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

Thu 29 April 2021, 10:00 - 12:15

Virtual Meeting, via webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

04-1.
To receive apologies for absence

David Highton

04-2.
To declare interests relevant to agenda items

David Highton

04-3.
To approve the minutes of the 'Part 1' Trust Board meeting of 25th March 2021

David Highton

Board minutes, 25.03.21 (Part 1).pdf (9 pages)

04-4.
To note progress with previous actions

David Highton

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

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

David Highton

Chair's report.pdf (1 pages)

04-6.
Report from the Chief Executive

Miles Scott

Chief Executive's report April 2021 v1.pdf (2 pages)

Integrated Performance Report

04-7.
Integrated Performance Report (IPR) for March 2021

Miles Scott and colleagues

IPR for March 2021.pdf (33 pages)

Planning and strategy

04-8.
Operating plans for the first half of 2021/22

Amanjit Jhund

Operating plans for the first half of 2021-22.pdf (14 pages)

04-9.
Strategy Deployment – corporate objectives for 2021/22

Amanjit Jhund

Strategy Deployment – corporate objectives for 2021-22.pdf (17 pages)

04-10.
Review of nurse staffing for ward and non-ward areas (major review)

Claire O'Brien

Review of Nurse staffing Ward and non-Ward areas.pdf (16 pages)

Assurance and policy

04-11.
Year-end review of the Board Assurance Framework, 2020/21

Kevin Rowan

Year-end review of BAF for 2020-21.pdf (5 pages)

04-12.
Infection prevention and control board assurance framework

Sara Mumford

IPC Board Assurance Framework - April 2021.pdf (43 pages)

04-13.
Six-monthly update on Estates and Facilities

Miles Scott

Six-monthly update on Estates and Facilities - April 2021.pdf (5 pages)

04-14.
Quarterly report from the Freedom to Speak Up Guardian

Christian Lippiatt and Ola Gbadebo-Saba

N.B. This item has been scheduled for 12.15pm

FTSU Board Report April 2021.pdf (8 pages)

Reports from Trust Board sub-committees

04-15.
Charitable Funds Committee, 23/03/21

David Morgan

Summary of Charitable Funds Cttee, 23.03.21.pdf (2 pages)

04-16.
Quality Committee, 14/04/21

Sarah Dunnett

Summary of Quality C'ttee, 14.04.21.pdf (1 pages)

04-17.
People and Organisational Development Committee, 23/04/21 (incl. quarterly report from the Guardian of Safe Working Hours; and approval of revised Terms of Reference)

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 23.04.21 (incl. revised ToR and Guardian for Safe Working Hours report).pdf (8 pages)

04-18.
Finance and Performance Committee, 27/04/21

Neil Griffiths

Summary of Finance and Performance C'ttee 27.04.21.pdf (1 pages)

04-19.
To consider any other business

David Highton

04-20.
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25TH MARCH 2021, 10 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)
	Cheryl Lee	Director of Workforce	(CL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	John Weeks	Director of Emergency Planning & Communications (for item 03-7)	(JWe)
	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]

03-1 To receive apologies for absence

No apologies were received.

03-2 To declare interests relevant to agenda items

SDu declared that she was an interim Non-Executive Director at East Kent Hospitals University NHS Foundation Trust.

[N.B. KC later declared, under item 03-21, that she was the Vice-Chancellor of the University of Kent]

03-3 To approve the minutes of the 'Part 1' Trust Board meeting of 25th February 2021

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

03-4 To note progress with previous actions

DH referred to the submitted report and invited questions or comments. MC referred to action 02-9a, stated that she would be interested in hearing more about the ophthalmology transfer, and initially proposed that the issue be considered further at the Patient Experience Committee or Quality Committee. AJ however then reported that discussions would continue with the Executive Director of Health Improvement/Chief Operating Officer at Kent and Medway Clinical Commissioning Group, and AJ would update the Patient Experience Committee as required. DH confirmed that the Patient Experience Committee could continue to monitor the issue.

Action: Ensure that the Patient Experience Committee continues to monitor the impact of the transfer of ophthalmology activity from Dartford and Gravesham NHS Trust (Chair of the Patient Experience Committee / Trust Secretary, March 2021 onwards)

03-5 Report from the Chair of the Trust Board

DH referred to the relevant attachment and highlighted the successfully recruitment of five Emergency Medicine consultants, which was testament to the strength of the Trust's Emergency Department (ED). DH then referred to the Health Service Journal (HSJ) Awards, where the Trust had been shortlisted for the "Acute Trust of the year", and stated that although the Trust did not win, staff should be proud for being shortlisted.

03-6 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the following points:

- Over 88% of staff had received their first dose of the COVID-19 vaccine, and circa 20% of staff had now received their second dose. A high proportion of Black and Asian Minority Ethnic (BAME) staff had also now received a vaccination. The vaccination rates would be reported to the Trust Board each month.
- This would be CL's last Trust Board meeting. CL had made an enormous difference to the Trust since she started six months ago, and would be missed. The Trust's new Chief People Officer, Sue Steen, would start at the Trust on 01/04/21 and would be at the next Trust Board meeting.

CL thanked MS for his comments and confirmed that she had felt very supported by other members of the Trust Board, and by EPM and RF in particular, via the People and Organisational Development Committee.

Assurance and policy 1

03-7 Emergency Planning Annual Report, 2020 and future emergency planning

JWe referred to the relevant attachment and gave a presentation that covered "EPRR Annual Report, Well prepared – Exceptional teams – Exceptional leaders"; "EU Exit & Transition"; "Incident Co-ordination Centre"; "COVID-19"; "Vaccination Centre"; "Normal Business"; and "Brave New World…" (which covered the future plans in relation to the merger of the Incident Co-ordination Centre into 'business as usual', horizon scanning for new or existing hazards and threats, the future emergency planning live exercises, the need to review the Resilience Committee (and in particular how that Committee reported to the Trust Board), the review of existing stock holdings, preparing for seasonal resilience, and responding to the political/economic situation).

MS then paid tribute to JWe and his team, as MS believed that the Trust had made its own luck during the COVID-19 pandemic, largely as a result of its robust emergency planning arrangements. MS added that it was more important than ever that Trust Boards paid attention to future emergency planning, so he had asked JWe that the item focus less on the past and more on the future, given the challenges the Trust would likely need to address. MS added that training would be an important aspect and then invited other Trust Board members to give their views.

CL emphasised the importance of the Trust optimising and capitalising on the different ways of working during the COVID-19 pandemic, which included working from home and remote working, along with the drive to increase the use of virtual outpatient appointments.

SDu then commended JWe and his team for their work and stated that she was confident that the Trust had benefitted from a forward-looking emergency planning team, but wondered how the Trust Board could improve in that regard. SDu queried, for example, whether some aspects could be included in the Integrated Performance Report (IPR). SDu also then noted that she had enjoyed reading the Pulse newsletter, but queried whether frontline staff wanted, needed, or had the time to read, a daily Pulse.

JW asked what lessons could be learned from the past year regarding the use of Trust's estate. JWe noted that there had been some good lessons learned, including in relation to oxygen supply, but he believed the 'can do' approach of the Trust's Estates and Facilities teams would stand the Trust in good stead for the future.

DM noted that the IPR contained much 'rear view mirror' content, but he had seen other Trusts include some forward-looking metrics in their IPR, informed by their risk registers, so queried whether that could be considered.

MC asked what corporate debrief on the COVID-19 pandemic had occurred thus far. MS confirmed that no formal debrief had been undertaken, but the need for that had been recognised, and JWe and PM had been asked to consider the issue and submit a proposal to the Executive Team Meeting (ETM). PM noted that the Chief Registrar had met with JWe and given his thoughts, and it was intended to submit a report to the ETM on 06/04/21.

RF highlighted the importance of responding to climate change. MS acknowledged the need to consider that, but emphasised that the Trust Board needed to discuss and debate how central that should be, compared to other priorities.

DH then asked JWe for his views on the relationship between the Incident Coordination Centre and the Command and Control Centre that was established to implement the TeleTracking system. JWe stated that he believed it would be best to merge them, and elaborated on the rationale.

Performance

03-8 Update on the plans for de-escalation and recovery

SB referred to the circulated report and first highlighted that it was still in draft, as much further work was required, including on the "Strategy Deployment" programme, before it was finalised. SB then drew attention to the following points:

- The recovery objectives had been balanced against the need to consider staff welfare, so although services would be fully open from 06/04/21, activity and utilisation levels would not be scrutinised until later that month.
- Many lessons had been learned from COVID-19 and these had informed the recovery plans
- The current organisational objectives, which were listed on pages 8 and 9 of 36, remained important, although the work on the future objectives was ongoing.

DH asked how patients had been communicated with in relation to their treatment plans. SB explained the intended approach to provide an indicative date by which patients would be seen and/or treated, but elaborated on the complexities involved, given the different categories of clinical priority. SB added that although the Trust had a higher number of 52-week waiting time breaches than it wanted, this compared very favourably to the higher numbers at other Trusts. SB added that the Trust wanted to halve the number of such breaches by October 2021, and reduce the number to zero by the end of March 2022. SB also noted that the Finance and Performance and Quality Committees were interested in the outpatient transformation work.

EPM then encouraged SB to carefully consider the number of objectives and asked when the recovery plan and objectives would be finalised. EPM also asked how the position would be monitored. SB confirmed that it was intended to finalise the work by the next Trust Board meeting, while the report submitted to next month's Trust Board meeting would be clear on the Key Performance Indicators (KPIs), and how these would be monitored.

03-9 Integrated Performance Report (IPR) for February 2021 (incl. planned and actual ward staffing for Feb. 2021)

MS referred to the relevant attachment and firstly highlighted that, as the peak of the second wave of COVID-19 had passed, the Trust was keen to ensure that there remained an emphasis on quality during the recovery plans SB had discussed under item 03-8. MS also noted that the IPR contained details of the modelling that had been undertaken for a third wave of COVID-19 cases, and it was important not to focus too much on the expected numbers, but on how the Trust would respond to a third wave, should that be experienced. MS continued that the ETM had, on 23/03/21, considered that response, which included the configuration between the Trust's two main hospital sites. MS added that it was also important to respond to a third wave without locking down outpatient and elective activity, should that be feasible.

COB then referred to the “Safe” domain and reported the following points:

- The number of falls had significantly reduced from previous months, as 109 falls had been reported, one of which was a Serious Incident (SI), and 10 of the patients involved had fallen more than once (which was also a reduction).
- The number of hospital-acquired pressure ulcers had also reduced.
- The number of SIs had reduced to three.

COB then referred to the “planned versus actual” data on page 36, and highlighted the key points therein, which included that the position was heading in the right direction.

SM then referred to the infection control aspects of the “Safe” domain and reported the following points:

- Clostridiodes difficile cases were below expected levels at that point in the year.
- E-coli infections were also below expected levels, although the number had increased.
- There had been one COVID-19 outbreak in February 2021, which was a significantly improved position.

PM then referred to the “Effective” domain and reported that stroke performance had been adversely affected by COVID-19, but the situation had improved, and new pathways regarding mechanical thrombectomy had been introduced via the Royal London and King’s College Hospital NHS Foundation Trust. PM also reported that the Best Practice Tariff (BPT) and Sentinel Stroke National Audit Programme (SSNAP) performance had both improved.

SDu referred to the “% Total Readmissions” and remarked that the current rate of “15.2%” seemed high, so queried whether the “Plan” of “14.6%” was ambitious enough. PM reported that there were some counting anomalies which prevented the “Plan” rate being more ambitious, but that would be resolved by the implementation of the Electronic Patient Record (EPR). PM added that when the issue was reviewed circa 12 months ago, assurance had been provided on the issue.

COB then referred to the “Caring” domain and reported the following points:

- More work was required on the Friends and Family Test (FFT) response rate, which was far lower than the Trust wanted.
- Complaints response performance was at 87.5%, which was fantastic.

SB then referred to the “Responsive” domain and reported the following points:

- SB hoped that it would be last month in which the Referral to Treatment (RTT) position had deteriorated.
- The Trust was expected to meet the 62-day cancer waiting time target for the 19th month in a row. The Trust was one of only three in the country that had achieved that feat.
- The Trust was, that week, the top Trust in the country for ED 4-hour waiting time target performance, and all involved should be thanked, as that indicator was a barometer for other performance across the Trust.

SO then referred to the financial aspects of the “Well-led” domain & reported the following points:

- The Trust remained on course to deliver the financial plan. The financial regime was divided into two halves during 2020/21, and although the second wave of COVID-19 cases had adversely affected the specific delivery of the Trust’s plan, the Trust had deployed flexibility to respond appropriately.
- The Trust’s cash balance was really strong, and the fact that the Trust would not get a final contract payment would help, but it was likely that the Trust would hold a cash balance that was higher than planned at the end of the year. NHS England/Improvement (NHSE/I) had however confirmed they were content with that position.

CL then referred to the workforce aspects of the “Well-led” domain & reported the following points:

- The staff vacancy rate was reducing, but CL believed there was an anomaly which related to the data cleansing that was taking place at present, although the data correlated with the staff survey data. The final effect of the COVID-19 second wave was not yet known.
- The Trust had focused on promoting the “ACT” acronym across the organisation.

- Staff turnover appeared to be subject to special cause variation, but more detailed analysis of a new leavers' survey was underway.
- SO was leading on an objective to reduce temporary staffing, and that would likely have a beneficial effect.
- Staff had reported more side effects from their second dose COVID-19 vaccine, but sickness was expected to reduce.

MS pointed out that the sickness absence data in the IPR was for January 2021.

NG asked how staff were feeling following the second wave of COVID-19, and the intended future recovery. CL explained the efforts than had been made regarding the "Annual Leave", "Conversation" and "Team" aspects of the aforementioned "ACT" acronym. SB added further context and stated that he believed morale was quite good, although there were variances. COB added her own perspective.

JW noted that the video prepared for the aforementioned HSJ award had highlighted the positive impact of the "One Team Runner" scheme and asked about the future plans for that scheme. COB confirmed that a Business Case was being developed for consideration by the Business Case Review Panel and approval by the ETM.

KC asked whether any work had been done or was planned about the future of work, given the changes that had been introduced by the COVID-19 pandemic. CL acknowledged that the Trust was not maximising the opportunities to work flexibly, and needed to consider how its policies could support new working, so she would ensure that aspect was included in her handover to the new Chief People Officer.

MS noted that the recent actions such as the "Recognition day" and the way the Trust had amended the bank rotas had been very well received by staff.

Planning and strategy

03-10 <u>To approve the capital programme for 2020/21</u>

SO referred to the relevant attachment and highlighted the following points:
- It had been unusual to not have a clear view about the capital programme so late in the year.
- The Finance and Performance Committee had received a report in January 2021 that outlined what the capital programme would be, should everything the Trust expected proceed, and that plan had largely been met.
- The Trust's requests for funding for COVID-19-related capital items in early 2020/21 had been approved, and the Trust had also been able to access some expenditure slippage from other local Trusts. The Trust had therefore been able to deliver a significantly higher value capital programme than had been the case in previous years.
- The Finance and Performance Committee had considered the submitted programme on 23/03/21, and supported it, although some specific Business Cases may need to be approved by the Trust Board at a future point. It was however also feasible that these would be able to be approved by the Finance and Performance Committee.

DH commended SO and the other members of the Executive Team that enabled the Trust to take advantage of the capital expenditure slippage experienced by other Trusts.

DM emphasised the large value of the programme and stated that the Trust Board should therefore be assured that the Trust had not compromised value for money by spending such a significant amount. DM also asked about the impact of the capital expenditure on future years. SO replied that the capital programme that had been developed for the year had identified priorities, while nothing in the plan had not been through the appropriate procurement process, so SO was confident that the items purchased met the Trust's strategic intentions or had been part of the Trust's prioritised capital needs. SO however acknowledged that the timing of the funding confirmation had played a part in some of the expenditure, as, for example, IT equipment was easier to purchase than complicated building projects. SO then stated that there would be some

financial impact on future financial years, although the value was likely to be hundreds of thousands of pounds.

DH noted that the IT investment had allowed the Trust to replace IT equipment that had not been replaced for the past five years, but now that had been done, the challenge would be to ensure that the future situation did not revert. The point was acknowledged.

The Trust Board approved the capital programme for 2020/21 as submitted.

03-11 Update on the future financial regime

SO referred to the relevant attachment and highlighted the following points:

- Additional information on the regime had been issued soon after SO had written the report.
- The regime the NHS operated under at present would be extended to Quarters 1 and 2 in 2021/22.
- There would like be an efficiency requirement for 2021/22.
- The formal planning guidance for 2021/22 was expected either later that day or on 26/03/21.
- A 'light touch' planning submission would likely be required in May 2021, with a more detailed submission required later in the year.
- The capital position across the Kent and Medway system would likely be constrained in 2021/22, so the Trust may need to prioritise its capital programme, or seek alternative funding via revenue-based models, which the Trust had been successful at in recent years.

Quality items

03-12 Quarterly mortality data

PM referred to the relevant attachment and highlighted the following points:

- The 12-month, and one-month, rolling Hospital Standardised Mortality Ratio (HSMR) continued to decline, although the one-month rolling position would likely increase slightly as the data was finalised.
- The Trust Board had previously asked why there had been such a reduction in HSMR, and PM had been unable to give a definitive response, although he believed several factors were involved, including improvement in clinical coding; the positive impact of the Trust's improved delivery of the ED 4-hour waiting time target; and the 7-day services working that had been introduced for medicine, which had helped reduce the variation between weekday and weekend mortality. However, the Summary Hospital-level Mortality Indicator (SHMI), which was measured differently to the HSMR, had also reduced, so PM believed that the improved cooperation on clinical pathways with the Trust's community partners would likely have had a beneficial effect.
- The CUmulative SUM (CUSUM) alerts did not reveal any particular cause for concern, but these would be explored.
- Learning from mortality reviews had identified the need for comprehensive and clear documentation for Venous Thromboembolism (VTE) assessment and that had been validated at the Divisional Performance Reviews (DPRs) on 24/03/21.
- The data showed that the Trust was an outlier for COVID-19 related mortality in March, May and June 2021, but PM was sceptical regarding that position, as the impact of the new COVID-19 variant that arose between the first and second COVID-19 waves needed to be considered, as did the fact that the Trust had been a net provider of mutual aid.

PM then speculated further on why the data showed the Trust as an outlier for COVID-19 related mortality, which included the Trust's active research programme, but concluded that the data was currently not secure, and PM believed it would likely be proved to be incorrect in time. PM did however give assurance that he would continue to monitor the position and respond appropriately.

DM referred to the HSMR charts in the report and asked for further details. PM acknowledged that the charts were not often straightforward but offered to provide a more detailed session on statistics to any Trust Board member who was interested. DH instead noted that the Quality Committee considered mortality regularly. SDu confirmed that was the case. DH therefore

suggested that an invitation be extended to DM, or any other Non-Executive Director who was interested, when the Quality Committee next undertook a 'deep dive' into mortality. The suggestion was acknowledged.

Workforce

03-13 The findings of the national NHS staff survey 2020

CL referred to the relevant attachment and highlighted the key points therein, which included that the Trust should not develop a traditional action plan that addressed multiple areas of the survey's findings, but instead focus on the following small number of areas:

- Making sure that everyone felt involved and able to contribute to changes and improvements in their area of work.
- Creating stronger team working environments.
- Ensuring the Trust had strong workforce plans in place so that staff felt that there were enough team members in place to do a good job.
- Continuing to improve staff health, well-being and safety.
- Addressing discrimination in the workplace.

CL also noted that further work was required regarding the communications associated with the survey, but the Trust had appointed a new Head of Communications.

Assurance and policy 2

03-14 Review of the Board Assurance Framework 2020/21

DM referred to the relevant attachment and highlighted the following points:

- Good progress was being made on the objectives although the project aim relating to the Care Quality Commission had been affected by the COVID-19 pandemic.
- The BAF would be superseded by the "Strategy Deployment" work.

DH added that the constituent parts of the BAF had been considered by the Trust Board sub-committees. The Trust Board then confirmed that the "Strategy Deployment" process, and the monitoring and reporting of the objectives therein, would replace the Trust's BAF from 2021/22 onwards, and should any external regulator be asked for evidence of the Trust's BAF, the Trust should refer to the "Strategy Deployment" work.

03-15 Infection prevention and control board assurance framework

SM referred to the relevant attachment and highlighted the key points therein, which included that the new content was highlighted in red. SM also confirmed there were no major areas of concern.

DH asked SM whether the changes to Peale Ward at Maidstone Hospital had helped the Trust with its patient isolation requirements. SM confirmed that the changes had helped improve the situation.

Reports from Trust Board sub-committees

03-16 Audit and Governance Committee, 03/03/21

DM referred to the relevant attachment and highlighted the following points:

- The annual review of Standing Financial Instructions, Reservation of Powers and Scheme of Delegation and Standing Orders had been agreed to be deferred again.
- The changes to the BAF had been noted.
- The responsibility for governance had been discussed and DM would like the Trust Board to clarify that the structure of the Trust's governance was primarily the responsibility of the Trust Board, although all Trust Board sub-committees could ask the Board to consider any issues they highlighted/discovered through fulfilling their own remits; while the primary responsibility for ensuring compliance with established governance structures rested with the Audit and Governance Committee.

The latter points were confirmed by the Trust Board. DH then confirmed that appraisal of the effectiveness of governance should be carried out as part of the annual board effectiveness

review, and proposed that the next review take place over the summer. DH added that he would liaise with KR regarding the timing of that review.

Action: Liaise to finalise the scheduling of the 2021 review of the Trust Board's effectiveness (Chair of the Trust Board and Trust Secretary, March 2021 onwards)

03-17 Patient Experience Committee, 04/03/21

MC referred to the relevant attachment and highlighted the "findings from the Independent Review of NHS Hospital Food" item. Questions were invited. None were received.

03-18 Quality Committee, 10/03/21

SDu referred to the relevant attachment and highlighted that the report from the Surgery Division included an update on the Sepsis Committee. SDu added that it had been agreed that data on the second COVID-19 vaccination should be reported to the Trust Board, and that had been enacted. Questions were invited. None were received.

03-19 People and Organisational Development Committee, 19/03/21

EPM referred to the relevant attachment and highlighted the change to a 'main' and 'deep dive' meeting. EPM added that she had agreed with KR that the 'deep dive' meetings would start in May 2021. Questions were invited. None were received.

03-20 Finance and Performance Committee, 23/03/21

NG referred to the relevant attachment and highlighted the progress that had been made with the implementation of the EPR. NG also noted that the Committee that discussed the Outline Business Case (OBC) for the Kent and Medway Medical School (KMMS) accommodation, and the Committee had recommended that the Trust Board approve the OBC, although several aspects still needed to be finalised. NG added that the OBC would be considered under item 03-21.

03-21 Approval of an Outline Business Case (OBC) for the Kent and Medway Medical School (KMMS) accommodation

AJ referred to the relevant attachment and highlighted the following points:

- The OBC was not complete, so the Trust Board was asked to authorise the final approval of the OBC to the KMMS Accommodation Oversight Group, which involved DH and NG.
- The tender responses had indicated a cost that was significantly lower than the Trust's quantify surveyors had estimated, so the Trust was working that through, as it had confidence in the quantity surveyors' value.
- It was likely that the approval would not be able to be sought from the KMMS Accommodation Oversight Group until w/c 05/04/21, rather than on 30/03/21, as stated in the OBC document. However, that would not affect the timetable.

DH then explained the rationale for the timing of the OBC decision.

KC then noted that she should have declared her role as the Vice Chancellor of the University of Kent under item 03-2.

The Trust Board delegated the authority to give final approval of the OBC to the KMMS Accommodation Oversight Group. KR then confirmed he would formally report the outcome of the KMMS Accommodation Oversight Group's decision to the Trust Board.

Action: Confirm the outcome of the KMMS Accommodation Oversight Group's decision regarding the approval of the Outline Business Case for the provision for Kent and Medway Medical School student accommodation (Trust Secretary, March 2021 onwards)

03-22 Charitable Funds Committee, 23/03/21

DM reported that the Trust's Fundraising Manager would soon leave the Trust, so that had led to a need for review the future arrangements, which AJ and JWe had committed to undertake.

03-23 To consider any other business

There was no other business.

03-24 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
03-4	Ensure that the Patient Experience Committee continues to monitor the impact of the transfer of ophthalmology activity from Dartford and Gravesham NHS Trust	Chair of the Patient Experience Committee / Trust Secretary	March 2021	An item has been scheduled for the June 2021 Patient Experience Committee, to enable the Committee to consider and confirm the monitoring arrangements for the impact of the transfer.
03-16	Liaise to finalise the scheduling of the 2021 review of the Trust Board's effectiveness	Chair of the Trust Board and Trust Secretary	March 2021	Liaison occurred and it has been confirmed that the review should be scheduled for June 2021.
03-21	Confirm the outcome of the KMMS Accommodation Oversight Group's decision regarding the approval of the Outline Business Case for the provision for Kent and Medway Medical School student accommodation	Trust Secretary	April 2021	The Group approved the Outline Business Case (OBC) but with the clear documentation on the outstanding unknowns that require clarification for the Full Business Case (FBC). Further details have been provided in a report that has been submitted to the 'Part 2' Trust Board meeting in April 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
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 scheduled to be onsidered at the Trust Board until September 2021

Ref.	Action	Person responsible	Original timescale	Progress

[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
31/3/21	Dr	Danielle Heather	Lewis	Diabetes & Endocrinology	TBC
20/04/21	Consultant Cardiologist with Specialist Interest in Heart Failure	Mihir Suryakant	Patel	Cardiology	TBC

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. Following on from the integrated care system (ICS) and sustainability and transformation partnership (STP) board meeting on 13 April, nine Improvement and Development priorities have been set out for 21/22 and these formed a key part of the ICS accreditation process in February 2021. The nine priorities require a dedicated focus from the system and are as follows:
   - **Continuing to respond effectively to the COVID-19 pandemic as a cohesive system** - with partnership working in place and co-ordination in the form of a system wide programme for recovery, and system oversight of the COVID-19 vaccination programme.
   - **Delivering against the Kent and Medway Improvement and Recovery Plan**. Delivering improvement in areas of mental health services, children and young people services and safeguarding. Also developing place based improvement plans with a focus on how partnership working can drive improvement in urgent and emergency care.
   - **Working as a system on increasing diagnostic capacity and elective capacity.** This includes managing long waits for planned care that have arisen as a result of the pandemic.
   - **Implementing 'ICS end state' -** reflecting the likely creation of ICS statutory entities in April 2022 this includes further work on the ICS governance model, ICS executive team, system behaviours, ways of working, and development of Integrated Care Partnerships and Primary Care Networks.
   - **Designing a detailed approach to population health management**, with the help of the NHSE/I Wave 3 Population Health Management (PHM) programme.
   - **Working with NHS England and Improvement (NHSE/I) to progress the system's two strategic change priorities** with necessary pace – the implementation of stroke and East Kent transformation.
   - **Rapidly exploring opportunities for further provider collaboration** – both clinical and non-clinical, including in back office, estates and workforce.
   - **Developing a strategy for the creation of county wide leadership, expertise and capacity for Quality and Service Improvement**, using a set of consistent tools and approaches across the county.
   - **Refreshing the system digital and analytics strategy -** creating system capability for digital through formalised matrix working and implementing an analytics strategy at pace.

   A forward planner for future ICS Executive Group meetings and ICS Partnership Board meetings is in development to show when significant deliverables/decisions arising from the nine priorities will be diarised for future meetings. This will be provided for the May Partnership Board meeting, following discussion with system sponsors and at the ICS Executive Group meeting at the end of April.

2. The West Kent Integrated Care Partnership has successfully recruited Sally McKinnon in the role of Programme Director, starting in July 2021. Sally has a wealth of experience in integrated care and commissioning. Two additional posts have been approved to expand the joint programme management portfolio. These posts will take forwards work on health inequalities and population health management, working in two of our most deprived wards; and in primary care to support demand and capacity planning and Primary Care Networks (PCN) development. The ICP members are considering the governance arrangements to reflect the mandated development of an ICS NHS Body and ICS Health and Care Partnership within the NHS Integration and Innovation white paper.

3. As the nation begins to see the journey towards normality unfold with the loosening of restrictions on social distancing, we're also continuing with our own plan towards recovery at the Trust. While our recovery plans have been phased in order to protect the wellbeing of our staff,

who have been under considerable pressure during the second wave of Covid-19, as of 6 April we re-opened all our theatres in order to restart our elective care and also increased our pre-operative assessment capacity. Within just the first few weeks of restarting some of our elective treatments, our teams were able to reduce the number of long waiting patients by almost a third. Our teams are also working with specialties across the organisation to safely reinstate outpatient activity, staggering appointment times and maximising the use of virtual clinics where appropriate, to ensure that those patients who do need to be seen face-to-face by a clinician can do so in a covid-secure manner. New technology will be introduced later in the summer to help improve outpatient flow around our hospitals and maximise the use of our socially distanced waiting rooms.

4. As of Monday 29 March, we updated our visiting guidance to support more visiting across our sites. This update means we're supporting visiting six days a week with many of our patients now able to nominate a visitor on set days and times. Our teams are also doing all they can to support contact with friends and family via the ipads we have on the wards.

5. Our Covid-19 vaccination programme at Maidstone Hospital has now closed, with the majority of MTW staff having receiving both doses of the vaccine. Since the centre opened in December 2020, the Trust has been able to issue over 30,000 doses to MTW staff as well as vulnerable patients and colleagues from partner organisations. Over 90% of our staff have had the first dose of the vaccine with 82% also having the second dose with similar figures also reported for our BAME colleagues. The Trust is operating a 'no person left behind' policy and ensuring any colleague who still hasn't had the vaccine is able to do so via the help of our Occupational Health Department and vaccination partners.

6. Despite the success of our vaccination programme, we are still ensuring all colleagues undertake twice weekly lateral flow tests (LFT) at home even after receiving their second dose. The deployed vaccinations are very effective at reducing both symptomatic and asymptomatic COVID infection; however, like any vaccine, they are not 100% effective. The continuation of regular testing helps to keep our patients and colleagues safe, with any colleagues experiencing Covid symptoms at any time after vaccination, supported to book a PCR test and not rely solely on LFT.

7. Congratulations to the winners of the Trust's Employee of the Month scheme for March – Lindsey Cooper from our Switchboard Team and Stephen Gaskin our Chief Pharmacy Technician. On behalf of the Trust Board I would like to say thank you to both Lindsey and Stephen for their fantastic work to help support our colleagues and patients.

8. I am delighted to announce that we have appointed Joanna Haworth as Chief Nurse for Maidstone and Tunbridge Wells NHS Trust. Jo will join the Trust in the summer, taking over from the current Chief Nurse, Claire O'Brien, who is retiring after 5 years at MTW and more than 41 years working in the NHS. With extensive experience as a nurse leader, Jo has held the role of Deputy Chief Nurse at King's College Hospital NHS Foundation Trust for the last three years and has worked across a number of large, London trusts including Barts Health and St George's Hospital. She is a powerful advocate for collaborative working and has a focus on quality and safety improvements which deliver the highest possible experience for both patients and staff. A graduate of the Nye Bevan Leadership Programme, Jo will lead the development of our nursing and midwifery workforce with skill, professionalism and compassion and we look forward to formerly welcoming her to the Trust in the coming months.

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

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for March 2021	Chief Executive / Members of the Executive Team

The IPR for month 12, 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?

- Finance and Performance Committee, 27/04/21 (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

March 2021

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 24 onwards)

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

MTW
exceptional people, outstanding care

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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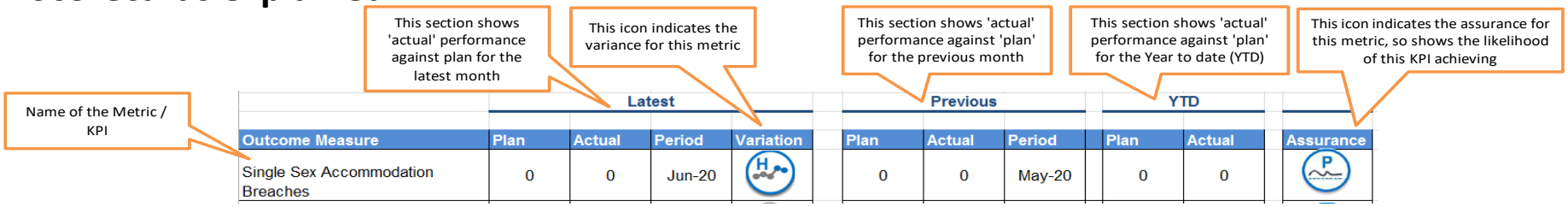
Maidstone and Tunbridge Wells NHS Trust

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



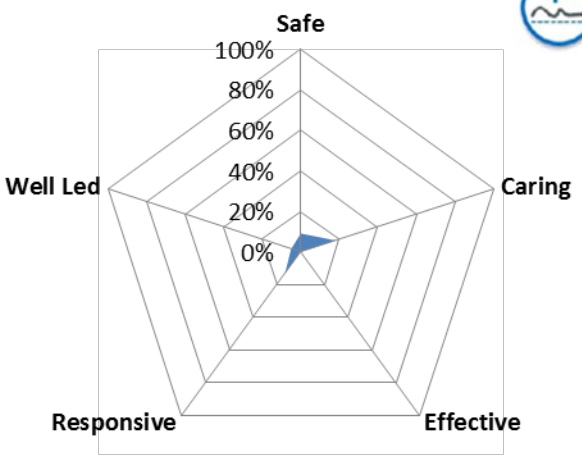
Further Reading / other resources

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:

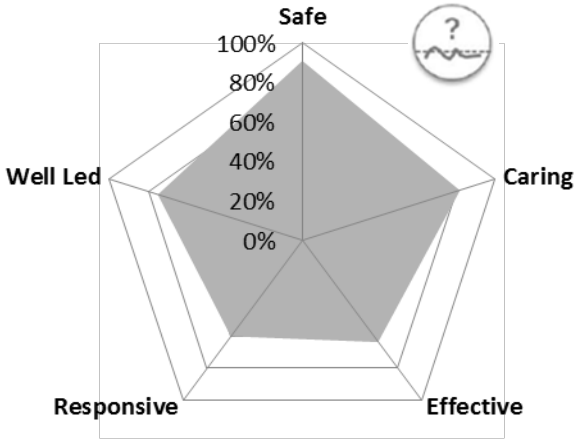
Safe:
- Trust Mortality (HMSR)

Caring:
- Mixed Sex Accommodation Compliance
- % VTE Risk Assessment

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

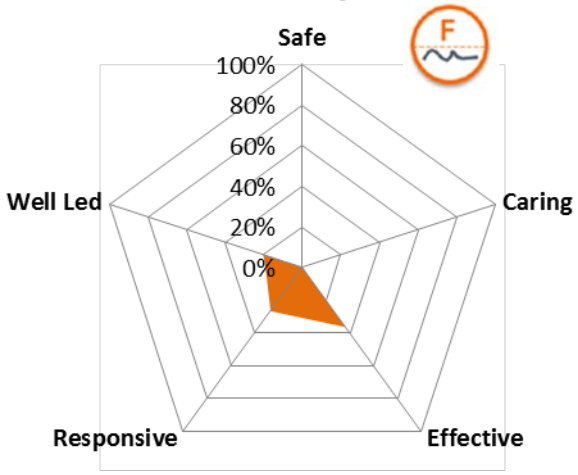
Effective:
- Outpatients DNA Rates and Hospital Cancellations, Readmissions Indicators, Stroke Indicators

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

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

Well-Led:
- Capital Expenditure, Cash Balance, Sickness Rates, Vacancy Rates, Appraisals, Staff FFT Recommended to work, Staff FFT Recommended Care, 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 performance
- 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
- Percentage of Trust policies within review date

Matrix Summary

March 2021

Variance	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause - Improvement	Stat and Mandatory Training (W)	Infection Control - Number of Hospital acquired MRSA (S), Stroke Best Practice Tariff (E), IP Friends & Family (FFT) % Positive (C), A&E Friends & Family (FFT) % Positive (C), Nursing vacancies (W), Covid Positive - number of patients (W) Cash Balance (W), Number of specialist services (W), Number of advanced practitioners (W), Staff Friends and Family % recommended work (W), Staff Friends and Family % recommended care (W)	Percentage of Non-face to face OP activity (E), Calls Answereed in under 1 min (E), Calls Answereed in under 3 min (E), Percentage of Trust policies within review date (W),
Common Cause	Standardised Mortality HSMR (S), Single Sex Accommodation Breaches (C), % VTE Risk Assessment (C), Cancer - 2 Week Wait (R), Cancer - 62 Day (R),	**See box (right)**	Turnover (W)
Special Cause - Concern		Safe Staffing Levels (S), Outpatient DNA Rate (E), Capital Expenditure (W), Elective Spells in London Trusts from West Kent (W), Vacancy Rates (W)	OP Utilisation (E), RTT (Incomplete) performance against trajectory (R), Number of patients waiting over 40 weeks (R), 52 week breaches (new in month) (R), Size of backlog (R) Use of Agency (W) Agency Spend (W)

Hit & Miss /

Sickness Rate - Covid (S)	Maternity Combined FFT % Positive (C),
Infection Control - Hospital Acquired Covid (S),	OP Friends & Family (FFT) % Positive (C),
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays (S),	Access to Diagnostics (<6w eeks standard) (R),
Infection Control - Rate of Hospital E. Coli Bacteraemia (S),	Theatre Utilisation (R)
Number of New SIs in month (S),	Average for new appointment (R),
Rate of Total Patient Falls per 100,000 occupied beddays (S),	A&E 4 hr Performance (R),
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions (S),	Super Stranded Patients (R),
Never Events (S),	Ambulance Handover Delays Rate > 30mins (R),
Outpatient Hospital Cancellation (E),	Bed Occupancy (R),
Outpatient Cancellations < 6 w eeks (E),	NE LOS (R),
Total Readmissions <30 days (E),	Cancer - 31 Day (R),
Non-Elective Readmissions <30 days (E),	Health and Wellbeing: How many calls received (W),
Elective Readmissions < 30 Days (E),	Health and Wellbeing: What percentage of Calls related to Mental Health Issues (W),
MetricRate of New Complaints (C),	Research grants (£) (W)
% complaints responded to w ithin target (C),	Sickness (W)
	Appraisal Completeness (W)

Items for escalation based on those indicators that are Failing the target or are unstable ('Hit & Miss') and showing Special Cause for Concern by CQC Domain are as follows:

Safe: Safe Staffing Levels

Caring: None

Effective: OP Utilisation, Outpatient DNA Rate

Responsive: RTT performance, RTT > 40 weeks, RTT > 52 weeks, Size of Cancer 62 day backlog

Well-Led: Use of Agency, Agency Spend, Capital Expenditure, Elective Spells in London Trusts from West Kent, Vacancy Rates

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

Trust Domains	Variation					Assurance				Total
						P	F	?	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	***9***	***1***	***0***	***1***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	4	1	1		1		4	3		7
Quality & CQC	3				1			4		4
Strategy - Estates									5	5
Effective Total	***7***	***1***	***1***	***0***	***2***	***0***	***4***	***7***	***5***	***16***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	3				1	2		2		4
ED Care	1				1			2		2
Maternity Care	2							2		2
Outpatient Care	1							1		1
Caring Total	***9***	***0***	***0***	***0***	***2***	***2***	***0***	***9***	***0***	***11***
CQC Domain Responsive										
Elective Access	2	1	2				3	2		5
Acute and Urgent Access	4							4	1	5
Cancer Access	3			1		2	1	1	1	5
Diagnostics Access	1							1		1
Bed Management	1							1		1
Responsive Total	***11***	***1***	***2***	***1***	***0***	***2***	***4***	***9***	***2***	***17***
CQC Domain Well-Led										
Staff Welfare	2							2	4	6
Finance and Contracts			2		1		1	2	3	6
Leadership	1				2			2	1	3
Strategy - Clinical and ICC	1			4	2		1	6	1	8
Workforce	3		2		1	1	2	3		6
Well-Led Total	***7***	***0***	***4***	***4***	***6***	***1***	***4***	***15***	***9***	***29***
Trust Total	***43***	***3***	***7***	***6***	***10***	***6***	***12***	***50***	***16***	***84***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	6		
S6	Rate of Total Patient Falls	5.80	5.95		
S7	Number of Never Events	0	0		
S8	Number of New SIs in month	11	7		
S10	Overall Safe staffing fill rate	93.5%	84.2%	L	

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	85.3%	96.6%		
R4	RTT Incomplete Pathway	86.7%	61.7%	L	F
R6	% Diagnostics Tests WTimes <6wks	99.0%	89.0%		
R7	Cancer two week wait	93.0%	97.4%		P
R10	Cancer 62 day wait - First Definitive	85.0%	86.8%		P

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	89.6		P
E3	% Total Readmissions	14.6%	16.6%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	68.0%	H	
R11	Average LOS Non-Elective	6.40	6.38		
R12	Theatre Utilisation	90.0%	85.5%		

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	- 5,896	- 566	No SPC	No SPC
W2	CIP Savings	Suspended due to COVID-19		No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	6.8%	H	
W8	Total Agency Spend	1,668	1,903	H	F
W10	Sickness Absence	3.3%	3.7%		

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%	61.1%		
C5	IP Friends & Family (FFT) % Positive	95.0%	96.1%	H	
C7	A&E Friends & Family (FFT) % Positive	87.0%	97.7%	H	
C10	OP Friends & Family (FFT) % Positive	84.0%	84.1%		

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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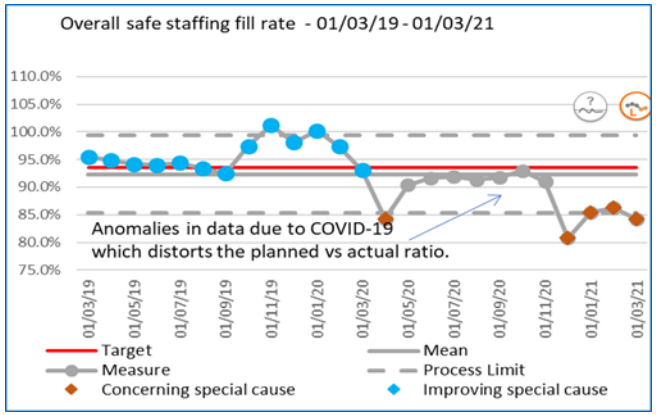
Safe - CQC Domain Scorecard

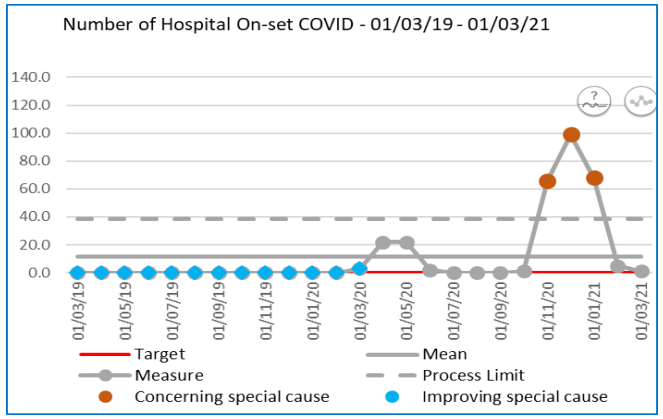
Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	84.2%	Mar-21		93.5%	86.2%	Feb-21	93.5%	88.4%	
Sickness Rate - Covid	0.0%	0.7%	Feb-21		0.0%	2.9%	Jan-21	0.0%	1.2%	
Infection Control - Hospital Acquired Covid	0	1	Mar-21		0	5	Feb-21	0	286	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	23.2	37.6	Mar-21		23.2	19.7	Feb-21	22.6	27.4	
Infection Control - Number of Hospital acquired MRSA	0	0	Mar-21		0	0	Feb-21	0	3	
Infection Control - Rate of Hospital E. Coli Bacteraemia	19.0	25.1	Mar-21		19.0	26.3	Feb-21	30.8	28.0	
Number of New SIs in month	11.0	5.0	Mar-21		11	3	Feb-21	132	122	
Rate of Total Patient Falls per 1,000 occupied beddays	5.8	6.0	Mar-21		5.8	7.1	Feb-21	5.8	7.8	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	2.6	Mar-21		2.3	2.8	Feb-21	2.3	2.4	
Standardised Mortality HSMR	100.0	89.6	Mar-21		100.0	85.1	Feb-21	100.0	89.6	
Never Events	0	0	Mar-21		0	0	Feb-21	0	2	

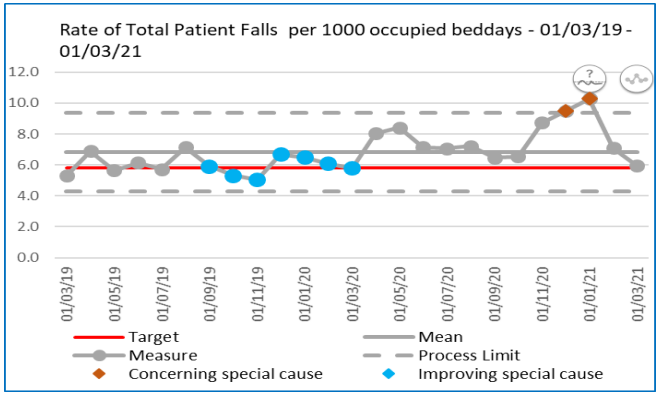
Safe - Reset and Recovery Programme: Patient and Staff Safety



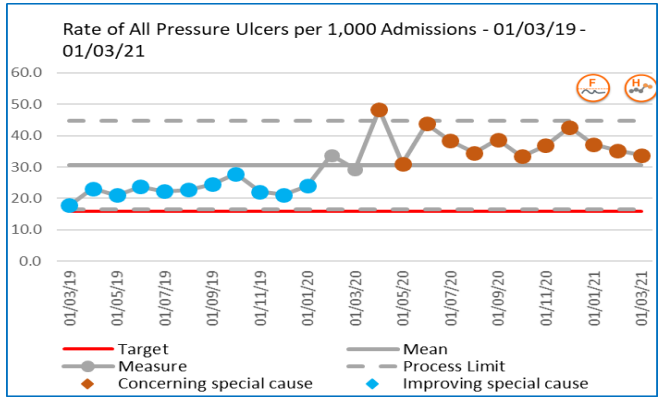
March-21
84.2%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
93.5%
Target Achievement
Metric is experiencing variable achievement



March-21
1
Variance Type
Metric is currently experiencing common cause Variation
Max Target (Internal)
0
Target Achievement
Metric is experiencing variable achievement



March-21
6.0
Variance Type
Metric is currently experiencing common cause Variation
Max Target
5.8
Target Achievement
Metric is experiencing variable achievement



March-21
33.8
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
16.0
Target Achievement
Metric is currently not achieving the target

Summary:

The level of **Hospital On-set COVID** continues to decrease from the high level seen in wave 2 of Covid and is now back within common cause variation.

Safe Staffing Fill Rate: The level reported remains below usual levels and is now in 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 and the increasing BAU activity which has distorted the planned vs actual ratio in addition to roster management of staff redeployment.

Falls: The number of Falls continues to reduce significantly across both sites and the overall rate for the Trust is now in now within common cause variation.

Pressure Ulcers: The rate of all pressure ulcers is experiencing special cause variation of a concerning nature and is not achieving the target. Hospital Acquired Pressure Ulcers continues to be within common cause variation.

Actions:

The Trust admitted 11 patients with Covid-19 infection during March, including 1 case of probable or definite hospital acquired infection (9% of the total).. No outbreaks of Covid-19 were identified during March. Assurance of compliance continues through the IPC BAF. Focus on reminding staff to continue with lateral flow testing and appropriate registering of results

Regular staffing huddles continue which review prospectively the nursing staff rosters to enable planning and action which seeks 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. Bank team members continue to engage with Matrons at the daily afternoon huddle to update on fil rate, key areas to focus on and deployment of staffing from the established Rapid response unit.

We continue to monitor falls rate monthly across the trust and on individual wards. Deep dive presentation on Falls in conjunction with Hospital Acquired Pressure Ulcers is being presented to Quality Committee on 14th April.

We are in the process of organising a 'Deep Dive' presentation in conjunction with the Falls practitioner to be presented at the Quality committee in April. We are looking to see if the patients admitted with COVID presented with increased rates of falls and pressure ulcers whilst they were inpatients

Assurance:

Patients and visitors wear masks and are encouraged to undertake hand hygiene regularly. Lateral flow testing available for all staff. Rapid testing available in ED on both sites. PCR tests available for pregnant women and their partners attending for scans

Regular staffing huddles with divisional leads and staff bank are ongoing to review substantive and temporary staffing requirements across all areas. The Trust launch of "Safe Care" to enhance the monitoring and oversight of patients acuity more effectively and support decisions around staffing requirements has now re started with increase areas going live and at implementation stage. Training has been shared with DDNQ's and the project plan has mapped areas for safe care implementation across the organisation. All staffing levels are reviewed for every shift, 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.

We have updated terminology to fall in line with National guidance and will refer to 'Community Acquired' pressure ulcers as 'Inherited' pressure ulcers from 1st April 2021. The Pressure Ulcer group have discussed learnings from recent incidents to ensure that they are shared across Directorates. We have provided the Governance gazette with Pressure Ulcer information for the next newsletter, to enable learnings to be shared with all Professional groups.

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	40.0%	40.8%	Mar-21	H	40.0%	45.0%	Feb-21	40.0%	46.4%	F
OP Utilisation	85.0%	48.7%	Mar-21	L	85.0%	44.5%	Feb-21	85.0%	49.2%	F
Outpatient DNA Rate	5.0%	6.8%	Mar-21	H	5.0%	5.8%	Feb-21	5.0%	5.8%	?
Outpatient Hospital Cancellation	20.0%	21.0%	Mar-21		20.0%	29.9%	Feb-21	20.0%	29.0%	?
Outpatient Cancellations < 6 weeks	10.0%	16.6%	Mar-21		10.0%	25.3%	Mar-21	10.0%	22.4%	?
Calls Answereed in under 1 min	75.0%	50.1%	Mar-21		75.0%	62.8%	Mar-21	75.0%	42.7%	F
Calls Answereed in under 3 min	100.0%	70.1%	Mar-21		100.0%	82.6%	Mar-21	100.0%	66.5%	F

Organisational Objectives: Quality and CQC

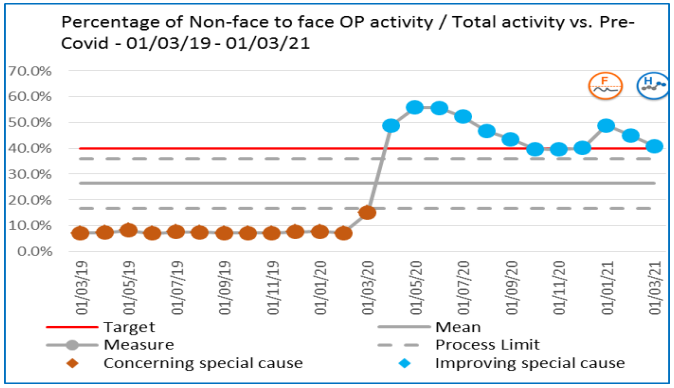
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	16.6%	Feb-21		14.6%	15.3%	Jan-21	14.6%	15.1%	?
Non-Elective Readmissions <30 days	15.2%	16.7%	Feb-21		15.2%	15.3%	Jan-21	15.2%	15.3%	?
Elective Readmissions < 30 Days	7.8%	13.9%	Feb-21		7.8%	16.0%	Jan-21	7.8%	9.8%	?
Stroke Best Practice Tariff	50.0%	63.9%	Mar-21	H	50.0%	65.0%	Feb-21	50.0%	58.4%	?

Effective - CQC Domain Scorecard

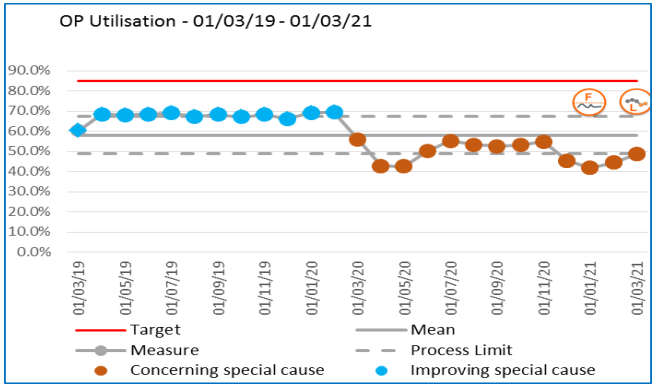
Organisational Objectives: Strategy - Estates

	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	Mar-21	No SPC	Under review	100:0	Feb-21	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Mar-21	No SPC	Under review	4.4:1	Feb-21	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Mar-21	No SPC	Under review	5808	Feb-21	Under review	5808	No SPC
Staff occupancy per m2	Under review	22.7	Mar-21	No SPC	Under review	22.6	Feb-21	Under review	23.3	No SPC
Energy cost per staff	Under review	£ 979.80	Mar-21	No SPC	Under review	£ 963.07	Feb-21	Under review	£ 814.5	No SPC

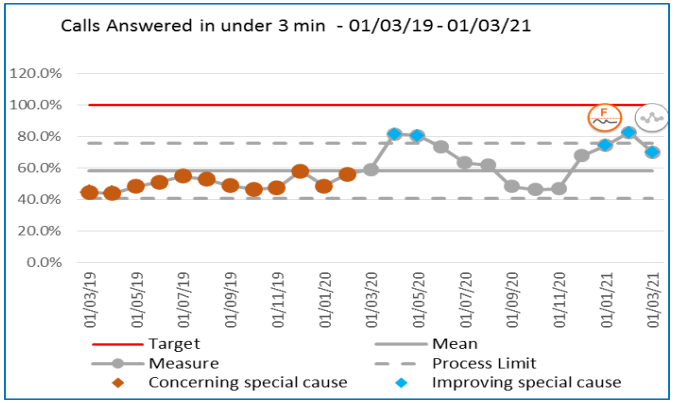
EFFECTIVE- Reset and Recovery Programme: Outpatients



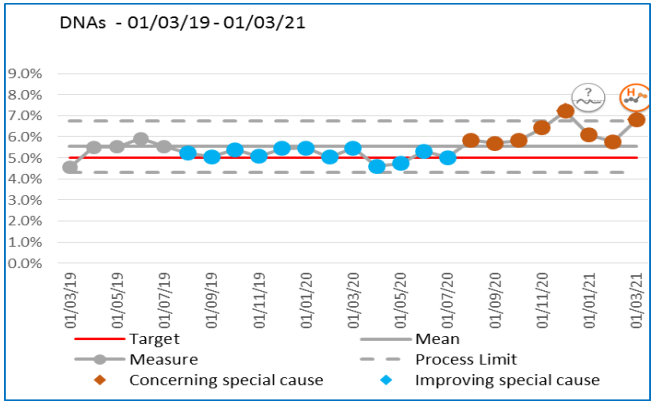
Mar-21
40.8%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
40%
Target Achievement
Metric is consistently failing the target



Mar-21
48.7%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target



Mar- 21
70.1%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
100%
Target Achievement
Metric is consistently failing the target



Mar-21
6.8%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

Summary:

The percentage of non-face to face OP Activity continues to experience special cause variation of an improving nature.

The number of calls answered in less than 3 minutes and less than 1 minute are both experiencing common cause variation but are consistently failing the 100% target.

As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased and remain lower than usual levels.
DNA rates are now experiencing special cause variation of a concerning nature and variable achievement of the target.

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. This includes viewing the clinic templates to ensure that utilisation is a true reflection.

Appointments are being reassessed as to what can be converted and cancelled due to the second wave. Activity is currently being assessed now we are in Opel 3 to see what clinics can start up again. Activity is beginning to restart so should see an increase in volume of activity and reduction in cancellations.

Assurance:

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

The clinic templates that are on Allscripts are in the process of being reviewed, which includes removing any old templates and correcting any templates that could be affecting the utilisation figures.

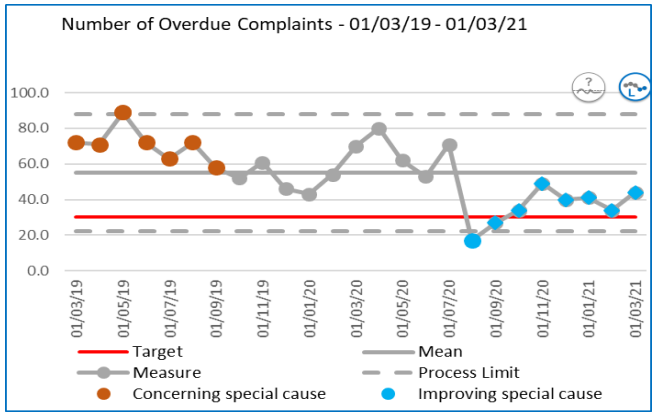
A netcall T&O review is underway which will then move to ENT and Ophthalmology to discover how to improve our call response time and improve the overall patient experience.

Caring - CQC Domain Scorecard

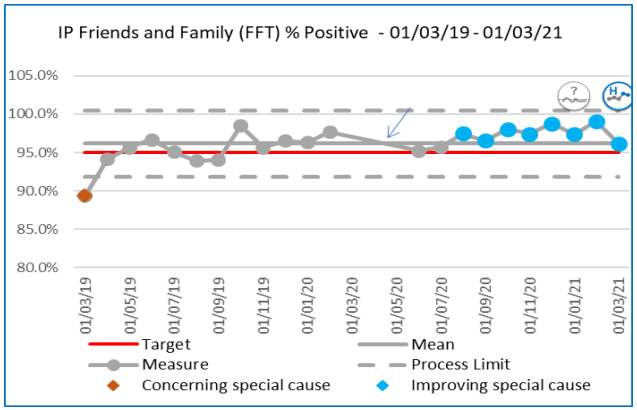
Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	Mar-21		0	0	Feb-21	0	0	P
Rate of New Complaints	3.9	2.6	Mar-21		3.9	1.8	Feb-21	3.0	2.2	?
% complaints responded to within target	75%	61.1%	Mar-21		75%	87.5%	Feb-21	75%	76.8%	?
IP Resp Rate Recmd to Friends & Family	25%	14.0%	Mar-21		25%	10.0%	Feb-21	25%	12.0%	?
IP Friends & Family (FFT) % Positive	95%	96.1%	Mar-21	H	95%	99.1%	Feb-21	95%	97.1%	?
A&E Resp Rate Recmd to Friends & Family	15%	2%	Mar-21		15%	No data due to COVID-19	Feb-21	15%	No data due to COVID-19	?
A&E Friends & Family (FFT) % Positive	87%	98%	Mar-21	H	87%		Feb-21	87%		?
Mat Resp Rate Recmd to Friends & Family	25%	5.2%	Mar-21		25%	2.7%	Feb-21	25%	20.7%	?
Maternity Combined FFT % Positive	95%	96.2%	Mar-21		95%	91.7%	Feb-21	95%	99.1%	?
OP Friends & Family (FFT) % Positive	84%	84.1%	Mar-21		84%	85.2%	Feb-21	84%	83.0%	?
% VTE Risk Assessment	95%	96.5%	Mar-21		95%	95.7%	Feb-21	95%	96.6%	P

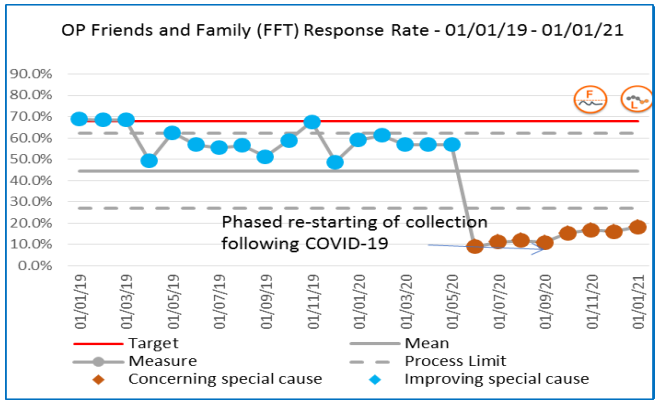
CARING- Organisational Objective: Quality and CQC



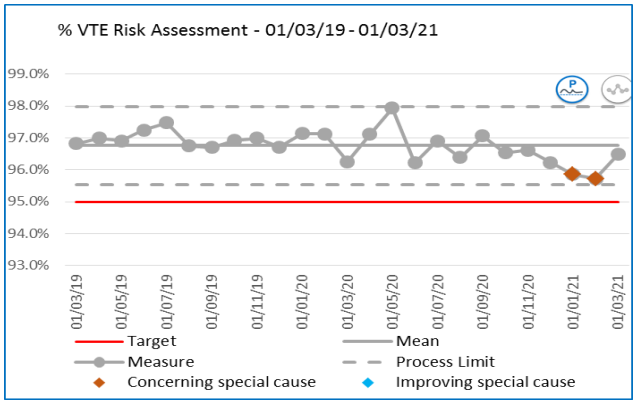
Mar-21
44
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Target (Internal)
60
Target Achievement
Metric is experiencing variable achievement



Mar-21
96.1%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
95%
Target Achievement
Metric is experiencing variable achievement



Mar-21
17.1%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
68%
Target Achievement
Metric is consistently failing the target



Mar-21
96.5%
Variance Type
Metric is currently experiencing common cause variation
Target (National)
95%
Target Achievement
Metric is consistently achieving the target

Summary:

Complaints: The number and rate of new complaints received continues to remain consistent experiencing common cause variation. However performance for the number of overdue complaints are once again experiencing special cause variation of an improving nature . The Trust achieved the 75% target for complaints responded to within target for the year at 76.8%.

Outpatient Friends and Family Response Rate continues to experience special cause variation of a concerning nature.

Inpatient Friends and Family % Positive Rate is now experiencing special cause variation of an improving nature

VTE Risk Assessment is now experiencing common cause variation and consistently achieving the target (following the data input issues being resolved).

Actions:

Complaints: Regular meetings with key divisional staff reinstated to monitor progress on open complaints. New format weekly reports issued with particular emphasis on overdue cases.

Realignment of complaints leads' portfolios to address fluctuations in activity between divisions. – under ongoing review.

OP FFT: OP Matron working with OPT & PE team to increase use of surveys / responses. IPADS purchased and VCA survey to be reconfigured with service leads post pandemic

FFT: Re-engaged with clinical leads , FFT dedicated meetings now re established with a move to reporting by exception. Global communications to all areas highlighting key areas of focus; card collection points, online survey availability. FFT action driver hierarchy to be sent for action to IQVIA

VTE: Delays in data input due to the wards been under considerable pressure through December and January had impacted the performance reported, however these issues have now been resolved and performance is back to consistently achieving the target.

Assurance:

Complaints: Continued regular monitoring of all open complaints with reports to CN. Learning and key messages published in the Governance Gazette.

Continued compliance despite operational challenges and no significant reductions in complaint activity.

OP FFT: continual engagement with heads of service / PE team

FFT: Monthly FFT meeting recommencing end of March to engage with leads and identify key issues for escalation. The action driver functionality to be complete by end of April 2021. FFT Oversight for FFT actions / issues to be provided by Patient Public Engagement Experience working group.

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) performance against trajectory	86.7%	61.7%	Mar-21	L	86.7%	65.3%	Feb-21	86.7%	61.7%	F
Number of patients waiting over 40 weeks	0	1204	Mar-21	H	0	1628	Feb-21	0	18253	F
52 week breaches (new in month)	0	315	Mar-21	H	0	413	Feb-21	0	2236	F
Access to Diagnostics (<6weeks standard)	99.0%	89.0%	Mar-21		99.0%	84.4%	Feb-21	99.0%	89.0%	?
Average for new appointment	10.0	8.9	Mar-21		10.0	7.7	Feb-21	10.0	8.9	?
Theatre Utilisation	90.0%	85.5%	Mar-21		90.0%	84.5%	Feb-21	90.0%	82.4%	?

Reset and Recovery Programme – Acute & Urgent Care

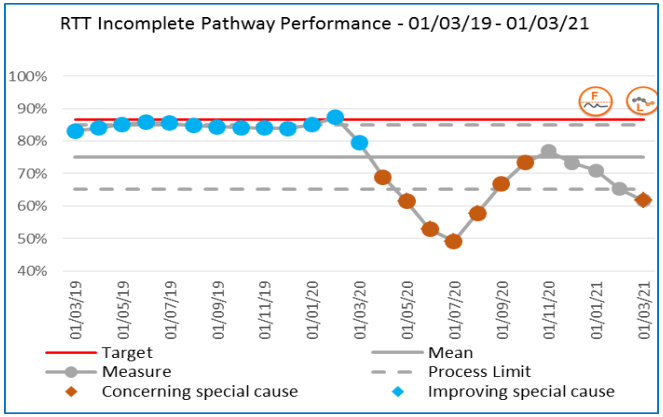
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referrals to ED from NHS 111	Coming April 21		Mar-21	No SPC	Coming April 21		Feb-21	Coming April 21		No SPC
A&E 4 hr Performance	85.3%	96.5%	Mar-21		85.3%	96.0%	Feb-21	85.3%	94.7%	?
Super Stranded Patients	80	61	Mar-21		80	82	Feb-21	80	61	?
Ambulance Handover Delays Rate > 30mins	7.0%	4.6%	Mar-21		7.0%	4.9%	Feb-21	7.0%	4.6%	?
Bed Occupancy	90.0%	82.6%	Mar-21		90.0%	87.8%	Feb-21	90.0%	66.1%	?
NE LOS	6.4	6.4	Mar-21		6.4	6.6	Feb-21	6.4	6.2	?

Responsive - CQC Domain Scorecard

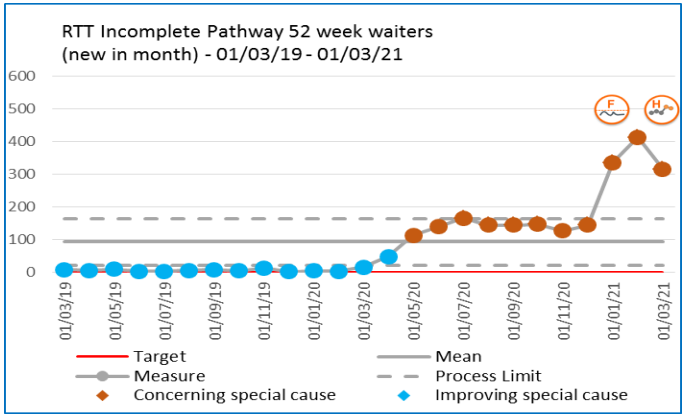
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Cancer - 2 Week Wait	93.0%	97.4%	Feb-21		93.0%	97.4%	Jan-21	93.0%	97.4%	P
Cancer - 31 Day	96.0%	94.9%	Feb-21		96.0%	94.9%	Jan-21	96.0%	94.9%	?
Cancer - 62 Day	85.0%	86.8%	Feb-21		85.0%	86.8%	Jan-21	85.0%	86.8%	P
Size of backlog	30	66	Mar-21	L	30	66	Feb-21	30	66	F
28 day Target	Coming Soon		Feb-21	No SPC	Coming Soon		Jan-21	Coming Soon		No SPC

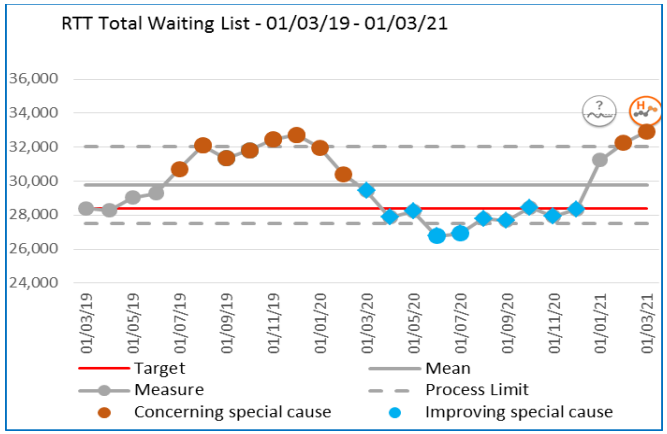
RESPONSIVE- Reset and Recovery Programme: Elective



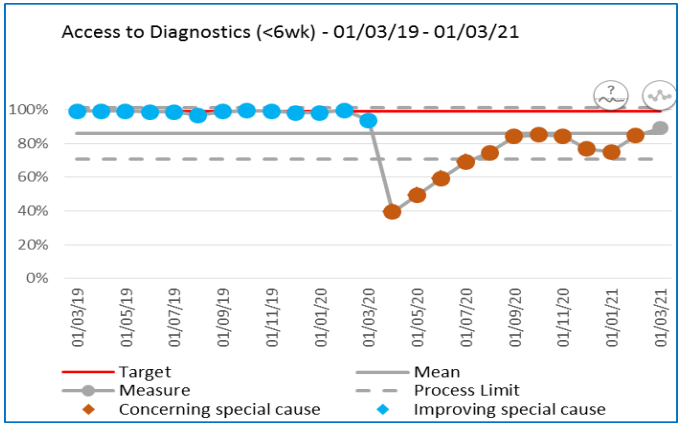
Mar-21
61.7%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
86.3%
Target Achievement
Metric consistently failing the target



Mar-21
315
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



Mar-21
32,918
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
28,412
Target Achievement
Metric is experiencing variable achievement



Mar-21
89.0%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

Due to the COVID-19 pandemic & the impact of wave 2 the YTD activity remains low for both elective & outpatient appointments which have adversely impacted the RTT performance. The March performance has dropped to 59.7% & the Total Waiting List has increased this month due to the closure of theatres & the cancellation of routine elective activity in previous months.

Large scale cancellations of elective activity throughout the year has resulted in admitted electives & daycases reducing by 42% compared to normal levels YTD, New Outpatient activity has reduced by around 26% & follow up activity by around 7% YTD compared to normal activity levels.

Following the decrease in performance for diagnostic waiting times once again during the second wave relating to Ultrasound, DEXA and ECHO's. performance is showing signs of recovery with an increase in March and is now back to experiencing common cause variation.

Actions:

Demand and capacity for all specialities has been reviewed in order to reset the recovery plan for elective care.

All theatres re-opened on 6th April.

Robust monitoring of patients in order to maximise clinic & theatre time & increase productivity.

To increase capacity & improve the waiting times of Utrasounds, DEXA & ECHO's.

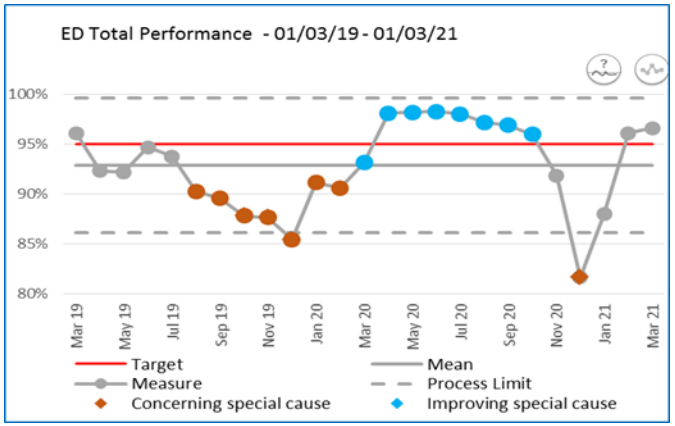
Assurance:

6-4-2 meetings are in progress, pre-operative assessment capacity has been increased to ensure patients are prepared for surgery in a timely manner. Collaborative working with the Independent Sector continues.

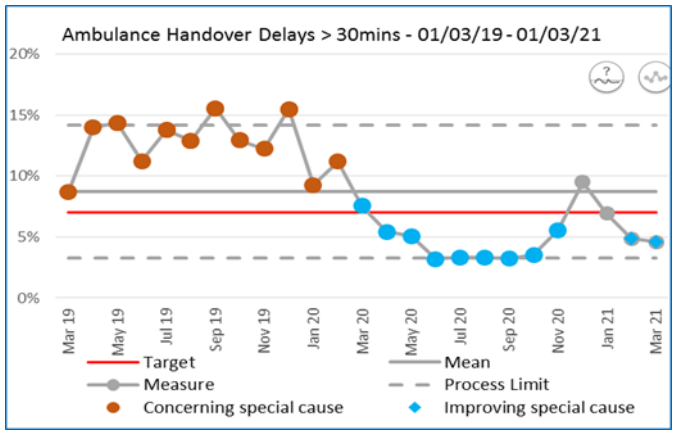
Clinical Prioritisation of waiting lists continues in line with national recommendations. Long waiting patients are in the process of being treated or are being scheduled for treatment.

The below plan are in place to aid with recovering activity;
Ultrasound – issue with AQP patients. Improvement plan in place with the CCG.
DEXA – capacity issues, outsourcing to Darent Valley Hospital
ECHO's – capacity issues, cardiology devising a recovery plan.

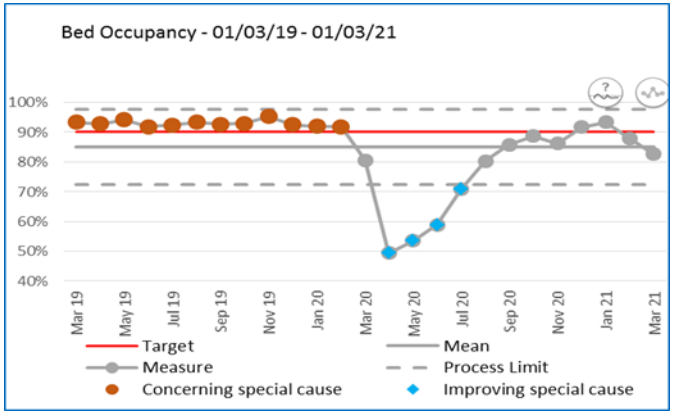
Responsive - Reset and Recovery Programme: Emergency Care



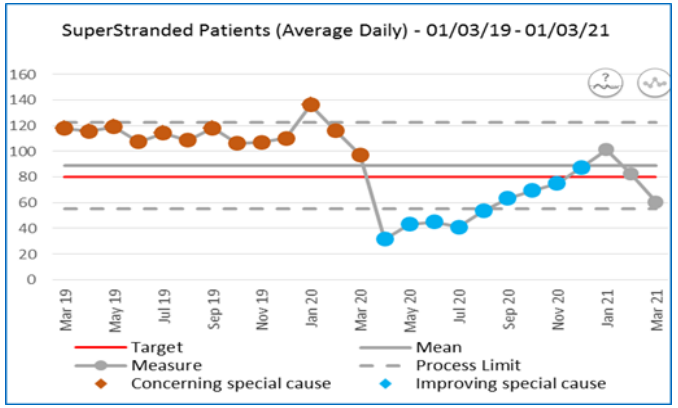
Mar-21
96.6%
Variance Type
Metric is currently experiencing common Cause Variation
Target
95%
Target Achievement
Metric is experiencing variable achievement



Mar-21
4.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
7.0%
Target Achievement
Metric is experiencing variable achievement



Mar-21
82.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



Mar-21
60.7
Variance Type
Metric is currently experiencing Special Cause Variation
Max Limit (Internal)
80
Target Achievement
Metric is experiencing variable achievement

Summary:

ED 4hr performance (inc MIU): Following the downward trend seen during the height of the second wave recovery continues and is still experiencing common cause variation (96.6% in March). The Trust achieved 94.7% for the year against the 95% target. Arrivals (Type 1) were 17.4% below model in March.

Ambulance delays had settled into 3.0-3.5%, but increased during the height of the second wave due to diverts for mutual aid and Covid. This is now starting to recover and is back to experiencing common cause variation (4.6% in March).

Total bed occupancy continues to recover and is now experiencing common cause variation.

Superstranded patients had been showing a steady increase over the last seven months but is now once again experiencing common cause variation, with reductions over the last 2 months.

Actions:

Flow Coordinators appointed across both sites. Developing cross-site rota plus appropriate competencies.

Development of 11/UTC in progress to extend service. Discussion with IC24 to increase referrals from ED to IC24 from April 21. IC24 contract extended by 1 year by CCG

Power BI report in development with four main KPIs to give daily info on key KPI's. Shadowing of new ED clinical standards from April 21 although no targets currently set.

4 WTE ED Consultant posts with interview date in March to support RAP

Development of improved handover times to reduce number of over 30 mins handovers in preparation for targets/winter.

Assurance:

Directorate/ Divisional meetings to review figures, with appropriate escalation.

CQC Focus Group Re-instated with Clinical Leads

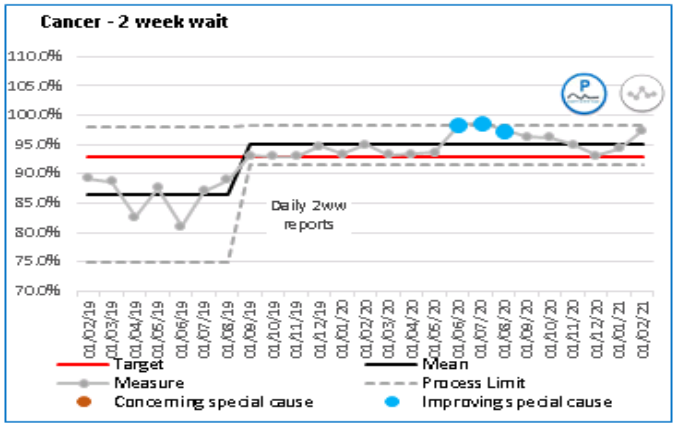
What's App groups in place to promote improved communications with larger team, giving daily performance updates.

Twice weekly meetings with Site Clinical Leads to ensure adequate junior ward/ on call cover for Medicine with Rota Team.

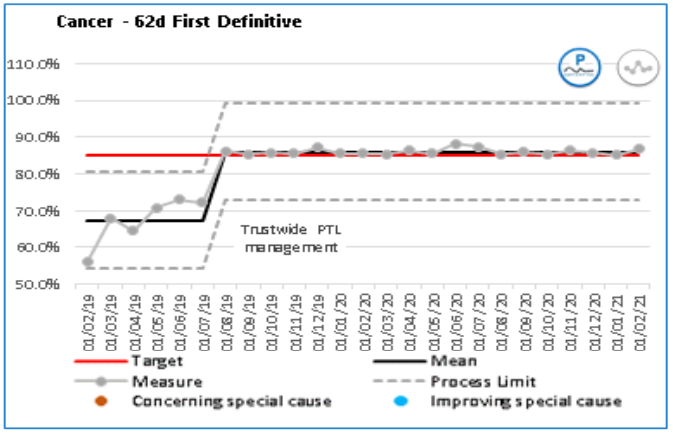
Good working relationship with SECAmb.

Visit from Director of OPs East Kent week commencing 15th March to share processes.

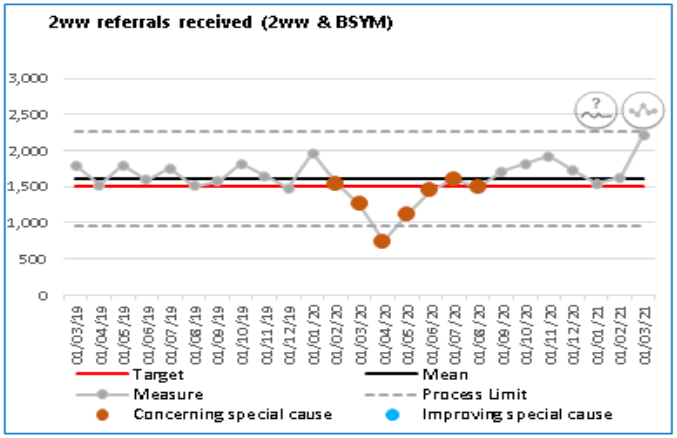
RESPONSIVE- Reset and Recovery Programme: Cancer



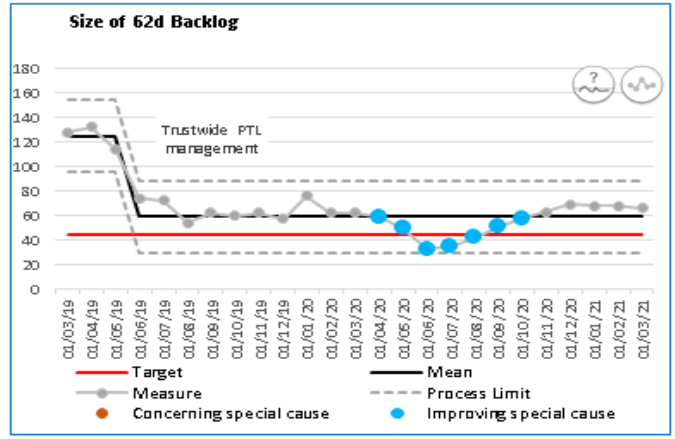
Feb-21
97.4%
Variance Type
Process change Sept 2019 now showing common cause variation
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Feb-21
86.8%
Variance Type
Process change Aug 2019 now showing common cause variation
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Mar-21
2220
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target
1500
Target Achievement
Metric is experiencing variable achievement of locally set target



Mar-21
66
Variance Type
After improvement in process from June 2019 – metric is experiencing common cause variation
Max Target (Internal)
45
Target Achievement
Metric is experiencing variable achievement of locally set target

Summary:

The 2ww standard continues to achieve the 93% target, reporting a current mean of 94.8% which is significantly improved from the previous mean of 86.7% to September 2019. The Trust has continued achievement of the 62 day standard and is reporting a current mean of 86.1% (above the 85% target) which is an improvement from the previous mean of 66.7% reported up to August 2019. The 2ww referral numbers have returned to previous numbers with 2220 referrals received in March 2021 – this remains within expected variation. The backlog on the 62d PTL is being consistently managed within expected variation limits

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.

Cancer Covid pathways have been reviewed to ensure the implementation of national guidance and the continuation of effective and efficient cancer diagnostics and treatments

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 pathway reviews.

28 day FDS meetings have been reinstated in preparation for national monitoring of this target.

Paper to executive team to highlight any changes and key information across each of the cancer pathways.

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	909	Jan-21	No SPC	Improving Quarterly	688	Sep-20	Improving Quarterly	688	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		69.0%	Jan-21	No SPC		67.0%	Sep-20		67.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		71.0%	Jan-21	No SPC		68.0%	Sep-20		68.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		69.0%	Jan-21	No SPC		69.0%	Sep-20		69.0%	No SPC
Health and Wellbeing: How many calls received	40	41	Feb-21		40	30	Jan-21	480	375	
Health and Wellbeing: What percentage of Calls related to Mental Health Issues	44%	36%	Feb-21		44%	33%	Jan-21	44%	50%	

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	3.7%	Feb-21		3.3%	6.8%	Jan-21	3.3%	4.6%	
Turnover	10.0%	11.4%	Mar-21		10.0%	11.4%	Feb-21	10.0%	11.4%	F
Vacancy Rates	9.0%	14.8%	Mar-21	H	9.0%	5.6%	Feb-21	9.0%	14.8%	
Use of Agency	81	314	Mar-21	H	81	296	Feb-21	81	314	F
Appraisal Completeness	95.0%	91.0%	Mar-21		95.0%	90.8%	Feb-21	95.0%	91.0%	
Stat and Mandatory Training	85.0%	89.9%	Mar-21	H	85.0%	89.7%	Feb-21	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	- 5,896	- 566	Mar-21	No SPC	- 5,896	- 798	Feb-21	- 5,000	330	No SPC
CIP Savings	Suspended		Mar-21	No SPC	Suspended		Feb-21	Suspended		No SPC
Cash Balance	1,000	26,221	Mar-21	H	1,000	69,560	Feb-21	37,452	69,560	?
Capital Expenditure	1,329	18,922	Mar-21	H	1,329	1,888	Feb-21	17,100	14,419	?
Agency Spend	1,667,793	1,902,818	Mar-21	H	1,667,793	2,046,320	Feb-21	14,939,824	18,487,454	F
Use of Financial Resources	3	No data	Mar-21	No SPC	3	No data	Feb-21	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%	7.1%	Mar-21	L	13.5%	-0.3%	Feb-21	13.5%	0.0%	?
Covid Positive - number of patients	0	11	Mar-21	L	0	130	Feb-21	0	2145	?

Well Led - CQC Domain Scorecard

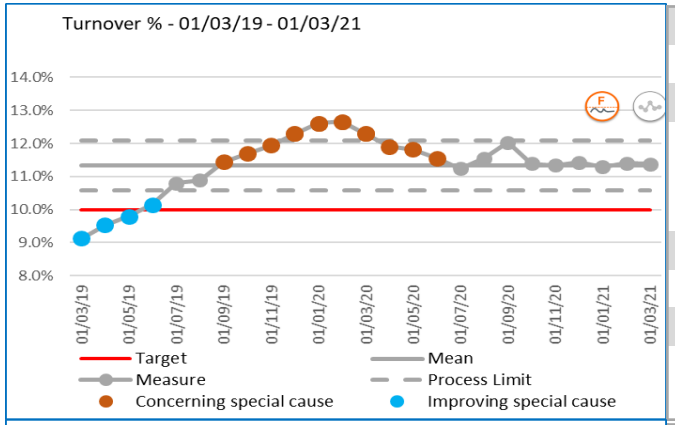
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Mar-21	L	35	30	Feb-21	35	360	?
Elective Spells in London Trusts from West Kent	329	300	Dec-20	L	329	257	Nov-20	329	3,532	?
Service contribution by division	Coming April 21		Mar-21	No SPC	Coming April 21		Feb-21	Coming April 21		No SPC
Research grants (£)	114	76	Mar-21		114	157	Feb-21	114	1,262	?
Number of advanced practitioners	25	31	Mar-21	H	25	31	Feb-21	25	31	?
Percentage of Trust policies within review date	90.0%	77.3%	Mar-21	H	90.0%	76.4%	Feb-21	90.0%	77.3%	F

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	70.0%	71.3%	Mar-21	H	70.0%	71.3%	Feb-21	70.0%	71.3%	?
Staff Friends and Family % recommended care	80.0%	81.4%	Mar-21	H	80.0%	81.4%	Feb-21	80.0%	80.0%	?
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming April 21		Mar-21	No SPC	Coming April 21		Feb-21	Coming April 21		No SPC

WELL LED- Operational Objective: Workforce

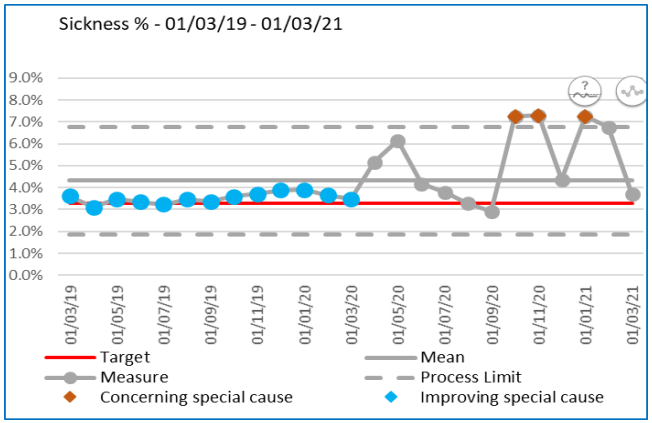


March-21
11.4%

Variance Type
Metric is currently experiencing Common Cause Variation

Max Target (Internal)
10%

Target Achievement
Metric is consistently failing the target

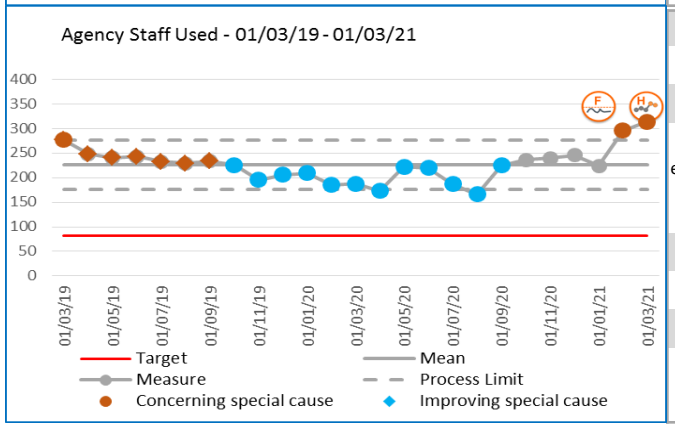


March-21
3.7%
(One Month Behind)

Variance Type
Metric is currently experiencing Common Cause Variation

Max Target (Internal)
3.3%

Target Achievement
Metric is experiencing variable achievement

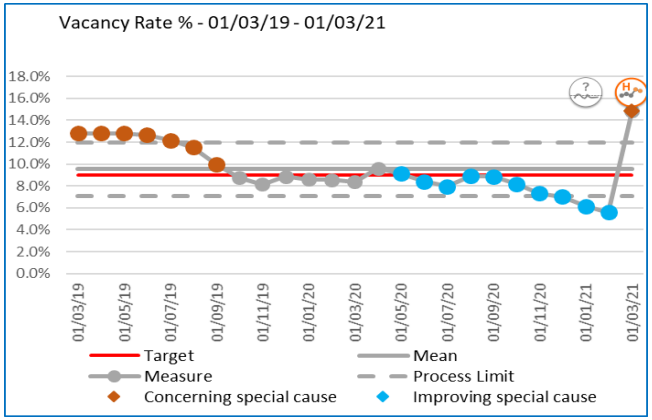


March-21
314

Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature

Target (Internal)
81

Target Achievement
Metric is consistently failing the target



March-21
14.8%

Variance Type
Metric is currently experiencing Special Cause Variation of an concerning nature

Max Limit (Internal)
9.0%

Target Achievement
Metric is experiencing variable achievement

Summary:

The Turnover rate for the last 12 months is once more within common cause variation but continues to consistently fail the target.
The level of Sickness greatly decreased in February compared to January (data reported one month behind) to 3.7% (of which 0.7% was COVID related sickness) . This is a drop on the previous month and is now within common cause variation as we head out of wave 2 of Covid-19. The overall sickness level for 2020/21 is 4.6%, an understandable increase from the previous year (3.4%). Covid related sickness for 2020/21 is 1.2%

The level of Agency staff used has shown a considerable increase and is its highest in the last 2 years. It is showing a special cause variation of a concerning nature.

There has been a large increase in the vacancy rate and WTE reported in this month's data – this is as a reflection of using the 2021/22 core establishment figures which account for agreed investment across the Trust moving forward. With this use of core establishment, vacancy rate is now experiencing special cause variation of a concerning nature.

Actions:

Sickness – we continue to monitor the impact on staffing levels. Sickness levels continue to reduce from 6.75% in February to 3.7% in March.
The Workforce (People) Function has 4 areas of focus: Temporary Staffing (Staff Hub) Recruitment, Vaccinations and Staff Welfare. We have completed the last Climate survey in February and preparing action plans to act on the results 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 continued to see a significant increase in temporary Nursing staff demand throughout March. Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff to bank. Additional demand has been created in the form of nursing units to fill gaps in critical areas, and financial incentives applied to these units which has increased the fill. A further update will be provided in the next IPR.

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 continue to work on various initiatives to fill vacancies, and have worked closely with Nursing leads to devise nursing workforce plans and scheduling. There are 103 international nurses in the pipeline, 49 of which will commence during April and May. 8 overseas nursing are currently in quarantine accommodation and due to commence on 26th April. The team have worked in partnership with NHSE/I in relation to CSW recruitment. A target was set for 70 WTE CSW's to be in post by the end of March, and 68 were successfully in post by that date, with a further 11 in the pipeline. The team are also working closely with Theatres / ITU to fill their 33 WTE Band 5 vacancy hotspot.
The Trust have developed a Staffing Hub and the bank team continue to work closely with the site team and matrons to find solutions to reduce agency spend. Due to the impact of Covid-19 we have continued to pay enhanced rates for bank staff filling certain shifts to mitigate staff shortages in critical areas. In addition, a temporary uplift in agency rates has been agreed to help fill the gaps in these areas and provide consistent cover, however, as this is removed it is anticipated that agency usage will return to lower levels.

NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

Supporting Narrative

Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, reporting 86.8% and 97.4% respectively. A&E 4hr performance has started to improve over the last few months and continues to experience common cause variation at 96.6% in March with a full-year performance of 94.7% (just below the 95% target). RTT performance decreased further in March. However as ITU demand has decreased theatres have been re-opening in a phased plan to commence recovering activity. Cancer and Clinically urgent activity is being maintained, however non-cancer and routine activity has now commenced both internally and in the Independent Sector. Early indications are that activity (and RTT performance) has started to recover in April with all internal theatres fully re-opened on 6th April 2021. Demand and capacity analysis has been undertaken for all specialities in order to reset the recovery plan for elective care. Some of the patient safety and quality indicators are showing signs of improvement as bed occupancy and staffing issues start to reduce.

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 achieved the trajectory for C.Difficile for the year. The Trust admitted 10 patients with Covid-19 infection during March, including 1 case of probable or definite hospital acquired infection (10% of the total). Though this is an increase on the rate in February, the volumes are very small. No outbreaks of Covid-19 were identified during March. Assurance of compliance continues through the IPC BAF. Focus on reminding staff to continue with lateral flow testing and appropriate registering of results

- **Falls:** The number of Falls has decreased across both sites, particularly in the Medical and Care of the Elderly specialties. The overall rate is now once again experiencing common cause variation and variable achievement of the target. The Trust did not achieve the Falls Rate target for the year at 7.8. Three SIs relating to Falls was reported. Falls rate continue to be monitored monthly across the trust and on individual wards. Risk assessment on the increased falls rate was completed and added to risk register with further reviews of actions planned.

- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers continues to decrease and has remains in common cause variation. The higher level of Deep Tissue Injuries (DTIs), particularly in the Medical and Care of the Elderly specialties has returned to previous levels. Total pressure ulcers (including inherited) continues to experience special cause variation of a concerning nature. The Pressure Ulcer group have discussed learnings from recent incidents to ensure that they are shared across Directorates. Pressure Ulcer information has been provided to the Governance gazette for the next newsletter, to enable learnings to be shared with all Professional groups.

- **Incidents and SIs:** The level of SIs reported increased to 7. Of these, 3 relate to Falls, 1 related to VTE, 2 for sub-optimal treatment and 1 related to a diagnostic Incident. The level of incidents reported and the rate of incidents that are severely harmful remains below the maximum limit of 1.23.

- **Stroke:** Three of the four Stroke Indicators, including the overall Best Practice Indicator, are now experiencing special cause variation of an improving nature and variable achievement of the target. All four indicators have achieved the internal targets for three consecutive months as well as overall for the year.

- **A&E 4 hour Standard and Flow:** Following the downward trend seen during the height of the second wave recovery continues and is back to experiencing common cause variation (96.5% in March). The Trust continues to implement the ED improvement action plan to support flow throughout the Trust with Flow Coordinators appointed across both sites. Development of 111/Urgent Treatment Centre (UTC) is in progress to extend the service. A&E Attendances had been fairly steady at around 85% of normal levels but were 17% below model. Emergency admissions have increased in March, driven by SDEC attenders. Total Bed Occupancy had been steadily increasing from pandemic levels to a high in January but is starting to recover and is now experiencing common cause variation. Both Medical Outliers and Super-Stranded Patients are also starting to recover. The A&E Conversion rate is showing an increasing trend due to the decrease in minor injury attendances.

- **Ambulance Handover Delays**: Ambulance delays had settled into 3.0-3.5%, but increased during the height of the second wave due to diverts for mutual aid and Covid. This continues to recover and is back to experiencing common cause variation (4.6% in March).

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** RTT performance decreased further to 61.72%. However, as ITU demand has decreased theatres have been re-opening in a phased plan to commence recovering activity with all internal theatres fully re-opened on 6th April 2021. Non-cancer and routine activity has now commenced. Weekly PTL meetings with patient level detail have re-commenced to ensure patients are treated in chronological order as timely as possible. Further recovery plan is being devised which includes increased use of the Independent Sector. The number of patients waiting >52 weeks has increased further. Long waiting patients are in the process of being treated or are being scheduled for treatment. Diagnostics waiting <6 weeks is starting to recover and is back to common cause variation (89% for March).

- **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 (reporting 86.8% for February 2021). A process step change has been applied to reflect this and this shows a significant improvement, where the calculated mean up to August 2019 was 66.7% and is now 87.9%, consistently above the target of 85%. The updated chart now reports common cause variation as confirmation of a currently stable process. The 62d Backlog remains at 5% of the total PTL.

- **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 (reporting 97.4% for February 2021). The recent 6 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 – utilizing the virtual clinics where possible. A process step change has been applied to this metric, which shows the improved performance increasing from a calculated mean of 86.7% up to September 2019 to 95.0% currently, consistently above the target of 93%.

- **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 some months reporting in excess of 114% over the same period in 2019. Overall the numbers of referrals being processed through the 2ww office has returned to expected numbers and is reporting common cause variation.

- **Finance:** The Trust delivered a surplus of £0.3m in 2020/21 financial year, which was £5.3m favourable to plan. The plan set assumed the annual leave accrual (£5m included within the plan) would be unfunded and cause a financial pressure, however the Trust has received income to match the accrual required (£4.7m). Excluding the impact of the annual leave accrual the Trust was £0.3m favourable to plan. The Trusts key variances to the plan (excluding annual leave accrual) set from October (month 7) are: The main underspends to plan were due to delays in investments associated with Stroke, ITU extension and Recovery and Reset developments (£9.4m) and a net £2.7m rates rebate benefit. These underspends were offset by the following pressures: Reduction in Kent and Medway block payments (£5.3m - to a breakeven position), investments in EPR and IT projects (£1.5m), RTA income expected credit loss adjustment (£1.3m for 2019/20 and prior years), Junior doctor study leave pressure (£0.7m), provision for potential compensation payments from legal claims (£0.6m), and estimate for enhancements not paid for staff who have been shielding or self isolating due to COVID(£0.2m) .

- **Workforce**: The Safe Staffing Nursing Fill Rate has decreased slightly and remains below usual levels which has impacted on the overall fill rate. Regular staffing huddles with divisional leads and staff bank continue 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. The level of Agency staff used has shown a considerable increase and is its highest in the last two years. It is showing special cause variation of a concerning nature. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend. The Turnover rate remains similar and is consistently failing the target. Climate survey data is being used to drive local interventions to aid retention. Following the high sickness levels reported in January (reported one month behind) as expected this has improved in February (3.7%) and has now returned to common cause variation. Of the 3.7% reported 0.7% was COVID related sickness which has greatly improved. The non-Covid related sickness remains at expected levels for this time of year. The level of Stress/Anxiety and Depression related sickness saw an increasing trend at the height of the Covid Waves. The Trust Daily Staff Hub / Cell continued to respond to Covid pressures during February but this is now easing as the number of Covid patients within the Trust is decreasing.

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 a surplus of £0.3m in 2020/21 financial year, which was £5.3m favourable to plan. The plan set assumed the annual leave accrual (£5m included within the plan) would be unfunded and cause a financial pressure, however the Trust has received income to match the accrual required (£4.7m). Excluding the impact of the annual leave accrual the Trust was £0.3m favourable to plan.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £36.1m. Excluding Swabbing and Vaccination centre costs (pass through costs) the level of spend incurred was £0.65m less than the spend in February.
- In line with NHSE/I guidance additional income has been included in the month 12 position to offset additional costs for the following main items: Employers pension increase (£12.8m), Annual leave accrual (£4.7m), PPE national push stock (£7.7m) and Flowers overtime (£0.5m).
- 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 key variances to the plan set from October (month 7) are:
  - The main underspends to the plan were due to delays in investments associated with Stroke, ITU extension and Recovery and Reset developments (£9.4m) and a net £2.7m rates rebate benefit. These underspends were offset by the following pressures:
  - Reduction in Kent and Medway block payments (£5.3m - to a breakeven position), investments in EPR and IT projects (£1.5m), RTA income expected credit loss adjustment (£1.3m for 2019/20 and prior years), Junior doctor study leave pressure (£0.7m), increase in dilapidations (£0.6m) and estimate for enhancements not paid for staff who have been shielding or self-isolating due to COVID(£0.2m) .
- The key current month variances are as follows:
  - Income is £25.9m favourable to plan, this is mainly due to additional £26.8m received to fund additional costs associated with Employers pension increase (£12.8m), PPE push stock (£7.7m), Annual leave accrual (£4.7m), donated assets mainly relating to nationally provided equipment to support COVID response (£1.1m) and Flowers overtime (£0.5m). Excluding this additional income the Trust was £0.9m adverse to plan, over performance within education and training income (£1.5m) was offset by £3m reduction to the Kent and Medway block payment.
  - Pay budgets were £13.1m adverse in March. This is mainly due to £12.8m employers pension increase (offset by additional income). The remaining pressure (£0.3m) is mainly due back dated local clinical excellence award payments (£0.6m higher than estimate). This pressure was partly offset by the annual leave accrual being £0.2m less than planned.
  - Non Pay budgets overspent by £6m in March, £6.2m due to reporting of 12 month spend of national PPE push stock (offset by income) therefore the net in month positon was £0.2m favourable variance. The Trust benefited from a £3.3m rates rebate in the month, this benefit was partly offset by increase in drug spend (£0.6m), increase in expected credit losses for RTA income (£0.9m) and increase in dilapidations (£0.6m).

- The closing cash balance at the end of March 2021 was £26.2m which was higher than the original cash plan of £1m, although this plan balance was revised to £9m carry forward within the last quarter of the year. Included within the £26.2m is an adjustment to the SLA block income to K&M CCG which is expected to be repaid in May, there is also a corresponding NHS creditor balance within the balance sheet. Additionally the Trust has been funded £4.8m from NHSE relating to the annual leave accrual which will be released in cash terms throughout 2021/22. The Trust has also carried forward c£5.4m capital creditors relating to the 2020/21 capital programme where the invoices were received in April instead of March; these will therefore be paid in April once they are approved.
- Within March the Trust paid March's Tax, NI, Pension and the PFI Unitary Payment totalling £14.4m which would normally be paid in April. The Trust also paid c£11.9m in capital payments

as well as Public Dividend Capital (PDC) of £1.2m and capital loans and associated interest of c£0.6m

- The Year-end Capital spend was £33.3m including PFI Lifecycle and donated and granted assets.
- The main areas of spend were £3m for Covid-19 equipment, ICT and estates costs; £2.9m for the ongoing EPR programme; £8.9m relating to ICT schemes, mainly the IVE programme on device replacement (£5.5m) and replacement of network infrastructure (£2.9m). In addition, national programme funding enabled spend on the Think 111 project (£0.5m) and Kent and Medway Care Record development (£0.45m). Expenditure of £2.8m was invested in the Urgent and Emergency Care projects (including the new SAU at TWH); and £2.9m related to Estates backlog, renewal and PFI Lifecycle.
- Equipment replacement schemes included:
  - £1.7m spent on the endoscopy equipment funded from national PDC.
  - £2.2m replacing Linear Accelerator at Canterbury (LA3C)
  - £1.0m replacing major breast screening equipment including the mobile units.
  - £0.9m to update and expand critical care and testing equipment to support Covid-19 treatment
  - £0.7m to renew the Interventional Radiology room at Maidstone Hospital. This project will be completed in 2021/22.
  - £0.6m for a new CT simulator for Radiotherapy patients and £0.2m on a new Pharmacy robot at Maidstone Hospital.
  - £0.7m for Ophthalmology equipment supporting the service transferred from Moorfields Hospital.
  - £1.8m of general Trustwide replacement of overage equipment, mostly clinical.
- The outturn donated spend of £1.4m includes £1.1m of centrally procured equipment loaned to the Trust during the pandemic. DHSC are proposing to transact these donations during 2021/22 to transfer them formally to Providers as donated assets. For 2020/21 Providers were instructed to recognise the assets in final accounts.
- The overall programme of £33.3m was funded by a combination of internally generated funds, additional STP Capital Resource Limit (CRL) where the Trust provided the cash, additional STP system emergency PDC where DHSC provided CRL and cash, and national programme PDC funding for specific project areas. The Trust also receives CRL to cover the PFI Lifecycle costs and capitalises relevant donated asset spend. The breakdown is:
  - £7.5m net internal resource including £2m asset sales cash brought forward from previous years
  - £5.7m additional system CRL
  - £8.6m additional system emergency PDC
  - £9.7m of national programme funding including Covid-19 reimbursements
  - £0.3m of PFI Lifecycle CRL and £1.4m of recognised donated assets including the nationally procured loan equipment
- A high level of spend was incurred in the last month of the financial year (c£19m including donated and PFI elements) reflecting the late year confirmation of available funding together with the significant additional resource that became available to the STP system in the last quarter of the financial year. As a consequence, some of the equipment and IT kit will be held in storage for the Trust with accompanying letters of ownership or vesting certificates as at the end of the financial year.

Maidstone and Tunbridge Wells NHS Trust

1. Dashboard

March 2020/21

	Current Month				Year to Date				Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	72.7	46.8	25.9		564.2	535.3	28.9		564.2	535.3	28.9	
Expenditure	(69.0)	(49.9)	(19.1)		(531.8)	(508.9)	(22.8)		(531.8)	(508.9)	(22.8)	
EBITDA (Income less Expenditure)	3.7	(3.1)	6.8		32.4	26.3	6.1		32.4	26.3	6.1	
Financing Costs	(6.4)	(3.5)	(2.8)		(34.5)	(32.2)	(2.3)		(34.5)	(32.2)	(2.3)	
Technical Adjustments	2.1	0.7	1.4		2.4	0.9	1.6		2.4	0.9	1.6	
Net Surplus / Deficit (Incl Top Up funding	**(0.6)**	**(5.9)**	**5.3**		**0.3**	**(5.0)**	**5.3**		**0.3**	**(5.0)**	**5.3**	
Cash Balance	26.2	1.0	25.2		26.2	1.0	25.2		26.2	1.0	25.2	
Capital Expenditure (Incl Donated Assets)	18.9	1.3	(17.6)		33.3	18.4	(14.9)		33.3	18.4	(14.9)	

Summary Current Month:

- The Trust delivered a deficit of £0.6m in the month which was £5.3m favourable to plan. The plan set assumed the annual leave accrual (£5m included within the plan) would be unfunded and cause a financial pressure, however the Trust has received income to match the accrual required (£4.7m). Excluding the impact of the annual leave accrual the Trust was £0.3m favourable to plan.
- The Trust in March has identified £2.2m of costs associated with COVID 19. Excluding Swabbing and Vaccination centre costs (p ass through costs) the level of spend incurred was £0.65m less than the spend in February.
- The reported position in March included the following key elements:
  - Rates rebates £3.3m benefit, £3m YTD Kent and Medway block income reduction, £0.7m estimate for junior doctor study leave pr essure, increase in dilapidations for laundry equipment and 5 leased building properties (£0.6m), £0.6m increase in drug spend and £0.2m estimate for enhancements not paid for staff who have been shielding or self isolating due to COVID .
- In line with NHSE/I guidance additional income has been included in the month 12 position to offset additional costs for the following main items: Employers pension increase (£12.8m), Annual leave accrual (£4.7m), PPE national push stock (£7.7m) and Flowers overtime (£0.5m).

Year to date overview:

- The Trust delivered a surplus of £0.3m in 2020/21 financial year, which was £5.3m favourable to plan. Excluding the impact of the annual leave accrual the Trust was £0.3m favourable to plan.
- 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 key variances to the plan (excluding annual leave accrual) set from October (month 7) are:

The main underspends to the plan were due to delays in investments associated with Stroke, ITU extension and Recovery and Reset developments (£9.4m) and a net £2.7m rates rebate benefit. These underspends were offset by the following pressures:

- Reduction in Kent and Medway block payments (£5.3m - to a breakeven position), investments in EPR and IT projects (£1.5m), RTA income expected credit loss adjustment (£1.3m for 2019/20 and prior years), Junior doctor study leave pressure (£0.7m), increase in dilapidations (£0.6m) and estimate for enhancements not paid for staff who have been shielding or self isolating due to COVID (£0.2m) .

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	32,815

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	4,096
Sick pay at full pay (all staff types)	447
COVID-19 virus testing (NHS laboratories)	2,507
Remote management of patients	45
Support for stay at home models	99
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)	2,770
Segregation of patient pathways	11,546
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	1,282
Decontamination	287
Backfill for higher sickness absence	2,502
NHS 111 additional capacity	0
Remote working for non patient activites	373
National procurement areas	1,970
Other	750
COVID-19 virus testing- rt-PCR virus testing	3,926
COVID-19 - Vaccination programme'	92
COVID-19 virus testing - Rapid / point of care testing	115

Summary: Loss of income

Total (£000s):	3,272

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	434

Grand Total

Total (£000s):	36,087

Commentary:
The Trust has identified the financial impact relating to COVID to be £36.1m, which includes £32.8m associated with additional expenditure and £3.3m 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 included £4.1m income in the position to offset the costs of COVID swabbing , rapid testing and vaccination programme. NHSE/I have confirmed funding to the month 11 forecast value of £3.9m, the remainder £0.2m (increase between actual and forecasted spend) is still to be validated by NHSE/I.

Mar-21		DAY				NIGHT				TEMPORARY STAFFING						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	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	67.0%	105.6%	-	100.0%	87.4%	102.4%	-	-	30.6%	29.8%	328	20.80	94	8.2	0.0%	0.0%	12	1	321,623	317,097	4,526
MAIDSTONE	Cornwallis (M) - NS959	0.0%	1.1%	-	-	1.1%	0.0%	-	-	0.7%	50.0%	2	0.15	1	0.4	0.0%	0.0%	0	0	79,076	17,383	61,693
MAIDSTONE	Culpepper Ward (M) - NS551	101.9%	89.1%	-	-	96.7%	103.2%	-	-	27.5%	29.2%	43	2.94	3	5.2	40.0%	100.0%	0	0	109,802	116,145	(6,343)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	98.5%	94.2%	-	-	101.4%	102.6%	-	-	34.2%	26.7%	100	6.90	6	6.4	35.0%	100.0%	4	0	146,351	168,232	(21,881)
MAIDSTONE	Intensive Care (M) - NA251	87.9%	124.2%	-	-	72.6%	96.3%	-	-	8.1%	0.0%	96	5.53	39	31.8			0	1	176,442	186,539	(10,097)
MAIDSTONE	Pye Oliver (Medical) - NK259	84.1%	87.3%	-	-	110.0%	103.2%	-	-	34.6%	46.7%	142	8.58	41	7.3	30.2%	84.2%	1	0	120,984	151,809	(30,825)
MAIDSTONE	Whatman Ward - NK959	79.7%	85.6%	-	100.0%	104.5%	153.6%	-	-	38.7%	21.0%	124	8.35	19	9.6	0.0%	0.0%	3	0	109,421	122,813	(13,392)
MAIDSTONE	Lord North Ward (M) - NF651	85.9%	83.2%	-	100.0%	98.8%	83.7%	-	-	19.1%	8.2%	58	3.90	17	7.2	203.4%	100.0%	1	2	101,692	103,153	(1,461)
MAIDSTONE	Mercer Ward (M) - NJ251	96.3%	82.2%	-	-	104.3%	98.5%	-	-	22.1%	25.0%	83	5.47	16	9.0	117.4%	100.0%	5	0	120,121	134,301	(14,180)
MAIDSTONE	Edith Cavell - NS459	75.1%	126.8%	-	100.0%	88.4%	254.8%	-	-	59.4%	41.5%	194	13.46	45	9.2	0.0%	0.0%	2	1	44,037	51,831	(7,794)
MAIDSTONE	Acute Medical Unit (M) - NG551	84.1%	87.5%	-	-	136.6%	187.9%	-	-	36.6%	18.4%	136	9.19	43	10.7	0.0%	50.0%	2	0	153,409	145,580	7,829
TWH	Ward 22 (TW) - NG332	81.7%	103.3%	-	100.0%	96.8%	126.3%	-	-	41.9%	31.4%	150	10.51	40	6.7	15.3%	100.0%	15	2	142,269	170,324	(28,055)
TWH	Coronary Care Unit (TW) - NP301	73.7%	87.1%	-	-	84.9%	-	-	-	33.1%	39.3%	116	6.92	46	11.1	60.6%	100.0%	0	0	74,317	80,512	(6,195)
TWH	Ward 33 (Gynae) (TW) - ND302	96.9%	93.6%	-	-	98.4%	100.0%	-	-	39.6%	3.0%	63	3.92	6	8.4	38.4%	100.0%	2	0	111,169	110,175	994
TWH	Intensive Care (TW) - NA201	143.3%	102.0%	-	-	130.1%	69.4%	-	-	22.6%	0.0%	158	10.13	10	35.7			0	0	316,236	317,273	(1,037)
TWH	Acute Medical Unit (TW) - NA901	79.1%	95.8%	-	100.0%	101.9%	101.1%	-	-	24.1%	17.2%	196	13.70	78	12.6	4.7%	100.0%	4	0	201,232	219,296	(18,064)
TWH	Surgical Assessment Unit (TW) - NE701	100.4%	99.5%	-	-	51.3%	59.7%	-	-	13.2%	0.0%	16	1.07	0		0.0%	0.0%	0	0	68,191	57,345	10,846
TWH	Ward 32 (TW) - NG130	78.8%	72.5%	-	100.0%	72.6%	63.0%	-	100.0%	14.8%	8.2%	74	4.76	13	9.3	0.0%	0.0%	0	0	131,644	105,870	25,774
TWH	Ward 10 (TW) - NG131	107.5%	96.7%	-	100.0%	96.0%	110.2%	-	-	37.0%	14.8%	134	8.42	22	6.4	0.0%	0.0%	5	0	124,141	146,803	(22,662)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	0.6%	1.6%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	-			0	0	7,056	6,146	910
TWH	Ward 12 (TW) - NG132	89.2%	101.7%	-	100.0%	98.9%	99.9%	-	-	29.7%	11.0%	109	6.34	39	6.2	7.9%	100.0%	5	0	128,675	150,281	(21,606)
TWH	Ward 20 (TW) - NG230	98.3%	110.6%	-	-	132.1%	112.1%	-	-	52.1%	37.3%	202	13.93	51	6.6	1.6%	100.0%	5	0	154,123	176,975	(22,852)
TWH	Ward 21 (TW) - NG231	89.6%	94.9%	-	100.0%	92.6%	122.6%	-	-	29.3%	29.1%	150	9.44	49	7.2	0.0%	0.0%	7	2	145,708	169,758	(24,050)
TWH	Ward 2 (TW) - NG442	86.8%	97.9%	-	100.0%	119.2%	134.8%	-	100.0%	28.1%	18.6%	122	7.62	52	9.0	31.9%	95.5%	6	1	142,495	147,098	(4,603)
TWH	Ward 30 (TW) - NG330	97.7%	99.3%	-	100.0%	101.1%	133.3%	-	-	33.2%	4.6%	94	5.46	27	7.5	0.0%	0.0%	7	3	139,933	154,737	(14,804)
TWH	Ward 31 (TW) - NG331	87.1%	100.4%	-	100.0%	96.8%	133.3%	-	-	48.3%	16.4%	181	11.02	56	7.1	0.0%	0.0%	4	3	149,938	174,022	(24,084)
Crowborough	Crowborough Birth Centre (CBC) - NP775	39.1%	89.3%	-	-	36.5%	44.4%	-	-	3.6%	0.0%	16	0.87	0					0	84,530	73,945	10,585
TWH	Midwifery (multiple rosters)	81.0%	54.4%	-	-	92.1%	90.4%	-	-	16.3%	1.0%	780	43.98	123	22.0	57.1%	94.8%	0	0	682,204	717,278	(35,074)
TWH	Hedgehog Ward (TW) - ND702	109.6%	99.9%	-	-	105.0%	-	-	-	30.9%	53.7%	169	11.49	32	12.9	14.2%	97.2%	0	0	193,997	196,704	(2,707)
MAIDSTONE	Maidstone Birth Centre - NP751	110.6%	90.0%	-	-	98.2%	100.0%	-	-	17.0%	0.0%	23	1.44	0				0	0	73,531	80,217	(6,686)
TWH	SCBU (TW) - NA102	82.2%	922.7%	-	100.0%	92.1%	-	-	-	21.0%	0.0%	143	7.73	2	16.0				0	177,213	192,395	(15,182)
TWH	Short Stay Surgical Unit (TW) - NE901	49.6%	91.5%	-	-	48.2%	75.0%	-	-	21.0%	7.1%	40	2.57	6	19.6			0	0	23,537	57,386	(33,849)
MAIDSTONE	Accident & Emergency (M) - NA351	97.9%	67.7%	-	-	116.3%	115.1%	-	-	47.5%	27.2%	518	35.16	155		0.5%	96.0%	1	0	303,333	347,377	(44,044)
TWH	Accident & Emergency (TW) - NA301	73.7%	64.4%	-	100.0%	87.9%	80.2%	-	-	40.4%	44.5%	606	42.16	171		3.3%	98.0%	2	0	389,970	485,290	(95,320)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	78.1%	37.8%	-	-	65.6%	-	-	-	12.6%	7.5%	13	0.80	1	16.8	0.0%	0.0%	0	0	56,893	47,047	9,846
MAIDSTONE	Peale Ward COVID - ND451	76.8%	79.2%	-	100.0%	124.7%	50.3%	-	-	23.7%	48.5%	101	6.89	30	13.6	4.2%	100.0%	2	0	211,039	116,400	94,639
MAIDSTONE	Foster Clark - NS251	92.2%	83.9%	-	100.0%	108.9%	84.9%	-	-	18.9%	0.0%	19	0.89	0	10.9	0.0%	0.0%	1	0	0	126,389	(126,389)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	62.8%	34.4%	-	-	25.7%	0.0%	-	-	1.5%	45.5%	41	3.10	36	29.7	0.0%	0.0%	1	0	58,692	11,865	46,827
																				5,775,024	**6,153,789**	**(378,765)**
																				44,033	44,948	(915)
																				0	0	0
																				-530	0	(530)
																				7,847	4,981	2,866
																				143,841	147,708	(3,867)
																				-137	10,906	(11,043)
																				6,445,565	4,603,738	1,841,827
																				12,415,643	**10,966,070**	**1,449,573**

Total Established Wards

Additional Capacity beds: Cath Labs; Whatman; Ward 32 (Wells Suite) (TW) - PP010; Chaucer; RECU - NS459; Foster Clarke Winter Escalation 2019

Other associated nursing costs

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

Operating plans for the first half of 2021/22	**Director of Strategy, Planning and Partnerships**

Please find enclosed the draft operating plans for the first half of 2021/22

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 20/04/21
- Trust Management Executive (TME), 21/04/21
- Finance and Performance Committee, 23/04/21

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

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

Phase 4 submission

1st Submission
20th April 2021

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

This document reflects the latest phase 4 planning position covering Q1 and Q2 of 21/22, which will feed into the K&M ICS submission

- This document covers the latest version of the finance, activity and workforce plans as of the 16th of April 2021
- Activity templates submission to ICS by 20th April
- Provider plans review sessions are scheduled for 21st- 23rd April with ICS colleagues
- Initial ICS planning return on 6th May, with final plan submission on 3rd June
- Regional assurance meetings with CEO and COO input on 20th and 27th May

Our out patient, elective day case and inpatient capacity plans are compliant each month in quarters one and two.

	Apr	May	Jun	Jul	Aug	Sep
First OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
21/22 Plan as % of 1920	95%	98%	98%	96%	105%	94%
FUP OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
21/22 Plan as % of 1920	100%	101%	97%	103%	105%	100%
All OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
21/22 Plan as % of 1920	99%	100%	97%	101%	105%	98%
Elective IP	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
21/22 Plan as % of 1920	95%	88%	94%	96%	93%	90%
Elective DC	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
21/22 Plan as % of 1920	92%	86%	93%	98%	96%	88%
Total Elective	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
21/22 Plan as % of 1920	92%	86%	93%	98%	96%	89%

Notes

- Independent sector patient choice is at 19/20 levels
- No WLIs or additional IS activity
- Independent sector activity is included in the activity baseline
- Elective recovery fund monitoring is based on financial value of activity delivered

Whilst we are doing more validation with services we propose to submit a plan which meets but does not exceed the monthly targets.

	Apr	May	Jun	Jul	Aug	Sep
First OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Scenario 1: 21/22 Plan as % of 1920	70%	75%	80%	85%	85%	85%
Scenario 2: 21/22 Plan as % of 1920	95%	98%	98%	96%	105%	94%
Activity difference between scenarios	3,294	2,723	2,492	1,492	2,473	1,252

FUP OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70.0%	75.0%	80.0%	85.0%	85.0%	85.0%
Scenario 1: 21/22 Plan as % of 1920	70%	75%	80%	85%	85%	85%
Scenario 2: 21/22 Plan as % of 1920	100%	101%	97%	103%	105%	100%
Activity difference between scenarios	9,967	8,209	6,164	6,333	6,359	5,164

All OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Scenario 1: 21/22 Plan as % of 1920	70%	75%	80%	85%	85%	85%
Scenario 2: 21/22 Plan as % of 1920	99%	100%	97%	101%	105%	98%
Activity difference between scenarios	13,261	10,932	8,656	7,826	8,832	6,416

	Apr	May	Jun	Jul	Aug	Sep
Elective IP	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Scenario 1: 21/22 Plan as % of 1920	70%	75%	80%	85%	85%	85%
Scenario 2: 21/22 Plan as % of 1920	95%	88%	94%	96%	93%	90%
Activity difference between scenarios	137	72	84	67	46	35

Elective DC	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Scenario 1: 21/22 Plan as % of 1920	70%	75%	80%	85%	85%	85%
Scenario 2: 21/22 Plan as % of 1920	92%	86%	93%	98%	96%	88%
Activity difference between scenarios	802	407	539	484	410	126

Total Elective	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Scenario 1: 21/22 Plan as % of 1920	70%	75%	80%	85%	85%	85%
Scenario 2: 21/22 Plan as % of 1920	92%	86%	93%	98%	96%	89%
Activity difference between scenarios	938	479	623	551	455	160

There is no requirement to submit an RTT trajectory, however if we funded additional WLIs and IS capacity for T&O our year end position would be significantly lower than year end 19/20, which was 79.5%

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
TRUST	**Total Waiting List**	30559	30198	29316	28456	27684	27111	26468	26586	26498	26476	26534	26449	26424
	IP Waiting List	6402	6586	6548	6537	6511	6572	6555	6737	6806	6831	6985	7041	7085
	OP Waiting List	24157	23612	22768	21919	21173	20540	19913	19850	19692	19645	19549	19408	19339
	IP Backlog	3134	3108	3040	3018	3017	3055	3053	3153	3219	3274	3455	3587	3709
	OP Backlog	5714	4819	3907	3219	2669	2379	2397	2883	3209	3533	4038	4373	4737
	Total %	**71.0%**	**73.8%**	**76.3%**	**78.1%**	**79.5%**	**80.0%**	**79.4%**	**77.3%**	**75.7%**	**74.3%**	**71.8%**	**69.9%**	**68.0%**
TRUST	**Total Backlog**	8848	7927	6947	6237	5686	5434	5450	6036	6428	6806	7493	7960	8445
	% IP	**51.0%**	**52.8%**	**53.6%**	**53.8%**	**53.7%**	**53.5%**	**53.4%**	**53.2%**	**52.7%**	**52.1%**	**50.5%**	**49.1%**	**47.7%**
	%OP	**76.3%**	**79.6%**	**82.8%**	**85.3%**	**87.4%**	**88.4%**	**88.0%**	**85.5%**	**83.7%**	**82.0%**	**79.3%**	**77.5%**	**75.5%**

Our core diagnostic services are broadly compliant with the exception of Non obstetric ultrasound

	Apr	May	Jun	Jul	Aug	Sep
MRI	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	106%	95%	101%	92%	91%	98%

CT	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	104%	97%	102%	99%	99%	100%

NOUS	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	81%	77%	85%	85%	88%	87%

Colonoscopy	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	100%	100%	100%	100%	100%	100%

Flexi Sigmoidoscopy	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	100%	100%	100%	100%	100%	100%

Gastroscopy	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	100%	100%	100%	100%	100%	100%

Draft Financial Plan

Statement of comprehensive income	2021/22 Plan H1 £'000
Operating income from patient care activities	270,702
Other operating income	20,146
Employee expenses	(177,381)
Operating expenses excluding employee expenses	(105,491)
OPERATING SURPLUS / (DEFICIT)	7,976
FINANCE COSTS	(16,512)
NET FINANCE COSTS	(8,536)
Technical Adjustments	307
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(8,229)**
Central Assumption Surplus	5,112
Gap from central assumption	**(13,341)**

- A Financial Plan has been developed to in line the planning guidance for H1 2021/22.
- The plan is a deficit of £8.2m and includes a CIP efficiency of 0.28%.
- There is a central assumption that the Trust will have a surplus of £5.1m, therefore there is a gap from this central assumption of £13.3m.
- The plan assumes additional income from Kent and Medway CCG which has not yet been confirmed.

Draft Financial Plan Investments

- The following assumptions are included in the H1 plan, values are for 6 months.
- A further breakdown will be provided at the Executive meeting 27 April 2021.

	H1 £000
National Requirements	
COVID	7,383
Car Parking Income (Staff)	276
Long COVID (PCAS)	393
Efficiency Savings	-800
	7,251
System Requirements	
ITU Extension	3,209
Moorfields	1,535
Stroke	2,163
UTC	223
	7,130

Investments	**H1 £000**
Agreed Business Cases	4,511
Recovery and Reset	7,968
Other Changes	7,100
	19,578
Cost Pressures	
Inflation (Income)	2,394
Increase in depreciation (above inflation uplift)	1,011
Other Cost Pressures	321
	3,725
Assumptions to note	
IS Funding (Patient choice)	5,400
Elective activity -	TBC
Non Elective growth	
Maternity (Growth)	TBC
Maternity (Ockenden)	TBC
Less CNST Adj	-61

Risks

Risk

- Income value not yet confirmed from Kent and Medway CCG
- The CCG expects the Trust to deliver a surplus position as per Quarter 3 20/21.
- System requirements expected to be funded but not confirmed;
  - Stroke
  - Ophthalmology service for DGS patients
  - ITU expansion to 31 beds
  - UTC
- PFI Support previously received by the Trust of £8m per year was expected to be reinstated. It has recently been confirmed that this is in the system envelope so this puts additional pressure on the system funding.

Risks

- There is a risk whether we can only access national funds for ISP through contracts on the national framework or with our existing contracts. Clarity has been sought from the national team to confirm.
- There is an expectation that Covid costs will start to reduce, this will be difficult if this isn't in line with IPC and operational guidelines.
- The plan assumes no further funding investments are agreed. There is a contingency of £2.5m for any unplanned cost pressures.

Assumptions:

Assumptions

- Non Pay is based on 19/20 activity levels plus inflation uplift
- Pay is based on the agreed establishments, with an adjustment at Divisional level for vacancies and temporary staff premiums.
- Income is based on matching the cost base for H1.
- We expect to meet the threshold targets for the ERF, we hope to be able to access the ERF to support additional waiting lists and outsourcing but this is dependent on overall system performance. There is no assumption of additional income or expenditure from the ERF at this stage.

Assumptions

- The following items are expected to be funded outside of the K&M system envelope;
  - Ockenden – Working with WCSH Division to bid for additional resource to meet Ockenden review actions.
  - Med Tech – we are reviewing if we can implement the four recommendations
  - COVID out of envelope including swabbing and vaccination centres
- AFC Pay Award funding will be allocated following pay review settlement.

Cost Improvement Programme (CIP)

Target H1

- There is an efficiency requirement CIP of 0.28% for H1, in addition the Trust may need to deliver CIP to fund internal investments made in year should these not be covered by additional funding received.

- The value of the CIP target is estimated at c£800k during H1. The Trust expects this to be delivered as a result of on-going work during 2020/21.
  - Rates
  - Estates
  - Agency
  - Procurement

H2 CIPs

- H2 will be a further challenge, there will be some FYE but further schemes will need to be developed during H1 to ensure delivery from H2.

- Review of previously agreed business cases to ensure savings are being delivered.

Next Steps

System level review for consistency of approach to draft plans.

Internal review

- Can we identify further income e.g. non NHS income
- Review of FOT and phasing assumptions
- Review if costs can be reduced, for example identify when some Covid costs can be reduced or removed.

The workforce position before 21/22 investment decisions has been developed with reconciliation of ledger and ESR.

Staff Group	Detail	WTE
A&C/Sen Man Staff Total	A&C/Sen Man Substantive	562
A&C/Sen Man Staff Total		**562**
Medical Staff	Consultants	342
Medical Staff	Medical Bank	0
Medical Staff	Other Medical Grades	536
Medical Staff Total		**878**
Nursing	Nurses Substantive - Trained	2,051
Nursing Total		**2,051**
Qualified Ambulance + Paramed	Ambulance + Paramedics Trained	6
Qualified Ambulance + Paramed Total		**6**
Scientific Therap & Tech Staff	Allied Health Prof Substant	452
Scientific Therap & Tech Staff	Healthcare Scientist Bank	0
Scientific Therap & Tech Staff	Healthcare Scientist Substant	243
Scientific Therap & Tech Staff	STT Substantive	203
Scientific Therap & Tech Staff Total		**898**
Support Staff	Support Substantive	547
Support Staff Total		**547**
Support to Clinical Staff	Clin Support to Nursing Subst	868
Support to Clinical Staff	Clin Support to Oth Clin Subst	1,000
Support to Clinical Staff	Clinical Support to AHPs Subst	97
Support to Clinical Staff Total		**1,965**
Grand Total		**6,906**

- Divisions are working through their workforce plans, expected completion 30 April 2021.
- The nursing pipeline has been updated across all the divisions including phasing of new roles over quarter 2 and 3. We were short **159.79 WTE** of our target
- Surgical Division - are looking for approx. 100 new roles which is mainly the ICU expansion (85 WTE).

NHS Maidstone and Tunbridge Wells NHS Trust

Strategy Deployment – corporate objectives for 2021-22	**Director of Strategy, Planning and Partnerships**

Please find enclosed the "Strategy Deployment – corporate objectives for 2021-22" report.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting (ETM), 27/04/21

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

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

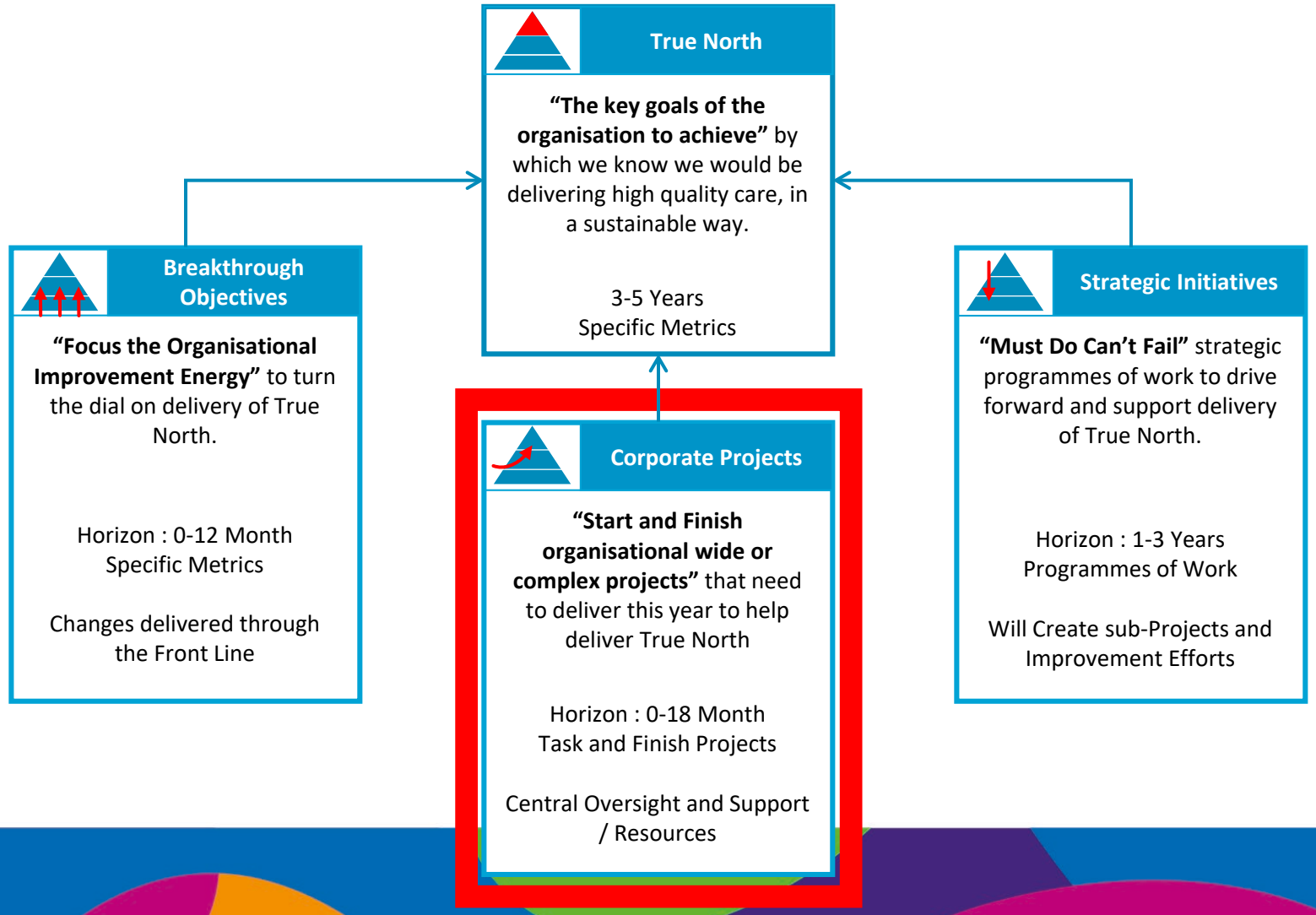
Strategy Deployment – corporate objectives for 2021/22

23rd April 2021

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

On the 19th of April MTW and UHS execs met to define the corporate projects related to our true north

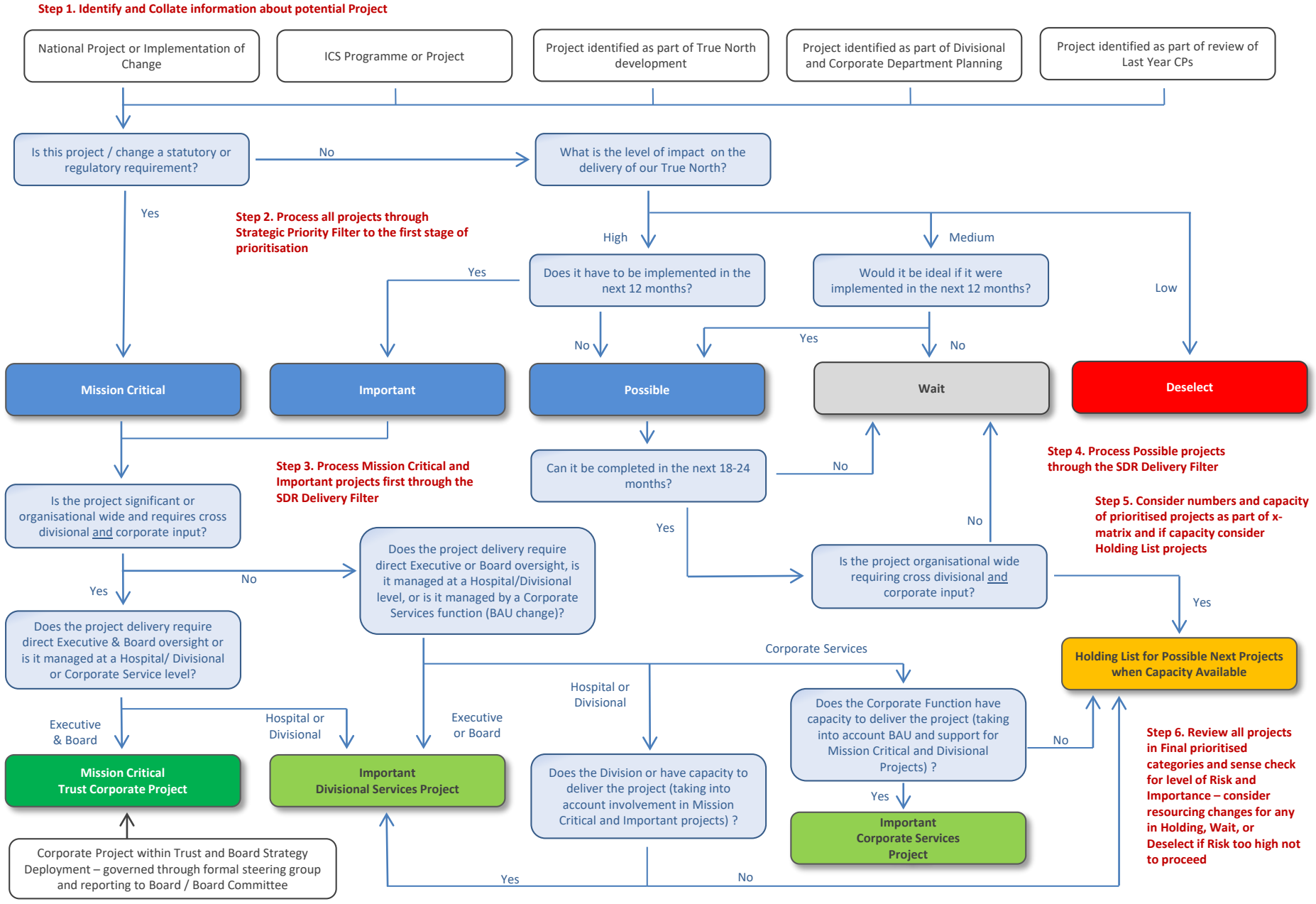


Potential projects were selected from a variety of sources

Potential sources of existing projects:

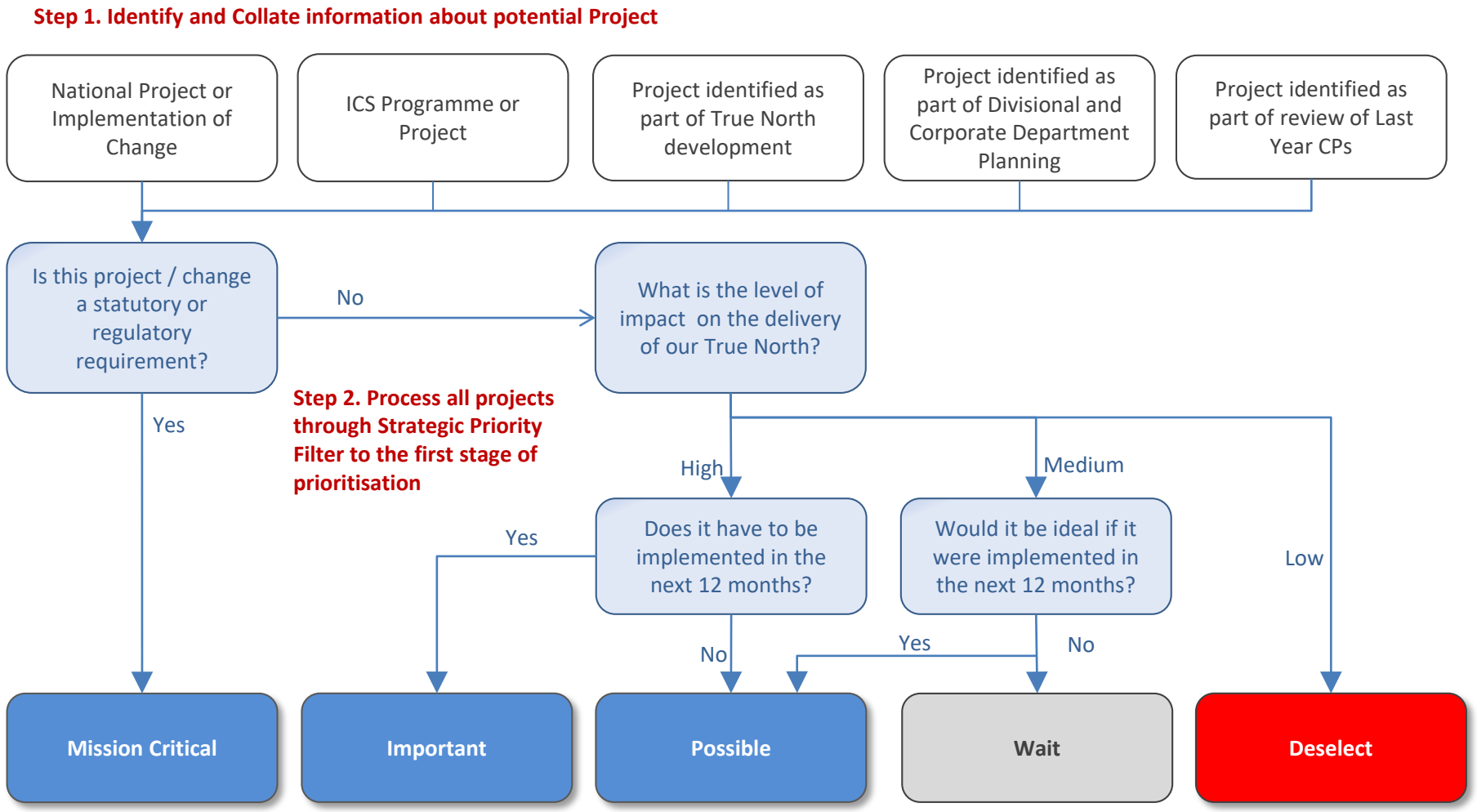
1. Clinical Strategy
2. Quality Strategy
3. People plan
4. Restore and Recover plan
5. Capital plan
6. Estates plan
7. IM&T/Digital plan
8. Efficiency plan
9. Ask Divisional Triumvirates what they're working on/priorities are
10. Ask the Transformation Team the same
11. Business Case pipeline
12. ICS/Commissioner priorities
13. Step 6 of True North A3's

Corporate Project Prioritisation Filter

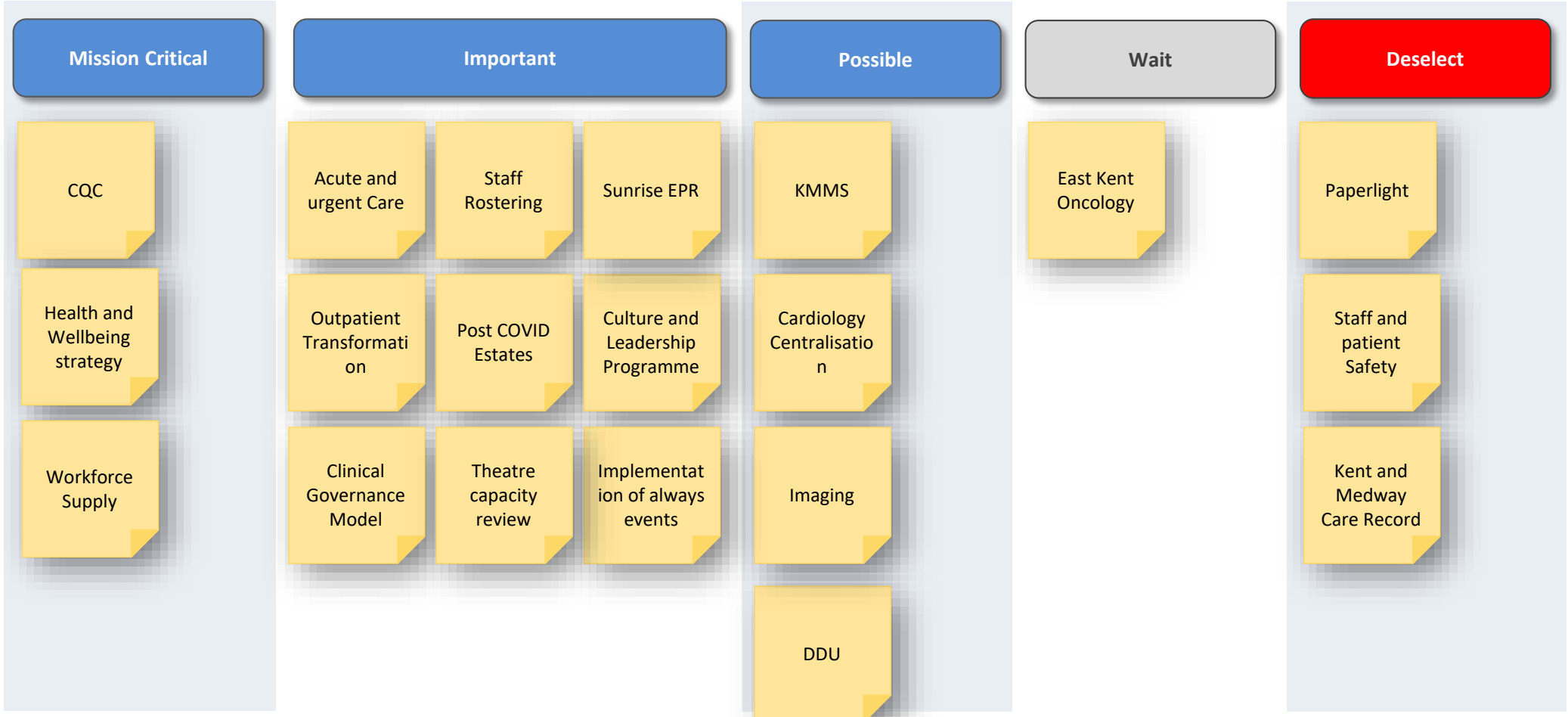


Potential projects were passed through stage 2 of the strategic filter

Strategic Project Filter: Gather projects, and process them to the first stage to determine importance.

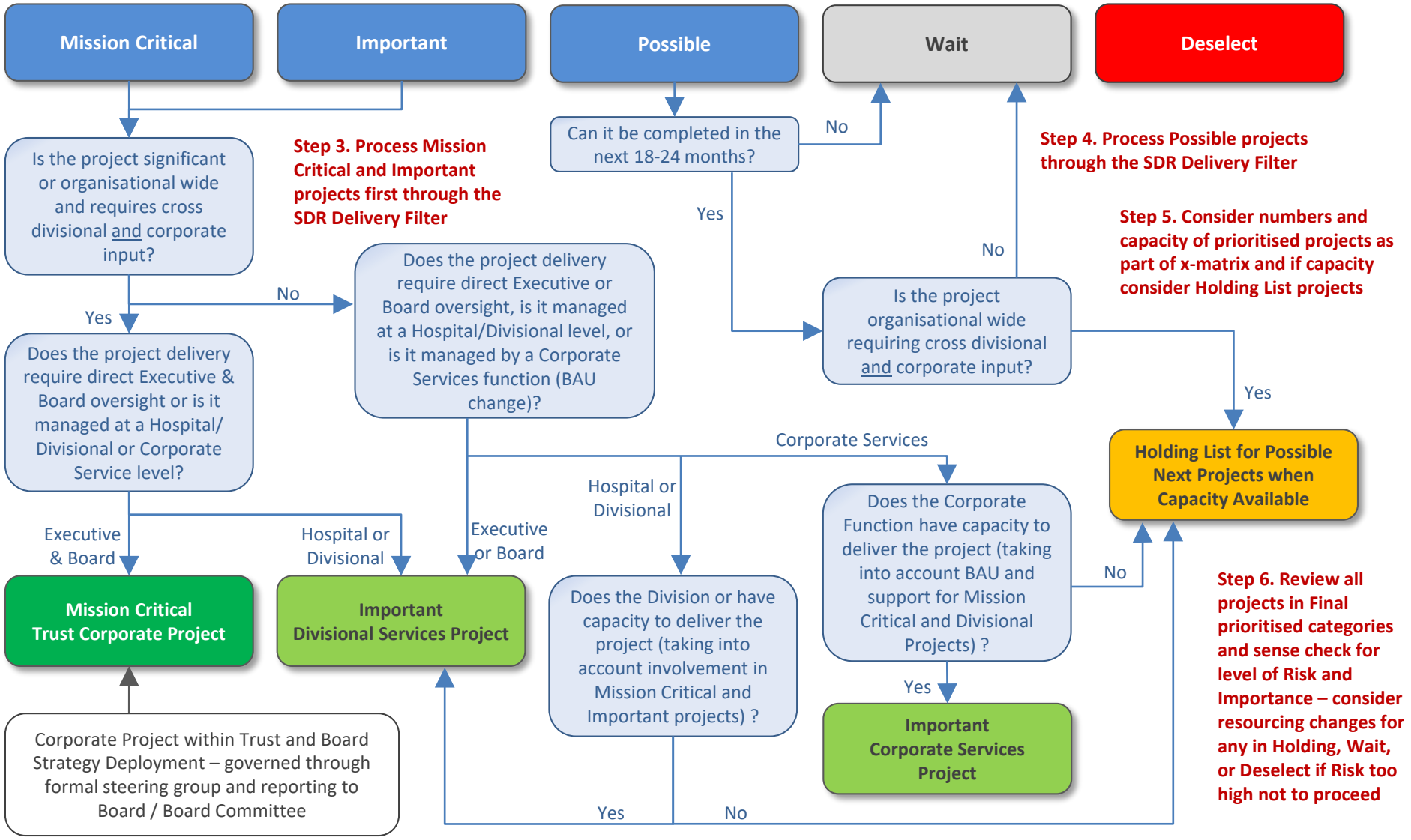


Outputs from stage 2



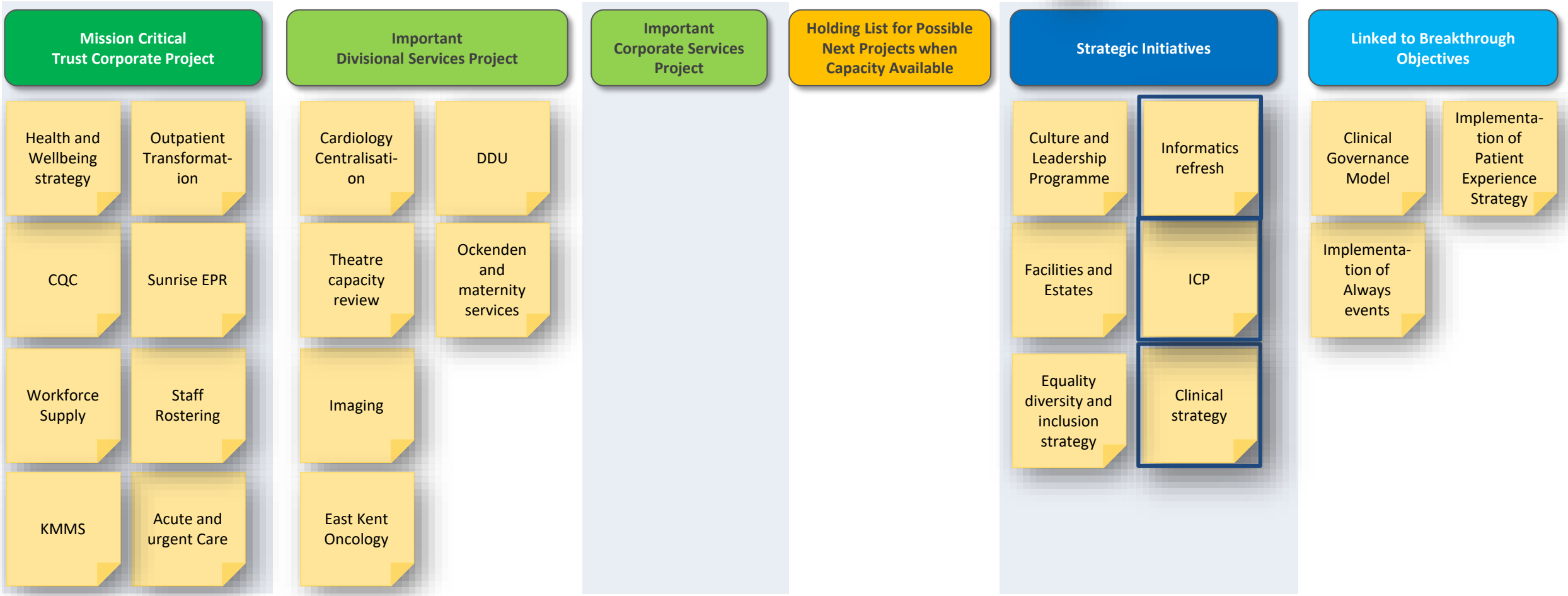
Steps 3 & 4

Strategic Project Filter: Process Mission Critical and then Important projects, followed finally by Possible Projects



The outcomes from the stages 3&4 of the filter have set our 8 key Trust level objectives for the year ahead

Taken from A3



One of the next key steps is for us to be clear about the scope and resource required for implementation

X-Matrix: Using the following format to map out who in your organisation will need to be involved in each of the schemes/projects. This should allow you to see where you may be over loading your available capacity, or where your strategy carries risk that will need your attention.

For each scheme, identify and record 1. the executive lead (X), 2. the lead business unit (L), and 3. any business units that are required to input into the scheme (I)

		Exec Lead					Clinical Divisions				….or, split down further					Corporate/Support Functions								Place			Partners								
Schemes	Patient First Strategic Theme?	Exec 1	Exec 2	Exec 3	Exec 4	*Etc.*	Div 1	Div 2	Div 3	Div 4	Pathology	Pharmacy	Immagining	ED	Maternity	IM&T	Estates	Portering	House keeping	Finance	PMO	Improvement Team	*Add more as required*	Site 1	Site 2	Site 3	CCG	Primary care	Ambulance Service	Trust 1	Trust 2	Trust 3	Council 1	Council 2	NHSEI

STRATEGY DEPLOYMENT –A3 OUTPUTS

Strategy Deployment A3

True North Category - Sustainability
Living within our means providing high quality services through optimising the use of our resources

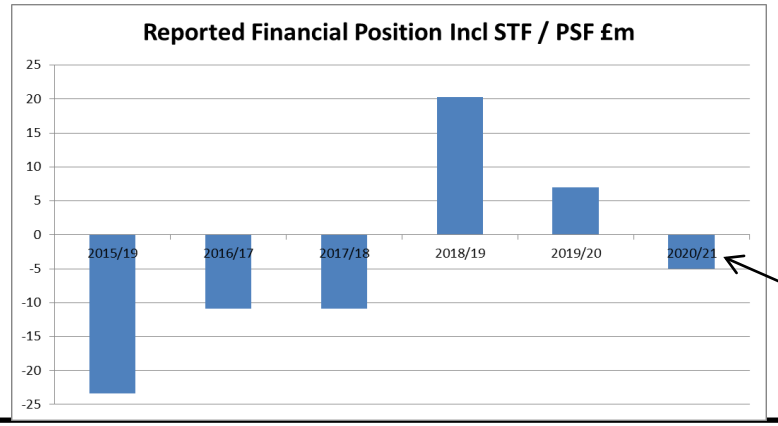
1) Problem statement

For our Trust, the ability to manage our finances effectively both impacts on our ability to invest in high quality services and infrastructure and is also a statutory and regulatory deliverable. The Trust has an underlying recurrent deficit where costs exceed income. If this is not resolved, our ability to support investments will be reduced as well as an increased potential for regulatory intervention.

2) Vision statement

Continued delivery of our financial plan, allowing us to invest sustainably in high quality services and infrastructure, improving patient experience and outcomes, and providing staff the tools they need to do their job.

3) Current state and proposed measures for baseline



Deficit in the current year solely linked to creation of annual leave accrual – this is to be confirmed as national guidance continues to change

4) Target and goal

Target:
Delivery of financial plan, including operational delivery of capital investment plan

Goal:
Continued delivery of financial plan, with a modern and fit for purpose environment and infrastructure

5) Analysis

Temporary staffing continues to increase despite increases in substantive staffing – although the rate of increase has slowed. Nursing did show a reduction following overseas recruitment. Medical is now the largest cost of temporary staff to the Trust

		Actual Spend £m			Movement £m		Movement %	
Grouping		2017/18	2018/19	2019/20	2018/19 v 2017/18	2019/20 v 2017/18	2018/19 v 2017/18	2019/20 v 2017/18
Substantive		214	223	241	9	18	4%	8%
Temporary Staffing		41	46	48	5	2	12%	4%
Reserves Pay		0	0	0	0	0	#DIV/0!	#DIV/0!
Total Pay		**255**	**269**	**288**	**14**	**20**	**6%**	**7%**

6) Implementation plan

Possible BTO – reduction in temporary staffing
Temp staffing continues to rise, even though substantive staffing is increase. Temp staff in use across all staff groups.

CP – staff rostering – particularly medical
For temp staff to be managed effectively, we need clear, relevant information on staffing. Manage annual and study leave, redeploy resources to cover gaps.

SI – clinical strategy implementation
Major capital funding needs to be found to support clinical strategy imperatives

Strategy Deployment A3

True North Category - Systems
Working with partners to provide the right care & support, in the right place, at the right time.

1) Problem statement

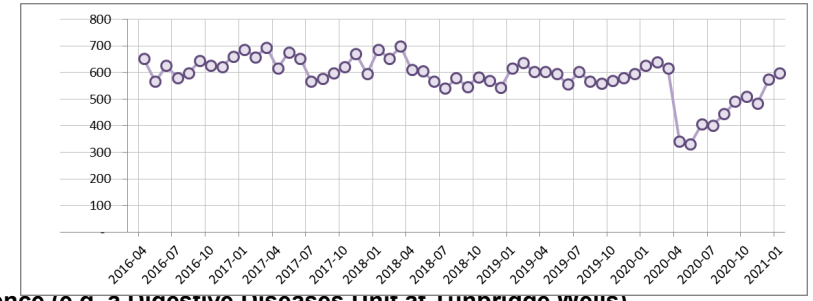
With changing demographics and ever growing demand we know that we need to respond to demand differently in the future as a system. At the moment we see people on an acute hospital site that could be more effectively treated in a community setting closer to home by a different type of clinician.
The impact of this is that both our specialist workforce and physical capacity and that of partners is often not maximised and we fail to allow clinicians to operate at the top of their licence

2) Vision statement

We want to have people receiving the right care in the right place as close to home as possible from the right person in order to allow our clinical staff to operate at the very top of their licence

3) Current state and proposed measures for baseline

Vertical integration – We want to work more closely with partners in West Kent to provide proactive acare and ensure that people only come to our hospitals and are admitted when they really need to be
Because we don't always proactively treat people in the community we have a higher number of people who end up in our beds as non-elective admissions - We have previously coped with an ongoing rise in NEL admissions but we need to respond differently to this in the future. This metric is to track and show how we are reducing the volume of activity that we should be trying to prevent in the community. The Trust has seen a reduction in NEL bed days during the COVID-19 pandemic but this is beginning to rise back up to pre-pandemic levels



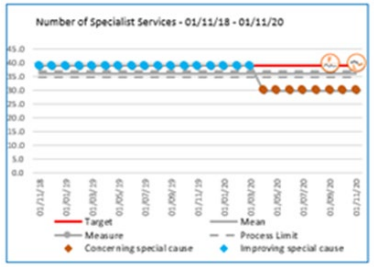
Horizontal Integration – We want to Implement our clinical strategy that Has ambitious goals around Establishing specialist centres of excellence (e.g. a Digestive Diseases Unit at Tunbridge Wells)
The way we track this is by looking at the volume of activity transferring out of West Kent that should be undertaken within West Kent –. Supported by an increase in specialist commissioned activity

4) Target and goal

Target: The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction)
If we can improve both how we work with partners (e.g. implementing a community frailty model) and our front door services (e.g. ambulatory care) we will reduce attendances and admit less patients which will result in lower numbers of NEL patients in our beds
Goal: No patients who could be treated in our community are transferred to our hospital or who could be treated in West Kent are transferred out

5) Analysis

Vertical Integration
The reduction in non elective bed days will be driven by increased utilisation of alternative settings of care – Proportion of ambulatory sensitive conditions treated in an ambulatory setting used as a proxy – this currently indicates opportunity in the High Sensitivity conditions
Horizontal Integration
Volume of activity flowing out of West Kent is determined by the lack of specialist commissioned services -Number of commissioned specialist services have decreased as of April 2020 and we need to expand on current offering starting with Bariatrics as a precursor to full DDU and driven by clinical strategy



6) Implementation plan

Breakthrough Objective
- Decreasing the volume of high and very high AEC sensitive conditions being admitted to our bed base as NEL admissions

Organisational Objectives
- Acute and urgent care

Associated strategic initiatives
- Post COVID Estates
- ICP development

Associated divisional objectives
- Gen Surg/Gastro DDU
- East Kent
- Cardiology PPCI
- Urology and Robot
- Imaging
- UTC

Strategy Deployment A3

True North Category - Patient Experience

To meet our ambition of always providing outstanding healthcare quality we need people to have a positive experience of care and support.

1) Problem statement

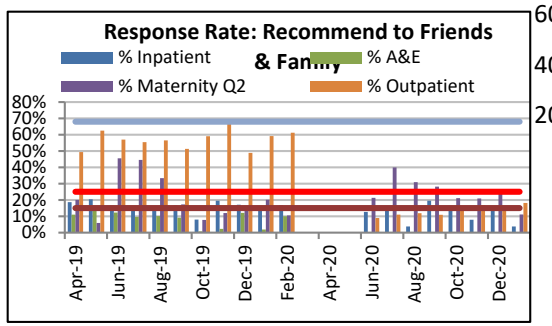
Providing the best possible experience of care is something we all aspire to. We are not getting enough feedback from patients, and we do not understand if staff are empowered to act upon it. This means we are not giving our staff every opportunity to deliver truly patient centred care, which could have significant benefits for patients and staff.

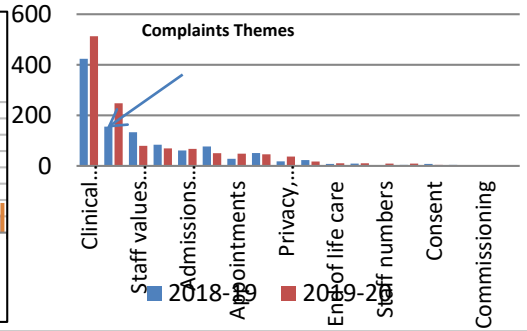
2) Vision statement

We take every opportunity to hear, and act upon the voice of patients, always providing outstanding, compassionate & personalised care.

3) Current state and proposed measures for baseline (Detailed Charts on additional slides)

- With the exception of maternity services we have low FFT response rates across all points of delivery with inpatient and A&E being the furthest from target. FFT positive response rate is at national target levels with the exception of OP services.
- Our patients are consistently reporting that communication, for example answering questions in an understandable way, waiting times and clinical care are areas of opportunity across National inpatient surveys, PALs and complaints.





4) Target and goal

Target: : Achieve the national FFT response rate target and maintain the positive response rate.

Goal: We are consistently recognised by patients as outstanding through FFT positive response rates nationally.

5) Analysis

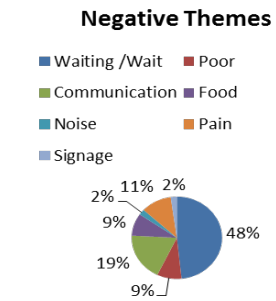
We know that we are going to focus on all areas for FFT response rate but have identified in the chart below wards which returned less than 10%

Inpatient Friends and Family Test Results

Overall Response Rate April 19 to Feb 20		
Site	**Ward/Site**	**Response Rate**
A&E	Maidstone	4.10%
A&E	TWH	12.60%
A&E	Trust	8.50%
Outpatients	Trust	57.10%
Inpatients	Maidstone	20.40%
Inpatients	TWH	12.60%
Inpatients	Trust	16.40%
Site	**Ward/Site**	**Rate <10%**
MGH	Acute Medical Unit	2.00%
TWH	Ward 11	2.80%
MGH	Riverbank	2.90%
TWH	HedgeHog	5.30%
TWH	Woodland Unit	5.65%
TWH	Ward 30	7.30%
TWH	Ward 31	8.90%
TWH	Ward 10	10.50%
TWH	Day Cases	10.80%
TWH	Acute Medical Unit	10.90%

Sub-Analysis of Communication Themes from PALs Contact for the last two years	
Poor communication with patient/relative	696
Test results not communicated	296
Unable to contact ward/department	284
Information requested/provided	120
Message not responded to/call not returned	106
Breakdown in communication	86
Inaccurate general information	84
Interpreting services	3

Adult Inpatient Survey : 1st October to 31st December 2020



6) Implementation plan

Breakthrough Objective: Increase response rates across all our FFT domains to meet the national target.

Linked to Breakthrough Objective:

- To reduce negative feedback related to communication and we anticipate that Always Events will be part of the solution.
- Patient Experience Strategy

Strategy Deployment A3

True North Category **Access – Ensuring all of our patients have access to the care they need to ensure they have the best chance of getting a good outcome**

1) Problem statement

Patients have the constitutional right to access care within set time frames across a number of clinical services. These guidelines were agreed by clinical experts who evidenced receiving care in a timely manner improved quality of care and mortality rates. MTW currently has a strong track record for achieving cancer standards and A&E standards, but currently fails to meet the RTT (18 week) standard resulting in poor patient experience and increased clinical risk.

2) Vision statement

All of our patients should be able to access the highest quality care and treatment when they need it, whether it's as an emergency, waiting for a cancer diagnosis or waiting for elective surgery.

3) Current state and proposed measures for baseline

Constitutional Standards other than RTT

Cancer standards maintained performance above target despite wave 2 of Covid

4 Hour performance and Ambulance handovers were effected slightly but overall perform well

Diagnostic waits are below target (see slide 4), following a similar pattern to RTT

RTT

Impacted by the second wave due to cancelling electives

18 weeks - 92% target, currently 71%, rolling 25 months -76%

52 week breaches target is 0, currently we have 564 patients (335 new in month)

No. waiters with a TCI date after breach date - 3882

Metric	Latest Performance	Rolling 18 Months
4 Hour Performance	96%	92%
Ambulance Handovers	6.90%	8.10%
Cancer 14 Days	95%	94%
Cancer 62 Days	86.50%	85.30%
Diagnostics DM01	75%	82%

4) Target and goal

Target: 1 We will achieve a 50% reduction in 52 week breaches by September 2021 and by April 2022 we will achieve the RTT standard whilst also ensuring no patient waits longer than 52 weeks for treatment.

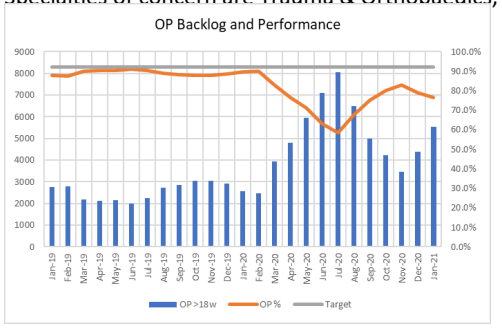
Goal: To ensure we are achieving all constitutional patient access standards.

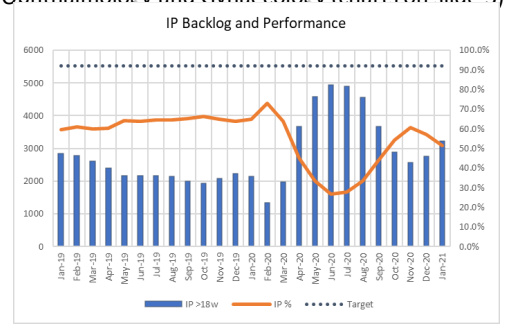
5) Analysis (Detailed analysis on following charts)

RTT

Outpatients have the largest volume of waiters over 18 weeks, however inpatient performance has worsened more severely.

Specialties of concern are Trauma & Orthopaedics, Ophthalmology and Gynaecology (charts on slide 3)





6) Implementation plan

Breakthrough: Ensure activity levels for theatres , diagnostics and outpatients match those pre-Covid

Corporate project: Outpatient Transformation - Programme to fundamentally improve outpatient offering in order to improve outpatient RTT pathways and patient communication.

Divisional Project: Theatre Scheduling - Maximising theatre capacity to enable more patients to be treated to improve RTT performance and reduce the number of 52 week waiters by 50% by September.

Strategy Deployment A3

True North Category **Patient safety & Clinical Effectiveness** **Working together to put quality at the heart of all that we do. Achieving outstanding clinical outcomes with no avoidable harm.**

1) Problem statement

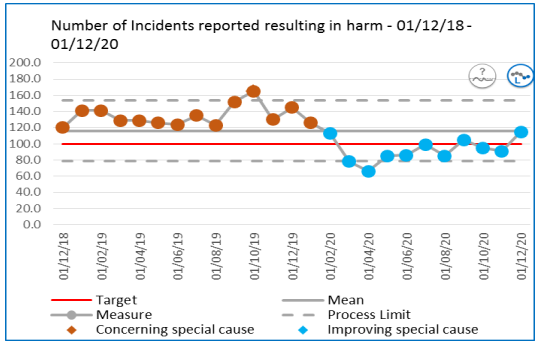
Patients should not experience harm whilst under our care. We achieve this in the majority of cases but some patients are suffering avoidable harm, and we can't be certain we learn from these events. This has a significant impact on patients, staff and the organisation.

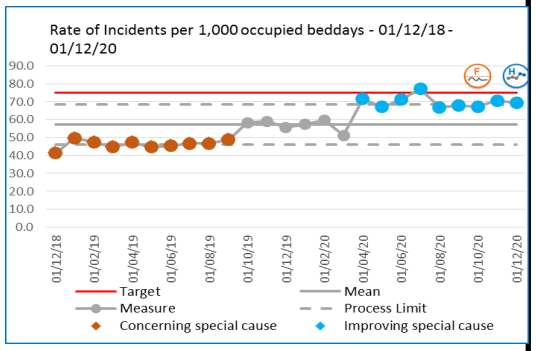
2) Vision statement

An organisation which has a blame free reporting and learning culture, delivering harm free hospital care.

3) Current state and proposed measures for baseline

- On average 15% of all incidents reported have caused harm. A breakdown of severity of harm is shown on slide 3. The main types of harm reported is shown in Section 5 Analysis.
- With the exception of one quarter, the NRLS has indicated MTW is potentially under-reporting incidents since 2014. We do not review incidents in a timely manner. There are a high number of incidents currently open more than 7 days
- Our HMSR is low, with a small difference in weekday and weekend rates (slide 4)





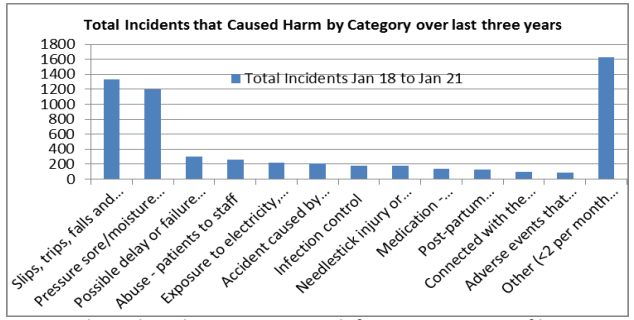
4) Target and goal

Target: A reduction in harm (target to be determined) by March 2022.

Goal: Zero harm episodes

5) Analysis

The highest level of Incidents resulting in harm and SIs is for Slips, Trips and Falls



SIs Reported Jan-19 to Dec-20	Total
Slip, Trip for Fall	57
Treatment Delay	35
HCAI/Infection control incident	33
Diagnostic incident including delay	26
Pressure Ulcers	8
Other (Mixture less than 10 each)	79
Total	238

NB: Other is less than two per month for any given type of harm

6) Implementation plan

BTO- Reduction in slips, trips and falls

Linked to BTO- Clinical Governance Model (Capturing and Learning lessons) developed and embedded

SI- Informatics refresh (data access & report architecture)

Strategy Deployment A3

True North Category - People: Creating a genuinely great place to work where I can come to work and be my best self

1) Problem statement

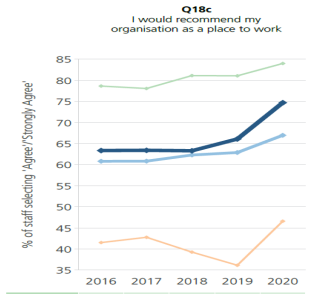
Our exceptional people: outstanding care vision is well known across the Trust but that vision is not always consistently applied. We cannot categorically say that all of our staff; irrespective of where they work have a consistently exceptional experience at work. We cannot say that we support and develop each and every one of our leaders so that they understand how their role can create the culture required deliver this standard. The impact of this is reduced engagement and increased turnover.

2) Vision statement

We recruit, support and develop exceptional people and create the conditions for success so that they can deliver outstanding care.

3) Current state and proposed measures for baseline

. Recommending the Trust as a great place to work, is one indicator of engagement; whilst it has improved this year, an even stronger focus on this proxy will raise engagement levels and have a dis-proportionate impact on other people indicators.



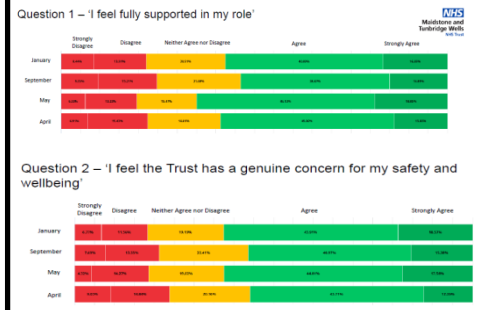
	2016	2017	2018	2019	2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	63.3%	63.4%	63.3%	66.1%	74.7%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

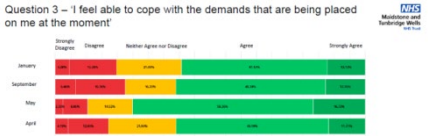
4) Target and goal

Target: We will be the top performing acute Trust for recommending MTW as a place to work.

Goal: We will be the best place to work in the NHS when benchmarked against others, using the NHS Staff Survey as our benchmark.

5) Analysis





6) Implementation plan

1. **Breakthrough Objective:** Each department and team improves their "recommendation as a place to work" by X percent.
2. **Strategic Initiative:** Building the strength and depth of leadership capability at all levels of the organisation because we know that line managers have a disproportionate impact on the experience of the individual at work.
3. **Corporate Divisional Project:** Transformation of the People Function so that it is people focused and aligns all policies and practices so that it genuinely creates the architecture required to make a great place to work.

NHS Maidstone and Tunbridge Wells NHS Trust

Review of nurse staffing for ward and non-ward areas (major review) **Chief Nurse**

The enclosed report provides the Trust board with the outcomes of the staffing establishment reviews that have been undertaken in non-ward areas, ward areas and specialities across the Trust.

Trust Board members should note that additional appendices to the report have been uploaded to the "Documents" section of Admincontrol for the Trust Board's information. (at Trust Board/Documents/Trust Board Meetings (Part 1)/2021/04. 29.04.21/Nurse staffing appendices).

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

NURSING & MIDWIFERY STAFFING REVIEW

A COMPREHENSIVE REVIEW OF MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST WARD AREAS, NON-WARD AREAS AND SPECIALITY SERVICES

Claire O'Brien: Chief Nurse
Gemma Craig: Deputy Chief Nurse

Trust Board - April 2021

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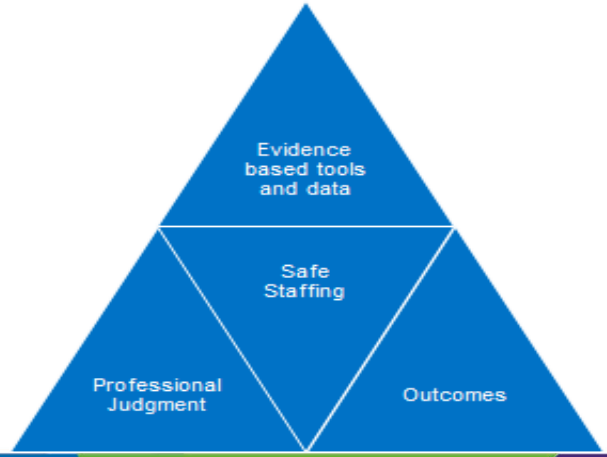
Introduction:

- Purpose of the presentation pack is to describe the methodology of the Annual Safe staffing reviews for Nursing and Midwifery staff.
- To provide assurance of Trust Compliance with National Quality Board(NQB) 2016 ‘Right staff, right Skills, in the right place’ (2013), ‘Safe, sustainable productive staffing’ (July 2016) and the new Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).
- To outline some key recommendations which ensure the Trust has the right level and skill mix of staff in place to support the on-going ability of the Nursing and Midwifery workforce in providing a safe, sustainable and productive service.

Methodology:

- Methodology used inline with NQB and NICE guidance by means of a triangulated approach to ensure the use of:
    - Evidence based tools (where they exist):
    - Professional Judgement: The Professional Judgement (Telford) model the National Audit Commission, endorsed by the RCN, supported by the NQB and NHSi Developing Workforce Standards. For ward areas the Carter Model was applied to include consideration of Care hours Per Patient Day (CHPPD).
    - Outcomes of nurse sensitive indicators including; pressure ulcers, falls, infection prevention control, nursing care complaints and feedback
    - Based on patients' needs, acuity, dependency and risks.



- Reviews were undertaken in Non-Ward Areas, Ward areas and Specialities across Maidstone and Tunbridge Wells NHS Trust.
- Review period September – December 2020
- Quarter 3 data has been reviewed post-meeting analysis.
- Discussion/review meetings included Ward Manager, Matron, Finance Manager, Associate Director of Nursing, Deputy Director of Nursing.
- The external report on midwifery staffing; Birth rate plus was reviewed with the Head of Midwifery
- **Considerations:**
  - Acuity & dependency: Safer Nursing Care Tool (SNCT) The Shelford Group.
  - Geography of ward / unit and relationship with co-dependent departments (e.g. surgical ward in relation to theatres).
  - COVID -19 and change in care delivery requirements, infection prevention control and Red / Amber / Green pathways

Reviews of Non Ward Areas and Specialities:

- Accident & Emergency
- Paediatrics
- Critical Care
- Theatres
- Head & Neck
- Oncology
- Maternity
- Gynaecology
- Endoscopy
- Cardiac Catheter Labs
- Integrated Sexual health
- Discharge Lounges

- Reviews followed the key methodology and included recommendations from relevant Royal Colleges, professional bodies and NICE guidance.

- Full details of the reviews can be seen in Appendix 1: Nursing and Midwifery staffing review (section 1 of the full report p 8 - 27).

Reviews of In Patient Ward Areas:

Maidstone Hospital

Ambulatory Assessment Unit (AAU)

Acute Stoke Unit (ASU)

Chaucer Ward

Cornwallis

Culpepper / CCU

John Day

Lord North

Mercer

Maidstone ITU

Maidstone Short Stay Surgical Unit (MSSU)

Maidstone Orthopaedic Unit (MOU)

Peale

Pye Oliver

Whatman / Frailty

Pre-operative Assessment (MH and TWH)

Tunbridge Wells Hospital

Surgical Assessment Unit

Tunbridge Wells ITU

Ambulatory Medical Unit (TAMU)

Coronary Care Unit (CCU)

Ward 2 / Acute Frailty Unit

Ward 10 Ward 22

Ward 11 Ward 30

Ward 12 Ward 31

Ward 20 Ward 32

Ward 21 Ward 33

Hedgehog Ward

The Wells Suite

Summary of outcomes can be viewed in Appendix 2.

Current Guiding Principles for Ward Establishments:

- Ratios: RN:CSW = 65/35, RN:PT 1:5 – 1:8
- Supervisory time for ward managers - 4 days per week for larger wards and 3 days for smaller wards
- Ward Clerk – not included in nursing numbers
- Headroom allowance 21% (to cover mandatory training, annual leave and sickness)
- Recognition of COVID -19 and the increase in staffing requirements to nurse safely across different pathways

Key Challenges:

- COVID-19 has impacted the Nursing and Midwifery safe staffing reviews, process and outcomes. Significantly however, it has tested the current ability to support monitoring and oversight of safe staffing at organisational level.
- Extensive changes in pathways requiring frequent opening and closing of wards.
- Significant requirements to uplift the nursing establishment in certain areas due to the impact of COVID-19 where services have had to increase capacity, change pathways, re design environments and upskill competencies for staff such as respiratory and critical care.
- Managing COVID related absences and the impact that National guidance, lock down measures, restricted visiting, reducing footfall, social distancing, PPE requirements and ensuring staffing skill mix to support patient and staff welfare and delivering safe, effective patient centred care.
- Frequent requirement to redeploy staff to maximise safe staffing.
- Ensuring Staff Welfare
- Ensuring Patient Experience
- Implementation of Safe Care put on hold during extreme site pressures (Opel level 3/4)

Current monitoring position:

- **MTW pre covid Position / ongoing monitoring**:

  Staffing levels are closely monitored daily in real time, at site meetings and through weekly staffing huddles, weekly bank and agency usage monitoring and weekly recruitment activity progress. A monthly report and publication return to NHSI / E indicating 'planned' and 'actual' nurse staffing by ward is submitted now with the inclusion of Trainee Nursing Associates and Nursing Associates. Implementation of Safe Care commenced October 2020.

- **COVID19 response:**

  Staffing levels are closely monitored daily in real time at site meetings and through the Interim Nursing Safe Staffing process (**Appendix 3**). Twice daily staffing huddles are in embedded, health roster management remains in place and decisions on staffing requirements are made according to the acuity and dependency requirements of the ward / unit and managed at a local level according to need and to maintain safe staffing levels. This will include ward closures and opening COVID wards / redeployed staff / managing any sickness in teams / any requirements to self-isolate / additional hours to support new pathways / setting up services.

Carter Model Hospital Comparisons:

NHSI Model Hospital Data: Nursing, January 2021

- Nursing staff cost per Weighted Activity Unit (WAU)

National Median	£933	
Peer Median	£942	
MTW	£710	**MTW within Quartile 1: Lowest quartile 25%**

- Care Hours Per Patient day (CHPDD):

National Median	9.3	
Peer Median	8.7	
MTW	8.3	**MTW within Quartile 1: Lowest quartile 25%**

- Staff retention rate for Nurses

National Median	87.9%	
Peer Median	86.1%	
MTW	87.4%	**MTW within Quartile 3**

Key findings of the review:

- The staffing establishments at the time of the review were appropriate given our current method of calculating our establishment requirements; however this process was more complex to measure given the complexities at the time with managing COVID with the increased requirement to augment the staffing levels to ensure safe care.
- There are a small number of recommendations which have been agreed with the divisions that will be followed up in business planning where there is some requirement to review the staffing levels in line with service changes. Examples of this include our emergency department who are working on a business case for further investment in nurse staffing.
- The Birth-rate plus report which was undertaken in partnership with an external company for our maternity services has identified a need to recruit some additional midwives to our service.
- There is a need to ensure that for many of our wards who have now appointed Nursing Associate roles into their teams to ensure that this new role and further new roles are included in the budgeted establishment for future workforce planning
- Our ability to be able to flex our staffing resource was stretched significantly this year in response to COVID , we experienced high levels of sickness over the winter months which was COVID related , this impacted on our ability to maintain safe staffing levels at all times.

Trust Recommendations:

- Confirm the ongoing requirement for safe COVID pathways and recruit to substantive establishment accordingly.
- Recommend a further Trust wide review of planned staffing levels to consider an uplift of the Nursing and Midwifery establishments in some key areas, would propose in the first instance to review the RN/CSW ratio at night time . This will support key areas of focus around quality and safety of our patients.
- By enhancing our establishments this will provide us with a more robust and resilient infrastructure which will increase our ability to support and implement new roles, increase placement capacity supporting a positive learning environment and increase our ability to offer more apprenticeships and overall impact on .
- Proactively recruit to winter escalation wards with substantive staff, lessoning the reliance on redeploying staff from current staffing base and destabilising teams.
- Continued focus on proactive recruitment working with the recruitment team which will include overseas recruitment and a range of other local and National initiatives including volunteer roles.
- Propose that we over recruit to some services to allow us to be able to recruit newly qualifying student nurses and midwives.
- Since the staffing review has been undertaken the Ockendan report has been published – this will require further investment in our service to support our response.

Trust Recommendations:

- To continue to strengthen our workforce planning skills; as part of this process to ensure that there is due consideration given to apprenticeships roles including Trainee Clinical Support Workers (CSW) Trainee Nursing Associates (TNA) and Registered Nurse Degree Apprenticeships (RNDA).
- Trust wide review of supervisory time for department managers and banding in recognition of role responsibility and accountability.
- Review the infrastructure in place in terms of clinical facilitator / practice development nurses and midwives to ensure that we have a structure to support learners and new staff to the Trust.
- Progress the Advance Clinical Practice work in relation to standardising roles, defining MTWs current position and roles developed in line with service need.

Trust Recommendations:

- Give consideration to identifying a dedicated strategic lead for Safe Staffing in the Trust which will provide oversight on all nursing and midwifery staffing metrics in line with the National agenda and ensure compliance with the Developing workforce Safeguards.
- To continue to build on the work that we have undertaken to ensure ongoing review, monitoring and escalation of staffing levels is undertaken using the data from safe care to inform decisions.
- To continue to work towards compliance with the Developing workforce Standards with the wider multi professional team in terms of understanding our total staffing requirements for our wards
- Full implementation of Safe Care across the organisation, which will provide us with more meaningful acuity data which will inform our staffing requirements.
- Await publication of the safe staffing decision making tool that the RCN is due to publish

MTW

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Year-end review of the Board Assurance Framework (BAF), 2020/21 **Trust Secretary**

The Board Assurance Framework (BAF)

The BAF is the document through which the Board identifies the main risks to the Trust meeting its objectives and ensures adequate controls are in place to manage those risks.

Key objectives for 2020/21, and year-end position

The objectives in the BAF were approved by the Trust Board on 23/07/20. This report describes the year-end status for each objective (project aim), in terms of whether they were "Fully achieved", "Partially achieved" or "Not achieved"[1]. This status is summarised in the following table:

Project aim	Achieved?[1]
1. Finance and Contracts: To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus.	Fully achieved
2. Operational Performance: To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources.	Partially achieved
3. Quality and CQC: To deliver high quality care to our patients and carers and be recognised as an outstanding organisation	Partially achieved
4. Electronic Patient Record (EPR): Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care	Partially achieved
5. Education/Kent and Medway Medical School (KMMS): To enable fulfilment of MTW's role in the delivery of an integrated reputable, high quality educational programme and student experience for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital and Tunbridge Wells Hospital in time for the first intake of KMMS students on 01/09/22.	Fully achieved
6. Strategy - Estates: To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams	Fully achieved
7. Strategy – Clinical: To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation	Fully achieved
8. Integrated Care Partnership (ICP) /External: To oversee and enable the ICP Development in West Kent and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).	Fully achieved
9. Organisational Development and Workforce: Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities	Partially achieved

Further details are provided below. This report will inform the content of the Trust's 2020/21 Annual Report. The Board is therefore asked to confirm the year-end ratings as valid.

The future of the BAF

It was confirmed by the Trust Board on 25/03/21 that the "Strategy Deployment" process, and the monitoring and reporting of the objectives therein, would replace the BAF from 2021/22 onwards.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]

To confirm the year-end ratings as valid (or agree an alternative rating for each objective).

[1] "Fully achieved" and "Not achieved" ratings are relevant when there is absolute clarity as to whether (or not) an objective has been achieved, and usually relate to the objectives with the most 'SMART' qualities. A "Partially achieved" rating may be applicable when an element of subjectivity is involved, or a more nuanced assessment of performance is required

[2] 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

Project aim

1 Finance and Contracts: To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus

Member of the Executive Team responsible for delivery of the project aim: Deputy Chief Executive/Chief Finance Officer

Trust Board sub-committee responsible for oversight: Finance and Performance Committee

Year-end position: Was the project aim achieved by the end of 2020/21?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The Trust has delivered its financial plan for 2021/22 (subject to audit).

Project aim

2 Operational Performance: To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources

Member of the Executive Team responsible for delivery of the project aim: Chief Operating Officer

Trust Board sub-committee responsible for oversight: Finance and Performance Committee

Year-end position: Was the objective achieved by the end of 2020/21?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The Trust is in the top five best performing Trusts for the Emergency Department (ED) 4-hour and 62-day cancer waiting time targets.
- However, the adverse impact of the COVID-19 pandemic has meant that the Trust has not achieved the 18-week Referral to Treatment (RTT) waiting time standard, and the number of patients waiting about 52 weeks for treatment has increased.

Project aim

3 Quality and CQC: To deliver high quality care to our patients and carers and be recognised as an outstanding organisation

Member of the Executive Team responsible for delivery of the project aim: Chief Nurse

Trust Board sub-committee responsible for oversight: Quality Committee

Year-end position: Was the objective achieved by the end of 2020/21?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The Trust has delivered its plans in relation to the project aim, in relation to action plans, Key Lines of Enquiry (KLOE) and the work of the Quality Improvement Committee.
- The Trust is also able to demonstrate that it delivers high quality care to patients and carers, via oversight of quality and safety from the Divisional Directors of Nursing & Quality; the Matrons' quality assurance reviews; monitoring of key quality and safety indicators (which are included in a 'heat map' which we have developed this year); and the development and monitoring of action plans that have been identified through the self-assessments of the Care Quality Commission KLOEs (which are monitored at the Quality Improvement Committee).
- The Trust has however not yet received an external validation of an "outstanding" rating, so is unable to rate the project aim as "Fully achieved".

Project aim

4 Electronic Patient Record (EPR): Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care

Member of the Executive Team responsible for delivery of the project aim: Medical Director

Trust Board sub-committee responsible for oversight: Finance and Performance Committee

Year-end position: Was the objective achieved by the end of 2020/21?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- Stage 3 and 4a of the programme has been completed, which includes the design, build and validation of the Emergency Department (ED), outpatients, order comms, core clinical, therapies and Paediatric workstreams
- The custom code required for the Pathology interface has been delivered by Allscripts
- User Acceptance Testing (UAT) 4 and 5 has been completed, and all 'go live' blockers identified have been addressed
- The Sunrise 18.4 upgrade has been completed.
- All five rounds of Data Priming planned in 20/21 have been concluded
- The Ive programme / Windows 10 rollout, which was scheduled to support the Sunrise 'go live' commenced on time in January 2021. A number of issues during Quarter 4 were identified with the roll out of Windows 10 and plans were put in place. At the end of March 2021 the Ive programme was on track to meet the requirements of the Technical go live in mid-April 2021.
- Due to the second surge of COVID-19, the 'go live' for April 2021 was reviewed and reset to mid-June 2021.
- The design and configuration of the initial Electronic Prescribing and Medicines Administration (EPMA) functionality to 'go live' in December 2021 is currently on track.
- A managed service solution continues to be explored with Allscripts to support IT capacity and capability post go live

Project aim

5 Education/Kent and Medway Medical School (KMMS): To enable fulfilment of MTW's role in the delivery of an integrated reputable, high quality educational programme and student experience for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital and Tunbridge Wells Hospital in time for the first intake of KMMS students on 01/09/22

Member of the Executive Team responsible for delivery of the project aim: Medical Director

Trust Board sub-committee responsible for oversight: People and Organisational Development Committee

Year-end position: Was the objective achieved by the end of 2020/21?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The Trust is on track to achieve the final objective by September 2022 when the first KMMS students arrive on placement.
- The KMMS have confirmed student placement numbers at the Trust of 40 in Year 3 starting in September 2022. There is also tentative agreement for similar numbers in years 4 and 5, but these have not yet been confirmed. The Programme Specification Curriculum was received 23/11/20 and detailed planning and identification of resource implications is underway through the Specialty Lead Groups starting with Year 3. Clinical teaching facilities have been defined and included in the design of new build facilities at Tunbridge Wells Hospital. The facilities at Maidstone Hospital are being considered as part of the overall post-COVID-19 estate rationalisation work. The medical school accommodation build design and location was agreed with the Non-Executive Director oversight group on 02/02/21 and formal planning approval was submitted on 05/03/21.

Project aim

6 Strategy - Estates: To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams

Member of the Executive Team responsible for delivery of the project aim:	Chief Executive (through the Director of Estates and Facilities)
Trust Board sub-committee responsible for oversight:	Finance and Performance Committee (on the basis that the Trust Board agreed in June 2020 that future "update on the response to the external Estates and Facilities review" reports should be submitted to the Finance and Performance Committee instead of the Trust Board).

Year-end position: Was the objective achieved by the end of 2020/21?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The Trust Estates strategy has been drafted, but it is awaiting the confirmed details of the Trust's capital funding allocation for 2021/22. Once that allocation has been confirmed (via the Kent and Medway Sustainability and Transformation Partnership), a Trust Board Seminar will be scheduled to discuss the draft strategy, prior to it being submitted for approval to a formal Trust Board meeting.

Project aim

7 Strategy – Clinical: To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation

Member of the Executive Team responsible for delivery of the project aim:	Director of Strategy, Planning and Partnerships
Trust Board sub-committee responsible for oversight:	N/A – Trust Board to provide oversight (this was confirmed by the Trust Board on 26/11/20)

Year-end position: Was the objective achieved by the end of 2020/21?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- All clinical reconfiguration projects were paused during the COVID-19 second wave but these have now restarted and all are delivering against their agreed timelines.
- A timeline has been agreed for the cardiology reconfiguration with an 18-month timeline developed and being implemented against for the move of inpatient cardiology services and catheter laboratory to Maidstone Hospital.
- A timeline has been agreed for gastroenterology reconfiguration with agreement through the Kent County Council Health Overview and Scrutiny Committee (HOSC) by August 2021. Engagement has begun with local members and patients, and an options appraisal has been successfully completed with clinicians.
- The development of a Tier IV Bariatrics service has been agreed with the Executive Director of Strategy and Population Health at NHS Kent and Medway Clinical Commissioning Group (CCG) & a joint Business Case is being developed for consideration at the Trust Board and CCG Governing Body in May 2021.
- A Full Business Case (FBC) for a managed MRI service is being developed with approval targeted at the Trust Board in July 2021 and contract award in August 2021.

Project aim

8 Integrated Care Partnership (ICP) /External: To oversee and enable the ICP Development in West Kent and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).

Member of the Executive Team responsible for delivery of the project aim:	Director of Strategy, Planning and Partnerships
Trust Board sub-committee responsible for oversight:	N/A – Trust Board to provide oversight (this was confirmed by the Trust Board on 26/11/20)

Year-end position: Was the objective achieved by the end of 2020/21?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The ICP has successfully moved to phase two of its governance structures.
- Transformational priorities have been defined in conjunction with clinical and professional board reviewing population health data.
- The resourcing for ICP development for the year ahead has been agreed with NHS Kent and Medway CCG.
- Cross-organisational discussions on resourcing within the ICP have resulted in a clear implementation and resourcing plan with a trebling of the Joint Project Management Office (JPMO) resource.
- New roles and assigned clinical and professional backfill are allowing integrated models of frailty, health inequalities and Primary Care Network (PCN)-focused workstreams (e.g. primary care demand and capacity) to progress.
- The first new roles have been successfully recruited to and the rest are in the course of being advertised.
- The stakeholder advisory forum and elected members forum are being supported by the NHS Kent and Medway CCG locality team, to ensure appropriate input into ICP work.
- The next stage of development will be to dovetail with the Kent and Medway ICS end state workstream, to ensure that the ICP continues to develop in accordance with the Kent and Medway ICS.

Project aim

9 Organisational Development and Workforce: Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities

Member of the Executive Team responsible for delivery of the project aim:	Deputy Chief Executive / Chief Finance Officer
Trust Board sub-committee responsible for oversight:	People and Organisational Development Committee

Year-end position: Was the objective achieved by the end of 2020/21?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

Explanation of year-end rating / detailed status of year-end position:

- The Trust has seen improvements in its results from the NHS staff survey in a number of domains, and positive feedback has been provided via the in-year climate surveys.
- However, several of the Trust's interventions will not start to deliver improvements until 2021/22 (although these have started to be implemented during 2020/21)

NHS Maidstone and Tunbridge Wells NHS Trust

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

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

The IPC BAF is required to be updated and reviewed by the QC and Trust Board on a monthly basis during the Covid-19 pandemic
Changes are highlighted in red in the document.

Section 1:

- Suspected patients are isolated on admission pending the results of PCR tests. Medical review must be documented before PCR negative suspected patients are stepped down to green beds
- Use of FFP3 masks for all direct care of non-AGP Covid patients has now been steeped down and remains under review
- National guidance followed to enable FRSM to be worn for non-covid AGP
- Junior doctors have induction training including Covid delivered by DIPC
- Business case under development to make FIT testing team substantive as part of IPC team
- Patient and Staff Safety work stream moved to BAU

Section 2:

- All suspected/ confirmed cases are admitted to side rooms on designated wards pending PCR results.
- ITU have identified beds for Covid

Section 3:

- Routine visiting re-started from 29 March 21. One hour per patient on alternate days
- No visiting on Monday
- Additional visitors permitted only on compassionate grounds and to assist patients with specific needs. ITU has separate arrangements

Section 4:

- Routine visiting re-started from 29 March 21. One hour per patient on alternate days
- No visiting on Monday
- Additional visitors permitted only on compassionate grounds and to assist patients with specific needs
- Viewings of deceased patients have re-started in the Trust mortuary including for patients diagnosed with Covid-19
- Ongoing work with project plan in place to allow partners to attend all obstetric appointments

Section 6:

- Local decision to use FFP3 masks for all direct patient care of Covid positive patients since late December 2020. Decision kept under review and stepped down to national guidance 14 April 21 in view of low numbers of patients and high uptake of vaccine amongst staff
- Provision made for staff with risk factors etc to continue to use FFP3.
- Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric ultrasound, and these variations will continue.

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 • Obstetric patients and their partners have Covid PCR 48-72 hours prior to scan appointments • 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		
• there are pathways in place which support minimal or avoid patient	• Patients with confirmed Covid infection cohorted in specified wards. Patients		

bed/ward transfers for duration of admission unless clinically imperative	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 • Suspected patients are isolated on admission pending the results of PCR tests. Medical review must be documented before PCR negative suspected patients are stepped down to green beds		
• That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid contacts are cohorted according to date of exposure • All contacts are nursed in side rooms or bays with the doors shut • All contacts are swabbed twice a week for 14 days • Cohorts with the same isolation date may be merged if necessitated by bed pressure		
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	• IPC audits continue to monitor practice including PPE and hand hygiene. Ward audits and IPC triangulation audits reported through IPCC		

○ Staff adherence to hand hygiene? ○ Staff social distancing across the workplace ○ Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical ▪ b) non-clinical setting	• 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 • Maximum occupancy notices on all non-clinical doors rooms and clinical offices		
• Monitoring of compliance with wearing appropriate PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE and hand hygiene 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 • PPE officers provide PPE training to new starters • Use of FFP3 masks for all direct care of non-AGP Covid patients has now been steeped down and remains under review • National guidance followed to enable FRSM to be worn for non-covid AGP		
• Implementation of twice weekly lateral flow antigen testing for NHS	• Symptomatic staff testing by PCR is in place and available both on and off site		

patient facing staff, which include organizational systems in place to monitor results and staff test and trace	• Escalation plan in place with trigger points for increasing asymptomatic testing • Positive lateral flow followed up with PCR • 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 Covid infection • Results recorded on on-line platform • Weekly performance report to execs • Plan in place to refresh supplies for those running out of kit • Tests also available for bank and agency staff		
• Additional targeted testing of all NHS staff, if your Trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team	• All staff on outbreak wards have lateral flow checked and additional swabs as necessary for PCR • Outbreaks closely monitored by IPC team • Additional targeted testing has not been necessary to date		
• 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 20. 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 • Junior doctors have induction training including Covid delivered by DIPC		
• 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 PPE that protects them for the appropriate setting and context as per the PHE national guidance	• 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. • 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 management of stocks by procurement leads. Electronic monitoring system in place • Active monitoring of PPE burn rate and stocks • Reusable masks and air powered respirators available for those who fail FIT testing • 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. • Repeat FIT testing available for those affected by national withdrawal of one type of FFP3 mask • Business case under development to make FIT testing team substantive as part of IPC team		
• There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• 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 • Posters widely displayed throughout the Trust • Screensavers for Hands Space Face		
• 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 • Patient and Staff Safety work stream moved to BAU • 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 aenigmatica* 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 (risk stepped down but recommendations on u/s gel stand)		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• DIPC is member of exec team and updates as required • Covid update is standing item on Board agenda • ICC risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings • All pre-existing IPC risk assessment processes and policies remain in place and in date for non-Covid-19 infections • Trust compliant with Hygiene Code prior to pandemic. • IPC team reinforce practice at ward level • 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.		

• that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily 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 manner	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff		
• This Board Assurance Framework is reviewed and evidence of assessments are made available and discussed at Trust Board	• IPC Board Assurance Framework is updated by the DIPC and reviewed monthly at Trust Board. Evidence base is available as required		
• 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 – stood down to weekly in January 21 – stood down end February 21– no active outbreaks • DIPC updates to execs and Board at every meeting • IPCC reports to Quality Committee • Daily sitrep of open outbreaks from IPCT		
• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Execs and senior managers visit clinical and non-clinical areas regularly		

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 • All suspected/ confirmed cases are admitted to side rooms on designated wards pending PCR results. • ITU on both sites have beds identified for Covid		
• 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 • Additional robotic UVC resource (Thor) procured • Cleaning robot for public areas		
• Assurance processes are in place for monitoring and sign off for terminal cleans as part of outbreak management	• Nurse in charge checks cleans and signs off • IPC team advise on cleaning levels for outbreak management		
• 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	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		
As per national guidance: • '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	• Non-clinical areas are part of the cleaning audit schedule. Action plans developed where areas fail audit		

to resolve issues in maintaining a clean environment			
• 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		
• Monitor adherence to environmental decontamination with actions in place to mitigate any identified risk	• A Covid-active disinfectant (DiffX) has been used throughout the pandemic response. • Cleaning audits carried out by domestic, nursing and estates MDT according to schedule. Reported to and monitored by IPCC		

• Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	• Wards also received audit results • Additional checks in outbreak areas • Commode cleaning audited with triangulation audits in addition. Reported to IPCC • Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks and included on MDT cleaning audits		
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	• Routine ward based audits suspended for April and May 20	• C. difficile PII audits continuing • Reports to IPCC reinstated for June 20

• mandatory reporting requirements are adhered to and boards continue to maintain oversight	maintained in second wave • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians • 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	• Routine visiting re-started from 29 March 21. One hour per patient on alternate days • No visiting on Monday • Additional visitors permitted only on compassionate grounds and to assist patients with specific needs. ITU has separate arrangements • 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 • 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 • Viewings of deceased patients have re-started in the Trust mortuary including for patients diagnosed with Covid-19 • Introduction of partners to antenatal scans following risk assessment, vaccination of staff, provision of FFP3 masks for sonographers and pre-scan testing for pregnant woman and partner • Ongoing work with project plan in place to allow partners to attend all obstetric appointments		
• 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/2020/12/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	• For inter-departmental transfer,		

the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	handover of information by telephone or accompanying nurse • PHE guidance on discharge of patients 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 • Posters in wards to encourage patients to wear face masks		
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 PCR results. Non-suspected patients remain in AAU/AMU until rapid 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 • Patients on non-covid pathway have Covid point of care test in A&E.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in.		

	confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• 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, amber 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	• Standard triage template supported y electronic system (Symphony) and		

for triage questions to ask • triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors • facemasks are available for all patients and they are always advised to use them • provide clear advice to patients on use of facemasks to encourage the use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care • ideally segregation should be with separate spaces, but there is potential to use screens eg to	printed version • Triage carried out by senior nursing staff. • Immediate allocation of patient to pathway • Obstetric triage in place with senior midwife. Labour ward has designated red and green beds • 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 • Face masks available for all patients and patients advised to use them rather than own face coverings • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside • Posters in ward bays and patient information available • Reception staff are protected with screens in all areas • ED reception has physical separation of staff by Perspex screens		

protect reception staff	• Perspex screens on outpatient 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		
• To achieve 2 metre social and physical distancing in all patient care areas	• 2m minimum bed spacing in all wards and ED • Outpatients waiting areas are socially distanced		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• 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. • All patients who test negative on admission are re-tested at 5-7 days in		

• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly • There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	line with national guidance. Additional day 3 swab implemented in November • All laboratory results submitted to PHE for national track and trace • 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 • Any patients with new symptoms after admission are tested and isolated until the result is known • All patients who test negative on admission are re-tested at day 3 then 5-7 days in line with national guidance. • National guidance followed in all cases. Local guidance developed from national guidance and published through daily staff Bulletin and Covid pages on intranet. • Negative patients swabbed within 48 hours of expected discharge date for discharge to residential care facility and result available before transfer • Post-covid patients (14+days since diagnosis) are not re-swabbed prior to discharge unless immunocompromised. • Covid positive patients within 14 days of diagnosis requiring discharge to care facility are only discharged to designated centres		

• patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately	• Revised guidance issued removing the need for negative swabs in de-escalated patients and restricting the requirement for negative swabs prior to discharge • 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 • Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		

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		

• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results 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 and working within the clinical environment 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 stations 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 records maintained • Records maintained for cleaning of reusable masks		

	• Records maintained of formal IPC training • On line learning and development system records mandatory training		
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• PPE audits ongoing and reported to IPCC • Combined hand hygiene and PPE audit in place • Action plans for non-compliance • Local decision to use FFP3 masks for all direct patient care of Covid positive patients since late December 2020. Decision kept under review and stepped down to national guidance 14 April 21 in view of low numbers of patients and high uptake of vaccine amongst staff • Provision made for staff with risk factors etc to continue to use FFP3. • Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric ultrasound, and these variations will continue.		
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 • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional breakout areas available • Covid secure offices identified • Staff advised of social distancing rules and to avoid car sharing • Reminders on intranet and in daily Pulse to follow public health advice at all times		
• 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 visually displayed 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 • 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 • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets • staff understand the requirements for uniform laundering where this is not provided for on site	• Ward based audits in place. • Triangulation audits completed monthly by IPCT. • Directorates report to IPCC • All hand wash basins are co-located with paper towel dispensers • All hand wash sinks have hand washing and drying guidance on back boards in both clinical and public areas • 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		

• 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. • 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)	work in their own clothes and change on site • Staff changing and shower facilities provided on both sites • 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 if symptomatic and 10 days if asymptomatic throughout. • Lateral flow testing available for all clinical staff. • Positive lateral flow tests confirmed by PCR • Post-vaccine infection followed up with additional swab and blood for antibody testing. Enhanced surveillance forms completed on-line • Community rates of infection are continuously monitored with information disseminated to senior		

• 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 • Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	managers • Discussed at strategic command meetings • Daily sitrep analysis available to managers • 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 • Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list • Outbreaks declared as Serious Incidents		
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	• Pathways clearly identified and approval process in place		

on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Surgical green pathway implemented and reviewed according to prevalence of infection • Visitors are not permitted in Covid positive areas except in compassionate circumstances		
• 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 • Windows in all ward areas opened for 15 minutes three times per day to		

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	improve ventilation • 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: • 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 • 24/7 service for near patient testing across the Trust		
• 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		
• 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 infections takes place	• MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies		

• That all emergency patients are tested for COVID-19 on admission • That those inpatients who go on to develop symptoms of COIVD-19 after admission are re-tested at the point symptoms arise • That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission • That sites with high nosocomial rates should consider testing COVID negative patients daily • That those being discharged to a care home are being tested for COVID-19 48 hours prior to	• All routine diagnostic microbiology continues including C difficile. • All patients on the green (non covid) pathway have point of care (SAMBA) testing on admission • All patients on the red pathway have point of care (LIAT) tests when available and/or PCR • Any inpatient who develops symptoms of Covid has a laboratory PCR test and clinical review • All patients who test negative on admission are re-tested in lline with national guidance on day 3 and day 5-7 • Testing guidance is published in the daily Pulse and available on the intranet • Trust nosocomial rate is in line with national experience. • Daily swabbing has not been implemented • Contacts of Covid patients are swabbed twice weekly for 14 days • All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home • Results are shared with the receiving		

discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge • That those being discharged to a care facility within their 14-day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation • That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	care facility • Post-Covid patients are not tested further for 90 days unless they develop new symptoms • All patients within 14 days of initial diagnosis of Covid who require discharge to a care facility are discharged to a designated care setting. • All elective patients are tested 3 days prior to admission and asked to self-isolate until admission • Some patients are required to self-isolate for a longer period due to their underlying illness • Plan under development to return to national guidance for all patients following decrease in community prevalence		

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 and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• 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 flow tests and vaccination centres – current practice already in line with guidance • All linen from patients on amber and red pathways treated as infectious linen		
• PPE stock is appropriately stored and accessible to staff who require it	• 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	• Discussions are documented and records stored electronically		

the staff member and held centrally within the organisation, as part of employment record including Occupational health • 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 • 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 • 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	• 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 • 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 • 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		

• All staff adhere to national guidance on social distancing wherever possible, particularly if not wearing a facemask and in non-clinical areas	• 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 • 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 areas • 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 • Occupational Health maintain a list of staff who test positive more than 10 days post-vaccination. Support provided and additional swab and blood tests arranged. Enhanced surveillance completed on-line		

NHS
Maidstone and Tunbridge Wells NHS Trust

Six-monthly update on Estates and Facilities **Chief Executive**

It has previously been agreed that the Trust Board should receive a Six-monthly update on Estates and Facilities. The latest report is enclosed.

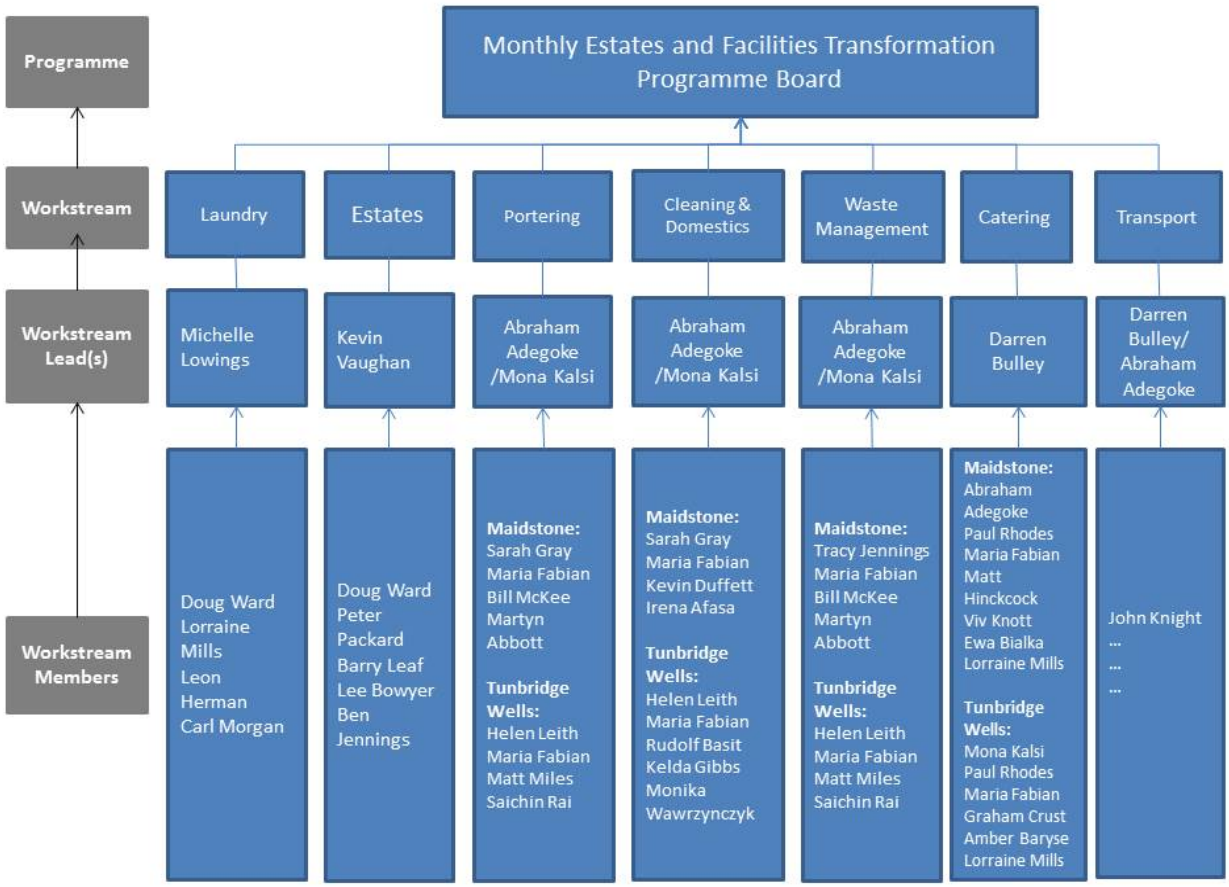
Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive (TME), 21/04/21
- Finance and Performance Committee, 27/04/21

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

Introduction

Estates and Facilities Transformation Workstreams



Arising out of the recommendations of the management consultants clear opportunities where presented were efficiency savings, economies of scale and financial savings could be obtained for the benefit of the Trust by improving working practices, driving in new efficiencies and tidying up assets in the following areas:

- Laundry
- Estates
- Portering
- Cleaning & Domestics
- Waste Management
- Catering
- Transport

The opportunity for signficant transformation changes is yielding results for a series of Estates & Facilities transformation programme workstreams. Lorraine Mills, Financial Improvement is directing the workstreams.

<u>Laundry Workstream</u>

The functionality of the Laundry in respect of operating costs and efficiency improvements have now been brought about. The cost of linen per piece has been reduced from 38p to 33p per unit.

Going forward if the Laundry is to be further improved investment is required in the purchase of leased equipment and the acquisition of a new tunnel washer.

The Trust has been working in conjunction with the STP with respect to the provision of Laundry services in Kent. There are currently three laundries functioning in Kent and a study has been undertaken with respect to reducing the three laundries to two across the Kent Trusts,

A report is being drafted on the Laundry finance and performance by Lorraine Mills. The report will outline the best option financially going forward for the Trust and the Laundry which shall be presented to the Finance and Performance Committee.

Transport Workstream

The Transport workstream has introduced a revised scheduling and collection of medical records from Paddock Wood. This arrangement has yielded financial savings. The Laundry schedule for collections and deliveries has now been rescheduled and the improved delivery regime will be evaluated over the coming months.

The Trust is undergoing studies working with the STP on transportation and couriers at present. The next detailed report from the STP is awaited on future opportunities on improving operational logistris and cost savings is awaited.

Estates Workstream

During the month progress has been made with developing the specification and business case for a new CAFM software system to operate Estates services from including a new help desk facility.

The Estates Directorate has now 8 fully functioning electric car charging points, 4 installed at Maidstone and 4 installed at Tunbridge Wells for the benefit of patients and staff. The uptake on usage of the electric chargers is growing and there have been a number of enquiries from staff regarding this facility who shall be purchasing electric cars in the near future. Highways England have acknowledged the Trust's investment in EV chargers and have requested that the Trust continues to install additional EV chargers at Maidstone and Tunbridge Wells Hospitals as demand increases.

Water Safety Management

Since the last update the Trust has now been successful with the appointment of a water safety manager who will be joining the Trust in three months. Changes to the water safety procedures are now being overseen by a locum water safety scientist who spends one day a week with the Trust managing water safety.

The new water Safety manager will take up his post in early June. The Trust in the interim continues with the support of a locum water safety scientist working in conjunction with Estates and Infection Prevention and Control. A number of pseudomonas readings have been found across both hospital sites and will now be vigorously addressed.

Contracts Non Pay

Sarh Stevens from the Procurement Directorate is now a member of the Estates department with a managerial reporting line to the Director of Estates & Facilities and a technical report line to the Procurement department. Substantial progress continues to be made with Estates contracts updating and improvement.

Last week a final meeting was held with the London Procurement Partnership (LPP) on the work they have undertaken with the introduction of sound governance methods in compliance with Trust standing financial

instrucitons to bring about a new Estates procurement system that is up to date and capable of interrogation and reporting facilities.

The author wishes to express his thanks to Bob Murray, Head of Procurement, for the task that has been undertaken in improving Estates contract procurement processes and governance.

Portering Workstream

Ongoing progress continues to be made with introducing efficiencies into the Portering programme by incorporating the provision of service into TeleTracking. The Teletracking system has provided significant improvement benefits to staff efficiencies in Portering. The teletracking system has also revealed areas at Tunbridge Wells Hospital were additional portering is indicated to be requied to meet clinical operational needs.

The facilities managers are working in close liaison with the Teletracking team and realising the significant benefits that the system has brought to the Trust. Ongoing modifications to Portering performance will be forthcoming over the coming months as the Teletracking system "beds down" and continues to provide added value and a good investment for operational hospital management cost optimisation.

A meeting with Teletracking and its overseas users is being held on Tuesday 20th April 2021 to discuss the post evaluation implementation of the Teletracking project in the Trust. The Facilities Directorate is being presented at the meeting by senior Facilities managers.

Cleaning & Domestics Workstream

The Cleaning and Domestic services are now fully managed by TeleTracking. This management tool is providing key driver efficiences in providing cleaning and domestic services and significant improvement in bed turn around times. The efficiencies that TeleTracking has provided for the domestic and cleaning staff have revealed other areas of significant inefficiences.

In conjunction with working with the Procurement department improvements are being made in mattress management and cost procurement.

The Trust has procured Thaw Ultra violet decontamination systems that are now in use and have led to further significant improvements in bed turnaround times as well as efficacy improvements to decontamination.

The Trust has now procured two "Ella" the floor cleaning robots for use at both acute hospital sites within the Trust. Delivery of the robots is anticipated to come about in May 2021.

Waste Management

Over the period of the second wave of the pandemic the Trust in line with other Trusts in the county experienced inadequate management of contracted waste removal. This matter was addressed by strong management in the facilities directorate and additional collections of waste were undertaken by independent contractors working with NHSE to rectify the backlog of waste on the acute sites.

Waste management efficiencies improve and the Trust is compliant with National specifications of performance and obligations.

Mona Kalsi, General Manager Facilities, manages the Trust waste schemes for both general and clinical waste. A report will be provided on change improvements that have come about in May 2021 with specific reference to recycling waste and the volumes achieved.

Catering Workstream

The independent Review of NHS Hospital Food is a significant departure form the recommendations provided within the Estates & Facilities management consultants report. Far reaching changes are being developed in conjunction with colleagues in the Nursing Directorate. In addition to this, the offering of food for staff and the possibilities of ongoing free food provision for staff is under review and scrutiny in the month of May.

The trust has, during the month, issued a new canteen menu with a line of food for vegan staff.

A report on the proposals arising out of the Independent Review on Hospital Food is being prepared and will be presented to the Executive Team for consideration in late May 2021.

Concluding Remarks

The Directorate is hopeful that the second wave of the pandemic has now ceased. The future is unclear as there is always the possibility of a third wave pandemic arising. In the interim, or perhaps the ongoing future, further work will be undertaken over the coming months on the implementation of the management consultant workstreams which will benefit the performance and quality of service provided by the Estates & Facilities Directorate.

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly report from the Freedom to Speak Up Guardian	Freedom to Speak Up Guardian / Deputy 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 Q4 (Jan – Mar 2021)

Action Requested / Recommendation

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

Summary

This is the 4th quarter and year-end report to the board which identifies trends and issues over the past year as well as a progress report and recommendations to improve and sustain the FTSU agenda

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

Date; April 2021

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Sue Steen
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

Freedom To Speak Guardian Survey 2020

There has been no case review since June 2020 however a report on the survey of Freedom to Speak Up Guardians conducted in 2020 has been released by the National Guardian Office and key findings from the survey are stated below:

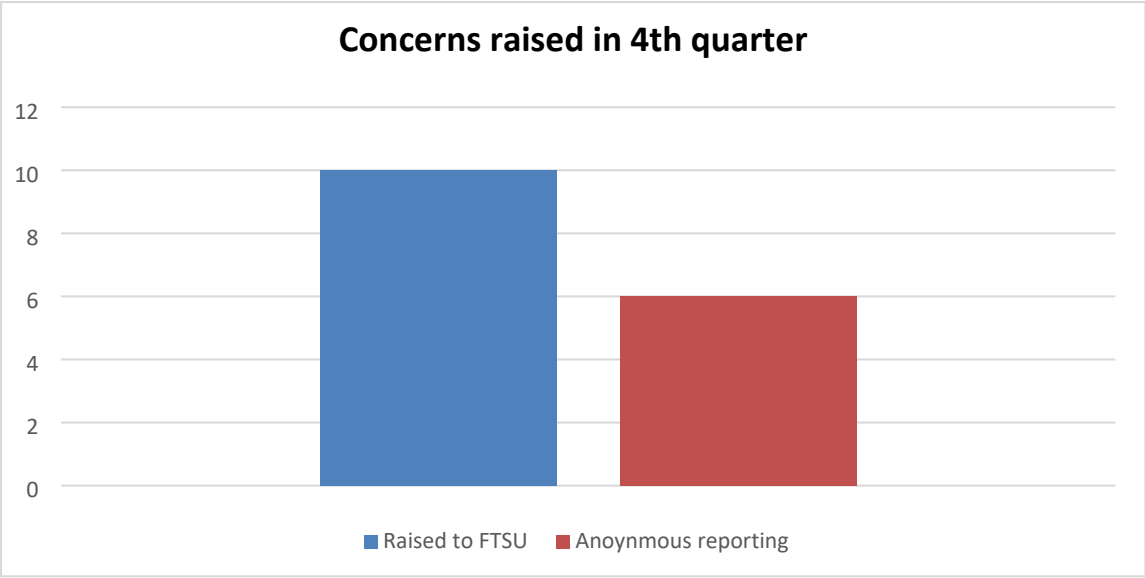
- 41% of Guardians were appointed to their role through open competition, up from 33% in 2019 and a greater percentage of the respondents have been in role for 18 months or longer. The responses to the survey suggest FTSU Guardians was diverse in the roles and grades/bands represented, with the largest proportion being in band 7 and 8a
- BAME groups were under-represented with 90% of respondents from NHS Trusts being identified as white. MTW is one of the few NHS Trust that has a BAME Guardian
- A larger proportion of respondents indicated speaking up training was available to workers and proposed that speaking up training should be mandatory
- 85% of respondents felt valued by senior leaders, whereas only 68% felt valued by middle managers
- There was an increase in the percentage of respondents who believed the FTSU Guardian role was making a difference in their organisation.
- Detriment for speaking up (often referred to as disadvantageous or demeaning treatment) remained a concern. There were diverse sources of detriment with line managers and middle managers more likely to be reported as a common source. We currently have a member of staff at MTW who has potentially suffered detriment and it's been reviewed.
- Black and ethnic minority workers and lesbian, gay and bisexual workers were among those cited as groups that had been identified as facing barriers to speaking up and leaders should work with FTSU Guardians to address barriers

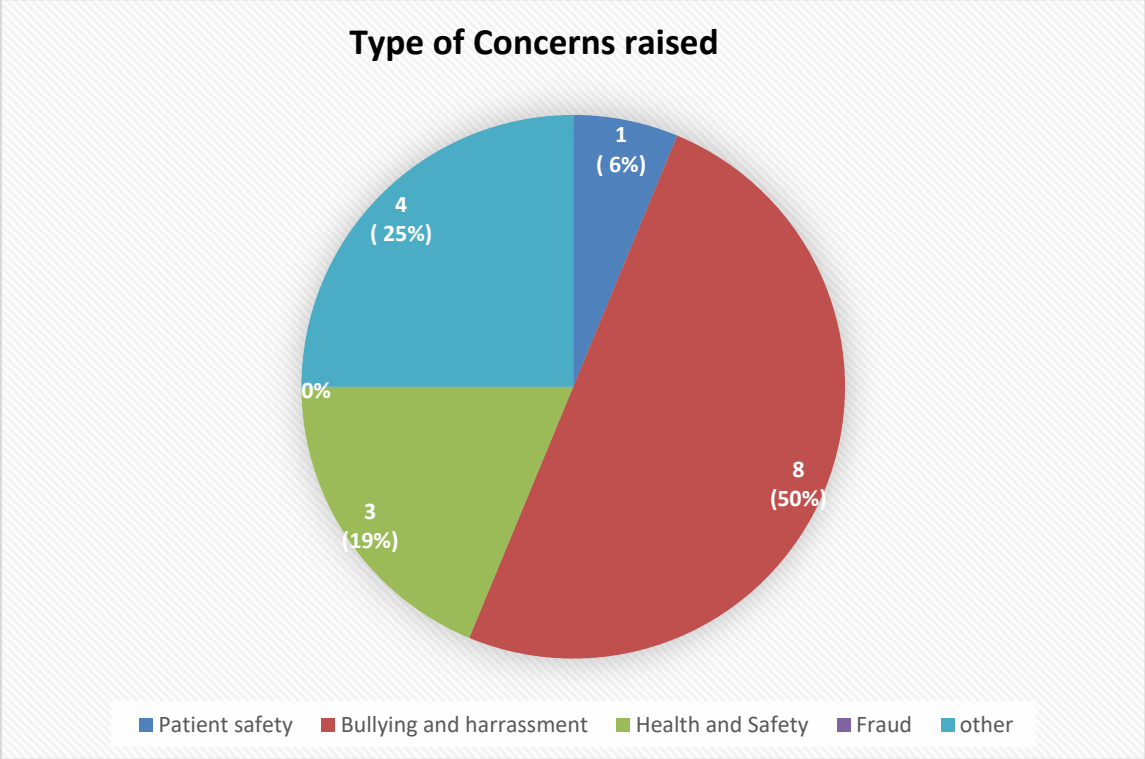
Themes / Issues

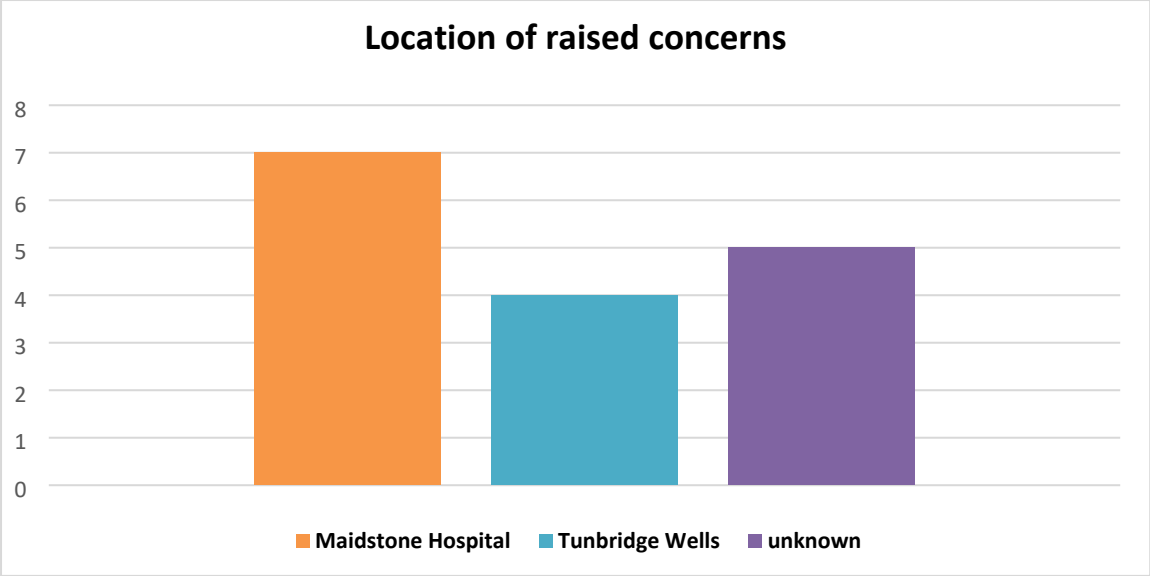
Sixteen **(16)** concerns were raised in the last quarter. Six **(6)** of these were raised through the anonymous reporting portal while the other ten **(10)** were raised directly to the FTSU guardians. There were two (**2)** anonymous concerns raised in Tunbridge wells - one on **infection control** and the other on **patient safety**. There was no location mentioned on the other four (4) anonymous concerns raised.

Seven **(7)** of the concerns raised directly to FTSU guardian were in Maidstone, and the other three **(3)** were in Turnbridge wells. Five **(5)** of the issues raised at Maidstone were on bullying and harrassment while the **other 2** were on sickness management and graduate scheme recruitment. All three (3) concerns raised at Tunbridge wells were on bullying and harrassment.

Ten **(10)** of the cases raised during the last quarter have now been successfully closed, the case on sickness management is still undergoing some investigation while the others are in the process of an informal meeting to resolve the concerns raised.

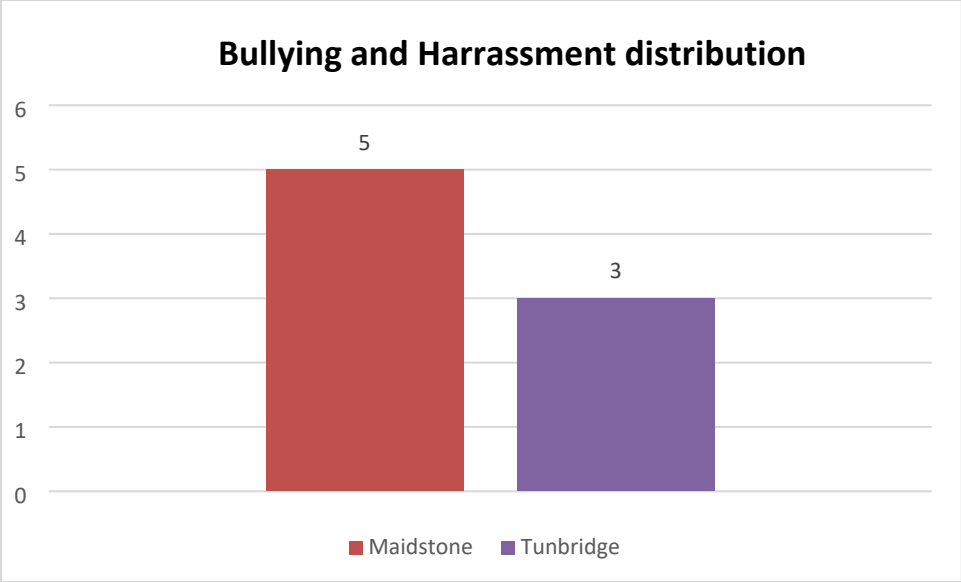

Concerns raised in 4th quarter
12
10
8
6
4
2
0
Raised to FTSU
Anoynmous reporting


Type of Concerns raised
1
(6%)
4
(25%)
0%
8
(50%)
3
(19%)
Patient safety
Bullying and harrassment
Health and Safety
Fraud
other



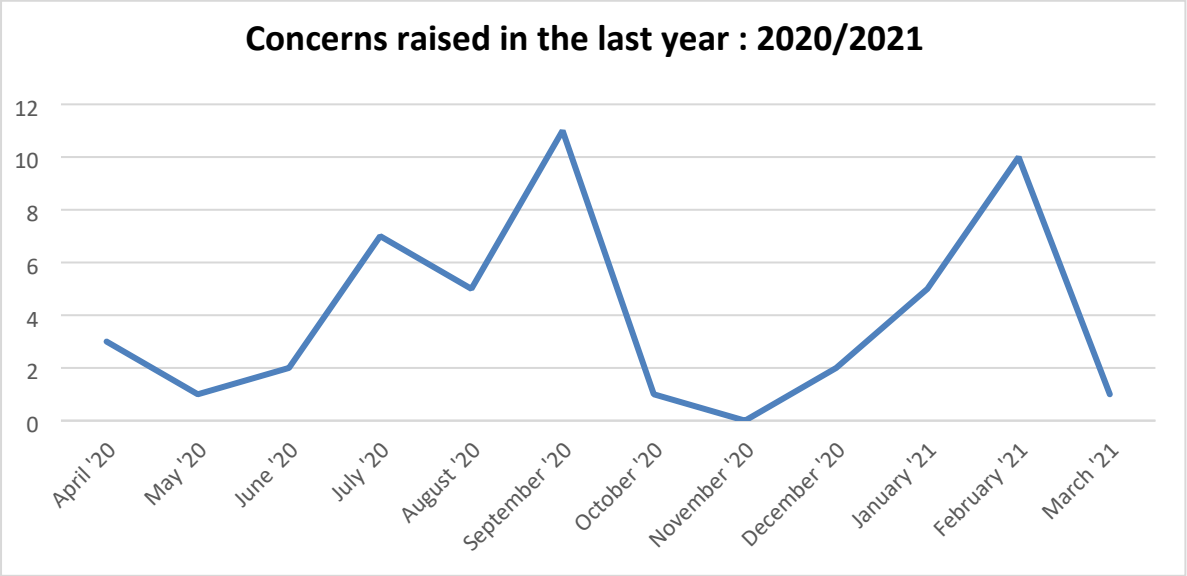
The concern on patient safety which was reported anonymously was about a patient who had died in Tunbridge Wells due to cardiac arrest and a DNAR form was claimed to be filled after death. This was immediately escalated to the clinical director/ matron of the department/ patient safety team and an investigation was requested to be carried out on the incident. Evidence from the investigation suggested that the plan was discussed with the patient, who expressed her wishes not to be resuscitated. The form was completed prior to time of death; however, the doctor was in a discussion with ITU, therefore his signature may have been post arrest.

Five (5) out of the eight (8) concerns raised on bullying and harrassment were in clinical areas (**3 on Maidstone** and **2 on Tunbridge Wells**) while the others were in non-clinical areas. All claims were against a direct line manager. All staff who raised concerns on bullying and harrassment reported they were suffering a heightened level of stress, anxiety and in some cases, they were already being seen by the well-being psychologist in the Trust. 4 of these cases have now been resolved through organising informal meeting between the member of staff, a representative (if requested by the member of staff), their manager and a senior manager. The other 4 cases are still being progressed and cannot be reported further at this point.



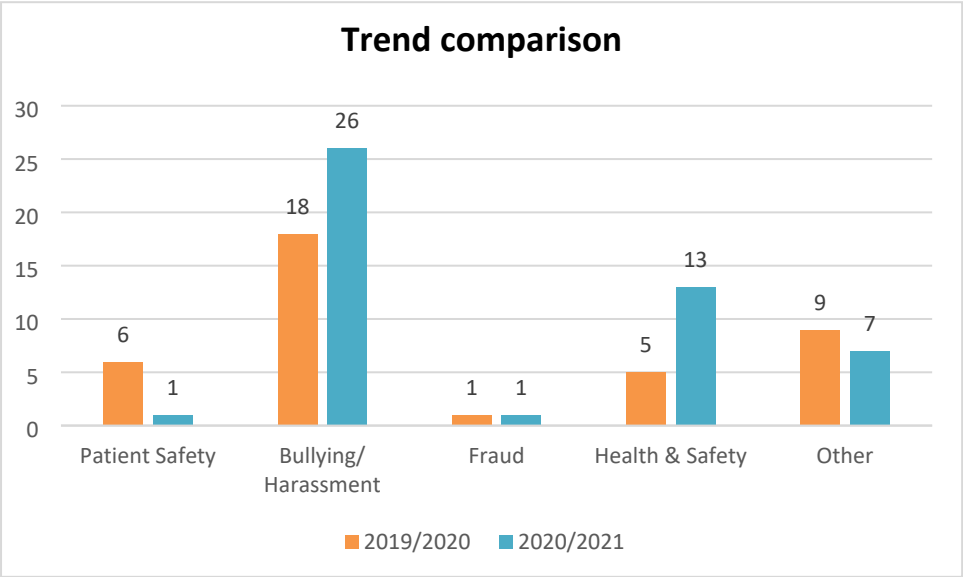
2020/2021-year Analysis

In the last year, we had a total of **49 cases** raised through FTSU, an increase of **10 cases** when compared to 2019/2020. As the lockdown started to be eased in June 2020 and more staff were returning on site to continue working, we saw a significant increase in cases with the highest recorded number of cases raised in September 2020. Again, as the number of covid 19 cases began to increase across the UK/ in the Trust and new lock down rules were introduced, the number of concerns raised through FTSU decreased and began to gain traction in January/February 2021.



Trends comparison

In comparison to 2019/2020, the highest number of concerns raised through FTSU were concerns around bullying/harrassment and health and safety, an increase of **8 concerns** for both concerns. In regards to patient safety, there was a huge decline, with only 1 concern raised in 2020/21, compared to **6 concerns** in 2019/2020.



FTSU strategy 4th quarter progress report

In addition to the number of concerns raised and in spite of the vaccine roll out during the previous quarter, the following things have been successfully achieved by the FTSU guardians to further promote the agenda

* FTSU Guardians continue to attend various network meetings and provide support to staff who raise concerns through the networks

* Materials /screensavers for publicising the FTSU agenda are now available and have been put up in staff areas on both sites

* An interview was held with Peter Maskell in January to promote the FTSU agenda

* BAME lived experience session was held with the BAME allies in January and a follow up meeting was held to discuss action plans which are currently been implemented

* Freedom to speak up presentation and a facilitated conversation which enabled BAME staff share some of their experiences and the support they received was held on 25th February during the Cultural and Ethnic Minority Network meeting

* The FTSU guardians, in partnership with the learning and development team have worked closely in embedding the FTSU agenda in trust inductions

* The process of recruiting safe space champions to work closely with EDI and FTSU team is on-going. A pilot training to review the content of the presentation was conducted in March with representatives from various networks, learning and development in attendance.

Growing the Speaking Up Agenda

The National Guardian office in partnership with Health Education England have launched two e-learning packages in regards to speaking up for all workers and line managers which is very useful for promoting the FTSU agenda. The first module – ***Speak Up*** – is for all workers while the second module***, Listen Up***, for managers and both modules focus on listening and understanding the barriers to speaking up. A final module, **Follow Up**, for senior leaders, will be launched later in the year to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems

We are working with the learning and development team to include these modules in MTW e-learning and we recommend that this should be a mandatory course for all MTW staff and these courses should be done every 3 years as a refresher course.

Data Collection; Concerns Raised

2020/21 details

Quarter	Month/Year	No. of Contacts	Open Cases		Quarter	Month/Year	MGH	TWH	Unknown
Q1	April-June '20	6	3		Q1	April-June '20	5	0	1
Q2	July-September '20	23	7		Q2	July-September '20	3	9	11
Q3	October-December '20	4	0		Q3	October-December '20	3	1	0
Q4	January-March '21	16	5		Q4	January-March '21	7	4	5
Total	**2020/21**	**49**	**15**		**Total**	**2020/21**	**18**	**14**	**17**

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	0
August	5	3	2
September	11	0	4
October	1	0	0
November	0	0	0
December	2	1	0
January	5	2	1
February	10	4	4
March	1	0	0
Total	**49**	**15**	**14**

Staff Group	
Estates & Facilities	5
Nursing	14
Midwifery	0
Medical	5
AHP's	10
Clinical Support	**0**
A&C	8
Unknown	7
Total	**49**

Theme	
Patient Safety	1
Bullying/ Harassment	26
Fraud	1
Health & Safety	13
Other	7
Total	**49**

2019/2020 Details

Quarter	Month/Year	No. of Contacts	Open Cases	MGH	TWH	Unknown
Q1	April-June '19	15	0	3	9	3
Q2	July-September '19	16	0	7	5	4
Q3	October-December '19	1	0	0	1	0
Q4	January-March '20	7	1	6	1	0
Total	**2019/20**	**39**	**1**	**16**	**16**	**7**

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**

Charitable Funds Committee, 23/03/21 **Committee Chair (Non-Executive Director)**

The Charitable Funds Committee (CFC) met on 23rd March 2021 virtually, via webconference.

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

- The **actions from previous meetings** were noted
- The Committee considered and agreed a **proposal regarding the delegation of authority to the Charity Management Committee for the approval of expenditure.**
- As part of the annual review process the Committee **approved the Charity Management Committee's Terms of Reference**, subject to the amendment of "To receive and approve funding applications for the General Charity Fund" to "To receive applications for the General Charity Fund and recommend the approval of such applications to the relevant fund holder" within the "Duties" section of the Charity Management Committee's Terms of Reference, to reference the proposal agreed under the previous item.
- The Committee undertook an **annual review of the risk register entries relevant to the Charitable Fund** wherein it was agreed that the Trust Secretary should ensure that future "Risk register entries relevant to the Charitable Fund" reports provided assurance regarding how the control measures were monitored and achieved for each risk. It was also agreed that the Assistant Trust Secretary should schedule a further review of the risk register entries relevant to the Charitable Fund for the Committee's meeting in July 2021.
- The Committee reviewed **the revised policy and procedures for charitable funds** wherein it was agreed that the Head of Financial Services should ensure that the "policy and procedures for charitable funds" was amended to include the process (once provided by the Trust Secretary) for the treatment of donations should the originally intended target for any fundraising campaigns not be achieved.
- The **audit approach for the 2020/21 Maidstone and Tunbridge Wells NHS Trust charitable fund accounts** was confirmed as an independent examination rather than a full on-site audit.
- The **financial overview at Month 11** was considered and it was noted that:
  - The fund balance stood at £969k, an increase of £206k since 1st April 2020
  - 80 specific donations had been received exceeding £1k totalling £387.3k. The largest single donation was £179.6k from NHS Charities Together for COVID-19
  - No requests for expenditure had been refused during the period
  - In total the Trust had received £269k from donations for COVID-19
  - The single largest expenditure was £195k for a Prone Biopsy system for Peggy Wood
- The Fundraising Manager provided the latest f**undraising update which included an update from the Charity Management Committee,** that the Trust's choir had released a single which was available for digital download via various platforms, an update on the development of the Trust's Charity website, and a progress report on the stage three submission to NHS Charities together.
- The Committee reviewed the **Trust's proposed fundraising priorities, initiatives and expenditure, for 2021/22** wherein a detailed discussion we held on the Trust's approach for the 2021/22 financial year and it was agreed the Director of Strategy, Planning and Partnerships should further develop "Option C" of the "The Trust's proposed fundraising priorities, initiatives and expenditure, for 2021/22" report to reflect the mechanisms by which the Trust Corporate and Clinical Divisions would support the Trust's fundraising priorities. It was also agreed that the Director of Strategy, Planning and Partnerships should consider, and confirm, the approach to be taken for the review of the revised "Option C" of the "The Trust's proposed fundraising priorities, initiatives and expenditure, for 2021/22" report, by Committee members, prior to the end of the Fundraising Managers tenure at the Trust.
- The Committee received an **update on proposed partnership with Maggie's Centres**
- The Committee agreed to undertake an **evaluation** for the first time, and also agreed the method of that evaluation (i.e. by a survey of all members and regular attendees)
- Under **Any Other Business** the Committee commended contribution of the Fundraising Manager during their tenure at the Trust.

2. In addition to the actions noted above, the Committee agreed that: N/A
3. The issues that need to be drawn to the attention of the Board are as follows: N/A
Which Committees have reviewed the information prior to Board submission? N/A
Reason for submission to the Board (decision, discussion, information, assurance etc.) [1] Information, assurance, decision

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Quality Committee, 14/04/21 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 14th April 2021 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The **progress with previous actions** was noted
   - The Deputy Chief Nurse attended for a **review of the Trust's response to the misplaced NG tube Never Event** wherein it was agreed that the Chief Nurse should consider, and confirm, the method by which the 'Main' Quality Committee should receive regular updates on the Trust's action plan for the misplaced Nasogastric Tube Never Event. It was also agreed that the Assistant Trust Secretary should schedule a "Review of the actions implemented in response to previous Never Events at the Trust" item at the Quality Committee 'Deep Dive' meeting in June 2021.
   - The Lead Nurse for Tissue Viability, Lead Nurse for Falls Prevention, the Tissue Viability Nurse and Deputy Chief Nurse attended for a **review of falls and pressure ulcers.** The presentation gave a comprehensive overview of falls and pressure ulcers at the Trust, the impacts of COVID-19 on the number of incidents, the monitoring mechanisms across the Trust and the action plans which had been developed to reduce the incidents of falls and pressure ulcers in the future at the Trust. It was also noted that there was a potential increased risk of falls in at risk groups in the community due to muscular deconditioning associated with a lack of physical activity due to shielding requirements. The committee commended that no Serious Incidents (Ss) related to pressure ulcers were declared for 2020/21.
   - A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein it was agreed that the Assistant Trust Secretary should schedule a "Review of the Trust's approach to a Care Quality Commission (CQC) inspection compared to the revised inspection approach which had been adopted by the CQC in 2021" item at the Quality Committee 'Deep Dive' meeting in August 2021

2. **In addition to the agreements referred to above, the meeting agreed that:** The Assistant Trust Secretary should circulate the "Review of the Trust's response to the misplaced NG tube Never Event" presentation to all Committee members

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

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

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

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

Summary report from the People and Organisational Development Committee, 23/04/21 (incl. the latest quarterly update from the Guardian of Safe Working Hours; and approval of revised Terms of Reference)	**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 23rd April 2021 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The Committee welcomed the Chief People Officer to their first Committee meeting.
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The **monthly update on the latest People Key Performance Indicators (KPIs)** was given and it was agreed that the Chief Finance Officer should liaise with the Business Intelligence Team to ensure that the "Vacancy rate %" metric within the "WELL LED- Operational Objective: Workforce" domain included a footnote which outlined that the increase was due to the utilisation of core establishment figures
- The **Monthly update on recruitment and retention which included the findings from staff exit interviews** was reviewed and the Committee commended the implementation of the 'moving on' survey which would support the provision of data to triangulate areas for improvement.
- The Committee reviewed the method by which the Committee should receive **assurance in relation to the patient experience associated with staffing levels at the Trust** and it was agreed that the Chief Nurse should investigate whether research undertaken by the King's Fund could be utilised to further develop the Patient Experience work in relation to staffing levels at the Trust. It was also agreed that the Assistant Trust Secretary should schedule an "Update on the method by which the Committee should receive assurance in relation to the patient experience associated with staffing levels at the Trust" item for each 'main' People and Organisational Development Committee from June 2021.
- The Chief People Officer provided an **update on Equality, Diversity and Inclusion (EDI).**
- The Committee reviewed an **update on the latest 'MTW Climate survey' and national NHS staff survey 2020** which included divisional engagement 'plans on a page' wherein it was agreed that the Organisational Development Consultant should liaise with the author of the Workforce Race Equality Standard (WRES) 2020 Action Plan to ensure that the action plan was amended to reflect the comments given at the Committee's meeting on 23/04/21.
- The Associate Director of Communications attended to provide the latest **quarterly review of internal communications** which included the communications plans in relation to the Trust's Staff survey findings and it was agreed that the Chief Finance Officer should investigate the establishment of meetings between Business Partners from the Trust's various Corporate Directorates to ensure improved data sharing and alignment of workstreams.
- The **Guardian of Safe Working Hours** attended to give their latest **quarterly update** (covering Jan to Mar. 2021), and it was agreed that the Chief Nurse should Submit a report which outlined the experience of trainees at the Trust during the second wave of COVID-19 to the Committee's 'main' meeting in June 2021. The report considered at the meeting has been included in full in Appendix 2.
- The **Director of Medical Education (DME)** gave their latest **quarterly update** which included an update on the Kent and Medway Medical School and outlined the impacts associated to changes to the GP training programme.
- Due to time constraints it was agreed that the **update on the relevant aspects of the Trust's risk register** should be rescheduled to the Committee's 'main' meeting in June 2021
- The **Committee evaluation** at the end of the meeting acknowledged the improvement of the quality of the reports the Committee received and the data contained therein.

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

The Chief People Officer should consider, and confirm, the frequency by which the Committee

should receive an update on the divisional engagement 'plans on a page'.

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

- The Committee's Terms of Reference were reviewed and the proposed changes were agreed. The revised Terms of Reference are enclosed in Appendix 1, for the Trust Board's approval
- The latest quarterly update from the Guardian of Safe working Hours (covering Jan to Mar. 2021) is enclosed in Appendix 2, for assurance

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

People and Organisational Development Committee

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

1 Purpose

The People and Organisational Development Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of people development, planning, performance and employee engagement.

The Committee will work to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success.

2 Membership

- Non-Executive Director (Chair) *
- Non-Executive Director or Associate Non-Executive Director (Vice Chair) *
- One other Non-Executive Director or Associate Non-Executive Director*
- Chief Nurse*
- Chief People Officer*
- Deputy Chief Executive / Chief Finance Officer ~~/ Deputy Chief Executive~~*
- Deputy Medical Director
- Director of Medical Education (DME)
- ~~Director of Workforce~~

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

Members can send an appropriate deputy if they are unable to be present at People and Organisational Development Committee meetings.

3 Quorum

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

- The Chair or Vice Chair of the People and Organisational Development Committee and one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team (i.e. Chief Nurse, Chief People Officer or Deputy Chief Executive/Chief Finance Officer). Deputies representing members of the Executive Team will count towards the quorum.

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

- The Chair or Vice Chair of the People and Organisational Development Committee and one other Non-Executive Director or Associate Non-Executive Director[1]
- One member of the Executive Team (i.e. Chief Nurse, Chief People Officer or Deputy Chief Executive/Chief Finance Officer). Deputies representing members of the Executive Team will count towards the quorum.

~~The Committee shall be quorate when two members of the Executive Team and two Non-Executive Directors (or Associate Non-Executive Directors) are in attendance.~~

~~Deputies sent by members will count towards these quorum requirements.~~

4 Attendance

All other Non-Executive Directors (including the Chair of the Trust Board~~) and any~~, Associate Non-Executive Directors~~,~~) and members of the Executive Team (i.e. apart from those listed in the "Membership") are ~~entitled~~ welcome to attend any meeting of the Committee.

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

Other staff, including members of the ~~Human Resources/workforce Directorate~~People Function, may be invited to attend, as required, to meet the Committee's purpose and duties.

5 Frequency of meetings

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

The Chair can call a meeting at any time if issues arise.

6 Duties

To provide assurance to the Trust Board on:

- people planning and development, including alignment with business planning and development;
- ~~equality and diversity~~equality, diversity and inclusion in the workforce;
- employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes~~;~~
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- staff recruitment, retention and satisfaction;
- employee engagement
- internal communications
- terms and conditions of employment, including reward~~;~~
- organisational development, organisational change management and leadership development in the Trust;
- training and development activity ~~in the Trust including prioritisation~~;
- reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training)
- The Trust's Freedom to Speak Up Guardian (FTSUG) arrangements

To convene task & finish groups to undertake specific work identified by the Committee or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

7 Parent committees and reporting procedure

The People and Organisational Development Committee is a sub-committee of the Trust Board.

A summary report of each People and Organisational Development Committee meeting will be submitted to the Trust Board. The Chair of the People and Organisational Development Committee will present the Committee's report to the next available Trust Board meeting.

8 Sub-committee~~s~~ and reporting procedure

The following Committee~~s~~ report~~s~~ to the People and Organisational Development Committee through its~~their respective~~ chair~~s~~ or representatives following each meeting~~. The frequency of reporting will depend on the frequency of each of the sub-committees~~:

- ~~Health and Safety Committee~~
- Local Academic Board (LAB) (reporting to occur via the report from the DME)

9 Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the People and Organisational Development Committee may, when an urgent decision is required between

meetings, be exercised by the Chair of the Committee, after having consulted at least two Committee members who are members of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the People and Organisational Development Committee, for formal ratification

10 Administration

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

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

11 Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the People and Organisational Development Committee at least annually, and then formally approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference agreed by Workforce Committee: 29th September 2016
- Terms of Reference approved by Trust Board: 19th October 2016
- Terms of Reference agreed by Workforce Committee: 30th October 2017
- Terms of Reference approved by Trust Board: 29th November 2017
- Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)
- Amended Terms of Reference approved by Trust Board: 1st March 2018
- Terms of Reference agreed by Workforce Committee: 28th March 2019
- Amended Terms of Reference approved by Trust Board: 25th April 2019
- Amended Terms of Reference approved by Trust Board, 31st October 2019 (to add the Health and Safety Committee as a sub-committee)
- Terms of Reference agreed by Workforce Committee: 26th March 2020 (as part of the annual review, and to include the Inclusion Committee as a sub-committee, to add the Deputy Medical Director as a member, and to reflect the agreement that members can send deputies if they are unable to be present)
- Terms of Reference approved by Trust Board: 30th April 2020 (as part of the annual review)
- Amended Terms of Reference agreed by Workforce Committee: 15th May 2020 (to withdrawn the membership of the Chief Operating Officer and to add the Chief Finance Officer as a member)
- Amended Terms of Reference approved by Trust Board: 21st May 2020
- Change approved by the Trust Board, 25th June 2020, to increase the frequency of meetings to monthly
- Change of the Committee's name and removal of the Inclusion Committee as a sub-committee, agreed by the Workforce Committee, 15th October 2020
- Change approved by the Trust Board, 22nd October 2020, to change the Committee's name (from the Workforce Committee to the People and Organisational Development Committee) and removal of the Inclusion Committee as a sub-committee.
- -Terms of Reference agreed by the People and Organisational Development Committee: 23rd April 2021 (as part of the annual review, to remove the Health and Safety Committee as a sub-committee, to reflect the change of job title from Director of Workforce to Chief People Officer, to include the differentiation between the 'main' and 'deep dive' meeting and to more explicitly indicate the q~~Q~~uorum requirements)
- Amended Terms of Reference approved by Trust Board: 29th April 2021

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – APRIL 2021

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (JANUARY TO MARCH 2021)	**GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period January to March 2021

- 146 Exception reports were raised in the period
- 77 from FY1, mainly in Medicine
- 69 from FY2
- Orthopaedics generated 92 exception reports & Medicine 45
- Covid19 second wave is likely to be the reason for a rise in reporting in the quarter due to increased workload and staff shortages.
- No work schedule reviews or fines were enforced in this period.

Reason for submission to the People and Organisational Development Committee
Assurance

Reporting Period: January – March 2021

Exception Reports

High-level data:

Number of doctors in training on 2016 TCS (total):	365

a) Exception reports (with regard to working hours)

Exception reports by department: January – March 2021				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Ortho	0	92	92	0
Medicine	0	45	45	0
Surgery	0	5	5	0
Gynae	0	3	3	0
Haematology	0	1	1	0
Total	**0**	**146**	**146**	**0**

Exception reports by grade: January – March 2021				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	77	77	0
F2	0	69	69	0
ST grade	0	0	0	0
Total	**0**	**146**	**146**	**0**

Report Commentary:

For the period January – March 2021 the trust received 146 Exception reports.

The first 3 months of 2021 have probably been the most challenging period for the trainee doctors since the contract commenced in 2016. Anxiety around catching Covid, covering wards that had the minimum of medical teams and increased workload were some of the challenges. Consequently, many more exception reports were received in this period compared to previous years.

It was clear to see during my visits to medical wards how hard the trainee doctors were working, with the support of consultants who were also, incredibly stretched. Credit must be given to the senior medical teams and rota co-ordinators for ensuring wards were covered and patients safe.

Looking at the exception reports by grade, 77 were from FY1 trainees, mainly in Medicine. There were 69 raised by FY2, with a large percentage from Orthopaedics. It is very unusual for Orthopaedics to generate so many exception reports. I discussed this with the Clinical Director of Orthopaedics, he had not personally been made aware of any specific issues in the department, apart from during the Covid second wave. During this time Orthopaedic FY2s were covering on medical wards at TWH, which likely accounts for the increase in reporting numbers, as there was reduced elective work happening. Reduced staff numbers compounded this.

The Clinical Director will discuss further with the Orthopaedic Clinical Tutor. The trainees will be made aware of the need to vocalise sooner any issues with excessive workload or hours, this will allow a more timely response in future.

Looking at the trends in exception reports generated they are always due to excessive workload, staying late, short staffing and occasionally missed breaks. It is rare in our Trust to receive reports relating to inadequate supervision, which is reassuring to me as Guardian and a credit to the Trust.

It is to be noted that interpretation of the increased numbers Exception reports this quarter was challenging due to a proportion of trainees having selected multiple specialist teams, grade and consultant educational supervisor, when submitting a report. The introduction of the Allocate system will allow trainees to more accurately select their correct areas, thus allowing easier identification of each one. As Guardian, I can then focus on the root cause of exception reports.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 27/04/21	**Committee Chair (Non-Exec. Director)**

The Committee met on 27th April, via a webconference.

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

- The **"Focus on…"** programme of items was reinstated for the first time since the start of the COVID-19 pandemic. The focus was on outpatients, and the Divisional Director of Operations for the Cancer Services Division attended and gave a helpful presentation highlighting the various workstreams in place. This was noted but also that it is very important to continue to make improvements.
- The Chief Operating Officer reported on the **month 12 non-finance related performance**, which highlighted that there had been a large increase in cancer-related referrals in March and April, and this would likely have an adverse impact on the Trust's performance on the two-week waiting time target.
- The **financial performance for month 12** was reviewed, which noted that the Trust had ended the 2020/21 year with a small surplus (of £330k), and had been able to carry forward its closing cash balance of £26.2m as an "undershoot" against its External Financing Limit. It was agreed to check whether the Trust could use the cash balance it carried forward to buy back/repay its Public Dividend Capital.
- The Director of Strategy, Planning and Partnerships attended to report on the **operating plans for the first half of 2021/22**, and a lengthy discussion was held**.**
- The latest **six-monthly update on the options being considered in relation to the PFI contract** at Tunbridge Wells Hospital was noted.
- The Director of Estates and Facilities attended to give the latest **update on the response to the external Estates and Facilities review**, and they agreed to ensure that future reports included details of the financial impact of the recent improvements in Estates procurement arrangements.
- An update was given on the **options regarding the laundry service** and it was agreed that the Trust should express frustration at the lack of a system wide approach despite efforts to identify a collaborative plan. An update on this would be submitted to the Committee's meeting in May 2021.
- The Committee **approved Business Cases** for "Outpatients room booking", "Outpatient flow", "Outpatient reset and recovery plan" and a "Post COVID assessment service".
- The programme of **reviews of previously approved Business Cases** covered the implementation of the Business Cases for RTT reporting from Allscripts, the Ive Programme (IT investment), and the Replacement Radiology Information System (RIS).

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

- The Deputy Chief Executive/Chief Finance Officer should check and confirm the reason/s for the marked increase in the vacancy rate between February and March 2021.
- The Trust Secretary should schedule a "Review of previously approved Business Case: Post COVID assessment service" item at the Committee's meeting in May 2021.
- The Trust Secretary should reschedule the "Capital plan for 2021/22 – NHS England/Improvement (NHSE/I) return" and "Update on IT strategy and related matters" items for the Committee's meeting in May 2021

3. The issues that need to be drawn to the attention of the Board are as follows:

- N/A

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

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