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

Thu 28 September 2023, 09:45 - 13:00

Virtually, via Webconference

NHS
Maidstone and Tunbridge Wells
NHS Trust

Agenda

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

09-1
To receive apologies for absence

David Highton

09-2
To declare interests relevant to agenda items

David Highton

09-3
To approve the minutes of the 'Part 1' Trust Board meeting of 27th July 2023

David Highton

Board minutes, 27.07.23 (Part 1).pdf (10 pages)

09-4
To note progress with previous actions

David Highton

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

09-5
Report from the Chair of the Trust Board

David Highton

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

09-6
Report from the Chief Executive

Miles Scott

Report from the Chief Executive - September 2023.pdf (4 pages)

Reports from Trust Board sub-committees

09-7
Quality Committee, 09/08/23 and 13/09/23

Maureen Choong

Summary of Quality C'ttee, 09.08.23.pdf (2 pages)
Summary of Quality C'ttee, 13.09.23.pdf (2 pages)

09-8
Finance and Performance Committee, 26/09/23 (incl. approval of revised Terms of Reference)

Neil Griffiths

N.B. The report will be issued after the meeting on 26/09/23.

09-9
People and Organisational Development Committee, 22/09/23 (incl. quarterly report from the Guardian of Safe Working Hours)

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 22.09.23 (incl quarterly update from the Guardian of Safe Working Hours).pdf (5 pages)

09-10
Patient Experience Committee, 07/09/23

Jo Webber

Summary of Patient Experience Committee 07.09.23.pdf (2 pages)

09-11
Charitable Funds Committee, 26/07/23

David Morgan

Summary of Charitable Funds Cttee, 26.07.23.pdf (1 pages)

Integrated Performance Report

09-12
Integrated Performance Report (IPR) for August 2023

Miles Scott and colleagues

N.B. The item will only be allocated 15 minutes (instead of the usual 1 hour)

Integrated Performance Report (IPR) for August 2023.pdf (31 pages)

Planning and strategy

09-13
Confirmation of the updated Vision Goals, Vision Targets, Breakthrough Objectives and Corporate Projects

Rachel Jones

Confirmation of the updated Vision Goals, Vision Targets, Breakthrough Objectives and Corporate Projects.pdf (13 pages)

09-14
Self-certification to deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation

Sean Briggs

Self-certification to deliver elective and cancer recovery ambitions....pdf (16 pages)

09-15
To approve a Business Case for the Nursing and Midwifery safer staffing review 2022/23

Joanna Haworth

To approve a Business Case for the Nursing and Midwifery safer staffing review 2022-23.pdf (28 pages)

Quality Items

09-16
The Trust’s well-led inspection by the Care Quality Commission (CQC)

Joanna Haworth

The Trust’s well-led inspection by the Care Quality Commission (CQC).pdf (13 pages)

09-17
Quarterly mortality data

Peter Maskell

Quarterly mortality data.pdf (10 pages)

09-18
Quarterly Maternity Services report (incl. a review of the Trust’s response to non-compliance with the Swab Count policy)

Kym Sullivan and Rachel Thomas

N.B. This item is scheduled for 11:30am.

Quarterly Maternity Services report (incl. a review of the Trust’s response to non-compliance with the Swab Count policy).pdf (27 pages)

09-19
Safeguarding update (Annual Report to Board, incl. the Trust Board refresher training)

Joanna Haworth

Safeguarding update (Annual Report to Board, incl. the Trust Board refresher training) - 2023.pdf (51 pages)

Systems and Place

09-20
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent HCP and NHS Kent and Medway ICB.pdf (8 pages)

Assurance and policy

09-21
Responsible Officer's Annual Report 2022/23

Peter Maskell

Responsible Officer's Annual Report 2022-23.pdf (27 pages)

09-22
Health & Safety Annual Report, 2022/23 and agreement of the 2023/24 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

Rob Parsons, Caroline Gibson and John Weeks

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

Health & Safety Annual Report, 202223 and agreement of the 202324 programme.pdf (34 pages)

09-23
Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

Sean Briggs and John Weeks

N.B. This item is scheduled for 12:10pm.

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment.pdf (17 pages)

Corporate governance

09-24
The NHS England Fit and Proper Person Test Framework for board members

Kevin Rowan

The Fit and Proper Person Test Framework.pdf (20 pages)

09-25
Response to NHS England's “Verdict in the trial of Lucy Letby” letter

Kevin Rowan

Response to NHS England's “Verdict in the trial of Lucy Letby” letter.pdf (7 pages)

09-26
Annual review of the Trust Board's Terms of Reference

David Highton and Kevin Rowan

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

09-27
To consider any other business

David Highton

09-28
To respond to any questions from members of the public

David Highton

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

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

09-29
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 JULY 2023, 9:45 AM, VIRTUALLY, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(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)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sue Steen	Chief People Officer	(SS)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Christian Lippiatt	Freedom to Speak Up Guardian (for item 07-25)	(CL)
	Debbie Morris	Director of Estates and Capital Projects (for item 07-23)	(DMo)
	Rachel Thomas	Director of Maternity (for item 07-19)	(RT)
Observing:	Jane Taylor	Associate Director, Deloitte LLP	(JT)
	The meeting was livestreamed on the Trust's YouTube channel.		

07-7 To receive apologies for absence

Apologies were received from Emma Pettitt-Mitchell (EPM), Non-Executive Director. It was also noted that Sara Mumford (SM), Director of Infection Prevention and Control; Jo Webber (JW), Associate Non-Executive Director; and Alex Yew (AY), Associate Non-Executive Director would not be in attendance.

07-8 To declare interests relevant to agenda items

No interests were declared.

07-9 To approve the minutes of the 'Part 1' Trust Board meetings of 29th June 2023 and 20th July 2023

The minutes were approved as true and accurate records of the meetings.

07-10 To note progress with previous actions

The content of the submitted report was noted.

07-11 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted the consultant appointments which had been made within the reporting period. DH then commended the continued response to industrial action by Trust staff.

07-12 Report from the Chief Executive

MS referred to the submitted report and highlighted the key points therein, which included an in-depth update on consultant and junior doctors' industrial action and the associated impacts; the continued focus on maintaining patient safety during periods of industrial action; commendation of the concerted effort of Trust staff to respond to the periods of industrial action; acknowledge of the

impacts of industrial action on Trust staff; details of the celebrations which had been held to mark the NHS' 75th birthday; the importance of recognising the contribution of the second Windrush generation at the Trust; a brief overview of the three core elements of the National NHS Workforce plan (i.e. 'train', 'retain' and 'reform'); the achievement of an A-rating on the latest Sentinel Stroke National Audit Programme (SSNAP); and that PM had been appointed as the Medical Director for Integrated Care for the West Kent Health & Care Partnership (HCP).

Reports from Trust Board sub-committees

07-13 Quality Committee, 12/07/23

MC referred to the submitted report and highlighted the key points therein, which included the decision to transition the harm review process for patients who had waited a long time to 'Business as usual' (BAU) due to the assurance which had been provided to the Committee.

DH supported the focus by the Committee on the increased clinical audit functionality afforded by the Electronic Prescribing and Medicines Administration (EPMA) and noted the associated benefits. MC highlighted the anticipated increased reporting of no and low harm incidents.

07-14 Finance and Performance Committee, 25/07/23

NG referred to the submitted report and highlighted the key points therein, which included details of the in-depth review of the outpatients transformation programme and the assurance which had been received in regards to the progress to date; the continued performance by the Trust despite the impact of industrial action and operational pressures; and that the Committee had recommended the Business Case for Cardiac Catheter Lab Equipment Replacement (Managed Service Agreement) for approval by the Trust Board.

07-15 People and Organisational Development Committee, 21/07/23

RF referred to the submitted report and highlighted the key points therein, which included that an in-depth discussion had been held regarding the work of the IEN/EIM Pastoral Care Network; the required development of a Trust-wide workforce plan in response to the National NHS Workforce Plan; the importance of ensuring that other forums at the Trust utilised an Equality, Diversity and Inclusion (EDI) lens within their reporting arrangements; and the assurance which had been received in relation to the "Strategic Theme: People" section of the Integrated Performance Report (IPR)

JH commented that the first 'Chief Nurse Listening Event' had illustrated the quantifiable difference in experience between those Internationally Educated Nurses (IENs) / Internationally Educated Midwives (IEMs) that arrived in December 2022 and those that had arrived at the Trust more recently. JH then detailed the measures which had resulted in such improvements, which included the introduction of the Lead Nurse for Pastoral Care. JH continued that although further work was required, the 'Chief Nurse Listening Event' had received positive feedback and would therefore be conducted quarterly.

DM queried when the People and Organisational Development Committee was next scheduled to receive an update on the Workforce Efficiency Programme and the associated benefits. RF replied that the Workforce Efficiency Programme was discussed at each 'main' People and Organisational Development Committee with the Programme Director, premium staffing spend in attendance. SO added that the Finance and Performance Committee would also receive an update on the Workforce Efficiency Programme which, if required, could be submitted to the Trust Board for further discussion. SO then provided assurance regarding progress which had been made in relation to the reduction of premium agency expenditure. RF added that robust assurance had been provided that the required expertise was in place to deliver the required improvements.

07-16 Audit and Governance Committee, 19/07/23 (incl. the External Auditor's Annual Report for 2022/23)

DM referred to the submitted report and highlighted the key points therein, which included details of the discussion which had been held regarding the risks and benefits of Artificial Intelligence (AI) and the proposal to develop further guidance for Trust Board members; and that as part of the "review

of the Trust's red-rated risks" item there had been an enhanced focus on understanding why the mitigations and controls had not reduced the risk rating and how certain risks, which had been downgraded to Amber, should continue to be monitored.

07-17 Charitable Funds Committee, 26/07/23

DM reported the progress which had been made by the Head of Charity and Fundraising in terms the embedding of charitable activity at the Trust; the increased disbursement of funds within the reporting period and the further work which was required to increase charitable donations; and the intention to acquire a raffle licence for each of the Trust's Hospitals, although, a robust policy and procedure was required to mitigate any associated risks.

Integrated Performance Report

07-18 Integrated Performance Report (IPR) for June 2023

SS referred to the "People" Strategic Theme and reported the following points:

- The "Reduce the Trust wide vacancy rate to 12%" metric continued to experience special cause variation of an improving nature.
- The Trust's appraisal period remained open with the intention to achieve the 95% appraisal completion target; although several factors had adversely impacted Trust's the performance to date.
- The "Reduce the Trust wide vacancy rate to 12%" metric had been reviewed and it had been agreed that target should be amended to 8%, in response to the Trust's continued achievement of the current target.
- The Trust's appraisal completeness was at 34.9%

SS then continued and explained the latest position in relation to the and "Sickness Rate" metric and reported that the Trust's sickness absence rate had reduced to 3.3% which was in part due to a large reduction in long-term sickness absence within the Estates and Facilities Directorates.

SS then continued and explained the latest position in relation to the and Equality, Diversity and Inclusion (EDI) percentages for Agenda for Change (AfC) Band 8c and above metrics and highlighted the key points therein, which included that further work was required to achieve the 12% target of AfC band 8c and above staff from Black, Asian and Minority Ethnic (BAME) backgrounds; the intention to establish an EDI Steering Group which would commence in September 2023 and be co-chaired by SS and SO, with six key workstreams for delivery; that the EDI Steering Group would provide an annual report to the Trust Board and regular reports to the Executive Team Meeting; and the improvement in the Trust's turnover rate, although, it was acknowledged that there was significant variation across staff groups and specialties.

DM emphasised the importance of ensuring the granular detail for the "Percentage of AfC 8c and above that are BAME" metric was considered, as each additional member of staff represented almost 1 percentage point and therefore the achievement of the metric required approximately 13 members of staff from the appropriate demographics to be AfC band 8c and above. SS acknowledged the point and outlined the discussions which had been held regarding an enhanced focus on AfC band 8a and above to ensure there was a robust succession pipeline and enable the appropriate talent management to be implemented to prevent such staff from hitting a 'glass ceiling'.

WW asked whether there were any areas with high vacancy rates which were hard to recruit to or areas with high turnover rates. SS highlighted that within small staffing groups individual vacancies represented a high vacancy rate and therefore the key area of focus was those areas wherein there was significant temporary staffing expenditure due to the vacancies within a staffing group and outlined the intention to convert high expenditure agency roles into substantive posts. SS then detailed those areas with high vacancy rates which included Anaesthetists and Radiographers, wherein there was a national skill shortage; however, noted that there were also high turnover rates in lower paid roles. SS added that further work was required in relation to those staff which left the Trust within the first 12 to 24 months of employment, to identify any issues with the induction process and provided details of the bespoke action plans which had been developed to improve retention in those areas with higher turnover rates. SS continued that, in terms of turnover, one of the reasons

which was submitted by staffing leaving the Trust was “unknown” which caused additional challenges in relation to identifying the root cause; however, noted that the key themes from the Trust’s Exit Interviews included proximity to London wherein a higher rate of pay could be achieved, and the cost of living in the South East.

DH noted that the higher than average turnover rate within one year or less of employment at the Trust may be indicative of challenging relationships within the department and emphasised the importance of continuing to monitor the turnover rate within the first year of employment to identify any managerial or induction issues. The point was acknowledged.

PM referred to the “Patient Safety & Clinical Effectiveness” Strategic Theme and highlighted the key points therein, which included the proposed change to the “Strategic Goal / Target” and the associated “Breakthrough Objective” and the associated challenges in terms of identifying comparable data; the continued improvement in the Trust’s falls rate; details of the improvement in the Trust’s mortality indicators including the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI); and the further work which was required to improve clinical coding.

JH then explained the latest position in relation to the "Infection Control - COVID" metric and highlighted the key points therein, which included that a Trust-wide incident meeting had been scheduled in response to the increase in the number of Clostridioides Difficile (C. Diff) cases, which reflected the national position, to investigate the root cause; details of the Kent and Medway C. Diff collaborative; and that the Trust continued to strive to achieve the national target of a 5% reduction in the rate of Hospital E. Coli per 100,000 occupied bed-days.

WW queried the severity of the increase in C. Diff cases and asked whether the Trust had the appropriate measures in place to address the issue. JH firstly provided assurance that no instances of cross-contamination between patients had been identified at the Trust. JH then outlined the root causes for the increase in C. Diff cases which included the change in antibiotic prescribing in response to COVID-19. JH continued that a meeting had been scheduled for the week commencing 31/07/23 to assess the Trust’s response and investigate what, if any, lessons could be learned from other Trusts. WW asked whether the Trust had previously experienced the current levels of C. Diff cases. PM confirmed that was the case in 2004/5; however, there had been significant improvements implemented by SM which had resulted in the Trust subsequently experiencing an exceptionally low case rate for C. Diff. PM continued that the current rise in C. Diff cases was associated with external factors and that such an increase had been replicated both regionally and nationally and outlined the differences between the current increase in C. Diff cases and the increase in C. Diff cases in 2004/5. JH then provided assurance that the planned C. Diff outbreak meeting included representatives from various staffing groups.

DH asked whether representatives from the Kent and Medway Integrated Care Board (ICB) provided expertise to the Kent and Medway C. Diff collaborative or whether their role was to facilitate the dissemination of the lessons learned nationally to providers within the Kent and Medway Integrated Care System (ICS). JH confirmed that the role of the Kent and Medway C. Diff collaborative was to facilitate the dissemination of lessons learned and ensure that Trusts were informed of any national developments.

SB referred to the “Patient Access” Strategic Theme and explained the latest position in relation to the “RTT Performance”, “Outpatient Calls answered <1 minute”, “Outpatient Clinic Utilisation”, “Planned levels of Diagnostics activity”, and “Planned levels of Outpatient Flow Up Activity” metrics and highlighted the key points therein, which included the adverse impact on staff morale of industrial action; the request which had been received from Northumbria Healthcare NHS Foundation Trust to visit the Trust as part of a lessons learned exercise in relation to Emergency Department performance; the reduction in the Cancer Patient Tracking List (PTL) backlog; and the discussions which had ben held at the Finance and Performance Committee in relation to the Trust’s Outpatients performance metrics to ensure the Trust focused on the appropriate metrics.

JH referred to the “Patient Experience” Strategic Theme and explained the latest position in relation to the “Complaints responded within target” metric which included the ambition to achieve 75% of

complaints responded to within target by September 2023; and commendation of the Trust's Clinical Divisions for their continued effort to maintain and improve the Trust's performance.

JH then continued and explained the latest position in relation to the "FFT Response Rates – Inpatients, A&E, Outpatients and Maternity" metric and highlighted the key points therein, which included the improved response rate within the Trust's Emergency Departments and Maternity Services; the intention to transition to a new Friends and Family Test provider; and that the Trust's performance would be compared to other NHS Trusts within Kent and Medway to investigate what, if any, lessons could be learned.

RJ referred to the "Systems" Strategic Theme and explained the latest position in relation to the "Discharge before Noon" metric and highlighted the key points therein, which included that the intention to achieve the 33% national target for number of patients laving the Trust before noon on the day of the discharge; the challenges presented by the utilisation of the 'nil' reason on Teletracking in terms of identification of the root causes for delays in discharge; that Electronic Discharge Notifications (EDNs) were scheduled for 'go live' on the 'Sunrise' Electronic Patient Record (EPR); and that potential cultural changes were under investigation to improve the Trust's performance.

WW asked when the Trust expected to achieve a further improvement in the number of patients discharged before noon. RJ replied that the 'go live' of Electronic Discharge Notifications (EDNs) on the 'Sunrise' Electronic Patient Record (EPR) was expected to enable significant improvements and noted that initial improvements were anticipated in August 2023.

NG asked how the Trust compared to other Trust's within the Kent and Medway ICS in terms of discharges before noon. RJ confirmed that the Trust was performing positively compared to other NHS Trusts within the Kent and Medway ICS and outlined the programme of work to explore what, if any, innovative approaches were utilised nationally.

DH asked whether the skill mix at the Trust was a factor in the number of discharges before noon and noted that some other Trusts had higher numbers of Physician Associates. RJ confirmed that skill mix would be a factor in increasing the number of discharges before noon and noted that an increase in senior staff on the wards as well as a focus on criteria led discharge would enable sustained improvements. RJ then emphasised the importance of improved staff rostering. PM added that the Trust intended to increase the number of Physician Associates employed in due course; however, further confirmation was required nationally in regards to the governance arrangements related to prescribing by Physician Associates. DH commented that the intention was to provide Physician Associates was prescribing responsibilities in 2024.

MC asked what the limiting factors were in relation to the discharge of patients that no longer met the criteria to reside for inpatient care and queried whether any additional support could be provided to community providers. RJ acknowledged the challenges in relation to external capacity within community providers to support the discharge of patients that no longer met the criteria to reside for inpatient care and outlined the programme of work within the West Kent Health and Care Partnership (HCP) to ensure accurate data regarding the availability of community beds and enable an informed decision-making process in relation to future investment to improvement patient flow. RJ then outlined the collaborative working approach which had been developed and noted the challenges nationally in terms of packages of care.

SO referred to the "Sustainability" Strategic Theme and explained the latest position, which included that the Trust was £1.1m adverse to plan due to the impact of industrial action and insufficient delivery of Cost Improvement Programmes (CIPs); the national guidance which had been received in relation to reporting of Elective Recovery Fund (ERF) income; that it had been agreed that the ERF performance target for April 2023 would be reduced from 107% to 105% in response to industrial action and that discussions were ongoing in relation to the approach to be adopted for June and July 2023' the anticipated impact of improvements to the Trust's rostering approach; the establishment of a Monthly CIP Delivery Board; the additional "Delivery of the variable Elective Recovery Funding (ERF) plan - £000" and "Delivery of Other Variable Income (Non-ERF) plan - £000" metrics which had been included in the submitted report; the expected increase in variable

income via the Community Diagnostic Centre (CDC); and that rationale for the reporting the additional data on a cumulative basis.

DH referred to the "Leased/IFRS 16 capital" section of the submitted report queried why the potential new lease capitalisation for the Kent and Medway Medical School (KMMS) accommodation was £15.3m when the expenditure for the KMMS accommodation was c.£23m. SO replied that only the KMMS accommodation had been capitalised as an operating lease, rather than for the full life expectancy of the asset and was therefore based on the Trust's expenditure during the operating lease.

DH referred to the "mechanism for accessing the funding has yet been confirmed or notified to Trusts" statement in relation to International Financial Reporting Standard (IFRS) 16 capital and highlighted the risk in relation to the Trust being unable to utilised any funding which had been requested. SO replied that full confirmation of the mechanism for accessing funding had also not ben confirmed in 2022/23; however, noted the additional risks in 2023/24 as some proposals may only receive partial funding; although advised that the Trust proceed with any proposals which had been agreed to date but exercise caution in relation to any new proposals.

RF asked whether there was sufficient focus on the identification of recurrent CIPs for future financial years and if a medium to long-term CIP strategy had been developed. SO replied that the Trust was currently focused on improving the CIP position for 2023/24; however, a number of the CIPs had a partial impact on future years or that would not be fully delivered until 2024/25. SO then outlined the programme of work in conjunction with RJ to ensure that the Business Case process appropriately captured the benefits associated with any proposed developments. SO continued that the majority of tactical opportunities had been exploited, therefore, future years required an enhanced focus on strategic and transformational initiatives to deliver the required reduction in expenditure such as the introduction of new roles and skills. SO added that initial work had commenced with the Trust's Clinical Divisions to investigate alternative methods for the delivery of care; although, noted that any financial benefits were unlikely to be realised until 2024/25. SO concluded that a robust CIP plan for 2024/25 would be available by the end of the current calendar year and noted the further discussions required with Operational Teams to identify additional recurrent CIPs. SO agreed to consider, and confirm to the Trust Secretary's Office, the scheduling of a "Review of the Trust's 2024/25 Cost Improvement Programmes (CIPs)" item at a future Finance and Performance Committee.

Action: Consider, and confirm to the Trust Secretary's Office, the scheduling of a "Review of the Trust's 2024/25 Cost Improvement Programmes (CIPs)" item at a future Finance and Performance Committee (Deputy Chief Executive / Chief Finance Officer, July 2023 onwards)

WW noted the constraints in terms of capital expenditure within the NHS and queried whether it would be beneficial to understand those assets which would require replacement, via capital, within the next 3-5 years to ensure that sufficient levels of service delivery were maintained. SO replied that over the next 3-5 years additional capital would need to be ringfenced for infrastructure expenditure which was broadly divided into three categories (i.e. IT, Equipment and Estates); however, the significant challenge was that NHS Trust's only generated sufficient capital to replace currently owned assets which prevented the allocation of capital for service developments. SO then noted the intention to develop a set of principles which underpinned the Trust's capital programme and enabled additional investment in the Trust's existing infrastructure; although, acknowledged the innovative approaches which would be required for service developments. SO provided assurance that the capital programme was reviewed at the Finance and Performance Committee.

Quality Items

07-19 <u>Quarterly Maternity Services report</u>

RT referred to the submitted report and highlighted the key points therein, which included the one 'Never Event' which had been declared within the reporting period; that three incidents had been submitted to the Healthcare Safety Investigation Branch (HSIB), two of which had no recommendations identified as part of the Trust's Serious Incident (SI) investigation process and the other had highlighted issues with the Trust's Did Not Attend (DNA) process; one stillbirth had been

had reviewed by the Perinatal Mortality Review Tool (PMRT); there had been an increase in the number of incidents of obstetric haemorrhages of over 1500mls, which was due, in part, due to a change in the method by which blood loss was measures and the increase in Caesarean-Sections; that the Trust's was below the national average for the first feed rate of breast milk and the measures which had been implemented to improve the Trust's performance; and the continued work to identify Fetal growth restriction.

MC asked what, if any, actions would be implemented to improve breastfeeding rates at Tunbridge Wells Hospital. RT replied that the establishment of a breastfeeding café was currently being investigated, although appropriate accommodation had not yet been identified, and that a Breastfeeding Midwife had been employed at TWH. RT continued that the Maternity Services Team were investigating the root cause for the lower breastfeeding rates at TWH.

MS asked whether the incidents which were submitted to the HSIB underwent the Trust's Serious Incident investigation process prior to submission. RT confirmed that such incidents were immediately submitted to the HSIB; however, also underwent an internal 72-hour SI review. MS asked whether any additional actions had been identified by the HSIB. RT clarified that the incidents remained under investigation by the HSIB; however, provided assurance that the Trust compared the recommendations to those of the Trust's SI investigation process and noted that the latest HSIB report had not made any safety recommendations.

MS queried whether there was a further review of the Trust's Maternity Services by the Regional Maternity Team scheduled and noted the associated benefits. RT replied that no further visits were planned; although, noted that assurance regarding the Trust's Maternity Clinical Negligence Scheme for Trusts (CNST) compliance would be submitted to the 'Part 1' Trust Board meeting in December 2023. MS requested that JH liaise with RT to consider whether it would be beneficial to request the Regional maternity team to facilitate a further review of the Trust's Maternity Services:

Action: Liaise with the Director of Maternity to consider whether it would be beneficial to request the Regional maternity team to facilitate a further review of the Trust's Maternity Services (Chief Nurse; July 2023 onwards)

KC referred to the two new red rated risks and asked whether there were any mitigations which focused on education, cultural and behaviour change, and team dynamics. KC queried what actions were required to reduce the risk rating for red to either amber or green. RT replied that, in terms of compliance failure with swab counting policy, After-Action Reviews (AARs) had been implemented to support immediate learning, and the development of a Local Safety Standards for Invasive Procedures (LocSSIPs) was under consideration. RT added that compliance with the swab counting policy had been identified as a key project under the Divisions Strategy Deployment Review (SDR) process to ensure there was appropriate oversight. RT commented that, in terms of the red-rated risk related to consent, there was a national challenge associated with the communication of consent and the associated patient expectations and that a 'deep dive' had been conducted into the Maternity Services Complaints for 2022 to investigate if the issues were replicated at the Trust. RT continued that a variety of measures would be implemented to improve the communication of consent requirements include the development of infographics for those patients without English as a first language and noted the intended involvement of the Maternity Voices Partnership in the programme of work. RT then detailed the respectful vaginal examinations project which had been developed and the further work which was required.

JH highlighted that World Breastfeeding Week commenced on the 1st August 2023 followed by the Ethnic Minority Breastfeeding Week which commenced on the 25th August 2023 and outlined the events which had been scheduled.

Workforce

07-20 <u>The NHS Long Term Workforce Plan</u>

SS referred to the submitted report and highlighted the key points therein, which included that the NHS long-term Workforce Plan covered a 15-year period, however, further detail was required in relation to the medium- to long-term initiatives; an investment of £2.4bn had been committed to

support the delivery of the NHS Long Term Workforce Plan; the three key pillars which had been identified (i.e. 'train', 'retain' and 'reform'); the importance of robust recruitment; the current vacancies within the NHS nationally which did not consider further growth requirements; the further work required to improve the staff development; the importance of identifying key, deliverable, milestones; the immediate next steps which had been identified for the Trust; the benefits associated with the development of the Nursing and Midwifery Five-year plan and the intention to develop an overview of each key area by operational group; the main priorities which had been developed for the Kent and Medway ICB; the discussions which were ongoing at a national level to inform the development of the key workstreams associated with the NHS Long Term Workforce Plan, and the Trust's involvement in such discussions; the increased importance of promoting the Trust's Employee Value Proposition (EVP to ensure that the Trust attracted high-quality candidates; and an overview of the discussions which had been held at the Executive Team Meeting regarding the issues associated with the availability of the infrastructure to support the delivery of the NHS Long Term Workforce Plan.

SO highlighted that the NHS Long Term Workforce Plan primary focused on the clinical requirements of the NHS and lacked the appropriate focus on support roles which provided a crucial role in the delivery of efficient patient care. SO then queried whether the 'Messenger Review' had been incorporated into the NHS Long Term Workforce Plan or whether it formed a standalone document. SS confirmed that there were references to the 'Messenger Review' included within the NHS Long Term Workforce Plan and that the key themes had been duly incorporated. SS continued that there was a robust focus on upskilling leadership and managers to reduce the turnover rated within the first 12 months of employment.

WW asked what, if any, consideration had been applied to changing workforce dynamics and the associated upskilling which was required with the increased focus on multidisciplinary working patterns. SS replied that discussions had been held regarding the changes in patient demographics and the increased prevalence of comorbidities and provided assurance that there was a focus on ensuring the Trust's workforce was positioned to adapt to patient requirements to continue to delivery the best possible patient care. SS outlined the focus on associate, non-specialist, and multidisciplinary roles.

RF acknowledged the importance of the NHS Long Term Workforce Plan; however, emphasised the need to develop a comprehensive Trust-wide workforce plan which incorporated all staff groups at the Trust. RF continued that the Trust-wide workforce plan should encompass an enhanced focus on team development and leadership and expressed concerns that the funding which had been identified nationally may not materialise as other national priorities developed; therefore, the Trust should be cognisant of alternative funding approaches. SO highlighted the potential financial impact for the Trust, beyond the nationality allocated funding, to enable the required training to be delivered.

Systems and Place

07-21 Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

RJ referred to the submitted report and highlighted the key points therein, which included an update on the discussions which had been held regarding the development of Provider Collaboratives; the new forums which had been introduced; and details of the new red-rated risk associated with the lack of funding available to support the development of Integrated Neighbourhood Teams (INTs).

DH emphasised the importance of further clarification regarding the key roles and responsibilities at each level within the Kent and Medway Integrated Care System and noted that further discussions would be held with MS, external to the meeting, to seek additional clarification from the Kent and Medway ICB.

Planning and strategy

07-22 The NHS equality, diversity, and inclusion improvement plan

SS referred to the submitted report and highlighted the key points therein, which included details of the key actions for NHS organisations and ICBs and the associated timelines. SS then recommended that a dedicated discussion should either be held at a future Trust Board Seminar or Trust Board 'away day'.

DH suggested that a Trust Board seminar, which focused on the Integration of EDI into all aspects of the Trust's Culture, be scheduled following a future Trust Board meeting. This was agreed.

Action: Liaise with the Chair of the Trust Board to confirm the scheduling of a Trust Board Seminar which focused on the integration of Equality, Diversity and Inclusion into all aspects of the Trust's culture (Assistant Trust Secretary, July 2023 onwards)

DH then noted the discussions which had been held at the Trust Board 'away day' regarding the implementation of a further reverse mentoring programme for Trust Board members. MS supported the importance of revisiting the reverse mentoring programme and requested that SS develop, and implement, a further reverse mentoring programme for Trust Board members which encompassed a range of protected characteristics.

Action: Develop, and implement, a further reverse mentoring programme for Trust Board members which encompassed a range of protected characteristics (Chief People Officer, July 2023 onwards)

07-23 Annual approval of the Trust's Green Plan

DMo referred to the submitted report and highlighted the key points therein, which included the objectives for the Trust; the establishment of the Green Champion Network; and the outputs from the first meeting of the Green Champion Network.

DM noted that the majority of NHS emissions resided within the "Scope 3: Indirect" category; therefore, the key area of focus should be on influencing the Trust's suppliers and those individuals which utilised the Trust's services. DMo detailed the key areas of focus for the Green Champions in terms of reducing the Trust's emissions; although, acknowledged that there was a significant programme of work required to reduce those emissions within the "Scope 3: Indirect" category.

WW highlighted the increased utilisation of solar panels within the Private Sector and asked whether the Trust had explored the utilisation of finance initiatives to support the installation of solar panels without the requirement of capital expenditure by the Trust. DMo replied the utilisation of solar plans had been incorporated into the Trust's Estates Plan and noted the intended discussions with Mitie's Sustainability Team to explore how they could support the Trust to generate electricity internally as well as access external funding. WW supported the importance of offsetting the expenditure required by the Trust. DMo then outlined the potential alternative utilisation of the Trust's steam boilers. SO then provided assurance that the Trust was actively investigating any available external funding sources.

The Trust's Green Plan was approved as submitted.

07-24 To approve the Business Case for the Cardiac Catheter Lab Equipment Replacement (Managed Service Agreement)

The content of the submitted report was noted.

The Business Case for the Cardiac Catheter Lab Equipment Replacement was approved as submitted.

Assurance and policy

07-25 Quarterly update from the Freedom to Speak Up Guardian

CL referred to the submitted report and highlighted the key points therein, which included thanks for the support provided by the Trust Board for the Freedom To Speak Up (FTSU) agenda; details of the interim solution to ensure the continued provision of the FTSU Service; an overview of the concerns which had been raised within the reporting period; the further work which was required with the People and Organisational Development Function to improve the culture within specific

service areas; and that the concerns which had been raised reflected the key themes from the Trust's 'listening events'.

SS thanked CL for their commitment during their tenure at the Trust and the support which had been provided to Trust staff. DH echoed the commendation.

Other matters

07-26 To consider any other business

There was no other business.

07-27 To respond to questions from members of the public

DJ confirmed that no questions had been submitted.

07-28 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
06-24	Schedule a "Confirmation of the updated Vision Goals, Vision Targets, Breakthrough Objectives and Corporate Projects" item at the Trust Board in July 2023.	Trust Secretary	September 2023	The item was scheduled for July 2023, but the Director of Strategy, Planning and Partnerships then requested a deferral to the Trust Board meeting in September 2023. A report has therefore been submitted to the Trust Board's meeting in September 2023.
07-18	Consider, and confirm to the Trust Secretary's Office, the scheduling of a "Review of the Trust's 2024/25 Cost Improvement Programmes (CIPs)" item at a future Finance and Performance Committee.	Deputy Chief Executive / Chief Finance Officer	September 2023	The item will be considered at the Finance and Performance Committee in October 2023.
07-19	Liaise with the Director of Maternity to consider whether it would be beneficial to request the Regional maternity team to facilitate a further review of the Trust's Maternity Services.	Chief Nurse	September 2023	Since the Trust Board meeting in July, the Trust's maternity services has been subject to an inspection by the Care Quality Commission (CQC), while the Regional Midwife and Director for Maternity and Neonatal Services for the NHS Kent and Medway Integrated Care Board have also recently visited so in view of this a further review of the service is not considered necessary.
07-22a	Liaise with the Chair of the Trust Board to confirm the scheduling of a Trust Board Seminar which focused on the integration of Equality, Diversity and Inclusion into all aspects of the Trust's culture	Assistant Trust Secretary	September 2023	Liaison occurred and a Trust Board Seminar has been scheduled for the afternoon of 28/09/23.

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
07-22b	Develop, and implement, a further reverse mentoring programme for Trust Board members which encompassed a range of protected characteristics.	Chief People Officer	September 2023	A reverse mentoring scheme has been designed and approved with the Executive Team. The programme will commence in November 2023.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
05-16	Liaise with the Executive Directors to undertake a light-touch review of the Trust's compliance with the new NHS Provider Licence conditions.	Trust Secretary	September 2023	It was subsequently agreed to submit a report to the Trust Board meeting in September 2023 (having been reviewed at the Executive Team Meeting (ETM) beforehand). However the Chair of the Trust Board subsequently requested a deferral to October 2023, due to the size of the agenda for the September 2023 Trust Board meeting.

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?
02/08/2023	Consultant General Radiologist	Daniel	Poon	Radiologist	01/11/2023	New post
11/08/2023	Consultant Respiratory	Goparaju	Reddy	Respiratory Medicine	06/11/2023	New post
30/08/2023	Consultant Paediatrician with special interest in High dependency	Emma Rose	Collinson	Paediatric	02/01/2024	New post
30/08/2023	Consultant Paediatrician with special interest in High dependency	Sabina	Wildman	Paediatric	02/01/2024	New post
13/09/2023	Consultant in Diabetes & Endocrinology	Syed	Bitat	Diabetes & Endocrinology	09/10/2023	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:

- We experienced further rounds of industrial action over the summer by our junior doctors and consultants, with the latest taking place last week. Joint action is now also planned for 2-4 October. The Trust's plans to prepare for industrial action are now well practiced, and our previous experience has enabled us to focus on making improvements that will help minimise the impact on our patients. This includes strengthening our sites over weekends to ensure we continue to provide all patients with the best possible care, as well as implementing additional services such as phlebotomy and pharmacy. This has taken a huge amount of effort from both clinical and administrative staff and I would once again like to thank them, on behalf of the Trust, for their commitment to our patients.

- With the news of school closures across the country due to a building material known as Reinforced Autoclaved Aerated Concrete (RAAC), our Estates and Facilities team have carried out an extensive survey of our sites. We can confirm that RAAC is not present in any of our buildings, including our off-site leased buildings.

- Following the Lucy Letby trial, the importance of having a strong patient safety culture has been emphasised across the healthcare sector, and we made sure to engage with our Neonatal Unit colleagues and the parents on the Unit at the time. Creating a culture of openness and learning is fundamental to the way we work at MTW. Our fortnightly new starter inductions include a session on how to raise a concern, and we also have a Freedom to Speak Up Guardian (FTSU) role which supports staff to speak up when they feel they are unable to in other ways. As a Trust, we want to ensure everyone feels able to raise a concern, which will help us to improve the care we provide to our patients, as well as the working environment and support for colleagues. A report on the letter that NHS England (NHSE) issued after the trial verdict has been submitted to the Trust Board meeting under a separate item.

- In March, inspectors from the Care Quality Commission (CQC) visited both Maidstone and Tunbridge Wells hospitals. They carried out a Well-Led review of the Trust and reviewed one service, End of Life Care. I am pleased to report that we have been rated as Good for Well-Led. Disappointingly we have been rated Requires Improvement for End of Life Care and have already taken steps to address the issues raised by the CQC in this area.

  We received many positive comments from the inspectors, who recognised the compassion and care shown to patients by staff in every department.

  This was a limited CQC inspection and the majority of our services were not inspected. As a result, while our specific ratings for End of Life Care and leadership across the Trust have been updated, our overall rating as an organisation has not changed. This overall rating remains Requires Improvement, which is based on the findings of the CQC's last comprehensive inspection in 2017. While the limited scope of the inspection meant we could not improve our overall rating, I am confident this will change when the CQC introduce a new inspection process.

  We welcomed the CQC again earlier this month, this time for a planned inspection of our Radiotherapy services at Maidstone Hospital. I will provide a further update once we have received feedback from their visit.

- Work continues at the Trust on a number of improvement plans, and we will use the CQC inspectors' feedback to further develop these. This includes pushing forwards with our widescale infrastructure developments, including the construction of the Kent and Medway Orthopaedic Centre (KMOC) at Maidstone Hospital. Ahead of the operational start date in

March next year, the project is progressing as planned with all modular units now installed and internal works started in the plant room and theatres areas. As well as the build, our recruitment work is also moving forwards. Overseas recruitment is on track for nursing, and allied health professional (AHP) recruitment for overseas staff is due to start in September. UK recruitment is in progress and will continue over the coming months.

- The fantastic work of our colleagues has been recognised in a number of ways over recent weeks:

  - *The Telegraph* has been ranking all acute trusts in England according to performance for the past year. Earlier this year MTW was ranked as fifth best performing trust, however we're absolutely delighted that, as of 10 August. we are now ranking in third place. This is an incredible achievement and wouldn't be possible without the hard work and dedication of the exceptional people who work here at the Trust.

    The Telegraph's NHS data tracker focusses on metrics including length of waiting lists, number of patients being seen in A&E within four hours, mortality rates, ambulance response times, how quickly cancer treatment is started after diagnosis, length of wait for diagnostic tests and wait time for face-to-face GP appointments.

  - The latest Sentinel Stroke National Audit Programme (SSNAP) has awarded an overall A-rating to the Stroke Unit at Maidstone Hospital. The latest results mean the Unit is currently the highest-rated stroke service in the Kent and Medway region, placing MTW in the top 5% of acute trusts in the country for stroke care.

    The national healthcare quality improvement programme measures how well stroke care is being delivered in the NHS in England. The SSNAP provides information to clinicians, commissioners, patients and the public which can be used to improve the quality of care that is provided to patients.

    As part of their overall A-rating, our Stroke Unit's performance was above the national average in a number of areas, including patient assessment times and the provision of therapy.

  - It is also fantastic to see the Trust shortlisted for the Performance Recovery Award at the Health Services Journal (HSJ) Awards 2023, recognising MTW's contribution to delivering outstanding patient care.

    A record-breaking 1,456 entries were received for this year's HSJ Awards, which recognise innovation and improvements in care. Against a backdrop of increasing demand for services, our entry highlighted the many new ways of working we have introduced to ensure patients in our local communities receive some of the fastest access to treatment in the country. These have included our real-time bed management system, the increase of our Same Day Emergency Care pathways, and investments in staff training and service developments.

    The winners of the HSJ awards will be announced at a ceremony due to be held on 16 November.

- Making improvements to our services so teams are able to work more efficiently and provide the highest levels of care is one of our key priorities. In addition to the developments mentioned above, we have also recently rolled out a new Picture Archiving and Communications Systems (PACS).

  This was the culmination of a two-year Kent-wide project alongside Medway NHS Foundation Trust and East Kent Hospitals University NHS Foundation Trust. The work saw the migration of more than 30 million images, including x-rays and CT scans, and has enabled the sharing of images across Kent and Medway which supports more efficient reporting and quicker patient diagnosis. Clinicians will be able to view all PACS images and reports from Medway and East Kent, bringing together a single record across the hospital trusts.

- As we start heading towards our most challenging months and move on with our winter planning, partnership working continues to be key. The Trust has recently begun a pilot for a new clinical pathway hub alongside South East Coast Ambulance Service (SECAmb) and Kent Community Health NHS Foundation Trust (KCHFT). The trial supports joint decision making, with ambulance crews considering whether patients require transport to ED or could receive more appropriate treatment elsewhere.

  On its first day, nine ambulance attendances at our emergency departments were avoided. I will keep the Board updated as the project develops.

- We are continuing efforts to increase outpatient clinic utilisation with the introduction of our new patient portal later this year. Powered by Patients Know Best through the NHS app, the portal will help us to reduce did not attend (DNA) rates and widen our capacity. Once the portal is live, our patients will be able to amend and cancel their appointments via a few clicks on their personal devices, saving them time calling into our teams and freeing up clinic space for others to book into. Our teams are currently finalising the implementation, and demos have given staff the opportunity to see the portal in action and relay any feedback to the project team.

- We want our patients and their families to be involved in every aspect of their care as we continue to focus on ensuring the needs of every person walking through our doors are met.

  As part of our drive for continuous improvement, we are currently in the process of building our new patient experience strategy, which follows on from the previous strategy published in 2018. The new strategy will aim to engage better with patients and work collaboratively with the local community.

  We will be running a consultation period throughout October, and will then develop our new strategy based on feedback received, with the aim of launching in Spring 2024. We are currently encouraging patients to tell us about their most recent experiences of using our services, and have also approached staff to provide their feedback.

- A new playroom for our young patients and their siblings has opened at Tunbridge Wells Hospital. The playroom will also be used by our Health Play Specialists, who help children and young people to understand their conditions and treatments through play techniques.

  The new space, which was made possible thanks to a generous donation from the Tunbridge Wells Hospital League of Friends, will provide a designated space for children to play and relax in during their stay. Play helps to normalise the hospital environment and encourages the child's development throughout their time in hospital, as well as helping to keep them motivated.

  On behalf of the Trust, I would like to thanks the League of Friends at Tunbridge Wells Hospital for their continued support in helping us to enhance the services we offer to our patients.

- Consultant Breast and Oncoplastic Surgeon, Deepika Akolekar, took on an epic climb to the summit of Mount Kilimanjaro over the summer, to help fund new cancer technology which will support patients across the region.

  Deepika, who leads our fantastic team in the Peggy Wood Breast Unit at Maidstone Hospital, was part of a group of seven who successfully reached the summit with the aim of raising £100,000 for Breast Cancer Kent to purchase a Faxitron. This state-of-the-art machine will revolutionise the care for patients with breast cancer in Kent and Medway by helping speed up turnaround times for important pathology results.

  Local MP Tracey Crouch, who was cared for by experts at our Trust after being diagnosed with breast cancer three years ago, also took part in the challenge.

- Our Emergency Department (ED) at Tunbridge Wells Hospital is one of three hospital EDs which will feature in a new Channel 5 series.

Provisionally called 'A&E After Dark', filming began two weeks ago and will be taking place in the evenings and overnight up until the first week in October. The series will focus on our colleagues who form one of the best performing EDs in the country, alongside our patients and families receiving treatment from the very busy service.

The production team have a wealth of experience in documentary programming in the healthcare sector, with rigorous filming protocols and consenting procedures in place. The crew visited the ED team in the month leading up to filming, to get to know staff and answer any queries they may have.

The series is due to air over winter and will give our Trust the opportunity to show a national television audience the amazing care our staff offers to patients every day.

- We are recognising the Trust's Employee of the Month for both July and August in this report.
  - Congratulations to the winners of the Employee of the Month award for July, Joe Brooks and Zack Corse, both from our Clinical System Support Services. Joe and Zack have worked together to adapt and develop the cataract model. This has ensured that staff can complete the cataract one stop clinic in the most efficient way. Miranda Selby-Shakespeare, Medway Eye Unit Manager, also received the Highly Commended award for the support she offers her team and for always looking at how the Unit can evolve to provide the best service for patients.
  - Congratulations also to the winner for the Employee of the Month award for August, Beena Sandhu, who is the HR Business Partner for our Estates and Facilities team. Thanks to Beena's work, the Facilities team has achieved huge improvements, including a 100% appraisal rate and a decrease in sickness levels. Beena is described as a model HR Business Partner, who always aims to be part of the solution. The team on our John Day Ward also received the Highly Commended award for their courage and professionalism when dealing with an incident involving a patient accidentally setting fire to themselves in a bay of other patients. Their skill and team work prevented the patient and those around them from sustaining any harm or serious injury.

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

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

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

Summary report from Quality Committee, 09/08/23 Committee Chair (Non-Exec. Director)

The Quality Committee met (face-to-face / in-person) on 9th August 2023 (a 'deep dive' meeting).

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

- The **actions from previous meetings** were noted.
- The Chief of Service, Medicine and Emergency Care; Assistant General Manager, Diabetes and Endocrinology; Clinical Director, Medical Specialties; Head of Nursing, Medical Specialties; and Clinical Lead, Diabetes and Endocrinology presented a **review of the management of diabetes at the Trust** which provided a comprehensive overview of the areas of notable good practice, the positive feedback which was received from senior trainees at the Trust and the impacts of technological innovations on the provision of patient care. A discussion was then held regarding the limiting factors in relation to the transition of Type 1 diabetes patients to insulin pumps. It was agreed that the Chief of Service, Medicine and Emergency Care; and Clinical Lead, Diabetes and Endocrinology should provide Committee members with details of the percentage of inpatients at the Trust with Type 1 diabetes that developed Diabetic ketoacidosis (DKA) compared to the national average and local NHS Trusts. It was also agreed that the Clinical Lead, Diabetes and Endocrinology should provide the Chief Nurse with feedback regarding what, if any, issues were experienced by the Community Diabetes Team (e.g. challenges connecting the wireless network in General Practice Surgeries).
- The Lead Nurse for Tissue Viability and Tissue Viability Clinical Nurse Specialist presented an **update of the management of pressure ulcers** which provided Committee members with details of the prevalence of community and hospital acquired pressure ulcers (HAPU); the key themes which had emerged from root cause analysis (RCA) investigations HAPUs; and the progress which had been made against the recommendations which were discussed at the Committee's meeting in February 2023. The Committee acknowledged the significant progress which had been made and noted the further work which was required to address the limiting factors in relation to the prevention of pressure ulcers. It was agreed that the Chief Nurse and Lead Nurse for Tissue Viability should liaise to consider what, if any, alternative approaches could be adopted to reduce the delays in Dietitian referrals being completed for patients with pressure ulcers.
- A key theme which emerged from both presentations was the wide-reaching impacts of the new InPhase Incident Reporting and Risk Management System and the 'Sunrise' Electronic Patient Record (EPR) and associated the importance of the development of robust reporting dashboards to ensure sufficient assurance was provided in regards to key areas of concern. A further discussion is intended to be held a future Quality Committee 'deep dive' meeting.
- The Committee reviewed the **items scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, and it was confirmed that the October 2023 Quality Committee 'deep dive' meeting would focus on a "Review of the Trust's Mental Capacity Act (MCA) compliance; Learning Disability Mortality Review (LeDeR) programme; and findings of the further audit of DNACPRs for patients with Learning Disabilities"; although it was acknowledged that further refinement of the scope of the Committee's request was required.

2. In addition to the agreements referred to above, the meeting agreed that:

- The Assistant Trust Secretary should schedule a "Further update on the management of Diabetes at the Trust (incl. future demand modelling and the initiatives to support improved patient outcomes)" item at the February 2024 Quality Committee 'deep dive' meeting.
- The Assistant Trust Secretary should schedule a "Further update on the management of pressure ulcers (incl. the progress with the implementation and embedding of the Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T))" item at the February 2024 Quality Committee 'deep dive' meeting.

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

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

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

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

Quality Committee, 13/09/23 **Committee Chair (Non-Executive Director)**

The Quality Committee met on 12th September (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**.
   - The **reports from the Committee's sub-committees** (The Complaints, Legal, Incidents, PALS, Audit, Risk and Mortality (CLIPARM) group; The Infection Prevention and Control Committee; The Sepsis Committee; The Drugs, Therapeutics and Medicines Management Committee; The Health and Safety Committee; and the Joint Safeguarding Committee) were considered, wherein the Committee acknowledged the improvement in the rate of Clostridioides Difficile (C. Diff) infections at the Trust and the action plan which had been developed to improve Mental Capacity Act (MCA) assessment compliance. It was agreed that the Director of Maternity and Chief of Service, Women's, Children's and Sexual Health should ensure that the Women's, Children's and Sexual Health Divisional Governance report to the November 2023 'main' Quality Committee meeting includes details of the action plan to address the areas for improvement identified within the Paediatrics Department. It was also agreed that the Chief Operating Officer should ensure that the "The Health and Safety Committee" report to the November 2023 'main' Quality Committee meeting includes assurance regarding the management of health and safety at the Trust's satellite locations.
   - The report from the last **Quality Committee 'deep dive' meeting** was noted.
   - The issues raised from the **reports from the clinical Divisions** included details of the significant staffing challenges within the Women's, Children's and Sexual Health Division; the programme of work to improve compliance with the Trust's Swab Count Policy; the increase rate of incident reporting related to incidents of low or no harm, which supported a culture of learning; the progress with key service developments; and the further work which was required to improve compliance with the Trust's internal duty of candour performance targets. It was agreed that the Divisional Director of Nursing and Quality, Surgery should Explore whether additional advertisements for Consultant Anaesthetist posts should be implemented, to address the staffing requirements of the Kent and Medway Orthopaedic Centre. It was also agreed that the Chief of Service, Women's, Children's and Sexual Health should provide Committee members with details of the current staffing challenges within the Women's, Children's and Sexual Health Division and what, if any, mitigations have been implemented.
   - The Women's, Children's and Sexual Health Divisional Governance report included the latest "Quarterly Maternity Services report" which has been submitted to the Trust Board under a separate agenda item.
   - The Deputy Chief of Service, Medicine and Emergency Care presented an **update on the management of Sepsis at the Trust** wherein the Committee noted the further work which was required to increase clinical engagement with the Trust's Sepsis education programme and the importance of the implementation of a Matron for the Deteriorating Patient role. It was agreed that the Deputy Chief of Service, Medicine and Emergency Care should liaise with each of the Chiefs of Service to develop Division specific action plans in relation to the management of sepsis and the provision of the associated training.
   - The Deputy Chief Nurse, Quality and Experience presented the J**oint Safeguarding Annual Report, 2022/23** which provided a comprehensive overview of the increase in safeguarding activity and the oversight which was provided by the Kent and Medway Integrated Care Board (ICB).
   - The Chief of Service for Medicine and Emergency Care presented the latest **Mortality update** and it was agreed that the Chair of the Quality Committee should liaise with the Trust's Medical Director to investigate whether it was feasible to obtain a breakdown of the Trust's mortality data by ethnicity and social deprivation, to enable the Committee to understand whether there were any underlying trends of concern.
   - The latest **Serious Incidents (SIs),** which included the report from the Learning and Improvement (SI) Panel, were reported by the Patient Safety Manager which included a

comprehensive overview of the progress with the closure of open SIs and the further work required to improve duty of candour compliance.

- The Deputy Chief Nurse, Quality and Experience provided the latest **update on the work to achieve an 'Outstanding' CQC rating** wherein the Committee were informed of the progress with the development of an action plan in response to the findings of the recent CQC inspections and the potential implications of the new CWC assessment framework, which had not yet been implemented, were acknowledged.
- The **recent findings from relevant Internal Audit reviews** were noted.
- Under **Any Other Business** it was agreed that the Assistant Trust Secretary should ensure that the November 2023 'main' Quality Committee meeting was scheduled as a Microsoft Teams meeting.

2. In addition to the agreements referred to above, the meeting agreed that:

- The Director of Quality Governance should ensure that future Divisional Governance reports provided additional assurance regarding the measures to improve Duty of Candour compliance.
- The Clinical Director of Pharmacy & Medicines Optimisation should liaise with the Chief Operating Officer to explorer what, if any, options were available regarding the provision of accommodation for the COVID-19 Medicines Delivery Unit, and ensure that Committee members were informed of the outcome of such discussions.

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

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

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

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

Summary report from the People and Organisational Development Committee, 22/09/23 (incl. quarterly update from the Guardian of Safe Working Hours (covering April to June 2023))

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on 22nd September 2023 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were reviewed and it was agreed that the Chief People Officer should ensure that Committee members were provided with details of the Trust's final appraisal compliance performance, which includes a breakdown of those staff which had not received an appraisal for more than one year. It was also agreed that the Chief People Officer and Chair of the Committee should liaise to consider what, if any, actions could be implemented to improve the accountability of line managers in relation to ensuring their staff received a high-quality appraisal.
- The **Guardian of Safety Working Hours** attended for the latest **quarterly update** which covered April to June 2023 (the report has been enclosed under Appendix 1). It was agreed that the Guardian of Safe Working Hours should ensure that future "quarterly update from the Guardian of Safe Working Hours" reports included quarterly and annual comparison data in relation to number of exception reports declared; benchmarking data against other NHS Trusts within the Southeast region; and details of the feedback process to Junior Doctors in response to the exception reports raised.
- The Deputy Chief Executive / Chief Finance Officer and Programme Director, Premium Staffing Spend provided the latest update on the **Workforce efficiency programme,** which included details of the benefits associated with the Patchwork Healthcare Workforce Solution and the importance of ensuring the data to illustrate the impact of the programme excluded the temporary staffing increases associated with industrial action. It was agreed that the Programme Director, Premium Agency Spend should ensure that future "Workforce efficiency programme" reports included details of the process by which the programme of work could transition to 'Business As Usual' (BAU) and the measures which would be implemented to maintain end-to-end accountability following the transition to BAU.
- The Deputy Chief People Officer, People and Systems; and Senior Human Resources Business Partner presented an **update on the development of Human Resources Business Partners (incl. the approach for an aligned Business Partnership mode)**, wherein the Committee were informed of the further engagement required from specific Directorates; the key areas of focus for the next 12 months; and importance of the integration of HRBPs into decision-making process to ensure that the people requirements are appropriately considered.
- The Head of Equality Diversity and Inclusion (EDI) and Engagement attended for the latest u**pdate on Equality, Diversity and Inclusion (EDI)**, which included approval of the Trust's action plans and proposed national data submissions for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The Committee emphasised the importance of developing robust targets associated with the WRES and WDES action plan and it was acknowledged that the programme of work may require further consideration, following discussions at the September 2023 Trust Board Seminar. The Committee acknowledged the impact of the lived experience of members of staff and the further work required.
- It was agreed that the consideration of **the mechanisms which should be implemented to provide Trust Staff who had attended the Exceptional Leaders programme with an update on the key elements** should be rescheduled to the Committee's meeting in November 2023, to enable the topic to receive the appropriate focus.
- The Committee reviewed the **relevant aspects of the Risk Register** wherein the Committee emphasise the importance of ensuring that the risk register included an appropriate focus on recovery in the event that the risk occurred and it was agreed that the Chair and Vice Chair of the Committee, the Chief People Officer, the Deputy Chief People Officer, Organisational

Development and the Deputy Chief People Officer, People and Systems should liaise to consider what, if any, amendments were required to the Committee's forward programme, utilising a horizon scanning approach, to ensure there was sufficient oversight of current and emerging risks within the People and Organisational Development Function. It was also agreed that the Chief People Officer should check, and confirm to Committee members, whether a risk associated with the pastoral support requirements for Internationally Educated Nurses / Midwives was included on a local risk register.

- The Deputy Chief People Officer, Organisational Development presented the **Annual update from the Health and Wellbeing Committee**, wherein the Committee noted the continued strive for the development of a culture of wellbeing and the funding challenges in relation to the 2023/24 winter wellbeing plan.
- The Committee noted the latest **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR);** the **recent findings from relevant Internal Audit reviews (6-monthly report);** and the **six-monthly review of internal communications.**
- The Committee's **forward programme** was noted and Committee members conducted a brief **evaluation of the meeting** wherein it was agreed that the Deputy Chief People Officer, People and Systems, should develop a rolling forward programme for the attendance of Human Resources Business Partners at future Committee meetings.

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:

- The quarterly update from the Guardian of Safe Working Hours (covering April to June 2023) is enclosed in Appendix 1, for information and assurance

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

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

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – SEPTEMBER 2023

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (APRIL TO JUNE 2023) **GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period April 2023 – June 2023:

- During this period there were a total 98 exception reports made
- Inadequate staffing levels were the main reason for excessive hours worked by trainee Doctors
- 4 exception reports were made due to patient safety – all related to inadequate staffing levels
- No exception reports were related to missed educational opportunities

Reason for circulation to People and Organisational Development Committee
Assurance

Reporting Period: April to June 2023

Exception Reports-Patient Safety

Specialty	Grade	No. Exceptions raised
General Medicine	FY1	1
General Medicine	CT1	2
General Medicine	CT2	1
Total		4

Exception Reports-Work Schedule related

Specialty	Grade	No. Exceptions raised
Cardiology	ST4	1
General Medicine	FY1	25
General Medicine	FY2	16
General Medicine	ST/CT	16
Surgery	FY1	2
Geriatric	FY1	3
Haematology	FY2	3
Haematology	CT1	20
Haematology	ST4	7
T&O	FY2	1
Total		94

Exception Reports-Educational Opportunities missed

NA-0

(**Total combined ERs = 98**)

Work Schedule Reviews

One ongoing work schedule review - in haematology.

Fines

No fines issued during this period.

Report commentary

During the period **April to June 2023** there were a total of 98 Exception Reports.

0 were due to missed educational opportunities
94 were due to work schedule/staffing levels
4 were due to patient safety (all of these were also recorded under work schedule review/staffing levels as this was the main concern

The numbers are similar to those seen in the first quarter of the year. They are considerably lower than the numbers seen in the last quarter of 2022. The largest number continue to be in the medical division.

Problems around rota have continued until recently in medicine. However now that the new patchwork system has replaced allocate there seems to be a greater degree of satisfaction amongst the doctors.

The response time from the clinical supervisors has improved; Andrea Stephens from the medical staffing team has been sending them more reminders, along with a guide on the reporting process.

There were 30 exception reports from haematology. The majority were made by non-resident registrars working more hours on site than their contracted hours. I have spoken to their manager and consultants. They tell me that they have made adjustments to the rota which should help address this issue.

Dr Tim Bell

Summary report from the Patient Experience Committee, 07/09/23	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 7th September 2023, Trust Management Room, The Annexe, Maidstone Hospital

The key matters considered at the meeting were as follows:

- The Assistant Facilities Manager and Car Parking Manager attended to provide an **update on the improvement plan for car parking at the Trust's sites** in which it was agreed that the Director of Strategy, Planning and Partnerships would liaise with the Director of Emergency Planning and Response to explore if any new approaches could be implemented to improve patient car parking at the Trust's hospital sites and a "Further update on the improvement plan for car parking at the Trust sites" report which included the details of the options already considered, to the Committee's meeting in December 2023.
- The Head of Patient Concerns attended to provide the **Complaints Annual Report, 2022/23** and confirmed that the "" report scheduled at the Committee's meeting in December 2023 included details of the development of the new complaints' procedure in line with the new Parliamentary and Health Service Ombudsman (PHSO) framework.
- The Deputy Chief Nurse for Quality and Experience provided an **update on the Friends and Family Test (FFT)** and highlighted that the response rate continued to increase.
- Due to time constraint the **review of the patient experience related aspects of the March 2023 Care Quality Commission (CQC) inspection findings** was not considered so it was agreed to reschedule the item to the Committee's meeting in December 2023.
- The Deputy Chief Nurse for Quality and Patient Experience provided a **review of the revised Patient Experience Strategic Theme, Patient Experience Strategy and the Framework pilot** in which it was agreed that the Deputy Chief Nurse for Quality and Patient Experience would check, and confirm to Committee members, the People and Organisational Development Committee's plans for improving the level of Mental Health training available to staff.
- The Deputy Chief Nurse for Quality and Patient Experience then reported the **Adults Inpatient Survey 2022 results and associated action plan** and highlighted the good response rate and key themes.
- The Deputy Chief Nurse for Quality and Patient Experience and Divisional Director of Nursing and Quality, Medicine and Emergency Care then discussed the **Urgent and Emergency Care Survey 2022 results and associated action plan** and it was agreed that a "Review of the 2022 Urgent and Emergency Care Survey action plan" item should be scheduled Committee's meeting in March 2024.
- The Director of Maternity then provided an updated on the **Trust's response to the findings from the Care Quality Commission Maternity survey 2022** and it was agreed that the Administration Assistant, Trust Secretary's Office should schedule a "Review of the patient experience related aspects of the Care Quality Commission (CQC) inspection of Maternity Services" item and a "Review of the 2022 Care Quality Commission Maternity survey action plan" item at the Committee's meeting in December 2023.
- The Head of Nursing for Paediatrics provided an update on the **Women's, Children's and Sexual Health Division** and highlighted the patient experience initiatives and improvement currently in place across the division.
- The Divisional Director of Nursing and Quality, Medicine and Emergency Care updated the Committee on the **Medicine and Emergency Care Division** in which it was agreed that an "Update on the progress made against the action plan to improve patient information in Medicine and Emergency Care" should be scheduled at the Committee's meeting in March 2024.
- The Lead Practitioner for Dementia attended to provide an **update on Dementia** and it was agreed that an "Update on the local data available from the "Dementia Care in General Hospitals Round 6 Audit"" should be scheduled at the Committee's meeting in December 2023 and the Assistant Trust Secretary should liaise with the Chair of the Quality Committee to consider, and confirm, the scheduling of an "Update on Dementia" item at a future Quality Committee meeting.

- The Patient Research Champion gave an **update from the Research and Innovation Department** and highlighted the benefits of involving patients and the public in the delivery of clinical trials and ensuring those who take part received an acceptable level of contact throughout.

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

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

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

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

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NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Charitable Funds Committee, 26/07/23	Committee Chair (Non-Executive Director)

The Charitable Funds Committee (CFC) met on 26th July 2023, virtually, via webconference.

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

- The Committee undertook a **review of the draft Charitable Fund Annual Report and Accounts for 2022/23** wherein it was agreed that the Head of Financial Services would provide a word version of the Charitable Fund Annual Report to Committee members to allow for review of the document by the end of September 2023. The Committee noted that the total income for 2022/23 was £158k, total expenditure was £362k, and loss on investments was £22k, resulting in a year-end balance of £878k.
- The **financial overview at Month 3, 2023/24** was considered wherein it was agreed that the Head of Financial Services should liaise with the Head of Charity and Fundraising to consider the proposed profile for the investment and expenditure of the Trust's Charitable Funds and circulate this to Committee members.
- The Committee reviewed the **Standard Operating Procedure (SOP) for requesting and allocating Charitable Funds** and it was agreed to amend the title of "fund holder" to "fund custodian" to better relate to the position.
- The Head of Charity and Fundraising provided a **review of the potential Customer Relationship Management (CRM),** in which it was agreed that a "Further review of the potential Customer Relationship Management (CRM) system" item should be scheduled at the Committee's meeting in November 2023 after further liaison with the potential suppliers.
- The Head of Charity and Fundraising then asked the Committee to **consider the acquisition of a raffle licence for the Trust** and it was agreed that a raffle licence should be applied for and, when received, the Head of Charity and Fundraising should investigate what, if any, controls should be implemented to ensure responsible use of the raffle license. It was also agreed that the Head of Charity and Fundraising should ensure that the Policy and Procedure and SOP for Charitable Funds included a section related to raffles and a "Review of the proposed controls for the Trust's raffle licence (incl. the amendments to the SOP)" item should be scheduled at the Committee's meeting in November 2023.
- An **update on the progress of the Charitable Fund Fundraising Strategy** was provided, which included that the improvement in marketing for the charity, particularly with the publicising of NHS75, had resulted in an increased query rate from staff despite the challenges of the industrial action.
- The Committee received a **fundraising update (incl. an update from the Charity Management Committee)** from the Head of Charity and Fundraising which included that the charity had been selected as the Mayor of Tunbridge Wells Charity of the Year and Just Giving had remained one of the most popular ways to donate to the Trust.
- The report submitted for the **update on the proposed partnership with Maggie's Centres** was noted and it was agreed that the next update report should include an overview of the roles and responsibilities of the associated project board.

2. In addition to the actions noted 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 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

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Integrated Performance Report (IPR) for August 2023	Chief Executive / Members of the Executive Team

The IPR for month 5, 2023/24, is enclosed, along with the monthly finance report and latest "Planned verses Actual" Safe Staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 26/09/23

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

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Integrated Performance Report

August 2023

MTW
exceptional people, outstanding care

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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

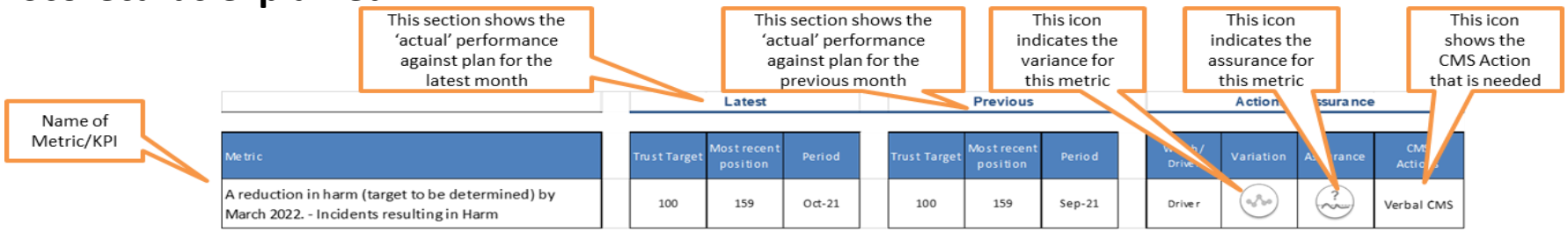
Escalation Rules:

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

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Executive Summary

Executive Summary: The Trust Vacancy Rate continues to experience special cause variation of an improving nature and passing the target for more than six months. Turnover Rate continues to experience common cause variation and consistently failing the target. Agency spend did not achieve the target for August 23 but remains in common cause variation and variable achievement of the target. Sickness levels are now experiencing special cause variation of an improving nature and have achieved the target for more than six consecutive months. The Trust Appraisal window officially closed at the end of July 2023, with a performance of 91.6%, however the window has been left open for some late data to be entered and performance as at August 23 had increased to 93.1%. The window remains open until the end of September so this performance may improve further. Statutory and Mandatory Training fell slightly below target in August 23 but remains in common cause variation and variable achievement of the target. With regards to the National Equality and Diversity Indicators (EDI) both the percentage of staff Afc 8a or above that are female or have a disability have achieved the target as at August. The indicator for those that are BAME is consistently failing the target but is in special cause variation of an improving nature. The Trust was £1.1m in surplus in the month which was £0.1m favourable to plan. Year to Date the Trust is £3.5m in deficit which is £1.5m adverse to plan, mainly due to additional costs associated with the industrial action and CIP slippage.

The Nursing Safe Staffing Levels continue to be below the target in August but remains in common cause variation and variable achievement of the target. The rate of incidents causing patients moderate or higher harm was slightly above the new target of 0.90 in August but remains in common cause variation and variable achievement of the target. The Target has been set to be in line with the best performing local Trusts in Kent and Medway, using local benchmarking data. The breakthrough objective indicator for this Strategic Theme is still under development. The rate of inpatient falls, C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. The rate of C.Difficile and E.Coli are escalated due to being in Hit or Miss for more than six months. Complaints response times have failed the target for more than 6 months and therefore remain escalated. Friends and Family Response rates remain challenging.

Diagnostic Waiting Times achieved the recovery trajectory target set for August 23 (+10%). It is no longer escalated as is now experiencing common cause variation and variable achievement of the target. RTT performance remains below the recovery trajectory, now experiencing special cause variation of a concerning nature and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters but have reported one month end breach in August 23. Performance for First outpatient activity levels is expected to achieve plan for August-23 (once all cashing up has taken place) and is now experiencing common cause variation and variable achievement of the target. Outpatient Utilisation continues to experience special cause variation of an improving nature but remains consistently failing the target. Diagnostic Imaging activity levels remain below plan for August 2023, but remain above 1920 levels. Elective (inpatient and day case combined) activity was above plan for August 2023 and remains above plan year to date. This metric is now experiencing common cause variation and variable achievement of the target.

The number of patients leaving our hospitals before noon continues to experience common cause variation and consistently failing the target. A&E 4hr performance was below trajectory for August 23 (-3.6%), now 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 remain in special cause variation of an improving nature and variable achievement. The Trust continues to achieve the Cancer Waiting Times 62 Day and 2 Week Wait (2WW) standard, both of which have passed the target for more than six consecutive months, with the 62 day standard now experiencing special cause variation of an improving nature. The Cancer Waiting Times 28 day Faster Diagnosis completeness indicator achieved the target in July, and compliance of the standard improved, achieving the 75% target for the first time in July 23.

Escalations by Strategic Theme:

People:
- Turnover Rate (P.8)
- % of Afc 8c and above that are BAME (P.9)

Patient Safety & Clinical Effectiveness:
- Infection Control – Rate of C.Diff and E.Coli (P.11)*

Patient Access:
- RTT Performance (P.13)
- Outpatient Calls answered <1 minute (P.14)
- Outpatient Clinic Utilisation (P.14)
- Planned levels of Diagnostics activity (P.14)

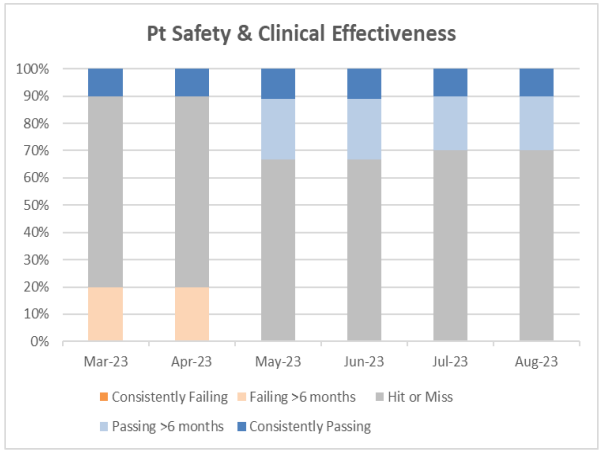
Patient Experience:
- Complaints responded within target (P.16)
- FFT Response Rates - A&E, Outpatients and Maternity (P.16)

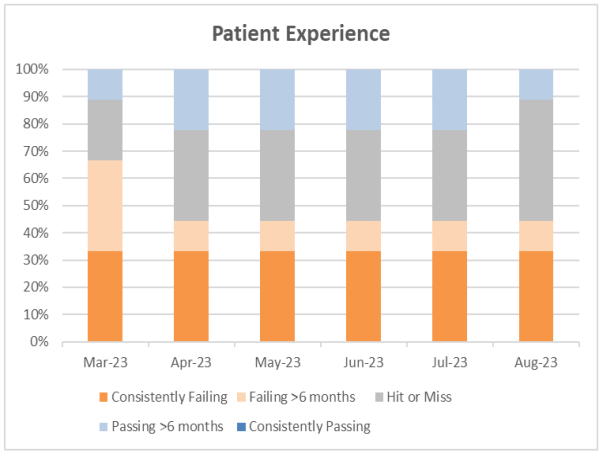
Systems:
- Discharges before Noon (P.18)

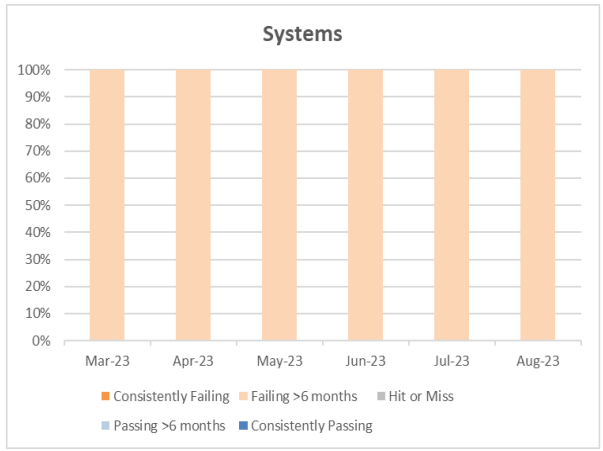
Sustainability: None

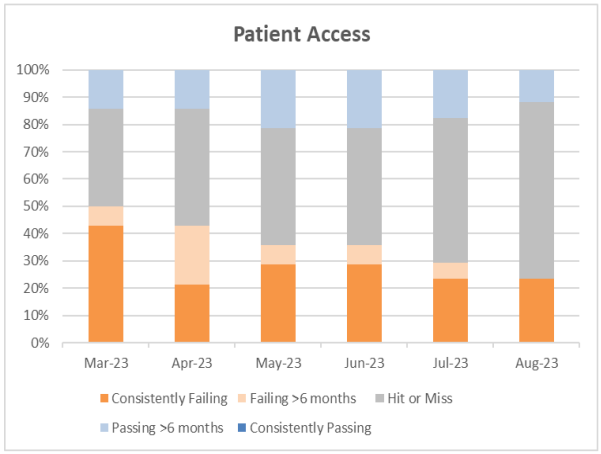
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

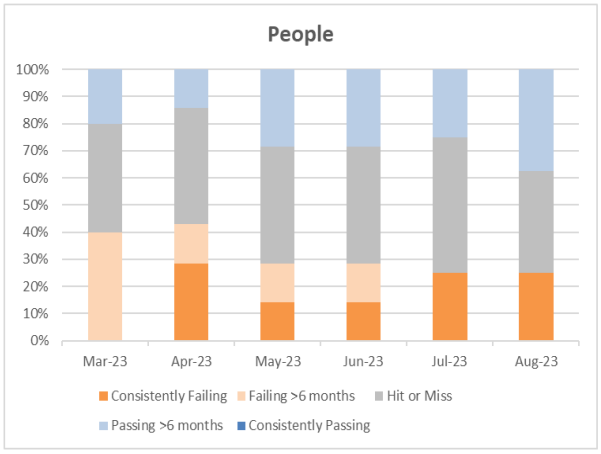
Assurance Stacked Bar Charts by Strategic Theme

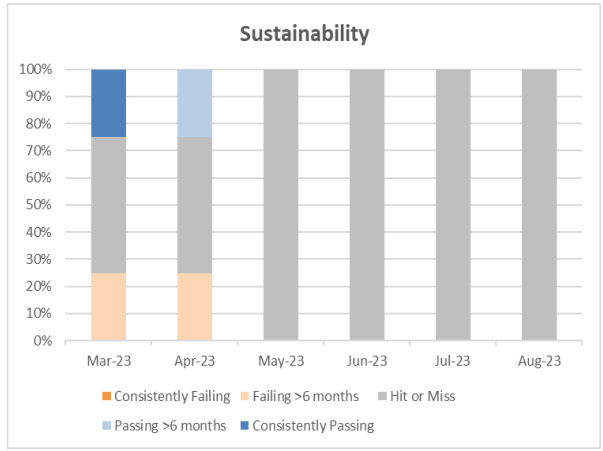












Matrix Summary

August 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% Sickness Absence Percentage of AfC 8c and above that are Female Never Events Cancer - 62 Day	Percentage of AfC 8c and above that have a Disability Flow: Ambulance Handover Delays >30mins Flow: Super Stranded Patients Flow: % of Emergency Admissions that are zero LOS (SDEC) Flow: % of Emergency Admissions into Assessment Areas Friends and Family (FFT) % Response Rate: Inpatients	% complaints responded to within target	Percentage of AfC 8c and above that are BAME Transformation: % OP Clinics Utilised (slots) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) Friends and Family (FFT) % Response Rate: A&E Friends and Family (FFT) % Response Rate: Maternity
Common Cause	Summary Hospital-level Mortality Indicator (SHMI)	Number of New SIs in month Cancer - 2 Week Wait Complaints Rate per 1,000 occupied beddays	Appraisal Completeness Statutory and Mandatory Training Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bd days Standardised Mortality HSMR Safe Staffing Levels IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Rate of patient falls per 1000 occupied bed days To achieve the planned levels of new outpatients activity (shown as a % 19/20) Access to Diagnostics (<6weeks standard) A&E 4 hr Performance Cancer - 31Day First Cancer - 28 Day Faster Diagnosis Compliance Cancer - 28 Day Faster Diagnosis Completeness To achieve the planned levels of elective (DC and IP cobined) activity (shown as a %19/20) To achieve the planned levels of outpatients follow up activity (shown as a %19/20) To reduce the overall number of complaints or concerns each month Maintain the National FFT positive response rate. A&E Maintain the National FFT positive response rate. Maternity Maintain the National FFT positive response rate. Outpatients To reduce the number of complaints and concerns where poor		Reduce Turnover Rate to 12% Transformation: CAU Calls answered <1 minute Friends and Family (FFT) % Response Rate: Outpatients To increase the number of patients leaving our hospitals by noon on the day of discharge
Special Cause - Concern			RTT Patients waiting longer than 40 weeks for treatment % VTE Risk Assessment (one month behind)		Achieve the Trust RTT Trajectory

Strategic Theme: People

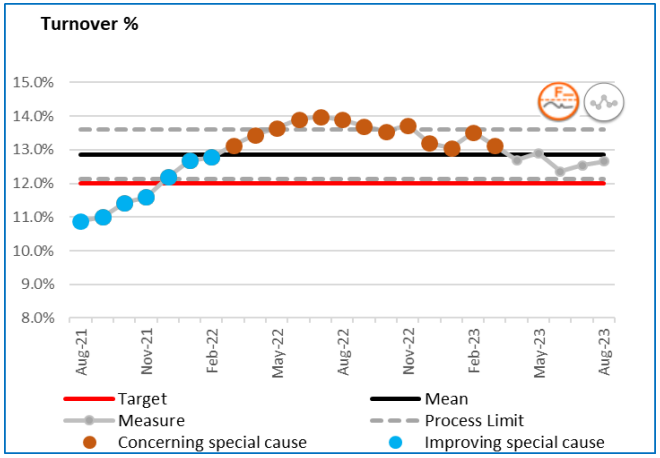
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%	12%	8.6%	Aug-23	12%	9.5%	Jul-23	Driver	L	P	Note Performance
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%	12%	12.7%	Aug-23	12%	12.5%	Jul-23	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	3.7%	Jul-23	4.5%	3.3%	Jun-23	Driver	L	P	Not Escalated
	Well Led	Appraisal Completeness	95.0%	93.1%	Aug-23	95.0%	91.2%	Jul-23	Driver		?	Not Escalated
	Well Led	Statutory and Mandatory Training	85.0%	84.4%	Aug-23	85.0%	88.4%	Jul-23	Driver		?	Not Escalated
	Well Led	Percentage of AfC 8c and above that are Female	62.0%	67.7%	Aug-23	62.0%	67.5%	Jul-23	Driver	H	P	Not Escalated
	Well Led	Percentage of AfC 8c and above that have a Disability	3.2%	3.9%	Aug-23	3.2%	4.1%	Jul-23	Driver	H	?	Not Escalated
	Well Led	Percentage of AfC 8c and above that are BAME	12.0%	8.7%	Aug-23	12.0%	8.9%	Jul-23	Driver	H	F	Escalation

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

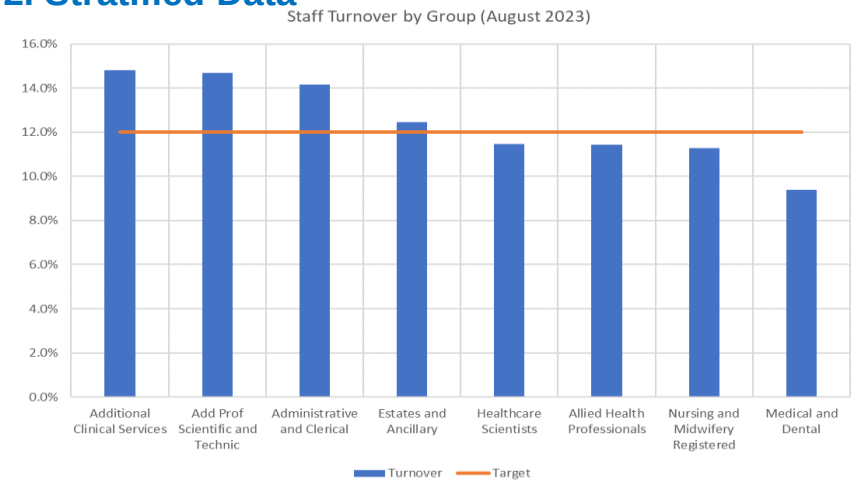
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Aug-23
12.7%
Variance / Assurance
Metric is currently Common Cause variation and is consistently failing the target
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target

2. Stratified Data



3. Top Contributors

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

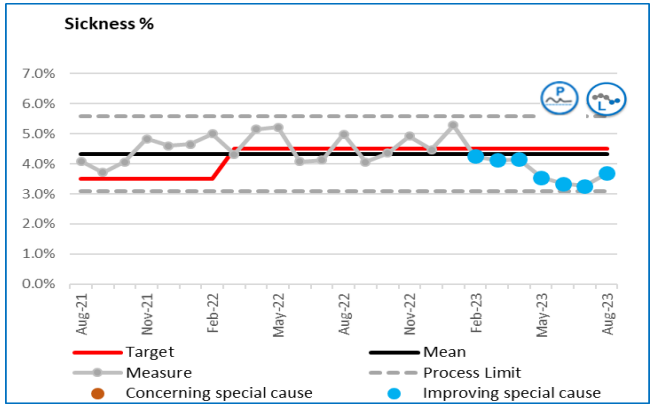
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership 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

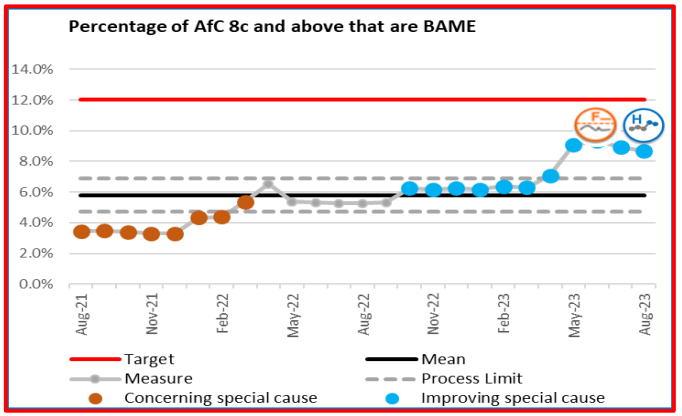
A full action plan by the working groups has been developed; some of the key actions shown:

Countermeasures	Target completion date
Pathway for consideration/approval of trust-based incentives created and awaiting sign off	Oct-23
New actions created for the Attraction workstream, including: develop a Media Attraction Campaign Dashboard, and showcase more internal development opportunities internally (using Realworld data)	Sep-23 - Jan-24
Streamline recruitment through automation	Ongoing
Review TRAC data looking at every candidate recruited since January and how many days it has taken from offer to start date	Sep-23
New actions created for the Processes workstream, including team away day to explore how Workforce can work more efficiently and effectively in terms of recruitment processes	Sep-23
Create talent pool/ list of names of people interested in promotion	Aug-23 (update due)
Review of existing, and creation of new actions, for the Learning & Development workstream expected	Oct-23
Introduce stay interviews	Aug-23 (update due)
New actions created for the Retention workstream, including Admin and Clerical retention-deep dive on data for patient facing and non patient admin and clerical roles	Dec-23

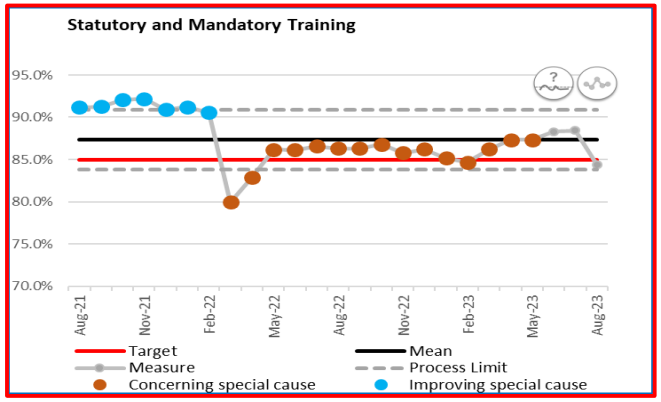
People – Workforce: CQC: Well-Led



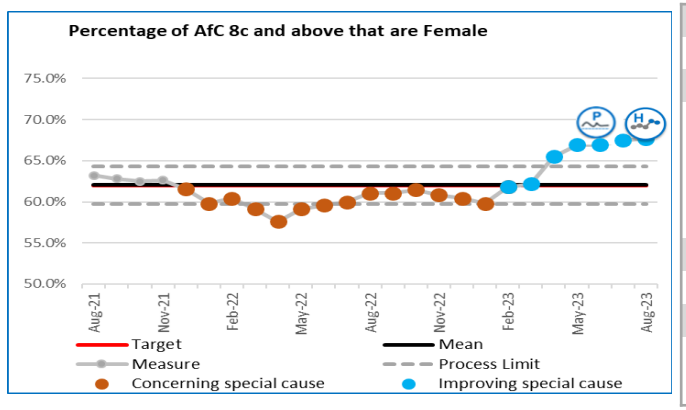
Jul-23
3.68%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and has achieved the target for 6+ months
Max Target (Internal)
4.5%
Business Rule
For information as is now passing for 6+ months



Aug-23
8.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (National)
12%
Business Rule
Full Escalation



Aug-23
84.4%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (National)
85%
Business Rule
Escalated as in hit and miss for 6+ months



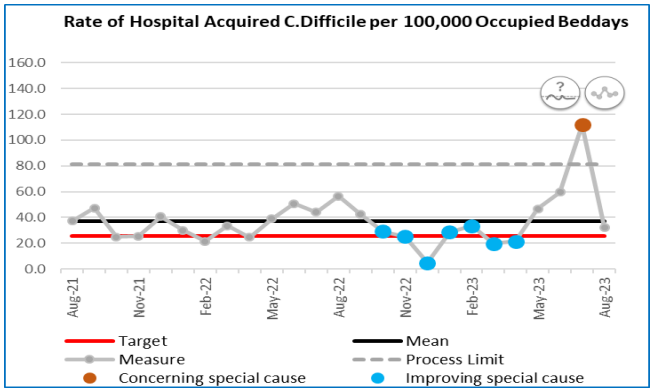
Aug-23
69.3%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and has passed the target for 6+ months
Target (National)
62%
Business Rule
Not Escalated but shown for info as is now passing the target

Summary:	Actions:	Assurance & Timescales for Improvement:
Sickness % - This metric is experiencing Common Cause Variation but has now passed the target for 6+ months **% of AfC 8c and above that are BAME:** This metric is experiencing special cause variation of an improving nature and consistently failing the target. **Statutory and Mandatory Training:** This metric is experiencing common cause variation and variable achievement of the target for 6+ months **% of AfC 8c and above that are Female:** This metric is experiencing special cause variation of an improving nature and has passed the target for more than six months	**Sickness**: More focused attention on longer term absence and close working with Divisional managers and HR Advisors. Absence rates remain at a good level, as expected for summer months **% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME :** As at August 23 the current number of staff (WTEs) that are AfC 8c and above is 127. Of these 5 have a disability , 11 are BAME and 86 are female. **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 NB: These are not rapidly changing indicators	**Sickness:** A slight increase in long term sickness absence is being monitored, but no cause for concern yet (only 1 month of increase) **Statutory and Mandatory Training**: Performance fell below target in August, due to the introduction of a new mandatory training course in August which not all staff are compliant with yet which has impacted the overall Trust compliance. Without this course included performance would have been 87.56%, in line with previous months. **% 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 will commence by September 2023, targeting recruiting managers in Divisions with high turnover.

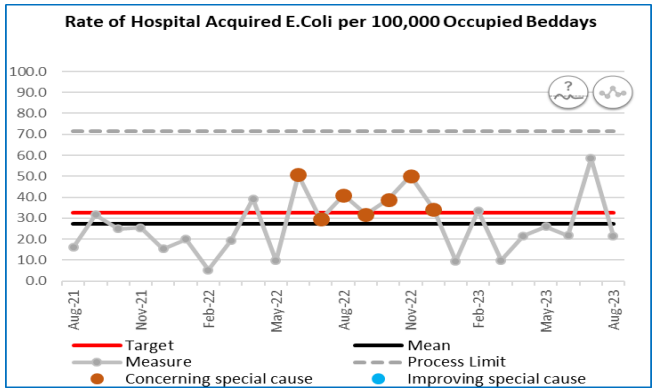
Strategic Theme: Patient Safety & Clinical Effectiveness

	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 rate of patient incidents resulting in Moderate+ Harm per 1000 bd days	0.90	0.90	Jul-23	0.90	1.35	Jun-23	Driver			Verbal CMS
Breakthrough Objectives	Safe	To be Determined	TBC	TBC	TBC	TBC	TBC	TBC	Driver	No SPC	No SPC	
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	7	Aug-23	11	8	Jul-23	Driver			Not Escalated
	Safe	Standardised Mortality HSMR	100.0	97.8	May-23	100.0	98.2	Apr-23	Driver			Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	90.0	May-23	100.0	90.0	Apr-23	Driver			Not Escalated
	Safe	Never Events	0	0	Aug-23	0	0	Jul-23	Driver			Not Escalated
	Safe	Safe Staffing Levels	93.5%	89.2%	Aug-23	93.5%	87.9%	Jul-23	Driver			Not Escalated
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays	32.6	21.6	Aug-23	32.6	58.6	Jul-23	Driver			Not Escalated
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	25.5	32.4	Aug-23	25.5	111.8	Jul-23	Driver			Not Escalated
	Safe	IC - Number of Hospital acquired MRSA	0	0	Aug-23	0	1	Jul-23	Driver			Not Escalated
	Safe	Rate of patient falls per 1000 occupied bed days	6.4	5.7	Aug-23	6.4	4.9	Jul-23	Driver			Note Performance

Patient Safety and Clinical Effectiveness: CQC: Safe



Aug-23
32.3
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Max Target
25.5
Business Rule
Escalated as in Hit & Miss for >6months



Aug-23
21.6
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
32.6
Business Rule
Escalated as in Hit & Miss for >6months

Summary:

Rate of C.difficile: is experiencing special cause variation of a deteriorating nature and variable achievement of the target.

Rate of E.coli:: is experiencing common cause variation and variable achievement of the target.

Actions:

Infection Control:

Following the sharp rise in C diff cases in July, August saw a significant reduction in cases close to the expected rates.

- Two Trust wide C diff incident meetings have been held to identify and monitor areas for improvement.
- A deep cleaning task and finish group has been formed to co-ordinate the deep cleaning programme at TWH which has commenced with Ward 12. Enhanced cleaning is being undertaken on wards at MH where possible
- Key C diff information has been published on the Trust intranet page
- The IPC team continue to deliver additional ward-based updates, promoting the completion of the c diff risk assessment and C diff related documentation
- Weekly C diff round involving the Consultant Microbiologist and IPC team are held weekly
- Rapid C diff reviews are being undertaken by the IPC team with clinician involvement to support timely identification of learning

E coli blood stream infection were within the expected rates for August. All healthcare associated cases are subject to data collection by the IPCT and full RCA where lapses of care are identified

Assurance & Timescales for Improvement:

Infection Control:

The Infection prevention team will continue to monitor and escalate where infection and nosocomial rates are rising.

RCA scrutiny will continue for alert organisms including C.difficile and gram negative blood stream infections. Learning from RCAs is shared within the Directorate and via the HCAI weekly status

Actions will continue to be identified and monitored through the Trust wide incident meeting held in September

Strategic Theme: Patient Access

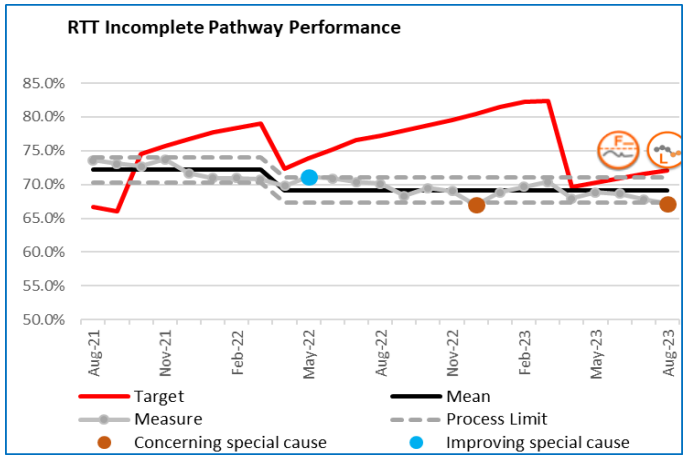
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory	72.1%	67.1%	Aug-23	71.6%	67.8%	Jul-23	Driver	L	F	Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	123.8%	122.3%	Aug-23	103.4%	104.3%	Jul-23	Driver		?	Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	642	1017	Aug-23	648	825	Jul-23	Driver	H	?	Not Escalated
	Responsive	Access to Diagnostics (<6weeks standard)	87.1%	97.1%	Aug-23	86.4%	96.1%	Jul-23	Driver		?	Not Escalated
	Responsive	A&E 4 hr Performance	88.3%	84.7%	Aug-23	89.2%	86.7%	Jul-23	Driver		?	Not Escalated
	Responsive	Cancer - 2 Week Wait	93.0%	95.3%	Jul-23	93.0%	96.4%	Jun-23	Driver		P	Not Escalated
	Responsive	Cancer - 31 Day First	96.0%	95.2%	Jul-23	96.0%	96.8%	Jul-23	Driver		?	Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.0%	Jul-23	85.0%	86.3%	Jun-23	Driver	H	P	Not Escalated
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance	75.0%	75.0%	Jul-23	75.0%	72.2%	Jun-23	Driver		?	Not Escalated
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness	80.0%	85.1%	Jul-23	80.0%	85.9%	Jun-23	Driver		?	Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	81.6%	Aug-23	85.0%	80.6%	Jul-23	Driver	H	F	Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	5.5%	Aug-23	1.5%	6.1%	Jul-23	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	70.3%	Aug-23	90.0%	60.2%	Jul-23	Driver		F	Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	5.0%	6.8%	Aug-23	5.0%	5.2%	Jul-23	Driver	L	?	Not Escalated
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	63.1%	Aug-23	65.0%	64.8%	Jul-23	Driver	H	?	Not Escalated
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	111.0%	109.8%	Aug-23	102.9%	98.2%	Jul-23	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	114.5%	110.6%	Aug-23	101.2%	100.7%	Jul-23	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	153.4%	139.7%	Aug-23	142.8%	127.4%	Jul-23	Driver	H	F	Escalation

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT

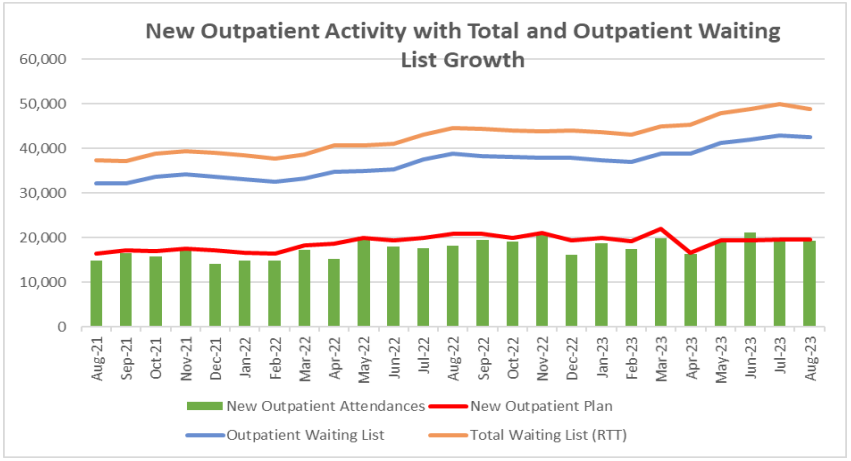
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Aug-23
67.15%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
72.1%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

RTT performance data being reviewed for this year which will be presented at Finance and Performance Committee in September.
Top 5 underperforming RTT specialties (under 60%)

- Gastro / Hepatology
- Neurology
- Gynae
- Surgery
- ENT

BAU actions within action plan continue and clinical engagement with Further Faster GIRFT Programme.

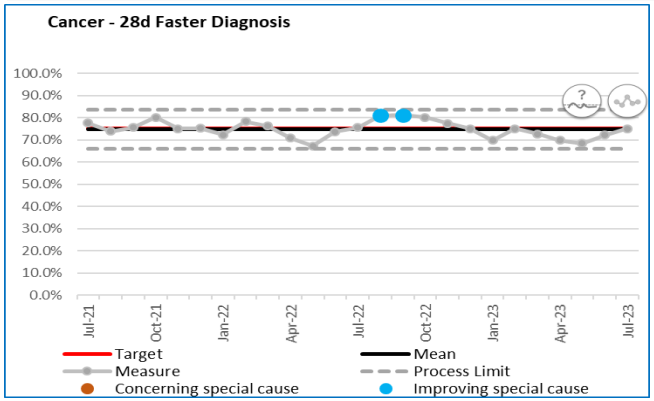
Key Risks:

- There is a risk that medical industrial action will affect achievement of the planned trajectory for activity affecting RTT.
- Waiting list growth could be affected due to increase in referrals and systems pressure.

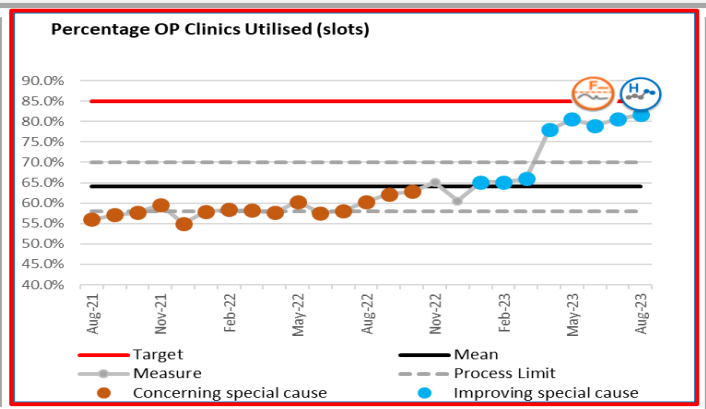
4. Action Plan

Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on the Breakthrough Objective to Increase New Outpatient Activity – GIRFT Further Faster and Straight to test pathways	SC	Ongoing
DNA Reduction	Two Way Text roll out	SC	July/August 23
	Trust wide DNA Task and Finish group looking at GIRFT recommendations and Patient Engagement due to be started in October	SC	March 24
	Paediatric Text Reminder Go Live	SC	August
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting Additional PTLs for Gastro, Gynae, Neurology and Surgery	RTT Lead and PAT team	Weekly and in progress

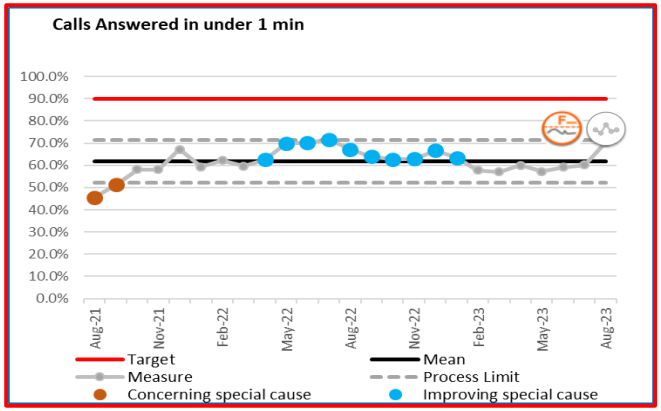
Patient Access: CQC: Responsive



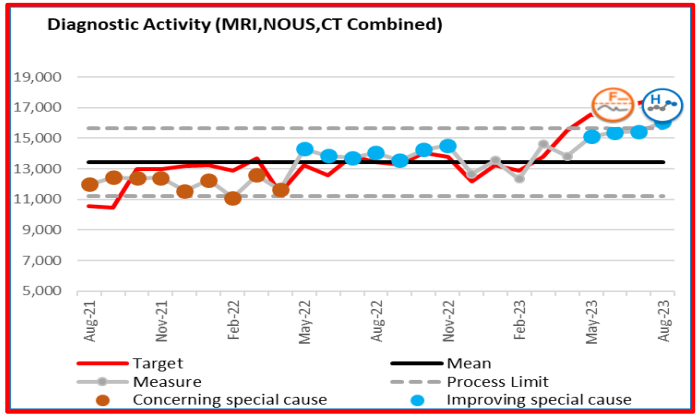
Jul-23
75%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for more than six months
National Target
75%
Business Rule
For info as now achieved target for first time



Aug-23
81.6%
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



Aug-23
70.3%
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



Aug-23
16,067
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target
17,633
Business Rule
Full Escalation as consistently failing the target

Summary:

CWT – 28 Day Faster Diagnosis Compliance: is experiencing common cause variation and variable achievement of the target. However the Trust achieved the 75% national target for the first time in July 23.

Calls Answered <1 min: is experiencing common cause variation and remains consistently failing the target. An improvement was seen in August 23. The areas with the lowest rate is 2WW, Women & Children, Surgical Specialties and General Surgery.

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

Diagnostic Activity: Activity levels are currently above 1920 levels for MRI, CT and NOUS and are now experiencing special cause variation of an improving nature. However, the metric continues to be consistently failing the target. Echocardiography is above the revised trajectory and is now experiencing common cause variation and variable achievement of the target.

Actions:

CWT – 28 Day Faster Diagnosis Compliance: Newly Cancer Alliance Funded roles are undergoing recruitment to support the delivery of the 28 day Faster Diagnosis Standard. These roles will support the manual process of recording FDS dates and developing diagnostic pathways within 28 days.

Performance against the under 1 minute KPI: Plan to increase trained admin staff on bank to cover CAU vacancies. Daily report by hour and by speciality are circulated to the General Managers and team leaders to highlight peaks and troughs of performance. The team are working with CAUs to review phone rotas and ensure all hours are covered - working with specialities to design a rota based on busiest call times.

Outpatient Clinic Slot Utilisation: The OPD team have worked with the CAU's on their clinic templates to improve utilisation by 20%. Next, the focus is on planned elective clinics with utilisation below 85%. Slot utilisation is discussed with specialities at the weekly RTT meeting.

Diagnostic Activity: MRI and CT activity is below plan for August 23 due to equipment issues; planning is in place to divert activity to the more resilient scanners. Reprofiled internally for recovery info.

Echocardiography Activity: was 10% above the recovery trajectory for August 2023. Activity being monitored weekly which also led to an improvement in the Diagnostic Waiting Times indicator

Assurance & Timescales for Improvement:

CWT – 28 Day Faster Diagnosis Compliance: Data completeness (number of pathways with a recorded FDS date) was over the 80% threshold in July. As completeness rises, performance (number of patients with an FDS date within 28 days) is likely to decrease, however individual pathway tumour site working groups are set up to ensure diagnostic pathways can reach the 28 day standard. Despite this, in July, we achieved the 75% target for 28 day FDS performance.

Calls Answered within 1 minute in the CAUs: All vacancies are now filled in the OPD contact team. Many speciality CAUs are reporting short staffing, however, an admin specific recruitment event took place on Saturday 16th September to support CAU recruitment.

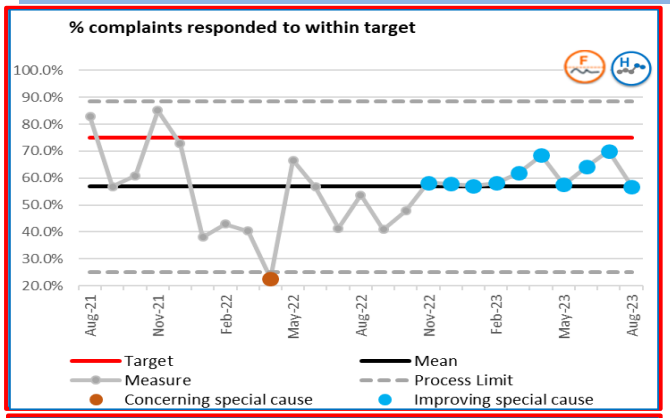
We achieved our interim target of 70% in August and new starters should help maintain that through further periods of Industrial Action.

Outpatient Slot Utilisation The aim is to ensure that no planned elective clinic is under 85% utilised. The OPD team have worked to identify 'planned elective' vs. 'emergency / hot clinics'. Currently mapping a Trust wide trajectory to improve from 80% to 85%.

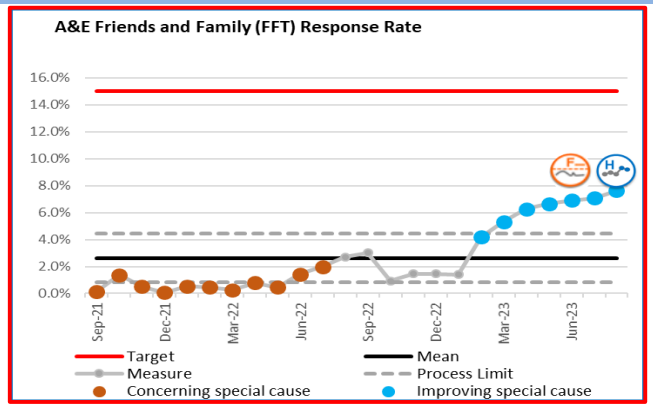
Strategic Theme: Patient Experience

			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	52	Aug-23	36	46	Jul-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	34	Aug-23	24	24	Jul-23	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays	3.9	2.8	Aug-23	3.9	2	Jul-23	Driver			Not Escalated
	Caring	% complaints responded to within target	75.0%	56.8%	Aug-23	75.0%	70.0%	Jul-23	Driver			Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	94.8%	Jul-23	95.0%	95.4%	Jun-23	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	29.8%	Aug-23	25.0%	30.4%	Jul-23	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	7.6%	Aug-23	15.0%	7.1%	Jul-23	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	17.4%	Aug-23	25.0%	15.7%	Jul-23	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	8.4%	Aug-23	20.0%	7.3%	Jul-23	Driver			Escalation

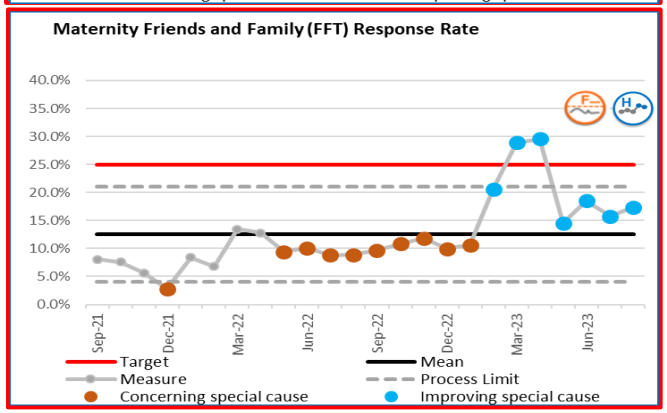
Patient Experience: CQC: Caring



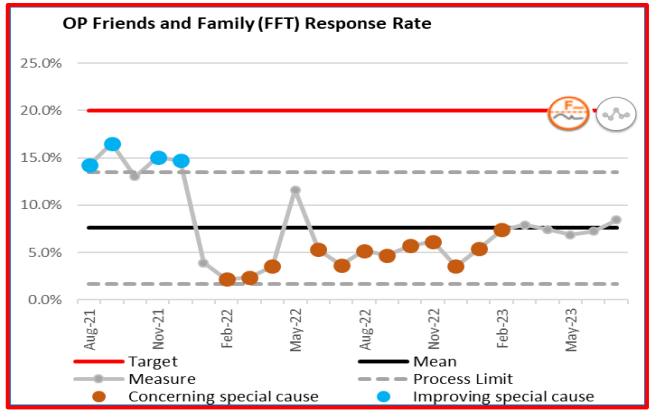
Aug-23
57.0%
Variance / Assurance
Metric is in special cause variation of an improving nature and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Aug-23
7.6%
Variance / Assurance
Metric is currently experiencing 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



Aug-23
17.4%
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 consistently failing the target



Aug-23
8.4%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

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

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 89.1%, compared to 82% nationally (July)
Friends and Family Response Rate - Maternity: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 100%, compared to 94% nationally (July)
Friends and Family Response Rate - Outpatients: Is experiencing common cause variation and is consistently failing the target
Recommended Rate is 95.5%, compared to 94% nationally (July)
Word clouds being reviewed for key sentiments and shared with divisions

Actions:

A&E: ED is an improving picture. Currently in the process of reviewing providers and to re-review the internal target of 15% (based on NHSE/I recommendations). The A&E FFT rate has increased from 7.1% to 7.6% compared to the national performance of 11.1% for July 23.
Maternity: Meetings held with the directorate to support improvements to FFT responses. Volunteers are supporting with FFT collection. The Maternity FFT rate has increased from 15.7% to 17.4% compared to the national performance of 13.7% for July 23.
Outpatients: The Outpatients FFT rate has increased from 7.3% to 8.4%. The OP Friends and Family (FFT) % Positive responses has been around 95% on average since July 2022 compared to a national performance of 94% for July 23.
Inpatient performance above the target at around 30% compared to a national performance of 22% for July 23 with a Recommended Rate of 97.7% compared to 95% nationally (July 23).
FFT Response All: Overall response rate for August was 7875, as compared to 7122 in July. Word clouds being compiled between and feedback received and what good looks like.
Main themes to be worked on from the August information:

- Did you receive timely information about your care and treatment?
- Were you made aware of any delays?
- Did you get a reminder about your appointment?

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Trust aiming to hit sustained delivery of the target response (75%) by September 2023, increasing to 90% by December 2023

Friends and Family (FFT) response Rates: Continue monthly review. Meetings with Netcall, IQVIA to monitor and review. 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 ongoing for sentiment analysis.
Comms put out reminding staff about FFT. Internet page updated to include more information about FFT and accessibility information.
We will continue to monitor all aspects of FFT.

Undertaking FFT benchmarking against other acute providers in Kent and Medway System.

Strategic Theme: Systems

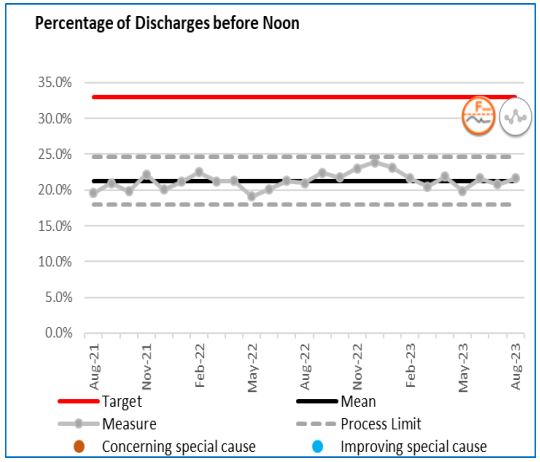
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	3.5	6.9	Aug-23	3.5	9.4	Jul-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%	21.6%	Aug-23	33.0%	20.8%	Jul-23	Driver			Full CMS

Breakthrough: Counter Measure Summary

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

Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Current Data Source: Teletracking
Aug-23
21.6%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data

Ward Discharges

Campus	Unit Category	Unit	Number of Records	% Before 12	% Before 3
*Maidstone	Medical	Culpepper	37	5%	24%
		Edith Cavell	51	22%	41%
		Foster Clark	50	24%	40%
		John Day	72	15%	36%
		Mercer	32	16%	41%
		Peale	36	22%	44%
		Pye Oliver	84	21%	33%
		Whatman	61	15%	44%
	Observation	Acute Stroke Unit	32	16%	22%
		Lord North	37	38%	46%
	Surgical	Cornwallis	126	13%	26%
*Tunbridge Wells	Medical	Ward 02	87	24%	48%
		Ward 12	108	20%	44%
		Ward 20	84	20%	37%
		Ward 21	126	27%	49%
		Ward 22	116	32%	55%
	Surgical	The Wells Suite	78	21%	45%
		Ward 10	110	13%	35%
		Ward 30	102	31%	58%
		Ward 31	76	24%	53%
		Ward 32	74	20%	39%
	Womens	Ward 33	95	5%	12%

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
Criteria Led Discharge	• Implement Stroke CLD action plan- Interim target 2 CLD per week (over next 2/52), rising to 10 per week (over 6/52). • Complete AAU trg competencies. • Develop AAU action plan for CLD (MTW) • Support surgery with Elective care CLD action plan implementation • Improve data availability of CLD attainment rate at trust and ward level	KC/ FR / NP NP NP RS	31.08.23 08.10.23 08.10.23	In Progress Complete In Progress In Progress For escalation

EDN	• RCA of EDN completion delays
	• Develop Clinically led action plan based on RCA *(*timeline is dictated by availability of Drs and nurses to support)*
	• Implement quick wins
	  • Ensure appropriate stock levels for over-labelled drugs in ward areas
	  • Cascade message to Jr DR regarding early completion of TTOs within EDN (and submit pre EDN completion)
	  • Replace silicone sleeve keyboards across ward areas
		BC
		BC
		
		HB
		
		FR
		
		SF
			
			28.09.23
			
			21.09.23
			
			21.09.23
			
			01.10.23
				Complete
				In progress
				
				In progress
				
				In progress
				Ordered 4/52 ago

Delay Reason	• Develop data export from Teletracking to BI warehouse to enable in house bespoke reporting • Develop data migration from Sunrise to Teletracking	RS JS		In Progress In Progress

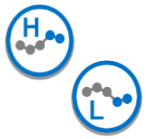
Strategic Theme: Sustainability

			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)	977	1,055	Aug-23	-305	-727	Jul-23	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	968	1324	Aug-23	1098	1140	Jul-23	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	2922	1287	Aug-23	2062	1743	Jul-23	Driver	No SPC	No SPC	Not Escalated
	Well Led	Cash Balance (£k)	18768	17266	Aug-23	14544	15310	Jul-23	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	5907	991	Aug-23	3963	5028	Jul-23	Driver			Not Escalated
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000	39885	40764	Aug-23	29545	30645	Jul-23	Driver	No SPC	No SPC	Not Escalated
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000	6760	6809	Aug-23	5009	4953	Jul-23	Driver	No SPC	No SPC	Not Escalated

Appendices

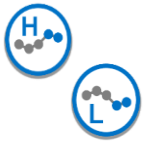
SDR Business Rules Driven by the SPC Icons

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

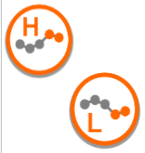
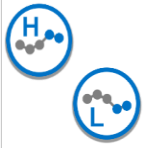
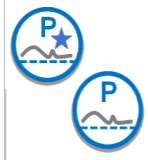
SDR Business Rules Driven by the SPC Icons

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:

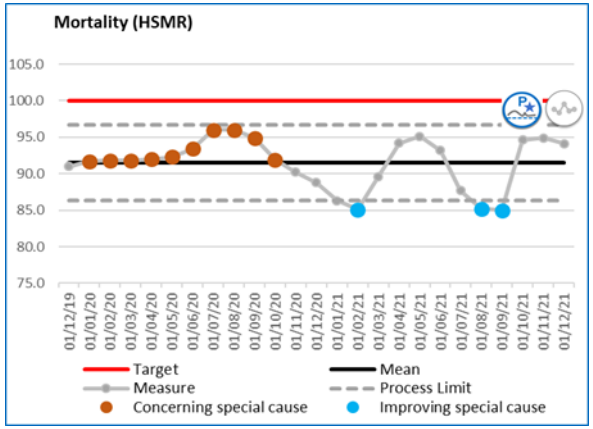
The **target** line **between** the **upper** and **lower** control limit for all metric types

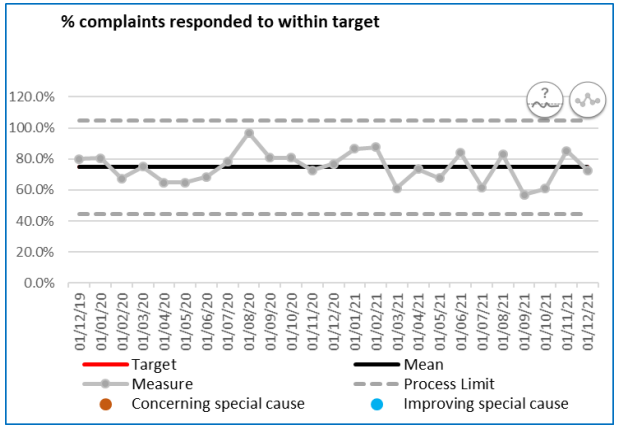
Metrics that consistently **fail** have:

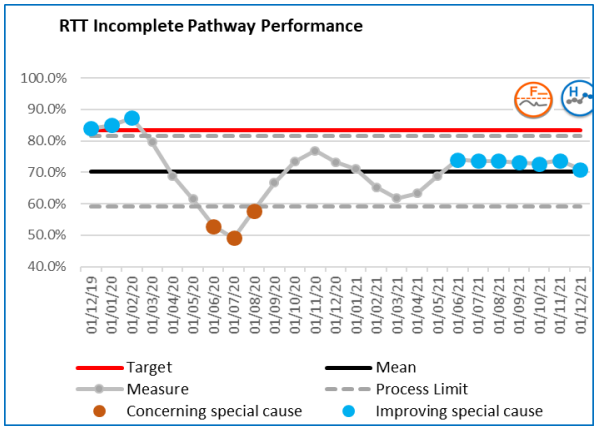
The **lower** control limit **above** the target line for metrics that need to be **below the target**

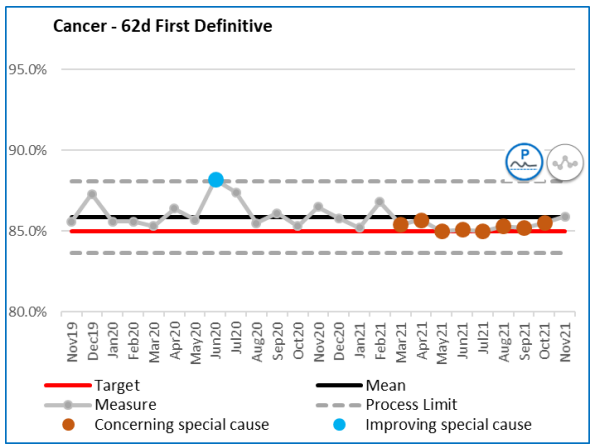
The **upper** control limit **below** the target line for metrics that need to be **above the target**

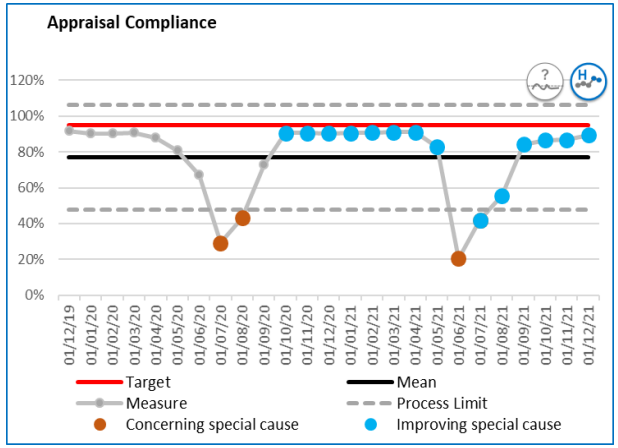
A metric not achieving the target for 6 months or more will be flagged as failing

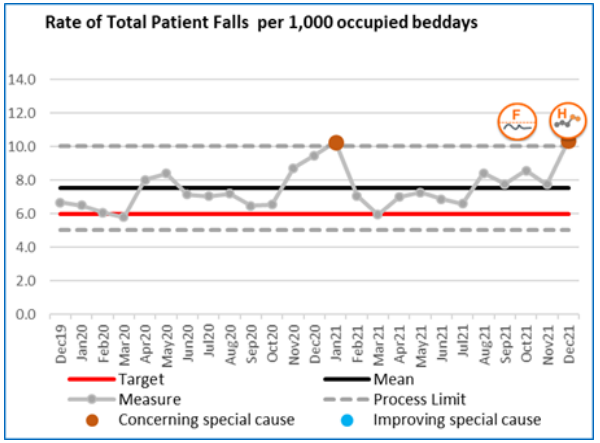












Executive Summary

- The Trust was £1.1m in surplus in August which was £0.1m favourable to plan. Year to date the Trust is £3.5m in deficit which is £1.5m adverse to plan.
- National guidance for Elective Recovery Fund (ERF) for August was for organisations to report actual performance to the target (rather than plan in previous months). The ERF target for April was also reduced in recognition of the impact of industrial action, this resulted in £2.3m of additional income in the month.
- In line with national guidance the position includes the impact of the medical pay award (6% increase plus £1,250 consolidated payment for certain grades). The estimated cost of this including backpay to April is £0.4m more than the additional income the trust is likely to receive.
- The key year to date pressures are; CIP slippage (£2.3m), CDC delay to fully opening and underutilisation of CT capacity (£1.3m), additional costs associated with the Industrial action £1.3m and net pay pressures (£1.3m). To mitigate these pressures the trust has had to release YTD held contingency (£0.5m), overperformed against variable income (£1.8m) and had non recurrent benefits of £2.6m
- Cost Improvement Plans (CIP) are behind plan by £2.3m year to date.
- The Trust is forecasting a £1.3m deficit to the breakeven plan which is a direct result of the additional costs incurred during the industrial action. The Trust is awaiting further information on how this will be supported but is anticipating additional income to offset additional costs and bring the forecast back to a breakeven position.
- To deliver the forecast the trust will need to identify additional CIP (£4m), reduce premium staffing spend (£3m), increase clinical income (£1.5m), release contingencies (£0.7m) and deliver £5m in run rate improvements.

Current Month Financial Position

- The Trust was £1.1m in surplus in the month which was £0.1 m favourable plan.
- The Industrial action in August led to a £0.4m increase in temporary staffing and lost income due to cancelled elective activity of £0.2m. National guidance for Elective Recovery Fund (ERF) for August was for organisations to report actual performance to the target (rather than plan in previous months). The ERF target for April was also reduced in recognition of the impact of industrial action, this resulted in £2.3m of additional income in the month.
- The Key variances to plan are:
    - CIP Slippage (£1.6m)
    - CDC delay to full capacity and also due to under utilisation of the CT capacity (£0.5m)
    - Impact of Industrial action (£0.6m)
    - Medical pay award (£0.4m). In line with national guidance the position includes the impact of the medical pay award (6% increase plus £1,250 consolidated payment for certain grades). The estimated cost of this including backpay to April is £0.4m more than the additional income the trust is likely to receive.
    - Release of contingency (£0.5m)
    - Non recurrent benefits mainly associated with a VAT review of 2022/23 financial year (£0.4m)

Year to Date Financial Position

- The Trust is £3.5m in deficit which is £1.5m adverse to plan.
- The key year to date variances is as follows:
    - **Adverse Variances**
        - CIP Slippage (£2.3m)
        - CDC delay to full capacity and also due to underutilisation of the CT capacity (£1.3m)

- Additional Costs associated with Industrial Action (£1.6m) and Medical payaward pressures (£0.4m)
- Net Pay overspend (£1.3m)

- **Favourable Variances**
  - Non recurrent benefits (£2.6m) and release of contingency (£0.5m)
  - Variable activity overperformance including change to ERF target (£1.8m)
  - Other operating income overperformance (£0.4m) and underspend to education budgets to the insourcing of the Exception People Outstanding Care training programme.

Risks

- **QFIT Service funding** – The ICB has confirmed funding will be allocated for 23/24 therefore this risk has now closed.
- **Community Diagnostic Centre (CDC**) delay to full occupancy – financial risk has arisen due to the delays in opening additional capacity in the CDC. Year to date there is under-performance against the income plan causing a net £1.8m pressure which is in part due to the delay to full capacity and also due to under utilisation of the CT capacity. There is a risk that costs won't be reduced to fully offset the loss in income.
- **CIP Delivery** - The Trust has a large CIP target for 2023/24 and there is £16.6m of unidentified CIP. The PMO continues to work with Divisions to improve CIP delivery.
- **Industrial Action** - The Trust will incur unfunded costs / loss in variable related income associated with future Industrial actions, based on current rates this could equate to c£0.9m pressure per month if consultants and junior doctors both strike.
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.

Cashflow position:

- The closing cash balance for August was £17.3m which is slightly lower than the plan value of £18.6m. The main variance relates to the Kent and Medway Orthopaedic Centre project where the expected spend has not been incurred in the first five months - the phasing information provided for the capital plan was based on orders rather than actual completion, so the plan year to date is ahead of expected delivery.
- 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 Trust is working with Suppliers, Procurement Department and budget holders/authorised signatories to ensure invoices are receipted, approved and paid as promptly as possible, this is to assist with the Trust adhering to the BPPC (Better Payment Practice Code) target of 95%. For August the percentages were for Trade suppliers by value 97.3% and by volume was 96.5%; for NHS suppliers by value 94.8% and by volume 89.9%.
- Within September the Trust has planned commitments paying PDC dividends of £3.4m and the capital loan and associated interest totalling £0.6m, both these commitments are paid in September and March.

Capital Position

- The Trust's capital plan, excluding IFRS16 items, agreed with the ICB for 2023/24 is **£38.5m**. The Trust's share of the K&M ICS control total is **£14.016m** for 2023/24. This includes **£4.996m** from system funds for the Phase 3 HASU completion; and **£6.41m** of the costs of the K&M Orthopaedic Centre (Barn Theatre) over and above the agreed national funding. Therefore the Trust has a net sum of **£2.6m** resource available to cover all other capital spend for the year. The Trust has now sold the MGH MRI for **£0.96m** (the net book value) as part of the outsourced contract, which in turn will support related enabling works for the new MRI at TWH. The cost of the enabling works has increased since the plan was set, but remains to be finally confirmed.

- **Additional Funding**
    - **£22.47m** of national funding for the Kent and Medway Orthopaedic Centre project is included. The FBC was approved at the NHSE/DHSC Joint Investment Scrutiny Committee on 12th June 2023. The Trust also received PDC of **£88k** for digital diagnostics for 2023/24. Subsequent to the plan submission, the Trust received confirmation from the ICB of the **£5.72m** required to complete the permanent CDC solution which was subject to slippage in 2022/23. The ICB will contribute £5.02m from the additional "fair-shares" capital and has obtained agreement that the additional £0.7m will be funded from NHSE national CDC funds. The CDC modular build tender is still under review and negotiation – the initial responses have come in over budget and with a timescale that moves the project completion into 2024/25. It is therefore now red rated as a risk.

- **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 5 Actuals (excluding IFRS16)**
    - The year to date spend at M5 is **£9.7m** against a year to date budget of **£22.9m**. The main variance relates to the Kent and Medway Orthopaedic Centre project where the expected spend has not been incurred in the first five months - the phasing information provided for the capital plan was based on orders rather than actual completion, so the plan year to date is ahead of expected delivery. Forecast outturn spend remains on plan.

- **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 lease remeasurements arising from increases to the rental agreements from inflation clauses, that now require to be capitalised. The remaining **£25.1m** is for potential new lease capitalisations: the most significant is the KMMS accommodation which is expected to be a value of **£15.3m** assuming completion by the end of 2023/24. NHSE regional office has indicated that expected commitments will be funded in 2023/24 but they are checking on assumptions in the submitted plans as overall Trusts have planned for more resource than HMT has allocated.

Year end Forecast:

- The Trust is forecasting to deliver a deficit of £1.3m which assumes there will be no further Industrial action.The Trust is awaiting further information on how this will be supported but is anticipating additional income to offset additional costs and bring the forecast back to a breakeven position.
- To deliver the forecast the trust will need to identify additional CIP (£4m), reduce premium staffing spend (£3m), increase clinical income (£1.5m), release remaining contingencies (£0.7m) and deliver £5m in run rate improvements.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 5
2023/24

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

August 2023/24

	Current Month					Year to Date					Annual Forecast / Plan		
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Variance*	*Forecast*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	61.1	58.9	2.1	(0.0)	2.2	286.0	283.9	2.1	(0.2)	2.3	697.7	686.7	11.0
Expenditure	(55.8)	(53.7)	(2.1)	0.0	(2.1)	(268.3)	(264.8)	(3.6)	0.2	(3.8)	(646.9)	(634.6)	(12.3)
EBITDA (Income less Expenditure)	5.2	5.2	0.0	0.0	0.0	17.7	19.1	(1.5)	0.0	(1.5)	50.8	52.1	(1.3)
Financing Costs	(4.2)	(4.3)	0.0	0.0	0.0	(21.4)	(21.4)	(0.0)	0.0	(0.0)	(69.5)	(69.4)	(0.1)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.0	0.0	0.0	17.3	17.3	0.0
Net Surplus / Deficit	**1.1**	**1.0**	**0.1**	**0.0**	**0.1**	**(3.5)**	**(2.0)**	**(1.5)**	**0.0**	**(1.5)**	**(1.3)**	**0.0**	**(1.3)**
Cash Balance	17.3	18.8	(1.5)		(1.5)	17.3	18.8	(1.5)		(1.5)	2.0	2.0	0.0
Capital Expenditure (Incl Donated Assets and IFRS16)	1.0	5.9	4.9		4.9	10.4	23.6	(13.2)		(13.2)	73.7	68.0	(5.7)
Cost Improvement Plan	1.3	2.9	(1.6)		(1.6)	6.3	8.5	(2.2)		(2.2)	16.7	33.3	(16.6)

Summary Current Month:
- The Trust was £1.1m in surplus in the month which was £0.1m favourable to plan. The Industrial action in August led to a £0.4m increase in temporary staffing and lost income due to cancelled elective activity of £0.2m.

Key Favourable variances in month are:
- National guidance for Elective Recovery Fund (ERF) for August was for organisations to report actual performance to the target (rather than plan in previous months). The ERF target for April was also reduced in recognition of the impact of industrial action, this resulted in £2.3m of additional income.
- Release of contingency (£0.8m) and non recurrent benefits mainly associated with a VAT review of 2022/23 financial year (£0.4m)

Key Adverse variances in month are:
- CIP Slippage (£1.6m)
- CDC delay to full capacity and also due to under utilisation of the CT capacity (£0.5m)
- Impact of Industrial action (£0.6m)
- Medical pay award (£0.4m). In line with national guidance the position includes the impact of the medical pay award (6% increase plus £1,250 consolidated payment for certain grades). The estimated cost of this

Year to date overview:
- The Trust is £3.5m in deficit which is £1.5m adverse to plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£2.3m)
- CDC delay to full capacity and also due to under utilisation of the CT capacity (£1.3m)
- Additional Costs associated with Industrial Action (£1.6m) and Medical payward pressures (£0.4m)
- Net Pay overspend (£1.3m)

Favourable Variances
- Non recurrent benefits (£2.6m) and release of contingency (£0.5m)
- Variable activity overperformance including change to ERF target (£1.8m)

CIP (Savings)
- The Trust has a savings target for 2023/24 of £33.3m and has delivered £6.2m year to date which is £2.3m adverse to plan.

Risks
- **QFIT Service funding –** The ICB has confirmed funding will be allocated for 23/24 therefore closing this risk.
- **Community Diagnostic Centre (CDC) delay to full occupancy** – financial risk has arisen due to the delays in opening additional capacity in the CDC. Year to date there is under-performance against the income plan causing a net £1.8m pressure which is in part due to the delay to full capacity and also due to under utilisation of the CT capacity. There is a risk that costs won't be reduced to fully offset the loss in income.
- **CIP Delivery -** The Trust has a large CIP target for 2023/24 and there is £16.6m of unidentified CIP. The PMO continues to work with Divisions to improve CIP delivery.
- **Industrial Action** - The Trust will incur unfunded costs / loss in variable related income associated with future Industrial actions.
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.

Aug-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	90.4%	87.4%	-	-	150.9%	222.6%	-	-	37.5%	37.6%	108	7.70	33	9.7	16.0%	94.1%	2	0		186,227	215,373	(29,146)
MAIDSTONE	Stroke Unit (M) - NK551	100.4%	77.2%	-	100.0%	105.6%	94.3%	-	-	48.5%	5.1%	279	19.61	38	9.9	54.2%	100.0%	7	1		672,350	430,346	242,004
MAIDSTONE	Cornwallis (M) - NS251	69.5%	124.7%	-	-	108.6%	221.7%	-	-	15.4%	6.1%	44	2.92	7	9.0	86.1%	96.2%	2	0		0	4,256	(4,256)
MAIDSTONE	Culpepper Ward (M) - NS551	109.1%	69.9%	-	-	122.6%	177.4%	-	-	19.2%	0.4%	19	1.26	2	5.3	2.9%	100.0%	0	0		118,416	142,441	(24,025)
MAIDSTONE	Edith Cavell - NS459	78.0%	85.1%	-	-	96.9%	91.9%	-	-	23.8%	13.2%	39	2.71	3	5.2	22.2%	100.0%	4	2		121,085	131,080	(9,995)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	87.3%	110.8%	-	-	103.2%	114.5%	-	-	22.7%	16.6%	77	5.29	17	6.5	44.8%	100.0%	5	2		156,436	181,804	(25,368)
MAIDSTONE	Intensive Care (M) - NA251	100.6%	86.7%	-	-	94.8%	87.6%	-	-	7.6%	0.0%	67	4.68	29	57.8	600.0%	100.0%	0	0		240,066	253,711	(13,645)
MAIDSTONE	Lord North Ward (M) - NF651	83.4%	98.2%	-	100.0%	98.8%	96.8%	-	-	15.6%	0.0%	35	2.60	6	7.1	34.5%	90.0%	3	2		117,054	126,585	(9,531)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	80.4%	51.4%	-	100.0%	77.4%	-	-	-	5.6%	0.0%	3	0.21	1	20.8	0.0%	97.4%	0	0		63,581	55,697	7,884
MAIDSTONE	Mercer Ward (M) - NJ251	87.4%	98.1%	-	100.0%	119.1%	106.5%	-	-	21.1%	2.5%	19	1.33	1	5.6	100.0%	100.0%	4	1		114,115	146,998	(32,883)
MAIDSTONE	Peale Ward COVID - ND451	82.4%	103.1%	-	100.0%	103.3%	123.3%	-	-	24.9%	2.8%	58	4.03	11	8.6	46.4%	100.0%	4	0		128,647	104,790	23,857
MAIDSTONE	Pye Oliver (Medical) - NK259	95.7%	103.7%	-	-	125.7%	109.7%	-	-	33.0%	4.2%	51	3.45	3	6.3	20.3%	78.6%	7	3		135,990	160,250	(24,260)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	90.3%	92.6%	-	-	87.0%	-	-	-	18.0%	0.0%	24	1.41	7	37.5	0.0%	100.0%	1	0		58,446	60,006	(1,560)
MAIDSTONE	Whatman Ward - NK959	104.9%	79.7%	-	100.0%	120.5%	200.0%	-	-	39.7%	8.8%	75	5.26	12	6.6	16.3%	100.0%	4	1		104,475	164,682	(60,207)
MAIDSTONE	Maidstone Birth Centre - NP751	94.8%	98.1%	-	-	99.9%	96.8%	-	-	20.2%	0.0%	33	1.91	0	34.9	0.0%	100.0%	0	0		77,570	95,101	(17,531)
TWH	Acute Medical Unit (TW) - NA901	86.2%	45.0%	-	100.0%	89.3%	71.4%	-	-	18.5%	12.5%	101	7.33	32	6.8	23.7%	82.1%	6	0		254,956	267,100	(12,144)
TWH	Coronary Care Unit (TW) - NP301	81.8%	72.7%	-	-	76.1%	-	-	-	12.2%	0.0%	27	2.02	8	10.0	56.5%	100.0%	0	0		75,962	74,374	1,588
TWH	Hedgehog Ward (TW) - ND702	75.8%	154.0%	-	-	76.9%	160.0%	-	-	26.7%	19.9%	129	8.77	41	9.0	38.9%	98.9%	0	0		153,164	191,084	(37,920)
TWH	Intensive Care (TW) - NA201	108.3%	92.5%	-	-	104.6%	88.7%		-	4.9%	0.0%	53	3.43	13	33.3	1400.0%	92.9%	0	1		381,661	380,138	1,523
TWH	Private Patient Unit (TW) - NR702	102.4%	84.7%	-	-	54.8%	103.2%	-	-	22.1%	0.0%	39	2.54	4	7.3	89.4%	100.0%	0	0		73,468	79,575	(6,107)
TWH	Ward 2 (TW) - NG442	69.5%	57.7%	-	100.0%	112.1%	121.1%	-	100.0%	24.7%	1.6%	72	5.20	24	6.2	79.1%	88.2%	9	3		183,318	187,436	(4,118)
TWH	Ward 10 (TW) - NG131	105.0%	81.9%	-	100.0%	87.0%	141.9%	-	-	29.8%	6.6%	78	5.44	18	6.1	29.6%	95.8%	2	0		149,847	175,966	(26,119)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	86.5%	60.3%	-	-	140.0%	75.7%	-	-	0.0%	No hours	0.00	0.00	0.00	-	-	-	0	0		-152,878	-41,180	(111,698)
TWH	Ward 12 (TW) - NG132	94.1%	87.0%	-	100.0%	135.6%	80.6%	-	-	25.8%	14.7%	114	7.43	30.00	5.9	49.3%	100.0%	6	1		149,950	183,684	(33,734)
TWH	Ward 20 (TW) - NG230	107.3%	64.3%	-	100.0%	174.2%	90.3%	-	-	38.2%	28.6%	120	7.86	37	6.8	56.5%	96.2%	2	2		176,689	213,023	(36,334)
TWH	Ward 21 (TW) - NG231	88.2%	94.2%	-	100.0%	105.8%	114.5%	-	-	18.2%	8.9%	85	5.48	24	6.0	12.5%	100.0%	9	0		152,563	183,832	(31,269)
TWH	Ward 22 (TW) - NG332	79.5%	75.6%	-	-	125.0%	93.8%	-	-	22.0%	0.9%	105	7.48	30	5.2	75.5%	86.5%	9	3		150,276	188,927	(38,651)
TWH	Ward 30 (TW) - NG330	83.7%	77.1%	-	100.0%	135.3%	127.8%	-	-	41.8%	0.0%	151	9.55	43	6.0	40.8%	85.0%	3	5		128,507	162,349	(33,842)
TWH	Ward 31 (TW) - NG331	86.4%	86.4%	-	100.0%	130.8%	106.0%	-	-	33.6%	0.6%	166	10.84	52	6.2	17.4%	100.0%	13	4		142,604	179,859	(37,255)
TWH	Ward 32 (TW) - NG130	85.9%	83.8%	-	100.0%	68.6%	65.6%	-	100.0%	24.5%	1.7%	92	6.17	24	7.5	0.0%	94.7%	1	0		151,293	159,337	(8,044)
TWH	Ward 33 (Gynae) (TW) - ND302	93.7%	77.6%	-	-	77.4%	93.1%	-	-	30.4%	0.0%	53	3.51	7	6.4	2.2%	100.0%	0	0		102,927	102,521	406
TWH	SCBU (TW) - NA102	89.7%	69.4%	-	-	93.2%	75.0%	-	-	17.8%	4.2%	103	6.26	2	16.1	80.0%	100.0%	0	0		212,704	197,166	15,538
TWH	Short Stay Surgical Unit (TW) - NE901	73.1%	62.9%	-	100.0%	67.0%	96.8%	-	100.0%	11.1%	4.8%	34	2.31	6	10.1	8.8%	97.1%	0	0		83,819	100,340	(16,521)
TWH	Surgical Assessment Unit (TW) - NE701	98.4%	134.5%	-	-	64.5%	96.8%	-	-	18.6%	0.0%	34	2.26	1	16.5	4.7%	95.0%	0	0		78,755	77,123	1,632
TWH	Midwifery (multiple rosters)	69.9%	69.6%	-	-	82.4%	87.8%	-	-	11.4%	1.2%	527	30.80	146	**12.0**	62.6%	99.7%	**0**	**0**		**848,850**	**888,056**	**(39,206)**
Crowborough	Crowborough Birth Centre (CBC) - NP775	58.0%	92.9%	-	-	55.7%	70.8%	-	-	11.7%	0.0%	67	3.51	19	184.5	16.3%	100.0%	0	0		149,148	101,005	48,143
MAIDSTONE	Accident & Emergency (M) - NA351	96.5%	89.7%	-	100.0%	101.3%	74.2%	-	-	40.9%	42.5%	481	33.17	43	-	0.0%	90.1%	3	0		386,824	485,065	(98,241)
TWH	Accident & Emergency (TW) - NA301	94.0%	77.6%	-	100.0%	97.4%	85.6%	-	100.0%	34.3%	31.4%	356	24.84	25	-	7.9%	88.3%	4	0		416,455	502,658	(86,203)
																				Total Established Wards	**6,745,320**	**7,312,556**	**(567,236)**
																				Additional Capacity bed: Cath Labs	57,909	50,266	7,643
																				Foster Clerke - NS251	320,356	264,317	56,040
																				Other associated nursing costs	4,777,917	5,070,777	-292,860
																				Total	#########	#########	**-796,414**

Under fill

Overfill

Green: equal to or greater than 90% but less than 110%

Amber Less than 90% OR equal to or greater than 110%

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

NHS Maidstone and Tunbridge Wells NHS Trust

Confirmation of the updated Vision Goals, Vision Targets, Breakthrough Objectives and Corporate Projects	**Director of Strategy, Planning and Partnerships**

The enclosed report provides information on the updated corporate objectives and corporate projects as part of the refresh of Strategy Deployment Review.

Which Committees have reviewed the information prior to Board submission?
The proposals have been considered by the Executive Management Team at multiple SDR review meetings and the Board away day in June

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

[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

Corporate Objectives Update 2023/24

Rachel Jones
Executive Director Strategy, Planning & Partnerships

September 2023

To be successful we must deliver the breakthrough objective and target of each strategic theme for the year ahead, along with our corporate projects.

Strategic Theme	Goal	Target	Breakthrough Objective
Patient Experience	To have 0 occurrence of negative communication themed complaints	To reduce the overall number of complaints or concerns each month to a target of 24 by March 2024.	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.
Patient Safety and Clinical effectiveness	No significant avoidable harm: 0.7 per 1000 beddays (eradicates all severe and above harm)	Reduce moderate and severe harm rate from a 12 month average of 1.0 per 1000 occupied bed days to 0.9 per 1000 occupied bed days by April 2024 and 0.85 per 1000 bed days by December 2024	Reducing Deteriorating patients and sepsis by 50%
Patient Access	To ensure we are achieving all constitutional patient access standards.	Achieve the Trust RTT Trajectory by March 2024	To achieve the planned levels of new outpatient activity shown as % 19/20
Systems & Partnerships	No patient resides in an acute hospital bed who needs care that can be provided in another setting.	Decrease the number of occupied bed days relating to delayed discharges from our hospitals	**Internal**- to increase the number of patients leaving our hospitals by noon on the day of discharge **External**- To provide appropriate care capacity to enable timely discharge of patients to other settings
Sustainability	Continued delivery of financial plan, with a modern and fit for purpose environment and infrastructure	Delivery of financial plan, including operational delivery of capital investment plan	Reduce the amount of money the Trusts spends on premium workforce spend
People	Achieve a Trust wide vacancy level of 7% over two years - by end financial year 2025-6. This would move MTW into one of the top performing NHS trusts in the South East.	Reduce the Trust wide vacancy rate to 8% by January 2024	Reduce turnover to 12% by March 2024

Our Corporate Projects enable delivery of our priorities, progress our corporate strategy and are aligned with the strategic themes

Proposed Corporate Projects 2023/24	1st Project Goal	Project SRO
Workforce Supply	Streamline the recruitment process, focusing on both the time to hire and candidate experience	Sue Steen
EDI Strategy Implementation	The key areas to be implemented for the project – • MTW EDI strategy 6 pillars • NHS England Improvement plan 6 High Impact Actions	Sue Steen
Outstanding Care Programme. Phase 2 QA Framework	*To establish a robust quality framework across the trust aligned to the KLOEs and EPOC. PFIS (patient first improvement system) will be used to address some of the gaps identified from the self assessments.*	Jo Haworth
Mental Health in Acute Care	1. Agree governance structure for the oversight of the holistic care of mental health patients being treated in MTW internally 2. Define datasets and enable reporting on patients with mental health requiring treatment in MTW	Jo Haworth
Overhaul of Incident reporting categories	Aim: to enable more meaningful incidents information gathering as 45 categories constitute 20% of moderate and above harm incidents which may be categorised better	Peter Maskell
EPMA	*The EPMA Project will ensure that the Trust has a robust system that delivers safe, high quality and cost-effective system to order prescriptions across MTW (excluding chemotherapy) .*	Peter Maskell
Patient Portal	Improve patient-provider communication through secure messaging, and increased patient participation in healthcare decisions.	Sean Briggs
Direct Access	Support patients gaining access to diagnostic services provided by MTW	Sean Briggs
Workforce Efficiencies	Achieve the 23/24 budget for agency and bank expenditure.	Steve Orpin

Following approval, the next steps are as follows:

Trust Level	• Finalise objectives at Trust Level • Update integrated score card to reflect 23/24 BTOs, targets and corporate projects
Divisional Level	• Update divisional scorecards • Cascade to Divisions through the scorecards • Divisional priorities to be agreed through a mini catch ball process
Collectively	• Ensure delivery capacity requirements can be met • Move into implementation phase

Appendices

Our Vision A3 2023/24

Our Vision Category- Patient safety & Clinical Effectiveness Working together to put quality at the heart of all that we do. Reducing moderate, severe and catastrophic avoidable harm.

1) Problem statement

An emerging patient safety issue linked to Failure to rescue (FTR) has been identified resulting in the most significant patient harm in the trust which needs to be addressed as a strategic priority. We provide quality care in the majority of cases but some patients suffer considerable avoidable harm, and we can't be certain we learn from these events. This has a significant impact on patients, staff and the organisation.

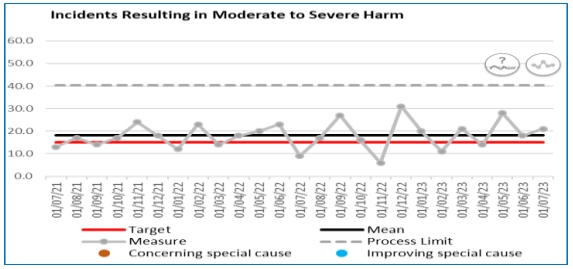
2) Vision statement

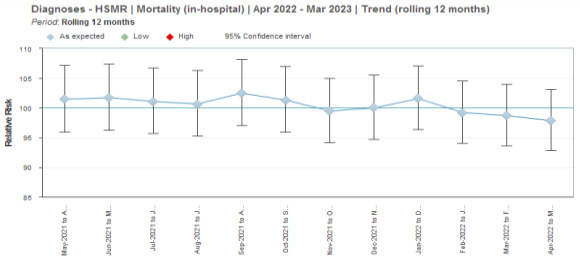
A patient safety focused organisation delivering safe care free from significant avoidable harm with a blame free reporting and real time learning culture.

3) Current state and proposed measures for baseline

.

- On average there are 18 incidents on a monthly basis causing moderate and above harm constituting 12% of all incidents reported within the trust. This cohort of harm incidents constitutes the principal impact to patient safety.
- The profile of patients affected and severity of harm greatly impacts on patient, staff, number legal cases, claims, inquests and adverse comms/reputation for the trust.
- Our HMSR is below 100 at 97.8 (Apr 22-Mar23), within expected levels, with weekday and weekend rates also within expected levels below 100.





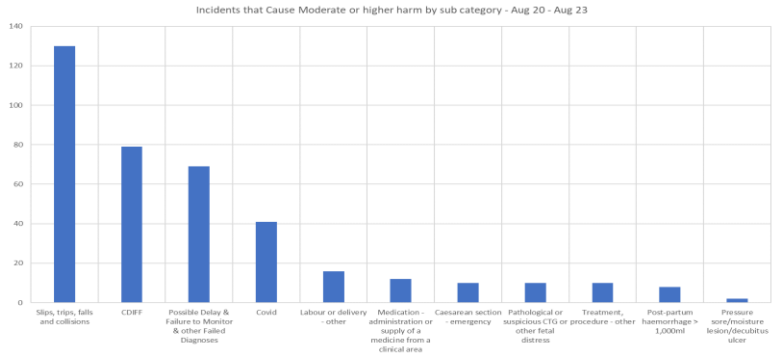
4) Target and goal

Target:
Reduce moderate and above harm rate from a 12 month average of 1.0 per 1000 occupied beddays to 0.9 per 1000 occupied beddays by April 2024 and 0.85 per 1000 beddays by December 2024

Goal: No significant avoidable harm: 0.7 per 1000 beddays
(eradicates all severe and above harm)

5) Analysis

The highest categories of incidents resulting in significant harm (fatality) and SIs is for Possible delay or failure to monitor



Serious Incidents reported by STEIS Category 2020-2023	Volume
Slips/trips/falls meeting SI criteria	50
Treatment delay meeting SI criteria	37
Failure to obtain appropriate bed for child who needed it	35
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	30
Radiation incident (including exposure when scanning) meeting SI criteria	24
HCAI/Infection control incident meeting SI criteria	21
Sub-optimal care of the deteriorating patient meeting SI criteria	21
Confidential information leak/information governance breach meeting SI criteria	11
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus. neonate and infant)	11
Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus. neonate and infant)	10
Surgical/invasive procedure incident meeting SI criteria	9
VTE meeting SI criteria	8
Apparent/actual/suspected self-inflicted harm meeting SI criteria	7
Major incident/ emergency preparedness. resilience and response/ suspension of services	7
Substance misuse whilst inpatient meeting SI criteria	7
Maternity/Obstetric incident meeting SI criteria: mother only	5
Other	28
Total	321

- Slips trips and falls is the biggest contributor to moderate and above harm, however extensive work has been completed within falls evidenced by a record rate if 4.9 per 1000 bed days in July 2023 a rate lower than pre Covid levels. Infection control includes Covid and CDIFF therefore the next biggest category is 'Possible delay and failure to monitor.

*SI framework is due to change in the near future and data for SI categories will no longer be collated.

6) Implementation plan

Breakthrough objective: Reducing Deteriorating patients and sepsis by 50%

Corporate Project: Overhaul of Incident reporting categories (Aim: to enable more meaningful incidents information gathering as 45 categories constitute 20% of moderate and above harm incidents which may be categorised better)

EPMA: EPMA has been delivered in all areas apart from W&C, with implementation in this division starting in January.

CP **Project Charter:** **Workforce Supply Corporate Project** **Date Charter Agreed** August 2023

Problem Statement

At MTW, there are issues recruiting the best talent to the Trust, and the time to hire, from offer to starting in post, can take several months with sometimes little contact with the new recruits in the interim. Once a new starter joins , the onboarding process can be inconsistent depending on the department, affecting the overall candidate experience. A poor onboarding experience, as well as a perceived lack of opportunity to professionally develop, are key reasons behind why staff are leaving the Trust, leading to a current turnover rate of almost 12.5%.

Scope

In Scope

- All staffing groups
- Temporary and staff

Out of Scope

- Agency staff

Project Goal

- Improve our methods of attraction into MTW
- Streamline the recruitment process, focusing on both the time to hire and candidate experience
- Review, improve and embed the current onboarding of new starters to the Trust
- Use consistent workforce planning and talent management practices in order to reduce turnover
- Use the outputs and insights from this Programme to develop a Workforce Supply Strategy

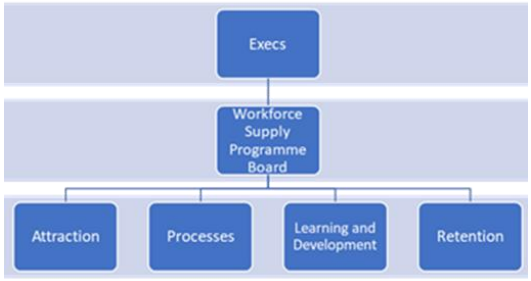
Exit Criteria

- Data quality and reporting available
- Holistic review of recruitment , onboarding, NHS Staff Survey and patient experience feedback that relate to primary and additional benefits – see below.
- Consistent delivery of talent management practices and of programme KPI measures – see below.
- Developed evidence-based Workforce Supply Strategy.

Sponsor & Project Team

Exec Sponsor – Sue Steen (Chief People Officer)
Project Lead – Rob Henderson (Deputy Chief People Officer)
Attraction Workstream Lead – Jenny Pett (Attraction Manager)
Resourcing Process Workstream Lead – Ramadan Cader (Interim Head of Resourcing)
Learning & Development (L&D) Workstream Lead – Haylie Usher (Head of Learning & Development)
Project Support – James Ripley (Senior CI Manager, I & D)
BI Lead – Gavin Ward (Information Business Partner: Corporate)

Governance Structure



Project Roadmap & Timescales

Key Milestones	Completed by
Review the current use of Recruitment & Retention Premia (RRP) and confirm and propose as appropriate a revised process for the consideration and approval of Trust-wide incentives for attraction and retention of staff, by October 2023	October 2023
95% of all eligible staff attend their values based induction session within 10 working days of start date by October 2023, based on a Q1 2023/24 baseline	October 2023
Introduce 12 key attraction and resourcing processes to support automation of the recruitment pathway, by January 2024, and deliver a reduction in appropriate Time To Hire (TTH) metrics by 45% from a Q1 2023/24 baseline	January 2024

Critical Success Factors & Key Risks

- MD team to lead improvement work
- Detailed analysis of reasons for leaving, with identified root causes/themes
- Communications strategy

Risks

- Lack of engagement from all staff groups
- Capacity to deliver workstreams
- National staff shortages
- Competition and pay (AfC pay scales)

Programme KPI's (Target)

KPI Measure	Target
Decrease overall time to hire (conditional offer letter to sign off) to 25 working days by December 2023	25 WD
Decrease the percentage of withdraws (AfC) from the offer stage to 10% by March 2024	10.0%
Decrease the percentage of withdraws (medical) from the offer stage to 10% by March 2024	10.0%
For all new eligible medical staff to attend values based session within 10 working days of start date	95%
For all new eligible clinical staff to attend values based session within 10 working days of start date	95%
For all new eligible corporate staff to attend values based session within 10 working days of start date	95%
Increase internal usage of apprenticeships funds by 10% for the year 2023-24 compared to the year 2022-23 (exc. Transferred funding)	Increase by 10%
Reduce the expired levy funds by 5% calculated on the 2021/2022 value	16.97%

Benefit Realisation

Primary benefits:

- Improved methods of attraction
- Reduced time to hire
- Improved career opportunities for staff for ongoing development

Additional benefits:

- Reduction in staff turnover, leading to improved retention
- Reduction on agency spend to fill vacancies
- Improved staff morale and motivation (Staff Survey)
- Reduction in staffing pressures due to improved staffing levels
- Enhanced patient experience

Project Charter: EDI Strategy Implementation

Date Charter Agreed: July 2023

Problem Statement

Throughout the NHS there is evidence that staff from under-represented groups have worse experiences at work. The COVID-19 pandemic has exacerbated this and for some it has highlighted further the inequalities they face, from pay and award gaps, recruitment and promotion gaps, under representation at senior levels in the workforce, lack of inclusion and being discriminated against. We hear the lived experiences of our staff from minority groups and see the data from our staff surveys, gender pay gap, workforce race and workforce disability reports.

Scope

In scope

EDI strategy
-MTW 6 pillars
- Inclusive recruitment, talents management and succession planning, civility, kindness and respect, Voice and engagement, leadership and values and behaviours
NHS England Improvement plan
6 High Impact Actions
- Leadership accountability, inclusive recruitment process, eliminate a gap, health inequalities within workforce, on boarding programme and eliminate bullying discrimination harassments

Out of scope

Workforce supply (attraction retention and flexible working)if

Project Goal

To implement the approved MTW EDI strategy by the Trust Board on 29 January 2023. The objective is to deliver and implement the equity diversity and inclusion strategy over the next 12 to 18 months for MTW. To provide the training, education and key process changes in the EDI strategy and measure against national targets.

The key areas to be implemented for the project –

- MTW EDI strategy 6 pillars
- NHS England Improvement plan 6 High Impact Actions

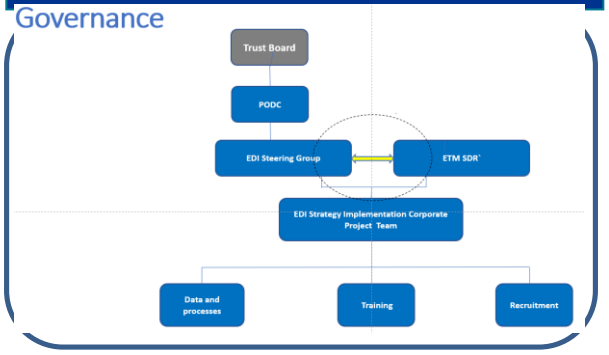
Exit Criteria

- Data quality and reporting available
- Review of WRES,WDES, NHS Staff Survey
- Delivery of all training modules - 90%
- Delivery of Education module – 90%
  download.cfm (mtw.nhs.uk)
- Training programme developed and part of BAU in terms of new managers / starters induction.

Sponsor & Project Team

- Steve Orpin - App Deputy Chief exec (co-chair)
- Sue Steen Chief for people Officer (Co-chair)
- CBC cultural and inclusive NED
- Jo Taylor – Project Lead
- TBC - Chief service divisional /director of operations/ divisional director of nursing and quality
- Network reps (3)
- Rob Henderson – HR Lead
- Haylie Usher – L&D Lead
- Ainne Dolan – Interim FTSU
- Carol Still – BI Lead
- Larissa Derek - Wellbeing
- PMO -Natacha Deschamps-Smith/Faith Aisien-Ezugwu
- TBC - patient experience lead

Governance Structure



Project Roadmap & Timescales

Key Millstones	Completed by
PID, TOR,	July to Aug 23
Workstreams	Aug-23
finalise scope, project governance, project and resource planning	Aug-23
Stakeholder Map	Aug-23
Baseline and Targets	Sep-23
Design Training programme	Sept 23 to Oct 23
Communication plan	Oct-23
Roll out – internal training to deliver and implement Roll out – external commission-based training	Oct 23 – July 24
Measure outcome	Jan-24
Face to Face/E-learning module for BAU	July - Aug 24

Critical Success Factors & Key Risks

Critical Success Factors

- Stakeholder engagement and collaboration
- staff are able to attend training
- Regular data reporting
- Improvement in staff survey

Risks

- Lack of managers/staff engagement
- Resistance to change – in not embedding EDI ethos into the existing MTW culture
- Lack of resources (staffing,)?
- Operational pressures
- Lack of quality data

Programme KPI's (Target)

KPI's	Baseline	Target
MTW acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	55.6%	69.4%
Discrimination at work from patients, relatives or members of the public	8.4%	2.7%
Discrimination at work from manager or colleagues	9.5%	4.2%
MTW respects individual differences (e.g. cultures, working styles, backgrounds, ideas etc)	71.3%	81.6%
People are polite and treat each other with respect	72.7%	78.9%
Confidence that MTW would address my concerns if I spoke up	57.3%	69.1%
Reporting harassment, bullying or abuse at work	46.6%	57.0%
Experiencing harassment, bullying or abuse at work from managers	13.0%	6.4%
Experiencing harassment, bullying or abuse at work from colleagues	21.0%	12.3%

Benefit Realisation

- Cultural competence
- Enhanced patient care
- Reduced health disparities
- Innovation and problem solving
- Staff satisfaction and retention
- increased accountability for leaders to embed inclusive leadership and promotion equal opportunities and fairness i.e. by having EDI reps in all interviews
- Increased numbers of diverse staff in the workplace in line with the national staff survey

Project Charter: Mental Health Patients' experience of care within MTW

Date Charter Agreed DRAFT

Problem Statement

Background:
In 2022, a significant percentage of the Trust's beds were occupied by patients presenting with a mental health condition or that have a physical illness with a mental health comorbidity. In the urgent care pathway these patients: MH Primary Patients represent around 4% of ED attendances, 4% of admissions and 6% of inpatient bed occupancy. MH Secondary patients represent 12% of ED attendances, 24% of admissions and 37% of bed occupancy. MH Prior patients represent 18% of ED attendances, 19% of admissions & 19% of bed occupancy. 41% of pregnant women who attend ED have the above characteristics. Finally, it is clear that more a patient displays a diagnosis or flag of mental health, the more likely they would have a frequent reattendance (for example: 65% of patients who have 6 or more reattendances have a diagnosis/flag of mental health and goes up to 85% for twelve or more. Given the large volume of patients in the Trust with either a primary or secondary mental health presentation or physical health condition with a mental health comorbidity, it is of real concern that we do not have a centralised or coordinated view of the access, quality, safety or experience of care the patients with a mental health diagnosis or flag receive at our hospitals. Consequently, the Trust Board is not sighted on the scale of demand, or the quality of care and experience that these patients receive in the Trust. In 2019, the CQC made it clear that as part of its regulatory framework, that the Trust would be expected to provide evidence on how the mental and physical health needs of all its patients were being met and how it was working in partnership with other organisations to ensure appropriate access to high quality care in appropriate environments.

Scope

In scope
- MTW patient pathways for patients with mental health needs

Out of scope
- Dementia and no other mental health flags
- Implementation of the strategy and solutions to improve care of mental health patients

Project Goal

1. Agree governance structure for the oversight of the holistic care of mental health patients being treated in MTW internally
2. Define datasets and enable reporting on patients with mental health requiring treatment in MTW
3. An organisational strategy that identifies key priorities for improvement in the care provided for patients with mental health issues
4. Evidence of improved collaboration in delivering the strategy.

Exit Criteria

1. Mental health strategy agreed by the Trust board
2. Appropriate governance for the oversight of the care of patients with mental health needs
3. Availability of dashboard reports on the care received by patients with mental health needs at MTW

Sponsor & Project Team

- Exec Sponsor: Jo Haworth
- Project Lead: Jim MacDonald
- Corporate Projects Lead: Puddy Makoyo & Natacha Deschamps-Smith
- CI Lead: Sriaswini Manjunathan
- BI: James Jarvis's team
- Sunrise Team: Jane Saunders

Governance Structure

Project Roadmap & Timescales

Planned Gateways / Milestones
Reporting:
- Defined Datasets on patients with mental health in our trust
- Pilot in one or more of the clinical areas on appropriate data capture required to provide datasets
- Change in IT systems to capture, update and report on, patients with mental health needs with details on the pathways

Collaboration:
- Stakeholder map
- MTW's input into ICS' Enhanced Care programme?
- Agreement on roles and responsibilities in the care of patients with mental health needs
- Governance put in place for oversight of care provided to mental health patients treated at MTW

Mental health strategy
- Feedback compiled from stakeholders (patients, family, MTW staff, KMPT staff) on key priorities for improvement in the care of patients with mental health needs identified
- Strategy drafted and approved by MTW Board

Critical Success Factors & Key Risks

Critical Success Factors
- Visibility of mental health patients via reports

Risks
- Funding may be required if any IT solution is necessary for the implementation of the project

Project KPI's (Target)

1. 90% of patients with mental health needs are included in reporting
2. Improvement in staff survey results -tbc

Benefit Realisation

Direct
- Staff satisfaction – Result from the Staff survey
- Reduction in negative feedback received from Patients, Friends and Family Testing
- Reduction in complaints linked to additional mental health needs

Economic
Reduced LoS for patients with mental health needs

CP **Project Charter:** Overhaul of Incident reporting categories | **Date Charter Agreed** | Draft Sept 2023

Problem Statement

There are over 84 categories under which harm occurring in the trust can be reported. 80% of overall harm can be attributed to 11 categories meaning that the other 20% of harm incidents reports is spread out over 70 categories that meaningful information cannot be retrieved to aid harm improvement. The vast number of categories under which a harm incident is reported under have very few incidents and by reducing the number of categories we should be able to produce more meaningful data to enable us to review by themes.

Scope

In scope:
- All harm incidents reported via InPhase

Out of scope:
- TBC

Project Goal

- Accurate reporting of harm incidents
- Reduction in the total number of categories
- Thematic reviews enabling learning through data

Exit Criteria

1. Recategorisation of InPhase incident categories to enable more meaningful incident reporting.
2. New Categories live on InPhase
3. All staff using correct categories

Sponsor & Project Team

- Sponsor –Peter Maskell
- Champion - Helen Callaghan
- Project lead – Carrie Parmenter
- Core delivery team: Patient Safety and Clinical effectiveness
- Exit Process Owner – Carrie Parmenter

Governance Structure

- Project report to ETM SDR via the Deteriorating Patients Steering Group
- Project workgroup reporting to Deteriorating patients and Steering Group

Project Roadmap & Timescales

Define	Define the objectives –Oct 23
Measure	Review of Categories Oct – Nov 23
Analyse	Identify new Category List – Nov 23
Improve	Active implementation Nov -Dec
Control	Monitoring of reporting Jan – March 24

Critical Success Factors & Key Risks

Critical Success Factors
- Engagement of clinical teams to support the corporate project.
- Adequate resource within the Patient Safety team to deliver the project

Risks
- Lack of engagement with the incident reporting process
- Inability to analyse all harm data in a meaningful way to aid quality improvement

Project KPI's (Target)

- Project will enable more meaningful KPI's across the Trust

Benefit Realisation

- More meaningful information about harm and areas needing improvement to be gained from incidents data
- Improved engagement with reporting incidents of harm within the trust

Project Charter: Direct Access | **Date Charter Agreed** | Draft Sept 2023

Problem Statement

Patients have been experiencing delays in gaining access to secondary care due to delays with accessing GP services that have historically been required to refer patients for investigations and diagnostic assessments. As part of the Patient Access strategy, we need to ensure that patients can access the care they need to ensure they have the best chance of getting a good outcome, there is therefore a need to create a clear pathway .

Scope

In scope:
Pathways with clear NICE guidelines criteria for seeking secondary care that MTW specialises in
(Local) population: West Kent only? East Sussex?

Out of scope
tbd

Project Goal

- Support patients gaining access to diagnostic services provided by MTW

Exit Criteria

Direct access pathways to specialist services in MTW available to patients with clear criteria without the need of a GP referral

Sponsor & Project Team

Executive Sponsor – Sean Briggs
Programme Director – Alice Farrell
Clinical Service Lead –
Divisional Lead –
Contracts Lead –
Finance Manager –
PMO Manager – Toyin Falana

Governance Structure

Project Roadmap & Timescales

Planned Gateways / Milestones

Critical Success Factors & Key Risks

Critical Success Factors
New triage system in place to assess whether direct access is appropriate

Risks

Project KPI's (Target)

Time to access diagnostics without a GP referral (similar to RTT)
Number of patients accepted without a referral

Benefit Realisation

Project Charter:	Workforce Efficiency Project	Date Charter Drafted	June 2023

Problem Statement

In the last financial year (2023/24), Trust expenditure on agency staffing was 6% of the overall pay-bill (c£28m). A further c£46m was spent on bank shifts. The Kent and Medway system has agreed a system ceiling of £72m on agency spend in 2024/25, ensuring that agency expenditure is no more than 3.8% of the overall pay-bill. For MTW, the plan for 2023/24 is a budget of £10.3m for agency and £26.6m for bank, within an overall pay budget of £403.5m.

Whilst divisions will remain responsible for the overall delivery of their financial plans, including pay and CIP, there are a number of elements of temporary staffing spend that require central coordination, given their scale and complexity. It is for this reason that the workforce efficiency programme has been established.

Scope

In scope

- AfC rostering and policy
- Medical rostering and policy
- Data and KPIs
- Training
- Consultant recruitment
- Bank efficiency

Out of scope

- Scope of workforce supply programme

Project Goal

- Achieve the 23/24 budget for agency and bank expenditure.
- Inform the 2024/25 CIP programme.

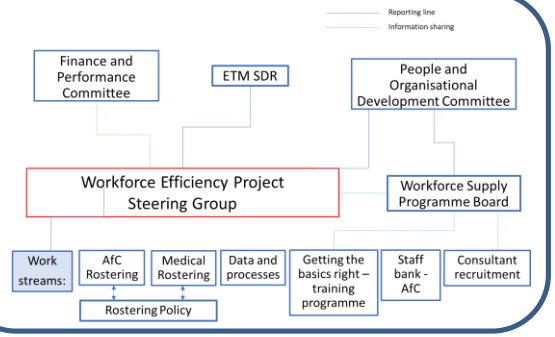
Exit Criteria

- All workstreams complete.
- Agency and bank expenditure improvements BAU within divisions and corporate directorates.

Sponsor & Programme Team

- Steve Orpin – SRO
- Katie Goodwin – Programme Lead
- Rob Henderson – Deputy Chief People Officer
- James Jarvis – AD of Business Intelligence
- Charlotte Wadey – Deputy Chief Nurse (workforce)
- Jim MacDonald – Deputy Medical Director
- Sarah Davis – Deputy Chief Operating Officer
- Hannah Ferris – Deputy Director of Finance
- Natacha Deschamps-Smith - PMO

Governance Structure



Project Roadmap & Timescales

Key Milestones	Completed by			
	Q3 2023	Q4 2023	Q1 2024	Q2 2024
Medical rostering pilot delivered - System specs clearly detailed	Oct 23			
Business Case for new medical rostering system		Dec 23		
Medical rostering policy created and approved			Feb 24	
AfC rostering policy reviewed and approved			Feb 24	
Training programme delivered and integrated in BAU processes			Mar 24	
Go Live with new medical and AfC existing or enhanced rostering systems				Apr 24
Data - Finance				

Critical Success Factors & Key Risks

Critical Success Factors

- Data: detailed reports to facilitate managerial actions
- Collaboration and engagement from all stakeholders

Risks

- Staff morale
- Patient safety
- Embedding efficiency within MTW culture
- Workforce strikes

Programme KPI's (Target)

1. Agency spend vs previous month, same month previous year and budget
2. Bank spend vs previous month, same month previous year and budget

NOTE: REMINDER TO BE CONFIRMED AND REPORTED AS PART OF PROGRAMME

Benefit Realisation

- Supporting "Team MTW" (ie substantive staff)
- Achieving budget for 2023/24
- Informing 2024/25 CIP programme

NHS Maidstone and Tunbridge Wells NHS Trust

Self-certification to deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation — **Chief Operating Officer**

Summary

As part of the protecting and expanding elective and cancer recovery for the year ahead, Trusts are required to provide assurance by 30 September 2023 against a set of activities that will drive outpatient recovery at pace by a self-certification process signed off by the Trust Board. The full letter is enclosed as Appendix 1.

Analysis and Conclusions

Section 1 – Validation
Section 2- First Outpatient appointment
Section 3- Outpatient Follow up
Section 4 – Support Required

Recommendation

Self-certification by the Trust Board

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 19/09/23

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

Discussion and decision

[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

Section 1: Validation

Section 2: First Outpatients

Section 3: Outpatient Follow Ups

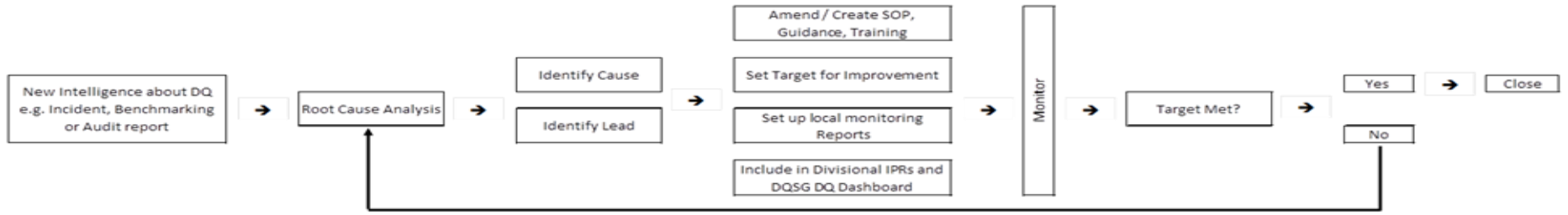
Section 4: Support Required

Section 1: Validation

- Luna is the national RTT Data Quality (DQ) tool which benchmarks providers against 13 DQ indicators
- MTW current position shows 99.37% confidence levels in the quality of the weekly minimum RTT data set
- The Luna metrics were benchmarked regionally in March 23 and MTW were 4th (out of 18) trusts for the lowest percentage of RTT pathways with a data quality issue
- This dataset is monitored weekly by the Deputy Director of Patient Access

- Luna metrics have been developed at specialty level and are audited by the Patient Access/Training team to identify areas of improvement (e.g patient pathways, RTT training)
- RTT Clinician training includes face to face training and visual aids for use in clinics
- Dedicated RTT training team in place delivering training to administrative and clinical teams. Including clinic outcome training and new starter training

Flow Chart for Data Quality Investigation and Learning



Section 1: Validation

90% of patients who have been waiting over 12 weeks are contacted and validated by 31st Oct 2023

RTT Weekly from Waiting List Minimum Data Set (WLMDS) Submission
>26 Week Validation

	Week Ending					
	06/08/2023	13/08/2023	20/08/2023	27/08/2023	03/09/2023	10/09/2023
Total Weekly RTT Open Pathways	*49485*	*49378*	*49807*	*49307*	*48547*	*48005*
Pathways in scope of the 26 Week Validation Exercise	5091	4846	4809	4909	4933	5036
Pathways still to be validated	498	542	507	727	285	79
Percentage of 'In Scope' validated in last 12 weeks	90.2%	88.8%	89.5%	85.2%	94.2%	98.4%

RTT Weekly from Waiting List Minimum Data Set (WLMDS) Submission
>12 Week Validation

	Week Ending					
	06/08/2023	13/08/2023	20/08/2023	27/08/2023	03/09/2023	10/09/2023
Total Weekly RTT Open Pathways	*49485*	*49378*	*49807*	*49307*	*48547*	*48005*
Pathways in scope of the 12 Week Validation Exercise	20570	20531	20533	20373	19900	19749
Pathways still to be validated	14088	14723	15056	14755	13367	11624
Percentage of 'In Scope' validated in last 12 weeks	31.5%	28.3%	26.7%	27.6%	32.8%	41.1%

The monthly RTT December 2019 return cannot be directly compared as the Quattro system for RTT PTL management was in use at that time and the method for recording validation was very different to the current RTTR method.

Section 1: Validation

Validation plan to achieve target by 31st October

- Weekly validation target to achieve deadline has been developed including support from operational management teams and patient access team.
- Request for AI digital solution to contact patients as an ICB initiative has been submitted to NHS England
- Weekly validation position being shared by the national team to enable monitoring of each Trusts position
- Internal validation plan being monitored weekly via Trust Assurance meeting to ensure Trust is on track to deliver plan

RTT rules and guidance- local access policies are applied and actions are properly recorded :

- Current Trust Patient Access to Elective Care Policy has been based on national RTT rules- review of the policy by Deputy Director of Patient Access in conjunction with Data Assurance Lead and Operational teams due in Q4 before policy update in Sept 24- available to access by patients via Trust intranet
- MTW Patient Access To Elective Care Policy has been reviewed against the Elective Care IST Future NHS page by the Trust Data Assurance Lead
- Face to Face scenario based Access to Elective Care Policy training being rolled out over Q2/3 to CAU's and wider admin teams

FUP waiting list position – clinical risk of patients sitting in the non-RTT cohorts :

- Since April 22 there have been 1 incident reported due to 'lost to follow up'
- New DQ report has been developed and rolled out to the operational teams. Progress on this report is monitored on a monthly basis by Data Assurance lead and Deputy Director of Patient Access
- Validation of follow up waiting lists both administratively and clinically have commenced by the operational teams
- Additional funding/support has been requested via the ICB for additional validation support
- GIRFT Further Faster support bid includes fail safe officers for W&C and Surgery
- Planning for mobilising Clinical validation is in discussion inline with GIRFT recommendations

Section 2: First Outpatients

Zero 65 Week patients by March 24

The trust have no patients waiting over 65 weeks and are focussing attention on reduction of patients waiting over 40 weeks by March 24

Independent Sector

Prime Provider Contract in place offering choice for patients

Insourcing currently being utilised to support ECHO capacity

Divisions are working on recovery plans following IA – including exploring insourcing and further outsourcing opportunities

Section 3: Outpatient Follow Ups

Outpatient FUPS (follow ups without procedure) – current performance against submitted planning return for reduction of OPA FUPs (FUPs without procedure

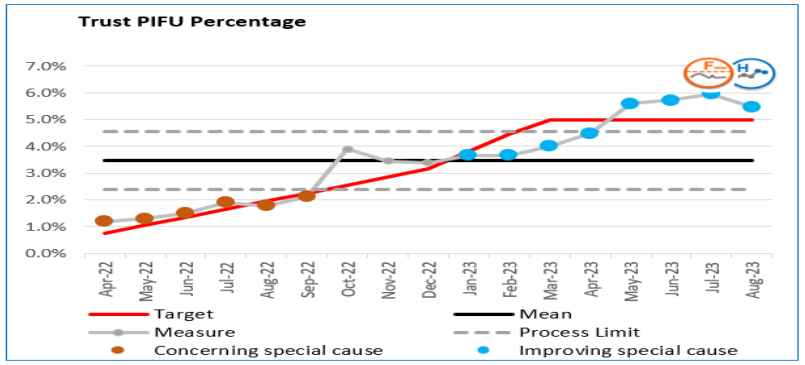
Total OP FUP without Procedure	2019/20 Actuals	2023/24 Plan	%age reduction plan v 1920	Apr-Aug 23 Plan	Apr-Aug 23 Actuals	Variance from Plan	%age reduction actuals v 1920
Total	264,039	245,243	-7.1%	100,568	113,869	13,301	13.2%

Divisions are currently working up plans to reduce their actual activity to meet the 25% reduction utilisation

- GIRFT Further Faster programme, including pathway review and utilisation of patient initiated follow up (PIFU) pathways
- Clinical Validation of follow up waiting lists
- Registrar training sessions

GIRFT GETTING IT RIGHT FIRST TIME

PIFU Position- plans to increase use of PIFU to achieve minimum of 5% with particular focus on those with long wait



- Overall the trust have exceeded the PIFU 5% target
- T&O, Paediatrics, Gynaecology and Gastro some of the top performing specialties
- Expansion of PIFU pathways being reviewed in line with GIRFT Further Faster
- Focus remains on discharge of patients and should not be put on PIFU pathways unless clinically appropriate
- Patient portal can be used in the future to expand PIFU pathways to manage patients with long term conditions

Section 3: Outpatient Follow Ups

DNA's – has a plan to reduce the rate of missed appointments by March 24, through engaging with patients to understand and address root causes

Att/DNA/CNC	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08
Attended	91.2%	91.2%	91.1%	92.3%	92.0%	92.0%	91.8%	92.0%	91.2%	91.8%	92.0%	93.3%	93.6%	92.3%	92.2%	93.0%	92.6%
DNA	8.8%	8.8%	8.9%	7.7%	8.0%	8.0%	8.2%	8.0%	8.8%	8.2%	8.0%	6.7%	6.4%	7.7%	7.8%	7.0%	7.4%

- 2 way text reminder service has been implemented trust wide through July/August
- Paediatric text reminders implemented in September
- Trust wide Missed Appointments working Group starting in October, including patient engagement, missed appointments demographics
- GIRFT Benchmarking through Further Faster Programme
- Patient Portal implementation improving communication to our patients reducing missed appointments

Specialist Advice- has a plan to increase use of specialist advice through job planning and clinical templates utilising GIRFT checklist

- There are 23 specialties at MTW available on Kinesis for Specialist Advice
- 71% of Specialist Advice requests to MTW were responded to within required 2 working days
- GIRFT Further Faster recommends the use of Specialist advice to reduce referrals into the trust and ensure that when patients are referred they are signposted to the correct specialty
- The West Kent Project EROS will incorporate Kinesis with an aim to expand and improve on referral quality through AI smart pathways.
- Job Plans being reviewed to ensure standardised approach to dealing with A&G

Section 3: Outpatient Follow Ups

Transformation Priorities

- Roll out of Patient Portal
- Pathway redesign:
  - Improved pathways through one stop clinics, forming part of outpatient workstreams, pathway mapping organised within ENT and Neurology
  - Reducing overall follow ups
  - EROS implementation reducing clinician time for triage
  - Digital dictation releasing clinical and administrative time

Section 4: Support Required

Area of support	Required	Requested from
1. Validation - contacting of patients	AI/Chatbot solution - ICB initiative	NHS England
2. Validation- 90% of patients validated by 31st October	5 x External Validators – requested via ICB elective recovery	ICB
3. GIRFT Further Faster	Bid Submitted - £80k has been signed off to support failsafe officers in Gen Surg and W&C plus extra support for clinical validation of the follow up waiting list/	GIRFT

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

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

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month**.**

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

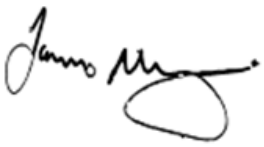
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

NHS Maidstone and Tunbridge Wells NHS Trust

To approve a Business Case for the Nursing and Midwifery safer staffing review 2022/23	**Chief Nurse**

Prior to the request for approval by the Trust Board the Business Case for the Nursing and Midwifery safer staffing review 2022/23 will be reviewed at the Finance and Performance Committee on 26/09/23. The Business Case is enclosed and the outcome of the review will be reported verbally.

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

- Executive Team Meeting, 29/08/23
- Finance & Performance Committee, 26/09/23

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

To approve a Business Case for the Nursing and Midwifery safer staffing review 2022/23

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

Summary of the report

The first annual establishment review against the new Nursing and Midwifery Establishment Review Policy was completed in October 2022. This was a review of all clinical areas within the Trust including adult and paediatric inpatient wards, out-patient services, clinical nurse specialists, critical care, theatres, endoscopy and maternity services. The recommendations from the review were presented to the MTW Executive Team on 15th November 2022 and the Trust Board in December 2022. A significant amount of work has taken place to address the Nursing and Midwifery vacancies to ensure the implementation of the recommended establishment changes have be phased appropriately.

Business Case objectives

- Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England to ensure delivery of safe, high quality care, across all our clinical settings.
- A reduction in the premium rate registered nursing temporary staffing expenditure.
- Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor by 40%.
- Improved staff wellbeing and experience by addressing concerns raised through ‘Voice boxes’ and the Trust ‘moving on’ Surveys, see appendix 3 for current examples.
- To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.

Expected benefits

- See appendix 1

High-level risks and mitigations

- Financials not approved: further prioritisation of posts has been undertaken with costs only released as recruitment is successful.
- Unable to recruit: A significant amount of work has taken place to address the Nursing and Midwifery vacancies to ensure the implementation of the recommended establishment changes have be phased appropriately.

Overall cost of the Business Case:

- Capital: £1.5k for IT equipment
- Revenue: £3.027m

Has the funding been identified and agreed?

No

Has the Case been considered by the Executive Team Meeting (ETM)?

Yes

If Yes, was the Case recommended for approval as submitted, or was there any further work required.

- The case will need to be authorised by the Kent and Medway Integrated Care Board (KM ICB), as it involved an increase in staffing.
- Further Board Approval required
- Establishments will be monitored closely and once full establishment has been achieved, new posts associated with this case will be released and recruitment will continue.
- Work continues and will be further embedded to ensure further efficiencies and improvements in roster management. This will include ongoing KPI monitoring, increased oversight of supernumerary allocation, and reduction in additional duties and utilisation of AL planning.

Summary of the report

- The Chief Nurse and senior nursing colleagues will continue to focus on reducing agency and temporary staffing usage. Building on the work already completed introduced, including closure of the rapid response pool, authorisation of agency at DDNQ level and executive level for non-framework.
- The Chief Nurse and Deputy Chief Nurse will work with the Divisional Directors of Nursing & Quality to achieve further efficiencies. Efficiencies already identified include:
    - Reduction in the number of enhanced care shifts
    - Further reduction in temporary staffing in areas with an increase in establishment.
    - Mapping shift patterns against activity in specific areas.
    - Nursing establishments will be looked at to consider further staggering of start and end times top ensure maximum efficiency.
    - Job planning for non ward based staff
    - Increased oversight and involvement from Corporate Nursing with the Business case review panel

Appendix 1

Measurable benefit Key Performance Indicator (KPI)	Baseline value	Target Value	Measure	Timing	Lead
Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England	Current ward establishments	Recommended establishments with further 6 monthly reviews.	Safe staffing review	October 2023	Corporate Nursing Team
A reduction in the premium rate registered nursing temporary staffing expenditure	Agency rate 20% above substantive rate Bank rate 5% above substantive rate Agency B5 - £917k in M1 to 2. Therefore £5.5m for the whole year assuming the same run rate. In 22/23the trust spent 9.3m Bank B5 – £1.094k in M1 to 2. Therefore £6.6m for the whole year assuming the same run rate. In 22/23 the trust spent 6.6m	Support the overall financial plan of reducing agency expenditure from £28m in 22/23 to £10m in 23/24	Reduction in temporary staffing spend	Phased as posts filled	Finance Team
Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor	17 April 2021- November 2022	Reduction of 40% per annum	No new Sis raised once posts filled	Phased as posts filled	Matrons and DDNQs
Improved staff wellbeing and experience	Concerns raised NHS Staff Survey results below 40%	No concerns NHS Staff Survey results above 40%	NHS staff surveys Voice Box Moving on surveys	Phased and annual review	Corporate Nursing Team
To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.	Turnover 11.6% Vacancy rate of 12.%	Turnover below 12% Vacancy rate of 10%	Turnover below 12% Vacancy rate of 10%	Phased as posts filled	HR

BUSINESS CASE

Title	Nursing and Midwifery safer staffing review 2022/3 v1

Stage of plan	Single stage "Justification"			
ID reference *Available from mtw-tr.bcrp@nhs.net*	945			
Division	Corporate			
Department/Site/ Directorate	Corporate Nursing			
Author	Zara Martin			
Clinical lead/Project Manager	Jo Haworth			
Prioritisation has been agreed at *(Highlight as applicable and please provided detail in strategic background section)*	**Capital prioritisation group – in capital plan**	**Service development priority in divisional annual plan**	**Charitable funds group/s**	**Other (Specify)** **December 2022 Trust Board following Safer Staffing Review**

Approved by This case is the phasing and implementation of the recommendations from the Safe Staffing Review undertaken in October 2022. This was devised with all Directorate Matrons, taken through divisional boards, ETM and Trust Board in December 2022 and BCRP July 2023.	**Name**	**Date approved**
Matrons	All	October 2022
Finance manager **Final version costs updated and phasing checked**	Oli/Dave Shelton Oliver Goss and Richard Sykes	13/7/23 August 23
Chief of Service	All	ETM/Board December 2022
Executive sponsor	Jo Haworth	12/7/23
Division Leadership Team	n/a	
Human Resources (HR) Business Partner **Final version**	All Rob Henderson and Claire Cloude	October 2022 August 2023
Deputy Chief Operating Officer	ETM	December 2022
Trust Board	All	December 2022
BCRP	All	18th July 2023

Executive Summary

The recommendation: This business case seeks approval to invest £800,814 in 2023/24, with full year effect totalling £3,026,955 in 2024/25 onwards.

The investment will deliver the recommendations of the Nursing and Midwifery establishment review completed in October 22, and agreed by the Trust Board in December 2022. The phased implementation plan was approved by ETM on 29th August 2023.

This programme will be closely monitored through a working group consisting of HR, Finance and Corporate Nursing. The next establishment review will be held in October 2023.

Strategic background context and need

Ensuring safety within the clinical areas is of paramount importance. A new Nursing and Midwifery Establishment Review Policy was introduced at MTW in September 2022 based on methodologies set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and NHS Improvement's "Developing Workforce Safeguards" (October 2018).

The primary purpose of this new policy is to ensure safe patient care and excellent patient experience through appropriate nurse/midwife staffing that meets patient acuity and dependency. In addition, this methodology ensures that the Trust is in line with national guidance and benchmarked against other Trusts.

The first annual establishment review against the new Nursing and Midwifery Establishment Review Policy was completed in October 2022. This was a review of all clinical areas within the Trust including adult and paediatric inpatient wards, out-patient services, clinical nurse specialists, critical care, theatres, endoscopy and maternity services. The recommendations from the review were presented to the MTW Executive Team on 15th November 2022 and the Trust Board in December 2022 and agreed. This case presents the phased implementation plan.

These recommendations have been reviewed, prioritised and split into four categories, full details can be found in appendix 2:

1. recommended change in 2023/24,
2. consider change in 2024/25,
3. divisional review
4. on hold.

It is recognised that these recommendations would require financial investment and an increase in headcount which would be further prioritised with a phased approach to recruitment.

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

1. Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England to ensure delivery of safe, high quality care, across all our clinical settings.
2. A reduction in the premium rate registered nursing temporary staffing expenditure.
3. Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor by 40%.

4. Improved staff wellbeing and experience by addressing concerns raised through 'Voice boxes' and the Trust 'moving on' Surveys, see appendix 3 for current examples.
5. To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.

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

Option 2

The recommendations from the workforce review have been prioritised by the Chief Nurse and Deputy Chief Nurse for Workforce and Education and split into four categories. The "recommended changes" category was created to identify and prioritise the most critical posts required in 2023/24.

During the phasing development of the case it was identified that Ward 11, operating as an escalation ward, has closed. The 2.48 WTE additional posts for this ward have been removed from this case and will be included in any request for escalation funding to open the ward.

The revised request is to begin recruitment of 65.22 WTE RN/RM/HCSW from August 2023 to all be in post by February 2024. The July 2023 pay increase has been included and the cost of this recruitment in 2023/24 will be £800,814, with full year effect totalling £3,026,955 in 2024/25 onwards.

This option will ensure the Trust is meeting the national standards. Further establishment reviews will be performed annually, with the next scheduled for October 2023, to review the acuity and dependency of patients and the associated staffing requirements. These reviews may require further adjustments to establishments.

Planned key benefits to come from the investment. *Include here the key benefits, investment in the preferred option will bring to the service and / or Trust*

Measurable benefit Key Performance Indicator (KPI)	**Baseline Position**	**Future Outcome**
Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England	Current ward establishments	Recommended establishments with further 6 monthly reviews.
A reduction in the premium rate registered nursing temporary staffing expenditure	Agency rate 20% above substantive rate Bank rate 5% above substantive rate Agency B5 - £917k in M1 to 2. Therefore £5.5m for the whole year assuming the same run rate. in 22/23the trust spent 9.3m Bank B5 – £1.094k in M1 to 2. Therefore £6.6m for the whole year assuming the same run rate. In	Support the overall financial plan of reducing agency expenditure from £28m in 22/23 to £10m in 23/24

	22/23 the trust spent 6.6m	
Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor	17 April 2021- November 2022	Reduction of 40% per annum
Improved staff wellbeing and experience	Concerns raised NHS Staff Survey results below 40%	No concerns NHS Staff Survey results above 40%
To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.	Turnover 11.6% May 2023 Vacancy rate of 12.5%	Turnover below 12% Vacancy rate of 10%

Further benefits of this proposal:

- Improved staff morale, resulting in a positive effect on patient care
- Reduce LOS
- Reduced Falls
- Increased number of discharges before 11am

Main risks associated with the investment *Include here any key risks involved with the project. Consider: 1) If it is not undertaken. 2) Risks in achieving your plan and 3) Risks that might remain after delivering your plan*

Risk of not doing it:
Disparity of care
Increased reliance on temporary staffing
Poor patient experience
Poor staff experience
Low retention rates
High recruitment costs

Delivery risk:
Financials not approved
Unable to recruit

Residual Risk:
Not applicable

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

2023/24 PYE costs £800,814
2024/25 onwards FYE costs £3,026,955

Summary of financial impacts			
CAPITAL COSTS	**£**	**FUNDING SOURCE**	**£**
Estates	**0**	Identified in the Trust capital plan	
IT	£1,535	Identified in directorate revenue budget	
Equipment	**0**	Other *(specify)*	
Total Capital Cost	**£1,535**	**Additional Financial Information**	
REVENUE COSTS			

Pay	£3,025,420	This will be mitigated to an extent by the reduction of temporary spend identified. 1 laptop and mobile phone will be required for the safeguarding post (standard laptop is currently £1,065 plus £40 for a laptop backpack, exc. VAT. Dock, mouse and headset will come from stock so no charge. Mobile phones are £429.71 inc. VAT) The rest of the posts will be ward based roles with IT infrastructure already in place. The recruitment programme will be closely monitored between Corporate Nursing, HR and Finance and will be reviewed following the recommendations of the October 2023 safe staffing review.
Non- Pay		
Capital Charges		
Total Revenue Cost per annum	**£3,025,420**	
INCOME	**0**	
SLA	**0**	
Other	**0**	
Loss	**£3,026,955**	

Timetable:
The revised request is to begin recruitment of 65.22 WTE RN/RM/HCSW from August 2023 to all be in post by February 2024. The recruitment of these posts has been prioritised in a milestone table using the below criteria:

1) Lone worker clinical areas/wards such as SSSU on both sites
2) High acuity wards e.g. John Day and Ward 21 (now accept level two respiratory patients) and safe guarding.
3) Others (all remaining posts)

Priority 3 'Others' posts will be recruited into and funding released as current vacancies are filled within clinical areas.

An approximate timeframe, assuming recruitment KPIs achieved by all involved parties and no further leavers, is detailed in the below table.

Priority	Month	WTE	Cost FYE	Monthly Cost	2023/24	
1 & 2*	Dec	21.99	£977,815	£81,485	£81,485	
3	Jan	30.19	£1,548,050	£129,004	£212,023	including IT
3	Feb	13.04	£499,555	£41,630	£253,653	
	March	0	0	0	£253,653	
	Total	**65.22**	**£3,025,420**		**£800,814**	
	IT laptop bag and phone		£1,535			
	Total		**£3,026,955**			

*this figure includes 5.91WTE priority 3 posts that could be filled in December 2023 by those in the pipeline already.

Strategic Case

Ensuring safety within the clinical areas is of paramount importance. A new Nursing and Midwifery Establishment Review Policy was introduced at MTW in September 2022 based on methodologies set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and NHS Improvement's "Developing Workforce Safeguards" (October 2018) using a triangulated approach to ensure the use of:

- Evidence based tools (where they exist)
- Professional Judgement
- Based on patients' needs, acuity, dependency and risks.

The primary purpose of this new policy is to ensure safe patient care and excellent patient experience through appropriate nurse/midwife staffing that meets patient acuity and dependency. This also brings the Trust in line with national guidance. The process for reviewing the Nursing and Midwifery workforce at Maidstone and Tunbridge Wells NHS Trust has been revised as a result.

The monitoring of safe staffing levels has been strengthened over the past 12 months. Staffing levels are closely monitored daily in real time at site meetings, daily staffing reports, daily staffing huddles and weekly recruitment activity progress. Progress has been made through the development of a Safe Staffing Guideline which includes rag rating staffing levels to ensure processes are in place to manage safety and risk in relation to staffing.

A monthly report and publication return to NHSI/E indicating 'planned' and 'actual' nurse staffing by ward is submitted known as Staffing Fill rates. The safe staffing paper is published monthly and incorporated in the Executive Team workforce update, it is also shared with Divisional Nursing and Midwifery Leads and at the monthly Nursing and Midwifery Recruitment and Retention Programme.

The first annual establishment review against the new Nursing and Midwifery Establishment Review Policy was completed in October 2022. This was a review of all clinical areas within the Trust including adult and paediatric inpatient wards, out-patient services, clinical nurse specialists, critical care, theatres, endoscopy and maternity services. The recommendations from the review were presented to the MTW Executive Team on 15th November 2022 and the Trust Board in December 2022 and agreed.

These recommendations have been reviewed and prioritised by the Chief Nurse and Deputy Chief Nurse for Workforce and Education and split into four categories, full details can be found in appendix 2:

1. recommended change in 2023/24,
2. consider change in 2024/25,
3. divisional review
4. on hold.

It is recognised that these recommendations would require financial investment, table 1, and an increase in headcount which would be prioritised with a phased approach, detailed in the Economic Case below, if financial approval was given. Close monitoring of temporary staffing spend will also be required with a view of this reducing as we better align the nursing roster templates.

Table 1 - Summary of total WTE agreed at the Board in December 2022:

WTE	Prioritisation notes
67.71 WTE	For progressing in 2023/2024
13.76 WTE	Consider change in 2024/25
40.7 WTE	Divisional Review
3.00 WTE	On hold
125.17 WTE	

The case for change

1. Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England to ensure delivery of safe, high quality care, across all our clinical settings.
2. A reduction in the premium rate registered nursing temporary staffing expenditure.
3. Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor by 40%.
4. Improved staff wellbeing and experience by addressing concerns raised through 'Voice boxes' and the Trust 'moving on' Surveys, see appendix 3 for current examples.
5. To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.

Case for change 1: Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England to ensure delivery of safe, high quality care, across all our clinical settings.

See appendix 2 for recommended changes per division as presented to the Trust Board.

Case for change 2: A reduction in the premium rate registered nursing temporary staffing expenditure.

The use of Registered Mental Health Nurses (RMNs) and Mental Healthcare Support Workers to provide 1-1 care were reviewed by ward and demonstrated a significant reliance on temporary staff to fill these shifts. The majority of the Ward Managers reported the Mental HCSWs were valuable in providing 1-1 care in particular at night and felt there was an overuse of RMNs which could be reduced or replaced by HCSWs.

Case for change 3: Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor by 40%.

There were 17 in serious incidents between April 2021 and November 2022 where suboptimal skill mix/staffing levels was a contributory factor. There are also eight risks on the Trust risk register relating to staffing shortages (2751, 2904, 3010, 2743, 2831, 3009, 2519, 2952).

Case for change 4: Improved staff wellbeing and experience by addressing concerns raised through 'Voice boxes' and the Trust 'moving on' Surveys, see appendix 3 for current examples.

The National NHS Staff Survey asks "There are enough staff at this organisation for me to do my job properly". From 2018 through to 2022 MTW have not scored above 40% in response to this question, with the average being 26%. When audited in 2022 the response from Nursing and Midwifery was 16.8%.

Case for change: To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.

Constraints and dependencies

Annual Safe Staffing Establishment Review

The next annual establishment review against the new Nursing and Midwifery Establishment Review Policy is planned for October 2023. This will again review all clinical areas within the Trust including adult and paediatric inpatient wards, out-patient services, clinical nurse specialists, critical care, theatres, endoscopy and maternity services. Using a triangulated method, the review will look at clinical outcomes, SCNT results and professional judgment. Elements which may cause a change in establishment include acuity and dependency of patients, ward profile and patient profile. The recommendations will be aligned to this programme and presented to the MTW Executive Team and the Trust Board.

Financial

It is requested that advertising and recruitment be enabled at risk with funding being released for posts as vacancies are filled. It is anticipated that the 65.22WTE recommended posts will be filled over the next 12 months. The monitoring of safe staffing levels has been strengthened over the past 12 months and will assist with the planned implementation of these posts. The corporate nursing team will work closely with finance to manage this.

The safe staffing paper is published monthly and incorporated in the Executive Team workforce update, it is also shared with Divisional Nursing and Midwifery Leads and at the monthly Nursing and Midwifery Recruitment and Retention Programme.

Ability to recruit

The national workforce issues have made recruitment of Healthcare Clinical Support Workers (HCSW) and Registered Nurses/Midwives (RN/RM) challenging. This has prompted national and local investment in Internationally Educated Nursing/Midwifery Campaigns which are proving successful. In 2021, MTW had approximately 407 WTE band 5 nursing vacancies across both sites. The international campaigns resulted in the employment of 212 international recruits between December 2020 to August 2022. Currently there are 97.7 WTE internationally educated nurses that are pending completion of the OSCE exam and subsequent NMC pin.

Significant recruitment progress has been made over the last 12 months, detailed in appendix 4 and vacancies have reduced to 124.43 WTE Healthcare Support Worker (HCSW) and 242.6 WTE Registered Nurses/Midwives (RN/RM) vacancies as at May 2023. Following the receipt of pending NMC pin detailed above the RN/RM vacancies will drop to 144.9 WTE. Updated vacancy figures are detailed in the timetable on page 14.

The 65.22 WTE are the prioritised posts within the establishment review, however this recruitment will be prioritised as detailed below:

RN/RM posts

1) Lone worker clinical areas/wards such as SSSU on both sites
2) High acuity wards e.g. John Day and Ward 21 (now accept level two respiratory patients) and safe guarding.
3) Others (all remaining posts)

The additional HCSW posts will be recruited into as vacancies are filled within clinical areas, concentrating in areas where there is a greater acuity of patients (establishment reviews).

Recruitment and Training
As this will be a phased recruitment programme the current Staff induction, Preceptorship and OSCE training programmes have capacity to support.

Support from other departments
A laptop and mobile phone will be required for the safeguarding lead only. The other recruits will only require access to current systems.

The Corporate Nursing Team have been working with divisions and HR to manager this programme. The number of International Recruits requiring accommodation is being mapped.

Economic Case - The current available options

Option 1 – Do nothing

Description
Maintain current staffing levels until safe staffing review in October 2023

Key activity and financial assumptions:
As of May 2023
Registered Nurses/Midwives (RN/RM) Establishment 1996.4WTE
Registered Nurses/Midwives (RN/RM) in post 1858.5WTE
Registered Nursing & Midwifery vacancies 144.9WTE
Healthcare Support Workers (HCSW) Establishment 762.13WTE
Healthcare Support Workers (HCSW) in post 637.70WTE
Healthcare Support Workers (HCSW) vacancies 124.43WTE

Strengths /Opportunities
No additional financial investment
Recruiting to establishment will reduce the temporary spend in some areas

Weaknesses/ Threats
Inequitable standards of care due to varied staffing levels across wards
Temporary staffing spend in particular for RMNs and HCSW who provide enhanced care
Poor impact on patient and staff experience
Reduced patient flow with less time to focus on discharge planning.
Retention rates above Trust and national average

This option is **Rejected** because it is not viable to continue with such low staffing establishments

Option 2 – Preferred Option

Description

Implement recommended changes only, to be reviewed in safe staffing review in October 2023.

Key activity and financial assumptions:

The recommendations from the workforce review have been prioritised by the Chief Nurse and Deputy Chief Nurse for Workforce and Education and split into four categories. The "recommended changes" category was created to identify and prioritise the most critical posts required in 2023/24.

The request is to begin recruitment of 65.22 WTE RN/RM/HCSW from August 2023 to all be in post by February 2024. The July 2023 pay increase has been included and the cost of this recruitment in 2023/24 will be £800,814, with full year effect totalling £3,026,955 in 2024/25 onwards. Full phasing plans are detailed on page 14.

This option will ensure the Trust is meeting the national standards. Further establishment reviews will be performed annually, with the next scheduled for October 2023, to review the acuity and dependency of patients and the associated staffing requirements. These reviews may require further adjustments to establishments.

Strengths /Opportunities

- Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England to ensure delivery of safe, high quality care, across all our clinical settings.
- A reduction in the premium rate registered nursing temporary staffing expenditure.
- Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor by 40%.
- Improved staff wellbeing and experience by addressing concerns raised through 'Voice boxes' and the Trust 'moving on' Surveys, see appendix 3 for current examples.
- To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.

Weaknesses/ Threats

Detailed above in constraints and dependencies.

This option is **Preferred.**

Option 3 – Do maximum

Description

Implement all recommendations: recommended change, consider change, divisional review and on hold.

Key activity and financial assumptions:
The phased increase in establishment once current vacancies have been filled as recruitment is successful to the level of 125.17 WTE across RN/RM and HCSWs. See appendix 2 for full breakdown.

Cost*	WTE**	Prioritisation notes
£2,957,094	67.71 WTE	For progressing in 2023/2024
£593, 378	13.76 WTE	For progressing once recommended changes implemented in a phased way from H2 2024/25 through to end of 2025/26
£1,739,531	40.7 WTE	
£110,924	3.00 WTE	
£5, 400,927	**125.17 WTE**	

*Pay costs based on 2021/22 scales
**as agreed at Trust Board on December 2022

Strengths /Opportunities
Will deliver all benefits detailed above

Weaknesses/ Threats
In the current financial climate, it is prudent to review the impact of the changes recommended before further investing. Annual safe staffing reviews will continue and inform future requirements.

This option is **Rejected** because it is not viable at this stage. This will be monitored through the safe staffing process and reviewed at the Annual Safe Staffing Reviews.

From this point on the sections should be completed for the preferred option only

The preferred option
Summarise how the preferred option optimises value for money

Commercial Case
Services, assets and space required
A laptop and mobile phone will be required for the safeguarding lead only. The other recruits will only require access to current systems.

The Corporate Nursing Team have been working with divisions and HR to manager this programme. The number of International Recruits requiring accommodation is being mapped.

Staffing plans
See appendix 2 for full breakdown, as presented to the Trust Board. The planned recruitment has been detailed in the management plan but is dependent on successful recruitment processes.

Impacts on and interfaces with other services.
The Corporate Nursing Team are working with Divisions to set up recruitment plans to include application review, interview and training schedules.

Activity, contractual and service level agreement implications. Commissioner involvement and input.
Not applicable

Procurement route
Not applicable

Financial Case – Funding and affordability

Priority	Month	WTE	Cost FYE	Monthly Cost	2023/24	
1 & 2*	Dec	21.99	£977,815	£81,485	£81,485	
3	Jan	30.19	£1,548,050	£129,004	£212,023	including IT
3	Feb	13.04	£499,555	£41,630	£253,653	
	March	0	0	0	£253,653	
	Total	**65.22**	**£3,025,420**		**£800,814**	
	IT laptop bag and phone		£1,535			
	Total		**£3,026,955**			

*this figure includes 5.91WTE priority 3 posts that could be filled in December 2023 by those in the pipeline already.

Management Case - Arrangements for successful implementation

Governance arrangements
This case has been led by the Chief Nurse in support of the Trust Divisions. The recruitment plan will be overseen by the Deputy Chief Nurse, Deputy Chief People Officer – People & Systems and Deputy Director of Finance – Performance. Divisional Directors of Nursing and Quality will report progress to the group.

Staffing levels are closely monitored daily in real time at site meetings, daily staffing reports, daily staffing huddles and weekly recruitment activity progress.

A monthly report and publication return to NHSI/E indicating 'planned' and 'actual' nurse staffing by ward is submitted known as Staffing Fill rates.

The safe staffing paper is published monthly and incorporated in the Executive Team workforce update, it is also shared with Divisional Nursing and Midwifery Leads and at the monthly Nursing and Midwifery Recruitment and Retention Programme.

The next annual establishment review against the new Nursing and Midwifery Establishment Review Policy is planned for October 2023 and will be reported to the Executive Team and

Trust Board. Its should be noted that this may make further recommendations using a triangulated methodology looking at clinical outcomes, SCNT audit and professional judgement.

Project team

SRO: Chief Nurse
Project Lead: Deputy Chief Nurse
HR Lead: Deputy Chief People Officer – People & Systems
Finance Lead: Deputy Director of Finance – Performance
Divisional Directors of Nursing and Quality.

Delivering the key measurable benefits

Measurable benefit Key Performance Indicator (KPI)	**Baseline value**	**Target Value**	**Measure**	**Timing**	**Lead**
Standardisation of staffing establishments in line with safe staffing guidance from the Chief Nursing Officer at NHS England	Current ward establishments	Recommended establishments with further 6 monthly reviews.	Safe staffing review	October 2023	Corporate Nursing Team
A reduction in the premium rate registered nursing temporary staffing expenditure	Agency rate 20% above substantive rate Bank rate 5% above substantive rate Agency B5 - £917k in M1 to 2. Therefore £5.5m for the whole year assuming the same run rate. In 22/23the trust spent 9.3m Bank B5 – £1.094k in M1 to 2. Therefore £6.6m for the whole year assuming the same run rate. In 22/23 the trust spent 6.6m	Support the overall financial plan of reducing agency expenditure from £28m in 22/23 to £10m in 23/24	Reduction in temporary staffing spend	Phased as posts filled	Finance Team
Reduction in serious incidents where suboptimal skill mix/staffing levels was a contributory factor	17 April 2021-November 2022	Reduction of 40% per annum	No new Sis raised once posts filled	Phased as posts filled	Matrons and DDNQs

Improved staff wellbeing and experience	Concerns raised NHS Staff Survey results below 40%	No concerns NHS Staff Survey results above 40%	NHS staff surveys Voice Box Moving on surveys	Phased and annual review	Corporate Nursing Team
To achieve and maintain turnover below the 12% Trust target and maintain a vacancy rate to < 10%.	Turnover 11.6% Vacancy rate of 12.%	Turnover below 12% Vacancy rate of 10%	Turnover below 12% Vacancy rate of 10%	Phased as posts filled	HR

Further benefits of this proposal:

- Improved staff morale, resulting in a positive effect on patient care
- Reduce LOS
- Reduced Falls
- Increased number of discharges before 11am

Timetable:

The request is to begin recruitment of 65.22 WTE RN/RM/HCSW from August 2023 to all be in post by February 2024. This recruitment has been further prioritised as detailed below:

1) Lone worker clinical areas/wards such as SSSU on both sites
2) High acuity wards e.g. John Day and Ward 21 (now accept level two respiratory patients) and safe guarding.
3) Others (all remaining posts)

Priority 1 and 2 posts will be advertised immediately and the RN posts filled by the Internationally Educated recruits in the pipeline currently to be in post by the end of December 2023. The HCSW posts will be filled with applicants from the August 2023 recruitment events to be in post by the end of December 2023.

RN/M

Priority	Post	WTE	Total Annual Cost
1	Short Stay Surgical Unit (TW) - NE901	0.71	£44,332
2	John Day Respiratory Ward (M) - NT151	2.71	£131,746
2	Ward 21 (TW) - NG231	1.36	£65,873
		4.78	**£241,952**

HCSW

Priority	Post	WTE	Total Cost
1	Short Stay Surgical Unit (M) - NE751	1.86	£71,770
2	John Day Respiratory Ward (M) - NT151	4.97	£200,398
2	Ward 21 (TW) - NG231	2.71	£87,531
2	Ward 21 (TW) - NG231	2.48	£100,199
		12.02	**£459,898**

The Safeguarding post is a new specialised role so will need to be advertised immediately using usual recruitment processes and is expected to be filled by January 2024.

2	Safeguarding Practitioner	1.00	£57,702
	IT laptop bag and phone		£1,535
		1.00	**£59,237**

Priority 3 posts

The priority 3 Registered Nurse posts will be allocated across the remaining Internationally Educated recruits in the pipeline to be in post by December 2023.

The priority 3 Registered Midwife posts will be allocated from the planned recruitment events to be in post by January 2024.

RN/M

Priority	Post	WTE	Total Annual Cost
3	Pye Oliver (Medical) - NA901	2.48	£143,698
3	Midwifery Services - Postnatal Ward - NF102	2.71	£132,268
		5.19	**£275,966**

3	Midwifery Services - Postnatal Ward - NF102	2.43	£140,432
3	Midwifery Services - Delivery Suite - NF102	2.71	£132,268
3	Midwifery Services - Delivery Suite - NF102	2.43	£140,432
3	Midwifery Services - Antenatal Ward - NF102	2.71	£143,167
3	Midwifery Services - Antenatal Ward - NF102	2.43	£152,005
3	SCBU (TW) - NA102	2.71	£161,419
3	SCBU (TW) - NA102	2.48	£176,063
		17.90	**£1,045,787**

The priority 3 HCSW posts will be recruited into as vacancies are filled within clinical areas, concentrating in areas where there is a greater acuity of patients (establishment reviews). Previous HCSW recruitment events have successfully appointed an average of 22 posts filling 20 WTE. Allowing for variation, turnover and recruitment delays, these posts have been phased cautiously by planned recruitment events.

HCSW

Priority	Post	WTE	Total Cost	Source
3	Whatman Ward - NK959	2.48	£100,199	October event
3	Mercer Ward (M) - NJ251	1.36	£43,766	October event
3	Stroke Unit (M) - NK551	4.97	£200,398	October event
3	Ward 2 (TW) - NG442	2.48	£100,199	October event
		11.29	**£444,561**	

3	Ward 30 (TW) - NG330	2.48	£100,199	December event
3	Ward 31 (TW) - NG331	2.48	£100,199	December event
3	Ward 10 (TW) - NG131	1.36	£43,766	December event
3	Ward 10 (TW) - NG131	5.19	£209,507	December event

3	Maternity Day Assessment Unit	1.53	£45,885	December event
		13.04	**£499,555**	

Managing any key risks associated with delivering the project

Risk	Baseline risk score (l x i)	Summary mitigation/ contingency	Mitigated risk score (L x i)	Lead
Financials not approved	12	Full review of requirements undertaken, prioritisation of posts in place to phase implementation. Governance in place to manage recruitment	9	Corporate Nursing
Unable to recruit	16	See appendix 4	9	HR

Appendices

Add any additional supporting information here. Include detail of activity and financial information as appropriate. Please do not embed files into this document.

Appendix 1 Links to latest NHS guidance. *Please refer to the guidance at the following link for additional requirements particularly for all cases > £15M. Including NHSE checklist, NPV calculation and financial limits*.

NHS England business-case-approval guidance for NHS providers
National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013)
https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf
'Safe, sustainable productive staffing' (July 2016)
https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Developing Workforce Safeguards (October 2018)
https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf

Appendix 2 – Key Recommendations of Workforce Changes following Establishment Review presented to the Trust Board in December 2022

Careful review by department was carried out to ensure we have safe, effective and consistent establishments across the Trust. The recommendations in workforce have been proposed as a result of this annual establishment review. It is recognised that these recommendations would require financial investment and an increase in headcount which would be prioritised with a phased approach if financial approval was given. Close monitoring of temporary staffing spend will also be required with a view of this reducing as we better align the nursing roster templates.
These recommendations have been reviewed and prioritised by the Chief Nurse and Deputy Chief Nurse for Workforce and Education and split into four categories; recommended change, consider change, divisional review and on hold. Whilst this is not a financial case a summary of the recommended and consider changes are below with associated costs. The remaining categories can be found in appendix 1. Important to note many of the recommendations for divisional review require a review of activity in conjunction with business planning and workforce demand.

Summary of totals:

Cost	wte	Prioritisation notes
£2,957,094	67.71 wte	For progressing in 2023/2024
£593, 378	13.76 wte	Not for progressing this financial year
£1,739,531	40.7 wte	
£110,924	3.00 wte	
£5, 400,927	**125.17 wte**	

Surgical Division Recommendations

	Band	Recommend Change
Ward 30 (TW) - NG330	2	increase night by 1 HCSW
Ward 31 (TW) - NG331	2	increase night by 1 HCSW
Short Stay Surgical Unit (TW) - NE901	5	Additional RN at night weekends (currently 1)
Short Stay Surgical Unit (M) - NE751	2	Increase 1 HCSW at night due to lone working
Ward 10 (TW) - NG131	2	Extend HCSW early into LD - total 4 HCSW
Ward 10 (TW) - NG131	2	Increase HCSW by 2 at night
Total cost: £505, 962		**Total wte: 14.08 wte**

	Band	Consider Change
Ward 30 (TW) - NG330	5	Extend 1 early into LD - Total of 5 RN on LD + 1 Early
Ward 31 (TW) - NG331	5	Extend 1 early into LD - Total of 5 RN on LD + 1 Early
Vascular Access Service - NT401	6	Additional 2 B6 WTE.
Vascular Access Service - NT401	3	Additional 2 B3 WTE.
Total cost: £390, 816		**Total wte: 9.42 wte**

Medicine & Emergency Care Division Recommendations

	Band	Recommended Change

Whatman Ward - NK959	2	Additional 1 HCSW at night
Mercer Ward (M) - NJ251	2	Extend early into LD - Total of 4 HCSW on LD
Stroke Unit (M) - NK551	2	Additional 2 HCSW at night (Total of 6 HCSW)
Ward 2 (TW) - NG442	2	Additional 1 HCSW at night
Pye Oliver (Medical) - NA901	5	Additional RN
Ward 11 (TW) Winter Escalation 2019 - NG144	5	Increase nights by 1 RN to align with other TWH wards
Ward 21 (TW) - NG231	5	Extend RN early into LD - Total of 6 RN on LD
Ward 21 (TW) - NG231	2	Increase HCSW by 1 LD
Ward 21 (TW) - NG231	2	Increase HCSW by 1 Night
John Day Respiratory Ward (M) - NT151	5	Additional 1 RN LD
John Day Respiratory Ward (M) - NT151	2	Increase HCSW by 2 Night
Total cost: £1,179,316		**Total wte: 30.49 wte**

	Band	Consider Change
A&E Paediatric Services Riverbank - NC370	5	Increase by 1 RCN
A&E Paediatric Services Riverbank - NC370	3	Increase by 1 NN to support 7-day service
Total cost £145,025		**Total wte: 3.34 wte**

Women Children & Sexual Health Division Recommendations

	Band	Recommendation
Midwifery Services - Postnatal Ward - NF102	5	1 RN to support with care of the mother
Midwifery Services - Postnatal Ward - NF102	5	1 RN to support with care of the mother
Midwifery Services - Delivery Suite - NF102	5	1 RN to support caesarean list
Midwifery Services - Delivery Suite - NF102	5	1 RN to support caesarean list
Midwifery Services - Antenatal Ward - NF102	6	Additional RM LD
Midwifery Services - Antenatal Ward - NF102	6	Additional RM Night
Maternity Day Assessment Unit	3	1 Additional MSW
SCBU (TW) - NA102	7	Supernumerary for BAPM Standards (day)
SCBU (TW) - NA102	7	Supernumerary for BAPM Standards (night)
Total cost: £1,214, 279		**Total wte: 22.14 wte**

	Band	Consider Recommendation
Paediatrics Out Patients - LC451 & LC402	7	BCG Clinic paediatrics & maternity
Total cost: £57, 537		**Total wte: 1.00 wte**

Other recommendations for WC&SH include reviewing shift times for maternity to increase the handover time in the evening moving from 15 mins to 30 mins in line with the morning handover and rest of the Trust.

Important to note that the maternity review was done in the absence of a recent completion of Birth rate+ which is provisionally planned for 2023.

It was reported that the safeguarding demand has increased in both paediatrics and maternity – this has been reported to the Deputy Chief Nurse for Quality who is currently reviewing the safeguarding demand and proposed that we increase the resource (see below).

Corporate Nursing* Recommendations

	Band	Consider Recommendation
Safeguarding Practitioner – AV851	7	1 Safeguarding Practitioner

Total cost: £57, 537		**Total wte: 1.00 wte**

*Excludes all other aspects of corporate nursing – safeguarding only.

Cancer Division Recommendations

Currently no recommendations in relation to establishment.

Divisional Considerations

Surgical Division

	Band	Division to consider with activity plans
Ward 30 (TW) - NG330	3	Activity co-oridnator
Ward 31 (TW) - NG331	3	Activity co-oridnator
Intensive Care (TW) - NA201	7	Additional Clinical Educator
Short Stay Surgical Unit (M) - NE751	5	Increase by 2 RN on the late to cover increased theatre activity
Short Stay Surgical Unit (M) - NE751	2	Consider additional HCSW to cover increased theatre activity
ENT Services EEMU - VC754	5	1 additional WTE RN
ENT Outpatients (TW) - LB101	5	1 additional WTE RN
Total cost: £215, 694		**Total wte: 5.58 wte**

Medicine & Emergency Care Division

	Band	Division to consider with activity plans
Accident & Emergency (TW) - NA301	5	Float nurse & additional triage nurse
Accident & Emergency (M) - NA351	5	Float Nurse
Accident & Emergency (M) - NA351	5	Float Nurse
Acute Medical Unit (TW) - NA901	5	Increased AEC by 1 RN weekend
Neurology Nurse Specialists - NA602	3	Additional 1 WTE A&C
Gastroenterology Specialist Nursing - NA604	7	Additional 1WTE
Endocrinology Specialist Nursing - NA603	6	Additional 1 WTE
Endocrinology Specialist Nursing - NA603	3	Additional 1 WTE A&C
Cardiology Specialist Nursing - DE201	6	Additional 1 WTE B6 (currently a secondment)
Total cost: £742, 180		**Total wte: 16.36 wte**
Ward 22 (TW) - NG332	6	Increase B6 by 0.7 - % to be funded by unfilled B5 post

Women Children & Sexual Health Division

	Band	Division to consider with activity plans
Paediatrics Out Patients - LC451 & LC402	2	1 additional HCSW for either site
Ward 33 (Gynae) (TW) - ND302	6	Triage Phone EGAU
Gynae Outpatient (TW) - LC502	2	2 additional HCSW
Gynae Outpatient (TW) - LC502	4	Need to calculate costs
Whitehead Ward (Gynae) (M) - NK359	6	Additional 0.8 WTE B6
Whitehead Ward (Gynae) (M) - NK359	3	Additional B3 A&C to make 1 WTE post, currently 0.64
Midwifery Services - Postnatal Ward - NF102	3	Additional 4 days B3 d/c co-oridnator (7-day service
Midwifery Services - Postnatal Ward - NF102	4	Increase infant feeding service to 7 days
Maidstone Birth Centre - NP751	3	1 WTE Ward Clark
Community Midwifery Services - NP751*	6	Consider additional 10 WTE B6 midwifes (needs review)

Maternity Services - Specialist Midwifery	6	Additional 1 WTE B6 Patient Experience midwife
Total cost: 892,581		**Total wte: 21.76 wte**
All Midwifery areas with Long Days		Handover increase 15 mins (not costed)

Appendix 3 - Staff Feedback

Anonymised Staff Feedback	
Voice boxes	Moving on Survey (Exit Survey)
“More staff needed. We work with dangerously low staff capacity. Its unfair for us.”	“Improvement on staffing issues would make a big difference. The nursing staff are unable to meet the patients care demands. Staff are trying to provide the highest level of care to their patients but most of the time these are difficult to achieve”
“Please employ more staff for this ward”	“Set up nurse-patient ratio (1 nurse to 4 patients), We are always short of staffed”
“More staff need to be recruited”	“Improve safe staffing, listen to feedback and concerns from staff, stop putting immense pressure on nursing staff, listen to why staff are leaving and attempt to employ new staff as soon as people leave”
“To allocate more staff to area”	“The understaffing is unsafe and a serious problem for all of maternity in mtw”

Appendix 4 - Nursing and Midwifery Workforce progress over the last 12 months, presented to Trust Board December 2022

Theme	Action
Healthcare Support Workers (HCSW)	• Standardisation of title and introduction of New to Care pathway for HCSW. • 61 HCSW completed the OET programme which supports HCSW to meet the English language requirements to successfully practice as a nurse in the UK. 32 have now completed their OSCE and are practicing as a registered Nurse.
Recruitment	• Enhanced advertising including social media activity and local radio advertising. • Introduction of monthly Saturday recruitment open days for Healthcare Support Workers • Introduction of quarterly Saturday recruitment open days for Registered Nurses and Midwives. • Delivery of ambitious international recruitment campaigns including two in-country campaigns with a total of 171 IENs recruited since January 2022. • Progress with the implementation of Divisional Nursing Workforce Trackers with starters and leavers in real time to enable accurate recruitment to turnover. • Standardisation of job descriptions with rolling adverts and interviews.
Retention	• Introduction of Retention Programme Board and associated working groups. • Introduction of monthly Recruitment and Retention newsletter. • Introduction of Staff Forums for all bands.
Safe Staffing	• Development of rag rated Safe Staffing levels with guidance. • Embedding of daily huddles and development of daily staffing reporting. • Night time staffing levels on Tunbridge Wells wards 12, 20, 22 and 30 have been increase by an additional registered nurse on duty at night. • Healthroster Confirm and Support framework written with monthly support meetings established to ensure rostering is effective. • SafeCare project on inpatient wards now live. • Development of Establishment Review Policy and Process.
Training and Development	• Recruitment of 7x Band 6 Clinical Skills Facilitators to support newly recruited Internationally Educated Nurses (IENs). • Increase in OSCE training capacity with a new expanded location for training. • Expansion of registered nurse/midwife degree apprenticeship (RNDA/RMDA) programme with 31 additional places funded this financial year. • Introduction of Learning Needs Analysis process to ensure training and development needs are being supported and met. • Implementation of monthly Career and Wellbeing Roadshows. • Introduction of Ward Manager/Unit Leader Band 7 Leadership Programme

NHS Maidstone and Tunbridge Wells NHS Trust

The Trust's well-led inspection by the Care Quality Commission (CQC) **Chief Nurse**

The enclosed report provides information on the results of the 2023 Well Led CQC Inspection

Background

- The CQC undertook a well-led Inspection in March 2023
- Concurrently a "core services" inspection of End of Life Care (EoLC) services was also undertaken
- This was followed by a recent "core services inspection of Maternity services and a separate CQC Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) focused inspection of radiotherapy services

Key Points to Note

- Multiple positive comments for the Well-Led inspection process
- Overall Well-Led was rated as Good
- The concurrent EoLC Inspection rating remained unchanged as "Requires Improvement" (with 12 specific improvements recommended for this service *one of these was a "must do" linked to improving risk management processes within the EoLC team
- There was one improvement recommendation for Well-Led linked to the strengthening of the oversight of the Trusts Equality Diversity and Inclusion (EDI) strategy

Next Steps

- Arrangements for an externally commissioned review of the Trusts governance processes by Deloitte LLP (planned pre-inspection) is near completion
- The Trust continues to work in conjunction with the local CQC engagement lead to highlight areas of continued improvement to feed into any future assessment process.
- The oversight of the EDI strategy via the Trusts People and Organisational Development Committee is being reviewed via a refreshed "EDI steering group", led by the Chief People Officer, the Deputy Chief Executive / Chief Finance Officer and the Head of EDI & Engagement for the Trust.
- The Trust's End of Life Care Committee has been restructured with 5 new improvement workstreams to oversee the delivery of the improvements required in respect of the Must and Should Do's from this core services inspection
- Work is underway to understand the new inspection framework for 2024
- The Trust awaits the outcome of the August 2023 Maternity core services inspection
- The Trust awaits the outcome of the September 2023 CQC IRMER inspection of radiotherapy services, noting an improvement notice was received and the CQC have accepted the Trusts submission in response to that notice.

Recommendations

The Trust Board is asked to note the findings of the inspection
Discussion is welcomed linked to the proposed improvement work as an outcome of this inspection

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

- ETM (Executive Team Meeting)

Reason for submission to the Trust Board[1]

discussion, information, 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

Results 2023 CQC Well Led Inspection MTW NHS Trust

Trust Board September 2023

Jo Haworth: Chief Nurse

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Exceptional people, outstanding care

Background

- *Maidstone & Tunbridge Wells NHS Trust is required to register with the Care Quality Commission (CQC) under Section 10 of The Health and Social Care Act 2008*
- *The Trust is required to be compliant with the fundamental standards of quality and safety.*
- *The CQC is in the process of revising its inspection framework, MTW is therefore one of the last acute Trusts to be inspected on the 2018 framework* **which moved away from a full comprehensive inspections of all core services to a more focused, risk orientated inspection approach, involving a new inspection cycle that included a core service inspection (a maximum of four core services), use of resources review and provider well led review*
- *The CQC undertook the Well-led Inspection and use of resources review in March 2023, they rated this specific review as "good"*
- *Concurrently an unannounced "core services" inspection of End of Life Care services was also undertaken, they rated this service as unchanged "requires improvement"*
- *This was followed by a recent unannounced "core services inspection of Maternity services *the draft report for this inspection is awaited*

Key components of the Well Led Inspection

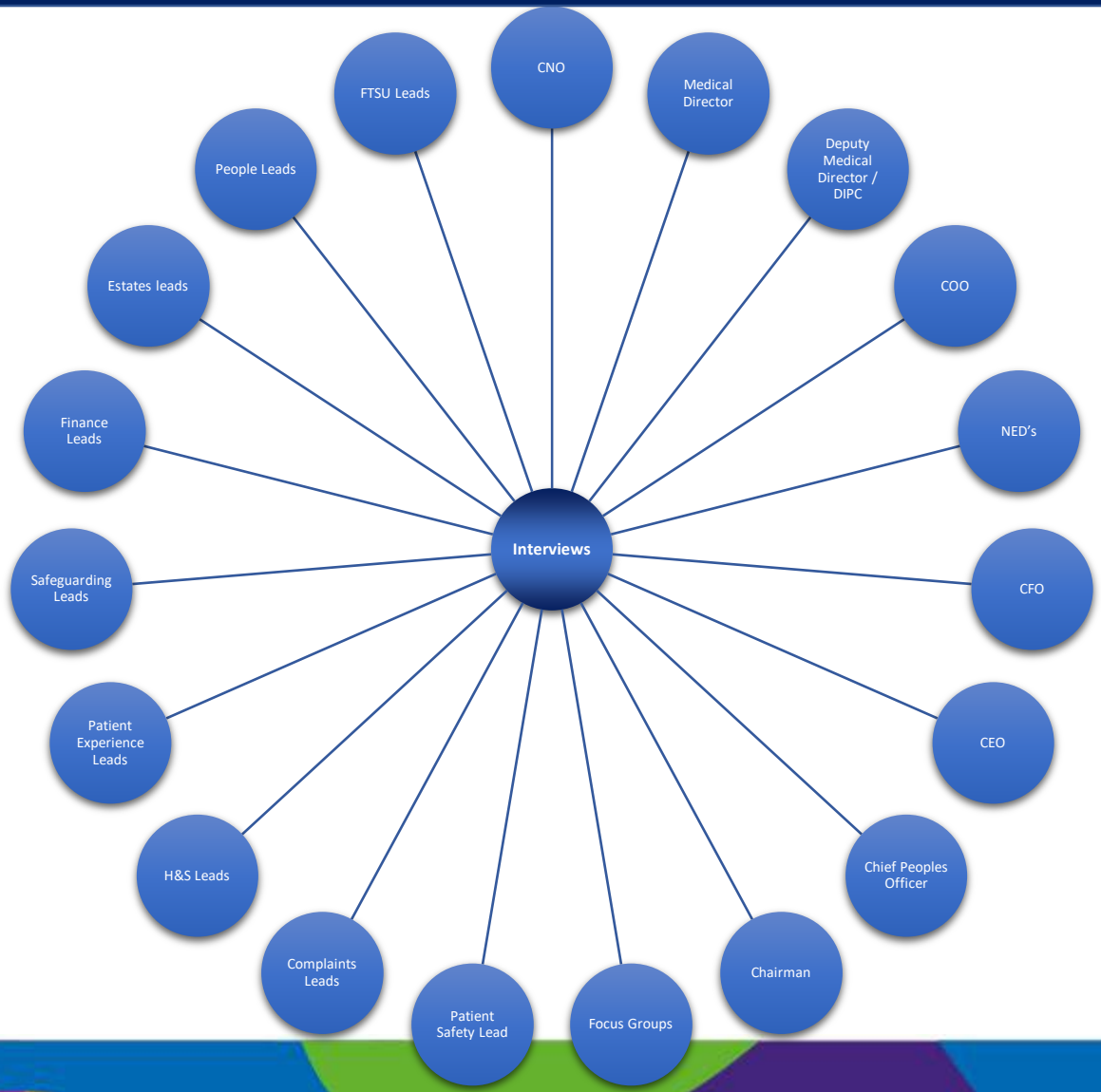
Multiple interviews undertaken with MTW Leaders over 2 days

Multiple documents requested as part of the inspections information review processes

Results were published on the 31st August 2023

Staff Interviewed

Well – Led Inspection



Exceptional people, outstanding care

Example of Information Requested

Well – Led Inspection

Exceptional people, outstanding care

Overview: Final Report

- The Provider Well-Led review was carried out by the CQC at MTW NHS Trust in March 2023, the Well-Led review rating was “good”.
- The Trusts overall rating remained unchanged from 2018 as “Requires Improvement” as only one core service was inspected at the same time as the well led review
- As described the Provider Well-Led inspection took place over two days, involving a wide range of interviews with senior leaders, including board members, executive directors and nonexecutive directors. In addition to this, interviews were held with senior clinicians and management leads for a number of areas, including workforce, quality and safety, freedom to speak up, safeguarding and equality and diversity.
- This was the first time the Trust had been inspected under the revised focused 2018 framework *which is due to be superseded imminently
- The final report from the CQC included a comprehensive summary of good practice relating to leadership, governance and culture at MTW NHS Trust commenting on the way this was used to drive improvements and deliver high quality person centred care to patients. There were multiple points of good practice identified
- The CQC identified 1 area for improvement as a “should do in the provider well led assessment, which is described in the “areas for improvement slide within this pack.
- The CQC identified 12 areas for improvement for the concurrent End of Life Care Core Services inspection, again these are described in the areas for improvement slide within this pack

Current Ratings

The Tunbridge Wells Hospital at Pembury

Overall: Requires improvement

Tonbridge Road, Tunbridge Wells, Kent, TN2 4QJ
Provided and run by: Maidstone and Tunbridge Wells NHS Trust

Medical care (including older people's care)	9 March 2018	Good
Services for children & young people	9 March 2018	Good
Critical care	9 March 2018	Requires improvement
End of life care	31 August 2023	Requires improvement
Maternity and gynaecology	3 February 2015	Requires improvement
Outpatients and diagnostic imaging	3 February 2015	Requires improvement
Surgery	9 March 2018	Requires improvement
Urgent and emergency services	9 March 2018	Requires improvement

Maidstone Hospital

Overall: Requires improvement

Hermitage Lane, Maidstone, Kent, ME16 9QQ (01622) 224796
Provided and run by: Maidstone and Tunbridge Wells NHS Trust

We are carrying out a review of quality at Maidstone Hospital. We will publish a report when our review is complete. Find out more about our inspection reports.

Medical care (including older people's care)	9 March 2018	Good
Services for children & young people	9 March 2018	Good
Critical care	9 March 2018	Good
End of life care	31 August 2023	Requires improvement
Maternity and gynaecology	3 February 2015	Good
Outpatients and diagnostic imaging	3 February 2015	Requires improvement
Surgery	9 March 2018	Requires improvement
Urgent and emergency services	9 March 2018	Requires improvement

Positive Findings

- Outstanding practice was recognised linked to the success of the Trusts Exceptional Leaders Programme (ELP)
- Effective leadership was sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.
- The Chair and CEO understood the importance of diversity and were taking actions to improve this at executive and leadership levels in the Trust.
- **Leaders**
  - had the skills and abilities to run the service.
  - were visible and approachable in the service for patients and staff
  - supported staff to develop their skills and take on more senior roles.
  - had the experience, capacity, capability, and integrity to ensure the strategy was delivered and risks to performance addressed.
  - Were compassionate, inclusive
- The Trust's Executive Team also played key roles in the local healthcare system, the report recognised the achievement of SOF1 status
- The Trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- The Trust promoted equality and diversity in daily work, and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service and with partner organisations.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Positive Findings

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders had plans to cope with unexpected events.
- Staff contributed to decision-making to help avoid financial pressures compromising the quality of care
- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.
- Leaders operated effective governance processes, throughout the service and with partner organisations.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- There were no “Must Do’s” specifically for the Well-led inspection

Well-Led Improvements Required (Should Do)

- The Trust should ensure there is clear and effective oversight of the equality, diversity and inclusion strategy and ensure the impact of actions and initiatives are evaluated in a timely way. (Regulation 17).

Well-Led Areas for improvement

- A team that did not have positive results for engagement in the most recent staff survey were facilities and estates. The improvement plan was also described within the report
- While there was good engagement with divisions, there were 11 committees directly reporting into the quality committee, the report noted this had the potential to impact the effectiveness of the committee. Through conversation it was clear this had been acknowledged and the Trust had plans in place to commission an external governance review.
- The core services for End of Life Care, which remained rated as requires improvement had the following 12 improvement recommendations (the first being a “Must Do”)

1. The Trust must ensure there is a robust process to monitor risk associated with the service (end of life care) . (Regulation 17)
2. The Trust should ensure plans are developed to ensure compliance with trust mandatory training requirements (Regulation 18)
3. The Trust should ensure that clinicians receive training to enable the early recognition of the dying patient (Regulation 18)
4. The Trust should ensure that patients who are identified as dying have an individualised care plan started as soon as possible to ensure their needs are understood. (Regulation 9)
5. The service should ensure that there is sufficient staffing cover within the team to train and develop ward based staff. (Regulation 12)
6. The service should ensure they develop systems to monitor their performance and achieve good outcomes for patients. (Regulation 17)
7. The Trust should ensure that staff report incidents in line with trust policy. (Regulation 17)
8. The service should ensure there is a robust process to monitor risk associated with the service. (Regulation 17)
9. The service should ensure that actions or escalations from meetings are documented, monitored and shared with relevant staff. (Regulation 17)
10. The Trust should consider additional training for ward based staff regarding relevant care for the dying patient to minimise specific risk issues such as pressure sores, nutrition and hydration.
11. The Trust should consider reviewing the level of chaplaincy cover across the trust.
12. The service should consider developing an audit schedule outside of the annual NACEL (National End of Life Care Audit) return.

Next Steps

- Arrangements for an externally commissioned review of the Trusts governance processes by Deloitte (planned pre inspection) is near completion
- The Trust continues to work in conjunction with the local CQC engagement lead to highlight areas of continued improvement to feed into any future assessment process.
- The oversight of the EDI strategy via the Trusts People and Organisational Development Committee is being reviewed via a refreshed “EDI steering group”, led by the Chief Peoples Officer, the Deputy CEO head and the Head of EDI & Engagement for the Trust.
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- The Trust awaits the outcome of the August 2023 Maternity core services inspection
- The Trust awaits the outcome of the September 2023 HSE CQC IRMER inspection of radiotherapy services, noting an improvement notice was received and the CQC have accepted our submission in response to that notice.

Recommendations

- The Trust Board is asked to note the findings of the inspection
- Discussion is welcomed linked to the proposed improvement work as an outcome of this inspection

Quarterly mortality data **Medical Director**

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

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 13/09/23

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

Discussion and assurance

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

MORTALITY – SUMMARY REPORT
July 2023

The last T health (Dr Fosters) update was in July of 2023, therefore the data period is Apr 2022 - Mar 2023

Background

The report provides an overview of mortality using the Hospital Standardised Mortality Ratio and the Standardised Mortality Ratio. The report presents intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysing in the Healthcare Intelligence Portal tool, this report examines in-hospital mortality, for all inpatient admissions for the 12-month time period Apr 2022 - Mar 2023.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including October 2022(unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

SHMI data for the time period Mar-22 – Feb-23 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

HEADLINES

Data Period: Apr 2022 - Mar 2023

Metric	Result
HSMR	97.8 (within expected) (92.8 – 103.1)
HSMR position vs. peers	Regional acute peer group = 17 trusts: • 11 lower-than-expected • 4 within expected • 2 higher-than-expected Peer group = 93.1 (lower-than-expected) (91.9 – 94.3)
All Diagnosis SMR	93.9 (lower-than-expected)
Significant Diagnosis Groups	• Congestive heart failure, nonhypertensive (742 superspells; 100 deaths) • Other acquired deformities (83 superspells; 2 deaths) • **Peritonitis and intestinal abscess (36 superspells; 6 deaths)** • Septicemia (except in labour) (757 superspells; 184 deaths)
CUSUM breaches	• Septicemia (except in labour) (Dec-22) (Feb-23) • Congestive heart failure, nonhypertensive (Oct-22) (Dec-22) • Substance-related mental disorders (Oct-22) • Conduction disorders (Aug-22)
SHMI position	(Mar-22 to Feb-23) 90.01 (as expected)

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

HSMR for Mar-23 is 87.92 (the second lowest in FY22/23) and “within expected”, based on 4294 superspells and 112 deaths (crude rate 2.61%).

HSMR for the period Apr-22 to Mar-23 (FY22/23) is 97.83 and “within expected”, based on 46,264 superspells and 1405 deaths (crude rate 3.04%). This is the third consecutive month of improvement in HSMR and is the lowest over all rolling periods in the last financial year.

Improvement in HSMR is being driven by a crude rate falling faster than expected rate. Compared to peers, the Trust remain inside funnel plot control limits, but have seen a slight improvement vs. the national trend.

Figure 1 – HSMR Monthly Trend

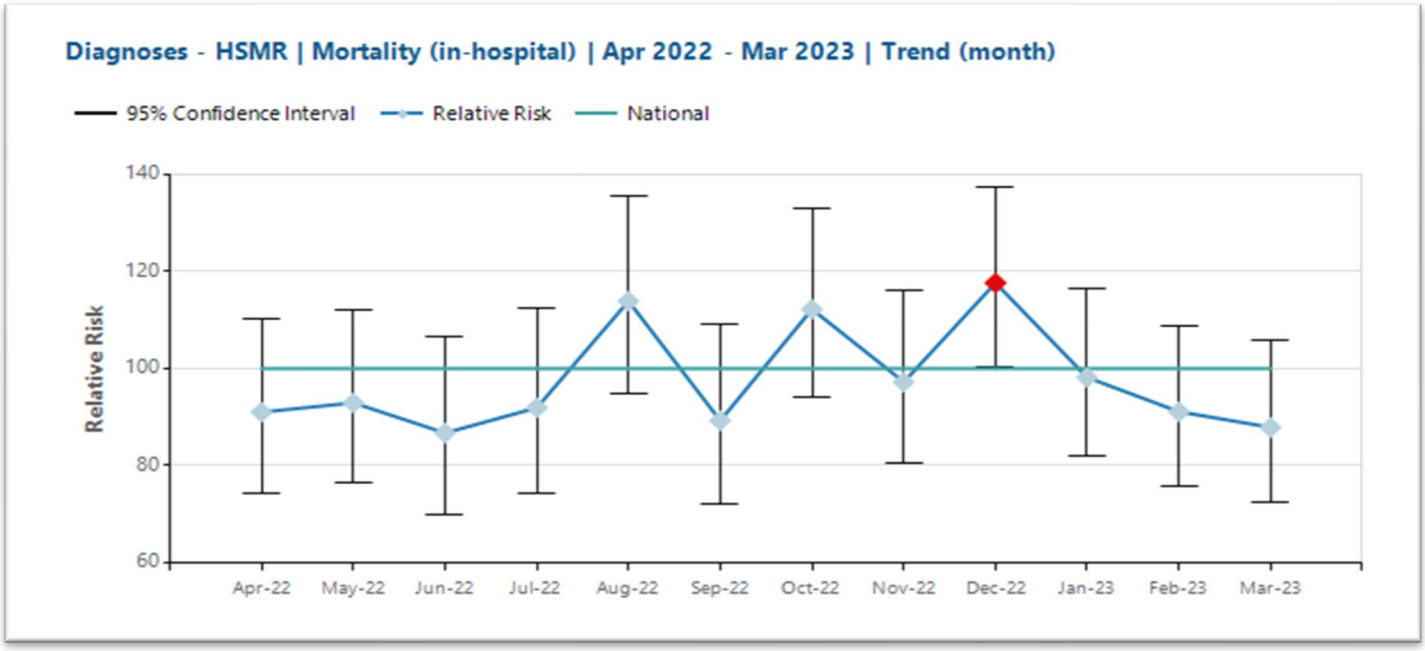


Figure 2 – HSMR 12 Month Rolling Trend

Figure 3 – HSMR 12 Month Peer Comparison

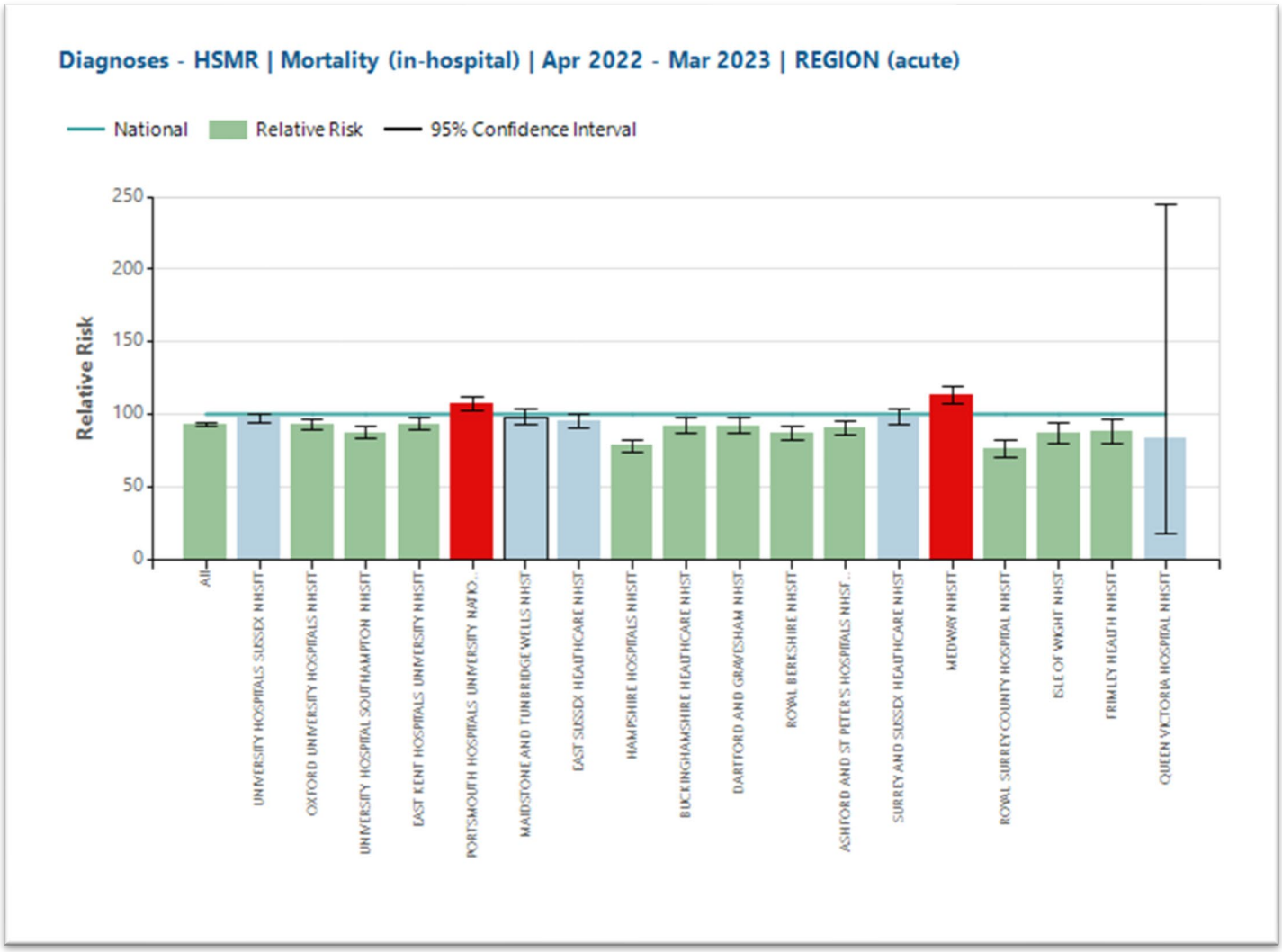
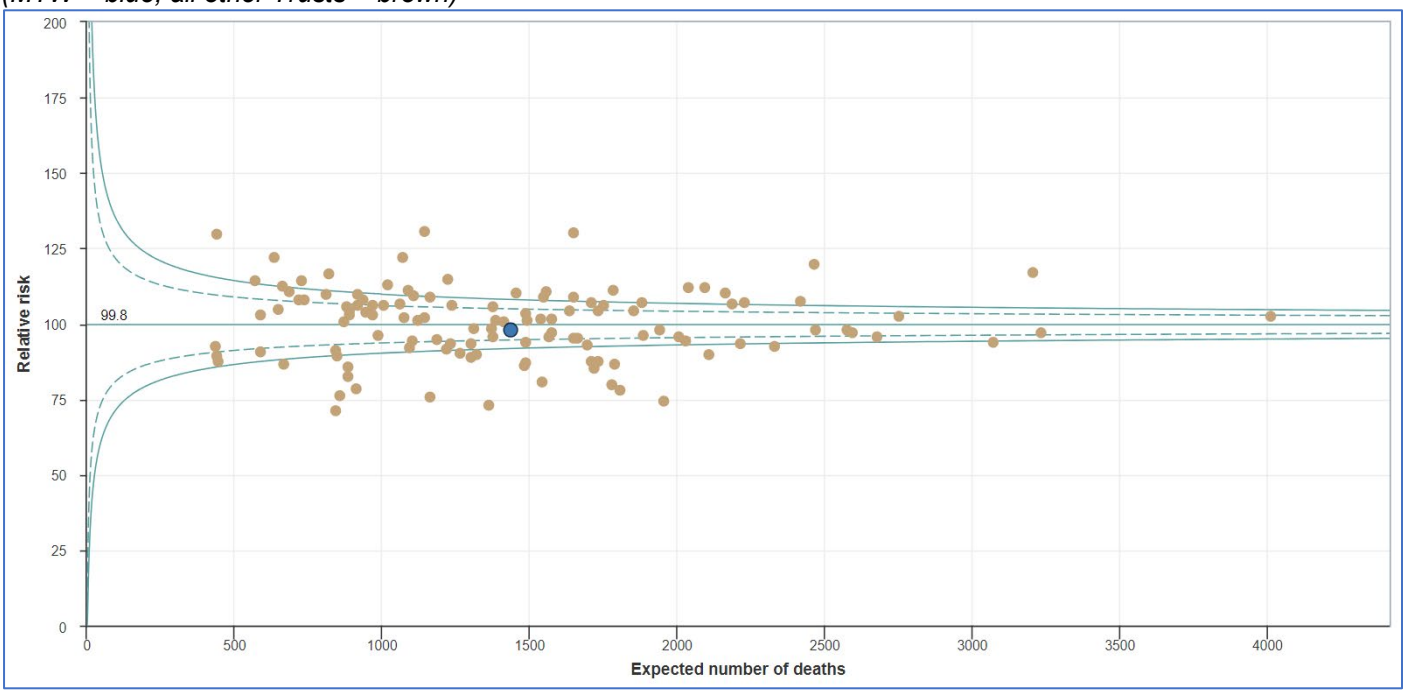


Figure 3.1 – HSMR 12 Month Peer Comparison: National (Acute, Non-Specialist) Funnel Plot
(MTW = blue; all other Trusts = brown)



MONTHLY SHMI

Key points

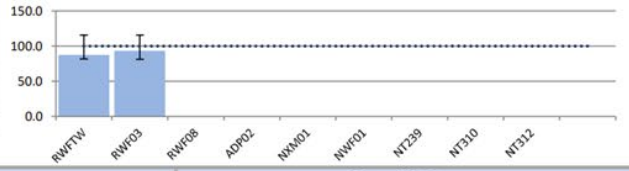
SHMI for the period Mar-22 to Feb-23 is 90.01 – very consistent with last month – and remains 'as expected'. There is one outlier using confidence interval methodology: acute and unspecified renal failure.

SHMI - Published (With Over Dispersion)

** click **group name** to filter; click **header title** to clear*

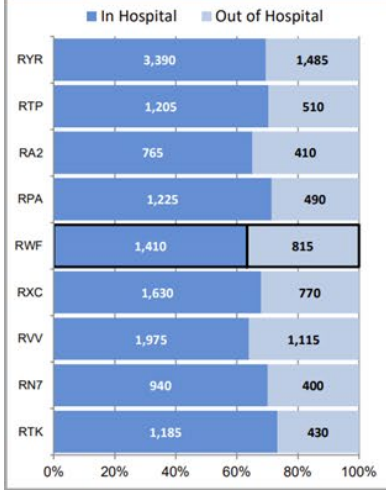
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTK	Ashford And St Peter'S Hospitals NHS Foundation Trust	56,060	1,615	1,810	-195	89.00	89.12	112.21
RN7	Dartford And Gravesham NHS Trust	52,130	1,345	1,350	-5	99.46	88.84	112.56
RVV	East Kent Hospitals University NHS Foundation Trust	89,870	3,095	2,985	110	103.69	89.44	111.80
RXC	East Sussex Healthcare NHS Trust	55,010	2,400	2,390	10	100.60	89.32	111.96
RWF	Maidstone And Tunbridge Wells NHS Trust	88,125	2,225	2,475	-250	90.01	89.34	111.93
RPA	Medway NHS Foundation Trust	53,160	1,720	1,500	220	114.45	88.95	112.42
RA2	Royal Surrey County Hospital NHS Foundation Trust	52,005	1,175	1,485	-310	79.02	88.94	112.44
RTP	Surrey And Sussex Healthcare NHS Trust	49,135	1,715	1,745	-30	98.05	89.09	112.25
RYR	University Hospitals Sussex NHS Foundation Trust	123,040	4,870	4,495	375	108.34	89.62	111.58
Group		618,535	20,160	20,235	-75	99.63		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
THE TUNBRIDGE WELLS HOSPITAL	58,205	1,175	1,345	87.49	84.34	118.57
THE MAIDSTONE HOSPITAL	28,845	1,050	1,130	93.09	84.20	118.76
CROWBOROUGH WAR MEMORIAL	340	0	*			
KIMS HOSPITAL (NEWNHAM COURT)	220	0	*			
THE HORDER CENTRE - ST JOHNS	200	0	*			
BENENDEN HOSPITAL	140	0	*			
NUFFIELD HEALTH, TUNBRIDGE	125	0	*			
SPIRE TUNBRIDGE WELLS HOSPITAL	40	0	*			
SPIRE ALEXANDRA HOSPITAL	10	0	*			

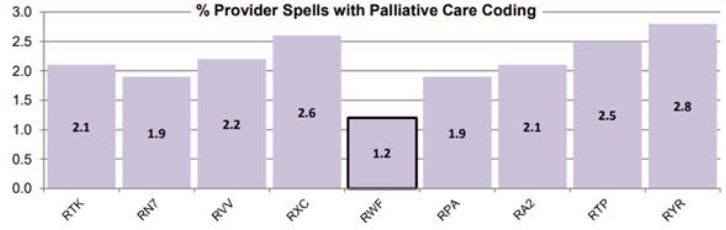


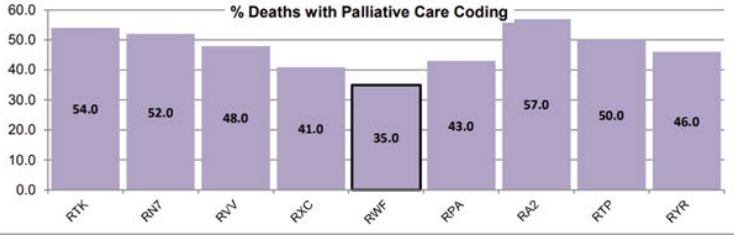
SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	190	170.00	110.21	85.26 117.28
Cancer of bronchus, lung	35	30.00	114.56	69.78 143.30
Secondary malignancies	80	80.00	102.66	80.31 124.52
Fluid and electrolyte disorders	50	40.00	115.78	72.95 137.09
Acute myocardial infarction	20	25.00	70.47	67.85 147.37
Pneumonia	245	255.00	95.58	84.48 118.38
Acute bronchitis	20	25.00	73.52	68.68 145.61
Gastrointestinal haemorrhage	20	30.00	71.71	70.20 142.45
Urinary tract infections	40	45.00	86.33	71.44 139.98
Fracture of neck of femur (hip)	45	55.00	81.70	75.18 133.01

Deaths: In / Out Hospital

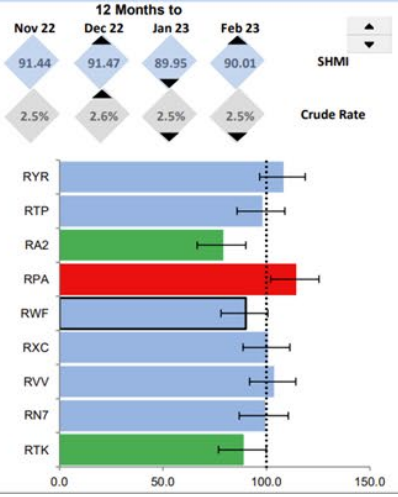


% Palliative Care Coding





Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(99) Acute and unspecified renal failure	65	50	130.00	100.33 165.70
(79) Respiratory failure, insufficiency, arrest (adult)	35	25	140.00	97.50 194.71
(65) Congestive heart failure, nonhypertensive	100	85	117.65	95.72 143.09
(66) Acute cerebrovascular disease	195	195	100.00	86.46 115.06
(78) Pleurisy, pneumothorax, pulmonary collapse	35	30	116.67	81.25 162.26
(92) Biliary tract disease	25	20	125.00	80.87 184.53
(77) Aspiration pneumonitis, food/vomitus	85	85	100.00	79.87 123.65
(82) Influenza, Acute and chronic tonsillitis, Other upper respiratory infections, Other upper respiratory	40	40	100.00	71.43 136.18

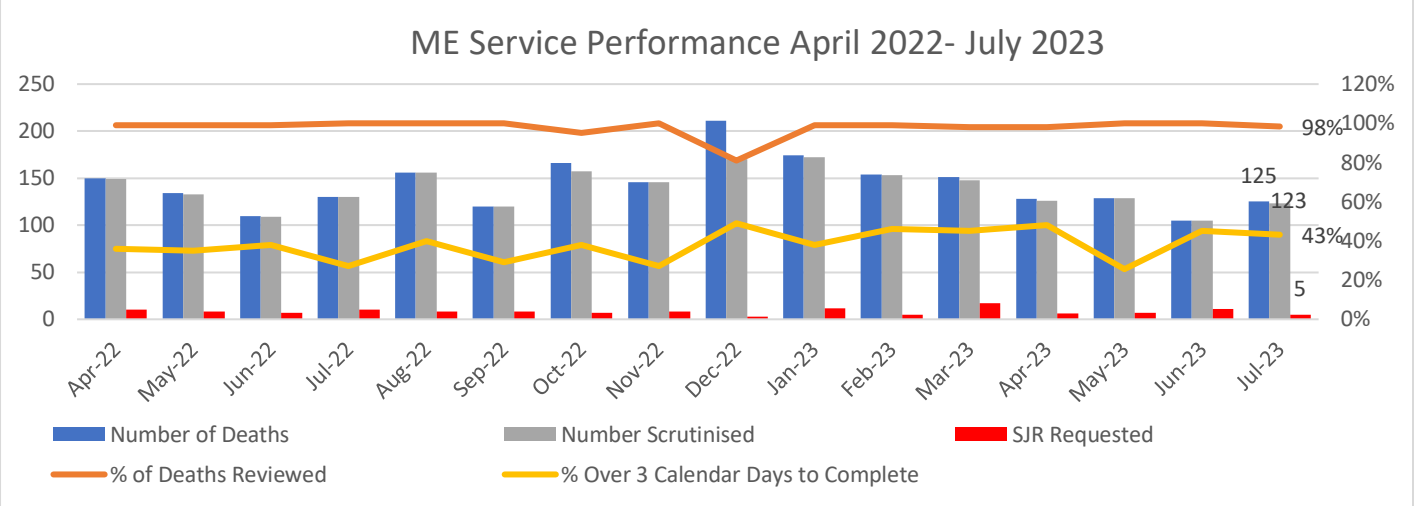
Mortality Surveillance Group (MSG) and Medical Examiner Service Update

Medical Examiner Service

ME Service Update

- In June and July 2023, the number of deaths was 105 and 125 respectively, there was a sharp decline in deaths in June 2023. Historically there is a decline in June deaths with deaths going back to usual levels in July as demonstrated in the table below. The Service achieved a 100% and 98% performance in number of cases scrutinised in June and July.
- The Service continues to perform well scrutinising a high percentage of deaths, however resilience within the Service to cover staff leave is an ongoing issue.
- As part of the roll out of the Service into the community, GPs continue to be onboarded with 41 GP practices of the 54 in West Kent signed up to use the Medical Examiner Service.
- Three more MEs are now on board; this will support the full roll-out of the Service into the community, which is on track.
- Engagement with community providers continues to be good, there have been a few GP practices deciding to opt out of using the ME Service until legislation is in place which is expected in April of 2024.

Month	Number of Deaths	GP Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Dec-22	211	170	81%	83	49%
Jan-23	174	172	99%	65	38%
Feb-23	154	153	99%	70	46%
Mar-23	151	148	98%	67	45%
Apr-23	128	126	98%	60	48%
May-23	129	129	100%	33	26%
Jun-23	105	105	100%	47	45%
Jul-23	125	123	98%	54	43%



Challenges faced by the ME Service

- Timeliness of death summary completion by attending physicians impacts on the ability of the Service to complete the scrutiny process within the stipulated 3 days
- Inability to adequately cover staff absences including leave and sickness
- Inadequate funding by NHSE/I to operate a good quality Service

Mortality Surveillance Group (MSG)

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

Learning from Mortality reviews identified the following needs:

- In a case discussed at MSG, end of life care could have been initiated earlier, when the patient was developing multiorgan failure and worsening sepsis. Feedback to the team involved in the care has happened.
- Sepsis continues to be a theme highlighted by the Structured Judgement Review. In a case discussed at MSG there was failure to document possible sepsis on admission despite evidence of infection in an unwell patient.
- In another case discussed at MSG the need for better communication with patients early in their care journey about their prognosis was highlighted.

The following practice was highlighted

- Good involvement of patient and family in all relevant decision-making with courageous but kind conversations with family members evidenced
- Good cross-specialty interaction and opinions obtained at appropriate times (Surgeons, Gastro, ITU)
- Good record keeping - especially by junior medical doctors collating a lot of complex information

Structured Judgement Review (SJR)

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

Year	Outstanding SJRs	Completed SJRs
Apr 21 to Mar 22	**3**	109
Apr 22 to Mar 23	**8**	98
Apr 23 to Mar 24	**9**	26
SJR Total backlog	**20**	**233**

- Additional capacity to support the SJR process and continuous work with SJR reviewers to clear the SJR backlog is yielding a positive result.
- The backlog has seen a massive decline as cases within the backlog are monitored and reviewed.
- The current SJR backlog position is 20, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4-week stipulated SJR turnaround time.
- There are 9 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 29, the lowest number of SJRs outstanding in the last 2 years.

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor Care'
Jun-23	11	0	0
Jul-23	9	0	1
Aug-23	MSG cancelled		

- In June, there was no SJR with an overall assessment of 'Poor care' or 'Very poor care' discussed at MSG.
- In July, the Mortality Surveillance Group reviewed 1 SJR with an overall assessment of 'Very poor care'.
- Learning from both very poor/poor care and good practices highlighted from cases reviewed at MSG continue to be highlighted to directorates.
- In August 2023, MSG was cancelled as many stakeholders were on planned leave and the meeting was not quorate.

Actions from 'Poor care' SJR Reviews

- The 'Very poor care' SJR discussed in July 2023 was referred to the SI panel to determine if it met the criteria for an SI declaration. It was reviewed by the SI panel and did not meet the SI criteria
- Feedback to Directorates to aid learning from all SJRs occurs via Mortality leads to team and through Clinical Governance meetings.

Next steps

- A review of all SJR cases in the last 12 months has been conducted highlighting key themes and trends. This is due to be discussed at the September MSG to ascertain further actions
- Continue to monitor SJR backlog to sustain the downward trajectory.
- Continue to progress the Medical Examiner community roll out project.

Quarterly Maternity Services report (incl. a review of the Trust's response to non-compliance with the Swab Count policy)	**Chief of Service, Women's, Children's and Sexual Health / Director of Maternity**

The enclosed report provides information about safety issues in Maternity, the themes and trends and the identified learning and action plans, including:

- Serious Incidents (SIs)
- Health Safety Investigation Branch (HSIB) cases
- Perinatal Mortality Review Tool (PMRT)
- Risk Register
- Complaints
- Maternity Dashboard
- Staff engagement and feedback incl. Safety Champion Feedback
- Patient feedback and engagement
- Progress in implementing Saving Babies Lives Care Bundle v2
- Progress with maternity staff training
- Progress with clinical workforce planning
- Maternity Continuity of Carer Plan
- Ockenden Report recommendations update

It should be noted that the full Serious Incident Investigation reports and the HSIB Maternity Investigation MI-021504 and MI-022299 reports have been submitted in a supplementary report in the 'Part 2' Trust Board meeting, as these reports contain confidential information that is not suitable for the public domain.

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

- 'Main' Quality Committee, 13/08/23
- Executive Team Meeting, 18/07/23

Reason for submission to the Trust Board

Assurance.

Executive Team Meeting (ETM)

NHS Maidstone and Tunbridge Wells NHS Trust

Maternity Services Quarterly Update Report

Reason/s for submission to the ETM (delete the tick for any that do not apply):

Decision	
Discussion	
Information	✓
Other (state) – National requirement for Trust Board oversight of maternity services	✓

Link to corporate breakthrough objective/s (delete the tick for any that do not apply):

Reduce complaints re poor communication	✓	Increase discharges by 12pm	
Reduce patient falls to 6.5 per 1000 OBD		Reduce premium workforce expenditure	
Achieve planned levels of new outpatient activity		Reduce staff turnover to 12%	

Executive Summary

Summary of the background section

This report provides the Trust Board with oversight and assurance with regards to requirements of:

- Ockenden (2020) Immediate and Essential Action 1 (IEA1) which requires Maternity and Neonatal services to provide the Board a locally agreed dataset in line with NHSE Guidance, “Implementing a Revised Perinatal Quality Surveillance Model”(2020).
- Supports the requirement of Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) in year 4 and year 5
- This report also provides assurance and oversight to the Board regarding all perinatal deaths as per the requirements of CNST Safety Action 1

Summary - This report provides an overview of the following for April – June 2023

- Summary of Serious Incidents (SIs) declared for Maternity Services, with full reports in appendix **
- Number of Healthcare Safety Investigation Branch (HSIB) cases reported **
- Number of Perinatal Mortality Review Tool (PMRT) case reviews*
- Themes and Trends from all investigations and case reviews**
- Staff engagement and feedback including Safety Champion Feedback
- Patient feedback and engagement
- Progress in implementing Saving Babies Lives Care Bundle v2*
- Progress with maternity staff training*
- Progress with clinical workforce planning*
- Maternity Continuity of Carer Plan
- Ockenden Report recommendations update

*Clinical Negligence Scheme for Trusts (CNST) requirement **Ockenden recommendation requirement

Number of Internal SI's Declared - 4 cases (2 HSIB cases)

STEIS Ref	Clinical Area	Synopsis
2023/7713	Postnatal Ward, TWH	Potentially avoidable injury following Monofer infusion
2023/8903	Delivery Suite, TWH	Severe haemolytic disease of the new born
2023/11413	Delivery Suite, TWH	HSIB case – see below
2023/11750	Delivery Suite, TWH	HSIB case – see below

Number of HSIB reported cases – 2 cases

HSIB Ref	Clinical Area	Synopsis
MI-027939	Delivery Suite, TWH	Baby born in poor condition following intrapartum haemorrhage, transferred to tertiary unit for cooling
MI-028304	Delivery Suite, TWH	Intrapartum stillbirth. Maternal splentic artery aneurysm

Number of Internal SI's closed – 3 cases, full reports included in appendices

STEIS Ref	Clinical Area	Synopsis
2023/2292	Delivery Suite, TWH	Retained swab following perineal suturing in Delivery Suite room – Never event
2023/7713	Postnatal Ward, TWH	Potentially unavoidable injury following Monofer infusion
2022/22498	Delivery Suite, TWH	Stillbirth

STEIS Ref	SI report recommendations	Actions
2023/2292	1. MDT training & support for new staff 2. Review of equipment used for procedures 3. Review of processes	1. Training programme, resources and competency under review 2. Ongoing monitoring of compliance with swab count process implemented 3. Equipment review in progress 3. A3 project in progress to review procedures and barriers to following correct process 4. Shared learning with LMNS 5. Learning event planned to share impact of failure to comply and the impact of human factors and team working

Number of Internal SI's closed – 3 cases (cont.)

STEIS Ref	SI report recommendations	Actions
2023/7713	1. Correct proforma to be updated and in use 2. Leaflet to be developed and given to patients to enable them to make informed choices 3. Trust wide learning on awareness of manufacturer's recommendation of cannula size to be used for iron infusions 4. Share learning to ensure staff understand the impact of listening to patient's experience	1. A maternity specific proforma incorporating patient information, prescription and infusion technique to be developed. Amendment to current guideline to reflect learning 2. Leaflet to be developed to give to patients 3. Midwives to undertake training, add to CLIPAM Trust wide learning slide, discuss at Medication Safety Group 4. To be discussed at clinical governance meetings, Trust wide intranet learning hub and ward meetings
2022/22498	1. Community use the offline E3 template and when they do not have access to the online system 2. Share learning regarding the risk of transcription error when using hand written clinic notes 3. Share learning in relation to the need for clear and legible notes to be completed in the medical records for all patients	1. Communication sent to community midwives to request that they download the offline E3 template 2. & 3. Case presentation at the maternity governance meeting to share the learning regarding the risk of transcription error when using hand written clinic notes

Number of HSIB reports received - 2 cases (full reports available in appendices)

HSIB Ref & summary	HSIB recommendations	Trust actions
MI-021504 – Baby born in poor condition following shoulder dystocia, transferred to tertiary unit for cooling	No safety recommendations	
MI-022299 – fractured neonatal skull and haematoma following impacted head at emergency caesarean section	1. The Trust to ensure that CTG interpretation is carried out as part of an in person holistic clinical review to support decision-making and achieve a timely birth. 2. The Trust should ensure that staff are supported to recognise a changing clinical picture by confirming maternal and fetal wellbeing. This will enable them to prioritise the urgency of the situation.	1. Case used in staff training to ensure that centralised monitoring is not used to review CTG. 2. Staff training programme to include ongoing assessment of whole clinical picture

Summary of PMRT - 4 cases reviewed

NHS Maidstone and Tunbridge Wells NHS Trust

Stillbirths and late fetal losses– number of cases	*Neonatal deaths – number of cases*	*Parents informed of PMRT review and invited to contribute their perspective/ concerns/ questions*
4	0	4 (100%)

	Grading of care of the mother and baby up to the point the baby was confirmed as having died	*Grading of care of the mother following confirmation of the death of her baby*	*Cause of death*
Case 1 – antepartum stillbirth 24-27 weeks	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	Maternal vascular malperfusion and placental insufficiency
Case 2 - antepartum stillbirth 24-27 weeks	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	The cause of death was undetermined
Case 3 - antepartum stillbirth 24-27 weeks	B - The review group identified issues with care which they considered would have made no difference to the outcome for the baby	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	Maternal vascular malperfusion and placental insufficiency
Case 4 - antepartum stillbirth 28-31 weeks	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	The cause of death was undetermined

Summary of PMRT - 4 cases reviewed (cont.)

Case number	Contributory factor	Issues	Actions
Case 1 – antepartum stillbirth 24-27 weeks	None	None	None
Case 2 - antepartum stillbirth 24-27 weeks	None	None	None
Case 3 - antepartum stillbirth 24-27 weeks	Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	This mother had pre-eclampsia/eclampsia during her pregnancy which was not managed according to national or local guidelines	To develop a pilot proforma to guide staff on discharge process
Case 4 - antepartum stillbirth 28-31 weeks	None	None	None

All cases of perinatal loss continue to be reviewed to identify learning. The maternity team are increasing the focus on cases involving families with health inequalities and those who may have difficulties in accessing care.

Work continues to meet the recommendations of the Saving Babies Lives Care Bundle v2 and benchmarking has begun to meet additional recommendations from the newly published SBLCB version 3.

Themes and trends identified from all investigations (SI / HSIB / PMRT)

- Failure to follow guidelines or correct procedures
- Need for updated guidance and processes
- Need for new / updated patient information
- Need to consider whole clinical picture during clinical assessment and decision making
- Challenge with resources – difficulties with access to wifi in community settings

Staff Engagement

- **Staffing Matters**
  - BirthRate+ maternity workforce review in progress. Caseload mix has identified increasing levels of complexity in maternity cases, which is likely to indicate need for additional midwifery hours.
  - Ongoing recruitment events have been successful with an improving vacancy rate.
  - Two Internationally Educated Midwives are on the preceptorship programme and a further recruit has arrived and is completing preparation for OCSE and NMC registration.
  - Work is in progress to support students and find alternative HIEs to continue their degree programme, following withdrawal of the midwifery programme from CCCU.
  - Planning in place to support increased medical student numbers from September.
- **Staff Engagement & Welfare**
  - OD plan to be shared with teams and actions identified
  - 4 new trainee PMAs commence training module in March to meet nationally recommended caseload ratio.
  - Task and finish groups at or near completion to review arrangements for on calls, recruitment and bank booking processes in maternity

Safety Champion Feedback

- **Themes:**
  - MBC to have Instagram account to promote birth centre to wider audience
  - Poor public wifi at MBC – poor patient experience
  - Concerns about staff safety - isolated at night
  - Concerns about staff safety – staff shortages
  - Staff feel well supported by Matron and Band 7 at Crowborough Birth Centre
  - Difficulties with confirming rupture of membranes (SROM)
  - Front door sticking
  - Staff feel well supported in Neonatal Unit (NNU)
  - Families feel well cared for in NNU
- **Actions:**
  - Instagram account set up
  - Working with IT team to resolve (MBC left off recent upgrade programme)
  - Security team looking into options for staff raising alarm (panic alarm / walkie-talkies
  - Successful recruitment – staff shortages much less likely
  - Positive feedback shared
  - Business case in progress to support implementation of a tool to confirm SROM
  - CBC team working with estates to resolve faulty door

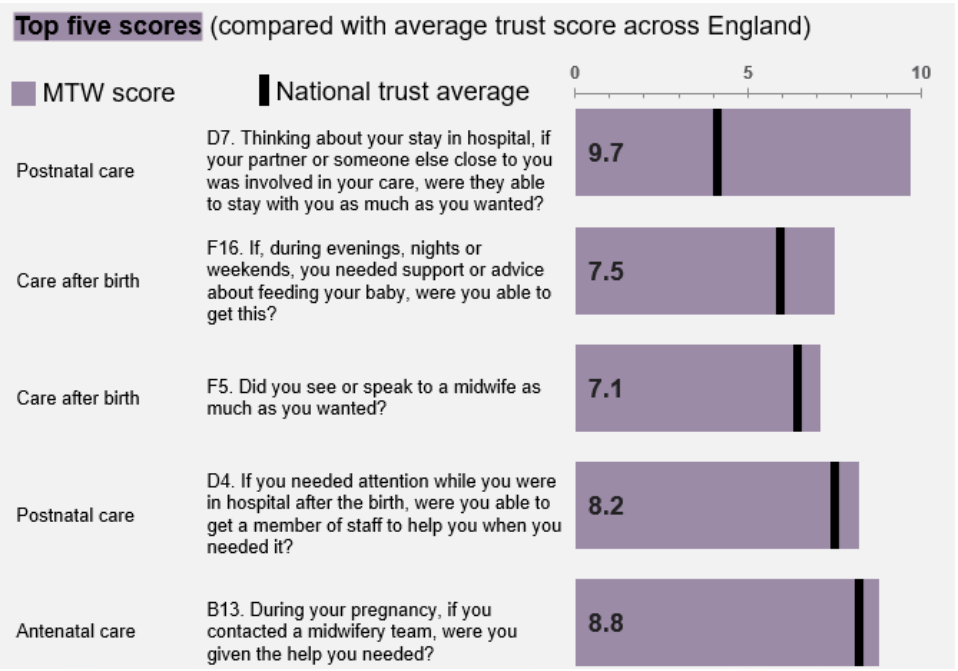
Patient Feedback and Experience

- **Friends and Family feedback**
  - April – June had 912 responses achieved across the departments and touch points for the maternity service. The average positive feedback was 97% across the quarter.
- **MNVP feedback**
  - Concern about content and tone of conversation with consultant
  - Concern about lack of contact with consultant and information about birth options
  - Midwife didn't recognise or respond to their concerns and uncertainty
  - The staff that did interact positively with them were important to their experience
  - BF support on PN is highly valued. Correlated with maternal confidence in feeding in early days and weeks
  - Hospital menu offering doesn't accommodate all dietary needs
  - Overnight support from and presence of partners is important – but it's not comfortable for them to stay
  - Quality of care at CBC highly valued
  - Triage not a positive experience
  - Slow transfer time from Triage to Delivery Suite and absence of information caused distress
  - BF support on PN is highly valued
- FFT & MNVP feedback is reviewed for themes and trends to inform quality improvement initiatives

CQC Maternity Survey 2022

Maidstone and Tunbridge Wells NHS Trust

- Of 370 who were invited to take part, 178 MTW patients responded to the survey = response rate 49%
- 51 questions covering AN care (B), labour and birth (C), PN care in hospital (D), feeding your baby (E) and PN care at home (F)
- Individual responses were scored and converted to a % from 0 to 100%. The higher the score, the better the trust's results.
- Scores then benchmarked to other trusts
  - **45 of MTW scores (88%) were "about the same" as all Trusts**
  - **6 scores in the "better than expected" compared with other trusts**
  - **0 scores were "worse than expected"**
- Most results were similar to 2021, with a statistically significant increase in 3 scores



Exceptional people, outstanding care

CQC Maternity Survey cont.

Maidstone and Tunbridge Wells NHS Trust

Actions in place to improve bottom five scores

During your pregnancy did midwives provide relevant information about feeding your baby?	• Virtual antenatal feeding information sessions have been implemented. • Breast feeding cafes welcome pregnant people to attend • Ongoing review of antenatal education in progress • Personalised care plans implemented to support meaningful conversations
After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	• Personalised care plans implemented to support meaningful conversations • Staff reminded to document conversations to facilitate monitoring of compliance
And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	• Induction of labour project group has updated the guideline and developed a new patient information leaflet, with MNVP input, to support conversations and decision making
Were you given information about your own physical recovery after the birth?	• Personalised care plans implemented to support meaningful conversations • Staff reminded to document conversations to facilitate monitoring of compliance
Thinking about your care during labour and birth, were you spoken to in a way you could understand?	• Personalised care plans implemented to support meaningful conversations • Collaborative work ongoing with LMNS to develop Maternity & Neonatal Equity and Diversity group to support patients with diverse needs

Progress with implementation of Saving Babies Lives Care Bundle version 2 (June 2023)

Element	Compliance Data	Target		Actions
Smoking in pregnancy	CO monitoring at booking	≥ 95%	**100%**	
	CO monitoring at 36 weeks	≥ 95%	**96%**	
Fetal growth restriction	Pregnancies where a risk status for fetal growth restriction is identified at booking	≥ 95%	**100%**	
	Pregnancies where a risk status for fetal growth restriction is identified at 20 week scan	≥ 95%	**97%**	
Reduced fetal movements	Women who receive information about reduced FMs by 28 weeks	≥ 95%	**100%**	
	Women attending with RFM who have a computerised CTG	≥ 95%	**93%**	Detailed audit to identify errors in documentation or poor compliance to share learning with staff
Fetal monitoring	Staff who have received training on CTG interpretation & auscultation	≥ 90%	**83%**	Training plan in place to ensure all staff have had training and assessment and to ensure that all staff providing intrapartum care are up to date
	Staff who have received training on human factors & situational awareness	≥ 90%	**83%**	
	Staff who have successfully completed mandatory annual competency assessment	≥ 90%	**83%**	

Progress with implementation of Saving Babies Lives Care Bundle version 2 (June 2023)

Element	Compliance Data	Target		Actions
Reducing preterm birth	Singleton live births <34 weeks having full dose of steroids within 7 days of birth	≥ 80%	**51%**	All cases are reviewed and learning shared where identified. However, many babies are born before a full course of steroids can be administered
	Singleton live births <34 weeks occurring > 7 days after completion of first course of AN steroids	N/A	**0%**	Positive finding – no babies were born more than 7 days after a first course of steroids
	Singleton live births <30 weeks receiving magnesium sulphate within 24 hours of birth	≥ 80%	**67%**	All cases are reviewed and learning shared where identified. However, many babies are born before magnesium sulphate can be administered
	Women having premature birth in an appropriate setting for gestation (>27+0, > 800g)	≥ 80%	**98%**	

Saving Babies Lives Care Bundle version 3 was published in May 2023, with an additional element for Diabetes in Pregnancy and further interventions recommended for all existing elements.
All providers are responsible for full implementation by March 2024 as part of the Three Year Plan for Maternity & Neonatal Services.
Compliance with the bundle will be monitored via the use of an implementation tool on the NHS Futures platform with oversight by the ICB

Progress with Maternity Multidisciplinary Staff Training

Maternity specific training		Actions
Fetal surveillance	83%	Training plan in place to ensure all staff have had training and assessment and to ensure that all staff providing intrapartum care are up to date
Neonatal resuscitation (PROMPT)	92%	Training plan in place to ensure all staff have had training with predicted compliance 99% by end November
Emergency clinical skills update (PROMPT)	92%	Training plan in place to ensure all staff have had training with predicted compliance 99% by end November
GAP & Grow – e-Learning	65%	Targeted reminder to staff to complete annual updates
GAP & Grow workshop	89%	Training plan in place to ensure all staff have had training
Infant Feeding Annual Update	85%	

A robust schedule has been put in place to ensure compliance is maintained across the year with a new approach to booking staff for mandatory training for 2023.
The education team work closely with the governance team to ensure programmes are continually updated to reflect learning from incidents and good practice.
The Maternity service continues to find it challenging to support staff to fulfil the national training requirements, in addition to trust mandatory training, with an uplift of only 21% to meet training and other absence.
The education team find it difficult to book rooms in which to deliver training for the large groups which are required to fulfil all the training requirements for the MDT teams

Progress with clinical workforce planning

Workforce	Latest review	Progress with actions from Maternity incentive scheme Year 4	Additional requirements for Year 5
Maternity workforce	Nursing and midwifery workforce review – October 2022	Requirements for increases in staffing have been identified and included in trust Nursing and Midwifery Staffing Business case. Draft report for 2023 BirthRate Plus assessment (funded by LMNS) received for review and final agreement	Recommendation to monitor midwifery red flags
Obstetric medical workforce	Audit of consultant attendance against Royal College of Obstetricians & Gynaecologists' recommended attendance in given clinical situations	Audit continues with work needed to improve data collection. Action required to improve evidence of evening attendance at MDT ward rounds	New standards for locum doctors and arrangements for compensatory rest following non-resident on call hours
Anaesthetic medical workforce	Obstetric anaesthetic cover meets national recommendations		
Neonatal medical workforce	Neonatal medical cover meets national recommendations		Workforce review between 30/5/2023 – 7/12/2023
Neonatal nursing workforce	Nursing and Midwifery Staffing Review – October 2022	Business case in progress for NNU ACP to meet BAPM recommendations	Workforce review between 30/5/2023 – 7/12/2023

Changes to requirements of Maternity Quarterly Report

- This report aims to provide an overview of the progress of the Maternity Service to meet recommendations and requirements laid out by the CNST, Maternity Incentive Scheme (MIS) and the Three Year Plan for Maternity and Neonatal services.
- Version 3 of the Saving Babies Lives Care Bundle and the MIS year 5 requirements have been published during the quarter which this report covers and will necessitate a review of the reporting for future Quarterly reports.

Summary of the recommendation/s section (incl. any action needed by the ETM)

- The report requests that the Board notes the detail of the report, the improvement actions in progress and the ongoing challenges
- The Board are requested to continue to offer their support to the maternity services to meet the safety actions for the Maternity incentive scheme, year 5 and deliver the requirements of the Maternity and Neonatal Three Year Delivery Plan

Maidstone and Tunbridge Wells NHS Trust

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA

2023

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool	0 cases	0 cases	1 case Themes: Failure to follow growth assessment protocol for high risk patient. Failure to identify growth restricted fetus	0 cases	2 cases Themes: No care issues identified prior to or following diagnosis of perinatal death	0 cases	1 case Themes: No care issues identified prior to or following diagnosis of perinatal death					
Findings of review of all cases eligible for referral to HSIB	1 case Themes: 41/40 Shoulder dystocia, cord snapped. Baby sent for cooling to Medway	2 cases Themes: Case 1 - Em LSCS in labour at 6cm dilatation, baby transferred to Level 3 NNU for management of skull fracture Case 2 - Intrapartum stillbirth at term	0 cases	0 cases	0 cases	2 cases Themes: Case 1 - Intrapartum haemorrhage, delivery expedited, baby born in poor condition, trnasferred to tertiary unit for cooling Case 2 - Intrapartum stillbirth at term, maternal medical condition diagnosed	2 cases Themes: Case 1 - Imaternal death 6 days after birth Case 2 - learly neonatal death at term, at Maidstone Birth Centre					
Report on:												
*The number of incidents logged as moderate or above and what actions are being taken	2 moderate incidents 1 serious incident Themes: - - 1 x unintended injury during monofer infusion - bladder injury at emergency caesarean section - retained swab - never event	2 moderate incidents 2 serious incidents Themes: - - 1 x delayed diagnosis of postpartum haemorrhage - 1 x failure to confirm presentation by ultrasound scan prior to caesarean section - 2 x HSIB cases	3 moderate incidents 0 serious incidents Themes: - - 1 x delayed senior attendence at ongoing postpartum haemorrhage - 1 x fetal skull fracture following operative vaginal birth - 1 x fetal skull fracture following failed operative vaginal birth and subsequent caesarean section birth	0 moderate incidents 1 serious incidents Themes: - 1 x Baby jaundiced within the 1st 24 hours, required exchange transfusion and transfer to tertiary unit. Maternal antibodies, late transfer of pregnancy care from overseas	1 moderate incidents 0 serious incidents Themes: - infected cannula site following antenatal admission	0 moderate incidents 0 serious incidents Themes:	0 moderate incidents 3 serious incidents Themes: - Maternal death - neonatal death - bowel resection following vaginal birth, ITU admission					
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	88%	91%	87%	85%	86%	89%	92%					
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour	57%	62%	94%	82%	84%	83%	81%					
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service User Voice Feedback - number of IQVIA (FFT) responses	193	235	407	470	127	315	280					
Service User Voice Feedback - % positive responses	95%	96%	98%	97%	97%	96%	98%					
HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No	No	No	No	No	No	No					
Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No					
Progress in achievement of CNST 10	MIS year 4 compliance reported to Trust Board and ICB for declaration in February	Declaration of compliance submitted Leads for Standards encouraged to continue to maintain levels of compliance to Year 4 requirements in anticipation of future updated standards.	Awaiting response following submission Awaiting publication of new safety actions Continuing to aim to meet Year 4 actions	Awaiting response following submission Awaiting publication of new safety actions Continuing to aim to meet Year 4 actions	MIS year 5 published	Requirements reviewed for ongoing actions from year 4 and new actions to be impleented for year 5. Leads for actions identified and plans in place to support delivery	Leads for actions identified and plans in place to support delivery					

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	64%

Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported Annually)	78%

Maidstone and Tunbridge Wells NHS Trust

Report for Maternity Board on Never Events: retained foreign object post procedure

18th August 2023

Calendar Year	2020	2022	2023
No of Never Events	1	1	1

Case 1 2020	Description
SI 2020/20784	Forceps delivery in room due to failure to progress in second stage. Sutured by Registrar. Swab left in situ as episiotomy oozing with plan to remove in 2 hours. No documentation or swab count in labour notes. Tail of swab not clipped to drape therefore not visible. Midwife forgot to remove and woman was discharged. Day 11 retained swab removed by community midwife. **Actions:** • Amendment to Swab, Needle and Instrument Count Maternity Guideline following agreement by Consultants to explicitly detail acceptable use of swab or vaginal pack, not item- completed • Learning Action Review to be completed with midwife involved- completed • Reflection by Registrar with Educational Supervisor- completed • Audit of 50 deliveries to capture spontaneous and operative deliveries both in the room and in theatre- completed • Introduction of postnatal SBAR handover tool- completed • Reminder to Obstetric staff to communicate plans regarding vaginal packs to women- completed • Message on Take 5, dissemination of Swab, Needle and Instrument Count Maternity Guideline to all staff- completed • Video teaching tool sent out on staff Facebook page communicating swab and needle count process-completed

Case 2 2021	Description
SI 2021/13255	The patient gave birth via a forceps delivery and episiotomy in the obstetric theatre. She had a blood loss of 650ml. The patient had multiple attendances at triage and in the community regarding her post-natal recovery. 4 weeks post-delivery retained swab removed by gynae on call team in EGAU

	Actions: • Practice of using spare swabs to clean patient means swabs available for use after final count completed presents risk to patient. Implement a new process within theatres of only using conti wipes to wash patients in theatre - completed • Use of technique wrapping tail of swab around rolled swab against specific guidance from previous never event. Individuals involved to amend practice and reflect upon incident- completed. • All staff involved in theatre cases to fully engage with WHO checklist at all stages and to complete accurately and legibly. Audit of WHO checklists- Theatres • Personal reflection of incident and learning from those involved- completed

Case 3	Description
SI 2023/2292	Decision for an extended episiotomy was made to expedite the delivery, this was performed by an Obstetric Registrar and a midwife was present throughout. The registrar sutured the episiotomy. The swab count was not documented correctly. The midwife signed for the registrar as the registrar left the room to attend another patient. 4 weeks post-delivery retained swab removed by gynae on call team in EGAU. **Actions:** • Swab count competency to be to be added to the MDT PROMPT training- not completed as awaiting new year of PROMPT programme in October 2023 • Perineal suturing competencies to include assessment of swab count- in progress • Development of a LOKSSIP for delivery suite- completed • Qualitative analysis of themes and trends of barriers to completion- in progress • Swab, needle and instrument count training video to be produced to show best practice- completed • Swab, needle and instrument count training video – part 2 to be produced to show common pitfalls that can lead to retained swabs- in progress for completion August 2023 • Focus group set up to address non-compliance and formulate an action plan to address embedding of process and ongoing monitoring of compliance- completed

	fishbone.docx • PMO support to the department to complete A3 quality improvement- completed • Take 5 informing staff of their responsibilities when participating in counting swabs-completed • Change of delivery packs to include artery forceps to enable clipping of the swab tail to the drapes- completed • Review of the recommendations from the NHSE/I review of technical solutions to improve visibility of swabs from the HSIB report into detection of retained vaginal swabs and tampons following childbirth- report not yet published • Collaboration with ICB for shared learning event with local acute providers for 'retained swab' never events- awaiting ICB response • MTW maternity learning event with case presentation from staff members who contributed to the investigation and action plan to demonstrate the improvements to processes, and support from theatres staff with an introduction to human factors and team work for surgical safety- presented at Clinical Governance

Further Actions

Action	Person responsible	Complete/in progress
10 sets of notes to be audited every 2 weeks	Barbara Weeks, Deputy Delivery Suite Manager	In progress starting 17th August 2023
New process for performance management if non-compliance repeated; 1st incident of non-compliance: discussion with manager/watch video/read guideline. 2nd incident: performance management	Delivery Suite Ward Managers	In progress starting 17th August 2023
Develop A3 project	Wendy Martin PMO Tracy Thresher/Mr Wildman	In progress – expected completion date 30th August 2023
MSWs to be trained to assist in swab count in delivery suite - Competency document to be devised - Training to be devised	Tracy Thresher, Matron Grace Anderson, Project Midwife	30th October 2023
Implement LOKSSIP Training to be rolled out on delivery suite	Delivery Suite Managers	25th August 2023
Free standing lamps needed to provide lighting for suturing	Delivery Suite Managers	On order
New perineal suturing trolleys ordered which can be stocked with appropriate resources including LOKSSIP paperwork	Delivery Suite Managers	On order

Bigger trolleys ordered for delivery suite rooms to ensure adequate space to count swabs	Delivery Suite Managers	On order
Poster to be displayed in staff area to highlight compliance	Delivery Suite Managers	18th August 2023

Appendices

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NHS Maidstone and Tunbridge Wells NHS Trust

Safeguarding update (Annual Report to Board, incl. the Trust Board refresher training) **Chief Nurse**

The safeguarding Annual Report, 2022-2023, including what the board needs to know is enclosed.

The Safeguarding Annual Report provides the Trust Board with an overview of all safeguarding adults and children activities within Maidstone and Tunbridge Wells NHS Trust (The Trust).

The purpose is to Inform the Trust Board, through the Joint Safeguarding Committee, on the following areas:

- How the Trust is meeting its statutory duties to safeguard adults and children by preventing and responding to concerns or risks of abuse, harm or neglect of patients, visitors and staff from April 2022- March 2023.
- Activity and demand related to safeguarding activities.
- Red rated risks associated with Safeguarding
- Education and training compliance in all areas associated with safeguarding

The Annual report is in three sections:

- Section 1 report on Children's safeguarding.
- Section 2 report on Midwifery Safeguarding.
- Section 3 report on Adult Safeguarding

Which Committees have reviewed the information prior to Board submission?

- Joint Safeguarding Committee, 18/07/23
- Executive Team Meeting, 12/09/23
- 'Main' Quality Committee, 13/09/23

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.

The Maidstone and Turnbridge Wells NHS Trust (The Trust) Board has a responsibility to ensure that there are policies and guidelines are in place that details the processes to protect both children and adults at risk. Regular reviews and updates of these policies are in place. It is the responsibility of each member of staff to be aware of, and work in in accordance with, the Trust's safeguarding children and adults' policies and procedures. This includes ensuring that they undertake statutory and mandatory safeguarding children and adult training appropriate for their role.

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The Section 11 audit (for Safeguarding Children services) was submitted in September 2022 and highlighted that the Trust was able to evidence that it meets all its statutory responsibilities in a robust and accessible manner. A revised Section 11 audit will be submitted in September 2023.

The Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with adults at risk and children undergo an enhanced level of assessment.

The Local Authority (Kent County Council - KCC) is the lead agency for investigations into Safeguarding concerns. KCC (and East Sussex County Council - ESCC) assume responsibility for triaging all referrals and ensuring learning outcomes are shared as needed. However, over the last 12 months the Local Authority have been absent from the joined-up approach to review investigation reports (section 42 enquiries) and share learning due to their staffing challenges and changes within their teams. A single point of contact has been identified to work with the Trust pending attendance from KCC at the learning and improvement panels.

The Trust made a total of 559 referrals to Integrated Children's Services in the reporting period. This compares with 453 in the previous 12 months. Consistently, the majority of referrals are submitted by ED or Maternity services. In the current reporting period the Trust has been notified of 18 Rapid Reviews (Children Safeguarding) and the Trust has contributed to 6 of these reviews. There has been an increase in reported Non-Accidental Injuries (NAI) from the West Kent HCP. Further discussions with the Kent and Medway integrated Care Board (ICB) and KCC are being planned.

104 children were admitted to Hedgehog Ward with Mental Health needs – the admissions were for a variety of reasons including Overdose, suicide ideation, Eating Disorder, self-injurious behaviours and anxiety. 9 children were detained under Mental Health Act [Sections 2, 3, 136 and 5(2)] – the majority of which were placed in a tier 4 setting or were discharged home after the detention period expired.

The Adult safeguarding service has supported 270 cases relating to safeguarding concerns, (82 relating to alleged hospital incidents and 188 relating to alleged community incidents). The alleged hospital safeguarding incidents have decreased by 31 incidents from last year. The alleged community safeguarding incidents raised by Trust staff have increased by 78 cases in the last year. The highest category of abuse was neglect. This mirrors the national picture for adult safeguarding.

The above increase in activity across all areas of safeguarding has regularly reviewed and short-term workforce reviews made to the services to accommodate the increase and demand. However, this continues to be a challenge as demand exceeds workforce available in the long term.

Workforce review of safeguarding practitioners will be undertaken by the Chief Nurse and deputy chief nurse as its recognised that the resources need to be increased against the activity and demand for the service. This is also mirrored at the ICB where a new director of safeguarding has been appointed and is currently reviewing their workforce and partnership working with the acute and community health providers.

The Child Death Review Guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in the Working Together Guidelines (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The Trust has a named paediatrician for Child Deaths. However, the Trust does not have an have a Human Tissue Authority (HTA) licence and work is in progress to remedy this. It is anticipated the Trust will start Kennedy sampling in late 2023 but will not be able to undertake any CT Scans of Skeletal Surveys. Discussions are ongoing with KCC, Kent Police and the HM Coroner Service.

The Trust has been successful in securing funding for a Hospital Independent Domestic Violence Advocate (HIDVA) service to be based across both sites for a period of 12 months to end in June 2024. Discussions with the ICB and KCC are ongoing to substantiate the post and align the Trust with neighbouring health providers. Previous risk on the register has now been closed. The Domestic Abuse Act 2021 places responsibilities on staff to ensure that children are safeguarded where all incidents of Domestic Abuse are known or recorded.

All staff commencing in the Trust have to undertake their Level 1 e-learning safeguarding training prior to commencement of employment.

Safeguarding supervision for named professionals and practitioners is now in place as a provider has been identified.

The following risks associated with safeguarding are currently on the Trust risk register and the controls in place are under regular review.

- Insufficient workforce within the 3 safeguarding teams (adult safeguarding, children safeguarding and midwifery safeguarding) to meet the current demand.
- Poor compliance with Mental Capacity Act 2005 (assessments and documentation).
- Section 42 Enquiry and Local Authority Assurance (Lack of Kent County Council (Local Authority) attendance at the Trust Safeguarding learning and improvement panel, where section 42 enquiry investigations are reviewed and outcomes agreed).
- Increase in number of Children under 12 months presenting with unexplained injuries (NAI).
- Liberty Protection Safeguards Implementation as a Responsible Body.
- Impact of increase in number of inpatients with mental health needs.

Safeguarding Leadership and Governance.

The Chief Nursing Officer has executive leadership for safeguarding for the Trust. Maidstone and Tunbridge Wells NHS Trust (The Trust) is fully committed to ensuring that all patients are cared for in a caring safe and, secure environment. A quarterly Safeguarding Report is presented to the Joint Safeguarding Committee and shared with the Kent and Medway Integrated Care Board (ICB) as part of the joint quality engagement and risk escalation framework (NHS England Oversight Framework 2022/2023 Schedule 4 and Schedule 6a).

The Joint Safeguarding Committee has a strategic responsibility to provide assurance to the Trust Board that the Trust fulfils its statutory responsibilities, that it promotes a more streamlined approach to Safeguarding and advances the 'Think Family' agenda within the Trust. The Trust's Safeguarding Committee is a constituted sub-committee of the Trust Quality Committee. It is chaired by the Chief Nurse and has core representation from the Named professionals, senior

leaders from the divisions and directorates (including therapies). The committee meets quarterly, in line with the required Safeguarding Quality quarterly reporting mechanisms to the ICB. New Terms of Reference (TORS) are reviewed and agreed yearly and approved at the Quality Main Committee.

Additionally, the Joint Safeguarding Committee implements and monitors the Safeguarding Frameworks and agendas. It has a remit to ensure that Safeguarding training is available for all staff to equip them with the knowledge and skills required to identify adults and children (and the unborn) that may need safeguarding. Training gives staff the skills to take all appropriate steps in response to concerns identified, and to assist in any investigations of those concerns with learning outcomes identified. The Committee draws its work plan and objectives from both local and national Safeguarding objectives. It is a forum for the review of practice and learning from incidents. Work streams are identified from themes and action plans arising from serious (Safeguarding) incidents, Safeguarding Adults Reviews, Domestic Homicide Reviews and Child Safeguarding Practice Reviews. The committee also provides a forum to support and facilitate feedback and discussion between clinicians, divisions and directorates, and the commissioners. It promotes closer working between the Trust and the ICB and will wish to have a view on the development of Integrated Care Partnerships and Integrated Care Systems.

The NHS Accountability and Assurance Framework (2019) sets out that NHS Trusts are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding. This report forms part of the Maidstone and Tunbridge Wells NHS Trust Boards assurance processes in respect to its statutory duties and responsibility around safeguarding. An updated Safeguarding Accountability and Assessment Framework was published in July 2022.

All individuals working for the Trust, or engaged by the Trust, have a statutory responsibility for the safety and wellbeing of patients, colleagues and visitors (of all ages) to the Trust. This is a statutory responsibility enshrined in the 'Safeguarding is Everyone's Responsibility' agendas and the Children Act 1989 and the Care Act 2014. Other Statutory requirements for safeguarding include the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and PREVENT (under the Counter-Terrorism and Security Act 2015). The Trust continues to review and challenge its arrangements in order to support safe and consistent practice, adhere to its statutory duties and will respond positively and assertively to any changing guidance and national reviews.

The day to day delivery of the Safeguarding agenda is delivered by the named professionals for Safeguarding with oversight provided by the Deputy Chief Nurse. The Trust has Named Safeguarding Professionals who lead on issues in relation to the safeguarding of children and adults. They are clear about their roles, have sufficient time and receive relevant support, and training, to undertake their roles, which includes close contact with other social and health care organisations. This complies with the current Working Together Guidelines (2018) and the Intercollegiate Documents (2018 and 2019).

Although the Named Professionals work in close partnership they have individual work streams that are pertinent to their areas and expertise.

They have joint responsibility for:

- Design and delivery of training for both Safeguarding Adults and Safeguarding Children with an emphasis on the 'Think Family' agenda; also includes training on the principles of the Care Act (2014), the role of the lead agency, application of the Mental Capacity Act (2005), Domestic Abuse, PREVENT (under the Counter-Terrorism and Security Act 2015), Exploitation and FGM
- PREVENT – both Named Nurses are Home Office approved trainers for the PREVENT agenda[1]
- Domestic Abuse – includes training, policy updating and support of staff & patients who are victims of Domestic Abuse; also includes developing the links with ED and local Domestic Abuse services.

[1] Noted that the PREVENT strategy is currently under review by the Home Office

Section One

Safeguarding Children Annual Report.

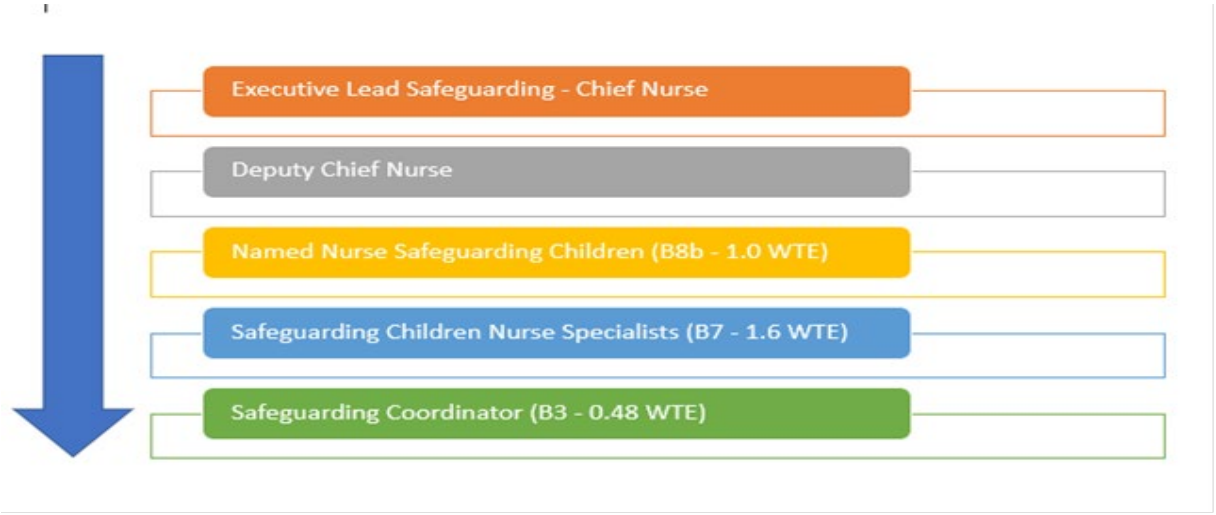
1. Introduction

The Trust is an active participant within the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and their constituted sub-groups. Both Named Nurses sit within sub-groups; the Named Nurse Safeguarding Children sits on the Emerging Themes and Joint Exploitation Sub-groups; they also represent the Trust on the Health Reference Group (HRG Children) which is chaired by the Safeguarding team within Kent and Medway ICB. The Named Nurse Safeguarding Adults sits on the Adult HRG.

The Integrated Care Board Designated Safeguarding Nurses for both children and adults are represented on this committee along with Trust senior nurses/matrons, AHP's and medical leads in the Trust. The Safeguarding Children Consultant Paediatrician also attends this committee.

Safeguarding activity is underpinned by a suite of learning and development opportunities, in line with national and local guidance. The Trust has access to multi-agency training via the KMSAB and KSCMP's, and on-line training provided by the e-Learning for Health platform. As the UK (and the NHS) has moved out of national restrictions the opportunities for more bespoke face to face training have arisen; we continually review our training offer and deliver a range of virtual and face to face sessions to all staff groups. Face to face Level 3 Safeguarding Children training has recommenced. This allows staff to be flexible as to how they learn. A pilot session on August will see an All Ages Safeguarding day for the new Foundation Doctors. It is hoped that should this be successful it can be rolled out across the Trust.

Managerial supervision for the Named Nurses is provided by the Deputy Chief Nurse. The Named Nurse Safeguarding Children also has close contact with the Named Midwife who provides oversight on Safeguarding Midwifery issues. See reporting structure below.



Supervision is provided to front line staff involved in significant or complex cases by the Named Nurses or members of their team.

Maidstone and Tunbridge Wells NHS Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment. The Trust has in place a requirement for all staff to have a repeat 3 yearly DBS check.

2. Governance and Safeguarding Structures

The Trust is accountable to the NHS Kent and Medway Integrated Care Board (ICB) and reports directly to the Trust Performance & Quality Committee. Additionally, quality and monitoring for East Sussex is captured on the Safeguarding Metrics and submitted to NHS Sussex. The ICB Designated Nurses for Safeguarding are members of the Trust's Safeguarding Committee.

The Trust Executive Lead for Safeguarding is the Chief Nurse, who delegates responsibilities to the Deputy Chief Nurse (DCN) in relation to both adults and children. The Director of Midwifery has additional responsibility for Safeguarding within Midwifery services and oversees the Safeguarding Midwifery service. Operational oversight of the Safeguarding Children's agenda is delegated to the Named Nurse for Safeguarding Children (NNSGC) and Named Midwife for safeguarding Children (NMSGC). The Trust Board has a responsibility to ensure that there are policies and guidelines are in place that details the processes to protect both children and adults at risk. The Trust Safeguarding Children Policy is undergoing an update as a result of emerging changes and will require a full update in 2027. It is important to note that it is updated regularly to take in to account new/revised legislation and national guidelines.

The Domestic Abuse Policy was published in April 2022 highlights new legislation on Domestic Abuse (Domestic Abuse Act 2021). This policy covers all patients, staff and visitors. The Safeguarding Children team attend MARAC where high risk victims of Domestic Abuse are discussed. The Local Authority is undertaking a review of the MARAC process as it currently felt to be not fit for purpose. The Named Nurse Safeguarding Children is part of the review and co-chairs the health review sub-group. The Trust has a Hospital Independent Domestic Abuse/Violence Advisor (HIDVA) who is able to provide expert advice and support for any victim of Domestic Abuse. It is anticipated that they will take over the MARAC responsibilities as they settle into working for the organisation. Funding for the HIDVA is for 12 months currently.

3. Interagency Working

The Named Nurse for Safeguarding Children is proactive in working with a variety of external partners in delivering the Safeguarding agenda across Kent and Medway. MTW has close ties with other acute and community providers, commissioner organisations and the Local Authority. As the NHS embeds Integrated Care Partnerships (ICP) and Integrated Care Systems (ICS), alongside established Primary Care Networks (PCN) the need for closer working will be self-evident. It is noted that the NHS Kent and Medway Integrated Care Board came into existence on 1.7.22. No longer can individual teams work within narrow confines; we all need to have a view on the bigger picture and how we can contribute to that world view. Safeguarding needs to be joined up between partners with clear information sharing and an understanding of the role of partners. Kent has a clear vision of what partnership working looks like and clear procedures for challenging any deviation from this normal. The Kent Safeguarding Children Multi-Agency Partnership (KSCMP – the Partnership) has been in existence since 2020 and has a clear vision on priorities for the coming 12-24 months. These include Youth Violence, Complex Needs in the Adolescent, Sexually Inappropriate Behaviours, and Harm to the under 2's. The Trust will align its own priorities to match these.

The Local Authority (Kent County Council - KCC) is the lead agency for investigations into Safeguarding concerns. KCC (and East Sussex County Council - ESCC) assume responsibility for triaging all referrals and ensuring learning outcomes are shared as needed.

Health providers and commissioners in Kent and Medway attend the Health Safeguarding group (HSG) to enable debate and information sharing between organisations. This attended by the Chief Nurses from across Kent. The Kent and Medway Health Reference Group feeds into the HSG. These fora are for Named Nurse Professionals to meet and share information, develop guidelines and raise concerns to the HSG. The HRG (Children) is chaired by the ICB designate.

The Named Nurse Safeguarding Children Represents the Trust at (amongst others) the Kent and Medway Joint Exploitation Group, Health Reference Group, and the Emerging Themes sub-group of the KSCMP the Named Nurse will also deputise for the Executive Lead for Safeguarding as requested.

The Safeguarding Children team has a close relationship with our Local Authority partners in both Kent and Medway and East Sussex. The Safeguarding Children team (including Safeguarding Midwives) attend Child Protection Conference's and Strategy Meetings across the Local Authority areas and are a key partner is developing Child Protection Plans for our most vulnerable children and the unborn child.

The Named Nurse Safeguarding Children has close working relationship with her counterparts in KCHFT, EKUHFT, MFT, KCHFT, DGS and ESCH and regularly meets with them to share information and learning. The Named Nurse works closely with the ICB Designated Nurses. The

Trust has a single point of access ICB Designated Nurse who can support the Trust as appropriate.

The Named Nurse Safeguarding Children supports practitioners to challenge decisions made by the Local Authority if there is professional disagreement. The Kent and Medway escalation process is clearly laid out and staffs are encouraged to use this framework if they feel an inappropriate decision has been reached. It is important that staff feel able to challenge decisions as this empowers staff in their decision making and serves to highlight the important role that health has in Safeguarding. It has been highlighted in recently published Safeguarding reviews that practitioners (across Kent and Medway) feel disempowered in challenging decisions made by the Local Authority. The Partnership is looking at barriers to challenge and will publish recommendations alongside a Local Safeguarding Practice Review.

4. **Oversight and Scrutiny**.

a. Disclosure and Barring (DBS) checks.

The Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with adults at risk and children undergo an enhanced level of assessment. All staff are currently having their DBS checks renewed as per national policy

b. Section 11 Audit

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The S.11 report for Maidstone and Tunbridge Wells NHS Trust was submitted in September 2022; the KSCMP noted that we, as an organisation, meet our statutory requirements to safeguard all Children and Young People. There was one outstanding action relating to a commissioned service for Safeguarding Supervision to the Safeguarding practitioners. This has now been resolved as a provider has been identified.

c. Was Not Brought

The Trust has a process in place for following up children who are not bought to outpatient appointments within any speciality to ensure their care and health is not affected in any way. The Named Nurse Safeguarding Children follows up on children not brought to appointments and liaises with Health Visitor team, GP's and the Local Authority (if needed). The Trust as a recently ratified 'Was Not Brought' policy for all ages.

d. Flagging Systems in Place for:

- Children who are subject to a child protection plan. The Trust has implemented the national Child Protection Information Sharing System (CP-IS) in the ED. The trust has further implemented the national FGM-IS.
- Children who are designated as a Child in Care

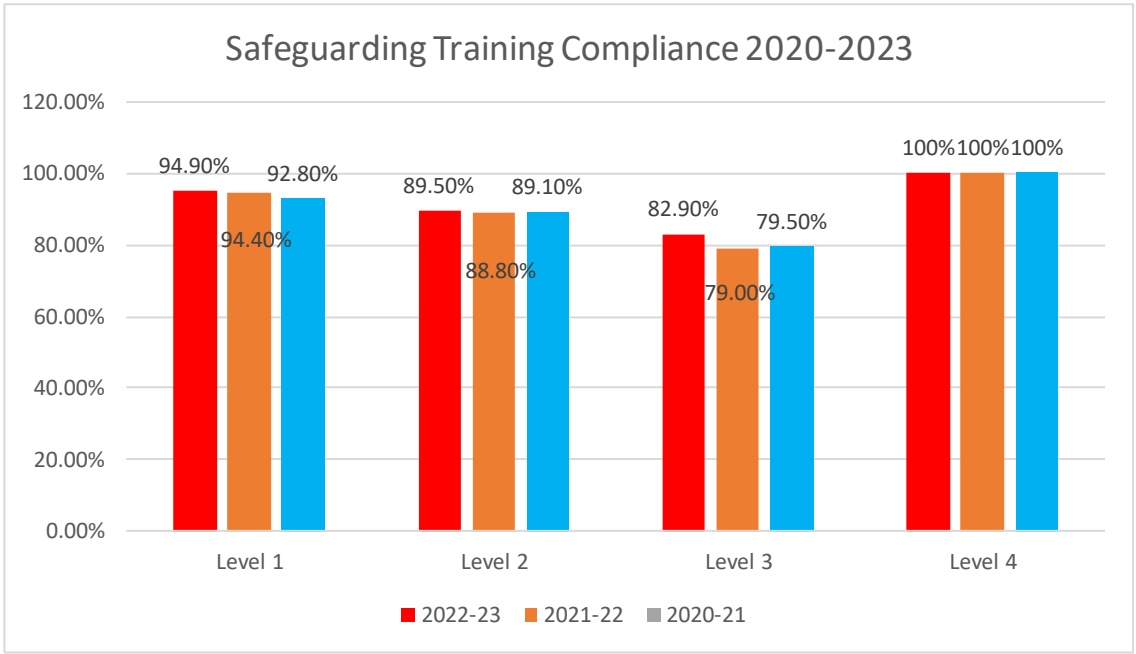
e. Training Design and Delivery

All eligible staffs are required to undertake relevant Safeguarding training; this is regularly reviewed to ensure it is up to date and fit for purpose. The Trust has a training strategy in place with regard to delivering safeguarding training. All Safeguarding Children training is in line with the current Intercollegiate Document (2019) and highlights emerging themes as highlighted by NHSE. All Safeguarding Adults training is commensurate with the Adult Intercollegiate Document (2018).

The Safeguarding team have adopted a more collaborative approach to training with joint training delivered by the Safeguarding Adults and Safeguarding Children specialists. This approach has focussed on the 'Think Family' agenda recognising the overlap between the adult and children safeguarding agenda.

5. Training

Due to the constraints imposed by the previous lockdowns, the Safeguarding team developed new ways of delivering training. As no face to face training was available there was a greater reliance on using on-line or e-learning training. Staffs have provided positive feedback on this way of delivering training and the aim is to continue to offer this with bespoke Safeguarding masterclasses for staff and small class sessions for discreet staff groups. Despite the absence of face to face training it is encouraging that training compliance was maintained or raised.



6. Care Quality Commission (CQC)

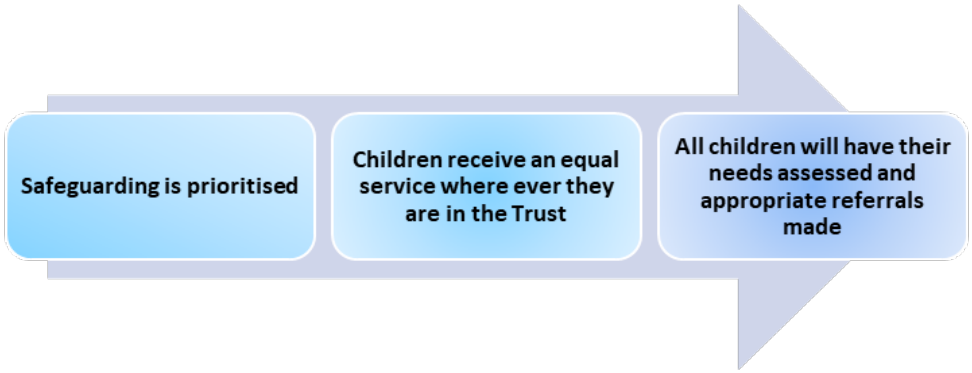
The Trust was inspected in March 2023. The Safeguarding team as a whole participated in this event and met with the inspection team. The report published in August 2023, following a review of the End of Life Care Service, did highlight that not all staff had completed their safeguarding training. Further opportunities for training have been available to all staff and this is monitored and reported at the joint safeguarding committee.

Our ethos puts CYP at the centre of all our work

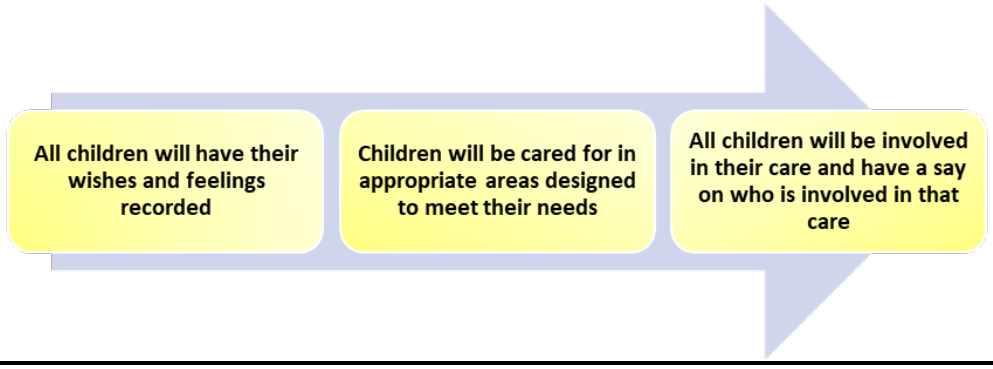
The Safeguarding Children team has taken the 5 CQC domains and uses these as our framework.

A. Caring- Putting CYP at the centre our work at MTW

B. Safe – the Welfare of the Child is Paramount

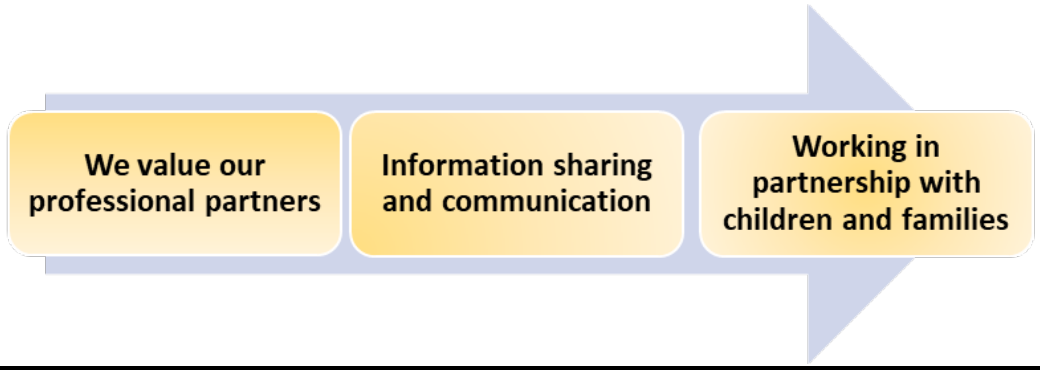


C. Responsive- Listening to the Child



D. Well Led- Safeguarding is Everyone's Responsibility

E. Effective Partnership working



7. Quality and Safeguards.

7.1 Mental Capacity, DoLS and LPS

The current legislation is applicable to 16 and 17 year who fall within the definition of a child. The Named Nurse Safeguarding Children provides expert advice on a range of consent issues for children and the application of legal frameworks around consent (especially the Fraser Guidelines and Gillick competence). The Named Nurse Safeguarding Children in conjunction with the Named Nurse Safeguarding Adults is part of a working group looking at the implementation of the new Liberty Protection Safeguards in 2025.

7.2 DoLS orders

Due to the legal complexity of some admissions to Hedgehog Ward, and the delay in discharges the Trust has sought legal advice to ensure that we are not depriving children of their liberty, and are using the least restrictive options when discharges are delayed. Between April and June 2022, the Trust obtained 2 x DOLS orders for children who were inpatients on Hedgehog Ward. The hearings in the High Court sought to provide the Trust with a safety net to keep children on Hedgehog Ward whilst alternative placements were found within Mental Health settings or Local Authority foster/residential settings. The High Court has been clear that The Trust has gone 'above and beyond' in what would be considered our usual care pathways. All legal processes were concluded by the beginning of July 2022 as both young people were discharged to alternative settings. The Trust Legal Services team has supported the Named Nurse Safeguarding Children through these legal proceedings.

8. External Review

Following two complex admission to MTW paediatrics ward, an external review was commissioned by the ICB, in agreement with MTW, to look into a system wide approach that included partnership

working, sharing of information and looking at what support was available, at the time, and what would be required in the future. The review also sought to understand the circumstances that led to the legal proceedings, and to understand what, if any, learning could be followed.
The review was led by two independent authors with a wealth of experience in Safeguarding; neither had had any oversight of the two cases. A learning tool was developed and the Trust submitted two comprehensive reports to aid the review. Both the Named Nurse Safeguarding Children and the DCN attended a learning event facilitated by the report authors. This allowed the network involved with both young people to reflect on their experiences and use this as a springboard for future management of complex cases.

There were multiple recommendations made – some of which are focused on Maidstone and Tunbridge Wells NHS Trust and some are more system wide and clearly for the commissioners.
For Maidstone and Tunbridge Wells NHS Trust our recommendations included –

- Individual cases should be identified early as complex and accordingly high risk using an appropriate assessment tool to be agreed, and a senior manager from across the partnership identified to take leadership role and to be accountable for the outcomes of individual cases.
- Where individuals are approaching sixteen, transition to adult services should form part of the considerations.
- A common approach to sharing and recording case details should be investigated and made a priority.
- Standards for supervision should be reviewed to ensure staff receive the levels of supervision sufficient to maintain effective professional practice and registration, but also to provide psychological support when dealing with particularly stressful and challenging cases
- Regular multiagency events should be planned to allow staff to learn from partner agencies and to enrich their practice.
- The multi- agency should review the process for when children and young people present in crisis to the Emergency Departments, so that there is a clear agreed pathway which is consistently understood and applied.

Maidstone and Tunbridge Wells NHS Trust has developed over the last 2 years risk assessments (for use in ED and wards) for identifying children at risk of an acute admission, where there is no medical need; these admissions are often referred to as ‘social admissions’ or a ‘place of safety’. The Named Nurse Safeguarding Children has excellent links with staff to highlight these Children and Young People and will be involved at the earliest opportunity to discuss [with the ‘network’] these very complex children. An escalation policy has been developed which allows a consistent approach to the management of these children, and allows for the early involvement of senior staff at the Trust.

The Trust has a formal transition policy for all children under the Specialist Nursing Team; the nationally recognised Ready Steady Go model is used (https://www.readysteadygo.net/). Currently there is a service gap whilst a new Matron for Transition is appointed. For all other children not within a specialist team transition may be a very much a 'hit and miss' process. This is undergoing further review within the Trust as the national Safeguarding team has identified Transition as a high priority.

Information sharing is of the utmost importance and it is how we Safeguard our Children and Young People. The Trust has clear IG processes but it is unclear how access to our IT systems, by external partners, can be facilitated safely.

9. Safeguarding Children Audits

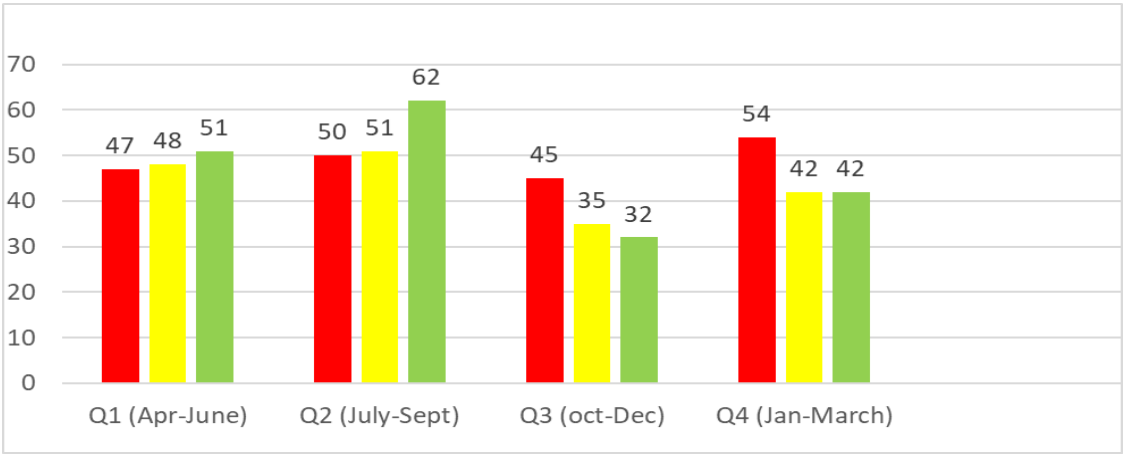
There are no Safeguarding Children audits in progress at the time of writing the report. However, the children safeguarding team are involved in the wider audit programme in paediatrics.

10. Safeguarding Referrals and Investigations- Children

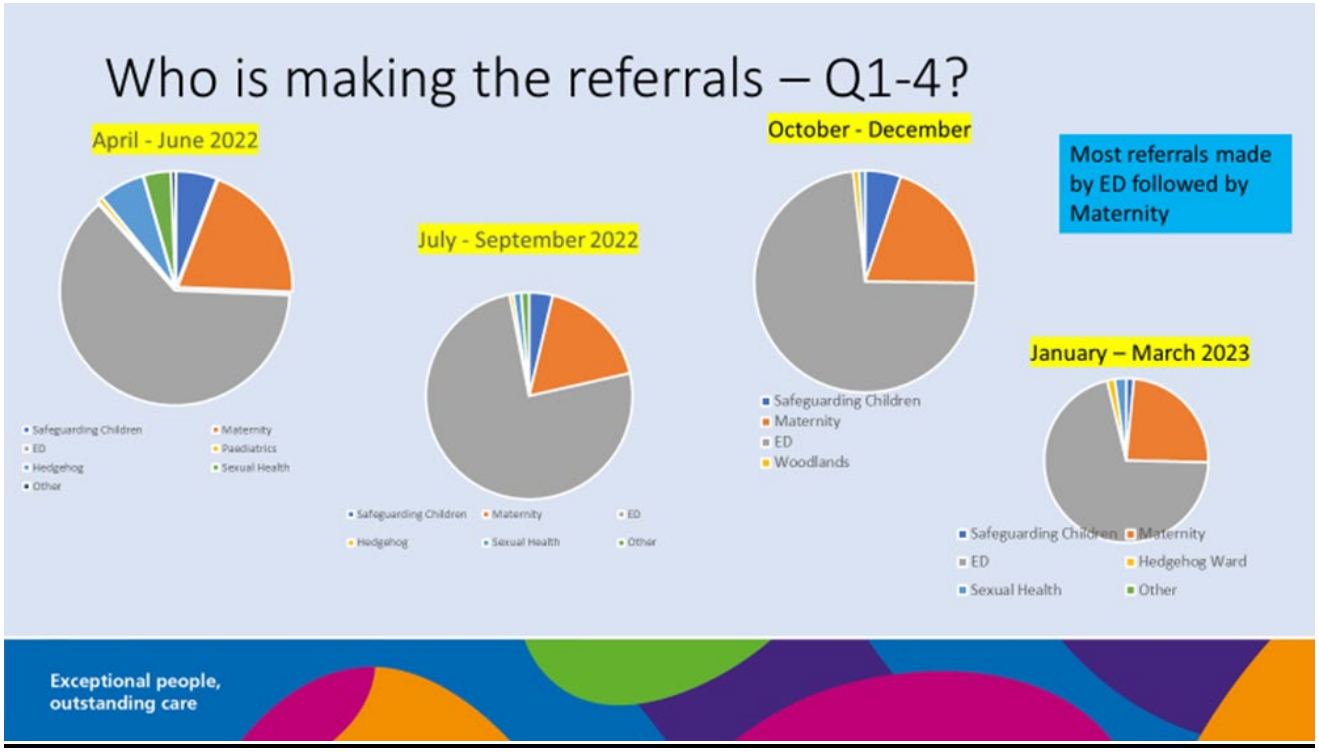
Safeguarding Children activity has been maintained in the 2022-2023 reporting period. The Trust made a total of 559 referrals to Integrated Children's Services in the reporting period. This compares with 453 in the previous 12 months.

Staff are more confident in using the referral system and identifying 'at risk' children. The Safeguarding Children team is also very visible; we operate an 'open door' policy which provides reassurance and support to staff.

The busiest months coincide with children returning to school after the summer break and transitioning to new schools where there is noticeable rise in children seeking help for mental health support.



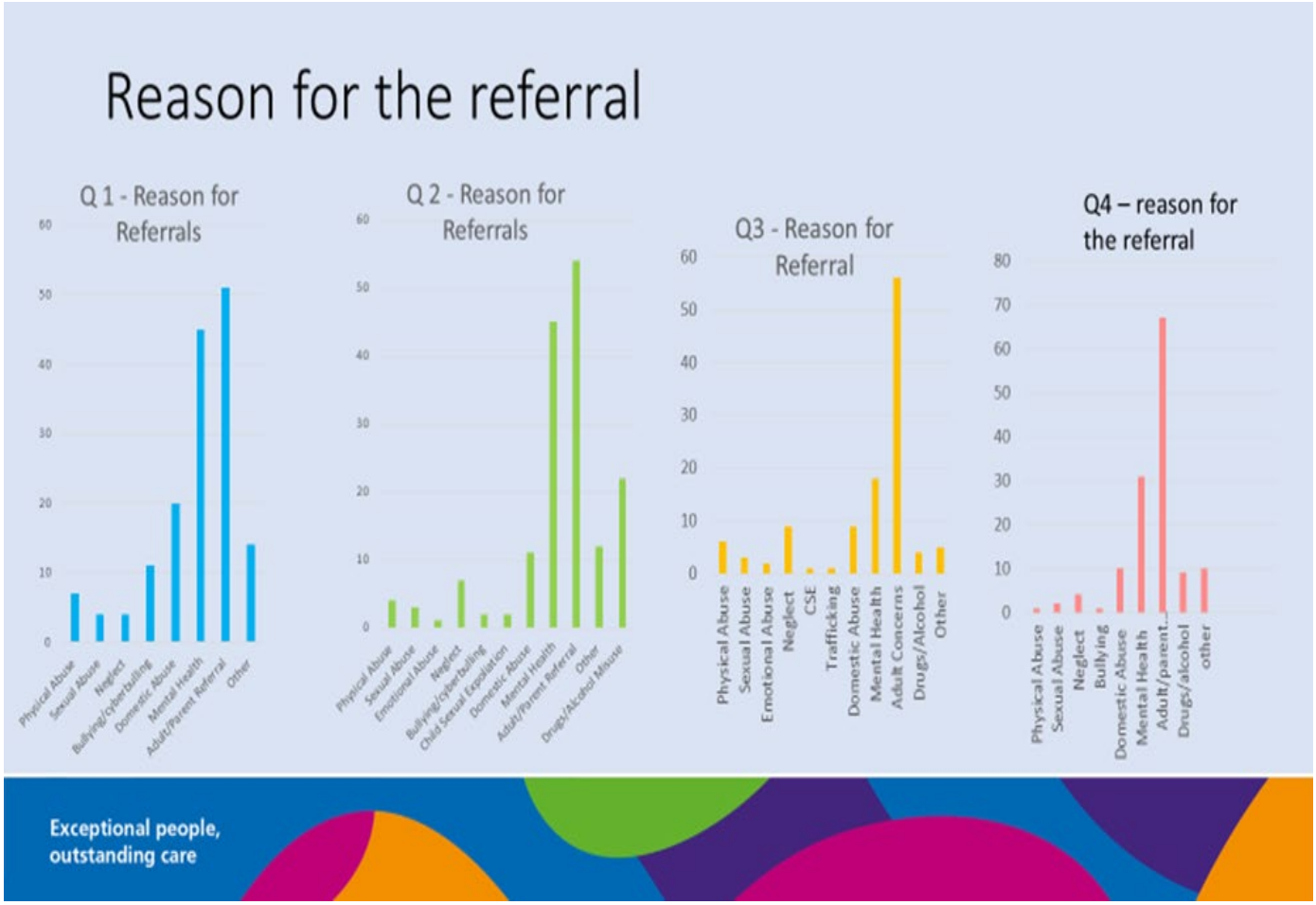
Who is making the referrals?



Consistently, the majority of referrals are submitted by ED or Maternity services.

A recent report published by HSIB (https://www.hsib.org.uk/investigations-and-reports/non-accidental-injuries-in-infants-attending-the-emergency-department/) highlighted the issues that Safeguarding teams are often located physically distant from ED's. this can create a perceived barrier to communication and liaison with the Safeguarding Children team. HSIB recommended that, if possible, safeguarding teams are located in ED or have a visible presence. Although the Trust has no permanent Safeguarding presence in either of the ED's. However, the Safeguarding team are highly visible and visit the departments regularly. Staff know how to contact the team and are proactive in doing so. Currently there is no commissioned out of hours service which could be interpreted as a gap. The Named Nurse Safeguarding Children will provide out of hours advice on an ad hoc basis.

Reason for the referral



An analysis of why referrals are being made shows that the majority are related to the Mental Health concerns of both adults and children (see section 14 below).

As a team the quality of the referrals are reviewed. Training is provided on 'how to make a quality referral' and staff are encouraged to get referrals reviewed by safeguarding practitioners prior to submission.

The Safeguarding Children team attend Child Protection Conference's for high risk children known to the Trust to support staff whose experience in Safeguarding may be limited. They also support staff to provide high quality reports for Child Protection Conference's; the Named Nurse also attend conferences as time permits.

Currently the Local Authority (Kent) has approximately 1300 children subject to a Child Protection Plan – the Trust flags these children on our IT systems. The Trust also flag known Children in Care and other high-risk children, including those that are frequently missing or display high risk behaviours.

Serious Case Reviews/Child Safeguarding Practice Reviews –

In the current reporting period the Trust has been notified of 18 Rapid Reviews and we have contributed to 6 of these reviews. We have further contributed to another 4 reviews since 1.4.23.

Recommendations include –

- Documentation, - ensuring that documentation is clear and contemporaneous; to ensure that it is accessible to all practitioners
- Domestic Abuse – ensuring that all conversations about Domestic Abuse are recorded and disclosures are acted upon
- Highlighting to Midwifery staff the process to follow when a woman/pregnant person books 'late' in their pregnancy for maternity services
- Fathers/male care givers – making fathers visible to services

11. Child Deaths

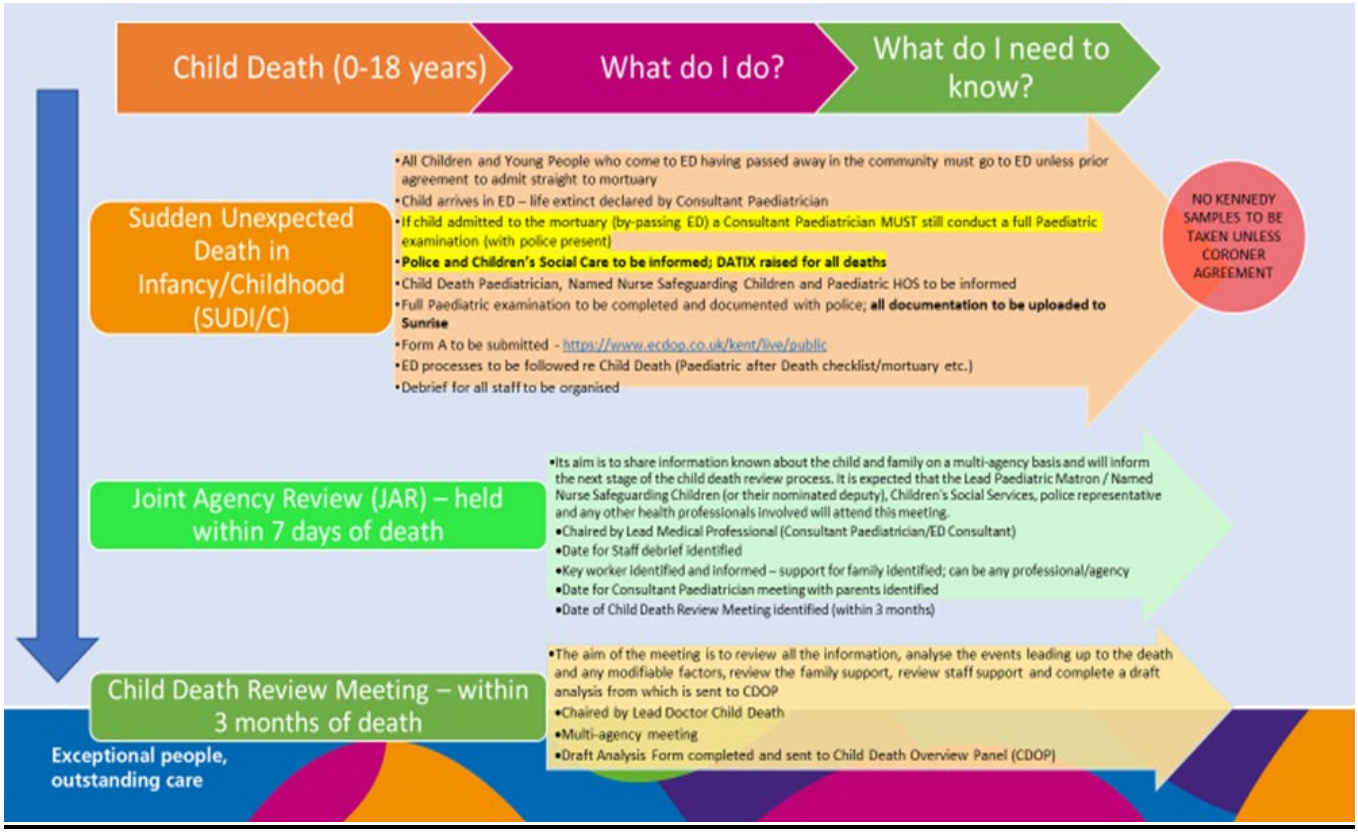
The Child Death Review Guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in the Working Together Guidelines (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidelines place a responsibility on all organisations to improve the experience of bereaved families, and professionals involved in caring for children. They also ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths.

The Trust is fortunate in that there are very few child deaths. The Named Nurse Safeguarding Children is notified of all Child Deaths in Kent – of which there are 98 in total in the current reporting period. Of these, sadly 25 children known to our services passed away in the reporting period. The majority were due to complex health needs or life limiting conditions.

Two children very sadly committed suicide out of hospital in March 2023. A multi-agency response was mobilised to support the Children and Young People who attended the schools where these children attended. The Named Nurse Safeguarding Children submitted Rapid Reviews to the Partnership and was part of the support plan in the acute period following the children's deaths.

The Named Nurse Safeguarding Children and Paediatric Head of Nursing lead on Child Death for the Trust. We have a Named Paediatrician for Child Death who works closely with the Leads.

The infographic below highlights our current process.



Kennedy Sampling

In 2016 Baroness Helena Kennedy reviewed the Child Death procedures, and recommended that, in the event of a sudden or unexpected death, various samples are taken immediately after death to aid the investigation into the child's death. These samples may include blood, urine, CSF and Nasopharyngeal Aspirate; physicians can also recommend that the child undergoes a CT scan and Skeletal Survey. This process is colloquially known as 'Kennedy Sampling'. All samples must be taken on HTA licensed premises and are nationally recognised guidelines. Up until now the Trust has not had an approved HTA licence.

Following an East Sussex Serious Case Review in 2019 it was recommended that the Trust start the process of becoming licensed. Following a scoping exercise across the Kent and Medway health economy it became clear that no acute Trust in Kent had an HTA licence; MFT have a limited agreement with the Medway Coronial Service to take some samples from children who are under 12 months old. No Trust offers a CT scan or Skeletal Survey.

Maidstone and Tunbridge Wells NHS Trust has led on this current project to agree the new licensing process across Kent and Medway and agreement has been reached around processes; the Coronial Service, Police, Mortuary Services, Safeguarding and Paediatric services have been involved in this new pathway. The Paediatric Head of Service has led on this project. It is

anticipated the Trust will start Kennedy sampling in late 2023 but will not be able to undertake any CT Scans of Skeletal Surveys as it stands.

12. Domestic Abuse.

In April 2021 The Domestic Abuse Act became law. There is a revised definition of Domestic Abuse –
'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members regarding of gender or sexuality'.

Throughout the Covid 19 public health emergency, domestic abuse was recognised as an issue through the Equality Impact Assessment carried out by NHS Safeguarding – this is highlighted in forms of domestic abuse such as honour based abuse and adolescent to parent/carer abuse.

The Trust ratified a new Domestic Abuse policy in 2021 which takes into account the new legislation. We have a cohort of staffs who are trained to carry out DASH assessments and they make timely referrals to MARAC.

12.1 Hospital Based Independent Domestic Abuse Advisor (HIDVA)

The Trust has been successful in securing funding for a HIDVA service to be based across both sites. Initially the service will be rolled out at Tunbridge Wells Hospital with Maidstone Hospital having access to the service. The Trust recognised that we had a gap in our service provision in support offered to victims of Domestic Abuse. This service will bolster the current training and support given to staff and empower them to become more proactive in recognising and acting on Domestic Abuse.
The role of the HIDVA is -

• To provide immediate support and advice to victims of domestic violence within hospital

• To link individuals and families to longer-term community-based support

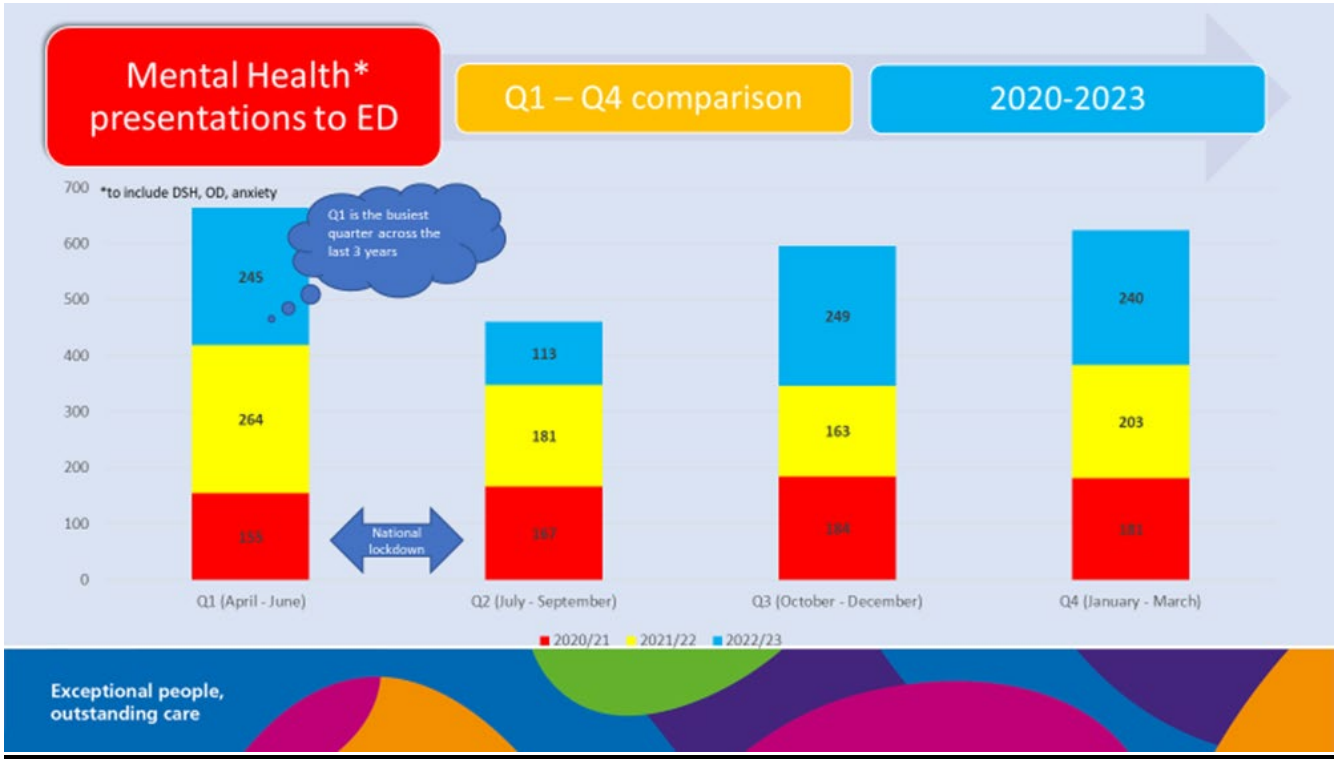
• To provide hospital staff with expert training so that they have the confidence to ask about domestic abuse

The services started in June 2023. The associated risk on the risk register has therefore been closed.

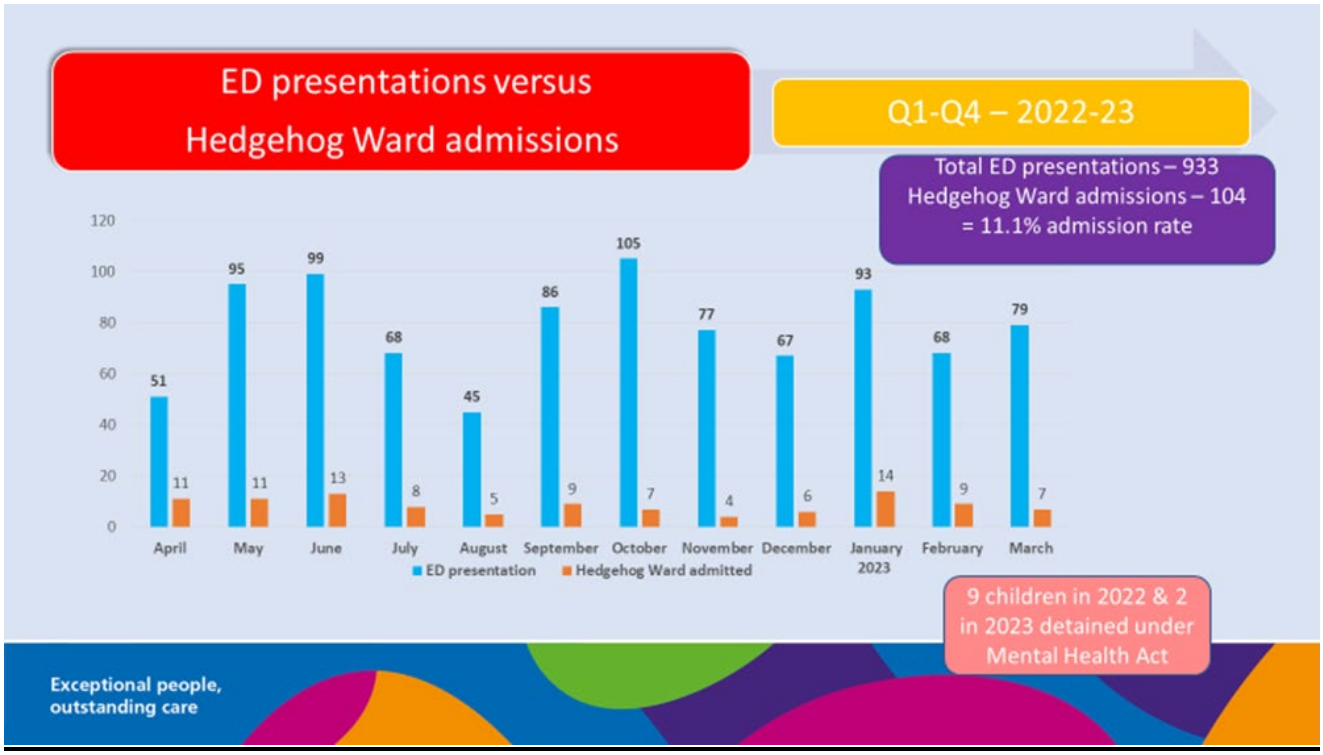
13. Children with Mental Health Needs.

Within this Trust it is apparent that an increasing number of children are being admitted with Deliberate Self-Harm (DSH) and overdoses. Staffs are ill-prepared for the risk that these children pose to themselves and struggle with the limited services provided by CAMHS. There are huge challenges in supporting admission to a tier 4 Mental Health bed; often this can take up to 4 weeks. This leaves very vulnerable children on an acute Paediatric ward receiving Mental Health care from agency RMN staff. It is also clear that staff have a limited understanding of the Mental Health Act. Training will be provided in 2023 for staff to enable them to understand the current legislation and what its impact means for our Children and Young People.

The Paediatric team on Hedgehog Ward now has a team of practitioners who lead on Children and Young Peoples Mental Health. Children and Young People have access to a Mental Health Liaison Nurse and Mental Health CSW's. This team works closely with the external Mental Health provider (NELFT) to develop safety plans, community plans and discharge plans. This model has been rolled out across other acute Trusts in Kent and Medway with high success rate.
The infographic below highlights Mental Health presentations to ED in the previous 3 years. It highlights the 20% increase in presentations over the past 3 years.



The following infographic highlights the presentation versus admission rate (to Hedgehog Ward) of children with Mental Health needs



In the current reporting period 104 children were admitted to Hedgehog Ward with Mental Health needs – the admissions were for a variety of reasons including Overdose, suicide ideation, Eating Disorder, self-injurious behaviours and anxiety.
9 children were detained under Mental Health Act [Sections 2, 3, 136 and 5(2)] – the majority of which were placed in a tier 4 setting or were discharged home after the detention period expired.

Children with multiple co-morbidities (ASC/ LD /Mental Health) are the most challenging in terms of coordinating care pathways and safe discharges. The complexities have resulted in the Trust seeking legal remedies under the Inherent Jurisdiction framework and obtaining DOLS orders. The orders have allowed to Trust to legally keep children at Tunbridge Wells Hospital whilst the Local Authority seeks a discharge placement.

The Trust has a robust care pathway and risk assessments for these children. Staffs are supported by both the Paediatric Head of Service, Paediatric Matrons and the Named Nurse Safeguarding Children. All work closely with the ICB, CAMHS, NHSE (as the 'bed manager' for tier 4 beds) and the Local Authority to ensure appropriate care for these children is given.

For all children admitted in a Mental Health crisis receive a daily CAMHS assessment. A weekly meeting is held with CAMHS to ensure that there are robust care plans in place and a Discharge Planning Meeting is held for the majority of children. Trust senior managers are updated on admissions and acuity on a regular basis by Paediatric Head of Service and/or Named Nurse

Safeguarding Children. The DCN would be part of a coordinated response to extended admissions due to lack of a forward placement or discharge address.

A new volunteer service to support children in ED with Mental Health that started in autumn 2021 is still ongoing. This is provided by a charity called EMERGE. They have vast experience of supporting children in an ED environment and aim to prevent admission. They work with the CAMHS crisis team to build a plan of support for the child and will follow up in the community for up to 3 months after presentation.

14. Non-Accidental Injuries (NAI's)

Between May and July 2023, the Trust admitted 9 children with Non-Accidental Injuries (NAI). These were unusual presentations for the Trust and the ICB had raised concerns due to high numbers in the West Kent Area. A review was undertaken by the paediatric team and looked at the notification process to the ICB. As part of the review, the NAI pathway together with the Child Medical Pathways were reviewed and discussed with responsible clinicians. In Addition, the Skeletal survey guidelines at MTW have been updated pending new national guidelines update. To note, the Trust follows the Royal College of Radiology and the Royal College of Paediatrics and Child Health guidance on the management for suspected of NAI's. The increase in the number of Children under 12 months presenting with unexplained injuries (NAI) remains on the Trust risk register (amber rating) with controls in place.

15. PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities. The revised PREVENT Duty was published in July 2022

PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation. The Trust has met the PREVENT training standard for Basic Awareness and achieved 93.5%. Face to face WRAP Training has not been delivered to staff in the last year.
The Trust made no referrals to the Prevent process in the reporting year.

16. Serious Incidents

No new SI's focusing on Safeguarding have been raised in the current reporting period.

17. Priorities for 2023-2024

The Trust recognises that there will be new and differing priorities for the coming 12 months and see Safeguarding as being central to business continuity for the Trust.

Safeguarding Children's priorities will be focused on the following key areas:

- Education and Training – increasing compliance on mandatory training by offering creativity in delivering training; increased use of on-line platforms
- Developing a 7 day Safeguarding Children service
- Strengthening the joint working between the Named professionals and looking at a co-located All Ages Safeguarding team
- Complex Needs –updating the process for escalation of children who may have complex needs that need robust discharge planning
- Domestic Abuse – rolling out the HIDVA service and developing training packages for staff
- NAI in the under 2's – highlighting in training the complexity of AHT, NAI's and care pathways
- Mental Health – strengthening the Safeguarding support for children with Mental Health needs

It is recognised that there have been challenges in the previous 12 months. The Safeguarding team has recognised and risen to the challenge to support all staff during this difficult time. They will continue to build on the positive work started in the previous 12 months.

SECTION TWO.

Midwifery Safeguarding

The Named Midwife works in partnership with the Chief Nurse, Dept. Chief Nurse, Named Nurse for Safeguarding Children and Named Nurse for Safeguarding Adults to deliver the day to day Safeguarding Agenda.

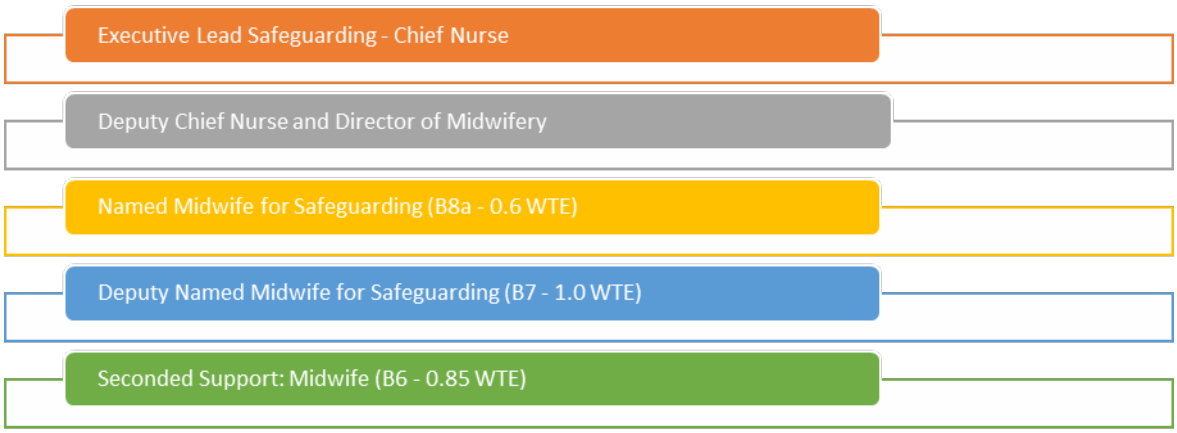
The Named Midwife (0.6WTE) provides vision, professional leadership, strategic direction and clinical support for the Safeguarding Midwifery service. Leading on key areas necessary to safeguard Children and Adults at risk. In addition, the Named Midwife is also 0.4WTE as Matron for the Antenatal Clinics (Cross site MGH and TWH), and Specialist Midwifery teams: Perinatal Mental Health, Thrive, Bereavement, Diabetes, Preterm Birth and Antenatal and New-born Screening.

The Named Midwife line manages the Deputy Named Midwife (1WTE), who manages the day to day operational duties, and is supported in the identification and implementation of service improvement initiatives, staff training & supervision.

The Safeguarding Midwifery Team work collaboratively, alongside the Adults and Children's teams to ensure there is effective, high quality safeguarding frameworks in place to support expectant parents, safeguarding the unborn and their siblings, and providing expert knowledge and support to all maternity staff involved in the family's care.

Due to unprecedented workload additional support was provided to the Safeguarding Midwifery team during 2022-2023 by way of internal secondment of a B6 Midwife (0.85WTE). However, despite this, the demands of increasing workload, complexity of Safeguarding cases, and team absence has meant that further support by way of an additional safeguarding professional 1WTE and administrative support is still required to ensure continued success and progress of the service.

Team Reporting Structure:



Despite the ongoing challenges faced over the last 12 months, the team have continued to maintain focus on the importance of providing a safe, informed, evidenced based service which places Maternity Safeguarding and the voice of the child as paramount. They have also continued to evaluate our service provision, start and/ or deliver on a number of high-profile service improvement initiatives.

Key Service Headlines 04/2022- 03/2023:

Year	Bookings	Additional Support Forms (ASF)	Social Services Referrals	Hubs	Supervisions
2023	6443 ↔	577 ↑	118 ↑	302 ↑	122 *
2022	6448	501	99	249	145
2021	6443	424	69	190	390

*Compliance with Trust supervision targets was not achieved for the last 3 quarters of 2022 this was due to staff availability and unit acuity. However, 100% of eligible staff were offered at least 3 supervisions in this period. From Jan 2023, eligible staff were given protected time to attend supervisions which thus far shows a marked improvement, we are on track to be compliant for Q1 this year.

Increasing Safeguarding Complexity:

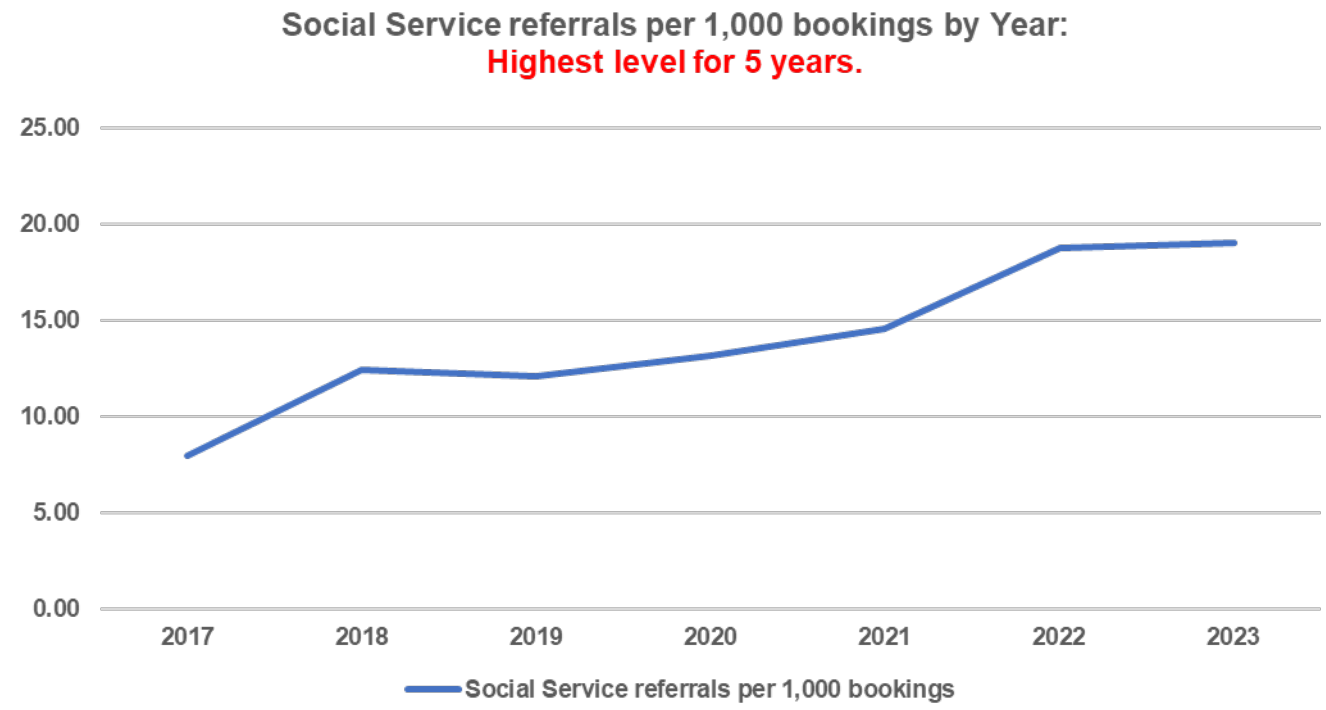
Despite an almost static volume of bookings compared to 2021, social service referrals and HUB cases continue to rise both in real terms and as a proportion of Bookings.

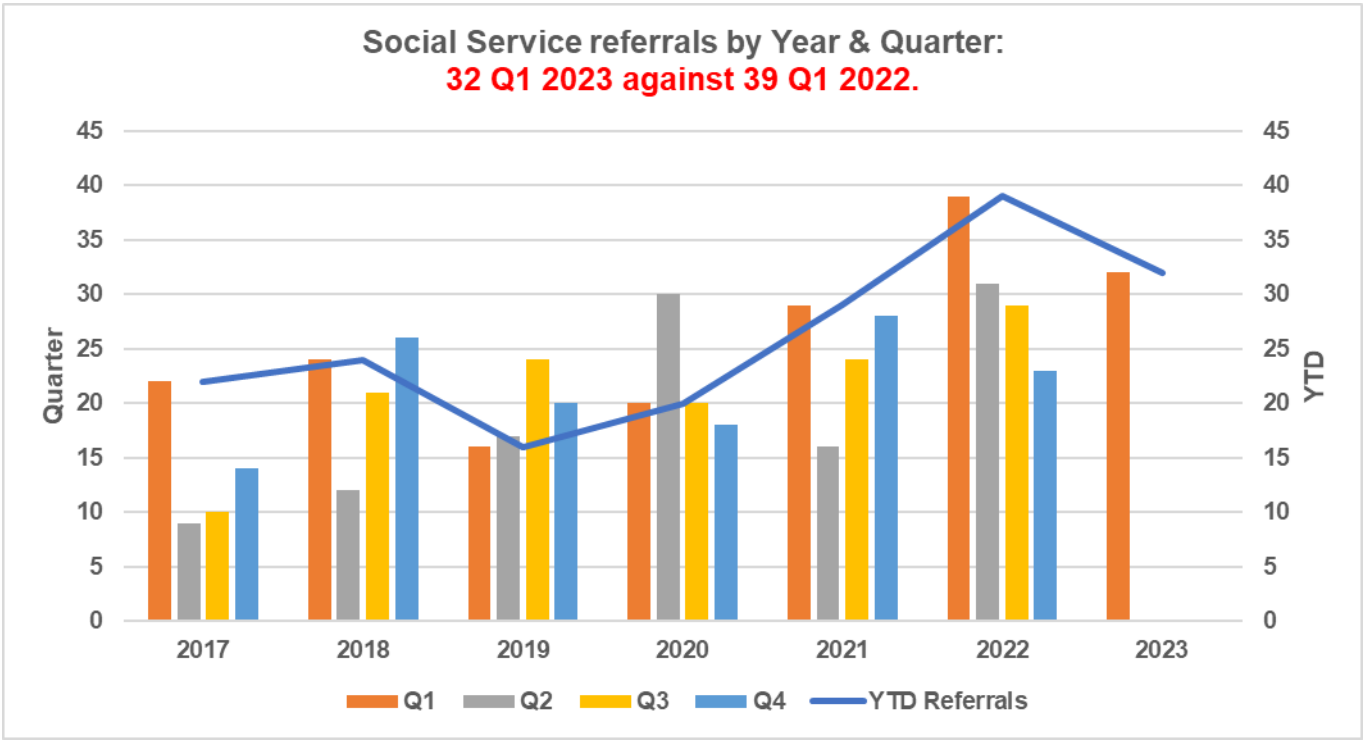
The largest proportion of primary referral reasons relating to social services involvement include Maternal Mental Health (176), Open to Social Services (91) and current domestic abuse (66). Complexity is also demonstrated in the increasing numbers of Separation and Supervised Mother and Baby postnatal placement.

Social Services referrals per 1000 bookings for 2022-23 continue to rise at an exponential rate and are currently the highest they have been when compared to the previous 5 years.

It is not expected that these upward trends will change, this is reflected in the National Safeguarding picture.

	2020	2021	2022	2023 so far
Separation	1	5	9	7
Mother & Baby Placement	No data	6	6	3
Mother & baby Unit (Psych)	No data	No data	2	0





Midwifery Hubs

Year	Number of Cases Discussed				
	Maidstone	T&M	W	SSTW	Total
3/22-4/23	150↑↑	96↑↑	90↑↑	75	411
2022	68	75	66	-	209
2021	33	19	37	-	89

Currently Maidstone Hub runs fortnightly and the Wealden Monthly (W), Sevenoaks South & Tunbridge Wells (SSTW) and Tonbridge & Malling (T&M) hubs run Bi-Monthly.

Due to the volume of cases SSTW & T&M are required to run monthly, however the team is currently unable to support this.

Innovative Practice: Working Together Project

This year the Safeguarding Midwifery Team successfully co-produced and delivered a new joint training programme between Safeguarding Midwifery Services and Social Work colleagues from Maidstone Children's Social Care.

The first of its kind Regionally, and perhaps Nationally, the project hoped to address the common themes in failings from both our own evaluation of serious case reviews and those repeatedly highlighted by numerous high-profile safeguarding children investigations in which communication failure, lack of interprofessional working, inadequate information sharing and poor communication were highlighted as contributing factors in adverse outcomes.

The aim of the project was to directly impact these negative barriers by training together, fostering positive working relationships and a deeper understanding of each other's roles and professional limitations.

The team have delivered two sessions in 2023 so far with Social Work colleagues which have been positively received, and have restructured our Midwifery Mandatory Training Programme which will now run interactive break out rooms with "real life" case examples delivered jointly by Safeguarding Midwifery and Social Work team leads. The Safeguarding Midwifery team have offered to provide expert midwifery insight and a visible presence by working remotely from the safeguarding offices once per month and in return our colleagues at Maidstone and Sevenoaks South and Tunbridge Wells have also agreed for MTW Midwives to have the opportunity to shadow a Duty Social Worker. It is hoped that through this networking we will remove some of the barriers between teams, increase knowledge and understanding of each other's roles and improve the quality of Safeguarding Midwifery referrals further improving the support provided to high risk families who may have otherwise fallen through the safety net.

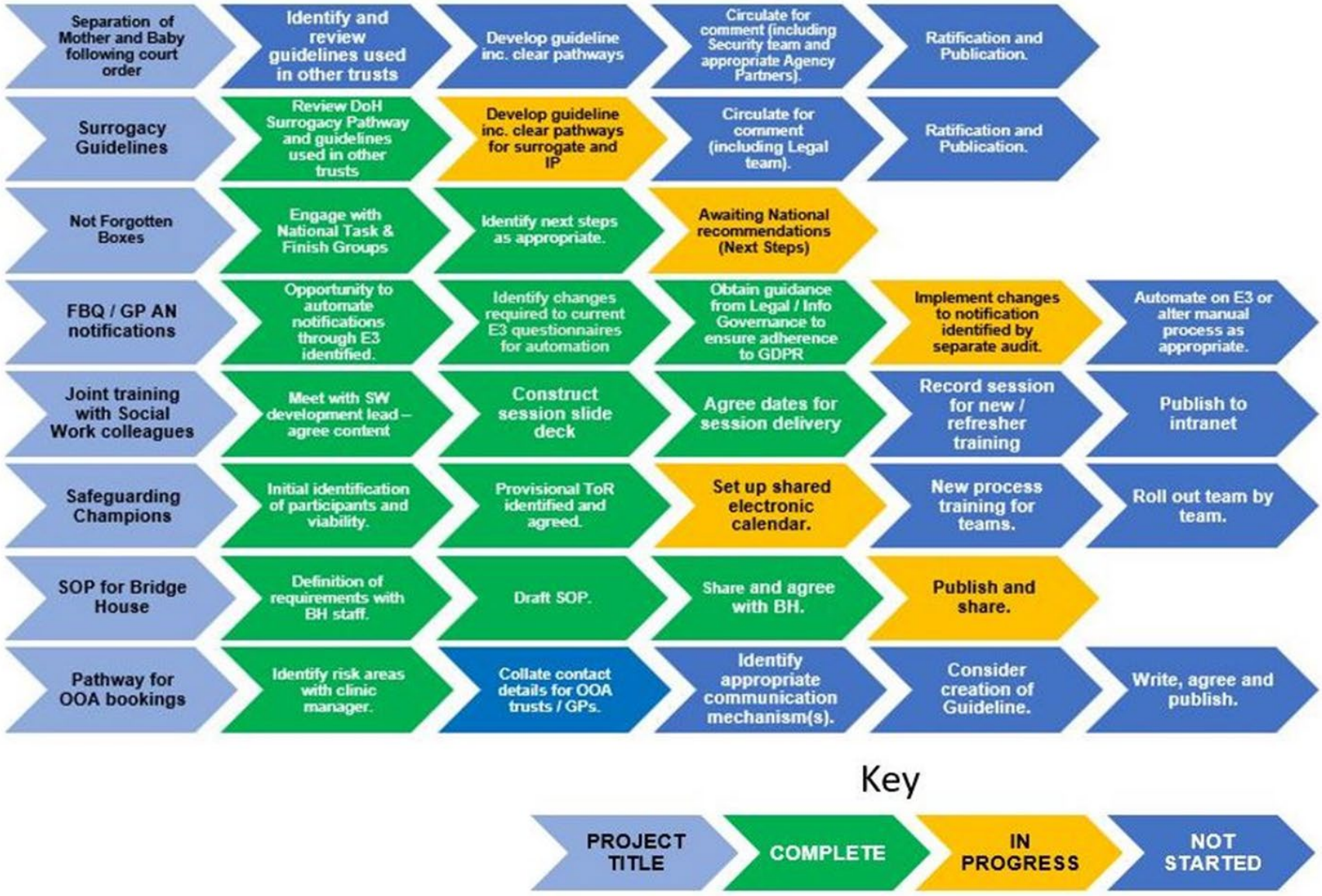
Further training sessions will be planned through the year and they will continue to evaluate this initiative over the next 6-12 months and audit its success.

In addition, the team has:

- Reinstated safeguarding champions in every community team and ward department.
- Launched an accessible online booking process for community midwifery supervision increasing our compliance & supervision capacity to 120 available slots per month.
- Safeguarding visibility in clinical areas has continued.

- Developing a joint Safeguarding Midwifery training programme with the Kent Children's services department to standardise and inform practice across safeguarding teams, improving working relationships and communication.
- Continued provision of pre-birth planning with social work, police, probation and other agencies as well as provision of complex case discharge planning.
- We have been unable to maintain the reinstatement of complex case reviews detailing all high-risk clients due each month due to team workload and case acuity, but continue to circulate a list of high-risk cases due each month as mitigation.
- In 2022 Q4, 42% of the Midwifery Safeguarding Team's time was spent in direct support of Midwives, face to face or virtually.
- A large proportion of time is also dedicated to chairing high risk Strategy meetings, Core Groups, and MARAC across the safeguarding midwifery team.
- Continued commitment to Safeguarding Training Provision including Midwifery, Students, Junior Doctors, and focused team or 1:1 support following incidents.
- Compliance with Trust supervision targets has been achieved for Q4 despite ongoing high acuity within Maternity. Headcount of midwives eligible for supervision has risen from 75 to 103 in the quarter, increasing the number of supervisions required to achieve target.

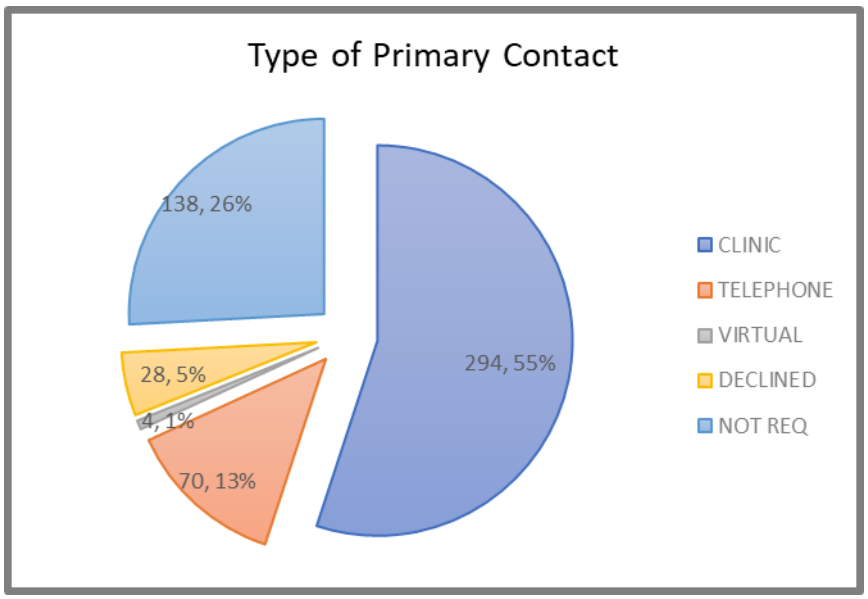
Safeguarding Midwifery Active Project Workflow:



Perinatal Mental Health: Key Service Headlines 04/2022- 03/2023

Total April 2022- March 2023	
Number of documented PMH referrals	547 (8.5% of total bookings)
High risk	109 (19.9% of referrals)
Medium risk	247 (45.2% of referrals)
Number of patients seen*	356

*note partial data collection Jan- Oct 2022



<u>Perinatal Mental Health Midwifery Service Updates:</u>

- New PMH Database Developed Partial Launch July 2022, full compliance delayed due to staffing issues. Effective data collection from October 2022.
- New PMH Midwifery SOP ratified 25/10/2022
- Joint safeguarding and Perinatal Mental Health ASF ratified and launched 25/10/2022
- Joint working between Safeguarding and Perinatal Mental Health Midwives- including joint ward round, PMH Midwife attendance at core groups and case conferences for joint cases.
- Thrive Specialist Midwife recruited 05/12/2022
- Perinatal Mental Health Specialist Midwife recruited 21/12/2022
- Thrive service launched 09/01/2023
- Thrive SOP ratified 24/01/2023
- Introduction of Trauma Informed Care Planning
- Quarterly reporting from Specialist Perinatal Mental Health and Thrive Midwives

Projects in progress:

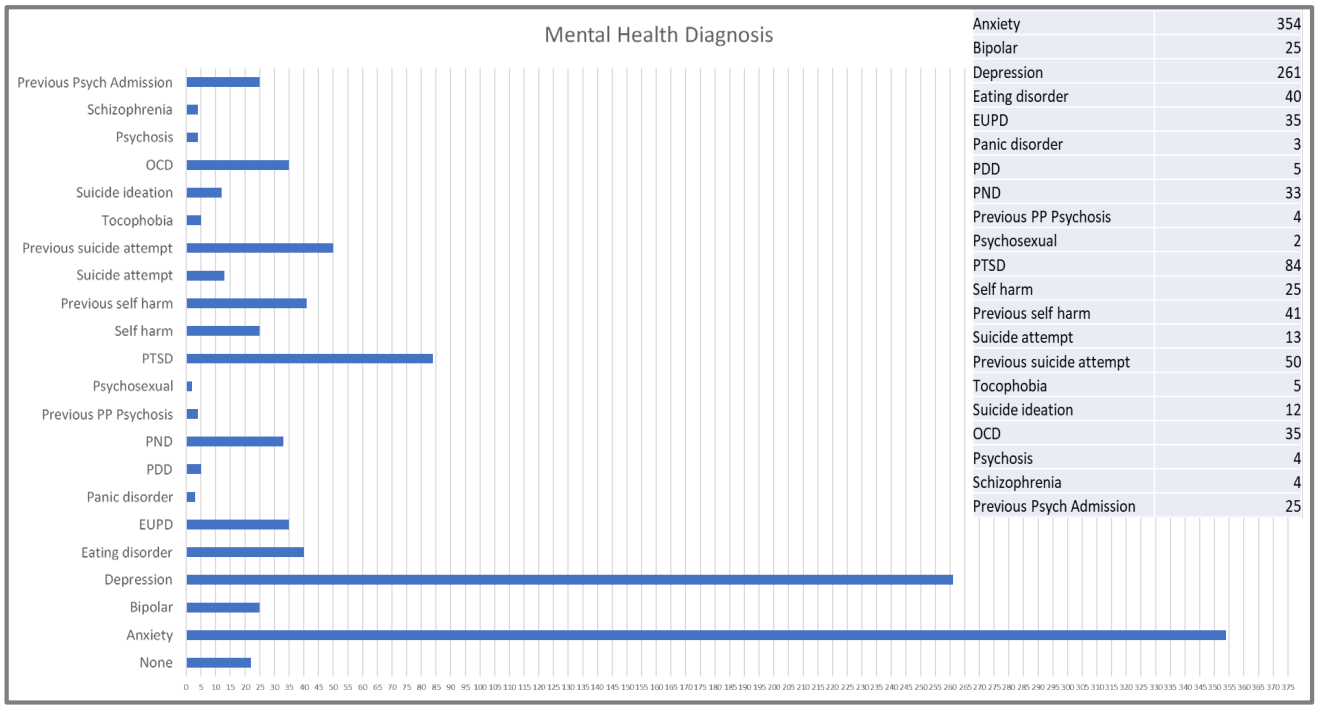
- HUGS Facilitated Selfcare & Wellbeing group- proposal.

HUGS- Helping You Grow Stronger: Is a 4week online programme open to all pregnant women struggling with their mental health.

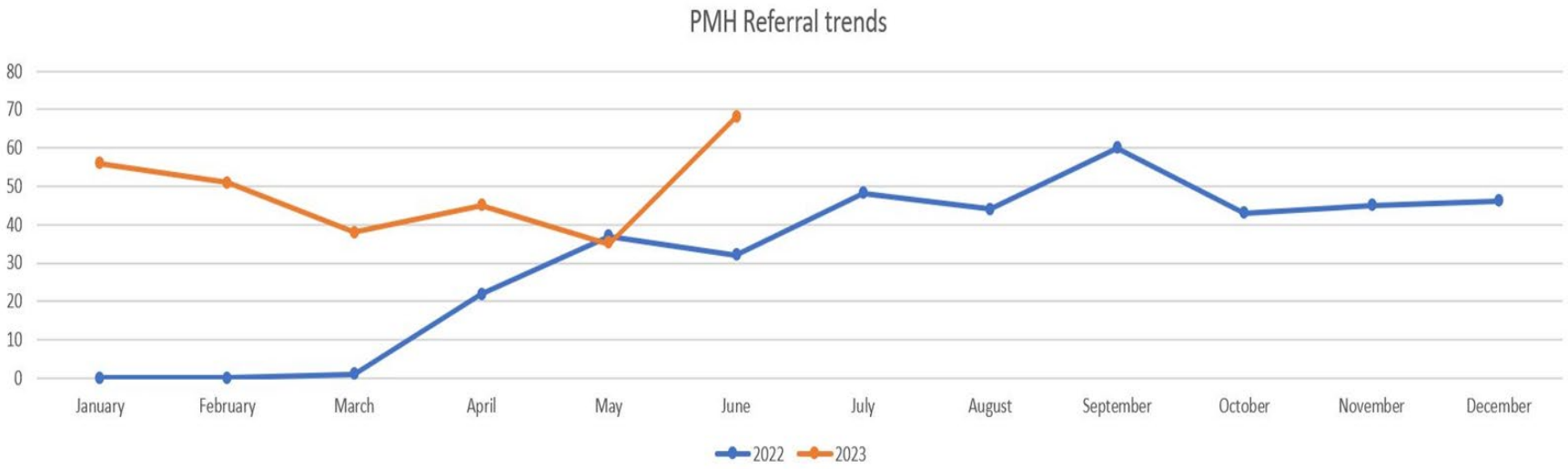
The group aims to be a safe space to explore techniques for managing symptoms of anxiety and low mood and is particularly helpful for those with low level anxiety not requiring specialist input or for those who do not meet criteria for perinatal mental health community services. It is not a forum for individual case discussion, but a non-threatening, supportive, de-stigmatising platform in which participants are guided by our specialist midwife to explore art therapy, journaling, mindfulness and grounding techniques. The group offers an additional layer of information and support in addition to more traditional methods of therapy such as talking therapy, and provides women with a direct line to individualised support should they need during their pregnancy.

Successfully launched and run for the last 2 years during her previous employment, it is something we hope to replicate in 2023-2024 at MTW.

Case Complexity in relation to Perinatal Mental Health and Safeguarding Risk



Anxiety	354
Bipolar	25
Depression	261
Eating disorder	40
EUPD	35
Panic disorder	3
PDD	5
PND	33
Previous PP Psychosis	4
Psychosexual	2
PTSD	84
Self harm	25
Previous self harm	41
Suicide attempt	13
Previous suicide attempt	50
Tocophobia	5
Suicide ideation	12
OCD	35
Psychosis	4
Schizophrenia	4
Previous Psych Admission	25


PMH Referral trends
80
70
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February
March
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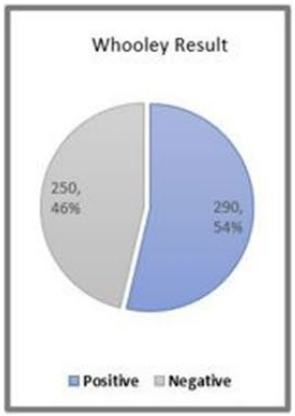
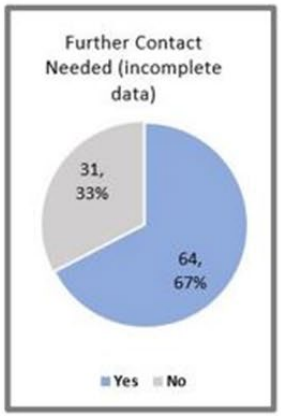
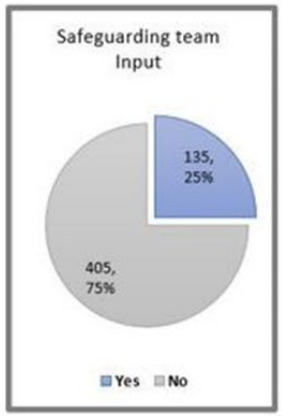
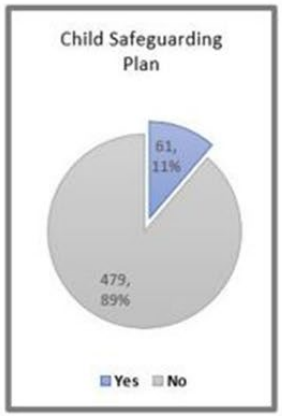
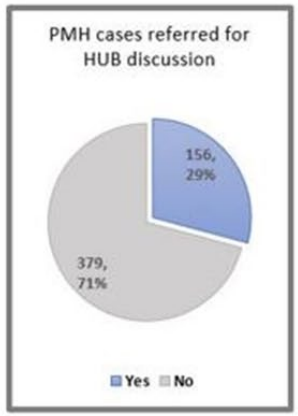
2022
2023

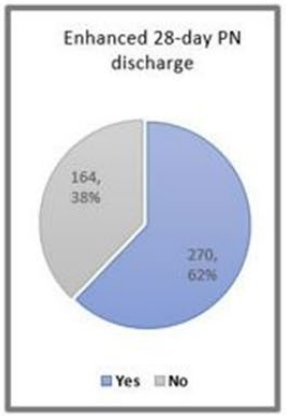

Whooley Result
250, 46%
290, 54%
Positive
Negative


Further Contact Needed (incomplete data)
31, 33%
64, 67%
Yes
No


Safeguarding team Input
135, 25%
405, 75%
Yes
No


Child Safeguarding Plan
61, 11%
479, 89%
Yes
No


PMH cases referred for HUB discussion
156, 29%
379, 71%
Yes
No


Enhanced 28-day PN discharge
164, 38%
270, 62%
Yes
No

SECTION THREE

ADULT SAFEGUARDING REPORT

Introduction.

The purpose of this report is to provide assurance that Maidstone and Tunbridge NHS Trust safeguarding arrangements for adults are effective and as such the Trust is upholding its statutory responsibilities to safeguard adults at risk who come into contact with the Trust.

This report evidences key safeguarding activity for 2022/2023 and highlights the challenges, risks and priorities for 2023/2024.

The Adult Safeguarding Service works closely with the Child Safeguarding service and together the services promote the 'Think Family' ethos. Adult Safeguarding adapted to new ways of working to ensure business continuity through the pandemic and is now utilising some of the positive changes from that whilst also getting back to more normal ways of working.

The Learning Disability Liaison Nurse is very busy supporting patients with a Learning Disability (PWLD) or autism directly to desensitise them to the hospital setting, working out pathways to ensure that PWLD have good access to healthcare when coming to hospital is very challenging for them and is working with community colleagues collaboratively to ensure that PWLD receive outstanding care from the Trust.

The MCA CNS is on a fixed term contract covering for maternity leave and has worked very well in her new environment having arrived to the Trust from a Community NHS Setting. The MCA re-audit has been completed this year and a robust action plan is being worked upon to ensure Trust staff are supported to enhance their confidence and competence in applying the Mental Capacity Act framework into their practice.

Key risks identified were:

- Domestic abuse service provision. This has now been resolved and the risk closed on the risk register.
- MTW is not compliant with national targets for safeguarding training, (this is due to a reset to zero for Level 3 Safeguarding Adults and MCA & DOLS training in March, these are on an upward trajectory after the reset). Poor compliance (with MCA 2005) in documenting assessments of mental capacity remain on the Trust risk register (rated Amber).
- The systems wide preparations for the advent of the Liberty Protection Safeguards (deferred beyond the life of the current Parliament), where roles and responsibilities shift from the Local Authority to Responsible Bodies (such as Hospital Trusts) and the required

workforce to implement the changes still remain a risk for the Trust. This is on the risk register (rated Amber).

Key priorities for 2023/2024 are:

- Continue planning for the implementation of the new Liberty Protection Safeguards
- Complete audits in inpatient adult areas; to include MCA, restraint and DNACPR
- Focus on disseminating lessons learned from local and national multi-agency reviews
- Continue to work on the Learning Disability Benchmarking Strategy
- Continue to promote the work of the integrated adult and children's safeguarding service
- Support the newly appointed hospital independent domestic violence advocate to work across the Trust with patients, staff and visitors who indicate that they are living in a domestic abuse relationship.

Safeguarding adults remains a priority and is everyone's responsibility.

Safeguarding adults remains a key priority for MTW with the Chief Nurse as Executive Lead and leadership provided by the Deputy and Chief Nurse and Named Nurse for Safeguarding Adults. The Adult Safeguarding Service (ASG) service is aligned with the Children's Safeguarding Service, Midwifery Safeguarding and together the services promote the 'Think Family' approach. MTW is committed to working in partnership with key stakeholders to ensure that adults at risk who come into contact with the Trusts services are identified early and protected from harm.

Safeguarding adults is the process of supporting adults with care and support needs who appear to be at risk of abuse or neglect and who are not able to protect themselves due to their needs for care and support (Definition of an Adult at Risk). The Local Authority is the lead agency and NHS Trusts have a statutory duty to work alongside them, in the multi-agency setting, to support those adults identified as being an adult at risk and is being abused in some way.

The Safeguarding Adults Service includes the Named Nurse for Safeguarding Adults and MCA Lead, Mental Capacity Clinical Nurse Specialist, Learning Disability Liaison Nurse and a share of a Safeguarding Co-ordinator.

The Safeguarding Learning and Improvement Panel and the Joint Safeguarding Committee advises the Quality Main Committee and the Trust Board on how its statutory obligations are being met.

Safeguarding Adults Activity

The Adult service has supported 270 cases relating to safeguarding concerns, (82 relating to alleged hospital incidents and 188 relating to alleged community incidents). The alleged hospital safeguarding incidents have decreased by 31 incidents from last year. The alleged community safeguarding incidents raised by Trust staff have increased by 78 cases in the last year.

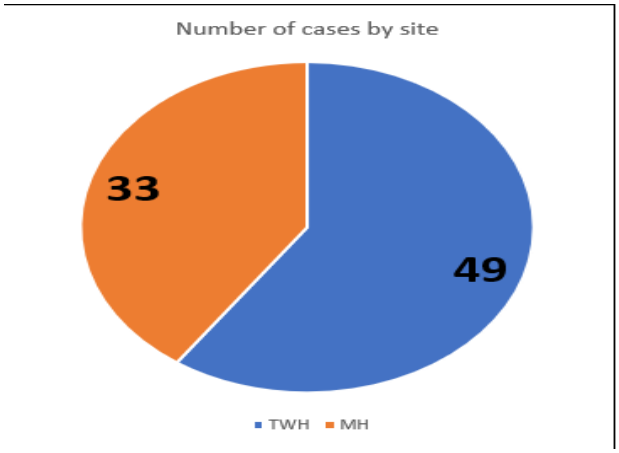
The information below gives data about safeguarding adult referrals raised about alleged incidents that are alleged to have occurred in the Trust. The split across the two hospitals reflects the fact that TWH has the higher bed base.

The data also highlights where the allegations of abuse have occurred but the Trust board should note that out of the 82 Trust incidents received only five incidents involving Trust staff were upheld. One of those upheld led to a disciplinary process. The board should note that 6.1% of allegations have been upheld in the past year, 24.39% were not upheld, 50% there was no further action under safeguarding required, 1.22% were partially upheld, 4.88% there was insufficient evidence to decide either way and 13.41% of cases remain ongoing – dates for investigations to be presented at the Safeguarding Learning and Improvement Panel have been diarised.

Overall Activity

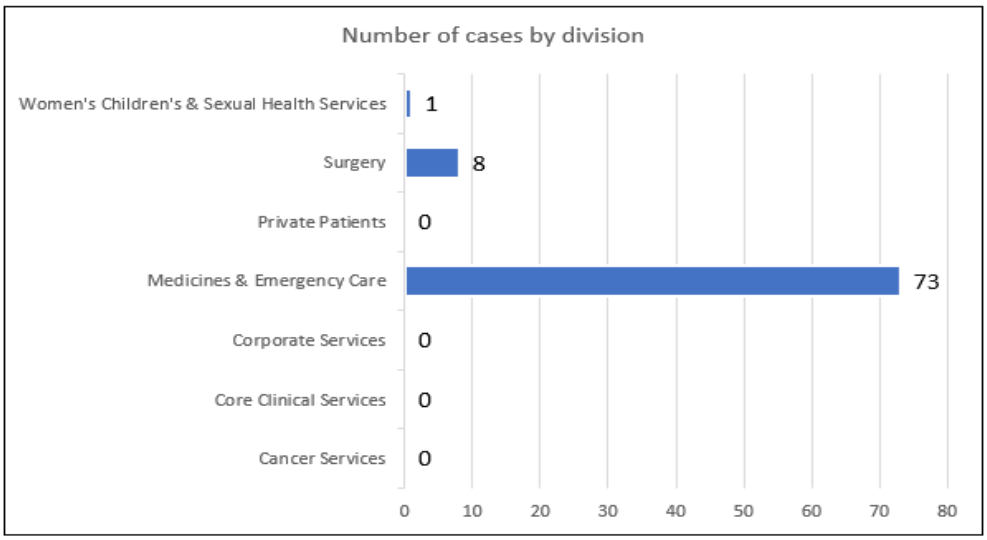
Number of cases	
TWH	49
MH	33

Reported by	
Reported by Trust staff	29
Reported Externally	53

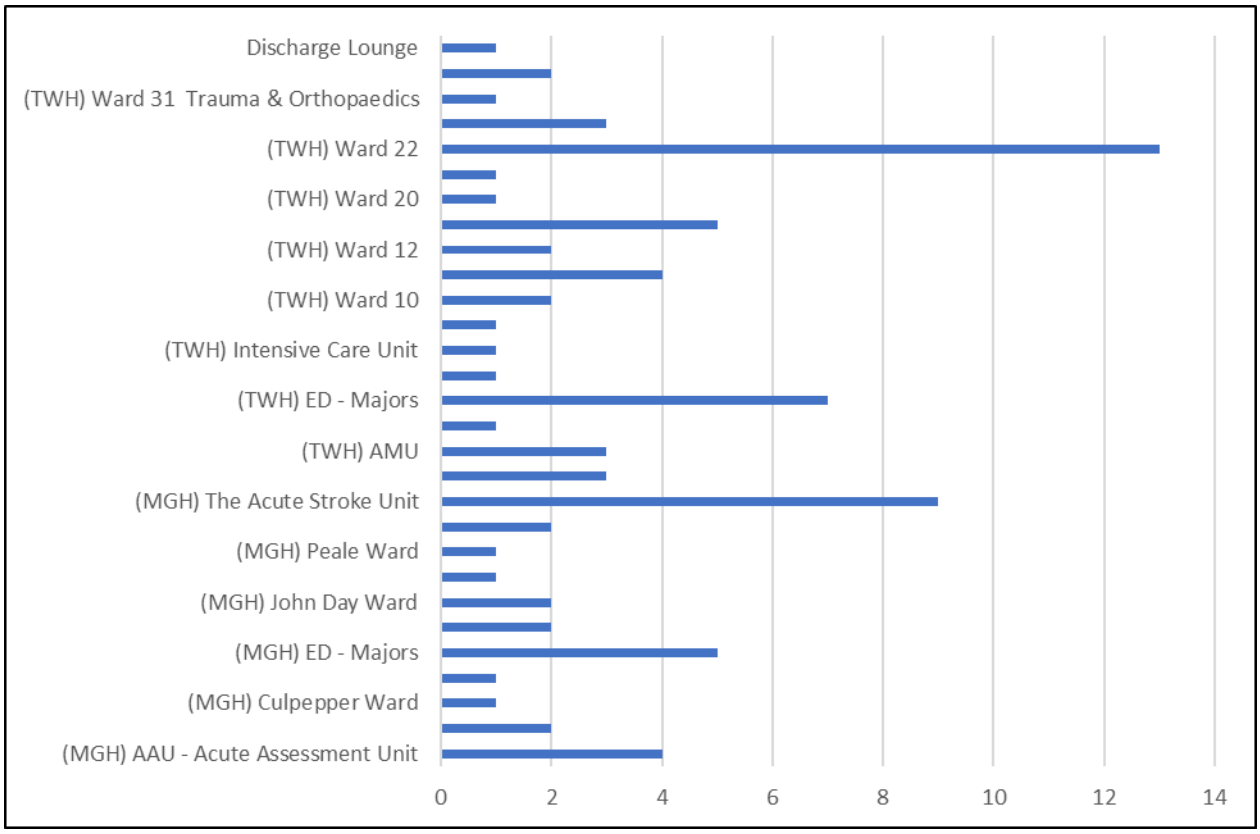


35.37% of Hospital alleged cases were raised by Trust staff in the last year – this denotes good practice whereby Trust staff recognise that abuse can happen anywhere and must be reported accordingly.

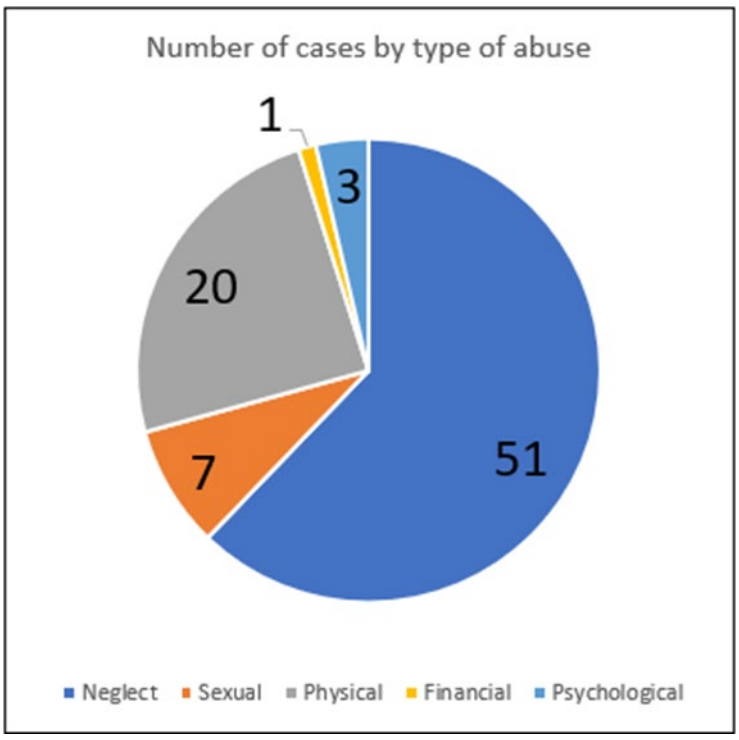
Activity by Division



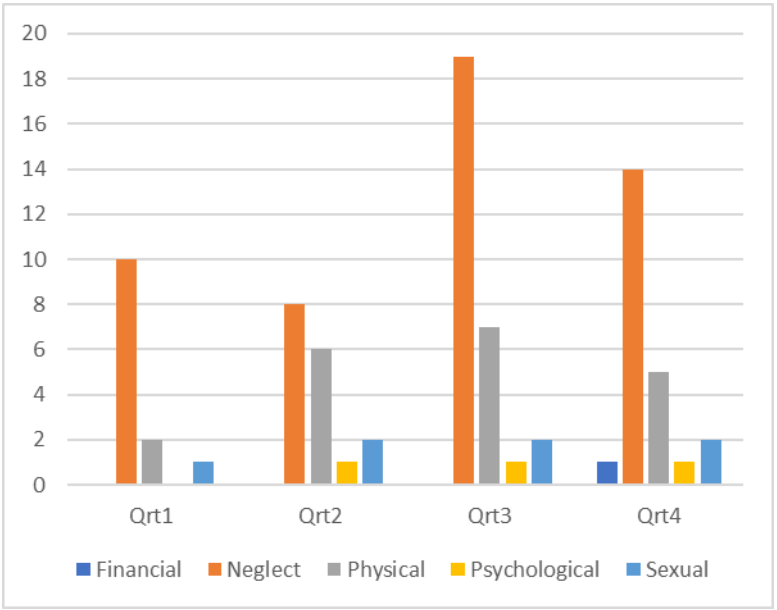
Activity by Area



Types of Alleged Abuse for Hospital Alleged Incidents

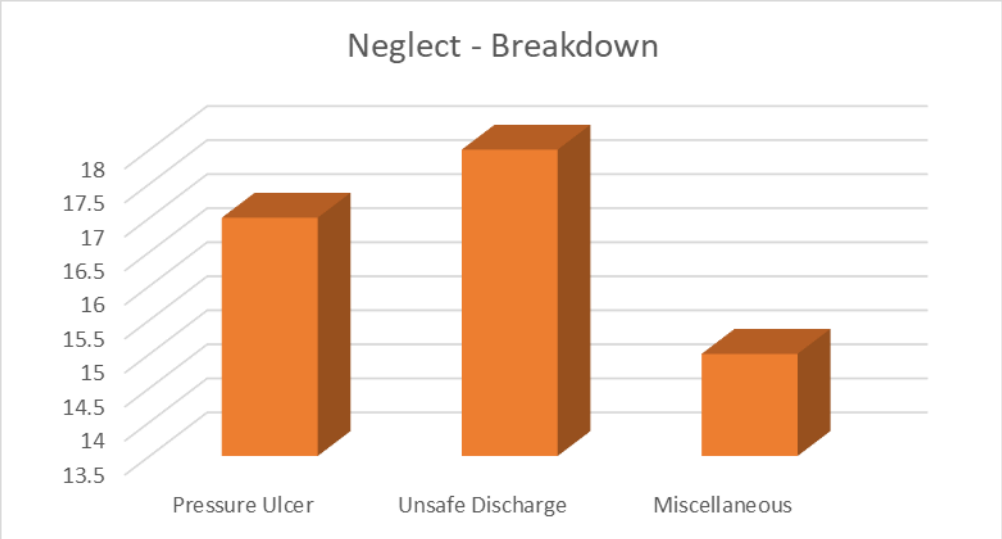


Breakdown per Quarter of Types of Abuse



The highest category of alleged abuse was neglect and this has been further split to show the types of neglect – see chart below.

Neglect Cases Broken Down into Categories

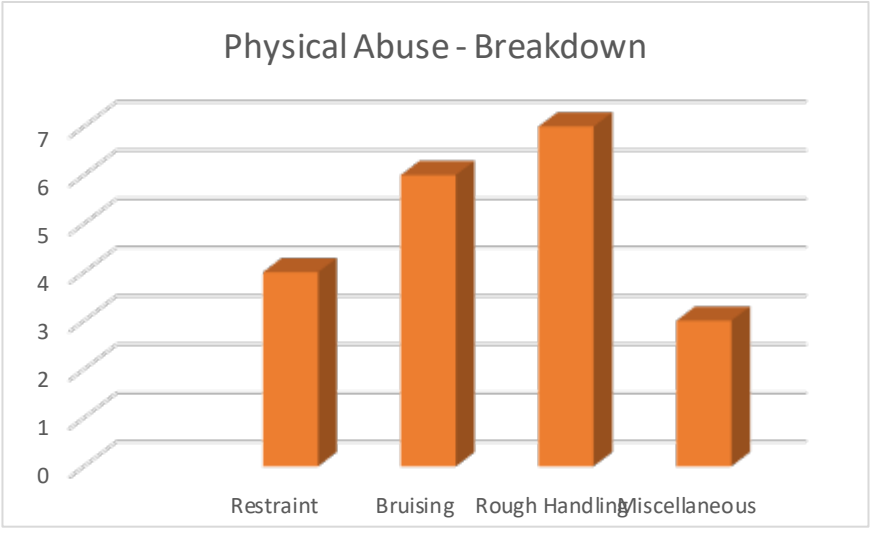


The Trust Board should note that of these cases one was upheld and this was for a hospital acquired pressure ulcer. The safeguarding team continues to promote the use of the 'Safeguarding Adults Protocol: Pressure Ulcer and the Interface with a Safeguarding Enquiry Decision Tool' that was adopted by the Kent and Medway Safeguarding Adults Board (KMSAB) for use across Kent, with nursing homes, social care colleagues and other organisations' nursing staff.

In relation to hospital discharges we continue to promote with staff the use of the Transfer of Care form and using Body Maps to show not just Pressure Ulcers but also bruising and marks to a patient's skin.

Alleged Physical Abuse cases broken down into categories

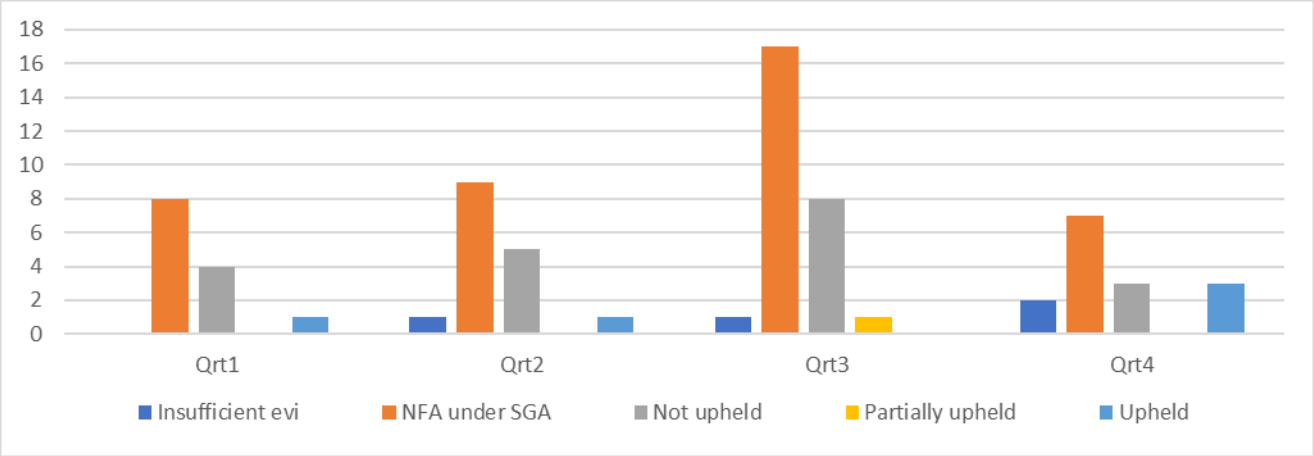
In relation to physical abuse these have been disaggregated between Restraint, Assault Bruising and Miscellaneous. The following chart gives this breakdown: -



Physical		
Restraint		**4**
Bruising		**6**
Rough Handling		**7**
Miscellaneous		**3**

Outcomes of Hospital Alleged Incidents

The following charts give a breakdown of the outcomes of alleged incident of abuse in the hospital setting: -



Breakdown of Upheld Cases	No	Responsible
Neglect-Pressure Ulcer	1	
Physical - Restraint	1	Agency staff
Physical – Rough Handling	1	Trust staff
Psychological	2	1 agency staff, 1 agency security staff

Of the five incidents that were upheld about hospital practice, the above breakdown gives the type of incident that occurred.

Outcomes	No	%
Not upheld	20	24.39
No Further Action under Safeguarding	41	50
Upheld	5	6.1
Partially Upheld	1	1.22
Insufficient Evidence	4	4.88
Case remains ongoing	11	13.41

To note one was upheld in relation to physical restraint resulting in the agency for the person responsible having to consider if disciplinary processes are applicable. One was upheld as a patient had had their fingernail-bed pressed by a Doctor as part of a medical examination. This was noted as an outdated technique to be used and the Doctor was informed immediately. The Doctor in this case has retired and no disciplinary actions were taken. With regards to the case that was upheld for hospital acquired pressure ulcer it was clear that staff had left a patient on a bedpan for up to 12 hours – disciplinary processes were completed in this case.

Of the two psychological cases that were upheld, one involved security staff swearing at a patient and this was witnessed and stopped straight away, employing agency informed. The other involved a doctor being verbally abrupt with a patient, the employing agency was informed and they will consider their actions with the Doctor going forward.

Partially Upheld Case	
Neglect - Misc.	1

This was a case whereby a patient self-discharged as they did not wish to return to the care home but they then went missing. The Care Home were concerned as the patient had been under a DOLS with them and Trust staff had assessed that the patient had capacity to make this decision for themselves. There was a lack of communication between the care home and the hospital about the status of the patient. Also noted that a previous ward had not used the new digital DOLS Form and so this application was not sent to the correct address. This led to the Trusts DOLS policy being updated urgently.

Not all of these outcomes have not all been agreed by the Local Authority who have the statutory duty to lead on safeguarding matters and make decisions about safeguarding cases, in line with the Care Act 2014. This is due to the fact that over the preceding year the Local Authority practitioners changed the way that they managed hospital safeguarding cases. They changed from overseeing the process of the safeguarding concern to closing the case, at outset, with no further action for them, but requesting the Trust to complete their own investigations. On occasions some Safeguarding Concerns were kept open and the Local Authority then liaised with the Trust about the outcomes outside of the Trusts Safeguarding Learning and Improvement Panel. The Trusts safeguarding team continues to forge close working relationships with our Local Authority colleagues in the new landscape of teams that have been formed (see below).

The attendance of the Integrated Care Board (ICB) Designated Nurse for Safeguarding Adults at the Trusts Safeguarding Learning and Improvement Panel has been valued. This has given external scrutiny and advice on outcomes of cases from the investigation reports presented.

The cases that are no further action under safeguarding have all been triaged by the Safeguarding Adults Team and the concerns raised have either been answered quickly or quashed at outset with no further report requested from clinical teams.

Domestic Abuse advice has been given throughout the year by both the Adult and Children's Safeguarding services. However, during the year the Trust was informed that funding had been secured for a Hospital Independent Domestic Violence Advocate (HIDVA) in line with neighbouring Trusts in Kent. Both Named Nurses welcome the chance to use this post positively going forward for patients, staff and visitors to the Trust and to enable staff to increase their knowledge, competence and confidence when dealing with Domestic Abuse issues going forward with assistance from the HIDVA.

The NNSA's and wider team have also given advice to staff on a number of occasions about patients with mental health decline or suicidal ideation. The level of advice given will be collated and NNSA's plans to collect this data in the forthcoming year using the In-Phase systems going forward.

Training and Compliance

Training is on a mandatory basis for all staff and this is aligned to the level that they are identified as needing, in line with the Adult Safeguarding: Roles and Competencies for Health Care Staff (Intercollegiate Document 2019, updated 2022). This document is currently under review and staff await the outcome of that review.

Delivery of training in this year has remained mainly online e-learning with some face to face training being offered at Level 3 for both Safeguarding Adults and Mental Capacity Act training at Level 3. The safeguarding team are working with the Learning and Development department to look at smarter ways to deliver this training to our busy clinical colleagues.

The NNSA's is involved in a Kent wide project to look at the offer of Level 3 Safeguarding Adults training to agree the training resource required and to gain agreement that this level of training can be accepted from organisation to organisation. Going forward this integrated approach is hoped to ensure that staff receive only the training they absolutely require when moving between health organisations in Kent.

The E-Learning for Health (ELfH) MCA/DOLS resources have been placed onto the Learning and Development platform and advertised out for staff to access to count towards the current training offer. These modules have been split into basic, intermediate and advanced learning opportunities for staff to access, with clear guidance as to which levels staff should access.

MCA and DOLS learning requirements have been mandated for staff clinically registered staff who are patient facing, to complete every 3 years as opposed to being a 'one off' requirement within the Trust. In the drive to improve competence and confidence amongst staff to apply MCA/DOLS into

their practice, the Trust took the decision in March 2022 to reset the training compliance for this subject matter for both Level 2 and Level 3 back to zero with all relevant staff notified that they need to complete their MCA/DOLS training in the near future to become compliant. Compliance rates are on an upward trajectory with the Trust end of year compliance being Level 2 67.6% and Level 3 71.0%. Staff will be required to refresh this training every 3 years.

All staff commencing in the Trust have to undertake their Level 1 e-learning prior to commencement of employment.

Training compliance remains good within the Trust with the latest report indicating that Trust staff overall are: -

Safeguarding Adults Training Compliance (against Trust target of 85%)

Level 1 End of Year = 95.3% compliance

Level 2 End of Year = 91.4% compliance

Level 3 End of Year = 77.6% compliance – continuing upward trajectory after redesign and reset of training

Mental Capacity Act (MCA) includes Deprivation of Liberty Safeguards – (Redesigned and compliance reset to zero)

Level 2 End of year = 67.6% Compliance

Level 3 End of year = 71.0% compliance

PREVENT

Basic Awareness End of Year = 96%

WRAP End of Year = 87.9%

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial. There have been no Prevent referrals made by the Trust in 2021/22.

Policies and Procedures

The Trust has a developed suite of Safeguarding Adults policies and procedures that are published on the Trusts document retrieval system. There are links provided to staff via the Safeguarding Adults Intranet pages for ease of access to these policies and procedures.

The NNSA's authored the 'Was Not Brought' policy which was ratified and published in relation to both children and adults with care and support needs, who have not been brought to their appointments.

Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS) Activity

There have been 552 Deprivation of Liberty Safeguards (DOLS) applications completed by hospital staff. This is a decrease the previous year's applications by 11 cases applied for.

The Trusts MCA project group was put on hold earlier in the year due to the delays in the implementation of the Liberty Protection Safeguards (LPS). The LPS is thought to be implemented post next General Election circa 2025.

Best Interest Meetings under the Mental Capacity Act 2005 continue to be promoted in contentious cases or when serious medical treatment is being proposed or withdrawn. Best Interest Discussions are promoted for people who lack capacity for decision to be made. Going forward the Mental Capacity Act Clinical Nurse Specialist (CNA) will be looking to audit Best Interest decisions made on behalf of incapacitated patients to check that the MCA Law has been complied with.

The Trust responded formally to the draft Liberty Protection Safeguards Code of Practice and the National Team are in the process of collating all responses and revising the LPS Code of Practice accordingly.

The Trust has employed a Mental Capacity Clinical Nurse Specialist to assist with promoting the use of the Mental Capacity Act (2005) competently, confidently and appropriately on behalf of our patients. The MCA CNS is making good strides forward with the developed Work Plan for MCA and DOLS.

The Trust is actively involved in local and regional steering groups to promote the use of MCA and to keep abreast of developments in relation to implementation of LPS. Especially in relation to the idea that Kent Health Provision should have a Health Hub to assist with the implementation and coordination of LPS for patients going forward. MCA CNS represents the Trust at all such meetings and is supported by the NNSA's in this work.

MCA re-audit on assessment and documentation was completed in March 2023. This showed that there has been an improvement in MCA documentation across the Trust. However, there is still room for further improvement. An Action Plan has been developed which includes the following: -

1) The template on Sunrise will need to be revised to ensure the functional test appears before the diagnostic test.
    a. A review of the capacity assessment template on Sunrise to ensure functional test is captured before diagnostic test.

2) Awareness to be raised about the importance of involving the right professionals in some complex mental capacity assessments
    a. To have MCA as a stand-alone item in the ward managers and Therapy led meetings meeting with the availability of MCA CNS to answer queries.
    b. Reintroduce the monthly access to talk with the MCA Lead- advertise dates on MTW intranet
3) Improve Mental Capacity Assessments competency levels within roles
    a. To develop a mental capacity competency framework for all registered practitioners using the MCA code of practice, when application of MCA is required in their day to day roles.

External Partnership working

The Chief Nurse, Executive Lead for Adult Safeguarding attends the KMSAB board meetings or delegates this responsibility to the Deputy Chief Nurse.

The KMSAB has a number of sub-groups to ensure a consistent approach across Kent in relation to Quality Assurance, Learning & Development, Practice, Policy & Procedures and Safeguarding Adults Reviews which the Named Nurse for Safeguarding Adults (NNSA's) and MCA CNS attend on behalf of the Trust.

Health services have a separate strategic group (Health Safeguarding Group) to enable debate and information sharing, which also acts as a conduit for communication between health organisations and the board; this is attended by the Chief Nurses from across Kent and MTW's Chief Nurse is a regular attender to this. The Kent wide Health Reference Group (A) is attended by MTW's NNSA's and this meeting feeds information and ideas, by report to the above HSG.

MTW are a keen participant of all the KMSAB Board meetings and subgroup meetings and this has remained the case throughout the year. The Trust welcomed a new Chief Nurse into role in August 2021 and the safeguarding, agenda continues to be upheld as being of paramount importance within the Trust.

The Trust had worked collaboratively with the Local Authority Safeguarding Teams and Integrated Care Board (ICB) Designated Nurses. This is borne out with the work that had been completed at the Trusts Safeguarding Learning and Improvement Panels which were set up as multi-agency panels, reviewing the investigation reports into hospital safeguarding incidents, and making decisions together in relation to outcomes. Learning from the Safeguarding Learning and Improvement Panel is shared both Trust-wide and locally within directorates.

Unfortunately, over the last 12 months the Local Authority have been absent from this joined up approach to review investigation reports, due to staffing issues and changes in their teams. This remains on the trust risk register (Section 42 enquiries and local authority assurance) rated as a red risk. The NNSA's and deputy continue to liaise with Local Authority partners in relation to individual cases, whether they are ongoing as Section 42 enquiries and outcomes where the Local authority has not closed the case.

Kent Adult Social Care changed the structure of their teams again in April 2023 and after the changes had been completed, they notified the health economy of the changes that had been implemented. It means that there are no longer dedicated safeguarding teams and practitioners in Kent Adult Social Care and as such the Trusts Safeguarding Team now has a number of Adult Social Care teams to liaise with as opposed to the one West Kent Safeguarding Team.

NNSA's has liaised with the Maidstone West Team Manager about this and agreed that she will be the Trust's Single Point of Contact (SPOC) going forward until we are notified otherwise.

The ICB Designated Nurse has not always been available to attend the Trusts Safeguarding Learning and Improvement Panel. This has left the Trust to review our own investigations and decide the outcomes of these without external scrutiny. This now as the majority of Hospital alleged safeguarding incidents are closed by the Local Authority at outset, with an expectation that the Trust will continue with an investigation process. Some Hospital incidents remain open with the Local Authority and it is this different practice that causes confusion. However, the Local Authority are clear that if a person or their family wish for the Local Authority to remain involved this is when they will keep the case open OR when the matter is judged to be serious they will also keep the case open. NNSA's will continue to work with our Local Authority Colleagues to gain a consistent approach to safeguarding cases where possible.

It has been clarified with the SPOC from the Local Authority that the Trust needs to have sight of all the Safeguarding Concern Forms that the Local Authority requests information on and that we are unable to rely upon email notes with regards to information sharing governance processes.

The Trusts NNSA's and deputy, continues to focus on triaging the safeguarding alerts received from the Local Authority to ensure that alerts are being raised for concerns relating to allegations of abuse and safeguarding issues as opposed to being used as an incident reporting mechanism by the referrer. By collaboratively working within the sub-groups of the KMSAB; the Trust has been involved in effecting change in practice and policy and procedures for such issues as promoting the use of the Decision Tool within National Guidance – Pressure Ulcers and the interface with a safeguarding enquiry and within the Self-neglect policy and procedure.

The Trust has completed the Self-Assessment Framework (SAF) developed by the KMSAB, which has been reviewed. The Trust were amber for 2 areas within the SAF in relation to the following: -

1) The organisation provides clear information to those at risk of self-neglect and/or hoarding regarding the support that can be provided. Learning from relevant reviews is shared with staff and there is a mechanism in place to measure the impact of this on practice/increase in knowledge.
   a) Poster in development for display in areas such as ED, PALS, Outpatients and Reception Areas.
2) Learning from relevant reviews is shared with staff and there is a mechanism in place to measure the impact of this on practice/increase in knowledge.

a) The Trust is an active participant in Safeguarding Adults Reviews, Domestic Homicide Reviews and LeDeR when requested. Learning from relevant reviews are shared with action plans developed for the Trust to improve practices following on from publication of such reviews. These are shared at the Safeguarding Committee with relevant senior personnel in attendance. Plans are in place to produce a monthly Safeguarding Snapshot - this will be a bite sized, one-page source of information that it is hoped staff will be able to access more readily. The Discharge Liaison Team have been engaged with the Safeguarding Team in relation to recent SAR's involving Self-neglect and using the KMSAB Self Neglect and Hoarding Policy; there is appetite to improve on the use of this within the Trust.

The action plan agreed for this SAF is being worked on and is on track for completion by year end.

The Trust has provided an Annual Report to the Kent and Medway Safeguarding Adults Board (KMSAB) and it is expected that a minimal proportion of this report will be included in the KMSAB Annual Report.

Safeguarding Adults Reviews (SAR's) are a process that is used to review cases where someone has died as a result of abuse of come to serious harm and agencies feel that if there were better multi-agency working this may have prevented the death or serious harm. The Trust is a proactive member of the SAR processes and currently we have an active role in eleven SARs where the Trust needs to produce an Independent Management Review (IMR) and or be involved in the ongoing SAR meetings with the Independent Authors.

The Trust has referred one potential SAR to the SAR working Group for their consideration.

The Trust meets its statutory requirements in relation to the Disclosure and Barring (DBS) checks. All staff employed at the Trust undergo a DBS check prior to employment and those working with children or adults at risk undergo an enhanced level of assessment. The Trust has in place a requirement for all staff to have a repeat three yearly DBS check.

The Trust is accountable to the NHS Kent and Medway Integrated Care Board (the ICB) and reports to the Trust Performance & Quality Committee. Additionally, quality and monitoring for East Sussex ICB, is captured on the Metric previously supplied by the CCG – going forward the Trust has agreed the content of the Schedule 4 monitoring schedule and will be completing Safeguarding data quarterly for the ICB.

The ICB Designated Nurses for Safeguarding are members of the Trust's Safeguarding Committee. The Adult Designated Nurse attends the Safeguarding Learning and Improvement Panels (sub-panel to the Serious Incident panel) in an advisory capacity.

In March 2023 the Trust underwent a Well-Led CQC inspection and there was a focus on the governance processes in relation to Safeguarding. The teams were able to answer queries from inspectors giving data to evidence information provided. There was a particular focus on learning from safeguarding adult hospital cases and the Team were able to demonstrate how learning is cascaded out across the Trust. We keenly await the final report to see if there are any requirements from CQC in relation to Safeguarding Adults practices in the Trust.

Learning Disability

The Learning Disability Liaison Nurse (LDLN) has continued supporting people with a learning disability (PWLD) throughout this past year and is proactively supporting patients to attend our Hospitals ensuring that reasonable adjustments are put into place.

The Venepuncture Pathway is working well and has supported some very challenging patients to have the array of tests that they have required under one sedation or General Anaesthetic. Trust

teams are very keen to make these reasonable adjustments to assist PWLD who may struggle to access hospital services for procedures such as blood tests, CT Scans and diagnostic testing.

The LDLN continues to support the LeDeR process on behalf of the Trust and has set up an Acute Hospitals LeDeR group to discuss processes, cases and outcomes.

The LDLN has been involved in piloting the new Mandatory Oliver McGowan Learning Disability and Autism training and the Trust awaits further updates on how this training will be implemented. The E-learning has been included on the MTW Learning and Development portal for staff to access – this is entry level training for all staff to access. The LDLN is liaising with colleagues in the ICB about how the different tiers of training are expected to be provided within the Trust and will keep key players in the Trust updated.

It is known that the Oliver McGowan LD Training will be mandatory.

The LDLN has assisted PWLD in paediatric services and is now assisting with the Transition of children to adult services. This work is ongoing and a scoping paper will be presented to the Safeguarding Committee to highlight the requirements and resources that might be required.

A good patient experience is key for PWLD when they access our services and the LDLN is forging good partnership working with the Patient Experience Lead within the Trust. Alongside this there has been a lot of work completed with our Community LD Nursing colleagues especially in relation to complex patients and development of individual complex care plans for PWLD. This has helped our community colleagues to understand pathways into the Acute Trust.

The LDLN devised and presented Learning Disability training to Trainee Doctors at Canterbury Christchurch University and this was well-received by the participants.

Work continues on the NHS Improvement and NHS England LD Benchmarking project.

The LDLN provides a full report inclusive of action plan to the Safeguarding Committee in relation to the learning disability standards and how the Trust benchmarks against other Trusts.

Accessible Information is key for PWLD and as such the LDLN has been involved with the Accessible Information Standards group and has formed a sub-group with PWLD and their carers to check through developed Accessible information to ensure it truly is accessible.

The LDLN has continued to offer advice and support to patients with autism. However, this is not within her remit.

The LDLN continues to work on the agreed LDLN workplan which reflects the standards set out in the NHS Learning Disability Improvement standards and covers or touches on the following: -

- Review outcomes and experiences of PWLD in hospital.
- Facilitate and prompt use of accessible information
- Implement reasonable adjustments
- Support LeDeR reviews and investigations
- Monitor and review DOLS including use of restrictive practices
- Promote anti- discriminatory practice
- Ensure patients with LD are flagged on the hospital database
- Prompt positive outcomes and benefits of LD champions and dedicated LDLN role
- Provide LD and Autism awareness training
- Work jointly patients, carers and families to improve outcomes for PWLD
- Review and support learning from complaints / feedback
- Empower patients with LD
- Support safe discharge planning
- Liaise with community mental health and LD teams as appropriate to ensure safe discharge
- Raise awareness of STOMP, STAMP and support facilitation of this in the hospital setting
- Ensure a workplan is in place to support the development of the Learning Disability Nursing role.

For the purpose of this work plan “review” is defined as: care planning, advising, MDT working (with community practitioners, family, IMCA’s, carers etc.), liaison, signposting to or creating easy read patient information.

Appendices:

Appendix 1

Individual Named Professionals Responsibilities:

The Named Nurse Safeguarding Adults has individual responsibility for:

- Policy and procedure development and review, ensuring that Trust policies are in line with both the Care Act (2014) and the Kent & Medway Safeguarding Adults Policy and Procedures; also - MCA, Consent, DOLS (to include Liberty Protection Safeguards) and Physical Restraint.
- Mental Capacity Act Lead for the Trust, which includes the Deprivation of Liberty Safeguards/LPS agenda.
- Internal Management Review (IMRs) - author of IMRs in response to requests for the preparation of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)
- Represents the Trust at KMSAB sub-groups
- Attends and chairs the Adult Heath Reference Group meetings
- Attends the Mental Capacity Act Local Implementation Network (MCA LIN).
- Oversees the Learning Disability agenda and line manage the Disability Liaison Nurse
- Safeguarding supervision: provides supervision to staff involved in complex or serious safeguarding cases.

The Named Nurse for Safeguarding Children leads on the key areas of work necessary to safeguard children at risk. These include:

- Named Nurse for Children in Care – responsible for ensuring that the Trust recognises the uniqueness of a child who is (or has been) in care and ensures that the appropriate support is available, and that local and national policies and guidelines are followed
- Policy and procedure development and review in line with the current legal frameworks applicable to children
- Agency Author for Rapid Reviews, Child Safeguarding Practice Reviews and Domestic Homicide Reviews that involve a child
- Represents the Trust at (amongst others) Kent and Medway Joint Exploitation Group, Health Reference Group, and the Emerging Themes Sub-group. the Named Nurse will also deputise for the Executive Lead for Safeguarding as requested.

- Safeguarding supervision: provides mandatory supervision to those staff identified as requiring it (e.g., Midwifery staff, Paediatric staff, NICU and ED staff); also provides supervision and debriefs to staff involved in complex or serious safeguarding cases.
- Ensures that all processes for reviewing Child Death are adhered to (in conjunction with the Named Doctor for Child Death and the Paediatric Head of Service)
- Line manages the Safeguarding Children Nurse Specialists,
- Safeguarding Audits in the Paediatric Department
- Coordinates the discharge of children who have complex and/or Mental Health needs within the trust

The Named Midwife for Safeguarding has specific responsibility for the safeguard of adults, children and the unborn child during the Maternity Continuum. These include:

- Undertake the role of Reviewing Officer when there is a Safeguarding Children Serious Case Review in conjunction with the Safeguarding, Named Nurse and the Named Doctor to ensure the actions of Serious Case Reviews are implemented in the Trust as appropriate.
- Facilitate delivery of high-quality safeguarding services for children to agreed quality standards which comply with all national legislation, local policy and guidance across the Trust.
- Ensure there is a robust training strategy and training programme to meet educational/training requirements across the Trust by developing planning, co-ordinating and reviewing Trust-wide training in collaboration with the Safeguarding Adults and Children's teams as appropriate.
- Lead on, in conjunction with the Deputy Chief Nurse, Director of Midwifery, Head of Midwifery, and Named Nurse for Safeguarding Children the strategic development of safeguarding children in the Maternity Services and ensure compliance to all key performance indicators.
- Undertakes and contributes to Local Child Safeguarding Practice Reviews, Individual Case Management Review, Individual agency reviews, Internal Management Reviews, and Child Death Reviews where requested.
- Co-ordinates, develops and contributes to the development, implementation and

NHS
Maidstone and Tunbridge Wells NHS Trust

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 on the process and timeline for developing provider collaboratives, and a focus on the key priorities for WK HCP.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 19/09/23

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

The support the next steps.

[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

ICB and West Kent HCP update

August 2023

Provider Collaboratives

How we're developing the plans

Define system elements	Establish scope and depth of collaboration	Develop indicative timeline and ownership	Describe how collaboratives will deliver roadmap
Confirm definitions of PCs in Kent and Medway – particularly in relation to HCPs and the ICB	*Map national and local programmes – to include pathway programmes and CEO initiatives / CFO initiatives and determine which are in scope of PCs (using defined criteria from last workshop)* *Define the depth of the collaboration required on each PC initiative*	*Define which collaboratives lead each deliverable* *Define timescales for delivery*	*Describe delegation and accountability* *Define reporting and governance structures* *Describe resources needed*

Plan on a page for PCs

- **July 31** – Chairs / CEOs; ICB mobilisation plan agreed; Mobilisation Plan Agreed
- **Aug 24** – Chair Meeting; Progress review
- **Sept 25** – Chairs / CEOs
- **Oct 20** – Sustainability & Transformation Board
- **Nov 7** – Integrated Care Board

West Kent HCP Area Profile

Indicator	Compared to England
School readiness	Better
Average Attainment 8 score	Better
Pupil absence	Better
Unemployment	Better
Children living in relative poverty	Better
Fuel poverty	Lower
Homelessness	Better
Violent crime	Similar
Life expectancy (male)	Better
Life expectancy (female)	Better
Smoking prevalence	Better
Adult excess weight	Similar
Year 6 excess weight	Better
Physical inactivity	Better
Alcohol admissions	Better
Air pollution	Not compared
Prescribed antibiotics	Similar
Breast cancer screening	Better

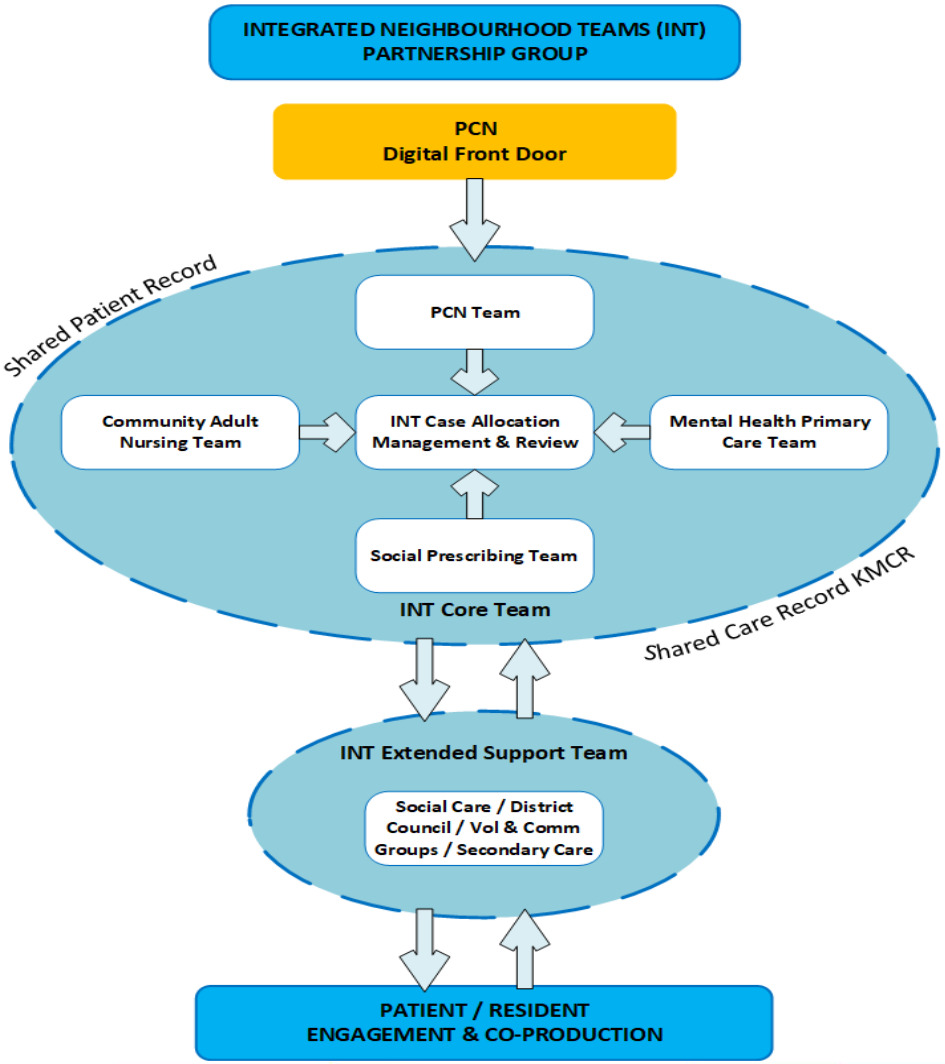
Indicator	Compared to England
Cervical cancer screening	Better
Bowel cancer screening	Better
Infant mortality	Better
Low birth weight	Better
AE attendances (0-4 yrs)	Worse
Dental decay (5 yrs)	Better
Under 18s conceptions	Similar
Asthma admissions (<19 yrs)	Better
Epilepsy admissions (<19 yrs)	Better
Diabetes admissions (<19 yrs)	Similar
Mental health admissions (0-17 yrs)	Better
Self-harm admissions (10-24 yrs)	Worse
Substance misuse adms (15-24 yrs)	Similar
Hypertension prevalence	Similar
Diabetes prevalence	Lower
CHD prevalence	Lower
CKD prevalence	Higher
Stroke prevalence	Similar

Indicator	Compared to England
Circulatory mortality (<75 yrs)	Better
Cancer mortality (<75 yrs)	Better
ACSC admissions	Better
Depression prevalence	Higher
Serious mental illness prevalence	Lower
Suicide (persons)	Worse
Suicide (male)	Similar
Dementia diagnosis rate	Not compared
Falls admissions (>65 yrs)	Worse
Hip fracture admissions (>65 yrs)	Similar
Osteoporosis prevalence	Higher

This information has helped shape the HCP work programme

West Kent Projects & Programmes	What we are doing now
Frailty & Adults Complex Needs	▪ Community falls prevention to reduce conveyances to ED ▪ Step down from hospital Virtual Wards ▪ Single point of access
Adults & Children's Mental Health	▪ Dementia diagnosis (exploration of DiADeM tool) ▪ Self-harm prevention ▪ Serious mental-illness ▪ LD Health Checks
Integrated Neighbourhood Teams	▪ Defining how the system works together on managing complex needs and embedding prevention ▪ A focus on wider health and wellbeing support ▪ Social prescribing and care navigation ▪ Addressing inequalities through shared data to inform local needs at a neighbourhood level ▪ Developing a representative Resident and Community Forum in each INT
Primary Care Demand and Capacity	▪ Establish a clear picture of the demand and capacity of each GP Practice in West Kent ▪ Build a comprehensive data system that can report at HCP level to better understand and manage demand and capacity
Maidstone Inequalities	▪ Targetting specific communities through wider determinants ▪ Tackling food insecurity
Discharge & Flow	▪ Developing better use of shared resources ▪ Establishing a single version of the truth through data to facilitate the patient journey towards discharge
Long Term Conditions	▪ Early identification (COPD, Cardiac and Pulmonary Rehabilitation) ▪ Proactive management of long-term conditions
Workforce	▪ Developing skills to enhance care support and deliver of key initiatives (i.e. social prescribing, support PHM and Prevention)
Digital & Data	▪ Embed better use of technology to provide community support ▪ Facilitate information sharing protocols to develop a reliable shared data set

Development of Integrated Neighbourhood Teams (INTs)



Digital Front Door

- A digital front door is an online platform that serves as the first point of contact between patients and healthcare. This is a technology-based triage system that will contribute to the development of integrated neighbourhood teams and improve access and patient experience. The system selected by the Tunbridge Wells PCN is Anima as it best meets the specification developed with local clinicians. Anima uses Artificial Intelligence to sort patient requests as they come into the practice/PCN from a range of entry points (telephone, face to face and electronic requests). This system has been tried and tested in a number of individual practices nationally and locally (Reach Health – Chatham).
- Tunbridge Wells PCN are planning to introduce Anima across several self-nominated practices in the PCN (all practices in the PCN will have a nominated rep on the project group to follow the development even if they are not in the first phase of implementers) but this group will also incorporate an element of wider stakeholder engagement in the process for example social, secondary and community care provider representatives. For example, MTW will be engaged in the design phase to ensure the Anima design set up will enable direct access referrals to various secondary care clinics and the community diagnostic centre. Similarly, the work will maintain close links with the PCN that is testing the core and extended team aspects of the INT model in West Kent working closely with social care. The Wells Medical Practice, Waterfield House Surgery and Kingswood Surgery have nominated themselves for phase one. The expected benefits are improved access with the same resources, improved experience, improved understanding of patient need and unmet demand and improved cross sector collaboration.

anima

Risks and challenges

- *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

Responsible Officer's Annual Report 2022/23 **Medical Director**

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

The appraisal year for doctors runs from 1st April to 31st March. At Maidstone and Tunbridge Wells NHS Trust medical appraisals are conducted every month except August

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

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 2023).

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

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

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

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

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

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

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

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

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

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

Designated Body Annual Board Report

Section 1 – General:

The board / ~~executive management team~~ of Maidstone and Tunbridge Wells NHS Trust (MTW) can confirm that:

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

Action from last year: None Comments: Dr Peter Maskell, Medical Director fulfils these requirements. As required he attends Responsible Officer (RO)/Medical Director (MD) training and meetings. Action for next year: Dr Sara Mumford fulfils these requirements and will take over as Responsible Officer on 1st October 2023 on appointment as Medical Director

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

Yes/~~No [delete as applicable]~~ Action from last year: To review annually the number of appraisers and when need to train new appraisers. Comments: The RO is supported by the Trust Appraisal Lead, the Appraisal and Revalidation Manager and Appraisal and Revalidation Coordinator (appraisal team). MTW NHS Trust has 77 appraisers (70 Consultant and 7 SAS doctors). Action for next year: MIAD training for 15 additional appraisers has been organised for the Autumn of 2023.

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

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

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

Action from last year: To present the completed updated policy Comments: The appraisal policy update is in progress. Action for next year: To present the completed updated policy

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

Actions from last year: None Comments: All appraisals are reviewed by the appraisal team. The two-stage sign off process for quality appraisals has been introduced – 1st review by Appraisal and Revalidation Manager and 2nd review by Trust Appraisal Lead. Final ratification by the Chiefs of Service, MD and Deputy Medical Director qualify the revalidation processes in place. Annual data is presented at the appraiser update training session and to the RO. Action for next year: External audit for new processes (L2P)

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

Action from last year: None Comments: MTW encourages all doctors to make the most of all development opportunities available to them. In house CPD is accessible to all doctors employed by MTW. All doctors are invited to attend annual appraisal training. This training explains the MTW appraisal system and how to use development opportunities within the Trust. Written information is circulated after the meetings. Action for next year: Ongoing

Section 2a – Effective Appraisal

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

Action from last year: To review and potentially introduce L2P appraisal 2022

Comments: The web based L2P appraisal system includes checklists to ensure that the relevant supporting information is uploaded and reflected on. The appraisal team review all appraisals and any requiring correction or additional information are referred back.

L2P allows doctors to upload their appraisal portfolio to the system. The two-stage approval process allows for identification of missing information. Appraisals are then referred back for the information to be added before approval by the appraisal lead.

All appraisals are reviewed to ensure that whole scope of practice is included.

The introduction of L2P in September 2022 and the change to an all year-round rolling appraisal calendar resulted in some doctors having a period of greater than 12 months between appraisal for the first appraisal after implementation. This has impacted on the number of appraisals completed in year.

The 2022 appraisal model was reviewed and a decision made not to adopt the 2022 model at this time.

Action for next year: Monitor appraisals and reduce number referred back for additional information.

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

Action from last year: To review and potentially introduce appraisal 2022

Comments: See 2a, section 1 above

Action for next year: None

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

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

Action from last year: To present an updated appraisal policy Comments: The appraisal policy update is in progress. Action for next year: To present an updated appraisal policy

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

Action from last year: None Comments: MTW has 77 trained medical appraisers and approximately 630 doctors for appraisal i.e. typically – 8.2 appraisals per year. The number of doctors for whom MTW is the designated body responsible for appraisal and revalidation, has increased significantly. Many appraisers may retire from the Trust during the next 12 months, therefore to maintain an achievable target of 6 appraisals per year, the Trust will need to train more appraisers. MIAD training for new appraisers booked for November 2023 Action for next year: Organise MIAD New Appraiser training for a further 15 appraisers in Summer 2024 to ensure necessary numbers.

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

Action from last year: None Comments: Annual update training sessions are delivered by the Appraisal Lead and there are quality assurance systems that provide feedback of performance to appraisers. Appraisees are asked to give feedback on their appraisal meetings via the L2P system and feedback has increased using the online system. Action for next year: Monitor appraisee feedback and report to appraisers and the RO.

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

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

Action from last year: None Comments: All appraisals are reviewed and quality assured by the appraisal team and annual data is presented at the appraiser update training sessions and to the RO. Action for next year: Ongoing

Section 2b – Appraisal Data

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

Name of organisation: Maidstone and Tunbridge Wells NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	**588**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**332**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**14**
Total number of agreed exceptions	**7**

Section 3 – Recommendations to the GMC

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

Action from last year: None

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

Action for next year: Ongoing

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

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

Section 4 – Medical governance

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

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

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

Action from last year: None Comments: Doctors discuss conduct and performance at their appraisal. The appraisal team add a note to the doctor's appraisal to ensure specific issues, for example complaints and Serious Incidents, are discussed during the appraisal meeting. Action for next year: Ongoing

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

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

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

Action from last year: None Comments: MTW have existing processes in place for responding to concerns about doctors which includes Non-executive director oversight Action for next year: Ongoing

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

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

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None Comments: MTW have existing processes in place to ensure safeguards exist and are free from bias and discrimination Action for next year: Ongoing

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None Comments: Processes are in place at MTW to undertake all mandatory pre-employment background checks before an individual's start date to ensure licenced medical practitioners are qualified and experienced for the role. The HR team do pre-employment checks and the Appraisal and Revalidation manager ensures that doctors are connected to the Trust and re-checks their status in a timely manner. Any non-compliance with this process is thoroughly investigated and lessons learned Action for next year: Ongoing

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

Actions completed

- Training has been organised for new Trust Appraisers in November 2023.
- Appraisal 2022 was reviewed and the Trust will continue with current appraisal form.

Actions still outstanding

- The updated MTW revalidation and appraisal policy is in progress following the introduction of the L2P system.
- A process has been introduced to highlight to an appraiser where an appraisee has been involved in an SI or complaint. Trust systems currently do not allow the identification of all doctors involved in a complaint (only those upheld) and key activity data is not available for all doctors. The appraisal team aim to develop the key dataset with a long-term plan to provide this for all doctors ahead of their appraisal meeting.

Current Issues

- Ensuring that all appraisals include key information; completion of mandatory training, Governance forms from non-NHS organisations etc. Requests for this information have been included in a bespoke checklist included in the L2P system

New Actions:

- Arrange external audit of L2P system
- Monitor appraisals and reduce number referred back for additional information.
- Organise MIAD New Appraiser training for a further 15 appraisers in Summer 2024.
- Monitor appraisee feedback and report to appraisers and the RO.

Overall conclusion:

The introduction of the new web based L2P appraisal system has been well received by most doctors.

The number of medical practitioners for whom MTW is now the designated body, responsible for appraisal and revalidation, has increased significantly in the past year and therefore the expansion of the appraisal team has helped to ensure all doctors have quality assured appraisals and the necessary paperwork for revalidation recommendations to be submitted promptly to the GMC.

Section 7 – Statement of Compliance:

The Board ~~/ executive management team~~ of Maidstone and Tunbridge Wells NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman (or executive if no board exists)

Official name of designated body: Maidstone and Tunbridge Wells NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

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

Publication reference: PR1844

Appraisal Report

2022-23

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Overview of appraisal 2022-23

- Dr Derek Harrington stood down as Trust Appraisal Lead, December 2022
- Dr Lesley Navaratne took up the role in April 2023
- Interregnum managed by the Deputy Medical Director assisted by the Chiefs of Services
- Jagdish Sandhu appointed as Appraisal and Revalidation coordinator
- Electronic L2P system embedded in the Trust

77 Trust appraisers

- 70 Consultants
- 7 SAS doctors

590 connected doctors

- 337 due an appraisal in 2022.23
- 7 on approved leave; 40 new doctors

April 2022 - March 2023

Revalidation Recommendations

- 64 positive recommendations to the GMC
- 20 deferrals – most for lack of a 360
- 0 non-engagement

31st March 2023

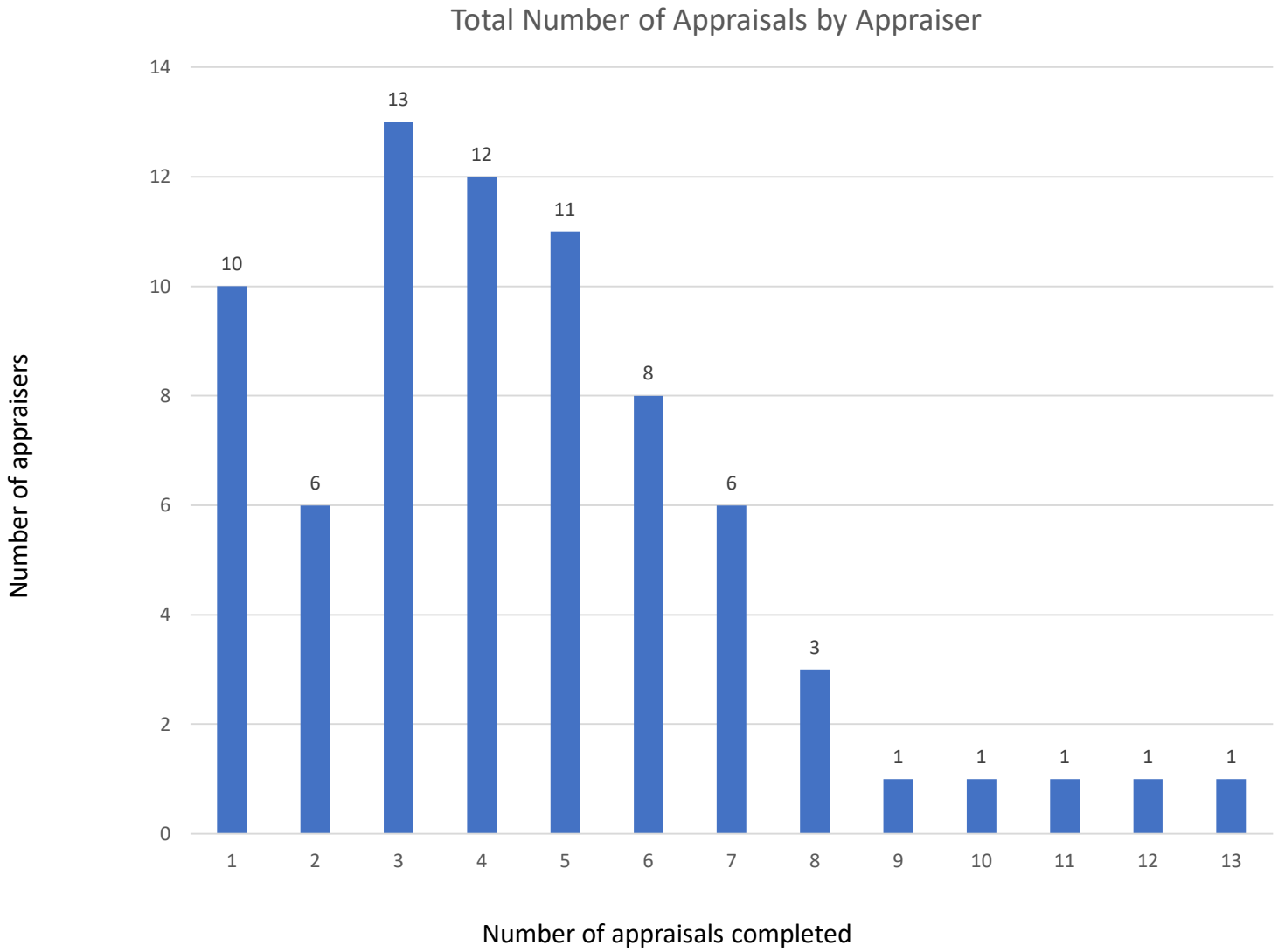
- 94.07 % appraisal rate
  - 95.94% Consultants
  - 93.85% SAS
  - 89.33% Locums (short term contracts)

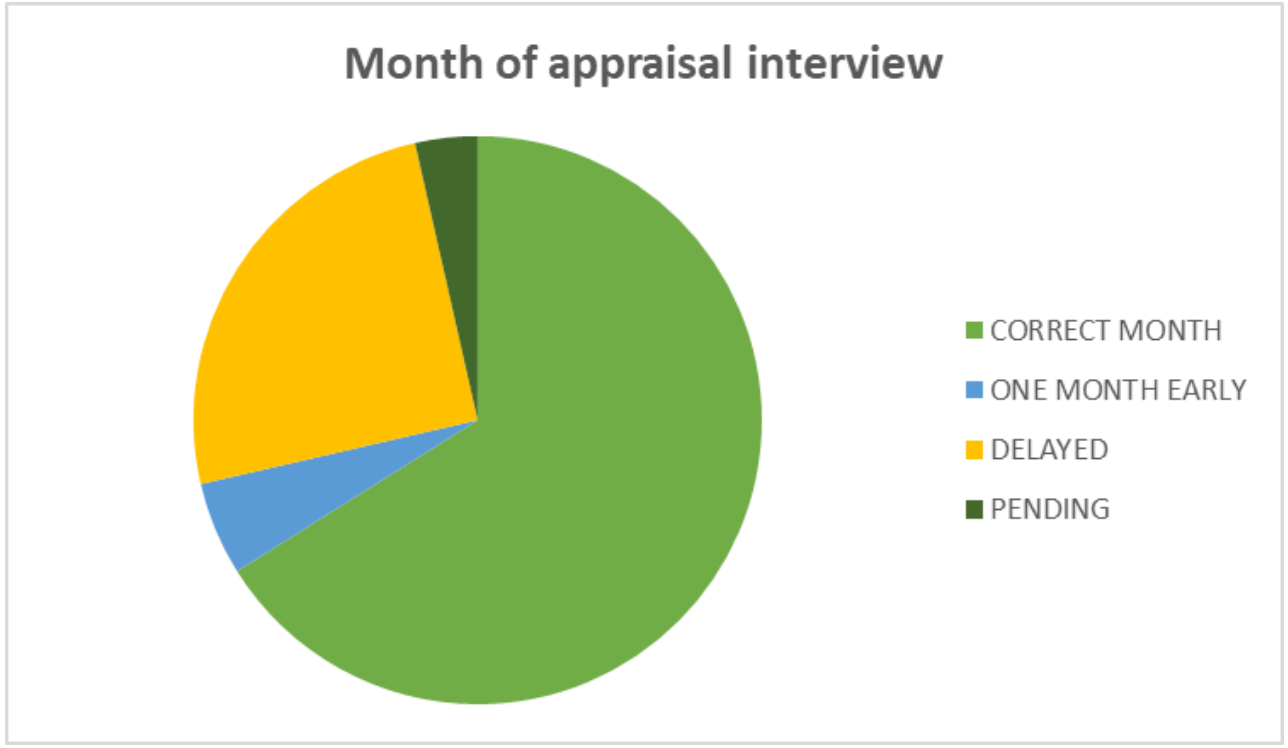
31st July 2023

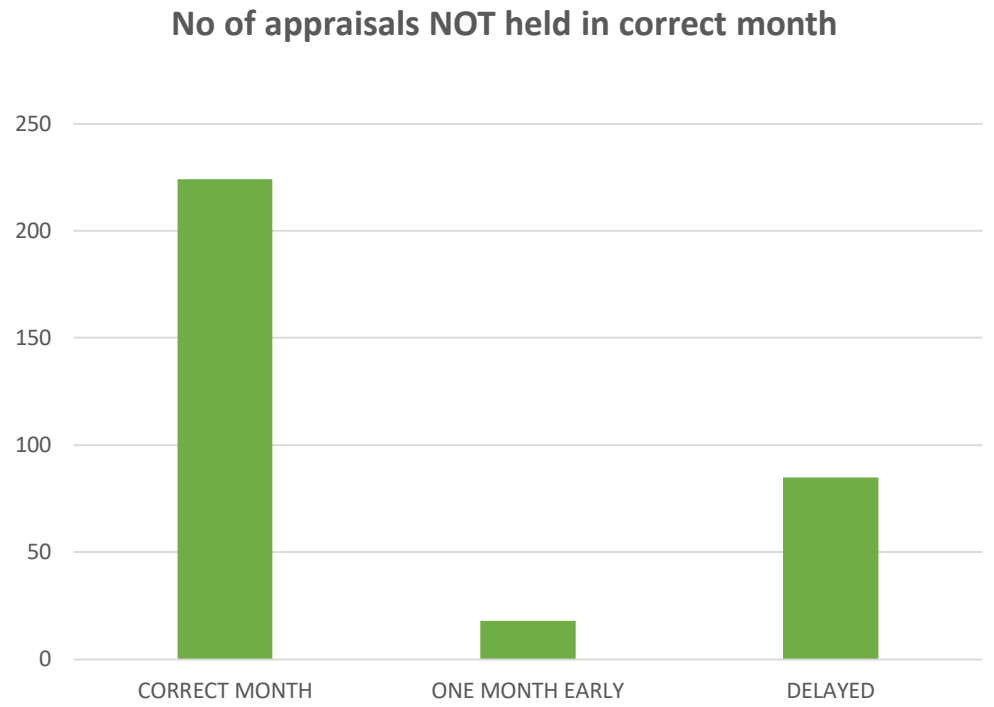
- 98.52% appraisals completed
  - 97.97% Consultants
  - 100% SAS
  - 98.67% Locums (short term contracts)

31st August 2023

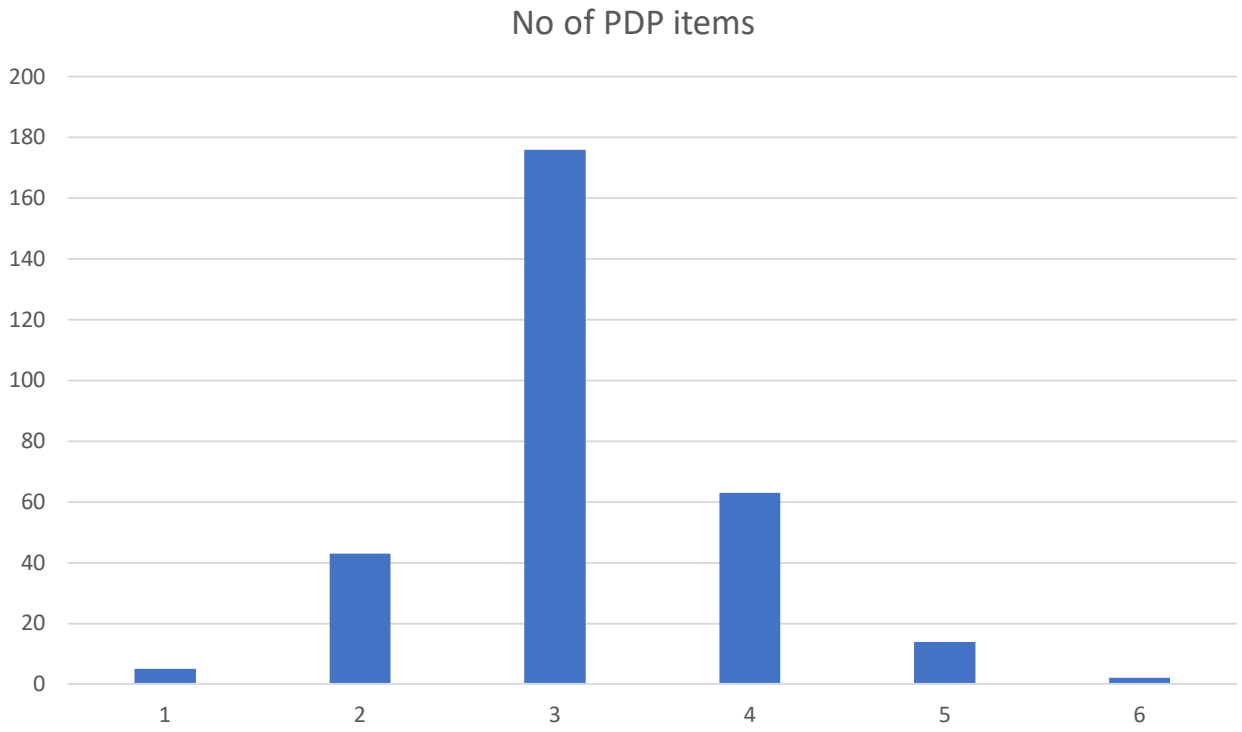
- 5 did not have an appraisal – 5 unapproved missed


Total Number of Appraisals by Appraiser
Number of appraisers
Number of appraisals completed
14
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
10
11
12
13
10
6
13
12
11
8
6
3
1
1
1
1
1


Month of appraisal interview
CORRECT MONTH
ONE MONTH EARLY
DELAYED
PENDING

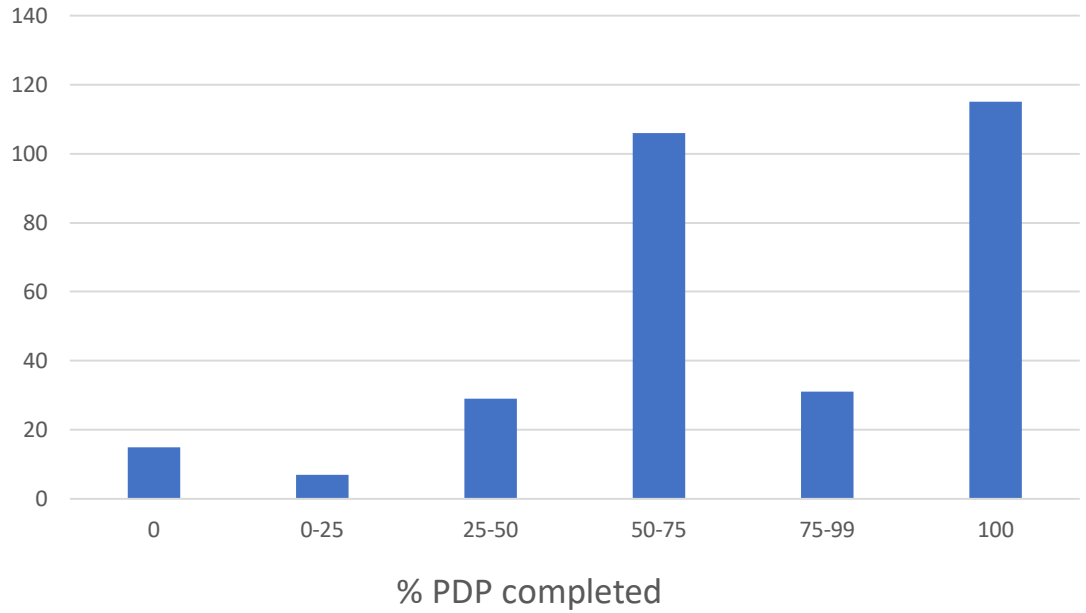

No of appraisals NOT held in correct month
250
200
150
100
50
0
CORRECT MONTH
ONE MONTH EARLY
DELAYED

N = 303 appraisals



PDP

- Mean planned 3.14 (3.3)
- Mean achieved 2.25 (2.5)



L2P

- System live 01/09/2022
- Well received by doctors
- Supporting information to be uploaded
- Appraisal team can upload information
- Checklists included
- Auditable compliance data
- Automated reminders

Key messages from appraisal

- 332 appraisals reviewed for 2022.2023
- The Trust introduced a year-round appraisal system from September 2022.
- 204 Doctors' appraisal months were moved in to the next reporting period.
- All doctors who held an appraisal between September 2022 and March 2023 used the web based L2P appraisal system. The MAG 4.2 form is no longer is use or supported by NHS England.
- The range of appraisals per appraiser was 1 – 13 with a mean of 4.215 (17/77 appraisers held more than 6 appraisals meetings).
- Approximately 1/4 of appraisals were late compared to 1/3 in 2021.2022.
- Mean PDP planned was 2.87 (3.3 - 2021.2022) and mean PDP achieved was 71% (75% - 2021.2022).

Key themes from appraisals:

- More doctors reported wellbeing concerns. Some but not all relating to ongoing hospital pressures and discussion on reducing clinical sessions was a common theme.
- CPD activity was increased compared to 2021.2022 but on-line learning remains significant and most supporting evidence remains verbal
- The majority of agreed PDPs are appropriate with mandatory training and out of work activity now infrequently seen.
- There is variation in the detail reported in appraisals. The majority are sufficient but some have limited discussion of the appraisal. Where appraisals are very limited this is fed back to the appraiser. The L2P appraisal system sets up the requirements of supporting information and provides prompts for a more detailed appraisal discussion to be documented.

Action Plan 2023-24

Action/Issue	Action required	Responsible person	Target Date	Progress
Review of Medical Appraisal policy	Review appraisal policy to include changes to appraisal process and introduction of electronic system	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	December 2023	Review in progress
Increase number of new Trust medical appraisers	Provide New Medical Appraiser training	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	July 2024	First round of New Appraiser training booked with Miad Healthcare November 2023 Additional training TBC for 2024
Ensure all new doctors are promptly connected to MTW	Review process with Bi team and amend as needed	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	July 2024	

Action Plan 2023-24

Action/Issue	Action required	Responsible person	Target Date	Progress
Reduce number of deferred appraisals	Promote and deliver medical appraisal virtual drop in sessions for Doctors to discuss any concerns	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	March 2024	
Encourage out of specialty appraisals by all Doctors at least once during revalidation cycle	Deliver feedback on medical appraisal outputs at specialty Clinical Governance meetings	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	December 2024	
Review available 360 patient and colleague feedback systems for cost efficiency to support increasing number of medical doctors working at MTW	Review and meet with alternative 360 patient and colleague feedback providers for medical appraisal	Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager	December 2024	

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Trust Board meeting – September 2023

NHS Maidstone and Tunbridge Wells NHS Trust

Health & Safety Annual Report, 2022/23 and agreement of the 2023/24 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)	**Risk and Compliance Manager / Trust Health and Safety Advisor / Director of Emergency Planning and Response**

This report has been prepared by the Trust's Competent Persons for the Board. The Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Formerly delegate the management to the Health and Safety Committee

This annual report provides:

- A review of the Trust's Health and Safety performance for 2022/23
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2022/23
- Identifies the strategy and action plan for the next year and going forward

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To discuss the report, note the role of the Board and to approve the work programme for 2023/24

[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

Attachment XX

REPORT TO:	**Trust Board**
REPORT FROM:	**Risk and Compliance Manager**
DATE:	**XXth September 2023**
SUBJECT:	**Health and Safety Annual Board Report 2023/24**

Summary / key points:

This report has been prepared by the Trust's Competent Persons for the Board.

The Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Formerly delegate the management to the Health and Safety Committee

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- Identifies the strategy and action plan for the next year and going forward

The data shows that around 18.4% of reported incidents relate to staff, Trust and public, with 81.6% relating to patients. There are many programmes and initiatives focused on patient safety so this report focuses more on issues relating to staff and public safety.

Reviewed by: Director of Operational Nursing (Chair of the Health and Safety Committee)

Reason for receipt by the committee:

- It is important that the Trust identifies and manages health and safety risks

Action required by the committee:

1. To discuss the report and note the role of the Board.
2. Accept the work programme for 2023/24.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2023/24

Requested/ Required by: Trust Board and the Trust Management Executive
- Health and Safety at Work etc Act 1974.
- Management of Health and Safety at Work Regulations 1999.

Main author: Risk and Compliance Manager (Rob Parsons)
Contact Details: rob.parsons@nhs.net

Other contributors:
Head of Fire and Safety
Trust Health and Safety Advisor
Occupation Health Lead Nurse
Head of Security Management
Radiation Protection Adviser (RPA)
Lead Nurse for Falls Prevention
Vascular Access Specialist Practitioners
Moving and Handling Advisor
Water Hygiene Manager

Document lead: **Chief Operating Officer**
(Board lead for Health and safety)

Directorate: Clinical Governance

Health and Safety – Annual Board Report and Programme for 2023/24

Requirement for document:	This annual report and programme: • Reviews the Trust's health and safety statistics and performance for 2022/23 • Makes an assessment against objectives and KPIs set in the previous year • Gives a discussion into key health and safety issues identified within the year • Is a discussion document for the Board to determine the objectives and 2023/24 KPIs • Identifies the strategy and action plan for the next year and going forward
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by Trust key policies and procedures: • Health and Safety Policy and Procedure • Risk Management Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016
18	Sixth annual Board Report	August 2017
19	Seventh annual Board Report	August 2018
20	Eighth annual Board Report	August 2019
21	Ninth annual Board Report	August 2020
22	Tenth annual Board report	August 2021
23	Eleventh annual Board report	August 2022
23	Twelfth annual Board report	August 2023

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7 Summary and Conclusions 21
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1. Executive Summary

Introduction

This report informs the Board on health and safety performance and provides the level of assurance to lead the strategy moving forward:

- Discuss and agree the Trust's health and safety objectives
- Formerly delegate the management of health and safety performance and strategy to the Health and Safety Committee

This annual report provides:

- A review of the Trust's health and safety statistics and performance for 2022/23.
- Assessment against objectives and KPIs set in the previous year.
- Discussion of the key health and safety areas identified within the year.
- Discussion document for the Board to determine the objectives and KPIs for 2023/24.
- Identifies the strategy and action plan for the next year and going forward.

Staff, Trust and public incident reports account for 18.4% of the total incidents reported, with the rest patient incidents. There are many programmes and initiatives for patient safety so this report concentrates on staff, contractor and visitor safety.

Key findings

- Overall reporting rates for staff, Trust and public incidents have increased by 26.4% compared with 2021/22. Harm incidents increased by 6.9%.
- After the very large increase in violence, abuse and harassment harm incidents in 2021/22, there was a reduction of 8% in 2022/23. This is despite the overall number of incidents (including near miss and no harm) increasing by 53.5% from 426 to 654. This indicates improved reporting practises.
- There was an increase of between 25% and 35% in three of the five most common harm incident categories, more than the overall upward trend in reports.
- Moving and handling saw a reduction in harm incidents by 28%. However, few near miss or no harm incidents were reported, and there were six moving and handling-related RIDDOR incidents.
- The number of incidents reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) decreased by one to 21 in 2022/23.
- The number of over 7-day injuries increased to 14, along with five specified injuries (no change) and a reduction in the number of dangerous occurrences, with two.
- Slips, trips and falls accounted for eight of the RIDDOR incidents, including all five specified injuries. Facilities has the most RIDDOR reportable incidents with four. Acute Medicines and Geriatrics, Emergency Medicine, Estates and Imaging all had three RIDDOR incidents each.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.

2. Introduction

The Trust has a duty to ensure the health, safety and welfare of employees and others affected by its undertaking so far as is reasonably practicable. “Others” refers to contractors, volunteers, visitors, patients etc. Typically, patients are most likely to suffer harm in a clinical environment, and this is reflected in the incident statistics. There are numerous standards, requirements and bodies whose key role is to protect patient safety. This report will focus on staff and public safety, which, in turn, can contribute to improved patient safety.

Staff, contractor and visitor incident statistics make up 18.4% of the total incidents reported. These have been divided into groups based on severity:

- Deaths to employees, contractors and visitors (deaths at work).
- Incidents and Injuries reportable to the HSE under RIDDOR.
- All staff and public injuries.

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 94.5% of the total staff, Trust and public incidents of harm fit into these categories. This allows for bench marking against all industry and the health sector:

- Falls (staff and visitor slip, trips and falls)
- Medical Sharps (needle stick injuries)
- Violence and abuse (including physical assault and trauma).
- Struck by or collision with an object
- Moving and handling
- Contact with machinery and hot surface (includes hot liquids)
- Contact with a hazardous substance (includes biological agents)

The Trust’s Occupational Health Service undertakes health surveillance on staff to identify or prevent occupational diseases where they may arise from the employee’s work. They also maintain records of referral of staff for workplace illness.

3. Review of Objectives and Programme set for 2022/23

In September 2022 the Trust Board agreed a programme for 2022/23:

Action	Leads	Progress and Comments
Health and Safety Management		
To provide the Health and Safety Committee with assurance that all areas are appropriately managing their health and safety risks through the continued audit process via a new H&S electronic management system	Trust Health and Safety Advisor	Health and Safety Committee is provided with report at each meeting on performance as reported in H&S management system. A new system is being looked into as InPhase Health and Safety application will not be ready by the end of the year.
To provide assurance that Trust senior staff, including the Board are informed as to their Health and Safety responsibilities	Risk and Compliance Manager	Board receive annual training as part of the Annual Health and Safety Board report. There were discussions around IOSH Safety for Senior Executives or other similar training but this has not come into fruition.
To develop and pilot Health and Safety specific training for front	Trust Health and Safety	This is still in progress and will be carried forward to 2023/24.

Action	Leads	Progress and Comments
line managers to better equip them with their duties	Advisor / Risk and Compliance Manager	
To ensure that Health and Safety-related policies are up-to-date and accurately reflect current safe systems of work and process (at least five P&Ps due by 31/03/23)	Trust Health and Safety Advisor / Risk and Compliance Manager	All Health and Safety-related policies are up-to-date. Three were extended to September 2023 but revisions have been made and are on schedule for publication.
Falls		
To reduce the monthly Trust Falls rate to at or below threshold of 6.36 by March 2023 per 1000 occupied bed days (OBDs)	Lead Nurse for Falls Prevention	The aim to achieve monthly falls rate at or below 6.36 per 1000 OBDs were achieved in months November 2022, February 2023 and March 2023.
Reduction in harm rate per 1000 occupied bed days (moderate, and above) resulting from Falls against the baseline 12-month total from April 2021-March 2022	Lead Nurse for Falls Prevention	The number of falls resulting in harm from moderate and above remained at 46 in 2022/23, therefore no reduction seen. However, there was a reduction in the number of harm incidents categorised as severe and catastrophic, but an increase in the number of moderate harm incidents.
Reduction in the percentage of recurrent falls (in a single hospital episode) out of the overall total, to 25% or under by March 2023 against the baseline 12-month total from April 2021-March 2022	Lead Nurse for Falls Prevention	The reduction in the percentage of recurrent falls of 25% was not achieved.
Radiation Protection		
Complete the Business Case Outline Proposal which has been submitted for a further Principal Clinical Scientist and full business case, if approved.	Trust RPA	The business case was completed.
Proceed with classification of Nuclear Medicine staff under IRR2017, as identified in risk assessment from July 2022.	Trust RPA	A process for the classification of Nuclear Medicine staff has been put into place.
Violence and abuse		
Convert security reporting from their current in-house reporting system to Datix. This will give a far more accurate picture of violence and aggression against staff	Operational Security Manager	This was completed in November 2023. Security staff are now reporting on InPhase as part of their normal duties.
Moving and Handling		
Develop training for all areas within the Trust to meet their specific requirements needed to	Moving and Handling Advisor	Training has been developed for all areas. The next step is the roll out of the training.

Action	Leads	Progress and Comments
undertake Moving and handling tasks within their roles		
To develop a pathway for Bariatric/additional need patients coming into the Trust	Moving and Handling Advisor	Ongoing
Sharps		
To continue to monitor and review medical sharp safety devices available in the marketplace, and to advise the Materials Management team regarding suitable available alternatives during supply outages.	Team Lead Vascular Access Specialist Practitioner (VASP) Band 7	The Vascular Access Team continue to review safety devices and have had supply issues some medical sharp devices. Advice has been provided to the Materials Management team by the VASPs to ensure that the most appropriate alternatives have been procured. Training and education have been cascaded across both Trust sites where able and educational flyers provided. The use of all variations of devices have been incorporated into Trust appropriate training courses and induction programmes. There have been episodes where cannulation and venepuncture trollies have not had sharps bins attached /or there has been supply and demand issues over extended long weekends. VASPs have highlighted this to ward manages to ensure forward planning for sharp bin supplies.
To continue reviewing medical sharps incidents, providing support and training where appropriate and identifying trends that require targeted intervention.	Team Lead Vascular Access Specialist Practitioner Band 7	When clinical demand has allowed, sharps injuries have been investigated by the VASPs, with both support and supplementary education provided to individuals where it has been appropriate. There have been no identifiable trends that have raised concerns.

4. Statistics for 2022/23

The Datix incident database was interrogated for all staff/ public/ Trust incidents for the period of 01/04/2022 to 31/03/2023.

4.1. Reporting

There were 3084 staff/ public/ Trust incidents in 2022/23. This is a 26.4% increase from 2439 reported incidents the previous year, 2021/22. This was expected as activity has

increased but the level of increase is significant. There is an overall upward trend for reporting.

Harm incidents also increased compared with 2021/22, however, this was at a lower rate (14.2%) than the overall increase in incidents reported. When Health and Safety-related harm incidents are analysed, there was an increase (+6.9%) from 331 in 2021/22 to 347 in 2022/23. The overall trend for harm incidents is level when compared with the previous nine years.

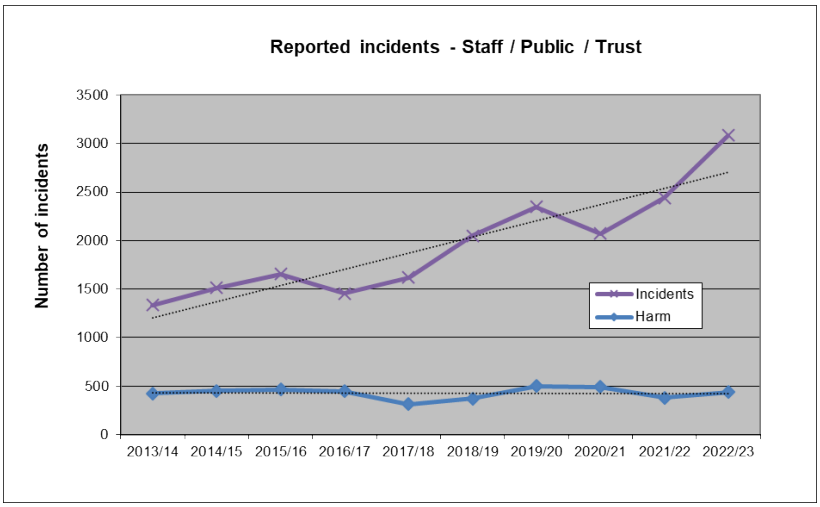


Figure one: Reported incidents and harm incidents 2013/14-2022/23

Looking at reporting rates over the last four years (see *Figure two* below), there does not seem to be a correlation between periods of increased reporting of Harm incidents and an overall increase in reporting levels in those same periods (see also *Figure three* below).

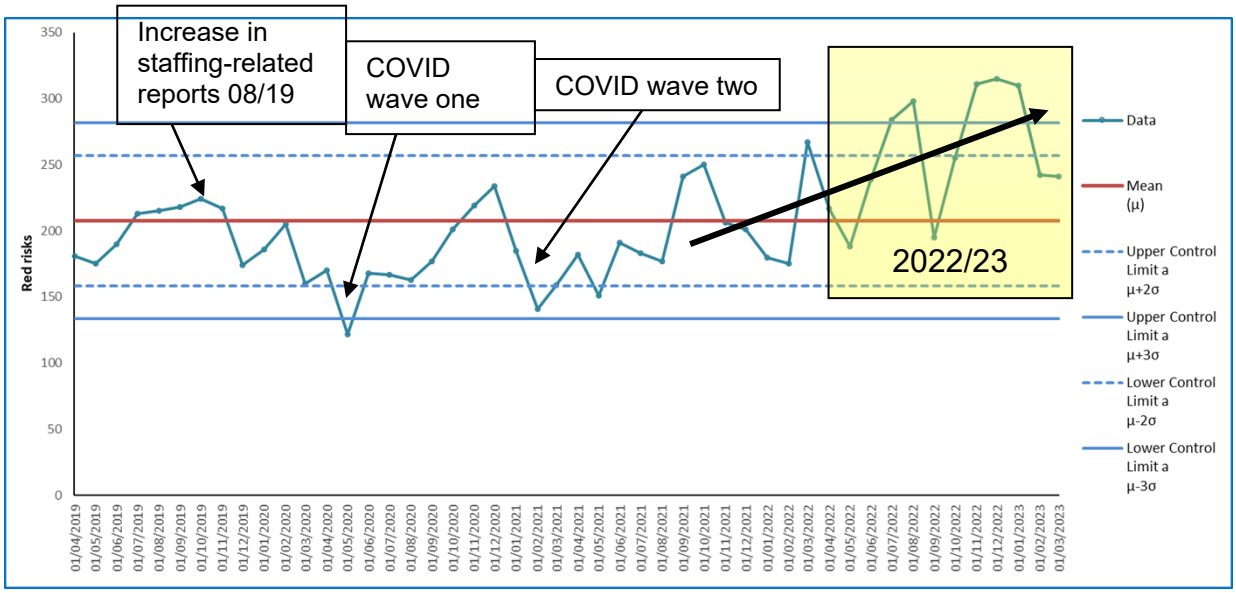


Figure two: Incident reports 04/2019-03/2023 SPC Chart

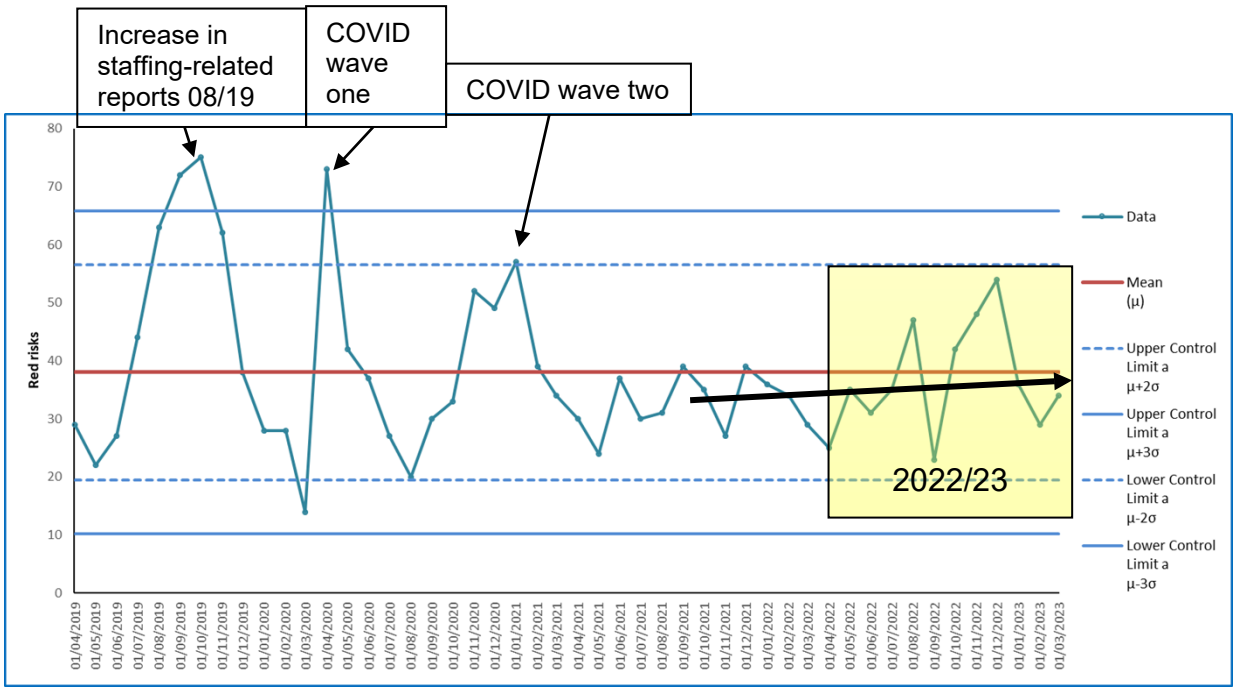


Figure three: Harm incident reports 04/2019-03/2023 SPC Chart

This suggests that when staff are under more pressure, incident reports for Harm incidents are submitted, but lower-level incident reports may not be.

4.2. Reporting of Incidents, Diseases and Dangerous Occurrences (RIDDOR) Incidents

The data for 2022/23 has been compared with the data from the previous 5 years.

RIDDOR Category	Year reported					
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
> 7-Day injury	16	15	17	12	12	14
Specified injury	3	5	5	9	5	5
Dangerous occurrences	4	6	2	0	5	2
Occupational Disease (not COVID)	0	0	0	1	0	0
Accidental death	1	0	0	0	0	0
	24 ↓	26 ↑	24 ↓	22 ↓	22↔	21↓

The Trust submitted 21 RIDDOR reports in the year at an average of 1.75 per month. This is one fewer than the previous year.

66.7% were submitted within HSE timescales, which is a decrease from 68.2% in 2021/22 and remains a concern. The proportion of over 7-day injuries remains higher than the other categories, which has had an effect on the percentage of reports submitted within HSE timescales. There have been communications to managers reminding them of RIDDOR timescales and reporting criteria and incident reports are monitored and chased if there are suspected RIDDOR incidents.

66.6% of RIDDOR reports were over 7-day injuries, an increase from the previous two years. Of these 14 incidents, six were primarily caused by moving and handling (four during patient handling, two non-patient handling), three were caused by slips, trips and falls, one was a collision with another person, one was as a result of a crush injury, one struck by a dropped cylinder, one trap in a closing door and one as a result of an injury suffered during a patient assault.

There has been no change in the number of specified injuries, with five. All were fractures as a result of slips, trips and falls.

There was one RIDDOR incident involving a member of the public, a slip and trip resulting in a fracture, compared with one in 2021/22.

There has been a decrease in the number of dangerous occurrences from five in 2021/22 to two in 2022/23. These were both as a result of needle stick injuries leading to exposure to known blood-borne viruses (BBV).

4.3. Categories of incidents resulting in harm

Harm incidents increased by 14.2% from 380 in 2021/22 to 434 in 2022/23. Directly Health and Safety-related harm incidents increased by 6.9% from 331 to 347.

The eight largest categories, in line with seven of the categories used by the HSE in their national statistics, make up 100% of all directly health and safety-related harm incidents. Five of these categories have seen an increase from the previous reporting year. Violence, abuse and harassment harm incidents have seen a decrease, as have moving and handling harm incidents.

	2021/22 (Harm)	% of total (2021/22)	2022/23 (Harm)	% of total (2022/23)	Change
Slips, trips and falls	51	15%	68	19%	+33%
Sharps (medical)	60	18%	75	21%	+25%
Violence, abuse and harassment	112	34%	103	29%	-8%
Collision, trap or struck by an object	34	10%	46	13%	+35%
Moving and handling	43	13%	31	8%	-28%
Contact with machinery or hot surface	7	2%	10	3%	+43%
Contact with hazardous substance	2	0.6%	5	1%	+150%
Cuts non-medical sharps	16	5%	16	5%	+/-0%
Others	6	2%	0	0%	-%
	331		**354**		+6.9%

The number of incidents categorised as ‘Other’ decreased to zero as all harm incidents were able to be categorised within the eight main categories.

There remains a discrepancy between sharps injuries reported and occupational health attendances (see **Section 5.4.3** below).

The chart below (figure four) compares 2022/23 incidents of Harm by type with injuries / Harm in the previous five years:

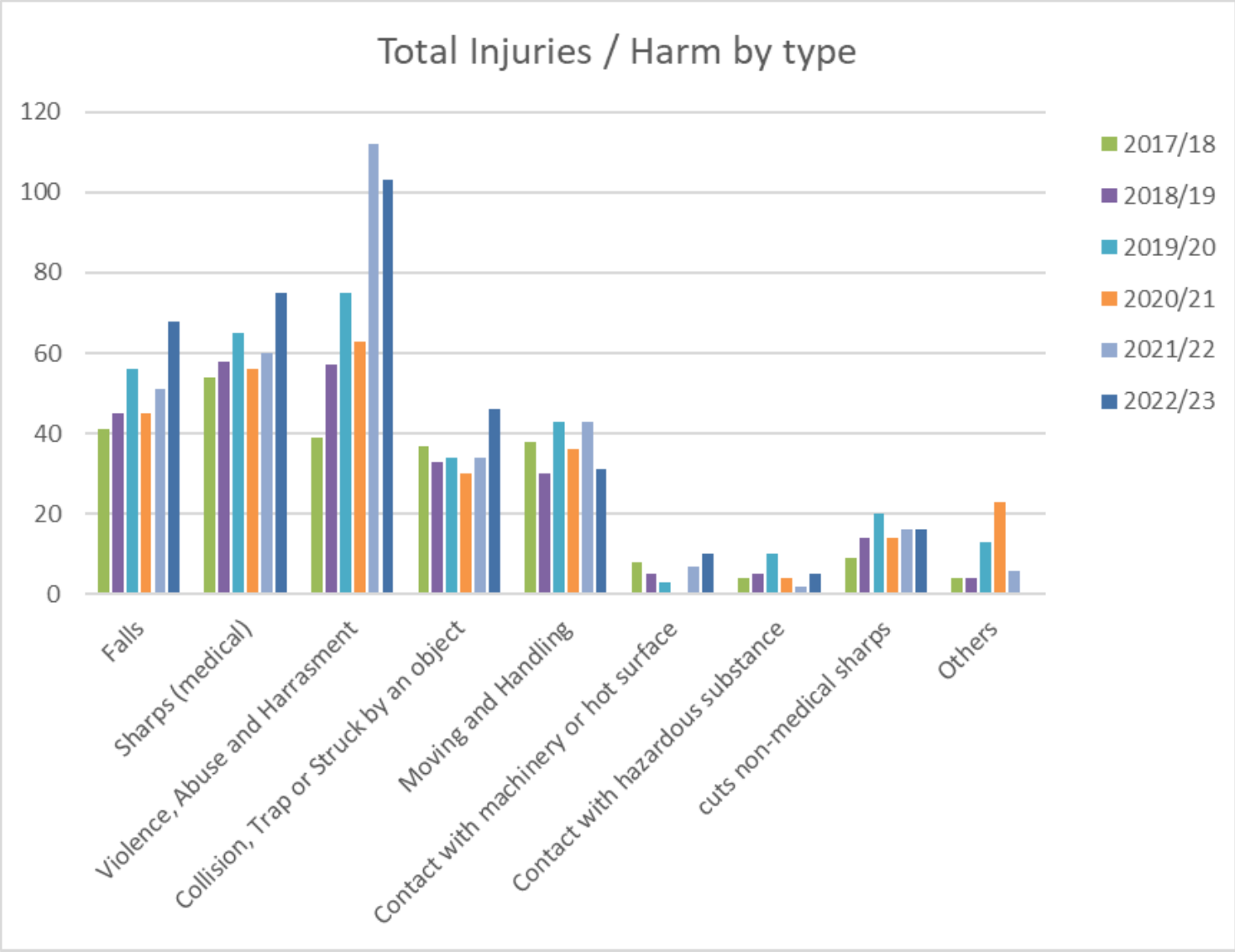


Figure four: Harm categories 2017/18-2022/23

4.4. Harm incidents by Division and Directorate

The table below shows Health and Safety incidents resulting in Harm by directorate/ specialty:

(RIDDOR incidents in brackets)
*Head and Neck became ENT & Audiology and Ophthalmology in 2021/22
+Private Patients moved to Surgery Division in 2022/23
#One of each of these RIDDOR incidents occurred in 2021/22

Division	Directorate	Slips, trips and falls	Sharps/ splash (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	***Total Incidents of Harm (2022/23)***	**Total Incidents of Harm (2021/22)**	Total Incidents of Harm (2020/21)
Cancer Services	Clinical Haematology	1		2							3	2	3
	Oncology	5	2		2						9	8	8
	Outpatients	3 *(1)*			3						6 *(1)*	5 *(1)*	2 *(1)*
		9 *(1)*	**2**	**2**	**5**						***18 (1)***	**15 *(1)***	**13 *(1)***
Corporate Services (including Trust wide)	Clinical Governance										-	2	-
	Corporate				1		1				2	9	6
	Decontamination		1								1	1	-
	Discharge Liaison Team							1			1	-	-
	Estates	15 *(3)*			4	2	1		1		23 *(3)*	15 *(2)*	9 *(3)*
	Facilities	7 *(1)*	3	8	9 *(2)*	4 *(1)*	1	2			34 *(4)*	25 *(5)*	26 *(7)*
	Finance	1			1	1					3	2	2
	Information Technology										-	-	2
	Nursing										-	-	2
	People and Culture	1	1				1				3	-	1
		24 *(4)*	**5**	**8**	**15 *(2)***	**7 *(1)***	**4**	**3**	**1**		***67 (7)***	**54 *(7)***	**48 *(10)***

Division	Directorate	Slips, trips and falls	Sharps/ splash (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	***Total Incidents of Harm (2022/23)***	**Total Incidents of Harm (2021/22)**	Total Incidents of Harm (2020/21)
Core Clinical Services	COVID Swabbing and Testing										-	1	-
	Imaging	1 *(2#)*	2		1	3 *(1)*					7 *(3)*	15	12
	Pathology	2	7		1	3	1				14	13 *(2)*	17 *(1)*
	Pharmacy										-	-	4
	Therapies					3					*3*	8 *(1)*	2
		3 *(2)*	**9**		**2**	**9 *(1)***	**1**				***24 (3)***	**37 *(3)***	**35 *(1)***
Medicines and Emergency Care	Acute Medicines and Geriatrics	5 *(1)*	11	37 *(1)*	3 *(1)*	1			4		61 *(3)*	76 *(1)*	46 *(4)*
	Emergency Medicine	3	5 *(1)*	14	4	2 *(2#)*			1		29 *(3)*	32 *(1)*	30
	Medical Specialties	4	3	22	3	3	2		1		38	38 *(3)*	20 *(1)*
		12 *(1)*	**19 *(1)***	**73 *(1)***	**10 *(1)***	**6 *(2)***	**2**		**6**		***128 (6)***	**146 *(5)***	**97 *(5)***
Surgery	ENT and Audiology*										-	1	-
	General Surgery	3		7	2	2			1		15	10	3
	Head and Neck*										-	-	6
	Ophthalmology*	6	4	2	3	1 *(1)*			2		18 *(1)*	1	-
	Orthopaedics	3	8 *(1)*	5		1 *(1)*					17 *(2)*	11	7
	Planned Care Co-ordination										-	1	-

Division	Directorate	Slips, trips and falls	Sharps/ splash (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	***Total Incidents of Harm (2022/23)***	**Total Incidents of Harm (2021/22)**	Total Incidents of Harm (2020/21)
Surgery	Private Patients+								1		1	-	[1]
	Surgical Specialties	1	4	2		1					8	1	3
	Theatres and Critical Care	4	19	3	7 *(1)*	3			3		39 *(1)*	31 *(5)*	38 *(1)*
		17	**35** ***(1)***	**19**	**12** ***(1)***	**8** ***(2)***			**7**		***98 (4)***	**56** ***(5)***	**57** ***(1)***
Women's Children's and Sexual Health	Children's Services		1	1	1	1	1	1			6	8	5 *(1)*
	Sexual Health						2		1		3	1	1
	Women's Services	3	4		1			1	1		10	14 *(1)*	15 *(3)*
		3	**5**	**1**	**2**	**1**	**3**	**2**	**2**		**19**	**23** ***(1)***	**21** ***(4)***
	Totals	**68** ***(8)***	**75** ***(2)***	**103** ***(1)***	**46** ***(4)***	**31** ***(6)***	**10**	**5**	**16**		***354 (21)***	**331** ***(22)***	**271** ***(22)***

The size of the respective divisions and directorates and the activities undertaken by them has a clear influence on the number and nature of incidents that occur.

- The overall number of harm incidents has increased (↑6.9%) but not in line with the overall increase in reporting of staff/ public/ Trust incidents (↑26.4%).
- Surgery saw the largest increase in the overall number of harm incidents from 56 in 2021/22 to 98 (↑42) in 2022/23, with an increase in all directorates in that division that reported harm incidents. Ophthalmology harm incident reports increased from 1 in 2021/22 to 18 in 2022/23 (↑17).
- Corporate Services also saw an increase (↑13) particularly in the Estates (↑8) and Facilities (↑9) Directorates. Some of these incidents relate to member of public and staff falls in communal areas and car parks.
- There was also a smaller increase in Cancer Services (↑3) harm incidents.
- After a large increase in 2021/22, the number of harm incidents reported in 2022/23 in Medicines and Emergency Care went down to 128 (↓18). It remains the highest reporting division.
- The highest reported category of harm incidents was violence, abuse and harassment (103). The overall number of harm incidents is down by 8% from 2021/22.
- Medicines and Emergency Care account for 70.9% of violence, abuse and harassment with 73 harm incidents, and 37 in the Acute Medicines and Geriatrics directorate alone. This is down from 90 harm incidents and 80.4% of the total in 2021/22.
- The second highest reported category of harm was sharps/splash (75) and Surgery (35) had the most by division, with Theatres and Critical Care (19) the most by directorate.
- Facilities has the most RIDDOR reportable incidents with four. Acute Medicines and Geriatrics, Emergency Medicine, Estates and Imaging all had three RIDDOR incidents each.

These figures are discussed in more detail in **Section 5** below.

5. Key Health and Safety Areas

5.1 Slips, trips and falls

There was an increase in the number of slips, trips and falls harm incidents. Slips, trips and falls accounted for 19.2% of staff/public/Trust harm incidents, compared with 15.4% in 2021/22. The number of harm incidents from non-patient falls was 68.

The overall number of slips, trips and falls incidents reported (including near misses and no harm incidents) increased by 20.2% to 107.

Estates had the most slip, trip and fall injuries, with 15, three of which were RIDDOR reportable. Some incidents in communal areas are attributed to Estates.

Eight of the RIDDOR incidents were related to slips, trips and falls. Three of these were >7-day injuries and five specified injuries. One of the specified injuries involved a member of the public, the same number as in 2021/22.

Five of the RIDDOR incidents relate to slips, three of which involved a spillage/ leak/ water, with the other two slips on ice. The remaining three RIDDOR incidents consistent of a trip during maintenance, a fall from a chair and a fall in a revolving door.

In terms of overall falls (including patient falls), in 2022/23 a number of focused workstreams contributed to the improvement in falls prevention and the reduction in patient falls rate. The commencement of falls prevention training for staff identified as essential for their role, Trust recruitment strategy, the falls Monitor replacement programme that was supported by our charitable funds and the spotlight placed on falls prevention by directorates and wards as well as the work undertaken by the Falls Working Group in 2022 has supported the reduction in falls.

Falls reduction remains focus for 2023/24. The Falls Champions Group meets monthly to review falls on wards for themes and trends as well as work collectively to improve falls prevention and support meeting of the Trust KPIs for Falls Prevention.

5.2 Violence and Abuse

Harm incidents from violence, abuse and harassment account for 29.1% of the total, and remains the highest single category. After a large increase in the previous reporting period, the number of harm incidents decreased by 8% from 112 in 2021/22 to 103 in 2022/23.

It is the highest directly health and safety-related incident category by overall number of incidents. The total number of incidents of violence, abuse and harassment reported (including near misses and no harm incidents) increased by 53.5% to 654, from 426 in 2021/22.

Medicines and Emergency Care account for 70.9% of violence, abuse and harassment with 73 harm incidents, and 37 in the Acute Medicines and Geriatrics directorate alone. This is down from 90 harm incidents and 80.4% of the total in 2021/22. The higher number of harm incidents in Acute Medicines and Geriatrics reflects the number of incidents where patient factors are a contributory factor.

A Trust-employed trainer started in September 2022, delivering conflict resolution training / breakaway / defence techniques as well as bespoke training to employees and contractors (Security).

Improved training of frontline staff and a directive that Security staff submit more incident reports to give a more accurate record would be expected to increase overall numbers of incident reports further in the future. The ratio between incident reports and harm incident reports would therefore be a clearer indicator as to whether improved reporting or increased risk accounts for the rise. The ratio in 2021/22 was approximately 4:1 and this went up to more than 6:1 in 2022/23. This indicates that improved reported accounts for the increase.

In terms of security infrastructure, the CCTV project for Maidstone was completed and there were a number of security upgrades on both sites.

5.3 Moving and handling

There was a decrease of 27.9% in the number of harm incidents, from 43 in 2021/22 to 31 in 2022/23. Moving and handling-related incidents account for around 9% of staff incidents of harm, a reduction of approximately 4% from the previous year.

Including near misses and no harm incidents, there were 40 in total in 2022/23, and this is not unusual – most reported moving and handling incidents result in harm.

Six RIDDOR reportable incidents were related to moving and handling activities, all >7-day injuries. Four of the six RIDDOR reportable incidents involved staff undertaking patient moving and handling, which is an increase from one in 2021/22. In 2021/22 four of

the five moving and handling-related RIDDORs involved Facilities staff moving inanimate loads.

Work with the Health and Safety Advisor has started with reference to the HSE letter and its recommendations for managing musculoskeletal disorders (MSDs) in the NHS. More specific training has been developed to support staff to learn new skills and knowledge to reduce MSDs within the workplace, this includes Portering and non-clinical training.

Work with occupational health is taking place and the Moving and Handling Advisor is notified of staff that require individual moving and handling risk assessments.

The link assessor pool is growing and training is ongoing to have more link assessors around the Trust to support with training and competencies.

5.4 Sharps/ splash

5.4.1. Medical sharps

Harm incidents from medical sharps increased by 25% when compared to the previous year, from 60 to 75.

The overall number of reported incidents (including near misses and those recorded as no obvious harm) decreased from 110 in 2021/22 to 108 in 2022/23. There is now better monitoring of reports to ensure harm incidents are correctly recorded as such.

In 2021/22 there were five RIDDOR reportable dangerous occurrences related to medical sharps use. In 2022/23 this decreased to two.

The Vascular Access Specialist Practitioners (VASPs) have continued to review safety devices. No changes have been made to cannulation equipment, however some alternative venepuncture equipment has been supplied to clinical areas and sharp safety training has been provided. There have again been difficulties in obtaining Gripper Plus non-coring safety Huber needles to access ports. EZ Huber needles have again been obtained to use as an alternative. There have been a number of different brands of safety hypodermic needle procured when suppliers are unable to fulfil demand. Devices are chosen according to the most similar safety activation feature.

The SHRAG has continued to discuss where sharps/splash incidents are not being investigated with uniform rigor. The VASPs have monitored sharps reports and investigated these incidents where time constraints and staffing allow.

5.4.2 Eye Splash Injury

One harm incident was reported in 2022/23 compared with four in 2021/22. A total of 16 eye splash incidents were reported in the Trust (including near misses and those recorded as ‘No obvious harm’), an increase from the 15 eye splash incidents reported in 2021/22, but levels remain consistent.

5.4.3 Sharps / Splash Injury Comparisons

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
OH attendances 2019/20	16	11	8	15	17	13	11	20	9	9	12	7	**148**
OH attendances 2020/21	8	6	11	5	9	9	12	9	16	8	15	12	**120**
OH attendances 2021/22	7	12	12	10	7	7	8	13	11	10	6	11	**114**
OH attendances 2022/23	*9*	*11*	*11*	*13*	*10*	*12*	*2*	*13*	*15*	*8*	*12*	*12*	***128***

There has been an increase of 14 cases (+12.3%) in 2022/23 compared with 2021/22, however, not all staff members are using the incident reporting system or going to OH following an exposure.

The disparity between incident reports and OH attendances from previous years remains. If only those reporting harm incidents attended, this would give a total of 76, significantly fewer than the actual OH attendance. If harm and no obvious harms attended, this would give a total of 124, closer, but still fewer than the actual attendance. There are incidents reported where OH attendance is not needed (e.g. near misses or sharps found) but further vigilance and education are required on the need to report sharps incidents and to report them accurately.

5.5 Collisions, Traps or Struck by an Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, housekeeping issues and rushing around and are often associated with moving and handling activities. There were 46 harm incidents in 2022/23 compared with 34 in 2021/22, a 35.3% increase.

There were four RIDDOR incidents in 2022/23, up from one in 2021/22. All of these were >7-day injuries. One was a collision with another person, one was as a result of a crush injury, one struck by a dropped cylinder and one trap in a closing door.

5.6 Machinery, Hot Surfaces and Fluids

There were ten burn/scald injury incidents reported in 2022/23, up from seven in 2021/22.

5.7 Cuts / lacerations, non-medical sharps

To distinguish between medical and non-medical sharps, this category was introduced. There was no change in the overall number of harm incidents, with 16 in 2022/23 as was the case in 2021/22.

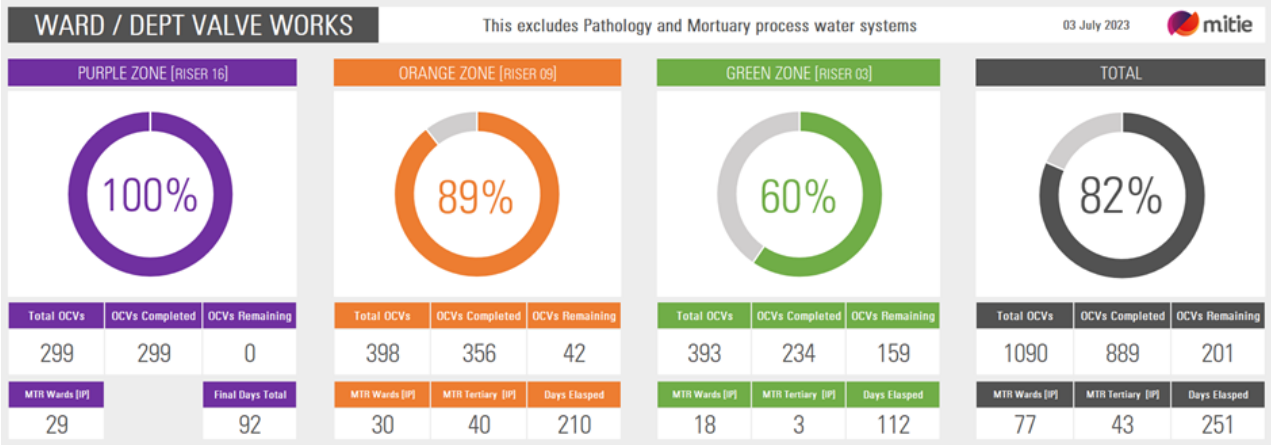
5.8 Water Hygiene

The water systems at both Maidstone and Tunbridge Wells Hospitals have inherent issues with the water systems. Both are caused by poor water circulation that is affecting the minimum temperature requirements. This in turn creates a risk of legionellosis due to non-compliant safe systems.

Both sites have water actions plans that are being managed to improve both circulation and temperatures.

5.8.1 Tunbridge Wells Hospital

The Domestic Hot Water System (DHWS) fails to circulate water to achieve the minimum temperature requirements. Mitie (the PFI contractor) has recorded temperatures that are non-compliant with the design requirements. This could lead to the proliferation of Legionella. Mitie considers the DHWS may never have been correctly commissioned throughout the system and that the original design was not fit for purpose.
An action plan has been devised to rectify this and a programme of works was carried out in 2022/23. As of June 2023, progress by zone is as follows:



Work is progressing until complete with intermediary and ongoing actions:

- An enhanced weekly sampling regime is in place, with agreed actions being agreed and undertaken by Mitie following positive results.
- Sampling has been varied to include not only the sentinel outlets but moving out into other areas of the hospital to ascertain a wider view of the Legionella proliferation.
- Initial high Legionella counts are being returned for the areas where valve work has been completed - this is possibly down to residual biofilm being dislodged when the pipework has been chlorinated.
- Subsequent legionella readings are showing some reduced counts. However, there are still many significant high counts being returned.
- Increase in numbers of samples taken in the first three months of 2023
- The Trust continues to carry out flushing compliance across TWH site, SAU, Paediatrics ED and associated trust buildings.
- The Trust Authorising Engineer and Director of Infection Prevention and Control have reiterated the need for a secondary control measure.

5.8.2 Maidstone Hospital

The DHWS is an ageing system and as such suffers in some areas with poor water circulation along with old pumps and valves. In addition to this, where additional buildings and departments have been added over years, this has led to the system becoming unbalanced in some places.

There are old, non-compliant items of plant that need to be removed or upgraded and an action plan has been produced.

Specific Issues

- The return pump has been changed in Breast Care following temperature control problems flagged up during TMV maintenance. This information has been given to the mechanical team at Maidstone and a new PPM has been created.
- Investigation is ongoing in ED to reduce air locks in the supply pipework.
- Ongoing investigation into repeat sample failures. Part of this investigation is around outlet usage, for example, there were 3 wash hand basins within the Lord North main corridor. These were fitted with data loggers for around two weeks. On

reviewing the data, it was confirmed that the basin closest to the main corridor was very rarely used. Therefore, having now spoken to IPC regarding the data and usage it was agreed this basin could be removed and is completed.

- Tank 3 requires cleaning, however currently there is a 6-inch valve that cannot be isolated for this to procced. Therefore, a new valve will need to be fitted before this can be achieved and Estates is awaiting cost for these works. This work has been handed over to the design team.

6 Health and Safety Executive Inspections and Investigations in 2021/22

6.1 Trust Inspection

The Care Quality Commission (CQC) took over much of the day to day enforcement responsibility from the HSE for health and social care activities. RIDDOR reports are passed on to the CQC from the HSE.

There has been a decline in the number of prosecutions of NHS Trusts and health and social care organisations by the HSE and these have been limited to clear and significant health and safety breaches, such as incidents involving violence and aggression, window restrictors and failure to assess the ligature risk.

Meanwhile, the CQC have initiated more prosecutions of NHS and other health and social care organisations for health and safety-related breaches, and the level of fines levied has increased.

The HSE will continue to inspect NHS Trusts periodically. In addition, they will carry out scheduled specialist inspections.

In 2022/23, two such inspections took place, both in November 2022 at Maidstone Hospital, one in the Containment Level Three (CL3) laboratories, and one of Nuclear Medicine.

The HSE gave verbal recommendations and sent formal written feedback following the inspection of the CL3 laboratories, which has been complied with.

The inspection of the Nuclear Medicine Department related to compliance with the Ionising Radiation Regulations (2017) and the Trust's consent for administration of radioactive substances to persons. The inspector was satisfied to the point where the Trust received no formal written feedback or enforcement action from HSE. An internal action plan has been produced and sent to the Trust Radiation Advisory Committee for monitoring through to completion.

The CQC should include health and safety as part of their inspections. The Trust was subject to a well-led inspection in March 2023 and the findings have not yet been published.

6.2 HSE Objectives for 2023/24

The HSE’s objectives in their 2023/24 Business Plan are unchanged and part of a ten-year strategy:

- Reduce work-related ill health, with a specific focus on mental health and stress
- Increase and maintain trust to ensure people feel safe where they live, where they work and, in their environment

- Enable industry to innovate safely to prevent major incidents, supporting the move towards net zero
- Maintain Great Britain's record as one of the safest countries to work in

The continued focus on mental health and stress, the inclusion of safety at home, which reflects the increase in numbers of people working at home, are notable. This is without neglecting efforts to prevent major incidents in high risk workplaces.

HSE are prioritising workplace ill-health and promoting wellbeing so that the UK can become one of the healthiest, as well as safest, places to work.

In the NHS the priorities are stress, moving and handling and violence and aggression, and these would be their areas of focus during a HSE inspection.

The HSE plan to *"lead, deliver and evaluate a programme of interventions including:*

…

- *avoiding violence and aggression, and MSDs, in the NHS. These can result in work-related stress. We (the HSE) will work in partnership with the NHS, health and social care regulators, trade bodies and unions to address work-related stress in the sector."*

7 Summary and Conclusions

7.1 Key headlines

From an analysis of the incident data, performance against objectives and other notable incidents, there are the following key headlines:

7.1.1 Violence, abuse and harassment

Incidents of violence, abuse and harassment have increased significantly, though harm incidents have decreased. This indicates better reporting practises. It remains the highest category of both reported incidents and reported harm incidents.

In early 2023/24 there have been more RIDDOR reportable incidents as a result of violence and aggression than seen previously. Conflict resolution training and disengagement techniques are now mandatory for many staff groups and it is important that staff receive this training early in their MTW careers with regular refreshers.

7.1.2 Slips on water and ice

As highlighted in Section 5.1, there is a particular risk to staff, patients and members of the public from slips. Five of the RIDDOR incidents related to slips, three of which involved a spillage/ leak/ water, with the other two slips on ice. It is therefore vital that any spillages or leaks are reported, highlighted and cleaned up as soon as possible and/or the cause of the leak is rectified. During icy weather vigilance is required by all parties to ensure that adequate salting takes place and extra care is taken outside.

7.1.3 Moving and handling of larger patients

A large proportion of reported moving and handling incidents cause harm as outlined in Section 5.3. There were six RIDDOR reportable moving and handling incidents in 2022/23. Four of these involved the moving and handling of patients. Bariatric patients present more complex needs and the availability of trained staff with the correct specialist equipment is vital to reduce the risk of harm to patients and staff.

7.1.4 Sharps/splash reporting

As highlighted above there is a continuing discrepancy between the number of sharps/splash incidents reporting and staff attending OH as a result. There is an ongoing risk from staff not reporting sharps/splash incidents, not attending OH or ED following injury or both. This issue has been highlighted at least in every report written since 2017.

7.1.5 Health and safety management system

Synbiotix was renewed for another year at the end of 2022, with a view to moving to InPhase in 2023/24. However, the InPhase health and safety application is unlikely to be ready meaning that an alternative will need to be sourced.

Whichever system is put into place, it will need to make risk assessments and inspections easier to input and share to provide assurance of compliance. A repository of generic risk assessments that can be sorted by division, directorate and hazard category would be another requirement of any new system.

7.2 Summary

- Overall reporting rates for staff, Trust and public incidents have increased by 26.4% compared with 2021/22. Harm incidents increased by 6.9%.
- After the very large increase in violence, abuse and harassment harm incidents in 2021/22, there was a reduction of 8% in 2022/23. This is despite the overall number of incidents (including near miss and no harm) increasing by 53.5% from 426 to 654. This indicates improved reporting practises.
- There was an increase of between 25% and 35% in three of the five most common harm incident categories, more than the overall upward trend in reports.
- Moving and handling saw a reduction in harm incidents by 28%. However, few near miss or no harm incidents were reported, and there were six moving and handling-related RIDDOR incidents.
- The number of incidents reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) decreased by one to 21 in 2022/23.
- The number of over 7-day injuries increased to 14, along with five specified injuries (no change) and a reduction in the number of dangerous occurrences, with two.
- Slips, trips and falls accounted for eight of the RIDDOR incidents, including all five specified injuries. Facilities has the most RIDDOR reportable incidents with four. Acute Medicines and Geriatrics, Emergency Medicine, Estates and Imaging all had three RIDDOR incidents each.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.

8 Objectives for 2023/24

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Health and Safety Management (Head of Fire and Safety, Health and Safety Advisor, Risk and Compliance Manager)					
To roll out a new H&S electronic management system. This has been pushed back a year due to Synbiotix being renewed for additional year and InPhase not having a H&S Application.	01/12/2023-31/03/2024	Trust Health and Safety Advisor	Risk and Compliance Manager / Head of Fire and Safety	Health and Safety Committee	70-75% compliance by 31/03/2024
To carry out Trust wide audit against the NHS Staff Council Workplace health and safety standards	31/03/2024	Trust Health and Safety Advisor	Risk and Compliance Manager / Competent Persons / Chair of Health and Safety Committee	Health and Safety Committee	Audit to be completed and report produced by 31/03/2024
To develop and pilot Health and Safety specific training for front line managers to better equip them with their duties	31/03/2024	Risk and Compliance Manager / Trust Health and Safety Advisor	Head of Fire and Safety / Competent Persons	Health and Safety Committee	Roll out and evaluation of pilot course
To ensure that the Policy and Procedure for the control of Contractors is reviewed, updated, approved, ratified and published	01/08/23-31/03/24	Trust Health and Safety Advisor	Head of Fire and Safety / Risk and Compliance Manager / Competent Persons	Health and Safety Committee	Policies reviewed, approved, ratified and published within required timescales
Falls (Falls Prevention Practitioner)					
To reduce the monthly Trust Falls rate to at or below threshold of 5.96 per 1000	April to September 2023 To review for	Lead Nurse for Falls Prevention	Deputy Chief Nurse for Nursing and Quality	Slips, Trips and Falls Group. Health and	5.96 per 1000 OBDs by 31/03/2024

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
occupied bed days	trajectory in Oct 2023			safety Committee Quality Improvement Committee	
Reduction in harm (moderate and above) each month	Target of at or below 45 incidents with harm (moderate and above) – pending review of data from previous year	Lead Nurse for Falls Prevention	Deputy Chief Nurse for Nursing and Quality	Slips, Trips and Falls Group. Health and safety Committee Quality Improvement Committee	Performance against target as of 31/03/2024
Reduction in recurrent falls each month	April 2023 to March 2024 monthly falls to be at 30 or less each month.	Lead Nurse for Falls Prevention	Deputy Chief Nurse for Nursing and Quality	Slips, Trips and Falls Group. Health and safety Committee Quality Improvement Committee	Performance against target as of 31/03/2024
Violence and abuse (Trust Security Manager)					
Included as part of the Security Annual Board report					
Moving and Handling					
Roll out training for all areas within the Trust to meet their specific requirements needed to undertake Moving and handling tasks within their roles	31/03/2025	Moving and Handling Advisor	Learning team	Moving and Handling Strategy group	Moving and handling raining compliance for all departments 85% by 31/03/2025
To develop a pathway for Bariatric/additional need patients coming into the Trust	31/03/2024	Moving and Handling Advisor	OT/Physio departments	Moving and Handling Strategy group	Shorter stay in hospital and fewer incidents compared

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
					with 2022/23 by 31/03/2024
Audit moving and handling equipment to determine replacement plan	31/03/2024	Moving and Handling Advisor	Procurement / Finance	Moving and Handling Strategy group	Audit completion and plan produced
Sharps/Splash (Safety, Health and Risk Advisory Group)					
To continue to monitor and review new sharp safety devices across the trust.	31/03/2024	Team Lead Vascular Access Specialist Practitioner Band 7	Vascular Access Specialist Practitioner Band 7	Health and Safety Committee SHRAG	N/A
To continue reviewing medical sharps incidents, providing support and training where appropriate and identifying trends that require targeted intervention.	31/03/2024	Team Lead Vascular Access Specialist Practitioner Band 7	Vascular Access Specialist Practitioner Band 7	Health and Safety Committee SHRAG	Qualitative assessment of sharps/splash incident reports; Training records
Radiation Protection					
Included as part of the Radiation Annual Board report					

Appendix A

2023/24 Training update – What does the Board need to know?

1. Health and safety

1.1. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached – members of the board have both collective and individual responsibility for health and safety.

1.2. Addressing health and safety offers significant opportunities, including:

1.2.1. Reduced costs and reduced risks – employee absence and turnover rates are lower, accidents are fewer, the threat of legal action is lessened;

1.2.2. Increased productivity – employees are healthier, happier and better motivated

2. Legal cases in 2022/23

2.1. The table below summarises some of the relevant prosecutions that took place in 2022/23:

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
May 2022	Shrewsbury and Telford Hospital NHS Trust	October 2019 and May 2020	Two patient deaths in two separate incidents. One patient was found by staff bleeding heavily from a disconnected line, resuscitation was attempted but was unsuccessful. Another patient was found trapped in a bariatric bed.	£1,375,712 fine	CQC	Patient supervision and training on bariatric equipment.
July 2022	Cwm Taf Morgannwg	November	Absconding patient fell in icy conditions and suffered fatal	£850,000 +	HSE	The Health Board had failed to act on previous

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
	Health Board	2019	head injury.	costs		absconding incidents, including an Improvement Notice at another of their sites.
September 2022	Alliance Medical	March and November 2019	03/19: A vial of a radioactive substance leaked after it was installed into medical-imaging scanner at St James's University Hospital in Leeds. Two staff contaminated with skin doses in excess of the annual dose limit as defined by IRR17. 11/19: Substance was unknowingly handled during the production process at the Alliance Medical Radiopharmacy Limited facility. A member of staff was contaminated with a skin dose in excess of the annual dose limit.	£420,000	HSE	Staff had not been made fully aware of localised instructions and were using personal protective equipment unsuitable for work with radioactive material. Radiation warning system at the second facility was not operational at the time of the incident and had not undergone routine maintenance or testing at suitable intervals.
October 2022	The Rotherham NHS Foundation Trust	Various	Four children were discharged with no safeguarding concerns raised despite non-accidental injuries. They all subsequently re-attended with further non-	£233,238	CQC	Ineffective reporting systems, out of date policies and not all staff had received relevant training.

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
			accidental injuries.			
November 2022	Powys Teaching Health Board	Various	Employees routinely operate handheld power tools such as lawn mowers, strimmers and hedge cutters without carrying out an assessment of the risks from exposure to vibration. Three staff developed HAVS.	£160,000 + costs	HSE	The health board had failed to properly assess the levels of exposure to its employees and that information, instruction and training given to staff was limited.
December 2022	Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	March 2019	Patient with chest pain had scan. Wrong result viewed. Patient discharged and subsequently died shortly after arrival two days later.	£60,000 + costs	CQC	Lack of adequate processes and systems to ensure staff reviewed correct scan results, and to ensure results showing abnormalities were appropriately escalated.
January 2023	Bupa Care Homes	July 2021	A lime tree near the entrance fell on an eight-year-old girl who was running past.	£400,000 + costs	HSE	The tree was diseased and had likely been rotting for years and hadn’t been identified.
January 2023	Nottingham University Hospitals NHS Trust	September 2019	Failure to provide safe care and treatment to a mother and her baby. Two charges to which the Trust has pleaded guilty.	£800,000 + costs	CQC	The Trust failed to ensure that adequate processes and systems were in place to ensure that all risks to their

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
						health and wellbeing were managed.
March 2023	University Hospitals of Derby and Burton NHS Foundation Trust	July 2019	Patient had dementia and had previously absconded twice. Fell climbing over barrier when absconding for the third time. Died from multiple traumatic injuries.	£200,000 + costs	CQC	Trust failed to put sufficient controls in place to deal with known absconder.

The examples given mostly relate to other NHS Trust though, where notable, cases from other health and social care organisations are given. The level of fines associated with prosecutions initiated by the CQC has continued to increase.

3. Risk Assessment refresher

The Trust Risk Assessment Policy and Procedure was recently reviewed. As a refresher an extract from that procedure follows.

3.1 Risk assessment

A risk assessment is a documented process by which hazards are identified and an assessment made as to the likelihood and consequence of harm occurring. Control measures are introduced to further reduce the likelihood and/or consequence to minimise the risk to an acceptable level.

3.2 Sources of risk assessment

There are many reasons for carrying out a risk assessment.

Under the Management of Health and Safety at Work regulations employers are also required to carry out specific risk assessments for young persons (those under 18 years of age) and new and expectant persons.

Competent persons will identify what generic Trust wide risk assessments are required and complete them.

3.3 Five stage approach

The HSE recommend a five-stage approach to risk assessment. The process is the same whether the risk is clinical or non-clinical in that it follows the same 5 stage approach and needs to meet the requirements of health and safety legislation.

3.3.1 Stage 1: Identify hazards

The risk assessor and manager should identify hazards that could reasonably cause harm or damage. To identify hazards:

- Use the hazard profile checklist
- Look for unsafe conditions
- Observe staff to determine potential unsafe acts
- Talk to employees and union representatives about what they have noticed and hazards that may not be immediately obvious
- Check manufacturers' instructions or material safety data sheets (MSDS) for chemicals and equipment; these can identify or clarify hazards and put them in perspective
- Take account of non-routine operations (e.g. maintenance, cleaning)
- Consider long-term hazards to health (e.g. noise, exposure to harmful substances)
- Learn from incidents, complaints, litigation etc.
- Consider all relevant Trust policies and procedures

Each hazard identified on the hazard profile checklist must be evaluated and scored. The checklist is not exhaustive so if there are other hazards present in the work environment not listed then add these under 'other'. If, with the controls in place, the risk is scored as Red or Amber, a formal risk assessment is required.

For certain hazards a generic risk assessment may be available. Where applicable these should be added to the department's risk assessment programme.

Relevant Trust policies and procedures, guidance and generic risk assessments are referenced with links on the hazard profile checklist.

3.3.2 Stage 2: Decide who might be harmed and how

For each hazard consider what the reasonably foreseeable outcomes might be and who or what could be affected, including:

- Patients
- People who might not be in the workplace all the time such as visitors and maintenance staff
- People who may be in the workplace outside of normal working hours
- Others with whom the workplace may be shared, such as contractors and volunteers
- Different times of day such as busy periods, meal times and night
- Young persons and new and expectant mothers
- Lone workers, vulnerable individuals, etc.

3.3.3 Stage 3: Evaluate the risks and decide upon controls

3.3.3.1 Evaluating risk

Having identified significant hazards and determined who can be harmed and how, the risk can be evaluated. If controls are present their effectiveness should be considered. The risk rating should be determined with reference to the Trust's 'Risk grading matrix'. If reasonably foreseeable risks are being controlled sufficiently then further action may not be required. If the residual risk is unacceptable and further risk reduction required, additional control measures are necessary.

3.3.3.2 Introducing control measures

In order to reduce the risk, further control measures are required. The higher the risk the more resources (money, time, trouble etc.) would be required to reduce it to an acceptable level. In order to determine which control measures are likely to be more effective a hierarchy of risk control should be followed:

To control hazards: assess controls according to the hierarchy of controls (in order):	
1	Elimination: can the hazard be removed?
2	Substitution: can the hazard be replaced with a lower risk alternative?
3	Engineering controls: can physical controls be put into place to reduce the risk?
4	Admin controls: use of procedures; what changes can be made in the way people behave / work to reduce the risk? Also, warning systems, e.g. signs, alarms, instructions, labels
5	Provide personal protective equipment (PPE): can PPE be used to reduce the risk?

Control measures at the top of the hierarchy of risk control are likely to be more effective, and protect more people, than those below them. Priority should be given to control measures which protect large numbers of people rather than individuals.

When introducing control measures it is important to consider whether they introduce any new hazards or increase other risk. When determining control measures what is considered reasonably practicable must adapt to technical progress, societal norms and industry standards.

3.3.4 Stage 4: Record significant findings

Significant findings from risk assessment need to be recorded and available to all relevant staff. The ‘Hazard profile checklist’ is used to record that hazards have been identified and acts as a sufficient record for Green (low) risks.

Where the score is Amber or Red a formal risk assessment must be completed. To assist a template risk assessment form is included in the appendices, though other forms can be used if they are more suitable provided they meet the requirements of the five-stage approach.

In addition, in order to comply with other health and safety legislation, such as the Control of Substances Hazardous to Health Regulations (COSHH), the Manual Handling Operations Regulations and the Health and Safety (Display Screen Equipment) Regulations (DSE Regs), specific risk assessment forms have been developed. Refer to the relevant policies and procedures for more information.

3.3.5 Stage 5: Review your assessment and update if necessary

Risk assessments must be reviewed following significant changes. For example:

- Conditions leading to new hazards
- Working area or workplace layout
- Staffing levels or competency
- Services and processes
- Changes in practice
- In response to incidents or newly identified hazards
- Technology and equipment
- Capacity and working intensity
- Working hours and shift patterns

- Changes identified through audit
- Changes in national guidance, legislation etc.

If there are no changes then the assessment must be reviewed periodically. A standard review period is annual but any decision on review period should be risk-based with higher risks being reviewed more frequently than lower risks.

Review can be used as an opportunity for continuous improvement and the introduction of new control measures to further reduce risk.

Significant findings following review must be shared with all relevant staff.

4. Fire Safety roles and responsibilities

4.1. Trust Board

The Trust Board has overall accountability for the activities of the organisation, which includes fire safety. The Trust Board should ensure that it receives appropriate assurance that the requirements of current fire safety legislation and the objectives of Department of Health's Firecode are being met. The Trust Board discharges the responsibility for fire safety through the Chief Executive.

4.2. Chief Executive

The Chief Executive will, on behalf of the Board, be responsible for ensuring that current fire legislation is complied with. They will ensure that all agreements for the provision of care and other services by third parties include sufficient contractual arrangements to ensure compliance with the trust's fire safety policy.

The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Director with fire safety responsibility.

4.3. Chief Operating Officer - Board Level Director (with fire safety responsibility)

The Director with fire safety responsibility is responsible for ensuring that fire safety issues are highlighted at Board level. This responsibility will extend to the proposal of programmes of work relating to fire safety for consideration as part of the business planning process.

This will include the management of the fire-related components of the capital programme and future allocation of funding.

At an operational level the Director with fire safety responsibility should be:
- assisting the Chief Executive with Board level responsibilities for fire safety matters;
- ensuring that the trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures;
- ensuring that all work that has implications for fire precautions in new and existing trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements;

- ensuring that all proposals for new buildings and alterations to existing buildings are referred to the Head of Fire & Safety before building control approval is sought;
- ensuring that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept;
- ensuring through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained;
- ensuring that agreed programmes of investment in fire precautions are properly accounted for in the trust's annual business plan;
- ensuring that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board;
- fully support the Fire Safety Manager function.

In line with delegated authority, the Director with fire safety responsibility devolves day-to-day fire safety duties to the Head of Fire & Safety.

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment	**Chief Operating Officer / Director of Emergency Planning and Response**

The enclosed report provides information on the Trust's statement of compliance with NHS England Core Standards on Emergency Preparedness, Resilience & Response.

The Trust is required under its contract and the Civil Contingencies Act 2004 to plan and respond to a wide range of emergencies. The NHS has published annual core standards which organisations must meet.

The standards cover:

- Governance
- Duty to assess risk
- Duty to maintain plans
- Command & Control
- Training & Exercising
- Response to Emergencies
- Duty to Warn & Inform
- Co-operation with other responders
- Business Continuity
- Chemical, Biological, Radiological & Nuclear Incident Preparedness

A Deep Dive each year is carried out that does not count towards the overall rating and this helps NHS E inform future planning and resources. This year the Deep Dive is around training. The Trust scored 100% in this area too. The overall assessment against the core standards is 100% and therefore fully compliant. The core standards and the evidence packs have been uploaded to Resilience Direct and the ICB will review the evidence and highlight good practice. The standards and scores are attached to this report. Actions by the Trust Board.

The Board are required to endorse and report compliance to a public Board Meeting.

Conclusion

The Trust remains well prepared and is assessed fully compliant against the Core Standards. The Trust Board receive a separate report on all aspects of Emergency Planning Response & Recovery activities at the start of each year. The Board are asked to approve the submission.

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 approval

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

MTW EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2023/24**, Maidstone and Tunbridge Wells NHS Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 62 of the core standards which are applicable to the organisation, Maidstone and Tunbridge Wells NHS Trust:

- is fully compliant with 62 of these core standards

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

The overall rating is: Fully Compliant

Sean Briggs (Chief Operating Officer – Accountable Emergency Officer)
Maidstone Tunbridge Wells NHS Trust
29th August 2023

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
Domain 1 - Governance							
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	**Resilience Direct (MTW Assurance 2023):** - Sean Briggs (COO) - Resilience Policy & Procedures - Organisational Structure - Clinical Structure - EPRR Team Structure (MTW RD Front Page)	Fully compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	**Resilience Direct (MTW Assurance (2023)** - Resilience policy and related appendices - EPRR Capabilities document (business objectives and processes) - Resilience Directorate Risk Register - Dedicated annual budget (outlined in resilience policy) - Dedicated team of: 4 k Emergency planners, x1 admin, x1 Director EPRR, Security, Health and Safety and Fire (Organisational Structure/Team Structure - Functions and/or organisation, structural and staff changes) - Resilience Committee (Meeting minutes)	Fully compliant
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	**Resilience Direct (MTW Assurance 2023):** - Trust board agenda and reports (annually) - Live Horizon scanning report on Trust intranet page (Execs have access) - Training prospectus - Exercise reports (debrief reports included) - Incident debriefs (including IT downtime) - LHRP exec minutes - evidence of MTW rep - Director and AEO attends daily exec huddle	Fully compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	**Resilience Direct (MTW Assurance 2023):** - Capabilities document (work plan) - Training and exercising (included within capabilities document) - Training prospectus - Resilience Policy and Procedure - Debrief exercise reports - LHRP exec minutes - evidence of MTW rep - EPRR Leads meetings reporting to ICB	Fully compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	**Resilience Direct (MTW Assurance 2023):** - Evidence of Resilience committee (meeting minutes) - Resilience Policy and Procedure - Emergency Planning 24/7 On Call - Comms/Strategic/Tactical Commander 24/7 On Call (On Call section included within Peoples policy pages 105 - 108) - Director of EPRR reports directly to AEO and is Deputy AEO - EPRR structure (front of MTW RD page) and organisational structure - Weekend plan and On-Call Structure	Fully compliant
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	**Resilience Direct (MTW Assurance 2023):** - Resilience policy and procedure - Incident and exercise debrief reports - Incident and exercise debrief reports reported to Resilience Committee (see committee minutes) - Daily Site Report including site issues - Director reports into board with Key Risks (Exec Daily Huddle) - Opportunities to raise at EPRR leads and LHRP DG/Exec - Exercise/Incident criteria grid (Capabilities document)	Fully compliant
Domain 2 - Duty to risk assess							
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	**Resilience Direct (MTW Assurance 2023):** - Resilience Directorate Risk Register - Live Horizon Scanning report on Trust intranet page - Risks reported to Resilience Committee and daily exec huddles - Daily site reports include site issues/risks - EPRR Health and Safety reports - Resilience policy and procedure - Weekend Plans highlighting Key Risks (weekly basis) - Head of Resilience Planning & Governance - Co-Chair of KRF Plans and Capabilities group that links in with monthly with KRF Risk Assessment Working Group - SHRAG Meeting Minutes - Internal Risk Group	Fully compliant
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	**Resilience Direct (MTW Assurance 2023):** - Resilience Directorate Risk Register - InPhase Incident/Risk reporting system - Live Horizon Scanning report on Trust intranet page - Weekend Plans highlighting Key risks (weekly basis) - Director sits on daily exec huddles and highlights risk if necessary - Topical risks raised at Resilience Committee - Daily site report highlights site issues/risks - Verbal updates (EPRR team) to daily site meetings on key risks - Presence in Care Coordination daily to report risks if appropriate	Fully compliant
Domain 3 - Duty to maintain Plans							
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	**Resilience Direct (MTW Assurance 2023):** - Capabilities Document - Joint working collaboration with KCHFT e.g. Joint Command Training teaching same principles - Example Plans with collaborative working: Water Contingency Plan, Child Abduction Plan, Lockdown, Emergency Response & Recovery Plan, Helicopter Policy, Adverse Weather, to name a few) - consultation process evidence within plans - Version control in all plans - All plans and procedure go to resilience committee and execs as relevant. Documented in resilience committee minutes - Resilience policy and procedure	Fully compliant
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - Emergency Response and Recovery Plan - new for 2023 (Signed off by Resilience Committee, chaired by AEO) - Exercise Analysis Grid (Evidence of exercising Major Incidents) (included within Capabilities document) - Regular training with stakeholders - including ED, security etc - Competency checklists for key roles - Regular Command Training - CPD for commanders live on intranet - Strategic and Tactical Commander Aid memoirs - Resilience policy and procedure	Fully compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	**Resilience Direct (MTW Assurance 2023):** - Capabilities Document - Adverse Weather Plan (amalgamated Heatwave, Cold Weather and Emerging risks e.g. High Winds, Drought, Dust Storms, Wildfire, Space Weather etc) - Review prior to both Heatwave and Cold Weather period (most recently in line with new UKHSA warning process) - Adverse Weather Intranet Page - Adverse Weather Included in live Horizon Scanning Page - Live Incident Report - Adverse Weather 2022 Exec Report - RD response page - Adverse Weather - Exercise Analysis Grid (Evidence of exercising Major Incidents) (included within Capabilities document) - Includes plan for Wildfire Exercise - Training prospectus introduction to major incidents, resources available on intranet (includes adverse weather training) - Staff Warning and informing evidence - Updates to resilience committee with key Adverse Weather risks	Fully compliant
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	**Resilience Direct (MTW Assurance 2023):** -Capabilities document (evidence of all plans) - VHF Policy and Procedures (QR code included) - Infectious Disease Outbreak Plan - new since last year - Pandemic Influenza plan - newly updated - Antibiotic and Vaccination Centre Plan - Plans agreed and ratified through Resilience Committee - Infection Control Team available 7 days a week - On Call Emergency Planning to support Infectious Disease incidents - Exercise Analysis Grid (Evidence of exercising Infectious Disease) (included within Capabilities document) - CBRN training and exercising evidence of staff training - Evidence of Monkeypox planning - Fit testing policies and procedures - Fit testing included in yearly mandatory training for the Trust - Training videos for VHF and Ebola - Live Horizon Scanning report on Trust Intranet page includes infectious disease risk	Fully compliant
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Resilience Direct (MTW Assurance 2023):** -Capabilities document - VHF Policy and Procedures - Infectious Disease Outbreak Plan - new since last year - Pandemic Influenza plan - newly updated - Antibiotic and Vaccination Plan - Plans agreed and ratified through Resilience Committee - Infection Control Team available 7 days a week - On Call Emergency Planning to support Infectious Disease incidents - Exercise Analysis Grid (Evidence of exercising Infectious Disease) (included within Capabilities document) - CBRN training and exercising evidence of staff training - Evidence of Monkeypox planning - Fit testing policies and procedures - Fit testing included in yearly mandatory training for the Trust - Training videos for VHF and Ebola - Live Horizon Scanning report on Trust Intranet page includes infectious disease risk - EPO Generic Account receives all new UKHSA infectious disease risk comms	Fully compliant
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements.	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - Antibiotic/Vaccination Plan - Evidence of successful Covid Vaccination centre (see trust board report, letter from parliament) - Tracey Crouch MP video - Vaccination centre - Letter from Parliament for Vaccine centre - STREP A EPRR support to Paediatrics	Fully compliant
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - Section 2.15 of the Emergency Response and Recovery Plan - Major incident cupboard includes equipment in the event of mass casualty - Major Incident Registration packs (best practice) - All plans shared appropriately with those required to use them on RD, Intranet and CJ Pulse - MTW major incident triage video	Fully compliant
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - Trust Evacuation Plan including shelter arrangements - All areas have individual Fire evacuation plans (example ink RD) - Yearly audit for clinical areas and fire evac (evidenced in Review of clinical area resources - uploaded to RD) - Fire Evacuation Flow Chart - included in all Clinical Area Resource Folders - Emergency Shelter Location Contacts form (uploaded) - Trust Evac system for clinical areas - labelling system (SOP uploaded) - Evac procedure video	Fully compliant
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - Operational Lockdown Procedure - Partial Lockdown during Covid - Attendance at Security Committee - Security Management within same directorate	Fully compliant
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - VIP, Protected Persons and celebrity Visits and Admissions and Firearms deployment Policy and Procedure - Recent prime minister visit success - PM and Chancellor visit (VIP visit pics) - July 2023 VIP Visits (NHS 75) (Pics included on RD) - Steve Barclay Visit (Evidence of VIP Procedure)	Fully compliant
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements	**Resilience Direct (MTW Assurance 2023):** - Capabilities document - Emergency Response and Recovery Plan (Includes Mass Fats section) - Mass fatalities plan under Kent resilience forum - Attendance from MTW EPRR - Agreement from exec level for local level agreement to use Trust facilities - Meetme minutes of KRF Mass Fats	Fully compliant
Domain 4 - Command and control							
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	**Resilience Direct (MTW Assurance 2023):** - Command Accreditation Course for all on call managers - On Call EPRR personnel 24/7 365 (On-Call Rota included) - On Call Executives (Strategic) 24/7 365 - On Call Managers (Tactical) 24/7 365 (Example July 2023 Rota) - Everbridge Alerting system for all key roles in a response - Tactical & Strategic Aid Memoirs for On-Call - Peoples policy (Pages 105 - 108) - Resilience Policy - Weekend Plan (Evidence of On-Call Teams) - Emergency Response and Recovery Plan - Command and Control Section (Section 1) - Visual Tools included in Command Centres (pic evidence) - Command Intranet Pave with associated tools	Fully compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	**Resilience Direct (MTW Assurance 2023):** - Command Accreditation Course for all on call managers - Live CPD for Commanders on Intranet - On Call EPRR personnel 24/7 365 - On Call Executives (Strategic) 24/7 365 - On Call Managers (Tactical) 24/7 365 - Everbridge Alerting system for all key roles in a response (RD - 'Everbridge') - Peoples policy (Pages 105 - 108) - Medical Physics On Call - On-Call Medical Teams - Emergency Response and Recovery Plan - Command and Control Section (Section 1) - Resilience Policy includes Training Needs Analysis	Fully compliant
Domain 5 - Training and exercising							
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	**Resilience Direct (MTW Assurance 2023):** - Capabilities document (see Training tab) - CBRN and Command competency portfolios - Training completed staff checklist - Command Trained personnel checklist - Command Training Package - Other training packages upon request - Resilience Policy - TNA included - Training prospectus - Appendix 6 Resilience policy - training needs analysis - Section 4 resilience policy and training materials/ equipment including videos	Fully compliant
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective.	**Resilience Direct (MTW Assurance 2023):** - Capabilities document (see exercise tab) - Comms Exercise Feb 23 - Briefing/Debrief Report - Exercise Ragdoll 5 (Table top) - Multiple Industrial Action Table Top exercises - Exercise Neptune 2 (Live exercise and CPX) - Radiation exercise (Live) - IT BC/CI Incident Debrief Report - Wider system Mahtsi Oak Exercise	Fully compliant
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	**Resilience Direct (MTW Assurance 2023):** - Training and Exercising Staff Participation Document - Reflective accounts from staff involved in incidents - CBRN and Command portfolios	Fully compliant
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	**Resilience Direct (MTW Assurance 2023):** -Training and Exercising Staff Participation Document - Included in all plans with role specific action cards (explained in training) - EPRR slots in all new staff induction training (pics included)	Fully compliant
Domain 6 - Response							
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	**Resilience Direct (MTW Assurance 2023):** - Emergency Response and Recovery Plan - ICC and CCC predefined and available 24/7 with backup location across all sites (Outlined in Emergency Response and Recovery Plan) - Ability to run an ICC virtually via Microsoft teams (evidenced in most recent exercising - Ex Neptune 2) - Regular ICC checks carried out with Clinical Site Managers owning this (with support from EPRR) - BC arrangements: Back up locations, 8 x 8 mobiles (telecoms resilience), satellite phone, radios - Command foundation training includes ICC training - Intro to major incident and On site emergencies training includes ICC training. - CSM competency training for ICC (checklist included) - Major incident cupboards reviewed annually with access to all equipment/information (checklist included) - Clinical area resources available on intranet - Evacuation recording system - Red locker evidence	Fully compliant
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	**Resilience Direct (MTW Assurance 2023):** -Physical copies located: ICC's, CCC, Back up ICC's, Strategic ICC's, Library, Emergency Planning Office, both EO departments - Digital copies located: Staff intranet, Staff Q-Pulse, MTW Resilience Direct - 24/7 EP On Call with access to all plans - Also available via mobile devices	Fully compliant
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	**Resilience Direct (MTW Assurance 2023):** - Emergency Response and Recovery Plan - Section 4 Business Continuity arrangements - Local Level BIA/BCP templates included - Local Level BIA/BCP examples included (John Day) - Local Level Clinical Area Resource Folders and Red Emergency Lockers - BC Exercise Toolkit - IT BC/CI Incident Debrief Report	Fully compliant
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained Loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	**Resilience Direct (MTW Assurance 2023):** - Pool of trained loggists - All included on Everbridge Mass Alerting - Emergency Response and Recovery Plan (Logging Section) - Loggist training presentation included - Loggist training included within prospectus - Trialling new RD logging process - Loggist video included	Fully compliant
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitReps Template	**Resilience Direct (MTW Assurance 2023):** - SitReps writing included in Command foundation training - SITREP SOPs included - BIA/BCP Sitrep templates (included as an appendix within templates)	Fully compliant
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	**Resilience Direct (MTW Assurance 2023):** - Hard copies in Trusts ED's + available on internet	Fully compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	**Resilience Direct (MTW Assurance 2023):** - Hard copies in Trust ICC's, CCC's and ED's	Fully compliant
Domain 7 - Warning and informing							
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	**Resilience Direct (MTW Assurance 2023):** - 24/7 On Call Communication Team (On Call Rota included) - Emergency Response and Recovery plan outlines comms involvement and on call arrangements and Media Management - MTW Comms and Engagement Strategy - Media Stakeholders distribution list - Weekend plan outlining On call teams including comms team - Media training mandatory in order to complete command training for on call managers - Switchboard on call rota plan for comms - Ex Neptune 2 - comms involvement - Op Sandpiper - evidence of comms team managing large scale incident, dealing with media requests - December 22 Water Incident Example - utilisation of 'All Staff Message' - Warning and informing examples - External Media training through Freshwater Communications - Everbridge Mass Notification Tool utilised in the event of an incident - IT downtime examples included - Helpline Procedure available if needed - tested (evidence included) - Snippets included of exercises, plan rollouts, incidents comms	Fully compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	**Resilience Direct (MTW Assurance 2023):** - Emergency Response and Recovery plan outlines comms involvement and on call arrangements and Media Management - Comms specific action cards in the event of MI, CI and BC (E Response & Recovery Plan) - 24/7 On Call Communication Team (On Call Rota included) - All have experience, training for incidents - Ex Neptune 2/Feb 23 Comms Exercise - IT BC/CI Incident - Comms utilised OOH - External Media training through Freshwater Communications - Dedicated Tactical Commander Inbox, Mobile and Bleep - Emergency Cascades - Incorporated onto Everbridge for quick notification (included within Emergency Response and Recovery Plan)	Fully compliant
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	**Resilience Direct (MTW Assurance 2023):** - Emergency Response & Recovery Plan outlining comms involvement, on-call arrangements, media management, management of friends and relatives, management of volunteers - Friends and Relatives Leaflet available in ERER Plan - Everbridge Mass Notification Tool utilised in the event of an incident - IT downtime examples included - December 22 Water Incident Example - utilisation of 'All Staff Message' - Up to date 'NHS Kent and MEDWAY Primary Contacts List' available on Resilience Direct and to On-Call Managers & Hard copies in ICC's - Up to date KRF directory available via RD and to On-Call managers - Media Stakeholders distribution list - MTW Facebook page for communicating with the public - Complaints (PALS) team readily available - Digital Boards (warning & informing example) displaying important public information - Helpline ready for immediate set up in the event of incident - Maps available across sites, available on trust website and on RD - Social media policy in place for communicating with patients + Comms engagement strategy - External Media training through Freshwater Communications - External PA system for communicating at ED and Main Reception - Capabilities document (Live Contacts Spreadsheet) - Horizon Scannine Live on intranet	Fully compliant
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	**Resilience Direct (MTW Assurance 2023):** - 24/7 On Call Communication Team (On Call Rota included) - All have experience, training for incidents - Dedicate EPRR Facebook and twitter account - Social Media Policy + Comms strategy - MTW trust Facebook account - Emergency Response & Recovery Plan outlining comms involvement, on-call arrangements, media management, management of friends and relatives, management of volunteers - Media training for commanders - External Media training through Freshwater Communications - Comms team present at daily exec huddle to update situational awareness	Fully compliant
Domain 8 - Cooperation							
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	**Resilience Direct (MTW Assurance 2023):** - AEO or Deputy AEO exec meeting representation - Senior EPRR Representation at Delivery Groups - Meetine minutes	Fully compliant
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	**Resilience Direct (MTW Assurance 2023):** - EPPR leads - Nominated leads documented with LRF - Mike Underhill - KRF Co-Chair Plans and Capabilities group - Mel Marekstow - Mass Fatalities - Capabilities document outlines meeting representation including LRF - Meetine to take place for site visit from KRT	Fully compliant
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	**Resilience Direct (MTW Assurance 2023):** - Mutual Aid section of Emergency Response and Recovery Plan - LHRP agreed Mutual Aid policy that we sign up to - 4 x 4 volunteers MOU - Adverse Weather Plan - Exploring mutual aid from fire service for drones	Fully compliant
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	[redacted]	Not applicable
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency		Not applicable
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas		Not applicable
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	**Resilience Direct (MTW Assurance 2023):** - Mutual Aid section of Emergency Response and Recovery Plan - Shared RD response page function -LHRP agreed Mutual Aid policy that we sign up to - Kent Medway Information sharing agreement - Revamp of intranet system - Imminent update of external website	Fully compliant
Domain 9 - Business Continuity							
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	**Resilience Direct (MTW Assurance 2023):** - Strategic Business Continuity Plan - Section 4 of the Emergency Response and Recovery Plan - Resilience Policy and procedure - BCP and BIA templates - BIA/BCP Overarching spreadsheet - BC Intranet Page including all Clinical Area Resources (Outlines steer towards Good Practice Guidelines)	Fully compliant
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	**Resilience Direct (MTW Assurance 2023):** - Strategic Business Continuity Plan - Section 4 of the Emergency Response and Recovery Plan - Resilience Policy and Procedure - BIA & BCP templates - interactive - including the use of trust risk matrix - Departmental BCP and BIA's - Role specific BC action cards (Section 4 of Emergency Response and Recovery Plan) - Clinical Area Resources evidenced - BC Action Cards (Emergency Response and Recovery plan) - Exemple best practice BCP/BIA's (Clinical Ward, Facilities, more available upon request) - MTW Intranet Page - business Continuity - BC Toolkit - BC Awareness Video - BIA/BCP Overarching spreadsheet - Capabilities document outlines local level BIA/BCP status - BC Awareness Week evidence - BC Intranet Pane evidence	Fully compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:	**Resilience Direct (MTW Assurance 2023):** - Resilience Policy and Procedure - Section 4 Emergency Response and Recovery Plan (Trust Strategic Business Continuity Plan) - High level Analysis as a whole to determine priority services - Template Run through video and training sessions provided by EPRR team - Yearly audit to ensure these are being done at a local level - BIA/BCP Overarching spreadsheet - BIA templates	Fully compliant
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties.	**Resilience Direct (MTW Assurance 2023):** - Section 4 Emergency Response and Recovery Plan (Trust Strategic Business Continuity Plan) - Includes evidence of planning for all 5 of the domains - Resilience Policy and Procedure - Personnel leading on BC have relevant qualifications (CBCI, DBCI, ISO22301) - BCP templates for services include all - Training and awareness videos include all	Fully compliant
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence:	**Resilience Direct (MTW Assurance 2023):** - Exercise Grid (included in Capabilities document) - Exercise Toolkit utilised regularly by staff to test internal plans - Ex Neptune 2 (Water Outage) & debrief (Live Exercise) - IT Business Continuity Incident (Live Incident) - Evacuation Exercise a Charlton Athletic attended by the BC Leads	Fully compliant
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	**Resilience Direct (MTW Assurance 2023):** - Action plan to obtain compliance acknowledged by NHSE/I	Fully compliant
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	**Resilience Direct (MTW Assurance 2023):** - Resilience policy and procedure - MTW EPRR Annual Report - MTW Overarching BC status spreadsheet - Yearly audit - BCAW Survey Monkey - Regular updates to Resilience Committee including statistics charts	Fully compliant
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	**Resilience Direct (MTW Assurance 2023):** - MTW Overarching BC status spreadsheet outlining current audit based on priority services - Outcomes are reported back to Resilience Committee with the results in turn going to board - Resilience Policy and Procedure - Section 4 of Emerenecy Response and Recovery Plan (Trust Strateic BC Plan)	Fully compliant
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	**Resilience Direct (MTW Assurance 2023):** - Resilience Policy and procedure - Section 4 - Emergency Response and Recovery Plan (Strategic BC Plan) - Just been completely reviewed and rewritten for continues improvement - BC Overarching status spreadsheet - Resilience Committee minutes covering BC updates and Recent BC incidents for the Quarter - BC Lead carries out regular review as per Resilience Policy - BC programme is based on BCI Good Practice Guidelines that incorporates: review, self assessment, quality assurance, performance appraisal, supplier performance etc - All Emergency Red Folders now updated with newly updated Business Continuity Action Cards	Fully compliant
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	**Resilience Direct (MTW Assurance 2023):** - MTW BC Supplier Agreement - all suppliers sign up to this agreement - Example of BC Leads reviewing external BC Plan (Laundry)	Fully compliant
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning	[redacted]	Not applicable
Domain 10 - CBRN							
56	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - Resilience Policy - All associated action cards in plans - Training Prospectus (Incorporates 27 sessions in total) - Equipment checks on both sites by ED departments - evidence uploaded	Fully compliant
57	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - CBRN 2023 - 24 Risk Assessment (Signed off by Health and Safety Trust Lead) - Staff Screening Questionnaires - Specific Risk Assessments	Fully compliant
58	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - Contact numbers included in all plans - In-house subject matter experts available via Everbridge (Medical Physics for Radiation, Infection Control and Microbiology) - UKHSA (PHE) Managing Hazmat Incidents Handbook based in both ED's	Fully compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
59	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •Command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - Training Prospectus (Incorporates 27 sessions in total) - SECAmb Peer Reviews - Signed Off (2021-2022) - Decon Tent Assembly Instructions - PRPS Donning & Doffing Instructions - CBRN Aide Memoirs - CBRN decon locations and back ups - CBRN Training sessions include training on all of the listed (Training prospectus) - CBRN for managers course (links to Command and Control Accreditation) - presentation and training prospectus included - Lockdown arrangements included in CBRN plans and lockdown plan - Mass Decon Info Sheet (in collaboration with KFRS)	Fully compliant
60	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients. 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - ED allocate roles at the start of each shift - ED rota evidenced on RD - CBRN Trained Database (Access Database) - Everbridge Mass Notification system with all CBRN trained personnel utilised 24/7 - CBRN Permit to Work Cards (evidence of competency) - staff carry round 24/7 - EPRR On-Call 24/7 - Medical Physics, Microbiology, Infection Control all on call 24/7 - ED Competency Checklist (CBRN Section)	Fully compliant
61	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - Peer review of equipment (2021 - 2022) - All equipment present as per NHS England requirements - Equipment checklists - PRPS lists - PRPS Donning and Doffing Instructions - Decon Tent Assembly Instructions - CBRN Risk Assessment	Fully compliant
62	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard S3	**Resilience Direct (MTW Assurance 2023):** - Maintenance, repair, calibration checks by ED - evidence included - PRPS and Tent Service evidence included - PRPS up to date list included - Contract with PPS for maintenance - Spare parts, spare tent, spare basin, spare bladder, spare pumps for resilience should primary go wrong - Estates included in maintenance and repair if appropriate - RAM Gene checks by ED included - Waste management included in all plans - ED named individual reasonsible for coverine CBRN remit and checks of eauipment	Fully compliant
63	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard S3	**Resilience Direct (MTW Assurance 2023):** - MTW Chemical Incident Plan (Signed off by AEO at Resilience Committee) - MTW Biological Plan (Signed off by AEO at Resilience Committee) - MTW Radiological & Nuclear Plan (Signed off by AEO at Resilience Committee) - Waste disposal processes included in plans	Fully compliant
64	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	**Resilience Direct (MTW Assurance 2023):** - Training prospectus (incorporating 27 CBRN sessions) - 6 senior members of staff with the ability to deliver CBRN - All with SECAmb Train the Trainer qualifications - Training Needs Analysis included Resilience Policy (CBRN documented) - CBRN Trained Staff list (Access Database) - Kent and Medway CBRN Standard - CBRN South East Forum attendance and minutes (Head of team is Deputy Chair) - CBRN Training Presentations included (in process of update)	Fully compliant
65	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	**Resilience Direct (MTW Assurance 2023):** - Training prospectus (incorporating 27 CBRN sessions) - Compulsory for all ED staff to be trained and hold a permit to work - Non-ED including nn-clinical members of staff also trained to support in response - CBRN training slides evidenced on RD (in the process of being updated) - CBRN permit to work database included - Staff screening questionnaires - ED Competency Checklist incorporates CBRN competency	Fully compliant
66	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availble for immediate deployment to safety undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	**Resilience Direct (MTW Assurance 2023):** - PRPS inventory spreadsheet - Included in all training sessions - Equipment inventory evidence included - Fit testing takes place during induction - compliance records on MTW Learning - Dedicated Fit testing team - High risk areas issued with re-usable masks and filters - Fit testing evidence included in daily staffing huddles (evidence included)	Fully compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
67	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence: • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Resilience Direct HMTW Assurance 2023\: - Exercise Springfield 1 Briefing and Debrief Report included - Capabilities Document (Exercise & Incident Grid)	Fully compliant
68	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.		Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).	[redacted]	Not applicable
69	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.		Not applicable
70	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. Evidence of progress/close-out of actions.		Not applicable
71	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.		Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.		Not applicable
72	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.		Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.		Not applicable
73	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.		NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.		Not applicable
74	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.		Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to acute Trusts, how often, etc.).		Not applicable

Over arching changes:	Domain 10 - CBRN renamed to Domain 10 - HazMat/CBRN Domain 10 standards reordered amd renumbered

Previous standard detail					New standard detail			
Ref	Domain	Standard	Detail	2023 Changes	Ref	Domain	Standard name	Standard Detail
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	No change	1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	Governance	EPRR Policy	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	No change	2	Governance	EPRR Policy	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	No change	3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	No change	4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	No change	5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	No change	6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess								
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	No change	7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	No change	8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								

9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Standard detail has been updated to emphasise the importance of joint working and collaborative planning with emergency services and health partners following lesson identified through JOL working group.	9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	No change	10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	No change	11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	No change	13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	No change	12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	No change	14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	No change	15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	No change	16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	No change	17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	No change	19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.	No change	20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	No change	21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	No change	22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	No change	23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	No change	24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	No change	25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Domain 6 - Response								

26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	No change	26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	No change	27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	No change	28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	No change	29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	No change	30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	No change	31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	No change	32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing									
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	No change	33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	No change	34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	No change	35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	No change	36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation									
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.	No change	37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	No change	38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.

39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	No change	39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	No change	40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	No change	41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	No change	42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.	No change	43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity									
44	Business Continuity	Business Continuity (BC) policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	No change	44	Business Continuity	Business Continuity (BC) policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	No change	45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	No change	46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change	47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
48	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	No change	48	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
49	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	No change	49	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change	50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	No change	51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
52	Business Continuity	BCMS continuous improvement process	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	No change	52	Business Continuity	BCMS continuous improvement process	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	No change	53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	No change	54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 10 - HazMat/CBRN									

				New Standard	56	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Amended wording of standard so not specific to telephony advice.	58	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Standard detail amended to include specific elements of Hazmat/CBRN plan	59	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Standard detail amended and supporting information developed with evidence of risk assessments.	57	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Standard detail amended to incroporate wet, dry, interim and improvised decontamination where necessary and availbilty of staff.	60	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be deployed within 30 mins to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s)
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/epr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Standard detail amended to reflect need to ensure equipment is in line with organisational Hazmat/CBRN risk assessments	61	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Standards merged.	66		PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.					
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Standards merged.	62	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment					
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Standard detail amended to reflect need to ensure the organisation has processes in place to manage waste, including but not limited to PPE.	63	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training					The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan

65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Hazmat/CBRN Training standards have been consolidated from four into two standards	64	Hazmat/CBRN	Hazmat/CBRN training resource	and associated risk assessments
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		65	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles of 'Remove, Remove, Remove' and isolation when necessary. (This includes (but is not limited to) acute,
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	New standard	67	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme
				New Core Standards applicable to NHS ambulance services and developed by NARU in consultation with all NHS Ambulance Services in England to standardise the approach and support offer to acute Trusts	68	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response.
					69	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.
					70	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).
					71	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.
					72	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.
					73	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.
					74	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised.	Action to be taken	Lead	Timescale	Comments
Deep Dive - EPRR Training											
DD1	EPRR Training	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders		**Resilience Direct (MTW Assurance 2023):** - MTW Emergency Response and Plan (Section One - Command, Control, Coordination and Communication) - All Plans reference this section - Resilience Policy and Procedure - Resilience Training needs analysis (Incorporated as an appendix within Resilience Policy)					
DD2	EPRR Training	Minimum Occupational Standards	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios		**Resilience Direct (MTW Assurance 2023):** - Commander Portfolio aligned with Principles of Health Command - New Tactical Portfolio evidenced - Strategic Portfolio evidenced - Commander Roles and Standards stated on back of ID cards - Command Trained Personnel spreadsheet with update dates					
DD3	EPRR Training	EPRR staff training	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff		**Resilience Direct (MTW Assurance 2023):** - Resilience Policy and Procedure					
DD4	EPRR Training	Senior Leadership Training	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.		**Resilience Direct (MTW Assurance 2023):** - Resilience Policy and Procedure - Resilience TNA					

DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	**Resilience Direct (MTW Assurance 2023):** - Command Portfolio Intranet Page - Internal Command Courses are mandatory before going On-Call - Training checklist included - Training Prospectus - MTW Learning Page - available for staff to join via this link (All courses available for enrolment via MTW Learning, 1 course evidenced)	
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	**Resilience Direct (MTW Assurance 2023):** - Training checklist including list of all trained staff with specific training undertaken - CBRN trained personnel - Commander trained personnel - Loggist pool	
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	**Resilience Direct (MTW Assurance 2023):** - Training checklists managed by EPRR Admin - Included on Annual Report - Reported to Resilience Committee which in turn reports to Health and Safety which in turn reports to Board (Governance structure) - Small Boats Incident Multi Agency Debrief	
DD8	EPRR Training	JESIP doctrine	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	**Resilience Direct (MTW Assurance 2023):** - Command Training includes all JESIP related content including Principles, Tools etc - CBRN Command and Control incoporates JESIP - ICC/CCC incorporates JESIP Tools - Commander Aide Memoirs incorporate JESIP	
DD9	EPRR Training	Continuous Improvement process	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	**Resilience Direct (MTW Assurance 2023):** - All training material updated in line with new EPRR plans and guidelines - Example of Command Training incorporating new MTW Emergency Response and Recovery Plan and UK Resilience Framework - Incident & Exercise Debriefs	
DD10	EPRR Training	Evaluation	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	**Resilience Direct (MTW Assurance 2023):** - Trust Feedback Forms for all Training - Currently moving this to digital to Survey Monkey and QR codes	

NHS Maidstone and Tunbridge Wells NHS Trust

The NHS England Fit and Proper Person Test Framework for board members

Trust Secretary

On 2nd August, NHS England (NHSE) published the new Fit and Proper Person Test ("FPPT") Framework for NHS board members, which was the culmination of work to respond to the recommendations in the "review of the Fit and Proper Person Test" undertaken by Tom Kark KC in 2019.

This report explains the key aspects of the new Framework, which comes into effect on 30/09/23, and how this has been, and will be, fully implemented at the Trust by 31/03/24.

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

- N/A (although the report will be considered by the ETM on 03/10/23)

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

Information and assurance

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

1. Introduction and background

- The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, that was published in 2013 recommended that a statutory 'fit and proper persons' requirement be imposed on health service bodies (in relation to their Directors[2]).
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were duly enacted and the relevant aspects (Regulation 5) came into force on 27/11/14. The regulations introduced the new requirement that Directors of health service bodies be "fit and proper".
- The associated guidance published by the Care Quality Commission (CQC) made it clear that the Regulations should apply regardless of a Director's voting rights on a Board, and should apply to permanent, interim & associate positions (providing they were members of the Board).
- In December 2014, the Trust Board approved Maidstone and Tunbridge Wells NHS Trust's approach to responding to the Regulations, which involved a self-declaration; Disclosure and Barring Service (DBS) check; due diligence checks; annual appraisal confirmation; and inserting specific text into Executive Directors' contract of employment. That approach was subsequently incorporated into the Trust's Standing Orders, which are subject to an annual review (and annual ratification by the Trust Board). The "Procedures to be applied in response to the "Fit and Proper Persons: Directors" Regulations" are managed by the Trust Secretary, and the full details are enclosed in Appendix 1 of this report.
- The Independent Review into Liverpool Community Health that was undertaken by Dr Bill Kirkup CBE, whose report was published in January 2018, recommended that the Department of Health "…review the working of the Care Quality Commission fit and proper person's test, to ensure that concerns over the capability and conduct of NHS executive and non-Executive Directors are definitively resolved and the outcome reflected in future appointments".
- In July 2018, the then Minister of State for Health, Stephen Barclay MP, therefore commissioned Tom Kark QC (now KC) to undertake an independent review of the Fit and Proper Persons Requirement, to assess how effectively it prevented unsuitable staff from being redeployed or re-employed in health and social care settings. The "A review of the Fit and Proper Person Test" ('The Kark review') report was duly published in February 2019 and made seven recommendations:
  1. "All directors (executive, non-executive and interim) should meet specified standards of competence to sit on the board of any health providing organisation. Where necessary, training should be available".
  2. "That a central database of directors should be created holding relevant information about qualifications and history".
  3. "The creation of a mandatory reference requirement for each Director".
  4. "The FPPT should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHSI and NHSE)".
  5. "The power to disbar directors for serious misconduct".
  6. That the text of Regulation 5 (3) (d) of "The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014" be amended to remove the words "been privy to".
  7. "We recommend that further work is done to examine how the test works in the context of the provision of social care and whether any amendments are needed to make the test effective".
- Five of the recommendations were accepted by the then Secretary of State for Health and Social Care – recommendations 5[3] and 7 were not accepted.
- General Sir Gordon Messenger stated, in his "Leadership for a collaborative and inclusive future" report from that was published in June 2022, that he felt it was necessary to consider the recommendations from the Kark review along his own review's recommendations, to ensure that poor leadership was dealt with effectively.
- The "NHS England Fit and Proper Person Test Framework for board members" that was published on 02/08/23 is the official response to the five recommendations that were accepted from the Kark review.

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[2] A statutory requirement for providers to ensure that their "workers" were "of good character" (inter alia) had been in place since 2010

[3] The Secretary of State for Health and Social Care did however state, in an oral statement to parliament on 04/09/23 regarding the Lucy Letby statutory inquiry, that "…the NHS actively considered Kark's recommendation 5 on disbarring senior managers, taking the view that introducing the wider changes he recommended in his review mitigated the need to accept this specific recommendation on disbarring…In light of evidence from Chester, and ongoing variation in performance across trusts, I have asked NHS England to work with my department to revisit this".

2. The main aspects of the new Fit and Proper Person Test (FPPT) Framework

- The FPPT Framework does not replace the underlying statutory requirement (which has not changed[4]) to ensure that directors are fit and proper on an ongoing basis. The core elements of the new Framework therefore also remain unchanged from the current requirements that apply to NHS provider organisations, so the new Framework strengthens, rather than fundamentally amends, the current arrangements. The Framework does however apply to Integrated Care Boards and two 'Arm's Length Bodies' (NHSE and the CQC) for the first time.
- The two main changes are the introduction of the Board Member Reference (BMR) process, and the recording of additional information about Trust Board members within the Electronic Staff Record (ESR). These two changes are described further section 3. below.
- The Framework also clarifies, and elaborates on, many aspects of the existing requirements, such as that temporary appointments to a Trust Board should have the FFT applied if such appointments are greater than six weeks. However the Framework states that, for the initial appointment of NHS Trust Chairs, once the NHS organisation has completed the fit and proper person assessment, FPPT approval should be sought from the NHSE Appointments Team before they commence their role.
- The Framework also provides additional guidance on:
  - how organisations should assess whether a Trust Board member is of "good character" (which includes assessing whether the individual is a person in whom the NHS organisation, CQC, NHSE, people using the Trust's services and the wider public can have confidence; and the extent to which the individual has adhered to the Nolan Principles of Standards in Public Life[5]);
  - the interpretation of "serious mismanagement or misconduct" (which is a key term used in the Regulations[4]);
  - determining the qualifications, competence, skills required and experience of Trust Board members; and
  - the reasonable adjustments that organisations should expect to make to support Trust Board members to carry out their role (in relation to their physical and mental health).
- The Framework also outlines the approach required for the joint appointment of a Trust Board member across different NHS organisations, shared roles within the same NHS organisation, and the temporary absence of a Trust Board member.
- Other elements of the Framework cover how breaches of the FFPT should be managed; how disputes should be resolved; and how the FFPT Framework will be monitored (this will primarily be done by the CQC as part of their Well Led inspections, as is currently the case).

3. The two main changes of the new Framework: The BMR process and the use of the ESR

- The new BMR process will apply to all Trust Board member roles and is mandatory. It will apply to new appointments and to those who are leaving an organisation's Board.
- For new appointments, the BMR process will apply after the individual has accepted the conditional offer of an appointment and after a full FPPT assessment has been carried out. It is therefore the final step in the appointment process.
- For leavers, once an individual is known to be leaving the Trust Board, the Chair of the Trust Board (for the Chief Executive and Non-Executive Directors) or Chief Executive (for Executive Directors) should complete a BMR, regardless of whether or not a reference has been requested by the individual's new employer/appointing organisation. That BMR will then be retained locally (currently, the template cannot be uploaded to the ESR) on a career-long basis.
- A standard reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. The reference is based on the six competence categories that will feature in the forthcoming Leadership Competency Framework (LCF) (see below). The reference template is enclosed in Appendix 2.
- New data fields have been added to the ESR to support recruitment referencing and ongoing development of Trust Board members. The FPPT information within ESR will only be accessible within the Trust Board members' own organisation[6] and there will be no public register.

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[4] The Regulations still contain the words "been privy to" i.e. "the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…"
[5] Selflessness, Honesty, Objectivity, Openness, Leadership, Integrity and Accountability
[6] Access will however also be provided to relevant individuals within the CQC where this information is necessary for their roles

- The FPPT assessment on initial appointment of a board member will now cover the following points (most of these will already be in place, but the FPPT makes these points explicit):
  - First name*
  - Second name/surname*
  - Organisation* (that is, current employer)
  - Staff group*
  - Job title* (that is, current job description)
  - Occupation code*
  - Position title*
  - Employment history* (i.e. detail of all job titles, organisation departments, dates, and role descriptions, although any gaps due to any protected characteristics, as defined in the Equality Act 2010, would not need to be explained).
  - Training and development
  - References* (available references from previous employers, board member references, including resignations or early retirement)
  - Last appraisal and date
  - Disciplinary findings (i.e. any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance/s (upheld) against the board member, whistleblowing claim/s against the board member (upheld) and employee behaviour upheld findings). Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
  - Type of DBS disclosed*
  - Date DBS received*
  - Disqualified directors register check
  - Date of medical clearance* (including confirmation of occupational health assessment/s)
  - Date of professional register check (e.g. membership of professional bodies)
  - Insolvency check
  - Self-attestation form signed
  - Social media check
  - Employment tribunal judgement check
  - Disqualification from being a charity trustee check
  - Board Member Reference*
  - Sign-off by the Chair of the Trust Board / Chief Executive
- The FPPT Framework states that NHS organisations should validate all the fields above annually, apart from those marked with an asterisk (*).

4. Information governance considerations

- As noted above, part of the new FPPT Framework involves new data points being added to ESR to record the testing of relevant information about Board members' qualifications and career history. Trust Board members were advised of these new data points, and their rights, under the UK General Data Protection Regulation (UK GDPR), with regards to the processing of that data, in an email from the Trust Secretary on 17/08/23. Any queries that Trust Board members have regarding this aspect of the FPPT Framework should be directed to the Trust Secretary (who is also the Trust's Data Protection Officer).

5. Monitoring and reporting on the new FPPT Framework

- As noted above, the external monitoring of compliance with the new Framework will primarily be done by the CQC as part of their Well Led inspections (as is currently the case).
- However, the Chair of the Trust Board will also be required to provide an overall summary of the FPPT outcome for their Board in an annual submission to the NHSE Regional Director (which should be made at the same time as the submission of the Chair's annual appraisal, which is currently required by the end of June each year). The template for this report is enclosed in Appendix 3. The outcome of the FPPT process for the Chair of the Trust Board should be submitted to the NHSE Regional Director by the person who undertakes that appraisal (which in the case of the Trust is the Vice Chair of the Trust Board) or the Trust Secretary.
- The Framework states that NHS organisations should:

- have an Internal Audit review every three years, to assess the processes, controls and compliance supporting the FPPT assessments (with the review including sample testing of FPPT assessment and associated documentation); and
- consider including the FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews.

- The Framework also states that "It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in the annual report or elsewhere on their websites", although it is not yet known whether this will be an explicit requirement in the Department of Health and Social Care's Group Accounting Manual (which dictates the content of NHS Trusts' Annual Reports).

6. Other considerations

- NHSE will publish a Leadership Competency Framework (LCF) in October 2023 which will provide guidance on the following six competence categories (against which a Trust Board member should be appointed, developed and appraised):
  1. Setting strategy and delivering long term transformation.
  2. Leading for equality.
  3. Driving high quality, sustainable outcomes.
  4. Providing robust governance and assurance.
  5. Creating a compassionate and inclusive culture.
  6. Building trusted relationships with partners and communities
- The LCF is expected to be incorporated into all senior leader job descriptions and recruitment processes and built into national leadership programmes and support offers.
- NHSE has published a "Directory of board level learning and development opportunities" to supplement the new FPPT Framework and forthcoming LCF. The directory lists support offers for Executive and Non-Executive board directors that NHSE have considered against a set of quality assurance criteria. The Trust's Board members will be familiar with many of the support offers listed (which include offers from the NHS Leadership Academy, Healthcare Financial Management Association, NHS Confederation, NHS Providers, Seacole Group, The King's Fund, and NHSE) but are encouraged to use the Directory as part of their own learning and development.
- A new board appraisal framework will be published, that incorporates the LCF, by March 2024. That framework will need to be used for all annual appraisals of all Trust Board directors for 2023/24 by the end of quarter 1 of 2024.
- NHSE have stated that they will review the FPPT Framework after 18 months to assess how effectively it has been embedded and its impact within NHS organisations. As part of that review, 'significant roles' may also be included within the scope of the Framework i.e. those senior individuals within NHS organisations who have significant influence at the board (or influence over other significant decisions) but are not directors for the purposes of Regulation 5 of the Regulations. Significant roles added to the Framework are likely as a minimum to include deputy directors, clinical leaders and those involved in key decision-making meetings (this last category will be determined at the discretion of individual NHS organisations). Furthermore, in future there could be NHS organisations with group structures that have a management board at the parent level, which is supported by subsidiary boards across the various legal entities within the structure. In such a scenario, if both the parent and subsidiary boards are responsible for strategic decision-making, it is expected that members across both boards should be subject to the requirements of this Framework.
- Future consideration will also be given to implementing a public facing register of board members who have been assessed and approved as being fit and proper.
- It should be noted that the new FPPT Framework does not address the current significant anomaly in complying with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to DBS checks. This relates to the fact that the DBS check eligibility criteria prevents an "Enhanced" or "Enhanced with lists" check being undertaken for most Trust Board members, despite the fact that the latter check is the only level of check that can objectively determine whether an individual is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 (which is one of the "grounds of unfitness" in the Regulations). The DBS eligibility criteria makes

it apparent that only a “Standard” DBS check is suitable for most NHS providers’ Trust Board members, based on the expectations of their role (and excluding any clinical duties they may have by the nature of their clinical profession), so NHS provider organisations are reliant on a Trust Board member’s self-declaration that they are not on the children’s or adults’ barred lists[7]. This anomaly was not considered by the Kark review, and it had not been addressed by the Independent Review of the Disclosure and Barring Regime that was published in May 2023.

7. Implications for the Trust and next steps

- The Trust Secretary has attended the national webinars that NHSE have held on the new Framework.
- Many aspects of the new FPPT Framework are already included within the Trust’s procedures, so the new Framework will not require a significant shift in approach. However, some aspects are new, so those procedures (which are an Appendix to the Trust’s Standing Orders) will need to be updated to ensure they reflect the new Framework in full.
- The aspects that are currently not included in the Trust’s process are the Board Member Reference (BMR); a social media check; an Employment Tribunal judgement check; the three-yearly review by Internal Audit; and the annual submission of the outcome from the Chair of the Trust Board to NHSE.
- The Trust’s current “‘Fit and proper person’ declaration for Trust Board Members” will need to be updated to match the text of the “New starter/annual NHS FPPT self-attestation” (see Appendix 4).
- These steps will be taken by the Trust Secretary. The Standing Orders are approved by the Audit and Governance Committee, and ratified by the Trust Board, so the update will be scheduled for the Audit and Governance Committee’s next meeting, on 09/11/23.
- The Trust Secretary’s office will also continue to liaise with colleagues in the People function, to ensure that the new FFPT fields within the ESR are populated, from 30/09/23 onwards.

[7] For a role to be eligible for an Enhanced DBS check within the Child Workforce it must meet the criteria outlined in the Child Workforce guidance, whilst for the role to be eligible for an Enhanced DBS check within the Adult Workforce it must meet the criteria outlined in the Adult Workforce guidance. It is not possible for an individual to request an “Enhanced with lists” check for themselves even if their employer instructs them to request such a check.

Appendix 1: The Trust's current "Procedures to be applied in response to the "Fit and Proper Persons: Directors" Regulations" (which are included in the Trust's Standing Orders)

1. The Fit and Proper Person requirements will apply to all Members of the Trust Board (as defined in the Standing Orders). The Chair of the Trust Board is responsible for ensuring that all Members of the Trust Board meet the fitness test and do not meet any of the 'unfit' criteria. A failure or refusal by a candidate for appointment to comply with any of the procedures set out below will immediately disqualify that person from the proposed appointment.
2. The Chair of the Trust Board may also determine that the Fit and Proper Person requirements should be applied to individuals who are not formal members of the Trust Board, if such individuals are expected to attend Trust Board meetings regularly, and contribute to proceedings.

Process for new appointments

3. The Trust has in place robust processes with regard to recruitment to Members of the Trust Board. These processes include pre-employment checks in accordance with NHS Employers pre-employment check standards. All appointments to the Trust Board will require:
   a. Identity checks
   b. Qualification and registration checks - Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator
   c. Right to work checks
   d. Disclosure and Barring Service (DBS) checks as appropriate to the role. To safeguard service users by identifying unsuitable candidates, any appointment will be dependent upon the satisfactory completion of a "Standard" disclosure through the DBS[8]. The level of check undertaken for members of the Executive Team will be determined by the type of activities required by their role and the level of access this will allow them to patients. The Trust will apply the "DBS update" process to all Members of the Trust Board. This enables (for an annual fee, which will be paid by the Trust) employers to be notified of any changes to an individual's DBS status proactively i.e. without the need to undertake a new check. If the DBS check identifies any convictions that have not been declared, the Chair of the Trust Board will discuss the findings of the check with the individual (and the Chief Executive, for members of the Executive Team), and instigate appropriate action. The reasons for any decisions made under this process will be recorded and shared with those who need to be made aware
   e. At least two references, one being from the most recent employer
   f. Health questionnaire and Occupational Health clearance - If the individual has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. In the event a prospective candidate identifies any physical or mental health concerns (and subject to further information being obtained from the candidate, if necessary) their appointment will be subject to clearance by Occupational Health as part of the pre-appointment process. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded by the Trust Secretary and shared with those that need to be aware
   g. Interview processes including panel interviews

      N.B. All of the checks listed above will be recorded and evidenced by the Trust Secretary's office, in liaison with the Trust's People function.

   h. Accounting within contracts of employment for all officer Members of the Trust Board for the fact that an individual cannot continue within the role should they meet any of the criteria for being "unfit"
   i. Completion of a self-declaration (Appendix 5 of the Standing Orders: RWF-COR-COR-FOR-1), which includes, among other aspects, confirmation that none of the unfit criteria

[8] The role expected to be undertaken by most Trust Board Members does not justify "Enhanced" or "Enhanced with lists" DBS checks being undertaken, based on the eligibility criteria for DBS checks (as described in the DBS' guides to adult and child workforce roles for registered bodies and employers)

apply. If an individual is unable to sign the declaration, the reasons should be discussed with the Chair of the Trust Board (the Trust Secretary will also be available for an initial discussion). For members of the Executive Team, the discussion should involve the Chief Executive. If, on discussion, the individual is deemed suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations, the declaration may be amended to reflect the specific circumstances of that individual and to enable them to sign it (providing this does not conflict with the Regulations). For example, the individual may have been convicted[9] in the UK of a minor offence, which would prevent them from the signing the declaration, but which, in the judgement of the Chair, would not mean that they were not of "good character". A record will be kept (by the Trust Secretary) of the reasons for the decision and why the declaration form was amended. Information about the decision will be shared with those that need to be aware.

4. Additionally, the Trust Secretary will undertake 'due diligence' checks for each Director (via searching the relevant registers and other on-line information), to determine whether the individual:
   a. is an undischarged bankrupt
   b. has had sequestration awarded (which has not been discharged) in respect of their estate
   c. is the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland
   d. is a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b))
   e. has made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it)
   f. is not prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities
   g. has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals
   h. has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity
   i. has been disqualified from being a charity trustee or is listed on the Charity Commission's Register of Removed Trustees.
   j. has been subject to a County Court Judgment (CCJ) (including any company of which they are the Director or Secretary)
5. Such 'due diligence' checking will also incorporate any specific qualification requirements for Executive roles (e.g. that the Director of Workforce be a member of the Chartered Institute of Personnel and Development), and will include (but not be limited to) publicly available registers, such as:
   a. the Individual Insolvency Register (IIR)
   b. the Companies House database of disqualified directors (under the Company Directors Disqualification Act 1986)
   c. the Insolvency Service's register of Directors they got disqualified
   d. Register of Removed Charity Trustees
   e. the List of Registered Medical Practitioners
   f. Nursing and Midwifery Council (NMC) register
   g. Other professional registers
   h. Publicly available investigation reports of failings within health and social care provision
6. For those Directors that have lived for periods abroad (non-UK) before joining the Trust the initial 'due diligence' checks, conducted by the Trust Secretary, will incorporate the equivalent registers, if available, from the country of origin; however, the annual 'due diligence' checks thereafter will only include the relevant UK registers

[9] In the UK "conviction" means an admission of guilt or a finding of guilt in a criminal court whether by judge, jury, magistrate or certain tribunal Chairman conducting criminal cases. Therefore fixed penalty notices and speeding fines are not convictions.

Assessment of on-going fitness

7. The annual appraisal process for all Trust Board members will incorporate a formal review and confirmation that the individual:
   a. continues to have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and
   b. continues to be able by reason of their health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the work for which they are employed
8. These aspects will be part of the formal documentation for such appraisals. This step is not intended to prevent any changes in an individual's circumstances being reviewed and responded to at the time such changes occur (i.e. relevant action should not be deferred until an individual's annual appraisal).
9. The Chief Executive will be responsible for appraising the members of the Executive Team, whilst the Chair of the Trust Board will be responsible for appraising the Non-Executive Directors and Associate Non-Executive Directors. The Chief Executive will be appraised by the Chair of the Trust Board. The appraisal of the Chair of the Trust Board will be undertaken by representatives of NHSE.
10. There will be an annual requirement for post holders to complete the self-declaration form described in point 3i. This will usually be scheduled to be undertaken at the same time as the annual declaration of Board Members' interests.
11. The Trust Secretary will also repeat the 'due diligence' checks outlined in paragraph 4 on an annual basis; with the exception of the check of the Register of Judgments (www.trustonline.org.uk) to review details of CCJs, which will only be conducted in respect of two members of the Trust Board, as selected by the Trust Secretary (although those checked in the previous year are excluded from selection in the following year). The Trust will pay the costs for the fee charged for undertaking such checks).

Concerns regarding an individual's continued FPPR compliance

12. Where matters are raised, identified or declared that cause concerns relating to an individual being fit and proper to carry out their role, the Chair of the Trust Board will oversee an investigation which will be appropriate, timely and proportionate to the matter raised. Any investigation will have due regard to the relevant Trust Policies and Procedures along with guidance issued by the Care Quality Commission (CQC) or NHS Improvement. The Chair of the Trust Board may consult with the Trust's Director of Workforce and / or Senior Independent Director on this. If the matters raised relate to or involve the Chair of the Trust Board, responsibility for oversight of the investigation will fall to the Vice-Chair of the Trust Board. If concerns are substantiated by evidence, proportionate, timely action will be taken to investigate this through either the FPPR or the Trust's "Disciplinary Policy and Procedure" or "Performance Management (Capability) Policy and Procedure", whichever is judged to be the most appropriate to the circumstances. Where an individual's fitness to carry out their role is being investigated appropriate interim measures will be considered to minimise any risk to service users or the Trust.
13. The final decision on whether the individual is fit and proper following an investigation under the FPPR lies with the Chair of the Trust Board. If the Chair determines that the individual does not or no longer meets the requirements of a fit and proper person, that person shall not be appointed, or their appointment will be terminated. Should the Chair determine that the individual is or remains a fit and proper person the reasons for this decision will be recorded and shared with those who need to be aware.

Sharing concerns with other bodies

14. Where appropriate, the Trust will also inform other organisations about concerns or findings relating to an individual's fitness, for example, professional regulators, the CQC and other relevant bodies. The Trust will also support any related enquiries or investigations carried out by others.

Assurance to the Trust Board

15. The Trust Board will receive an annual report to confirm implementation of the FPPR for existing post holders. The Chair of the Trust Board is the responsible officer for ensuring compliance for new starters. A summary of compliance will also be included in the Trust's Annual Report.

Appendix 2: The new Board Member Reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		

12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 3: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: FPPT outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	

For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 4: Fit and Proper Person Test annual/new starter self-attestation

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

NHS Maidstone and Tunbridge Wells NHS Trust

Response to NHSE's "Verdict in the trial of Lucy Letby **Trust Secretary**

On 18/08/23 Lucy Letby was found guilty of seven counts of murder and seven counts of attempted murder which were committed between June 2015 and June 2016, while she worked as a neonatal nurse at Countess of Chester Hospital (which is run by the Countess of Chester Hospital NHS Foundation Trust).

The Department of Health and Social Care (DHSC) announced, on 18/08/23, that an independent, non-statutory, inquiry would be established to look into the circumstances of the case. The DHSC then announced, on 30/08/23, that the inquiry would be statutory (and therefore operate in accordance with the Inquiries Act 2005). Lady Justice Thirlwall has subsequently been announced as the inquiry chair, but no other details of that inquiry have been published to date.

NHS England (NHSE) issued a "Verdict in the trial of Lucy Letby" letter on 18/08/23 to the senior leaders of all NHS Integrated Care Boards and provider Trusts. That letter is enclosed in Appendix 1.

This report aims to provide the Trust Board with some assurance in relation to the issues referred to in the letter from NHSE. It should however be emphasised that the full details of what occurred during Letby's time at the Countess of Chester Hospital, in relation to internal governance, are not yet known. It is expected that this will be the focus of the aforementioned inquiry, and the Trust will of course respond to any relevant recommendations arising from that.

Trust Board members should also note that the NHSE letter refers to the Fit and Proper Person Test (FPPT) Framework that was published on 02/08/23, and a report on the new Framework has been submitted to the Trust Board meeting on 28/09/23 under a separate agenda item.

Which Committees have reviewed the information prior to Trust Board submission?
- ETM, 19/09/23

Reason for submission to the Trust 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

Introduction

On 18/08/23 Lucy Letby was found guilty of seven counts of murder and seven counts of attempted murder which were committed between June 2015 and June 2016, while she worked as a neonatal nurse at Countess of Chester Hospital (which is run by the Countess of Chester Hospital NHS Foundation Trust). Letby was found not guilty of two further counts of attempted murder, and verdicts were not reached on six counts of attempted murder. Letby had previously (in June 2022) had one not guilty verdict recorded for a further murder charge[2].

NHSE issued a "Verdict in the trial of Lucy Letby" letter on 18/08/23 (see Appendix 1). The letter:

- Highlighted the existence of the Medical Examiners' service, which provides independent scrutiny of all deaths not investigated by HM Coroner.
- Highlighted the new Patient Safety Incident Response Framework (PSIRF) which will be implemented across the NHS in the autumn of 2023.
- Reminded NHS senior leaders of the importance of listening to the concerns of patients, families and staff, following 'whistleblowing' procedures, and that NHS organisations were expected to adopt the new national Freedom to Speak Up (FTSU) policy by January 2024.
- Reminded NHS senior leaders of the importance of good governance in relation to the FTSU policy, and specifically in ensuring that:
  - All staff have easy access to information on how to speak up;
  - Relevant departments, such as Human Resources and Freedom to Speak Up Guardians were aware of the national Speaking Up Support Scheme and actively referred individuals to the scheme.
  - Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up, or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of, or have access to, the policy or processes supporting speaking up.
  - Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up were put in place.
  - Boards sought assurance that staff can speak up with confidence and 'whistleblowers' are treated well.
  - Boards were regularly reporting, reviewing and acting upon available data.
- Reminds NHS organisations of their obligations under the 'Fit and Proper Person' (FPP) requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements.
- Highlights the new Fit and Proper Person Test (FPPT) Framework that was published in August 2023.

This report aims to provide the Trust Board with some assurance in relation to the issues referred to in the letter from NHSE. It should however be emphasised that the full details of what occurred during Letby's time at the Countess of Chester Hospital, in relation to internal governance, are not yet known. It is expected that this will be the focus of the aforementioned inquiry, and the Trust will of course respond to any relevant recommendations arising from that.

The Medical Examiner service

- The Trust's Medical Examiner service was established in September 2020.
- The service aims to strengthen safeguards for the public; provide robust, independent proportionate scrutiny of all deaths not referred directly to HM Coroner for investigation; ensure that appropriate deaths are referred to a Coroner and to other individual care organisations for further investigation if required; provide intelligent analysis and system level reporting of concerns found during scrutiny to relevant stakeholder services; improve the quality of death certification; provide expert advice to doctors completing the Summary of Death form, based on discussion and a proportionate scrutiny of relevant clinical records; ensure at the same time that the Medical Cause of Death follows an acceptable sequence of causation; give the bereaved a voice and avoid unnecessary distress; allow the bereaved to voice complaints/problems/worries concerning the death and act upon them; and give an explanation of the cause of death once

[2] Mr Justice Goss formally directed a verdict of not guilty be recorded as the Crown Prosecution Service had provided no evidence in relation to the count.

produced and giving information, where applicable, of any factors raised by the bereaved. Also, answer any other questions raised about the circumstances of death and notifying any relevant stakeholders where further investigation is needed.
- The service has a Lead Medical Examiner (who is a Consultant Histopathologist), a Medical Examiner Services Manager, three Medical Examiners (all consultants) and two Medical Examiner Officers.
- Information about the Medical Examiner service is included in the "Quarterly mortality data" reports that the Medical Director submits to the Trust Board (the latest of which has been submitted to the Trust Board meeting in September, under a separate agenda item).

The Patient Safety Incident Response Framework (PSIRF)
- The PSIRF framework will replace the Serious Incident Framework in autumn 2023, and the implementation is being led by the Director of Quality Governance and Patient Safety Team.
- Significant changes have been made to date (including designing a new Trust response to patient safety incidents; restructuring the Patient Safety Team; and the appointment of a Patient Safety Partner for a 12-month fixed period as a patient voice on safety committees).
- The implementation of the new Framework will enable the Trust to better engage with the NHSE Learn from Patient Safety Events (LFPSE) service (this is a national database which will improve the recording and analysis of patient safety events that occur in healthcare). The Trust is now LFPSE-compliant via the introduction of its new incident safety software, "InPhase".

The implementation of the new national FTSU policy
- The Trust's existing "Freedom to speak up: raising concerns" policy and processes comply with the national speak up policy.
- Following the departure of the Trust's previous Freedom to Speak Up Guardian (FTSUG), there will in future be a Lead FTSUG, supported by two others who are FTUSG-trained (the Chief People Officer and Deputy Chief People Officer, Organisational Development). There will be no Deputy FTSUG role, but a full time FTSUG will be appointed (initially an interim Lead FTSUG is being appointed, but a substantive Lead FTSUG will then be appointed within the coming months).

FTSU - staff access to information on how to speak up
- The Trust has a dedicated "Freedom to speak up" section of its intranet, which includes the contact details for the Freedom to Speak Up Guardian and with links to the "Freedom to speak up: raising concerns" policy and "Process for raising and escalating a concern" guidance.
- There is a monitored FTSU email inbox.
- Freedom to Speak Up is covered in the corporate induction programmes for all new staff.
- The intranet also contains details of the Trust's Safe Space Champions - a network of staff members from different areas and roles within the Trust who provide a listening ear and safe space for staff to discuss any worries or concerns, in confidence, about themselves or patient care.
- The Trust has an anonymous reporting system in place, to complement the Freedom to Speak Up process (and to ensure that all staff feel they can report concerns without having to give their names). Red post boxes marked "Staff anonymous reporting" are located in the in the cafes and main entrance areas of both main hospitals; and there is a dedicated phone line which goes straight to a confidential voicemail system so members of staff can leave messages. Staff can also raise concerns through the anonymous reporting intranet page. Work is also underway in the design of a digital reporting form via InPhase that will be sent to the Trust FTSU lead.

FTSU - awareness and use of the national Speaking Up Support Scheme
- The People and Organisational Development Directorate and Freedom to Speak Up Guardian service is aware of the national Speaking Up Support Scheme and has referred individuals to the scheme. The Trust also offers local support to those wishing to speak up.

FTSU - Support for staff who may have cultural barriers to speaking up, or who are in lower banded roles and may be less confident to do so; and support for staff who work unsociable hours and may not always be aware of, or have access to, the policy or processes supporting speaking up.

- In addition to the Freedom to Speak Up Guardian service, the Trust has a network of Safe Space Champions from different areas and roles within the Trust who provide a listening ear and safe space for staff to discuss any worries or concerns, in confidence, about themselves or patient care.
- The Trust does however recognise that it could strengthen its current arrangements on this aspect, and this will be a focus for the Trust in the coming months.

FTSU - Communicating with staff to build healthy and supporting cultures

- The FTSU works alongside the Organisational Development (OD) function, equality, diversity and inclusion (EDI) team, staff engagement and Employee Relations teams to conduct listening events with staff across the Trust. The FTSU Guardian also engages with staff networks across the Trust.
- The OD and Human Resources Business Partner team works with the divisional and directorate triumvirates to support them to develop and implement people and culture improvement plans.

FTSU - Board assurance that staff can speak up with confidence and 'whistleblowers' are treated well; and Board reporting, reviewing and acting upon available data

- The Trust Board has received a report from the Freedom to Speak Up Guardian each quarter since April 2019, and the Guardian attends the Trust Board meeting to speak to their report.

The FPP requirements and new FPPT Framework

- The first "Annual report on the implementation of the Fit and Proper Persons Regulations for Trust Board members" has been submitted to the 'Part 2' Trust Board meeting Trust Board meeting in September.
- A report on the new FPPT Framework has also been submitted to the 'Part 1' Trust Board meeting Trust Board meeting on 28/09/23 under a separate agenda item.

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

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

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

NHS
Maidstone and Tunbridge Wells NHS Trust

Annual review of the Trust Board's Terms of Reference — Chair of the Trust Board

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. That review and approval last took place in September 2022, so a further review is now due.

Some amendments are proposed, which are shown as 'tracked' on the following pages. As can be seen, all the changes reflect 'housekeeping' (including the change that was made in the last revision of the Standing Orders from "Member of the Executive Team" to "Executive Director"; and the removal of the reference to the Trust's "members").

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To approve the revised Terms of Reference for the Trust Board

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

Trust Board

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

Purpose and duties

1. The Trust exists to provide goods and services for the purposes of the health service[2], and has a general duty to exercise its functions effectively, efficiently and economically[1]. In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to the health and well-being of the people of England; the quality of services provided to individuals by relevant bodies[3] (or in pursuance of arrangements made by relevant bodies[2]), for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; and efficiency and sustainability in relation to the use of resources by relevant bodies[2] for the purposes of the health service in England[4].

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to an ~~Member of the~~ Executive Director~~Team~~. The voting members of the Trust Board comprise a Chair (Non-Executive), five other Non-Executive Directors, the Chief Executive, and four specified ~~Members of the~~ Executive Directors~~Team~~. Other, non-voting members of the Trust Board attend Trust Board meetings and contribute to its deliberations and decision-making.

3. The Trust Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each individual Trust Board Member, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served ~~and members of the organisation~~.

5. The practice and procedure of the meetings of the Trust Board – and of its sub-committees – are described in the Trust's Standing Orders.

General responsibilities

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost-effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of all Trust Board Members.

Leadership

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a People and Organisational Development strategy and its appropriate implementation and operation.

[2] National Health Service Act 2006
[3] NHS England, Integrated Care Boards, and other NHS Trusts and NHS Foundation Trusts
[4] Health and Care Act 2022

Strategy

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
   9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
   9.4. Develops and maintains an annual forward programme and ensures its delivery as a means of implementing the strategy of the Trust to meet the expectations and requirements of stakeholders;
   9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Code of Conduct ~~has been developed~~ to guide the operation of the Trust Board and the behaviour of Trust Board Members~~. This Code~~ is incorporated within the Trust's ~~Gifts, Hospitality, Sponsorship and Interests Policy and Procedure~~Standing Orders.

Governance

12. The Trust Board:
   12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
   12.2. Ensures that the Trust complies with its governance and assurance obligations;
   12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
   12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
   12.5. Ensures that the statutory duties of the Trust are effectively discharged;
   12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk management

13. The Trust Board:
   13.1. Ensures an effective system of governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
   13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
   13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and ~~Members of the~~ Executive Directors~~Team~~.

Ethics and integrity

14. The Trust Board:
   14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;

14.2. Ensures that Trust Board Members and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders, Reservation of Powers and Scheme of Delegation, and/or by the Board from time to time

Communication

16. The Trust Board:
    16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
    16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
    16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
    16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality success and financial success

17. The Trust Board:
    17.1. Ensures that the Trust operates effectively, efficiently, and economically;
    17.2. Ensures the continuing financial viability of the organisation;
    17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
    17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
    17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chair

18. The Chair of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chair is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chair is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chair of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

Membership of the Trust Board

24. The Trust Board will comprise the following persons:
    24.1. The Chair of the Trust Board
    24.2. Up to five Non-Executive Directors. One of these will be designated as Vice-Chair
    24.3. The Chief Executive
    24.4. The Deputy Chief Executive / Chief Finance Officer
    24.5. The Medical Director
    24.6. The Chief Nurse

24.7. The Chief Operating Officer

Non-voting Trust Board Members (as stated in the Trust's Standing Orders) will be invited to attend Trust Board meetings at the discretion at the Chair.

Quorum

25. The Board will be quorate when four Trust Board Members including at least the Chair (or Non-Executive Director nominated to act as Chair), one other Non-Executive Director, the Chief Executive (or ~~member of the~~ Executive Director~~Team~~ nominated to act as Chief Executive), and one other ~~member of the~~ Executive ~~Team~~ Director (voting member) are present[5].

26. An officer in attendance for a voting member of the Executive Team but without formal acting up status may not count towards the quorum at Trust Board meetings

Attendance

27. The Trust Secretary will normally attend each meeting.

28. Other staff members and external experts may attend Trust Board meetings to contribute to specific agenda items, at the discretion of the Chair

Frequency of meetings

29. The Trust Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

30. The Chair, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a 'balanced board' where the skills and experience available are appropriate to the challenges and priorities faced;

31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

32. The Trust Board has the following sub-committees
    32.1. The Quality Committee
    32.2. The Patient Experience Committee
    32.3. The Audit and Governance Committee
    32.4. The Finance and Performance Committee
    32.5. The People and Organisational Development Committee
    32.6. The Charitable Funds Committee
    32.7. The Remuneration and Appointments Committee

33. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance and Performance Committee, Charitable Funds Committee, and People and Organisational Development Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair of that meeting) in a timely manner

34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

[5] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chair and members (including at least one Executive Director and one Non-Executive Director) is present"

Emergency powers and urgent decisions

35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chair of the Trust Board and Chief Executive after having consulted at least two Non-Executive Directors.

36. The exercise of such powers shall be reported (by the Chair of the Trust Board) to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

Administration

37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    37.1. Agreement of the agenda for Trust Board meetings with the Chair and Chief Executive;
    37.2. Collation of reports for Trust Board meetings;
    37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    37.4. Advising the Trust Board on governance matters.

38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chair and Chief Executive.

Conflict with Standing Orders Set

39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

40. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 28~~9~~th September 202~~2~~3