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

Thu 26 September 2024, 09:45 - 13:00

Lecture Rooms 1 and 2, Education Centre, Tunbridge Wells Hospital

Maidstone and Tunbridge Wells NHS Trust

Agenda

09:45 - 09:45

Please note that members of the public will be able to attend the meeting, in Lecture Rooms 1 and 2, The Education Centre, Tunbridge Wells Hospital

09:45 - 09:46

09-1
To receive apologies for absence

Annette Doherty

09:46 - 09:46

09-2
To declare interests relevant to agenda items

Annette Doherty

09:46 - 09:47

09-3
To approve the minutes of the 'Part 1' Trust Board meeting of 25th July 2024

Annette Doherty

Board minutes 25.07.24 (Part 1).pdf (12 pages)

09:47 - 09:50

09-4
To note progress with previous actions

Annette Doherty

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

Patient Experience story

09:50 - 10:15

09-5
Patient experience story

Representatives from the Maternity Services Directorate

N.B. This item has been scheduled for 09:50am

Patient Expereince Story - Maternity Services.pdf (5 pages)

Reports from the Chair of the Trust Board and Chief Executive

10:15 - 10:20

09-6
Report from the Chair of the Trust Board

Annette Doherty

Report from the Chair of the Trust Board - September 2024.pdf (2 pages)

10:20 - 10:25

09-7
Report from the Chief Executive

Miles Scott

Chief Executive's report - September 2024.pdf (167 pages)

Reports from Trust Board sub-committees

10:25 - 10:30

09-8
Quality Committee, 14/08/24 and 12/09/24

Maureen Choong

Summary reports from the Quality C'ttee, 14.08.24 and 12.09.24.pdf (4 pages)

10:30 - 10:35

09-9
Finance and Performance Committee, 27/08/24 and 24/09/24

Neil Griffiths

Summary of Finance and Performance C'ttee 27.08.24.pdf (1 pages)
Summary of Finance and Performance C'ttee 24.09.24.pdf (2 pages)

10:35 - 10:40

09-10
People and Organisational Development Committee, 20/09/24

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 20.09.24.pdf (2 pages)

Integrated Performance Report

10:40 - 11:25

09-11
Integrated Performance Report (IPR) for August 2024

Miles Scott and colleagues

Integrated Performance Report (IPR) for August 2024.pdf (45 pages)

Quality

11:25 - 11:35

09-12
Quarterly mortality data

Sara Mumford

Quarterly mortality data.pdf (8 pages)

11:35 - 11:40

09-13
Safeguarding update (Annual Report to Board)

Joanna Haworth

Safeguarding update (Annual Report to Board).pdf (57 pages)

Systems and Place

11:40 - 11:55

09-14
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB) (incl. the system-aspects of patient discharges)

Rachel Jones

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (8 pages)

Planning and strategy

11:55 - 12:05

09-15
Review of the draft winter plan for 2024/25

Sean Briggs

Review of the draft winter plan for 2024-25.pdf (21 pages)

Assurance and policy

12:05 - 12:10

09-16
Responsible Officer's Annual Report 2023/24

Sara Mumford

Responsible Officer's Annual Report 202324.pdf (20 pages)

12:10 - 12:20

09-17
Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

Sean Briggs

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment.pdf (11 pages)

12:20 - 12:25

09-18
Ratification of the revised Risk Management Policy and Procedure

Joanna Haworth

Ratification of the revised Risk Management Policy and Procedure.pdf (28 pages)

12:25 - 12:35

09-19
Board Assurance Framework (BAF) development update

Joanna Haworth

Board Assurance Framework Development Update.pdf (5 pages)

Items to be noted for information and/or assurance

12:35 - 12:35

09-20
Assurance statement in response to the Patient safety and quality of care in pressurised services letter

Joanna Haworth

N.B. The report should be noted, with questions or comments raised external to the meeting

Assurance statement in response to the Patient safety and quality of care in pressurised services letter.pdf (4 pages)

12:35 - 12:35

09-21
Update on the new Committee structure

Joanna Haworth

N.B. The report should be noted, with questions or comments raised external to the meeting

Update on the New Committee Structure - September 2024.pdf (2 pages)

Other matters

12:35 - 12:36

09-22
To consider any other business

Annette Doherty

12:36 - 12:37

09-23
To respond to any questions from members of the public

Annette Doherty

12:37 - 12:38

09-24
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

Annette Doherty

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 25TH JULY 2024, 09.45AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Neil Griffiths	Non-Executive Director (Chair)	(NG)
	Maureen Choong	Non-Executive Director	(MC)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Sara Mumford	Medical Director / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director (from item 07-4)	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Daryl Judges	Deputy Trust Secretary	(DJ)
	Mel Norbury	Interim Trust Secretary	(MN)
	Dominic Chambers	Clinical Director of Pathology and Care after Death Directorates (for item 07-20)	(DC)
	Lydia Judge-Kronis	Head of Service, Care After Death Directorate (for item 07-20)	(LJK)
	Danny Lawes	Chief of Service, Surgery (for item 07-17)	(DL)
	Jack Richardson	Freedom To Speak Up Guardian (for item 07-18)	(JR)
	David Robinson	Divisional Director of Operations, Surgery (for item 07-17)	(DR)
	Emma Sutton	Divisional Head of Quality and Governance, Core Clinical Services (for item 07-5)	(ES)
Observing:	The meeting was recorded live and uploaded to the Trust's YouTube Channel.		

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

07-1 To receive apologies for absence

Apologies for absence were received from Sean Briggs (SB), Chief Operating Officer; and Annette Doherty (AD), Chair of the Trust Board. It was also noted that Rachel Jones (RJ), Director of Strategy, Planning and Partnerships; and Alex Yew (AY), Associate Non-Executive Director would not be in attendance.

MS informed Trust Board members that it was MN's last meeting at the Trust and thanked MN for the support which had been provided to the Trust during a period of increased operational pressures.

07-2 To declare interests relevant to agenda items

No interests were declared.

07-3 To approve the minutes of the 'Part 1' Trust Board meeting of 27th June 2024

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

07-4 To note progress with previous actions

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

- **04-11 ("Ensure that future Integrated Performance Reports highlight those metrics which directly contributed to the Trust's value weighted activity as part of the productivity calculation").** SO reported that a discussion had been held at the Finance and Performance Committee wherein it was agreed that a range of productivity metrics would be incorporated into

the Integrated Performance Report (IPR), with the intention for the proposed metrics to be included by the September 2024 Trust Board meeting, as a separate section within the IPR in the first instance. The Trust Board members agreed that the action should therefore be closed.

- **06-15 ("Provide assurance to a future Trust Board meeting regarding the Trust's scenario planning for potentially catastrophic cyber security incidents").** SO reported that discussions had been held with the Director of IT and Director of Emergency Planning and Response and that the requested assurance would be provided to the September 2024 'Part 2' Trust Board meeting, due to the confidential nature of the Trust's cyber security arrangements.

Patient experience

07-5 <u>Patient experience story</u>

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

- Mrs X presented to the Faster Diagnosis Standard (FDS) pathway with a history of breast cancer and kidney stones and was scheduled for a Computed Tomography (CT) scan for 15 days after the initial consultation; however, the scheduling was challenged and investigated by a family member who worked within the Core Clinical Services Division, and a revised appointment booked for seven days after the initial consultation.
- Following the CT scan the patient was referred to the Gastrointestinal (GI) pathway, with a Multidisciplinary Meeting (MDM) scheduled for the end of June 2024. A liver biopsy and molecular testing was requested to expedite the patient pathway with the intention to discharge Mrs X from the FDS pathway; but, the nurse involved raised concerns regarding the proposed approach and it was agreed that Mrs X should remain on the FDS pathway until the outputs from the GI MDM were received.
- Under Martha's Rule a second opinion was required from a Consultant Pathologist who required the case with a Brest Surgeon wherein it was agreed that the case should be considered at the Brest Multidisciplinary Meeting (MDM)
- A final interaction with the Faster Diagnosis Standard (FDS) Clinician highlighted communication issues in relation to the technical language which was utilised and a lack of confirmation of support present for Mrs X.
- Positive feedback was received in relation to the MDM, the reception and nursing team and the Aseptics Team.
- The patient story had been identified by a member of staff at the Trust which required health and wellbeing support, which included a discussion of the key stressors within the particular case. The family Mrs X confirmed that they did not want to raise a complaint, but emphasised that the communication had been insufficient during parts of the patient pathway.
- Feedback would be provided to the FDS doctor involved about patient manner and communication and the patient story would be discussed at a range of forums and networks across the Trust to support sharing of the lessons learned; which included the importance of kindness and caring throughout the patient pathway and the need to provide appropriate challenge in relation to any concerns.

MC supported the empathetic approach to patient care which had been adopted by the majority of staff involved and the further work to improve communication, where required. MC noted that it was important to consider the frequency at which circumstances were created for staff to sit and listen to patients and to inform patients and their family of their ability to question and challenge decisions.

SM noted that concerns related to the clinician involved would be actively discussed; however, stated that if there were any challenges with such discussions they should be escalated accordingly. SM then provided assurance that the case would be discussed as part of the appraisal process for the clinician involved.

MS noted the importance of addressing the lessons learned from the patient experience story and commended the next steps which had been developed and the support which was available from SM; however, emphasised the importance of acknowledging the positive impact of staff from across the Trust that actively worked to resolve the issues experienced by Mrs X and to improve the patient experience.

NG emphasised the importance of the presentation of patient experience stories at the Trust Board and thanked ES for the manner in which the story was presented.

EPM commended the communication approach which had been adopted for the patient experience story, which enabled the lessons learned to be circulated Trust-wide and noted that such an approach enabled Trust staff to reflect on the care that had been provided. JH replied that the communication approach remained under development with the Communications Team; but, noted it was important to ensure lessons learned and the patient experience was communicated with a range of professional groups.

Reports from the Chair of the Trust Board and Chief Executive

07-6 Report from the Chair of Trust Board

NG referred to the submitted report and highlighted the three consultant appointments which had been made in the reporting period.

07-7 Report from the Chief Executive

MS referred to the submitted report and highlighted the key points therein, which included the continued outstanding work of Trust across the staff in relation a range of activities such as the integration of Fordcombe Hospital into the Trust, the provision of system support for 2500 long waiting patients, maintaining Emergency Department performance in response to a sustained increase in demand over the preceding five-year period, and the achievement of a number of regional and national awards by teams across the Trust.

Reports from Trust Board sub-committees

07-8 Quality Committee, 10/07/24

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

- Partial assurance was received in relation to the revised sub-committee structure as, although the revised structure provided increased opportunity for challenge and enhanced discussions, further monitoring was required to ensure the structure operated effectively and provided continued assurance over an extended timeframe.
- A beneficial discussion had been held regarding the Trust's quality related risks, which highlighted the variation in processes between the clinical Divisions.

07-9 Finance and Performance Committee, 23/07/24

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

- An in-depth discussion had been held regarding the Trust's current financial position and the financial improvement plan; wherein, the Committee had acknowledged the scale of the programme of work and active engagement across the Trust, but had expressed concerns in relation to the current Cost Improvement Programme (CIP) performance.
- The Full Business Case for Robotic Assisted Surgery had been recommended for approval by the Trust Board.

DM added that there had been a number of cross-cutting projects identified, the benefits of which should begin to be captured within the August 2024 financial position. DM then noted that the risks associated with the Kent and Medway Medical School (KMMS) Accommodation had substantially diminished and the mitigation of the risks associated with the age of the Trust's imaging equipment had been further enhanced.

07-10 People and Organisational Development Committee, 19/07/24 (incl. quarterly report from the Guardian of Safe Working Hours)

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

- The Committee was assured that there was sufficient planning and focus on the workforce efficiency programme; but, acknowledged the further progress which was required to support the delivery of the Trust's financial plan.

- An update on Internationally Educated Professionals wherein the work required to ensure alignment between the progress made in each professional group was highlighted.
- The Multidisciplinary Learning and Development Strategy was at stage three of a four stage development process and would be considered at the Committee's meeting in September 2024.
- The latest quarterly report from the Guardian of Safe Working Hours was included under appendix 1, for assurance and information.

NG asked whether there were any further specific details to report in relation to the reduction of temporary staffing utilisation. EPM replied that the Committee had acknowledged the importance of the development of the Business Case for the temporary staffing team. SS then stated that a further update on the reduction of temporary staffing would be provided as part of the discussion of the IPR.

07-11 Audit and Governance Committee, 15/07/24 (incl. the External Auditor's Annual Report for 2023/24)

DM referred to the submitted report and highlighted the following points:
- A facilitated education session on Artificial Intelligence (AI) provided a comprehensive overview of the potential utilisation of AI and the associated risks, benefits and opportunities.
- Although a Limited Assurance Internal Audit review had been received for Outpatients Utilisation, there was evidence that a false positive had been received regarding the number of appointments cancelled under 6-weeks due to administrative changes to clinics which were recorded as cancellations.
- Risk management continued to be a key area of focus; but, significant progress had been made to date.
- The External Auditor's Annual Report for 2023/24, was enclosed under appendix 1 which provided an unmodified audit opinion and highlighted the further work required in relation to CIPs as part of the value for money assessment.

07-12 Charitable Funds Committee, 17/07/24

DM referred to the submitted report and highlighted the progress which had been made by the Head of Charity and Fundraising in relation to embedding charitable activities within the Trust which had resulted in an increase in donations received to circa £500k per annum, the disbursement of which was supported by Charity Management Committee.

NG asked whether there was further opportunity to increase the charitable funds received by the Trust. DM confirmed that was the case and elaborated that the initial focus had been on receiving regular donations through platforms such as Just Giving and service users; however, the next step was targeted fundraising campaigns for specific projects. MS added that as well as the Trust's charity there were a number of partner charities dedicated to the Trust; and noted the responsibilities of the Head of Charity and Fundraising in relation to supporting and managing the relationships with partner charities as well as ensuring there were robust governance arrangements for the allocation of charitable funds from partner charities.

JW queried whether donors were aware of how their donations were utilised by the Trust. DM replied that such a question had been raised within the meeting and it had been explained that those donors that utilised the Just Giving platform were able to 'opt-in' to receive details of the expenditure of the donations received by the Trust. DM added that the Head of Charity and Fundraising was in the process of developing a charity newsletter; although, acknowledged there were further opportunities to ensure donors were informed of the utilisation of their donations.

WW asked to what extent the Head of Charity and Fundraising utilised the social media marketing expertise at the Trust. DM provided assurance that there was a close working relationship between the Head of Charity and Fundraising and the Director of Communications, as illustrated by the level of awareness regarding the charity abseiling event; but, acknowledged that there continued to be opportunity for further enhancements.

Integrated Performance Report (IPR)

07-13 Review of the Integrated Performance Report (IPR) for June 2024

MS referred to the submitted report and drew Trust Board members' attention to the "Executive Summary" section on page 6 of 48. SS referred to the "People" Strategic Theme and highlighted the following points:

- The Trust's turnover rate continued to improve, with a performance of 11.3% against a target 12%; so, it was expected that the "Reduce Turnover Rate to 12%" metric would be de-escalated within the next iteration of the IPR; however, enhanced focus would be applied to those employees which left the Trust within the first 24 months of employment and those 'hot spot' areas for staff turnover, wherein 48% of leavers were classified as 'avoidable' so it was important to ensure staff were incentivised to remain at the Trust.
- An internal target of 8.1% had been allocated for the percentage of Agenda for Change (AfC) 8c and above that are Black, Asian or Minority Ethnic (BAME), to provide a stretch target for the Trust to achieve in the first instance. A detailed review would be conducted for each AfC band 8c and above role, and that the process had been extended to include AfC band 8a and above staff, to create a talent and succession pipeline for BAME staff. A number of actions had been introduced to improve the Trust's performance, which included specific training for recruitment panels for AfC band 8a and above staff; a review of all job descriptions to remove any unconscious bias within the recruitment adverts; and a requirement for a report from each recruitment panel to illustrate the actions which had been implemented to increase diversity within the role.

MS referred to the stratified data on page 11 of 48 and queried whether the turnover percentage for those staffing that left the Trust within the first 24 months was a percentage of total turnover, rather than a percentage of staff employed for less than 24 months. MS then stated that it would be beneficial to receive understand how the turnover of staff within the first 24 months compared both over time and to other comparable NHS Trusts. SS replied that a substantial programme of work had been commissioned through the NHS People Promise Exemplar programme which indicated that once staff had been employed for longer than 24 months there was a significant decrease in the turnover rate, which was comparable to other NHS organisations. SS continued that there was an increased focus on flexible working patterns and career development, so it was important to consider how staff careers could be managed in an active manner, and agreed to provide additional granular detail regarding staff turnover within the first 24 months of employment as part of the Integrated Performance Report to the September 2024 Trust Board meeting.

Action: Provide additional granular detail regarding staff turnover within the first 24 months of employment as part of the Integrated Performance Report to the September 2024 Trust Board meeting (Chief People Officer, July 2024 onwards)

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

- Deteriorating patients had been identified as the third top contributor to incidents of moderate to severe harm, and a number of mechanisms had been introduced to support the management of deteriorating patients, such as enhanced access to treatment escalation plans on the 'Sunrise' Electronic Patient Record (EPR); however, further work was required in relation to data collection, and addressing the underlying causes. The Deteriorating Patient Lead Practitioner was scheduled to be recruited during the week commencing 29th July 2024, with the role intended to provide education to Trust staff and support the implementation of Martha's Rule.
- There had been an improvement in the rate of *Clostridium difficile (C. diff)* infections in June 2024, with a further improvement expected for July 2024. A further Trust-wide outbreak meeting had been conducted and the next steps included a deep clean of the Acute Medical Unit (AMU) at Tunbridge Wells Hospital, which would be supported by decanting patients to Ward 10.
- The rate of patient falls was in common cause variation; but, there had been a reduction in the rate of patient falls during June 2024.

WW queried whether SM expected the Trust's *C. diff* target to be achieved in the short to medium-term and asked how the Trust benchmarked to other NHS organisations. SM replied that there were national challenges in relation to the prevalence of *C. diff* following the COVID-19 pandemic; but, the Trust remained an outliner within the Kent and Medway Integrated Care System (ICS) with higher than average rates of *C. diff*; although, noted that July 2023 continued to impact the Trust's 12-month

rolling average in terms of *C. diff* rates, so there was expected to be an improvement in the August 2024 data. SM then provided an update on the mechanism which had been implemented to improve the Trust's *C. diff* performance, which included an enhance focus on antimicrobial stewardship to prevent the inappropriate utilisation of IV antibiotics and noted that there had been a decrease in the utilisation of antibiotics; although, there remained specific challenges within the Trust's EDs so additional education was being provided by the Trust's Microbiologists to address any inappropriate prescribing. SM continued that consultants had been requested to conduct ward rounds of areas with high antimicrobial utilisation and the Trust's prescribing guidelines remained under review; but, noted the requirement for specific software to provide additional antimicrobial guidance, which was under investigation.

WW asked if the challenges were reflected across both of the Trust's hospital sites. SM confirmed that was the case; however, provided assurance that antimicrobial prescribing was monitored by the Infection Prevention and Control Committee with further clinical audits conducted of any 'hot spot' areas and the provision of training for Junior Doctors. SM highlighted the positive progress which had been made in terms of antimicrobial prescribing and the impact of the bed and mattress audits. SM then emphasised the intention for the Trust to achieve the target rate set for 2023/24, as a national target rate for 2024/25 had not yet been set.

MS then referred to the "Patient Access" Strategic Theme and highlighted the following points:

- It was important to note that the areas of escalation reflected the ambitious targets which had been set by the Trust and that the Referral to Treatment (RTT) performance was monitored both in terms of the Trust's core performance and the provision of system support, to ensure that any deterioration in the Trust's core RTT performance was identified and addressed.
- There had been continued increased demand within the Trust's Emergency Departments (EDs), which demonstrated the important of the Trust's focused improvement work.

JW highlighted the potential industrial action by General Practitioners and the proposed 'work to rule' approach and queried whether the Trust had sufficient capacity to respond to the potential increase in attendances. MS provided assurance that as part of the West Kent Health and Care Partnership (HCP) Urgent and Emergency Care programme of work a plan had been developed to respond to any potential industrial action; but, noted the national focus on recovering ED performance standards and acknowledged that there would be challenges in recovering the 95% ED performance standard at the Trust. MS continued that the continued increase in ED attendances emphasised the importance of new service developments, such as the mobilisation of the virtual ward programme.

MS then referred to the "Systems" Strategic Theme and highlighted the following points:

- The number of patients discharged before noon continued to improve, and a number of practical actions had been developed as part of the counter measure summary to support further improvements in the Trust's performance.

NG asked what, if any, focus was afforded to discharges before noon by the NHS Provider Collaborative. MS replied that the discharges before noon metric was a Trust specific metric; however, patient flow within the community was an area of focus for the West Kent HCP which included the development of Integrated Neighbourhood Teams.

JH then referred to the "Patient Experience" Strategic Theme and highlighted the following points:

- There was ongoing work with Divisional representatives to understand the challenges impacting complaints performance and to support the development of tailored action plans; but, there remained staffing challenges within the Complaints Team, which would be addressed through substantive recruitment. The key priority was to address the backlog of open complaints and to ensure that new complaints were managed on a day-to-day basis.
- Friends and Family Test response rates had improved in both ED and Outpatients; but, further work was required to increase response rates within Maternity Services, which would be supported by the new Patient Experience Lead for Maternity Services who would work collaboratively to maximise patient feedback.

JH then referred to the "Maternity Metrics" and highlighted the following points:

- There was an ongoing programme of work to ensure compliance with the wait time targets for Induction of Labour (IoL); but, further information had been received which confirmed that the target of time for IoL should be set at six-hours; so, the Trust's target would be adjusted accordingly.
- There had been an improvement in the Category 2 caesarean section performance; although, further work was required.

SO then referred to the "Sustainability" Strategic Theme and highlighted the following points:
- The Trust was £1.1m adverse to plan for year-to-date at the end of Month 3 of 2024/25; so a Financial Improvement Plan had been developed which focused on three key areas (i.e. budgetary control, cross-cutting transformational projects, and downside mitigations), which had been considered at the Finance and Performance Committee. There was Trust-wide engagement with the Financial Improvement Plan and the cross-cutting projects were intended to improve quality of care and patient safety whilst delivering a sustainable financial position.
- There had been a slightly improvement in temporary staffing expenditure in the reporting period; however, the Trust's overall position had plateaued following a significant initial improvement.

SS commented that it had been assumed that as the Trust's vacancy rate and turnover rate had reduced there would be a similar reduction in temporary staffing expenditure; however, there had been an increase in expenditure on bank staff; so, as part of the temporary staffing cross-cutting project three key areas of focus had been identified to support the reduction of temporary staffing expenditure, including bank staffing expenditure, which included improved accuracy and availability of data to support decision-making; increased transparency regarding the rationale for the utilisation of bank staff, through a reduction in the number of criteria which managers could select; and the introduction of the Patchwork Healthcare Workforce Solution within Medical Staffing, with the initial implementation to focus on the Trust's EDs. SS then explained the challenges which had been identified in terms of the 'go live' of Patchwork Healthcare Workforce Solution. SS continued that further work was required to ensure an even distribution of annual leave across the financial year and noted that the South East Collaborative had commissioned a framework for rates of pay, to ensure a uniform approach across the region.

NG asked whether there was a risk of an increase in the Trust's turnover rate due to the reduction in available bank shifts. SS confirmed that bank shifts supported the total financial reward statement of some staff, so such considerations would be factored into the programme of work; however, noted that the expenditure on bank staff at the Trust was higher than across the South-East region.

EPM queried whether any alternative approaches had been adopted for the reduction of temporary staffing expenditure by other Trusts within the Kent and Medway ICS. SS first highlighted that the Trust had delivered one of the largest turnarounds in relation to the reduction of temporary staffing expenditure in the South East region and noted that the South East Collaborative enabled lessons learned to be shared. SS then detailed the key areas of focus which had been incorporated into the 'A3 Thinking' process for the temporary staffing cross-cutting project.

RF acknowledged that the reduction in temporary staffing expenditure had plateaued and asked whether SS was confident in the Trust's ability to deliver the £12m target within the six-month period. SS replied that the totality of the efficiency savings was not expected to be delivered within the 2024/25 financial year; however, there would be a focus on the deliverables included within each of the interventions and noted that the previous programme of work had primarily focused on premium agency expenditure, whereas the temporary staffing cross-cutting project included a range of short, medium and long-term interventions. SS continued that the next steps included investigating acceleration the Patchwork Healthcare Workforce Solution implementation and noted the invest to save discussions which were required in relation to the expansion of the Temporary Staffing Team. SS then acknowledged the scale of the challenge; but provided assurance there was trust-wide focus.

EPM asked at what point delays to the Kent and Medway Orthopaedic Centre (KMOC) were expected to significantly impact the Trust's financial position. SO replied that the initial delay, from 2023/24 until July 2024 had been factored into the Trust's financial plan; however, work was ongoing to mitigate the financial impact from the further delay until September 2024, which included an

overperformance on Trauma and Orthopaedic activity which would have been provided through KMOC. SO continued that the delays to the KMOC opening date were expected to be reflected in the Trust's financial position for August and September 2024. EPM then requested an update on the people impacts of the delays to KMOC. SO replied that the majority of staff for KMOC had been recruited and subsequently redeployed to other surface areas to support the delivery of additional activity and provided assurance that sufficient staff had been recruited to deliver the intended activity levels from KMOC; although, noted the potential impact on those service areas which were currently supported by those staff intended for KMOC. SS provided a further update and assurance from the KMOC Resourcing Group.

WW asked whether the Trust expected to receive any additional funding in response to the expenditure associated with the Junior Doctors industrial action. SO replied that there had been no formal announcement regarding funding support in response to the Junior Doctors industrial action; but, confirmed the Trust was likely to receive funding to address the direct costs.

WW noted the initial statements from the new UK Government and the focus on the delivery of targets within the NHS and asked what, if any, impact was expected on the Trust's financial plan. SO continued that the initial expectation was that the NHS deliver the financial plan for 2024/25, with discussions ongoing about any potential new funding streams and deliverables for 2025/26 onwards; and noted the potential positive impacts associated with a nationally funded pay award for the NHS, opposed to previous financial years wherein the pay award was funded from existing budgets. SO continued that there had been an increase in the number of recurrent and non-recurrent CIPs identified, although there was further work required to achieve the Trust's target and elaborated on the key areas of focus as part of the Trust's Financial Improvement Plan.

WW queried whether SO was confident in the delivery of the Trust's financial targets. SO replied that the key factor was the delivery of the overall financial plan for 2024/25, followed by delivery of CIPs and then delivery of CIPs on a recurrent basis; but, noted that there remained risks and associated with the delivery of the financial plan for 2024/25; although, there was increased confidence compared to the same time period for the 2023/24 financial year.

[N.B. A brief recess was held at this point]

People

07-14 <u>Six-monthly update on the implementation of the sexual safety in healthcare charter</u>

SS referred to the submitted report and highlighted the key points therein, which included that a review of the relevant Trust-wide policies had been conducted; restorative and just practice training was under development; a process had been developed for serious case reviews and all cases which involved sexual harassment were reviewed by a multidisciplinary team to identify any formal issues; and that the next step was the developing a Trust-wide communication campaign, which was informed by best-practice across the NHS.

MC asked whether the Trust was explicit in relation to the duty for all Trust staff, including active bystanders, to act in response to any concerns raise. SS replied that further work, as part of the communication strategy, was required to provide the requested assurance; however, noted that as part of the professional registration process there was a duty to act and a number of Freedom to Speak Up (FTSU) cases had been reported by other members of staff. SS added that the duty to act was enshrined within the sexual safety in healthcare charter.

WW commended SS on the progress which had been made to date; and asked whether as a Trust an additional cultural focus was required and how the Trust benchmarked to comparable NHS organisations. SS replied that it was difficult to allocate any acceptable level as any instances of inappropriate sexual behaviour should not be permitted and noted that circa 5% of respondents to the 2023 national staff survey had reported experiencing inappropriate sexual behaviour within the previous 12 months. SS continued that, in terms of benchmarking, the Trust performed favourably; however, stated that an internal focus should be the priority to address the issue.

Planning and strategy

07-15 Annual approval of the Trust's Green Plan

MS referred to the submitted report and highlighted the key points therein. MS added that, in terms of the generation of renewable green energy at the Trust approximately one third of the power required by Maidstone Hospital could be generated through current solar panel technology and discussions were ongoing regarding Tunbridge Wells Hospital.

DM referred to the "The Trust's Carbon Footprint Plus – Progress this year" section of the submitted report and queried the rationale for the increase in total footprint plus. DM then asked for further details of the Trust's responsibilities regarding the impact from external providers, such as the laundry service which had been outsourced. MS replied that the level of responsibility was determined by the Trust Board and suggested that discussions be held with the Director of Estates and Capital Developments to enable an update to be provided to an appropriate forum regarding the calculation of the Trust's Carbon Footprint Plus. EPM queried whether there was process to track the Trust's carbon emissions. MS confirmed that there was a robust process for tracking the Trust's carbon emissions; and stated that further details of the established model could be provided, if required. NG requested that MS liaise with the Director of Estates and Capital Developments to provide clarification to the September 2024 Finance and Performance Committee regarding the calculation and monitoring of the Trust's Carbon Footprint Plus.

Action: Liaise with the Director of Estates and Capital Developments to provide clarification to the September 2024 Finance and Performance Committee regarding the calculation and monitoring of the Trust's Carbon Footprint Plus (Chief Executive, July 2024 onwards)

JW asked whether an environmental impact assessment was conducted for all new infrastructure developments and acquisitions. MS confirmed that was the case as all infrastructure developments had a sustainability impact assessment incorporated as part of the national contracting framework; although, noted the importance of ensuring such an assessment was adopted for small scale initiatives.

The Trust's Green Plan was approved as submitted.

07-16 To approve the Business Case for Estates Capital backlog work 2024/25

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

- The Business Case had been considered a part of the Trust's governance processes and the majority of the £1.3m of capital funding would be utilised at Maidstone Hospital.
- The main objectives of the Business Case were to reduce the backlog maintenance at the Trust; improve safety at Maidstone Hospital and Tunbridge Wells Hospital; and reduce statutory non-compliance.

DM queried the impact of the proposed £1.3m expenditure on the Trust's overall risk associated with estates backlog work. SO confirmed that the capital expenditure would reduce the overall risk profile; however, noted that there had been reduced infrastructure investment over the preceding financial years to support investment in service developments; therefore, a balance was required between achieving statutory compliance of the Trust's infrastructure and delivering service developments.

The Business Case for Estates Capital backlog work for 2024/25 was approved as submitted.

07-17 To approve the Full Business Case for Robotic Assisted Surgery

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

- The recommended option, as agreed at the Finance and Performance Committee, was a seven-year contract with Intuitive for two Da Vinci XI Surgical Robots as part of lease agreement under International Financial Reporting Standard (IFRS) 16. The surgical robots would be installed over a two-year period, with the initial surgical robot being installed at Maidstone Hospital in Quarter 3 of 2024/25.
- Benefits associated with the provision of robotic assisted surgery included the ability to attract and retain high-quality candidates; improved clinical outcomes; reduced length of stay for patients; and development opportunities for clinical staff.

- Risks associated with the "do nothing" option included the potential loss of services and challenges attracting high-quality candidates.

DL informed Trust Board members that for a number of surgical procedures the gold standard was the utilisation of robotic surgery which included urological and gynae-oncology procedures and detailed the significant improvement in surgical outcomes provided by robotic assisted surgery, which was likely to replace laparoscopic surgery as the primary surgical modality.

DM confirmed support for the Full Business Case (FBC) and noted the favourable financial position associated with the lease option under IFRS16; but, queried whether there was also reduced incentive to pursued additional productivity as part of the pay per procedure approach, which should also inform the decision-making process. DL replied that the most cost-effective option was a capital purchase; however, due to capital constraints and the pace at which the technology was developing, it was agreed a lease option should be pursued, to expedite access to the new technology, when available. DR then detailed the partnership working with Intuitive to ensure that the efficiencies available for robotic assisted surgery were maximised by the Trust.

WW queried whether, as part of the lease agreement, the Trust would receive any new versions of the Da Vinci surgical robot. DR replied that the Trust would be afford priority for the new DA Vinci surgical robot, which had recently been approved for utilisation in the United States of America; however, a new contract would be required for the Trust to be granted the latest surgical robot, although improved terms would be provided to the Trust. DL added that the latest version of the Da Vinci surgical robot would not be accessible in the United Kingdom for circa four years, with a roll-out programme required.

WW asked what productivity gains were expected to be delivered as part of the transition to robotic assisted surgery. DR referred to the "Option 2 Key activity assumptions" section of the Business Case and further elaborated on the productivity enhancements which were expected to be delivered. DR added that a review of the theatre schedules had been conducted to increase operating capacity and that there was a weekly performance meeting within the Surgery Division to support the delivery of additional efficiencies. WW emphasised the importance of validating the productivity assumptions. DR referred to the "Key Performance Indicator Measurable benefits" section of the submitted report, which had been agreed as part of the Business Case Review Panel (BCRP) discussion. NG provided assurance that the Finance and Performance Committee monitored the delivery of the expected benefits from Business Cases.

SM confirmed support for the Business Case, and highlighted the appointment of an Endometriosis Consultation with a Senior Fellowship in robotic surgery.

The Full Business Case for Robotic Assisted Surgery was approved as submitted.

Assurance and policy

07-18 <u>Quarterly report from the Freedom to Speak Up Guardian</u>

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

- Initial work had commenced to improve data collection and comparison, which included the introduction of a feedback form and the separation of Estates and Facilities concerns.
- A Freedom to Speak Up (FTSU) Communication plan was expected to 'go live' rollout imminently, which had been aligned with NHS People Promise Exemplar programme.
- There had been an increase in the number of concerns raised through the Safe Space Champions and there was a focus on increasing representation within clinical areas.
- The three main objectives were to maintain a consistent service, increase the confident of Trust staff to raise concerns verbally and maximise the ability to capture concerns within specific service areas.
- Bullying and harassment had been identified as a key theme within the reporting period, particularly in relation to a lack of adherence to People policies by middle managers and the utilisation of 'mangers discretion'; so, additional mandatory training was under development with the Learning and Development Team for new managers.

- There had been an increase in reporting from staff members with disabilities; so, a collaborative working approach had been adopted with the Disability Network to provide reporting on the issues experienced by disabled staff.
- Feedback was invited from Trust Board members in regards to any initiatives which could be adopted to enhance collaborative working.

NG noted the importance of a robust focus on improving middle management behaviours. EPM provided assurance that middle management behaviours remained a key topic of discussion at the People and Organisational Development Committee and that a number of interventions had been implemented to upskill middle managers such as the exceptional leaders programme.

MC commended the progress which had been made to date and supported the revitalisation of the Safe Space Champions; however, recommended that it would be beneficial for a number of senior managers should to be identified as Safe Space Champions. The recommendation was acknowledged.

WW commented that JR was working closely with AD and SS on the future strategy for the FTSU service, an update on which would be provided to a future Trust Board meeting; however, invited initial feedback from Trust Board members, external to the meeting.

07-19 <u>Six-monthly review of the Trust's red-rated risks</u>

JH referred to the submitted report and highlighted the following points:
- As of the 8th July 2024 there were 37 open red-rated risks, the majority of which resided within the "Sustainability" and "Patient Safety" strategic themes.
- Progress had been made in relation to the Trust's risk management improvement plan. The work which had been undertaken to date included a review of open risks in collaboration with the Trust's Clinical Divisions and Corporate Directorates and the next step for the Head of Risk Management included the development of an education programme to support the management and accurate recording of risks.
- The next step was to educate Trust staff in relation to the allocation of risk rating targets and risk appetite as a number of the open red-rated risks had been allocated an unrealistic target score. The education programme would also address those risks with the same initial risk rating and current risk rating after mitigations had been implemented.

DM supported the positive progress which had been made in terms of risk management; but, noted that the next step was to use the Trust's risk management process to support the appropriate mitigation of risks. EPM acknowledged that overall accountability for risk management resided with JH as the Senior Responsible Officer; but, queried whether individual executive directors were accountable for the risks within each strategic theme. JH replied that the Board Assurance Framework (BAF), which was under development, would provide clarification regarding where accountability resided; although confirmed the alignment with each Strategic Theme.

JW noted those risks which had were overdue for review and asked what actions were intended to be implemented to ensure that achievable review and end dates were allocated for risks. JH replied that such aspects would be addressed as part of the risk management improvement plan and the associated education programme. JH provide assurance that comprehensive discussions would be held with risk owners in relation to risk appetites and the allocation of target dates.

Other matters

07-20 <u>Six monthly update on mortuary issues</u>

JH introduced DC and LJK and outlined the background for the submission of the report. DC then referred to the submitted report and highlighted the following points:
- The Care After Death Directorate had been established and was awarded the team of the year aware in the staff star awards.
- A number of improvements in Mortuary Security had been implemented which included a monthly audit of access control logs, a randomised review of 24 hours of CCTV footage, and an extension of the retention period for CCTV footage.

- There had been three InPhase reports which related to the Mortuary Service and a further twelve which had been reported by the Mortuary Service.
- There had been one Human Tissue Authority Reportable Incident (HTARI)) during the reporting period, for which the Human Tissue Authority had been satisfied with the Trust's investigation.
- The contracts with local county councils to provide mortuary services for East Sussex County Council (ESCC) had been completed and for Kent County Council (KCC) were in progress.
- The Mortuary Services Directorate continued to prepare for any unannounced HTA inspections.

NG suggested that it would be beneficial to include a 'Red, Amber, Green' (RAG) rating for each of the six domains within future updates to the Trust Board. The point was acknowledged.

RF requested assurance that there was continued communication with the families of the deceased throughout the process. DC outlined the statutory requirements. LJK added that the Trust had introduced Liaison Bereavement Coordinators which actively communicate with the families of the decreased and ensured that any information was provided in a timely manner. LJK highlighted the 'personal touch' that the Bereavement Team were able to provide. LJK noted that once the process had been embedded a service user survey would be circulated to for the Medical Examiners, Bereavement and Mortuary services. DC then outlined the programme of work in relation to viewing cards and memento boxes.

WW commended the system and cultural enhancements which had been delivered; but, queried how services demands were managed. LJK replied a demand assessment had been conducted and detailed the procedural changes which had been implemented to enable reductions in the length of stay and improve the experience of families involved. DC added that the Trust had provided an update to the National Society of Allied and Independent Funeral Directors (SAIF) on the reforms to the Medical Certificate of Cause of Death documentation.

JH emphasised the compassion of the Mortuary Team and the focus on maintaining patient dignity and respect.

07-21 To consider any other business

DJ requested that the Trust Board delegate authority to the August 2024 Finance and Performance Committee to consider, and if appropriate approve, the Full Business Case for Cardiology Reconfiguration. The Trust Board duly delegated the required authority.

07-22 To respond to questions from members of the public

DJ confirmed that no questions had been received ahead of the meeting.

07-23 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
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'
07-13	Provide additional granular detail regarding staff turnover within the first 24 months of employment as part of the Integrated Performance Report to the September 2024 Trust Board meeting	Chief People Officer	September 2024	The requested information has been included within the Integrated Performance Report (IPR).
07-15	Liaise with the Director of Estates and Capital Developments to provide clarification to the September 2024 Finance and Performance Committee regarding the calculation and monitoring of the Trust's Carbon Footprint Plus	Chief Executive	September 2024	A "To review the calculation and monitoring of the Trust's Carbon Footprint Plus" item was submitted to the September 2024 Finance and Performance Committee meeting.

Actions not yet due (and still 'open')

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Patient Experience Story **Representatives from Maternity Services Directorate**

Patient stories are undeniably powerful in gaining an understanding of their experience and many Trusts nationally now use patient stories at Trust Board meetings. The purpose of using stories to illustrate the experience of care at Board level is to:

- Forge a connection between the experience of patients and the leadership of the Trust and its role in establishing the right strategic context for improvement and change
- To triangulate experience of care with reported data and information and provide insight into how this can influence improvements in quality and patient experience
- The voices and stories of patients are an effective and powerful way of making sure the improvement of services is centred on the needs of the people using those services
- To seek assurance that the organisation is learning from individual stories to benefit the wider experience of care
- For the board to gather insight into what happens between episodes of clinical care and how patient safety events affect the experience of care.
- For the board to consider how inequalities in access to and experiences of health services affect a group of patients, carers or relatives.

Patient stories will provide feedback, from patients themselves on what actually happened in the course of receiving care or treatment at the Trust, both the objective facts and their subjective views of it. Jane's* story describes her experience and birthing journey.

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

Reason for submission to the Trust Board: 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

Glossary:

Birth place assessment: A check-up to help decide the safest place for a person to give birth, based on their health and any risks.

BMI (Body Mass Index): A way to check if someone's weight is healthy for their height.

Continuity of carer: A way of giving care during pregnancy, where the same midwife or team of midwives supports the person throughout their pregnancy.

Due date: The estimated time when a baby might be born, usually about 40 weeks from conception. Babies can be born anytime between 37 to 42 weeks and be considered full term. If a baby is born earlier, it is called pre-term.

Indwelling catheter: a flexible tube used to empty the bladder and collect urine in a drainage bag.

Maidstone Birthing Centre: A 'home from home' facility at Maidstone Hospital run by midwives where people can give birth.

Membrane sweep: A procedure where a midwife or doctor stimulates the cervix (neck of the womb) to produce hormones that may trigger natural labour.

MDT (multi-disciplinary team) - MDT is a group of different healthcare professionals who work together to give the best care for pregnant people.

Named midwife: The midwife who looks after the pregnant person and their baby throughout their pregnancy, birth and the postnatal period.

Out-of-hospital setting (OOH): Giving birth at home or at a birthing centre instead of a hospital.

Perineum: The area of skin and muscle between the vagina and the anus.

Phoenix Team: A group of midwives at Maidstone and Tunbridge Wells NHS Trust that provides continuity of care to young people under 21 years old with their pregnancy and birth.

Post-partum haemorrhage: When someone loses more blood than usual after giving birth. Losing more than 500ml of blood is called a minor haemorrhage, and losing more than 1000ml is called a major haemorrhage.

Patient Story

Name: Jane (name changed to anonymise birthing person's identity)	Services/wards experienced at Maidstone and Tunbridge Wells NHS (MTW):
Date of care experienced: **23rd April 2024**	**Maidstone Birth Centre (MBC)** **Tunbridge Wells Hospital (TWH)**

Outline of experience:

Jane is a 19-year-old white British woman from the Gypsy, Roma, and Traveller community. She experienced a miscarriage at 12 weeks of pregnancy in March 2023 and has no other significant medical history.

Jane was booked with the Phoenix Continuity of Care Community Team due to her age.

Both Jane and the father of the baby, have additional learning and social needs and therefore her maternity care was shared with a range of specialist services including social care.

Jane's pregnancy was low-risk, and she received care from the Phoenix Continuity of Carer Team under a named midwife, whom she saw at every appointment. This model of care offers personalised care to optimise experience and clinical outcomes.

Jane chose to birth her baby at Maidstone Birthing centre and birth place assessment supported her in this decision.

At 40+6 weeks, Jane had a routine membrane sweep performed by her midwife. She was admitted to MBC in labour at 02:00 am.

She used the birthing pool and gas and air for pain relief, and gave birth to a healthy baby girl. Jane experienced some minor trauma to her perineum and her blood loss was measured at 750ml at birth.

Six hours post-birth, she lost a further 150ml of blood and was transferred via ambulance to the Delivery Suite at Tunbridge Wells Hospital (TWH) for further care as per our escalation and transfer of care guidance protocols.

On arrival at TWH, Jane was clinically stable but unable to pass urine, therefore an indwelling catheter was inserted with a plan to keep it in place for 48 hours post-birth.

She remained an inpatient on the postnatal ward until 11:00 the next day, when she requested discharge home. Hospital at Home and postnatal care from the Phoenix Team were arranged in order to support her choice for early discharge.

Jane was discharged from midwifery care at 28 days postnatal which is the maximum length of time within a midwife's scope of practice with ongoing support from a social worker and health visitor.

Positive points to highlight:	Learning points to highlight:
Jane's Feedback ***"The birth centre was really good and better than the hospital as it was much calmer and not too much stress"*** ***"It was quiet and peaceful (MBC)"*** ***"When I started bleeding, everyone explained what was happening. I was scared as I was bleeding a lot but understood it more when they explained it to me"*** ***"My midwife said that everything was ok. When she said that I stopped stressing and I knew I had someone I knew there"*** ***"Pembury (TWH) looked after me very well"*** **Continuity of Carer:** Jane received consistent support throughout her pregnancy from the Phoenix Continuity of Care Team, with her named midwife seeing her at each contact. This approach is particularly beneficial for providing personalised care for individuals with protected characteristics and social concerns. **Birth Place Assessment**: At 34 weeks, Jane was assessed and deemed suitable for giving birth at Maidstone Birth Centre, demonstrating effective risk assessment and planning. **Labour:** Availability of choice and personalised care options supported. Jane had a vaginal birth in a supportive environment of her choice which was one of our stand-alone birth centres. The national requirement of 1:1 care was achieved. **Positive points to highlight** **Personalised Care/Self-Advocacy:** Jane's birth journey from booking to birth promoted personalised care and equity for mothers and babies as recommended within the 3-year national maternity delivery plan.	**Postpartum Haemorrhage (PPH)**: Jane experienced a blood loss of 750ml at birth, followed by a further 150ml six hours later. Consideration of transferring Jane to TWH when the measured blood loss exceeded 500mls should have been considered and guidance followed. As there was no evidence of further bleeding and maternal observations were stable, the decision was made to remain at MBC. However, when there was a further 150ml blood loss and Jane began to feel unwell, there was quick and immediate escalation to TWH. **Urinary Retention**: Jane was unable to pass urine after birth, necessitating the insertion of an indwelling catheter at TWH. Frequent monitoring of urine output at Maidstone Birth Centre (MBC) could have potentially identified this issue earlier.

Postnatal Care: Jane continued to receive ongoing care from the Phoenix Team, with additional support from a social worker and health visitor, ensuring comprehensive postnatal support.	

Actions to take from this:

- Share learning with all midwifery staff groups and celebrate positive feedback, timely transfer and management of change from low to high risk care – This was shared on the 17th September 2024 at Maternity Services Clinical Governance Meeting. This will also be shared via a number of other communication channels.
- Consider further expansion of Continuity of Carer to targeted vulnerable groups, in line with the recommendations of the 3-year Delivery Plan.
- Learning from cases of minor PPH, including early recognition and intervention, inform development of our training programmes and clinical skills scenarios.
- Management of fluid balance has been identified as a learning need within maternity services nationally, this was added to our MDT training programme and we will scope potential audit opportunities to monitor this.

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

We have a number of changes in senior leadership this month. Over the next few days, Sean Briggs, Chief Operating Officer (COO), and Sue Steen, Chief People Officer (CPO), will be moving onto new roles at major London hospital trusts. I am delighted to announce that Sarah Davis, MTW's Deputy Chief Operating Officer, has been appointed as the new COO and will move into the role at the end of this month. Helen Palmer, who has had a long career across the private sector in a number of global companies, has been appointed as the Trust's new CPO and has taken up her post this week.

Following the sudden and very sad death of Kevin Rowan in February, Louise Thatcher has been appointed as the new Trust Secretary. Louise, who is currently at Dartford and Gravesham NHS Trust, will also join us at the end of this month.

In the Medicine and Emergency Care Division, Dr Simon Webster, Respiratory Consultant and MTW's Clinical Director for Medical Specialities, has replaced Dr Laurence Maiden as Chief of Service.

On behalf of the Board, I would like to thank Sean, Sue and Laurence for all their fantastic hard work, support and leadership, and welcome Sarah, Helen, Louise and Simon into their new roles.

We are now just days away from the full integration of the Fordcombe Hospital site on 1 October and we look forward to welcoming our new colleagues who will be bringing such a wide range of skills to help improve the experience we provide to patients. I want to once again thank all colleagues involved for delivering this project, which will help many of the longest waiting patients from across Kent and Medway to get the treatment they need as soon as possible.

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?
05/08/24	Consultant Ophthalmologist with special interest in Cornea	Sundas	Ejaz Maqsood	Ophthalmology	1/9/24	New
05/08/24	Consultant Ophthalmologist with a special interest in cornea/glaucoma	Hasan	Naveed	Ophthalmology	TBC	New
12/08/24	Gastro Consultant	Rahel	Mahmud	Med Spec	TBC	New
16/08/24	Cardiology Consultant	Osman	Najam	Med Spe	TBC	New
09/09/24	D&E Consultant x2	Shemitha Komal	Rafique Rao	Med Spec	X2 TBC	Replacement
16/09/24	Consultant Otolaryngologist	Iva	Topic Grahovac	ENT	TBC	Replacement

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

Reason for submission to the Trust 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:

- In July this year, the Secretary of State for Health and Social Care commissioned Lord Darzi to conduct an immediate and independent investigation of the NHS. Lord Darzi's report was published on 12 September and is attached to my report in full (appendix 1). The report is a clear assessment of the challenges currently facing the health service, and highlights that these have been caused by a number of factors including the long-term impacts of the 2012 Health and Social Care Act as well as the consequences of underinvestment throughout the 2010s. The Government will now use the Darzi Report to inform its 10-year plan to reform the NHS. An element of this work will involve sharing improvement methodology through regional Learning and Improvement Networks (LINs) across the country, and I have been asked, alongside Chief Executive of Royal Surrey NHS Foundation Trust, Louise Stead, to lead the south east LINs.

  Though Lord Darzi states in his report that the NHS is in a critical condition, he also states that its vital signs are strong, commending staff's extraordinary depth of talent, passion and shared commitment to making NHS services better for our patients. And nowhere is this more apparent than at MTW. The improvements, innovations and initiatives that we will be talking about in the coming weeks and months are only possible thanks to the people who work across our organisation and our strong collaborative work with local NHS partners, and the Board remains firmly committed to supporting, investing and developing MTW's staff now, and in the future.

- There have been key developments this month in the Trust's large-scale projects:
  - Fordcombe Hospital: The Trust is on schedule to take over the Fordcombe Hospital site on 1 October. The Hospital will enable us to create additional capacity at both Maidstone and Tunbridge Wells hospitals and support the NHS across Kent and Medway by taking on a significant number of the longest waiting patients. To date, 1,455 patients have now been transferred to MTW for treatment, with an agreement to ensure 2,500 patients are transferred by the end of the financial year. Fordcombe will close to patients for two weeks in the second half of September to enable us to complete the installation of IT systems, continue estates work and carry out staff training and induction sessions.
  - Kent and Medway Orthopaedic Centre (KMOC): based at Maidstone Hospital, handover of the new building from the construction company took place in early August, with the Centre opening to patients on 16 September. The theatre complex supports system working by expanding capacity across the region for routine orthopaedic operations. This will include up to 2,000 more knee and hip replacements each year, helping Kent and Medway patients who need planned surgery on bones, joint and muscles. KMOC is currently working towards accreditation as a Surgical Hub where patients have all their admitted care in one place.
  - Kent and Medway Medical School (KMMS): This month marks the arrival of the first cohort of final year students from KMMS, who began their studies in 2020. The total number of KMMS students this academic year is 114. The students will be the first to move into the new medical student accommodation building at Tunbridge Wells Hospital, which is nearing completion and will provide accommodation for up to 145 medical students and trainee doctors, as well as academic teaching spaces.

- Robot-assisted surgery (RAS) is being introduced at the Trust, and two surgery robots will be installed over the coming months. The first robot will be brought on stream at Maidstone Hospital in October and will support gynae-oncology procedures, current urological activity and general surgery procedures. The second robot will be delivered to Tunbridge Wells Hospital next year in the spring and will support general surgery - including colorectal and bariatrics - as

well as benign gynae procedures. For patients, RAS reduces complication rates and allows a minimal access approach in cases which may not have been possible without the assistance of a robot. This means reduced operative and post-operative complications, shorter hospital stays, less pain and quicker recovery. The robot-assisted surgery programme is an important step forward for the Trust, as reduced recovery times for patients and less likelihood of readmission will create more capacity for short stay surgery. It will also help MTW secure a position as a leading surgical centre in the region and enable us to attract and retain the best medical and clinical staff.

- Winter planning is underway, as the Trust and wider NHS head into the most challenging time of the year which will once again see extensive pressures on site and higher numbers of attendances, particularly in our Emergency Departments. A key part of winter planning involves reviewing all areas of activity to identify any potential gaps or risks while focussing on increasing capacity, working with local partners and doing all we can to support patient and staff wellbeing during the winter months. As part of this work we have recruited more than 90 peer vaccinators for the roll out of the staff flu/COVID-19 vaccine programme, to ensure as many of our 8,000 staff can get protected as soon as possible. We will also be rolling out the respiratory syncytial (RSV) vaccine to vulnerable groups of patients and staff. Preparations have also involved testing resilience plans ahead of winter, including testing business continuity plans and recently running a live exercise that simulated a fire with casualties at Maidstone Hospital. Emergency services including Kent Police, Kent Fire and Rescue and the South East Coast Ambulance Service all took part in the exercise, in partnership with MTW. Live exercises are a vital part of ensuring the Trust and emergency services can deal with incidents while maintaining its services and keeping people safe.

- It's the second anniversary of the Trust's Patient First Improvement System (PFIS) this month, which has empowered staff over the last two years to make changes that will benefit patient care. Eighty-four teams have so far been trained in PFIS, with a final two cohorts due to run by the end of this year, bringing the number of trained staff to approximately 500. Since PFIS was introduced, a total of 730 improvement tickets have been raised to date. Recent projects over the last three months include:
  - Language barriers were making it difficult for staff on our Antenatal ward to understand patients' signs of labour before interpreters could be sourced. Translation cards with a list of basic questions in a range of languages have now been produced for the ward, resulting in improved communication and a better experience for patients in labour.
  - Patients on the Short Stay Surgical Unit (SSSU) at Tunbridge Wells Hospital were arriving at 7am for afternoon surgery, leading to long waiting times. Appointment letters were updated for all SSSU patients, confirming they would be contacted the day before their surgery with an arrival time. This has resulted in reducing patient waiting times in the Unit.
  - 250ml bottles of pain relief (the smallest size manufactured) were being issued to a number of patients, and in some cases the volume exceeded the patients' needs. Capsules are now being given instead of liquid where possible, reducing waste while also having cost-saving implications for the Trust and ensuring patients are given amounts more appropriate to their needs.

- Developing innovative systems and new ways of working are a key part of the Trust's continued work in consistently delivering outstanding care and increasing capacity. This was recognised in this year's HSJ Awards, which shortlisted the Trust's Stroke team in the Acute Sector Innovation of the Year category for the Stroke Assessment Unit. One of the first in England at the time it was developed, the Stroke Assessment Unit at Maidstone Hospital has meant that over 70% of suspected stroke admissions are directly brought in to the Unit from the ambulance on arrival, ensuring patients receive the right care in the right place at the right time. A stroke ambulatory pathway also enables clinically-safe same day discharges, allowing patients with minor stroke symptoms to attend rapid appointments the following day. Overall, the Stroke Assessment Unit has contributed to the Stroke service now being able to care for over 1,200 patients a year with a stroke diagnosis.

The Trust's Care Coordination Centre was also shortlisted in the HSJ Partnership of the Year category for the team's work with healthcare tech company Teletracking on the Trust's electronic bed and capacity management system. The technology provides real-time information about bed occupancy 24 hours a day, seven days a week, significantly reducing the amount of time a bed is empty and the time a patient spends in ED before they are transferred to a bed. The winners of the HSJ Awards will be announced at a ceremony due to be held on 21 November.

- MTW recently celebrated caring for the 1,000th patient on our Virtual Ward pathway, which was launched in 2022. Running 24 hours a day, seven days a week, the Virtual Ward helps to reduce hospital admissions by treating patients in the comfort of their own home when they can't be discharged as need active monitoring. The patients regularly check in with personal or Trust-issued devices so that they can speak virtually with a team of clinical staff. Wearable devices ensure their symptoms and condition are monitored in real-time. The Virtual Ward has a number of clinical pathways including stroke and gastroenterology and we also have a generalised ward, which supports the transfer of any patient with a diagnosis and treatment plan onto the Virtual Ward pathway.

- Our teams have recently delivered a number of services aimed at safely improving waiting times for non-emergency surgery. Delivering pioneering high intensity theatre (HIT) lists, for example, is enabling our Orthopaedic teams to help treat more patients by removing delays. Aiming for peak efficiency and safety, HIT lists maximise the time the surgeon has to operate, meaning the team can perform more surgeries in one day, helping to treat more patients. By using the HIT list model, our Orthopaedic teams can perform up to seven hip replacement surgeries in one day (a 50% increase). HIT lists also enable up to ten patients a day to benefit from hand or upper limb surgery, with many returning home on the same day. The Ophthalmology team also recently held a 'super Saturday' clinic, which safely supported patients with issues affecting their vision and/or quality of life. The team saw 47 patients and performed 35 procedures over the course of the day, ranging from eyelid biopsies and drainage of styes to the removal of eyelid cysts, meaning the team now has more capacity to support other patients. Feedback from patients has been hugely positive, with many commenting on the efficiency of the services.

- Maidstone Birth Centre celebrated the first birthday of their Newborn Café last month, which provides feeding support to new parents of babies up to 12 weeks old in the local area. Run by a team of experts including midwives, maternity support workers, and infant feeding and tongue tie specialists, the Café has already supported hundreds of parents and caregivers. It's also been a great opportunity to meet other parents, share ideas and receive moral support in the first few weeks of having a baby. The Café is free to attend and takes place every Tuesday at the Maidstone Birth Centre at Maidstone Hospital.

- I am delighted to announce that Maidstone Hospital volunteer, Mike Williams, has won the Volunteer Award in the BBC's Make a Difference Awards, in recognition of his 44-year volunteering career. Mike has been a League of Friends volunteer at Maidstone Hospital for 30 years, and has also volunteered with other local support groups and charities. We have over 250 volunteers across our hospitals and, like Mike, they are all a vital part of the Trust's day-to-day work. On behalf of the Board, I would like to congratulate Mike on winning this award and thank him for the invaluable support he gives to our staff, patients and visitors.

- We are recognising the Trust's Employee of the Month for both July and August in this report:
  - Congratulations to our winner of the Trust's Employee of the Month award for July, Owen Pickett, in the Retention team. Owen has been a huge asset to the team in his role as Retention Lead, and his contribution to inclusion and retention has included leading on the re-launch of MTW's long service awards and his work with the MTW Proud Network. Gemma Riches, Occupational Therapist, also received the Highly Commended Award for displaying

excellent leadership skills during her team's recent re-location, supporting staff and patients throughout.

- Congratulations also to the joint winners of the Employee of the Month award for August, Anna Powell, in the Rheumatology team, and Sally Biggs, from our Faster Diagnosis Service. Anna and Sally assisted a distressed patient in a hospital car park, showing vigilance and care which ensured the patient did not come to further harm. Senior Graphic Designer, Rob Cachia, also received the Highly Commended Award for his work in delivering innovative and engaging designs which engage patients and help to attract, retain and develop Trust staff.

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

Independent Investigation of the National Health Service in England

The Rt Hon. Professor the Lord Darzi of Denham OM KBE FRS FMedSci HonFREng

September 2024

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Independent investigation of the National Health Service in England

Contents

Summary letter from Lord Darzi to the Secretary of State for Health & Social Care

Dear Secretary of State,

You asked me to undertake a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system. I have examined areas such as the health of the nation and social care system in so far as they impact on the NHS, although these were outside the formal scope of the Investigation. My attention has also been drawn to some worrying health inequalities that will require further examination than has been possible in the time available, although I do highlight some particular areas of concern.

This report contains my findings, which are summarised as follows:

1. **The National Health Service is in serious trouble.**

   The British people rely on it for the moments of greatest joy – when a new life comes into being – and those of deepest sorrow. We need it when we are suffering from mental distress or hurting from physical pain and for all the times when care and compassion matter most. Yet public satisfaction – which stood at a record high in 2009 – is now at its lowest ever.

2. **The first step to rebuilding public trust and confidence in the NHS is to be completely honest about where it stands**.

   Everyone knows that the health service is in trouble and that NHS staff are doing their best to cope with the enormous challenges. The sheer scope of issues facing the health service, however, has been hard to quantify or articulate. That is why this

report has not held back, even if it has been a rapid assessment over just nine weeks. Although I have worked in the NHS for more than 30 years, I have been shocked by what I have found during this investigation—not just in the health service but in the state of the nation's health.

3. **The state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance.**

   Overall life expectancy increased in the 2000s, but plateaued during the 2010s, before decreasing during the Covid-19 pandemic. It has started to rise again now, but the absolute and relative proportion of our lives spent in ill-health has increased.

   Many of the social determinants of health – such as poor quality housing, low income, insecure employment – have moved in the wrong direction over the past 15 years with the result that the NHS has faced rising demand for healthcare from a society in distress.

   There has been a surge in multiple long-term conditions, and, particularly among children and young people, in mental health needs. Fewer children are getting the immunisations they need to protect their health and fewer adults are participating in some of the key screening programmes, such as for breast cancer. The public health grant has been slashed by more than 25 per cent in real terms since 2015 and the country's main public health institution was abolished – split into two new bodies – in the middle of the pandemic.

4. **This report sets out where the NHS stands now, how we arrived at this point, and some of the key remedies.**

   My terms of reference preclude me from making specific policy recommendations. But I would note that the NHS has been through very difficult times in the past and has emerged stronger, and that many of the measures needed to tackle the current malaise are already well known. So, without providing policy detail, I do, as requested, set out the major themes for the forthcoming 10-year health plan. These are the steps that I believe are needed to turn the NHS around.

Performance of the NHS

5. **How long people wait, and the quality of treatment, are at the heart of the social contract between the NHS and the people. The NHS has not been able to meet the most important promises made to the people since 2015.**

   From access to GPs and to community and mental health services, on to accident and emergency, and then to waits not just for more routine surgery and treatment but for cancer and cardiac services, waiting time targets are being missed. It is inevitable that public trust and confidence will have been damaged by the inability of the NHS to meet the promises of the NHS constitution for the reasons that this report describes.

6. **People are struggling to see their GP.**

   GPs are seeing more patients than ever before, but with the number of fully qualified GPs relative to the population falling, waiting times are rising and patient satisfaction is at its lowest ever level. There are huge and unwarranted variations in the number of patients per GP, and shortages are particularly acute in deprived communities.

7. **Waiting lists for community services and mental health have surged.**

   As of June 2024, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people. By April 2024, about 1 million people were waiting for mental health services.

   Long waits have become normalised: there were 345,000 referrals where people are waiting more than a year for first contact with mental health services—more than the entire population of Leicester—and 109,000 of those were for children and young people under the age of 18.

8. **A&E is in an awful state.**

   There are three types of A&E department. Type 1 are what most people think of as A&E—they are major departments and able to deal with the full range of emergencies. Type 2 are for specific conditions such as dental or ophthalmology and type 3 are for minor injuries and illnesses.

In 2010, 94 per cent of people attending a type 1 or type 2 A&E were seen within four hours; by May 2024 that figure had dropped to just over 60 per cent (and for all three types of A&E combined, performance is now at 74 per cent). More than 100,000 infants waited more than 6 hours last year and nearly 10 per cent of all patients are now waiting for 12 hours or more.

According to the Royal College of Emergency Medicine, these long waits are likely to be causing an additional 14,000 more deaths a year—more than double all British armed forces' combat deaths since the health service was founded in 1948.

9. **Waiting times for hospital procedures have ballooned.**

The promise is that for most procedures, treatment will start within 18 weeks. In March 2010, there were just over 2.4m on the waiting list, of whom 200,000 had been waiting longer than 18 weeks. Of those, 20,000 had waited more than a year. By contrast, in June 2024, more than 300,000—fifteen times as many—had waited for over a year, and 1.75 million had been waiting for between 6 and 12 months. One recent improvement is that only some 10,000 people are still waiting longer than 18 months, a sharp fall from 123,000 in September 2021.

10. **Cancer care still lags behind other countries.**

While survival rates at 1-year, 5-years and 10-years have all improved, the rate of improvement slowed substantially during the 2010s. The UK has appreciably higher cancer mortality rates than other countries. No progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, rates have risen from 54 per cent to 58 per cent in 2023, with notable improvements in the early detection of lung cancer due to the targeted lung check programme.

In 2024, more than 35,000 genomic tests are being completed each month but only around 60 per cent on time. Recent research from the Tessa Jowell Brain Cancer Mission found that in practice, only around 5 per cent of eligible patients with brain cancer are able to access whole genome sequencing, which is important for treatment selection.

The 62-day target for referral to first treatment has not been met since 2015 and in May 2024, performance was just 65.8 per cent. More than 30 per cent of patients are waiting longer than 31 days for radical radiotherapy.

11. **Care for cardiovascular conditions is going in the wrong direction.**

    Once adjusted for age, the cardiovascular disease mortality rate for people aged under 75 dropped significantly between 2001 and 2010. But improvements have stalled since then and the mortality rate started rising again during the Covid-19 pandemic. Rapid access to treatment has deteriorated—the time for the highest risk heart attack patients to have a rapid intervention to unblock an artery has risen by 28 per cent from an average of 114 minutes in 2013-14 to 146 minutes in 2022-23. The percentage of suspected stroke patients who receive the necessary brain scan within an hour of arrival at hospital varies from 80 per cent in Kent to only around 40 per cent in Shropshire.

12. **The picture on quality of care is mixed.**

    For the most part, once people are in the system, they receive high quality care. But there are some important areas of concerns, such as maternity care, where there have been a succession of scandals and inquiries. There have been improvements in patient safety, with more error-free care in hospitals and a reduction in the number of suicides in inpatient mental health facilities, partly as a result of sustained political attention. The power of prevention is illustrated through the impressive achievements of the Diabetes Prevention Programme, which reduces the risk of type II diabetes by nearly 40 per cent.

13. **The NHS budget is not being spent where it should be—too great a share is being spent in hospitals, too little in the community, and productivity is too low.**

    Hospitals are where most waiting list procedures take place. But they present an apparent paradox. Growth in hospital staff numbers has increased sharply since the pandemic—rising 17 per cent between 2019 and 2023. There are 35 per cent more nurses working with adults and 75 per cent more with children than 15 years ago. The number of appointments, operations and procedures, however, has not increased at the same pace and so productivity has fallen.

    The key reason for this is that patients no longer flow through hospitals as they should. A desperate shortage of capital prevents hospitals being productive. And the dire state of social care means 13 per cent of NHS beds are occupied by people waiting for social care support or care in more appropriate settings. The result is there are 7 per cent fewer daily outpatient appointments for each consultant, 12 per cent less surgical activity for each surgeon, and 18 per cent less activity for each clinician working in emergency medicine.

It needs to be stressed that falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds.

Too many people end up in hospital, because too little is spent in the community. Many people will have experienced congested A&E departments themselves. If you had arrived at a typical A&E on a typical evening in 2009, there would have been just under 40 people ahead of you in the queue. By 2024, that had swelled to more than 100 people.

This is because we have underinvested in the community. We have almost 16 per cent fewer fully qualified GPs than other high income countries (OECD 19) relative to our population. After years of cuts, the number of mental health nurses has just returned to its 2010 level. Between 2009 and 2023 the number of nurses working in the community actually fell by 5 per cent, while the number of health visitors, who can be crucial to development in the first five years of life, dropped by nearly 20 per cent between 2019 and 2023.

Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community. In practice, the reverse has happened. Both hospital expenditure and hospital staffing numbers have grown faster than the other parts of the NHS, while numbers in some of the key out-of-hospital components have declined. Between 2006 and 2022, the share of the NHS budget spent on hospitals increased from 47 per cent to 58 per cent.

This distribution is perpetually reinforced: performance standards are focused on hospitals, not on primary care, community services or mental health. Single-year budgets necessarily reinforce the status quo—and when things go wrong the knee-jerk response from ministers has been to throw more money at hospitals where the pressure is most apparent as waiting areas fill up and ambulances queue outside.

The result is that NHS has implemented the inverse of its stated strategy, with the system producing precisely the result that its current design drives. The problems are systemic. In the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.

14. **The NHS is not contributing to national prosperity as it could.**

At the start of 2024, 2.8m people were economically inactive due to long-term sickness. That is an 800,000 increase on pre-pandemic levels with most of the rise accounted for by mental health conditions. Being in work is good for wellbeing. Having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work.

More than half of the current waiting lists for inpatient treatment are working age adults. And there are long waits for mental health and musculoskeletal services, too, which are the biggest causes of long-term sickness. Improving access to care is a crucial contribution the NHS can make to national prosperity.

There are still wide variations in performance, so my findings may be explanations, but they are not excuses. So, the real question is how such a situation has arisen in the system as a whole: what has caused it? Why has it happened?

Drivers of performance

Four heavily inter-related factors have contributed to the current dire state of the NHS. They are austerity in funding and capital starvation; the impact of the Covid-19 pandemic and its aftermath; lack of patient voice and staff engagement; and management structures and systems.

15. **Austerity. The 2010s were the most austere decade since the NHS was founded, with spending growing at around 1 per cent in real terms.**

Until 2018, spending grew at around 1 per cent a year in real terms, against a long-term average of 3.4 per cent. Adjusted for population growth and changes in age structure, spending virtually flatlined.

In 2018, for the service's 70th birthday, a more realistic promise was made of a 3.4 per cent a year real terms increase for five years in revenue spending. The promise did not include capital spending, medical training, nor any increase in public health expenditure.

The 2018 funding promise was broken. Spending actually increased at just under 3 per cent a year in real terms between 2019 and 2024—below both the 2018 promise and the historic rate on which it had been based.

16. **Capital. The NHS has been starved of capital and the capital budget was repeatedly raided to plug holes in day-to-day spending.**

    The result has been crumbling buildings that hit productivity – services were disrupted at 13 hospitals a day in 2022-23. The backlog maintenance bill now stands at more than £11.6 billion and a lack of capital means that there are too many outdated scanners, too little automation, and parts of the NHS are yet to enter the digital era.

    Over the past 15 years, many sectors of the economy have been radically reshaped by digital technologies. Yet the NHS is in the foothills of digital transformation. The last decade was a missed opportunity to prepare the NHS for the future and to embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'—a shift I called for in *High Quality Care for All*, more than 15 years ago.

    Some £4.3 billion was raided from capital budgets between 2014-15 and 2018-19 to cover in-year deficits that were themselves caused by unrealistically low spending settlements.

17. **On top of that, there is a shortfall of £37 billion of capital investment.**

    These missing billions are what would have been invested if the NHS had matched peer countries' levels of capital investment in the 2010s. That sum could have prevented the backlog maintenance, modernised technology and equipment, and paid for the 40 new hospitals that were promised but which have yet to materialise. It could have rebuilt or refurbished every GP practice in the country.

    Instead, we have crumbling buildings, mental health patients being accommodated in Victoria-era cells infested with vermin with 17 men sharing two showers, and parts of the NHS operating in decrepit portacabins. Twenty per cent of the primary care estate predates the founding of the health service in 1948.

18. **The pandemic. The impact of the pandemic and its aftermath: a bigger backlog than other health systems**

    The combination of austerity and capital starvation helped define the NHS's response to the pandemic. It is impossible to understand the current state of the NHS without understanding what happened during it.

The decade of austerity preceding Covid-19, along with the prolonged capital drought, saw the NHS enter the pandemic with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems. The NHS's resilience was at a low ebb.

What is less widely known, is that **the NHS delayed, cancelled or postponed far more routine care during the pandemic than any comparable health system.** Between 2019 and 2020, hip replacements in the UK fell by 46 per cent compared to the OECD average of 13 per cent. Knee replacements crashed a staggering 68 per cent compared to an average fall of 20 per cent. Across the board, the number of discharges from UK hospitals fell by 18 per cent between 2019 and 2020, the biggest drop across comparable countries.

19. **Patient engagement. The patient voice is not loud enough.**

The NHS should aspire to deliver high quality care for all, all of the time. That not only means care that is safe and effective but that treats people with dignity, compassion and respect, making their experiences as positive as they can be. Yet patient satisfaction with services has declined and the number of complaints has increased, while patients are less empowered to make choices about their care. A familiar theme in inquiries into care failings has been patients' concerns not being heard or acted upon. The NHS is paying out record sums in compensation payments for care failures, which now amount to nearly £3 billion or 1.7 per cent of the entire NHS budget.

20. **Staff engagement. Too many staff are disengaged.**

There is also compelling evidence that, post-pandemic, too many staff have become disengaged, and there are distressingly high-levels of sickness absence – as much as one working month a year for each nurse and each midwife working in the NHS.

The experience of the pandemic was exhausting for many and its aftermath continues to reverberate. NHS staff not only mourned deaths of their colleagues on the frontline but were at the sharp end of the Covid rules. They had to insist that mothers gave birth alone and that elderly and other patients had to die without the comforting touch of their loved ones. The result has been a marked reduction in discretionary effort across all staff groups.

21. **Management structures and systems. Still reeling from a turbulent decade and the growth in oversight.**

The Health and Social Care Act of 2012 was a calamity without international precedent. It proved disastrous. By dissolving the NHS management line, it took a "scorched earth" approach to health reform, the effects of which are still felt to this day. It has taken more than 10 years to get back to a sensible structure. And management capability is still behind where it was in 2011.

Some sanity has been restored by the 2022 Act which put integrated care systems on a statutory basis. This has the makings of a sensible management structure, consisting of a headquarters, seven regions and 42 integrated care boards (ICBs) whose strategy to tackle inequalities, and to improve population health, is set by an Integrated Care Partnership (ICP) that includes local government and the third sector alongside the NHS itself.

Across ICBs, there are differing understanding of their roles and responsibilities, including how far they are responsible for the performance management of providers, and quite how and at what level they should tackle population health. The NHS in England has emulated Wales and Scotland and changed its improvement philosophy from competition to collaboration. The framework of national standards, financial incentives and earned autonomy as part of a mutually reinforcing approach is no longer as effective as it once was, and needs to be reinvigorated.

22. **A further effect of the 2012 Act has been a costly and distracting process of almost constant reorganisation of the 'headquarters' and 'regulatory' functions of the NHS.**

Although there are ongoing reductions in management spend and headcount numbers continue to fall, some 19,000 people are employed between NHS England and the Department of Health and Social Care (having peaked at 23,000 in 2022). Some 5,200 of the 16,000 employed by NHS England provide shared services to the NHS such as IT infrastructure and 3,500 are in its seven regions. The Department of Health and Social Care has increased in size by more than 50 per cent in the past 10 years, employing fewer than 2,000 people in 2013 compared to more than 3,000 in 2024, as it reabsorbed staff following the abolition of Public Health England.

Accountability is important. But too many people holding people to account, rather than doing the job, can be counterproductive. Regulatory type organisations now employ some 7,000 staff, or 35 per provider trust, having doubled in size over the past 20 years. Taken together, there are nearly 80 people employed in regulatory and headquarters functions for each NHS provider trust. And there are a multitude of other organisations that produce guidance, recommendations and standards. NHS organisations should focus on the patients and communities they serve, but

the sheer number of national organisations that can 'instruct' the NHS encourages too many to look upwards rather than to those they are there to serve.

The Care Quality Commission – which inspects the NHS – is not fit for purpose, as the recent independent review made clear. Its focus on inputs rather than outcomes has played a major role in driving up the numbers of clinicians in hospitals to unprecedented levels.

Conclusion: the NHS is in critical condition, but its vital signs are strong

23. **It is apparent from this report and from the accompanying analysis that the NHS is in critical condition**.

    It continues to struggle with the aftershocks of the pandemic. Its managerial capacity and capability have been degraded, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated.

24. **Some have suggested that this is primarily a failure of NHS management. They are wrong.**

    The NHS is the essential public service and so managers have focused on "keeping the show on the road". Some fantasise about an imaginary alternative world where heroic NHS managers were able to defy the odds and deliver great performance in a system that had been broken. Better management decisions might have been taken along the way, but I am convinced that they would have only made a marginal difference to the state that the NHS is in today.

25. **Despite the challenges, the NHS's vital signs remain strong.**

    The NHS has extraordinary depth of clinical talent, and our clinicians are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients. They are the beating heart of the NHS. Despite the massive gap in capital investment, the NHS has more resources than ever before, even if there is an urgent need to boost productivity.

26. **Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay.**

    With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance play a bigger role—are more expensive, even if their funding tends to be more stable. It is not a question, therefore, of whether we can afford the NHS. Rather, we cannot afford not to have the NHS, so it is imperative that we turn the situation around.

27. **It has taken more than a decade for the NHS to fall into disrepair so improving it will take time.**

    Waiting times can and must improve quickly. But it will take years rather than months to get the health service back to peak performance. I have no doubt that significant progress will be possible, but it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term. Just as we in the NHS have turned around performance before, we can do so again.

28. **There are some important themes that have emerged for how to repair the NHS, which will need to be considered alongside strategies to improve the nation's health and reforms to social care.**

    You asked me to identify the major themes for the forthcoming 10-year health plan. These include the following:

    - *Re-engage staff and re-empower patients*. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.

    - *Lock in the shift of care closer to home by hardwiring financial flows*. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

    - *Simplify and innovate care delivery for a neighbourhood NHS*. The best way to work *as* a team is to work *in* a team: we need to embrace new multidisciplinary

models of care that bring together primary, community and mental health services.

- *Drive productivity in hospitals*. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and re-engaging and empowering staff.

- *Tilt towards technology*. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation's prosperity*. With the NHS budget at £165 billion this year, the health service's productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.

- *Reform to make the structure deliver*. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.

* * *

In an unprecedented act of transparency, my report is being published with an accompanying technical annex containing over 330 analyses that my team and I have commissioned for this investigation. These have been completed by NHS England and the Department of Health and Social Care at remarkable speed.

At my insistence, every piece of analysis includes all available data going back to 2001 or from the first creation of datasets thereafter. It is my hope that this will mark the start of a more open and honest conversation between ministers, the NHS and the public about performance.

In addition, I have examined more than 500 pages of analysis from charities, professional bodies, and other organisations that have a shared passion for the NHS, its values, and its future.

I have also benefitted enormously from the advice and wisdom of the Expert Reference Group. This comprised of the leadership of more than 75 of the most important organisations contributing to the health service today (listed at annex A). I would like to express my sincere thanks to all contributors and to the team that has delivered this report at such speed. I am also grateful to those organisations that hosted me for my programme of visits.

The NHS is now an open book. The issues are laid bare for all to see. And from this shared starting point, I look forward to our collective endeavour to turn it around for the people of this country, and to secure its future for generations to come.

ARA DARZI
Paul Hamlyn Chair of Surgery, Imperial College London
Consultant Surgeon, Imperial College Healthcare NHS Trust
and the Royal Marsden NHS Foundation Trust
Independent Member of the House of Lords

Part I

Performance of the NHS

Introduction

The purpose of the National Health Service

1. We can only understand the performance of the NHS if we understand what it is there to do. The goal of this rapid review is to establish whether the NHS is fulfilling its promise to the people, and if it is not, setting out how and why this is the case.

2. The NHS Constitution—its contract with the people implied from its creation and codified since 2009—describes the purpose of the health service. It is worth restating it here:

> *"The NHS belongs to the people.*
>
> *It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.*
>
> *It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.*
>
> *It touches our lives at times of basic human need, when care and compassion are what matter most."*

3. The NHS Constitution describes the values and principles of the health service and the rights and responsibilities of those that use it as well as those that work in it. It sets out pledges to patients and the public on the standards of access and quality that they can expect and to staff on ways in which the NHS will work.

4. In this review, we examine how well the NHS is living up to its promises to patients and the public and to its staff. To understand how well the NHS is doing, it is important to begin by understanding what challenges it faces. We now explore how demand for healthcare has changed and the reasons why it has risen.

1

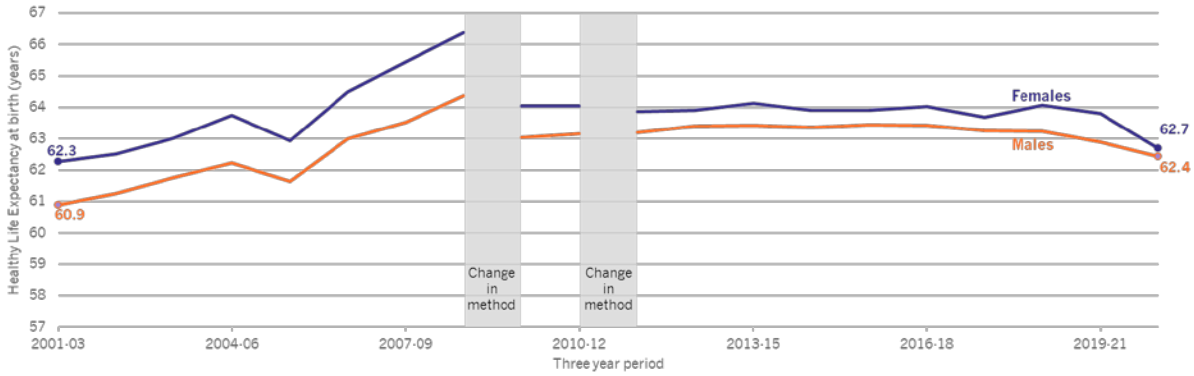
Health of the nation

1. To understand how well the NHS is performing, we first must understand how and why the demands placed upon it have changed. In this chapter, we briefly survey the health of the nation and the implications that it has for the health service. We also touch on other important contextual factors including advances in technology and the state of the social care system.

Life expectancy, preventable and treatable mortality

2. The health of the nation has deteriorated. Overall life expectancy improved in the first decade of the century, plateaued during the 2010s, fell during the Covid-19 pandemic and is now starting to increase again[1]. The picture is even worse for healthy life expectancy, where the absolute and relative proportion of our lives spent in ill-health has increased. As healthy life expectancy for both men and women has fallen, the gap between the two has narrowed. People in England can now expect to live until their early-60s in good health[2].

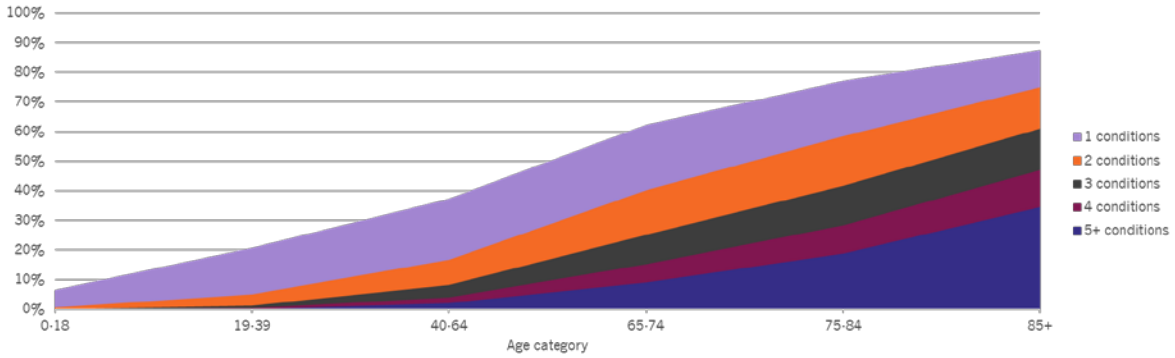
Figure I.2: Trends in Healthy Life Expectancy at birth in England, between 2001 to 2003 and 2020 to 2022



Rising demand for healthcare

3. When national health systems were first conceived, it was imagined that health would be a diminishing part of the economy. This was rooted in the belief that as society became wealthier it would become healthier, and so the demands placed upon the health system would fall over time. Instead across all advanced countries, the healthcare sector has tended to expand more quickly than the rest of the economy, meaning an increasing share of national income is devoted to health[3].

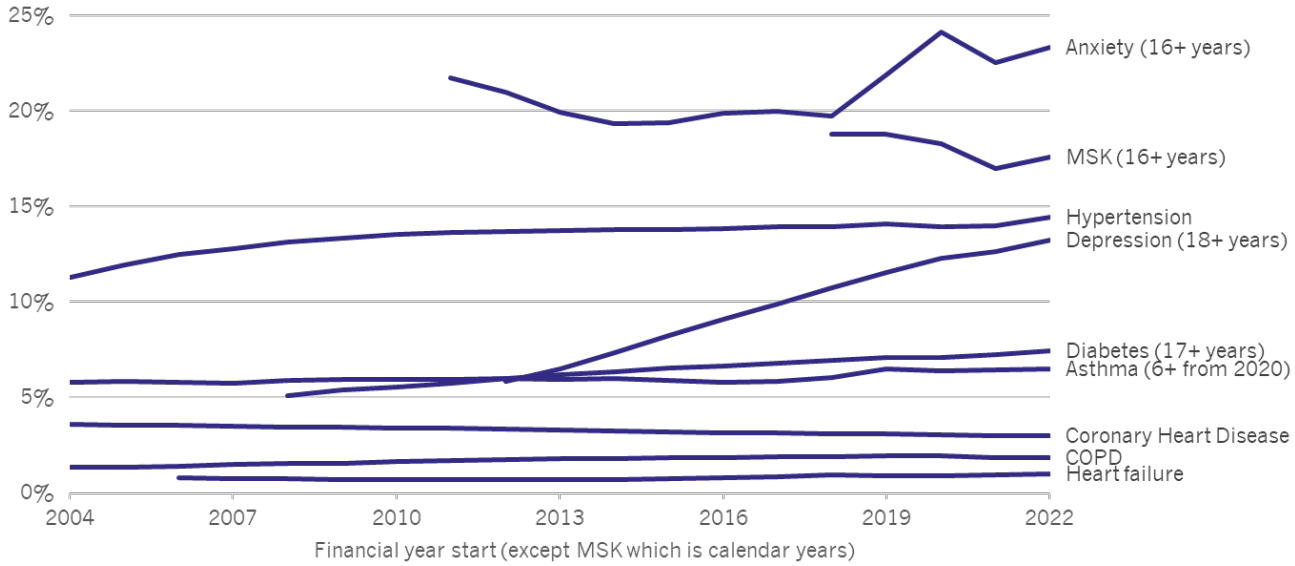
Figure I.5: Share of patients with no, one, or multiple long-term conditions by age



4. An ageing population is the most significant driver of increased healthcare needs since it is associated with the development of long-term conditions such as diabetes, breathing difficulties, or depression[4]. The analysis above is based on NHS England's patient level data. It shows that by the time people are aged 65-74, a majority will have at least one long-term condition and some 40 per cent will have two or more. By the time people are aged 75-84, this rises to nearly 60 per cent having two or more, and by the time people are aged 85 or above, 9 out of 10 will have at least one long-term condition[5].

5. As we can see below, the prevalence of some long-term conditions appears to be rising inexorably. Take diabetes, for example, which has increased from 5.1 per cent prevalence in 2008 to 7.5 per cent in 2022[6]. While the prevalence of high blood pressure (and its associated risks) was 11.3 per cent in 2004, by 2022 it has risen to 14.4 per cent[7].

Figure I.6: Recorded prevalence of health conditions by year (financial or calendar) for all ages (except where indicated) in England, 2004 and 2022



6. But it is our mental health that appears to have deteriorated most significantly in the past decade. The prevalence of depression has shot up from 5.8 per cent in 2012 to 13.2 per cent a decade later in 2022[8]. But the rise in need for mental health services is not evenly distributed in the population. For adults, mental health referrals have been increasing at a rate of 3.3 per cent a year[9]. But for children and young people, the rate of referrals has increased by 11.7 per cent a year from around 40,000 a month in 2016 to almost 120,000 a month in 2024[10]. And referrals for perinatal services for mothers has risen by 23 per cent a year since 2016, rising from around 1,400 a month in 2016 to more than 7,600 a month in 2024[11].

7. While ageing may be the most significant driver of increased healthcare needs, the health of the nation is affected by many other factors too. The wider determinants[12] such as income, education, work, housing, relationships, families and our natural and physical environment can have enormous impacts on our health. Many of these are moving in the wrong direction.

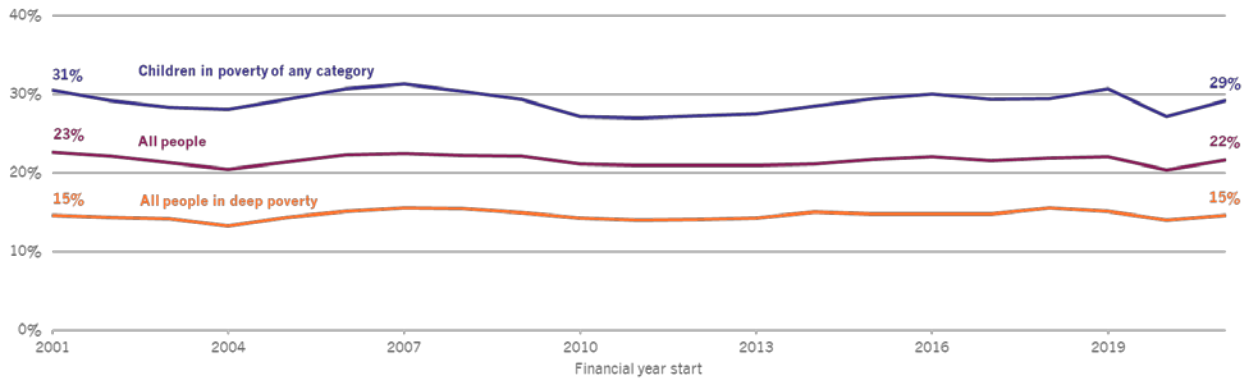
An economy and society in distress

8. The NHS has been impacted by wider changes beyond the health system. Our health is the result of our genetic inheritance, our lifestyle and behaviours, and our social and economic circumstances which shape our lives. These include income, housing and access to healthy food, amongst others. It has a particular impact for the most deprived and disadvantaged in society.

9. While the poorest households saw their income increase by 2.3 per cent a year in real terms during the 2000s, this plummeted to just 0.0 per cent real income growth in the 2010s for the bottom quintile. This compares to 0.9 per cent and 0.6 per cent real income growth across for these decades respectively for the top income quintile[13]. This has, of course, impacted poverty rates, particularly for children. The proportion of children living in poverty fell from 31 per cent to 27 per cent between 2007 and 2010. But it steadily rose from then, so that by 2019, all the progress had been reversed and 31 per cent of children were living in poverty, and the latest data shows that this is now 29 per cent[14].

10. According to the Joseph Rowntree Foundation (JRF), around 3.8 million people have experienced destitution in a year, one million of whom are children – nearly triple the number of children since 2017[15]. And in their submission to the Investigation, the Child Poverty Action Group pointed out that the UK had the largest rise in relative child poverty of any advanced nation between 2014 and 2021.

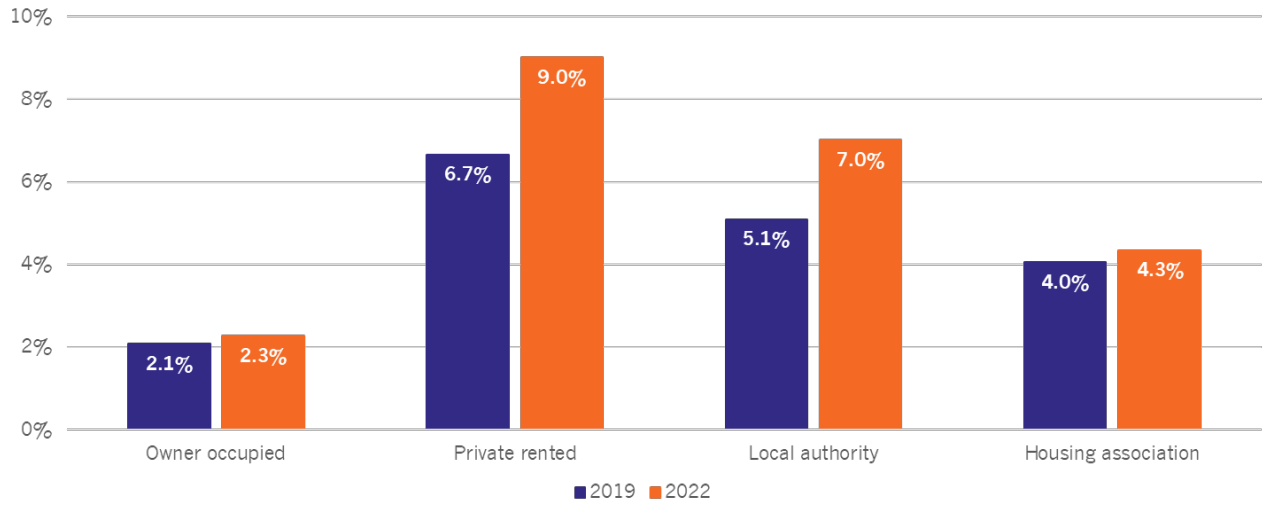
Figure I.9: Poverty rates



11. With worsening poverty, there has been an upward trend in food insecurity. Data from the Trussell Trust shows an increase in the number of food supply parcels from 1.4 million in 2017-18 to the highest recorded level of 3.1 million in 2023-24[16]. Healthy and nutritious food is comparatively expensive; cheap food is associated with higher obesity levels, which has many different health impacts. The Office for National Statistics (ONS) reported that between 18 October 2023 and 1 January 2024, 20 per cent of households in the most deprived quintile reported eating less fruit and fewer vegetables because of cost-of-living increases[17], compared to 8 per cent of the least deprived quintile. Almost half of primary care providers are running foodbanks, according to the JRF.

12. The housing crisis has continued to get worse, with the UK having the highest rates of homelessness in the OECD when measured by the proportion of the population in temporary accommodation[18]. Housing quality impacts health outcomes: poor housing is associated with increases in respiratory conditions and communicable diseases. The number of homes with damp problems has increased between 2019 and 2022[19]. While this rose across all sectors, the starkest increases were in private and local authority rentals. People in privately rented homes are nearly four times as likely to experience damp issues as those who own their homes.

Figure I.11: Dwellings with any damp problems, England, 2019 and 2022



13. It is not just our material conditions that impact our health and therefore the NHS. The rise in social media use has reshaped our lives. While there have been many benefits, there are harms, too. Studies are split on the impact on our physical and mental health. But it seems highly unlikely that the dramatic rise in mental health needs is wholly unconnected from social media. Studies have found 14-year olds that use social media excessively (more than five hours a day) were more likely to be depressed[20]. But it is unclear whether it was the cause or the consequence of depression.

Expanding possibilities

14. A further reason for the growth in healthcare expenditure should be celebrated: medical and scientific advances means that disease can be better diagnosed and treated than ever before. The scope of what is possible continues to expand: at the start of the century, nearly 1,500 diseases had a known molecular basis, and some 1,000 gene mutations were understood to cause disease[21]. By 2024, that had

increased to nearly 7,500 diseases with a known molecular basis and around 5,000 identified gene mutations that caused or contributed to disease[22].

15. Over the past decade, NHS spending on drugs for specialised services has grown at 8.9 per cent a year, while for devices it has increased at 10.2 per cent annually[23]. This far outpaces the rate of growth of the total NHS budget, meaning that specialised services account for a growing share of expenditure. While it means more diseases and conditions can be treated—such as putting England on a trajectory to eliminate hepatitis C ahead of the rest of the world[24]—it creates an inexorable pressure on costs.

Overall impact

16. Analysis commissioned for this report found that NHS activity has increased, notably for primary care and mental health services; that complexity has risen, with the proportion of NHS patients with disabilities notably increasing at more than 9 per cent a year between 2017 and 2023[25]; and that spending on specialised services has increased at a much faster rate than routine care[26].

17. On every front, the demands placed upon the NHS have accelerated. This means that we are much closer to the 'slow uptake' scenario than the 'fully engaged' scenario described by Derek Wanless in his 2002 review of long-term health financing[27] that looked at expenditure to 2022. Indeed, the 'slow uptake' scenario was defined as:

    "Life expectancy rises, but by the smallest amount in all three scenarios. The health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity."[28]

    This seems to rather presciently capture the situation we are in today. The consequence is a very significant mismatch between the demands placed upon the NHS and the resources available to it.

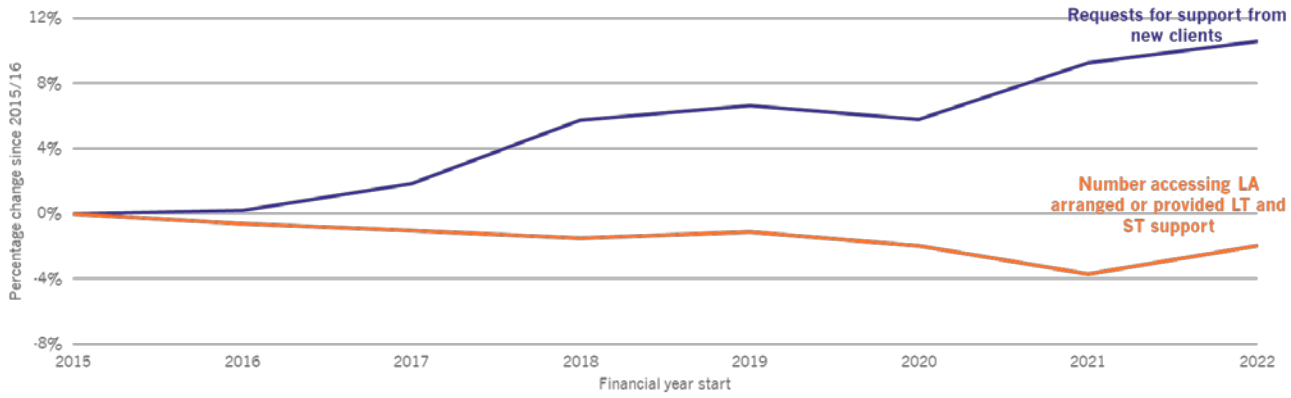
Social care challenges impacting the NHS

18. It is impossible to understand what has been happening in the NHS without understanding what has happened to social care, although social care itself is outside the remit of this Investigation.

19. Social care is a vital service in its own right, helping people with disabilities, and all of us as we age, to lead full and independent lives for as long as possible. While public debate on social care tends to focus on the needs of older people, there are very significant needs for many children and working age adults with disabilities. According to a submission from the Royal College of Occupational Therapists, 30 per cent of their members surveyed in 2023 said they could not provide equipment or adaptations for children who needed it. Social care has not been valued or resourced sufficiently, which has both a profound human cost and economic consequences.

20. While the health service endured a significant slowdown in funding during the 2010s, local government had real-terms cuts to its expenditure[29]. The result is that publicly funded social care is provided for fewer and fewer people while the demand for it has risen, largely as the result of an ageing population. Analysis by The King's Fund shows how a colossal gap has opened up between resources and need, as the chart below shows. In their submission to the Investigation, the Local Government Association highlighted that the vacancy rate in adult social care is nearly three times that of the economy as a whole.

Figure I.17: Changes to requests for support and user of long-term and short-term care to maximise independence support arranged or provided by local authorities in England, 2015-16 to 2022-23



21. Whereas the NHS is funded by taxpayers and free at the point of need, social care is means-tested and only provided to those with the greatest need and least ability to pay. With each passing year, the gap grows between those in need and those receiving publicly funded care[30]. This places an increasingly large burden on families and on the NHS. The impact on the NHS has been more people staying in hospital for longer than their medical needs require them to be there[31]. This means older people have been stuck in acute hospital wards rather than in facilities better suited to their needs (so-called delayed discharges[32]).

22. It is apparent that the different economic models between the NHS and social care is driving the most expensive outcome—people spending time in hospital when there is no medical reason for them to be there—that is also a poorer experience for elderly people and their families. The impact of delayed discharges is equivalent to 13 per cent of all NHS beds[33].

* * *

23. Rising demand from a society where people have become older and sicker alongside a social care system that is far from supporting the scale of needs of the population, are the crucial context in which NHS performance must be understood. We now turn to how well the NHS is fulfilling its commitments to the people.

2

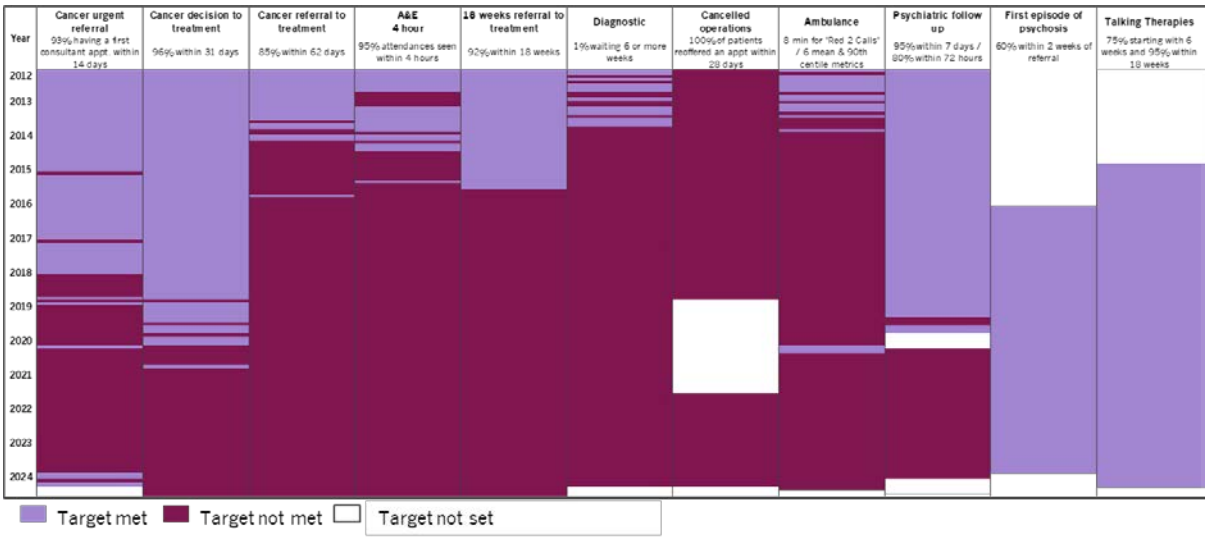
Access to NHS services

1. In this chapter, we explore speed of access to services. An essential promise between the NHS and the people is that the health service should deliver timely access to care when it is needed. While many people know that it is harder to access care, what may be less well understood—and more worrying—is the depth and breadth of access problems in the health service today.

NHS Constitutional standards

2. The majority of the NHS's most important promises to the people were no longer being met by 2015[34]. These are at the heart of the social contract between the NHS and the people. It is inevitable that public trust and confidence will have been damaged by the inability of the NHS to meet its promises.

Figure II.1.1: NHS constitutional targets and whether they are being met



3. The NHS's constitutional standards include some of the most important aspects of what the health service delivers. They include speed of access when cancer is suspected, waiting times for operations, and consistent follow up by psychiatric

services. It is striking that the NHS was unable to meet most of these promises since well before the pandemic.

Access to the front door of the NHS

NHS 111

4. The goal of NHS 111 is to enable patients to access the right care, in the right place. In the last decade, NHS 111 has grown in usage from around a million calls a month to well over 1.5 million[35]. The service has struggled to keep up with demand: as we can see from the charts below, the rate of calls that are abandoned has increased as have calls that have taken more than a minute to answer. While NHS England mandates that abandoned calls should be 3 per cent or less, the average proportion of calls abandoned every month between August 2022 and May 2024 has been 11.3 per cent – or nearly four times the acceptable level[36].

Figure II.2.1A: NHS 111 Calls Received (numbers)

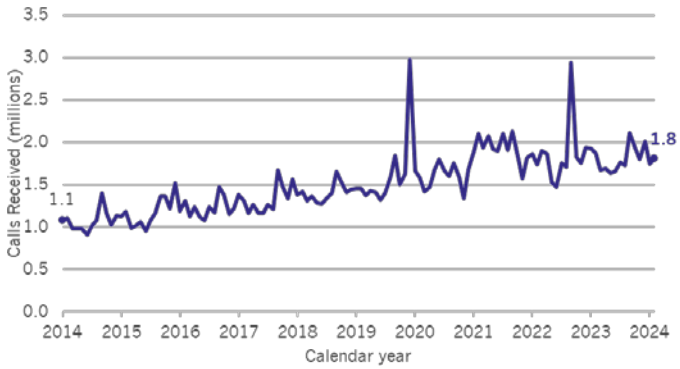
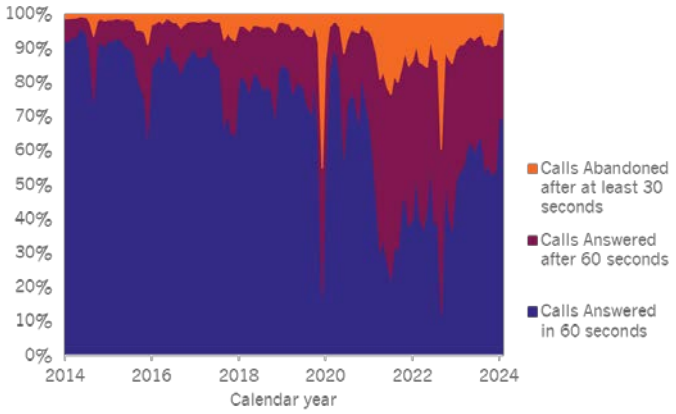


Figure II.2.1B: Call volumes split by answered in under and over 60 seconds and abandoned in over 30 seconds (percentage)



5. Where 111 callers are advised to go for help has been broadly stable over time, with 43 per cent told to contact their General Practice, 12 per cent advised to attend A&E or other urgent care and 12 per cent given an ambulance response. Self-care remains a relatively small proportion at less than 1 in 10 callers[37].

Digital front door

6. The Covid-19 pandemic led to a rapid increase in registrations for the NHS App, with nearly 80 per cent of adults now registered. But less than 20 per cent use it monthly[38]. The NHS App is not delivering a 'digital-first' experience similar to that found in many aspects of daily life, although there is huge potential. While there has

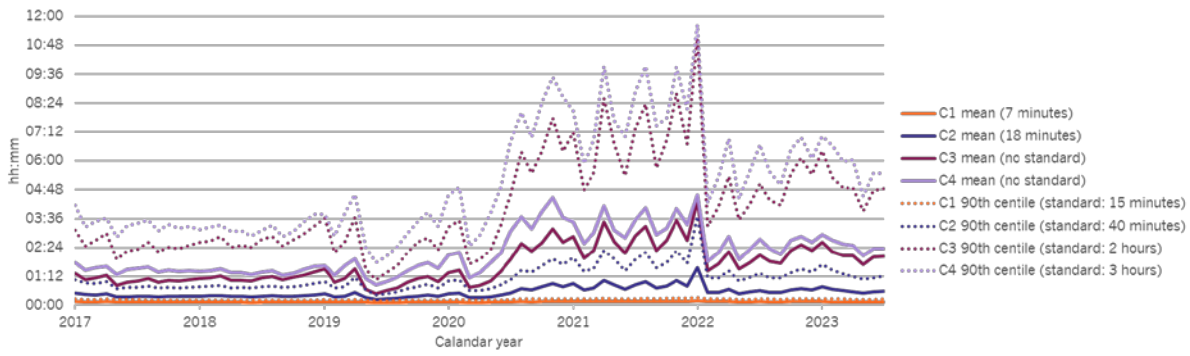
been growth in ordering repeat prescriptions and managing hospital appointments, just 1 per cent of GP appointments are managed via the App (although many book their GP appointments through other online systems)[39]. With the huge success in registrations, an important opportunity is being missed to improve both efficiency and patient experience.

Ambulance services

7. The ambulance service is there for those times when we need immediate, emergency help from the NHS. The way in which the NHS categorises ambulance responses changed in 2017. As we can see in the chart below, response times increased very sharply during the pandemic and have remained stubbornly high since then. NHS England has responded by promising to increase capacity: more than 800 new ambulances were promised by 2023-24, but only 300 new ambulances were reported to be operational by February 2024[40] and these were replacements of those in the existing fleet.

8. Calls are triaged into four categories according to the patient's need. Category one calls are those where there is an immediate threat to life, such as cardiac arrest; response times should be 7 minutes on average with 90 per cent responded to within 15 minutes. As the chart below shows, since 2021, response times for the category one 90th centile initially deteriorated before improving and nearly meeting the targets by May 2024. This trend is not reflected in the category one mean response times, which have shown a steady improvement but have not yet recovered, with the June 2024 figure recorded at 8:21 minutes[41].

Figure II.8.2: Category 1 to 4 ambulance response times, England



9. Category 2 calls include serious conditions such as stroke, sepsis, heart attack or major burns. The response time is set to be 18 minutes on average with 90 per cent responded to within 40 minutes. Response times were at their worst in December

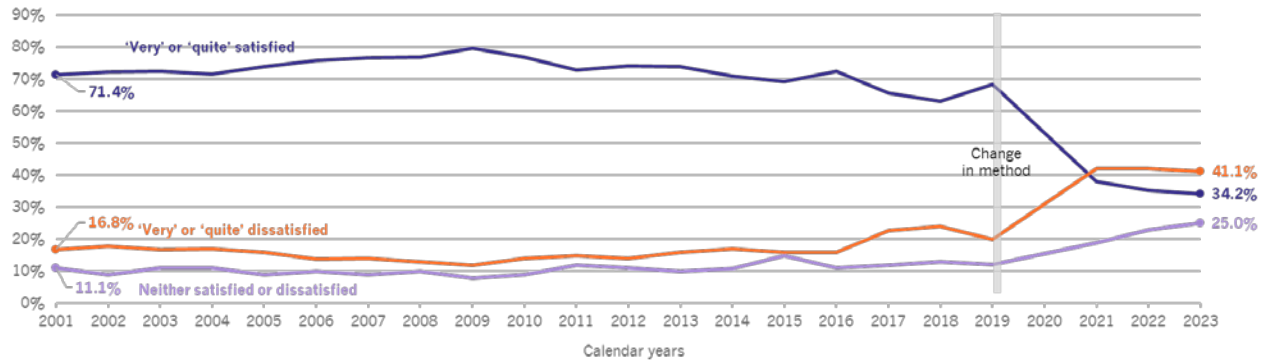
2022 (as we can see from the chart above), when there was an average response time of just over an hour-and-a-half, with the 90th centile standing at nearly 4 hours. By May this year, responses had improved to an average of 32 minutes and 90 per cent responded to within 1 hour and 8 minutes[42].

10. While there has been a sharp focus on these waits for category 2, the position for other patient groups is likely to be causing as much harm. Category 3 incidents include some of the most vulnerable in society, such as those for frail older people who have fallen and people in mental health crisis, which each make up 10 per cent of the total call volume to 999. By May 2024, the 90th centile of category 3 calls waited up to 4 hours 45 minutes (or 2 hours on average) for a response[43].

Access to General Practice

11. For most people, their GP practice remains their most common interaction with the NHS. The overall trend is for more GP appointments than ever before[44], with GPs working harder and seeing more patients. Yet there is still a struggle to meet patient demand, as the percentage of respondents to the GP patient survey who said they had to wait a week or more for a GP appointment increased from 16 per cent in 2021 to 33 per cent in 2024[45]. Satisfaction with GP services dramatically reduced during the Covid-19 pandemic, accelerating a decade in decline in satisfaction since 2009[46].

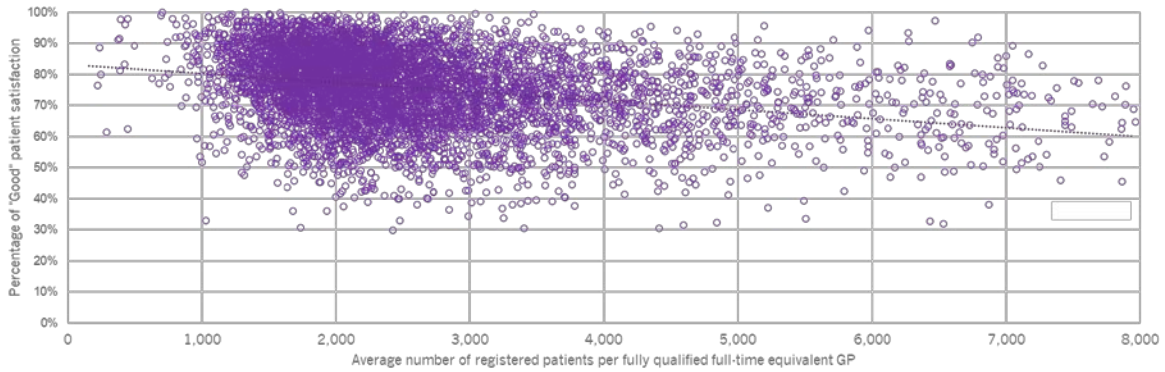
Figure II.3.3: Question asked: 'From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of the parts of the NHS runs nowadays: Local doctors or GPs



12. GPs are spread unevenly across the country. There are 1,467 patients per GP in Devon, compared to 2,261 patients per GP in North West London[47], a 54 per cent difference. Moreover, there are wide variations in the numbers of patient per GP within Integrated Care Boards (ICBs) as well as across them. This is important as a

smaller number of patients per GP is associated with higher satisfaction (see chart below)[48]:

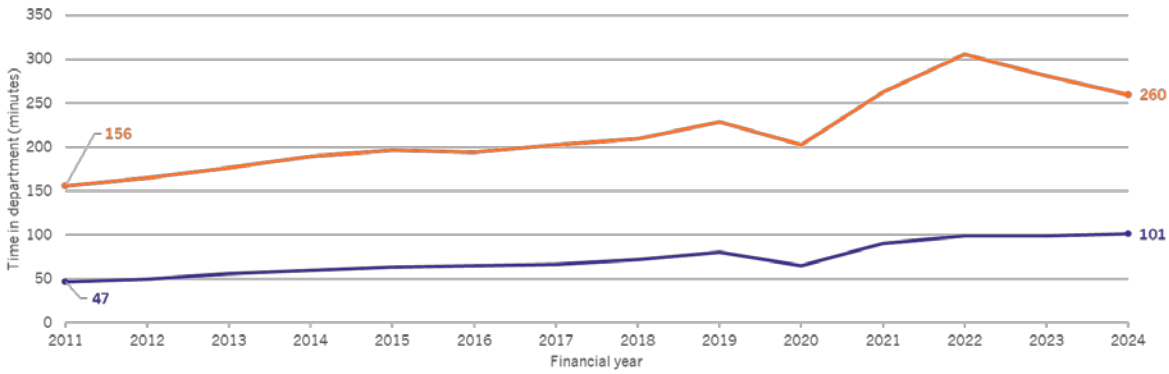
Figure II.3.7: Reported patient satisfaction by average numbers of registered patients per GP, June 2024



13. There have been positive developments in growing the wider workforce in general practice such as clinical pharmacists and occupational therapists. These should be supplements, rather than substitutes to GPs though and more GP time is required to coordinate multidisciplinary working. In particular, more GPs are needed in under-doctored areas.

14. Many, although not all, urgent treatment centres and walk-in centres are GP-led. They too have faced significant increases in demand that have resulted in longer waits. As we can see in the chart below, waiting times have increased significantly, more than doubling between 2012 and 2024 from around 50 minutes to more than an hour-and-a-half. There are also now some long waits, with the 95th centile waiting 4 hours and 20 minutes[49].

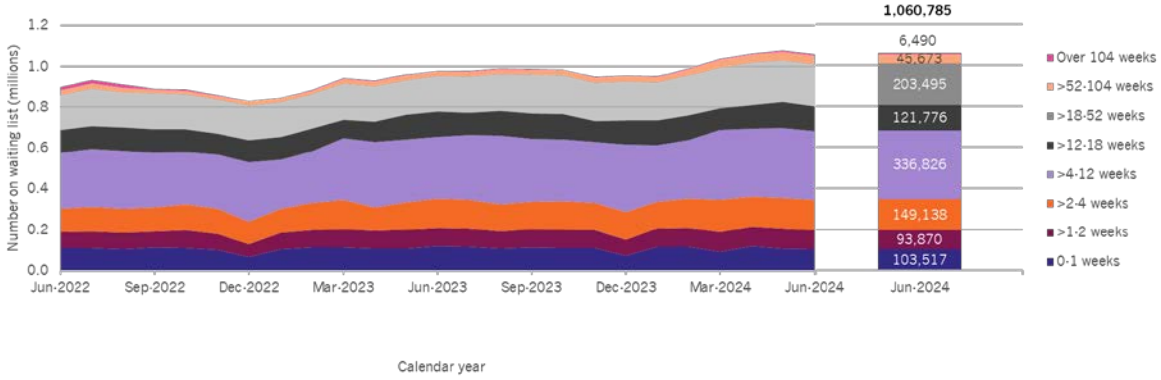
Figure II.3.8: Total time in department from arrival to admission, transfer or discharge, UTCs and WICs



Access to community services

15. High quality community services are essential to create a sustainable NHS and have been highlighted by national strategies to shift care closer to home for decades. Yet properly assessing access in NHS community services is hampered by the lack of data. Data on the total waiting list size is only available from 2022. As of June this year, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people (see chart below)[50]:

Figure II.7.1: Total community health services waits by waiting times, June 2022- June 2024

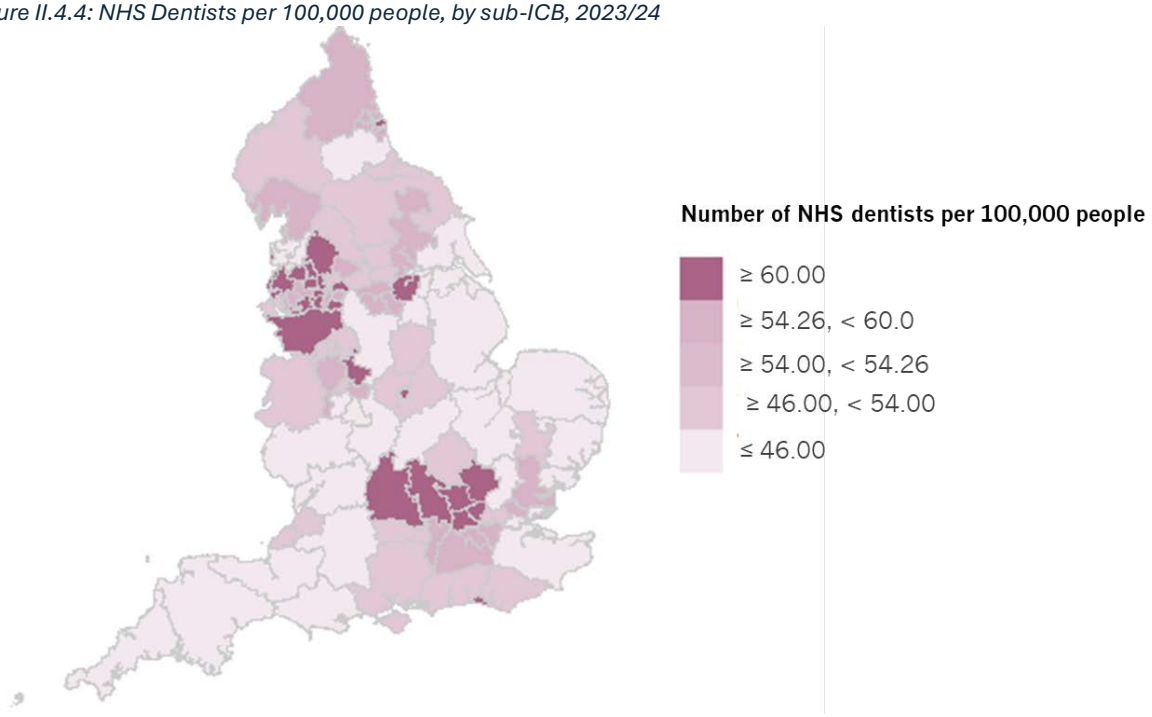


16. Set against a backdrop of growing need, the overall numbers of community nurses have held steady since 2016[51], whilst the number of district nurses (nurses who have completed additional training to become specialist community practitioners) has actually declined[52]. There has been a worrying reduction in the number of health visitors between 2019 and 2023[53] – a crucial role given the extensive evidence base on the importance of getting a good start to life. Community services need to be more visible and have a higher priority given to them.

Access to dentistry

17. Good dental health is essential for adults and children alike. Yet only about 30 and 40 per cent of NHS dental practices are accepting new child and adult registrations respectively[54]. And as this chart from the Nuffield Trust shows[55], there are wide variations in the number of NHS dentists per population in different areas of the country. Rural and coastal communities particularly lack access to NHS dentistry.

Figure II.4.4: NHS Dentists per 100,000 people, by sub-ICB, 2023/24



18. Dental access was particularly badly hit by the Covid-19 pandemic and is still recovering. If dentistry is to continue as a core NHS service, urgent action is needed to develop a contract that balances activity and prevention, is attractive to dentists and rewards those dentists who practice in less served areas. There are enough dentists in England, just not enough dentists willing to do enough NHS work, which impacts provision for the poorest in society.

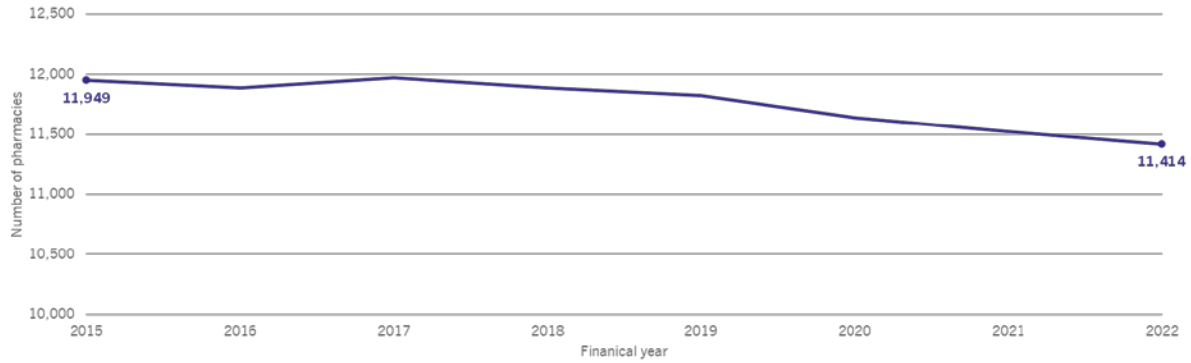
Access to community pharmacy

19. One of the great strengths of the health service in England has been the accessibility of community pharmacy. Historically, the contract promoted a highly efficient distribution of pharmacies. Indeed, in contrast to many aspects of care, deprived communities are better served. More than 93 per cent of patients living in areas of highest deprivation live within 1 mile of a pharmacy compared to 71 per cent in areas of the lowest deprivation[56]. While access has started to deteriorate in recent years, more than 85 per cent of people live within one mile of a community pharmacy[57].

20. Yet pharmacies are now closing in significant numbers. As the chart below shows, around 1,200 pharmacies have shut their doors since 2017[58]. While pharmacies have expanded the range of clinical services that they provide – such as blood

pressure checks, prescription contraception, and minor illnesses – the total level of spending on the community pharmacy contract has fallen by 8 per cent[59].

Figure II.5.1: Number of pharmacies in England from 2017 to 2024



21. There is the potential for community pharmacy to provide even more value-added services for the NHS and there have been notable successes already, such as the Pharmacy First programme. As the Royal Pharmaceutical Society pointed out in their submission to the Investigation, nearly 30 per cent of existing pharmacists are independent prescribers and changes to pharmacy education mean that from 2026 all newly-qualified pharmacists will be[60].

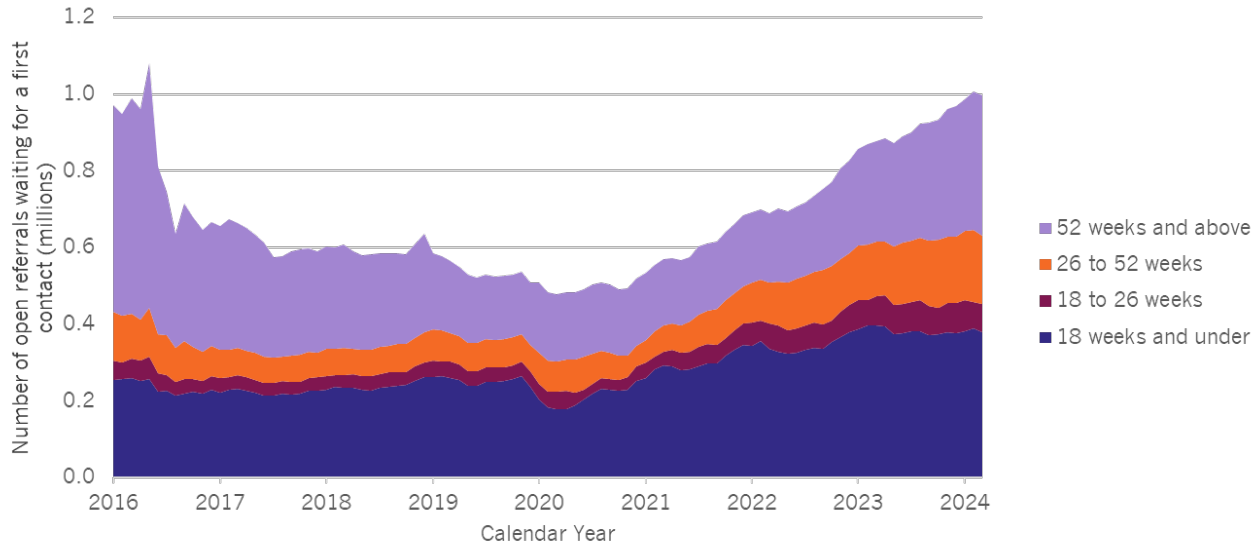
22. There is huge potential for a step change in the clinical role of pharmacists within the NHS. Expanded community pharmacy services are likely to include greater treatment of common conditions and supporting active management of hypertension. But there is a very real risk that on current trajectory, community pharmacy will face similar access problems to general practice, with too few resources in the places where it is needed most.

Access to mental health services

23. The need for mental health services has been growing rapidly. In 2016, around 2.6 million people were in contact with mental health services; by 2024, this had increased to 3.6 million people[61].

24. By April 2024, around 1 million people were waiting for mental health services[62]. Long waits have become normalised: there were 345,000[63] referrals where people are waiting more than a year for first contact with mental health services— a figure higher than the entire population of Leicester[64].

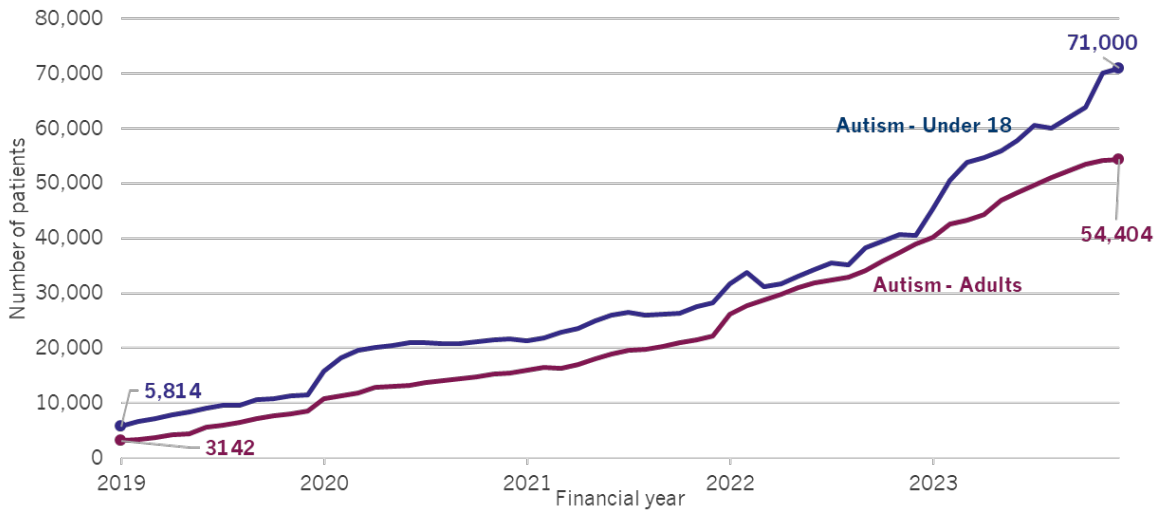
Figure II.6.5: Number of Open Referrals for people of all ages at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact



25. Some 343,000 referrals for children and young people under the age of 18 are waiting for mental health services, including around 109,000 referrals waiting for more than a year[65] (equivalent to the population of Maidstone[66]). For any person, a year wait is far too long. But for young people who are going through profound life changes, this is particularly concerning.

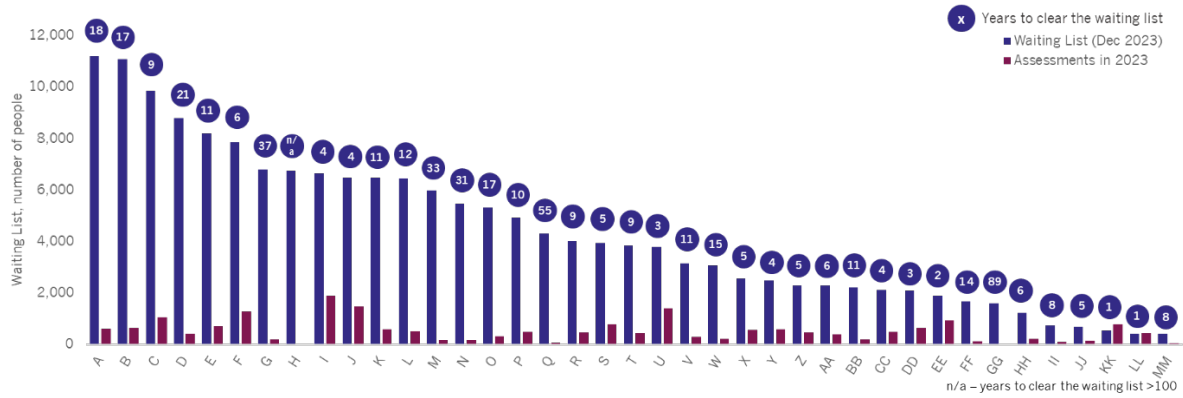
26. Demand for assessments for ADHD and Autism have grown exponentially in recent years. Since 2019, the number of children waiting at least 13 weeks for an assessment for Autism has increased at a rate of 65 per cent a year, while for adults the increase has been 77 per cent a year[67]. Activity has risen too, with services now seeing 33,000 people a month[68]. But as of March 2024, there were still more than 70,000 children and young people under 18 and more than 50,000 adults waiting at least 13 weeks for an assessment for Autism[69].

Figure II.6.12: Number of patients with a referral for suspected autism, open for at least 13 weeks, who were still waiting for a first contact, April 2019 to March 2024



27. The growth in demand for ADHD assessments has been so significant that it risks completely overwhelming the available resource. As the chart below sets out, there is a huge mismatch between demand for assessment and their availability. The result is that, at current rates, it would take an average of 8 years to clear the backlog in adult ADHD assessments – and for many trusts, at current rates, the backlog would not be cleared for decades.

Figure II.6.10: Implied clearance time for adult ADHD assessments based on activity and wait list size (based on 44 providers, in England, Wales and Scotland)



28. There is no consensus around what explains the dramatic increase in demand for assessment for ADHD and autism. Some believe that it is the conversion of unmet need into demand for assessment as stigma has reduced and awareness has increased. Others argue that is the result of self-diagnosis induced by misleading

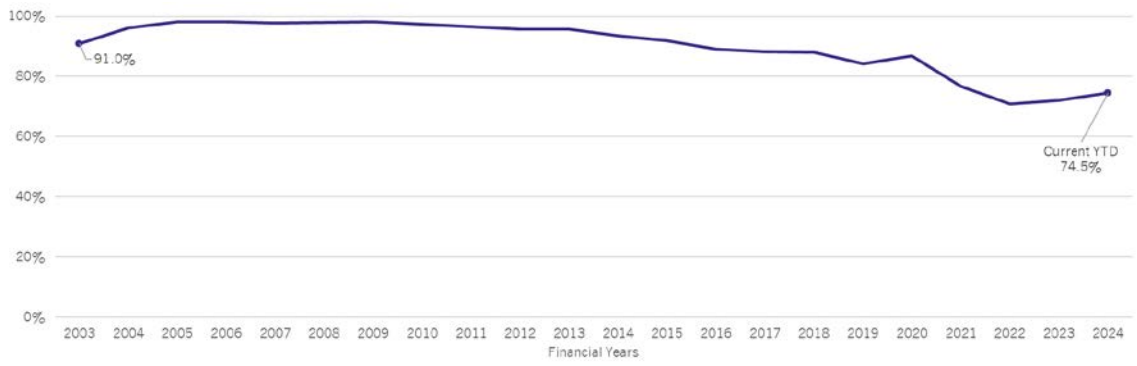
discussion on social media. No matter the cause, it is clear that with services overwhelmed, many people who need help will be missing out. NHS England's taskforce on ADHD[70] will have important recommendations to make.

Access to acute hospital services

Waiting times for A&E departments

29. In 2022, for the first time since the start of the century, more of the public were unhappy with how A&E departments are run than were satisfied. In 2023, nearly 40 per cent of people were dissatisfied, with just over 30 per cent satisfied[71]. This is not surprising. As the chart below shows, in 2011, 96.6 per cent of people attending A&E were seen within four hours; by 2024 that figure had dropped to just 74.5 per cent[72]. Between 2011 and 2023, the number of people attending A&E increased by 22.5 per cent to some 26.3 million[73].

Figure II.8.6: Percentage of attendances admitted, transferred or discharged within 4 hours of arrival at A&E



30. The poor state of the headline figures can obscure some of the important nuances that sit beneath. The average waiting time for infants has increased by around 60 per cent over the last 15 years. But it is particularly concerning that nearly 250,000 infants (aged 0-2) were left waiting for more than four hours and more than 100,000 infants waited more than six hours in 2023-24[74]. There is a similar picture for children aged three to 17, with almost 500,000 waiting more than four hours and 225,000 waiting for more than six hours in A&E[75].

31. Older people have endured particularly long waits. The average waits for people over the age of 65 have nearly doubled over the past 15 years from just over three hours to nearly seven[76]. But some have had particularly appalling experiences: at

the 95th percentile, people have been waiting for more than 24 hours in A&E[77]. Analysis from the Royal College of Emergency Medicine (RCEM), submitted to the Investigation, found that in December 2023, almost a third of people over 80 waited for 12 hours or more. The RCEM also found that people who were over the age of 90 were five times more likely to wait 12 hours or more than people aged 18 to 29[78].

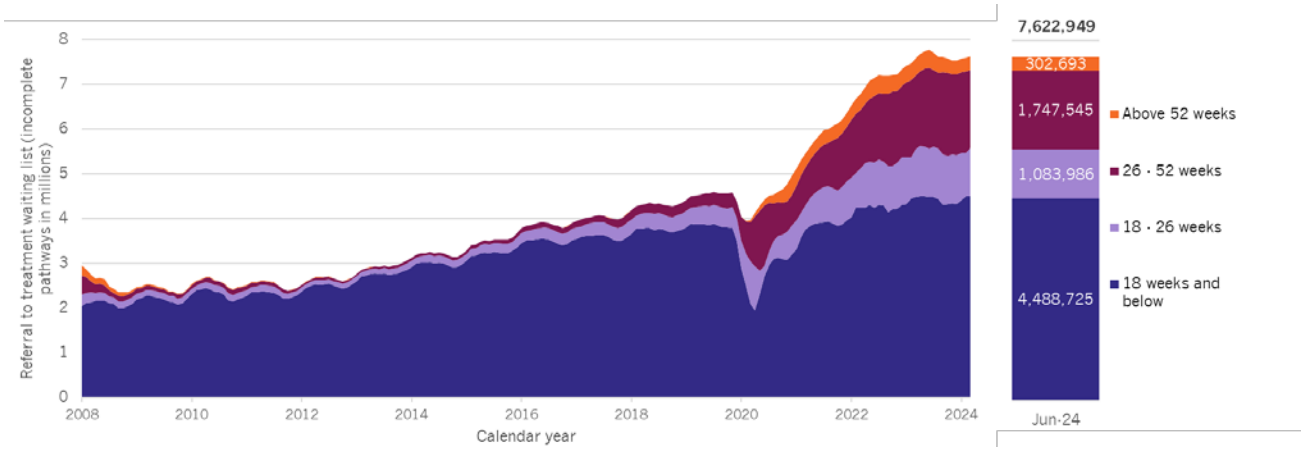
32. There has been a similar experience for people coming to A&E in a mental health crisis. People with a mental health flag tend to experience wait times that are approximately 25 per cent longer than those without[79]. For the 95th percentile, these waits have been getting worse and worse since the pandemic, such that in May 2024, waits were nearly 30 hours[80] and one patient with complex mental health needs spent more than 18 days in an A&E department in August 2024. In 2023-24, more than 80,000 people with mental health crises waited more than 12 hours and more than 26,000 waited for more than 24 hours in A&E departments[81]. Analysis from the RCEM showed that patients in 2022 with a primary diagnosis of mental illness were twice as likely to wait for 12 hours or more than the rest of the population[82]. Bright, busy and noisy A&E departments are completely inappropriate places for someone in mental distress.

Waiting times for consultant-led treatment of non-urgent conditions

33. In March 2010, the NHS Constitution, published in 2009 following the recommendation of *High Quality Care for All*, was amended with a new right for patients to start consultant-led treatment for non-urgent conditions within a maximum of 18 weeks from referral by their GP. In that month, just over 2.4 million people were waiting for NHS treatment. This included 2.21 million people waiting for treatment within 18 weeks; 200,000 waiting between 18 weeks and a year; and 20,000 waiting for more than a year[83]. In 2012, it became a statutory requirement that at least 92 per cent of patients should have a referral-to-treatment time of less than 18 weeks.

34. As we can see in the chart overleaf, in June 2024, the total waiting list stood at 7.6 million people. More than 300,000 people had waited for over a year, and some 1.75 million people had waited for between 6 and 12 months[84]. More than 10,000 people are still waiting longer than 18 months (although this has fallen sharply from its peak of 123,000 people waiting that long in September 2021)[85]. By far the largest group waiting were working age adults – some 4.2 million people[86]. As we will explore in the next chapter, the Covid-19 pandemic saw the most rapid rise in waiting lists. But in February 2020, waiting list already stood at some 4.6 million people, over 2 million more than 10 years earlier[87].

Figure II.8.15: Referral to treatment waiting list over time by weeks waiting



* * *

35. In almost all NHS services, performance on access to care has declined. Long waits have become normalised across the NHS and public satisfaction has declined as a result. Turning the situation around will take time, but it cannot come soon enough. Too many people are waiting too long for the care that they need.

3

Quality of Care in the NHS

1. In my 2008 report, *High Quality Care for All*, I made the case that raising the quality of care should be the organising principle of the NHS. In this chapter, we examine how the NHS is performing in terms of the quality of care that it provides. It is structured around the main pathways, examining the quality of care from the start of life to its end. We then explore three key areas that cause the most avoidable deaths: cancer, cardiovascular conditions, and suicide. We conclude by looking at complaints and clinical negligence – what happens when things go wrong.

Maternity and newborn

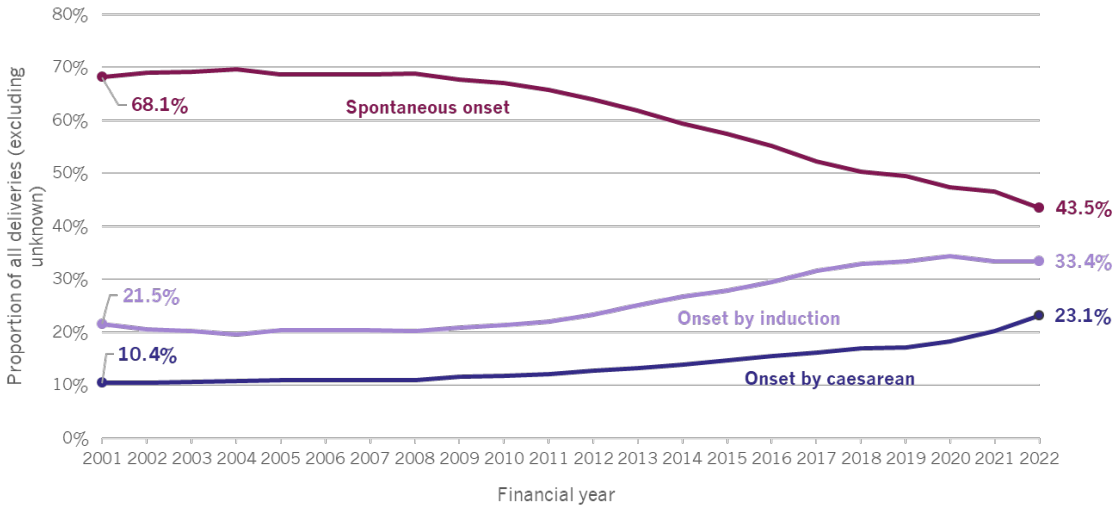
2. There have been positive developments in reductions of stillbirths and a small decrease in neonatal mortality and serious brain injuries. Yet maternal deaths have increased since the pandemic[88], including when adjusted for the direct impact of Covid-19. Most worrying are the huge inequalities that exist in maternity care. For instance, black women are almost three times as likely as white women to die in childbirth. And neonatal mortality of the most deprived quintile is more than double that of the least deprived[89].

3. The lack of progress in some areas occurs at a time when we have had a succession of scandals and subsequent inquiries into maternal care, such as in East Kent, Shrewsbury and Morecambe Bay. A recurring theme is that the recommendations of previous reviews have not been universally adopted.

4. Complexity continues to steadily rise as the age that women become pregnant increases and more expectant mothers have other conditions such as obesity[90] or diabetes[91], whose prevalence is increasing in the population (and also increases with age). This is also reflected in trends in the onset of labour. As the chart below shows, fewer than half of women now go into labour spontaneously, compared to around 70 per cent in the early 2000s[92]. Births by caesarean section are now much

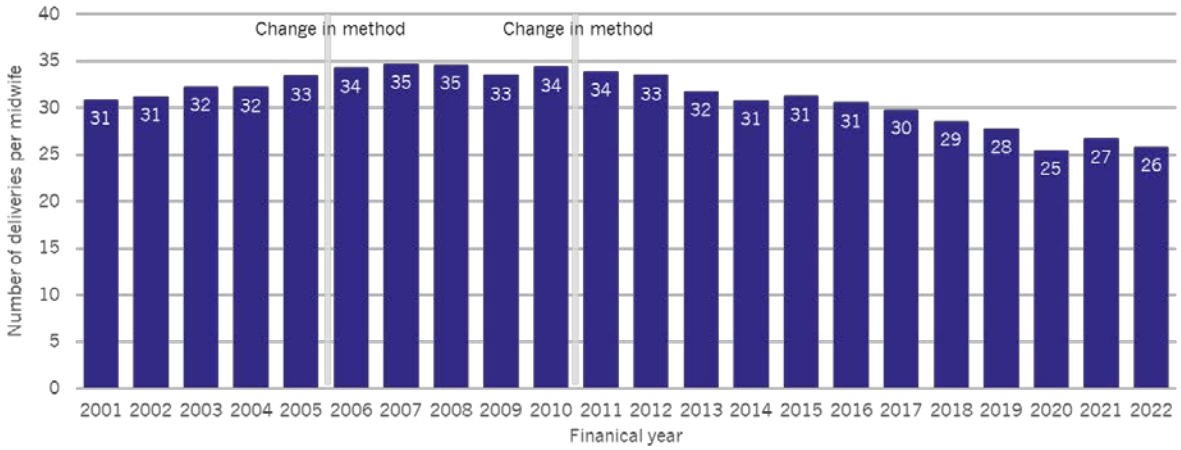
more common, having risen at annual rate of 4.6 per cent since 2005 while inductions have risen at an annual rate of 2.9 per cent over the same period[93].

Figure III.2.1: Rates of onset of labour by induction, spontaneous and caesarean section as a percentage of all deliveries of known onset method



5. While complexity has increased, it has occurred at a time when births have been falling and the number of midwives has risen. The overall result is that the number of deliveries per midwife each year has fallen from a peak of 34.7 in 2007 to 25.8 in 2022, as the chart below shows[94]. This was a notably better ratio than France (31.3 births per midwife in 2021), Germany (31.8 births per midwife in 2021) and Spain (34.3 births per midwife in 2021) and similar to Italy (23.7 births per midwife in 2021)[95].

Figure III.2.10: Deliveries per midwife



6. High rates of sickness absence – equivalent to one working month (22 days) per midwife per year across the NHS as a whole – are likely having an impact[96]. But even

when this is considered, capacity alone does not appear to be the constraint on improvement. This suggests that a deeper conversation needs to be had on skills, staffing mix, clinical models, leadership and culture in maternity services.

7. The Investigation received an important submission from Dr Bill Kirkup, former Associate Chief Medical Officer for England, who most recently led the review into the quality of care at East Kent. Dr Kirkup describes the issues that are supported by published evidence:
    a. Pressure and stress are at high levels which contributes to poor morale. This leads to burnout, absenteeism, high turnover, and the loss of trained staff. This dynamic impairs patient safety.
    b. Training in silos impairs teamwork which compromises patient safety. This is partly a result of divergent curricula for different staff groups that damage attitudes and a lack of focus on learning the skills for teamwork.
    c. Unstable working patterns and the lack of rest space impair teamworking and morale. Having dedicated space and refreshments benefits staff and improves patient safety.
    d. Leadership is crucial particularly Clinical Directors, but the Clinical Director role is poorly developed, supported and managed.
    e. Capacity for compassion is variable, sensitive to environment and pressure, but can be systematically improved.
    f. Transgressive behaviour is more common than admitted, which is very difficult to deal with, and damaging to morale and patient safety.
    g. Response to safety incidents is dominated by personal reactions; fear of blame by colleagues and others is a significant disincentive to investigation and learning; a culture of openness is essential to patient safety, but often lacking.

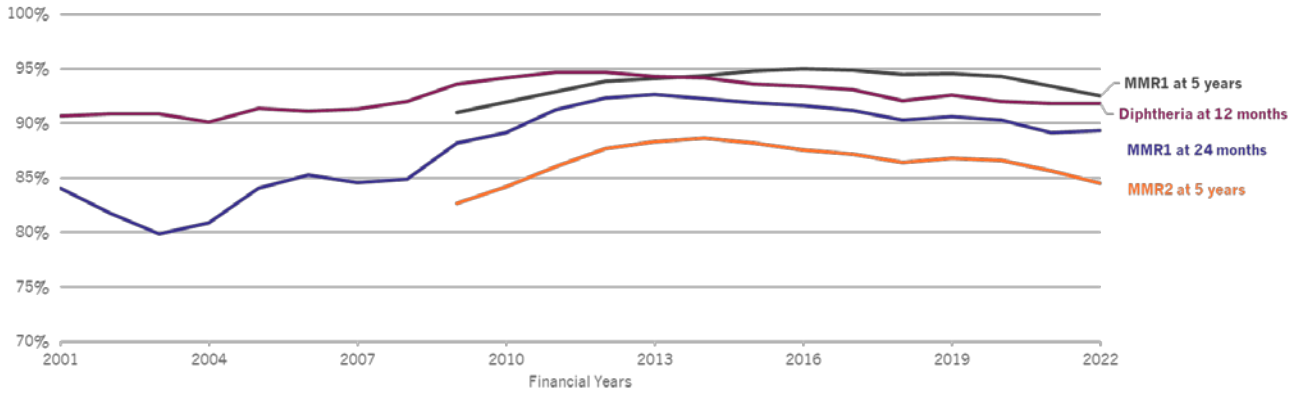
8. Today, too many women, babies and families are being let down. None of the issues described by Dr Kirkup are insurmountable. Each can be solved with sufficient time, attention and focus. The first step is to acknowledge that the problems are complex and that the data suggests that adding more staff will not by itself address them.

Children and Young People

9. Children and young people are 24 per cent of the population and account for 11 per cent of NHS expenditure. Their mental and physical health appears to have been deteriorating in recent years. Since 2019/20, for example, there has been an 82 per cent increase in hospital admissions for eating disorders[97]. Between 2001 and 2018, there was a 250 per cent increase in the prevalence of life-limiting and life-threatening conditions in children and young people[98]. This may reflect an increase in survival in this population as well as an increase in recording of diagnoses. Such children are increasingly likely to have lengthy hospital stays, as the Children's Hospital Alliance (CHA) highlighted in their submission to the investigation. Similarly, the Royal College of Paediatrics and Child Health pointed out that the number of children with eight or more chronic conditions nearly doubled from 7.6 per cent in 2012-13 to 14.0 per cent in 2018-19 and the number of children receiving long-term ventilation more than doubled between 2013 and 2020[99].

10. There are multiple challenges in delivering high-quality care for children and young people. Vaccinations are one of the safest and most cost-effective health interventions. Yet in England, childhood vaccination rates have been declining since 2013-14[100]. This needs to be addressed.

Figure III.3.7A: Vaccine coverage of children aged 24 months with the MMR vaccine (dose 1) and aged 5 years with the MMR (dose 1 and dose 2) and diphtheria vaccines, in England

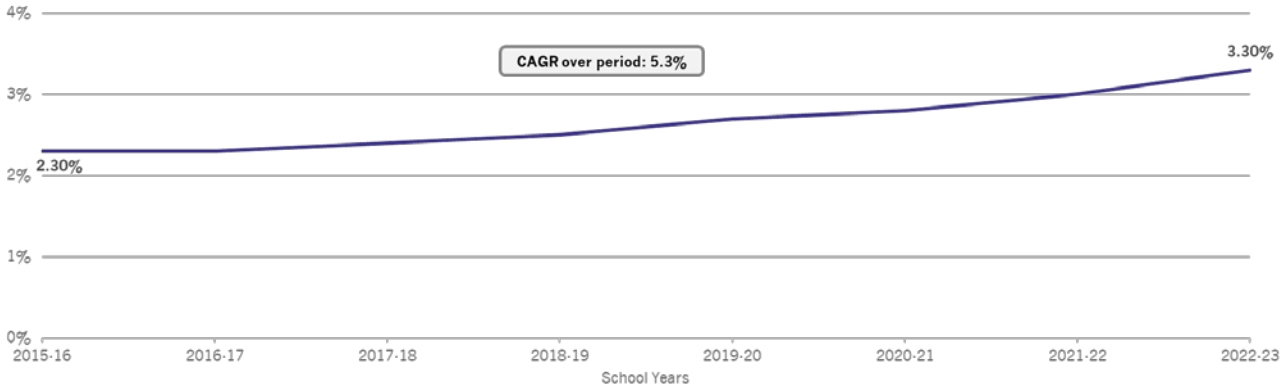


11. It is also clear that health inequalities begin at a very young age. Children from the most deprived decile are 2.1 times as likely to be obese in Reception than children from the least deprived decile, and this extends to 2.3 times by Year 6[101]. It is utterly shocking that in the poorest communities, nearly one-in-three children are obese by year 6[102]. Moreover, according to a submission from the Royal College of Paediatrics and Child Health (RCPCH), 2.5 million children and young people in England are affected by excess weight or obesity, with 1.2 million living with obesity-related complications[103].

12. Under-18 smoking rates continue to fall, and it is unequivocally good news that the government intends to proceed with legislation to create a smoke free generation. But there has been a worrying rise in vaping by children[104]. While vaping is substantially less harmful than smoking, it is not risk free. Given that the long-term health implications are not known, this is a cause for concern.

13. There is a significant rise in mental health needs amongst children, as analysis from the charity Young Minds shows. The percentage of school pupils with social, emotional and mental health needs increased from 2.3 per cent in 2015-16 to 3.3 per cent in 2022/23[105]. Between 2004 and 2023 the number of patients on ADHD medication has been increasing by just over 10 per cent each year[106]. And as we have seen, access to mental health services is a huge problem for children and young people.

Figure III.3.6: Percentage of school pupils who have educational support for social, emotional and mental health needs (school age)



14. Paediatric services for physical health are under pressure, too. As we have seen, waiting list size and duration of waits have grown more rapidly for children than for adults. And according to the RCPCH, children are 13 times more likely than adults to wait over a year for access to community services[107].

15. As the Children's Hospital Alliance (CHA) points out, paediatric intensive care unit (PICU) beds are regularly over 90 per cent occupancy with some units at 100 per cent. Length of stay is also increasing (notably, with more 100+ day patients), leading to cancellations of cardiac and cancer elective operations[108]. More children are attending A&E, but the emergency admission rate has not increased, suggesting that they could be cared for elsewhere.

16. There are real concerns about the NHS' capacity and capability to deliver high-quality care for children. Only 25 per cent of GPs now receive paediatric training[109]. The centralisation of paediatric surgery to specialist centres during the pandemic means some surgeons and anaesthetists in non-specialist acute hospitals are more reluctant to operate on children[110]. Paediatrics is not a requirement of doctors' training at foundation level, and for many specialties only happens after full adult training (such as for pathology and radiology)[111].

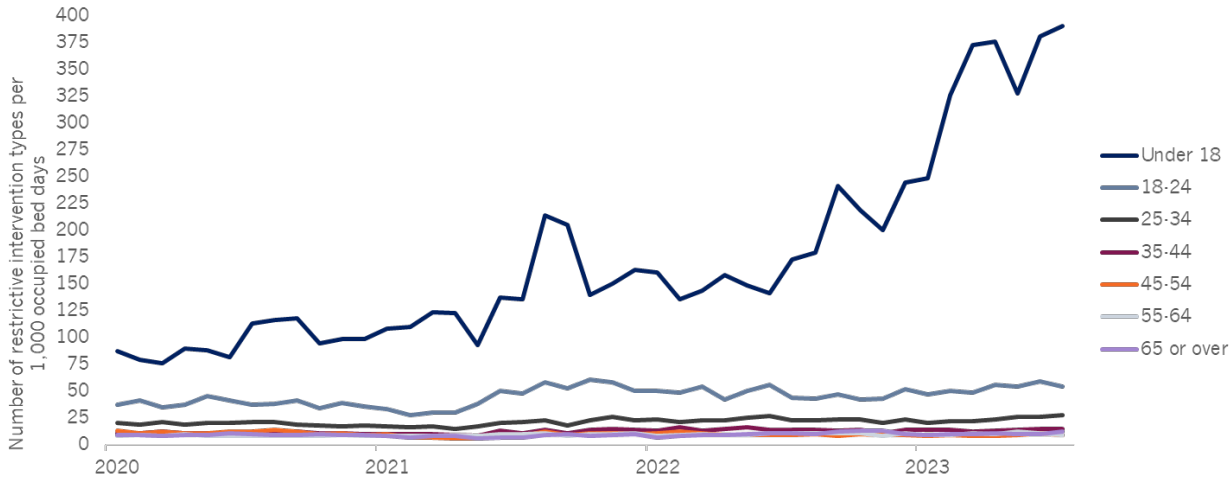
17. The problems faced by all NHS patients are similarly encountered by children and young people. At the moment, too many are being let down. Childhood is precious because it is brief; too many children are spending too much of it waiting for care. It is apparent that the NHS must do better and that national policymaking on care for children and young people needs to be more joined up.

Mental health

18. There has been a notable success in the Improving Access to Psychological Therapies programme. The proportion of people with anxiety or depression who have been able to access Talking Therapies has increased from 6.1 per cent in 2013/14 to 15.9 per cent in 2022/23[112]. The recovery rate for those who complete a course of talking therapies has remained steady at approximately 50 per cent[113].

19. For those receiving inpatient mental health care there has been an increase in restrictive interventions, such as physically restraining patients to administer medication or gastro-nasal feeding, over the last four years. As this chart shows, that increase is being driven by a dramatic and concerning surge in restrictive interventions for children under 18[114]. This goes alongside a dramatic rise in admissions, which have increased by 82 per cent since 2019, according to analysis done using NHS data, though changes in reporting practices as well as an increase in the number of organisations reporting may account for some of this increase[115].

Figure III.5.4: Number of restrictive intervention types per 1,000 occupied bed days (Sep 2020 - Mar 2024)



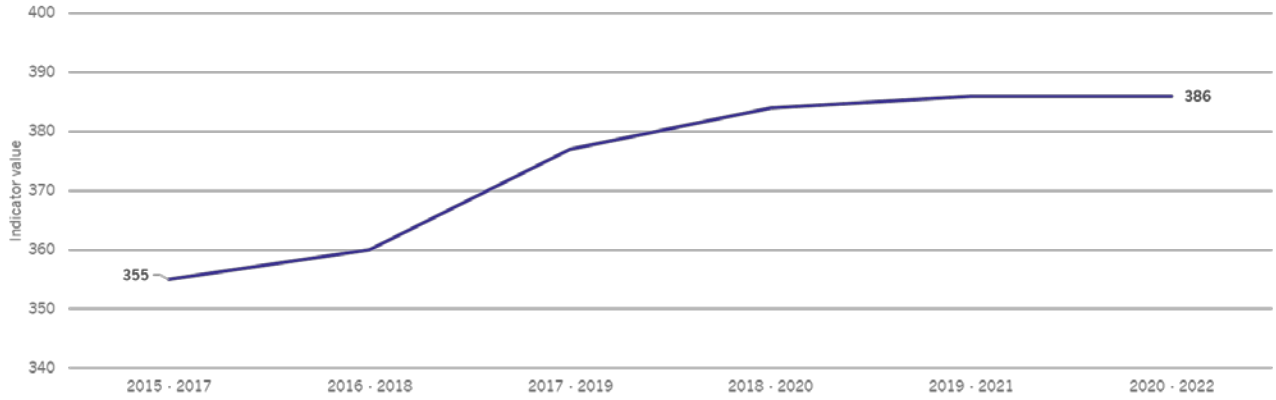
20. There has been a significant expansion in access to perinatal mental health services. Despite the significant impact of the pandemic, between 2019-20 and 2023-24, the numbers of women accessing care grew by two thirds[116]. The aim is to expand it further so that 66,000 mothers are helped this year.

21. People living with serious mental illnesses have significantly lower life expectancy than the rest of the population, typically dying 15 to 20 years earlier[117]. This problem is well-documented. Yet while psychiatric liaison exists in acute physical hospitals, there is no physical health liaison in mental health wards.

22. There have been positive developments with more mental health patients receiving physical health checks. In their submission to the Investigation, the Royal College of Psychiatrists pointed out that there had been an annual increase in physical health checks of 127 per cent, rising from nearly 160,000 to more than 360,000[118]. This is close to, but still below, the ambition set in the 2019 NHS Long Term Plan.

23. Yet excess mortality for those with serious mental illnesses has been going in the wrong direction, as the chart below shows. According to the RCPsych, there were an estimated 130,400 premature deaths among adults with severe mental illness during 2020-2022, compared to an estimated 100,476 in 2015-2017.

Figure III.5.7: Excess Under 75 mortality rates in adults with serious mental illness, 2015-17 to 2020-22, England



24. The NHS has a special responsibility to those that it treats while they are detained under the Mental Health Act. During visits as part of this investigation I saw some high-quality, modern facilities that are world-leading. But I was appalled to uncover that mental health patients continue to be accommodated in rooms that were constructed for a Victorian asylum. In one ward that I visited, patients' rooms were 7' x 8'6" with a fixed bunk that measured 6'6" by 3', occupying more than a third of the room.

> "We shouldn't be living like this. We're human beings at the end of the day. How are we supposed to recover from our mental illness when we have to live like this? We shouldn't be living with leaks and floods and cockroaches and mice. We have two showers for 17 men. It's totally wrong."
> *A patient speaking to Lord Darzi during a service visit*

25. Patients told me how nearly 20 men were expected to share just two showers, how the laundry facilities often broke down, and how they struggled to maintain their personal hygiene and dignity. They spoke of infestations of mice and cockroaches

which no amount of pest control had managed to eradicate from the decrepit estate. Under the current capital rules, even if the Trust concerned raised the capital from disposals of other assets, they would not have the discretion to spend it on replacing or rebuilding the unit.

26. According to a submission from the Royal College of Psychiatrists, more than a third of single rooms across mental health and learning disability sites in 2022-23 lacked ensuite facilities, amounting to more than 6,600 patient rooms. Many patients stay in these facilities for months at a time, and some for many years. If the measure of a society's humanity is how it treats its most vulnerable, then we are falling far short.

27. I was therefore particularly concerned to discover that a decision was taken to remove three out of five of the mental health schemes in the new hospitals programme, as part of the review of the programme by HM Treasury. NHS England's prioritisation, based on objective assessment of the merits of the schemes, was overruled.

28. The lack of sufficient good quality facilities contributes to mental health inpatients being accommodated far from their family, friends and loved ones. Inappropriate out-of-area placements of mental health service users have decreased at a rate of 8 per cent a year since 2018 but while they fell from their 2019 peak through to 2022, they began to rise again in 2023 and stood at nearly 6,000 in that year[119]. Being far from a support network hinders recovery and makes it harder for people to get back to daily life. And as we have seen, bed capacity and management problems mean that all-too-often patients are waiting for excessively long times in hospital accident and emergency departments as no mental health beds can be found[120].

29. There has been a steady decline in suicides completed by people with diagnosed mental illnesses, both those who are living in the community and those who are inpatients. The numbers of mental health inpatients that have completed suicide have reduced from 100 in 2009 to fewer than 60 in each year since 2017[121]. This reflects sustained efforts to reduce ligature risk and to improve observations. But

there is still further to go to ensure inpatient wards are as safe as possible for people in mental distress.

30. At the same time, there are also concerns about the rigor with which patients who have serious mental illnesses are followed up in the community and how effectively risk is managed. There are a number of cases, high profile and not, where people with serious mental illness have not had appropriate risk assessments or sufficiently assertive follow up[122]. There is significant scope for improvement in the quality, safety and consistency of care.

Long-term conditions

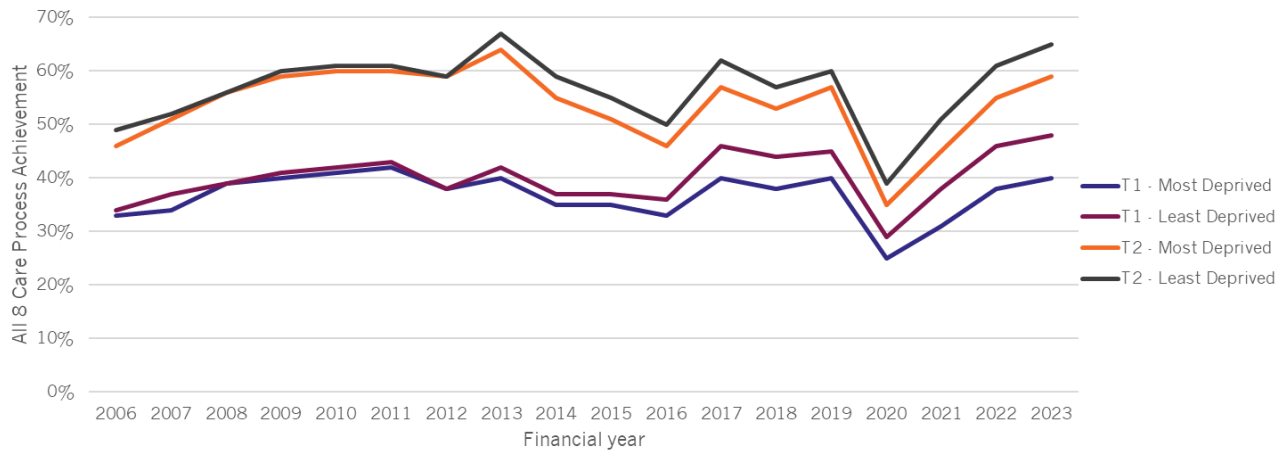
31. As we saw in chapter 1, there has been a substantial rise in the prevalence of some long-term conditions. Perhaps more significantly, more people now have multiple long-term conditions: between 2017 and 2022, the number of people with two or more long-term conditions increased at an annual rate of 6.1 per cent[123]. This matters because multiple conditions can interact with each other, which increases complexity and makes their management more challenging. Many long-term conditions are caused or exacerbated by lifestyle factors, such as tobacco or alcohol consumption, and obesity.

32. As the disease burden has shifted towards long-term conditions, multidisciplinary team working has become more important. Yet NHS structures have not kept pace. GPs are expected to manage and coordinate increasingly complex care, but do not have the resources, infrastructure and authority that this requires.

33. As we saw in chapter 1, the probability of having one or more long-term conditions rises substantial with age. In their submission to the Investigation, Age UK analysis of the GP patient survey found significant declines in the proportion of older people who feel supported to manage their long-term conditions in the community. Rates fell by around 10 per cent across all older adult age cohorts between 2018 and 2023.

34. For many long-term conditions, there is a strong evidence base about what interventions are required. People with diabetes, for example, should have eight care processes that are well-defined and evidence-based. Yet while there has been some progress, there are wide disparities between the most and least deprived communities, with the least deprived 5 per cent more likely to receive all eight than the most deprived, as we can see in the chart below[124].

Figure III.7.3: Percentage of patients with all 8 Care Process achieved, by diabetes type and deprivation quintile (most and least deprived)

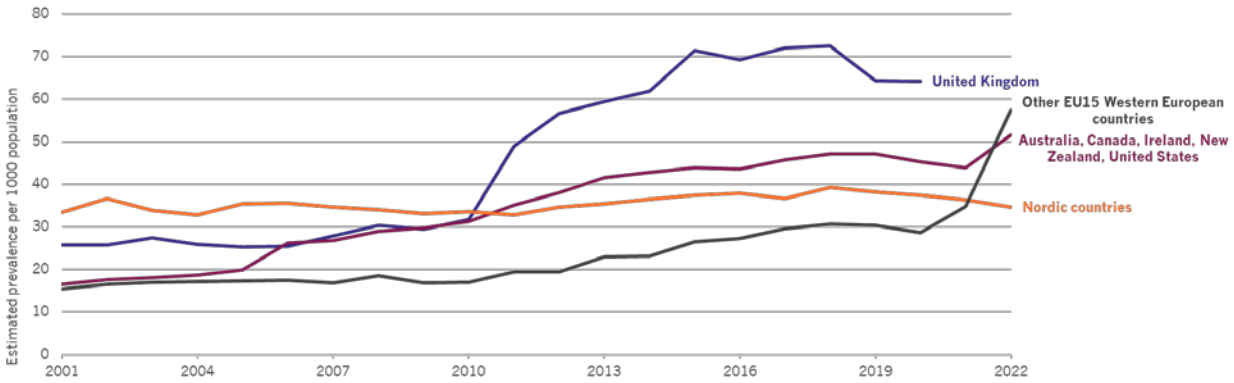


35. A similar picture is true for other long-term conditions, such as chronic breathing difficulties. Moreover, 35 per cent of patients with long-term conditions still do not have a care plan, which is one of the most important tools to coordinate and manage care[125].

Dementia

36. The number of people aged 65 years and over increased from 9.2 million in 2011 to over 11 million in 2021 and the proportion of people aged 65 years and over rose from 16.4 per cent to 18.6 per cent[126]. The Alzheimer's Society estimates that there are approximately 982,000 people living with dementia[127]. Analysis of OECD data finds that prevalence of dementia is 19 per cent below the OECD20 but that the UK has a substantially higher rate of dementia deaths, which have been above 60 per 100,000 patients since 2014 (though this may reflect difference in recording)[128].

Figure III.9.2: Dementia deaths per 100,000 patients (standardised rates)



37. In addition, dementia diagnosis rates have not improved in recent years. The dementia diagnosis rate for people aged 65 and over has only recovered to around 65 per cent compared to 68 per cent before the Covid-19 pandemic[129]. Concerningly, the proportion of patients with dementia receiving a care plan or care plan review in the preceding 12 months dropped to less than 40 per cent during the Covid-19 pandemic[130].

38. In their submission to the Investigation, the Alzheimer's Society argued that there are "high levels of unwarranted variation in access to diagnosis and treatment [and] insufficient adherence to clinical guidelines". As society continues to age, there is an important challenge to improve both the quality and quantity of care for people with dementia.

Planned care

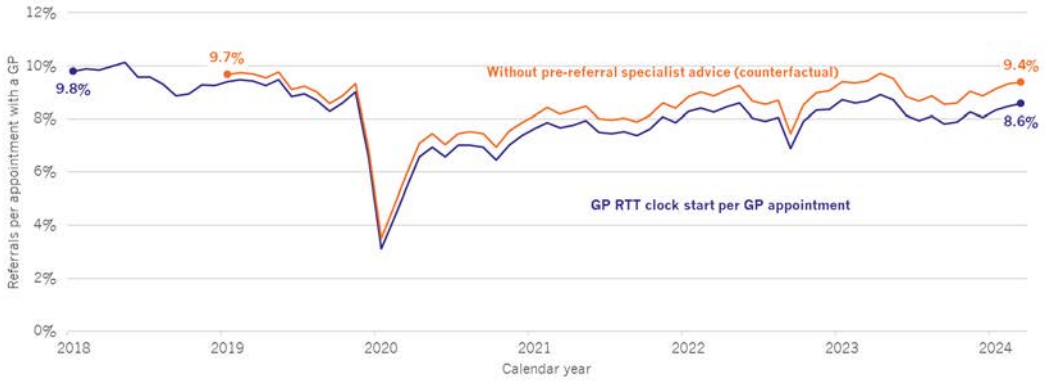
39. As we have seen above, there have been large increases in waiting times for planned procedures. Long waits for treatment have a significant impact on patients. For some, it means waiting for longer periods in discomfort or with limited mobility. For others it can limit their ability to work or to enjoy leisure time with family. From a clinical perspective, it can mean a worse prognosis, more complex interventions, more powerful medications, and longer recovery times.

40. There has been a significant increase of 2.3 per cent a year in outpatient referrals from 2008 to 2023[131]. Progress has been made in reducing the number of follow-ups to first outpatient appointments[132]. This has a quality and efficiency benefit: it

focuses on resolving issues the first time while also freeing up clinician time to see new cases.

41. There has also been important progress in expanding the role of specialist advice. As the chart below shows[133], this has helped to slow the rate of consultant-led treatment, as more patients can be managed by their GP, with appropriate specialist input.

Figure III.4.6: Estimated impact of pre-referral specialist advice on the GP referral rate for consultant-led treatment per appointment

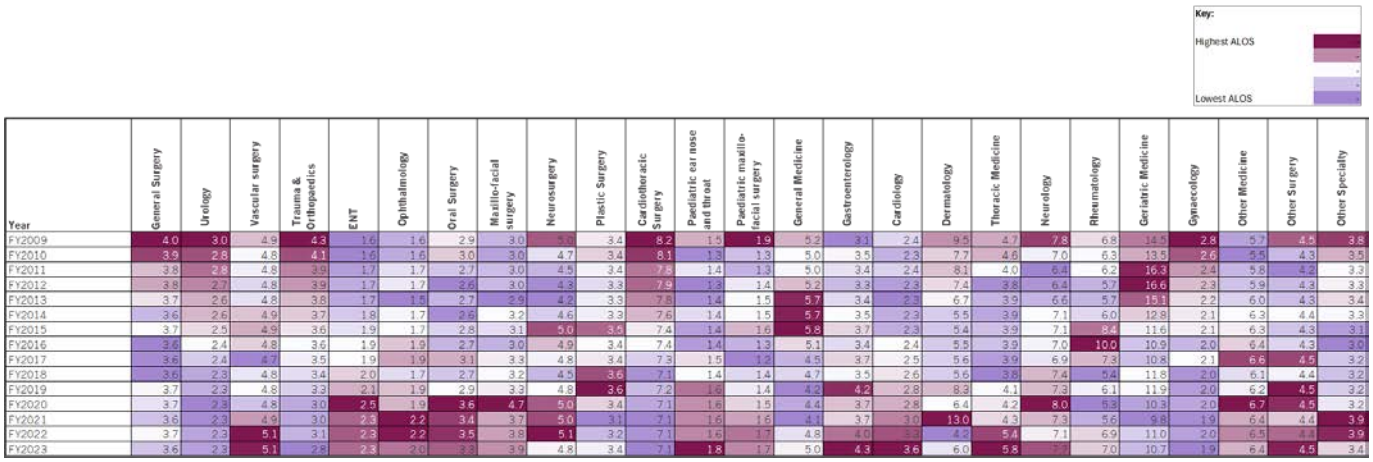


42. Other innovations include "virtual wards". A virtual ward (also known as hospital at home) is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. It is a substitute for acute inpatient hospital care. Since the national programme was launched in April 2022, virtual wards have been established in all integrated care systems in England with 12,365 'beds' in place in July 2024[134] and the ambition to be able to be able to admit 50,000 patients a month[135].

43. Where effective, virtual wards have the potential to support two key areas of system impact: reducing attendances and admissions to hospital for 'step up' virtual wards and secondly to support reductions in length of stay in hospital through 'step down' virtual wards where the acute episode of care is completed in the home setting.

44. Another measure of greater efficiency and quality is reducing length of stay for planned care. Here the overall progress in reducing length of stay masks significant variation by specialty, as the chart below shows. This may reflect a shift to day-cases, which means that only the most complex patients stay in hospital. The precise reasons why some specialities have reduced their length of stay, whilst others have increased, is worth closer examination.

Figure III.4.3: Variation in elective overnight average length of stay by treatment function



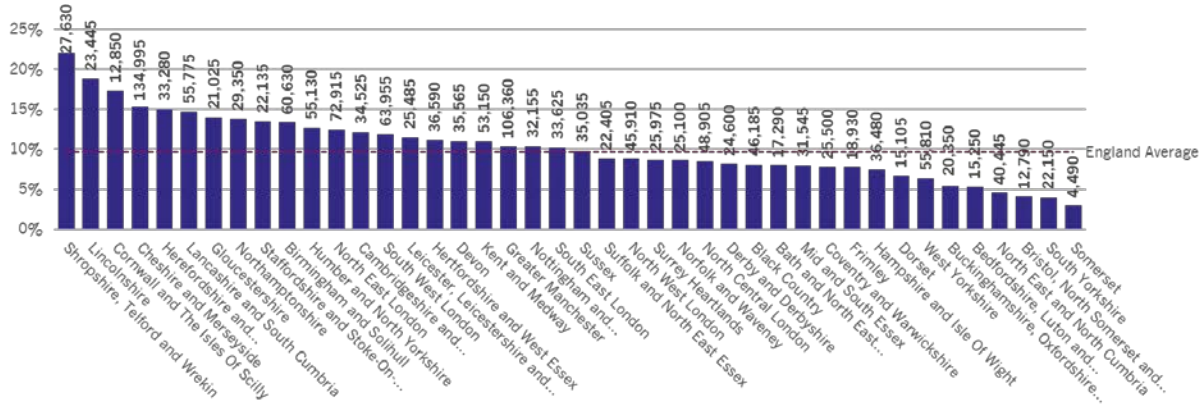
Year	General Surgery	Urology	Vascular surgery	Trauma & Orthopaedics	ENT	Ophthalmology	Oral Surgery	Maxillo-facial surgery	Neurosurgery	Plastic Surgery	Cardiothoracic Surgery	Paediatric ear nose and throat	Paediatric maxillo-facial surgery	General Medicine	Gastroenterology	Cardiology	Dermatology	Thoracic Medicine	Neurology	Rheumatology	Geriatric Medicine	Gynaecology	Other Medicine	Other Surgery	Other Specialty
FY2009	4.0	3.0	4.9	4.3	1.6	1.6	2.9	3.0	5.0	3.4	8.2	1.3	1.9	5.2	3.1	2.4	9.5	4.7	7.8	6.8	14.5	2.8	5.7	4.5	3.8
FY2010	3.9	2.8	4.8	4.1	1.6	1.6	3.0	3.0	4.7	3.4	8.1	1.3	1.3	5.0	3.5	2.3	7.7	4.6	7.0	6.3	13.5	2.6	5.5	4.3	3.5
FY2011	3.8	2.8	4.8	3.9	1.7	1.7	2.7	3.0	4.5	3.4	7.8	1.4	1.3	5.0	3.4	2.4	8.1	4.0	6.4	6.2	16.3	2.4	5.8	4.2	3.3
FY2012	3.8	2.7	4.8	3.9	1.7	1.7	2.6	3.0	4.3	3.3	7.9	1.3	1.4	5.2	3.3	2.3	7.4	3.8	6.4	5.7	16.6	2.3	5.9	4.3	3.3
FY2013	3.7	2.6	4.8	3.8	1.7	1.5	2.7	2.9	4.2	3.3	7.8	1.4	1.5	5.7	3.4	2.3	6.7	3.9	6.6	5.7	15.1	2.2	6.0	4.3	3.4
FY2014	3.6	2.6	4.9	3.7	1.8	1.7	2.6	3.2	4.6	3.3	7.6	1.4	1.5	5.7	3.5	2.3	5.5	3.9	7.1	6.0	12.8	2.1	6.3	4.4	3.3
FY2015	3.7	2.5	4.9	3.6	1.9	1.7	2.8	3.1	5.0	3.5	7.4	1.4	1.6	5.8	3.7	2.3	5.4	3.9	7.1	8.4	11.6	2.1	6.3	4.3	3.1
FY2016	3.6	2.4	4.8	3.6	1.9	1.9	2.7	3.0	4.9	3.4	7.4	1.4	1.3	5.1	3.4	2.4	5.5	3.9	7.0	10.0	10.9	2.0	6.4	4.3	3.0
FY2017	3.6	2.4	4.7	3.5	1.9	1.9	3.1	3.3	4.8	3.4	7.3	1.5	1.3	4.5	3.7	2.5	5.6	3.9	6.9	7.3	10.8	2.1	6.6	4.5	3.2
FY2018	3.6	2.3	4.8	3.4	2.0	1.7	2.7	3.2	4.5	3.6	7.1	1.4	1.4	4.7	3.5	2.6	5.6	3.8	7.4	5.4	11.8	2.0	6.1	4.4	3.2
FY2019	3.7	2.3	4.8	3.3	2.1	1.9	2.9	3.3	4.8	3.6	7.2	1.6	1.4	4.2	4.2	2.8	8.3	4.1	7.3	6.1	11.9	2.0	6.2	4.5	3.2
FY2020	3.7	2.3	4.8	3.0	2.5	1.9	3.6	4.7	5.0	3.4	7.1	1.6	1.5	4.4	3.7	2.8	6.4	4.2	8.0	8.3	10.3	2.0	6.7	4.5	3.2
FY2021	3.6	2.3	4.9	3.0	2.3	2.2	3.4	3.7	5.0	3.1	7.1	1.6	1.6	4.1	3.7	3.0	13.0	4.3	7.3	5.6	9.8	1.9	6.4	4.4	3.9
FY2022	3.7	2.3	5.1	3.1	2.3	2.2	3.5	3.8	5.1	3.2	7.1	1.5	1.7	4.8	4.0	3.3	4.3	5.4	7.1	6.9	11.0	2.0	6.5	4.4	3.9
FY2023	3.6	2.3	5.1	2.8	2.3	2.0	3.3	3.9	4.8	3.4	7.1	1.8	1.7	5.0	4.3	3.6	6.0	5.8	7.3	7.0	10.7	1.9	6.4	4.5	3.4

45. There has been good progress in improving patient safety, partly as a result of sustained focus and political attention, notably from the Rt Hon. Jeremy Hunt MP who was the longest serving health secretary and a passionate advocate for improvement. The proportion of care that is error-free has increased, while avoidable harms like pressure ulcers have fallen[136]. Good progress was made in reducing healthcare acquired infections from 2007-08 to 2011-12, though since then progress has plateaued[137]. Deaths from venous thromboembolism (blood clots in the veins, which can result from hospital stays) spiked during the Covid-19 pandemic and have not yet returned to pre-pandemic levels[138].

Urgent and emergency care

46. Very long waits in A&E have become all too common, and they are a quality of care issue as well as an access problem. While around 60 per cent are seen within four hours and 30 per cent within 12 hours, some 10 per cent of people are now waiting for 12 hours or more[139]. As the chart below shows[140], in some parts of the country, more than one-in-five people are now waiting for 12 hours or more.

Figure II.8.14: ICB A&E waiting times, 12+ hour waits from time of arrival



47. The Royal College of Emergency Medicine has highlighted that very long waits are associated with an increase in deaths. Their analysis shows that this may have resulted in as many as 268 additional death per week in 2023, or nearly 14,000 over the year as a whole[141]. The first priority in addressing issues in A&E should be to eliminate very long waits.

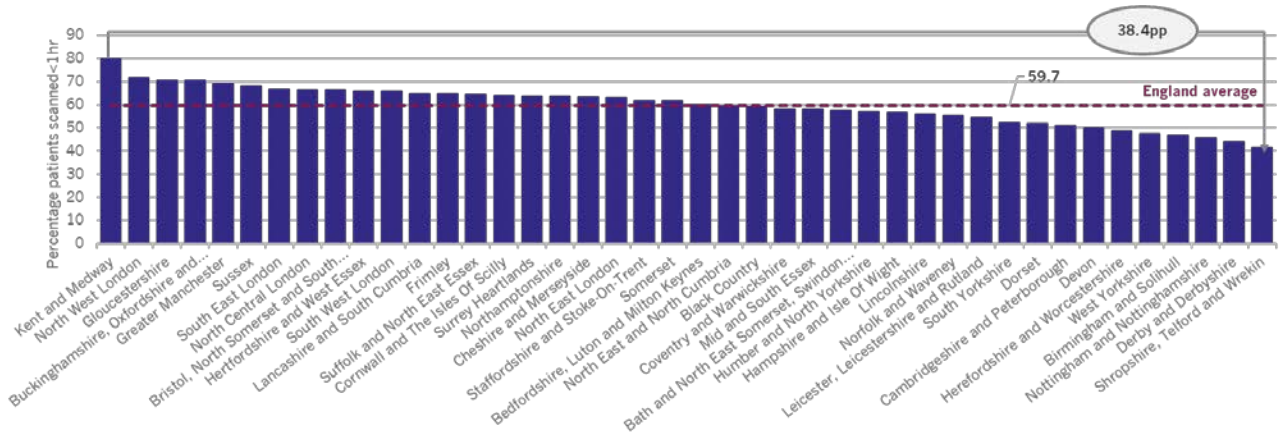
48. Unsurprisingly patient satisfaction has declined with longer waits. In 2010, 60 per cent of the public were very or quite satisfied with Accident and Emergency Services. This had declined to 54 per cent by 2019 and then fell sharply to just 30 per cent by 2022[142]. It remains at historically low levels.

49. Analysis by Age UK, submitted to the Investigation, found that there were more than a million admissions or readmissions to hospital per year from conditions that should not normally require hospital treatment. On any given day, over 2,000 people aged over 65 are admitted to hospital in an emergency for a condition that could have been treated earlier in the community or prevented altogether (such as a fall). Moreover, Age UK found that one-in-six emergency admissions of those aged over 75 were people that had been discharged from hospital within the previous 30 days.

50. Rapid access to treatment for cardiovascular conditions has deteriorated and varies dramatically across the country. For example, the 'call-to-balloon' time for higher risk STEMI heart attack patients in England, Wales and Northern Ireland has risen by 28 per cent from an average of 114 minutes in 2013-14 to 146 minutes in 2022-23[143]. The rise has the greatest impact on the 25 per cent of patients who are now waiting more than 130 minutes for this emergency procedure. Moreover, there is a more than two-fold difference between ICB areas: patients in Surrey are likely to receive the procedure in less than 90 minutes while those in Bedfordshire, Luton and Milton Keynes must wait around four hours[144].

51. There is a similar picture with stroke care. Rapid access to brain imaging is required when patients arrive in hospital to confirm stroke diagnosis and the right course of treatment. But the percentage of patients who receive the necessary brain scan within an hour of arrival at hospital is hugely variable. As the chart below shows, in Kent, 80 per cent of patients will receive that standard of care; while in Shropshire, only around 40 per cent will do so[145].

Figure III.8.6: Percentage of patients scanned within one hour of arrival, by ICB (England) / LHB (Wales) 2023/24

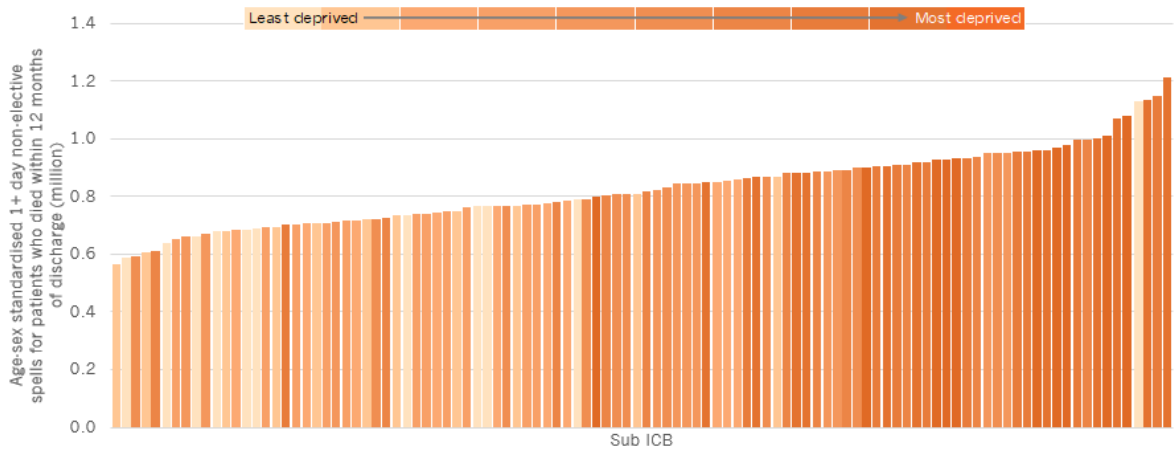


End of life care

52. Dignity, compassion and respect are important at the end of life. According to polling by YouGov commissioned by the charity Compassion in Dying and submitted to the investigation, 83 per cent of adults would prioritise quality of life over living longer in the last years of life[146]. As the Chief Medical Officer has said, better quality at the end of life may require "less medicine, not more"[147]. Yet as the Nuffield Trust has found, one in four people in the last year of life have three or more unplanned hospital admissions[148].

53. New analysis prepared for this report highlights some important disparities. People in the most deprived communities are far more likely to have multiple emergency admissions to hospital in the last year of their lives, as we can see in the chart below. There are likely to be complex reasons for this: people in poorer communities are more likely to die of treatable conditions; GP access is less good, so there are less likely to be end of life plans; and there may be cultural factors[149]. This should be examined more closely, especially in light of Compassion in Dying's findings that many bereaved people believe their loved ones had medical treatment they would not have wanted[150].

Figure III.10.3: Sub-ICB age-sex standardised rates of 1+ day non-elective spells in the last year of life, shaded by proportion of population living in more deprived areas



54. Many people express a preference to die at home. While there are major data limitations, analysis of those countries submitting data to the OECD found that the UK performs in the middle of the pack[151]. There may be lessons to be learned from the Netherlands' consistently low rates and from Ireland's steep reductions. Analysis of primary care data found that the proportion of people with a recorded preference increased substantially from just over 10 per cent in 2009 to nearly 50 per cent in 2019. Since then, it has plateaued[152]. Society needs to restart the conversation about how to die well: with dignity, compassion, and preferences respected.

Avoidable deaths

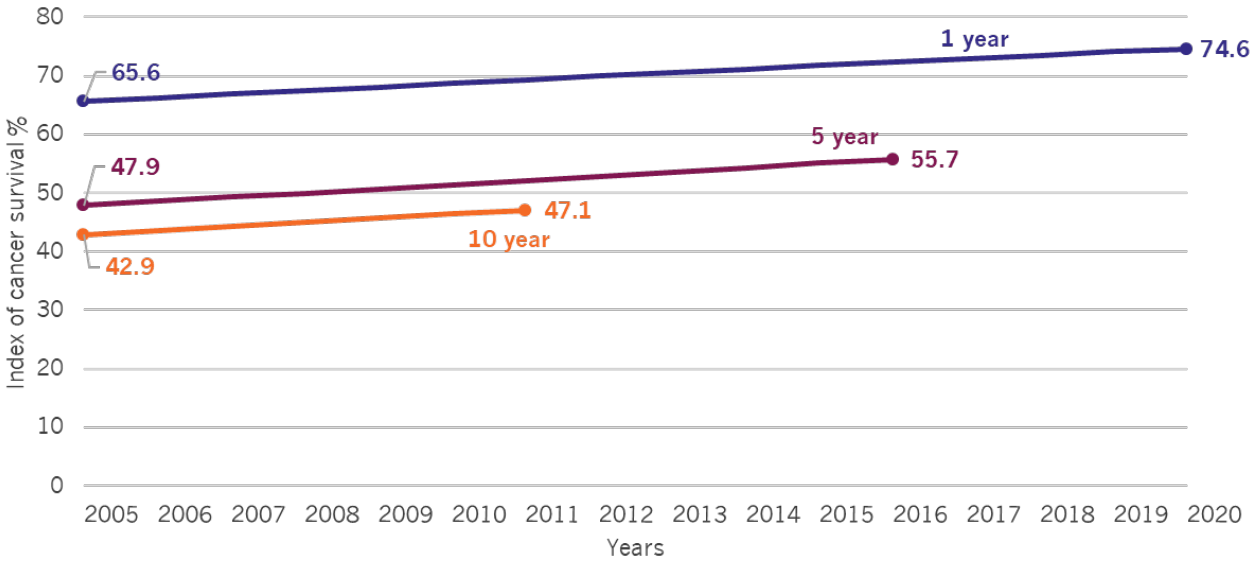
55. Far too many lives are lost to avoidable causes, meaning that they are either preventable or treatable. There is significant scope to improve the performance of the NHS and to save lives. Here, we examine three of the most significant areas: cancer, cardiovascular disease, and suicide.

Cancer

The number of cancer cases in England has risen at a rate of 1.7 per cent a year from 2001 to 2021. When standardised for age, it has still risen at 0.6 per cent annually[153]. The result is that there were around 96,000 more cases of cancer in 2019 than in 2001. While survival rates at 1-year, 5-year and 10-year have all

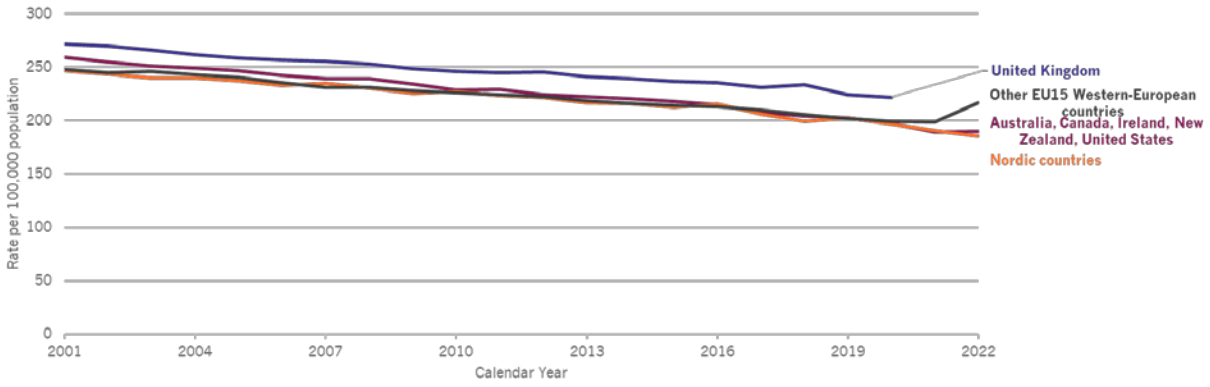
improved, the rate of improvement slowed substantially during the 2010s, as the chart below sets out[154]:

Figure III.12.2: Index of cancer survival by calendar year of diagnosis in England, Persons aged 15 to 99 years, diagnoses 2005 to 2020



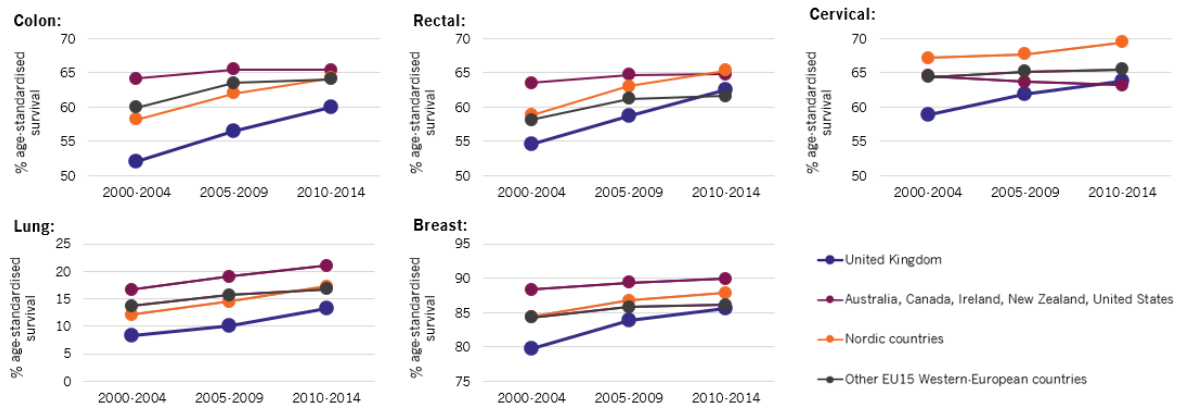
56. International comparisons of cancer mortality find that the UK has substantially higher rates than our European neighbours, Nordic countries, and countries that predominantly speak English (see chart below)[155].

Figure III.12.4: Standardised rate of malignant neoplasms deaths per 100,000 patients, 2001 to 2022 (or nearest year)



57. While cancer survival rates have improved more quickly than many peer countries, they have done so from a low base. This means that the UK is still behind the Nordic countries for all major cancers and behind other European countries and other predominantly English-speaking countries for three out of five cancer sites analysed, as the chart below shows[156]:

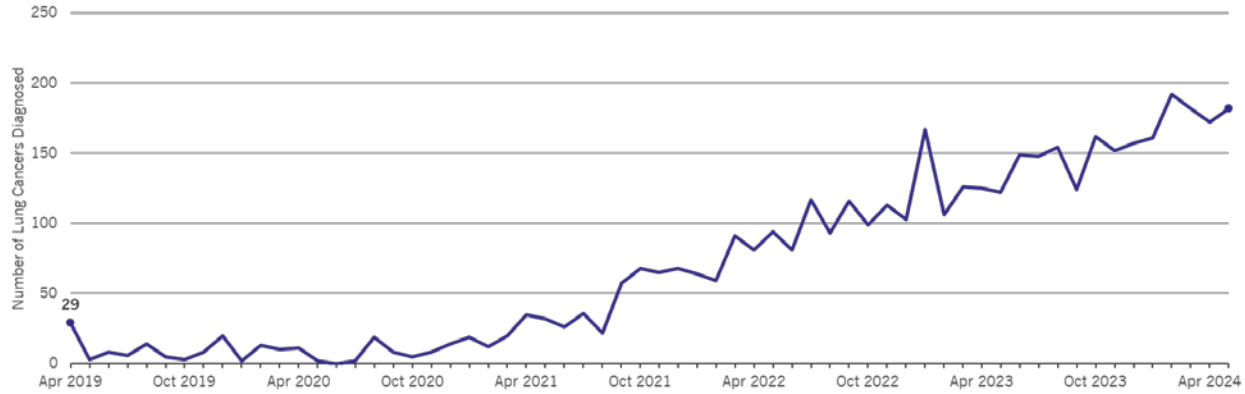
Figure III.12.5: % age-standardised five-year net cancer survival, 15 years and above, 2000 to 2014



58. The route to diagnosis has changed over time, in particular with the uptake of the urgent suspected cancer pathway. Important progress has been made in reducing the number of cancers diagnosed as result of an emergency presentation, with the proportion falling from nearly 25 per cent in 2006 to below 20 per cent in 2018 and 2019[157]. There are important inequalities, with the most deprived more likely to present as an emergency.

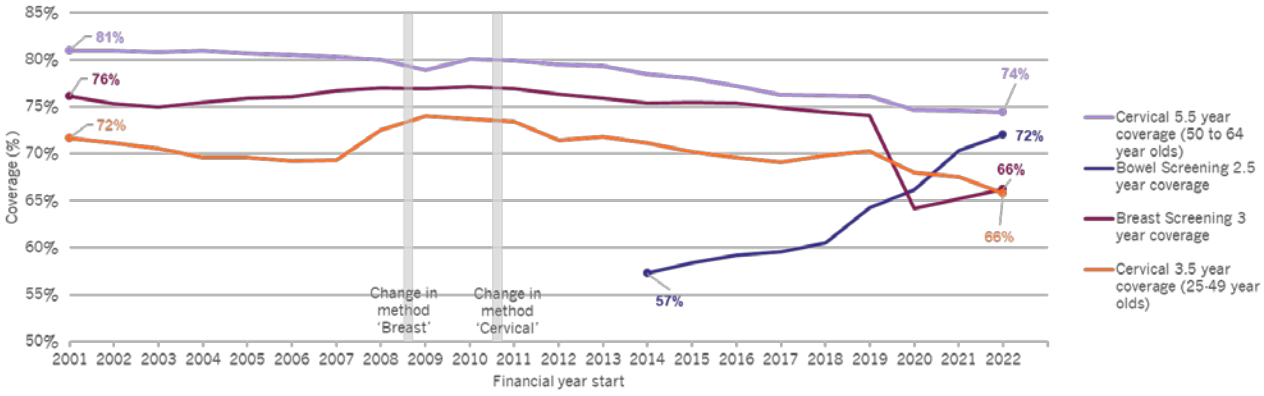
59. Early diagnosis is an important priority since it is associated with higher survival rates. Yet despite its importance, no progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, there have been some signs of hope as rates of early-stage diagnosis have improved from around 54 per cent to 58 per cent in 2023[158]. This is likely to be in significant measure due to the Targeted Lung Health Check programme which has identified more than 4,000 cases of lung cancer since 2019, with 76.7 per cent at stage I or II[159]. This important success should be celebrated and the transferable lessons applied to other areas.

Figure III.12.11: The number of Lung Cancers Diagnosed each month through the TLHC Programme April 2019 – May 2024 (TLHC Management Information Return)



60. One contributor to the early diagnosis challenge may be declining participation in screening programmes. Screening coverage rates for breast and cervical screening have both been going in the wrong direction since around 2010, as the chart below shows[160]. Rates of bowel screening have increased at an impressive rate since the programme was started but still have further to go.

Figure III.1.10: National Cancer Screening Programmes Coverage (%) 2002 - 2023

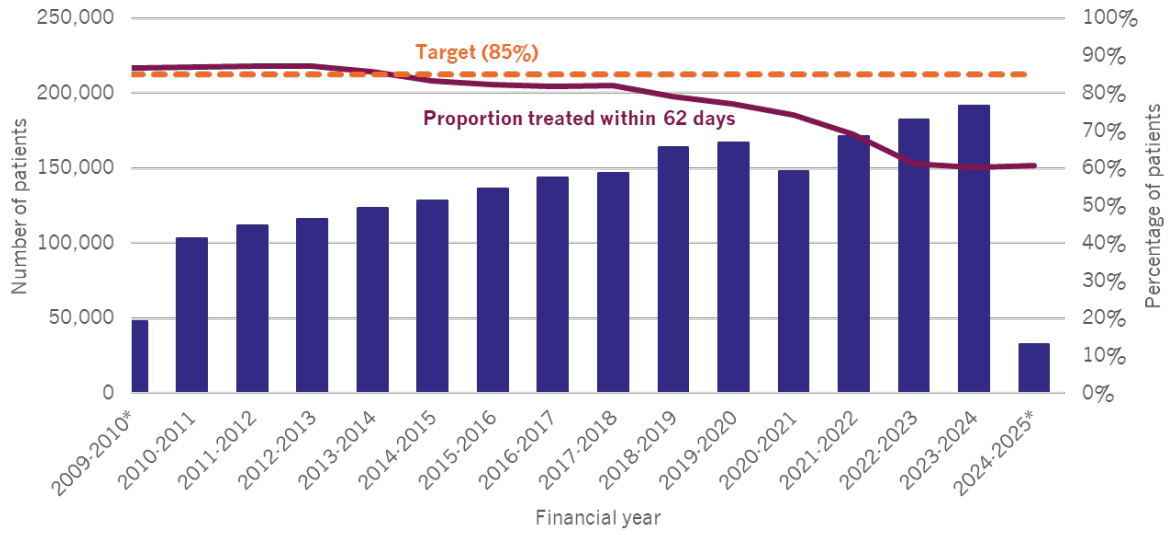


61. Treatments are becoming more sophisticated, but less timely. In 2024, more than 35,000 genomic tests are being completed each month. But the turnaround times are poor, with only around 60 per cent of test being performed to the agreed timeframes[161]. This can delay the start of treatment which often depends on the result. Genomic testing is routinely commissioned across 7000 rare diseases and 200 cancer indications. And the NHS is the first in the world to offer whole genome sequencing as part of routine care. However, there is more to do to ensure access for everyone who could benefit. Research shared with the investigation by the Tessa Jowell Brain Cancer Mission found that 72 per cent of UK neuro-oncology centres

were able to deliver whole genome sequencing to at least some of their patients but that no centre was able to offer it to all eligible patients. Moreover, the authors estimated that in 2023, on average, less than five per cent of eligible adult brain tumour patients were having whole genome sequencing through NHS commissioned pathways[162].

62. Waiting times for treatment have been deteriorating, too. As Cancer Research UK pointed out in their submission to the investigation, the 62-day target for referral to first definitive treatment for cancer has not been met since December 2015[163]. Since the pandemic, the backlog of long waiters has been prioritised, and partly as a result in May 2024, performance was just 65.8 per cent[164]. If the target had been met, around 5,200 additional patients would have been treated on time. Similarly, more than 30 per cent of patients are waiting longer than 31 days for radical radiotherapy[165].

Figure III.12.16: Number of patients receiving a first definitive treatment for cancer and proportion treated within 62 days, England (USCR routes only)



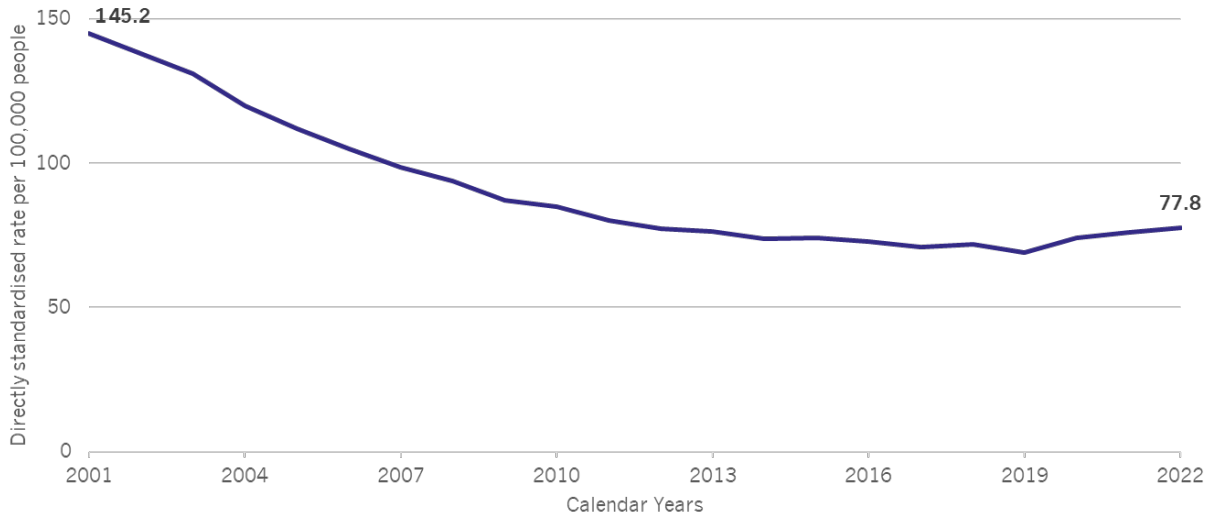
63. When it comes to systemic anti-cancer therapies, there continue to be significant disparities in how quickly patients are able to access new treatments. The time from approval by NICE to adoption of new cancer drugs such as alpelisib and fulvestrant varied from less than a month in nine provider trusts to more than a year in nine other organisations[166]. There is no excuse for such wide variation, which is fundamentally unfair to patients and goes against the principles of a universal service. Overall, the UK ranks ninth out of 37 OECD countries for the adoption of medicines.

Cardiovascular health

64. Cardiovascular disease remains a leading cause of death in England. Once adjusted for age, the cardiovascular disease mortality rate for people aged under 75 dropped significantly between 2001 and 2010. But improvements have stalled since then, and the mortality rate started rising again during the Covid-19 pandemic[167].

65. Cardiovascular disease is strongly linked to health inequalities. In 2022, people under the age of 75 living in the most deprived areas of England were more than twice as likely to die from heart disease than people living in the least deprived areas[168].

Figure III.13.1: Directly standardised mortality rate from all circulatory disease, persons under 75s, England, 2001 to 2022



66. Cardiac rehabilitation is a programme of exercise, education and psychological support that is proven to reduce hospital readmissions, deliver better outcomes and is cost effective. For patients who have experienced myocardial infarction (MI) and/or coronary revascularisation, attending and completing the exercise-based component of cardiac rehabilitation is associated with an absolute risk reduction in cardiovascular mortality from 10.4 per cent to 7.6 per cent when compared to those who do not participate, as well as a significant reduction in acute hospital admissions. Yet despite the compelling evidence, there is wide variation. In one ICB

area, more than 80 per cent of eligible patients participate, whereas in four ICBs, fewer than 20 per cent do so[169].

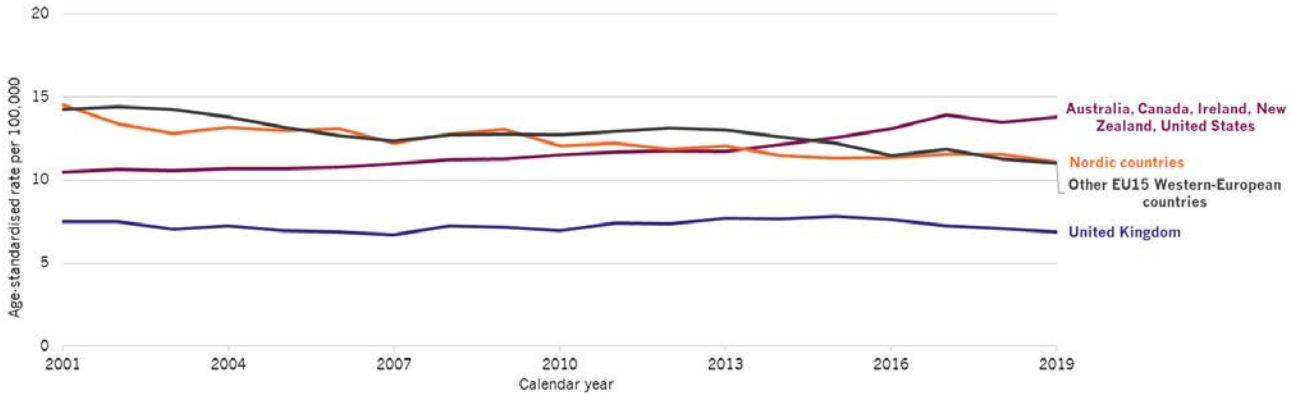
67. Lipid lowering therapies are an important tool in preventing cardiovascular disease. In March 2024, 62.1 per cent of people at high risk of cardiovascular disease were treated in this way (in line with the NHS Long Term Plan target of 60 per cent)[170]. There has also been good progress towards the objective to treat 95 per cent of people with cardiovascular disease with lipid lowering therapies, with 85.1 per cent receiving this treatment in March 2024[171].

> "We are extremely concerned that the significant progress made on heart disease and circulatory diseases (CVD) in the last 50 years is beginning to reverse. The number of people dying before the age of 75 in England from CVD has risen to the highest level in 14 years"
> *British Heart Foundation submission to the Investigation*

Suicide

68. Overall suicide rates in the UK are significantly below many other countries and relatively stable over time as shown below[172]. Analysis shows that while rates have been declining in European countries, they start from a much higher point, meaning that there is still a large gap between the UK and the EU15. Suicide rates in other predominantly English-speaking countries have steadily increased such that by 2019, they were nearly double those of the UK.

Figure III.14.1: Age-standardised suicide rates per 100,000 population, 2001 to 2019



69. While the suicide rate among adolescents aged 15 to 19 was 44 per cent below the OECD in 2019, there has been a worrying increase in suicides of young people[173]. There was a particularly large increase during the years running up to the pandemic, with the number of young women and girls (10-24) completing suicide rising 6.9 per

cent a year between 2015 and 2019, while the numbers of young men and boys increased by 3.2 per cent a year[174]. Suicide rates are now at their highest levels this century, and this is an area where close attention will need to be paid in the years ahead[175].

Figure III.14.4: CAGR change in suicide rates for males and females by age group, England, 2001 to 2021

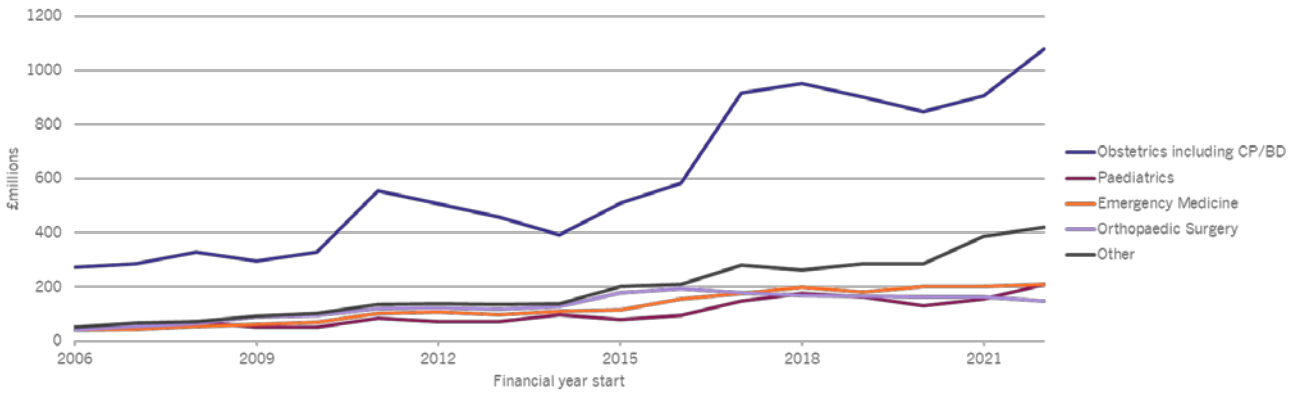
	10 to 24 years		25 to 44 years		45 to 44 years		65 years and over	
	Males	Females	Males	Females	Males	Females	Males	Females
2001-2005	-6.4%	0.9%	-1.5%	-0.1%	-1.1%	1.9%	-2.1%	-3.6%
2005-2010	-2.0%	-0.7%	-2.4%	-3.5%	0.8%	-2.7%	-2.8%	-2.8%
2010-2015	4.6%	1.9%	0.5%	1.2%	2.3%	2.8%	1.5%	3.4%
2015-2019	3.2%	6.9%	3.1%	4.2%	2.0%	-1.1%	-0.6%	-3.9%
2019-2022	-4.7%	2.6%	-0.4%	2.0%	-1.8%	0.5%	-0.1%	0.0%

Complaints and clinical negligence

70. The number of formal complaints raised about NHS services has changed over time as awareness of the complaints process has risen. But it is still striking that complaints have nearly doubled in a little over a decade, according to data shared with the Investigation by the Parliamentary and Health Service Ombudsman. As the highest level to which complaints about the NHS can be directed, they received 14,615 formal complaints in 2011-12, rising to 28,780 complaints by 2023-24[176].

71. As a Health Select Committee report points out[177], the NHS in England is an outlier in clinical negligence payments, devoting double the share of total health spending as New Zealand, ten times the level of Australia, and twenty times as much as Canada. In the year 2023/24, clinical negligence payments increased to £2.9 billion or 1.7 per cent of the entire NHS budget[178]. To put this in context, that amounts to more than the combined budget of every GP practice for the whole of the Midlands[179] serving more than 10 million people, and is the same as the NHS spending on 1.2 billion pathology tests each year. Aside from pensions and nuclear decommissioning, NHS clinical negligence claims are the largest liability on the Government's balance sheet[180].

Figure III.15.3: Cost of clinical negligence claims settled each year in clinical specialties with the highest costs of claims



72. As we can see from the chart above, while cost of claims has been rising across all specialties, they have risen much more quickly in obstetrics over the past two decades, amounting to around £1 billion in 2023-24[181].

* * *

73. On balance, the picture on quality of care is mixed. There are some notable improvements, such as the targeted lung check or the increase in specialist advice and virtual wards. But in too many areas, we have been going in the wrong direction. Complaints have doubled, and clinical negligence claims are at record levels. There is much work to be done if quality of care is to become the organising principle of the NHS once more.

4

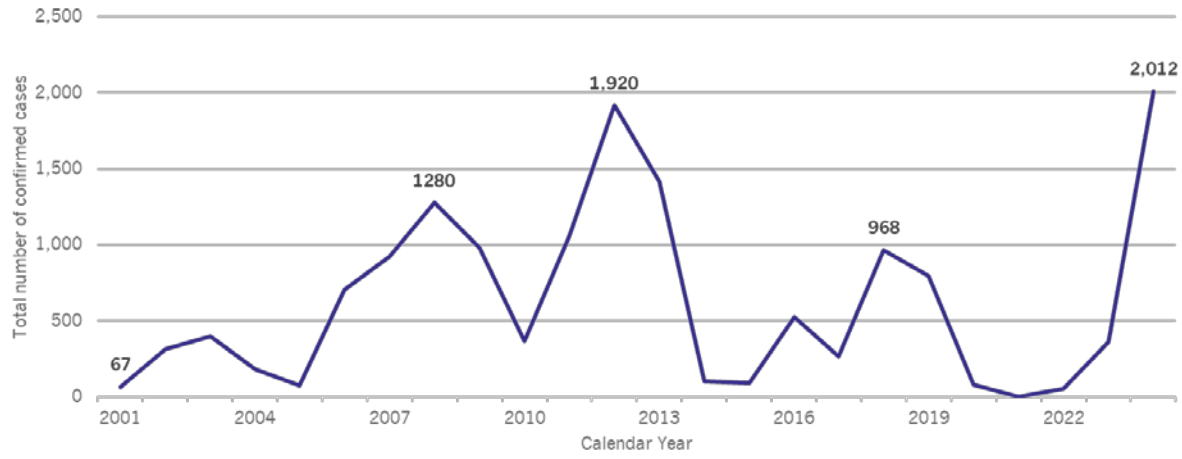
Health protection, promotion and inequalities

1. We now turn to three themes that cut across all aspects of the NHS. How well our health is protected from infectious disease in the wake of the pandemic, how effectively good health is promoted, and the inequalities experienced by people in health and care services.

Health protection

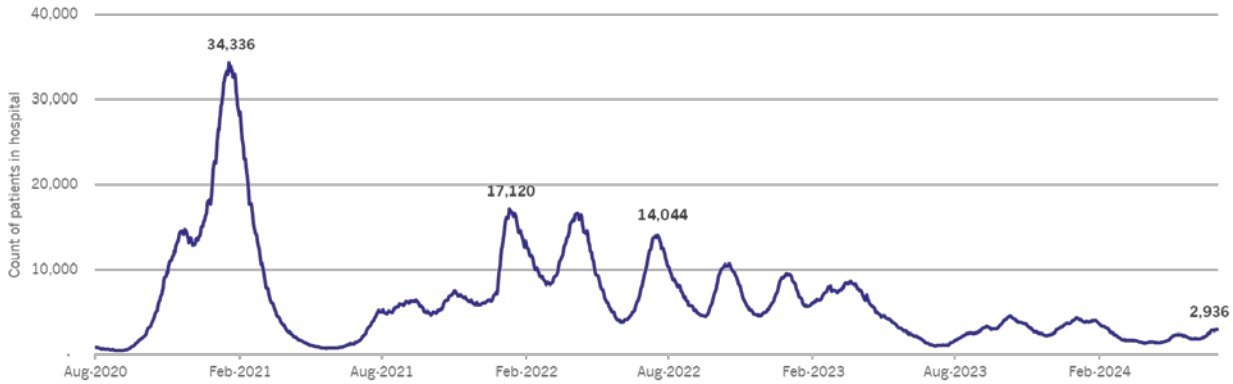
2. In the wake of the Covid-19 pandemic, it is apparent that infectious diseases remain a major challenge for all health systems. Well known infectious diseases could be on the rise as vaccination rates fall: measles cases in 2024 have been the highest this century as shown below[182]. It is too early to tell if this is a temporary spike like in 2012, or a new sustained level.

Figure III.6.5: Confirmed cases of measles in England, 2001 to 2024



3. Covid-19 remains an ongoing challenge for the NHS. While it has receded from public discussion, it continues to affect significant numbers of people. In the summer 2024 wave, Covid-19 has caused around 200 deaths per week between mid-July and mid-August[183]. There will continue to be patients who require hospital care and there may be periodic spikes as illustrated in this chart[184].

Figure III.6.1: Daily count of confirmed COVID-19 patients in hospital at 8am, England, August 2020 to June 2024



4. The Covid-19 pandemic had a very significant negative impact on the NHS and health outcomes, as is evident throughout this report and explored further in Chapter 8. However, there were some benefits of the public health interventions from the pandemic, including emphasising the importance of flu vaccinations (seasonal flu vaccination rates did increase during the pandemic for 65+ year olds and remain above pre-pandemic levels)[185]. Social distancing, meanwhile, contributed to rates of sexually transmitted disease falling and these have remained below pre-pandemic levels[186].

5. A looming threat is Anti-Microbial Resistance (AMR), which by 2050 could kill 10 million people globally every year—that is more than cancer[187]. AMR occurs where microbes are becoming resistant to the drugs meant to kill them and is particularly a challenge for keeping antibiotics working. Thanks to the championing of Dame Sally Davies, the UK Special Envoy on Antimicrobial Resistance, this country has been leading the way in tackling AMR and this year published a new five year action plan[188]. The Fleming Initiative, which I chair, looks to share solutions globally, often drawing from UK success—including the forthcoming centenary of Fleming's world-changing discovery[189]. Yet there is still more the UK needs to do to decrease inappropriate antibiotic usage and accelerate the development of new diagnostics and drugs.

Health Promotion

6. It is apparent that where bold action has been taken, health has improved. This is notably the case for smoking where a succession of interventions have driven smoking rates down[190], with consequential positive impacts on cardiovascular disease and cancer incidence and survival.

7. In contrast, bold action has been sorely lacking on obesity and regulation of the food industry. This means that childhood obesity rates for 10-11 year olds have risen[191] and inactivity rates in adults have remained constant[192]. As we have seen, the prevalence of diabetes has increased from 5.1 per cent prevalence in 2008 to 7.5 per cent in 2022 as a result of this inaction[193]. Similarly, when tough action was taken on the harm caused by alcohol, deaths attributed to it stabilised. As the chart below shows, alcohol is becoming more affordable over time, and deaths are rising at an alarming rate. In the pandemic, there was an 10.8 per cent annual increase between 2019 and 2022[194]:

Figure III.1.3A: Age-standardised alcohol-specific mortality rate per 100,000 in the United Kingdom, 2001 to 2022

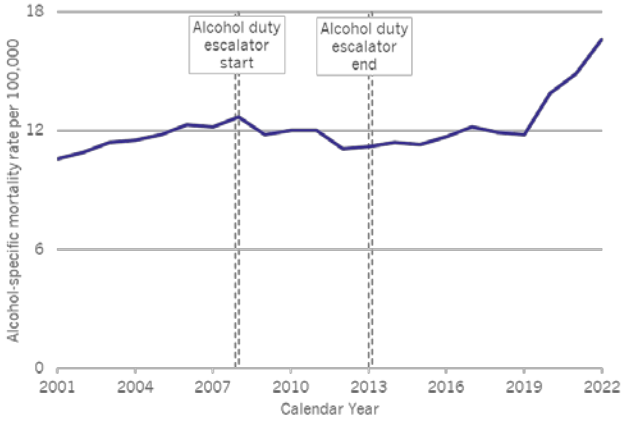
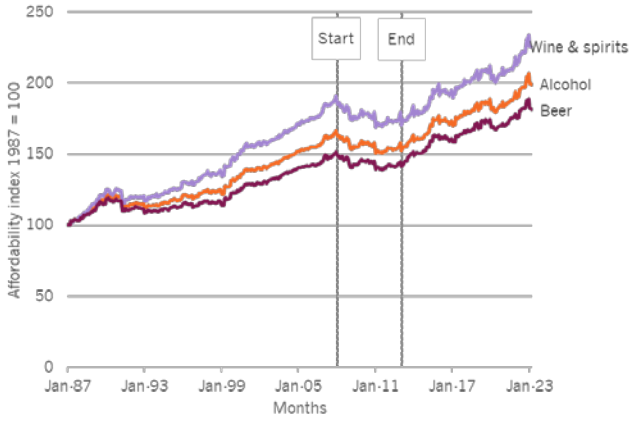
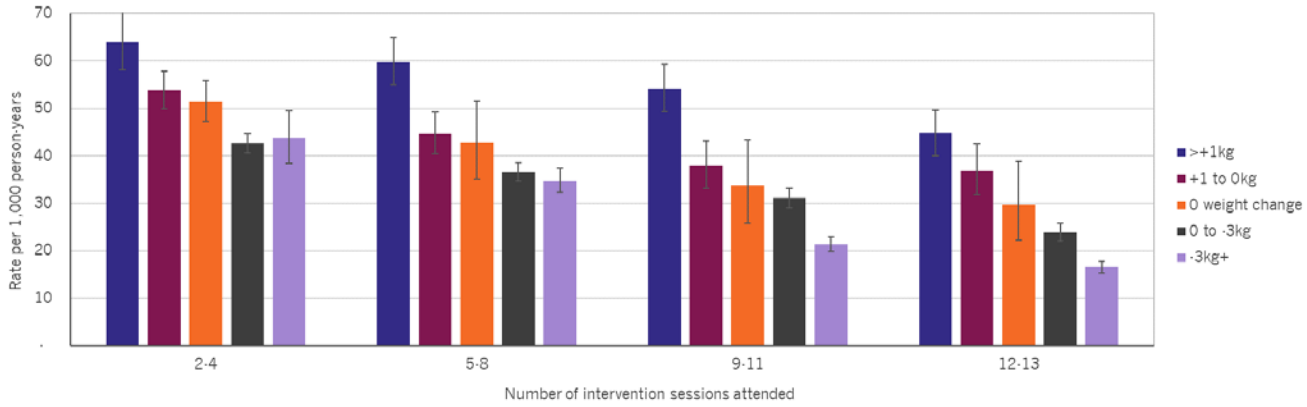


Figure III.1.3B: Alcohol affordability in the United Kingdom, January 1987 to March 2023



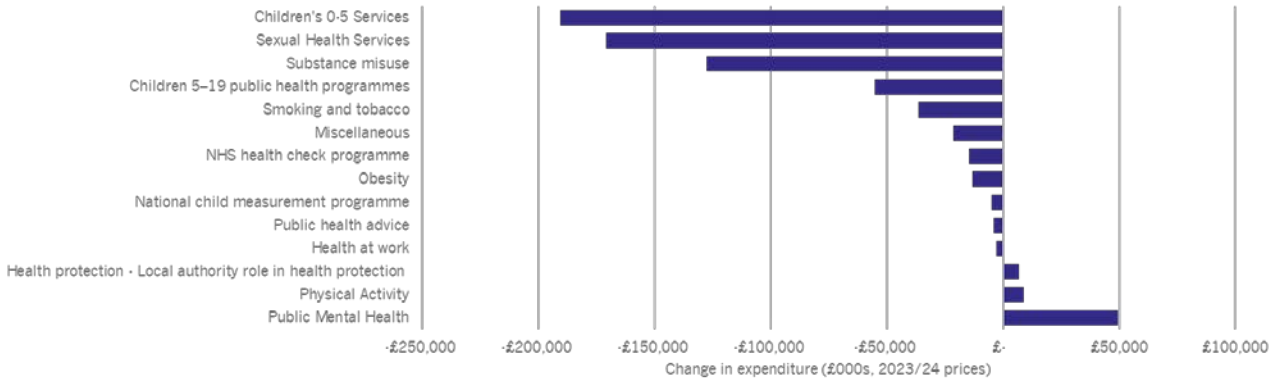
8. Everybody knows that prevention is better than cure. Interventions that protect health tend to be far less costly than dealing with the consequences of illness. Take the NHS-funded Diabetes Prevention Programme which reduces the risk for type II diabetes by nearly 40 per cent[195]. Given the potential power of preventative interventions, it is perverse that the public health grant to local authorities has been cut so substantially. Analysis from the Health Foundation shows that the public health grant was cut by more than a quarter between 2015-16 and this year[196]. Moreover, cuts to public health allocations have tended to be greater in cash terms in more deprived areas.

Figure III.7.6: Incidence of type 2 diabetes between April 2018 and March 2023 for individuals referred to the NHS DPP



9. The consequences are felt by individuals and families across the country in a reduction in the services that are offered to them. Spending on NHS health checks, for example, has dropped by £15 million[197]; participation rates in the programme have fallen by 20 per cent[198]. The £171 million reduction in sexual health services spending[199] comes at a time when there are concerns about the rise in cases of mpox[200]. It is particularly saddening to see the £191 million cuts to services for young children[201].

Figure III.1.8: Change in reported local authority spend on public health services from 2016/17 to 2022/23, 2023/24 prices



10. People in the most deprived areas die much earlier on average; this is well recognised and deeply entrenched[202]. It is preventable. It is often assumed that if we reduce premature mortality, we will extend the period in ill health. But this is wrong. Those in less deprived areas live substantially less time in ill health as well as having longer lives[203]. Prevention which reduces premature mortality leads to less time spent in ill health.

11. There is extraordinary power in getting public health right. We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This

in turn reduces the burden on the NHS and social care while enabling us to be more productive in our working lives so strengthening the economy. This is the desired outcome for individuals, families, the public purse. But it takes the political will and willingness to invest to achieve it, with the skills to successfully engage the public.

Inequalities in health and care

12. The impact of the deterioration in access and the challenges around quality of care have not been felt equally. As we have seen, there are important disparities in almost all aspects of care. The 'inverse care law' seems to apply: that those in greatest need tend to have the poorest access to care[204]. In this section, we draw from the expertise of a number of charities and campaigners who have informed this report.

The impact of poverty

13. In their submission to the Investigation, the Joseph Rowntree Foundation (JRF) pointed out that people living in poverty are getting sicker and accessing services later. For the most deprived groups, A&E attendances are nearly twice as high and emergency admissions 68 per cent higher that the least deprived. People who live in the most deprived areas of England are twice as likely to wait more than a year for non-urgent treatment. In 2021 the undiagnosed diabetes rate was double for those in the bottom Indexed of Multiple Deprivation (IMD) quintile compared to the top.

14. A recent JRF survey found that of those in the bottom income quintile whose health has been negatively impacted by the cost-of-living crisis, only 33 per cent had accessed mental health services, and 39 per cent physical health services[205]. This presents a challenge for the NHS in finding those with an unmet need for healthcare.

15. Greater illness and poorer access to care contribute to worse health outcomes[206]. The result is that the mortality rate in the lowest Index of Multiple Deprivation (IMD) decile is almost double that of the highest[207]. Analysis by the JRF and The King's Fund described the impact of deprivation on mental health: in the poorest communities, the depression rate was twice as high, double the number of people were in contact with mental health services, and nearly four times as many were sectioned under the mental health act[208] as in the least deprived. There are similar findings for bowel cancer, where fewer people take part in screening at 64 per cent

for the most deprived compared to 75 per cent for the least deprived, diagnoses are 36 per cent lower, and the mortality rate is 25 per cent higher[209].

Homelessness is a health catastrophe

16. Between 2010 and 2023, the number of people in temporary accommodation doubled from around 90,000 to 180,000[210]. In the same time period, the number of people sleeping rough more than doubled from 1,768 to 3,898 (although this was down from a pre-pandemic peak of 4,751 in 2017)[211].

17. People experiencing homelessness are far more likely to have asthma or other breathing problems, heart disease, or epilepsy[212]. A study of homeless hospital inpatients found that 64 per cent had three or more physical health co-morbidities, while a survey of people experiencing homelessness found that 82 per cent had a mental health diagnosis[213]. Poor health can precipitate homelessness and homelessness creates poor health[214].

18. According to a submission to the Investigation from Pathway's Lived Experience Programme, people facing homelessness do not receive the same level of care as those who have a safe place to call home. They experience stigma and discrimination as negative social attitudes in society are also present in the NHS. The result is that services are harder to access than they should be.

19. A survey of Faculty for Homeless and Inclusion Health members found health services are very difficult for inclusion health patients to access. Given the population's high rates of mental health need, difficulties accessing mental health services are of pressing concern, which respondents felt was due to poor service accessibility, digital exclusion, and stigma[215]. In primary care, lack of identity documents or proof of address is a major problem. Indeed, a mystery shopper exercise found that only 31 per cent of people with no ID/address were able to register with a GP, despite this not being a legal requirement[216].

20. The result of poor access to primary and community care is a costly overreliance on urgent and emergency care: people experiencing homelessness attend A&E four times as often as the general population and are eight times as likely to need inpatient care[217].

21. The outcomes are tragic. According to the ONS, the average age of death for homeless men was 45 years and for women it was 43 years[218]. There were seven times as many deaths of men as of women. As of 2021, the death rate had increased in every region of England since 2013.

Disparities by ethnicity

22. Data from the NHS Race and Health Observatory that was submitted to the investigation finds widespread disparities[219]. Minority ethnic groups, particularly Asian people, experienced disproportionally longer waits for elective care after the pandemic than those from white backgrounds. Asian people experienced an 8 per cent overall fall relative to White groups in elective procedure rates—with this as high as 23 per cent in therapeutic cardiac appointments[220]. Black people also experienced a large drop in some areas, with a 19 per cent drop in cataracts procedures relative to the white population[221].

23. Similarly, in mental health, people from minority ethnic groups experienced worse outcomes; waited longer for assessment; and were less likely to receive a course of treatment following assessment in the NHS Talking Therapies Programme[222]. There is a substantial evidence base that shows that people from minority backgrounds are more likely to be sectioned under the Mental Health Act. Indeed, as the RCPsych point out, in the latest annual data for 2022-23, the standardised rate of detention under the Mental Health Act for Black or Black British people was more than 3.5 times higher than the rate for White people[223]. As Mind described in their submission to the Investigation, black people are more than ten times as likely as white people to be subject to a community treatment order, where they can be recalled to hospital if they do not comply with treatment protocols[224].

24. Analysis from the NHS Race and Health Observatory, set out in the chart below, finds that the median age at death was 62 years for people from white backgrounds, whereas it was 40 years for Black people, 33 years for Asian people, and just 30 years for those from a mixed background[225]. It is vitally important that the reasons for this are better understood so that these extraordinary differences can be addressed.

People with learning disabilities

25. There are particularly severe disparities in learning disabilities. According to a submission from Mencap to the Investigation, only four-in-10 people with a learning disability will live to see their 65th birthday[226]. People with a learning disability are twice as likely to die from preventable causes[227] and four times as likely to die from treatable causes[228]—with areas such as respiratory care and cancer care of

particular concern. There are multiple barriers that prevent people with learning disabilities from accessing the care that they need.

26. There are important variations in access to care. Around three-quarters of people with a learning disability are not on the GP learning disability register[229]. Mencap points out that there is no target for registration but that there is a target to provide health checks for 75 per cent of those on it. This may be disincentivising adding people to the register.

27. More than 2,000 people with severe learning disabilities and/or autism continue to be detained in inpatient mental health settings. The 2024-25 NHS Planning Guidance re-states the target to reduce inpatient numbers by 50 per cent, but this is in the context of failure to meet 2014, 2019, 2020 and 2024 targets. Current estimates suggest that it may not be achieved until 2030—and Mencap believes it will be later than that[230].

Carers

28. In 2024, 4.7 million people were unpaid carers in England, 1.4 million of whom provided more than 50 hours of care each week[231]. Nearly 60 per cent of carers are women, and the largest group are in their late 50s[232]. There are more very elderly carers, including 6.3 per cent of women aged over 85 and 2.9 per cent of women aged over 90[233]. Many carers struggle with their own health, with 28 per cent having a disability and 7 per cent reporting that their health was bad or very bad, according to Carers UK. One-third of all NHS staff are carers themselves[234].

29. The *State of Caring 2023* report by Carers UK found that 30 per cent of carers who were waiting for hospital treatment or assessment for themselves, had been waiting for over a year. More than 40 per cent said they needed more support from the NHS, while 60 per cent said they were not involved in hospital discharge[235]. In particular, carers were often not asked about either their willingness or ability to care. A striking 14 per cent said they had accompanied the person they cared for to hospital appointments more than 20 times in the previous 12 months[236].

30. Carers UK points out that all too often, unpaid carers do not receive the recognition and support that they need and deserve from the NHS. Instead, they feel invisible, misunderstood and unsupported despite their huge contribution. A fresh approach is needed which regards unpaid carers both as people with their own needs where caring is a significant factor in their lives, but also as a provider of care who should be treated as an equal partner. The current paradigm leads to poorer outcomes for

people needing care, for carers, and for the health service. A different approach is needed.

5

Where and how the money is spent

1. In this chapter, we explore where and how the NHS has sought to spend its budget. This is both an aspect of NHS performance, and a driver of it. We look at its major priorities—providing care that is more joined-up and delivered in the communities where people live—and how and whether resources are distributed to match. From there, we provide a high-level examination of the resources and productivity in each of the different main settings of care: general practice, community services, mental health, and acute hospitals.

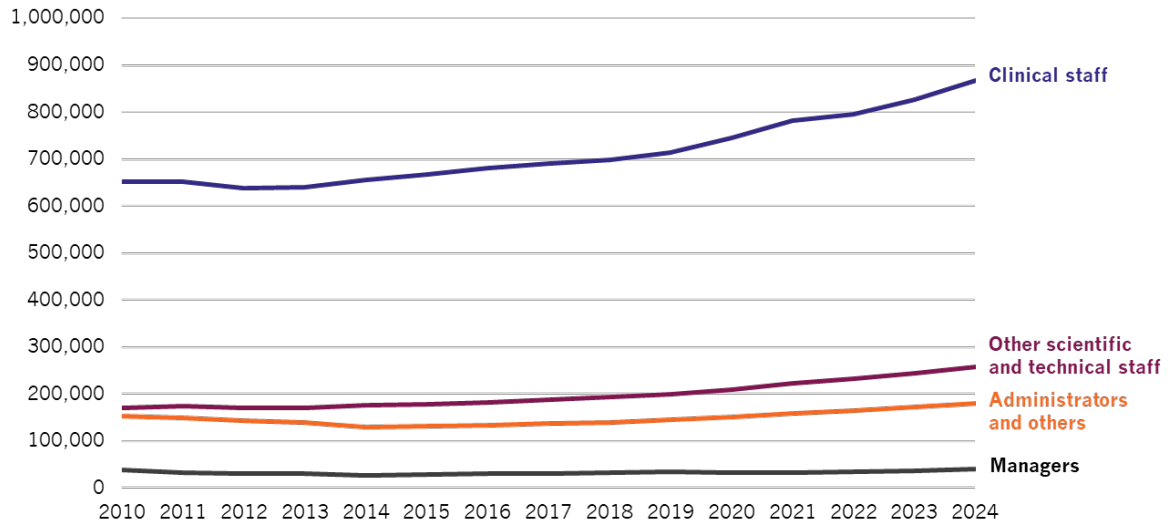
2. At the highest level, the NHS has had the strategic intention to shift spending from reactive care in hospitals to more proactive care in the community setting – but care has in fact moved in the other direction. Hospitals have attracted a greater share of NHS spending, meaning that other settings have received a smaller share. Accordingly, there has been a significant boost in hospital-based staff[237].

3. Regrettably, productivity in the NHS has all-too-often become associated with simply spending less or working harder. Neither is correct. Narrowly, productivity is the output, in terms of quantity and quality, produced relative to input. What it is really about is how much healthcare value can be created with the resources available. This encompasses everything from detecting disease earlier so that it is more amenable to treatment, embracing new innovations at the frontiers of scientific possibility, through to making care more planned and more consistent. It means using healthcare resources to provide the highest quality care, at the right time, and in the right place. Above all, it means using the full talents of NHS staff to help patients to get better outcomes. Not only is it possible to be smarter, not to just work faster, it is better for patients' outcomes and experiences and for staff and their enjoyment of work.

The big picture: workforce and productivity

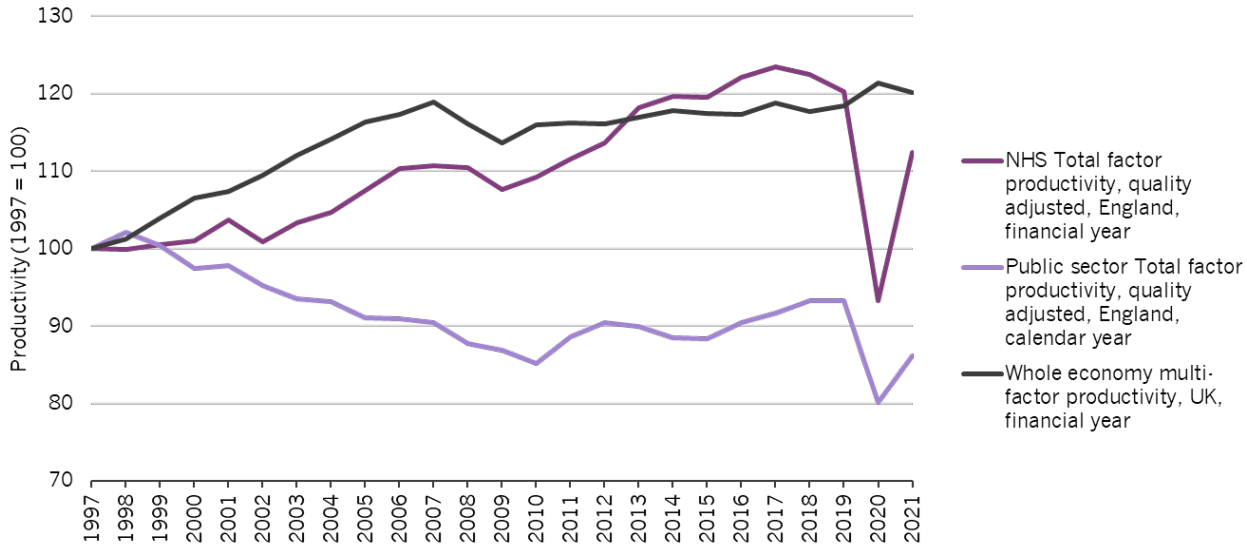
4. Overall staff numbers increased gradually during the 2010s, in line with the slow-down in funding increases over the same period[238]. Staff numbers have since increased more rapidly, as funding has risen[239], as we can see in the chart below[240]. Between 2022 and 2024, the rate of clinical staff growth has been 4.5 per cent compared to just 0.7 per cent between 2010 and 2016 and 3.3 per cent a year during the pandemic years from 2020 to 2022[241]. Other scientific and technical staff (who support clinicians) have increased at more than 5 per cent a year since 2020[242]. The number of managers fell at an annual rate of 4 per cent in the first half of the 2010s, and from that lower base, it has since grown again, rising at 5.8 per cent a year in the past two years[243].

Figure VIII.2.1: Hospital and Community Health Services (HCHS) staff by staff group, in NHS Trusts and other core organisations, March 2010 to 2024



5. During the 2010s, NHS productivity increased more quickly than the wider public sector and in a number of years it rose faster than the economy as a whole. But there was a deep drop in NHS productivity during the pandemic, when NHS productivity declined far more significantly than the economy as a whole or the wider public sector, as the chart below shows. It still remains below its 2019 level[244].

Figure VIII.2.3: Total factor productivity level for the NHS in England, wider public sector in England and the whole UK economy



6. Understanding productivity requires us to look at both where and how resources are spent. We now turn to where the resources the NHS receives are spent and the NHS's main strategic imperatives. From there, we examine how well they are spent in each of the main settings of care.

Changes in the population and strategic priorities for service change in the NHS

7. The fundamental driver of change in healthcare provision is change in the needs of the population. As we saw in chapter one, as people age, they tend to have more long-term conditions such as diabetes, breathing difficulties, or heart failure. There is a strong evidence base about what interventions help people to manage their conditions and to maintain their independence. This means that care can and should be more planned – such as the eight care processes for diabetes that were described in chapter three – and typically requires a multidisciplinary team of professionals to provide it.

8. To respond to this change in the needs of the population, the NHS has embraced two main strategic ideas, in common with many international health systems. The first is that care should be more joined up, or more "integrated". This is to reflect the fact the people living with long-term conditions need the help of a variety of different physical and mental health professionals and often rely on social care too. The frequency of their interactions with the health service mean that their care is more complex and therefore requires coordination. This is particularly true for people with two or more conditions (whose prevalence is growing over 6 per cent

annually), who may require care from different specialists and the expertise of GPs and others to understand the interactions between their conditions, treatments, and medicines. Since healthcare is organised around groups of professionals with similar skills (such as GP practices, mental health or community trusts, and hospitals), it requires organisations to work well together.

9. The second idea is that care should be delivered in the community, closer to where people live and work, and that hospitals should be reserved for specialist care. This is more convenient for patients – especially for those with long-term conditions who will need contact with the NHS more frequently. It builds on the fact that General Practice is how most people commonly interact with the health service and GPs' expertise as generalists. Indeed, research by the NHS Confederation has demonstrated that spending in primary and community settings had a superior return on investment when compared with acute hospital services[245]. It therefore makes sense that this should be the fundamental strategic shift that the NHS aspires to make.

10. The problem is that to provide high-quality, multidisciplinary care in the community requires resources that often are not there. These include the right professionals with the right skills—and the modern facilities, digital infrastructure, and diagnostics to support them. Over time, then, there must be a shift in the distribution of resources towards community-based primary, community and mental health services. Research from the NHS Confederation found that, on average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and A&E attendances[246].

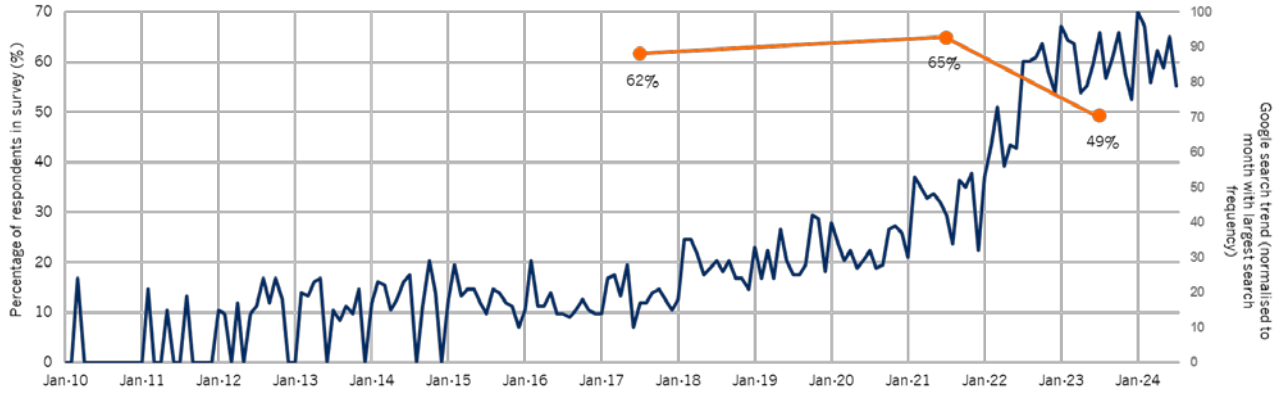
11. In the NHS, this goal of rebalancing care towards the community is sometimes described as the "left shift". Since at least the *Our Health, Our Care, Our Say* White Paper of 2006, and arguably before, the NHS has been committed to this change in the pattern of services. Similarly, pilots of integrated care were well underway in 2010, the 2014 Five Year Forward View described the NHS' commitment to integrated care, and integrated care systems have existed in one form or another since at least 2016. And integrated care boards and integrated care partnerships have been on a statutory footing since 2022.

12. So, if integrated care and the "left shift" have been the core of the NHS's service strategy, how far has the NHS progressed towards them?

Integrated care

13. While we heard—and indeed, saw—various examples of brilliant integrated care around the country, there has not yet been a systematic shift at scale. Indeed, the more the NHS has talked about integration, the less satisfied patients have become with the coordination of their care[247], as the analysis below shows:

Figure VIII.1.3: Google Trends for 'NHS integrated care' compared patient responses to "How often does your regular doctor or someone in your doctor's practice help coordinate or arrange the care you receive from other doctors and places?" (% of respondents 'always' and 'often')



14. There are three essential steps for delivery of integrated care[248]. First, it requires an understanding of the population and their needs using integrated datasets. Second, it requires the creation of multidisciplinary teams of health and care professionals. Third, it requires the whole team to work to a shared care plan that is developed in partnership with individuals and their carers and families and includes preventative interventions to keep people well.

15. If there are not population insights, multidisciplinary teams, and shared care plans, then integrated care is not happening. Where new multidisciplinary teams have formed, for example, around primary care networks, they report significant positive impact. The proportion of people with long-term conditions that report having an agreed a care plan with a health or care professional has been stuck at about 60 per cent from 2018 to 2023 (indeed, it slightly declined over the period). So, there is still much further to go.

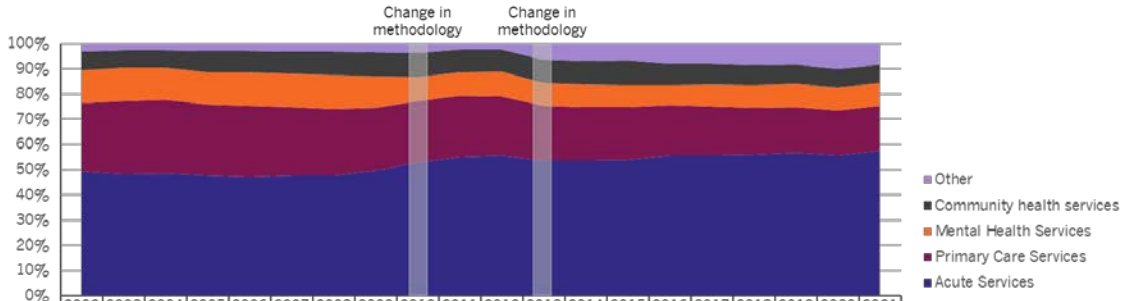
The "left shift"

16. So how far has the NHS come in meeting its stated strategy to shift care closer to home? As the chart below shows, since the NHS stated its intention to move care closer to home in the 2006 white paper, spending has drifted towards the acute hospital sector. The data suggests that this happened in broadly three phases: between 2002 and 2009, it was fairly stable changing from 49 per cent to 50 per

cent from beginning to end. It then rose to 53 per cent in 2010 and stood at 56 per cent by 2012. It then remained relatively stable, hovering between 54 and 56 per cent, before rising again during the pandemic years.

17. The overall result is that since the 2006 commitment to shift care towards the community, the share of NHS spending on hospitals increased from 47 per cent to 58 per cent in 2021 (the most recent year of data available)[249]. The "left shift" could, in fact, be characterised as a "right drift", when the whole period is examined. This means that the NHS has implemented the inverse of its stated strategy. Moreover, it is notable that the biggest rises occurred when the NHS's commissioning structure was at its most distracted: from the publication of the *Liberating the NHS* white paper in 2010 and the passing of the Health and Social Care Act of 2012. It seems unlikely that this is merely a coincidence.

Figure VIII.1.1: Estimation of NHS group spend by healthcare service



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Other	3%	3%	2%	3%	3%	3%	3%	3%	4%	2%	2%	6%	7%	7%	8%	8%	8%	8%	10%	8%
Community health services	7%	7%	7%	8%	9%	9%	9%	10%	10%	9%	9%	9%	9%	10%	8%	8%	8%	8%	8%	7%
Mental Health Services	13%	13%	13%	13%	13%	14%	14%	13%	10%	9%	10%	9%	9%	9%	8%	9%	9%	9%	9%	9%
Primary Care Services	27%	29%	29%	28%	28%	27%	26%	25%	24%	24%	24%	22%	21%	21%	20%	19%	19%	18%	18%	18%
Acute Services	49%	48%	49%	48%	47%	48%	48%	50%	53%	55%	56%	54%	54%	54%	56%	56%	56%	57%	56%	58%

18. In 2011, the Coalition Government published its mental health strategy, *No health without mental health*, in which it stated "we are clear that we expect parity of esteem between mental and physical health services"[250]. Yet in the year of publication, the number of mental health nurses fell and would continue to fall for each of the following five years[251]. The 2023 National Audit Office report *Progress in improving mental health services in England*[252] omits this vital context by only examining what had happened from 2016-17 to 2022-23.

19. Since 2016, the NHS has applied the "mental health investment standard". This important intervention has helped by protecting mental health budgets and so keeping it share of NHS spending constant at 9 per cent[253]. This has enabled much of the mental health capacity that was cut in the first part of the 2010s to be rebuilt. Nonetheless, it took until 2023 for the number of mental health nurses to return to their 2009 levels[254], while both prevalence and referrals rose steadily throughout the

period. The result is a much larger treatment gap for mental health than for physical health[255], while people with severe mental illnesses die nearly two decades earlier than others in society and the gap is widening[256].

20. There is no question that rebalancing healthcare resources is complex and challenging. But the "right drift" is not an accidental outcome. It is the result of financial flows that have funded hospitals for their activity and much of the rest of the NHS for their efforts. It was the choice of successive governments to exclude primary care, mental health and community services waiting times from NHS constitutional standards, which are instead focus on hospital care. This has been reinforced by the failure to invest in the measurement of primary, community and mental health services, which has obscured the real consequences of cuts to block budgets.

21. Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home will be strategic priorities of the NHS in the future because they are derived from the changing needs of the population. Getting them right requires as strong a focus on strategy as much as performance; to invest in the quality and capacity of management as well as clinicians; and on the skills and capabilities to commission care wisely as much as to provide it well.

22. So, if there has been limited progress on integrated care and the left shift of resources has drifted in the opposite direction, why is that? What has been the focus and the challenges for integrated care boards?

Where have ICBs focused

23. As the NHS has made this move to formalise integrated care systems, it has invested significant effort in forming new collaborations between NHS organisations. Collaboration and integration are often conflated, but they are not the same. Service or clinical integration[257] is about a fundamental change in the way health services are organised for patients rather than the degree to which NHS organisations cooperate with one another as institutions.

24. NHS organisations are certainly working more collaboratively together now than in the past, with many formally joining group or collaborative structures[258]. We can see this in the increasing consolidation of NHS providers over time. This allows for scale economies to be captured and to concentrate managerial talent on solving difficult problems once rather than many times over. But the benefits of ever larger provider trusts for frontline patient care are yet to be proven, and there is a risk that

underlying performance is obscured in averages, while the distance from board to ward may become too great.

25. Collaboratives should be a means to deliver more integrated care and to spread good practice that raises the quality and consistency of care—but it is not obvious that this is the case. Simplifying governance from the top-down and capturing scale benefits are not good enough reasons in themselves. If collaboratives prove unable to change the way care is delivered, then there is a real risk that they amount to displacement activity from the strategic priorities of delivering integrated, preventative care closer to home.

26. Part of the challenge for ICBs comes from their conception. The Health and Care Act 2022 put integrated care systems on to a statutory footing, establishing integrated care boards and integrated care partnerships, and set out their four aims in legislation. The NHS Confederation's most recent *State of the ICSs*[259] report describes how local ICSs have found it challenging to fulfil their aims on population health and on the wider contribution to social and economic development. In the call for evidence, we heard conflicting accounts of the definition of population health and the ways in which Integrated Care Boards interpret their duty to improve it. NHS England has aimed not to be prescriptive in the way in which ICBs have formed and how they fulfil their aims. Including "integrated care" in the title of organisations does not make it thus.

27. Some ICBs interpret their population health duties as requiring them to act upstream of healthcare needs on the social determinants of health, where the NHS has few direct levers[260]. Other ICBs interpret their population health duties as requiring them to understand and adjust healthcare services to match the needs of the population that they serve, in line with the NHS Operating Framework[261]. Some interpret it as both and others as neither, preferring to focus on what they see as their "traditional" role of performance managing providers. The roles and responsibilities of ICBs need to be clarified.

28. Having examined the distribution of resources and the integration of care, we now turn to the productivity of services in the main care settings. We examine each of general practice, community services, mental health services, and acute services in turn. Given the short time frame for this investigation and the lack of readily accessible data, we have not examined productivity in dentistry, community pharmacy, ambulances or NHS 111.

Resources and productivity of services by setting

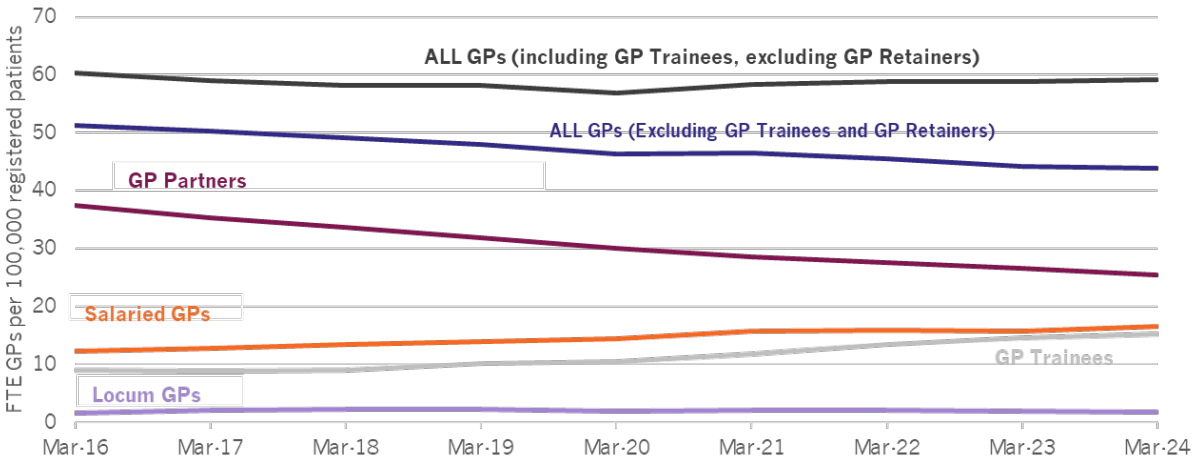
29. As we turn to resources and productivity of services, one thing that stands out is the degree of detail that is available for acute hospitals services versus other settings of care. This reflects the availability of data—and in itself demonstrates the need to invest in measurement and transparency across all areas of the NHS.

General Practice

30. It has long been said that General Practice is the "jewel in the Crown of the NHS"[262]. However, our analysis finds that the UK has 15.8 per cent fewer GPs per 1,000 population than the OECD average[263]. The number of GPs per 100,000 population declined by 1.9 per cent a year between 2016 and 2024, with the number of GP partners falling sharply, as we can see in the chart below[264]. It is a complex picture, however, since the absolute number of qualified GPs increased by 6 per cent between 2015 and 2022. Since in the same time period, the numbers of GPs choosing to work part-time has increased, and the population has expanded, the overall result is that there has been a decline in the numbers of whole-time equivalent GPs per 100,000 population[265].

31. As we have seen, there are wide variations in the numbers of GPs in different parts of the country, while patient satisfaction is better when there are fewer patients per GP. Moreover, more and more demands are being placed upon GPs who are expected to deliver an ever-wider range of services and to integrate care for more and more complex patients.

Figure VIII.3.2: Number of GPs FTE per 100,000 registered patients, by GP type – March 2016 to March 2024

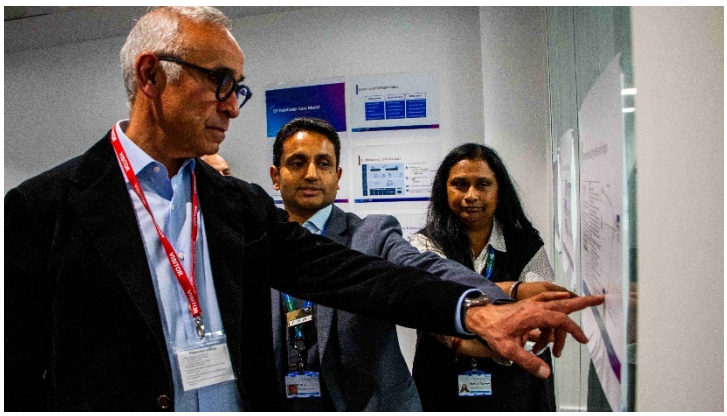


32. At present, multiple disincentives conspire against allocating additional funding to match known higher primary care workload in deprived areas. Primary care workforce recruitment is more challenging; consultation workload is progressively higher for each additional deprivation quintile; deprived area additional funding areas allocated according to the Carr-Hill formula does not take account of factors such as the social dimension of health and higher consultation rates[266]. Taken together, the Health Foundation estimated that current funding results in a 7 per cent shortfall in funding for practices serving more deprived populations per 'need adjusted' patient than those serving less deprived populations[267].

33. As independent businesses, General Practices have the best financial discipline in the health service family as they cannot run up large deficits in the belief that they will be bailed out. Despite rising productivity, an expanding role, and evident capacity constraints, the relative share of NHS expenditure towards primary care fell by a quarter in just over a decade, from 24 per cent in 2009 to just 18 per cent by 2021, continuing a downward trajectory from their peak in 2004[268].

34. With primary care doing more work for a lesser share of the NHS budget, we heard significant irritation felt by GPs who perceive that more and more tasks are being shifted from secondary care back to primary care, with a never-ending flow of letters demanding follow-ups and further investigations. This frustration is understandable when the hospital workforce appears to have expanded to the amongst the highest levels in the world.

35. In the face of such difficult challenges, some GP practices have embraced extraordinary innovations. GPs have made significant shifts towards a digital model for those patients who want it, they have introduced impressive approaches to triage, and have boosted their responsiveness to patients. During visits as part of the investigation, I saw some remarkable examples of local innovations that were improving access and quality of care, while also relieving pressures on acute hospitals.



36. While there have been some impressive programmes to support GP innovation, such as the GP Pathfinders, I also heard how the current GP standard contracts are complex and can mean that doing the right thing for patients can require doing the wrong thing for GP income. That cannot be right.

37. The primary care estate is plainly not fit for purpose. Indeed, 20 per cent of the GP estate pre-dates the founding of the NHS in 1948 and 53 per cent is more than 30 years old[269]. More recent buildings are bedevilled by problems with the management of LIFT (PFI-type) schemes that give GPs too little control over their space and that some GPs described as having charges that are unreasonably high during visits to the frontline as part of the investigation. It is just as urgent to reform the capital framework for primary care as for the rest of the NHS.

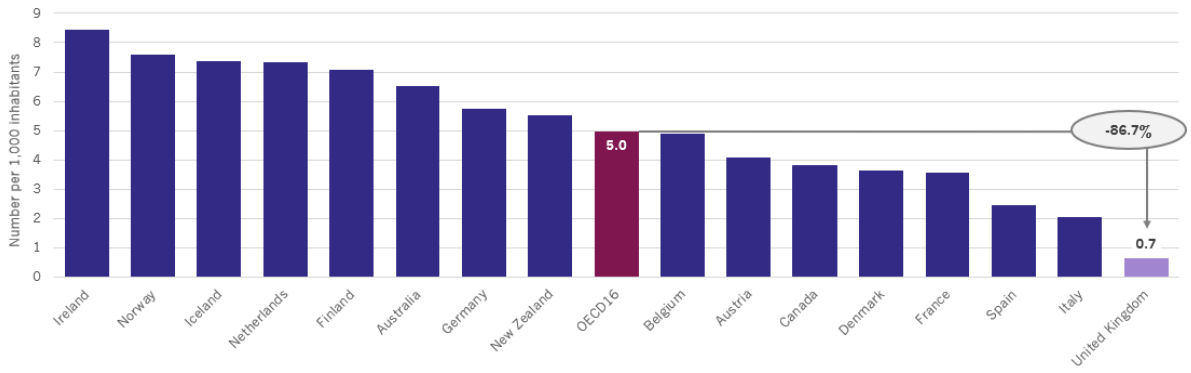
Community services

38. The poor quality of data means it is difficult to establish how well or how poorly community services are performing. In the NHS, what gets measured, gets funded. The community services dataset was only recently established. It contains nearly four times as many metrics as acute services[270], even though the NHS spends eight times as much on acute services as on community. It is little surprise, then, that completion rates are poor. The overall result is that there are tens of thousands of NHS staff working in community settings[271] and far too little is known about their performance and productivity. It even proved impossible to get precise headcount figures.

39. Community services are significant outliers in international comparisons of resources. We believe the UK has far fewer nurses working outside of hospital compared to other countries. Analysis seems to suggest that the UK may be as much as 86.7per cent below the OECD average in the numbers of nurses and midwives working outside of hospital, as the chart below shows.

40. While we treat this with caution—we speculate that it might exclude, for example, GP practice nurses or maybe acute hospital staff that are community based. If the data under-reported by a factor or four, we would still have the lowest level of resource among comparable countries. This therefore suggests that we may have too few resources in the community, compared to other health systems. Indeed, the Nuffield Trust has observed that, despite pledges to increase spending on care outside hospital, community services spending was cut in real terms in three out of the six years between 2016-17 and 2022-23[272]. What is clear is that it requires further investigation and that the first step to giving greater priority to community services is to properly count the number of people working in them.

Figure VIII.4.1: Practicing nurses and midwives per 1,000 inhabitants outside of hospital, 2023 (or nearest year)

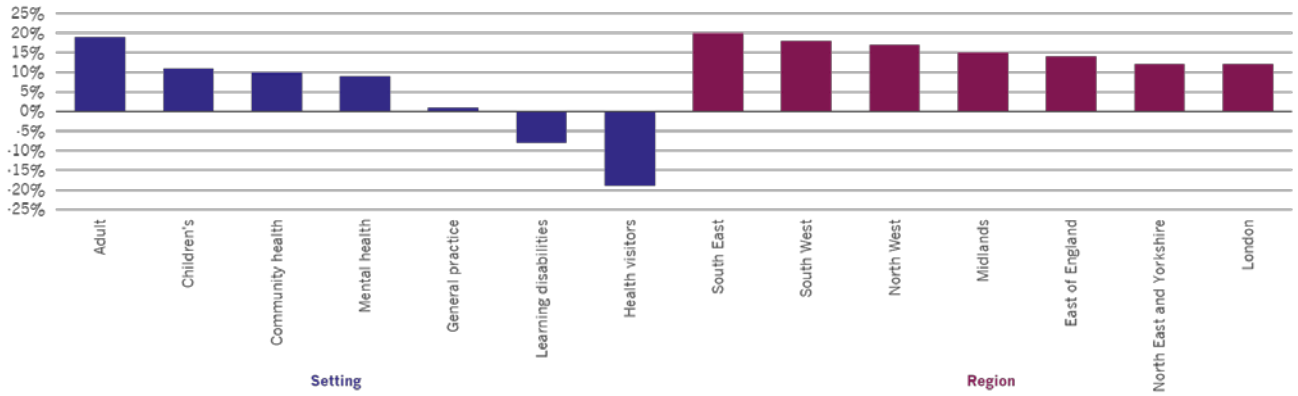


41. Despite rising demand, there were 5 per cent fewer nurses working in the community in September 2023 than September 2009[273]. During the same period, hospital nurses working with adults increased by 35 per cent and for children's hospitals, there has been a 75 per cent increase in nurses[274]. Analysis published by the NHS Confederation shows that for community services, spend is not correlated with needs (in a way that it is for primary care, mental health services, and acute hospital services)[275]. There is, therefore, an unfair postcode lottery in community services.

42. The Health and Social Care Act moved the commissioning of public health services to local authorities. As we have seen, the public health grant has fallen by more than 25 per cent in real terms. This has had a particular impact on Health Visiting,

where numbers of health visitors have fallen by nearly 20 per cent since 2019, as the chart below shows. Given the extensive evidence base on the importance of the first 1,000 days of life[276]; it is clear the NHS is missing an opportunity to intervene early.

Figure VIII.4.5: Change in the number of nurses in hospital, community and general practice settings, December 2019 – September 2023

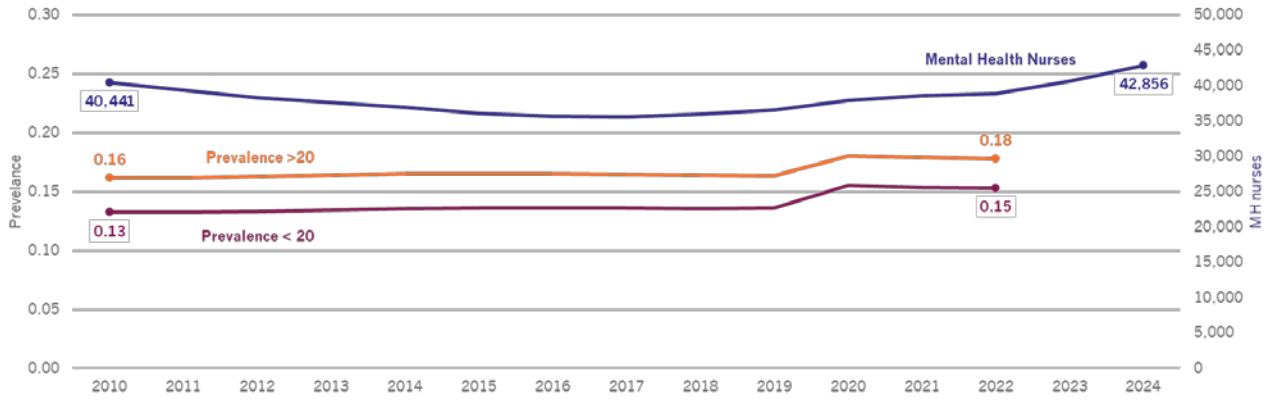


43. The lack of data makes it difficult to assess the productivity of community services. It means the unit costs and minimum efficient scale are poorly understood. This is particularly true with assumptions that subscale outpatient clinics are cheaper when delivered out of hospital. A modest reduction in capital costs is dwarfed by an increase in operational costs since scale efficiencies cannot be achieved. Simply shifting the setting of care without changing the care model will have a poor return on investment[277].

Mental Health services

44. Despite rapidly rising mental health needs of children and young people and working age adults, the overall mental health workforce reduced by 9.4 per cent between 2010-11 and 2016-17[278]. The number of mental health nurses dropped by 13 per cent between 2009-10 and 2016-17[279]. The workforce then expanded by 26.5 per cent between the start of 2017-18 and the end of 2023-24[280]. But the number of mental health nurses only returned to their 2009-10 level by 2023-24[281]. There remains a wide gap between need and resources[282], which explains the problems for people who need access to services.

Figure VIII.5.2: Prevalence of mental disorders by age group – England vs Mental Health Nurses



45. There has been a particularly concerning drop in the number of learning disabilities nurses. Since 2010-11, the number has declined by 44.1 per cent on average, and by even more in some regions, as we can see in the following chart[283]. As we have seen, there are serious concerns about very wide disparities in life expectancy for people with learning disabilities. This deserves further investigation.

Figure VIII.5.3A: NHS Hospital & Community Health Service (HCHS) Mental Health Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region

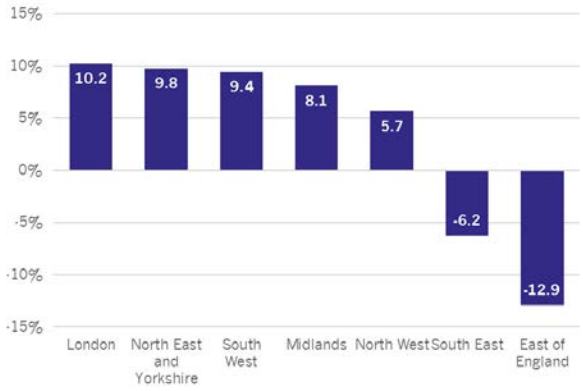
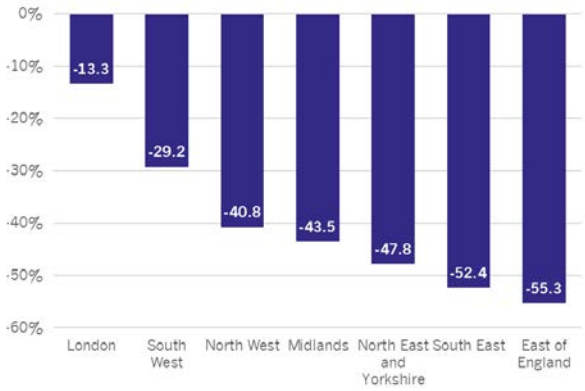


Figure VIII.5.3.B: NHS Hospital & Community Health Service (HCHS) Learning Disability Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region



46. More comprehensive mental health data has only been recorded since 2016, and insufficient data is recorded to make definitively assessments of productivity. Nonetheless, a number of local estimates of productivity have been shared from different areas of the country. These seem to suggest that productivity has remained broadly constant, meaning that the increase in resources has resulted in a similar rise in activity.

47. In common with community services, there has been chronic underinvestment in technologies that could improve the efficiency of mental health community teams. Technology platforms that allow for automated route planning and easy-to-use data recording have existed for at least 15 years but are still a novelty in the NHS. It is

said that productivity has not dropped—but neither was it likely to be high to begin with, given the poor use of technology and the absence of sufficient management information to drive up performance.

48. There are perpetual access problems for inpatient services. As we have seen above, difficulties in finding mental health beds contribute to long waits for patients with a mental health flag at acute hospital emergency departments[284]. This means patients are kept waiting in an environment that is not suitable to their needs and as high-stress places, could exacerbate a mental health crisis. Moreover, the data shows that having brought down the number of inappropriate out-of-area placements between 2019 and 2002, numbers have started to rise again, reaching nearly 6,000 in 2023[285]. This is a worse result for the patient and a higher cost for the NHS, meaning a significant hit to productivity.

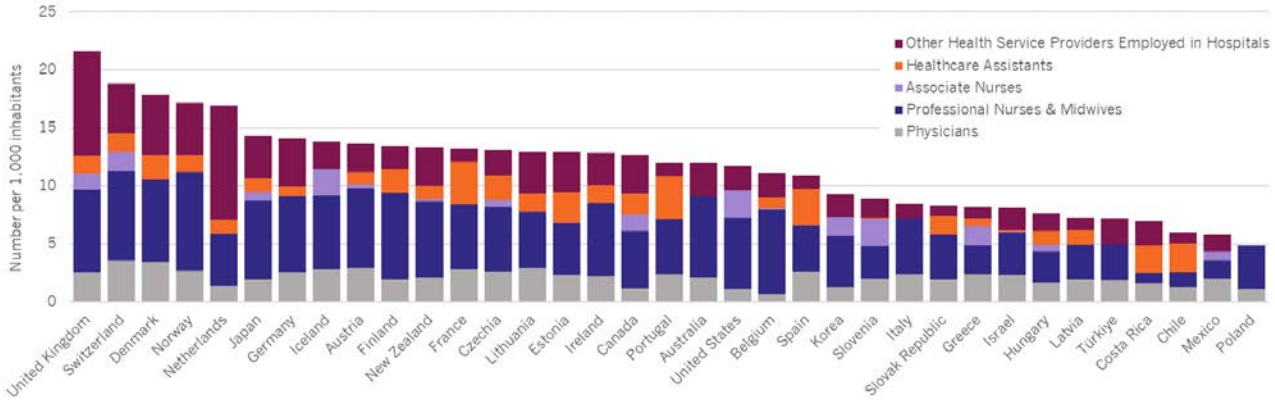
49. There is a fundamental problem in the distribution of resources between mental health and physical health. Mental health accounts for more than 20 per cent of the disease burden[286] but less than 10 per cent of NHS expenditure[287]. This is not new. But the combination of chronic underspending with low productivity results in a treatment gap that affects nearly every family and all communities across the country[288].

Acute hospital services

50. The hospital workforce has expanded very significantly in recent years, rising 17 per cent between 2019 and 2023[289]. On first examination, the UK appears to have the highest level of hospital employment in the world[290], and when looking at a narrower part of the healthcare team—doctors, nurses, and midwives—the UK is ranked fourth highest among OECD countries[291].

51. We treat this data with caution, even though it is taken from official statistics. The Office for National Statistics (ONS) submits data on behalf of HM Government to the Paris-based, intergovernmental Organisation for Economic Cooperation and Development (OECD). The NHS provides the source data to the ONS. We speculate that it may include staff working in the community but employed by acute hospital trusts. Should this be the case, then the inability to even distinguish community staff in official statistics suggests that insufficient priority has been given to them. Without accurate and frequent measurement and recording, it is surely impossible for the NHS to know whether or not its strategy is succeeding.

Figure VIII.6.1: All healthcare workers employed in hospitals per 1,000 inhabitants, 2022 (or nearest year)



52. This dramatic expansion of the hospital workforce, rising by 17 per cent between 2019 and 2023[292], has come at the expense of other settings of care, as the proportion of the total NHS budget dedicated to acute hospitals has continued to rise, partly driven by costs incurred by the pandemic[293], even as the NHS's stated strategy has been for resources to shift to the community.

53. Despite this significant flow of resources into hospitals, output has not risen at nearly the same rate. The result is that a large productivity gap has opened up. Overall, hospital productivity is at least 11.4 per cent lower now than it was in 2019[294], which is a reason why it is taking longer to tackle the big increase in waiting times in recent years (alongside the decisions to cancel more hospital activity than any other comparable health system during the pandemic[295].
Looking across clinical workforce crude productivity metrics, a pattern is readily apparent: productivity has fallen (see the chart below)[296]. The number of clinicians for each bed has increased by 13 per cent, while key measures have declined. A&E attendances per emergency medicine clinician are down 23 per cent; outpatient appointments per consultant are down 10 per cent; and surgical activity is down 15 per cent.

54. At the same time, many frontline clinicians say they are working harder than ever. This appears to present a paradox. But it is possible for both to be true at the same time: productivity is not a measure of effort, but of value creation. And, as we shall see, the central problem is that patients are not flowing efficiently through hospitals anymore and neither have we upgraded the infrastructure – diagnostic scanners, operating theatres and so on – with which they work. That slowdown in flow generates more non-value adding work and less output.

Figure VIII.6.11A: Clinical WTEs per G&A bed

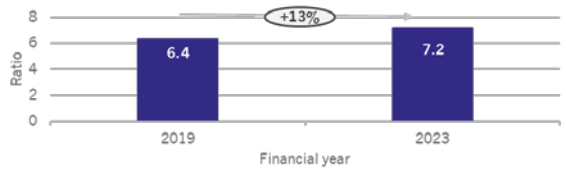


Figure VIII.6.11B: Non-admitted emergency activity (per calendar day) per medical emergency medicine WTE.

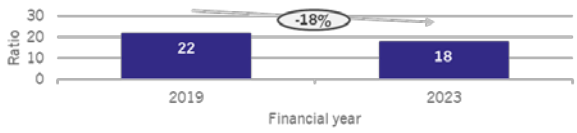


Figure VIII.6.11C: Outpatient attendances (price-weighted, per working day) per consultant WTE

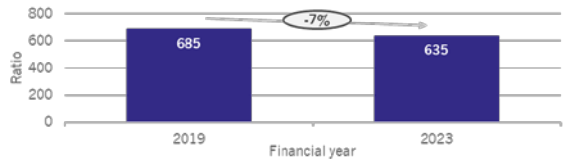
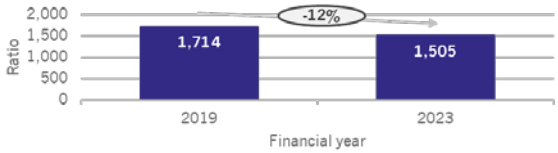


Figure VIII.6.11D: Surgical specialty spells per medical WTE in surgical specialties

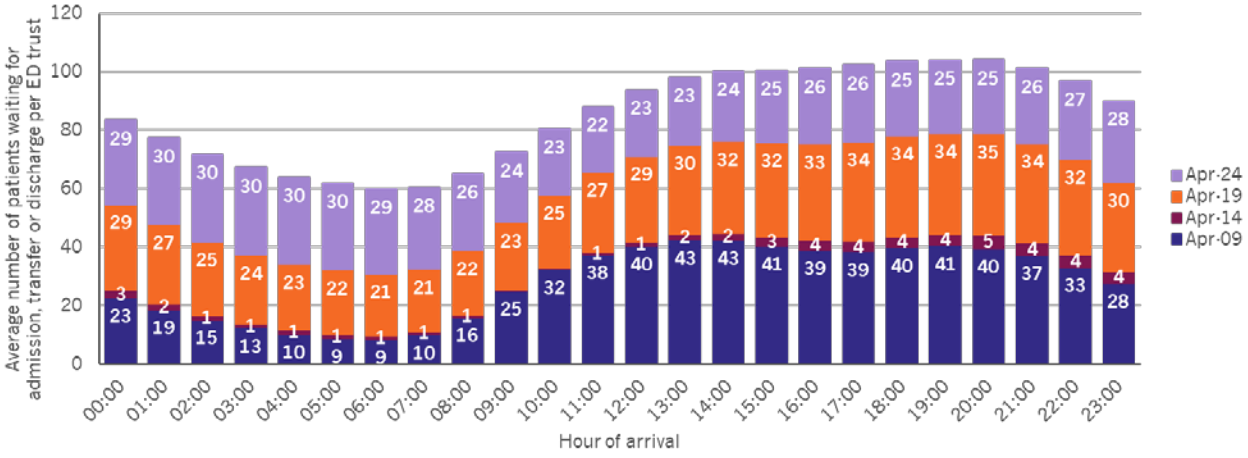


Congested hospital emergency departments

55. The data shows a significant rise in attendances at hospital emergency departments[297]. This is the result of push and pull factors: the failure to invest in primary, community and mental health services outside of hospital has pushed people towards them. Patients flocking to hospitals is also the inevitable consequence of concentrating resources within them that creates a pull of its own.

56. New analysis prepared for this report shows that had a patient arrived at a typical A&E on an average evening in 2009 (when sufficiently detailed data began to be collected to make this analysis possible) there would have been 39 people waiting in the queue. By 2024, this had increased to more than 100 people waiting at an average A&E department on a typical evening, as shown in the chart below[298].

Figure VIII.6.12: Average number of patients arrived but not admitted, transferred or discharged per A&E Trust, A&E CDS & ECDS

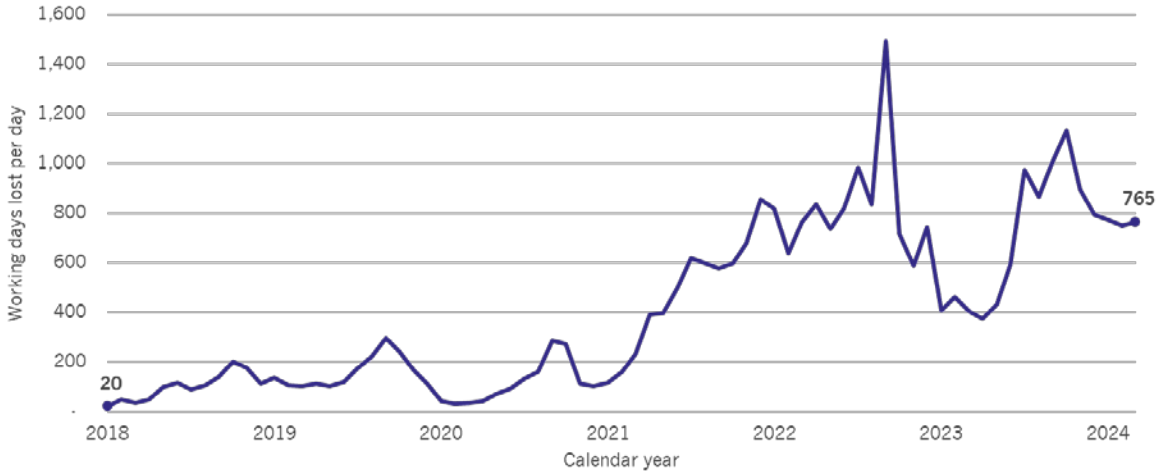


57. A significant proportion of people presenting at emergency departments are those that say they were unable to get a GP appointment[299]—or perhaps they *believed* that they could not and so did not try. The number of GP appointments has increased significantly[300], even as the number of GPs on a population basis has declined. This appears, therefore, to be a capacity rather than a performance issue.

58. As attendances have risen and emergency departments have become more congested, waiting time performance and productivity have declined. The rate of attendance at emergency departments in the UK is double that of the Netherlands, and the second highest in a group of comparator countries[301]. As we have set out above, the Royal College of Emergency Medicine has shown that very long waits are a serious quality of care issue, since they appear to lead to higher mortality[302]. They also lower productivity, as they necessitate clinical activities that would never have occurred without the wait, for example, providing pain relief to patients stuck waiting in corridors.

59. Congested emergency departments also reduce the productivity of ambulance services. A huge amount of time is lost to handover delays[303] where ambulances arrive at emergency departments but there is no space for their patients. In 2024, around 800 working days, each day, have been lost to these delays[304], which are only counted when they exceed 30 minutes. In aggregate, it is the full-time equivalent of nearly 1,400 paramedics over the course of a year[305]. By tying up paramedics and their vehicles, it contributes to the significant increase in ambulance waiting times.

Figure VIII.6.13: Working days lost per day due to ambulance handover delays, England (assumes 7.5 hours lost is equivalent to a working day lost for two staff)



Slow flow of patients through hospitals

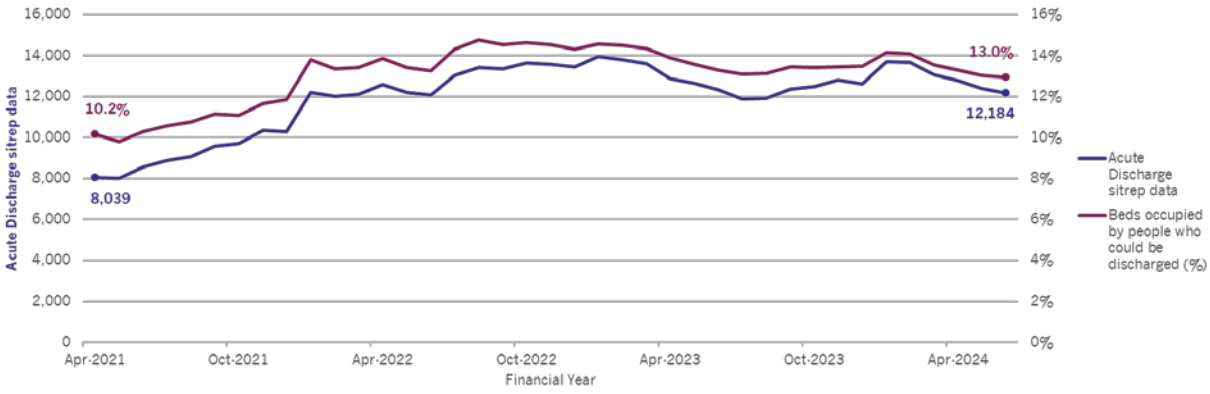
60. The inability of patients to flow through emergency departments results from the capacity of the departments themselves, both workforce and physical space, as well as from elsewhere in the hospital, such as the availability and speed of diagnostics and the availability of beds for admission[306]. At its core, this is a result of the intersection of high levels of demand (caused by the lack of investment in the community[307]), chronic capital underinvestment in both facilities and technology[308], combined with operational planning and management issues.

61. Underinvestment in diagnostics extends the stay of patients in hospital, as we have seen[309]. Despite the first clinical use of MRI taking place in an NHS hospital, the health service has far fewer MRI and CT scanners than comparable countries[310]. Moreover, many of the machines are old[311]: this means that they are less powerful and so take longer for each scan and that more time is lost due to breakdown and maintenance.

62. The chronic lack of capital investment and cost-improvement targets set alongside imperatives to increase clinical staffing levels means that hospital managers are always under pressure to reduce beds. The result is that the number of beds has fallen more quickly than length of stay, putting many hospitals into a perpetual bed crisis, and damaging productivity. National planning guidance required hospitals to reduce occupancy from 94 per cent to 92 per cent[312], but even at the reduced level it will inevitably cause occupancy to exceed 100 per cent during peak periods such as a particularly cold snap during winter.

The most immediate solution to hospital capacity issues is to address delayed discharges. This would free up beds and get patients flowing through hospitals again. As the chart shows[313], up to 13 per cent of hospital beds could be freed up if patients could be transferred to appropriate nursing homes or other care facilities.

Figure VIII.6.18: Beds occupied by people who no longer meet the criteria to reside, April 2021 to June 2024



63. Falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds. A low productivity system creates a worse experience of work for staff, as well as increasing waiting times for patients.

Systems

64. Wide variations in performance by providers within the same settings, in similar as well as different areas of the country, shows that there is plenty of scope for improvement for many organisations[314]. At the same time, many of the productivity problems in the NHS are caused by the interaction between different parts of the system. The only sustainable solution to congestion in acute hospitals, for example, is to build up the capacity, capability, infrastructure and technology base of care that is delivered in the community, including general practice, community services, and mental health services. By keeping people well for longer, they are less likely to need hospital treatment.

65. Yet the current distribution of resources is perpetually reinforced: performance standards are focused on hospitals, not on primary care, community services or mental health, as is measurement. Single-year budgets necessarily reinforce the status quo—and when things go wrong the knee-jerk response is to throw more money at hospitals where the pressure is most apparent as waiting areas fill up and

ambulances queue outside. Indeed, the system produces precisely the result that its current design drives. And in the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.

66. Given the very significant increase in resources in acute hospitals[315], it is implausible to believe that simply adding more resource will address performance. One large hospital trust I visited had expanded its workforce by nearly a fifth from before the pandemic to after it, while its yearly elective care activity (routine operations such as knee replacements) was up by just 0.3 per cent. Low productivity is both a provider and a system problem that will require a systemic solution.

* * *

67. There are no easy solutions. Fundamental reform will be needed to improve where and how the NHS budget is spent so that the highest quality care can be delivered in the most timely and efficient way to all people who need it, all of the time.

68. A starting point, however, would be to increase transparency into the activity, workforce, spending and therefore productivity in each setting of care. By making this information freely available to all in an easy-to-access format, it would empower clinicians and managers to create insights that allow action. But it will require a step-change improvement in data quality for community and mental health services in particular.

69. As a Nobel prize winning economist once observed, productivity isn't everything, but in the long-run, productivity is almost everything[316]. And that's because a productive NHS can mean high quality care for all—and right now, too many are waiting too long for its help.

6

Health and prosperity

1. The NHS is an important part of the national economy, so its performance and productivity directly impacts economic performance. Health and care is one of the most important sectors of the economy. It has increased as a share of gross value added from 6 per cent in 2001 to 8 per cent in 2023, a 33 per cent rise in just over 20 years[317]. And the NHS accounted for 43 per cent of all-departmental government spending in 2023, up from 26 per cent in 1998-99[318] so it is an important destination for tax receipts.

2. The Commission on Health and Prosperity, which I co-chair, describes how health and prosperity are mutually reinforcing[319]. Healthier workers are more productive, and the UK has a strong life sciences sector which drives innovation and exports. We now explore how well the NHS is supporting the nation's prosperity.

Work and health

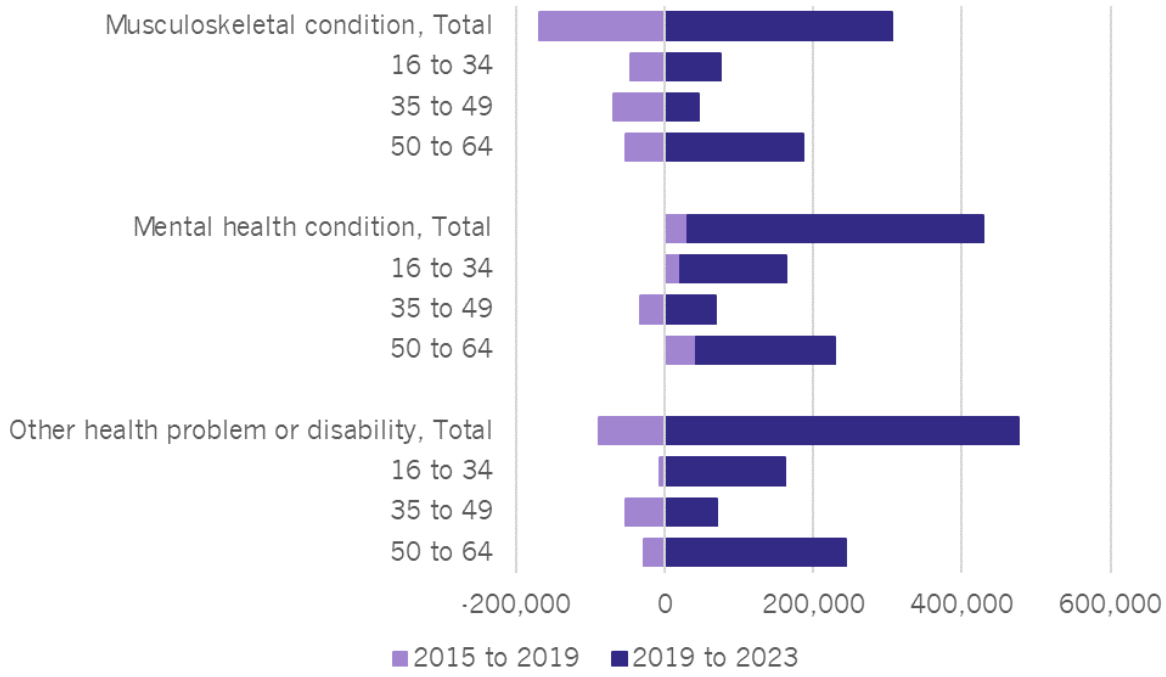
3. The health of our economy is dependent on a healthy workforce. There are many reasons why people are economically inactive, including education, retirement, disability or caring responsibilities. The number of people who are economically inactive because of long-term sickness has risen to record highs[320]. Long-term sickness as a proportion of those who are economically inactive decreased during the 2000s, stayed constant in the 2010s and then increased sharply during and after the COVID-19 pandemic (2020-24)[321].

4. At the start of this year, long-term sickness was the most common reason why people were out of the workforce, accounting for 30 per cent of the total or some 2.8 million people[322].

5. Most of the recent rise in long-term sickness is being driven by mental health conditions, especially for two main age groups: 16 to 34 year olds and 50 to 64 year olds. The fastest growth in long-term sickness absence was for 16 to 34 year olds, with growth of 9.5 per cent between 2015 and 2019, rising to a staggering 57.1 per cent between 2019 and 2023[323].

6. For musculoskeletal conditions and other health problems or disabilities, the previous downward trend in long-term sickness absence between 2015 to 2019 was replaced with significant growth between 2019 to 2023[324]. Worryingly, younger people are most adversely affected; long term sickness absence for people aged 16 to 34 with musculoskeletal conditions declined at an annual rate of 9.7 per cent in 2015 to 2019 before growing 16.4 per cent between 2019 to 2023[325].

Figure IV.2: Change in the number of people aged 16-64 in the UK who are economically inactive due to long-term sickness by age and main or secondary health condition, 2015 to 2019 and 2019 to 2023



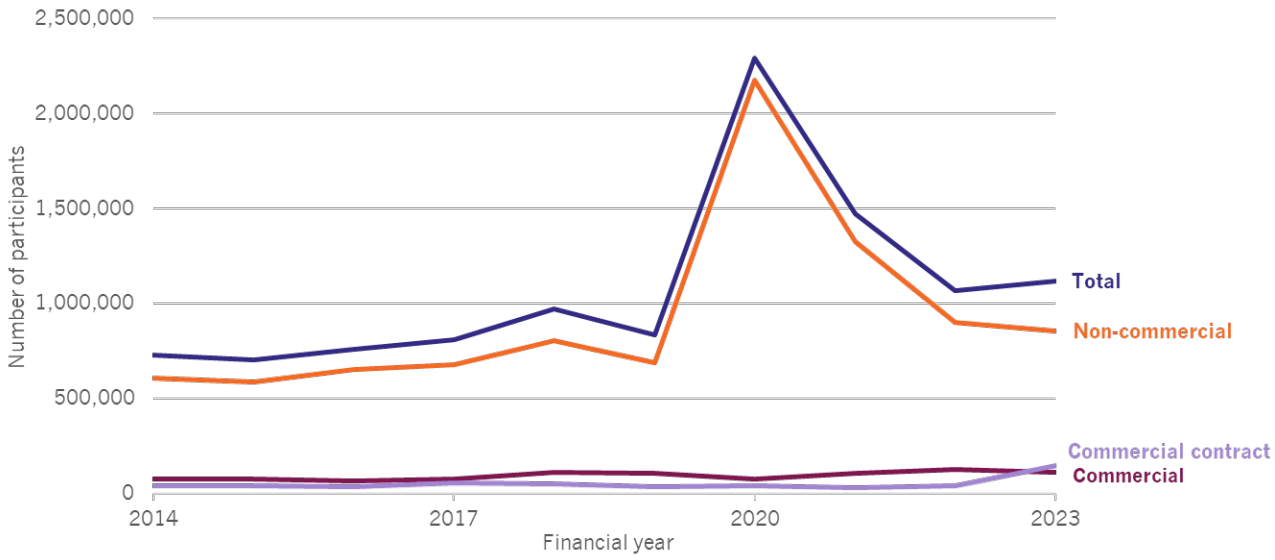
7. Being in work is good for wellbeing[326] and having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work. As we have seen, however, there are long waiting lists for both mental health services and for musculoskeletal (MSK) services. Improving access to care is a crucial contribution the NHS can make to national prosperity.

A scientific superpower

8. The NHS and the life sciences sector make important contributions to one another that benefit both: innovations improve the effectiveness of treatments and offer hope where treatments have not existed before. During the pandemic, it was the Recovery trial in the NHS that discovered the benefits of dexamethasone for patients with severe Covid—that discovery went on to save one million lives globally[327]. From the first clinical use of MRI to the Oxford-AstraZeneca vaccine to dexamethasone, there is much in the past and present to celebrate in the NHS' rich history of collaboration with life sciences.

9. The number of participants recruited into studies held fairly steady between 2015 and 2019, followed by a sharp spike during the Covid-19 pandemic. Yet this decreased dramatically in 2021 and in 2024 the number of participants recruited to studies dropped although remained slightly above the pre-pandemic baseline[328].

Figure IV.3: Number of participants recruited into studies in the UK held on the National Institute for Health and Care Research (NIHR) Clinical Research Network's Central Portfolio Management System (CPMS), 2014/15 to 2023/24



10. Commercial clinical trials are the lifeblood of the life sciences industry. As life sciences is a globally competitive industry, how the UK compares to others is vitally important. The UK ranked fourth in the number of industry clinical trials initiated in 2021 behind the USA, China and Australia[329]. This position is under threat as countries like Spain increase their clinical trials capacity. Lord O'Shaughnessy's review of commercial clinical trials found that the process for establishing trials in the UK needs to be made simpler and faster to maintain competitiveness.[330]

11. What's more, there are declining numbers of clinical academics practising in the NHS. This is a worrying trend. Clinical academics bring together research and practice and have a vital role in delivering each. They are an essential resource in bridging the gap between research and clinical practice so that research focuses on the areas of greatest need and patients in the clinic benefit from breakthroughs faster.

12. For the NHS, partnerships with the life science sector for research or treatment too often fall into the category of 'important but not urgent'. It is doubtful that there is an NHS leader in the country who would not recognise that research and innovation are important. It has simply not been a high enough priority in a world where waiting lists are long, and finances are tight. But in the medium term, it is innovation that can make the NHS more sustainable.

A Greener NHS

13. The World Health Organisation has described the climate crisis as the "single biggest threat facing humanity"[331]. The NHS is a large contributor to England's carbon footprint (4 per cent) and we must play a part in our national drive to net zero[332]. The NHS has set ambitious targets of reaching net zero by 2040 for its direct emissions and 2045 for wider emissions such as those of suppliers. The impact of climate breakdown will be felt more directly, such as the health impacts of heatwaves.

14. Important progress on carbon reduction has been made in recent years, through reducing emissions across the NHS estate, reducing the carbon footprint of clinical care, and decarbonising the supply chain, but it will become more challenging as easier reductions are made first. Through its participation in the public sector decarbonisation scheme, projects in the NHS are set to reduce the energy bill for the health service by £260 million a year and cut nearly 3 million tonnes of carbon over the lifetime of the programme. According to polls, there is public support for this agenda. But that support has declined recently, most likely due to concern over problems with access to care[333].

15. Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health. The NHS has the second largest fleet (after Royal Mail), in the country, consisting of over 20,000 vehicles travelling over 460 million miles every year—and electrifying the NHS fleet is set to

save the NHS over £59 million annually[334] while cleaning up the air. Active travel reduces emissions and improves cardiovascular health.[335]

* * *

16. In part I, we have seen how the NHS is performing in terms of access to services, quality of care, public health and inequalities, its distribution and use of resources and its contributions to national prosperity. These have been examined in the context of the health of the nation. We now turn to the drivers of performance, in an attempt to understand why the NHS is so far from peak performance.

Part II

Drivers of performance

7

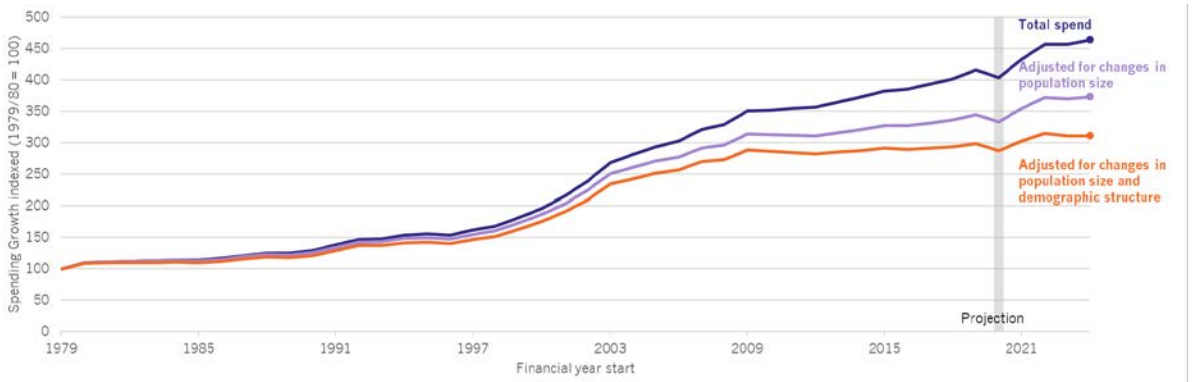
Funding, investment and technology

1. In this chapter, we explore whether the NHS has had the resources it needs. We look at the revenue funding that pays for things like wages, medicines, and all the other day-to-day expenses of the NHS. We then turn to capital investment – examining spending on diagnostic scanners or modern buildings – that is the engine of a more efficient NHS. We then turn to digital technology and explore how well prepared the health service is for the future.

NHS revenue funding

2. Apart from the exceptional funding boost in the Covid period, since 2010, NHS funding has increased by just over 1 per cent in real terms each year. This compares to the long run average annual increase of around 3.4 per cent, and a per person increase of 5.8 per cent a year in the first decade of this century[336]. The 2010s, in the run up to the pandemic, were the most austere decade since the NHS was founded in 1948. Such increases have essentially left funding flatlining, once adjusted for changes in population numbers and changes in population age structure.

Figure V.1.1: Real Terms spending on the NHS in England adjusted for population size and demographic profile

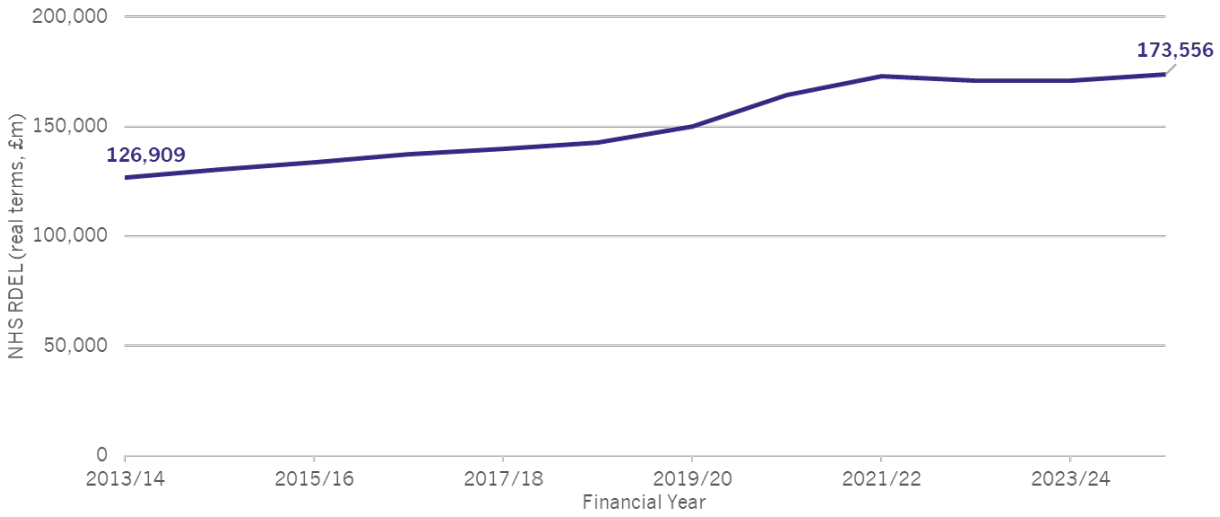


3. It was not until 2018, with a new prime minister, that the then health secretary and NHS chief executive were able to negotiate for a return to the NHS' long-term

average spending increases of 3.4 per cent[337]. When it was announced, the prime minister noted that "increases in health funding have often been inconsistent and short-term – creating uncertainty over what the funding position will be in as little as two years' time. This has led to a system of planning from one year to the next, preventing much needed investments in technology, buildings and workforce"[338].

4. In common with other advanced countries, health system funding surged dramatically during the pandemic. This meant that whereas in 2019 the UK was spending a similar share of GDP on health as EU15 and Nordic countries (approximately 10 per cent[339]), by 2022, it was spending relatively more (amounting to some 11 per cent of GDP[340]), and its comparators were other countries where English is predominantly spoken[341]. But the funding promised in 2018 did not materialise, and between 2019 and 2024 funding actually increased just under 3 per cent a year in real terms between 2019-20 and 2024-25[342].

Figure V.1.2: Resource DEL (exc. depreciation) NHS England – real terms (£m), 2013/14 to 2024/25

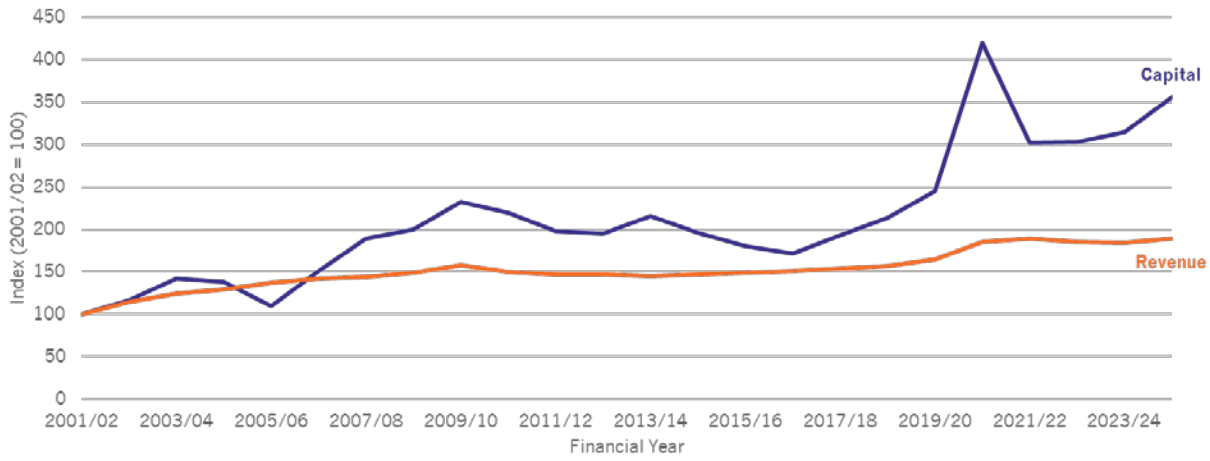


5. When analysed per person at purchasing parity, the UK spends about the same as other European countries ($5,600 compared to an EU15 average of $5,800). But we spend substantially below both countries where English is predominantly spoken and the Nordic countries, which spend about $1,900 and $900 per person more respectively[343]. This reflects differences in the performance of the economy overall (in those countries, GDP per capita is higher[344], so the same percentage share translates into higher spending).

The shortfall in capital investment in the NHS

6. During the 2000s, capital investment increased markedly, such that by 2007, the UK was investing more than the average of the EU15 and continued to do so until 2010[345]. Investment peaked in 2009 at 0.54 per cent of GDP. From then onwards, capital investment sharply declined[346]. By 2013, it stood at just 0.26 per cent of GDP, less than half of its 2009 high and well below peer countries. It then increased incrementally until the Covid-19 pandemic[347]. In the NHS, capital spending per person increased at 9.1 per cent a year in the first decade of the century, falling to 1.2 per cent in the 2010s, before rising to 7.8 per cent per year during the pandemic, as shown below[348].

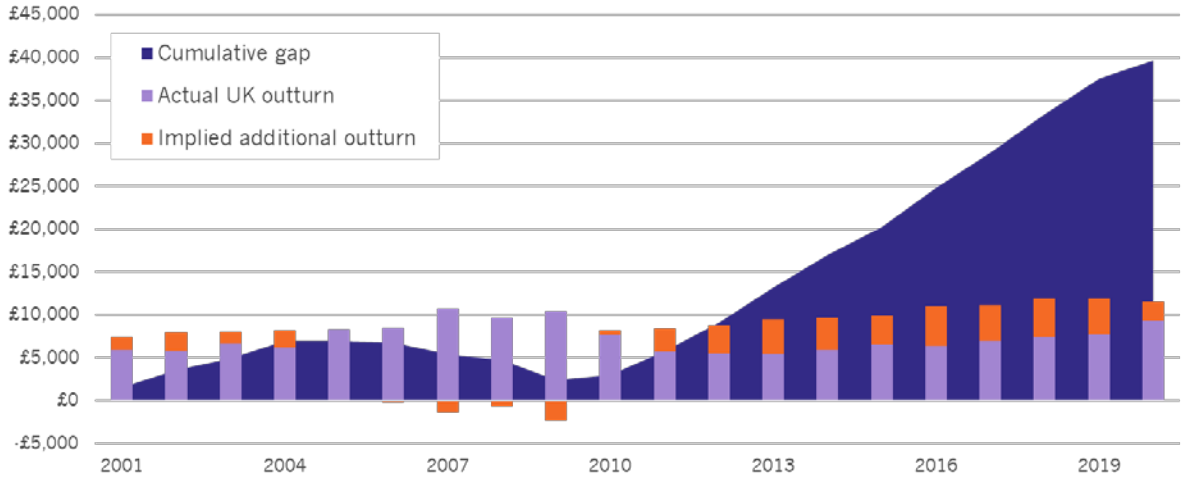
Figure V.2.4: Total NHS spend per person – revenue and capital, 2001/02 to 2024/25



7. New analysis prepared for this investigation has looked at what we would have invested, had the UK matched international benchmarks in the two decades since 2001 (shown in the chart below, in 2020 prices)[349]. Had the UK matched EU15 or Nordic levels of capital investment from 2001 to 2010, it would have actually invested slightly less; had it matched levels of investment in predominantly English-speaking countries, it would have invested substantially more[1]. So, capital investment was somewhere in the middle – similar to the Nordics, more than the EU15 and less than countries such as Australia or the United States.

[1] OECD capital investment data across countries relates to 'gross fixed capital formation' – that is, the purchase of assets (for example, buildings and scanners) minus the sale of assets in that year. Research and development spending may be counted if it involves the purchase or sale of an asset or leads to intellectual property. Private Finance Initiatives and all other private capital spending in health care may be included.

Figure V.2.5: Cumulative capital gap UK vs peers, £ millions, constant 2020 prices

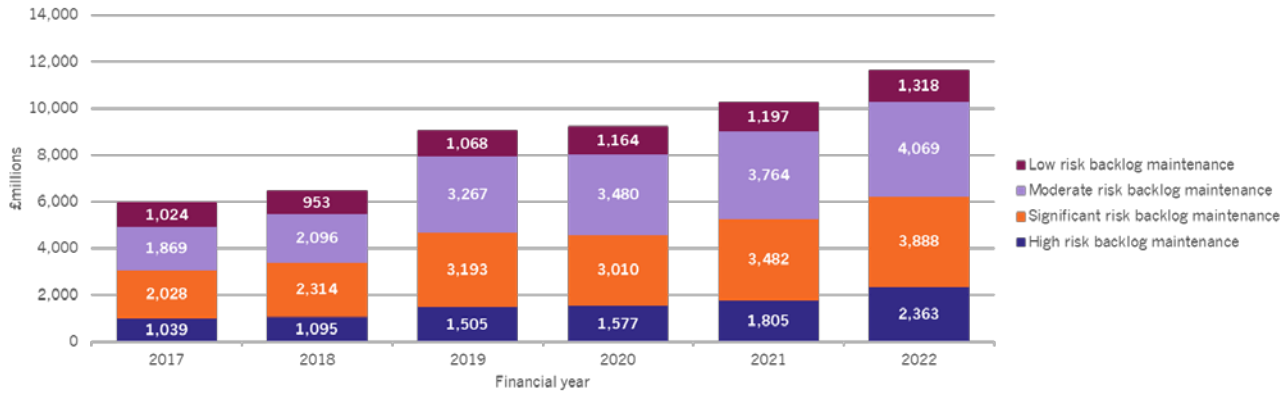


8. During the 2010s, a staggering capital gap opened up between the UK and other countries. There would have been £27 billion more capital investment, had we matched the EU15, £35 billion more had we matched the Nordic countries, and £46 billion more had we matched the investment levels of predominantly English-speaking countries[350]. Had we matched the average of all peers, this would have amounted to an additional £37 billion[351].

9. This could have eliminated all backlog maintenance (now standing at £11.6 billion in 2022)[352] and have already funded the 40 new hospitals announced in 2019 before the pandemic hit[353]. The £37 billion to match the all-peers' average alternatively amounts to some £4.9 million for every GP practice[354], so it could have paid for every community in the country to have a purpose-built, modern GP practice complete with diagnostics, space for specialist input, and a base for mental health and community services.

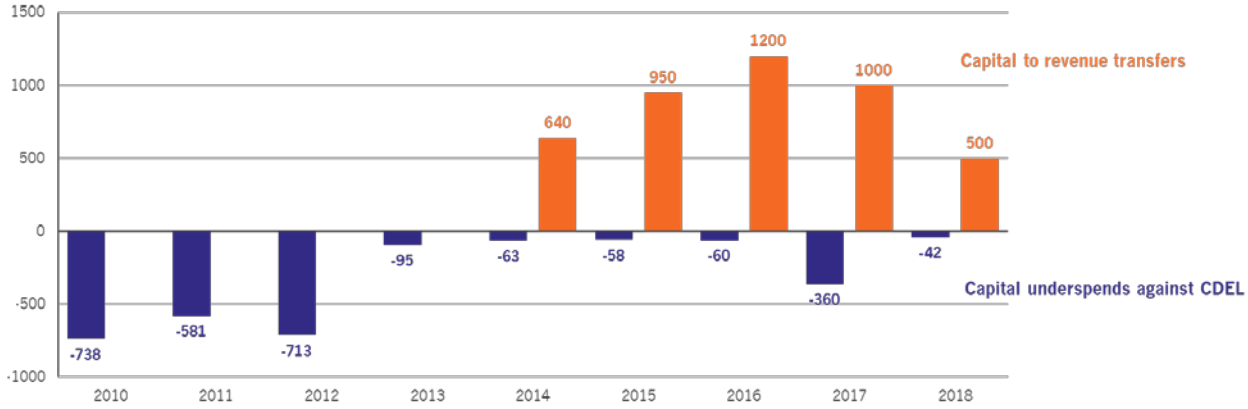
10. From HM Treasury to NHS provider trust, the capital regime is widely recognised to be dysfunctional; the Hewitt Review was the most recent call for it to be overhauled[355]. Capital expenditure limits are imposed on NHS trusts by HM Treasury that cannot be exceeded, even if the funds to make such investments are available. And the capital approvals process is so byzantine that it is hard to find an NHS senior manager who understands it. It has left much of the NHS estate crumbling, notably in primary care, with a backlog of maintenance across the service that amounted to £11.6 billion in 2022, as the chart below shows.

Figure V.2.13: Backlog Maintenance - Actual



11. The result is that the NHS routinely underspends its capital allocation, despite it being insufficient to begin with. These underspends have been used to plug deficits in day-to-day expenditure, by switching from capital to revenue. The chart below shows that between 2014-15 and 2018-19, £4.3 billion was transferred from capital to revenue[356]. The Department of Health and Social Care and HM Treasury have effectively used the NHS capital budget as an informal reserve to protect against NHS deficits. This is obviously dysfunctional and stores up problems for the future.

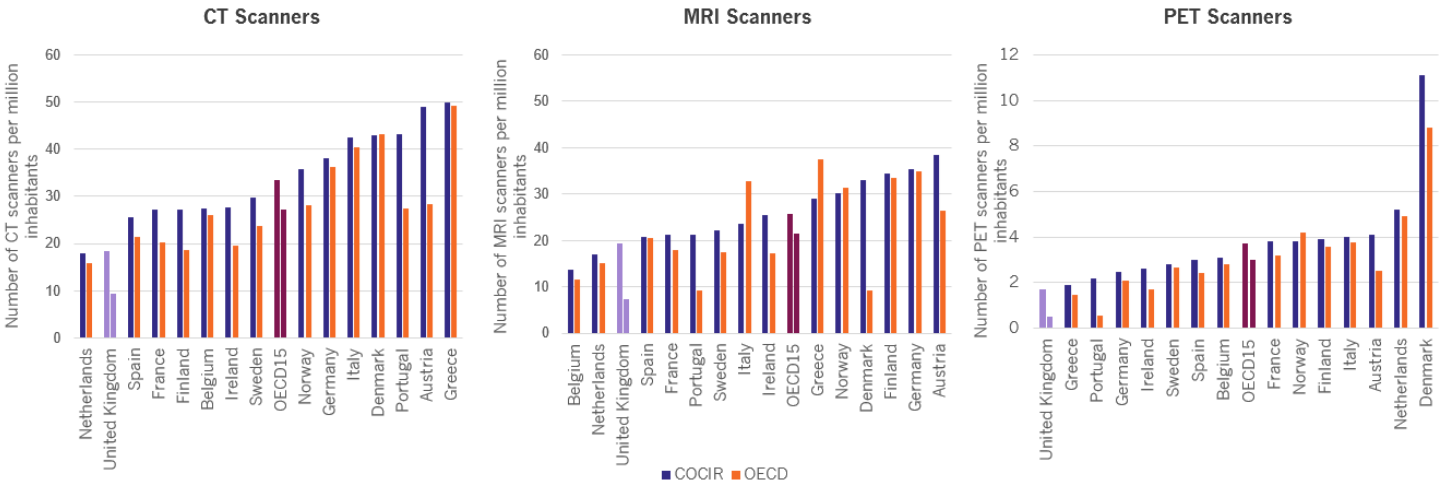
Figure V.2.6: Annual transfers from capital spending to revenue spending, and underspends against the capital limit, 2010-11 to 2018-19 (£ millions)



12. The outcome is that the NHS has been starved of capital, so the service has too few scanners, too little investment in digital automation in laboratories and pharmacy, and too little digital technology to support its workforce. One hospital chief executive described to us how his organisation had to reduce the number of operating shifts for MRI scanners from three daily to two daily, since the aged

machines would break down if used too intensively. Using both OECD and industry benchmarks, the UK is far behind other countries in the levels of CT, MRI and PET scanners for its population[357].

Figure V.3.1: Number of CT, MRI and PET scanners per million inhabitants, 2023 (or nearest year)

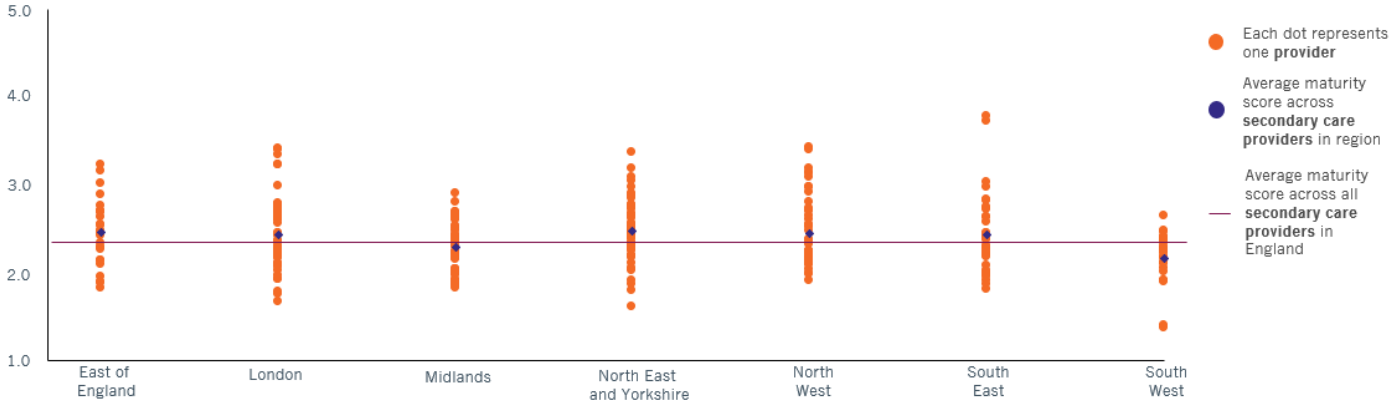


Technology

13. Over the past 15 years, many sectors of the economy, in this country and internationally, have been radically reshaped by platform technologies. From the way we shop, to the way we socialise and how our politics is conducted, technology has transformed daily life. By contrast, while there are many excellent examples of technology having an important impact in the NHS—from virtual wards to remote dermatology consultations—it has not radically reshaped services. The NHS remains in the foothills of digital transformation. Indeed, the last decade was a missed opportunity to prepare the NHS for the future and to embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'—a case that I made in my report *High Quality Care for All*, more than 15 years ago.

14. The NHS, in common with most health systems, continues to struggle to fully realise the benefits of information technology. It always seems to add to the workload of clinicians rather than releasing more time to care by simplifying the inevitable administrative tasks that arise. The extraordinary richness of NHS datasets is largely untapped either in clinical care, service planning, or research. As the chart below shows, digital maturity is still low across much of the NHS.

Figure V.3.5: Digital Maturity Assessment secondary care provider scores (out of 5)



15. The NHS has made some significant investments, such as the Federated Data Platform, which have great promise and have started to show some impact locally[358]. Similarly, there are dozens of examples of start-ups that have created apps that improve the quality and efficiency of care[359]. But too many of these remain subscale. And as we have seen, the NHS App is not currently living up to its potential impact given the vast scale of its registered user base.

16. Investment in information technology continues to focus on acute hospitals, rather than other providers, as shown in the chart below[360]. Take community-based services such as district nursing or mental health home treatment. Technology platforms that have existed in the private sector—such as automated route planning—for more than 15 years are rarely found in the NHS. There are many possible technologies that would support more efficient, higher quality, safer care in the community. But they are largely absent. Given the shift in the disease burden towards long-term conditions, there is a greater need for information systems that work across different settings.

Figure V.3.4: IT capital investment per clinical FTE by NHS provider type (cash terms), England

17. While there are some examples of breakthroughs, the NHS has struggled with data-sharing to support higher quality care. The Whole Systems Integrated Care dataset in north-west London is one example that integrates data at the patient level from all settings of care since 2013[361]. More recently, the OpenSAFELY programme[362], created in 2020, has built an extraordinary platform that integrates general practice data from across the country. Yet its enormous potential to transform care is largely untapped.

18. Similarly, we are on the precipice of an artificial intelligence (AI) revolution that could transform care for patients. A submission from the Royal College of Radiologists to the Investigation reported that 56 per cent of NHS trusts are already using AI tools within radiology[363]. From the discovery of new treatments to novel diagnostics and biomarkers to routine process automation, there are a multitude of ways in which the health service could see extraordinary change. With its deep and broad datasets, and the global AI hub that has emerged in the UK, the NHS could be at the forefront of this revolution with NHS patients the first to see the benefits. But to capture those opportunities, there will need to be a fundamental tilt towards technology.

* * *

19. A core tenet of industrialisation that transformed our prosperity in the 19th and 20th centuries was increased use of capital relative to labour to drive up productivity. In recent years, it appears that the NHS has been subjected to a kind of capitalism-in-reverse: forced to increase labour relative to capital, rather than the other way round.

    The workforce has been rapidly expanded while its capital base has been artificially constrained, since the health service as a whole—as well as individual trusts—lacks the authority to decide how the NHS budget is divided between day-to-day spending on wages and consumables versus capital investment in digital technology, diagnostic scanners, or modern buildings.

    It is little wonder, then, that productivity has declined when capital per worker fell year-on-year during the 2010s[364]. But the period of capital starvation was to have a far more costly impact during the pandemic, as we shall see in the next chapter.

8

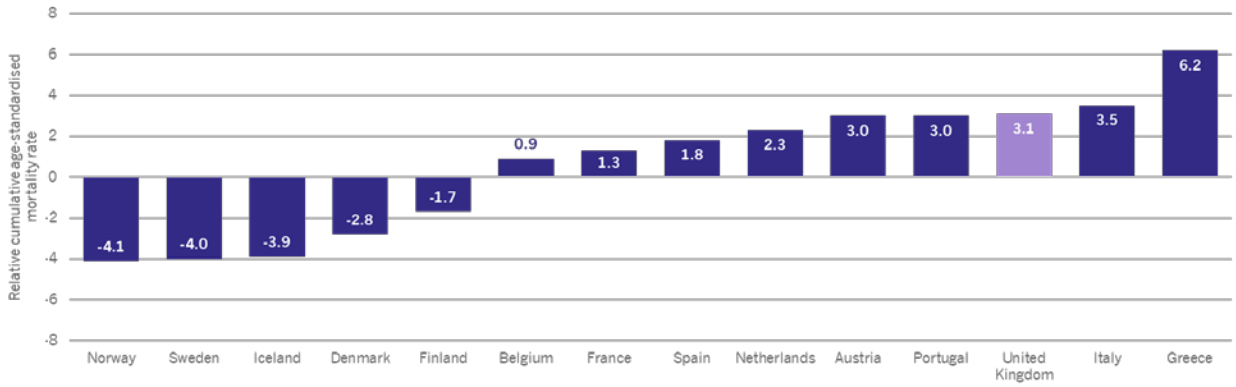
The impact of the Covid-19 pandemic

1. As we have seen, the NHS entered the pandemic after the most austere decade of funding in its history with chronic underinvestment in its infrastructure. In this chapter, we explore the impact of the Covid-19 pandemic on the NHS, and how its aftermath continues to affect the service today.

The impact of the Covid-19 pandemic

2. The Covid-19 global pandemic strained societies, economies, and health systems of every country on earth. Many lives were lost, including those of clinicians who were working at the frontline. It upended daily life for all of us. It was an unprecedented challenge in the modern era, that policymakers all over the world struggled to respond to. Analysis from the Health Foundation shows that, when measured by excess mortality, the UK did worse than many other comparable countries[365]. Indeed, as we can see in the chart below, cumulative excess mortality was amongst the highest of selected comparator countries[366].

Figure VI.2: Cumulative excess mortality, relative to the 2015 to 2019 average mortality rate, week ending 3 January 2020 to week ending 1 July 2022



3. One part of the explanation is the adequacy of the public health measures that were the direct response of the Government to the pandemic, which is the subject of the Covid-19 public inquiry. Yet as we have seen in chapter 1, the health of the

population had also deteriorated in the years preceding the pandemic. The population was, therefore, less resilient to infectious disease precisely because it was less healthy going into the pandemic. For instance, people with conditions such as obesity[367] or type II diabetes[368] were more likely to die from Covid-19.

The impact on the NHS

4. The resilience of the NHS was at a low ebb at the start of the pandemic. Analysis from the Nuffield Trust (updated with more recent data from the OECD and World Bank) shows that the NHS went into the pandemic with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems[369], as shown in the chart below.

Figure VI.3: International comparison of health system capacity going into the Covid-19 pandemic

	Practising physicians per 1,000, 2019	Practising nurses per 1,000, 2019	Hospital beds per 1,000, 2019	Occupancy rate of curative (acute) care beds, 2019	Total health spending, US dollars per capita, 2019	Average length of stay in hospital, 2019	Capital expenditure on health as share of GDP, average over 2015–19
UK	**3.0**	**8.2**	**2.5**	**89.1**	**4,268.7**	**6.7**	**0.4**
Australia	3.8	12.2			5,545.9	5.3	0.8
Austria	5.3	10.4	7.2	73.0	5,263.0	8.3	0.9
Belgium	3.4	11.6	5.6	72.5	5,049.6	6.0	1.0
Canada	2.7	10.0	2.5	91.6	5,116.0	7.6	0.5
Denmark	4.3	10.1	2.6		6,059.0		0.8
Finland	3.6	13.5	3.4		4,460.0	7.7	0.7
France	3.2	8.8	5.8	75.9	4,504.5	8.8	0.6
Germany	4.4	11.8	7.9	78.9	5,487.0	8.8	1.1
Ireland	3.3	13.4	2.9	89.9	5,462.7	5.9	0.4
Israel	3.3	5.1	3.0	91.6	3,354.0	6.7	0.6
Italy	4.1	6.2	3.2	78.1	2,911.0	8.0	0.4
Netherlands	3.8	10.8	3.0	63.7	5,341.0	4.4	0.9
Portugal	5.3	7.0	3.5	82.0	2,222.0	8.0	0.7
Spain	4.4	5.9	3.0	75.9	2,716.8	8.1	0.6
Sweden	4.3	10.9	2.1		5,653.0	5.6	0.6

Bottom third
Middle third
Top third

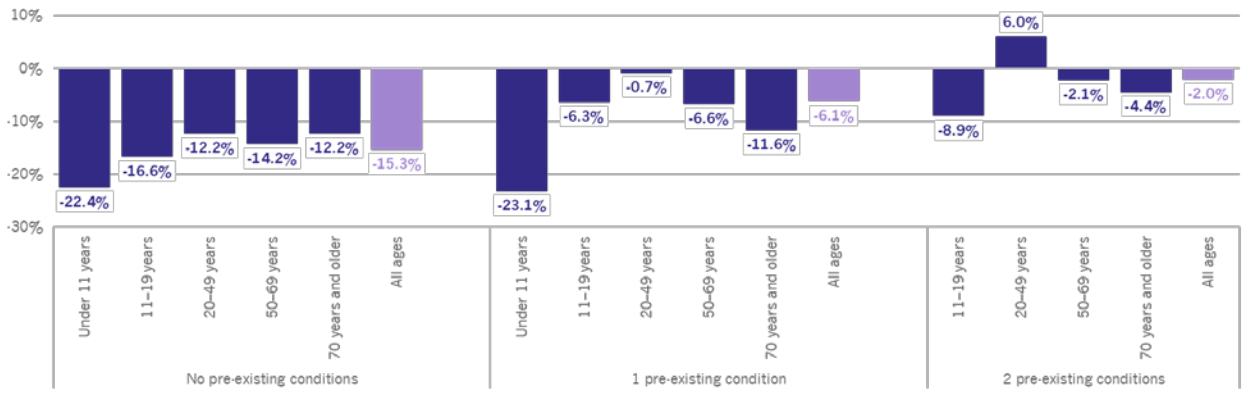
5. Countries with greater pre-existing capacity, and that more effectively contained coronavirus, were in a better position to cope with care backlogs arising from the pandemic and recover from its consequences. It is impossible to understand the state of the NHS today without understanding what happened to routine care during the pandemic as a result.

6. It is widely recognised that lockdowns caused a significant drop in the number of people accessing healthcare, both in this country and around the world. But what is not commonly understood is how much harder the NHS was hit than other comparable health systems.

7. Figures from the Health Foundation show that this impact was felt by people without health conditions as well as those with existing health conditions, as we

can see in the chart below[370]. Reductions in interactions with primary care meant fewer physical and mental health problems could be identified earlier[371] as the consultation rate fell by around 15 per cent for those with no preexisting conditions[372]. Moreover, for people with preexisting conditions it may well have meant a reduction in the early detection of deterioration and poorer adherence to medication. As we all know, the pandemic also led to a very significant increase in the need for mental health services[373].

Figure VI.4: Percentage change in consultation rate in 2020 compared to 2019, by number of pre-existing conditions and age



8. International comparisons show that the impact on the NHS appears far more severe than elsewhere. While almost all health systems that reported data saw significant falls in activity, the reductions were far greater in the UK than in almost all other similar countries with available data. Moreover, it is striking that the UK was an outlier, reducing its routine healthcare activity by a far greater percentage than any other health systems that recorded comparable data for areas such as hip or knee replacements, which fell 46 per cent and 68 per cent respectively[374] between 2019 and 2020. The UK also had the second greatest reductions in mastectomies which fell by 15 per cent compared to an OECD average of 9 per cent[375], which suggests that cancer treatment was also more significantly disrupted than other countries in the same time period.

Figure VI.6A: Hip replacement, percentage change between 2019 and 2020

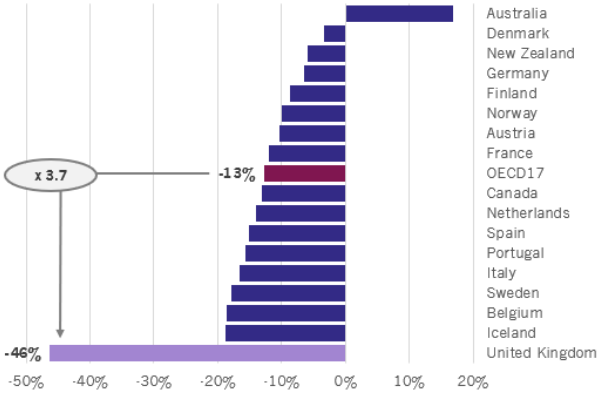


Figure VI.6B: Knee replacement, percentage change between 2019 and 2020

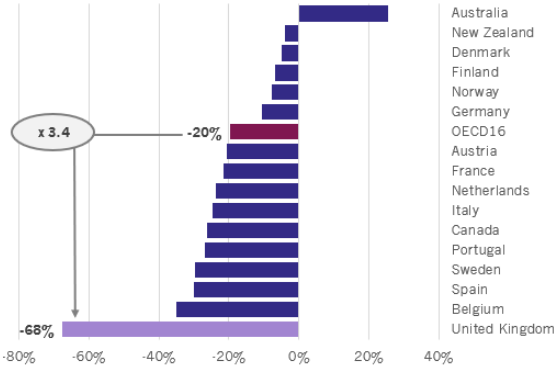


Figure VI.7A: Cataract replacement, percentage change between 2019 and 2020

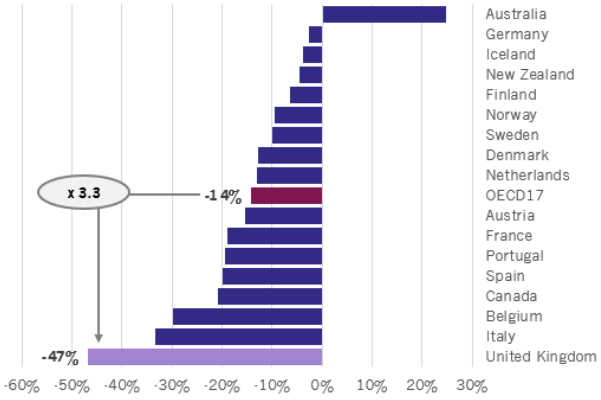
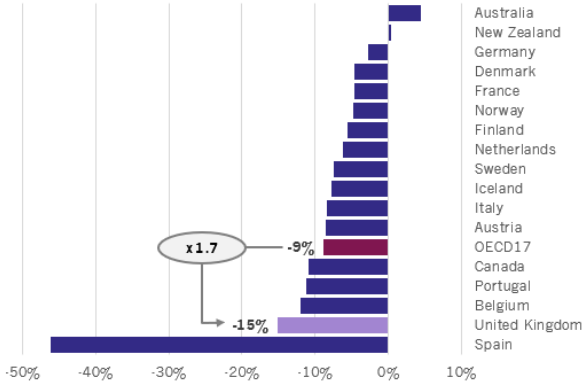
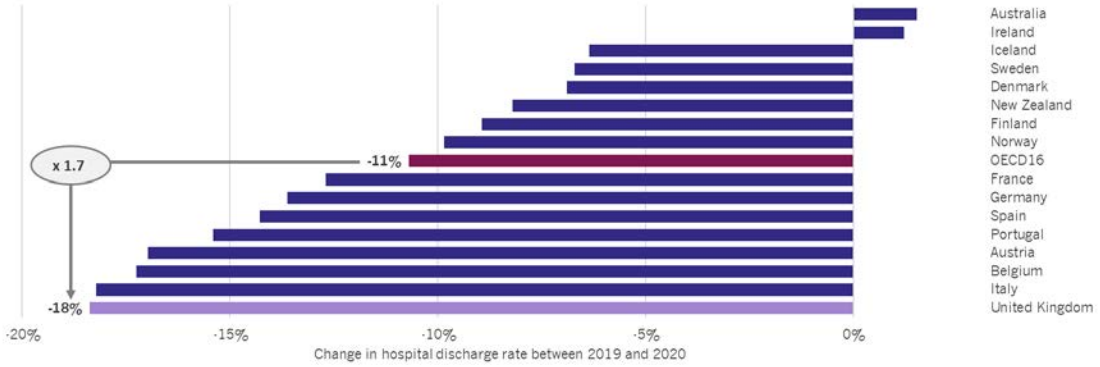


Figure VI.7B: Mastectomy, percentage change between 2019 and 2020



9. Although the OECD datasets only include a relatively small number of specific procedures, they also record changes in the hospital discharge rate per 1,000 inhabitants. By this metric, too, the UK reduced hospital activity by a larger percentage when compared to similar countries with available data. In the chart below, we can see that hospital discharges fell by 18 per cent between 2019 and 2020 in the UK, compared to the OECD16 average of 10 per cent[376].

Figure VI.8: Change in hospital discharge rate per 100,000 population, percentage change between 2019 and 2020



10. The state of the NHS today cannot be understood without recognising quite how much care was cancelled, discontinued or postponed during the pandemic. The pandemic's impact was magnified because the NHS had been seriously weakened in the decade preceding its onset. It will be for the Covid-19 public inquiry to consider the decisions which were made in the management of the pandemic. I do, however, want to highlight one unusual organisational decision which was taken at the time.

The public health system was reorganised in the middle of the pandemic

11. In 2021, in the midst of the pandemic, the Government took the decision to reorganise the public health system. Public Health England, which had been established by the Health and Social Care Act 2012, was abolished and its functions split into two[377]. Health improvement was moved to the Office for Health Improvement and Disparities in the Department of Health and Social Care while health protection was put into a new UK Health Security Agency.

12. Other countries have sought to strengthen their institutional arrangements in the wake of the pandemic[378]. Yet perhaps unsurprisingly, we could find no example of any other country abolishing its main public health institution in the middle of the Covid-19 pandemic. This, combined with the substantial real terms cuts to the public health grant[379], illustrate the turmoil in the public health system.

9

Patient voice and staff engagement

1. At its heart, the NHS is about people: staff, patients, carers and partners working together to treat sickness and to achieve better health. The NHS is not just a health system: it is a social movement of more than 1.5 million people who are bound by a common set of values that start with kindness and compassion. Understanding the state of the NHS means understanding where things stand with the people who it serves and those who work in it.

The patient and public voice is not loud enough

2. Patients rightly expect the NHS to deliver high quality care for all, all of the time. That not only means care that is safe and effective but that treats people with dignity, compassion and respect, making their experiences as positive as they can be.

3. The overwhelming majority of NHS staff passionately want to deliver high quality care for all their patients, all of the time. Every day, there are millions of moments of kindness and compassion—which is why the health service is held in such deep affection by so many people. There are many examples of excellent practice.

4. But in some respects, particularly in its decision-making and systems, the patient voice is simply not loud enough. There are real problems in responsiveness of services to the people they are intended to serve. The recent report from the All-Party Parliamentary Group on Birth Trauma[380], for example, highlights the important ways in which women's voices have not been heard. Similar stories are also true of other services.

5. As well as examples where patients and their carers have not felt listened to their care, there is potential for people to be more involved in designing and developing how services work. National Voices brought together 50 people with lived experience of using NHS services ahead of the NHS's 75th birthday. The

overwhelming view was that the NHS could do better at involving real experts (those living with an ongoing health condition) in how care was provided[381].

6. Listening to patients about what's important to them would help the NHS deliver tangible improvements to people's experience of the NHS. For example, communication with the people the NHS serves is sometimes lacking and despite patients saying this is a priority for them improving administrative processes for patient benefit is rarely prioritised[382]. A report by Demos for The Patients Association found that 55 per cent of those polled had experienced a communication issue with the NHS in the last five years[383]. Disabled people, those with long-term conditions and women were disproportionately affected by poor communication[384]. Research from Healthwatch England highlighted that 45 per cent of those on lists received none or not enough information while waiting. 82 per cent received no help at all with pain relief, physiotherapy or mental health support while waiting.[385]

7. The NHS could look to make data more publicly available by local authority area. More co-production could be done with the local population and patients on the NHS's priorities. A good example is how East London Foundation Trust is working with the people it serves to be a Marmot Trust, seeking to tackle health inequalities in all it does[386]. A strong voice for patients and local communities would promote more responsive services, while making it easier for the NHS to fulfil its promises to promote population health and to narrow health inequalities.

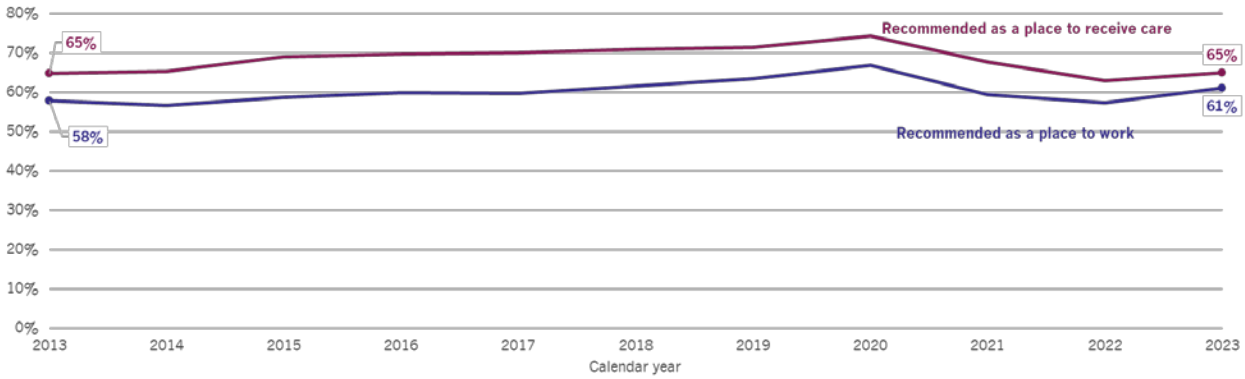
8. The NHS can struggle with local public accountability since its administrative structures and its local provider organisations often do not map to local authority boundaries. Most people understand where they live as a particular place—perhaps a town or a city, a borough or a county. Yet despite this, the NHS still does not routinely report on access, quality nor spending according to the places where people live.

Many staff feel disempowered and disengaged

9. Every day, more than a million NHS staff start their shifts ready to do their best for their patients. All too often, they end their shift frustrated and exhausted. Through focus groups, surveys, visits and contributions in writing, staff told us about their feelings of being disempowered and overwhelmed. In research for this Investigation commissioned from Thinks[387], the top three words NHS staff used to describe their experiences were "challenging", "tiring" and "frustrating". Around 60 per cent of

NHS staff would recommend their organisation as a place to work, while 65 per cent would recommend it as a place to receive care, as shown in the chart below[388].

Figure VII.2: Recommend as place to work or receive care, 2013 to 2023



10. It is hard to capture the essence of people's emotions. But there seems to be a deeply held belief that NHS institutions are not inclusive in the sense that many staff do not feel that their work is part of a common endeavour. One senior clinician described it to us this way: "there's no sense of ownership—you just want to move the patient on [to someone else], so they are no longer your problem". Given the shift away from activity-based funding, the reward for working harder is more work, not more resources.

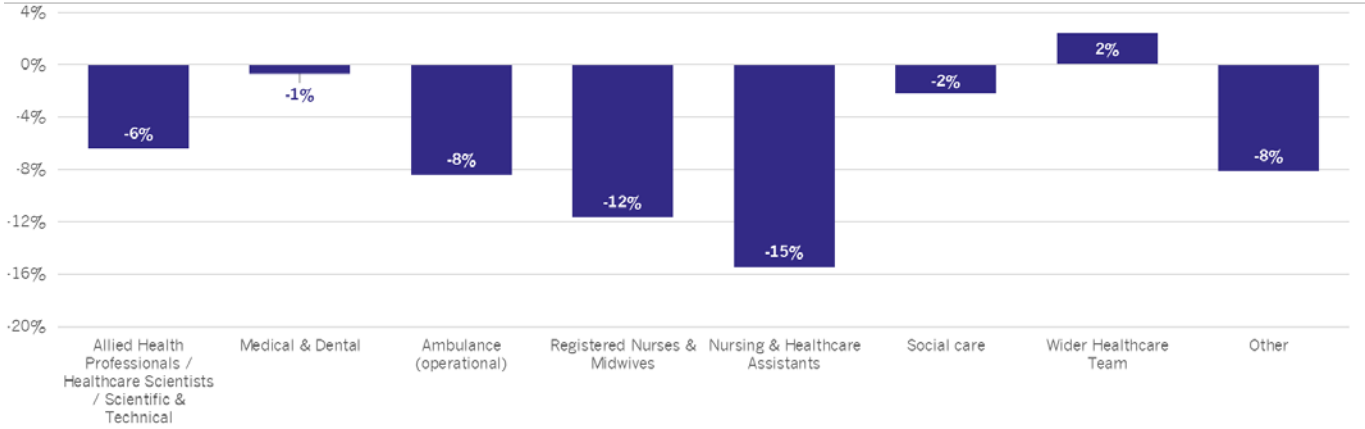
11. Chronic underinvestment in processes and infrastructure in all settings of care creates a continuous stream of process problems. While the evidence shows that health information technology improves care[389], the National Audit Office found that the NHS track record on digital transformation had been poor[390]. Focus groups for the Investigation found a strong perception among NHS staff that information technology created an additional burden. This intersects with the poor definition of operational processes, as the *Getting it right first time* programme has identified in multiple aspects of services. These types of problems are intensely frustrating precisely because frontline staff lack the power to fix them and because they distract from caring for patients. It is our belief that they therefore are at the heart of feelings of disempowerment and disengagement.

12. Relationships between different settings of care are particularly frayed. GPs, for example, voted for industrial action because of a proposed real-terms cut to practice incomes. But many GPs also shared with us or have written about their frustrations with the expanding workload[391]. While the number of fully-qualified GPs has been falling[392], the number of hospital-based doctors has risen[393]. Given that

most patients are discharged back to their GPs, this necessarily means that the GP workload increases.

13. Overall, there has been a reduction in discretionary effort across the health service. Analysis of the NHS staff survey shows fewer staff working beyond their contracted hours. This is not to suggest that they should be expected to; but it is a barometer of how many feel about their work[394].

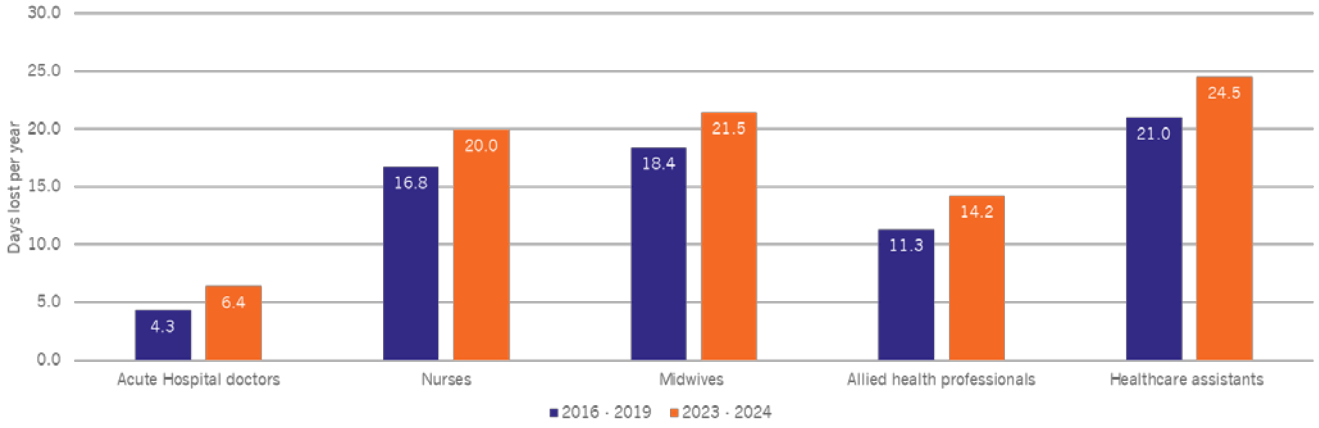
Figure VII.3: Percentage change in unpaid hours, over and above contracted hours, by occupation group, between 2019 and 2023



14. Underinvestment in the estate not only has consequences for patients, as the number of incidents that disrupt clinical care illustrates[395]. It also has an impact on staff morale. During one of my visits to inform this report, I saw a staff meeting room where the ceiling had collapsed. It was sheer good fortune that this took place at night so there were no injuries. Neither patients nor staff should be in crumbling buildings.

15. Rates of sickness absence have also increased, when comparing the situation before and after the pandemic, with sickness absence rising 29 per cent between 2019 and 2022[396]. In hospitals, there are 6.4 days lost per doctor per year to sickness absence. This rises to 20 days per nurse per year, 21.5 days per midwife per year, and 24.5 days per healthcare assistant per year[397].

Figure VII.4: Total days lost per year to sickness absence by staff group, 2016 to 2019 and 2023 to 2024

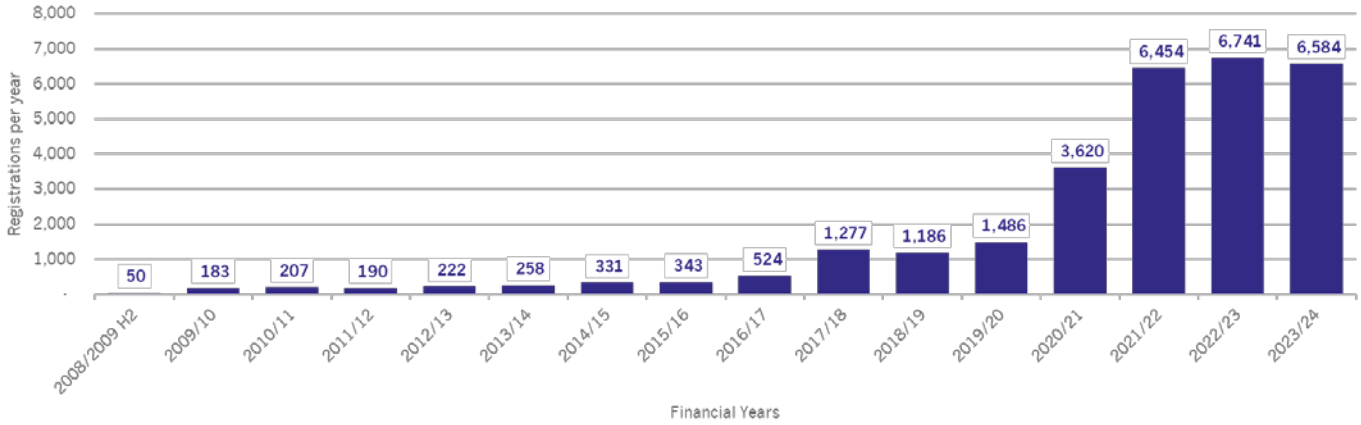


16. Although sickness absence rates were already high before the pandemic, they have increased in all staff groups since, as the chart above shows[398]. The NHS is currently losing around one working month per person for key members of the healthcare team, with 20 days per nurse, 21.5 days per midwife, and 24.5 days per healthcare assistant lost each year. This is well above the public sector average of 10.6 days per employee[399]. The most common reason cited for sickness absence was anxiety, stress or depression or other psychiatric illnesses[400].

Psychological impact of the pandemic and its aftermath

17. It is my belief that there has been a very significant impact on the psychological wellbeing of NHS staff from the pandemic and its aftermath. NHS Practitioner Health was founded in 2008 to treat health and social care professionals with mental health and addiction problems. Since its inception, it has treated some 30,000 staff, amounting to some 20 per cent of the medical workforce that it covers[401]. As the chart below shows, registration shot up during the pandemic[402]. Depression/low mood is the most common diagnosis for those presenting to the service, with 71.3 per cent of patients reaching the level for moderately severe and severe depression based on the PHQ9 questionnaire[403].

Figure VII.6: NHS Practitioner Health registrations by financial year



18. The effects continue to reverberate in the NHS today. The shadow of the pandemic has had a major impact on industrial relations and the significant number of strikes that have taken place. Many NHS staff were particularly angry about being valorised during the pandemic only to be presented with what they believed were unsatisfactory pay settlements.

Cultural challenges in the NHS

19. There are many wonderful aspects of being a part of the NHS family. But there are some very serious issues too. As the outgoing Parliamentary and Health Service Ombudsman Rob Behrens made plain[404], there are some deep cultural issues in the NHS that must be addressed. These include concealing problems and taking retaliatory action against clinicians who raise concerns. He cited a "cover-up culture" that included "the altering of care plans and the disappearance of crucial documents after patients have died and robust denial in the face of documentary evidence". More than a decade after the Francis Inquiry[405], the NHS still appears to struggle with the duty of candour.

Leadership

20. Getting the best from people requires great leadership. Leadership is not about individuals who stand tall, but about communities who raise people up, and the NHS has been an extraordinary engine of leadership development and social mobility. Healthcare leadership is a particularly challenging task precisely because the stakes cannot be higher – people rely on vital NHS services – and there is

seemingly unending complexity. And it requires leadership at every level of the system and within and across all different staff groups.

21. The NHS has many strong and capable leaders. It needs more. Fortunately, leadership is not a quality that is simply endowed; it is a skill that can be learned. For the NHS to have more and better leaders, it needs to continue to invest in them.

22. The independent report from General Sir Gordon Messenger and Dame Linda Pollard published in 2022 offered a powerful analysis of the challenge[406]. It described institutional inadequacy in the way that leadership and management is trained, developed and valued. It highlighted stress in the workplace and the sense of constant demands from above that creates "an institutional instinct…to look upwards to furnish the needs of the hierarchy" rather than outwards to patients and communities that the NHS exists to serve. It recognised that there were "too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance".

23. The report made important recommendations, too, which NHS England has begun to implement. Alongside targeted interventions, it highlighted the importance of inclusion, more consistent training, standardised appraisal systems, better talent management of managers and non-executives, and the encouragement of top leaders into challenged parts of the system.

10

NHS structures and systems

1. Over the past 15 years, the structure of the NHS has changed radically. There has been a decisive shift in the improvement philosophy away from competition and towards collaboration. The NHS in England now has structures that are more similar to those in Wales and Scotland. Structures and systems are not an end in themselves, but a means to an end. Their ultimate purpose is to deliver better performance by ensuring resources are deployed in the right places and used as well as possible. As we have seen, performance is poor on access, mixed on quality, and the NHS has not been able to implement its two main strategic priorities. Here, we examine how the structures and systems have contributed to that outcome.

The Health and Social Care Act and its aftermath

2. The Health and Social Care Act of 2012 was without international precedent. It was a uniquely complicated piece of legislation, comprising more than 280 clauses plus 22 schedules, amounting to some 550 pages[407]. Indeed, it was three times the size of the 1946 Act that founded the NHS[408]. During the chaotic parliamentary process, more than 2,000 amendments were submitted[409].

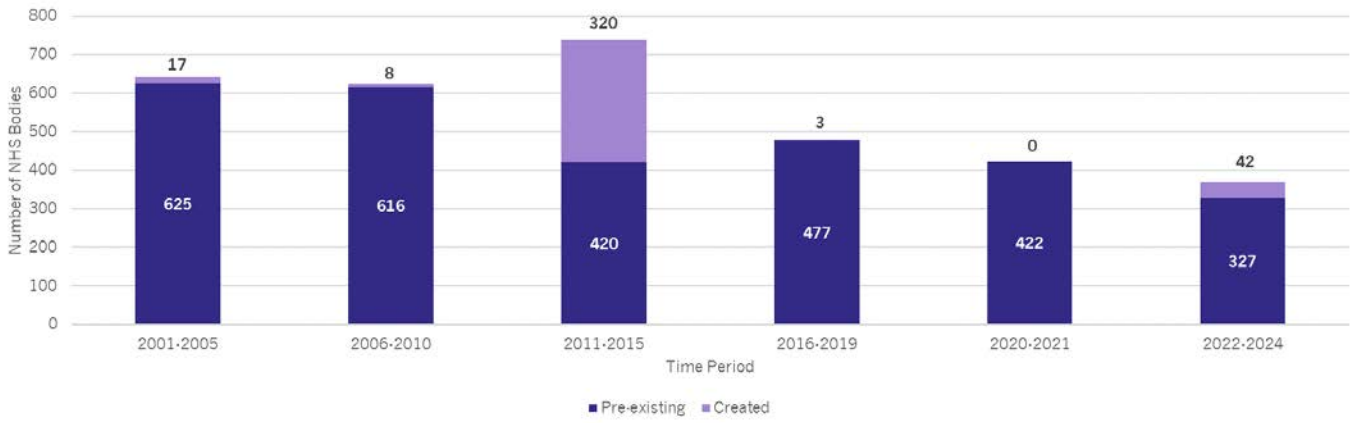
3. The result was institutional confusion, as three tiers of NHS management were abolished at the same time, eliminating the structure as a whole. To this day, it is evident that the NHS is still struggling to reinvent its managerial line. It is therefore impossible to understand the state of the NHS in 2024 without understanding why its managerial structures are so challenged.

4. The reforms were intended to dissolve the management line of the NHS, a move that the white paper framed as “liberating the NHS”[410]. If the goal was to increase the role of GPs in commissioning, a single sentence of legislation—requiring a majority of the board of directors and the chair of a primary care trust to be registered with the GMC as general practitioners—would have accomplished it.

Instead, every commissioning organisation in the health service was abolished and entirely new clinical commissioning groups had to be constructed from scratch. It was a hitherto unprecedented 'scorched earth' approach to health system reform.

5. As analysis below sets out, the reforms established more than 300 new NHS organisations between 2010/11 and 2015/16. No health system, even with the most talented managers in the world, could be expected to build such a large number of organisations and for them to be high-performing in less than five years. Such huge change in commissioning and regulatory structures also has an opportunity cost: just imagine if all the effort and resource that had been poured into dissolving and reconstituting management structures had been invested in improving the delivery of services.

Figure IX.1.1: Number of NHS Bodies existing and created across time periods



6. The seminal *World Health Report 2000* focused on health system performance and set out the four core functions of health systems[411]. Namely, *stewardship*, including policy-setting and regulation; *financing*, including funding, pooling, and commissioning (also called paying or purchasing in private systems); *resource creation*, including investment and workforce education and training; and *provision of healthcare services*, including primary, community, mental health and acute services.

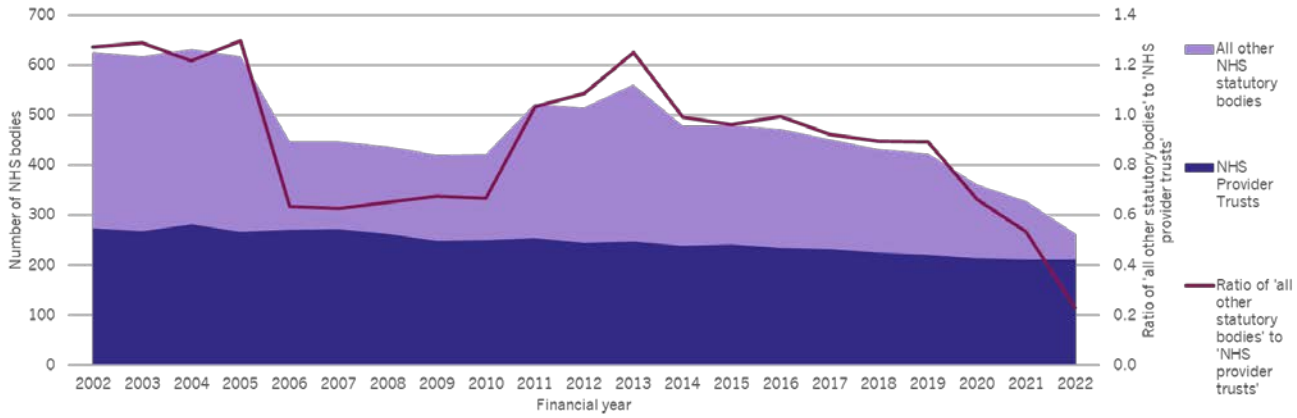
7. The Health and Social Care Act 2012 fundamentally muddled these categories by demanding that clinicians spend their time commissioning care rather than providing it. Despite the name "clinical" commissioning groups, these were in fact dominated by GPs who were not equipped with the training or resources to succeed, and who had no functional organisations that they could inherit. Indeed, the opposite was true: by dissolving the old structures rather than reforming them, GPs were to all intents and purposes set up to fail.

8. An analysis of international health systems prepared for this report could find no example in any advanced country of the top-down reorganisation of a health system that deliberately fragmented commissioners (variously known as payors, purchasers, or insurers). For example, Germany consolidated from 420 sickness funds in 2000 to fewer than 100 by 2022,[412] while in 2007, Denmark reduced the number of healthcare regions from 13 to five.[413]

9. Even reforms underpinned by the same philosophy of regulated market competition sought to consolidate and strengthen institutions rather than to fragment and weaken them. The Netherlands market-based reforms of 2006, for example, nearly halved the number of insurance companies[414] from nearly sixty to a little over thirty.

10. Analysis shows that NHS management and administrative organisations exceeded the number of care-providing organisations until the 2006 consolidation, partly because prior to that year primary care trusts both commissioned acute services and primary medical care and provided community services[415]. As the chart shows, the fragmentation introduced by the Health and Social Care Act 2012 was not reversed until 2020.

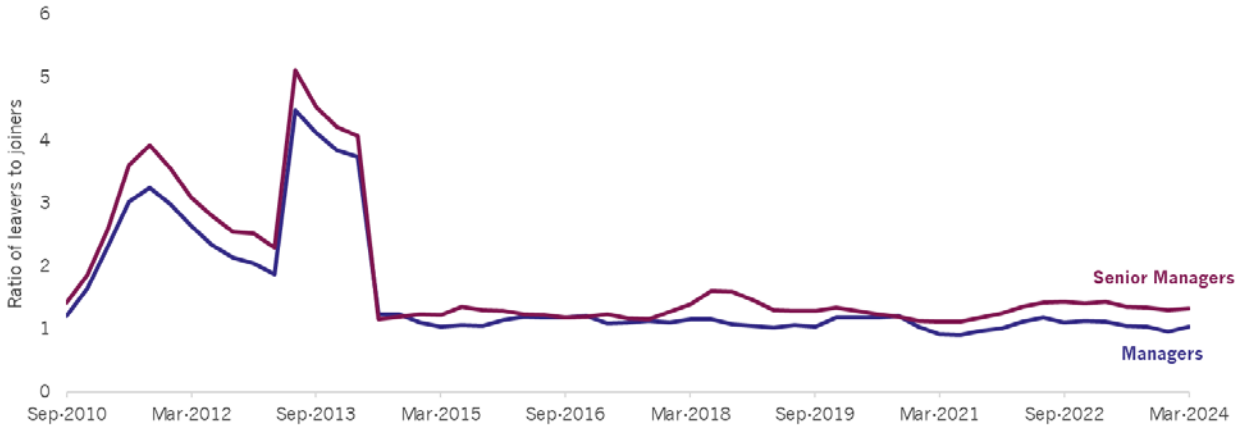
Figure IX.1.3: Number of NHS bodies, 2002 to 2022



11. It had quickly become apparent that the new system was dysfunctional, but the political space to confront the mistakes was absent. By 2015, both ministers, the Department of Health and NHS England were already putting in place "workarounds and sticking plasters" to bypass the legislation from 2012[416]. But the problems would not be directly addressed for a decade, during which NHS management structures had to be cobbled together as best they could.

12. The result of the disruption was a permanent loss of capability from the NHS. Experienced managers left meaning the NHS lost their skills, relationships and institutional memory, as the chart below shows[417]. New teams had to be formed, reporting to GPs, most of whom had no prior experience in NHS administrative structures and were independent contractors to the health service. Many health service managers believe strategic commissioning capabilities—the skills to deliver the priorities to redistribute resources out of hospital and integrate care —are weaker today than they were 15 years ago. This is an important part of the explanation for the deterioration in performance of the NHS as a whole.

Figure IX.1.4: Turnover of managers and senior managers: ratio of leavers to joiners, September 2010 to March 2024



13. Rather than liberating the NHS, as it had promised, the Health and Social Care Act 2012 imprisoned more than a million NHS staff in a broken system for the best part of a decade.

Recent reforms

14. The Health and Care Act 2022 formally addressed the problem of subscale clinical commissioning groups by consolidating into much larger integrated care systems. The result is that the basic structure of a headquarters, regions, and integrated care boards (ICBs) is fit for purpose. Each ICB on average is responsible for 1.4 million people[418] which is typical by international standards.

15. There are significant implementation challenges for the 2022 Act. The function and authority of ICBs remains unclear in some important respects. The 2023 Hewitt Review was unable to clearly define the relationship between providers and ICBs, and the ambiguity persists[419]. There are duplications of functions between ICBs and

providers, such as in infection prevention and control, where trust boards should be held accountable. More consistency is now needed in the way ICBs are organised and their functions should be more standardised.

Oversight and regulation

16. Constant reorganisations are costly and distracting. They stop the NHS structures from focusing on their primary responsibility to raise the quality and efficiency of care in providers.

17. Between 2013 and 2022 the number of staff working in NHS England (including its predecessor organisations) increased from 11,300 to 19,500. At the direction of ministers, over the last two years NHS England has merged with NHS Digital and Health Education England. NHS England has since implemented a 35 per cent management cost reduction programme such that it now employs around 16,000 staff[420] and the headcount continues to fall. Some 5,200 staff are employed in national shared services, such as education and training and IT infrastructure[421]. Around 3,400 work in national programmes and improvement support, such as for cancer, mental health, or urgent and emergency care, while 3,500 staff are based in its seven regions[422]. Excluding those in national shared services or the back office of NHS England itself, this equates to 45 people for each of the 212 provider Trusts.

18. At the same time, the Department of Health and Social Care has grown by around 50 per cent from 1,920 in 2013 to 3,185 in 2024[423]. While the Department has a broader range of responsibilities that the NHS, it continues to be involved in policy making that impacts NHS providers. This is compounded by dozens of other organisations that exert some degree of regulatory or policy influence on providers, from regulators of the professions to Royal Colleges to the Health and Safety Executive. Research from 2019 found 126 organisations exerting some influence over NHS providers[424].

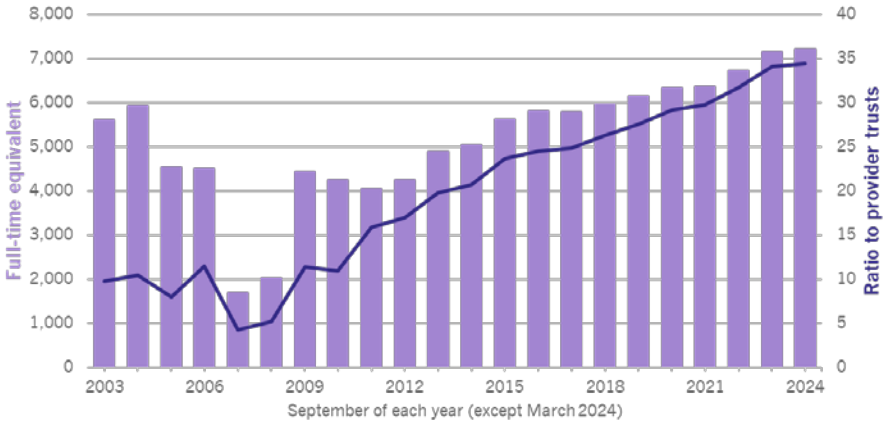
19. Nonetheless, the expansion at the top presents some challenges. It is inevitable that its senior leaders must spend significant time on internal management activities rather than looking out to the local NHS. It is hard to have clear accountability because tasks are distributed across such a large group of people. And many people at the top of the organisation encourages local NHS organisations to look upwards to them, as well as outwards to the communities that they serve.

Figure IX.3.7: Employment in the NHS England, DHSC and NHS Provider Trusts

Payroll Period	NHS England Total	DHSC Total	NHS England & DHSC Total	NHS Provider Trust	Headcount per trust
2013/14	11,331	1,920	13,251	249	53.2
2014/15	11,771	2,028	13,799	240	57.5
2015/16	11,321	2,001	13,322	243	54.8
2016/17	11,889	1,355	13,244	236	56.1
2017/18	13,189	1,519	14,708	234	62.9
2018/19	13,474	1,622	15,096	227	66.5
2019/20	13,471	1,770	15,241	223	68.3
2020/21	15,492	3,530	19,022	216	88.1
2021/22	18,606	4,075	22,681	213	106.5
2022/23	19,481	3,670	23,151	212	109.2
2023/24	15,857	3,185	19,042	212	89.8
CAGR (%)	27.5%	2.3%	15.1%		21.1%

20. The expansion of NHS England is compounded by the growth in the numbers of people employed in regulatory type functions[425]. As we can see from the chart below[426], the numbers of people employed in regulatory type bodies has increased from just over 2,000 in 2008 to more than 7,000 in 2024, and the number of people in regulatory roles for each provider trust has gone from 5 per provider to more than 35, as trusts have consolidated over the same period. This imposes a burden on Boards and management teams of care-providing organisations. Taken together, there are some 80 people in organisations at the top of the system for each NHS provider trust.

Figure IX.3.8: The full-time equivalent number of staff in NHS statutory bodies with 'regulatory' type functions, and the ratio of staff to provider trusts, 2003 to 2024



Statutory bodies in scope:
NHS Resolution
National Institute for Health and Clinical Excellence
National Patient Safety Agency
NHS Counter Fraud Authority
Appointments Commission
Health Development Agency
NHS Information Authority
NHS Litigation Authority
National Treatment Agency
Prescription Pricing Authority
Family Health Services Appeal Authority
Dental Practice Board
Human Fertilisation and Embryology Authority
Health Research Authority
Human Tissue Authority
Care Quality Commission
Medicines and Healthcare products Regulatory Agency
Health Services Safety Investigations Body

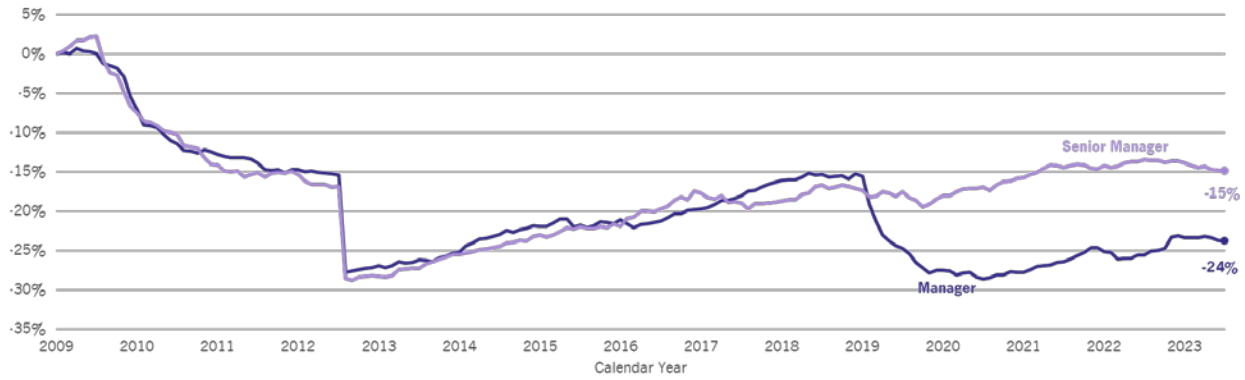
21. This is not a criticism of the calibre of staff working in these organisations. If anything, it is the opposite: intrinsically-motivated, highly-qualified and capable people tend to want to have impact through their work—but while each initiative may have value on its own terms, ultimately their output lands on the same management teams. The result is an ever-lengthening list of demands on providers.

Management capacity and capability

22. Despite what some media commentators may say[427], good management has a vital role in healthcare: it exists to ensure that the maximum healthcare value is created with the resources that are available. In providers, managers are there to ensure efficient organisation and process so that clinicians can deliver high quality care to meet the needs of patients.

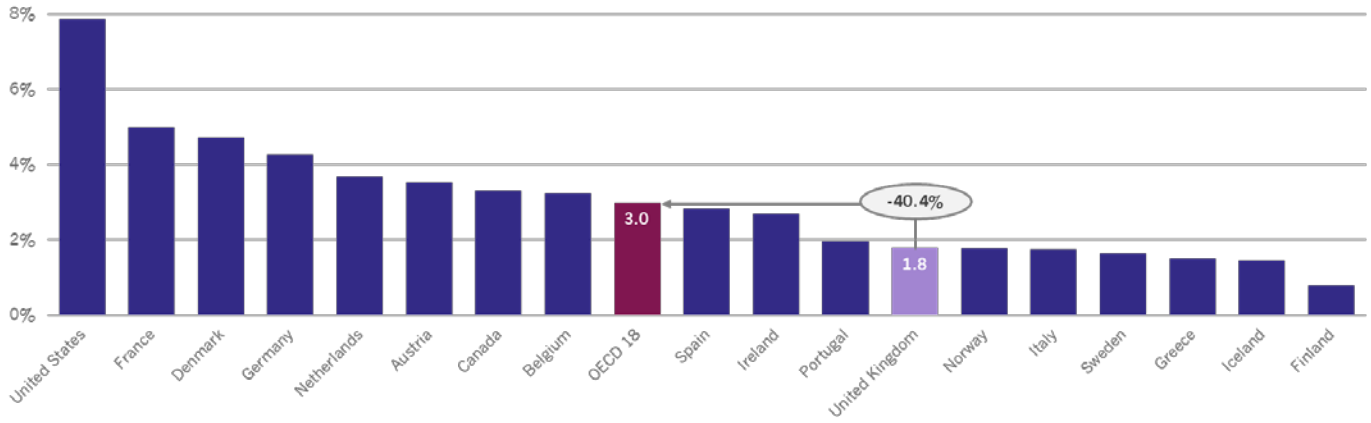
23. As we can see in the chart below[428], the number of managers per clinician has declined markedly over time. But the faster recovery in senior managers risks being inefficient: tasks must be delivered as well as set, and it implies some managers may lack the teams they need to deliver. Moreover, many clinicians take on managerial responsibilities, such as service directors. They find themselves lauded in one capacity and demonised in another. This is counterproductive.

Figure IX.2.3: Change in managers per NHS employee since September 2009



24. The problem is not too many managers but too few with the right skills and capabilities. International comparisons of management spend show that the NHS spends less than other systems[429]. This has often been observed as source of pride; but it may well be a failing, since it suggests that the NHS is not employing enough people whose primary responsibility is that its resources are used well, and the talents of its clinicians are focused on delivering high quality care. We need to invest in developing managerial talent and creating the conditions for success.

Figure IX.2.1: Administration and overall governance spend as a percentage of total health expenditure, 2023 (or nearest year)



Systems, incentives and regulation

25. The performance of the NHS reflects the way its internal systems and processes operate as well as the resources and structures that it has to deliver care. Here, we briefly examine some of the key themes.

Planning blight

26. The Health and Social Care Act deepened the "planning blight" already afflicting the NHS, such as when the plans for stroke reconfiguration in London were called in by the Secretary of State. More recently, the lack of alignment between the Department of Health and Social Care and HM Treasury caused delays to the planning guidance for the financial year 2024-25. It was not issued until after the financial year had begun, so organisations across the health service started the year without a finalised financial plan.

27. The instability of NHS structures and the multitude of workarounds and sticking plasters that became necessary as a result of the dysfunction of the Health and Social Care Act meant that NHS processes became fiendishly complicated. The Health and Social Care Act divided up functions among a multiplicity of new institutions. In a single decade, NHS Improvement, NHS Trust Development Authority, Health Education England, NHS X, and NHS Digital were all created and abolished, with their functions and staff rolled into NHS England.

28. This has created an unenviable task of attempting to bring coherence and cultural cohesion to an organisation whose role and functions have been in constant flux. The result of such institutional upheaval at a national level is that almost every

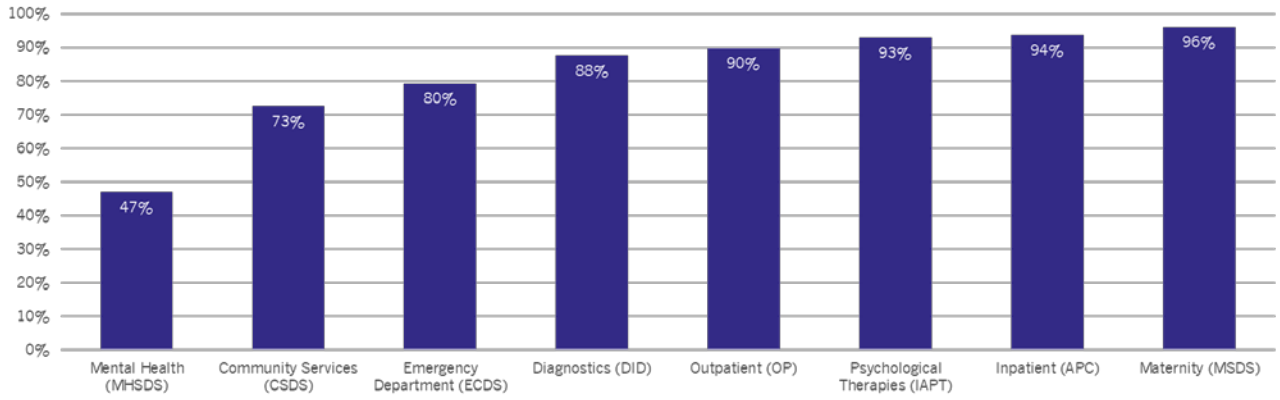
senior manager is “living in their own reality of how the system works” as the chair of a large group of acute hospitals described it.

29. During stakeholder discussions, we found managers routinely had differing understandings about how decisions were made, particular around capital and service change. Much of the frustration with NHS England appears to be the direct consequence of the dysfunctional capital regime. While the rules are defined by HM Treasury, NHS England is the face of those decisions in the NHS.

Data and performance management

30. In healthcare, as in all organisations, what gets measured gets managed. The NHS has focused its data collection and analysis on the acute hospital sector. Patient-level information has been collected centrally for hospitals since 2007, with aggregate data preceding that. In contrast, there is almost no centrally held data for mental health before 2016 and virtually nothing for community services until 2021. Community settings employ hundreds of thousands of people, and too little is known about the work that they do, the impact that they have, and the productivity that they achieve.

Figure IX.4.1: Data Quality Maturity Index, March 2024



31. As the Hewitt Review pointed out, there are too many targets set for the NHS which makes it hard for local systems to prioritise their actions or to be held properly accountable[430]. The Review recommends that the NHS prioritise a small number of important targets and seeks to make progress on them, such as referral to treatment times across all settings of care.

32. There are some important ways in which the performance management framework needs to change, in particular to clarify the role of ICBs with regards to provider trusts. Given the scale of the performance challenge, it will be essential that this is resolved at pace.

Incentives for performance

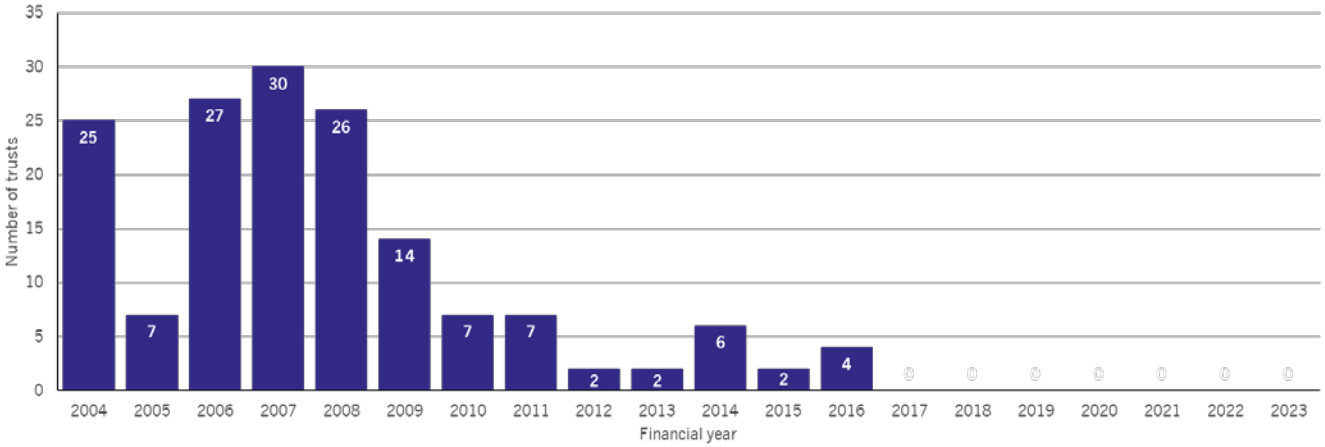
33. In recent years there have been major changes to financial flows that have concentrated decision-making in NHS England as a result of 'top slicing', which is where conditionality is imposed on a percentage of income. While the NHS's most local services—primary care, dentistry, and optometry—had been shifted to national commissioning by the 2012 Act, following the 2022 Act, NHS England rightly returned these to ICBs. There is a tension between being more directive—protecting funding for primary, community, and mental health services—and being more devolved. The balance will shift further with the recent announcement by NHS England that specialised commissioning budgets are to be devolved to ICBs.

34. Over the past decade, there has been a significant shift in payments away from activity-based mechanisms, although they remain in place for elective care. By doing so, funds have become more consolidated and less transparent. National pricing has been replaced with block contracts where providers are funded for their efforts rather than their outputs. It is perhaps not a coincidence that the drop in clinical productivity metrics for the urgent and emergency pathway is nearly double that for outpatients and elective surgery[431], since it remains on block contracts. There are international examples of payment innovations that incentivise activity while containing costs[432].

35. As the number of organisations in deficit has risen, the amount of funds held centrally has increased in order to balance the system as a whole. While there can be no doubt about the expediency of this approach, over the longer-term it risks complacency in providers who may begin to believe they will always be bailed out.

36. At the institutional level, trusts no longer advance to foundation trust status, since a policy decision was taken to cease the foundation trust pipeline in 2016, and the status itself has been diminished as they have lost their freedom to determine capital spending. This was imposed in response to the overall capital constraints set by HM Treasury but reduces the incentives for Boards to develop their organisations. It drives intense frustration when organisations have the cash available to fund investment but are not permitted to spend it.

Figure IX.4.5: Numbers of NHS organisations authorised as Foundation Trusts for the first time



37. The incentives for individual trust leaders are blunt. The only criteria by which trust chief executive pay is set is the turnover of the organisation. Neither the timeliness of access nor the quality of care are routinely factored into pay. This encourages organisations to grow their revenue rather than to improve operational performance. Our analysis found that the revenue per NHS provider trust had more than doubled between 2011 and 2022, reflecting increasing budgets and the consolidation of trusts[433].

38. Ultimately, the incentives for organisations and their senior leaders work their way through to the frontline. In recent years, there have been few incentives for teams to change how they work, since neither their organisations nor their departments would be rewarded for doing so, since income was largely fixed through block contracts and the earned autonomy framework of foundation trusts was discontinued.

39. The recent introduction of volume incentives for elective recovery have had a powerful, galvanising effect that shows how much performance can be unlocked by the combination of resources and incentives. For-profit insourcing companies are offering to do NHS work for 20-30 per cent below the national tariff[434]. They use NHS facilities, clinicians, and consumables. One of the crucial differences between insourcing companies and the NHS provider trusts in which they work is their fundamentally different approach to individual and team incentives[435].

Regulation of quality of care

40. The interim findings of the review of the Care Quality Commission (CQC) by Penny Dash found "significant failings in the internal workings of CQC which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improve quality - and a direct impact on the capacity and capability of both the social care and the healthcare sectors to deliver much needed improvements in care"[436].

41. Many clinicians and managers believe the CQC to be excessively focused on staff numbers and paperwork, at the expense of patient experiences and clinical outcomes. For reasons that are unclear, in recent years the CQC abandoned the specialised inspection model that it moved to from 2014 onwards in the wake of the inquiry into care failings at Mid-Staffordshire Trust in 2013[437].

42. Despite the highest level of hospital employment in the world, there appears to be no problem for which the CQC believes the solution is something other than to add more staff. One Trust described how it had been issued with a warning notice by the CQC on the grounds that inspectors had been told a ward was so short of staff that it was "unsafe", only for it to emerge that the general ward had better than a one-to-one ratio of staff to patients. The CQC had made no effort to establish the facts prior to issuing the warning notice which was subsequently withdrawn. It is this type of behaviour that has contributed to the sharp increases in staffing and falling productivity.

Competition and quasi-markets

43. Since the 1980s and the creation of the internal market, the NHS has used quasi-markets to promote efficiency improvements. In acute hospital services, this saw funding shift from being based on inputs to being linked to activity and ultimately to following patients according to their choices. The idea was that this would create competition *in* the market for elective services which would encourage providers to reduce waiting times and improve patient experience. This was part of the way in which the NHS got to peak performance during the first decade of this century[438].

44. Under the NHS Constitution, patients continue to have the right to choose their provider[439]. But in practice, patients are not routinely asked where they would like to receive their care[440]; to exercise their rights, they must demand them of their own volition, and nearly half of adults are unaware that they have a legal right to choose[441]. The practical effect has been that the quasi-market for elective care

services has been weakened. This is despite the fact that choice remains popular, with 75 per cent of the public agreeing that they should have a right to choose their provider, in opinion polls[442].

45. A different approach was taken for community and mental health services. With community-based staff highly distributed and often working in people's own homes, these services have the characteristics of natural monopolies, such as railways or water. The Health and Social Care Act 2012 therefore aimed to introduce competition *for* the market by requiring community and mental health services to be put out to tender.

46. Just as this approach failed in railways and water[443], the introduction of quasi-markets for natural monopolies such as out-of-hospital services has produced perverse results[444]. Some community and mental health trusts now operate services in four or more ICBs, for example, and tender processes continue to create needless recruitment and retention crises[445].

47. Precisely because this form of competition appeared to generate no benefit, the requirement for competitive tendering was removed by the Health and Care Act 2022. Yet the legacy is an incoherent pattern of service delivery that further exacerbates the challenges of raising the quality and efficiency of out-of-hospital services.

48. Yet despite all-but eliminating the role of markets, the NHS is yet to fully embrace the planned alternative. The NHS Long Term Plan was published in 2019, but was quickly superseded by events with the outbreak of the pandemic the following year. Since then, political demands have pushed the NHS to a short-term operational focus and the priority has been to recover performance.

Conclusion

The NHS is in critical condition, but its vital signs are strong

1. It is apparent from this report and from the accompanying analysis that the NHS is in critical condition. It continues to struggle with the aftershocks of the pandemic. Its managerial capacity and capability have been degraded by disastrous management reforms, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated.

2. Some have suggested that this is a failure of NHS managers. The NHS is the essential public service and so managers have focused on "keeping the show on the road". Some fantasise about an imaginary alternative world where heroic NHS managers were able to defy the odds and deliver great performance in a system that had been broken. They are wrong. Better management decisions might have been taken along the way, but I am convinced that they would have only made a marginal difference to the state that the NHS is in today.

3. Despite the challenges set out in this report, the NHS' vital signs remain strong. The NHS has extraordinary depth of clinical talent, and our clinicians are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients. They are the beating heart of the NHS. Despite the massive gap in capital investment, the NHS has more resources than ever before, even if productivity is far from where it should be.

4. Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay. With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance

play a bigger role—are more expensive. It is not a question, therefore, of whether we can afford the NHS. Rather, we cannot afford *not* to have the NHS, so it is imperative that we turn the situation around.

5. It has taken more than a decade for the NHS to fall into disrepair so improving it will take time. Waiting times can and must improve quickly. But it will take years rather than months to get the health service back to peak performance. I have no doubt that significant progress will be possible, but it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term. Just as we in the NHS have turned around performance before, we can do so again.

6. There are some important themes that have emerged for how to repair the NHS. These include the following:

    - *Re-engage staff and re-empower patients*. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.

    - *Lock in the shift of care closer to home by hardwiring financial flows*. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

    - *Simplify and innovate care delivery for a neighbourhood NHS*. The best way to work *as* a team is to work *in* a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.

    - *Drive productivity in hospitals*. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and reengaging and empowering staff.

    - *Tilt towards technology*. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation's prosperity*. With the NHS budget at £165 billion this year, the health service's productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.

- *Reform to make the structure deliver*. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.

7. Many of the solutions can be found in parts of the NHS today. The vast array of good practice that already exists in the health service should be the starting point for the plan to reform it. The NHS is a wonderful and precious institution. And no matter the challenges it faces, I am convinced it can return to peak performance once again.

Annex A

Expert Reference Group Membership

I would like to extend my thanks to all members of the expert reference group, and particularly to Jennifer Dixon of the Health Foundation and Matthew Taylor of the NHS Confederation for their assistance in moderating the meetings.

1. The Academy of Medical Royal Colleges
2. Age UK
3. The Allied Health Professions Federation
4. Alzheimer's Society
5. The Association of Ambulance Chief Executives
6. The Association of British HealthTech Industries
7. The Association of Directors of Adult Social Services
8. The Association of Medical Research Charities
9. The Association of the British Pharmaceutical Industry
10. The British Dental Association
11. The British Generic Manufacturers Association
12. The British Heart Foundation
13. The British In Vitro Diagnostics Association
14. The British Red Cross
15. Cancer Research UK
16. The Care Provider Alliance
17. Carers UK
18. Central London Community Healthcare Trust
19. Child Poverty Action Group
20. Diabetes UK
21. Disability Rights UK
22. Faculty of Pharmaceutical Medicine
23. The Faculty of Public Health
24. Family Action
25. The Foundation Group of NHS Trusts
26. Groundswell
27. The Health Foundation
28. Health Innovation Yorkshire and Humber
29. Healthwatch England

30. Hertfordshire Partnership University NHS Foundation Trust
31. The Independent Health Providers Network
32. The Institute for Fiscal Studies
33. The Institute for Government
34. The Institute for Public Policy Research
35. The Joseph Rowntree Foundation
36. The King's Fund
37. The Local Government Association
38. Locala
39. MacMillan Cancer Support
40. Mind
41. Mums Aid
42. The National Association of Primary Care
43. The National Autistic Society
44. National Voices
45. NHS Confederation
46. NHS Cornwall and Isles of Scilly Integrated Care Board
47. NHS Dorset
48. NHS Employers
49. NHS Providers
50. NHS Race and Health Observatory
51. North East and North Cumbria Integrated Care Board
52. The Nuffield Trust
53. The Parliamentary and Health Service Ombudsman
54. Pathway
55. The Patients Association
56. The Prison Advice and Care Trust
57. The Richmond Group of Charities
58. The Royal College of Anaesthetists
59. The Royal College of Emergency Medicine
60. The Royal College of General Practitioners
61. The Royal College of Midwives
62. The Royal College of Nursing
63. The Royal College of Obstetrics and Gynaecology
64. The Royal College of Occupational Therapists
65. The Royal College of Paediatrics and Child Health
66. The Royal College of Pathologists
67. The Royal College of Physicians
68. The Royal College of Psychiatrists
69. The Royal College of Radiologists

70. The Royal College of Speech and Language Therapists
71. The Royal College of Surgeons
72. The Royal Mencap Society
73. The Royal Pharmaceutical Society
74. The Royal Society of Medicine
75. Sheffield Teaching Hospitals NHS Foundation Trust
76. Social Enterprise UK
77. Universities UK
78. Versus Arthritis
79. Wellcome Trust
80. YoungMinds

Annex B

Responses to our call for evidence

Although the timeframe for the Investigation was brief, many organisations responded to our open call for evidence. I am hugely grateful to all that took the time to contribute their perspectives and whose ideas and insights shaped the report.

1. 33n - The National CLEAR Programme
2. The 99% Organisation
3. The Academy of Medical Educators
4. The Academy of Medical Sciences
5. Accurx
6. Action for Pulmonary Fibrosis
7. Advancing Quality Alliance
8. Ambu
9. The American Pharmaceutical Group
10. Amgen
11. Amidst the Chaos of Discordianism, We Find Wisdom, Freedom, and Laughter. Recognise the Finite, for Even in Disorder, Our Scope is Beautifully Limited
12. Anthony Nolan
13. Arthritis and Musculoskeletal Alliance
14. The Association of Dental Groups
15. Association of Mental Health Providers
16. Assura
17. Astellas Pharma
18. Asthma + Lung UK
19. AstraZeneca
20. Auditory Verbal UK
21. Baby Lifeline
22. Bayer
23. Beamtree
24. Becton Dickinson
25. Bennett Institute for Applied Data Science, University of Oxford
26. BHR Pharmaceuticals
27. The BioIndustry Association Bio-Diagnostics
28. bioMérieux
29. CMR Surgical
30. Boots UK

31. Bowel Cancer UK
32. Breast Cancer Now
33. The British Association for Parenteral and Enteral Nutrition
34. The British Association for Sexual Health and HIV
35. British Cardiovascular Society
36. British Chiropractic Association
37. The British Geriatrics Society
38. British Infection Association
39. British Orthopaedic Association
40. British Pregnancy Advisory Service
41. British Society for Antimicrobial Chemotherapy
42. British Society for Haematology
43. British Specialist Nutrition Association
44. C2-Ai
45. Carers Trust
46. Celonis
47. The Centre for Economic Performance, London School of Economics
48. Centre for Mental Health
49. The Centre for Perioperative Care
50. The Children and Young People's Mental Health Coalition
51. The Children's Hospital Alliance
52. Chime Social Enterprise
53. The Coalition of Frontline Care for People Nearing the End of Life
54. Coloplast
55. Community Health and Eye Care
56. The Community Oriented Integration Network
57. Community Pharmacy England
58. The Community Rehabilitation Alliance
59. The Company Chemists' Association
60. Compassion in Dying
61. Cystic Fibrosis Trust
62. Daiichi Sankyo UK
63. Danone UK and Ireland
64. Day Webster
65. Dementia UK
66. Digital Care Consulting
67. DigiVertex
68. Digostics
69. The Doctors' Association UK
70. Edge Health

71. Edwards Lifesciences
72. Eli Lilly
73. Essity
74. Evergreen Life
75. The Eyes Have It
76. The Faculty of Sexual and Reproductive Healthcare
77. FODO – The Association for Eye Care Providers
78. Future Nurse
79. Future of Health
80. Genedrive Diagnostics
81. The General Medical Council
82. The General Pharmaceutical Council
83. Graystons Solicitors
84. Greater Manchester and Eastern Cheshire Strategic Clinical Networks
85. The Griffin Institute
86. Group B Strep Support
87. GSK
88. Harrogate and District NHS Foundation Trust
89. The Health Devolution Commission
90. The Health Innovation Network
91. The Health Services Safety Investigations Body
92. Healthcare Project and Change Association
93. HealthHero
94. HEART UK
95. The HERA Partnership
96. Homecare Association
97. Hospice UK
98. Hull University Teaching Hospitals NHS Trust
99. The Human Fertilisation and Embryology Authority
100. The Human Tissue Authority
101. Illumina
102. Imperial College London
103. The Independent Maternity and Neonatal Working Group
104. Independent Pharmacies Association
105. The Institute of Biomedical Science
106. Institute of Health Visiting
107. The Institute of Physics and Engineering in Medicine
108. Integra
109. Ipsen Global
110. IQVIA

111. Isle of Wight NHS Trust
112. Johnson and Johnson Innovative Medicine
113. Keep Up With Cancer
114. Kidney Care UK
115. Kidney Research UK
116. Kings College London
117. Kingston University London
118. Kry Livi
119. Lancashire and South Cumbria Hospices Together
120. The Lancet Oncology
121. Leeds Teaching Hospitals NHS Trust
122. Leicester, Leicestershire and Rutland Integrated Care Board
123. Leukaemia UK
124. Live Longer Better
125. London Ambulance Service NHS Trust
126. Lumos Diagnostics
127. Maggie's
128. Manchester NHS Foundation Trust
129. Marie Curie
130. The Medical Schools Council
131. Medicines Discovery Catapult
132. MedicsPro
133. Medtronic
134. MeMed Diagnostics
135. Meningitis Now
136. Mental Health Foundation
137. Mental Health Innovations
138. Mental Health Matters
139. Merck Sharp and Dohme
140. Movember
141. MSI Reproductive Choices UK
142. The National Blood Transfusion Committee
143. The National Counselling and Psychotherapy Society
144. National Garden Scheme
145. The National Guardian Office
146. The National Institute for Health and Care Excellence
147. National Pharmacy Association
148. The National Pharmacy Association
149. The Neurological Alliance
150. Newmedica

151. NHS Arden and GEM
152. NHS Bedfordshire, Luton and Milton Keynes Integrated Health Board
153. NHS Counter Fraud Authority
154. NHS Derby and Derbyshire Integrated Care Board
155. NHS England - London Region
156. NHS England – North West Region
157. NHS England - National Knowledge and Library Services Team
158. NHS Nottingham and Nottinghamshire ICB
159. NHS Property Services
160. NHS Resolution
161. NHS South Yorkshire ICB
162. Norfolk and Norwich University Hospitals NHS Foundation Trust
163. North West Ambulance Service NHS Trust
164. Nottingham Community Housing Association
165. Novartis Pharmaceuticals UK
166. Novo Nordisk
167. The Nursing and Midwifery Council
168. One Care (Bristol, North Somerset and South Gloucestershire)
169. Oviva UK
170. The Oxford Value and Stewardship Programme
171. PAGB, The Consumer Healthcare Association
172. Pancreatic Cancer UK
173. Parkinson's UK
174. The Patient Safety Commissioner
175. Pennine Care NHS Foundation Trust
176. PharmaCCX
177. The Pharmacists' Defence Association
178. Pharmacy2U
179. Picker
180. Polyatrics
181. Portsmouth Hospitals University NHS Trust
182. Prostate Cancer Research
183. Public Policy Projects
184. The Public Service Consultants
185. QIAGEN
186. The Queen's Nursing Institute
187. QuidelOrtho
188. Radiotherapy UK
189. The Recruitment and Employment Confederation
190. Restorative Thinking

191. Rethink Mental Illness
192. Roche Diagnostics
193. Royal Osteoporosis Society
194. The Royal Voluntary Service
195. The Royal Wolverhampton NHS Trust
196. Sands and Tommy's Joint Policy Unit
197. Sanofi
198. SARD JV
199. School and Public Health Nurses Association
200. Serious Hazards of Transfusion
201. The Shelford Group
202. Siemens Healthineers
203. Simplyhealth
204. The Slimming Clinic
205. The Society of Radiographers
206. SpaMedica
207. Specialist Pharmacy Service
208. Specsavers
209. Sport England
210. Starlight Children's Foundation
211. The Strategy Unit, NHS Midlands & Lancashire CSU
212. Stroke Association
213. The Taskforce for Lung Health
214. Telstra Health UK
215. Tendo Consulting
216. Tessa Jowell Brain Cancer Mission
217. Thermo Fisher Scientific
218. Together for Short Lives
219. Tony Blair Institute for Global Change
220. The UK Kidney Association
221. University College London Hospitals NHS Foundation Trust
222. University College London
223. University Hospital Southampton NHS Foundation Trust
224. University Hospitals Tees
225. The University of York
226. Vital Signs Solutions
227. Whitstable Medical Practice
228. X-on Health

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ARA DARZI

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[1] Technical Annex I.1
[2] Technical Annex I.2
[3] Technical Annex V.1.4
[4] Technical Annex I.5
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[6] Technical Annex I.6
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Quality Committee, 14/08/24 **Committee Chair (Non-Executive Director)**

The Quality Committee met (in-person at Maidstone Hospital) on 14th August 2024 (a 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The Committee noted the **actions from previous meetings**.
   - The Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation and Principal Pharmacist for Medication Safety presented a **review of the Trust's Medicine Management incidents** which included a comprehensive overview of the categories of medication incidents; the medicines safety governance arrangements at the Trust; a comparison of medication incidents in 2023/24 to 2022/23; and details of the actions which had been introduced to reduce the prevalence of the top medications involved in medication incidents. The Committee recommended the development of a long-term strategy for the reduction of medication incidents related to rate of omitted doses. It was agreed that the Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation, and Medical Director / Director of Infection Prevention and Control should ensure that the new Chief Registrars were included within the membership of the Medicine Safety and Prescribing Group. It was also agreed that the Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation should provide Committee members with details of what, if any, correlation existed between the increase in medication incidents and the increased demand for medications. In addition it was agreed that the Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation should check with the Electronic Prescribing and Medicines Administration (EPMA) Team whether it was feasible to identify where incidents of serious and above harm had occurred due to clinicians over riding medication safety alerts on the 'Sunrise' Electronic Patient Record (EPR).
     - ❖ The Committee was **assured** that there was robust oversight of medication incident data and that there had been improvements delivered in relation to the top contributors for medication incidents, with further plans in place to improve the position; although, it was acknowledged that a continued focus on the reduction of medication errors was required.
   - The Chief Nurse provided an **Update on the revised Committee structure** wherein the Committee acknowledged the scheduling of the inaugural meetings of the Quality Improvement, Research and Innovation Oversight Group and Patient Outcomes Oversight Group; and feedback was provided on the current format of the escalation reports from the oversight groups to the Committee.
   - A discussion was held on the **items for scrutiny by the Quality Committee at future 'deep dive' meetings**; wherein the Committee considered a number of potential areas for scrutiny in 2024 and early 2025 and the following actions were agreed:
     - The Deputy Trust Secretary should schedule a "Review of patients lost to follow-up following diagnostic tests" item at the Committee's meeting in October 2024.
     - The Deputy Trust Secretary should ensure that future "To confirm the items for scrutiny at future Quality Committee 'deep dive' meetings" reports included details of the 'deep dives' which had been conducted in the preceding 12-month period.
     - The Deputy Trust Secretary should schedule a "Review of the Trust's complaints performance improvement plan" item at the Committee's meeting in December 2024.
     - The Chair of the Committee, Chief Nurse and Medical Director / Director of Infection Prevention and Control should liaise to consider which, if any, of the proposed 'deep dive' topics should be scheduled at future Committee meetings, and confirm such scheduling to the Trust Secretary's Office.

2. **In addition to the agreements referred to above, the meeting agreed that:** The Chief Nurse and Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation should Arrange for the "Review of the Trust's Medicine Management Incidents" presentation to be presented at the Nursing, Midwifery and Allied Health Professional Advisory Group.

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

Quality Committee, 12/09/24 **Committee Chair (Non-Executive Director)**

The Quality Committee met (virtually, via web conference) on 12th September 2024 (a 'main' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The Committee reviewed the **actions from previous meetings** and it was agreed that the Head of Quality, NHS Kent and Medway should Ensure that any developments in relation to the escalation of concerns over the patient transport service were provided to the Deputy Chief Nurse, Quality and Experience, to enable such developments to be monitored at the Experience of Care Oversight Group.
   - The updated **Terms of Reference** were reviewed; however, it was agreed that the Deputy Trust Secretary should reschedule the "To agree updated Terms of Reference" item to the Committee's meeting in November 2024, to enable further consideration of the proposed amendments by Committee members and it was noted that "Medical Director" should be amended to "Chief Medical Officer" within the Committee's Terms of Reference.
   - The Chief Medical Officer presented the **summary report from the Patient Safety Oversight Group** which included the reduction in *Clostridium difficile* (*C. diff*) rates; and the next steps in relation to the thematic review of patients lost to follow-up; but, it was noted that further work was required in relation to Venous Thromboembolism (VTE) Risk Assessments. It was agreed that the Chief Medical Officer should explore the development of a combined escalation report to the Quality Committee for those Oversight Groups which met on a monthly basis.
     - ❖ The Committee was **assured** that there was a robust focus on the areas of concern which had been identified and noted the positive assurances which had been received within the reporting period.
   - The Deputy Chief Nurse, Quality and Experience presented the **summary report from the Experience of Care Oversight Group (EOCOG)** wherein an in-depth discussion was held regarding the Trust's current complaints performance and it was agreed that the Deputy Chief Nurse, Quality and Experience should provide an update on the Complaints Improvement Plan and the trajectory for the improvement in complaints performance to the Committee's meeting in November 2024. The Committee was also informed of the establishment of Patient / Carer Panels, which was supported; although, it was noted that it would be beneficial to have representatives that had both acute and long-term experiences of the Trust.
     - ❖ The Committee was **partially assured** as although there was a robust focus on the improvement of communication and progress had been delivered major against the actions commissioned by the EOCOG; there remained areas for improvement such as the Trust's complaints performance, which the Committee allocated **limited assurance** and requested to review the complaints improvement plan and associated improvement trajectory.
   - The Director of Maternity the **summary report from the Maternity and Neonatal Assurance Group** wherein the Committee highlighted the importance of pastoral support for nursing and midwifery staff and acknowledged the importance of a consistent induction process for interim / locum clinical staff; so, it was agreed that the Chair of the Quality Committee should liaise with the Chief People Officer to ensure that there was an appropriate induction process for all interim / locum clinical staff. It was also agreed that the Director of Maternity should liaise with the Head of Risk Management to review and, if appropriate, amend the descriptions for the Trust's maternity and neonatal risks.
     - ❖ The Committee was **assured** regarding the enhancements which had been developed to support service delivery within Maternity and Neonatal Services; although, acknowledged that the Maternity Services Improvement Plan was ongoing.
   - The Committee reviewed the **Joint Safeguarding Annual Report for 2023/24** (which has been submitted to the Trust Board under a separate agenda item) which included details of safeguarding compliance across the Trust, and the Mental Capacity Act audit which was scheduled for October 2024. The Committee emphasised the importance of considering all aspects of safeguarding incidents beyond the primary presentation / allocated terminology.

- ❖ The Committee was **assured** that there was sufficient focus on the management of safeguarding incidents and a robust action plan to enhance training compliance.
- The **minutes of the Quality Committee 'deep dive' meeting, 10/04/24**, and the **recent findings from relevant Internal Audit reviews** were noted.
- The Committee conducted an **evaluation of the meeting** wherein Committee members provided their observations and reflections on the meeting which included the enhanced functionality afforded by the revised Committee structure and the important of the development of the Board Assurance Framework (BAF).

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

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

- The Committee allocated a limited assurance rating in relation to the Trust's complaints performance.

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

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

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

Summary report from the Finance and Performance Committee, 27/08/24	Committee Chair (Non-Exec. Director)

The Committee met on 27th August 2024, virtually, via web conference.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The Deputy Chief Executive / Chief Finance Officer presented a 'deep dive' into **the Trust's Financial Improvement Plan** wherein in-depth consideration was given to the Trust's updated forecast financial position, the status of the downside assumptions which had been included, and the risks not included in the forecast. It was agreed that Total Headcount should be included as a metric within future financial forecasting reports to the Finance & Performance Committee (FPC) and to schedule monthly reports on the Trust's Financial Improvement Plan to the committee (to include delivery against the phased forecast for the year and further potential actions to be taken to achieve the plan, with trigger dates)
     - ❖ The Committee was **assured** re the focus and clarity evidenced in the report and by the progress made in certain areas, including reduction of agency costs; however, the need to retain focus on delivery of the actions within the plan, to confirm trigger dates for difficult decisions, and to identify further actions to achieve full recovery of the Trust's financial position was acknowledged.
   - The review of **Kent and Medway Pathology Network joint venture proposal** provided an update on progress with the development of a business case for a joint venture between the four acute trusts in Kent and Medway to deliver pathology services from 2025. It was noted that Maidstone and Tunbridge Wells NHS was considering the role of host for the joint venture, along with one other local trust. The intention to commence with a simple joint venture model, retaining workforce & budgets within existing trusts, with a single overarching management committee, but with longer term plans to develop a more advanced model was noted.
     - ❖ The Committee was **assured** by the level of planning and engagement evident, but noted the need for a collaborative approach to the venture and continued engagement with other partners to address any specific concerns re the proposed arrangements
   - The **Full Business Case for Cardiology Reconfiguration** was presented, and the proposed arrangements for funding the new build and refurbishment elements of the case, confirmed. The lack of some detail and level of development within the case was noted, due to the need to meet timescales for funding in the current year and to resolve complex contractual issues relating to the new build. In the light of this, approval was granted to move forward with the ward refurbishment work, including capital expenditure in year, getting fixed costs as a first step to allow for a go/no go decision at the FPC meeting in September. Approval was also granted to continue working with Medtronic and advisers to explore the viability the new build arrangements. More generally, the need for improved planning and governance based on learning from the Trust's other recent major capital projects was noted.
   - The Committee's **forward programme** was noted.

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

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

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

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

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

Summary report from the Finance and Performance Committee, 24/09/24	Committee Chair (Non-Exec. Director)

The Committee met on 24th September 2024, face-to-face / In-person, at Maidstone Hospital.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The Financial Improvement Director and Deputy Chief Executive / Chief Finance Officer presented a 'deep dive' into **the Trust's Financial Improvement Plan.** It was acknowledged that a significant amount of work was being done to address the financial challenge this year. Despite this effort, further work was needed regarding the development of phase two downside actions and associated triggers to support the delivery of the financial position by the end of the year. It was agreed that the Deputy Chief Executive / Chief Finance Officer should ensure that the "Monthly update on the Trust's Financial Improvement Plan" report to the Committee's meeting in October 2024 includes details of the phase two options and associated potential triggers and, where feasible, risk adjusted values for those risks not included in the financial forecast.
     - ❖ The Committee was **assured** regarding the improvement in the financial forecast for 2024/25; however, acknowledged the remaining risks to the financial position and the importance of contingencies to support the delivery of the financial plan.
   - The Chief Operating Officer and Director of Strategy, Planning and Partnerships presented an **update on Cardiology Reconfiguration**, which included a summary of the current position; details of the timeline for the development of the Full Business Case; and the key risks and mitigations which had been identified. It was agreed that the Deputy Director of Finance, should review the financial model associated with cardiology reconfiguration to ensure the impact on the Trust's income and expenditure was accurately captured. It was also agreed that the Director of Strategy, Planning and Partnerships should ensure the "Update on Cardiology Reconfiguration" report to the Committee's meeting in October 2024 includes details of the potential impacts and sensitives of the associated risks.
     - ❖ The Committee was **assured** regarding the development of the Full Business Case; but, noted the importance of ensuring the risks were sufficiently addressed.
   - The Committee reviewed the **financial performance for August** and a discussion was held regarding the importance of identifying the remaining Cost Improvement Programmes (CIPs) for 2024/25.
   - The Committee reviewed the latest **quarterly productivity report** wherein a discussion was held regarding the proposed productivity and efficiency scorecard. The Committee supported the proposed approach and the introduction of quarterly 'deep dives' into the productivity and efficiency of specific service areas; but acknowledged the challenges in terms of comparison to other NHS providers. It was agreed that the Deputy Chief Executive / Chief Finance Officer should investigate the inclusion of the financial implications of any changes in productivity within future "Quarterly productivity report" reports and include details of the denominator and numerator for the productivity growth metrics.
   - The Deputy Director of Finance, Performance presented the **annual report on the capacity and effectiveness of the finance function** which included an overview of the staffing composition of the finance function, the stability of senior finance team, and the capacity and risks within the finance function. The Committee noted the strong performance of the finance team.
     - ❖ The Committee was **assured** regarding the effectiveness of the finance function; although, acknowledged that further investment may be required in the future as the Trust was an outlier in terms of expenditure on the finance function.
   - The **Patient Access strategic theme metrics for August** were reviewed, and the Committee was informed of improvement in the cancer treatment backlog and the progress in relation to the provision of system support.
     - ❖ The Committee was **assured** regarding the continued delivery of operational performance.
   - The Committee reviewed the **plan for the forthcoming winter period**, which has been submitted to the Trust Board under a separate agenda item, wherein the Committee

acknowledged the forecast gap in terms of capacity and the mitigations which had been identified to reduce the gap between forecast activity and available bed capacity at the Trust.
  - ❖ The Committee **did not allocate an assurance rating** as it was acknowledged that a further iteration of the plan for the forthcoming winter period would be considered in October 2024.
- The Director of Estates and Capital Developments attended for the latest **update on the Estates Directorate** wherein the Committee acknowledged the implicit of financial constraints on the delivery of the Estates transformation programme.
  - ❖ The Committee was **assured** that there was sufficient focus on improving the Trust's Estate and mitigating any associated risks.
- The Committee reviewed the **second completion for the acquisition of the Spire Tunbridge Wells Hospital** and the updated business plan for the remainder of 2024/25. The Committee noted the changes to the plan overall which still delivered the required levels of activity plus creating further opportunities for the Trust. The committee emphasised the importance of considering any further productivity and efficiency enhancements. It was agreed that the Deputy Chief Executive / Chief Finance Officer should provide clarification regarding the accounting for the financial position associated with the Spire Tunbridge Wells Hospital in the first half of 2024/25. The Committee agreed to recommend that the Trust Board approve the second completion for the acquisition of the Spire Tunbridge Wells Hospital, which has been submitted to the 'Part 2' Trust Board meeting.
- The Director of IT and Associate Director of Business Intelligence attended for the latest **quarterly update on the implementation of the Digital and Data Strategy** which included the delays associated with the introduction of the governance structure for the Digital and Data Strategy and the potential implications of the Independent investigation of the NHS in England.
- The **summary report from the from the June 2024 People and Organisational Development Committee meeting;** the **report submitted to the People and Organisational Development Committee in relation to the "Reduce the amount of money the Trusts spends on premium workforce spend" Breakthrough Objective** and the **review of the calculation and monitoring of the Trust's Carbon Footprint Plus** were noted.
- The Committee received notification of the **use of the Trust Seal.**

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

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

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 20/09/24	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (Face-to-face / in-person at Maidstone Hospital) on 20th September 2024 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Committee conducted a **review of the risk, impact and assurance of the temporary staffing financial improvement programme** wherein the Committee held an in-depth discussion regarding the actions required to reduce Premium Workforce spend by a further £1.5m per month, noting the main areas of focus which included the establishment of a standardised medical bank rate framework; implementation of roster performance meetings to support divisions in reducing temporary staffing spend; the removal of non-clinical agency; and reduction in bank/overtime in corporate areas. The importance of creating a culture of accountability for bank expenditure within the triumvirates was also highlighted.
  - ❖ The Committee was **assured** as there were a number of measures in place, and preparations for further controls, to help reduce the temporary staffing spend. It was also noted that there was a clear next step to include more accurate figures for the estimated monthly value and the estimated value of the scheme for 2024/25, in order to gain a stronger understanding of how and where each control would provide a direct expenditure saving.
- An **update on the Multi-professional Learning and Development Strategy** was provided, and it was noted that a 'deep dive' into the Strategy would be presented at the Committee meeting in November 2024, with a launch date of April 2025 as planned, due to being unable to establish the required focus groups as anticipated.
- The Head of Risk Management and Head of People Performance and Improvement presented the latest **review of the Trust's People related risks** which included that from the current red-rated risks, two out of the four had been confirmed as closed, or would be closed within the next two weeks, with controls in place to mitigate the other risks. A discussion was then held around where the risk of racism and discrimination would lie within the Trust, and it was highlighted that an increase in reports of racist comments and feedback on structural racism within the Trust had been identified following the recent civil unrest, with mechanisms in place to ensure staff were listened to.
  - ❖ The Committee was **assured** that the vacancy risks were reducing and that clear management of the remaining Trust's People related risks was in place.
- The Head of People Performance and Improvement presented the latest monthly review of the "**Strategic Theme: People" section of the Integrated Performance Report (IPR)** which included that the Trust had achieved the 7th successive month in a row of turnover falling and sitting below the target of 12%, which was the Trust's corporate breakthrough objective for the Strategic Theme: People. A discussion was then held around the turnover and recruitment hotspot area of Medicine and Emergency Care and it was agreed that the Head of People Performance and Improvement should include additional information on the turnover countermeasures, specific to the Medicine and Emergency Care division, in the next "Monthly review of the "Strategic Theme: People"…" report and for the People Business Partner for Medicine and Emergency Care to attend for the item in October 2024.
  - ❖ The Committee was **assured** that there was the appropriate focus on continued improvements.
- The Committee reviewed the latest **annual report on the outcome of the Trust's internal compliance checks regarding the DBS checking process**, and it was noted that monthly sessions had been implemented to ensure there was a regular forward look on the data and an escalation process for any outstanding DBS checks. In addition to this, it was noted that the team were also investigating how to make the renewal process more user-friendly (with a focus on simplifying guidance) and for both renewals and new starters to sign up to the government's automatic service. A conversation was then held around who was responsible for ensuring DBS

checks were completed for the Trust's Contractors, and it was agreed that the Deputy Chief People Officer – People and Systems would investigate whether Contractors should be included within the Trust's internal compliance regarding the DBS checking process.

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

- The Deputy Medical Director, Workforce and Digital would provide Committee members with further details of the costs relating to the potential implementation of more regular 360 discussions for medical staff.
- The Head of People Performance and Improvement would ensure that accurate figures in relation to bank expenditure and data relating to the tracking of time to appoint for consultants, would be included within the next "Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)" report.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for August 2024	Chief Executive / Executive Directors

The IPR for month 5, 2024/25, 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, 24/09/24

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

August 2024

MTW
exceptional people, outstanding care

Contents

Appendices

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

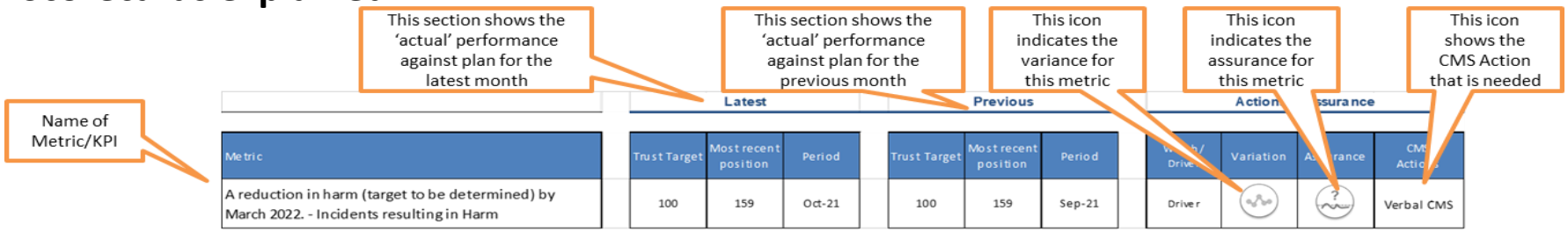
Escalation Rules:

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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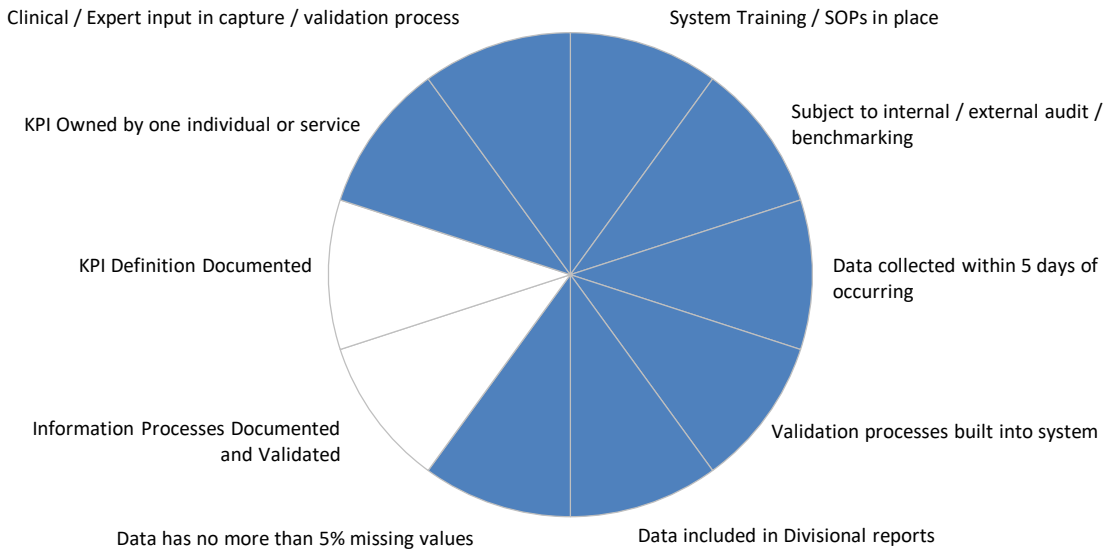
Forecasts

	CQC Domain	Metric	DQ Kite Mark	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions	Forecast: 3 Month Forecast	Forecast: Variation	Forecast: Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%		12%	8.5%	Sep-23	12%	8.6%	Aug-23	Driver			Note Performance	8.1%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	12.8%	Sep-23	12%	12.7%	Aug-23	Driver			Full CMS	12.7%		

A three month forward view forecast has been included in the IPR for the Vision and Breakthrough metrics. Variation and Assurance icons being generated for the forecasted position to give an indicative view of performance at that point. There are varying approaches being used to generate these forecasts. Some are statistical and others based on detailed plans and / or upcoming known events. These are signed off by Exec. SROs.

Data Quality Kite Marks



A Kite Mark has been assigned to each metric in the report. This has been created by assessing the source system against relevant criteria as well as the documentation and oversight associated with each metric.

A point has been assigned for each of the criteria met. The maximum score is ten. There are ten segments in the Kite Mark image and the corresponding segments are shaded blue based on those that have been met.

The ordering of the criteria has been kept consistent so users can see which criteria are met/unmet. So in the example shown, the 'KPI documentation' and 'Information Process documentation' are unmet.

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The Trust continues to have a significant number of indicators that are now experiencing special cause variation of an improving nature and passing the target for more than six consecutive months.

Vacancy Rate increased slightly above the 8% limit in August at 8.5%, but continues to experience common cause variation and variable achievement of the target. Turnover Rate continues to experience special cause variation of an improving nature and is no longer escalated and continues to achieve the target for six consecutive months. The new indicator for the number of staff that leave within 12 months (as a percentage of all leavers) and the number of staff that leave within 24 months (as a percentage of all leavers) is now escalated as has not achieved the new target for six months. Agency spend failed the target in August after achieving the target for the first time in July, but continues to be in common cause variation and variable achievement of target. The Trust continues to implement a number of actions to improve performance. The Nursing Safe Staffing levels were at 100% in August and the target has been achieved for more than six consecutive months. Sickness levels has reached the maximum limit at 4.5%. Statutory and Mandatory Training continues to experience special cause variation of an improving nature and consistently passing the target.

The targets for the national EDI metrics for representation at 8c and above have increased for 2024/25. The Trust is consistently achieving the target for both the percentage that are female or have a disability. The percentage of staff Afc 8c or above that are BAME continues to experience common cause variation and consistently failing the target. Recognising there is work to be completed to improve the position for BAME representation, a monthly improvement trajectory has been developed and the Trust continues to implement a number of actions to improve performance is this area. The Trust was £2.8m in deficit in the month which was £1.1m adverse to plan. Year to Date the Trust is £11.5m in deficit which is £3.3m adverse to plan.

The rate of incidents causing patients moderate or higher harm decreased sharply in August and has returned to common cause variation and variable achievement of the target. The breakthrough indicator of incidents of moderate+ harms due to potential mismanagement of deteriorating patients is now confirmed, though a target is yet to be determined. The rate of C.Difficile continues to experience common cause variation and failing the target for more than six months. The Rate of E.Coli continues to experience common cause variation and passing the target for more than six months. The Rate of Falls per 100,000 occupied beddays remains in common cause variation and variable achievement of the target and remains escalated as has been in variable achievement of the target for more than six months. Complaints data is now fully updated. The number of complaints related to communication issues remains in common cause variation and variable achievement of the target. VTE performance was lower than the national target of 95% in July and continues to experience special cause variation of a concerning nature and consistently failing the target. An action plan for improving performance for this indicator is being developed. Friends and Family Response rates for Outpatients and A&E continue to improve in August following the launch of the new provider.

Diagnostic Waiting Times continues to experience common cause variation and variable achievement of the target. Focus work continues for the two modalities mostly affecting the overall under-performance. With regards to RTT the Trust continues to provide system support (SYS) to other Trusts across Kent and Medway which is therefore adversely affecting the Trust's performance that is reported nationally. RTT was below the trajectory target for August of 76.7% at 72.2% (Excluding SYS). Nationally we reported 70.9% (including SYS). This indicator is experiencing common cause variation and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters. Nationally we have reported 418 52 week breaches at the end of August 24, an improvement from July 24. Of the 418 52 week breaches, 2 were for non-SYS patients. The Trust continues to achieve the internal target of less than 1.5% of total patients waiting having waited more than 40 weeks (Excluding SYS) and remains in special cause variation of an improving nature and passing the target for more than six consecutive months.

Executive Summary (continued)

Executive Summary (Continued):

Outpatient Utilisation is no longer escalated as is now experiencing common cause variation and variable achievement of the target. The finalised performance for July achieved the target of 85% at 86%. August performance will continue to improve as cashing up of clinics continues. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute is now experiencing common cause variation. The percentage of patients on a PIFU Pathway is experiencing special cause variation of an improving nature and has passed the target for more than six months. Performance for both First Outpatients and Elective Activity (Inpatients and Day Case combined) were above plan and 19/20 levels for August. Both have passed the target for more than six consecutive months. The Trust is now monitoring performance against the new indicator for the rate of all outpatient appointments that are either a new appointment or a follow up appointment with a procedure. The national target is to have a rate of 49% or above. For August the Trust achieved a rate of 57%. This indicator is experiencing special cause variation of an improving nature and passing the target for more than six consecutive months. Diagnostic Imaging activity levels were above plan and 19/20 levels in August and continues to experience special cause variation of an improving nature and has passed the target for six months.

The number of patients leaving our hospitals before noon is experiencing common cause variation and consistently failing the target. The top contributors have been identified and a number of actions continue to be implemented to improve the timely discharge of patients. The rate of patients no longer fit to reside remains in common cause variation. Ambulance Handovers <30mins continues to experience common cause variation and has passed the target for six months. The Trust's performance for A&E 4hrs was below the trajectory target for August at 85.7%, having now failed the target for more than six consecutive months. Performance remains one of the highest both Regionally and Nationally. Work continues to improve flow across the Trust. The Trust continues to achieve the new combined 62 day First Definitive Treatment Standard, 28 Day faster diagnosis compliance standard and the new combined 31 day first definitive treatment standard. Work continues to maintain compliance of all the Cancer Waiting Times (CWT) standards. CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh.

Both of the indicators for Women waiting for Induction of Labour (in less than 2 or 4 Hours) are consistently failing the target. The project continues to review demand and capacity and to identify opportunities to improve flow throughout the department. Both of the indicators for Decision to delivery interval (Category 1 and Category 2) caesarean sections are experiencing special cause variation of an improving nature but are not at the required level. Category 1 <30mins has failed the target for more than six months and Category 2 <75 mins is consistently failing the target. Improvement activity and the A3 project continues to identify the root cause of delays and potential mitigation and solutions.

Escalations by Strategic Theme:

People:
- % of Afc 8c and above that are BAME (P.10)
- Staff Leavers <12 mths (as a % of all leavers) (P.10)
- Staff Leavers <24 mths (as a % of all leavers) (P.10)

Patient Safety & Clinical Effectiveness:
- Infection Control – Rate of C.Diff (P.12)
- Rate of Falls per 1,000 occupied beddays (P.12)*

Patient Access:
- RTT Performance (P.15)
- Outpatient Calls answered <1 minute (P.16)
- A&E 4hr Performance (P.16)
- Emergency Admissions in Assessment Areas (P.16)*

Patient Experience:
- New Complaints Received (P.18)*
- Complaints responded within target (P.19)
- VTW Risk Assessment (P.19)
- FFT Response Rates: All areas (P.20)

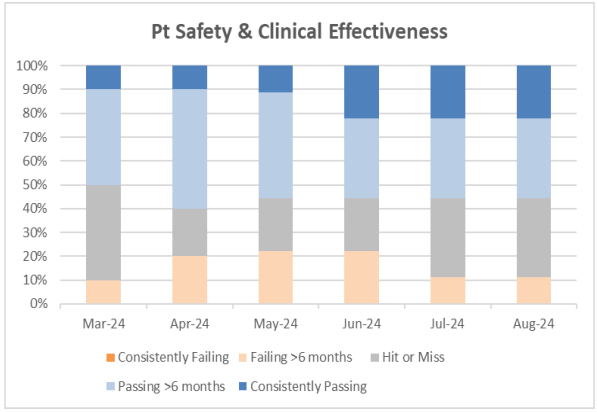
Systems:
- Discharges before Noon (P.22)

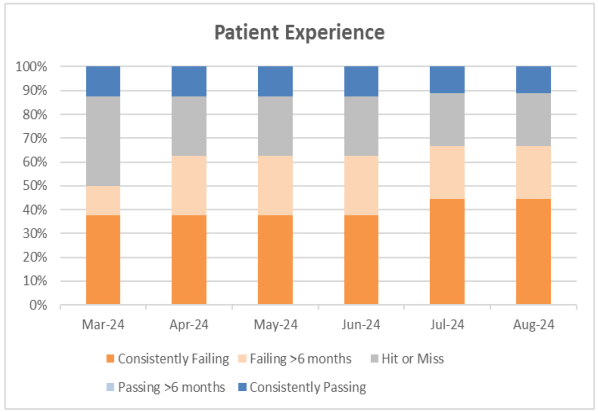
Sustainability:
- None escalated

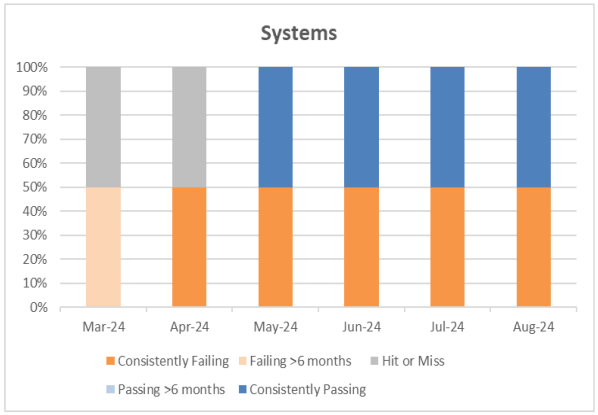
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.25)
- Women waiting for Induction of Labour <4 Hrs (P.25)
- Decision to delivery interval Category 1 caesarean (P.25)
- Decision to delivery interval Category 2 caesarean (P.25)

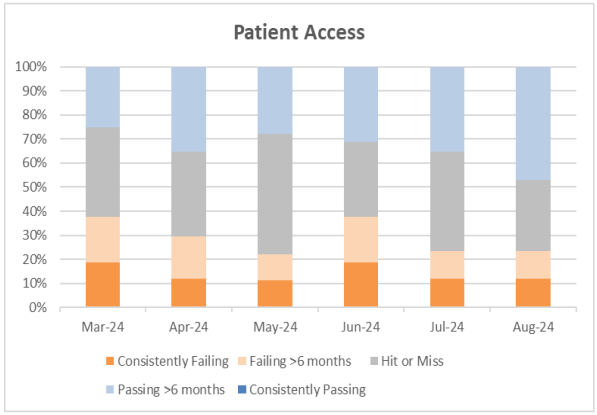
** Escalated due to the rule for being in Hit or Miss for more than six months being applied*

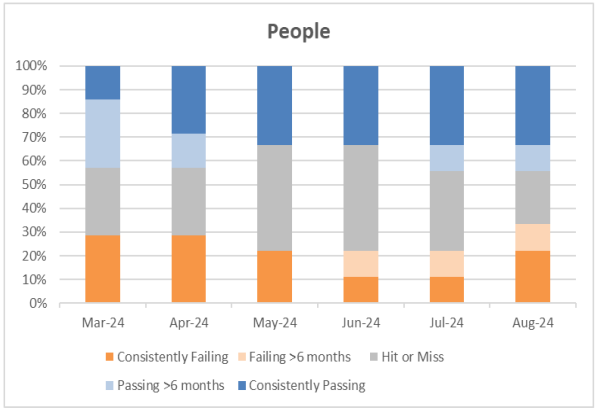
Assurance Stacked Bar Charts by Strategic Theme

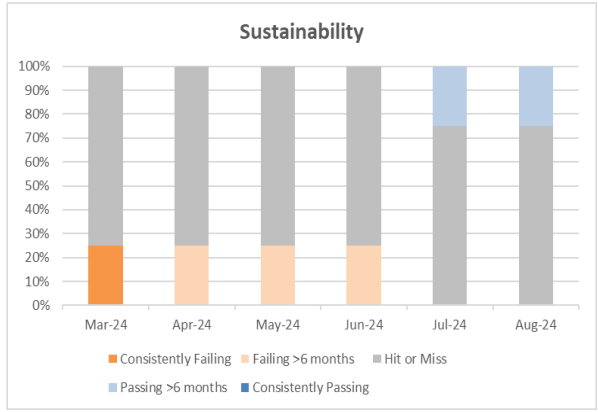












Matrix Summary

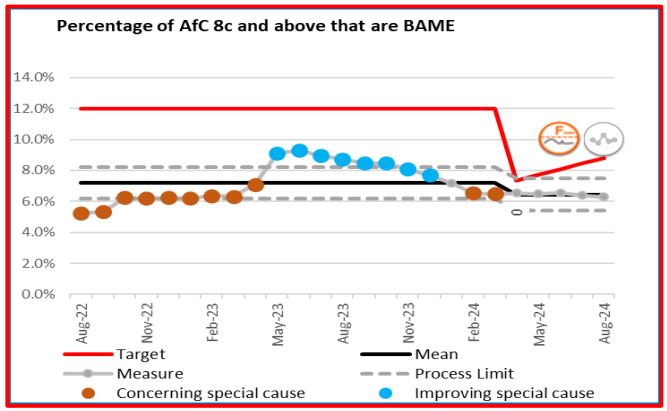
August 2024

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement	Statutory and Mandatory Training Standardised Mortality HSMR	Reduce Turnover Rate to 12% Never Events Safe Staffing Levels (Nursing) IC - Rate of Hospital E.Coli per 100,000 occupied beddays Cancer - 62 Day (New Combined Standard) data runs one month behind Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) Transformation: % of Patients Discharged to a PIFU Pathways To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	To achieve the planned levels of new outpatients activity (shown as a % 19/20) Ensure activity levels for diagnostics match those pre-Covid - Colonoscopy Ensure activity levels for diagnostics match those pre-Covid - Flexi Sigmoidoscopy Ensure activity levels for diagnostics match those pre-Covid - Gastroscopy RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Transformation: % OP Clinics Utilised (slots)		Achieve the Trust RTT Trajectory (Excluding SYS) Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally Transformation: CAU Calls answered <1 minute Friends and Family (FFT) % Response Rate: A&E Friends and Family (FFT) % Response Rate: Outpatients
Common Cause	Percentage of AfC 8c and above that are Female Percentage of AfC 8c and above that have a Disability Summary Hospital-level Mortality Indicator (SHMI) Complaints Rate per 1,000 occupied beddays Decrease the percentage of occupied bed days for patients identified as no longer meets the criteria to reside (NCTR)	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) Cash Balance (£k)	Reduce the Trust wide vacancy rate to 8% Sickness Absence Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) IC - Number of Hospital acquired MRSA Bacteraemia Rate of patient falls per 1000 occupied bed days Access to Diagnostics (<6weeks standard) Cancer - 31 Day First (New Combined Standard) - data runs one month behind To reduce the overall number of complaints or concerns each month To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000 Capital Expenditure (£k)	Staff Leavers within 12 months (as a % of all leavers) Staff Leavers within 24 months (as a % of all leavers) IC - Rate of Hospital C.Difficile per 100,000 occupied beddays A&E 4 hr Performance Flow: % of Emergency Admissions into Assessment Areas % complaints responded to within target	Percentage of AfC 8c and above that are BAME To increase the number of patients leaving our hospitals by noon on the day of discharge
Special Cause - Concern				Friends and Family (FFT) % Response Rate: Inpatients	% VTE Risk Assessment (one month behind) Friends and Family (FFT) % Response Rate: Maternity

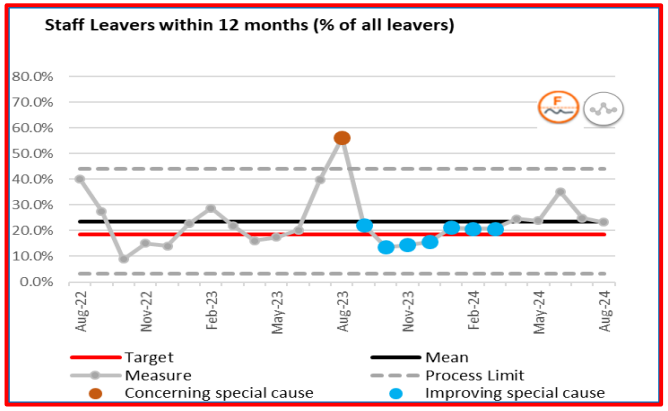
Strategic Theme: People

	CQC Domain	Metric	DQ Kite Mark	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions	Forecast: 3 Month Forecast	Forecast: Variation	Forecast: Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	8.5%	Aug-24	8.0%	8.3%	Jul-24	Driver			Verbal CMS	6.9%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12.0%	11.0%	Aug-24	12.0%	11.1%	Jul-24	Driver			Note Performance	10.8%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	4.5%	Jul-24	4.5%	4.1%	Jun-24	Driver			Not Escalated	4.36%		
	Well Led	Appraisal Completeness		95.0%	90.4%	Aug-24	N/A	N/A	Jul-24	Driver			Not Escalated	95.0%		
	Well Led	Statutory and Mandatory Training		85.0%	92.0%	Aug-24	85.0%	91.9%	Jul-24	Driver			Not Escalated	92.85%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	72.7%	Aug-24	66.0%	72.3%	Jul-24	Driver			Not Escalated	73.58%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	6.3%	Aug-24	4.0%	5.7%	Jul-24	Driver			Not Escalated	6.48%		
	Well Led	Percentage of AfC 8c and above that are BAME		8.8%	6.3%	Aug-24	8.4%	6.4%	Jul-24	Driver			Escalation	6.01%		
	Well Led	Staff Leavers within 12 months (as a % of all leavers)		18.4%	23.4%	Aug-24	18.4%	24.9%	Jul-24	Driver			Escalation	23.8%		
	Well Led	Staff Leavers within 24 months (as a % of all leavers)		35.3%	45.2%	Aug-24	35.3%	54.7%	Jul-24	Driver			Escalation	47.7%		

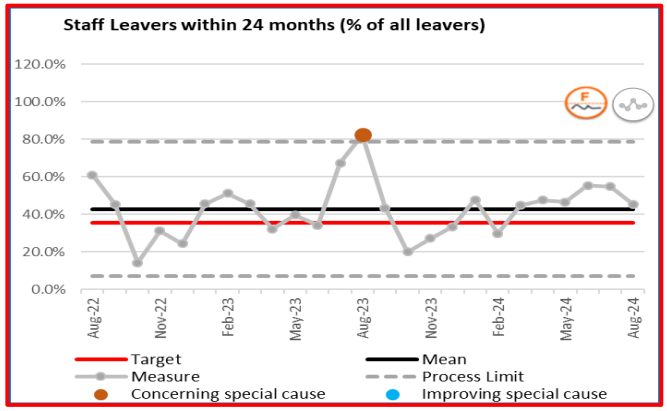
People – Workforce: CQC: Well-Led



Aug-24
6.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
8.4%
Business Rule
Full Escalation



Aug-24
23.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has failed the target for >6months
Max Limit (Internal)
18.4%
Business Rule
Full Escalation as failed the target for >6 months



Aug-24
45.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has failed the target for >6months
Max Limit (Internal)
35.3%
Business Rule
Full Escalation as failed the target for >6 months

Summary:

% of AfC 8c and above that are BAME: This metric is experiencing common cause variation and consistently failing the target.

Staff Leavers within 12 months (as a % of all leavers): This metric is experiencing common cause variation and has failed the target for >6months

Staff Leavers within 24 months (as a % of all leavers): This metric is experiencing common cause variation and has failed the target for >6months

Actions:

% of AfC 8c and above that are BAME:

Actions:

- Launch of focussed work on inclusive recruitment for bands 8b+
- Inclusive recruitment workshops extended to all recruiting managers
- Q3 24/25 focus on inclusive recruitment. Reverse mentoring cohort 3 planned.
- Increased visibility of staff networks through corporate briefing
- Whilst the EDI project is closing down, focus on EDI strategy and NHSE deliverables will continue for this group.

Staff Leavers within 12 AND within 24 months(as a % of all leavers):

- Actions associated with managing the number of leavers with 12 months or less service have been identified, with leads assigned. Work is underway to implement these actions.
- Our NHS People Promise Exemplar Programme focusses on flexible working, civility and respect and staff voice will also support this particular focus.
- We are also looking at more granular data to use in reporting for staff leavers in these cohorts, especially HCSWs and as part of divisional 'hotspots' work.

Assurance & Timescales for Improvement:

% of AfC 8c and above that are BAME:

- Since June, all band 8B and above roles have People BPs working closely with recruiting managers to support reviewing of JDs, adverts, shortlisting, interview and selection process. Will review progress in Q3.
- Between June and end of July, 5 x Inclusive recruitment workshops were delivered for recruiting managers in bands 8b and above – attendance 9, DNA 2, cancelled 1. Inclusive recruitment workshops extended to all recruiting managers to end Q3 24/25. 12 sessions - all fully booked
- EDI team have supported with the review of 6 x JDs for bands 8b+.
- Case study on success on reverse mentoring programme written and submitted to the ICB, to be submitted to NHS Futures Platform. Room availability challenge for launch of RM cohort 3.

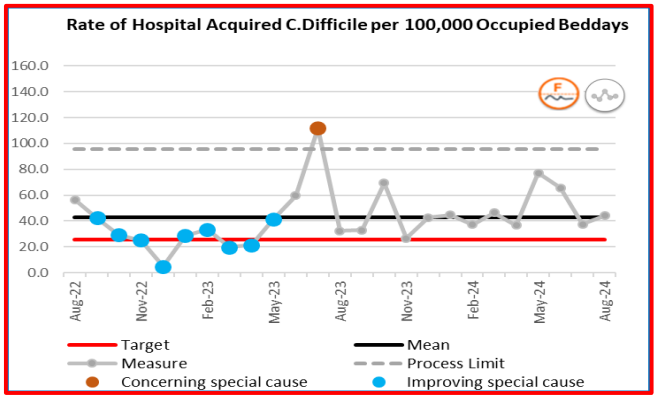
Staff Leavers within 12 AND within 24 months(as a % of all leavers):

- October 2023 review of divisional turnover hotspots
- Taking forward of remaining workforce supply programme board counter measures on turnover
- Q3 24/25 introduction of more granular metrics from surveys etc.

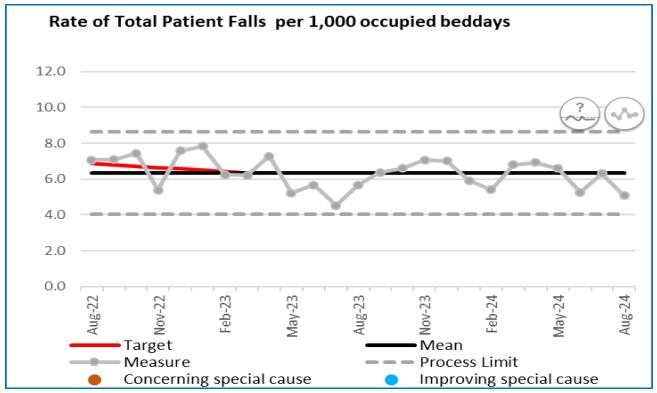
Strategic Theme: Patient Safety & Clinical Effectiveness

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	0.86	Jul-24	0.90	2.25	Jun-24	Driver			Verbal CMS	1.29 Jul 24		
Breakthrough Objectives	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		TBC	3	Jul-24	TBC	3	Jun-24	Driver				3		
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month	TBC	TBC	0	Aug-24	TBC	3	Jul-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month	TBC	TBC	9	Aug-24	TBC	16	May-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month	TBC	TBC	3	Aug-24	TBC	3	Jul-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	81.9	May-24	100.0	83.8	Apr-24	Driver			Not Escalated	79.1		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	93.0	May-24	100.0	93.0	Apr-24	Driver			Not Escalated	93.5		
	Safe	Never Events		0	0	Aug-24	0	0	Jul-24	Driver			Not Escalated	0		
	Safe	Safe Staffing Levels (Nursing)		93.5%	100.3%	Aug-24	93.5%	101.0%	Jul-24	Driver			Not Escalated	100.9%		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	5.5	Aug-24	32.6	0.0	Jul-24	Driver			Not Escalated	-8.4		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	44.2	Aug-24	25.5	37.5	Jul-24	Driver			Escalation	55.7		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Aug-24	0	0	Jul-24	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	5.1	Aug-24	6.4	6.3	Jul-24	Driver			Verbal CMS	5.6		

Patient Safety and Clinical Effectiveness: CQC: Safe



Aug-24
44.2
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Max Target
25.5
Business Rule
Escalated as failed target for 6+ months



Aug-24
5.08
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (Internal)
6.36
Business Rule
Has been in variable achievement for 6+ months

Summary:

Rate of C.difficile: is experiencing common cause variation and has failed the target for 6+ months.

Inpatient Falls Rate - is experiencing common cause variation and has been in variable achievement of the target for 6+ months

Actions:

Infection Control: We saw 7 cases of CDI during July which was lower than the preceding month. Actions being taken include.

- Further Trust wide incident held July with good attendance further actions identified to support a reduction in cases.
- Avoidable cases presented and discussed at PSIRG and escalated to Swarm huddle as needed.
- Deep cleaning planned for TW AMU at the end of August – ward 10 to be used as a decant facility
- Antimicrobial, IPC, PII audits undertaken to monitor compliance
- Ongoing surveillance and monitoring of cases – All sample ribotyped to support surveillance monitoring, sub-typing requested where there is suspicion of transmission of infection
- Weekly review of patients with CDI by the IPC team and with the Consultant Microbiologist during the C diff round
- Timely feedback of lessons learnt from rapid review investigations
- Enhanced cleaning undertaken on discharge and transfer of patients with CDI
- Review of bed turn around team at TW has improved turn around time as well as ensuring standards are being met and maintained
- Further subtyping (MLVA) has been sent to reference laboratory for 2 cases of 015 identified on Edith Cavell during July to ascertain if transmission of infection may have occurred
- IPC team to undertake further CDI focused interventions to address learning from incidents

Inpatient Falls Rate:

Monthly slip, trips and falls meeting taking place with the ward leaders (falls champions), matrons and heads on nursing. This also involves medical lead for falls prevention and education and AHP's

Use of the live falls dashboard at the monthly slip trip and falls meeting to review themes and trends. Further review is ongoing on areas that have high falls rate to identify keys actions required to support the clinical areas. Next steps to explore falls prevention with Patient First Improvement System (PFIS) local training.

Monthly falls champions meetings to follow up actions, good practice and learning from AAR and local incident reviews.

Monthly audits for lying and standing blood pressure in progress- current compliance trust at 73% in August-24 (Target is 85%). Certificates of achievement would now be given monthly to wards achieving above target consistently.

Weekly reviews of high risk falls patient now in place and supported by falls prevention practitioner.

Assurance & Timescales for Improvement:

Infection Control:

- Reduction in numbers seen in July
- IPC team involvement in ICB CDI collaborative exploring local and regional interventions
- Rapid reviews of all cases provide timely feedback of learning from cases
- Learning from investigations are shared within the Directorate via the HCAI weekly status and IPC monthly newsletter.
- Directorate IPC reports presented to IPCC with actions identified for improvement

Inpatient Falls Rate:

Training compliance for August-24 was 84% (Target 85%)- This is an improving trajectory. More training dates have now been released. Training will continue to be provided to ensure sustainability of good practice.

Reduction on the number of recurrent fallers to/ below 30 achieved for the past 4 months, ongoing review of recurrent fallers to prevent further falls.

Recruitment of the falls lead practitioner has taken place, start date confirmed 7th October, 2024.

Thematic reviews from AAR's ongoing, support provided in identifying any trends and also in providing learnings from incidents.

Monthly reports provided to the directorates identifying falls incidents and trajectories.

Falls action plan for 24/25 with KPI's approved at the Patient Safety Oversight Group July 2024. Next step is to align the milestones on how the actions will be achieved- this is lead by patient safety lead and the lead Nurse for Falls Prevention. First copy of milestone drafted.

Inpatient falls prevention and updates against the KPI's remain a standing item at the monthly patient safety oversight group.

Strategic Theme: Patient Access

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory (Excluding SYS)		76.7%	72.1%	Aug-24	76.0%	74.0%	Jul-24	Driver	H	F	Full CMS	73.8%	H	F
		Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		76.7%	70.9%	Aug-24	76.0%	72.5%	Jul-24	Driver	H	F	Business Rules not applied (for info only)			
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		115.3%	114.7%	Aug-24	134.7%	142.7%	Jul-24	Driver	H	?	Note Performance	116.7%	H	?
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		597	604	Aug-24	606	570	Jul-24	Driver	L	?	Not Escalated	636	L	?
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	541	Aug-24	N/A	681	Jul-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 52 weeks for treatment - Reported Nationally		N/A	418	Aug-24	N/A	496	Jul-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		98.0%	97.5%	Aug-24	98.0%	98.0%	Jul-24	Driver		?	Not Escalated	99.2%	H	?
	Responsive	A&E 4 hr Performance		86.5%	85.7%	Aug-24	86.5%	82.6%	Jul-24	Driver		F	Escalation	84.2%		F
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	97.4%	Jul-24	96.0%	97.8%	Jun-24	Driver		?	Not Escalated	96.0%	H	?
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.3%	Jul-24	85.0%	85.4%	Jun-24	Driver	H	P	Not Escalated	86.5%		P
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	77.1%	Jul-24	75.0%	75.4%	Jun-24	Driver	H	P	Not Escalated	78.8%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	93.6%	Jul-24	90.0%	91.7%	Jun-24	Driver	H	P	Not Escalated	95.4%	H	P

* The RTT Trajectory and Patients waiting more than 40 weeks excludes the patients that have been added to our waiting list as the Trust is now providing system support (SYS) to our neighbouring Trusts across Kent and Medway to help reduce long waiting patients to ensure these patients are treated as quickly as possible.

- CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh and the position is expected to improve.

Strategic Theme: Patient Access (continued)

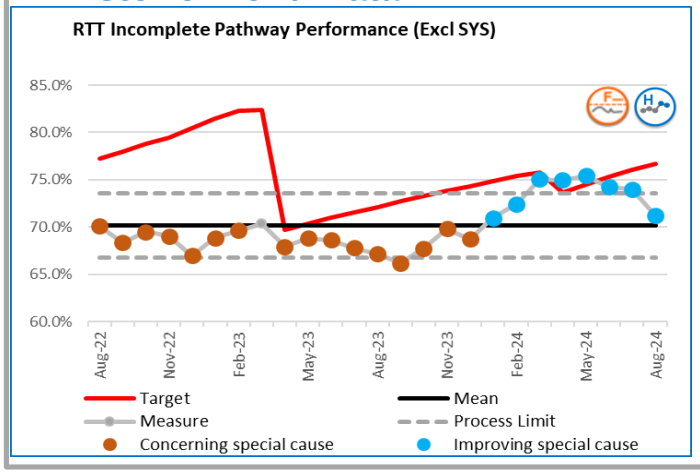
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	83.8%	Aug-24	85.0%	86.0%	Jul-24	Driver			Not Escalated	84.1%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		6.5%	6.7%	Aug-24	5.9%	7.5%	Jul-24	Driver			Not Escalated	7.4%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	87.4%	Aug-24	90.0%	86.8%	Jul-24	Driver			Escalation	92.2%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	3.9%	Aug-24	5.0%	4.7%	Jul-24	Driver			Not Escalated	3.7%		
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	62.4%	Aug-24	65.0%	61.4%	Jul-24	Driver			Escalation	61.7%		
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		119.9%	121.9%	Aug-24	122.9%	122.1%	Jul-24	Driver			Not Escalated	105.3%		
	Responsive	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	53.8%	Aug-24	49.0%	52.9%	Jul-24	Driver			Not Escalated	50.5		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		142.8%	155.3%	Aug-24	139.4%	146.5%	Jul-24	Driver			Not Escalated	165.0%		

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT (Excluding System Support)

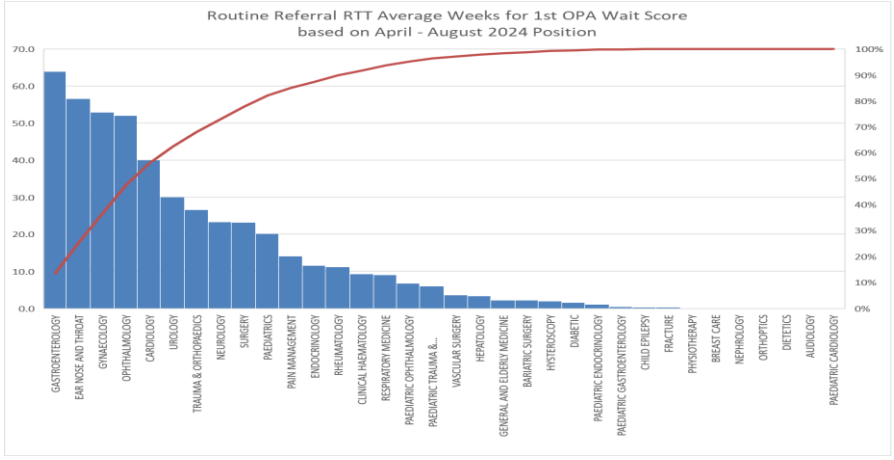
Owner: Chief Operations Officer
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Aug-24
71.2%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
76%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

Despite being above plan for our new outpatients, some of the key specialties with long waits are still under plan.
To further improve the trust RTT position the focus will look at reduction in waits for 1st routine elective appointment.
This was identified as the trust top contributors affecting achievement of the RTT national standard of 92%.

- Long waits for 1st Outpatient appointment – average wait @19 weeks.

BAU actions continue and focussed clinical engagement with Further Faster GIRFT Programme. Including implementation of STT, Clinical Validation, expansion of advice and guidance and delivering on Activity plans.

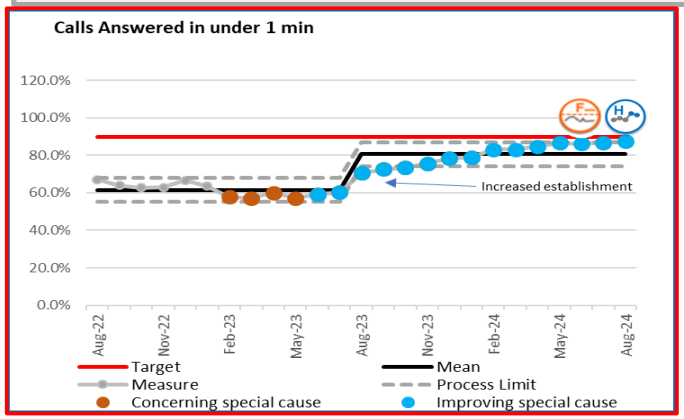
Key Risks:

- Waiting list growth could be affected due to increase in referrals and systems pressure.
- Industrial Action could affect internal improvement plans
- System long waiting patients affecting overall long waits and RTT position

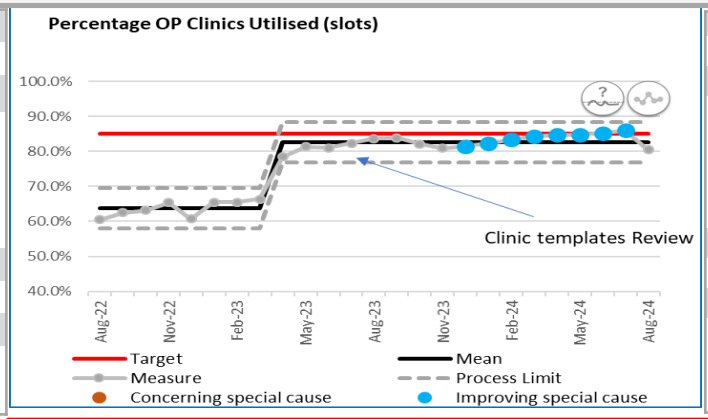
4. Action Plan

Countermeasures	Action	Who / By when	Complete
Trajectory	Trajectory for achievement of reduction in waits for 1st appointment agreed and communicated with specialty teams	SD/SC	June 24✓
Data Review	Review of data to identify specialties with longest waits.	SC/GM's	June 24✓
	Complete initial fishbone diagram with Root causes of waits for 1st appointments	SC/Tleads	July 24✓
	Identify 2 areas for focussed improvement- Gynaecology and ENT with further data to drill down on improvement areas	SC/GM	Aug 24 ✓
Improved New Outpatient Activity	Focussed work on GIRFT Further Faster initiatives,. Clinical validation standardisation pilots Reduction in FUPS and replacing with News in T&O following clinical validation	SC	On-going
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	Nov 24
Deep Dive into process	Process Mapping sessions with ENT and Gynaecology	SC/DAL/GM	September

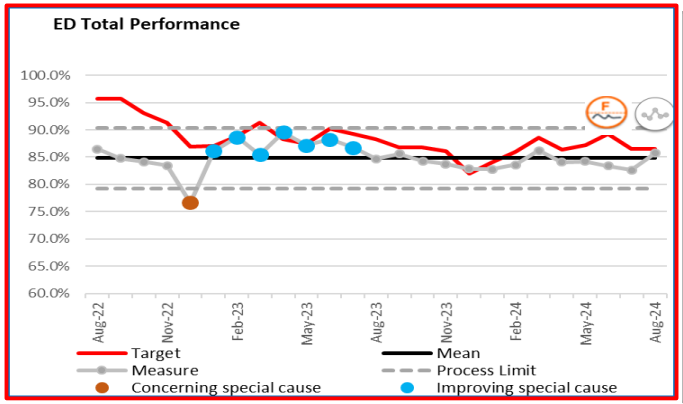
Patient Access: CQC: Responsive



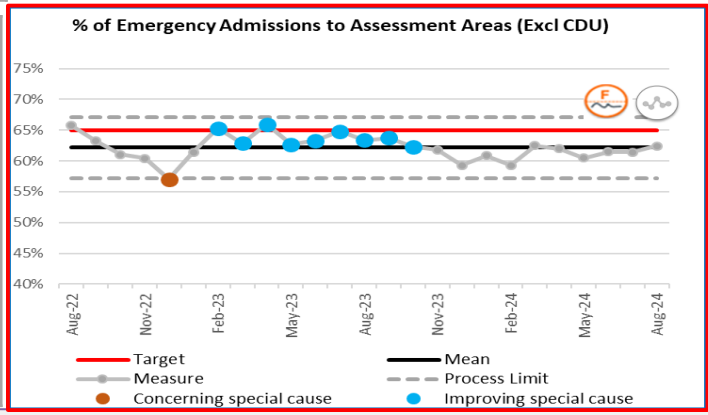
Jul-24
87.4%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as consistently failing the target



Jul-24
80.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target (Internal)
85%
Business Rule
Not escalated but shown for info



Jul-24
85.7%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for >6 months
Target (Internal)
86.5%
Business Rule
Full escalation as has failed the target for 6+months



Aug-24
62.4%
Variance / Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Target (Internal)
65%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

Calls Answered <1 min: is experiencing special cause variation of an improving nature and remains consistently failing the target. The areas currently below target consistently are: Endoscopy, Surgical Specialties, and T&O.

Outpatient Utilisation: is now experiencing common cause variation and variable achievement of the target. All Divisions are now achieving above 80% utilisation. **This indicator is no longer escalated.**

ED Performance <4hrs: is experiencing common cause variation and has failed the target for more than six months

% of Emergency Admissions to Assessment Areas (Excl CDU): is experiencing common cause variation but has failed the target for 6+ months.

Actions:

Performance against the under 1 minute KPI:. Daily report by hour and by speciality are circulated to the General Managers and team leaders to highlight peaks and troughs of performance. Bi-weekly KPI meetings with specialities to put in place actions to improve performance metrics.
Outpatient Clinic Slot Utilisation: All specialities are above 85% for clinic template utilisation for August 2024.
ED Performance<4hrs: The ED team are constantly reviewing ways to improve our performance and ensure consistency as we are seeing thousands more patients each month. The front to back door workstream has improvement ideas to try improve flow into and out of the hospital.
% of Emergency Admissions to Assessment Areas (Excl CDU): Medical SDEC performance continues to be at above national standard of 33% of medical take with AFU and AEC taking over 47%-48% of medical NE attenders. A trust wide working group for flow will have a focus on improvements in surgical SDEC including SAU pulling over night and OAU taking more patients from ED.

Assurance & Timescales for Improvement:

Calls Answered within 1 minute in the CAUs: Remain on upward trajectory. Focus on underperforming specialities to reach 90%. OCC has one vacancy being recruited to currently. Improving month on month towards the target.
Outpatient Slot Utilisation All specialities are above 85% for clinic template utilisation for August 2024.
ED Performance<4hrs: We continue to strive for our patients to be seen and either discharged or admitted within 4 hours. We have been working at our front door to stream what we can from initial assessment to the best areas which could be SDEC areas or our Urgent Treatment Centre. We are reviewing our current UTC capacity as we utilise the current slots
% of Emergency Admissions to Assessment Areas (Excl CDU): Outcomes from working group reviewed and action plan developed.

Strategic Theme: Patient Experience

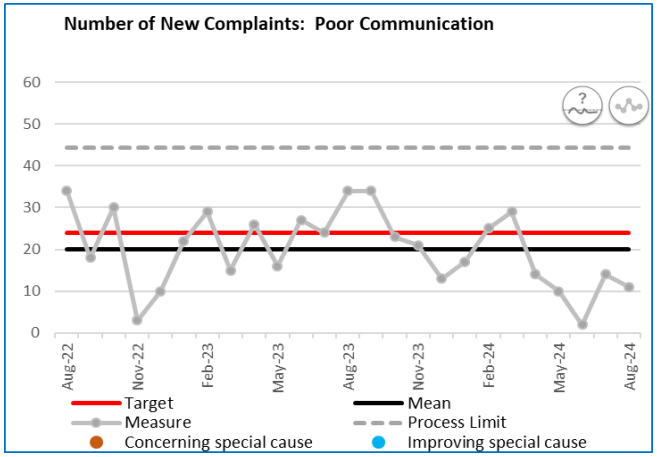
			Latest			Previous			Actions & Assurance				Forecast		
CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Caring	To reduce the overall number of complaints or concerns each month		36	37	Aug-24	36	25	Jul-24	Driver			Verbal CMS	33		
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	11	Aug-24	24	14	Jul-24	Driver			Verbal CMS	12		
Caring	Complaints Rate per 1,000 occupied beddays		3.9	2.0	Aug-24	3.9	1	Mar-24	Driver			Not Escalated	2.2		
Caring	% complaints responded to within target		75.0%	33.3%	Aug-24	75.0%	26.5%	Jul-24	Driver			Escalation	35.16%		
Caring	% VTE Risk Assessment (one month behind)		95.0%	83.6%	Jul-24	95.0%	85.1%	Jun-24	Driver			Escalation	87.78%		
Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	4.4%	Aug-24	25.0%	6.5%	Jul-24	Driver			Escalation	3.00%		
Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	15.74%	Aug-24	15.0%	12.51%	Jul-24	Driver			Escalation	13.57%		
Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	8.0%	Aug-24	25.0%	12.2%	Jul-24	Driver			Escalation	8.01%		
Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	11.3%	Aug-24	20.0%	8.3%	Jul-24	Driver			Escalation	8.92%		

Breakthrough: Counter Measure Summary

Metric Name – To reduce the number of complaints related to communication

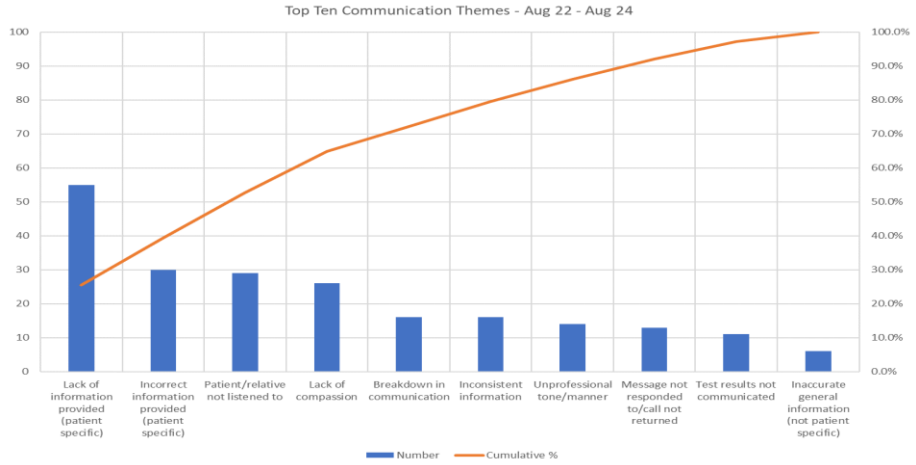
Owner: Chief Nurse
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Aug-24
11
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
36
Target Achievement
Metric is in variable achievement of the target for 6+ months

2. Stratified Data



3. Top Contributors and Key Risks

Using A3 Thinking, we have understood the themes of complaints received and poor communication was one of the main issues affecting patient experience.

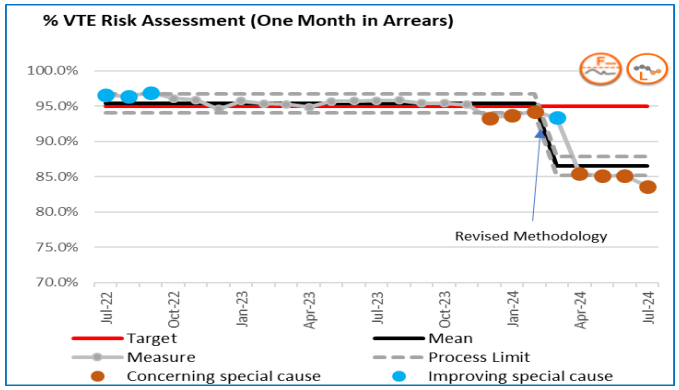
Key Risks:

1. The key risk to delivery of the breakthrough objective actions is primarily staff capacity.
2. Standardisation of measures about Divisional actions for complaints
3. Competing workloads for Divisional teams to execute actions related to feedback received.

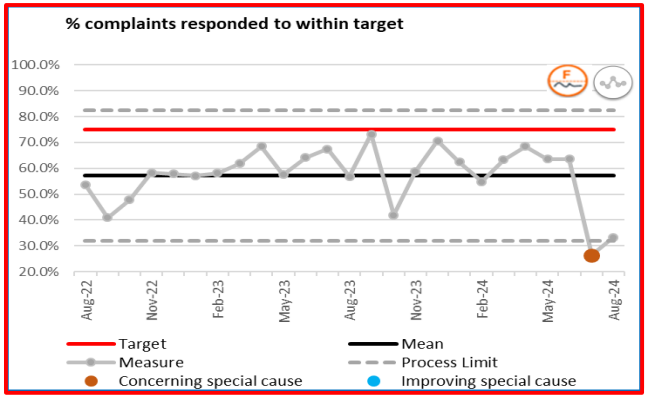
4. Action Plan of the Breakthrough Objective:

Workstreams	Action	Who
Written Communication - Patient Information Leaflets	• Working with the PILG group – to streamline processes and assurance for written information given to patients through Patient Leaflets	RG, GK
Education and Training	• Working with the Human Factors training team to create a bespoke training for Communication training	RG, SM, Sim team
Divisional Assurance	• Surgery and Medicine have **completed** their action plans – PDSA cycles are being followed. W&C are gearing up for their action plan	RG,S,M Divisional leads
Review of Communication theme from FFT	• Data from FFT being used to drive improvement action plans.	RG, RS, SM, SJ
Outpatient Communication themes	• To discuss with OPD GMs – specific themes relating to Outpatients departments	RG, GD, SM

Patient Experience: CQC: Caring



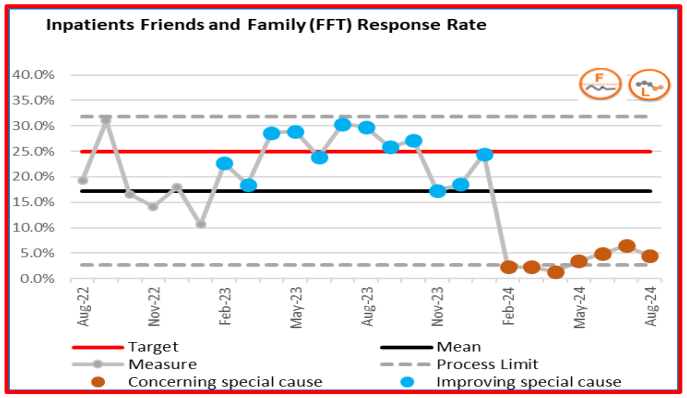
Jul-24
83.6%
Variance / Assurance
Metric is special cause variation of a deteriorating nature and consistently failing the target
Target (National)
95%
Business Rule
Full Escalation as Consistently Failing Target



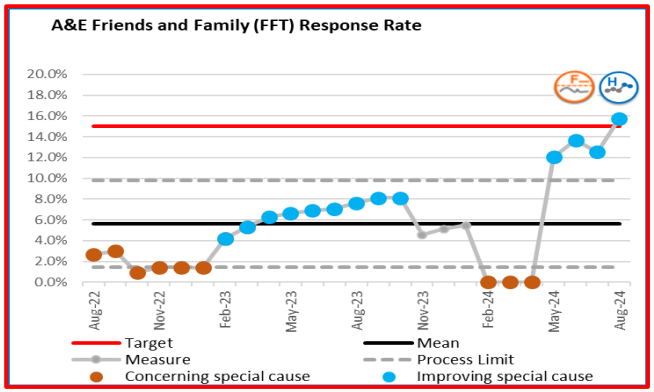
Aug-24
33.3%
Variance / Assurance
Metric is currently experiencing common cause variation and is failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as consistently failing the target

Summary:	Actions:	Assurance & Timescales for Improvement:
VTE Assessment : this indicator is experiencing special cause variation of a concerning nature and is consistently failing the target **Complaints Response Rate: T**his indicator is experiencing common cause variation and is has failed the target for 6+ months	**VTE Assessment:** 1. Addition of reminder and subsequent 'hard-stop' in Sunrise to prevent ordering if VTE risk assessment not completed. This went live 8th August but had to be retracted due to issues affecting paediatrics. Looking to reinstate ASAP. This will then be audited in Q2. 2. We are meeting with CIOs to look at ways of ensuring that the actual prescribing is being addressed. This is the area of most concern as evidenced by SIs, PSIIs and other incidents. 3. Adding VTE and anticoagulation as a Trust wide patient safety theme 4. Presentation at CG for Medicine in September 2024 to highlight issue. 5. Revisit VTE mandatory training for junior members of medical team **Complaints Response Rate:** Complaints performance recovery and stabilisation actions include: Expanding the number of Complaint Leads from two to five (as of the end of August, 4.5 WTE are in post). In addition, three interim Complaint Leads are currently providing support to the complaints team. Oversight meetings taking place with the DQG as well as weekly meetings between Complaints Leads and the directorates. A formal recovery plan and improvement trajectory is being finalised with the full details of actions being taken for review by the relevant committees.	

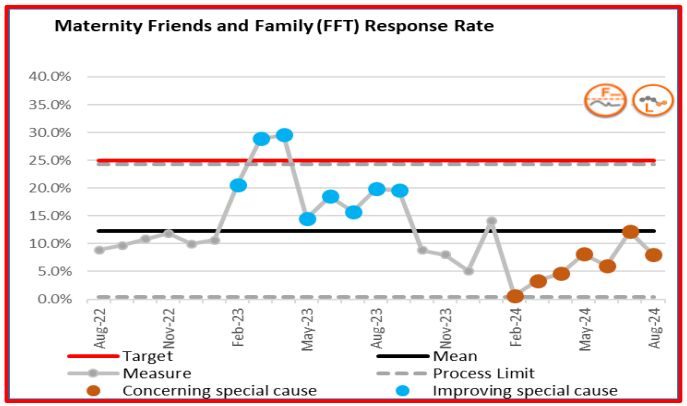
Patient Experience: CQC: Caring



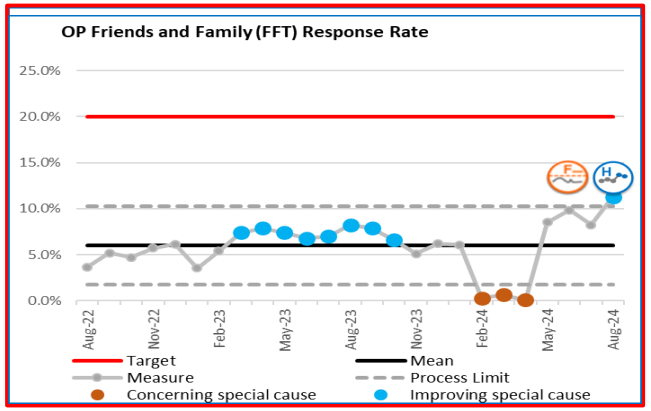
Aug-24
4.4%
Variance / Assurance
Metric is currently experiencing special cause variation of a deteriorating nature and has failed the target for 6+ months
Target (National)
75%
Business Rule
Full Escalation as Consistently Failing Target



Aug-24
15.7%
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-24
12.2%
Variance / Assurance
Metric is currently experiencing special cause variation of a deteriorating nature and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Aug-24
11.3%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

Friends and Family Response Rate - Inpatients: Is experiencing Special Cause Variation of an deteriorating nature and is consistently failing the target. National Rate – 21.6%
Recommended Rate is 92.3%

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
National Rate – 11.2%
Recommended Rate is 84.3%

Friends and Family Response Rate - Maternity: Is experiencing special cause variation of a deteriorating nature, but is consistently failing the target. National Rate – 13.1%
Recommended Rate is 92.5%

Friends and Family Response Rate - Outpatients: Is experiencing Special Cause Variation of an improving nature variation and is consistently failing the target. National Rate – 1.6%
Recommended Rate is 93.8%

Actions:

A&E: Response rate stays from 13.6% to 12.54% in July, compared to 11.2% nationally. Positivity is at 82%. ***Top themes positive:*** staff attitude, implementation of care, environment and waiting times. ***Themes to improve:*** *staff attitude, environment, waiting time, communication to patients, friends and family in addition to communication across the Multi-Disciplinary Team (MDT).*

Maternity: Response rate has increased from last month to 12.2% in July. 4 touch points has been deployed for text reminders as recommended by NHSE and with volunteers to help. Patient Experience team has just circulated FFT cards and posters containing QR codes to provide further options for response. Positivity rate is highest at 96.6%. Further review of the volunteers and their support to gather patient feedback in Maternity.

Sexual Health: Positive responses for recommendation of service 95% (212 responses for the month of July), 99% of patients felt they were treated with respect, 95% of patients said the treatment plan was explained clearly to them. Positive words include: *Helpful, made to feel very comfortable, caring, amazing, easy to access*. Areas of improvement include *waiting times, patients concerns not listened to.*
185 (81%) were booked appointments as compared 19% (43) walk in and wait.

Outpatients: Response rate is 8.9% in July compared to 10.2% in June. Top positive themes: *Staff attitude, implementation of care and environment* and top improvement theme were: *Staff attitude & communication (brusque, inaccurate information or instructions),environment waiting times within department (clinics consistently running late).*

Inpatients: Response rate has slightly increased since June to around 7%. Top positive themes: *Staff attitude (compassion and care, commitment), implementation of care, environment.* Top themes for improvement*: Staff attitude, environment and waiting times.* Emphasis now on the use of volunteers and FFT cards to get feedback from patients.

FFT Response All: Ongoing meetings with HCC to ensure correct mapping of clinical areas to feedback. Survey fatigue is currently set at 30 days for day cases and outpatient departments. This is currently under review and triangulate with repeat appointments within 30 days per patient.
Positivity rate continues to remain high at 94.25% for overall FFT responses.

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: SMS onboarding nearing completion for all clinical areas apart from Kent Oncology and Sexual health. Plans in place to include Fordcombe and KMOC in the hierarchy. FFT cards have been circulated along with posters with QR codes. First batch of cards for July have been sent to HCC for transcribing.
Sexual Health Services: Due to patient confidentiality, these services use a different FFT system and will continue to do so.

Strategic Theme: Systems

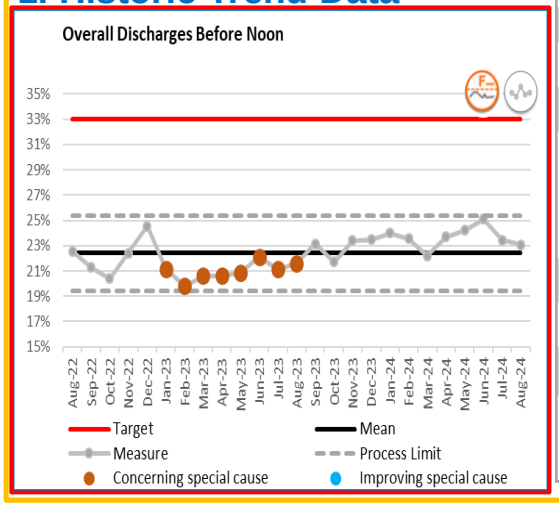
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the percentage of occupied bed days for patients identified as no longer meets the criteria to reside (NCTR)		24.5%	22.8%	Aug-24	24.5%	22.3%	Jul-24	Driver			Note Performance	23.2%		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	23.1%	Aug-24	33.0%	23.4%	Jul-24	Driver			Full CMS	23%		

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%

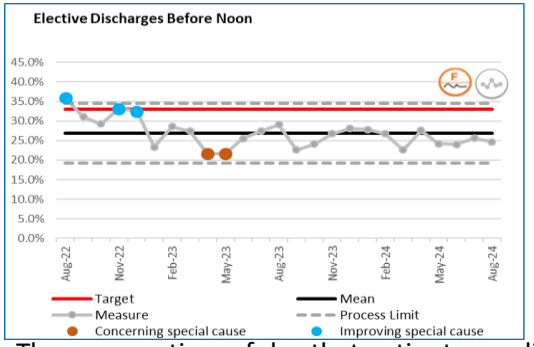
Owner: Director Strategy, Planning & Partnerships
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

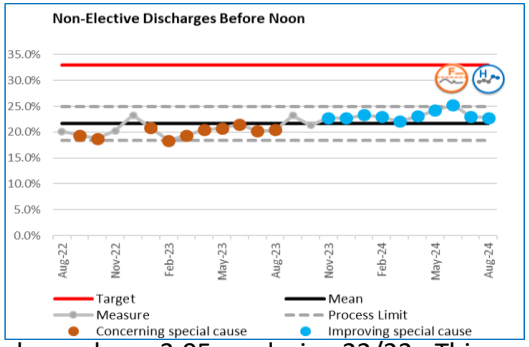
1. Historic Trend Data



Current Data Source: PAS
Aug-24
23.1%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data – improving special cause for Non-Elective DBN





The average time of day that patients are discharged was 3:05pm during 22/23. This has improved to 2.40pm throughout 23/24

3. Top Contributors and Key Risks

Area of Analysis	Considered a Top Contributor?
EDN	EDN completion is the top contributor in delays in discharge time.
TTOs & medicines optimisation	This could be linked to availability of the EDN, as this is the trigger for TTO related processes and the pharmacy internal KPIs are being achieved.
Criteria Led Discharge	Data shows Criteria led discharge was only utilised 1.3% of all discharges – hence focus around identifying patients with CLD and recording them on Sunrise, have been identified. Currently a key issue is inability to pull accurate data to identify no. of Criteria led discharges

1. Clinical capacity to prioritise EDNs
2. Clinical capacity to focus on discharge processes in times of severe operational pressures
3. Clinical buy-in to manage CLD processes differently.
4. Alignment of resource to support wide ranging improvement process.

4. Action Plan

Counter Measure	Action	Who	When	Complete
Board Round Pilots	1. Understand barriers to consistent review of discharge(s) as part of board rounds on wards 30 & 31, and develop mitigation plan.	Surgical division	Aug	Complete
	2. Roll out board round structure to other surgical wards	Surgical division	Sept	In progress
	3. Audit impact of starting eDNs and ordering post Op. tests in recovery with wards 30 & 31 with a view to lessons learned and roll out to other surgical activities	Tim Hubbard	Aug	In progress, initial delay
	4. Utilising Front to back door program roll out communication to Drs regarding early completion of TTO section of eDN.	Sally Foy	Sept	Complete
	5. Support FTBD program to pilot use of EDDs for pathway 0 patients	Sally Foy	Sept-Nov	In progress
	6. Review and update SOP for board rounds		Sept-Nov	
	1. Virtual workshop		Sept	18/09/24
	2. Recommendations and document changes		Oct	
	3. Implementation		Oct-Nov	
	7. Understand barriers and action plan for afternoon board rounds (once morning boards optimised	FTBD	Ongoing	
Criteria Led Discharge	1. Meet with Medical Directors Office to approach to medical engagement with CLD.	BC & JM	Aug	Complete
	2. Develop action plan	BC & NP	Aug	Outstanding
	3. Implementation of agreed action plan	NP	Sept	

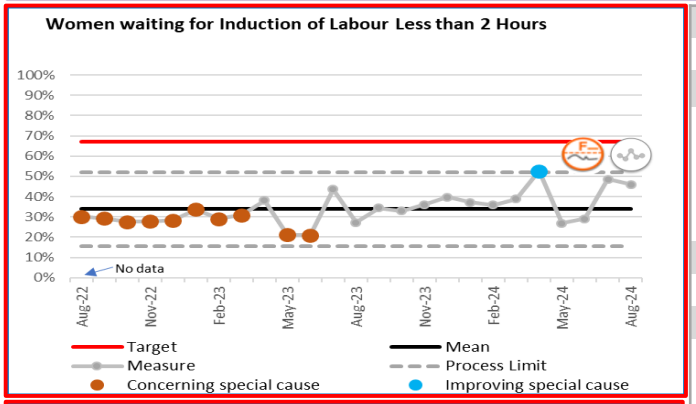
Strategic Theme: Sustainability

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		-1,742	-2,802	Aug-24	786	-283	Jul-24	Driver			Verbal CMS	-2,485		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		958	1,140	Aug-24	1,029	1,016	Jul-24	Driver			Verbal CMS	999		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		2,208	2,347	Aug-24	2,320	1,483	Jul-24	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		5,299	15,050	Aug-24	4,823	19,858	Jul-24	Driver			Not Escalated	4,233		
	Well Led	Capital Expenditure (£k)		2,464	1,541	Aug-24	5,651	1,371	Jul-24	Driver			Not Escalated	3,860		
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		65,992	61,554	Aug-24	TBC	49,051	Jul-24	Driver			Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		10,126	13,691	Aug-24	TBC	10,566	Jul-24	Driver			Not Escalated			

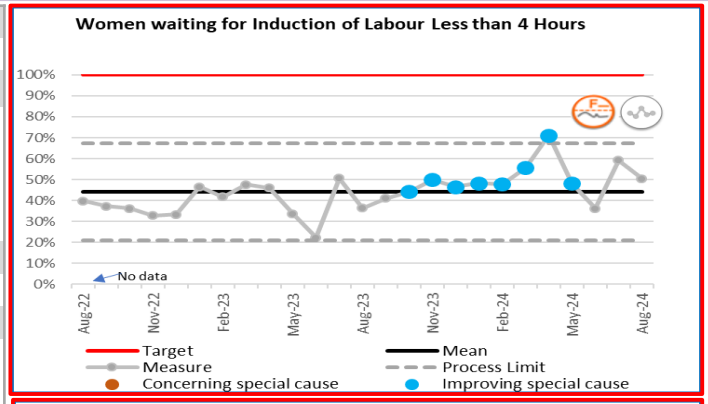
Maternity Metrics

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Maternity Metric	Registerable Births		No target	467	Aug-24	470	487	Jul-24	Driver		No target	Not Escalated	488		No SPC
	Maternity Metric	Antenatal bookings		No target	476	Aug-24	545	586	Jul-24	Driver		No target	Not Escalated	520		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	18.9%	Aug-24	No target	23.0%	Jul-24	Driver		No target	Not Escalated	20.1%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	23.9%	Aug-24	No target	20.9%	Jul-24	Driver		No target	Not Escalated	22.7%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	24.1%	Aug-24	36.0%	22.1%	Jul-24	Driver			Not Escalated	25.7%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	45.9%	Aug-24	67.0%	48.5%	Jul-24	Driver			Escalation	43.9%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	50.5%	Aug-24	100.0%	59.2%	Jul-24	Driver			Escalation	55.7%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	6.0%	Aug-24	6.0%	6.8%	Jul-24	Driver			Not Escalated	7.3%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	6.0%	Jul-24	4.0%	3.1%	Jun-24	Driver			Not Escalated	3.4%		
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Aug-24	0.4%	0.4%	Jul-24	Driver			Not Escalated	-0.3%		
	Maternity Metric	PPH >=1500% Rate		3.0%	3.3%	Aug-24	3.0%	3.1%	Jul-24	Driver			Not Escalated	3.3%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	1.5%	Aug-24	2.5%	2.6%	Jul-24	Driver			Not Escalated	2.3%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	77.2%	Aug-24	75.0%	79.8%	Jul-24	Driver			Not Escalated	79.1%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	57.7%	Aug-24	95.0%	68.8%	Jul-24	Driver			Escalation	83.6%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	76.2%	Aug-24	95.0%	73.9%	Jul-24	Driver			Escalation	76.4%		

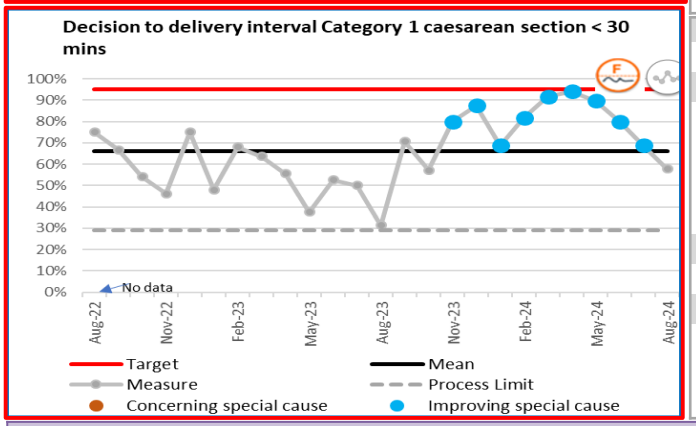
Maternity Metrics



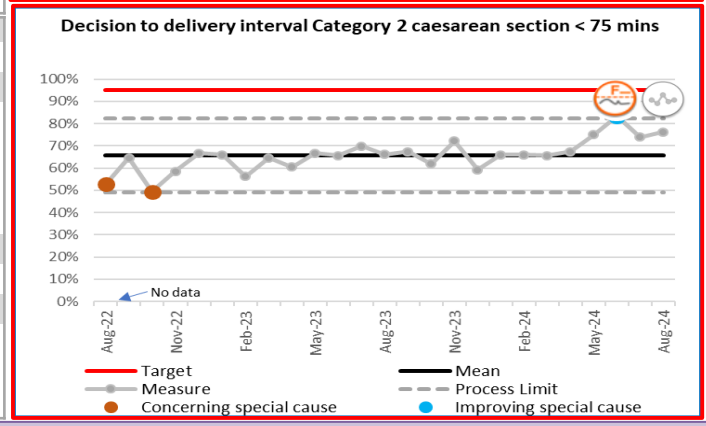
Aug-24
45.9%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full Escalation as consistently failing the target



Aug-24
50.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Aug-24
57.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Full escalation as has failed the target for >6 months



Aug-24
76.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Full escalation as consistently failing the target

Summary:

Women waiting for Induction of Labour less than 2: is experiencing common cause variation and consistently failing the target.

Women waiting for Induction of Labour less than 4 Hours: is experiencing common cause variation and consistently failing the target.

Decision to delivery interval Category 1 caesarean section: is experiencing common cause variation and has failed the target for more than six months

Decision to delivery interval Category 2 caesarean section :is experiencing common cause variation and has failed the target for more than six months

These are new metrics with data collection from June 22

Actions:

Women waiting for Induction of Labour less than 2 or 4 Hours: Work continues to review demand and capacity and to identify opportunities to improve flow throughout the department and reduce the occurrence of lack of bed or midwife capacity on Delivery Suite to enable timely transfer of women for ongoing induction of labour.

Decision to delivery interval Category 1 and Category 2 caesarean section:

A3 projects continue to identify and mitigate challenges with meeting Cat 2 CS target times and with accessing second theatre.

MDT staff engagement has seen improved team working to meet target times for Category 2

Challenges to maintaining compliance with Category 1 targets are under review

Assurance & Timescales for Improvement:

Women waiting for Induction of Labour less than 2 or 4 Hours:

This metric is impacted by periods of high activity which are largely unpredictable.

Ongoing risk assessment and prioritisation in place to maintain the safety of women whose care is delayed. Timescales for improvement will be dependent on the outcome of the demand and capacity project and any actions required as a result.

Decision to delivery interval Category 1 and Category 2 caesarean section:

Improvements with compliance with Category 2 target time has been made in recent months.

Small total numbers for Category 1 cases results in more variance in compliance rates. Of 10 cases delayed, 4 were by less than 5 minutes and 6 by 6-10 minutes.

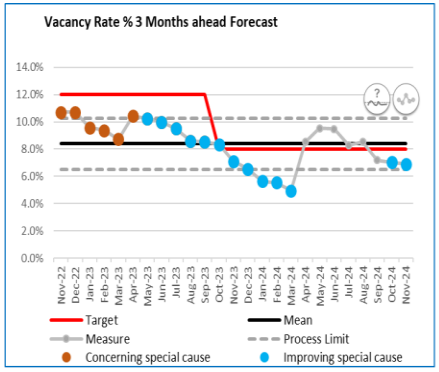
All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified.

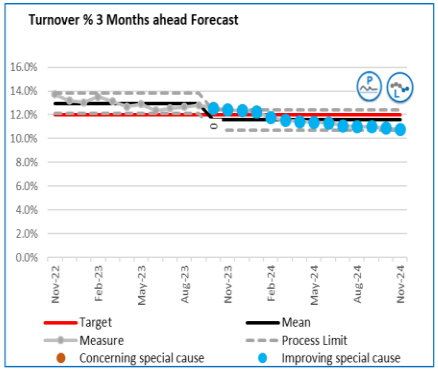
NHS
Maidstone and Tunbridge Wells NHS Trust

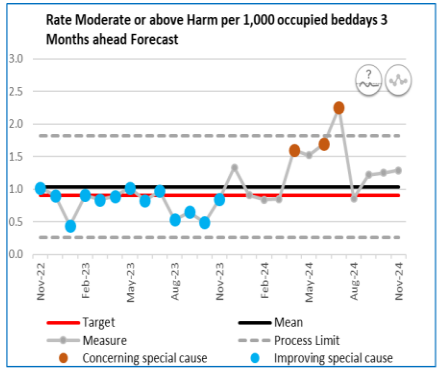
Appendices

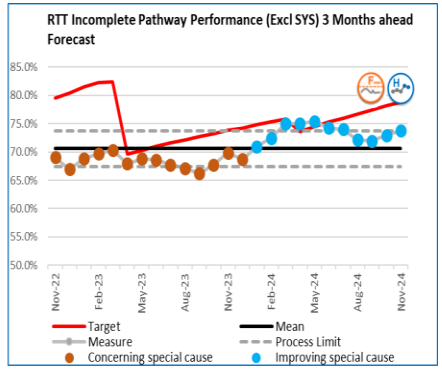
MTW
exceptional people, outstanding care

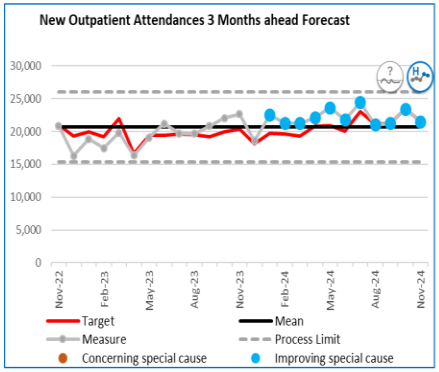
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

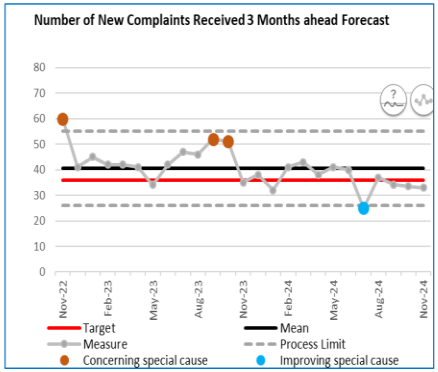


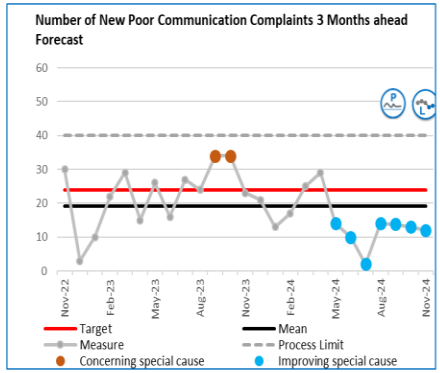


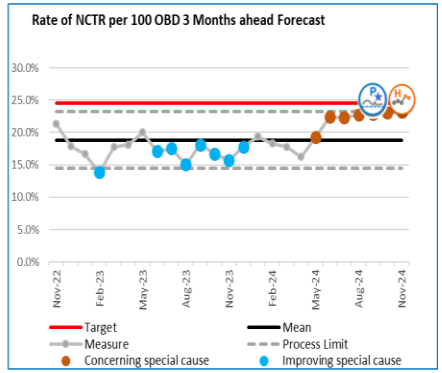


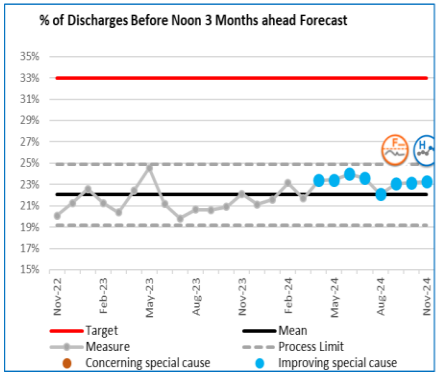


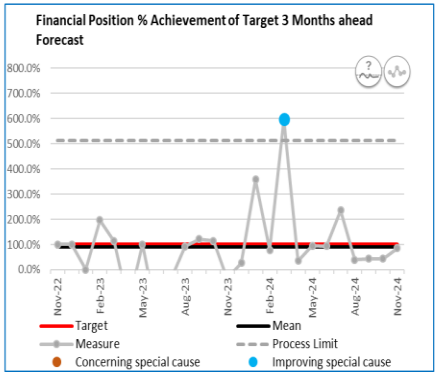


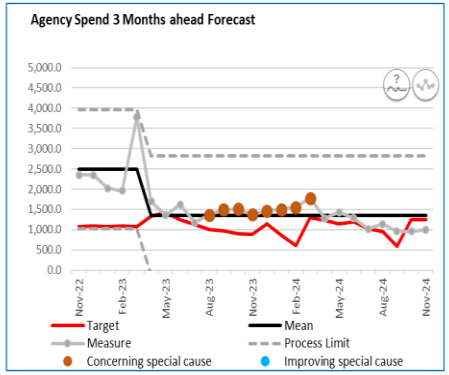


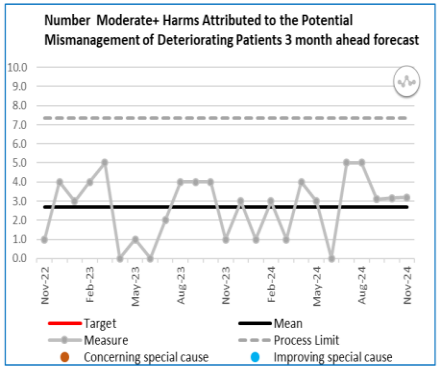




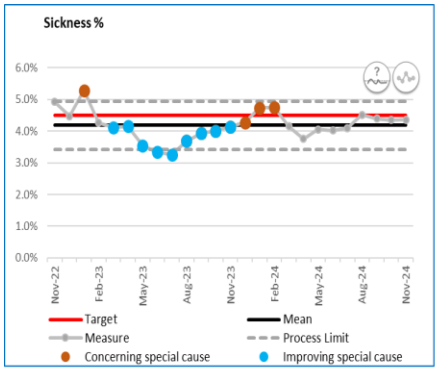


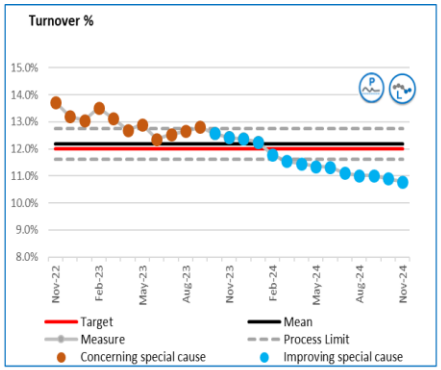


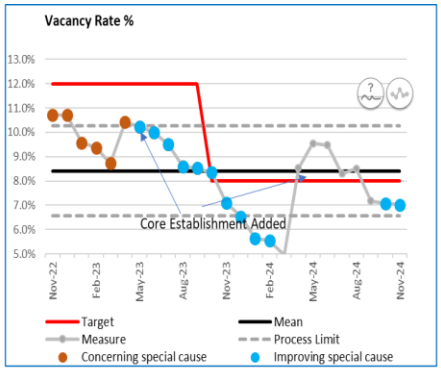


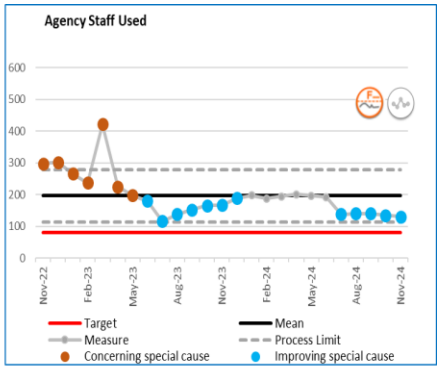


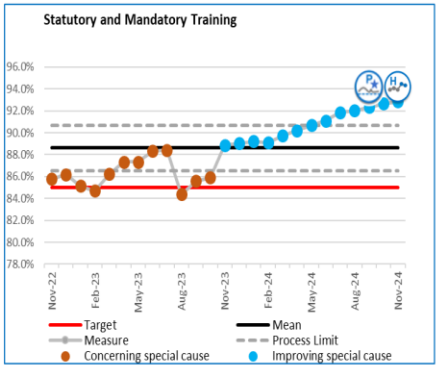
Forecast SPCs (3 month forward view) for People Indicators

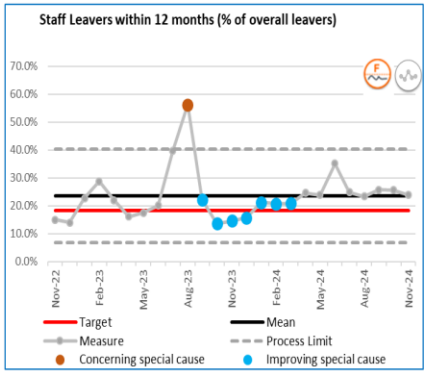


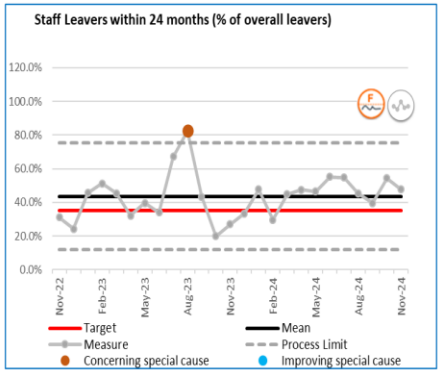


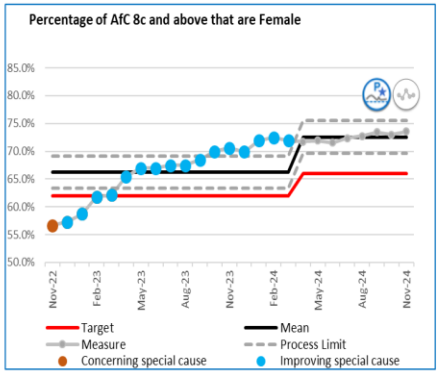


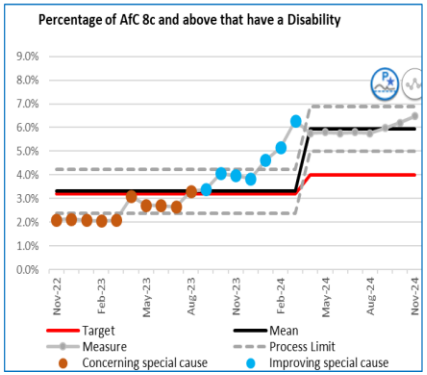


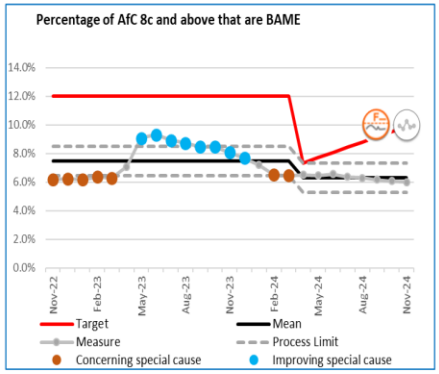


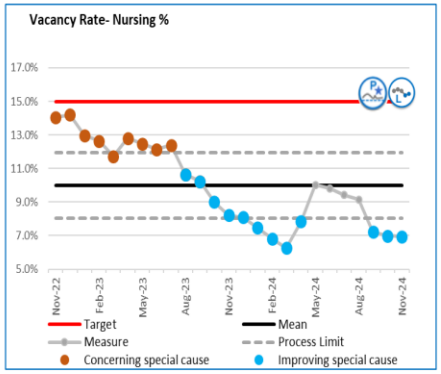




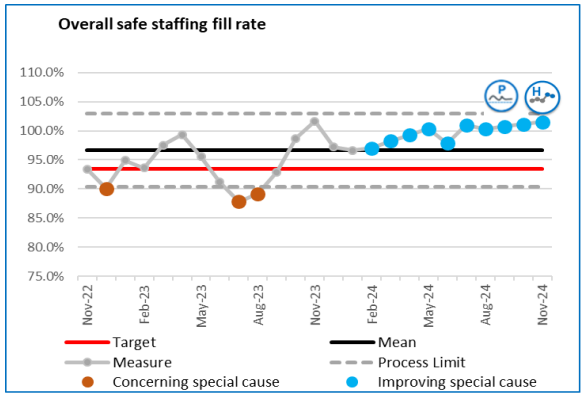


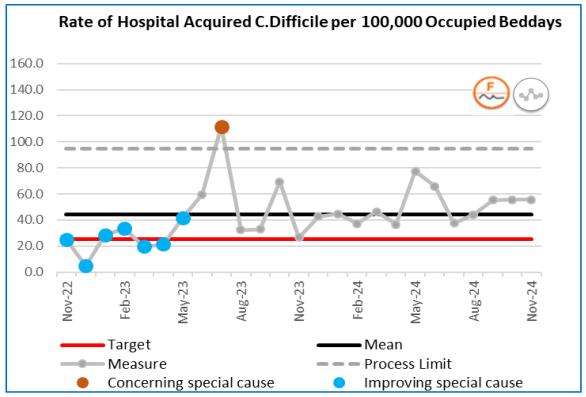


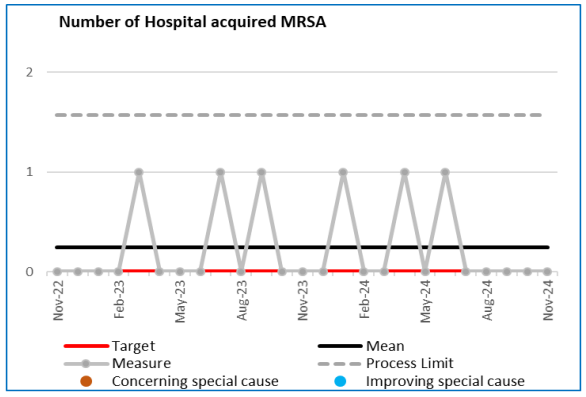


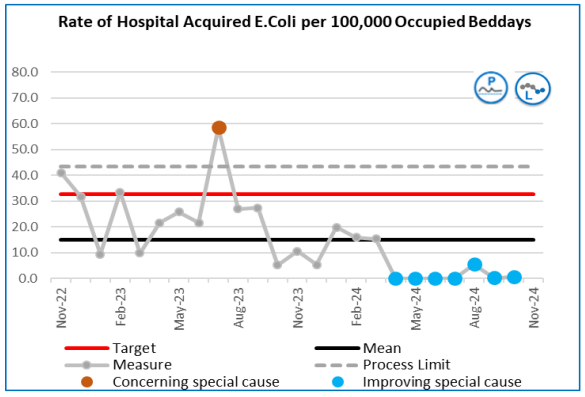


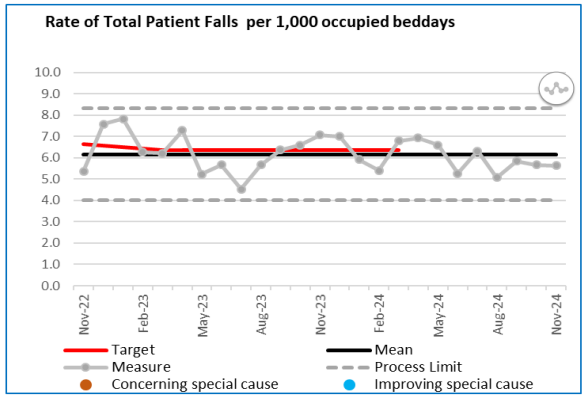
Forecast SPCs (3 month forward view) for Patient Safety Indicators

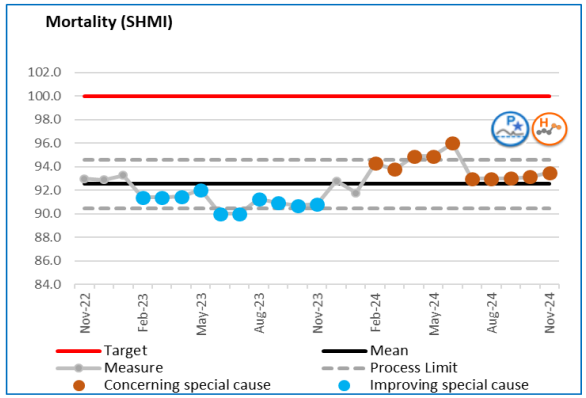


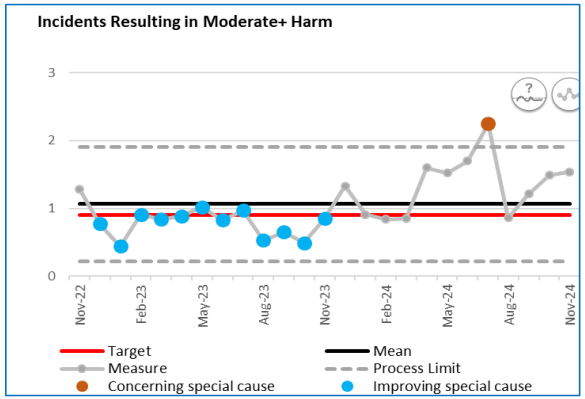


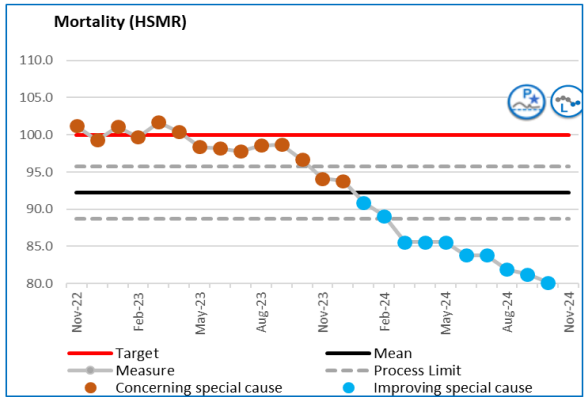




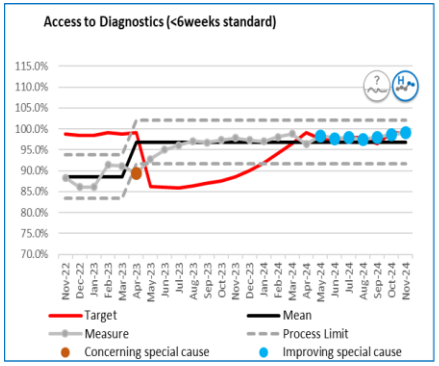


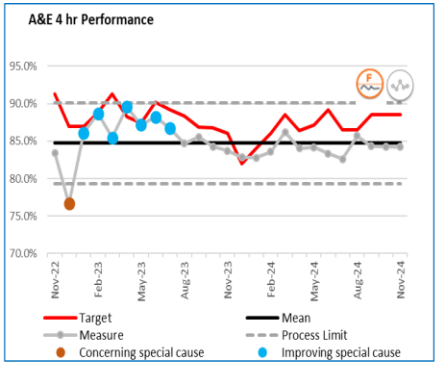


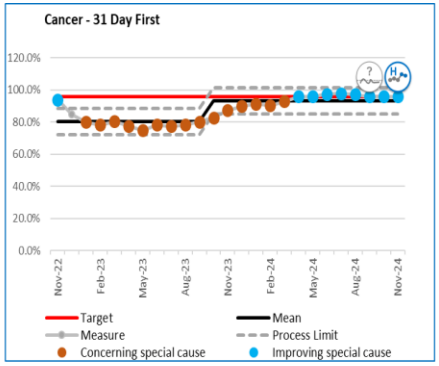


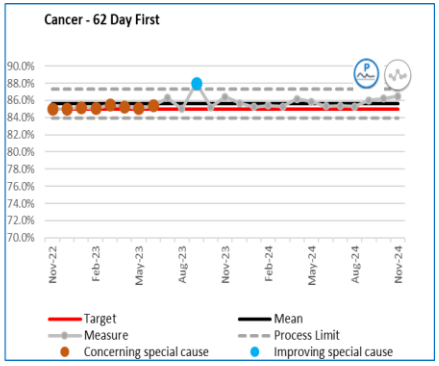


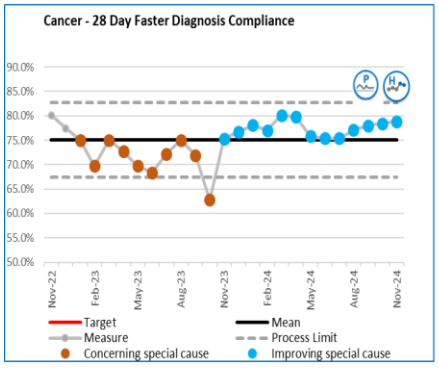
Forecast SPCs (3 month forward view) for Patient Access Indicators

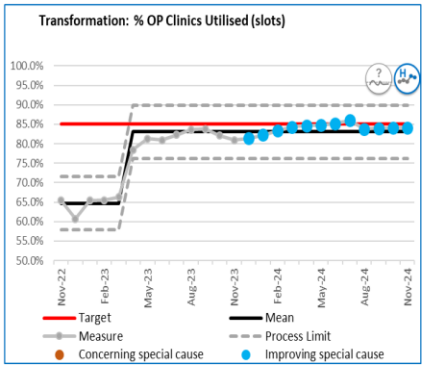


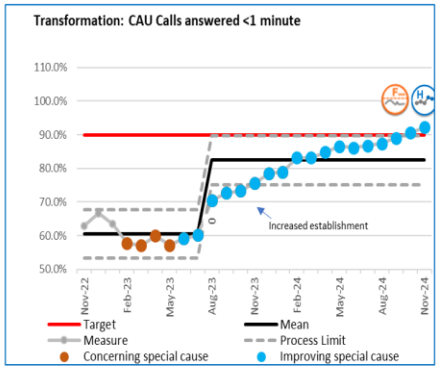


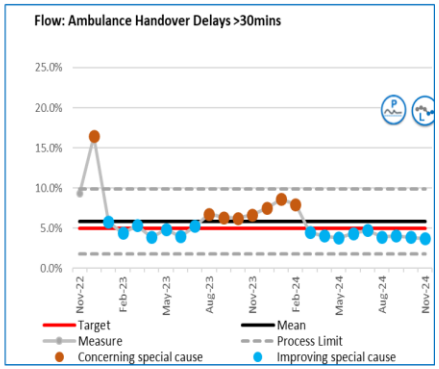


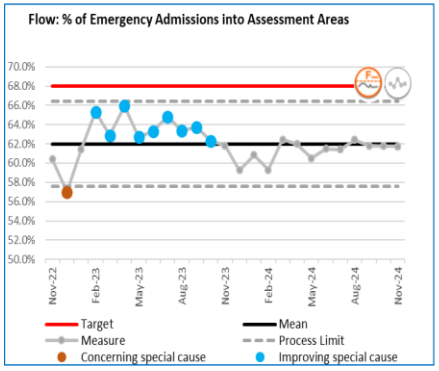


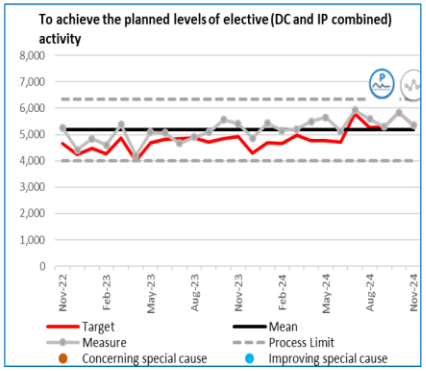


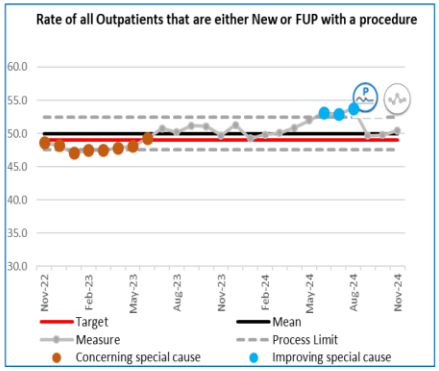


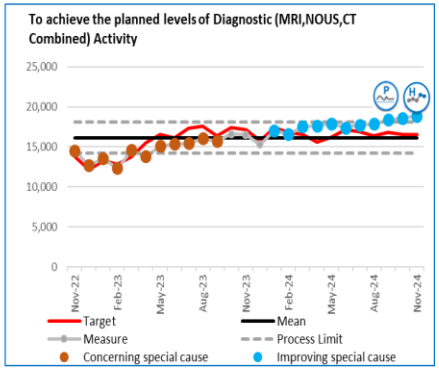




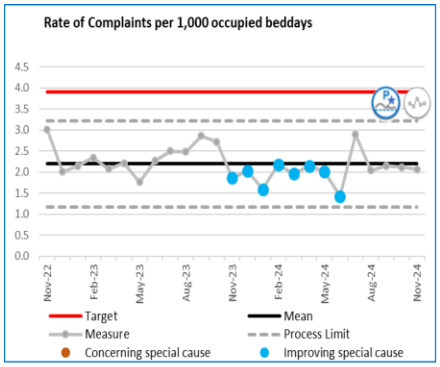


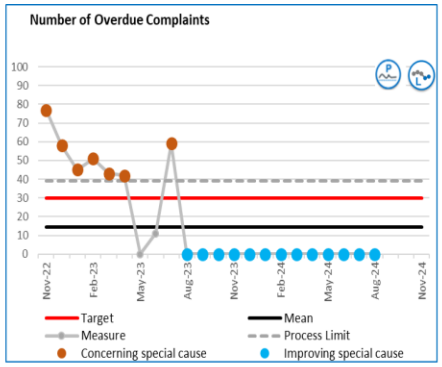


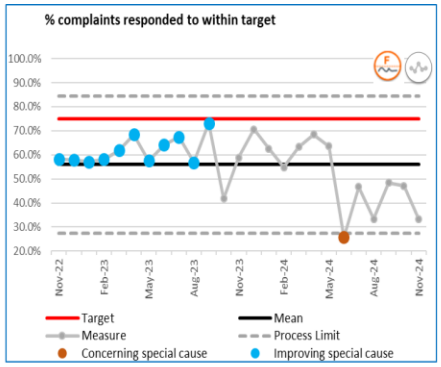


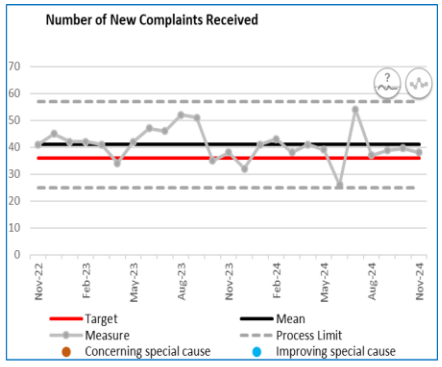


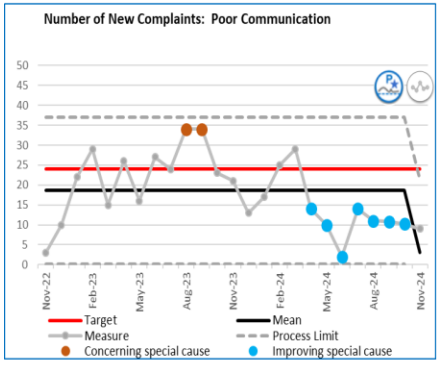
Forecast SPCs (3 month forward view) for Patient Experience Indicators

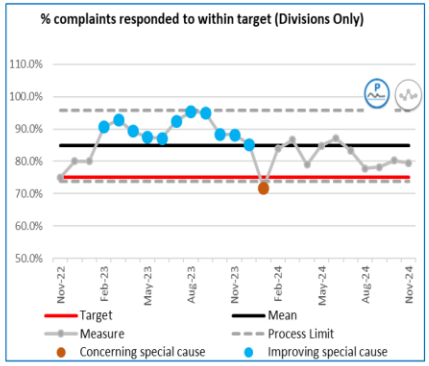


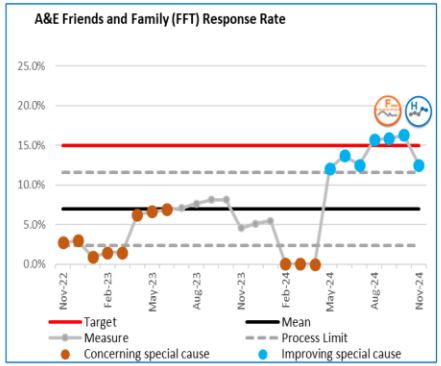


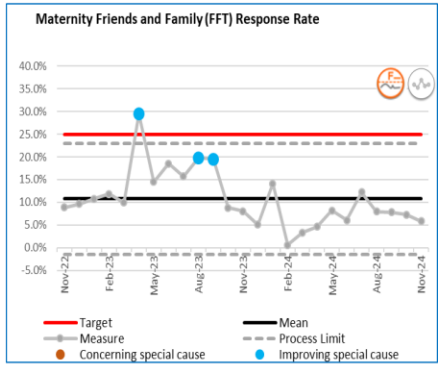


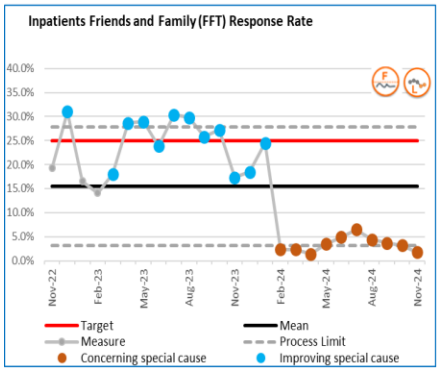


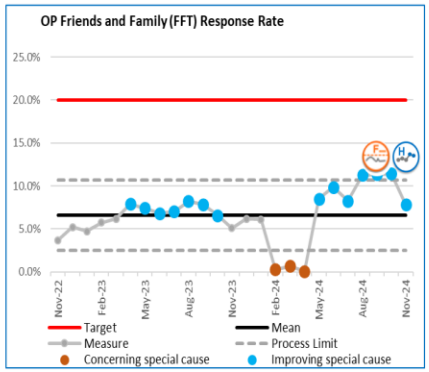


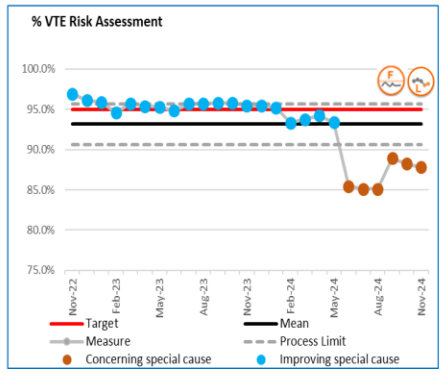




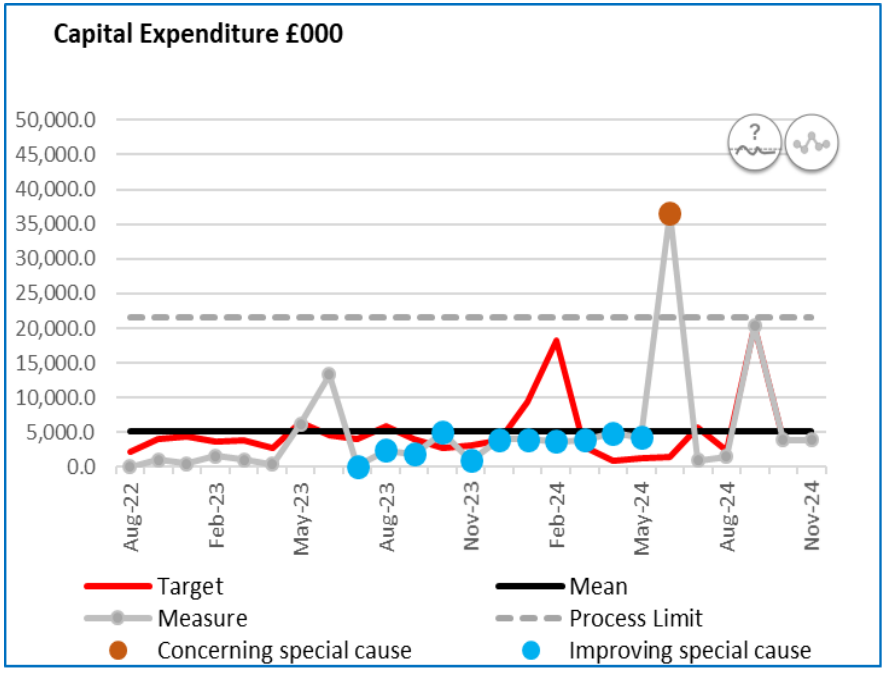


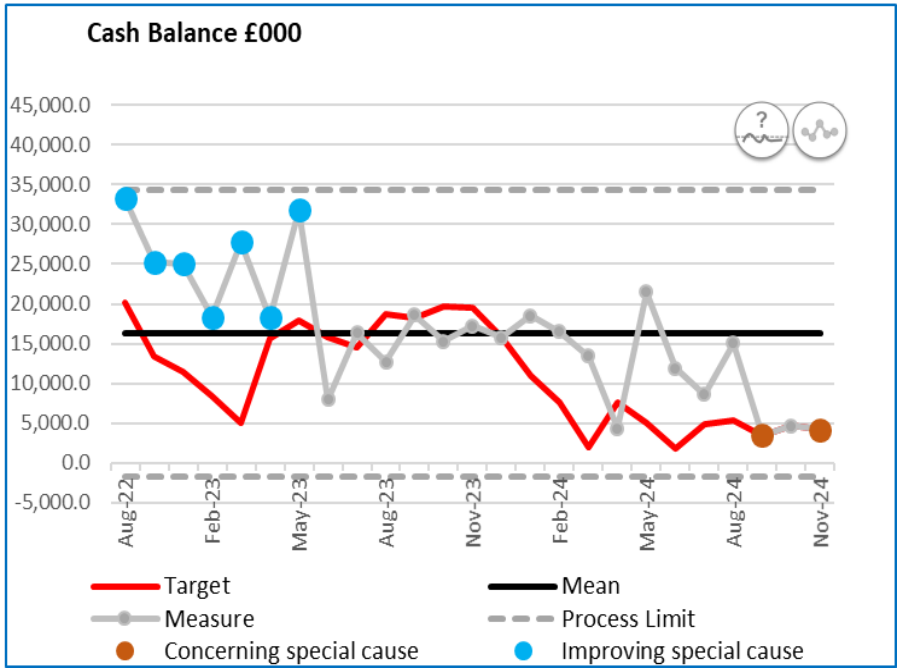




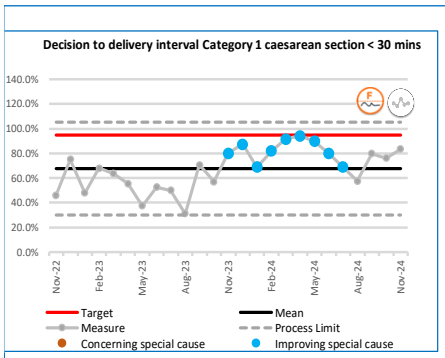


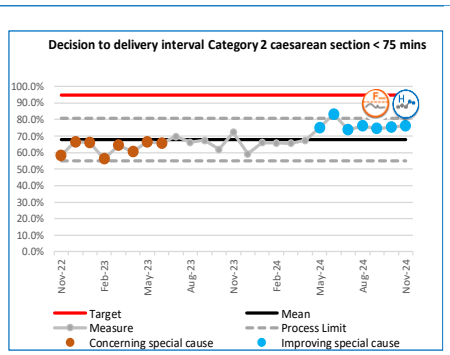
Forecast SPCs (3 month forward view) for Sustainability Indicators

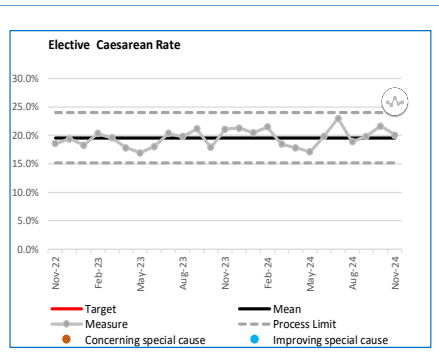


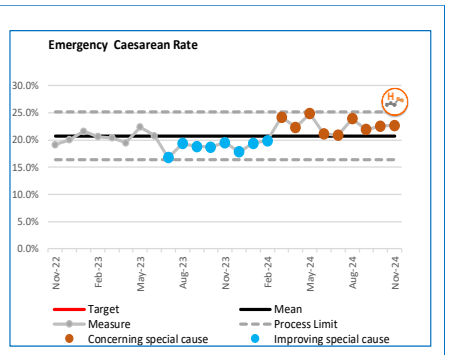


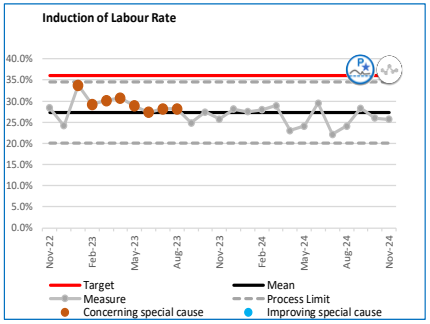
Forecast SPCs (3 month forward view) for Maternity Indicators

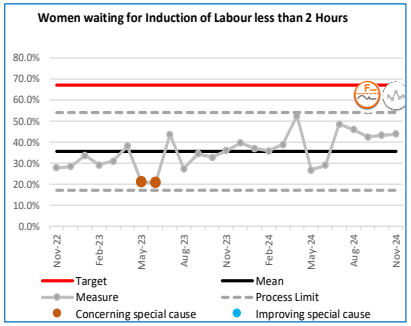


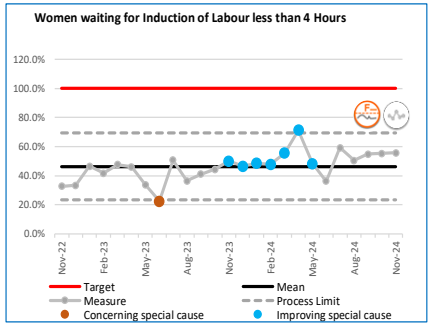


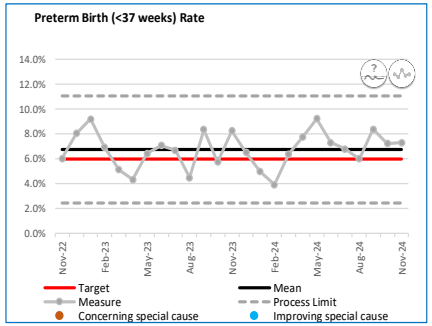


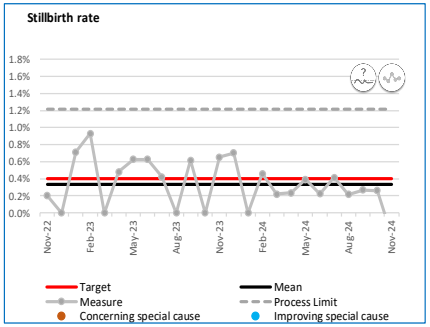


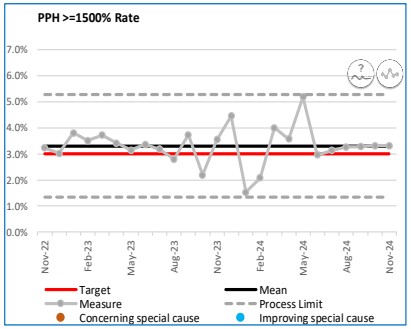


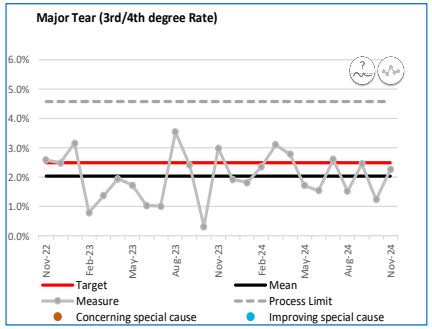


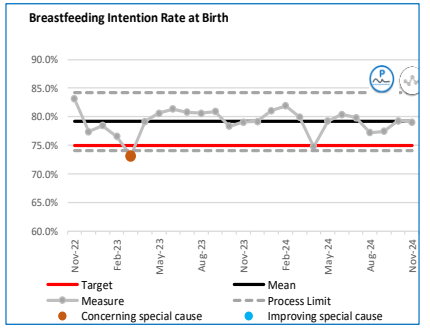






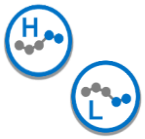






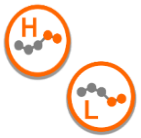
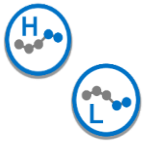
SDR Business Rules Driven by the SPC Icons

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

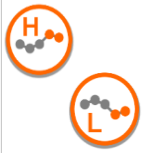
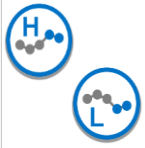
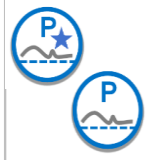
SDR Business Rules Driven by the SPC Icons

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:

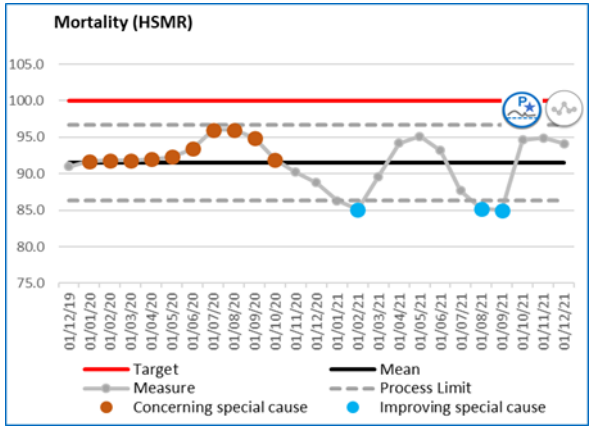
The **target** line **between** the **upper** and **lower** control limit for all metric types

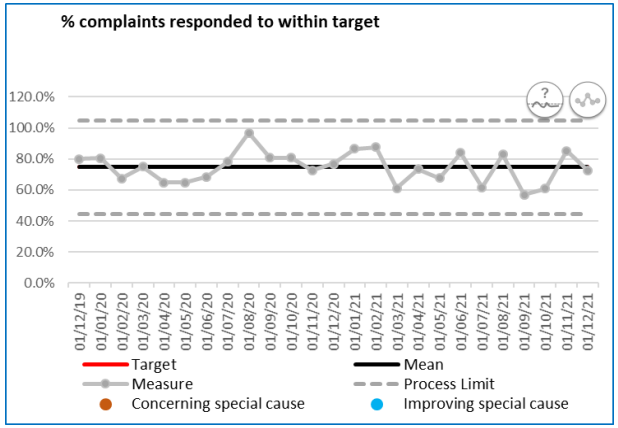
Metrics that consistently **fail** have:

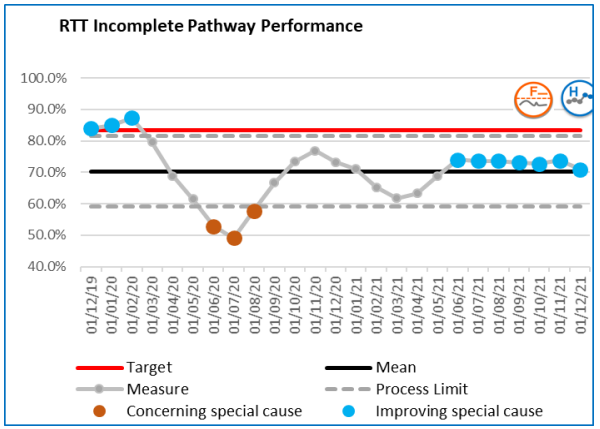
The **lower** control limit **above** the target line for metrics that need to be **below the target**

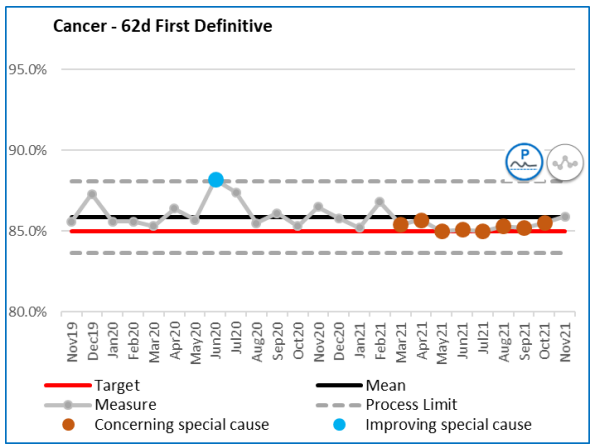
The **upper** control limit **below** the target line for metrics that need to be **above the target**

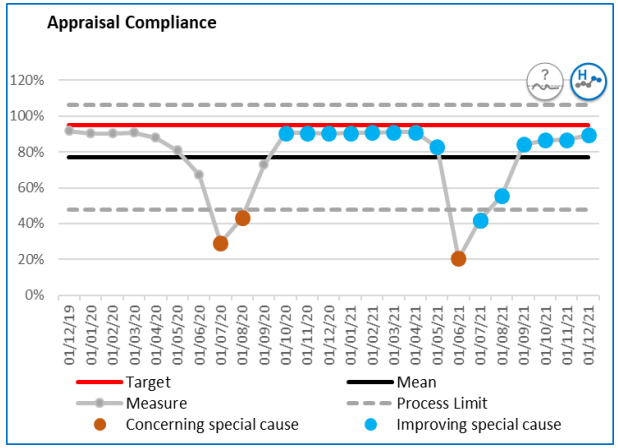
A metric not achieving the target for 6 months or more will be flagged as failing

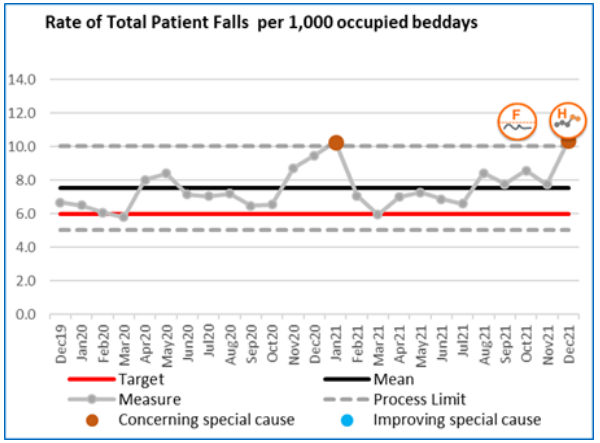












Maternity Metrics Definitions

Type	Section	Metric Name	Measure	Definition	Calculation - extracted from E3	Target	Target source	Rationale for inclusion
Activity	Women Birthed	Number of births	Women birthed	Women who gave birth (includes all registerable live births and stillbirths).	Number of women birthed	> 470	Average births per month at MTW last 5 years	- For use as denominator - Indicator of workload - Trends
	Caesarean birth	Elective caesarean birth rate	Elective	Women who gave birth that had elective caesarean section as the method of birth (Category 4 CS only).	Number of women birthed by an elective caesarean section	NA	National recommendation not to set targets for type of birth	- Provide insight into contributing factors for total c/s rate - Maternal risks - Impact on baby care and feeding - Length of stay
		Emergency caesarean birth rate	Emergency	Women who gave birth that had an emergency caesarean section as the method of birth (Categories 1-3 CS only).	Number of women birthed by an emergency caesarean section	NA	National recommendation not to set targets for type of birth	- Provide insight into contributing factors for total c/s rate - Maternal risks - Impact on baby care and feeding - Length of stay
	Induction of labour	Induction of labour rate	% of women	Women who commenced induction of labour with prostaglandins, artificial rupture of membranes or a syntocinon drip when not in labour	Number of women with onset of labour is induced	< 36%	Average National Rate (March 2024)	- Indicator of workload - Trends
Bookings	Number of new Bookings	Bookings	No of women	Women who have the first booking visit with the midwife, including transfers in where a previous booking visit has taken place out of area.	Number of women booked	> 545	Average bookings per month at MTW last 5 years	- For use as denominator - Indicator of workload - Trends
Clinical Indicators	Timely EMCS	Category 1 caesarean birth - decision to birth ≤ 30 mins	% of women	Women having Category 1 caesarean section within 30 minutes of decision for procedure	The % of all women having Cat 1 C-section with decision to birth interval less than or equal to 30 minutes	100%	RCOG best practice	- Indicator of workload - Trends - Maternal & fetal risks
		Category 2 caesarean birth - decision to birth ≤ 75 mins	% of women	Women having Category 2 caesarean section within 75 minutes of decision for procedure	The % of all women having Cat 2 C-section with decision to birth interval less than or equal to 75 minutes	100%	RCOG best practice	- Indicator of workload - Trends - Maternal & fetal risks
	Maternal Morbidity	Post partum haemorrhage ≥ 1500ml	% of women	Women who gave birth who had a measured blood loss of 1500ml or over	Number of women who have birthed with PPH ≥ 1500ml	< 3%	National Maternity Dashboard average	- Morbidity & mortality - Length of stay
		3rd/4th degree tear	% of women	Women with a vaginal birth (spontaneous or assisted) who sustained a 3rd or 4th degree perineal tear	Number of women with 3rd and 4th degree tear, by women having a vaginal birth	< 2.5%	National Maternity Dashboard average	- Potential long term impact - Morbidity & mortality - Length of stay
	Breastfeeding	Women who intend to breastfeed following birth	% of women	Women whose intention is to breastfeed their baby/ies at the time of birth.	Number of women with intention to breastfeed at time of birth	> 75%	National Maternity Dashboard average	- Infant health benefits - Maternal health benefits - Trends
	Premature births	Premature births <37 weeks gestation	% of births	Live babies born who are born less than or equal to 36+6 weeks	Number of preterm births at less than or equal to 36+6 weeks by the total births	< 6%	Saving Babies Lives Care Bundle national target	- Reducing premature births is a national target - Morbidity and mortality - Length of stay - Trends
	Neonatal morbidity & mortality	Stillbirth rate	per 1000 births	All babies stillborn after 24 weeks gestation	Number of stillbirths	< 4	2022 ONS data	- Reducing stillbirths is a national target - Mortality - Trends
		Unanticipated admission to NNU >37 weeks	% of births	All babies born on or after 37 weeks who are admitted to the neonatal unit	Number of admissions to NNU by number of births after 37 weeks gestation	< 4%	National Standard (ATAIN)	- Reducing avoidable term admissions to NNU is a national target - Morbidity and mortality - Length of stay - Experience - Trends
	Timely Procedures	Induction of labour delayed < 2 hours	% of women	Women having induction of labour who are transferred to Delivery Suite for the next stage of the process within 2 hours of identification that the	The % of all women having induction of labour who transfer within 2 hours	67.0%	Local target to aim for improvement	- Indicator of workload - Trends - Maternal & fetal risks
		Induction of labour delayed < 4 hours	% of women	Women having induction of labour who are transferred to Delivery Suite for the next stage of the process within 4 hours of identification that the	The % of all women having induction of labour who transfer within 4 hours	100.0%	Local target to aim for improvement	- Indicator of workload - Trends - Maternal & fetal risks

Executive Summary

- The Trust was £2.8m in deficit in August which was £1.1m adverse to plan. Year to date the Trust is £11.5m in deficit which is £3.3m adverse to plan.
- The key year to date pressures are: Kent and Medway ICB contract issues including system stretch target slippage (£4.2m), CIP slippage (£2.2m), delay in opening of Kent and Medway Orthopaedic Centre (KMOC – estimated £1.9m net adverse impact), net CDC slippage (£1.3m), unfunded escalation costs (£0.7m), unfunded impact of industrial action (£0.4m), Fordcombe hospital adverse to plan by £0.4m. These pressures were partly offset by variable activity overperformance (£2.7m), non-recurrent benefits (£4.3m) and release of service development and contingency budgets (£1.9m).
- The Trust is forecasting to deliver the planned breakeven position, £25.4m of recovery actions are being identified and implemented.

Current Month Financial Position

- The Trust was £2.8m in deficit in the month which was £1.1m adverse to plan
- **Key Adverse variances in month are:**
  - The Trust plan assumed the Kent and Medway Orthopaedic Centre (KMOC) will be open on the 1st July. The delays in opening has caused an estimated £0.8m net adverse impact in the month.
  - The Trust plan assumed additional funding above the base contract from the Kent and Medway ICB to fund certain items. The ICB has confirmed these won't be specifically funded therefore adversely impacting the position by £0.5m which includes the additional system stretch target of £0.2m per month.
  - Fordcombe and Net CDC slippage (£0.3m)
  - Other Expenditure pressures include overspends within Theatres consumable budget (£0.1m) and increase in doubtful debt (£0.1m)
- **Key Favourable variances in month are:**
  - The Trust overperformed against ERF/Variable activity by £0.8m which was mainly due to back dated CDC Activity in the month
  - The Trust released £0.5m relating to Service development and contingency budgets offset income and expenditure pressures incurred

Year to Date Financial Position

- The Trust is £11.5m in deficit which was £3.3m adverse to plan
- **Key Adverse variances year to date are:**
  - The Trust has reflected the majority of the Kent and Medway ICB income assumption for items outside the main contract which resulted in a £3.4m YTD adverse impact. The Trust is also adversely impacted YTD by £0.8m linked to the additional system stretch target.
  - CIP Slippage (£2.2m)
  - The Trust plan assumed the Kent and Medway Orthopaedic Centre (KMOC) will be open on the 1st July. The delays in opening has caused an estimated £1.9m net adverse impact
  - Net CDC slippage (£1.3m)
  - Unfunded Ward escalation costs (£0.7m)
  - Estimate impact of Junior Doctor Strike in June was £0.4m
  - Fordcombe Hospital adverse to plan by £0.4m

- Other Expenditure pressures include overspends within Theatres consumable budgets (£0.7m), increase in security costs (£0.4m) and overspend on non-passthrough related drugs (£0.2m)

- **Key Favourable variances year to date are:**
  - The Trust has benefited by non-recurrent benefits of £4.3m
  - ERF/Variable activity overperformance (£2.7m)
  - The Trust released £1.9m relating to Service development and contingency budgets offset income and expenditure pressures incurred
  - Other key non-pay underspends include: Pathology trade income overperformance (£0.3m) and Depreciation (£0.1m)

Cost Improvement Plan

- The Trust has a savings target for 2024/25 of £37.3m. In August the Trust saved £2.3m which was £0.1m favourable to plan, year to date the Trust is £2.2m adverse to plan.

Cashflow position:

- The closing cash balance at the end of August was £15.0m, this is higher than the plan value by £9.8m. The main reasons for a slightly higher cash balance is due to the Trust receiving £9.2m additional PDC funding from NHSE. Additionally, the Trust is receiving as part of the monthly block income an element that relates to the salary payrise which is due to be paid out in October, once this has been paid this will reduce the closing October month end balance.
- The Trust receives its monthly block SLA income on the 15th of each month so the month-end cash balance is required to cover commitments for the first two weeks of the following month – this includes weekly supplier payment runs and weekly payroll including 247-time agency.
- The cashflow is updated daily and the forecast is regularly updated and reviewed if costs during the year increase eg; salaries are higher than plan and the remaining months are amended to be in line with the current charges.
- The Trust is working closely with local NHS organisations and agreeing "like for like" arrangements when possible to reduce the debtor/creditor balances for both organisations.
- The Trust has been awarded £5m Urgent and Emergency Care (UEC) incentive capital – however this capital does not come with additional PDC cash. The Trust will therefore need to improve its liquidity to avoid further pressure on revenue payments.
- The Better Payment Practice Code (BPPC) which is a target that all NHS Organisations are measured to ensure suppliers are paid within 30-day payment terms; the target all NHS organisations are measured against is 95%. For August the Trust's percentages were: Trade value 79.1% and quantity 77.6%; NHS value 92.1% and quantity 79.6%.

Capital Position

- **Capital Plan**
  - The Trust's capital plan, excluding IFRS16 leases, for 2024/25, is **£26.531m**. The Trust's share of the K&M ICS control total is **£19.412m** for 2024/25, including £10.134m from system funds (CDC £2.134m, Cardiology £3m and Urgent and Emergency Care (UEC) Winter Incentive £5m). The Trust also plans to receive National funding of **£5.343m** (CDC £1.9m, Frontline Digitisation £2.790m and Digital Pathology £653k).
  - The Trust's application for System Capital Support of £9.278m of PDC Cash was approved in July and the cash has now been drawn down. This provided cash to support the internally resourced schemes, where the cash had been used at the end of 2023/24 to purchase the Fordcombe Hospital.

- **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 **£200k** relating to forecast donations in year.

- **Project Updates**
  - **Major Schemes** - KMOC is due to be open for patients on 16/9/24, CDC is progressing well and due to be completed early 2025.
  - **Estates** – Diagnostic Enabling and Backlog schemes are in progress, the MRI and CT enabling is complete.
  - **ICT** – Work is ongoing to install IT infrastructure and network systems at Fordcombe Hospital, orders are in progress to upgrade Compucare for the private patient system.
  - **Equipment** – The majority of business cases have been approved, including Endoscopy decontamination systems for both sites (£638k), surgical power tools for TWH (£273k), KMMS Fixture and Fittings (£434k) and other emergency purchases.
  - **Security & Facilities** – Orders have been raised for MGH access controls and TWH CCTV and access controls (£215k)
  - **Donated** – The potential schemes have now increased the outturn figure to £240k this includes, Mobile Resuscitaire, Microtomes, Helipad resurfacing, Mammography upgrades and Wellbeing Service Hub

- **Month 5 Actuals (excluding IFRS16)**
  - The YTD spend at M5 is £6.347m against a YTD budget of £7.975m.
  - YTD variance relates to Diagnostic enabling works being finalised, invoices are pending. Estates backlog works are in process of ordering, there is some delay compared to plan. ICT Clinical applications delayed in YTD. CDC part funded nationally, early months charged to national funding. Frontline Digitisation anticipated funding, but not yet approved by NHSE.

- **Leased/IFRS16 capital**
  - The Trust included £25.456m of in-year IFRS 16 lease capital resource in its planning submission to cover planned additions (£22.092m) and remeasurements arising from rent reviews or the application of contractual rent uplifts (£3.364m). This is subject to approval and confirmation of this element of the financial regime in terms of final ICS allocations for 2024/25. The most significant element of the additions is the initial lease capitalisation of the Kent and Medway Medical School Accommodation building (£16.5m) on the TWH site that the Trust will recognise under IFRS 16 when it becomes available for use. The YTD spend of £0.4m relates to contractual rent uplifts for property leases; the new projects that were planned for the first half of the year are either at business case stage or delayed to later in the financial year, these include Urological Robot, park and ride bus and offsite car parking and Leases being taken over from Spire relating to Fordcombe Hospital.

Year End Forecast

- The Trust is forecasting to deliver the planned breakeven position, £25.4m of recovery actions are being identified and implemented.
- A Financial Improvement Plan has been developed which details the actions and process being undertaken to deliver the recovery actions required.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 5
2024/25

Maidstone and Tunbridge Wells NHS Trust

Summary

August 2024/25

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-throu	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	63.2	63.9	(0.7)	0.1	(0.8)	313.2	317.2	(4.1)	1.5	(5.6)
Expenditure	(61.7)	(61.1)	(0.6)	(0.1)	(0.4)	(302.4)	(303.0)	0.6	(1.5)	2.1
EBITDA (Income less Expenditure)	1.6	2.8	(1.3)	0.0	(1.3)	10.7	14.2	(3.5)	0.0	(3.5)
Financing Costs	(3.8)	(4.0)	0.2	0.0	0.2	(32.0)	(32.2)	0.3	0.0	0.3
Technical Adjustments	(0.5)	(0.5)	(0.0)	0.0	(0.0)	9.7	9.7	(0.0)	0.0	(0.0)
Net Surplus / Deficit	**(2.8)**	**(1.7)**	**(1.1)**	**0.0**	**(1.1)**	**(11.5)**	**(8.3)**	**(3.3)**	**0.0**	**(3.3)**
Cash Balance	15.1	5.3	9.8		9.8	15.1	5.3	9.8		9.8
Capital Expenditure (Incl Donated Assets and IFRS16)	2.6	2.5	(0.2)		(0.2)	6.7	11.9	(5.1)		(5.1)
Cost Improvement Plan	2.3	2.2	0.1		0.1	8.3	10.5	(2.2)		(2.2)

Summary Current Month:
- The Trust was £2.8m in deficit in the month which was £1.1m adverse to plan.

Key adverse variances in month are:
- The Trust plan assumed the Kent and Medway Orthopaedic Centre (KMOC) will be open on the 1st July. The delays in opening has caused an estimated £0.8m net adverse impact in the month.
- The Trust plan assumed additional funding above the base contract from the Kent and Medway ICB to fund certain items. The ICB has confirmed these won't be specifically funded therefore adversely impacting the position by £0.5m which includes the additional system stretch target of £0.2m per month.
- The Trust overspent by £0.3m against non passthrough drugs
- Fordcombe and CDC slippage to plan (£0.3m)
- Other Expenditure pressures include overspends within Theatres consumable budgets (£0.1m) and increase in doubtful debt (£0.1 m)

Key favourable variances in month are:
- The Trust overperformed against ERF/Variable activity by £0.8m which was mainly due to back dated CDC Activity in the month. The Trust released £0.5m relating to Service development and contingency budgets in August to partly offset income and expenditure pressures incurred.

Year to date overview:
- The Trust is £11.5m in deficit which is £3.3m adverse to the plan, the Trusts key variances to the plan are:

Adverse Variances:
- The Trust has reflected the majority of the Kent and Medway ICB commissioner income assumptions for items outside the main contract which resulted in a £3.4m YTD adverse impact. The Trust is also adversely impacted YTD by £0.8m linked to the additional system stretch target
- CIP Slippage (£2.2m)
- The Trust plan assumed the Kent and Medway Orthopaedic Centre (KMOC) will be open on the 1st July. The delays in opening has caused an estimated £1.9m net adverse impact
- Net CDC slippage (£1.3m) and Fordcombe Hospital adverse to plan by £0.4m
- Unfunded Ward escalation costs (£0.7m)
- Estimate impact of Junior Doctor Strike in June was £0.4m
- Other Expenditure pressures include overspends within Theatres consumable budgets (£0.7m), increase in security costs (£0.4m) and overspend on non-passthrough related drugs (£0.2m)

Favourable Variances
- ERF/Variable activity overperformance (£2.7m) and non recurrent benefits (£4.3m)
- The Trust released £1.9m relating to Service development and contingency budgets offset income and expenditure pressures incurred
- Other key underspends include: Pathology trade income overperformance (£0.3m) and depreciation (£0.1m)

CIP (Savings)
- The Trust has a savings target for 2024/25 of £37.3m, year to date the Trust has saved £8.3m which is £2.2m below plan

Forecast
- The Trust is forecasting to deliver the planned breakeven position, £25.4m of recovery actions are being identified and implemented.

Aug-24			DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators					Financial review		
Hospital Site name	Ward name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
Maidstone	Acute Assessment Unit (M)	Acute Medical Unit (M) - NG551	89.5%	146.6%	-	-	99.2%	177.1%	-	-	49.7%	48.3%	87	6.11	24	12.5	-	-	5			190,137	221,527	(31,390)
Maidstone	Stroke Unit	Stroke Unit (M) - NK551	99.4%	97.7%	-	100.0%	98.8%	98.1%	-	100.0%	30.2%	6.5%	93	6.48	5	7.5	7.7%	100.0%	5	3		230,374	235,767	(5,393)
Maidstone	Hyperacute Stroke Unit	HASU (34) - NK552	99.0%	83.9%	-	-	103.8%	106.5%	-	-	35.7%	13.8%	126	8.83	13	12.3	-	-	1			150,124	156,938	(6,814)
Maidstone	Cornwallis	Cornwallis - NS251	101.2%	98.8%	-	-	101.1%	99.9%	-	-	17.4%	5.1%	39	2.65	1	7.7	30.7%	92.6%	4			123,385	118,684	4,701
Maidstone	Culpepper and CCU	Culpepper Ward (M) - NS551	101.7%	92.1%	-	-	100.0%	125.8%	-	-	30.8%	7.8%	6	0.41	0	5.1	27.3%	100.0%	1			120,901	136,374	(15,473)
Maidstone	Culpepper and CCU	CCU (M) - NS551	-	-	-	-	-	-	-	-	-	0.0%	36	2.46	1	-	180.0%	100.0%	1					
Maidstone	Edith Cavell	Edith Cavell - NS459	136.5%	80.2%	-	100.0%	105.0%	112.9%	-	-	33.4%	63.0%	95	6.57	5	7.3	-	-	7	1		157,509	141,271	16,238
Maidstone	John Day	John Day Respiratory Ward (M) - NT151	88.4%	95.5%	-	No Hours	100.3%	86.6%	-	-	28.8%	4.8%	107	7.50	19	7.2	22.9%	87.5%	3	1		187,980	208,573	(20,593)
Maidstone	Intensive Care (M)	Intensive Care (M) - NA251	90.4%	80.6%	-	-	100.0%	85.1%	-	-	13.8%	0.0%	69	4.72	5	53.5	0.0%	-	0			245,106	248,322	(3,216)
Maidstone	Lord North	Lord North Ward (M) - NF651	92.0%	128.6%	-	100.0%	102.2%	100.0%	-	-	21.2%	0.0%	52	3.74	8	8.2	20.7%	100.0%	0			119,377	115,437	3,940
Maidstone	Mercer	Mercer Ward (M) - NJ251	95.8%	100.9%	-	100.0%	102.4%	135.6%	-	100.0%	33.8%	19.9%	61	4.25	4	6.1	8.7%	100.0%	3	2		123,153	149,254	(26,101)
Maidstone	Peale	Peale Ward COVID - ND451	99.2%	117.0%	-	-	95.7%	151.6%	-	-	29.5%	41.0%	46	3.21	6	9.0	33.3%	85.7%	0	1		109,875	100,198	9,677
Maidstone	Pye Oliver	Pye Oliver (Medical) - NK259	105.1%	149.3%	-	-	100.1%	166.6%	-	-	67.9%	29.9%	99	6.87	4	7.8	14.0%	83.3%	6	1		159,240	192,905	(33,665)
Maidstone	Short Stay Surgery Unit (M)	Short Stay Surgical Unit (M) - NE751	97.8%	75.0%	-	-	84.5%	5.0%	-	-	2.5%	0.0%	3	0.22	1	37.5	0.0%	100.0%	0			71,252	63,491	7,761
Maidstone	Whatman	Whatman Ward - NK959	100.0%	86.6%	-	-	100.0%	160.6%	-	100.0%	35.1%	21.5%	84	5.63	3	8.4	4.5%	100.0%	4	1		153,117	173,152	(20,035)
Maidstone	Maidstone Birth Centre	Maidstone Birth Centre - NP751	93.7%	100.0%	-	-	88.7%	90.3%	-	-	19.8%	0.0%	37	2.06	0	52.4	0.0%	100.0%	0			81,802	92,634	(10,832)
TWH	Acute Medical Unit (TW)	Acute Medical Unit (TW) - NA901	92.7%	117.0%	-	-	100.4%	140.7%	-	-	46.8%	26.6%	156	11.20	38	11.4	-	-	8			269,637	293,211	(23,574)
TWH	Coronary Care Unit (TW)	Coronary Care Unit (TW) - NP301	93.6%	89.1%	-	-	98.9%	-	-	-	22.3%	3.3%	27	1.80	10	12.4	-	-	0			77,556	74,006	3,550
TWH	Hedgehog Ward	Hedgehog Ward (TW) - ND702	89.6%	121.5%	-	-	87.6%	116.0%	-	-	18.2%	31.0%	94	6.31	18	12.2	0.6%	-	0			212,165	200,290	11,875
TWH	Intensive Care (TW)	Intensive Care (TW) - NA201	93.5%	87.2%	-	-	91.6%	70.9%	-	-	4.2%	0.0%	52	3.66	5	41.6	-	-	0			389,675	402,954	(13,279)
TWH	Wells Day Unit	Private Patient Unit (TW) - NR702	101.3%	98.1%	-	-	100.0%	106.5%	-	-	29.2%	0.0%	11	0.74	0	9.1	13.3%	100.0%	0			75,130	94,006	(18,876)
TWH	Ward 2	Ward 2 (TW) - NG442	86.7%	102.9%	-	100.0%	99.9%	126.1%	-	100.0%	34.4%	5.0%	74.00	5.38	18.00	7.3	3.4%	100.0%	9			199,272	197,702	1,570
TWH	Ward 11	Ward 11 (TW) - NG131	100.7%	112.0%	-	-	108.9%	91.1%	-	-	25.7%	1.3%	75	5.22	21	7.6	16.4%	70.0%	5			177,657	177,934	(277)
TWH	Ward 12	Ward 12 (TW) - NG132	102.5%	96.8%	-	-	102.4%	91.9%	-	-	30.4%	11.1%	103	6.50	15	6.6	3.4%	50.0%	4			238,264	179,746	58,518
TWH	Ward 20	Ward 20 (TW) - NG230	109.8%	139.6%	-	100.0%	120.4%	135.5%	-	-	50.9%	61.7%	152	10.03	21	8.6	14.0%	100.0%	7			209,648	206,973	2,675
TWH	Ward 21	Ward 21 (TW) - NG231	97.5%	87.3%	-	100.0%	97.5%	98.9%	-	-	26.9%	0.6%	85	5.50	15	6.9	10.9%	80.0%	1	1		188,933	184,014	4,919
TWH	Ward 22	Ward 22 (TW) - NG332	92.2%	121.6%	-	100.0%	98.2%	135.7%	-	-	42.1%	22.2%	84	5.71	16	6.9	23.8%	100.0%	13			178,179	196,467	(18,288)
TWH	Ward 30	Ward 30 (TW) - NG330	98.5%	93.8%	-	100.0%	97.7%	107.9%	-	100.0%	25.9%	0.7%	84	4.95	8	6.7	28.2%	81.8%	5	2		165,833	194,453	(28,620)
TWH	Ward 31	Ward 31 (TW) - NG331	101.4%	102.3%	-	100.0%	98.4%	101.6%	-	-	9.0%	3.9%	37	2.16	3	6.8	5.7%	100.0%	4	3		163,114	180,655	(17,541)
TWH	Ward 32	Ward 32 (TW) - NG130	101.4%	98.7%	-	100.0%	101.6%	102.5%	-	100.0%	14.1%	5.7%	57	3.90	7	9.9	0.0%	90.0%	2			154,655	168,238	(13,583)
TWH	Gynae Ward	Ward 33 (Gynae) (TW) - ND302	102.0%	90.8%	-	-	98.4%	106.5%	-	-	44.8%	1.2%	73	4.64	2	8.9	-	-	1			106,464	111,988	(5,524)
TWH	SCBU	SCBU (TW) - NA102	108.0%	98.5%	-	-	113.3%	52.8%	-	-	19.7%	1.2%	96	5.65	7	11.5	25.0%	100.0%	**0**			**220,322**	**217,265**	**3,057**
TWH	Short Stay Surgical Unit (TW)	Short Stay Surgical Unit (TW) - NE901	82.6%	67.9%	-	100.0%	100.7%	100.0%	-	-	6.3%	0.0%	21	1.41	1	14.4	8.8%	97.1%	1			89,372	98,270	(8,898)
TWH	Surgical Assessment Unit	Surgical Assessment Unit (TW) - NE701	96.0%	100.0%	-	-	100.0%	100.0%	-	-	18.7%	1.8%	37	2.62	3	21.5	4.7%	95.0%	0			80,568	91,341	(10,773)
TWH	Delivery Suite	Midwifery Services - Delivery Suite - NF102	95.1%	-	-	-	98.7%	-	-	-	37.8%	37.8%	361	22.78	89		-	-	0			401,902	448,553	(46,651)
TWH	Delivery Suite	Midwifery Services - MSW (2022) - NF102	-	98.2%	-	-	-	87.4%	-	-	27.8%	0.0%	-	-	-	6.8	-	-	-					
TWH	Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	82.5%	-	-	-	88.2%	-	-	-	43.3%	4.4%	130	7.73	35		-	-	0			102,170	89,924	12,246
TWH	Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	94.6%	83.0%	-	-	79.3%	100.0%	-	-	40.2%	4.8%	255	14.78	55		-	-	0			189,981	144,655	45,326
Crowborough	Crowborough Birth Centre	Crowborough Birth Centre (CBC) - NP775	97.6%	82.7%	-	-	73.4%	71.0%	-	-	23.4%	0.0%	65	4.25	18	102.4	30.8%	87.5%	0			74,231	67,885	6,346
Maidstone	A&E (M)	Accident & Emergency (M) - NA351	102.8%	104.0%	-	100.0%	102.8%	116.1%	-	100.0%	45.0%	34.4%	379	25.17	11	-	0.0%	85.0%	6			386,011	446,504	(60,493)
TWH	A&E (TW)	Accident & Emergency (TW) - NA301	99.6%	88.8%	-	100.0%	101.1%	94.1%	-	100.0%	39.9%	22.6%	431	29.70	21	-	14.8%	83.5%	3			443,463	459,288	(15,825)
TWH	Specialist Midwives	Midwifery Services - Specialist Midwives - NF152	89.4%	2.6%	-	-	104.0%	-	-	-	9.5%	0.0%	50	2.15	1		-	-	-			152,370	160,878	(8,508)
TWH	Womens Services Management	Midwifery Services - Management - AY451	87.3%	-	-	-	-	-	-	-	0.0%	-	-	-	-		-	-	-			99,260	100,119	(859)
TWH	Antenatal OP Clinic	Midwifery Services - Antenatal Clinic - NF142	72.8%	61.4%	-	-	-	-	-	-	6.7%	0.0%	17	0.60	0		-	-	-			50,300	45,657	4,643
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - NJ160	49.8%	-	-	-	-	-	-	-	1.0%	0.0%	2	0.07	0		-	-	-					
TWH	Community Midwifery Services (TW)	Community Midwifery Services - TW/Ton/PW/Hawkhurst - NJ160	59.4%	37.6%	-	-	-	-	-	-	5.4%	0.0%	35	1.61	4		-	-	-					
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - NJ160	62.9%	60.2%	-	-	2.1%	-	-	-	1.3%	0.0%	3	0.13	0		-	-	-					
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Eden/Seven/Mallings - NJ160	63.8%	15.5%	-	-	-	-	-	-	10.8%	0.0%	47	2.42	10		-	-	-					
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Maidstone/Leeds - NJ160	59.2%	38.6%	-	-	-	-	-	-	10.4%	0.0%	49	2.32	6		-	-	-					
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Crowborough - NJ160	56.3%	64.7%	-	-	-	-	-	-	4.5%	0.0%	9	0.45	2		-	-	-					
		Midwifery TW (four IP rosters)	92.8%	95.3%	-	-	91.6%	89.2%	-	-	36.8%	17.2%	746	45.29	179		-	-	-					
		Midwifery TW Community (six comm. rosters)	59.2%	36.2%	-	-	2.1%	-	-	-	6.7%	0.0%	450	26.76	108		-	-	-					
		Midwifery TW (all thirteen rosters)	75.6%	64.1%	-	-	87.7%	89.2%	-	-	18.4%	15.1%	829	51.93	119		-	-	-			332,249	306,001	26,248
																					Total Established Wards	#REF!	#REF!	#REF!
																					Additional Capacity bed Cath Labs	59,124	54,190	4,934
																					Whatman	342,419	215,116	127,303
																					Other associated nursing costs	5,815,979	5,464,518	351,461
																					Total	#REF!	#REF!	#REF!

Under fill

Overfill

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Chief Medical Officer**

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?
- N/A

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

August 2024

The reporting period for this report is May 23 - Apr 24 with the most recent HSMR data refresh in August 2024.

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 May 2023 - Apr 2023.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including February 2024(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 Apr 23 – Mar 24 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

HEADLINES

Data Period: May 2023 - Apr 2024

Metric	Result
HSMR	82.33 (lower-than-expected) (77.88 – 87.08)
HSMR position vs. peers	Regional acute peer group = 18 trusts: • 11 lower-than-expected • 3 within expected • 3 higher-than-expected Peer group = 93.1 (lower-than-expected) (91.9.3 – 94.3)
All Diagnosis SMR	81.0 (lower-than-expected)
Significant Diagnosis Groups	N/A
CUSUM breaches	Diagnosis groups: • Septicemia (except in labour) (May-23) Procedure groups: • Compensation for renal failure (Aug-23) • Rest of Operations covering multiple systems (Nov-23)
Emergency Weekend HSMR	90.3 (lower-than-expected)
Emergency Weekday HSMR	79.9 (lower-than-expected)
SHMI position	(Apr-23 to Mar-24) 93.32 (as expected)

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

HSMR for Apr 24 is 77.66 and “lower-than-expected”, based on 4607 superspells and 97 deaths (crude rate 2.11%).

HSMR for the period May 23 to Apr 24 is 82.33 and “lower-than-expected”, based on 51,728 superspells and 1222 deaths (crude rate 2.36%).

The Trust is currently performing statistically significantly better than both regional and national peers.

Figure 1 – HSMR 12 Month Rolling Trend

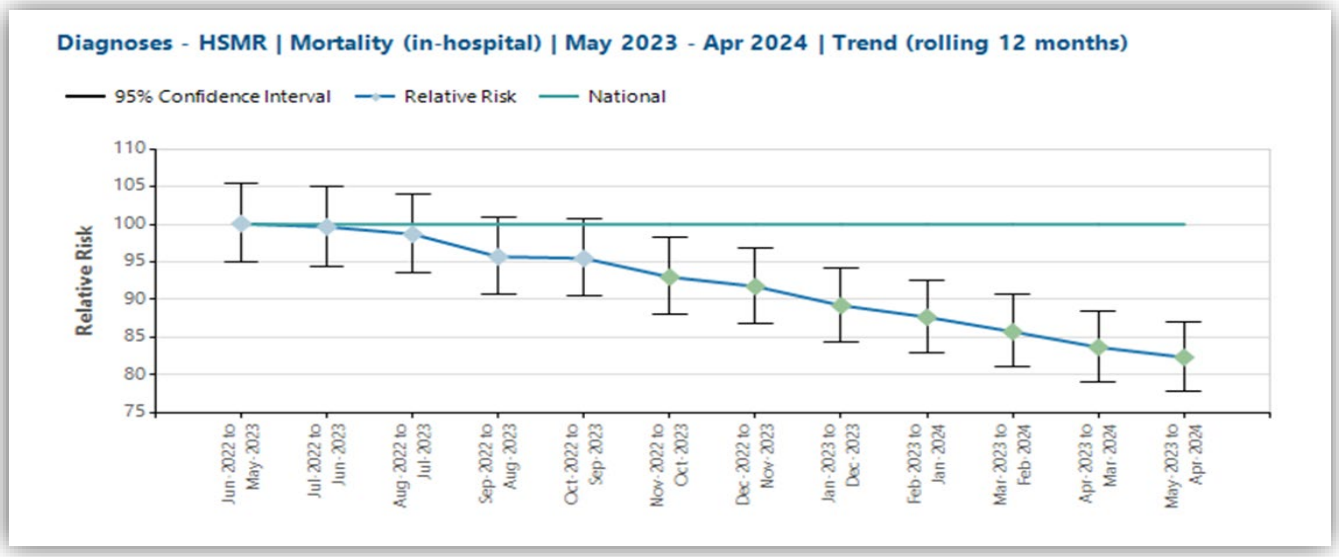
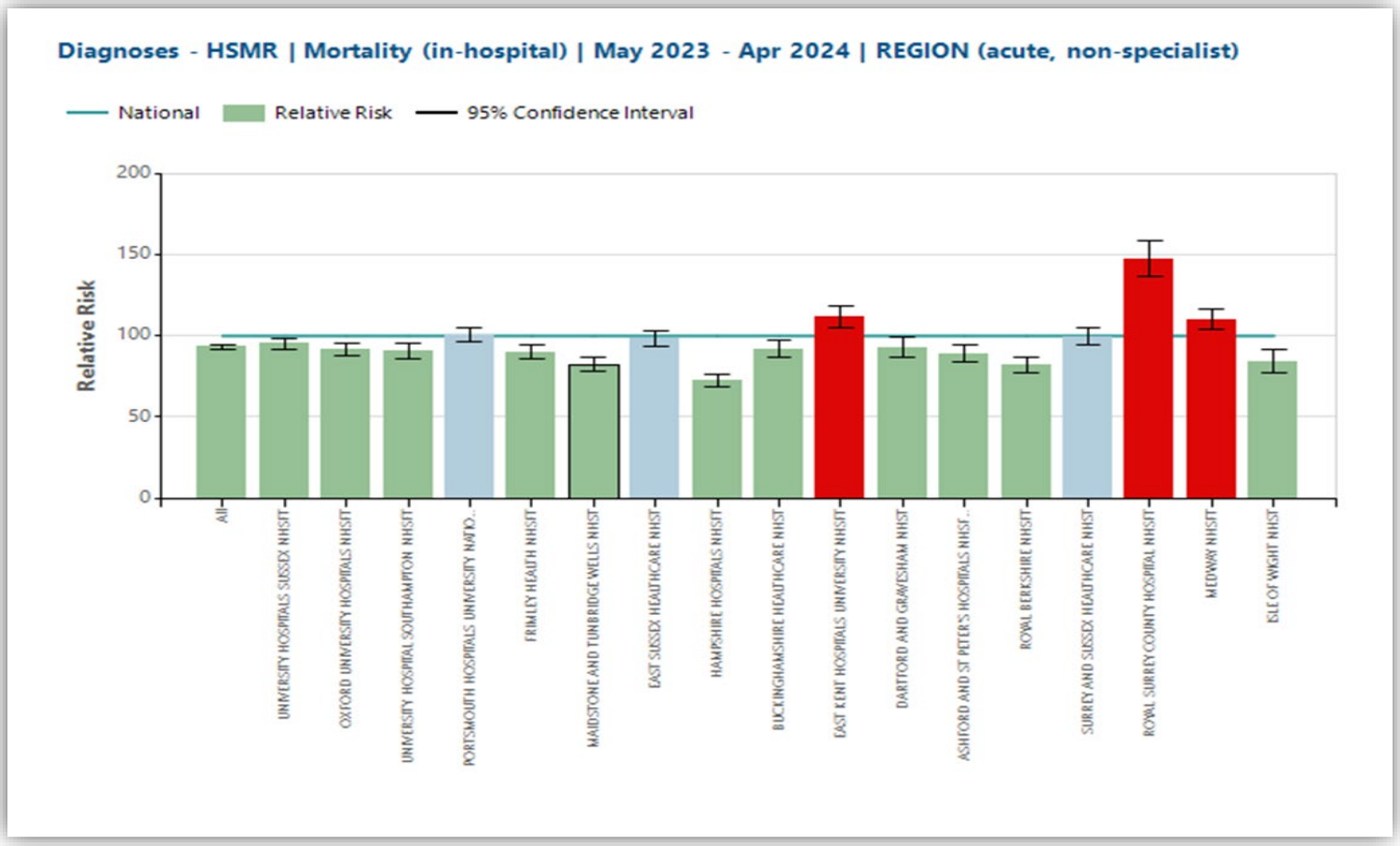


Figure 2 – HSMR 12 Month Peer Comparison



MONTHLY SHMI

Key points

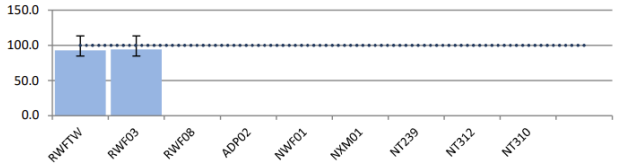
SHMI value for Jan-23 to Dec-24 is 94.94 and 'as expected'.

SHMI - Published (With Over Dispersion)

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

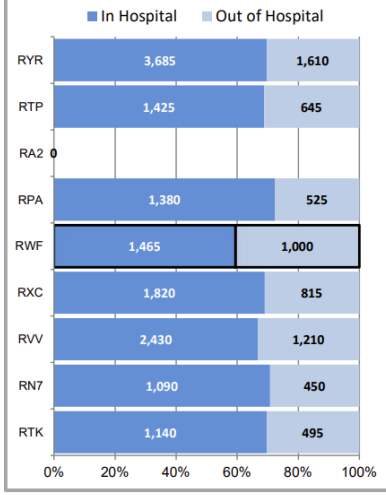
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTK	Ashford And St Peter'S Hospitals NHS Foundation Trust	58,460	1,635	1,660	-25	98.74	88.88	112.51
RN7	Dartford And Gravesham NHS Trust	56,175	1,540	1,500	40	102.52	88.79	112.62
RVV	East Kent Hospitals University NHS Foundation Trust	95,755	3,640	3,465	175	105.10	89.35	111.92
RXC	East Sussex Healthcare NHS Trust	62,940	2,635	2,625	10	100.42	89.21	112.10
RWF	Maidstone And Tunbridge Wells NHS Trust	99,765	2,465	2,640	-175	93.32	89.21	112.09
RPA	Medway NHS Foundation Trust	52,720	1,905	1,595	310	119.32	88.85	112.55
RA2	Royal Surrey County Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTP	Surrey And Sussex Healthcare NHS Trust	60,245	2,070	2,045	25	101.27	89.05	112.30
RYR	University Hospitals Sussex NHS Foundation Trust	151,625	5,290	5,040	250	104.99	89.49	111.75
Group		637,685	21,180	20,570	610	102.97		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
THE TUNBRIDGE WELLS HOSPITAL	62,815	1,275	1,375	92.79	86.74	115.29
THE MAIDSTONE HOSPITAL	35,785	1,190	1,265	93.94	86.66	115.39
CROWBOROUGH WAR MEMORIAL	285	0	*			
KIMS HOSPITAL (NEWNHAM COURT)	240	0	*			
BENENDEN HOSPITAL	215	0	*			
THE HORDER CENTRE - ST JOHNS	210	0	*			
NUFFIELD HEALTH, TUNBRIDGE	165	0	*			
SPIRE ALEXANDRA HOSPITAL	30	0	*			
SPIRE TUNBRIDGE WELLS HOSPITAL	15	0	*			

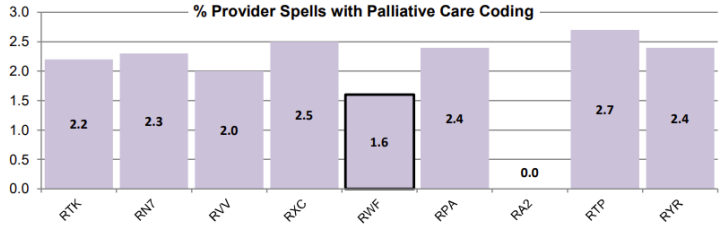


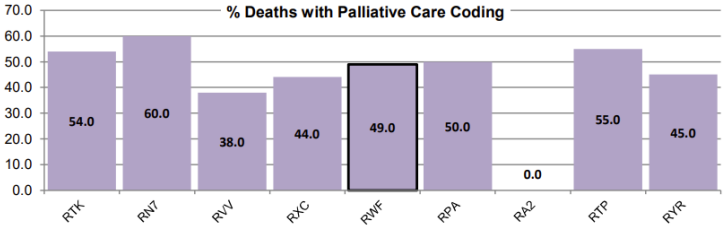
SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	170	150.00	114.74	81.19 123.17
Cancer of bronchus, lung	25	30.00	89.92	69.46 143.98
Secondary malignancies	60	70.00	83.20	76.92 130.00
Fluid and electrolyte disorders	45	40.00	115.32	68.94 145.06
Acute myocardial infarction	30	25.00	102.97	68.62 145.72
Pneumonia	255	290.00	87.90	85.08 117.54
Acute bronchitis	20	30.00	63.80	66.65 150.03
Gastrointestinal haemorrhage	30	35.00	86.54	72.07 138.75
Urinary tract infections	55	50.00	107.86	71.25 140.36
Fracture of neck of femur (hip)	55	50.00	107.92	75.80 131.93

Deaths: In / Out Hospital

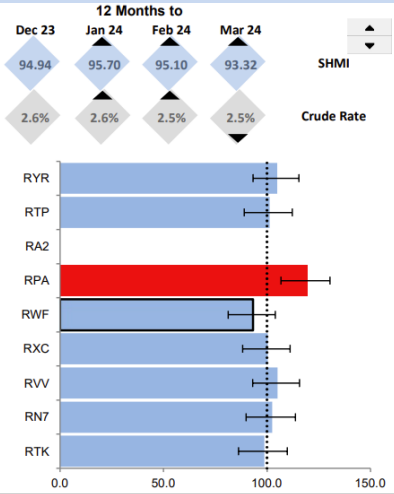


% Palliative Care Coding





Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(128) Complication of device, implant or graft	30	20	150.00	101.18 214.14
(99) Acute and unspecified renal failure	50	40	125.00	92.77 164.80
(75) Chronic obstructive pulmonary disease and bronchiectasis	60	50	120.00	91.57 154.47
(77) Aspiration pneumonitis, food/vomitus	90	80	112.50	90.46 138.28
(129) Complications of surgical procedures or medical care	15	10	150.00	83.89 247.42
(12) Cancer of liver and intrahepatic bile duct	15	10	150.00	83.89 247.42
(63) Cardiac dysrhythmias	20	15	133.33	81.41 205.93
(38) Nutritional deficiencies, Disorders of lipid metabolism, Other nutritional, endocrine, and metabolic	20	15	133.33	81.41 205.93

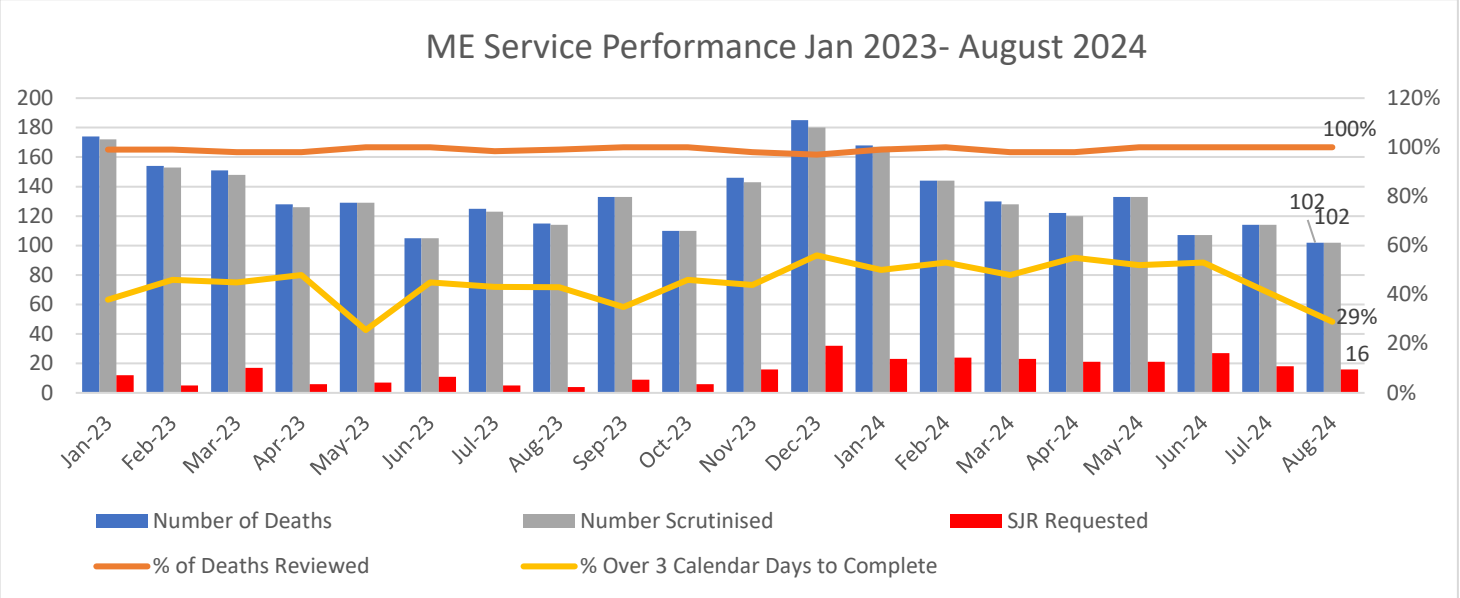
Medical Examiner Service

ME Service Update

- There has been a decrease in the number of deaths across the trust over the last 3 months (Jun-Aug 24) compared to the preceding 3 months (Mar-May 24). Deaths occurring in June 2024 were 107, then 114 in July 2024, and 102 deaths in August 2024.
- The Service continues to perform well normally scrutinising 98-100% of cases in the month. In the last 3 months, 100% of all deaths have been scrutinised.
- The ME Service became a statutory function on 9 September 2024. The Service in preparation for this change has engaged with all community care providers, recruited additional staff, and implemented systems and processes to support the increased caseload
- There are still a handful of community providers who are not engaged with the introduction of this change.

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Mar-24	130	128	98%	62	48%
Apr-24	122	120	98%	66	55%
May-24	133	133	100%	69	52%
Jun-24	107	107	100%	57	53%
July-24	114	114	100%	47	41%
Aug-24	102	102	100%	30	29%

ME Scrutiny Vs Deaths and SJRs Raised



The increase in SJRs raised by the ME Service in the last few months is due to the ME Service flagging all cases where Sepsis is mentioned. All of these cases may not require an SJR, however, they are being highlighted to support the work around Deteriorating Patients and Sepsis.

Challenges faced by the ME Service

- Staffing still presents a challenge but recruitment plans are going ahead for a Senior Medical Examiner Officer (MEO) to maintain oversight of daily operations of the Service.
- Induction of new junior doctors has meant a focus on death certification completion training which is time consuming. However, this training process builds better working relationships with new doctors and improves the quality of their documentation.

Learning from Deaths Group (LfDG)

The role of the Learning from Deaths 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 learned from Mortality reviews are disseminated appropriately and actions implemented to improve outcomes for patients and the quality of services provided.

Learning from Mortality reviews identified the following needs:

- Delay in requesting CT scan of approx. 6 hours and requested as routine not urgent. In the same case, there was failure to replace a cannula for over 12 hours needed to provide IV fluids as primary treatment for a patient with severe symptoms.
- From digital records there was no obvious medical review over the weekend. In the same case, there was no discussion about resuscitation status during admission for a frail patient with complex co-morbidities. Inappropriate resuscitation despite Community DNAR order in place. Action from LfDG was for the case to be discussed at divisional Clinical Governance to share learning.
- End of life care not initiated despite overwhelming sepsis and multiorgan failure

The following good practice was highlighted

- Comprehensive plan of care to look at all possible causes for symptoms, early input from relevant specialists and members of the MDT.
- Good communication from the ambulance service with a pre-alert call to ED
- Good treatment planning and execution. Daily consultant review, including at the weekend.
- Compassionate and open discussions with patients and family regarding treatment options and escalation
- Good management of sepsis and AKI, with good input from medical SpR on call, ITU and outreach to support teams

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.

Key Themes Highlighted by SJRs

- Communication: Good compassionate discussion with family members/loved ones about patient's condition and treatment plan including ceilings of care.
- Multidisciplinary involvement in patient care has been highlighted with senior clinical input
- Good management of Sepsis and AKI including the use of Sepsis 6 protocol

SJR Backlog Position

Year	Outstanding SJRs	<4 weeks	Completed SJRs
Apr 23 to Mar 24	**5**	**0**	98
Apr 24 to Mar 25	**8**	**12**	29
SJR Total backlog	**13**		

- The current SJR backlog position is 13, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4-week stipulated SJR turnaround time.
- There are 12 additional SJRs allocated to reviewers this year not within the backlog and 18 SJRs raised by the ME Service yet to be assigned to a reviewer.
- This brings the total number of SJRs to be reviewed to 43 with 13 in the backlog.
- 3 new SJR reviewers were trained in July 2024, this should support the current backlog position.

Summary of 'Poor Care' and 'Very Poor Care' from SJR Reviews

LfDG Meeting	No of SJRs	Overall 'Poor Care'	Overall 'Very Poor Care'
Jun-24	LfDG Meeting Cancelled		
Jul- 24	LfDG Meeting Cancelled		
Aug-24	18	2	0

- In June and July 2024, the Learning from Deaths Group meeting was cancelled as the meeting was not quorate in line with LfDG Terms of Reference.
- In August, the Learning from Deaths Group reviewed 2 SJRs with an overall assessment of 'Poor Care'.

- Learning from poor care and good practices highlighted from cases reviewed at the LfDG continue to be shared with directorates.
- Learning is also being shared via the Learning from Deaths Section in the Patient Safety Learning Hub on the intranet.
- Divisional mortality reports including mortality indicators and learning from SJRs are now provided to divisions to be presented at Clinical Governance meetings monthly.

Actions from 'Poor Care' and 'Very Poor Care' SJR Reviews

- There were 2 cases assessed as 'Poor Care' discussed at the August LfDG meeting.
- One case was referred through the Patient Safety team for review to determine if it meets the PSIRF threshold for further investigation. This case is open pending a review outcome
- The action for the other 'Poor Care' case was for it to be presented at the divisional Clinical Governance meeting.
- Feedback to directorates to aid learning from all SJRs occurs via mortality leads to teams, letters to clinical directors, and senior clinicians involved in the case. Cases are also discussed at Clinical Governance meetings.

Next steps

- 2 additional doctors have expressed an interest in becoming SJR reviewers, training is being organised for them.
- Continue to monitor the SJR backlog position

SAFEGUARDING UPDATE (ANNUAL REPORT TO BOARD)	CHIEF NURSE

Executive Summary.

The safeguarding Annual Report, 2023-2024, 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 and provide assurance to 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 2023- March 2024.
- 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 page 3 - 30
- Section 2 report on Adult Safeguarding page 31- 47
- Section 3 report on Midwifery Safeguarding page 48 -55

Key areas to note are:

National

The NHS Safeguarding Accountability and assurance Framework was updated in June 2024 and provides guidance and minimum standards for safeguarding in line with underlying legal duties.

Regional

The Trust is an active participant within the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and the Kent and Medway Safeguarding Adults Board (KMSAB) and their constituted sub-groups.

The Trust has access to multi-agency training via both the KMSAB and KSCMP on-line training provided by the e-Learning for Health platform.

The Trust contributed to 15 Safeguarding Adult Review (SAR's) requests across 2023-2024, including some backlog work from the previous year.

The Kent and Medway ICB designated safeguarding leads have continued to attend the MTW safeguarding learning and improvements panels held at MTW.

Local

The Trust's safeguarding activities comply with the current Working Together Guidelines (2023) the Intercollegiate Documents (2018 and 2019) and the NHS Accountability and Assurance Framework (2024).

Key policies and training updated to reflect the Fuller Inquiry on the safeguards and care of the deceased.

The majority of the total safeguarding adults' referrals were related to self-neglect. This is similar to the national data available. There is a noted increase in activity in relation to safeguarding referrals and complex hospital cases across safeguarding adults, children and midwifery teams.

The Trust authorised a total of 664 deprivation of liberty safeguards (DOLS) representing a 20% increase from the previous year.

The total safeguarding adults' referrals for 2023-2024 reached 436, with 98 of these referrals related to hospital practice. This was an increase of 61% compared to the previous year. Specifically, safeguarding allegations concerning hospital practice increased by 19% during this period. The outcomes for hospital alleged incidents were as follows: 23% of the alleged incidents were not upheld, and 67% did not progress to a Care Act section 42 enquiries.

Supervision compliance in midwifery remains below target. Actions are in place to address the concerns.

The Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks.

5 red rated risks are associated with safeguarding and are being addressed.

Non-completion of MCA audit for 2023 however this is now planned for October 2024.

Safeguarding training re-alignment ongoing for all staff in line with the intercollegiate Documents 2018 and 2019.

The Trust completed 126 LeDeR reports as compared to 83 for the previous year. The Trust made 6 referrals for further review

During the reporting period, the Trust saw an increase in the number of non-accidental injuries (NAI) where 9 children were reported as having suffered from NAI. The ICB commissioned a deep dive across the Kent and Medway region and the results are pending.

Section 11 Children Act 2004 audit (for Safeguarding Children services) have highlighted that the Trust was able to evidence that it meets all its statutory responsibilities.

Which Committees have reviewed the information prior to Board submission?

- Joint Safeguarding Committee in July 2024
- Patient Safety Oversight Group in August 2024
- Quality Committee Main in September 2024

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

Safeguarding Annual Report 2023-2024

Introduction and overview.

The Trust holds a statutory responsibility to safeguard children and adults under the Care Act (2014) and accompanying guidance Care and Support Statutory Guidance (DoH 2016), Children Act 2004, Working Together to Safeguard Children 2018, Safeguarding Vulnerable People in the NHS, Accountability and Assurance Framework 2018 and the Children and Social care Act 2017. The NHS Accountability and Assurance Framework (2024) 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 Trust Board assurance processes in respect to its statutory duties and responsibility around safeguarding.

The Trust also complies with the Care Act (2014) and NHS Guidance by having in place named professionals for safeguarding adults, safeguarding children and a named midwife to ensure the it fulfils its legal duty towards adults or children at risk of harm or abuse.

Governance and Oversight

The Trust Executive Lead for Safeguarding is the Chief Nurse, who delegates responsibilities to the Deputy Chief Nurse (DCN) in relation to both adults, children and midwifery. The Safeguarding Midwifery team have recently moved across to the Corporate Nursing team and the DCN has oversight on this service. Professional accountability for the Safeguarding Midwives is overseen by the Director of Maternity. The Trust is accountable to the NHS Kent and Medway Integrated Care Board (ICB) and reports directly to the Trust 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.

Joint Safeguarding Committee

The Trust Safeguarding 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 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 Kent and Medway ICB and will have a view on the development of Integrated Care Partnerships and Integrated Care Systems.

Section 1

Safeguarding Children Report 2023-2024

1.0 INTRODUCTION

This annual report is to provide assurance to the board that the Trust is meeting its statutory duties to safeguard children by identifying, preventing and responding to concerns of abuse, harm or neglect of patients, visitors and staff from April 2023 to March 2024. Useful information outside of these time frames will inform the report. 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 to the Trust.

The Statutory requirements for Safeguarding include The Care Act 2014, Children's Act (1989/2004), Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and PREVENT (under the Counter-Terrorism and Security Act 2015). 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.

An updated Section 11 audit (for Safeguarding Children services) will be submitted in September 2024. Previous audits for 2021 -2022 and 2022-2023 have highlighted that the Trust was able to evidence that it meets all its statutory responsibilities in a robust and accessible manner.

2.0 GOVERNANCE

The Trust Board has a responsibility to ensure that there are policies and processes in place that details the processes to protect both children and adults at risk. The Trust Safeguarding Children Policy has been reviewed and updated to consider recent legislative and statutory guidance changes; both the Safeguarding Supervision policy and the Domestic Abuse policy have also undergone recent updating, in line with new legislation. The Domestic Abuse policy covers all patients, staff and visitors.

The Safeguarding Children team has incorporated the Recommendation 17 of the Fuller Report into all its training. This ensures that all staff are aware of their responsibility to treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

The Safeguarding Children practitioners attend Multi-Agency Risk Assessment conferences (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 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; funding, through the Kent County Council (KCC) and the Kent and Medway ICB has been agreed for a further 12 months. Operational oversight of the Safeguarding Children's agenda is delegated to the Named Nurse for Safeguarding Children (NNSGC).

They NNSGC and the Named Nurse for Safeguarding Adults (NNSA) have joint responsibility for:

- Design and delivery of training for Safeguarding Adults, Safeguarding Midwifery, 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 –the Named Nurse Safeguarding Children is a Home Office approved trainer 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

The Named Midwife for Safeguarding Children leads on the key areas of work necessary to safeguard unborn children at risk. Further analysis will be provided in their report.

3.0 THE NHS SAFEGUARDING ACCOUNTABILITY AND ASSURANCE FRAMEWORK (2024)

The safeguarding of children, young people and adults who are at risk is a fundamental obligation for everyone who works in the NHS and its partner agencies. Safeguarding

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

children and adults at risk of abuse or neglect must be kept constantly under review. While there are some similarities, the safeguarding of children and adults are distinct and separate entities which need different approaches. Each person requires a unique safeguarding approach by a professional based on their circumstances and needs.

This SAAF (2024) aims to provide guidance and minimum standards for safeguarding, but should not be seen as constraining the development of effective local safeguarding practice and arrangements, in line with the underlying legal duties.

The responsibilities for safeguarding forms part of the statutory functions for each organisation, and its executive board must therefore ensure effective discharge within agreed baseline funding.

Fundamentally, every NHS organisation (including MTW), and every individual healthcare professional working in the NHS, must ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied: the needs of these at-risk citizens and communities must be at the heart of everything the NHS does.

Partnership working is essential, and it is vital that local practitioners continue to develop relationships and work closely with colleagues across their local safeguarding system. This will help to develop ways of working that are collaborative, encourage constructive challenge, and enable learning in a sustainable and co-ordinated way.

4.0 INTERAGENCY PARTNERSHIP WORKING

The Named Nurse for Safeguarding Children is proactive in working with a wide range of external partners in delivering the Safeguarding agenda across Kent and Medway. The Trust has close ties with our partners in other provider and commissioner organisations, and the Local Authority.

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 its priorities for the coming 24 months. These include the Mental Health of Children and Young People, the Impact of Parent Mental Health, Effective Multi-Agency Working, and On-line Safety. The Trust aligns 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 forum is 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

5.0 SAFEGUARDING ADULTS AND SAFEGUARDING MIDWIFERY

The Named Nurse Safeguarding Children, and wider team, work closely with both the Safeguarding Adults and Safeguarding Midwifery teams to provide a seamless and robust Safeguarding service.

6.0 SAFEGUARDING CHILDREN

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 their 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 has highlighted this as an area of concern and is looking at barriers to challenge and will publish recommendations alongside a Local Safeguarding Practice Review

7.0 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 will be submitted in September 2024; the KSCMP have previously noted that we, as an organisation, meet our statutory requirements to safeguard all Children and Young People. There are no outstanding actions from the previously submitted audit in 2022.

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, and the wider team, follow up on children not brought to appointments and liaises with Health Visitor teams, GP's and the Local Authority (if needed). The Trust has a ratified an all age '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 currently uses the national Female Genital Mutilation information sharing system (FGM-IS).
- Children who are designated as a Child in Care
- Adults and Children subject to MARAC procedures

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 are looking at a more collaborative approach to training, in anticipation of developing joint training across the three services. This approach will focus on the 'Think Family' agenda recognising the overlap between the Midwifery, adult and children safeguarding agendas.

8.0 SAFEGUARDING CHILDREN TRAINING

Safeguarding Children training is now delivered across a hybrid model of virtual and face to face options. Staff have access to external training from a wide variety of providers and are actively encouraged to do so. Face to face training is covered in one day and encompasses a wide variety of subject matter, including, Recognising and Responding to Abuse, Non-Accidental Injuries, Domestic Abuse, Exploitation, FGM, and Mental Health.

Compliance for level 3 Safeguarding Children training has consistently been rising all areas. At the end of the reporting period in March 2024, the training compliance was 85.1% against Trust target of 85%. The Safeguarding Children team target areas where compliance is less than 85% and support with bespoke training

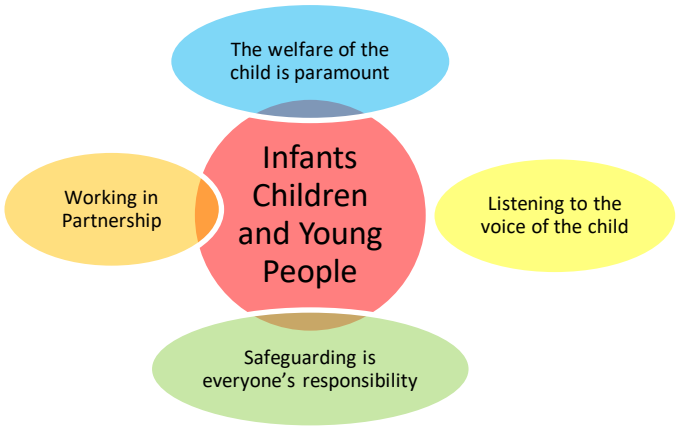
Compliance for both level 1 and 2 is above Trust standard and sits at 90% and above at the end of the report period.

The Named Nurse Safeguarding Children is compliant with Level 4 Safeguarding Children training as required by the current Intercollegiate Document.

9.0 CARE QUALITY COMMISSION

The Trust was inspected in March 2023. The Safeguarding team as a whole participated in this event and met with the inspection team to provide feedback relating to the safeguarding children service.

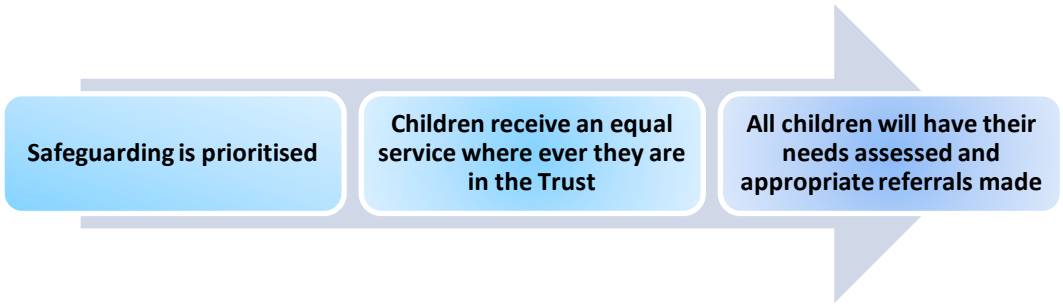
10.0 SAFEGUARDING CHILDREN – Our ethos puts children and young people at the centre of all of MTW services.



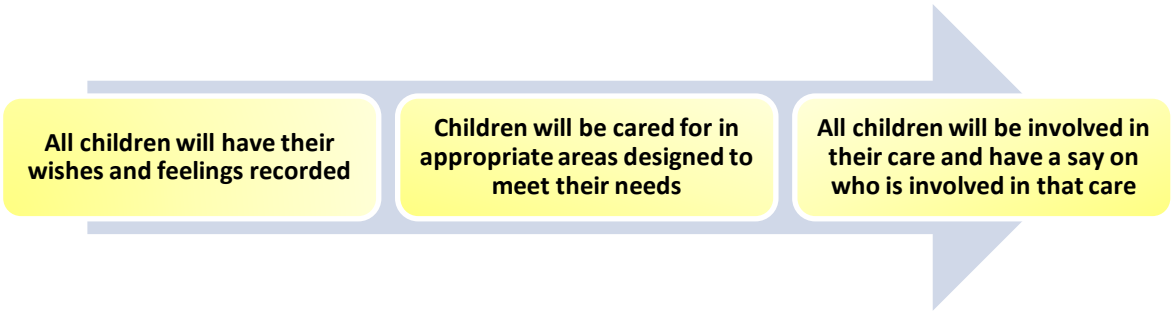
The Safeguarding Children team has taken the 5 CQC domains and uses these as our framework

A. CARING - PUTTING CYP AT THE CENTRE OF OUR WORK

B. SAFE – THE WELFARE OF THE CHILD IS PARAMOUNT



C. RESPONSIVE – LISTENING TO THE VOICE OF THE CHILD



D. WELL-LED – SAFEGUARDING IS EVERYONE'S RESPONSIBILITY

E. EFFECTIVE PARTNERSHIP WORKING

11.0 QUALITY AND SAFEGUARDING

11.1 Mental Capacity Act and Deprivation of Liberty (DOL) Safeguards

The current legislation (Mental Capacity Act) is applicable to 16- and 17-year olds 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 Young People, and the application of legal frameworks around consent (especially the Fraser Guidelines and Gillick competence). The named professionals work together to provide consistent advice to areas where the Mental Capacity Act may be applicable.

11.2 Deprivation of Liberty 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.
In April 2024 the Trust initiated proceedings to apply for a Deprivation of Liberty (DOL) order for a 14-year young person who had no agreed discharge address. The DOL order was approved and the Trust has returned to court on 8 occasions for a review and renewal of the order. The Local Authority have now agreed a placement for this young person. The High Court was clear that The Trust had gone 'above and beyond' in what would be considered our usual care pathways. The Trust Legal Services team has supported the Named Nurse Safeguarding Children through these legal proceedings.

A previous review in 2023, led by an independent author, identified some learning for the Trust. This included:

- Individual complex cases should be identified early as possible and a senior manager from across the partnership (to include MTW) identified to take leadership role and to be accountable for the outcomes of individual cases.
- MTW has developed a clear escalation pathway for Children and Young People who are at risk of delayed discharge due to their multiple complexities.
- The Named Nurse Safeguarding Children and Paediatric Head of Nursing review all extended/delayed discharges to understand the sequence of events, and take learning for these incidences

- The Named Nurse Safeguarding Children works with external agencies to develop and share community safety plans for Children and Young People. There are on-going discussions as to where these plans will be held (e.g., GP, ICB etc.), and how professionals can have access to these important documents
- There is a further movement towards developing 'Admission Avoidance Plans'; these enable Young People and their families to understand what to do if the young person is in crisis and who to contact; it is hoped that these plans may result in fewer ED presentations and inappropriate admissions
- 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.

Maidstone and Tunbridge Wells NHS Trust has developed risk assessments (for use in ED and wards) for identifying children at risk of an acute admission, where there is no medical need for admission; 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 Teams; the nationally recognised Ready Steady Go model is used (https://www.readysteadygo.net/).

Information sharing is of the utmost importance and it is how we Safeguard our Children and Young People. The Trust has clear information governance (IG) processes in place to facilitate the sharing of information.

Supervision for staff – the Safeguarding team receives supervision from an external provider (The Wellbeing Collective) which has proved to be effective and much welcomed.

11.3 Safeguarding Children Audits

There are no current Safeguarding Children audits in progress at the time of writing the report. However, the Named Nurse Safeguarding Children has agreed with the Trust Clinical

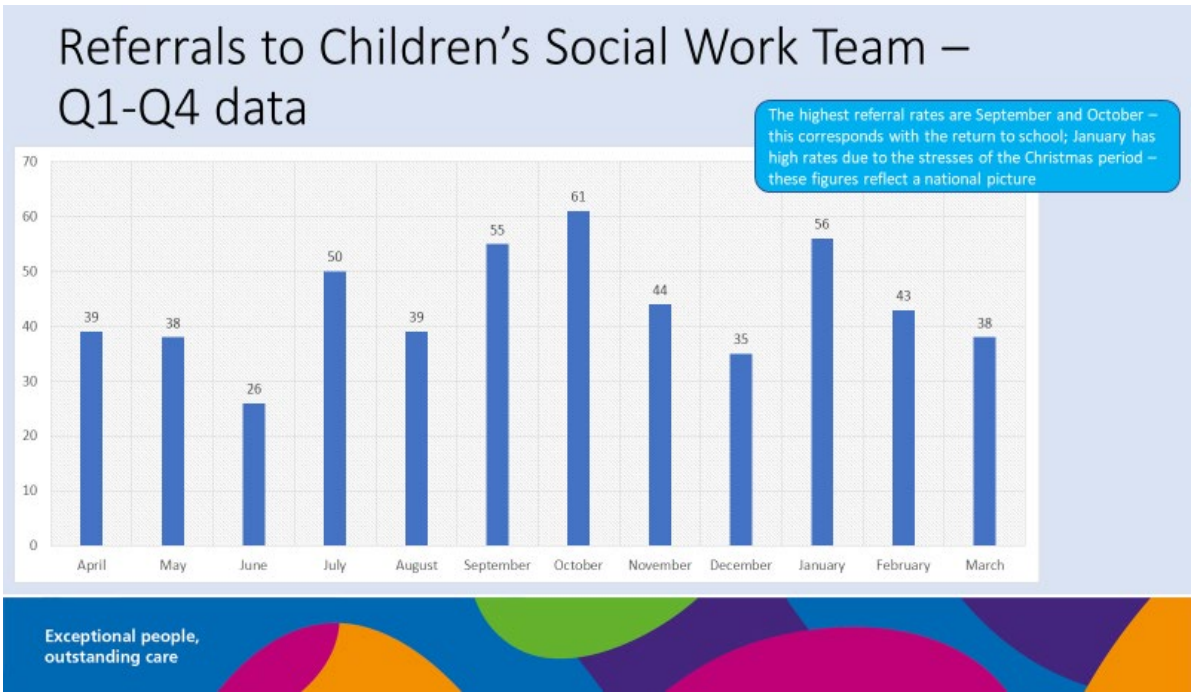
Audit team a series of audits that will be carried out in 2024; these include auditing the number of Safeguarding assessments completed in ED.

12.0 SAFEGUARDING REFERRALS AND INVESTIGATIONS - CHILDREN

Safeguarding Children activity has been maintained in the 2023-2024 reporting period. The Trust made a total of 524 referrals to Children's Services in the reporting period. This compares with 559 in the previous 12 months; a drop of 6.2%. It is noted that June 2023 saw a large drop in the referral rate – there would appear to be no obvious reason why, particularly as attendance rates for <18 years olds to ED was >4000 in that month (average presentation 3700/month).

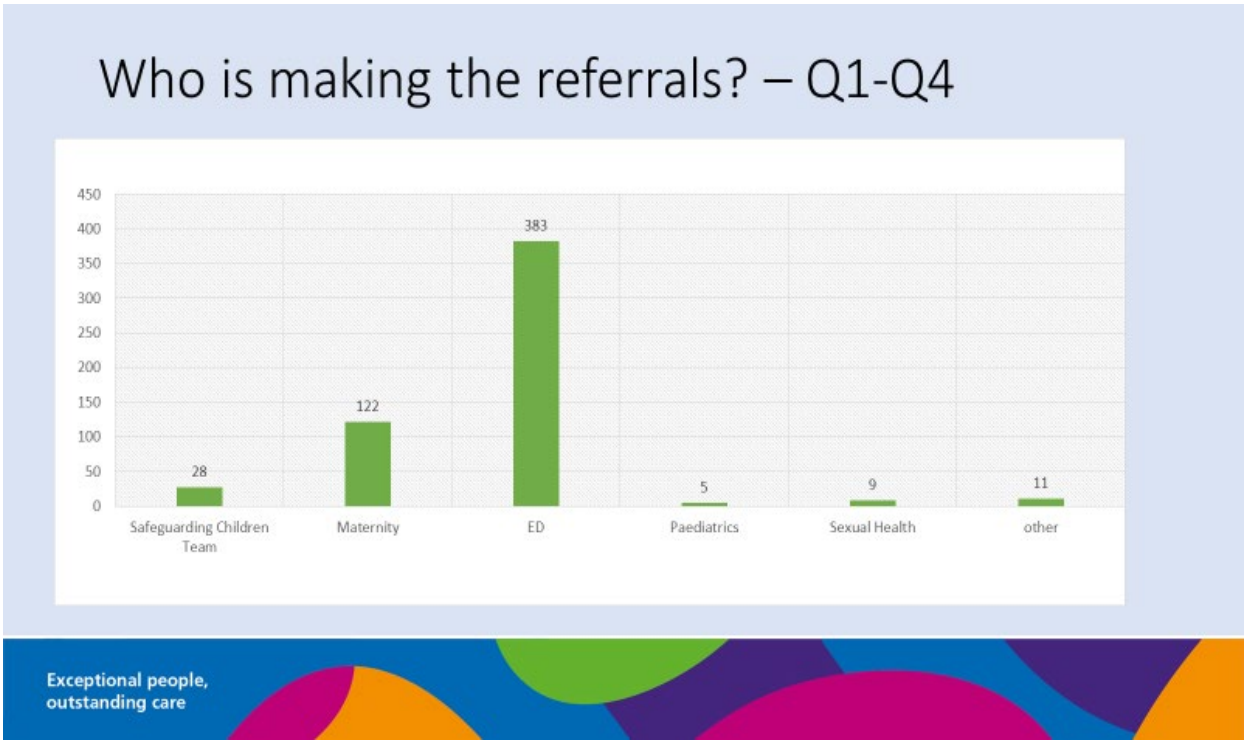
Staff are more confident in using the Local Authority referral systems, and identifying 'at risk' children. This is seen as a result of increasing training compliance within ED, and the bespoke training also provided to ED staff. The Safeguarding Children team is very visible within ED and has excellent relationships with the department; the team operates an 'open door' policy which provides reassurance and support to staff.

The busiest periods are Q2 and Q3 – these coincide with school holidays and the subsequent return to school.



In the 12-month previous reporting period (2023/24) 453 referrals were made; the updated data represents an 6.2% decrease in the referral rate from the previous reporting period.

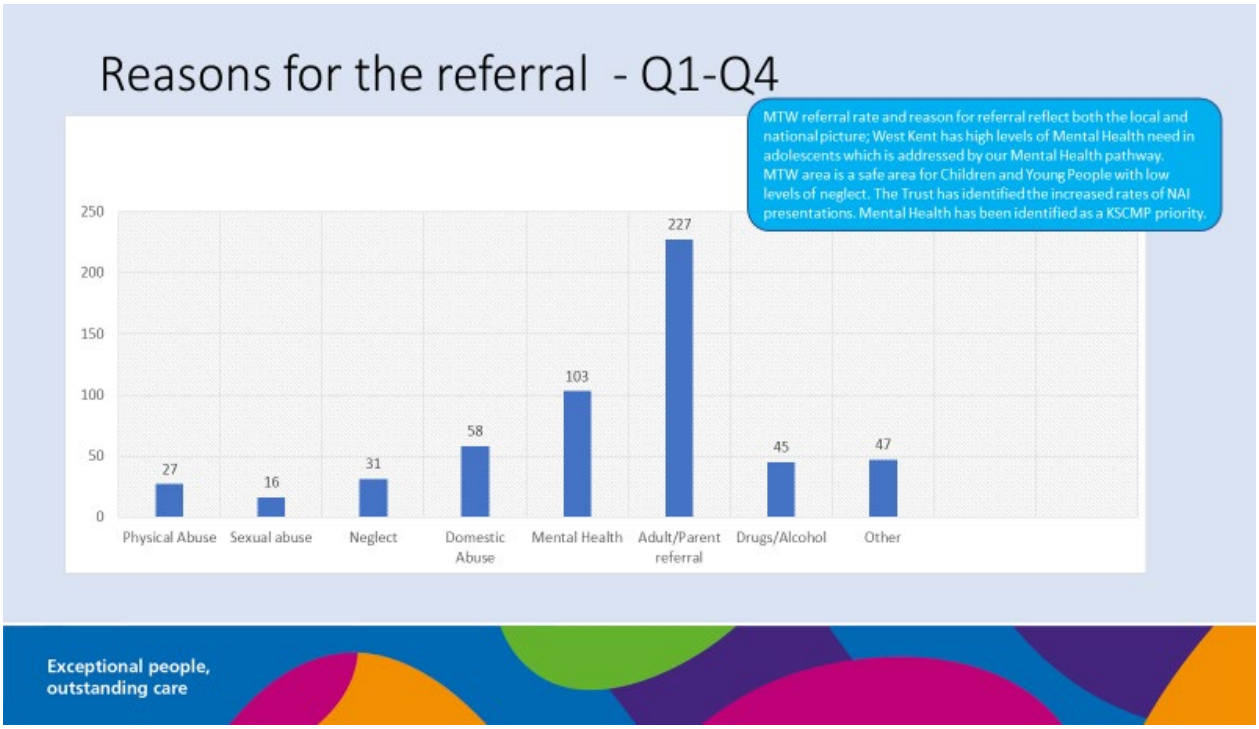
12.1 Who is making the referrals?



Consistently, the majority of referrals are submitted by ED or Maternity services.

Although the Trust has no permanent Safeguarding presence in either of the ED's the Safeguarding team are highly visible and visit the departments regularly. Staff know how to contact the team and are proactive in doing so. The Named Nurse Safeguarding Children will provide out of hours advice on an ad hoc basis. Out of hours support is available through the local authorities.

12.2 Reason for the referral



An analysis of why referrals are being made shows that the majority are related to both Adult/parent concerns, and the Mental Health concerns of both adults and children. There are wider workstreams within the Kent and Medway ICB, KSCMP and KMSAB in relation to mental health concerns, domestic abuse, self neglect and substance misuse.

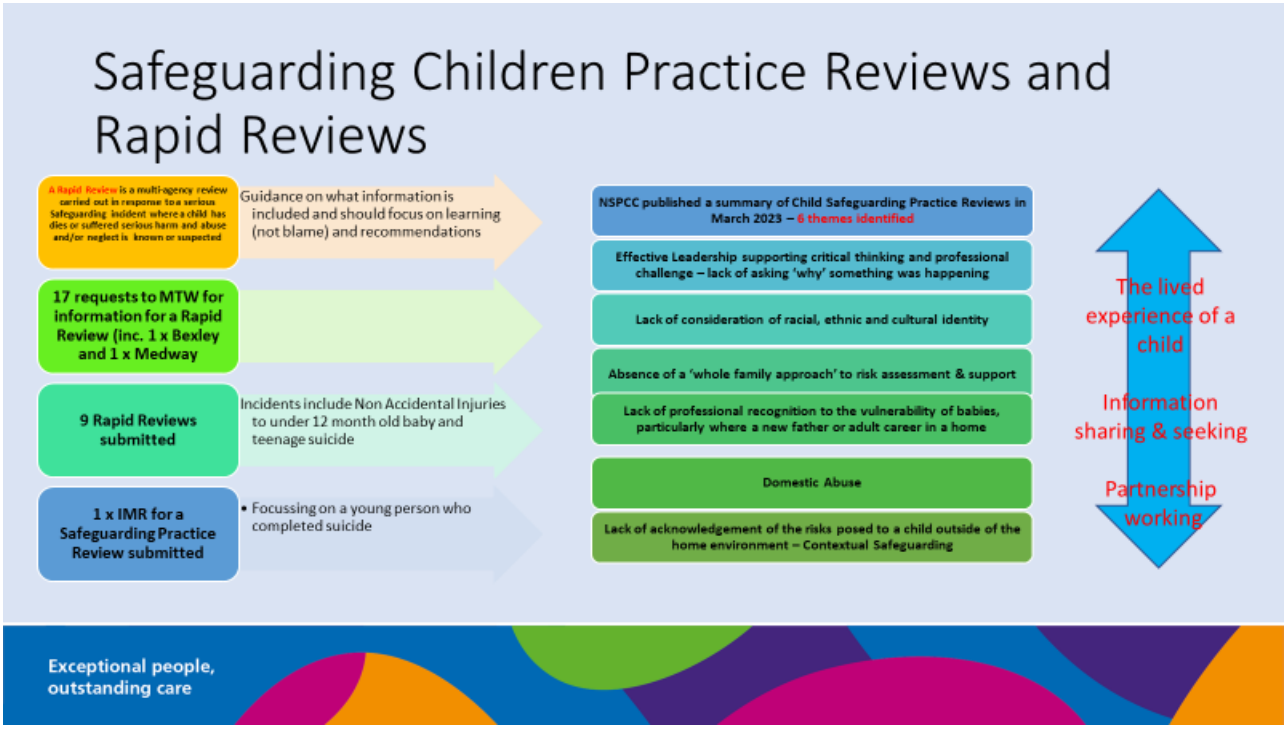
As a team the quality of the referrals are reviewed. Training is provided on 'how to make a quality referral', and staff are encouraged to get referrals reviewed by safeguarding practitioners prior to submission.

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. The team support staff to provide high quality reports for Child Protection Conference's where the Named Nurse will also attend conferences as required. 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 IT system is also flag known Children in Care and other high-risk children, including those that are frequently missing or display high risk behaviours. Staff at MTW are supported in managing the high-risk behaviours by involving

multi professionals that have worked with the children in the community and also share their risk management plans.

12.3 Local Child Safeguarding Practice Reviews

In the current reporting period the Trust has been notified of 17 Rapid Reviews and we have contributed to 9 of these reviews. The Trust has also submitted an Individual Management Review (IMR) regarding a 16-year-old young person who sadly completed suicide. This review did not highlight any new concerns for Maidstone and Tunbridge Wells NHS Trust but reiterated the importance of accurate and contemporaneous documentation.

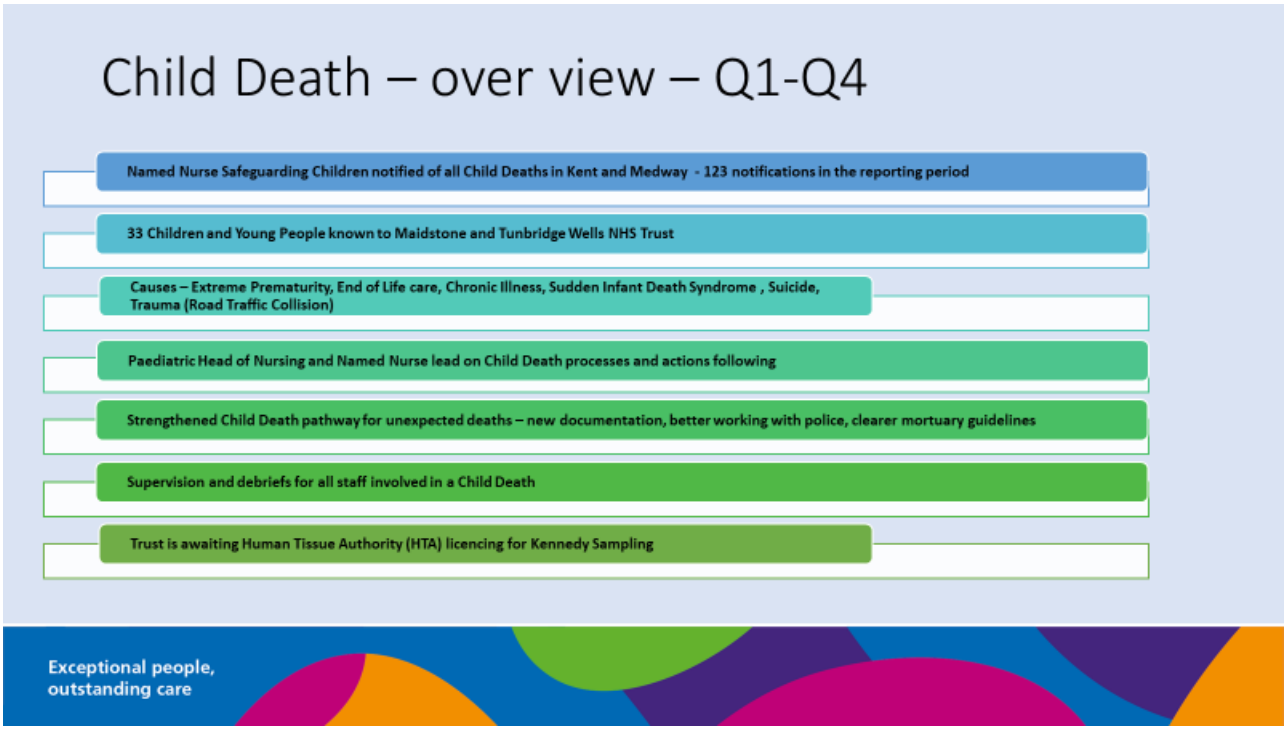


13.0 CHILD DEATHS

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 (2023), 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 compared to other local hospitals. The Named Nurse Safeguarding Children is notified of all Child Deaths in Kent – of which there are 123 in total in the current reporting period. Of these, sadly 33 children known to our services passed away in the reporting period. The majority were due to complex health needs or life limiting conditions.



13.1 Child Death team at MTW

The Named Nurse Safeguarding Children and Paediatric Head of Service lead on Child Death for the Trust. We have a Named Paediatrician for Child Death who works closely with the Leads.

The infographic above highlights the Trust current process.

13.2 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, Cerebral Spinal Fluid (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[2]-licensed premises and are nationally recognised guidelines.

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 has a HTA licence; Medway Foundation Trust has 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, following death.

[2] Human Tissue Authority - https://www.hta.gov.uk/

Maidstone and Tunbridge Wells NHS Trust has led on the project to agree the new licensing process across Kent and Medway. The region is awaiting finalisation of the agreements and it is anticipated the Trust will be licenced during the latter part of 2024; we will not be offering CT Scans or Skeletal Surveys when a child is declared life extinct at the Trust.

14.0 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'.

The Trust ratified a new Domestic Abuse policy in 2021 which considers the new legislation. This policy has since been reviewed and updated; it will be ratified in late July 2024

14.1 Hospital Based Independent Domestic Abuse Advisor (HIDVA)

The Trust has secured funding for the HIDVA service for a second 12-month period.
The role of the HIDVA is -

- To provide immediate support and advice to victims of domestic violence within the hospital setting; this service is for patients, staff and visitors and is a cross-site service
- 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

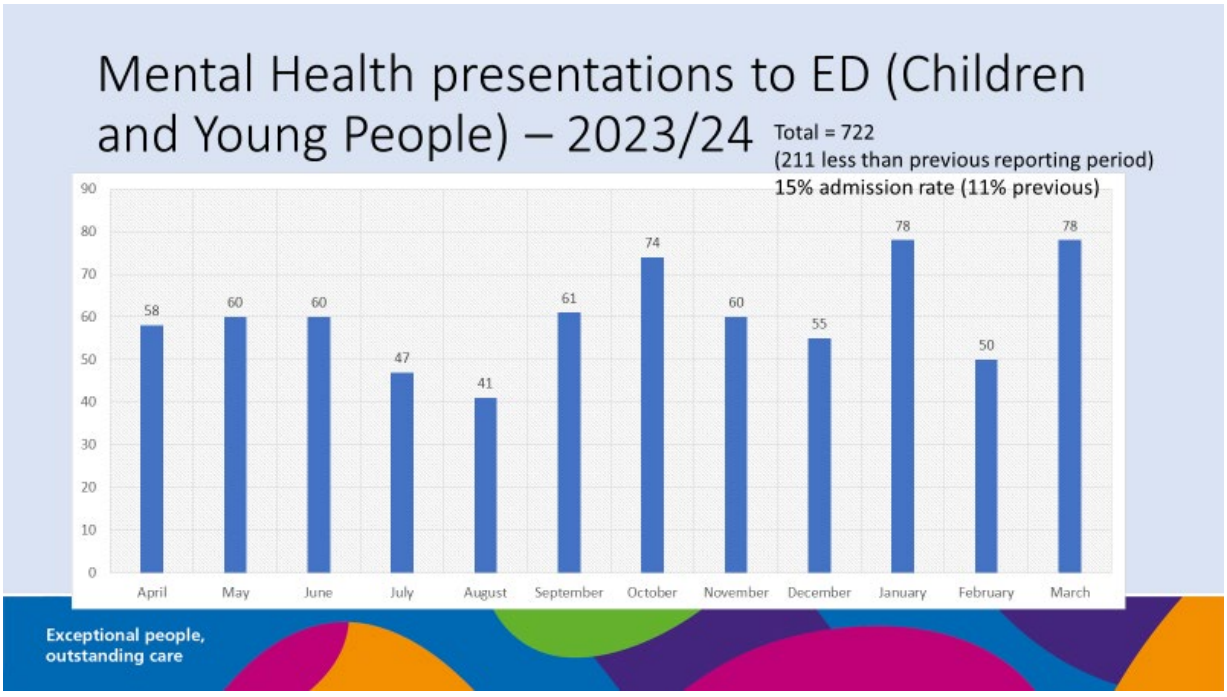
The Named Nurse Safeguarding Adults will provide a more in-depth analysis of the HIDV role

15.0 CHILDREN WITH MENTAL HEALTH NEEDS

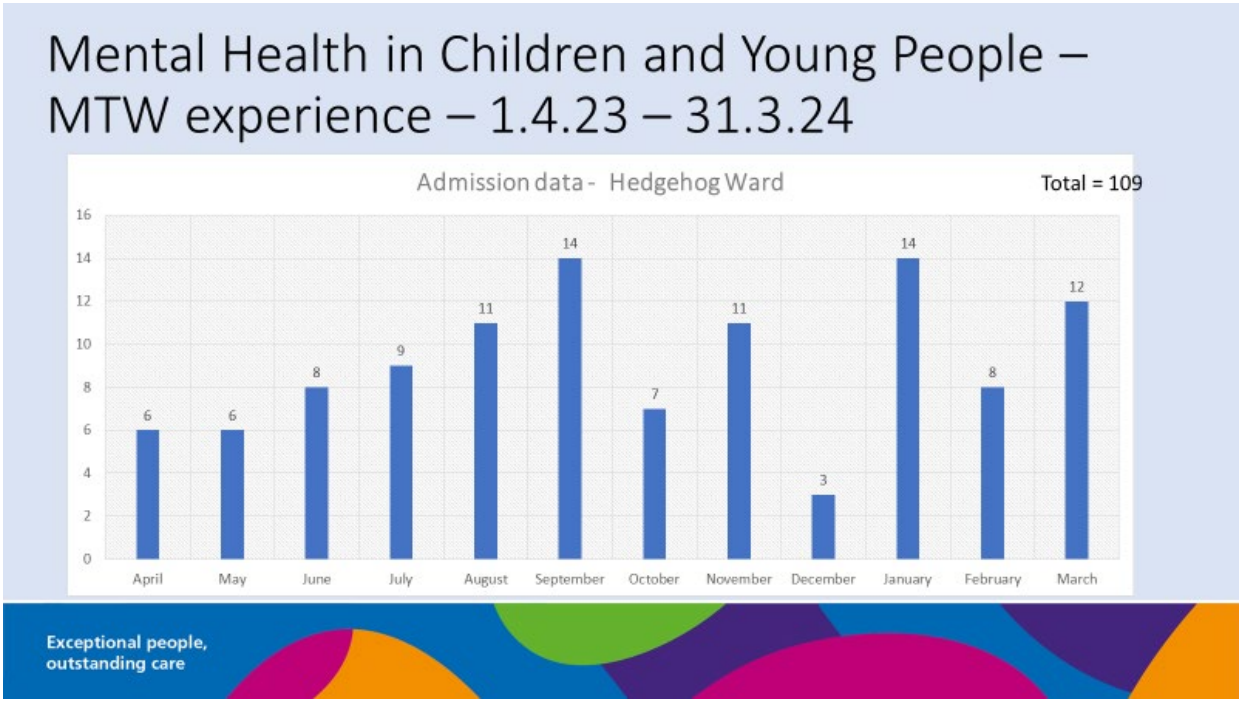
Within this Trust it is apparent that an increasing number of children are being admitted with acute Mental Health needs; these include anxiety, Deliberate Self-Harm (DSH) and overdoses. Staffs are ill-prepared for the risk that these children pose to themselves and struggle with the limited services 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 (and longer). This leaves children on an acute medical paediatric ward receiving Mental Health

care from agency RMN staff. To address this, the staff on Hedgehog Ward have 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.

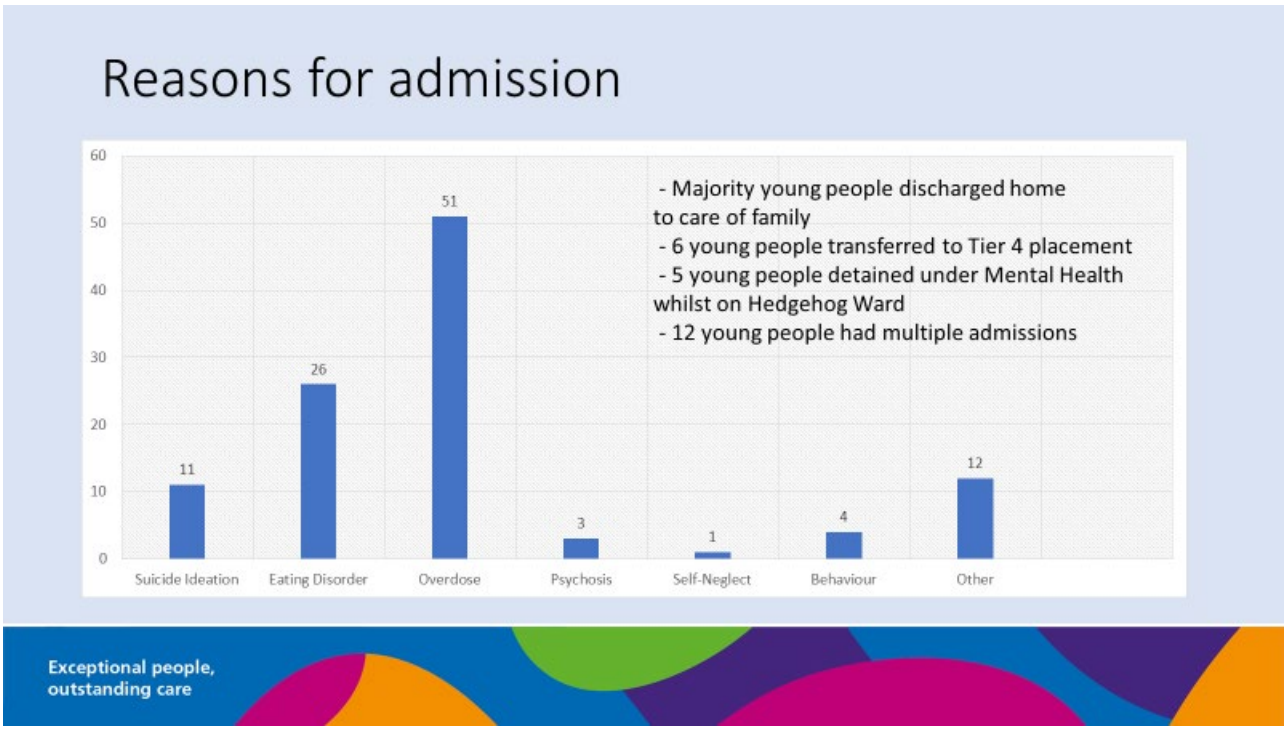
The following infographic highlights the presentation data to ED of children with Mental Health needs in the reporting period:



Admissions to Hedgehog Ward:



In the current reporting period 109 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. It is noted that 5 young people were detained under the Mental Health Act whilst on Hedgehog Ward



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 DOL 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.

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 started in autumn 2021. 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.

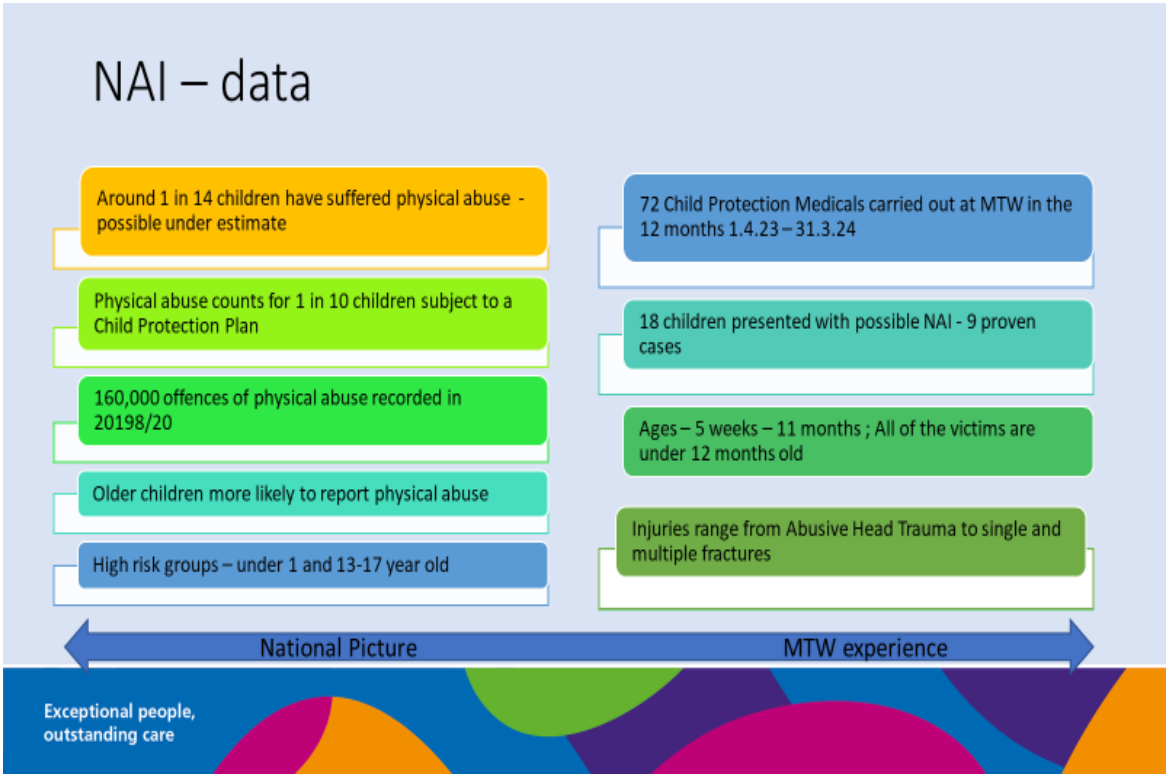
16.0 NON-ACCIDENTAL INJURIES (NAI)

In May 2023 the Trust started to see an increase in children presenting with a suspected NAI. Over the 12-month period ending in March 2024, 18 children were seen and assessed through our NAI pathway (see below); 9 children were deemed to have proven non-accidental injuries.

Once a NAI is suspected this will trigger a process which involves admission to Hedgehog Ward (at Tunbridge Wells Hospital), referral to the Local Authority and police involvement. The child undergoes a series of investigations which include a Skeletal Survey, CT scan (dependant on age), ophthalmic review and a full set of bloods are taken. Advice is sought from external Radiologists to confirm any injury reported by MTW Radiologists.

The Named Nurse Safeguarding Children (or representative) will liaise with our external statutory partners (Police and Local Authority) to agree a safety plan for the child/ren. For those children where an injury is proven and unexplained the usual course is for a child to be placed in Local Authority foster care.

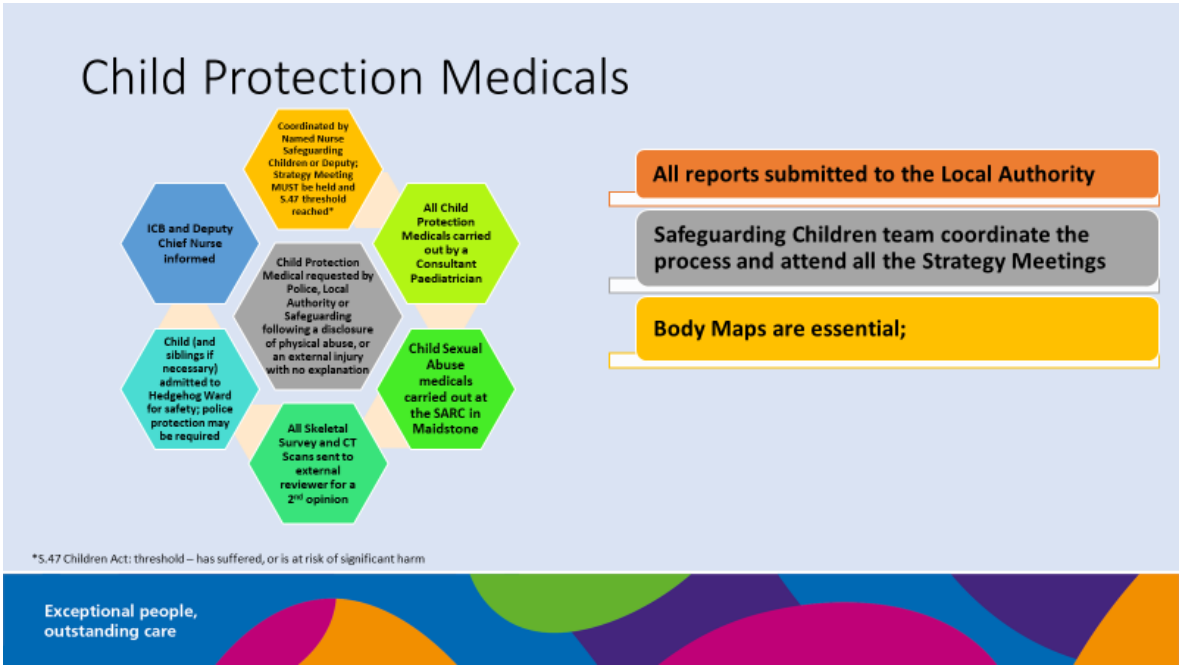
As part of a review looking at out NAI pathway the Named Nurse Safeguarding Children and the Lead Paediatrician for Safeguarding Children have strengthened how we care for these children and updated the Skeletal Survey Guidelines. A revised Child Protection Medical pathway was agreed by the Paediatrician's.



The following graphics highlight our processes:

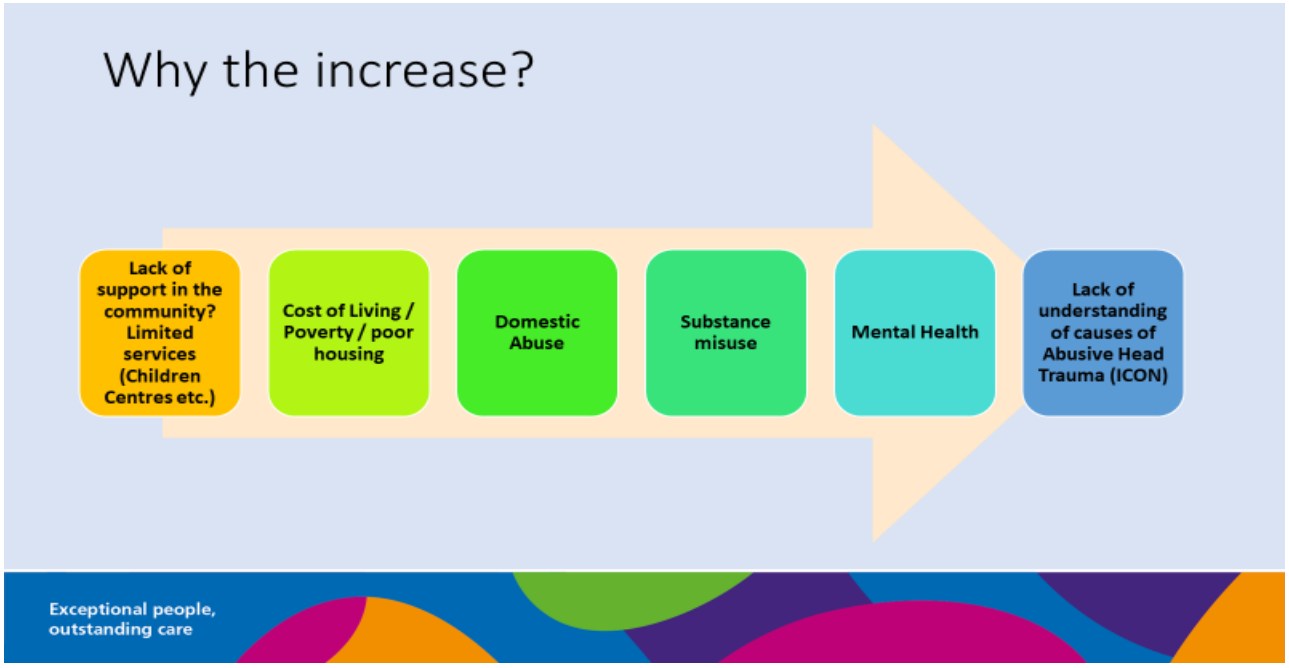
16.1 Child Protection Medical

As part of the review of the NAI pathway the process for completing a Child Protection Medical was reviewed and agreed. It is as follows:



Analysis:

An analysis of the cases reviewed did not highlight any one issue that explained the increase. Of note the Trust has seen a further 6 children since 1.4.24 for assessment. The following is a brief analysis of the cases:



The ICB has commissioned a deep dive into the increasing incidence of NAI's across the Kent and Medway region. The Named Nurse Safeguarding Children will update when more information is available.

17.0 WORKING TOGETHER ARRANGEMENTS

In December 2023 the government published the updated Working Together Arrangements. They can be found via the following link:
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 .
Staff at MTW are working together to ensure that MTW is aligned with the new working together arrangements and these will be monitored at the joint safeguarding committee.

18.0 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[3]

[3] https://www.gov.uk/government/publications/the-prevent-duty-safeguarding-learners-vulnerable-to-radicalisation/the-prevent-duty-an-introduction-for-those-with-safeguarding-responsibilities

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.

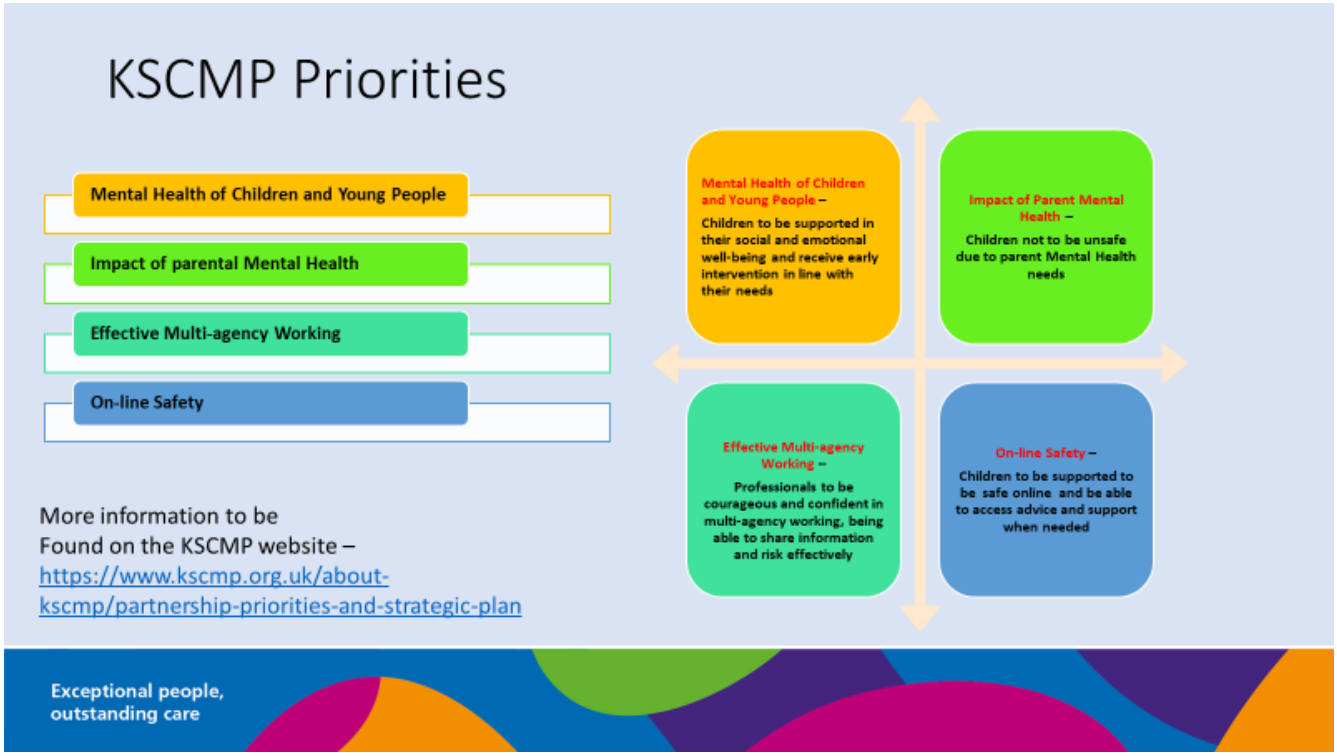
The Trust made no referrals to the Prevent process in the reporting year.

19.0 KENT SAFEGUARDING CHILDREN MULTI-AGENCY PARTNERSHIP (KSCMP)

The KSCMP brings together the Statutory Partners (Local Authority, ICB Police) in a local area to ensure that there are arrangements in place to promote the welfare of all children in a local area. Each partner has an equal and joint duty to act as indicated.

The Partnership sets out its priorities on a bi-annual basis. Each priority is reviewed and progress checked against a locally agreed dashboard. As would be expected MTW will feed into these priorities and monitor our progress against the agreed standards.

The Priorities for 2024/26:



More information can be found via the following link:
https://www.kscmp.org.uk/about-kscmp/partnership-priorities-and-strategic-plan

20.0 PATIENT SAFETY INCIDENT REVIEW FRAMEWORK (PSIRF)

There has not been any patient safety incidence (PSI) focusing on Safeguarding have been raised in the current reporting period.

21.0 RIGHT CARE RIGHT PERSON (RCRP)

The Right Care Right Person framework changed the way that emergency services (in particular the Police) respond to people experiencing a mental health crisis. When people are in a mental health crisis, they need timely access to support that is compassionate and meets their needs. While there will always be cases where the police need to be involved in responding to someone in mental health crisis (for example, where there is a real and immediate risk to life or serious harm, or where a crime or potential crime is involved), police are increasingly involved when they are not the most appropriate agency to respond, and they are not able to handover care to a more appropriate professional in a timely manner. This impacts on the ability of the police to carry out their other duties effectively, and importantly, can result in people with mental health needs experiencing greater distress and having poorer experiences of the mental health care pathway.

At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. RCRP is aimed at ensuring that the right agency deals with health-related calls instead of the police.

The threshold for a police response to a mental health-related incident is:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm

The challenges for MTW were to ensure that there are:

- procedures in place for when a patient goes ‘missing’ (or absconds) from a ward/ED/department in the Trust
- procedures in place for anyone under 18 who goes missing
- Safeguarding processes in place which are not overridden by the RCRP philosophy

Under the leadership of ED and the Director of Emergency Planning, with oversight by the Named Nurse Safeguarding Children and Paediatric Head of Service, a working document was agreed as to how to protect Children and Young People where they may go missing from the Trust.

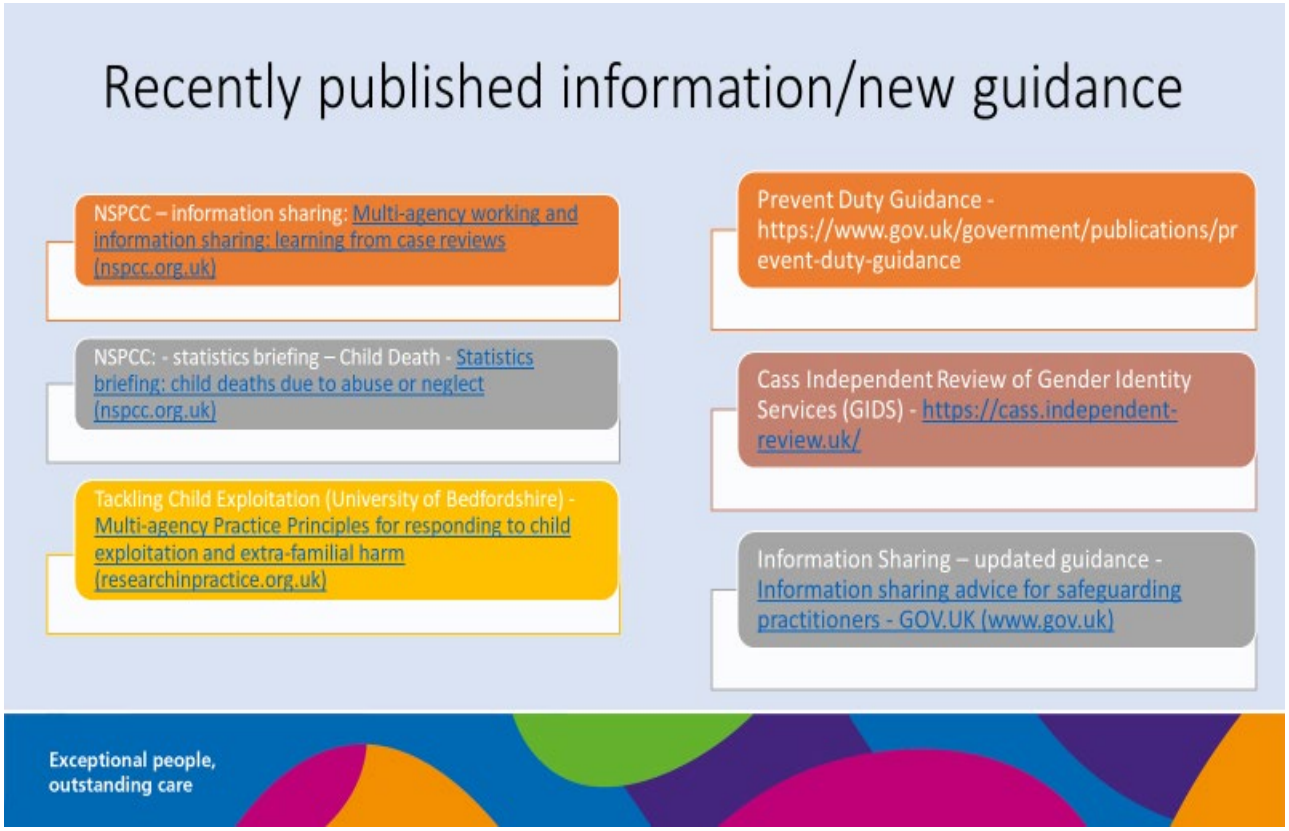
The following has been implemented:

- Better use of Mental Health support workers
- All Children and Young People will be reported missing to the Police in accordance with national guidance
- All pregnant people will be flagged as high risk if they abscond/go missing
- Staff can report 'low risk missing persons and request a welfare check via the Kent Police website

Monthly meeting to review the policy are on-going.

22.0 ANY OTHER INFORMATION

22.1 Recently published guidance:



23.0 PRIORITIES FOR 2024 - 2025

We recognise that there will be new and differing priorities for the coming 12 months and we see Safeguarding as being central to business continuity for the Trust.

Our priorities will be focused on the following –

- Education and Training – increasing compliance on mandatory training by offering creativity in delivering training; increased use of on-line platforms
- Strengthening the joint working between the Named Nurses and looking at a co-located All Ages Safeguarding team
- Complex Needs –building on the process for escalation of children who may have complex needs that need robust discharge planning
- 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

Section 2

Safeguarding Adults Report 2023-2024

1.0 INTRODUCTION

The Adult Safeguarding Service (ASG) is aligned with the Children's Safeguarding Service and together the services promote the 'Think Family' approach. The Trust is committed to working in partnership with key stakeholders to ensure that adults at risk who come into contact with the Trust's 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 are subject to any form of abuse.

The Trust has proactively updated its safeguarding adults' policies and procedures to align with the SAAF, ensuring that the role of a Person in Position of Trust is clearly defined as required.

These Key steps are already implemented within the Trust:

1. Policy and Procedure Updates:
    - The Trust has updated its safeguarding policies and procedures to meet legal requirements and best practice standards.
2. Integration into Commissioning Processes:
    - Safeguarding has been integrated into the Trust's commissioning processes, ensuring that safeguarding considerations are embedded in all service contracts and agreements.
3. Comprehensive Safeguarding Policies:
    - MTW have implemented comprehensive safeguarding policies that cover all aspects of adult safeguarding, ensuring a consistent and thorough approach across the Trust.
4. Staff Training:
    - MTW provides comprehensive safeguarding training for all staff, ensuring that everyone understands their roles and responsibilities in protecting adults at risk.
5. Leadership and Accountability:
    - Clear leadership and accountability for safeguarding activities have been established, with responsible safeguarding leads at senior levels within the organization.

6. Safeguarding Reporting Pathways:
    - Clear and accessible pathways for reporting safeguarding concerns have been established, ensuring that concerns are promptly and effectively addressed.
7. Multi-Agency Collaboration:
    - We actively engage in multi-agency collaboration, working closely with local authorities, the police, and other partners to provide a coordinated response to safeguarding issues.
8. Quality and Assurance Improvements:
    - Quality assurance improvements are evidenced through our safeguarding learning and improvement panels. We continually review and improve our safeguarding practices based on feedback and lessons learned.
9. CQC Compliance and Improvement Plans:
    - The Trust is committed to maintaining and improving compliance with Care Quality Commission (CQC) standards with regular audits and the implementation of safeguarding learning and improvement panel, together with the Joint Safeguarding Committee advises Trust Board on how its statutory obligations are being met.

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 Administrator.

2.0 Safeguarding Adults Activity.

The total safeguarding adults' referrals for 2023-2024 reached 436, with 98 of these referrals related to hospital practice. This was an increase of 61% compared to the previous year. Specifically, safeguarding allegations concerning hospital practice increased by 19% during this period

The majority of the total safeguarding adults' referrals were related to self-neglect, while hospital allegations primarily involved neglect by staff. Many of these referrals were managed through the learning and improvement panel, and only 7 of the hospital-related allegations were upheld.

The information below gives data about safeguarding adult referrals raised about alleged incidents relating to practice of abuse or neglect that might have occurred in the Trust. The split across the two hospitals reflects the fact that TWH has the higher bed base and single rooms might have attributed to the vulnerability of the patients.

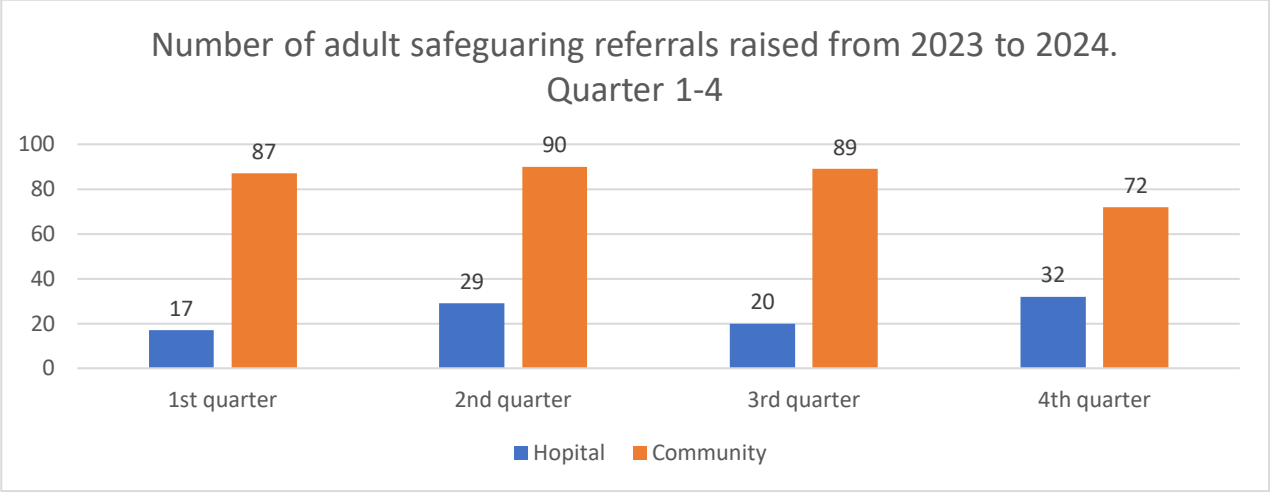
The data also highlights where the allegations of abuse have occurred but the committee should note that out of the 98 Trust alleged incidents received only 7 incidents involving

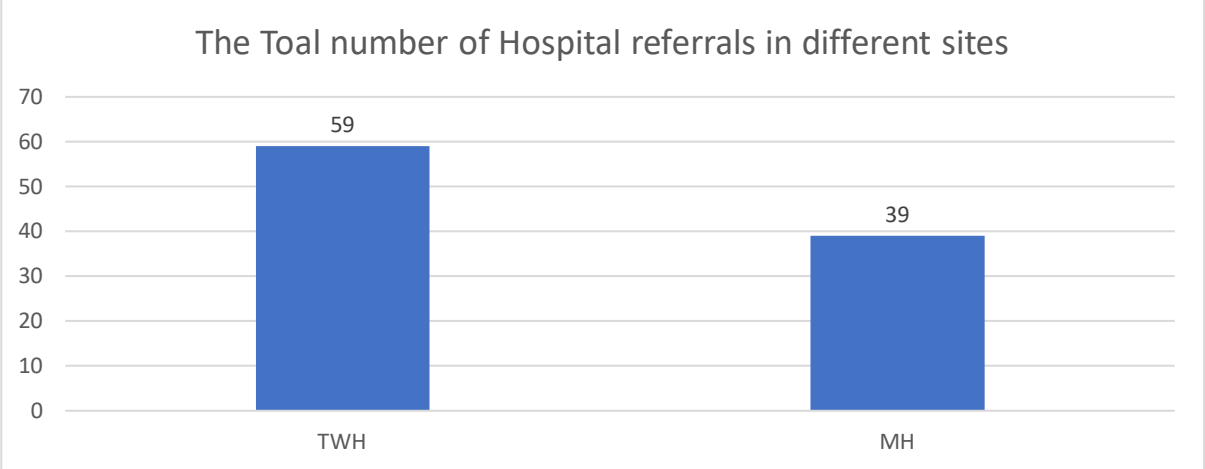
Trust staff were upheld. Action and learning were put in place to mitigate such risks from happening in the future and to share learning with staff during the safeguarding training sessions.

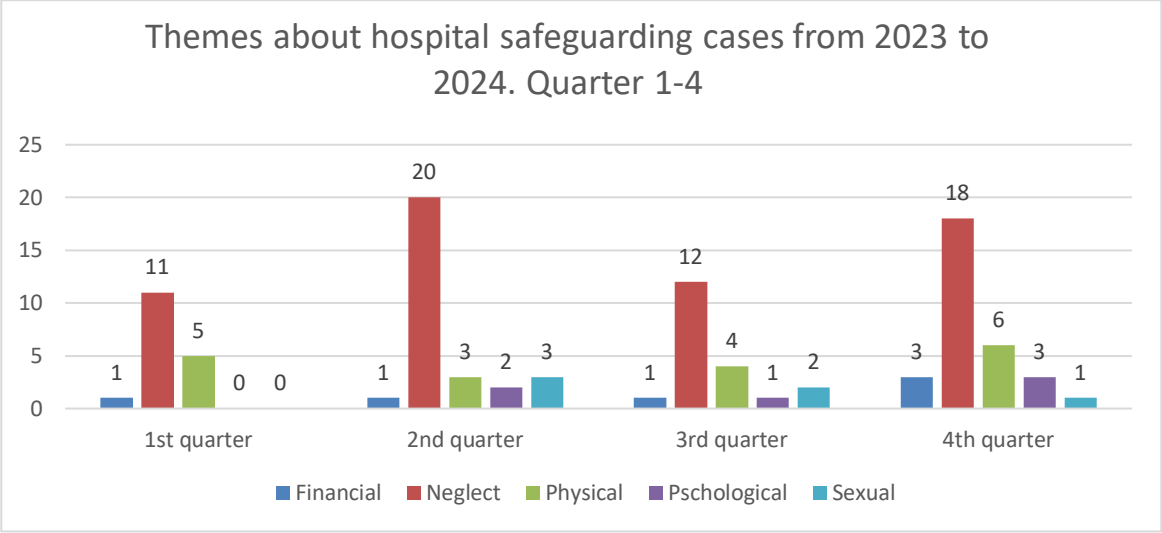
The board should note that the total outcomes for hospital alleged incidents were as follows: 23% of the alleged incidents were not upheld, and 67% did not progress to a Care Act s42 enquiries. Since the compilation of this data, the local authority has added a new section to how they report outcome which is the no further action NFA.

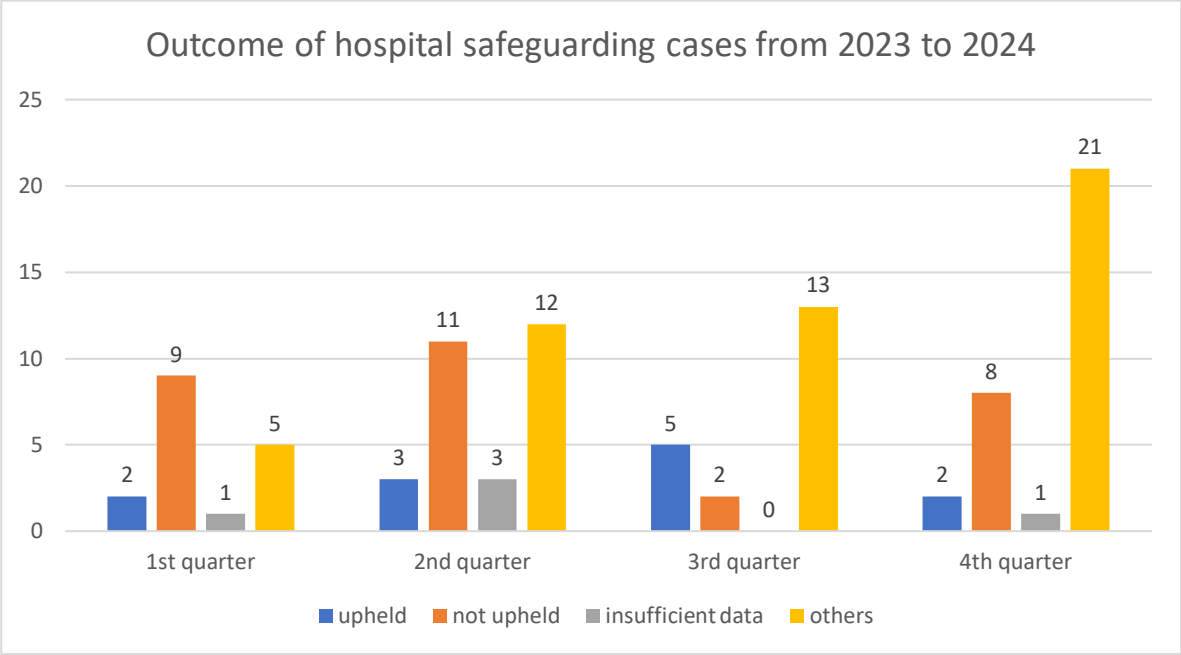
It is important to recognise the 62% of community safeguarding referrals by Trust staff in the previous year evidence good practice whereby Trust staff recognise that abuse can happen anywhere and must be reported accordingly.

2.1 Overall Activity



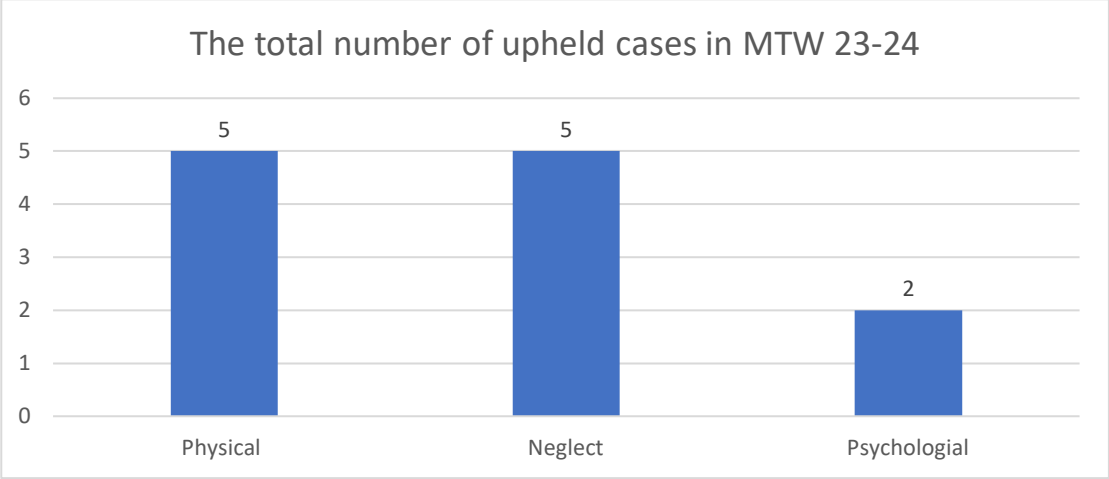




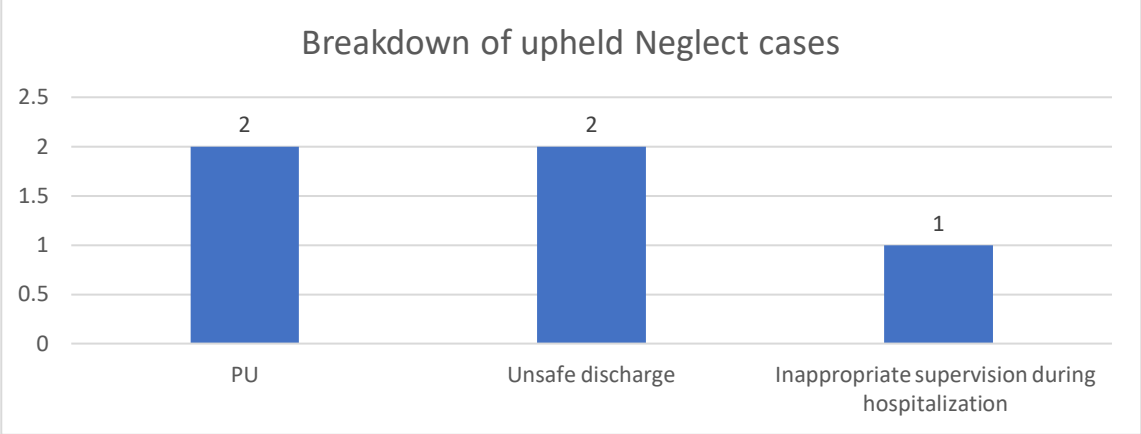


At the time of writing the report, the 'others' column above represent the referrals that the local authorities had not closed under their remit of Section 42 enquiries. However, as at the quarter (Q)1 of 2024/2025, all these referrals have been closed.

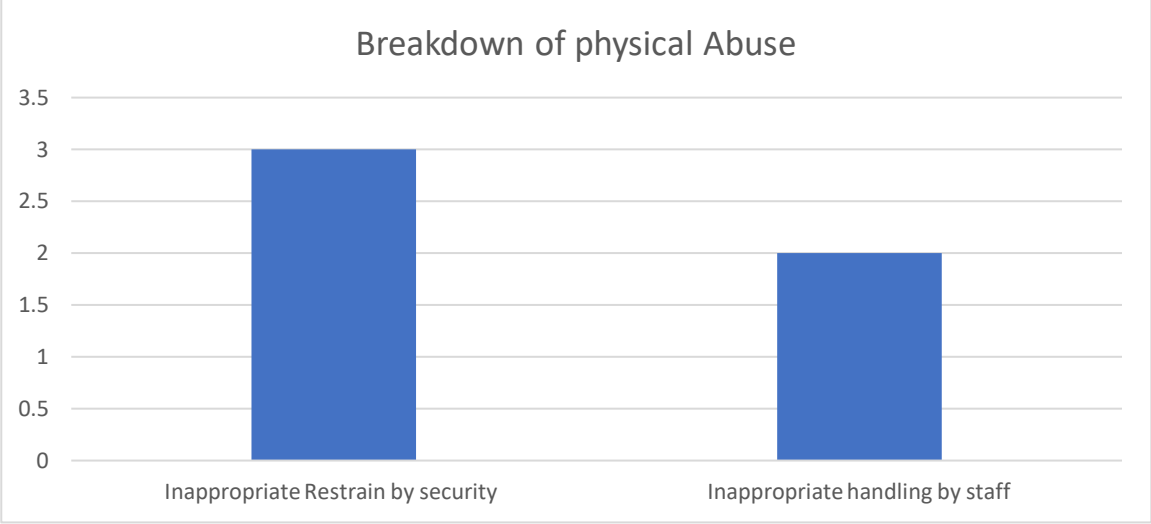
Breakdown of Upheld Cases	**No**	**Responsible**
Neglect-Pressure Ulcer	2	Trust
Physical – Inappropriate Restraint	3	External partners
Physical – Rough Handling	2	Trust
Psychological	2	Trust
Unsafe Discharge	2	Trust



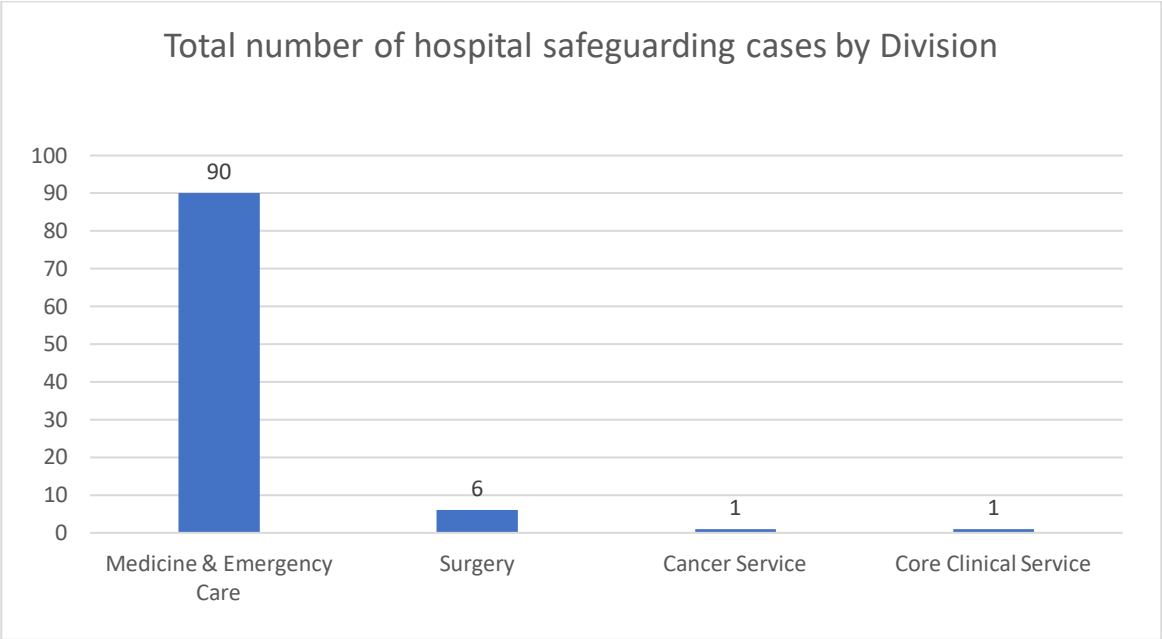
Neglect Cases Broken Down into Categories



*PU- Pressure Ulcer

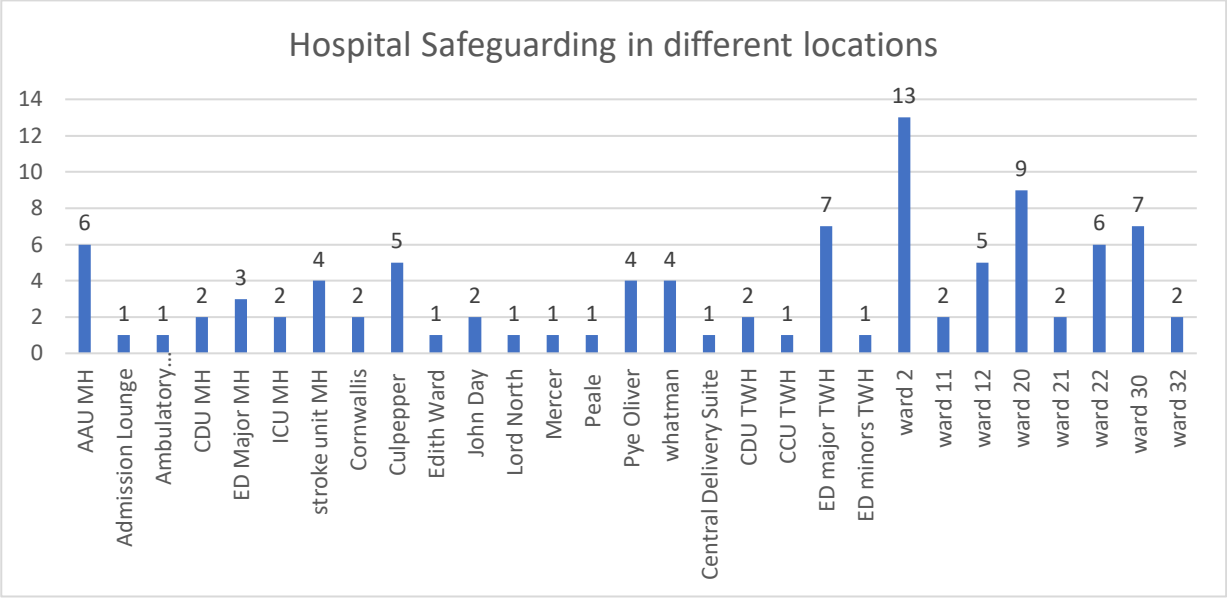


2.2 Activity by Division



There are no hospital safeguarding concerns raised in sexual health directorate. However, further work is required between the safeguarding team and the directorate to ensure that cases highlighted to the community teams are also flagged to the hospital safeguarding team.

Activity by Area



2.3 Incident Breakdown and Themes

Of the seven upheld incidents concerning hospital practice, the breakdown reveals the nature of these occurrences. The predominant themes of alleged abuse included physical abuse, either through restraint or rough handling by staff, and neglect. Notably, the physical restraints were documented by security staff, insourced by the security management team. Further work has taken place to ensure that security staff that attend MTW are now trained to use appropriate levels of restraint and have the required safeguarding training before they provide their service to MTW.

2.4 Addressing Neglect and Pressure Ulcers

The safeguarding team works closely with the Tissue Viability team when allegations of neglect related to pressure ulcers are raised. The 'Safeguarding Adults Protocol: Pressure Ulcer and the Interface with a Safeguarding Enquiry Decision Tool,' initially adopted by the Kent and Medway Safeguarding Adults Board (KMSAB), was temporarily withdrawn by the Department of Health and Social Care in 2023. Recognising its value, the Trust continued using the protocol pending a policy review. In 2024, the Department of Health reintroduced the protocol, reinforcing its importance in safeguarding practices.

To enhance hospital discharge procedures, staff are encouraged to use the Transfer of Care form and Body Maps to document pressure ulcers, bruising, and other marks on a patient's skin.

2.5 Person in Position of Trust (PiPoT) Protocols and Psychological Abuse

Regarding upheld cases of psychological abuse, The Trust has made significant strides in strengthening system assurance for adult safeguarding during 2023-2024. The Trust has focused on enhancing Professional Boundaries and Person in Position of Trust (PiPoT) protocols. Upon receiving an allegation concerning a person in a position of trust, the reporting manager immediately escalates the concern to the Named Nurse for Safeguarding Adults. The Named Nurse then coordinates a PiPoT panel meeting to ensure a prompt, structured response. The PiPoT panel uses a robust risk assessment framework to make immediate safeguarding decisions, swiftly activating protective measures to prevent potential abuse or neglect.

Additionally, it is also recognised that such allegations against staff members will have a negative impact on their well-being. Staff support is provided through the well-being teams, pastoral support and sign posting to other staff networks like the cultural and minority ethnic networks for further advice and support.

2.6 Coordination with Local Authorities

Over the last year, there has been several changes within the local authority teams that are responsible for the management of hospital related safeguarding concerns as per the Care Act 2014. This has necessitated the re-establishing of working relations between the Trust and the local authority, a challenge experienced by other partner agencies and escalated to the KMSAB. The non-attendance of the local authority to the Trust safeguarding learning and improvement panels (sec 42) remains on the Trust risk register.

2.7 Governance

Significant progress has been made in advancing the safeguarding adults agenda, aligning the team with clinical governance groups to improve the assurance framework and evidence compliance with statutory duties. The identified governance structure includes a safeguarding adults dashboard of performance metrics, providing quarterly assurance to the Trust Safeguarding Committee. Consistency in adult safeguarding approaches across both sites has been achieved, with shared learning disseminated.

The attendance of the Integrated Care Board (ICB) Designated Nurse for Safeguarding Adults at the Trust's Safeguarding Learning and Improvement Panel and the Safeguarding Committee has been valuable, offering external scrutiny and advice on case outcomes from investigation reports.

2.8 Triage and Resolution of Cases

Cases deemed to require no further action under safeguarding are triaged by the Safeguarding Adults Team. Concerns are either quickly addressed or dismissed at the outset, with no further reports requested from clinical teams.

These initiatives and collaborative efforts evidence the Trust's commitment to maintaining a proactive and responsive safeguarding culture, ensuring the safety and well-being of adults at risk.

3.0 Training and Compliance

Training is mandatory for all staff, tailored to their specific roles in accordance with the "Adult Safeguarding: Roles and Competencies for Health Care Staff" (Intercollegiate Document 2019, updated 2022). This document is currently under review, and stakeholders are awaiting the outcome.

This year, training delivery has primarily been face-to-face for Level 3 Safeguarding Adults and Level 3 MCA training. In collaboration with the Learning and Development team, Level 2 training for both safeguarding and MCA has also transitioned to face-to-face sessions.

these sessions are integrated into the Trust induction for new starters, while remaining available to other staff members.
The KMSAB multi-agency training is advertised to all staff for their attendance. Despite limited availability for the Trust staff, KMSAB has been flexible in accommodating organisational requests.

The E-Learning for Health (e-LfH) MCA/DOLS resources have been integrated into the Learning and Development platform and are widely promoted for staff access. These modules are categorised into basic, intermediate, and advanced levels, with clear guidance on appropriate access levels for staff.

MCA and DOLS training requirements have been mandated for all clinically registered, patient-facing staff to be completed every three years, moving away from the previous 'one-off' requirement. Since resetting compliance for MCA/DOLS training in March 2022, there has been a steady increase in compliance rates, reflecting improved competence and confidence among staff in applying MCA/DOLS in their practice.

All new staff are required to complete their Level 1 e-learning before commencing employment at the Trust.

Training compliance remains strong within the Trust. The latest report indicates that Trust staff overall are maintaining high levels of compliance with the mandated training requirements. This continued commitment to training ensures that all staff are well-equipped to uphold the highest standards of safeguarding and patient care. Training days and bespoke sessions for clinical areas are also offered to ensure that apart from a positive trajectory of compliance, staff are able to engage with new information provided by the trainers.

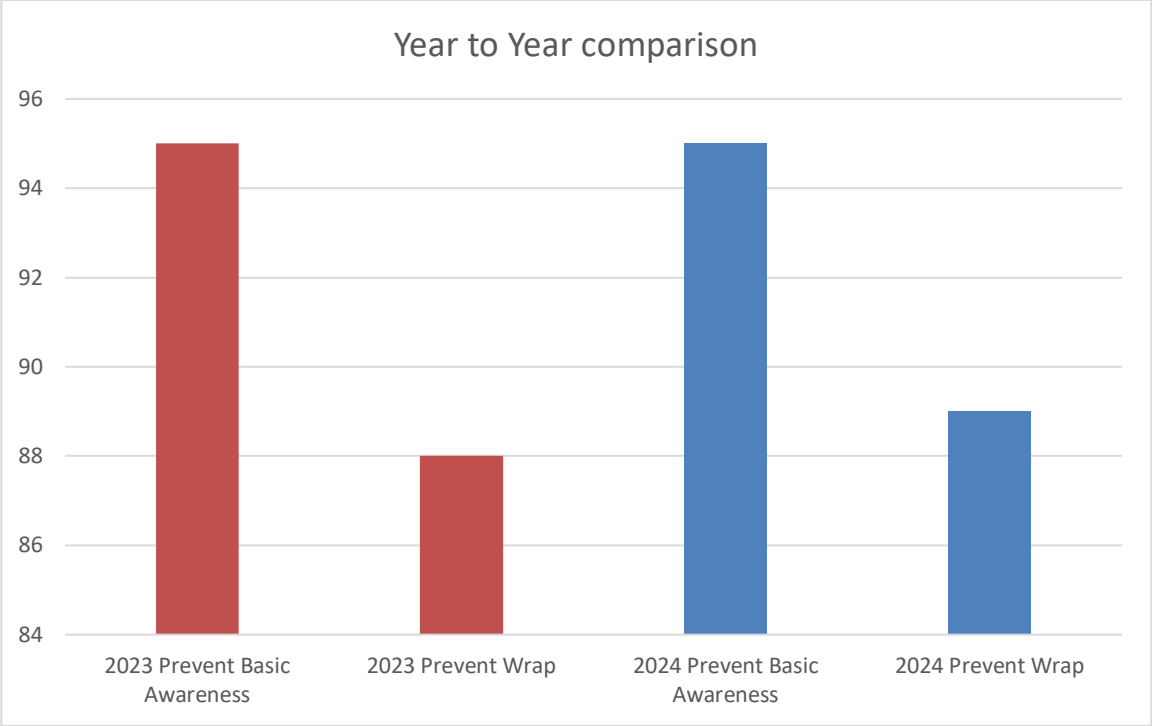
The training complinace at the end of the financial year 2024 was as follows (Trust target is et at 85%):

Statuatory and Mandatory Training Board Summary Report Division / Directorate	The Oliver McGowan Mandatory Training on Learning Disability and Autism Tier 1 (3 year update)	Mental Capacity Act Level 2 - Intermediate (3 yearly update)	Mental Capacity Act Level 3 (3 yearly update)	Prevent Basic Awareness (3 Year Update)	Prevent/Wrap (Three Year Update)	Safeguarding Adults at Risk Level 1 (3 Year Update)	Safeguarding Adults at Risk Level 2 (3 Year Update)	Safeguarding Adults at Risk Level 3 (3 Year Update)
Trust Totals - March 2024	81.1%	81.3%	79.8%	95.0%	88.8%	94.0%	92.6%	80.6%

3.1 **PREVENT**

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. MTW had no Prevent referrals made in 2023/2024.

The Prevent basic and Prevent Wrap has a good compliance in the Trust, the chart below shows comparison of compliance for 2023-2024 against the Trust target of 85%.



4.0 Policies and Procedures

The Safeguarding Adults policies and procedures was revised to include the Person in Position of Trust. MTW has significantly strengthened system assurance for adult safeguarding by enhancing Professional Boundaries, PiPoT protocols and following the recommendations from the Fuller Inquiry, ensuring immediate and effective safeguarding measures and safeguards are in place. These efforts have led to measurable improvements in the efficiency and effectiveness of MTW's safeguarding interventions, ensuring that individuals at risk receive timely and coordinated support and protection. The Trust's ongoing commitment to these priorities continues to drive positive outcomes and enhance the overall safeguarding framework.

The MCA policy has been reviewed to correct the reversal of the two-stage test, now referencing the updated Code of Practice. The functional stage is assessed first, followed by the diagnostic stage to determine the 'causative nexus' of the impairment.

There was no full MCA audit for 2023-2024 due to the ongoing project with the Sunrise team (Patient Electronic Records) to build a new MCA assessment tool within the Sunrise electronic patient records (EPR). The new MCA assessment tool has now been incorporated into Sunrise EPR and a comprehensive MCA audit, not solely focusing on DOLS, is planned for October 2024.

5.0_Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) activities

Deprivation of Liberty Safeguards (DOLS) Authorisations

The Trust authorised a total of 664 DOLS, representing a 20% increase from the previous year. This rise can be attributed to enhanced staff awareness and support from the specialist MCA lead, who has been instrumental in educating staff on the legal framework of DOLS and the Cheshire West case law relating to the acid test criteria for DOLS.

Mental Capacity Act Application

The accurate application of the MCA, particularly in the assessment of capacity and use of best interest meetings, requires improvement across the Trust. Despite accessible guidance through safeguarding training, the MCA hub on the intranet, and specific ad hoc training sessions, documentation and feedback indicate that staff continue to need support in appropriately applying all principles of the Act. The safeguarding team provides additional training for ward-based staff and supports complex cases involving capacity assessments and best interest decisions. This support also extends to issues involving lasting powers of attorney, advanced decisions, and Independent Mental Capacity Advocate (IMCA) involvement.

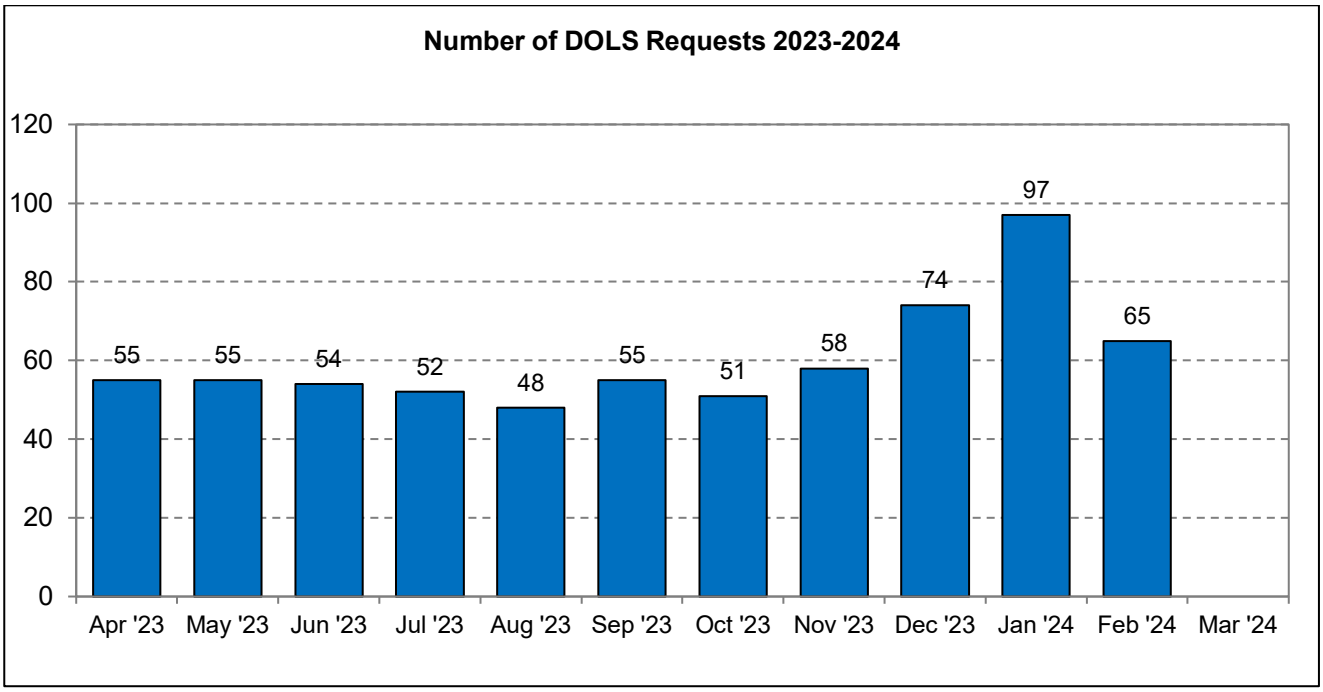
Liberty Protection Safeguards (LPS) Implementation

The Trust's MCA project group for Liberty Protection Safeguarding is on hold due to delays in the government's implementation schedule. According to ADASS, implementation is expected post-General Election. Despite these delays, it is crucial to ensure all adults at risk are adequately safeguarded.

MCA and DOLS Audit

An MCA audit focused on DOLS authorisation highlighted the progress made by inpatient wards in complying with MCA and DOLS applications. The aim is for 100% of Urgent DOLS authorisations to have an accompanying MCA, in line with the Mental Capacity Act (2005). Audit outcomes indicate ongoing need for support, which the safeguarding adult's team addresses through ward visits to help staff identify patients requiring DOLS. Additional training sessions on DOLS have been implemented across clinical groups, leading to a quarterly increase in DOLS referrals.

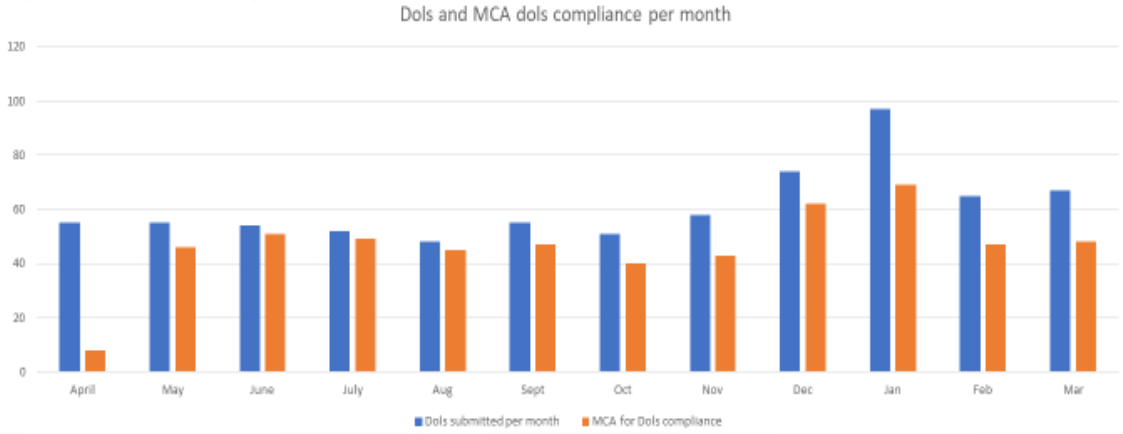
The charts below evidence our ongoing commitment to improving MCA practices and ensuring compliance with MCA and DOLS requirements, thereby safeguarding adults at risk within our care.



2023 – 2024 Deprivation of Liberty Safeguards (DoLS) & MCA Compliance

The MCNS's have been auditing all Urgent DoLS Authorisations to ensure an accompanying Mental Capacity Assessment is included.

The graph below shows the total number of DoLS applied for per month (blue) and the number that had an appropriate accompanying Mental Capacity assessment (orange):



2023 – 2024 DoLS & MCA Compliance Continued

The graph below shows the Mental Capacity assessment for DoLS compliance rate as a percentage:

6.0 External Partnership working

Effective partnership working, fostering trusting relationships, and maintaining high levels of communication are essential to safeguarding adults with care and support needs.

The Trust is a key partner of the Kent and Medway Safeguarding Adults Board. The Chief Nurse, who serves as the Executive Lead for Adult Safeguarding, regularly attends KMSAB board meetings or delegates this responsibility to the Deputy Chief Nurse.

The overarching purpose of these partnerships is to ensure that adults with care and support needs are safeguarded from abuse and neglect. As part of our adult safeguarding responsibilities, we engage in the activities of these partnerships through membership of the Boards and their sub-groups, and by participating in learning reviews.

All NHS agencies and organisations are required to participate in statutory reviews when requested. The input and involvement required are discussed and agreed upon in the terms of reference for the review. Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) are essential components of multi-agency partnerships' safeguarding strategies.

SARs review cases where an individual has died or come to serious harm due to abuse, and it is believed that improved multi-agency working could have prevented these outcomes. The action plans from SARs for 2023-2024 have been completed, peer-reviewed, and closed. The KMSAB SAR Working Group is compiling all SAR actions into a Thematic

Database to address repeat recommendations in SARs. MTW contributed to 15 SAR requests across 2023-2024, including some backlog from the previous year.

The Health Reference Group (HRG), a separate strategic group, facilitates debate, information sharing, and communication between health organisations and the board.

The KMSAB self-assessment framework (SAF) for 2023-2024 was peer-reviewed, with some completed actions reverting to amber, indicating the need for more evidence to confirm completion. Currently, 11 SAF actions are still remain open and will be reviewed at the next SAF panel in October 2024, evidence for completion have been compiled awaiting peer review. It is expected that the Trust will be compliant with the SAF.

The KMSAB annual report was completed and submitted within the stipulated timeframe. This year, the Board required minimal information detailing activity and impact from non-statutory agencies. During Safeguarding Awareness Week, November 2023, daily 7-minute briefings were published covering topics such as leadership in safeguarding, individual roles in safeguarding, caring for carers, trauma-informed practice, and self-neglect. The MTW communication team supported these publications to highlight that safeguarding is everyone's business.

In March 2023, the Trust underwent a Well-Led CQC inspection with a focus on governance processes related to safeguarding. The teams were able to respond to inspectors' queries with data-supported information. Inspectors particularly focused on learning from safeguarding adult hospital cases, and the Team demonstrated effective dissemination of learning across the Trust. Areas such as End of Life care were rated 'Good' in the safety domain, with inspectors noting that staff understood how to protect and safeguard individuals at risk of abuse and neglect.

7.0 Domestic Abuse

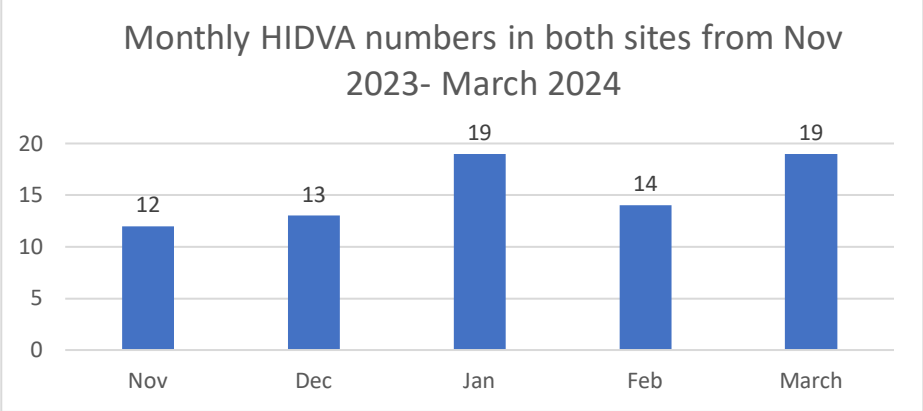
The management of the Hospital Independent Domestic Violence Advisor (HIDVA) service is overseen by the Named Nurse for Safeguarding Adults, with substantial support from the Named Nurse for Safeguarding Children. Since the introduction of the HIDVA service in June 2023, there has been a notable increase in demand from both staff and patients.

To better manage and highlight the importance of domestic abuse data, domestic abuse referral statistics were separated from the general safeguarding adult's data and a dedicated dashboard was established in November. Since its inception, 77 domestic abuse referrals have been made directly to the HIDVA. In the last quarter of 2023-2024, 7 cases were approved at the Multi-Agency Risk Assessment Conference (MARAC), and the HIDVA supported 7 survivors in fleeing from their perpetrators.

Domestic abuse remains a critical focus within safeguarding adults training. The team collaborates with LookAhead to co-deliver domestic abuse training as part of the Level 3 safeguarding adults training. This integrated approach ensures comprehensive education and awareness among staff.

The Trust has contributed to the chronology of Domestic Homicide Reviews (DHRs) number 52 and 59 and the main learning for all agencies involved was the early identification of domestic abuse. This has now been embedded into the domestic abuse training materials to maintain relevancy and up-to-date practices.

Future data collection for domestic abuse will be recorded in Inphase, with access restricted to authorised practitioners only. This ensures both the security and accuracy of sensitive information, supporting ongoing improvements in the Trust's response to domestic abuse cases.



8.0 Learning Disability

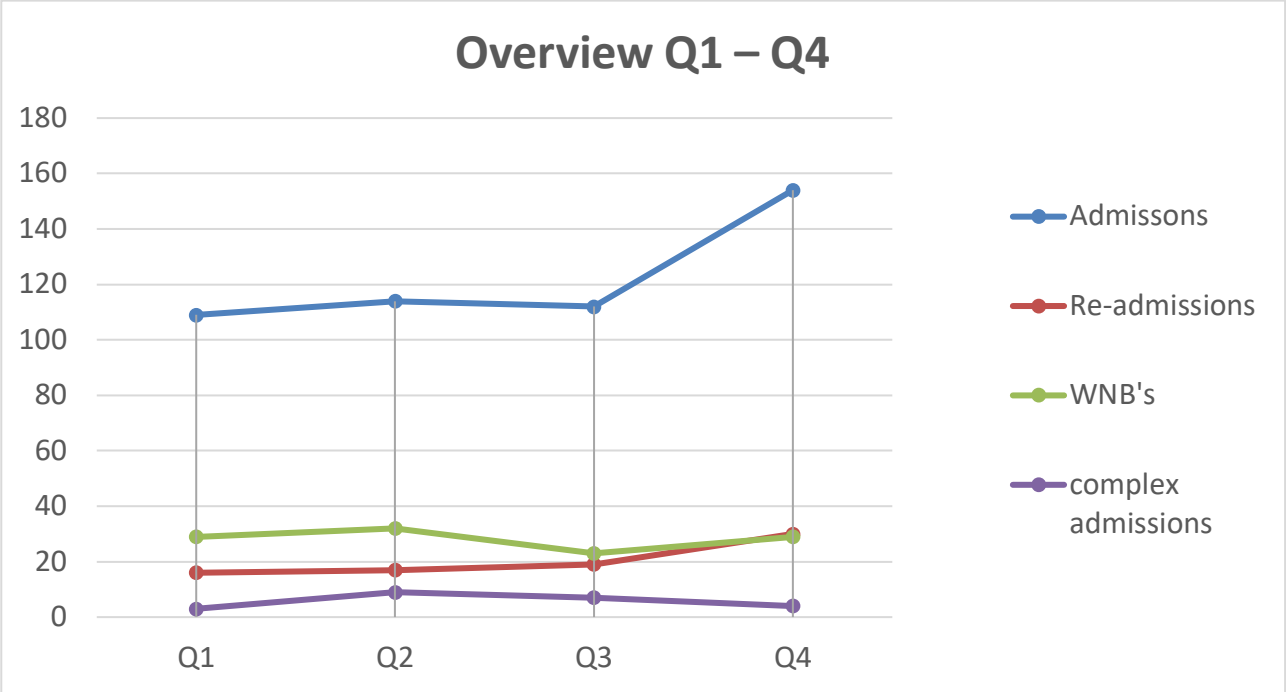
The 2023-2024 period was exceptionally busy for the learning disability (LD) service, with 126 LeDeR reports completed compared to 83 in the previous year. Completing these reports requires significant time and effort and must be submitted in a timely manner. With the capacity of a whole-time equivalent LDLN, 61% of the reports were successfully submitted on time. MTW referred six LD deaths in 2023-2024. Although none of these were the primary focus, actions from LeDeR related to one of the referrals were highlighted and discussed at the MTW Mortality Surveillance Group during the Structured Judgement Review (SJR). Issues identified included:

- No record of discussion with family or carers on DNARCPR.
- Initial rationale for DNACPR was LD. This was challenged by the LDLN and subsequently amended with an appropriate clinical rationale.

Complex admissions, readmissions, and instances of "Was Not Brought" (WNB) were major focuses for the LDLN. The chart below highlights the significance of these issues. Re-

admission rates were notably high in Q2, representing patients readmitted within 7 days of discharge from MTW. The LDLN continues to work with ED, inpatient, and outpatient departments to ensure consistent implementation of reasonable adjustments.

In Q2, there was an increase in WNB cases. The LDLN prioritized establishing reasons why some LD patients repeatedly missed appointments. Rectifying the WNB policy is crucial for managing and implementing reasonable adjustments. The Board should note that some issues with LD WNB patients were attributed to patient transport. The ICB is aware of this and is reviewing the contract. However, it is important to recognise the health inequalities LD patients face due to these issues.



The Oliver McGowan training is now mandatory for all staff and the compliance for the training was 81% at the end March 2024 against the Trust target of 85%.

Section 3
Safeguarding Midwifery Report 2023-2024

1.0 Introduction.

The Named Midwife works in partnership with the Trust's Chief Nurse, Deputy Chief Nurse, Named Nurses for Safeguarding Children & Adults (and their respective teams) to deliver the Safeguarding agenda. Promoting the early identification and management of safeguarding concerns through professional leadership, expert practice, research and education to ensure that the Trust effectively discharges its statutory Safeguarding duties.

The named midwife and her team work synchronously in regards to areas of joint responsibility such as Mandatory Staff Training, PREVENT, Domestic Abuse and FGM.

The Deputy Chief Nurse provides direct line Management to the Named Midwife for Safeguarding. Professional midwifery guidance is provided by the head of midwifery or director of Maternity. Additionally, the Named Midwife for Safeguarding provides support and expert opinion on the Maternity and Neonatal Assurance Board and Maternity Oversight Meetings. The Named Midwife provides additional support to the maternity Risk team as required for AAR, Rapid Review and relevant incident investigations.

Outside of the Joint Safeguarding Committee's Quarterly and Yearly Reporting structure, there is High Level oversight from the Maternity Service in respect of Safeguarding service development, service provision & any safeguarding risks which may affect Maternity Services. This is communicated via the Perinatal Quality Surveillance Model (PQSM) report, Midwifery team briefings at the Maternity and Neonatal Assurance Board, Clinical Governance meeting and during the weekly B8 Oversight Meeting chaired by the Head of Midwifery.

The Named Midwife and Deputy Named Midwife work closely with their direct counterparts in Kent, Medway and East Sussex to safeguard families across the County and neighbouring borders.

There is a well-established Regional Network of safeguarding specialist Midwives who meet regularly across the South East and further afield as part of the National Maternity Safeguarding Network. Both forums are chaired by NHS England providing peer support, National Updates and project work as well as an opportunity to benchmark Safeguarding Service Provision Nationally.

The Named Midwife works closely with the Head of Quality and Neonatal Services (Kent & Medway LMNS) and the service receives external oversight from the ICB Kent & Medway Designate Safeguarding Lead.

2.0 Maternity Safeguarding activity

Maternity activity dashboard indicating total numbers of new safeguarding referrals and new social services referrals against the total number of pregnancy bookings for 2023-2024.

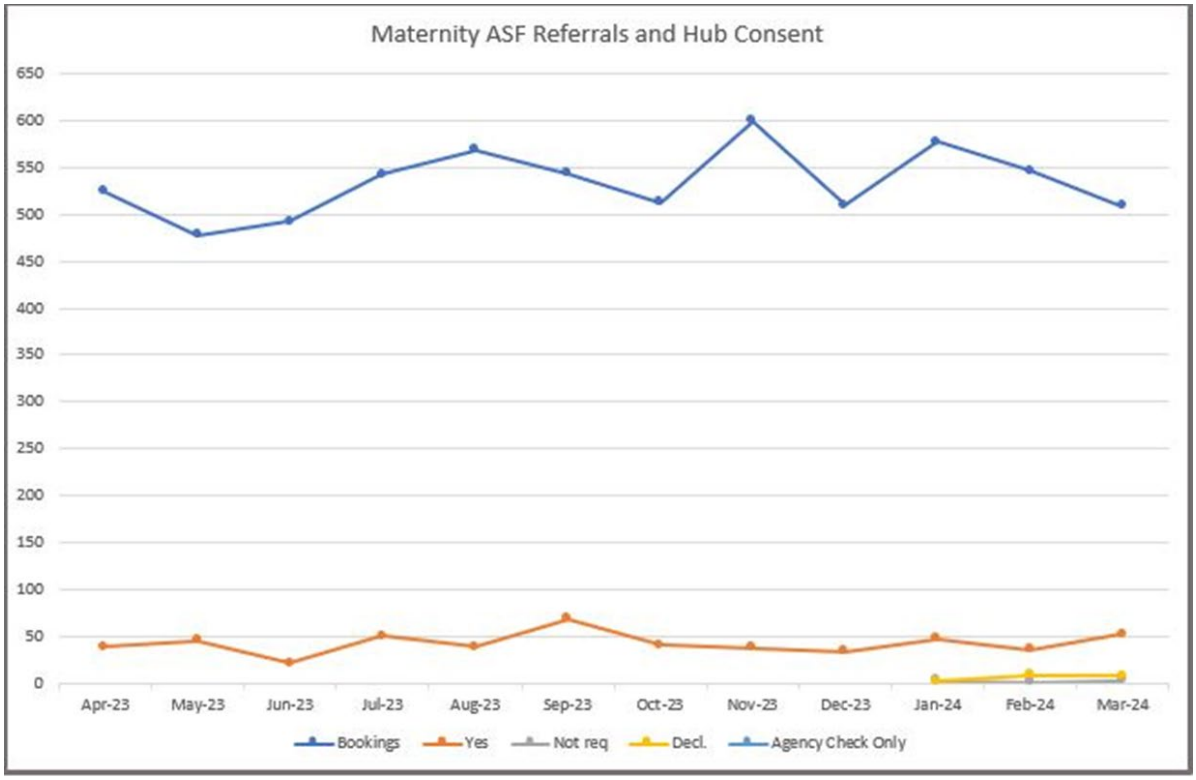
Type	Section	Metric Name	Measure	2020-2021	2021-2022	2022-23	2023-24
	Induction	Induction of labour	% of all women	24%	28%	29%	28%
	Pregnancy bookings	Number of bookings	no. of women booked this month	6958	6340	6467	6390
		Number of first bookings (not transfers)	no. of women booked this month	6448	6008	5961	5933
		Bookings before 10 weeks	% of women booked this month	78%	78%	77%	70%
		Bookings before 12+6 weeks	% of women booked this month	97%	96%	96%	97%
		Bookings before 12+6 weeks including transfers	% of women booked this month including transfers	92%	92%	90%	91%
	Safeguarding	New Safeguarding Referrals	No of women				527
		New Social Services Referrals	No of women				123

The safeguarding referrals for the reporting period were 527 as compared to 577 for the period 2022-2023 indicating a slight drop. However, there was a slight increase in the numbers of social services (SS) referral from 118 to 123.

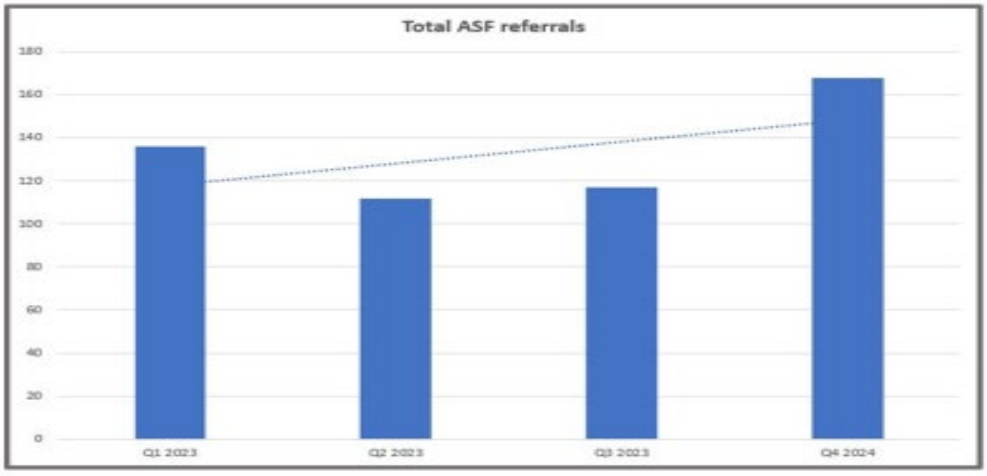
The table below indicates previous years activity against the total bookings:

Year	ASF's	SS. Ref
2022-2023	577 ↑	118 ↑
2021-2022	501	99
2020-2021	424	69

The safeguarding referrals/ notifications to the safeguarding team are sent using the additional support form (ASF) which is a joint Safeguarding and Perinatal Mental Health Midwifery referral (Although only ASF's with a Safeguarding element are included here.
These referrals provide access to Safeguarding Advice, Midwifery Hub and Enhanced Health Visiting if required. Birthing people are required to consent to the referral. However, in cases where consent for discussion at hub is declined, the cases are discussed directly with children social care. A referral can be made on the basis of 'making safeguarding personal' and proportionate to the need that is required.



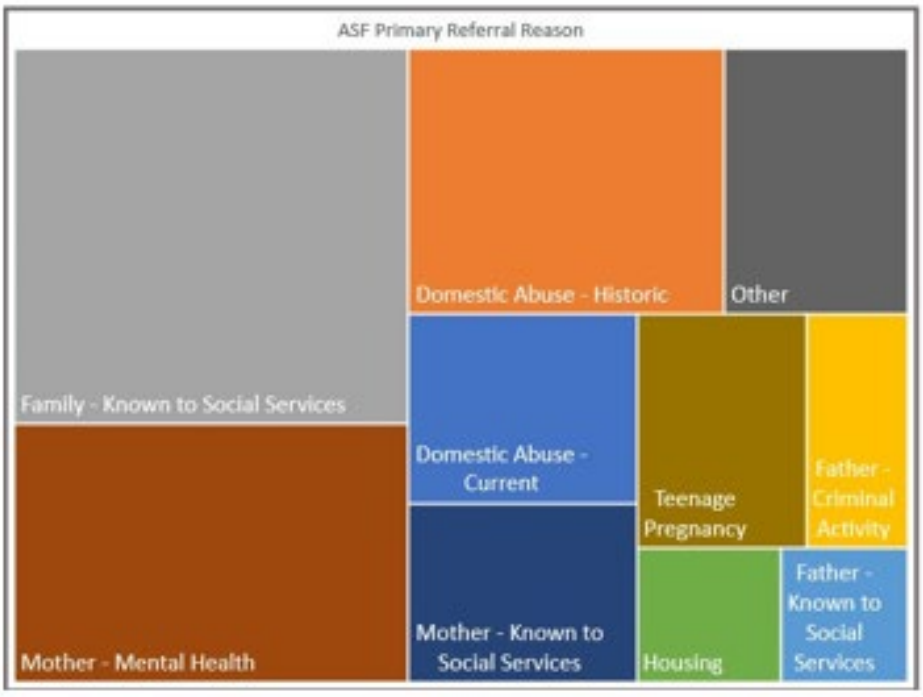
The increase in the referrals in Q4 2023/4 is likely related to the recent service and supervision improvements resulting in greater staff understanding, competence and confidence.



The three main primary reasons for the ASF referrals are:

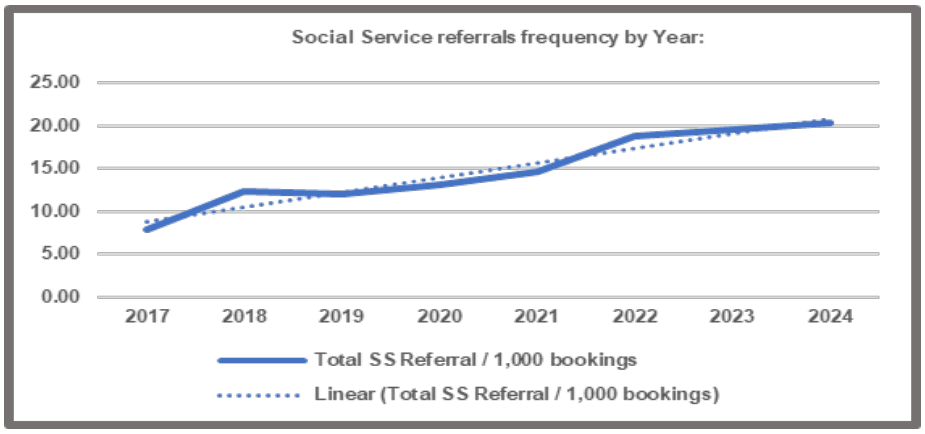
- Family known to social services
- Mother has existing mental health
- Domestic Abuse.

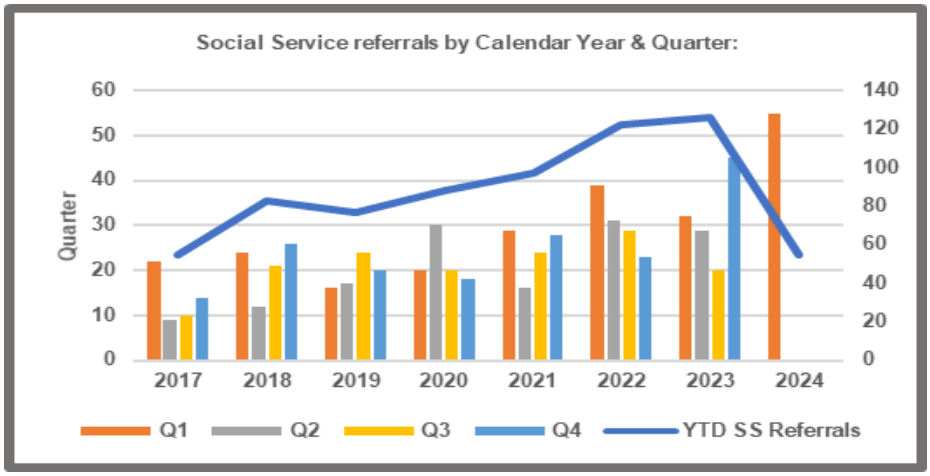
This reflects both local and the national picture in maternity safeguarding services.



3.0 Children's Social Care referrals (CSC).

Formally known as 'Social Services', CSC support children, young people and families who need additional help to protect children and young people from Harm.





Q4 Jan- Mar 2024 and Q1 Apr-Jun 2024 had the highest rate of CSC referrals to date, this is likely in part a reflection of the alignment of the safeguarding statistics to Financial Year rather than Calendar Year reporting as was done previously.

4.0 Maternity Hubs

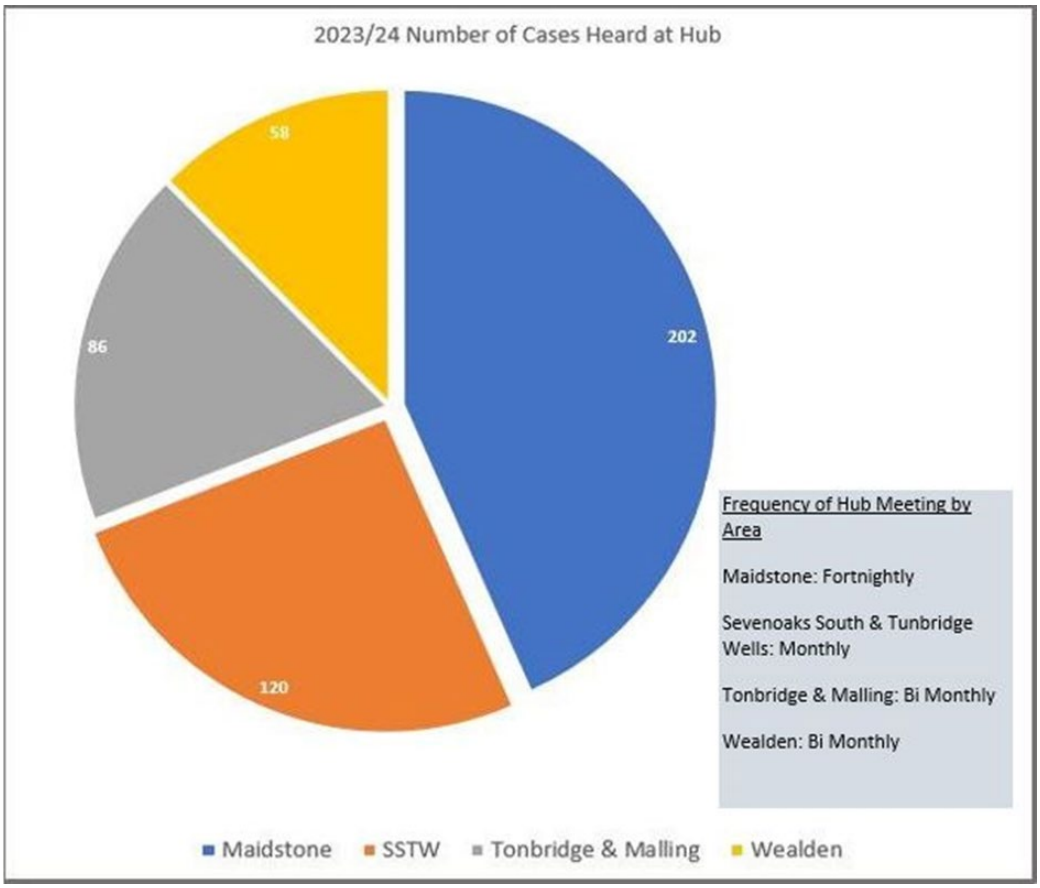
The Maternity Hub Process was first initiated around 2016 at MTW. Its original intent was a multidisciplinary safeguarding information sharing forum to discuss complex cases. Chaired by the named midwife and a senior social worker it brings together teams from Midwifery, Health Visiting, Family Partnership Practice (FPP), Perinatal Mental Health Services, Early Help, and Clarion Housing to discuss complex safeguarding Maternity cases and provide peer support and advice. As the numbers of complex Safeguarding Midwifery cases have evolved, the Maternity Hub has evolved with it seeing an ever-increasing volume of cases being discussed.

The Hub process, Intent and format is currently under review, with respective TORs and SOP to be updated in due course.

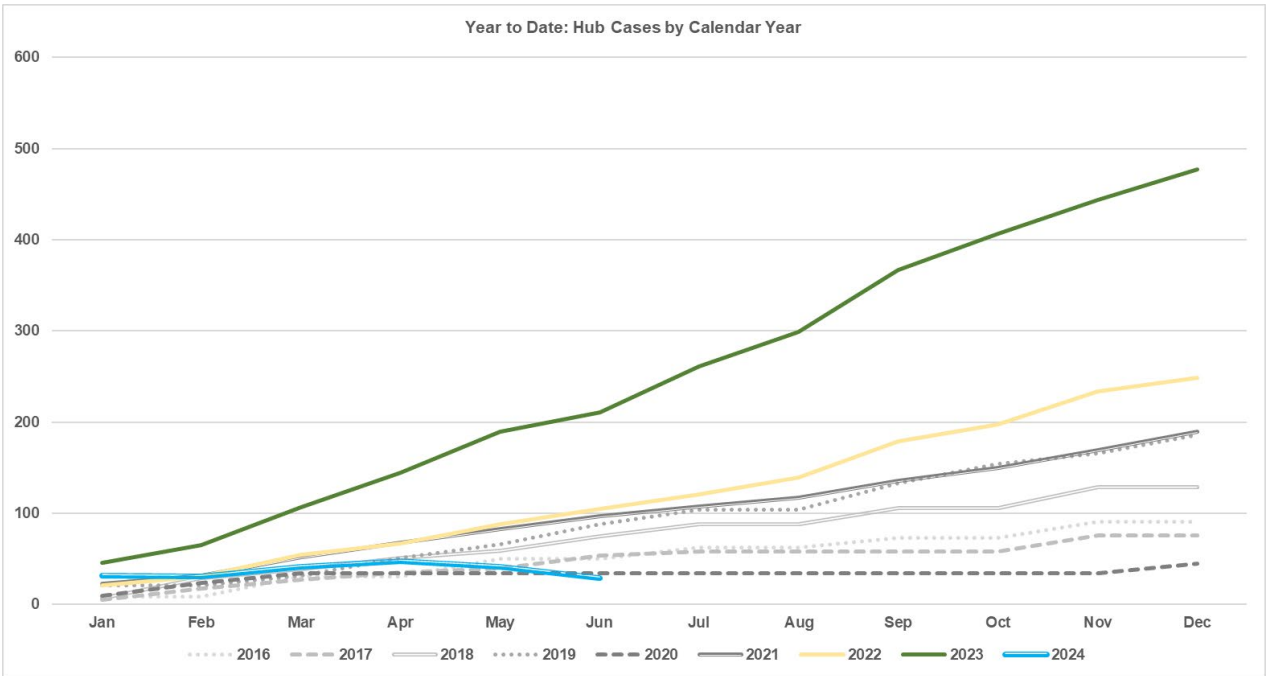
Due to staff absence within the midwifery safeguarding team, the children safeguarding practitioners have continued to support and chair the hub meetings as they also form the quoracy of the hub meetings.

There are 4 hubs around the MTW catchment area and these are:

- Maidstone
- Sevenoaks South, and Tunbridge Wells SSTW).
- Tonbridge and Malling
- Wealden (Crowborough)



Hub activity by cases per calendar year

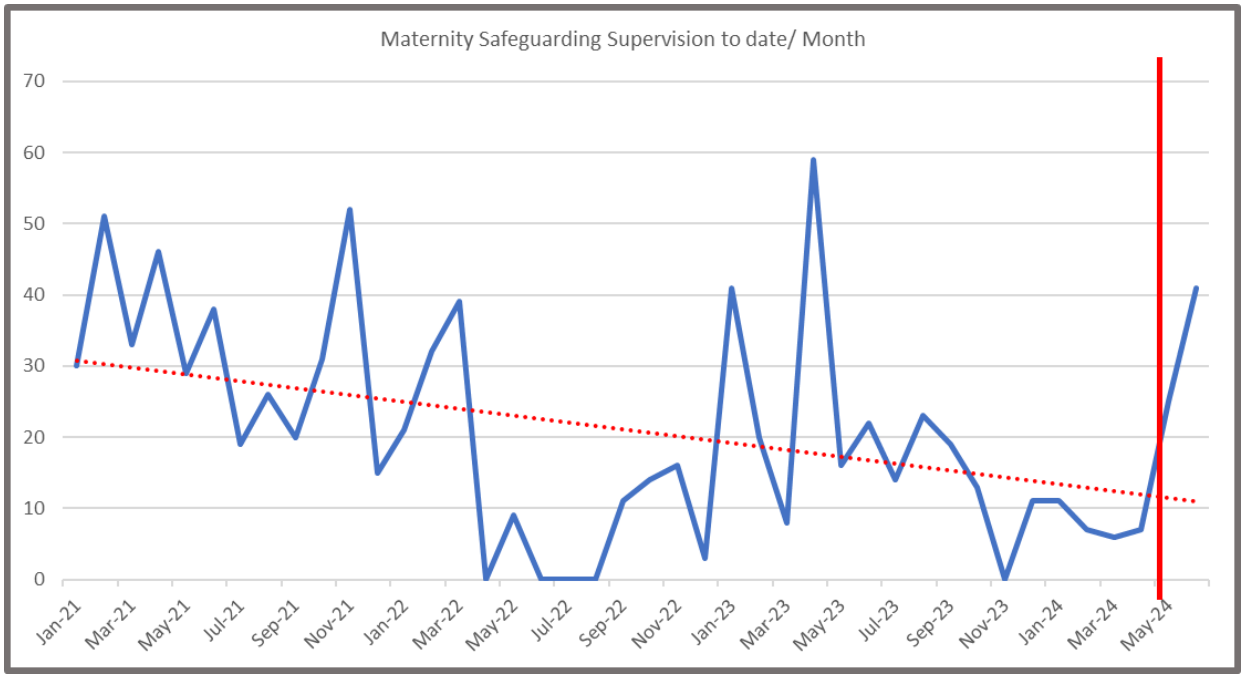


5.0 Midwifery safeguarding supervision.

During the reporting period of 2023-2024, it was recognised that staff in maternity were noncompliant with the midwifery safeguarding supervision.

There have been subsequent changes to the model of supervision following feedback and barriers to effective supervision from the staff members.

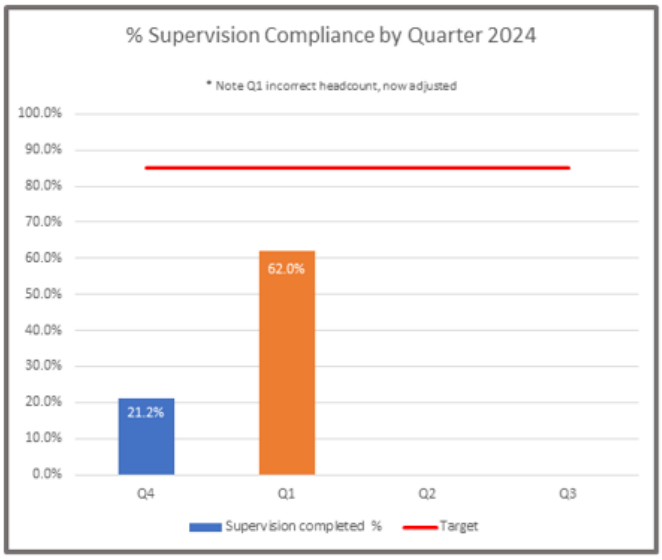
The figure below represents the supervision data before the model change taking place on the 29/04/2024.



	Q4 23-24	Q1 2024
Total Supervisions Completed	25	75

	Q4 23-24	Q1 2024
Total Non Attendance	83	38

Cancellation to these sessions remain high due to increasing work pressures in the community



The actions now taking place as part of Q1 2024-2025 include:

- Staff now able self book onto supervision sessions.
- Group Supervision reflections: No longer limited to current cases- can also be a past case, case that has affected the team, or reflection on process or procedure.
- Mandatory supervision sessions for new starters every 8 week for the first 12 months. Thereafter, mandatory every 12 weeks as a minimum.
- Supervision sessions are arranged for early morning or late afternoon to reduce interference with staff working arrangements.
- Sessions last no longer than one hour unless requested.
- Matrons (Community and Antenatal clinics) and Midwifery Managers (Community, Birth centres and Antenatal Clinic) are receiving bespoke supervision sessions quarterly to enable them to better support and guide staff managing complex cases.
- Extra sessions available in case staff members are required to work clinically at short notice

NHS Maidstone and Tunbridge Wells NHS Trust

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB) (incl. the system-aspects of patient discharges)	**Director of Strategy, Planning and Partnerships**

The purpose of the report is to update the Board on the K&M system and West Kent Health Care Partnership areas of focus and progress.

NHS Kent & Medway are also are currently developing the NHS Strategy with 4 workstreams led by system CEOs. It outlines our ambition and vision for NHS services of the future. It does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships and focuses only on healthcare services.

The ICB are planning to proceed to tender for community services and are reviewing the use of Health Inequalities monies. KCC are planning to go to consultation on the provision of community prevention.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 24/09/24
- Other Trust Boards and the ICB for NHS Strategy.

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

Information and discussion.

The Board is asked to note the TUPE of staff from the ICB to MTW to support the work of the HCP and the local priorities.

For the NHS Strategy, the Board is asked to:
The Board is asked to:

- Note the co-production approach to the development and delivery of NHS Strategy.
- Support the continued development of the strategy which is likely to come to Board in October/November

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

Maidstone and Tunbridge Wells NHS Trust

University Hospitals Sussex NHS Foundation Trust

ICB and West Kent HCP update

September 2024

Exceptional people, outstanding care

ICB/ System news

- Lord Darzi's report on the Independent Investigation of the National Health Service in England was published last week.
- As reported by the NHS Confederation, the investigation has found the NHS is in a 'critical condition' amid surging waiting lists and a deterioration in the nation's health.
- It points to four heavily interrelated drivers of current performance: austerity and constrained funding; the impact of the pandemic; a lack of patient voice and staff engagement; and management structures and systems.
- In particular, the report highlights a £37 billion capital spending shortfall over the past decade and a half, the negative impact of the coalition government's NHS reforms and stripping out management capacity.

ICB/ System news

- Development of the system financial recovery plan continues as does the work on the strategy for the NHS partners in Kent and Medway.
- This strategy is will provide the direction of travel and shared priorities across all NHS partners in Kent and Medway. It will be owned by the NHS system, including but not limited to the ICB, and to this end, it is being jointly led with NHS trust providers and colleagues in primary care. A series of workshops have been held and there was a CEO meeting on Friday 18th October to consider it alongside the Primary Care Strategy, Integrated Care Strategy and the Estates and Infrastructure Strategy.
- The ICB is leading on improving community healthcare and have reported on a period of engagement with a broad range of stakeholders undertaken during June and July.
- The invitation to tender for interested providers is expected shortly. This is a significant amount of work for interested providers.

ICB/System news

- KCC are planning to go to consultation on the provision of community prevention services and the ICB are reviewing the use of Health Inequalities monies.
- The system Director of Planning and Partnerships is out for recruitment with an outcome expected early November.

West Kent HCP

- The Executive Group took place on Thursday 12th September and the Development Board took place on Thursday 19th September. The focus remains on developing INTs, signing off the winter plan including better use of beds and the consideration of cost improvement programmes. The Q2 Oversight meeting took place on Friday 13th September.

- The HCP continues to drive implementing the better use of beds programme in West Kent. The work has been considered alongside that which already exists in providers to reduce admissions and length of stay and we have a workshop to agree the areas of focus with system partners on 30th September.

West Kent HCP

- The process to TUPE the HCP facing staff currently employed by the ICB is underway with the staff expected to come across from 1st November.
- The project implementing a digital front door in Tunbridge Wells PCN has provided its first report. They have seen a 5% increase in clinical triage appointments and an 18% increase in planned appointments since implementing the Amina system (full triage). Now, 99% of patients are seen within 2 weeks.
- Healthwatch have undertaken a staff and patient satisfaction survey which shows improved patient satisfaction (14%) and, whilst many staff feel it has increased their workload in the short term, they believe it's a positive change.

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services and 2025/26 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.
- *Finance pressures* – the system pressures and focus on financial balance is likely to have an impact on the development activities of the HCP for 24/25 and 25/26.

NHS Maidstone and Tunbridge Wells NHS Trust

Review of the draft winter plan for 2024/25 — Chief Operating Officer

NHS England wrote to all Trusts on 23rd August 2024 outlining the key focus areas for winter 2024/25. These include reducing hospital handover delays, capacity management and supporting frail patients in the community.

The draft winter plan for 2024/25 is enclosed, with an executive summary on pages 3 to 7 of the submitted report.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 24/09/24
- Finance and Performance Committee, 24/09/24

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

Maidstone and Tunbridge Wells NHS Trust

Winter Plan 24/25
V9.0 06/09/24

Maidstone and Tunbridge Wells NHS Trust

Contents

Section A: Executive Summary & Finance

Objectives of the Winter Plan

The purpose of the Winter Plan is to review all areas of activity across the Trust during the winter period (December to March), identifying gaps and risks, developing mitigation to ensure that safe and timely care is provided for patients with robust staff welfare. Working within the agreed financial spend is of paramount importance. Performance metrics are key to providing best patient care and therefore these are also key to the winter plan.

NHSE Winter Guidance and Preparation

NHSE wrote to all Trusts on 23rd August 2024 outlining the key focus areas for winter 24/25. These include reducing hospital handover delays, capacity management and supporting frail patients in the community. Work commences in September to reduce the number of inappropriate mental health placements. The region will be tasked with providing an additional 6,400 contacts per week including new OPA's, inpatient treatments and diagnostic procedures, with further details to follow. Systems are asked to ensure that waiting times of 65 weeks and over for elective patients are eliminated. Along with no endoscopy surveillance backlog.

Governance of the Winter Plan

The winter plan is a dynamic document and will require updating, as more information is made available in terms of demand and capacity modelling and plans are developed. Plans have been discussed in Senior Operational and Divisional Director meetings. Each Division plans its own winter response through their own governance structure. Financial planning is undertaken as part of BAU – this planning incorporates winter pressures where possible.

The Trust works with both Kent and Medway ICB and West Kent HCP to develop plans for winter. The Trust has contributed to these sessions in June and July. This plan is being shared with K&M colleagues in draft, to support the system plans. In addition an MTW Trust-wide Winter Planning event was held in August with Divisional leads. The infection prevention control team continue to review risks, especially around respiratory illnesses (adult and paediatric) and MPOX.

Emergency Planning

The Emergency Planning department leads on system and Trust wide exercises to prepare operational staff for emergency incidents and severe weather throughout the year, to allow the Trust to be as resilient as possible. The Care Coordination Centre (CCC) coordinates the site response on a daily basis and continues to become embedded in the organisation, overseeing the work of the Incident Control Centres (ICC) on both sites. This will go live in December 24. In the winter of 23/24, the Tactical Commander was a temporary role which offered a 7 day service from January 2024. This role has now been recruited to substantively and is embedded into the organisation, to ensure clear communication and proactive decision making, backed by real time data. This supports best patient pathways and effective partnership working.

Battle Rhythm and System Partnership Working

The site will be run on a daily basis by the Deputy COO, Sally Foy or the Director of Operations for Medicine and Emergency Care, Tim Hubbard, supported by the Head of the CCC, Vicky Simons and Tactical Commanders. There is a clinical site management team in place covering 24 hours a day, 7 days a week, supported by a Senior Manager on call (8c and above) as well as an Executive Lead.

The Trust works within the OPEL framework which was updated in 23/24 and will expand this year to include mental health and community providers to represent the whole ICS system. Winter operating functions will be active 7 days a week through Kent and Medway daily system calls from 1st November 2024, with 7 day UEC Sitrep reporting from that date.

There will be daily MTW site meetings at 9am, 1pm, 4pm, 6pm and 10pm and a daily system call at 9.30am. Additional calls will be scheduled if required to respond to issues or incidents. A daily site report will be published detailing retrospective activity and issues. The site meetings will address changes required. The Executive team huddle at 08.15am on weekdays reviews high level issues and actions. There is a Medicine huddle which is well established taking place at 8.30am each weekday looking at patient and staff issues, supporting surges in activity.

Twice weekly meetings are in place to review patients in hospital over 14 days, with additional Pathway 0 meetings led by the Tactical Commander. A What's App group functions on a daily basis, highlighting issues and escalations, with input by all departments, to support safe and timely discharge.

There will be a detailed weekend plan published on the intranet and Christmas and New Year detailed plans in place. Clear plans around escalation and de-escalation of areas will be outlined, with an appropriate governance structure for approval.

Infection Prevention and Control

The team is rolling out the flu vaccine programme and reviewing risks around mpox and measles. Mpox is an infectious disease that is caused by infection with monkeypox virus and does not spread easily between people unless there is very close contact. Neither mpox or measles are classed as seasonal infections but the team is reviewing its resilience around these emerging risks, including:

- Mpox - Ensuring mpox pathways are up to date/ ensuring staff are trained in the donning and doffing of PPE required for high consequence infectious disease (HCID) / All relevant staff are fit tested / rooms in ED are allocated for the care and management of patients with HCID
- Measles - to have a better understanding of staff's vaccination status – staff who are unaware of their vaccination status should be followed up with Occupational Health
- A prompt response to staff and patients requesting contact tracing

Real time data and Teletracking Innovation

Since its implementation in 2020, Teletracking has been further embedded to provide both quality and operational real time data as well as continuing to reduce lost bed time, through greater utilisation of the electronic bed management tracking system. These quality and performance benefits have been driven by further innovation including the digital handover, system updates, improved training offer, development of performance dashboards, the use of a Therapies console within the electronic bed management system, increased capture of quality benefits and a more substantive Care Coordination Centre (CCC).

Further innovation in the next 6 – 12 months includes:

- Workflow IQ – process improvements in endoscopy
- Phase 2 interfacing (sunrise/ Teletracking)
- SaaS implementation – new system hosting infrastructure resulting in no future downtime
- AI – development of EDD & Discharge percentage probability

Communication strategy

The CCC is working with the Communications team to ensure that there is appropriate messaging across the system, encouraging patients to use alternative pathways to the Emergency Department and to prepare carers/ families for their patients to come home at an appropriate time in the day. This will be targeted through social media and will look at specific population groups.

Information Technology

IT works closely with the CCC to ensure that updates or changes are well organised. The Sunrise update is planned to be completed in mid October, before the winter peaks. Windows 11 work will be ongoing in small chunks across the organisation, in liaison with all clinical and operational teams.

Workforce

Wellbeing support

MTW is able to offer the following direct support to managers, wards and individuals as part of an extensive wellbeing approach:

Health and Wellbeing

- Listening Ear (one-to-one) wellbeing conversations and onward signposting to external support services.
- Mindfulness, auricular acupuncture, NHS health checks (over 40's), exercise classes and promotion of healthy lifestyles.
- Financial Wellbeing (including Money Guide sessions, Blue Light card, Financial Wellbeing booklet, Food Pantry, Healthy Eating on a Budget booklet and free fruit/breakfast from canteens).
- Winter Wellbeing themed communications and engagement (including Wellbeing Wednesday, stands, drop-ins, in-reach sessions, Student Café, IEN Listening Events, Film Club and promoting NHSE national winter campaigns).

Staff Psychological Support

- Psychological Support (assessment, therapeutic support and psychoeducation).
- Post-incident response and debrief, reflective practice, stress prevention and management, in-reach sessions and specialist signposting.
- Mental Health First Aid.

Occupational Health

- Flu and Covid Vaccination programme commencing in October 2024.
- Special Vaccine Clinics are up and running to provide MMR and Pertussis vaccinations by appointment.

Finance

- The Trust is in a challenging financial position in 24/25, working within a tightly structured Financial Improvement programme across all areas. The overall CIP target is £37m which has not yet been identified.
- One of the projects within the Financial Improvement programme is the Front to Back Door Project, led by the Director of Ops for Medicine and Emergency Care. This project is looking at a number of areas to improve flow including:
    - Front Door – morning Board Round to review DTA to avoid admission, setting EDD earlier for P0 patients,
    - Middle section – basics on Board Rounds, SAFER metrics, 7 day improved working
    - Back door – additional Therapy discharge model
- Any unallocated funding attributed to winter will need to take unidentified CIPs into consideration.
- All Divisions have been asked to identify enablers and schemes which will support best flow, high quality of patient care and staff experience. Some of these schemes require additional funding which is currently not available.
- There are many quality benefits through improved flow, all of which translate into financial benefits
    - Earlier discharges/ reduced LOS improve ED performance by reducing overcrowding in the department. This has a quality benefit for patients as well as reducing pay spend on bank/ agency staff
    - Reduced LOS creates capacity which can reduce the number of “FIT” ITU patients waiting for a ward bed, reducing pay spend
    - Increased theatre capacity reduces LOS, leading to patients being discharged earlier and reducing escalation
    - Increased SDEC activity leading to reduction in inpatient stay – reducing escalation leading to reducing pay and non pay spend
    - Increased admission avoidance leading to reduction in inpatient stays – reduction in pay and non pay spend
    - Improved throughput at the weekend reducing LOS and increasing capacity – reduction in pay spend
- Therefore some of the enablers/ schemes from the Divisions are requesting funding, in order to provide greater capacity which will improve quality and reduce pay/ non pay spend. Any winter funding made available to enable winter schemes must be tracked to ensure reduced bed days (linked to cost). This will form part of the Financial Improvement governance structure. The NHSE incentive Scheme, linked to Q4 performance has not yet been fully announced but will include improving A&E performance, improving Category 2 response times and 4 hour performance.

Section B: NE activity – winter 24/25

- Attendances are predicted to increase by over 4%, peaking between Oct to Dec 24
- UTC utilisation at 85% with scope to improve, taking 43% of the activity
- Over the last 6 months we have enabled ambulances to be handed over under 30 mins 95.9% of the time – this is a continued focus.
- A key focus will be on time in the department from time of attendance (not DTA) and ambulance handovers
- LOS currently at 8.5 days but predicted to decrease according to the modelling
- NCTR – continued work underway across the system to reduce
- Mitigation in place including:
    - Real time data, electronic bed management and centralised Care Coordination System
    - Excellent system and partnership working, Medicine daily huddle
    - Good flow to all SDEC including increased Ortho SDEC to 7 days from Nov 24
    - Good ambulance handover performance
    - NIC at Site Meetings feeding back and taking actions
    - “breach bag” to ensure meeting 4 hour performance targets
    - Rota management to ensure adequate cover within financial limits, low vacancy rate
    - Minors clinics covered overnight and funding requested for GP overnight
    - SPoA diverting ambulances from ED in place (SECAmb/ KCHFT/ MTW joint clinical hub), with trial to divert GP patients on pink list via hub to promote alternative pathways from Sept

ED modelled attendances

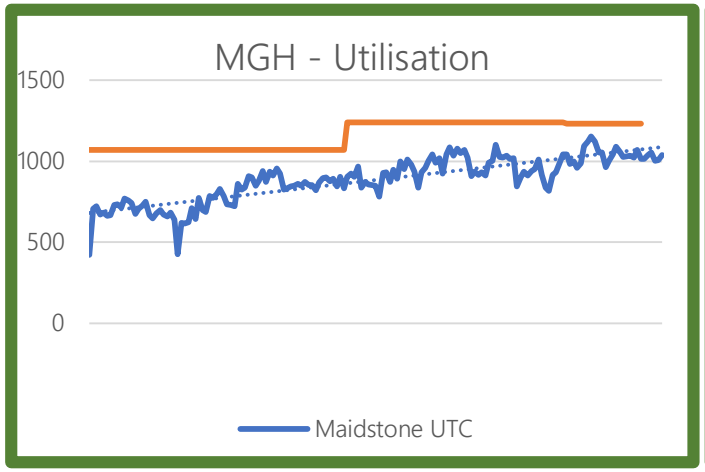
Month	2023/24 Actual	2024/25 Model	% Increase
Oct	18,051	19,688	9%
Nov	18,056	19,042	5.5%
Dec	17,905	19,367	8.2%
Jan	18,779	19,213	2.3%
Feb	17,666	17,914	1.4%
Mar	19,266	19,312	0.2%

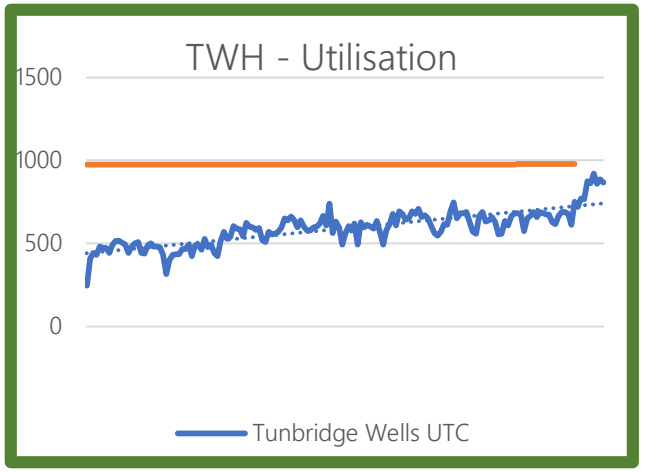
The prediction of attendances is carefully monitored by MTW B.I., taking into account previous seasonal variations, predicted severe weather and surges in infections. In the past few years, there has been an underlying growth in ED attendance of around 6.5-7.0% per annum. The seasonal weather variations are not expected to be out of the norm.

MTW B.I. are currently forecasting Winter attendances 4.4% higher than last winter, with the highest increases between Oct to Dec 24. These increased attendances are walk-ins with lower acuity.

Ambulance conveyances have levelled out their demand in the last year – partly due to the SPoA schemes and other ambulance See and Treat schemes. – any increase in demand seems to be offset by ambulance schemes like see & treat. This winter plan requests additional minors staff.

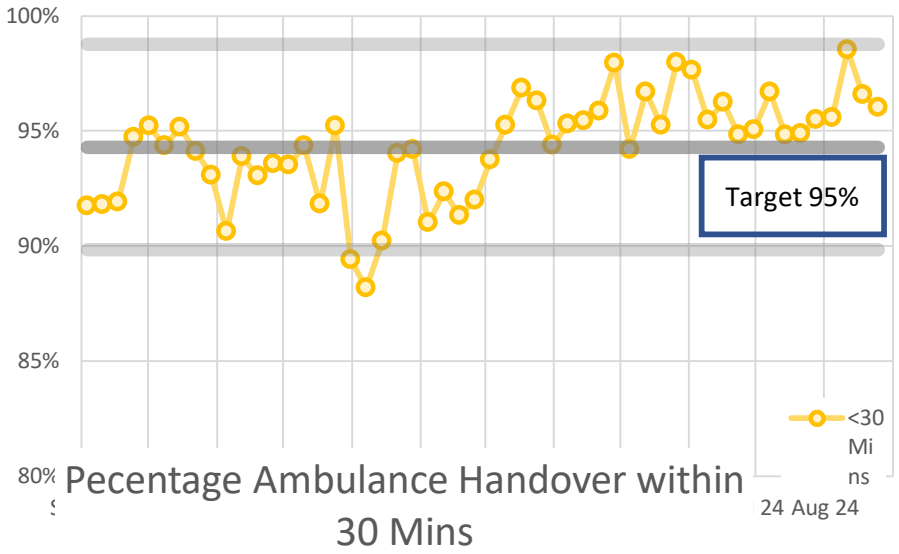
UTC: GP & Minors in ED





- Urgent Treatment Centre (UTC) available capacity for Minors and GP patients is 1232 Maidstone and 980 TW per week and approx. 500 at Sevenoaks
- Utilisation has steadily increased at MGH, TW and Sevenoaks since 2021 with a spike at TW since June. The slots are currently around 85% utilised.
- UTC slots cater for approximately 43% of all activity at MGH and TW (see table)

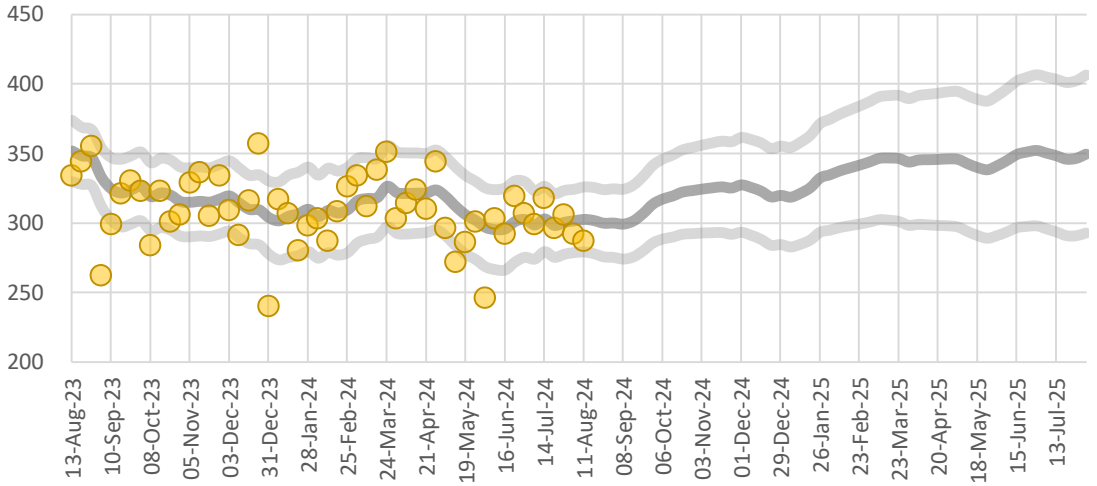
NE activity (ED): ambulances



Ambulance handover times in the South East are some of the best in the country. In MTW, over the last 6 months we have enabled ambulances to be handed over under 30 mins 95.9% of the time (over target). MTW has also met the over 60 minute target averaging 99.8% over the last year.

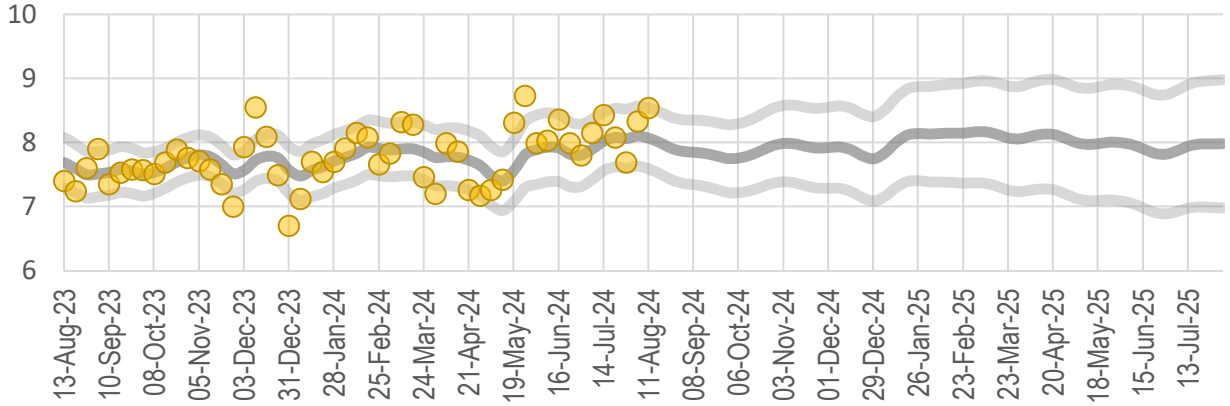
- Amb 15 : Percentage ambulance handover < 15mins : Averaged 53.6% over past year, but 56.4% in the past 6 months, so improving.
- Amb 30 : Percentage ambulance handover < 30mins : Averaged 94.3% over past year, but 95.9% in the past 6 months, so improving.
- Amb 60 : Percentage ambulance handover < 60mins : Averaged 99.8% over past year, but clean sweep since 18-Jan

SDEC activity (Type 5)



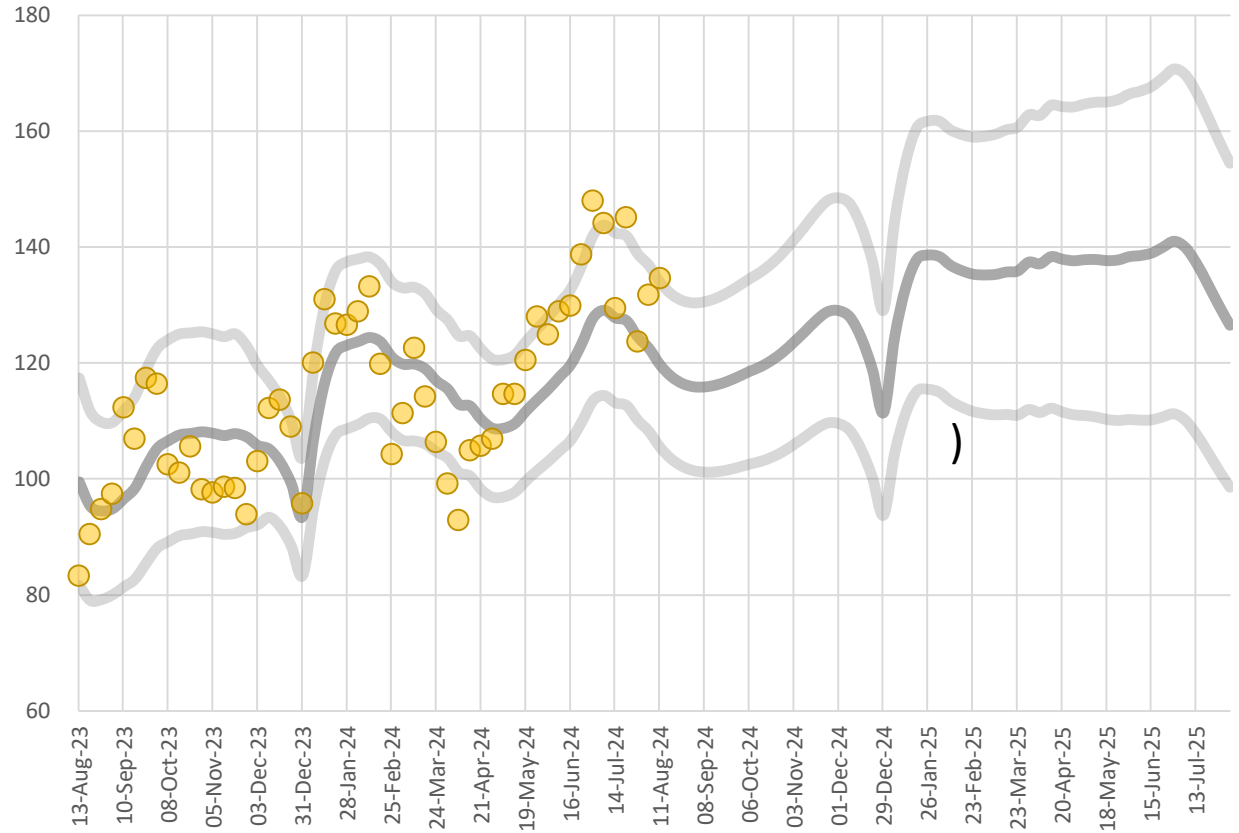
- This is the current count of zero LoS assessment activity that is due to be reclassified as Type 5 ED. This is known as Same Day Emergency Care (SDEC).
- This consistently sits at 300 per week (all Divisions included). The number of patients going to a designated assessment ward (Frailty, AEC, SAU etc as a percentage of the total take average 28.5% over the year.
- Focussed work is underway in all areas to ensure that SDECs are maximised, using clinical workforce working at the top of their grade, including ACP and senior nurses.
- Ortho SDEC in place 5 days a week from 2023 but will increase to 7 days from Nov 24
- The Single Point of Access (or SPoA) refers directly to SDEC areas allowing patients to access these areas from an ambulance referral, following triage in the SPoA

Length of stay (NE)



- This is the LoS of admissions, measured by discharges per week. This does not include 0 day LOS admissions.
- The LOS is currently at 8.5 days and is predicted to reduce to approximately 8 days, with the lowest at the beginning of October and again the end of December 24.
- A reduction in LOS and earlier discharges will support safe and timely flow.
- Work is underway through the SDR “discharges before noon” (supported by Safer Better Sooner) and the Front-To-Back Door Financial Improvement targeted programme to ensure that SAFER basics are adhered to.

NCTR - Patients with no criteria to reside

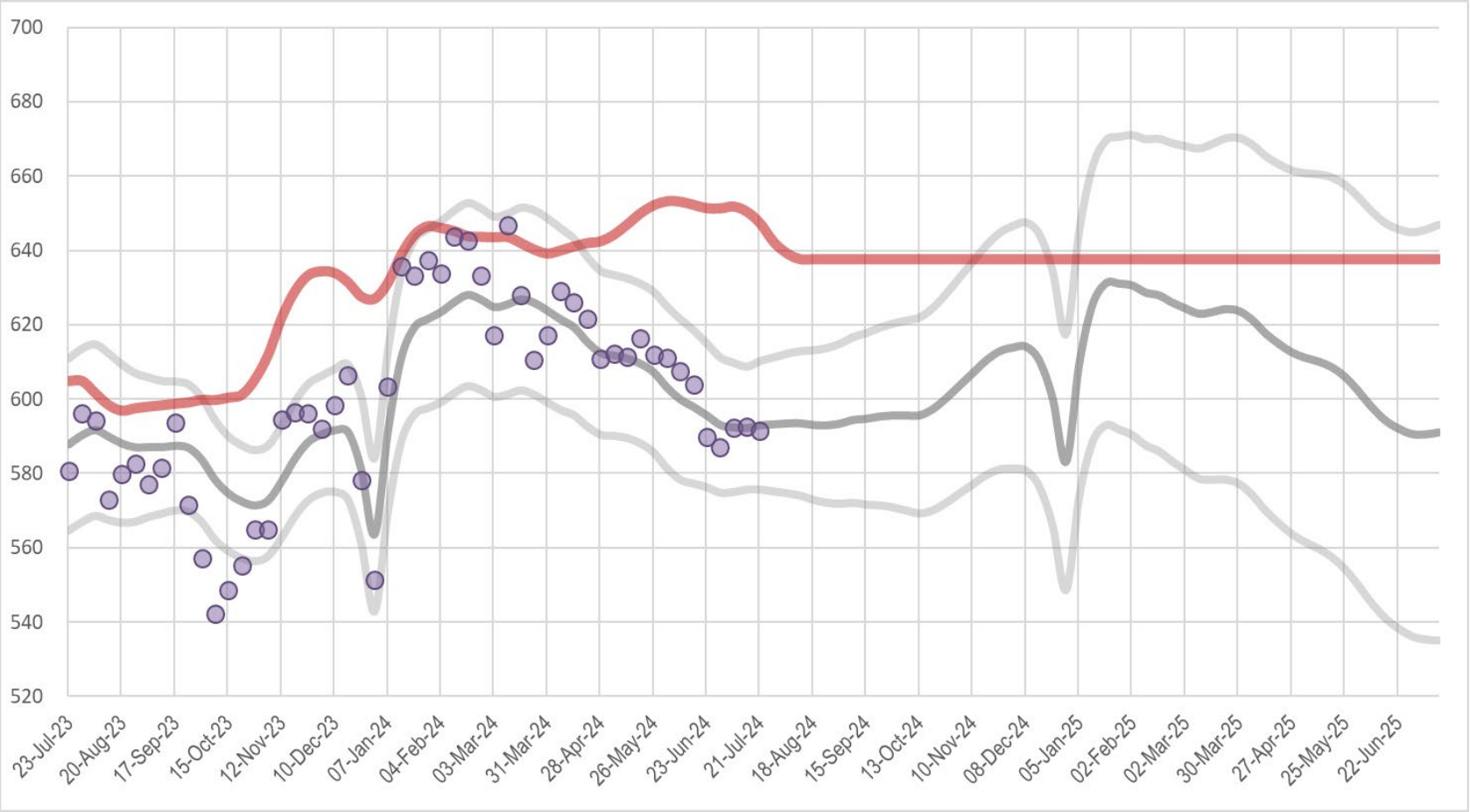


Patients who do not meet the criteria to reside has increased since May 24.

Issues and mitigation

- Process - Transfer of Care Hub pilot commenced 29/8/24 with key stakeholders (KCC, KCHFT, MTW, ICB) to reduce delays. Creating Capacity events in place at MTW over the year prior to holiday periods, using new format attending ward board rounds. Pathway 0 meetings in place with Site Director. Change to over 21 day meeting to 2 x 14 day LOS meetings weekly led by Head of Discharge
- Automation - Development of IP Discharge Note on Sunrise to automate national sit rep, reducing admin tasks. Development of pathway categories on TT – increased visibility..
- P1 and P3 OOA - Patients who are out of area (eg E Sussex) are a factor. Weekly meetings are in place to identify delays and escalation routes followed, but due to lack of capacity these can contribute to a high number of NCTR days.
- P1 - Risks around Pathway 1 from Oct 24 due to the recommissioning of this pathway by KCC. KEAH plus has been rolled out successfully however in N Kent. Operational meetings are in place to agree processes and recruitment underway. Funding requested in Winter Plan to mitigate any shortfall. Working with ICB on potential £150k intermediate care funding. Considering patients who may not be seen due to changeover from Hilton to KEAH plus.
- P2 - Sevenoaks Hospital was closed (19 beds) due to H&S concerns. Net loss 4 beds. Patients were discharged or transferred to Tonbridge Cottage with additional mitigation in Westview (Tenterden). Working with KCHFT to reduce LOS to mitigate loss.
- P3 - Xyla (CHS) bed placement service. Additional monthly placements have been negotiated in 24/25 for the same financial annual cost. Re-direction of referrals to reduce delays to P3 to Hawkhurst House. Reviewing possibility of replicating in 3 care homes for Fast Track and Recovery patients

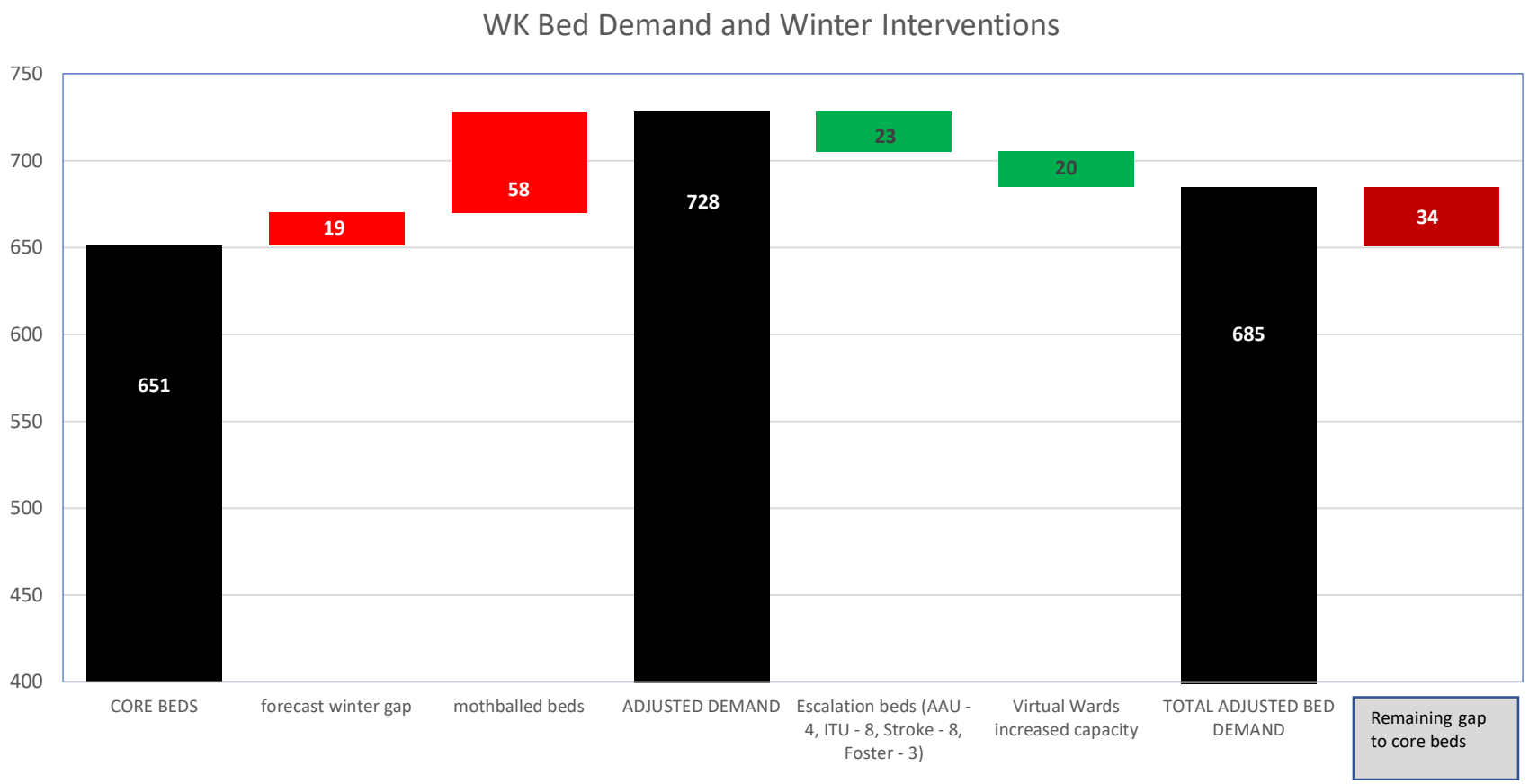
Section C: Bed modelling: demand 640-670 beds



This is in line with last year's peak of 660-670, and has been arrived at by combining the modelling for admissions, length of stay, actual bed occupancy & virtual ward usage.

- The chart shows the actual weekly average overnight bed occupancy for the previous 12 months, excluding Paeds.
- The dark grey line is our forecast for the previous & following 12 months.
- The red line shows 92% bed occupancy
- The pale grey lines above & below are the 80% confidence intervals. **The assumption is that we are working to requiring the higher tolerance of 670 beds.**

Waterfall to close the gap



- Baseline of core beds and escalation beds for MTW (excl. Paeds) are 651.
- As 670 beds are required, therefore there is a gap of 19 beds. 58 beds have been taken out (W10 and FC) This leaves an adjusted demand of 728 and a gap of 77 beds.
- **There are 23 additional escalated beds, some of which require funding. Th**ese include Foster 3, AAU overnight beds 4, ITU escalation 8, Stroke 8 . The gap is now 54
- There is a scheme to increase Virtual Ward by 20 beds which would support this gap. There is a gap of 34 beds
- Divisional schemes offering 33 beds are in place to reduce the remaining gap (see Section D). The gap is now 1.
- PPU 10 beds to be ring fenced for private patients leading to a net loss of another 5 beds. The gap is now 6 for winter pressures
- Further prioritisation of funding is in the following slides

Section D: Winter funding requested to support Schemes and escalation beds (further detail in following slides)

TOTALS	All schemes	Beds released (all)	Priority 1	Beds released (1)
Divisional schemes	£1.2m	33	£497k	22
Escalation beds	£856k	43	£368k	35 (incl. VW, Stroke, AEC and FC)
Total	£2m		£865k	57

- Divisions have developed pathways/ schemes in order to release bed days, equating to 33 beds.
- If all schemes were to be funded it would cost £1.2m. If all escalation beds were funded, it would cost £856k
- Through prioritisation, the costs are reduced and the number of beds available is reduced. New cost £865k.
- There is a possibility of £150k from the HCP Intermediate Care Fund to mitigate the P1 transfers, led by the Discharge and Flow Programme Board. There is an additional possibility of community funding to support stroke, led by MEC.

Closing the Gap - Op Flow / Transfer of Care/ Facilities

No.	Enabler / Scheme	Bed days released per week	Cost £	Priority
1	P1 Additional Care Provider to support 3 - 6 months dependant on gaps identified	25 bed days	175,000	1
2	P2 recovery patients in Hawkhurst House incl. NWB and those not suitable for community – already in place , can spot purchase in other providers/ nursing homes if required	3 bed days	0	
3	Bed & Breakfast option for patients requiring short term/ short notice accommodation	Admission avoidance/ reduction of LOS	13,000	3
4	Extend working hours of Flow Co-ordinators	7 bed days	21,000	4
5	Refurbishment of TW Bariatric rooms X 10 patients	70 bed days	20,000	1
6	Facilities –Porters TW		20,000	1
	TOTAL	95 bed days per week	249,000	

Closing the gap- Surgery/ Medicine

No.	Surgery Scheme/ Enabler	Bed Releasing Days per week	Cost	Priority
1	SDEC: OAU-7 day service	4 bed days	£0	3
2	WARD: Additional resource to manage winter surge		£180,000	3
3	THEATRE: Minor trauma day case lists (MGH) THEATRE: Additional 2 complex trauma theatre sessions TW WARD: NOF streamlined pathway with 2 ringfenced beds	58 bed days	£60,000	2
4	THEATRE: Additional Trauma capacity	Improved quality of care	£20,000	2
	Total	62	£260,000	

No.	Medicine Scheme/ enabler	Bed Releasing days per week	Cost	Priority
1	Respiratory Consultant weekend Cover Discharge SHO x 1 when required	3 bed days	34,000 10,000	4
2	Additional overnight GP Cover in UTC	Improved ED performance	137,000	1
4	AEC Additional Reg or ACP twilight shift Mon/ Tues	2 bed days	36,000	3
5	Post take reviewed by geriatrician TW	8 bed days	45,000	1
6	SPoA accepting GP refs for pink list, promoting alternative pathways to the acute	5 bed days	0	1
7	Bolstering senior leadership in ED plus corridor TW/ triage nurse both sites	Improved ED performance	60,000	3
Total		18	322,000	

Closing the gap – Core Clinical/ Cancer/ W&C

No.	Core Clinical Scheme/ Enabler	Bed Releasing days per week	Cost	Priority
1	Additional Therapies support	5 days	£100,000	1
2	Pharmacy discharge - supernumerary 'early' discharge team & w/e staff	2 days	£120,000	4
3	Diagnostic Flow Coordinators to remove admin work from clinical staff	Earlier discharges before noon	£20,000	4
4	Additional Portering / RDA to support flow (link to Op Flow request)	Earlier discharges before noon	£50,000	2
5	IR additional sessions x 3 INITIAL PILOT OF 1 X IR LIST TO TEST CYCLE OF CHANGE	3 bed days	£50,000	2
	Total	10 days	£340k	

No.	Cancer Enabler/ Scheme	Bed Releasing days per week	Cost	Priority
1	Provision of internal brace fitting to avoid lengthy transfer to external provider (2 patients p/mth £2k p/patient 6 months)	7 bed days per week	£24,000	3
2	Acute oncology SDEC from 2 to 5 days p/week by Feb 25	35 bed days	£0	2
	Total	42	24k	
No.	W&C Enabler/ Scheme	Bed Releasing days per week	Cost	Priority
1	Hedgehog increased to 26 beds		£23k	2

Key risk – KEAH + (P1)

The private provider Hilton has offered 50 slots for Pathway 1 care, commissioned by KCC over the last few years. This will change from 9th Sept at Maidstone and 16th Sept TW to KEAH plus, which is an inhouse KCC provider. KEAH plus has already rolled out in Swale and DGS. A number of risks have been identified (see below) and it has been difficult to get clarity on the service specification, despite ICB/ HCP support. Comms is in place across the organisation and operational meetings have taken place.

£175k funding is requested to support additional care packages which would go through the P3 team who are located in the hospital. This pathway has been trialled this week. In addition the Urgent Care team (Rapid Response) in the community will flex capacity to support at the weekend. There may be additional funding available through the HCP (Discharge and Flow Programme Board) of £150m to support gaps.

Potential changes	Risk to patients	Level of Risk	Proposed Mitigation
Referrals must be made on weekdays	Patients identified after 1600 on Fridays may remain NCTR in acute beds until Monday / Tues.		Raised with KEAH + - they have said they will be flexible. Urgent Care from KCHFT will mitigate through Rapid Response for first few weekends. Data to be captured through ToC Hub.
Referrals must be received by 1600 for possible discharge the following day. 1 hour response time to upload referral. 3 hour response time for referrals.	Patients are unlikely to be discharged the same day as identified suitable for P1 in contrast to current same day service (capacity dependent). This may lead to a delay in discharge related actions such as TTOs, transport booking, etc.. KPI starts again if referral incomplete or declined.		Daily huddle in place with KCC (as per current practice) to monitor discharges
Referrals will be screened for potential health funded long term care (CHC) cases. Service will reject these referrals.	Patients that are deemed to have long term health needs will not have access to a P1 D2A service, creating a lack of parity between patients with long term health and social care needs. Concerns about what KCC identify as priority health need and what health prioritise as health need This cohort of patients is likely to experience a significant number of NCTR bed days whilst CHC assessments are undertaken and/ or suitable support to return home is sourced and mobilised. Any solutions are likely to be an additional cost to health on top of contributions to a partial P1 service.		Further service may be required. Funding request submitted through Winter Plan MTW. £150k available through Intermediate Care Fund (overseen through Discharge and Flow Prog Board)
No set/ minimum capacity. No. of staff to upload referrals and triage appears low.	The ability to plan and find alternatives for patients in the event of demand exceeding capacity will be restricted leading to challenges in timely, accurate communications with patients and families.		As above. Comms to staff, operational meetings have taken place. Data to be captured through Transfer of Care Hub
No agreed daily huddle (as current practice), no shared spreadsheet to monitor delays, Therapies need to send separate ref for TADS			IDT have met with KCC to suggest daily huddles. To be set up 12.30pm daily for 2/3 weeks initially Requested similar spreadsheet and urgent flow chart

Section E: Conclusion

- It is predicted that 670 beds are required. This leaves a gap of 77 beds as W10 and Foster are closed following bed modelling. PPU beds will also be reduced due to Fordcombe plans.
- Divisions have developed pathways/ schemes in order to release bed days, some of which require funding. Funding is also requested to open additional escalation beds.
- There may be some additional funding from other sources, i.e. £150k from the HCP Intermediate Care Fund to mitigate the P1 transfers, led by the Discharge and Flow Programme Board. MEC Division are requesting additional ICB funding to support stroke discharges, mitigating reduced community capacity. Neither are confirmed. Robust governance structures are required to ensure that any money invested would deliver the bed requirement.
- If all schemes were to be funded it would cost £1.2m. If all escalation beds were funded, it would cost an additional £856k. The table below shows a reduced funding request following prioritisation but this increases the gap.

TOTALS	Priority 1	Beds released (1)
Divisional schemes	£497k	22
Escalation beds	£368k	35 (incl. VW, Stroke, AEC and FC)
Total	£865k	57

NHS Maidstone and Tunbridge Wells NHS Trust

Responsible Officer's Annual Report 2023/24 **Chief Medical Officer**

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]
Information and discussion.

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

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board of Maidstone and Tunbridge Wells NHS Trust (MTW) can confirm that:

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

Action from last year:	Dr Sara Mumford to be appointed as Responsible Officer in October 2023
Comments:	Dr Sara Mumford was appointed as Medical Director at MTW and is an appropriately trained medical practitioner who fulfils the requirements of a Responsible Officer. Dr Mumford was appointed as Responsible officer in January 2024
Action for next year:	No changes expected so continue as above

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	To arrange an accredited training for additional 15 new MTW appraisers
Comments:	Two new appraiser training sessions were delivered by an external accredited company MIAD Healthcare We currently have 96 appraisers (86 consultants and 10 Specialty Doctors) and 727 Doctors working at MTW. Each appraiser should have an average of 7-8 appraisals each year. The current system requires a Dr to request an appraiser and the number of appraisals undertaken by each appraiser can range between 1 and 11 per year.
Action for next year:	To monitor and maintain the number of appraisers. To move to an appraiser allocation available on the L2P system to evenly distribute Drs medical appraisal between all appraisers

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	The Responsible Officer, Medical Appraisal and Revalidation Lead, Medical Appraisal and Revalidation Manager and the Coordinator regularly update and review all Drs joining and leaving MTW are appropriately connected and disconnected from MTW. All have password access to secure GMC connect website for updating this data.
Action for next year:	Continue as above

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	To present the updated medical appraisal policy
Comments:	The medical appraisal policy has been updated along with a Medical Appraisal Quality Assurance Document and a Job description for medical appraisers and are awaiting final approval
Action for next year:	Approve documents as above in next 3 months

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None
Comments:	Peer review of our Appraisal and Revalidation (A&RV) process is internal and within the A&RV team. This involves a two-stage process for reviewing all completed appraisals and referring back any appraisals that are incomplete or missing key documents that provide assurance that Drs are working safely eg Medical Indemnity, Private Practice Provider Governance Form. All appraisals are reviewed by the Medical Appraisal Coordinator and then again by the Medical Appraisal and Revalidation lead for final approval. Any appraisals undertaken by the Medical Appraisal and Revalidation lead are approved by the Responsible Officer. A revalidation summary document is prepared by the Medical Appraisal and Revalidation Lead for all Drs under notice for Revalidation once a month and distributed to the RO, Chiefs of Service, Medical Director and Deputy Medical Directors to review and discuss any concerns, and written approval for recommendation is obtained. The summary has had additional detail added this year to ensure information provided is relevant to support approving revalidation. Doctors are invited to complete a feedback questionnaire about the appraisal process every time they complete an appraisal via the L2P medical appraisal system. Data is regularly reviewed by the Medical Appraisal Manager and Medical Appraisal Lead. The Medical Appraisal Manager and Medical Appraisal and Revalidation Lead attend the Southeast Higher-Level RO (HLRO) team regional network meetings where updates on changes are shared and receive South East HLRO information updates electronically. A Self-assessment tool to help all organisations demonstrate its clinical governance processes to support revalidation was distributed in September 2024 from the South East HLRO and should be undertaken this year. External review has not been undertaken this year
Action for next year:	To continue with the two-tier process of checking appraisal completion and revalidation approval process. To complete the South East HLRO Self-assessment tool and present next year. To identify where, in the forward external audit calendar, audit of the medical appraisal system can be carried out.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are

supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None
Comments:	All doctors who join MTW are invited to attend a New Doctor appraisal training session to familiarise themselves with the appraisal process. All doctors working at MTW will be provided with the access to IT facilities, library facilities, or study leave to attend conferences and courses to support Continuing Professional Development. All Doctors can attend or watch directorate Clinical Governance meetings, and can be involved in Quality Improvement activities. All Doctors are expected to discuss any patient safety events, and complaints that they are involved in within their appraisal with their designated body for revalidation. MTW will provide Doctors with a connection outside our organisation with a governance form that summarises if the Doctorr has, or has not been involved in any specific incidents and their participation in clinical governance. Information on the Appraisal and Revalidation Process is available on the Trust Intranet Medics Hub.
Action for next year	Maintain annual New Doctor appraisal and revalidation training Maintain the Appraisal and Revalidation Pages in the Medics Hub

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, 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.

Action from last year:	Monitor appraisals and review the number referred back for additional information
Comments:	The L2P medical appraisal system was introduced in September 2022 to replace the previous MAG4 form. The L2P appraisal system has a set template that supports provision of all the relevant information relating to a Doctors fitness to practice. Sections include scope of work (inclusion of non-NHS work), well-being, relevant CPD, QI work, compliments, complaints and significant events as per the NHSE Medical Appraisal Guide 2022. Doctors are expected to provide and discuss their clinical outcome data at the appraisal. The L2P system has facility to upload all supporting documents to facilitate appraisal discussion and reflection. Doctors can also bring any additional evidence to their appraisal if they wish. Doctors may be asked to reflect on specific incidents if necessary and the Medical Appraisal team ensure that the Doctor and appraiser are made aware of this. The L2P appraisal Multisource Feedback was also introduced in March 2024, replacing the previous system, to manage the patient and

	colleague feedback required once in a 5-year revalidation cycle. All Doctors have had a date set for when the MSF is due and the system automatically informs Doctors when to start this so it is ready in time for revalidation. The purpose of moving from the previous MSF system (360 Equiniti) was to centralise all of the documents required for revalidation into one system and this has been successfully implemented. In addition, the reminder prompts aim to ensure Doctors complete the MSF in time for discussion at the Year 4 appraisal in preparation for revalidation. A change in the Medical and Appraisal Revalidation lead occurred in April 2023. The two-tier process for reviewing medical appraisals was continued and the standards of completion were also updated as part of introducing the Medical Appraisal Guide 2022 so the number referred back was higher in 23/24.
Action for next year:	Monitor satisfactory completion of appraisal documentation Monitor completion of the L2P MSF in time for revalidation

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	Introduce the NHSE standards Medical Appraisal Guide 2022 MAG 2022
Comments:	This has been introduced via the L2P system and within the appraisal check list undertaken by the Medical Appraisal Coordinator. Failure to provide enough evidence, or complete an appraisal satisfactorily would be referred to the Medical Appraisal and Revalidation Lead, and escalated to the RO if non-engagement was the reason
Action for next year:	Monitor satisfactory completion of the appraisal documentation in line with NHSE MAG 2022 standards – referred back rates and reasons for this to be shared with RO and Doctors via the Appraisal Newsletter.

1B(iii) 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:	Present an updated Medical Appraisal Policy
Comments:	Medical Appraisal Policy has been updated but not yet approved
Action for next year:	Obtain approval in next 3 months

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Organise new appraiser training with the accredited MIAD Healthcare
Comments:	Two New Appraiser training sessions have been delivered, one in November 2023 and one in February 2024 and a total of 26 new appraisers attended (30 invited to attend) Medical appraisers = 96 and includes 86 consultants and 10 SAS Drs, and is an increase of 19 appraisers (24%) since last year Doctors working at MTW = 727 Current doctor: appraiser ratio is 7.5 appraisers per year (8.2 in 22/23) The number of doctors and appraisers is in constant flux and further training session will be needed to achieve the target of 6.0 appraisals per appraiser An additional 13 Doctors are on the New Appraiser waiting list (MIAD Healthcare allow a maximum of 15 doctors per training session).
Action for next year:	Arrange one additional accredited New Appraiser training session

1B(v) 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 or equivalent).

Action from last year:	Monitor appraisee feedback and report to appraisers and the RO
Comments:	Three appraiser update training sessions were delivered by the Medical Appraisal and Revalidation Lead held in 23/24. Not all appraisers could still attend so this year additional focus on ensuring that all Doctors can receive this training will be made and we aim to record an update session for those who cannot attend the virtual sessions. A Medical Appraisal and Revalidation newsletter has been circulated twice this year to help update appraisers and doctors on any new developments in the appraisal and revalidation process such as the new L2P system, completing the L2P document correctly and updated GMC guidance on Good Medical Practice 2024

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	All Doctors are sent a post appraisal questionnaire for feedback on the appraisal process to obtain real time feedback on the appraisal process and the appraisers. Summary of the feedback from 23/24 and 2023 in brackets is reviewed in four domains: **Process review 207 responses** 94% felt that they had sufficient time for the appraisal discussion (93%) 92% had an appraisal that lasted at least one hour or more (91%) **Appraiser Overview 524 responses** 99% felt happy to have the same appraiser again (99%) 99% felt that their appraiser skills were either satisfactory, good or very good (100%) – 1% wanted more challenge **Doctors opinion of how useful they find the appraisal process 524 responses** 91% felt useful for personal development (91%) 92% felt useful for professional development (92%) 95% felt useful for revalidation (93%) 89% felt useful for promoting QI in their work (91%) 87% felt useful for improving patient care (82%) **Appraiser ratings from 524 responses** 97/100 appraisers had a rating of 4.5 - 5.0
Action for next year:	Provide annual appraiser updates in 24/25 (booked for October and November 24) and share feedback Monitor Drs feedback and reflect on how to include training to support appraisers in maintaining quality appraisals

1B(vi) The appraisal system in place for the doctors in our 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:	A quality assurance document has been developed along side the medical appraisal policy Appraisal assurance tools that we have included for Medical Appraisal: Medical Appraiser role description Medical Appraisal Quality assurance document Medical appraisal feedback questionnaire Audit of completed appraisals using the Appraisal Summary and PDP Audit Tool (ASPAT) – not completed in 23/24
Action for next year:	Undertake an audit of completed appraisals using the NHS England Appraisal Summary and PDP Audit Tool (ASPAT) as a measure of quality

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	MTW will continue to refer Doctors where there are fitness to practice concerns in line with GMC requirements. The Medical Appraisal Lead will continue to review all Doctors under notice for revalidation each month by reviewing appraisals and the valid MSF and provide a recommendation summary document for revalidation approval. These recommendations are then ratified by the Chiefs of service, Chief Medical Officer and Responsible Officer.
Action for next year:	No changes expected

1C(ii) 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, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	The Medical Appraisal and Revalidation Manager ensures that recommendations are made to the GMC in a timely manner. All doctors for whom a deferral is recommended are contacted by the Medical Appraisal and Revalidation lead by letter explaining the reason for the deferral and the lead works with the doctor to ensure that a positive recommendation is made by the end of the deferral period. Non-engagement is escalated to the Medical Director for further action and referral to the GMC when necessary. There were no ‘non-engagement’ recommendations were made 23/24.
Action for next year:	No new changes

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None
Comments:	Clinical governance is a system through which MTW are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish". It involves monitoring systems and processes to provide assurance of patient safety and quality of care across the organisation. Monitoring Doctors performance and development is a key contributor to delivering effective clinical governance. Quality includes patient experience, safety and clinical effectiveness and is a key marker of operational performance. Appraisal is an opportunity to discuss on how a doctor is contributing as an individual in both positive ways and to reflect honestly on incidents where things went less well and learn from such events so that they can prevent future mistakes and reduce risk of harm. All Doctors are working in managed departments to help make changes that are less likely to cause harm and processes are in place to help understand why things go wrong. Any involvement in After Action Reviews, Serious Incident investigations, Coroners' inquests and SJRs should be discussed and reflected upon at appraisal and included within the appraisal document. The GMC guidance on Supporting Information for Appraisal Jan 2024 provides differing types of information that Doctors can provide as evidence for their appraisal that reflects on how they are working within good clinical governance focussing on CPD and how to record this, acceptable evidence of QI activities, and maintaining professional standards as set out in the GMC guidance on Good Medical Practice 2024. These are available as documents on the Trust intranet, All Doctors are able to engage in regular clinical governance meetings, audits and research and are supported by audit and research and development departments. Log book of activity of work can be a challenge to produce for some Doctors but other forms of evidence such as patient outcome data, and mortality and morbidity meetings etc are available for Doctors to discuss their performance. A Doctor can be asked to discuss any specific issue at their appraisal by the RO when relevant.
Action for next year:	No changes expected this year

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	None

Comments:	Doctors are expected to discuss conduct and performance at their appraisal including any Maintaining High Professional Standards (MHPS) issues where relevant. Involvement in SIs, SJR reviews, performance issues, complaints and any incidents that caused harm should be discussed at the appraisal and reflection on the learning from these events. If known the Medical Appraisal team will add a note to the appraisal requesting that the specific issue be discussed and will check for this when the appraisal is submitted.
Action for next year:	No changes expected

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None
Comments	The L2P system allows Doctors to upload documents as supporting information provided that it is anonymised data with no limit on the number of documents that can be attached.
Action for next year:	No changes expected

1D(iv) There is a process established for responding to concerns about a medical practitioner's 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:	There is a clear process for responding to concerns about a Doctor at MTW Medical appraiser training includes discussion on managing a Doctor who is found to be breaching professional standards and how this must be escalated to the RO in a timely way dependent on the nature of the concern. MTW follows the NHS practical guidance on responding to concerns: • Patients must be protected. • Clinicians too must be safeguarded. • All action must be based on reliable evidence. • The process must be clearly defined and open to scrutiny. • The process should demonstrate equality and fairness.

	• All information must be safeguarded. • Support must be provided to all those involved.
Action for next year:	No change expected

1D(v) 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 and country of primary medical qualification.

Action from last year:	None
Comments:	MTW expects all Doctors to maintain high professional standards and acts to manage and resolve performance concerns. To do this the Responsible engages with the following organisations: - Practitioner Performance Advice service (Maintaining High Professional Standards) - General Medical Council (GMC) The Responsible Officer will oversee those doctors about whom concerns are raised. Disciplinary procedures including MHPS investigations will be instigated as necessary where fitness to practice concerns exist, however other processes including coaching, remediation and additional training are also used to support doctors of concern. Doctors in distress for any reason will also be supported to return to full practice as appropriate. Significant issues are included in the Notification of significant employment issues report to the Trust Board The Practitioner Performance Advice Service collects data on the cases referred to them for advice.
Action for next year:	No changes expected

1D(vi) 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 our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	None

Comments:	Doctors working at MTW with concerns but connected to another designated body, or working at another organisation while connected to MTW can have information shared from RO to RO. Written information can be transferred via the Medical Practice Information Transfer (MPIT) form. MPIT forms are also requested on new doctors joining MTW from their previous Responsible Officer
Action for next year:	No changes expected

1D(vii) 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 is committed to dealing firmly and fairly with doctors whose fitness to practise is in doubt. Response to concerns must be based on reliable evidence, and should demonstrate equality and fairness. All information must be safeguarded. Support must be provided to all those involved as they proceed through any internal or external investigation MTW follows procedures free from bias and discrimination and works together with the Practitioner Performance Advice service, General Medical Council and the Medical Practitioners Tribunal service to seek a resolution.
Action for next year:	Continue as above

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	None
Comments:	Patient Safety Incident Response Framework (PSIRF) was implemented in April 2024 at MTW. This NHSE framework sets out how to develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

	The David Fuller Inquiry in 2022 involved MTW NHS trust and the Fuller Independent Inquiry Phase 1 report made 15 recommendations for the Trust which have all been implemented. In addition, the Trust has undertaken a full review of the Governance structure within the organisation during 2024
Action for next year:	Continue with PSIRF

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	None
Comments:	The following has been implemented for staff who are working at MTW: -Exceptional leaders programme for all within Trust -Standard appraisal systems in place for medical staff and other staff -Training programme for Clinical Directors In addition, MTW has also published an EDI strategy to support all staff working in the Trust.
Action for next year:	Further development of CD training programme Development of leadership framework for consultants

1E – Employment Checks

1E(i) 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:	All Doctors are required to undertake all mandatory pre-employment checks with the Department of Medical Staffing before they can start working at MTW to ensure that Doctors are GMC licenced medical practitioners with appropriate verified qualifications and clinically experienced for their role.
Action for next year:	Continue as above

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	None
Comments:	The MTW Equality, Equity, Diversity and Inclusion strategy (Jan 2023) ensures that we aim to bring EDI to the heart of everything we do. Our NHS People Promise has a focus on flexible working, kindness and respect and employee listening Our Senior Leadership program included a focus on Kindness in Action when raising a concern. The L2P system is a better system for appraisal and feedback has been very positive. The introduction of the MSF component now means that we have bought all of the documentation needed for revalidation into one system. The MSF report not only provides feedback on Doctors but also shows that the Doctor is receiving feedback from wider members of the MDT (admin, nursing, allied HCP and medical)
Action for next year:	No changes expected

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None
Comments:	Trust PRIDE values Active EDI and OD team to promote inclusivity Exceptional leaders programme centred on compassionate leadership
Action for next year:	No changes expected

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None
Comments:	Freedom To Speak Up Guardian ensuring the safety and well-being of both our patients and staff.

	PSIRF implemented with learning panels and shared learning across organisation Revised governance structure with enhanced oversight of patient safety, patient outcomes, patient experience (PSIRF)
Action for next year:	Continue as above

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards process by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	None
Comments:	Local processes for managing informal complaints Formal complaints procedure in place Complaints and patient safety incidents discussed at appraisal
Action for next year:	Continue as above

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None
Comments:	Formal complaints procedure EDI policy
Action for next year:	Continue as above

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending

network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None
Comments:	South East HLRO quarterly meetings South East HLRO Self-assessment tool to help all organisations demonstrate its clinical governance processes to support revalidation Advice from PPAS/NHS Resolution
Action for next year:	Network with other Trust Appraisal and Revalidation teams

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2023	724

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**574**
Total number of appraisals approved missed	**6**
Total number of unapproved missed	**5**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	100
Total number of late recommendations	1
Total number of positive recommendations	100

Total number of deferrals made	10
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	22
Total number of trained case managers	3
Total number of new concerns registered	13
Total number of concerns processes completed	9
Longest duration of concerns process of those open on 31 March	5 months
Median duration of concerns processes closed	**6 months**
Total number of doctors excluded/suspended	**1**
Total number of doctors referred to GMC	**4 (one by the trust and 3 by other)**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	298 Resident doctors 186 Trust 116
Number of new employment checks completed before commencement of employment	100%

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	Ongoing
Total number of appeals against the designated body's professional standards processes made by doctors	None
Number of these appeals upheld	None

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Dr Sara Mumford to be appointed as Responsible Officer in October 2023 Trained 26 new appraisers Reviewed and updated the following polices: Medical Appraisal Policy Medical Appraisal Quality Assurance Medical Appraiser Job description
Actions still outstanding
Policies to be approved: Medical Appraisal Policy Medical Appraisal Quality Assurance Medical Appraiser Job description
Current issues
To monitor and maintain an appropriate Appraisers:Doctor. ratio Continue to provide New Dr appraisal and revalidation training Continue to provide annual appraiser updates in 24/25 (booked for October and November 24) Continue to monitor Drs feedback and reflect on how to include training to support appraisers in maintaining quality appraisals To continue with the two-tier process of checking appraisal completion and revalidation approval process Monitor satisfactory completion of appraisal documentation, appraisals referred back, and completion of the MSF in time for revalidation Maintain the Appraisal and Revalidation Pages in the Medics Hub
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To move to an appraiser allocation available on the L2P system To complete the South East HLRO Self-assessment tool and present next year. Undertake an audit of completed appraisals using the NHS England Appraisal Summary and PDP Audit Tool (ASPAT) as a measure of quality Network with other local Appraisal and Revalidation Leads
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
This year we have successfully introduced an appraisal newsletter and the L2P MSF for doctors. The MSF requires approval by the Medical appraisal team which allows us to review raters chosen and ensure that there is a good representation from the wider MDT and not just other medical colleagues.

The increase in appraiser numbers has meant a smaller number of Drs have done large numbers of appraisals (more than 8). However the need to request an appraiser has also caused delays in appraisal completion on time so a move to allocation of appraisers to Doctors will hopefully improve this and is due to start in April 2025.

Section 4 – Statement of Compliance

The Board/executive management team have 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 the designated body:	Maidstone and Tunbridge Wells NHS Trust

Name:	
Role:	
Signed:	
Date:	

NHS Maidstone and Tunbridge Wells NHS Trust

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment — **Chief Operating Officer**

The enclosed report provides information on the Trust's statement of compliance with NHS England Core Standards on Emergency Preparedness, Resilience & Response for 2024/25.

The Trust is fully compliant with all the 62 Core Standards which incorporate:

- Domain 1 - Governance
- Domain 2 - Duty to Risk Assess
- Domain 3 - Duty to Maintain Plans
- Domain 4 - Command & Control
- Domain 5 - Training & Exercising
- Domain 6 - Response
- Domain 7 - Warning & Informing
- Domain 8 - Cooperation
- Domain 9 - Business Continuity
- Domain 10 - CBRN

The "Deep Dive" for 2024/2025, as confirmed by NHSE/I relates to Cyber Security and these standards do not contribute to the overall Core Standards rating and the Executive Team will receive a separate report on this.

The Trust Board is requested to approve the submission of the EPRR Core Standards self-assessment for 2024/2025 to the Kent and Medway Integrated Care Board (ICB).

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to note and approve the submission of the EPRR Core Standards self-assessment for 2024/2025.

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

1. Introduction

The NHS must proactively prepare for and effectively respond to a broad spectrum of incidents and emergencies that could impact health services or patient care. These incidents may range from extreme weather events and infectious disease outbreaks to major transportation accidents. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS-funded care are legally required to demonstrate their capability to manage such incidents while continuing to deliver essential services.

NHS England has established core standards for Emergency Preparedness, Resilience, and Response (EPRR), which set out the minimum requirements that NHS organisations and providers of NHS-funded care must adhere to. Each organisation's Accountable Emergency Officer is responsible for ensuring compliance with these standards.

2. Statement of Compliance – Core Standards

As part of the national EPRR assurance process for **2024/25**, 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.

Therefore, the overall rating is: 100% Fully Compliant

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

3. Statement of Compliance – Deep Dive

The Deep dive this year relates to Cyber Security. The deep dive does not contribute to the Trusts overall rating but is intended as an indication of the NHS position and the Executive Team will receive a detailed report on this shortly.

4. Conclusion

The Trust's commitment to Emergency Preparedness remains robust and is integral to the organisation's overall resilience and operational effectiveness. This dedication is evidenced by our achievement of 100% compliance with the NHS core standards for Emergency Preparedness, Resilience, and Response (EPRR), underscoring our ability to manage and respond to a wide range of potential incidents.

Additionally, Cyber Security continues to be a critical workstream within our EPRR framework. Ongoing collaboration with the MTW Cyber Security team is a priority to maintain and further strengthen our resilience in this area. We are committed to ensuring that we achieve and sustain 100% compliance in this area as we move forward, safeguarding both our systems and the services we provide.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG 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. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
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.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	**Resilience Direct (MTW Assurance 2023):** - Sean Briggs (COO) **Resilience Direct (MTW Assurance 2024):** - Resilience Policy & Procedure (Updated since 2023) - Updated organisational and clinical structures - 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.	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 2024):** - Resilience Policy & Procedure (Updated since 2023) - Resilience Directorate Risk Register - EPRR Capabilities document (Business objectives and processes - screenshot example of section of workplan) - Resilience Committee (Meeting minutes) - Dedicated team of: 4 X Emergency planners, x1 admin, x1 Director EPRR, Security, Fire Safety (Organisational Structure/Team Structure - Functions and/or organisation, structural and staff changes) - Training Prospectus 2024	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	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 2024):** - Trust board agenda and reports (annually) - Training Prospectus 2024 - Live Horizon scanning report on Trust intranet page (Execs have access) - 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.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	**Resilience Direct (MTW Assurance 2023):** - EPRR Leads meetings reporting to ICB **Resilience Direct (MTW Assurance 2024):** - Capabilities document (work plan) - Training and exercising (included within capabilities document) - Training prospectus - Lessons Identified Document - Debrief Reports from multiple incidents - Resilience Policy & Procedure (Updated since 2023) - 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.	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):** - Comms/Strategic/Tactical Commander 24/7 On Call (On Call section included within Peoples policy pages 105 - 108) **Resilience Direct (MTW Assurance 2024):** - Evidence of Resilience committee (meeting minutes) - Resilience Policy and Procedure (Updated since 2023) - Emergency Planning 24/7 On Call - 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.	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 2024):** - Resilience policy and procedure (Updated since 2023) - Incident and exercise debrief reports reported to Resilience Committee (see committee minutes) - Lessons Identified Document - 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.	• 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 2024):** - 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 (Updated since 2023) - Weekend Plans highlighting Key Risks (weekly basis) - Head of Clinical Resilience attends KMRF Mass Fatalities Group (Minutes)	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	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 2024):** - 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 (e.g. Entry Exit System, Business Continuity and Mass Decontamination 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 including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	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):** - 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 **Resilience Direct (MTW Assurance 2024):** - Capabilities Document - All plans and procedure go to resilience committee and execs as relevant. Documented in resilience committee minutes - Resilience policy and procedure (updated since 2023)	Fully compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG 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. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
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.	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):** - Emergency Response and Recovery Plan - new for 2023 (Signed off by Resilience Committee, chaired by AEO) - Regular training with stakeholders - including ED, security etc - Competency checklists for key roles - CPD for commanders live on intranet - Strategic and Tactical Commander Aid memoirs **Resilience Direct (MTW Assurance 2024):** - Capabilities document - Exercise Analysis Grid (Evidence of exercising Major Incidents) (included within Capabilities document) - Regular Command Training (see Training Prospectus 2024 - Resilience policy and procedure (updated since 2023)	Fully compliant
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.	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):** - 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 - Live Incident Report - Adverse Weather 2022 Exec Report **Resilience Direct (MTW Assurance 2024):** - Capabilities Document - Adverse Weather Included in live Horizon Scanning Page - 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	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.	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):** - VHF Policy and Procedures (QR code included) - Infectious Disease Outbreak Plan - Pandemic Influenza plan - 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) - 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 **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans) - CBRN training and exercising evidence of staff training - 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	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):** - VHF Policy and Procedures (QR code included) - Infectious Disease Outbreak Plan - Pandemic Influenza plan - 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) - 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 **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans) - CBRN training and exercising evidence of staff training - Live Horizon Scanning report on Trust Intranet page includes infectious disease risk	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	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. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	**Resilience Direct (MTW Assurance 2023):** - 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 **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans)	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.	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 Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	**Resilience Direct (MTW Assurance 2023):** - 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 Q Pulse - MTW major incident triage video **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans)	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.	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):** - 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 **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans)	Fully compliant

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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.	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):** - Operational Lockdown Procedure - Partial Lockdown during Covid - Security Management within same directorate **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans) - Attendance at Security Committee (minutes)	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.	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):** - 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) **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans)	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.	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 • outline any staff training required	**Resilience Direct (MTW Assurance 2023):** - Emergency Response and Recovery Plan (Includes Mass Fats section) - Agreement from exec level for local level agreement to use Trust facilities **Resilience Direct (MTW Assurance 2024):** - Capabilities document (evidence of all plans) - Mass fatalities plan under KMRF - Attendance from MTW EPRR - Meeting minutes of KRF Mass Fats - Mass Fatalities Test at Tunbridge Wells Hospital	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.	• 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):** - Everbridge Alerting system for all key roles in a response - Tactical & Strategic Aid Memoirs for On-Call - Peoples policy (Pages 105 - 108) - Emergency Response and Recovery Plan - Command and Control Section (Section 1) - Visual Tools included in Command Centres (pic evidence) - Command Intranet Page with associated tools **Resilience Direct (MTW Assurance 2024):** - 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 (see weekend plan) - On Call Managers (Tactical) 24/7 365 (see weekend plan) - Resilience policy and procedure (Updated since 2023)	Fully compliant
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	• 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 - Everbridge Alerting system for all key roles in a response (RD - 'Everbridge') - Peoples policy (Pages 105 - 108) - Emergency Response and Recovery Plan - Command and Control Section (Section 1) **Resilience Direct (MTW Assurance 2024):** - On Call EPRR personnel 24/7 365 (On-Call Rota included) - On Call Executives (Strategic) 24/7 365 (see weekend plan) - On Call Managers (Tactical) 24/7 365 (see weekend plan) - Resilience policy and procedure (updated since 2023 - 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.	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):** - Command Portfolios - Training completed staff checklist - Command Trained personnel checklist - Command Training Package - Other training packages upon request **Resilience Direct (MTW Assurance 2024):** - Capabilities document (see training tab) - CBRN Portfolios - Resilience Policy Training Needs Analysis + Training Materials/Equipment - Training Prospectus 2024	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)	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. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	**Resilience Direct (MTW Assurance 2023):** - Capabilities document (see exercise tab) - 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 Mighty Oak Exercise **Resilience Direct (MTW Assurance 2024):** - Capabilities document (see exercise tab) - Training Prospectus 2024 - Comms Exercise July 2024 - EX PEARCE Part 1 - EX PEARCE Part 2 - Major Incident Debrief Report	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 involvement in exercising and incident response as well as any training undertaken to fulfil their role	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 - Command Portfolios **Resilience Direct (MTW Assurance 2024):** - CBRN 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.	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						

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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.	• 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.	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 ED 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).	• 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	• 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 - Trialling new RD logging process - Loggist video included **Resilience Direct (MTW Assurance 2024):** - Loggist training included within Training Prospectus - Providing direct support to K&M Loggist Forum (currently supporting with a digital training programme)	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.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep 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.	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)	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.	• 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):** - Emergency Response and Recovery plan outlines comms involvement and on call arrangements and Media Management - MTW Comms and Engagement Strategy - Media Stakeholders distribution list - 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' - 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 **Resilience Direct (MTW Assurance 2024):** - Weekend plan outlining On call teams including comms team - Warning and informing examples	Fully compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• 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) - 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) **Resilience Direct (MTW Assurance 2024):** - 24/7 On Call Communication Team (On Call Rota included) - All have experience, training for incidents - July 2024 Comms Exercise	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.	• 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 ER&R 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 **Resilience Direct (MTW Assurance 2024):** - Horizon Scanning Live on Intranet - Capabilities document (Use Contacts Spreadsheet)	Fully compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG 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. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• 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):** - Social Media Policy + Comms strategy - 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 **Resilience Direct (MTW Assurance 2024):** - 24/7 On Call Communication Team (On Call Rota included) - All have experience, training for incidents - Dedicate EPRR Facebook and twitter account - MTW trust Facebook account	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.	• 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 2024):** - AEO or Deputy AEO exec meeting representation (see minutes) - Senior EPRR Representation at Delivery Groups (see LHRP DG RD page for 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.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	**Resilience Direct (MTW Assurance 2024):** - EPPR leads - Nominated leads documented with LRF - Mel Marktelow - Mass Fatalities - Capabilities document outlines meeting representation including LRF - Hosted site visit from Kent & Medway Resilience Team (18.10.23)	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.	• 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 - 4 x 4 volunteers MOU - Adverse Weather Plan - Exploring mutual aid from Fire Service and Police for drones **Resilience Direct (MTW Assurance 2024):** - Mass Decontamination Exercise - Tunbridge Wells Hospital July 2024 - LHRP agreed Mutual Aid policy that we sign up to	Fully compliant
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.	• 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 - Kent Medway Information sharing agreement - Revamp of intranet system - Imminent update of external website **Resilience Direct (MTW Assurance 2024):** - LHRP agreed Mutual Aid policy that we sign up to	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.	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) **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 2023)	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.	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 - 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) - Example 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 Page evidence	Fully compliant
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).	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: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	**Resilience Direct (MTW Assurance 2023):** - 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 **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 2023)	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	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. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	**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 - BCP templates for services include all - Training and awareness videos include all **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 2023)	Fully compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG 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. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
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.	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 Post exercise/ testing reports and action plans	**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.	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.	• Business continuity policy • BCMS • performance reporting • Board papers	**Resilience Direct (MTW Assurance 2023):** - Yearly audit - BCAW Survey Monkey **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 2023)	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.	• 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):** - Section 4 of Emergency Response and Recovery Plan (Trust Strategic BC Plan) **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 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 - Regular updates to Resilience Committee including statistics charts	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.	• 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):** - Section 4 - Emergency Response and Recovery Plan (Strategic BC Plan) - 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 **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 2023) - MTW Overarching BC status spreadsheet outlining current audit based on priority services - Audit review started with MS Forms utilised to allow for service self-assessment	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.	• 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
Domain 10 - CBRN						
55	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	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) - All associated action cards in plans **Resilience Direct (MTW Assurance 2024):** - Resilience Policy and procedure (updated since 2023) - Training Prospectus (incorporates 17 sessions in total) - Equipment checks on both sites by ED departments - evidence uploaded	Fully compliant
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	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) - Specific Risk Assessments **Resilience Direct (MTW Assurance 2024):** - Staff Screening Questionnaires	Fully compliant
57	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	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	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG 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. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
58	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	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) - 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 **Resilience Direct (MTW Assurance 2024):** - RAR Aide Memoirs - Training Prospectus (Incorporates 17 sessions in total) - SECAmb Peer Reviews - Signed Off (09.08.24) - Mass Decon Info Sheet (in collaboration with KFRS) - uploaded for 2023 but being updated for 2024/2025	Fully compliant
59	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.	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) - 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
60	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	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	- 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 - All equipment present as per NHS England requirements - Equipment checklists - PRPS lists - PRPS Donning and Doffing Instructions - Decon Tent Assembly Instructions - CBRN Risk Assessment **Resilience Direct (MTW Assurance 2024):** - SECAmb Peer Reviews - Signed Off (09.08.24)	Fully compliant
61	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 where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump	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	**Resilience Direct (MTW Assurance 2023):** - 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 - RAM Gene checks by ED included - Waste management included in all plans - ED named individual responsible for covering CBRN remit and checks of equipment **Resilience Direct (MTW Assurance 2024):** - PRPS and Tent Service - evidence included on RD	Fully compliant
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	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 53	**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
63	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	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 Needs Analysis included Resilience Policy (CBRN documented) - CBRN Trained Staff list (Access Database) - Kent and Medway CBRN Standard - CBRN Training Presentations included **Resilience Direct (MTW Assurance 2024):** - Training Prospectus (incorporates 17 sessions in total) - 5 senior members of staff with the ability to deliver CBRN - All with SECAmb Train the Trainer qualifications - CBRN South East Forum attendance and minutes (Head of team is Deputy Chair) - Training materials	Fully compliant
64	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	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):** - Compulsory for all ED staff to be trained and hold a permit to work - Non-ED including non-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 **Resilience Direct (MTW Assurance 2024):** - Training Prospectus (Incorporates 17 sessions in total)	Fully compliant

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG 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. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
65	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 available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	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	Fully compliant
66	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	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	**Resilience Direct (MTW Assurance 2023):** - Exercise Springfield 1 Briefing and Debrief Report included **Resilience Direct (MTW Assurance 2024):** - Capabilities Document (Exercise & Incident Grid) - Lessons Identified document	Fully compliant

NHS Maidstone and Tunbridge Wells NHS Trust

Ratification of revised Risk Management Policy and Procedure **Chief Nurse**

The revised Risk Management Policy and Procedure is enclosed. A full review of the policy has been undertaken to incorporate the improvements identified through the Deloitte LLP's external governance review. The key responsibilities for risk at an Executive and Operational level have been clarified and the review and monitoring arrangements have been included within the policy and its Appendices.

The policy has been widely consulted upon with comments sought from members of the Executive Team Meeting, Audit and Governance Committee and the Risk and Regulation Oversight Group. The policy was approved at the Risk and Regulation Oversight Group in July, endorsed by Audit and Governance Committee in July and recommended for ratification by the Policy Ratification Committee in August.

Risk management training to support the implementation of the policy is being piloted in September and will be rolled out to relevant staff following evaluation.

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

- Risk and Regulation Oversight Group, 08/07/24
- Audit and Governance Committee, 15/07/24
- Policy Ratification Committee, 08/08/24

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Risk management policy and procedure

Target audience:	All Trust staff
Author:	Head of Risk Management **Contact details:** 07858 818804
Owner:	Chief Nurse
Division:	Corporate Services
Directorate:	Quality Governance
Specialty:	Risk
Supersedes:	Risk management policy and procedure (Version 10.0 October 2020) Risk management policy and procedure (Version 10.1, July 2021) Risk management policy and procedure (Version 10.2, March 2023) Risk management policy and procedure (Version 10.3, September 2023) Risk management policy and procedure (Version 10.4, March 2024)
Policy administrator:	Corporate Governance Assistant
Approved by:	Risk and Regulation Oversight Group, 8th July 2024
Endorsed by:	Audit and Governance Committee, 15th July 2024
Recommended for ratification by:	Policy Ratification Committee, 8th August 2024
Ratified by:	Trust Board, 26th September 2024
Review date:	TBC

This policy has been written for implementation during periods of standard functioning within the Trust. Outside of those periods (such as major incidents or national emergencies) other 'emergency' policies may be written to supersede or run alongside this policy.

Disclaimer: Printed copies of this document may not be the most recent version.
The master copy is held on Q-Pulse: Organisational Wide Documentation database
This copy – REV11.0

Document history

Requirement for document:	• ISO31000:2018 Risk Management - Guidelines • Deloitte governance review 2023 • TIAA Internal Audit Board Assurance Framework and Risk Management 2024
References (external):	1. International Organization for Standardization (ISO)(2018). ISO31000:2018 Risk Management – Guidelines 2. UK Government (2023) – The Orange Book Management of Risk – Principles and Concepts 3. HM Treasury (July 2009). Risk Management assessment framework 4. HM Treasury (December 2012). Assurance frameworks 5. Alarm (The Public Risk Management Association). The Alarm National Performance Model for Risk Management in the Public Services 6. Paul Hopkin (2018). Fundamentals of Risk Management 5th Edition
Associated documents (internal):	• Health and safety policy and procedure [RWF-OPPPCS-NC-CG1] • Incident management policy and procedure [RWF-OPPPCS-NC-CG22] • Patient safety incident response policy [RWF-GQU-PTS-POL-2] • Risk Management training needs analysis

Keywords:	Risk	Risk appetite	Risk score
	Risk management	Risk mitigation	Risk register
	Control	Assurance	

Version control:		
Issue:	**Description of changes:**	**Date:**
10.0	Completed the pro forma review process as set out in the 'Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for policies') - RWF-OPPPCS-NC-CG25. Non-material amendments made to the following: Changes to risk action levels (Red, Amber, Green) in line with updated 'Risk assessment policy and procedure' and associated 'Risk grading matrix'. Inclusion of description of Executive Team 'Red Risk' reviews. Incorporation of recommendations from internal audit. Updates to duties, job titles and committee names, structure and roles.	October 2020
10.1	Following findings of internal audit, references to Workforce Committee changed to People and Organisational Development Committee and remit of that committee with regards to risks added in section 5.5	July 2021
10.2	Removal of references to the Board Assurance Framework (BAF), following the Trust Board's decision (on 25/03/21) to withdraw the BAF (and inclusion of the alternative approach to managing the risks to the Trust's key objectives, through the Integrated Performance Report (IPR)). Replacement of Datix with more general term – risk management information system – to future proof transition	March 2023

Version control:		
Issue:	**Description of changes:**	**Date:**
	to a new system. Changes to job titles. Expansion of duties of Chief Nurse. Addition of cultural and system risks to the definition of risk and Section 6.1. Primarily associating Appendix 5 to this document due to upcoming changes in risk management information system. Removal of Appendix 7 and references to this document as this has been removed from the 'Health and safety policy and procedure'.	
10.3	Non-material changes only: • Section 3.1.2 and Section 3.7.14: updated references to the SIRO being the Chief Nurse; the SIRO is now the Executive Director Strategy, Planning & Partnerships	September 2023
10.4	Non-material changes: • Addition of the 'Next review date - timescales & guidance' as Appendix 7; although this is a new appendix, this simply provides additional detail around an existing requirement. • Removal of Guidance on risk register administration and review [RWF-OPPCS-NC-GG14] from Associated documents and references within the policy	March 2024
11.0	Rewrite of previous policy	September 2024

Maidstone and Tunbridge Wells NHS Trust

Summary for

Risk management policy and procedure

This policy outlines Maidstone and Tunbridge Wells NHS Trust (the Trust) commitment to managing risks in an effective and appropriate manner to enable the provision of the highest quality of care to its patients. Of equal relevance is the legal duty of the Trust to control any potential risk to staff and the public, as well as safeguarding the Trust's assets.

This is achieved through a robust risk management framework and process and a culture in which all staff are risk aware. All risks will be systematically identified, either proactively through risk assessment, or reactively through the reporting and investigation of incidents. Risks are managed through the Trust's risk register with time-based action plans. This policy describes the Trust's risk management framework.

Contents

1.0 Introduction, purpose and scope

Risk management is the identification, assessment and control of the impact of events to which the Trust is exposed. This process is carried out in order to minimise the likelihood and impact of adverse events and take advantage of opportunities. It covers the full range of risk exposure and therefore includes financial, regulatory, reputational, operational, cyber, clinical and non-clinical risk as well as any risk that threatens the achievement of the Trust's annual and strategic objectives.

The aim of this policy is to ensure that the Trust has a proactive and consistent approach to the management of risk.

It describes in detail the process for identifying, managing and escalating risk.

This policy applies to all members of Trust staff at all sites including students, volunteers and agency staff working on behalf of the Trust. Where contractors and third-parties on Trust sites do not have their own risk management policies this policy should be followed.

2.0 Definitions/glossary

Term	Definition
Assurance	An objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and controls processes for the organisation.
Board Assurance Framework (BAF)	A tool for the Board corporately to assure itself about successful delivery of the Trust's strategic objectives.
Controls	Controls are the many different things that are in place to mitigate risk and assist in securing the delivery of objectives. They should make it less likely to happen, or reduce (mitigate) effect if it does happen. They are arrangements and systems that are intended to minimise the likelihood or the severity of a risk. Controls are intended to improve resilience.
Current risk grading	The risk that remains after controls are considered.
Initial risk grading	The risk that an activity would pose if no controls or other mitigating factors were in place.
Internal audit	The Trust's internal auditors primarily provide an independent and objective opinion to the Trust on the degree to which risk management, control and governance processes support the achievement of the Trust's objectives.
Issue	An issue is a risk that has happened. Risks are potential future problems and issues are current problems.
Risk	Risk is the combination of the probability of an event and its consequence. Consequences can range from positive to negative.
Risk appetite	The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.
Risk management	The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or

Term	Definition
	anticipate them, and monitoring and reviewing progress.
Risk maturity	Risk maturity is a measure of how well an organisation identifies, assesses, manages and monitors risk.
Risk register	A risk register is used to document risks, analysis and responses, and to assign clear ownership of actions. The Trust has segmented its risk register into two levels: Board Assurance Framework (BAF) and operational (InPhase). See section 6.2.
Risk tolerance	Reflects the boundaries within which the executive management are willing to allow the day-to-day risk profile of the Trust to fluctuate.
Target risk grading	The desired risk level after risk actions have been implemented.

3.0 Duties

The duties and responsibilities of the various Trust committees involved in the management of risk are set out in Appendix 5 'Trust committee structure for managing risks', this includes Executive-led meetings.

Person/Group	Duties
Trust Board	Accountable to NHS England for ensuring that sound governance systems and processes are in place and that risks associated with any of its functions are managed within a robust compliance framework. They: • delegate to managers the responsibility to design, implement and monitor the policy • receive assurance regarding the effectiveness of the risk management process • ensure there are processes in place to enable complete, timely, relevant, accurate and accessible risk disclosure to stakeholders • set the risk appetite and risk tolerance of the Trust and the system for enabling risk control and contingency decisions.
Chief Executive	Has overall responsibility for risk management at the Trust as the Accountable Officer. Responsible for: • ensuring that a risk management system is established, implemented and maintained in accordance with this policy • ensuring that full support and commitment is provided and maintained in activities relating to risk management.
Chief Nurse	Provides executive sponsorship of risk management activities across the Trust, ensuring that Trust's key risk management objectives are met. • Provides executive responsibility for ensuring that risk management processes are reviewed, updated and driven forward by the Trust • Accountable to the Chief Executive and the Board for ensuring that this policy is implemented effectively and evaluated consistently.

Person/Group	Duties
Executive Directors	Have overall responsibility for the implementation of this policy. Responsible for: • the oversight of the processes for identifying and assessing risk, and for advising the Chief Executive as required • ensuring that, so far as is reasonably practical, resources are available in order to manage risk • ensuring that risks that threaten the achievement of the Trust's strategic objectives within their sphere of responsibility are actively identified and managed.
Trust Secretary	• Ensures an appropriate Board Assurance Framework (BAF) is prepared and regularly updated, and that it receives appropriate consideration at relevant committees and the Trust Board. • Co-ordinates the production of the Annual Governance Statement and ensures it adequately reflects the risk management processes within the Trust.
Director of Quality Governance	• Has operational management responsibility for the implementation of the risk management agenda through the management of the risk management and patient safety functions.
Head of Risk Management	• Responsible for development of policies and process documents with regard to risk management • Responsible for the implementation of all aspects of risk management including embedding risk management across the Trust • Supports Divisions with ensuring their risk registers are fit-for-purpose • Undertakes audits of local risks registers on a quarterly basis • Provides training, information and support for Trust staff in relation to risk management • Responsible for the continuing development of a pro-active risk management culture and practice throughout the Trust, actively promoting and ensuring good risk management practices.
Chiefs of Service	• Take a strategic approach which anticipates the future demands for doctors and the impact on patient care in order to identify potential options and risks • Support the Divisional Director of Operations and Divisional Director of Nursing and Quality (or equivalent) in the delivery of the constitutional standards to the highest standards of clinical safety, quality and experience balancing risk across their Division and Trust-wide • Oversee, with the Division leadership team, the governance, assurance and effective risk management of the Division
Divisional Director of Operations	• Responsible for ensuring maintenance of a live and relevant risk register and establish and maintain clear mechanisms within the Division to ensure that this is reviewed regularly • Escalate risks in quality and compliance to Chief Operating

Person/Group	Duties
	Officer, Medical Director and Chief Nurse as appropriate • Identify and, where possible, pre-empt significant financial issues and lead the development of strategies to mitigate the risk • Escalate issues to the Chief Finance Officer and Chief Operating Officer, as appropriate, and seek further assistance as necessary • Ensure systems are in place for delivery of plans identified through risks, incidents and other intelligence in a timely manner and that appropriate interventions are made to improve the safety and quality of service delivery and care
Divisional Director of Nursing and Quality (or equivalent)	• Oversee, with the Division's leadership team the governance, assurance and effective risk management of the Division • Take a strategic approach which anticipates the future staffing demands and the impact on patient care in order to identify potential options and risks • Support the Divisional Director of Operations, and Chief of Service in the delivery of the constitutional standards to the highest standards of clinical safety, quality and experience balancing risk across the Division
All managers	• Ensure that there is a regular multidisciplinary governance meeting at which the departmental risk register is reviewed • Align the clinical audit programme with actual and emerging clinical risks • Implement and monitor any identified risk management control or assurance measures within their designated area/and scope of responsibility. Departmental managers are expected to address low level risks as they arise • Where significant risks have been identified and where local control measures are considered to be potentially inadequate and where local resolution has not been satisfactorily achieved, managers are responsible for and have the authority to: ○ Arrange for the addition of new/emerging risks to their relevant risk area on the InPhase system ○ Bring these risks to the attention of their Directorate leadership ○ Develop and submit business cases where appropriate to support mitigation and improvements.
All staff including students, volunteers and agency staff working on behalf of the Trust	• Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks. • Resolve risks or being risks to the attention of their line manager • Undertake training and any other risk training deemed necessary for their role as described in the Trust Risk Management Training Needs Analysis • All staff have individual responsibility for engaging in risk management activities. Staff are made aware of the policy by publication on the intranet and through the performance management structure.

4.0 Training and competency requirements

The Trust has a responsibility to ensure that its staff are competent with the appropriate knowledge and skills to deliver high quality care to its service users, and that all users of its sites are safe. Risk Management training, for all staff groups, is described in the Risk Management Training Needs Analysis that can be found on the Trust intranet and the expectation is that all staff will comply and undertake the appropriate training programme.

Training will be appropriate to the staff groups receiving it and commensurate with their risk management responsibilities. The Risk Management Training Analysis will identify, how, where and when risk training will take place. This will be approved by the Risk and Regulation Oversight Group and available for staff on the Trust intranet.

5.0 Risk appetite and tolerance

Risk appetite is the level of risk that an organisation is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

Risk tolerance is the predetermined upper level of risk that can be assigned to an objective. It is the level of residual risk below which the Board expects sub-committees to operate and management to manage. Breaching the tolerance requires escalation to the Board for consideration of the impact on other objectives, competing resources and timescales.

The Trust's risk appetite and risk tolerance levels are set and reviewed by the Trust Board on an annual basis, or sooner, if required.

6.0 Risk management process

6.1 Establishing objectives and context

Effective risk management requires a thorough understanding of the context in which the Trust and its Divisions operate. The analysis of this operating environment enables managers to define the parameters within which the risks to their outputs need to be managed.

The context sets the scope for the risk management process. The context includes strategic, organisational and risk management considerations. Strategic context defines the relationship between the organisation and its environment. Factors that influence the relationship includes financial, operational, competitive, political (public perceptions / image), social, cultural and legal. The definition of the relationship is usually communicated through analysis frameworks such as the SWOT (organisational Strengths, Weaknesses, Opportunities and Threats) and PESTLE (Political, Economic, Social, Technological, Legal and Environment). Other tools can also be used. A formal process of horizon scanning should be undertaken by the Trust Board on an annual basis.

Whether a new risk has been identified or staff need to know what to do next, clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk, it must first be understood what the objectives/outcomes to be achieved are. By clarifying the objectives, it can be identified whether there is a risk to manage.

All staff are responsible for bringing to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility of horizon scanning and to formally communicate matters in the appropriate forum relating to their areas of accountability.

6.2 Identifying risks to objectives

Risk identification involves examining all sources of potential risk that the Trust may be exposed to from the perspective of all stakeholders. When identifying potential risk, there are two key approaches: top down and bottom up approach.

- **Top down (identifying strategic risk):** strategic risk management is undertaken through executive management and committee structures and enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trust's objectives.

  The Board Assurance Framework (BAF) provides clarity over the risks that may impact on the Trust's ability to deliver its strategic objectives. This simplifies Board reporting and prioritisation, which in turn allows more effective performance management. The BAF, which is reported to the Board at least four times a year, also facilitates the preparation of the Board agenda and reporting of key information to the Board. At the same time, it records structured positive assurances about where risks are being managed effectively and objectives are being delivered.

  Any new strategic risks will be considered and approved by the Board before being accepted as such and added to the BAF. The Board will also consider for approval any recommendation to remove strategic risks from the BAF.

  The populated BAF articulates clearly the key strategic controls in place to ensure strategic risks are being managed and the sources of evidence, or assurance, that the controls are operating effectively to secure delivery of the Trust's strategic objectives.

  Individual Executive Directors review their BAF entries at regular intervals to monitor progress against actions and to identify changes that need to be reported in the next BAF update.

  The Board sub-committees receive the BAF on a regular basis and provide the Trust Board with assurance that the correct risks are identified on the BAF within their scope of responsibility, that they are assured the risk is being appropriately managed and that the controls and actions are appropriate to mitigate the risk to a tolerable level within a specified timeframe.

- **Bottom up (identifying operational risk):** operational risk management activity is supported by staff working in adherence to organisation's policies and procedures. Operational risks may present themselves, via incidents, complaints, claims, patient feedback, safety inspections, external review, ad-hoc assessments, non-compliance with commissioned regulated standards, risks to accreditation of services etc. which may impact on the Trust's ability to deliver its objectives.

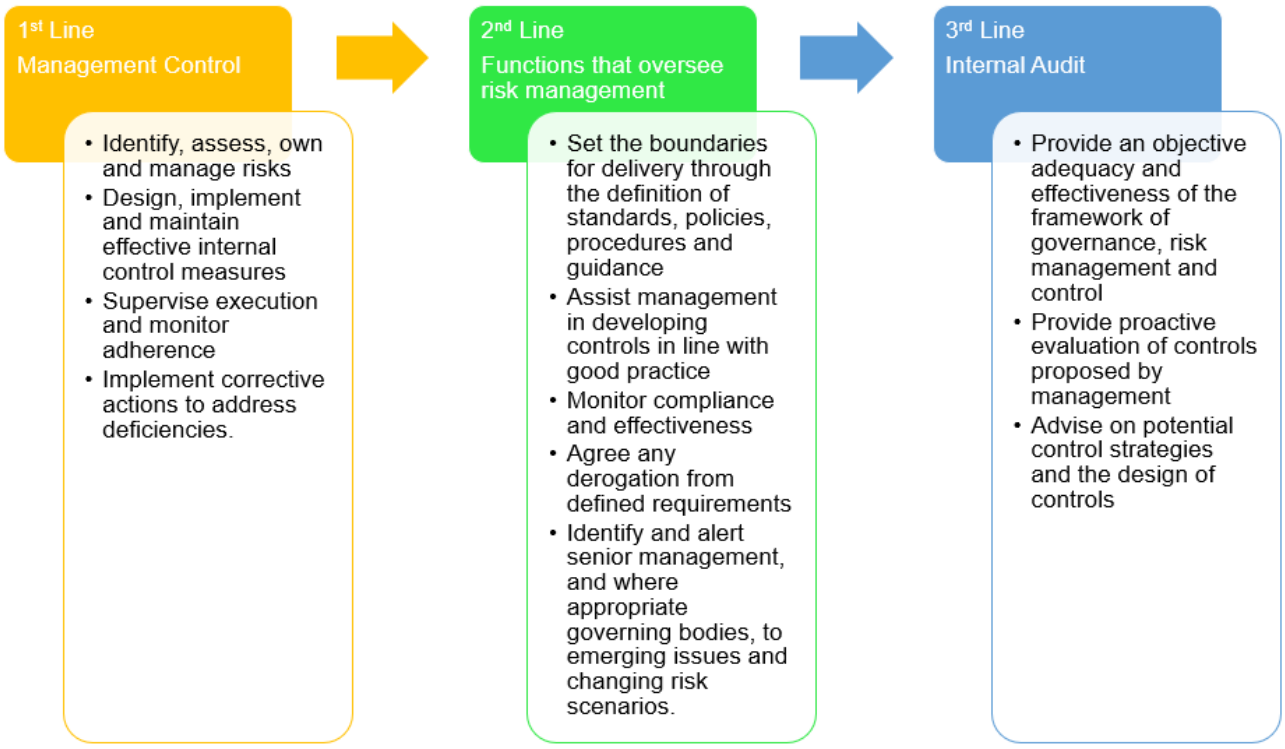
The Trust has segmented its risk register into two levels: Board Assurance Framework (BAF) and operational (InPhase). This enables the Board to take a holistic view of the Trust's risk profile through assessment of risk across the Trust as well as taking a 'bottom up' perspective from local operational areas. Through the risk grading matrix identified at Appendix 4 the Board is able to prioritise attention on those risks that have the greatest potential to impact the Trust's strategic direction.

6.2.1 **Analyse the risk:** identify the controls (currently in place) that deal with the identified risks and assess their effectiveness. Controls are the framework of processes, policies, procedures, activities, devices, practices, or other condition and/or actions that maintain and/or modify risk. They should make it less likely to happen, or reduce (mitigate) the effect if it does happen. Controls may be actions that are repeated, either regularly or in response to events, or they may be one-off actions or decisions.

Based on this assessment, the risks must be analysed in terms of likelihood and consequence. The risk grading matrix at Appendix 4 should be used to assist in determining the level of likelihood and consequence, and the current risk level (combination of likelihood and consequence).

6.3 Providing assurance

Once controls are identified, the assurance record will provide confidence and evidence (internal and/or external) of the effectiveness of each control in managing the risk (that what needs to be happening is actually happening in practice). Assurance of the effectiveness of the control should be provided within the InPhase system.



6.3.1 **Evaluate the risk:** this stage of the risk management process determines whether the risks are acceptable or unacceptable. This decision is made by the person with the appropriate authority. A risk that is determined as acceptable should be monitored and periodically reviewed to ensure it remains acceptable.

A risk deemed unacceptable should be treated (see 6.3.2). In all cases the reasons for the decision should be documented by the risk owner within InPhase for future reference.

6.3.2 **Treat the risk:** the range of risk treatment options or combination of risk treatments will vary dependent upon each risk and the costs and benefits applied to each option.

The 5Ts provide an easy list of treatment options available to anyone considering how to manage (control) risk:

- **Tolerate:** the likelihood and consequence of a particular risk happening is accepted
- **Treat:** work carried out to reduce the likelihood or consequence of the risk (this is the most common action)
- **Transfer:** shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party
- **Terminate:** an informed decision not to become involved in a risk situation, e.g. terminate the activity
- **Take the opportunity:** actively taking advantage, regarding the uncertainty as an opportunity to benefit

Potential mitigation options are developed according to the selected treatment strategy. The selection of the preferred mitigation options considers factors such as the cost effectiveness. The determination of the preferred treatments also includes the documentation of implementation details (e.g. responsibilities, a timetable for implementation and monitoring requirements). The intention of these risk treatments is to reduce the risk level of unacceptable risks to an acceptable level (i.e. the target risk level).

There will be risks where the target has been attained with all current mitigating actions completed but a level of risk remains and there is little or no scope for further mitigation in the immediate future. These risks are considered to be tolerated risks and should be closed. Closed risks remain available on the InPhase system.

6.3.3 **Monitor and review:** Managers are required to monitor the effectiveness of risk treatment and have the responsibility to identify new risks as they arise and treat them accordingly. Managers are required to report on the progress of risk mitigation at regular intervals. The person who has the responsibility for risk mitigation is expected to provide feedback to the risk owner on progress being made. Monitoring should consider the potential effect of the implementation of mitigation and any potential risk causes and risk effect obstacles.

6.3.4 **Communicate and consult:** involving key individuals/groups that may be affected by the risk can help with gaining an understanding of their perspective and ensure commitment and buy-in to changes that may be required for treatment. Communication may occur at any phase of the process and particularly when authority for decision is required.

7.0 Risk escalation

To ensure monitoring and review of risks and their management, the following processes must be applied:

- Directorates or departments should complete the 'Add New Risk' form on InPhase. Once this form is saved it is submitted for review by the Trust Risk Team. Any risks scored at 15+ require Divisional agreement from the leadership team before being submitted for approval to the Risk Team.
- The Trust Risk Team approve the risk description, the strategic theme, controls in place, risk scoring and actions required. The Risk Team will discuss any areas for clarification or amendment with the risk owner prior to the risk being added to the Trust Risk Register. The Risk Team will also align the risk to a reporting committee within the governance structure to ensure appropriate oversight.
- If the risk has an agreed current rating of 15 or higher by the Divisional leadership team this will be escalated to the Executive Team Meeting for notification of the risk at this score prior to escalation to the Risk and Regulation Oversight Group.
- It is the responsibility of the risk owner to ensure the risk is updated according to the frequency specified in section 8.0 of this policy. Reminders will be sent by the Risk Team to the risk owner on a monthly basis. Non-compliance will be escalated to the Risk and Regulation Oversight Group at each meeting.
- For each risk, the controls, assurances and actions will be allocated a responsible owner to ensure risk management actions are delivered as planned.
- Where risks affect more than one area (Directorate/Division/department/site) assigning a risk control or action to another control owner must only be done by mutual agreement and only to those who are capable of controlling the risk. In the event there is no clear agreement, the matter should be escalated to the Head of Risk Management for a decision on where the risk control or action should sit. No changes in this regard can be made on the InPhase system until clarity on the assignment is agreed.
- Monthly reviews of Divisional risk registers will take place at the Divisional Board (or quality and governance equivalent) meeting before being presented to the relevant executive-led meetings by the Divisional leadership team, e.g. Patient Safety Oversight Group, Capital Steering Group, Experience of Care Oversight Group which includes progress of control measures, assurances and action plans.
- The relevant executive-led meetings will provide assurance to the Board sub-committees that key risks are being appropriately managed and escalate any risks that they consider to be significant, either through their scoring or effect on multiple Divisions.
- The Board sub-committees will escalate any risks outside of the risk appetite through a Chair's assurance report to the Trust Board. Risk management responsibilities of the Board sub-committees can be found at Appendix 5.

- A report of risks rated 15+ will be provided to the Trust Board six-monthly by the Head of Risk Management. The Board Assurance Framework will be reported to the Trust Board quarterly by the Trust Secretary.
- The Audit and Governance Committee provide assurance to the Trust Board that the risk management processes are working effectively. They receive the Board Assurance Framework from the Trust Secretary, a report of risks rated 15+ and an overview of Board sub-committee risk activity on a quarterly basis from the Head of Risk Management.

8.0 Risk review and monitoring

The following minimum periods for review have been set for all risks and are aligned to the current risk score.

Risk score	Priority	Review period
1 – 6	Low	**Quarterly review** – must involve Directorate leadership
8 – 12	Moderate	**Two-monthly review** – must involve Directorate leadership
15 – 16	High	**Monthly review** – must involve Divisional leadership
20	High	**Weekly review** – minimum by member of Divisional leadership
25	High	**Daily review** – must involve Executive director

All risks must be reviewed and updated in line with these timeframes on InPhase. More frequent review may be undertaken as necessary/required/directed by Division.

During the review risk owners should review the risk description to ensure this still reflects the current risk. If the risk has fundamentally changed, the risk should be closed and a new risk opened, linking the closed risk to the new risk opened to enable audit.

The controls in place should be reviewed to determine whether they remain and assurance given as to their effectiveness. The current risk score should be reviewed to determine whether any additional controls or completed actions have reduced either the impact of the risk or the likelihood of the risk occurring.

Any relevant documents should be added to support the ongoing management of the risk; this could be minutes of meetings, standard operating procedures and performance reports. The outstanding actions should be reviewed to determine whether these are adequate to reduce the risk to its target score or whether additional action is required.

Progress updates against individual actions should be included as part of the review. An overarching update should be made to the 'progress notes' section of the risk on InPhase, including any progress that has been made to mitigate the risk and any amendments that have been made to the risk.

The next review date should be updated in line with the guidance included in the table above. Once all possible risk actions have been implemented and the target risk achieved or the event has passed and the risk mitigated, the risk owner should recommend closing the risk on the InPhase system to the relevant group as identified in section 7.0. More detailed guidance can be found in Appendix 6.

9.0 Risk de-escalation

If, once reviewed, the controls or completed actions mean that the impact of the risk or the likelihood of the risk occurring has been reduced the score of the risk should be updated to reflect this reduction. The level of assurance should be reviewed and effectiveness of the risk control documented within the risk.

The change in score can be completed by the risk owner, however, this should be presented to the next Divisional Board (or quality and governance equivalent) meeting. The reason for the change in score should be documented within the 'progress notes' of the risk on InPhase.

10.0 Risk closure

Risks should be closed when

a) the risk has materialised (e.g. the risk has become an issue and is managed as such)
b) the risk is tolerated as all reasonable actions have been undertaken to mitigate the risk to an acceptable level (e.g. budget constraints mean that there are no further actions that can be undertaken and the controls in place reduce the risk to a tolerable level)
c) the risk has been transferred to another service or provider (e.g. a contract has been awarded for service delivery by another organisation)
d) the activity causing the risk has been stopped (e.g. industrial action has ceased)

Clarification can be sought from the Head of Risk Management if further guidance is needed on whether to close a risk. The decision to close a risk rated 15+ should be made by one of the committees outlined in Appendix 5. The decision to close a risk of 12 or below can be made by the risk owner, however, this should be presented to the next Divisional Board (or quality and governance equivalent) meeting. When closing a risk, the date of closure should be documented on InPhase along with a reason for the closure of the risk. When closing a risk, all control measures should be included within the risk and how the Trust gains assurance documented so that if the risk exposure changes the risk can be reopened or redefined. Consideration should also be given as to the current score of the risk and whether this now meets its target score. Where a risk is closed and the target score has not been met the reason for this should be documented within the closure statement.

Each Division should review closed risks on at least an annual basis to identify whether the risk exposure has changed. This should be completed in line with business planning to enable any investment to be sought to reduce the risk exposure for the Division.

11.0 Key risk indicators (KRIs)

An essential element in effective risk management is the integration of performance indicators within the risk framework so that data analysis can be used routinely to make risks and their mitigation visible.

KRIs need to be identified for risks that threaten the strategic objectives of the Trust (where applicable) to assess the likelihood and impact of the risk. These should be identified by the risk owner and recorded on InPhase.

KRIs are measures that provide insight into potential events. They can simply be described as an early warning signal for the risk identified. They serve as an indicator that the likelihood of the risk occurring may increase and may also provide insight into the impact of the risk. In order to identify the KRI, it is important to have a clear understanding of the risk and the factors affecting it.

Examples may include sickness absence levels, staff survey results, clinical audit results, performance against the constitutional standards, internal audit results.

Appendix 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy to the Corporate Governance Assistant (CGA) who will upload it to the policy database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'. Notification of the posting is included on the intranet 'News Feed' and in the Chief Executive's newsletter.
- On reading of the news feed notification, all managers should ensure that their staff members are aware of the new publications.
- This policy must be ratified by the Trust Board.
- Implementation will be progressed through a process of continuous improvement. This will continue to ensure that once an acceptable standard is reached, it is maintained and improved. The KPIs documented within this Appendix (see 2.0) will be monitored through the Trust's governance structure.

2.0 Monitoring compliance with this document

- Risk management key performance indicators will be monitored through the Risk and Regulation Oversight Group at each meeting and the Audit and Governance Committee at each meeting. These will be reported by the Head of Risk Management. The key performance indicators being monitored are:
    - Percentage of red risks reviewed and progress notes completed within review timeframes
    - Percentage of risks below 15 with review overdue
    - Percentage of risks with open action plans
    - Percentage of open actions beyond target date
    - Percentage of risks open for over 12 months
- Reporting arrangements will be reviewed annually when reviewing the Terms of Reference of the Trust Board.
- Ensuring that strategic risks are assessed, reviewed and aligned with the annual objectives will be assessed by an audit of process by the Trust's internal auditors annually.
- Risk management training compliance will be reported to the Risk and Regulation Oversight Group and Audit and Governance Committee annually by the Head of Risk Management.
- A formal review of the Trust's risk management maturity will be conducted annually and reported to the Audit and Governance Committee by the Head of Risk Management.

3.0 Review

This policy and all its appendices will be reviewed at a minimum of once every four years.

4.0 Archiving

The policy database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

Appendix 2

CONSULTATION ON: Risk management policy and procedure
Version no.: 11.0
Please return comments to: Head of Risk Management
By date: 25 June 2024

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff must be included in all consultations:				
Corporate Governance Assistant	11/06/24 15/07/24	14/06/24 26/07/24	N Y	N Y
Senior Anti-Crime Manager (tiaa)	11/06/24			
Anti-Crime Specialist (AE)	11/06/24			
Anti-Crime Specialist (BD)	11/06/24			
Sunrise EPR Team	n/a			
Clinical Audit Lead	11/06/24	27/06/24	N	N
Health and Safety Manager	11/06/24			
Head of Fire, Safety and Environment	n/a			
Chief Pharmacist	n/a			
Formulary Pharmacist	n/a			
Staff-Side Chair	n/a			
Head of Patient Concerns	n/a			
Emergency Planning Team	n/a			
Head of Staff Engagement and Equality	11/06/24			
Healthcare Records Manager	n/a			
All individuals listed on the front page	11/06/24			
Authors of other policies with a content overlap	n/a			
The relevant lead for the local Q-Pulse database	n/a			
All members of the approving committee (Risk and Regulation Oversight Group)	11/06/24			
Other individuals the author believes should be consulted				
Director of Quality Governance	11/06/24			
Chief Executive	11/06/24			
Chief Nurse	11/06/24			
Executive Directors	11/06/24			
Trust Secretary	11/06/24			
Chiefs of Service	11/06/24			
Divisional Directors of Operations	11/06/24			
Divisional Directors of Nursing and Quality	11/06/24			
Divisional Head of Quality and	11/06/24	13/06/24	Y	Y

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Governance				
All members of Audit and Governance Committee	11/06/24			
All members of Executive Team Meeting	11/06/24			
The following staff have given consent for their names to be included in this policy and its appendices:				

Appendix 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of policy	Risk management policy and procedure
What are the aims of the policy?	To ensure that the Trust has a proactive and consistent approach to the management of risk.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination for the groups listed below (yes/no)? If yes give details.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
Pregnant women and individuals, or those on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
Armed Forces Community status (including: serving member of the forces; reservist; veteran; immediate family member of someone who has served or is serving)	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	*N/A*
When will you monitor and review your equality impact assessment?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your equality impact assessment?	As Appendix 3 of this document.

Further appendices

The following appendices are published as related links to the main policy on the policy database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Risk grading matrix	RWF-OWP-APP51	Risk assessment policy and procedure [RWF-OPPPCS-NC-CG6]
5	Trust committee structure for managing risks	Unique ID	This policy
6	Next review date – timescales and guidance	RWF-GQU-RSK-APP-3	This policy

Trust committee structure for managing risk

The following describes how responsibilities of different Trust committees for risk management are executed.

Trust Board

The Trust Board is ultimately accountable for ensuring that the Trust is complying with its Terms of Authorisation, which includes its arrangements for integrated governance and effective risk management. The Trust Board and the Chief Executive are also responsible for ensuring that an open and just culture is developed and sustained throughout the Trust; there is an essential foundation for effective risk management. The Trust Board receive the Board Assurance Framework (BAF) in full quarterly, from the Trust Secretary.

Audit and Governance Committee

Reporting to the Trust Board, the Audit and Governance Committee has responsibility for monitoring and review of the risk, control and governance processes which have been established in the organisation, and the associated assurance processes. This is in order to help the Trust Board be fully assured that the most efficient, effective and economic risk, control and governance processes are in place and the associated assurance processes are optimal. The Audit and Governance Committee receive the BAF from the Trust Secretary and a report of risks rated 15+ from the Head of Risk Management at each meeting.

Finance and Performance Committee

Reporting to the Trust Board, the Finance and Performance Committee has responsibility for reviewing the financial strategy and for monitoring and review of the risk, control and governance processes associated with financial management of the Trust. The outcomes of discussion on any additions to or changes in the evaluation of financial risks are noted by the Finance and Performance Committee and incorporated into the BAF or the Trust Risk Register.

Quality Committee

This committee reports to the Trust Board and is responsible for ensuring that the Trust 'Risk management policy and procedure' is implemented in relation to quality issues. It provides control, governance and assurance to the Trust Board on quality related risks. The red risks relating to quality and patient safety are reviewed by the Quality Committee. A report is provided at regular intervals by the Head of Risk Management.

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People and Organisational Development Committee

Reporting to the Trust Board, the People and Organisational Development Committee has responsibility for raising concerns to the Board on any workforce risks that are significant or require escalation. They also consider the control and mitigation of workforce-related risks and provide assurance to the Trust Board that such risks are being effectively controlled and managed.

Executive Team Meeting (ETM)

The ETM is the senior management committee within the Trust. The ETM has specific duties with respect to risk management and internal control to:

- Ensure that all key assurance and risk issues identified through the work of the group are identified and recorded
- Escalate any risks of corporate significance or seriousness to the Trust Board, for consideration and/or action
- Review and endorse the Trust's Annual Governance Statement, prior to this being considered at the Audit and Governance Committee and Trust Board
- Undertake regular review of risks rated 15+, and the action/s being taken to mitigate such risks

Risk and Regulation Oversight Group

This Group reports to the Trust's Audit and Governance Committee that ensures effective oversight and assurance in relation to risk and regulatory compliance. It ensures the Trust is operating an effective risk management system through the oversight and monitoring of the management of risks on the risk register. It will receive at each meeting reports from Divisions and corporate departments in relation to the management of risk and escalate to the Audit and Governance Committee as necessary.

Health and Safety Committee

This committee meets the requirements of the Health and Safety at Work Act 1974 and reports to the Risk and Regulation Oversight Group. The Strategic Health and Safety Committee acts as the operational committee for supporting the management of health and safety risks.

Divisional Strategy Deployment Reviews

The Divisions are responsible for ensuring systematic and effective risk management takes place (including recording of risks on InPhase) across the areas within their sphere of responsibility; ensuring that risks are brought to the attention of the Strategy Deployment Reviews and either managed within their resources or escalated where appropriate to the Risk and Regulation Oversight Group or Executive Team Meeting.

Patient Safety Oversight Group

This Group reports to the Quality Committee. It receives risks within its scope relating to patient safety on a quarterly basis and provides assurance of the management of these risks and any matters for escalation to the Quality Committee through a highlight report.

Experience of Care Oversight Group

This Group reports to the Quality Committee. It receives risks within its scope relating to patient experience on a quarterly basis and provides assurance of the management of these risks and any matters for escalation to the Quality Committee through a highlight report.

Capital Steering Group

The Capital Steering Group receives a monthly report of all risks that require capital investment to ensure this aligns with the capital programme.

Next review date - timescales and guidance

1. The following minimum periods for review have been set for all risks and are aligned to the current risk score.

Risk score	Priority	Review period
1-6	Low	**Quarterly review** - must involve Directorate leadership
8-12	Moderate	**Two-monthly review**- must involve Directorate Leadership
15-16	High	**Monthly review** – must involve Divisional leadership
20	High	**Weekly review** - minimum by member of Divisional leadership
25	High	**Daily review** – must involve Executive Director

2. All risks must be reviewed and updated in line with these time frames on InPhase. More frequent review may be undertaken as necessary/required. The next review date must be updated as this measures progress.

3. When undertaking a risk review staff must consider the following questions:

Question	Action
Risk description – does the risk still fit the current situation?	Update the risk description / controls to reflect the change. If the risk has significantly changed, close the risk and raise a new one.
Has the risk occurred?	What was the impact? Have any new issues or incidents arose as a result of the risk occurring?
Have there been related incidents, complaints or claims?	Review the risk score.
Are the controls in place effective enough to reduce the risk?	Review the risk score.
Have mitigating actions been completed? If so how effective are they in reducing the risk?	Review the risk score.
Target score - Is the target score still achievable or has it been reached?	Change to target score or closure of the risk.

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NHS Maidstone and Tunbridge Wells NHS Trust

Board Assurance Framework (BAF) Development Update — Chief Nurse

The Trust Board agreed to re-establish a dedicated Board Assurance Framework (BAF) as part of our response to the Deloitte LLP external governance review earlier this year. A task and finish group met to develop proposals for the board, taking account of discussions on this subject in developing the Deloitte action plan. This group comprised:

David Morgan – Chair of the Audit and Governance Committee
Miles Scott – Chief Executive
Steve Orpin – Deputy Chief Executive / Chief Finance Officer
Jo Haworth – Chief Nurse
Rachel Jones – Director of Strategy, Planning and Partnerships
Helen Callaghan – Director of Quality Governance
Rhiannon Adey – Head of Risk Management

The attached slides summarise the approach developed by the task and finish group. The Head of Risk Management will work with the New Trust Secretary to develop a draft BAF for consideration at the October Trust Board meeting.

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

Board Assurance Framework

August 2024

Author: Rhiannon Adey – Head of Risk Management

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Purpose

The Board Assurance Framework is an agreement between the board and the trust's management which summarises:

- The organisation's strategic objectives
- The risks to achieving these
- The controls in place and further mitigations to minimise the likelihood or effect of those risks materialising
- The assurances the board needs to be confident that the controls are operating effectively

The Board Assurance Framework is the key document that should be driving the board and committee agendas. Provides the board with a simplified approach to reporting and prioritisation and drive the board's cycle of business. Encourage individuals and groups within the organisation to proactively think about their objectives, with board agendas focused on strategic and reputational risks rather than operational issues. The BAF is a key tool to help boards identify when they should seek assurance or reassurance

Difference between the Board Assurance Framework and the Trust risk registers

Board Assurance Framework	Operational risk registers
Comprises strategic risks aligned to the strategic objectives	Comprises operational risks arising from the trust's day-to-day activities
Risks are trust-wide in their scope and impact	Some risks are trust-wide in nature, others are specific to particular services but have been escalated because of the high level of risk
Risks are identified, defined and assessed by the executive team or board (top down)	Risks are usually identified by services or departments themselves and escalated to corporate level (bottom up)
Decision to include risks in the BAF, remove or adjust risk scores, is taken by the Board	Escalation and de-escalation of risks is decided by the Risk and Regulation Oversight Group
Board assurance committees review risks relating to their remit in detail	Board assurance committees may receive an extract of risks relevant to their remit and discuss risks by exception

Format

Principal risk (what could prevent us achieving this strategic objective)	The failure to deliver the Trust financial plan related inability to deliver our cost improvement programme resulting in an inability to invest in developing services					**Strategic objective**	Sustainability
Lead committee	Finance and Performance	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Financial
Lead director	Steve Orpin	**Consequence**	5 High	3 medium	2. low	**Risk appetite**	Low
Initial date of assessment	20/05/2024	**Likelihood**	5 High	3 medium	3 Low		
Last reviewed		**Risk rating**	25	9	6		
Last changed							

Insert SPC

Strategic threat (What might cause this to happen)	**Primary risk controls** (what controls / systems and processes do we already have in place to assist us in managing the risk and reducing the likelihood /impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to deliver our cost improvement programme	We have some CIPs already identified which are being further developed. We are working on a non recurrent bridging plan recognising we are unlikely to realise a full year impact of recurrent schemes. We are focussing on generating elective income and on pathway transformation CIP programme partially developed PMO support to Divisions to deliver CIP Strategy Deployment Reviews monthly	To develop CIPs to meet the required level (£37m) with strong delivery plans	To initiate a financial recovery programme across the organisation. To consider further internal controls to reduce unbudgeted spend. To focus on elective activity income Fully develop CIP Programme	Integrated Performance Report, Trust financial posiiton monthly reports, CIP Programme reporting monthly to the CFO and Exec Team. Finance and Performance Committee meet monthly and provide assurance to the Board Strategic Deployment Review meetings held with Divisions monthly	CIPs not all yet identified - the financial recovery plan is being implmented. Month 2 overall financial position off plan - month 3 forecast with mitigation plans being developed to deployment during the year should that be necessary.	

Process

- Strategic objectives identified
- Board workshop undertaken to identify risks to achievement
- Horizon scanning (internal and external) informs the strategic context

- Executive Directors take ownership of the strategic risk and identify existing controls, assurances and any gaps
- Identify actions to be undertaken to address gaps in control and assurance

- Board of Directors approve the Board Assurance Framework
- Board Assurance Framework is used to set agenda to ensure focus on strategic risk

- Strategic objectives (and the related strategic risks) are aligned with the Board sub-Committees
- Board sub-Committees receive the Board Assurance Framework and scrutinise the assurance that the risk is appropriately mitigated

- Board sub-Committees provide assurance to the Board that the strategic risks are appropriately identified and whether it is assured that the risks are appropriately mitigated
- Board receives the Board Assurance Framework quarterly (alongside the IPR to develop an accountability framework that highlights where future performance against the BAF is compromised)

NHS Maidstone and Tunbridge Wells NHS Trust

ASSURANCE STATEMENT IN RESPONSE TO THE PATIENT SAFETY AND QUALITY OF CARE IN PRESSURISED SERVICES LETTER	CHIEF NURSE

Executive Summary.

The purpose of this report is to provide assurance to the Trust Board in response to the "Maintaining focus and oversight on quality of care in pressurised services" letter to all Integrated Care Board's and NHS Trusts, dated 26th June 2024.

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

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

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

Introduction and Background

The pressures on the healthcare system, particularly in the NHS, are a result of several key factors, including rising patient demand, inefficiencies in patient flow, and gaps in both health and social care capacity. These issues can make it challenging to deliver the level of care patients expect and deserve, despite the incredible efforts of our staff.

At MTW (Maidstone and Tunbridge Wells NHS Trust), it's clear that the aspiration is to provide care that meets the highest possible standards. However, due to the current challenges in the system, the experience and outcomes for patients may fall short of some of these standards at times.

The purpose of this paper is to offer assurance that quality remains central to service delivery at Maidstone and Tunbridge Wells NHS Trust (MTW). This commitment to quality extends across all stages of patient care, from admission to discharge, with a focus on optimising patient outcomes through effective service delivery.

The letter from NHS England outlines a number of interventions that if delivered ensures a continued focus on care and experience for our patients in our most challenging times. The key areas are addressed below.

Key Areas of Focus:

1. Alternative pathways & hospital avoidance
2. Appropriate Streaming to maximise flow
3. OPEL Framework & Patient Care in Undesignated Areas
4. Whole system response

	Topic	Assurance
1	**Alternatives to ED attendance & admission to maximise hospital flow**	Embedded Hospital Avoidance Team that supports multi agency working including VW and Hospital at Home community nurses
		Single Point of Access (SPoA)
		The Single Point of Access (or SPoA) redirects patients to the correct pathway that prevents admission to hospital by referring directly to Same Day Emergency Care (SDEC) areas and community teams. The SPoA requires joint working from multiple agencies including SECAmb/ KCHFT and the MTW joint clinical hub
		Same Day Emergency Care (SDEC's)
		SDEC's across both sites taking direct admissions from SECAmb including • Frailty: Open 7 days 8am – 8pm with senior therapy support

		• Ambulatory Emergency Care • Surgery Assessment Unit • Orthopaedic Assessment Unit • Oncology • EGAU • Stroke assessment • Paediatric
		Virtual Ward (VW)
		Acute model to support acutely unwell patients in their own home. VW supports patient from multiple speciality pathways 24/7 and releases acute capacity for the sickest patients. Designated frailty virtual ward pathway to support patients who reside in 24-hour care/residential/nursing homes to return home with face-to-face input from the Home Treatment Service and remote monitoring.
2	**Appropriate Streaming to Maximise Flow**	SAFER bundle principles imbedded in practice with a programme of work to improve board rounds.
		Front door streaming and early speciality review in ED
		Introduction of digital bed management to support patients getting into right bed first time
		Discharge before noon programme to support ED safety and ensure capacity earlier during the day
		Clear data on patient discharge pathways with clear escalation processes for delays
3	**OPEL Framework & Patient Care in Undesignated Areas**	System calls at 8.15am to ensure joint up working across ICB's
		Review & Declaration of Operational Pressure Escalation Levels (OPEL) status at each site meeting with a 4-hourly review in line with NHS guidelines.
		Standard Operating Procedure in place outlining criteria & action plan for corridor care with clear exclusion criteria to ensure patient safety
		Corridor Care Standard Operating Procedure (SOP)
		Digital systems are also utilised to ensure that appropriate patients are highlighted for boarding
		'Plus one' guidelines in place. Initiated in line with OPEL framework and site safety and agreed at director level.
		Clear monitoring of patients who are being nursed in undesignated areas with matron oversight to ensure patients receive care in a dignified manner.

5	**Whole system response**	Multiple creating capacity events throughout the year ahead of the bank holidays with multiple agencies invited to review patients to facilitate discharge
		Multi agency surge planning
		Daily OCC system calls
		Better Use of Beds programme to ensure care given close to home
		Daily multi-disciplinary transfer of care hubs including Social Services, IDT & external agencies
		Twice weekly meetings are in place to review patients in hospital over 14 days, with additional Pathway 0 meetings led by the Tactical Commander.
6	**Effective Leadership**	Daily oversight of flow and patient safety by site director
		Daily safety Huddles
		Flow quality metrics reported at Executive Trust Meetings
		Escalations available across the 4 daily site meetings, with support from divisional management & tactical commands

Update on the New Committee Structure **Chief Nurse**

The enclosed report provides information on the progress of the Trusts implementation of a revised quality governance committee structure. As the Board are aware, this work was undertaken in response to the feedback from the Deloitte 2023 Trust governance review. This review specifically recommended a series of new executive chaired "oversight committees" be implemented, to ensure that identified issues have a robust improvement plan before being tabled at a NED chaired assurance committee.

Progress continues to be made since the last update and each new committee has met bar the "Patient Outcomes Oversight Group" which is due to have its inaugural meeting in October 2024. An additional progress review and discussion was held at Quality Committee Deep Dive in August 2024. Of note attendees were assured by the progress made to date

Overall there has been a positive reception to the new oversight groups and it is expected this work will become business as usual activity from November 2024, removing the need for further specific implementation updates to the Board.

The Board of Directors are asked to consider whether they are assured by the work undertaken to date and also as to whether they require any further future updates on this workstream.

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

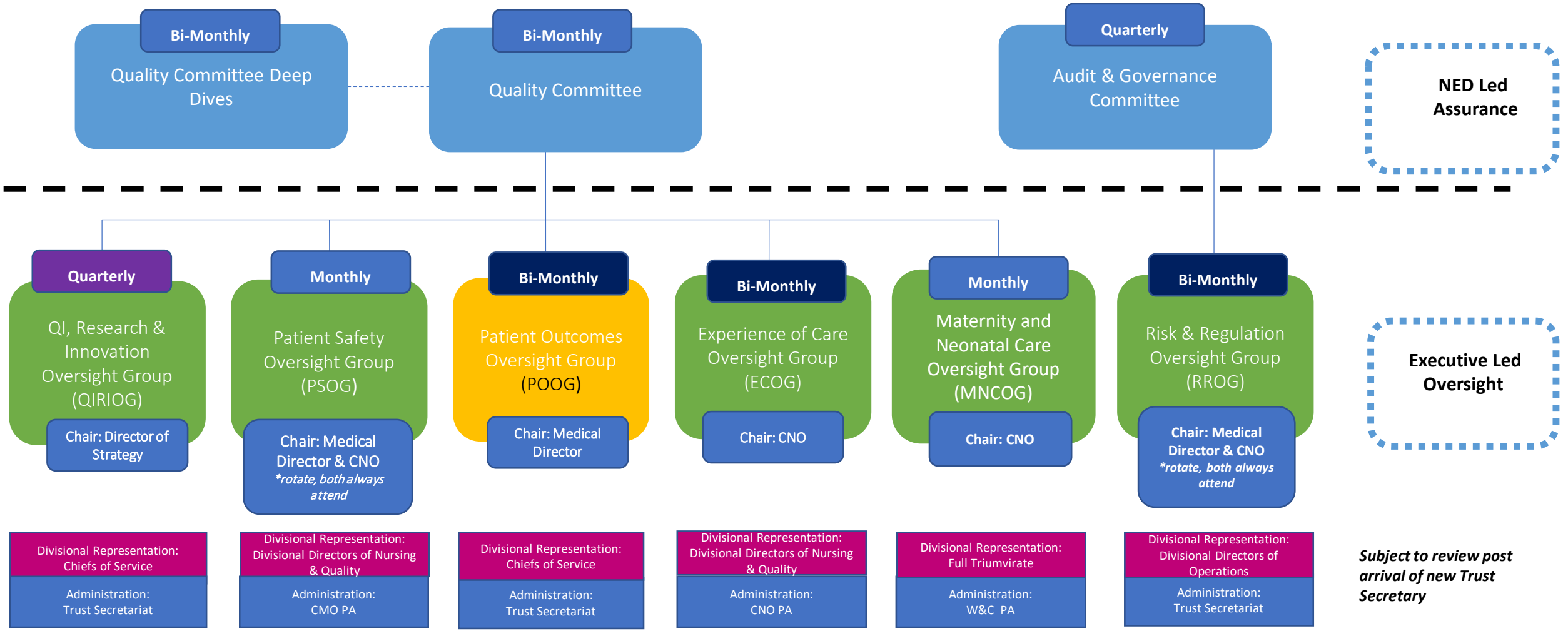
- Executive Team Meeting (ETM), 06/08/24
- Quality Committee 'Deep Dive', 14/08/24

Reason for submission to the Trust 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

Progress New Quality Governance Committee Structure



Subject to review post arrival of new Trust Secretary