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

Thu 28 January 2021, 10:00 - 12:15

Virtual Meeting, via webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrIuzYSc29211EQ).

01-1.
To receive apologies for absence

David Highton

01-2.
To declare interests relevant to agenda items

David Highton

01-3.
To approve the minutes of the 'Part 1' Trust Board meeting of 17th December 2020

David Highton

Board minutes, 17.12.20 (Part 1).pdf (7 pages)

01-4.
To note progress with previous actions

David Highton

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

01-5.
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

01-6.

Report from the Chief Executive

Miles Scott

Chief Executive's report January - 2021.pdf (2 pages)

01-7.
Update on COVID-19

Sean Briggs and colleagues

01-7.1.
Operational response (incl. Critical Care capacity, mutual aid, use of Independent Sector Providers, and testing)

Sean Briggs and colleagues

01-7.2.
Demand and capacity modelling

Sean Briggs and colleagues

01-7.3.
Workforce issues

Sean Briggs and colleagues

01-7.4.
Vaccinations

Sean Briggs and colleagues

01-8.
The impact of COVID-19 on operational performance

Sean Briggs

The report will follow

01-9.
Integrated Performance Report (IPR) for December 2020 (incl. planned and actual ward staffing for Dec. 2020)

Miles Scott and colleagues

IPR for Dec 2020 (incl. planned and actual ward staffing).pdf (34 pages)

Planning and strategy

01-10.
Update on the Kent and Medway Medical School (KMMS) accommodation

build at Tunbridge Wells Hospital

Amanjit Jhund

Update on the Kent and Medway Medical School (KMMS) accommodation build at Tunbridge Wells Hospital.pdf (8 pages)

01-11.
Approval of a Business Case for the recruitment and retention of registered nurses

Claire O'Brien

Business Case for recruitment and retention for registered nurses.pdf (35 pages)

Quality items

01-12.
The Trust's response to the Ockenden review of maternity services

Sarah Flint and Sarah Blanchard-Stow

N.B. This item is scheduled for 11.30am.

The Trust's response to the Ockenden review of maternity services.pdf (18 pages)

Assurance and policy

01-13.
Infection prevention and control board assurance framework

Sara Mumford

Infection prevention and control board assurance framework, January 2021.pdf (39 pages)

01-14.
Quarterly report from the Freedom to Speak Up Guardian

Christian Lippiatt

N.B. This item is scheduled for 11:55am

FTSU Board Report - January 2021.pdf (4 pages)

Reports from Trust Board sub-committees

01-15.
People and Organisational Committee, 11/12/20 and 22/01/21

Emma Pettitt-Mitchell

The report from the meeting on 22/01/21 will be verbal.

Summary of People and Organisational Development Cttee, 11.12.20.pdf (1 pages)

01-16.
Quality Committee, 13/01/21

Sarah Dunnett

Summary of Quality C'ttee, 13.01.21.pdf (2 pages)

01-17.
Finance and Performance Committee, 26/01/21

Neil Griffiths

N.B. The report will be issued after the meeting on 26/01/21.

01-18.
To consider any other business

David Highton

01-19.
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960,representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 17TH DECEMBER 2020, 9.45 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

12-1 To receive apologies for absence

Apologies were received from Cheryl Lee (CL), Director of Workforce.

12-2 To declare interests relevant to agenda items

No interests were declared.

12-3 To approve the minutes of the 'Part 1' Trust Board meeting of 26th November 2020

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

12-4 To note progress with previous actions

The submitted report was noted.

12-5 Report from the Chair of the Trust Board

DH referred to the relevant attachment and highlighted that he had chaired the Advisory Appointments Committee Panel held on 11/12/20 and a Trauma and Orthopaedics consultant had been appointed, although they had not accepted the offer by the time the report had been issued. DH continued that the individual had now accepted the offer, and KR reported that the individual was called Dr Sehjal.

DH then highlighted that the Trust was now in Operational Pressures Escalation Level (OPEL) 4, and he therefore intended to conclude the Trust Board meeting quickly, to enable members of the Executive Team to provided the required support to Trust staff.

12-6 Report from the Chief Executive

MS acknowledged the comments made by DH under item 12-5 and therefore just invited questions or comments on the submitted attachment. None were received.

12-7 Update on Phase three (of NHS response to COVID-19) performance, the OPEL and COVID-19 escalation framework, and 9-week plan (incorporating the winter plan)

MS introduced the item by highlighting that as the Trust was now in OPEL 4, all elective activity had been cancelled, and that position would last until at least 06/01/21. MS elaborated that circa 400 staff had been required to self-isolate as a result of being in contact with someone who had tested positive for COVID-19, which was often their children, although the vast majority of such staff had not tested positive themselves. MS added that that was a significantly higher sickness absence rate than usual, and posed considerable operational challenges.

DH asked about the staffing cell/hub that was being developed jointly by COB and CL. COB reported the latest position, which involved working with the Business Intelligence team to understand the totality of COVID-19-related absence for all staff groups, and plot a projected return date for such staff. COB continued that 122 nurses and 41 Clinical Support Workers were currently off work because of COVID-19, but it was known which areas had gaps to enable staff to be redeployed. COB also reported that work was underway with some Roster Managers to update the rosters to understand the gap between the planned staffing levels and the available levels, while the "SafeCare" system was being implemented on two wards. COB added that two cell/hub meetings were held each day, at 9.30am and 3.30pm, and a Standard Operating Procedure was in place for the redeployment of staff. COB also reported that "One Team Runners" had been introduced to support ward staff, and although these had originally been recruited from existing staff working in non-clinical areas, payment would now be given to those who wanted to undertake that role outside their normal working hours.

COB also reported that Bank pay rates had been increased and additional administrative support had been allocated, while student nurses returning from universities would be contacted to seek their help. COB added that the staff had found the constant redeployment very challenging and COB had included a message in the daily staff 'Pulse' briefing to thank the staff being redeployed and the staff in the receiving areas for making such staff feel welcome. COB added that staffing had been the Trust's greatest challenge and it had struggled to ensure safe staffing, so staff were being asked to prioritise on some of the key areas of practice. PM added that such prioritisation that was the key aspect and all staff were feeling the strain. PM also reported that there had been an increase in patient falls, which was likely due to several factors, although some of the actions staff needed to take to prevent cross-infection between patients had increased the risk of falls. PM continued that medical staffing had also been challenged but doctors were adapting their practice and were undertaking some tasks they would not normally do; for example, they would today be asked to take patients' blood due to staffing absences in the phlebotomy department. PM also noted that the increase in Serious Incidents (SIs) was in part related to the increased outbreaks of COVID-19 that had been seen during the second wave.

DH referred back to the "One Team Runners" initiative and noted that the Non-Executive Directors had queried whether these could be appointed from outside the Trust, and in particular from COVID-19 negative students returning from university. DH added that KC had offered to promote a request among the students at the University of Kent. KC highlighted that she could also promote the request among students at Canterbury Christ Church University, and suggested that COB liaise with her directly. COB welcomed the offer, confirmed that all ideas for support were appreciated, and added that the Trust was currently in liaison with St John Ambulance to explore the support they could provide.

MC acknowledged the tremendous pressure faced by staff and stated that it would be helpful to understand the safety 'triggers'/model being used to assess the capacity for accepting additional patients, given the difficult choices being faced by staff. MC therefore suggested this be discussed at the next Quality Committee meeting.

Action: Schedule a discussion at the 'main' Quality Committee in January 2021 on the safety 'triggers'/model used to assess the Trust's capacity to accept additional patients during the operational pressures faced in December 2020 (Trust Secretary, December 2020 onwards)

MC also referred to the support the Trust had provided to partners in the local system and asked about the impact of accepting ambulance diverts from other Trusts. SB noted that the Trust currently had approximately two wards of inpatients that had been diverted from Medway NHS Foundation Trust (MFT). SB added that the Trust had not planned to receive such patients and the issue was one of the root causes of the Trust's current predicament. SB also pointed out that the Trust was still receiving requests for ambulance diverts from MFT and had actually accepted some diverts on 16/12/20, although SB had then refused further requests on the evening of 16/12/20.

SDu asked for assurance on the plan that would be deployed should the COVID-19 infection rates in the Trust's catchment area rise markedly. PM firstly replied that he did not believe the local infection rates warranted total pessimism, but then explained the actions that would be taken to create additional inpatient capacity in two main areas. SDu welcomed the increase but asked how the areas would be staffed. PM stated that he believed there were still 'untapped' areas of the Trust that would enable the aforementioned clinical areas to be staffed. PM then commented on the potential impact of the COVID-19 vaccine and highlighted that staff were extremely frustrated that the vaccine had not been made available directly, which meant the Trust was reliant on obtaining small amounts of the vaccine from other local NHS partners, despite reports that the vaccine had been given to low-risk staff at other Trusts, and low-risk patients. SB agreed with PM, but emphasised that the number of vaccines the Trust was likely to receive from other Trusts would be insufficient to vaccinate all the Trust's frontline staff. SB also remarked that the Trust could not see an end in sight to the current situation. MS highlighted that it was important that the Trust had provided support to its partners, as it was part of the NHS, but there was clearly a cost to providing such support, and that needed to be understood.

SDu referred back to the Trust being in OPEL 4, and the cancellation of non-elective activity, and asked what communication had been given to patients, as the Trust's website did not provide full details of the cancellations. SB explained that the decision to move to OPEL 4 had been made late on 16/12/20, so communication with patients would proceed that day and in the coming days.

JW asked about COVID-19 testing. MS noted that the implementation of lateral flow device testing was a considerable logistical challenge but the COVID-19 testing directorate and the cultural change team were providing the necessary support, although the full implementation would take time. MS added that polymerase chain reaction (PCR) testing capacity was now sufficient to meet the Trust's needs, while some rapid COVID-19 testing machines had now been received, which would help, although patients may need to stay longer in the Emergency Department until their test result was obtained, to ensure they were transferred to the appropriate area. SM added that lateral flow testing was a 'game-changer', but the logistical challenges involved meant that the benefits would likely materialise in the long-term rather than the short-term.

MC referred to staff morale and asked whether the aforementioned reports of the vaccine being administered outside of the national guidance had been investigated, to enable staff to be informed of the truth. PM speculated that some of the reports would likely be related to the fact that the vaccines were delivered in boxes of 975, and vaccines at the end of a box may have been given to individuals outside of the priority groups to avoid the vaccine being wasted. PM added that he was however unable to explain all of the reports he had heard regarding the vaccines, but acknowledged the importance of investigating such reports and 'myth-busting' wherever possible.

NG asked for further details of MFT's current position. MS replied that the position remained extremely stretched, although the community infection rate was no longer on an increasing trajectory, and he understood that the number of patients at MFT was not rising, so the situation was not getting worse. PM confirmed that was his understanding.

EPM asked whether there was any evidence to suggest that lateral flow testing would reduce the number of staff required to be absent from work. SM replied that there was some evidence of a positive effect of lateral flow testing but the extent was not yet certain. DH noted that although identifying COVID-19 positive staff who were asymptomatic would mean they would be unable to work, it would reduce the risk of nosocomial infection. SM confirmed that was correct.

EPM then asked whether neighbouring Trusts had declared OPEL 4. MS confirmed that the other local Trusts had already declared OPEL 4 and the Trust was therefore the last to do so.

DH noted that he understood there were 245 COVID-19 patients across both of the Trust's hospital sites.

RF then asked whether the NHS hierarchy had been supportive. MS replied that patients needed to be treated, so the Trust needed whatever support it could get to ensure that happened and not be constrained by finances etc., but if the Trust wanted the Independent Sector to work completely differently than at present, regional or national intervention would be required, and the Trust had raised that possibility earlier that week, although such a step would take time.

12-8 Integrated Performance Report (IPR) for November 2020 (incl. planned and actual ward staffing for Nov. 2020)

DH referred to the "Executive Summary" section of the relevant attachment and asked MS whether anything required the Trust Board's particular attention. MS invited SM to provide further details of infection control practices and the ten key actions for which Boards were responsible. SM duly reported the latest position on non-COVID-19 infections and confirmed that the Trust was meeting the ten key actions, adding that these had been covered in detail at the last Trust Board meeting.

SDu then asked whether SM's time was still being divided between the Trust and another local organisation. SM confirmed that was still the case and noted that although the intensity of the work at that other organisation had decreased, and they had appointed their own Director of Infection Prevention and Control (DIPC), she expected to still be involved until mid-March 2021.

SO then referred to the "Well-led" domain, reported the latest financial position and described the support that was being provided to clinical areas. EPM asked whether any procurement- or legislative- related issues were delaying such support being provided. SO confirmed there were no such issues.

DH asked whether the capital funding position had now been agreed. SO confirmed that was the case and added that although there was still a degree of uncertainty, the Trust had determined its approach, to ensure all available capital funding was utilised.

DM referred back to the "Executive Summary" section and asked whether any of the targets that would ordinarily be scrutinised closely were considered to be inappropriate given the Trust's current circumstances, or whether staff were still under pressure to deliver the targets. MS clarified that one of the principles that had been applied during the COVID-19 pandemic was to trust clinical staff to make the best decisions for patients, within the framework of the Trust's policies and expected standards. MS added that there would be no negative impact on staff if targets were breached for good clinical reasons. DH added that the move to OPEL 4 would mean that the monitoring of some national access targets, such as the Referral to Treatment (RTT) target, would be temporarily lessened. DM clarified that his query related to a desire to avoid unintended consequences. The point was acknowledged.

COB then referred to some of the clinical metrics and explained the rationale for the changes.

The 'planned vs actual' staffing report was then noted.

Planning and strategy

12-9 Update on the progress with the provision of accommodation for students from the Kent and Medway Medical School

DH introduced the item by noting that an Outline Business Case (OBC) intended to be submitted to the Trust Board soon. AJ then referred to the relevant attachment and highlighted the key points therein, which included that the OBC was intended to be submitted to the Trust Board in January 2021, or if not, in February 2021. AJ then reported that the deferral of the implementation of International Reporting Financial Reporting Standards (IFRS) (leases) to 2022/23 had given the opportunity to explore option 2b, so the OBC had to be re-written to include that option. AJ also

referred to the “Next Steps” on page 8 of 8 and noted that there was some uncertainty as to whether NHS England/Improvement (NHSE/I) would need to approve the project, as that would depend on the terms of the lease. AJ added that option 2b remained the preferred option, although work was still continuing on option 2c.

AJ then emphasised that rapid progress was required, given the challenging timeline, so SO had suggested it would be helpful to establish a small working group of Trust Board members, similar to the group that had been established for the disposal of the Trust’s properties at Springwood Road, Maidstone, to enable Non-Executive Director oversight. DH welcomed the idea of establishing a task and finish sub-group of the Trust Board, as he believed such a group had worked well on the aforementioned Springwood Road project. DH stated that he would therefore seek expressions of interest from the Non-Executive Directors after the meeting.

Action: Liaise with the Chair of the Trust Board to establish a Task and Finish sub-group of the Trust Board to oversee the project for the provision of accommodation for students from the Kent and Medway Medical School (Director of Strategy, Planning and Partnerships, December 2020 onwards)

DH then noted that he looked forward to considering the OBC at the next Trust Board meeting if at all possible.

12-10 Update on the Trust’s planning for 2021/22

DH firstly noted that the Trust’s Head of Strategy and System Integration had given a detailed presentation on 2021/22 planning at the Finance and Performance Committee meeting on 15/12/20, although national planning guidance had yet to be issued and the financial regime for 2021/22 had not yet been determined. AJ then referred to the relevant attachment and highlighted the key points therein, which included that the work would build on the work undertaken for the Phase three (of NHS response to COVID-19) plans. AJ added that although the planning approach appeared to be streamlined compared to previous years, the Trust was making more progress than many of its neighbouring Trusts. SO added caution that the intended timeline may be disrupted by the fact that corporate staff may be redeployed to support clinical colleagues, given the Trust’s OPEL 4 status. The point was acknowledged.

Quality items

12-11 Quarterly mortality data

PM referred to the relevant attachment and highlighted the key points therein, which included that the report contained the Dr Foster data relating to COVID-19 mortality. SDu added that mortality was a regular item at the Quality Committee and gave assurance that the situation was able to be far more clearly articulated that had been the case in the past.

Assurance and policy

12-12 Infection prevention and control board assurance framework

SM referred to the relevant attachment and highlighted that the assurance framework now contained some different questions, which were highlighted in red.

DH noted that the Care Quality Commission (CQC) had announced that it would be inspecting infection control practices at some Trusts, so asked whether asked what standards would be applied to such inspections. SM replied that she would expect such inspections to be based on the Hygiene Code. COB added that the Trust had a good relationship with the CQC, so if the Trust had been identified for such an inspection, she was confident that she had would have been made aware. COB also noted that the Health and Safety Executive (HSE) had announced an intention to inspect some NHS hospitals and had invited the CQC to join them.

Reports from Trust Board sub-committees

12-13 People and Organisational Development Committee, 20/11/20 (incl. Guardian of Safe Working Hours Annual Report 2019/20) and 11/12/20

EPM referred to the relevant attachment and highlighted that it included the Guardian of Safe Working Hours Annual Report for 2019/20. EPM also reported that the meeting held on 11/12/20 had been shortened because of the current operational pressures. Questions were invited. None were received.

12-14 Charitable Funds Committee, 24/11/20 (incl. approval of revised Terms of Reference and approval of the Annual Report and Accounts of the Charitable Fund, 2019/20))

DM referred to the relevant attachment and highlighted the key points therein, which included that the balance of the charitable fund was currently strong. DM also reported the revised Terms of Reference had been agreed, while the Annual Report and Accounts for 2019/20 had been recommended for approval by the Trust Board. Questions were invited. None were received.

The revised Terms of Reference were approved as submitted. The Annual Report and Accounts of the Charitable Fund, 2019/20, were also approved as submitted.

12-15 Patient Experience Committee, 01/12/20 (incl. approval of revised Terms of Reference)

MC referred to the relevant attachment and highlighted the key points therein, which included the Committee's disappointment at the continued delayed decision by the Secretary of State for Health and Social Care in relation to the establishment of Hyper Acute Stroke Units (HASUs) in Kent and Medway. Questions were invited. None were received.

The revised Terms of Reference for the Patient Experience Committee were approved as submitted.

12-16 Quality Committee, 10/12/20

SDu referred to the relevant attachment and highlighted the key points therein, which included the continued disappointment at the delayed approval for the HASU; the concerns raised by the stroke team regarding scanning capacity; the presentation that emphasised the comprehensive nature of the Trust's training; and the progress on the policies that had passed their review dates. SDu added that for the latter issue, the Trust Board needed to be aware of the programme of work to address the current situation and the amount of work involved.

12-17 Proposal to amend the Quality Committee's Terms of Reference (in relation to the quorum requirements for Quality Committee 'deep dive' meetings)

SDu referred to the relevant attachment and explained the rationale for the proposed change. Questions were invited. None were received. The proposal was approved as submitted.

12-18 Finance and Performance Committee, 15/12/20

NG referred to the relevant attachment and highlighted the key points therein, which included that the meeting had been shortened because of the operational pressures. Questions were invited. None were received.

12-19 To consider any other business

DH noted that he understood that 17 Trusts had been selected for an inspection by the HSE and asked whether the Trust had been selected. COB confirmed that the Trust had not received any contact from the HSE.

COB then highlighted the recent efforts made by the children's and maternity services and explained that the report of the Ockenden review of maternity services, which had been published

recently, would pose some challenges, and an action plan needed to be submitted on 21/12/20. COB added that the action plan would be submitted to the Trust Board in January 2021. MS noted that the only gap the Trust had in complying with the relevant standards was that it did not have open access to all pregnancy scans by partners, and although the Trust acknowledged the benefit of achieving that standard, it had been decided to restrict such access, to avoid having to reduce the number of scans it carried out. MS added that plans to meet the standard were being introduced, but these would take time to implement.

MS then reported that the staff flu vaccination rate that CL had reported to the Trust Board meeting on 26/11/20 had been adjusted, as although the number of staff that had been vaccinated had been recorded correctly, the denominator contained an error. MS added the correct data would be therefore be reported in the meeting minutes, via a post-meeting note.

[Post-meeting note: at 17/12/20, a total of 4699 flu vaccines had been given to staff during the 2020 campaign, of which 3836 vaccines given to frontline staff (a frontline staff rate of 72.6%)]

12-20 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]
10-9	Consider how the Trust's overseas nursing staff recruitment programme could be evaluated to inform the future plans to meet the needs of overseas recruits and ensure all staff were content to work in the environment in which they were placed.	Chief Nurse	January 2021 (extended from October 2020 onwards at the Trust Board meeting on 26/11/20)	A verbal update will be given at the meeting.
12-9	Liaise with the Chair of the Trust Board to establish a Task and Finish sub-group of the Trust Board to oversee the project for the provision of accommodation for students from the Kent and Medway Medical School.	Director of Strategy, Planning and Partnerships	December 2020 onwards	A verbal update will be given at the meeting.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
12-7	Schedule a discussion at the 'main' Quality Committee in January 2021 on the safety 'triggers'/model used to assess the Trust's capacity to accept additional patients during the operational pressures faced in December 2020.	Trust Secretary	December 2020	The item was scheduled for the 'main' Quality Committee in January 2021.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
09-12	Arrange for the Responsible Officer's Annual Report for 2020/21 to include details of the key messages arising from medical staff appraisals (rather than just the statistics associated with such appraisals)	Medical Director	September 2021	The report is not scheduled to be considered at the Trust Board until September 2021

Ref.	Action	Person responsible	Original timescale	Progress
09-13	Ensure that the Health & Safety Annual Report for 2020/21 included content on water-related safety issues	Chief Operating Officer (via the Risk and Compliance Manager)	September 2021	The report is not cheduled to be onsidered at the Trust Board until September 2021

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

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

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and 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	Surname	Department	Potential / Actual Start date
07/12/2020	Professor	Marie Therese	Manipadam	Histopathology	To be confirmed
05 /01/2021	Consultant Oncoplastic Breast Surgeon	Victoria	Teoh	Breast Surgery	To be confirmed
05/01/2021	Consultant Oncoplastic Breast Surgeon	Michal	Uhercik	Breast Surgery	To be confirmed
18/01/2021	Consultant Clinical Oncologist	Jennifer Wing See	Pang	Oncology	To be confirmed

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chief Executive **Chief Executive**

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

1. Following three weeks of national lockdown, MTW is starting to see a decline in Covid-19 patients at the Trust indicating we are now past the second wave peak of inpatients across our sites. However, with our critical care units still under considerable pressure and the second wave peak three and a half times the size of the first wave peak, it is going to be a much longer road to recovery this time around and we require all colleagues to continue to adhere to government guidance around social distancing and infection control.

2. Our vaccination centre at Maidstone Hospital has now vaccinated over 10,000 people with their first dose of the Covid-19 vaccine, including MTW colleagues as well as those from partner organisations such as KCHFT and KMPT. As the vaccine roll-out continues, we have implemented the government decision to prioritise first dose vaccinations to increase the pace of the campaign. The reasoning behind this is that the first dose of the vaccine gives a large degree of coverage by day 14. The second dose will be provided at 12 weeks allowing for greater population coverage in the first weeks of the vaccination campaign.

3. Our new Surgical Assessment Unit (SAU) opened at Tunbridge Wells Hospital on Monday 21 December as part of our ongoing commitment to ensure patients access emergency care services in a prompt and timely way. SAU, which was based inside the hospital, is now located in a new modular building adjacent to the Emergency Department (ED). The move forms part of our plans to enhance our Same Day Emergency Care (SDEC) pathway so that more patients can benefit. The acute unit is operational 24 hours a day seven days a week and we thank all our colleagues involved with delivering care on the new unit.

4. In addition to the new unit, other conversions across the Trust have also taken place with Peale Ward being reconfigured to create extra side rooms which have been completed and been in clinical use since 21 December and ICU at Maidstone also completely moving to the old AMU to open up more critical care beds and allow for additional patients.

5. The trust has successfully been awarded 3 NHSE bids for international nursing recruitment to support the arrival of 134 nurses between October 2020 and November 2021 alongside a further successful NHSE bid to support Clinical Support Workers with funding to undertake the English language tests in preparation for their Objective Structured Clinical Examination (OSCEs) - 32 Clinical Support Workers have been supported with this initiative. There are currently 146 nurses in the recruitment pipeline this month and 5 international nurses have arrived at the beginning of January.

6. South East Coast Ambulance Foundation Trust (SECAMB) have been experiencing unprecedented pressures in response to the current Covid-19 pandemic with MTW monitoring ambulance response times and the impact this may have on some of our services. To help alleviate some of the significant pressures on SECAMB's services, Trusts across Kent, Surrey and Sussex have taken the difficult decision to temporarily suspend home births and birth centres to reduce demand for emergency transfers. However, we have been able to maintain the service at Maidstone Birthing Centre by providing a dedicated private ambulance as part of our Brexit planning. Therefore, our services as of 31 December 2020 are as follows:
   - Home birth – suspended
   - Crowborough Birth Centre – suspended
   - Maidstone Birth centre – normal services but may be subject to change
   - Tunbridge Wells – normal services apply with low risk birthing options available

While we understand that this may be upsetting news, we are committed to maintaining safe standards of care and the safety of families in our care is paramount. We continue to monitor this situation extremely closely and will resume normal services across the board as soon as safe to do so. We apologise for any disappointment this may cause and thank you for your understanding in this matter.

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

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

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

Integrated Performance Report (IPR) for December 2020 (incl. planned and actual ward staffing for Dec. 2020)	**Chief Executive / Members of the Executive Team**

The IPR for month 9, 2020/21, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 19/01/21 (IPR)
- Finance and Performance Committee, 26/01/21 (IPR)

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

December 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 22 onwards)

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

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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	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate 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.

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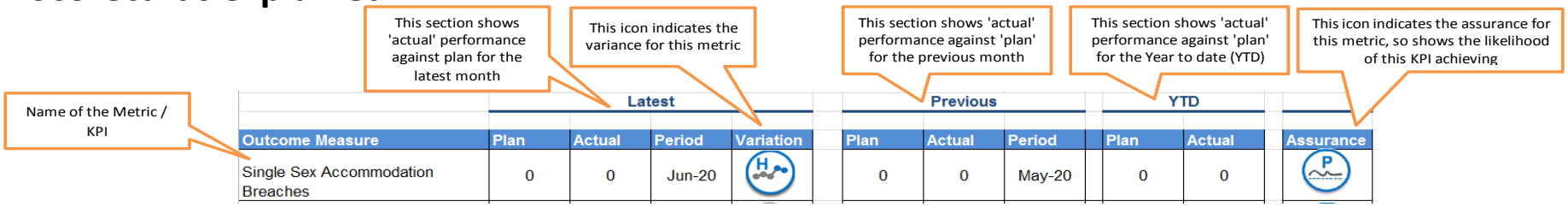
Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Areas are escalated for reporting if:

- They have special cause variation (positive or negative) in their performance
- They have a change in their assurance rating (positive or negative)

Scorecards explained



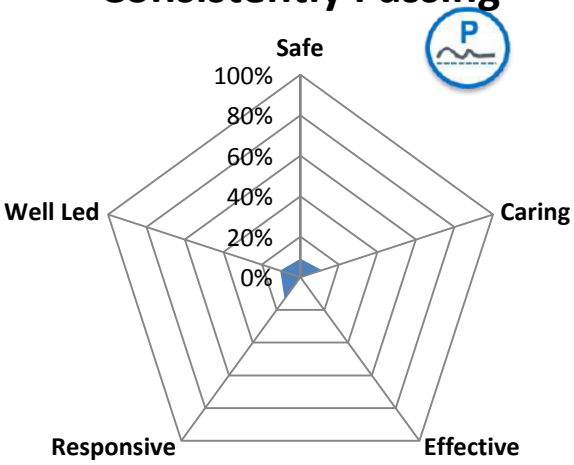
Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Consistently Passing



Consistently Passing:
The following Key Performance Indicators are all consistently achieving the target:

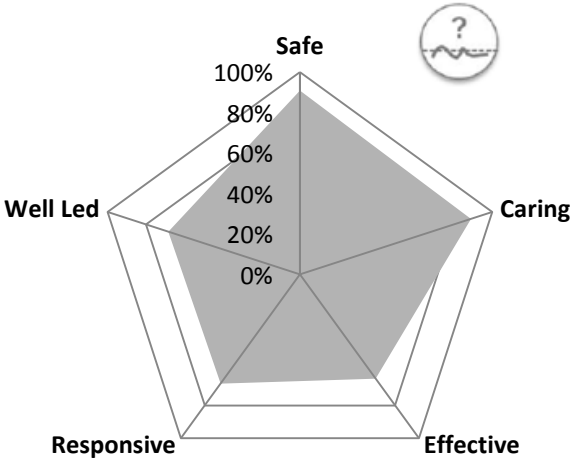
Safe:
- Trust Mortality (HMSR)

Caring:
- Mixed Sex Accommodation Compliance

Responsive:
- Cancer 62 Day Waiting Times Standard
- Cancer 2 week Waiting Times Standard

Well-Led:
- Mandatory Training Compliance

Hit and Miss



Hit and Miss:
The following Key Performance Indicators are experiencing inconsistency (passing or failing target)

Safe:
- Safe Staffing, Infection Control Indicators, Incident Reporting, Harm Free Care Indicators

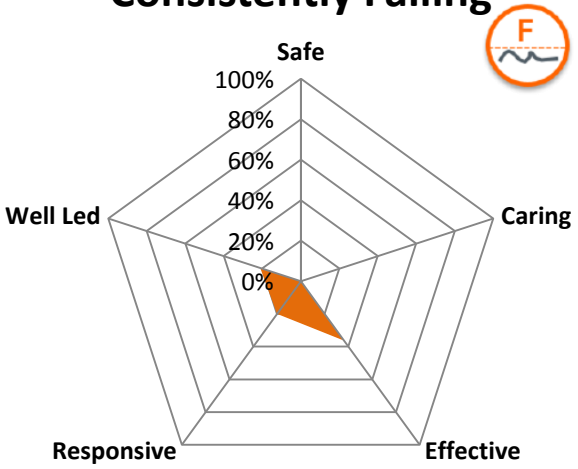
Effective:
- Outpatients DNA Rates and Hospital Cancellations, Readmissions Indicators, Stroke Indicators

Caring:
- Complaints Indicators, Friends & Family Percentage Positive, Friends & Family Response Rates – Inpatients, Maternity & Outpatients

Responsive:
- RTT performance, Diagnostics Waiting Times, Theatre Utilisation, Cancer 31 Day Standard
- A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NELOS

Well-Led:
- Capital Expenditure, Cash Balance, Sickness Rates, Vacancy Rates, Appraisals, Staff Friends & Family Recommended to work, Health and Well-Being and Clinical Strategy Indicators

Consistently Failing



Consistently Failing:
The following Key Performance Indicators are all consistently failing the target:

Effective:
- Percentage of Non-Face to Face Outpatient Appointments
- Outpatient Utilisation
- Outpatient – Calls answered within 1 or 3 minutes

Responsive:
- RTT Number of >40 week Waiters
- RTT Number of >52 week Waiters
- Cancer PTL – size of Backlog

Well-Led:
- Agency Staff used
- Agency Spend
- Turnover Rate
- Friends & Family Recommended Care

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains									No SPC	
CQC Domain Safe										
Infection Control	3		1					4		4
Harm Free Care			2					2		2
Incident Reporting	2							2		2
Safe Staffing	1	1						2		2
Mortality				1		1				1
Safe Total	***6***	***1***	***3***	***1***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	3	2	2				4	3		7
Quality & CQC	2			2				4		4
Strategy - Estates									5	5
Effective Total	***5***	***2***	***2***	***2***	***0***	***0***	***4***	***7***	***5***	***16***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	3	1				1		3		4
ED Care									2	2
Maternity Care	1				1			2		2
Outpatient Care	1							1		1
Caring Total	***7***	***1***	***0***	***0***	***1***	***1***	***0***	***8***	***2***	***11***
CQC Domain Responsive										
Elective Access	3		2				2	3		5
Acute and Urgent Access	1	1		2				4	1	5
Cancer Access	1			1	2	2	1	1	1	5
Diagnostics Access		1						1		1
Bed Management	1							1		1
Responsive Total	***6***	***2***	***2***	***3***	***2***	***2***	***3***	***10***	***2***	***17***
CQC Domain Well-Led										
Staff Welfare	2							2	4	6
Finance and Contracts	2				1		1	2	3	6
Leadership		1			1	1	1		1	3
Strategy - Clinical and ICC	1		1	3	1			6	1	7
Workforce	1			1	1	1	2	3		6
Well-Led Total	***6***	***1***	***1***	***4***	***4***	***2***	***4***	***13***	***9***	***28***
Trust Total	***30***	***7***	***8***	***10***	***7***	***6***	***11***	***48***	***18***	***83***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	5		
S6	Rate of Total Patient Falls	5.80	9.47	H	
S7	Number of Never Events	0	0	H	
S8	Number of New SIs in month	11	22		
S10	Overall Safe staffing fill rate	93.5%	80.2%	L	

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	88.8	L	P
E3	% Total Readmissions	14.6%	10.1%	L	
E6	Stroke: Best Practice (BPT) Overall %	50.0%	42.5%		
R11	Average LOS Non-Elective	6.40	7.08		
R12	Theatre Utilisation	90.0%	85.0%		

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		P
C3	% complaints responded to within target	75.0%	76.9%		
C5	IP Friends & Family (FFT) % Positive	95.0%	98.8%		
C7	A&E Friends & Family (FFT) % Positive	87.0%	No data due to COVID-19	No SPC	No SPC
C10	OP Friends & Family (FFT) % Positive	84.0%	84.1%		

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	82.7%	80.2%	L	
R4	RTT Incomplete Pathway	85.3%	73.3%		
R6	% Diagnostics Tests WTimes <6wks	99.0%	76.8%	L	
R7	Cancer two week wait	93.0%	95.0%	H	P
R10	Cancer 62 day wait - First Definitive	85.0%	86.5%	H	P

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	No data	No data	No SPC	No SPC
W2	CIP Savings	Suspended due to COVID-19		No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	7.0%	L	
W8	Total Agency Spend	1,777	1,646		F
W10	Sickness Absence	3.3%	4.4%		

Variation			Assurance			
H / L	H / L		P	?	F	No SPC
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	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

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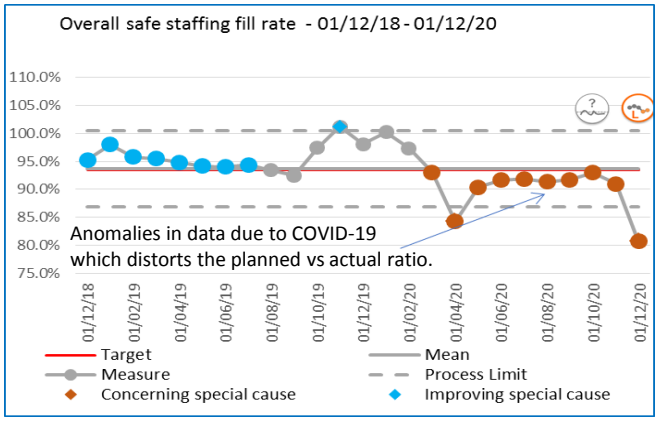
Safe - CQC Domain Scorecard

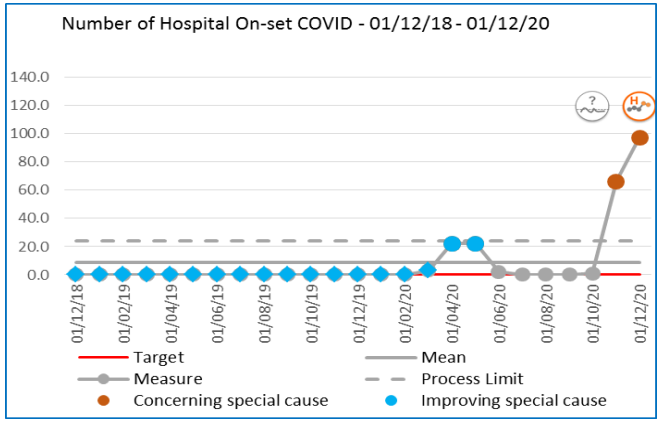
Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Safe Staffing Levels	93.5%	80.2%	Dec-20	L	93.5%	91.0%	Nov-20	93.5%	89.5%	?
Sickness Rate - Covid	0.0%	0.9%	Nov-20		0.0%	0.2%	Oct-20	0.0%	0.9%	?
Infection Control - Hospital Acquired Covid	0	97	Dec-20	H	0	66	Nov-20	0	210	?
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	18.7	26.2	Dec-20		18.7	34.9	Nov-20	23.4	25.8	?
Infection Control - Number of Hospital acquired MRSA	0	0	Dec-20		0	0	Nov-20	0	3	?
Infection Control - Rate of Hospital E. Coli Bacteraemia	14.0	36.6	Dec-20		14.0	23.3	Nov-20	31.6	28.1	?
Number of New SIs in month	11.0	22.0	Dec-20		11	22	Nov-20	99	100	?
Rate of Total Patient Falls per 100,000 occupied beddays	5.8	9.5	Dec-20	H	5.8	8.7	Nov-20	5.8	7.8	?
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	3.2	Dec-20	H	2.3	1.9	Nov-20	2.3	2.2	?
Standardised Mortality HSMR	100.0	88.8	Dec-20	L	100.0	90.2	Nov-20	100.0	88.8	P
Never Events	0	0	Dec-20		0	1	Nov-20	0	2	?

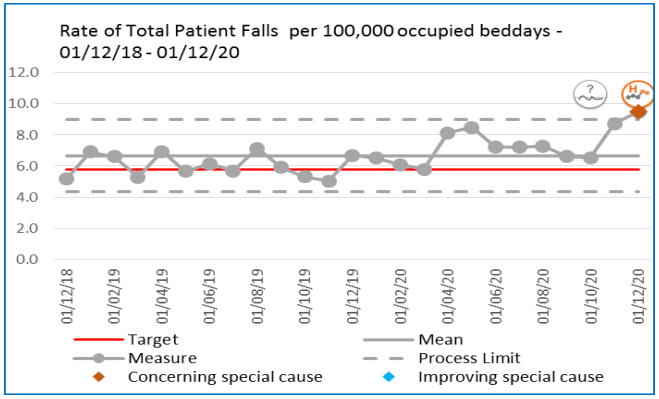
Safe - Reset and Recovery Programme: Patient and Staff Safety



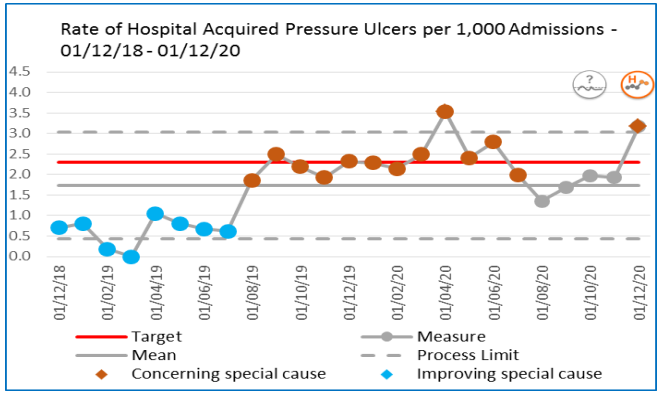
December-20
80.2%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
93.5%
Target Achievement
Metric is experiencing variable achievement



December-20
97
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
0
Target Achievement
Metric is experiencing variable achievement



December-20
9.47
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target
5.8
Target Achievement
Metric is experiencing variable achievement



December-20
3.2
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
5.0
Target Achievement
Metric is experiencing variable achievement

Summary:

The level of **Hospital On-set COVID** continues to increase.

Safe Staffing Fill Rate: The level reported has decreased significantly and remains below usual levels. This metric is experiencing special cause variation of a concerning nature. The staffing levels have been significantly impacted due to COVID related absence alongside the requirement to increase capacity, staff escalation areas and deliver care in line with new pathways. There continues to be some anomalies in the data that reflect operational decisions to open and close clinical areas in response to the COVID Pandemic which has distorted the planned vs actual ratio in addition to roster management of staff redeployment.

Falls: The number of Falls has increased significantly at the TWH site and the overall rate for the Trust is now once again experiencing special cause variation of a concerning nature with the highest level ever reported. Maidstone continues to also report a high level of Falls.

Pressure Ulcers: The rate of hospital acquired pressure ulcers is now experiencing special cause variation of a concerning nature. The increase has mainly been in Deep Tissue Injuries (DTIs).

Actions:

The Trust admitted 679 patients with Covid-19 infection during December, including 97 cases of probable or definite hospital acquired infection (14% of the total). This is a reduction from 23% in November. 8 outbreaks of Covid-19 were identified in December, two of which affected staff only. New variant Covid -19 found to be endemic in Kent and Medway. Key messages on the importance of PPE, social distancing and hand hygiene continue to be raised with staff.

Twice daily staffing huddles established to review prospectively the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust; and to ensure joint working between the nursing teams and the Bank office.

Information on the use of Safety Huddles focussed on falls included in the Executive Team Brief to support wards in bringing awareness to ward teams on the patients who are at risk and actions required to reduce risk of falls. We are deploying a number of new roles in practice that will aim to provide additional support to our clinical staff to allow them to focus on direct clinical care.

We have reviewed and amended the process for investigating hospital acquired pressure ulcers with the patient safety team, which we hope will be more time affective for the investigating staff, freeing up time to work directly with patients and evidencing the learnings from incidents quicker. New monthly Pressure Ulcer group set up – first meeting February 2021.

Assurance:

Patients and visitors wear masks and are encouraged to undertake hand hygiene regularly. Outbreak control measures implemented on affected wards and areas including contact tracing and quarantine of patient contacts. Lateral flow testing available for all staff. Rapid testing available in ED on both sites.

Twice Daily staffing huddles with divisional leads and staff bank are ongoing to review substantive and temporary staffing requirements across all areas. The Trust launched "Safe Care" to enhance the monitoring and oversight of patients acuity more effectively and support decisions around staffing requirements. Whilst the initial roll out phase has been paused temporarily the templates for all rosters have been completed so that this can be used as an oversight tool for staffing until more areas adopt full utilisation of this. Training has been shared with DDNQ's and next 3 departments identified to implement safe care. All staffing levels are reviewed for every shift, every with oversight monitored by the Senior Leadership Team and appropriate redeployment to support staffing levels across the Trust. Increased multi professions representation are on the wards to help support the nursing staff.

Continuing to monitor falls across all areas. Resources for assessment of patient at risk of falls made available to support with early identification of falls risk . We are working with the multi professional team to ensure that Falls is considered as everyone's business.

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Non-face to face OP activity / Total activity	40.0%	38.3%	Dec-20	L	40.0%	38.9%	Nov-20	40.0%	46.7%	F
OP Utilisation	85.0%	43.2%	Dec-20	L	85.0%	54.0%	Nov-20	85.0%	50.1%	F
Outpatient DNA Rate	5.0%	4.1%	Dec-20		5.0%	6.4%	Nov-20	5.0%	5.3%	?
Outpatient Hospital Cancellation	20.0%	40.5%	Dec-20	H	20.0%	20.3%	Nov-20	20.0%	27.8%	?
Outpatient Cancellations < 6 weeks	10.0%	32.4%	Dec-20	H	10.0%	15.2%	Dec-20	10.0%	20.8%	?
Calls Answereed in under 1 min	75.0%	42.5%	Dec-20		75.0%	26.2%	Dec-20	75.0%	38.8%	F
Calls Answereed in under 3 min	100.0%	67.9%	Dec-20		100.0%	47.0%	Dec-20	100.0%	63.4%	F

Organisational Objectives: Quality and CQC

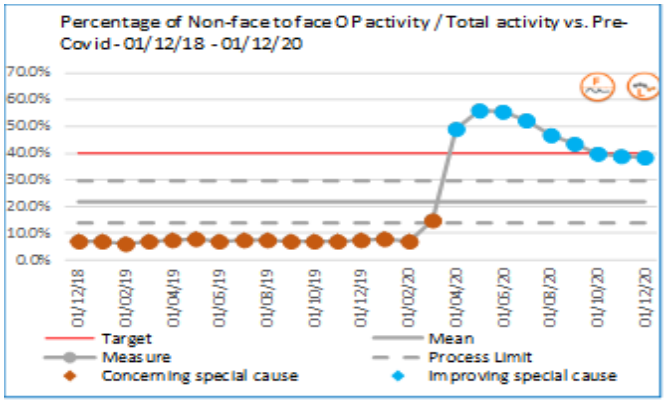
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	10.1%	Nov-20	L	14.6%	15.0%	Oct-20	14.6%	14.5%	?
Non-Elective Readmissions <30 days	15.2%	10.4%	Nov-20	L	15.2%	15.4%	Oct-20	15.2%	14.8%	?
Elective Readmissions < 30 Days	7.8%	6.3%	Nov-20		7.8%	9.7%	Oct-20	7.8%	9.4%	?
Stroke Best Practice Tariff	50.0%	42.5%	Dec-20		50.0%	54.8%	Nov-20	50.0%	49.6%	?

Effective - CQC Domain Scorecard

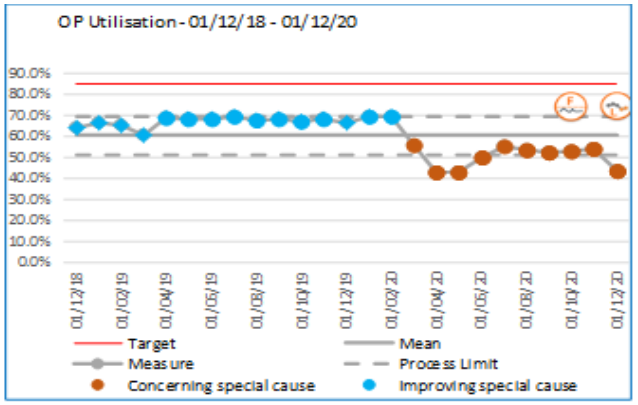
Organisational Objectives: Strategy - Estates

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100:0	Dec-20	No SPC	Under review	100:0	Nov-20	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Dec-20	No SPC	Under review	4.4:1	Nov-20	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Dec-20	No SPC	Under review	5808	Nov-20	Under review	5808	No SPC
Staff occupancy per m2	Under review	23.2	Dec-20	No SPC	Under review	23.3	Nov-20	Under review	23.5	No SPC
Energy cost per staff	Under review	£ 1,071.14	Dec-20	No SPC	Under review	£ 903.93	Nov-20	Under review	£ 749.8	No SPC

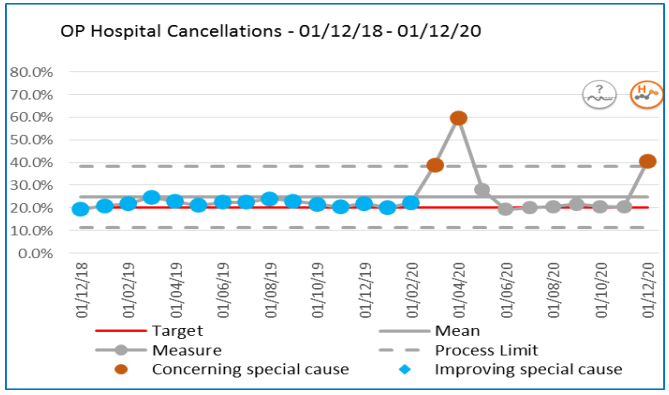
EFFECTIVE- Reset and Recovery Programme: Outpatients



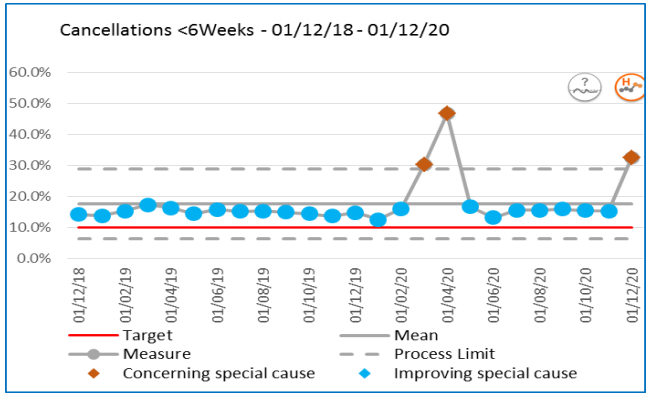
Dec-20
38.3
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Dec-20
43.2%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
85%
Target Achievement
Metric is constantly failing the target



Dec-20
40.5%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
20%
Target Achievement
Metric is experiencing variable achievement



Dec-20
32.4%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
10%
Target Achievement
Metric is experiencing variable achievement

Summary:

As we are now in Opel Level 4, all non urgent outpatient appointments have been cancelled or converted to virtual. This has led to a fall in the volume of consultations and an increase in the number of hospital cancellations.

As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased and remain lower than usual levels. The number of calls that is answered within 1 minute is constantly failing the target , this increased in December due to the importance of cancelling appointments in Opel level 4.

DNA rates for December has fallen as patients have been only informed to attend if urgent.

Actions:

Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs.

The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients.

Appointments are being reassessed as to what can be converted and cancelled due to the second wave.

Assurance:

Outpatient recovery plan is being considered with the different speciality teams and will be implemented with support from PMO.

The demand and capacity remodelling has been completed and shared with the divisions. This is being reviewed to ensure we are aiming to achieve the phase 3 targets. Weekly monitoring of this is being undertaken in the performance meetings to ensure achievement of the target.

Caring - CQC Domain Scorecard

Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	Dec-20		0	0	Nov-20	0	0	P
Rate of New Complaints	3.9	1.7	Dec-20		3.9	2.3	Nov-20	2.9	2.2	?
% complaints responded to within target	75%	76.9%	Dec-20		75%	72.7%	Nov-20	75%	76.3%	?
IP Resp Rate Recmd to Friends & Family	25%	15.3%	Dec-20		25%	7.9%	Nov-20	25%	12.7%	?
IP Friends & Family (FFT) % Positive	95%	98.8%	Dec-20		95%	97.4%	Nov-20	95%	97.1%	?
A&E Resp Rate Recmd to Friends & Family	15%	No data due to COVID-19	Dec-20	No SPC	15%	No data due to COVID-19	Nov-20	15%	No data due to COVID-19	No SPC
A&E Friends & Family (FFT) % Positive	87%		Dec-20	No SPC	87%		Nov-20	87%		No SPC
Mat Resp Rate Recmd to Friends & Family	25%	25.5%	Dec-20		25%	20.9%	Nov-20	25%	26.9%	?
Maternity Combined FFT % Positive	95%	98.7%	Dec-20	H	95%	98.6%	Nov-20	95%	99.0%	?
OP Friends & Family (FFT) % Positive	84%	84.1%	Dec-20		84%	83.5%	Nov-20	84%	82.2%	?
% VTE Risk Assessment	95%	92.3%	Dec-20	L	95%	96.5%	Nov-20	95%	96.5%	?

Responsive- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

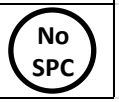
	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
RTT (Incomplete Pathways) performance against trajectory	85.3%	73.3%	Dec-20		85.3%	76.9%	Nov-20	85.3%	73.3%	
Number of patients waiting over 40 weeks	0	2204	Dec-20	H	0	1740	Nov-20	0	13502	F
52 week breaches (new in month)	5	144	Dec-20	H	5	127	Nov-20	45	1173	F
Access to Diagnostics (<6weeks standard)	99.0%	76.8%	Dec-20	L	99.0%	76.8%	Nov-20	99.0%	76.8%	
Average for new appointment	10.0	8.6	Dec-20		10.0	10.7	Nov-20	10.0	8.6	
Theatre Utilisation	90.0%	85.0%	Dec-20		90.0%	85.3%	Nov-20	90.0%	81.8%	

Reset and Recovery Programme – Acute & Urgent Care

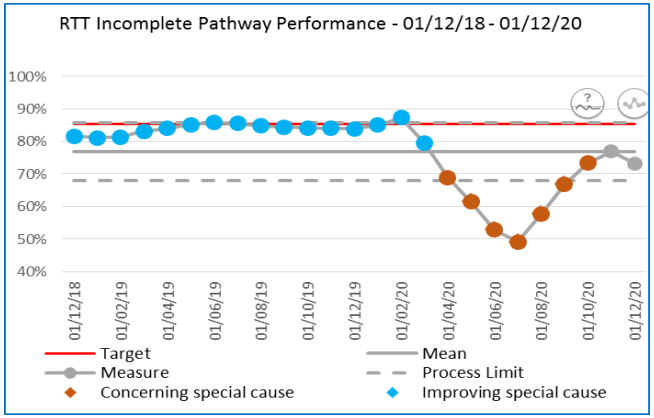
	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Referrals to ED from NHS 111	Coming December 20		Dec-20	No SPC	Coming December 20		Nov-20	Coming December 20		No SPC
A&E 4 hr Performance	88.2%	80.2%	Dec-20	L	88.2%	91.8%	Nov-20	88.2%	94.7%	
Super Stranded Patients	80	88	Dec-20	L	80	75	Nov-20	80	88	
Ambulance Handover Delays Rate > 30mins	7.0%	9.5%	Dec-20	L	7.0%	5.6%	Nov-20	7.0%	9.5%	
Bed Occupancy	90.0%	91.6%	Dec-20		90.0%	86.2%	Nov-20	90.0%	66.1%	
NE LOS	6.4	7.1	Dec-20		6.4	6.0	Nov-20	6.4	6.0	

Responsive - CQC Domain Scorecard

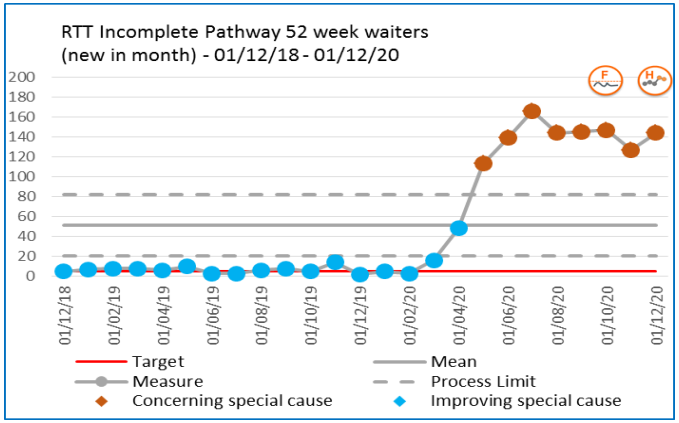
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Cancer - 2 Week Wait	93.0%	95.0%	Nov-20		93.0%	95.0%	Oct-20	93.0%	95.0%	
Cancer - 31 Day	96.0%	98.3%	Nov-20		96.0%	98.3%	Oct-20	96.0%	98.3%	
Cancer - 62 Day	85.0%	86.5%	Nov-20		85.0%	86.5%	Oct-20	85.0%	86.5%	
Size of backlog	30	69	Dec-20		30	69	Nov-20	30	69	
28 day Target	Coming Soon		Nov-20		Coming Soon		Oct-20	Coming Soon		

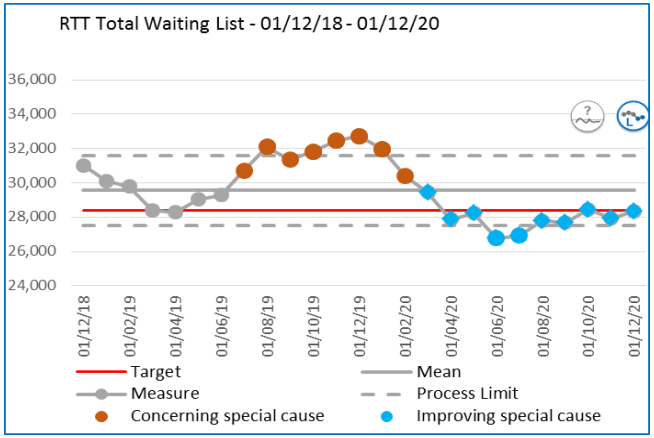
RESPONSIVE- Reset and Recovery Programme: Elective



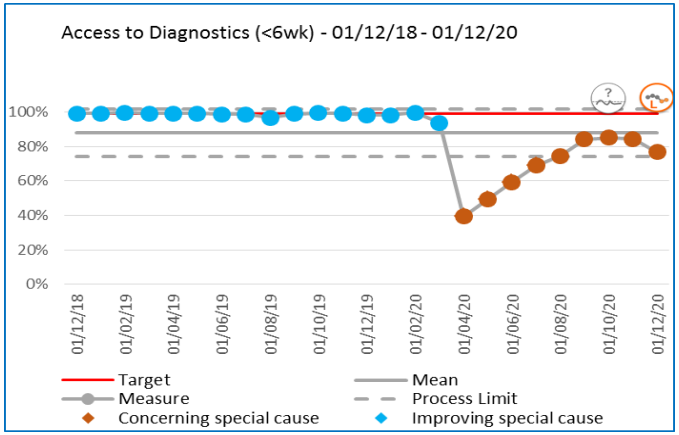
Dec-20
73.3%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
86.3%
Target Achievement
Metric consistently failing the target



Dec-20
144
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
8
Target Achievement
Metric is consistently failing the target



Dec-20
28,342
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
28,412
Target Achievement
Metric is experiencing variable achievement



Dec-20
76.8%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

Although elective activity levels had significantly increased in October, due to the COVID-19 pandemic & the impact of wave 2 the YTD activity remains low for both elective and outpatient appointments which have adversely impacted the RTT performance. The December performance has dropped to 73.3% (unvalidated position) & the Total Waiting List has increased this month due to the closure of theatres & the cancellation of routine elective activity

The elective activity levels have been decreasing since November due to the 2nd wave COVID-19 with inpatients showing a larger decrease than New outpatient activity. Large scale cancellations of elective activity has resulted in admitted electives & daycases reducing by 42% on normal levels YTD and New Outpatient activity has reduced by around 26% & follow up by around 7% YTD on normal activity levels.

Following the decrease in performance for diagnostic waiting times during the first wave this had been improving for both endoscopy and imaging but is now once again experiencing special cause variation of a concerning nature .

Actions:

To ensure that cancer activity is facilitated in line with the further expansion of intensive care provision to meet the Covid-19 demand.

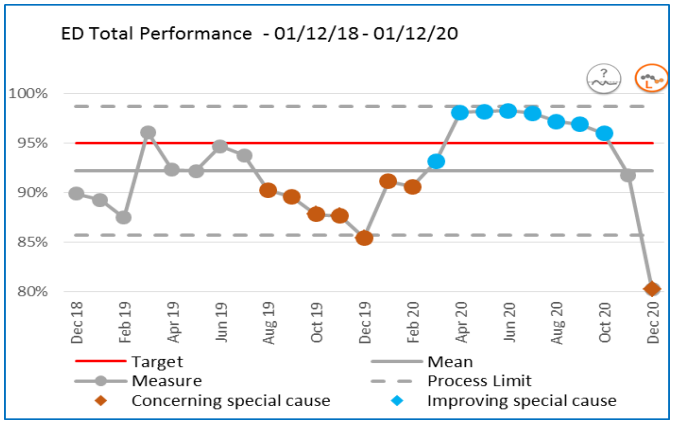
To decrease long waiting patients - ongoing

Assurance:

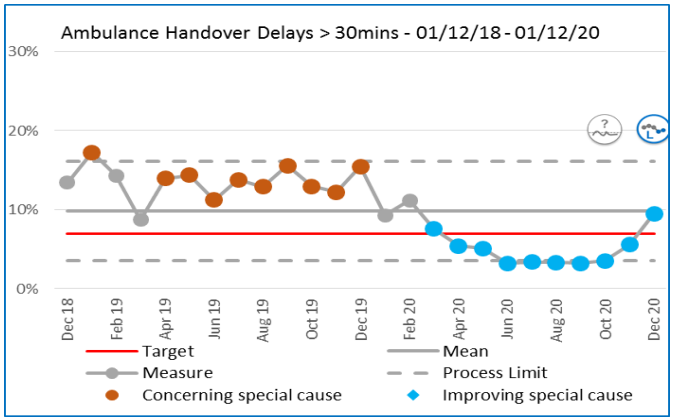
Theatre schedule further reduced. Independent sectors being utilised to facilitate simple and intermediate cancer activity and P1 and P2 activity.

Long waiting patients continue to be monitored although the backlog will increase due to the future expansion of intensive care provision to meet the Covid-19 pandemic.

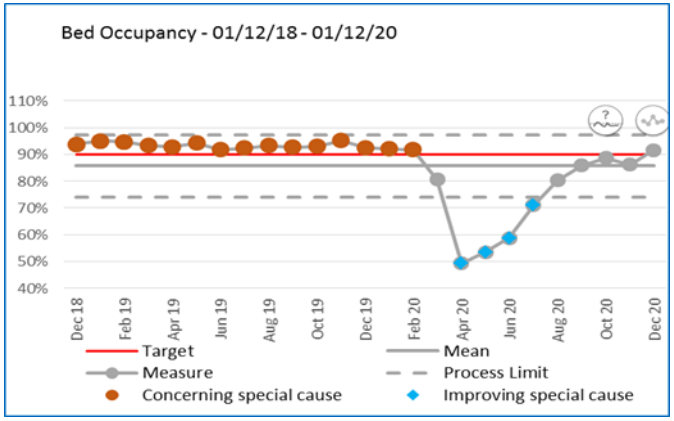
Responsive - Reset and Recovery Programme: Emergency Care



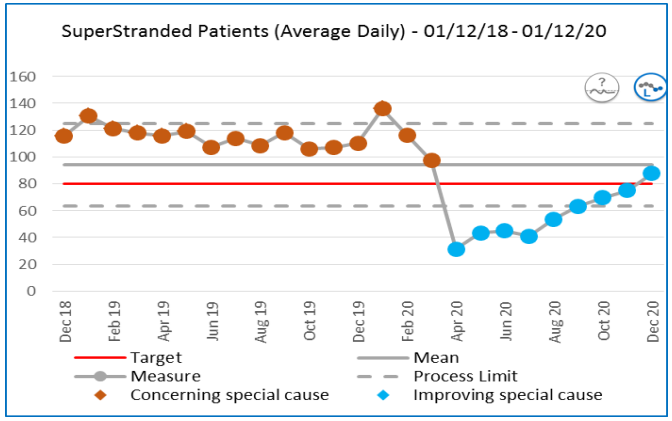
Dec-20
80.2%
Variance Type
Metric is currently experiencing Special Cause Variation of an concerning nature
Target
95%
Target Achievement
Metric is experiencing variable achievement



Dec-20
9.5%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
7.0%
Target Achievement
Metric is experiencing variable achievement



Dec-20
91.6%
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



Dec-20
87.6
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
80
Target Achievement
Metric is experiencing variable achievement

Summary:

- ED 4hr performance (inc MIU) had been above 98.0% for 4 months, but is showing a downward trend over the last few months (80.21% in December). Arrivals (Type 1) were 18% below model in December.
- Ambulance delays had settled into 3.0-3.5%, but have been increasing since October. Ambulance diverts for mutual aid & Covid have both been factors.
- Total bed occupancy dropped to under 50% during the pandemic but has been steadily increasing to 91.6% in December (first week of December average was 86% but rest of December average was 94%)
- Superstranded patients came down to less than half it's previous levels, but has been steadily increasing.

Actions:

Daily tasks and competencies being developed for Flow Coordinator role on both sites to standardise and embed.

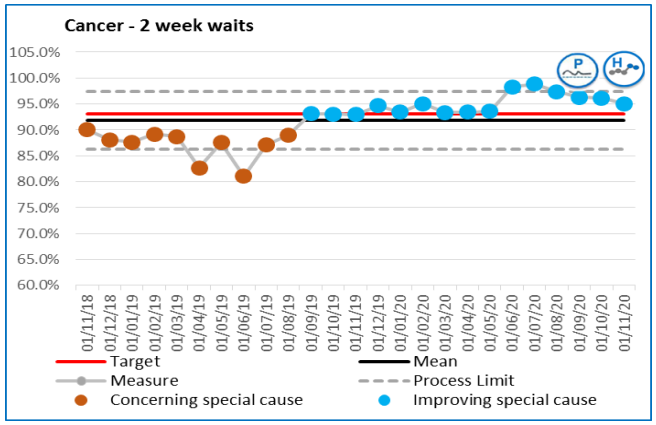
Escalated to ICC/ CCG that a large number of out of area patients are being booked into Maidstone for UTC/ ED. Continuing technical issues with WASP. Weekly meetings to resolve.

Development of improved daily/ weekly report detailing breach reasons. Increased access to Symphony for specialty teams. Staffing issues highlighted where CDU not able to open with targeted recruited of staff to work in this low risk area. Flow days in place by managers to support department

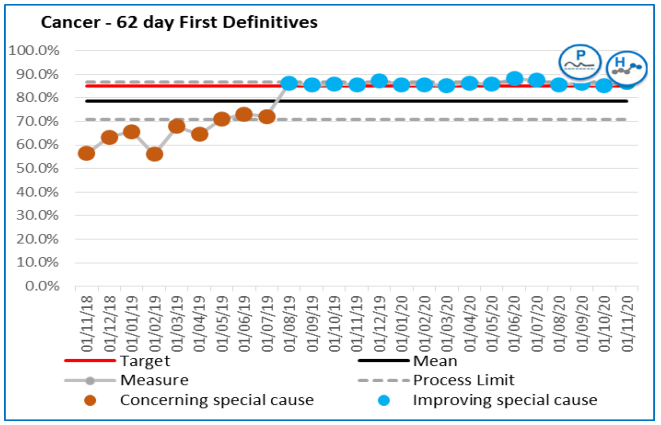
Assurance:

Rotas in place to cover temporary admin shortage. Teletracking training continues to be embedded. Business case approved at Execs to support increased substantive recruitment of ED consultants to ensure workforce resilience and senior clinical presence in RAP where ambulances arrive. Continued liaison with SECAmb to support flow. Advanced notice from Stroke Assessor team where medical cover required to support service if assessors required to cover nursing shifts. Regular meetings with junior doctors to support robust ward cover across all medical wards, working with Medical Education to change rotas where appropriate.

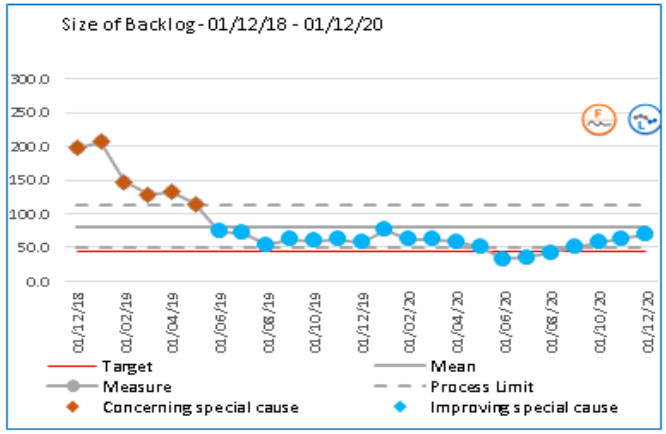
RESPONSIVE- Reset and Recovery Programme: Cancer



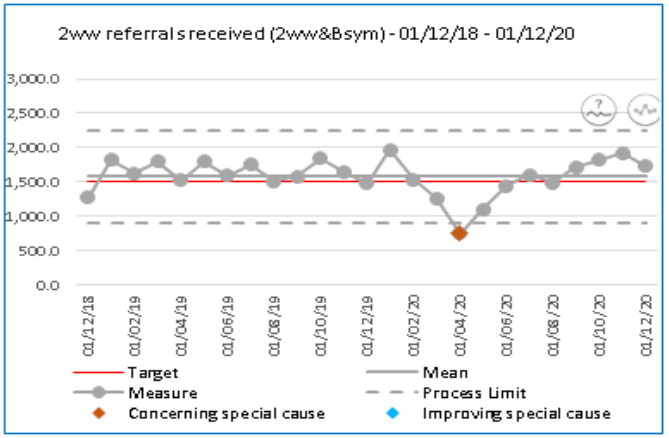
Nov-20
95.0%
Variance Type
Metric is showing Special Cause Variation of an improving nature
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Nov-20
86.5%
Variance Type
Metric is showing Special Cause Variation of an improving nature
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Dec-20
69
Variance Type
Metric is showing Special Cause Variation of an improving nature
Max Target
45
Target Achievement
Metric is consistently failing to achieve the target set locally



Dec-20
1726
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
1500
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Summary:

The Trust has continued to achieve both the targets for 62 day First Definitive treatment (86.5%) and the 2 week wait first seen (95.0%). From next month the SPC chart will be updated to show the process limit changes following the improvement in the process for both 62 Day and 2 Week Wait standards.

The number of 2ww referrals received in December was slightly less, as expected with the Bank Holidays, but is continuing with an increase over last year's numbers. This remains consistent with common cause variation.

Although the Total PTL numbers have risen to an average of 1650 through December, the overall size of the backlog is being maintained with an average of 69 patients (which remains at 4.1% of the total PTL)

Actions:

Ongoing work is needed to engage all services further and to ensure that both the 28day FDS and the 62d performance targets can be met.

Recruitment of additional roles designed to support the continuation of renewed pathways during Covid is underway. This includes: STT nurses, pathway navigators and oncology flow coordinators. Key plans are being reviewed to ensure national guidance is being implemented / will be implemented during this second lockdown period to ensure cancer diagnostics and treatments can continue efficiently and effectively across services.

From next month the SPC charts will be updated to show the process limit changes following the improvement in the process for both 62 Day and 2 Week Wait standards

Assurance:

The ongoing daily huddles with each tumour site team are in place and monitoring the growth in the PTL as referral numbers fluctuate. Management of the daily PTLs continues to give oversight and hold services to account for patient next steps. Diagnostic services attend these huddles to escalate booking or reporting delays on the day.

The weekly performance meetings continue to oversee the cancer performance and include funding initiatives and quality assurance i.e. 104 day clinical harm reviews.

28 day FDS meetings will be reinstated in preparation for national monitoring of this target.

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	688	Sep-20	No SPC	Improving Quarterly	738	Jun-20	Improving Quarterly	738	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		67.0%	Sep-20	No SPC		72.0%	Jun-20		72.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		68.0%	Sep-20	No SPC		71.0%	Jun-20		71.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		69.0%	Sep-20	No SPC		76.0%	Jun-20		76.0%	No SPC
Health and Wellbeing: How many calls received	40	22	Nov-20		40	33	Oct-20	40	482	?
Health and Wellbeing: What percentage of Calls related to Mental Health Issues	44%	32%	Nov-20		44%	52%	Oct-20	44%	44%	?

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	4.4%	Dec-20		3.3%	3.7%	Nov-20	3.3%	4.0%	?
Turnover	10.0%	11.4%	Dec-20		10.0%	11.9%	Nov-20	10.0%	11.9%	F
Vacancy Rates	9.0%	7.0%	Dec-20	L	9.0%	7.3%	Nov-20	9.0%	7.0%	?
Use of Agency	0	246	Dec-20		0	240	Nov-20	0	246	F
Appraisal Completeness	95.0%	90.4%	Dec-20		95.0%	89.9%	Nov-20	95.0%	89.9%	?
Stat and Mandatory Training	85.0%	90.1%	Dec-20	H	85.0%	89.9%	Nov-20	85.0%	89.9%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty	No data		Dec-20	No SPC	No data		Nov-20	No data		No SPC
CIP Savings	Suspended		Dec-20	No SPC	Suspended		Nov-20	Suspended		No SPC
Cash Balance	50,614	74,655	Dec-20	H	50,614	69,090	Nov-20	50,614	74,655	?
Capital Expenditure	1,480	1,686	Dec-20		1,480	1,475	Nov-20	13,669	9,249	?
Agency Spend	1,776,603	1,646,371	Dec-20		1,776,603	1,691,906	Nov-20	9,803,992	12,939,561	F
Use of Financial Resources	2	No data	Dec-20	No SPC	2	No data	Nov-20	No data		No SPC

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Nursing vacancies	13.5%	10.7%	Dec-20	L	13.5%	10.5%	Nov-20	13.5%	0.0%	?
Covid Positive - number of patients	0	690	Dec-20	H	0	291	Nov-20	0	1361	?

Well Led - CQC Domain Scorecard

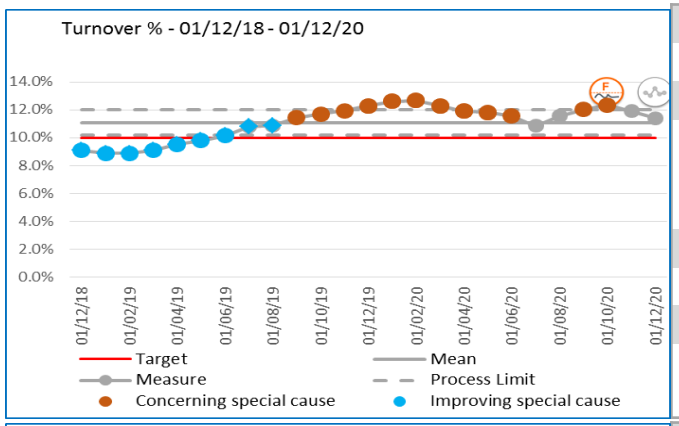
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Dec-20		35	30	Nov-20	35	270	
Elective Spells in London Trusts from West Kent	329	193	Sep-20		329	154	Aug-20	329	2,545	
Service contribution by division	Coming February 21		Dec-20	No SPC	Coming February 21		Nov-20	Coming February 21		No SPC
Research grants (£)	114	79	Dec-20		114	105	Nov-20	114	866	
Number of advanced practitioners	25	31	Dec-20		25	31	Nov-20	25	31	

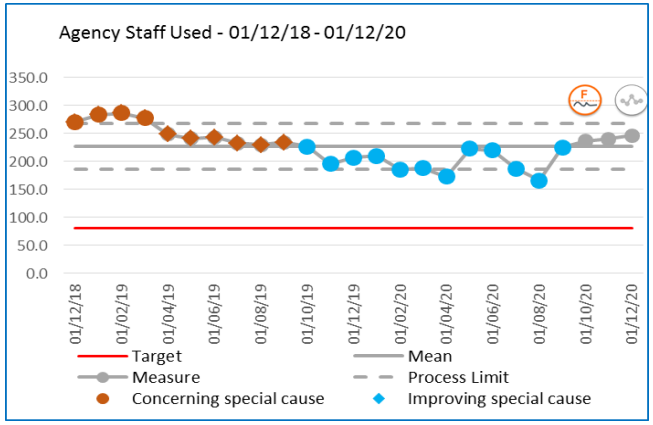
Organisational Objectives – Exceptional People

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	57.0%	72.2%	Dec-20		57.0%	72.2%	Nov-20	57.0%	72.2%	
Staff Friends and Family % recommended care	80.0%	77.8%	Dec-20		80.0%	77.8%	Nov-20	80.0%	77.8%	
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming April 21		Dec-20	No SPC	Coming April 21		Nov-20	Coming April 21		No SPC

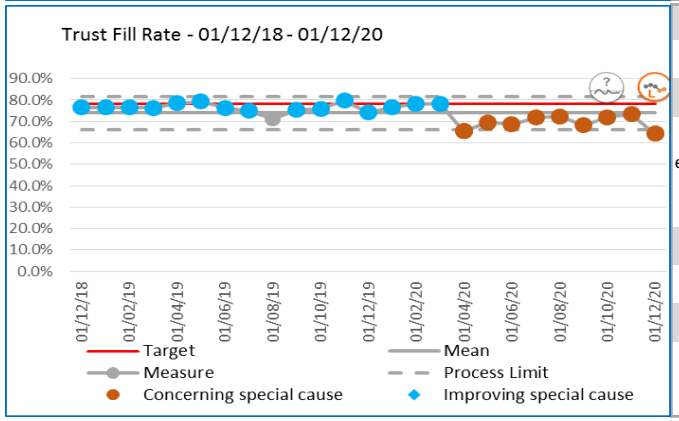
WELL LED- Operational Objective: Workforce



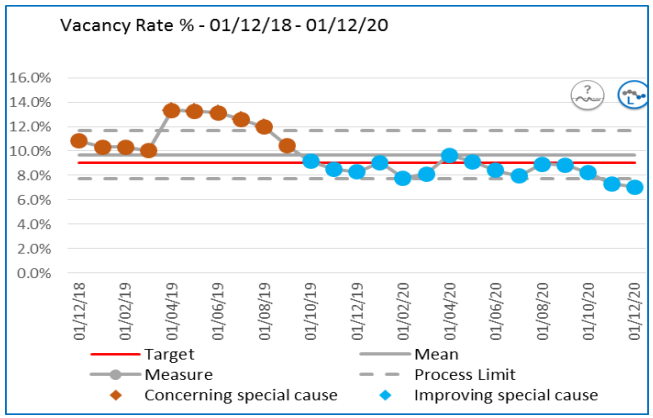
December-20
11.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
10%
Target Achievement
Metric is consistently failing the target



December-20
246
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
81
Target Achievement
Metric is consistently failing the target



December-20
64.1%
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Target (Internal)
78%
Target Achievement
Metric is experiencing variable achievement



December-20
7.0%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
9.0%
Target Achievement
Metric is experiencing variable achievement

Summary:

The Turnover rate for the last 12 months is now experiencing common cause variation but is consistently failing the target.

The level of Agency staff used has again shown a marginal increase which is understandable given Covid-19 second wave impacts. There are also some areas which continue to challenge the Trust due to the roles being on the shortage occupation list, and we continue to work with colleagues to consider innovative solutions for MTW.

The Trust fill Rate remains below the target level of 78% and is experiencing special cause variation of a concerning nature. This has been affected by the decrease in the Nursing Staff Fill Rate . The staffing levels have been significantly impacted due to COVID related absence alongside the requirement to increase capacity, staff escalation areas and deliver care in line with new pathways. There continues to be some anomalies in the data that reflect operational decisions to open and close clinical areas in response to the COVID Pandemic which has distorted the planned vs actual ratio in addition to roster management of staff redeployment.

The Vacancy Rate remains below the Trust maximum limit and is therefore experiencing special cause variation of an improving nature.

Actions:

The Workforce (People) Function has 4 areas of focus: Temporary Staffing (Staff Hub) Recruitment, Vaccinations and Staff Welfare. We have continued to refine our survey approach to build on the success of the Climate survey and are still planning to undertake the Jan 2021 survey. Given the Pandemic, we have postponed the launch of the joiner (onboarding) survey until February. We continue to progress the use of Climate survey data to drive local interventions to aid retention and implementation plans. Turnover can be impacted by quality of managers and leaders and we are working with HRBPs to help managers with this. We have also postponed the first phase of Exceptional Leaders and the roll out of Ward Manager Programme.

December saw a significant increase in demand on temporary staffing, with the pandemic affecting Agency and Bank staff availability. The fill rate has declined due to more shifts needing to be filled the number of shifts filled, however 4,857 shifts were filled (Nov 20 5,116) Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff. The Covid-19 second wave is impacting as staff may already be working extra shifts and because of Covid-19 illness or self isolation requirements or school closures. Ongoing recruitment and delivery of international nurse recruitment programme continues.

Assurance:

Delivery of 2020/21 Workforce plans are supported by the HRBP and workforce information teams. Divisions are reviewing existing workforce and recruitment plans and staff engagement and retention work is supported by divisional action plans for the national staff survey and local pulse checks. Progress against these action plans is reviewed in Divisional Performance reviews.

The recruitment team are undertaking various initiatives at present to support vacancies: This includes international nurse recruitment, generic Covid-19 focussed advertising and open event attendance. HRBPs are working up plans on recruitment hotspot areas across all areas, not solely focusing on nursing, and are working with leadership teams to look at alternative solutions.

Bank team continue to work closely with the site team on finding solutions to reduce agency spend. Due to the impact of Covid-19, we are paying enhanced rates for Bank staff (including Bank Only workers) to mitigate staff shortages, encourage staff to pick up bank shifts and reduce wider agency spend up until 31/01/2021.

The Trust has developed its Staff Hub to respond to Covid pressures. As community transmission of Covid-19 remains very high, the ability to respond has become more limited due to pandemic infection and restrictions. School closures are also currently having a big impact.

Appendices

Supporting Narrative

Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, throughout the Covid-19 pandemic, reporting 86.5% and 95% respectively for November 2020. The increase in second wave Covid has impacted performance in some areas with the A&E 4hr standard reducing further to 80.2% in December. As expected the RTT performance decreased and the RTT waiting list has seen an increase in December due to the impact of only Cancer and clinically urgent patients being facilitated in order to increase ITU surge capacity. Of the constitutional standards the RTT and Diagnostics standards remain the most at risk due to the decrease in capacity (with the impact of social distancing and use of PPE) and the uncertainty as to the likely level of demand. In addition some of the patient safety and quality indicators have also been adversely impacted due to the high bed occupancy (particularly for older and more complex patients) as well as the current staffing challenges (particularly nursing staff) facing the Trust due to the Pandemic.

Key Performance Items:

- **Infection Control:** Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. The Trust admitted 679 patients with Covid-19 infection during December, including 97 cases of probable or definite hospital acquired infection (14% of the total). This is a reduction from 23% in November. 8 outbreaks of Covid-19 were identified in December, two of which affected staff only. New variant Covid -19 found to be endemic in Kent and Medway. Key messages on the importance of PPE, social distancing and hand hygiene continue to be raised with staff. Patients and visitors wear masks and are encouraged to undertake hand hygiene regularly.

- **Falls:** The number of Falls has increased significantly at the TWH site, particularly in the Medical and Care of the Elderly specialties. The overall rate for the Trust is now once again experiencing special cause variation of a concerning nature with the highest level ever reported (9.47). Maidstone continues to also report an increasing level of Falls. Two SIs relating to Falls were reported. There have been challenges around staffing impacting on availability of staff to implement monitoring at the level required for patients at risk of falls. We are deploying a number of new roles in practice that will aim to provide additional support to our clinical staff to allow them to focus on direct clinical care. Information on the use of Safety Huddles focussed on falls included in the Team Brief.

- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers increased and is now experiencing special cause variation of a concerning nature. The increase has mainly been in Deep Tissue Injuries (DTIs), particularly in the Medical and Care of the Elderly specialties (8 out of the 10 DTIs reported). Process for investigating hospital acquired pressure ulcers with the patient safety team has been reviewed and amended, which will be more time affective for the investigating staff, freeing up time to work directly with patients and evidencing the learnings from incidents quicker.

- **Incidents and SIs:** 22 SIs were reported in December, same number as November. 11 of the 22 are COVID-infection related (this includes 2 outbreaks that happened in November). The rate of incidents that are severely harmful increased in December (11 incidents resulting in severe harm and 9 resulting in death). Of the 11 incidents, 3 are falls resulting in severe harm and have been declared as SIs. The remaining 8 are linked to Covid outbreaks. These are being investigated and the level of harm may be downgraded once the care has been reviewed. Of the 9 incidents resulting in deaths, 4 have been declared SIs and the remaining incidents are awaiting clinical review to assess and validate the level of harm.

- **Stroke:** Performance for December decreased further to 42.5% which is below the 50% Best Practice internal target (may increase with late data recording). All of the three stroke indicators continue to experience common cause variation and inconsistency (wide process limits).

- **A&E 4 hour Standard:** Performance in December reduced further to 80.2% in December. The Trust continues to implement the ED improvement action plan to support flow throughout Trust which is proving ever more challenging with the high bed occupancy levels, particularly for COVID patients. A&E Attendances are now fairly steady at around 85% of normal levels (including an increase from other areas as we provide mutual aid). Emergency admissions are almost back to previous levels. Total Bed Occupancy has been steadily increasing with December at 91.6%. However this is due to lower occupancy for the first week of December. Since the middle of December the occupancy has been around 94% for December with January currently at 95.8%.

- **Ambulance Handover Delays**: This had improved, holding steady at around 3.0-3.5% of all handovers delayed 30 mins or longer, however this has been increasing since October. Diverts from others Trust and second wave Covid have both been factors.

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** As expected due to the COVID-19 pandemic and the need to only facilitate Cancer and clinically urgent patients in order to increase ITU surge capacity, activity levels continue to remain low for both elective and outpatient appointments. This has adversely impacted the RTT performance for December which has decreased further to 73.3%. Diagnostics waiting <6 weeks performance has also decreased to 76.8% in December.

- **Outpatient Activity Face to Face vs Virtual:** As we are now in Opel Level 4, all non urgent outpatient appointments have been cancelled or converted to virtual. This has led to a fall in the volume of consultations and an increase in the number of hospital cancellations. The increased use of Virtual vs Face to Face outpatient appointments (where clinically appropriate) is part of the Trust's Reset and Recovery Programme.

- **Cancer 62 Day:** From August 2019, when the Trust implemented robust PTL management with service managers across the Trust, the 62 day standard has shown an improved performance and has consistently achieved the 85% standard (86.5% for November). Treatment numbers remain lower than in 2019, with 90 patients treated in November (68% of the average treatment numbers for 2019-20). From next month the SPC charts will be updated to show the process limit changes following the improvement in the process for both 62 Day and 2 Week Wait standards.

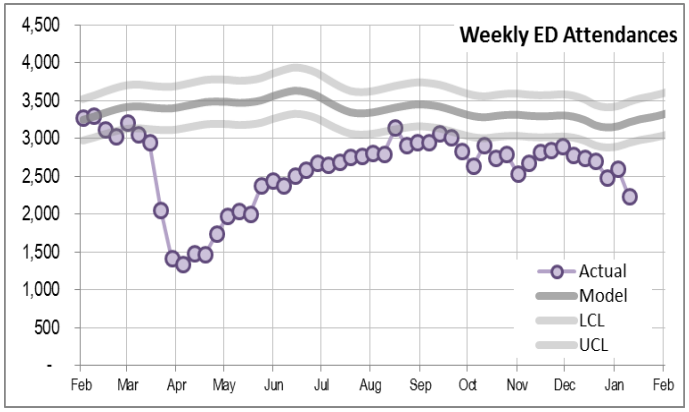
- **Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement in the achievement of the 2ww first seen standard, with a consistent achievement of the target. (95.0% for November). The recent 5 months of improved performance is likely due to the lower than expected number of 2ww referrals and the Trust continuing to appoint suspected cancer patients as a priority, utilising the virtual clinics where possible. There were 1553 first seen appointments against the 2ww standard in November 2020, which is almost 114% over the average monthly first seen appointments through 2019-20.

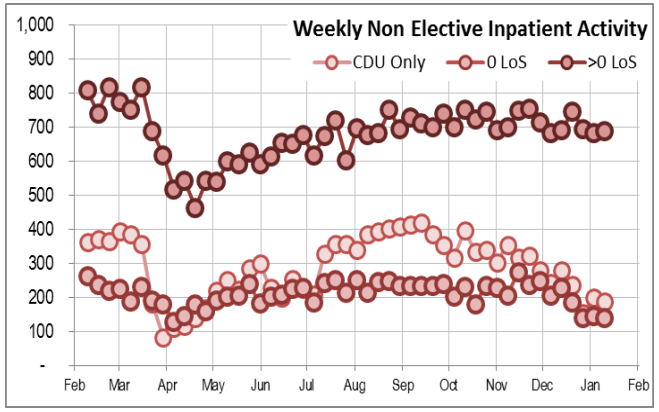
- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, incoming referral numbers have increased through the remainder of 2020, with 1877 referrals received in December 2020. This results in a daily average of 114% over the average for the same period last year

- **Finance:** The Trust has delivered the financial plan generating a £2.5m surplus. The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners, this plan includes an allocation to fund COVID related spend (£11.2m). The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are: Pay underspends (£4.5m) mainly within Nursing (£3.1m), STT (£1.8m) staff groups due to higher than planned vacancies, Delays in investment associated with Stroke, ITU extension and Recovery and Reset developments (£3.4m), Drugs (£2.8m) mainly due to reduction in Oncology and Ophthalmology high cost drugs and £0.2m underspend within clinical supplies due to reduction in elective activities. These underspends are partly offset by pressures associated with Car Parking (£0.3m), RTA income recovery adjustment for 2016/17 and 2017/18 (£0.4m), reduction in block payment from commissioners (£0.8m - net underspend), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m) and increase in reserves(£0.1m).

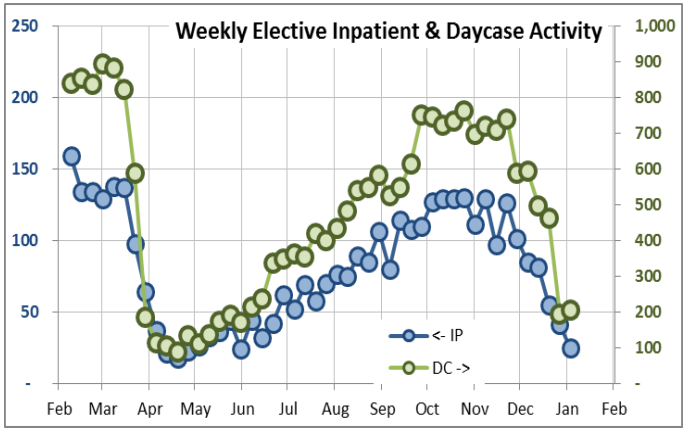
- **Workforce:** The Safe Staffing Nursing Fill Rate has decreased further which has impacted on the overall fill rate. Twice daily staffing huddles with divisional leads and staff bank established to review prospectively the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust. Increased multi professions representation are on the wards to help support the nursing staff. Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff. The Turnover rate has decreased further but is consistently failing the target. Climate survey data is being used to drive local interventions to aid retention. Sickness levels increased further in December (4.4%) as expected for this time of year, however both confirmed Covid & self isolation have increased since late October as our Covid patient numbers have increased. The Trust has developed a Staff Hub / Cell to respond to Covid pressures. As community transmission of Covid-19 remains very high, the ability to respond may become more limited, especially if staff and Bank Only workers are impacted. School closures are also currently having a big impact.

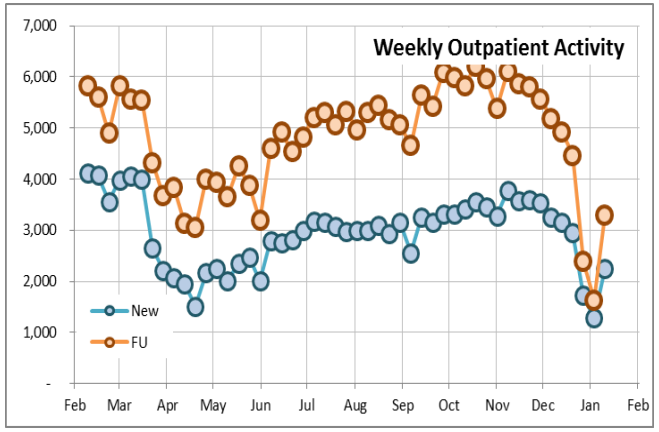
Escalation: COVID-19





ED Attendances: Attendances fell to around 40% of modelled attendances at the height of the pandemic. This recovered steadily until September, then levelled off at 80-90% of normal. The second wave, the move to the Urgent Treatment Centre model where the more minor attendances are booked via NHS 111, and now the second lockdown all appear to have brought this down further.





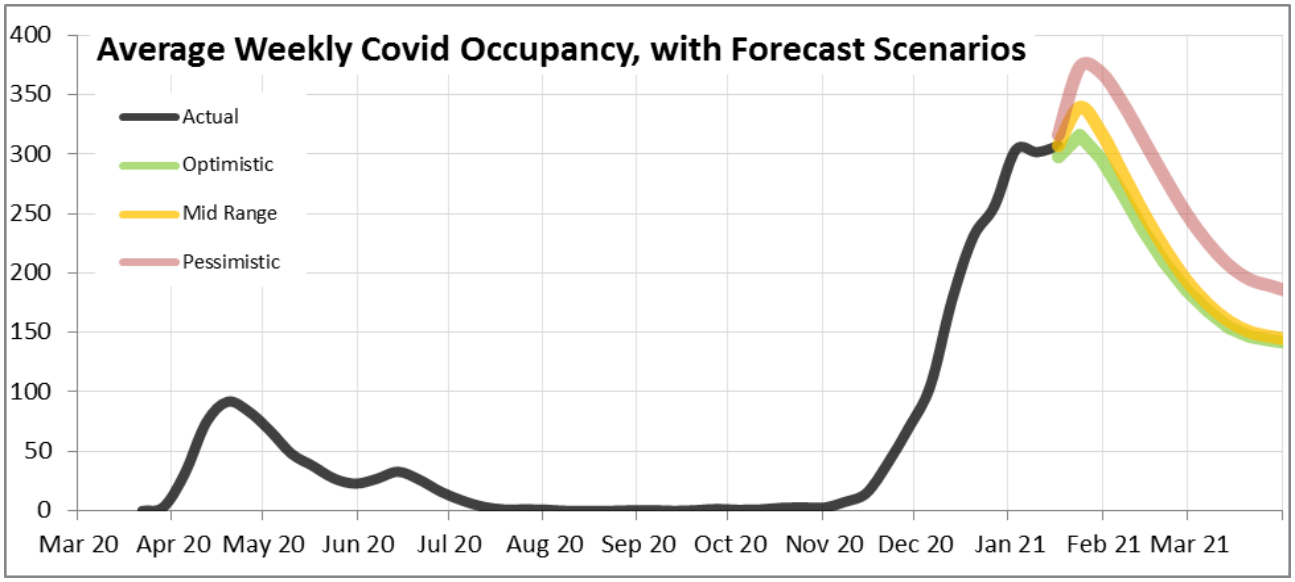
Emergency Admissions: Non-zero emergency admissions had settled in to being around 10% down on normal through the Autumn, and has held fairly constant in the second wave, SDEC activity went back to normal or slightly above, but has come back down, and is around 40& below normal. CDU Only was higher than normal over the summer, but has steadily reduced since October, probably influenced more by patient flow changes.

Elective / Daycase Activity: Large scale cancellations of elective activity resulted in admitted electives reducing by 75-80% on normal levels, and daycases also 80-85% in April. They have both recovered steadily until October, as the Trust restart & recovery programmes came into effect, but have been brought down in recent weeks by the effects of the 2nd wave of the Pandemic, and are now back down to levels seen in the Spring

Outpatient Activity: Similarly with elective activity, outpatients recovered to a little below normal into the Autumn, but has been reduced in recent weeks, especially FU activity, which was more heavily reduced over Xmas .

Summary : Almost all types of activity had had recovered into the range of normal to 20% down on normal during September / October, and has been pushed down in recent weeks by the 2nd wave of the pandemic, and our increased escalation levels.

Escalation: COVID-19



Covid occupancy peaked at 334 on Mon 04-Jan, exceeding the worst case scenario forecasts on last month's report. The new, more infectious variant had not been recognised at that point, and community infection rates had not started to change trajectory.

There appears to have been an levelling off of both community rates & admissions, and occupancy has been in the 270-285 range this week,

The optimistic forecast sees us coming back up slightly over the next couple of weeks before coming back down to around 150 at the end of March. The Mid-range forecast sees us going back up to the 330-350 range, but then coming down in a similar way, and the pessimistic up to 360-380.

So far, actual admissions seems to have tracked 10-15% below the optimistic forecast.

Please note that any increase in LoS of these patients will push the occupancy upwards, and this is a very real risk, as increasing numbers of staff going sick could affect discharges, and the winter weather always applied upward pressure on LoS. There is also a risk that if infections in care homes suddenly increases, even modest numbers of additional frail & elderly Covid patients could take up even more beds.

Forecast Models

BI has developed a model of bed occupancy for the next couple of months, based on forecasts of incoming Covid admissions provided by KMCCG, and applying observed LoS profiles to the patients coming in. This model re-bases daily depending on actual occupancy.

The three scenarios are :

Optimistic (green) based on minimal social mixing over Xmas

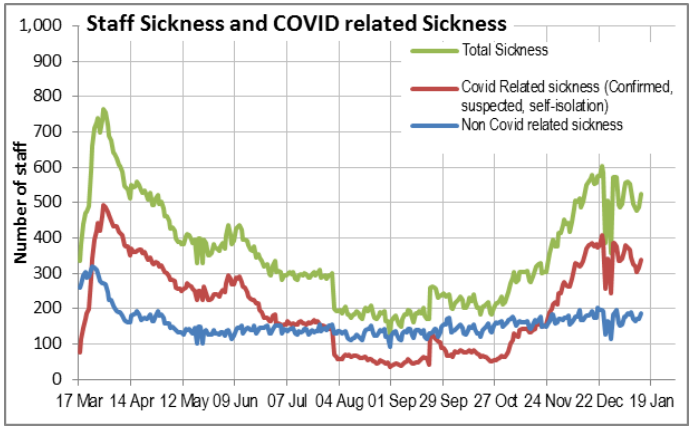
Mid-Range (amber) based on increased social mixing over Xmas

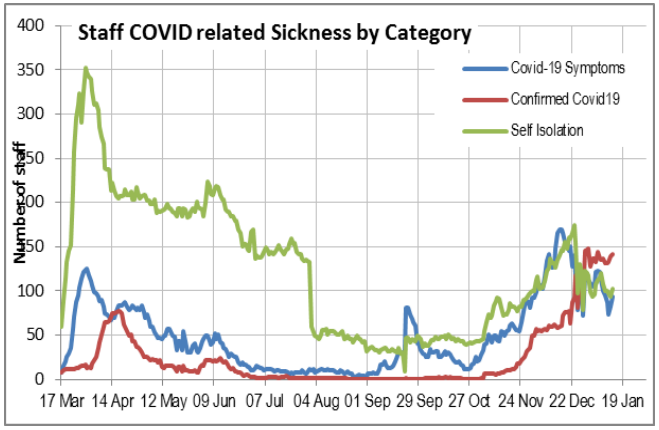
Pessimistic (red) based on this, plus reduced social distancing compliance

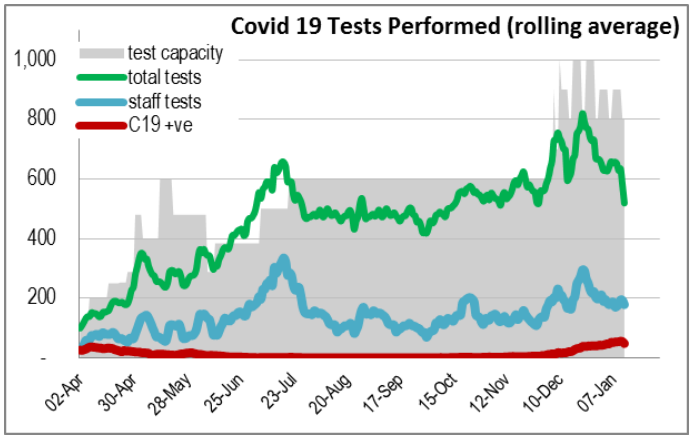
These forecasts now account for school attendance being curtailed as a result of the new lockdown, which removes a forecast third peak going into February.

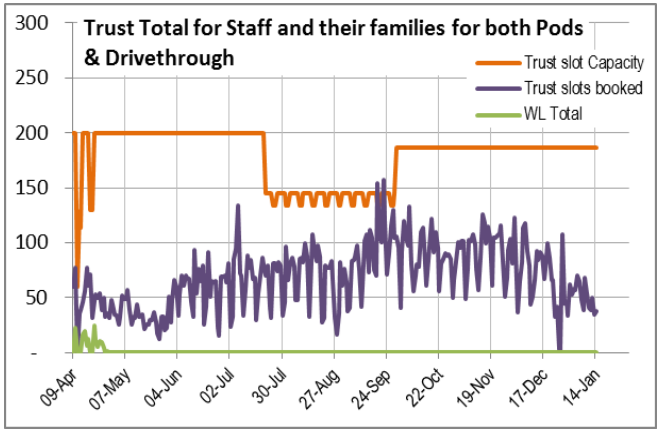
Early indications based on community infection rates are that the optimistic forecast is the closest to the actual, and that at least in the local area, people did minimise social mixing over Xmas, leading to reductions in infection rates even before the tightened restrictions on 05-Jan

Escalation: COVID-19









Staff Non-Covid related sickness peaked at just over 300 in late March, but is now back at normal levels for the time of year (average 150-190 per day).

Covid-19 Related Sickness: The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply at first, peaking at just under 500 at the end of March, went under 100 over Summer but is now back up in the 300-400 range. This is a combination of confirmed & unconfirmed symptomatic & self isolation

Self-Isolation: Similar to Covid related sickness, this peaked in early April (~350), fell to under 50 through the Autumn, then came up sharply, peaking at ~170 just before Xmas. It's now at around 100

Swabbing: Overall Trust slot capacity for staff and their families increased throughout April and is currently at 200 slots available per day (a slot could have 1 to 6 people attending depending how many in the family require swabbing). The number of tests increased gradually into the autumn, but has since fallen back under 50 a day

Pathology – COVID-19 Tests Performed: Total tests have again exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just around 600 total tests after peaking at ~800 just before Xmas, and over 200 a day on our staff. The percentage of tests showing positive has started to come back up.

Summary: Summary: Non-Covid related sickness is at the sort of levels we expect, but both Covid related, confirmed Covid & self isolation have increased since late October as our Covid patient numbers have increased

Additional Metrics – in development

Metric	Domain	Corp. Ob / R&R Prg.
Reduction in number of paper blood and X-ray requests received within MTW	Effective	EPR
Reduction in number of requests for paper records from health records	Effective	EPR
Reduction in print costs for pre- printed paperwork	Effective	EPR
Reduction in missing records reported as incidents	Effective	EPR
Reduction in duplicate tests being ordered	Effective	EPR
Dementia rate	Effective	ICP / External
Mental health – Children – Hospital admissions as a result of self harm (age 1(	Effective	ICP / External
Frailty – Admissions due to falls	Effective	ICP / External
System financial performance (£)	Effective	ICP / External
West Kent estates footprint (sqm)	Effective	ICP / External
Number of staff home working against plan	Well Led	Social Distancing / Home
Staff swabbing compliance against guidelines	Well Led	Social Distancing / Home
Compliance with risk assessments e.g. BAME / at-risk staff / VDU	Well Led	Social Distancing / Home
Use of associated technology e.g. MS Teams	Well Led	Social Distancing / Home
Staff reporting having the equipment they need to comply with rules	Well Led	Social Distancing / Home
Implementation of Teletracking	Well Led	ICC
PPE availability	Well Led	ICC
Number of medical students at Trust	Well Led	Education / KMMS
Number of clinical academic posts	Well Led	Education / KMMS
Number of non-medical educators	Well Led	Education / KMMS
% of students reporting a good or better educational experience	Well Led	Education / KMMS
% of medical students retained as FY1s	Well Led	Education / KMMS

The metrics listed above have been removed from the main report whilst the Business Intelligence Team work with Corporate Objective and Programme Leads to source the required to report against these, then they will be reintroduced to the report.

Please note that some metrics relate to programmes that are not live at this point e.g. Tele-tracking and Sunrise, so these will be included at the appropriate time.

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the year to date (£2.5m surplus) and Decembers financial plan (£0.4m deficit).
- The plan set for October to March was set at a system level with the financial risk held by the commissioner, as a result the Trust is currently assuming the net underspend to plan in the month of £0.4m will be given back to the commissioner.
- The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position. However from 1st October this has changed to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners. This plan includes an allocation to fund COVID related spend (£11.2m).
- In line with NHSE/I reporting guidance the values reported in this month exclude any impact associated with the Elective incentive scheme. It is currently anticipated this will be managed at a system level.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £27.7m year to date (£3.4m in December).
- The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are:
  - Pay underspends mainly within Nursing (£3.1m) and STT (£1.8m) staff groups due to higher than planned vacancies (£4.5m)
  - Delay in investments associated with Stroke, ITU extension and Recovery and Reset (£3.4m)
  - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£2.8m)
  - Clinical supplies underspend (£0.2m) due to reduction in elective activities.
  - RTA income recovery adjustment for 2016/17 and 2017/18 (£0.4m)
  - Car Parking lights pressure (£0.3m)
  - Reduction in block payment from commissioners (£0.8m - net underspend to plan)
  - EPR project costs pressure (£0.3m)
  - Income reductions within Diagnostics relating to independent sector activity (£0.3m)
  - Investments associated with Ive programme and Teletracking (£0.3m)
  - Increase in contingency reserves (£0.1m).

- The key current month variances are as follows:
  - Income excluding Top up income support and pass-through related costs is on plan. Clinical Income is £0.5m adverse to plan in the month this is due to an agreed adjustment with commissioners relating to bed placement support (£0.5m). Other Operating Income excluding pass-through costs were on £0.5m favourable in December. This mainly relates to £0.2m over performance associated with cash donations for Capital Assets however this is offset as a technical adjustment (zero net impact) and over performance within pathology associated with trade organisations (£0.1m) and backdated estates and facilities charges associated with Alliance Medical (£0.1m)
  - Pay budgets adjusted for pass-through items were £1m favourable in December which was mainly a result of underspends against the central held budgets for Stroke, ITU Extension and Recovery and Reset developments (£1.2m). The position reflects the enhanced bank rates implemented in December (£0.3m) and an assessment for the potential bank 'bonus' incentive (£0.3m). Additional ITU beds have been open during December to support COVID 19 patients; these have been staffed by redeploying staff from theatres. In turn this has meant cancellations of elective activity which will have to be carried out in the future.
  - Non Pay budgets adjusted for pass through items overspent by £0.5m in December. The Increase in COVID related spend on clinical supplies £0.5m and the increase in drugs costs (£0.4m) mainly within Oncology where partly offset by £0.2m underspend on central held budgets associated with Stroke, ITU extension and Recovery and Reset developments.

- The closing cash balance at the end of December 2020 is £74.7m which is more than the cash plan of £50.6m. The higher than normal cash balance is due to the Trust receiving an advance block SLA payment from the six main CCG's as per the national agreement totalling c.£36.6m. Within the cash flow forecast the Trust is assuming that it will not receive any block income in March 2021. Additionally in December the Trust received income relating to January which has been deferred to ensure the income received is matched against the January expenditure. There has also been a delay in the approval and commencement of capital projects therefore the cash flow phasing for the spending is back-ended which also contributes to the high current cash balance.
- Capital spend by the end of month nine is £9.2m; £2.9m relates to Covid-19 equipment, ICT and estates costs – these costs have all been submitted to NHSEI Regional team as part of the funding claims. NHSEI have notified the Trust that £322k has been approved by DHSC. The remaining Phase 1 schemes (£2.5m) have not yet been approved by DHSC and therefore the Trust has needed to plan to cover the costs from other funding sources. The Trust has identified schemes that it could potentially spend against the funding if it becomes available in sufficient time within this financial year, and continues to work with the STP Capital lead to obtain further certainty from the Regional NHSE/I team about confirmation of the funding.
- The main other areas of expenditure year to date are £1.4m related to the ongoing EPR programme; £1.3m relating to the IVE Programme; £1.5m on the Urgent and Emergency Care projects (including the new SAU at TWH); £0.8m related to backlog and renewal Estates schemes; and £0.5m relating to equipment schemes.
- A high level of capital spend remains to be made in the final quarter of the year; some of this is the continuation of schemes already in progress (e.g. EPR, Estates schemes, UEC project) but some significant elements have only been ordered in the last two months, including:
  - ICT spend on additional devices and network access switch costs: £1.5m
  - Linear Accelerator replacement at Canterbury: £2.1m
  - Medical equipment orders including CT SIM for Oncology: £2.1m
  - Breast screening equipment replacement: £0.8m
  - Endoscopy equipment: £1.7m
- They are all projected to be completed by 31st March, but there remains risk of supply chain delay in the current circumstances.

The Trust is forecasting to deliver the financial plan (breakeven) before the annual leave carry over accrual. The current assessment for the carry over annual leave accrual is £6.4m which is £1.4m more than the plan value (£5m).

1. Dashboard

December 2020/21

	Current Month						Year to Date						Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	46.7	46.8	(0.1)	(0.1)	(0.1)		399.2	394.7	4.5	(0.9)	5.4		539.1	535.3	3.8	
Expenditure	(44.3)	(44.7)	0.4	0.1	0.4		(373.9)	(369.3)	(4.7)	0.9	(5.5)		(514.7)	(509.0)	(5.7)	
EBITDA (Income less Expenditure)	2.4	2.1	0.3	0.0	0.3		25.3	25.4	(0.1)	0.0	(0.1)		24.4	26.3	(1.9)	
Financing Costs	(2.7)	(2.8)	0.1	0.0	0.1		(23.0)	(23.3)	0.3	0.0	0.3		(32.0)	(32.2)	0.2	
Technical Adjustments	(0.2)	0.2	(0.4)	0.0	(0.4)		0.2	0.3	(0.2)	0.0	(3.4)		1.1	0.9	0.3	
Net Surplus / Deficit (Incl Top Up funding	**(0.4)**	**(0.4)**	**0.0**	**0.0**	**0.0**		**2.5**	**2.5**	**0.0**	**0.0**	**0.0**		**(6.4)**	**(5.0)**	(1.4)	
Cash Balance	74.7	50.6	24.0		24.0		74.7	50.6	24.0		24.0		1.0	1.0	0.0	
Capital Expenditure (Incl Donated Assets)	1.7	1.5	(0.2)		(0.2)		9.3	13.7	13.7		13.7		26.6	18.4	(8.1)	

Summary Current Month:

- The Trust delivered the financial plan in December by achieving a £0.4m deficit. This includes the assumption that £0.4m will be given back to the commissioner, this is because the plan set for October to March was at a system level with the financial risk held by the commissioner. Without this adjustment the Trust would have be en £0.4m favourable to plan.
- The Trust in December has identified £3.4m of costs associated with COVID 19 this was £0.8m more than the income incorporated into the plan and represented an increase of £0.9m between months.
- A shortfall in the available workforce has caused delays to the anticipated investments associated with Stroke, ITU extension and Recovery and Reset developments the Trust underspent by £1.5m against these projects. This underspend to plan has helped to offset the COVID spend above income (£0.8m), £0.2m back dated pathology invoices and enabled the Trust to pass back £0.4m of top up funding to commissioners.
- In line with national guidance this included £0.8m additional income support associated with COVID swabbing and testing.
- The Trust recieved in full the final retrospective top up value (£4.6m relating to September).

Year to date overview:

- The Trust has delivered the financial plan generating a £2.5m surplus. The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners, this plan includes an allocation to fund COVID related spend (£11.2m).
- The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are:

Pay underspends (£4.5m) mainly within Nursing (£3.1m), STT (£1.8m) staff groups due to higher than planned vacancies, Delays in investment associated with Stroke, ITU extension and Recovery and Reset developments (£3.4m), Drugs (£2.8m) mainly due to reduction in Oncology and Ophthalmology high cost drugs and £0.2m underspend within clinical supplies due to reduction in elective activities. These underspends are partly offset by pressures associated with Car Parking (£0.3m), RTA income recovery adjustment for 2016/17 and 2017/18 (£0.4m), reduction in block payment from commissioners (£0.8m - net underspend), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m) and increase in reserves(£0.1m).

Forecast:

- The Trust is forecasting to deliver the financial plan (breakeven) before the annual leave carry over accrual. The current assessment for the carry over annual leave accrual is £6.4m which is £1.4m more than the plan value (£5m).

Risks:

- The has the following key income assumptions included within the year to date position.
- The Trust has £2.75m income included in the position to offset the costs of COVID swabbing which is in line with the guidance. NHSE/I are currently reviewing Octobers and Novembers cost (£1.8m) and will then notify the Trust of the funding they will receive in January with Decembers (£1m) to be notified in February.
- In line with national guidance the financial position does not reflect any impact (positive or negative) associated with the Elective Initiative Scheme (EIS). This scheme will impact the level of income the Trust can recognise and is dependent on delivering the activity levels.

Maidstone and Tunbridge Wells NHS Trust

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	24,457

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	2,294
Sick pay at full pay (all staff types)	293
COVID-19 virus testing (NHS laboratories)	2,456
Remote management of patients	27
Support for stay at home models	70
Direct Provision of Isolation Pod	7
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	1,954
Segregation of patient pathways	8,695
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	1,117
Decontamination	276
Backfill for higher sickness absence	1,934
NHS 111 additional capacity	0
Remote working for non patient activites	351
National procurement areas	1,940
Other	445
COVID-19 virus testing- rt-PCR virus testing	2,593
COVID-19 - Vaccination programme'	3

Summary: Loss of income

Total (£000s):	3,198

Breakdown by income type	£s
Car parking income	1,353
Catering	218
Pathology Trade Income	120
Private Patient Income	946
Research and Development	200
Other	360

Grand Total

Total (£000s):	27,655

Commentary:
The Trust has identified the financial impact relating to COVID to be £27.6m, which includes £24.4m associated with additional expenditure and £3.2m due to lost income (mainly commercial income).

The main cost includes costs associated with virus testing , expansion of ITU capacity, purchase of PPE, staff welfare such as providing meals, purchase of IT equipment and software licenses to enable staff working from home. Additional shifts required in ED, ITU areas, sickness cover, additional on calls and extended opening hours for support teams.

The Trust has received in December the final retrospective top up funding relating to September (£4.6m).

The Trust has £2.6m income included in the position to offset the costs of COVID swabbing which is in line with the guidance. NHSE/I are currently reviewing Octobers and Novembers cost (£1.8m) and will then notify the Trust of the funding they will receive in January with Decembers (£0.8m) to be notified in February.

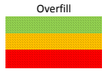
Dec-20		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	65.3%	72.6%	-	100.0%	67.7%	86.9%	-	-	28.3%	46.1%	432	29.27	219	5.5	0.0%	0.0%	15	1	321,623	254,524	67,099
MAIDSTONE	Cornwallis (M) - NS959	82.8%	76.6%	-	100.0%	73.6%	121.3%	-	-	24.6%	8.9%	89	6.26	48	5.2	0.0%	0.0%	2	0	79,076	105,250	(26,174)
MAIDSTONE	Culpepper Ward(CCU) (M) - NS551	44.0%	69.6%	-	-	50.0%	61.3%	-	-	18.2%	33.0%	134	9.82	90	4.7	0.0%	0.0%	2	0	109,802	118,003	(8,201)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	94.6%	106.5%	-	-	95.6%	117.7%	-	-	41.2%	20.7%	186	12.66	78	6.6	2.0%	100.0%	13	0	146,351	170,260	(23,909)
MAIDSTONE	Intensive Care (M) - NA251	86.9%	104.6%	-	-	87.5%	89.6%	-	-	18.7%	2.4%	248	17.12	151	26.3	0.0%	0.0%	0	0	227,442	218,824	8,618
MAIDSTONE	Pye Oliver (Medical) - NK259	71.2%	60.1%	-	-	80.3%	60.7%	-	-	21.6%	46.2%	173	10.74	82	4.5	0.0%	0.0%	6	3	120,984	124,744	(3,760)
MAIDSTONE	Chaucer Ward (M) - NS951	-	-	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand	-					7,847	739	7,108
MAIDSTONE	Whatman Ward - NK959	59.6%	83.0%	-	100.0%	86.6%	125.9%	-	-	26.8%	28.4%	158	11.25	90	6.4	0.0%	0.0%	4	3	109,421	111,491	(2,070)
MAIDSTONE	Lord North Ward (M) - NF651	75.6%	32.0%	-	100.0%	66.7%	45.2%	-	-	4.1%	0.0%	16	1.16	6	9.5	0.0%	0.0%	2	0	101,685	95,403	6,282
MAIDSTONE	Mercer Ward (M) - NJ251	84.7%	86.0%	-	-	86.2%	74.2%	-	-	17.3%	31.7%	86	5.86	34	5.3	0.0%	0.0%	6	1	120,121	115,480	4,641
MAIDSTONE	Edith Cavell - NE751	87.2%	55.1%	-	No Hours	90.7%	88.1%	-	-	27.5%	30.7%	86	6.08	41	3.0	5.4%	100.0%	1	0	44,037	48,427	(4,390)
MAIDSTONE	Acute Medical Unit (M) - NG551	79.5%	80.5%	-	-	123.2%	171.0%	-	-	26.3%	18.6%	161	11.07	81	8.7	0.0%	0.0%	7	0	153,409	153,585	(176)
TWH	Ward 22 (TW) - NG332	66.0%	86.3%	-	100.0%	74.3%	81.5%	-	-	39.4%	28.1%	191	13.53	81	4.6	0.0%	0.0%	21	3	142,269	142,885	(616)
TWH	Coronary Care Unit (TW) - NP301	75.4%	86.0%	-	-	74.5%	-	-	-	27.8%	16.5%	125	7.73	61	10.4	30.3%	100.0%	1	0	110,164	67,980	42,184
TWH	Ward 33 (Gynae) (TW) - ND302	101.0%	85.3%	-	-	93.5%	96.8%	-	-	19.9%	0.0%	48	2.94	14	3.2	1.0%	100.0%	1	0	111,169	115,376	(4,207)
TWH	Intensive Care (TW) - NA201	145.7%	76.4%	-	-	155.7%	79.4%	-	-	33.1%	0.0%	262	17.29	37	24.3	0.0%	0.0%	0	0	341,094	326,386	14,708
TWH	Acute Medical Unit (TW) - NA901	81.5%	64.2%	-	100.0%	82.3%	84.3%	-	-	20.0%	20.8%	190	13.50	100	6.7	25.8%	96.7%	9	0	201,232	206,077	(4,845)
TWH	Surgical Assessment Unit (TW) - NE701	109.0%	150.3%	-	-	95.2%	96.8%	-	-	33.0%	0.0%	48	2.88	4	17.5	0.0%	0.0%	0	0	68,191	85,443	(17,252)
TWH	Ward 32 (TW) - NG130	92.0%	98.6%	-	100.0%	74.2%	70.3%	-	100.0%	12.7%	1.5%	49	3.45	13	8.3	0.0%	0.0%	5	2	131,644	123,644	8,000
TWH	Ward 10 (TW) - NG131	109.3%	85.7%	-	100.0%	95.2%	141.8%	-	-	24.3%	5.1%	89	6.05	32	6.6	0.0%	0.0%	2	0	124,141	152,061	(27,920)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	31.4%	43.6%	-	-	65.9%	54.8%	-	-	32.8%	26.1%	226	15.27	135	4.5	0.0%	0.0%	8	0	7,056	53,711	(46,655)
TWH	Ward 12 (TW) - NG132	113.4%	81.5%	-	100.0%	153.8%	92.7%	-	-	40.0%	52.8%	210	13.47	48	7.2	13.8%	100.0%	12	0	128,675	167,156	(38,481)
TWH	Ward 20 (TW) - NG230	70.5%	99.6%	-	No Hours	89.2%	97.7%	-	-	24.9%	7.0%	137	9.71	68	5.3	31.9%	100.0%	13	1	154,123	144,913	9,210
MAIDSTONE	Foster Clarke Ward - NR359	35.3%	41.5%	-	100.0%	41.5%	-	-	-	47.8%	38.7%	221	16.18	126	2.1	0.0%	0.0%	6	0	-137	65,926	(66,063)
TWH	Ward 21 (TW) - NG231	97.5%	85.8%	-	100.0%	85.3%	85.5%	-	-	22.3%	11.2%	175	11.58	107	5.7	2.4%	100.0%	11	1	145,708	156,478	(10,770)
TWH	Ward 2 (TW) - NG442	83.7%	62.3%	-	100.0%	103.2%	102.6%	-	No Hours	35.5%	17.1%	209	13.39	120	6.8	0.0%	0.0%	17	0	142,495	160,663	(18,168)
TWH	Ward 30 (TW) - NG330	101.9%	80.3%	-	100.0%	103.5%	102.0%	-	-	33.7%	20.7%	163	10.46	65	6.0	0.0%	0.0%	7	0	139,933	155,305	(15,372)
TWH	Ward 31 (TW) - NG331	87.7%	89.7%	-	100.0%	77.3%	106.2%	-	-	24.1%	3.1%	148	9.17	81	5.9	0.0%	0.0%	7	1	149,938	144,731	5,207
Crowborough	Crowborough Birth Centre (CBC) - NP775	71.2%	88.7%	-	-	100.9%	87.1%	-	-	9.8%	0.0%	26	1.73	0		70.4%	98.7%		0	84,530	96,599	(12,069)
TWH	Midwifery (multiple rosters)	84.7%	54.0%	-	-	90.0%	93.1%	-	-	14.8%	3.4%	627	35.39	107	22.2			0	0	**682,204**	**731,410**	**(49,206)**
TWH	Hedgehog Ward (TW) - ND702	124.2%	36.4%	-	-	118.9%	-	-	-	35.0%	65.6%	198	13.55	37	13.8	0.0%	0.0%	0	0	193,997	191,765	2,232
MAIDSTONE	Maidstone Birth Centre - NP751	101.3%	79.8%	-	-	95.7%	95.9%	-	-	18.3%	0.0%	29	1.80	0		0.0%	0.0%	0	0	73,531	82,759	(9,228)
TWH	SCBU (TW) - NA102	75.1%	733.6%	-	100.0%	91.0%	-	-	-	13.1%	0.0%	101	5.06	1	21.5	0.0%	0.0%		0	177,213	192,671	(15,458)
TWH	Short Stay Surgical Unit (TW) - NE901	27.7%	52.3%	-	-	34.0%	35.5%	-	-	18.9%	12.3%	69	4.96	44	2.0	0.0%	0.0%	0	0	23,537	33,582	(10,045)
MAIDSTONE	Accident & Emergency (M) - NA351	100.0%	79.9%	-	-	128.3%	154.8%	-	-	46.7%	24.6%	481	33.05	197		0.0%	0.0%	1	0	303,333	310,651	(7,318)
TWH	Accident & Emergency (TW) - NA301	82.3%	55.1%	-	100.0%	85.6%	62.7%	-	-	34.8%	39.4%	545	37.79	160		0.0%	0.0%	5	0	431,553	480,464	(48,911)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	-	-	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand		0.0%	0.0%			56,893	40,878	16,015
MAIDSTONE	Peale Ward COVID - ND451	54.7%	54.0%	-	100.0%	71.0%	30.6%	-	-	6.2%	25.5%	110	7.18	79	19.5	0.0%	0.0%	0	0	211,039	74,973	136,066
MAIDSTONE	Respiratory Enhanced Care - NS459	59.3%	66.8%	-	100.0%	60.9%	141.9%	-	-	38.7%	27.9%	199	14.11	98	21.7	0.0%	0.0%	0	0	143,841	88,730	55,111
MAIDSTONE	CPU Medicine	No hours	0.0%	-	No Hours	No hours	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0.0	0.0%	0.0%	1	0	0	0	0
MAIDSTONE	Short Stay Surgery Unit (M) - NE959	74.0%	60.7%	-	-	88.2%	-	-	-	7.7%	5.0%	21	1.19	4	12.0	0.0%	0.0%	1	0	58,692	67,611	(8,919)
																				6,079,856	**6,177,558**	**(97,702)**
																				44,033	38,328	5,705
																				0	0	0
																				-530	1,060	(1,590)
																				4,234,574	4,115,540	119,034
																				10,357,933	**10,332,486**	**25,447**

Cath labs
Whatman
Ward 32 (Wells Suite) (TW) - PP010

RAG Key

Under fill

Overfill



Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

NHS Maidstone and Tunbridge Wells NHS Trust

Update on the Kent and Medway Medical School (KMMS) accommodation build at Tunbridge Wells Hospital	**Director of Strategy, Planning and Partnerships**

The enclosed report provides a further update from the position reported at the December 2020 Trust Board meeting on the Kent and Medway Medical School (KMMS) accommodation build at Tunbridge Wells Hospital.

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

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Kent and Medway Medical School (KMMS) Accommodation build at TWH

Project update - 28th Jan 2021

MTW
exceptional people, outstanding care

Background

- Kent opened its first medical school (KMMS) in September 2020 to attract and train local students for our local hospitals
- In their third, fourth and fifth year of study, students from KMMS will come on clinical placements to MTW hospitals.
- We expect up to 40 students per year group. The first cohort starts with us in Autumn 2022
- By the end of March 2022 our plan is to have a new accommodation block on the Tunbridge Wells site ready, capable of housing KMMS medical students and overseas staff.
- The building will include a Multi-purpose Digital Learning Hub
- Students will continue training at KMMS and need accommodation at TWH for many decades to come.

Our Objectives

- To provide high quality student accommodation for medical students and other healthcare staff.
- To attract students to the hospital
- To give them an attractive well designed environment to live close to their work

Progress to date

- Expected Trust staff and student accommodation requirements, including for KMMS medical students and other staff groups reviewed.
- Academic estates requirements including classrooms, learning hub, lecture rooms, break out rooms reviewed
- Current accommodation income and costs reviewed
- Feasibility study by construction consultancy suggested a capital cost of £15.4M
- A student forum and the education department and have informed a draft specification for the new build
- Pre planning advice has been sought and a dialogue continues with the Principle Planning Officer from the local authority planning department
- A group of contractors from NHS SBS 'Modular Procurement Framework' potentially capable to undertake the build have been identified and initial approaches made
- A professional Design and Construction Consultancy (WT Partnership) has been engaged to progress:
  - Technical specification (Employer's requirements)
  - Detailed cost plans
  - 'Abnormal' assessments (e.g. relating to complexities of a sloping site)
  - Cost comparisons to help us negotiate the best deal

A summary of our outline specification for the building

- A place for KMMS students and staff to live, learn and work. Options of number of rooms are 100, 140 and 180 and these options will be evaluated through the business
- 5% of flats designed with enhanced accessibility in mind
- Studio rooms with double bed space and ensuite facilities
- Cluster flat facilities including shared kitchen, dining and social facilities for every 6 rooms
- A Multi-purpose Digital Learning Hub large enough for 40 students and capable of splitting into 3 separate rooms by retractable walls. Area to be sized to allow 5 groups of 8 students to simultaneously split into separate teaching groups.
- An academic office
- A separate area equipped to allow students to gather in a relaxed environment whilst studying and accessing online materials.
- Indoor social area
- Outdoor covered social space
- Parking spaces for emergency access and drop off only

Proposed location (shaded red)

An artist's impression

Key next steps

Maidstone and Tunbridge Wells NHS Trust

Key next steps:

1. Design, Local authority planning permission

   Estates team with input on design from academic team representatives

2. Financial affordability and funding. The build is expected to cost over £15M

   Costing estimates from professional consultancy, mini competition process through Procurement. Financial affordability and funding mechanisms being assessed by Finance Team. Checkpoint in early February 2021

3. Related to that ,the requirement to meet the requirements of accounting standard of 'IAS17' relating to an operating lease agreement

   Finance team testing requirements and feasibility to meet requirements of IAS 17 with checkpoint in early February 2021.

   Completion deadline needed before 31/3/22 before accounting changes to IFRS 16.

4. NHSE/I assurance

   Finance testing of costs against NHSI/E limits to inform next steps

   Internal check point in February 2021 with a business case in March.

MTW exceptional people, outstanding care

Summary proposed timeline and work plan

- Design team are developing Employers Requirements and planning application
- Initial cost review - by 22nd January 2021
- Finalise Employer's Requirements – by end of January 2021
- Topographical survey, ecological report, arboriculture report etc - procured during January 2021
- Check point – Outline review of plan, funding , affordability and procurement - Early February 2021
- Submit planning application – by end March 2021
- Mini competition –Feb to mid March
- Business case to F&P and Board March 2021
- Appoint contractor – March/April 2021
- Planning approval received –TBC
- On going assurance for within construction programme from contractors
- Completion and Handover by 31/3/22
- Occupation from Apr 2022
- Students arrive Sep 2022

Checkpoint

The aim of the Checkpoint in February is to provide an opportunity for internal review and seek approval to progress plans on a preferred option , not to approve the investment .

The Trust Board will review the final business case, to approve investment , in March 21

The Checkpoint Report (early February 21) will include:

- Strategic case, background, case for change
- Options and evaluation including a recommended preferred option and why we chose the option. (Costing based on professional estimates)
- Description/specification of the proposed build
- Proposed contract form, proposed funding route and estimated financial impact
- Time table, action plan and key risks

NHS
Maidstone and Tunbridge Wells NHS Trust

Approval of a Business Case for the recruitment and retention of registered nurses

Chief Nurse

Please find enclosed a Business Case for the recruitment and retention of registered nurses. The costs involved in the Business Case require the Trust Board's approval. The Finance and Performance Committee has therefore been asked to consider the enclosed document and recommend that the Trust Board approves the Business Case at its meeting on 26/01/21. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Finance and Performance Committee meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 27/10/20 and 19/01/21
- Finance and Performance Committee, 26/01/21

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

Approval

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

Title: **Recruitment and retention for registered nurses**

Issue date/Version number	15/01/2021
ID reference Department	748
Division	Corporate Nursing
Directorate	Corporate Nursing
Clinical lead **Department/Site**	Judy Durrant
Author Executive Sponsor	Claire O'Brien
Clinical lead/Project Manager	XXXXXXXXX

Approved by	**Name**	**Signature**	**Date**
General Manager/Service Lead	Elizabeth Parker recruitment lead		
Finance manager	John Coffey		
Clinical Director	Judy Durrant		
Executive sponsor	Claire O'Brien		
Division Board	Cheryl Lee		
Supported by	**Name**	**Signature**	**Date**
Estates and Facilities Management (EFM)	Darren Bulley	These were obtained by email in November 2020	
ICT	Sue Forsey		
Diagnostics and Clinical Support Services (DCSS)	Neil Bedford		
Emergency Planning	John Weeks		
Human Resources (HR) Business Partner	Elizabeth Parker		
Procurement	Bob Murray		
EME Services Manager	Michael Chalklin		

Business Case Summary

Strategic background context and need

Due to the significant challenges of the Covid 19 Pandemic this year, there has been a shortfall in recruitment during 2020-21 the recruitment and corporate team have worked closely with the divisions in recent weeks to consider their vacancies, turnover and predicted needs including service growth for the rest of the financial year and into 2021-22.

During the start of the C19 Pandemic, international recruitment ceased between February-September 2020, there was some 'business as usual' recruitment activity, including the new initiative of the 'bring back to work scheme'.

This business case outlines a combination of concurrent recruitment activities; which include overseas recruitment, return to practice and conversion to Registered Nurses (RNs) for former overseas RNs working as Clinical Support Worker's (CSWs) and business as usual pipeline for RNs by end of March 2022.

At the end of November 2020 there were 407 Registered Nursing posts reflecting the current vacancies, predicted turnover and requirement to deliver high quality safe care through the ongoing Covid 19 Pandemic and seasonal pressures for 2020-21.

The proposal is to undertake a focused and staggered overseas recruitment campaign for approximately 49 nurses by the end of March 2021 and an additional 184 nurses by end of March 2022, due to the resource intensity for integrating the nurses into the organisation with appropriate levels of support,

To ensure the success of this recruitment activity and the successful completion of the OSCE ;

- We will seek to recruit an additional 2 WTE band 7 practice development nurses to support the OSCE preparation and supervision in the clinical areas due to the resource intensity for integrating the nurses into the organisation without appropriate levels of support, clinical areas will struggle to cope during the time immediately post registration.

Additional recruitment strategies include the;

- Immediate educational support for 39 internal clinical support workers (CSW's) who have been registered as nurses overseas to become RNs in the UK
- A local recruitment campaign for Return to Practice Nurses (RtP) a minimum of **5**

This is directly linked to the following Trust strategic objectives:

- Provide consistently safe, high quality, patient focused services.
- Promote a caring workforce through high value and staff development support in their roles within our improvement-driven and high performing organisation.

This is clinically necessary in order to fill vacant posts, reduce high levels of temporary nursing usage and associated costs and support retention through development of our staff and succession planning for leadership roles to continue to develop safe and high-quality clinical care across all clinical settings within the trust.

Focused recruitment including Overseas (non-EU):

The investment will support the recruitment of a minimum of 49 WTE nursing staff from Overseas, in addition to our 'business as usual' local recruitment activities by March 2021 and then an additional 184 nurses by March 2022.

The trust has recently awarded a contract to an agency for the supply of OSCE ready nurses and has agreed a framework for OSCE ready nurses which if other trusts engage with, MTW will be able to receive £200 per nurse as income.

The trust has been successful in securing funding from 3 NHSE bids to support 'additional costs' related to international recruitment due to the pandemic such as pastoral care and OSCE preparation during quarantine.

- **NHSE Strand A** October 2020-January 2021 for £53,000 to support the arrival of 30 recruited RNs by the end of January 2021
- **NHSE Strand B** November 2020-October 2021 for 99,000 to support recruiting a target of 104 WTE RNs by November 2021. Additionally NHSE has awarded an additional £7000 per nurse, to support the recruitment and arrival of an additional 50 nurses by the end of April 2021 within the Strand B numbers, making a total of 154 nurses in post by March 2022
- **NHSE Strand C** for funding the preparation courses and test fees of the 39 CSWs.

The achievement of the original deadlines for these strands has been impacted by delays in international recruitment timelines; this may impact the funding availability.

Support for internal support staff who have been registered as nurses Overseas

MTW has band 3 CSWs, who were RNs in their home countries (EU and non-EU), who have demonstrated interest to become RNs in the UK. For them to register in the UK, the NMC requires them to pass an English test such as IELTS or OET.

Previous CSWs were supported by the Trust with their Pre-course Preparation for OET (which includes Online General English Course and Online English for Nurses) and test fees. Most recently 4 CSWs were successful in passing their first attempt OSCE's in October 2020 following some intensive support from the practice development nurses, there are now an additional 4 newly registered and retained RNs.

The Trust has been successful with a 3rd bid to NHSE for funding the preparation courses and test fees of the 39 CSWs.

This proposal is to additionally support the preparation for their OSCE to support the internal recruitment and retention of 39 Newly RNs by March 2022.

Local Return to Practice Nurses (RtP):

The national shortage of RNs means that we must recruit and retain our returners. To date at MTW, RtP students have completed their practice hours in an unpaid supernumerary capacity. The nature of returners (predominantly local mothers/carers) means that they prefer to work for their local trust.

MTW have had numerous recent enquires about the programme and 22 individuals have completed the programme and gained substantive posts since 2012. MTW has had 2 RtP nursing students who obtained their NMC Pin in this current academic year.

We are competing with Trusts that pay their returners, therefore proposing to pay our return to practice students for both nursing and midwifery programmes, this would be advantageous and competitive for MTW.

A paid return to practice will help attract and retain returners, who could not previously afford to return to practice, and hopefully increase our number of students each year. We have benchmarked against neighbouring trusts that are currently paying their RtP students Band 3.

It is anticipated that we will be able to recruit RtP nurses, if we actively advertise and promote our offer of support to them in a paid capacity. We will aim for recruiting 5 RtP nurses by April 2022.

It is proposed that registered and non-registered returners are allocated to a ward that will eventually employ them as an RN and are paid a Band 3 salary whilst undertaking their RTP clinical updating hours.

Objectives -

1. To ensure we have a fully established nursing workforce to deliver safe, high quality care, across all our clinical settings, by reducing the number of vacant registered nursing positions across the Trust through a number of recruitment activities.
2. Reduce cost of employing overseas nurses by encouraging existing staff to encourage friends and family to directly apply for roles within the trust.
3. To improve retention of our substantive nursing staff by supporting existing 'support' staff members, who are potential nurses to register with the NMC.
4. We will seek to recruit 2 WTE band 7 practice development nurses to support the OSCE preparation and supervision in the clinical areas.

The preferred option.

This plan is to implement a combination of concurrent recruitment activities in addition to business as usual recruitment to enable the trust to recruit 228/407 RNs, through the provision of educational and pastoral support to Overseas and local candidates.

Focused recruitment including Overseas (non-EU) :

The Recruitment Team met with the divisional leads during September 2020 to establish the Staff Nurse requirements for 2020-21. The divisions have based this on current vacancies, expected turnover and business cases from September 2020-March 2021.

The investment will provide the educational and pastoral support needed for a minimum of 184 WTE nursing staff from Overseas, in addition to our 'business as usual' local recruitment activities by March 2022.

Support for internal support staff who have been registered as nurses Overseas

MTW has 39 CSWs, who were RNs in their home countries (EU and non-EU), who have demonstrated interest to become RNs in the UK. The Trust is supportive in funding the test fees. However, the preparation courses are costly and may not be affordable for our CSWs.

Funding has been awarded by NHSE/HEE to provide financial support for the;

- Preparation course to pass the required English test and OET test fee.
- The trust will be need to continue existing training support in preparation for the CBT test with the NMC and,
- Providing OSCE (Objective Structured Clinical Examination) Training for Supervised Practice Nursing.

This would be provided after successfully passing the English Test and receipt of the decision letter from the NMC to proceed with the CBT, Test of Competence.

Local Return to Practice Nurses (RtP):

Returners are usually locally recruited with an interest in supporting their local trust, if they are internally supported to re-register; the national recruitment evidence is that they will remain in the trust. We are competing with Trusts that currently pay their returners and we would like to offer the following for each group. We will be able to recruit 5 RtP nurses if we can offer them the support outlined in the business case. The cost to this initiative is minimal as these nurses will be filling existing band 5 vacant posts but paid band 3 whilst they prepare to re-register. Once registered they will then be paid band 5.

Main benefits associated with the investment

These approaches will enable the Trust to engage in some targeted recruitment for RNs and provide opportunities for existing staff to develop their careers which will support retention.

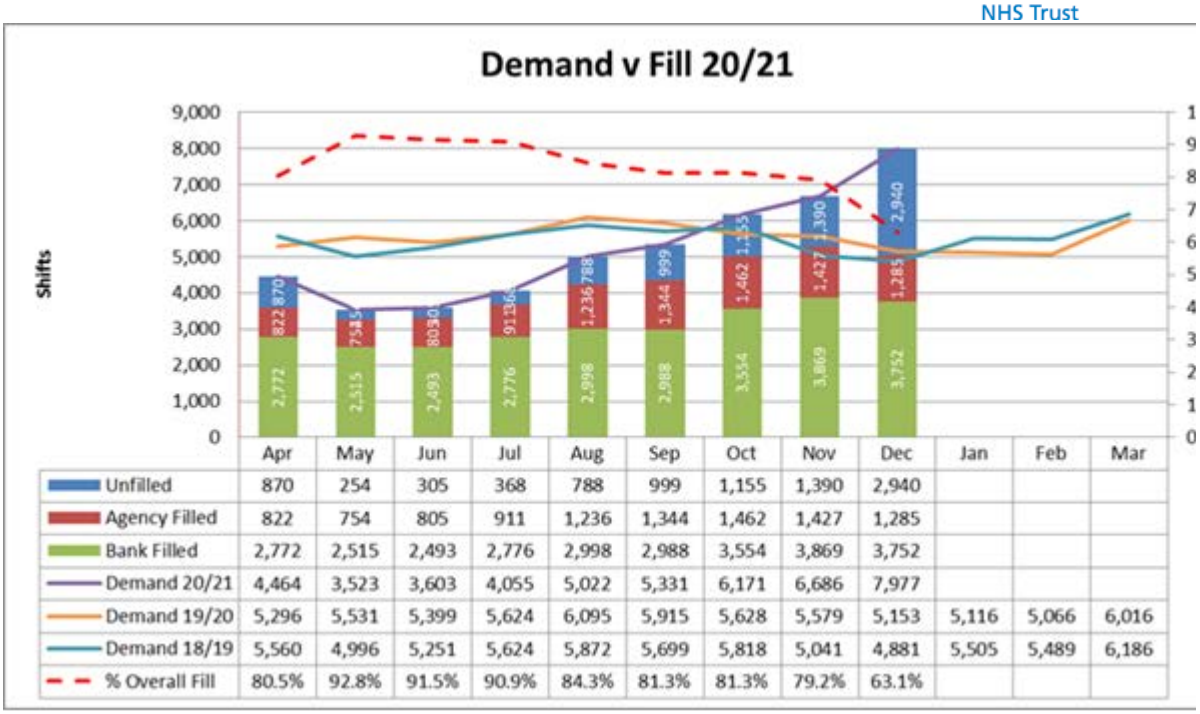
The main benefits of this proposal are outlined as below:

- A planned flow and reduction in the number of vacant nursing positions across the Trust
- Reduction in costs associated with temporary nursing usage although there will be no immediate impact during the winter period during this financial year.
- Improved retention of substantive nursing staff as a result of improved work life balance
- Improved staff morale, thus resulting in a positive effect on patient care
- Continuity of safe, high-quality care delivery to our patients
- Increased diversity of our nursing workforce

Tables 1 and 2 illustrate the demand and fill rates over the last 2 years for temporary staffing. In 2020 the demand for shifts were increased because of the Covid 19 pandemic, but the number of hours filled agency had reduced and predominantly filled by internal bank staff.

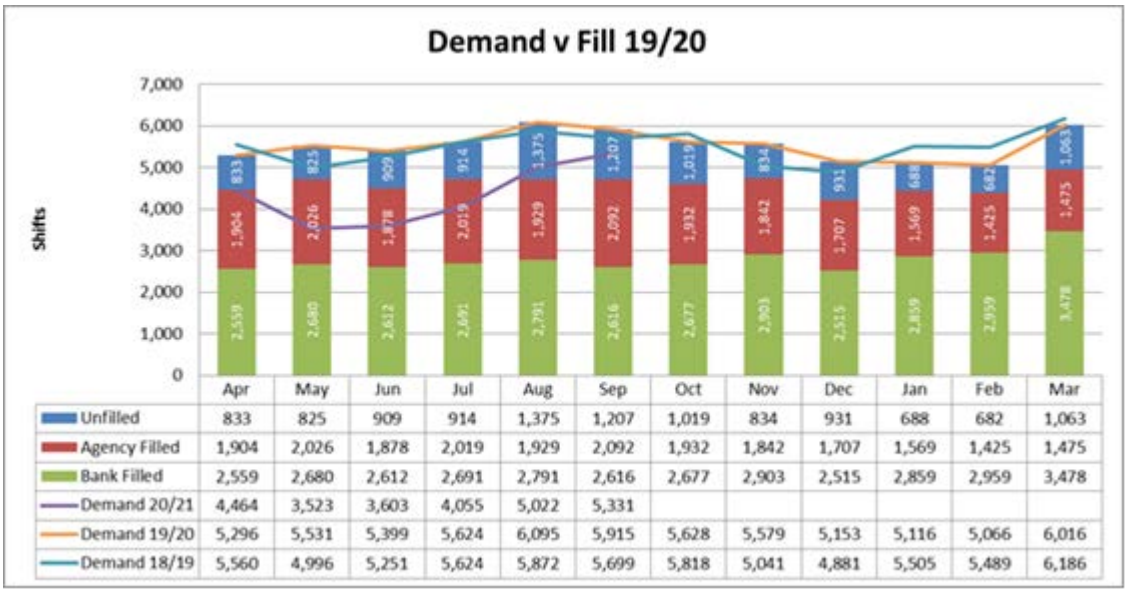
Nursing turnover and increased activity has begun to impact the requests for temporary staffing and the numbers of shifts filled by agency are increasing again.

Table 1



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unfilled	870	254	305	368	788	999	1,155	1,390	2,940			
Agency Filled	822	754	805	911	1,236	1,344	1,462	1,427	1,285			
Bank Filled	2,772	2,515	2,493	2,776	2,998	2,988	3,554	3,869	3,752			
Demand 20/21	4,464	3,523	3,603	4,055	5,022	5,331	6,171	6,686	7,977			
Demand 19/20	5,296	5,531	5,399	5,624	6,095	5,915	5,628	5,579	5,153	5,116	5,066	6,016
Demand 18/19	5,560	4,996	5,251	5,624	5,872	5,699	5,818	5,041	4,881	5,505	5,489	6,186
% Overall Fill	80.5%	92.8%	91.5%	90.9%	84.3%	81.3%	81.3%	79.2%	63.1%			

Table 2



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unfilled	833	825	909	914	1,375	1,207	1,019	834	931	688	682	1,063
Agency Filled	1,904	2,026	1,878	2,019	1,929	2,092	1,932	1,842	1,707	1,569	1,425	1,475
Bank Filled	2,559	2,680	2,612	2,691	2,791	2,616	2,677	2,903	2,515	2,859	2,959	3,478
Demand 20/21	4,464	3,523	3,603	4,055	5,022	5,331						
Demand 19/20	5,296	5,531	5,399	5,624	6,095	5,915	5,628	5,579	5,153	5,116	5,066	6,016
Demand 18/19	5,560	4,996	5,251	5,624	5,872	5,699	5,818	5,041	4,881	5,505	5,489	6,186

Main risks associated with the investment

Risk of not doing it:

The breadth of this recruitment campaign is essential as there is a recognised nursing skills shortage in the UK and the current supply of UK trained available staff remains less than normal annual turnover.

There is an immediate increased need for registered nurses to support usual trust activity, this winter and future waves of the Covid pandemic and significant numbers of the workforce reaching retirement age.

If CSW's and RtP are not supported to undertake development, they will not progress to become NMC RNs and may seek employment elsewhere.

Delivery risk:

The proposal forms part of a larger recruitment strategy for the Trust as despite continued focus and sustained efforts to recruit, we are unable to maintain a sufficient supply of appropriately skilled nurses to meet our current level of clinical activity.

Without this immediate recruitment, there are financial, quality and patient safety risks:

- Escalating temporary nursing spend will be highly likely as we face winter and phase 2-3 of the Covid pandemic, this would include increased demand for additional specialist nurses;, many of whom come from non-framework agencies, that have not signed up to meet the rigorous quality and safety standards agreed within the NHSE framework and also cost more e.g. Intensive care, paediatrics.
- We are likely to see an increase in staff absence in sickness. There is a risk to staff morale as too few staff will result in increased stress and inefficiency.
- Unfamiliar nurses within ward environments and not working routinely as part of the team can reduce efficiency and add to length of stay.
- We could see an increase in unfilled shifts resulting in incident's causing harm to patients e.g. increase in pressure ulcers, falls, poor nutrition and hydration and increase in complaints.
- Doing nothing is likely to impact on the phase 3 recovery plans and our ability to manage electives and the backlog of elective prolonging patient's waiting lists.
- Continue with current recruitment activity. Despite the success of ongoing local and overseas recruitment initiatives, the Trust has approximately 407 vacant nursing positions, inclusive of turnover and new posts and will not be able to fill these without this additional support.

Risks associated with the specific delivery of the CSW and RtP support;

- Dropout – there may have withdrawal from the preparation course.
- Ineffective Use of Study Time – the allocated study time may not be used effectively for learning. To rectify this, there will be a weekly report on attendance, progress and usage of online materials from the provider.
- Unsuccessful OET Results – if the CSW fail the English test, there may be a need to re-sit the test. If the candidate is not successful, the resit fee is the same fee as the first attempt.

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

Funding and affordability			The Financial Case
Capital costs of the preferred investment option			
Capital	2020-21	2021-22	2022-23
Equipment			
Estate			
IT	9,600		
Other			
VAT			
Total capital	9,600		
Notes on capital costs: 10 IPADs			
Revenue changes associated with the preferred investment option			
Revenue changes	2020-21	2021-22	2022-23
Total income	237,660		
Recruitment Fee	361,828	1,191,309	0
Supernumerary Time	169,143	655,833	0
Agency cover			
Recruitment and supernumerary total	**530,971**	**1,847,142**	**0**
Additional PDN resource	**0**	**117,394**	**117,394**
Capital charges & depreciation	2,088	2,088	2,088
Total costs	**533,059**	**1,966,625**	**119,482**
Net cost	295,399	1,966,625	119,482

Notes on revenue costs:

The income relates to 3 bids made to NHSI. The criteria for the first tranche requiring 30 nurses to be recruited by 31st January was not achieved (15). A discussion with NHSI will be required to see if this can be deferred.

OSCE recruitment:-
20 nurses recruited between October 2020 and 31st March 2021
4 weeks supernumerary period at band 5

Non OSCE recruitment:-
20 nurses recruited between October 2020 and 31st March 2021
4 weeks supernumerary period at band 3
4 weeks supernumerary period at band 5

Direct Recruit:-
9 nurses recruited between October 2020 and 31st March 2021
4 weeks supernumerary period at band 3
4 weeks supernumerary period at band 5

Support to CSW registered as Trained Nurses overseas:-

In addition to course fees and tests, temporary staff to backfill study time has been included

The Case includes the need for additional PDN resource (B8a x 2.00 wte)

The Case is linked to the costs of recruitment of specific posts and excludes ongoing salary costs arising from other agreed developments (including escalation areas)

Approval of this proposal will have risks involved and the most obvious risks associated with this strategy are outlined below:

- The length of time from conditional offer of employment to arrival in the UK for non-EU nurses is predicted to be approximately 3 to 6 months.
- Appointed overseas candidates will be expected to undertake the OSCE test after arrival in the UK, meaning candidates will work as 'supervised practice nurses' until they achieve OSCE.
- The requirement to meet NMC registration within 3 months from the start of their sponsorship.
- The pass rate for OSCE at MTW has been 100% after first or second attempt.
- Our temporary nursing spend will continue throughout the supernumerary phase as temporary nursing staff will still be required to backfill these positions, whilst the newly appointed candidates undergo the necessary tests. This will be mitigated to some extent by Clinical Support Worker vacancy and the use of apprentices in this cohort.
- Without this immediate recruitment, there is a financial risk of escalating temporary nursing spend will be highly likely as we approach winter and phase 2-3 of the Covid pandemic, which may include increased demand for specialist nurses from non-framework agencies e.g. Intensive care, paediatrics.

The Business Case

1. Strategic context

National

The NHS People Plan has underlined ongoing commitment to recruitment and retention of nurses and international nurse recruitment.

Local

This proposal is directly linked to the following Trust strategic objectives:

- Provide consistently safe, high quality, patient focused services.
- Promote a caring workforce through high value and staff development support in their roles within our improvement-driven and high performing organisation.

2. Objective(s) and case for change of the proposed investment

- To ensure we have a fully established nursing workforce to deliver safe, high quality care, across all our clinical settings, by reducing the number of vacant registered nursing positions across the Trust through a number of strategies

- Reduce cost of employing overseas nurses by encouraging existing staff to encourage friends and family to directly apply for roles within the trust and keeping in touch with the overseas to nurses to evaluate their experiences as they settle in a new healthcare system and country.

- To improve retention of our substantive nursing staff by supporting existing 'support' staff members who are potential nurses to register with the NMC

Objective 1. To ensure we increase the number of substantive nursing workforce to deliver safe, high quality care, across all our clinical settings, by reducing the number of vacant registered nursing positions across the Trust through a number of strategies

The current picture of nursing vacancies and expected turnover

Despite continued proactive recruitment activity, the Trust has approximately 407 WTE band 5 nursing vacancies across both sites. These figures include a high number of vacancies within Trauma and Orthopaedics and Acute Medicine, and also some of the 'hard to recruit' ward areas such as Acute Stroke Units, Care of the Elderly, and Theatres.

Business as usual recruitment activity has failed to maintain a sufficient nursing workforce.

Analysis demonstrates an ageing nursing workforce which will further impact on our ability to recruit and retain qualified nursing staff

The Recruitment Team met with the Divisional Directors of Nursing (Midwifery) and Quality to identify the projected numbers for band 5 Staff Nurse Requirements for 2020-21, shown in table 1. These numbers were based this on current vacancies, expected turnover and business cases from September 2020-March 2021.

These numbers were forecast pre-Covid and will need to be reviewed once the Covid pandemic has reduced, however these numbers were still confirmed as a true reflection in discussions during December 2020.

Table 1

1. Numbers of Registered Nursing Vacancies & Turnover	
Medicine & Emergency	307.5
Critical Care and Surgical Services	47.12
Cancer and Haematology & Outpatients	33.2
Women's and Children	18.84
Total	**406.66**
2. Divisional breakdown of numbers above Medicine	
Turnover	28
Vacancies	130
COVID staffing increase (new)	38
Winter(new)	30

Total	**226**
Accident and Emergency	
Turnover	28
Vacancies	22
COVID staffing increase (new)	31.5
Total	**81.5**
Critical Care and Surgical Services	
Turnover	28
Vacancies	19.12
Total	**47.12**
Cancer Services/OPD	
Turnover	15.6
Vacancies	17.6
Total	**33.2**
Recruitment support to progress this recruitment	
Practice Development Nurses band 7	2

Problems / risks of current situation:

We recruited over 200 international nurses last 2019-20 and learnt that some divisions felt overwhelmed by the number of new starters they were receiving each month and felt that they were unable to provide sufficient support. For this reason, the departments will be confirming how many nurses they can effectively and safely induct without impacting upon patient and staff experience.

This Case focuses on the recruitment of nurses to support the immediate need in 2020-21 but offers a staggered approach to recruit into 2021-22 to prevent overwhelming services.

The recruitment team will support interviewers so that nurses with the right skills, knowledge and values base are appointed.

The gaps from where we are to where we need to be

Despite the high volume of recruitment last year there has been a high volume of turnover and an increase dependency and cost in temporary staffing.

The expected benefits of achieving the change:

To fill a significant number of vacant nursing posts and reduce dependence on agency usage and improved retention of our substantive staff.

<u>Objective 2.</u> Reduce cost of employing overseas nurses by encouraging existing staff to encourage friends and family to directly apply for roles within the trust

Current situation:

We recruit the majority of overseas nurses from agency suppliers which has worked very successfully during the last year. Going forward we are refining our approach to overseas nurses:

- **Non OSCE:** We will aim to recruit internationally **directly** to the trust via advertisement, social media and recommendations from our current international colleagues to try and keep our cost to a minimum.
- Our second phase would be to engage with agency suppliers for non OSCE nurses, but these will incur an agency placement fee.
- **OSCE Ready:** We have now awarded a contract to a supplier for OSCE ready nurses- however this will be finalised in mid- October 2020**.**

The table 2 below identifies the differences in baseline costs between routes to recruit internationally. This includes placement fees and relocation costs per nurse based on current information.

The cost of Covid support relates to accommodation, food and pastoral care for nurses during their period of quarantine.

Table 2			
	£ OSCE Ready (incl agency cost)	£ Non OSCE Ready (incl agency cost)	£ Non OSCE Ready (direct recruitment)
Supplier	4,500	1,950	
Health Care Visa (3 years)	232	232	232
Flight	800	800	800
IELTS/OET	400	400	400
NMC CBT	83	83	83
NMC application/ registration fee	293	293	293
NMC Osce Test	794	794	794
Accommodation (3 months subsidised)	750	750	750
Recruitment	**7,852**	**5,302**	**3,352**
Covid Support	**1,777**	**1,777**	**1,500**
Total	**9,629**	**7,079**	**4,852**

The current financial modelling assumes the Trust will be paying a Supplier charge for any nurses recruited. If the non OSCE posts are directly recruited, the supplier cost will not be incurred.

Problems / risks of current situation:

The cost of direct Overseas recruitment will be significantly less than through an agency, but this alone will not enable the trust to recruit to fill all vacant posts therefore we aim to minimise the cost of using Non-OSCE suppliers.

Our temporary nursing spend will continue throughout the supernumerary phase as temporary nursing staff will still be required to backfill these positions whilst the newly appointed candidates undergo the necessary tests. This will be mitigated to some extent by Clinical Support Worker vacancy and the use of apprentices in this cohort.

Tables 3 and 4 below identify the previous relocation costs per nurse and proposed relocation costs for **non-OSCE directly recruited nurses**.

We propose increasing the repayment clause should a nurse leave up until 24 months from £1000 to £1500. After this period, they will not be required to repay the trust.

Table 3

Previous Relocation Package	Price
I.H.S	£3,000
Visa	£464
CBT	£83
OSCE	£794
Flight	£800
IELTS/OET	£400
NMC Application/Registration	£293
Accommodation (3 months subsidised)	£750
	£6,584

Clause 24 months after pin £1000

Proposed Relocation package	Price
Health care visa (up to 3 years)	£232
Flight	£800
IELTS/OET	£400
NMC CBT	£83
NMC application/ registration fee	£293
NMC OSCE Test	£794
Accommodation (3 months subsidised)	£750
	£3352

Clause 24 months after pin £1500
If they leave within 24 months, they pay 1500, after that they pay nothing

The gaps from where we are to where we need to be:

Approval of this proposal will have risks involved and the most obvious risks associated with this campaign are outlined below:

- The length of time from conditional offer of employment to arrival in the UK for non-EU nurses is predicted to be approximately 8-12 weeks.
- Appointed candidates from Overseas will be expected to undertake the OSCE test after arrival in the UK, meaning candidates will work as ‘supervised practice nurses’ until they achieve OSCE.
- The requirement to meet NMC registration within 3 months from the start of their after arrival in the UK, meaning candidates will work as ‘supervised practice nurses’ until they achieve OSCE.

The expected benefits of achieving the change:

- Non-OSCE Nurses recruited directly from Overseas will be friends and family of existing overseas nurses who it is reasonable to predict that retention will be within the trust as a more stable workforce.
- A system of keeping in touch with the overseas to nurses during their first year to evaluate their experiences during their first year will be established as they settle in a new healthcare system and country.

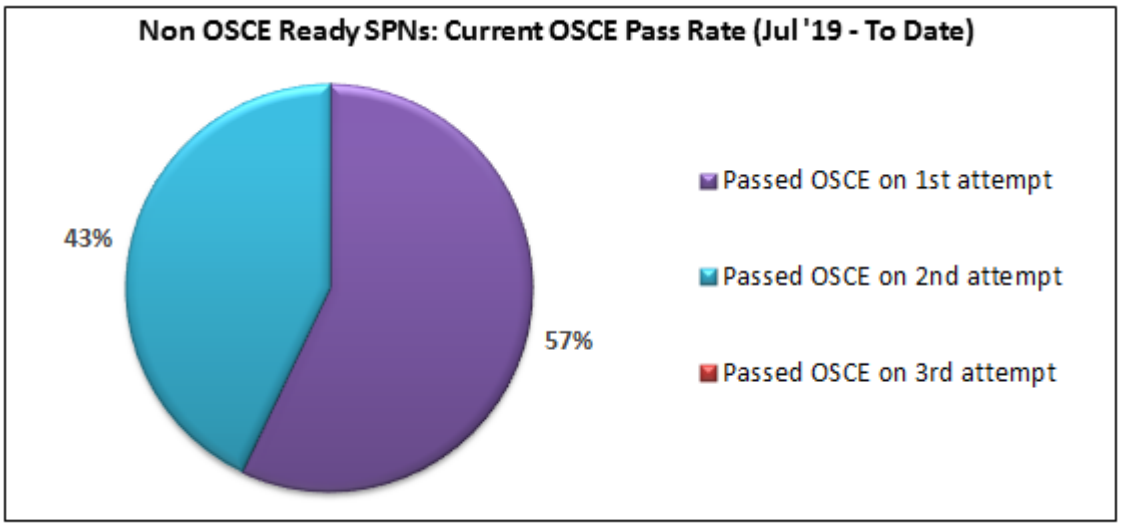
Objective 3. To improve retention of our substantive nursing staff by supporting existing 'support' staff members who are potential nurses to register with the NMC

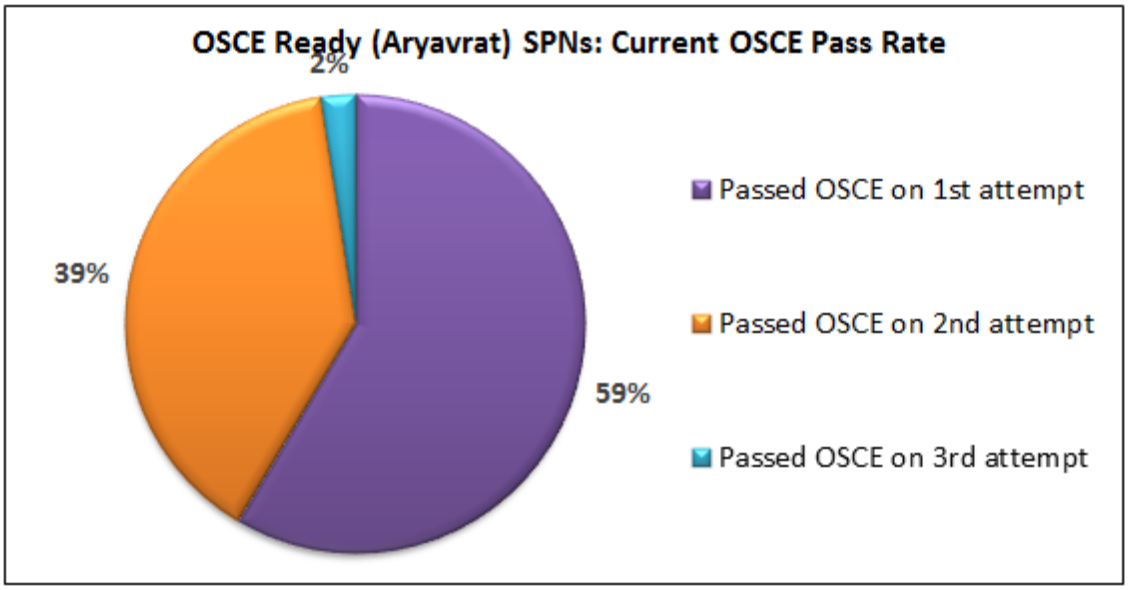
MTW has 39 Clinical Support Workers, who were RNs in their home countries (EU and non-EU), who have demonstrated interest to become RNs in the UK. For them to register in the UK, the NMC requires them to pass an English test such as IELTS or OET. Some of them were already supported by the Trust with their Pre-course Preparation for OET (which includes Online General English Course and Online English for Nurses) and test fees. The Trust is supportive in funding the test fees. However, the preparation courses are costly and may not be affordable for our CSWs.

3. Constraints and dependencies

Approval of this proposal will have risks involved and the most obvious risks associated with this campaign are outlined below:

- The length of time from conditional offer of employment to arrival in the UK for non-EU nurses is predicted to be approximately 8-12 weeks.
- Appointed overseas candidates will be expected to undertake the OSCE test after arrival in the UK, meaning candidates will work as 'supervised practice nurses' until they achieve OSCE.
- The requirement to meet NMC registration within 3 months from the start of their sponsorship.
- The pass rate for OSCE at MTW has been 100% at first attempt in 2019-20, shown in the chart below.





- Our temporary nursing spend will continue throughout the Non-OSCE Nurses supernumerary phase as temporary nursing staff will still be required to backfill these positions whilst the newly appointed candidates undergo the necessary tests. This will be mitigated to some extent to the proactive ongoing recruitment of Clinical Support Workers and the development of apprentices in this cohort.

- Current constraints identified within the proposal to support CSW's are linked to the required level of English to register with the NMC. All Overseas nurses are expected to achieve the 4 sections of OET

  • At least a grade C+ in the writing section
  • At least a grade B in the reading, listening and speaking sections

Dependencies:

• Providers being able to accommodate the CSWs for the training support.
• The department/clinical area's ability to allocate CSW's study time

4. Short list of options

Option 1 The do-nothing option

Without this immediate recruitment, there are financial, quality and patient safety risks:

- Escalating temporary nursing spend will continue to be high in 2020-21 during winter and phase 2-3 of the Covid pandemic, which would include increased demand for additional specialist nurses;, many of whom come from non-framework agencies, which have not signed up to meet the rigorous quality and safety standards agreed within the NHSE framework and also cost more e.g. Intensive care, paediatrics.
- We have seen an increase in staff absence in sickness. There is a risk to staff morale as too few staff will result in increased stress and inefficiency.
- Unfamiliar nurses within ward environments and not working routinely as part of the team can reduce efficiency and add to length of stay.
- We have seen an increase in unfilled shifts and short staffed wards resulting in incident's causing harm to patients e.g. increase in pressure ulcers, falls, poor nutrition and hydration and increase in complaints.
- Doing nothing is likely to impact on the phase 3 recovery plans and our ability to manage electives and the backlog of elective prolonging patient's waiting lists.
- Continue with current recruitment activity. Despite the success of ongoing local and overseas recruitment initiatives, the Trust has approximately 407 vacant nursing positions, inclusive of turnover and new posts and will not be able to fill these without this additional support.
- Continue our business as usual recruitment alongside rolling generic adverts, Staff Nurse Open Days and various recruitment initiatives and events
- Continue retention forums to ascertain what we need to change and /or improve in order to retain our own current staff.
- Continue to guarantee an offer of employment to student nurses who have trained within the trust.

Key activity and financial assumptions

The status quo of is maintained but there will be significant recruitment shortfall which will put significant pressure on all clinical services and the ability to deliver safe staffing in patient areas is likely to impacted.

Option 2. Undertake a combination of 3 concurrent separate recruitment activities

This proposal outlines the plan for a combination of concurrent recruitment activities in addition to business as usual recruitment, to enable the trust to recruit 184 RNs through the provision of educational and pastoral support to Overseas and local candidates.

Focused recruitment including Overseas (non-EU):

- The investment will support the recruitment of a minimum of 184 WTE nursing staff from Overseas, predominantly India, in addition to our 'business as usual' local recruitment activities. The trust has recently awarded a contract to an agency for the supply of OSCE ready nurses which is expected to mobilise from start of November 2020.
- OSCE-ready have two weeks supernumerary period within the time that OSCE exams are undertaken, however many require supervision once registered up to a month, this differs from person to person which is similar to the preceptorship support and induction periods for all newly registered staff within the Trust

- Non-OSCE ready require at least 6-8 weeks before registration- this is to factor in the period for induction, OSCE training and OSCE exam. For this case a period of 6 weeks at a band 3 (pre OSCE) and however many require supervision once registered up to a month, this differs from person to person which is similar to the preceptorship support and induction periods for all newly registered staff within the Trust.

Support for internal support staff that have been registered as nurses overseas:

The Trust has been awarded the funding by NHSE/HEE for the 39 CSWs, who were RNs in their home countries (EU and non-EU), who have demonstrated interest to become RNs in the UK.

The funding will provide financial support for the;

- Preparation course to pass the required English test and OET test fee.
- The trust will be need to provide the backfill support existing training support in providing OSCE (Objective Structured Clinical Examination) Training for Supervised Practice Nursing.

1. **Preparation Course** to pass the required English test.

   The Trust has been supported with the funding of the preparation course fee (£650 per person for 150 hours course and the test fee

2. **OET and CBT test fees**

   The OET test fee costs £350. We have funding for this fee.

   CBT for the NMC fee costs £84.

3. (If required) **OET resit test fee**

   The OET resit test fee costs £350. This may be paid upfront by the Trust and will be paid back by the staff member through staggered deduction from salary over an agreed period.

4. **Backfill/Temporary Staffing** Cost

   Whilst the staff member attends the study time (maximum of 10 hours per week for 15-weeks course), temporary staff will be needed to cover

   (15 *10-hour* shifts = £1,893) per person for 150 hours course

- Educational support by providing study leave for the preparatory course/classes.

- The CSWs will require maximum of 10 hours per week for 15-week (estimated maximum support required 150 hours course). As the number of hours is dependent on the CSW's level of English (assessed by the Benchmarking Test), the study hours will be less for a higher assessment level). The CSW can be supported by providing paid study leave in order for them to be able to attend the classes.

- Continue existing training support in providing OSCE (Objective Structured Clinical Examination) Training for Supervised Practice Nursing. This would be provided after successfully passing the English Test and receipt of the decision letter from the NMC to proceed with the Tests of Competence.

Subject to internal recruitment processes, we would seek to start this process from January 2021, however numbers will need to be staggered as we source OSCE training facility that will accommodate candidates and maintain social distancing.

We propose introducing a repayment clause should a nurse leave up until 24 months from £1500. After this period, they will not be required to repay the trust.

Local Return to Practice Nurses (RtP):

The national shortage of RNs means that we must recruit and retain our returners. To date RtP students have completed their practice hours in an unpaid supernumerary capacity. The nature of returners (predominantly mothers/carers) means that they prefer to work for their local trust. MTW have had numerous recent enquires about the programme and 22 individuals have completed the programme and gained substantive posts since 2012.

MTW has had 2 RtP nursing students who obtained their NMC Pin in this current academic year. Midwifery team usually has 1-2 RtP students each year.

We are competing with Trusts that pay their returners, therefore proposing to pay our return to practice students for both nursing and midwifery programmes as this would be advantageous and competitive for MTW. A paid return to practice will help attract returners who could not previously afford to return to practice, and hopefully increase our number of students each year. We have benchmarked against neighbouring trusts that are currently paying their RtP students Band 3.

It is anticipated that we will be able to recruit RtP nurses, if we can offer them the support outlined in the business case. We will not be able to quantify this until we can actively advertise that we will support them in a paid capacity.

It is proposed that registered and non-registered returners are allocated to a ward that will eventually employ them as an RN and are paid a Band 3 salary whilst undertaking their RTP clinical updating hours.

There are two groups of RtP nurses;

- Non-registered returners – have to complete a university-based RTP programme plus a clinical placement with the Trust
- Registered returners – still on the NMC register but require/request clinical updating in an acute Trust

Non-Registered Returners

- The non-registered returner will approach the Trust to RTP.
- The returner will be asked to apply for a bank CSW post.
- The interview will be conducted by the staff bank or Nurse Recruitment and Retention Lead and the Lead for RTP.
- Once the returner has worked 45 hours, they will be asked to identify 3 wards/departments where they would like to work once re-register.
- The lead for RTP will look at the RN vacancies and liaise with the Practice Placement Facilitator (PPF) and contact one ward/department to negotiate a paid band 3 RTP student position for the clinical updating and subsequent employment.
- The returner will not require a licence to operate because they will have a contract of employment.

- Once the returner is registered with the NMC, via the university or OSCE route, the line manager will complete a changes form to convert the returner to band 5 RN pay.

Registered Returners

- Registered returners will approach the Trust for clinical updating. The returner will be asked to apply for a band 3 RTP student post and identify a preferred specialty.
- The lead for RTP will look at the RN vacancies and liaise with the Practice Placement Facilitator (PPF) and contact one ward/department to negotiate a paid band 3 RTP student position for the clinical updating and subsequent employment.
- The interview will be conducted by the relevant ward manager or Nurse Recruitment and Retention Lead and the Lead for RTP.
- The returner will not require a licence to operate because they will have a contract of employment.
- Once the returner has completed the band 5 RN induction competencies, the line manager will complete a changes form to convert the returner to band 5 RN pay.
- It is anticipated that the period of supervision will be for three months of training and one month of additional supervision as a registered nurse, which is similar to the preceptorship support and induction periods for all newly registered staff within the Trust
- We propose introducing a repayment clause should a nurse leave up until 24 months from £1500. After this period, they will not be required to repay the trust.

Key finance Assumptions:

- Assumes 49 non-EU nurses to start in between October 2020- March 21 being paid Band 3 until they obtain NMC registration.
- An additional 135 non-EU nurses to start in between April 2021 –March 22 being paid Band 3 until they obtain NMC registration
- Costs assume this will take 6-8 weeks to complete, becoming Band 5. However, Home Office regulations stipulate that the OSCE test must be passed within three months of employment start date, otherwise employment will be terminated. NMC registration should be received imminently after passing the OSCE but costs allow for delays within NMC.
- Temporary staffing costs will be incurred whilst nurses are in supernumerary position in preparation for the OSCE test.
- OSCE ready nurses do their OSCE within a week of arrival, followed by a period of induction and supervision.
- Other recruitment fees for include Visa, OSCE test, and NMC registration.

Workforce (HR) impact.

The infrastructure to support the recruitment campaign is already in place.

The workforce teams will see an impact to their workloads as listed below:

- Increased numbers of new starters requiring documentation validation, file sign off, and payroll entry
- Increased number of new starters requiring occupational health clearance
- Increased number of Visa / Certificate of Sponsorship applications and funding
- Increased numbers of DBS requirements, although, a reduction in requests for temporary staffing
- An iterative decrease in the number of requests for temporary staff.

Estates impact

The majority of the overseas nurses will require temporary accommodation.

Quarantine- At present many of the international nurses will be required to quarantine for the first 10 days when they arrive in the UK. To ensure the nurses do not feel isolated on their arrival and to commence the induction process we would need an accommodation site which has a large common area.

We have liaised with Estates and Facilities who have confirmed that we currently have a lease on King Street hotel in Maidstone which holds **18** rooms with end-suites and has a large reception area where induction duties could commence. We have agreement to use this for the first 14 days and then transfer the nurses to MTW accommodation.

Additionally sourcing affordable accommodation close to the TWH site remains a significant challenge to support the retention of nurses on the TWH site.

Potential options and solutions for this problem are in consideration and have been considered within the plans and business case for;
The provision of accommodation for students from the Kent and Medway Medical School led by the Director of Strategy, planning and partnerships.

This will not be an immediate solution but supports long term planning for increasing staff accommodation.

Challenges

In 2019-20 the Professional Standards Team had the use of the empty Edith Cavell ward as an empty ward for OSCE training. This was also available for the nurses to use in their spare time to continue practicing for their exam. However, at present we do not have a fixed training space available which could impact on OSCE exam preparation and results. The professional standards team lead is currently working with the senior nursing team to secure a venue for this year. The Head of Learning and Libraries are aware of this and exploring use of the Mercure hotels hire conference rooms at the rate of £250 per day.

We will seek to recruit 2 WTE band 7 practice development nurses to support the OSCE preparation and supervision in the clinical areas during the induction periods which are tailored to support individual development of confidence and competency.

Due to the quarantine period, the induction for the nurses will be different to previous years which will also have costs attached, once finalised they will be added into the Business case. (E.G- Food shopping for two weeks, more resources required for swabbing, PPE etc.) These costs form the aforementioned bid to NHSE to support the current additional costs of recruitment.

Case for change – Risks

This proposal will pose the risks detailed below, though some of the risks can be adequately mitigated.

- Ongoing employment with the Trust is conditional upon the successful achievement of OSCE.
- A reduction in temporary spend will not be demonstrated immediately as a number of temporary nursing staff may still be required to back fill these positions whilst the newly appointed candidates undergo the necessary tests.
- We have a new/ junior RN workforce and the ability to support induction and supervision to develop competencies may be stretched in the clinical areas.
- Additional financial risk includes quarantine and accommodation

Constraints

Dependencies

- Being able to meet our requirements to fill 184 WTE vacant nursing positions through Overseas OSCE ready and direct employment.
- The Trust obtaining a sufficient Certificate of Sponsorship allocation from the Home Office.
- The Trust being able to offer affordable accommodation.
- Clinical support in practice whilst preparing for OSCE (will need to recruit in cohorts of no more than 20 so as not to jeopardise existing undergraduate student support in practice).

Non-financial benefits associated with the option 2 for this financial year

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
To be able to provide safe levels of nursing staff to provide quality care in areas which have increased capacity and changed care pathways in line with Covid 19 requirements	Safe RN to patient ratios	Each area meets the Safe RN to patient ratios in line with national recommendations and in line with Covid pathways	The ability to increase our capacity and adhere to patient pathway requirements; demonstrated in planned vs actual staffing reports	Three times daily organisational oversight of safe levels of staffing and monthly reporting to trust board and NHSI	Divisional Directors of Nursing and Quality

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Cost pressures of quarantine Airport transfers for nurses recruited directly to the trust Food allowance for each nurse during quarantine- (suggest 1 food shop delivery per week) PPE needed for nurses and HR department during quarantine King street hotel – will be used for quarantine period Revised relocation package Welcome packages **Risk** Longer induction period should a nurse become symptomatic during quarantine period- (they would need to wait till next induction) Limited spaces on induction (currently running with a 2-month delay) Junior nursing workforces and the ability to support and upskill **Demand on services** Increase in demand on Recruitment Team due to quarantine- (organising taxis, induction during quarantine etc.) Catering	15	These additional costs need to be paid as a requirement to support overseas nurses, we have been successful in bidding for additional funding with the NHSE strand a and b bids	10	Deputy chief Nurse/ IR lead

department for ordering food shopping Swabbing team- should the nurses become symptomatic Professional standards team- extra inductions may be required to enable nurses to commence by the end of the financial year.				

4a. Summary of non-monetary benefits and risks of each option

Non - monetary benefits and risks of each option - *Summarise the non-monetary benefits and risks of each option*		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 **Do nothing**	This option would be a retrograde step. We are likely to see an increase in staff absence in sickness. There is a risk to staff morale as too few staff will result in increased stress and inefficiency There is a financial risk of escalating temporary nursing spend is highly likely as we approach winter and phase 2-3 of the Covid pandemic, which may include increased demand for specialist nurses from non-framework agencies which will impact on safety and quality Unfamiliar nurses to ward environments not working routinely as part of the team can reduce efficiency and add to length of stay It could impact on the phase 3 recovery plan and our ability to manage electives and the backlog of elective prolonging patients waiting lists	20
Option 2	This will enable the trust to recruit a permanent workforce throughout the winter and will mitigate the risks as described in the do-nothing option. Benefits are that we will have a combination of recruitment methods This proposal will pose the risks detailed below, though some of the risks can be adequately mitigated. • Ongoing employment with the Trust is conditional upon the successful achievement of OSCE. • A reduction in temporary spend will not be	15

	demonstrated immediately as a number of temporary nursing staff may still be required to back fill these positions whilst the newly appointed candidates undergo the necessary tests and supervision. • We have a new/ junior RN workforce and the ability to support induction and supervision to develop competencies may be stretched in the clinical areas. • Additional financial risk includes quarantine and accommodation	

4b. Summary of information on each option

Category	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Capital costs *(One off upfront costs)*		£9.6k		
A) Annual revenue income		Yr 1 £238k		
B) Annual costs		Yr1 £533k / Yr2 £1967k		
Net annual cost		Yr 1 £295k / Yr 2 £1967k		
Benefits *(non-financial)* score *and or rank of option*				
Risks score *and or rank of option*				
Summary of option (Preferred / discounted/ deferred)				

The income relates to 3 bids made to NHSI. The criteria for the first tranche requiring 30 nurses to be recruited by 31st January was not achieved (15). A discussion with NHSI will be required to see if this can be deferred.

4c. Directorate decision on which option is preferred and why

Has the cost, benefit and risk been identified?

NOTE: From this point onwards, the sections should be completed for the preferred option only.

5. Commercial considerations (preferred option)

5. a. Services and/or assets required

NA

5. b. Procurement route

The trust has recently awarded a contract to an agency for the supply of OSCE ready nurses who will be ready to mobilise at the start of November 2020

We have existing contracts for the supply of non-OSCE ready nurses

5. c. Activity and service level agreement (SLA) implications. Commissioner involvement and input.

NA

5.d. Workforce impact preferred *option*

Summary of workforce changes (WTE and band) workforce issues. Include any necessary arrangements for training.

Staff type & band	Change (WTE)
Overseas recruitment	184
CSWs registered as Trained nurses overseas	39
Return to Practice	5
Total	**228**

	2020-21							2021-22	Total
	Oct	Nov	Dec	Jan	Feb	Mar	Total		
Overseas - OSCE	1	0	2	3	2	12	**20**	**55**	**75**
Overseas - Non OSCE	1	0	2	3	2	12	**20**	**55**	**75**
Direct Recruit	1	0	0	2	0	6	**9**	**25**	**34**
Support to CSW registered as Trained Nurses overseas	0	0	0	0	0	0	**0**	**39**	**39**
Return to Practice	0	0	0	0	0	0	**0**	**5**	**5**
	3	**0**	**4**	**8**	**4**	**30**	**49**	**179**	**228**

6. Financial impact of the preferred option –

Funding and affordability			The Financial Case
Capital costs of the preferred investment option			
Capital	2020-21	2021-22	2022-23
Equipment			
Estate			
IT	9,600		
Other			
VAT			
Total capital	9,600		
Notes on capital costs: 10 IPADs			
Revenue changes associated with the preferred investment option			
Revenue changes	2020-21	2021-22	2022-23
Total income	237,660		
Recruitment Fee	361,828	1,191,309	0
Supernumerary Time	169,143	655,833	0
Agency cover			
Recruitment and supernumerary total	**530,971**	**1,847,142**	**0**
Additional PDN resource	**0**	**117,394**	**117,394**
Capital charges & depreciation	2,088	2,088	2,088
Total costs	**533,059**	**1,966,625**	**119,482**
Net cost	295,399	1,966,625	119,482

Notes on revenue costs:

The income relates to 3 bids made to NHSI. The criteria for the first tranche requiring 30 nurses to be recruited by 31st January was not achieved (15). A discussion with NHSI will be required to see if this can be deferred.

OSCE recruitment:-

20 nurses recruited between October 2020 and 31st March 2021

4 weeks supernumerary period at band 5

Non OSCE recruitment:-

20 nurses recruited between October 2020 and 31st March 2021

4 weeks supernumerary period at band 3

4 weeks supernumerary period at band 5

Direct Recruit:-

9 nurses recruited between October 2020 and 31st March 2021

4 weeks supernumerary period at band 3

4 weeks supernumerary period at band 5

Support to CSW registered as Trained Nurses overseas:-

In addition to course fees and tests, temporary staff to backfill study time has been included

The Case includes the need for additional PDN resource (B8a x 2.00 wte)

The Case is linked to the costs of recruitment of specific posts and excludes ongoing salary costs arising from other agreed developments (including escalation areas)

Recruitment Costs

	2020-21							2021-22
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**	
Overseas - OSCE	9,129	250	18,508	27,887	19,508	110,798	**186,080**	**533,095**
Overseas - Non OSCE	6,579	250	13,408	20,237	14,408	80,198	**135,080**	**392,845**
Direct Recruit	4,352	250	250	8,704	500	26,612	**40,668**	**122,800**
Support to CSW registered as Trained Nurses overseas	0	0	0	0	0	0	**0**	**142,569**
Return to Practice	0	0	0	0	0	0	**0**	
	20,060	**750**	**32,166**	**56,828**	**34,416**	**217,608**	**361,828**	**1,191,309**

Supernumerary Cover

	2020-21							2021-22
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**	
Overseas - OSCE	2,952	0	5,905	8,857	5,905	35,429	**59,048**	**162,381**
Overseas - Non OSCE	2,524	2,952	5,048	15,690	11,690	36,190	**74,095**	**324,810**
Direct Recruit	2,524	2,952	0	10,952	4,429	15,143	**36,000**	**168,643**
Support to CSW registered as Trained Nurses overseas	0	0	0	0	0	0	**0**	
Return to Practice	0	0	0	0	0	0	**0**	
	8,000	**5,905**	**10,952**	**35,500**	**22,024**	**86,762**	**169,143**	**655,833**

Recruitment Costs and Supernumerary Cover	**28,060**	**6,655**	**43,118**	**92,328**	**56,440**	**304,370**	**530,971**	**1,847,142**

7. Quality Impact Assessment (preferred option)

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Yes Discussed at Recruitment & Retention group meetings, Nursing, midwifery and Allied Health Professions Steering Group (reports to Clinical Governance and Trust Management Executive).	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Review of practice within other organisations	
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Yes NMC regulation	
Are there any risks to clinical effectiveness? If yes, list	
Yes Supernumerary status and risk associated with clinical skills of existing workforce being diluted initially	
Have the risks been mitigated?	
Consideration being given to introducing new recruits to the workforce in control numbers. Consideration being given to placing recruits in well-established wards during supernumerary phase prior to allocation to areas with significant vacancy.	
Have the risks been added to the departmental risk register and a review date set?	
Vacancy already listed as a risk. Individual risks associated with this plan will be refined once approval to proceed has been granted.	
Are there any benefits to clinical effectiveness? If yes, list	
Yes; long term improvements with a reduction in vacancy and increase potential for a stable workforce. Non-EU nurses traditionally stay with sponsoring organisations longer than EU nationals.	
Patient Safety	
Has the impact of the change been considered in relation to?	
Infection Prevention and Control?	Yes
Safeguarding vulnerable adults/ children?	Yes
Current quality indicators?	Yes
Quality Account priorities?	Yes
CQUINS?	Y/N/A
Are there any risks to patient safety? If yes, list	
Small risk associated with new recruits, as detailed above. Mitigated with rotational plans similar to UK under-graduate training programmes. Could be further mitigated with enhanced support from Clinical Skills Facilitator.	
Have the risks been mitigated?	
As above	
Have the risks been added to the departmental risk register and a review date set?	
No	
Are there any benefits to patient safety? If yes, list	

Improved standards of care as a consequence of a stable workforce Staff morale will improve which will have a positive impact on patient care
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
Limited assessment. However, in the last year there has a positive reception by patients to the care received from non-EU nurses
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
Not directly. Addressed as part of the wider Trust operational plans and STP/ICP strategy
Does the redesign lead to improvements in the care pathway? If yes, identify
Not directly – see note above.
Are there any risks to the patient experience? If yes, list
Minimal
Have the risks been mitigated?
Yes.
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to the patient experience? If yes, list
Yes ; as above
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Yes
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No
Has any negative impact been added to the departmental risk register and a review date set?
N/A
Service
What is the overall impact on service quality? – please tick one box

Improves quality	x	Maintains quality		Reduces quality	

Clinical lead comments

9. QSIR Methodology

10. Arrangements *The Management Case*

Project management arrangements

Project evaluation (PPE)

Timetable

Business assurance

Complete the following section now

Name of Division/Directorate
Evaluation manager
Project Title & Reference
Total Cost
Start date
Completion date
Post project evaluation Due Date

Complete this section by PPE due date

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

SECTION 2: PROJECT PROCESS EVALUATION

Project documentation issues
Project execution issues
Project governance issues
Project funding issues
Human resource issues
Information issues
What worked well in developing case?
What could be improved in developing a case?
Summary of recommendations for developing a case

SECTION 3: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives?
Objective 1
Objective 2
Objective 3 How were they achieved?

SECTION 4: BENEFITS

Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

SECTION 5: VALUE FOR MONEY

What methodology was used to assess quality, funding and affordability and value for money of service provided? What were the conclusions?

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

What problems were encountered during implementation of the project, and how where such resolved?

What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

11. Appendices

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

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
2	08/10/2020	Presented to BCRP	Judy Durrant Deputy Chief Nurse/ John Coffey
3	22/10/2020	Edited following BCRP	Judy Durrant Deputy Chief Nurse/ John Coffey
4	09/11/2020	Edited following executive team discussion	Judy Durrant Deputy Chief Nurse/ John Coffey
5	25/11/2020	Edited to reflect 85 overseas nurses	Judy Durrant, John Coffey, Elizabeth Parker, Toks Ojo
	13/01/2021	Edited to reflect 228 overseas nurses 39 CSWs and the addition of the NHSE funding	Judy Durrant, John Coffey, Elizabeth Parker, Toks Ojo

The Trust's response to the Ockenden review of maternity services	**Chief of Service for Women's, Children's and Sexual Health / Divisional Director of Nursing, Midwifery and Quality**

The Ockenden report was published on the 10th December 2020 following an independent review to outline the failings within the Maternity Services at Telford and Shrewsbury Hospitals NHS Trust. The report defined an immediate response required from all maternity providers and a national response relating to 'next steps'.

The enclosed report provides information on:

- The seven immediate and essential actions outlined in the report
- The corresponding actions that link to the NHS Resolutions Maternity Incentive Scheme and urgent clinical priorities
- A workforce analysis of maternity staffing
- Appendices that demonstrate the full gap analysis of the Ockenden report, workforce report and the Birthrate Plus report received in October 2020. This report is currently being benchmarked against a business case to support the investment of 1 x band 7 midwife, 8 x band 6 midwives and 4 x midwifery apprenticeship students.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee 13/01/21 (in part)
- Executive Team Meeting 19/01/21

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

National request for overview and sign off. Once approved a final submission is required to the Regional Chief Midwife and the Local Maternity System (LMS) for final sign off and submission to NHS England / Improvement (NHSE/I)

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

The Ockenden report was published December 2020 following an independent review to outline the failings of the Telford and Shrewsbury Hospitals NHS Trust. The report defined an immediate response required from all maternity providers and a national response relating to 'next steps'. Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families.

The information within this report has been outlined to provide the trust board with the assurance that maternity services meet the recommendations of the recent Ockenden report (2020) and the actions required with full compliance. This report details an oversight of the essential recommendations within the main report, and including the 7 immediate and essential actions; containing 12 clinical priorities and the link to the CNST requirements. It further incorporates a gap analysis of the workforce plan; both of which requires trust board oversight and sign off.

We like to provide the following assurance on the 12 clinical priorities:

Enhanced Safety

The LMS has a plan in place to strengthen maternity quality surveillance at ICS level, which aligns with all of the information we have received to date about the anticipated NHSE guidance. MTW will work collaboratively with both the LMS and the ICS to achieve this.

At MTW we have a robust Governance process that is supported at executive level and is presented at both Trust Board and Quality Committee (main). The LMS will ensure that they immediately put a system in place for SI review at 3 monthly intervals within the existing CCG nursing and quality structure to meet the recommendations of the report. PMRT is presented quarterly to the trust board and we have full external representation at each of these meetings. All actions within the governance structure are transferred into the CLIPA agenda and this is monitored in terms of compliance on a monthly basis with MDT commitment.

Listening to Women and their Families

A trial patient safety role has been created to support the trust and work collaboratively with the MVP, Health watch and the trust patient experience lead. Feedback is shared across the organisation via Clinical Governance, Maternity Board and the Patient experience committee. Regular attendance of the senior management team at the Patient Experience Committee and full engagement with external review and questionnaire responses allow a benchmark for improvements to our service.

Our non-executive director is Sarah Dunnett and Executive Sponsor and Safety Champion is Claire O'Brien. Both of which support our service and engage with the quality agenda.

We work collaboratively with HSIB and ensure that women and families and supported and offered feedback sessions following case reviews. More recent correspondence from the national team (12.1.21) discuss a trust level independent person to support maternity and neonatal cases of debrief and feedback. This is something that will need to be explored in further detail but will more likely require investment from the trust and a conversation of who this role would sit with to maintain an independent overview.

Staff Training and working together

Multidisciplinary training is delivered by classroom based and socially distanced scenario training, live skills drills and video sessions which support the eLearning package. The current percentage for compliance with PROMPT training is 52.6% and has been impacted with the COVID 19 pandemic. Further MDT training is achieved with CTG sessions that are delivered weekly on line. The compliance has been impacted with COVID 19 but a new plan is in place to support an improved percentage and twice monthly training sessions in comparison to the historic once monthly agendas. The majority of this is on line. This has previously been recognised with the year 2 CNST scheme and assurance methods will be further developed to feedback to the LMS on

a 3 times a year basis. Training compliance is monitored within the division and reported at Maternity Board and Divisional Governance meeting.

Consultant led ward rounds are completed twice daily, 5 days a week with once daily at weekends. This is supported with clinical workforce planning on a yearly basis.

All external funding for training is ring fenced and used to support the training agenda of the staff. Again due to COVID, the training agenda has been limited but where online training has been available we have utilised this.

Managing complex pregnancy

The trust has a plethora of guidance that supports complex pregnancy agendas and identifies the lead consultants for each specific condition. This is collected and supported via our E3 system and regular audits not only support this compliance but also support national benchmarking associated with MBRRACE reporting. Audits required for future consideration as part of the evidence to support this requirement.

The ICS and LMS system have planned to meet in the new year to map a Kent wide approach in maternal medicine centres. This will be led by the LMS and supported with the organisation.

Saving babies lives is in motion but a further business case is being developed to support the fetal wellbeing midwives with the CTG aspect of this. This is an area of risk following on from our maternity deep dive report and requires the additional investment to progress. The directorate contains a dashboard that supports this work and is presented to the maternity board.

Risk Assessment throughout pregnancy

The organisation has an electronic system that supports an 'each contact' risk assessment. This ensures all women are assessed at each contact and allows an opportunity to support altered pathways in a responsive manner. This information is captured and can be supported with regular documentation audits however it is recognised that a more formal audit process is required to support this recommendation.

The risk assessments used prompt care planning for place of birth and ensure that women are supported with their decision making. The directorate has further concluded a project which supports planning place of birth resources that base information on the trusts statistic data in terms of Robson Groups, assisted vaginal delivery and syntocinon. A regular audit program is required to support the evidence of this action.

Monitoring Fetal Wellbeing

MTW have a fetal wellbeing midwife that encompasses the 5 elements of the SBLCBv2. This is further supported by the obstetric lead consultant. A recent 'deep dive' into the services highlighted that CTG required further focus and attention in terms of quality matrix. A fetal surveillance team is being scoped to mirror that of trusts that have significantly reduced the amount of HIE cases due to improved CTG knowledge and understanding in the workforce.

Our central monitoring systems support all areas across the clinical floor with upgrades due for early 2021. All consultant colleagues have the ability to review CTG cases remotely and can play an active role in remote advice and clinical decision making.

All adverse outcome cases are reviewed as part of a multidisciplinary meeting in a timely manner and escalated if concerns arise about the care given. Yearly 'deep dive' reports are being produced as part of usual practice. The next is due before 31st March 2021

Informed Consent

MTW have developed birth planning resource tools to support planning place of birth. The LMS have further supported the collaboration with DadPad where MTW will be leading on and supporting a new tool for Dads/partners that describe planning place of birth.

MTW have recently completed a project ensuring the website for women is full of current and useful information. A series of videos to support this decision making is now being explored.

Where possible MTW link to national information which is updated in line with new recommendations. In cases where women wish to birth outside of guidance a full and documented discussion takes place and care planning is achieved to support the safest option agreed by all parties. This is routinely led by the community services, the obstetricians and the consultant midwife. For any deviations from the 'norm' staff are alerted and supported accordingly.

Data and feedback that is received is used to improve our services and address thematic concerns. The Head of Midwifery also liaises with the MVP chair to understand what approach is best given the circumstance.

NICE Guidance related to maternity

The directorate will use NICE guidance in the majority of cases but where deviation is required due to internal audit or other guidance that supports a more robust level of support and guidance. In these instances a clear and robust risk assessment is performed. All guidelines are reviewed and agreed at the risk management meeting and approved or rejected accordingly.

Workforce planning

As an organisation MTW can confirm that we have received a baseline BR+ report on 26 October 2020 with a further draft Continuity of Carer projection summary report that was received on 10 December 2020. A business case is being drafted to support the baseline report with future plans to work collaboratively with the LMS for the Continuity of Carer agenda.

We further boast a robust maternity support worker development programme which has been recognised by HEE as forward thinking and recently been showcased in midwifery journals. MTW have been key stakeholders with supporting the new midwifery apprenticeship scheme and we are about to embark on a second year of support for this initiative (years 3 and 4 have been incorporated into the business case for consideration to allow a 4 year rolling program). This is in addition to supporting our HIE colleagues and the national agendas by increasing our midwifery placement numbers by 2 each year to date. MTW have been successful in reducing a 24 WTE vacancy rate in early 2019 to 0 WTE in 2020. This is supported with an ongoing recruitment and retention strategy and engaging responsively yearly to the staff survey and pulse results. MTW have further increased our PMA provision from 0 in 2018 to 14 being trained in 2020. The team are working to support staff welfare and support the Maternity Safety Champions with any concerns that are being voiced via the restorative clinical supervision sessions.

The following supporting documents have been appended to this report:
Appendix 1: Birthrate Plus (BR+) report
Appendix 2: Ockenden GAP analysis
Appendix 3: Workforce and Leadership GAP analysis

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

MAIDSTONE AND TUNBRIDGE WELLS TRUST

BIRTHRATE PLUS® DRAFT BASELINE SUMMARY

1. This is a draft baseline summary of the results dated 20/10/2020. A resume of the draft results is on page 4 followed by key points for discussion.

2. The draft results were based on using the 2 months' casemix from 2018, with adjustments made based on clinical outcomes provided from the maternity dashboard and other sources. Activity was based on annual data for 2019/2020.

3. Similar to 2018, a 21% allowance has been applied for annual, sick and study leave and 12.5% for community travel.

4. Deliveries have reduced by 470 births from 5976 in 2018 to 5506 births in 2019/20 of which:

    a. 4755 are on Delivery Suite (DS)
    b. 414 on The Maidstone Birth Centre (MBC)
    c. 196 on The Crowborough Birth Centre (CBC)
    d. 141 at home

5. The Birthrate Plus® staffing is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care.

6. The workforce requirements including 21% uplift have been calculated on providing minimum staffing in the 2 Birth Centres and also without minimum staffing so based on activity and the methodology:

Option 1

Minimum staffing for both MBC and CBC - total clinical wte is 223.90wte

Of the clinical total wte

a. 139.58 wte for hospital services – intrapartum, maternity wards and outpatients.
b. 62.63 wte for community and home births
c. MBC:10.84wte
d. CBC: 10.84wte

Option 2

Without minimum staffing for MBC and CBC - total clinical wte is 213.26wte

Of the clinical total wte

e. 139.58 wte for hospital services – intrapartum, maternity wards and outpatients.
f. 62.63 wte for community and home births
g. MBC:7.65wte
h. CBC: 4.81wte

7. Most maternity units work with a minimum of 90/10% skill mix split of the clinical total wte, although this is a local decision by the Senior Midwifery Team. The current skill mix is 87% RMs and 13% Postnatal MSWs which if working well, is appropriate and will not impact on midwives being available to cover peak activity on the BC and DS.

8. The total clinical establishment does not include the following roles:
   - Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
   - Practice Development role
   - Clinical Governance role
   - IT and Information role
   - Time for Baby Friendly Initiative, to produce & monitor guidelines & undertake audits
   - Consultant Midwife
   - Safeguarding Coordinator
   - Additional hours for antenatal screening and specialist midwives to undertake audits and training
   - PMAs (A-Equip)

9. The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. an addition of 9% equates to between 19.19 wte and 20.15wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties.

10. Summary:

BR+ WTE	90/10 skill mix minimum staffing in BCs	87/13 skill mix minimum staffing in BCs		90/10 skill mix based on activity in BCs	87/13 skill mix based on activity in BCs
Total Clinical, Specialist & Management	244.05	244.05		232.45	232.45
Postnatal MSWs	22.39	29.11		21.33	27.72
RMs (Bands 5 – 8)	221.66	214.94		211.12	204.73

SUMMARY of DATA & REQUIRED WTE for

Maidstone & Tunbridge Wells NHS Trust

Final draft 22/10/2020

Annual Data 2019/20

Total Births	5506
Total Community Cases	6193
Total Bookings	6727

Casemix Adjusted with 2020 data	Cat I	Cat II	Cat III	Cat IV	Cat V
D/S % Casemix	3.0	18.5	17.5	31.0	30.0
Generic % Casemix	5.5	22.0	16.0	29.0	27.5

		Annual Nos.	Required WTE	
Delivery Suite				
Delivery Suite Births		*4755*	55.70	**57.88**
Non-birthing activity			2.19	
Triage/Phone Line		*9768*	15.36	**15.36**
Antenatal Care	Antenatal admissions	*1195*	6.72	**10.84**
	Inductions	*1235*	2.20	
			0.00	
Postnatal Care	Postnatal women	*4755*	40.05	**46.91**
	Postnatal Re-admissions	*123*	0.64	
	NIPE	*2825*	1.81	
	Extra Care Babies	*850*	4.41	
OUTPATIENT SERVICES				
Antenatal Clinics	Midwife Clinics		0.98	**6.81**
	Obstetric Clinics		3.21	
	Specialist Clinics		2.33	
	Fetal Medicine		0.29	
Day Assessment Unit		*1697*	1.77	**1.77**
TUNBRIDGE WELLS HOSPITAL CLINICAL WTE REQUIRED				**139.58**
		Annual Nos.		
COMMUNITY SERVICI	Home Births	*141*	3.97	**3.97**
	Community Cases	*6052*	58.01	**58.66**
	Community Bookings ONLY	*534*	0.65	
MAIDSTONE BIRTH CENTRE				
	Births & PN care	*414*	6.14	**10.84**
	Transfers to DS	*113*	0.37	
	Ward Attenders/Cat X	*576*	0.92	
CROWBOROUGH BIRTH CENTRE				
	Births	*196*	2.91	**10.84**
	Unplanned cases	*384*	0.25	
	Transfers out	*56*	0.46	
				84.32
BIRTH CENTRES & COMMUNITY CLINICAL WTE REQUIRED				
TOTAL CLINICAL MIDWIFERY WTE REQUIRED				**223.90**
Senior Management & Specialist Midwives (non-clinical			**20.15**	

Discussion of Draft Staffing Results

Maidstone and Tunbridge Wells NHS Trust

1. Since the 2018 workforce review there has been an increase in the delivery suite (DS) casemix of women in the 2 higher categories IV and V from 58% in 2018 to 61% in 2020, and a decrease in the % of women in the lower categories I to III from 42% to 39%. The majority of 'low risk/midwife led' women birth in the birth centres which affects the overall casemix. The casemix is unique to each service as reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines.

2. There is a match between the casemix, and maternity stats recorded on the dashboard especially in relation to Induction rates, delivery method, post-delivery problems and more.

3. The DS casemix has been used to calculate the staffing for intrapartum and postnatal services, whilst the generic casemix which includes the women who birth in the birth centres is used for the community.

4. The additional 200 antenatal cases seen on delivery suite require one to one care and are often warded once stable so are not classed as a Triage episode.

5. Inductions of labour (prostin/propess n = 1235) are based on the annual number of doses administered so will be less women and is allocated to the maternity ward although a small % may be undertaken on DS.

6. The Birthing Centres provide intrapartum care to 414 at MBC and 196 women at CBC including postnatal care and NIPE. In addition, women may transfer out in labour or immediately after to the delivery suite if complications arise (MBC:113, CBC:56). There is also some 'triage' activity on both birth centres (MBC:576, CBC:384)

7. The staffing for the Birth Centres is calculated on having a minimum of 2 midwives 24/7 although for comparative purposes staffing for activity only has also been included.

8. The staffing for Triage is based on having a 24/7 service with 2 midwives working 12 hour shifts and 1 midwife working an 8 hour shift 7/7. There is also a Maternity Phone Line, 1 midwife 7/7 for 12 hours.

9. The Day unit is open 5 days a week with 1 midwife working 11 hours.

10. The annual admissions to the antenatal ward of 1195 exclude elective cases.

11. There has been an increase in the number of 'extra care babies' from 340 to 850, those that have a postnatal stay longer than 72hrs. This is reflective of the increase in acuity/case mix.

12. The postnatal wards may see a small number of ward attenders and has approximately 123 readmissions. Provision has been made for 2825 NIPEs to be undertaken by a midwife.

13. Outpatient Clinics are based on the actual time that clinics/sessions run allowing for overrunning and number of midwives and support staff needed using professional judgement. Time is included for preparation and administration of clinics.

14. The hospital clinical wte (with minimum staffing) of 139.58wte will primarily be midwives with a small % being postnatal MSWs – ranging from 11.00 to 15wte. The actual split between RMs and PN MSWs is a local decision.

Community

15. There are 441 women who birth in M&TW but from out of area, so receive their community care from neighbouring Trusts.

16. There are 896 women who have birthed in neighbouring units and receive community care locally.

17. The total number of community cases in M&TW is 6193 which includes 215 home births.

18. In addition, there are 534 women who do not complete pregnancy or move out of area.

19. The actual split between RMs and PN MSWs is a local decision and based on size and configuration of service can be between 10-13% overall with approximately half in hospital and half in community.

Comparison of Staffing

To be discussed as will involve comparing the Birthrate Plus WTE with current midwifery and postnatal MSWs, and the contribution from midwife specialist roles to clinical care –see table below.

MAIDSTONE & TUNBRIDGE WELLS	22/10/2020	Based on Minimum Staffing	
	RMs	**MSWs**	**Bands 3-7**
Current Total Clinical	175.48	28.31	212.99
Contribution from Specialist MWs	9.20		
Total Current Funded	**184.68**	**28.31**	**212.99**
BR+ Clinical wte			**223.90**
Skill Adjustment (90/10)	201.51	22.39	
Variance +/-	-16.83	5.92	**-10.91**
Skill Mix Adjustment (87/13) -Current Funded Mix	**194.79**	**29.11**	
Variance +/-	**-10.11**	**-0.80**	**-10.91**
	BR+	**Current**	**Variance**
Non Clinical @ 9%	20.15	17.00	**-3.15**
Total Variance			**-14.06**

Based on Minimum Staffing for the Birth Centres and a skill mix of 90:10, comparing the current funded establishment and the Birthrate Plus recommended wte, there is deficit of -10.91wte clinical staff for the service. The breakdown indicates that there is a gap of -16.83 MWs; however, there is a surplus of +5.92 MSWs.

If a skill mix of 87:13 is applied, the overall deficit remains at -10.91wte however the breakdown changes to -10.11 MWs and -0.80 MSWs

The non-clinical wte indicates that there is a small deficit of -3.15wte, which results in an overall deficit of -14.06wte Bands 3 - 8.

MAIDSTONE & TUNBRIDGE WELLS	22/10/2020	Based on Activity in the Birth Centres	
	RMs	**MSWs**	**Bands 3 - 7**
Current Total Clinical	175.48	28.31	212.99
Contribution from Specialist MWs	9.20		
Total Current Funded	**184.68**	**28.31**	**212.99**
BR+ Clinical wte			**213.26**
Skill Mix Adjustment (90/10)	191.93	21.33	
Variance +/-	-7.25	6.98	**-0.27**
Skill Mix Adjustment (87/13) -Current Funded Mix	**185.54**	**27.72**	
Variance +/-	-0.86	0.59	**-0.27**
	BR+	**Current**	**Variance**
NON CLINICAL (9%)	19.19	17.00	**-2.19**
Total Variance			**-2.46**

Based on activity in the birth centres and a skill mix of 90:10 skill mix, comparing the current funded establishment and the Birthrate Plus recommended wte, there is a small deficit of -0.27 wte clinical staff for the service. The breakdown indicates that there is a gap of -7.25 MWs and a surplus of +6.98 MSWs.

If a skill mix of 87:13 is applied, the overall deficit remains at -0.27wte; however, the breakdown changes to -0.86 MWs and +0.59 MSWs

The non-clinical wte indicates that there is a small deficit of -2.19wte, resulting in an overall deficit of -2.46wte Bands 3 - 8.

Based on 5506 births and an uplift of 21%, the BR+ calculated overall ratio for Maidstone & Tunbridge Wells Trust is 24.6 births to 1 wte with minimum staffing and 25.8 births to 1 wte without minimum staffing.

STANDARD | **MTW Maternity Services Assessment and Assurance tool**

IEA REQUIREMENT 1 (ENHANCED SAFETY): Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG
Ockenden safety requirement Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	The LMS has a plan in place to strengthen maternity quality surveillance at ICS level, which aligns with all of the information we have received to date about the anticipated NHSE guidance. MTW will work collaboratively with both the LMS and the ICS to achieve this. External contribution to PMRT is welcomed and this will be extended to HIE cases (although these are also independently reviewed by HSIB) and in the event of a maternal death. At MTW we have a robust Governance process that is supported at executive level and is presented at both Trust Board and Quality Committee (main). The LMS will ensure that they immediately put a system in place for SI review at 3 monthly intervals within the existing CCG nursing and quality structure to meet the recommendations of the report.	The LMS are currently reviewing the surveillance and assurance methods they will using as part of a new process. This will presented at the LMS board w/c 11th January 2021. PMRT we currently have external representation and the yearly report on PMRT is part of the yearly Deep Dive report. Any outstanding actions will go to the CLIPA meeting. we are supported heavily by the Trust Governance Team. We have a yearly Deep Dive review to identify trends across SIs, complaints, PMRT and HSIB cases. We have a dashboard that collates outcomes. Any actions go via CLIPA. The PDM team support the actions and learning from incidents by proactive methods of engagement with staff. Local LMS scrutiny still to be developed and embedded into the system.	We would see a reduction of incidents and th	Work with LMS as plan develops Ensure external input for RCAs for HIE cases Develop action plan based on finding of recent deep dive of which the PMRT was one component	LMS Women's Governance Team, Senior Maternity Team, March 2021	Await guidance from LMS regarding surveillance and assurance methods	From January 2021 all HIE cases are independently reviewed by HSIB Actions from PMRT are monitored via CLIPA monthly and are RAG rated according to completion date. Bi-monthly Governance reports highlights issues from all incidents and investigations. Actions that are difficult to complete should be individually discussed with senior management team. This process needs to be reviewed.	
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Are you submitting data to the Maternity Services Dataset to the required standard? Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	PMRT is used for all cases of stillbirth and neonatal death. External input is used in every case. Maternity Dataset is submitted to the required standard 100% cases are notified to HSIB and ENS	Quarterly PMRT report to Board Key messages from PMRT and SIs is presented at monthly clinical governance meetings Actions from PMRT are monitored through CLIPA but needs to be presented more widely to drive improvements.	Number verified through MBRRACE A deep dive was completed of all data from 2018-2019 and from now our aim is to do a annual deep dive. This will provide evidence that we are meeting the requirements of what actions we need to take	Ensure external representation at HIE RCAs Develop action plan based on finding of recent deep dive of which the PMRT was one component Actions that are difficult to complete should have a process identified where they can be discussed with senior management to determine how to take forward	Liz Griffiths, Quality & Safety Manager Rachel Thomas Deputy head of Midwifery March 2021			
Link to urgent clinical priorities (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	a)Plan to use the Perinatal Clinical Quality Surveillance Model when it is received b) SIs are shared with the board via the Patient Safety Team. SIs are reported on the Quality Committee report on a monthly basis. All SIs are presented to the SI panel which has representation from the Exec Team. Will share with LMS when new process has been defined.	As above	Reduction in similar incidents	Ensure that data is submitted to LMS when knew services are defined.	LMS and Maternity Governance	awaiting defined process from LMS		
IEA REQUIREMENT 2 (LISTENING TO WOMEN & FAMILIES): Maternity services must ensure that women and their families are listened to with their voices heard.	**What do we have in place currently to meet all requirements of IEA 2?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	
Ockenden Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	A trial patient experience role has been created to support the trust and work collaboratively with the MVP, Health watch and the trust patient experience lead. Feedback is shared across the organisation. Regular attendance of the senior management team at the Patient Experience Committee and full engagement with external review and questionnaire responses allow a benchmark for improvements to our service. Our non-executive director is Sarah Dunnett and Executive Sponsor and Safety Champion is Claire O'Brien; both of whom support our service and engage with the quality agenda. We work collaboratively with HSIB and ensure that women and families and supported and offered feedback sessions following case reviews.	Creation of Patient Experience Role. Themes are being collated and the aim is to use them to inform quality improvement projects Bereavement Midwives provide comprehensive support and will accompany women to follow up appointments. They act as the family advocate	New role but is a rich source of data	We need to understand how the new patient experience role could assume the role of an independent advocate or whether a separate role is required. Further exploration needed with MVP about the creation of an independent advocate. Initial conversations with the MVP rep indicate that they regard the Patient Experience Midwife as an independent role. The patient experience midwife will need to collate the feedback and the form of a regular report to be shared with the Directorate and Maternity Board and externally	Rachel Thomas Deputy Head of Midwifery 31 January 2021	Possible funds will be needed if a role independent of the Trust needs to be recruited to. Ongoing funding needed to support the patient experience role	Patient experience midwife and bereavement team	
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	PMRT is being used for every Stillbirth and Neonatal Death Feedback via Patient Experience and IQVIA however we recognise that this is not an independent role and further advice from LMS is awaited. Bi-monthly meetings between Safety Champions and Board Level Champion do occur and can be evidenced	PMRT database and MBRRACE data. CNST requirement fulfilled 2019/2020 Database of feedback plus data collection from digital system IQVIA Diary evidence of meetings	All cases captured Feedback is being received. Discussion around MVP following up with women at a later stage in the post-partum period Rolling action log	We need to explore the role of the non-executive director and how they can best support us to deliver quality improvements	Bereavement Team Patient Experience Midwife Maternity Safety Champions and NED			

Appendix 2 - Ockenden gap analysis

Link to urgent clinical priorities (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	a) Feedback via Patient Experience and IQVIA. MVP, Healthwatch and CQC patient perspective and social media contribute to service developments through attendance at relevant meetings, support with guidelines and patient information, including website. b) the non-executive director responsible for maternity services is Sarah Dunnett	Diary evidence of meetings	Diary evidence of meetings	Need to formally discuss process of action taken when we have feedback from the MVP We need to explore the role of the non-executive director and how they can best support us to deliver quality improvements Feedback to be collated into a report for shared learning This is a new role and we need to explore how the feedback can be used to drive up standards of care. Further discussion with the MVP regarding this Need to formally discuss process of action taken when we have feedback from the MVP	Patient Experience Midwife 28 February 2021 Rachel Thomas Deputy Head of Midwifery 31st January 2021	More user reps to support this line of work	Carry on with obtaining feedback from Patient experience and IQVIA	
IEA REQUIREMENT 3 (STAFF TRAINING & WORKING TOGETHER): **Staff who work together must train together**	**What do we have in place currently to meet all requirements of IEA 3?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	
OCKENDEN Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Multidisciplinary training is delivered by classroom based and socially distanced scenario training, live skills drills and video sessions which support the eLearning package. This has been impacted with COVID 19 but a new plan is in place to support an improved percentage. This has previously been recognised with the year 2 CNST scheme and assurance methods will be further developed to feedback to the LMS on a 3 yearly basis. Consultant led ward rounds are completed twice daily, 5 days a week. We are working on the plan for weekends of which the cover is currently 8.30am-2pm This is supported with clinical workforce planning on a yearly basis. All external funding for training is ring fenced and used to support the training agenda of the staff. Again due to COVID the training agenda has been limited but where online training has been available we have utilised this.	Maternity Board and agenda item on the Governance meeting Training funding is monitored monthly and ringfenced for the division with addition monies spent when available. Current examples would include CTG training for March 2021 and medical prescribers course	We utilise funding based on risk and need	Develop mechanism for LMS to externally validate 3 times a year as per new assurance role. MDT training is currently being reviewed to ensure we rapidly improved compliance despite current pressures Review the use of online training which has currently replaced most face to face sessions Options regarding consultant cover at the weekends needs to be discussed and an action plan devised. At present on the weekend evenings the consultant will call to discuss the clinical situation but alternative options to this need to be explored.	Transformation Lead Governance Lead March 2021 Miss W Ogunnoiki Clinical Director and Miss S Flint, Chief of Service	Unknown at present They may be a financial implication if presence at the weekend is to be extended	Increased live skills drills. Twice monthly virtual MDT training Consultant on call will call in to unit on weekend evenings to assess clinical situation	
CNST Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Consultant job plan is held on the Allocate database for all consultants. Junior doctor and middle Grade staffing is discussed at Directorate and there is a consultant obstetrician who is RCOG College Tutor & Honorary Senior Lecturer. Midwifery staffing is reviewed every 6 months with the HOM, Deputy Chief Nurse and the Chief Nurse. Every other year there is a Birthrate plus report which reviews the staffing. The next one is due 2022. Midwifery staffing is reviewed every week day at the huddle and there is a Care Pathway Coordinator who manages the staffing throughout the shift. Sonography has funding to train a student every year and regular reviews regarding staffing are undertaken. In previous years we have always met the compliance for MDT training. Currently targets are not met due to pressures of Covid pandemic. Plan in place to ensure that 90% of staff have attended multidisciplinary training with introduction of "Virtual Prompt" pandemic pressures allowing.	Workforce reports are discussed at Directorate and Divisional Performance meetings Currently reported at Women's Governance and Divisional Board	Minutes from the meetings will provide evidence of discussion. Datixes are monitored for workforce issues and escalated as appropriate. There is DDTM training and we have had external funding for a prescibers course. We are utilising the apprenticeship levy to put more midwifery support workers through midwifery training. Training compliance is discussed at Divisional Governance and Maternity Board We monitor datixes regarding clinical outcomes and this is reported monthly at Clinical Governance via the Risk Report	Review consultant presence at the weekend and incorporate in annual job planning process. Provide plan with how compliance will be reached by July 2021. Twice monthly virtual PROMPT occurring	Miss Wunmi Ogunnoiki, CD, March 2021 Practice Development Team	Funding for additional consultant hours Twice monthly PROMPT virtual sessions should improve compliance quickly	Consultant ward rounds at end of resident shift on weekends Increased live skills drills training	
Link to urgent clinical priorities (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 5 days per week with weekends demonstrating 2 reviews but one not necessarily being a ward round. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	a. Twice daily ward rounds are occurring 7 days a week b. TNA is current. Virtual multidisciplinary training is occurring twice a month. With the current strain on anaesthetic department during the pandemic, supporting the MDT training is difficult. Weekly CTG training is multidisciplinary.	Reported at Directorate and Consultant meeting Currently reported at Women's Governance and Divisional Board Governance	whilst we recognise that we do not have twice weekly ward rounds at weekends, there is strong consultant presence on the weekends and a further review is undertaken before the consultant leaves at 2pm b) in previous years we have consistently been in line with the training targets however due to the pressures with the pandemic this has understandably taken its toll on compliance.	Review consultant presence at the weekend and incorporate in annual job planning process. Provide plan with how compliance will be reached by July 2021. Twice monthly virtual PROMPT occurring with limited face to face sessions for those who are new to the Trust or those who need particular support which has been recognised through risk or PMA	Miss Wunmi Ogunnoiki, CD, March 2021 Practice Development Team	Funding for additional consultant hours Twice monthly PROMPT virtual sessions should improve compliance quickly	Consultant review at end of resident shift on weekends. Increase live skills drills training following pandemic when permitted. Increased live skills drills training	
IEA REQUIREMENT 4 (MANAGING COMPLEX PREGNANCY): **There must be robust pathways in place for managing women with complex pregnancies**	**What do we have in place currently to meet all requirements of IEA 4?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	

Appendix 2 - Ockenden gap analysis

OCKENDEN Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	The ICS and LMS system have planned to meet in the new year to map a Kent wide approach in maternal medicine centres. This will be led by the LMS and supported with the organisation. Women have a named consultant. Condition led care document describes process for referral to appropriate obstetric consultant. Condition led care document describes process for referral to appropriate obstetric consultant. ANC staff triage referrals to ANC to ensure appropriate timing of appointments. Specialist joint clinics support women with complex conditions e.g. haematology, diabetes, mental health. On the day of the clinic the midwives ensure that the women are allocated to the correct consultant and speciality clinic	Documentation Audits reported to Monthly Quality Assurance meetings ANC to devise a proforma to audit women with complex pregnancies and confirm whether the referrer has requested the right clinic and whether the women was seen in the correct clinic	Maternal medicine centre information to be confirmed Documentation audits which includes named consultant. Datixes highlight cases where a specialist pathway has not be followed	Ensure good communication and engagement with discussion regarding maternal medicine hubs. Devise protocols for referral process when necessary	Through QA meetings and Datix June 2021	Midwifery time to undertake audit	Identification of incorrect risk assessment or inappropriate consultant referral through Datix	
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	MTW have a fetal wellbeing midwife that encompasses the 5 elements of the SBLCBv2. This is further supported by the obstetric lead consultant. A recent 'deep dive' into the services highlighted that CTG required further focus and attention in terms of quality matrix. A fetal surveillance team is being scoped to mirror that of trusts that have significantly reduced the amount of HIE cases. Our central monitoring systems support all areas across the clinical floor with upgrades due for early 2021. All consultant colleagues have the ability to review CTG cases remotely and can play an active role in remote advice and clinical decision making. All adverse outcome cases are reviewed as part of a multidisciplinary meeting in a timely manner and escalated if concerns arise about the care given.	Dashboard of compliance	following on from the deep dive, it is recognised that the SBLCBv2 is extensive and 1WTE cannot embed the changes required for CTG interpretation. Therefore a business case is being developed to allow for a fetal surveillance team that would allow for a cohesive pathway for CTG interpretation	Ensure dashboard is presented at Maternity Forum and Maternity Board Complete and present business case for fetal surveillance team To continue to monitor through legal claims and yearly deep dive exercise .	Fetal Wellbeing team Senior management Team	Support and funding for fetal surveillance team	Compliance is discussed at weekly Governance team meeting and formally at Maternity Board	
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	a) All women with complex pregnancy have a named consultant. b) The ICS and LMS system have planned to meet in the new year to map a Kent wide approach in maternal medicine centres. This will be led by the LMS and supported with the organisation	a) Audit required	audit results will demonstrate	a) Add to Quality Assurance Agenda b) work closely with LMS and ICS to identify maternal medicine centres	Governance Team LMS and ICS liaision with MTW March 2021	None	A joint maternal medicine post may support the delivery of regional maternal medicine	
IEA REQUIREMENT 5 (RISK ASSESSMENT THROUGHOUT PREGNANCY): **Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.**	**All adverse outcome cases are reviewed as part of a multidisciplinary meeting in a timely manner and escalated if concerns arise about the care given.**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	The organisation has an electronic system that supports an 'each contact' risk assessment. This ensures all women are assessed at each contact and allows an opportunity to support altered pathways in a responsive manner. This information is captured and can be supported with regular documentation audits. The risk assessments used prompt care planning for place of birth and ensure that women are supported with their decision making. The trust has further concluded a project which supports planning place of birth resources that base information on the trusts statistic data in terms of Robson Groups. Infographics for syntocinon and assisted vaginal birth have also been developed to consistency and quality of information given during labour.	Not currently reported on and so an audit is required	add to agenda of Quality assurance once and month and audit	Add to the agenda for Quality Assurance once a month Add to the Proforma for documentation for the Quality assurance week. The maternity personal health records will be introduced in Jan and this needs to be audited and reviewed	Grace Anderson, Project Midwife 31 March 2021	None	Datix will identify if a person has been incorrectly risk assessed.	
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	As above (line 16) MTW has a SBLCBv2 dashboard	As per line 16	As above (line 16)	As above (line 16)	As above (line 16)	As above (line 16)	As above (line 16)	
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	The organisation has an electronic system that supports an 'each contact' risk assessment. This ensures all women are assessed at each contact and allows an opportunity to support altered pathways in a responsive manner. This information is captured and can be supported with regular documentation audits. The risk assessments used prompt care planning for place of birth and ensure that women are supported with their decision making. The trust has further concluded a project which supports planning place of birth resources that base information on the trusts statistic data in terms of Robson Groups.	Not currently reported on and so an audit is required	add to agenda of Quality assurance once and	Add to the agenda for Quality Assurance once a month Add to the Proforma for documentation for the Quality assurance week. The maternity personal health records will be introduced in Jan and this needs to be audited and reviewed	Grace Anderson, Project Midwife 31 March 2021	None	Datix will identify if a person has been incorrectly risk assessed.	
IEA REQUIREMENT 6 (MONITORING FETAL WELLBEING): **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**	**What do we have in place currently to meet all requirements of IEA 6?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	

OCKENDEN All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	MTW have a fetal wellbeing midwife that encompasses the 5 elements of the SBLCBv2. This is further supported by the obstetric lead consultant. A recent 'deep dive' into the services highlighted that CTG required further focus and attention in terms of quality matrix and that this areas was underressourced given the enormity of the task. A fetal surveillance team is being scoped to mirror that of trusts that have significantly reduced the amount of HIE cases. Our central monitoring systems support all areas across the clinical floor with upgrades due for early 2021. All consultant colleagues have the ability to review CTG cases remotely and can play an active role in remote advice and clinical decision making. All adverse outcome cases are reviewed as part of a multidisciplinary meeting in a timely manner and escalated if concerns arise about the care given. A recent deep dive has demonstrated that further work is needed in relation to CTG interpretation, and Gap and Grow. A business case is being developed to support this.	Continued assessment of cases of unexpected admission to SCBU, HIE cases etc. Risk cases involving fetal monitoring are discussed in the monthly governance report which is presented at clinical governance and included in the governance report we do yearly deep dive and the gap analysis of SBLCBv2 which aids our decision making in driving improvement.		Complete business case and once approved, recruit the team. Training for the workforce to ensure principles of SBLCBv2 is embedded Develop robust system to review new CTG interpretation	Senior Triumverate	Investment in the team	Regular consultant led CTG teaching sessions in clinical area.	
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	As above	As above	As above	As above	As above	As above	As above	
Link to urgent clinical priorities a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Lead midwife - fetal wellbeing midwife Lead consultant TBC	Risk cases involving fetal monitoring are discussed in the monthly governance report which is presented at clinical governance and included in the governance report Yearly Deep Dive will identify issues of concern which may include cases with elements of SBLCBv2	Learning from adverse outcomes is a priority for the service. Learning gained from many sources including regular audits, risk reviews, deep dive and complaints.	Once business case is approved, recruit the team	Business case to be completed by Senior Management Team	Investment in the team	Regular consultant led CTG teaching sessions in clinical area. Widespread discussion within department of the SBLCBv2 dashboard	
IEA REQUIREMENT 7 (INFORMED CONSENT): **All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	**What do we have in place currently to meet all requirements of IEA 7?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	
OCKENDEN All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	A tool for staff with data on local outcomes for Robson Group 1-5 has been recently published which enables discussion regarding choices in labour with women. The LMS have further supported the collaboration with DadPad whereby MTW will be leading on and supporting a new tool for Dads/partners that describe planning place of birth. More use of infographics for imparting information and Syntocinon and Assisted Vaginal Delivery. Utilisation of NICE/RCOG guidance patient information leaflets are used where possible. MTW have recently completed a project ensuring the website for women is full of current and useful information. All information on the website can be translated into 40 different languages which is especially important when considering access to information from BAME groups. A series of videos to support this decision making is now being explored. We have further developed the relationships with the MVP to ensure we support womens choice and opinion when guiding our services Where possible MTW link to national information which is updated in line with new recommendations. In cases where women wish to birth outside of guidance a full and documented discussion takes place and care planning is achieved to support the safest option agreed by all parties. This is routinely led by the community services, the obstetricians and the consultant midwife. For any deviations from the 'norm' staff are alerted and supported accordingly.	We aim to use the feedback to improve the services we give and ensure that they are women focused at all times. We need to ensure that we have a constant cycle of feedback and monitoring of themes. Themes should prompt service improvements and research projects were feasible. We further use IQVIA, patient experience lead, MVP, Health watch and CQC patient perspective feedback to improve our service.	We monitor complaints and have changed the way in which we debrief and offer our post natal care	Ensure the patient experience report is presented at Maternity Forum and Maternity Board. Actions should be monitored and completed and audits undertaken to ensure service improvements have been demonstrated Review website to ensure that appropriate information relevant to consent is readily available Continue to work with the patient experience pilot and review the themes as part of this initiative and change praxtice accordingly.	Patient Experience Midwife 10 January 2021	Trust Patient Experience Team have been aiding the Patient Experience Midwife with collating the findings but this may not be able to be continued in the long term. MVP could be approached to see if any user reps could support	Feedback is being provided at present and urgent concerns addressed	
CNST Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Feedback via Patient Experience and IQVIA. MVP, health watch and CQC surveys contribute to service developments through attendance at relevant meetings, support with guidelines and patient information, including website.	We aim to use the feedback to improve the services we give and ensure that they are women focused at all times. We need to ensure that we have a constant cycle of feedback and monitoring of themes. Themes should prompt service improvements and research projects were feasible.	Themes and trends differ over time which demonstrates a move in feeling of specific agenda items.	Ensure the patient experience report is presented at Maternity Forum and Maternity Board. Actions should be monitored and completed and audits undertaken to ensure service improvements have been demonstrated	Patient Experience Midwife 10 January 2022	Trust Patient Experience Team have been aiding the Patient Experience Midwife with collating the findings but this may not be able to be continued in the long term. MVP could be approached to see if any user reps could support	Feedback is being provided at present and urgent concerns addressed	
Link to urgent clinical priorities a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	MTW have recently completed a project ensuring the website for women is full of current and useful information. A series of videos to support this decision making is now being exploredand rolled out. Where possible MTW link to national information which is updated in line with new recommendations.	We have further recently procured a 4 year contract with Dadpad which keeps fathers informed in a number of evidence based topics. MTW are due to lead on a new 'DadPad' topic of planning place of birth. MVP has heavily supported with the website updates.	Feedback from women and families of a positive nature re our communication strategies	Develop process to review website regularly to ensure that appropriate information in line with national policy is readily available	Grace Anderson, Project Midwife Digital Midwives 31 March 2021	Support from trust Comms team with website content and production of video content.	Website content updated regularly, especially in light of changes to services due to COVID	

MATERNITY WORKFORCE PLANNING -	What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Can you demonstrate an effective system of clinical workforce planning to the required standard?	Job planning is performed yearly and clinical commitments outlined as part of this work. Junior Doctor workforce is discussed at Monthly Directorate meeting as are all workforce issues.	This is reviewed annually and services are developed in response to datix and service requirments. Locum and temporary staffing is supported to fill in any 'gaps'. We ensure the staff that are employed on a temporary process follow the same rigorous process to that of a substantive member of staff and induction documents are supported.	This is yearly and ongoing - no change	Continue as normal	Chief of service, Clinical Direvtor and General Manager Continue yearly	Nothing additional	NA
Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Twice yearly corporate led staff planning. This incorpoartes an overview of safe staffing and outlines any deviation or requirements needed. Every two years (last one performed October 2020) we have a BR+ review for a basline review. We further enhanced on this and commissioned a CofC assessment of which we still require benchmarking. Business case is currently underway to support the findings of the 2020 baseline recommendations. Staffing is reviewed on a daily basis at the Huddle during the week and plans are made accordingly to account for sickness etc.	Each year the system is reviewed against the deep dive document and staffing is reviewed and requested via a business case in response to this. Furthermore a full staffing review was perfomred in 2018 to ensure that the right staff were in the right place at the right time. Staffing concerns are reviewed and listened to and the introduction of the PMA team has been supporting staff with wellbeing sessions and restorative clinical supervision. Any issues that are identified with staffing and standards of care are discussed discussed as an MDT and reviewed as part of the risk process. This may be incorporated into a risk register and business case developed to support this need. This is reviewed and signed off at trust board	This is twice yearly with a bi annual BR+ review (next to be perfomred in 2022). No change	Continue as normal	Head of Midwifery, corporate lead for safe staffing and Chief nurse Continue yearly	Support with the business case in response to both the deep dive and the BR+ review	We are currently using bank staff as an interim for the community provision. We have engaged external support for CTG training delivery which is due in March 2021. Consultant monies in the budget
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	Business case is being developed to support 8WTE midwives for the community setting, 1 band 7 MECU lead and 4 apprenticeship midwifery staff	At present we incorporate our safe staffing reviews in line with the corporate report and have performed a baseline BR+ review every two years. The last being 2020. We have further and additionally commissioned a CofC workforce review to support this national agenda.	No change - continue with above	Continue as normal and push forward with the business cases and support	Chief of service, Clinical Direvtor and General Manager Continue bi annually and use in conjunction with the corporate safe staffing reviews	As above	As above
MIDWIFERY LEADERSHIP (RCM Manifesto standards)							
Director of Midwifery in every trust: Every trust should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.	At MTW the current structure is a Divisional Director of Quality and Nursing and Head of Midwifery. She is currently supported by a Deputy Head of Midwifery.	NA although the trust is reviewing the staffing structure and pay of senior leaders and this will hopefully support this transition.	Trust Board and chief nurse aware of the requirements with plans in place to change the detail and potential structure. This will need further work to finalise and agree any changes to be made.	The trust to consider what the midwifery leadership 'looks like' and how this can be supported in practice.	Trust board decision	HR processes to be followed	Continue with HoM in post and continue supporting the midwifery agenda.
Regional & national lead midwives: A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	The South East coast has a Regional Midwife in post who represents both Nationally and Regionally.	NA	Regional and national teams are in post. Good system wide engagement and regular meetings.	Nil	NA	NA	NA
More consultant midwives: We would like to see at least one consultant midwife in every maternity unit. For those responsible for providing services in remote and rural areas, one option could be to appoint a consultant midwife across more than one trust / health board, providing consistency and clarity of professional guidance for this very specific kind of midwifery service.	At MTW we have one substantive consultant midwife and havve recently reviewed succession planning for her role and implemented a deputy consultant midwife post.	One consultant midwife with the support of a deputy is felt to be adequate and supports the agenda set.	No further action required. MTW has both a consultant midwife and a deputy in post. Both of which are pushing improvement agendas and supporting staff with research based decision making.	Nil	NA	NA	NA

Specialist midwives in every trust: A range of specialist midwife roles should be the norm in every trust / health board across the United Kingdom. The mix of specialisms will depend upon the needs of the service locally. Midwives should have access to and be able to draw upon these midwives' skills and experience as they strive to deliver and improve care e.g.: smoking cessation FGM specilaist substance misuse mental health specialist	At MTW we have a range of specialist midwives and have reviewed this alongside a succession planning model. Therefore all specialist often have a deputy post to enable a more streamlined service and a succcession model to support the service in the future.	This is reviewed and changed according to need and national movement and capacity. At present there is no real changes although a band 7 MECU/theatre lead has been requested as part of a business case	MTW have specialist midwives that support the high risk and national agendas. Following a recent BR+ report it was highlighted that further investment was required. An area of need is the MECU area and the maternity theatres given the ongoing care concerns that are associated with the high risk situations. The development of a lead post and to champion more high risk training across the division is recommended within the BR+ business case	Complete, submit and present the business case.	Senior triumverate ASAP	Funding identified within the business case	Continue to support these areas but this doesn't include the intensive and 'spotlight' support that is required.
Strengthening midwifery leadership in education & research: Lead Midwives for Education (LMEs) are experienced, practising midwife teachers who lead on the development, delivery and management of midwifery education programmes 13. They help to ensure high standards in midwifery education and are a vital intermediary between the professional regulator (the Nursing and Midwifery Council) and the universities.	The HoM and LME's work closely together to ensure high quality learning is adopted throughout the midwifery journey. At MTW we additionally work closely with our link lecturers and have recently employed one to support the PMA team and the staff as an ongoing piece of work.	NA	NA	NA	NA	NA	NA
Fund ongoing midwifery leadership development: A commitment to fund ongoing midwifery leadership development.	We have funded staff on leadership courses inclusive of university based masters programs and the florence nightingale course. We further support staff with the apprenticeship leadership modules and additional training that enhances both the staff wellbeing but also the unit. eg non medical prescribers course	Ongoing	More staff accessing midwifery leadership modules. Delivery of the RCM leadership course which has been commissioned for some time (delayed due to covid)	Continue to support staff	Ongoing - all senior leaders to ensure staff are developed and succession planning is supported.	Continued access to training funds	NA
Professional input into the appointment of midwife leaders: Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services. The appointment of the right individual is an important matter, and selection procedures within the NHS should be focused on ensuring that the right people get into the right jobs.	A thorough interview process was adopted at the appointment of the Head of Midwifery in 2018 which included a stakeholder engagement event.	Yearly appraisals perfomred and 121's with the chief nurse.	Continue with current HR and assurance measures	Ensure appraisals are perfomred	Chief of Service and Chief Nurse	Nil	NA

Infection prevention and control board assurance framework	**Director of Infection Prevention and Control**

The Trust Board will recall that the infection prevention and control board assurance framework was submitted to the June 2020 meeting. It was noted at the Trust Board meeting in November 2020 that an updated infection prevention and control board assurance framework would be submitted to December 2020 and monthly thereafter. The latest report is enclosed.

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

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

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

Infection Prevention and Control board assurance framework

Summary of changes:

Section 1:

- Revised guidance released removing the need for negative swabs for de-escalated Covid patients prior to transfer to residential care
- Concerns re new variant and high level of staff sickness have led to the Trust recommending FFP3 masks for all staff on Covid wards. Initially for a month but now extended due to delays in second dose vaccination
- All staff now have lateral flow kits except for those within 3 months of Covid infection with plan in place to refresh supplies for those running out of kit
- Emerging risk of *Burkholderia aenigmatia* infection associated with the use of multi-use bottles of ultrasound gel on ITU. Information shared with clinicians and sterile single patient use gel implemented

Section 2:

- Deep clean programme for wards as they are de-escalated is being planned. Existing UVC light decontamination technology to be employed

Section 3:

- Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians

Section 5

- Vaccination centre has been organized with social distancing and separate spaces

Section 6

- Outbreaks reported via national on-line platform
- Standard SI concise investigation template under review

Section 8

- Near patient testing available with 8 machines at Maidstone and 4 at TWH

Section 9

- New guidance for disposal of lateral flow tests and vaccination centres –current practice already in line with guidance
- Staff vaccination centre established and vaccine available to all Trust staff and offered to some partner agencies

1. Systems are in place 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 posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes and Symphony. Copy of ED notes in in-patient record for admitted patients. Pathway documented and agreed with CRG and ICC • Temperature checks in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • All patients and visitors have temperature check at front door. Mask provided to patients and visitors who do not have face coverings • Checks in place at oncology entrance		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from ICU care only. • Stated aim is to keep confirmed cases		

	in Covid cohort area throughout their inpatient stay. Where step-down is necessary for clinical reasons, PHE guidance is followed. Patients must be 14 days post positive swab, be apyrexial for 48 hours without anti-pyretic medication and have some respiratory improvement. ITU and immunocompromised patients must have negative swabs prior to de-escalation		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• National guidance followed in all cases. Local guidance developed from national guidance and published through daily staff Bulletin and Covid pages on intranet. • Some beds available in designated homes for persistently positive patients • Revised guidance issued removing the need for negative swabs in de-escalated patients and restricting the requirement for negative swabs prior to discharge	• Some residential homes insisting on negative swabs despite new guidance	• System level solution under discussion
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	• IPC audits continue to monitor practice including hand hygiene. Ward audits and IPC triangulation audits reported through IPCC • PPE stocks closely monitored to ensure supplies available • PPE posters on all wards.		

	• IPC policies available on the intranet • Concerns re new variant and high level of staff sickness have led to the Trust recommending FFP3 masks for all staff on Covid wards. Initially for a month but now extended due to delays in second dose vaccination		
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE audits ongoing and reviewed at Infection Prevention and Control Committee • PPE officers on duty every day. Educational, supportive and monitoring role. Advise on PPE use. Induction training for new staff • Sessional mask wearing guidance implemented. Masks provided for non-patient facing staff	• Move to online training has restricted PPE donning and doffing training	• PPE officers to provide PPE training at the same time as FIT testing for new starters
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of Covid-19 increase	• Symptomatic staff testing by PCR is in place and available both on and off site • Asymptomatic testing by PCR for oncology and elective green pathway has been in place since June • Escalation plan in place with trigger points for increasing asymptomatic testing • Lateral flow roll-out plan in place • Occupational Health and local managers assess risk of staff contacts of positive cases • All staff now have lateral flow kits except for those within 3 months of		• PCR testing available if needed for outbreak investigation

	Covid infection • Plan in place to refresh supplies for those running out of kit		
• Training in IPC standard infection control and transmission-base precautions are provided to all staff • IPC measures in relation to Covid-19 should be included in all staff induction and mandatory training	• All staff receive infection control training at induction which includes a section on Covid-19 • National e-learning package level 1 and 2 in place since November. Face to face training prior to this. • All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 • Non-clinical staff have bi-annual training (level1) which includes Covid-19 • Additional ad hoc training on ward during IPC visits		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Extensive communication with staff on face masks, hand hygiene and space through staff Pulse publication, posters, social media etc. • All staff wear face masks • Hand hygiene audits reported to IPCC – no concerns		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to	• National guidance on PPE implemented within Trust. FIT testing for FFP3 masks in place with resources identified and PPE project team managing resources on day to day basis.	• Availability of differing types of FFP3 masks is variable	• Active management of stocks by procurement leads. Electronic monitoring system in place • Repeated FIT testing

PPE that protects them for the appropriate setting and context as per the PHE national guidance	• Dedicated FIT testing team in place on both sites. • New staff FIT tested as part of induction as required • Regular discussion at executive level. • Procurement lead sits in ICC • Active monitoring of PPE burn rate and stocks • All patient facing staff trained in use of PPE and supported by PPE officers • Use of powered air respirators monitored through site offices with documented log and cleaning • Regular updates provided to staff through ICC and daily bulletin • PPE guidance available on Covid page of Trust intranet • Posters and signage with PPE information in donning and doffing areas.		required on new mask stocks • Investment in reusable respirator masks
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • DIPC is SRO for Patient and Staff Safety work stream • IPC team support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation • IPC leadership on key work streams • Emerging risk of *Burkholderia*		

	aenigmatia infection associated with the use of multi-use bottles of ultrasound gel on ITU. Information shared with clinicians and sterile single patient use gel implemented		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC is member of exec team and updates as required • Covid update is standing item on Board agenda		
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• ICC risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings	• IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks recognised eg for C. difficile and Covid co-infection	• IPC team advising on a case-by-case basis. Variation to some policies required. Documented on ICNet.
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place for non-Covid-19 infections • Trust compliant with Hygiene Code prior to pandemic. • IPC team reinforce practice at ward level		
• that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sit rep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff		

manner • ensure Trust board has oversight of ongoing outbreaks and action plans	• Ongoing outbreaks discussed at daily exec strategic command meetings • Twice weekly outbreak meetings for Trust chaired by deputy DIPC • DIPC updates to Board at every meeting • IPCC reports to Quality Committee		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on both sites including respiratory HDU and ICU escalation areas. • ICU training programme for non-ICU trained staff required to work on ICU. • Consultant anaesthetist rota to provide 24/7 on site ICU cover. • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist. • Covid wards fully staffed. Consultant of the week rota for senior medical cover • IPC team and PPE officer support to Covid wards • Respiratory HDU staffed by respiratory trained nurses and consultants • NIV patients cared for by trained staff		

• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Cleaning standards in place for cleaning during the pandemic. • Facilities staff trained in donning and doffing PPE and FIT tested where appropriate.		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Decontamination and terminal cleaning completed according to national guidelines. • HPV and UVC decontamination available when required • All surfaces cleaned with Diff X including walls • In-house cleaning teams in place • Cleaning audits reported to IPCC and divisions • Lapses in cleaning standards reported as Datix incidents and investigated with shared learning • Deep clean programme for wards as they are de-escalated is being planned • Existing UVC light decontamination technology to be employed		
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Increased frequency of cleaning complies with national guidance • Regular cleaning audits undertaken and results monitored. • Audits reported to IPCC		

• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses	• Diff X confirmed as suitable cleaning agent for enveloped viruses by IPCT		
• Manufacturer's guidance and recommended product contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		
• 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• In place since June 20 • Ward staff clean high-touch surfaces including keyboards and telephones • Disinfectant wipes available for cleaning workstations in non-clinical areas		
• Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance. • Pre-existing guidance for clinical areas		

• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Regular twice daily cleaning in place		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards treated as infectious linen • Laundry is compliant with HTM 01-04 • Laundry report goes to IPCC and Health and Safety committee		
• single use items are used where possible and according to Single Use Policy	• Single use items used widely across the Trust. • Policy in place and available to staff on the Trust intranet		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• The provider of surgical reusable instrument decontamination for MTW: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been put in place in line with local, PHE and national policy.		

• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Non-clinical areas are part of the cleaning audit schedule. Action plans developed where areas fail audit		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single pass air supply and no recirculation of internal for infection control purposes. • Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical production areas all installed with HTM 03-01 ventilation systems. • Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation		
• there is evidence organisations have reviewed the low risk Covid pathway, before choosing and	• A Covid-active disinfectant (DiffX) has been used throughout the pandemic response.		

decision made to revert to general purpose detergents for cleaning as opposed to widespread use of disinfectants	• Any change would be made only with the approval and recommendation of the DIPC and IPC Team through the IPCC		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • Training for new doctors has continued • Ward pharmacists review prescribing • Guidance for antibiotic prescribing in Covid patients issued by ASG • Prescribing of antibiotics is low compared with peer K&M organisations • Audits and reporting restarted and maintained in second wave • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians	• Routine ward based audits suspended for April and May	• C. difficile PII audits continuing • Reports to IPCC reinstated for June

• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued. • IPCC and DTMMC report to Quality committee		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• Visitors permitted only on compassionate grounds and to assist patients with specific needs • Birth partner allowed. Both parents can visit in neonatal unit. Covid testing in place to facilitate this. • Outpatients have accompanying person only when required for care needs • Review of visiting is included in objectives of Patient and Staff Safety work stream • All visitors have temperature checks at the front door • Mask provided to patients and visitors who do not have face coverings • Support in place for relatives to deliver patient property • Ethics committee have reviewed		

	Visiting policy • Viewings of deceased patients have continued in the Trust mortuary including for patients diagnosed with Covid-19 • Visiting suspended at Maidstone Hospital as a result of high numbers of cases during second wave. • Introduction of partners to antenatal scans	• Challenges to decision due to Tier 3 designation and staff concerns	• Ultrasound trained medical staff to assist with routine scans
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Signage is in place to identify Covid areas and advise on PPE requirements on entry • Restricted access by swipe card only is in place • Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene • Masks are available at the exit of all Covid areas allowing change of mask on leaving the area		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information for staff is available on the Trust intranet Covid page • Coronavirus information for the public can be found at https://www.mtw.nhs.uk/2020/06/latest-information-on-the-coronavirus/	• Easy read version not yet available	• Information currently under review prior to submission to the Accessible Information Standard group for conversion into easy read.
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient	• For inter-departmental transfer, handover of information by telephone or accompanying nurse • PHE guidance on discharge of patients		

needs to be moved	is implemented. Local guidance based on national guidance is published on trust intranet Covid page and has been shared through ICC bulletin. • Integrated discharge team manages discharge of patients to residential care facilities. • Designated care home beds now available • All patients being discharged to residential care have Covid test 48 hours before expected date of discharge with result available. • Any patients self-isolating following confirmed Covid contact receive a letter explaining their need to self-isolate. Medically fit patients may complete their self-isolation at home • Staff use appropriate PPE for all patient transfers • All patients have EDN on discharge		
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Posters prominently displayed in public areas • Hand, Face and Space logo on trust Covid internet pages		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to			

ensure: • Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Contacts of positive cases tested twice a week for 14 days whilst inpatients • All non-elective admitted patients (suspected and non-suspected) are tested for Covid-19 in ED, SAU, EGAU, Woodlands unit or delivery suite. Suspected medical patients are admitted directly to side rooms on Covid cohort ward awaiting results. Non-suspected patients remain in AAU/AMU until results available. Surgical, T&O, gynae, paediatric and obstetric patients admitted directly to single room on specialty ward pending results. Pathways in place and agreed through CRG and ICC. • All suspected patients who do not require admission are tested prior to discharge from ED. Positive cases are followed up by ED with results to provide anticoagulation therapy. Pathway approved by ICC • Patients screened day 1, 3 and 5-7		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. • Triage nurse performs infection risk assessment and patient directed through red or green pathway for further assessment and separation.		

	Pathway documented and agreed with CRG and ICC • Red and green pathways are accommodated separately in different zones of ED • Isolation room available for immunocompromised and shielding patients in ED • Temperature check and triage in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures • All patients and visitors entering through main entrances have temperature check and are given masks • Paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • All pathways documented and agreed with CRG and ICC and published on Covid page of Trust Intranet		
• staff are aware of agreed template for triage questions to ask • triage undertaken by clinical staff	• Standard triage template supported y electronic system (Symphony) and printed version • Triage carried out by senior nursing staff.		

who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Immediate allocation of patient to pathway • Obstetric triage in place with senior midwife. Labour ward has designated red and green beds		
• face coverings are used by all outpatients and visitors	• All patients asked to wear a face mask on entering ED. • All outpatients and visitors wear masks except for those carrying exemption certificates • Masks provided at front entrance if required • Information on Trust website to support		
• facemasks are available for patients with respiratory symptoms	• Face masks available for all patients		
• provide clear advice to patients on use of facemasks to encourage the use of surgical facemasks by all inpatients in the medium and high risk pathways if this can be tolerated and does not compromise their clinical care	• All inpatients encouraged to wear face masks if tolerated, especially when leaving the bedside		
• ideally segregation should be with separate spaces, but there is potential to use screens eg to protect reception staff	• Reception staff are protected with screens in all areas • ED reception has physical separation of staff by Perspex screens • Perspex screens on outpatient		

• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	reception areas, outpatient pharmacy and main entrance reception • Cubicles in ED majors are separated by solid walls • Social distancing in place in waiting areas • Vaccination centre has been organized with social distancing and separate spaces • Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. The rationale for testing is documented in the patient's notes • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information and duty of candour letter. Medically fit patients who are discharged to their own home continue to self-isolate at home. • Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care. • Suspected patients who test negative have medical review prior to step down to non-Covid ward. Those who continue to be suspected cases have repeat testing and remain in side room on Covid ward • All patients who test negative on admission are re-tested at 5-7 days in		

• patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately	line with national guidance. Additional day 3 swab implemented in November • All laboratory result submitted to PHE for national track and trace • All outpatients have temperature checking at the front door. • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook		
6. Systems 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			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimize contact between pathways. For example this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas	• Separate entrances for staff and patients • Stay left signs in corridors • Visitors and patients not permitted to use staff catering facilities		• Face to face training widely available. • PPE videos available • On-line package remains valid for non-covid infections
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results		

personal safety and working environment is safe	recorded and database maintained • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • Online training for medical care of Covid patients • ICU training in place for non-ICU trained staff • PPE officers provide face to face training on wards. • IPC team provide training to staff • Mandatory IPC e-learning package includes Covid-19. National package in use		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Donning and Doffing videos available on Trust intranet site. • PPE officers provide workplace training. • PPE helpers available in ICU • Donning and doffing areas provided on Covid wards • FIT testing available for all staff who require it and when available masks change. • Signage and posters displayed in donning and doffing areas		
• a record of staff training is maintained	• Fit testing and cleaning of reusable masks records maintained • Records maintained of formal IPC training • On line learning and development system records mandatory training		

• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Re-use of visors and cleaning guidelines available and communicated through daily staff bulletin from ICC • Guidelines in place for cleaning of re-useable respirator masks • Individual reusable respirator masks allocated • Site team holds records of reusable air powered respirator use and cleaning • EME support monitoring and management of powered air respirators • Other PPE will only be re-used with ICC and IPC agreement and release of clear guidance		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• All incidents relating to PPE reported as datix incidents • Risk assessments in place for reusable respirator masks and air powered respirators • Incidents investigated and learning shared • ICC monitors incidents and takes urgent action as required		
• adherence to PHE national guidance on the use of PPE is regularly audited	• PPE audits ongoing and reported to IPCC		

hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimize Covid-19 transmission such as:			
• hand hygiene facilities including instructional posters	• Hand wash basins widely available. • Instructions on all splash backs • Sanitising gel widely available including entrances to all clinical areas		
• good respiratory hygiene measures	• All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside		
• maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional breakout areas available		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Disinfectant wipes available in both clinical and non-clinical areas • I am clean stickers in use • Domestic and nursing cleaning in place on wards • High touch areas frequently disinfected		
• clear advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas	• PPE posters widely displayed • Non-clinical areas assessed for Covid-secure status • Advice widely publicised through staff Pulse magazine and Trust internet and intranet pages		

• staff regularly undertake hand hygiene and observe standard infection control precautions	• Ward based audits in place. • Triangulation audits completed monthly by IPCT. • Directorates report to IPCC		
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• All hand wash basins are co-located with paper towel dispensers		
• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets	• All hand wash sinks have hand washing and drying guidance on back boards in both clinical and public areas		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Scrubs are worn on all Covid wards and several other wards and clinical areas. • Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • Uniform bags gifted to the Trust provided for staff to carry uniform		

	home and launder with uniform. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on both sites		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• Staff sickness line available to report symptoms • Information on symptoms of Covid shared widely including posters, staff bulletin and intranet site • Staff testing available in drive through facility and on-site testing pods. On-line appointment system in place. Also available for family members and partner organisations • All staff members testing positive for Covid-19 have their result delivered by occupational health. • Occupational Health support and maintain contact with self-isolating staff • Staff testing positive self-isolate for a minimum of 14 days. • Lateral flow testing currently being rolled out across the Trust		
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patients/individuals)	• Community rates of infection are continuously monitored with information disseminated to senior managers • Discussed at strategic command meetings • Daily sitrep analysis available to managers		

• Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger and outbreak investigation and are reported	• Outbreaks declared according to national guidance • All outbreaks are investigated and Serious Incidents declared. • Concise investigation and consistent Terms of reference developed –under review • Twice weekly outbreak meetings • IIMARCH forms completed for all outbreaks • Outbreaks reported via national online platform		
• Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	• Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Pathways clearly identified and approval process in place • Surgical green pathway implemented and reviewed according to prevalence of infection • Visitors are not permitted in Covid positive areas		

• Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff understand the different risk areas	• Signage in place • Wards accessible by swipe access • Restricted access to Covid areas		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated cohort wards. Suspected cases are placed in side-rooms until test results are available	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors with swipe card card access. • Not used as staff/visitor throughfare
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Cohort bays have privacy curtains between the beds to minimise opportunities for close contact. • Separated from non-segregated areas by closed doors • Signage displayed warning of the segregated area to control entry • Cohort areas differentiate the level of care (general, respiratory HDU, Covid ICU) • Paediatric confirmed patients isolated in single rooms with en-suite facilities		
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Pre-existing IPC policies continue to apply. • Some variance required to meet the requirements of Covid levels of PPE and co-infected patients • Active management of side room		

	provision by ICP team		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Ensure screens taken on admission are given priority and reported within 24 hours	• Laboratory pathways in place to ensure priority for ED samples. Red bags in use. • Staff symptomatic testing prioritized via another pathway.		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Turnaround times closely monitored • Results usually available within 24 hours		
• testing is undertaken by competent and trained individuals	• Testing undertaken by registered BMS staff with documented competencies. • Method validated prior to diagnostic testing		
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• In house testing turnaround time of less than 24 hours • Tests sent to Pillar 2 labs when demand outstrips capacity • Extended laboratory working hours to deliver service • All non-elective patients are tested on admission		

	• All positive patient results are phoned to ward by IPCN and provided to site team and ICC. • All results reported to PHE via Co-surv • All elective patients are tested 24-48 hours prior to admission • Online booking for staff and elective patient testing. • Weekly testing for all patient-facing staff by end of June 2020 • All staff positive results are delivered by Occupational health staff • Staff results sent by text message directly from on-line system • Antibody testing available to all patients and staff on request • Near patient testing available with 8 machines at Maidstone and 4 at TWH		
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• All positive inpatients reported directly to IPC team and site practitioners via email • All staff positives reported to Occupational Health via email • All positives reported to consultant microbiologists • Results directly authorized and available in real time		
• screening for other potential	• MRSA, MSSA, GRE, and CPE		

infections takes place	screening continues as in pre-covid policies • All routine diagnostic microbiology continues including C difficile.		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
• staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC team supports wards. All wards visited daily. Full range of policies and procedures in place. • Advice available from IPC team and consultant microbiologists. On call rotas in place. • All IPC policies reviewed and in date		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • IPC team support ward staff in implementing changes		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B (orange) clinical waste stream. • New guidance for disposal of lateral		

current national guidance • PPE stock is appropriately stored and accessible to staff who require it	flow tests and vaccination centres – current practice already in line with guidance • PPE central stocks held on both main sites • Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place. Managers advised to ensure all staff risk assessed. Risk assessment developed with BAME network and Ethics committee • Redeployment opportunities and working from home enabled for high risk staff • Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support. • Staff sickness phone line in use.		

• that risk assessments are undertaken and documented for any staff members in an at risk shielding group, including Black, Asian and minority ethnic (BAME) and pregnant staff	• 93% of BAME staff have risk assessment completed • 80% of 'at risk' staff have had a risk assessment completed • Weekly return submitted		• HRBPs/divisions have plan in place to complete outstanding risk assessments
• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held in ICC		
• staff who carry out fit test training are trained and competent to do so	• Dedicated FIT testing team in place and fully trained		
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• A database of FIT testing outcomes is maintained. • Staff provided with information identifying the type of mask to be worn		

• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• As above • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks • Records are kept and stored electronically		
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• If all respirator options are unsuitable staff work from home wherever possible • Manager works with HR to identify re-deployment opportunities • New opportunities to work with vaccination teams available		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	• Discussions are documented and records stored electronically		
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• An electronic system is in place to record and store details for risk assessments and any necessary mitigation to support individual members of staff. Any redeployment decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm		

• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• database of all staff maintained and includes record of all FIT testing • Weekly assurance template submitted by divisions against rotas • All staff not tested provided with FIT testing prior to shift • All areas have access to powered air respirators • ICC and site team receive assurance template for weekend shift		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between panned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Patient and Staff Safety workstream (part of Reset and Recovery programme) has defined the principles to be used when developing elective pathways • Green pathways for elective care developed. • Weekly executive and divisional meeting to discuss progress and interdependencies • Staff screened for Covid-19 • Ward areas maintained as secure with minimal footfall • Theatre SOP in place designating green and red pathways to avoid cross over		
• All staff adhere to national guidance on social distancing wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Staff social distancing in corridors and queues. • Work to ensure that office spaces are socially distanced with risk assessments completed. • CCG review identified good practice in		

	social distancing interventions • Staff working from home wherever possible • Consideration to 7 day working and shifts to reduce the number of staff in non-clinical areas. • All ward staff to wear masks at all times on wards from 1 June • Continual mask wearing guidance implemented for patient facing staff from 10 June. Non-patient facing staff from 22 June • Computers on wheels provided in some areas to support social distancing • Managers asked to review all office space to ensure social distancing in COO letter 12 June. • Managers also requested to review staff working patterns and breaks to reduce the number of non-clinical staff working on site at any time • Additional breakout areas created on both sites including outdoor space		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• All non-clinical areas assessed for Covid security. • Maximum occupancy identified on signage • Disinfectant wipes available to staff in non-clinical areas to clean workstations • Homeworking support package including training and IT kit in place for staff who now work at home		

• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Advice given to staff to don masks whenever moving around Covid secure area • Continued communication via team brief, Pulse and Directors communications to re-iterate "hands – face – space" campaign		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support/ first aiders. • Staff sickness phone line in use and covered daily, 7 days from 1st December 2020, providing advice and information on sickness, swabbing and other COVID sickness questions. • Newly established "staffing hub" designed to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing. • Roll out of lateral flow underway • ICC monitors sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home. Home working toolkit published • All staff able to access testing via on-line booking system • Symptomatic staff can access testing • Weekly asymptomatic testing to be rolled out to all patient facing staff by		

	end of June • Review of cases of staff Covid infection to identify any key themes and learning • Trust-wide Pulse survey in April and May. Results reviewed at executive and divisional level. Learning identified • Staff vaccination centre established and vaccine available to all Trust staff and offered to some partner agencies		
• staff that test positive have adequate information and support to aid their recovery and return to work.	• Occupational health support Covid-positive staff and advise on return to work and re-testing • Psychological support available		

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly report from the Freedom to Speak Up Guardian — Freedom to Speak Up Guardian

The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.

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

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

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q3 (Oct – Dec 2020)

Action Requested / Recommendation

The Trust Board is asked to read the report and discuss the content and recommendations.

Summary

The Deputy Freedom To Speak Up Guardian has been appointed and resumed 30th November 2020. Raising awareness on the FTSU agenda has commenced with Interviews with Peter Maskell and posters and leaflets across sites.

Author; Ola Gbadebo-Saba, Deputy Freedom To Speak Up (FTSU) Guardian

Date; January 2021

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Cheryl Lee
Freedom To Speak Up Guardian	Christian Lippiatt
Deputy Freedom To Speak Up Guardian	Ola Gbadebo-Saba

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that;

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as opportunities for learning and improvement

National Guardians Office (NGO)_Case Reviews

- There has been no case review since the previous Board report.
- The National Guardian has currently suspended face to face training, but is offering new post holders a 2 hour remote session one to one followed by a video conference group training session. Our new Deputy FTSU Guardian has completed both training sessions. We are still awaiting an on-line release for training / awareness for NHS staff in general.

Themes / Issues

We had 3 concerns raised during the last quarter, all of which relate to bullying and harrassment in clinical areas on Maidstone hospital site. Whilst reported cases had been seeing an increase, during the height of the pandemic pressures on staffing and patient care has seen the workforce pull together and work hard to keep patients safe. Through feedback from various channels it is believed this leaves staff with little energy to pursue formal concerns.

One of the cases relate to racial harrassment from neighbours and one of the neighbours is also employed in the Trust. The case which was initially being dealt with by the police but was closed because a request for mediation had been made. This was refused by the neighbour and is now re-opened with the police and supported by voluntary organisations. Although this case has no direct impact on patient safety, it inevitably has a psychological impact on the staff members involved which could affect patient care.

The other 2 cases relate to bullying from line managers, with one of the cases being about lack of support from managers. The case was referred to HR to organise facilitated conversation between the employee and line manager which was useful in reaching a resolution. The other staff member unfortunately resigned before we could reach a resolution.

The Trust is currently working on organising mediation training for a few staff members to assist in reducing the turn over time in resolving workplace conflicts and further reduce the number of cases that have to go through formal investigations.

Growing the Speaking Up Agenda

The Deputy Freedom to Speak Up Guardian, Ola has now resumed with the Trust and had the National Guardian Introductory session. As a result of the pandemic, the NGO office has had to stop the face-to-face foundation training but they are currently working on an e-learning training which should be released sometime this year and the Deputy FTSU Guardian will be enrolled on that course. She has met with chairs of staff networks in the Trust, as well as other Guardians in the region.

The FTSU team is working closely with the Communication team to promote and publicise the speaking up agenda, starting with a brief on Pulse and Trust News and an interview with Medical Director, Peter Maskell on 18th January. In addition to this, posters, leaflets and screensavers, publicising the FTSU agenda across both sites is being designed.

The next steps in the FTSU strategy can be summarised in 3 parts;

- Communication and awareness of the agenda through the use of current Trust communication channels and a designated 'FTSU day' by June 2021
- Working closely with Learning and Development in embedding the FTSU agenda in Trust inductions
- Work closely with Equality and Diversity team on engaging Safe Space champions.

Data Collection; Concerns Raised

2020/21

20/21 Month	No. of contacts	Anonymous	All Open Cases
April	3	0	0
May	1	0	1
June	2	0	2
July	7	5	2
August	5	3	2
September	11	0	11
October	1	0	0
November	0	0	0
December	2	0	2
January			
February			
March			
Total	**32**	**8**	**20**

Staff Group	
Estates & Facilities	2
Nursing	7
Midwifery	
Medical	2
AHP's	8
Clinical Support	
A&C	4
Unknown	6
Total	**32**

Theme	
Patient Safety	0
Bullying/ Harassment	18
Fraud	1
Health & Safety	10
Other	3
Total	**32**

2019/2020 Details

Quarter	Month/Year	No. of Contacts	Open Cases
Q1	April-June '19	15	0
Q2	July-September '19	16	0
Q3	October-December '19	1	0
Q4	January-March '20	6	1
Total	**2019/20**	**39**	**1**

Staff Group	Number
Estates & Facilities	3
Nursing	7
Midwifery	0
Medical	1
AHP's	1
Clinical Support	10
A&C	10
Unknown	10
Total	**39**

Theme	Number
Patient Safety	6
Bullying/ Harassment	18
Fraud	1
Health & Safety	5
Other	9
Total	**39**

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 11/12/20	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met on 11th December 2020 (virtually, via webconference).

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Committee received an **update on COVID-19** wherein it was agreed that the Chief Nurse should provide an update to the February 2021 meeting on the patient feedback received in relation to the staffing levels on the wards during the second wave of COVID-19. It was also agreed that the Interim Director of Workforce should submit an update on the business cases for the Trust's legacy staff welfare initiatives to the February 2021 meeting.
- The Director of Workforce provided the latest **monthly update on the plans to improve the Human Resources function (incl. update on recruitment and retention and the Workforce Race Equality Standard (WRES))** wherein an update was provided on the recruitment process for a substantive "Chief People Officer" (formerly known as the Director of Workforce).
- The Committee **reviewed the Clinical Divisions' 'plan on a page'** wherein the following agreements were made for the Organisational Development Consultant:
  - Liaise with the Divisional Triumvirate for the Women's, Children's and Sexual Health Division to confirm the progress against the timelines of the actions outlined within the Divisions 'plan on a page'.
  - Ensure that future iterations of the Clinical Divisions' 'plan on a page' included both qualitative and quantitative data.
  - Ensure that the meeting with the Human Resources Business Partners, which was scheduled for the 17th December 2020, included an update on the expectations for line managers to instigate communication and engagement initiatives with team members.
- The Director of Finance provided the latest **monthly update on the Exceptional People, Outstanding Care (EPOC) programme** wherein it was noted that the programme narrative needed to reflect all aspects of Digital Transformation and that with the intended outcome of the EPOC programme was that the principles would become part of the Trust's "business as usual".
- The Committee received an **update on the Trust's flu and COVID-19 vaccination campaigns** wherein it was agreed that the Interim Director of Workforce should Notify the Trust Board, at its meeting on the 17th December 2020, of the adjusted data for flu vaccination uptake amongst staff.
- The **relevant aspects of the Board Assurance Framework (BAF)** were noted.
- Under **Any Other Business** it was agreed that the Assistant Trust Secretary should Schedule an update to the January 2021 meeting summarising the Trust-wide Human Resources Policies that were beyond their review date including the associated implications

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

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

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

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

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

Summary report from Quality Committee, 13/01/20	Committee Chair (Non-Executive Director)

The Quality Committee met on 13th January (a 'main' meeting), via virtual means.

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

- The **findings from the Committee's 2020 evaluation** were discussed & it was confirmed that the Committee should continue to operate as per its current processes, but that the Deputy Director for Quality Governance should liaise with Divisional representatives to reflect on the format of the Divisional report template with specific consideration of the method for highlighting the points for action or discussion; and the inclusion of issues arising from any Trust-wide, but Divisional-governed, committees and that any follow-up reviews from items considered at the Quality Committee 'deep dive' meeting should be undertaken at the 'main' Quality Committee and not the 'deep dive' meeting, unless agreed otherwise.
- The issues raised from the **reports from the clinical Divisions** included the response to the Ockenden review of maternity services; staffing issues; the suspension of Home Births and births at Crowborough Birth Centre to support the South East Coast Ambulance Service (SECamb); the escalation of Intensive Care Unit (ICU) capacity; the challenges to effective patient flow; the actions taken in response to Phlebotomy issues in Primary Care due to social distancing; the problems encountered with the repatriation of patients to community settings; and the actions taken in response to the Never Event (which related to the misplacement of an NG tube). Under the Surgery Divisional Governance report reference was made in regards to the ethical issues associated with potential access to Intensive Care Unit (ICU) / High Dependency Unit (HDU) facilities. It was agreed that the Chair of the Trust Board would consider, and discuss with the Medical Director, the allocation of an additional Non-Executive Director to the COVID-19 Ethics Committee to ensure consistent Non-Executive Director attendance.
- The Medical Director reported on the **output from the COVID-19 Ethics Committee and Clinical Reference Group**.
- The Medical Director and Chief Nurse provided a report on **the safety 'triggers'/model used to assess the Trust's capacity to accept additional patients during the operational pressures faced in December 2020** wherein it was noted that the triggers were determined by the Integrated Care System (ICS).
- The Divisional Director of Nursing and Quality for Surgery gave an **update on harm reviews for patients who have waited a long time**, and it was agreed that they should liaise with the Divisional Director of Operations for Surgery to investigate if the mechanisms of harm review completion rate could be expedited, including giving consideration to the utilisation of staff who were shielding.
- The Deputy Chief Nurse gave an **update on the work to achieve an 'Outstanding' CQC rating**.
- The Committee reviewed the progress with implementing the **Quality Strategy**
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality**, which included the impact the new Medical Examiner role was having on mortality reviews.
- The latest **Serious Incidents (SIs)** were reported by the Deputy Director of Quality Governance.
- The Deputy Director of Quality Governance provided an **update on the implementation of the Quality Accounts priorities for 2020/21.**
- The Deputy Director of Quality Governance delivered the **update on complaints** (for quarters 1 & 2 of 2020/21), which highlighted the recent improvement in complaints response rate and introduction of the "One Team Runner" role.
- The **draft Internal Audit plan for 2020/21** was reviewed and no amendments were proposed.
- The **relevant aspects of the Board Assurance Framework** and report from the last **Quality Committee 'deep dive' meeting** were noted.
- Reports were received from the **Committee's sub-committees** (the Complaints, Legal,

Incidents, PALS, Audit and Mortality (CLIPAM) group; the Infection Prevention and Control Committee; and the Drugs, and Therapeutics and Medicines Management Committee)
- The **summary report from the Patient Experience Committee** meeting held on 01/12/20 was noted.

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

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

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

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

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