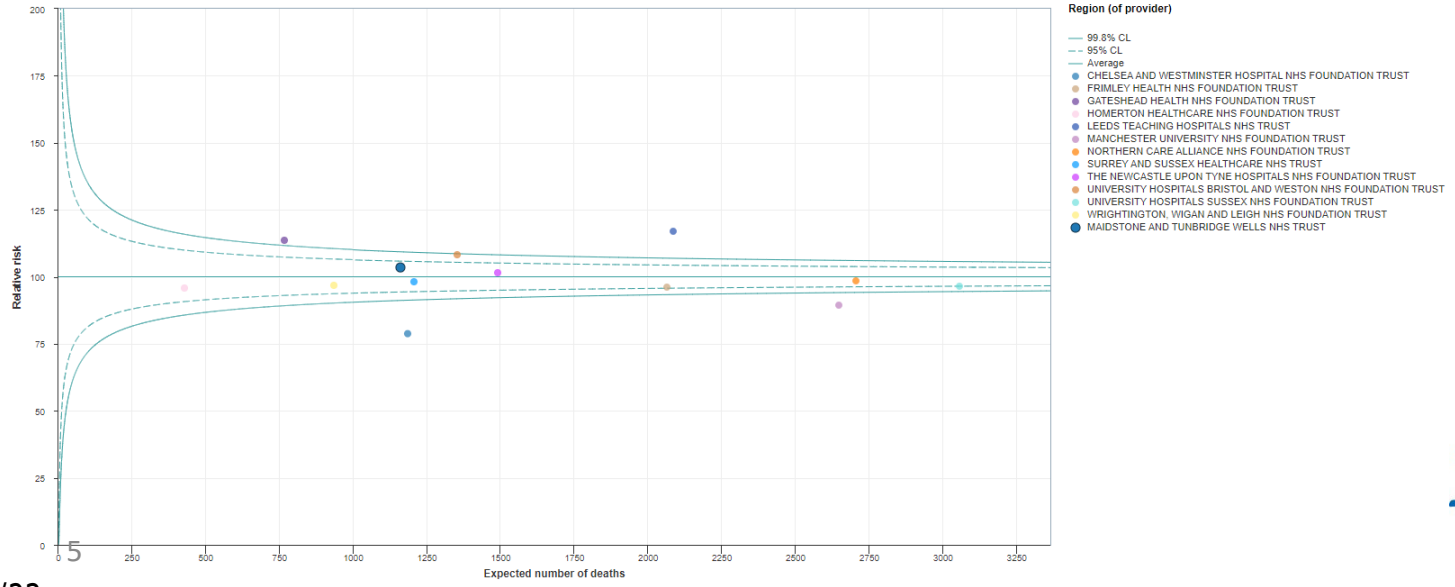
Maidstone and Tunbridge Wells NHS Trust

Kent Peers



MTW continues to perform well both amongst local peers as well as with Trusts rated 'Good' or 'Outstanding' by the CQC

Good & Outstanding Trusts



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CUSUM Alerts - Overview

Maidstone and Tunbridge Wells NHS Trust

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 8	128148	1636	1575.4	1.3	103.8				
HSMR (56 diagnosis groups)	1	39429	1201	1160.6	3.0	103.5				
Congestive heart failure, nonhypertensive	1	701	88	66.8	12.6	131.7				
Intestinal infection	1	1016	15	9.4	1.5	160.2				
Multiple sclerosis	1	29	1	0.7	3.4	148.2				
Occlusion or stenosis of precerebral arteries	1	5	1	0.1	20.0	1459.3				
Other upper respiratory infections	1	479	2	0.4	0.4	567.0				
Pneumonia		1621	243	202.7	15.0	119.9				
Residual codes, unclassified	2 4	8309	111	65.8	1.3	168.7				
Septicemia (except in labour)	1	716	130	98.9	18.2	131.5				
All Procedures	1	76808	1094	1065.1	1.4	102.7				
Chemotherapy		320	6	2.0	1.9	303.8				
Diagnostic imaging of heart		1058	49	34.5	4.6	142.2				
Other destruction of haemorrhoid	1	41	1	0.0	2.4	5904.1				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Residual codes, unclassified	168.7	8309	111	65.8	45.2
Pneumonia	119.9	1621	243	202.7	40.3
Septicemia (except in labour)	131.5	716	130	98.9	31.1
Congestive heart failure, nonhypertensive	131.7	701	88	66.8	21.2
Rest of Upper GI	109.3	1189	185	169.2	15.8

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	84.2	34	14	41.2
Aspiration pneumonitis, food/vomitus	109.7	239	68	28.5
Respiratory failure, insufficiency, arrest (adult)	112.7	70	16	22.9
Occlusion or stenosis of precerebral arteries	1459.3	5	1	20.0
Septicemia (except in labour)	131.5	716	130	18.2

CUSUM alert for Residual Codes, unclassified

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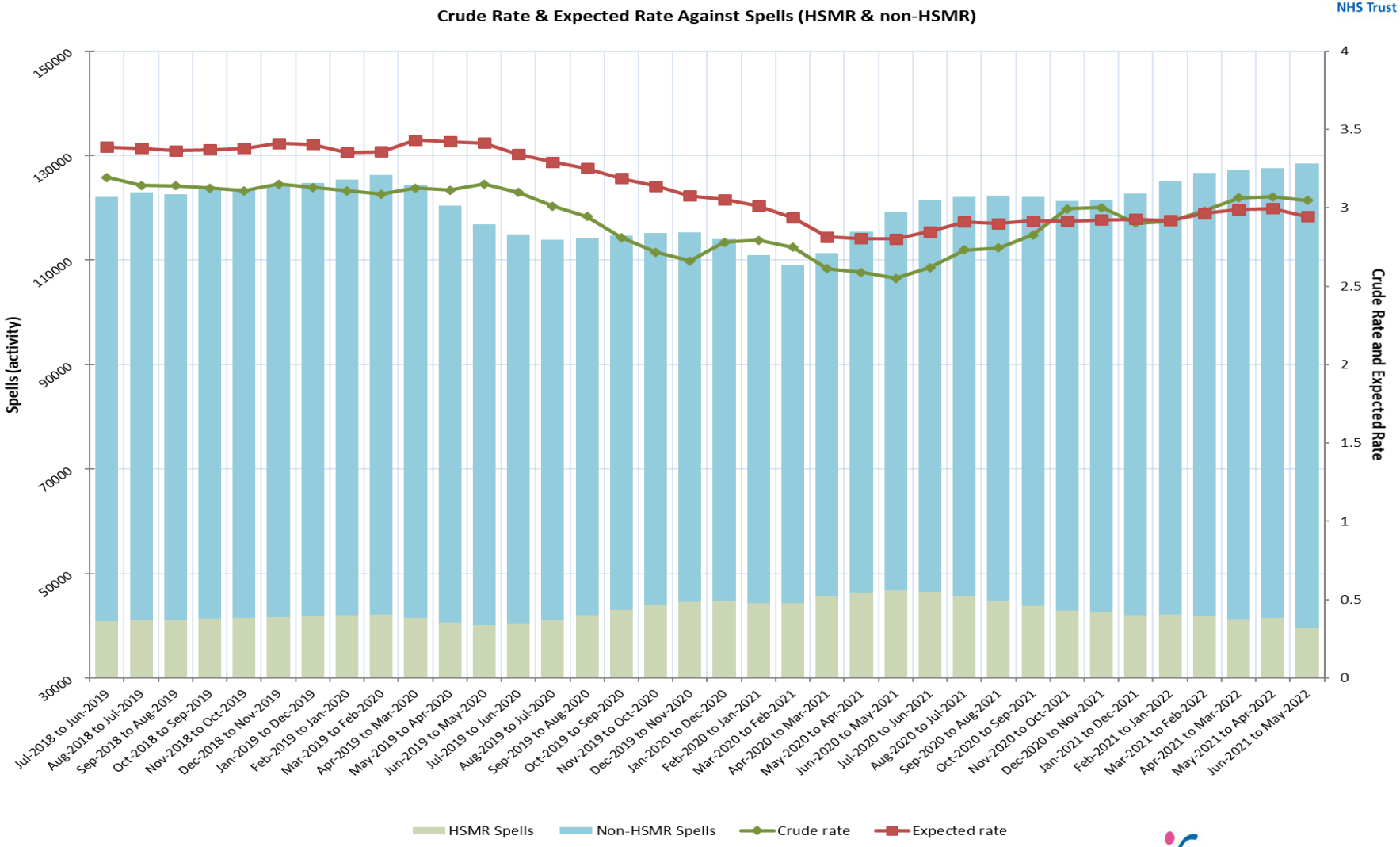
Crude & Expected Rate Against Spell Comparison

Maidstone and Tunbridge Wells NHS Trust



Crude mortality marginally higher than the expected rate, combined with increased spell volumes. Crude mortality is falling, however

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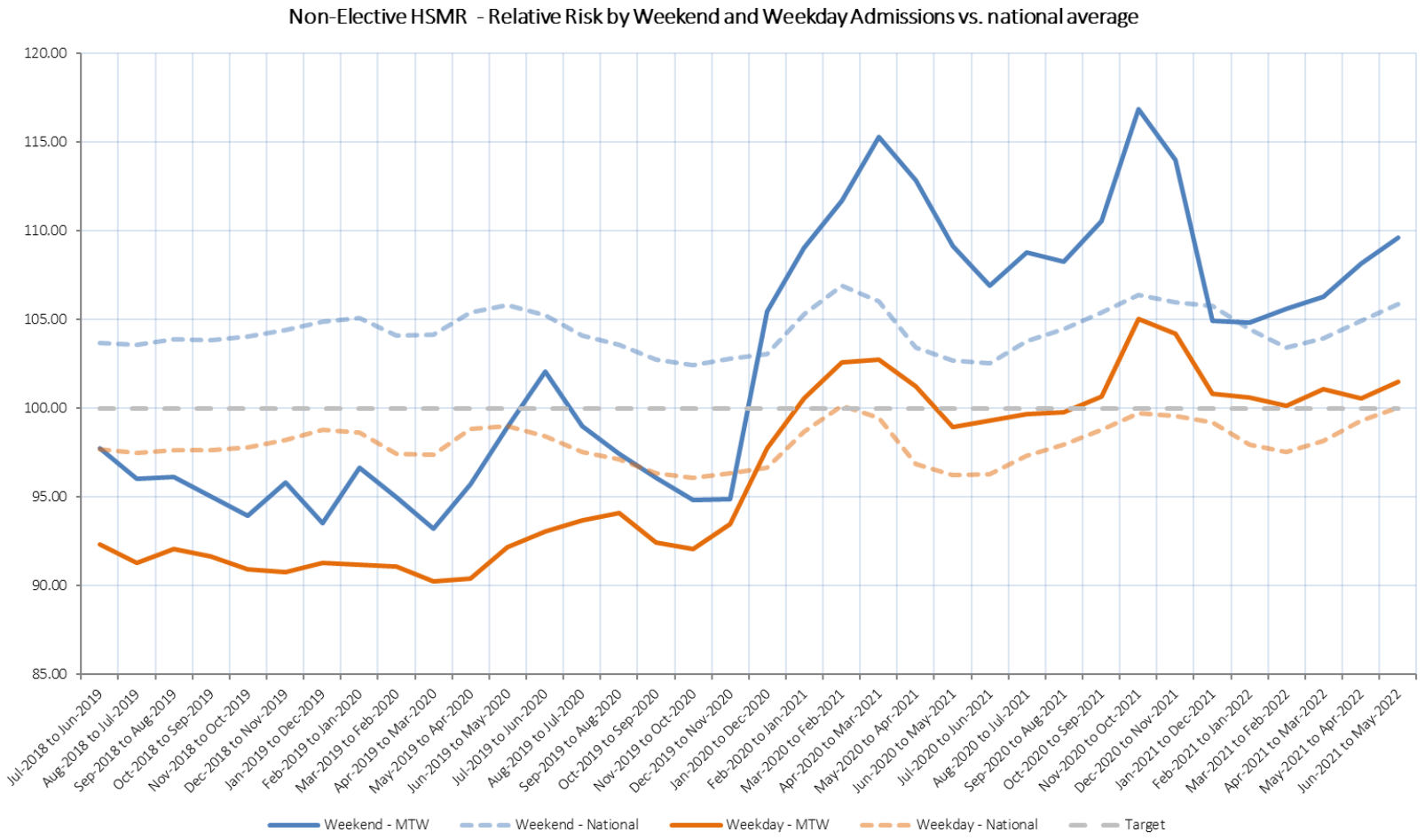
HSMR – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



Weekend and Weekday HSMR for non-elective care are above the national average, with relative risks of **109.63** and **101.50** respectively. Whilst above the national average, these remain in the "as expected" bracket.

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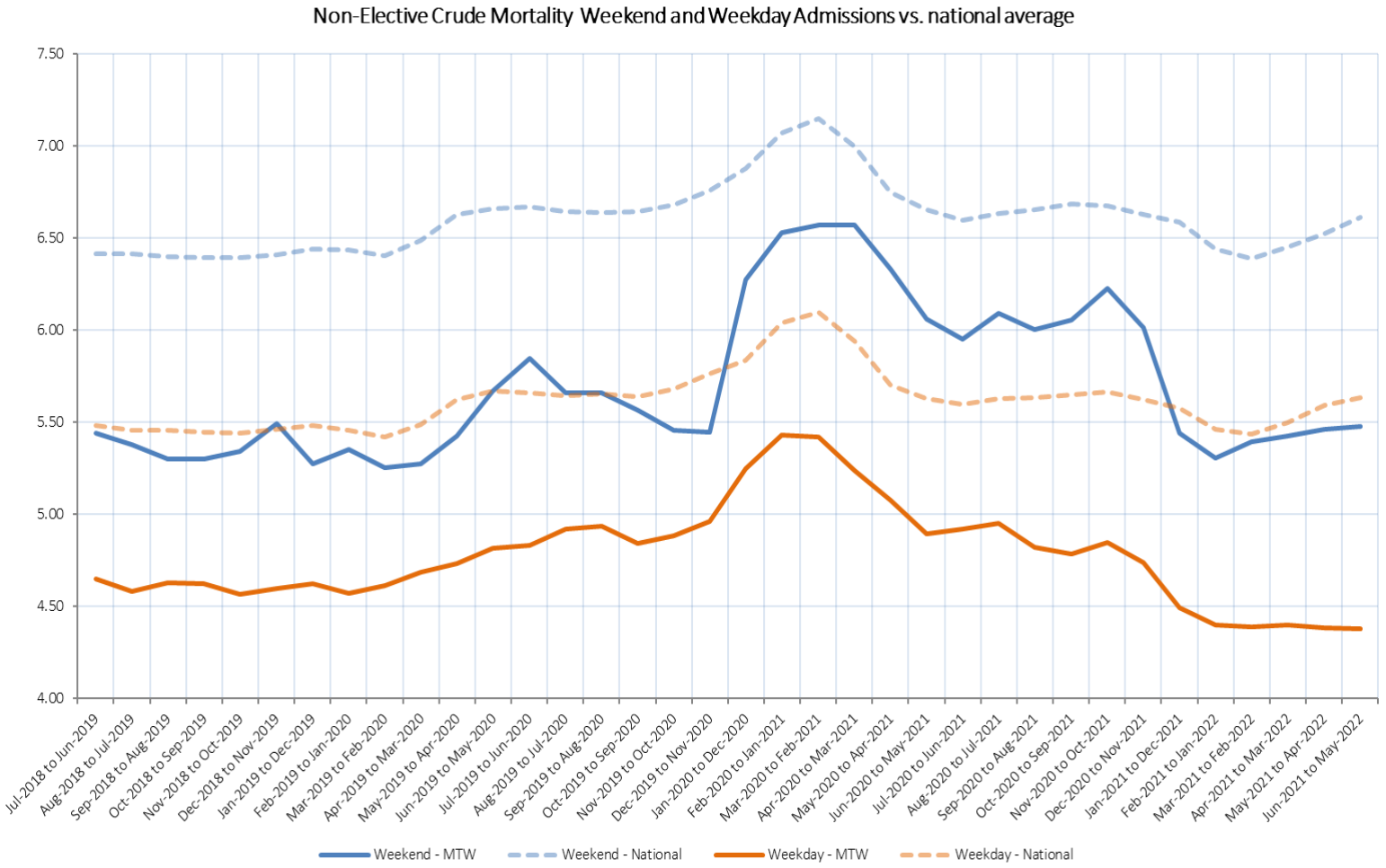
Crude Mortality – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



When doing the same weekend-Weekday comparison for crude mortality, we see that MTW is consistently lower than the national averages, pointing to an interaction with the expected mortality rate driving HSMR above the national average

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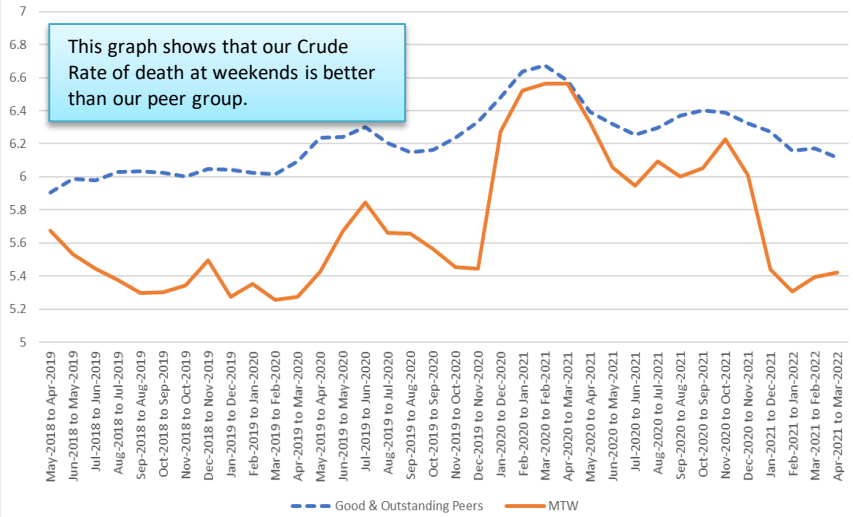
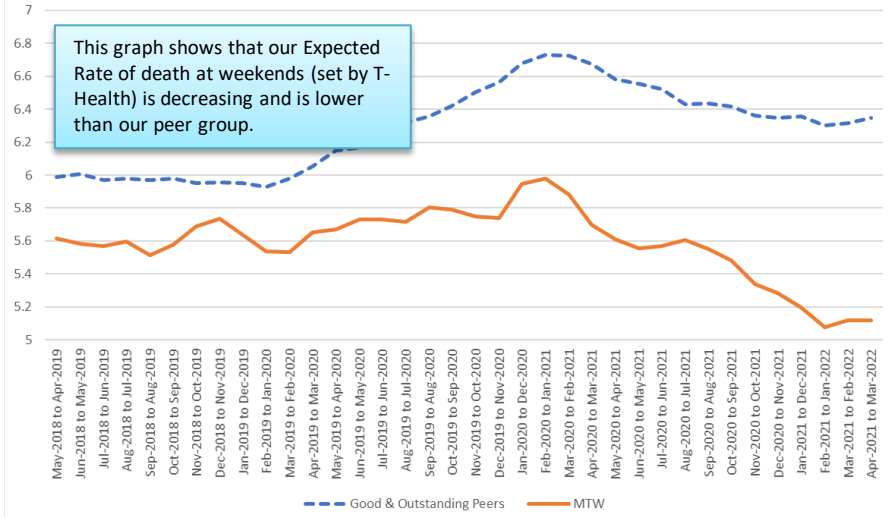
Analysis into mortality following a Weekend Non-Elective Admissions for a diagnosis within HSMR

Maidstone and Tunbridge Wells NHS Trust

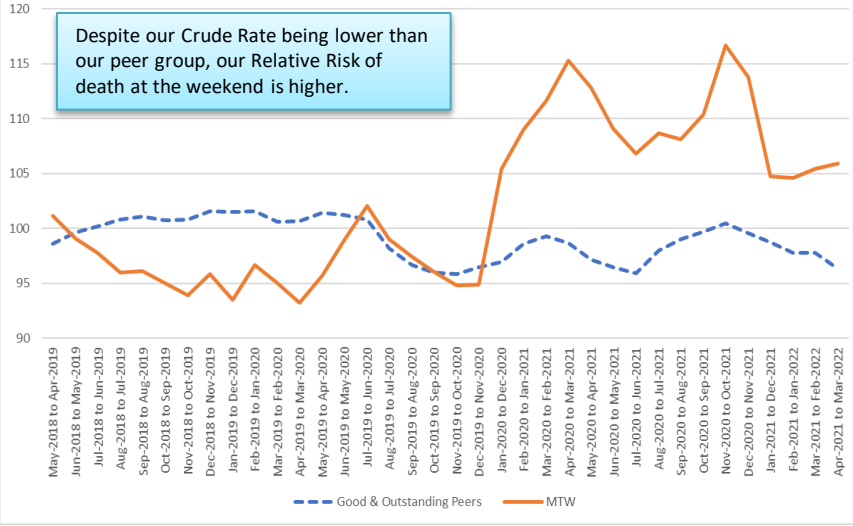
HSMR: Crude Rate for NEL Weekend Admissions



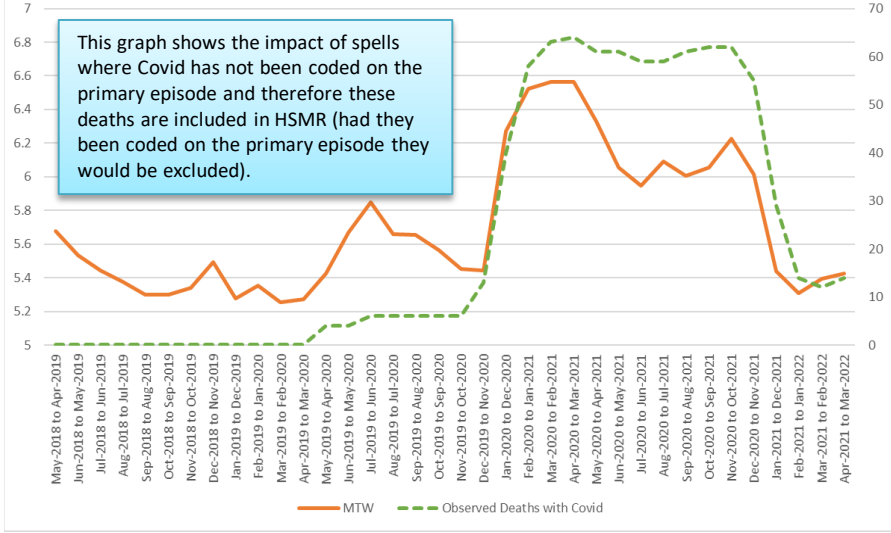
HSMR: Expected Rate for NEL Weekend Admissions



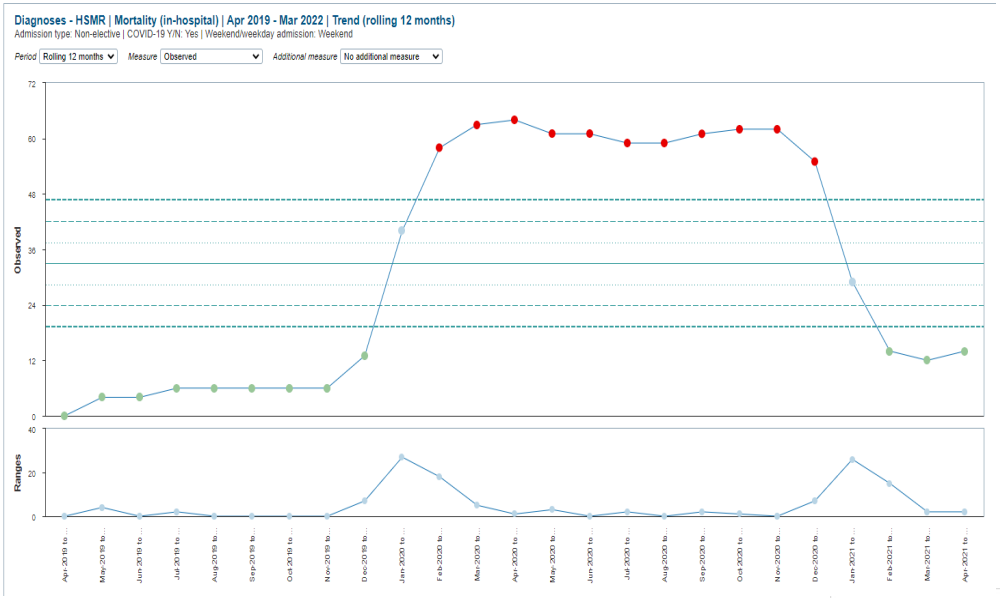
HSMR: Relative Risk for NEL Weekend Admissions



HSMR: Crude Rate for NEL Weekend Admissions with Covid Deaths overlaid



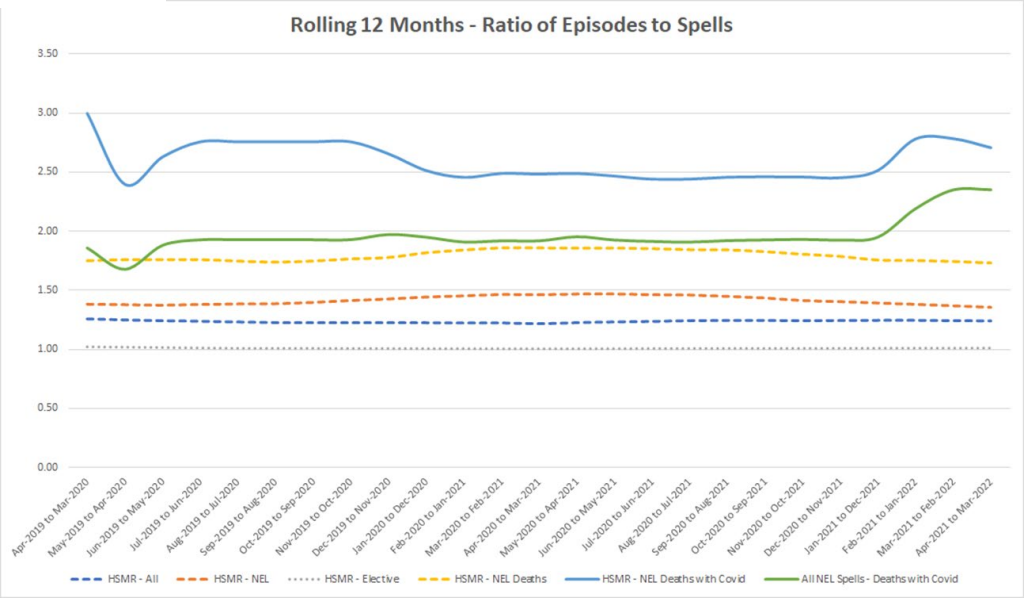
The Covid Factor



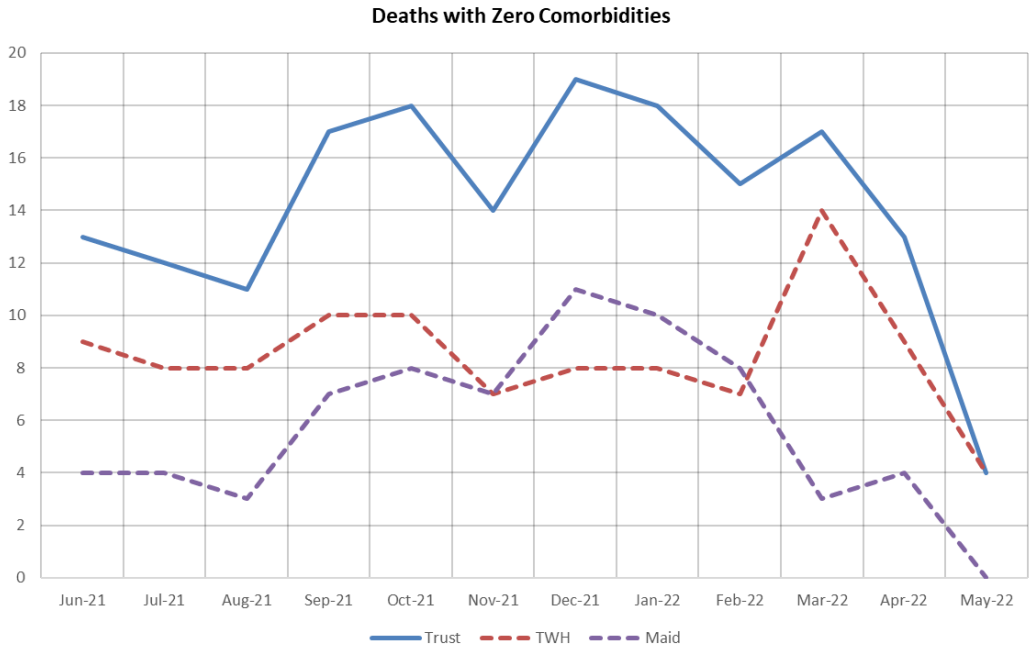
The left graph shows the observed Covid deaths included in the HSMR as they were not on the primary Episode

While the graph below shows that Covid spells have more episodes in them and therefore have a higher chance to not have a Covid diagnosis in the primary position

The modelling in T-Health for expected mortality is based on a retrospective dataset that is further behind than the live data and only now coming out of the Covid peaks. This is an influencing factor on the lower expected rate of death and is likely driven by a casemix and coding.



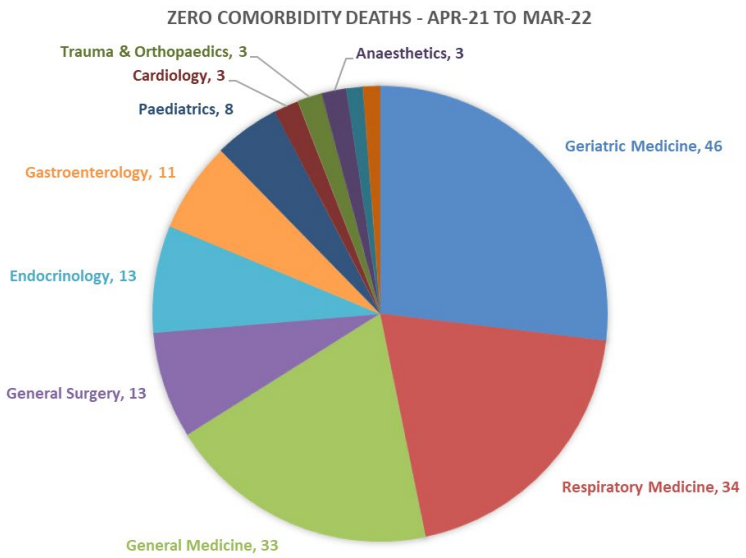
Deaths with Zero Comorbidities



Month	Trust	TWH	%	Maid	%
Jun-21	13	9	69.2	4	30.8
Jul-21	12	8	66.7	4	33.3
Aug-21	11	8	72.7	3	27.3
Sep-21	17	10	58.8	7	41.2
Oct-21	18	10	55.6	8	44.4
Nov-21	14	7	50.0	7	50.0
Dec-21	19	8	42.1	11	57.9
Jan-22	18	8	44.4	10	55.6
Feb-22	15	7	46.7	8	53.3
Mar-22	17	14	82.4	3	17.6
Apr-22	13	9	69.2	4	30.8
May-22	4	4	100.0	0	0.0
All	**171**	**102**	59.6	**69**	40.4

Of the **1,201** deaths recorded in the period of **June 2021 to May 2022**, **171** had no comorbidities recorded (**14.24%**). The volume of deaths recorded with no comorbidities has reduced slightly (183 in previous period).

Deaths with Zero Comorbidities – By Specialty



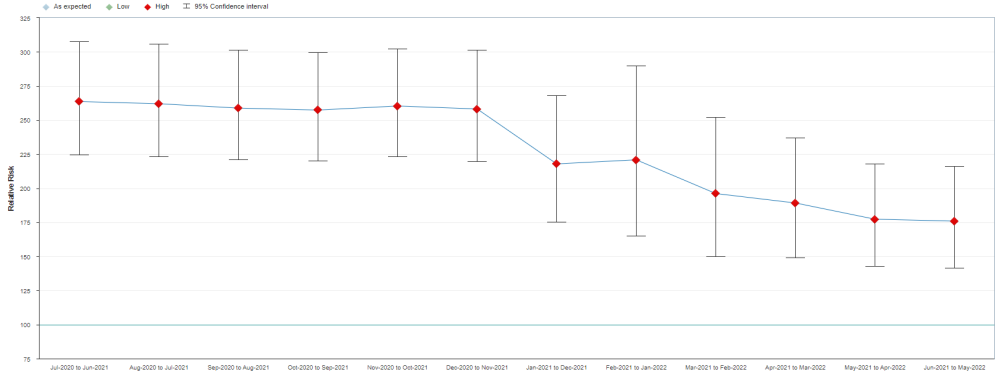
	Mar-21 Feb-22		Apr-21 Mar-22		Jun-21 May-22	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	54	30%	54	30%	46	27%
Respiratory Medicine	32	18%	35	19%	34	20%
General Medicine	28	16%	34	19%	33	19%
General Surgery	14	8%	16	9%	13	8%
Stroke Medicine	9	5%		0%		0%
Gastroenterology	10	6%	11	6%	11	6%
Endocrinology	9	5%	10	5%	13	8%
Cardiology	5	3%	4	2%	3	2%
Clinical Haematology	4	2%	3	2%	2	1%
Trauma & Orthopaedics	3	2%	3	2%	3	2%
Anaesthetics	1	1%	2	1%	3	2%
Accident & Emergency	2	1%	3	2%	2	1%
Paediatrics	6	3%	7	4%	8	5%
ENT	1	1%		0%		0%
Gynaecology		0%	1	1%		0%
Well Babies		0%		0%		0%
Urology		0%		0%		0%
All	178		183		171	

The majority of zero comorbidity deaths continue to be in **Geriatric Medicine and Respiratory Medicine Specialties**.

Covid 19 Mortality

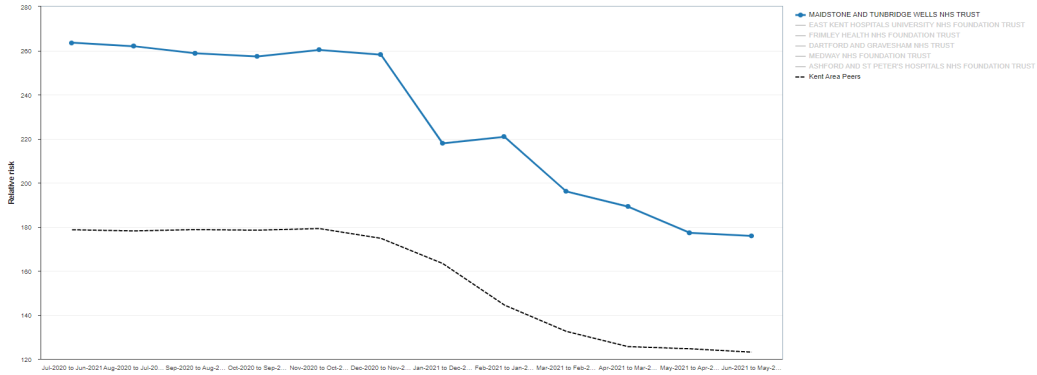
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Month Relative Risk for Covid Diagnoses



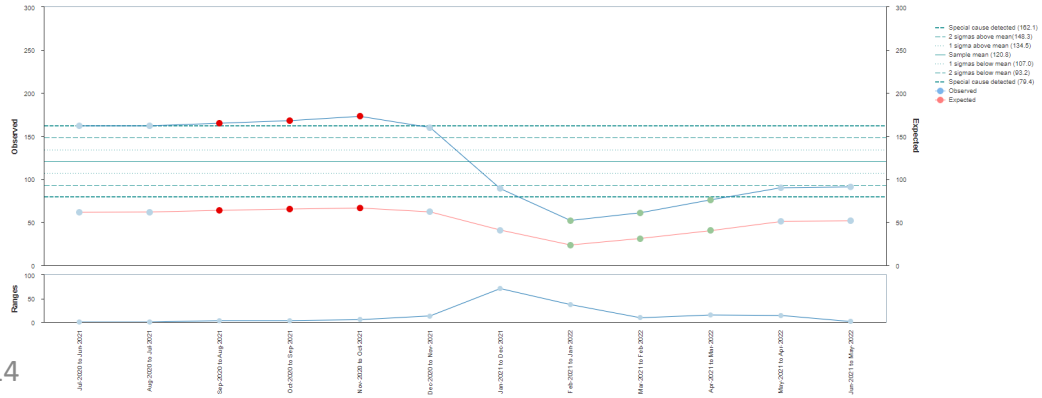
Relative Risk for Covid continues to drop, remaining in the "high" bracket however, with the period of **Jun 21 to May 22** at **175.9**

Relative Risk Compared to Kent Peers – Rolling 12 Months



Our Relative Risk continues to be higher than that of our Kent peers at **175.9** against **123.1**. This continues to reduce over previous reporting periods and is converging

Expected Deaths against Observed Deaths – Rolling 12 months

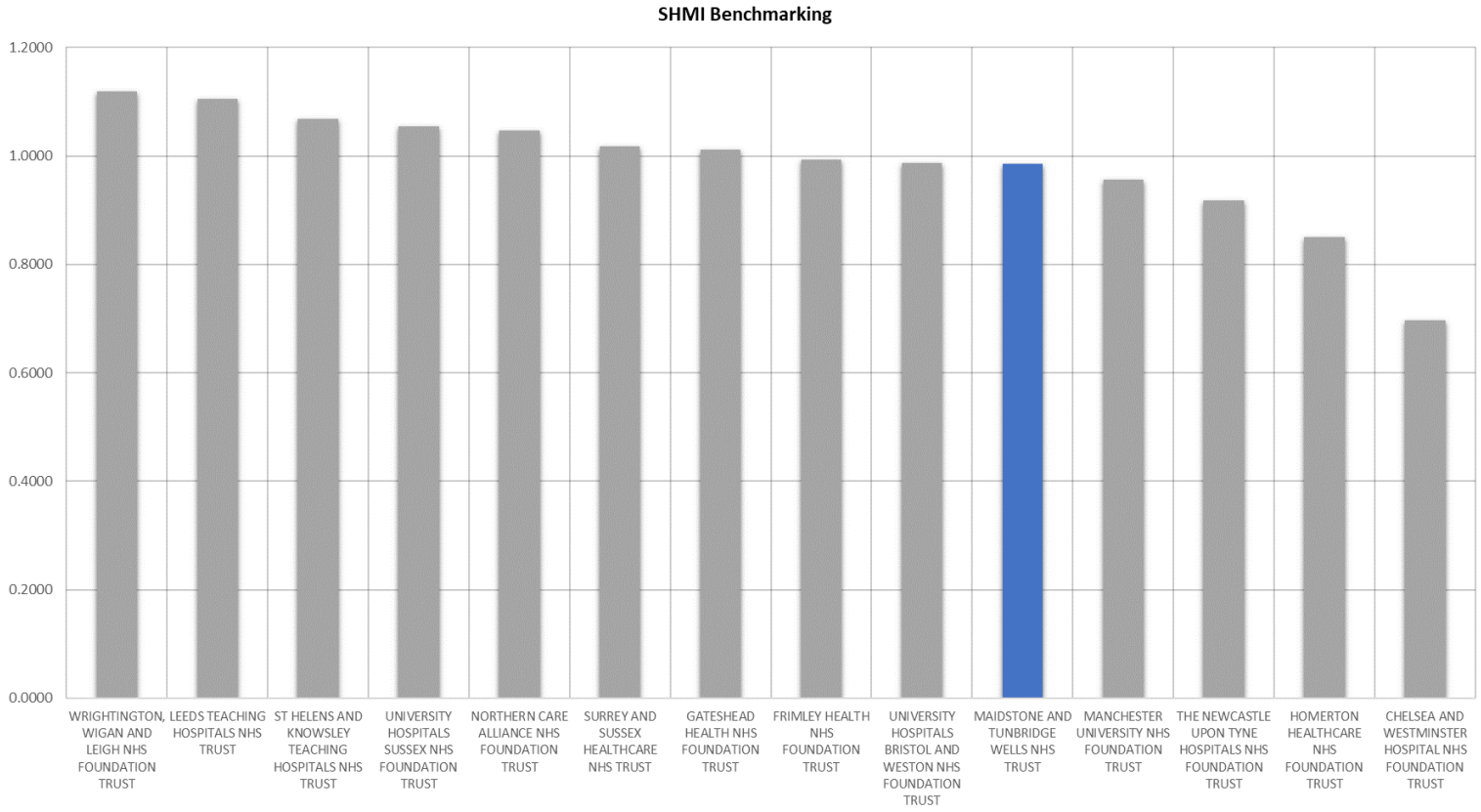


Our Observed Covid deaths continues to be higher than Expected deaths. This gap points further to the case-mix and coding being a factor in the expected rate

MTW exceptional people, outstanding care

SHMI

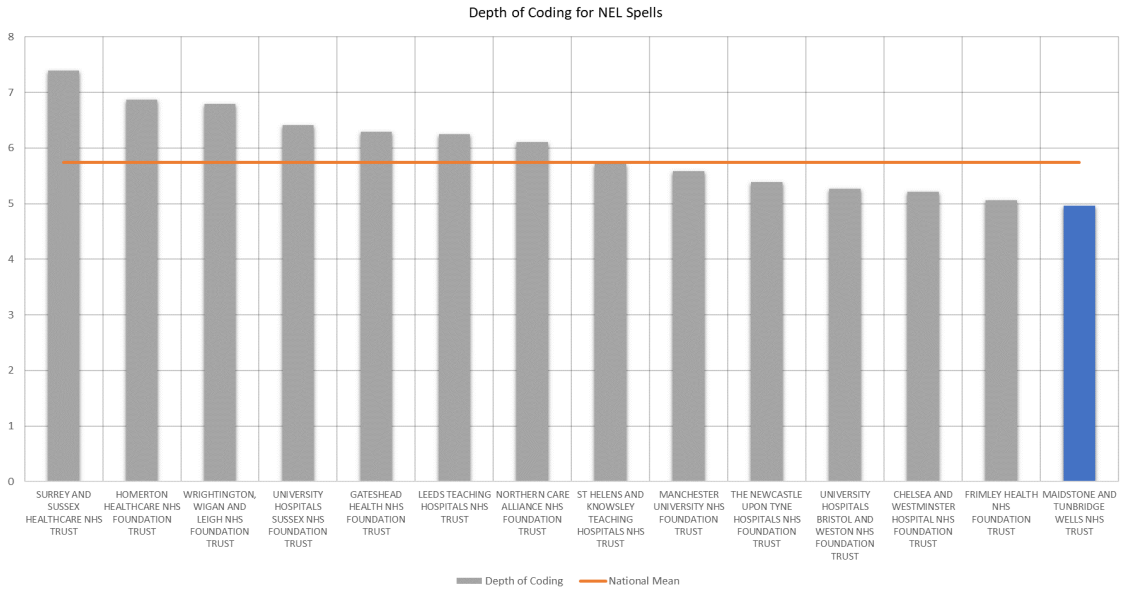
Maidstone and Tunbridge Wells NHS Trust



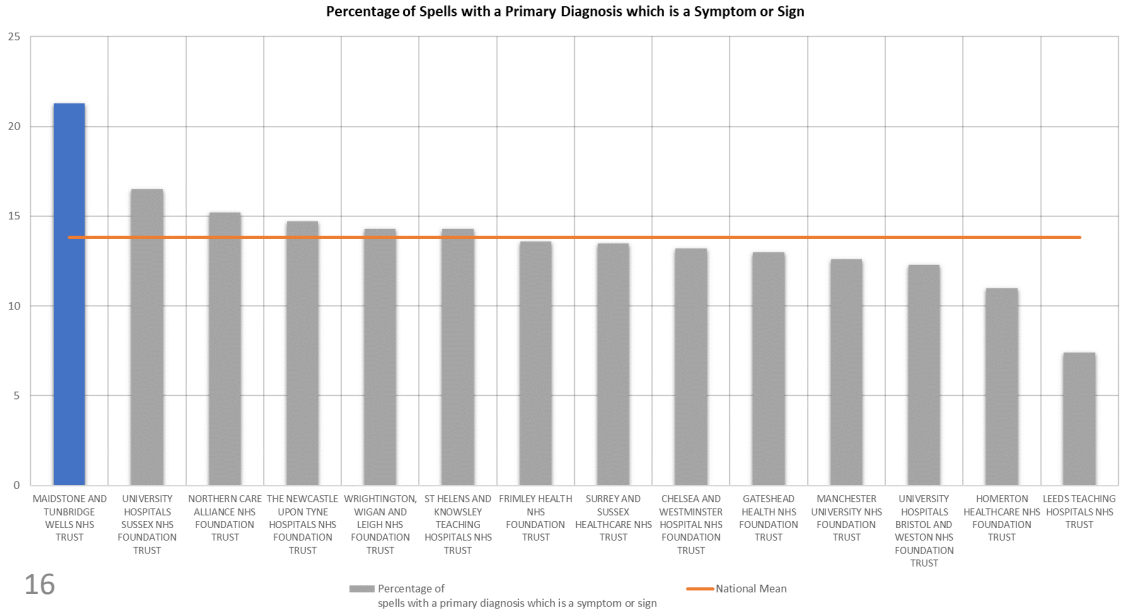
As a trust we are performing favourably against our peers on SHMI – with a SHMI of **0.99** for the period of **April 2021 to March 2022** and continue to be rated 'As Expected'.

MTW exceptional people, outstanding care

SHMI – Contextual Indicators

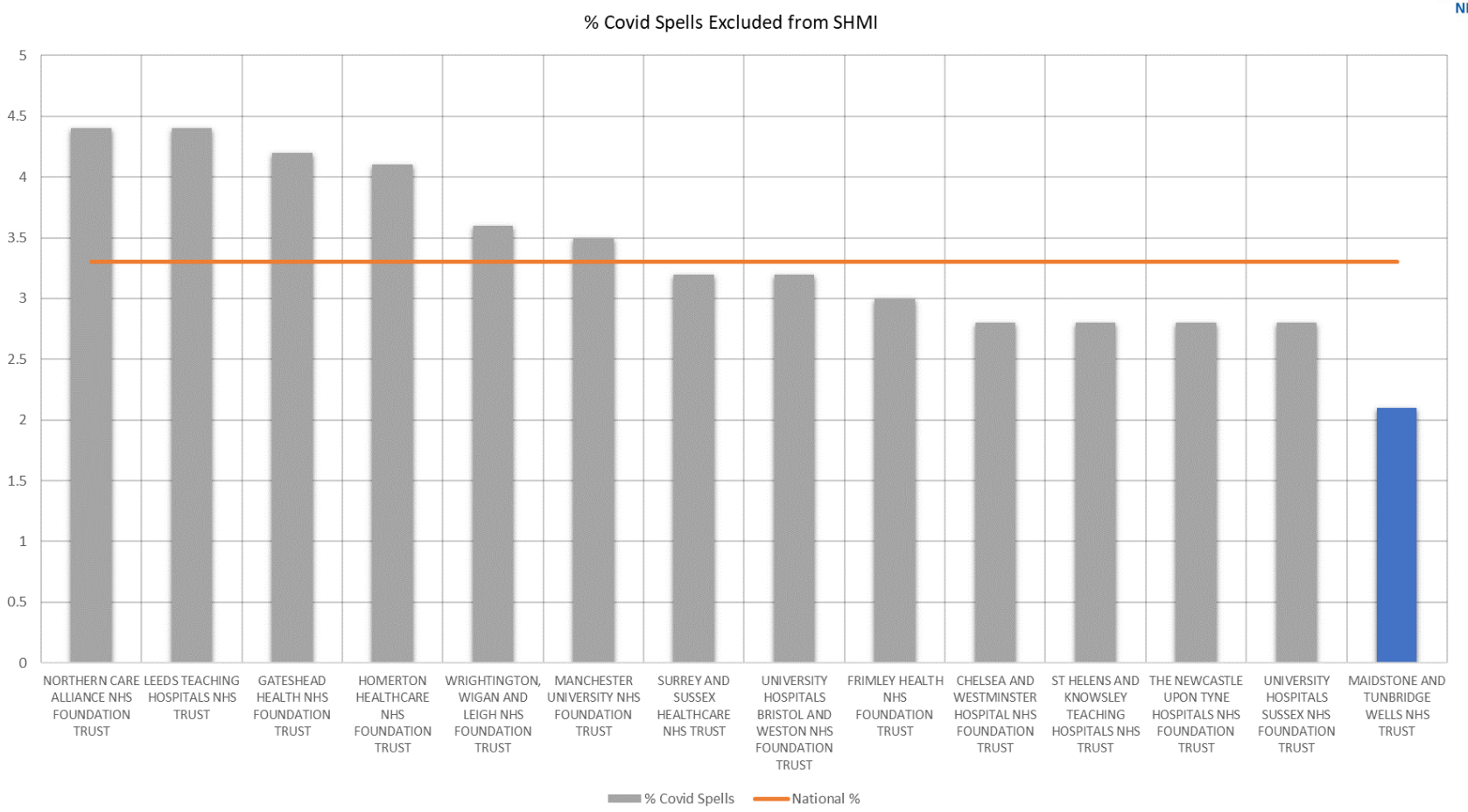


Depth of coding for the Trust remains below national average and in the lowest quartile of our Outstanding and Good Rated peers.



The Trust's percentage of spells that have a Primary Diagnosis that is a symptom or sign is above the national average and has the highest percentage amongst our Outstanding and Good rated peers.

SHMI – Contextual Indicators - Covid



SHMI excludes Covid Spells, but does track spells excluded due to Covid. We continue to be an outlier on the number of spells excluded due to Covid – the lowest percentage amongst our Good and Outstanding peers. This points further to uncoded Covid spells being included in non-covid mortality data.

Coding update

Historical data is keeping our primary diagnosis with signs and symptoms score high, Once T Health can reflect October 2022 coded data we should be able to see the improvements that have been made.

These improvements are:

- Only Coders who hold the National Accreditation Qualification code deceased patients
- Any deceased patient with a sign or symptom code recorded in primary is validated by our Clinical Coding Audit team
- The Chief of Medicine and Emergency Care/ Trust Mortality lead has been tasked with nominating a clinical representative to join one of the clinical coding data quality groups to validate these cases and confirm the content of the healthcare record and that the coding is correct.

The coding team can confirm on average only of 1 or 2 cases a month and 0 on some months are occurring

Medical Examiner Service

ME Service Update

- In the month of June 2022, the number of cases scrutinised by the ME Service saw a sharp decline however returning to expected levels in July. The Service continues to perform well scrutinising 99-100% of in hospital non coronial deaths.
- The expansion of the Service into the community has commenced with some community hospital and hospice deaths being scrutinised.
- Two GP practices have consented to being used at pilot sites for the roll out into the community. Both practices use Emis to record and store patient information.
- The Service is awaiting training from Emis, now scheduled for October 2022 to commence scrutiny of deaths in the community where GP practices are responsible for the death certification process.

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calender Days to Complete
Jan-22	173	173	100%	83	48%
Feb-22	141	141	100%	55	39%
Mar-22	157	154	98%	50	32%
Apr-22	150	149	99%	53	36%
May-22	134	133	99%	47	35%
Jun-22	110	109	99%	41	38%
Jul-22	130	130	100%	35	27%

Challenges faced by the ME Service

- Engagement with all 53 GP practices in West Kent will take a considerable amount of time and has required the roll out to the community to be done in stages.
- The original funding envelop for the set up and extension of the ME Service into the community does not adequately meet the requirement to deliver a quality Service. Therefore, support is required from the Trust to meet the shortfall.
- Delays to the completion of scrutiny within the stipulated 3 days target is difficult to meet due to timeliness of death summaries being provided to the ME Service. This has been an ongoing issues since the inception of the Service.

Mortality Surveillance Group (MSG)

The role of the Mortality Surveillance Group involves supporting the Trust to provide assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary investigated. A further responsibility of the group is to ensure lessons learnt from Mortality reviews are disseminated appropriately and actions implemented to improve outcome for patients and quality of services provided.

Learning from Mortality reviews identified the following needs:

- Only clinical staff with appropriate training should be responsible for insertion of NG tube.
- Early intervention with respect to nutritional support, especially in patients unable to swallow to allow administration of enteral medications such as antihypertensives as in the case discussed at MSG
- Hip fracture patients should be operated on within 48 hours, and if unable to achieve this then documentation detailing reasons should be recorded.

The following practice was highlighted in :

- Good family involvement with patients family contributing to setting the appropriate ceiling of care for them.
- Exemplary documentation of cardiac arrest call, good documentation
- Good multi specialty treatment approach

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

Structured Judgement Review (SJR)

An SJR is a standardised review of a patient's death undertaken by a trained clinician making safety and quality judgement of care phases. The SJR reviewer makes explicit comments about phases of care with scores attributed to each phase and the overall care received.

Year	Previous position	Current Position
	Outstanding SJRs	Outstanding SJRs
Apr 18 to Mar 19	2	0
Apr 19 to Mar 20	6	0
Apr 20 to Mar 21	9	9
Apr 21 to Mar 22	27	23
Apr 22 ro Mar 23	9	18
SJR Total backlog	53	50

- There has been progress with eradicating the historical backlog for 2018/19 and 2019/20. The focus now is on the 2020/21 backlog
- Whilst work is ongoing to reduce the backlog, there has been a slight setback with 3 SJR reviewers stepping down.
- The effectiveness of the ME Service has increased the demand for SJR reviews which negates the monthly progress made towards reducing the overall backlog .
- The current SJR backlog position is 50, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4 week stipulated SJR turnaround time.
- There are 4 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 62.

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor Care'
Jul-22	10	0	0
Aug-22	5	1	0

- In July, there was no SJR with 'Poor care' or a 'Very poor care' assessment reviewed at the MSG meeting.
- In August, there was 1 SJR with an overall assessment of 'Poor care' discussed at MSG.
- Learning from both poor care and good practices highlighted from cases reviewed at MSG continue to be fed back to directorates

Mortality Surveillance Group (MSG)

Actions from 'Poor care' SJR Reviews

- The 1 SJR with an overall assessment of 'Poor care' was discussed at MSG and with the Directorates
- No SJRs resulted in an SI being raised
- Learning from all SJRs have been feedback to Directorates through Clinical Governance meetings.

Next steps

- Training for prospective SJR reviewers is in the process of being scheduled after getting confirmation of a suitable trainer.
- Follow up on engagement with Trust Clinical Directors and Chiefs about nominating members from their teams to join the MSG and train to become SJR reviewers.
- Continue to progress the Medical Examiner community roll out project.

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Summary of the changes to the updated NHS Safeguarding accountability and assurance framework	**Deputy Chief Nurse for Quality and Experience**

At the July 2022 Trust Board meeting the Chief Nurse stated that an updated Trust Board annual Safeguarding refresher training (incl. a summary of the changes to the "Safeguarding accountability and assurance framework") report would be submitted to the September 2022 'Part 1' meeting. The Chair then requested that as the Board had received the refresher training at the meeting in July 2022 the report should just summarise the changes arising from the new framework. This report is therefore enclosed.

The full "Safeguarding accountability and assurance framework" document can be accessed in the "Documents" section for the Board's information at "Trust Board/Documents/2022/09. 29.09.22/Safeguarding accountability and assurance framework".

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

[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

Summary of changes to the updated NHS safeguarding accountability and assurance framework (SAAF)

September 2022

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Executive Summary

- This report provides a summary of the updates made to the SAAF. It outlines the roles and responsibilities for providers within the system.
- It builds on its 2019 predecessor by strengthening the NHS commitment to promoting the safety, protection and welfare of children, young people and adults.
- It has been updated to reflect changes in policy and legislation since its last iteration. The 2022 SAAF may well be subject to further iterations as we recover and rebuild from COVID-19 and further statutory guidance.
- It provides the flexibility needed at local level to support the professional practice of individuals and the partnerships needed to promote healthy behaviours to keep individuals and communities safe from harm.
- It remains the responsibility of every NHS-funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the well-being of those children and adults is at the heart of what we do.

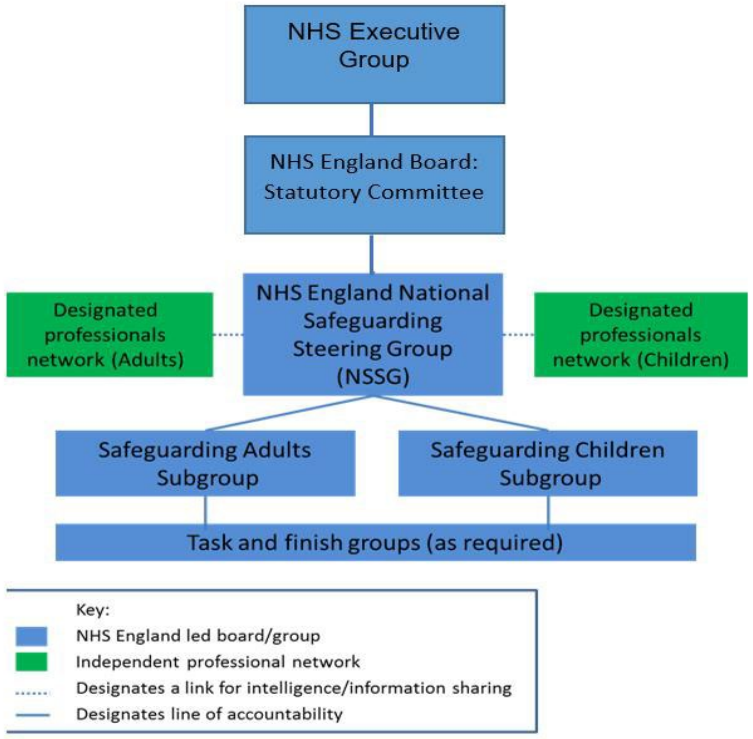
The SAAF aims to:

- Identify and clarify how relationships between health and other systems work at both strategic and operational levels to safeguard children, young people and adults under the care of the NHS at risk of abuse or neglect
- Clearly set out the legal framework for safeguarding children and adults as it relates to the various NHS organisations, in order to support them in discharging their statutory requirements to safeguard children and adults
- Outline principles, attitudes, expectations, and ways of working that recognise that safeguarding is everybody's responsibility and that the safety and wellbeing of those in vulnerable circumstances are at the forefront of our business
- Identify how NHS England regional and national teams work with integrated care board (ICB) accountable leadership and ICB place-based leadership to support partnerships (new addition in 2022)
- Identify clear arrangements and processes to be used to support evidence based practice and provide assurance at all levels, including NHS England Board, that safeguarding arrangements are in place
- Promote equality by ensuring that health inequalities are addressed and are at the heart of NHS England values.

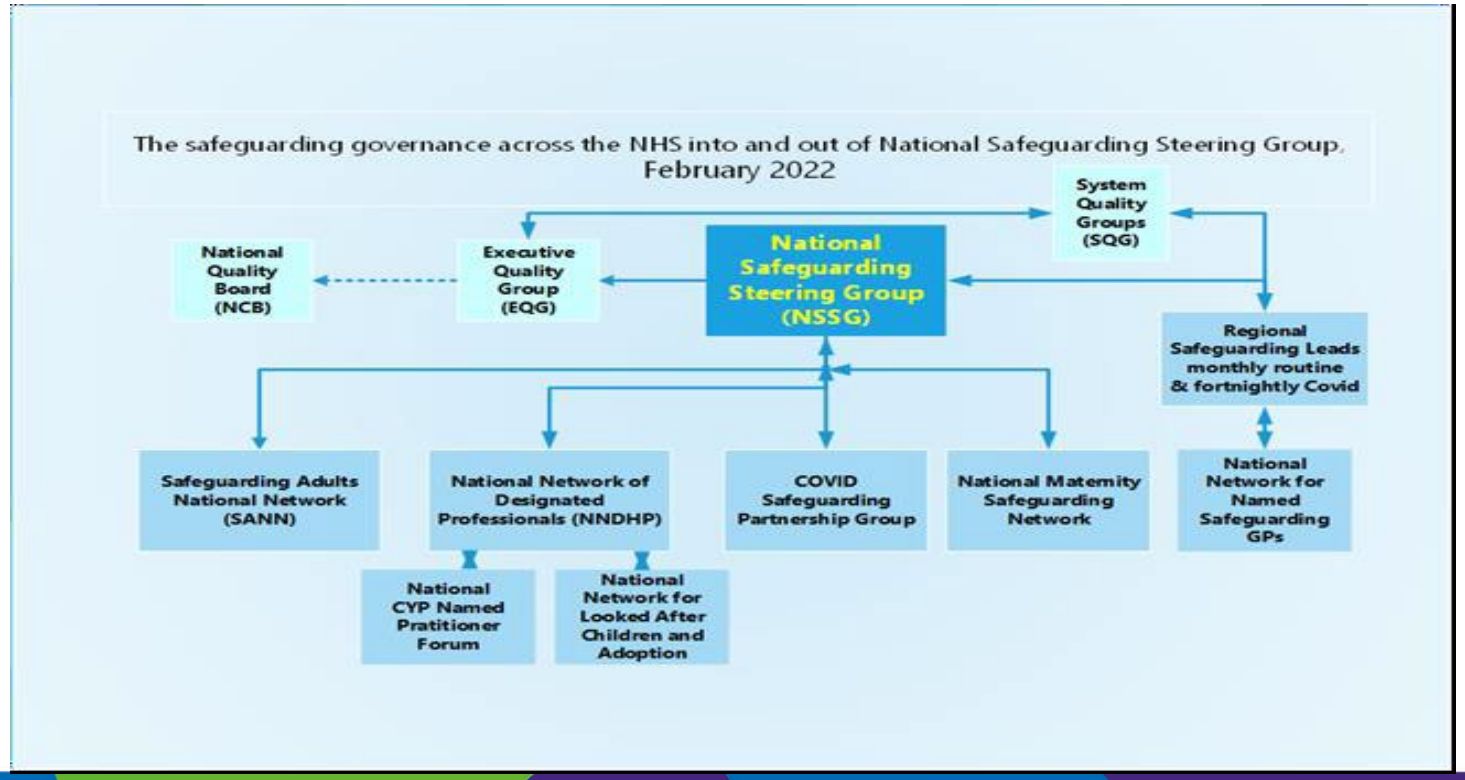
How NHS England maintains oversight of safeguarding.

The chief nursing officer (CNO) for NHS England has executive lead and accountability to ensure the effective discharge of NHS England statutory responsibilities. The system-wide National Safeguarding Steering Group (NSSG) co-ordinates these forums and gains assurance on behalf of the CNO

2019 Model



2022 Model



Legislation and mandatory reporting:

Legislation for	
The Crime and Disorder Act 1998 Female Genital Mutilation Act 2003 Sexual Offences Act 2003 (New) Mental Capacity Act 2005 Convention on the Rights of Persons with Disabilities 2006 Mental Health Act 2007 Children and Families Act 2014	Modern Slavery Act 2015 Serious Crime Act 2015 Mental Capacity (Amendment) Act 2019 NHS Constitution and Values (updated Jan 2021) (New) Domestic Abuse Act 2021 (New) Serious Violence Duty: Draft guidance 2021 (New) Prevent Duty 2015 (New)

Safeguarding children	Safeguarding young people transitioning into adults, including children in care	Safeguarding adults
United Nations Convention on the Rights of the Child 1989		European Convention on Human Rights (New)
Children Act 1989 and 2004		The Care Act 2014
Promoting the Health of Looked After Children Statutory Guidance 2015		Care & Support Statutory Guidance- Section 14 Safeguarding
Children and Social Work Act 2017		
Working Together to Safeguard Children Statutory Guidance 2018		
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019	Looked After Children: Roles and Competencies of healthcare staff 2020	Adult Safeguarding: Roles and Competencies for Health Care Staff 2018

- New legislation and draft guidance has been added (marked ‘new’) to provide the legal framework that the Trust is required to adhere to.

Organisational assurance

The organisation will review its arrangements to assure ourselves that we working effectively to the safeguarding commissioning assurance toolkit (safeguarding-CAT).

There are 6 keys areas that are reviewed as part of the self assessment:

- Patient engagement and supervision
- Safer recruitment Human Resources
- Interagency working
- Leadership and organisational accountability
- Training
- Implementation (sharing and learning good practice)

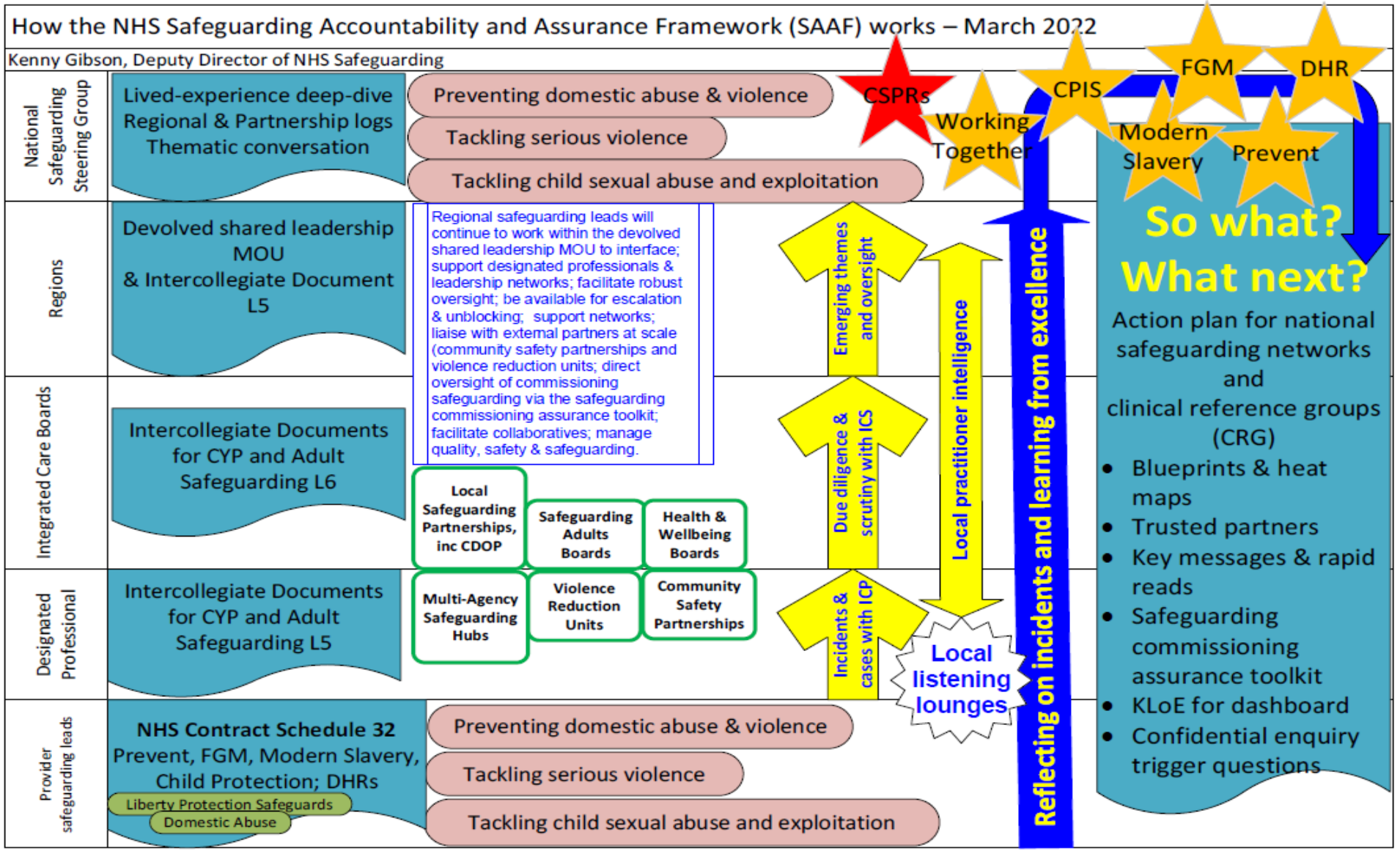
We will continue to provide our yearly self assessment as part of the assurance framework to the ICB.

Current requirements and status at MTW

Organisational leadership		Trust Chief Nurse is the executive lead for safeguarding
Disclosure and barring service		This is in place as part of preemployment checks for all staff
Fit and proper persons tests		Requirements for persons employed and requirements for directors in place.
Duty of candour (DoC)		The duty of candour is triggered by a 'notifiable safety incident. Monitored by patient safety teams. Statutory time frame not always achieved. Gap identified in knowledge base regarding DoC and time frames. Training to be provided to all staff.
Information sharing		Information sharing is covered by legislation, principally the General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018. This is further supported by the Caldicott principles. This is in place and coordinated by the ICB through the safeguarding boards
The Mental Capacity Act (2005) and Mental Capacity (Amendment) Act (2019)		Provides the legal framework around consent in relation to care, treatment and support for those who may not have capacity to do so.
Female genital mutilation cases		Mandatory reporting to NHS Digital
Allegations against staff involving child abuse		Reported to the local authority designated officer (LADO). This is also reported to the Chief Nurse or Deputy Chief Nurse

Current requirements and status at MTW

Allegations against staff involving abuse or neglect of an adult		Reported to the local authority through the safeguarding adults concern form. This is also reported to the Chief Nurse or Deputy Chief Nurse.
Training of all staff		Training provided that is commensurate with their role. This includes induction programmes for all staff and volunteers.
Annual safeguarding report		Submitted annually to the Trust board.
Named professionals		The Trust has a named adult safeguarding nurse, named Children safeguarding nurse, named doctor and named midwife for safeguarding children.
Mental Capacity Act (MCA) lead		There is a named lead
Interagency working		The Trust participates in the in the statutory and mandatory reviews.


How the NHS Safeguarding Accountability and Assurance Framework (SAAF) works – March 2022
Kenny Gibson, Deputy Director of NHS Safeguarding
National Safeguarding Steering Group
Lived-experience deep-dive
Regional & Partnership logs
Thematic conversation
Preventing domestic abuse & violence
Tackling serious violence
Tackling child sexual abuse and exploitation
CSPRs
Working Together
CPIS
FGM
DHR
Modern Slavery
Prevent
Regions
Devolved shared leadership MOU
& Intercollegiate Document L5
Regional safeguarding leads will continue to work within the devolved shared leadership MOU to interface; support designated professionals & leadership networks; facilitate robust oversight; be available for escalation & unblocking; support networks; liaise with external partners at scale (community safety partnerships and violence reduction units; direct oversight of commissioning safeguarding via the safeguarding commissioning assurance toolkit; facilitate collaboratives; manage quality, safety & safeguarding.
Emerging themes and oversight
Integrated Care Boards
Intercollegiate Documents for CYP and Adult Safeguarding L6
Local Safeguarding Partnerships, inc CDOP
Safeguarding Adults Boards
Health & Wellbeing Boards
Due diligence & scrutiny with ICS
Local practitioner intelligence
Reflecting on incidents and learning from excellence
So what?
What next?
Action plan for national safeguarding networks and clinical reference groups (CRG)
Blueprints & heat maps
Trusted partners
Key messages & rapid reads
Safeguarding commissioning assurance toolkit
KLoE for dashboard
Confidential enquiry trigger questions
Designated Professional
Intercollegiate Documents for CYP and Adult Safeguarding L5
Multi-Agency Safeguarding Hubs
Violence Reduction Units
Community Safety Partnerships
Incidents & cases with ICP
Local listening lounges
Provider safeguarding leads
NHS Contract Schedule 32
Prevent, FGM, Modern Slavery, Child Protection; DHRs
Liberty Protection Safeguards
Domestic Abuse
Preventing domestic abuse & violence
Tackling serious violence
Tackling child sexual abuse and exploitation

Impact on Maidstone and Tunbridge Wells NHS Trust.

- From 2022, SANN will monitor risks within provider organisations for adult safeguarding, Mental Capacity Act, Deprivation of Liberty safeguards (DoLS) and prepare for the health implications of the Liberty Protection Safeguards (LPSs) that replace DoLS once approved by Parliament.
- Named practitioners and designated leads at MTW will be required to attend forums, partnership groups, system quality groups, review panels and safeguarding boards for support and to provide assurance on the safeguarding arrangements and identifying and share good practice initiatives.
- Develop stronger workforce resilience within safeguarding team to enable them fulfil their statutory responsibilities.
- To appoint the MCA operational practitioner to cover maternity leave.

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Update on the Kent and Medway Integrated Care Board (ICB) and West Kent Health and Care Partnership (HCP)	Director of Strategy, Planning and Partnerships

The enclosed report provides information and updates on the establishment of the Kent & Medway Integrated Care Board (ICB) and the West Kent Health Care Partnership (WKHCP).

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 20/09/22

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and discussion, to facilitate feedback between MTW, the HCP and the wider system.

[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

Kent & Medway ICB

The Kent and Medway ICB replaced the Clinical Commissioning Group on 1st July 2022. The majority of posts are confirmed (below):

- Chief Finance Officer – Ivor Duffy
- Chief Medical Officer – Dr Kate Langford
- Executive Director Corporate Governance – Mike Gilbert
- Chief of Staff – Natalie Davies
- Chief Nurse – Eileen Sills
- Chief Strategy Officer – Vincent Badu
- Chief People Officer – Rebecca Brad

The following posts have been recruited to on an interim basis with formal recruitment processes underway:

- Chief Digital Officer
- Chief Delivery Officer
- Executive Director Communications and Engagement

Updates

The formal feedback for the MTW and West Kent HCP oversight meetings has been received (attached). In addition to positive feedback, recognising strong performance which is amongst the best in the country for a number of metrics, challenges were also recognised. The most significant of those being the number of patients no longer meeting the criteria to reside in MTW but also in our community and mental health in-patient facilities.

MTW are leading on three Kent & Medway developments which not only support the organisation but are system wide resources. These are an elective orthopaedic centre being built on the Maidstone site, the Kent Medical School accommodation and Academic Centre being built on the Tunbridge Wells site and the Community Diagnostic Centre which is located close to Maidstone Hospital in Hermitage Court.

Kent County Council have been engaging with key stakeholders on plans to move to locality based adult social care teams. There was overall support for the model which aligns more closely with HCPs then the current model. The main concern was the demand and capacity intelligence supporting the proposed savings. A letter has been sent to Richard Smith inviting him to join the discussion on neighbourhood integrated teams at the West Kent HCP away day in October.

WKHCP Highlights

The HCP continues to progress its key priorities, notably the implementation of the virtual ward capacity and improving the pathway for falls as part of a wider Frailty programme led by Peter Maskell. The initial work on virtual wards is expanding the community support for frail patients building on the community led Home Treatment service, the development aims to provide additional support for winter.

The partnership is also exploring how they can develop a stronger neighbourhood team model based on the GP Primary Care Network areas to address the high demands being experienced in practices and to better used the community services and additional roles now attached to practices. This work is being explored practically through the local development of a mental health MDT in the Weald area. The area model for integrated neighbourhood teams has been discussed in the last 6 months by the HCP executive group as part of an NHSE place development programme and will further be explored at the away day in October.

The ICB held a Winter Planning event on 5th August for West Kent which was well attended by partners. The session was informed by data from the regional Lightfoot Insights Platform which has

data available down to GP surgery level. Winter planning is now focussing on closing the demand gaps, most notably inpatient beds including occupancy, pathway 1 capacity, mental health capacity/support.
Work has commenced, using A3 thinking, on the discharge and flow workstream.

Conversations are taking place at pace around the delegation of responsibility to place. We are working with the ICB system development team on agreeing those functions that will remain in the ICB and those that could be delegated. In line with this we are looking to further align the HCP and Integrated Care Commissioning Teams. There are discussions in other HCPs to formalise this alignment and the West Kent HCP and ICC directors are working closely together to develop a road map for agreement.

WKHCP Risks and Challenges

The 2 top rated red risks are:

Workforce - All providers are identifying capacity issues with staffing core services and 2022/23 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue and nursing capacity pressures in secondary care.

Demand pressures - Pressures across WK system arising from range of sources including: planned care backlog; COVID-19/Post COVID-19 related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.

NHS
Kent and Medway

Private and confidential
Miles Scott
Chief Executive
Maidstone and Tunbridge Wells NHS Trust

NHS Kent and Medway
c/o Kent House
81 Station Road
Ashford
Kent
TN23 1PP

Sent via email

Monday, 25 July 2022

www.kentandmedway.icb.nhs.uk

Our Ref: PB/CMC19.22

Dear Miles,

Provider Oversight Meeting – Maidstone and Tunbridge Wells NHS Trust

Thank you to you and the whole team for attending the Maidstone and Tunbridge Wells NHS Trust provider oversight meeting on 15 July 2022.

The aim of these oversight meetings is to have open, values-based, improvement-focused conversations, where we meet to discuss and hold each other to account in the delivery of priorities.

These meetings also provide an opportunity to discuss issues and risks that may impact on the wider system or require system support, including quality, performance, and health inequality challenges where relevant.

Key discussion highlights at the meeting were:

The positive operational performance of the Trust is noted. There has been sustained and meaningful improvement across several areas, particularly in cancer and diagnostic standards. Cancer performance targets have been consistently met, with the Trust on track to achieve a maximum waiting time of 40 weeks for cancer pathways by the end of the year. Diagnostic performance improvement is also noted, with the Trust achieving 96% against a 99% performance target.

The West Kent Elective Orthopaedic Unit Barn project was discussed, which aims to increase elective capacity and support elective recovery across the system.

- A revised proposal has been agreed between the acute trusts in Kent and Medway where all activity is delivered in 3 rather than 4 theatres. The Trust will meet the capital pressure

which the revisions to the scheme require within the local system and is looking at mitigations to reduce costs with ICB support., including utilising a managed equipment service.

- The business case is progressing through Trust and ICB governance processes and will be submitted to NHS England at the beginning of August.

- The Trust is keen to ensure that recruitment will be a net increase to the current Kent and Medway workforce position, rather than creating additional pressures elsewhere, and have assured that delayed timescales will have no negative impact on winter plans for 2022/23.

- Progress against actions following the Ockenden maternity review and Maternity Continuity of Carer were discussed. The regional assessment was broadly positive, with a recognition of the use of Quality Improvement methodologies, which the region is looking to take forward with other organisations. A few areas were identified for required improvement, particularly regarding the national issue of wrap around training and upskilling of Band 5 staff. The Trust raised that the current Maternity Voices Partnership (MVP) chair is stepping down from the role in the near future, which will create a gap. The Trust look forward to receiving a formal report in the next 6-8 weeks.

- Maternity Continuity of Carer did not feature in the regional assessment. The Trust recognise that current trajectories will not bring them in line with the March 2024 requirement, however, feel that a roll out across 21 teams and a wide geography at a rate of 3 teams per year is the safest and most practical approach. The Trust already have one team using the Continuity of Carer model, supporting younger pregnant people, and roll out will be phased to prioritise teams supporting the most vulnerable groups and geographies first to mitigate risk. The ICB Quality Team will work with the Trust on the outlined trajectory for implementation.

- Financial risks and issues regarding the Elective Recovery Fund (ERF) and Capital Improvement Plan (CIP) were discussed:

  - The Trust has underperformed against the ERF baseline (104% of 19/20 activity) which equates to £2.5m. April activity was significantly impacted by the second highest Covid peak however since then the Trust has delivered a month-on-month improvement in activity across , May and June and remain confident that current recovery plans are deliverable, although Covid continues to impact capacity and staff sickness.

  - The Trust is broadly on plan for CIP delivery, however, there is recognition that plans will escalate from July 2022 onwards as time has been required to implement the CIP and this has been built into trajectories. Covid continues to impact on spend, with reduced funding not matching the required spend due to need.

- There are several large-scale programmes of work underway which are expected to deliver in the future (e.g., EPMA), however, the Trust is currently relying on non-recurrent mitigations to cover the gap.

- The Trust has ambitions to achieve an Oversight Framework Segment 1 allocation and are in a strong position to do so . The Trust is engaging well across the wider system and has been instrumental in supporting and leading on key programmes of work at place-level, with a view to engaging beyond West Kent where appropriate.

Challenges:

- Discharge and flow remain an issue across the West Kent system. The Trust is continuing to address this with partners through the Health and Care Partnership (HCP). The HCP and ICB have jointly commissioned a piece of work with Kent County Council to address demand and capacity issues, which will be followed up through Place Oversight Meeting discussions.

- Nursing workforce remains a key priority. The Trust is focussing efforts on staff retention and long-term recruitment through apprenticeships to address this challenge.

Next steps:

- The ICB Quality Team will continue to support the Trust in the implementation of the Maternity Continuity of Carer model to ensure mitigation of risks to vulnerable groups while roll out is ongoing. The ICB Quality Team will work with the Trust on the outlined trajectory for implementation.

- The Trust will work to identify additional Cost Improvement Plans to reduce the need for non-recurrent mitigations.

- The ICB will work to support the Trust in identifying areas of focus to progress to Oversight Segment 1 in the coming year.

- The Trust will provide comments and virtually agree the draft Terms of Reference presented for the Provider Oversight Meeting within the next week.

It is clear that the Trust has covered a lot of ground over the last period, which is reflected in positive performance and outcomes. I look forward to discussing the progress made over the next period at the subsequent Maidstone and Tunbridge Wells NHS Trust oversight discussion. And I would like to take the opportunity again to thank you and the team for the strong progress and the hard work which has achieved this progress.

Letter reference: PB/CMC19.22

Yours sincerely

Paul Bentley
Chief Executive
NHS Kent and Medway

Cc:
Jackie Huddleston, Locality Director Kent & Medway, NHS England
Natalie Davies, Chief of Staff, NHS Kent and Medway
Gerrie Adler, Director of Performance and Assurance, NHS Kent and Medway

NHS
Kent and Medway

Private and confidential
Miles Scott
Senior Responsible Officer
West Kent Health & Care Partnership

Sally MacKinnon
Director, West Kent Health & Care Partnership

NHS Kent and Medway
c/o Kent House
81 Station Road
Ashford
Kent
TN23 1PP

www.kentandmedway.icb.nhs.uk

Sent via email

Tuesday, 26 July 2022

Our Ref: PB/CMC22.22

Dear Miles and Sally,

Place Oversight Meeting – West Kent

Thank you for participating in the West Kent Place oversight meeting on 18 July 2022. I also want to thank you for your leadership of the partnership and would ask that you share my thanks on behalf of the ICB with the wider leadership team within the partnership for the work you have delivered and the progress you have made.

The aim of these meetings is to have open, values-based, improvement-focused conversations at place-level, where we meet to discuss and hold each other to account in the delivery of priorities and how we can proactively support Place development together.

These meetings also provide an opportunity to discuss the wider issues and risks of the geography, including quality, performance, and health inequality challenges where relevant.

Key discussion highlights were:

The positive progress at place-level is recognised and the partnership relationship continues to strengthen as the Place develops.

Tangible outcomes from work underway towards delivery plan priorities were explored and this was particularly evident through the Population Health Management approach adopted in the Weald PCN Neighbourhood Model work and Maidstone Health Inequalities programmes. The Place has made excellent progress on both the Frailty workstream, which will inform the

development of the Virtual Ward programme, and the Primary Care demand and capacity work to identify areas of focus, which is a 'first' in the work of partnerships across the ICS.

- Mental Health remains a key priority and the Health and Care Partnership (HCP) is working closely across Primary and Secondary Care and local mental health providers to improve adult and children's mental health services, and to support patients in secondary care with dual diagnoses. The HCP will continue to engage with the Mental Health Provider Collaborative to strengthen mental health services.

- There are several positive steps being taken towards Place development:

  - Partnership working was discussed. The HCP Development Board has a broad membership, with representation from several system partners; including health partners, Healthwatch, Local Authorities, Public Health, Adult Social Care and Voluntary and Community Sector partners; taking an holistic approach to the development of the HCP across Health and Social Care. This broad base is a real strength of the partnership and is very much welcomed.

  - The HCP is keen to adopt a needs-based approach to governance, where governance is determined by the needs of the population and identified priorities, following system delegation and Memorandum of Understanding discussions. The ICB is eager to delegate responsibilities to the HCP where possible and will support the HCP in ensuring that governance underpins the successful delivery of delegated responsibilities.

  - Organisational Development work is progressing well. The Place has benefitted from the NHSE Place Development Offer, working within existing priorities to identify key public health management areas to focus delivery plans and using the action learning sets to develop the HCP vision and implementation strategy and to facilitate relationship building across partners.

- Strong progress is being made to develop a single place-level roadmap. The HCP has identified a number of longer-term priorities, including discharge and flow, sustainability of primary care and health inequalities. Public Health colleagues are refreshing the local needs assessment over the next few months to help inform strategic agenda setting and are also working on a Kent and Medway Joint Health and Wellbeing Strategy and Covid impact assessment which will feed into the longer-term roadmap and Integrated Care Strategy.

Challenges:

- Discharge and flow remain an issue across the system, particularly with regards to domiciliary care capacity. The scope of the existing integrated therapies priority workstreams will be expanded to support the programme of work moving forward. The HCP is working with social care and healthcare partners to improve flow and reduce the number of patients No Longer Fit

to Reside in acute and community settings and are also working to embed 100-day plans into the Winter Plan, with a focus on maximising intermediate care interventions.

- The unified bed reporting that has been developed between community and acute providers will support real-time discharge planning, however, there is still additional work needed to improve patient pathway 1 commissioning to ensure bridging patients are included in capacity plans and tangible progress can be made.

- The ICB has recently appointed Non-Executive Directors to the ICB Board from adult social care, to support strategic discussions and a jointly commissioned piece of work is being taken forward with Kent County Council to address demand and capacity issues, which is being led by the ICB Executive Director for Digital Transformation. The ICB will follow up the progress of this work outside of the meeting and provide an update.

- The Primary Care demand and capacity, neighbourhood and workforce programmes are progressing well, however, the capacity of the Joint Programme Management Office to support this work is limited. The HCP would like support from the ICB in securing transformational resource to further progress these workstreams linked to PCN sustainability and the Fuller Review.

Next steps:

- The ICB will work together with the Place and HCP to discuss the governance approach once all Place oversight discussions have taken place.

- The ICB will follow up the progress of the jointly commissioned demand and capacity work and provide an update to the HCP within the next week. The HCP will continue to challenge itself to do everything it can to collaboratively maximise impact in this area.

- The ICB People and Organisational Development team will work with the HCP to support transformational Primary Care Workforce Plans around sustainability once the ICB Chief People Officer is in place.

- The HCP will feed back comments and virtually agree the draft Terms of Reference presented for the Place Oversight Meeting within the next week.

It is evident that there is a strong partnership in place, and this is paying dividends in adding value to development conversations, particularly in relation to the patient and service user perspective. It is clear what the Place is trying to achieve and what the potential derailers are and West Kent HCP is well placed to be very high performing and able to support NHS organisational partners in progressing to Oversight Framework Segment 1.

I look forward to discussing the progress made at the next West Kent Place oversight discussion.

Letter reference: PB/CMC22.22

Once again I do want to take the opportunity to thank you for your leadership of the partnership and would ask that you extend my thanks on behalf of the ICB to the wider leadership team of the partnership.

Yours sincerely

Paul Bentley
Chief Executive
NHS Kent and Medway

Cc:
Jackie Huddleston, Locality Director Kent & Medway, NHS England
Natalie Davies, Chief of Staff, NHS Kent and Medway
Gerrie Adler, Director of Performance and Assurance, NHS Kent and Medway

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve a Business Case for a Sunrise infrastructure upgrade	Deputy Chief Executive / Chief Finance Officer

Please find enclosed the Business Case for the Sunrise infrastructure upgrade. The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 27/09/22, to consider the Business Case and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 13/09/22
- Finance and Performance Committee, 27/09/22

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

Guidance notes on completing this template are available on the Trust Intranet.

Title: **Sunrise Infrastructure Upgrade**

Issue date/Version number	0.8
ID reference	904
Division	Corporate
Directorate	Finance
Department/Site	IT
Author	Simon Parker
Clinical lead/Project Manager	Sue Forsey / Simon Parker

Approved by	**Name**	**Signature**	**Date**
General Manager/Service Lead	Sue Forsey		
Finance Manager	John Coffey		
Clinical Director	N/A		
Executive Sponsor	Steve Orpin		
Division Board	N/A		
Supported by	**Name**	**Signature**	**Date**
Estates and Facilities Management (EFM)	Mark Hope		
ICT	Sue Forsey		
Deputy Chief Operating Officer	Sarah Davis		
Diagnostics and Clinical Support Services (DCSS)	Katie Goodwin		
Emergency Planning	John Weeks		
Human Resources (HR) Business Partner	Claire Cloude		
Procurement	Bob Murray		
EME Services Manager	Michael Chalklin		

Maidstone and Tunbridge Wells NHS Trust

Business Case Summary

Strategic background context and need

Summarise the background to the proposal including its relevance to strategic aims and objectives identified in Division business plan. Identify the key stakeholders. Summarise the needs or demands that are to be addressed and deficiencies in existing service.

Background

Sunrise EPR went live in the Trust in June 2021. This followed nearly 3 years of configuration and quality assurance with several changes to scope as a result of delays caused by the COVID pandemic.

The Sunrise EPR has 5 Hardware Environments, with 10 instances, used to develop, test, train and run Production.

The Non-Production environments were hosted on legacy Trust Infrastructure, with the Production System running on Huawei infrastructure, procured specifically for the purpose.

The current production version of Sunrise EPR is no longer a currently supported version and additional costs of £4,000 per month will continue to be incurred until the Trust upgrade to a supported version. This arrangement is only available to the Trust until December 2023.

The Trust need to perform an upgrade to a supported version of the Sunrise EPR, which requires additional capacity to run the application, with more concurrent users than initially estimated and enhanced functionality, as well as giving capacity for parallel environments to be created to facilitate cut-over between versions.

There is currently no further capacity in the non-production hardware to support the upgrade.

The production hardware needs to be expanded to allow the upgrade, but this cannot be achieved with the existing Huawei infrastructure, as Huawei have exited the UK server market following US/UK sanctions.

Strategic Aims and Objectives

Sunrise EPR is at the centre of the Trusts Digital Transformation Strategic Intent – ongoing support and continuous development of new functionality, to support clinical colleagues caring for our patients, must be maintained.

Objectives

1. Allow upgrade of Sunrise to supported version
2. Provide additional/replacement hardware to support the upgrade and on-going requirements of the Sunrise EPR Production System.
3. Provide additional / replacement Infrastructure to support the upgrade and ongoing requirements of the Sunrise EPR Non-Production System.
4. Provide a foundation and knowledge/experience for future Cloud-based deployment of Digital Transformation initiatives.

Key Stakeholders

- Clinical and Administrative Users of Sunrise EPR
- Users of Clinical Support systems that are connected to Sunrise EPR
- Sunrise EPR Team
- IT Team
- Altera Health

Needs and Demands

- Additional Functionality within Sunrise EPR including Sunrise Surgical Care.
- Additional Concurrent Users of Sunrise EPR which is more than original predictions.

- Bi-Annual Upgrade of Sunrise EPR to maintain contracted supplier support.
- Ability to continue developing new functionalities for the benefit of patients and clinicians.

Deficiencies in existing services

- Capacity within existing IT Infrastructure to undertake upgrade to Sunrise EPR without slowing down development of new functionalities.

Options considered: -

	Rationale
Production	
Do Nothing	Unable to implement upgrade, meaning breach of contract and long-term security risk.
Expand Existing Huawei Hardware	Huawei have exited the UK Market meaning expansion is not an option.
Infrastructure in the Cloud	Requires dedicated diverse routing, architectural design and an additional investment of £84k per month
Procure New Hardware	Preferred Option
Non-Production	
Do Nothing	Unable to implement upgrade, meaning breach of contract and long-term security risk.
Expand Existing Legacy Hardware	Huawei have exited the UK Market meaning expansion is not an option.
Infrastructure in the Cloud	Preferred Option
Procure New Hardware	Constraints on available Capital Funding due to level of investment required.
Production & Non-Production	
Only Upgrade Production	Unable to develop new capability while undertaking upgrade

Considerations: -

NHS Digital are setting a strategic direction for production systems to start moving to Cloud Infrastructure. Following discussions with Altera (Sunrise Supplier) and Medway NHS Foundation Trust it is felt that this is not yet achievable for our Sunrise Production system at this point. Moving production computing to the Cloud moves the emphasis away from hardware deployment and support to becoming dependent on connectivity, network latency, and Wide Area Network resilience. This requires further investment and architecting before it can be considered a viable option for MTW.

Using physical On-Premises hardware for Production and Cloud computing for non-Production environments is the current approach adopted by Medway NHS Foundation Trust. This approach allows us to increase our understanding of Cloud computing in our non-Production environments providing the Trust with the knowledge and experience to move Production environments to the Cloud in future.

Procurement Route

The Trust has invested in Dell technology since Huawei has withdrawn sales from the UK market and will therefore use the national contract to purchase Dell hardware via compliant frameworks.

The Cloud implementation will be provided by Block Solutions as one of the key partners of the Trust, which will be awarded via the GCloud 13 framework.

Implementation services will be awarded with the associated contracts.

Future considerations

The hardware lifecycle within this business case will have a 7-year lifespan and associated depreciation. Further funding will be required in Year 6 to replace this infrastructure and will be included in the infrastructure strategy and feed into the capital prioritisation at the time.

The ongoing revenue requirements for Cloud hosted services will need approval from the Executive Team as this is a cost pressure to the organisation, however, the Sunrise EPR solution cannot be provided without the development of cloud solutions and the organisation will breach its commercial arrangement with Altera the upgrade cannot be completed.

Objectives - *List the project objectives. (What you wish to achieve for patients, not what you wish to purchase)*

1. Allow upgrade of Sunrise to supported version

2. Provide additional/replacement hardware to support the upgrade and on-going requirements of the Sunrise EPR Production System.

3. Provide Cloud-based Infrastructure to support the upgrade and ongoing requirements of the Sunrise EPR Non-Production System.

4. Provide a foundation and knowledge/experience for future Cloud-based deployment of Digital Transformation initiatives.

The preferred option. *List exactly what is required in terms of staff (WTE and band) / equipment/estate*

	2022/23		**2023/24**		**2024/25**		**2025/26**	
	Cap	**Rev**	**Cap**	**Rev**	**Cap**	**Rev**	**Cap**	**Rev**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Production Hardware								
Hardware Cost (Compute & Storage)	420							
Software Licences				208		208		208
Resourcing Costs (External Supplier)	82							
Resourcing Costs (Altera)		10						
Resourcing (Ext Integration)	40							
Resourcing (B7 Technician – 1.0 WTE)	28							
Implementation Services	30							
Non-Production Hardware								
Cloud Hosting (3 Years)		102		205		205		205
Resourcing (Ext Support – 3 Years)		40		80		80		40
Extended Support (£4k pm)		15		42				
Net Cost	**600**	**167**	**0**	**535**	**0**	**493**	**0**	**453**
Cost of Capital & Depreciation				105		102		99

Main benefits associated with the investment *Include here the key benefits the investment would bring to the service.*

Key Performance Indicator (KPI)	Baseline Position	Future Outcome
Financial cost improvement – Remove Extended Support	£4k pm	£0k pm
Contractual obligation – Keep within two version releases	v 18.4	v 22.x or v 23.x
National EPR expansion – Future Proof Infrastructure for expansion	Prod – Huawei Infrastructure Non-Prod – Physical Hardware	Prod – Physical Dell Hardware Non-Prod – Cloud Deployment

Main risks associated with the investment *Include here the key risks if the project is not undertaken, not undertaken in the timescale you outline and key risks associated with the delivery of the project*

Risk of not doing it: -

1. Unable to upgrade Sunrise to the latest version
2. Unable to support the higher number of concurrent users using Sunrise
    a. Higher than planned concurrent users (Existing Functionality)
    b. Additional Users being added for EPMA and Surgical Care
3. Unable to support additional requirements to increase functionality, both clinical documentation (Tracking Boards) and integration with additional clinical systems (Point of Care Testing, Vital Signs Medical Devices, Kent Oncology Management System, Teletracking)

Delivery risk: -

1. Supply Chain delays for IT Servers and Networking equipment.
2. Sunrise Support costs increase as current version goes out of support.
3. Sunrise Client Rollout – Only one version of the Sunrise Client can be installed on a PC - Solution being sort.
4. Conflicting priorities for IT Resources – Cost of additional resource included in business case.

Residual Risk: -

1. Internal support for Cloud Infrastructure, as this is new technology for the Trust – use external provider for support, which is included in the Cloud proposition.
2. NHS Digital strategic direction to move critical system infrastructure into the Cloud – Dedicated Diverse routing to Cloud for Sunrise PROD would cost additional £84k per month

Financial impact of the preferred option – full year effect – include VAT unless recoverable

Production Infrastructure

Funding and affordability							The Financial Case
Capital costs of the preferred investment option							
Capital	2022-23 £000	2023-24 £000	2024-25 £000	2025-26 £000	2026-27 £000	2027-28 £000	2028-29 £000
Equipment							
Estate							
IT	420						
Other	180						
Total capital	600	0	0	0	0	0	0
Notes on capital costs:							
Revenue changes associated with the preferred investment option							
Revenue changes	2022-23 £000	2023-24 £000	2024-25 £000	2025-26 £000	2026-27 £000	2027-28 £000	2028-29 £000
Total income							
Pay							
Non Pay expenditure	25	250	208	208	208	208	208
Other (non- operating) expenditure							
Capital charges & depreciation	0	105	102	99	96	93	90
Total costs	25	355	310	307	304	301	298
Net financial benefit							

Non-Production Infrastructure (Cloud)

Funding and affordability							The Financial Case
Capital costs of the preferred investment option							
Capital	2022-23 £000	2023-24 £000	2024-25 £000	2025-26 £000	2026-27 £000	2027-28 £000	2028-29 £000
Equipment							
Estate							
IT							
Other							
Total capital	0	0	0	0	0	0	0
Notes on capital costs:							
Revenue changes associated with the preferred investment option							
Revenue changes	2022-23 £000	2023-24 £000	2024-25 £000	2025-26 £000	2026-27 £000	2027-28 £000	2028-29 £000
Total income							
Pay							
Non Pay expenditure	143	285	285	245	205	205	205
Other (non- operating) expenditure							
Capital charges & depreciation	0	0	0	0	0	0	0
Total costs	143	285	285	245	205	205	205
Net financial benefit							

Funding Source - £600k Capital Funding allocated from IT Capital Budget and prioritised in line with the ICB's agreed risk matrix. Revenue to be funded by reprioritisation of Ive Programme for financial year 2022/23. Future years will require additional funding to maintain the cloud environment.

Timetable

Include at a minimum the expected key milestones e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.

Milestone	Date	Responsible
Approval of Business Case	August '22	Trust Board
Procurement of Non-Production Infrastructure	September '22	Procurement
Procurement of Production Infrastructure	September '22	Procurement
Delivery of Non-Production Infrastructure	November '22	Block Solutions
Delivery of Production Infrastructure	March '23	Dell
Build of Non-Production Infrastructure	January '23	Block Solutions
Build of Production Infrastructure	March '23	IT Services
Infrastructure Upgrade Project Complete	**March '23**	
Non-Production Sunrise EPR Installed (Sunrise EPR Upgrade Project)	March '23	Altera
Production Sunrise Installed (Sunrise EPR Upgrade Project)	May '23	Altera
Sunrise EPR v22.x Go-Live	October '23	EPR Team

NHS
Maidstone and Tunbridge Wells NHS Trust

The Kent and Medway Vascular Surgery Decision-Making Business Case	Director of Strategy, Planning and Partnerships

Please find enclosed a summary of the Kent and Medway Vascular Surgery Decision-Making Business Case.

The full Business Case and appendices are available in the "Documents" section of Admincontrol for the Board's information at "Trust Board/Documents/2022/09. 29.09.22/Kent and Medway Vascular Reconfiguration Decision Making Business Case and Appendices".

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 27/09/22

Reason for receipt at 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

Title of meeting:	NHS Kent and Medway Executive Team	**Date 17/08/22**
Title of report:	Kent and Medway Vascular Surgery Decision-Making Business Case	
Reporting officer:	Vincent Badu, Executive Director Strategy and Population Health	
Lead member:	Vincent Badu, Executive Director Strategy and Population Health	
Freedom of information (FOI) status:	*This paper is disclosable under the FOI Act*	

Purpose: This paper is for

Assurance		Decision	√	Information		Discussion	

Report summary:

Vascular services reconstruct, unblock or bypass arteries and are often one-off specialist procedures to reduce the risk of sudden death or amputation and prevent stroke.

Vascular surgical services are specialised services that are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and commissioned locally by NH Kent and Medway, specialised services are planned nationally and regionally by NHS England Specialised Commissioning.

Currently, specialised vascular services in east Kent, Medway and the Maidstone catchment of West Kent are delivered from two surgical centres – Medway Maritime Hospital in Gillingham and the Kent and Canterbury Hospital in Canterbury.

In December 2014, NHS England Specialised Commissioning initiated a review of the vascular services provided in Kent and Medway. This review highlighted that neither of the two Trusts that provided inpatient vascular surgical services in Kent and Medway met the necessary service requirements. As a result, both Trusts (East Kent Hospitals University NHS Foundation Trust and Medway Foundation Trust) were put under commissioner derogation.

In 2018, a further review led by NHS England Specialised Commissioning acknowledged that the future, permanent location of the arterial center for Kent and Medway would be determined through the East Kent Transformation Programme (part of the local Sustainability and Transformation Programme (STP)). It was clear that this permanent solution may take a number of years to be implemented, but it was agreed that the permanent location for the arterial centre would be at whichever of the east Kent hospital sites is identified as a major emergency centre.
NHS England Specialised Commissioning therefore decided that they were not prepared to continue to commission vascular surgical services from two Trusts, both under derogation, and agreed that it was necessary to implement an interim move of vascular services ahead of the permanent solution being implemented under the wider East Kent Transformation Programme.

Following a detailed options appraisal, the preferred option was identified to establish an interim arterial centre at the Kent and Canterbury Hospital.

In April 2019, NHS England wrote to the Medical Directors of the two acute hospital Trusts outlining NHS England's intention to implement the recommendations of the review.

In December 2019, as a result of vascular consultant shortages, Medway Foundation Trust requested support in maintaining safe Abdominal Aortic Aneurysm (AAA) surgery and, following a review, it was agreed the safest solution was to make an interim emergency transfer of AAA surgery to the Kent and Canterbury Hospital. This was implemented on 6th January 2020 and related to between around 45 patients per year.

Since January 2020, East Kent Hospitals University NHS Foundation Trust's Vascular team has been supporting Medway Foundation Trust with its Vascular surgical services.

A Pre-Consultation Business Case for the interim vascular centre model was approved by Kent and Medway Clinical Commissioning Group in August 2021 and a 6-week public consultation was undertaken in February and March 2022 to seek stakeholder's views on the preferred solution.

This decision-making business case (DMBC) has been prepared by NHS England Specialised Commissioning in collaboration with NHS Kent and Medway (as the successor organisation of Kent and Medway NHS Clinical Commissioning Group), and is based on the evidence compiled in the pre-consultation business case, feedback from public consultation and further evidence compiled post-consultation.

The Decision-Making Business Case will formalise the interim arrangements for Kent and Medway's Vascular surgical services. These interim arrangements are likely to be in place for a number of years until the wider East Kent Transformation programme delivers the permanent solution.

Proposal and/or recommendation:

Our ambition is to create a vascular centre of excellence for Kent and Medway that:

- Ensures the best outcomes and chances of survival for patients based on best practice agreed by experts
- Ensures we have more specialists available 24/7 with the right specialist skills, equipment and infrastructure; and
- Meets the national standards for vascular surgery

To achieve these ambitions we need to change the way services are provided.

The proposals would result in all specialised vascular surgery that requires an overnight hospital stay being transferred from Medway Maritime Hospital to the Kent and Canterbury Hospital.
The medium term vascular inpatient centre would therefore be located at Kent & Canterbury Hospital until a final site is determined through the wider East Kent Transformation Programme.
All outpatient appointments, diagnostic tests and scans will continue to be provided locally within the existing local hospitals which form part of the Kent & Medway vascular network: Kent & Canterbury Hospital, Queen Elisabeth Queen Mother, William Harvey Hospital. Buckland Hospital, Maidstone Hospital and Medway Foundation Trust which will also continue to provide vascular day case surgery.
These proposed changes would affect around 265 patients a year.

EKHUFT have forecast an achievable service contribution of £261k under the preferred option. The trust has agreed to utilise the net surplus of £261k associated with the move of vascular services in the preferred option to support the pay costs associated with the service enhancement.

However, the trust is still left with an annual shortfall of £342k. This £342k has been jointly approved by the Kent and Medway CCG and NHS England Specialised Commissioning finance and performance committees on a non-recurrent basis for 12 months from implementation of the option, in support of the proposed preferred option.

There are no capital expenditure costs associated with implementing the preferred option.

The Executive Team is asked to endorse the Decision-Making Business Case so that it can be presented to the NHS Kent and Medway ICB Board for final approval on 6th September 2022.

ICB/S priorities:			
Priority 1: Leading our operational recovery with a focus on elective, urgent and emergency care, cancer, diagnostics.	√	**Priority 5:** Establishing a high-performing integrated care board (ICB) and transitioning well from the CCG	
Priority 2: Leading, with our providers, the improvement of East Kent and Medway hospital trusts to improve from their Segment 4 ratings	√	**Priority 6:** Setting our integrated care system (ICS) strategy and ICB joint forward plan, including our shared ambition and deliverables	√
Priority 3: Implementation of K&M general practice development plan and development of primary care strategy		**Priority 7:** Leading the development of our ICS; developing our places, provider collaboratives and how all partners work together to be a high performing ICS	√
Priority 4: Working with our partners to build and grow our social care sector			

Identified risks, issues and mitigations:

Whilst the JHOSC have supported the proposed service changes there is a risk that this will not be supported by the Kent HOSC and/or the Medway HASC. This is being mitigated by NHS England Specialised Commissioning Team engaging directly with the HOSC and HASC.

If the Decision-Making Business Case does not receive formal approval from NHS Kent and Medway, the Vascular Programme Team will address any identified shortfalls as necessary and will return to a future meeting for approval.

Resource implications and finance approval:

The financial impact of the emergency moves has been supported by both specialist commission and NHS Kent and Medway Clinical Commissioning Group.
Resources have been identified to support the proposed interim service model.

Sustainability considerations:

The proposed changes for vascular surgical services in Kent and Medway will require some patients to have to travel further for their inpatient surgical care. An analysis of the sustainability impact of the proposals is set out in the Integrated Impact Assessment that has been undertaken for the programme. The changes in travel emissions caused as a result of the proposals are expected to a very small proportion of the overall NHS Kent and Medway carbon footprint, therefore the predicted changes in emissions are considered to be negligible.

Public and patient engagement considerations

There has been extensive public and patient engagement over the last 8 years. Full details of this extensive engagement are set out in the decision-making business case, but in summary, this consisted of

- An engagement and listening event in July and August 2015
- Deliberative, testing the model event in February 2016
- Update events in February and August 2017 which included testing six evaluation criteria
- Further public engagement event in September 2019
- Further assurance of the proposal undertaken by NHS England & Improvement November 2021

There was also a formal 6-week public consultation undertaken in February and March 2022. A formal report of this public consultation forms part of the business case documentation.

The Programme has also been subject to regular scrutiny by a Kent and Medway Joint Health Overview and Scrutiny Committee.

Equality and diversity assessment

Has an equality assessment been undertaken?

☒Yes *(please attach the action plan to this paper)*

☐Not applicable *(please indicate why an equality assessment was not required)*

Legal implications

There is a potential risk of legal challenge however this is believed to be very small. Our regular updates and discussions with the JHOSC have been well received and Members are generally supportive of the changes being made, requesting at their last meeting for the changes to be made sooner rather than later.

Healthwatch Kent and Healthwatch Medway have both been heavily involved in the planning of these proposed changes for the last 3 years.

NHS England have undertaken a review of the 5 tests for service reconfiguration and have confirmed their support for the proposals.

Report history / committees reviewed

August 2022 – **Kent and Medway Vascular Programme Oversight Group** (Membership from Medway NHS Foundation Trust, EKHUFT, NHS Kent and Medway, NHS England, NHS England Specialised Commissioning, and Maidstone and Tunbridge Wells NHS Foundation Trust).

Next steps:

The approval of the Decision-Making Business Case by NHS Kent and Medway will enable the proposed changes to be implemented. A detailed implementation plan is included in the main business case document. Implementation will commence with a Human Resources consultation with Medway Foundation Trust's vascular staff who will be asked to transfer their employment to East Kent Hospitals University NHS Foundation Trust. Full implementation of the proposed changes is expected to take up to three months.

Appendices:
Supporting information to the report should be listed here. Any supporting documents are to be provided as standalone documents and not embedded.

List staff contributing to the paper and any conflicts of interest (COI) identified:
Simon Brooks-Sykes, Associate Director for Strategy and Population Health – no conflicts of interest

For further information or for any enquiries relating to this report please contact:
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NHS
Maidstone and Tunbridge Wells NHS Trust

Responsible Officer's Annual Report 2021/22 **Medical Director**

As a designated body, the Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer, the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. At Maidstone and Tunbridge Wells NHS Trust medical appraisals are conducted between September and July.

The Board is asked to review the report and approve the Statement of Compliance (Appendix D) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 2022).

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
1. To review the report and;
2. To approve the Statement of Compliance (Appendix D) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation

[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

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Final version, September 2022

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of **Maidstone and Tunbridge Wells NHS Trust** can confirm that:

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

Action from last year: None Comments: Dr Peter Maskell, Medical Director fulfils these requirements. As required he attends RO/MD training and meetings Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No [delete as applicable]~~ Action from last year: The MAG4 will no longer be used at MTW. A business case for a web-based appraisal system and additional appraisal / revalidation administrative staff was approved by the Trust. The appraisal team introduced a web-based portfolio system on 01.09.2022 this will be used for the 2022.2023 appraisal round and for all future rounds. The additional team member is due to be recruited later this year. Comments: The RO is supported by an Appraisal Lead and an Appraisal Manager. MTW NHS Trust has 80 appraisers (71 Consultant and 9 SAS doctors). Action for next year: To review annually the number of appraisers and when need to train new appraisers.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None Comments: This is maintained on the GMC Connect website and regularly checked by the Revalidation Manager and Trust Revalidation Lead. Action for next year: Ongoing

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Update the policy and include changes made in the annual report.

Comments: Terms of reference updated. The appraisal policy update is in progress. It has been agreed with the Trust Audit manager that the policy will not be submitted until the web-based system is established.

Action for next year: To present the completed updated policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: To continue an annual audit of appraisal documentation

Comments: All appraisals are reviewed by the Trust Appraisal Lead and annual data is presented at the appraiser update training session and to the RO.

Internal audit was completed in 2021. Overall conclusion was "reasonable assurance". There were 4 actions required.

0 Urgent

1 Important – To ensure that Trust appraisers attend update training. Two annual sessions are held. All appraisers are invited and asked to attend at least one session each 2 years. Appraisers are sent copies of the session slides and a record of attendance is kept. Where necessary one to one update sessions are held with the appraisal lead.

Specific L2P training sessions have been held with 3 completed to date and more planned.

3 Routine

To update the terms of reference – completed

To update the appraisal and revalidation policy – ongoing and deferred until the L2P system is introduced

To when in the revalidation cycle that a 360 should take place. The recommendation is that the 360 should occur in the 2 years prior to revalidation this will be included in the updated policy

Action for next year: Ongoing

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

Action from last year: To continue

Comments: MTW encourages all doctors to make the most of all development opportunities available to them. In house CPD is accessible to all doctors employed by MTW.

All doctors are invited to attend annual appraisal training. This training explains the MTW appraisal system and how to use development opportunities within the Trust. Written information is circulated after the meetings

Action for next year: Ongoing

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: To continue to highlight the importance of supporting information as a part of the appraisal process. Comments: The new web based L2P appraisal system will include checklists to ensure that the relevant supporting information is included and reflected on. Appraiser training sessions have included a discussion of the types of supporting information required. The L2P system does not as yet include the Appraisal 2022 model. The company aim to introduce this later this year. We will review the new system when available and potentially introduce this in September 2023. Action for next year: To review and potentially introduce appraisal 2022.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A Comments: See 2a Section 1 Action for next year: To review and potentially introduce appraisal 2022

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The policy will be reviewed in January 2022

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments: The appraisal policy update is in progress. Terms of reference have been agreed. Following discussions with the Trust Audit manager that the policy will not be submitted until the web-based system is established

.Action for next year: To present an updated appraisal policy

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To continually review with the appraisal team, appraiser numbers and the need for new appraisers

Comments: MTW has 80 trained medical appraisers and approximately 550 doctors to appraisal i.e. typically - 7 appraisals per year. Thus, current numbers are sufficient. This is regularly reviewed and new appraisers will be trained when needed.

Historically doctors have selected an appraiser typically working in their own speciality. We encourage doctors selecting appraisers from outside their speciality.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: None

Comments: Annual update sessions are held by the Appraisal Lead and there are quality assurance systems that permit feedback of performance to appraisers. Appraisees are asked to give feedback on their appraisals. The Appraisal Lead reviews all appraisals and any deficiencies are fed back and correction requested when needed.

Appraiser feedback forms are less frequently completed that previously. The new L2P system includes feedback and we will monitor the level of feedback received.

Action for next year: Ongoing

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: An external audit of the appraisal system has taken place by TIAA. All appraisals are reviewed by the Trust Appraisal Lead and annual data is presented at the appraiser update training sessions.

Action for next year: Ongoing

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	532
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	446
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	86
Total number of agreed exceptions	70

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: There are existing processes and MTW will continue to refer individuals where there are fitness to practice concerns, in line with GMC requirements. The Appraisal Lead reviews all on-notice doctors and makes provisional recommendations based on appraisals and a valid 360. These recommendations are ratified by the Chiefs of Service, the Medical Director and the Deputy Medical Director. This year all recommendations were made ahead of the recommendation deadline.

Action for next year: Ongoing

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None Comments: The Revalidation Manager ensures timely recommendations. The Revalidation Lead contacts all doctors for whom a deferral is recommended explaining the reasons for the deferral and working with the doctor to ensure a positive future recommendation. No non-engagement recommendations were made this year. Action for next year: Ongoing

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None Comments: Monitoring doctors' performance and development is a key contributor to clinical governance. Doctors are encouraged to critique their performance, reflect on positive and adverse events in order to learn without fear of persecution or blame, pursue CPD activities and record/analyse outcomes. Doctors may be asked to discuss a specific issue at their appraisal. Action for next year: Ongoing

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None Comments: Doctors will discuss conduct and performance at their appraisal. We are developing a system to ensure that an appraiser is aware before the appraisal meeting of any complaints or SIs involving a doctor they are due to appraise. In the future the appraisal team may make a note in a doctor's appraisal documentation ensuring that a specific issue is discussed. Action for next year: Ongoing

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Comments: MTW have existing processes for responding to concerns about doctor's fitness to practise Action for next year: Ongoing

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: None Comments: MTW have existing processes in place for responding to concerns about doctors Action for next year: Ongoing

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: None Comments: If there are concerns about a doctor working in this Trust and the doctor works for another provider then the MTW RO will contact any other ROs as required. Transfer of information is conducted via an Medical Practice Information Transfer (MPIT) Form. Action for next year: Ongoing

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None Comments: MTW have existing processes in place to ensure safeguards exist and are free from bias and discrimination Action for next year: Ongoing

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None Comments: Processes are in place at MTW to undertake all mandatory pre-employment background checks before an individual's start date to ensure licenced medical practitioners are qualified and experienced for the role. Action for next year: Ongoing

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report:

Actions completed

- A web-based appraisal system has been introduced
- An appraisal checklist to cover key information that should be documented in all appraisals was developed. This will be replaced by the checklist that is included in the L2P system

- The “appraisal season” has been replaced with appraisals now running September to July every year. Equal numbers of doctors have been allocated per month thus spreading the workload for appraisers.
- Specific training and guidance on the new appraisal system has been provided for Trust appraisers.
- Final recommendations for those whose revalidation had been delayed by the COVID19 pandemic have now been made in a timely manner.

Actions still outstanding

- Processes to provide Appraisers with Supporting Information e.g. key activity and quality data, SIs, complaints etc. prior to medical appraisal: A process has been introduced to highlight to an appraiser where an appraisee has been involved in an SI. Trust systems currently do not allow the identification of all doctors involved in a complaint (only those upheld) and key activity data is not available for all doctors. The expanded appraisal and revalidation team aim to develop this key data set with a long-term plan to provide this for all doctors ahead of their appraisal meeting

Current Issues

- Ensuring that all appraisals include key information; completion of mandatory training, Governance forms from non-NHS organisations etc. Requests for this information have been included in a bespoke checklist included in the L2P system.

- **New Actions:**
- An updated MTW revalidation and appraisal policy will now be written following the introduction of the L2P system.

Overall conclusion:

The MTW appraisal system is well supported by appraisers and appraisees, doctors in all specialities are willing to act as appraisers.

All MTW appraisals are reviewed and where needed clarification or correction is requested from the appraiser. This does ensure that all appraisals are satisfactory

Doctors who are due a revalidation recommendation are reviewed by the Revalidation Lead and recommendations are approved by the Medical Director, Deputy Medical Director and Chiefs of Service.

The new L2P system is designed to improve appraisal quality and engagement with the appraisal process.

Section 7 – Statement of Compliance:

The Board of **Maidstone and Tunbridge Wells NHS Trust** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Maidstone and Tunbridge Wells NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: B1844

Appraisal check list

- Scope of work – document that entire practice was discussed and specify what that practice is (clinical private practice, medico-legal, locum work etc.).
- Comment on PDP progress x of y PDP items were achieved and why some were not.
- CPD - discuss whether CPD covers all aspects of clinical practice – would expect a broad range of activities planned over more than one year.
- Mandatory training complete? (including any speciality specific) – verbal confirmation sufficient.
- Governance forms from other hospitals and clinics.
- Discuss complaints and incidents and document how reflection has led to specific learning.
- Attendance at Clinical Governance sessions.
- Review 360 if recently completed and discuss any changes planned based on feedback. Agree when next 360 required.
- In section 20 select yes to PDP progress if there has been progress. This cannot be selected if 1st appraisal and no previous PDP or it there is no PDP progress documented.
- PDP would typically include the following with all being covered in a 2 year cycle
    - CPD – please be specific, refresh knowledge in a specific area, attend specific conference or develop specific skill not “general CPD”.
    - Audit / QIP- need a specific project with approximate time frame for completion.
    - Teaching and training – can include Educational supervisor refresher sessions as well as delivery of teaching and training sessions. Can include contributions to development of departmental teaching and training for doctors, medical students or other healthcare professionals
- Other PDP items: research, work / life balance / service development can be included but typically in addition to the standard areas listed above.

MTW – 2021/2022

- 80 Trust appraisers
  - 71 Consultants
  - 9 SAS doctors

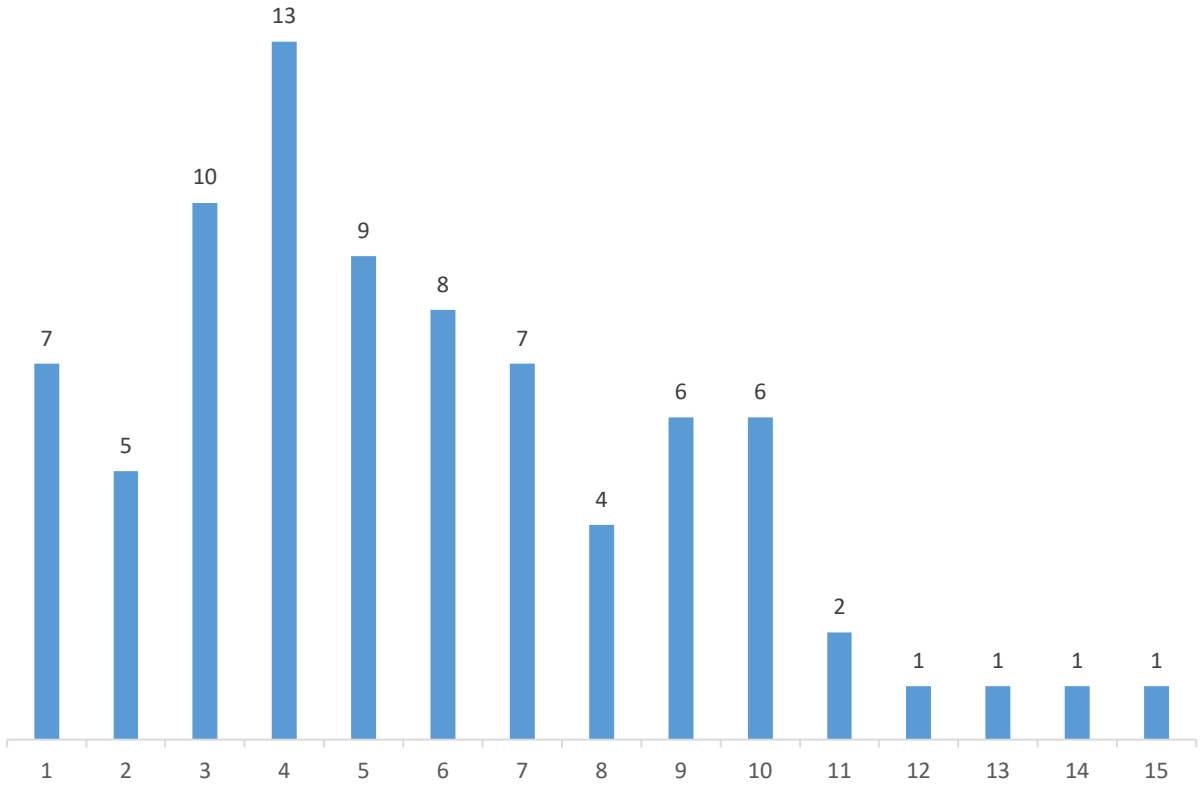
- 533 connected doctors
  - 468 due an appraisal in 2021.22
  - 11 on approved leave; 54 new doctors

MTW – 2021/2022

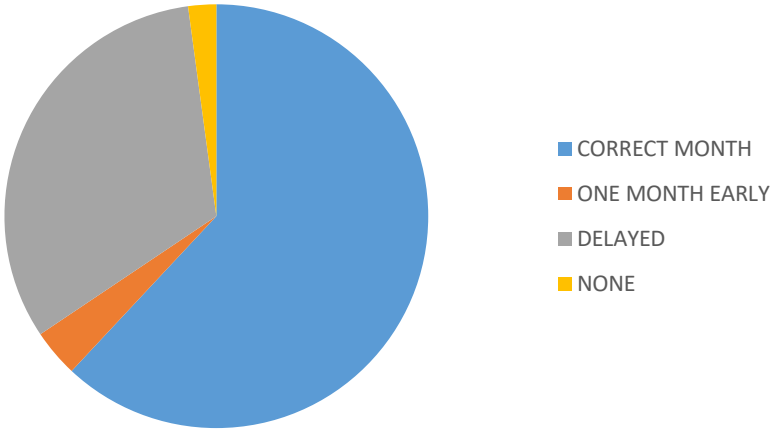
- **31st March 2022**
- 94 (85) % appraisal rate
- 90 (87)% Consultants
- 80 (67) % SAS
- 70 (58) % Locums (short term contracts)
- **31st July 2022**
- 98 (95) % appraisals completed
- 92 (97)% Consultants
- 83 (80) % SAS
- 74 (74) % Locums (short term contracts)
- **22nd August**
    - 4 Did not have an appraisal – 1 approved missed / 3 unapproved missed

MTW – 2021/2022

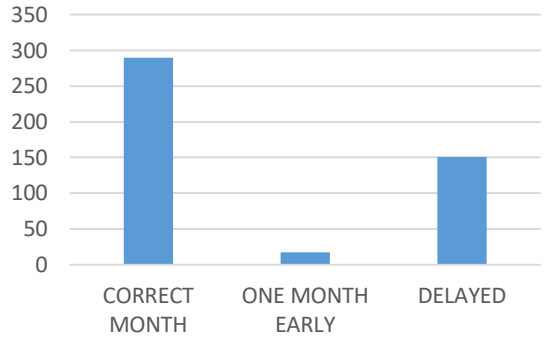
- **April 2021 - March 2022**
- Revalidation Recommendations
  - 171 positive recommendations to the GMC
  - 40 deferrals – most for lack of a 360
  - 0 non-engagement


Total No of Appraisals by Appraiser
7
5
10
13
9
8
7
4
6
6
2
1
1
1
1
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15

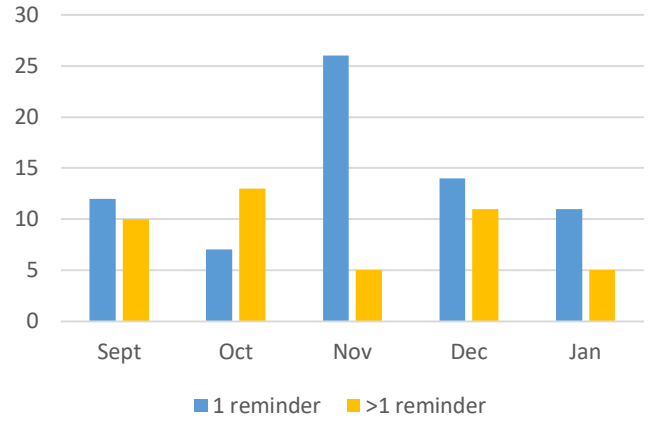
Month of appraisal interview



No. of appraisals NOT held in correct month

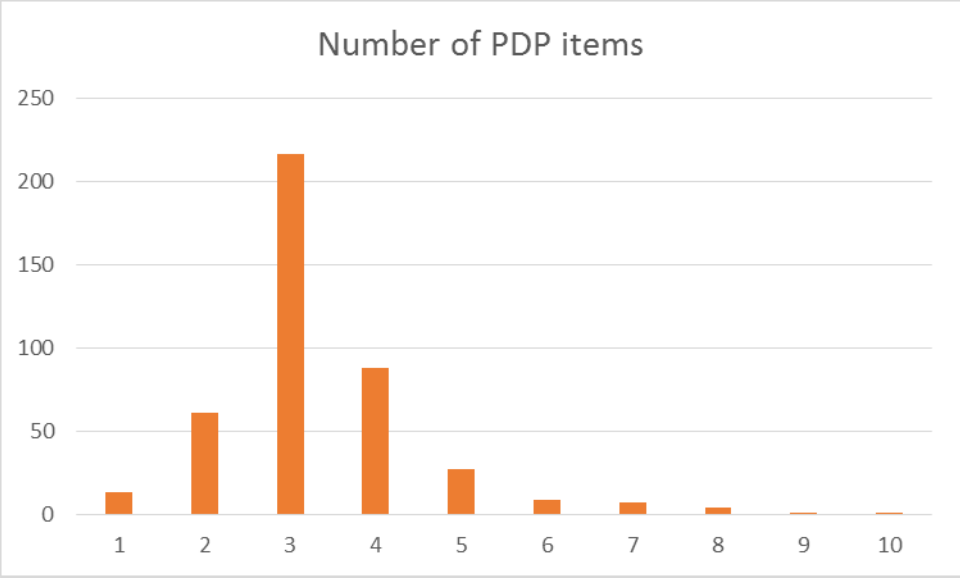


No. who required reminders



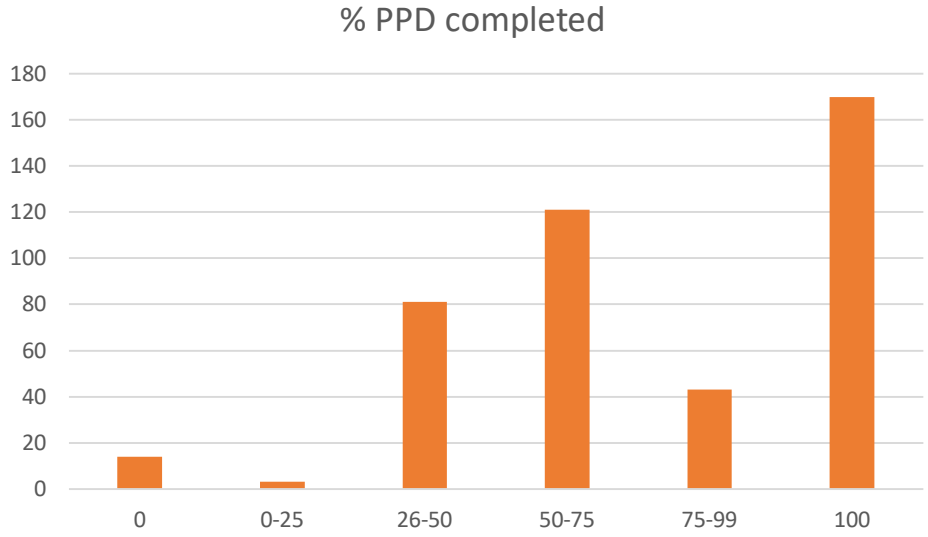
- N = 428 appraisals
- PDP
  - Mean planned 3.3 (3.5)

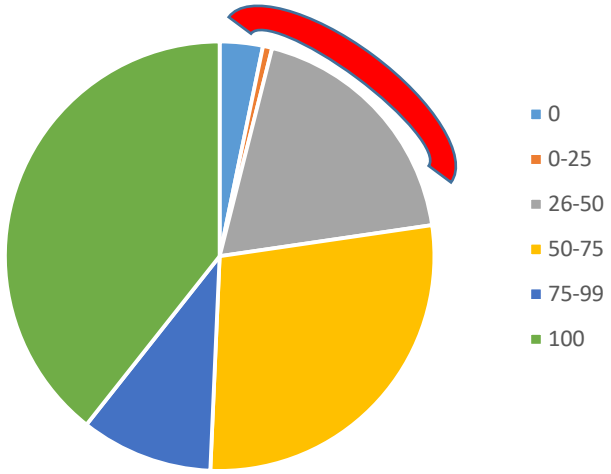
PDP no	N=428
1	13
2	61
3	217
4	88
5	27
6	9
7	7
>8	4



- N = 432 appraisals
- PDP
  - Mean planned 3.3 (3.5)
  - Mean achieved 2.5 (2.1)

% PDP achieved	N=432
0	14
1 – 25	3
25 – 50	81
50 – 75	121
75 – 99	43
100	170





- System live 01/09/2022
- Modified version of the old MAG4 format
  - No domains section to complete
- Will be followed by a Wellbeing format
- Intuitive
- Supporting information to be uploaded
- Appraisal team can upload information
- Specific appraiser but not appraisee training
- Checklist included

Action: Arrange for the Responsible Officer's Annual Report for 2020/21 to include details of the key messages arising from medical staff appraisals (rather than just the statistics associated with such appraisals) (Medical Director, September 2021)

Annual action plan 2021.2022 onwards

471 appraisals reviewed

Similarly, to 2020.2021 the majority of doctors used the new shortened version of the MAG4 form. This encourages a more supportive appraisal and allows for verbal supporting information rather than written.

The range of appraisals by per appraiser was 1 – 15 with a mean of 5.3 (18/80 appraisers did more than 8 appraisals) – similar to 2020.2021

Approximately 1/3 of appraisals were late – similar to 2020.2021

Mean PDP planned was 3.3 (3.5 2020.2021) and mean PDP achieved was 75% (60% in 2020.2021)

Key themes from appraisals:

Doctors more likely to report wellbeing concerns – some but not all relating to COVID-19. Mental health issues more commonly discussed than previously. There did seem to be more frequent reporting of time off work due to mental health.

Discussion of early retirement was very rare but discussion on reducing clinical sessions was a common theme.

CPD activity was increased compared to 2020.2021 but on-line learning remains significant and most supporting evidence remains verbal

The majority of PDPs are appropriate with mandatory training and out of work activity now infrequently seen.

There is variation in the detail reported in appraisals. The majority are sufficient but some have limited discussion of the appraisal. Where appraisals are very limited this is fed back to the appraiser. The L2P appraisal system will require more detailed documentation of the appraisal discussion.

Action Plan for Maidstone and Tunbridge Wells NHS Trust - September 2021

Action/Issue	Action required	Responsible person	Target Date	Progress
To introduce a web-based appraisal system	Discuss with other Trust appraisal leads Review and consult on potential systems Complete a business case	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	September 2022	All completed. L2P system selected and live as of 01.09.2022
To introduce an appraisal checklist to cover key information that should be documented in all appraisals	Liaise with appraisers and agree the contents of a checklist Circulate the checklist to all appraisers	Trust Appraisal & Revalidation Lead	September 2022	Completed (see attached) and used in the 2021.2022 appraisal round. Now superseded by the bespoke check list in the L2P system
To explore, once a web-based appraisal system is introduced, whether the "appraisal system" should be replaced with appraisal throughout the year	Seek feedback from appraisees and appraisers re this change. Liaise with the GMC re a potential one-off gap of 18 months between appraisals. Produce a new annual timetable and circulate to all doctors	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	September 2022	All completed. All year-round appraisals more popular with all doctors. GMC advise that they approve this change. ROs from local non-NHS hospitals advised. All doctors now contacted with their new appraisal month and given to opportunity to request an alternative.

NHS
Maidstone and Tunbridge Wells NHS Trust

To receive assurance regarding the confidentiality of patient information, in light of the 'Approaching Standards' submission on the Data Security and Protection Toolkit for 2021/22	**Deputy Chief Nurse for Quality and Experience**

At the Board meeting in June 2022 additional assurance was requested regarding the Trust processes concerning the confidentiality of patient information. This report provides assurance on the measures taken within the Trust to ensure patient data is secured confidentiality.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

For 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. Background and Scope

The Trust made its 2021/22 Data Security and Protection Toolkit submission on 30 June 2022. The submission made was that of 'Standards Not Met', due to the IT protection standard not being fully compliant. This was subsequently upgraded by NHS Digital to Approaching Standards.

The Board requested specific assurance that patient data is confidentiality maintained.

2. Confidentiality of patient information

Each year the Trust commission an independent audit of compliance against the National Data Guardian's 10 data security standards. The standards are:

- People – Standards 1, 2 and 3: ensure staff are equipped to handle information respectfully and safely, according to Caldicott Principles
- Processes – Standards 4, 5, 6 and 7: ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses
- Technology – Standards 8, 9 and 10: ensure technology is secure and up-to-date

The audit has concluded the following level of assurance for the last three years

Year	Auditor assurance rating
2019-20	Reasonable assurance
2020-21	Substantial assurance
2021-22	Moderate assurance

2021-22 – assurance breakdown

National Data Guardian (NDG) Standard	NDG Standard Level Risk Ratings	Overall DSP Toolkit level Ratings***
	Overall Risk Rating at the National Data Guardian Standard level**	Overall risk assessment across all 10 NDG Standards
1. Personal Confidential Data	Substantial Assurance	Moderate Assurance
2. Staff Responsibilities	Substantial Assurance	
3. Training	Substantial Assurance	
4. Managing Data Access	Substantial Assurance	
5. Process Reviews	Substantial Assurance	
6. Responding to Incidents	Substantial Assurance	
7. Continuity Planning	Substantial Assurance	
8. Unsupported Systems	Substantial Assurance	
9. IT Protection	Limited Assurance	
10. Accountable Suppliers	Substantial Assurance	

As noted previously the Trust has a robust action plan, agreed with NHS Digital, to address the technical issues impacting assurance levels associated with Standard 9.

3. Information Governance committee

The Information Governance committee meets six times a year and has membership representation from all Divisions of the Trust. The Committee ensures the Trust has effective policies and management arrangements covering all aspects of Information Governance in line with current legislation, NHS guidance/policies, professional codes of practice and the Trust's overarching Information Governance Policy.

4. Incident reporting and monitoring

The Board are advised that in the past 12 months the Information Governance Committee has received regular reports of Datix reportable incidents that have occurred across the Trust that have an IG element: not the right information, information not in the right place or not available at the time it is required, cannot be accessed by those who need it, or information cannot be understood.

Examples of such incidents would be:

- Incorrect discharge time recorded
- Patient gender incorrectly recorded
- Inability to access data due to a technical system issues
- Patient notes not available at time of appointment
- Blood units not fated on system correctly
- Records misfiled
- Email sent to the wrong recipient

15,092 Datix incidents were raised in the past twelve months. Of these 1,517 incidents had an IG element only one of which required reporting to the Information Commissioner's Office (ICO).

5. Information Governance Breaches

In the last 12 months the Trust has had one data breach that met the criteria for reporting to the Information Commissioner's Office (ICO).

This came about as a result of a staff member removing 13 clinic outcome letters from site, without authorisation and in breach of policy. The staff member has been subject to disciplinary processes. The ICO have advised that no further action will be taken by the ICO on this occasion as:

- Steps have been taken to contain the breach as the documents have been retrieved by the Trust.
- The member of staff responsible has been suspended preventing any further access to information.
- There is no evidence that the affected data subjects have incurred any detriment as a result of the breach.
- This breach is an isolated incident which is attributable to the actions of a sole staff member, as opposed to being indicative of a wider, systemic, data protection issue within the Trust.

6. Training

In each of the last 3 years over 95% of staff have received mandatory information governance training.

The above detail aims to provide the Board with assurance that the confidentiality of patient data is treated with the utmost seriousness within the Trust and measures are in place to ensure security of this data.

NHS Maidstone and Tunbridge Wells NHS Trust

Health & Safety Annual Report, 2020/21 and agreement of the 2021/22 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)	**Risk and Compliance Manager**

This report has been prepared by the Trust's Competent Persons for the Board. The Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Formerly delegate the management to the Health and Safety Committee

This annual report provides:

- A review of the Trust's Health and Safety performance for 2021/22
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2022/23
- Identifies the strategy and action plan for the next year and going forward

The data shows that around 17.8% of reported incidents of harm relate to staff, Trust and public, with 82.2% relating to patients. There are many programmes and initiatives focused on patient safety so this report focuses more on issues relating to staff and public safety.

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To discuss the report, note the role of the Board and to approve the work programme for 2022/23

[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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2022/23

Requested/ Required by: Trust Board and the Trust Management Executive
- Health and Safety at Work etc Act 1974.
- Management of Health and Safety at Work Regulations 1999.

Main author: Risk and Compliance Manager (Rob Parsons)
Contact Details: rob.parsons@nhs.net

Other contributors:
Head of Fire and Safety
Deputy Head of Fire and Safety
Occupation Health Lead Nurse
Operational Security Manager
Radiation Protection Adviser (RPA)
Lead Nurse for Falls Prevention
Vascular Access Specialist Practitioners
Moving and Handling Advisor
Water Hygiene Manager

Document lead: **Chief Operating Officer**
(Board lead for Health and safety)

Directorate: Clinical Governance

Health and Safety – Annual Board Report and Programme for 2022/23

Requirement for document:	This annual report and programme: • Reviews the Trust's health and safety statistics and performance for 2021/22 • Makes an assessment against objectives and KPIs set in the previous year • Gives a discussion into key health and safety issues identified within the year • Is a discussion document for the Board to determine the objectives and 2022/23 KPIs • Identifies the strategy and action plan for the next year and going forward
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by Trust key policies and procedures: • Health and Safety Policy and Procedure • Risk Management Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016
18	Sixth annual Board Report	August 2017
19	Seventh annual Board Report	August 2018
20	Eighth annual Board Report	August 2019
21	Ninth annual Board Report	August 2020
22	Tenth annual Board report	August 2021
23	Eleventh annual Board report	August 2022

Contents

1. Executive Summary

Introduction

This report informs the Board on health and safety performance and provides the level of assurance to lead the strategy moving forward:

- Discuss and agree the Trust's health and safety objectives
- Formerly delegate the management of health and safety performance and strategy to the Health and Safety Committee

This annual report provides:

- A review of the Trust's health and safety statistics and performance for 2021/22.
- Assessment against objectives and KPIs set in the previous year.
- Discussion of the key health and safety areas identified within the year.
- Discussion document for the Board to determine the objectives and KPIs for 2022/23.
- Identifies the strategy and action plan for the next year and going forward.

Staff, Trust and public incident reports account for 17% of the total incidents reported, with the rest patient incidents. There are many programmes and initiatives for patient safety so this report concentrates on staff, contractor and visitor safety.

Highlights

Improved RIDDOR investigation process

The new process to ensure better quality investigation of RIDDOR incidents has become more embedded. The quality of investigations before final approval has improved and as a result there will be better learning from incidents and more evidence to defend potential claims.

Better communication with the Directorates

There is regular communication from Health and Safety Team regarding H&S Audit compliance, incidents and other items of note. While the H&S Audit compliance performance is not on trajectory, it has improved. In addition, the better lines of communication have increased awareness of need so the Health and Safety Team can be more responsive.

Pilot of lone worker device in Facilities Directorate

A lone worker device is being piloted by selected staff in the Facilities Directorate. A meeting has been held with LoneAlert in regard to a system demonstration and options of devices that could be trialled, this was received positively. Further discussions are being held with the Security team to see whether the devices currently in use would be able to be implemented within the Facilities Directorate. If successful there is the potential for this to be rolled out in other areas.

Fire and Security Infrastructure

Work has been carried out to improve the fire and security infrastructure within the Trust, particularly at Maidstone Hospital. This includes new surveillance cameras in higher risk areas for better coverage, replacement smoke detectors and fire panels, as well as upgrades to the CCTV room at Maidstone. Work continues into 2022/23.

Key findings

- Overall reporting rates have increased by 17.6% compared with 2020/21. Harm incidents increased by 22%.
- There was an increase of between 7% and 19% in four of the five most common harm incident categories, reflecting the overall upward trend in reports.
- The outlier was harm incidents of violence, abuse and harassment where there was a 78% increase in harm incidents and a 110% increase overall. This was the most common type of health and safety-related incidents.
- The number of incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) remained at 22 in 2021/22.
- There was no change in the number of over 7-day injuries, but an increase in the number of dangerous occurrences.
- The Facilities Directorate had a higher number of moving and handling-related RIDDOR incidents, with four of the five reported.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.
- The number and nature of incidents have returned to pre-pandemic levels. Total incidents were 2347 in 2019/20 and 2439 in 2021/22, H&S-related harm incidents 333 in 2019/20 and 331 in 2021/22.

2. Introduction

The Trust has a duty to ensure the health, safety and welfare of employees and others affected by its undertaking so far as is reasonably practicable. “Others” refers to contractors, volunteers, visitors, patients etc. Typically, patients are most likely to suffer harm in a clinical environment, and this is reflected in the incident statistics. There are numerous standards, requirements and bodies whose key role is to protect patient safety. This report will focus on staff and public safety, which, in turn, can contribute to improved patient safety.

Staff, contractor and visitor incident statistics make up 17% of the total incidents reported and 17.8% of Harm incidents. These have been divided into groups based on severity:

- Deaths to employees, contractors and visitors (deaths at work).
- Incidents and Injuries reportable to the HSE under RIDDOR.
- All staff and public injuries.

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 93.4% of the total staff, Trust and public incidents of harm fit into these categories. This allows for bench marking against all industry and the health sector:

- Falls (staff and visitor slips, trips and falls)
- Medical Sharps (needle stick injuries)
- Violence and abuse (including physical assault and trauma).
- Struck by or collision with an object
- Moving and handling
- Contact with machinery and hot surface (includes hot liquids)
- Contact with a hazardous substance (includes biological agents)

The Trust’s Occupational Health Service undertakes health surveillance on staff to identify or prevent occupational diseases where they may arise from the employee’s work. They also maintain records of referral of staff for workplace illness.

3. Review of Objectives and Programme set for 2021/22

In September 2020 the Trust Board agreed a programme for 2020/21:

Action	Leads	Progress and Comments
Health and Safety Management		
Health and Safety Inspection programme aligned to Fire Safety Inspections to inspect all departments on main Trust sites	Health and Safety Advisor / Head of Fire and Safety	Majority of wards at Maidstone completed. Tunbridge Wells to be completed by October 2022.
System that successfully audits Health and Safety performance by location to be operational	Health and Safety Advisor / Head of Fire and Safety	Ongoing. Synbiotix is still in place, but a new system will be implemented when the Synbiotix contract ends in December 2022.
Departments to complete and submit Health and Safety audit information on agreed system and undertake local inspections	Departmental Managers	End of July 57% compliance against a 90% trajectory. Audit includes a section on local inspections, though assurance could be improved in this respect.
RIDDOR incidents to be reported within timescales	Health and Safety Advisor / Head of Fire and Safety / Risk and Compliance Manager	2021/22 saw 68.2% RIDDOR incidents reported within timescales, down from 72.7% in 2020/21. Communications were sent out to managers to remind them of the reporting requirements and timescales, but the issue remains, particularly with over seven-day injuries.
Reduction in number of RIDDOR incidents which need to go back to investigator for further input before closure	Health and Safety Advisor	Following the introduction of a more robust and in depth RIDDOR investigation form and process fewer investigations have had to go back to the investigator for further input.
Falls		
Reduction in falls resulting in Harm by 5 % (moderate, severe and death)	Lead Nurse for Falls Prevention	Reduction in falls resulting in harm by 5% was achieved. The rate fell from 0.257 per 1000 occupied bed days (OBDs) in 2020-21 to 0.193 per 1000 OBDs in 2021-22.
Falls Prevention training to be mandatory for patient facing staff	Lead Nurse for Falls Prevention	Falls Training incorporated as part of Patient Safety Training Day that was launched in October 2021.
National Audit for Inpatient Falls	Lead Nurse for Falls Prevention	All patient meeting criteria for submission from January 2021 to December 2021 was included in the audit. Facility audit submitted March 2022.
Incorporate Falls as indicator in	Lead Nurse	This inclusion was requested in

Action	Leads	Progress and Comments
SafeCare Tool	for Falls Prevention	March 2021 and the decision for inclusion has been deferred.
Radiation Protection		
Continue to improve resilience in non-ionising radiation protection.	Trust RPA	A Senior Clinical Technologist is now a competent ultrasound imaging assessor and is training to be a Laser Protection Adviser. Funding of around £2800 has been requested for training to support the LPA certificate. Recruitment is currently progressing for a 0.5WTE Principal Clinical Scientist to provide leadership in non-ionising radiation physics.
Improve medical physics support for imaging with ionising radiation to address concerns raised in CQC 2019 annual IR(ME)R report and the Richards' Review, Diagnostics: Recovery and Renewal	Trust RPA	Recruitment is progressing for a 0.5WTE Principal Clinical Scientist to provide Medical Physics Expert support to improve compliance with the IR(ME)R2017 regulations. A Business Case Outline Proposal has been submitted for a further Principal Clinical Scientist.
Violence and abuse		
To review current policy and practices around restraint and put forward proposals to make changes to better protect staff from extreme violence	Security Manager	Security Policy has been reviewed and has gone out for initial consultation. The Violence and Aggression and Restraint policies are being reviewed by a consultant in combination with staff/SME's and will follow due process soon. Breakaway training is being delivered and a new trust employed trainer will be joining the team soon to deliver bespoke training to areas of concern.
Moving and Handling		
To pilot and train link assessors into different departments	Moving and handling Advisor	One cohort has been completed departments have the option to roll this out so that more bespoke training can happen. The link assessors are starting to complete update training with their teams.
To improve initial patient handling assessment with new document, which will support more use of slide sheets when moving patients to reduce tissue viability issues and injury to staff and patients, as well as reducing falls associated with risk identification	Moving and handling Advisor	Due to the assessment not being user friendly on Sunrise a pilot has been started with Ward 2 to see whether the assessment is user friendly as a paper copy and whether any changes might be needed. Then a decision will be made whether this goes fully on Sunrise, kept as a paper copy or

Action	Leads	Progress and Comments
		summary items from paper copy go on Sunrise.
To explore equipment that would improve care when moving a Bariatric patient	Moving and handling Advisor	This is still ongoing and, with reference to this year's objectives, a bariatric/additional needs pathway to support this further would be beneficial.
Sharps		
To continue to review new safety devices in the market place across the site	Vascular Access Specialist Practitioners (VASPs)	Due to unprecedented supply issues, numerous medical sharp devices have been purchased by the procurement team, that have not been through the usual trust screening systems. Advice has been provided to the Materials Management team by the VASPs to ensure that the most appropriate alternatives have been procured. Training and education have been cascaded across both trust sites where able and educational flyers provided. Use of all variations of devices have been incorporated into trust appropriate training courses and induction programmes. Venepuncture safety devices have been placed onto the risk register.
To continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required	Vascular Access Specialist Practitioners (VASPs)	When clinical demand has permitted, sharps injuries have been investigated by the VASPs, with both support and additional education provided to individuals where it has been appropriate. There have been no identifiable trends that have raised concerns.
Occupational Health		
Specify new IT system for OH to replace old one which is no longer supported. Test and implement system into live environment	Head of Occupational Health	This remains in progress- implementation date is September 14th 2022 for transfer to new system. Currently in the process of testing the new IT system.
Set up and embed new Psychological / Psychology service within OH. Ensure the Trust not only meets but exceeds its requirement to minimise / mitigate stress at work under the H&S act.	Head of Occupational Health	A psychological team has been appointed and are in post but the OH and well-being teams are going through a review and it maybe that in 6 months' time this team are a separate team and not linked to OH.
Increase accommodation for OH clinicians to operate on-site face to face services for staff; current	Head of Occupational Health	Accommodation/space for occupational health has not been increase and as a result limited

Action	Leads	Progress and Comments
accommodation not sufficient for all clinicians. Aim to provide safe, effective, appropriate and timely OH services to managers and staff alike		availability to deliver face to face consultations.
Move all health surveillance questionnaires to on-line forms; ensure greater governance around surveillance and follow up of issues	Occupational Health Clinical Nurse Manager	As part of this MTW online appraisal portal, some of the generic health surveillance questionnaires were added to try and increase awareness and update.
Bring eyecare services back on-site to enable easy access to opticians and sight test. Providing free sight tests to staff and discounted glasses. Ensures Trust wide access and compliance with VDU assessments	Occupational Health Clinical Nurse Manager	Currently under review. Aiming to co-ordinate and arrange an external company to support this in the autumn.

4. Statistics for 2021/22

The Datix incident database was interrogated for all staff/ public/ Trust incidents for the period of 01/04/2021 to 31/03/2022.

4.1. Reporting

There were 2439 staff/ public/ Trust incidents in 2021/22. This is a 17.6% increase from 2074 reported incidents the previous year, 2020/21. This was expected as footfall from both staff and members of the public increased within both main hospital sites following the COVID-19 pandemic. There is an overall upward trend for reporting.

Harm incidents decreased compared with 2020/21, however, when Health and Safety-related harm incidents are analysed, there was an increase from 271 in 2020/21 to 331 in 2021/22. This is in line with levels seen before the COVID-19 pandemic. The overall trend for harm incidents is level when compared with the previous eight years.

The ratio of incident reports to harm incidents has increased to approximately 7.4 reports for every harm incident in 2021/22 from 6.1 reports per harm incident in 2020/21.

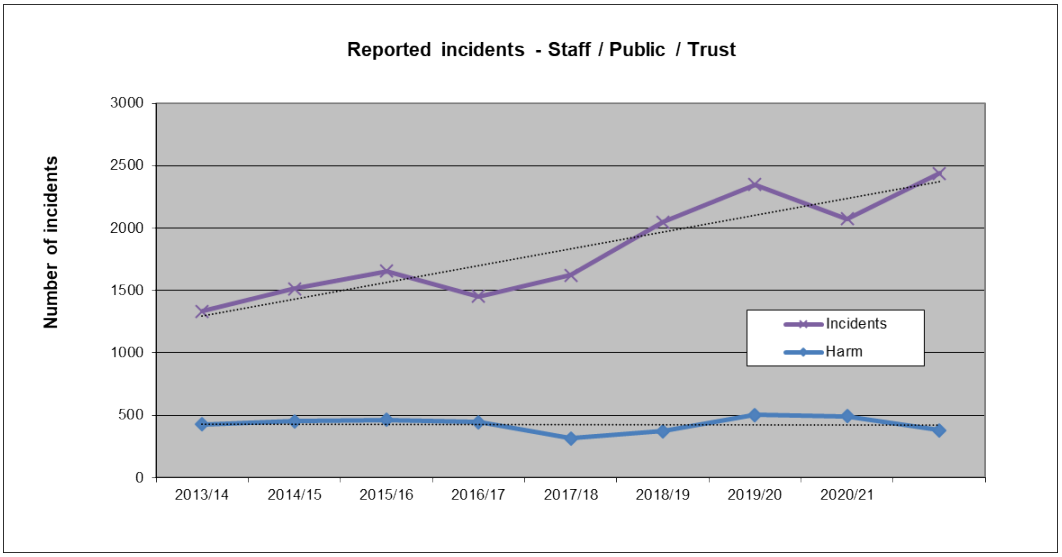


Figure one: Reported incidents and harm incidents 2013/14-2021/22

Looking at reporting rates over the last three years (see *Figure two* below), there does not seem to be a correlation between periods of increased reporting of Harm incidents and an overall increase in reporting levels in those same periods (see also *Figure three* below).

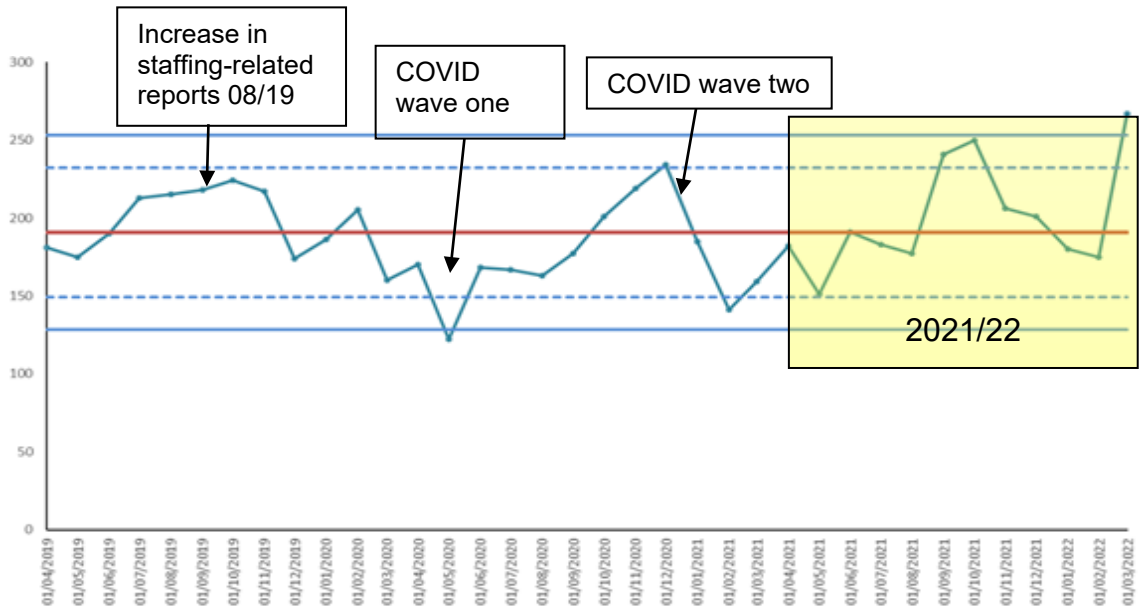


Figure two: Incident reports 04/2019-03/2022 SPC Chart

This suggests that when staff are under more pressure, incident reports for Harm incidents are submitted, but lower-level incident reports may not be.

4.2. Reporting of Incidents, Diseases and Dangerous Occurrences (RIDDOR) Incidents

The data for 2020/21 has been compared with the data from the previous 4 years.

RIDDOR Category	Year reported				
	2017/18	2018/19	2019/20	2020/21	2021/22
> 7-Day injury	16	15	17	12	12
Specified injury	3	5	5	9	5
Dangerous occurrences	4	6	2	0	5
Occupational Disease (not COVID)	0	0	0	1	0
Accidental death	1	0	0	0	0
	24 ↓	26 ↑	24 ↓	22 ↓	22↔

The Trust submitted 22 RIDDOR reports in the year at an average of 1.8 per month. This is no change from the previous year.

68.2% were submitted within HSE timescales, which is a decrease from 72.7% in 2020/21 and remains a concern. The proportion of over 7-day injuries remains higher than the other categories, which has had an effect on the percentage of reports submitted within HSE timescales. There have been communications to managers reminding them of RIDDOR timescales and reporting criteria and incident reports are monitored and chased if there are suspected RIDDOR incidents.

54.5% of RIDDOR reports were over 7-day injuries, as was the case in 2020/21. Of these twelve incidents, five were caused by slips, trips and falls, four were primarily caused by moving and handling (one during patient handling, three non-patient handling), one was as a result of a crush injury, one cut by a broken pipette and one ‘other’.

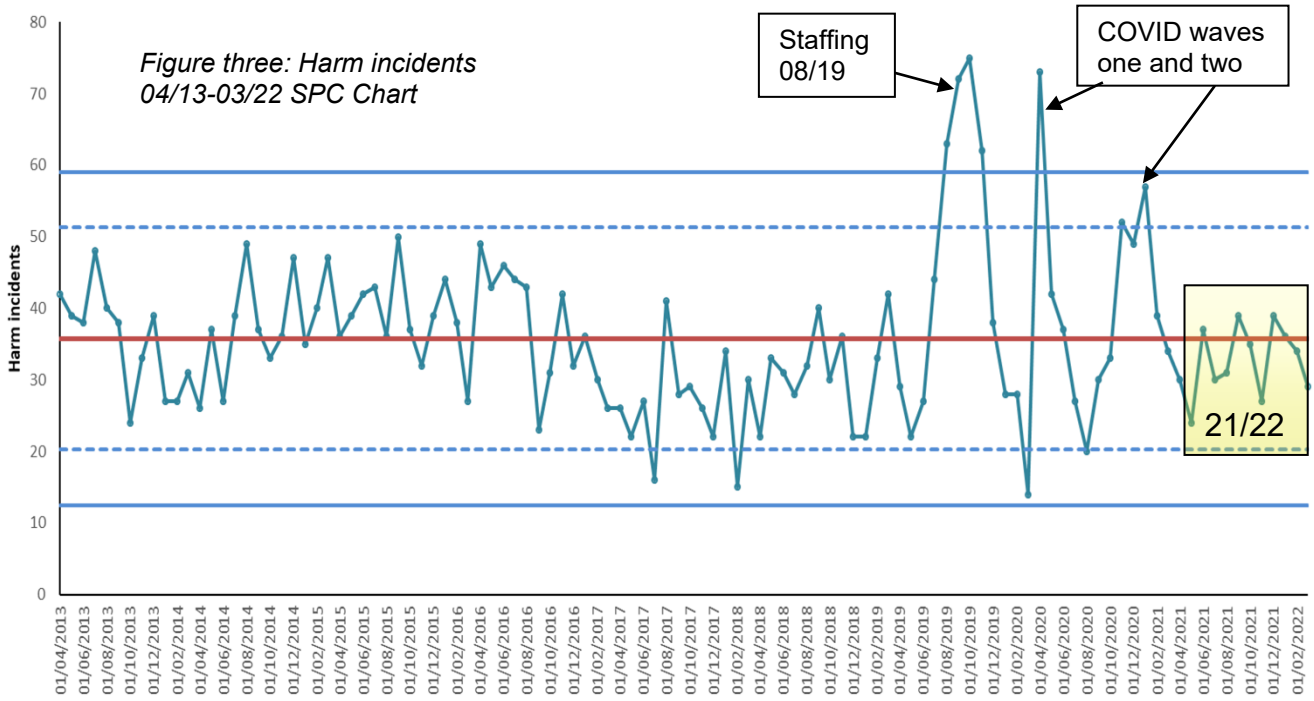
There has been a decrease in the number of specified injuries, with five. All were fractures, with three as a result of slips, trips and falls, one as a result of dropping a gas cylinder and one impact injury suffered during a demonstration.

There was one RIDDOR incident involving a member of the public, a slip and trip resulting in a fracture, compared with two in 2020/21.

There has been an increase in the number of dangerous occurrences from none in 2020/21 to five in 2021/22. These were all as a result of exposure to known blood-borne viruses (BBV), with four needle stick injuries and one splash incident.

4.3. Categories of incidents resulting in harm

An analysis of harm incidents by month since April 2013 shows that in the past year the reporting levels are in line with what would be expected after peaks around summer 2019 due to staffing and during COVID-19 waves one and two.



Harm incidents decreased from 493 in 2020/21 to 380 in 2021/22, largely due to a reduction in COVID-related staff incidents. However, directly Health and Safety-related harm incidents increased from 271 to 331.

The eight largest categories, in line with seven of the categories used by the HSE in their national statistics, make up approximately 98.5% of all directly health and safety-related harm incidents. Most of these categories have seen an increase from the previous reporting year. However, only violence, abuse and harassment incidents have seen arise above the overall increase of 22%. **The increase in violence, abuse and harassment incidents (+78%) has been significant and is well above pre-pandemic levels.**

	2020/21 (Harm)	2021/22 (Harm)	% of total (2020/21)	% of total (2021/22)	Change
Falls	*45*	51	*17%*	15%	+13%
Sharps (medical)	*56*	60	*21%*	18%	+7%
Violence, abuse and harassment	*63*	112	*23%*	34%	+78%
Collision, trap or struck by an object	*30*	34	*11%*	10%	+13%
Moving and handling	*36*	43	*13%*	13%	+19%
Contact with machinery or hot surface	*0*	7	*0%*	2%	+
Contact with hazardous substance	*4*	2	*1%*	0.6%	-50%
Cuts non-medical sharps	*14*	16	*5%*	5%	+14%
Others	*23*	6	*8%*	2%	-74%
	271	**331**			**+22%**

The number of incidents categorised as ‘Other’ decreased by 74%, in keeping with pre-pandemic levels. All 23 of the ‘Other’ incidents in 2020/21 related to reports of pressure damage or irritation from wearing FFP3 masks or other face masks as required for

personal protection during the COVID-19 pandemic period, so a decrease would be expected.

There remains a discrepancy between sharps injuries reported and occupational health attendances (see **Section 6.4.3** below).

The chart below compares 2021/22 incidents of Harm by type with injuries / Harm in the previous five years. The increase in violence, abuse and harassment incidents is the clear outlier:

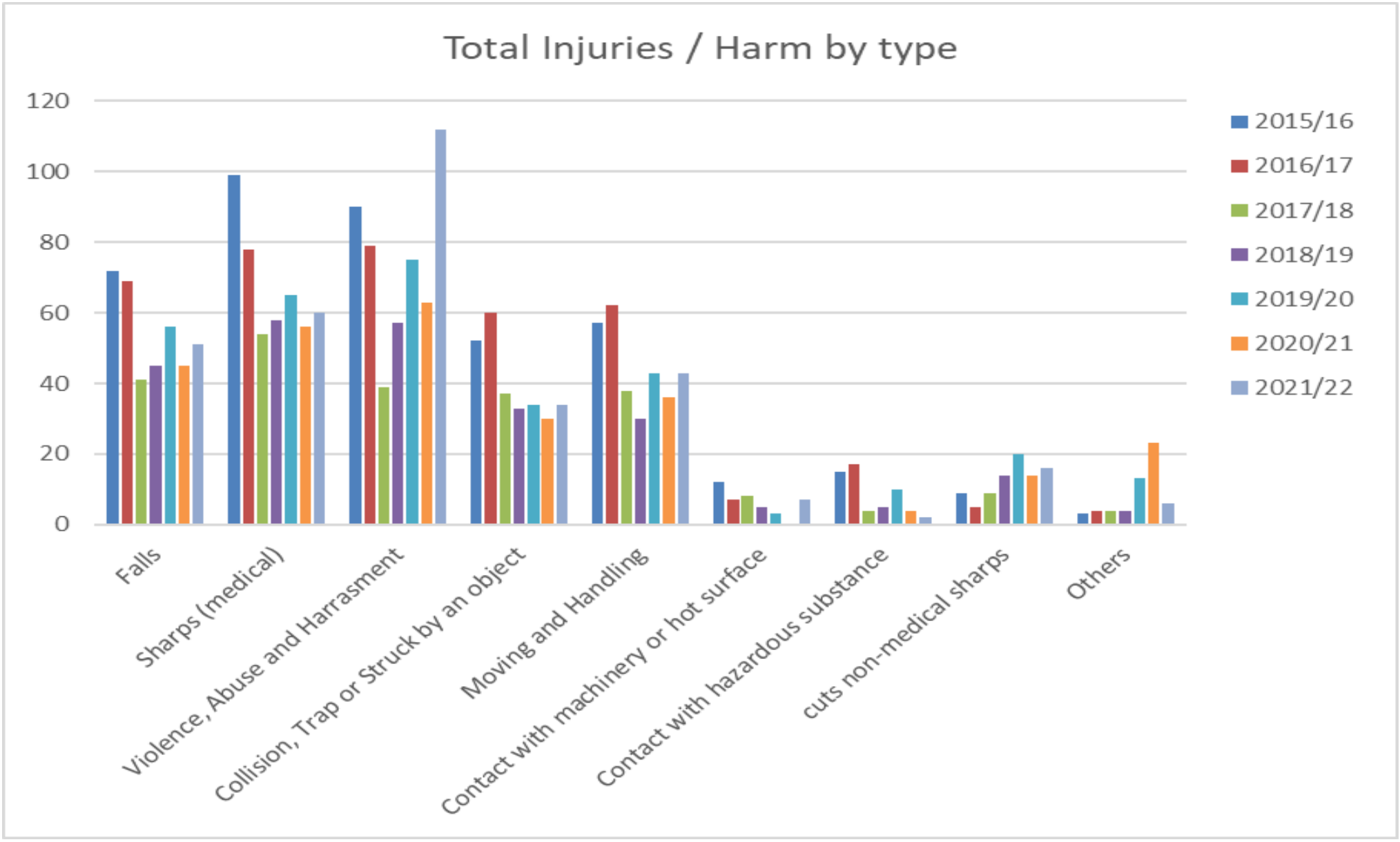


Figure four: Harm categories 2015/16-2021/22

4.4. Harm incidents by Division and Directorate

The table below shows Health and Safety incidents resulting in Harm by directorate/ specialty:

(RIDDOR incidents in brackets)
*Head and Neck became ENT & Audiology and Ophthalmology in 2021/22

Division	Directorate	Falls	Sharps/ splash (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	***Total Incidents of Harm (2021/22***	Total Incidents of Harm (2020/21)	Total Incidents of Harm (2019/20)
Cancer Services	Clinical Haematology		1		1						2	3	4 *(1)*
	Oncology	3	2			1		1	1		8	8	13 *(2)*
	Outpatients	4 *(1)*			1						5 *(1)*	2 *(1)*	9
		7 *(1)*	**3**		**2**	**1**		**1**	**1**		**15 *(1)***	**13 *(1)***	**26 *(3)***
Corporate Services (including Trust wide)	Clinical Governance					1		1			2	-	2
	Corporate	4		2	1	1			1		9	6	3
	Decontamination								1		1	-	1
	Estates	10 *(2)*			3				2		15 *(2)*	9 *(3)*	13 *(2)*
	Facilities	4 *(1)*	2	3	3	7 *(4)*	4		2		25 *(5)*	26 *(7)*	34 *(3)*
	Finance				1	1					2	2	4 *(1)*
	Information Technology										-	2	6
	Nursing										-	2	3
	People and Culture										-	1	2
		18 *(3)*	**2**	**5**	**8**	**10 *(4)***	**4**	**1**	**6**		**54 *(7)***	**48 *(10)***	**68 *(6)***

Division	Directorate	Falls	Sharps/ splash (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	***Total Incidents of Harm (2021/22***	Total Incidents of Harm (2020/21)	Total Incidents of Harm (2019/20)
Core Clinical Services	COVID Swabbing and Testing			1							1	-	-
	Imaging	3	4	1	1	2			1	3	15	12	13 *(1)*
	Pathology		8 *(1)*		1	1	1		2 *(1)*		13 *(2)*	17 *(1)*	16 *(1)*
	Pharmacy										-	4	1
	Therapies	1			1	5 *(1)*			1		8 *(1)*	2	9
		4	**12 *(1)***	**2**	**3**	**8 *(1)***	**1**		**4 *(1)***	**3**	**37 *(3)***	**35 *(1)***	**39 *(2)***
Medicines and Emergency Care	Acute Medicines and Geriatrics	4 *(1)*	8	50	3	10			1		76 *(1)*	46 *(4)*	51 *(1)*
	Emergency Medicine	5	5 *(1)*	15	2	4			1		32 *(1)*	30	24 *(2)*
	Medical Specialties	4 *(2)*	5 *(1)*	25	3		1				38 *(3)*	20 *(1)*	28 *(4)*
	Private Patients										-	1	-
		13 *(3)*	**18 *(2)***	**90**	**8**	**14**	**1**		**2**		**146 *(5)***	**97 *(5)***	**103 *(7)***
Surgery	ENT and Audiology*								1		1	-	-
	General Surgery	1	1	4	1	2				1	10	3	13 *(1)*
	Head and Neck*										-	6	5

Division	Directorate	Falls	Sharps/ splash (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	***Total Incidents of Harm (2021/22***	Total Incidents of Harm (2020/21)	Total Incidents of Harm (2019/20)
Surgery	Ophthalmology*					1					1	-	-
	Orthopaedics		6	1	2	1				1	11	7	15
	Planned Care Co-ordination					1					1	-	-
	Surgical Specialties	1									1	3	1
	Theatres and Critical Care	1 *(1)*	10 *(2)*	3 *(1)*	9	4	1		2 *(1)*	1	31 *(5)*	38 *(1)*	33 *(4)*
	Urology										-	-	4
		3 *(1)*	**17 *(2)***	**8 *(1)***	**12**	**9**	**1**		**3 *(1)***	**3**	**56 *(5)***	**57 *(1)***	**71 *(5)***
Women's Children's and Sexual Health	Children's Services		2	6							8	5 *(1)*	15
	Sexual Health		1								1	1	1
	Women's Services	6	5	1	1 (1)	1					14 *(1)*	15 *(3)*	10 *(1)*
		6	**8**	**7**	**1 (1)**	**1**					**23 *(1)***	**21 *(4)***	**26 *(1)***
	Totals	**51 *(8)***	**60 *(5)***	**112 *(1)***	**34 *(1)***	**43 *(5)***	**7**	**2**	**16 *(2)***	**6**	**331 *(22)***	**271 *(22)***	**333 *(24)***

The size of the respective divisions and directorates and the activities undertaken has a clear influence on the number and nature of incidents that occur.

- Overall the number of harm incidents returned to pre-pandemic levels.
- While there was an increase in the overall number of harm incidents, there was only a large increase in the Medicines and Emergency Care Division. This was largely due to the increase in incidents of violence, abuse and harassment.
- There were 90 harm incidents as a result of violence, abuse and harassment in Medicines and Emergency Care in 2021/22, 80.4% of the Trust total. This compares with 49 harm incidents in 2020/21 and 59 in 2019/20. There were 50 harm incidents in Acute Medicines and Geriatrics alone.
- Facilities and Theatre and Critical Care were the Directorates with the most RIDDOR reportable incidents with five each.
- Within Facilities four of these five RIDDOR reportable incidents involved moving and handling. Though the overall number of RIDDOR incidents is down from seven in 2020/21, only one of these 2020/21 RIDDOR incidents involved moving and handling.
- In Theatres and Critical Care two of the five were dangerous occurrences relating to sharps/splash exposure to BBV. Theatres and Critical Care also had the most Sharps/Splash incidents of any Directorate with ten, though this is not significantly different to previous years (nine in 2020/21, ten in 2019/20).

These figures are discussed in more detail in **Section 6** below.

5. Benchmarking

The HSE uses accident rates to compare organisations. One measure is the number of RIDDOR reportable incidents per 100,000 employees. The HSE publish data for the health sector and for all industries. Data is based on total employee numbers rather than whole time equivalents.

	RIDDOR rate per 100,000 employees
All industries (2020/21)	185
Human health and social work (2020/21)	280
MTW 2016/17	479
MTW 2017/18	358
MTW 2018/19	370
MTW 2019/20	329
MTW 2020/21*	255
MTW 2021/22	280

*This figure does not include COVID-19 occupational disease RIDDOR reports

There has been a small increase in the Trust RIDDOR rate per 100,000 employees.

Further comparison data was obtained from other local trusts. The Healthcare Risk Management Group (HRMG) has members from many trusts in the South East.

Type of Trust	Total RIDDORs	Employees	RIDDOR Rate (per 100,000 staff)	
MTW	22	7859	280	2021/22
Health sector (HSE national data)			280	2020/21
Acute NHS Trust	9	26000	35	2021/22
Acute & Community NHS Trust	9	3800	237	2021/22
Acute & Community NHS Trust	31	7848	395	2021/22
Acute NHS Trust	5	1000	500	2021/22
Specialist Hospital NHS Trust	12	8000	150	2021/22
Community NHS Trust	9	6234	144	2021/22
Private Healthcare	4	950	421	2021/22
HMRG Total	101	61691	164	2021/22

MTW's RIDDOR rate is equal to the health sector average and higher than that of the HRMG. However, the HRMG rate is skewed by one very large Trust with very low RIDDOR numbers. If that Trust is discounted then the rate becomes 258 per 100,000 staff, and much closer to the MTW rate. The variety of trusts providing data and the fact that data was available from just two other acute NHS trusts, one very large and one quite small, makes direct comparison difficult, with the closest other comparators acute and community trusts. Benchmarking was only possible against organisations willing to share their data.

6. Key Health and Safety Areas

6.1 Falls

Falls accounted for 15.4% of staff/public/Trust harm incidents, compared with 16.6% in 2020/21. The number of harm incidents from non-patient falls was 51.

The overall number of slips, trips and falls incidents reported (including near misses and no harm incidents) increased by 3.5% to 89.

Estates had the most slip, trip and fall injuries, with ten, two of which were RIDDOR reportable. Some incidents in communal areas are attributed to Estates.

Eight of the RIDDOR incidents were related to slips, trips and falls. Five of these were >7-day injuries and three specified injuries. One of the specified injuries involved a member of the public, though this is fewer than in 2020/21, when there were two. Four of the RIDDOR incidents relate to slips, three of which involved a spillage/ leak/ water. Three of the RIDDOR incidents were trips, with two trips over equipment and one over a cone.

The impact from lockdown as part of the measures for the Covid-19 has increased the risk of falling for the population due to general deconditioning and this has resulted in increased in the number of patients presenting with falls. Reduction in falls is a part of the Trust Quality Improvement Programme. A focus on reduction in inpatient falls through a Falls Stakeholder event in October 2021 that saw engagement Trust wide and subsequently three falls prevention working groups were formed to focus on the high impact actions identified from the stakeholder event.

6.2 Violence and Abuse

Harm incidents from violence, abuse and harassment account for a third of the total (33.84%), and remains by far the highest single category. The number of harm incidents increased by 78% from 63 in 2020/21 to 112 in 2021/22.

It is the highest directly health and safety-related incident category by overall number of incidents. The total number of incidents of violence, abuse and harassment reported (including near misses and no harm incidents) increased by 110% to 426 from 203 in 2020/21. There were significantly fewer numbers of visitors and others on site during 2020/21, but in 2019/20 there were 269 incidents and in 2018/19, 318. Therefore, this increase goes beyond pre-pandemic levels. Security staff have been encouraged to report more on Datix, but this doesn't fully account for the increase.

80.4% of harm incidents take place in the Medicines and Emergency Care Division, with almost 45% in Acute Medicines and Geriatrics alone. The higher number of harm incidents in Acute Medicines and Geriatrics reflects the number of incidents where patient factors are a contributory factor.

A new Trust-employed trainer is starting in September 2022 and will be delivering conflict resolution training / breakaway / defence techniques as well as bespoke training to employees and contractors (security).

A new security contract has been awarded and this will be closely monitored to ensure quality service is being delivered in line with Trust expectations. It will provide a team of 5 guards per site 24/7.

Improved training of frontline staff and a directive that Security staff submit more incident reports to give a more accurate record would be expected to increase overall numbers of incident reports further in the future. The ratio between incident reports and harm incident reports would therefore be a clearer indicator as to whether improved reporting or increased risk accounts for the rise. The ratio in 2021/22 was approximately 4:1.

In terms of security infrastructure, the CCTV project for Maidstone is nearing completion and there are a number of security upgrades in progress on both sites.

There are now monthly audits of the access control system and a more robust system in place for access requests.

6.3 Moving and handling

There was an increase of 19.4% in the number of harm incidents, from 36 in 2020/21 to 43 in 2021/22. However, moving and handling-related incidents account for around 13% of staff incidents of harm, the same percentage as in 2021/22.

Five RIDDOR reportable incidents were related to moving and handling activities, four >7-day injuries and one specified injury. Four of the five RIDDOR reportable incidents involved staff from Facilities and they have been identified as a higher risk group for inanimate load handling.

Moving and handling-related incidents are reviewed by the Moving and Handling Advisor and assistance and guidance is offered to investigators and managers.

Work is ongoing in the review of moving and handling safe systems of work and risk assessments.

Work is ongoing with procurement, infection prevention and E.M.E services to make sure the Trust standard equipment is reviewed and catalogued, this also includes making sure the equipment is still fit for purpose.

Face to face training has now commenced by an outside training company. Development of training will roll out this year to meet specific moving and handling tasks within different roles within the Trust, including those in Facilities.

6.4 Sharps/ splash

6.4.1. Medical sharps

Harm incidents from medical sharps increased by 7.1% when compared to the previous year, from 56 to 60. This is below the overall rate of increase in harm incidents.

The overall number of reported incidents (including near misses and those recorded as no obvious harm) decreased from 111 in 2020/21 to 110 in 2021/22.

In 2020/21 there were no RIDDOR reportable dangerous occurrences, however, in 2021/22 there were five.

The Vascular Access Specialist Practitioners (VASPs) have continued to review safety devices. No changes have been made to cannulation equipment, however, there are currently four different versions of safety butterfly needles for venepuncture in clinical use. Attempts have been made to cohort devices into clinical areas, in order to prevent all four products being used simultaneously in the same department. There have again been difficulties in obtaining Gripper Plus non-coring safety Huber needles to access ports. EZ Huber needles have again been obtained to use as an alternative while supplies are poor. There have been a number of different brands of safety hypodermic needle procured when suppliers are unable to fulfil demand. Devices are chosen according to the most similar safety activation feature.

The SHRAG has continued to discuss where sharps/splash incidents are not being investigated with uniform rigor. The VASPs have monitored Datix sharps reports and investigated these incidents where time constraints allow.

6.4.2 Eye Splash Injury

Four harm incidents were reported compared with one in 2020/21. A total of 15 eye splash incidents were reported in the Trust (including near misses and those recorded as 'No obvious harm'), a decrease from the 17 eye splash incidents reported in 2020/21. One incident was reportable under RIDDOR due to exposure to known BBV.

6.4.3 Sharps / Splash Injury Comparisons

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
OH attendances 2019/20	16	11	8	15	17	13	11	20	9	9	12	7	**148**
OH attendances 2020/21	8	6	11	5	9	9	12	9	16	8	15	12	**120**
OH attendances 2021/22	*7*	*12*	*12*	*10*	*7*	*7*	*8*	*13*	*11*	*10*	*6*	*11*	**114**

There has been a reduction of six cases (-5%) in 2021/22 compared with 2020/21, however, not all staff members are using Datix or going to OH following an exposure. In recent months three cases have been picked up through Datix which were not reported directly to the Occupational Health department.

With the introduction on the new Occupational Health IT system, it will be easier for staff members to report incidents outside of core working hours and be able access all the relevant information in one place.

The disparity between Datix reports and OH attendances from previous years remains. If only those reporting harm incidents attended, this would give a total of 64, significantly fewer than the actual OH attendance. If harm and no obvious harms attended, this would give a total of 125, more than the actual attendance. There will be incidents reported where OH attendance is not needed but further vigilance and education are required on the need to report sharps incidents and to report them accurately.

6.5 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, housekeeping issues and rushing around and are often associated with moving and handling activities. There were 34 harm incidents in 2021/22 compared with 30 in 2020/21, a 13% increase, smaller than the overall increase in harm incidents.

There was one RIDDOR incident in 2021/22, down from four in 2020/21. This was a crush between a bed being moved and a closing door.

6.6 Machinery, Hot Surfaces and Fluids

There were seven burn/scald injury incidents reported in 2021/22, up from none in 2020/21. Four of these were in facilities, with catering and laundry staff at particular risk.

6.7 Cuts / lacerations, non-medical sharps

To distinguish between medical and non-medical sharps, this category was introduced. An increasing number of incidents are being categorised this way, with 16 in 2021/22, compared with 14 in 2020/21. There were two RIDDOR incidents, both over seven-day injuries, caused by cuts / lacerations in 2021/22.

6.8 Water Hygiene

The Water Hygiene Manager was appointed in May 2021. In addition, a new Authorised Engineer (AE) was appointed in 2021/22. The AE acts as an independent professional advisor for the Trust.

6.8.1 Tunbridge Wells Hospital

The Domestic Hot Water System (DHWS) fails to circulate water to achieve the minimum temperature requirements. Mitie FM has recorded temperatures that are non-compliant with the design requirements. The low temperatures recorded are prevalent in many domestic hot water tertiary circulation loops and towards the ends of numerous sub-circulation loops. Some parts of the system have reported sub-par temperatures. Mitie FM considers the DHWS may never have been correctly commissioned throughout the system (tertiary and sub loops not all checked/ recorded). These issues have been readvised to the new Director of Estates.

This work will require some significant sections (ward areas) to be isolated to achieve compliance safe systems. Prior to this work commencing and once this work starts there will be a considerable clinical input required. Below are the current items that need to be progressed via Mitie FM and Kent and East Sussex Weald Hospitals Limited (KESWHL):

- Improve water circulation to enable 55°C to be consistently achieved throughout the system, thereby reducing the risk of legionella proliferation.

- Reduce the risk of insufficient water flow.
- Reduce thermal heat loss and gain.
- Increase the number of locations where domestic hot water (DHW) flow measurements can be taken and sub-loop regulation.
- Create access to valves where presently none or inadequate.
- Reduce service interruption by installing additional valves.
- Provide means of adding Chlorine for pipework chlorination to sections of the DHWS distribution.
- Discuss 'Secondary' means of legionella control (Water Treatment).
- Extend the scope of BMS system monitoring /or means continuous monitoring and recording (DHW sub-loop extremities)
- Update or, where required, create Mechanical Services Drawings and valve schedules.

The Trust Authorising Engineer (AE) has recommended the items below:

- Due to the high and ever-increasing risk of Legionella at Tunbridge Wells, consideration should be given to re-educating all clinical staff about the signs, symptoms and treatment of Legionnaires disease.
- Urine antigen tests for Legionella bacteria should be available and staff should be encouraged to test patients wherever Legionnaires disease is suspected so the correct antibiotics can be administered.
- Due to the ever-increasing risk of Legionella consideration should be given to point of use filters being fitted to all patient showers across site and all outlets in high Legionella risk wards.
- Chlorine dioxide biocide dosing should be pursued without further delay.
- Defined time scales, schedules and impact on clinical services for the proposed work.

6.8.2 Maidstone Hospital

- The Legionella Risk Assessment has now been completed. An action tracker is currently in the process of being constructed and works will be undertaken based on risk rating.
- Maidstone thermostatic mixing valve TMV/TMT maintenance continues.
- Quarterly shower head and hose change ongoing, with monthly changes in Lord North.
- Annual Inspection planned preventative maintenance (PPM) issued and completed for the all Maidstone Hospital cold water storage tanks and Rowan House at the residences. All work has been completed.

7. Health and Safety Executive Inspections and Investigations in 2021/22

7.1 Trust Inspection

The Care Quality Commission (CQC) took over much of the day to day enforcement responsibility from the HSE for health and social care activities. RIDDOR reports are passed on to the CQC from the HSE.

There has been a decline in the number of prosecutions of NHS Trusts and health and social care organisations by the HSE and these have been limited to clear and significant health and safety breaches, such incidents involving violence and aggression, window restrictors and failure to assess the ligature risk.

Meanwhile, the CQC have initiated more prosecutions of NHS and other health and social care organisations for health and safety-related breaches, and the level of fines levied have increased.

The HSE will continue to inspect NHS Trusts periodically. In addition, they will carry out scheduled specialist inspections of areas such as Containment Level Three (CL3) laboratories.

The CQC should include health and safety as part of their inspections.

7.2 HSE Objectives for 2022/23

The HSE's objectives in their 2022/23 Business Plan are to:

- Reduce work-related ill health, with a specific focus on mental health and stress
- Increase and maintain trust to ensure people feel safe where they live, where they work and, in their environment
- Enable industry to innovate safely to prevent major incidents, supporting the move towards net zero
- Maintain Great Britain's record as one of the safest countries to work in

The continued focus on mental health and stress, the inclusion of safety at home, which reflects the increase in numbers of people working at home, are notable. This is without neglecting efforts to prevent major incidents in high risk workplaces.

Previously more specific objectives by sector were given in addition to the overall HSE strategy and business plan. In healthcare the priorities were stress, moving and handling and violence and aggression. It would be reasonable to assume that were the HSE to inspect these would be their areas of focus.

8 Summary and Conclusions

8.1. Key headlines

From an analysis of the incident data, performance against objectives and other notable incidents, there are the following key headlines:

8.1.1. Violence, abuse and harassment

Incidents of violence, abuse and aggression have increased significantly, with a 78% rise in harm incidents and a 110% in reporting overall. This is by far the most common health and safety-related incident category. Security have been encouraged to report more, but this in itself does not account for such an increase, which is still significantly larger than pre-COVID-19 levels. The Medicines and Emergency Care Division, and Acute Medicines and Geriatrics in particular, account for a large proportion of these incidents. A training

plan is in place to deliver more conflict resolution training and disengagement techniques and the security infrastructure is being improved. This needs to be an area of focus as it is the top health and safety-related risk to staff based on incident data.

8.1.2. Absconding patients

There have been serious incidents and near misses linked to patients, usually with mental health concerns, absconding with suicidal and self-harm ideation. This report focuses on staff rather than patient safety, however, there are risks to staff's physical and mental wellbeing from caring for these patients. In addition, there is a risk to the Trust in the event of further incidents. It is reasonably foreseeable that such incidents will take place so risks need to be controlled so far as is reasonably practicable. The construction work being carried out on both main sites increases the risk of an adverse outcome. Enforcement action and potentially prosecution would be a possibility should the worse happen.

8.1.3. Legionella at Tunbridge Wells Hospital

As highlighted in Section 6.8.1, there is a risk to patients, staff and others of infection from the water system at Tunbridge Wells Hospital. The conditions exist for the proliferation of Legionella bacteria and sampling has shown this to be the case. A plan is in place and remedial work has been carried out, but more needs to be done. While KESWHL and Mitie are responsible for the building and maintenance respectively, the Trust has a duty of care to its patients and an outbreak could have catastrophic consequences.

8.1.4. High risk inanimate load moving and handling

The Facilities Directorate consistently has higher levels of moving and handling incidents. In 2021/22 there were also more RIDDOR moving and handling incidents in this Directorate as porters, domestics, transport, laundry staff etc. continue to work without the training commensurate to the moving and handling risk. There are plans to improve the training to make it more bespoke, and a review of the risk assessments and the processes in place as well as more ergonomically designed task and equipment would also be beneficial.

8.1.5. Sharps/splash reporting

As highlighted above there is a continuing discrepancy between the number of sharps/splash incidents reporting and staff attending OH as a result. There is an ongoing risk from staff not reporting sharps/splash incidents, not attending OH or ED following injury or both. While this issue has been highlighted at least in every report written since 2017, there has not been an improvement and in the last two reports the situation has got worse. In addition, there were five RIDDOR reportable dangerous occurrences in 2021/22 and on occasions OH have to remind staff to report even these.

8.1.6. Health and safety inspections and risk assessment audit compliance

While there has been an improvement, this is still below trajectory. Up-to-date and suitable and sufficient risk assessment is a legal requirement, as are regular health and safety inspections. There is an incomplete picture, which in itself only tells half the story as the quality of the documentation is not under sufficient scrutiny. The audit tool will be replaced in 2022/23, and while this presents an opportunity, there will also be the

challenge of ensuring relevant staff are made aware and given the training needed to utilise the system effectively.

8.2. Summary

- Overall reporting rates have increased by 17.6% compared with 2020/21. Harm incidents increased by 22%.
- The number and nature of incidents have returned to pre-pandemic levels. Total incidents were 2347 in 2019/20 and 2439 in 2021/22, H&S-related harm incidents 333 in 2019/20 and 331 in 2021/22.
- There was an increase of between 7% and 19% in four of the five most common harm incident categories, reflecting the overall upward trend in reports.
- The outlier was harm incidents of violence, abuse and harassment where there was a 78% increase in harm incidents and a 110% increase overall. This was the most common type of health and safety-related incidents.
- The number of incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) remained at 22 in 2021/22.
- There was no change in the number of over 7-day injuries, but an increase in the number of dangerous occurrences.
- The Facilities Directorate had a higher number of moving and handling-related RIDDOR incidents, with four of the five reported.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.

9 Objectives for 2022/23

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Health and Safety Management (Head of Fire and Safety, Health and Safety Advisor, Risk and Compliance Manager)					
To provide the Health and Safety Committee with assurance that all areas are appropriately managing their health and safety risks through the continued audit process via a new H&S electronic management system	01/12/2022-31/03/2023	Deputy Head of Fire and Safety	Risk and Compliance Manager / Head of Fire and Safety	Health and Safety Committee	70-75% compliance by 31/03/2023 (reduced target as new system will be rolled out in 2022/23)
To provide assurance that Trust senior staff, including the Board are informed as to their Health and Safety responsibilities	31/12/2022	Risk and Compliance Manager	Head of Fire and Safety / Deputy Head of Fire and Safety / Chair of Health and Safety Committee	Health and Safety Committee	90% training compliance by 31/03/2023
To develop and pilot Health and Safety specific training for front line managers to better equipment them with their duties	31/03/2022	Risk and Compliance Manager / Deputy Head of Fire and Safety	Head of Fire and Safety / Competent Persons	Health and Safety Committee	Roll out and evaluation of pilot course
To ensure that Health and Safety-related policies are up-to-date and accurate reflect current safe systems of work and process (at least five P&Ps due by 31/03/23)	Ongoing 01/04/21-31/03/23	Deputy Head of Fire and Safety / Risk and Compliance Manager	Head of Fire and Safety / Competent Persons	Health and Safety Committee / RIDDOR panel	Policies reviewed, approved, ratified and published within
Falls (Falls Prevention Practitioner)					
To reduce the monthly Trust Falls rate to at or below	31/03/2023	Lead Nurse for Falls	Deputy Chief Nurse for Nursing	Slips, Trips and Falls Group. Health	6.36 per 1000 OBDs by

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
threshold of 6.36 by March 2023 per 1000 occupied bed days		Prevention	and Quality	and safety Committee Quality Improvement Committee	31/03/2023
Reduction in harm rate per 1000 occupied bed days (moderate, and above) resulting from Falls against the baseline 12-month total from April 2021-March 2022	31/03/2023	Lead Nurse for Falls Prevention	Deputy Chief Nurse for Nursing and Quality	Slips, Trips and Falls Group. Health and safety Committee Quality Improvement Committee	10% by 31/03/2023
Reduction in the percentage of recurrent falls (in a single hospital episode) out of the overall total, to 25% or under by March 2023 against the baseline 12-month total from April 2021-March 2022	31/03/2022	Lead Nurse for Falls Prevention	Deputy Chief Nurse for Nursing and Quality	Slips, Trips and Falls Group. Health and safety Committee Quality Improvement Committee	25% 31/03/2023
Violence and abuse (Trust Security Manager)					
Convert security reporting from their current in-house reporting system to Datix. This will give a far more accurate picture of violence and aggression against staff	31/03/2023	Operational Security Manager		Health and Safety committee	Conversion to be completed by 31/03/2023
Moving and Handling					
Develop training for all areas within the Trust to meet their specific requirements needed to undertake Moving and handling	31/03/2023	Moving and Handling Advisor	Learning team	Moving and Handling Strategy group	Moving and handling raining compliance for all departments

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
tasks within their roles					85-90% by 31/03/2023
To develop a pathway for Bariatric/additional need patients coming into the Trust	31/03/2023	Moving and Handling Advisor	OT/Physio departments	Moving and Handling Strategy group	85-90% compliance by 31/03/2023
Sharps/Splash (Safety, Health and Risk Advisory Group)					
To continue to monitor and review medical sharp safety devices available in the marketplace, and to advise the Materials Management team regarding suitable available alternatives during supply outages.	31/03/2023	Team Lead Vascular Access Specialist Practitioner Band 7	Vascular Access Specialist Practitioner Band 7	Health and Safety Committee SHRAG	N/A
To continue reviewing medical sharps incidents, providing support and training where appropriate and identifying trends that require targeted intervention.	31/03/2023	Team Lead Vascular Access Specialist Practitioner Band 7	Vascular Access Specialist Practitioner Band 7	Health and Safety Committee SHRAG	Qualitative assessment of sharps/splash incident reports; Training records
Radiation Protection					
Complete the Business Case Outline Proposal which has been submitted for a further Principal Clinical Scientist and full business case, if approved.	31/10/2022	Trust RPA	Risk and Compliance Manager	Health and Safety Committee	Recruit from October 2022 if approved
Proceed with classification of Nuclear Medicine staff under IRR2017, as identified in risk assessment from July 2022.	30/09/2022	Trust RPA	Risk and Compliance Manager	Health and Safety Committee	100% compliance by 31/10/2022

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Occupational Health					
Implement the "Pertussis vaccination program for MTW employees working with vulnerable infants and pregnant people". Following National Guidance Pertussis: occupational vaccination of healthcare workers - GOV.UK (www.gov.uk)	Implementation started in June 2022. Currently we are visiting relevant wards to provide "on-site vaccination" and we are offering the vaccine on-commencement – to employees who meet the criteria.	Acting Head Occupational Health – Amanda Lain	Occupational Health Nurses	Ongoing documentation Audit trails	
Implement the "BCG vaccination program for MTW employees". Following National Guidance Green Book: Chapter 12 Immunisation of healthcare and laboratory staff (publishing.service.gov.uk)	Implementation started in May 2022. Currently targeting higher risk areas with cross site clinics (each site fortnight clinics)	Acting Head Occupational Health – Amanda Lain	Occupational Health Nurses Bank Nurse (due to limited OH resources).	Ongoing documentation Audit trails	
Implement OPAS G2 software, replacing current OPAS in use.	Implementation date is planned for the 14.09.2022. This system will facilitate and streamline communication with management/ people's services and the employee, whilst maintaining confidentiality and compliance with data protection.	Acting Head Occupational Health – Amanda Lain	Occupational Health Team. Human resources' Recruitment Team Medical Staffing Managers Project management IT CIVICA (OPAS G2)	As with any implementation we anticipate that the transition period may take some time. We aim to be "optimised" by 6 to 12 months post-implementation.	

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
	As with any software transition, there are some potential issues that we are currently planning for. For example, we have a plan for "working paper based" for at least 3 weeks whilst the information is being merged. OPAS G2 will interact with TRAC. OPAS G2 will allow an easier audit trail, will have specific health surveillance programs, will allow an update on pre-commencement assessments and questionnaires, amongst other benefits not only for OH but for all MTW.				
Reporting of Sharps/Splashes/Blood Borne Viruses incidents to became "online" via a link to OPAS G2	OPAS G2 implementation date is the 14.09.2022. System is currently being tested and configurated to support an "online" reporting of	Acting Head Occupational Health – Amanda Lain	Occupational Health Nurses Administrative staff	Audit trail	

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
	the incident. Where information about "immediate actions" will be available immediately to the employee affected.				
Improve Occupational Health staffing levels. The aim is to be adequately staffed to provide OH service/functions to all MTW in a timely, safe and efficient.	New OH clinic nurse started in April 2022. 2 qualified OH nurses are joining the team in August and September 2022. There is ongoing in-house training and a program of induction for all roles. OH is currently under a re-design plan therefore further changes to staffing requirements may arise but nothing is decided so far. New trained OH nurses are being recruited. OH currently work with bank and agency trained nurses to ensure service needs are adequality	Acting Head Occupational Health – Amanda Lain	Occupational Health Nurses Administrative staff	Staff recruitment and retention levels.	

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
	covered.				
Provide equal access as far as practical with regards to location, shift patterns and the availability of trained staff. We work cross site; however, we have limited facilities – currently 4 consultation rooms available at each site, but these are shared with psychology and KMPT. Space remains a challenge.	New trained OH nurses are being recruited. OH currently work with bank and agency trained nurses to ensure service needs are adequality covered. Most of management referral appointments are done on the telephone due to limited space and people's resources.	Acting Head Occupational Health – Amanda Lain	Occupational Health Nurses Administrative staff MTW "facilities"/space planners	Facilities /Space planners	

Appendix A

2022/23 Training update – What does the Board need to know?

1. Health and safety

1.1. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached – members of the board have both collective and individual responsibility for health and safety.

1.2. Addressing health and safety offers significant opportunities, including:

1.2.1. Reduced costs and reduced risks – employee absence and turnover rates are lower, accidents are fewer, the threat of legal action is lessened;

1.2.2. Increased productivity – employees are healthier, happier and better motivated

2. Legal cases in 2021/22

2.1. The table below summarises some of the relevant prosecutions that took place in 2021/22:

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
June 2021	Essex Partnership University NHS Foundation Trust	November 2004 to March 2015	The Trust failed to effectively manage recognised risks from potential fixed ligature points in its inpatient wards. Eleven patients died in the timeframe.	£1.5m fine + £86k costs	HSE	This is a mental health trust, so the ligature risk is greater, however this reinforces the need to manage the ligature risk effectively in all healthcare settings.
June 2021	East Kent Hospitals University NHS	November 2017	Baby born in very poor condition. Resuscitation attempts were mishandled	£761,170 fine and costs	CQC	Multiple findings of neglect including lengthy hypoxia and failure to

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
	Foundation Trust		and not intubated for 25 minutes. Died seven days later.			have a consultant present and to call for consultant earlier during resuscitation.
October 2021	Aster Healthcare Ltd	February 2015	Resident scalded in hot bath and subsequently died.	£1.04m fine and costs	HSE	Corporate Manslaughter conviction. The need to manage scalding risk.
November 2021	Morecambe Bay NHS Foundation Trust	April 2021	Not all persons had received adequate 'face fit' testing to ensure that the RPE was sealed to the wearer's face. A radiographer died of COVID in April 2021.	Formal written advice	HSE	Ensure adequate fit testing in place. No action beyond formal written advice by the HSE.
November 2021	Dudley Group NHS Foundation Trust	March 2018	Two patients died, one from multiple organ failure caused by severe infection and the other caused by a build-up of fluid on her brain and sepsis. The Dudley Group pleaded guilty to failing to provide safe care and treatment.	£2.5m fine	CQC	The Dudley Group had failed to address known safety failings which the CQC repeatedly raised with the trust in the months before the deaths.
January 2022	BUPA Care Services	March 2016	A 69-year-old wheelchair user at the home, died in a fire	£937,500 fine plus £104,000	London Fire Brigade	Smoking risk assessment did not

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
			whilst smoking unsupervised in a shelter in the garden of the home.	costs (UK highest ever fine for fire safety breaches)		assess his use of emollient creams, which can be flammable if allowed to build up on skin, clothing or bedding.
March 2022	United Lincolnshire Hospitals NHS Trust	March 2019	Patient fainted and fell unsupervised from a commode. Due to exposed hot water pipes and surfaces in patient rooms, she suffered avoidable burns after her fall	£100k fine and £11k costs	CQC	Failure to provide and maintain a safe environment.

The examples given mostly relate to other NHS Trust though, where notable, cases from health and social care are given. The level of fines associated with prosecutions initiated by the CQC has increased.

3. Bow Tie Analysis

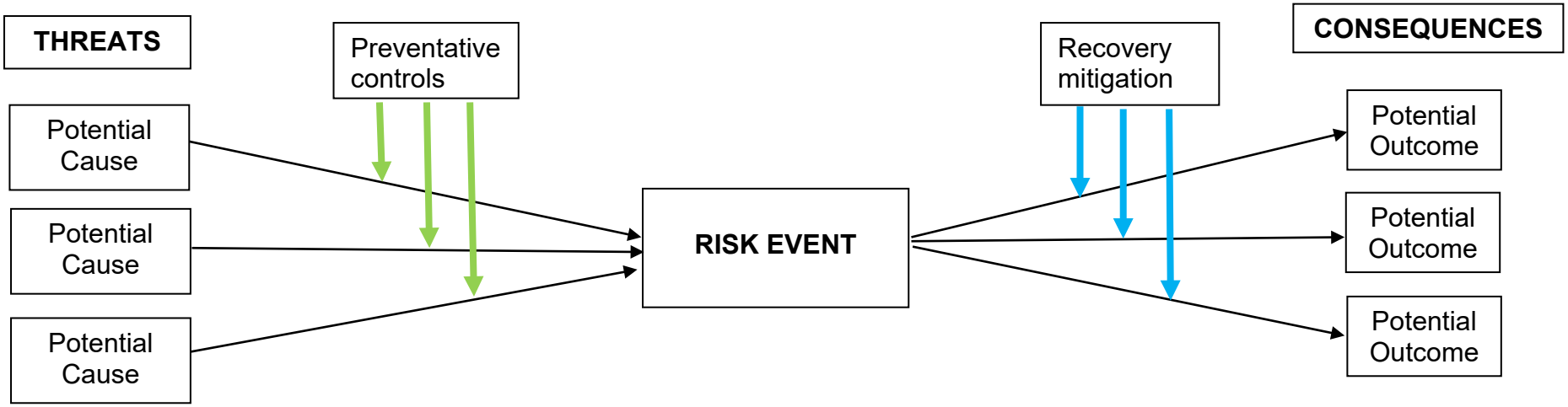
When describing risks on the Trust risk register there can be the tendency for the cause or effect of the risk to be outlined as the main issue, rather than the risk itself. For example, a piece of equipment may have gone past its recommended lifecycle or be about to do so. The causes of this may be many – a lack of planning, insufficient resources or availability of replacement. The effects would similarly be varied – there could be a reduction in the support that can be provided by the manufacturer, increasing the risk of breakdown and impacting on patient care and service delivery.

If the focus of the risk description is on the cause then the controls could skew toward preventative measures such as an asset replacement programme, ensuring sufficient budget and resources are in place to replace the equipment and have it operational before the old equipment becomes obsolete.

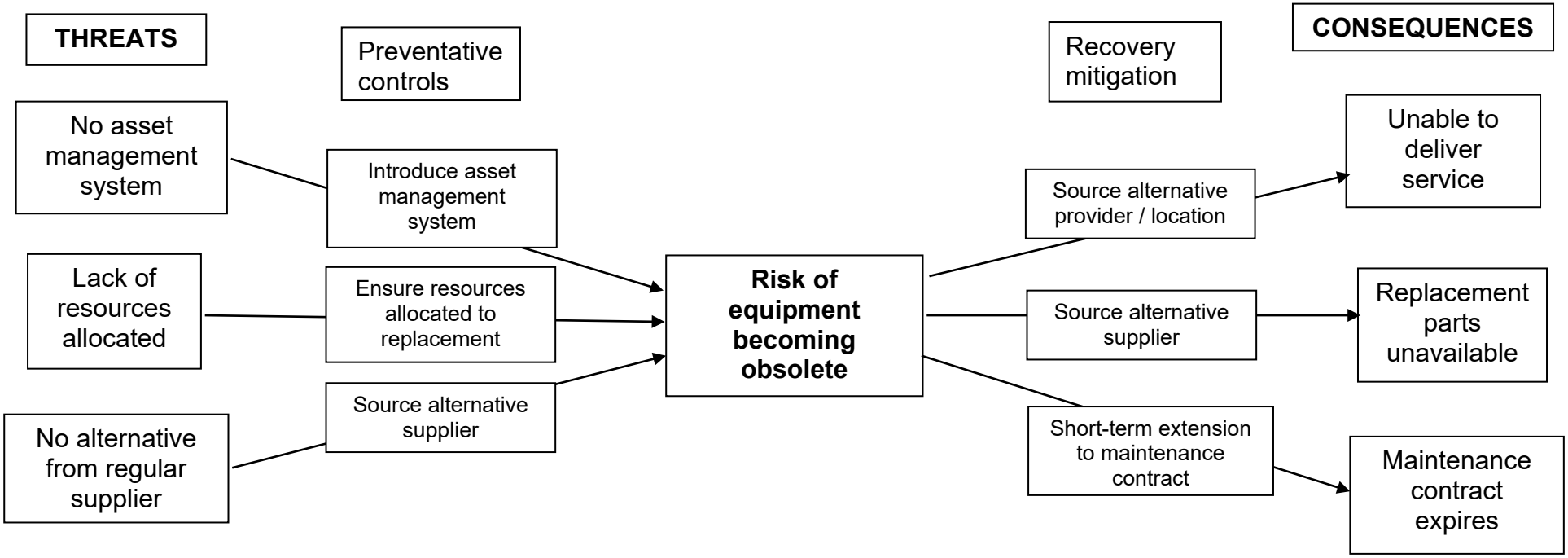
Were the description to be more concerned with the effects then the controls could be more response and recovery focused. For example, having an alternative sourcing replacement parts and repairs from different sources or extending the service contract.

While proactive and preventative controls are preferable, they may not always be realistic and cover all foreseeable eventualities, so looking at both sides is important in order for suitable and sufficient control and mitigation to be place. This is where Bow Tie Analysis can be a useful tool. Not only will it help the risk be described more accurately, it will also help to ensure that cause and effect are considered along with the associated controls.

Here is the general structure, which resembles a bow tie:



So, for the example given:



Moving forward, an introduction Bow Tie Analysis will be included in the training risk leads receive and will be highlighted in consultations and communications regarding risk. This should help to make the risk register a more effective tool in management risk rather than documenting potential problems (threats) or outcomes that have already occurred (consequences).

4. Fire Safety update

4.1. Overview of planned works and improvements 2022/23.

4.1.1. Works have already begun on upgrade the fire detection system at Maidstone Hospital. This includes the increase in the number of fire alarm panels to futureproof the system's capacity for forthcoming expansion and alterations to the hospital.

4.1.2. In addition, all smoke and heat detectors will be replaced as they have reached and, in some cases, exceeded their 10-year lifecycle. Fire system cabling is also being replaced at the same time to improve the efficiency of the fire detection system.

4.1.3. Following the completion of a competent contractor survey we have identified deficiencies in the fire stopping capability of the hospital and many defects to fire doors. Improvement works to fire doors will be carried out throughout the year and fire stopping will now be compulsory for any future project involving building a cabling works.

4.1.4. To address the fire stopping issues planned project works will include reparation of any fire stopping identified within the area in which works are taking place.

4.2. The Head of Fire and Safety will formulate a 10-year plan highlighting improvement works required year on year to prevent the significant unbudgeted investment that was required in 2021/22 to address fire safety issues. The plan will identify works required and in association with Senseco, our fire system maintainer, will include estimated cost which can then be included within the annual hospital maintenance budget.

5. Moving and handling update

5.1. A review of equipment and processes currently in place is being undertaken for staff that carry out higher risk inanimate load moving and handling in Estates and Facilities. There has been an increase in Datix reports for these staff so practical training is being developed to try and reduce the injuries and incidents. This would also aim to reduce the damage to fire doors and demonstrate correct techniques for pushing and pulling equipment as well as addressing concerns about number of staff for certain task, equipment, safe moving and handling techniques and the associated risks.

5.2. Education and support around the movement of gas cylinders and safety within the manifolds is being developed for relevant staff. The Moving and Handling Advisor is working with Estates and Facilities to develop a generic safe system of work/risk assessment for anyone who uses the cylinders within their roles. This would also cover the storage and movement within wards with clinical staff as well. The Maintenance Workshop Manager is already sourcing train the trainer courses for staff to train others on the safe use of the cylinders in general. The Moving and Handling Advisor will be supporting this.

5.3. Information/guidance for all staff on the equipment that the Trust has and also how to assess appropriately patients that have additional/complex needs. The Moving

and Handling Advisor has been looking at the pathways/guidance that needs to be in place with information on how to access equipment and support. Audits are being undertaken to determine whether patients are being assessed properly and the most appropriate equipment is being used so that staff can be supported and educated.

5.4. Following a review of the age of the moving and handling equipment, a lot of the hoists are past the manufacturing recommendations. In some areas they are not used a lot, and in other ward areas they wait for the hoists to be condemned before ordering new ones. In addition, the pandemic has meant that equipment can't be moved from green to red areas and so wards need more equipment.

5.5. Work is being developed to look at meeting each department's needs within the Trust. The development of more practical/bespoke training has been started for:

- Estates/Facilities
- Maternity
- Paediatric
- OT/Physio
- Oncology
- Outpatient areas

Development of a more bespoke plan would be conjunction with the roll out of Link assessors.

NHS Maidstone and Tunbridge Wells NHS Trust

Ratification of the revised Health & Safety Policy and Procedure — **Risk and Compliance Manager**

The Reservation of Powers and Scheme of Delegation reserves the ratification (i.e. final authorisation for use within the Trust) of a small number of policy documents to the Trust Board. One such document is the "Health & Safety Policy and Procedure".

The "Health & Safety Policy and Procedure" is due for its routine review, and has been duly reviewed/revised, consulted and approved (by the Health and Safety Committee). For policies that are ratified by the Trust Board, the Policy Ratification Committee (PRC) undertakes a review, and considers whether to recommend that the Board ratifies the document. That PRC review took place on 16/09/22 and the policy and its Appendices are now submitted for ratification

The names and contact numbers for Trust staff within Appendix 5 "key contacts" have been redacted for the purpose of the submission to the Trust Board; however, are available on the Trust's Intranet for Trust staff and will be available within the final ratified version upon upload to the Trust's Q-Pulse policy database system.

Appendix 7 "Trust committee structure chart" is primarily linked to the Trust's "Standing Orders" (which were ratified at the 'Part 1' Trust Board meeting in March 2022) and therefore does not require ratification as part of the "Health & Safety Policy and Procedure".

Which Committees have reviewed the information prior to Board submission?

- Health and Safety Committee, 01/09/22
- Policy Ratification Committee, 16/09/22

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

Ratification (i.e. final authorisation for use within the Trust).of the revised Health & Safety Policy and Procedure

[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

Health and safety policy and procedure

Target audience:	All Trust staff
Author:	Risk and Compliance Manager **Contact details:** rob.parsons@nhs.net
Other contributors:	Head of Fire and Safety Deputy Head of Fire and Safety
Owner:	Chief Operating Officer
Division:	Corporate
Directorate:	Trust Management
Specialty:	Risk
Supersedes:	Health and safety policy and procedure (Version 12.0; September 2018)
Policy administrator:	Corporate Governance Assistant
Approved by:	Health and Safety Committee, 1st September 2022
Recommended for ratification by:	Policy Ratification Committee, 16th September 2022
Ratified by:	The Trust Board, 29th September 2022
Review date:	September, 2026

This policy has been written for implementation during periods of standard functioning within the Trust. Outside of those periods (such as major incidents or national emergencies) other 'emergency' policies may be written to supersede or run alongside this policy.

Document history

Requirement for document:	• To state the Trust's and management commitment to health and safety • To set out the organisational health and safety management structure • To identify and indicate health and safety responsibilities • To meet Health and Safety at Work etc. Act 1974 Section 2(3) duties • To meet the NHS Staff Council Workplace Health and Safety Standards
Cross references (external):	1. Health and Safety at Work etc. Act 1974. Available at: www.legislation.gov.uk/ukpga/1974/37/contents 2. Management of Health and Safety at Work Regulations 1999. Available at: www.legislation.gov.uk/uksi/1999/3242/contents/made 3. Safety Representatives and Safety Committees Regulations 1977. Available at: www.legislation.gov.uk/uksi/1977/500/contents/made 4. Health and Safety (Consultation with Employees) Regulations 1996. Available at: www.legislation.gov.uk/uksi/1996/1513/contents/made 5. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Available at: www.legislation.gov.uk/uksi/2013/1471/contents/made 6. Provision and Use of Work Equipment Regulations (PUWER) 1998. Available at: www.legislation.gov.uk/uksi/1998/2306/contents/made 7. Health and Safety Executive (HSE) (2013) *Leading health and safety at work,* INDG417, HSE. 8. Health, Safety and Wellbeing Partnership Group (2013) *Workplace health and safety standards*, The NHS Staff Council.
Associated documents (internal):	• Artificial optical radiation safety policy and procedure [RWF-OPPPCS-NC-CG15] • Bomb and suspect package policy and procedure [RWF-OPPPCS-NC-EST1] • Central alerting system policy and procedure (CAS) [RWF-OPPPCS-NC-CG24] • Closed circuit television policy and procedure [CCTV] [RWF-OPPPCS-NC-FH2] • Control of Substances Hazardous to Health (COSHH) policy and procedure [RWF-OPPPCS-NC-CG16] • Display screen equipment policy and procedure [RWF-OPPPCS-NC-CG17] • Environmental disinfection policy and procedure [RWF-OPPPCSS-C-PATH11] • Estates and facilities management policy [RWF-ESF-GEN-POL-1] • Fire safety policy and procedure [RWF-OPPPCS-NC-CG4] • First-aid in the workplace policy and procedure [RWF-OPPPCS-NC-CG41] • Hand hygiene policy and procedure [RWF-OPPPCSS-C-PATH13] • Incident management policy and procedure [RWF-OPPPCS-NC-CG22]

	• Infection prevention and control policy [RWF-OPPPCSS-C-PATH15] • Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) policy and procedure [RWF-OPPPCSS-C-RAD1] • Ionising radiation safety policy and procedure [RWF-OPPPCS-NC-CG18] • Learning and development policy and procedure [RWF-OPPPCS-NC-WF20] • Lone worker policy and procedure [RWF-OPPPCS-NC-FH1] • Major incident plan [RWF-OPPP-CS-NC1] • Management & prevention of sharps/splash injuries policy and procedure (incorporating blood-borne virus exposure) [RWF-OPPPCS-C-WF5] • Management of individuals with suspected or confirmed latex allergy policy and procedure [RWF-OPPPCS-NC-CG19] • Management of legal claims policy and procedure [RWF-OPPPCS-NC-CG30] • Medical devices policy and procedure [RWF-OPPPCS-NC-EST2] • Medical gases and pipeline system policy and procedure [RWF-OPPPCS-C-EST1] • Medicines policy and procedure [RWF-OPPPCSS-C-PHAR1] • Noise and vibration at work policy and procedure [RWF-OPPPCS-NC-CG42] • People policies manual [RWF-HUM-HUM-POL-4]: Alcohol and substance misuse • People policies manual [RWF-HUM-HUM-POL-4]: Civility, dignity and respect (including bullying and harassment) • People policies manual [RWF-HUM-HUM-POL-4]: Disciplinary • People policies manual [RWF-HUM-HUM-POL-4]: Freedom to speak up: raising concerns • People policies manual [RWF-HUM-HUM-POL-4]: Induction and mandatory training • People policies manual [RWF-HUM-HUM-POL-4]: Occupational Health • People policies manual [RWF-HUM-HUM-POL-4]: Partnership agreement Trade Union recognition • People policies manual [RWF-HUM-HUM-POL-4]: Stress management • People policies manual [RWF-HUM-HUM-POL-4]: Supporting employees • Policy and procedure for management and prevention of non-patient slips, trips and falls [RWF-COR-COR-POL-1] • Policy and procedure for management of concerns and complaints [RWF-OPPPCS-NC-CG31] • Policy and procedure for the control of contractors [RWF-OPPPCS-NC-EST5] • Policy and procedure on the management of the electrical infrastructure safety [RWF-OPPPCS-NC-EST6]

	• Policy and procedure for the management and prevention of slips, trips and falls for adult patients [RWF-OPPPCS-NC-CG20] • Policy and procedure for the management of violence and aggression [RWF-OPPPCS-NC-FH8] • Policy and procedure for the management of water hygiene [RWF-OPPPCS-NC-EST9] • Policy and procedure for moving and handling of patients and loads [RWF-OPPPCS-NC-FH11] • Policy and procedure on being open / duty of candour [RWF-OPPPCS-NC-CG2] • Professional registration policy and procedure [RWF-OPPPCS-NC-WF56] • Research adverse event and safety reporting policy and procedure [RWF-OPPPCS-NC-CG36] • Research misconduct and fraud policy and procedure [RWF-OPPPCS-NC-CG37] • Resilience policy and procedures [RWF-OPPCS-NC-TM25] • Resuscitation policy / do not attempt cardiopulmonary resuscitation policy and procedures [RWF-OPPPPS-C-TIO3] • Risk assessment policy and procedure [RWF-OPPPCS-NC-CG6] • Risk management policy and procedure [RWF-OPPPCS-NC-CG13] • Safeguarding adults at risk policy and procedure [RWF-OPPPCS-C-NUR5] • Safeguarding children policy and procedure [RWF-OPPPCS-C-NUR6] • Safety of electrical appliance policy (SEAP) and procedure [RWF-OPPPCS-NC-EST8] • Security policy and procedure [RWF-OPPPCS-NC-FH3] • Serious incidents (SI) policy and procedure [RWF-OPPPCS-NC-CG23] • Smoke-free policy and procedure [RWF-OPPCS-NC-TM37]

Keywords:	Environment	H&S	Risk
	Regulations	Safety	

Version control:		
Issue:	**Description of changes:**	**Date:**
12.0	Reviewed - Formatted into new policy and procedure template. Structural changes made and repetition removed.	July 2018
13.0	Reviewed – Associated documents updated in 'Associated documents' to reflect new, revised and removed documents and the People Policies Manual. Changes in committee reporting structure and organisational structure reflected in duties and other sections. Removal of previous Appendix 4 as it was impractical to maintain. Addition of new Appendix 4 – Statement of intent.	September 2022

Summary for

Health and safety policy and procedure

Maidstone and Tunbridge Wells NHS Trust (MTW or the Trust) recognises its responsibilities under the Health and Safety at Work etc. Act 1974 (HSWA 1974) and all associated legislation enabled under the Act. The Trust is committed to safeguarding the health and safety of its employees, patients, visitors, volunteers, contractors and others who are affected by its activities. The Trust seeks to provide safe and healthy working conditions and to enlist the active support of all staff in achieving this.

Managers, employees and other stakeholders will work together to make their environment as safe as is reasonably practicable both for themselves and others. The Trust expects all managers and staff to be involved in the development and implementation of its health and safety policies and procedures through active joint consultation.

The use of risk assessment to identify, assess and manage all risks arising from the Trust's undertakings is the key to health and safety management within the Trust. Where unforeseen risks result in adverse incidents these will be investigated and action taken to significantly reduce the likelihood of recurrence.

The Trust will ensure that adequate resources are allocated for health and safety as required; identified from approved Trust policies and fully considered risk assessments.

Contents

1.0 Introduction, purpose and scope

Maidstone and Tunbridge Wells NHS Trust (MTW or the Trust) recognises its responsibilities under the Health and Safety at Work etc. Act 1974 (HSWA) and all associated legislation enabled under the act. The Trust is committed to safeguarding the health and safety of its employees, patients, visitors, volunteers, contractors and others who are affected by its activities.

This policy is prepared in accordance with Section 2(3) of HSWA 1974 that employers with five or more employees must produce a written health and safety policy. It is the policy of the Trust to provide safe and healthy working conditions and to enlist the active support of all staff in achieving this.

It is the duty of all staff to ensure strict compliance with this policy and other associated policies and procedures. Failure to do so could lead to disciplinary action.

This policy is supported by many other specific policies and procedures. Many of the Trust's health and safety arrangements are encompassed within these documents. The relevant documents are listed in the associated documents section.

2.0 Definitions / glossary

Term	Definition
Competent Persons	The Trust employs adequate numbers of Competent Persons to assist in undertaking the measures necessary to comply with health and safety legislation. These are individuals with specialist skills, knowledge and qualifications that are assessed by external bodies such as the 'Institute for Occupational Safety and Health' (IOSH).
Directorate Risk Leads	Each directorate has a nominated Directorate Risk Lead. The Risk Lead has delegated responsibility for health, safety and welfare on behalf of their directorate.
Kent and East Sussex Weald Hospital Limited (KESWHL)	KESWHL is a special purpose vehicle that was formed to enter into a private finance initiative (PFI) concession contract with the Trust to design, build, finance and operate Tunbridge Wells Hospital. The contract was signed in March 2008 and will run until 2042. KESWHL has no direct employees but sub-contracts to Mitie for the provision of certain services at Tunbridge Wells Hospital (see above)
Mitie	A facility management company contracted by Kent and East Sussex Weald Hospital Limited (KESWHL) at Tunbridge Wells Hospital. They are responsible for: • Building maintenance and the life cycle of the estate • Grounds and gardens • Utilities • Fire detection systems and alarms
Undertakings	The activities carried out by the Trust in order to fulfil its function.

3.0 Duties

Person/Group	Duties
Trust Board	• Ensures that all relevant statutory instruments are complied with and that appropriate arrangements are in place for resourcing and managing risk. • Receives a Health and Safety Annual Report. • Discusses and modify the Key Performance Indicators (KPIs), targets and programme outlined in the Health and Safety Annual Report as required. • Delegates the monitoring and implementation of the programme to the Chief Operating Officer and the Health and Safety Committee. • Ratifies the 'Health and safety policy and procedure', thereby demonstrating top level commitment to health and safety within the Trust.
Chief Executive	• Has overall accountability for the management of health and safety within the Trust. • Ensures that effective policies and procedures are developed and implemented and that the performance of these is monitored and evaluated against statutory obligations and Trust objectives. • Signs the 'Health and safety statement of intent' (see Appendix 4) to demonstrate top-level commitment.
Quality Committee	• Oversees the work of the Health and Safety Committee. • Receives reports from the Health and Safety Committee. • Assists in the management of health and safety risks that cannot be managed at divisional and directorate level, including accepting risk on behalf of the Trust. • Makes recommendations to the Trust Board, as required.
Health and Safety Committee	• Acts as the Trust's health and safety committee as required under the HSWA 1974 and Safety Representatives and Safety Committees Regulations 1977. • Acts as the key committee for health and safety issues that are not covered by other specialist committees. • Makes recommendations to the Trust Board and/or the Chief Executive and/or the Quality Committee on matters relating to the health and safety of the Trust's employees or those affected by the Trust's activities. • Monitors the annual health and safety KPIs and targets. • Implements the annual health and safety programme. • Manages and monitors a health and safety action plan. • Manages and monitors the implementation of this policy and other key health and safety-related policies, procedures and documentation. • Provides reports to the Quality Committee. • Seeks assurance from divisions and directorates that they are managing their health and safety risks.

Person/Group	Duties
	• Audits and monitors directorate risk assessments and risk assessment programmes. • Monitors the outcomes from workplace audits. • Monitors suitable health and safety statistics to detect trends and plan programmes to reduce adverse incidents and harm to staff and patients. For terms of reference of the Health and Safety Committee see **Appendix 6**
Chief Operating Officer	• Responsible for the day-to-day organisation and implementation of health and safety. • Ensures that sufficient resources are available so that all staff are provided with appropriate and effective information, instruction, supervision, training and where necessary supervision to enable them to fulfil their health and safety responsibilities within the workplace. • Ensures the Trust has suitable and sufficient arrangements in place for the management of health and safety including the appointment of sufficient Competent Persons to assist the Trust in complying with legal requirements.
Chief People Officer	• Responsible for ensuring the provision of Occupational Health Services. • Ensure processes are in place to check the competence of potential new employees, including the checking of qualifications and registration. • Ensure records of accredited staff representatives from unions and staff-side organisations are maintained. • Encourage the election and development of staff representatives. • Ensure that job descriptions contain health and safety responsibilities, both statutory and job specific, and that these job descriptions are reviewed and amended as required.
Director of Estates	• Responsible for compliance with relevant health and safety statutory requirements with regards to the buildings, traffic routes, environment and infrastructure. This also includes responsibility for the management of contractors. • To be the 'Trust Representative' and be responsible for the coordination of the Project Agreement between the Trust and the Kent and East Sussex Weald Hospital Limited (KESWHL) to ensure an environment that is safe for the Tunbridge Wells Hospital at Pembury. • As 'Trust Representative', and as a member of the 'Programme Liaison Committee' and the Trust 'Health and Safety Committee', the Director of Estates coordinates the two organisation's health and safety arrangements.
Deputy Chief Operating Officer	• Responsible for the Facilities functions within the Trust including security and the management of violence and aggression on all Trust premises.

Person/Group	Duties
Director of Operational Nursing	• Chairs the Health and Safety Committee and reports to the Quality Committee on relevant matters.
Chiefs of Service / Directors / Clinical Directors	• Each is responsible for the overall management of health and safety within their Division / Directorate. • Ensure systems are in place and resources available to allow staff at all levels to participate in managing health and safety effectively. • Review Divisional / Directorate health and safety performance. • Ensure work-related risks faced by staff and others within their Division / Directorate are suitably assessed. • Ensure effective arrangements are in place for planning, implementing, monitoring and reviewing preventative and protective measures. • Ensure staff within the Division / Directorate are provided with understandable and relevant information on the risks they face and the preventative and protective control measures in place that effectively manage those identified risks. • Ensure that all wards/departments within have a suitable number of competent staff to manage health and safety and risk including undertaking risk assessments, adverse incident reporting and investigation, workplace health and safety inspections and providing reports to Directorate meetings and other relevant committees.
Directorate Risk Leads	• Have delegated responsibility for health, safety and welfare on behalf of their senior managers and directors. • Develop and implement individual policies in line with the Trust's health and safety objectives to ensure compliance within all workplaces under their control. • Monitor and report on Divisional and Directorate health and safety performance to relevant committees. • Ensure health and safety training is relevant and appropriate to the roles and responsibilities of staff within the Directorate and monitor compliance. • Ensure risk assessments within the Directorate are carried out according to the 'Risk assessment policy and procedure'. • Ensure health and safety-related recommendations for remedial action are undertaken as soon as is practicable. • Attend the Health and Safety Committee or nominate an appropriate and suitably briefed deputy.
Departmental / Ward Managers	• Responsible for the day-to-day implementation of Trust policy and are empowered to take all reasonable measures to ensure that all workplaces and work practices within their areas of responsibility are safe, healthy and meet legal requirements. • In conjunction with local risk assessor(s), design and implement safe systems of work for any tasks that pose a significant risk to health and safety.

Person/Group	Duties
	• Consult with staff as appropriate prior to incorporating local written policies and procedures. • Ensure all staff receive training in the use of appropriate control measures prior to undertaking any task. • Ensure identified staff attend the Occupational Health Department for health surveillance as required. • Ensure each individual's health and safety responsibilities, both statutory and job specific, are contained in their written job description and that these are reviewed and amended as required. • Ensure that all staff are appraised annually and that the appraisal includes a review of compliance with health and safety policy and practice. • Allow any accredited staff representatives from unions and staff-side organisations sufficient time to develop and carry out their function. • Ensure that appropriate health and safety signage and equipment within the local work environment is in place, appropriate and within date. • Ensure all staff are provided with suitable and sufficient information, instruction, supervision and training on health and safety issues relevant to their workplace as identified by risk assessment. • Ensure all adverse incidents are reported, investigated and action taken to reduce/ eliminate recurrence in accordance with the 'Incident management policy and procedure'. • Ensure all equipment, plant and machinery is regularly serviced, maintained and records kept. • Report defects and faults in buildings, grounds, equipment and machinery. • Ensure remedial action is carried out effectively and in accordance with Trust guidelines. • Report defects and faults in electrical / mechanical medical equipment to local Electro-medical Engineering (EME) department telephone number 01622 223151 for all sites. • Ensure that systematic and documented safety inspections of the workplace and work practices take place at least every three months. • Ensure re-assessments are carried out following any significant changes. • Have a suitable number of competent staff to undertake workplace health and safety audits, providing reports to Directorate Meetings, via the Directorate Risk Lead. • If managing teams or individuals who are unable to use or access computers, managers must provide Trust-wide communications in an appropriate format. • Consult and/or meet with staff, their representatives and other

Person/Group	Duties
	relevant parties for the discussion and resolution of local risk issues. • Where a manager engages the services of non-Trust personnel to undertake business on behalf of the Trust, both on and away from Trust premises, they shall consult with those persons before work begins to ensure that risks to all persons are identified, assessed and controlled. • Ensure that staff, contractors and other visitors are given an appropriate health and safety induction according to relevant Trust policy and procedure.
Competent Persons	• Promote and provide advice and guidance on health, safety and risk management. • Undertake Trust-wide risk assessments in key areas of hazard and risk. From these they will develop policies and procedures, including safe systems of work. • Monitor performance and provide reports to managers and committees. • Identify new legislation and guidance and review related policies and procedures. • Serve on Trust committees and advise on risk issues. • Act as key contacts with enforcing officers from regulatory bodies.
Risk and Compliance Manager and Deputy Head of Fire and Safety	• Give advice and support all staff in the management of health and safety. • Ensure that all key staff and managers have access to sufficient health and safety information and training to undertake their duties. • Ensure health and safety training delivered as part of the statutory and mandatory programme is relevant and appropriate to the roles and responsibilities of staff. • Carry out risk management performance audits against KPIs.
Occupational Health Department	• Provide health assessment, personal and environmental monitoring and health surveillance where required by statute, risk assessment and organisational need.
Learning and Development Department	• Responsible for the planned delivery of induction training. • Responsible for the training needs analysis and the planned delivery of mandatory and statutory update training.
All staff	• Take care of their own health and safety and that of other employees, patients, visitors and non-employees who may be affected by their acts or omissions. • Comply with all health and safety regulations and notices issued by an enforcement agency. • To co-operate with the Trust so far as is necessary to enable compliance with all health and safety regulations and notices issued by an enforcement agency. • Comply with safe systems of work and recognised procedures

Person/Group	Duties
	as identified by risk assessment. • Not interfere with, misuse or intentionally disregard the appropriate use of any equipment, item or notice provided by the Trust in the interest of health and safety. • Bring to the attention of their managers any shortcomings they are aware of in respect of health and safety policies, procedures, practice, guidelines, safe systems of work, training and supervision. • Report any adverse incident of which they are aware to their line manager or person in charge of the workplace at the time of the incident and complete an incident report form in accordance with the 'Incident management policy and procedure'. • Participate fully in any training programme identified by their manager. • Report any health issue that may inhibit the individual's ability to carry out the full range of duties in a safe manner. These requirements also apply to contractors working for and within the Trust. Employees of KESWHL and Mitie are also expected comply with Trust policy, procedures and safe systems of work.

4.0 Training and competency requirements

The provision of information, instruction, training and supervision is a general duty of employers under HSWA 1974.

It is a requirement that employees, including volunteers, receive appropriate health and safety training which is refreshed periodically and in line with new and changing risk.

Training for those who use and/or supervise the use of work equipment is required under Provision and Use of Work Equipment Regulations (PUWER) 1998 (PUWER). This also includes non-employees if they need to use Trust equipment.

Corporate and local induction is an important means of safeguarding the health and safety of those whose lack of familiarity with the workplace may place them at greater risk. For more information see 'People policies manual [RWF-HUM-HUM-POL-4]: Induction and mandatory training'.

Statutory and mandatory training includes a general health and safety course. This is carried out online, with a requirement to be completed at least every three years. For more information see the 'People policies manual [RWF-HUM-HUM-POL-4]: Induction and mandatory training'.

Line managers must ensure that time be made available for statutory health and safety (including online training) to take place during normal working hours.

Competent Persons must have the specialist skills, knowledge and qualifications to undertake their duties in relation to health and safety. In order to maintain their skills, knowledge and expertise, which may be a requirement for external bodies assessment of competence, the Trust will support their continuing professional development with regards to health and safety.

5.0 Procedure

5.1.1 Staff consultation processes

The Trust will consult with staff on health and safety matters directly through the Communications Department, through employee representatives and Directorate Risk Leads on the Trust's Health and Safety Committee. The Trust has also established appropriate management and staff consultative structures including the Joint Consultative Forum.

5.1.2 Staff safety representatives

The Trust acknowledges the roles of both union accredited and locally elected staff safety representatives and encourages their active participation in both the organisation and implementation of health and safety within the Trust. All recognised trade unions and professional organisations who are signed up to the Trust Partnership Agreement have a right to a place on the Health and Safety Committee, as do persons who are elected from a work group who are not represented by a trade union or professional organisation.

The Trust encourages the election and development of staff representatives and ensures that staff representatives have sufficient time for their function.

Representatives feedback issues discussed at Health and Safety Committee to their members and to the Staff-Side Chair for further discussion at the Joint Consultative Forum.

5.1.3 Direct communication

As well as communication through the union safety representatives (Staff-Side), the Trust also consults with staff directly on health and safety matters. This direct communication includes:

- Email to all staff through the Communication Department
- Cascade of information through line managers via local management meetings
- The Chief Executive's update to all staff
- MTW News
- The Pulse
- Talking Heads
- Common Operating Picture (COP)
- The Clinical Governance newsletter to all staff
- Through the Trust's intranet site
- Committee minutes and reports
- Mandatory update training
- Internal safety alerts issued by the Quality Governance Directorate
- Posters, including the statutory health and safety poster
- Health and safety statement of intent (see Section 5.1.3.1 below and Appendix 4)

For staff unable to use or access computers, their managers will ensure access to communications in an appropriate format.

5.1.3.1 Health and safety statement of intent (see Appendix 4)

This document, signed by the Chief Executive, summarises the Trust's health and safety duties and responsibilities as well as those of staff. It demonstrates top-level commitment to health and safety, is reviewed annually and copies of the statement of intent are displayed on staff noticeboards.

5.2 Hazard identification and risk assessment

The process is described in detail in the 'Risk assessment policy and procedure'.

5.2.1 Local hazard identification and risk assessment

Risk assessments should be reviewed according to the 'Risk assessment policy and procedure' which includes an annual review of the 'hazard profile checklist' for that area. This checklist lists reasonably foreseeable hazards for the general hospital environment as well as scope to expand to include other, more specific, hazards.

Managers will ensure that local health and safety inspections are undertaken at least quarterly, during which they may identify further hazards.

Adverse incident reporting and management will also identify previously unforeseen hazards.

Depending on the level of risk and associated Trust-wide policy, procedure or risk assessment, managers will:

- Where a hazard is trivial or not applicable, record this in the hazard profile checklist.
- Record how lower risk activities and processes are managed in the hazard profile checklist.
- Complete formal risk assessments for significant hazards.

The manager must share all the documentation with all relevant staff who must sign to confirm they have read and understood.

5.2.2 Trust-wide hazard identification and risk assessment

The Trust's Competent Persons identify hazards within their area of expertise. They undertake specialised risk assessments for these hazards. The results of these assessments are incorporated into policies, procedures and safe systems of work that are implemented Trust-wide. Significant assessments are added to the Risk Register. Some assessments will be appended to policies and procedures.

The Trust's Competent Persons view all adverse incidents in their areas of expertise. They sit on Trust committees so are able to identify or indicate hazards around the Trust.

Where policies, procedures or assessments exist they are hyperlinked to the hazard profile checklist to assist local managers.

5.3 Adverse incident reporting

All adverse incidents must be reported and managed in accordance with the Trust's 'Incident management policy and procedure'.

5.4 Policy and procedure

The Trust's 'undertakings' are complex and with numerous potential risks. There are a large number of risk assessments carried out at all levels of the Trust. These result in 'safe systems of work' ranging from local rules and method statements through to Trust-wide policies, procedures and guidance documents. Some policies and procedures are specifically required by the Department of Health and Social Care and its enforcing agencies and bodies.

This policy is supported by a framework of specific policies and procedures. These each undergo consultation and peer review before approval through specialist committees. Many of the Trust's health and safety arrangements are encompassed within these documents. The relevant documents are listed in the 'Associated documents' section.

5.5 Health and safety assistance

The Trust employs Competent Persons to assist it in complying with the requirements of any relevant statutory provisions, and for the provision of advice, guidance, instruction and training. The names of the staff in these roles at present are given in **Appendix 5**.

For an outline of a number of the key Competent Persons and their role in Trust risk management arrangements see the 'Risk management policy and procedure'.

Appendix 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the policy database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'. Notification of the posting is included on the intranet 'News Feed' and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy should be read in conjunction with other associated health, safety and risk management policies. These policies will form the basis of health, safety and risk management training provided for all staff at all levels.
- The implementation of this policy will be driven by that of the 'Risk management policy and procedure', which defines the organisation and arrangements for managing all risk, including health and safety.

2.0 Monitoring compliance with this document

- The Trust Board, through its review of the Health and Safety Annual Report, the Quality Committee and the Health and Safety Committee will monitor the implementation of this policy.
- Health and safety KPIs are also reported on and monitored at divisional and directorate meetings, the specialist health and safety committees and groups and the Quality Committee.
- Health and Safety KPIs are set through the 'Risk management policy and procedure', other Trust policies and by key committees. These KPIs will be monitored to measure the Trust's performance and be used as part of the directorate review process to assess compliance.
- The Risk and Compliance Manager and Deputy Head of Fire and Safety carry out risk management performance audits against KPIs. Each department and directorate will be compared as part of a benchmarking exercise across the Trust. The Trust will be compared with national figures from similar Trusts taken from HSE databases. Performance will be reported to the Health and Safety Committee. This will be part of a process of continuous improvement.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every four years.

4.0 Archiving

The policy database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

Appendix 2

CONSULTATION ON: Health and safety policy and procedure
Version no.: 13.0
Please return comments to: Risk and Compliance Manager
By date: 26/08/2022

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff must be included in all consultations:				
Corporate Governance Assistant	12/08/22 05/09/22	15/08/22 06/09/22	N Y	 Y
Senior Anti-Crime Manager (tiaa)	12/08/22	16/08/22	N	
Anti-Crime Specialist	12/08/22			
Anti-Crime Specialist	12/08/22			
Sunrise EPR Team	12/08/22			
Clinical Audit Lead	n/a			
Head of Fire and Safety	12/08/22			
Chief Pharmacist and Formulary Pharmacist	n/a			
Formulary Pharmacist	n/a			
Staff-Side Chair	12/08/22			
Complaints & PALS Manager	12/08/22			
Emergency Planning Team	12/08/22	15/08/22	N	
Head of Staff Engagement and Equality	12/08/22			
Health Records Manager	n/a			
All individuals listed on the front page	12/08/22			
Authors of other policies with a content overlap	15/08/22			
The relevant lead for the local Q-Pulse database	12/08/22			
All members of the approving committee (Health and Safety Committee)	15/08/22	01/09/22	N	
Other individuals the author believes should be consulted				
All members of the Quality Committee	12/08/22			
The following staff have given consent for their names to be included in this policy and its appendices: Rob Parsons, Miles Scott, Mark Vince, Caroline Gibson, Vinnay Bhandari, Carrie Parmenter, Tracey Martin, Mark Knight, Amanda Lain, Lesley Smith, Simon Davis, Mark Hope				

Appendix 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Health and safety policy and procedure
What are the aims of the policy?	To ensure the health and safety of employees and others
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	Respond
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	Yes. This policy and associated control measures, health and safety signage and notices may not be understood
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Minimal and justifiable. Measures are in place to assist those for whom English is not a first language.
When will you monitor and review your Equality impact assessment?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document.

Further appendices

The following appendices are published as related links to the main policy/procedure on the policy database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Health and safety statement of intent	RWF-XXX-XXXX	This policy
5	Key contacts	RWF-OWP-APP4	This policy
6	Terms of reference of the Health and Safety Committee	RWF-OWP-APP725	This policy
7	Trust committee structure chart	RWF-OWP-APP2	Standing orders [RWF-OPPCS-NC-TM23]

Health and safety statement of intent

Maidstone and Tunbridge Wells NHS Trust (the Trust) as an employer has a legal requirement and moral duty to comply with Health and Safety Law.

The Trust will ensure, so far as is reasonably practicable, the health, safety and welfare of all of its employees, patients, visitors, volunteers, contractors and others who are affected by its activities.

In line with its mission, vision and values the Trust will establish and implement a health and safety management system to manage, monitor and review the risks associated with all its premises and activities.

The health and safety management system will be regularly monitored to ensure that the Trust is achieving its objectives through its commitment to the health, safety and welfare policies and procedures.

To ensure the above, it is the policy of the Trust, so far as is reasonably practicable to:

- Maintain premises and work equipment to a standard that ensures that risks are effectively managed
- Communicate and consult with employees on all issues affecting their health and safety
- Provide adequate training for employees to enable them to work safely and effectively and to ensure they are competent and confident in the work they carry out
- Ensure the provisions of a safe place of work, with safe access
- Actively promote an open attitude to health and safety, encouraging the identification and reporting of hazards so that a safer working environment can be achieved

Under the Health and Safety at Work Act 1974, all employees at work have a legal requirement and moral duty to:

- Take reasonable care of their own safety
- Take reasonable care for the health and safety of others who may be affected by their acts or omissions
- Co-operate with the Trust, so far as is necessary, to enable any duty or requirement imposed on the Trust by any relevant statutory provisions to be performed or complied with
- Ensure that anything provided in the interests of health, safety and welfare is not interfered with or misused

The Trust is committed to the health, safety and well-being of its staff and all those affected by what it does as it strives to be an outstanding place to work.

[Insert signature here]
Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Key contacts

Risk and Compliance Manager	[redacted]	[redacted]
Fire Officer	[redacted]	[redacted]
Deputy Head of Fire and Safety	[redacted]	[redacted]
Legal Services Manager	[redacted]	[redacted]
Patient Safety Manager	[redacted]	[redacted]
Moving and Handling Advisor	[redacted]	[redacted]
Radiation Protection Adviser	[redacted]	[redacted]
Occupational Health Lead Nurse	[redacted]	[redacted]
Nurse Consultant Infection Prevention and Control	[redacted]	[redacted]
Operational Security Manager	[redacted]	[redacted]
Energy and Sustainability	[redacted]	[redacted]
Dangerous Goods Safety Advisor	[redacted]	[redacted]
Estates Department Help line - Maidstone		[redacted]
Mitie helpline – Tunbridge Wells		[redacted]
KESWHL project agreement 'Trust Representative'	[redacted]	[redacted]
Electro Mechanical Engineering Services (EME) Help line		[redacted]
Police		Via main switchboard
Fire		Via main switchboard

Maidstone and Tunbridge Wells NHS Trust

Terms of Reference for the Trust Health and Safety Committee

1 Constitution

The Health and Safety Committee is constituted at the request of the Quality Committee to ensure the implementation and management within the Trust of the operational aspects of health, safety and risk.

The aim of the Trust Health and Safety Committee shall be to promote the closest co-operation and understanding between management and staff in order to secure an acceptable standard of health and safety and to enable the Trust to meet its duties under the Health and Safety at Work etc. Act 1974 and regulations enabled under the Act.

The Trust Health and Safety Committee may make recommendations to the Chief Executive or to the Quality Committee on any subject which it considers appropriate to the health and safety of the Trust's employees or to persons who may be affected by the work activities of such employees.

2 Membership

2.1 Management membership.

- Director of Operational Nursing (Chair)
- Risk and Compliance Manager (Vice-chair)
- Director of Quality Governance
- Head of Fire and Safety
- Operational Security Manager
- Radiation Protection Advisor (RPA)
- Occupational Health Manager
- Nurse Consultant for Infection Prevention and Control
- Deputy Head of Fire and Safety
- Moving and Handling Advisor

Managers can send a deputy to the meeting. The initials of the deputy will be recorded in the attendance report and be recorded as present.

2.2 'Staff-Side' Membership

- Chair of Joint Consultative Forum
- All recognised 'Staff-Side' Union Representatives

Staff side representatives have functions rather than duties under health and safety law. The Staff-Side chair or delegated deputy must attend wherever possible Other 'Staff-Side' Union Representatives can attend up to reasonable numbers.

2.3 Directorate Risk Leads (one from each Division)

- Medicines and Emergency Care
- Cancer Services
- Surgery
- Core Clinical Services
- Women's, Children's and Sexual Health Services
- Non-clinical Risk Leads where not covered by a co-opted member, to include a Corporate representative

At least one Directorate Risk Lead or nominated deputy is required to attend on behalf of each division. It is for the Division's Risk Leads to determine how to present their assurance reports to ensure all Directorates are covered appropriately. The initials of any deputy will be recorded in the attendance report and be recorded as present.

2.4 Co-opted members as required by the committee to provide reports and to discuss specific issues.

- General Manager Facilities (Waste Group)
- Chair of the Slips, Trips and Falls Group
- Chair of Pathology Health and Safety Committee
- Electro-Medical Engineering (EME) Services and Technical Services Manager (Medical Devices Committee)
- Emergency Planning Officer (EPO) (Resilience Committee)
- Other Trust Officers and specialists as required

3 Quorum

1 Chair or Vice-chair
3 Managers
1 'Staff-Side' member or, where due to organisational pressures attendance is not possible, an agreement in principle on the meeting content
Directorate Risk Leads (or a deputy) from at least four Divisions

4 Attendance

Attendance level required by Managers – four out of six meetings.
Attendance level required by Directorate Representatives
– all meetings (may send a nominated deputy).
Attendance level required by co-opted members – two out of six meetings.

Managers, Leads and Representatives can send a deputy to the meeting. The initials of the deputy will be recorded in the attendance report and be recorded as present. Managers, Leads and Representatives can deputise for each other. However, an individual cannot deputise for more than one member. Directorate Risk Leads cannot deputise for a Risk Lead outside of their own division.

5 Frequency of meeting

Meetings will be held every two months throughout the year.

6 Terms of reference

- Promote a positive health and safety culture throughout the Trust with consistent attitudes, beliefs and behaviours.
- Demonstrate management commitment to health and safety.
- Oversee the operational management of risk within the Trust.
- Consider health and safety issues raised by union safety representatives, competent persons, managers, directors etc.
- Ensure effective communication, consultation and cooperation with staff on health and safety issues.
- Ensure the Trust meets all its duties under the Health and Safety at Work etc. Act 1974 and regulations enacted under the Act.
- Monitor the local management of Reporting of Injuries, Diseases, Dangerous Occurrence Regulations 2013 (RIDDOR) reportable incidents.
- Monitor health and safety reporting, such as the level of accidents and notifiable diseases, to identify levels and trends that enable risk of harm to be minimised.
- Receive and review hazard alerts and monitor Trust compliance under the Central Alerting System (CAS) for Medical Devices Alerts (MDA) and Estate alerts.
- Set and monitor KPIs and targets to measure Directorate performance in the management of health, safety and risk.
- Monitor the management of risks by reviewing Directorate risk management reports.
- Receive reports from site representatives on local issues that have Trust-wide implications.
- Ensure that risks are addressed by specialists with appropriate expertise and competencies by receiving reports from the Chair or representatives from the specialist committees described in Section 7.
- Actively monitor the management of significant health and safety risks through the health and safety action plan and oversee the annual health and safety programme on behalf of the Trust Board.
- Ensure suitable and sufficient numbers of staff are identified and trained to allow health and safety to be adequately managed.
- Review and approve mandatory training requests for health and safety-related training
- Approve, review and monitor the implementation of relevant risk-related policies and procedures.
- Consider recommendations and consultative documents from external agencies such as the Health and Safety Executive (HSE).
- Report to the Quality Committee, specialist committees and the Trust Board, on significant health and safety issues, as appropriate.

7 Reporting

The committee is a sub-committee of the Quality Committee (a sub-committee of the Trust Board). The committee will also report to Directorate committees through the Directorate Risk Leads.

The following committees report to the Health and Safety Committee through their respective chairs or representatives:

- Asbestos Management Group
- Electrical Safety Group
- Slips, Trips and Falls Group
- Kent and East Sussex Weald Hospital Ltd (KESWHL) quarterly Liaison Meeting
- Medical Gas Committee
- Pathology Health and Safety Committee
- Trust Radiation Advisory Committee (RPA)
- Resilience Committee (EPO)
- Safety, Health and Risk Advisory Group
- Trust Security Committee (Operational Security Manager)
- Waste Group
- Water Steering Group

8 Administration and duties

The committee is supported by the Personal Assistant to the Director of Operational Nursing, whose duties will include:

- Agreement with the Chair and the Risk and Compliance Manager of an Annual Work Programme setting out the dates of planned meetings and key agenda items.
- Agreement of agenda for next meeting with the Chair and attendees.
- Call for papers from attendees and invitees at least two weeks before a meeting.
- Collation and distribution of papers one week before the date of the meeting.
- Taking the minutes and the circulation of draft minutes following each meeting.
- Maintaining a record of meeting papers and minutes as a corporate file for the Trust.

9 Review of terms of reference and monitoring compliance

These terms of reference will be agreed by the Health and Safety Committee and approved by the Quality Committee. They will be reviewed annually or sooner if there is a significant change in the arrangements.

At each meeting the attendance record, the annual plan and the policy list will be presented and reviewed. Non-compliance with the terms of reference will be noted and action taken by the chair. The quorum of the committee will be confirmed.

Terms of reference agreed by Health and Safety Committee: 14/04/2022
Terms of reference approved by Quality Committee: 11/05/22
Terms of reference to be reviewed: April 2023

NHS
Maidstone and Tunbridge Wells NHS Trust

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment — **Chief Operating Officer**

The enclosed report provides information on the Trust's statement of compliance with NHS England Core Standards on Emergency Preparedness, Resilience & Response.

The Trust is fully compliant with the 64 Core Standards which incorporate:

- Domain 1 - Governance
- Domain 2 - Duty to Risk Assess
- Domain 3 - Duty to Maintain Plans
- Domain 4 - Command & Control
- Domain 5 - Training & Exercising
- Domain 6 - Response
- Domain 7 - Warning & Informing
- Domain 8 - Cooperation
- Domain 9 - Business Continuity
- Domain 10 - CBRN

This year the "Deep Dive" relates to Evacuation & Shelter and these standards do not contribute to the overall Core Standards rating. They are designed as an information gathering and status check for NHS England.

For the "Deep Dive", our rating is as follows:

Emergency Response to Evacuation & Shelter - fully compliant with 4 of 13 – the deep dive outstanding standards that are partially compliant relate to some aspects of internal planning but in particular, local partnerships and response planning as a wider system. For those partially compliant, there is evidence of EPRR arrangements but these require further development/testing.

MTW EPRR Team are currently undergoing a major review of the Trust Evacuation & Shelter processes and procedures. This includes the design of evacuation rucksacks that will be stored within the Emergency Resource Lockers in each area of the Trust. Additionally, working in collaboration with Security, Fire Safety and Health & Safety to ensure planning arrangements are aligned.

Furthermore, a training video is being created to ensure staff have the ability to learn both through verbal and visual training aids.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 27/09/22

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

1. Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

2. Statement of Compliance

As part of the national EPRR assurance process for **2022/23**, Maidstone and Tunbridge Wells NHS Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 64 of the core standards which are applicable to the organisation, Maidstone and Tunbridge Wells NHS Trust: is fully compliant with 64 of these core standards.

The overall rating is: Fully Compliant.

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

3. Areas to be considered

The Deep dive this year relates to Evacuation and Shelter. The deep dive does not contribute to the Trusts overall rating but is intended as an indication of the NHS position.

Fully Compliant	Partially complaint	Non-compliant
4	9	0

The responsibility for implementing an improvement plan in relation to the deep dive sits with the EPRR team. From this, the MTW EPRR Team are currently undergoing a major review of the Trust Evacuation & Shelter processes and procedures. This includes a complete review of the Trust Evacuation plan as well as the design of evacuation rucksacks that will be stored within the Emergency Resource Lockers in each area of the Trust. Additionally, working in collaboration with Security, Fire Safety and Health & Safety to ensure planning arrangements are aligned

4. Conclusion

The Trust's Emergency Preparedness remains strong and is an essential aspect of the organisation. This has been proven by 100% compliance with the core standards. Over the past year, the Trust has reviewed its evacuation and shelter plans however in light of the deep dive section of EPRR Assurance, the team recognises the need to focus its efforts on improving its documentation and processes with evacuation and shelter protocols.

Ratification of the revised policy and procedure for the production, approval and ratification of Trust-wide policies ('policy for policies')	**Trust Secretary**

The Trust's current Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies') was ratified by the Trust Board on 22/10/20. It is one of the few policies that is reserved for ratification by the Trust Board (the Policy Ratification Committee (PRC) is authorised to ratify all other policies).

It was not yet therefore due a detailed review. However the confirmation, by the Executive Team Meeting (ETM), of the permanent introduction of the use of a 'policy manual' approach, which was trialled for the Trust's People policies, required the 'policy for policies' to be revised, to allow the use of alternative formats to the policy template. The opportunity was therefore also taken to review the policy in full, and make some other changes. The changes are summarised as follows:

- Change of name to "Policy and procedure for the production, approval and ratification of Trust-wide policies ('policy for policies')"
- Addition of an "Overview of procedure to be followed for amendments to existing policies" flowchart.
- Amendments to account for established review prompt process.
- Amended to include 'policy manuals' in section 5.2.3 (Exceptions to using the 'Policy template'); also, added supporting definitions in section 2.0, amendments to information about appendices in section 5.10, and new appendix (8).
- Additional text added to make it clear that local policies should not conflict with any Trust-wide policies, and in the event of a conflict the Trust-wide policy should take precedence.
- Elaboration on some points of process throughout the policy, to provide additional clarity.
- Change of the default consultation period from four to three weeks.
- Only permitting two six-month extensions to a review date.
- Amended references from "Assistant Trust Secretary" to "Administration Assistant, Trust Secretary's Office"; along with further 'housekeeping'/ cosmetic changes.

The changes were first discussed at the PRC in June 2022. The policy and all appendices were then issued for a comprehensive consultation (which included all Trust Board members) in July 2022. The documents were then approved by the ETM on 06/09/22, and further reviewed by the PRC on 17/06/22. The PRC agreed to recommend that the policy be ratified by the Trust Board.

The revised policy is therefore submitted for ratification. For the purposes of brevity, the last seven appendices (i.e. 4, 5, 6, 7, 8, 8a and 8b) have not been included within this report. These documents have however been made available to Trust Board members in the "Documents" section of Admincontrol (at "Trust Board/Documents/Trust Board Meetings (Part 1)/2022/09. 29.09.22/Policy for policy appendices").

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 06/09/22 (for approval)
- Policy Ratification Committee (PRC), 17/06/22 (pre-consultation review) and 16/09/22 (to review, prior to ratification)

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

To ratify the revised "Policy for policies"

[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

Policy and procedure for the production, approval and ratification of Trust-wide policies ('policy for policies')

Target audience:	All Trust staff involved in the production or review of Trust-wide policies
Author:	Trust Secretary **Contact details:** Ext. 28698
Other contributors:	Corporate Governance Assistant (CGA) Members of the Policy Ratification Committee (PRC)
Owner:	Chief Executive
Division:	Corporate
Directorate:	Corporate
Specialty:	Corporate
Supersedes:	Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 7.0: April 2020]
Policy administrator:	Corporate Governance Assistant
Approved by:	Executive Team Meeting (ETM), 6th September 2022
Recommended for ratification by:	Policy Ratification Committee, 16th September 2022
Ratified by:	The Trust Board, 29th September 2022
Review date:	September 2026

This policy has been written for implementation during periods of standard functioning within the Trust. Outside of those periods (such as major incidents or national emergencies) other 'emergency' policies may be written to supersede or run alongside this policy.

Document history

Requirement for document:	• To comply with national recommendation for good practice. • To ensure a clear and robust approach and system is in place for the production, approval and ratification of Trust-wide policies.
References (external):	1. The Freedom of Information Act 2000. 2. NICE Style Guide Corporate document [ECD1]. National Institute for Health and Care Excellence (NICE), 2016. 3. Inclusive language: words to use and avoid when writing about disability. The Department for Work & Pensions and the Office for Disability Issues, 2021 4. Care and Support Jargon Buster. Think Local Act Personal?, 2020 5. Writing for NICE: a guide to help you write more clearly. National Institute for Health and Care Excellence, 2016 6. Scientific Nomenclature. The Centers for Disease Control and Prevention, 2020. 7. Bureau International des Poids et Mesures (BIPM). International System of Units, 2020.
Associated documents (internal):	• Policy Ratification Committee (PRC) pre-submission checklist [available from the Administration Assistant, Trust Secretary's Office]. • Publication Scheme available at www.mtw.nhs.uk/freedom-of-information/publication-scheme/. • Reservation of powers and scheme of delegation [RWF-OPPCS-NC-TM21]. • Standing Orders [RWF-OPPCS-NC-TM23]. • Terms of Reference of the Policy Ratification Committee (PRC) [available from the Trust Secretary's office]. • Trust committee structure [RWF-OWP-APP2].

Keywords:	Ratification	Consultation	PRC
	Approval	Trust-wide	Author
	Policy for policies	Policy policy	SOP
	Policy Ratification Committee	Owner	

Version control:		
Issue:	**Description of changes:**	**Date:**
7.0	• Amendments to clarify the required process when a policy is ratified with content that directly affects the content of another policy (section 5.3.3 and 5.9.3, and Policy template in Appendix 5). • Updated section 5.5.1 to reflect current Trust committee structure with respect to approval authority. • Addition of new appendix (Appendix 6: Style guide for Trust-wide policies and procedures). • Amended definition of 'Trust-wide policy' to be a policy that covers the method of working across more than one Division (rather than one Directorate).	April 2020

Version control:		
Issue:	**Description of changes:**	**Date:**
	• Amended definition of a 'Local policy (and procedure)' to be a policy (and procedure) that covers the method of working within a single Division (and the staff therein) (rather than a single Directorate). • Inclusion of the definition of a Division. • Formalisation of the Policy Ratification Committee's determination on the use of gender specific language (described within the new style guide in Appendix 6). • Replacement of 'Executive Lead' for a policy with 'Owner' (to enable 'Owners' to include persons other than members of the Executive Team). • Inclusion of the definition of Standard Operating Procedure (SOP). • Confirmation that policy documents and any appendices that are primarily linked to that policy must be reviewed in full by the approving committee (and thereby removing the option of the approving committee only receiving a synopsis of a policy) • Further precision being described for the steps required when documents no longer wish to be regarded as Trust-wide policies	
7.1	The following material amendments were approved at Executive Team Meeting on 29th September 2020, recommended for ratification by Policy Ratification Committee on 8th October 2020, and ratified by the Trust Board on 22nd October 2020: • Removal of the requirement for a 'Mandatory detailed review' to be undertaken every four years, and enable policies that have been previously ratified by the Policy Ratification Committee to be set for a further four years if the Author and Owner confirm that the document is still needed and fit for purpose. • Addition of a further Appendix (a 'Policy review pro forma', to enable the Owners and Authors to confirm the need for a policy to be considered again by the Policy Ratification Committee). • Granting of the authority to the Executive Team Meeting to amend, suspend or replace any Trust-wide policy and procedure during periods of exceptional disruption.	October 2020
7.2	Pro forma review procedure flowchart added on page 8. Procedure itself is unchanged from version 7.1. Non-material amendment.	June 2021
7.3	Non-material amendments, although noted and agreed at Policy Ratification Committee 12th November 2021: • Added clarification about Health Records Committee ratification of documents that make up part of the patient healthcare record (in section 5.2.4) • Added Joint Medical Consultative Committee to section 5.5.1 • Clarification of consultation requirement added to 5.9.2	November 2021
8.0	• Change of name to 'Policy and procedure for the production, approval and ratification of Trust-wide policies ('policy for	September 2022

Version control:		
Issue:	**Description of changes:**	**Date:**
	policies')' • Addition of an 'Overview of procedure to be followed for amendments to existing policies' flowchart. • Amendments to account for established review prompt process (section 5.8.1). • Amended references from "Assistant Trust Secretary" to "Administration Assistant, Trust Secretary's Office" • Amended to include 'policy manuals' in section 5.2.3 (Exceptions to using the 'Policy template'); also, added supporting definitions in section 2.0, amendments to information about appendices in section 5.10, and new appendix (8) • Additional text added to make it clear that local policies should not conflict with any Trust-wide policies, and in the event of a conflict the Trust-wide policy should take precedence. • Elaboration on some points of process throughout the policy, to provide additional clarity. • Change of the default consultation period from four to three weeks (section 5.3.2). • Only permitting two six-month extensions to a review date (section 5.8.1).	

Summary for

Policy and procedure for the production, approval and ratification of Trust-wide policies ('policy for policies')

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Division.

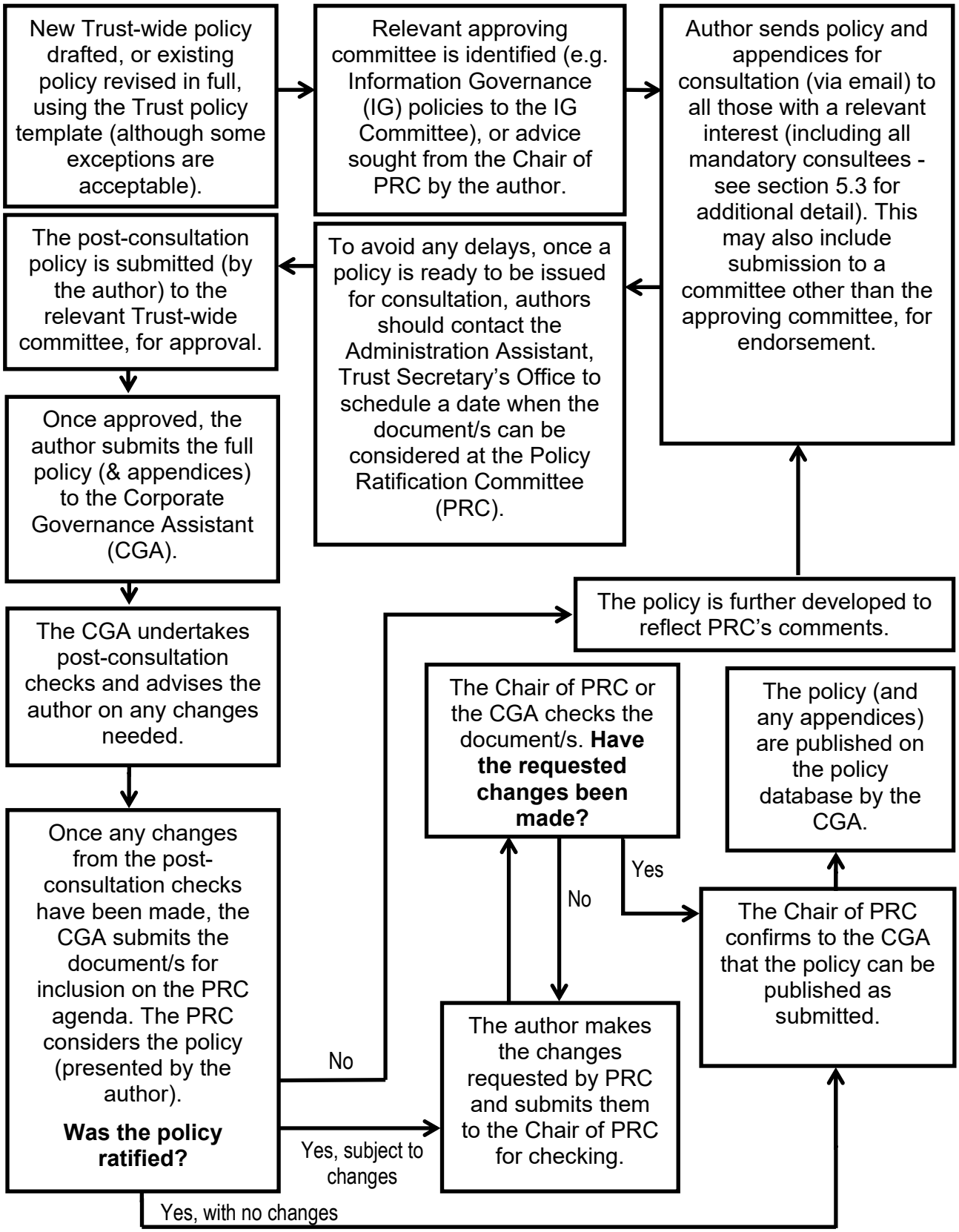
All NHS organisations need a robust process to ensure the policies they expect their staff to follow:

- are developed with due rigour
- take account of appropriate external guidance and internal opinion
- are well-written
- meet the needs of staff and the organisation
- meet expected equality standards.

This policy describes the Trust's approach to ensuring that Trust-wide policies are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

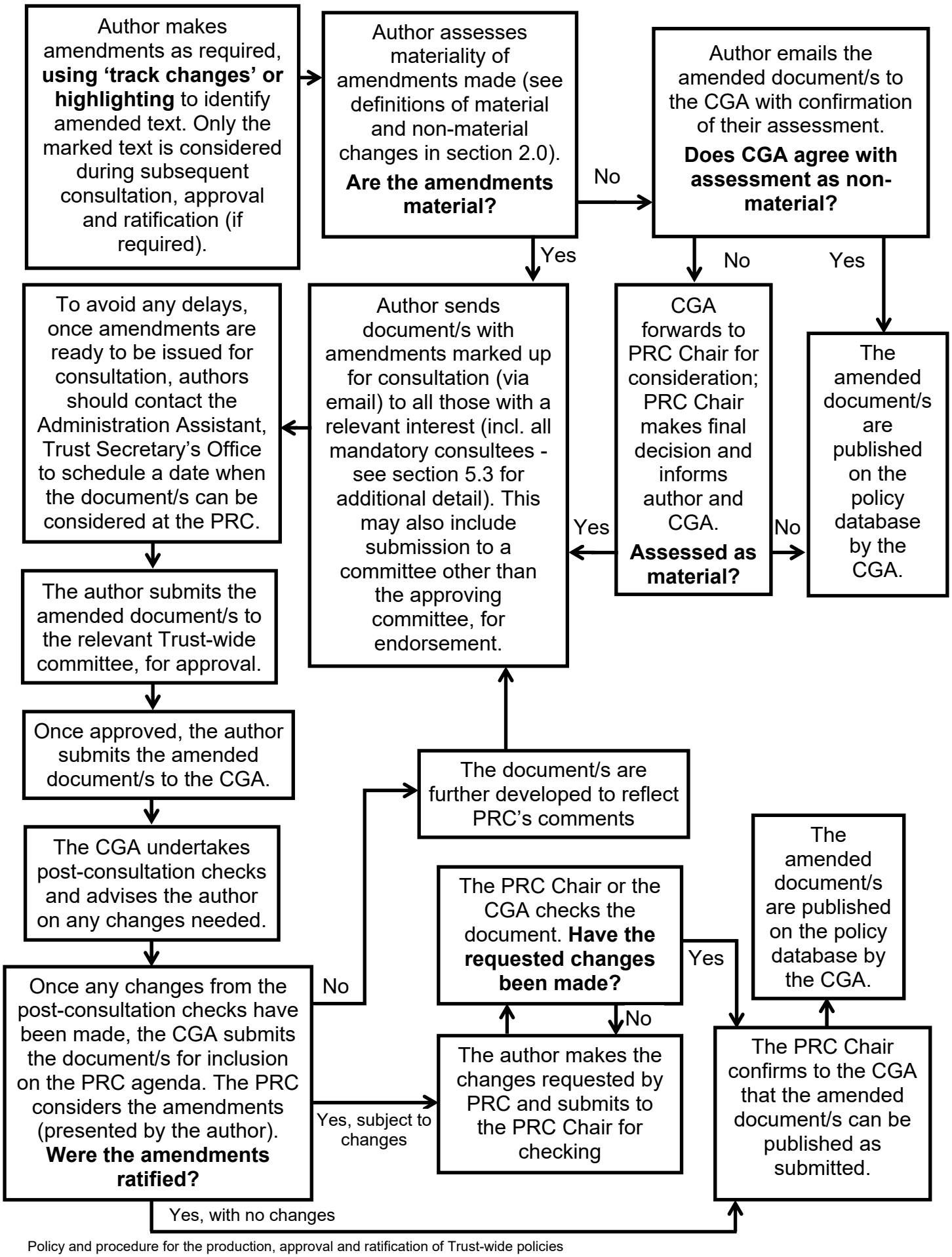
Content

Overview of standard development procedure to be followed for new policies, or full revisions of existing policies that use the 'Policy template
(Refer to the policy for the full details and requirements of each step)

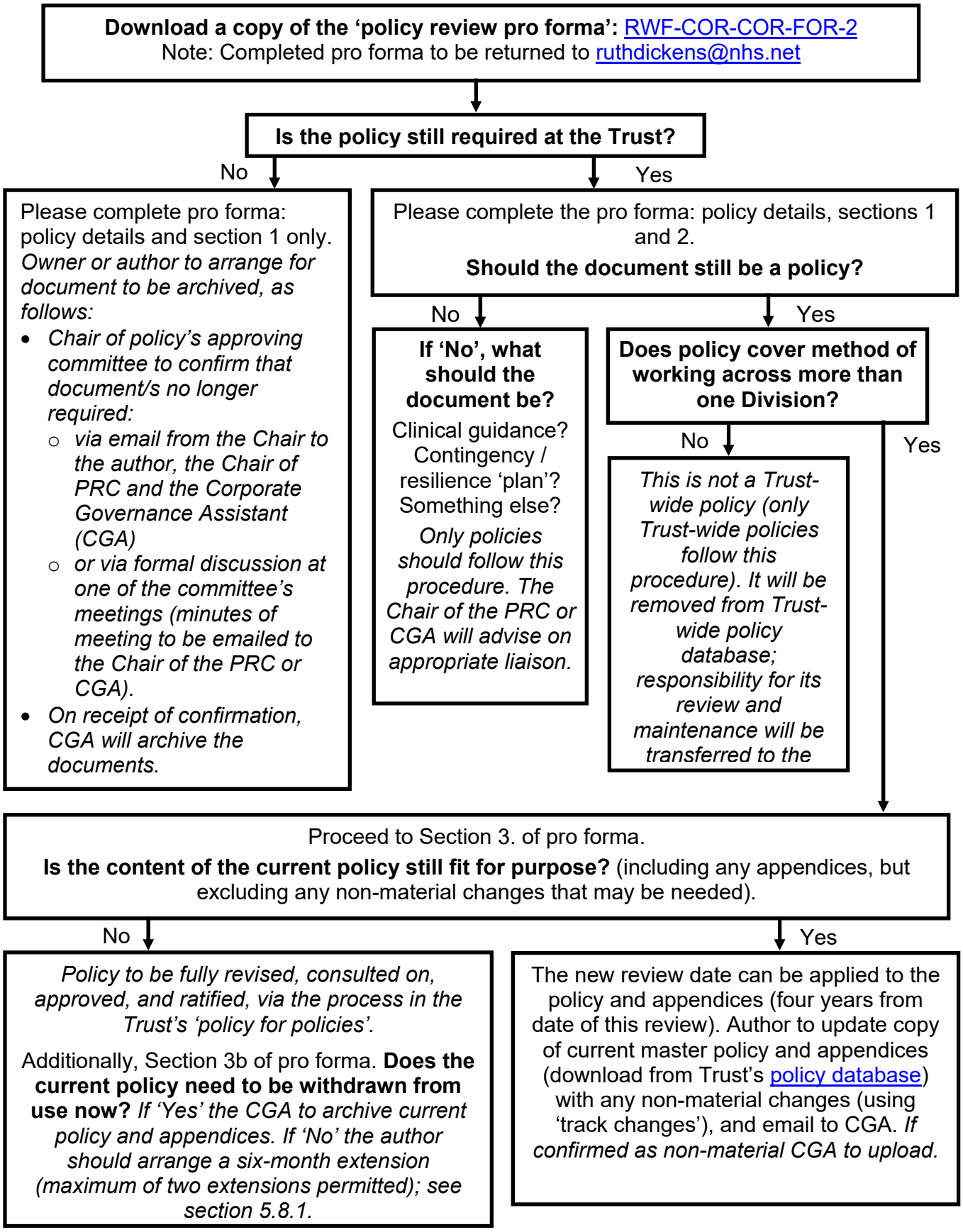


Overview of procedure to be followed for amendments to existing policies that use the 'Policy template (Refer to the policy for the full requirements of each step)

NHS Maidstone and Tunbridge Wells NHS Trust



Overview of pro forma review procedure to be followed (see also section 5.8.2)



1.0 Introduction, purpose and scope

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Division.

All NHS organisations need a robust process to ensure the policies they expect their staff to follow:

- are developed with due rigour
- take account of appropriate external guidance and internal opinion
- are well-written
- meet the needs of staff and the organisation
- meet expected equality standards.

This policy describes the Trust's approach to ensuring that Trust-wide policies are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

This policy applies to all Divisions, Directorates and locations within the Trust. However, this policy does not apply to the following documents:

- Local policies (i.e. those that are not 'Trust-wide'). These should be produced and approved or ratified in accordance with local procedures.
- Corporate strategy documents. These will differ in format, according to their content, but any strategy affecting the whole Trust should be approved or ratified by the Trust Board (having been subject to appropriate consultation beforehand). Strategies should also have been review and agreed by the relevant Trust Board sub-committee.
- Clinical guidance documents. A separate process is in place. For advice refer to the Trust Intranet or Governance Team/Director of Quality Governance.
- Trust-wide plans. These can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Plans may or may not be required to be formally approved but this should be considered by the person with overall responsibility for implementing the plan.

Documents may have different titles, which may be influenced by convention, external requirements, local considerations or previous precedent. It is therefore the intent, and not the title, that should determine whether this policy applies to a particular document, taking into account the definitions in section 2.0. In this context, documents that 'look and feel' like Trust-wide policies should not be labelled as 'plans' or 'strategies' to avoid having to comply with this policy.

1.1. Principles

This policy has been developed in accordance with the following principles:

- The Trust will only produce, approve, ratify and apply the Trust-wide policies that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.
- Trust-wide policies are matters for the Trust 'Executive'. Therefore, although it may be appropriate to include Non-Executive Directors (and the committees on which they sit) as part of the consultation on a particular policy, the default position is that policies will be approved by Executive-led committees (unless expressly agreed otherwise by the Trust Board or one of its sub-committees).

- All Trust-wide policies are to be ratified for four years unless a shorter period is required. Regardless of this, all policies should be revised within that four-year period to reflect changes as and when they arise.
- Policies should be reviewed and revised (as required) before their review date is exceeded.
- Policies should be revised before the next review date if significant changes are made to the regulation, guidance or best practice on which the policy is based.
- Once ratified, non-material changes to a Trust-wide policy can be made without seeking re-approval and re-ratification.
- All Trust-wide policies should have a target audience identified in recognition that not all Trust-wide policies are of relevance to all Trust staff.
- All Trust-wide policies should be written in the current 'Policy template' (Appendix 5) and follow Trust guidance for style and formatting (Appendix 6). However, in certain circumstances there are exceptions to using the 'Policy template'. See section 5.2.3.
- All Trust-wide policies should be well-written (including ensuring appropriate grammar, format and style, see Appendix 6), be clear to follow, and contain as much information as is required to provide the appropriate support to its target audience.
- All Trust-wide policies will be available to the public, on request (in accordance with the requirements of the Freedom of Information Act 2000 and the Trust's associated publication scheme).
- Local policies are not required to comply with this policy, but local policies should not conflict with any Trust-wide policies. In the event of a conflict between a local policy and a Trust-wide policy, the Trust-wide policy should take precedence. Local policies can go beyond the requirements of a Trust-wide policy for the relevant local area, but the owner of the local policy must ensure they have the authority to enforce such requirements.

2.0 Definitions / glossary

Term	Definition
Appendix	An additional document, with subsidiary information relating to the main body of a policy that is required or expected to be read by the target audience, but which is not optimally located within the main body of a policy. Examples include forms, flowcharts, posters, standard operating procedures (SOPs), and registers.
Approval	Official agreement by an appropriate committee that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy: • meets applicable national and regional standards • meets the standards of this policy • is suitable to be submitted for ratification. Approval is the penultimate step before a policy is issued for use. Approval can only be given by the appropriate formal Trust-wide committee.
Author	The employee who drafts the policy, procedure and appendices (and subsequent updates or revisions) in accordance with the requirements of this policy. Staff will be designated as the author of

Term	Definition
	a policy according to the role they are employed to perform. An author may not be the person who drafted the original first version of the policy, but may inherit the role from a predecessor. Such individuals are nonetheless responsible for the written content of the policy.
Backup archive	Masters of current and archived policies and their appendices are held on the policy database. Copies of these are additionally held in an archive, which can be found in: S:\Directorate\CEOffice\Policy Ratification Committee (PRC)\Q-Pulse masters. These can be accessed by all members of the Trust Secretary's team.
Clinical guidance	Any document designed to guide clinical practice. This includes clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc. Such documents are recommendations of good practice, which are expected to be applied, but which permit exceptions, based on the judgement of the practitioner. Clinical guidance documents allow individuals to use their professional judgement and decision-making skills. Such documents are excluded from this policy.
Consultee	A person or group who has been sent a policy, prior to it being submitted for approval, to enable that person or group to comment or propose amendments.
Division	A grouping of two or more 'Clinical Directorates' into a single operating unit, for the purposes of oversight. However, for the purposes of this policy (and the definitions of Trust-wide and local policies in particular), corporate areas (i.e. Finance, IT, People and Organisational Development, Corporate Nursing) should also be considered as Divisions.
Endorsement	The provision of formal support to a policy (and thereby acknowledgement that the content is fit for purpose and ready for approval), by a group/committee, prior to its approval. Endorsement can be provided by more than one group/committee, if relevant. Endorsement is not compulsory, but authors or approving committees may wish to seek endorsement to support the process of approval.
Hyperlink	A link from text in one document to another internet location, usually activated by clicking on a highlighted word or image.
Local policy (and procedure)	A policy (and procedure) that does not meet the definition of being 'Trust-wide' i.e. which covers the method of working within a single Division (and the staff therein).
Mandatory consultees	Those identified by the PRC as needing to be included in the consultation of all Trust-wide policies (or all Trust-wide policies covering a particular subject). The list of mandatory consultees is contained within the 'Policy template' (and within the 'Policy manual toolkit: Record of consultation' (Appendix 8a).

Term	Definition
Material change	A change to an existing Trust-wide policy that fundamentally affects what staff are expected to do under that policy. Examples of material changes include: • changes that have resource implications that cannot be applied in a straightforward manner • changes that may be contentious or require debate • changes that would result in the 'target audience' considering the changed policy as being fundamentally different to the existing policy. The inclusion of a new appendix, or the removal of an existing appendix, should be considered, by default, as a material change, unless the author can provide a rationale for the inclusion or removal to be considered as non-material.
Non-material change	A change to an existing Trust-wide policy that does not fundamentally affect what staff are expected to do under that policy. Non-material changes should not be contentious or require debate. Examples of non-material changes include: • changes to the names of jobs, roles, contact details, committees, clinical areas, locations • corrections to typographical errors, formatting etc. • minor changes to policy-related documentation (such as requests for small amounts of additional information on forms).
Other contributors	Individuals who are closely involved in the production or review of a policy but who are not the author. Such persons will be listed on the front cover of each Trust-wide policy.
Owner	The most senior employee responsible for the content of a policy (and for ensuring the policies under their specific areas of responsibility have been developed in accordance with this policy). Owners must be a member of the Executive Team Meeting (ETM). Owners will be allocated policies by the Chair of the PRC according to the areas/subjects within their area of responsibility/portfolio. Further advice and clarification can be obtained from the Chair of the PRC.
Plan	Plans can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Such documents are excluded from this policy.
Policy	A statement of corporate intent, explicitly stating responsibility and accountability, and containing details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Some documents may involve a mixture of 'policy' and 'guidance'. The determination of whether a document should be considered a 'policy' therefore depends on the extent of that mix i.e. if the substance of the document is mostly concerned with content that employees are expected to adhere to, the document should be regarded as a policy. If the substance of the document is mostly concerned with recommendations of good practice, the document should be regarded as guidance.

Term	Definition
Policy database	The database that holds the master versions of all Trust-wide ratified policies and appendices. The current system used for the database is called 'Q-Pulse'. Trust-wide policies and their appendices are held in the Q-Pulse database, "Organisational Wide Documentation".
Policy manual	A combined policy format in which any number of policies from a particular subject area may be combined within one document.
Policy manual toolkit	Three Word documents, comprising a 'Policy manual form', 'Record of consultation', and 'Equality impact assessment'. See Appendix 8.
Policy template	A Word document that describes the format, style and layout that Trust-wide policies should use (for exceptions see Section 5.2.3). The 'Policy template' is set by the Policy Ratification Committee (PRC) - see Appendix 5. A style guide is provided in Appendix 6.
Policy Ratification Committee (PRC)	The committee authorised to ratify Trust-wide policies for use in the Trust. PRC members are a pool of committed staff from clinical and non-clinical departments who have responded to invitations to be involved in PRC. PRC members are deliberately not representing their department or area of work, nor are they experts in the subject matter covered by most policies.
Post-consultation check	Checks undertaken by the Corporate Governance Assistant (CGA), prior to documents being submitted to the PRC, to determine whether the documents meet the requirements of this policy, including the latest 'Policy template' (see Appendix 5) or 'Policy manual toolkit' (see Appendix 8).
Procedure	A standardised method of performing a task/s. A procedure related to a policy defines the specific course of action relevant employees are expected to follow.
Process	A series of interconnected activities that transform an input into an output.
Q-Pulse	The software used by the Trust for the storage of various documents. Local documents are uploaded to the eight local Q-Pulse databases by local administrators. Trust-wide policies are uploaded to the Organisational Wide Documentation Q-Pulse database by the CGA. Other Trust-wide documents are uploaded to the Organisational Wide Documentation Q-Pulse database by the appropriate administrator.
Ratification	Final authorisation for use within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board (see section 5.6.6). Ratification consists of: • checking that the policy has been subject to an appropriate consultation and approval process • 'sense-checking' the full text of the policy and its primary appendices, to assess whether they make sense, flow well, are internally consistent and can be understood by the most junior member of staff to which the policy is expected to apply • checking the policy complies with the format, style and layout

Term	Definition
	requirements of the latest 'Policy template', or with the requirements of the 'Policy manual toolkit' and • proof-reading the policy for errors.
Review	The process of examining the content of an existing policy or appendix, to determine whether it is still required and that the information is current, adequate and comprehensible to ensure consistent application by its target audience.
Review date	The date by which a Trust-wide policy is required to be fully reviewed, and, if appropriate, the revised version uploaded. A review date is not however an expiry date, and a policy does not become automatically unfit for purpose solely because its review date has passed.
Standard operating procedure (SOP)	A document that provides accurate and detailed instructions on how to perform a defined process or procedure, to ensure consistency and standardisation. The purpose is to eliminate variations in processes which need to be completed the same way every time. Policies may contain SOPs (even if they are not labelled as SOPs), and the decision as to whether an SOP falls under the scope of this policy depends on whether the SOP is Trust-wide. Trust-wide SOPs would usually be expected to be included as an appendix to the relevant Trust-wide policy.
Strategy	A document outlining a long-term goal/s (with details of how the goal is intended to be achieved). Such documents are excluded from this policy.
Trust-wide policy	A policy that covers the method of working across more than one Division.
Uploading	Placing a document on the policy database, to enable it to be accessed by Trust staff.

3.0 Duties

Person/Group	Duties
Trust Board	• Ensures the Trust has a robust approach to ensuring the policies staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the Trust. This responsibility will be met by ratifying this policy (and seeking assurance on compliance, as required). • Ratifies certain Trust-wide policies (see 5.6.6).
Chief Executive	Ensures there are sufficient resources in place to implement this policy.
Executive Team Meeting (ETM)	• Authorises the amendment, suspension or replacement of any Trust-wide policy during periods of exceptional disruption to the Trust's standard functioning (such as major incidents or national emergencies) • Considers the status of policies with no clear indication of a

Person/Group	Duties
	plan for review, escalated to them by the Chair of the PRC. • Oversees the process described in this policy, via monitoring the work of its sub-committee, the PRC.
Policy Ratification Committee (PRC)	• Ratifies Trust-wide policies in accordance with this policy. • Arbitrates of any decisions relating to the approval or ratification of Trust-wide policies. • Agrees the 'Policy template' and 'Policy manual toolkit' applicable to Trust-wide policies.
Approving committee	Ensures that the content of policies they approve have been properly considered, that the content matches the best practice in relation to the subject matter of the policy, and that the policy is suitable for ratification.
Owner	• Ensure the policies under their specific areas of responsibility have been developed in accordance with this policy. • Ensure that an author is appointed to each policy under their specific areas of responsibility (and re-appointing if an author leaves or moves role).
Author	• Ensuring their policies are produced, consulted, approved and ratified in accordance with this policy. This includes any subsequent revisions. • Arrange 'special' formatting of new or amended 'policy manuals' (see section 5.2.3)
Trust Secretary	• Responsible for implementing this policy. • Chairs the PRC, and ensures it complies with its Terms of Reference. • Provides advice on the implementation of this policy. • Escalates policies with no clear indication of a plan for review to the Executive Team Meeting. • Authors the 'policy for policies'
Administration Assistant, Trust Secretary's Office	• Schedules the policies to be reviewed at the PRC. • Liaises with the CGA, to ensure that policies submitted to PRC have completed the correct process.
Corporate Governance Assistant (CGA)	• Administers the policy database. • Uploads policy documents to the policy database. • Issues reminders to authors in relation to review dates, offering and explaining the six-month extension process or policy review pro forma process, as appropriate. • Provides advice on the implementation of this policy. • Undertakes post-consultation checking of policies. • Undertakes post-PRC checking of policies against requested changes • Provides reports to the PRC, Chair of the PRC, and others as required; this includes the monthly 'Review status of all Trust-wide policies'

4.0 Training and competency requirements

There are no training or competency requirements at this time. However, advice and guidance are available from the Chair of the PRC, Ext. 28698, kevinrowan@nhs.net; or Corporate Governance Assistant, Ext. 25343, ruthdickens@nhs.net. 'Frequently asked questions' (FAQs) (see Appendix 4) and a style guide (see Appendix 6) are also available.

5.0 Procedure

Refer to the flow diagram on page 7 for an 'Overview of standard development and review procedure to be followed'. The specific steps required are as follows:

5.1 Identifying and confirming the need for a Trust-wide policy

5.1.1 New policy content

The Trust should only produce, approve, ratify and apply the Trust-wide policies that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.

The need for a new Trust-wide policy may be identified via a number of different sources, such as a requirement from external agencies, incidents, complaints or other events; internal audit reviews; in-house or external assessment etc.

However, before concluding that a completely new policy is required, a search of existing policies should be undertaken, via Q-Pulse, and consideration should be given as to whether it is feasible to extend the scope of an existing policy to incorporate the new content.

If it is considered feasible to extend the scope, liaison should occur with the author of the existing policy, and agreement should be reached as to who the author of the revised/extended policy should be. That person will be responsible for ensuring the revised/extended policy complies with this policy.

If it is not considered feasible to extend the scope of an existing policy, a new policy should be proposed to be produced. However, before that document is drafted, the proposed owner should be identified and approached (by the intended author of the new policy), to obtain their written confirmation that they believe a completely new policy is required. Email confirmation will suffice.

5.1.2 Existing policies

The Trust should only produce, approve, ratify and apply the Trust-wide policies that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties. There should therefore be a regular assessment of whether existing policies are still required, as it is possible that the rationale for the policy being produced has changed or ended. This assessment can occur at any time, but will be formally required of the authors in accordance with the review prompt process, as described in section 5.8.1.

If a policy is assessed as no longer being required, it should be withdrawn from publication and archived (see section 5.11.1).

If a policy is assessed as still being required, it should be reviewed in accordance with section 5.8.

5.2 Drafting a new policy / reviewing and revising an existing policy

5.2.1 New policies

The author should firstly download the latest 'Policy template' from the policy database (see Appendix 5). The author should then draft the policy using the 'Policy template', and follow the guidance therein (including that for format, style, and layout; also see Appendix 6). The Chair of the PRC may defer policies not written using the latest 'Policy template' from being considered at the PRC. There may however be exceptions to using the 'Policy template' (see section 5.2.3).

5.2.2 Existing policies

The author should firstly download the latest 'Policy template' (see Appendix 5) and the latest version of the policy under review from the policy database. The author should then critically review the content of the existing policy and amend/update as required. The revised policy must adhere to the latest 'Policy template', and should therefore follow the guidance therein (including that for format, style and layout; also see Appendix 6). The Chair of the PRC may defer policies not written using the latest 'Policy template' from being considered at the PRC. There may however be exceptions to using the 'Policy template' (see section 5.2.3). If the policy has previously been ratified by the PRC, the process in section 5.8.2 should be followed.

5.2.3 Exceptions to using the 'Policy template'

Some policies may be exempt from adhering to the 'Policy template'. These may be policies that are required or expected to be produced in a specific format or style, for example because they are national, or local, 'model' policies, or because they have been agreed in conjunction with several external agencies. They may also be policies which the originating authors and owners have identified as suitable for combining into a 'policy manual'.

In such circumstances, prior to drafting a new policy, or revising an existing policy (that has not already been authorised to be exempt from using the 'Policy template'), the author or owner should email the Chair of the PRC requesting an exemption from using the 'Policy template', and explaining the reasons for the exemption.

The request will be assessed and if an exemption is considered to be warranted, the author will, as appropriate, either be:

- Authorised to add a sentence to the cover page of the policy stating that "This policy has been confirmed to be exempt from strictly adhering to the Trust's 'Policy template'."

  Exempt policies still need to include certain elements of the 'Policy template', to enable them to be recognised as policies of the Trust. These elements are as follows:

  - Cover page
  - 'Document history', 'Keywords' and 'Version control'
  - 'Summary'
  - Table of contents
  - Appendices 1 to 3.

or

- Authorised to create a 'policy manual'.

  Policy manuals still need to include certain elements taken from the 'Policy template', to enable them to be recognised as policies of the Trust. These elements are as follows:

  - Table of contents
  - Policy manual toolkit (see Appendix 8)

If the request for an exemption is rejected, the author is required to draft or revise the policy using the latest 'Policy template'.

5.2.4 Appendices – to append or to reference?

The decision as to whether a document should be included as an appendix to a policy, or just be listed as either a 'reference' (if an external document) or 'Associated document' (if an internal document) depends on the author's expectations regarding that document.

If the document is not required or expected to be read by the target audience, and is listed in case they wish to, for example, find out more about the rationale or background to the policy, this should be listed as a 'reference' or 'Associated document'.

If the document is expected to be read and understood by the policy's target audience, the document should be included as an appendix.

If an appendix is in a format that is unable to be included as a separate document (such as a web-based form), consideration should be given to having an appendix that shows the original appendix as a 'screen shot', and signposts readers to the location of the appendix (i.e. a website/URL, with a hyperlink if suitable).

The author should adopt the approach they believe would result in the best understanding by the target audience, and result in the best 'flow' of the main policy document. The PRC may override the views of the author or approving committee if the PRC feels that the understanding of the target audience would be impaired by the submitted approach.

If an appendix is produced externally (i.e. published by a body other than the Trust), it may still meet the above criteria for being included as an appendix, although it is accepted that amendments to the document might not be possible. See section 5.10 for further details.

Appendix documents which, when used, become part of the patient healthcare record (e.g. referral forms, prescription and observation charts, care plans and pathways) require ratification at both the Health Records Committee (HRC) and PRC. These documents should ideally follow the HRC ratification process after being approved at the appropriate formal Trust committee, but before being submitted with the policy for ratification at PRC.

5.3 Consultation

Consulting with the key individuals and groups who have an interest in a policy is important. It enables the content to be considered by those who have detailed knowledge of the subject matter, as well as enabling the document/s to be 'sense checked' by those who have not been directly involved in their production.

5.3.1 Scheduling at the Policy Ratification Committee (PRC)

To avoid any delays, once a policy is ready to be issued for consultation, authors should contact the Administration Assistant, Trust Secretary's Office (Ext. 77628, jenny.turner13@nhs.net) to schedule a date when the document/s can be considered at the PRC. The dates of PRC are listed on the Intranet.

5.3.2 Consultation period

The default period for consultation is three weeks. This recognises that those asked to consider and comment on a policy will likely have to accommodate this whilst performing their own duties. This period also takes account of any potential annual (or other) leave such individuals may have.

There may however be occasions when a reduced consultation period is required. This would usually be expected to apply if a policy is required to be produced or revised by a specified deadline (for example for a forthcoming external assessment or inspection).

In addition, it is acceptable to apply a reduced consultation period for policies that are reviewed annually, on the basis that staff will have had an opportunity to comment on the document within the past year.

A consultation period should not however be less than two weeks.

Consultation periods less than two weeks can only be authorised by the owner for the relevant policy, and such authorisation should be confirmed in writing to the author. The author should also ensure, before submitting the policy for approval, that the Chair of the approving committee is content to consider approving in the context of a further reduced consultation period. The Chair of the PRC and CGA should be notified of such authorisation, and such authorisation should be confirmed by the PRC when it considers the policy. Absence of such authorisation is likely to result in PRC deferring the policy, to enable a longer period of consultation to occur.

It may also be beneficial to consult in stages, to allow those with a more direct interest in the policy (and who are more likely to propose amendments that will be accepted) to be consulted first, before issuing the policy to a larger number of consultees.

Once all consultation feedback has been addressed the policy and appendices should be emailed to the CGA for post-consultation checking. Once the post-consultation check feedback has been agreed the author can proceed with submitting the documents for endorsement or approval.

5.3.3 Consultees

Appendix 2 of the 'Policy template' (and Appendix 8a, which is part of the 'Policy manual toolkit') contains the list of persons who have been identified as mandatory consultees. This includes the members of the approving committee i.e. such individuals should not just receive the documents when they are formally submitted to the committee for approval. The PRC may change the list of mandatory consultees, for example, to reflect changes in the Trust's structure, and therefore

authors should consult the latest version of the 'Policy template' or 'Policy manual toolkit' prior to any consultation.

In addition to the mandatory consultees, authors should include the following within the consultation:

- All persons or groups who, by the nature of their role/duties, could reasonably be expected to have a specific interest in the policy. This involves a judgement by the author, but it is an important consideration, as excluding a person or group who has a specific interest is likely to result in PRC deferring the policy for further development, and the author being required to re-consult.
- Authors of other policies which contain an overlap in content, e.g. where a new system or process is introduced by the Trust and described in the policy under development, and is also referred to or described within another policy or policies. Wherever possible, these other policies should adopt the wording of the policy under development, once it has been ratified.

It may also be appropriate to include external parties in a consultation (for example, other NHS Trusts) if the policy is likely to have a significant effect on that party's practice.

Emails circulating the policy for consultation must also include the CGA, who monitors the minimum requirements for correct consultation, such as the inclusion of mandatory consultees and the correct documents.

5.3.4 Response to consultation

When issuing a policy for consultation, authors are providing consultees with the opportunity to read, consider, comment, and propose amendments.

Consultees are under no obligation to respond to this offer, but if they choose not to do so, any subsequent critique is likely to be dismissed (unless the content identified as unsafe or not fit for purpose – see section 5.11.2).

Authors are expected to give due consideration to any comments or proposed amendments arising from the consultation. However, they are not obliged to make the proposed amendments if they disagree, unless the issues raised relate to ensuring that Trust template requirements have been met. Any contentious issues arising from the consultation are expected to be resolved, by the author, before the policy is submitted for approval.

A record of the consultation should be kept by the author and this should be documented within the relevant mandated appendix (authors should refer to the latest 'Policy template' or 'Policy manual toolkit', as appropriate).

5.4 Endorsement

Policies need only be submitted to one committee for approval, but certain policies may be of interest to more than one committee. If the author or the Chair of that committee regards the committee's interest as sufficiently important, the policy may be formally submitted to that committee, to obtain the committee's support before the policy is submitted to the approving committee. This support will be considered to be 'endorsement', and if obtained, should be

recorded on the front cover of the policy. Endorsement can be provided by more than one group/committee, if relevant, but all such endorsement should occur before approval is sought.

The version of the policy submitted for endorsement should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered before the document/s are submitted.

It is up to the endorsing committee to determine whether it wishes to receive the full policy document (plus all appendices) when considering whether the policy should be endorsed. Certain committees may, for example, only wish to receive a synopsis of the policy, outlining the key content and perhaps any changes made to the previous version. There is no standard format for this synopsis, and this can therefore be set by the endorsing committee.

5.5 Approval

Policies submitted for approval should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered, and the CGA post-consultation check completed, before the author submits the document/s for approval.

5.5.1 Approving committee

The approving committee should be a formal Trust-wide committee (i.e. where the membership is not limited to staff from one Division), and should be the committee with the most relevant role in relation to the content of the policy.

For most policies, the approving committee should be obvious, but if authors are uncertain, advice can be sought from the Chair of the PRC. The precedent set by previous, similar, policies may also be useful. The following list should be considered as a guide only, for illustrative purposes.

Type of policy	Approving committee
People and Organisational Development / workforce	Joint Consultative Forum Committee
Employment policy exclusive to medical and dental staff in the Trust.	Joint Medical Consultative Committee
Clinical operational	Clinical Operations and Delivery Committee
Information governance	Information Governance Committee
Health and safety, fire, Estates and Facilities	Health & Safety Committee
Infection prevention and control	Infection Prevention and Control Committee
Policies which: • Set the overall framework of major clinical or corporate governance matters (e.g. Risk management policy and procedure, Policy and procedure for the production, approval and ratification of Trust-wide policies etc.). • Have significant implications in relation to widespread changes of practice among staff. • Have significant resource implications. • Are likely to be contentious.	Executive Team Meeting (ETM)
General clinical policies (for which there is no specific Trust-wide forum)	Clinical Operations and Delivery Committee
Medicines-related policies	Drugs, Therapeutics and Medicines Management Committee

The list of Trust-wide committees can be obtained from viewing the 'Trust committee structure chart' (which is an appendix to the Standing Orders).

5.5.2 Approval by a Trust Board sub-committee

In accordance with the principles listed in section 1.0, policies would not ordinarily be expected to be approved at a Trust Board sub-committee. However, any Trust Board sub-committee may undertake the role of an approving committee if the Trust Board or the sub-committee itself wishes to undertake this role.

5.5.3 The documents to be considered for approval

The policy document and any appendices that are primarily linked to that policy must be considered in full by the approving committee, as part of the formal agenda and reports for the meeting.

This is because in approving a document, the approving committee is officially agreeing that any resource implications associated with

implementation of the policy have been properly considered, and that the content of a policy:

- meets applicable national and regional standards
- meets the standards of this policy
- is suitable to be submitted for ratification.

By not considering the documents in full, the approving committee therefore risks approving documents that are not well-written and contain (for example) consistency errors.

5.5.4 Documenting approval

Approval should be documented in the minutes of the approving committee meeting at which the policy was considered, and noted by the author on the front page of the policy.

5.5.5 Approval of sub-standard documents

If the PRC considers that an approving committee is repeatedly approving policies that are sub-standard, i.e. that are poorly-written, not complying with this policy, or not adhering to the 'Policy template' or 'Policy manual toolkit', the Chair of the PRC will contact the Chair of the approving committee to make this known, and request that the approving committee consider whether the processes it applies when approving policies are sufficiently robust to enable the approving committee to fulfil its duties under this policy.

After approval has been obtained the author should email the approved draft/s to the CGA. The CGA will complete a final check prior to emailing the draft/s to the Administration Assistant, Trust Secretary's Office for inclusion on the PRC agenda.

5.6 Ratification

Ratification is the authorisation for the use of a policy within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board (see section 5.6.6).

5.6.1 The documents to be considered for ratification

The documents submitted to PRC should include:

- The full version of the main policy document.
- The full version of any further appendices that have that policy as their primary policy (see section 5.10).

5.6.2 The ratification process

Before a policy can be considered at PRC, the author should liaise with the Administration Assistant, Trust Secretary's Office and complete a PRC pre-submission checklist, to confirm that all necessary steps have been taken.

Policies are considered in detail at the PRC, and therefore someone who is familiar with the content needs to attend PRC when their policy is being considered, to respond to any queries/proposed amendments. This is expected to be the author, but if they are unavailable, they may send a representative who is able to speak on their behalf.

Ratification consists of the following aspects:

- Checking that the policy has been subject to an appropriate consultation and approval process.

- 'Sense-checking' the full text of the policy and its primary appendices, to assess whether they make sense, flow well, are internally consistent and can be understood by the most junior member of staff to which the policy is expected to apply.
- Checking the policy complies with the format, style and layout requirements of the latest 'Policy template' or 'Policy manual toolkit' (or that an exemption has been obtained in the correct manner – see section 5.2.3).
- Proof-reading the policy for errors.

The PRC may propose amendments to the policy. Authors are expected to consider proposed amendments, but are not obliged to accept them. Any objections should be raised by the author at the PRC meeting and debated, to enable a conclusion to be reached. However, if the PRC believes that the amendment is essential to ensuring that the policy is fit for purpose, it may insist that such amendments are made before the policy is ratified. This position should be made clear within the PRC meeting. Any disputes will be considered according to the principles within section 5.6.5.

5.6.3 Outcome of the ratification process

Once PRC has completed its consideration, the policy will either be ratified (as submitted, or subject to changes) or deferred for further development. This latter option will be chosen if the PRC believes that the policy is not fit for purpose or is not substantially compliant with this policy.

If ratified, the author will be asked to make any changes that have been agreed, and submit the final version of the policy (including any further appendices) to the Chair of the PRC. **Note:** Authors of policies contained within policy manuals must arrange for their amendments to be applied to the master manual, using the appropriate editing software. A PDF version of the master should be supplied to the CGA for upload, along with the original file format master to be held in the policy backup archive.

All amendments must be made within three months of the date of consideration by the PRC, or the policy would require re-submission to PRC. Discretion may however be applied by the Chair of the PRC, to take account of any extenuating circumstances for missing this three-month deadline.

If authors have chosen not to make certain changes proposed by PRC, this should be explained. The Chair of the PRC, or the Chair's nominated representatives, will then check that the requested changes have been made, or whether the rationale for not making any changes had been provided (and is credible), and if this is the case, will confirm the documents can be uploaded (at which point the CGA will be asked to upload them to the policy database).

If the Chair of the PRC concludes, after checking, that the changes requested by PRC have not been made, and a rationale for this has not been provided, the author will be notified, asked to make the changes

requested by PRC, and re-submit to the Chair of the PRC or the Chair's nominated representatives, for checking.

The Chair, or the Chair's nominated representatives, will then check that the requested changes have been made, and if this is the case, will confirm the documents can be uploaded (at which point the CGA will be asked to upload them to the policy database).

If the policy is deferred for further development, the author will need to amend the document/s to reflect PRC's comments, and then follow the processes described earlier for consultation, approval and ratification.

Any disputes will be considered according to the principles within section 5.6.5.

5.6.4 Documenting the ratification decision

The ratification decision should be documented in the minutes of the PRC meeting at which the policy was considered.

5.6.5 Resolution of disputes

If an author fundamentally disagrees with an amendment proposed by the PRC, PRC will determine, by the verdict of the majority of those present at the meeting, whether it regards the amendment as essential to ensuring that the policy is fit for purpose. If this is confirmed, the author will be invited to reconsider their position. If the author maintains their position, the policy will be unable to be ratified at that PRC meeting, and should therefore be deferred, pending further discussion.

The author should then discuss the proposed amendment with the owner for the policy. The Chair of the PRC should also provide the owner with the rationale for the PRC's view. The owner should be asked to confirm whether they support the author's view or the view of the PRC. The owner's decision will then be followed (and the policy re-scheduled for a PRC meeting, to enable formal ratification, reflecting the decision made), unless the Chair of the PRC feels that a further discussion, with the Chief Executive, is required. In this case, the Chair of the PRC will arrange for a meeting between the Chief Executive, the owner and themselves, to consider the matter. The decision of the Chief Executive will be final. The policy should then be re-scheduled for a PRC meeting, to enable formal ratification, reflecting the Chief Executive's decision.

5.6.6 Policies ratified by the Trust Board

Certain policies may be required or desired to be ratified by the Trust Board, because of an external requirement to do so, or because the owner or approving committee regards the policy as important enough to warrant this. Such policies are listed in the Reservation of Powers and Scheme of Delegation.

It would be inappropriate for PRC to consider such policies after the Trust Board (as the most senior forum in the Trust) had ratified them. Such policies should therefore be ratified at the Trust Board having first been considered and 'recommended for ratification' by the PRC. Such policies would still be required to be approved by the appropriate committee.

5.7 Publication

Trust-wide policies are uploaded to the Trust's policy database, which is accessible via the Trust's Intranet, to ensure that they are available to all relevant staff.

Staff are notified of any newly-uploaded policies via the monthly Trust-wide policy publication table which can be accessed via the 'Policies & guidelines' page on the Intranet. Notification of the posting of each month's table is included on the intranet 'News Feed' and in the Chief Executive's newsletter.

Hard copy versions of Trust-wide policies should not be circulated, as there can be no guarantee that the hard copy is the latest version to be uploaded.

The Trust does not currently publish its Trust-wide policies on its public website. However, in the interests of openness and accountability, staff are permitted to share uploaded versions of Trust-wide policies with any external party, including patients and staff from other Trusts.

5.8 Review of policies

5.8.1 Review dates

All Trust-wide policies are ratified for four years, unless a shorter period (one, two, or three years) is required by an external agency, the author, or the approving committee. Policies should be reviewed and revised (as required) before their review date is exceeded.

To ensure this, the CGA and Chair of the PRC meet monthly to discuss the status of Trust-wide policies as evidenced by the monthly 'Review status of all Trust-wide policies' report produced by the CGA. Appropriate action for each policy that is overdue review or approaching its review date is agreed. Unless the review process has already begun, or other circumstances commend a different course of action being adopted, this action would usually take the form of an email from the CGA to the policy author:

- **Prompting review:**
  - Asking if the policy is still needed. If the policy is no longer required, the process described in section 5.11.1 should be followed.
  - Prompting review, reminding the author of the steps involved in reviewing, approving and ratifying the document/s.
- **Offering a short extension (maximum six months, to allow time for the policy to be reviewed, consulted, approved and ratified):**
  - If the author is satisfied for the policy to remain in place during this time, they should arrange for an extension request to be made via email (from the Chair of the approving committee), or via formal discussion at one of the committee's meetings.
  - The email, or minutes of the relevant meeting, must be sent to the CGA.
  - Verbal confirmation from the Chair of the approving committee to the Chair of the PRC will also suffice, providing the Chair of the PRC reports such confirmation to the CGA via email (which should be copied to the Chair of the approving committee).

Only two such extensions i.e. covering a maximum of 12 months, will be permitted. Any requests for further extensions should be escalated (by the Chair of the PRC) for consideration by the Chief Executive.

- **Offering the pro forma review process (if the policy qualifies):** If the current version of the policy has been considered and ratified by the PRC (or considered at PRC and ratified by the Trust Board) the CGA's email should offer the opportunity to follow the policy review pro forma process. If this is the case, the CGA will partially complete a policy review pro forma and attach it to the email to the author. See section 5.8.2.

The author is asked to reply to the CGA's email, confirming their intended course of action. If no response, or no satisfactory response, to the CGA's email is received by the following month's policy review meeting, further action will be discussed and agreed (this usually being to repeat the steps above, but to engage with the policy owner instead of the author).

5.8.1.1 Expiry of extension or continued lack of satisfactory response to review prompts

If an extension expires, unless the policy is close to completing the ratification process, or unless the author considers an additional extension to be safe and appropriate and this has been agreed by the Chair of the approving committee (and if necessary, the Chief Executive), the Chair of the PRC will submit a request to the Executive Team Meeting to consider the policy's status, possibly resulting in the policy being withdrawn.

Similarly, where repeated review prompts have resulted in no response, or no satisfactory response from the author or owner with a clear plan to complete either an extension or review process, the Chair of the PRC will submit a request to the Executive Team Meeting to consider the policy's status, possibly resulting in the policy being withdrawn.

5.8.2 Reviews for policies previously ratified at the PRC

Refer to the flow diagram on page 9 for an overview of the pro forma review procedure. Policies that have been previously ratified, or recommended for ratification, by the PRC should, before the 'Review date' is reached, be reviewed, and the author and owner should confirm whether the policy is still a) needed (including whether it should still be a Trust-wide policy, or some other form of corporate document); and if so, b) fit for purpose (notwithstanding any non-material changes). The 'Policy review pro forma' in Appendix 7 should be used to document the review and its outcome. If both are confirmed by the owner and author, the review date should be set for a further four years (or less, if required by an external agency, the author, or the approving committee).

Policies confirmed as no longer needed should be archived (see section 5.11).

Policies still required but not considered fit for purpose should, as a priority (and in accordance with the author's assessment of the level of risk), be fully revised, consulted on, approved, and ratified in accordance

with the process in section 5.2. However, in the interim, if the level of risk is considered too high and the policy deemed to be 'unsafe', the author must follow the process set out in section 5.11.2.

5.8.3 Reviews for policies using the policy manual format

While interim amendments are allowed to individual component policies of a policy manual, the full review process must be followed for the entire policy manual.

5.9 Changes to existing policies

See also: 'Overview of procedure to be followed for amendments to existing policies' on page 8.

5.9.1 Non-material changes

Non-material changes to existing policies can be made any time these are identified as being needed. Ordinarily, the author would be expected to identify the need for such changes, but there may be occasions when others identify this need (in which case this should be brought to the attention of the author).

If the need for non-material changes is identified, the author should email the amended document/s to the CGA, using 'tracked changes' or highlighting to identify the proposed changes and confirming that these are non-material. If the CGA agrees the changes are non-material, they will check and upload the updated document/s. If, however, the CGA disagrees or is uncertain they will contact the Chair of the PRC for advice. If the Chair of the PRC agrees that the change is non-material, they will email the CGA to formally request that the change be made. The CGA will then check, and upload the updated document/s.

Note: Authors of policies contained within policy manuals must arrange for their amendments to be applied to the master manual, using the appropriate editing software. A PDF version of the master should be supplied to the CGA for upload, along with the original file format master to be held in the policy backup archive.

Requests for amendments from individuals who are not the named author will not be accepted unless the author or the owner has confirmed the amendment can be made, in writing (via an email to the CGA or Chair of the PRC).

5.9.2 Material changes

Material changes to policies can only be made with the approval of the relevant approving committee, after completing appropriate consultation (see section 5.3). In such circumstances, the author should arrange for the approving committee to consider, and approve, the proposed changes. If approval is granted, the approved draft/s should be emailed to the CGA for pre-PRC checking. The CGA will submit the final drafts to the Administration Assistant, Trust Secretary's Office for inclusion on the PRC agenda.

All material changes to policies are required to be ratified at PRC (but the PRC will only be required to ratify the sections of the policy that have changed).

5.9.3 Changes as a result of ratified content in a newer policy or appendix
Changes to an existing policy or appendix that result from newer ratified content in another policy or appendix do not require further approval or ratification. The author of the existing policy or appendix should make the required changes, adopting the newer ratified wording wherever possible, and email this to the CGA who will then check, and upload the updated document/s.

5.10 Policy appendices (format and process)
All appendices to policies should be numbered sequentially, and must be referred to within the body of the policy, including appropriate text.

- For policies using the 'Policy template', Appendices 1 to 3 are standard and should be incorporated within the main policy document. All subsequent appendices should be listed within the policy document (in accordance with the latest 'Policy template'), but should be uploaded as separate documents.
- For policies being combined into a 'policy manual', Appendices 1 to 3 have been incorporated into the 'policy manual toolkit'. The 'Policy manual toolkit' remains separate to the policy manual, but is uploaded, for administrative access only, with the policy on the policy database.

Each separate appendix document can be an appendix to more than one policy. However, each appendix should be primarily linked to only one policy. This primary policy should be identified in the list of 'Further appendices' that appears at the end of each main policy document.

Appendices are to be treated in the same way as the primary policy to which they are linked, i.e. such appendices should be reviewed, revised, consulted on, approved, and ratified at the same time as their primary policy. The same process for applying changes (as stated in section 5.9) also applies to appendices.

Appendices are not required to conform to specific template requirements, but must be in Arial font and must include the following:

- The current Trust logo in the header
- The Trust footer (see sample on page 10 of the 'Policy template')
- The Trust disclaimer (i.e. that used for main policy documents)

Appendices that are linked to policies being reviewed and revised, but which are not the appendices' primary policy, are not required to be included in that review process. Such appendices are therefore not required to be submitted for consultation to the approving committee, or be submitted to the PRC when the policy is considered for ratification.

If an appendix is an externally-produced document (i.e. published by a body other than the Trust), its place within the policy should be approved, and ratified, although it is accepted that revisions to the document might not be possible. In such circumstances, authors would be expected to relay any identified errors to the body who publishes the document, but it is accepted that the Trust may not be able to influence the correction of such errors. However, the policy content should be scrutinised by the approving and ratifying committees against the appendix content, to ensure there are no inconsistencies or conflicts that should be rectified within the policy.

5.11 Withdrawing Trust-wide policies from use

5.11.1 Policies no longer required

If an existing policy is no longer considered to be required, it can be archived. For this to happen, the Chair of the approving committee for the current policy should confirm that the document/s is no longer required. This can be done via email (from the Chair to the author, Chair of the PRC and CGA), or via formal discussion at one of the committee's meetings. If the latter route is chosen, the minutes of the relevant meeting will need to be provided to the Chair of the PRC or CGA.

- For individual policies which use the 'Policy template', on receipt of the confirmation, the CGA will archive the policy and any appendices solely 'attached' to that policy. Appendices primarily attached to another policy will not be archived. If an appendix is primarily attached to the withdrawn policy but is additionally attached to other policies, the author of the withdrawn policy should liaise with the other policy authors. If still required by others, the appendix should be allocated to another 'primary' policy, which should be updated to reflect this. If not required by any other policy, each author should update their policy accordingly to remove the appendix and liaise with the CGA "…to establish whether removing the appendix would be considered a material change, and to advise on process.
- For policies contained within a 'Policy manual', the policy author must then arrange for the policy to be withdrawn from the original file format of the 'Policy manual master', a new PDF master to be created and both masters emailed to the CGA, for upload and storage in the policy backup archive. Consideration must also be given to arrangements for any appendices attached to component policies within a 'Policy manual'.

If the approving committee no longer exists, the most appropriate alternative committee should be asked to provide the relevant confirmation, via either of the methods listed above. If there is no appropriate alternative committee, the owner for the current policy should be asked to provide the relevant confirmation, via email (to the Chair of the PRC and CGA).

5.11.2 Policies identified as unsafe

If an existing, uploaded, policy is identified by any member of Trust staff (including the policy author) as being unsafe, that member of staff should email the Chair of the PRC as soon as possible, explaining the rationale. The Chair of the PRC will consider the matter as soon as possible (which may involve liaison with the author) and if there is felt to be any credence to the claim, will ask the CGA to withdraw the policy from the policy database (see 5.11.2.1).

The Chair of the PRC will then notify the policy owner and ask the author to liaise with the person raising the concerns and change the policy to address such concerns (or just change the policy if it was the author that made the request). The process described in section 5.9 should then be followed.

5.11.2.1 When a policy is withdrawn in such circumstances, it should be replaced (on the policy database) with a notice explaining that the policy has been withdrawn for a temporary period, and advising staff which staff member or department they can contact for advice until the policy is amended and re-uploaded. This would usually be the policy author, or the department of that author. **Note:** For policies contained within a 'Policy manual', the policy author must arrange for the policy to be withdrawn from the original file format of the 'Policy manual master' and replaced with a notice as described above, a new PDF master to be created and both masters emailed to the CGA, for upload and storage in the policy backup archive.

5.11.3 Policies with no clear intention to be reviewed

As noted in section 5.8.1, a policy may be withdrawn from publication when its review date is reached, and there has been no clear indication of a plan for reviewing the policy. Such circumstances are exceptional, and the author and owner for the policy should do all they can to prevent it being withdrawn.

However, if the Chair of the PRC does not receive satisfactory assurances, they will submit a request to the Executive Team Meeting to consider the policy's status, possibly resulting in the policy being withdrawn.

5.11.4 Documents that are no longer regarded as Trust-wide policies

There may be occasions when a document that has previously been considered to be a Trust-wide policy is still required, but which is no longer considered appropriate to be regarded as a Trust-wide policy. This may be because of changes to the emphasis of the document, or the way the document is perceived. It may also be related to the fact that the document is, or acts like, an operational plan. The key consideration should be whether the content of the document/s is sufficiently different from the definition of a 'Trust-wide policy' to warrant it being excluded from the policy ratification process.

In such circumstances, the owner for the document should confirm (to the Chair of the approving committee) that they are content for the document to no longer be regarded as a Trust-wide policy. The approving committee should then be asked to formally approve the proposal. It should be made clear to both that if the proposal proceeds, the document could, if desired, remain uploaded to the 'policy database' (which also holds guidelines, SOPs etc.), but it would no longer be subject to the monitoring process applied to Trust-wide policies. In this regard, the author would not be reminded of the document review date, or pursued to ensure this review occurs. The document would also not be obliged to adhere to the Trust's 'Policy template' or 'Policy manual toolkit'.

If the approval is granted, the Chair of the approving committee should arrange for the CGA to be notified, to enable the document/s to be removed from the policy database. **Note:** Individual policies which are contained within a 'Policy manual' but are no longer regarded as Trust-

wide policies must follow the approval process for removal as a policy as described above. However, the policy author must then arrange for the original file format of the 'Policy manual master' to be updated as appropriate, a new PDF master to be created and both masters emailed to the CGA, for upload and storage in the policy backup archive.

If the author or owner wants the document/s to remain uploaded to the policy database, this is possible, but the author should ensure that the documents are not also uploaded to other locations (such as the Intranet or shared folders that can be accessed by the target audience). This will avoid the risk of alternative versions of the document/s being accessed. The author must also amend the format of the document/s, so that it could not be reasonably perceived by readers to be a Trust-wide policy, yet still provides appropriate version control and provenance information; guidance can be found on the intranet: http://mtwintranet/policies/document-development-and-review-processes/.

If the author wishes to promote the awareness of the document/s by referring to these on, for example, a dedicated Intranet page, the page should just contain hyperlinks to the document/s that are uploaded to the policy database.

5.11.4.1 Trust-wide policies that are requested to become clinical guidance

If the owner of a Trust-wide policy wants the document to become a guideline, and the approving committee approves the proposal for the document to no longer be a Trust-wide policy, the document must either complete the guideline approval and ratification process (which is overseen by the Director of Quality Governance), or complete the process to become clinical guidance as an appendix to an appropriate policy (see sections 5.9 and 5.10 of this policy).

Please note that individual policies which are contained within a 'Policy manual' but are now to become clinical guidelines must follow both the approval process for removal as a policy, and the guideline process, as described above. However, the policy author must then arrange for the original file format of the 'Policy manual master' to be updated as appropriate, a new PDF master to be created and both masters emailed to the CGA, for upload and storage in the policy backup archive.

5.12 Authors leaving the Trust

If an author leaves the Trust, the responsibility for the policies they authored will be transferred to their successor. A list of policies under the original author's name can be generated, to share with the new appointee, by the CGA, on request. Please note that the CGA cannot update the policy database to reflect the new author's name unless they are informed of the new appointment.

Where no successor is appointed, or where there is a gap between an individual leaving and their successor starting in post, responsibility will transfer

to the original author's line manager. In the event of a dispute, the owner will appoint an author.

5.13 Policies without procedures

Some Trust-wide documents consist of policy but no accompanying procedures. Such documents should not therefore include 'procedures' in their title nor include any references to 'procedures' in the main body of the policy.

5.14 Exceptions to this policy

This policy aims to cover all circumstances relating to the production, consultation, approval and ratification of Trust-wide policies. It is however recognised that there may be some circumstances that warrant exceptional arrangements. In the event of such circumstances arising, which necessitate a request to deviate from this policy, such requests should be made, in writing, to the Chair of the PRC for their consideration, and potential authorisation. The Chair of the PRC should take into account the circumstances, and make a judgement in the best interests of the Trust. Any authorised exceptions should be reported to the next available meeting of the PRC.

The PRC may also authorise any deviations that it considers necessary.

See Section 5.2.3 for **'Exceptions to using the 'Policy template'**

5.15 Policies during periods of exceptional disruption

The Executive Team Meeting (ETM) is authorised to amend, suspend or replace any Trust-wide policy during periods of exceptional disruption to the Trust's standard functioning (such as major incidents or national emergencies). The terms of such amendments, suspensions or replacements shall be determined by the ETM. The ETM may also delegate such authority to other parties, including, for example, Incident Command Centres.

Such amendments, suspensions or replacements should be notified to the Chair of the PRC, who will request that the CGA updates the policy database and the front covers of any affected policies.

Such amendments, suspensions or replacements will, unless otherwise stated by the ETM, last for the entirety of the period of exceptional disruption. However, if this period lasts longer 12 months, the ETM should review the amendments, suspensions or replacements, and either confirm their continuation for a further period (to be set by the ETM) or confirm that the policy should revert to its previous state (i.e. before the period of exceptional disruption).

Appendix 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the PRC will email this policy to the CGA who will upload it to the policy database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'. Notification of the posting is included on the intranet 'News Feed' and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

- A summary report of the output from each PRC will be submitted to the ETM at the earliest opportunity.
- The PRC will receive regular reports on the review status of each Trust-wide policy, and agree any action to be taken (including escalating issues to the relevant owner or ETM).

3.0 Review

This policy and all its appendices will be reviewed at a minimum of once every four years.

4.0 Archiving

The policy database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

Appendix 2

CONSULTATION ON: Policy and procedure for the production, approval and ratification of Trust-wide policies ('Policy for policies')
Version no.: 8.0
Consultation process – Use this form to ensure your consultation has been adequate for the purpose.
Please return comments to: Trust Secretary
By date: 5th August 2022

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff must be included in all consultations:				
Corporate Governance Assistant	07/07/22	25/07/22	Y	Y
Senior Anti-Crime Manager (Tiaa)	07/07/22			
Head of Fire, Safety and Environment	07/07/22			
Chief Pharmacist and Formulary Pharmacist	07/07/22			
Staff-Side Chair	07/07/22			
Complaints & PALS Manager	07/07/22			
Emergency Planning Team	07/07/22			
Head of Staff Engagement and Equality	07/07/22			
Health Records Manager	07/07/22			
All individuals listed on the front page	07/07/22			
All members of the approving committee (the Executive Team Meeting).	07/07/22		N	N/A
Other individuals the author believes should be consulted				
All PRC members	17/06/22 & 07/07/22	17/06/22	Y	Y
Divisional Directors of Nursing & Quality	07/07/22			
Divisional Directors of Operations (DDOs)	07/07/22	08/07/22 (DDO for Surgery)	N	N/A
Clinical Directors	07/07/22			
Head of Internal Audit	07/07/22	02/08/22	Y	Y
Chair of the Trust Board	07/07/22			
Non-Executive Directors	07/07/22	11/07/22 (RF)	N	N/A
		11/08/22 (DM)	N	N/A
Associate Non-Executive Directors	07/07/22			
Risk and Compliance Manager	07/07/22			
Head of Information Governance	07/07/22			
Director of Quality Governance	07/07/22			

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Head of R&D	07/07/22			
Clinical Lead for Research	07/07/22			
Deputy Director of Finance (Financial Governance)	07/07/22			
Deputy Director of Finance (Financial Performance)	07/07/22			
Deputy Medical Director / Director of Infection Prevention and Control (DIPC)	07/07/22			
Director of IT	07/07/22			
Head of Employee Relations	07/07/22			
Deputy Chief People Officer, Organisational Development	07/07/22			
Deputy Chief People Officer, People and Systems	07/07/22			
Head of Financial Services	07/07/22			
Assistant Director of Business Intelligence	07/07/22			
Associate Director of Procurement	07/07/22			
Deputy Chief Nurse - Quality and Experience	07/07/22			
Deputy Chief Nurse – Workforce & Education	07/07/22			
Director of Medical Physics	07/07/22			
Deputy DIPC	07/07/22			
Director of Delivery Development	07/07/22			
Director of Medical Education	07/07/22			
E.M.E. & Technical Services Manager	07/07/22			
Programme Director for EPR (Sunrise) and Digital Transformation	07/07/22	08/07/22	N	N/A
Trust Lawyer	07/07/22	08/07/22	N	N/A
Clinical Audit & Regulatory Compliance Lead	07/07/22	05/08/22	Y	Y
Chief Clinical Information Officer	07/07/22			
Trust Lead Cancer Clinician	07/07/22			
Assistant Trust Secretary	07/07/22	05/08/22	Y	Y
Freedom to Speak Up Guardian	07/07/22			
The following staff have given consent for their names to be included in this policy and its appendices: Ruth Dickens, David Kenealy, Andrew Ede, Beth Durcan, Mark Vince, Mildred Johnson, Amanda LePage, Jo Garrity, Louise Dunkley, Angela Savage, Stephanie Smith				

Appendix 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy development exercises.**

Title of policy or practice	Policy and procedure for the production, approval and ratification of Trust-wide policies ('Policy for policies')
What are the aims of the policy or practice?	To ensure the policies Trust staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the organisation
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination? (yes/no)** No If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
Pregnant women and individuals, or those on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document.

Further appendices

The following appendices are published as related links to the main policy/procedure on the policy database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Policy ratification - frequently asked questions (FAQs)	RWF-COR-COR-APP-1	This policy
5	Policy template	RWF-OP-DocTemp-Policy1	This policy
6	Style guide for Trust-wide policies	RWF-COR-COR-APP-4	This policy
7	Policy review pro forma (for policies that have previously been ratified by the Policy Ratification Committee (PRC))	RWF-COR-COR-FOR-2	This policy
8	[Policy manual toolkit] Policy manual form	RWF-XXXXXXX [TBC]	This policy
	8a: Record of consultation	RWF-XXXXXXX [TBC]	This policy
	8b: Equality impact assessment	RWF-XXXXXXX [TBC]	This policy

NHS
Maidstone and Tunbridge Wells NHS Trust

Annual review of the Trust Board's Terms of Reference — Chair of the Trust Board

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. That review and approval last took place in July 2021, so a further review is now due.

Some amendments are proposed, which are shown as 'tracked' on the following pages. The main proposed change reflects the introduction of the 'triple aim' duty for NHS bodies (to have regard to the wider effect of decisions) within the Health and Care Act 2022.

Trust Board members are aware that NHS England consulted on an updated Code of governance for NHS provider trusts in May 2022. The new Code, which is expected to be published in the autumn, will formally apply to NHS Trusts for the first time, and it is possible that some further revisions to the Trust Board's Terms of Reference may be required in response to the Code's content. This will be considered once the new Code has been published and reviewed.

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To approve the revised Terms of Reference for the Trust Board

[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

Trust Board

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

Purpose and duties

1. The Trust exists to provide goods and services for ~~any~~ the purposes of the health service[2], and has a general duty to exercise its functions effectively, efficiently and economically[1] ~~related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health~~. In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to the health and well-being of the people of England; the quality of services provided to individuals by relevant bodies[3] (or in pursuance of arrangements made by relevant bodies[2]),for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; and efficiency and sustainability in relation to the use of resources by relevant bodies[2] for the purposes of the health service in England[4].

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to a Member of the Executive Team. The voting members of the Trust Board comprise a Chair (Non-Executive), five other Non-Executive Directors, the Chief Executive, and four specified Members of the Executive Team. Other, non-voting members of the Trust Board attend Trust Board meetings and contribute to its deliberations and decision-making.

3. The Trust Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each individual Trust Board Member, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Trust Board – and of its sub-committees – are described in the Trust's Standing Orders.

General responsibilities

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost-effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of all Trust Board Members.

Leadership

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;

[2] National Health Service Act 2006
[3] NHS England, Integrated Care Boards, and other NHS Trusts and NHS Foundation Trusts
[4] Health and Care Act 2022

8.2. Ensuring the Trust is an excellent employer by the development of a People and Organisational Development strategy and its appropriate implementation and operation.

Strategy

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
   9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
   9.4. Develops and maintains an annual forward programme and ensures its delivery as a means of implementing the strategy of the Trust to meet the expectations and requirements of stakeholders;
   9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Code of Conduct has been developed to guide the operation of the Trust Board and the behaviour of Trust Board Members. This Code is incorporated within the Trust's Gifts, Hospitality, Sponsorship and Interests Policy and Procedure.

Governance

12. The Trust Board:
   12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
   12.2. Ensures that the Trust complies with its governance and assurance obligations;
   12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
   12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
   12.5. Ensures that the statutory duties of the Trust are effectively discharged;
   12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk management

13. The Trust Board:
   13.1. Ensures an effective system of ~~integrated~~ governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
   13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
   13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Members of the Executive Team.

Ethics and integrity

14. The Trust Board:

14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
14.2. Ensures that Trust Board Members and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders, Reservation of Powers and Scheme of Delegation, and/or by the Board from time to time

Communication

16. The Trust Board:
16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality success and financial success

17. The Trust Board:
17.1. Ensures that the Trust operates effectively, efficiently, and economically;
17.2. Ensures the continuing financial viability of the organisation;
17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chair

18. The Chair of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chair is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chair is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chair of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

Membership of the Trust Board

24. The Trust Board will comprise the following persons:
24.1. The Chair of the Trust Board
24.2. Up to five Non-Executive Directors. One of these will be designated as Vice-Chair
24.3. The Chief Executive
24.4. The Deputy Chief Executive / Chief Finance Officer

24.5. The Medical Director
24.6. The Chief Nurse
24.7. The Chief Operating Officer

Non-voting Trust Board Members (as stated in the Trust's Standing Orders) will be invited to attend Trust Board meetings at the discretion at the Chair.

Quorum

25. The Board will be quorate when four Trust Board Members including at least the Chair (or Non-Executive Director nominated to act as Chair), one other Non-Executive Director, the Chief Executive (or member of the Executive Team nominated to act as Chief Executive), and one other member of the Executive Team (voting member) are present[5].

26. An officer in attendance for a voting member of the Executive Team but without formal acting up status may not count towards the quorum at Trust Board meetings

Attendance

27. The Trust Secretary will normally attend each meeting.

28. Other staff members and external experts may attend Trust Board meetings to contribute to specific agenda items, at the discretion of the Chair

Frequency of meetings

29. The Trust Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

30. The Chair, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a 'balanced board' where the skills and experience available are appropriate to the challenges and priorities faced;

31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

32. The Trust Board has the following sub-committees
    32.1. The Quality Committee
    32.2. The Patient Experience Committee
    32.3. The Audit and Governance Committee
    32.4. The Finance and Performance Committee
    32.5. The People and Organisational Development Committee
    32.6. The Charitable Funds Committee
    32.7. The Remuneration and Appointments Committee

33. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance and Performance Committee, Charitable Funds Committee, and People and Organisational Development Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair of that meeting) in a timely manner

34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Emergency powers and urgent decisions

[5] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chair and members (including at least one Executive Director and one Non-Executive Director) is present"

35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chair of the Trust Board and Chief Executive after having consulted at least two Non-Executive Directors.

36. The exercise of such powers shall be reported (by the Chair of the Trust Board) to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

Administration

37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    37.1. Agreement of the agenda for Trust Board meetings with the Chair and Chief Executive;
    37.2. Collation of reports for Trust Board meetings;
    37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    37.4. Advising the Trust Board on governance matters.

38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chair and Chief Executive.

Conflict with Standing Orders Set

39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

40. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 29th September~~July~~ 2022~~1~~