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

*Thu 25 May 2023, 09:45 - 13:00*

**Virtually, via Webconference**

Maidstone and Tunbridge Wells NHS Trust

## Agenda

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

### 05-1
### To receive apologies for absence

*David Highton*

### 05-2
### To declare interests relevant to agenda items

*David Highton*

### 05-3
### To approve the minutes of the 'Part 1' Trust Board meeting of 27th April 2023

*David Highton*

Board minutes, 27.04.23 (Part 1).pdf (12 pages)

### 05-4
### To note progress with previous actions

*David Highton*

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

## Reports from the Chair of the Trust Board and Chief Executive

### 05-5
### Report from the Chair of the Trust Board

*David Highton*

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

## 05-6
## Report from the Chief Executive

*Miles Scott*

Chief Executive's report May 2023.pdf (3 pages)

# Reports from Trust Board sub-committees

## 05-7
## Quality Committee, 10/05/23 (incl. the Annual Fire Safety Report, 2022/23; and approval of the revised Terms of Reference (annual review))

*Maureen Choong*

Summary of Quality C'ttee, 10.05.23.pdf (18 pages)

## 05-8
## Finance and Performance Committee, 23/05/23

*David Morgan*

Summary of Finance and Performance C'ttee 23.05.23.pdf (1 pages)

## 05-9
## People and Organisational Development Committee, 19/05/23

*Emma Pettitt-Mitchell*

Summary of People and Organisational Development Cttee, 19.05.23.pdf (2 pages)

## 05-10
## Audit and Governance Committee, 16/05/23

*David Morgan*

Summary of Audit and Governance Committee, 16.05.23.pdf (3 pages)

# Integrated Performance Report

## 05-11
## Integrated Performance Report (IPR) for April 2023

*Miles Scott and colleagues*

Integrated Performance Report (IPR) for April 2023.pdf (35 pages)

# Systems and Place

## 05-12
## Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

*Rachel Jones*

Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (2 pages)

# Planning and strategy

## 05-13
## Update on the corporate objectives for 2023/24

*Rachel Jones*

N.B. This will be a verbal update.

## 05-14
## Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital

*Sean Briggs*

Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital.pdf (1 pages)

# Assurance and policy

## 05-15
## Six-monthly review of the Trust’s red-rated risks

*Joanna Haworth*

Six-monthly review of the Trust’s red-rated risks.pdf (12 pages)

## 05-16
## NHS provider licence: Self-certification for 2022/23

*Kevin Rowan*

Provider Licence self-certification.pdf (62 pages)

## 05-17
## Ratification of Standing Orders, Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)

*Kevin Rowan*

N.B. The full documents, with the proposed changes shown as 'tracked', have been provided to Trust Board members as supplementary reports available via the Trust Board "documents" section of the Admincontrol meetings portal.

Ratification of revised SOs, SFIs and SoD.pdf (2 pages)

# Other matters

## 05-18
## To consider any other business

*David Highton*

## 05-19
## 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 individual 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), via mtw-tr.palsoffice@nhs.net.

## 05-20
## 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 27TH APRIL 2023, 9:45 AM, PENTECOST-SOUTH, ACADEMIC CENTRE, MAIDSTONE HOSPITAL**

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) |
| | Peter Maskell | Medical Director | (PM) |
| | David Morgan | Non-Executive Director | (DM) |
| | Steve Orpin | Deputy Chief Executive / Chief Finance Officer | (SO) |
| | Emma Pettitt-Mitchell | Non-Executive Director | (EPM) |
| | Miles Scott | Chief Executive | (MS) |
| | Wayne Wright | Non-Executive Director | (WW) |
| In attendance: | Karen Cox | Associate Non-Executive Director | (KC) |
| | Sarah Davis | Deputy Chief Operating Officer | (SD) |
| | Ainne Dolan | Deputy Chief People Officer, Organisational Development | (AD) |
| | Richard Finn | Associate Non-Executive Director | (RF) |
| | Rachel Jones | Director of Strategy, Planning and Partnerships | (RJ) |
| | Sara Mumford | Director of Infection Prevention and Control | (SM) |
| | Jo Webber | Associate Non-Executive Director | (JW) |
| | Alex Yew | Associate Non-Executive Director | (AY) |
| | Kevin Rowan | Trust Secretary | (KR) |
| | Paul Bentley | Chief Executive of the NHS Kent and Medway Integrated Care Board (KM ICB) (for part of item 04-11 - refer to the relevant minute for the specific details; and items 04-13 & 04-14) | (PB) |
| | Cedi Frederick | Chair of the KM ICB (for part of item 04-11 - refer to the relevant minute for the specific details; and items 04-13 and 04-14) | (CF) |
| | Christian Lippiatt | Freedom to Speak Up Guardian (for item 04-20) | (CL) |
| | Rachel Thomas | Interim Director of Midwifery and Gynaecology (for item 04-17) | (RT) |
| 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]*

**04-1 To receive apologies for absence**

Apologies were received from Sean Briggs (SB), Chief Operating Officer, but it was noted that SD was attending in SB's place. It was also noted that Sue Steen (SS), Chief People Officer would not be in attendance, but AD was attending in SS' place. DH also noted that it was AY's first face-to-face/in-person Trust Board meeting.

**04-2 To declare interests relevant to agenda items**

AY declared that he was a non-Board Associate Non-Executive Director at the KM ICB, and would be a member of the ICB's Performance and Investment Committee (which was relevant for all the ICB-related items on the agenda).

**04-3 To approve the minutes of the meeting of 30th March 2023.**

The minutes of the meeting of the 30th March 2023 were approved as a true and accurate record of the meeting.

**04-4 To note progress with previous actions**

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

- **02-10a ("Consider adjusting the target for the "Appraisal Completeness" metric to reflect the fact that performance would likely decline during the appraisal 'window', and the final position would not be known until the 'window' had closed").** AD referred to the content of the "Progress" column and added that the action was in progress and liaison was taking place with Human Resources Business Partners. DH therefore confirmed that the action could be closed, on the basis that it would addressed via the Integrated Performance Report (IPR) that would be considered at the Trust Board meeting in May 2023.
- **03-20a ("Arrange for the typographical errors in the Patient Safety Incident Response Plan that was considered by the Trust Board on 30/03/23 to be corrected, prior to its further circulation/publication").** JH reported that the errors had been corrected so it was confirmed that the action could be closed.

DM then referred to action 03-3 ("Explore what could be developed to show the 'arch' for each of the major income and expenditure categories, to enable Trust Board members to better understand the delivery of the CIP for 2023/24"), which had been closed, but stated that he could not see the information in the planning update that had been submitted under item 04-18, as had been stated in the "Action taken to 'close'" column. SO acknowledged that the information had not been included in that report, but it would be included in a report that would be submitted to the Finance and Performance Committee's meeting in May 2023, and SO would be content to submit that detail to the Trust Board. This was agreed. DH added that the Trust would need to submit a further 2023/24 planning submission in the near future.

**Action: Ensure that the Trust Board was provided with details of the 'arch' that had been developed for each of the major income and expenditure categories (Deputy Chief Executive/Chief Finance Officer, April 2023 onwards)**

**04-5 Report from the Chair of the Trust Board**

DH referred to the submitted report and highlighted the following points:
- The Trust had had to deal with much instability at present, in relation to financial planning and also future industrial action. DH therefore wanted to thank all staff for their positive response.
- A Palliative Care consultant had been appointed in April, and a further consultant appointment had been made at the end of that month that had been too late to include in the report.

**04-6 Report from the Chief Executive**

MS referred to the submitted report and highlighted the following points:
- MS was hugely appreciative of the medical and workforce teams for managing during the recent junior doctors' industrial action. The Trust had been able to maintain good patient flow and patient safety, and the Trust's consultant body had been very supportive. The Trust's productivity for April would however had been considerably adversely affected.
- The Royal College of Nursing (RCN) had scheduled a strike for its members from 30/04/23, but that would not affect the Trust, as the ballot return for the Trust's nursing staff did not meet the required threshold for industrial action. The same position applied to all of the acute Trusts in Kent and Medway, although nursing staff at Kent Community Health NHS Foundation Trust and the KM ICB would be taking industrial action. Members of the Royal College of Midwives and Unison had accepted the government's pay offer, but the ballot results from other unions, including Unite, would be announced soon. An NHS Staff Council meeting would also be held on 02/05/23. The position would therefore become clearer in the coming weeks, although the RCN intended to re-ballot its members for further industrial action. The outcome of the British Medical Association's ballot of its consultant members was also expected soon.
- The Trust had received some initial feedback from the Care Quality Commission Well Led inspection that took place at the end of March, and that was contained in the submitted report.
- The Trust's Cancer Services team had been highlighted on a BBC South East news TV feature.
- The Trust's Staff Star Awards would be held on 28/04/23, and it would be the first face-to-face/in-person staff awards ceremony since before the COVID-19 pandemic.
- Several staff had also been nominated for awards by external organisations.
- MS had attended an 'away day' event for the ophthalmology team on 26/04/23, which had been organised by RJ's team. The event intended to discuss the future strategy for the service, as the

previous strategy had been developed five years ago. MS wanted to commend the positive spirit and multidisciplinary nature of the event.

JW referred to the RCN's intention to hold a further ballot and asked if the basis for the ballot would be the same as the previous ballot. MS and JH confirmed that the details of any future ballot were not yet known.

JW also asked for details of the impact of the recent junior doctors' strike. SD reported that approximately 1500 outpatient appointments, and approximately 66% of elective activity had been cancelled. WW asked whether that impact would have a material effect on the Trust's financial plan. MS replied that it was hoped that the Trust would be able to recover its elective activity plans, and provided further context on what the Trust had learned from the way it had managed the industrial action, including the impact that striking staff had had on other, non-striking, departments.

EPM then asked for further details of the ophthalmology 'away day'. AD duly elaborated on the event and highlighted that all of the staff present had had an equal voice and some achievable outcomes had been agreed.

**Reports from Trust Board sub-committees**

**04-7 Quality Committee, 12/04/23**

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

- The draft quality priorities for 2023/24 had been agreed, although further iterations would be developed.
- An update on the management of sepsis had been given.
- A detailed review had been undertaken on the mortality rate and learning from deaths, including Structured Judgment Reviews (SJRs).
- The next 'deep dive' meeting would hear from the stroke team and consider medicines optimisation.

DH referred to the latter point and asked whether the medicines optimisation item would include details of the plans to use generic medicines when the patents for branded medications expired. MC stated that she had not yet seen the presentation for the item, but confirmed that she could ask the team to include such information.

**Action: Request that the "Review of the Trust's medicine management and optimisation" item at the Quality Committee 'deep dive' meeting in June 2023 included details of the plans to use generic medicines when the patents for branded medications expired (Chair of the Quality Committee, April 2023 onwards)**

**04-8 Finance and Performance Committee, 25/04/23**

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

- The meeting had had an excellent session on outpatients, which included the implementation of the patient portal, and acknowledged the need to improve telephone call times and clinic utilisation. It was agreed that the subject would be reviewed again in three months.
- Several other items that had been considered would feature separately on the Trust Board meeting agenda.
- The Committee continued its focus on the Cost Improvement Programme (CIP).
- The Trust had delivered its financial plan for 2022/23 and also delivered many patient access targets, so that achievement should be acknowledged and commended.

**04-9 People and Organisational Development Committee, 24/03/23 (incl. quarterly report from the Guardian of Safe Working Hours)**

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

- SO and the Programme Director for Premium Staffing Spend had attended for an update on agency and bank staffing expenditure, and it was agreed that the issue would be reviewed regularly by the Committee in the future.

- The Trust's gender pay gap data had been discussed.
- The Guardian of Safe Working Hours had attended & their report was contained in Appendix 1.
- The Committee had discussed the vacancy rate within the Trust's lower banded support roles in some detail.
- The first update from the Wellbeing Committee had been considered.

**04-10 To approve the revised Terms of Reference for the Remunerations and Appointments Committee (annual review)**

DH referred to the submitted report, which highlighted the proposed changes, and asked that such changes be approved.

The revised Terms of Reference were approved as submitted.

**Integrated Performance Report**

**04-11 Integrated Performance Report (IPR) for March 2023**

MS introduced the item by highlighting the Trust's strong delivery for 2022/23, which included achieving the financial plan for the fifth year in a row, which should be commended. MS also noted that the Daily Telegraph produced a 'league table' for NHS Trusts and the Trust performed very well.

MS then referred to the Trust's objectives and reported that the "Vision Goals / Targets" would remain the same for 2023/24 as they had been for 2022/23, but the Executive Directors were currently refreshing the Breakthrough Objectives for 2023/24, and the Trust Board would be asked to approve those in May 2023.

AD then referred to the "People" Strategic Theme and reported the following points:
- The vacancy rate continued to be low.
- The staff turnover rate was currently at 13.1%, which compared to the target of 12%. The first 'deep dive' into administrative and clerical (A&C) roles had now been conducted.
- The work regarding the appraisal rate would be developed for inclusion in the IPR in May, as had been noted when action 02-10a had been discussed under item 04-4.
- The performance for Statutory and Mandatory training was above the target.

DM referred to the vacancy rate, noted that there were two ways of reducing the rate i.e. to hire staff to vacant posts or to remove the vacant posts, and asked for assurance that the vacant posts had been recruited to rather than removed from establishments. AD gave assurance that vacant posts had been filled. MS however clarified that a change had been made to only include posts that related to new developments at the point at which that development had started, rather than at the point the posts had been agreed. SO then added further details.

SO also pointed out that a vacancy rate of 9% had intended to be the Trust's target rate for three years' time, so the extent of the success in achieving the current rate should be fully recognised. The point was acknowledged.

JW referred to stratified data on staff turnover and queried whether the Trust was content that the target was realistic for all staff groups, particularly as staff in A&C roles had many options to work outside the NHS. AD welcomed having an overall target but noted that work was underway with specific groups. JS clarified that her question was whether the target needed to be varied for particular staff groups. AD confirmed that she felt it was important to have an overall target, but it was an interesting point as to whether sub-targets should be developed. SO added that sub-targets may be helpful, but the Trust was not yet in a position to understand the full context, given that the 'deep dive' on A&C staff had only just been done.

WW commented that the People and Organisational Development Committee had highlighted that ensuring all staff had had an appraisal should help with retention, as circa 700 staff had not had an appraisal during the last year. WW therefore asked AD to elaborate on the actions that would be taken to increase the appraisal rate. AD explained the approach that was planned, while EPM emphasised that the staff turnover metric should not be considered in isolation. EPM also stated that she did not believe the turnover target needed to be varied as JW had suggested, as EPM believed

that the main focus should be on staff retention. DM highlighted the difference between 'good' turnover, which involved staff being promoted internally; 'bad' turnover, which involved good staff leaving the Trust; and 'acceptable' turnover, which involved staff retiring, and asked how such categories were reflected in the Trust's turnover data. AD explained that the Trust was in the process of developing its data sources to use such categories, but she was aware that some turnover reflected internal promotions.

AY asked about the plans to use the feedback obtained from staff appraisals and other sources. AD explained the approach and confirmed it was an ongoing process.

DH observed that the major productivity challenge that ministers had levied at the NHS was that staffing had increased by 11%, as many posts had been added during the COVID-19 pandemic which had not then been removed, but activity had not recovered to pre-pandemic levels. SO confirmed that that was the position at a macro level across the NHS, but that was not the position at the Trust, and provided further context. WW asked for further details of the Trust's activity plans. SO obliged and DH explained the concept of 'value weighted activity'.

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

- Mortality was monitored via the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR), and also through the Mortality Surveillance Group (MSG). The Trust's mortality rates had triggered the Strategy Deployment Review (SDR) requirement for a Counter Measure Summary, but the HSMR was actually stable, and the latest SHMI data, which had been published on 26/04/23, was lower than in previous months and was now very close to being 'lower than expected'.
- The MSG would now receive a report on mortality in patients with a learning disability at each meeting.
- The Medical Examiners had been told to slow down their work on examining all deaths in the community.
- Letters had started to be issued to those who were considered to have provided excellent care, following an SJR.
- Telstra Health (formerly Dr Foster) had been a lot more engaged, and had undertaken far more 'deep dive' reviews in response to particular issues arising from the data.
- The Trust was in a period of 'business as usual' monitoring in relation to patient falls, and with four days to go in April, the Trust would be at, or below, its trajectory for the "Reduction in the rate of patient falls…" Breakthrough Objective. However, falls had been selected for that Breakthrough Objective because it had been felt that reducing falls would lead to a reduction in incidents resulting in harm, as 13% of such incidents were related to falls. However incidents resulting in harm had actually increased. A stakeholder meeting had therefore been scheduled to discuss this. It should however be noted that JH and the Director of Quality Governance had encouraged staff to report patients falls, while the Trust had transferred to a new incident reporting system, so there would likely be some fluctuation in the incident numbers.
- Sepsis and deteriorating patients would likely be the next areas of focus to reduce harm, but the Trust would be driven by data.

SM then reported the following points in relation to the infection prevention and control performance:

- The number of COVID-19 inpatients had continued to reduce, and the number of cases was now circa 30 across both main sites.
- The Trust had ceased the widespread use of face masks at the start of February, but that had coincided with an increase in COVID-19 cases in the community. That had therefore adversely affected the number of cases at the Trust, but the position had now stabilised, and the Trust now had only one COVID-19 outbreak.
- The number of *clostridiodes difficile* cases had now stabilised and SM was confident that the maximum limit of 62 cases for 2023/24 would be achieved.
- There had been one case of MRSA bacteraemia in March, which had occurred in the ICU. The Root Cause Analysis had not identified any breakdown in nursing or medical management, so it was thought that a contaminant was likely to have been the cause. The case was therefore likely

to be stepped down from being a Serious Incident (SI), as no actions had been identified for the clinical team and the patient had received very good care.

SD then referred to the “Patient Access” Strategic Theme and reported the following points:

- The Trust had continued to perform well on the Emergency Department (ED) 4-hour waiting time target, and the Trust had been able to close an escalation ward.
- The cancer access targets continued to be met.
- The year-end position for the 18-week Referral to Treatment (RTT) standard was just over 70%. The Trust had no patients waiting over 52 weeks for treatment, but 571 patients had waited more than 40 weeks. That was disappointing but still represent a significant achievement.
- The Trust continued to receive requests to support other Trusts with their clinical activity.
- The Diagnostics Waiting Times and Activity (DM01) standard continued to be affected by echocardiogram performance. However there had been some improvement and this was expected to continue.
- The outpatients programme was progressing, and the Trust had the opportunity to bid for funding to enable the patient portal to be implemented from September 2023 rather than March 2024.

JH the referred to the “Patient Experience” Strategic Theme reported the following points:

- The complaints response time performance had been maintained at 60%. It was intended to achieve the current target of 75% by September 2023 and then increase the target to 90%, which was the generally-accepted target nationally.
- The number of re-opened complaints had reduced.
- The new Head of Patient Concerns had started in post at the end of March 2023, and they had made good progress in understanding some of the barriers to improved response time performance. The Divisions were also now taking on responsibility for the quality control of their complaint responses.
- The Friends and Family Test (FFT) response performance had generally improved, and it had now been agreed to capture responses from a broad range of methods, such as QR codes, text messages, hard copy surveys and the use of volunteers, as it had been acknowledged that there had previously been too much reliance on a single method.
- 95% of the patients that submitted an FFT response in the ED had recommend the Trust, but JH recognised that more was required to improve communication, although more specific details were being explored.

JW commended the marked improvement in the FFT response rate for maternity and asked what action had been taken to achieve that outcome. JH explained that the maternity service had applied a greater focus. JW asked whether the learning would be shared with other areas, including outpatients. JH pointed out that the outpatients FFT process was reliant on text message reminders, so the outpatient FFT improvement work would be focused on that aspect.

RF also commended the improvement in FFT response performance, but noted that there had been a low starting point. RF then asked whether the focus would now shift to responding to the content of the FFT surveys. JH confirmed that work was already being done to review the feedback, for which communication was a major theme, and elaborated on the range of issues that were covered under that heading, and the work being done to address such issues. RF asked whether the Ward meetings discussed what constituted good communication. JH noted that she did not attend all Ward meetings, but she would expect such meetings to discuss communication.

KC asked what would happen if a patient reported a real concern via an FFT survey i.e. would the issued be followed up. JH clarified that the FFT surveys were a very crude form of obtaining feedback from patients, and the surveys were completed anonymously, so no follow up could occur with individuals. JH also noted that she was keen to consider how compliments could be better used, while JH had changed the Patient Experience Breakthrough Objective to shift the focus away from the FFT response rate.

EPM commented that some investment had been made in the central complaints team so asked if the return on investment had been measured. JH confirmed it had not, but stated that she believed the investment that had been made was insufficient. MC concurred and JH elaborated on the issues.

DH noted that the Trust would be changing its FFT survey provider, but the Trust was also aiming to link its new patient portal with the NHS App, so asked whether there was a risk of duplication between the systems. JH noted that the patient experience aspects could not be provided by the patient portal provider that had been selected, so the Trust had had to engage a different FFT provider. DH suggested that JH consider whether the FFT provider could integrate their system with the NHS App in the future. JH agreed to raise that point when she next met with the provider.

**Action: Establish whether the Trust's new Friends and Family Test (FFT) provider had plans to integrate their system with the NHS App (Chief Nurse, April 2023 onwards)**

AY asked whether complaints and compliments were considered as part of pay progression and appraisals for staff. JH confirmed that these were not part of pay progression and explained the complexities involved. SM however added that complaints and compliments were integrated into the appraisal system for doctors and PM or SM could request that an issue be discussed in a particular doctor's appraisal, should they consider that to be necessary.

*[N.B. PB and CF were present for the remainder of item 04-11]*

RJ then referred to the "Systems" Strategic Theme and reported the following points:

- The "Discharge before noon" performance had been maintained at 22%, which was below the 33% target. However 22% was the average performance, and there had been many days where discharges had been significantly above 22%. The Trust had just implemented the new Electronic Discharge Notification (eDN) process on two orthopaedic wards and RJ was hopeful that good practice could be applied to other areas.
- Further work was still required in relation to the 'top contributors', but data revealed that only a small number of discharges had been adversely affected by pharmacy delays.
- The data on the number of inpatients who no longer met the criteria to reside was very interesting, as there had been a large increase, but the presence of very senior clinical staff on the first day of the recent junior doctors' strike coincided with a discharge before noon rate of 44%. The details of the patients who had been discharged on that day would therefore be reviewed to determine whether the theory was correct.

MS referred to the latter point and noted that the Quality Committee had explored the issue of senior decision making and confidence in discharging patients, so asked whether the data had been considered in that context. RJ noted that the data was still being analysed but RJ suspected that there had been fewer occurrences of diagnostic tests being requested after a patient had been deemed fit for discharge, which seemed to be more common with junior doctors. PM added further context and noted that the position varied across the Trust, and between consultants and their junior teams, as consultants had different approaches to teaching their juniors.

SO referred to the "Sustainability" Strategic Theme and reported the following points:

- The financial plan for 2022/23 had been achieved with a small surplus, subject to audit. As had been noted as the start of item 04-11, 2022/23 was the fifth year in succession that the financial plan had been delivered. The only negative aspect was that the plan had been achieved via non-recurrent means.
- The draft financial accounts for 2022/23 would be submitted later that day.
- One escalation area had closed and plans were in place to close another.
- The temporary staffing and agency expenditure Breakthrough Objective had started to improve in February, but had deteriorated in March. Performance had been affected by three things: the coterminous Annual Leave (A/L) year, which meant staff took most of their A/L entitlement at particular common periods during the year; the aforementioned recent junior doctors' strike; and SO's team ensuring that all expenditure was accounted for, as part of their end of year actions. However, a range of actions were in place to improve the position, and if the trajectory for 2023/24 was delivered, the Trust would be below the national average.

DM noted that there had been far less of a peak in Bank and agency expenditure in March 2021, so asked whether that was related to staff being able to take their A/L forward into 2022/23. MS agreed that that was likely, although SO pointed out that the A/L taken in March was lower than that taken in August but the temporary staffing was still higher in March. DM speculated that the position may be related to A/L in August being more planned, with A/L in March being taken at

shorter notice. DM also asked for further details on rostering and on the financial value involved in achieving the objective. SO provided the requested details and emphasised that the objective involved significant financial values.

RF then remarked that he had been impressed by the approach that SO and his team had taken in relation to the objective i.e. to address the controls first. RF also noted that the temporary staffing usage was evenly divided between nursing staff, doctors and A&C staff, so asked whether work would also be focused on the latter group. SO confirmed that would be the case, but pointed out that A&C staff were already subject to rostering.

**04-12 Update on the provision of non-emergency patient transport**

RJ reported the following points:

- The contract had been for an initial six year period with an option to extend for a further three years, and the three-year extension had been enacted, although that decision was likely to have been related to the limited capacity to undertake a wider tendering exercise during the COVID-19 pandemic, rather than satisfaction with the performance of the existing provider.
- The contract would therefore expire in July 2025.

DH asked whether a place-based contract would be large enough to be financially efficient, or whether a further Integrated Care System (ICS)-wide contract would be needed. RJ stated that a 'one size fits all' contract would not be appropriate. RJ also asked whether the Trust Board was keen to ask for a major review of the contract. DH confirmed the Trust Board's support for such a review, but emphasised that the review should not be dependent on the procurement capacity within the ICB. The point was acknowledged.

MS added that the Trust was effectively subsidising the contract financially, by paying for additional transport to cover gaps in provision by the current contractor, so any new contract should not be constrained by the existing budget. MS also asserted that the ICB should not continue to claim that no action was possible when faced with problems with service provision. The points were acknowledged.

**Systems and Place**

**04-13 Update on the Kent and Medway Integrated Care Board (KM ICB)**

DH welcomed CF and PB to the meeting, and CF and PB gave brief details of their respective previous experience and roles. PB then gave a presentation which covered "Key Planning and Partnership Bodies"; "Integrated Care Strategy"; "Where next: Next steps for the Integrated Care Strategy"; "DRAFT Organisational Priorities"; "Where we are"; "Finances – delivering more, faster with reduced resources"; "What do we need to do to deliver faster with reduced resources – planning 23/24"; and "Maidstone and Tunbridge Wells NHS Trust" (during which PB thanked the Trust for its contribution to the ICS).

DH observed that ensuring provider Non-Executive Directors were apprised of ICB and ICS developments was an ICS-wide problem, although the Maidstone and Tunbridge Wells NHS Trust Board had a standing update item on the agenda of every meeting. CF acknowledged the problem and proposed that this be addressed via the governance review that the ICB had planned. DH confirmed that would be acceptable.

JW asked how the ICB could use the collective expertise of the Trust Board members of the ICS partner organisations, to enable individuals to add value. PB gave his perspective but acknowledged the opportunities that existed to utilise the available expertise.

WW stated that he was not yet clear what the key strategic issues would be that would make a difference at the ICS. PB acknowledged the need to be clearer, but highlighted that one of the key issues was elective activity. CF however pointed out that the NHS was only a part of the ICB's work, as CF believed that the public's reliance on the NHS needed to be reduced, which therefore required engagement with Local Authorities and other sectors, such as housing and education. CF therefore emphasised the importance of also focusing on population health and health inequalities.

MC highlighted to the importance of health economics and public health interventions, and stated that it would be beneficial to see more explicit information on such issues, while if the intention to work more with the third sector was serious, the evidence base should be clear. CF agreed and noted that the ICB was in discussions with system leaders, although it would take time for certain sectors to acknowledge their role in helping to solve the issues.

NG noted the presentation from PB had referred to the variance in performance between the providers within the ICS, so asked what the ICB's position was on such variance. PB explained that he was keen to ensure that the providers that needed support received it, while the providers that were performing well continued to do so, and that the poorer performing providers did not dominate the agenda. CF added that there was no doubt that the ICBs would be held to account for the performance of the ICS as a whole, and acknowledged the importance of the ICB working to address the performance of the poorer performing providers.

JW asked for further details of the ICB's enabling role. CF emphasised that the ICB did not have levers that enabled CF to instruct DH, for example, what to do in relation to Maidstone and Tunbridge Wells NHS Trust, but the ICB did have some tools that CF could deploy. CF also stated that he wanted the ICB to be held to account by the ICB's providers, partners and the wider community. PB added his further perspective and stressed the importance of the ICB working with its partners.

**04-14 <u>To approve the Joint Forward Plan for the Kent and Medway Integrated Care System (ICS)</u>**

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

- The Forward Plan was an interim plan, and it would be updated once the wider Integrated Care Strategy was updated.
- The Plan had been submitted to the Executive Team Meeting (ETM) and RJ had received some comments that she would provide to the ICB.

MS referred to the latter point and stated that the main aspect that he felt the ICB should reconsider was that the Plan referred to local access, but did not include anything about access to primary care, while the access to secondary care had been referred to in the context of local access, so MS would be keen for that to be changed. PB acknowledged the point and confirmed that MS' comments had already been relayed.

SO also noted that the "NHS delivery and continuous improvement review" had now been published, and SO felt the Plan did not contain sufficient content on improvement, so adding further content on that would be helpful in the next version. PB confirmed that such additional content should be included in the version that would be approved in June 2023.

SO also highlighted the potential to utilise established improvement methodology to ICS-wide issues and emphasised the success of the Trust's improvement approach. PB confirmed that the Joint Forward Plan should also be amended to include such content.

RF opined that the "How we will make Kent and Medway a great place for our colleagues" chapter could be strengthened, given the ICB's position. RJ however explained that the content from the forthcoming NHS workforce plan would be incorporated into the Plan once the former plan had been published.

The Joint Forward Plan for the Kent and Medway Integrated Care System was approved, subject to the inclusion of the agreed amendments.

**04-15 <u>Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)</u>**

RJ referred to the submitted report, which highlighted the key recent headlines and noted that much of the content had been discussed under item 04-13. Questions or comments were invited. None were received.

**04-16 Review of the outcome of the Hewitt Review of Integrated Care Systems**

RJ referred to the submitted report and highlighted the recommendations arising from the review. RJ also noted that the NHS Providers' summary had been included in the submitted report, but it was not yet certain how the government would respond to the recommendations.

**Quality items**

**04-17 Quarterly Maternity Services report**

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

- The reporting period for the report was December 2022 to January 2023, so RT would liaise with KR to ensure future reports contained three months of data.
- One Never Event had occurred, which related to a retained swab.
- One case had been referred to the Healthcare Safety Investigation Branch (HSIB), which involved a shoulder dystocia. Further details of the HSIB reports had been submitted for consideration at the 'Part 2' Trust Board meeting later that day.

DH stated that he understood the HSIB would in future both maternity and non-maternity incidents, so asked whether the referral to the HSIB reflected that organisation's former role for maternity incidents. RT confirmed that was correct.

RT then continued and highlighted the following points:

- The Trust's stillbirth rate still the lowest within the Local Maternity & Neonatal System (LMNS).
- The Trust was developing a good relationship with new Maternity Voices Partnership Chair.
- There had been an increased number of midwifery students, following the withdrawal of the students from William Harvey Hospital.
- An Organisational Development (OD) plan was being developed to address some of the points raised in the listening activities with staff and the comments from the "Safety Champion".
- The compliance with "gap and grow" was a concern.

DH referred to the "Progress with Implementation of Saving Babies Lives Care Bundle…" section and stated that the Independent Investigation into East Kent Maternity Services had criticised the Board at East Kent Hospitals University NHS Foundation Trust for taking assurance from metrics that were performing at 90% and above, so referred to the "Pregnancies where a risk status for fetal growth restriction is identified at 20 week scan" metric, which was at 98%, and asked whether, as an example, that level of performance was acceptable. RT explained the context and gave assurance regarding the 2% non-compliance of that metric. DH however clarified that he had selected that metric to illustrate a point in relation to metrics that were not complied with 100%. JH acknowledged DH's point and stated that she would work with RT to consider how that could be addressed. MC noted that the metrics were reviewed in significant detail at the Maternity Board meeting, while more specific, confidential details had been submitted to the 'Part 2' Trust Board meeting scheduled for later that day.

RT then continued and then elaborated on the plans regarding the Continuity of Carer initiative.

KC referred to the new red-rated risk for "Lack of CTG machines on TWH maternity unit" and asked for further details. RT confirmed that the risk had been identified from a Maternity Champions 'walkaround' and confirmed that the machines had been ordered, so the risk would be closed once they had been issued for use.

KC then encouraged RT and her colleagues to innovate and consider alternative approaches to achieving the spirit of the Continuity of Carer requirements, despite the conclusion that the original plan was not achievable. MC agreed and added that the LMNS had encouraged a non-binary approach to the initiative.

**Planning and strategy**

**04-18 The final planning submissions for 2023/24**

DH firstly noted that the report had been discussed in detail at the Finance and Performance Committee meeting on 25/04/23. SO then referred to the submitted report and highlighted the following points:

- The Trust had submitted a plan in March 2023 with a deficit of £12.9m, which was an improvement of £2.5m on the initial submission in February.
- A further pressure of £0.8m had arisen from the PFI inflation value being confirmed in March, but the Trust had been able to improve the plan to a £4.5m deficit. The Trust expected to receive an additional £2.7m income to support excess inflation, so the delivery of a further stretch target of £1.8m would enable the Trust to achieve a breakeven position.
- The CIP for 2023/24 was unfortunately loaded towards delivery at the end of the year, as there remained a significant proportion of unidentified CIP schemes at the start of the year.
- A new governance arrangement for CIP monitoring would be implemented, and regular oversight would be provided by the ETM and Finance and Performance Committee.

DH acknowledged the importance of reducing agency staffing costs and commended colleagues for the closure of the aforementioned escalation ward. DH added that it would be interesting to see how that closure had affected the position for April 2023. SO agreed but noted that initial indications were that Bank staffing expenditure had reduced, not agency expenditure. SO also provided further details of the actions being taken to address the continued use of agency staff, and particularly the more longstanding agency staff.

DM noted the additional income from elective activity and asked whether there was scope for more income. SO replied that it was not clear what the ICB's approach would be if the Trust undertook additional activity, given the 'cost and volume' approach that would be applied in 2023/24, but SO was somewhat optimistic that there would be an opportunity for additional income. DH noted that the IPR did not include value-weighted elective activity, so proposed that indicator be monitored each month. SO confirmed that data was available. DH therefore asked that it be included in the IPR and SO agreed.

**Action: Arrange for data on value-weighted elective activity to be included in the Integrated Performance Report (IPR) (Deputy Chief Executive/Chief Finance Officer, April 2023 onwards)**

DH also stated that it should be possible to calculate the level of financial opportunity if the Trust delivered 113% of the value of its activity in 2019/20. DM agreed and MS added his further perspective.

DH then confirmed that MS and SO had the authority to submit the next iteration of the Trust's 2023/24 plan on 04/05/23, on behalf of the Trust Board.

**04-19 Update on the corporate objectives for 2023/24**

This item was covered by MS at the start of item 4-11.

**Assurance and policy**

**04-20 Quarterly report from the Freedom to Speak Up Guardian**

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

- The visits to the Trust's satellite sites had continued, and future dates were planned.
- CL continued to work with the Trust's equality, diversity and inclusion team to recruit Safe Space Champions, particularly in the satellite locations.
- The National Guardian's Office had previously decided not to collect data on protected characteristics, but CL had collected such data at the Trust for three or four years. The National Guardian's Office had however now asked for CL's insight on the issue, as they had agreed to reconsider their approach.
- The overall number of concerns had increased slightly when compared to previous years but, more could still be done to encourage staff to 'speak up'.

MS stated that he had been encouraged by the proactive approach to the satellite areas and asked CL to elaborate on the differences between that and the previous, reactive, approach. CL explained that the initial contact with a particular satellite area had led to some work with the Health and Safety team and Infection Prevention and Control teams, and that had then prompted the application of a similar approach to other areas. MS asked whether Gravesend Community Hospital and Medway Maritime Hospital were on CL's list of places to be visited in the future. CL confirmed that both locations were on the list.

JH asked when the next "FTSU index" data would be published, to enable the Trust's relative performance to be reviewed. CL stated that he was not aware of the "FTSU index". JH therefore confirmed she would provide CL with the relevant details.

**Action: Provide the Trust's Freedom to Speak Up Guardian with details of the "FTSU Index" that was published by the National Guardian's Office (Chief Nurse, April 2023 onwards)**

EPM commended CL on his approach regarding the collection of protected characteristic data; while RF commended CL in extending the FTSU role and obtaining feedback from other means. AD pointed out that when CL visited the Trust's satellite sites, he contacted all the departments with the People function in advance, to obtain all relevant information about the area to be visited.

**Other matters**

**04-21 To consider any other business**

There was no other business.

**04-22 To respond to questions from members of the public**

KR confirmed that no questions had been received.

**04-23 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] |
|---|---|---|---|---|
| 04-11 | Establish whether the Trust's new Friends and Family Test (FFT) provider had plans to integrate their system with the NHS App. | Chief Nurse | April 2023 onwards | This functionality is still being explored. |
| 04-18 | Arrange for data on value-weighted elective activity to be included in the Integrated Performance Report (IPR). | Deputy Chief Executive / Chief Finance Officer | April 2023 onwards | This is being worked on and will be introduced in the month 2 reporting. |

**Actions due and 'closed'**

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|---|---|---|---|---|
| 04-4 | Ensure that the Trust Board was provided with details of the 'arch' that had been developed for each of the major income and expenditure categories. | Deputy Chief Executive / Chief Finance Officer | May 2023 | The information was included in the report submitted for the "Confirmation of the Trust's final planning submissions for 2023/24" item at the Finance and Performance Committee's meeting in May, which was circulated to all Trust Board members on 22/05/23. |
| 04-7 | Request that the "Review of the Trust's medicine management and optimisation" item at the Quality Committee 'deep dive' meeting in June 2023 included details of the plans to use generic medicines when the patents for branded medications expired. | Chair of the Quality Committee | May 2023 | The request was made (to the Clinical Director of Pharmacy & Medicines Optimisation), and it was confirmed that the presentation to the Quality Committee 'deep dive' meeting would include that aspect. |
| 04-20 | Provide the Trust's Freedom to Speak Up Guardian with details of the "FTSU Index" that was published by the National Guardian's Office. | Chief Nurse | April 2023 | The details were provided to the Freedom to Speak Up Guardian. |

**Actions not yet due (and still 'open')**

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

**Report from the 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? |
|---|---|---|---|---|---|---|
| 24/04/23 | Clinical Oncology | Gemma | Hegarty | Clinical Oncology | 03/07/23 | New post |

**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

**Report from the Chief Executive** **Chief Executive**

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

- The incredible work of staff and volunteers at MTW was celebrated at the Trust's Exceptional People, Outstanding Care Star Awards celebration on Friday 28 April. Therapists, nurses, domestic assistants and doctors were among those honoured as awards were presented in 10 categories and more than 240 staff attending the event in Maidstone. You can read about all our winners on our website, including Employees of the Year, Stacy Davis and Karen Smart, and the winners of the Chairman Award, Ervis Kuka and the Electronic Patient Record Team.

- Following the announcement of the NHS Agenda for Change non-consolidated award for 2022/23, staff are expected to receive this payment in their June salary and we're also supporting staff on Universal Credit by ensuring they have the opportunity to have their payment made in multiple instalments, rather than as a lump sum. Our teams are continuing to monitor the ongoing situation and plan for any further potential industrial action from staffing groups.

- Earlier this month, we entered the next exciting stage in the development of a hyper-acute stroke unit (HASU) at Maidstone Hospital as part of the Kent and Medway stroke reconfiguration. Having completed phase 1 at the end of 2022, phases 2 and 3 are anticipated to be completed in December. Our stroke inpatient bed numbers will be reduced during this time however we have developed a number of strategies and pathways to support patient flow and minimise any disruption. Every stroke patient will continue to be cared for by staff with stroke specialist knowledge and skills and receive the same level of high-quality stroke care that is provided on the Stroke Unit.

- Secretary of State for Health and Social Care, Steve Barclay has written to the Trust to express his gratitude to colleagues for their hard work in achieving the Government's target of virtually eliminating 18-month waits for elective treatments, with MTW currently having no patients waiting over 52 weeks for treatment. In his letter, Mr Barclay says: "Cutting waiting lists is one of this government's top priorities. Last year, the NHS successfully met the first target in our plan to virtually eliminate waits of over two years for elective treatment. This was down to the great work of our fantastic NHS staff. Your efforts at Maidstone and Tunbridge Wells NHS Trust in delivering our April target have been truly impressive and I am hugely grateful to all the staff for working so tirelessly to arrange and deliver treatment and care for thousands of patients, day in, day out. I am well aware of the challenges you have all faced in the last few years and how difficult it has been to achieve this, and I cannot thank you enough for your continued persistence towards achieving these goals." The letter follows a visit to the Trust made by Mr Barclay back in January, visiting our Emergency Department and Care Co-Ordination Centre at Maidstone Hospital.

- Following a public consultation held last year, teams providing vascular care at hospitals in east Kent and in the Medway and Maidstone areas are now working together as one team – the Kent and Medway Vascular Network. The change was introduced as evidence shows that patients who need inpatient vascular treatment receive better care and have better outcomes when they are treated by one team of vascular surgeons, interventional radiologists, nurses and therapists, who treat a large number of these patients. For patients living in the Medway or Maidstone areas, all vascular treatments which require an overnight stay in hospital will now take place at Kent and Canterbury (K&C) Hospital, and not at Medway Maritime Hospital. For patients living in east Kent, there is no change, and treatment will continue as it is provided now at K&C Hospital. Vascular outpatients at Tunbridge Wells Hospital will also not be affected

by this change, and will continue to access inpatient care in London. More information is available on our website.

- On Thursday 18 May, we welcomed Maidstone Borough Council (MBC) Chief Executive, Alison Broom, who met our Integrated Discharge Team (IDT) at Maidstone Hospital. The teams within the IDT aim to get patients the care they need in the right place at the earliest opportunity by linking with other agencies including MBC, and they also work collaboratively with ward staff to ensure patients' needs are understood. They play an important role in sharing information between our acute hospital's community care providers, borough and county councils and Involve Kent and have regular meetings with partners to ensure the discharge of our most vulnerable patients is discussed. During her visit, Alison heard more about the work we are doing to discharge patients as quickly and safely as possible and spoke to IDT colleagues about areas of improvement.

- Our Neonatal Unit at Tunbridge Wells Hospital has become one of only four units in the UK to receive platinum accreditation in the Bliss Baby Charter. Run by Bliss, a charity supporting premature or sick babies, the Baby Charter was started in 2005 with the aim of standardising high-quality, family-centred care across the UK. By creating a framework against which neonatal units can audit their practices, it allows them to develop meaningful plans to achieve changes that benefit babies and their families. The Baby Charter journey for the Neonatal Unit began in 2012, and since then the team have worked their way through each of the different stages to achieve the highest level of accreditation. In order to do this, they have had to demonstrate and evidence the quality of the family-centred care they deliver against a framework of seven core principles including decision making, feeding and support for families. After assessing the unit in February, Bliss said that they were impressed by many aspects of the Unit's care, but elements that stood out in particular were the availability of a dedicated Family Support and Bereavement Lead Nurse, a Safeguarding Lead and an expert in Development Care with dedicated non-clinical hours ensuring the provision of regular cot-side training for staff.

- Improvements in services, medicines and care are supported by the incredibly rich heritage of research and invention within the NHS. And I am delighted to report it has been a very successful year for research and innovation at the Trust. More than 6,700 patients took part in 85 trials in the last 12 months, clear evidence that research at MTW is growing and developing following the pandemic. Recent developments within the Research Department include:

  - BBC South East and ITV Meridian featuring reports on the LIVing Donor Allograft for Anterior Cruciate Ligament Reconstruction Study (LivD_ACLR) with MTW the only Trust in the country participating in the study. The surgery is usually done by taking part of the child's own hamstring tendon to create a new anterior cruciate ligament, which connects the two bones making up the knee. The surgery being trialled at the Trust involves taking the hamstring tendon – a donor tendon – from a parent to make the repair. The technique was pioneered in Australia and it is hoped that eventually it may be offered as routine surgery in the UK.

  - The Maternity service are opening the CaPE trial (Calcium Supplementation for Prevention of Pre-eclampsia in High Risk Women), in partnership with the University of Birmingham. Led by Principle Investigator, Dr Urmee Jahan and supported by the Maternity Research team, the intention is to consent 30 women each month to the trial which is running for a year. The aim of the CaPE trial is to find out whether taking calcium tablets, alongside aspirin, further reduces the risk of women developing pre-eclampsia.

- Jasmine Turner, CT Superintendent Radiographer, has become the third practising radiographer in the UK to complete the level 1 HCSE (Health Care Systems Engineering) qualification. Jasmine is now the second member of staff at MTW to qualify in the discipline, following in the footsteps of colleague Richard Flood, HCSE manager for Core Clinical Services. HCSE helps hospitals and healthcare providers to look at their current practices,

identify areas of improvement and implement changes that benefit patients and improve their care.

- Congratulations to the winner of the Trust's Employee of the Month award for April – Healthcare Support Worker, Glen Pace. Glen has worked in the Stroke Unit for many years and is described as a fundamental member of the team. He is a great mentor and support to all the other HCSWs and regularly receives fantastic feedback from our patients and visitors.

**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

| **Quality Committee, 10/05/23 (incl. the Annual Fire Safety Report, 2022/23; and approval of the revised Terms of Reference (annual review))** | **Committee Chair (Non-Executive Director)** |
|---|---|

The Quality Committee met on 10th May (a 'main' meeting), via virtual means.

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

- The Committee reviewed the **actions from previous meetings** and it was agreed that Director of Infection Prevention and Control / Deputy Medical Director should liaise with the Deputy Chief of Service, Medicine and Emergency Care to investigate what, if any, actions could be implemented in response to the root causes for Trust staff starting, but not completing, the Sepsis Electronic Screening Tool.
- The Committee agreed **revised Terms of Reference**, as part of the routine annual review; although, it was acknowledged that further amendments may be required pending the outcome of the review of the Committee's sub-committees. These are enclosed in Appendix 1, with the proposed changes shown as 'tracked', and the Trust Board is asked to approve the changes.
- The **reports from the Committee's sub-committees** (The Complaints, Legal, Incidents, PALS, Audit, Risk and Mortality (CLIPAM) group (Formerly the Complaints, Legal, Incidents, PALS, Audit, and Mortality (CLIPAM) group); The Infection Prevention and Control Committee; The Drugs, Therapeutics and Medicines Management Committee; The Sepsis Committee; and The Health and Safety Committee) were considered and revised Terms of Reference were approved for the latter. It was also agreed that the Assistant Trust Secretary should ensure that Committee's summary report to the May 2023 'Part 1' Trust Board meeting includes the "Annual Fire Safety Report, 2022/23" report as an appendix (enclosed under Appendix 2)
- The **summary report from the Patient Experience Committee** meeting held on 02/03/23 was noted.
- The report from the last **Quality Committee 'deep dive' meeting** was noted.
- The issues raised from the **reports from the clinical Divisions** included the continued decrease in the Divisions vacancy rates; details of those areas which required targeted recruitment initiatives; an update on the implementation of the Patient First Improvement System (PFIS); the challenges associated with the prevention of falls at Tunbridge Wells Hospital; the achievement of the platinum BLISS accreditation by the Neonatal Team; and the challenges associated with the patient transport service. It was agreed that the Medical Director, Chief of Service, Medicine and Emergency Care, and Chief Operating Officer should liaise to investigate what, if any, actions could be implemented to support the repatriation of Medicine and Emergency Care Division patients located on Foster Clarke ward to within the Medicine and Emergency Care Division's bed base (i.e. rather than in the Surgery Division's bed base). It was also agreed that the Lead Matron, Medicine and Emergency Care should investigate the root cause for some staff within the Medicine and Emergency Care Division not undergoing an appraisal as part of the Trust's 2022 appraisal process and ensure that such staff received an appraisal as part of the Trust's 2023 appraisal process.
- The Deputy Chief Nurse, Quality and Experience provided an **update on the work to achieve an 'Outstanding' CQC rating** which outlined the initial feedback which had been received in response to the Care Quality Commission (CQC) Well-Led inspection.
- The Medical Director provided the latest **Mortality update** which included details of the prioritisation process to address the backlog of Structured Judgement Reviews (SJRs).
- 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.
- The Deputy Chief Nurse, Quality and Experience provided the latest **update from the Enteral feeding and Nasogastric tube (NGT) placement working group** wherein the Committee emphasised the importance of ensuring staff were empowered to raise any concerns related to the management of NGT placement.
- The Committee reviewed the **draft Quality Accounts 2022/23,** which highlighted the positive work of the Trust's Clinical Divisions.

- The **quarterly update on the 2022/23 Commissioning for Quality and Innovation (CQUIN) programme** was received by the Committee, which included details of the Trust's anticipated year-end performance.
- The Chief Operating Officer and Deputy Director of Operations, Medicine and Emergency Care provided details of the **quality assurance during Winter Surge 2022/23,** which included a comprehensive overview of the initiatives which had been implemented by the Trust to maintain patient flow and patient safety and it was agreed that the Deputy Director of Operations, Medicine and Emergency Care should consider whether an "Operational Pressure Surge Response Group", and associated triggers for implementation, should be developed to respond to any future surges in operational pressures due to external factors. It was also agreed that the Deputy Chief Nurse, Quality and Experience should provide the Committee with details of the patient feedback received as part of the Trust's response to the 2022/23 winter surge.
- The Director of Quality Governance provided an **update on the process for the allocation and monitoring of outstanding Central Alerting System (CAS) alert action plans**, which included details of the utilisation of the InPhase Incident Reporting and Risk Management System.
- The Medical Director and Deputy Chief Nurse, Quality and Experience provided a **closure report for the "Reduction in the rate of patient falls…" breakthrough objective (incl. the findings of the Healthcare Quality Improvement Partnership Audit of Inpatient Falls (Clinical 2021 and Facilities 2022),** wherein the Committee was informed of the progress that had been made; and the further focus which was required in relation to the reduction of falls at Tunbridge Wells Hospital. A brief discussion was also held regarding the identification process for the next breakthrough objective for the Patient Safety and Clinical Effectiveness Strategic Theme, wherein the Committee supported a focus on the reduction of incidents of severe harm.
- The Committee conducted an **evaluation of the meeting**, wherein the importance of the completion of executive summaries for reports to the Committee was emphasised.

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

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

- The Committee's Terms of Reference were reviewed and the proposed changes were agreed. The revised Terms of Reference are enclosed in Appendix 1, for the Trust Board's approval.
- The Annual Fire Safety Report, 2022/23 is enclosed in Appendix 2, for the Trust Board's information.

**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

# QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

## 1. Purpose

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

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

## 2. Membership

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

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

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

## 3. Quorum

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

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director)
- Three clinical divisional representatives (i.e. either the Chief of Service, DDNQ (or equivalent) or an appropriate deputy for either)

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

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

## 4. Attendance

The following are invited to attend each 'main' meeting

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

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

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

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

## 5. Frequency of Meetings

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

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

## 6. Duties

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

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

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

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

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

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

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

## 7. Parent committees and reporting procedure

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

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

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

## 8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

1. The Cancer Services Divisional Clinical Governance Committee (or equivalent)
2. The Core Clinical Services Divisional Clinical Governance Committee (or equivalent)
3. The Medicine & Emergency Care Divisional Clinical Governance Committee (or equivalent)
4. The Surgery Divisional Clinical Governance Committee (or equivalent)

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

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

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

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

## 10. Patient Experience Committee

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

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

## 11. Administration

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

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

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

## 12. Emergency powers and urgent decisions

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

## 13. Review of Terms of Reference

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

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**Review history**

- Agreed by Quality and Safety Committee: 13 March 2013

- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015
- Revised Terms of Reference agreed by the Quality Committee, 6th January 2016
- Revised Terms of Reference approved by the Trust Board, 27th January 2016
- Revised Terms of Reference agreed by the Quality Committee, 11th January 2017
- Revised Terms of Reference approved by the Trust Board, 25th January 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Revised Terms of Reference agreed by the Quality Committee, 10th January 2018
- Revised Terms of Reference approved by Trust Board, 25th January 2018
- Revised Terms of Reference agreed by the Quality Committee, 8th May 2019
- Revised Terms of Reference approved by Trust Board, 23rd May 2019
- Revised Terms of Reference agreed by the Quality Committee, 10th July 2019 (to add the Drugs, Therapeutics and Medicines Management Committee as sub-committee, and add the Clinical Director of Pharmacy & Medicines Optimisation as a member of the 'main' Quality Committee)
- Revised Terms of Reference approved by Trust Board, 25th July 2019
- Revised Terms of Reference agreed by the Quality Committee, 6th May 2020
- Revised Terms of Reference approved by the Trust Board, 21st May 2020
- Amendment approved by the Trust Board, 26th November 2020 (to add the Health and Safety Committee as sub-committee)
- Amendment approved by the Trust Board, 17th December 2020 (to enable deputies attending the Quality Committee 'deep dive' meeting for members of the Executive Team to count towards the quorum requirements)
- Revised Terms of Reference agreed by the Quality Committee, 12th May 2021
- Revised Terms of Reference approved by the Trust Board, 27th May 2021
- Amendment agreed by the Quality Committee, 12th January 2022 (to add the Sepsis Committee as a sub-committee)
- Revised Terms of Reference approved by the Trust Board, 27th January 2022
- Revised Terms of Reference agreed by the Quality Committee, 11th May 2022
- Revised Terms of Reference approved by the Trust Board, 26th May 2022
- Amendment agreed by the Quality Committee, 12th October 2022 (to add the Patient Safety Manager to the Committee's membership)
- Revised Terms of Reference approved by the Trust Board, 27th October 2022
- Revised Terms of Reference agreed by the Quality Committee, 10th May 2023
- Revised Terms of Reference approved by the Trust Board, 25th May 2023

NHS
Maidstone and Tunbridge Wells
NHS Trust

# Annual Fire Safety Report 2022/23.


**04 April 2023**

**Maidstone and Tunbridge Wells NHS Trust**
**Report Completed by: Mark Vince MIFSM CFRAR**
**Head of Fire and Safety**

The Institute of Fire Safety Managers IFSM Member

The Institute of Fire Safety Managers IFSM Tier 2 Competent Fire Risk Assessor (CFRAR) 2023

## Contents

# Annual Fire Safety Report 2022/23.

## 1. Summary of Activity.

| | |
|---|---|
| Summary of Activity: | • Monitoring of fires and Unwanted Fire Signals;<br>• Risk management via the Risk Assessment Programme;<br>• Training of staff and response to emergency incidents;<br>• Fire safety for capital projects;<br>• Strategic Aims.<br><br>**Key findings;**<br>• Fires on site have remained the same as the previous year, with only one incident, this was an electrical fire in the Accident and Emergency Department at Tunbridge Wells. The fire was caused by an electrical fault in a socket. Two fire fighting appliances attended but the fire self extinguished before their arrival. A report was submitted following investigation by the Head of Fire and Safety and this was accepted by the Kent Fire and Rescue Service. There was no follow up investigation required by the Kent Fire and Rescue Service. There were no casualties.<br>• Unwanted fire signals are significantly down by 13.<br>• Risks identified during the risk assessment process generally fall into one of two categories and will be monitored as part of the ongoing inspection programme. They are;<br>• Fire compartmentation;<br>• Upgrade of fire doors.<br><br>**Conclusions;**<br>Evidence would suggest that there have been improvements within some areas of fire safety management especially in the area of Unwanted Fire Signals, (UFS). This can largely be explained by;<br><br>• The fact that the Trust invested significant funds to upgrade and future proof the smoke detectors, fire alarm panels and associated cabling.<br>• Improved reporting by staff of excess clutter, helping to quickly reduce storage of combustibles.<br>• The Strategic Aims will give us measurable indicators which will form evidence of pro-active fire safety management. |
| Trust objective: | Provide a safe working environment in line with the Trust objective of exceptional people delivering outstanding care. |
| Legal: | Maidstone and Tunbridge Wells NHS Trust acknowledges its responsibilities under the Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) and ensures that fire risk assessments are carried out on its premises to determine the general fire precautions and protective measures needed to comply with the articles imposed under this order. This is conducted in line with PAS 79-1. PAS 79 (Fire risk assessment – Guidance and a recommended methodology) is a Publicly Available Specification published by the British Standards Institution. |

## 2. Introduction.

Maidstone and Tunbridge Wells NHS Trust, (MTW), has a statutory duty to ensure that all of the premises owned or operated by it comply with current fire safety legislation. The Trust has to ensure that suitable and sufficient arrangements are in place for the management of fire safety and the implementation of any necessary fire safety measures as required under the Regulatory Reform (Fire Safety) Order 2005.

Current fire safety law requires an employee to take a risk-based approach to fire management. This will ensure significant risks are identified and adequate controls are put in place. The effectiveness of these controls will become evident by the number of fire service interventions on site, the number of unwanted fire signals, the effects of these calls on service delivery and the reactions of staff to a fire emergency.

2.1 Fire Safety Report 2022/23.

The purpose of this report is to give a clear indication as to the Trust's performance in fire safety management and legal compliance.

The first section covers matters of performance over the reporting period whilst the second section looks at the aims for the coming year and performance monitoring. The second section contains specific risks currently active on the Trust Risk Register. The third comments on matters of day to day fire management and maintaining a safe environment. The final section covers statistics and year on year statistical comparison.

## 3. Performance.

3.1 During the last twelve months there have been no audits conducted by the Kent Fire and Rescue Service. Audits were cancelled due to either the ongoing Covid restrictions to reduce exposure to their staff and to reduce footfall through hospitals or due to lack of Fire Service staff availability.

Due to extensive construction under way on both the main sites we are of course expecting the Kent Fire and Rescue Service to be involved in the construction and pre-occupation phases of building projects, as well as pre-occupation exercises of the Kent and Medway Orthopaedic Centre and Student Medical accommodation.

In addition, we have been in constant communication with the Kent Fire and Rescue Service with regard to the inoperability of the local fire hydrants at the Maidstone site and the unavailability of firefighting lifts at Tunbridge Wells, either through routine maintenance or lift failure. This issue with regard to fire hydrants on the Maidstone site is recorded and tracked on the Trust Risk Register, works are now underway to address this issue.

3.1 Fires on Trust Premises.

There was one fire on the MTW site this year, this was an electrical socket fire in the A&E Department at TWH. The fire burned itself out quickly, however, the Kent Fire and Rescue Service were called and attended the incident. The Head of Fire & Safety conducted a thorough investigation which concluded the fire started as a result of a loose wiring connection which arced causing ignition. There were no reported casualties. The report was submitted to the Kent Fire and Rescue Service, who were happy with its conclusion. A copy of this report can be obtained on request from the Head of Fire and Safety.

| Fires on MTW sites | 2021/22 | 2022/23 |
|---|---|---|
| | | |
| | 1 | 1 |

3.2 Unwanted Fire Signal (UFS).

A UFS is defined as follows;
"An incident to which the Fire Service may have been called and that on investigation no fire is found."
It should be noted that although many calls to the Trust can be unwanted by the Fire and Rescue Service they would be as a result of staff following Trust policy. For example, a smell of burning may well prompt a member of staff to raise the alarm in accordance with the policy. However, if no fire is found the Trust will record this as an UFS.

| UFS's at MTW | 2021/22 | 2022/23 |
|---|---|---|
| | 81 | 68 |

*See section 8 for a statistical breakdown of these figures.*

Clarification as to current performance;

- There has been a decrease in UFS over the reporting period. This is due to the fact that the Trust invested significant funds to upgrade and future proof the smoke detectors, fire alarm panels and associated cabling.

3.4 Other Trust Sites;

**Oncology Kent and Canterbury Hospital;** Following a recent inspection concerns were highlighted about lack of emergency evacuation awareness of our staff. Subsequently we have made contact with the fire safety manager for this site and requested evacuation plans and maps. Once received the Head of Fire and Safety will conduct bespoke training for our staff, including fire warden training. This training is scheduled for completion by the end of May 2023.

**Crowborough;** We had an emergency evacuation of our Birth Centre in July following a fire alarm activation caused by a visitor mistaking the fire alarm call point for the door release on the inpatient ward not controlled by this Trust. Following investigation by the Head of Fire and Safety it was agreed with the site management team that the evacuation was unnecessary. The Head of Fire and Safety has developed a new fire alarm response plane which has been shared with both the Birth Centre and our Outpatient Department to prevent recurrence. In addition, the Site management team have fitted covers to the fire alarm call points to prevent accidental activations.

**Sexual Health Clinics, (Dartford, Gravesham and Tunbridge Wells);** All inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

**Health Records Paddock Wood;** Compliant risk assessments in situ, no concerns identified. Net inspection scheduled for May 2023.

**Park Wood;** Final risk assessment conducted prior to the closure of laundry services, no concerns identified. Further inspection will be scheduled if the site is to be used for other services going forward.

**Magnitude House;** Inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

**Abbey Court;** inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

**Priory Gate;** inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

3.5 Fire Risk Assessments.

One of the key factors of good fire safety management is an ongoing system of risk assessment and review. During 2022/23 considerable efforts have gone into ensuring all areas of the MTW site have current risk assessments in accordance with PAS 79-1 requirements.

On completion of fire risk assessments any significant findings that are identified during this process have been placed on the Datix Risk Register and will be transferred to the new In Phase system when it goes live within the next month.

The Head of Fire and Safety has an electronic inspection system and inspection programme that will ensure all areas under the control of the Maidstone and Tunbridge Wells NHS Trust receive at least one inspection for fire safety throughout the course of the following year.

## 4. Significant Risks and Actions.

The following section lists the current fire safety issues recorded on the Trust Risk Register.

**ID 2858 – Fire Hydrant Shut Down.** (Amber).

**Description;**

We have discovered a leak in our fire hydrant system at Maidstone Hospital and as a result the hydrants have been shut down whilst we source an engineering solution.

**Control Measures in Place;**

There is a Southern water main hydrant at the main entrance road that is still functional and a static tank to the rear of the building that can also be used. For the main hospital building the risers remain fully operational.

**Latest Update;**

Contractor sourced and works are underway to rectify the issue.

**Target Completion Date;** 30/06/2023

**ID 2991 – Maidstone Hospital Fire Dampers.** (Amber).

**Description;**

Fire dampers around the hospital are not being identified and serviced by a competent contractor.

**Control Measures in Place;**

Some location maps of dampers are available but no assurance all have been identified.

**Latest Update;**

Tendering process underway for competent contractor to address this issue.

**Target Completion Date;** 25/09/2023

**ID 3016 – Fire Doors Main Hospital Street.** (Amber).

**Description;**

Many of the fire doors protecting the main hospital street are not compliant and therefore does not achieve the required 60 minute compartmentation requirements.

**Control Measures in Place;**

Ward improvement working group in place. Estates maintenance aware and will address.

**Latest Update;**

This will form part of this year's strategy, the Estates Department will look to repair/replace defective doors as part of the fire safety improvement strategy for this financial year.

**Target Completion Date;** 18/09/2023

## 5. Strategic Aims for 2022/23.

5.1 To reduce the number of potential fire incidents and their consequences.
This will be achieved through;

- Establish a Fire Safety Committee to monitor regulatory compliance, action plans generated through independent fire audit and that the monthly PPM process is carried out and recorded accordingly. The committee will report into the Health and Safety Committee.
- Recruitment of an Assistant Fire Officer through the apprenticeship scheme. This will provide additional support to the Head of Fire and Safety to perform statutory duties and increase the scope of the annual fire inspection process, as well as introducing a level of succession planning.
- Bespoke training to be created for the Fire Response team to ensure they fully understand their duties and to increase their overall knowledge of fire safety and fire incident response duties.
- Continued promotion of the role of Fire Warden throughout the Trust, in particular in outlying services and improved access to training on e-Learning. Heightening intelligence to the safety department in the prevention of fires as well as potential arson.

5.2 To continue to reduce the number of Unwanted Fire Signals (UFS) and the disruption to service delivery.
This will be achieved through;

- Review of all UFS incidents, where appropriate enforce action to reduce issues identified.
- Continuation of monitoring misuse of the fire alarm call points which was the main cause of unwanted fire signals this year. Should the situation not improve the Head of Fire and Safety will consider solutions to reduce their numbers.
- Fire Safety and Security teams will have an increased focus on reduction of potential of arson attack which continues to be highlighted as an increased threat nationwide.

5.3 To manage fire safety in line with current laws and regulations using a risk-based approach with effective action plans.
This will be achieved through;

- Monthly inspection regime, which will create effective action plans based on risk to ensure the Trust remains compliant with current law and legislation and that future construction projects meet the recommendations by Dame Judith Hackitt following the Grenfell inquiry which has been incorporated into the new Building Safety Act.
- Record and monitor any unresolved issues through the Trust Risk Register, ensure these unresolved issues are escalated and have robust plans, with associated achievable deadlines to resolve issue in an effective manner.

5.4 To ensure the workforce have a sound understanding of fire safety provisions and emergency procedures.
We will achieve this through;

- Staff mandatory training, moved to e-Learning for ease of access, especially during major incidents, this will be reviewed during the course of the year to ensure it remains compliant with newly introduced legislation.
- The Head of Fire and Safety, in conjunction with the Emergency Planning and Response team will carry out exercises across both hospital sites involving multi-disciplinary response to ensure staff are familiar with their responsibilities in relation to fire incident management. This will include the two new major construction projects, namely the Kent and Medway Orthopaedic Centre at Maidstone and the Student Medical accommodation at the Tunbridge Wells site.

## 6. Maintaining a Safe Environment.

Satisfying legal requirements and the pursuit of performance indicators can, at times, become so much the point of focus that day to day management of fire safety gets overlooked.

It is with this in mind that the following comments are made as part of this report in order to highlight how changing situations can impact upon fire safety management.

### 6.1 Storage.

Since the hospital was opened in the early 1980s there have been considerable changes not only to the layout of the building but also in the way patients are cared for. Certain pieces of equipment, that were not so prolific in the 80s have become standard items on wards and therefore require space in which to be stored. In addition, the increased requirement for effective infection prevention and control, and the changeover of mattresses and beds, has also created a need for space.

As part of the Head of Fire and Safety's duties it is necessary to carryout routine audits of wards and departments in support of the risk assessment programme. It does need to be noted that one recurring problem is the storage of stock and equipment in circulation spaces such as corridors and doorways, particularly at the Maidstone site. The Progressive Horizontal Evacuation system which is a key part of the fire procedure relies upon the ability to move patients and beds from one area to another without unnecessary delay. The build-up of stored items in circulation spaces could have a detrimental influence upon our ability to undertake such an evacuation.

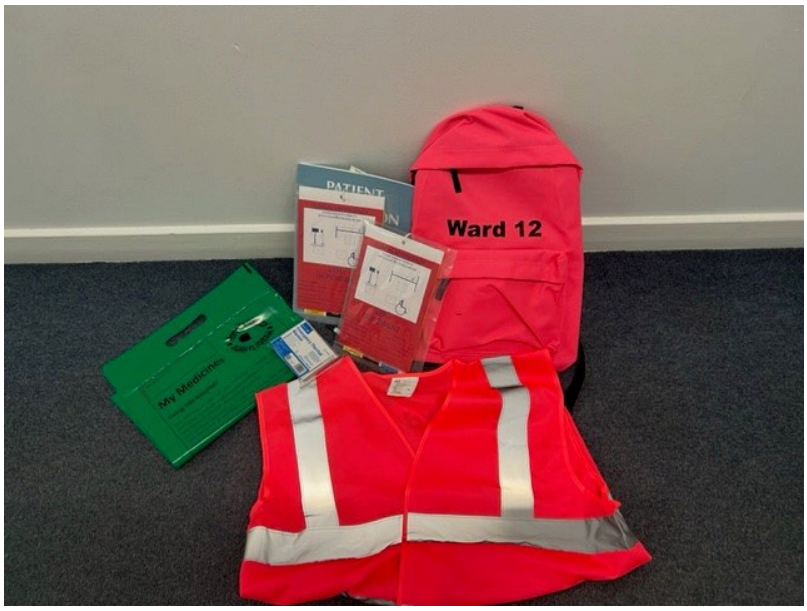
Management of storage is included in the fire safety inspection reports but staff members are quick to comment that there is often little choice but to store items in such locations.

### 6.2 Fire Drills.

The hospital fire routines are tested throughout the year. This can be as a result of a legitimate actuation of the fire alarm or by a routine exercise led by the Emergency Planning and Response team. Following all such occasions the actions of staff are reviewed as part of the exercise debrief. In most instances the routines operate effectively, however, should a matter of concern be identified remedial actions will be implemented.

6.3 Evacuation Bags.

In the event an evacuation is required, the Emergency Planning and Response team have developed the new evacuation bags. Bright pink, they are easily visible and contain everything a ward manager or nurse in charge will need should an evacuation be required. They have also filmed a video taking staff through the process step by step and this can be found on the Trust intranet.




## 7. Building Projects

The forthcoming year will see a number of building projects that require specific fire safety input at both planning and construction stages. In the coming year will see construction continue, with the Kent and Medway Orthopaedic Centre, Student Medical Accommodation, Hyper Acute Stroke and Cardiology all having the need of significant fire safety involvement.

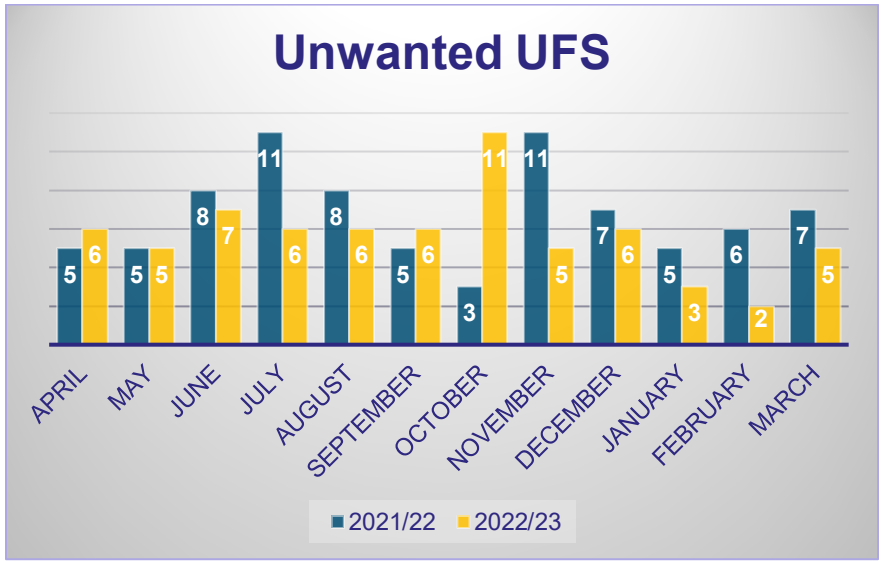
Ensuring that all fire safety requirements are dealt with at the earliest point in the project is essential so as to avoid problems post construction. The working relationship with the Estates Projects team and outside agencies has been positive and constructive but there is a constant need for monitoring throughout the project. This is to ensure building works do not compromise the safety of the hospital and that of staff and patients.

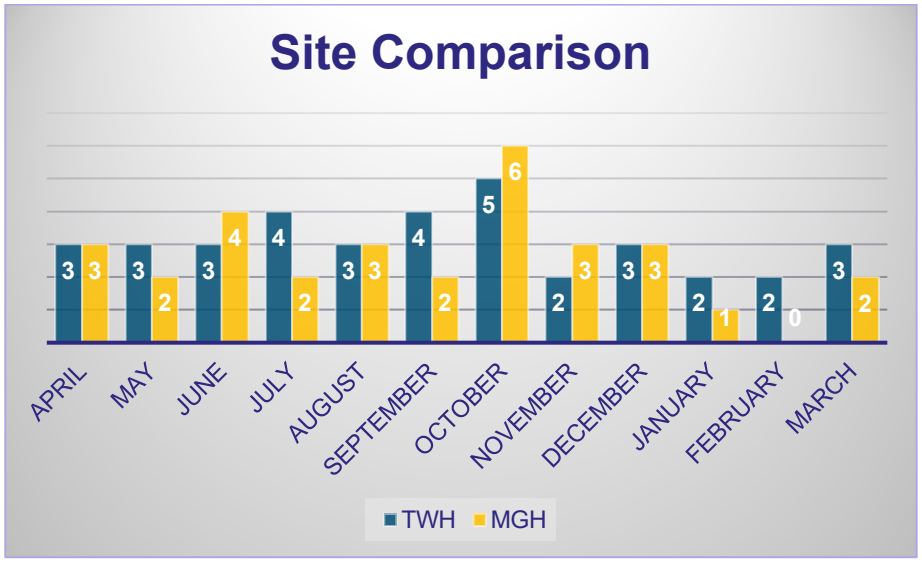
The Head of Fire and Safety can then spend dedicated time to monitoring the activities of contractors and revising the risk assessments as necessary.

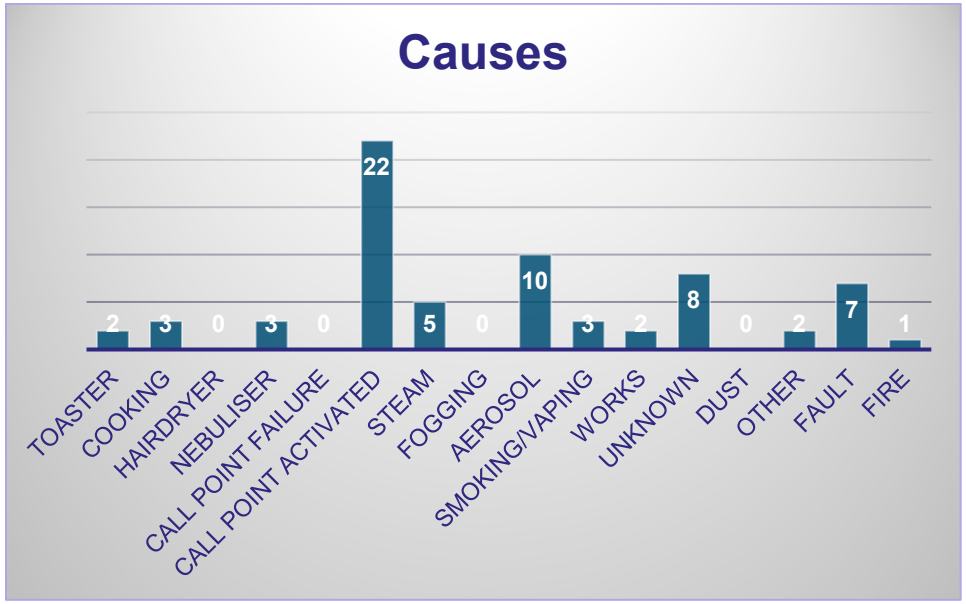
## 8. Statistics and Comparison.

| UFS | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021/22 | 5 | 5 | 8 | 11 | 8 | 5 | 3 | 11 | 7 | 5 | 6 | 7 | 81 |
| 2022/23 | 6 | 5 | 7 | 6 | 6 | 6 | 11 | 5 | 6 | 3 | 2 | 5 | 68 |

| Site Comparison | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TWH | 3 | 3 | 3 | 4 | 3 | 4 | 5 | 2 | 3 | 2 | 2 | 3 | 37 |
| MGH | 3 | 2 | 4 | 2 | 3 | 2 | 6 | 3 | 3 | 1 | 0 | 2 | 31 |






| Causes | |
|---|---|
| Toaster | 2 |
| Cooking | 3 |
| Hairdryer | 0 |
| Nebuliser | 3 |
| Call Point Failure | 0 |
| Call Point Activated | 22 |
| Steam | 5 |
| Fogging | 0 |
| Aerosol | 10 |
| Smoking/Vaping | 3 |
| Works | 2 |
| Unknown | 8 |
| Dust | 0 |
| Other | 2 |
| Fault | 7 |
| Fire | 1 |
| Total | 68 |

| Summary report from the Finance and Performance Committee, 23/05/23 | Committee Chair (Non-Exec. Director) |
|---|---|

The Committee met on 23rd May 2023, via a webconference.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meeting**s were reviewed and it was agreed that the Divisional Director of Operations (DDO) for Cancer Services should be asked to explore whether it was feasible to send a brief feedback survey to a patient's smartphone after each telephone call to the Trust's outpatients service (as was the case in some GP practices), to monitor the quality of outpatient telephone call responses.
   - The DDO for Medicine and Emergency Care, and Deputy Director of Operational Flow attended for a 'deep dive' into the **Cost Improvement Programme (CIP) scheme to reduce escalation capacity.** A lengthy discussion was held on the risks to delivery of the scheme and the actions being taken in response, and it was agreed that the Chief Operating Officer would give an update to the Committee's meeting in July 2023 on the current status of the non-emergency patient transport service. It was also agreed that the Deputy Chief Executive/Chief Finance Officer would consider how the benefits arising from the delivery of CIP schemes could be better monitored (such as the 13,800 reduction in bed days that was targeted by the CIP scheme to reduce escalation capacity).
   - The **Patient Access strategic theme metrics for month 1** (i.e. April 2023) were reviewed, and the continued good performance in relation to the Emergency Department (ED) 4-hour waiting time target and cancer access targets was noted. It was also noted that there had been some improvement in outpatient performance.
   - The review of **financial performance for month 1** confirmed that the Trust had ended the month with a £0.4m deficit, which was £0.3m adverse to plan, although the majority of that variance was related to the junior doctors' industrial action during April. It was agreed that future monthly financial performance reports to the Committee would confirm whether any in-month overperformance/variance against the associated plan (such as the £0.2m variance in "Education and Training" income that had occurred in month 1) was indicative of a trend that would also affect subsequent months.
   - The Head of Costing and SLR attended to enable the Committee to **confirm the approach to be taken for the compilation of the mandatory National Cost Collection (NCC); and to receive the latest information from the Costing Transformation Programme (CTP)**.
   - The **Trust's final planning submissions for 2023/24** were discussed in detail and it was noted that the Trust's plan was for a break-even year-end position with a challenging CIP target of £33.3m. The report also included details of the "Pay Plan Bridge", "Non Pay Plan Bridge" and "Clinical Income Plan Bridge" which had been requested at a previous meeting.
   - The Chief Operating Officer gave an **update on a proposal to extend, and expand the scope of, the Trust's contract with TeleTracking Technologies, Inc.** and it was confirmed that the proposal should be scheduled for consideration by the Committee (and approval by the Trust Board) in June 2023.
   - The **summary report from the People and Organisational Development Committee in April 2023** was 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:** 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 the People and Organisational Development Committee, 19/05/23 | Committee Chair (Non-Exec. Director) |
|---|---|

The People and Organisational Development Committee met (virtually) on 19th May 2023 (a 'deep dive' meeting).

**The key matters considered at the meeting were as follows:**

- The **actions from previous 'main' meetings** were reviewed.
- The Head of Leadership Development and Head of Organisational Development attended for a further **update on the plans to extend the Exceptional Leaders programme to all People Leaders with particular focus on the data on the bands that have attended the programme (incl. the purpose of the "Affina Team Journey" assessment and development tool),** which included the amendments which had been made to the Exceptional Leaders programme based on the feedback which had been received; the intended utilisation of the Lumina psychometrics tool; and the intention to develop Trust staff based on their previous / current experience levels, their current role and responsibilities and their career aspirations. Committee members applauded the report and the initiative to develop all leaders at the Trust and an in-depth discussion was then held wherein Committee members provided a range of feedback on the plans to extend the Exceptional Leaders Programme and the following actions were agreed:
  - The Head of Leadership Development and the Head of Organisational Development should review and amend the proposed "Reduction of patient complaints directly resulting from leadership actions by 20%" Key Performance Indicator (KPI) to ensure appropriate alignment with the impacts of the Exceptional Leaders Programme.
  - The Head of Leadership Development and the Head of Organisational Development should ensure that the "Exceptional Leaders: overview of attendees" includes an overview of whether the attendees worked full-time or part-time at the Trust.
  - Th Deputy Medical Director should check, and confirm to Committee members, the leadership development requirements included as part of the education programme for medical students.
  - The Head of Leadership Development and the Head of Organisational Development should explore the alignment of the key areas of focus for the Exceptional Leaders Programme to Divisional priorities, to ensure robust engagement from line managers to support participants in the Exceptional Leaders Programme.
  - The Deputy Chief People Officer, Organisational Development should ensure the "leadership behaviours" outlined within the Exceptional Leaders Programme were circulated to Trust Board members, as a reminder of the key areas of focus for the programme of work.
  - The Head of Leadership Development and the Head of Organisational Development should consider what, if any, mechanisms should be implemented to provide Trust Staff who had attended the Exceptional Leaders programme with an update on the key elements of the Exceptional Leaders programme, to ensure that such elements remained sufficiently embedded.
- The Committee conducted the latest **Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)**, which included details of the reduction in the Trust's vacancy and Turnover rates; the reduction in the Trust's temporary staffing demand; and the further work which was required in specific service areas, and it was agreed that the Deputy Chief Nurse, Workforce and Education should liaise with the Deputy Chief People Officer, People and Systems to ensure that future "Monthly update on the "Strategic Theme: People" section of the Integrated Performance Report (IPR)" reports included details of the turnover rate and associated time in post for International Nurses. It was also agreed that the Deputy Chief People Officer, People and Systems should ensure that future "Monthly update on the "Strategic Theme: People" section of the Integrated Performance Report (IPR)" reports included details of the recruitment pipeline and vacancy rate for Doctors.
- The Committee's **forward programme** was noted.

- The Committee conducted an **evaluation of the meeting** wherein the robust discussions which had been held were commended.

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

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

**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

**Audit and Governance Committee, 16/05/23** **Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met, virtually via web conference, on 16th May 2023.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were reviewed.
   - The Chief Nurse and Risk and Compliance Manager attended for a **review of the Trust's red-rated risks** wherein a discussion was held regarding the importance of system-working in relation to risks which were reflected across the Kent and Medway Integrated Care System (ICS) and the wider NHS and it was agreed that the Risk and Compliance Manager should ensure that future "Review of the Trust's red-rated risks" reports reflected the comments received at the May 2023 Committee meeting (i.e. inclusion of trend data for the average risk age in months; and target dates for the achievement of "risk rating (target)"). It was also agreed that the Risk and Compliance Manager should investigate the implementation of an audit trail for the target dates for the achievement of "risk rating (target)", to ensure that Committee members were aware of any amendments to the target dates. Furthermore, it was agreed that the Chief Nurse should liaise with the Risk Owner for risk ID2990 ("Poor compliance with nursing documentation standards (Trust wide)") to investigate whether the "Risk Rating" should be downgraded to reflect the findings of the recent audit of compliance with nursing documentation standards.
   - The Director of IT attended for the **Limited assurance internal audit review: ICT Review of Core Systems,** wherein the Committee were informed of the actions which had been implemented by the Director of IT in response to the recommendations and it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should consider, and confirm to the Committee, the mechanism by which the Committee should be informed of Tiaa Ltd's work in relation to the implications of Artificial Intelligence (AI). It was also agreed that the Director of IT should provide Committee members with details of the approach by which the Trust assessed the risk rating associated with ICT Core Systems.
   - The Director of IT attended for the **Limited assurance internal audit review: Assurance Review of Disaster Recovery,** which included the importance of robust documentation of the Trust's Disaster Recovery plans (DRPs) and it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should provide the Director of IT with examples of 'best practice' Disaster Recovery plans (DRPs), where feasible, to support the expedited development of DRPs at the Trust.
   - The Director of IT then provided and **update on cyber security,** in which the benefits associated with the Trust's Network upgrade programme were acknowledged and it was agreed that the Director of IT should ensure that the "Update on cyber security" report to the Committee's meeting in July 2023 included details of the risks to, and benefits for, the Trust in relation to increased utilisation of Artificial Intelligence (AI).
   - The Chief of Service for Core Clinical Services and Divisional Director of Operations attended to provide an **in-depth review of risk ID2992 "Age of the Imaging Equipment in Radiology at MTW"** (incl. details of the genesis of the risk), wherein the Committee expressed significant concerns in relation to the age of the Trust's Diagnostic equipment and the associated risks to the service delivery and the patient experience. It was agreed that the Head of Service, Radiology should reconsider the "Risk Rating" for risk ID2992 ("Age of the Imaging Equipment in Radiology at MTW") to ensure the rating accurately reflected the "Likelihood" and "Severity" of the risk. It was also agreed that the Deputy Chief Executive / Chief Finance Officer; and Assistant Trust Secretary should ensure that the concerns raised under the "In-depth review of risk ID2992 "Age of the Imaging Equipment in Radiology at MTW" …" item were considered at the Executive Team Meeting, prior to such concerns being raised at the May 2023 'Part 1' Trust Board meeting.
   - The Committee received the **Internal Audit Annual Report for 2022/23** (incl. the draft Head of Internal Audit Opinion) and an **Update on progress with the Internal Audit plan for 2022/23** (incl. progress with actions from previous Internal Audit reviews) wherein the

Committee approved the proposed amendments to the Internal Audit plan for 2022/23.

- The **findings from the review/survey of Internal Audit Service** were reviewed.
- The Committee received the **Counter Fraud Annual Report for 2022/23** wherein the Trust performance in relation to the Counter Fraud Functional Standard Return (CFFSR) was highlighted.
- The **Findings from the review/survey of Counter Fraud Service** and the **Informing the audit risk assessment for Maidstone and Tunbridge Wells NHS Trust 2022/23 – The Trust's response** reports were noted.
- The **"Audit Progress Report and Sector Update" from External Audit** was reviewed and a brief discussion was held regarding the assessment of Value For Money (VFM) arrangements.
- The **Findings from the review/survey of External Audit service** were reviewed
- The **Draft Annual Report for 2022/23 (incl. the Annual Governance Statement) and the Draft Annual Accounts for 2022/23 (incl. the latest losses & compensations data)** were reviewed wherein it was agreed under the former that the Trust Secretary should ensure that the Annual Governance Statement 2022/23 was amended to reflect that four "Limited Assurance" ratings had been issued by Internal Audit in 2022/23.
- The Committee approved the **"Audit and Governance Committee Annual Report for 2022/23"** which will be submitted to the Extraordinary 'Part 1' Trust Board meeting in June 2023 as part of the assurances required, by the Trust Board, for approval of the Trust's Annual Report and Accounts for 2022/23.
- The **latest single tender / quote waivers data** was reviewed and the **detail of interests declared under the Conflict of Interest policy and procedure** were noted.
- The Committee reviewed the **Security issues annual report** which has been submitted to 'Part 2' Trust Board meeting, as a supplementary report, for information, due to the confidential nature of the information contained therein.
- The **Standing Orders, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions** were approved, following their annual review and revision (the documents have been submitted to the Trust Board separately, for ratification).
- The Committee reviewed the **findings from the Committee self-assessment / compliance with the Terms of Reference**.
- The **forward programme** was noted.
- The Committee undertook an **evaluation of the meeting** wherein it was agreed that the Trust Secretary should liaise with the Chief Nurse, Director of Quality Governance and Risk and Compliance Manager to develop a proposed schedule of future "spotlight on…" items based on the Trust's risk register. It was also agreed that the Assistant Trust Secretary should schedule a "Counter Fraud Annual Work Plan for 2023/24" item at the Committee's meeting in July 2023.

2. **The Committee received details of the following completed Internal Audit reviews:**
   - "IT Disaster Recovery" (which received a "Limited Assurance" conclusion due the availability of further opportunities to minimise the risk to the Trust in the event of a major incident)
   - "Core Financial Assurance – Financial Accounting and Non-Pay Expenditure" (which received a "Substantial Assurance" conclusion)
   - "Recruitment Processes" (which received a "Reasonable Assurance" conclusion)
   - "Data Subject Access Request (DSAR) Processes" (which received a "Reasonable Assurance" conclusion)
3. **The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:** N/A
4. **The Committee agreed that (in addition to any actions noted above):** The Chair of the Committee and Assistant Trust Secretary should ensure that the concerns raised by the Committee in relation to risk ID2992 ("Age of the Imaging Equipment in Radiology at MTW") were escalated to the May 2023 'Part 1' Trust Board meeting.
5. **The issues that need to be drawn to the attention of the Board are as follows:** N/A

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

[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

| **Integrated Performance Report (IPR) for April 2023** | **Chief Executive / Members of the Executive Team** |
|---|---|

The IPR for month 1, 2023/24, 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?**
Finance and Performance Committee, 23/05/23

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

# Integrated Performance Report

## April 2023

MTW
exceptional people, outstanding care

# Contents



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

# Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

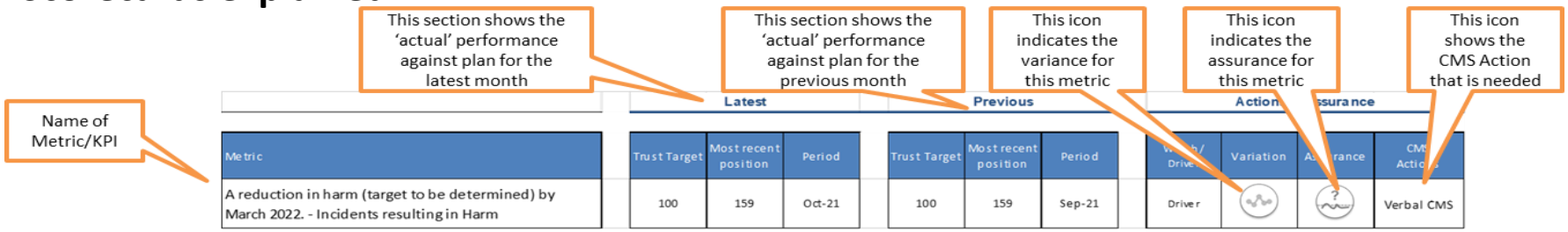
## Escalation Rules:

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

## Escalation Pages:

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

## Scorecards explained




## Further Reading / other resources

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

MTW exceptional people, outstanding care

# Executive Summary

## Executive Summary

An increase in the Vacancy Rate is shown this month, however this is due to the re-basing of the budgeted WTEs that happens at the beginning of each financial year. The rate continues to experience special cause variation of an improving nature and passing the target for 6+ months. Turnover Rate has failed the target for more than six months and continues to be in special cause variation of a concerning nature. Agency spend has failed the target for >6 months but has moved back to common cause variation. Sickness levels remain in variable achievement of the target and common cause variation. The Trust Appraisal window only opened mid-April so the Appraisal rate is expected to increase significantly before the window closes at the end of July 2023. This will only be reported during the Appraisal window, with a trajectory to move from 1% to 95% . Statutory and Mandatory Training remained above the target in April 23 but remains in special cause variation of a concerning nature and variable achievement of the target. The Trust was £0.4m deficit in the month which was £0.3m adverse to plan.

With the continued lower level Nursing Vacancy Rate, the Nursing Safe Staffing Levels have improved further to 99.3% for April 23. The rate of inpatient falls continues to experience common cause variation and variable achievement of the target. Hospital on-set of COVID remains in escalation. These indicators also impact the Incidents resulting in harm indicator which continues to experience common cause variation and failing the target for more than six months. Complaints response times have failed the target for >6 months, however the number of overdue complaints has been showing a downward trend and is experiencing special cause variation of an improving nature. Friends and Family Response times remain challenging but have seen some improvements in Maternity, Inpatients and A&E with all three experiencing special cause variation of an improving nature.

Diagnostic Waiting Times has achieved the recovery trajectory target set for April 23 and is therefore no longer escalated as is now experiencing special cause variation of an improving nature and variable achievement of the target. RTT performance is slightly below the recovery trajectory for April 23, now experiencing special cause variation of a concerning nature and not achieving the trajectory target for more than six months. We remain one of the best performing trusts in the country for longer waiters. Performance for First outpatient activity levels has improved and is slightly below expected levels in April 23, experiencing common cause variation and failing the target for more than six months. Outpatient Utilisation is now experiencing special cause variation of an improving nature but is consistently failing the target. Diagnostic Activity levels are below plan for April 2023 due to phasing of the Community Diagnostic Centre (CDC) and operational challenges, but remain above 1920 levels. Elective (inpatient and day case combined) activity has once again achieved the target for April 2023 and continues to experience common cause variation of an improving nature and passing the target for more than six consecutive months.

The number of patients leaving our hospitals before noon continues to experience special cause variation of an improving nature. A&E 4hr performance has achieved the trajectory set for April 23 at 89.6%, experiencing common cause variation and variable achievement of the target. The Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers continue to experience common cause variation and variable achievement of the target and are no longer escalated. The Trust has once again achieved the Cancer Waiting Times 62 Day standard for the month of March and has continued to achieve the national 2 Week Wait (2WW) Standard. Achievement of these standards continues to remain increasingly challenging.

### Escalations by Strategic Theme:

**People:**

- Turnover Rate (P.8)
- Sickness Rate (P.9)*
- % of Afc 8c and above that have a Disability (P.9)
- % of Afc 8c and above that are BAME (P.9)

**Patient Safety & Clinical Effectiveness:**

- Incidents resulting in Harm (P.11)
- Infection Control - COVID (P.12)

**Patient Access:**

- RTT Performance (P.14)
- Planned levels of new outpatients activity (P.15)
- Outpatient Calls answered <1 minute (P.16)
- Outpatient Clinic Utilisation (P.16)
- Planned levels of Diagnostics activity (P.16)

**Patient Experience:**

- Complaints responded within target (P.18)
- FFT Response Rates - Inpatients, A&E, Outpatients and Maternity (P.19)

**Systems:**

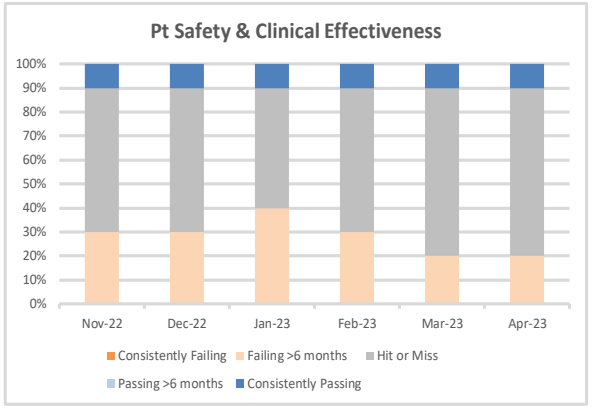
- Discharges before Noon (P.21)

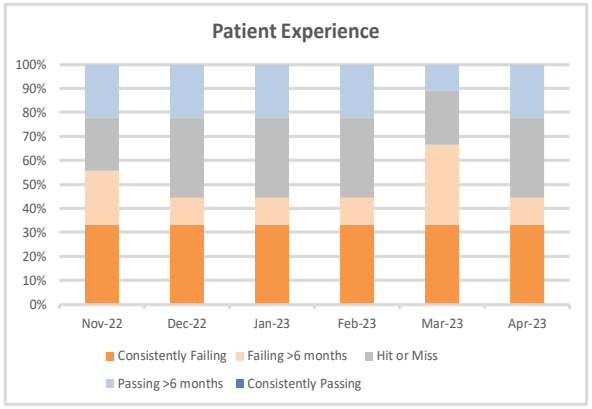
**Sustainability**

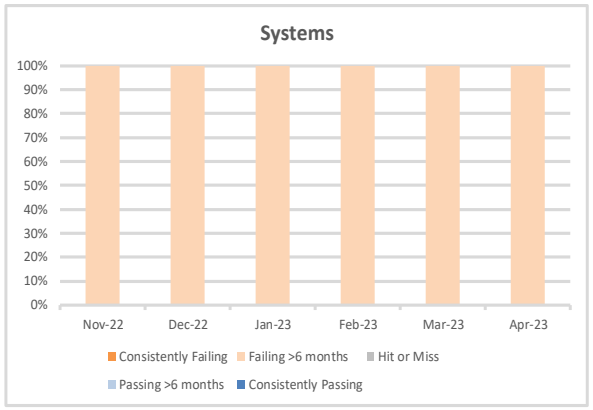
- Agency Spend (P.23)

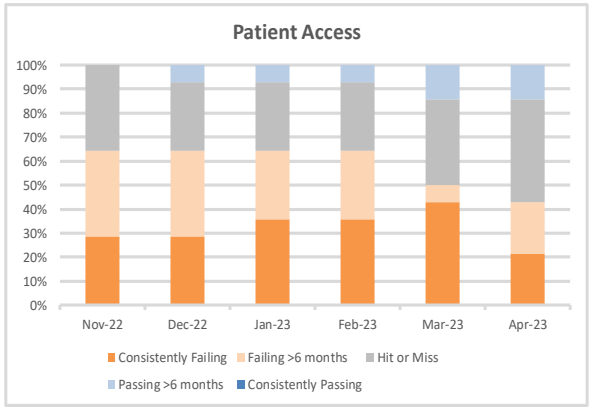
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

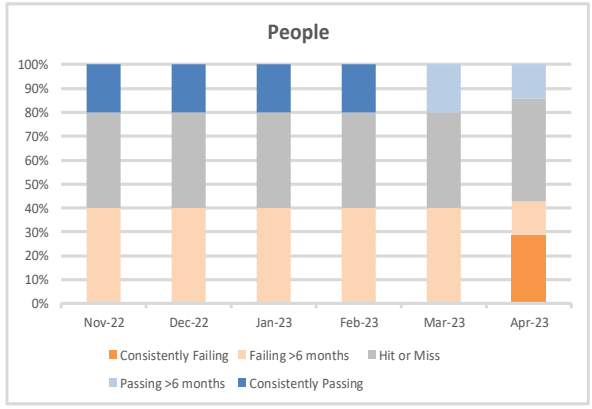
# Assurance Stacked Bar Charts by Strategic Theme

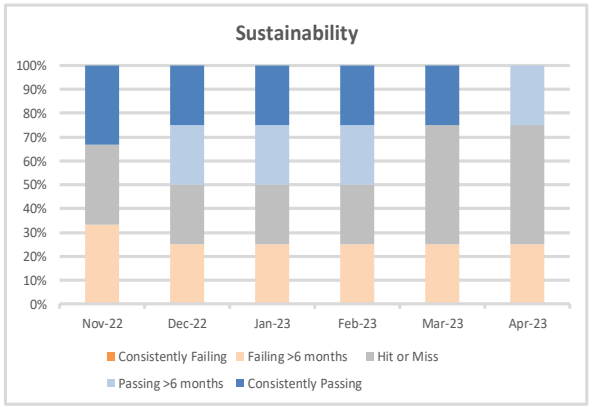


# Matrix Summary

**April 2023**

| Variance | Assurance: Pass★ | Assurance: Pass | Assurance: Hit and Miss | Assurance: Fail | Assurance: Fail - |
|---|---|---|---|---|---|
| **Special Cause - Improvement** | | Reduce the Trust wide vacancy rate to 12% | EDI: % of AfC 8c and above that are Female<br>Safe Staffing Levels<br>Access to Diagnostics (<6weeks standard)<br>Friends and Family (FFT) % Response Rate: Inpatients | | EDI: % of AfC 8c and above that are BAME<br>To increase the number of patients leaving our hospitals by noon on the day of discharge<br>Transformation: % OP Clinics Utilised (slots)<br>Friends and Family (FFT) % Response Rate: A&E<br>Friends and Family (FFT) % Response Rate: Maternity |
| **Common Cause** | Summary Hospital-level Mortality Indicator (SHMI) | Ensure activity levels for theatres match those pre-Covid - Total Elective<br>Cancer - 2 Week Wait<br>Complaints Rate<br>To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.<br>Cash Balance (£k) | Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days<br>A&E 4 hr Performance<br>Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients<br>To reduce the overall number of complaints or concerns each month<br>Number of New SIs in month<br>Cancer - 62 Day<br>Never Events<br>Sickness Absence<br>% VTE Risk Assessment (one month behind)<br>IC - Rate of Hospital C.Difficile per 100,000 occupied beddays<br>IC - Number of Hospital acquired MRSA<br>Flow: Ambulance Handover Delays >30mins<br>Flow: % of Emergency Admissions into Assessment Areas<br>Capital Expenditure (£k) | Reduce Turnover Rate to 12%<br>Reduction in incidents resulting in harm by 8.2%<br>RTT Patients waiting longer than 40 weeks for treatment<br>To achieve the planned levels of new outpatients activity (shown as a % 19/20)<br>% complaints responded to within target<br>Infection Control - Hospital Acquired Covid<br>Reduce the amount of money the Trusts spends on premium workforce spend | EDI: % of AfC 8c and above that have a Disability<br>Diagnostic Activity (MRI,NOUS,CT Combined)<br>Transformation: CAU Calls answered <1 minute |
| **Special Cause - Concern** | | | Standardised Mortality HSMR<br>Delivery of financial plan, including operational delivery of capital investment plan.<br>Statutory and Mandatory Training | Achieve the Trust RTT Trajectory | Friends and Family (FFT) % Response Rate: Outpatients |

# Strategic Theme: People

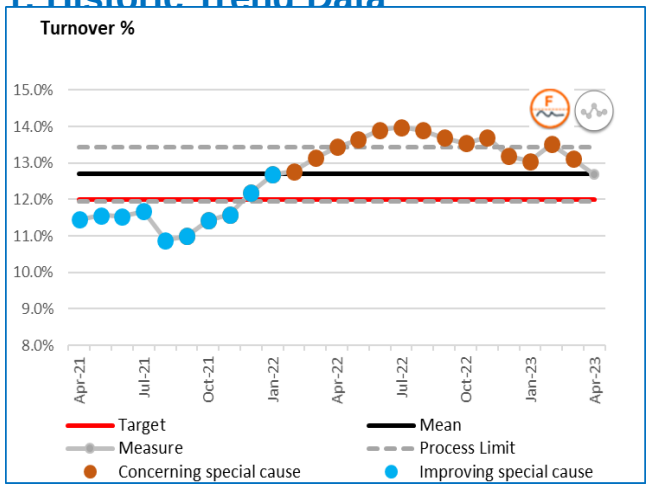
| | | | Latest | | | Previous | | | Actions & Assurance | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CQC Domain | Metric | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions |
| **Vision Goals / Targets** | Well Led | Reduce the Trust wide vacancy rate to 12% | 12% | 10.4% | Apr-23 | 12% | 8.7% | Mar-23 | Driver |  |  | Note Performance |
| **Breakthrough Objectives** | Well Led | Reduce Turnover Rate to 12% | 12% | 12.7% | Apr-23 | 12% | 13.1% | Mar-23 | Driver |  |  | Full CMS |
| **Constitutional Standards and Key Metrics (not in SDR)** | Well Led | Sickness Absence | 4.5% | 4.2% | Mar-23 | 4.5% | 4.1% | Feb-23 | Driver |  |  | Not Escalated |
| | Well Led | Appraisal Completeness | 0.0% | 1.3% | Apr-23 | 95.0% | 90.1% | Mar-23 | Driver |  |  | Not Escalated |
| | Well Led | Statutory and Mandatory Training | 85.0% | 87.3% | Apr-23 | 85.0% | 86.2% | Mar-23 | Driver |  |  | Not Escalated |
| | Well Led | Percentage of AfC 8c and above that are Female | 64.0% | 66.4% | Apr-23 | 62.0% | 63.2% | Mar-23 | Driver |  |  | Not Escalated |
| | Well Led | Percentage of AfC 8c and above that have a Disability | 3.6% | 2.6% | Apr-23 | 3.2% | 2.6% | Mar-23 | Driver |  |  | Escalation |
| | Well Led | Percentage of AfC 8c and above that are BAME | 16.0% | 6.9% | Apr-23 | 12.0% | 7.0% | Mar-23 | Driver |  |  | Escalation |

# Breakthrough Objective: Counter Measure Summary

## Metric Name – Reduce Turnover Rate to 12%

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

## 1. Historic Trend Data




| Apr-23 |
|---|
| 12.69% |
| **Variance / Assurance** |
| Metric is currently Common Cause variation 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

NOTE: The theatre ODPs have been recoded from "Add Prof Scientific and Technic" to "Allied Health Professionals". This swing in staff has affected the turnover calculation, pushing "Add Prof Scientific and Technic" from second highest to highest


## 3. Top Contributors

These are some of the main contributors of focus for the working groups

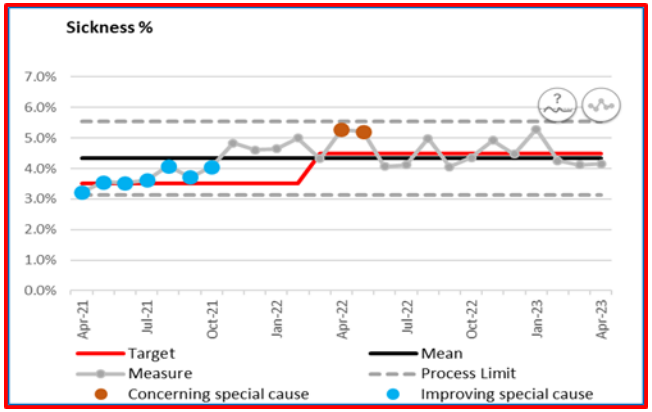
| Attraction | Learning & Development |
|---|---|
| Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW | No clear progression path / Upskilling does not lead to promotion |
| Inadequate break times / Poor wellbeing | Onboarding slow / Gaps in leadership capability |
| | Not enough locally trained staff / Lack of staff development |
| **Processes** | **Retention** |
| Retire and return policy out of date, putting people off returning | Not feeling valued, engaged, part of a team / Feedback from listening events taking too long to action |
| TRAC process takes too long, leading to delays / lack of transparency in recruitment | No outer London waiting, losing staff to Dartford / easier to find better pay elsewhere |

## 4. Action Plan

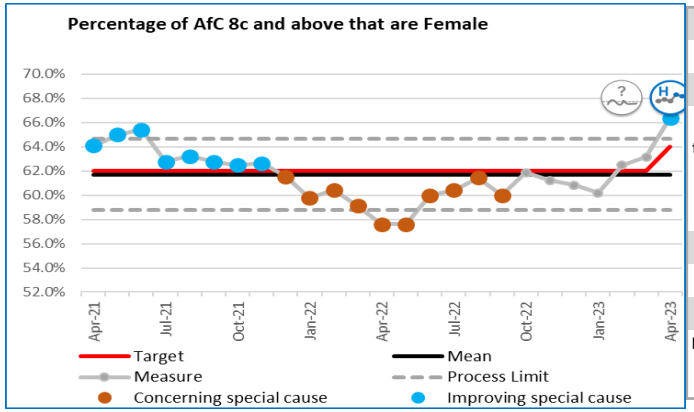
A full action plan by the working groups has been developed; some of the key actions shown:

| Countermeasures | Target Completion Date |
|---|---|
| Introduce localised trust-based incentives for both attraction and retention | May-23 |
| Create talent pool/ list of names of people interested in promotion | Aug-23 |
| Review Inequalities in relation to career progression for staff from ethnic minority backgrounds | Jun-23 |
| Introduce virtual onboarding info pack | May-23 |
| Introduce a clear and consistent Recruitment and Retention Premium approach (for hard to recruit roles) | End of April-23 |
| Introduce stay interviews | May-23 |
| Introduce staff voice box | End of April-23 |

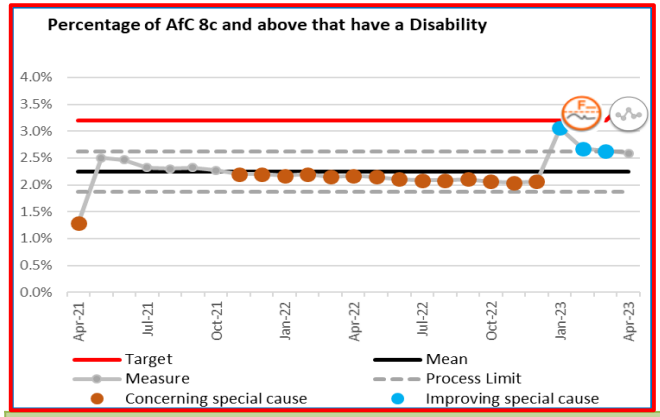
# People – Workforce: CQC: Well-Led



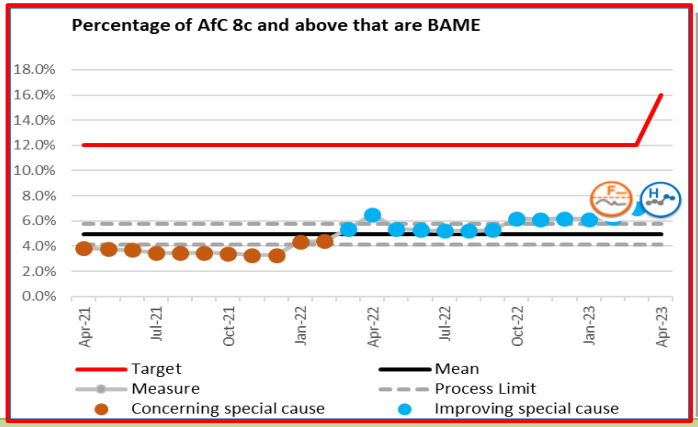

| Mar-23 |
|---|
| 4.15% |
| **Variance / Assurance** |
| Metric is currently experiencing Common Cause Variation and variable achievement of the target |
| **Max Target (Internal)** |
| 4.5% |
| **Business Rule** |
| Escalated as in Hit & Miss for >6months |




| Apr-23 |
|---|
| 66.4% |
| **Variance / Assurance** |
| Not able to due SPC due to only 3 months of data that is monitored as per the Appraisal Cycle. Currently April only. |
| **Target (National)** |
| 62% |
| **Business Rule** |
| Not Escalated but shown for info as is a new metric |




| Apr-23 |
|---|
| 2.6% |
| **Variance / Assurance** |
| Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target |
| **Target (National)** |
| 3.2% |
| **Business Rule** |
| Has failed the Target for 6+ Months |




| Apr-23 |
|---|
| 6.9% |
| **Variance / Assurance** |
| Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target |
| **Target (National)** |
| 12% |
| **Business Rule** |
| Has failed the Target for 6+ Months |

**Summary:**

**Sickness % - T**his metric is experiencing Common Cause Variation and variable achievement of the Target

Three new indicators that form part of the National Single Oversight Framework have now been included:

**% of AfC 8c and above that are Female:** This metric is experiencing special cause variation of an improving nature and variable achievement of the target.

**% of AfC 8c and above that have a Disability:** This metric is experiencing special cause variation of an improving nature and consistently failing the target.

**% of AfC 8c and above that are BAME:** This metric is experiencing special cause variation of an improving nature and consistently failing the target.

**Actions:**

**Sickness**: A deep dive analysis on reporting on sickness absence, focussing on long-term vs short-term sickness will be included in the next Integrated Performance Reports

**% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME :**

As at April 23 the current number of staff (WTEs) that are AfC 8c and above is 113. Of these 3 have a disability and 8 are BAME.

**Actions:**

- Communications targeted at bands 8c and above to promote updated EDI data on ESR through ESS.
- Mandate for EDI recruitment reps to be on all interview panels of 8C and above

**Assurance & Timescales for Improvement:**

**Sickness:** Continued monitoring of any spikes for non-seasonal reasons for absence. Undertake a further review of the sickness target to bring this down further.

Increased numbers of sickness management cases are brought through to support people on long-term absence or with underlying health conditions.

**% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME:**

Develop and deliver values based recruitment training by July 2023, targeting recruiting managers in Divisions with high turnover.

# Strategic Theme: Patient Safety & Clinical Effectiveness

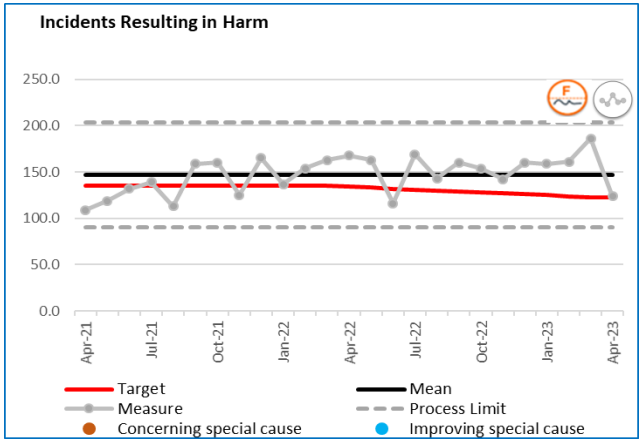
| | | | Latest | | | Previous | | | Actions & Assurance | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CQC Domain | Metric | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions |
| **Vision Goals / Targets** | Safe | Reduction in incidents resulting in harm by 8.2% | 123 | 124 | Apr-23 | 123 | 186 | Mar-23 | Driver | | F | Full CMS |
| **Breakthrough Objectives** | Safe | Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days | 6.36 | 7.28 | Apr-23 | 6.36 | 6.16 | Mar-23 | Driver | | ? | Verbal CMS |
| **Constitutional Standards and Key Metrics (not in SDR)** | Safe | Number of New SIs in month | 11 | 0 | Apr-23 | 11 | 6 | Mar-23 | Driver | | ? | Not Escalated |
| | Safe | Standardised Mortality HSMR | 100.0 | 101.7 | Dec-22 | 100.0 | 99.7 | Nov-22 | Driver | H | ? | Not Escalated |
| | Safe | Summary Hospital-level Mortality Indicator (SHMI) | 100.0 | 91.5 | Dec-22 | 100.0 | 91.4 | Nov-22 | Driver | | P | Not Escalated |
| | Safe | Never Events | 0 | 0 | Apr-23 | 0 | 0 | Mar-23 | Driver | | ? | Not Escalated |
| | Safe | Safe Staffing Levels | 93.5% | 99.3% | Apr-23 | 93.5% | 97.6% | Mar-23 | Driver | H | ? | Not Escalated |
| | Safe | Infection Control - Hospital Acquired Covid | 0 | 15 | Apr-23 | 0 | 63 | Mar-23 | Driver | | F | Escalation |
| | Safe | IC - Rate of Hospital C.Difficile per 100,000 occupied beddays | 22.7 | 21.6 | Apr-23 | 22.7 | 19.7 | Mar-23 | Driver | | ? | Not Escalated |
| | Safe | IC - Number of Hospital acquired MRSA | 0 | 0 | Apr-23 | 0 | 1 | Mar-23 | Driver | | ? | Not Escalated |

# Vision: Counter Measure Summary

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

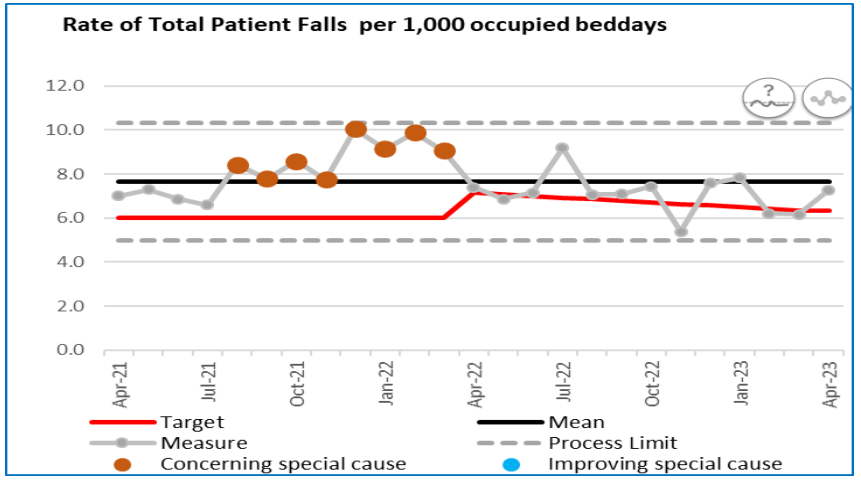
**Owner: Peter Maskell**
**Metric:** Incidents resulting in harm
**Desired Trend:** 7 consecutive data points below the mean

## 1. Historic Trend Data

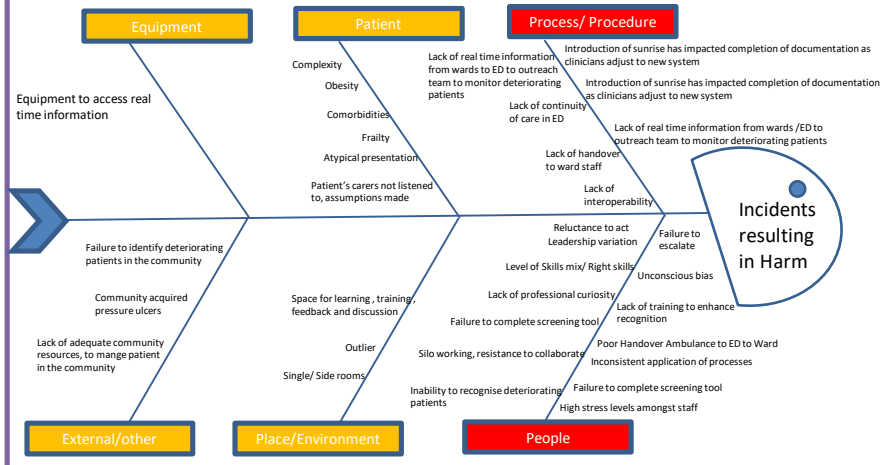



| Apr-23 |
|---|
| 124 |
| **Variance / Assurance** |
| Metric is currently experiencing common cause variation and has not achieved the target for more than 6 months |
| **Max Target (Internal)** |
| 123 |
| **Business Rule** |
| Apr |

## 2. Stratified Data



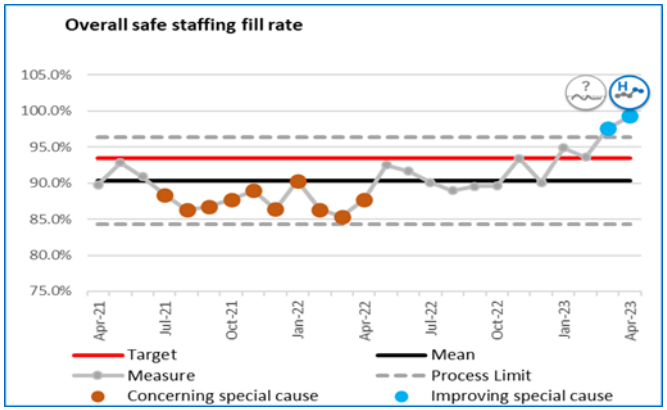

## 3. Top Contributors



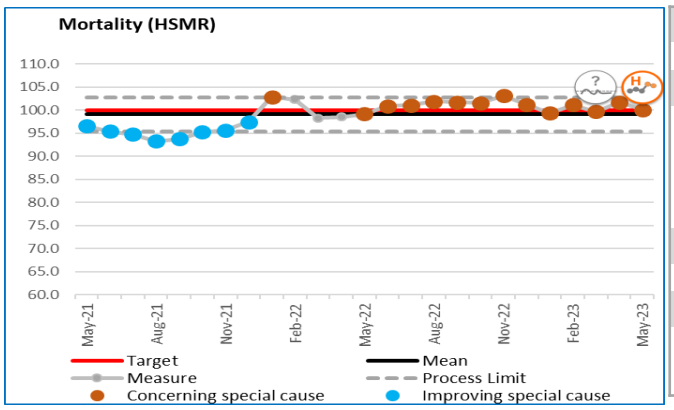

## 4. Action Plan

| Contributor | solution /countermeasure | Owner | Due By |
|---|---|---|---|
| Workforce | Safer staffing fill rate levels | CNO/CPO | Ongoing |
| Environment/ Equipment/ Process | **Focus on Slips, trips and falls,** as major contributing factor to incidents resulting in severe harm (30%).<br>-Falls has increased slightly in April at 135 compared to March at 127 across the trust. Achieving 7.28 per 1000 bed days against the 6.36 per 1000 bed day target for falls<br><br>A **Harm A3 Engagement Session** was held on the 17th of May 2023 with stakeholders from the divisions, patient safety and representatives from significant areas of harm impact including pressure ulcer, outreach, sunrise and resus.<br><br>Analysis of the harm data indicates a large no of incidents relate to low harm. Increased validation and awareness of harm has impacted positively on levels of harms being reported.<br><br>Falls – Fall will continue to be an ongoing initiative, returning to business as usual with a focus on monitoring and sustaining initiatives implemented. Some of the area of focus being developed include deteriorating patients, failure to escalate, sepsis, Acute Kidney Injury (AKI), missed diagnostics and pressure ulcers. | Medical Director | Ongoing - BAU |

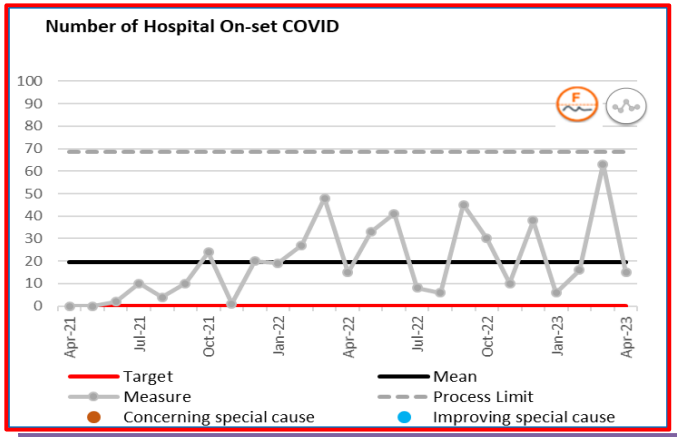
# Patient Safety and Clinical Effectiveness: CQC: Safe



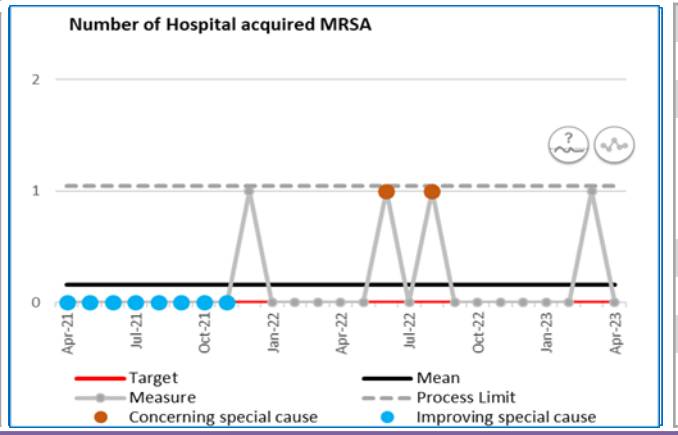

| Apr-23 |
|---|
| 99.3% |
| **Variance / Assurance** |
| Metric is currently experiencing special cause variation of an improving nature and variable achievement of the target |
| **Target (Internal)** |
| 93.5% |
| **Business Rule** |
| For information as has moved special cause improving |




| Dec-22 |
|---|
| 100.1 |
| **Variance / Assurance** |
| Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target |
| **Max Target (Internal)** |
| 100.0 |
| **Business Rule** |
| Returned to variable achievement |




| Apr-23 |
|---|
| 15 |
| **Variance / Assurance** |
| Metric is currently experiencing common cause variation and has not achieved the target for >6 months |
| **Max Target (Intern** |
| 0 |
| **Business Rule** |
| Full Escalation as has not achieved the target for > 6 months |




| Apr-23 |
|---|
| 1 |
| **Variance / Assurance** |
| Metric is currently experiencing Common Cause Variation and variable achievement of the target |
| **Max Target** |
| As Expected |
| **Business Rule** |
| For information as has returned to hit & miss |

## Summary:

**Safe Staffing Fill Rate:** The level reported has moved to special cause variation of an improving 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.

**Mortality (HSMR):** Metric is experiencing special cause variation of a concerning nature but has moved to variable achievement of the target. It should also be highlighted that Trust are still rated 'as expected' by Dr Foster (T-Health). The methodology being used in this calculation is based upon a 12 rolling month period for each data point, so provides a more stable view of performance than individual months. The Mortality Surveillance Group received monthly updates from Dr Foster and in depth analysis. This is then reported onwards into the Quality Committee. A one month lag in our reporting is currently being applied to offset the impact of the uncoded activity in our initial ('flex') submission to SUS. This will be reviewed as our percentage of coded episodes submitted at flex improves.

## Actions:

**Safe Staffing Fill Rate:** The Matrons afternoon staffing huddles are supported by the Bank team to ensure the staffing allocations mitigate any safety risks. The Deputy Chief Nurse and HON for Safe Staffing are now included in the risk assessments for non framework agency requests. Embedding of new staff staffing processes detailed in the Safe Staffing policy is in the planning stage. These new practices will be piloted within the Acute and Geriatric Directorate prior to Trust wide roll out. A deep dive into bank and agency processes is underway in relation to the management of restrictions placed on practice. This will focus initially on bank staff. Retention of Registered Nurses/Midwives and Healthcare Clinical Support Workers (HCSWs) is now a focus with a view to reduce turnover rates. Career roadshows and the Corporate Nursing retention group is ongoing. Student Councils are ongoing with an increase in attendance seen at the last meeting. This forum will continue to expanded and will eventually include students from all professions

**Infection Control:** Following national guidance, changes to patient and staff COVID testing was introduced at the end of April. For patients this meant that lateral flow tests (LFTs) are no longer required to stepdown immunocompetent patients. These patients can be stepped down after 5 days as long as they are 48 hours without a temperature and had a clinical assessment. Immunocompromised patients still require LFTs and can be stepped down after 10 days. Staff working with immunocompetent patients are no longer required to test if they are symptomatic, they should feel well enough to come to work (without a temperature) and wear a mask if they have respiratory symptoms. LFTs are still required for symptomatic staff working with immunocompromised patients

## Assurance & Timescales for Improvement:

**Safe Staffing Fill Rate:** Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. The Safe Staffing policy is now live on Qpulse. Reports following the first Safer Nursing Care Tool Audit at MTW are currently being compiled by BI. These will be produced for all clinical areas who participated in the audit. Recruitment activity continues to move at pace. A decrease in HCSW vacancies has been seen. The HCSW recruitment process has been assessed and amended to support both candidates and Clinical Teams. International recruitment activity is ongoing, and a broadening of the number of recruitment agencies has been actioned to support this activity.

**Infection Control:** The numbers of COVID in our hospitals have reduced, with less patients presenting through ED and as inpatients. We still identify some patients as positive on their discharge LFT test to care home and see sporadic outbreaks involving both patients and staff. IPC control measures are put in place in any areas identified as having an outbreak including enhanced cleaning and the wearing of masks for all staff entering or working in that area.

# Strategic Theme: Patient Access

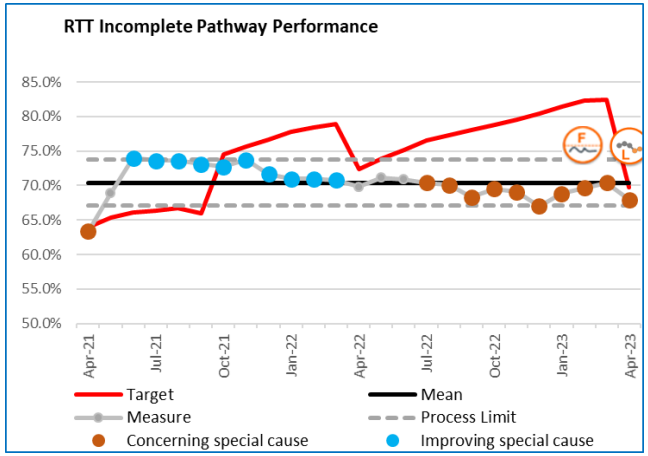
| | | | Latest | | | Previous | | | Actions & Assurance | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CQC Domain | Metric | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions |
| **Vision Goals / Targets** | Responsive | Achieve the Trust RTT Trajectory | 69.7% | 67.9% | Apr-23 | 82.4% | 70.4% | Mar-23 | Driver | L | F | Full CMS |
| **Breakthrough Objectives** | Responsive | To achieve the planned levels of new outpatients activity (shown as a % 19/20) | 101.1% | 99.3% | Apr-23 | 151.9% | 136.2% | Mar-23 | Driver | | F | Full CMS |
| **Constitutional Standards and Key Metrics (not in SDR)** | Responsive | RTT Patients waiting longer than 40 weeks for treatment | 663 | 704 | Apr-23 | 422 | 571 | Mar-23 | Driver | | F | Escalation |
| | Responsive | Access to Diagnostics (<6weeks standard) | 86.2% | 89.4% | Apr-23 | 99.1% | 91.1% | Mar-23 | Driver | H | ? | Not Escalated |
| | Responsive | A&E 4 hr Performance | 88.3% | 89.6% | Apr-23 | 91.3% | 85.4% | Mar-23 | Driver | | ? | Not Escalated |
| | Responsive | Cancer - 2 Week Wait | 93.0% | 93.9% | Mar-23 | 93.0% | 95.2% | Feb-23 | Driver | | P | Not Escalated |
| | Responsive | Cancer - 62 Day | 85.0% | 85.3% | Mar-23 | 85.0% | 85.5% | Feb-23 | Driver | | ? | Not Escalated |
| | Effective | Transformation: % OP Clinics Utilised (slots) | 85.0% | 68.6% | Apr-23 | 85.0% | 66.7% | Mar-23 | Driver | H | F | Escalation |
| | Effective | Transformation: % of Patients Discharged to a PIFU Pathways | 1.5% | 3.3% | Apr-23 | 1.5% | 3.6% | Mar-23 | Driver | No SPC | No SPC | Not Escalated |
| | Effective | Transformation: CAU Calls answered <1 minute | 90.0% | 60.0% | Apr-23 | 90.0% | 57.1% | Mar-23 | Driver | | F | Escalation |
| | Effective | Flow: Ambulance Handover Delays >30mins | 5.0% | 3.9% | Apr-23 | 5.0% | 5.3% | Mar-23 | Driver | | ? | Not Escalated |
| | Effective | Flow: % of Emergency Admissions into Assessment Areas | 65.0% | 65.9% | Apr-23 | 65.0% | 62.9% | Mar-23 | Driver | | ? | Not Escalated |
| | Responsive | To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20) | 92.8% | 95.7% | Apr-23 | 141.0% | 154.4% | Mar-23 | Driver | | P | Not Escalated |
| | Responsive | To achieve the planned levels of outpatients follow up activity (shown as a % 19/20) | 90.5% | 98.5% | Apr-23 | 119.2% | 125.4% | Mar-23 | Driver | | ? | Not Escalated |
| | Responsive | To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) | 143.6% | 127.9% | Apr-23 | 141.0% | 149.5% | Mar-23 | Driver | | F | Escalation |

# Vision: Counter Measure Summary

## Project/Metric Name – Achieve the Trust RTT

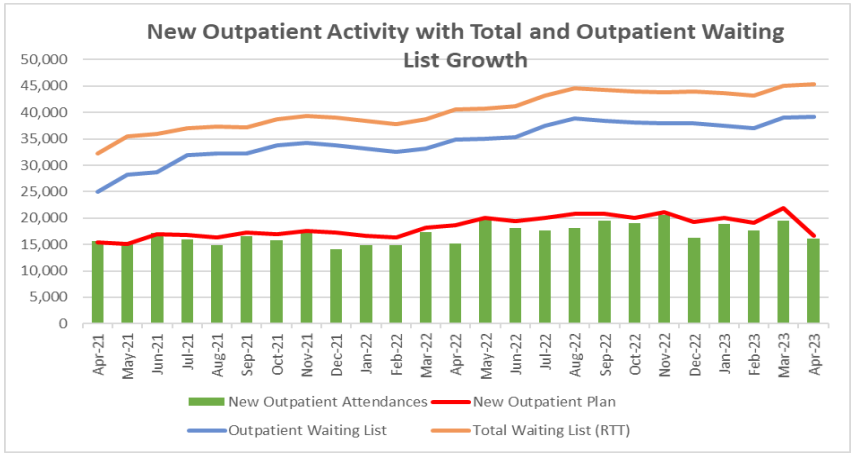
**Owner:** Sean Briggs
**Metric:** Referral to Treatment time Standard
**Desired Trend:** 7 consecutive data points above the mean

## 1. Historic Trend Data




| Apr-23 |
|---|
| 67.9% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (Internal)** |
| 69.7% |
| **Target Achievement** |
| Metric has not achieved the target for >6 months |

## 2. Stratified Data




## 3. Top Contributors

New A3 being developed from updated RTT performance data to understand any changes to top contributors

BAU actions within action plan continue

## 4. Action Plan

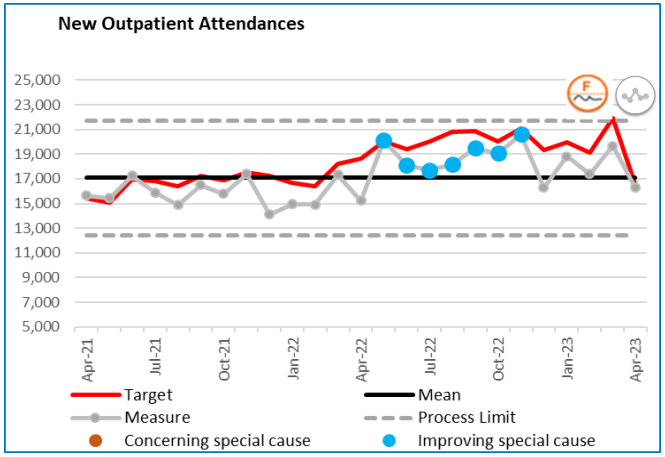
| Countermeasures | Action | Who / By when | Complete |
|---|---|---|---|
| Improved New Outpatient Activity | Focussed work on the Breakthrough Objective to Increase New Outpatient Activity | SP | Ongoing |
| Additional PTL | Gynae team – focus on patients from 28 weeks to longest waiter | Specialty GM, Patient Access and Deputy COO | Ongoing |
| Close monitoring of all patients over 40 weeks | Tuesday PTL and Trust Access Performance meeting | RTT Lead and PAT team | Weekly and in progress |
| Update RTT top contributors | Develop new A3 with updated RTT data | SC/BI/PMO | End June 23 |
| | | | |

# Breakthrough Objective: Counter Measure Summary

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

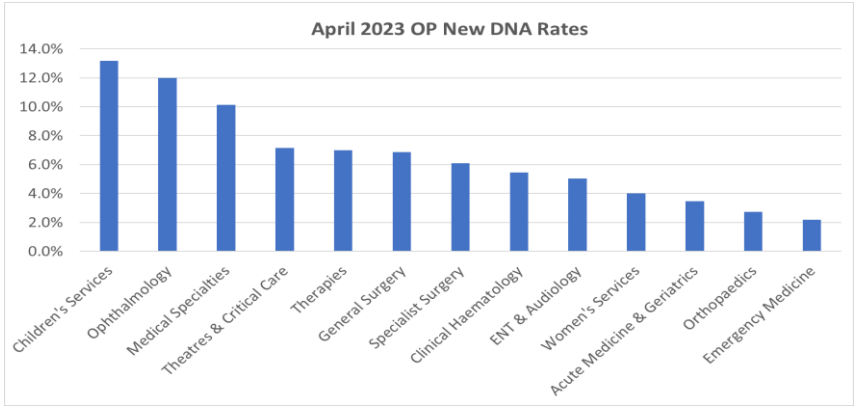
**Owner:** Sean Briggs
**Metric**: Elective Activity: New Outpatients
**Desired Trend:** 7 consecutive data points above the mean

## 1. Historic Trend Data



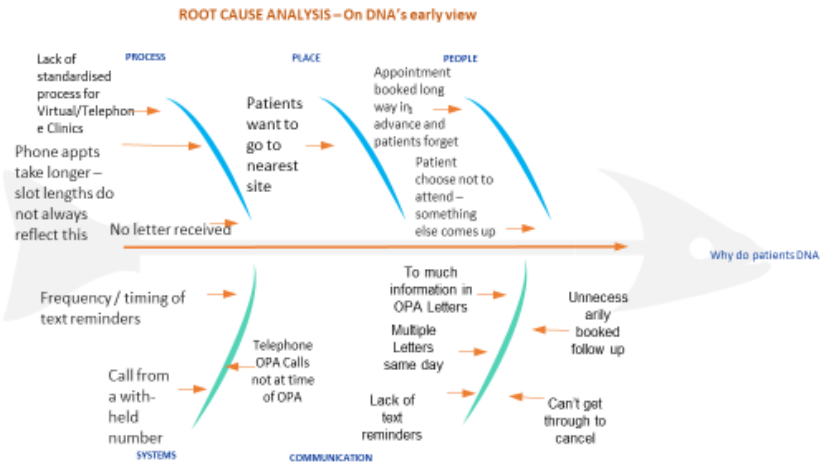

| Apr-23 |
|---|
| 16,301 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 16,611 |
| **Target Achievement** |
| Metric has failed the target >6months |

## 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

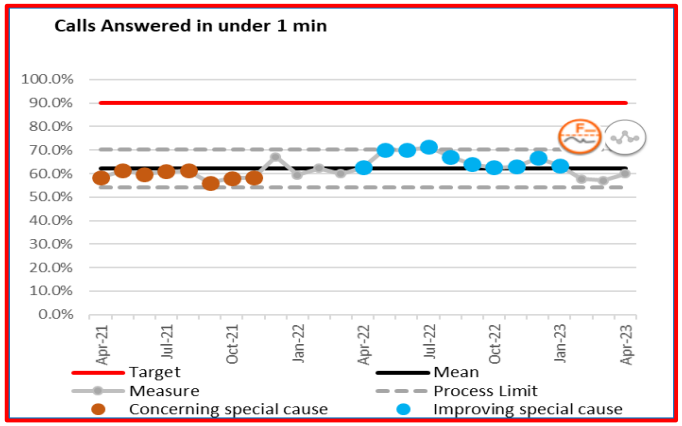
## 3. Top Contributors



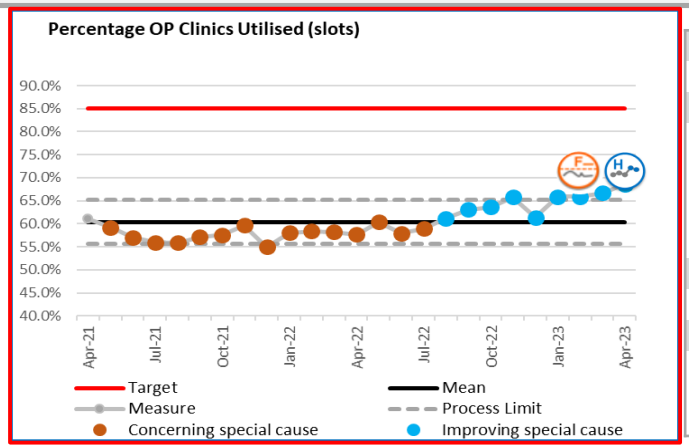

## 4. Action Plan

| Countermeasures | Action | Who / By when | Complete (Y/N) |
|---|---|---|---|
| Two way text | Implementation plan developed | Project Team | Complete |
| | Operational process flows for CAU to be agreed | Project team | Feb 23 |
| | IT Load balancers installed | IT | Delayed TBC |
| | Go live | Project Team | TBC- IT work dependant |
| Switch on Paediatric Text under 13's reminders (agreed for Ophth) | SOP & Policy Document sign off by Governance and W&C directorate | SP/KS/JT | May 23 |
| Telephone Clinics – review of letters & OPA flow | Monitor Telephone Clinic DNA's to see improvement. OP team auditing virtual clinics to identify areas of improvements | SC/LL/FS | In progress |
| Comms Plan | ICB Posters to be updated with MTW details and circulated to OP areas/intranet site | FJ/SC | In progress |

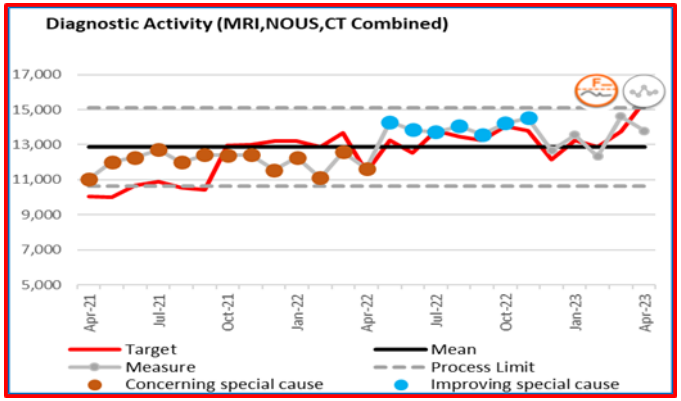
# Patient Access: CQC: Responsive



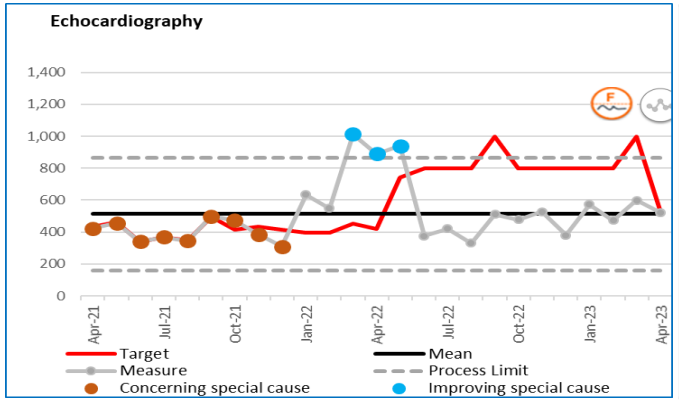

| Apr-23 |
|---|
| 60% |
| **Variance / Assurance** |
| Metric is currently experiencing Common Cause Variation and consistently failing the target |
| **Target (Internal)** |
| 90% |
| **Business Rule** |
| Full Escalation as consistently failing the target |




| Apr-23 |
|---|
| 68.6% |
| **Variance / Assurance** |
| Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target |
| **Target (Internal)** |
| 85% |
| **Business Rule** |
| Full Escalation as consistently failing the target |




| Apr-23 |
|---|
| 13,780 |
| **Variance / Assurance** |
| Metric is currently experiencing common cause variation and consistently failing the target |
| **Target** |
| 15,478 |
| **Business Rule** |
| Full Escalation as consistently failing the target |




| Apr-23 |
|---|
| 524 |
| **Variance / Assurance** |
| Metric is currently experiencing common cause variation and failing the target >6 months |
| **Target (Internal)** |
| 536 |
| **Business Rule** |
| Shown for info as contributes to overall activity levels |

## Summary:

**Calls Answered <1 min:** is experiencing common cause variation and remains consistently failing the target. The areas with the lowest rate is Endoscopy and Surgical Specialties.

**Outpatient Utilisation:** is experiencing special cause variation of an improving nature and consistently failing the target. The Divisions below 75% are Core Clinical Services, Medicine and Women & Children's Services.

**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.

**Diagnostic Echocardiography Activity:** Activity is slightly below the revised recovery trajectory set for April 23. Metric is now experiencing common cause variation and has failed the target for >6 months.

## Actions:

**Performance against the under 1 minute KPI:** no speciality achieved the target, Head & Neck had the strongest performance >70%, Endoscopy was particularly low at <30%

**Outpatient Clinic Slot Utilisation: t**he OPD team will continue to work with the CAU's on their clinic templates and the utilisation of clinic slots. Slot utilisation is discussed at the RTT meeting.

**Diagnostic Activity:** MRI and CT activity is below plan for April 2023 due to phasing of CDC and operational challenges.

**Echocardiography Activity:** was slightly below revised trajectory for April 2023. Activity being monitored weekly.

## Assurance & Timescales for Improvement:

**Calls Answered:** The CAU teams are continuing with their local plans. The OPD Contact Centre has been expanded and are now supporting 7 main CAU areas of the trust. Recruitment to expand the team further is progressing.

**Outpatient Slot Utilisation:** There is a 6-4-2 forward look report of both room and slot utilisation that is being updated to provide more accurate data, in conjunction with the ODP & BI teams.

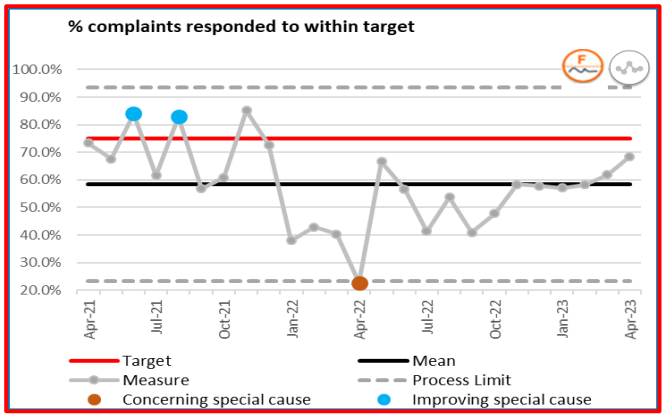
**Diagnostic Activity:**. Activity is being monitored weekly.

**Echocardiography**: aim to book up to 6 weeks in advance and call patients prior to appts to reduce DNAs

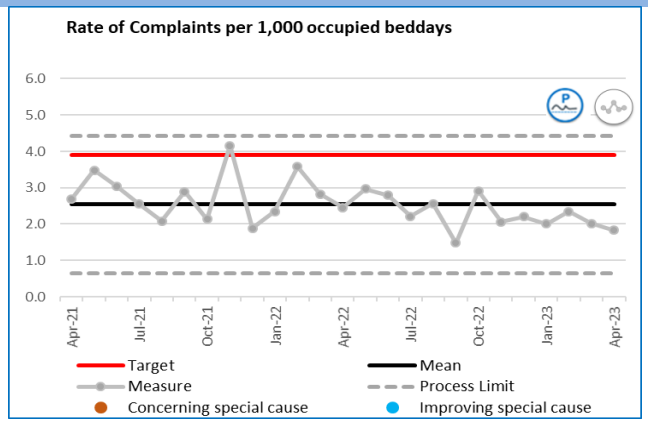
# Strategic Theme: Patient Experience

| | | | 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 | 34 | Apr-23 | 36 | 41 | Mar-23 | Driver | | | Verbal 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 | 12 | Apr-23 | 24 | 15 | Mar-23 | Driver | | | Note Performance |
| **Constitutional Standards and Key Metrics (not in SDR)** | Caring | Complaints Rate per 1,000 occupied beddays | 3.9 | 1.8 | Apr-23 | 3.9 | 2 | Mar-23 | Driver | | | Not Escalated |
| | Caring | % complaints responded to within target | 75.0% | 68.4% | Apr-23 | 75.0% | 61.9% | Mar-23 | Driver | | | Escalation |
| | Caring | % VTE Risk Assessment (one month behind) | 95.0% | 94.7% | Mar-23 | 95.0% | 94.9% | Feb-23 | Driver | | | Not Escalated |
| | Caring | Friends and Family (FFT) % Response Rate: Inpatients | 25.0% | 28.5% | Apr-23 | 25.0% | 18.4% | Mar-23 | Driver | | | Not Escalated |
| | Caring | Friends and Family (FFT) % Response Rate: A&E | 15.0% | 6.3% | Apr-23 | 15.0% | 5.3% | Mar-23 | Driver | | | Escalation |
| | Caring | Friends and Family (FFT) % Response Rate: Maternity | 25.0% | 29.6% | Apr-23 | 25.0% | 28.9% | Mar-23 | Driver | | | Escalation |
| | Caring | Friends and Family (FFT) % Response Rate: Outpatients | 20.0% | 7.8% | Apr-23 | 20.0% | 7.4% | Mar-23 | Driver | | | Escalation |

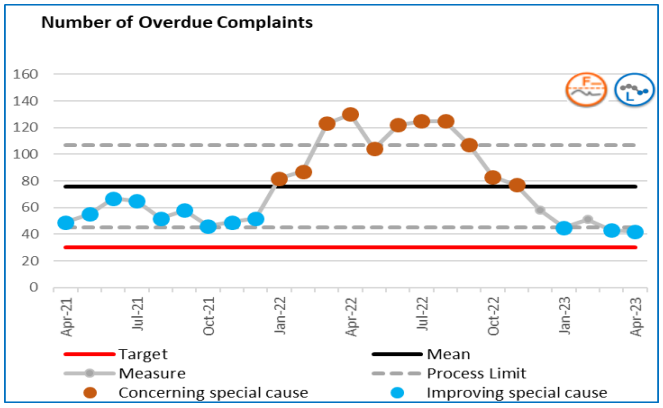
# Patient Experience: CQC: Caring (Hit or Miss >6 months)



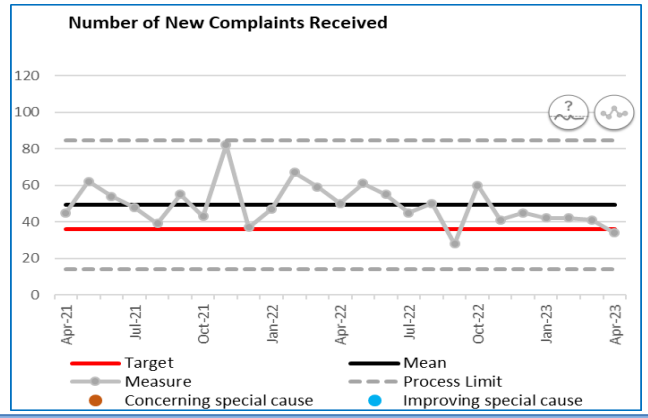

| Apr-23 |
|---|
| 68.4% |
| **Variance / Assurance** |
| Metric is in common cause variation and failing the target for 6+ months |
| **Target (Internal)** |
| 75% |
| **Business Rule** |
| Full Escalation failed the target 6+ months |




| Apr-23 |
|---|
| 1.8 |
| **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 Information as linked to % Complaint Responded |




| Apr-23 |
|---|
| 42 |
| **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 |




| Apr-23 |
|---|
| 34 |
| **Variance / Assurance** |
| Metric is currently experiencing common cause variation and variable achievement of the target |
| **Max Limit (Internal)** |
| 36 |
| **Business Rule** |
| For Information as linked to % Complaint Responded |

## Summary:

**% Complaints responded to within target:** this indicator is experiencing common cause variation and has failed the target for >6months, noting the target has not been met since November 2021

Over the last 5 months, complaints performance has stabilised and is currently averaging 59%. Performance for April was 68.4%.

## Actions:

**% Complaints responded to within Target:**

Complaints performance recovery and stabilisation actions include;

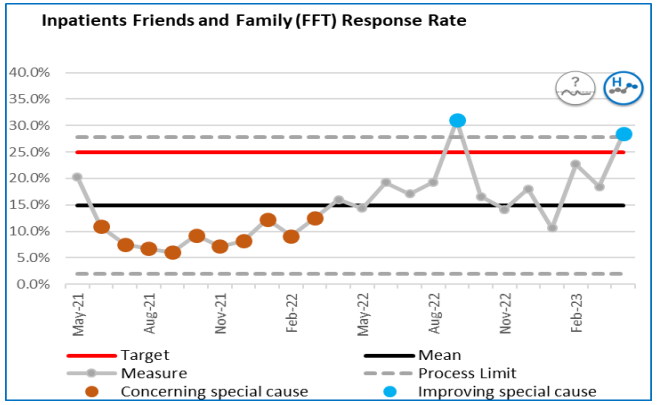
- Interim performance monitoring reported weekly to CN
- Weekly oversight meetings led by CN and DQG
- Successful recruitment to x2 Complaint Lead posts
- Business case for revised complaints model (meeting new 2022 National framework) submitted
- Complaints QA now handed back to divisional leads
- Complaints staff supporting A3 projects in Surgery and Women's to improve complaint response times
- Introduction of new 40 day target to support more complex cases
- New head of complaints & PALS commenced in post 27 March '23

## Assurance & Timescales for Improvement:

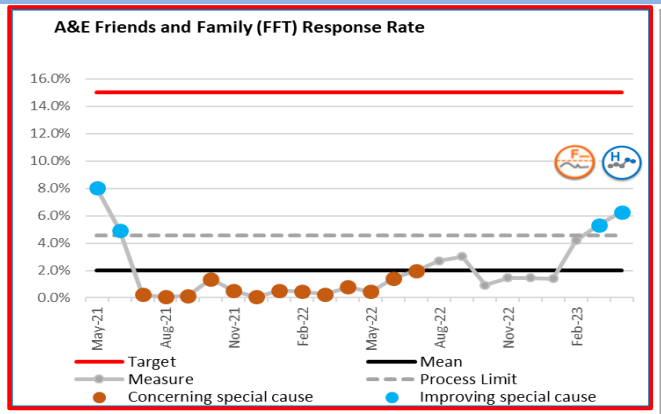
**% Complaints responded to within Target:**

- We expected to see an improvement in % compliance from November 2022 as a result of the introduction of a new 40-day timeframe for amber complaints and the recovery actions in place
- We are aiming to hit sustained delivery of the target response (75%) by September 2023
- We are aiming to increase our target response time % measure from 75% to 90% by December 2023

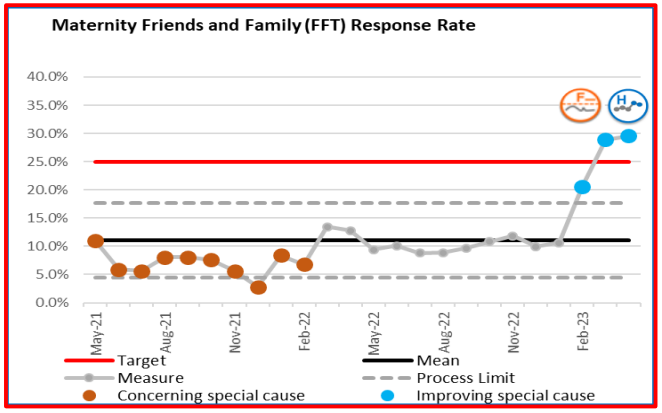
# Patient Experience: CQC: Caring



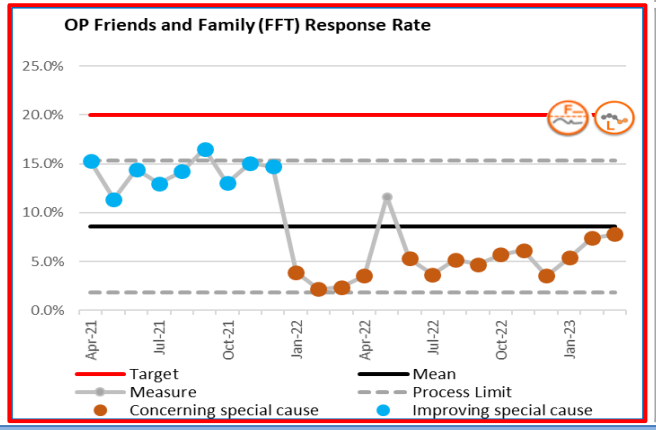

| Apr-23 |
|---|
| 28.5% |
| **Variance / Assurance** |
| Metric is currently experiencing Common cause variation And in common cause variation |
| **Target (Internal)** |
| 25% |
| **Business Rule** |
| For information as has moved to Variable Achievement |




| Apr-23 |
|---|
| 6.3% |
| **Variance / Assurance** |
| special cause variation of an improving nature and is consistently failing the target |
| **Target (Internal)** |
| 15% |
| **Business Rule** |
| Full Escalation as consistently failing the target |




| Apr-23 |
|---|
| 29.6% |
| **Variance / Assurance** |
| Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target |
| **Target (Internal)** |
| 25% |
| **Business Rule** |
| Full Escalation as not achieved target for >6months |




| Apr-23 |
|---|
| 7.8% |
| **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:**

**Inpatients (Daycase and IP):** Is experiencing common cause variation and has failed the target for 6+ months.
Recommended Rate is 98.7%

**A&E:** Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 89.8%

**Maternity:** Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 98.0%

**Outpatients:** Is experiencing special cause variation of a concerning nature and is consistently failing the target
Recommended Rate is 95.8%

**Actions:**

**Inpatients:** Figures for April showed an increase and overall this is an improving picture - to continue with current methodology. Paper card uploads with the facility to use QR code and online. Volunteers are supporting with FFT collection.
**A&E:** This an improving picture – to continue with current methodology. Hybrid method using text, QR code and online. Ongoing meetings with Netcall and ED to review progress and to continue to monitor and support.
**Maternity:** This is an improving picture. Meeting held with the directorate to support improvements to FFT response rate. Volunteers are supporting with FFT collection.
**Outpatients:** SMS text messaging - initial review indicated poor patient response rate. Potential problem identified with mapping and text messaging. Meeting held in April to work through improvements.
**FFT Response All:** Overall response rate for March was >7,000, our highest ever monthly return.
Scoping in progress for new provider to provide FFT responses and surveys.

**Assurance & Timescales for Improvement:**

**Inpatients:** Continue monthly review and support for inpatient areas
**A&E:** Continue monthly review
**Maternity:** Assurance they will continue to promote FFT in clinical areas. Continue monthly review.
**Outpatients:** Continue monthly review.
**All:** Meetings with Netcall and ED in March and April to monitor and review. Improvements identified to mapping for Netcall to implement. Ward auto remove out of date cards, promote FFT and increase response rate.
Meetings held with ED and Maternity to review FFT and actions put in place including updating IQVIA hierarchy, printing and supplying FFT posters, using iPads and volunteers supporting with FFT collection.
Updated FFT reports circulated to staff.
Imperial Research project
Comms put out reminding staff about FFT. Internet page updated to include more information about FFT and an accessibility information.
We will continue to monitor all aspects of FFT.

# Strategic Theme: Systems

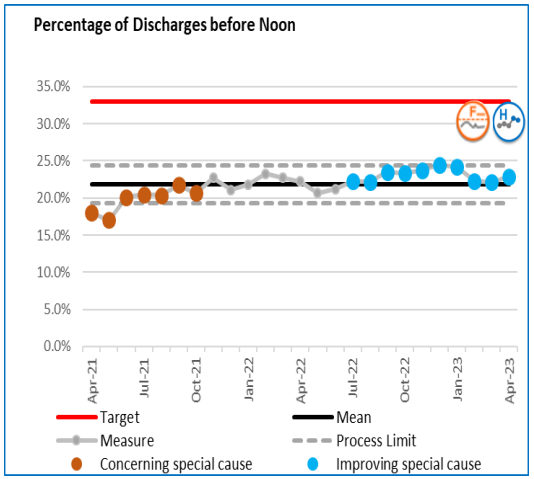
| | | | Latest | | | Previous | | | Actions & Assurance | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CQC Domain | Metric | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions |
| **Vision 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 | 11.3 | Apr-23 | 3.5 | 8.9 | Mar-23 | Driver | No SPC | No SPC | - |
| **Breakthrough Objectives** | Effective | To increase the number of patients leaving our hospitals by noon on the day of discharge | 33.0% | 22.9% | Apr-23 | 33.0% | 22.1% | Mar-23 | Driver | H | F | 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

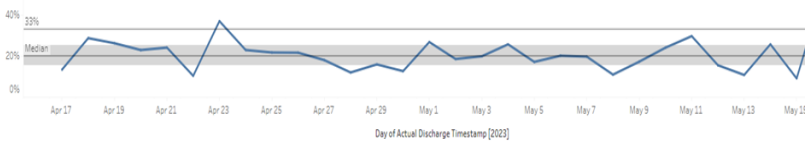
## 1. Historic Trend Data

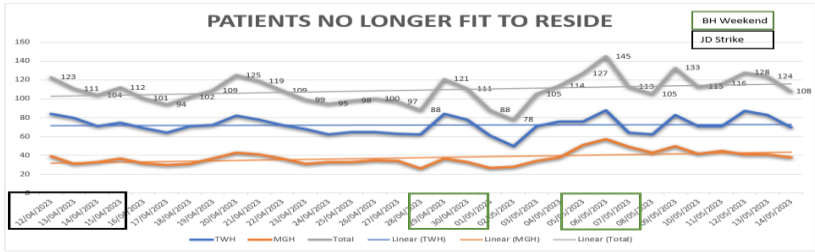



| Current Data Source: Teletracking |
|---|
| **Apr-23** |
| 22.9% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of an improving nature |
| **Target (Internal)** |
| 33% |
| **Target Achievement** |
| Metric is consistently failing the target |

## 2. Stratified Data

TT DBN Data: For context, the junior doctors strikes occurred on 11th to 15th April. The NCTR performance improved through the last two weeks of April however started to increase towards the May BH weekends with a drop off on the Tuesdays. The NCTR rates are higher throughout May overall compared to April. The DBN performance had improved for April, however as with NCTR the May performance has slightly dropped. It is hoped that the EDN programme rollout throughout will help to improve performance in June and July.




**Delay Reasons**

| | |
|---|---|
| Null | 1,322 |
| Awaiting clinician to c.. | 923 |
| Awaiting Pharmacist .. | 169 |
| Awaiting to be dispen.. | 120 |
| Awaiting pharmacy t.. | 106 |
| Awaiting Hilton | 76 |
| Awaiting CLT | 58 |
| Other | 44 |
| Awaiting P3 | 22 |
| Awaiting POC | 9 |
| Awaiting Out of Area .. | 4 |

17.04.23-16.05.23 Top contributors for delayed discharge on teletracking are 'NULL' and 'EDN completion'. TT Team to be requested to make delay reason mandatory to eliminate 'NULL'.

## 3. Top Contributors

| Area of Analysis | Considered a Top Contributor? |
|---|---|
| EDN Completion Times | EDNS are a top contributor in delays in discharge time. There is a clinically led EDN project group focussing on this including utilising Sunrise for a more integrated EDN: EPMA process. |
| Criteria Led Discharge | The data in Aug 2022 showed that Criteria Led Discharge was only utilised in 1.3% of all discharges, therefore there is an opportunity to increase DBN using this process. |

## 4. Action Plan

| CM | Action | Who | When | Complete |
|---|---|---|---|---|
| Hilton Pathway | • Hilton Stroke pathway improvements moved to BAU with daily meetings established. | Hilton/ MTW | | Complete |
| Criteria Led Discharge | • Medical Director support received for CLD.<br>• Video of the process being developed as part of communications.<br>• CLD embedment into clinical pathways being developed i.e. board rounds/ handover sheets. | KC/ FR / NP | 31.05.23 | In Progress |
| EDN | • Pilot for EDN in sunrise commenced. Programme of works underway with expectation of TWH wards rollout throughout May / early June.<br>• To undertake an assessment of the impact of the EDN project on orthopaedic wards. | RG / SF / JS | 30.06.23 | In Progress |
| NCTR | • Continued focus work being undertaken on data quality to deduce impact on BTO projects. | RS/ RG | 31.07.23 | In Progress |

# Strategic Theme: Sustainability

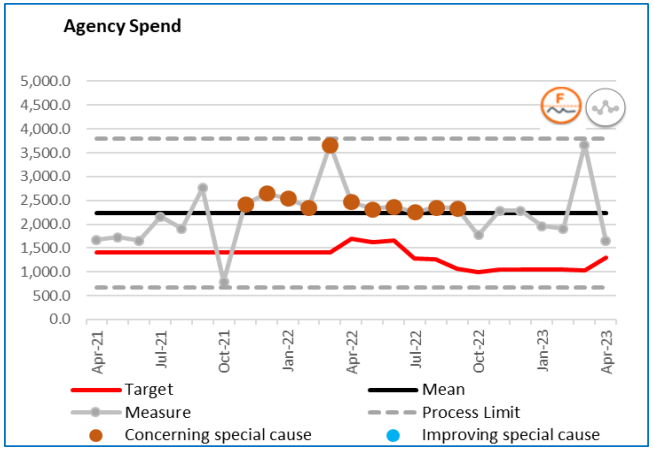
| | | | Latest | | | Previous | | | Actions & Assurance | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CQC Domain | Metric | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions |
| **Vision Goals / Targets** | Well Led | Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000) | -127 | -430 | Apr-23 | 1,247 | 1405 | Mar-23 | Driver | L | ? | Verbal CMS |
| **Breakthrough Objectives** | Well Led | Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000 | 1295 | 1648 | Apr-23 | 1035 | 3669 | Mar-23 | Driver | | F | Full CMS |
| **Constitutional Standards and Key Metrics (not in SDR)** | Well Led | CIP | 993 | 538 | Apr-23 | 4097 | 2120 | Mar-23 | Driver | No SPC | No SPC | Not Escalated |
| | Well Led | Cash Balance (£k) | 15698 | 16377 | Apr-23 | 5000 | 7984 | Mar-23 | Driver | | P | Not Escalated |
| | Well Led | Capital Expenditure (£k) | 2670 | 124 | Apr-23 | 3854 | 13275 | Mar-23 | Driver | | ? | Not Escalated |

# Breakthrough: 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

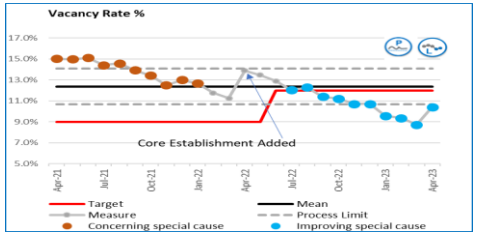
## 1. Historic Trend Data



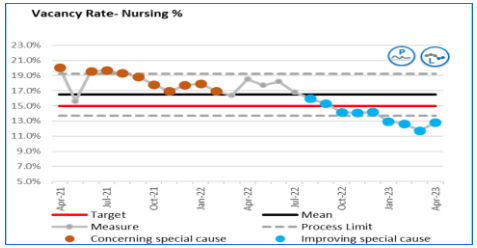

| Apr-23 |
|---|
| 1,648 |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (Internal)** |
| 1,295 |
| **Target Achievement** |
| Metric has not achieved the target for >6 months |

Note the Oct 22 value is low due to a release of accruals from previous months

## 2. Stratified Data




**Vacancy Rate:** Metric is experiencing special cause variation of an improving nature and has passed the target for six months or more.




**Nursing Vacancy Rate:** Metric is experiencing special cause variation of an improving nature and has passed the target for six months or more.

## 3. Top Contributors

Contributing factors to premium workforce spend have been narrowed down to:

- Healthroster usage and controls
- Training gaps particularly for new and junior managers
- Unfunded escalation areas
- Reduction in vacancies without a corresponding reduction in agency usage
- Enhanced control environment

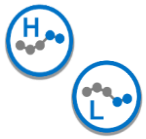
## 4. Action Plan

| Action | Status |
|---|---|
| Closure of escalation wards | MH closed in April and TW due to close imminently. |
| eRostering for non-medical staffing – controls and usage. | Weekly working group commenced **9/5/23** with all divisions represented. Specific focus on: authorisation rights, pay to grade, longest serving agency staff, rapid pool and areas with escalated rates. |
| Data and reporting | BI colleagues supporting to produce a weekly view of agency and bank spend as well as a monthly, detailed, payroll report. **Date TBC.** |
| Accountability and training | Reinvigorating confirm and support for top areas of temporary staffing spend in nursing – "core rosters". **Commence June 23.** Early discussions over managerial training programme for B7-B8c managers – getting the basics right. |
| Medical rostering | Decision to be made on most appropriate supplier **by end of May** – pilot implemented in time for next rotation in medicine (Aug 23). |
| Enhanced care business case | Ongoing. **Timescales TBC** |

# Appendices

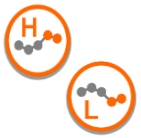
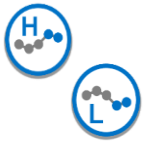
# SDR Business Rules Driven by the SPC Icons

## 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. 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. Consider next steps. |
|  |  | 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 |

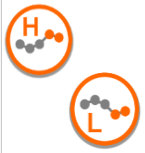
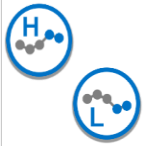
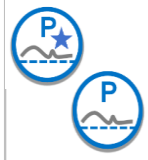
# SDR Business Rules Driven by the SPC Icons

## 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 improvement | 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 improvement | 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. | 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** |
| Any |  | Assurance indicates inconsistently hitting or missing the target. | A Driver Metric that remains in Hit & Miss for 6 months or more will need to complete a **full CMS** | N/A |

# 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:

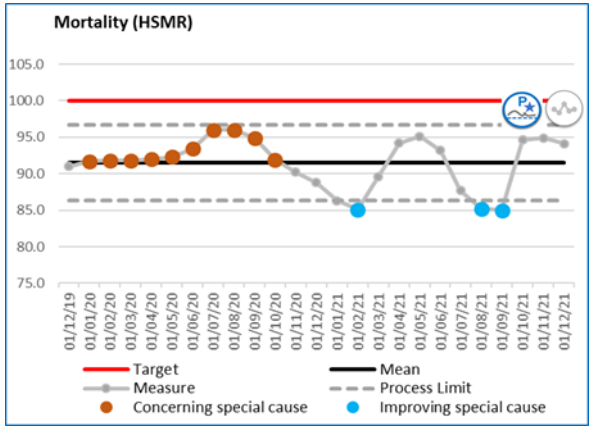
The **target** line **between** the **upper** and **lower** control limit for all metric types

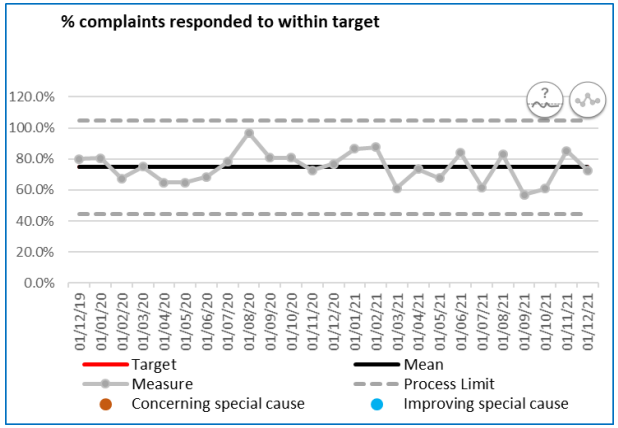
Metrics that consistently **fail** have:

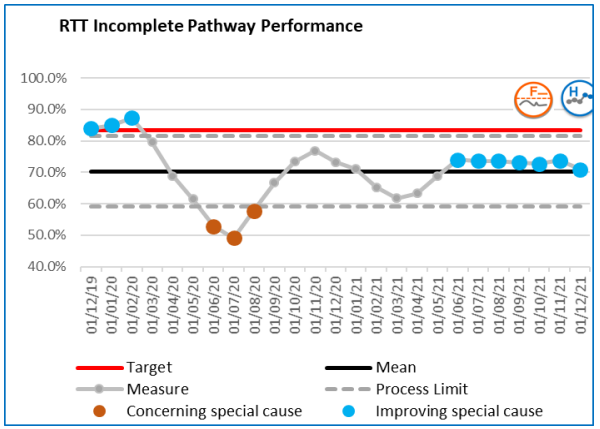
The **lower** control limit **above** the target line for metrics that need to be **below the target**

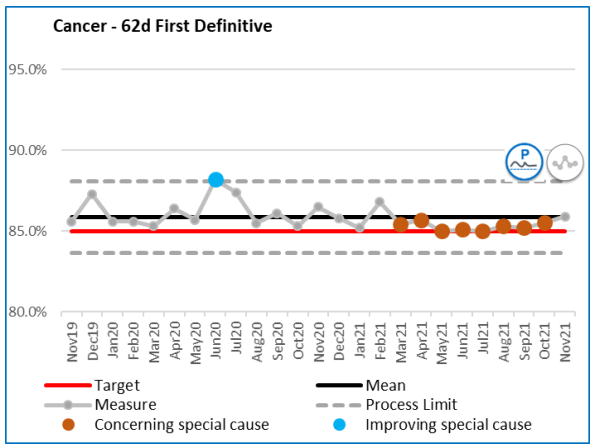
The **upper** control limit **below** the target line for metrics that need to be **above the target**

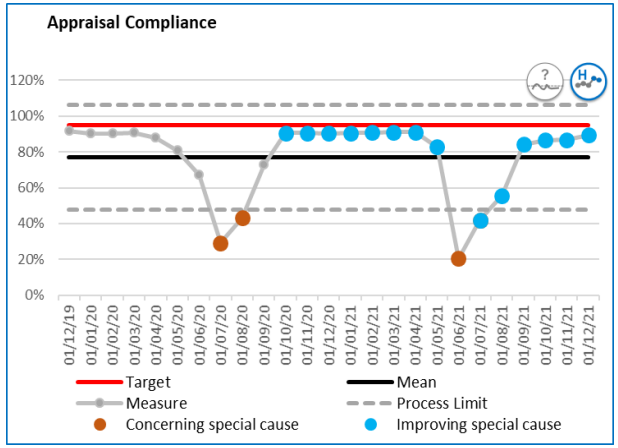
**A metric not achieving the target for 6 months or more will be flagged as failing**

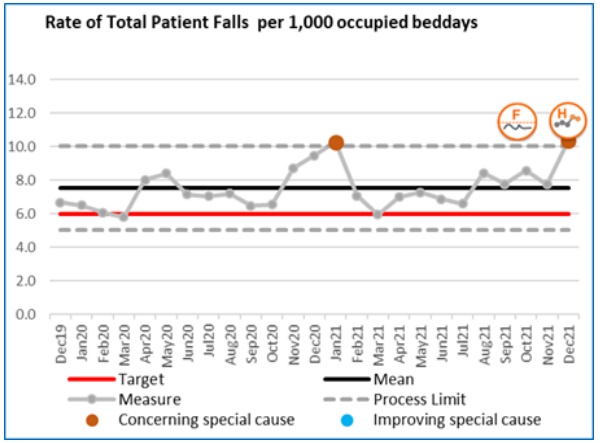


**Executive Summary**

- The Trust was £0.4m in deficit in the month which was £0.3m adverse to plan.
- The key pressure is within pay budgets which are adverse to plan by £2.1m in the month which included an additional £0.7m of costs above plan associated with the 5% Agenda for Change (AFC) pay award offer. Therefore the normalised position was £1.4m adverse to plan. The estimated cost associated with the junior doctor industrial action in April was c£0.4m therefore leaving £1m overspend associated with other pressures.
- Cost Improvement Plans (CIP) are behind plan by £0.5m in the month.
- The April financial position includes £0.7m of costs and income relating to the 5% pay award offer for staff on AFC contract which was 2.9% more than the plan. The funding for this increase has not been confirmed therefore there is a risk that if the funding received is less than the current estimate this will cause a pressure in future months.

**Current Month Financial Position**

- The Trust was £0.4m in deficit in the month which was £0.3m adverse to plan
- The Key variance to plan are:
    - Income overperformed by £1m in April which included £0.7m above plan associated with the 5% AFC pay award offer therefore the normalised position was £0.3m favourable to plan. The main areas of overperformance related to Education and Training income (£0.2m) and £0.1m income to support the recruitment of internally trained nurses (offsetting costs incurred).
    - Pay overspent by £2.1m in the month which included £0.7m of costs above plan associated with the 5% AFC pay award offer. Therefore the normalised position was £1.4m adverse to plan. The estimated cost associated with the junior doctor industrial action in April was c£0.4m therefore this leaves £1m overspend associated with other pressures.
        - The trust overspent on temporary staffing by £2.1m which was partly offset by underspend on substantive staffing (£0.7m), agency spend as a percentage of total pay was 4.7% which was 0.8% more than planned.
        - The main staff groups overspent in the month were: Nursing (£0.6m), Support to nursing (£0.3m) and Medical (£0.4m), divisions have been provided with a detailed pay trend report to fully understand the key reasons for this overspend.
    - Non Pay underspent by £0.8m in the month which was mainly due underspends within clinical and general supplies (£0.7m) which included a non recurrent benefit of £0.4m and drugs underspend of £0.1m

**Risks**

- **CIP Delivery -** The Trust has a large CIP target for 2023/24 and is currently identifying additional schemes. However in April the Trust is already behind plan by £0.5m. Fortnightly meetings with divisions are in place and a Trust wide steering group has been convened to identified further schemes.
- **Pay award Income** - The position assumes the pay award will be funded in full and includes £0.7m of income to offset the costs above plan (plan was for 2.1% pay award however 5% for AFC staff will be paid in June). Further guidance is expected to be published in the near future.
- **Medical Bank Increase** - The Trust has agreed to increase the consultant medical bank rate to be closer to the BMA rate card, this is estimated to cost c£1.5m per annum.
- **Contracts not yet agreed or signed (excluding K&M) -** uncertainty exists with regard to the Trusts final contract values with NHS England and the Associate ICB Commissioners (Sussex, Surrey and South East London) and the in-year contract management of the Kent and Medway contract is still be finalised which may give rise to financial risk if this extends too far into the year. Contracts are expected to be signed by the end of May 2023 which will therefore provide certainty.

- **QFIT Service funding –** The Trust has an unpaid old year debt of £0.6m relating to QFIT service, additionally there is currently no formal agreement of funding in 2023/24 (£0.7m for the year) which remains a risk to achievement of the plan. The Trust is seeking urgent confirmation from the ICB that a funding allocation has been identified and will be allocated to the Trust.

**Cashflow**

- The closing cash balance at the end of April 2023 was £16.4m which is higher by £0.7m compared with the plan submitted in May 2023. Due to the Trust paying March's Pension and Unitary payment within March assisted with the higher cash balance. The Trust ended the year with capital creditors of £2.6m of which £1.4m were paid in April.
- The Trust's cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance Sheet. If the in-year I&E position moves adversely then this has a negative impact on the Trusts cash flow and the Trust would need to implement various strategies to ensure the Trust cash remains in balance whilst meeting its commitments. The cash flow is updated daily to ensure that the Trust can meet all its commitments as well as working towards ensuring prompt payment is made to suppliers. The Trust is retaining producing two payment runs a week and are paying all invoices when they are approved to ensure all non-NHS suppliers are paid as soon as possible. The closing cash balance for the Trust is £2m.
- Within April the Trust also repaid £0.2m of the capital element of the Salix loan, this is repaid twice a year with the next repayment due in October.
- 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 are reviewing regularly , the Trusts BPPC at the end of April is - Trade in value 96.0% and by quantity is 97.1; for NHS by value is 97.7% and by quantity is 86.9%.

**Capital Position**

- The Trust's capital plan, excluding IFRS 16 items, agreed with the ICB for 2023/24 is **£38.5m** comprising:

  **System control total**

  - The Trust's share of the K&M ICS system control total is **£14.016m** for 2023/24. This includes **£4.996m** from system funds for the Phase 3 HASU completion.
  - Within this total the Trust is funding **£6.41m** of the costs of the Kent and Medway Orthopaedic Centre over and above the expected national funding.
  - Therefore the Trust has a net sum of **£2.6m** resource available to cover all other capital spend for the year. This has been shared between the three main capital areas (Estates, ICT and Equipment). The Trust is also selling the MGH MRI as part of the outsourced contract, which will support related enabling works for the new MRI at TWH, and associated diagnostic equipment.

  **National Funding**

  - **£22.47m** of national funding for the Kent and Medway Orthopaedic centre project is included, part of which is already approved but the bulk of the funding is planned on the basis of approval of the FBC at the NHSE/DHSC Joint Investment Scrutiny Committee in June 2023. The Trust also has pre-agreement for **£88**k of digital diagnostics funding for 2023/24.
  - The plan does not include the **£5.72**m required to complete the permanent CDC solution which was subject to slippage in 2022/23. The ICB has been working with the Trust to seek a funding solution and has confirmed that it is planning to fund this resource from a combination of the additional "fair-shares" capital that it is expecting for achieving the revenue control total for 2022/23 (£5m) with the additional £0.7m funded from either NHSE funds under discussion, or by deferring an element of other system provider CDC projects.

**Other Funds**

- PFI lifecycle spend per the Project company model of **£1.5m** - actual spend will be notified periodically by the Project Company.
- Donated Assets of **£0.4m** relating to forecast donations in year.

**Month 1 Actuals**

- The M1 spend is £124k against a budget of £2.67m. The variance relates to the Kent and Medway Orthopaedic Centre project where the expected spend has not been incurred in the month – the external Project Management agent has chased the contractors for invoices due.

**Capital Position – Leased/IFRS 16 capital**

The Trust has included £29.4m of potential IFRS 16 liabilities in its 23/24 plan. This includes £4.3m of expected "remeasurements" arising from increases to the rental agreements from inflation clauses. Of the £25.1m of new lease capitalisations, the most significant is the KMMS accommodation which is expected to be a value of £15.3m if capitalised at the currently planned completion date of February 2024. NHSE has indicated that a funding agreement for IFRS 16 has been reached with HMT, but details of what funding will flow to systems is not yet confirmed.

Maidstone and Tunbridge Wells NHS Trust

# Finance Report

## Month 1
## 2023/24

Maidstone and Tunbridge Wells NHS Trust

## 1a. Dashboard

April 2023/24

| | Current Month | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *Actual* | *Plan* | *Variance* | Pass-throug | *Revised Variance* | *Actual* | *Plan* | *Variance* | Pass-throug | *Revised Variance* |
| | £m | £m | £m | £m | £m | £m | £m | £m | £m | £m |
| Income | 54.8 | 53.9 | 0.9 | (0.1) | 1.0 | 54.8 | 53.9 | 0.9 | (0.1) | 1.0 |
| Expenditure | (51.0) | (49.8) | (1.3) | 0.1 | (1.3) | (51.0) | (49.8) | (1.3) | 0.1 | (1.3) |
| EBITDA (Income less Expenditure) | 3.8 | 4.1 | (0.3) | 0.0 | (0.3) | 3.8 | 4.1 | (0.3) | 0.0 | (0.3) |
| Financing Costs | (4.3) | (4.3) | 0.0 | 0.0 | 0.0 | (4.3) | (4.3) | 0.0 | 0.0 | 0.0 |
| Technical Adjustments | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Net Surplus / Deficit (Incl Top Up funding support)** | **(0.4)** | **(0.1)** | **(0.3)** | **0.0** | **(0.3)** | **(0.4)** | **(0.1)** | **(0.3)** | **0.0** | **(0.3)** |
| Cash Balance | 16.4 | 15.7 | 0.7 | | 0.7 | 16.4 | 15.7 | 0.7 | | 0.7 |
| Capital Expenditure (Incl Donated Assets) | 0.1 | 2.7 | 2.5 | | 2.5 | 0.1 | 2.7 | (2.5) | | (2.5) |
| Cost Improvement Plan | 0.5 | 1.0 | (0.5) | | (0.5) | 0.5 | 1.0 | (0.5) | | (0.5) |

**Summary Current Month:**

- The Trust was £0.4m in deficit which was £0.3m adverse to plan. The April position includes £0.7m of costs and income relating to the 5% pay award offer for staff on Agenda for Change contract which was 2.9% more than the plan. The funding for this increase has not been confirmed therefore there is a risk that if the funding received is less than the current estimate this will cause a pressure in future months.
- The Key variance to plan are:
- Income overperformed by £1m in April which included £0.7m above plan associated with the 5% AFC pay award offer therefore the normalised position was £0.3m favourable to plan. The main areas of overperformance related to Education and Training income (£0.2m) and £0.1m income to support the recruitment of internally trained nurses (offsetting costs incurred).

- Pay overspent by £2.1m in the month which included £0.7m above plan associated with the 5% AFC pay award offer therefore the normalised position was £1.4m adverse to plan. The estimated cost associated with the junior doctor industrial action in April was c£0.4m therefore this leaves £1m overspend associated with other pressures.
The trust overspent on temporary staffing by £2.1m which was partly offset by underspend on substantive staffing (£0.7m), agency spend as a percentage of total pay was 4.7% which was 0.8% more than planned.
The main staff groups overspent in the month were: Nursing (£0.6m), Support to nursing (£0.3m) and Medical (£0.4m), divisions have been provided with a detailed pay trend report to fully understand the key reasons for this overspend.

- Non Pay underspent by £0.8m in the month which was mainly due underspends within clinical and general supplies (£0.7m) which included a non recurrent benefit of £0.4m and drugs underspend of £0.1m

**CIP (Savings)**

- The Trust has a savings target for 2023/24 of £33.3m and has delivered £0.5m in the month which is £0.5m adverse to plan.

**Risks**

- **Contracts not yet agreed or signed (excluding K&M) -** uncertainty exists with regard to the Trusts final contract values with NHS England and the Associate ICB Commissioners (Sussex, Surrey and South East London) and the in-year contract management of the Kent and Medway contract is still be finalised which may give rise to financial risk if this extends too far into the year.
- **Variable Income** - Linked to the above uncertainty with the Contracts means that the current assessment of variable income may be overstated because no final agreement on the targets to be applied in the contracts with NHS England and the Associate ICB Commissioners has been reached. Currently the Month 1 assessment is based on the Trusts planning assumptions.
- **QFIT Service funding –** The Trust has an unpaid old year debt of £0.6m relating to the QFIT service, additionally there is currently no formal agreement of funding in 2023/24 (£0.7m for the year) which remains a risk to achievement of the plan. The Trust is seeking urgent confirmation from the ICB that a funding allocation has been identified and will be passed on to the Trust.
- **CIP Delivery -** The Trust has a large CIP target for 2023/24 and there is £XXm of unidentified CIP, additional schemes are being identified. However in April the Trust is already behind plan by £0.5m.
- **Pay award Income** - The position assumes the pay award will be funded in full and includes £0.7m of income to offset the costs above plan (plan was for 2.1% pay award however 5% for AFC staff will be paid in June)
- **Medical Bank Increase** - The Trust has agreed to increase the consultant medical bank rate to be closer to the BMA rate card, this is estimated to cost c£1.5m per annum.

| Apr-23 | | DAY | | | | NIGHT | | | | 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 | 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 | | | | | FFT Response Rate | FFT Score % Positive | Falls | PU ward acquired | Comments | Budget £ | Actual £ | Variance £ (overspend) |
| MAIDSTONE | Acute Medical Unit (M) - NG551 | 102.3% | 92.2% | - | - | 106.0% | 103.7% | - | - | 25.7% | 28.1% | 74 | 4.89 | 15 | 9.1 | 17.5% | 90.9% | 3 | 0 | | 168,393 | 196,018 | (27,625) |
| MAIDSTONE | Stroke Unit (M) - NK551 | 84.4% | 116.8% | - | 100.0% | 209.2% | 96.0% | - | 100.0% | 45.7% | 20.7% | 324 | 21.06 | 88 | 7.9 | 146.4% | 97.6% | 7 | 2 | | 279,628 | 373,851 | (94,223) |
| MAIDSTONE | Cornwallis (M) - NS959 | 62.2% | 52.3% | - | - | 52.2% | 133.3% | - | - | 4.3% | 15.4% | 11 | 0.73 | 3 | 8.1 | 200.0% | 100.0% | 2 | 0 | | 0 | 99,041 | (99,041) |
| MAIDSTONE | Culpepper Ward (M) - NS551 | 90.7% | 98.1% | - | - | 98.3% | 145.9% | - | - | 25.3% | 17.1% | 17 | 1.19 | 1 | 5.2 | 0.0% | 100.0% | 1 | 0 | | 115,145 | 137,248 | (22,103) |
| MAIDSTONE | Edith Cavell - NS459 | 116.0% | 116.1% | - | 100.0% | 108.8% | 120.3% | - | - | 48.3% | 46.7% | 104 | 7.48 | 13 | 6.3 | 68.4% | 100.0% | 1 | 2 | | 117,739 | 132,616 | (14,877) |
| MAIDSTONE | Foster Clark - NS251 | 83.1% | 98.3% | - | - | 99.2% | 91.1% | - | - | 25.9% | 23.3% | 110 | 7.47 | 30 | 7.6 | 54.3% | 100.0% | 4 | 0 | | 155,754 | 173,636 | (17,882) |
| MAIDSTONE | John Day Respiratory Ward (M) - NT151 | 99.9% | 120.5% | - | - | 108.2% | 124.0% | - | 100.0% | 43.8% | 29.0% | 150 | 10.43 | 15 | 7.2 | 81.6% | 100.0% | 7 | 1 | | 152,114 | 214,218 | (62,104) |
| MAIDSTONE | Intensive Care (M) - NA251 | 90.4% | 84.9% | - | - | 96.6% | 85.0% | - | - | 8.0% | 0.0% | 33 | 2.28 | 9 | 43.5 | 500.0% | 100.0% | 0 | 0 | | 233,434 | 257,896 | (24,462) |
| MAIDSTONE | Lord North Ward (M) - NF651 | 96.2% | 89.9% | - | 100.0% | 100.0% | 96.7% | - | - | 8.8% | 15.6% | 23 | 1.71 | 5 | 7.0 | 59.3% | 100.0% | 1 | 0 | | 116,373 | 123,536 | (7,163) |
| MAIDSTONE | Maidstone Orthopaedic Unit (M) - NP951 | 108.0% | 44.3% | - | 100.0% | 91.7% | - | - | - | 18.3% | 5.7% | 25 | 1.75 | 0 | 19.0 | 0.0% | 97.4% | 1 | 0 | | 58,744 | 58,117 | 627 |
| MAIDSTONE | Mercer Ward (M) - NJ251 | 97.0% | 132.7% | - | 100.0% | 113.2% | 145.0% | - | - | 37.5% | 41.1% | 60 | 4.25 | 11 | 6.8 | 58.6% | 100.0% | 2 | 1 | | 110,963 | 146,025 | (35,062) |
| MAIDSTONE | Peale Ward COVID - ND451 | 96.9% | 143.8% | - | 100.0% | 102.2% | 192.9% | - | 100.0% | 45.2% | 38.1% | 67 | 4.66 | 17 | 8.7 | 147.4% | 100.0% | 1 | 2 | | 125,094 | 116,723 | 8,371 |
| MAIDSTONE | Pye Oliver (Medical) - NK259 | 90.2% | 138.1% | - | - | 110.2% | 171.1% | - | - | 49.9% | 43.5% | 81 | 5.73 | 16 | 7.1 | 67.3% | 97.3% | 5 | 1 | | 132,233 | 173,345 | (41,112) |
| MAIDSTONE | Short Stay Surgical Unit (M) - NE751 | 79.3% | 82.1% | - | - | 72.7% | - | - | - | 19.3% | 9.0% | 24 | 1.60 | 7 | 34.4 | 0.0% | 98.2% | 0 | 0 | | 56,832 | 61,878 | (5,046) |
| MAIDSTONE | Whatman Ward - NK959 | 113.5% | 98.4% | - | 100.0% | 112.5% | 145.1% | - | 100.0% | 76.3% | 33.0% | 144 | 10.06 | 9 | 7.3 | 22.6% | 100.0% | 4 | 1 | | 101,589 | 194,889 | (93,300) |
| MAIDSTONE | Maidstone Birth Centre - NP751 | 112.9% | 94.8% | - | - | 102.6% | 100.0% | - | - | 9.1% | 0.0% | 21 | 0.94 | 0 | 41.4 | 0.0% | 100.0% | 0 | 0 | | 75,428 | 85,619 | (10,191) |
| TWH | Acute Medical Unit (TW) - NA901 | 94.5% | 93.9% | - | 100.0% | 102.7% | 101.6% | - | 100.0% | 37.4% | 32.6% | 188 | 13.59 | 55 | 8.4 | 21.1% | 93.5% | 5 | 0 | | 239,173 | 256,469 | (17,296) |
| TWH | Coronary Care Unit (TW) - NP301 | 93.2% | 105.8% | - | - | 99.0% | - | - | - | 16.1% | 11.3% | 29 | 2.13 | 9 | 11.1 | 61.3% | 100.0% | 0 | 0 | | 73,863 | 82,724 | (8,861) |
| TWH | Hedgehog Ward (TW) - ND702 | 93.7% | 134.9% | - | - | 116.6% | 143.5% | - | - | 33.0% | 22.0% | 140 | 9.49 | 33 | 9.1 | 10.9% | 92.9% | 2 | 0 | | 148,934 | 211,692 | (62,758) |
| TWH | Intensive Care (TW) - NA201 | 93.4% | 105.7% | - | - | 99.5% | 66.7% | - | - | 8.6% | 0.0% | 135 | 9.01 | 29 | 43.3 | 0.0% | 100.0% | 1 | 1 | | 371,120 | 396,486 | (25,366) |
| TWH | Private Patient Unit (TW) - NR702 | 116.2% | 104.9% | - | - | 90.0% | 106.7% | - | - | 24.8% | 8.1% | 54 | 3.64 | 16 | 10.0 | 93.0% | 100.0% | 0 | 0 | | 71,438 | 83,904 | (12,466) |
| TWH | Ward 2 (TW) - NG442 | 88.9% | 119.2% | - | 100.0% | 113.5% | 175.6% | - | 100.0% | 42.1% | 50.7% | 95 | 6.58 | 28 | 7.6 | 130.8% | 94.1% | 13 | 1 | | 178,255 | 190,109 | (11,854) |
| TWH | Ward 10 (TW) - NG131 | 92.5% | 120.9% | - | 100.0% | 114.2% | 166.7% | - | - | 48.1% | 35.7% | 147 | 10.06 | 34 | 6.7 | 15.8% | 100.0% | 4 | 0 | | 145,708 | 192,677 | (46,969) |
| TWH | Ward 11 (TW) Winter Escalation 2019 - NG144 | 83.3% | 153.5% | - | 100.0% | 130.2% | 95.4% | - | - | 77.0% | 48.3% | 262.00 | 18.22 | 55.00 | 7.6 | 36.6% | 100.0% | 5 | 2 | | 202,407 | 207,256 | (4,849) |
| TWH | Ward 12 (TW) - NG132 | 95.7% | 124.3% | - | 100.0% | 104.4% | 123.3% | - | - | 47.4% | 52.9% | 156 | 10.25 | | 6.0 | 37.7% | 100.0% | 12 | 1 | | 145,809 | 164,060 | (18,251) |
| TWH | Ward 20 (TW) - NG230 | 86.2% | 110.2% | - | 100.0% | 166.7% | 108.2% | - | - | 50.0% | 57.5% | 249 | 17.26 | 81 | 7.0 | 57.4% | 97.1% | 12 | 0 | | 171,810 | 168,284 | 3,526 |
| TWH | Ward 21 (TW) - NG231 | 91.3% | 118.6% | - | - | 104.8% | 128.3% | - | - | 36.4% | 51.6% | 160 | 10.84 | 45 | 6.3 | 41.7% | 96.7% | 3 | 0 | | 148,348 | 165,891 | (17,543) |
| TWH | Ward 22 (TW) - NG332 | 82.2% | 132.9% | - | 100.0% | 103.4% | 131.7% | - | - | 53.8% | 54.4% | 175 | 12.44 | 44 | 7.0 | 52.7% | 96.6% | 10 | 0 | | 146,125 | 181,834 | (35,709) |
| TWH | Ward 30 (TW) - NG330 | 93.6% | 89.7% | - | 100.0% | 95.0% | 133.5% | - | - | 44.6% | 27.3% | 175 | 10.72 | 46 | 6.3 | 58.5% | 100.0% | 7 | 1 | | 124,959 | 160,527 | (35,568) |
| TWH | Ward 31 (TW) - NG331 | 92.0% | 130.2% | - | 100.0% | 86.6% | 141.1% | - | - | 34.2% | 25.0% | 125 | 8.13 | 35 | 7.0 | 84.6% | 100.0% | 13 | 1 | | 138,666 | 191,938 | (53,272) |
| TWH | Ward 32 (TW) - NG130 | 84.1% | 94.9% | - | 100.0% | 94.2% | 103.4% | - | 100.0% | 25.0% | 33.6% | 109 | 7.63 | 27 | 7.9 | 0.0% | 100.0% | 2 | 0 | | 147,114 | 153,183 | (6,069) |
| TWH | Ward 33 (Gynae) (TW) - ND302 | 97.3% | 94.5% | - | - | 98.3% | 96.7% | - | - | 27.2% | 1.9% | 42 | 2.62 | 5 | 7.1 | 17.3% | 100.0% | 2 | 0 | | 100,085 | 98,402 | 1,683 |
| TWH | SCBU (TW) - NA102 | 98.4% | 162.5% | - | - | 115.7% | 53.3% | - | - | 29.7% | 7.5% | 137 | 8.42 | 9 | 7.8 | 60.0% | 100.0% | 0 | 0 | | 206,830 | 233,667 | (26,837) |
| TWH | Short Stay Surgical Unit (TW) - NE901 | 83.0% | 89.8% | - | 100.0% | 101.6% | 100.0% | - | 100.0% | 12.1% | 13.5% | 31 | 2.16 | 6 | 12.7 | 18.6% | 95.2% | 0 | 0 | | 81,504 | 90,179 | (8,675) |
| TWH | Surgical Assessment Unit (TW) - NE701 | 94.1% | 173.6% | - | - | 98.3% | 100.0% | - | - | 28.4% | 4.8% | 45 | 3.02 | 6 | 23.4 | 4.5% | 93.8% | 0 | 0 | | 76,580 | 83,067 | (6,487) |
| TWH | Midwifery (multiple rosters) | 77.3% | 55.4% | - | - | 94.7% | 90.0% | - | - | 15.9% | 6.3% | 621 | 35.01 | 80 | **11.1** | 87.9% | 98.6% | **0** | **0** | | **819,551** | **940,114** | **(120,563)** |
| Crowborough | Crowborough Birth Centre (CBC) - NP775 | 82.0% | 86.4% | - | - | 56.4% | 100.0% | - | - | 12.5% | 0.0% | 35 | 2.08 | 2 | 113.8 | 40.3% | 100.0% | 0 | 0 | | 145,028 | 97,954 | 47,074 |
| MAIDSTONE | Accident & Emergency (M) - NA351 | 99.7% | 95.9% | - | 100.0% | 101.6% | 81.4% | - | - | 35.0% | 41.7% | 374 | 26.31 | 32 | - | 0.0% | 87.6% | 4 | 0 | | 376,140 | 450,898 | (74,758) |
| TWH | Accident & Emergency (TW) - NA301 | 102.8% | 104.8% | - | 100.0% | 101.3% | 94.4% | - | 100.0% | 42.8% | 45.9% | 477 | 33.33 | 48 | - | 6.4% | 91.9% | 3 | 0 | | 404,954 | 548,772 | (143,818) |

| | | | |
|---|---|---|---|
| Total Established Wards | **6,663,864** | **7,894,746** | **1,230,882** |
| Additional Capacity beds | | | |
| - Cath Labs | 56,309 | 41,128 | 15,181 |
| Other associated nursing costs | 4,817,104 | 4,861,045 | -43,941 |
| Total | 11,537,277 | 12,796,919 | 1,202,122 |


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%

| **Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)** | **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) and includes details of the teams which have been developed to support the programme of work and referenced the discussions in relation to Primary Care Senior Leadership.

**Which Committees have reviewed the information prior to Trust Board submission?**

- Executive Team Meeting, 16/05/23

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

The report is for 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

# West Kent HCP and K&M ICB update May 2023

## Kent & Medway Integrated Care Board

The updated operational plan was submitted on 4th May and we await feedback. A meeting is taking place on 11th May to discuss the Pathology Network Collaboration Agreement with a view to taking through providers governance processes in June. The Pathology Network has successfully appointed a Medical Director (Dr Supriya Joshi) and Managing Director (Francesca Trundle).
We await an update from the ICB on progressing with phase 2 of our Community Diagnostic Centre.
The ICB are currently engaging with their staff on views to reduce the workforce by 30% which is a national request. The design phase is taking place during May and we expect the developing options to be shared in June with likely formal consultation. We continue to work on formal delegation to ensure readiness when we are able to progress the process, recognising the 2 strands of work are linked.

The ICB are holding 2 'Re-imagining Community Services' events on 11th May (letter attached).

## West Kent Health & Care Partnership Highlights

Please see attached the HCP work programme for 2023/24. The main areas of focus are the development of Integrated Neighbourhood Teams, reducing health inequalities and place flow. We have now had confirmation of the discharge funding allocation which totals £6.39m, of which £1.62m is allocated for the Virtual wards.

The primary care Medical Director role is out to advert and will be a key post in developing INTs in West Kent as well as providing strong links with the ICB Medical Director and team.

## WKHCP Risks and Challenges

The 3 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/Post Covid related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.

*Lack of funding to develop INTs* – Circa 50% of the funding has been found from within the HCP and the ICB committed to reviewing additional opportunities however have recently confirmed no further funding is available.

NHS
Maidstone and Tunbridge Wells NHS Trust

**Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital** — **Chief Operating Officer**

It was agreed at the Trust Board meeting on 24/11/22 that an update on the project to develop a Maggie's Centre at Maidstone Hospital should be submitted on a six-monthly basis. The latest update in therefore enclosed.

**Introduction**
Since November 2022 we have continued to engage with the Maggie's team on a regular basis to provide information as requested.

**The following meetings/correspondence have taken place:**

| | |
|---|---|
| November 2022 | Maggie's Teams meeting |
| December 2022 | Maggie's Teams meeting |
| December 2022 | Sent Maggie's signed Heads of Terms |
| January 2023 | Maggie's Teams meeting |
| February 2023 | Site meeting with architects. Very positive feedback. |
| March 2023 | Site meeting with design team |

**Next steps**
Maggie's are now identifying the scope of investigations they want to carry out on site ranging from early non-intrusive, topographical/arboriculture surveys and then later on, more involved physical site investigations. All survey work will be defined and share with the Trust for review and approval to proceed (timings/dates etc). To this end Maggie's have been introduced via email to the Director of Estates and Capital Investments and Associate Director of Capital Development. The Associate Director of Capital Development has been providing Maggie's with relevant technical information, including site plan, final redline plan, services of the wider site, future developments and photographs.

**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 information – to provide a six month update

[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

**Six-monthly review of the Trust's red-rated risks** **Chief Nurse**

This report summarises the status of Trust risks and red risks and is based on legacy data from the Datix risk module as well as initial migrated data to InPhase.

**Overview of risk register**

As of 15/05/2023 there were 153 risks on the Trust risk register (21 red, 129 amber, three green).

Further information is provided based on the risk register review of 27/04/2023, with 156 total risks.

**Red risks**

The risks are further grouped by 'Risk Type' as indicated on Datix, though there is overlap for some of the risks and the ultimate decision on 'Risk Type' is usually closest fit at the time the risk was opened. A thematic analysis of red risks is included. As the richness of data on InPhase increases more information will be added, including the link to Trust strategic themes.

As of 15/05/2023 there were **21** open, finally approved, red risks.

**This report is the final report to use the Datix risk register data. The next report will be based solely on data from InPhase.**

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

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

**Executive Summary**

This report provides a summary of the current risk profile of the Trust, highlighting the overall number of risks, a breakdown of risks by score and theme, with further analysis of the red risks. As noted the Trust is currently transferring its risk register function from Datix to InPhase. Once InPhase is embedded this will allow for improved alignment of risks to strategic themes enabling future reports to provide greater oversight of risk.

The red risks were considered at the Audit Committee on 16 May 2023, with recommendations to include further trend data for the age of risks and the achievement of target dates.

The risks are reviewed by the risk owner on a regular basis, this review is supported by the Trust's Risk and Compliance Manager. Risk actions are monitored according to process described in the Risk Management Policy and Procedure.

**Overview of Trust risk register**

As of 15th May 2023, there were 153 open, finally approved risks on the risk register.

There were three Green, 129 Amber and 21 Red (seven rated '15' and 14 rated '16'):

Between 28th February 2023 and 27th April 2023, **28** risks were opened and **29** closed.

Between 20th February 2023 and 28th April 2023, **two** risks were upgraded to red and **six** new red risks added, **nine** red risks have been downgraded to Amber and **one** red risk was closed.

**Risks by Division**

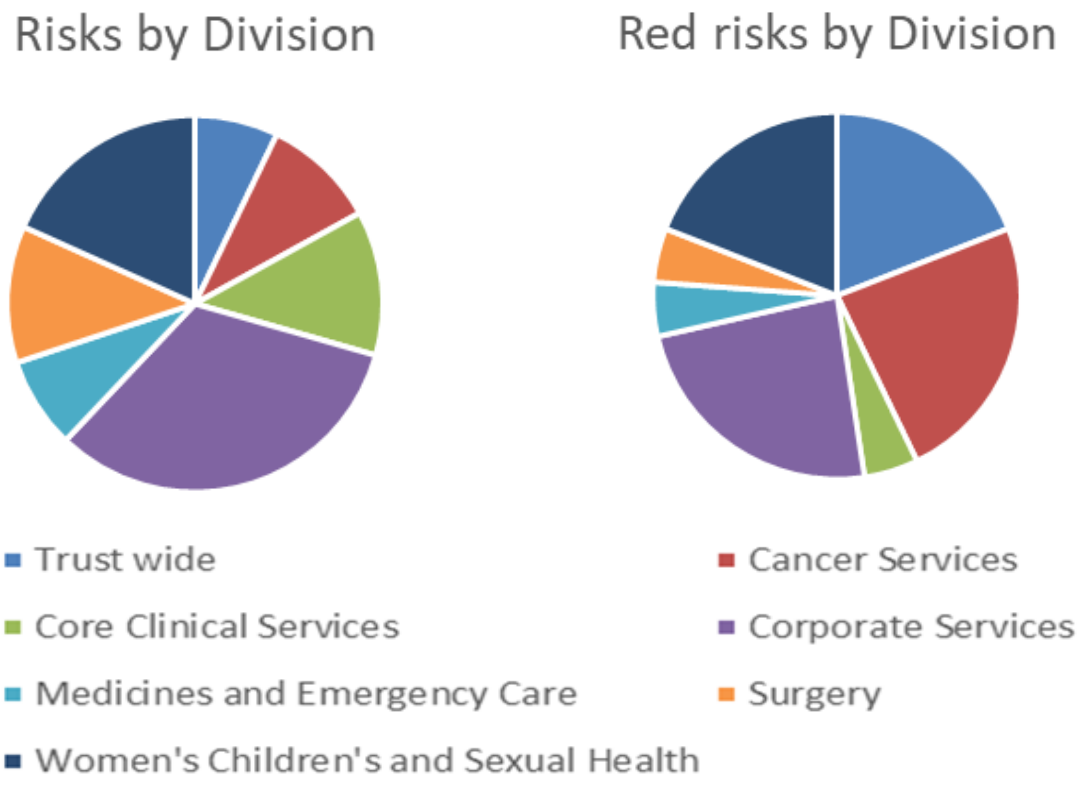
Risks are reviewed at Divisional Governance Committees as well as during regular reviews with the Risk and Compliance Manager.

The table below outlines the general themes by Division as of 27th April 2023, as well as the change in numbers of risks since the previous two monthly review:

| Division | # open risks | Change from February 2023 report | Themes |
|---|---|---|---|
| **Cancer Services** | 15 | -2 | Staffing/recruitment; IT issues/ infrastructure; outpatient infrastructure |

| | | | |
|---|---|---|---|
| **Corporate Services (inc. Trust wide)** | 65 | +9 | Varied - Staffing/recruitment; meeting targets/standards; Estates/infrastructure issues |
| **Core Clinical Services** | 19 | -4 | Equipment; infrastructure (space); IT systems; Staffing/recruitment/capacity |
| **Medicines and Emergency Care** | 12 | -2 | Staffing/retention/capacity/skill shortages; meeting targets/standards; IT issues |
| **Surgery** | 18 | -1 | Capacity and staffing; meeting standards; infrastructure |
| **Women's Children's and Sexual Health Services** | 27 | -1 | Staffing, skill shortages, capacity; meeting standards |

A large number of risks were added to Corporate Services between February and April 2023. Staffing, equipment, infrastructure and meeting standards are common themes across the divisions. Corporate Services has the largest number of risks and once Trust wide are incorporated, a high proportion of red risks. Cancer Services has a large number of red risks compared with its overall number.



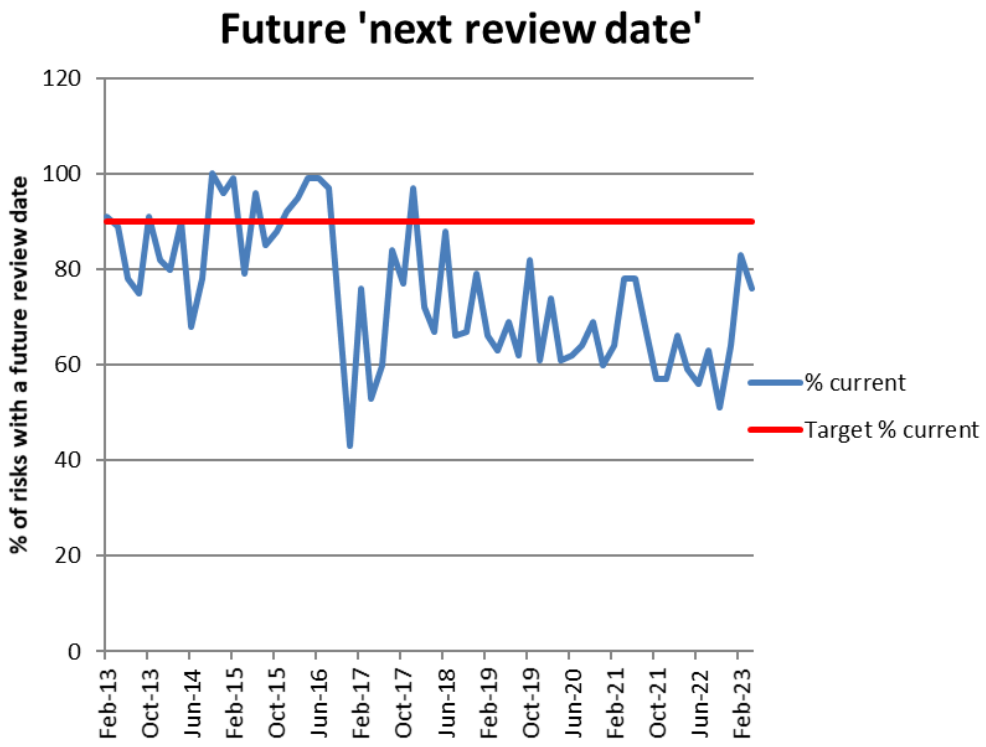
**Analysis of Trust risk register**

A review of the Trust risk register was undertaken on 27th April 2023 prior to the migration to InPhase. The key findings from this are outlined below.

**Risks with a future 'next review date'**

Risk owners are encouraged to ensure that the next planned review date is recorded and that this is a future date. This requirement is reiterated as part of the regular reports such as the two-monthly risk register review, the risk report to the Health and Safety Committee, in addition to the regular meetings between the Risk and Compliance Manager and divisional and directorate risk leads.

There was a decrease in the number of risks with a documented future 'next review date' entered on Datix Web to **75.6%** (from **82.8%** in February 2023).

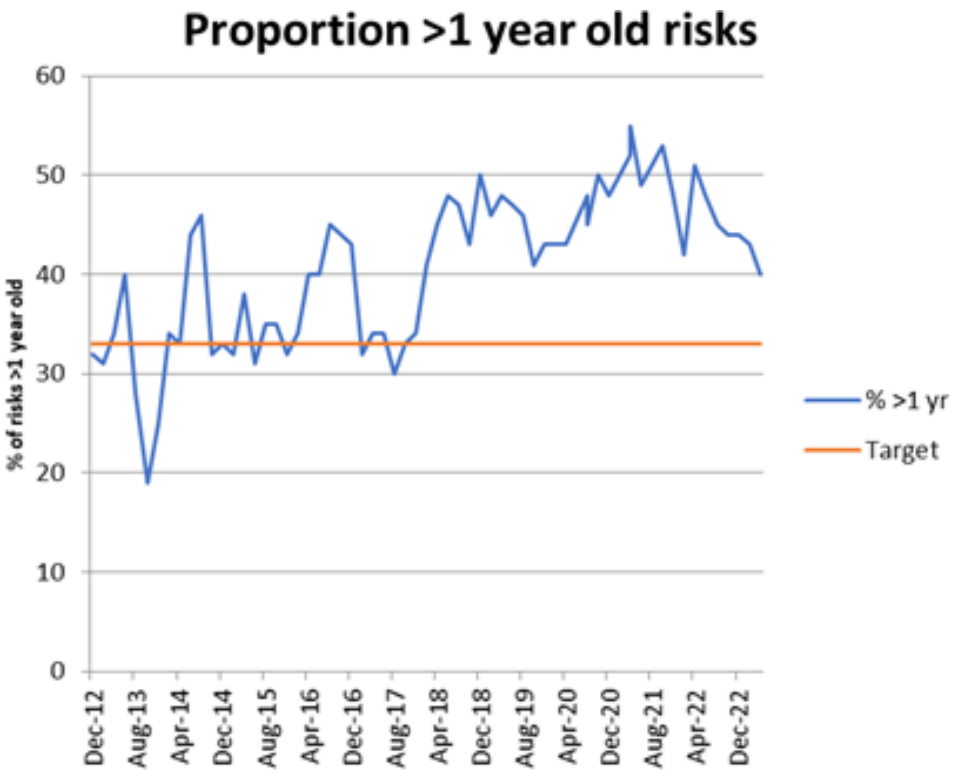



The 'Next review date' field will continue to be mandatory in InPhase, and an overall 'Target completion date' is also now a mandatory field.

**Risks over one year old**

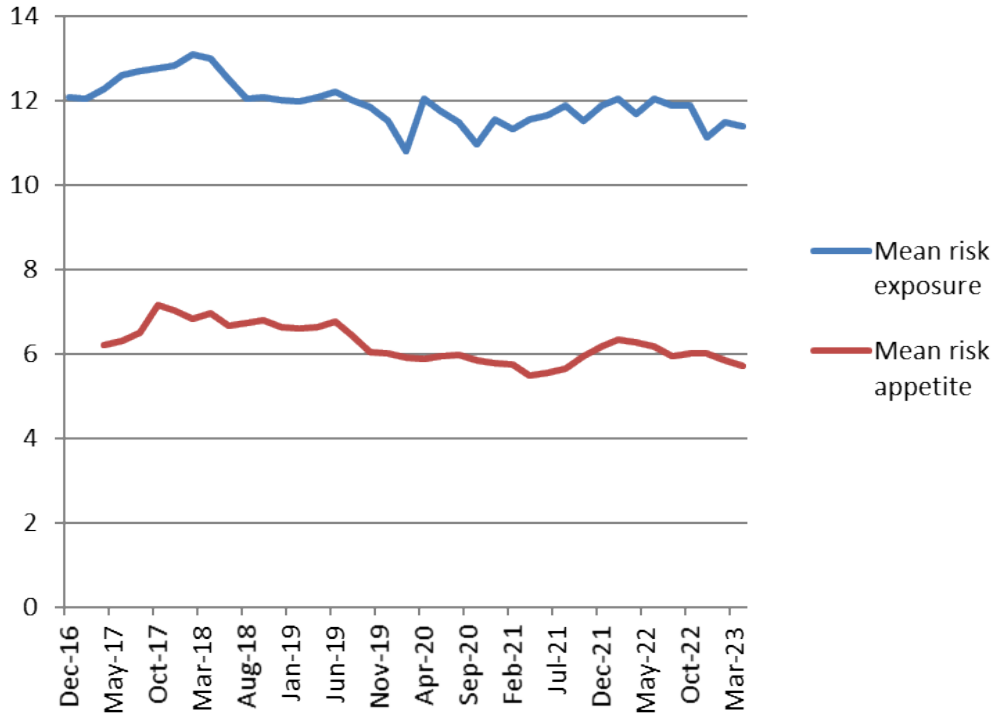
Divisional and directorate risk leads are asked to keep risk entries as up-to-date as possible, with updates at least every two months. Older risks may indicate that a risk is not being actively managed. Therefore, the proportion of risks over one year old is monitored.

There has been a decrease in the proportion of risks over one year old, from **42.7%** in February to **39.7%** in April 2023.




**Risk exposure / appetite**

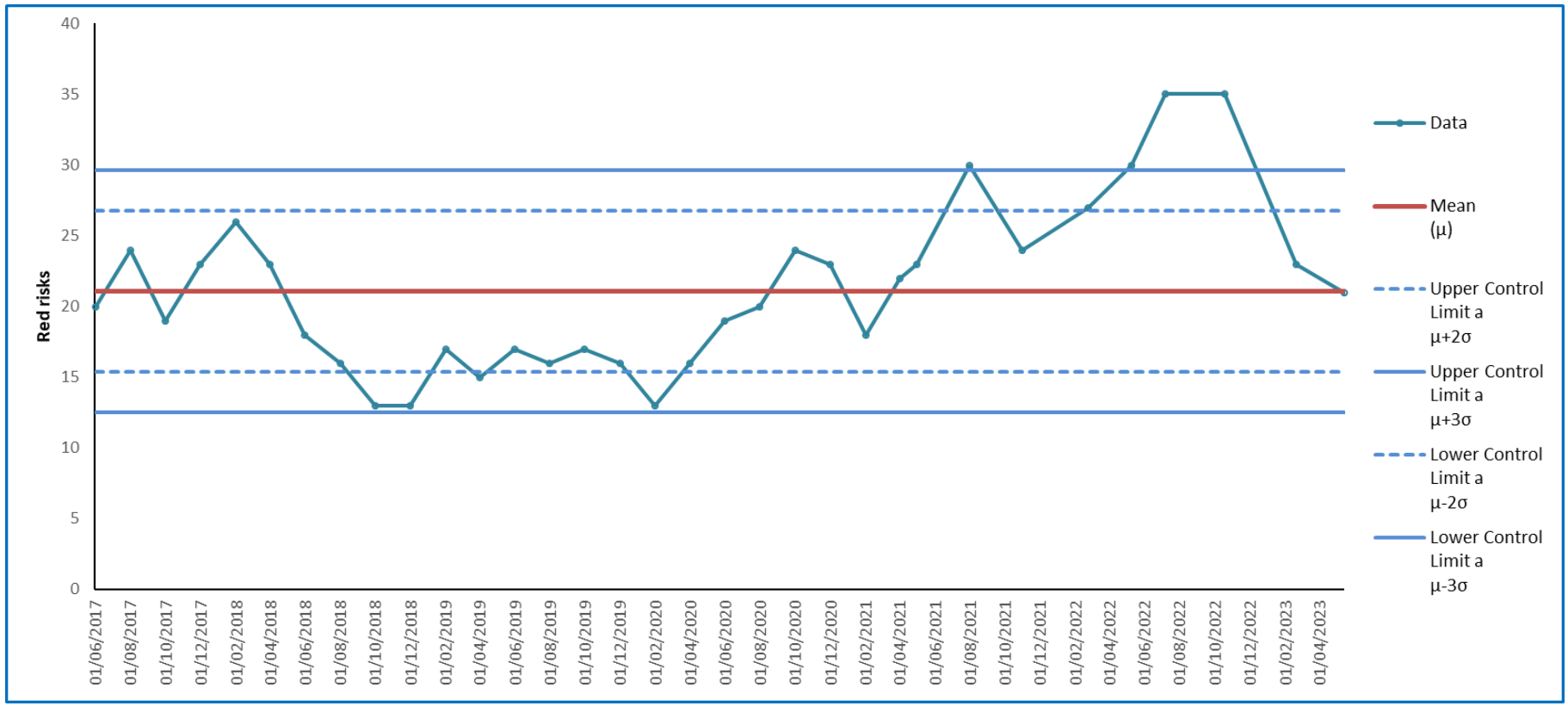
The average current risk score gives the risk exposure. The average target risk score gives the risk appetite. As of 27th April 2023, the risk exposure was 11.37 and the risk appetite 5.71. These have reduced over time but the figure remains steady, with a moderate (amber) overall exposure and a low (green) appetite.



**Overview of Red Risks**

**Number of red risks June 2017 – May 2023: SPC Chart**

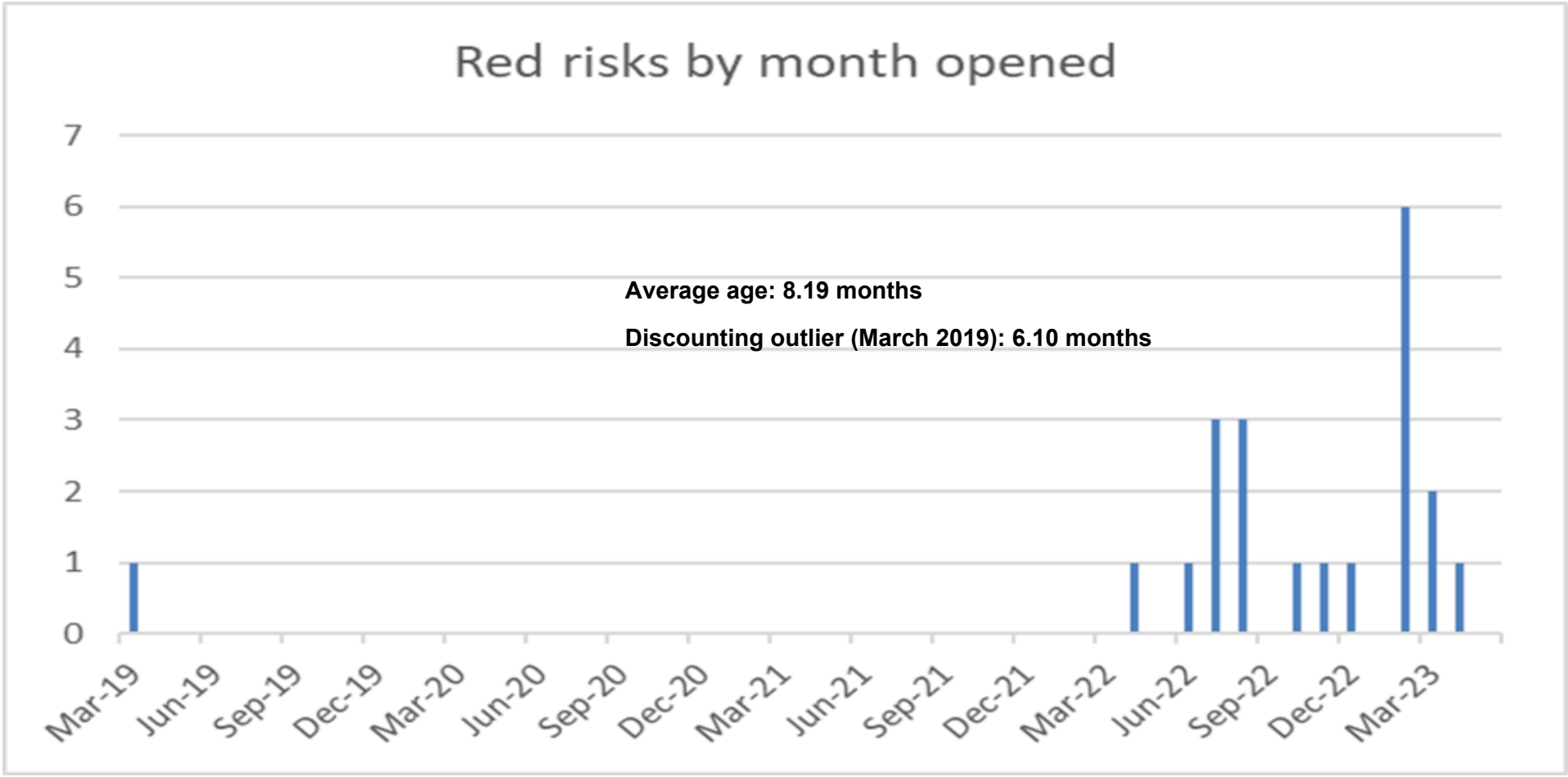
The number of red risks is monitored to determine whether there are too many, too few or if it is within expected parameters. After a period of red risks far beyond what would be expected between May 2022 and January 2023, the numbers have decreased to more 'normal' levels, and the current number of 21 red risks (Data from June 2017 to April 2021 comes from two monthly risk register reviews, April 2021 onwards from "Red risk report to the Audit and Governance Committee").



**Red risk date opened and average age**

The graph below shows when the **current 21** red risks were opened. 11 were opened within the last six months and all but one since April 2022. The red risk originally opened in March 2019, was upgraded to red in April 2023.

This average age of red risks will continue to be monitored with a view to keeping it as low as possible, indicating that they are actively managed and action is taken to mitigate the risk so they can be downgraded or closed in a reasonable timeframe.



**Red risk thematic analysis**

Red risks are reviewed regularly by the Executive Team Meeting and Audit and Governance Committee. In addition, other Trust committees and divisional governance meetings review relevant risks. The table below provides thematic analysis of the current red risks, highlighting the most commonly occurring themes across all red risks, as noted staffing continues to be the prevalent theme amongst the red risks, as it is with all risks.

As noted previously the Trust began migrating to a new platform for recording risks in early May 2023. As the richness of data on InPhase increases more information and mandatory fields will be added, including the link to Trust strategic themes and target completion timescales.

| Theme | Number of risks | % of total risks | Total current risk score | Mean risk score | % of total score |
|---|---|---|---|---|---|
| **Staffing-related** | **7** | **33.33%** | **110** | **15.71** | **33.43%** |
| **Standards (e.g. compliance against target, legislation, guidance etc.)** | **4** | **19.05%** | **63** | **15.75** | **19.14%** |
| **Competence (training, skill shortage)** | **3** | **14.29%** | **48** | **16** | **14.59%** |
| **Infrastructure (e.g. lack of space, facilities)** | **2** | **9.52%** | **30** | **15** | **9.12%** |
| **Delays** | **2** | **9.52%** | **30** | **15** | **9.12%** |
| **Equipment (lack of equipment, equipment past recommended lifespan)** | **2** | **9.52%** | **32** | **16** | **9.73%** |
| **IT systems** | **1** | **4.76%** | **16** | **16** | **4.86%** |
| | **21** | | **329** | **15.66** | |

**Open red-rated risks (15/05/2023)**

*ID numbers shown are InPhase / Datix

| ID* | Opened | Title | Division | Directorate | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|
| **Risk Type: Clinical Services (Nine risks)** | | | | | | |
| **837 / 2587** | 07/03/2019 | Delays in transport following outpatient appointments | Cancer Services | Outpatients | 15 | 6 |
| **1180 / 2933** | 11/07/2022 | Lack of room space in Outpatient clinics | Cancer Services | Outpatients | 15 | 6 |
| **1195 / 2953** | 28/07/2022 | Limited access to devices to enter patient observations directly onto Sunrise in real time | Trust Wide | Trust Wide | 16 | 8 |
| **1235 / 2990** | 30/11/2022 | Poor compliance with nursing documentation standards (Trust wide) | Corporate Services | Trust Wide | 15 | 6 |
| **1255 / 3007** | 03/02/2023 | Delays in psychiatric pathways | Medicines & Emergency Care | Emergency Medicine | 15 | 6 |
| **1260 / 3013** | 09/02/2023 | Potential for poor patient experience regarding consent and personalised care | Women's Children's & Sexual Health Services | Women's Services | 16 | 4 |
| **1262 / 3015** | 13/02/2023 | Breast Consultant Oncologist Gaps | Cancer Services | Oncology | 16 | 8 |
| **1275 / 3032** | 01/03/2023 | Compliance failure with swab count policy | Women's Children's & Sexual Health Services | Women's Services | 16 | 4 |
| **3059** | 28/04/2023 | Consultant pay rate consultation | Women's Children's & Sexual Health Services | Children's Services | 16 | 6 |

| ID* | Opened | Title | Division | Directorate | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|
| **Risk Type: Corporate and Strategic (Three risks)** | | | | | | |
| **1154 / 2906** | 26/04/2022 | Challenges in maintaining staff moving and handling skills | Trust Wide | Trust Wide | 16 | 6 |
| **1270 / 3026** | 23/02/2023 | Lack of centralised medical devices training in the Trust | Trust Wide | Trust Wide | 16 | 4 |
| **3050** | 24/03/2023 | Failure to meet national targets for complaints performance | Corporate Services | Clinical Governance | 16 | 6 |

| ID* | Opened | Title | Division | Directorate | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|
| **Risk Type: Equipment and Suppliers (One risk)** | | | | | | |
| **1238 / 2992** | 07/12/2022 | Age of the Imaging Equipment in Radiology at MTW | Core Clinical Services | Imaging | 16 | 4 |

| ID* | Opened | Title | Division | Directorate | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|
| **Risk Type: Estates and Facilities (One risk)** | | | | | | |
| **1205 / 2959** | 12/08/2022 | Patients are at risk of legionella infections | Corporate Services | | 15 | 10 |

| ID* | Opened | Title | Division | Directorate | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|
| **Risk Type: Human Resources (Six risks)** | | | | | | |
| **1171/ 2925** | 09/06/2022 | Orthoptic department vacancies | Surgery | Ophthalmology | 15 | 4 |
| **1189 / 2948** | 20/07/2022 | Lack of paediatric middle grade doctors | Women's Children's & Sexual Health Services | Children's Services | 16 | 6 |
| **1201 / 2955** | 09/08/2022 | Impact on turnover/retention/wellbeing due to the cost of living crisis | Corporate Services | People and Organisational Development | 16 | 12 |
| **1202 / 2956** | 09/08/2022 | Industrial Action | Corporate Services | People and Organisational Development | 16 | 12 |
| **1220 / 2974** | 03/10/2022 | Radiotherapy Service Delivery | Cancer Services | Oncology | 15 | 6 |
| **1259 / 3012** | 08/02/2023 | Statutory & Mandatory Training Compliance | Trust Wide | Trust Wide | 16 | 12 |

| ID* | Opened | Title | Division | Directorate | Rating (current) | Rating (Target) |
|---|---|---|---|---|---|---|
| **Risk Type: IM&T (One risk)** | | | | | | |
| **1269 / 3024** | 22/02/2023 | IT system risk | Cancer Services | Oncology | 16 | 5 |

**Conclusion**

This is the first iteration of the risk register report, providing a snapshot of the current risk profile within the Trust. This report will evolve and provide further oversight as InPhase is embedded into practice. Suggested amendments to the report are welcomed.

**NHS Provider licence: Self-certification for 2022/23** **Trust Secretary**

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

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

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

It is up to providers how they undertake their self-certification, but any process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance. NHS England/Improvement (NHSE/I) (as was) provided templates which Trusts could (but were not obliged to) use. NHS providers were required to self-certify against condition G6 by 31st May and against condition FT4(8) by 30th June each year. Providers must then publish their G6 self-certification by 30th June (the publication is itself a licence condition). NHS Trusts are not required to submit their self-certification declarations to NHSE/I unless specifically requested to do so. NHSE/I had the option of contacting a select number of NHS Trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off.

The proposed self-certification, which uses the template previously provided by NHSE/I, is enclosed. The Trust Board is asked to review, and approve, the content.

**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 review and approve the proposed self-certification for 2022/23; and
2. To note the extension of the NHS provider licence to NHS Trusts, and the associated licence conditions (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

**2022/23 Self-certification**

As had been the case in most previous years, the Board would receive the Annual Report, which contains the Annual Governance Statement (AGS), at the same meeting it considered the self-certification (under a separate agenda item), and the Annual Report and AGS would usually provide sufficient information and supporting evidence to enable the Board to self-certify that the Trust has been compliant with all relevant licence conditions.

However, as the timetable for the 2022/23 Annual Accounts reflects the later timescales that were applied during the COVID-19 pandemic, the Board will not see the draft Annual Report for 2022/23 until its meeting on 22/06/23. Ideally, the self-certification process would be deferred to that meeting, but as the self-certification timescale has not been changed, a draft version of the AGS has been included in this report (in Appendix 1), to support the proposal that the Trust Board self-certify that the Trust has been compliant with all relevant licence conditions. This same approach was taken for the self-certification for 2020/21 and 2021/22, which the Trust Board approved in May 2021 and May 2022 respectively (i.e. before it then approved the Annual Reports for 2020/21 and 2021/22).

The proposed self-certification, which uses the template previously provided by NHSE/I, is enclosed. The Trust Board is asked to review, and approve, the content.

**The NHS provider licence 2023/24 onwards**

It should be noted that this will be the last year that such a self-certification will be required. A new NHS provider licence regime took effect from April 2023, and the licence was formally extended to NHS Trusts for the first time. NHS England (NHSE) therefore issued the Trust with its first licence, and licence number, on 1st April 2023.

The licence conditions were amended to align with current statutory and policy requirements, and the new conditions removed the requirements for licensees to self-certify against the licence and report on past and future compliance with the licence. The removal of this condition was proposed during the consultation that took place on the new licence at the end of 2022.

The Standard Conditions of the new licence have been enclosed in Appendix 2, for information. As can be seen, the vast majority of the licence conditions reflect existing requirements that NHS providers have from other sources, including legislation (such as having regard to the ‘triple aim’ of achieving better health and wellbeing for the population, better quality of health care services, and more sustainable and efficient use of resources). The licence will therefore continue to form part of NHSE’s oversight of NHS providers, and be part of NHSE’s associated enforcement regime, but providers are not now required to declare compliance with the licence conditions.

**Worksheet "FT4 declaration"**

**Financial Year to which self-certification relates** | **2022/23**

## Corporate Governance Statement (FTs and NHS trusts)

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

| | Corporate Governance Statement | Response | Risks and Mitigating actions |
|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | Refer to the content of the draft 2022/23 Annual Governance Statement for full details (see Appendix 1) |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | Refer to the content of the draft 2022/23 Annual Governance Statement for full details (see Appendix 1) |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | Refer to the content of the draft 2022/23 Annual Governance Statement for full details (see Appendix 1) |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | Refer to the content of the draft 2022/23 Annual Governance Statement for full details (see Appendix 1) |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | Confirmed | Refer to the content of the draft 2022/23 Annual Governance Statement for full details (see Appendix 1) |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | Confirmed | Refer to the content of the draft 2022/23 Annual Governance Statement for full details (see Appendix 1) |

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

**Signature** | **Signature**

**Name** Miles Scott | **Name** David Highton

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

A: N/A

**Worksheet "G6 & CoS7"**

**Financial Year to which self-certification relates** 2022/23

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

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

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

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

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

**EITHER:**

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

**OR**

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

**OR**

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

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

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

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

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

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | Miles Scott | **Name** | David Highton |
| **Capacity** | Chief Executive | **Capacity** | Chair of the Trust Board |
| **Date** | 25th May 2023 | **Date** | 25th May 2023 |

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

N/A

# Annual Governance Statement for 2022/23

## Scope of responsibility

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

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2023 and up to the date of approval of the Annual Report and Accounts.

## Capacity to handle risk

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

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. The overall Executive Lead for risk management is the Chief Nurse, who was supported in this role during 2022/23 by a range of staff, including the Trust Secretary and Risk and Compliance Manager. A number of specific risk-related roles were also held by Trust Board Members during 2022/23, as follows:

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

The Trust has a Risk Register in place, which is subject to an annual review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2022/23 gave an overall assessment of *TBC [N.B. the outcome of the "Risk Management and Board Assurance" review was not available at the time this Statement was drafted (fieldwork was nearing completion), although a "reasonable assurance conclusion is expected]*.

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

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

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. In addition to the Trust's Risk Management Policy and Procedure, a comprehensive range of risk management policies and guidance is made available to staff. This includes the policies and procedures for risk assessment, incident reporting, managing complaints, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Quality Governance department includes patient safety/clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); and legal services. The systems to oversee staff health and safety are managed via the Fire/Health and Safety team, which is part of the Director of Emergency Planning & Response's team, but there is close liaison with other relevant staff, including the Risk and Compliance Manager, who is the Trust's 'appropriate person' to advise on health and safety legislation, and the Trust's key contact with the Health and Safety Executive (as required by the Health and Safety at Work etc Act 1974). In addition, Directorates and sub-specialities have clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialties.

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

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

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

## The risk and control framework

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

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. Mitigations are aimed to be identified in advance (where appropriate), so that these can be applied should the identified risk materialise. Most risks are identified at local level and initially managed by department managers. Identified risks are added to the Risk Register and are then either managed locally or escalated through the Trust's management and/or committee structure. The individuals at the Trust with specialist skills, knowledge and qualifications (that are assessed by external bodies who are able to advise managers and employees on all aspects of health, safety and risk) meet via the Safety, Health and Risk Advisory Group (SHRAG). They also identify hazards within their area of expertise and undertake Trust-wide

risk assessments for hazards that affect multiple areas. Risks are identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents, which includes grading risks for their potential impact and likelihood of harm using a standard 'Risk grading matrix'. The risk score determines the priority, response and level of management required to manage the risk, and the 'Risk grading matrix' is used to determine an acceptable level of risk. This is the 'target risk score' and reflects the risk appetite, although the risk appetite can change over time and be influenced by internal and external factors. The Trust's Risk Management policy states that target risk scores should be at as high as can be tolerated.

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

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

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

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

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the last published outcome of such an inspection related to inspections that took place in 2017 (which resulted in an overall assessment of "Requires Improvement"). However, the Trust was subject to an unannounced inspection of its End of Life Care services by the CQC on 1st March 2023, and a Well-Led inspection on 28th and 29th March 2023. The outcome of these inspections is awaited at the time this Statement was drafted, and a draft inspection report will be provided to the Trust during 2023/24. However the CQC inspectors provided high-level feedback on 29th March 2023 that highlighted several positive areas, as well as some areas for improvement. The Trust will respond in full to the CQC's findings and recommendations during 2023/24.

### How risks to data security are managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the National Data Guardian's ten data security standards. That assessment is primarily done via the Data Security and Protection Toolkit, and although the Trust's Toolkit submission for the 2021/22 year was categorised as "Approaching Standards", due to some mandatory assertions not being met, the Trust's improvement plan was deemed satisfactory by NHS Digital, and the Trust Board has received quarterly updates on progress with that plan since the Toolkit submission. The Trust is required to make its submission for the 2022/23 Toolkit by the end of June 2023.

The Trust established a dedicated cyber security team in early 2022, in response to the Trust's increasing use of digital solutions and the growing need to have a comprehensive Digital and Cyber Strategy. The Team comprises one Cyber Architect and two Cyber Analysts. On a day to day basis the team are responsible for the

oversight and monitoring of cyber activity and threat monitoring; responding to intelligence-led monitoring; and actively supporting incidents as needed. The Team are crucial to the development of the Trust's Cyber Strategy and Cyber Security Improvement Plan. It was also agreed during 2022/23 that the Audit and Governance Committee should receive an update on cyber security at each standard meeting, and the first such report was considered at the Committee's meeting in March 2023.

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

The Trust's objectives for 2022/23 were approved by the Trust Board in June 2022, and these were again grouped under six "strategic themes": People; Patient Safety and Clinical Effectiveness; Patient Access; Patient Experience; Systems & Partnerships; and Sustainability. Each theme had a "Goal", "Target", and "Breakthrough objective".

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the monthly Integrated Performance Report (IPR). In addition, a number of risks were rated as 'red' in 2022/23. Red-rated risks are reviewed and validated at the Executive Team Meeting (ETM) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2022/23, and each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk. The top five risk themes at the end of 2022/23 were staffing; infrastructure (e.g. lack of space, facilities); standards (e.g. compliance against target, legislation, guidance etc.); capacity; and competence (training, skill shortage). The Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

### Are the Trust's services well-led (under NHS England's well-led framework)[4]?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-Led domain, but the Trust was subject to Well-Led inspection by the CQC on 28th and 29th March 2023. The outcome of is awaited at the time this Statement was drafted but the Trust will respond in full to the CQC's findings and recommendations during 2023/24.

### The principal risks to compliance with the NHS provider licence[5], condition 4[6], and actions identified to mitigate these risks

In May 2022, the Trust Board completed the required self-certification (for 2021/22) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement, for 2021/22. The Trust Board will be asked to undertake the required self-certification for 2022/23 at its meeting in May 2023, and it will again be proposed that full compliance be confirmed.

[4] https://www.england.nhs.uk/well-led-framework/

[5] NHS Trusts were exempt from the requirement to apply for and hold the licence during 2022/23, although directions from the Secretary of State effectively required NHS Trusts to comply with conditions equivalent to the licence as were deemed appropriate.

[6] To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; For timely and effective scrutiny and oversight by the Board of the Licensee's operations; To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and to ensure compliance with all applicable legal requirements.

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

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

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling.
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted, via, for example, the "Governance Gazette" newsletter produced by the Quality Governance department; and the "Patient Safety Learning Hub" on the Trust's Intranet, which was updated and re-launched during 2022/23. The Hub is a platform for sharing learning from patient safety incidents and improvement initiatives, and contains sections on SI and Never Event activity; Learning from SIs and Never Events; Patient Safety Alerts / national reports published; 'Deep dive' presentations to the Quality Committee; Incident activity; and Divisional incident information.
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning and Cost Improvement Programme (CIP) arrangements, primarily via the Quality Impact Assessment (QIA) process.

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

The Trust complies with the "Developing Workforce Safeguards"[7] recommendations via the following methods:

- The Trust introduced two new policies during 2022/23: a "Nursing and Midwifery safe staffing policy and procedure"; and a "Nursing and Midwifery establishment review policy and procedure".
- A twice-yearly review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[8] and the Trust's "Nursing and Midwifery safe staffing policy and procedure", and covers the required three components of evidence-based tools, professional judgement and outcomes. The annual review was considered by the Trust Board in December 2022.
- The Trust has a workforce plan that aligns with its annual financial and activity plans. The Trust Board discusses all of these plans before submission to the relevant external parties.
- The ETM received regular updates during 2022/23 on progress against the Trust's recruitment plan.
- Service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse.
- The Trust Board reviews workforce metrics each month, via the IPR, to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.
- The Trust's People and Organisational Development Committee (a sub-committee of the Trust Board, which is chaired by a NED) meets every month, and provides assurance to the Board in the areas of people

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

development, planning, performance and employee engagement. The Committee also works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success.

### Care Quality Commission (CQC) registration

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

### Register of interests

In December 2022, the Trust developed and published a new "Conflicts of interest policy and procedure", to ensure the Trust complied with NHS England's (NHSE's) "Managing Conflicts of Interest in the NHS" guidance. The implementation of the new policy commenced in January 2023, but is not yet complete, as not all decision-making staff (as defined in the new policy) have made the required declaration. The Trust has not therefore published on its website an up-to-date register of interests, including gifts and hospitality, for its decision-making staff within the past twelve months. The Audit and Governance Committee has however continued to receive reports of the declarations that have been made, including those made under the previous "Gifts, hospitality, sponsorship and interests policy and procedure", and all Trust Board members declare any interests on appointment (and re-appointment, in the case of NEDs) and annually thereafter. The details of Trust Board members interests can be found in the Trust's Annual Report for 2022/23. The Trust will implement its new "Conflicts of interest policy and procedure" in full during 2023/24, which will include publishing the declarations for its full complement of decision-making staff.

### NHS Pension scheme

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

### Obligations under equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Further details of such measures can be found in the Trust's Annual Report for 2022/23.

### Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has plans in place which take account of the "Delivering a Net Zero Health Service" report under the Greener NHS programme. This is primarily driven via the Trust's Green Plan, which was last approved by the Trust Board in June 2022, and through the work of the Trust's Green Committee, a sub-committee of the ETM that was established during 2022/23. Further details can be found in the "Sustainability Report" within the Trust's Annual Report for 2022/23.

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

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the People and Organisational Development Committee and Quality Committee have also participated in this oversight during 2022/23. The Trust's annual Internal Audit plan for 2022/23 also included several reviews relating to this area, including "Recruitment Processes", "Financial Assurance – Payroll" *[TBC]*, "ICT Asset Management" *[TBC]*, and "Financial Accounting and Non-Pay Expenditure". All *[TBC]* of these reviews achieved an overall assessment of "Reasonable

Assurance", although the latter review actually achieved a rare "Substantial Assurance" conclusion. *[N.B. The outcome of the "Financial Assurance – Payroll" and "ICT: Asset Management" reviews was not available at the time this Statement was drafted (the fieldwork has been completed and the draft report is being produced)].*

## Information governance

The Trust had three serious incidents involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO), as described within the NHS Data Security Incident Reporting Tool, during 2022/23. All three were subject to an internal investigation and remedial action was taken. The ICO confirmed it was satisfied that appropriate measures were taken for all three incidents. Further details of the incidents can be found in the Trust's Annual Report for 2022/23.

## Data quality and governance

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

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

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

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. The "Data Quality of Key Performance Indicators" that was undertaken as part of the 2021/22 Internal Audit plan (and which was issued in June 2022) covered the Emergency Department (ED) four-hour waiting time target and 18 weeks Referral to Treatment (RTT) incomplete pathway, and gave an overall assessment of "Reasonable Assurance". A "Processes for Dealing with Data Quality Issues" Internal Audit review was also undertaken as part of the 2022/23 Internal Audit plan, and that resulted in a "Reasonable Assurance" conclusion. The final report of the "Data Quality of Key Performance Indicators" Internal Audit review for 2022/23 was not available at the time of drafting this Statement.

In addition, the Trust's contract with the Kent and Medway Integrated Care Board (KM ICB) during 2022/23 included a requirement to have a Data Quality Improvement Plan (DQIP). The governance processes defined in the contract mean that any data quality issues relating to the Trust's RTT or cancer waiting times can be raised and resolved via that route. The Trust's commissioners received copies of the Trust's performance reports, as well as information provided to them via NHSE, to support the performance management of the Trust's services (with the aim of ensuring the achievement of key targets such as the RTT and cancer waiting time standards). Any associated data quality issues are raised as part of this dialogue and are managed via the technical groups established under the contract and documented in the DQIP. Furthermore, all Trusts now have to submit a weekly copy of their RTT waiting list (Patient Tracking List, or PTL) to NHSE, and NHSE have developed a Data Quality assurance report that is linked to this called "LUNA". All Trusts had the target to

reach an RTT PTL confidence level of 95% by December 2021, which the Trust successfully achieved and maintained throughout 2022/23.

## Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Maidstone and Tunbridge Wells NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in the Trust's Annual Report, and this Annual Governance Statement, and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and the Audit and Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2022/23 states that "My overall opinion is that Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk." This latter sentence reflects the fact that some of the Internal Audit reviews carried out during 2022/23 resulted in a 'limited assurance' conclusion, and the Trust's response to these is explained below. *[N.B. The Head of Internal Audit Opinion has "draft" status at the time this Statement was drafted, although no change in the conclusion is expected].*

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Finance and Performance Committee, People and Organisational Development Committee, and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2022/23 resulted in an overall 'Reasonable assurance' assessment, four reviews resulted in a 'Limited assurance' conclusion: the "Assurance Review of Bed and Trolley Management"; the "ICT Review of Core Systems"; the "Assurance Review of Disaster Recovery" (for ICT); and the "Assurance Review of Falls". The "Assurance Review of Bed and Trolley Management" contained four 'priority 1' (urgent) recommendations, but a response to each was considered at the Audit and Governance Committee meeting in March 2023 (as is the standard practice for reviews with a 'Limited assurance' conclusion). The "ICT Review of Core Systems" (which contained no 'priority 1' recommendations); and the "Assurance Review of Disaster Recovery" review (which contained two 'priority 1' recommendations) will be reviewed in detail at the Audit and Governance Committee meeting on 16th May 2023, with the Director of IT in attendance. The "Assurance Review of Falls" (which contained one 'priority 1' recommendation) will be subject to a detailed review at the Audit and Governance Committee meeting in July 2023. All reviews with a 'Limited assurance' conclusion are also subject to follow-up by the Internal Auditors, to monitor compliance with the actions agreed in response to the recommendations, and the findings from that follow-up are reported to the Audit and Governance Committee.

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

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting). All but one of Trust Board's meetings in 2022/23 were held 'virtually', as a result of the continued risks associated with COVID-19, but the requirement to meet in public was met via all of the Trust Board meetings being broadcast

live on the internet, via the Trust's YouTube channel. The agenda and reports for all 'Part 1' Trust Board meetings are available via the Trust's website, and members of the public are able to submit questions, in advance of the meeting, in relation to any of the agenda items.

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

### The role of other forums (including the Audit and Governance Committee and other Trust Board sub-committees), and other review/assurance mechanisms in reviewing the effectiveness of the system of internal control

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

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control; and oversight of the Internal and External Audit and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, and is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a NED, and meets five times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other NEDs (apart from the Chair of the Trust Board) are members, and all Associate NEDs are invited to attend each meeting, as is the Deputy Chief Executive/Chief Finance Officer. During 2022/23, the Committee started to receive a standing "Security issues" report at each standard Committee meeting, to support the Committee Chair in fulfilling their role as the Trust's Security Management NED Champion. The Committee also agreed to consider a Security Annual Report, and the first such report is scheduled to be considered at the Committee's meeting on 16th May 2023.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a NED, and usually meets three times per year, although it met four times during 2022/23.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on Information Technology (IT) performance (and IT-related business continuity). The Committee is chaired by a NED, and meets monthly.
- The Patient Experience Committee. This considers the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations. The Committee is chaired by a NED, and meets quarterly. In addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from the Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.

- The People and Organisational Development Committee. This provides assurance to the Trust Board in the areas of people development, planning, performance and employee engagement; and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success. The Committee is chaired by a NED and meets monthly in two alternating forms – a 'main' meeting and a 'deep dive' (which enables a small number of subjects to be scrutinised in greater detail).
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a NED and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of members of the Executive Directors; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met twice during 2022/23).

Although not a Trust Board sub-committee, the ETM enables key clinical and managerial issues to be discussed, debated, developed, scrutinised, monitored and agreed and/or approved. The ETM generally meets every week throughout the year, is chaired by the Chief Executive and its membership comprises all the Executive Directors, the five Divisional Chiefs of Service, the Director of Infection Prevention and Control and the Director of Estates and Capital Development. The ETM is authorised to make decisions on any matter that is not reserved for the Trust Board or its sub-committees.

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, an Infection Prevention and Control Committee; a Health and Safety Committee; a Sepsis Committee; a Drugs, Therapeutics and Medicines Management Committee; an Information Governance Committee; and a Joint Safeguarding Committee.

### Significant internal control issues

The following significant internal control issue[9] has been identified in 2022/23:

1. Three "Never Events" were declared at the Trust in 2022/23. These related to a wrong lens implant in ophthalmology; a wrong sided biopsy in interventional radiology; and a retained swab in the delivery suite. The incidents were subject to scrutiny through the SI investigation process, and the Quality Committee, to aim to ensure that lessons were learnt to prevent recurrence.

## Conclusion

The Trust has maintained a sound system of internal control during 2022/23 and has identified only one significant internal control issue during the year.

[9] The Trust considered the following criteria when identifying if any significant internal control issues had occurred during 2022/23: Might the issue prejudice achievement of priorities? Could the issue undermine the integrity or reputation of the NHS? What view does the Audit and Governance Committee take on this point? What advice has internal or external audit given? Could delivery of the standards expected of the Accountable Officer be at risk? Has the issue made it harder to resist fraud or other misuse of resources? Did the issue divert resources from another significant aspect of the business? Could the issue have a material impact on the accounts? Might national or data security or integrity be put at risk? It was also noted that the Trust was not issued with any Regulation 28 ("Report to Prevent Future Deaths") reports by HM Coroner during 2022/23.

Classification: Official

Publication reference: PR00191

# NHS Provider Licence

## Standard Conditions

31 March 2023

# Version History

| Version number | Date | Comments |
|---|---|---|
| 1.0 | 26 March 2013 | Created |
| 2.0 | 04 April 2013 | Formatting changes |
| 3.0 | 27 October 2022 | Draft updated licence for consultation |
| 4.0 | 31 March 2023 | Updated licence conditions |

# Contents

**NHS Provider Licence Standard Conditions**

# Section 1 – Integrated Care

**IC1: Provision of Integrated care**

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

    where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

**IC2: Personalised Care and Patient Choice**

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

# Section 2 – Trusts Working in Systems

**WS1: Cooperation**

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
     i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
     ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
     iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
     i. as necessary and appropriate for the purposes of delivering NHS services.
     ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:

a. the Secretary of State for Health and Social Care; or
b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

**WS2: The Triple Aim**

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, "the triple aim" refers to the aim of achieving:
    a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
    b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
    c. more sustainable and efficient use of resources by NHS bodies,

and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

**WS3: Digital Transformation**

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

# Section 3 – General Conditions

**G1: Provision of information**

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

**G2: Publication of information**

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

**G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)**

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
    a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
    b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
    c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
    d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
    a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
    b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
        i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
        ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;

iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;

iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;

v. which passes any resolution for winding up;

vi. which becomes subject to an order of a Court for winding up; or

vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

## G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

**G5: Systems for compliance with licence conditions and related obligations**

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   a. the Conditions of this Licence,
   b. any requirements imposed on it under the NHS Acts, and
   c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   b. regular review of whether those processes and systems have been implemented and of their effectiveness.

**G6: Registration with the Care Quality Commission**

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
    a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
    b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
    a. be made within 7 days of:
        i. the making of an application in the case of paragraph (a), or
        ii. becoming aware of the cancellation in the case of paragraph (b), and
    b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
        i. the making of an application in the case of paragraph (a), or
        ii. the cancellation in the case of paragraph (b).

**G7: Patient eligibility and selection criteria**

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

**G8: Application of section 6 (Continuity of Service)**

1. The Conditions in Section 6 shall apply:
    a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
    b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
    c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
    d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
    e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
    a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
    b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
    c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
    d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
    a. in writing,
    b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or
b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or
b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or

d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

# Section 4 – Trust Conditions

**NHS1: Information to update the register**

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee's constitution;
    b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee's most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the

document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

**NHS2: Governance arrangements**

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
    c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

# Section 5 – NHS Controlled Providers Conditions

**CP1: Governance arrangements for NHS-controlled providers**

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
d. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

a. effective board and committee structures;
b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).

5. The Licensee shall establish and effectively implement systems and/or processes:

a. to operate efficiently, economically and effectively;

b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

# Section 6 – Continuity of Services

**CoS 1: Continuing provision of Commissioner Requested services**

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

**CoS 2: Restriction of the disposal of assets**

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:

a. with the consent in writing of NHS England, and
b. in accordance with the paragraphs 6 to 8 of this Condition.

6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:

a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
    i. transactions of a specified description; or
    ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

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| “disposal” | means any of the following:<br>(a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or<br>(b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or<br>(c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or<br>(d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to “dispose” are to be read accordingly; |
| “relevant asset” | means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee’s ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced; |
| “relinquishment of control” | includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and “relinquish” and related expressions are to be read accordingly. |

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee’s ability to provide

Commissioner Requested Services should be regarded as materially prejudiced.

**CoS 3: Standards of corporate governance, financial management and quality governance**

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

**CoS 4: Undertaking from the ultimate controller**

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"):

a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
   a. a health service body, within the meaning of section 9 of the 2006 Act;
   b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
   c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
   d. a trustee of the Licensee and the Licensee is a charity.

**CoS 5: Risk pool levy**

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

**CoS 6: Cooperation in the event of financial or quality stress**

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
    a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
    b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
    c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
    a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
    b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
    c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.

**CoS 7: Availability of resources**

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources".
c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts;

"Required Resources" means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

# Section 7 – Costing Conditions

**C1: Submission of costing information**

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:

    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:

    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

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| “the Approved Guidance” | means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England. |
| “other relevant information” | means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information. |

**C2: Provision of costing and costing related information**

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
    a. in the case of information (data) or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

**C3: Assuring the accuracy of pricing and costing information**

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
    a. Regular assessments by the providers internal and/or external auditor
    b. specific work by NHS England or NHS England nominated representative on costing related issues and
    c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
    d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

# Section 8 – Pricing Conditions

**P1: Compliance with the NHS payment scheme**

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

# Section 9 – Interpretation and Definitions

**Condition D1: Interpretation and Definitions**

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

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| “the 2006 Act” | the National Health Service Act 2006 c.41; |
| “the 2008 Act” | the Health and Social Care Act 2008 c.14; |
| “the 2009 Act” | the Health Act 2009 c.21; |
| “the 2012 Act” | the Health and Social Care Act 2012 c.7; |
| “the 2022 Act” | The Health and Care Act 2022; |
| “the Care Quality Commission” | the Care Quality Commission established under section 1 of the 2008 Act; |
| “Commissioner Requested Service” | a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition; |
| “Commissioners” | NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB; |
| “Director” | includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of:<br>(i) an NHS foundation trust,<br>(ii) an NHS Trust or<br>(iii) a company constituted under the Companies Act 2006; |

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| “Governor” | a Governor of an NHS foundation trust; |
| “Hard to replace provider” | has the meaning given in condition G8 of the licence; |
| “Integrated Care Board” | a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act; |
| “the NHS Acts” | the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act; |
| NHS Controlled provider | An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of IFRS 10; |
| “NHS England” | the body named as NHS England in section 1 of the 2022 Act; |
| “NHS foundation trust” | a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act; |
| “NHS Trust” | an NHS trust established under section 25 of the 2006 Act; |
| “Relevant bodies” | NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act; |
| “Trusts” | means NHS foundation trusts and NHS trusts. |

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.
3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request.

**Ratification of Standing Orders, Standing Financial Instructions; and Reservation of Powers and Scheme of Delegation (annual review)** — **Trust Secretary**

The Trust has committed to reviewing the Trust's Standing Orders, Standing Financial Instructions (SFIs) and Reservation of Powers and Scheme of Delegation (SoD) each year. The last such review was undertaken in March 2022. In January 2023 however the Chair of the Audit and Governance Committee agreed to a short deferral request, to enable the review to be undertaken in May 2023. The three documents have therefore been reviewed and updated, and some proposed changes have been made. The documents were circulated widely for consultation by email on 24/04/23 and 25/04/23[1], and then "approved" (as submitted) by the Audit and Governance Committee on 16/05/23. The Trust Board is now asked to "ratify" the documents, to enable them to be published via the Trust's intranet.

As had been the case for the annual reviews in the past few years, the full documents, with the proposed changes shown as 'tracked', have been made available to Trust Board members as supplements to the formal 'pack' of Trust Board reports[2]. Trust Board members are therefore welcome to read the supplements, to see the precise details of the proposed changes, but are not expected to do so.

The main proposed changes to the SFIs are listed below:

- Changes to the process for obtaining external approval of significant Business Cases (to reflect the new "Capital investment and property business case approval guidance for NHS trusts and foundation trusts" from NHS England (NHSE).
- Confirmation that any leases will now count as capital purchases for the purposes of the national capital limits, and will need to be subject to the Trust business case approval process in the same way as direct capital purchases.
- The inclusion of monthly monitoring returns from the Trust to the Kent and Medway Integrated Care Board (KM ICB).
- Clarification of the arrangements when aggregation is applied to Orders (re procurement); and confirmation that a record of all correspondence between bidding suppliers and the Trust designated officers should be kept.
- Confirmation that all appointed Contract Managers shall be required to undertake the Government Commercial Function Contract Management Foundation training module.
- Confirmation that disposals over the relevant threshold (of £25m) also require approval by NHSE and the Department of Health and Social Care (DHSC).
- Clarification of the arrangements for prepayment of goods and/or services.
- Further clarification of the arrangements for use of the Trust's credit card.
- The addition of a new section on "Lease Right to Use Assets".
- Further details regarding the arrangements for "Goods received".
- Inclusion of a reference to the Charitable Funds Committee in relation to funds held on trust.
- Additional information regarding International Financial Reporting Standards (IFRS) 16 (Leases).
- Removal of reference to previous NHS consultancy spending and revenue contract controls.
- Updating of the Internal Audit section to separate out the requirements for an annual plan and a strategic 3 year plan.

The main proposed changes to the Reservation of Powers and Scheme of Delegation are listed below:

- Addition of a reserved power for the Trust Board to approve the Trust plans for both revenue and capital resource, including the duty on the Trust to exercise its functions with a view to delivering its part in the collective ICB/partner Trust system duty to deliver its financial objectives e.g. revenue breakeven and capital spend within the system control total.

[1] The circulation included all members of the Trust Board.

[2] The three supplements are available via the "Documents" section of the Admincontrol meetings portal ("Documents>Trust Board>Trust Board Meetings (Part 1)>2023>05.25.05.23>Standing Orders, Scheme of Delegation and SFIs (track changes versions)")

- Changes to the process for obtaining external approval of significant Business Cases (to reflect the new "Capital investment and property business case approval guidance for NHS trusts and foundation trusts" from NHSE.
- The inclusion of a reference for consultancy spending to be in accordance with the DHSC's Group Accounting Manual.
- Clarification of the Executive Directors who are able to authorise the booking of bank, locum or agency staff.
- Removal of the ability to authorise filling a funded post that is not on the establishment (i.e. thereby increasing the establishment and the revenue cost to the Trust).
- Removal of the ability to authorise extensions of contract beyond normal retirement age in exceptional circumstances.

The main proposed changes to the Standing Orders are listed below:
- Expansion of the different types of "forum".
- Addition of definitions of "responsibility" and "accountability".
- Removal of specific content relating to pecuniary interests, to denote that the Trust's Conflicts of interest policy and procedure is the definitive source of definitions of interests.
- Amendments to the Procedures to be applied in response to the "Fit and Proper Persons: Directors" Regulations (Appendix 4) to incorporate the inclusion of a routine check, on appointment, of whether any County Court Judgements had been issued; to explain the approach for any Directors that have lived for periods abroad (non-UK) before joining the Trust Board; and to remove the random selection aspects of the annual check of County Court Judgements.

The main proposed changes that affect all three documents are listed below:
- Updated cross references.
- Change of terminology in relation to "Executive Director" and "member of the Executive Team".
- Replacement of references to the previous "Gifts, hospitality, sponsorship and interests policy and procedure" to the new "Conflicts of interest policy and procedure"
- Removal of references to the Trust Management Executive (TME), following that forum's disestablishment on 31/05/22.
- Expansion on the organisations that were formalised by the Health and Care Act 2022.
- Non-material 'housekeeping' changes (changes to job titles etc.)

**Which Committees have reviewed the information prior to Board submission?**
- Finance and Performance Committee, 25/04/23 (summary of proposed changes, for information)
- Audit and Governance Committee, 16/05/23 (full revised documents, for approval)

**Reason for submission to the Board (decision, discussion, information, assurance etc.)** [3]
Ratification

[3] 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