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

Thu 28 November 2024, 09:45 - 13:00

Large Meeting Room, Unit D (The Oast), Hermitage Court, Hermitage Lane, ME16 9NT

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to attend the meeting, in the Large Meeting Room, Unit D (The Oast), Hermitage Court, Hermitage Lane, ME16 9NT.

11-1
To receive apologies for absence

Annette Doherty

11-2
To declare interests relevant to agenda items

Annette Doherty

11-3
To approve the minutes of the 'Part 1' Trust Board meeting of 31st October 2024

Annette Doherty

Board minutes 31.10.24 (Part 1).pdf (8 pages)

11-4
To note progress with previous actions

Annette Doherty

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

Patient Experience story

11-5
Patient Experience story

Representatives from the Cancer Services Directorate

N.B. This item is scheduled for 09:50am.

Patient Experience story.pdf (4 pages)

Reports from the Chair of the Trust Board and Chief Executive

11-6
Report from the Chair of the Trust Board

Annette Doherty

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

11-7
Report from the Chief Executive

Steve Orpin

Chief Executive's report November 2024.pdf (3 pages)

Reports from Trust Board sub-committees

11-8
Quality Committee, 13/11/24 (incl. approval of revised Terms of Reference)

Maureen Choong

Summary of Quality Cttee, 13.11.24 (incl. revised Terms of Reference).pdf (7 pages)

11-9
Finance and Performance Committee, 26/11/24 (incl. approval of revised Terms of Reference)

Neil Griffiths

Summary of the Finance and Performance Committee, 261124.pdf (12 pages)

11-10
People and Organisational Development Committee, 22/11/24

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee 22.11.24 v2.pdf (3 pages)

11-11
Audit and Governance Committee, 07/11/24 (incl. approval of revised Terms of Reference)

Maureen Choong

Summary of Audit and Governance Cttee, 07.11.24 (incl. revised Terms of Reference).pdf (10 pages)

11-12
Charitable Funds Committee, 20/11/24 (incl. approval of the revised Terms of Reference and approval of Annual Report and Accounts of the Trust’s

Charitable Fund, 2023/24)

David Morgan

Charitable Funds Committee, 20.11.24 (incl. Terms of Reference and Annual Report and Accounts).pdf (45 pages)

Integrated Performance Report

11-13
Integrated Performance Report (IPR) for October 2024

Steve Orpin and colleagues

Integrated Performance Report (IPR) for October 2024.pdf (50 pages)

Quality Items

11-14
Annual Report from the Director of Infection Prevention and Control

Sara Mumford

Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training).pdf (27 pages)

11-15
Maternity workforce establishment review

Joanna Haworth

Maternity workforce establishment review.pdf (23 pages)

Systems and Place

11-16
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (6 pages)

Assurance and policy

11-17
Ratification of Standing Orders, Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)

Louise Thatcher

Ratification of Standing Financial Instructions, Standing Orders and Scheme of Delegation (annual review).pdf (4 pages)

11-18
Health & Safety Annual Report, 2023/24 and agreement of the 2024/25 programme

Caroline Gibson and John Weeks

N.B. This item is scheduled for 12:30pm.

Health & Safety Annual Report, 202324 and agreement of the 202425 programme.pdf (30 pages)

Corporate governance

11-19
Annual review of the Trust Board's Terms of Reference

Annette Doherty and Louise Thatcher

Annual review of the Trust Board's Terms of Reference.pdf (6 pages)

11-20
To consider any other business

Annette Doherty

11-21
To respond to any questions from members of the public

Annette Doherty

11-22
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 31ST OCTOBER 2024, 09.45AM, MARIE SOUTH AND ALAN PENTECOST ROOMS, ACADEMIC CENTRE, MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Annette Doherty	Chair of the Trust Board (Chair)	(AD)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Davis	Chief Operating Officer	(SD)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Sara Mumford	Chief Medical Officer / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Helen Palmer	Chief People Officer	(HP)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Tasha Gardner	Director of Communications and Corporate Affairs	(TG)
	Daryl Judges	Deputy Trust Secretary	(DJ)
	Louise Thatcher	Trust Secretary	(LT)
	Member of the public		

10-1 To receive apologies for absence

Apologies for absence were received by Emma Pettitt-Mitchell, Non-Executive Director, David Morgan, Non-Executive Director and Richard Finn, Associate Non-Executive Director.

10-2 To declare interests relevant to agenda items

No interests were declared.

10-3 To approve the minutes of the 'Part 1' Trust Board meeting of 26th September 2024

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

10-4 To note progress with previous actions

There were no open actions.

Patient experience

10-5 Patient experience story

The paper will be tabled at a future meeting.

Reports from the Chair of the Trust Board and Chief Executive

10-6 Report from the Chair of Trust Board

AD referred to the submitted report and highlighted the following points and noted the work shared:

- Attention was drawn to the regional meetings attended by AD and MS, which involved discussions of development of the 10-year plan and noted the worked shared with colleagues across the region on innovations and development in pathways of care. Both sessions provided the opportunity for collective learning and sharing best practice to drive improvements across the sector
- The group's attention was drawn to the work done to recruit four new Consultant colleagues

10-7 Report from the Chief Executive

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

- The acquisition of Fordcombe Hospital and the provision of Robot Assisted Surgery, both projects of which have gone live since the last meeting and MS thanked colleagues around the organisation for all their hard working in realising these two significant achievements
- Attention was drawn to the Trust's patient portal, Patient's Know Best, which now has 130,000 registered patients and is improving experience for patients and productivity in the provision of care
- The group heard that a number of teams and individuals have received awards this month, including two maternity support workers (MSWs) being presented with NHS England's Chief Midwifery Officer's Awards and the Radiography team in the Kent Oncology Centre, won 'Radiography Team of the Year' for the south east region in the Society of Radiographers' Radiography Awards
- Although not included in the report, MS informed the Board of two regulatory visits which had occurred in the week commencing 21 October. CQC conducted a 2-day inspection of maternity services at The Tunbridge Wells Hospital. The service has received high level feedback and await the final report. The inspection team provided positive feedback about the team, its culture and the progress made since the last inspection, which included improvements to the triage service. They noted an area of improvement for the service to consider, in regard to managing birthing persons during induction of labour. JH noted there was a significant request of information prior to and during the inspection, which was submitted in time for the deadline. AD thanked JH for her leadership and extended her thanks to the team. MC added the team have completed a lot of improvement work, staff were engaged with the process and positive feedback had been received from the Maternity Voice Partnership. The HTA conducted an unannounced inspection, in the same week, feedback has not yet been received, but no concerns have been raised by the inspection team to date. Feedback will be shared when it has been received
- A discussion was held about the financial constraints both in the Kent and Medway System and the impact that has on the organisation's ability to meet the financial plan. The group discussed the importance of the role we play in the system and our ability to support the system by delivering on our own financial plan. It was noted that there is an opportunity to work more cohesively, with system partners in holding one another to account and delivering improvements collectively. There was a discussion about the impact of the autumn budget on the NHS in general and that more detail was required to fully understand what the impact would be, on the organisation's financial situation

Reports from Trust Board sub-committees

10-8 Quality Committee, 16/10/24

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

- The last meeting received a number of presentations as part of the deep dive. The Head of Mental Health presented a review of the management of patients presenting with mental health issues, which included a comprehensive overview of the measures which had been introduced to support those patients. The committee were assured by the demonstration of good progress with the strategy and the significant improvements delivered in work completed. MC thanked JH and SD for their work in supporting this progress
- There was a review of patients lost to follow-up, following diagnostic tests for which the committee felt partially assured. This was due to the data involved in the review not being validated. Patients lost to follow up are those who have had an appointment or diagnostic test, but do not have a follow up appointment booked. The review evaluated the key themes and challenges identified, which included the impact of taking patients from other organisations across the system. The deep dive was requested because patients have been managed from across the system, rather than it being identified as an area of emerging concern. Lost to follow had not been identified as a theme from complaints received
- Concerns were noted about the complaints response times and the potential failure to learn in a timely manner, which will be subject to a full deep dive in December

10-9 Finance and Performance Committee, 29/10/24

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

- There is continued focus on completing the remaining KMSS work and the committee was partially assured, because of the work still required. An oversight group is established to ensure this progress continues
- The Outpatient team delivered a presentation on the transformation work that has been completed and clearly demonstrated significant improvements in patient experience, productivity and theatre utilisation. The work done to date provides a good foundation for further improvements and the committee was assured on the Outpatient transformation programme
- Financial improvement work was noted and the committee were partially assured, as although a number of mitigations have been implemented in regard to temporary staffing use and cost improvement programmes, further information was requested on the next steps for downside actions detailed in the financial improvement plan
- AD drew attention to the East Kent oncology service and the challenges it faces. NG confirmed there have been some increasing concerns around the service being provided and the committee are reviewing how support could be sourced, if required. AD noted a substantial piece of work has been done regarding this and MS confirmed an outline business case has been signed off, a full final business case being developed with East Kent

10-10 People and Organisational Development Committee, 25/10/24 (incl. the Guardian for Safe Working Hours Annual Report 2023/24)

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

- The Committee was assured in regard to the temporary staffing programme and thanks were given to staff for supporting the significant work undertaken, with an emphasis on further work around the culture for controls
- Assurance was noted for the Equality, Diversity and Inclusion update and it was acknowledged that further assurance would be required on actions to increase diversity of staff who were Agenda for Change (AfC) Band 8c and above
- The committee was assured regarding the equal pay annual audit and recognised greater scrutiny of the data was required. The challenges identified reflected a national, rather than local picture
- Reports were received from the Guardian of Safe working hours and from the Wellbeing Committee who reported providing a more preventative medicine approach to help our people to be well
- In addition, approval was given to submissions to the Workforce Race Equality survey and the Workforce Disability Equality survey, which were shared in the papers

AD brought attention to the gender pay gap and any work which may being done to mitigate this. HP confirmed this is a national rather than local challenge, but reviewing data in relation to the Trust staff, it has been identified that there are a larger number of women in lower paid roles and a larger number of men in higher paid roles. In addition, it was noted that women are more likely to take a career break and have carer responsibilities. There is an opportunity to review the management of gender pay gap in private organisations and identify an approach which could be used. It was noted that there are some limits to the flexibility the Trust can offer as an NHS organisation, as it has to operate within a framework based on skills, experience and training. A discussion was held which confirmed the importance of understanding the scale of the issue, which may also include consideration of protected characteristics to be able to fully develop the approach which may need to be taken

Integrated Performance Report (IPR)

10-11 To review the finalised Strategy Deployment Review (SDR) proposal

RJ provided an update on the changes to the Integrated Performance Report (IPR), which are to merge the financial recovery plan with performance, so the two are visible to the board. Details on additions to the domains are included in the papers and this change will be for a 6-month period. Changes mean the report will have a different appearance, but here is no loss of information. A query was raised as to why reduction in agency spend for Registered Mental Health Nurses (RMNs) have been split the report of the other staff groups. JH explained that agency spend for RMNs is part

of the work around supporting patients with mental health needs, so that element sits within the Patient Experience theme.

10-12 Review of the Integrated Performance Report (IPR) for August 2024

HP referred to the "People" Strategic Theme and highlighted the following points:

- The temporary staff spend work was presented at People and Organisations Development Committee and drew attention to the top contributing areas. Considerable work has been undertaken on bank staff spend, but it was identified that staff needed more support, to make decisions to align staffing and budgets. The People team have developed a tool which enables services to identify how many of hours of staff time they need and how many hours they have available within their budget, which will be trialled in the coming week
- It was acknowledged that the percentage of staff in the AFC 8c group, from the global majority is a data point which is not moving and needs meaningful action. Attention was drawn to more focussed work on inclusive improvement, including workshops for all recruiting managers and with the 3rd cohort of reverse mentoring staff. In addition, People business partners are supporting recruitment throughout the process and are regular members of interview panels, which has received positive feedback from other members of interview panels
- The trend in data around staff leavers within 12-24 months appears to be worsening in the presented data point. The data for the last few years has been reviewed and there is a comparable trend for the time period. Exit interviews have identified that staff are leaving for career opportunities
- The organisation is challenged with retention of lower banded staff due to external options and favourable conditions outside the NHS. The organisation is considering the current government budgetary announcement to changes in the minimum wage and how this will compare with staff wages for colleagues on lower bands. The recent clarifying amendments to band 2 and band 3 roles will also pose challenges to the organisation's position
- The current report refers to percentages of leavers and clarification was given that the People team have committed to reporting in numbers of people rather than percentages and drive this as a percentage of the workforce. Areas of retention to focus on have been identified as Health Care Support Workers (HCSWs) and portering staff. JH brought attention to the work on 'new to care', which supports HCSWs who have not worked in care services before to undertake periods of observation before moving into frontline care, which has improved retention in this staff group

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

- There is a slight increase in patient incidents resulting in moderate (and above) harm, which has been found to be due to a change in grading of pressure ulcers and consideration needs to be taken as to whether the measurement of this vision needs to be amended
- Improvement was noted in the breakthrough metric, of the number of moderate harms (and above) attributed to the potential mismanagement of deteriorating patients. A lead practitioner for deteriorating patients has recently been appointed and will be developing a new educational package. Good engagement was noted across nursing and medical teams and a stakeholder event will be held to plan next steps in additional the implementation of Martha's rule
- Work has been undertaken in Outpatients to improve the new to follow up rate, which frees up additional appointments and improves patient experience. "Triage to Test" enables patients to be directed straight to an investigation at their first attendance. An IT solution is being sourced to support this process and areas for piloting the IT solution have been identified
- Theatre utilisation is improving, but not at the desired rate, which has been attributed to the "soft launch" of Kent and Medway Orthopaedic Centre (KMOC) in September, which meant not as many beds were used, as were available. The implementation of 6-4-2 meetings, supports services to review the use of theatres over the next 6, 4 and 2 weeks and has realised improved theatre utilisation. Further work will be done to address late starts, early finishes and cancellations
- Work to reduce the rates of Clostridium Difficile (C.Diff.) is continuing, with full deep cleans of two inpatient areas at Maidstone Hospital rates and all actions being completed when infection is identified. A question was raised around mitigations for escalation areas during the winter period, but confirmation that the use of escalation areas was not in the winter plan

- Actions are in place to improve the number of inpatient falls and a falls lead nurse has recently been appointed, with previous experience in that role, meaning there is now a falls lead at Maidstone and Tunbridge Wells Hospitals. It was noted that the Fordcombe site was not included in the current data, but would be in the next report

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

- The access to diagnostic measurement has changed to include endoscopy procedures, which has resulted in a reduction in measured performance
- Reduction in the Length of Stay (LOS) is supported by a "front to back door" project, which considers patients deconditioning with an increased LOS and aims to mitigate this. Other key themes to support the work are; the virtual ward, pathway zero and pathway one. Pathway zero is the pathway patients follow, when they are discharged home or to a usual place of residence with no new or additional health and/or social care needs. Pathway one, is the pathway patients follow when they are discharged home, or to a usual place of residence with new or additional health and/or social care needs
- It was noted the referral to treatment time (RTT) was below the aspired target and recovery work was being undertaken to improve the position
- There was a decrease in performance for calls answered within one minute, which was secondary to vacancies in that team
- The "front to back door" project is supporting the maintenance of performance in the Emergency Department (ED), in addition to other specialities considering how they could use Same Day Emergency Care (SDEC) and gastroenterology was given as an example of a potential service which could implement SDEC. Other work includes nurse to nurse referral, to improve the movement of patients from ED in a timelier way. A query was raised in regard to the potential impact of temporary staff use reduction, on the work being done. Assurance was given that staffing requirements were being very closely monitored to keep staffing levels safe

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

- Work continues on reducing the number of complaints detailing communication as an issue. The main theme in communication is around lack of information, which is reflected in the results of the inpatient survey. Two divisions are completing quality improvement projects to improve areas of communication and these improvements are being shared across the organisation. The Experience of Care Oversight Group has been strengthened, to identify further areas for improvement, in response to what patients are telling us
- The response to complaints target in October was 78% and the team have worked hard to clear the backlog in complaints. The metrics will be presented differently going forward to represent both the complaints backlog and performance data. Thanks, were given to the divisional and complaints teams for improving the response time to complaints
- AD offered congratulations to the team in bringing improvements to the response rate to complaints
- It was noted, there is still a low response rate to the Friends and Family Test (FF) from inpatient areas. Maternity services have a reduced response rate, as patients prefer to use paper response forms which have not consistently been uploaded to the system. Patient engagement forums had stopped during the pandemic and there is a plan from them to restart in the near future
- The ambition to reduce agency spend for RMN and HSCW staff groups has not been realised, as there some elements beyond control, because of the complexity of care required for some of our patients and the length of stay this brings. To address this, a complex case panel has been established to support our patients in the best way possible, the enhanced care policy has been developed and the team are looking to develop enhanced HSCWs to assist them in their roles in supporting patients with more complex issues
- The Maternity service continue to have challenges in meeting targets in with regard to induction of labour. The teams have reviewed the targets and are confident they should remain the same and a risk assessment tool, which supports the regular review of patients is in place to mitigate risks. As part of the overarching investment in Maternity service, two consultants have been recruited and the directorate is undertaking a demand and capacity review
- Reference was made to a second obstetric theatre which has been identified as a requirement for a number of providers across the system and the Local Maternity and Neonatal System

(LMNS) are taking forward a system wide piece of work to understand the issue. SD confirmed the team have also reached out to other organisations with similar demographics to understand how they work and if the challenges they experience are the same

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

- There is an enhanced focus on ensuring coding of procedures is being completed correctly, in order to be appropriately reimbursed for the activity undertaken. A key area of focus is on procedures undertaken during outpatient appointments. The team are working in outpatients to identify how activity is being recorded and support teams in completing the work to ensure robust processes are in place to capture the work is done correctly. Coding patients with a number of comorbidities has been identified as an area for improvement. An audit tool has been acquired to help to support teams to identify other comorbidities. SO added that this work will support the organisation more fully in regards to patient safety and other quality metrics, in addition to the financial element. This was a view support by other members of the board
- It was noted that there is a lack of movement in the metric in regard to discharging patients by noon. The metric has been moved in the "front to back door" project work, with a focus on improvements in board rounds, timely Electronic Discharge Notifications (EDN) and To Take Home medication (TTO) availability. SD referred to the identification of "diamond patients" for discharges, which means, as soon as patients are ready for discharge, teams work to get all the other processes aligned to facilitate the discharge. The teletracking system helps to support and keep focus on these patients, including the steps needed to be completed. It was acknowledged that the data presented should be interrogated at ward level to identify the nature of issues and that a process map would enable teams to see what needs to be done prior to discharge and enable identification of areas for improvement

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

- Attention was drawn to overall financial plan and position. The Trust was £2.1m in deficit in September which was £1.8m adverse to plan. Year to date, the Trust is £13.7m in deficit which is £5.1m adverse to plan
- The expectation was that some of the improvements would be realised in the second half of the year. However, the forecast has improved, as additional income has been identified in regard to the national income recovery funds
- There are clear and demonstrable measures of making process by driving work through the remainder of the year. This includes; Non-pay expenditure work; reduction of agency spend; fully functioning Kent and Medway Orthopaedic Centre (KMOC); Community Diagnostics Centre (CDC) and planned completion of the Kent and Medway Medical School (KMSS) to fully capitalise all resources by the end of the year
- AD thanked the team for all their work

Quality Items

10-13 <u>Findings of the national inpatient survey 2023</u>

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

- The National Inpatient survey is carried out by the Care Quality Commission every year. The survey looks at the experiences of people who stayed at least one night in hospital as an inpatient
- The criteria for inclusion in the survey was articulated and it was noted the greatest responses were from white woman over 66 years old with a Long-Term Condition. It is a broadly a positive patient survey being rated about the same as other Trusts in most areas and better than expected than other Trusts in three areas
- Improvement was noted in noise at night and virtual ward experiences. Areas for improvement were identified as giving patients an opportunity to provide feedback, which is echoed in the FFT response rates and the feedback on information given to patients when they leave the hospital. This links to the theme on communication in complaints received. The Nutrition and Hydration Steering Group are focussing on the availability of food outside normal meal times. The Experience of Care Oversight Group will monitor the identified areas for improvement and any additional comments submitted as part of the survey would be reviewed

Systems and Place

10-14 Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

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

- The financial recovery for the HCP was referred to and how it links with the Trust's own financial recovery plan
- Seventeen staff will be welcomed to the Trust under the Transferred of Undertakings (Protection of Employment) regulations (TUPE) and thanks were offered to the Finance, People and IT teams for their support in achieving this
- Conversations have been ongoing with integrated neighbourhood teams in regard to the transfer of patients on pathway one discharges. The change in provider resulted in delays in discharging patients on this pathway but short-term actions are in place to mitigate this

10-15 Review of the Kent and Medway NHS Strategy

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

- The exec team have been involved in the development in the themes for the strategy and this has been a good exercise in bringing teams together across the system. The work on this started before the Darzi report, so will need to be revisited in the spring
- The Board were invited to comment on its contents. Key points were raised:
  - There are areas of deprivation across the system and it would be helpful to have clarity on this issue, to understand the potential impact on health inequalities
  - There is reference to isolation in the document, and may be a cohort who are digitally excluded and have carers, who don't have the capacity to support or deal with those issues, identifying this clearly, may support the work forward
  - It would be helpful to have a view of times scales, clarity and focus in the goals presented and actions to achieve the goals identified
- It was agreed that the 10-year plan would help to concentrate the strategy further. The board supported the direction of the strategy

Planning and strategy

10-16 Update on Fordcombe Hospital

SD gave a verbal update on the Fordcombe work to date.

- One thousand six hundred and seventy-six patients have been transferred from across the system and treated to date. Thanks were offered to all members of the multidisciplinary team who have helped to realise this. Work continues and is progressing well
- The Chair of the Integrated Care Board (ICB) visited the site and spoke with a number of staff there, which the staff welcomed and was a positive visit

10-17 To review the updated plan for the forthcoming winter period

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

- The forecast data predicts there will be a peak in activity from October to December.
- There has been an increase in walk-through patients and the organisation has been in Opel 4 for 10 days preceding the meeting
- The closure of Sevenoaks hospital at short notice has resulted in an increase in patients with no criteria to reside. Mitigations are in place and achieving positive results, but there remains a four-bed deficit
- Detailed bed modelling has considered' worst case scenario' and a proposal in how the bed shortfall would be addressed was suggested: additional capacity front-back door, increasing virtual ward capacity, utilisation of beds in HASU at peak demand and repurposing of bariatric rooms, from single to double occupancy should the need arise
- External funding has been requested for management of patients on pathway one because of the challenges experienced with the change in provider
- Improvements in managing patient journeys from front to back door must be made to support the work required, however, it was noted that not all that is required to be done is funded, which

becomes more challenging as the Trust is currently off its financial plan. Progress is being made on financial risks, but they remain open
- Confirmation was given that the winter plan is complimented by the system partner's winter plans and funds have been identified in the HCP to support the frailty pathway
- It was noted that utilisation of the virtual pathway is key in supporting the winter plan and it was confirmed, other services have been approached to increase their virtual ward capacity
- AD commended SD and her team on the report

Assurance and policy

10-18 Quarterly report from the Freedom to Speak Up Guardian (FTSUG)

HP referred to the submitted report and highlighted the following points:
- This is the second report in the time period and enhancements in education, validation and trust building has resulted in the busiest quarter since the FTSUG began
- Bullying and harassment is the category most reported on and concerns have been received through various routes: direct contact with the FTSUG, anonymous portal logs, safe space champions, exit interviews and staff side conversations
- The guardian has active involvement in engagement events throughout all locations of the Trust and have shared a number of communications to inform staff of their work and how to contact them
- The impact of increased calls and increased complexity of cases has resulted in the increase in response time to five days
- Consideration is being taken on the impact of the success of the programme on one person in the role. A strategy is being developed which will address the future of the service
- It was noted that reports to the FTSUG is diagnostic barometer of what is going on the in the organisation and the work the team have done in giving staff a voice, who may not have felt this previously was commended

Other matters

10-19 To consider any other business

There was no other business.

10-20 To respond to questions from members of the public

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

10-21 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'
N/A	N/A	N/A	N/A	N/A

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

Title of report	**Patient Experience Story**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-7					
Executive lead	Joanna Haworth, Chief Nurse					
Presenter	Tracey Spencer-Brown – Head of Nursing Oncology & Cancer Performance					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	☐	☐	☐	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Patient stories are unquestionably powerful in gaining an understanding of patients experience at Maidstone and Tunbridge Wells NHS Trust. This Patient story will provide feedback on the experience of care from one patient under the care on Oncology services. This story has been written by the patient and is told in their own words.
Any items for formal escalation / decision	The Board is asked to consider and discuss the ongoing actions related to the patient story as outlined in the appendix.
Appendices attached	• Appendix A – Experience of care patient story.

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Nursing and Midwifery Conference at Maidstone and Tunbridge Wells NHS Trust	22nd October 2024	Discussed as part of the theme on developing the skills to provide outstanding care.
Nursing, Midwifery, Allied Health Professionals and Pharmacy Board	26th November 2024	Discussed as part of experience of care and shared learning

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	N/A- The BAF is currently under development
Links to Trust Risk Register (TRR)	Nil Risks.
Compliance / Regulatory Implications	Nil

Appendix A **Experience of Care- Patient Story**

Name: Ms C	
Date of care experienced: **May 2024-ongoing**	**Services/wards experienced:** **Oncology Services & Medicine Ward**

Outline of experience:

Please Note: This story has been written by the patient and is told in their own words.

Hi, my name is Ms C and I have stage 3 Inflammatory Breast Cancer.

It all started when I first noticed my left breast looking different to my right. It was swollen like a bowling ball. I did not get the normal signs that they tell you to look and feel for, so I ignored it for a few months.

My G.P. did an urgent referral & I had my first appointment at the breast clinic in Pembury Hospital on 1st May 2024. At this appointment I had a mammogram, an ultrasound scan, and a biopsy and on that day, I was told I had breast cancer, this is where my journey began.

I had an appointment on 16th May with a consultant who confirmed that I had an aggressive cancer and it was stage 3. Over the next few weeks I had a series of investigations including scans, CT, M.R.I. and Micro Bubbles and then started my Chemotherapy treatment on 13th June 2024 in the chemo unit.

I have had 6 rounds of Chemotherapy in total, the last one was on 11th October 2024, and the side effects I have experienced have been cumulative and severe at times. They are hair loss, bad taste, nausea / vomiting, and low levels of potassium and magnesium. After my 3rd chemotherapy session my consultant reduced the dosage.

On one occasion due to severe diarrhoea, I was admitted and I ended up staying as an inpatient for 12 days on Pye Oliver Ward, which sadly was not a great experience. This was due to lack of empathy and care by some of the staff. On one particular night when I had really bad diarrhoea and vomiting. I requested medication several times and was refused by a nurse. I was told that I would have to wait until the Doctor came on the ward the next day to be prescribed them. When I was admitted I had brought my regular prescribed medication in with me, when I asked if I could have my own they refused. Also,

the same nurse had written up her report on me by 8.30pm that evening, prior to me becoming unwell, and nothing was added to that report thereafter about me. One of the medical staff apologised on their behalf the next day for the night nurses' error.

I believe that there should be specific oncology ward for cancer patients and that we should have access to oncology nurses 24/7 while we are inpatients. General wards and the staff a have very limited or no knowledge regarding cancer patients, the drugs they are on, and the side effects they experience. Many times, I would ask the nurse on the ward something and I would have to write it down and wait for an acute oncology nurse or my breast care nurse to come and see me, that could be 24hrs after I had asked the question. I would say all cancer patients would agree.

All the staff on the oncology unit and Charles Dickens Unit are amazing. From the reception staff through to all the nursing staff and my consultant and her registrar, they have made me feel welcome and at ease. I am needle phobic, every nurse's nightmare patient, however, whilst having chemotherapy and having to have cannulas, I have had nurses hold my hand and I can honestly say they have helped me on this journey. I do not feel nervous any more coming for any treatment, if anything I am there so regular, I almost feel like one of the team.

Acute Oncology SDEC has helped me and other patients so much, as this avoids cancer patients having to wait in emergency department for long periods of times when they are at their most vulnerable and immune suppressed. It is a shame that this service only operates 3 days a week, funding should be found to extend this invaluable service to Monday - Friday.

I still have a long journey ahead of me, but with the lovely, kind, caring nurses in oncology that I have encountered, it's a journey I no longer fear.

Positive points to highlight:	**Negative points to highlight:**
Positive Experience of Care feedback in the Acute Oncology Same Day Emergency Care (SDEC). Ongoing Pilot of service for Business Case application in Quarter 4 204/25.	Experience of Care on Pye Oliver
Staff being kind and feeling part of a team.	Lack of training and education for ward staff in managing oncology patients holistically.
Effective breaking bad news consultation when diagnosed with Breast cancer.	Feeling vulnerable as a cancer patient in ED whilst immunocompromised.
	Information overload at point of diagnosis-patient information
	No Oncology beds across Kent and Medway region.

Patient feeling like part of the team and a sense of belonging in a team about her care & treatment.	

Ongoing actions with case:

Practice Development Nurse for Cancer started on 4th November 2024 and one of her roles is, together with divisional Practice Development Nurses (PDNs), to undertake learning needs analysis across the Trust to support upskilling ward staff with the required knowledge and skills.

Business case to be submitted early 2025 to an Acute Oncology SDEC 5 days a week- as business as usual.

Triangulation of patient feedback from other cancer patients in medical wards via the FFT portal, complaints and PALS

Discussion with Pye Oliver and potentially some focused work with ward staff on managing oncology patient concerns.

All ward areas have Acute Oncology Teams Details and the escalation process to the out of hours on call consultant.

Safety netting of oncology patients being admitted/ flagging system on Sunrise.

Wider discussion within the Kent and Medway ICB at system level to determine the need across the region for oncology beds, Virtual ward pathway.

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-5					
Executive lead	Annette Doherty, Chair of the Trust Board					
Presenter	Annette Doherty, Chair of the Trust Board					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chair's Report for the November Trust Board meeting.		
Any items for formal escalation / decision	N/A		
Appendices attached	There are no appendices to this report.		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
N/A		N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • N/A
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • N/A
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report • N/A

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

At the end of last month, the Trust Board attended a seminar by the Health Services Safety Investigations Body (HSSIB). HSSIB promote safety learning to improve NHS care at national level, and the session provided the opportunity for HSSIB representatives to discuss safety and quality with executive leaders from the Trust. I also attended the NHS Kent and Medway Provider collaborative Board meeting in Ashford, to support our continued system partnership working.

A recent visit to Canterbury Christchurch University alongside the Trust's Chief Executive enabled us to continue to build our links with the University and the Kent and Medway Medical School (KMMS). MTW provides clinical placements for third year medical students from KMMS, giving them the opportunity for hands-on learning across the Trust's hospitals in a range of medical and surgical specialties.

I was delighted to attend a number of MTW NHS Milestones events throughout this month, alongside the Trust's Chief Executive and Non-Executive Directors. Formerly known as the Long Service Awards, these events celebrate MTW staff who have served in the NHS between 10 and 50 years. It's been wonderful to attend and watch our long serving staff receiving the recognition they deserve for the hard work and dedication they have given to the NHS.

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?
16/10/2024	Consultant Colorectal and General Surgeon	**Liam**	**Poynter**	General Surgery	TBC	Replacement
08/11/2024	Consultant Anaesthetist - Pain Management	**John**	**Batty**	Anaesthetics	TBC	Replacement
08/11/2024	Consultant Anaesthetist	**Michael Paul**	**Michael Gilhooly**	Anaesthetics	TBC	Replacement
08/11/2024	Consultant Anaesthetist	**Andrew David**	**Feneley**	Anaesthetics	TBC	Replacement
08/11/2024	Consultant Anaesthetist	**Ahmed Badr Metwally Kotb**	**Aboelneil**	Anaesthetics	TBC	Replacement
08/11/2024	Consultant Anaesthetist	**Devaraj Nidagatte**	**Dyamanna**	Anaesthetics	TBC	Replacement
08/11/2024	Consultant Anaesthetist	**Natalie Laura**	**Shields**	Anaesthetics	TBC	Replacement
18/11/2024	Consultant Oculoplastic Surgeon	**Saekyung Christina**	**Lim**	Ophthalmology	TBC	New

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board**					
Date of meeting	28th November 2024					
Agenda item no.	11-6					
Executive lead	Miles Scott, Chief Executive					
Presenter	Miles Scott, Chief Executive					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chief Executive Report for the November Trust Board meeting, summarising Trust developments and achievements over the last month.		
Any items for formal escalation / decision	N/A		
Appendices attached	There are no appendices to this report.		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
N/A		N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • N/A
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • N/A
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report • N/A

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

- Improving performance is critical to the Trust, alongside having a safe winter. As part of our winter planning, colleagues are currently involved in a 'Front to Back Door' project to support flow through our hospitals, with a focus on patient pathways, reducing length of stay and working with external partners. Key areas of work include increasing the use of the Virtual Ward, effective board rounds which identify patients who are ready for discharge earlier in the day and patient discharge pathways. Our Emergency Departments are a good barometer of how the whole hospital is responding and MTW came second in the country recently for ED performance, a result which really demonstrates the hard work of staff and the impact this project is making. The Trust is also continuing with the staff COVID-19 and flu winter vaccination programme, which began on 3 October.

- The Trust is preparing to rollout Martha's Rule with a scheduled go live of January 2025. Martha Mills died in 2021 after developing sepsis in hospital. The three components of Martha's Rule are:
  1. All staff will have access to an escalation route for concerns about deteriorating patients by contacting a Critical Care Outreach team who can provide rapid review 24/7. This is already in place across our sites.
  2. This escalation route will also be available to patients themselves, and their carers and families.
  3. Patients will be asked, at least on a daily basis, about any worries or concerns about their condition. This information will then be used in a structured way to escalate concerns.

  To prepare for the launch, plans are underway to pilot stage three of Martha's Rule at two wards from this month; one at Maidstone Hospital and one at Tunbridge Wells Hospital. MTW has also appointed a Deteriorating Patient Lead Practitioner, a new role for the Trust, who took up the role at the start of this month and will support with education on deteriorating patients and training.

- Lord Darzi's Report published in September provided expert view on the challenges currently facing the health service. In response to the Report, the Government is developing a 10-year plan for the NHS, combining investment and reform to address Lord Darzi's diagnosis. The plan will revolve around three main 'shifts': hospital to home, analogue to digital processes and treatment to prevention.

  The Trust will have the opportunity to contribute to the Government's 10-Year Plan for Health by submitting an organisational response by 2 December, reflecting on the three main shifts, including how best to implement these and any perceived challenges. We are also being invited to share ideas on what needs to change across the health and care system. In addition, the Government has called on the public to share their experiences of the health service and give their views on its future and the 10-Year Plan for Health. MTW has encouraged staff, patients and visitors to submit their ideas and feedback through the 10-Year Health Plan online portal.

  NHS England (NHSE) will be changing its operating model to address Lord Darzi's findings. NHSE recently wrote to all chairs and chief executives of integrated care boards, and NHS trusts and foundation trusts across England, outlining their plan. This will look at simplifying system responsibilities and reducing any duplication, shifting resources to neighbourhood health, devolving decision-making to those best placed to make changes and enabling leaders to manage issues at a local level. NHSE have set up an NHS System Development and Reform programme, which will include an advisory group of chairs and chief executives across the system to help develop the changes to their operating model.

- The Intensive Care Unit (ICU) at Tunbridge Wells Hospital has become the first in the UK to receive the prestigious HU-CI and AENOR Certification of Good Practices in Humanisation of Intensive Care. The HU-CI Project evaluates different aspects of intensive care, and the ICU team at Tunbridge Wells Hospital scored an 'Excellent' rating across 160 standards ensuring the best care possible is being delivered, setting a benchmark for hospitals across

Europe. Intensive care units support people with serious and life-threatening conditions, and can be overwhelming places for patients and their families. The HU-CI accreditation process focuses on supporting the wellbeing of the patient, their family and the healthcare team around them, including promoting good communication, supporting self-care, and giving access to natural light. The Unit scored highly for initiatives such as its garden with bed and wheelchair access, and having an 'open door' so that relatives can be present and feel involved. The team were also commended for supporting patients with language or communication difficulties. Hospitals with HU-CI accreditation have seen a reduction in patients' length of stay in intensive care and the use of mechanical ventilation, and a decrease in the symptoms of anxiety and depression. Research has also shown a fall in the number of patients discharged to a care home or rehabilitation facility, helping them get home more quickly. On behalf of the Board, I would like to congratulate the ICU team at Tunbridge Wells Hospital for gaining this important accreditation, which highlights their commitment to providing patient-centred care.

- The final development phase of the West Kent Community Diagnostic Centre (CDC) at Hermitage Court is close to completion. This last stage has seen the building of a dedicated unit to house CT and MRI scanners, along with outpatient rooms, phlebotomy and point of care testing. The new unit is due to be handed over to the Trust at the end of this year. IT installation and relevant estates work will continue into the new year, with the aim of opening to patients in February.

- The Trust recently welcomed NHS England's Regional Head of Staff Experience, Engagement and EDI, Jeanette Williams, to Maidstone Hospital. She was joined by Steve Rowley, Regional People Promise Manager for NHS England, and Taylor Pryer Freeman, Deputy Director of System Workforce at NHS Kent and Medway. The visit was an opportunity for our People and Organisational Development team to showcase how the NHS People Promise programme is being embedded across the organisation through various projects, and the positive impact this has had on staff and patients. The People Promise sets out in the words of thousands of staff what will most improve their experience at work and make the NHS the workplace we all want it to be. The three People Promise themes are staff voice, kindness and respect, and flexible working. Projects covering the themes have included team-based rostering trials to facilitate flexible working, piloting a People Promise Impact Council, and using feedback from colleagues to draft an Employee Listening Strategy. Speaking after the visit, Jeanette Williams commented that the People Promise work our teams are delivering across all workstreams is exemplary.

- MTW held remembrance services this month to remember and thank those who served and gave their lives to defend our freedom, and those who continue to serve in our armed forces. The Trust is proud to be recognised as Veteran Aware for our commitment to improving NHS care for veterans, reservists, members of the armed forces and their families. On Remembrance Sunday, I was honoured to be invited to lay a wreath on behalf of the Trust at a civic service in Tunbridge Wells with community representatives, councillors and MPs. On Monday 11 November, our hospital chaplains and members of our Executive team took part in commemorative events at Maidstone and Tunbridge Wells hospitals.

- Congratulations to the winner of the Trust's Employee of the Month award for October, Amanda Cane, Agenda for Change Rostering Team Leader. Amanda provides essential rostering guidance across the whole Trust, and the exceptional support she provided to the team at Fordcombe Hospital during the transition to MTW was described as invaluable. Deputy Trust Secretary, Daryl Judges, also received the Highly Commended Award for the support he provided to his team at a very sad and difficult time earlier this year, following the sudden and unexpected death of former Trust Secretary Kevin Rowan.

Title of report	**Summary report from the Quality Committee (incl. approval of revised Terms of Reference)**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-8					
Executive lead	Maureen Choong, Non-Executive Director					
Presenter	Maureen Choong, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	✓	☐	☐	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Quality Committee met (virtually, via webconference) on 13th November 2024. The Committee considered the following topics and allocated the assurance ratings accordingly: 1) The Committee was assured in relation to the progress made in work by the Patient Safety Oversight Group; Experience of Care Oversight Group and Maternity and Neonatal Care Oversight Group; 2) The Committee was assured regarding the progress which had been made with the Quality Account priorities for 2024/25; although, acknowledged those which required additional focus to support the achievement of the target
Any items for formal escalation / decision	The Trust Board is requested to approve the revised Terms of Reference for the Quality Committee.
Appendices attached	Appendix 1 – Terms of Reference

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	N/A
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

The Quality Committee met (Virtually via webconference) on 13th November 2024.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed and it was agreed that the Trust Secretary should liaise with representatives from the Trust's IT Department, to determine how best to restrict access to specific documents, ensuring that such documents could be accessed during periods of sickness absence and issue some Trust-wide communications regarding the proposed approach. It was also agreed that the Trust Secretary and Chief Nurse should amend the Terms of Reference for the Ethics Committee to reflect the feedback received at the November 2024 'main' Quality Committee, including consideration of how to ensure staff were appropriately prepared and supported.
- The **Terms of Reference** were reviewed as part of the annual process and the proposed amendments were agreed. The revised Terms of Reference are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Chief Nurse presented the **summary report from the Patient Safety Oversight Group** which included the improvement in Breast Pathology turnaround times; and the establishment of a task and finish group in response to the patients lost to follow-up 'deep dive', wherein it was agreed that the Deputy Chief Operating Officer should submit an update to the on the current position and next steps in relation to patients lost to follow-up, to the Committee's meeting in January 2025.
  - ❖ The Committee was **assured** in regards to the monitoring of patient safety; although, acknowledged there was further work required in relation to patients lost to follow-up.
- The **summary report from the Experience of the Care Oversight Group** was then presented by the Chief Nurse which included a comprehensive overview of the measures which had been introduced to increase patient feedback; the progress which had been made in relation to complaints performance; and the benefits of local resolution meetings.
  - ❖ The Committee was **assured** regarding the measures to improve the patient experience at the Trust and capture additional patient feedback.
- The Director of Strategy, Planning and Partnerships presented the **summary report from the Quality Improvement, Research and Innovation Oversight Group** wherein an in-depth discussion was held regarding research and innovation at the Trust, in which it was acknowledged that the Trust was in a positive position in relation to research; however, that further work was required to support the development of innovation at the Trust, which would be supported by the development of an innovation strategy.
- The Committee then reviewed the **summary report from the Patient Outcomes Oversight Group**, and a discussion was held around the proposed Terms of Reference, wherein some further amendments were proposed and it was agreed that the Trust Secretary should amend the Terms of Reference for the Patient Outcomes Oversight Group to reflect the feedback received at the November 2024 'main' Quality Committee meeting, including clarification as to reason for the specific inclusion of the Clinical Directors for Surgery as an attendee.
- The Director of Maternity highlighted the key points within the **summary report from the Maternity and Neonatal Assurance Group**, which included the focus on clinical outcomes; the measures which had been implemented to improve staffing levels within the Community Midwifery Team; and the positive feedback which had been received from services users within Maternity Services. The Committee acknowledged the review process for any term admissions to the Neonatal Unit and the associated improvement project which had been implemented.
  - ❖ The Committee was **assured** that there was a robust focus on the improvement of delivery of Maternity and Neonatal Services.
- The Head of Risk Management attended to present the **review of the Trust's Quality related risks**, wherein an in-depth discussion was held regarding the increase in the number of open risks at the Trust which was, in part, due to the increased risk management education of Trust staff, and the Committee emphasised the importance of a robust escalation process, which was sufficiently embedded, for those risks with a risk rating of 20 or above. The Committee acknowledged the continued implementation of the risk management improvement plan, and the benefits associated with the introduction of the Risk and Regulation Oversight Group.

- The Chief Nurse provided an **update on the implementation of Quality Accounts priorities 2024/25**, wherein the Committee noted the progress which had been made to date and those Quality Priorities which required additional focus to achieve the target and it was agreed that the Director of Quality Governance should provide an update to the Committee, via the Patient Safety Oversight Group, on the reasons for the deterioration in the Trust's performance against the "reduction in rate of patient incidents resulting in moderate+ harm…" quality priority.
  - ❖ The Committee was **assured** regarding the progress which had been made with the Quality Account priorities for 2024/25; although, acknowledged those which required additional focus to support the achievement of the target.
- The Committee noted the **Report from the Quality Committee 'deep dive' meeting, 16/10/24.**
- A review was then conducted of the method of the **Committee's evaluation for 2024**, wherein it was agreed that the Deputy Trust Secretary amend the Quality Committee's evaluation for 2024 to reflect the amendments requested at the Committee's meeting in November 2024 prior to circulation to Committee members

QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

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

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

2. Membership

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

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

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

3. Quorum

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

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

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

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

4. Attendance

The following are invited to attend each 'main' meeting

- Chief of Healthcare Professions

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

- The Chief Nurse (or an appropriate deputy, as they determine) from NHS Kent and Medway Integrated Care Board
- The Chiefs of Service for the five clinical divisions
- The Divisional Directors of Nursing & Quality (DDNQs) (or equivalent) for the five clinical divisions

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

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

5. Frequency of Meetings

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

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

6. Duties

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

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

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

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

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

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

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

7. Parent committees and reporting procedure

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

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

8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

1. Experience of Care Oversight Group (EOCOG)
1.2. Maternity ~~Board~~and Neonatal Care Oversight Group (MNCOG)
~~2. Patient Experience Committee (PEC)~~
3. Patient Outcomes ~~Committee~~ Oversight Group (PO~~C~~OG)
4. Patient Safety Oversight Group ~~Committee~~ (PSOG~~C~~)

5. Quality Improvement, Research and Innovation ~~Board / Committee~~Oversight Group (QIRIOG)

A report from the Quality Committee's sub-committees will be given after each sub-committee meeting, on an exception reporting basis, whereby any issues for escalation are raised, using a format approved by the Chair of the Quality Committee.

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

11. Administration

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

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

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

12. Emergency powers and urgent decisions

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

13. Review of Terms of Reference

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

Review history

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

- Revised Terms of Reference agreed by the Quality Committee, 6th May 2020
- Revised Terms of Reference approved by the Trust Board, 21st May 2020
- Amendment approved by the Trust Board, 26th November 2020 (to add the Health and Safety Committee as sub-committee)
- Amendment approved by the Trust Board, 17th December 2020 (to enable deputies attending the Quality Committee 'deep dive' meeting for members of the Executive Team to count towards the quorum requirements)
- Revised Terms of Reference agreed by the Quality Committee, 12th May 2021
- Revised Terms of Reference approved by the Trust Board, 27th May 2021
- Amendment agreed by the Quality Committee, 12th January 2022 (to add the Sepsis Committee as a sub-committee)
- Revised Terms of Reference approved by the Trust Board, 27th January 2022
- Revised Terms of Reference agreed by the Quality Committee, 11th May 2022
- Revised Terms of Reference approved by the Trust Board, 26th May 2022
- Amendment agreed by the Quality Committee, 12th October 2022 (to add the Patient Safety Manager to the Committee's membership)
- Revised Terms of Reference approved by the Trust Board, 27th October 2022
- Revised Terms of Reference agreed by the Quality Committee, 10th May 2023
- Revised Terms of Reference approved by the Trust Board, 25th May 2023
- Revised Terms of Reference agreed by the Quality Committee, 13th March 2024 (to amend the reflect the recommendations of the Deloitte LLP external governance review, including the revised sub-committee structure)
- Revised Terms of Reference approved by the Trust Board, 28th March 2024
- Revised Terms of Reference agreed by Quality Committee, 12th September 2024 (to reflect the revised naming conventions of the Quality Committee sub-committees)
- Revised Terms of Reference approved by the Trust Board, 26th September 2024

Title of report	**Finance and Performance Committee, 26/11/24 (incl. approval of revised Terms of Reference)**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-9					
Executive lead	Neil Griffiths, Non-Executive Director					
Presenter	Neil Griffiths, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
☐	✓	✓	☐	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Finance and Performance Committee met (virtually, via webconference) on 26th November 2024. The Committee considered the following topics: • An update on Fordcombe was provided, which summarised the key deliverables and objectives for each of the workstreams. • The most recent developments relating to the Kent and Medway Medical School (KMMS) Accommodation were presented and the Committee heard that completion work was progressing • An update on the financial improvement plan was provided and the committee noted the plan's progress • The Cardiology Reconfiguration work was presented and an update provided • An initial review of a business case for Maternity Services
Any items for formal escalation / decision	The Trust Board is requested to approve the revised Terms of Reference for the Quality Committee.
Appendices attached	Appendix 1 – Terms of Reference

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	BAF development in progress
Links to Trust Risk Register (TRR)	3243,3161,3136,3130,3113,3109,3000,2998,2947,2945,1310,1304, 1286
Compliance / Regulatory Implications	

The Finance and Performance Committee met (Virtually via webconference) on 26th November 2024.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Committee conducted an **annual review of compliance with the Committee's Terms of Reference** and discussed the process of benefits realisation, which is considered at the Business Case Review panel. It was agreed that the Director of Strategy, Planning & Partnerships would provide Committee members with an update on the completion of benefits realisation at a future meeting.
- The **updated Terms of Reference of the Committee** were agreed as submitted.
- A 'deep dive' **review of Fordcombe Hospital** was presented by the Chief of Service for Wells Health and the Hospital Director, and the Committee were informed that system activity included 1759 patients transferred for treatment and a further 1344 patients, on validation of data, were transferred for other treatment. Administrative support has provided system support in typing 2683 letters and booking 2876 patients. Further work will be done to clarify progress with a number of workstreams, changes in the way patients are booked onto the service and the systems required to support this.
- The **Patient Access strategic theme metrics** for October were reviewed, and the Committee was informed of the changes to the vision and breakthrough objectives, in addition to new financial breakthrough objectives. It was noted that a key area of focus was the average non-elective length of stay for patients and the committee were informed that the Trust's performance for Accident and Emergency 4-hour target was below the trajectory for the month. However, it was recognised that the Trust's performance in this area remains one of the highest both regionally and nationally. 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. The Committee discussed that the purpose of the investment in Kent and Medway Orthopaedic Centre and Fordcombe was to be managing the treatment of longer waiting patients in the system, and that further conversation with the other system providers, would ensure this is happening equitably.
- The Deputy Chief Executive / Chief Finance Officer then provided an **update on the Trust's Financial Improvement Plan,** which included an update on the financial forecast for 2024/25; the mitigations which had been identified; the improvements which had been delivered to the financial forecast; and the weighted risks which had been identified. The Committee noted that daily activity monitoring, consistent and correct coding of activity and divisional identification of initiatives were all in train and supporting the work of the plan. The Committee discussed the significant amount of work undertaken to date and that there remained further work required to achieve the financial plan for 2024/25.
- The **financial performance month 7, 2024/25** was then presented by The Deputy Chief Executive / Chief Finance Officer, wherein an update was provided that, the Trust is forecasting to deliver the planned breakeven position, however recovery actions are still required for the plan to be delivered. It was noted that the recovery actions have had no impact on activity or level of performance in the organisation.
- The Director of Strategy, Planning & Partnerships provided the Committee with an update on the latest developments in relation to the **Kent and Medway Medical School (KMMS) Accommodation**, wherein the Committee heard that works to completion were underway, which would include the commissioning of services within the building.
- An **update on Cardiology Reconfiguration** was then provided, which included an overview of the program of work completed to date.
- The Director of Strategy, Planning & Partnerships then provided updates on the **Business Cases for the East Kent Oncology Build** and the **Maternity Services,** wherein the committee hear of the positive impact to reducing health inequalities the East Kent Oncology build would bring and the planned improvements in quality of services the maternity service business case would realise.
- The Trust Secretary provide a **review of the Trust's finance and sustainability related risks** and highlighted that a more detailed review of individual risks is being undertaken at divisional meetings.

- The Committee reviewed the **Summary report from the People and Organisational Committee, Oct. 24** and the **"Temporary staffing programme" report.** The Committee also noted the **latest information from the Costing Transformation Programme (CTP);** the **annual review of the Standing Financial Instructions, Standing Orders and Scheme of Delegation;** and the **notification of the use of the Trust Seal.**
- The method of the **annual Committee evaluation** was reviewed, and it was agreed that the committee would undertake a review using the format presented
- The Committee noted the **forward programme**.

Under **Any Other Business** Kate Goodwin, was thanked for all her work in a number of areas within the organisation as she leaves to start a new role next week.

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1. Purpose

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

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

2. Membership

Membership of the Committee is as follows:

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

Members are expected to attend all relevant meetings.

3. Quorum

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

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

4. Attendance

The following are invited to attend each meeting of the Committee:

- Chief People Officer (or an appropriate deputy, as they determine)
- Deputy Director of Finance (Performance)

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

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

5. Frequency of meetings

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

6. Duties

The Committee has the following duties:

Financial Management

- To review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals.
- To ensure a comprehensive budgetary control framework is in place and operating effectively
- To monitor financial performance against plan, and ensure corrective action is taken where appropriate.
- To develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- To review and monitor the delivery of the Trust's Cost Improvement Programme (CIP).
- To monitor the delivery of any recommendations arising from The Model Health System programme, and associated work.
- To ensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national or local system-wide initiatives.

Treasury Management

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

Capital Expenditure and Investment

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

Financial Governance, Reporting, Systems and Function

- To review and assess the arrangements for financial governance.
- To review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust.
- To assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- To review and approve the Trust's approach to its National Cost Collection return/s.

Procurement

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

Performance

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

Informatics / Digital and Data (including Information Technology)

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

Assurance and Risk

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

Green issues

- To review the Trust's Green Plan each year, prior to the Plan being submitted to the Trust Board, for approval.

7. Parent Committees and reporting procedure

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

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

8. Sub-Committees and reporting procedure

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

9. People and Organisational Development Committee

A summary report from the People and Organisational Development Committee will be submitted to the Committee, as means of alignment as pay-roll by way of example represents a significant aspect of the expenditure for the Trust, for information / assurance (the summary report submitted from the People and Organisational Development Committee to the Trust Board will be used for the purpose).

~~9.~~10. Emergency powers and urgent decisions

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

~~10.~~11. Administration

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

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

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

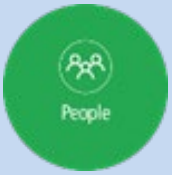
~~11.~~12. Review of Terms of Reference and monitoring compliance

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

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2019
- Terms of Reference (revised) approved by the Trust Board, September 2019
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2020
- Terms of Reference (revised) approved by the Trust Board, September 2020
- Terms of Reference approved by the Trust Board, January 2021 (to address the anomaly regarding the listing of an “Associate Non-Executive Director” in the membership rather than a third Non-Executive Director)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2021 (annual review, but also to include formalising the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, September 2021
- Terms of Reference (revised) agreed by the Finance and Performance Committee, May 2022 (to remove the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, May 2022 (to remove the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2022 (annual review, but also to include formalising the Committee’s role in relation to Green issues)
- Terms of Reference (revised) approved by the Trust Board, September 2022
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2023 (annual review, and to amend the Committee’s specific role in relation to Green issues, following confirmation at the Committee’s meeting on 27/06/23)
- Terms of Reference (revised) approved by the Trust Board, September 2023
- Removal of the duty “To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)”, approved by the Trust Board, October 2023.
- Terms of Reference (revised) agreed by the Finance and Performance Committee, November 2024 (annual review, but also to include formalising the Committee’s relationship with the People and Organisational Development Committee)
- Terms of Reference (revised) approved by the Trust Board, November 2024 (pending)

Title of report	**To agree updated Terms of Reference (annual review)**					
Board / Committee	**Finance and Performance Committee**					
Date of meeting	26th November 2024					
Agenda item no.	11-6					
Executive lead	Louise Thatcher, Trust Secretary					
Presenter	Louise Thatcher, Trust Secretary					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	☐

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	☐	✓	☐	☐	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Finance and Performance Committee's Terms of Reference are due their annual review. The enclosed revised Terms of Reference are therefore submitted to the Committee for review and agreement, prior to being submitted to the Trust Board, for approval (in November 2024). The proposed changes are shown as 'tracked'. Most of these are minor/'housekeeping' changes. The two material changes that are proposed relate to the Committee's relationship with the People and Organisational Development Committee, and to provide clarification regarding the regular attendees at each Committee meeting, for the duration of the meeting. The Committee is however welcome to agree any further changes it wishes to see.
Any items for formal escalation / decision	To agree the revised Terms of Reference, to enable these to be submitted to the Trust Board, for approval
Appendices attached	Appendix 1: Revised Terms of Reference.

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	N/A
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1. Purpose

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- An objective assessment of performance-related issues affecting the key operational targets and the Trust's financial position.
- Advice and recommendations on all key issues of financial management, financial performance and operational performance.
- Assurance on Information Technology / Digital and Data performance (and IT-related business continuity).

2. Membership

Membership of the Committee is as follows:

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

Members are expected to attend all relevant meetings.

3. Quorum

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

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

4. Attendance

The following are invited to attend each meeting of the Committee:

- Chief People Officer (or an appropriate deputy, as they determine)
- Deputy Director of Finance (Performance)

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

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

5. Frequency of meetings

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

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The Committee has the following duties:

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- To develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- To review and monitor the delivery of the Trust's Cost Improvement Programme (CIP).
- To monitor the delivery of any recommendations arising from The Model Health System programme, and associated work.
- To ensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national or local system-wide initiatives.

Treasury Management

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

Capital Expenditure and Investment

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

Financial Governance, Reporting, Systems and Function

- To review and assess the arrangements for financial governance.
- To review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust.
- To assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- To review and approve the Trust's approach to its National Cost Collection return/s.

Procurement

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

Performance

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

Informatics / Digital and Data (including Information Technology)

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

Assurance and Risk

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

Green issues

- To review the Trust's Green Plan each year, prior to the Plan being submitted to the Trust Board, for approval.

7. Parent Committees and reporting procedure

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

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

8. Sub-Committees and reporting procedure

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

9. People and Organisational Development Committee

A summary report from the People and Organisational Development Committee will be submitted to the Committee, as means of alignment as pay-roll by way of example represents a significant aspect of the expenditure for the Trust, for information / assurance (the summary report submitted from the People and Organisational Development Committee to the Trust Board will be used for the purpose).

~~9.~~10. Emergency powers and urgent decisions

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

~~10.~~11. Administration

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

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

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

~~11.~~12. Review of Terms of Reference and monitoring compliance

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

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2019
- Terms of Reference (revised) approved by the Trust Board, September 2019
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2020
- Terms of Reference (revised) approved by the Trust Board, September 2020
- Terms of Reference approved by the Trust Board, January 2021 (to address the anomaly regarding the listing of an “Associate Non-Executive Director” in the membership rather than a third Non-Executive Director)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2021 (annual review, but also to include formalising the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, September 2021
- Terms of Reference (revised) agreed by the Finance and Performance Committee, May 2022 (to remove the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, May 2022 (to remove the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2022 (annual review, but also to include formalising the Committee’s role in relation to Green issues)
- Terms of Reference (revised) approved by the Trust Board, September 2022
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2023 (annual review, and to amend the Committee’s specific role in relation to Green issues, following confirmation at the Committee’s meeting on 27/06/23)
- Terms of Reference (revised) approved by the Trust Board, September 2023
- Removal of the duty “To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)”, approved by the Trust Board, October 2023.
- Terms of Reference (revised) agreed by the Finance and Performance Committee, November 2024 (annual review, but also to include formalising the Committee’s relationship with the People and Organisational Development Committee)
- Terms of Reference (revised) approved by the Trust Board, November 2024

Title of report	**People and Organisational Development Committee, 22/11/24**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-10					
Executive lead	Emma Pettitt-Mitchell, Non-Executive Director					
Presenter	Emma Pettitt-Mitchell, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	☐	☐	✓	✓	✓

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The People and Organisational Development Committee met (virtually, via webconference) on 22nd November 2024. The Committee considered the following topics: ▪ A monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR) incl. an update on pay controls ▪ An update on the Workforce plan for 2024/25 ▪ A review of the Multi-professional Learning and Development Strategy ▪ A review of violence and aggression against Trust staff		
Any items for formal escalation / decision	N/A		
Appendices attached	N/A		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
N/A		N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	BAF development in progress
Links to Trust Risk Register (TRR)	
Compliance / Regulatory Implications	

The People and Organisational Development Committee met (Virtually via webconference) on 22nd November 2024 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Committee conducted a **review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR) (Incl. an update on pay controls)** wherein the committee received an update on the overall temporary staffing spend, which included the effect of recently implemented controls. The number of short-term staff leavers, now reported in numbers rather than percentages was discussed and the work being done, which includes effective appraisal and career conversations, and it was agreed that the Deputy Chief People Officer, Organisational Development would report more detail in regard to appraisal information, as numbers currently include information in regard to new starters, staff on long term sickness absence and maternity leave, which may skew the data. The committee heard that triangulation of information is taking place monthly at divisional level with the support of People business partners and work arising from this is completed by division, in consideration with any actions arising from the staff survey. The committee heard that a number of pay controls have been added as a result of the system being placed into level 4 of the finance regime, and it was agreed that the Head of People Performance and Improvement would present information on pay controls as a monthly update to the committee.

    - The Committee was **assured** regarding the work being done on pay controls and the analysis of information in regard to short term leavers, to clearly identify areas of improvement and action.

- The Deputy Chief People Officer / Temporary Staffing Programme Director provided an **update on the Workforce plan for 2024/25,** which included an overview of the last 6 months. Overall workforce figures are above plan and additional controls are in place along with the additional levels of reporting required as the system is in level 4 of the finance regime. The biggest workforce change noted was the addition of Fordcombe staff who were successfully transferred to the Trust. The transfer includes all staff receiving occupational health screening, a consultation for staff moving to the agenda for change pay scale and the Wells Health division moving into the Trust's governance structure. Staff have been supported through the process and it has reportedly been a positive experience.
- The committee discussed the reduction in temporary staff spend and the impact this has had on leadership teams, divisions and operational staff. The committee were reassured that accountability, training and support for staff has been welcomed has but significant disruption is expected with medical staffing in mid-January, which will need to be reflected in the risks. It was agreed that the Head of People Performance and Improvement would identify the associated risk regarding medical staffing and articulate the nature of the risk.

    - The Committee **partially assured**

- The Head of Learning & Development attended to present a **review of the Multi-professional Learning and Development Strategy,** wherein an in-depth discussion was held around the development of the strategy which will inform the development of the next people and organisational strategy. The key aims of the strategy were articulated and were developed with a number of stakeholder engagement events, focussed surveys. Socialisation of the strategy is planned with a wider group of stakeholders. Governance process have been strengthened and a proposed governance structure was presented. The budgeting around learning and development was considered and the committee heard of development of a system wide academy and leadership development across the ICB is in the early stages of development.
  The impact of the new strategy on staff and the organisation was discussed which includes the improved visibility of the Learning & Development team, the positive affect of the change in governance process in aligning the divisions and improving equitability of access to training. The

advancements in technology was discussed and considered should be included in the strategy going forward.

- A **review of violence and aggression against Trust staff** was provided, which highlighted the causes of violence and aggression and training available to staff, which has seen increase compliance over the year. A security dashboard is being developed to provided improved quality in data for the organisation better to understand the issues. Seven recommendations were presented and the violence aggression standards were shared. Consideration of compliance with the standards will be undertaken at a violence and aggression summit. A number of schemes are in train which will support the management of violence and aggression, but additional in house training resource would be beneficial in further progressing this work. It was agreed that the Director of Emergency Planning and Response would provide an update on progress made following the violence and aggression summit. Date to come back TBC.

- The Committee noted the **forward programme** and conducted an **evaluation of the meeting,** wherein Committee members noted the quality of the papers and that they supported effective conversations.

Title of report	**Summary report from the Audit and Governance Committee, 07/11/24 (incl. approval of revised Terms of Reference)**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-11					
Executive lead	David Morgan, Non-Executive Director					
Presenter	Maureen Choong, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
☐	☐	☐	☐	☐	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Audit and Governance Committee met (virtually, via webconference) on 7th November 2024. The Committee considered the following topics and allocated the assurance ratings accordingly: 1) The Committee was assured regarding the progress which had been made in relation to the development of the Board Assurance Framework (BAF) and acknowledged the next steps which had been identified. 2) The Committee was partially assured as part of the review of red-rated risks as although there was a robust focus on improving risk management at the Trust, further staff training was needed and the process of assured to the Committee required further development
Any items for formal escalation / decision	The Trust Board is requested to approve the revised Terms of Reference for the Audit and Governance Committee. The Standing Orders, Standing Financial Instructions, and Reservation of Powers and Scheme of Delegation have been submitted to the Trust Board, under a separate agenda item, for ratification.
Appendices attached	Appendix 1 – Terms of Reference

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	N/A
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

The Audit and Governance Committee met (Virtually via webconference) on 7th November 2024.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. As part of the review propose it was agreed that the Deputy Trust Secretary should liaise with the Director of IT to identify a representative from the Trust's cyber security team for inclusion in the "Attendance" section of the Committee's Terms of Reference. It was also agreed that the Deputy Trust Secretary should amend the "Sub-committees and reporting procedure" section of the Committee's Terms of Reference, to explicitly outline the requirement for the escalation report to include details of the review of the Trust's Risk Register and Board Assurance Framework (BAF); and amend the Terms of Reference to highlight the Committee's role in relation to the BAF. The revised Terms of Reference, with the additional amendments requested by the Committee, are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Chief Nurse and the Head of Risk Management presented a comprehensive review of the **Trust's red-rated risks** wherein an in-depth discussion was held regarding the Trust's risk management process and the method by which the Committee was provided assurance; wherein the Committee acknowledged the significant education programme which had been developed and was in the process of being rolled-out Trust-wide; but, highlighted the additional focus which was required in relation to recovery in the event that a risk crystallised. It was agreed that the Chief Nurse and Head of Risk Management should liaise with representatives from the Core Clinical Services Division to review, and if appropriate amend, risk ID3000 "Linac LA1C – Canterbury". It was also agreed that the Chief Nurse and Head of Risk Management should liaise with the Chair and Vice Chair of the Committee to decide what, if any, amendments should be made to future "Review of red-rated risks" reports (incl. in relation to illustrating the clinical and financial impacts of red-rated risks) to reflect the discussions held at the Committee's meeting in November 2024
  - ❖ The Committee was **partially assured** as although there was a robust focus on improving risk management at the Trust, further staff training was needed and the process of assured to the Committee required further development.
- The Committee reviewed the **Board Assurance Framework (BAF)** wherein the Trust Secretary highlighted the background for the development of the BAF and the associated next steps, which included further discussions required with the Trust's Executive Directors to confirm their key strategic risks. A brief discussion was then held regarding the importance of ensuring any actions identified to address the risks had a realistic timeframe allocated and it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should provide the Trust Secretary and Head of Risk Management with examples of 'best practice' BAFs, to inform and support the development of the Trust's BAF.
  - ❖ The Committee was **assured** regarding the progress which had been made in relation to the development of the BAF and that the appropriate next steps had been identified and were being progressed.
- The Director of Audit, Tiaa Ltd provided an **update on progress with the Internal Audit plan for 2023/24** (incl. progress with actions from previous Internal Audit reviews) which included details of the implications of the new Internal Audit Code of Practice (Global Internal Audit Standards) and an overview of the Internal Audit reviews which had been completed within the reporting period. The Committee agreed a deferral of the Pathology Back Up Review to enable the completion of improvements which had been commissioned by the Trust.
- The Committee reviewed the latest **Counter Fraud update** which included details of the proactive work undertaken by the Counter Fraud Service during the reporting period and the implementation of an action tracker, to monitor progress against actions identified as part of the proactive reviews.
- The Director, Audit, Grant Thornton UK LLP presented the **"Audit progress Report and Sector Update" from External Audit**, which included details of the schedule for the 2024/25 external audit.
- The **summary of the latest Financial issues** was presented by the Deputy Chief Executive/Chief Finance Officer, wherein the Committee noted the key areas of focus to improve the Trust's financial position.

- The Associate Director of Procurement provided the **latest single tender/quote waivers data** which included details of the single tender/quote waivers which had been rejected within the reporting period and details of the Trust's purchase order expenditure.
- The latest **details of interests declared under the Conflict of Interests policy and procedure** and latest **losses & compensations data** was noted by the Committee.
- The Director of Emergency Planning and Response attended for the latest an **update on security issues** wherein a brief discussion was held regarding incidents of abuse against Trust Staff and it was agreed that the Director of Emergency Planning and Response should liaise with ward staff to check, and confirm, whether such staff had a robust understanding of how, and when, to contact the Security Team regarding any disturbances from patients and visitors.
- The Trust's Cyber Security Architect provided an **update on Cyber Security** wherein a brief discussion was held regarding the potential risks associated with the utilisation of Artificial Intelligence (AI) and it was agreed that the Director of IT and Cyber Security Architect should inform Trust staff, via a Trust-wide communication, regarding the risks associated with the utilisation of AI within a healthcare setting.
- The **Standing Orders, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions** were approved, following their annual review and revision (the documents have been submitted to the Trust Board separately, for ratification).
- The Committee also noted the **forward programme** and conducted an **evaluation of the meeting** wherein Committee members acknowledged the candid discussions which had been held

In following additional actions were also agreed:

- The Trust Secretary should amend the Terms of Reference for the Risk and Regulation Oversight Group to provide further clarification regarding the role of the Oversight Group in the review of the Trust's Risk Register and BAF.

Audit and Governance Committee

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive sub-committee of the Trust Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Trust Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework (BAF)); and oversight of the Internal and External Audit, and Counter Fraud functions. The Committee has primary responsibility for ensuring compliance with the Trust's established governance structures.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of External Auditors, and on the maintenance of independent relationships with such Auditors.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.2 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chair of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Chair of the Trust Board, together with a Vice-Chair. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair and Vice-Chair of the Committee will also act as Chair and Vice-Chair (respectively) of the Auditor Panel.

3.2 Other individuals may be co-opted to become formal members of the Committee, to address issues of specific concern, at the discretion of the Committee Chair.

3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.

3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Committee Chair may require the affected member to withdraw at the relevant discussion or voting point.

4. Quorum

4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair).

4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[1].

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Associate Non-Executive Directors
- Cyber Security Architect
- Deputy Chief Executive / Chief Finance Officer
- Deputy Director of Finance (Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit Engagement Lead and/or other appropriate representatives
- Senior Anti-Crime Manager (formerly Local Counter Fraud Specialist)
- Trust Secretary

5.2 Members (listed above) are expected to be present at all meetings of the Committee. Those listed in section 5.1 are expected to be in attendance at all meetings of the Committee.

5.3 The Chief Executive, other Executive Directors, or any other member of staff will be invited to attend if the Committee is discussing areas of risk or assurance that are the responsibility of that individual and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chair.

5.5 The Committee will, if requested by the External and Internal Auditors, meet privately with those Auditors at the start of each meeting. A private session with the External and Internal Auditors will however be held once a year, ahead of the first Audit and Governance Committee meeting following the completion of the audit of the Annual Report and Accounts, regardless of whether the Auditors have any issues to raise. Individual Committee members can however approach the External or Internal Auditors in private, should such members consider this necessary.

5.6 The Trust Secretary will provide appropriate support to the Chair and Committee members, and will be responsible for the administration of the Committee (see section 10).

5.7 The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to fulfil the 'Committee's purpose and/or meet its duties.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may also put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the

[1] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

7. Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, risk management and internal control

7.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (or successor bodies).

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executive Directors and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective BAF to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter (or equivalent), operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the BAF.

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications & management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to 'those charged with governance' (TCWG), agreement of the Auditor's Annual Report (formerly the Annual Audit Letter) (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other assurance functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, as it sees fit, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health and Social Care's Arm's Length Bodies or regulators/inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of Counter Fraud work. The Committee will ensure that any suspicions of fraud, bribery and corruption are referred to the NHSCFA.

Management

7.11 The Committee shall request and review reports and positive assurances from the Executive Directors and managers on the overall arrangements for governance, risk management and internal control.

7.12 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance (in so far as they may affect the Trust's Annual Report and Accounts).

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy

of the information provided to the Trust Board. This duty will usually be met via the commissioning of, and reviewing the outcome of, the Core Financial Assurance reviews within the annual Internal Audit programme.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The text of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The Letter of Management Representation
- Explanations for significant variances
- Qualitative aspects of financial reporting

Freedom to Speak Up

7.16 The Committee shall support the People and Organisational Development Committee and Trust Board in reviewing the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements, as the Committee sees fit.

Security issues

7.17 The Committee shall support the Committee Chair in fulfilling their role as the Trust's Security Management Non-Executive Director (NED) Champion via the following methods:

- The consideration of a standing "Update on ~~S~~security issues" item at each standard Committee meeting.
- The consideration of a standing "Update on Cyber Security" item at each standard Committee meeting.
- The consideration of a Security Annual Report.

Auditor Panel

7.18 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:

- Agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advising the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advising (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on (and approving) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advising the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

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

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary's Office. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the BAF, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements. The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed. The work of the Committee as the Trust's Auditor Panel should also be included.

8.4 The Committee shall undertake an annual self-assessment to ensure the objectives of the Terms of Reference are being met.

8.5 The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.

8.6 The Chair must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

9.1 The Committee has ~~no~~ the following sub-committees.

1. Risk and Regulation Oversight Group

A report from the Audit and Governance Committee's sub-committees will be given after each sub-committee meeting, on an exception reporting basis, whereby any issues for escalation are raised, and details of the review of the Trust Risk Register and BAF are provided, using a format approved by the Chair of the Audit and Governance Committee.

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

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary's Office, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one other Non-Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

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

History
Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013

Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015
Terms of Reference approved by the Trust Board, November 2015
Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)
Terms of Reference agreed by the Audit and Governance Committee, November 2016
Terms of Reference approved by the Trust Board, November 2016
Terms of Reference agreed by the Audit and Governance Committee, November 2017
Terms of Reference approved by the Trust Board, November 2017
Terms of Reference agreed by the Audit and Governance Committee, December 2018
Terms of Reference approved by the Trust Board, December 2018
Terms of Reference agreed by the Audit and Governance Committee, November 2019
Terms of Reference approved by the Trust Board, November 2019
Terms of Reference agreed by the Audit and Governance Committee, November 2020
Terms of Reference approved by the Trust Board, November 2020
Amended Terms of Reference agreed by the Audit and Governance Committee, May 2021 (to reflect the Committee's primary responsibility for ensuring compliance with the Trust's established governance structures).
Amended Terms of Reference approved by the Trust Board, May 2021
Terms of Reference agreed by the Audit and Governance Committee, November 2021 (annual review)
Terms of Reference approved by the Trust Board, November 2021
Terms of Reference agreed by the Audit and Governance Committee, November 2022 (annual review, and the inclusion of content related to security issues)
Terms of Reference approved by the Trust Board, November 2022
Terms of Reference agreed by the Audit and Governance Committee, November 2023 (annual review)
Terms of Reference approved by the Trust Board, November 2023
Terms of Reference agreed by the Audit and Governance Committee, November 2024 (annual review)
Terms of Reference approved by the Trust Board, November 2024

Title of report	**Charitable Funds Committee, 20/11/24 (incl. approval of the revised Terms of Reference and approval of Annual Report and Accounts of the Trust's Charitable Fund, 2023/24)**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-12					
Executive lead	David Morgan, Non-Executive Director					
Presenter	David Morgan, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	☐	☐	✓	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Charitable Funds Committee met (virtually, via webconference) on 20th November 2024. The Committee considered the following topics: ▪ The Terms of Reference were reviewed as part of the annual process and some proposed amendments were agreed. ▪ The Charitable Fund Annual Report and Accounts for 2023/24 ▪ The financial overview at month 7, 2024/25 ▪ The annual review of Investment Strategy ▪ The Chair's action in relation to the Helipad Business Case ▪ A fundraising update, ▪ An update on the proposed partnership with Maggie's Centres
Any items for formal escalation / decision	The Trust Board is requested to approve the revised Terms of Reference for the Charitable Funds Committee, and the Annual Report and Accounts of the Trust's Charitable Fund, 2023/24.
Appendices attached	Appendix 1 – Terms of Reference Appendix 2 – Annual Report and Accounts of the Trust's Charitable Fund, 2023/24

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	BAF development in progress
Links to Trust Risk Register (TRR)	1038 – The effect of Business Continuity Incidents on the Trust's ability to manage its charitable funds 1037 – The effect of potential misuse of charitable funds 1036 – The effect of inadequate governance regarding management of charitable funds
Compliance / Regulatory Implications	N/A

The Charitable Funds Committee met (Virtually via webconference) on 20th November 2024.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference, with the additional amendments requested by the Committee, are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The **Charitable Fund Annual Report and Accounts for 2023/24** was then reviewed by the Committee. The Annual Report and Accounts for 2023/24 is enclosed in Appendix 2 for the Trust Board's approval.
- The Head of Financial Services provided the **financial overview at month 7, 2024/25** which included the efficient use of charitable funds in the month, but noted that a review of aged funds should be undertaken to identify those which could be expedited
- The Committee conducted the **annual review of Investment Strategy** wherein the Head of Financial Services highlighted that a review of alternative investments had been undertaken and recommended continuation with current investment arrangements, which the committee approved
- **The Chair's action in relation to the Helipad Business Case** was formally approved by the Committee.
- The Head of Charity and Fundraising provided a **fundraising update**, which included presentation of the first mass participation event, which took place on 19 October involving 100 members of staff abseiling off The Tunbridge Wells hospital building. The positive impact on staff and the organisation was noted of the support received from funding
- The Chair of the Charity Management Committee provided an **update on the proposed partnership with Maggie's Centres** was then provided, which included an update on the progress of the project and engagement events with key stakeholders
- The Committee also noted the **forward programme**.

Appendix 1

CHARITABLE FUNDS COMMITTEE

NHS Maidstone and Tunbridge Wells NHS Trust

Terms of Reference
FOR APPROVAL

1. Purpose

The Charitable Funds Committee has been established as a sub-committee of the Trust Board to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund, known as MTW Hospitals Charity is managed efficiently and effectively in accordance with the directions of the Charity Commission, Code of Fundraising Practice, relevant NHS legislation and the wishes of donors.

2. Membership

Membership of the Committee is as follows:

- The Committee Chair – a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board.
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board.
- A further Non-Executive Director or Associate Non-Executive Director.
- Director of Strategy, Planning and Partnerships
- The Deputy Chief Executive / Chief Finance Officer.
- The Head of Financial Services.
- The Trust Secretary.
- Chair of the Charity Management Committee

If a member cannot attend a meeting, they may send a representative in their place.

3. Quorum

The Committee shall be quorate when one Non-Executive Director (or Associate Non-Executive Director) and three other members are present. Deputies representing members will count towards the quorum.

4. Attendance

The Head of Charity and Fundraising will routinely attend meetings of the Committee (but will not be a member).

The Committee Chair may invite other staff, Non-Executive Directors (or Associate Non-Executive Directors) to attend, as required, to fulfil the Committee's purpose and/or meet its duties.

5. Frequency

The Committee shall meet at least three times per financial year (and more frequently if required to fulfil its purpose and/or meet its duties).

6. Duties

The Committee will act on behalf of the Corporate Trustee (Maidstone and Tunbridge Wells NHS Trust) and will:

- Develop the strategy and objectives of MTW Hospitals Charity, for approval by the Trust Board.
- Ensure that MTW Hospitals Charity complies with relevant law and with the requirements of the Charity Commission; in particular ensuring the submission of Annual Returns and Accounts and the Code of Fundraising Practice.
- Oversee the delivery of the strategy and objectives of MTW Hospitals Charity.
- Identify and mitigate any risks to the income received to MTW Hospitals Charity.
- Oversee MTW Hospitals Charity expenditure and investment plans, including:
  - Approving relevant policies and procedures.
  - Agreeing approval and authorisation limits for expenditure from charitable funds in line with the Trust's Reservation of Powers and Scheme of Delegation.
  - Approving and monitoring investment strategies.

Appendix 1

The specific duties of the Committee in relation to MTW Hospitals Charity are to:

Policy and other matters

- To approve, on behalf of the corporate Trustee:
  - The Policy and procedures for charitable funds.
  - Specific fundraising appeals (provided these align with the approved Charitable Fund strategy).
  - A reserves policy (if considered by the Committee to be required).
  - An investment strategy (and to formally review the strategy annually).
  - A grant making policy (if considered by the Committee to be required).
  - Guidance for fundraising activities (if considered by the Committee to be required).

Operational matters

- To approve the annual management and administration fee payable to the Trust.
- Be advised of and consider the application of all new legacies.
- Approve proposals regarding the establishment of any new funds.
- Authorise financial procedures and financial limits.
- Receive details of any expenditure refused.
- To approve the banking arrangements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund.
- To authorise expenditure at the limits reserved for the Committee (as stated in the Trust's Reservation of Powers and Scheme of Delegation).

Internal and External control

- To seek assurances that all income is secured and that expenditure is within the objects of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund.
- To ensure compliance of all statutory legislation and charity regulations, and seek assurance on compliance where considered necessary.
- To ensure there is adequate provision for the independent monitoring of investment activity.
- To receive all relevant internal and external audit reports, and ensure compliance with any recommendations.

Financial reporting

- To review income and expenditure reports for each of the reporting periods.
- To review and agree the principal accounting policies to be adopted.
- To review, and agree the Annual Report and Annual financial accounts for the Charitable Fund, for approval by the Trust Board.
- To receive, where appropriate, the annual investment report.
- To ensure the Deputy Chief Executive / Chief Finance Officer is compliant with the reporting requirements of the Committee and the Trust Board (as the agent of the Trustee).

7. Parent committees and reporting procedure

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

A written summary report of each Charitable Funds Committee meeting will be provided to the Trust Board. The Chair of the Charitable Funds Committee will present the Committee report to the next appropriate Trust Board meeting.

8. Sub-committees and reporting procedure

The Committee has the following sub-committee:

- The Charity Management Committee.

A written summary report from each sub-committee will be received at each meeting of the Charitable Funds Committee. The Terms of Reference of each sub-committee will be reviewed, and approved, at the Charitable Funds Committee every year.

The Charitable Funds Committee may also establish fixed-term working groups, as required, to support the Committee in meeting its duties as it, or the Trust Board, sees fit.

Appendix 1

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted either the Deputy Chief Executive / Chief Finance Officer or Director of Strategy, Planning and Partnerships. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Charitable Funds Committee, for formal ratification.

10. Administration

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

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

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

11. Review

The Terms of Reference of the Committee will be reviewed annually by the Committee, and approved by the Trust Board.

History

Agreed at Charitable Funds Committee, July 2014
Approved at Trust Board, September 2014
Agreed at Charitable Funds Committee, July 2015
Approved at Trust Board, September 2015
Agreed at Charitable Funds Committee, November 2016
Approved at Trust Board, December 2016
Agreed at Charitable Funds Committee, 16th October 2017
Approved at Trust Board, 29th November 2017
Agreed at Charitable Funds Committee, 27th November 2018 (annual review)
Approved at Trust Board, 20th December 2018
Agreed at Charitable Funds Committee, 29th October 2019 (annual review)
Approved at Trust Board, 28th November 2019
Agreed at Charitable Funds Committee, 24th March 2020 (to include the Charity Management Committee as a sub-committee)
Approved at Trust Board, 30th April 2020
Agreed at Charitable Funds Committee, 24th November 2020 (annual review)
Approved at Trust Board, 17th December 2020
Agreed at Charitable Funds Committee, 24th November 2021 (annual review, and to add a further Non-Executive Director or Associate Non-Executive Director to the membership)
Approved at Trust Board, 22nd December 2021
Agreed at Charitable Funds Committee, 17th November 2022 (annual review)
Approved at Trust Board, 24th November 2022
Agreed at Charitable Funds Committee, 22nd November 2023 (annual review)
Approved at Trust Board, 30th November 2023
Agreed at Charitable Funds Committee, 20th March 2024 (to remove the Deputy Director of Finance (Governance) from the Committee's membership and to process the transition of executive responsibility for the Trust's Charity from the Chief Operating Officer to the Director of Strategy, Planning and Partnerships)
Approved at Trust Board, 28th March 2024
Agreed at Charitable Funds Committee, 20th November 2024 (annual review)
Approved at Trust Board, 28th November 2024 (pending)

Appendix 2

Summary

The following report highlights changes from the draft submission of the charitable funds annual report and accounts as presented in the July Committee meeting to the proposed final version.

The 2023/24 Charitable Funds Annual Report, Accounts and working papers have been independently examined by Grant Thornton and the following amendments have been done.

There was one main change within the accounts which affects Balance sheet; Statement of Cashflows; Debtors and Creditors. This relates to the purchase of the Faxitron machine. The invoice included VAT which should not have been applied to medical equipment. At the end of the financial year the Trust was waiting for the credit note for the VAT element of the invoice totalling £20k, this has been received in 2024/25. There is no overall change to the individual funds or to the financial position. The areas that has been affected by this adjustment are shown in the following table:

Area of Change	Category	Draft Accounts Value	Audited Accounts Value	variance
Balance Sheet	Debtors	0	20	20
Balance Sheet	Creditors	(163)	(183)	(20)
Statement of Cashflows	Debtors	0	(20)	(20)
Statement of Cashflows	Creditors	(44)	(24)	20
Note 6.2 Debtors	Debtors	0	20	20
Note 7.1 Creditors	Creditors	(163)	(183)	(20)

Other minor amendments made have primarily been rounding issues and where appropriate additional disclosures to improve the information for the reader of the accounts.

To recap the key points:

- The Trust has prepared the 2023/24 Charitable Funds Accounts in accordance with FRS 102 and the charities SORP FRS 102 (Appendix A)

- The key results reported for the 2023/24 financial year were income of £536k (2022/23 £158k) including investment income of £39k (2022/23 £24k) and expenditure of £478k (2022/23 £367k), in the year.

- The overall position was a net positive outflow of £57k (2022/23 negative £230k) in the year, increasing the balance of funds of the charity at 31st March 2024 to £930k (2022/23 £873k).

- A total of £433k was received from donations (£134k 2022/23) and income from legacies £64k received this year (£0k 2022/23).

    - £98.5k from Breast Care Kent for a Faxitron Machine
    - £61.5 from Peggy Wood Foundation
    - £66.0k from NHS Charities Together for stage 3 funding
    - £29k in total from Just Giving

- Key purchases within the year

    - Faxitron Path Vision Machine (£98.5k);
    - Genius Tissue Morcellator (£30.0k);
    - Bladder scanners (£47.4k);
    - Recliner chairs for T&O (£15.1k) and
    - Butterfly ultrasound scanners (£15k)

Appendix 2

Recommendations:

The auditors confirmed on 13th November that they have completed their independent examination review of the annual report and accounts and there are no further changes to be made.

The Committee are asked to recommend that the 2023/24 Charitable Funds Annual Report and Accounts along with the Letter of Representation are adopted and approved at the November Trust Board.

Following Trust Board approval, the Annual Report and Accounts will then be submitted to the Charity Commission before the deadline of 31st January 2025.

MTW Hospitals Charity
Supporting your local hospitals

r 7:kj Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust Charitable Fund Annual Report and Accounts For the year ended 31st March 2024

Charity Number 1055215

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Fundraising foreword

Welcome to the annual report of Maidstone and Tunbridge Wells NHS Charitable Fund for 2023/2024. We are the sole charity of the Trust, working on behalf of NHS patients and their families across Maidstone, Tunbridge Wells and the surrounding areas to provide resources and facilities to meet the needs of our NHS partners, patients and their families.

Key highlights of our year include:

- Exceeding our fundraising target and almost tripling the income from the previous year which has enabled the Charity to go further and help more patients, visitors and staff and to ensure that Maidstone and Tunbridge Wells NHS Trust really does offer outstanding care to everyone when they need it.

- Celebrating the 75th Birthday of the NHS in July with our local community, which included a community fundraising campaign #75for75 raising over £3,500 as well as assemblies and competitions with local schools.

- We are continually grateful to you, our local community, who go above and beyond to raise funds to support the work of the Charity. From sponsored Ironman events to truck pulls and walks, your donations ensure we can continue to do more to improve the lives of those who work for and who live within our catchment area.

- This year Maidstone and Tunbridge Wells NHS Charitable Fund were honored to be chosen as the Mayor of Tunbridge Wells Charity of the Year. This prestigious award allowed the charity to have a renewed focus within Tunbridge Wells area and to be the sole beneficiary of the retiring collection from the pantomime held at the Assembly Halls in the Town. Raising over £3,000 to support the work of the charity alone.

These are just a few examples of the work of the Head of Charity and Fundraising over the last twelve months. Your donations made this work possible, and your future donations are the key to our continued success. With your support we will continue to focus on helping the population of Maidstone, Tunbridge Wells and the surrounding areas to live fulfilling and healthy lives.

Looking forward to the next 12 months the Charity is hosting the first mass participation event which will see over 100 people abseil down the side of Tunbridge Wells Hospital hoping to raise over £15,000 to continue to support our patients, visitors and staff and ensuring that we can continue to support our local hospitals to grow.

If you would like to get involved in the work of the charity, support us with a donation or become a volunteer, details about how to do this are at the end of this report. Please do consider supporting us, every pound counts.

Our performance

The charity aims to raise vital funds to make Maidstone and Tunbridge Wells NHS Trust a truly outstanding, patient friendly provider for the patients and families cared for every year and to support the amazing staff who deliver exceptional care to those patients and their families.

We aim to continue to promote understanding of and increase charitable giving to Maidstone and Tunbridge Wells NHS Charitable Fund demonstrating the difference this makes. We will support the Trust to meet its ambition of always providing exceptional healthcare and ensuring all patients have a positive experience of care and support.

We will use funds donated to us to provide additional resources above and beyond what the NHS can currently provide which will lead to an improved environment for patients and staff; additional equipment that can make a real difference to patient care and additional opportunities for staff training and support. We will also ensure that the Trust continues to be a leader of scientific research and treatment advances by raising funds to support the investment of latest technology and patient innovations.

Our achievements

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds (the Charity's) Annual Report and the audited financial statements for the year ended 31st March 2024.

The financial statements set out on pages 21 to 35 comply with the charity's trust deed, Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) relevant to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS) applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019).

Trustee Statement

The generosity of the many people who have raised funds, given donations and made provisions in their will, is recognised by the Trustee, the Charitable Funds Committee, and staff. The Trustee, Charitable Funds Committee and staff would like to express their sincere gratitude to all those who have made a contribution which has enabled the Charity to enhance the standard of care, services and facilities provided by Maidstone and Tunbridge Wells NHS Trust to patients, their relatives, visitors and staff.

The role of the Charity

Maidstone and Tunbridge Wells NHS Trust ('the Trust') is the Corporate Trustee of the charitable fund under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Charity is constituted by a Trust Deed and registered with the Charity Commission under charity number 1055215, and includes funds in respect of the hospitals of Maidstone and Tunbridge Wells NHS Trust.

During the year the Charity was situated on two main sites in Kent: Maidstone Hospital and Tunbridge Wells Hospital.

The Charity is an 'NHS Umbrella Charity' under which there are individual sub-funds that are held for administrative purposes, principally to respect the wishes of the donors.

Within the Umbrella there were a total of 36 individual funds at the 31st March 2024 with a total value of £0.930m (year 2022/23 £0.874m). The number of funds in each category is as follows:

- 16 restricted funds[1].

Appendix 2

- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 18 unrestricted[2] or designated[3] funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.
- The major funds within each of these categories are disclosed in Note 8 in the accounts.

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[1] Restricted funds are the funds of the charity that are required to be expended in a certain way, or limited to expenditure for a particular purpose.
[2] Unrestricted funds are the funds of the charity that may be spent entirely at the discretion of the Trustee
[3] Designated funds are funds set aside for designated purposes. Designated funds are unrestricted as the Trustee can remove the designation at any time

Appendix 2

The Corporate Trustee

Maidstone and Tunbridge Wells NHS Trust is the sole Corporate Trustee of the Charity.

The Trust Board effectively adopts the role of Trustee as defined by the Charity Commission (it is considered to be the agent of the Trustee). Individual members of the Trust Board are therefore not trustees under charity law.

Details of appointments and terminations within the financial year are shown below:

Executive Directors	Non-Executive Directors	Other Directors
Miles Scott – Chief Executive	David Highton – Chair of the Trust Board-Left Board 30/04/2024	Sara Mumford – Director of Infection Prevention & Control/Medical Director
Steve Orpin – Deputy Chief Executive / Chief Finance Officer	David Morgan	
Peter Maskell – Medical Director Left Board 31/12/2023	Wayne Wright	
Sean Briggs – Chief Operating Officer	Maureen Choong	
Joanna Haworth – Chief Nurse	Neil Griffiths	
Sue Steen – Chief People Officer	Emma Pettitt-Mitchell	
Rachel Jones – Director of Strategy, Planning and Partnerships	Alex Yew – Associate Non-Executive Director	
	Jo Webber – Associate Non-Executive Director	
	Karen Cox – Associate Non-Executive – -Left Board on 25/06/2024	
	Richard Finn – Associate Non-Executive Director	

None of the Members of the Trust Board have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee (in 2022/23 this was also none)

The principal office of the Charity is:
Trust Headquarters,
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital,
Hermitage Lane,
Maidstone,
Kent,
ME16 9QQ

Appendix 2

Principal advisors:

Independent Examiner Grant Thornton UK LLP 30 Finsbury Square London EC2A 1AG	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers (Closed on 25.06.2024) Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
Solicitors Capsticks Solicitors LLP 1 St George's Road Wimbledon, London SW19 4DR	Bankers National Westminster Bank PLC (RBS/GBS) 2nd Floor 280 Bishopsgate London EC2M 4RB
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB

Governance and Management of the Charity

Governance

The Board of Maidstone and Tunbridge Wells NHS Trust became responsible for the funds with effect from the 1st April 2000, following the merger of Kent and Sussex Weald NHS Trust, which was based at Tunbridge Wells, and Mid Kent Healthcare NHS Trust, which was located at Maidstone. The Trust Board delegates the daily stewardship of the funds to the Charitable Funds Committee, which within its annual programme of meetings, includes relevant training and updates as required to assist in the performance of its role as Trustee.

The Charitable Funds Committee operates according to Terms of Reference that are approved annually by the Trust Board, and plans to meet at least three times a year; for the financial year 2023/24 the Committee met four times.

The proceedings and decisions of the committee are recorded. The minutes of each meeting are formally agreed by the Chair of the Committee and circulated to all members. A written summary of each Charitable Funds Committee meeting is also submitted to the Trust Board.

Recruitment and Training of Trust Board and Charitable Funds Committee Members

All Trust Board and Committee members undertake an induction programme within the Trust upon joining. They are also able to focus on a particular area of the Trust in which they have a special interest or concern.

Management of the Charity

The management of the Charity is operated in accordance with the Trust's "Policies and Procedures for Charitable Funds", which are approved by the Charitable Funds Committee. That policy was reviewed and updated during 2021/22, approved by the Charitable Funds Committee on 28th July 2021, and then ratified by the Policy Ratification Committee on 10th September 2021. There is a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised Fund Holders The Fund Holders consist mainly of senior department managers. Each individual Fund Holder is approved by the general manager or Clinical Director of the Directorate, and also made aware of the Trust's Standing Orders and Standing Financial Instructions that apply to Charitable Funds. Each Fund Holder receives a detailed financial statement of the fund each month. The Charitable Funds Committee agree the charitable fundraising strategy for year 2023 to 2027 on 20th January 2023.

Risk Management

The major risks to the Charity have been assessed, and in the opinion of the Corporate Trustee, all necessary action has been taken and procedures have been put in place to minimise those risks wherever possible. The risk policies and financial controls of the Trust apply to the Charitable Funds; however, a separate section of the Trust's risk register was created (using the Trust's existing risk assessment process and framework) to register risks that are relevant to the Charitable Fund; and an "Annual review of the risk register entries relevant to the Charitable Fund" item has been scheduled for consideration at the Charitable Funds Committee, with the outcome of that review to be included in the "Risk Management" section of this Annual Report.

The latest annual review of the four high-level risks that had been identified and assessed (which were informed by the Charity Commission's "NHS charities guidance" and "Managing your charity…" guidance; and the charitable fund risk registers at several other NHS Trusts) was duly

considered at the Charitable Funds Committee's meeting in March 2024. During the annual review the Committee confirmed that the risk related to the risk of non-compliance with Charity Commission rules and regulations (including the over- or under- performance of any fundraising appeals) should be closed, as there was sufficient assurance that Trust's Charitable Funds policy, and the processes and governance implemented by the Head of Charity and Fundraising for appeals and fundraising, were adequate to prevent the risk of non-compliance.

The Committee also requested that the risk related to the effect of Business Continuity Incidents on the Trust's ability to manage its charitable funds be amended to remove any reference to the COVID-19 pandemic and focus explicitly on Business Continuity Incidents, in general. The Committee also requested that a further in-depth review of the risk related to the effect of potential misuse of charitable funds and the risk of the effect of inadequate governance regarding management of charitable funds be conducted, to consider whether the two risks should be replaced by a new, overarching risk which considered the totality of the risk to the Trust's charitable funds. The proposed amendments and the further in-depth review will be discharged during 2024/25.

The Committee also considered whether there were any omissions from the risk register and it was confirmed that no further additions were required.

As of the end of the 2023/24 financial year the three high-level risks were as follows:

1. Governance arrangements and management of charitable funds (i.e. that a lack of sufficient governance arrangements and resources within the corporate Division to adequately manage the raising, allocation and financial management of Charitable Funds could result in adverse outcomes);
2. Potential, actual or perceived misuse/misallocation of charitable funds (i.e. that damage could be caused should charitable funds be misappropriated, not allocated with due governance; not used for their intended purpose; or not used optimally within the bounds of Trust policy and procedure); and
3. Impact of Business Continuity Incidents on the Trust's ability to manage its charitable funds (i.e. that decreased on site staffing resource could affect day to day running of charitable activities, that the inability to undertake normal charitable activities could impact earning potential, and that a significant increase in donations could result in funds being unallocated for specific or intended purposes).

One aspect of the management of charitable funds relates to investment performance the Corporate Trustee has adopted a relatively low risk policy regarding this, although 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £85k per banking institution operating under a separate banking license. The adopted policy is that the maximum investment is up to £85k in each banking institution outside the Government Banking Scheme. Therefore, there is no risk on theseinvestments.

Investment Powers

The investment powers of the charitable fund are stated in the Declaration of Trust registered with the Charity Commission, which provides for the following:

''*to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustee in their discretion think fit but so that the trustees:*

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) *shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures or traded options);*

c) *shall not have power under this clause to engage in trading ventures; and*

d) *shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.*''

Investment strategy

The investment strategy of the charity is defined, by the charitable fund committee on behalf of the corporate trustee as follows:

"*to maximise total returns whilst minimising any risk to the total value of the fund in both the short to medium term.*"

The strategy identifies the current preferred investment mix for the charity as:

- 84% Cash;
- 8% Equities; and
- 8% Bonds.

The Charitable Funds Committee monitors the performance of the investments on a regular basis.

Professional Advisors

Grant Thornton UK LLP is the Trust's appointed External Auditor and they act as the charitable fund's independent examiner. For the 2023/24 financial year, an independent examination was carried out as the charity's gross income falls below £1m.

In addition, TIAA, the Internal Auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

The key objective of the Trustee of the Maidstone and Tunbridge Wells NHS Charity is to ensure that donations and legacies received are used in accordance with the wishes of the donor and the aims of the Trust. The Trustees therefore consider that the charity clearly falls within the definition of a public benefit entity under the terms of FRS 102.

The Corporate Trustee confirms that the guidance provided by the Charity Commission has been referred to with regard to the need for public benefit when reviewing their aims and objectives and future activities.

The purpose of the Charity is to raise vital funds to make Maidstone and Tunbridge Wells NHS Trust a truly outstanding, patient friendly provider for the patients and families cared for every year and to support the amazing staff who deliver exceptional care to those patients and their families. To achieve our purpose, we have four main strategic objectives:

- Promote understanding of and an increase in charitable giving;
- Supporting the Trust to always provide exceptional healthcare;
- Providing additional resources above and beyond what the NHS can currently provide; and
- Ensure the Trust continues to be a leader of scientific research and treatment

advances. The objects of the Charity are stated in the Trust deed as follows: -

"*The Trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for such purposes relating to Hospital Services (including Research), or to any other part of the Health Service associated with any hospital as the Trustees think fit.*"
The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the Charity.

Strategy for Achieving its Objectives

The Charitable Funds are used to support the overall objectives of the Trust, and include the provision of a wide range of equipment and facilities for both patients and staff. This allows the Trust to develop its services through new equipment and facilities and to provide training for staff which enhances their skills and knowledge allowing them to improve their contribution to the provision of its services to the public benefit.

The development of the Trust's services may be dependent on both the Charitable Funds and the funds received from the Exchequer. This interdependency provides opportunities for the Charity to contribute to services which make a greater impact than the cash sum would make on its own.

Reserves and Commitments

Charity Reserves as defined by Charities SORP (FRS 102) are those funds which become available to the charity to be spent at the Trustee's discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

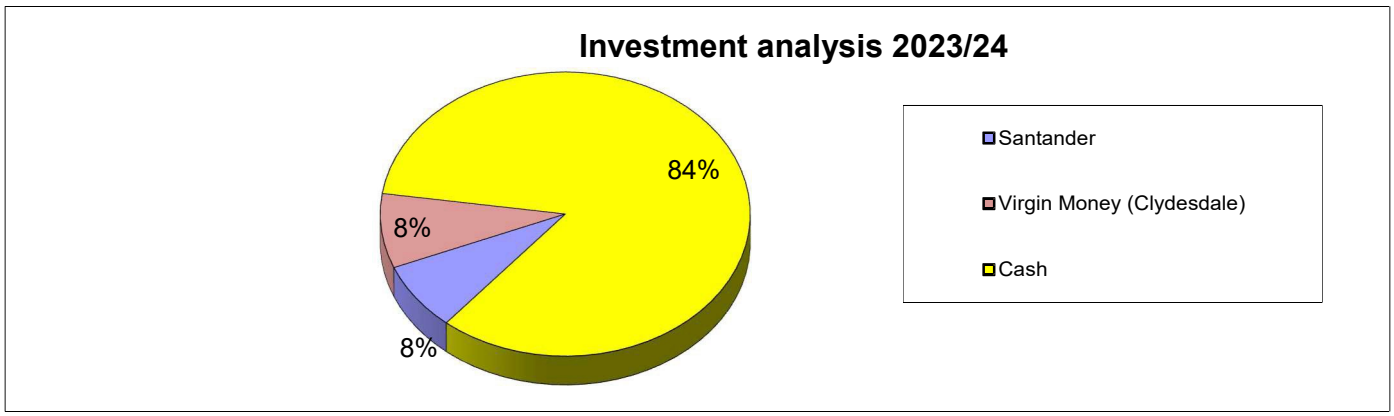
The Corporate Trustee has not made any changes to policy during the year and still requires that commitments against each fund are made only when the resources needed are available.

Major items of expenditure for both goods and services are agreed in advance in order that the necessary liquid resources can be released from the Investment Managers on a planned and timely basis. None of the funds held by the Investment Managers are committed on a long-term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

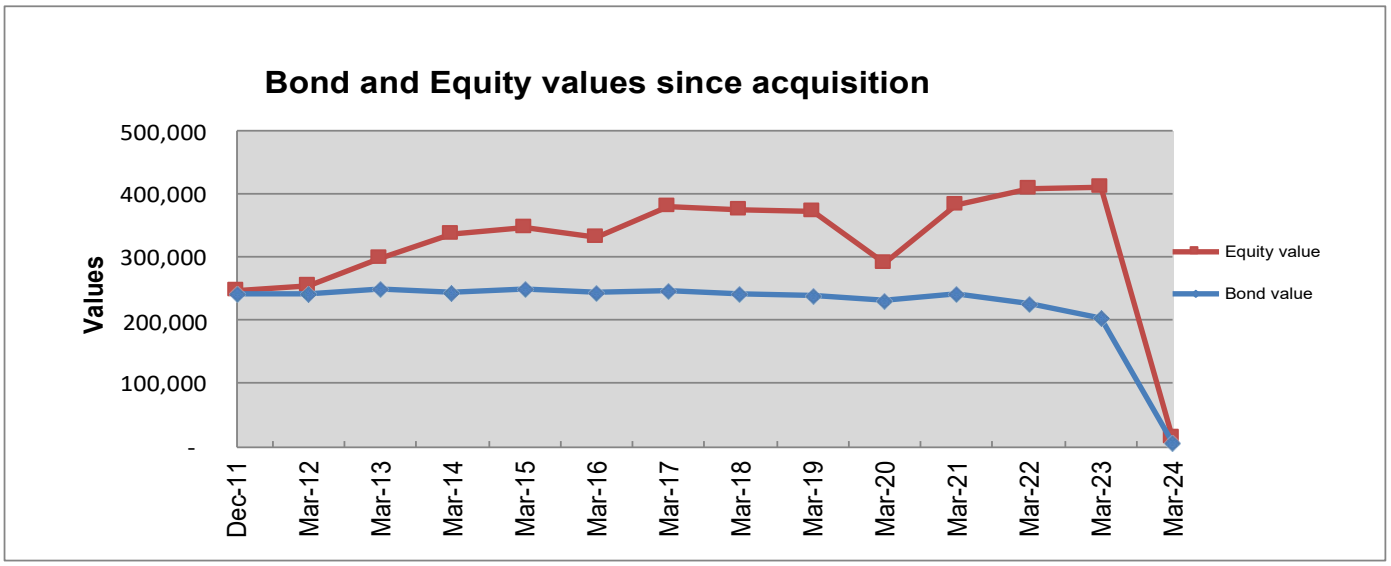
Investment Performance

Investment income for the year was £39k (in 2022/23, £24k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The value of investments was decreased as of 31 March 2024 compared to the previous year and therefore withdrawn the both equity and bond last year in July 23. At this point there may be a residual value laying in the investment accounts. The Trustee continues to review its investment strategy to seek to maximise its resources whilst maintaining liquidity and security of assets.

The current asset portfolio of cash and investment allocation totaling £1,075k at 31 March 2024 is shown in the following graph:



The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

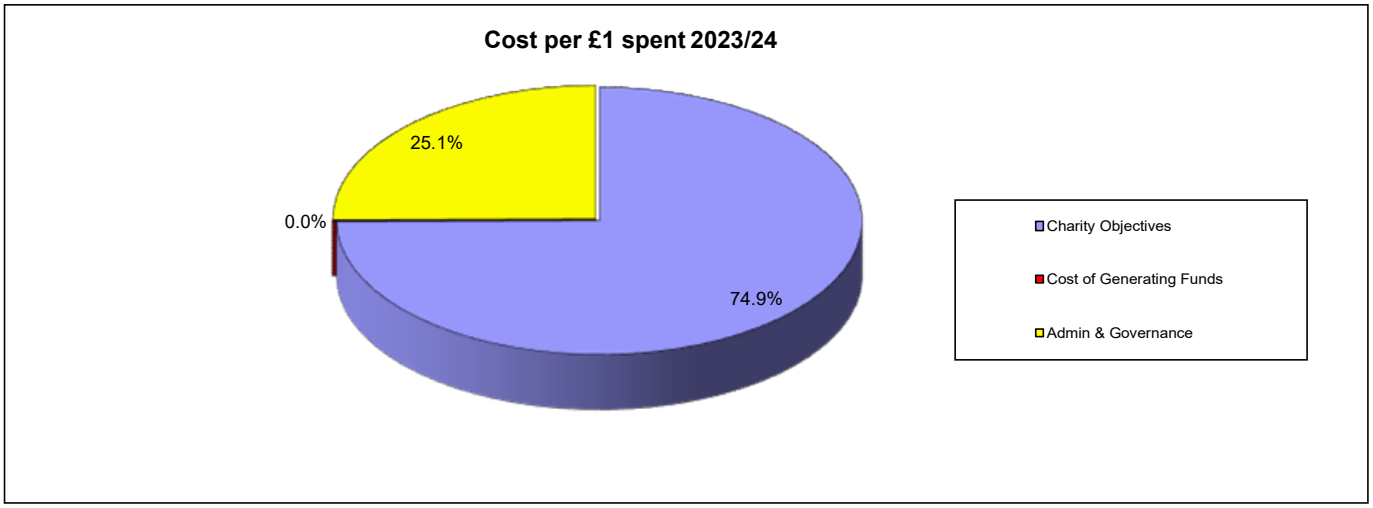


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

The Trust applies its charitable funds to enhance services and amenities for the public both as patients and visitors as well as staff through the purchase of equipment and support for projects.

The graph below shows that in this financial year for every £1 of expenditure, 75 pence was spent in directly achieving the objectives of the charity. This has changed compared to equivalent ratio for 2022/23 (81 pence).



Charitable expenditure for the year is detailed below.

Expenditure

Total resources expended by the Charity within this financial year were £478k (in 2022/23, £367k), breakdown as follows:

Contribution to NHS:
- £286k Medical Equipment & Furniture (in 2022/23, £199k)

Support and fundraising cost:
- £120k Support and fundraising costs (in 2022/23, £70k)

Staff Welfare:
- £56k Staff Welfare and amenities (in 2022/23,£85k)

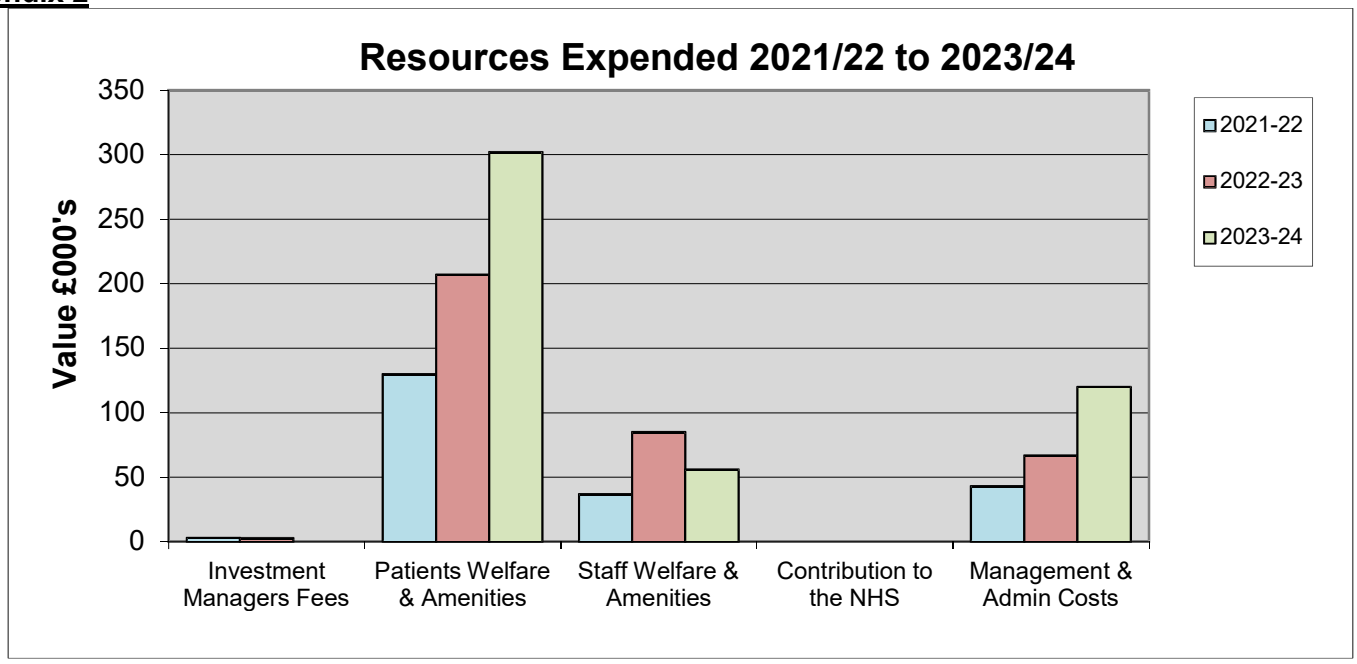
Patients Welfare:
- £17k Patients welfare and amenities (in 2022/23, £9k)

Cost of Generating funds £0k (2022/23 £3k)

Included within the governance cost of £114k are the internal management fees for financially administering the funds and the costs of the Fundraiser Manager. The fees are agreed each year by the Trustees. These costs are charged proportionately across the unrestricted funds whose balance is greater than £1k on a quarterly basis.

The following graph provides an analysis and comparison with previous two years:

Appendix 2



Medical Equipment & Furniture– Total spend £286k (in 2022/23, £199k)

Medical equipment has been funded within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities. Of which the main items funded were: Faxitron Pth vision Machine (£98.5k), out of four bladder scanners brought (£47.4k), two are for our unit at East Kent Canterbury Hospital, and the rest are for Maidstone Hospital. Also, bought four Butterfly ultrasound scanners(£15k) for Maidstone Hospital.

Faxitron Path Vision Machine funded:

Appendix 2

Two of the bladder scanner's funded at our unit at the East Kent Hospital:

Butterfly ultrasound scanners funded: .

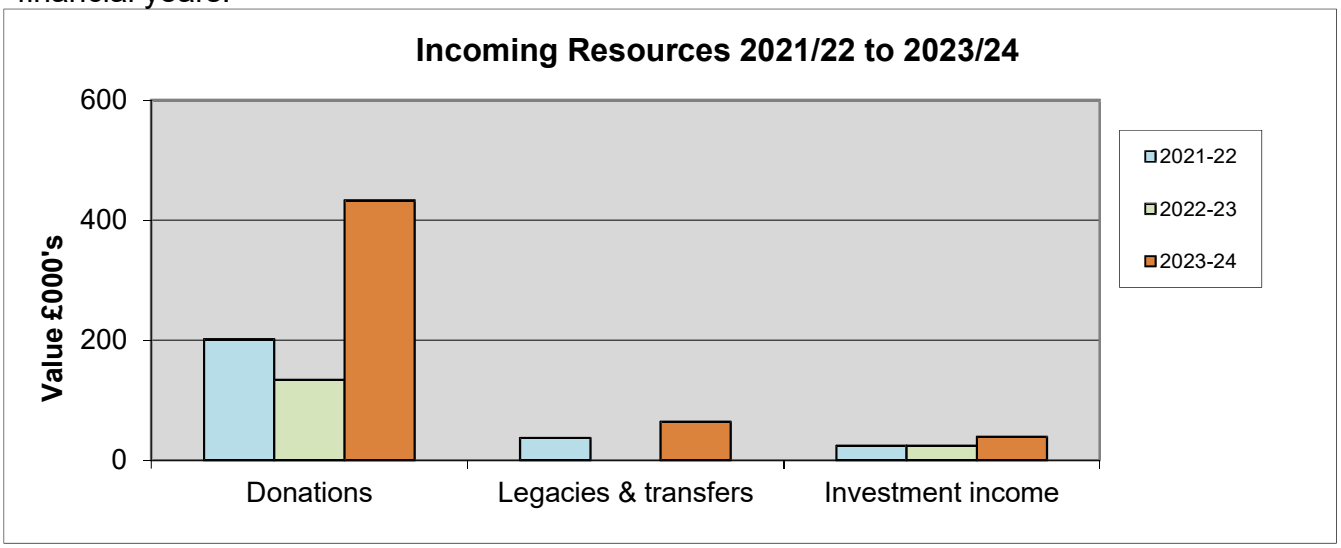
Staff Amenities and Welfare – Total spend £56k (in 2022/23, £85k)

Staff throughout the Trust 'go the extra mile' to ensure the best quality of care for patients. The corporate Trustee recognises this commitment and the hard work and care given to patients and to those who visit the Trust.

Of the £56k; - £27k from Unrestricted funds and the rest from Restricted funds, £20k for staff wellbeing, £12k on training, £12k for staff events and £12k related to various items.

Income

The graph below shows an analysis of income sources for the current and two previous financial years:



The majority of income received by the Charity is from grateful patients and relatives who wish to support the Trust in appreciation of the work and care provided by the Trust staff.

A total of £433k was received from donations (in 2022/23, £134k).

Legacies

The Trust has received a total of £64k from legacies (£nil in 2022/23).

We will continue to promote gifts in wills as a way for people to support the Charity.

Online fundraising

The Charity's 'Just Giving' page received donations of £29k (£11k 2022/23) this year and this is included in the total donations.

Intangible Income

The Statement of Financial Activity does not include any estimation of intangible income in respect of volunteers' services or the free use of Trust premises.

Looking Forward - our plans for the future

Over the next twelve months the Charity is hoping to move into a dedicated fundraising hub within Maidstone Hospital which will enable the Charity to become a much more visible presence within the Hospital and allow donors to interact with the Charity Team, increasing the income to the Charity. Plans are also underway to grow the Charity Teams which will allow fundraising to become much more proactive, rather than reactive and allow for more events and supporter-led events to be supported by the Team members.

The Charity is going to be working closely with the Trust to improve a number of the public areas around the Hospital, ensuring that staff and patients alike have access to garden areas that provide a haven to escape to from the hustle and bustle of the Hospital. These will provide another welcome addition to the grounds and a way in which to bring the Charity front and center with our visitors and staff.

The Charity will continue to work with Wards and Departments to support them to not only accept donations from grateful patients and visitors but to spend those donations appropriately and to ensure the greatest good for all concerned. We will work to publish good news stories across both internal and local press to encourage further donations and support and to make Maidstone and Tunbridge Wells NHS Charitable Fund, the local charity to support.

The Charity work closely with the League of Friends at both Maidstone and Tunbridge Wells Hospitals, we are grateful for their continued support of our patients, visitors and staff and look forward to continuing this relationship over the coming year.

Making donations

There are several ways people can donate including making online donations via www.justgiving.com/mtwnhscharitablefund. Please make cheques payable to Maidstone and Tunbridge Wells Hospital Charity. Payments can also be made via Bacs on request or via the cashiers at our hospitals.

Appendix 2

Statement of Trustee responsibilities in respect of the Trustee Annual Report and the financial statements

Under charity law, the Corporate Trustee is responsible for preparing the Annual Report and the financial statements for each financial year which show a true and fair view of the state of affairs of the Charity and of the financial position at the end of the year.

In preparing these financial statements, generally accepted accounting practice requires that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether the recommendations of the SORP FRS 102 have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the Trust deed, subject to any material departures disclosed and explained in the financial statements;
- prepares the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity and the rules of the charity, within the framework of trust law. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that where any statements of accounts are prepared by the trustee under section 132(1) of the Charites Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustee has general responsibility for taking such steps as are reasonably open to the trustee to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the corporate and financial information included on the charitable company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement as to disclosure to our Independent Examiner

In so far as the trustee is aware at the time of approving its Annual Report:

- there is no relevant information, being information needed by the Independent Examiner in connection with preparing their report, of which the Independent Examiner is unaware, and
- the trustee, having made enquiries of fellow directors and the Independent Examiner that they ought to have individually taken, have each taken all steps that he/she is obliged to take as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

By Order of the Trustee

Signed:

Dr Annette Doherty,
Chair of the Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date:

Appendix 2

Independent examiner's report to the corporate trustee of Maidstone and Tunbridge Wells NHS Charity

To follow after the accounts have been audited

Statement of Financial Activities for the year ended 31st March 2024

					2023/24	2022/23
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	**Total Funds**
		£000	£000	£000	£000	£000
Income	2					
Donations		328	105	-	**433**	**134**
Legacies		64	-	-	**64**	**-**
Total Donations and Legacies		**392**	**105**	**-**	**497**	**134**
Investment income		16	23	-	**39**	**24**
Total income		**409**	**128**	**-**	**536**	**158**
Expenditure	3					
Costs of generating funds	3.1	-	-	-	**-**	**(3)**
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(242)	(236)	-	**(478)**	**(364)**
Total expenditure		**(242)**	**(236)**	**-**	**(478)**	**(367)**
Gains / (losses) on investments	4	-	-	-	**-**	**(21)**
Net income/expenditure		**166**	**(109)**	**-**	**57**	**(230)**
Fund transfer	4	-	-	-	**-**	**-**
Net movement in funds	4	**166**	**(109)**	**-**	**57**	**(230)**
Fund balances brought forward at 31 March 2023		308	557	8	**873**	**1,104**
Fund balances carried forward at 31st March 2024		**474**	**448**	**8**	**930**	**874**

The notes at pages 24 to 35 form part of these financial statements.
Please note there may be some rounding's within the numbers

Appendix 2

Balance Sheet as at 31st March 2024

					2023/24	2022/23
	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Total Funds
		£000	£000	£000	£000	£000
Non current assets	5					
Investments	5.1	10	9	-	**19**	612
Total Non Current Assets		**10**	**9**	**-**	**19**	612
Current Assets	6					
Cash and Cash equivalents	6.1	548	519	8	**1,075**	469
Debtors due within one year	6.2	10	10	-	**20**	-
Total Current Assets		**558**	**529**	**8**	**1,095**	469
Liabilities						
Creditors due within one year	7.1	(94)	(89)	-	**(183)**	**(207)**
Net Current Assets		**465**	**439**	**8**	**911**	262
Total Net Assets		**474**	**448**	**8**	**930**	**874**
Funds of the Charity	8					
Endowment Funds		-	-	8	**8**	8
Restricted Funds		-	448	-	**448**	559
Unrestricted Funds		474	-	-	**474**	307
Total Funds		**474**	**448**	**8**	**930**	**874**

For purposes of splitting assets / liabilities by category, restricted and unrestricted funds are categorised by transactions, whilst endowment funds are categorised only as cash.

The charitable funds financial statements were approved by the Trust Board on the XXX and signed on its behalf as Trustee by:

Dr Annette Doherty,
Date:
Chair of the Trust Board, Maidstone and Tunbridge Wells NHS Trust

Statement of cash flows at 31st March 2024

Cash flows from operating activities:	Note	2023/24 £000	2022/23 £000
Net income / (expenditure) for the reporting period (as per the statement of financial activities)	4	57	(230)
Adjustments for:			
(Gains) / losses on investments	4	-	22
Dividends, interest and rents from investments	2	(39)	(24)
(Increase) / decrease in debtors	6.2	(20)	21
Increase / (decrease) in creditors	7.1	(24)	164
Net cash provided by (used in) operating activities		**(26)**	**(47)**
Cash flows from investing activities:			
Dividends, interest and rents from investments		39	24
Net cash provided by (used in) investing activities		**39**	**24**
Cash flows from financing activities:			
Net cash provided by (used in) financing activities		**0**	**0**
Change in cash and cash equivalents in the reporting period		13	(23)
Cash and cash equivalents at the beginning of the reporting period		469	493
Cash and cash equivalents at the end of the reporting period	6.1	1,075	470
Analysis of cash and cash equivalents:			
Cash in bank		**1,075**	**470**

Notes to the financial statements for the year ended 31st March 2024

1. Principal accounting policies

1.1. Basis of preparation

The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective October 2019 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

The financial statements are prepared in accordance with the historical cost convention, except for Investments, which are included at market value. During the year, the Charity reviewed its accounting policies and made no changes.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern and uncertainties affecting the current year's accounts. The charity ended the year with £874k in available funds which the trustees consider to be sufficient to ensure that the charity is able to meet its existing plans and obligations. The charity receives donations and legacies at differing levels from year to year but the underlying healthcare activities are continuing which supports a reasonable assumption of future donations. The Trustees are considering a range of proposals to enhance the visibility of the charity and to increase its fundraising effectiveness.

1.2. Reconciliation with previous generally accepted accounting practices

These accounts are continued to be prepared in accordance with FRS 102 and the charities SORP FRS 102.

Governance and administration costs are classified as a support cost and have therefore been apportioned between fundraising activities and charitable activities on a cost basis (see note 3). The Trustees consider this is an equitable treatment to avoid disadvantaging funds with high volume low value transactions. All funds attract administrative costs even without any expenditure as these have to be monitored, fund managers approached for future plans, investment transactions and overhead charges. The cost of the transaction does not necessarily reflect on the work involved to achieve that expenditure and therefore consistency is maintained by working with an activity cost based apportionment.

1.3. Income

Donations, grants, legacies and gifts in kind (voluntary Income)
All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. It is not the charity's policy to defer income.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, and then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for as incoming resource either on receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control
- Where the amount of the legacy can be reliably estimated.
- Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is disclosed as a contingent asset.

Income resources from Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by Trustees.

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods.

Intangible Income
Intangible income, which comprises donated services or use of Trust property, is included in income at a valuation which is an estimate of the financial cost borne by the donor where such a cost is material, quantifiable and measurable. No income is recognised when there is no financial cost borne by a third party.

Investment Income
Investment Income and gains and losses on investments are credited / charged to the funds quarterly using the average fund balance to apportion the gain / loss.

1.4. Expenditure

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities. All expenditure is recognised when the following criteria are met:

- There is a present legal of constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives.
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

Irrecoverable VAT
Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, costs of fundraising, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs and overheads from Maidstone and Tunbridge Wells NHS Trust and are apportioned on an average fund balance monthly across all funds.

Charitable activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the trustees and accepted by thebeneficiaries.

Exceptional Items
Exceptional Items are shown on the face of the Statement of Financial Activities under the category to which they relate with further detail, where appropriate, provided in the notes. For the financial year 2023/24 there were no Exceptional Items.

Costs of generating funds
The costs of generating funds are the costs associated with generating income for the funds held on trust. This will include the costs associated with Investment Managers, Fundraising staff and other promotional and fundraising events including any trading activities.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

Analysis of grants
The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of it charitable aims. The total cost of making grants, including support costs, is presented on the face of the Statement of Financial Activities and further analysis in relation to activity is provided in note 3.

1.5. Structure of funds

Unrestricted funds are general funds, which are available for use at the discretion of the Trustee in furtherance of the objectives of the Charity. Funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes are designated funds.

Where there is a legal restriction or a binding agreement with a donor, on the purpose for which a donation may be use, the fund is classified in the accounts as a restricted fund.

Endowment Funds are funds that hold capital in perpetuity. Investment income resulting from these capital holdings may be utilised in accordance with the donor's wishes.

Transfers between funds are made at the discretion of the Trustee, taking account of any restrictions imposed by the donor.

The purposes of each fund with a balance in excess of £10k at the year-end are set out in note 8.1 to the financial statements.

1.6. Finance and Operating Leases

The Charity has no finance or operating leases.

1.7. Investments

Investments
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds. Please see investment strategy on page 11 for further information.

1.8. Gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later). Investment income and gains/losses are allocated quarterly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.9. Cash and Cash equivalents

Cash is represented by the balance maintained in the charity bank accounts and is used to meet the operational costs of the charity as they fall due.

Cash equivalents are short term liquid investments held for a period of 3 months or less in interest bearing accounts that are readily convertible to cash with no risk of change in value.

As a requirement of FRS 102, a statement of cash flows has been included in the accounts to provide information about the ways in which the charity uses the cash generated by its activities and about changes in cash and cash equivalents held by the charity.

1.10. Financial Instruments

The Charity only has financial assets and financial liabilities that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of investments which are subsequently measured at fair value.

A financial asset is derecognised when it is settled, or when the contractual rights to the cashflows expire. If substantially all the risks and rewards are transferred, the financial asset is derecognised. If substantially all the risks and rewards are retained, the financial asset is not derecognised. A financial liability is derecognised only when it is cancelled, expired or discharged.

1.11. Pensions

The Charity has no direct employees but does charge costs relating to finance support staff and the full costs of the fundraiser. These employees are contracted by the Trust and pension liabilities are charged as part of the recharge.

1.12. Prior Year Adjustments

The Charitable Fund has not made any prior year adjustments Due to the following tables being reported in thousands there may be some rounding differences but the overall totals are correct.

Appendix 2

2. Income

Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	2023/24 Total Funds	2022/23 Total Funds
	£000	£000	£000	£000	£000
Donations	328	105	-	**433**	134
Legacies	64	-	-	**64**	-
Total Donations and Legacies	392	105	-	497	134
Investment income					
Dividends from investment portfolio	3	4	-	**7**	10
Interest from investment portfolio	-	-	-	-	8
Bank Interest	13	19	-	**32**	6
Total Investment income	16	23	-	**39**	24
Total incoming resources	408	128	-	**536**	158

3. Expenditure

				2023/24	2022/23
3.1. Cost of generating funds	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	**Total Funds**
	£000	**£000**	**£000**	**£000**	**£000**
Investment managers fees	-	-	-	**-**	(3)
Total cost of generating funds	-	-	-	**-**	**(3)**
				2023/24	**2022/23**
3.2. Charitable Activities	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	**Total Funds**
	£000	£000	£000	**£000**	£000
Patients welfare and amenities					
Hospitality	-	-	-	-	-
Other	(10)	(7)	-	**(17)**	(9)
Complimentary Therapies	-	-	-	**-**	-
Total patients welfare and amenities	**(10)**	**(7)**	**-**	**(17)**	(9)
Staff welfare and amenities					
Training	(10)	(2)	-	**(12)**	(11)
Wellbeing	-	(20)	-	**(20)**	(38)
Christmas Events	(11)	(1)	-	**(12)**	(7)
Other	(6)	(6)	-	**(12)**	(29)
Total staff welfare and amenities	**(27)**	**(29)**	**-**	**(56)**	(85)
3.2. Charitable Activities continue					
Medical and Rehabilitation Equipment	(129)	(130)	-	**(259)**	(199)
Furniture and Fittings	(27)	(0)	-	**(27)**	-
Other	-	-	-	**-**	-
Governance - Salaries & overheads	(47)	(67)	-	**(114)**	(65)
Governance - Audit Fees (external)	(2)	(4)		**(6)**	(5)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(205)**	**(201)**	**-**	**(406)**	(269)
Total cost of charitable activities	**(242)**	**(237)**	**-**	**(479)**	(363)
Total resources expended	**(242)**	**(237)**	**-**	**(479)**	(366)

Employee Information

The Charity does not employ any staff directly, although members of the finance team support the governance and administration function of the Charity and a full time Fundraiser is employed by the Trust and recharged in full to the Charity. Their costs have been included in the table above.

During the year none of the members of the NHS Trust Board or senior NHS staff or parties related to them were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the NHS Trust Board has received honoraria, emoluments, or expenses in the year and the Corporate Trustee has not purchased trustee indemnity insurance.

4. Net Movements in Funds

Note 4	Unrestricted Funds	Restricted Funds	Endowment Funds	2023/24 Total Funds	2022/23 Total Funds
	£000	£000	£000	**£000**	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	166	(109)	-	**57**	(208)
Gains/Losses on Investments	-	-	-	**-**	(22)
Total net movement in funds	**166**	**(109)**	**-**	**57**	(230)
Funds transfers	-	-	-	**-**	-
Total net movement in funds after transfers	**166**	**(109)**	**-**	**57**	(230)
Fund balances at 1 April 2023	308	557	8	**873**	**1,104**
Fund balances carried forward at 31 March 2024	**474**	**448**	**8**	**930**	874

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/2023	Additions to investment at cost	Disposals at carrying value	Net gain/ (loss) on revaluation	Carrying value at 31/03/2024
	£000	£000	£000	£000	£000
CAF Bond Income Fund (UK)	205	-	(197)	(2)	**6**
CAF Equity Growth Fund (UK)	407	-	(396)	3	**14**
Total Fixed Asset Investments	**612**	**-**	**(593)**	**0**	**19**

6. Current Assets

6.1. Cash and cash equivalents	2023/24 Total Funds	2022/23 Total Funds
	£000	£000
Cash Investments:		
Santander	83	83
Virgin Money (Clydesdale)	91	91
Operational Bank Accounts:		
GBS bank account	900	275
Nat West bank account	-	21
Total Cash and cash equivalents	**1,075**	**470**

6.2. Debtors	2023/24 Total Funds	2022/23 Total Funds
	£000	£000
Amounts falling due within one year	20	-
Total Debtors due within one year	20	-

7. Current Liabilities

7.1. Creditors	2023/24 Total Funds	2022/23 Total Funds
	£000	£000
Amounts falling due within one year		
Trade Creditors	-	(8)
Other Creditors	-	-
Owed to Maidstone and Tunbridge Wells NHS Trust	(179)	(191)
Accruals	(4)	(8)
Total Creditors due within one year	(183)	(207)

8. Details of Funds

Description	Fund number	Fund Type	Balance 01-Apr-2023	Incoming Resources	Resources Expended	Gain&(losses)on	Balance 31-Mar-2024
			£000	£000	£000	£000	£000
A.Haines - Cip	67020	Endowment	7	0	0	0	7
E.C.Beedle Fund - Cip	67010	Endowment	1	0	0	0	1
Total Endowment Funds			**8**	**-**	**-**	**-**	**8**

Description	Fund number	Fund Type	Balance 01-Apr-2023	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2024
			£000	£000	£000	£000	£000
Cardiac Equip Fd Ms Crow Legac	65450	Restricted	18	1	(3)	-	17
Cardio Equip Tw Hayling Legacy	65460	Restricted	27	1	(9)	-	20
E&M Dir Diabetes Fund Tw	65410	Restricted	45	2	(7)	-	40
Oncology Centrifuge Fund	61490	Restricted	20	1	(3)	-	18
Pierre Fabre Grant Fund	61720	Restricted	48	2	(8)	-	41
E&M Directorate - Frances Gibson Legacy	65180	Restricted	21	1	(3)	-	19
Maskell Equipment Legacy Fund	69702	Restricted	76	3	(40)	-	39
COVID 19 Fund	69900	Restricted	235	11	(37)	-	209
Staff Hardship Fund	61030	Restricted	19	1	(20)	-	0
Fundrasier Non Pay Items	61130	Restricted	39	5	(3)	-	41
Other Restricted Funds (closing balances <£10,000)			27	100	(122)	-	4
Total Restricted Funds			**576**	**128**	**(255)**	**-**	448

Appendix 2

Description	Fund number	Fund Type	Balance 01-Apr-2023	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2024
			£000	£000	£000	£000	£000
Trust Management Dir Fund	61000	Unrestricted	64	125	(60)	0	129
Emergency & Medical Dir Fund	61020	Unrestricted	20	3	(15)	0	7
Critical Care Dir Fund	61060	Unrestricted	7	4	(7)	0	4
Surgery Directorate Fund	61140	Unrestricted	26	1	(17)	0	10
WOMENS DIRECTORATE FUND	61320	Unrestricted	11	1	(12)	0	(0)
Cancer Services Dir Fund	61350	Unrestricted	54	169	(80)	0	143
Sutcliffe Fund	61370	Unrestricted	22	1	(3)	0	20
Paediatric Dir Fund	61540	Unrestricted	18	21	(10)	0	29
Cardiac Fund	65400	Unrestricted	17	1	(2)	0	15
Special Care Baby Unit Fund	65660	Unrestricted	22	10	(21)	0	12
Equality + Diversity Fund	68900	Unrestricted	10	2	(10)	0	3
Other Unrestricted Funds (closing balances <£10,000)			19	70	14	0	102
Total Unrestricted Funds			**288**	**409**	**(223)**	**0**	**474**

Please note that there may be some rounding's within the above numbers:

8.1 Nature and Purpose of Material Funds (Closing balance > £10,000)

Restricted Funds	**Nature and purpose of Fund**
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures
Oncology Centrifuge Fund	Supports the purchase of a centrifuge for the Oncology Centre
Cardio Equip Hayling Legacy Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Cardiac Equip Crow Legacy Fund	Supports the Cardiac Unit at Maidstone Hospital
E&M Dir Diabetes Fund TW	Supports the Diabetic Unit at Tunbridge Wells Hospital
E&M Directorate Gibson Legacy	Supports the emergency & Medical Directorate
Maskell equipment Legacy	Supports equipment purchases at Tunbridge Wells Hospital
COVID-19 Trust Fund	Donation from NHS Charities Together from money raised by Sir Tom Moore to support staff
Fundraiser Non-Pay Items	Revenue budget to support the work of the Charity.
Unrestricted Funds	**Nature and purpose of Fund**
Cancer Services Fund	Supports the Cancer Services department
Cardiac Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Surgery Directorate Fund	Supports the Surgery Directorate
Paediatric Directorate Fund	Supports the Paediatric Directorate Department
Sutcliffe Fund	Supports the purchase of medical equipment for the Haematology and Oncology departments
Special Care Baby Unit Fund	Supports the Baby's Directorate
NHSCT Stage 3 Funding	Donation from NHS Charities Together to fund some work with the wellbeing team.

8.2 Charity Tax

Maidstone and Tunbridge Wells NHS Trust Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

9 Related Parties

The Charity is established to hold the charitable funds of Maidstone and Tunbridge Wells NHS Trust.

During the year none of the NHS Trust Board or members of key management staff or parties related to them has undertaken any material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Charity has made revenue and capital payments, in the form of grants, to Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition, £179k (in 2022/23, £191k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration and fundraising activities of the Charity. The amount of transactions is 238 in total.

10 Events after the reporting year

The Charitable Fund does not have any events after the reporting period.

Our Ref: SO/jr

Steve Orpin
Deputy Chief Executive/Chief Finance Officer
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

Tel: 01622 229002
Email: stephen.orpin@nhs.net

Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

November 2024

Dear Grant Thornton UK LLP

Maidstone and Tunbridge Wells NHS Charitable Fund accounts for the year ended 31 March 2024

This representation letter is provided in connection with the independent examination of the accounts of Maidstone and Tunbridge Wells NHS Charitable Fund for the year ended 31 March 2024 for the purpose of making of an independent examiner's report in accordance with Section 154 of the Charities Act 2011.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Accounts

i. We have fulfilled our responsibilities for the preparation of accounts in accordance with **section 132** of the Charities Act 2011 and comply with the Statement of Recommended Practice for accounting and reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) ('Charities SORP (FRS 102)'), effective 1 January 2019.

ii. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

iii. The methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

iv. Except as stated in the accounts:

   a there are no unrecorded liabilities, actual or contingent;

   b none of the assets of the charity has been assigned, pledged or mortgaged;

   c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

v. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of United Kingdom Generally Accepted Accounting Practice and the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement.

vi. All events subsequent to the date of the financial statements and for which United Kingdom Generally Accepted Accounting Practice and the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vii. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules identified during the course of the audit. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

viii. The financial statements are free of material misstatements, including omissions.

ix. We can confirm that:

a. all income has been recorded;

b. the restricted funds have been properly applied;

x. The charity has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

xi. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xii. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.

xiii. The charity meets the conditions for exemption from an audit of the accounts as set out in section 145 of the Charities Act 2011.

Information Provided

xiv. We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the accounts such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your examination; and

c. unrestricted access to persons from whom you determine it necessary to obtain evidence.

xv. We have disclosed to you the results of our assessment of the risk that the accounts may be materially misstated as a result of fraud.

xvi. All transactions have been recorded in the accounting records and are reflected in the accounts.

NHS
Maidstone and Tunbridge Wells NHS Trust

xvii. We have disclosed to you our knowledge of fraud or suspected fraud affecting the charity involving:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the accounts.

xviii. We have disclosed to you our knowledge of any allegations of fraud, or suspected fraud, affecting the charity's accounts communicated by employees, former employees, analysts, regulators or others.

xix. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing accounts.

xx. We have disclosed to you the identity of the charity's related parties and all the related party relationships and transactions of which we are aware.

xxi. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the accounts.

xxii. We confirm that we have reviewed all correspondence with regulators, which has also been made available to you, including the guidance 'How to report a serious incident in your charity' issued by the Charity Commission.

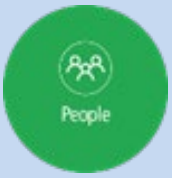
We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the date of signing of the balance sheet.

Yours faithfully

Steve Orpin
Deputy Chief Executive/Chief Finance Officer

Signed on behalf of Maidstone and Tunbridge Wells NHS Charitable Fund

Title of report	**Integrated Performance Report (IPR) for October 2024**					
Board / Committee	**Trust Board**					
Date of meeting	28th November 2024					
Agenda item no.	11-13					
Executive lead	Chief Executive / Executive Directors					
Presenter	Chief Executive / Executive Directors					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The IPR for month 7, 2024/25, is enclosed, along with the monthly finance report, and latest “Planned verses Actual” Safe Staffing data.		
Any items for formal escalation / decision			
Appendices attached			
Report previously presented to:			
Committee / Group		Date	Outcome/Action
Finance and Performance Committee		26/11/24	

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	The BAF remains under development
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

October 2024

MTW
exceptional people, outstanding care

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- Business Rules for Assurance Icons — Pages 38 - 40
- Consistently, Passing, Failing and Hit & Miss Examples — Page 41
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Note: Detailed dashboards and a deep dive into each SDR and CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

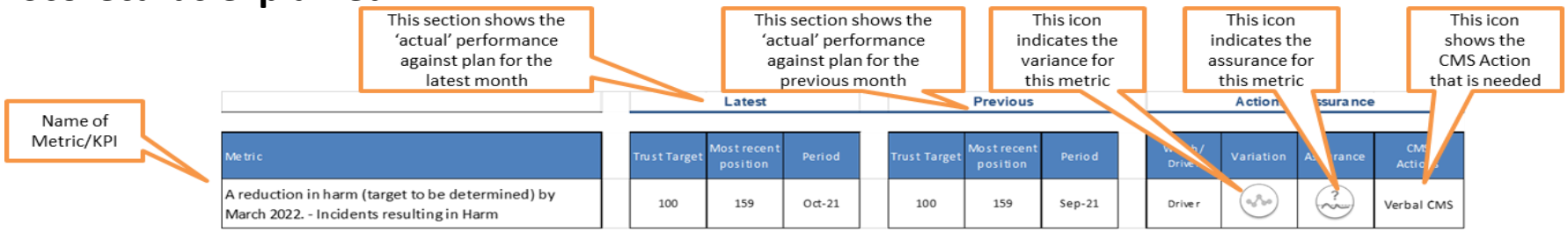
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

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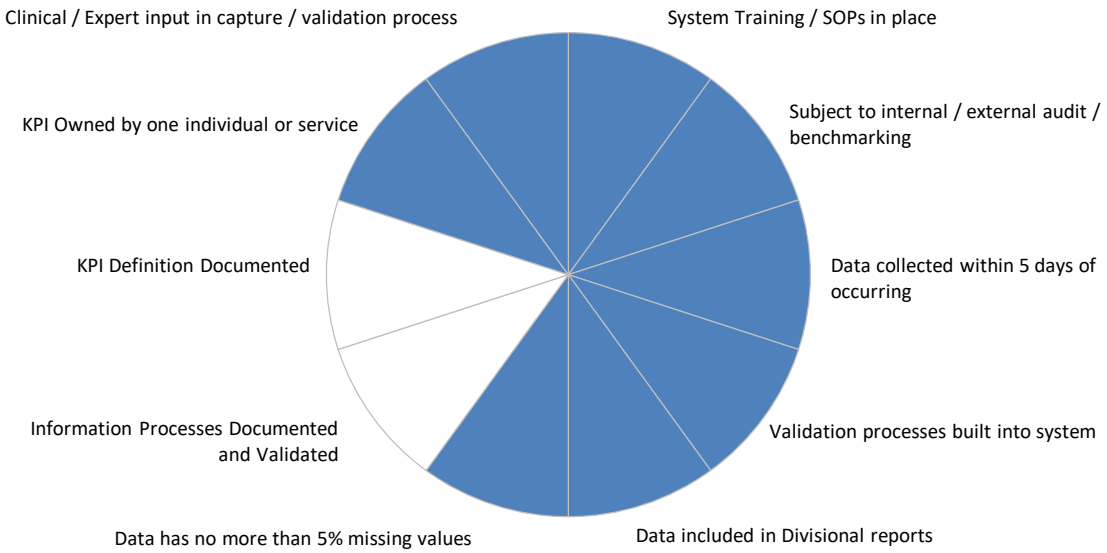
Forecasts

				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	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 refocus the Strategy Deployment Review (SDR) process to support the delivery of the Financial Improvement Programme across the organisation. We have therefore merged the six financial recovery workstreams into our existing SDR governance structure and have changed some of the Vision and Breakthrough Objectives as well as adding some new Financial Breakthrough Objectives.

People: An area of focus for the Trust is a reduction in the Total Pay Spend. Whilst this is currently consistently achieving the target it is also in special cause variation of a concerning nature. The Trust is therefore implementing a target reduction and a number of actions to improve performance over the coming months. The overall temporary staffing spend as a percentage of the total pay send is now experiencing special cause variation of an improving nature and consistently failing the target. Agency staff spend as a proportion of the total pay spend is currently experiencing special cause variation of an improving nature and variable achievement of the target. Vacancy Rate 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 achievement of the target for more than six consecutive months. The number of staff that leave within 12 months or within 24 months have not achieved the target for six months. Agency spend was slightly above the target in October, experiencing common cause variation. The Nursing Safe Staffing levels has achieved the target for more than six months.

Sickness levels remain in common cause variation and Statutory and Mandatory Training continues to experience special cause variation of an improving nature and consistently passing the target. The Trust continues to consistently achieve the target for both the percentage of staff Afc 8c or above that are female or have a disability. Performance for the percentage of staff Afc 8c or above that are BAME improved in October and is now experiencing special cause variation of an improving nature but consistently failing the target. The Trust continues to implement a number of actions to improve performance.

Patient Safety & Clinical Effectiveness: The rate of incidents causing patients moderate or higher harm is now experiencing special cause variation of a concerning nature and has failed the target for six consecutive months. The number of incidents of moderate+ harms due to potential mismanagement of deteriorating patients is experiencing common cause variation and variable achievement of the target. Theatre Utilisation is experiencing special cause variation of an improving nature but is consistently facility the target. The rate of all outpatient appointments that are either a new appointment or a follow up appointment with a procedure is experiencing special cause variation of an improving nature and passing the target for more than six consecutive months. The Trust reported one Never Event in October which is currently being investigated. Both the Rates of E.Coli and C.Diff are now experiencing common cause variation and variable achievement of the target The rate of Falls has now passed the target for six consecutive months.

Patient Access: A key area of focus is to reduce the average non-elective length of stay by 10%. This indicator is therefore currently experiencing common cause variation and consistently failing the target. The number of non-elective admissions remains in common cause variation. Ambulance Handovers <30mins is now experiencing common cause variation and variable achievement of the target. The Trust's performance for A&E 4hrs was below the trajectory target for October at 82.2%, 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. Diagnostic Waiting Times is now experiencing special cause variation of a concerning nature and variable achievement of the target. This indicator was changed nationally last month to include endoscopy surveillance patients which has adversely affected the overall performance. Focussed work and a number of actions are underway and will continue to ensure that these patients have their diagnostic test by their target date.

Executive Summary (continued)

Patient Access (Continued): 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 October of 78.1% at 71.5% (Excluding SYS). Nationally we reported 71.1% (including SYS). This indicator is experiencing special cause variation of an improving nature and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters. Nationally we have reported 95 52 week breaches at the end of October 24, an improvement from September 24. All of the 95 52 week breaches were for System (SYS) patients. The Trust continues to achieve the trust internal target of less than 1.5% of total patients waiting having waited more than 40 weeks (Excluding SYS) and continues to experience special cause variation of an improving nature and passing the target for more than six consecutive months.

Outpatient Utilisation continues to experience common cause variation and variable achievement of the target. The finalised performance for September achieved the target of 85%. October 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 special cause variation of an improving nature. The percentage of patients on a PIFU Pathway was slightly below target this month and is now experiencing special cause variation of an improving nature and variable achievement of the target. Performance for both First Outpatients and Elective Activity (Inpatients and Day Case combined) were above plan and 19/20 levels for October. Both have passed the target for more than six consecutive months. Diagnostic Imaging activity levels were above plan and 19/20 levels in October and continues to experience special cause variation of an improving nature and variable achievement of the target.

Patient Experience: The number of overall complaints remains in common cause variation and variable achievement of the target. Complaints related to communication issues have now passed the target for 6+ months. Complaints responded to within the target date passed the target last month for the first time in the last two years and is now in variable achievement of the target. The new indicator for agency spend specifically related to B5 RMNs and Band 4 HSCWs is experiencing special cause variation of a concerning nature and failure of the target for more than six months. A number of actions are being implemented to reduce the spend in this area. VTE performance continues to experience common cause variation and variable achievement of the target. Friends and Family Response rates for Inpatients and Maternity are experiencing special cause variation of a concerning nature, however both Outpatients and A&E continue to improve, experiencing special cause variation of an improving nature.

Systems: The level of elective Income from activity undertaken increased in October but remains below plan. The new indicator to monitor the depth of coding is experiencing special cause variation of an improving nature but consistently failing the target based on the national average. The rate of patients no longer fit to reside remains in common cause variation.

Sustainability: The Trust was £3.8 in surplus in the month which was £0.8m favourable to plan. Year to Date the Trust is £9.9m in deficit which is £0.4m adverse to plan. Delivery of the financial position, along with the reduction in non-pay spend and a reduction in agency spend are experiencing common cause variation and variable achievement of the target. The Trust has implemented it's financial recovery plan.

Maternity: 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.

Executive Summary (continued)

Escalations by Strategic Theme:

People:
- Overall Temporary Staff Spend as a % of Total Spend (P.11)
- % of Afc 8c and above that are BAME (P.12)
- Staff Leavers <12 mths (as a % of all leavers) (P.12)
- Staff Leavers <24 mths (as a % of all leavers) (P.12)

Patient Safety & Clinical Effectiveness:
- Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (P.14)
- % Capped Theatre utilisation (P.15)

Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.28)
- Women waiting for Induction of Labour <4 Hrs (P.28)
- Decision to delivery interval Category 1 caesarean (P.28)
- Decision to delivery interval Category 2 caesarean (P.28)

Patient Access:
- 10% Reduction in Non-Elective LOS (P.18)
- RTT Performance (P.19)
- Outpatient Calls answered <1 minute (P.19)
- A&E 4hr Performance (P.19)
- Emergency Admissions in Assessment Areas (P.19)

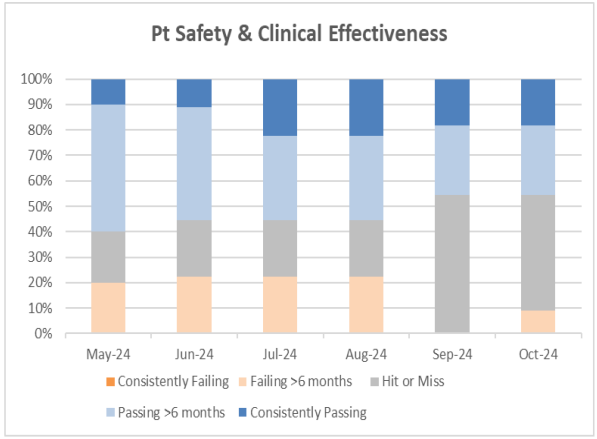
Patient Experience:
- Reduction in agency spend (specific to B5 RMNs
- and B3 HCSW) (P.21)
- Complaints responded within target (P.22)
- FFT Response Rates: All areas (P.23)

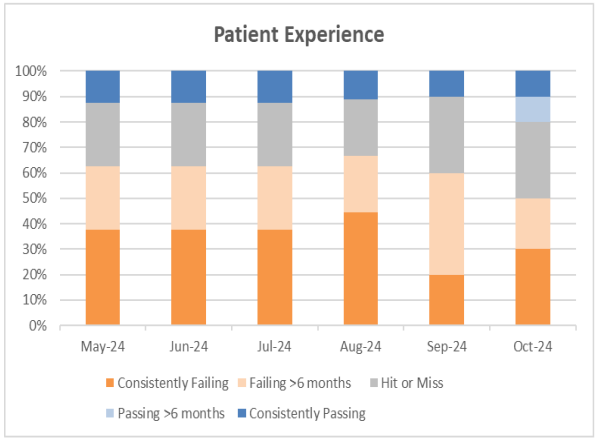
Systems:
- Depth of Coding - Average Number of Codes per Elective Episode (P.25)

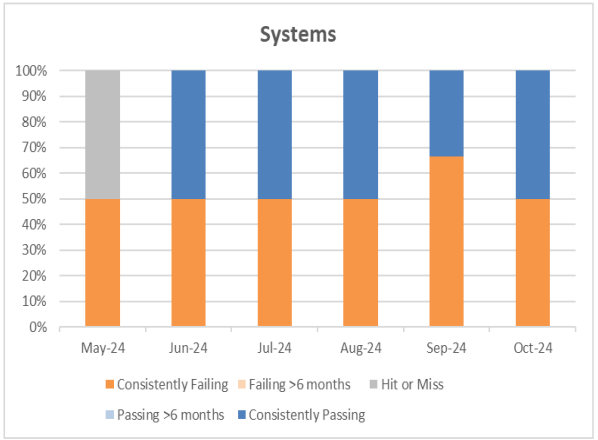
Sustainability:
- None escalated

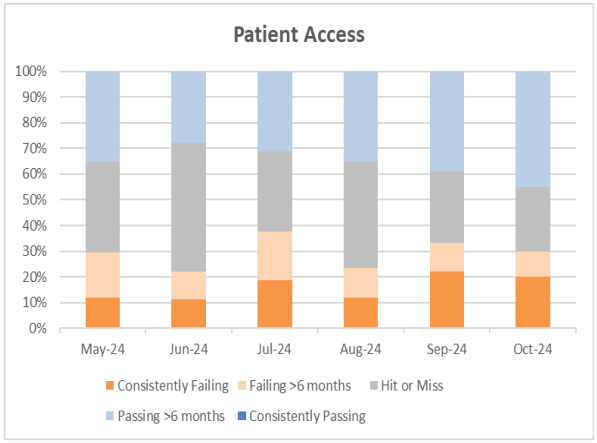
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

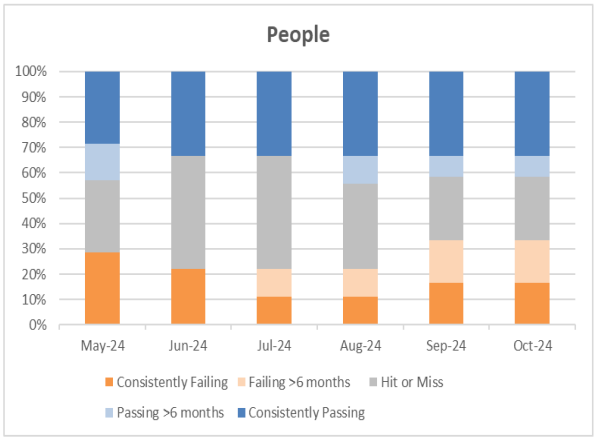
Assurance Stacked Bar Charts by Strategic Theme

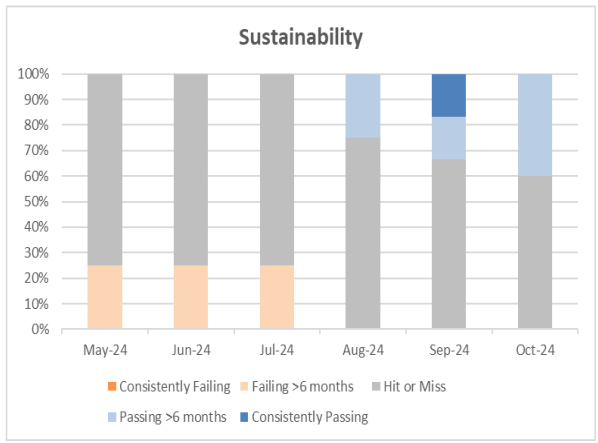












Matrix Summary

October 2024

Assurance

Variance	Pass ★	Pass	Hit and Miss	Fail	Fail -
Special Cause - Improvement	Statutory and Mandatory Training Standardised Mortality HSMR	Reduce Turnover Rate to 12% Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) To achieve the planned levels of new outpatients activity (shown as a % 19/20) RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Cancer - 31Day First (New Combined Standard) - data runs one month behind 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) Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) Capital Expenditure (£k)	Agency Spend as a % of spend – target of 3.2% Transformation: % of Patients Discharged to a PIFU Pathways		Overall Temporary Staff Spend as a % of Total Spend 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 Depth of Coding - Average Number of Codes per Elective Episode (Data runs one month behind)
Common Cause	Complaints Rate per 1,000 occupied beddays Decrease the percentage of occupied bed days for patients identified as no longer fit to reside (NCTR) Percentage of AfC 8c and above that are Female Percentage of AfC 8c and above that have a Disability	Safe Staffing Levels (Nursing) Rate of patient falls per 1000 occupied bed days To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20) To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Cash Balance (£k)	Reduce the Trust wide vacancy rate to 8% Sickness Absence Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Bacteraemia Total NEL admissions (including Zero LOS & Excluding Type 5) Transformation: % OP Clinics Utilised (slots) Flow: Ambulance Handover Delays >30mins To reduce the overall number of complaints or concerns each month % complaints responded to within target % VTE Risk Assessment (one month behind) Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Reduce non-pay spend Reduction in Postage Costs Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000 Conversation rate from ED (Excluding Type 5 and including Direct Admissions)	Staff Leavers within 12 months Staff Leavers within 24 months A&E 4 hr Performance	Percentage of AfC 8c and above that are BAME Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5) Friends and Family (FFT) % Response Rate: Maternity Friends and Family (FFT) % Response Rate: Outpatients
Special Cause - Concern	Reduction in Total Pay SpendSummary Hospital-level Mortality Indicator (SHMI)		Never Events Access to Diagnostics (<6weeks standard)	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) Flow: % of Emergency Admissions into Assessment Areas Reduction in agency spend (specific to B5 RMNs and B3 HCSW) Friends and Family (FFT) % Response Rate: Inpatients	

Strategic Theme: People

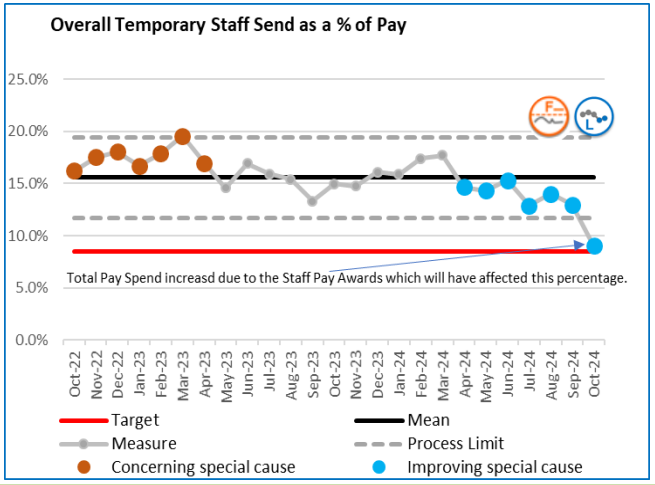
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Well Led	Reduction in Total Pay Spend		50,015	50,722	Oct-24	38,384	38,543	Sep-24	Driver			Verbal CMS			
Financial Breakthrough Objectives	Well Led	Overall Temporary Staff Spend as a % of Total Spend		8.5%	9.0%	Oct-24	8.5%	13.0%	Sep-24	Driver			Full CMS			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	2.1%	Oct-24	3.2%	2.2%	Sep-24	Driver			Note Performance			
Constitutional Standards and Key Metrics	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	7.3%	Oct-24	8.0%	7.9%	Sep-24	Driver			Not Escalated	6.7%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.8%	Oct-24	12.0%	11.1%	Sep-24	Driver			Not Escalated	10.6%		
	Well Led	Sickness Absence		4.5%	4.1%	Sep-24	4.5%	3.9%	Aug-24	Driver			Not Escalated	4.14%		
	Well Led	Appraisal Completeness		95.0%	95.4%	Oct-24	N/A	N/A	Sep-24	Driver			Not Escalated	95.0%		
	Well Led	Statutory and Mandatory Training		85.0%	91.0%	Oct-24	85.0%	91.9%	Sep-24	Driver			Not Escalated	92.90%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	74.0%	Oct-24	66.0%	74.5%	Sep-24	Driver			Not Escalated	80.81%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	6.8%	Oct-24	4.0%	6.9%	Sep-24	Driver			Not Escalated	4.71%		
	Well Led	Percentage of AfC 8c and above that are BAME		9.5%	6.2%	Oct-24	9.2%	6.2%	Sep-24	Driver			Escalation	7.31%		
	Well Led	Staff Leavers within 12 months		15.3	17	Oct-24	15.3	31	Sep-24	Driver			Escalation	1917.7%		
	Well Led	Staff Leavers within 24 months		27.8	38	Oct-24	27.8	46	Sep-24	Driver			Escalation	3669.7%		

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Overall Temporary Staff Spend as a % of Total Spend

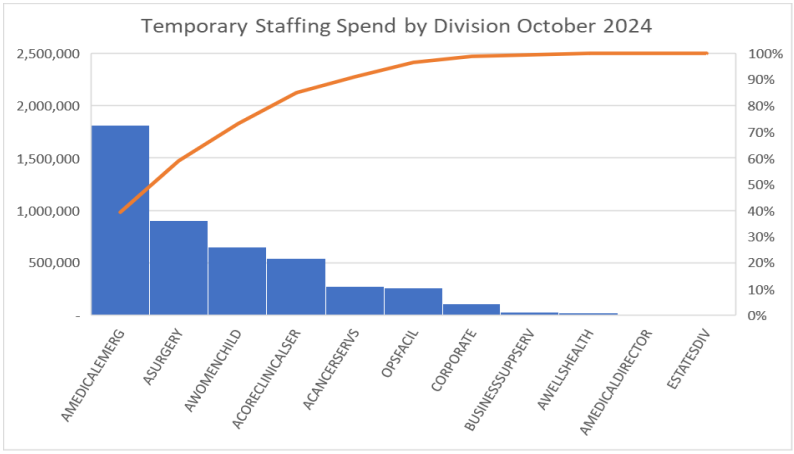
Owner: Chief People Officer
Workstream: Temporary Staffing
Metric: Overall Temporary Staff Spend as a % of Total Spend
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Oct-24
9%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and is consistently failing the target
Max Target (Internal)
8.5%
Business Rule
Full Escalation as is consistently failing the target

2. Stratified Data



9 of 11 Divisions reduced temp spend in October compared to September

3. Top Contributors & Risks

Top Contributors:

- Inconsistent controls to assess requests for temporary staffing
- High levels of retrospective rostering creating inaccurate bank demand
- Variation in medical bank rates paid
- Medical rosters not recorded consistently

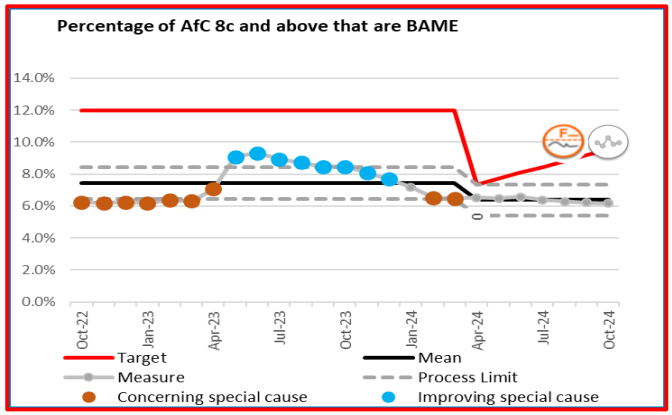
Risks:

- There is a risk that Divisions will not reduce their pay forecasts by the target level of 1.9% (£9m)
- There is a risk that unexpected high demand on services will cause temporary staffing levels to be higher than planned
- There is a risk that the temporary staffing team do not have sufficient resource capacity to deliver project deliverables

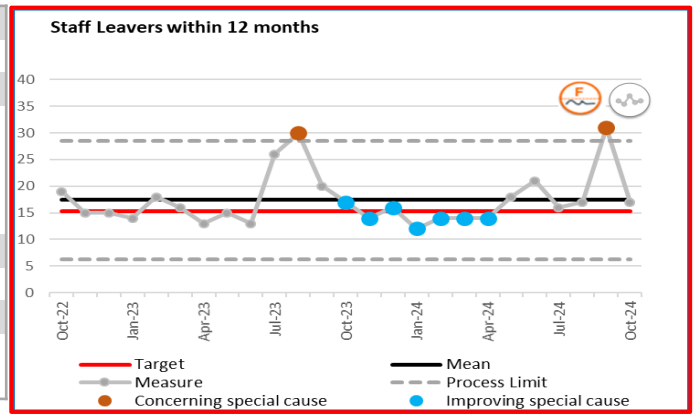
4. Action Plan of the Breakthrough Objective

Workstreams	Actions	When	Who
Programme Delivery	Develop an A3 to identify strategic divisional actions to take forward	Jan 2025	Senior Continuous Improvement Manager
Rostering Performance	Launch Temporary Staffing Dashboard to give operational teams visibility of key temporary staffing performance	Nov 2024	Deputy CPO / Financial Improvement Director
	Division / directorate forecast meetings – including focus on areas over £50k variance to budget	Nov 2024	Deputy CPO / Financial Improvement Director
	Introduction of rostering performance meetings for AHPs	Nov 2024	Chief of Healthcare Professions
Vacancy and Pay Controls	Pause and review of AFC Bank rates including comparison to neighbouring trusts	Dec 2024	Deputy CPO / Financial Improvement Director
	Review of Corporate Consultancy usage and baseline	Nov 2024	
Medical Rate Framework	New Framework implementation	Jan 2025	Deputy Medical Director
Medical Rostering (Patchwork rollout)	Finalise plan for rollout of Patchwork in ED inc staff engagement and communications.	Nov 2024	Temporary Staffing Programme Director

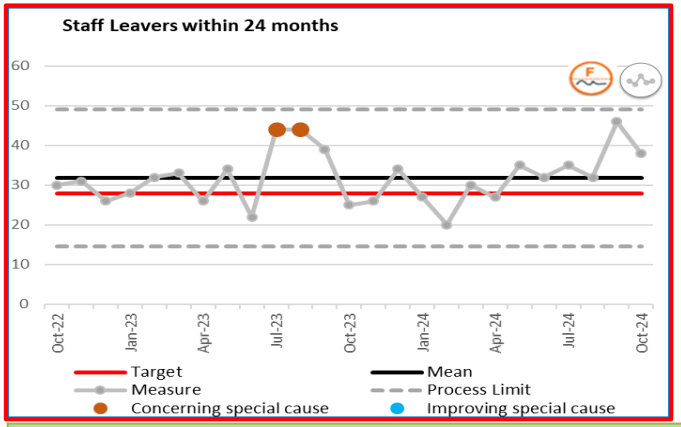
People – Workforce: CQC: Well-Led



Oct-24
6.2%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
8.4%
Business Rule
Full Escalation



Oct-24
17
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has failed the target for >6months
Max Limit (Internal)
15
Business Rule
Full Escalation as failed the target for >6 months



Oct-24
38
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has failed the target for >6months
Max Limit (Internal)
29
Business Rule
Full Escalation as failed the target for >6 months

Staff leavers within 24 months (short term leavers with <12 months and <24 months service metrics):

- Following the development of a dashboard to focus on short term leavers, at the October PODCO meeting it was discussed that there was particular senior level concern that there was wide variation between months on a % basis and on Health Care Support Workers, part of which may be mismatches between vacancies, establishment and ESR records.
- This was further discussed as part of the IPR review and a review undertaken.
- When these metrics were first derived they were a raw headcount, however, when converted to a percentage the dominator used was WTE.
- As noted previously , these metrics may not then provide correct insight. On the percentage charts (without the target) both metrics have stayed within common cause variation for the last 2 years, with some seasonality. However, we see a similar pattern, but with more statistical significance in September 24 that triggered a special cause variation of a deteriorating nature for leavers within 12 months.
- This is because the smoothing effect of applying a percentage of leavers means that if the Trust has a particularly bad month for leavers then this will have a concealing effect on these metrics as the denominator is higher and so drives the performance down.
- The data already excludes leavers due to the big seasonal peaks, but will include some of that – hence the seasonality we see on the charts and the understandable concern this may cause.
- We have therefore proposed that we monitor raw headcount of leavers each month, as this has less risk of concealing potential issues and the figures are now restated on this basis.

Summary:

% of AfC 8c and above that are BAME: This metric is common cause variation and consistently failing the target.

Staff Leavers within 12 months: This metric is experiencing common cause variation and has failed the target for >6months

Staff Leavers within 24 months: 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.

Staff Leavers within 12 AND within 24 months (now showing headcount rather than 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 supporting this 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
- Given the decline in performance, we are also reviewing H1 24/25 recruitment data to further pinpoint stages where declines in performance are happening and exploring further measures with EDI reps being used at earlier stages and enhanced earlier use of recruitment and people business partners. This is part of the Q3 planned review.
- We discussed in October 2024 the need for greater senior focus to support any action plans developed from the above and appetite for more radical interventions, such as those under s159 for positive action under the Equalities Act 2010. While performance has improved, need to continue the conversation and the People and OD team are continuing to review further actions.
- Between August and end of October, 8 x Inclusive recruitment workshops were delivered for recruiting managers in bands 8b and above – attendance 52, DNA 14, cancelled 6. More workshops have been scheduled during January. Plan to create e-Learning workshops
- A new Power BI Dashboard for EDI Indicators has been launched to be able to use evidence-based data to highlight areas of focus to drive improvements.

Staff Leavers within 12 AND within 24 months:

- October 2024 review of divisional turnover hotspots
- Taking forward of remaining workforce supply programme board counter measures for October
- Q3 24/25 introduction of more granular dashboard developed to focus on short term leavers.

Strategic Theme: Patient Safety & Clinical Effectiveness

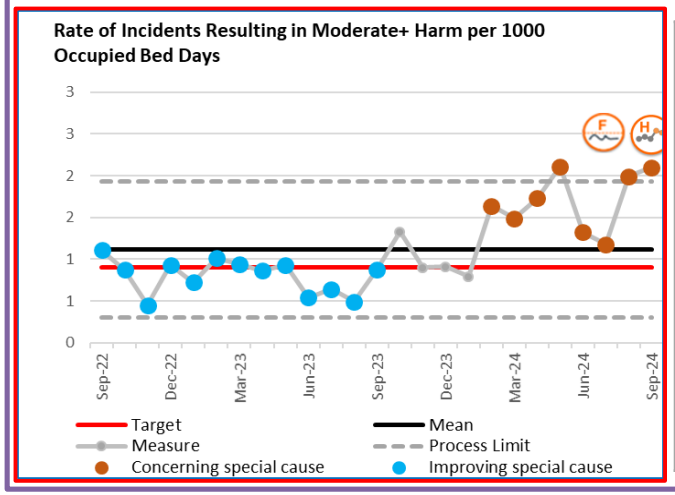
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	2.10	Sep-24	0.90	1.99	Aug-24	Driver			Full CMS	1.94 Nov 24		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	1	Sep-24	2.1	2	Aug-24	Driver			Verbal CMS	2 Nov 24		
Financial Breakthrough Objectives	Safe	% Capped Theatre utilisation.		85.0%	80.8%	Oct-24	85.0%	80.8%	Sep-24	Driver			Full CMS			
	Safe	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	53.8%	Oct-24	49.0%	53.1%	Sep-24	Driver			Note Performance	54.4		
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month	TBC	TBC	4	Oct-24	TBC	4	Sep-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month	TBC	TBC	31	Oct-24	TBC	13	Sep-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month	TBC	TBC	0	Oct-24	TBC	2	Sep-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	85.1	Jul-24	100.0	82.7	Jun-24	Driver			Not Escalated	79.6		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	94.0	Jul-24	100.0	94.0	Jun-24	Driver			Not Escalated	94.8		
	Safe	Never Events		0	1	Oct-24	0	0	Sep-24	Driver			Not Escalated	0		
	Safe	Safe Staffing Levels (Nursing)		93.5%	102.0%	Oct-24	93.5%	103.0%	Sep-24	Driver			Not Escalated	103.4%		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	57.6	Oct-24	32.6	21.0	Sep-24	Driver			Not Escalated	36.0		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.4	52.4	Oct-24	44.4	60.7	Sep-24	Driver			Not Escalated	56.6		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Oct-24	0	0	Sep-24	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	5.9	Oct-24	6.4	6.1	Sep-24	Driver			Not Escalated	5.8		

Vision: Counter Measure Summary

Project/Metric Name – Reduction in harm : Incidents resulting in moderate to severe harm and death

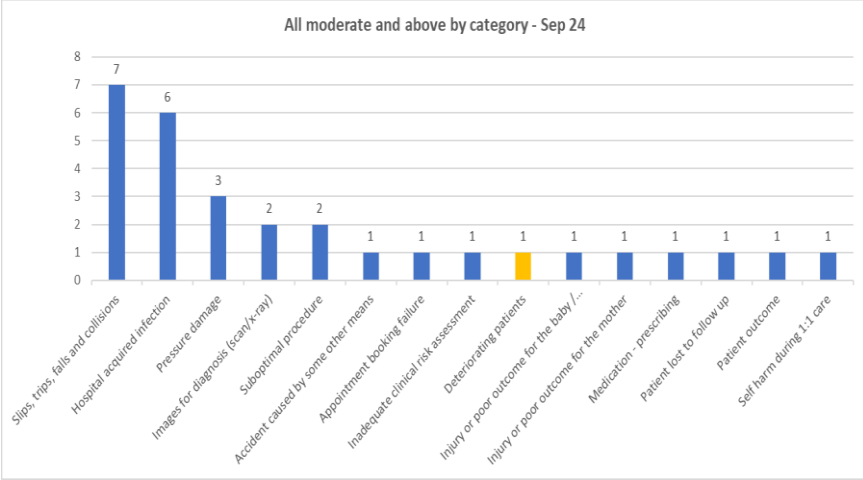
Owner: Medical Director
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

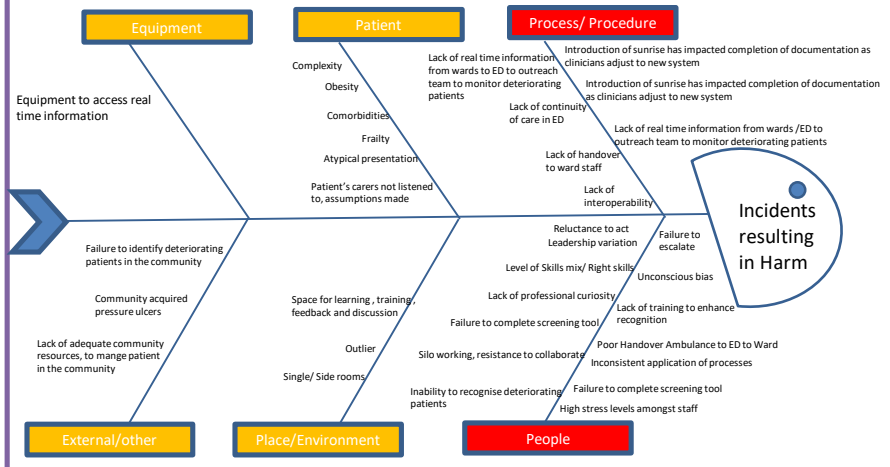


Sep-24 (1 month arr)
2.1
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
0.9
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



3. Top Contributors



4. Action Plan

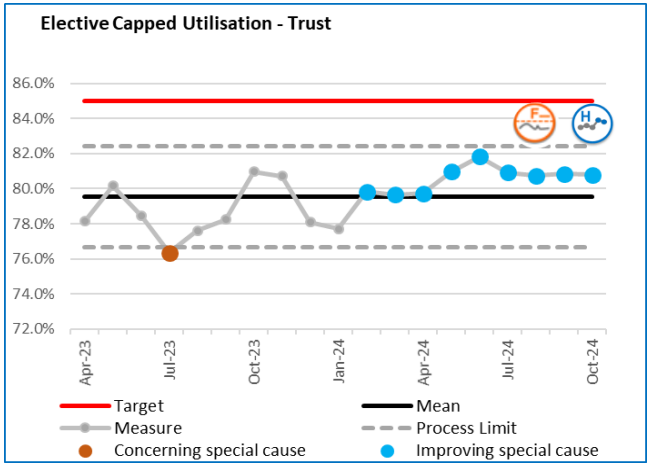
Actions	Leads	Due by
HCAIs		
Quality improvement project to improve the management and care of urinary catheters	IPC Team	Nov-24
Participation in ICB HCAI collaborative targeting key intervention to reduce HCAIs	IPC Team	Ongoing
Improved systems in place for bed and trolley mattress integrity checks and cleanliness	IPC Team	Jan-25
Falls		
Review of training compliance to ensure staff aware of fall prevention protocols and procedures: refreshing knowledge on consistent use of risk assessments, environmental checks, promoting patient engagement with fall prevention	Ward Managers	Dec-24
Ward visits undertaken regularly to provide oversight and to assist departments in mitigating some risks and preventing further harm to patients	Falls Team	Ongoing
Triangulation with the PFIS Team regarding training as part of the wards' improvement journey	Falls Team	Jan-25
Deteriorating Patients		
Undertake Stakeholder Engagement Event to identify further contributors and countermeasures	Project Team	Dec-24

Financial Breakthrough: Counter Measure Summary

Project/Metric Name – % Capped Theatre utilisation.

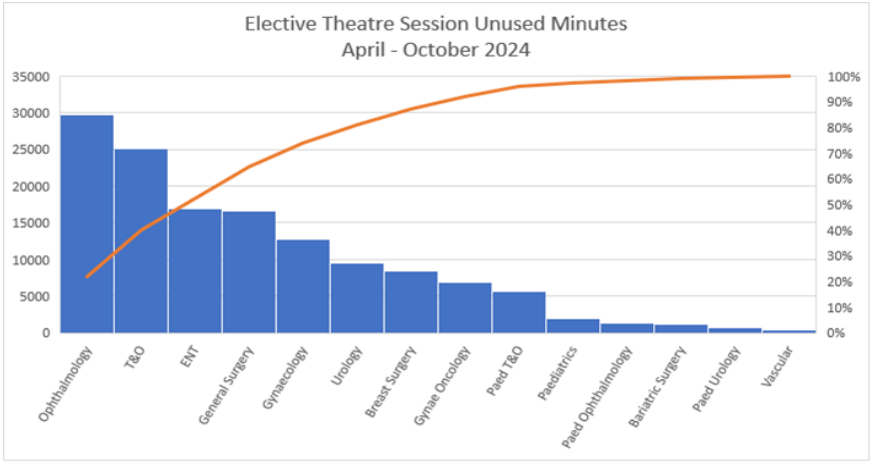
Owner: Medical Director
Workstream: Productivity
Metric: % Capped Theatre utilisation.
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Oct-24
80.8%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target.

2. Stratified Data



3. Top Contributors

Theatre Utilisation

- Elective paediatric beds
- Incorrect procedure times
- Cancellations
- Scheduling – some lists being booked at short notice due to workforce availability
- Backfilling of sessions in ortho (due to leave and on calls substantive consultants work a 39 week elective year)
- Gynae WLI requirements
- T&O

Key Risks:

- Lack of capacity for specialties providing EK mutual aid
- Holes in sets
- Freeing up theatre slots will only create room for day cases impacting on the income opportunity
- Not enough Paeds beds which is impacting on being able to fully book lists

4. Action Plan

Action	Deadline/ Next Review	Status
Review of paediatric bed availability / requirements by WCSH & identify next steps	Dec 24	Open
Complete an A3 in Ophthalmology to understand root causes for underutilisation and cancellations	Dec 24	Open
Directorates working on opportunities to improve procedure times	Dec 24	Open
Identify a cohort of patients in key specialties who are available at short notice to utilise cancelled slots	Dec 24	Open
Introduction of T&O and Urology bespoke scheduling meetings	Nov 24	Open
Increased emphasis on filling funded gynae sessions before weekend WLIs are booked	ongoing	Open

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	Responsive	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5)		5.9	7.2	Oct-24	5.9	6.8	Sep-24	Driver			Full CMS			
Financial Breakthrough Objective	Responsive	Conversation rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	15.9%	Oct-24	16.0%	15.2%	Sep-24	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Responsive	Achieve the Trust RTT Trajectory (Excluding SYS)		78.1%	71.5%	Oct-24	77.4%	71.1%	Sep-24	Driver			Escalation	72.4%		
	Responsive	Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		78.1%	71.1%	Oct-24	77.4%	70.3%	Sep-24	Driver			Business Rules not applied (for info only)			
	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		126.0%	131.1%	Oct-24	122.8%	131.8%	Sep-24	Driver			Not Escalated	125.3%		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		674	622	Oct-24	669	578	Sep-24	Driver			Not Escalated	582		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	132	Oct-24	N/A	311	Sep-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 52 weeks for treatment (System Support only) - Reported Nationally		N/A	95	Oct-24	N/A	244	Sep-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		98.5%	89.7%	Oct-24	98.2%	89.3%	Sep-24	Driver			Not Escalated	90.4%		
	Responsive	A&E 4 hr Performance		84.1%	82.2%	Oct-24	84.5%	83.1%	Sep-24	Driver			Escalation	82.0%		
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	96.7%	Sep-24	96.0%	96.6%	Aug-24	Driver			Not Escalated	96.0%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.2%	Sep-24	85.0%	85.1%	Aug-24	Driver			Not Escalated	86.5%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	77.2%	Sep-24	75.0%	75.4%	Aug-24	Driver			Not Escalated	79.3%		
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	92.5%	Sep-24	90.0%	94.6%	Aug-24	Driver			Not Escalated	96.7%		

* 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)

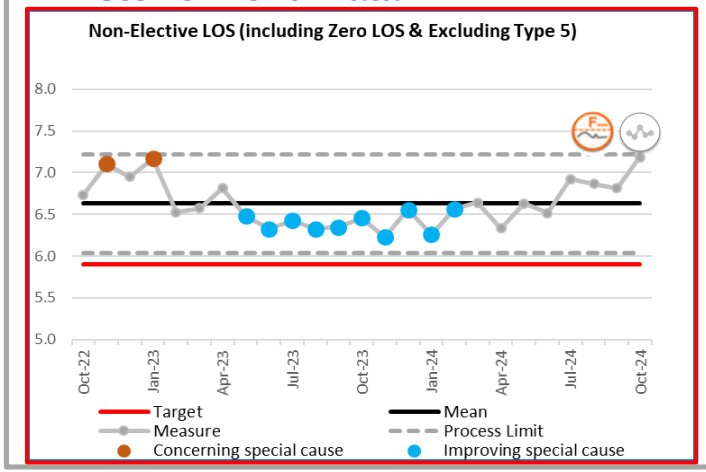
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	80.6%	Oct-24	85.0%	85.0%	Sep-24	Driver			Not Escalated	85.0%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		6.3%	6.2%	Oct-24	6.7%	6.8%	Sep-24	Driver			Not Escalated	6.7%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	83.5%	Oct-24	90.0%	86.8%	Sep-24	Driver			Escalation	89.9%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	6.1%	Oct-24	5.0%	5.1%	Sep-24	Driver			Not Escalated	5.6%		
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	58.0%	Oct-24	65.0%	54.5%	Aug-24	Driver			Escalation	57.9%		
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		119.5%	125.2%	Oct-24	111.2%	115.2%	Sep-24	Driver			Not Escalated	107.1%		
	Responsive	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	53.8%	Oct-24	49.0%	53.1%	Sep-24	Driver			Not Escalated	54.4		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		141.4%	163.0%	Oct-24	156.1%	158.8%	Aug-24	Driver			Not Escalated	161.6%		

Vision: Counter Measure Summary

Project/Metric Name – Achieve 10% Reduction in Non-Elective LOS

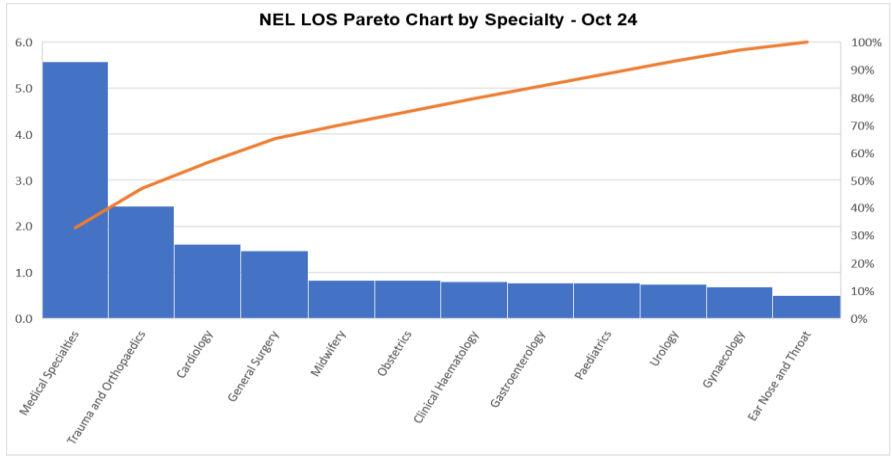
Owner: Chief Operations Officer
Workstream: Front to Back Doors
Metric: Non-Elective Length of Stay (LOS)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Oct-24
7.2
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
5.9
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

- Inconsistent Board Round Processes
- High number of DTA's overnight impacting on flow
- Review of SDEC pathways/utilisation
- Deconditioning of patients with extended stays

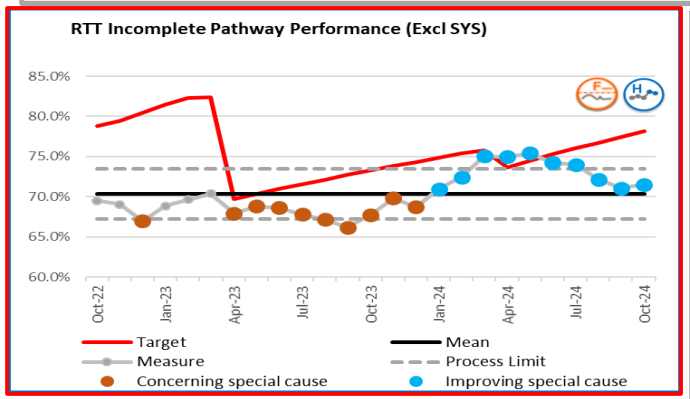
Quick win

- Pathway 0 management

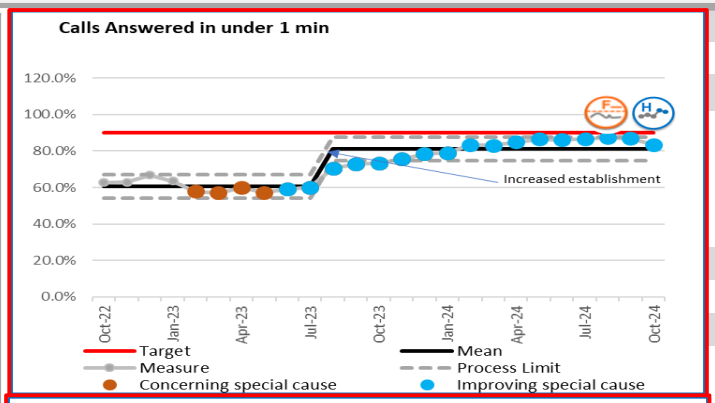
Key Risks:
Change of provider for pathway one, leading to delays to patient pathways.
Mitigations:

Contributors	Action	When
Inconsistent board rounds	• Review opportunity for PM Board Rounds to be implemented in Surgery • Board round audit carried out and findings being reviewed • Post BR EDN pilot on ward 11 to start	30th Nov 24 22nd Nov 24 22nd Nov 24
DTA's Overnight	• Assurance monitoring in place • Agree plan to sustain	Nov 2024 30th Nov 24
Pathway 0 management	• 'Pick your pathway week' held via comms • Review of data highlighting delays • Review and development of internal standards	4 Nov 24✓ 22nd Nov 24 30th Nov 24
SDEC	• OAU exclusion criteria and referral and Nurse referral go live • Gastro SDEC model agreed	4th Nov 24✓ 14th Nov 24
Deconditioning	• Acute therapy pathway design and baseline data completed	Oct 2024✓
Pathways 1-3	• Escalation ladder developed for East Sussex • Agreement of escalation ladders for Neuro rehab and Mental Health	Nov 2024✓ Dec 2024

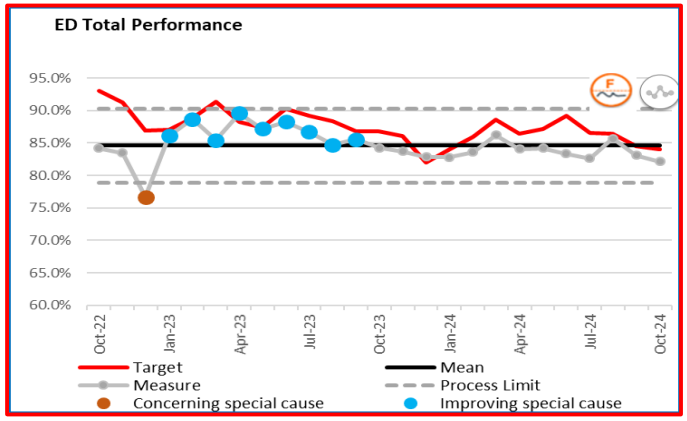
Patient Access: CQC: Responsive



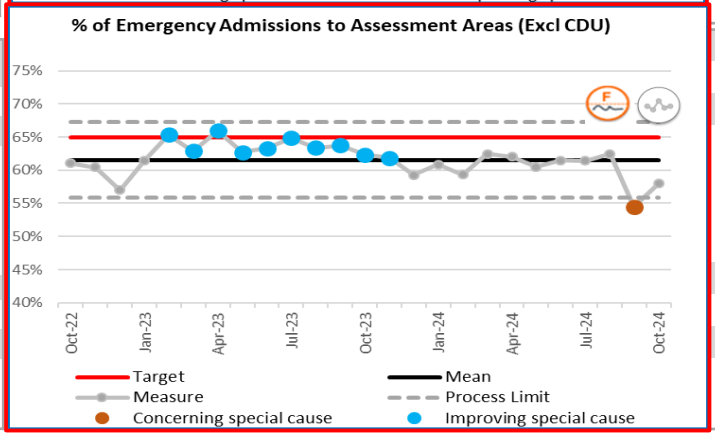
Oct-24
71.5%
Variance Type
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target (Internal)
78.1%
Target Achievement
Metric is consistently failing the target



Oct-24
83.5%
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



Oct-24
82.2%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for >6 months
Target (Internal)
84.5%
Business Rule
Full escalation as has failed the target for 6+months



Oct-24
58%
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:

RTT: is experiencing special cause variation of an improving nature and is consistently failing the target.

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.

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 and has failed the target for 6+ months.

Actions:

RTT: Review of data to identify specialties with longest waits. Identify 2 areas for focussed improvement- Gynaecology and ENT with further data to drill down on improvement areas, Process Mapping sessions planned.
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. Share and learn event being set-up and under-performing specialities escalations to GM level. Review of data underway to identify themes and trends in the calls received to understand demand.
ED Performance<4hrs: The ED team are constantly reviewing ways to improve our performance and ensure consistency of patient care. Improvement ideas are constantly being suggested and reviewed for impact.
% 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:

RTT: We've established and communicated a clear trajectory for reducing wait times for first appointments with the specialty teams. Teams are implementing super clinics, and we're continuing to enhance the straight-to-test pathways. Notably, there have been improvements in gynaecology regarding their wait times for first appointments. However, some progress has been affected by the resources allocated to system support, particularly for Gastro and ENT services.
Calls Answered within 1 minute in the CAUs: Remain on upward trajectory. Focus on underperforming specialities to reach 90%. OCC has two new starters in post taking them back to full-establishment.
ED Performance<4hrs: With the volumes of attendances increasing, the team have been flexing capacity and staffing provisions in line with the demand.
% of Emergency Admissions to Assessment Areas (Excl CDU): The assessment areas have been reviewed and T&O are currently trialling an exclusion criteria rather than an inclusion criteria for patients who are able to be reviewed in this area. So far, patient throughput has increased by 1-2 patients per day.

Strategic Theme: Patient Experience

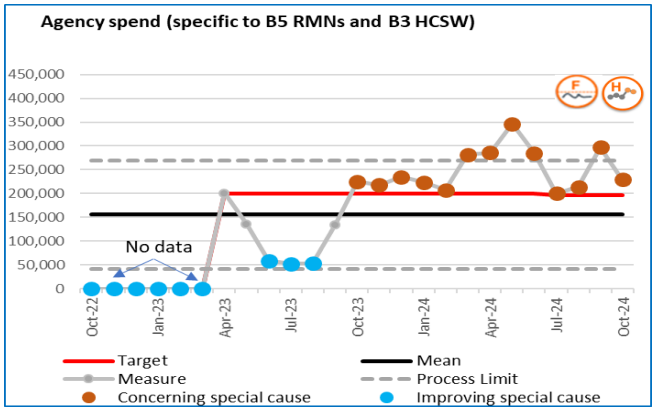
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Caring	To reduce the overall number of complaints or concerns each month		36	35	Oct-24	36	25	Sep-24	Driver			Verbal CMS	34		
Breakthrough Objective	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	21	Oct-24	24	11	Sep-24	Driver			Note Performance	2		
Financial Breakthrough Objective	Caring	Reduction in agency spend (specific to B5 RMNs and B3 HCSW)		196,000	229,537	Oct-24	196,000	296,877	Sep-24	Driver			Full CMS			
Constitutional Standards and Key Metrics	Caring	Complaints Rate per 1,000 occupied beddays		3.9	1.9	Oct-24	3.9	1.4	Mar-24	Driver			Not Escalated	1.9		
	Caring	% complaints responded to within target		75.0%	81.0%	Oct-24	75.0%	52.0%	Sep-24	Driver			Not Escalated	75.0%		
	Caring	Complaints Backlog – Older than 4 months	TBC	0	30	Oct-24	0	-	Sep-24	Driver			Not Escalated			
	Caring	Complaints Closed in Month	TBC	38	47	Oct-24	38	40	Sep-24	Driver			Not Escalated			
	Caring	Complaints - 3 Day acknowledgement	TBC	95.0%	97.0%	Oct-24	95.0%	-	Sep-24	Driver			Not Escalated			
	Caring	% VTE Risk Assessment (one month behind)		95.0%	94.8%	Sep-24	95.0%	95.4%	Aug-24	Driver			Not Escalated	94.60%		
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	4.4%	Oct-24	25.0%	3.4%	Sep-24	Driver			Escalation	-2.57%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	11.89%	Oct-24	15.0%	12.31%	Sep-24	Driver			Escalation	12.41%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	4.8%	Oct-24	25.0%	5.8%	Sep-24	Driver			Escalation	-0.39%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	8.8%	Oct-24	20.0%	8.2%	Sep-24	Driver			Escalation	7.79%		

Financial Breakthrough: Counter Measure Summary

Metric Name – Reduction in agency spend (specific to B5 RMNs and B3 HCSW)

Owner: Chief Nurse
Workstream: Enhanced Care
Metric: Reduction in agency spend (specific to B5 RMNs and B3 HCSW)
Desired Trend: 7 consecutive data points below mean

1. Historic Trend Data

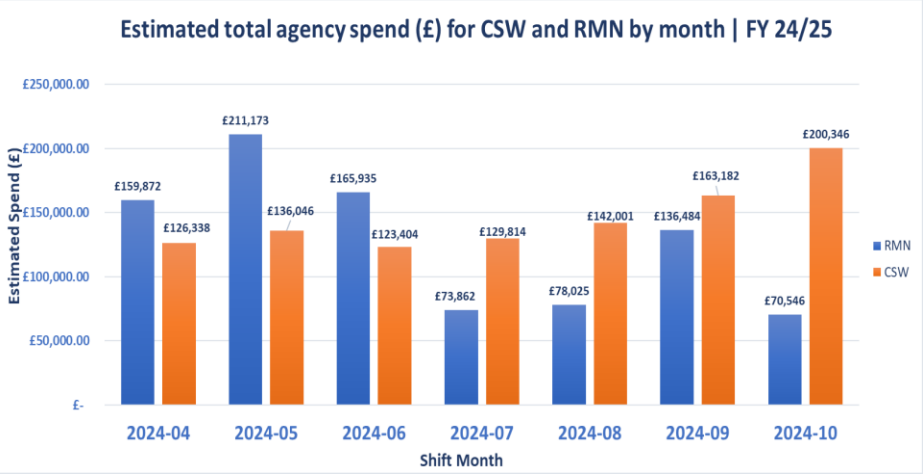


Oct-24
229,537
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
196,000
Target Achievement
Metric has not achieved the target for 6+ months

Phased target - reduce by 2% from the mean during Quarters 2 and 3 and 5% from the mean during Quarter 4 24/24

2. Stratified Data

Data source: Health Roster



3. Top Contributors and Key Risks

- Work to ensure the enhanced care pathways are robust enough and have operational oversight.
- Poor understanding of clinical need for Agency RMN and Band 3 CSW requests.
- No substantive workforce to support enhanced care pathways.
- Complex case pathway patients require a higher level of enhanced care meaning higher usage of agency staff and spend.

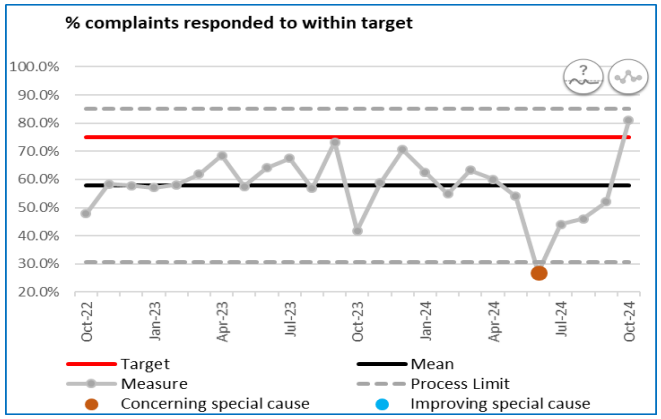
Key Risks:

1. Focussing on reducing agency spend only without ensuring there is a substantive or bank workforce in place, may result in unmet demand which may impact on patient care or could lead to higher reliance on overtime from internal staff, which may become financially unsustainable in the long term.
2. Project may fail to deliver the expected cost-savings if internal staffing solutions are not effectively implemented. Poor execution could lead to even higher costs in the long run.
3. There is a risk that MTW might not attract permanent Bank staff.

4. Action Plan of the Breakthrough Objective:

Workstreams	Action	When	Who
Data and Finance	Triangulate data based on current spend, health roster booking reason codes, ward specific resources and complex case patients	Nov 24	PS/SH
Data and Finance	Develop trajectory and dashboard to show weekly/monthly trends on spend for Band5 RMNs and Band3 CSWs	Dec 24	PS/SH
Enhanced care policy	Future process for enhanced care pathway is in draft and is being reviewed by the team	Dec 24	AD/LP
Enhanced care policy	Gemba walk on high spend areas to identify improvement opportunities	Dec 24	AD/LP
Enhanced care policy	Focus on high spend areas and start piloting improvements identified from workshop on 24th	Jan 25	AD
Extended project group	Start a new Task and Finish group for developing an internal bank pool of enhanced care temporary staff.	Nov 24	AD/PM
Enhanced care Temporary staffing	Business case development for enhanced care model	Nov 24	CW

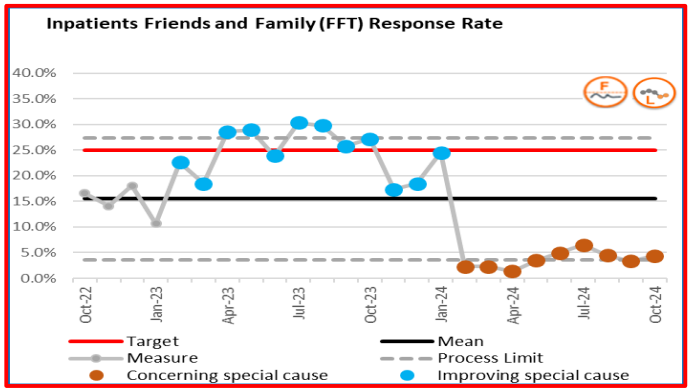
Patient Experience: CQC: Caring



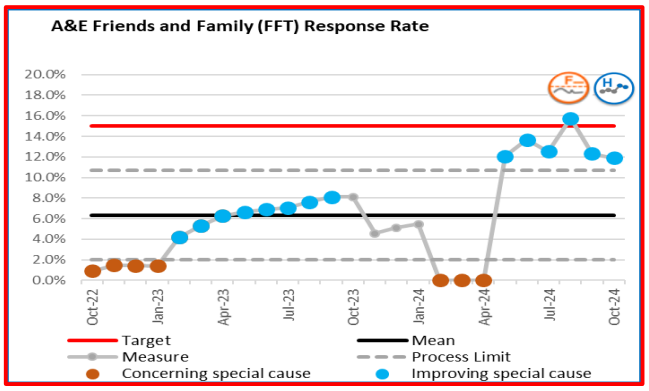
Oct-24
81%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (Internal)
75%
Business Rule
For information as is no longer failing target

Summary:	Actions:	Assurance & Timescales for Improvement:
Complaints Response Rate: This indicator is experiencing common cause variation and variable achievement of the target.	**Complaints Response Rate:** Expanded substantive complaints team now embedded Sustained improvement linked to number of complaints being closed each month and the total number of open complaints reducing month on month since June 2024, this is now starting to positively impact on performance which is expected to continue. An increase in cases being resolved via “early resolution” is also positively impacting on performance Plans to cease agency usage have been delivered X2 weekly operational oversight meetings continue with senior support and presence Weekly oversight meetings in place with CNO and DoQG Improvement / recovery plan now in place and being tracked at Experience of Care	

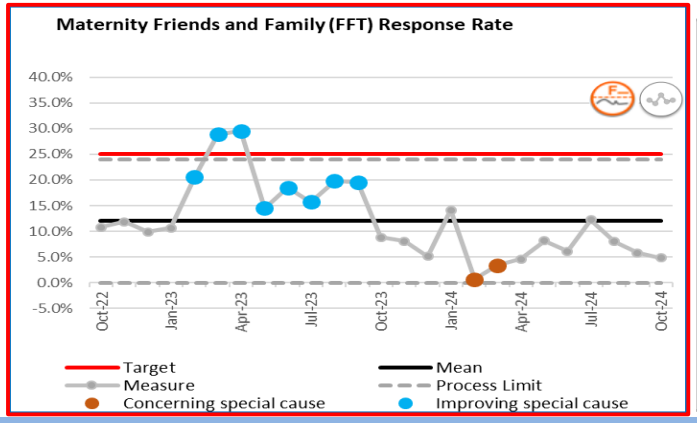
Patient Experience: CQC: Caring



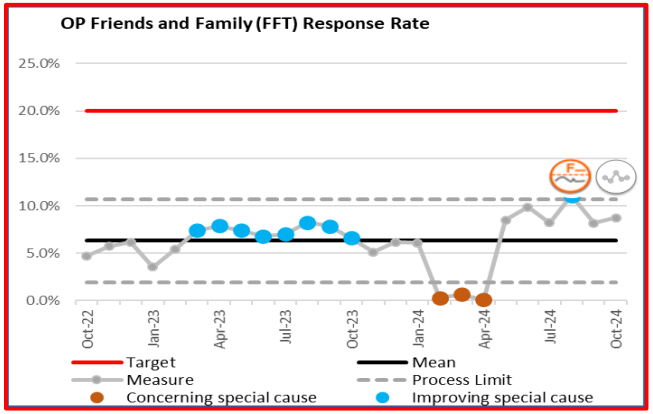
Oct-24
4.4%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Target (National)
25%
Business Rule
Full Escalation as Consistently Failing Target



Oct-24
11.9%
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



Oct-24
4.8%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Oct-24
8.8%
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 a concerning nature and is consistently failing the target.
National Response – 21.7%
Trust Recommended Rate is 91.7%

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
National Response – 10.6%
Trust Recommended Rate is 79.1%

Friends and Family Response Rate - Maternity: : Is experiencing Special Cause Variation of a concerning nature and is consistently failing the target
National Response – 11.9%
Trust Recommended Rate is 100%

Friends and Family Response Rate - Outpatients: Is experiencing Special Cause Variation of an improving nature variation but is consistently failing the target.
National Response – 14.8%
Trust Recommended Rate is 93.2%

Actions:

Inpatients: Response rate has increased marginally this month. 550 paper feedback forms are recorded as received in relation to inpatient care on the provider platform for the month of October. However, this is not currently included within the reported response rates, quality assurance review with BI and HCC is currently underway. Of the paper forms received 87% (479/550) contained responses to Q2. Top positive themes: Staff attitude (compassion and care, commitment); implementation of care; environment. Top themes for improvement: Staff attitude & communication; environment and waiting times. Several comments reference the individuals intention to contact PALS or make a complaint.

A&E: Response rate has dipped slightly since September with the vast majority of responses received digitally. Positive themes: staff attitude, implementation of care, environment and waiting times. Areas for improvement: staff attitude, physical environment (lack of refreshments; chairs uncomfortable, cold temperature), lack of or inaccurate updates in relation to expected waiting time, lack of or poor communication.

Maternity: FFT cards & posters containing QR codes on display, link is also shared by post-natal team as part of information resources sent. Feedback is also being shared via other means e.g. social media this may impact on response rates for FFT, to liaise with Maternity Patient Experience Facilitator to explore means of increasing response rate/consolidating feedback. Positivity rate of feedback received is high with standard of care provided by staff, being a recurrent theme.

Sexual Health: Feedback was limited by the relevant system being down, paper feedback forms were circulated for 2 weeks of October. Positive responses from patients, (94 responses), 95% of patients felt very satisfied with our service. Positive comments include: Staff are kind, helpful, friendly and respectful and patients left feeling reassured

Outpatients: Response rate has slightly increased since last month. An additional 200 paper feedback forms have also been received which are not included within the return. Top positive themes: staff attitude, implementation of care and environment. Areas for improvement: staff attitude & communication (staff not prioritising patients, lacking compassion), waiting times within department (clinics consistently starting late & running late, lack of accurate updates).

FFT Response All: Ongoing meetings with HCC to ensure correct mapping of clinical areas to feedback. Work on-going to review returns generated by text or hardcopy card. The number of comments received continues to increase. Divisions are putting action plans in place and reporting via the Experience of Care committee. SMS onboarding nearing completion for all clinical areas, work is on-going to incorporate Kent Oncology centre appointments from the Kent Oncology Management System (KOMS). quality assurance measures are being instigated including return of feedback received via hardcopy forms in the data return to the BI team.

Assurance & Timescales for Improvement:

Friends and Family (FFT) Response Rates: Inpatient and maternity responses rates remain a challenge as there is minimal engagement with text messaging from inpatients. However, the teams are now using the FFT post cards to obtain feedback from inpatient wards. A review is ongoing in maternity as the patients bookings are recorded via E3 system and not PAS system (which is used to automate the text messaging system). FFT cards are now being used across the four touch points of maternity care. Following the successful introduction of text appointment reminders for paediatrics work is now being undertaken to initiate text requests to parents/legal guardians to provide feedback on their experiences. Regular meetings are ongoing with HCC to review their contractual obligations in providing feedback obtained from FFT cards. A communications plan is being developed with the team which includes patient and staff education/information and continuing promotion of FFT via a variety of means. This is likely to be fully instigated in January 2025 although some interventions like information resource and engagement stand across both sites will take place in December 2024.. This has also been extended to Healthwatch to participate, if available. Engagement with volunteers is being undertaken to develop a small team able to actively gain feedback via iPads and or paper forms.

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	Effective	Capture elective income (ERF) from activity undertaken		99,948	90,841	Oct-24	80,712	74,452	Sep-24	Driver	No SPC	No SPC	No SPC			
Financial Breakthrough Objectives	Effective	Depth of Coding - Average Number of Codes per Elective Episode (Data runs one month behind)		6.1	4.6	Sep-24	6.1	4.6	Aug-24	Driver			Full CMS			
Constitutional Standards and Key Metrics	Effective	Decrease the percentage of occupied bed days for patients identified as no longer fit to reside (NCTR)		24.5%	21.5%	Oct-24	24.5%	21.6%	Sep-24	Driver			Note Performance	22.4%		

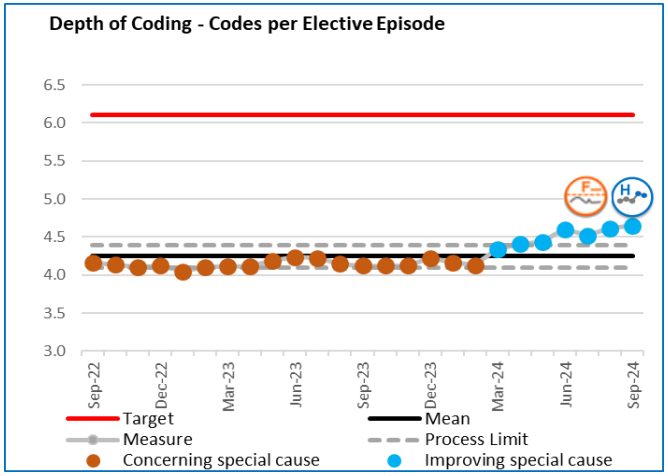
NB – Vision KPI and it's applicability to be discussed at board

Financial Breakthrough: Counter Measure Summary

Project/Metric Name –To improve Coding – Depth of Coding – Codes per Elective Episode

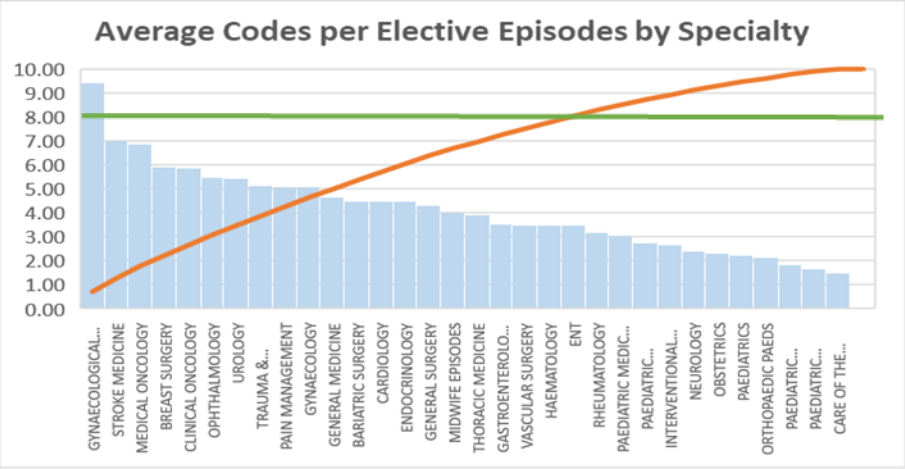
Owner: Director Strategy, Planning & Partnerships
Workstream: Capturing Income
Metric: Codes per Elective Episode
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Sep-24 (one month behind)
4.6
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Nat Average)
6.1
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors and Key Risks

Top Contributors

- Quality of clinical information recorded at depth appropriate to patient complexity

Key Risks

- Resourcing the Coding Team to run Simple Coding audits. Audits report missing income.
- Resourcing the Coding Team to improve depth of coding
- Engagement from clinicians to understand and adopt effective coding practices.
- Poor quality of information within the clinical systems and documentation

4. Action Plan

Workstreams	Action	Who
Inpatient Activity Coding	• Run Simple Code Live Audit tool • Resource the activity • Create SOPs and processes for use of the tool.	Clinical Coding Team
Education and Awareness (inpatient)	• Identify opportunities for additional training support. • Delivery of training to Improve organisational awareness of coding and existing processes for use of electronic documentation.	Clinical Coding Team / Sunrise Team
Communication	• Report performance of coding practices at Clinical Governances • Improve organisational awareness of coding through the corporate induction.	CMS Team / Clinical Coding Team
Additional	• Focus on the coding of interventional radiology procedures, including biopsies.	Radiology GMI, DDO Core Clinical Services
Resource	• Review the impact of financial recovery programmes on clinical coding resource • Agree future state resourcing for Coding Team	Clinical Coding Team

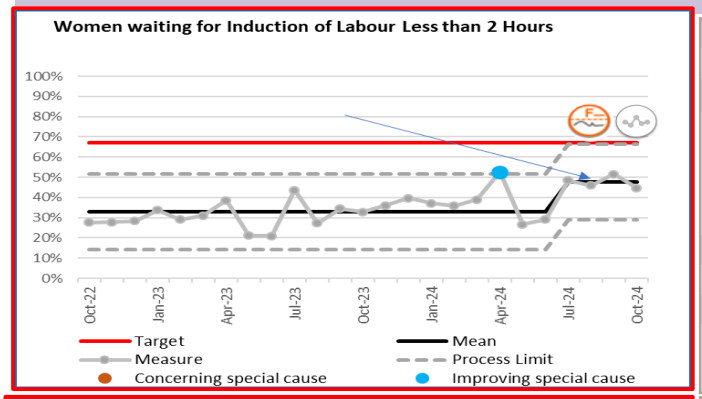
Strategic Theme: Sustainability

				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	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		2,961	3,771	Oct-24	-255	-2,087	Sep-24	Driver			Verbal CMS	4,577		
Financial Breakthrough Objectives	Well Led	Reduce non-pay spend		19,153	22,379	Oct-24	22,081	21,409	Sep-24	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		888	1,100	Oct-24	953	862	Sep-24	Driver			Not Escalated	841		
	Well Led	CIP		3,550	1,815	Oct-24	3,038	1,742	Sep-24	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		4,668	17,652	Oct-24	3,444	10,326	Sep-24	Driver			Not Escalated	1,592		
	Well Led	Capital Expenditure (£k)		3,884	3,878	Oct-24	20,354	2,524	Sep-24	Driver			Not Escalated	2,592		
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		99,948	90,841	Oct-24	80,712	74,452	Sep-24	Driver			Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		14,456	14,109	Oct-24	12,147	10,039	Sep-24	Driver			Not Escalated			

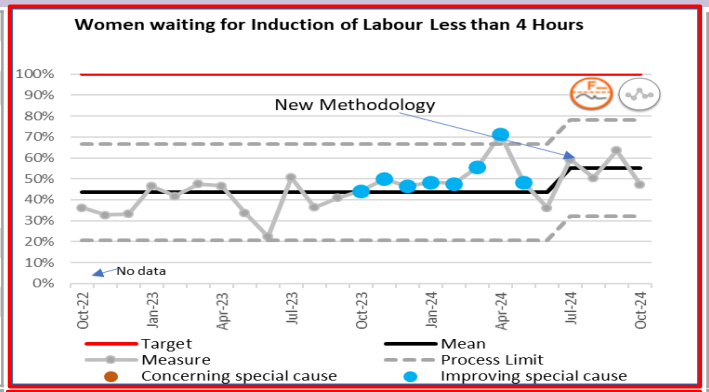
Maternity Metrics

				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	Maternity Metric	Registerable Births		No target	476	Oct-24	470	458	Sep-24	Driver		No target	Not Escalated	468		No SPC
	Maternity Metric	Antenatal bookings		No target	579	Oct-24	545	497	Sep-24	Driver		No target	Not Escalated	556		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	22.8%	Oct-24	No target	21.8%	Sep-24	Driver		No target	Not Escalated	21.4%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	20.9%	Oct-24	No target	24.0%	Sep-24	Driver		No target	Not Escalated	22.5%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	24.1%	Oct-24	36.0%	29.3%	Sep-24	Driver			Not Escalated	24.3%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	44.7%	Oct-24	67.0%	51.5%	Sep-24	Driver			Escalation	48.5%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	47.4%	Oct-24	100.0%	63.6%	Sep-24	Driver			Escalation	58.3%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	5.3%	Oct-24	6.0%	6.1%	Sep-24	Driver			Not Escalated	6.6%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	6.8%	Sep-24	4.0%	7.5%	Aug-24	Driver			Not Escalated	6.0%		
	Maternity Metric	Stillbirth rate		0.4%	0.4%	Oct-24	0.4%	0.2%	Sep-24	Driver			Not Escalated	0.2%		
	Maternity Metric	PPH >=1500% Rate		3.0%	2.1%	Oct-24	3.0%	3.3%	Sep-24	Driver			Not Escalated	3.1%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	3.4%	Oct-24	2.5%	0.8%	Sep-24	Driver			Not Escalated	2.4%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	77.2%	Oct-24	75.0%	77.3%	Sep-24	Driver			Not Escalated	78.1%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	68.8%	Oct-24	95.0%	73.7%	Sep-24	Driver			Escalation	85.8%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	63.5%	Oct-24	95.0%	72.5%	Sep-24	Driver			Escalation	75.3%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Oct-24	100.0%	100.0%	Sep-24	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	Oct-24	100.0%	100.0%	Sep-24	Driver			Not Escalated	100.0%		

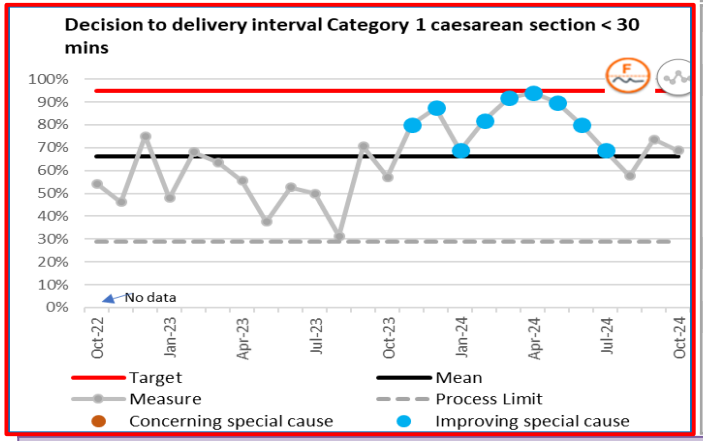
Maternity Metrics



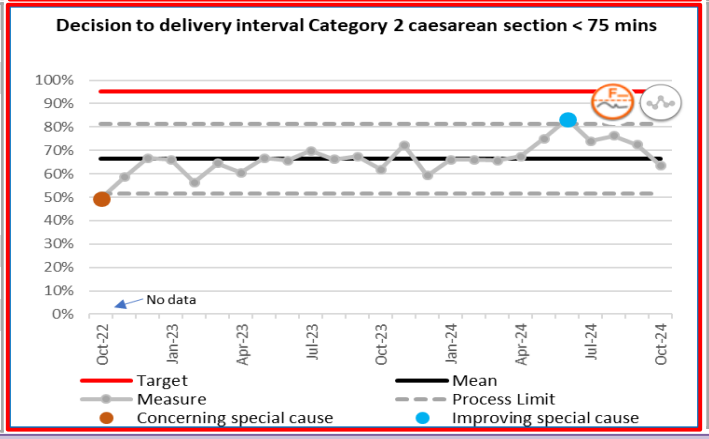
Oct-24
44.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full Escalation as consistently failing the target



Oct-24
47.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Oct-24
68.8%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Full escalation as has failed the target for >6 months



Oct-24
63.5%
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

Actions:

Fresh eyes approach. Reviewing capacity of Workstream Lead for next phase of work. Escalation policy under review.

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

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, as well as staffing availability.
Ongoing risk assessment and prioritisation is 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 1 and 2 target times has been made. All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified and shared for learning. that on review, once the clinically justifiable reasons are applied the compliance is 88% for cat 1 and 95% for cat 2 for September.

NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
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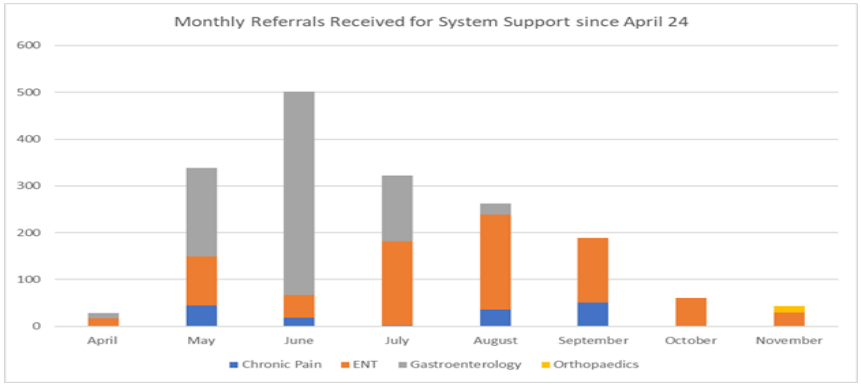
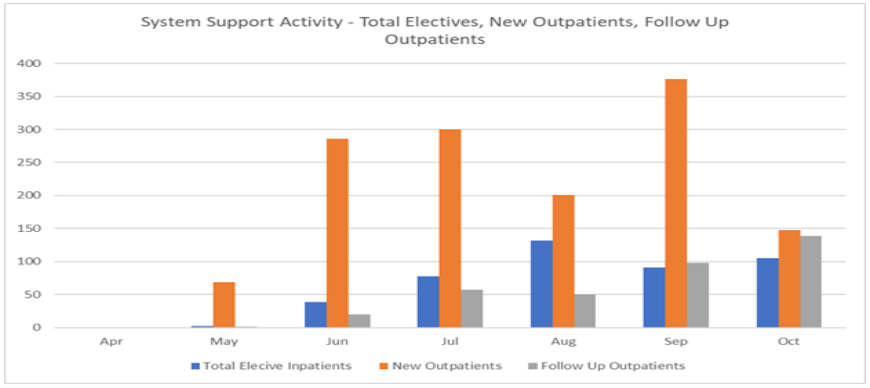
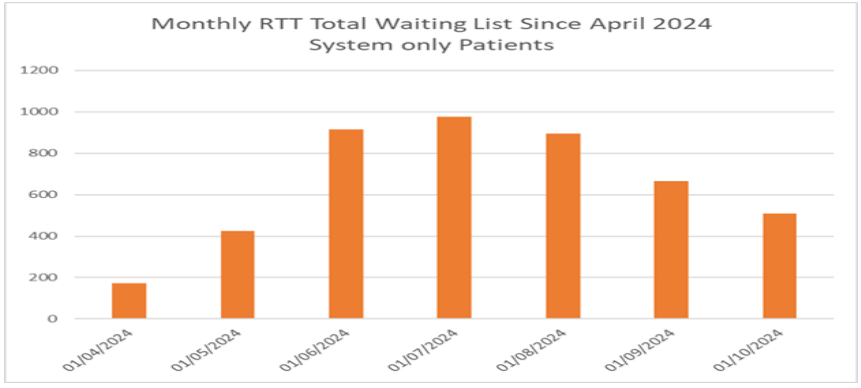
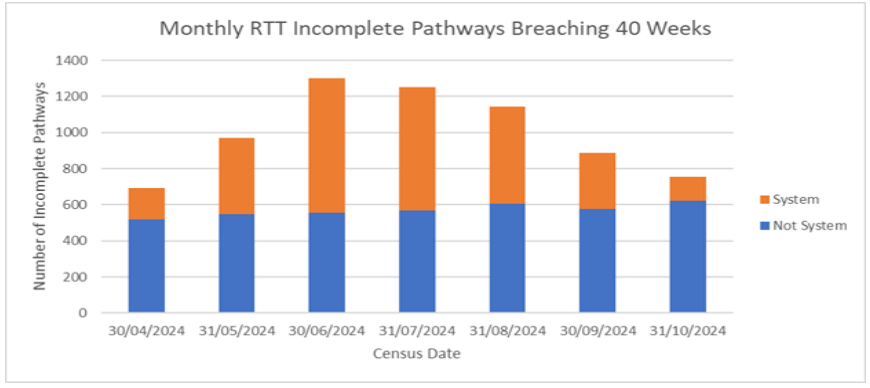
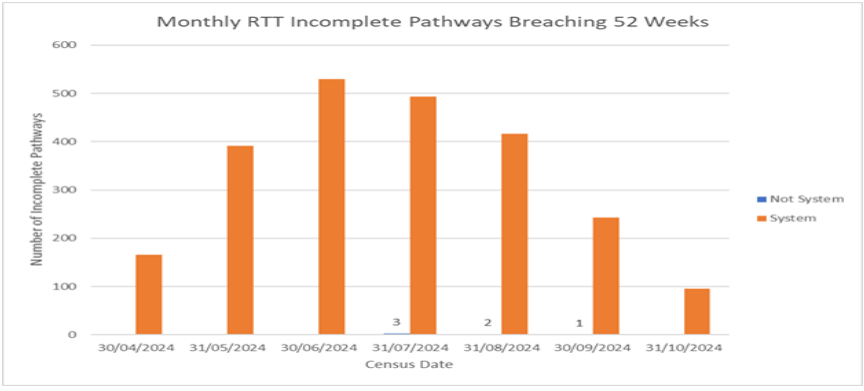
Patient Access: System Support Analysis











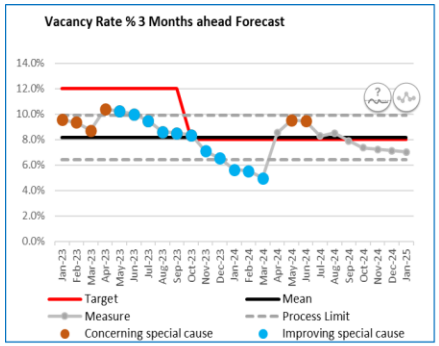
Summary:

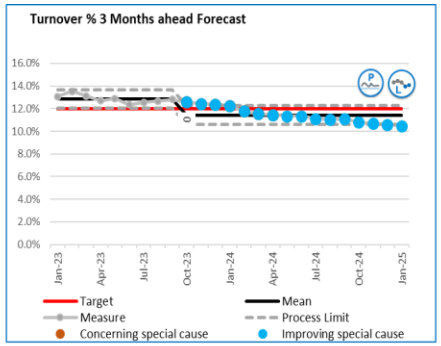
Since April 24 the Trust has received 1,746 referrals for System Support.

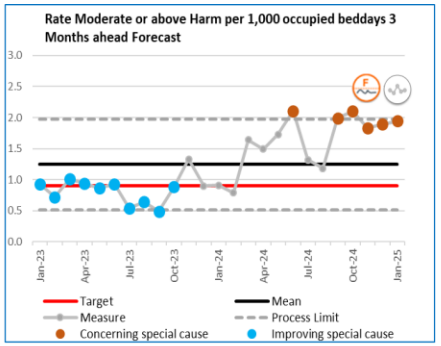
During April 24 to October 24 the Trust treated 447 inpatients, 1,380 New Outpatient attendances and 365 follow up outpatient attendances.

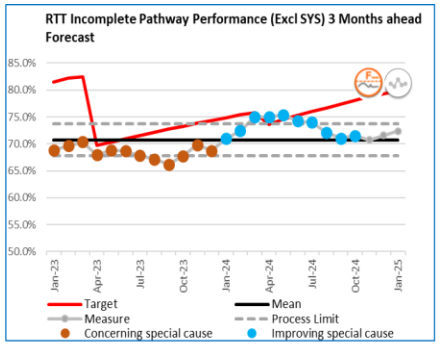
There are currently 509 System Support patients on the RTT Waiting List as at 31st October 2024. Of these 132 have been waiting more than 40 weeks of which 95 have been waiting more than 52 weeks. The numbers of over 40 weeks and over 52 week waiters has been reducing month on month.

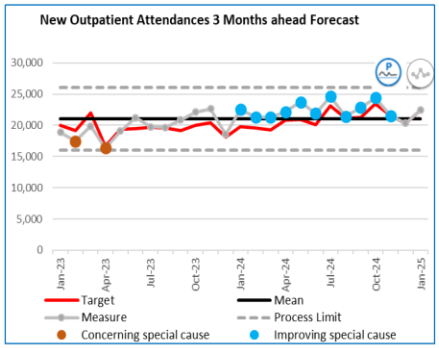
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

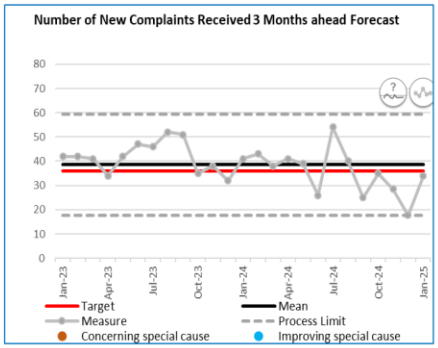


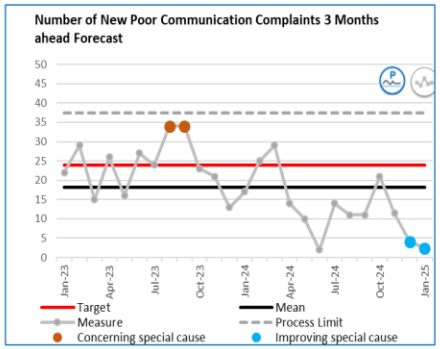


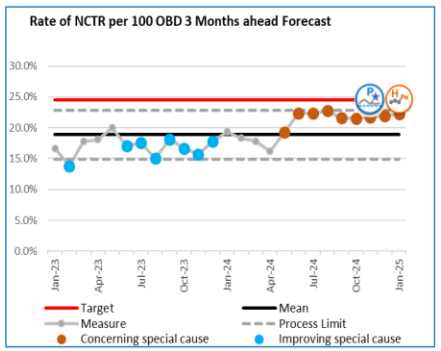


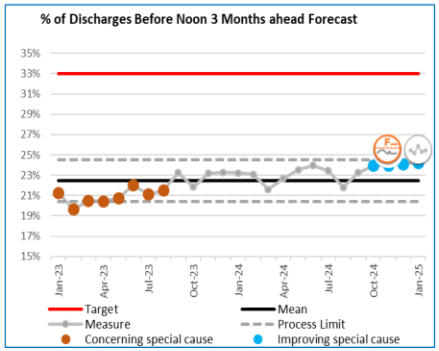


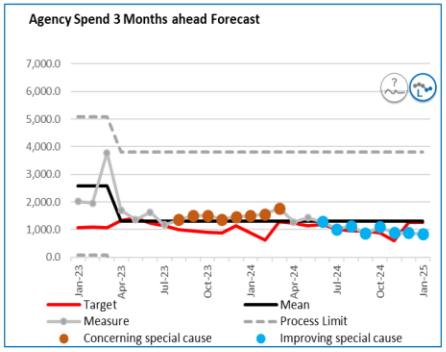


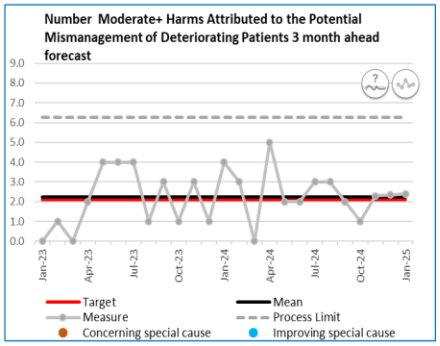




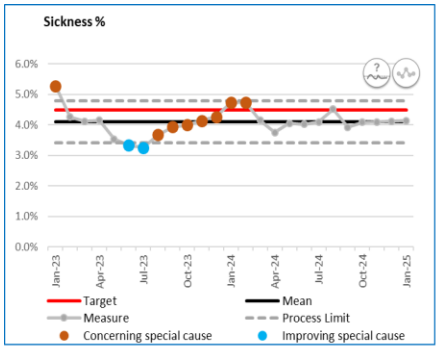


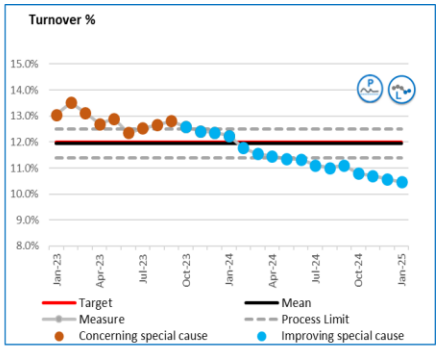


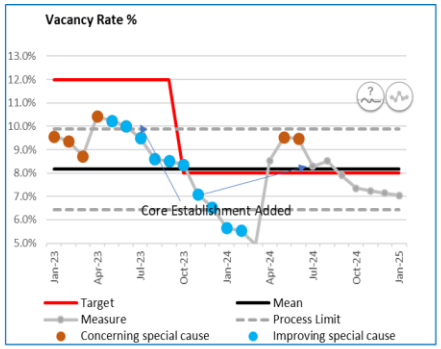


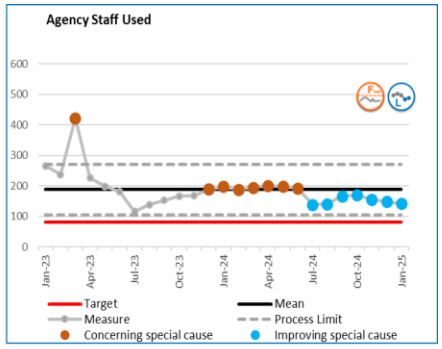


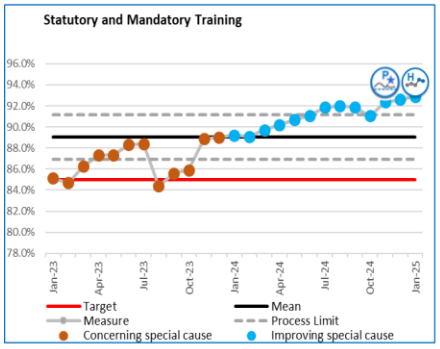
Forecast SPCs (3 month forward view) for People Indicators

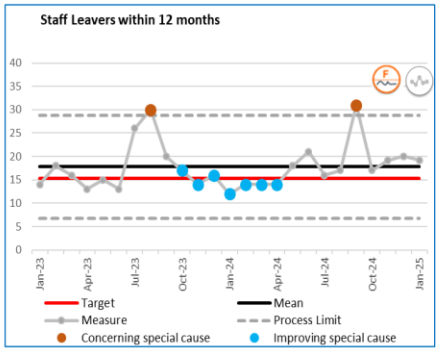


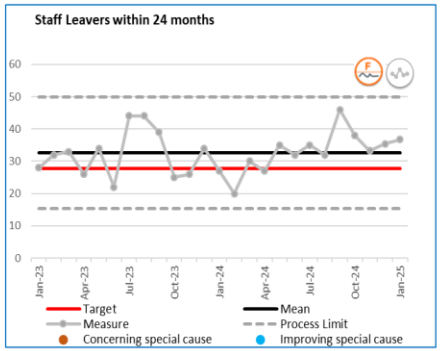


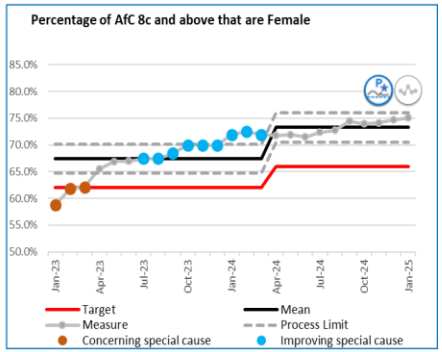


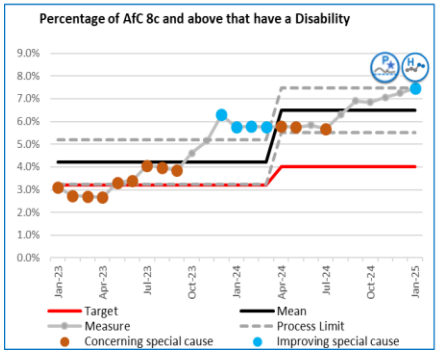


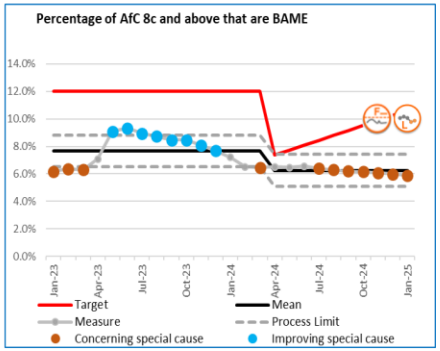


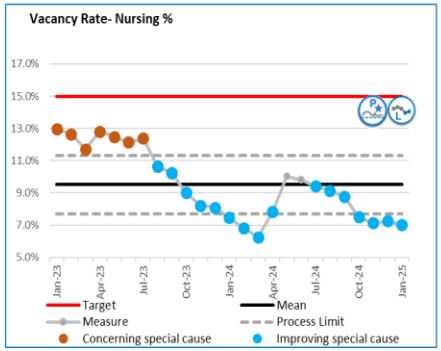




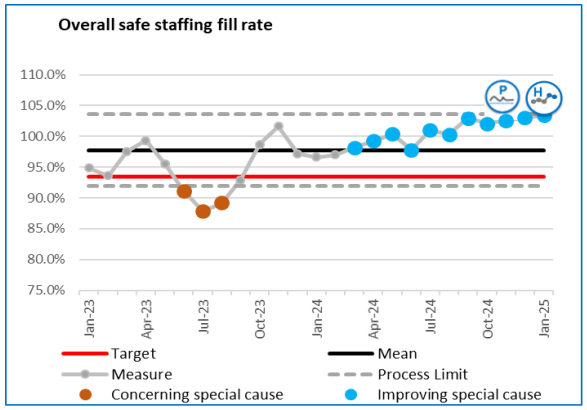


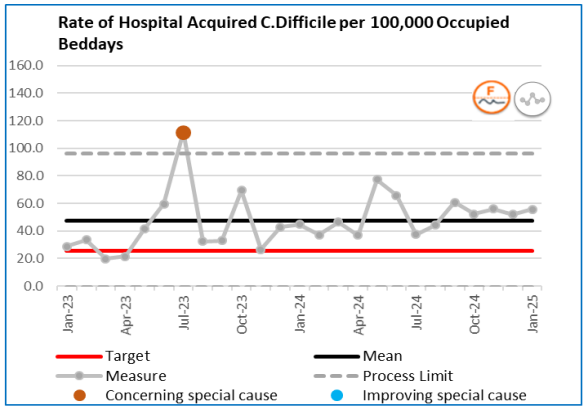


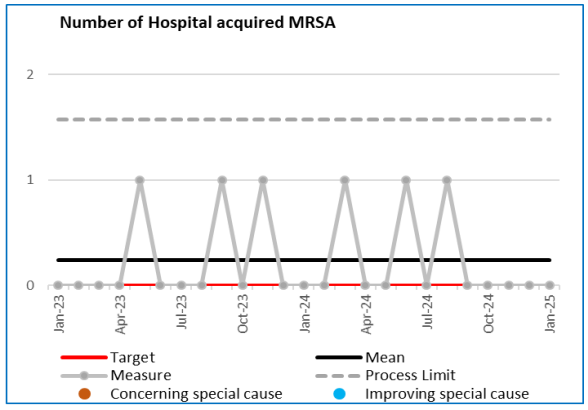


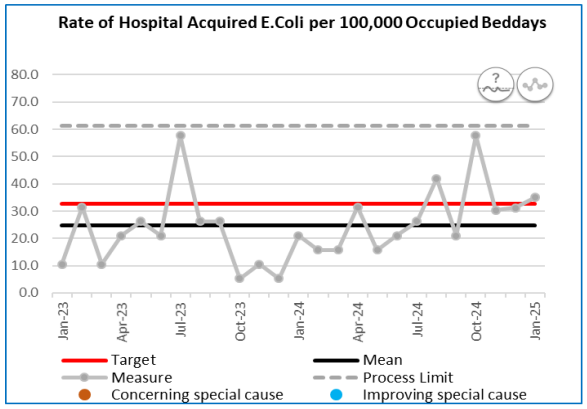


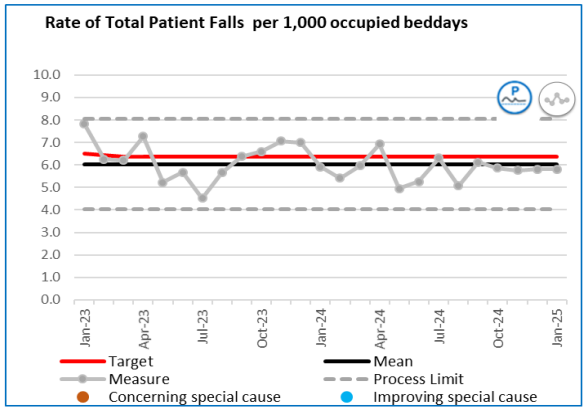
Forecast SPCs (3 month forward view) for Patient Safety Indicators

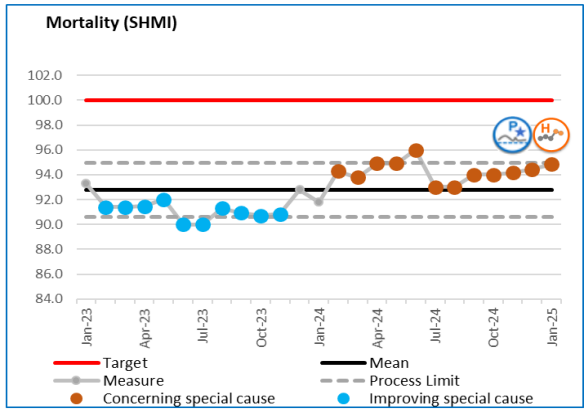


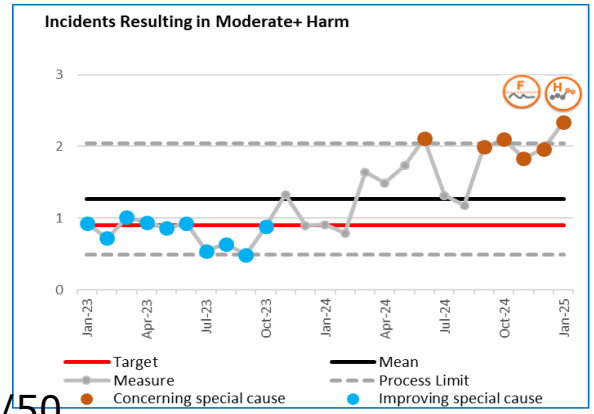


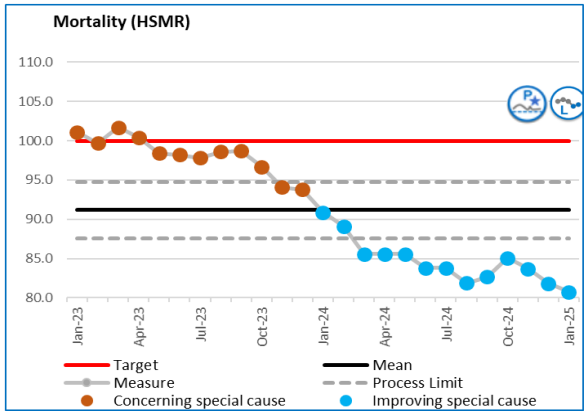




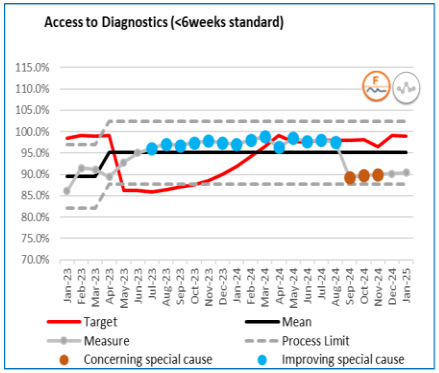


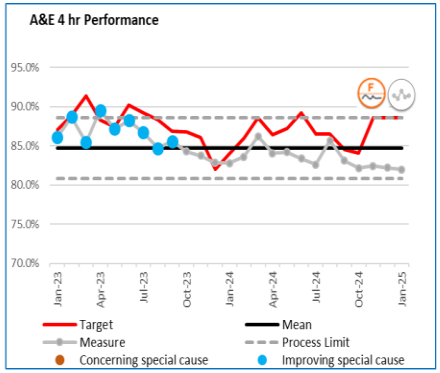


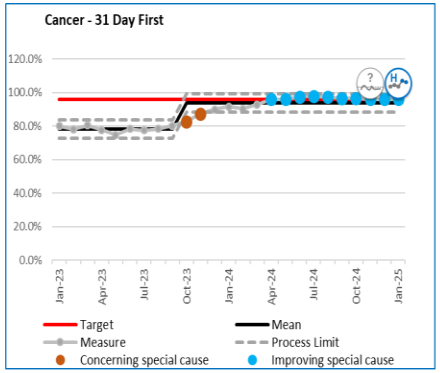


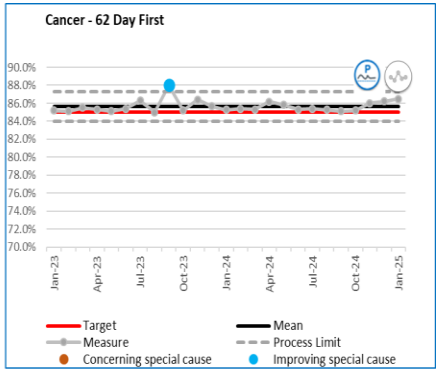


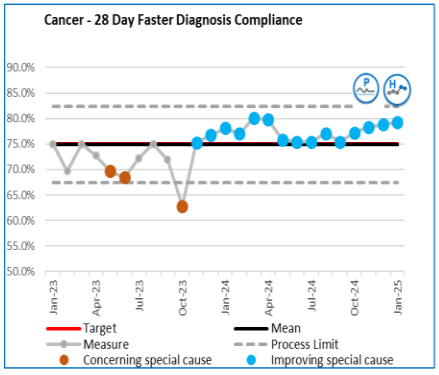
Forecast SPCs (3 month forward view) for Patient Access Indicators

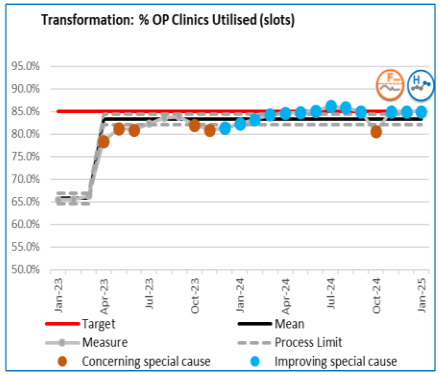


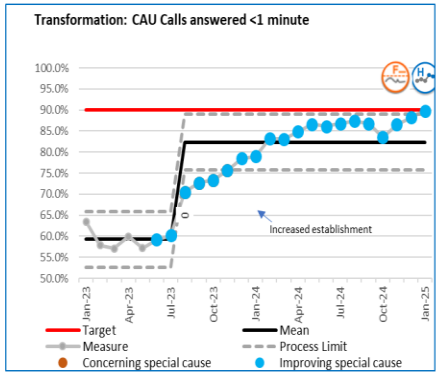


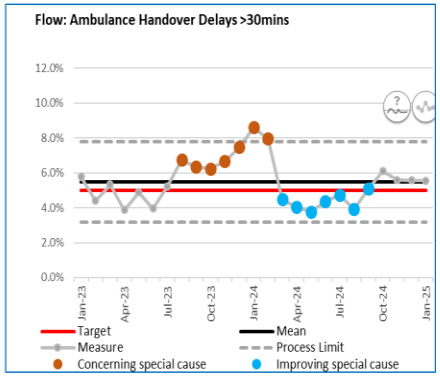


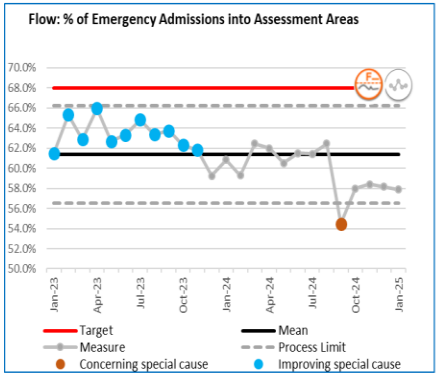


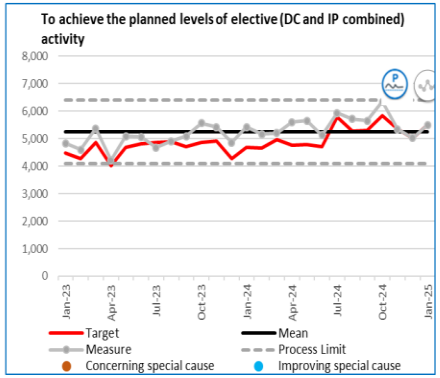


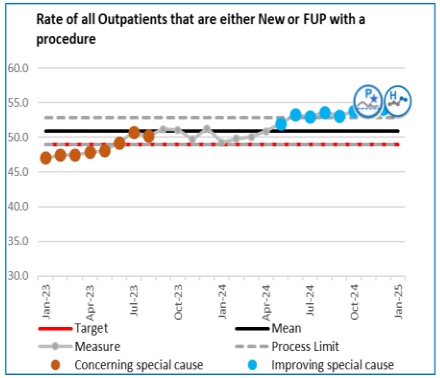


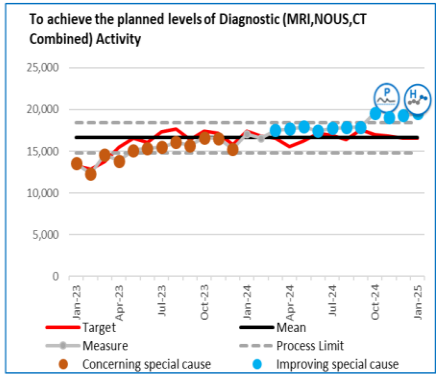




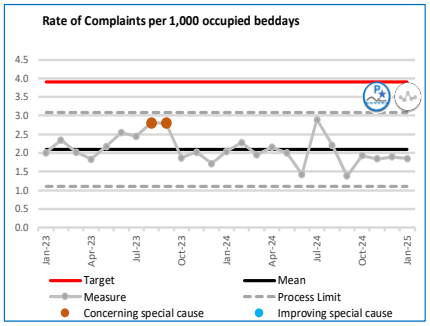


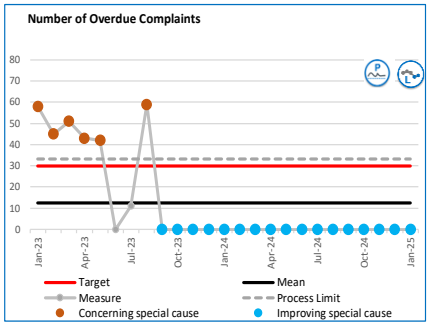


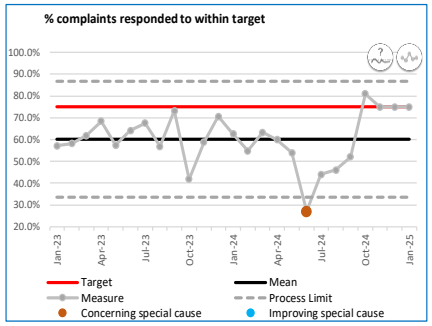


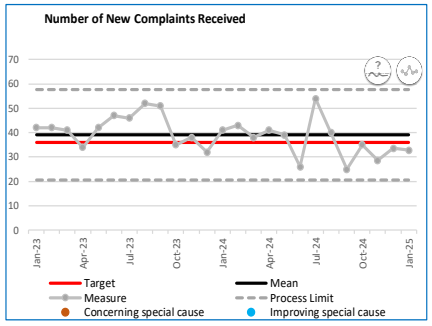


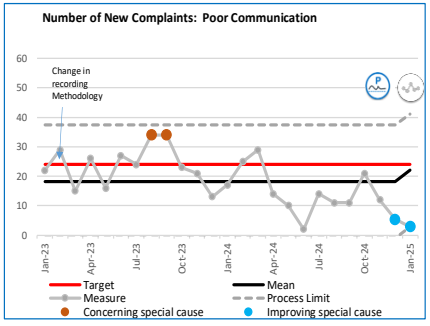
Forecast SPCs (3 month forward view) for Patient Experience Indicators

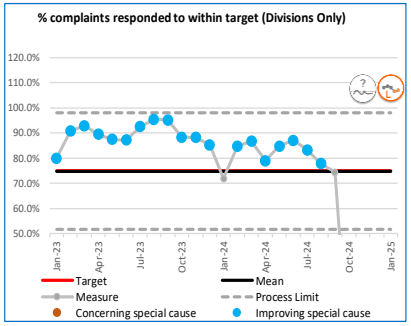


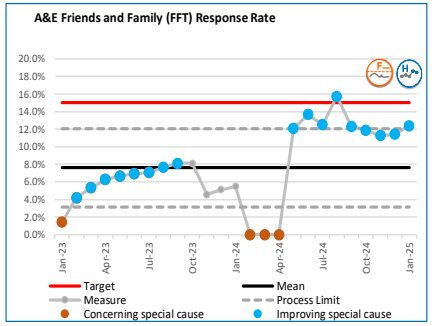


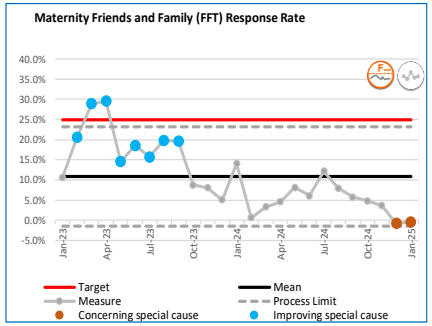


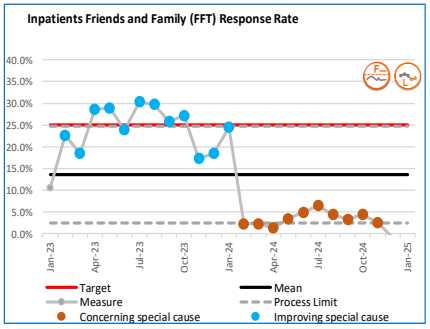


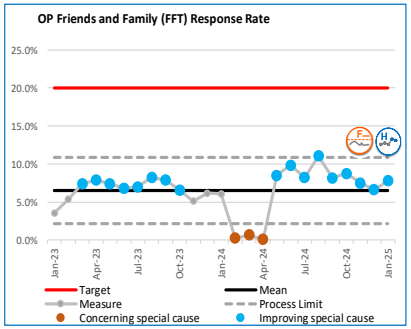


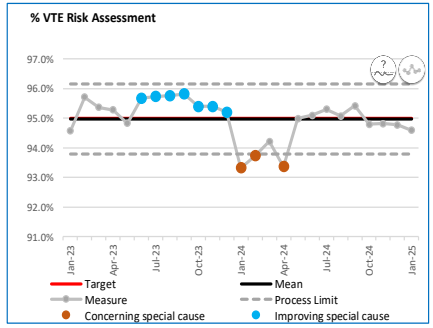




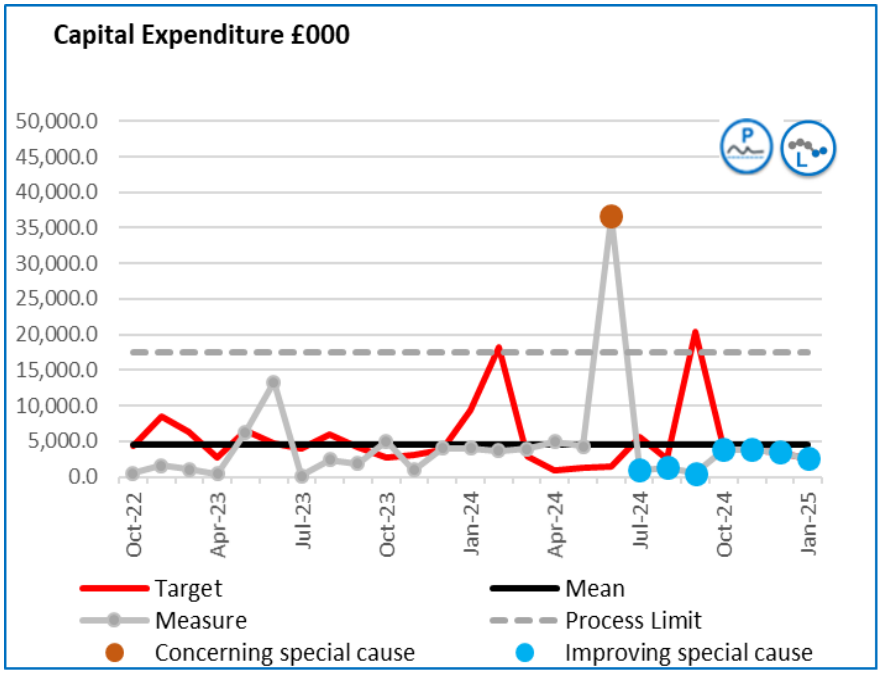


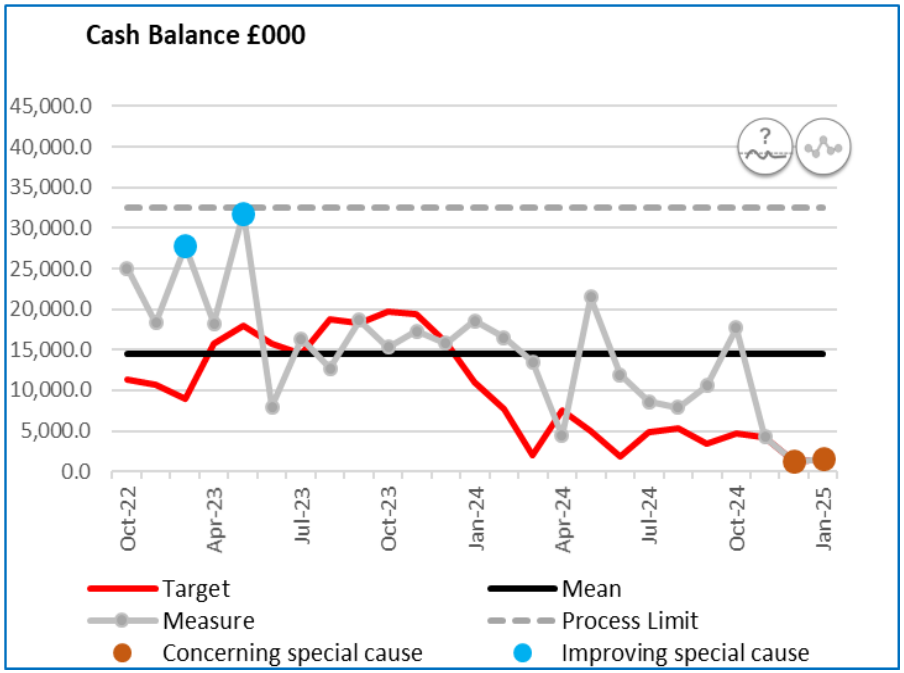




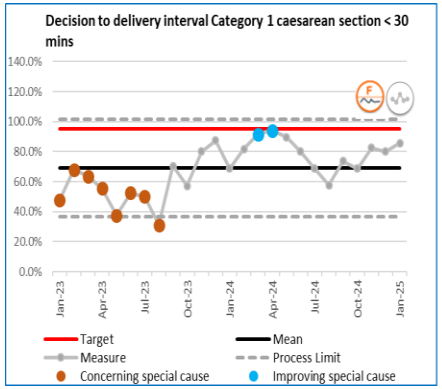


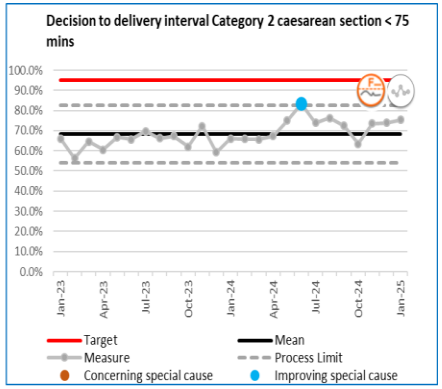
Forecast SPCs (3 month forward view) for Sustainability Indicators

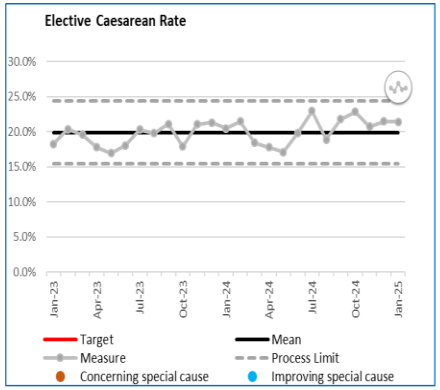


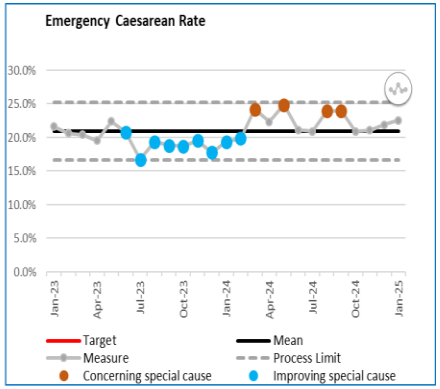


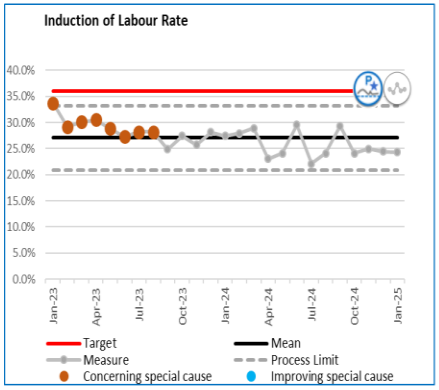
Forecast SPCs (3 month forward view) for Maternity Indicators

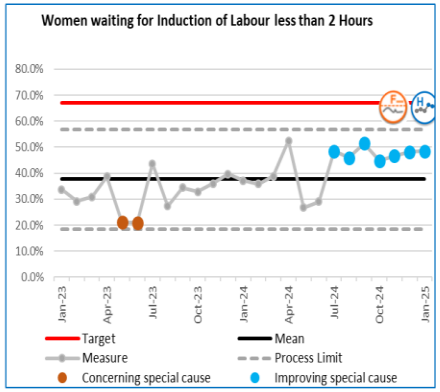


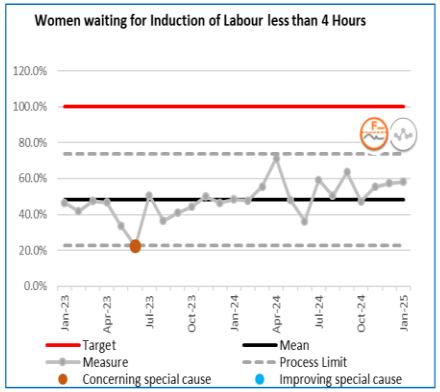


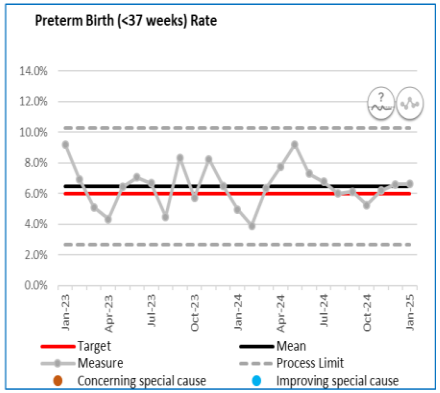


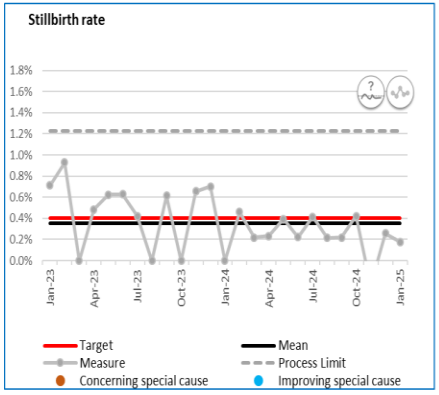


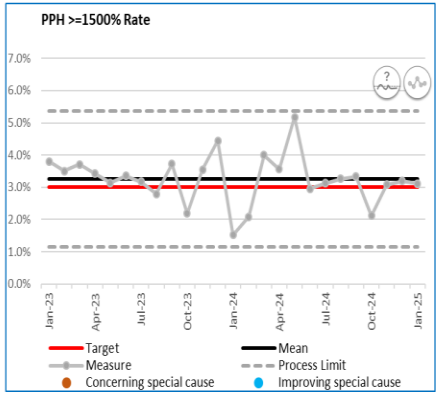


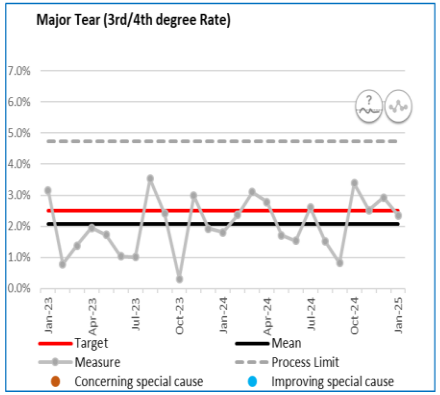


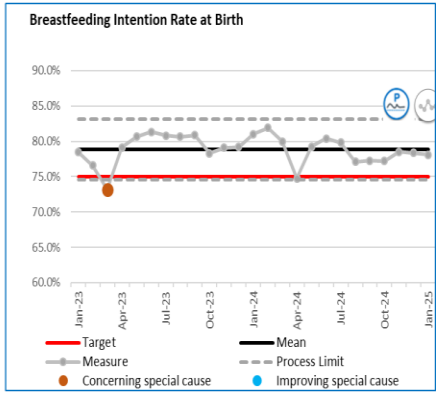






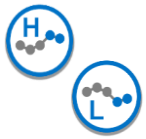






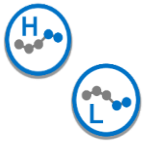
SDR Business Rules Driven by the SPC Icons

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

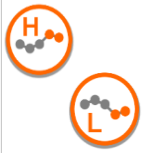
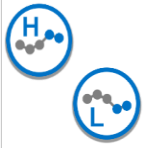
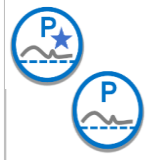
SDR Business Rules Driven by the SPC Icons

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:

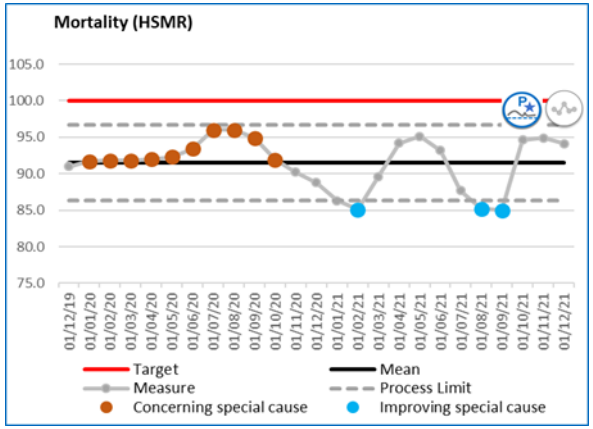
The **target** line **between** the **upper** and **lower** control limit for all metric types

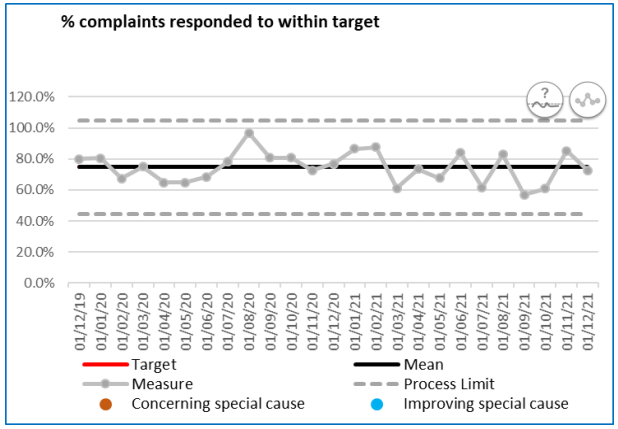
Metrics that consistently **fail** have:

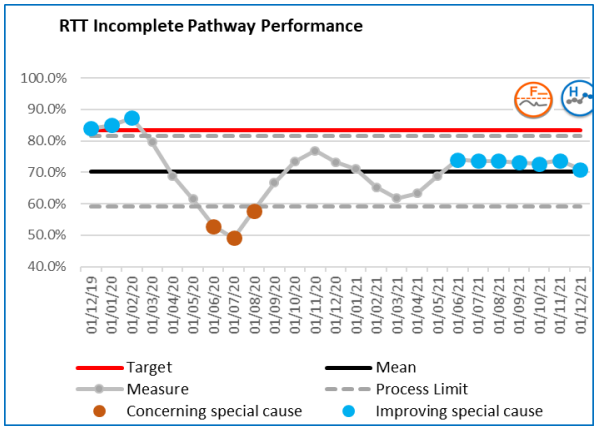
The **lower** control limit **above** the target line for metrics that need to be **below the target**

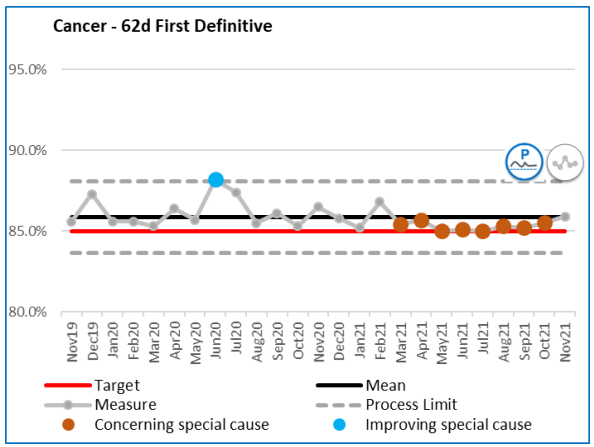
The **upper** control limit **below** the target line for metrics that need to be **above the target**

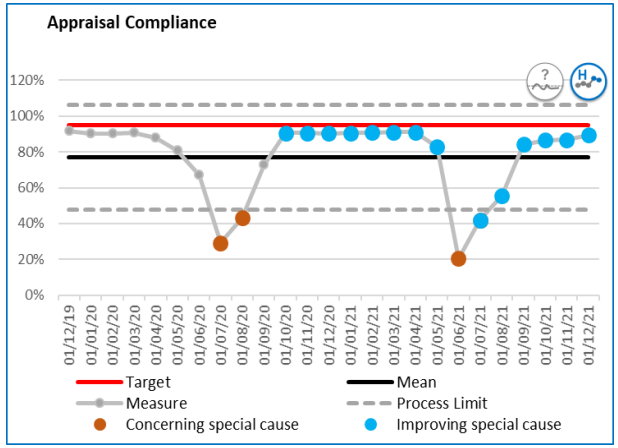
A metric not achieving the target for 6 months or more will be flagged as failing

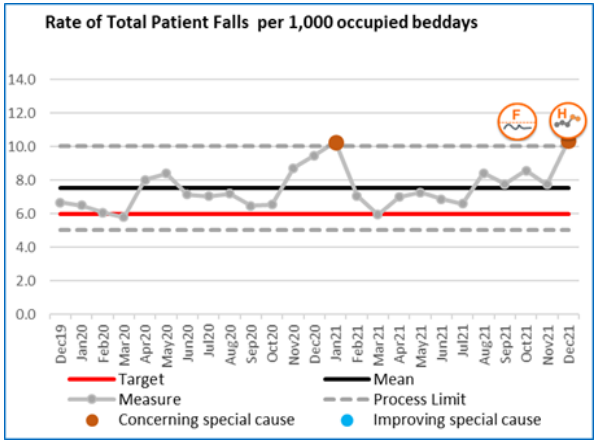












Maternity Metrics Definitions

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 £3.8m in surplus in October which was £0.8m favourable to plan. Year to date the Trust is £9.9m in deficit which is £4.3m adverse to plan.
- The key year to date pressures are: Kent and Medway ICB contract issues including system stretch target slippage (£2.2m), CIP slippage (£4.8m), delay in opening of Kent and Medway Orthopaedic Centre (KMOC – estimated £1.9m net adverse impact), CDC slippage (£0.8m), Fordcombe hospital adverse to plan by £2.2m, overspends within non passthrough related drugs/devices (£1.2m), unfunded escalation costs (£0.7m), overspend within surgical consumables (£0.5m) and additional security costs (£0.2m). These pressures were partly offset by variable activity overperformance (£0.9m), non-recurrent benefits (£4.4m), release of service development and contingency budgets (£3.2m) and education income overperformance (£1.5m)
- Pay budgets in October have been adjusted to reflect the 2024/25 pay award for AFC and Medical staff. Income budgets have also been increased to reflect the latest Cost uplift factor (CUF) which is the funding source for the pay award. The increase in income has broadly offset the actual payments made to staff however there is a recurrent shortfall when compared to recurrent establishments of c£3.9m.
- The Trust is forecasting to deliver the planned breakeven position however recovery actions of £20.2m are required to be delivered.

Current Month Financial Position

- The Trust was £3.8m in surplus in the month which was £0.8m favourable to plan
- **Key Adverse variances in month are:**
    - CIP Slippage (£1.7m)
    - Fordcombe was adverse to plan by £1.1m in the month
    - Non-passthrough related drugs/devices (£0.7m)
- **Key Favourable variances in month are:**
    - In the month the trust has made several major changes to the income position to reflect; latest cost up lift factor to reflect the 2024/25 pay award, refreshed outpatient activity data set going back to April 24, reflected the NHSE notified values for months 1-4 ERF overperformance and adjusted CDC income to match latest notified values from the ICB.. Overall these changes have improved the in-month position by £3.6m
    - The Trust released £0.5m relating to Service development and contingency budgets in October to partly offset income and expenditure pressures incurred.
    - Depreciation and Interest (£0.3m)

Year to Date Financial Position

- The Trust is £9.9m in deficit which was £4.3m adverse to plan
- **Key Adverse variances year to date are:**
    - 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 £2.2m YTD adverse impact which includes £1.2m linked to the additional system stretch target
    - CIP Slippage (£4.8m)

- 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
- CDC slippage (£0.8mm) and Fordcombe Hospital adverse to plan by £2.2m
- Unfunded Ward escalation costs (£0.7m)
- Other Expenditure pressures include overspends within Theatres consumable budgets (£0.5m), increase in security costs (£0.2m) and overspend on non-passthrough related drugs (£1.2m)

- **Key Favourable variances year to date are:**
  - The Trust has benefited by non recurrent benefits of £4.4m
  - ERF/Variable activity overperformance (£0.9m)
  - The Trust released £3.2m relating to Service development and contingency budgets offset income and expenditure pressures incurred
- Education and Training income overperformance (£1.5m)

Cost Improvement Plan

- The Trust has a savings target for 2024/25 of £37.3m. In October the Trust saved £1.8m which was £1.7m adverse to plan, year to date the Trust is £4.8m adverse to plan.

Cashflow position:

- The closing cash balance at the end of October was £17.7m, this is higher than the plan value by £13m. The main reason for a higher cash position is that due to the payrise which was backdated to April paid to employees in October the associated Tax, NI and Pension liability which will be paid in November is significantly higher than first estimated, therefore the Trust has retained a further £5m to pay this liability. Also being paid in November is the junior doctors payrise and back pay (backdated 18 months) along with the additional increment payments for all band 8's and above. The Trust is retaining sufficient cash balances to ensure these commitments are met.
- The Trust receives its monthly block SLA income on the 15th of each month so the month-end cash balance needs to take in account 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 October the Trust's percentages were: Trade value 81.5% and quantity 82.6%; NHS value 91.7% and quantity 81.7%. If we look at March 2024 percentages as a comparison to the current percentage Trade value 95.8% and quantity 96.3%; and NHS value 92.3% and quantity 89.3%.

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. A further application for PDC cash will be made in November to support the system funded items and UEC allocations, that did not come with cash backing (£10.1m).

  - **Other Capital Funding**
  - 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.

  - **External Capital Funding**
    - In addition to the Plan, National Funding has been agreed to purchase 2 Mammography Systems for **£739k** as part of the Diagnostic Screening Programme.

- **Month 7 Actuals (excluding IFRS16)**
  - The YTD spend at M7 is **£9.5m** against a YTD budget of **£14.57m**.
  - 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 due to the necessary focus on Fordcombe arrangements. CDC part funded nationally, early months charged to national funding. Frontline Digitisation anticipated funding, but not yet approved by NHSE.

  - **Project Updates**
    - **Major Schemes** - KMOC is now open, the CDC is progressing well and due to be completed by end of December 2024.
    - **UEC Funding** – The ETM have agreed a total of £4.6m of schemes to-date, with £0.4m to be confirmed in Nov/Dec.
    - **Cardiology** – The ETM are reviewing timings on cardiology project – there is likely to be slippage on the scheme in 2024/25. Funds will be re-allocated towards other priorities and bringing forward 2025/26 key schemes.
    - **Estates** –. Diagnostic enabling works being finalised, invoices are pending. Estates Backlog works are in process of ordering, there is some delay compared to plan.
    - **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 emergency purchases.
    - **Security & Facilities** – MGH access control works are complete, the TWH CCTV and access controls are progressing.
    - **Donated** – The potential schemes have now increased the outturn figure to £449k.

- **Leased/IFRS16 capital**
    - The Trust included £25.46m of in-year IFRS 16 lease capital resource in its planning submission to cover planned additions (£22.08m) and remeasurements arising from rent reviews or the application of contractual rent uplifts (£3.38m). This is subject to approval and confirmation of this element of the financial regime in terms of final ICS allocations for 2024/25. The year to date spend is £2.55m which includes the Urological Robot at Maidstone and equipment assets linked to Fordcombe Hospital that went live in October. Also included within the £2.55m is £0.4m relating to contractual rent uplifts for property leases. The most significant element of the additions expected to be delivered within this financial year is the initial lease capitalisation of the Kent and Medway Medical School Accommodation building (£17.4m) on the TWH site that the Trust will recognise under IFRS 16 when it becomes available for use, which is expected to be by the end of December.

Year End Forecast

- The Trust is forecasting to deliver the planned breakeven position however recovery actions of c£20.2m are required to be delivered.
- 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 7
2024/25

Maidstone and Tunbridge Wells NHS

Summary

October 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	82.3	78.8	3.5	0.5	3.1	457.9	461.4	(3.5)	2.5	(6.0)
Expenditure	(74.0)	(71.1)	(2.9)	(0.5)	(2.5)	(436.7)	(435.1)	(1.6)	(2.5)	0.9
EBITDA (Income less Expenditure)	8.3	7.7	0.6	0.0	0.6	21.2	26.3	(5.1)	0.0	(5.1)
Financing Costs	(4.0)	(4.2)	0.2	0.0	0.2	(39.7)	(40.5)	0.8	0.0	0.8
Technical Adjustments	(0.5)	(0.5)	(0.0)	0.0	(0.0)	8.6	8.7	(0.0)	0.0	(0.0)
Net Surplus / Deficit	**3.8**	**3.0**	**0.8**	**0.0**	**0.8**	**(9.9)**	**(5.6)**	**(4.3)**	**0.0**	**(4.3)**
Cash Balance	17.7	4.7	13.0		13.0	17.7	4.7	13.0		13.0
Capital Expenditure (Incl Donated Assets and IFRS16)	3.9	3.9	0.0		0.0	12.1	36.1	(24.0)		(24.0)
Cost Improvement Plan	1.8	3.5	(1.7)		(1.7)	12.4	17.2	(4.8)		(4.8)

Summary Current Month:
- The Trust was £3.8m in surplus in the month which was £0.8m favourable to plan.

Key adverse variances in month are:
- CIP Slippage (£1.7m)
- Fordcombe was adverse to plan by £1.1m in the month
- Non-passthrough related drugs/devices (£0.7m)

Key favourable variances in month are:
- In the month the trust has made several major changes to the income position to reflect; latest cost uplift factor to reflect the 2024/25 payaward, refreshed out patient activity data set going back to April 24, reflected the NHSE notified values for months 1-4 ERF overperformance and adjusted CDC income to match latest notified values from the ICB.. Overall these changes have improved the in month position by £3.6m
- The Trust released £0.5m relating to Service development and contingency budgets in October to partly offset income and expenditure pressures incurred.
- Depreciation and Interest (£0.3m)

Year to date overview:
- The Trust is £9.9m in deficit which is £4.3m 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 £2.2m YTD adverse impact which includes £1.2m linked to the additional system stretch target
- CIP Slippage (£4.8m)
- The Trust plan assumed the Kent and Medway Orthopaedic Centre (KMOC) will be open on the 1st July. The delay in opening has caused an estimated £1.9m net adverse impact
- CDC slippage (£0.8m) and Fordcombe Hospital adverse to plan by £2.2m
- Unfunded Ward escalation costs (£0.7m)
- Other Expenditure pressures include overspends within non-passthrough related drugs/devices (£1.2m), Surgery consumables (£0.5m) and additional security costs (£0.2m)

Favourable Variances
- ERF/Variable activity overperformance (£0.9m) and non recurrent benefits (£4.4m)
- The Trust released £3.2m relating to Service development and contingency budgets offset income and expenditure pressures incurred
- Education and Training income overperformance (£1.5m)

CIP (Savings)
- The Trust has a savings target for 2024/25 of £37.3m, year to date the Trust has saved £12.4m which is £4.8m below plan

Forecast
- The Trust is forecasting to deliver the planned breakeven position however recovery actions of c£20.2m are required to be delivered

Oct-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	94.5%	152.6%	-	100.0%	99.2%	209.5%	-	-	55.7%	61.1%	92	6.41	17	10.5	-	-	6	-		238,102	278,292	(40,190)
Maidstone	Stroke Unit	Stroke Unit (M) - NK551	94.4%	100.5%	-	100.0%	100.6%	102.3%	-	100.0%	33.5%	5.3%	153	10.74	25	8.0	0.0%	-	7	3		337,562	276,771	60,791
Maidstone	Hyperacute Stroke Unit	HASU (34) - NK552	98.8%	105.4%	-	-	105.6%	112.9%	-	-	42.6%	14.5%	145	10.14	15	11.5	30.4%	100.0%	2	-		186,912	195,519	(8,607)
Maidstone	Cornwallis	Cornwallis - NS251	96.1%	94.2%	-	-	100.0%	100.0%	-	-	17.2%	6.1%	44	2.75	6	6.8	7.5%	100.0%	4	-		154,100	150,703	3,397
Maidstone	Culpepper and CCU	Culpepper Ward (M) - NS551	106.6%	99.5%	-	-	101.6%	122.6%	-	-	26.3%	19.9%	7	0.49	0	7.6	16.0%	75.0%	-	-		150,880	155,719	(4,839)
Maidstone	Culpepper and CCU	CCU (M) - NS551	99.1%	-	-	-	100.0%	-	-	-	25.8%	0.0%	33	2.26	0		33.3%	75.0%	-	-				
Maidstone	Edith Cavell	Edith Cavell - NS459	134.6%	77.1%	-	100.0%	105.3%	140.6%	-	-	33.1%	47.1%	42	2.92	6	7.0	13.0%	100.0%	5	-		154,319	180,993	(26,674)
Maidstone	John Day	John Day Respiratory Ward (M) - NT151	93.8%	110.8%	-	-	100.7%	97.5%	-	-	27.4%	26.5%	85	5.75	14	7.6	5.6%	100.0%	2	1		234,582	243,053	(8,471)
Maidstone	Intensive Care (M)	Intensive Care (M) - NA251	82.9%	83.9%	-	-	93.2%	91.9%	-	-	5.9%	0.0%	39	2.72	5	49.3	-	-	-	1		305,948	275,379	30,569
Maidstone	Lord North	Lord North Ward (M) - NF651	97.4%	125.6%	-	100.0%	94.6%	109.4%	-	-	7.8%	0.0%	23	1.61	4	7.6	25.0%	100.0%	3	-		148,909	138,272	10,637
Maidstone	Mercer	Mercer Ward (M) - NJ251	97.2%	104.8%	-	100.0%	103.3%	143.8%	-	-	33.5%	26.0%	55	3.82	5	6.2	10.0%	100.0%	3	1		155,469	163,275	(7,806)
Maidstone	Peale	Peale Ward COVID - ND451	97.9%	114.4%	-	-	97.8%	131.5%	-	-	31.3%	17.8%	58	4.06	3	9.2	18.8%	100.0%	3	-		85,969	122,817	(36,848)
Maidstone	Pye Oliver	Pye Oliver (Medical) - NK259	120.0%	130.9%	-	-	114.7%	159.1%	-	-	60.4%	55.0%	132	9.26	8	8.0	15.0%	50.0%	6	1		195,136	218,874	(23,738)
Maidstone	Short Stay Surgery Unit (M)	Short Stay Surgical Unit (M) - NE751	96.3%	82.6%	-	-	98.5%	14.3%	-	-	3.0%	0.0%	8	0.54	1	45.3	0.0%	100.0%	-	-		89,120	78,171	10,949
Maidstone	Whatman	Whatman Ward - NK959	97.6%	114.7%	-	-	100.0%	209.9%	-	-	44.6%	28.6%	67	4.38	6	9.5	11.5%	100.0%	3	-		191,541	212,968	(21,427)
Maidstone	Maidstone Birth Centre	Maidstone Birth Centre - NP751	81.5%	85.6%	-	-	92.7%	84.8%	-	-	22.6%	0.0%	40	2.38	0	51.2	0.0%	100.0%	-	-		101,922	108,859	(6,937)
TWH	Acute Medical Unit (TW)	Acute Medical Unit (TW) - NA901	93.2%	112.8%	-	100.0%	98.3%	167.1%	-	-	48.4%	36.1%	139	9.97	25	9.5	-	-	11	-		334,440	336,280	(1,840)
TWH	Coronary Care Unit (TW)	Coronary Care Unit (TW) - NP301	96.7%	86.4%	-	-	98.9%	-	-	-	9.5%	5.0%	16	1.07	3	11.6	-	-	-	-		96,815	83,895	12,920
TWH	Hedgehog Ward	Hedgehog Ward (TW) - ND702	100.3%	92.8%	-	-	97.5%	99.7%	-	-	30.7%	30.6%	163	10.89	26	9.1	0.5%	100.0%	-	-		255,395	208,541	46,854
TWH	Intensive Care (TW)	Intensive Care (TW) - NA201	104.1%	77.0%	-	-	104.9%	77.2%	-	-	7.9%	3.4%	97	6.77	13	29.6	200.0%	100.0%	-	3		496,124	529,012	(32,888)
TWH	Wells Day Unit	Private Patient Unit (TW) - NR702	95.9%	92.0%	-	-	98.4%	86.0%	-	-	13.8%	0.0%	1	0.08	1	11.2	10.5%	100.0%	3	-		93,970	94,860	(890)
TWH	Ward 2	Ward 2 (TW) - NG442	92.4%	89.1%	-	100.0%	111.8%	108.7%	-	100.0%	28.7%	7.6%	94.00	6.60	24.00	6.9	3.0%	-	10	4		249,203	223,891	25,312
TWH	Ward 11	Ward 11 (TW) - NG131	99.5%	103.5%	-	-	100.0%	92.7%	-	-	19.1%	2.8%	57	4.04	20	7.0	6.0%	100.0%	4	-		218,321	212,704	5,617
TWH	Ward 12	Ward 12 (TW) - NG132	93.2%	100.0%	-	-	96.0%	103.2%	-	-	33.4%	20.3%	102	6.29	24	6.5	13.0%	85.7%	11	-		191,063	197,681	(6,618)
TWH	Ward 20	Ward 20 (TW) - NG230	109.3%	148.3%	-	100.0%	121.8%	133.0%	-	-	46.9%	62.2%	147	9.93	25	8.3	6.1%	33.3%	6	-		250,972	245,092	5,880
TWH	Ward 21	Ward 21 (TW) - NG231	90.5%	88.8%	-	100.0%	98.1%	93.5%	-	-	22.2%	5.4%	86	5.54	21	6.6	17.3%	88.9%	7	2		233,236	201,663	31,573
TWH	Ward 22	Ward 22 (TW) - NG332	91.8%	123.5%	-	100.0%	93.5%	139.4%	-	-	51.8%	23.2%	96	6.67	20	6.9	7.7%	100.0%	10	1		225,437	235,136	(9,699)
TWH	Ward 30	Ward 30 (TW) - NG330	94.2%	98.8%	-	100.0%	99.2%	113.2%	-	100.0%	34.0%	0.5%	105	6.49	14	6.8	11.7%	57.1%	11	1		196,982	203,594	(6,612)
TWH	Ward 31	Ward 31 (TW) - NG331	91.1%	111.3%	-	100.0%	96.8%	107.4%	-	-	23.2%	4.0%	111	6.89	25	6.8	13.2%	40.0%	7	2		198,080	232,856	(34,776)
TWH	Ward 32	Ward 32 (TW) - NG130	96.1%	95.3%	-	100.0%	94.4%	104.6%	-	100.0%	12.9%	0.0%	59	4.06	6	9.5	0.0%	87.5%	2	-		193,180	172,716	20,464
TWH	Gynae Ward	Ward 33 (Gynae) (TW) - ND302	94.6%	90.6%	-	-	98.4%	96.8%	-	-	44.5%	0.0%	74	4.72	8	7.5	-	-	-	-		132,566	127,885	4,681
TWH	SCBU	SCBU (TW) - NA102	103.3%	125.0%	-	-	116.2%	7.1%	-	-	15.9%	1.4%	75	4.20	2	11.3	-	-	-	-		306,630	248,469	58,161
TWH	Short Stay Surgical Unit (TW)	Short Stay Surgical Unit (TW) - NE901	94.9%	93.8%	-	100.0%	103.8%	112.0%	-	100.0%	12.0%	0.0%	39	2.52	2	15.4	11.1%	100.0%	-	-		111,666	124,048	(12,382)
TWH	Surgical Assessment Unit	Surgical Assessment Unit (TW) - NE701	94.6%	112.5%	-	100.0%	100.1%	100.0%	-	-	9.4%	0.0%	10	0.73	0	17.0	2.9%	92.3%	-	-		100,669	101,059	(390)
TWH	Delivery Suite	Midwifery Services - Delivery Suite - NF102	90.3%	-	-	-	94.3%	-	-	-	37.5%	35.1%	347	21.94	81		-	-	-	-		495,359	445,038	50,321
TWH	Delivery Suite	Midwifery Services - MSW (2022) - NF102	-	90.3%	-	-	-	89.7%	-	-	29.4%	0.0%	-	-	-	7.9	-	-	-	-				
TWH	Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	89.9%	-	-	-	90.4%	-	-	-	35.5%	3.0%	84	5.25	22		-	-	-	-		126,454	118,189	8,265
TWH	Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	102.3%	82.6%	-	-	91.0%	96.8%	-	-	36.4%	2.0%	235	13.77	59		-	-	-	-		236,566	237,623	(1,057)
Crowborough	Crowborough Birth Centre	Crowborough Birth Centre (CBC) - NP775	114.2%	97.2%	-	-	99.0%	96.9%	-	-	24.4%	0.0%	49	3.17	6	120.3	11.5%	100.0%	-	-		91,887	84,221	7,666
Maidstone	A&E (M)	Accident & Emergency (M) - NA351	104.0%	132.3%	-	100.0%	103.8%	138.5%	-	-	47.4%	40.4%	387	25.92	7	-	0.0%	79.3%	2	-		482,977	540,503	(57,526)
TWH	A&E (TW)	Accident & Emergency (TW) - NA301	104.8%	89.9%	-	100.0%	104.7%	85.7%	-	100.0%	37.8%	30.1%	435	29.89	17	-	11.2%	78.8%	3	-		541,446	533,402	8,044
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - NJ160	47.7%	-	-	-	-	-	-	-	0.6%	0.0%	2	0.10	1	-	-	-		-				
TWH	Community Midwifery Services (TW)	munity Midwifery Services - TW/Ton/PW/Hawkhurst -	60.5%	41.8%	-	-	-	-	-	-	6.8%	0.0%	46	2.21	5	-	-	-		-				
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - NJ160	61.3%	97.8%	-	-	0.0%	-	-	-	3.3%	0.0%	6	0.34	0	-	-	-		-				
TWH	Community Midwifery Services (TW)	mmunity Midwifery Services - Eden/Seven/Mallings - N	71.2%	25.7%	-	-	-	-	-	-	11.4%	0.0%	44	2.20	5	-	-	-		-				
TWH	Community Midwifery Services (TW)	ommunity Midwifery Services - Maidstone/Leeds - NJ1	63.9%	32.9%	-	-	-	-	-	-	11.5%	0.0%	56	2.56	5	-	-	-		-				
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Crowborough - NJ160	65.7%	42.4%	-	-	-	-	-	-	0.2%	0.0%	1	0.02	0	-	-	-		-				
		Midwifery TW (four IP rosters)	94.0%	88.8%	-	-	92.7%	90.7%	-	-	35.1%	15.7%	666	40.95	162	-	-	-		-		384,187	392,970	(8,783)
		Midwifery TW Community (six comm. rosters)	62.8%	39.4%	-	-	0.0%	-	-	-	7.2%	0.0%	368	22.18	87	-	-	-		-		413,359	354,747	58,612
		Midwifery TW (all thirteen rosters)	79.5%	64.9%	-	-	88.7%	90.7%	-	-	17.5%	13.4%	755	48.10	94	-	-	-		-				

	Budget £	Actual £	Variance £ (overspend)
Total Established Wards	**9,387,455**	**9,285,742**	**101,713**
Additional Capacity bed Cath Labs	74,118	67,521	6,597
KMOC	399,389	283,153	116,236
Other associated nursing costs	7,505,272	6,594,400	910,872
Total	17,366,234	16,230,816	1,135,418

Under fill

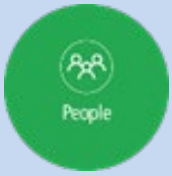
Overfill

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%

Title of report	**Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-14					
Executive lead	Dr Sara Mumford, Chief Medical Officer/Director of Infection Prevention and Control					
Presenter	Dr Sara Mumford, Chief Medical Officer/Director of Infection Prevention and Control					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	✓	***Information***	

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	☐	☐	✓	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The annual report for Infection Prevention and Control outlines the Trust's IPC activity in 2023/24. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT). Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control annual programme of work, based on local priorities and incorporating the K&M ICS HCAI strategy and national initiatives for the reduction of infection rates. The structure and headings of the report follows the ten criteria laid out in the 2015 revision of the Health and Social Care Act 2008 and it's Code of Practice in the prevention and control of infections and related guidance, also known as the Hygiene Code. A compliance statement is available on the Trust website.
Any items for formal escalation / decision	
Appendices attached	• Appendix A –Infection Prevention and Control Annual Work Plan

Report previously presented to:		
Committee / Group	Date	Outcome/Action
IPCC	21/11/24	

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: •
Links to Corporate Risk Register (CRR)	Please list any risks on the Corporate Risk Register to which this report relates •

Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report • Implementation of PSIRF as part of NHS standard contract • CQC Regulation 20 – duty of candour

Infection Prevention and Control Annual Report 2023/2024

&

Healthcare Associated Infection Reduction Plan 2024/2025

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's IPC activity in 2023/24. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control annual programme of work, based on local priorities and incorporating the K&M ICS HCAI strategy and national initiatives for the reduction of infection rates.

The Infection Prevention and Control Team (IPCT) advises and co-ordinates activities to prevent and control infection; however, it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPCT also works closely with other stakeholders in relation to strategies for prevention of infection including NHS England, K&M ICS and NHS Sussex, UK Health Security Agency (UKHSA) and Regional Specialist Laboratories.

There are national contractual reduction objectives for *Clostridioides difficile* infections (CDI) and gram-negative blood stream infections (GNBSI), with mandatory reporting in place for CDI, GNBSI and *Staphylococcus aureus* blood stream infections.

The structure and headings of the report follows the ten criteria laid out in the 2015 revision of the Health and Social Care Act 2008 and it's Code of Practice in the prevention and control of infections and related guidance, also known as the Hygiene Code. A compliance statement is available on the Trust website

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

IPC Governance

The Trust Board has collective responsibility for overseeing IPC arrangements in the Trust. The Chief Nurse is the executive lead for quality within the Trust.

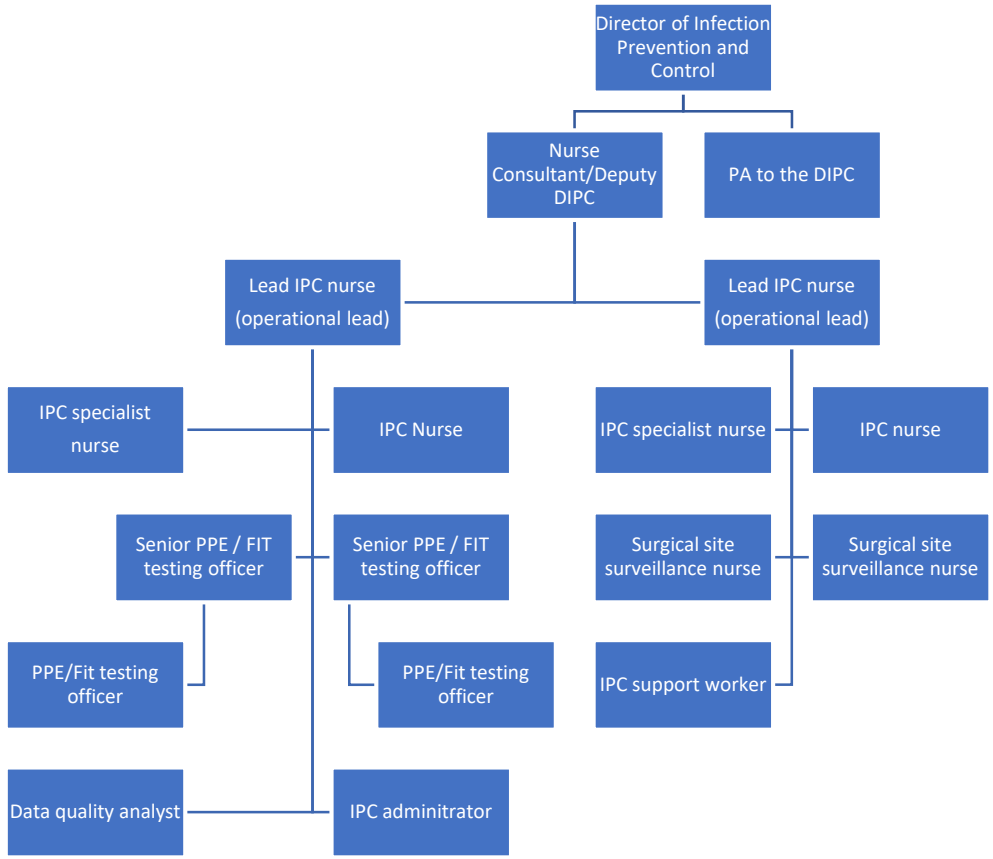
The Chief Medical Officer holds the post of Director of Infection Prevention and Control (DIPC), is a consultant microbiologist with specific training and experience in infection prevention and control and reports directly to the Chief Executive Officer. The DIPC is supported by the Deputy DIPC (Nurse Consultant in Infection Prevention and Control) and the IPCT.

C. difficile, MRSA and *E. coli* blood stream infection numbers and rates are detailed on the Board level dashboard together with non-elective MRSA screening rates

Directorates report to the Infection Prevention and Control Committee on IPC matters including ward, triangulation and antimicrobial audits, HCAI rates, learning from incidents and improvement plans

Kent and Medway ICB were MTW's main commissioning organisation during 2023/24. IPC is a key element of quality commissioning and forms part of quality schedule 4. The MTW DIPC has been Senior Responsible Officer for IPC in Kent and Medway since September 2021.

Infection Prevention Control team structure 2023-24



Infection Prevention and Control Committee

- The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets bi-monthly. The committee has wide representation from services within the Trust and has external representation from Kent and Medway CCG and UKHSA. The Chief Nurse is the Executive Director member of the committee
- The IPCC reports to the Quality Committee, a sub-committee of the Board
- Reports are received each of the clinical directorates, estates and facilities, the vascular access team, the antimicrobial pharmacist, occupational health, risk manager, water safety group, decontamination lead and others as required
- The IPCC reviews the IPC related risks in the risk register and receives reports from the risk manager three times per year

Surveillance

- Using the ICNet surveillance system the IPCT undertakes continuous surveillance of target organisms and alert conditions, advising on appropriate use of infection prevention and control precautions and monitor overall trends
- The IPCT actively participates in national surveillance schemes, submitting epidemiological data on all *C. difficile* cases, MRSA, MSSA, *E. coli, Klebsiella* and *Pseudomonas* blood stream infections and selected surgical site infections to the UK Health Security Agency (UKHSA) HCAI data capture system (DCS)

The national HCAI objectives for MTW for 2023/24 set by NHSE were:

- MRSA – a continued zero tolerance to all MRSA blood stream infections
- CDI – to have no more than 61 patients with Trust-attributable CDI.

In addition the HCAI annual work plan set out to:

- To achieve no avoidable hospital acquired MSSA blood stream infection
- Reduce gram-negative blood stream infection (national target for 50% reduction in healthcare associated infections by 2024/25)

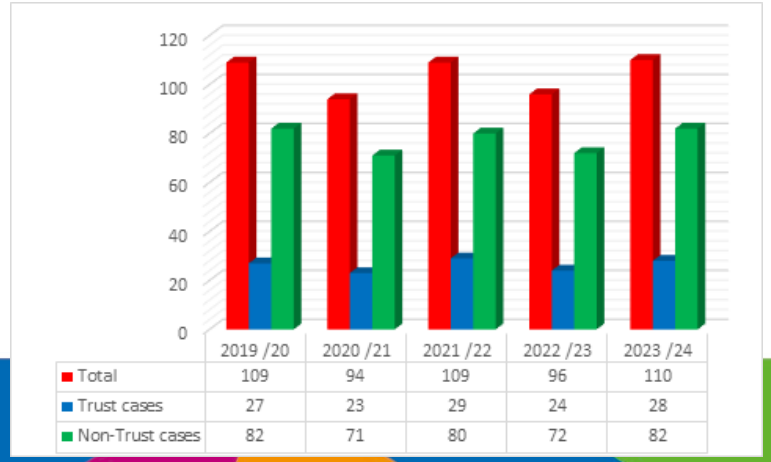
Meticillin Sensitive Staphylococcus aureus (MSSA)

- There is no national objective set for MSSA bacteraemia.
- All Trust-attributable cases of MSSA blood stream infection have a post–infection review which aim to identify the likely root cause and reviewed by the Infection Control table top exercise, feeding back learning to ward teams and matrons.
- The number of hospital attributed cases have increased from 24 to 29 cases however the number of Trust attributed avoidable cases have significantly decrease from 10 (8 peripheral cannula related) to 4 (0 peripheral cannula related).
- A quality improvement project to improve the management and care of peripheral cannulas was commenced in November 23 to support the reduction of peripheral cannula related MSSA blood stream infections. This project demonstrated a 100% reduction in peripheral cannula related blood stream infection

MSSA screening:

MSSA has been known to be a contributing cause of orthopaedic surgical site infection and prosthesis infections. One third of the normal population have nasal colonisation with *Staphylococcus aureus*. A screening programme for pre-operative total hip and knee replacement was introduced in November 2014. Patients found to be positive on pre-operative screening are treated with nasal antibiotic cream to reduce their risk of post-operative infection.

MSSA bacteraemia cases



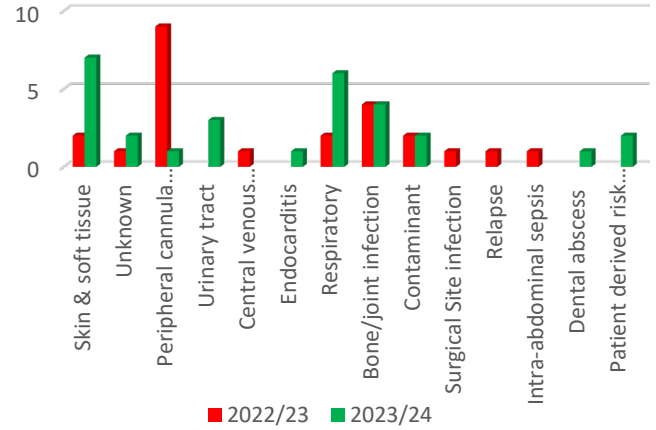
Meticillin Resistant Staphylococcus aureus (MRSA)

There was no national HCAI objective for MRSA blood stream infections for 2022/23. However there was an expectation that no avoidable infections would be seen.
Post Infection Reviews (PIR) are carried out on all cases and the Trust investigates every MRSA blood stream infection in collaboration with other care providers associated with the case. This process identifies lessons to be learned across the patient's pathway and determines the final assignment of the case to the ICB, Trust or Third Party.

The Trust reported 3 Trust apportioned cases:

1. Avoidable case due to hospital acquired MRSA colonisation which resulted in likely contaminated blood culture
2. Unavoidable case due to community colonisation with cellulitis resulting in bacteraemia
3. Unavoidable case, cause unknown, underwent surgery aboard with subsequent infection.

MSSA bacteraemia root cause 2022/23-2023/24

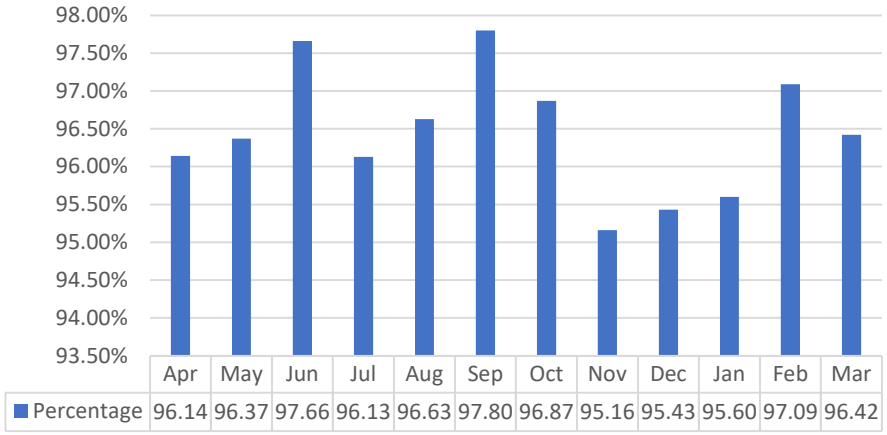


MRSA Screening

The Trust continues to use a robust approach to screening the majority of patients, either pre-operatively or on admission. Since 2009, it has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health and Social Care policy and guidance.

Non-elective patients who are colonised are usually identified from screening swabs within 24 hours of admission. Some colonised patients are also identified as a result of clinical samples. Early detection allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients.

MRSA non-elective admission screening 2023-24



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Percentage	96.14	96.37	97.66	96.13	96.63	97.80	96.87	95.16	95.43	95.60	97.09	96.42

Periods of increased incidence

- Where two or more new hospital attributed acquisitions (whether related or not) of MRSA colonisation are identified by screening on the same ward within 28 days, a Period of Increased Incidence (PII) is declared for the ward where the acquisitions occurred. A single case of MRSA bacteraemia will also trigger a PII.

PII actions include:

- Weekly audits of compliance with the Control and Management of Meticillin Resistant *Staphylococcus aureus* (MRSA) including Screening and De-colonisation policy
- Weekly audits of antibiotic prescribing
- The antibiograms of the MRSA isolates are examined for similarity. If the isolates are indistinguishable by antibiogram, they are sent to the reference laboratory for further typing.
- Where cross infection is proven:
  - An incident investigation is initiated.
  - Ward staff may be screened if further cases are identified

Clostridiodies difficile infection (CDI)

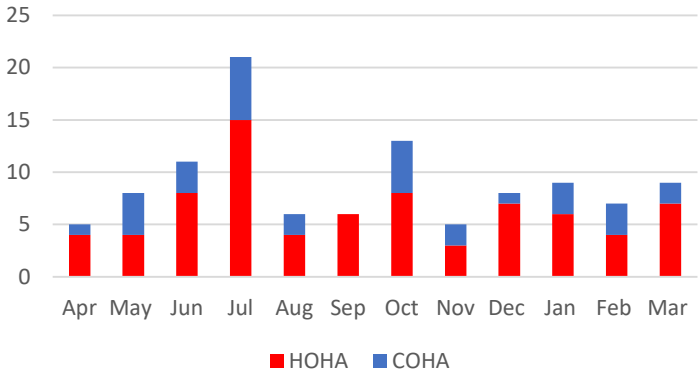
- The CDI standard contract objective for MTW for 2023/24 was to have no more than 61 cases

Cases are designated into one of four groups:

- **Hospital-onset healthcare-associated (HOHA)** - Date of onset is ≥ 2 days after admission (where day of admission is day 1)
- **Community-onset healthcare-associated (COHA)** - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode
- **Community-onset indeterminate association (COIA)** - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode
- **Community-onset community-associated (COCA)** - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.
- In 2023/24 a total of 107 Trust attributable cases were seen, 75 HOHA cases and 32 COHA cases, a rate of 31.6 HOHA cases per 100 000 bed days (compared with 24.5 for the previous year and an England rate of 20.9).

The increase in the rate of cases reflected a wider increase in cases across England and Kent and Medway in particular.

C difficile HOHA and COHA cases

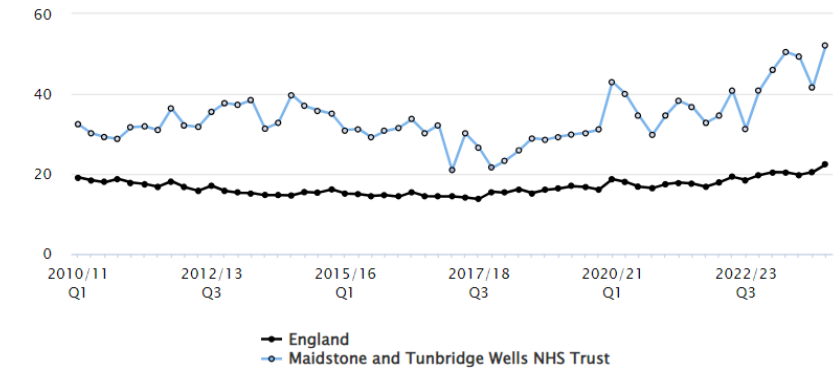


Laboratory Diagnosis

C. difficile tests are processed on diarrhoea samples according to national guidelines. During 2023/24, the microbiology laboratory processed 10955 samples (19% increase) for *C. difficile* including those from GP patients, inpatients in acute or community settings, MTW A&E and outpatient attenders.

- All toxin positive cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Further testing can be requested where a link between cases is possible.
- Ribotyping enables us to be confident that we are not seeing patient to patient transmission of *C. difficile* infection

C difficile toxin test per 1000 bed days compared to England average 2019/20 – 2023/24



CDI case review

All healthcare-associated cases of *C. difficile* infection (CDI) are assessed by root cause analysis investigation. The IPCT works collaboratively with the Integrated care board infection control teams to investigate COHA cases.

From April to July root cause analysis multidisciplinary meetings were held for HOHA and COHA cases. This process changed in August 23 to a rapid review. This allowed more timely feedback of lessons learned and aligns with the Patient Safety Incident Review Framework (PSIRF) methodology

All root cause analysis and rapid reviews are signed off at a table top review and learning shared with the directorates

The outcomes of root cause analysis shown in the table below:

Cross infection	Inappropriate antibiotics	Appropriate antibiotics	Relapse	Community antibiotics	Patient derived risk factors	Unknown
2	12	81	4	2	5	1

15 cases were considered to be avoidable predominately due to Inappropriate antibiotics and cross infection

The main lessons learnt from the investigations included: *C difficile* and diarrhoea risk assessments not completed; delay in sending stool specimens and incomplete documentation of stool charts

Action plans were developed in response to all identified issues which are included in the directorate reports that are presented to the Infection Prevention and Control Committee

Period of increased incidence (PII)

At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed.

In response to the PII declaration, several actions have to be taken including structured IPC audits, antimicrobial prescribing audits, additional cleaning and support and education from the IPCT

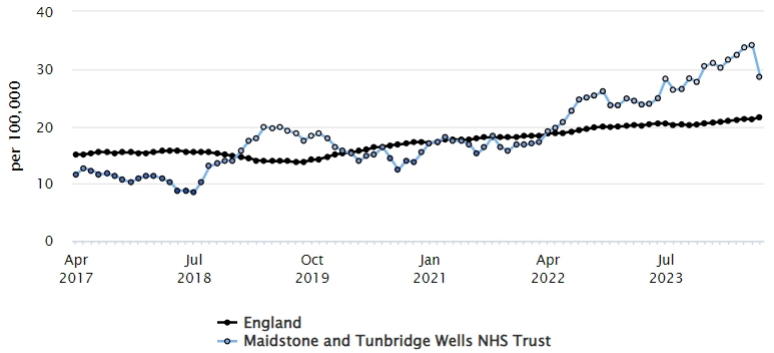
If a second case occurs in the same ward area the PII is escalated to an incident and an investigation commences. If ribotyping leads to suspicion of cross infection or there is a third case, the incident is escalated to an outbreak and the Outbreak Policy is followed.

During 2023/24 68 PIIs where declared for *C difficile* (42 at Tunbridge Wells and 26 at Maidstone hospital and 7 were re-declared due to standards not being maintained after initial closure and intensive support provided to the wards.

Non-Trust attributed CDI cases

There was an increase in the number of patients with non-Trust attributed CDI (COCA & COIA) from 60 in 2022/23 to 77 in 2023/24

12 month rolling rate of Hospital onset-healthcare associated cases per 100 000 occupied bed days up to July 2024



Blood stream infections

A total of 1283 patients had positive blood cultures during 2023/24, an increase (of 257 patients) on the previous year. *E. coli* is the commonest organism causing blood stream infection in the Trust accounting for around 26% of all positive cultures.

Some isolates are seen in small numbers but are highly significant for their ability to cause severe infection. They include *Neisseria meningitidis* (a cause of meningitis), MRSA and glycopeptide resistant *enterococcus.*

Gram negative blood stream infections

The NHS Long Term Plan supports a 50% reduction in Gram-negative bloodstream infections (GNBSIs) by 2024/25.These include:

- *E. coli*
- *Klebsiella species*
- *Pseudomonas aeruginosa*

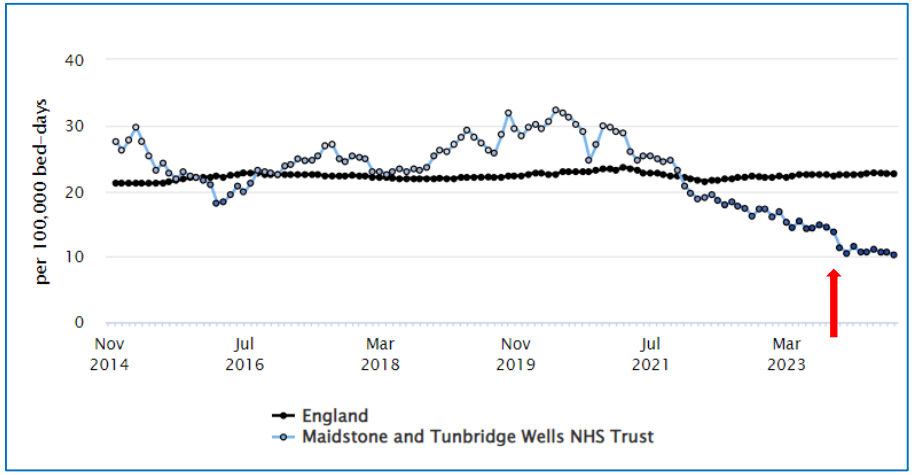
The Trust has been submitting *E. coli* surveillance data to UK Health Security Agency for many years and from April 2017 *Klebsiella species* and *Pseudomonas aeruginosa* data was also required

Escherichia coli (*E.coli*) bacteraemia

E. coli bacteraemia may be caused by primary infections such as urinary tract infections, biliary tract infections and others, spreading to the blood.

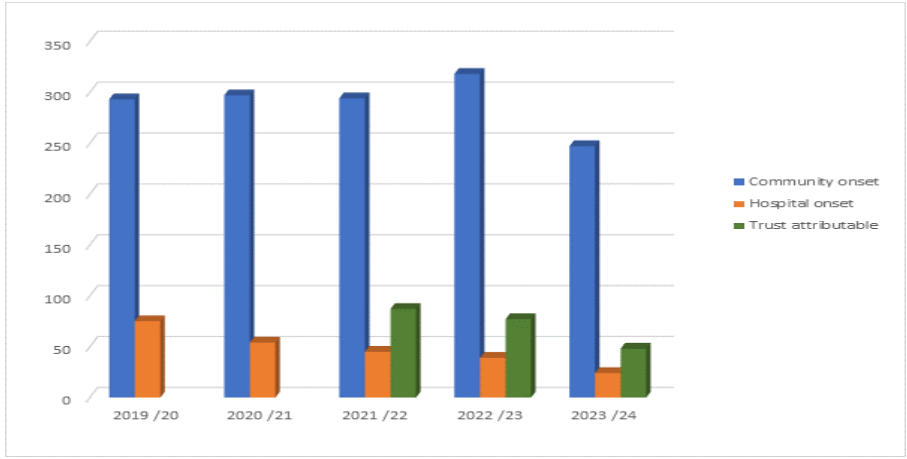
The MTW rate of hospital attributable *E. coli* infections for 2023/24 was 10.7/100 000 bed days compared with an England rate of 22.7/100 000 bed days, a significant reduction from the rate in 2022/23 of 15.2/100 000 bed days.

Similar definitions apply for blood stream infections as C difficile (COHA, HOHA, COCA with the exclusion of COIA). Cases arising in the community which occur within 28 days of discharge from the reporting Trust are classified as Community onset healthcare associated



12 month rolling rate of *E.coli* BSI per 100 000 occupied bed days to July 2024

The reduction in cases in these two graphs is striking and increased further in November 2023 when improved mattress integrity checks and replacement were put in place



Number of cases of *E. coli* blood stream infection 2019-2024

Klebsiella species bacteraemia

Klebsiella species are gram negative rod-shaped bacteria which are ubiquitous in the environment and are found in the human gut. Common presentations include ventilator-associated pneumonia (VAP), wound infections and urinary and biliary tract infections.

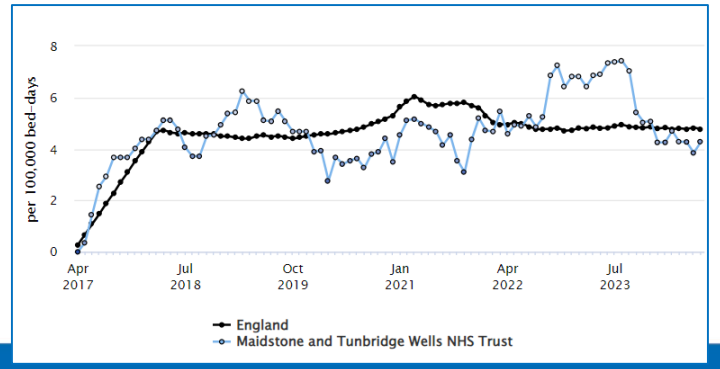
Case numbers remain low with a rate of 7.7/100 000 occupied bed days against an England mean of 11.1/100 000 obd.

Pseudomonas aeruginosa bacteraemia

Pseudomonas aeruginosa is an opportunistic pathogen that infrequently causes infection in healthy individuals. It can cause a wide range of infections, similar to other gram negative organisms.

In a healthcare setting pseudomonas can contaminate devices that remain moist such as respiratory equipment and catheters but also ice-making machines and equipment with a water reservoir.

An increase in cases was seen between October 2022 and October 2023. There was concern that this may have been related to the water system in one ward. Control measures were put in place and the rate of infection has returned to below the England mean rate; 4.7 per 100 000 obd in March 2024 compared with the England mean of 4.8 per 100 000 obd.



12 month rolling rate of *P. aeruginosa* BSI per 100 000 occupied bed days to July 2024

Glycopeptide resistant Enterococci (GRE)

Glycopeptide-resistant enterococci are resistant to at least two important antibiotics widely used to treat infection in immunosuppressed patients. They are of particular concern in haematology patients who can be severely immunosuppressed as a result of both their underlying disease and chemotherapy.

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. 42 new GRE cases were identified in this group from April 2023 – March 2024

There were 4 healthcare associated GRE blood stream infections recorded during this time

Carbapenem resistant / Carbapenemase producing Enterobacteriaceae (CRE/CPE)

CPE and CRE are gram negative organisms found in the gut which are resistant to virtually every antibiotic including the Carbapenem group of antibiotics. They represent a major cross infection risk. Some of these organisms have the ability to transfer their resistance genes from one bacterium to another, even across species.

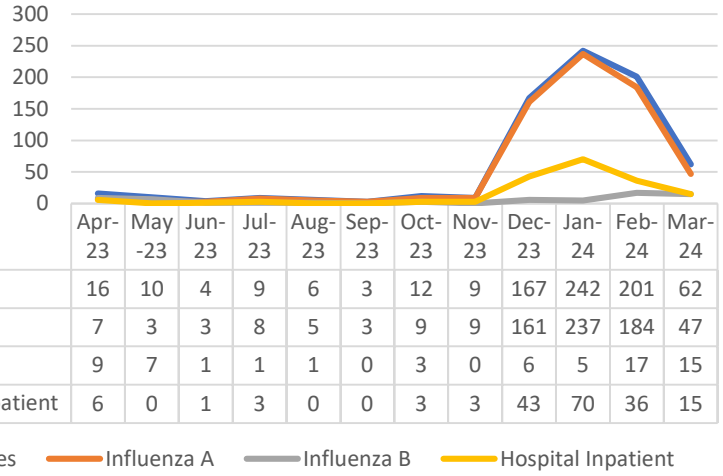
All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2023/24, 1323 CRE/CPE screening swabs were processed, slightly more than the previous year.

11 patients were identified as positive for carriage of CRE/CPE on admission screening; most had had a recent admission to a London hospital. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

Influenza

740 cases of influenza were identified during 23/24 with cases peaking in December. The majority (508) were identified through A&E and not admitted. Influenza A dominated with only a few Influenza B cases seen late in the season. The introduction of rapid diagnostics in Emergency departments allowed earlier decision making on admission. Both the total number of cases and the peak number of admissions was lower than the previous winter.

Influenza diagnosis and admissions 2023-24



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Cases	16	10	4	9	6	3	12	9	167	242	201	62
Influenza A	7	3	3	8	5	3	9	9	161	237	184	47
Influenza B	9	7	1	1	1	0	3	0	6	5	17	15
Hospital Inpatient	6	0	1	3	0	0	3	3	43	70	36	15

SARS-CoV-2 (COVID-19)

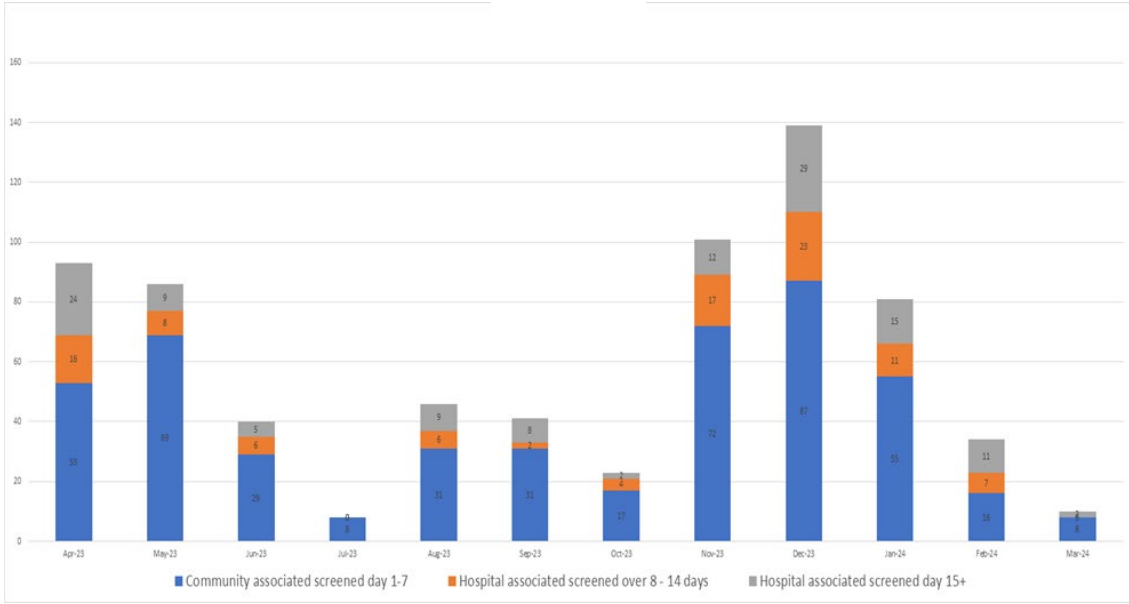
We manage COVID-19 in the same way as other respiratory viruses with staff using respiratory precautions including masks to provide care. Patients are isolated or nursed in cohorts as necessary.

Testing is undertaken on patients who develop or present with respiratory symptom, most of whom are diagnosed in A&E, managed through Same Day Emergency Care (SDEC) and avoid admission

There were 702 COVID-19 inpatients across the year. 476 were community associated (screened day 1-7), 226 were hospital associated (screened day 8 onwards).

December 2023 was the peak month for COVID-19 with 139 cases inpatients at MTW.

Covid-19 inpatients by months April 2023 – March 2024



Serious incidents and outbreaks

COVID-19: Outbreaks of COVID are often difficult to prevent because of the highly transmissible nature of the virus and patients may be incubating the infection on admission

35 ward-based outbreaks of COVID were identified from April 2023 to March 2024

Influenza: Similarly, patients may be incubating influenza on admission which may result in inadvertently exposing other patients to the. Where this occurs, prophylactic anti-viral medication is given to at risk patients to prevent or modify infection.

5 ward-based outbreaks of Influenza were identified from April 2023 to March 2024

Norovirus: There were 7 outbreaks of Norovirus resulting in ward or bay closures and 23 confirmed cases.

Clostridium difficile: There were 2 small outbreaks which resulted from transmission of infection from one patient to one other.

Following the exceptionally high rates seen in July 23 Trust wide incident meetings were held with key actions identified below to support a reduction

- Enhanced cleaning:
  - decant ward available at TW to facilitate ward deep cleaning programme
  - Maidstone bays to be deep cleaned with HPV if possible
- Integrity checks on mattresses to be under taken
- Antimicrobial policy moved to more prominent position on front page of intranet
- *C difficile* updates and info provided on the intranet and daily comms (Pulse)
- IPC induction training moved to face to face
- Additional ward based training provided to further promote core IPC practice (supported by matrons and ward managers)
- Revised SOP for cleaning of computers of wheels and stickers designed to remind staff to clean hands & keyboards and not wear gloves when using keyboards
- Screen savers deployed across the Trust

Mandatory surveillance of surgical site Infections

All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter

Patients are monitored for the first 60 days and infection rates monitored for up to a year post operatively

MTW completes the mandatory surveillance of elective total hip, knees and fractured neck of femurs continuously throughout the year

Repair of neck of femur

During 23/24 for repair of neck of femur the number of confirmed SSIs spiked in Jan-Mar 2024 at 4 confirmed cases which exceeded the national benchmark. Infection rates expressed as a percentage are volatile due to the impact of a single infection on rates

Total knee replacements

The average TKR incidence rate was 2.17, which is above the national benchmark of 1.00.

The number of confirmed SSIs spiked in Jul-Sep 2023 and remained relatively high in the following quarters although decreasing towards the benchmark.

Total Hip replacements

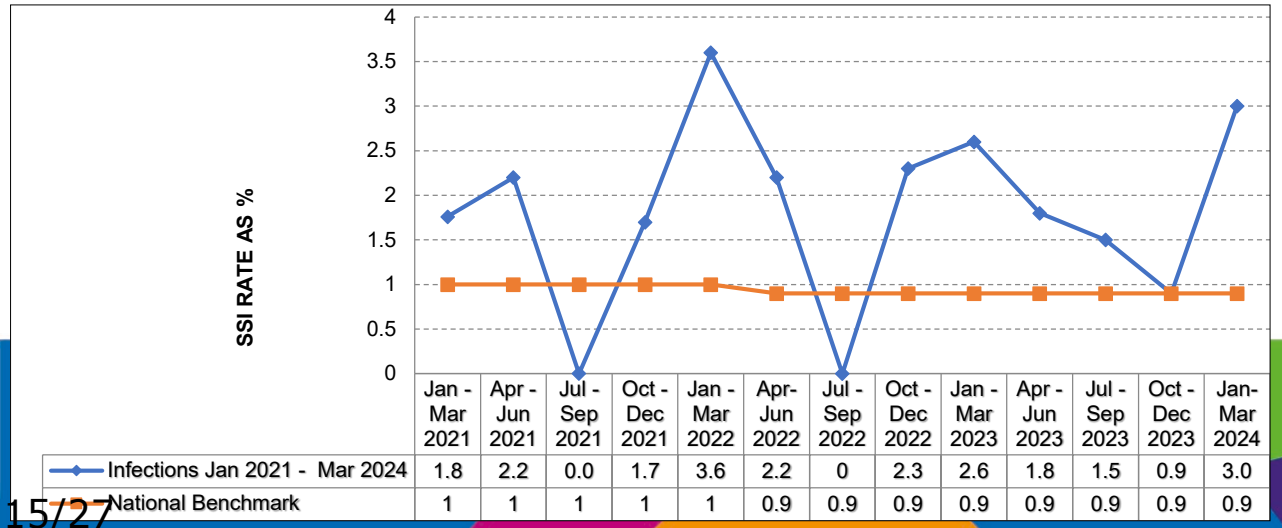
The average THR incidence rate was 0.48, which is below the national benchmark of 0.72. The number of confirmed SSIs spiked in Oct-Dec 2023.

The data indicates a generally low incidence of SSIs, with occasional spikes that were promptly addressed

Actions taken:

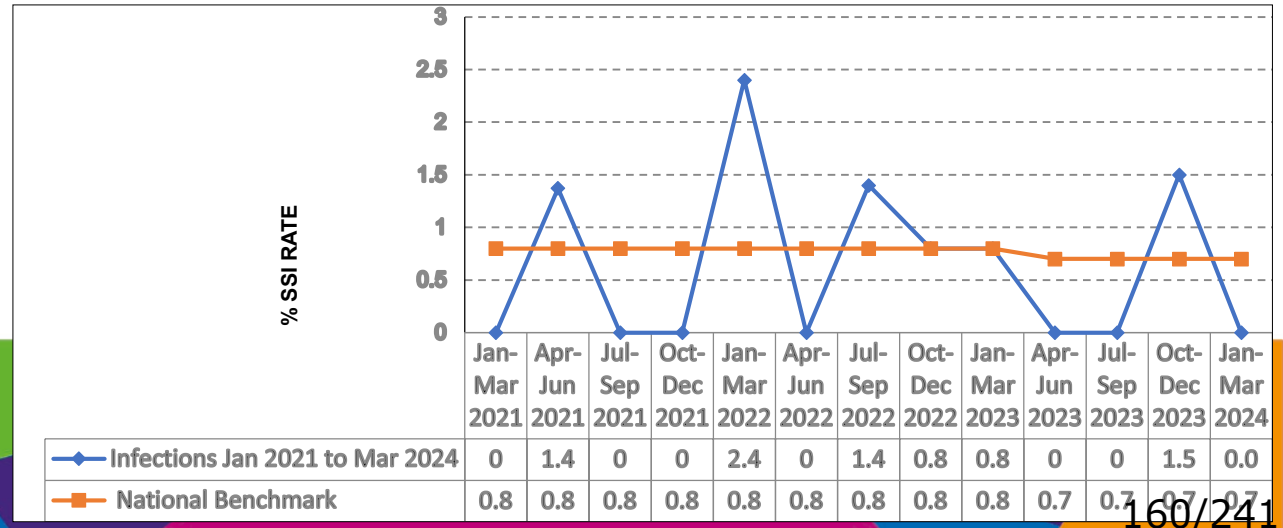
- Maidstone Orthopaedic Unit had a deep clean and a maintenance on the HVAC system to ensure high quality theatre standards were maintained
- Pre-operative washes audit.
- Repair of NoF pathway is being revised.

Repair of neck of femur data (excludes patient reported SSIs Jan 2021-Mar 2024



	Jan - Mar 2021	Apr - Jun 2021	Jul - Sep 2021	Oct - Dec 2021	Jan - Mar 2022	Apr- Jun 2022	Jul - Sep 2022	Oct - Dec 2022	Jan - Mar 2023	Apr - Jun 2023	Jul - Sep 2023	Oct - Dec 2023	Jan- Mar 2024
Infections Jan 2021 - Mar 2024	1.8	2.2	0.0	1.7	3.6	2.2	0	2.3	2.6	1.8	1.5	0.9	3.0
National Benchmark	1	1	1	1	1	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

THR (inc Rev) data (excludes patient reported SSI's Jan 2021 to Mar 2024



	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023	Jan-Mar 2024
Infections Jan 2021 to Mar 2024	0	1.4	0	0	2.4	0	1.4	0.8	0.8	0	0	1.5	0.0
National Benchmark	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.7	0.7	0.7	0.7

Compliance Criterion	What the registered provider will need to demonstrate
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Refurbishment and New Builds

Planning – The IPCT are asked for input in reviewing plans to ensure that any refurbishments or new builds offer the best facilities to reduce the risk of infections in line with any relevant Health Building Notes and Health Technical Memorandum

Operation – The IPCT are asked to review methods to reduce the risk of any infections presented by the actual refurbishment/build process.

Current projects include the CDC development, Acute Stroke Unit, Kent and Medway Orthopaedic centre and various ventilation issues,

Decontamination

The Decontamination Committee meets quarterly to consider all aspects of decontamination within the Trust.

All decontamination and sterilisation of reusable surgical instruments is carried out off-site by an external provider. During the year the performance has been closely monitored and twice-yearly reports are submitted to the IPCC. No major concerns have been raised and the service is compliant with HTM 01-01.

Decontamination and high-level disinfection of flexible endoscopes is carried out in the endoscopy departments on both sites. The departments have maintained all requirements for both HTM 01-06 and the Joint Advisory Group (JAG).

Trust laundry requirements are provided by a third party provider. Monitoring processes are in place and the IPCC receives a report bi-annually

Cleaning

The National Standards of Healthcare Cleanliness 2021 are used within the Trust to monitor performance. Audits are conducted using MyAudit, a digital compliance system.

The facilities department provide a very high level of support to the Infection Prevention and Control Team and are able to respond quickly to infection prevention issues such as urgent deep cleans and hydrogen peroxide (HPV) fogging.

A range of cleaning levels have been in place in the Trust for many years and these are regularly reviewed to ensure that they are fit for purpose and enable the most efficient turnaround times. Most discharge cleans are now completed by the Bed Turnaround teams

TWH	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2022/23	39007	632	3182	581
2023/24	42410	2666	3665	521
MH	**Level 2 Discharge Cleans**	**Level 3 - Steams**	**Level 3 – UV's**	**Level 4 - FOGs**
2022/23	28181	730	1289	273
2023/24	31051	673	788	251

Several wards at TWH were deep cleaned during the summer, decanting patients into ward 11 during the cleans. Some estates works were carried out prior to each deep clean to ensure that planned maintenance work was up to date.

Water Safety

The quarterly Water Hygiene Steering Group meets to discuss water hygiene policies and procedures plus remedial and improvement works being carried out within the Trust

Work on the water system at TWH continues in order to rebalance the system.

Regular water testing continues with remedial actions taken as required. The IPCT is closely involved with all work related water safety .

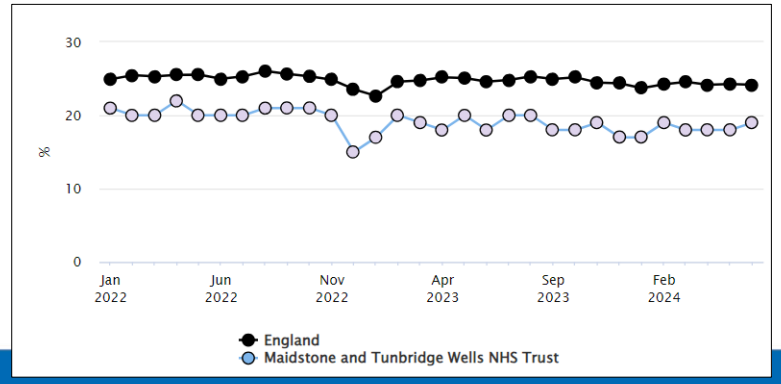
Compliance Criterion	What the registered provider will need to demonstrate
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance

Antimicrobial Stewardship

The Trust multidisciplinary Antimicrobial Stewardship Group (ASG) is responsible for promoting and monitoring the prudent use of antimicrobials as outlined in the DoH guidance “Antimicrobial Stewardship - Start Smart then Focus” and recommendations from NICE guidelines (NG15). The ASG meets monthly to ensure the Trust antimicrobial stewardship programmes are implemented and review issues relating to antimicrobial use. The group members include consultant microbiologists, antimicrobial pharmacists, deputy chief pharmacist and KM ICB antimicrobial pharmacist and invites other clinicians to join to discuss specialist guidelines. The group reports to the Drugs, Therapeutics and Medicines Management committee (DTMMC) and provides reports to the IPCC.

The group manages the antimicrobial guidance on a rolling basis or sooner if guidance changes significantly.

The ASG also leads the antimicrobial CQUIN work – the target for IV to oral switch was achieved for 2023-24. The Trust performs well against the benchmark for proportion of antibiotics prescribed administered orally.



Proportion of total antimicrobial prescribing administered IV

Antimicrobial training and Education

A number of education sessions were delivered by the antimicrobial pharmacists and consultant microbiologists to medical staff and pharmacists. Education sessions include induction sessions for all new doctors, FY1 and FY2 teaching sessions and more advanced sessions for core medical trainees.

Antimicrobial information leaflets are issued to new locum doctors and FY1 as part of their induction welcome packs.

Antimicrobial Audit

The pharmacists complete bi-monthly audits against the Antimicrobial prescribing policy. The audit results are reported to individual consultants, directorates and to the IPCC through the directorate reports. In line with antimicrobial stewardship best practice, evidence of 72 hours review is now included in this audit.

In addition, weekly audits against the policy are carried out on wards where there is a PII in place.

Compliance Criterion	What the registered provider will need to demonstrate
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The Trust provides all service users with information as required. This includes IPC information in the form of information leaflets, posters and resource folders for staff, and information leaflets and posters for patients and visitors. Policies, clinical guidelines, care pathways for specific conditions and other IPC resources are available on the Trust intranet.

During outbreaks or infection prevention incidents, duty of candour is completed for all patients affected either directly or indirectly..

Information is provided to external partners as appropriate including:

- Notifications of *C. difficile* cases and gram negative blood stream infections to the relevant ICB HCAI team
- Electronic discharge notifications include MRSA status
- Inter-hospital transfer forms include information relevant to IPC
- Patients identified as *C. difficile* carriers or with *C. difficile* infection are issued with a 'green card' which advises other healthcare providers of their diagnosis and the importance of prudent antimicrobial prescribing
- IPC information is shared with GPs for information on a case by case basis
- COVID information is available for patients and visitors on the Trust internet site

The infection prevention team attend the site meeting at least daily to share information regarding IPC risks and concerns. The daily executive strategic command call is attended by the DIPC and deputy DIPC or Lead IPC nurse to share relevant IP&C information in real time.

Compliance Criterion	What the registered provider will need to demonstrate
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

The Infection Prevention and Control Team provides a 7-day service and an on-call microbiology service (laboratory and consultant) is available out of hours. The laboratory also provides 7 day working and extended hours on weekdays.

The IPC team regularly visit the wards and review patients with infectious diseases.

All urgent microbiology results are telephoned to clinicians to ensure prompt treatment and review.

Side rooms are actively managed by the Infection Prevention team and the Isolation Policy, including risk assessments for side room requirement and leaving doors open, is available on the Trust intranet.

The IPCT performs risk assessments for any potential infectious disease incident in the Trust. Contact tracing for both staff and patients is facilitated by the IPCT working with Occupational Health where necessary.

Policies are available for the management of patients with diarrhoea and a wide range of infectious diseases.

Patients are screened for MRSA, MSSA, GRE, CRE/CPE, Influenza and COVID as appropriate (see Criterion 1).

An outbreak policy is in place and EPRR colleagues are available to assist with outbreak control if required.

Advice is available from UKHSA 24 hours a day.

Compliance Criterion	What the registered provider will need to demonstrate
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Staff Development and Training

The infection control team undertakes both formal and informal teaching as part of its training and education role. E-learning is available with national packages for clinical and non-clinical staff.

Compliance with training is above the target of 85% for annual, biannual and three-yearly training

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

Other bespoke practical training sessions have been developed to provide targeted training to facilitate learning in staff who may not have English as a first language.

Virtual link nurse meetings are held monthly. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition, a link nurse study day is held annually with invited speakers and this is also open to MTW staff who are not link nurses and healthcare staff from other organisations.

The DIPC teaches on the aspiring DIPC training course run by the Hospital Infection Society.

Within the IPCT members of the team are actively encouraged to pursue educational opportunities.

Fortnightly regional teleconferences for IPC teams continue to share learning and experience. An IPC Leadership forum for DIPCs and their deputies meets monthly and is chaired by the MTW DIPC as SRO for IPC for the system.

System-wide educational days are also provided by the ICB IPC team.

Hygiene code compliance

The Health Act 2008, now superseded by the Health and Social Care Act 2012, contains a Code of Practice usually referred to as the Hygiene Code. The Code was most recently updated in December 2022. The 2008 Act requires acute Trusts to comply with the Code.

MTW has declared compliance with the Hygiene code every year since 2009, maintaining evidence files and undertaking self assessment of compliance on an annual basis, reporting the outcome to the IPCC.

There is a compliance statement on the Trust website. This report demonstrates how we comply with the Code.

Governance and Assurance

The Board receives assurance through the governance reporting structure and directly from the DIPC at Trust Board meetings.

C. difficile, MRSA and gram-negative bacteraemia numbers and rates are on the Board level dashboard.

In 2023-24 the IPCC reported to the Quality Committee which is a sub-committee of the Board.

National Priorities

The next phase of the UK 5-year antimicrobial resistance strategy was published in May 2024. It focusses on four key themes

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access
- Being a good global partner

Confronting antimicrobial resistance 2024 to 2029 - GOV.UK

Compliance Criterion	What the registered provider will need to demonstrate
7	The provision or ability to secure adequate isolation facilities

Isolation facilities

The Isolation policy is published on the Trust Intranet, together with the standard infection control policy which includes the use of personal protective equipment.

The Trust has a high proportion of single rooms although there is a disparity between the two sites with Tunbridge Wells Hospital having over 95% of beds in side rooms and Maidstone Hospital with 57 side room beds. Overall 54% of the beds in the Trust are in single rooms with 50.4% en-suite, compared with 29.9% single rooms in England, 17.9% en-suite.

The target time for isolating patients with unexplained and potentially infectious diarrhoea (Pathway 1) is two hours. A rapid risk assessment is in place for all patients with diarrhoea

Active management of side room provision continues. The Infection Prevention team works closely with the central control team to ensure the best use of the side rooms available at Maidstone Hospital and to alert staff of infection control issues at Tunbridge Wells Hospital. The team alerts site teams to community issues such as outbreaks of norovirus in local nursing homes and community hospitals and any wider outbreaks which may result in patients attending A&E.

All *C. difficile* patients are isolated on diagnosis, if not already in a side room, and remain in isolation throughout their admission. In addition, those identified as carriers are isolated whilst they are symptomatic and for at least 48 hours after they become asymptomatic.

Pathways have been developed and are in use in A&E to separate respiratory and non-respiratory patients and ensure that there is no contact between the streams. COVID and flu patients are cared for in side rooms and cohorted when numbers outstrip the number of available single rooms. Strict conditions are in place to determine when the patients can be stepped down safely to general ward areas.

There are planned facilities in both Emergency Departments for isolating patients suspected of having High Consequence Infectious Diseases, eg Ebola. The pathway for these patients is practised regularly to ensure that staff are aware of the enhanced precautions and how to don and doff the protective suits.

Compliance Criterion	What the registered provider will need to demonstrate
8	The ability to secure adequate access to laboratory support as appropriate

Laboratory services

Microbiology laboratory services are based at Maidstone Hospital. The laboratory has ISO 15189 accreditation and is inspected on a regular basis by the UK Accreditation Service (UKAS).

The laboratory is open 7 days a week and provides a 24-hour service with on call facilities from 6pm to 8am.

Reference laboratory support is available at all times from both the UKHSA reference laboratories and other commercial laboratories which provide additional rapid diagnostics.

The laboratory, together with the other MTW pathology departments, is part of the Kent and Medway Pathology Network which enables laboratories to provide and receive mutual aid when required.

The microbiology laboratory also manages the Point of Care testing service in ED for COVID and other respiratory viruses.

Compliance Criterion	What the registered provider will need to demonstrate
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections

The infection control team work closely with the audit department to develop a comprehensive rolling audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust. Audits are reported to the IPCC. Formal audits included:

- Commode audit
- Invasive devices audit of documentation and practice on two high risk wards
- Endoscopy re-audit on the manual cleaning of flexible endoscopes, prior to decontamination through an Automated Endoscope Reprocessor (AER).
- Re audit of compliance with screening for Carbapenemase producing enterobacteriaceae (CPE).
- Audit of compliance with best practice guidelines to reduce risk of pseudomonas, aeruginosa and legionella contamination in augmented care. The use of personal protective equipment (PPE)
- External Audit of Sterile Services
- Re-audit of catheter associated urinary tract infections and compliance with the HOUDINI criteria
- National Surveillance of bloodstream infections and *Clostridium difficile* Audit 23/24
- National point prevalence survey on Healthcare associated infections, Antimicrobial use and antimicrobial stewardship in England

In addition to these audits the IPCT undertakes bi-monthly triangulation audits which are compared with the monthly ward audits and reported as a performance report to the IPCC by the directorate matrons.

As part of the PII process additional audits are completed on

Ward laundry management
Decontamination of reusable devices

Compliance Criterion	What the registered provider will need to demonstrate
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

The Occupational Health service provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff.

The occupational health department continues to review sharps injuries and examine ways to reduce the incidence with the Health and Safety team. An average of 8-12 sharps/splash injuries are seen each month. Staff can self refer themselves to support the management of sharps injuries

Occupational health support the IPC team with contract tracing of staff who may have been exposed to infectious diseases at work including measles, whooping cough, Strep A, meningitis and tuberculosis.

Booster vaccinations are available for whooping cough for those health professionals bring them into contact with pregnant women and/or infants.

Covid and Flu vaccinations were offered to all staff from October 2023. Uptake was poor and only achieved 45.1% coverage.

Appendix A – Infection Prevention and Control Annual Work Plan

INFECTION PREVENTION AND CONTROL WORK PLAN 24/25

MTW Infection Prevention and Control
exceptional people, outstanding care

RAG RATING DEFINITION	
R	ACTIONS APPEARS UNACHIEVABLE NEEDS RE-BASELING / REASSESSING
A	SUCESSFUL DELIVERY OF PROJECT TIME AND THERE ARE NO THREATS TO DELIVERY
G	COMPLETED AND CLOSED NO FURTHER ACTIONS REQUIRED

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
CULTURE AND ENGAGEMENT									
CE-001	Apr-24	APW	Improved attendance and engagement to the IPC Link workers programme and meetings	1) Monthly link worker meetings to be held via Microsoft teams and face to face 2) Link worker attendance to be monitored, fed back to divisions and monitored through IPCC 3) Summary report to be presented to IPCC with action plan to improve attendance and engagement such as, re-introduction of link of th year.	Mar-25	Q4	Clair Taylor (Lead IPC nurse)	25 in April, 28 in May and 18 in June Link worker report in progress Regular updates and training provided for dissemination	
CE-002	Apr-24	APW	Monitor and improve compliance with IPC practice and procedures	1) IPC team working with wards where non-compliances are identified, providing additional training and support 2) PPE compliance is monitored by the PPE / fit testing team and presented at IPCC 3) Findings from PII investigations are fed back, followed up and monitored 4) Audit/ QI programme developed and available on the Q drive. Also refer to Audit and Surveillance section of this work plan	Mar-25	Q4	Lesley Smith (DDIPC)	IPC training provided as needed. PPE team working on HCID PPE requirements in accordance with the National IPC manual. PII audits undertaken with learning fed back to the wards Positive feedback received from wards who have been involved in the QIP	
CE-003	Apr-24	APW / K&M IPC Strategy	All medical devices and equipment to meet IPC requirements for use	1) IPC team to work with procurement to provide IPC advice on new products being considered 2) Attend the Medical devices meeting 3) IPC approval of products via pre-purchase questionnaire (PPQ) 4) Consider joint procurement of equipment with other care providers within the ICB where feasible	Mar-25	Q4	Danny Moore (Infection Prevention Nurse)	IPC team provide ongoing support and advice for the purchase of new equipment including new builds / services such as KMOC	
CE-004	Apr-24	APW / K&M IPC Strategy	Continue to raise the profile of Infection Prevention and control	1) IPC attendance at ward managers and Matrons meetings 2) IPC team to visit wards & department daily 3) Participate in national and local initiatives to promote IPC. (Global Hand hygiene day, glove awareness week, International Infection Prevention week) 4) Use of social Media to promote IPC team and deliver key messages 5) Monthly IPC newsletter 6) Participate in national campaigns to improve HCAI rates	Mar-25	Q4	Lesley Smith (DDIPC)	- Attendance to the ward managers meetings providing updates and feedback from lessons learnt from incidents - Shortlisted for IPS and Nursing Times Awards - DDIPC Asked to present QIP outcome to regional meetings including the SE Network meeting	
CE-005	Apr-24	K&M IPC Strategy	Development and learning opportunities for all members of the IPC team	1) IPC team members to attend local, regional and national IPS conferences, meetings and webinars 2) Explore and support opportunities for IPC team to experience primary care / community care placements and vice versa 3) Support apprentice and student placements as appropriate	Mar-25	Q4	Lesley Smith (DDIPC)	Band 7 undertaking MSc Administrator / data analysis undertaking apprenticeship in data analysis IPC leads attending HIS training	
CE-006	Apr-24	K&M Local metrics	To meet the quality requirements of the K&M Acute schedule 4 local metrics 2024-25	1) To provide the IPC annual report 2) Regular participation at the K&M) system wide leadership forum and K&M Antimicrobial Medical Optimisation Group 3) To have an annual assessment against the Health and Social care Act. To provide a copy of the assessment and any action plan to address any gaps 4) To have an annual infection control programme in place. 5) MRSA screening of eligible patients in line with locally agreed policy 6) Evidence of a antibiotic stewardship strategy 7) To be assured of robust adherence with National water hygiene guidance including risk assessments for augmented care areas 8) Evidence of an effective, quality, link practitioner program 9) Audit programme in place and completion as part of annual work plan 10) Statutory mandatory IPC training programme is delivered as per locally agreed plan for each staff group to include hand hygiene training and assessment 11) Hand Hygiene performance audit compliance 12) Evidence of fit testing programme for the relevant patient facing staff 13) COCA MRSA bacteraemia to be reported to the ICB within 2 working days of the positive result 14) All MRSA bacteraemia cases are reported on DCS as per NHS standard contract (Zero tolerance for MRSA bacteraemia cases). 15) Notify ICB of all CDI cases (HOHA, COHA, COCA & COIA) within 3 working days of identification. 16) All CDI cases are reported on UKHSA Data Capture System (DCS) as per NHS standard contract. 17) Periods of increased incidence (PIIs) of CDI and outbreaks are reported to the ICB. ICB IPC representation invited to outbreak meetings. PII defined as two or more cases in the same ward or unit in a 28 day period 18) All reportable (MSSA) bacteraemia are reported on DCS as per NHS standard contract. 19) All reportable Gram-negative bacteraemia cases are reported on DCS as per NHs standard contract. The Trust to participate in E. coli surveillance, collecting and submitting risk factors onto the DCS system. 20) Orthopaedic surgical site infection surveillance undertaken as per UKHSA guidelines, is reported to the ICB. To undertake PIR investigation for any confirmed deep orthopaedic SSI. Reported as per UKHSA HCAI & AMR, SSI mandatory national reporting requirements 21) Implementation of regional and national guidance such as local catheter insertion guidelines and NHSE catheter guidelines, care plans and passport - Associated audit to be in place. 22) ICB to be invited to MRSA bacteraemia review as per local PSIRF methodology. 23) In conjunction with the ICB, and other providers where relevant, undertake incident review of healthcare associated case of C. diff and MRSA bacteraemia as per local PSIRF methodology to identify Trust learning. 24) Confirmed outbreaks of HCAIs where there is evidence of transmission to be investigated in line the local PSIRF methodology	Mar-25	Q4	Lesley Smith (DDIPC)	Regular attendance and participation in the K&M IPC leadership forum and CDI / HCAI collaborative Annual programme of work approved at May IPCC MRSA non-elective screening audit undertaken monthly and included in the HCAI weekly status report IPC attend the AMSG which reports to IPCC IPC attend the WSG which report to IPCC Audit programme in place and monitored through the IPCC IPC training compliance included in the directorate reports that are presented to IPCC Hand hygiene audit reported included in the directorate reports that are presented to IPCC Fit testing compliance report presented to IPCC All COCA MRSAs reported to ICB and all mandatory reportable HCAIs entered on the DCS All outbreaks reported to the ICB Surgical site surveillance undertaken to meet the mandatory requirements Currently reviewing catheter passport (national) for printing and distributions PSIRF methodology adopted and implemented	
CE-007	Apr-24	APW	Deliver IPC study day / conference	1) Academic centre at Maidstone booked for Thursday 17th October 2) Reps and speakers to be contacted to support event 3) Evaluation and short report to be presented to IPCC	Nov-24	Q3	Clair Taylor (lead Nurse IPC)	Draft agenda in place with some funding for lunch from reps secured. 47 attendees booked on with capacity for > 70	
SAFE AND CLEAN ENVIRONMENT									

SCE-001	Apr-24	APW	Safe water systems	1) IPC representation at the Water Safety Meeting 2) All water sampling results and mitigating action taken to be sent to the IPC team for information & follow up as necessary 3) *Pseudomonas* risk assessment reviewed and updated yearly 4) Water safety workstream to be supported by consultant microbiologist	Mar-25	Q4	Joanne Green (Lead Nurse IPC)	IPC consistently represented at WSG and involved in reviewing water safety incidents Oversight on high legionella counts on the renal units and working with IPC leads at EKUFT to resolve (MTW responsible for the estate - EKUFT responsible for the services) Remedial works to address the legionella counts at TW remain on going - with further tap replacement programme in progress (sensor taps being replaced with manual taps). Point of use filters remain in place to mitigate the risk to users IPC team have undertaken water safety risk assessment on all augmented care areas and a water safety audit	
SCE-002	Apr-24	APW	Environment is designed and refurbishments are completed with infection prevention and control in mind	1) IPC representation at capital planning meetings 2) IPC commissioning SoP is followed for all relevant new builds / refurbishments 3) IPC to be involved in all relevant estates works to advise on IPC requirements and issues	Mar-25	Q4	Joanne Green (Lead Nurse IPC)	IPC lead has been heavily involved in the plans for KMOC and commissioning of new builds. SOP in place for IPC sign off IPC attend the NSC meetings which also monitor the progress of estates issues Recently supported the completion of essential estates work in MoU and TWAMU as part of the their deep cleaning programme	
SCE-003	Apr-24	KLOE (S1) H&SCA	Systems in place to ensure that patient equipment is clean between use and assurance that standards are maintained (Criterion 2.1)	1) Where deficiencies are identified through PII and audit, the process for the cleaning of patient equipment within the wards and department will be reviewed 2) Devise a process to identify if cleaning of patient equipment is robust across the Trust	Mar-25	Q4	Danny Moore (Infection Prevention Control)	IPC team continue to advise on the correct process and requirements for the cleaning of patient equipment. Standards are monitored through the PII audits undertaken and fedback to the wards - More focus piece of work is need to ensure robust processes are in place for the cleaning of patient equipment	
SCE -004	Apr-24	KLOE & BAF (S1)	Greater involvement in cleaning and environmental audits to provide assurance of standards being reported	1) Ward / Department staff to attend the cleaning audits that are undertaken by the domestic supervisor 2) IPC team to attend a number of cleaning audits for assurance purposes 3) IPC to participate in PLACE assessments 4) IPC to participate in mock CQC walkabouts	Mar-25	Q4	Joanne Green (Lead Nurse IPC)	IPC team members are now attending some of the environmental audits IPC team are involved and attend PLACE inspections Ward staff have been asked to attend environmental audits but often find it difficult to allocate the time	
SURVEILLANCE & AUDIT									
SA-001	Apr-24	APW	Programme of audit / QIP to be developed and completed for 23/24 & Support the introduction of the electronic audit programme (InPhase)	1) Audit / QI programme to be developed and agreed at IPCC 2) Support the completion of IPC audits on InPhase 3) Ward /Dept environmental audits 4) PII audits of MRSA and CDI 5) IPC team to attend and participate in InPhase implementation meetings	Mar-25	Q4	Jo Green (Lead Nurse IPC)	Audit programme in place IPC audits are currently being put on InPhase and mattress checklist is uploaded and ready to trial Water safety audit has been completed Tolley mattress audit has been completed on the MH site, TW due to be completed in Oct Diarrhoea audit completed QI project to reduce blood stream infections by improving the care and management of peripheral cannulas has been completed	
SA-003	Apr-24	APW & K&M IPC Strategy	Mandatory reporting of surgical site surveillance	1) SSIS to be reported 6 monthly to IPCC 2) Quarterly reports to UKHSA 3) Feedback of findings to orthopaedic directorate 4) Increase scope for SSIS to include breast and laparotomies 5) support the implementation of the SSIS on ICNet	Mar-25	Q4	Linda Baker (surgical site surveillance Nurse) & Clair Taylor (Lead Nurse IPC)	6 monthly reports presented to IPCC Finding fedback to directorate Breast SSIS data started to be collected but proving to be problematic Unable to utilise ICNet to support data collection however a review of IT systems, supported by BI has improved the way that data is collected	
SA-004	Apr-24	APW / K&M IPC Strategy / K&M local metrics	No avoidable HOHA/COHA MSSA / MRSA bacteraemia (10 avoidable MSSA in 22/23) (4 avoidable MSSA in 23/24)	1) All COHA/HOHA MSSA / MRSA bacteraemia to be reported on the DCS 2) Rapid reviews to be completed on all COHA/HOHA MSSA/MRSA bacteraemia within 5 days and presented to the monthly panel for sign off / escalation to PSIRG 3) Trends and lessons learnt to be monitored and shared 4) Panel outcomes to be shared with IPCC & on HCAI report 5) monitor and review action plans to reduce MSSA & MRSA 6) Community acquired MRSA bacteraemia to be reported to the ICB within 2 working days of positive result 7) ICB IPC to be invited to MRSA swarm huddles 8) Continue to implement of DRIPP vascular access resources https://dripp.org.uk/Resources/	Mar-25	Q4	Lesley Smith (DDIPC)	No avoidable MSSA bacteraemia identified in the first 6 months of the year. Process for MSSAs have been reviewed following the PSIRF - it was agreed that the finding from the data collection form would be reviewed by the IPC team to identify the likely cause and any learning 2 MRSA, 1 case (ward 12) considered likely avoidable and due to a peripheral cannula. Learning included: •Missed opportunity to decolonise the patient from MRSA because there was no evidence of screening and therefore not known whether the patient acquired this in hospital or not. •Completing the check list on admission was not always prioritised. •Need to have a system to ensure MRSA screening is followed up on all patients admitted to the ward and follow up on results. •Documentation to be completed on all cannula assessments and VIP scores. •Review Cannula site care and the dressings used and ensure these processes follow the Trust's guidelines. •Consider using a longline for patients who require longer term cannulation. The other case (TWHDU) of MRSA is pending the outcome of the SWARM	
SA-005	Apr-23	APW	Reduce rates of MSSA by 5% (44) 46 cases (29 HOHA and 17 COHA) in 23/34	1) Continue to promote good IPC practice 2) Act on lessons learnt from rapid reviews and disseminate for shared learning - focus on cannula care and central lines 3) Complete actions identified above (SA-004) to prevent avoidable infections	Mar-25	Q4	Lesley Smith (DDIPC)	With 9 cases up until the 18/09/24 we are within our locally agreed thresholds The learning and actions taken for the QIP to support the management and care of peripheral cannulas is likely to have supported this reduction	

SA-006	Apr-22	APW & K&M IPC Strategy	Support the NHS's long term plan for a 50% reduction in gram negative blood stream infections by 2024/25 National thresholds received Aug 24 based on previous years performance E.coli (52) Aeruginosa (17) Klebsiella (33) Previous year: E.coli 48 cases (23 COHA & 22 HOHA) Aeruginosa 18 cases (10 HOHA & 7 COHA) Klebsiella spp 34 (16 COHA & 15 HOHA)	1) Patient indwelling catheter cards to be provided to patients going home with indwelling catheters (E1.5) 2) Preventing CAUTI cards which promote Houdini (E1.5) 3) Laminated 'tea cup posters to be provided to ward to promote the hydration of patients (E1.5) 4) Continue to promote catheter passport 5) Report all E.coli, Klebsiella and Pseudomonas aeruginosa bacteraemia on the National Data Capture System 6) Rapid reviews to be completed on all gram negative bacteraemia which are considered avoidable and / or identify areas for learning 7) Volunteers to support additional drinks rounds to assist in promoting hydration. 8) Monitor trends against the national UKHSA fingertip data 9) Gram negative reduction meetings to be held 10) utilisation of GNBSI reduction plan tools and plan available at: https://improvement.nhs.uk/resources/gram-negative-bloodstream-infection-reduction-plan-and-tools/ 11) Monitor and review action plans to reduce gram negative blood stream infections 12) Re-introduce hydration project	Mar-25	Q4	Clair Taylor (Lead Nurse IPC)	Threshold have been updated National catheter passport currently being review and agreement source from urinary catheter bag rep to print them E.coli, Pseudomonas and Klebsiella rates remain within the expected limits Plan to re-introduce the hydration project QIP to improve the care and management of urinary catheters currently in progress Process for investigating gram negative cases reviewed - IPC team undertake a review of the data collection to establish lessons learnt and likely cause	
SA-007	Apr-23	APW / K&M IPC Strategy / K&M local metrics	*Clostridium difficile* Trust attributable infections to be within the Trust Limit of 102 20/21, 50 cases against a limit of 55 21/22, 68 against a limit of 55 22/23 79 cases against a limit of 62 (31% per 100,000 bed days) 23/24 107 case against a year end limit of 61	1) Monitor trends from the rapid reviews and act on findings 2) All rapid reviews are to be completed in 5 working days and presented to the table top review for agreement and sign off. 3) All samples to be sent for Ribotyping 4) Monitor for any evidence of transmission of infection 5) Monitor and review action plans to reduce CDI 6) COCA, COIA to be reported to the ICB within 2 working days 7) Escalate any increased rates of CDI including Trust wide C diff incident meetings	Mar-25	Q4	Lesley Smith (DDIPC)	Trust wide incident meeting held in May 24 which identified additional actions including review of BTT, avoiding boarding on wards on PII and further enhanced cleaning. Further incident meetings held in 23/07/24 & 03/09/24. Whilst the rates of CDI remain high, they have slowed with 54 cases up until Sept 24 No evidence of transmission of infection identified Reference lab are no longer routinely undertaking ribotyping of all cases of CDI as there is a significant cost implication. The IPC team will now request ribotyping where there is possible transmission of infection due the patients (with CDI) being on the same ward and the same time	
SA-008	Apr-23	BAF	Board assurance framework is reviewed on a regular basis and presented to Trust Board when there is significant changes	1) Significant changes to board assurance frame work to be presented to the Trust Board	Mar-25	Q4	Sara Mumford (DIPC)	Not a mandatory requirement - will be updated by exception	
SA-009	Apr-23	KLOE (S1)	Bed and Trolley mattresses to be clean and systems in place to ensure that checked, condemned and replaced if needed	1) Participation with annual bed and trolley mattress & pillow audits out and reports presented to IPCC 2) Complete trolley mattress audit and support bed mattress audits 3) Review bed and trolley mattress checking and cleaning process and implement 4) Triangulation mattress audits completed by the IPT and fed back to divisions and wards 5) Support the introduction of mattress audit process that wards can complete (? on InPhase) monthly	Mar-25	Q4	Danny Moore (IPC Nurse)	Trolley mattress audit in progress >50 trolley mattresses have been replaced at MH. Audit at TW due in October Pillow audit undertaken found damaged and soiled pillows in use (update provided at CDI incident meeting) IPC team attend the bed and mattress meeting and support the review of related policies and procedures	
TRAINING & EDUCATION									
TE-001	Apr-23	APW	All training to be updated to reflect the IPC education framework and best practice guidance	1) Liaise with learning and development to review the IPC education framework and its implementation Review all IPC training to ensure that it is up to date and meets the requirement of the framework including *Online training package *Face to Face training *Hand hygiene practical sessions *Doctors training	Mar-25	Q4	Clair Taylor (Lead Nurse IPC)	All training has been updated Online no-clinical training currently under further review following some comments received	
TE-002	Jan-23	H&SCA	Criterion 3.5: New Doctors to be provided with ongoing antimicrobial training updates	Mandatory e-learning antimicrobial training to be developed and introduced	Mar-25	Q4	Grace Sluga (Consultant Microbiologist)	update needed	
NATIONAL & LOCAL STANDARDS									
NLS-001	Apr-23	APW	Delivery of the local Antimicrobial Resistance Strategy	1) ASG to report to the IPCC 6 monthly 2) IPC team to support the antimicrobial awareness week and other campaigns to support AMS 3) IPC representation to the ASG meetings	Mar-25	Q4	Helen Burns (Deputy Chief Pharmacist) & Grace Sluga (Consultant Microbiologist)	6 monthly reports presented to IPCC - IPC team attend and contribute to the ASG and AMS campaigns Monthly antimicrobial audits are included in the directorate reports that report to IPCC	
NLS-002	Apr-23	APW / KLOE / K&M IPC Strategy	Demonstrate Shared learning from lesson learned from rapid reviews and incidents	1) Lessons learnt from reviews to be identified and shared 2) Trends to be monitored and reported for wider shared learning 3) Closing the loops from investigations- Actions from reviews to be monitored through the IPCC to ensure that all actions have been completed (W4) 4) Lessons learnt to be included in the monthly IPC newsletter 5) Take opportunities to share learning across the K&M system 6) Outcome and lessons learned from rapid reviews / swarm huddles to be included in HCAI weekly status report	Mar-25	Q4	Lesley Smith (DDIPC)	Lessons learnt are shared via the IPC monthly news letter and the HCAI weekly status Updates and learning is also shared at the link worker meetings	
NLS-003	Apr-23	APW / K&M IPC Strategy	Support the Implementation of the Annual Flu plan	1) Plan for vaccinators to support the 90% vaccination of frontline staff vaccination to be agreed 2) Fit testing of front-line staff 3) IPC team to support flu Campaign 5) Surveillance of flu cases 6) Timely raising awareness emails to be sent regarding signs and symptoms of flu and differential diagnosis	Mar-25	Q4	Clair Taylor (Lead Nurse IPC)	Point of care testing in ED will now include Flu (LFT) All staff are required to be fit tested every 2 years	

NLS-004	Apr-23	APW & H&SCA / K&M IPC Strategy	Develop a Policy review programme to spread across the next 3 years to avoid Policies expiring at the same time Ensure Policies are reviewed in accordance with new national recommendations Review format of policies to consider similar format to the HR's peoples policy Implement the National IPC manual alongside local policy updates Criterion 4.1: Patient impact of care including PPE to be incorporated into IPC policies	Further introduce the National IPC manual for England into our policies and update the following 1) Candida auris (New) (In progress) 2) Notification of Infection (New) (In progress) 3) Surveillance and data collection (New) 4) Immunisation of patients (New) **24/25** - Control of resistant organisms Oct 2024 (presented to IPCC Sept 24) - Blood borne viruses - October 2024 - Norovirus - Oct 2024 - Hand hygiene - Oct 2024 - safe handling of blood and body fluids - Oct 2024 - Single use medical devices - Oct 2024 - Ward closure - Oct 2024 - VZV - Oct 2024 - Environmental disinfection -October 2024 - TSE policy- November 2024 - Outbreak of communicable disease - October 2024 - Decontamination of Mattresses - February 2025 **25/26/27/28** - Hepatitis A - February 2026 - Clostridium difficile December 2026 - Meningococcal disease Feb 2026 - GAS policy and flow charts May 25 - Diarrhoea Policy October 2027 - ANTT July 2027 - CPE - May 2027 - VHF Sept 2027 - TB - July 2027 - MRSA May 2027 - Infection Prevention and Control policies and procedures (Standards precautions policy updated to reflect the impact of PPE / IPC on patients) July 2027 - Isolation - January 28 - Scabies policy - February 28 - Laundry- April 28 - Animal visitor policy June 2028	Mar-25	Q4	Jo Green (Lead Nurse IPC) IPT	National IPC manual presented to sept IPCC meeting for implementation - recognising that there are a few local differences such as the use of DiffX instead of Chlorine base disinfectants. The manual will supersede some of our existing core policies such as hand hygiene once it is in place	
NLS-005	Apr-23	APW / K&M IPC Strategy	Determine compliance with the code of practice the prevention and control of HCAIs	1) Self assessment tool for prevention and control of HCAIs to be completed and reviewed quarterly 2) Declare compliance on the Trust Website 3) Compliance to be reported to IPCC	Mar-25	Q4	Lesley Smith (Consultant Nurse IPC)	To be undertaken in November	
NLS-006	Apr-23	APW & H&SCA	Revise all IPC leaflets due for update during 24/25	All leaflets that require updating for 23/24 to be reviewed 1) Hand hygiene information for staff - (October 2024) 2) Hand hygiene for patients (Nov 25) 3) Hand hygiene easy read (Feb 27) 4) CPE / CRE - adult (Sept 27) 5) CPE / CRE - children and parents (June 25) 6) MRSA - (National leaflets 'Here's what to do' and How to avoid catching') 5) MSSA small and large print (May 27) 6) ESBL (Jan 27) 7) Antimicrobial leaflet for patients and visitors (Sept 27) 8) isolation / IPC leaflet for patients and visitors (Oct 27) 9) GAS (Nov 27) 10) GRE (Jan 27) 11) Influenza (Dec 26) 12) Norovirus (Jan 27) 13) COVID-19 leaflet to be developed (including easy read version	Mar-25	Qu4	Jo Green (Lead Nurse IPC)		
NLS-007	Apr-23	APW	Seek opportunities to publise and promote the work undertaken by the IPC team both locally and nationally	1) Utilise social media to promote the IPC service and team 2) Consider areas for innovation 3) Undertake QI projects and present findings 4) Seek opportunities to submit to national awards	Mar-25	Qu 4	Lesley Smith (DDIPC)	IPC team have been shortlisted for the nursing times awards and the IPS awards for the QIP that they have done to reduce blood stream infections related to peripheral cannulas	
NLS-008	Apr-23	H&SCA	Criterion 3.5: Antimicrobial resistant data to be effectively communicated back to prescribers in primary & secondary care	Policy for the investigation of HCAIs and alert organisms surveillance to include annual antimicrobial susceptibility data feedback to primary and secondary care on commonly used antimicrobials	Mar-25	Q4	Grace Sluga (Consultant Microbiologist)	update needed	
NLS -010	Apr-23	H&SCA	Criterion 9.3p: required to ascertain who is responsible to controlling polluting emissions to the air	Make enquiries to identify responsible person and if systems are in place to control air emissions	Mar-25	Q4	Lesley Smith (DDIPC)	No responsible person for emissions - this is being addressed by the Sustainability Manager when in post IPC work with green champions to look at opportunities to reduce our carbon footprint Sustainability manager now in post and looking into this action	
NLS-011	Apr-23	H&SCA	Criterion 10.2: ensure that systems are in place for the review and follow up of staff immunisation	Further assurance needed that systems are in place for the following up on staffs immunisation status	Mar-25	Q4	Lesley Smith (DDIPC)	OH have been working of improving the vaccination records for staff especially in response the increased prevalence of measles Further update need on the progress with this	
NLS -012	Apr-23	APW & K&M IPC strategy	Imbed PSIRF methodology and after action review to identify real time learning from incidents and HCAIs	1) Further review process to incorporate AAR and PSIRF 2) Work with K&M network to standardise approach 3) Work with patient safety team to further imbed the PSIRF processes	Mar-25	Q4	Lesley Smith (DDIPC)	PSIRF methodology has been adopted by IPC further work is needed to ensure that there is greater ownership and accountability of investigations as the rapid review process is predominately led by the IPC team	
NLS-013	Apr-23	K&M IPC Strategy	Ensure that preparedness plans are in place for future IPC adverse events (including pandemics and emerging threats)	1) Work with EPRR team to ensure that pandemic and outbreak plans are in place and up to date 2) Support the preparedness training of relevant staff - such as VHF PPE training for ED staff 3) support the vaccination of staff (see NLS-003)	Mar-25	Q4	Lesley Smith (DDIPC)	IPC team and Fit testing team have been involved in pandemic preparedness planning meetings	
NLS - 014	Apr-23	K&M Local metrics	Produce and publish Annual IPC report	1) Annual report to be presented to IPCC, Trust Board 2) Ratified report to be sent to ICB	Mar-25	Q4	Sara Mumford (DIPC)	In progress	

Key	
APW	Annual Programme of Work
KLOE	Key Lines of Enquiry
BAF	Board assurance Framework
EPOC	Exceptional people outstanding care
H&SCA	Health and Social Care Act

Completed actions

SA-008	Apr-23	APW	Implementation of the updated ICNet system	1) ICNet advanced training to be delivered to IPC team 2) IPC team to implement the new ICNet system into their day to day work	Aug-24	Q4	Clair Taylor (Lead Nurse IPC)	26/07/22: ICNet system implemented July 22. Initial training provided to IPC team - 16/11/22: ICNet now fully implemented	
NLS-012	Jan-23	H&SCA	Criterion 4.1: Patient information to be reviewed by patient representative	IPC leaflets and information to be reviewed by patient representatives - future plans for each directorate to have their information reviewed by a patient representative	Mar-23	Q4	Lesley Smith (DDIPC)	Email confirmation received from patient experience lead to say that there is patient representation of the PILG	
NLS -016	Jan-23	H&SCA	Criterion 9.3p: Waste Contingency plans to be in place	Develop contingency / emergency waste management plans	Mar-23	Q4	Clair Taylor (Lead Nurse IPC)	Confimation of contingency plans received and available in the evidence folder	
NLS-009	Apr-23	H&SCA	Criterion 4.1: Provide assurance that specific vulnerabilities and protective characteristics have been considered in information and	seek further evidence that specific vulnerabilities and protective characteristics have been considered in training and information for staff and service users	Mar-24	Q4	Jo Green (Lead Nurse IPC)	Large print and easy reader leaflets available	

Title of report	**Maternity workforce establishment review**					
Board / Committee	**Trust Board**					
Date of meeting	28th November 2024					
Agenda item no.	11-15					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Jo Haworth, Chief Nurse					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	☐	✓	✓	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This report is presented to the Trust board to fulfil some of the requirements for the safety actions for the Maternity Incentive Scheme: Biannual Maternity and Neonatal Workforce Report Quarter 1 of the Perinatal Mortality Review Tool report Confirmation that the Board Maternity Safety Champions have met with the Perinatal Quad Leadership team to discuss cultural improvements within the service and that no specific support from the Trust Board is indicated at present.
Any items for formal escalation / decision	Safety SA8 requires 90% training compliance with mandatory training in obstetric emergencies and fetal monitoring. However, for rotational medical staff that commenced work on or after 1 July 2024, a lower compliance will be accepted, provided there is a documented commitment and action plan approved by Trust Boards and recorded in Trust Minutes to recover this position to 90% within a maximum 6 month period from their start date with the Trust. If there is a shortfall in compliance these actions will be taken: • Booking staff onto the next available training date • Ensuring their rota enables their attendance
Appendices attached	• Appendix A – Biannual Maternity and Neonatal Workforce Report • Appendix B – PMRT quarterly report Quarter 1. The embedded documents are available upon request from the Trust Secretary's Office.

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	19.11.2024	For Trust Board information and action for SA8 decision

Assurance and Regulatory Standards	
Links to Board Assurance	N/A

Framework (BAF)	
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	Fulfils requirements for Maternity Incentive Scheme

Maidstone and Tunbridge Wells NHS Trust

BI Annual MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

November 2024

1. Background

It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board 2016 (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) state that procedures are developed to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and birthing people and babies in all settings.

Previously midwifery staffing data has been included in the Nursing & Midwifery Workforce report, however, to provide further evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate summary is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics. Midwifery will however, continue to be included in the annual establishment review process and feature in the twice yearly N&M workforce report.

2. Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 5.

3. Progress against Ockenden Actions

Additional funds have been allocated to support the Ockenden staffing recommendations for bereavement, workforce retention, improving clinical placement experience, obstetric leadership capacity and support for Maternity Support Workers. Resource have been uplifted in the bereavement midwifery team, workforce lead, extra support for students out of hours and weekends with a supernumerary “buddy” role, increase in sessions for Obstetric Leadership training and the appointment of a maternity support worker lead.

20 actions have been completed and 4 are in progress.

Recommendation	Action Required	Progress	RAG
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	- RECOMMENDATION 5 Trust to develop and conduct a regular audit to demonstrate there are Twice daily consultant led and present MDT ward rounds on labour ward as outlined within the Interim Ockenden Report	Twice daily ward round are established in practice. Difficulties collecting the data to evidence the ward round and so a QR code is being developed for clinicians to scan prior to the ward round. This audit will be monitored at the Maternity and Neonatal Improvement Programme meeting.	

	(2020).Regional support offer		
Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Agreed pathways and audit required	Electronic Referrals for the Maternal Medicine are discussed with the Network by the Maternity Medicine Leads (OW and GM). The SOP for this is currently being incorporated into the Antenatal Booking SOP agreed at the Audit Compliance Oversight Group. OW and GM to ensure audit of compliance of referral criteria is represent to the ACG on a quarterly basis.	
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Insights - RECOMMENDATION 6 Trust to formalise audit reporting and governance process for Personalised Care Support Plan within the Maternity Service	Audit tool for PCSP is being developed nationally so await the introduction of this. In the meantime, E3 audits will take place quarterly and monitored at Patient Experience Meeting. Please see attached files for the messages regarding PCSP booklets to all staff	
URGENT A review and solution to address the current perceived inequity in maternity on calls is required		Oct '23 On call task and finish group in progress. Consultation completed regarding unit on calls. March '24 implementation of new unit on call provision, now reduced to one on call per night. Oct '24 On call survey and T&F in progress for Community on calls provision. For medical staff, compensatory rest policy in practice with audit for consultants and consultant attendance audit monitored	

4. Birthrate Plus Workforce Planning

In June 2023, the LMNS commissioned a Birthrate Report for all four providers including MTW. Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. It should be mentioned that this methodology does not take in to account the increased responsibilities on maternity units from CNST, the Three Year Delivery Plan and national reports such as Ockenden and Kirkup.
This review did not recommend a birth to midwife ratio but calculated the ratio at MTW to be 24.2 births per 1 WTE midwife across the Trust.

Summary of Birthrate Plus results:

Current Funded Midwives	% Uplift	Birthrate Plus wte	Variance wte
261.02	21%	261.98	-0.96
261.02	23%	267.53	-6.51

The end summary is that 0.96 wte midwives is needed to comply with BR+ calculations.

This shows the current funded establishment is adequate to provide the additional roles. NICE (2017) recommend that an assessment is carried out every three years. In addition, the trust undergoes a yearly establishment review in October to ensure that the staffing number reflect the demand for staff in each area.

At the October 2022 annual establishment review several new posts were identified as being required and approved from the business case that was subsequently developed. Maternity had the following posts transferred into the budget in April 2024:

Post	WTE
Postnatal Ward B5	5.14
Delivery Suite B5	5.14
Antenatal Ward B6	5.14
MSW Day Assessment Unit	1.53

Total Nursing and Midwifery: 15.42

Total MSW: 1.53

The B5 posts will be in post by the end of November, bar 0.28 WTE (10.5 hours) which is still out to recruitment.

It is to be noted that these posts are for a Registered Nurse B5. The reasons for this are twofold:

1. The service has been using nurses when there are staffing deficits. The nurses have complemented the midwives on shift and bring specific skills especially in terms of caring for patients in MECU and those having an operative birth.

2. Recruitment of midwives can be challenging in this climate and diversifying the workforce means potentially more successful recruitment.
The successful recruitment of these posts would more than meet the 23% uplifted establishment outline by BR+ for the maternity service, with the acknowledgment that these extra posts are for nurses and not midwives.

3.1 The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

This was shared at an LMNS meeting on the 13th August 2024

3.2 Action Plan to address findings from workforce review table-top exercise

At the 2022 annual establishment review, an additional 10.28 wte registered nurses were approved and added to the substantive budget in April 2024. Whilst there have been temporary nurses (bank and agency) on duty within midwifery services, this is a new model to employ RNs to care for women following a caesarean section releasing midwives to provide pre and postnatal midwifery care. Recruitment is currently underway for these RN positions.

5. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient areas for September 2024

Sep-24		DAY		NIGHT		TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)
Ward name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing			
Maidstone Birth Centre	Maidstone Birth Centre - NP751	84.1%	94.1%	93.1%	96.7%	1.3%	0.0%	252	0.16	17
Delivery Suite	Midwifery Services - Delivery Suite - NF102	92.7%	-	95.8%	-	3.9%	29.6%	3,608	2.19	728
Delivery Suite	Midwifery Services - MSW (2022) - NF102	-	89.2%	-	95.3%	3.2%	0.0%	No Demand	No Demand	No Demand
Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	82.0%	-	86.9%	-	4.4%	1.1%	1,162	0.72	318
Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	106.2%	84.0%	92.1%	96.7%	4.8%	0.4%	2,474	1.55	382
Crowborough Birth Centre	Crowborough Birth Centre (CBC) - NP775	108.3%	91.5%	97.3%	96.6%	3.4%	0.0%	604	0.37	69

Work has now been completed to cleanse the roster as part of the establishment reviews.

The maternity escalation policy is currently being reviewed. It will include the resources we have to use when staffing numbers are not as planned these include:

- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Request the specialist on call to work clinically
- Managers at Band 7 level and above work clinically
- Delivery suite on call staff are called in (one per night shift) Request additional support from the on-call midwifery manager.
- Consider workforce across the three sites and community to see what staff can be redeployed (may result in services being suspended)
- Request mutual aid from neighbouring sites.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

6. Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This has now been added to the maternity dashboard so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

Month	**July 24**	**August 24**	**September 24**
Birth to midwife ratio	1:26	1:24.5	1:25.3

7. Specialist Midwives

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives.

This report is required to outline the current funded establishment of non-clinical roles which include specialist midwives and management positions. This is expected to be 9-11% of the midwifery workforce.

Current funded wte	% Uplift	Birthrate Plus wte	Variance wte
27.81	21%	25.96	1.85

Although the Birthrate Plus report identifies that MTW meets the expected standard in terms of numbers of specialist midwives, it should be acknowledged that the recent CQC report highlights areas where extra investment in staffing is needed in order to be assured that the service has effective governance and audit processes. Many trusts are now operating on an uplift above 23%, and this may explain why although the staffing meets requirements set out in the Birthrate Plus report, further investment in posts is needed. To date, two additional posts are in the process of being recruited to in the Governance team (Head of Maternity Governance and Lead for Patient Safety expected start date December 2024).

8. Birth Rate Plus Live Acuity Tool

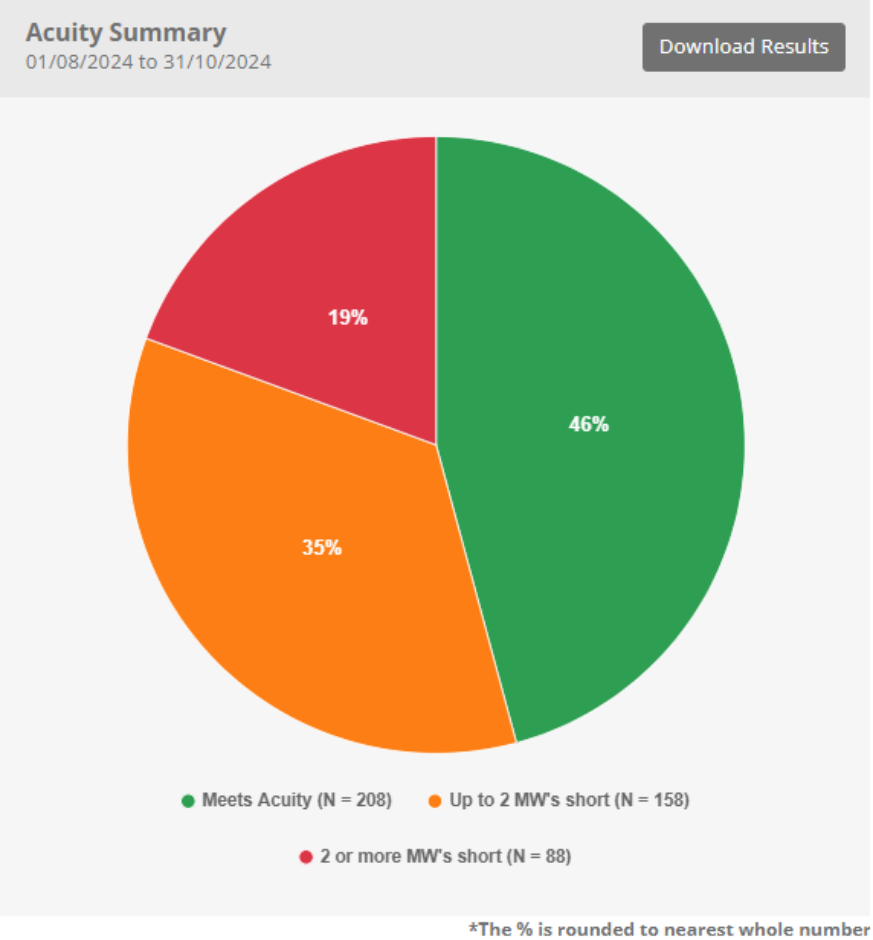
The Birth Rate Plus Live Acuity Tool is implemented in the intrapartum areas and other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the

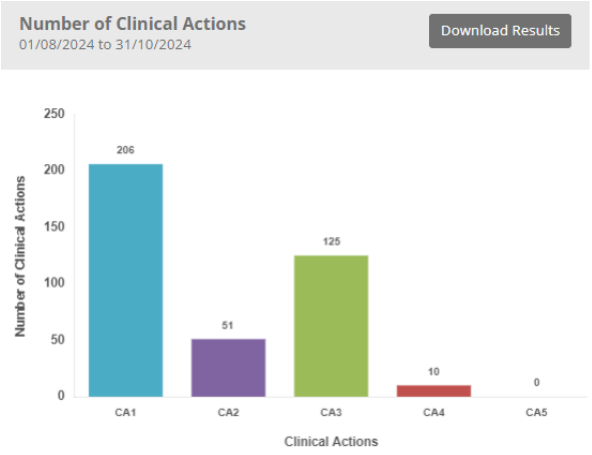
minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

This chart below demonstrates the outcomes of the TWH Delivery Suite acuity tool records for August to October 2024, showing recommended staffing levels were achieved for 46% of entries, 35% of entries show up to 2 midwives' shortfall and 19% more than 2 midwives short, with an entry compliance rate of 82%.



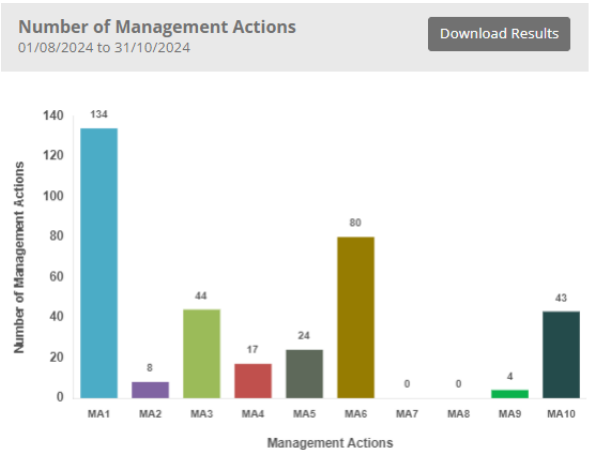
The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.



Number of Clinical Actions
01/08/2024 to 31/10/2024 — Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay of more than 4 hours for ARM/ Augmentation	206	53%
CA2	Delay in Commencing IOL	51	13%
CA3	Delay In Continuing IOL	125	32%
CA4	Delay In Elective LSCS	10	3%
CA5	Refusal of In-Utero Transfers Due To Acuity	0	0%
TOTAL		392	

*The % is rounded to nearest whole number



Number of Management Actions
01/08/2024 to 31/10/2024 — Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeply Staff Internally	134	38%
MA2	Redeploy Staff Externally	8	2%
MA3	Staff Unable To Take Breaks	44	12%
MA4	Staff Stayed Beyond Rostered Hours	17	5%
MA5	Management/ Specialists Working Clinically	24	7%
MA6	Instigate Escalation Policy	80	23%
MA7	Cancel Study days	0	0%
MA8	Cancel Meetings	0	0%
MA9	Transfer To Neighbouring Sites	4	1%
MA10	On call Midwives Utilised	43	12%
TOTAL		354	

*The % is rounded to nearest whole number

This demonstrates the challenge with our induction of labour pathway. This is being reviewed with fresh eyes as an A3 project and will be reported on at Strategic Deployment Review Meetings, as well as in internal meetings

8. Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

The following table outlines the compliance by month This data is extracted from daily MOPEL status report. Any occurrence of a breach of coordinator status will be recorded on InPhase

	Compliance
March 2024	100%
April 2024	100%
May 2024	100%
June 2024	100%
July 2024	100%

August 2024	100%
September 2024	100%

9. One to One in Established Labour

Women and birthing people in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

	March	April	May	June	July	August	Sept
Maidstone Birth Centre	100%	100%	100%	100%	100%	100%	100%
Crowborough Birth Centre	100%	100%	100%	100%	100%	100%	100%
Labour Ward Tunbridge Wells	100%	100%	100%	100%	100%	100%	100%

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

Delivery Suite Red Flags, September 2024

Headlines

56 recordings of delayed inductions there may be more than recording of each episode - see graph on next slide

2 episodes of no 1:1 care in labour, both on the same day, no InPhase reports regarding this. This is not validated on E3 so most likely 1:1 care for a high dependency lady rather than labour

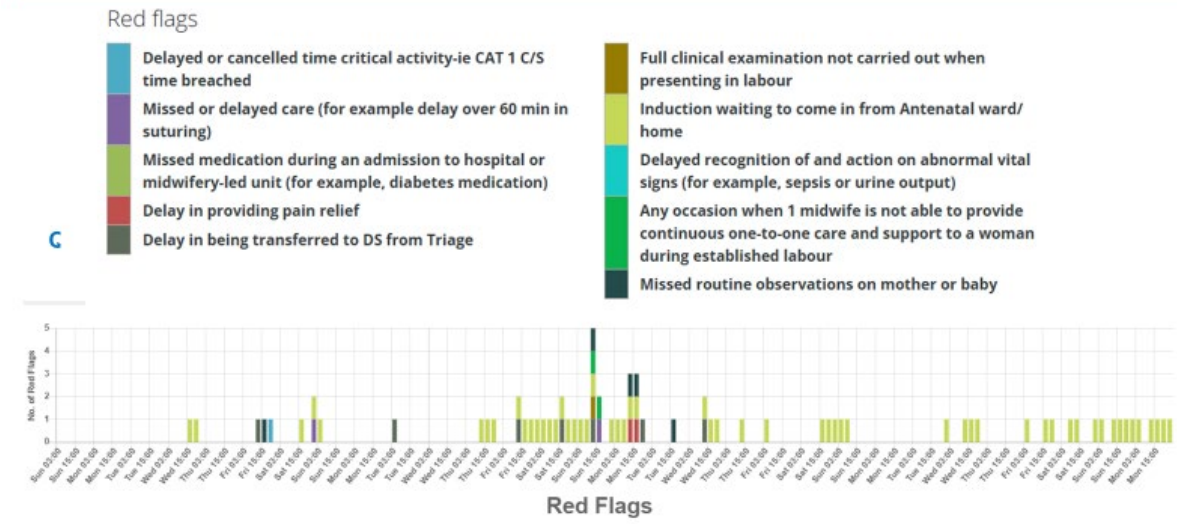
Future validations of entries will be reviewed more regularly and frequently to validate with reporting coordinators.

Please note
Errors made on the acuity tool can only be edited in a 30 minute window.

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity-ie CAT 1 C/S time breached	1	1%
RF2	Missed or delayed care (for example delay over 60 min in suturing)	2	3%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	2	3%
RF5	Delay in being transferred to DS from Triage	7	9%
RF6	Full clinical examination not carried out when presenting in labour	1	1%
RF7	Induction waiting to come in from Antenatal ward/ home	56	74%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	2	3%
RF10	Missed routine observations on mother or baby	5	7%
TOTAL		76	

*The % is rounded to nearest whole number

Delivery Suite Red Flags, September 2024



This demonstrates the challenge with our induction of labour pathway. This is being reviewed with fresh eyes as an A3 project and will be reported on at Strategic Deployment Review Meetings, as well as in internal meetings

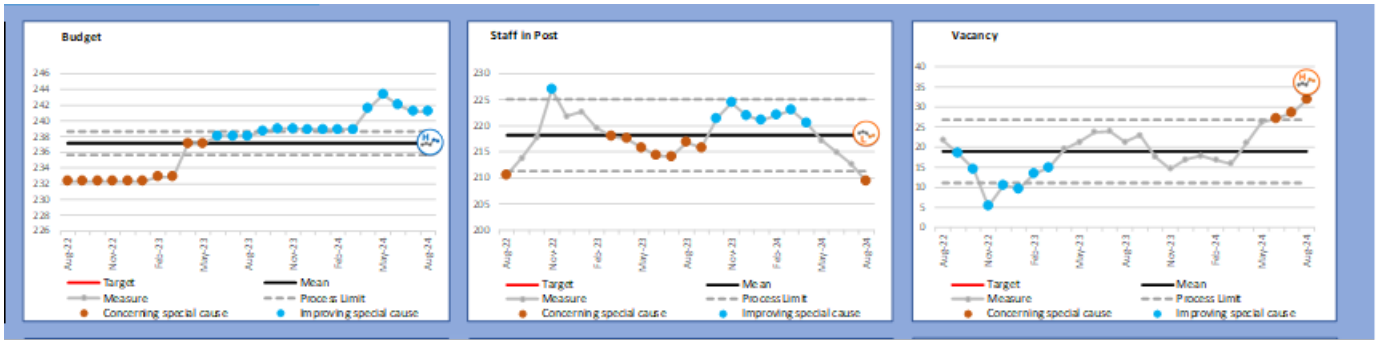
Midwifery red flags are monitored and incident reports submitted where applicable in order to identify and minimise any associated risks.

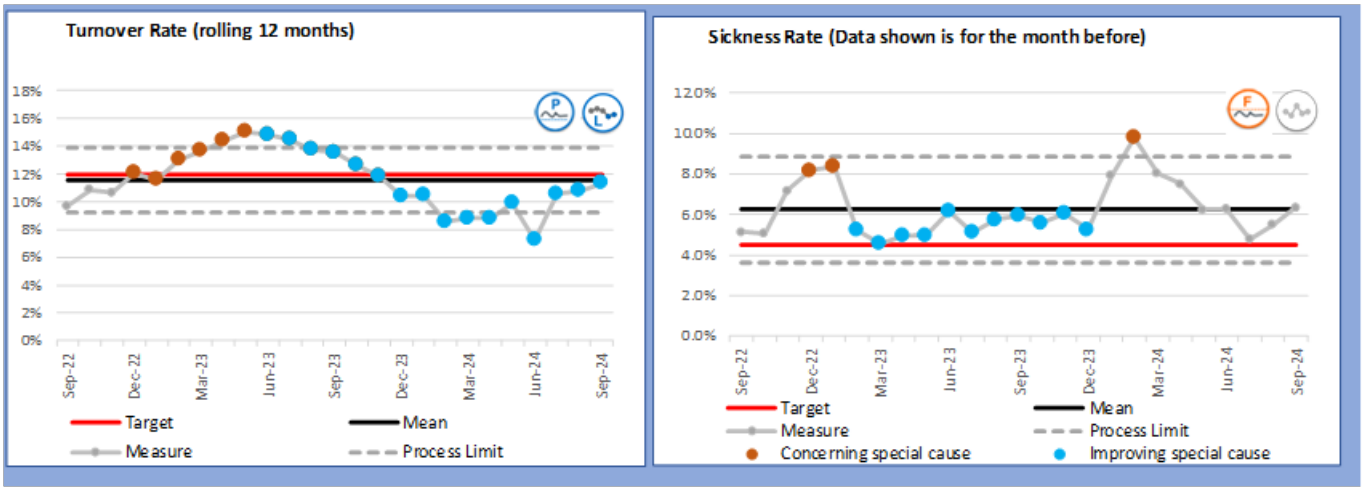
11. Midwifery Vacancy and Recruitment

The table below presents the current workforce position for Midwifery registered and Nursing registered as at September 2024. As can be seen in the graph we have a slight increase in the vacancy rate, part of this is due to the new roles as part of the Maternity Business Plan as well as leavers. The turnover rate is currently 11.3%, with 4 staff leaving within the month due to retirement, promotion and work life balance. The division will be linking in with the People Promise flexible working workstream, to review any learning and in discussion within the division is two manager sign-off for all flexible working application to ensure consistency and fairness. The sickness rate has increased slightly over the last couple months, largely due to long term absence which is being proactively through collaborative working between Manager and ER Advisor and offering support from the Trust as appropriate. There are now monthly recruitment meetings with the Deputy Chief Nurse for Workforce & Education and Head of Resourcing to ensure that corporate support is given with recruitment campaigns. In addition, the Division have recently recruited a Band 4 Workforce Coordinator and have plans to develop a recruitment tracker to track starters and leavers in real time.

Staff Group	Budget WTE	Staff In Post	Vacancy	Vac. Rate	Starters	Leavers	Turnover	Sick Rate
Nursing and Midwifery Registered	**254.5**	**214.7**	**39.8**	**15.6%**	**1.8**	**3.1**	**11.3%**	**6.4%**
Midwifery Registered	241.2	207.9	33.3	13.8%				
Nursing Registered	13.3	6.8	6.5	48.8%				

The graph below presents Midwifery registered workforce.





11.1 Current Pipeline

The table below represents our midwifery recruitment pipeline, and we have been working closely with recruitment team and corporate nursing in recruiting to recruit to our vacancies. You can see from the table below we have 32.79 wte in the recruitment pipeline (both internal and external candidates). We have 11 candidates booked start dates over the next few months into January 2025. For newly qualified midwifes, the information remains unchanged from last month with 2 staff commenced in September, 9 wte due in January 2025 and 9 wte due in April 2025.

For community, we have established the teams do not have high vacancy levels against their budget, and with current recruitment pipeline will have a vacancy of 2.54 wte. That said, we do need to review this against the model for midwife to caseload numbers compliance as we are showing as an outlier. Birthrate plus states that the acceptable levels are 1:95 (midwife to woman or birthing person) and currently the ratio is 1:114. The estimated additional staff needed will be calculated and included in the safe staffing review due to be completed end of November 2024.

The table below represents our Midwifery recruitment pipeline.

	Vacancy	Live Vacancy Pipeline	Applicant Pipeline	Start date booked	Total Pipeline	Remaining Vacancy
Band 5	8.5	0	1.0	7.0	7.0	1.5
Band 6	25.7	11.03	4.31	3.85	18.89	6.81

Band 7		4.1	2.8	0	6.9	

11.2 Domestic Recruitment

The recruitment events have recently been refreshed to run as combined RN/HCSW open days on Saturday's every 6 weeks. These events enable candidates to visit the site, meet members of the clinical team with the option of an interview and potential job offer on the day.

Student Nurses and Midwives are given the opportunity to join the Trust once they have qualified and are invited to complete an expression of interest form in their third year of training. Where possible students are allocated their preferred choice depending on vacancies.

11.3 Nurse to Midwife conversion

To assist with our maternity workforce a new programme is being offered to Registered Nurses to complete a two-year conversion course to become a Midwife. There are 6 funded spaces available to RNs who would embark on an academic programme with placements in the maternity department. Currently there are 2 nurses on the Sept 2024 and will qualify in September 2026.

11.4 International Recruitment

To date 3 Internationally Educated Midwives (IEM) have been recruited to. Currently our IEMs have to complete their OSCE training at another location as we do not provide the training here at MTW due to the low number of candidates, this provides a financial challenge and as such there are no further plans to recruit IEMs.

12. Obstetric staffing

Consultants:

Funded posts WTE	SIP WTE	Mitigation	Next Steps
18	15	2. x Locum 1 Locum in recruitment process	4 New Posts approved: 1 x Fetal Medicine 1 x High Risk Obstetrics 1 x Endometriosis 1 x General Gynae

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent

further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

An audit is undertaken twice a year to review consultant attendance. The most recent audit (Jan-Jul 2024) showed that Consultants attend 94% of the time when informed that there was a clinical situation they must attend. The main occasions consultants are not attending is when there is a PPH of >2 litres. This is due to late escalation and then bleeding having stopped when the consultant was informed and so attendance would not make any significant positive impact to outcome. Audit and suggested next steps are on the attached presentation:

consultant attendance Jan - Jul

For note, Consultant attendance was 100% for August and September 2024.

Trusts should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

The RCOG guidance was used to develop the attached SOP which was implemented in January 2024. A tracker is used by the Directorate to collate the data and ensure evidence is collected.

SOP - Medical Agency and Internal

O&G medical action plan MIS 6- 2

The Trust needs to report on the compliance with the engagement of Long Term Locums criteria. The compliance against these criteria is 100%

Data is reported monthly to the Women's Directorate Board and then via PQSM to the Maternity and Neonatal Assurance Board (MNAB). The safety champion and LMNS both attend MNAB.

Trusts should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

The RCOG guidance for non-resident consultants and SAS doctors has been implemented. Compensatory rest is recorded on the attached tracker and reported monthly at the Women's Directorate Board:

Copy of Safety action 4-Compensatory rest

13. Anaesthetic staffing

For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

There is 24h anaesthetic cover for Obstetrics. The allocated anaesthetist does not have any additional duties other than cover in obstetrics/delivery suite (they do not cover elective obstetrics):

Month	July 2024	August 2024	September 2024
% compliance	100%	100%	100%

14. Neonatal medical staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

Junior Medical Staffing - compliant with BAPM standards and form part of the paediatric and neonatal formal rota

Neonatal Consultants – The paediatric and neonatal rota are now separated and currently 6 Neonatal consultants are in post on a 1:6 rota. Business case under development to increase to a seventh Neonatal consultant to match updated BAPM standards from 2025.

15. Neonatal nursing staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

- The Neonatal unit does not meet BAPM standards for nurse staffing and this is demonstrated in the PQSM report and an action plan is in place to support the staffing gap

- Safe staffing reviews in place yearly for the neonatal unit with trust leads. Funding approved following last year's safe staffing review for Band 7 Supernumerary Shift leaders with a phased approach. We have commenced interviews with substantial support from HR and Recruitment teams to optimise applications for these band 7 coordinator roles

- There is a national shortage of QIS (Qualified in Speciality Nurses) and despite extensive recruitment efforts this remains challenging with an action plan place for substantive and bank/ agency recruitment
- There is a formal training programme in place to develop QIS trained staff and there are currently two nurses waiting for QIS results and two further started the course this September.
- Nurse staffing (detailed in September quarterly network data) 54.3% of the total nursing workforce is Qualified in Speciality (QIS) against a national target of 70%. This has increased slightly from 54% in March 2024.
- To support the gap in band 6 staff, as not supported in previous business cases we have increased the bank and agency availability for QIS staff with 9 additional QIS staff now available on agency lines and further work is ongoing on this

Neonatal Nurse Staffing – Sept 2024 (from Badgernet)				
	% shifts staffed to BAPM recommendations	**% of shifts QIS to toolkit**	**% of shifts with supernumerary shift leader**	**% of nursing workforce Qualified in speciality (QIS)**
MTW	**83.33**	**85.19**	**3.7**	**54.3 (reported quarterly by network)**
National Comparison (Level 2 units)	**80.11**	**74.06**	**61.32**	**70% BAPM recommended target**

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN)

The neonatal safe staffing review occurs yearly and the action plan for staffing workforce tool is shared with the ODN on a quarterly basis

Role Specific Training (Newborn Life Support)	**Compliance*** (Target 90%)		**Compliance*** (Target 90%)
Nursing Staff: band 5 and above	**93.7%**	Specialist Trainees and Permanent NNU doctors	**100%**
ANNP's	**100%**	Foundation doctors and GP trainees	**100%**
Consultants	**100%**		

16. Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes compliance with BAPM standards for both neonatal nurse staffing and neonatal medical workforce if compliance is met, or agree to the action plan if not met.

17. Action Plan for Maternity Incentive Scheme, Safety Action 4

Recommendation	Action	Owner	Timeframe
Consultant Attendance			
Ensure all staff are aware that all PPH over 2 litres need to be notified to the Consultant	Add to PROMPT study day	MA	October 2024
Ensure all doctors in training know the criteria for contacting the Consultant	Add to Drs Induction	OW	October 2024
Present Consultant Audit at Clinical Governance	Confirm date	OW	November 2024
Long and Short Term Locums			
Long Term Locums Trust should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance or an action plan	Yearly audit programme of locum process compliance to be developed with medical staff booking	AL	September 2024
	Develop robust process of ensuring locum documentation is completed and filed	AL	New tracker implemented. New process and responsibilities to be agreed.
	Set up service line reporting monthly to Directorate Board to provide assurance	PQSM lead	Added to PQSM for September
Neonatal Medical Staffing			
Need to move from 1:7 to 1:6 rota	A business case is in progress to secure the funding for an extra WTE consultant post	AL	January 2025
Neonatal Nursing Staffing			
Does not meet BAPM standards	Recruit band 7 coordinator - roles are currently out to advert	LM/JT	December 2024
	A business case is in progress to include funding for posts which have not been approved previously	LM/JT	December 2024
	There are currently two nurses waiting for QIS results and two further started the course this September	LM/JT	September 2024 September 2025

Maidstone and Tunbridge Wells NHS Trust

Q1 2024/2025 Perinatal Mortality Surveillance Model Report

19th November 2024

Summary

The enclosed PMRT reports provides an overview of the reviews using the Perinatal Mortality Review Tool and compliance against Safety Action 1 for the Maternity Incentive Scheme Year 6

1. All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days	100%
2. Seek parent's views of care: For at least 95% of all deaths of babies in your trust eligible for PMRT review, Trust should ensure parents are given the opportunity to provide feedback, share perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards	100%
3. c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within 6 months.	100%

- MTW stillbirth rate was 2.7 per 1000 for the year of 2023. National data will not be available until the end of the year 2024. National rate for 2022 was 4 per 1000.
- Q1 reported 4 stillbirths and 0 neonatal deaths. 2 of the cases had an undetermined cause of death with no direct learning. The remaining 2 other cases had areas of learning which included lack of adherence to the "Reduced Fetal Movement" Guideline, and lack of awareness and understanding regarding Parvovirus. Full actions are in the report.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Perinatal Mortality Review Summary April to June 2024

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Maidstone and Tunbridge Wells NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/4/2024 to 30/6/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *5*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
6	2	0	4	1

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
1	1	0	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK

Cause of death

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 4)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**4 causes of death out of 4 reviews**
	The cause of death was undetermined
	Infection
	The cause of death was undetermined
	Congenital Parvovirus infection
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

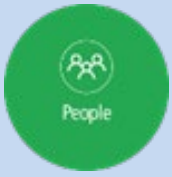
Actions

Perinatal Case ID	Issue Text	Outcome Contribution	Contributory Factor	Issue comment	Action plan text	Implementation text	Person responsible	Target completion date
92741/1	This mother had oligohydramnios or polyhydramnios during her pregnancy which was not managed according to national or local guidelines	Not relevant to the outcome, but action is needed	Task Factors - Guidelines, Policies and Procedures	The review group agreed that fetal medicine input should have been sought when the polyhydramnios was diagnosed	Department to adapt Medway polyhydramnios guidance for local use	Allocated consultant to liaise with Medway Fetal Medicine Unit and obtain guidance	Chief of Service	31/12/2024
93250/1	This mother presented with reduced fetal movements but on the basis of her scans and/or other investigations an appropriate management plan was not put in place	Relevant and future action needed	Task Factors - Guidelines, Policies and Procedures	The current Trust guidance for 'Reduced Fetal Movements (RFM)' advises that with ≥2 episodes of RFM an Antenatal Clinic appointment should be arranged. This was not completed	Share learning with obstetric team involved	Obstetric Consultant Lead for Maternity Risk to share this learning with the obstetric team who reviewed [redacted] on this day	Obstetric Consultant Lead for Maternity Risk	31/08/2024
93250/1	This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	Relevant and future action needed	Task Factors - Guidelines, Policies and Procedures	The current Trust guidance for 'Reduced Fetal Movements (RFM)' advises that with ≥2 episodes of RFM an Antenatal Clinic appointment should be arranged. This was not completed	Share learning with obstetric team involved	Obstetric Consultant Lead for Maternity Risk to share this learning with the obstetric team who reviewed [redacted] on this day	Obstetric Consultant Lead for Maternity Risk	31/08/2024

93250/1	This mother's risk status during labour was assessed and it had changed but she was not managed appropriately	Relevant and future action needed	Task Factors - Guidelines, Policies and Procedures	[redacted] was not advised to come to Tunbridge Wells Hospital within 24 hours of her waters breaking, she was advised to call Antenatal Ward (ANW) at 0800 the following day which was 37 hours following membrane rupture.	Obtain agreement on amendment required to Induction of Labour guidance regarding expectant management of pre-labour rupture of membranes at term	Guideline to be approved through Guideline Group, ratified through Maternity Risk and Review Group (MRRG) and published.	Compliance and Safety Midwife	31/12/2024
93573/1	This mother had viral issues relevant to maternal and/or fetal outcome during her pregnancy and there was a delay in the diagnosis	Relevant and future action needed	Task Factors - Guidelines, Policies and Procedures	MTW 'Parvovirus in Pregnancy' policy was not followed correctly.	- Patient information (from NHS website) to be shared on MTW website and social media page(s). - 'Referral following exposure to Parvovirus in Pregnancy' guideline to be shared with all maternity staff. - Discussion with A&E manager to ensure staff are made aware of the correct pathway of care	- Governance team to discuss with Digital Midwives about sharing information on social media pages - Guideline to be shared via 'Take 5' and GLOW updates - Governance Team and Bereavement Team to arrange a meeting with A&E department to share learning	Governance Team	30/09/2024

93573/1	This mother had viral issues relevant to maternal and/or fetal outcome during her pregnancy which was not managed according to national or local guidelines	Relevant and future action needed	Task Factors - Guidelines, Policies and Procedures	MTW 'Parvovirus in Pregnancy' policy was not followed correctly.	- Patient information (from NHS website) to be shared on MTW website and social media page(s). - 'Referral following exposure to Parvovirus in Pregnancy' guideline to be shared with all maternity staff. - Discussion with A&E manager to ensure staff are made aware of the correct pathway of care	- Governance team to discuss with Digital Midwives about sharing information on social media pages - Guideline to be shared via 'Take 5' and GLOW updates - Governance Team and Bereavement Team to arrange a meeting with A&E department to share learning	Governance Team	30/09/2024

Title of report	**Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)**					
Board / Committee	**Executive Team Meeting**					
Date of meeting	26th November 2024					
Agenda item no.	11-16					
Executive lead	Rachel Jones. Director of Strategy, Planning and Partnerships					
Presenter	Rachel Jones. Director of Strategy, Planning and Partnerships					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	☐

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	☐	☐	☐	✓	☐

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This is the monthly update on the activities and focus within the Integrated Care Board and West Kent Health Care Partnership. Areas of focus are finance, pathway 1 capacity/winter planning and INT development.		
Any items for formal escalation / decision	None		
Appendices attached	None		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
Executive Team Meeting		12/11/24	

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: •
Links to Corporate Risk Register (CRR)	Please list any risks on the Corporate Risk Register to which this report relates •
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report •

NHS
Maidstone and Tunbridge Wells NHS Trust

University Hospitals Sussex NHS Foundation Trust

ICB and West Kent HCP update

November 2024

Exceptional people, outstanding care

ICB/ System news

- The K&M system has been placed in level 4 financial oversight by NHSE.
- This reflects low confidence in our ability to deliver our plans and may ultimately affect our oversight framework rating too.
- The ICB is developing a Sustainable Health Care Unit which will be repository of impact and financial information linked to reducing health inequalities. This being led by the Chief Medical Officer and HI team.
- NHS K&M launched its 5 year Primary Care Strategy in October.

West Kent HCP

- The Development Board away day took place on 23rd October. The focus remains on developing INTs, HCP relationships and health inequalities.

- The HCP continues to drive implementing the better use of beds programme in West Kent. The areas of focus have now been agreed and we are working to cross reference across all partners existing work as we do not want to duplicate.

- The HCP has been focussed on working closely with the ICB on the re-provision of out of hours services and the significant issues in discharge delays caused by the transition from Hilton to KEaH +.

West Kent HCP

- The process to TUPE the HCP staff is complete with staff coming across on 1st November as planned. There are remaining issues to resolve around IT, IG and finance but actions are in place.

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services and 2022/23 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue and nursing capacity pressures in secondary care.
- *Demand pressures* - Pressures across WK system arising from range of sources including: planned care backlog; Covid/Post Covid related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.
- *Finance pressures* – the system pressures and focus on financial balance is likely to have an impact on the development activities of the HCP for 23/24 and 24/25.

Title of report	**Ratification of Standing Orders, Standing Financial Instructions; and Reservation of Powers and Scheme of Delegation (annual review)**					
Board / Committee	**'Part 1' Trust Board meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-17					
Executive lead	Miles Scott, Chief Executive					
Presenter	Louise Thatcher, Trust Secretary					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	☐	✓	☐	✓	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Trust has committed to reviewing the Trust's Standing Orders, Standing Financial Instructions (SFIs) and Reservation of Powers and Scheme of Delegation (SoD) each year. The last such review was undertaken in May 2023. In March 2024 however the Chair of the Audit and Governance Committee then however agreed to a short deferral request, to enable the review to be undertaken in November 2024. The three documents have therefore been reviewed and updated, and some proposed changes have been made. The documents were circulated widely for consultation by email on 17/10/24, which included all members of the Trust Board, and then "approved" (as submitted) by the Audit and Governance Committee on 07/11/24. The Trust Board is now asked to "ratify" the documents, to enable them to be published via the Trust's intranet. As had been the case for the annual reviews in the past few years, the full documents, with the proposed changes shown as 'tracked', have been made available to Trust Board members as supplements to the formal 'pack' of Trust Board reports[1].
Any items for formal escalation / decision	To ratify the changes to the Standing Financial Instructions, Standing Orders and Scheme of Delegation
Appendices attached	There are no appendices to this report

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Audit and Governance Committee	07/11/24	Approved to proceed to Trust Board, for ratification
Finance and Performance Committee	26/11/24	Provided for information.

[1] The three supplements are available via the "Documents" section of the Admincontrol meetings portal ("Documents>Trust Board>Trust Board Meetings (Part 1)>2024>05.28.11.24>Standing Orders, Scheme of Delegation and SFIs (track changes versions)")

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	N/A
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	The Standing Financial Instructions, Standing Orders and Scheme of Delegation are the main mandatory governance documents for the Trust

The proposed changes to the Standing Financial Instructions are as follows:

- Updates relating to statutory and regulatory guidance e.g. Cabinet Office Commercial spend controls, the Health Care Services (Provider Selection Regime) Regulations 2023, the Code of Governance for NHS Provider Trusts
- Update to responsible post holders e.g. DPO, SIRO
- Update to Audit section for inclusion of the Risk and Regulation Oversight Group, and the prospective move to Global Internal Audit Standards from January 2025 (section 2)
- Inclusion of ICB/ICS governance elements e.g. recovery controls and capital approval processes (e.g. section 4)
- Expansion of Annual Accounts section to include National Cost Collection (section 5)
- Inclusion of Cabinet Office Spending controls (section 4, section 8 etc). N.B. the largest Commercial Activity category has been confirmed as applying to the NHS from May 2024 and the relevance of the other categories has been clarified by the Cabinet Office via NHSE.
- Updates to section 8 for public procurement regime changes and proposed increase of quotation requirement level from £10k to £12.5k
- Updates to section 9 NHS contracts to include Provider Selection Regime regulations, and to clarify requirements for new contract services
- Staffing section 11 updates to funded establishment section, staff appointment rules, and exit pay regulatory limits.
- Non-Pay section 12 updated for ICS elements, and for inclusion of credit card section to cover the Procurement purchasing card
- Borrowing section 13 updated to latest NHSE regime
- Capital Investment section 15 updated for ICB and Cabinet Office approval requirements, and addition of detail in IFRS 16 leasing
- Section 24 Insurance section updated for third party equipment on site
- Annex B financial limits updated for changes
- Appendix 1 Process requirements updated
- Appendix 3 Equalities Impact Assessment updated
- Updated cross references.
- Non-material ‘housekeeping’ changes (changes to job titles etc.)

The proposed changes to the Reservation of Powers and Scheme of Delegation are as follows:

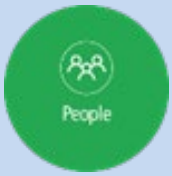
- Update of document section for regulatory guidance e.g. Procurement Act 2023, Cabinet Office Spending controls (now rolled out to NHS progressively), Code of Governance for Provider Trusts.
- Update to section 1 to replace Accountability code with Provider Code of Guidance.
- Update of 2.7 to include ICS/ICB capital threshold limit.
- Section 3.3.1 Authorisation of orders and Section 3.3.2 Authorisation of invoices, both updated to separate out existing capital limits for greater clarity.
- Section 3.3.3 Business Cases updated to include both the ICB/ICS capital approval levels and also the Cabinet Office Spending Controls (commercial activity – other categories of spend to be confirmed as applicable).
- Section 3.3.4 Purchasing/tendering/contracting updated for public contract levels, and Tender Receipt amendment to reflect use of e-portal.
- Section 3.16 Workforce and Pay: inclusion of vacancy panel and bank controls; addition of VSM appointment thresholds for approval; update of Exit package limits for approval.
- Section 3.37 & 3.38: consolidation of requirements relating to gifts/hospitality register.
- Housekeeping changes (e.g. job titles, amendments to Appendix 1 on Process requirements and Appendix 3 on EIA)

The proposed changes to the Standing Orders are as follows:

- Addition of Fordcombe Hospital to Trust’s principal places of business
- Amendment of the “Process requirements” (appendix 1) to reflect the process for the notification of Trust staff in relation to any policy publications or changes.
- Complete restructure of the ‘Trust Committee structure’ (appendix 6) to reflect the revised Committee structure implemented following the Deloitte LLP external governance review

- Amendment to the ‘Procedures to comply with the ‘Fit and Proper Persons: Directors’ Regulations and Fit and Proper Persons Test Framework’ (Appendix 5) to reflect the proportional approach adopted in response to social media checks
- Inclusion of the responsibility of Divisional Directors of Operations in regards to Risk Management.
- Provision of clarification that an electronic signature, if appropriate authorised, can be used for signing the Trust Board minutes.
- Non-material ‘housekeeping’ changes (changes to job titles etc.).

Title of report	**Health & Safety Annual Report, 2023/24 and agreement of the 2024/25 programme**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-18					
Executive lead	Sarah Davis, Chief Operating Officer					
Presenter	Caroline Gibson – Head of Health and Safety					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	☐	☐	✓	☐	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Section 2.2 – Health and Safety Issues updates for 2023/2024 Section 3 - Of the twelve objectives set for 2023/2024 only five were achieved, with five partially met Section 6.1 – Enforcement Notices update following HSE inspection Section 6.2.1 - Health and Safety Executive (HSE) - Recommendations for Managing Violence and Aggression and Musculoskeletal Disorders in the NHS
Any items for formal escalation / decision	Section 4 - Agree the work programme and objectives for 2024/2025
Appendices attached	• Appendix A – Legal Cases

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Health and Safety Committee	22/08/2024	Approval at Risk and Regulatory Oversight Group
Risk and Regulatory Oversight Group	01/10/2024	Approval at Audit and Governance Committee
Audit and Governance Committee	07/11/2024	No actions

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Not applicable
Links to Trust Risk Register (TRR)	Not applicable
Compliance / Regulatory Implications	Not applicable

NHS
Maidstone and Tunbridge Wells NHS Trust

REPORT TO: Trust Board

REPORT FROM: Head of Health and Safety

DATE:

SUBJECT: Health and Safety Annual Board Report 2023/2024

AGENDA ITEM NO: XXX

Executive Summary	The purpose of this report is to provide assurance on compliance with Health and Safety legislation and Trust policies to the Trust Board. Included within the report is statistical analysis and key information regarding health and safety activity, audit programme and progress, training compliance, reported incidents, Reporting of Injuries, Diseases and Dangerous Occurrences incidents and investigation outcomes, together with monitoring and responding to the health and safety needs of the Trust.			
	Of the twelve objectives set for 2023/2024 only five were achieved, with five partially met, for further details please see section 3.			
	This is the thirteenth health and safety annual report produced. The report and purpose of it conforms to the Trusts Health and Safety Policy and Procedure, Safety Representatives and Safety Committees Regulations 1977 and Health and Safety (Consultation with Employees) Regulations 1996.			
	Assurance	X	Approval	X
Action required by Trust Board	1) To discuss the content of the report 2) Agree the work programme and objectives for 2024/2025			

Committee / Group and date submitted:	Health and Safety Committee				22/08/2024
	Risk and Regulation Oversight Group				01/10/2024
	Audit and Governance Committee				07/11/2024
Trust Strategic Initiatives (please mark with 'X' the box to indicate)	**People - X**		Patient Experience		Patient Safety and Clinical Effectiveness
	Patient Access		Systems		Sustainability
Relevant CQC Domain (please mark with 'X' the box to indicate)	**Safe X**	Effective	Caring	Responsive	**Well-Led X**
Document reviewed by:	Deputy Chief Operating Officer (Deputy Chair of the Health and Safety Committee)				

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2024/25

Requested / Required by:	Trust Board and the Trust Management Executive • Health and Safety at Work etc Act 1974. • Management of Health and Safety Regulations 1999.
Main author:	Head of Health and Safety (Caroline Gibson) Contact Details: cgibson1@nhs.net
Other contributors:	Head of Occupational Health Head of Security Management Radiation Protection Adviser (RPA) Lead Nurse for Falls Prevention Vascular Access Specialist Practitioners Moving and Handling Advisor Water Hygiene Manager
Document lead:	Chief Operating Officer (Board lead for Health and Safety)
Directorate:	Corporate
Requirement for document:	This annual report and programme: • Reviews the Trust's health and safety statistics and performance for 2023/24 • Makes an assessment against objectives and KPIs set in the previous year • Gives a discussion into key health and safety issues identified within the year • Discussion document for the Board to determine the objectives for 2024/25 • Identifies the strategy and action plan for the next year and going forward
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by Trust key policies and procedures: • Health and Safety Policy and Procedure • Risk Management Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016
18	Sixth annual Board Report	August 2017
19	Seventh annual Board Report	August 2018
20	Eighth annual Board Report	August 2019
21	Ninth annual Board Report	August 2020
22	Tenth annual Board report	August 2021
23	Eleventh annual Board Report	August 2022
24	Twelfth annual Board Report	August 2023
25	Thirteenth annual Board Report	August 2024

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1) Introduction

The Annual Health and Safety report enables an appraisal and overview of the health and safety function to the Maidstone and Tunbridge Wells NHS Trust Board (hereinafter referred to as the Trust).

The purpose of this report is to provide assurance on compliance with legislative and regulatory requirements, and Trust policies to the Trust Board and Health and Safety Committee.

Health and Safety covers several elements for staff, patients and visitors including:

- Slips and Trips
- Manual Handling
- Violence and Aggression / Challenging Behaviour / Conflict
- Lone Working
- Work-Related Stress
- Driving at Work
- Hazardous Substances (COSHH)
- Radiation
- Management of Sharps
- Provision and Use of Work Equipment including Display Screen Equipment
- First Aid
- General Working Conditions
- Office Safety

Elements of bullying and harassment; safety of medical devices; food safety and hygiene; infection prevention control; premises compliance, radiation and fire safety tend to overlap within the remits of health and safety, however these areas are directly managed by separate services in the Trust, and therefore will not be referenced within this report.

There are many programmes and initiatives for Patient Safety therefore this report concentrates on staff, public and Trust safety.

2) Key Findings

2.1 - Statistics

- Overall reporting rates for staff, Trust and public incidents have decreased by 7% compared with 2022/23.
- Moving and Handling saw a reduction in harm incidents by 3%. There were 5 Moving and Handling-related RIDDOR incidents.
- The number of incidents reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) increased by 1 to 22 in 2023/24.
    - The number of over 7-day injuries increased to 15 (compared to 14 for 2022/2023)
    - Specified injuries increased to 6 (compared to 5 for 2022/2023)

- Dangerous occurrences decreased to 1 (compared to 2 for 2022/2023).

- Slips, trips and falls accounted for 11 of the RIDDOR incidents
- Medicine and Emergency Care Division had the most RIDDOR reportable incidents with 6
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.
- Reporting rates have decreased by 7% this can be due to the change to InPhase currently a patient-centric focused reporting system

2.2 - Health and Safety Issues

- Entonox
  In December 2022 the issue was raised in regard to workplace exposure limits for nitrous oxide in our Maternity settings following prevention of use of Entonox at East Kent Hospital. The Health and Safety team completed a risk assessment and worked with Estates team at Maidstone Hospital and Mitie Services at Tunbridge Wells Hospital to review the ventilation of the area. The Deputy Chief Pharmacist arranged for personal dosimeters for staff to wear to understand the level of Entonox exposure, there were only two instances where levels were over the workplace exposure limit and this were attributed to one room in each Birthing Centre that had been used in an emergency due to capacity levels.
  Ongoing work is being undertaken by the Estates department to ensure that the ventilation system and appropriate number of air extract changes are compliant, this is required for Maidstone Birth Centre and Crowborough Birth Centre. This is being monitored through the Trusts Ventilation Committee.

- Patients at Risk of Suicidal Ideation at Tunbridge Wells Hospital
  There have been incidents of absconding patients attempting self-harm/suicidal ideation by climbing over the low-level wall and shrubbery by the Women's and Children's emergency entrance at Tunbridge Wells Hospital, there is a three storey drop from the multi-storey car park in this area.
  A risk assessment and subsequent external report has identified that there is insufficient falls protection in this area, recommendations have been made to install a fence of sufficient height and material to deter and prevent patients from accessing this hazard.
  Following an increase in incidents, including at Tunbridge Wells Hospital by the ITU/staff entrance at level -1, further work will be undertaken to review all potential areas for suicidal ideation or intentional self-harm from heights across the Trust in 2024/2025.

- Violence and Aggression in the Emergency Departments
  The Emergency Departments are experiencing a significant increase in patients presenting with violence and aggressive tendencies, these could be attributable to patients diagnosed with dementia, an addictive disease or those suffering from a mental health crisis. Risk assessments have been undertaken for the threat of violence and aggression towards staff at Maidstone Hospital following one significant incident, recommendations have been made to review the current layout of the emergency department, the location and allocation of panic alarms in addition to the increase in CCTV.
  Work is on-going with the Security team to provide the staff with a safe place of work. Funding for improved CCTV in the Emergency Department and Acute Assessment Unit at Maidstone Hospital was secured in 2023/24. Funding for improved CCTV and panic alarm in the

psychiatric assessment room at Tunbridge Wells Hospital has been approved for 2024/25. It is essential that all Emergency Department staff attend Conflict Resolution every three years.

- Environmental Ligature Risk Assessments
  Following the development and implementation of the new Environmental Ligature risk assessments the Divisions have worked hard this year to ensure that these have been completed to identify the high-risk areas within their wards and departments. This will contribute to the individual risk assessment for any patient who attends or is admitted with tendencies/actual self-harm or suicidal ideation.
  There is work in progress to link the Environmental Ligature risk assessment and guidance to a new policy and procedure for patients at risk of self-harm and/or suicidal ideation.

3) Review of Objectives set for 2023/2024

Objective	Leads	Progress and Comments	Met / Partially Met / Not Met
Health and Safety Management			
To roll out a new health and safety electronic management system. This had been pushed back a year due to Synbiotix being renewed for additional year and InPhase not having a health and safety Application.	Trust Health and Safety Advisor	Discussions have taken place with InPhase it is possible to utilise the existing audit module with amendments for the health and safety application.	Not met
To carry out Trust wide audit against the NHS Staff Council Workplace health and safety standards	Trust Health and Safety Advisor	On-going, 55% completion of audit. Awaiting contributions from specialist services	Partially met
To develop and pilot health and safety specific training for front line managers to better equip them with their duties	Risk and Compliance Manager / Trust Health and Safety Advisor	Due to changes within the department this has not progressed. This has been included within the Health and Strategy 2024-2027.	Not met
To ensure that the Policy and Procedure for the Control of Contractors is reviewed, updated, approved, ratified and published	Trust Health and Safety Advisor	Full review of the policy is in progress, an extension has been granted for completion by 30th September 2024 In addition to the policy review the Contractors Induction, Site Safety Rules and training for	Partially met

Objective	Leads	Progress and Comments	Met / Partially Met / Not Met
		Trust Representatives is being reviewed.	
Falls			
To reduce the monthly Trust Falls rate to at or below threshold of 5.96 per 1000 occupied bed days	Lead Nurse for Falls Prevention	As of March 2024, the threshold was 5.97 per 1000 occupied bed days.	Not met
Reduction in harm (moderate and above) each month	Lead Nurse for Falls Prevention	Total harm incidents for 2023/2024 = 36 • 20 moderate harm • 13 serious harm • 3 catastrophic This was below the KPI of 45 incidents of harm	Met
Reduction in recurrent falls each month	Lead Nurse for Falls Prevention	Unfortunately, this objective was only met for 1 month (February, 23) in the year 2022-23 with the set target being 30 recurrent falls/month.	Not met
Moving and Handling			
Roll out training for all areas within the Trust to meet their specific requirements needed to undertake Moving and handling tasks within their roles	Moving and Handling Advisor	Training needs analysis completed, looking at the delivery of this. Business case for an inhouse team to support this	Met
To develop a pathway for Bariatric/additional need patients coming into the Trust	Moving and Handling Advisor	Working alongside key stakeholders to develop pathway to be recorded into a SOP	Partially met
Audit moving and handling equipment to determine replacement plan	Moving and Handling Advisor	Audit completed, now looking at the criteria and needs highlighted within the audit	Met
Sharps/Splash			
To continue to monitor and review new sharp safety devices across the trust.	Team Lead Vascular Access Specialist Practitioner	Continuous review of safety devices and advise of appropriate alternatives if stock is unavailable and cascade training and	Met

Objective	Leads	Progress and Comments	Met / Partially Met / Not Met
		education across both Trust sites The use of all variations of devices have been incorporated into trust appropriate training courses and induction programmes. There have been episodes where cannulation and venepuncture trollies have not had sharps bins attached /or there has been supply and demand issues over the extended long weekends. VASPs have highlighted this to ward manages to ensure forward planning for sharp bin supplies.	
To continue reviewing medical sharps incidents, providing support and training where appropriate and identifying trends that require targeted intervention.	Team Lead Vascular Access Specialist Practitioner	When clinical demand has allowed, sharps injuries have been investigated by the VASPs, with both support and supplementary education provided to individuals where it has been appropriate. Due to staff shortages and increased clinical demands this has been difficult to achieve however staffing levels are now improving. VASPs are now linked up with sharps and splash injuries via InPhase highlighting sharps injuries to be investigated. There have been no identifiable trends. New sharps smart reusable sharp disposal containers have been disseminated throughout the trust and attached to procedure trollies as required and no identified problems have been highlighted.	Met

4) Objectives for 2024/2025

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Health and Safety Management					
Utilise InPhase for health and safety risk assessment for effective management and distribution of information	01/07/2024-31/03/2025	Head of Health and Safety	Health and Safety Manager InPhase Systems Lead	Health and Safety Committee	90% compliance by 31/03/2025
Engage with the Patient Safety Specialist regarding the integration of Synbiotix Health and Safety audits and inspections onto InPhase	01/05/2024-31/03/2025	Head of Health and Safety	Health and Safety Manager Patient Safety Specialist	Health and Safety Committee	90% compliance by 31/03/2025
Liaise with the Occupational Health department in the improvement of health surveillance awareness and engagement such as; • Workplace drivers • Dermatitis • Exposure to substances • Musculoskeletal Disorders	31/03/2025	Head of Health and Safety	Occupational Health Manager Moving and Handling Advisor Health and Safety Manager	Health, Safety and Welfare Group reporting into the Health and Safety Committee	Roll out and evaluation of referrals and incident reports
To complete and report on the Trust wide audit against the NHS Staff Council Workplace health and Safety Standards	31/03/2025	Head of Health and Safety	Health and Safety Manager Competent Persons Chair of Health and Safety Committee	Health and Safety Committee	Audit to be completed and report produced by 31/03/2025
Falls (Health and Safety Management)					
Staff and Public Falls	01/04/2024 – 31/03/2025	Health and Safety Manager	Head of Health and Safety	Health and Safety Committee	Target of at or below 30 incidents with harm (moderate and

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Reduce the number of harm incidents (moderate and above) for the year					above) – pending review of data from previous year
Implement inspection programme of external and internal pedestrian routes to ensure safe and prevention of incidents	31/03/2025	Health and Safety Manager	Head of Health and Safety Estates Maintenance Team	Health and Safety Committee	Reduction of falls incidents for staff and public Reduction in claims against the Trust
Moving and Handling					
Roll out training from new training needs analysis, including looking at how this is delivered and by whom	01/06/25	Moving and Handling Advisor	Learning team	Moving and Handling Strategy Group	Moving and Handling training compliance above 90% in all areas by 31/03/25
To develop a Bariatric / additional need pathway and incorporate this into a standard operating procedure	31/12/24	Moving and Handling Advisor	Occupational Therapists Physiotherapy Clinical Leads / Managers	Moving and Handling Strategy Group	Less injuries and improved patient support
Assess and review Moving and Handling equipment, looking at whether appropriate fit for purpose, work with Procurement to have a standardised equipment list	31/03/25	Moving and Handling Advisor	Procurement, Infection Prevention Control Team	Moving and Handling Strategy Group	Audits show the correct equipment used for the right task
Develop and deliver a Moving and Handling Strategy	01/01/25	Moving and Handling Advisor	Head of Health and Safety	Moving and Handling Strategy Group	Improvement in staff injuries / sickness absent, staff practice and reduction in patient time spent in hospital
Sharps/Splash					

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
To continue to monitor and review new sharp safety devices across the trust.	01/04/2024 – 31/03/2025	Team Lead Vascular Access Specialist Practitioner	Health and Wellbeing Team and Vascular Access Specialist Practitioner	Health and Safety Committee	N/A
To continue reviewing medical sharps incidents, providing support and training where appropriate and identifying trends that require targeted intervention.	01/04/2024 – 31/03/2025	Team Lead Vascular Access Specialist Practitioner	Health and Wellbeing Team and Vascular Access Specialist Practitioner	Health and Safety Committee	Qualitative assessment of sharps/splash incident reports / training records

5) Governance Arrangements

The Director for delegated responsibility for health and safety within the Trust is the Chief Operating Officer with the Director of Urgent Care having deputy responsibilities and direct management responsibility for the Health and Safety team.

The Health and Safety Committee previously established on the authority of the Quality Committee to assist the Trust Board in fulfilling its responsibilities in relation to health and safety, following a Deloitte Governance review in December 2023 the reporting committee structure has been restructured, the Health and Safety Committee now reports into the Risk and Regulations Committee.

6) Enforcement Notices and Improvement Plans

The Care Quality Commission (CQC) took over much of the day to day enforcement responsibility from the Health and Safety Executive (HSE) for health and social care activities. RIDDOR reports are passed on to the CQC from the HSE.
There has been a decline in the number of prosecutions of NHS Trusts and health and social care organisations by the HSE and these have been limited to clear and significant health and safety breaches.
Meanwhile, the CQC have initiated more prosecutions of NHS and other health and social care organisations for health and safety-related breaches, and the level of fines levied has increased.
The HSE will continue to inspect NHS Trusts periodically. In addition, they will carry out scheduled specialist inspections.

6.1 - Enforcement Notices

The Trust received an improvement notice from the HSE in July 2023 in relation to the loading bay at Tunbridge Wells Hospital.

The improvement notice stated that the Trust was in material breach of the following;

- Regulation 6(3) of the Work at Height Regulations 2005 - requires employers to take suitable and sufficient measures to prevent, so far as is reasonably practicable, any person falling a distance liable to cause personal injury.
- Regulation 17(1) of the Workplace (Health, Safety and Welfare) Regulations 1992 - requires workplaces to be organised in such a way that vehicles and pedestrians can circulate safely

The notice followed a visit from HSE on the 22nd June 2023, the HSE inspector was following up on a RIDDOR reportable incident whereby a member of staff had fallen over a pallet in the loading bay at Tunbridge Wells hospital sustaining a specified injury.

The circumstances around the RIDDOR incident were not of concern to the HSE inspector. On the visit to the loading bay the HSE inspector noted that there was insufficient loading bay protection or segregation of pedestrians to vehicles on the service road of Tunbridge Wells Hospital therefore issued the Trust with an improvement notice.

The Trust responded to the improvement notice with a risk assessment of the area, plan of action for the quotation and installation of barrier controls, the HSE closed the intervention in September 2023 following receipt of photographic evidence of the barrier installation.

Radiation
Nuclear Medicine welcomed the CQC inspectors for an Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection on 16th May 2024. The team inspected the Trust's process for adhering to the IR(ME)R 2017 regulations providing safe process for the use of radiations to patients. The report was very positive citing a positive culture and good practice including staff training and audit.

The Trust has a certified Appointed Doctor in Occupational Health who is able to carry out the Ionising Radiation medical surveillance for Classified Radiation Workers in-house.

The Trust's use of open radioactive sources on the Maidstone site was inspected by the Environment Agency under the Environmental Permitting Regulations on 12th June 2024. The subsequent report contained some minor recommendations and actions which are being implemented.

CQC Inspection 2023
The Trust was subject to a well-led inspection in March 2023, the findings were published in September 2023. There were no identified areas for improvement for health and safety.

6.2 - Improvement Plans
HSE are prioritising workplace ill-health and promoting wellbeing so that the UK can become one of the healthiest, as well as safest, places to work.

In the NHS the priorities are stress, moving and handling and violence and aggression, and these would be their areas of focus during an HSE inspection.
The HSE plan to "lead, deliver and evaluate" a programme of interventions including:

- avoiding violence and aggression, and MSDs, in the NHS. These can result in work-related stress. We (the HSE) will work in partnership with the NHS, health and social care regulators, trade bodies and unions to address work-related stress in the sector."

6.2.1 - Health and Safety Executive (HSE) - Recommendations for Managing Violence and Aggression and Musculoskeletal Disorders in the NHS
Between 2018 and 2022 the Health and Safety Executive (HSE) carried out a series of inspections to assess the management and control of risk from musculoskeletal disorders (MSDs) and violence and aggression (V&A) in the NHS.

From these inspections the HSE made recommendations to consider four main categories where management failings have been identified to satisfy that the Trust and Board is managing the following areas in such a way as to comply with health and safety law;

- Risk Assessment
- Training
- Roles and Responsibilities, and
- Monitoring and Review

For the HSE to be assured that suitable action has been taken, they will be undertaking further interventions with the NHS over the next 12 months (report was issued March 2023)
A report of findings was submitted to the Health and Safety Committee in February 2024, below is precis of the report.

An audit was completed reviewing the risk rating on the hazard profile checklist and identification of whether a formal risk assessment was required.

Meetings were held with the Trusts Security Core Skills Trainer and Conflict Resolution Training Lead and the Trusts Moving and Handling Advisor in regard to the training, roles and responsibilities and monitoring and review of the criteria findings.

Summary of Findings

- Majority of risk assessments completed were on the incorrect form (forms amended following updates to Policy and Procedures)
- Majority had been duplicated across wards/departments
- V&A incident numbers indicate that areas have not completed a suitable and sufficient risk assessment
- Low incident numbers for MSDs compared to Occupational Health referrals received
- There were no risk assessments completed for MSDs – high number of referrals would suggest RA are required
- MSDs are not covered in any policy or procedure – MSDs are linked to moving and handling, repetitive work and awkward positions, display screen equipment, vibration e.g. driving, machinery
- Attendance at training, there are a significant number of non-attendances to mandatory training sessions, in particular nursing attendance (this may be due to pressures on the ward areas) however, this does have a direct impact of the health and safety of our staff e.g. musculoskeletal injuries.

Summary of Recommendations

- Amendments and updates to risk assessment templates to be widely circulated
- Education to all wards and areas in regard to the requirement to complete own risk assessments and not duplicate other wards/areas
- Information on musculoskeletal causes and injuries, and reasons for reporting as incidents, to be published on the Intranet and circulated, include links to external resources e.g. HSE, NHS Employers
- Communication with Occupational Health re themes and trends of musculoskeletal referrals to identify areas of concern to enable discussions and risk assessments to be completed
- Audit and Governance Committee are monitoring compliance of training

Specific to Moving and Handling

- Training space and resource to be made available to ensure that mandatory training and competency is kept up to date
- Review and update risk assessment training to include, or have standalone, moving and handling training

7) Changes to Legislation

The Health and Safety Executive (HSE) is committed to helping business and other stakeholders adapt to changes in occupational health and safety law and practice in line with Government policy on 'Common Commencement Dates' which are:

- 6 April (the start of the tax year); and
- 1 October

7.1 - Update on the Retained EU Law (Revocation and Reform) Act 2023

The Retained EU Law (Revocation and Reform) Act 2023 has the potential to impact on health and safety regulations that were derived from Europe. This will not affect the primary legislation, The Health and Safety at Work Act etc. 1974.
At the present time there has been no changes or further information on how or when potential changes to the regulations will take place.

7.2 - Changes in effect in 2024

The Health and Safety Executive's First aid at Work: Guidance on Regulations Document L74, third edition has been further updated with minor amendments in 2024 to:

- emphasise employers' responsibilities to take account of employees' mental health in their first-aid needs assessment
- change the term 'catastrophic bleeding' to 'life-threatening bleeding' with more guidance on what employers should do if they identify this as a risk in their workplace
- simplify guidance on how to decide what first aid to provide

Selecting a first-aid training provider: A guide for employers (General Information Sheet No 3 (rev2)) updates include simplified guidance on what employers should consider when selecting a training provider

The Health and Safety team monitor upcoming legislative changes and report these into the Health and Safety Committee for potential escalation or for review of amendments to policy and procedures where required.

8) Incident Reporting and Statistics for 2023/2024

The InPhase incident database was interrogated for all staff, public and Trust incidents for the period of 01/04/2023 to 31/03/2024. Staff, public and Trust incidents statistics make up 18.2% of the total number of incidents reported. These have been divided into groups based on severity;

- Deaths to employees, contractors and visitors (death at work)
- Incidents and injuries reportable to the HSE under RIDDOR
- All staff and public injuries

8.1 - Reporting

There were 2874 staff, public and Trust incident reported in 2023/2024. This is a 7% decrease from 3099 reported incidents the previous year, 2022/2023. This is attributed to the change in the incident reporting system from Datix to InPhase, there was a significant decrease in reporting for staff, public and Trust incidents in April 2024 when the system was first introduced.

- There were no catastrophic incidents reported for 2023/2024
- There were 22 RIDDOR reportable incidents – further information in section 8.2

Further work is required to ensure that InPhase captures staff, public and Trust incidents and near miss incidents, it is a patient-centric incident system and there are on-going communications with the InPhase team on how this can be improved to increase reporting of health and safety incidents.

The following data provides a breakdown of the incidents reported for 2023/2024;

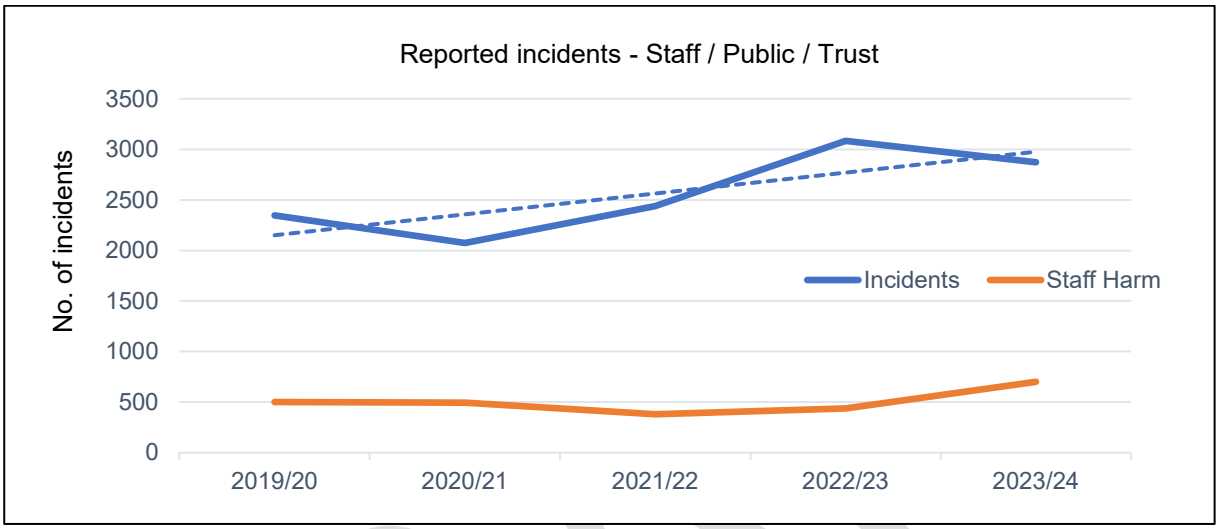


Figure 1 – Reported incidents compared to harm incidents for Staff, Public and Trust 2019/20-2023/24

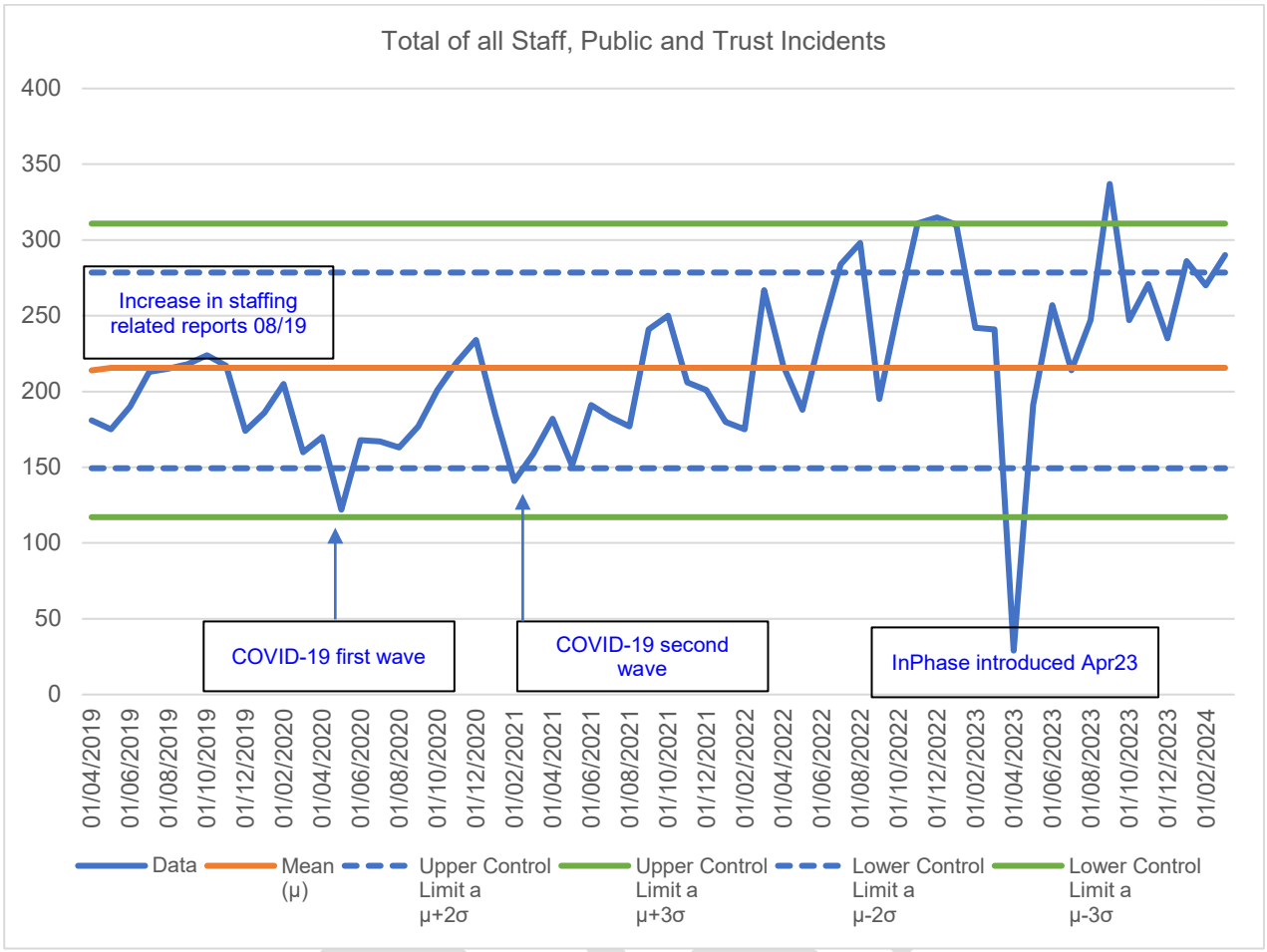


Figure 2 – SPC Chart - Total number of Staff, Public and Trust Incidents 2019/20-2023/24

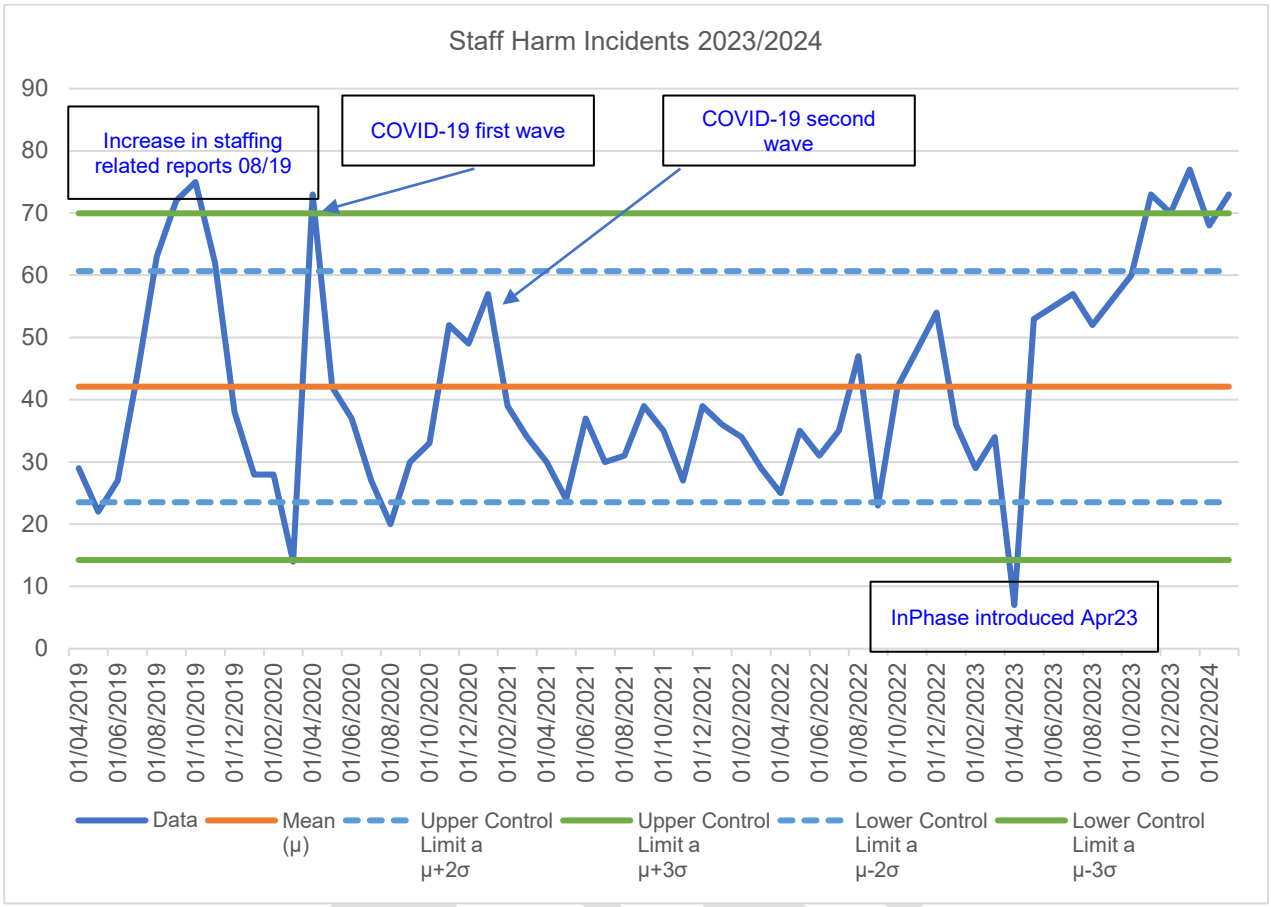


Figure 3 – SPC Chart – Staff Harm Incidents 2019/20-2023/24

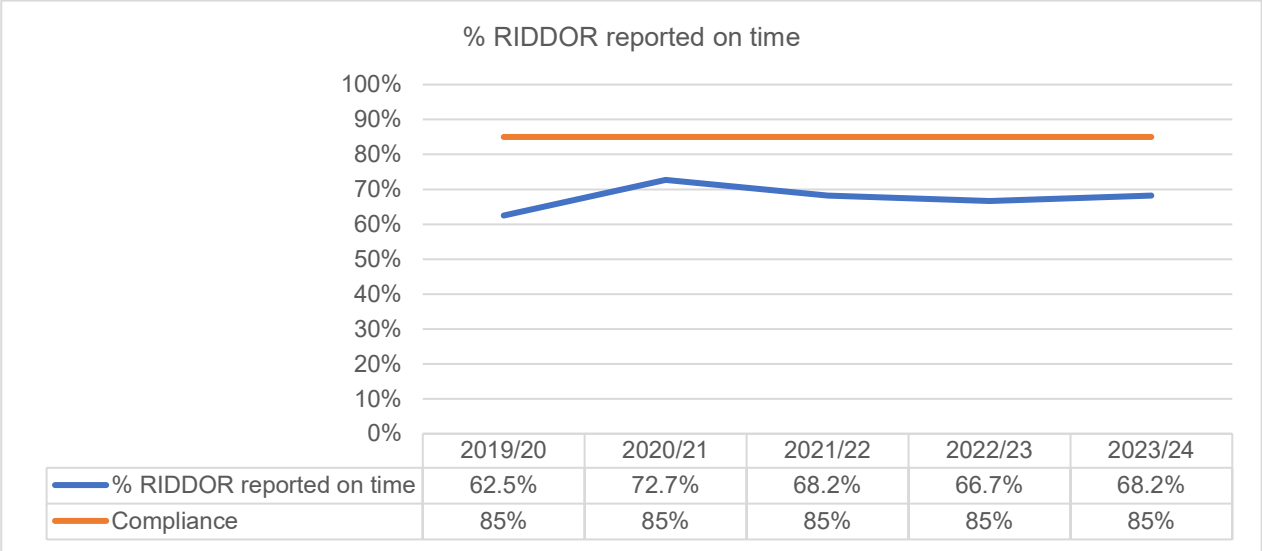
8.2 - Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Incidents

Under the RIDDOR Regulations the Trust has a responsibility to report certain work place accidents, incidents, ill-health and certain near miss incidents to the Health and Safety Executive.

The RIDDOR data for 2023/2024 has been compared with the data from the previous 5 years.

RIDDOR category	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Over 7-day injuries	17	12 ↓	12	14 ↑	15 ↑
Specified Injuries	5	9 ↑	5	5	6 ↑
Dangerous Occurrences	2	0 ↓	5 ↑	2 ↓	1 ↓
Occupational Disease	0	1 ↑	0	0	0
Total	**24**	**22** ↓	**22**	**21** ↓	**22** ↑
Incidents reported within timescales to HSE	62.5%	71.4% ↑	68.2% ↓	66.7% ↓	68.2% ↑

Figure 4 – Number and Types of RIDDOR incident reports 2019/20-2023/24



	2019/20	2020/21	2021/22	2022/23	2023/24
% RIDDOR reported on time	62.5%	72.7%	68.2%	66.7%	68.2%
Compliance	85%	85%	85%	85%	85%

Figure 5 – RIDDOR reporting compliance against compliance key performance indicator 2019/20-2023/24

Of the incidents report 68.2% were submitted within the HSE timescales, which is an increase from 66.7% in 2022/2023 however, this is still not in line with the key performance indicator of 85%.

The Trust has historically performed poorly when reporting RIDDOR incidents within the regulatory timescales. KPI% reporting for the Divisions is presented to the Health and Safety Committee and also within the Divisional monthly health and safety reports. Regular reminders have been communicated to managers of their responsibilities and of the reporting requirements.

The Trust submitted 22 reports in the year, this is one more than the previous year;

- 20 of the incidents concerned staff members
- 1 incident involved a member of public
- 1 incident involved an outpatient.

The Health and Safety team carry out a daily review of all the incidents reported onto InPhase to ensure early capture of potential RIDDOR reportable incidents, delays are from incidents being reported late or delay in communication of required information to enable the report to be made.

The main themes for the RIDDOR reportable incidents are slip, trips and falls (majority of reported incidents at 11), moving and handling injuries (5 incidents) and physical assault from patients attributing to over 7 days absence from work (3 incidents).

Learning from the RIDDOR investigations;

- Individual risk assessments to be completed where staff member has a known pre-existing medical condition or injury that may affect their daily working tasks to prevent injury
- Undertake Conflict Resolution and Break Away Training to prevent injury from unexpected episodes of violence and aggression from patients
- Adhere to correct Moving and Handling techniques
- Adhere to correct procedures for the disposal of sharps

9) Key Health and Safety Areas

9.1 - Violence and Aggression

Incidents of violence and aggression have increased in 2023/2024 and remain the highest category of reported incidents and harm incidents reported for staff.
Head of Security Management compiles an annual report for the Board on all Security issues and is a standing agenda reported to the Audit and Governance Committee, this will include training, action taken and recommendations in relation to Violence and Aggression across the Trust.

9.2 - Sharps

Harm from medical sharps decreased by 7% when compared to the previous year 75 incidents in 2022/2023 to 70 incidents in 2023/2024. This is the second highest category of reported incidents and harm incidents report for staff.

The main causes of the sharp's injuries are;

- Incorrect disposal, sharps have been disposed in clinical waste bags rather than sharps boxes
- Sharps boxes overfilled
- Sudden patient movement
- Incorrect technique or distraction when re-sheathing of the needle

The Vascular Access Specialist Practitioners (VASPs) have continued to review safety devices. No changes have been made to cannulation equipment, however there have still some alternative venepuncture equipment which has been supplied to clinical areas and sharp safety training has been provided.

The Health, Safety and Wellbeing team has continued to discuss where sharps/splash incidents are not being investigated with uniform rigor. The VASPs have monitored sharps reports and investigated these incidents where time constraints and staffing allow.

Work needs to be undertaken to ensure that sufficient information is provided within the incident report and investigation to enable appropriate actions to be taken such as training or safe systems of work on the safe handling and disposal of sharps if required.

9.3 - Slips, Trips and Falls

Slip, trips and falls for staff and other users, public and contractors, are the third highest occurring incident type, and one of the three main causes of RIDDOR incident reports (11 incidents) due to fractures and prolonged absences from work.

The main causes of the slip, trips and falls incidents are;

- Tripping over an object due to obstructions in the working environment e.g. chairs, rubbish bins
- Tripping due to uneven surfaces mainly external premises
- Slipping on wet floors main causes are due to cleaning practices, unknown spillages, inclement weather and muddy environments caused by building works
- Ice and snow: for one day of heavy snowfall these can be contributed to by a failure of the gritting company attending site

The Health and Safety team review each staff and public incident reported and follow up to ensure that remedial action has taken place to prevent recurrence. At the present time there is no formal process for undertaking inspections of all external and internal pedestrian routes. Individual wards and departments are responsible for their own areas of work and ensuring that housekeeping is undertaken with any identified issues reported to the Estates helpdesk.

9.4 - Moving and Handling

Moving and handling tasks for staff, are the fourth highest occurring incident type, and have caused five RIDDOR incident reports. Although there has been a decrease in harm incidents, moving and handling is recognised as a significant risk within our healthcare setting.

Cause of injuries vary;

- Incorrect moving and handling techniques whilst assisting patients
- Injuries caused whilst assisting bariatric patients to reposition
- Aggravation of existing injuries through pushing or pulling, equipment and/or patients

As referenced in section 6.2.1 - An action plan has been developed with the Head of Health and Safety with reference to the Health and Safety Executives letter and its recommendations for managing musculoskeletal disorders (MSDs) in the NHS. More specific training has been developed to support staff to learn new skills and knowledge to reduce MSDs within the workplace, this includes Portering and non-clinical training. This was also reflected in the training needs analysis that has been completed and bespoke training that has commenced.

Work with Occupational Health is taking place and the Moving and Handling Advisor is notified of staff that require individual moving and handling risk assessments. Collaborative work with different leads has started, this involves looking at documentation, data trends and producing guidance for staff.

9.5 - Water Hygiene

The Water Steering Group reports into the Health and Safety Committee in regards to updates on progress of the actions and assurance that works are progressing to mitigate any risk.

The water systems at both Maidstone and Tunbridge Wells Hospitals have inherent issues with the water systems, both are caused by poor water circulation that is affecting the minimum temperature requirements. This in turn creates a risk of legionellosis due to non-compliant safe systems.

Below is a precis of the progression ongoing works;

Tunbridge Wells Hospital

- Domestic Hot water – Circulation
    - A rectification plan is being discussed for the tertiary circulation loops and sub loops – of which some actions have already been agreed and are ongoing.
    - Laing O'Rourke attended site to commission the new pump in green zone, all went well with the results showing improved circulation temperatures

The below table shows valve replacement status.

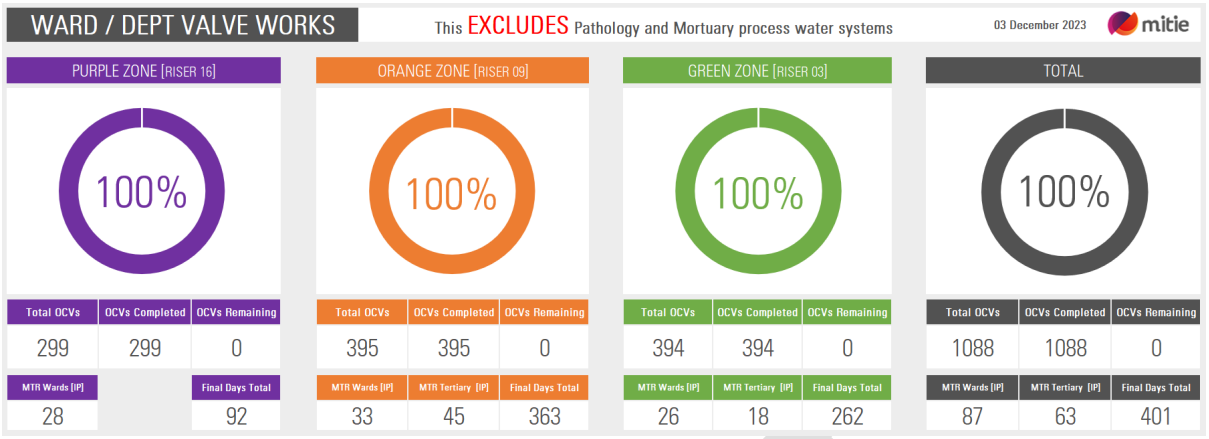


Figure 6 – Valve replacement works at Tunbridge Wells Hospital

- Tap replacement.
  - This is to replace the sensor taps within the patient rooms for Markwick 21 plus leaver taps
  - The tenders have now been evaluated by mite and passed to KESWEL for approval.

Maidstone Hospital

Maidstone Hospital has now been placed on the trust risk register. The Domestic Hot Water Systems are not compliant to the NHS Health Technical Memorandum HTM 04-01 Safe Water in Health Care Premises.

Specific Issues

- Investigation ongoing in A&E to reduce air locks in the supply pipework
- Lord North Ward - Water Cooler has now been removed until further notice
- Works on Lord North Ward - this will include the below;
  1. Rebalancing of system
  2. Chlorination of system
  3. Re-commissioning of Thermostatic Mixed Valves (TMVs) and Thermostatic Mixing Taps (TMTs).

The Water Hygiene Manager has instructed a new water sampling contractor, Pro economy. They will be undertaking Pseudomonas sampling at Tunbridge Wells Hospital and Maidstone Hospital starting in June 2024 along with Legionella sampling at Maidstone Hospital.

10) Training

In line with the Health and Safety Strategy for Maidstone and Tunbridge Wells NHS Trust, to ensure that there is an effective safe and healthy culture across the Trust this must be led from Executive level.

An objective has been set for the following;

- Executive Directors with responsibility for Health and Safety will attend IOSH training course Leading Safely - Essential learning for senior leaders
- Senior Managers will lead by example and attend all appropriate Health and Safety Courses

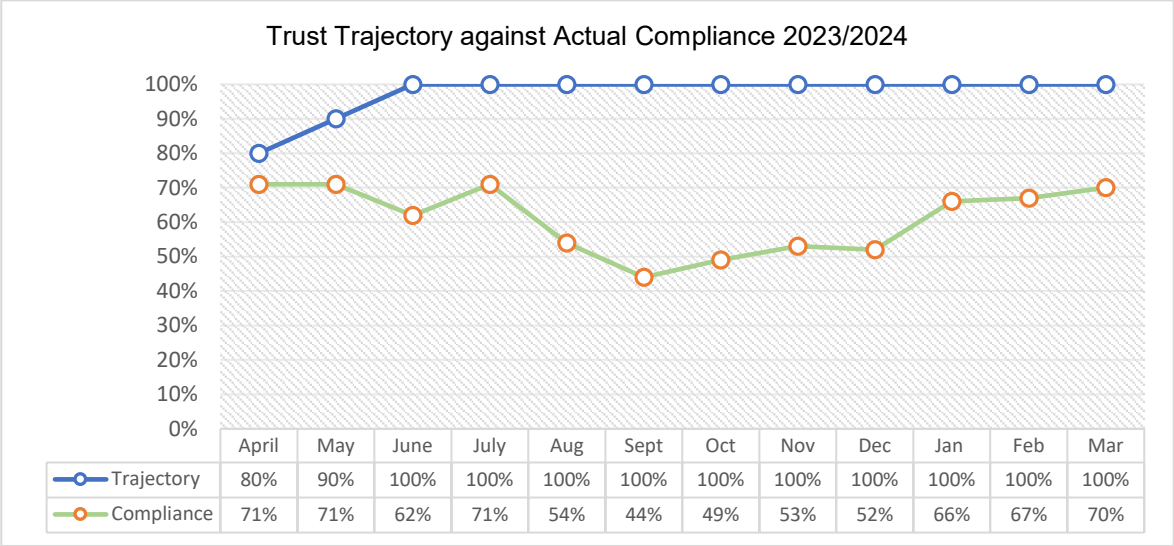
The Health and Safety department have reviewed, updated and implemented a schedule of risk assessor training. In the first six months of 2024, over 70 staff members Trust-wide have completed their training, the training is open to all staff members who are responsible for completing risk assessments within their ward or department.

11) Audit Compliance

Compliance as of end of March 2024
We have not managed to reach the trajectory compliance of 100% for the Trust however there has been a variance in compliance since the beginning of the financial year 2023/2024;

Starting compliance in April 2023 = 71%

There was a decrease in compliance between Aug and Dec 2024 with an increase to March 2024 compliance = 70%



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	80%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance	71%	71%	62%	71%	54%	44%	49%	53%	52%	66%	67%	70%

Figure 7 – Compliance of Health and Safety Audits against Trust trajectory 2023/2024

The main areas requiring improvement with compliance is the external offices and accommodation areas, currently 15 areas, managed by MTW. These will be picked up as part of an improvement programme by the Health and Safety Team.

The audit for Health and Safety is currently completed on Synbiotix, the Trust Patient Safety Specialist is leading an improvement programme, Digitalising our Quality Checklists Workstream - Non Maternity, of which the Health and Safety team are contributors. This workstream is identifying InPhase as a systematic approach for quality assurance on all audits and inspections, this will alleviate the need for Synbiotix in the future.

12) Summary and Conclusions

There continues to be improvements in Health and Safety across the Trust, with the changes occurring within the team and implementation of the health and safety module on InPhase this will enable further work to progress in supporting the Divisions to increase their compliance with risk assessments, local health and safety audits and inspections.

The recruitment of new members to the Health and Safety team, including the Moving and Handling Advisor, will ensure that the workplan and strategy can be delivered.

The objectives for 2023/2024 and Health and Safety Strategy are key pieces of work required to improve upon identified issues, these objectives will be monitored locally and by the Health and Safety Committee.

13) Appendices

Appendix A – Legal Cases

Appendix A – CQC/HSE Legal Cases 2023/2024

The table below summarises some of the relevant prosecutions that took place in 2023/2024.

Summary of learning
Patients were failed to be appropriately assessed for the medical condition and mitigate against the risk of harm occurring

- Failure to mitigate against the risk of falls
- Failure to undertake an environmental ligature risk assessment to prevent harm
- Failure to provide appropriate pressure ulcer care

Date	Organisation	Incident date(s)	Incident detail	Penalty	Prosecuted by	Learning
April 2023	Rossendale Nursing Home	06/11/2019 13/01/2020	One resident died from choking, it was the fourth time they had choked but hadn't been referred on for help. The other resident had a history of falls and had fallen 14 times while at the home. Taken to the hospital after last fall where they had sustained a fractured left neck of femur. The fall and subsequent injury contributed to death.	£40,000 + costs	CQC	Failure assess, monitor or manage the risk or make the referral. Failure to mitigate the risk of falls, and to ensure patient was promptly referred to the appropriate service i.e. falls team
June 2023	Highbury House Care Home	28/06/2019	Patient admitted to care home in 2017 with no history of pressure ulcer wounds. Patient was treated by district nurses until April 2019. From April 2019 to June 2019 there were a further 44 entries evidencing the return of the pressure ulcer wounds. Care Home Manager decided to treat them herself. June 2019 patient was found unresponsive, taken to hospital	£120,000 + costs	CQC	Failure to ensure patient received proper treatment for pressure ulcers and failed to ensure she received adequate preventative pressure sore care. The registered provider failed to show governance and oversight and its preventing pressure sores policy was outdated and did not refer sufficiently to national guidance.

Appendix A – CQC/HSE Legal Cases 2023/2024

Date	Organisation	Incident date(s)	Incident detail	Penalty	Prosecuted by	Learning
			inspection of her pressure areas revealed multiple areas of damage across her body. Pressure ulcers and deep tissue injuries were found on Mary's heels, elbows, hip, buttock, natal cleft and toes. Patient died in July 2019, primary cause of death was multi-organ failure caused by septicaemia, pressure sores and generalised atherosclerosis.			
21/09/2023	Cygnet Hospital Ealing	November 2018	In November 2018 a young woman was admitted to a ward in Cygnet Hospital Ealing. In July 2019, the young woman was able to take her own life while resident on the ward. Cygnet Ealing were aware of this young woman trying to harm herself in an almost identical way four months earlier, yet they failed to mitigate the known environmental risk she was exposed to.	£1.5million + costs	CQC	CQC brought the prosecution as it believed that if Cygnet Health Care Limited had complied with its statutory obligations at Cygnet Hospital Ealing, this young woman would not have been exposed to such a significant risk of harm. They acknowledged failings of: • providing a safe ward environment to reduce the risk of people being able to use a ligature • ensuring staff observed people intermittently in line with the company procedures • training staff to be able to resuscitate patients in an emergency.
November 2023	Picktree Court Care Home	No date in press release	Patient became a resident on 31 October 2019 aged 93. Before she arrived at the home, the manager	£20,000 + costs	CQC	The provider failed to ensure that patient had the necessary support in place to reduce the likelihood of

Appendix A – CQC/HSE Legal Cases 2023/2024

Date	Organisation	Incident date(s)	Incident detail	Penalty	Prosecuted by	Learning
			carried out a pre-admission assessment which showed that she had a history of experiencing falls. Although the home was aware of the risks, she had a number of falls while living at Picktree Court.			falls. CQC brought the prosecution as it believed that if Premier Care Homes Limited had put effective systems in place, patient would not have been exposed to such a significant risk of harm.
November 2023	Greystones Nursing Home	1st March 2020	Patient, a resident at Greystones, had 23 recorded incidents involving him falling, placing himself on the floor and being found by staff, or having unexplained injuries.	£5,000 + costs	CQC	The provider didn't take sufficient action as a result of these incidents to mitigate the risk of these reoccurring. Also, risk assessments and care plans were not reviewed and updated after each one, as required.
November 2023	Birchwood Care Home	February 2020	Patient, a 53-year-old resident, suffered second degree scalds while being supported by two care workers to have a bath. The supporting staff members did not check the water temperature before placing her in. Patient sustained second-degree immersion scalds from the bottom of her feet to the top of her ankles.	£100,000 + costs	CQC	Support plans, policies and risk assessments did not provide good enough guidance to staff as to what was considered to be a safe water temperature as per the Health and Safety Executive Guidelines.
29/11/2023	Oakbank Care Home	January 2020	Patient was admitted to Oakbank and was noted as being at high risk of falls. He suffered several falls during his time at Oakbank.		CQC	Care Home Manager failed to ensure that patient's risk assessments and care plans were adequate in dealing with management of falls, that there was adequate reporting of falls, and there was a failure to respond appropriately to changes in patient's behaviour. These failures

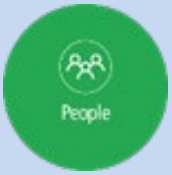
Appendix A – CQC/HSE Legal Cases 2023/2024

Date	Organisation	Incident date(s)	Incident detail	Penalty	Prosecuted by	Learning
						meant that Care Home Manager did not provide patient with safe care and treatment, and thereby exposed him to a significant risk of avoidable harm.
December 2023	Richmond Lodge Care Home	March 2020	Patient was a resident at Richmond Lodge. He was referred to a speech and language therapy team (SALT) as he was experiencing swallowing difficulties. After an assessment it was decided he required a modified diet in order to reduce his risk of choking. He was given pizza, chips and baked beans. He choked and collapsed while eating, then sadly died.	£50,000 + costs	CQC	The registered provider and registered manager failed to ensure patient received safe care and treatment as they failed to make sure appropriate guidance was followed regarding his food intake.
February 2024	Runwood Homes Limited – Cherry Tree Lodge	October 2021	A former registered manager failed to adequately assess and mitigate the risks posed by someone and protect a female resident living at Cherry Tree Lodge from abuse and improper treatment.	£10,000 + costs	CQC	Failure to adequately assess and mitigate the risks posed by this man and protect the female resident living at Cherry Tree Lodge from abuse and improper treatment, leading to this incident.
08/03/2024	Woodbourne Priory Hospital	September 2020	Patient, who was receiving care from Woodbourne Priory Hospital, absconded on 7 September 2020 by scaling a courtyard fence. After he absconded, patient was tragically killed after being struck by a train.	£650,000 + costs	CQC	Priory Healthcare Limited failed to provide safe care and treatment in that it failed to carry out a full review of security of the fences on Beech Ward following previous incidents relating to the courtyard fence over which patient absconded. That failure exposed people on Beech Ward, including

Appendix A – CQC/HSE Legal Cases 2023/2024

Date	Organisation	Incident date(s)	Incident detail	Penalty	Prosecuted by	Learning
						patient, to a significant risk of avoidable harm.
11/03/2024	Tees, Esk and Wear Valleys NHS Foundation Trust	February 2020	In February 2020 patient died following an incident, whilst she was a resident on the Tunstall Ward at Lanchester Road Hospital. Patient had been under the care of community child and adolescent mental health services (CAMHS) since February 2017, until shortly before her death in February 2020.	No fine	CQC	CQC brought the prosecution as it believed Tees, Esk and Wear Valleys NHS Foundation Trust had exposed patient to a significant risk of avoidable harm, however, following consideration of expert evidence during the trial, the judge was satisfied that this **was not the case.**

Title of report	**Annual review of the Trust Board's Terms of Reference**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	28th November 2024					
Agenda item no.	11-19					
Executive lead	Louise Thatcher, Trust Secretary					
Presenter	Annette Doherty, Chair of the Trust Board					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	☐

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	☐	✓	☐	☐	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Trust Board's Terms of Reference are due their annual review. The enclosed revised Terms of Reference are therefore submitted for review and approval. The proposed changes are shown as 'tracked'. Most of these are minor/'housekeeping' changes. The one material change that has been made is the removal of the Patient Experience Committee as a sub-committee to the Trust Board, as this no longer exists.
Any items for formal escalation / decision	To approve the revised Terms of Reference.
Appendices attached	Appendix 1: Revised Terms of Reference.

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	N/A
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

Trust Board

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

Purpose and duties

1. The Trust exists to provide goods and services for the purposes of the health service[1], and has a general duty to exercise its functions effectively, efficiently and economically[1]. In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to the health and well-being of the people of England; the quality of services provided to individuals by relevant bodies[2] (or in pursuance of arrangements made by relevant bodies[2]), for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; and efficiency and sustainability in relation to the use of resources by relevant bodies[2] for the purposes of the health service in England[3].

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to an Executive Director. The voting members of the Trust Board comprise a Chair (Non-Executive), five other Non-Executive Directors, the Chief Executive, and four specified Executive Directors. Other, non-voting members of the Trust Board attend Trust Board meetings and contribute to its deliberations and decision-making.

3. The Trust Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each individual Trust Board Member, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served.

5. The practice and procedure of the meetings of the Trust Board – and of its sub-committees – are described in the Trust's Standing Orders.

<u>General responsibilities</u>

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost-effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of all Trust Board Members.

<u>Leadership</u>

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a People and Organisational Development strategy and its appropriate implementation and operation.

[1] National Health Service Act 2006
[2] NHS England, Integrated Care Boards, and other NHS Trusts and NHS Foundation Trusts
[3] Health and Care Act 2022

Strategy

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
   9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
   9.4. Develops and maintains an annual forward programme and ensures its delivery as a means of implementing the strategy of the Trust to meet the expectations and requirements of stakeholders;
   9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Code of Conduct to guide the operation of the Trust Board and the behaviour of Trust Board Members is incorporated within the Trust's Standing Orders.

Governance

12. The Trust Board:
   12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
   12.2. Ensures that the Trust complies with its governance and assurance obligations;
   12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
   12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
   12.5. Ensures that the statutory duties of the Trust are effectively discharged;
   12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk management

13. The Trust Board:
   13.1. Ensures an effective system of governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
   13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
   13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Executive Directors.

Ethics and integrity

14. The Trust Board:
   14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
   14.2. Ensures that Trust Board Members and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders, Reservation of Powers and Scheme of Delegation, and/or by the Board from time to time

Communication

16. The Trust Board:
    16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
    16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
    16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
    16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality success and financial success

17. The Trust Board:
    17.1. Ensures that the Trust operates effectively, efficiently, and economically;
    17.2. Ensures the continuing financial viability of the organisation;
    17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
    17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
    17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chair

18. The Chair of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chair is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole, plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chair is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chair of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

Membership of the Trust Board

24. The Trust Board will comprise the following persons:
    24.1. The Chair of the Trust Board
    24.2. Up to five Non-Executive Directors. One of these will be designated as Vice-Chair
    24.3. The Chief Executive
    24.4. The Deputy Chief Executive / Chief Finance Officer
    24.5. The ~~Medical Director~~Chief Medical Officer
    24.6. The Chief Nurse
    24.7. The Chief Operating Officer

Non-voting Trust Board Members (as stated in the Trust's Standing Orders) will be invited to attend Trust Board meetings at the discretion at the Chair.

Quorum

25. The Board will be quorate when four Trust Board Members including at least the Chair (or Non-Executive Director nominated to act as Chair), one other Non-Executive Director, the Chief Executive (or Executive Director nominated to act as Chief Executive), and one other Executive Director (voting member) are present[4].

26. An officer in attendance for a voting member of the Executive Team but without formal acting up status may not count towards the quorum at Trust Board meetings

Attendance

27. The Trust Secretary will normally attend each meeting.

28. Other staff members and external experts may attend Trust Board meetings to contribute to specific agenda items, at the discretion of the Chair

Frequency of meetings

29. The Trust Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

30. The Chair, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a 'balanced board' where the skills and experience available are appropriate to the challenges and priorities faced;

31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

32. The Trust Board has the following sub-committees
    32.1. The Quality Committee
    ~~32.2. The Patient Experience Committee~~
    ~~32.3.~~32.2. The Audit and Governance Committee
    ~~32.4.~~32.3. The Finance and Performance Committee
    ~~32.5.~~32.4. The People and Organisational Development Committee
    ~~32.6.~~32.5. The Charitable Funds Committee
    ~~32.7.~~32.6. The Remuneration and Appointments Committee

33. For the Quality Committee, ~~Patient Experience Committee,~~ Audit and Governance Committee, Finance and Performance Committee, Charitable Funds Committee, and People and Organisational Development Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair of that meeting) in a timely manner

34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Emergency powers and urgent decisions

35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chair of the Trust Board and Chief Executive after having consulted at least two Non-Executive Directors.

36. The exercise of such powers shall be reported (by the Chair of the Trust Board) to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

Commented [TL1]: Replaced with the Experience of Care Oversight Group-reporting to the Quality Committee

[4] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chair and members (including at least one Executive Director and one Non-Executive Director) is present"

Administration

37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    37.1. Agreement of the agenda for Trust Board meetings with the Chair and Chief Executive;
    37.2. Collation of reports for Trust Board meetings;
    37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    37.4. Advising the Trust Board on governance matters.

38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chair and Chief Executive.

Conflict with Standing Orders Set

39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

40. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 28th September 2023