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

*Thu 23 September 2021, 09:45 - 13:00*

**Virtual meeting, via webconference**

NHS
Maidstone and Tunbridge Wells NHS Trust

## Agenda

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

### 09-1
### To receive apologies for absence

*David Highton*

### 09-2
### To declare interests relevant to agenda items

*David Highton*

### 09-3
### To approve the minutes of the 'Part 1' Trust Board meeting of 29th July 2021

*David Highton*

Board minutes, 29.07.21 (Part 1).pdf (9 pages)

### 09-4
### To note progress with previous actions

*David Highton*

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

### 09-5
### Report from the Chair of the Trust Board

*David Highton*

Chair's report.pdf (1 pages)

### 09-6
### Report from the Chief Executive

*Miles Scott*

Chief Executive's report - September 2021.pdf (3 pages)

## Quality items 1

### 09-7
### Infection prevention and control board assurance framework

*Sara Mumford*

Infection prevention and control board assurance framework - September 2021.pdf (47 pages)

## Integrated Performance Report

### 09-8
### Integrated Performance Report (IPR) for August 2021

*Miles Scott and colleagues*

Integrated Performance Report (IPR) for August 2021.pdf (31 pages)

## Planning and strategy

### 09-9
### To approve the Trust's Estates Strategy

*Doug Ward*

N.B. This item has been scheduled for 10.55am

To approve the Trust's Estates Strategy.pdf (75 pages)

## Quality items 2

### 09-10
### Quarterly mortality data

*Peter Maskell*

Quarterly Mortality Update - September 2021.pdf (22 pages)

## Planning and strategy

### 09-11
### To approve the Business Case for gastroenterology inpatient centralisation

*Amanjit Jhund*

Business Case for gastroenterology inpatient centralisation.pdf (48 pages)

### 09-12
### To approve the Business Case for the development of a Community Diagnostic Hub

*Lynn Gray*

To approve the Business Case for the development of a Community Diagnostic Hub.pdf (30 pages)

## Assurance and policy

### 09-13
### Responsible Officer's Annual Report 2020/21

*Peter Maskell*

Responsible Officer's Annual Report 202021.pdf (18 pages)

### 09-14
### Health & Safety Annual Report, 2020/21 and agreement of the 2021/22 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

*Rob Parsons*

N.B. This item is scheduled for 11.35am

H&S Annual Report 2020-21 and work programme 2021-22.pdf (35 pages)

### 09-15
### Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

*Lynn Gray*

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment.pdf (20 pages)

## Reports from Trust Board sub-committees

### 09-16
### Charitable Funds Committee, 27/07/21

*David Morgan*

Summary of Charitable Funds Cttee, 28.07.21.pdf (2 pages)

## 09-17
## Audit and Governance Committee, 04/08/21 (incl. the External Auditor's Annual Report for 2020/21)

*David Morgan*

Summary of Audit and Governance Committee, 04.08.21 (incl. External Audit Annual report 2020-21).pdf (29 pages)

## 09-18
## Finance and Performance Committee, 25/08/21 and 21/09/21 (incl. approval of revised Terms of Reference)

*Neil Griffiths and David Highton*

Summary of Extroordinary Finance and Performance C'ttee 25.08.21.pdf (1 pages)
Summary of Finance and Performance C'ttee 21.09.21 (incl. revised Terms of Ref.).pdf (6 pages)

## 09-19
## Patient Experience Committee, 02/09/21

*Maureen Choong*

Summary of Patient Experience Committee, 02.09.21.pdf (2 pages)

## 09-20
## Quality Committee, 15/09/21

*Sarah Dunnett*

Summary of Quality C'ttee, 15.09.21.pdf (1 pages)

## 09-21
## People and Organisational Development Committee, 17/09/21 (incl. approval of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans and national data submissions)

*Emma Pettitt-Mitchell*

The report also contains the latest quarterly report from the Guardian of Safe Working Hours

Summary of People and Organisational Development Cttee, 17.09.21.pdf (19 pages)

## 09-22
## To consider any other business

*David Highton*

## 09-23
## 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 29TH JULY 2021, 9:30 A.M, VIRTUAL 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 (except items 07-9 to 07-10) | (SDu) |
| | Neil Griffiths | Non-Executive Director | (NG) |
| | Peter Maskell | Medical Director | (PM) |
| | David Morgan | Non-Executive Director | (DM) |
| | 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 and Partnerships | (AJ) |
| | Sue Steen | Chief People Officer | (SS) |
| | Jo Webber | Associate Non-Executive Director | (JW) |
| | Aoife Cavanagh | Deputy Director of Quality Governance (representing the Chief Nurse) | (AC) |
| | Kevin Rowan | Trust Secretary | (KR) |
| | Ola Gbadebo-Saba | Deputy Freedom to Speak Up Guardian (for item 07-16) | (OGS) |
| | Christian Lippiatt | Freedom to Speak Up Guardian (for item 07-16) | (CL) |
| | Doug Ward | Director of Estates and Facilities (for item 07-13) | (DW) |
| | 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]*

## 07-5 To receive apologies for absence

There were no apologies but it was noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

## 07-6 To declare interests relevant to agenda items

KC declared that she was Vice Chancellor of the University of Kent, which was relevant to item 07-14.

## 07-7 To approve the minutes of the 'Part 1' Trust Board meetings of 24th June 2021 and 8th July 2021

The minutes of the meetings held on 24th June 2021 and 8th July 2021 were approved as true and accurate records of the meetings.

## 07-8 To note progress with previous actions

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

- **06-7 ("Arrange for staff to be surveyed on their current and future childcare and/or carer support needs (to enable the Trust to consider what support could be offered).").** SS confirmed that the survey would be revisited in September 2021. DH therefore confirmed the date in the "Original timescale" column should be changed to September 2021.

## 07-9 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted his thanks to Trust staff for responding to the continued pressures. DH added that he had received an email from the Chair of South East Coast

Ambulance Service NHS Foundation Trust that described the current circumstances as a 'perfect storm', although the number of COVID-19 inpatients at the Trust had stabilised since DH had written his report, while the number of staff who had to self-isolate had also reduced. DH continued that the Chief Executive of NHS Providers had likened the current pressures to those faced by the NHS during the second wave of COVID-19 cases, albeit it was a different form of pressure, so Trust staff needed to be commended for dealing with such conditions, and for preparing for the likely pressure that would arise during the summer holiday period.

DH also noted that there had been one further consultant appointment in the month.

**07-10 Report from the Chief Executive**

MS firstly echoed the sentiments regarding staff that DH had given under item 07-9. MS then referred to the submitted report and highlighted the key points therein, which included the acknowledgement of the major impact the new Kent and Medway Medical School (KMMS) would have. MS added that the most discussed item at the Executive Team Meeting (ETM) earlier that week had been the Trust's clinical strategy, and it had been apparent that there was a real desire to continue with the Trust's plans to develop services, which was an important factor in improving staff morale and staff retention.

DH welcomed MS' acknowledgement of the importance of the Trust's continued development.

**Integrated Performance Report**

**07-11 Integrated Performance Report (IPR) for June 2021**

MS introduced the report and commented that June had been an exceptionally busy month, and that fact had been evident from the performance within that month. MS also commended the Trust's stroke team for achieving an "A" rating on the Sentinel Stroke National Audit Programme (SSNAP). MS then invited colleagues to report on each domain, and DH highlighted that AC was standing in for the Chief Nurse at the meeting. AC duly referred to the "Safe" domain and reported the following points:

- The rate of falls had decreased marginally last month and the Lead Nurse for Falls Prevention continued to provide support to staff. PM was also leading work on reducing harm more generally, which included slips, trips and falls.
- Two Never Events had been declared in June and the investigations of both were underway.
- There had been a slight reduction in the "Overall Safe staffing fill rate", so the action being taken included reminding staff of the staffing escalation processes, and the establishment of the staffing rapid response unit.

EPM referred to virtual training sessions on pressure ulcers that were described on page 10 of 34 and asked whether the sessions were focused on the areas where the Trust had concerns. AC stated that she understood that was the case, as the Tissue Viability team identified areas of risk.

KC asked for further details of the staffing rapid response unit. AC explained that the unit had been established to focus on specific areas of staffing need and elaborated on the details.

PM then referred to the "Effective" domain and reported the following points:

- The Hospital Standardised Mortality Ratio (HSMR) was at 95 and work was ongoing with regards to mortality relating to COVID-19 patients.
- The modelling for future COVID-19 inpatients indicated that the Trust was likely to face a plateau of cases.
- The average age of COVID-19 admissions had dropped by a decade and the average length of stay (LOS) of such patients had reduced. There was therefore confidence that the COVID-19 vaccine had broken the link between community transmission and hospital admission. People with underlying health conditions were however still at risk.
- A single approach for dealing with nosocomial infections had now been agreed, which was based on the work undertaken by AC and her team.

- A new COVID-19 treatment medication had been introduced, but there were limiting factors regarding its use, as an antibody test was required. It was therefore not yet clear how that treatment would be introduced.

JW asked for an update on the potential for COVID-19 'booster' vaccinations for staff in the autumn. PM noted there was some evidence, although that was not clear, that the effectiveness of the COVID-19 vaccines waned over time, but the Chief of Service for Diagnostics & Clinical Support Services was working to re-establish the COVID-19 vaccination centre, and PM was keen to offer staff a third dose of the vaccination.

SDu referred to the outpatient service, and the link between "OP New DNAs" and "Percentage of Virtual OP Appointments" and asked for further details. PM referred to the outpatient transformation programme, while SB gave further details of the plans to achieve 50% for the "Percentage of Virtual OP Appointments", but acknowledged that the Did Not Attend (DNA) rate was an important factor. SB also stated that he was keen to improve telephone call response times. MS added that the key issue with virtual appointments was how these translated into effective clinical practice and suggested that the Quality Committee may wish to explore that point further. DH commented that he believed the introduction of patient-initiated follow-up appointments would assist, as it was likely that many patients who felt well did not attend their scheduled follow-up appointment. MS agreed that step would make a difference but also emphasised the need to consider the effectiveness of the current patient interactions. The point was acknowledged.

AC then referred to the "Caring" domain and reported the following points:
- The complaints response target had been exceeded for the month.
- The Friends and Family Test (FFT) response rate had been adversely affected by some technical issues regarding uploading, but actions had been taken to improve the use of text messaging and that was expected to lead to an improvement.

RF asked whether the technical issues had been the reason why the outpatient FFT response rate was 11%. AC confirmed that had been one of the reasons but acknowledged that there was also an issue regarding engagement with the FFT process. AC stated that she did however expect improvement in the future.

SB then referred to the "Responsive" domain and reported the following points:
- The cancer access targets continued to be met, which was a significant achievement, but the number of patients on the waiting list backlog had increased. That had, in part, been influenced by an increase in the number of late referrals received from other Trusts i.e. where patients had already exceeded the 62-day cancer waiting time target. It was a challenging situation but SO and SS had been very helpful in trying to address the challenges.
- Once the month had passed the Trust would have achieved the cancer access targets for two successive years.
- The backlog of patients waiting over two weeks was within the 60s, which was the lowest since the start of the COVID-19 pandemic.
- 90% of the Patient Tracking List (PTL) had now had a clinical prioritisation "p" code added.
- The Trust had delivered 74% against the Referral to Treatment (RTT) Incomplete Pathway target, which was a significant achievement.
- The implementation of the Electronic Patient Record (EPR) had led to some challenges, but an increase in performance had now commenced.
- Staffing, and staff morale, was a major issue, and some staff considered the current situation to be similar to the pressures faced during the second wave of COVID-19 cases. Additional measures had therefore been implemented, which included having a site director for each hospital site, reorganising within Medicine & Emergency Care to enable senior clinical staff to be allocated to the Emergency Department (ED); and a variety of other actions. SB noted that there were some issues in relation to the consistency of Ambulatory Emergency Care (AEC), but the ETM on 03/08/21 had been extended by an hour to enable the challenges to be discussed in detail.

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

- The Trust's financial position was being delivered according to plan, although the Trust had performed beyond its plans in relation to the Elective Recovery Fund (ERF) thresholds, so discussions were being held with Kent and Medway Clinical Commissioning Group (CCG), as the ERF monies were allocated to the CCG in the first instance. The receipt of ERF monies by the Trust was not therefore certain, but if the funds were received as intended, these would be used to 'pump prime' certain initiatives, to further address the aforementioned challenges faced by the Trust.
- The recruitment of further temporary staff had been difficult, as the additional staff required had not been able to be engaged, although the Trust was exceeding its planned temporary staffing expenditure.

NG added that the issues reported by SO had been discussed at the Finance and Performance Committee meeting held earlier that week, so asked SO to elaborate on the potential plans to respond to the financial position. SO duly noted that the second half of 2021/22 (i.e. "H2") was likely to be more challenging than the first half ("H1"), and would likely see a higher level of efficiency demands and a reduction in COVID-19 funding, while 2022/23 would be an even greater challenge. SO also noted that NHS England/Improvement wanted to return to the financial projections within the NHS Long Term Plan, which would not be as great a challenge for the Kent and Medway Integrated Care System (ICS) as it would for some other ICS'. SO also highlighted that the Trust's Cost Improvement Programme (CIP) would be re-established with the Divisions, with a particular focus on identifying recurrent CIP schemes, as the non-delivery of recurrent CIP schemes had been one of the major factors that had led to the Trust being placed into Financial Special Measures in the past.

DM referred to the "Well Led - CQC Domain Scorecard" section of the IPR and observed that for many of the indicators, the data within the "Latest", "Previous" and "YTD" columns of the table was the same. SO stated that he had identified the same issue and confirmed he had relayed such comments to the persons who completed the report.

MC asked whether the forthcoming financial challenges represented an opportunity for the Trust to proactively review its Quality Impact Assessment (QIA) process, in light of what had been learned over the past year or so. SO agreed that it would be timely and appropriate to undertake such a review. PM agreed and added his observations.

SS then referred to the workforce aspects of the "Well-led" domain and reported the following points:

- Recruitment was active and there were 183 Whole Time Equivalent (WTE) nursing staff in the recruitment pipeline, while recruitment activity was taking place in all of the key 'hotspot' areas.
- Efforts were being made to increase the availability of Bank staff across the Trust, which included the introduction of financial incentives and the rapid response team/unit that AC had referred to earlier in the meeting.
- Fatigue was a key factor among staff, which affected several issues, including staff's willingness to undertake additional Bank shifts.
- The latest Pulse survey finding had reflected the link between the current issues and the morale of the workforce.
- There was however good awareness of the issues, and activity was taking place (with further action planned) in the relevant areas, which also included action on staff retention.

RF then noted that there had been an extended discussion about recruitment and retention at the People and Organisational Development Committee 'deep dive' meeting on 23/07/21, following the raising of the issue at the 'main' Quality Committee. RF added that regular updates on the issues had been requested and RF would meet with SS in due course to discuss things further. The point was acknowledged.

RF also referred to the climate survey, and asked for a comment on the percentage of staff who felt able to cope with the demands they were facing; and also on reduction in the staff that had completed the survey. SS replied that she believed the findings from the survey accurately reflected the current staffing challenges; and also gave assurance that staff engagement, and the

response to staff surveys, was a key focus of the discussions between the members of the Executive Team and the Divisions.

**Planning and strategy**

**07-12 Update on the implementation of the Electronic Patient Record (EPR) (incl. details of performance metrics)**

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

- The report was very similar to the report considered by the Finance and Performance Committee on 27/07/21.
- The report contained details of the initial benefits from the implementation, although the major benefits would not occur until the future.
- The report also contained details of the lessons learnt, and the role of the EPR Incident Coordination Centre (ICC) had been emphasised.
- The report did not include that the Core Clinical Documents implementation had gone 'live' on three wards on 28/07/21, and the implementation had proceeded well thus far, although comments had been made that too many systems were expected to be used, including the Nervecentre system.
- The reasons for the delay in the implementation had been multi-factorial.
- The largest area of non-compliance with downtime forms had been oncology, but that had been planned.
- Further work was underway to understand the impact of the delays on the remaining steps, including the wider implementation of Core Clinical Documents.
- A 'Task Force' had been established to concentrate on some of the issues face in the EDs, and two meetings had been held that week.

RF referred to the "Lessons learnt" section and opined that the lessons were not as comprehensive as they could be, as the original design did not appear to be correct. RF therefore asked whether more 'sandpits' would be introduced for future phases. RF also noted that there was no mention of the effectiveness of online training. RF finally emphasised the importance of Organisational Development (OD) so asked for OD input into the programme, and whether the EPR Programme Board had a senior OD representative. PM acknowledged that the online learning had not been effective, but confirmed that the training approach had been revised to reflect the previous experience. PM then elaborated on the details but noted that the training for Core Clinical Documents had not been changed as the training content had already been written. PM also confirmed that there were now six 'sandpits' on each hospital site, and these had been better used and supported by members of the EPR team. PM then stated that there were seven members of the EPR team that were specifically employed to manage 'business change', but there was no pure OD specialist on the EPR Programme Board, so he would implement that suggestion.

**Action: Arrange for an individual with organisational development expertise to join the EPR Programme Board (Medical Director, July 2021 onwards)**

DH welcomed the increase in the number of 'sandpits'.

JW noted that the EPR implementation had previously been deferred, partly because of potential winter pressures, so asked for the latest position on the timescales. PM replied that the current plan was that the Core Clinical Documents would be implemented fully by 30/09/21, but PM was keen to see whether that could be brought forward. PM added that 'winter' pressures was now a misnomer, as it was likely that the Trust would just face 'pressures' across the year, but acknowledged the importance of not adding to such pressures.

**07-13 Response to the queries posed about the Trust's Green Plan at the Trust Board meeting on 27/05/21**

DH welcomed DW to the meeting. MS then introduced the item and reminded Trust Board members of the discussion that had taken place when the Green Plan had been considered by the Trust Board in May 2021. DW then referred to the first submitted report and highlighted the following points:

- The report erroneously stated that "Nationally the Trust has fared well on reducing $CO_2$ emissions but we have to do much more to meet the 2050 targets", but the targets had in fact now been brought forward to 2040.
- It had been announced on 21/07/21 that a Phase 2 Public Sector Low Carbon Skills Fund had been launched that would be managed by a delivery business partner, Salix.

DW then referred to the "MTW Trust Carbon Reduction Opportunities for 2040 to meet Net Zero Emissions" chart within the supplementary report and highlighted that the red line indicated the position if the Trust did not undertake any work on carbon emissions i.e. if the Trust relied solely on the work of the energy industry. DW continued that in that scenario, although there would be a reduction, that would be insufficient to achieve net zero emissions by the target date. DW then referred to the green line on the chart and explained the work that was intended to establish a "Green Committee" and develop schemes to submit bids for funding.

DM commended the planned electrification of the infrastructure, and the establishment of a Green Committee, but noted that reducing the use of plastics was more related to reducing plastic pollution, not climate change. DM also noted that some of the Trust's activities, such as the disposal of clinical waste, would be carbon positive, so to achieve a net zero target, some net negative activities would be required. The points were acknowledged.

EPM asked whether any external agencies would likely be approached to participate in the proposed Green Committee. DW stated that the main suggestion thus far had been to engage external consultants although DW did not consider that would be necessary for the coming year, as there were several in-house staff that could be further engaged.

DH noted that sustainability was one of the Trust's strategic themes and proposed that the Green Committee become a sub-committee of the Finance and Performance Committee. NG agreed. KR however pointed out that the Trust already had a "Sustainable Development & Environment Committee" established, as a sub-committee of the Trust Management Executive (TME), although KR understood that Committee was dormant. KR therefore confirmed he would arrange for that Committee to be disestablished, as well as formalising the establishment of the Green Committee.

**Action: Formalise the establishment of the Green Committee as sub-committee of the Finance and Performance Committee; and the disestablishment of the Sustainable Development & Environment Committee (Trust Secretary, July 2021 onwards)**

**07-14 <u>To approve the Full Business Case (FBC) for the Kent and Medway Medical School (KMMS) accommodation</u>**

AJ referred to the submitted report and highlighted the following points:
- The Trust Board was not being asked to approve the FBC, but was being asked to delegate the authority to approve the FBC to the KMMS Accommodation Oversight Group.
- There had been some delays in the originally-intended timescale, as a result of the Trust not receiving the costs as per the required deadline. Once the costs had been provided, they had increased significantly, and the timescales within the project plan had slipped. Swift discussions were then held and all of the cost increases, and the timescales in the project plan, had been recovered.
- However, two outstanding issues need to be resolved before the FBC was able to be approved. One pertained to the external audit opinion regarding the proposed operating lease arrangement, and that opinion was awaited from the Trust's external auditors.
- The second issue related to the approval by M&G's Board, which was scheduled for later that day.
- The ground-breaking ceremony scheduled for w/c 02/08/21 would however proceed as scheduled, as it was considered that the outstanding issues represented a low risk.

SO added that as an entity, the Trust was seen as operating in a higher risk category, given its annual income was now over £500m, so, the Trust's external auditors needed to obtain an opinion from their technical team, and although SO was confident that opinion would not cause difficulties, confirmation was still required. DM asked what the alternative plan would be if the accounting treatment was unable to proceed as intended. SO replied that one of the two potential options

would be to consider funding the scheme via the Trust's capital programme, although the value would have significant implications for other items in the programme. SO continued that a further option would be to explore alternative locations for the accommodation. DH added that if the external audit opinion was related to the lease, the specific lease arrangements could be reviewed to consider if these could be changed. DM asked whether an alternative option would be to seek an exemption to the NHS rules that required the Trust to have an operating lease rather than a financial lease. SO acknowledged DM's point but confirmed that he would not expect any such exemptions to be given.

The Trust Board approved in principle, subject to satisfactory resolution of all the outstanding requirements, that the Trust entered into a contract with ESS for the construction of the new student accommodation; and entered into the relevant development and lease contracts with M&G (and its chosen vehicles) for the funding and lease arrangements for the new accommodation.

The Trust Board also delegated the authority to finalise the approvals to the KMMS Accommodation Oversight Group (which involved DH, NG and DM), to enable the outcome to be reported to the Trust Board in September 2021.

**Action: Arrange for the KMMS Accommodation Oversight Group to approve the final version of the Full Business Case for the accommodation, and confirm the approval to the Trust Board, in September 2021 (Director of Strategy, Planning and Partnerships, July 2021 onwards)**

MC then asked whether environmental impact assessments could be applied to the scheme, as some issues had been raised at the Patient Experience Committee in relation to the impact of capital construction scheme on trees. AJ confirmed that a substantial environmental impact assessment had been applied to the scheme, but accepted that the introduction of environmental impact assessments for smaller scale schemes would be sensible. DH suggested that issue would perhaps be appropriate for the aforementioned Green Committee to explore. The suggestion was acknowledged.

**Quality items**

**07-15 Safeguarding update (Annual Report to Board, including Trust Board annual refresher training)**

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

- An internal safeguard review had been undertaken in October 2020 which resulted in the children's Safeguarding team joining the corporate nursing team.
- A self-assessment had been undertaken and two areas for improvement had been identified.
- The 'section 11 audit' had been completed in November 20200 and the Children's Safeguarding Partnership had no concerns or queries.
- Level 3 training compliance had not been reported, but work was continuing on that.
- An increasing number of children were presenting with mental health needs, given the continuing challenges regarding the availability of tier 4 Child and Adolescent Mental Health Services (CAMHS) beds.

DH referred to the latter point and noted that the site report stated that the Trust regularly had four to six children admitted who required a tier 4 CAHMS bed, so it would be useful to see the data on the LOS for such patients on Hedgehog ward, as that was not an appropriate long-term location for such patients. DH added that the data would serve to highlight the problem. AC agreed to check and confirm the position.

**Action: Check and confirm the length of stay details for the patients that were admitted to Hedgehog ward that required a Tier 4 Child and Adolescent Mental Health Services (CAMHS) bed (Deputy Director of Quality Governance, July 2021 onwards)**

**Assurance and policy**

**07-16 Quarterly report from the Freedom to Speak Up Guardian**

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

- There were high-levels of anxiety in the concerns that had been raised, which included occurrences of micro-aggression. Work was therefore taking place with the Learning and Development team to understand the root causes of the cases in particular areas.
- The Safe Space Champion programme was progressing well.

OL then continued and described the details of a concern that had been raised by a particular member of staff, the advice that CL and OL had given that person, and the feedback that the individual had relayed to OL and CL after implementing that advice, which highlighted the importance of having someone to talk to. OL added that the case was one of the success stories. OL then explained the approach that she and CL took when concerns were raised.

EPM welcomed the details of the case and encouraged OL and CL to continue their good work. DH agreed and noted the positive nature of the position within the quarter.

**Reports from Trust Board sub-committees**

**07-17 Quality Committee, 14/07/21**

SDu referred to the submitted report and highlighted the following points:
- The issue of staff morale, which was discussed earlier within the Trust Board meeting, had been discussed.
- An Enteral feeding and Nasogastric tube (NGT) placement working group had been established, which would report to the Committee.
- Water Safety had been discussed and it had been acknowledged that some residual issues needed to be addressed.

**07-18 People and Organisational Development Committee, 23/07/21**

RF referred to the submitted report and highlighted the following key points:
- The meeting had been a 'deep dive', and there had been an interesting discussion on staff who received unsocial hours payments being hesitant about being promoted, because of the potential loss of income. The People Function had therefore been asked to explore what could be done.
- A discussion had been held regarding the restrictions on external funding for upskilling and placement support.
- Recruitment and retention had been discussed, as had been noted under item 07-11.

DH asked for further details of the unsocial hours issue. RF explained that the issue related to the financial loss that could arise from such staff accepting promotions where unsocial hours payments were not made. MS remarked that it was a very longstanding issue, particularly within nursing, and suggested the issue be linked with SB's work with the Chiefs of Service and Divisional Directors of Nursing & Quality regarding leadership roles, although it had been useful to have the issue highlighted. The suggestion was acknowledged.

**07-19 Finance and Performance Committee, 27/07/21**

NG referred to the submitted report and highlighted the following points:
- There had been a very useful discussion on the development of the IPR, and there would be an opportunity for NG, DM and JW to contribute to that development.
- An update on the options for the Trust's laundry service was given.
- It was agreed to reconsider the Committee's approach to monitoring progress in implementing previously-approved Business Cases.

**07-20 Charitable Funds Committee, 28/07/21**

DM reported that several routine issues would be reported, in written form, to the Trust Board in September 2021, but donations and disbursements had reduced significantly, despite the receipt of £250,000 from NHS Charities Together. DM continued that the situation had coincided with the departure of the previous Fundraising Manager, although a fundraiser had been engaged on a temporary basis and they would therefore explore the options available and submit a report to the Committee's next meeting in November 2021.

DM also reported that the work regarding the Maggie's Centre was progressing and a location had been identified.

**Other matters**

**07-21 Annual review of the Trust Board's Terms of Reference**

DH referred to the submitted report and highlighted the key points therein, noting that some changes may be required to the Trust Board sub-committees during the year, but such changes would be addressed as and when required. The point was acknowledged.

The revised Terms of Reference were approved as submitted.

**07-22 To consider any other business**

KR referred to the report that was submitted under item 07-19 and asked the Trust Board to delegate the authority to approve the FBC for a managed MRI service to the Finance and Performance Committee during August 2021. The requested authority was duly granted.

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

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

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

**Actions due and still 'open'**

| Ref. | Action | Person responsible | Original timescale | Progress[1] |
|---|---|---|---|---|
| 07-13 | Formalise the establishment of the Green Committee as a sub-committee of the Finance and Performance Committee; and the disestablishment of the Sustainable Development & Environment Committee. | Trust Secretary | July 2021 onwards | The establishment of the Green Committee as a sub-committee of the Finance and Performance Committee will be formalised once the Trust Board approves revised Terms of Reference for the Finance and Performance Committee (a separate report has been submitted to the Trust Board meeting for that purpose). The Sustainable Development & Environment Committee will be formally disestablished at the next meeting of the Trust Management Executive (TME), on 20/10/21. |
| 07-15 | Check and confirm the length of stay details for the patients that were admitted to Hedgehog ward that required a Tier 4 Child and Adolescent Mental Health Services (CAMHS) bed. | Chief Nurse (transferred from the Deputy Director of Quality Governance) | July 2021 onwards | A verbal update will be given at the meeting. |

**Actions due and 'closed'**

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|---|---|---|---|---|
| 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 submitted to the Trust Board meeting in September 2021 contains the requested information. |
| 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 submitted to the Trust Board meeting in September 2021 contains the requested information. |
| 06-7 | Arrange for staff to be surveyed on their current and future childcare and/or carer | Chief People Officer | September 2021 | A workforce taskforce has been established which has significant activity on both |

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

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|---|---|---|---|---|
| | support needs (to enable the Trust to consider what support could be offered). | | | recruitment and retention. The workstreams have been identified and childcare / holiday clubs is included. This will include surveying staff / feedback on potential requirements/needs. |
| 07-12 | Arrange for an individual with organisational development expertise to join the EPR Programme Board. | Medical Director | September 2021 | There are currently two EPR Programme Board members with organisational development (OD) expertise, who have both served on the board since April 2021. An extension of their services has been requested beyond the end of the year when their current contracts end. There is a longer term plan to link in with central Trust OD resources, which have been established following the appointment of the Chief People Officer |
| 07-14 | Arrange for the KMMS Accommodation Oversight Group to approve the final version of the Full Business Case for the accommodation, and confirm the approval to the Trust Board, in September 2021. | Director of Strategy, Planning and Partnerships | August 2021 | The KMMS Accommodation Oversight Group met on 13/09/21 to review final changes to the Full Business Case and the Joint Contracts Tribunal (JCT) Contract with any final issues for resolution. Further details of the outcome of the Group's meeting have been submitted to the 'Part 2' Trust Board meeting. |

**Actions not yet due (and still 'open')**

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

**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/s | Surname | Department | Potential / Actual Start date | New or replacement post? |
|---|---|---|---|---|---|---|
| 09/08/21 | Consultant Cardiologist with specialist interest in Imaging | Smitha Reddy | Pulapalli | Cardiology | TBC | New |
| 06/09/21 | Consultant Radiologist in Cross sectional / Oncology | Rupert Charles | Berkeley | Radiology | TBC | New |
| 06/09/21 | Consultant Radiologist in Cross sectional / Oncology | Vivienne Nkechi | Eze | Radiology | TBC | New |
| 15/09/21 | Consultant Clinical Oncologist- Special interest in UGI & LGI | Sam Robert | Enefer | Oncology | TBC | New |

**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. With schools returning from the summer break we are prepared for a potential rise in admissions which may follow from the close interaction of children in classrooms and the subsequent contact between families and carers. However, with the continued effectiveness of the vaccine we are unlikely to experience the patient numbers seen in previous waves. As we move from our summer surge plan towards the winter, our planning will focus on getting the basics right as well as new initiatives to support patient flow. We are working with system partners across Kent and Medway to ensure we can deliver safe and effective care over the coming months. This includes reviewing our ambulance handover processes, the Urgent Treatment Centre stream and Same Day Emergency Care (SDEC) and there will also be an emphasis on criteria led discharges and use of the discharge lounges as good patient flow centres on our ability to discharge patients in a safe and timely manner. The situation in our Emergency Departments remains challenging as patient attendances and the acuity of patients has changed as a result of the Covid pandemic. We continue to experience one of the busiest times on record in our Emergency Departments, with daily attendances averaging 530 across both hospitals. Although the site is under pressure we are maintaining elective activity by concentrating on cancer patients and day case activity. We continue to reduce our backlog of long waiting patients although this is challenging given the non-elective demand. We also continue to protect and separate patient pathways due to the prevalence of Covid cases within the community. A big thank you to all our staff who continue to work tirelessly, not only in ED but across the organisation to ensure our patients have a good experience and outcomes.

2. The increased pressures across the site means that our workforce is currently under a great deal of pressure. We are working hard to support our staff and our recruitment team is focused on high volume recruitment in fields such as nursing, and also targeted recruitment for specialist skills, with the aim to fill all our current vacancies. The process for recruiting staff is being overhauled and we are working to ensure the onboarding process for new staff is as quick and smooth as possible. We are promoting the Trust as an attractive place to work highlighting staff benefits such as free parking and free food not always offered at other Trusts.

3. This month saw our second phase of senior leaders starting the Exceptional Leaders Programme (ELP), and those from the first phase returning for their second module which focuses on the ‘Team’ and getting the best from others. Leadership is the most powerful influence on the culture of the organisation and Exceptional Leaders is a crucial foundation for helping us to create a culture of compassion and inclusion, innovation and improvement within MTW. For some time there has been a growing body of evidence that shows there is a direct correlation between the health, happiness and wellbeing of staff and quality of care, patient outcomes and organisational performance. The more compassionate the culture of an organisation the better the outcomes for patients and staff. We have designed the Exceptional Leaders Programme with compassion at its centre and have been working with Professor Michael West, a world leader in leadership and culture in health and social care. We are also using principles of Professor West’s work and others in this field, to inform our other organisational development programmes so we can ensure that we build and sustain the behavioural and cultural changes that we want to see and experience in MTW. These include our People and Culture strategy, Equality Diversity and Inclusion strategy and Wellbeing strategy. The leadership development team is currently working on the evolution of ELP for other levels of leaders within the Trust with the view of extending the programme next year.

4. The wellbeing and welfare of our staff is vitally important to the running of the Trust and the quality of care that our patients receive. As we move into winter pressure and potential Covid-19 surges we want to support our staff in the best way we can. The executive team made the decision in early August to significantly increase wellbeing support for staff by funding a team that is currently being recruited. The team will have a wellbeing service lead and four wellbeing practitioners to work in-reach with leaders and managers to support and develop teams and to provide individual help where necessary. We are also providing support for those suffering with long Covid symptoms – a condition that we know is impacting many of our staff.

5. Despite the incredible pressures our staff are working under, I am delighted to report that a number of teams and colleagues at the Trust have been nominated and shortlisted for awards recently, celebrating the fantastic work to care for patients. Congratulations to our Care Co-ordination Centre and TeleTracking bed management system (shortlisted for the 'Driving Efficiency through Technology' award at the HSJ Awards 2021); our drive through pharmacy at Maidstone Hospital has been shortlisted for the Excellence in Hospital Pharmacy Practice category in this year's Clinical Pharmacy Congress Awards; Noella Aers, Interim Antenatal and Harriet Burke, have both been shortlisted in the Midwives' Midwife of the Year category in this year's Royal College of Midwives Awards; Sarah Gregson and Shazia Nazir, have also been shortlisted for the Innovation in Maternity Care category for their birth planning infographics document; MTW has been shortlisted in the Public Sector Employee of the Year category at this year's Qube Awards (Qube are a training provider that we use for some of the apprenticeships we offer here at the Trust) and congratulations to the maternity team who have made the shortlist of the HSJ Patient Safety Awards 2021.

6. The annual national NHS survey launches later this month and it's an opportunity for our staff to have their say about what they like and don't like about working at MTW and use their voice to shape our Trust. We want MTW to be a workplace where staff have a healthy work/life balance, are safe and respected and feel fulfilled. It's only by speaking out that we can collectively create change and make a difference. The results from the survey enable us to focus on improving the things that matter to our staff by identifying areas where we can do more to support. This year the survey has been redeveloped to align with the NHS People Promise. A promise to each other to improve the experience of working in the NHS for everyone.

7. Our new Electronic Patient Record (EPR) system has now been rolled out to all ward areas at Maidstone Hospital and over the coming weeks the team will be rolling this out at Tunbridge Wells Hospital. Thank you again to everyone who has been involved in this work – a real team effort. The EPR team will now be working on some additional projects for our clinical documentation to ensure we are utilising as much of our new system as possible, including developing an interface between EPR and our Radiology Information System Soliton so referrals no longer need to be printed; the roll out of mobile devices and developing interfaces to enable medical devices to automatically enter observation data.

8. Our staff networks have been very busy recently. The Trust's Cultural and Ethnic Minorities Network (CEMN) held its second annual general meeting this month, and saw committee members reflecting on the amazing work carried out by the CEMN over the last 18 months. This includes leading on the Kent and Medway System Black Asian Minority Ethnic (BAME) Mentorship programme (the first of its kind for the NHS), the Reverse Mentoring Programme at MTW, and currently planning for a system wide career development event for our BAME staff members – The Power of Me! We have also seen the launch of our See ME First badge, part of our ongoing commitment at MTW to treating all BAME staff with dignity and respect. Our Women's Network held its first face to face meeting recently and it was an opportunity for staff in attendance to meet new people and talk about both current projects and plans in the pipeline. Our Disability Network is currently trialling the MTW health passport prior to its launch in the autumn to help support our staff with long-term health conditions or disabilities, and the latest network meeting focused on reasonable adjustments and the support staff have received from their manager. Our LGBT+ Network celebrated our first MTW Pride event at the end of July in a rainbow of colours and is now busy planning an event in November covering a range of learning opportunities for our staff.

9. Congratulations to the winners of the Trust's Employee of the Month scheme for July – Carrie Parmenter and August - Tosh Solanki. On behalf of the Trust Board I would like to say thank you to both Carrie and Tosh for their fantastic work to help support our colleagues and patients.

**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

| 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 Trust Board on a monthly basis during the Covid-19 pandemic
Changes are highlighted in red in the document. The BAF questions have been updated by NHSE&I. Where the wording of a question has changed but the previous answer remains relevant the question is noted in red but the answer is in black.
Changes to responses for this reporting period are as follows:

Section 1:

- Hierarchy of Controls risk assessment template in place. Risk assessment for the use of FFP3 masks in place and available on the staff intranet. Communicated to staff via the Pulse. Consideration of ventilation included as standard. Infectivity of predominant local variant included Delta variant is endemic in local area. Positive samples referred for sequencing
- Waiting areas arranged to allow social distancing to be maintained. Bed spacing >2m in all ward areas. Screens implemented in some clinical areas to enable social distancing
- Dual role created for fit testing and PPE officer
- Staff caring for green pathway patients to use Standard Infection Control Precautions (PPE only for blood and body fluid risk)
- Non-patient facing staff to request test kits from national supply during transition to new 'pull' supply system
- PPE project team managing resources on day to day basis during wave 1&2. Now BAU.
- Fit testing team ensuring all staff are tested against at least two masks as appropriate
- Covid risk added to Board level risk register
- Guidance on continued use of face masks in healthcare issued on 15 July 2021

Section 4:

- Use of the Supporting excellence in IPC toolkit has been considered and elements will be implemented as part of the IPC strategy

Section 5:

- Criteria in place for admission to haematology ward to ensure only Covid negative patients are on the ward. Staff LFT monitored
- CEV patients isolated in A&E and on wards and prioritised for single rooms
- Inpatient compliance monitored by IPC walk-arounds. No formal audit. Advice given to ward staff as required

Section 6:

- Training events and face to face formal meetings enabled to use 1m+ distancing when seated. Masks to be worn when standing

**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:<br>• local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;<br>• the documented risk assessment includes:<br>  ○ a review of the effectiveness of the ventilation in the area;<br>  ○ operational capacity;<br>  ○ prevalence of infection/variants of concern in the local area.<br>• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; | • Hierarchy of Controls risk assessment template in place<br>• Risk assessment for the use of FFP3 masks in place and available on the staff intranet. Communicated to staff via the Pulse<br>• Included as standard<br>• Infectivity of predominant local variant included<br>• Delta variant is endemic in local area<br>• No other variants of concern currently<br>• Positive samples referred for sequencing<br>• 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 | | |

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| | • 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<br>• Obstetric patients and their partners have Covid PCR 48-72 hours prior to scan appointments<br>• All patients and visitors have temperature check at front door. Mask provided to all patients and visitors<br>• Checks in place at oncology entrance<br>• Clinically vulnerable patients are prioritized for side room in ED.<br>• Checks on swab results/symptoms for all elective patients | | |
| • when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; | • Risk assessment in place using the Hierarchy of Controls to allow staff to wear FFP3 masks when giving direct clinical care to Covid positive patients | | |
| • there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative | • Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from ICU care only.<br>• Stated aim is to keep confirmed cases in Covid cohort area throughout their inpatient stay. Where step-down is necessary for clinical reasons, PHE | | |

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| | 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<br>• 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<br>• Clinically vulnerable patients are prioritised for side room on inpatient wards depending on other IPC risks | | |
| • 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<br>• All contacts are nursed in side rooms or bays with the doors shut<br>• All contacts are swabbed twice a week for 14 days<br>• Cohorts with the same isolation date may be merged if necessitated by bed pressure<br>• Level 4 cleaning and UVC decontamination for areas stepped down from Covid to non-Covid | | |
| • 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 | | |

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| ○ Staff adherence to hand hygiene<br><br>○ Patients, visitors and staff are able to maintain a 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE<br><br>○ Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:<br>▪ a) clinical<br>▪ b) non-clinical setting<br>○ Monitoring of compliance with wearing appropriate PPE, within the clinical setting<br><br>• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered | • PPE stocks closely monitored to ensure supplies available<br>• PPE posters on all wards.<br>• IPC policies available on the intranet<br>• Maximum occupancy notices on all non-clinical room doors and clinical offices<br>• Waiting areas arranged to allow social distancing to be maintained<br>• Bed spacing >2m in all ward areas<br>• Screens implemented in some clinical areas to enable social distancing<br><br>• PPE and hand hygiene audits ongoing and reviewed at Infection Prevention and Control Committee<br><br>• Dual role created for fit testing and PPE officer<br>• PPE officers have educational, supportive and monitoring role. Advise on PPE use. Induction training for new staff | | |

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| | • Sessional mask wearing guidance implemented. Masks provided for non-patient facing staff<br>• PPE officers provide PPE training to new starters<br>• Use of FFP3 masks for all direct care of non-AGP Covid patients has now been stepped down and remains under review<br>• National guidance followed to enable FRSM to be worn for non-covid AGP<br>• Staff caring for green pathway patients to use Standard Infection Control Precautions (PPE only for blood and body fluid risk) | | |
| • That twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems in place to monitor results and staff test and trace | • Symptomatic staff testing by PCR is in place and available both on and off site<br>• Escalation plan in place with trigger points for increasing asymptomatic testing<br>• Positive lateral flow followed up with PCR<br>• Occupational Health and local managers assess risk of staff contacts of positive cases<br>• All staff now have lateral flow kits except for those within 3 months of Covid infection<br>• Results recorded on Trust on-line platform<br>• Weekly performance report to execs<br>• Plan in place to refresh supplies for those running out of kit | | |

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| | • Tests also available for bank and agency staff<br>• Non-patient facing staff to request test kits from national supply during transition to new 'pull' supply system | | |
| • 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<br>• Outbreaks closely monitored by IPC team<br>• Additional targeted testing has not been necessary to date | | |
| • Training in IPC standard infection control and transmission-base precautions are provided to all staff<br>• 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<br>• National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this.<br>• All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19<br>• Non-clinical staff have bi-annual training (level1) which includes Covid-19<br>• Additional ad hoc training on ward during IPC visits<br>• Junior doctors have induction training including Covid delivered by DIPC | | |
| • All staff (clinical and non-clinical) are trained in: | • All staff have PPE training as part of induction and mandatory training | | |

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| ○ putting on and removing PPE;<br><br>○ what PPE they should wear for each setting and context;<br><br>• All staff (clinical and non-clinical 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<br>• Dedicated FIT testing team in place on both sites.<br>• New staff FIT tested as part of induction as required<br><br>• PPE project team managing resources on day to day basis during wave 1&2. Now BAU.<br>• Active management of stocks by procurement leads. Electronic monitoring system in place<br>• Active monitoring of PPE burn rate and stocks<br>• Reusable masks and air powered respirators available for those who fail FIT testing<br>• All patient facing staff trained in use of PPE and supported by PPE officers<br>• Use of powered air respirators monitored through site offices with documented log and cleaning<br>• Regular updates provided to staff through ICC and daily bulletin<br>• PPE guidance available on Covid page of Trust intranet<br>• Posters and signage with PPE information in donning and doffing areas.<br>• Repeat FIT testing available for those affected by national withdrawal of one type of FFP3 mask | | |

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| | • Business case under development to make FIT testing team substantive as part of IPC team<br>• Fit testing team ensuring all staff are tested against at least two masks as appropriate | | |
| • 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.<br>• All staff wear face masks<br>• Hand hygiene audits reported to IPCC – no concerns<br>• Posters widely displayed throughout the Trust<br>• 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.<br>• Updates shared with staff in daily Covid Bulletin and Covid intranet page<br>• Patient and Staff Safety work stream moved to BAU<br>• IPC team support ward staff in implementing changes<br>• IPC team work arrangements flexed to provide 24/7 cover during escalation<br>• IPC leadership on key work streams<br>• 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 | | |

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| | stepped down but recommendations on u/s gel stand)<br>• Updated national guidance published 1 June 2021<br>• Guidance on continued use of face masks in healthcare issued on 15 July 2021 | | |
| • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted | • DIPC is member of exec team and updates as required<br>• Covid update is standing item on Board agenda | | |
| • risks are reflected in risk registers and the Board Assurance Framework where appropriate | • ICC risk register reflects IPC risks associated with Covid-19<br>• DIPC attends Trust Board meetings<br>• Covid risk added to Board level risk register | | |
| • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens | • All pre-existing IPC risk assessment processes and policies remain in place and in date for non-Covid-19 infections<br>• Trust compliant with Hygiene Code prior to pandemic.<br>• IPC team reinforce practice at ward level<br>• IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks recognised eg for C. difficile and Covid co-infection<br>• IPC team advising on a case-by-case basis. Variation to some policies required. Documented on ICNet. | | |

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| | • Hierarchy of controls adopted for IPC risk assessments | | |
| • 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. | • Signed off by Head of ICC under delegated authority from CEO<br>• 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<br>• From July 2021, BAF to be reviewed by Board when new guidance is published or there is significant change to report | | |
| • ensure Trust board has oversight of ongoing outbreaks and action plans | • Ongoing outbreaks discussed at daily exec strategic command meetings<br>• 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<br>• DIPC updates to execs and Board at every meeting<br>• IPCC reports to Quality Committee<br>• Daily sitrep of open outbreaks from IPCT | | |
| • There are check and challenge opportunities by the executive/senior leadership teams | • Execs and senior managers visit clinical and non-clinical areas regularly | | |

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| in both clinical and non-clinical areas | | | |

| **2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• 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.<br>• ICU training programme for non-ICU trained staff required to work on ICU.<br>• Consultant anaesthetist rota to provide 24/7 on site ICU cover.<br>• ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist.<br>• Covid wards fully staffed. Consultant of the week rota for senior medical cover<br>• IPC team and PPE officer support to Covid wards<br>• Respiratory HDU staffed by respiratory trained nurses and consultants<br>• NIV patients cared for by trained staff<br>• All suspected/ confirmed cases are admitted to side rooms on designated wards pending PCR results.<br>• ITU on both sites have beds identified for Covid<br><br>• Cleaning standards in place for cleaning during the pandemic. | | |

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| • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. | • 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.<br>• HPV and UVC decontamination available when required<br>• All surfaces cleaned with Diff X including walls<br>• In-house cleaning teams in place<br>• Cleaning audits reported to IPCC and divisions<br>• Lapses in cleaning standards reported as Datix incidents and investigated with shared learning<br>• Deep clean programme for wards as they are de-escalated is being planned<br>• Existing UVC light decontamination technology to be employed<br>• Additional robotic UVC resource (Thor) procured<br>• Cleaning robot for public areas | | |
| • Assurance processes are in place for monitoring and sign off for terminal cleans as part of outbreak management and actions are put in place to mitigate any identified risk | • Cleaning audits carried out by domestic, nursing and estates MDT according to schedule. Reported to and monitored by IPCC<br>• Wards also received audit results<br>• Additional checks in outbreak areas<br>• Nurse in charge checks cleans and signs off | | |

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| | • IPC team advise on cleaning levels for outbreak management | | |
| • Cleaning and decontamination is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses | • Diff X confirmed as suitable cleaning agent for enveloped viruses by IPCT | | |
| • Manufacturer's guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance | • Manufacturer's guidance is followed in all areas<br>• Instructions are displayed where needed<br>• Environmental cleaning policy reflects manufacturers requirements | | |
| • A minimum of twice daily cleaning of:<br>○ Areas that have higher environmental contamination rates as set out in the PHE and other national guidance<br>○ 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, | • Increased frequency of cleaning complies with national guidance<br>• In place since June 20 | | |

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| ○ Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards | • Ward staff clean high-touch surfaces including keyboards and telephones<br>• Disinfectant wipes available for cleaning workstations in non-clinical areas<br>• Non-clinical areas are part of the cleaning audit schedule. Action plans developed where areas fail audit | | |
| ○ 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 | | |
| • Reusable non-invasive care equipment is decontaminated:<br>○ Between each use<br>○ After blood and/or body fluid contamination<br>○ At regular predefined intervals as part of an equipment cleaning protocol<br>○ Before inspection, servicing or repair of equipment | • Staff advised to clean equipment as in guidance.<br>• Pre-existing guidance remains in place for clinical areas<br>• Commode cleaning audited with triangulation audits in addition. Reported to IPCC<br>• Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks and included on MDT cleaning audits | | |
| • 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<br>• Laundry is compliant with HTM 01-04<br>• Laundry report goes to IPCC and Health and Safety committee | | |

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| • single use items are used where possible and according to Single Use Policy | • Single use items used widely across the Trust.<br>• 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 and that actions are taken to mitigate any identified risk | • The provider of surgical reusable instrument decontamination for MTW: IHSS Ltd: is run in accordance with audited quality management systems.<br>• The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V.<br>• 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.<br>• Action plans in place as required | | |
| • Where possible ventilation is maximized by opening windows 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.<br>• Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design | | |

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| | 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.<br>• Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation | | |
| **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:<br>• arrangements around antimicrobial stewardship are maintained | • Antimicrobial stewardship continues as for pre-Covid.<br>• Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee<br>• Antimicrobial report to IPCC<br>• Training for new doctors has continued<br>• Ward pharmacists review prescribing<br>• Guidance for antibiotic prescribing in Covid patients issued by ASG<br>• Prescribing of antibiotics is low compared with peer K&M organisations<br>• Audits and reporting restarted and maintained in second wave | | |

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| • mandatory reporting requirements are adhered to and boards continue to maintain oversight | • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians<br>• Ward based audits were suspended in March and April 2020 but reinstated for May 2020<br>• Mandatory reporting of antimicrobial usage has continued.<br>• 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:<br>• implementation of national guidance on visiting patients in a care setting | • Routine visiting re-started from 29 March 21 and extended 17 May. One hour per patient each day<br>• Additional visitors permitted only on compassionate grounds and to assist patients with specific needs. ITU has separate arrangements<br>• Birth partner allowed. Both parents can visit in neonatal unit. Covid testing in place to facilitate this.<br>• neonatal visiting extended to Grandparents<br>• Outpatients have accompanying person only when required for care needs | | |

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| | • All visitors have temperature checks at the front door<br>• Mask provided to patients and visitors who do not have face coverings<br>• Support in place for relatives to deliver patient property<br>• Viewings of deceased patients have re-started in the Trust mortuary including for patients diagnosed with Covid-19<br>• 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<br>• Partners able to attend all obstetric appointments<br>• Guidance clarified to allow accompanying partners even if no lateral flow test on a case by case basis. | | |
| • 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<br>• Restricted access by swipe card only is in place<br>• Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene<br>• Masks are available at the exit of all Covid areas allowing change of mask on leaving the area | | |

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| • 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<br>• 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 the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved | • For inter-departmental transfer, handover of information by telephone or accompanying nurse<br>• 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.<br>• Integrated discharge team manages discharge of patients to residential care facilities.<br>• Designated care home beds now available<br>• All patients being discharged to residential care have Covid test 48 hours before expected date of discharge with result available.<br>• 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<br>• Staff use appropriate PPE for all patient transfers<br>• All patients have EDN on discharge<br>• Posters prominently displayed in public areas | | |

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| • there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice | • Hand, Face and Space logo on trust Covid internet pages<br>• Posters in wards to encourage patients to wear face masks | | |
| • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk) | • Use of the toolkit has been considered and elements will be implemented as part of the IPC strategy | | |
| **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:<br>• 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<br>• 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 | | |

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| | admitted directly to single room on specialty ward pending results. Pathways in place and agreed through CRG and ICC.<br>• 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<br>• Patients screened day 1, 3 and 5-7<br>• 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 confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance | • ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in.<br>• 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<br>• Red, amber and green pathways are accommodated separately in different zones of ED<br>• Isolation room available for immunocompromised and shielding patients in ED<br>• 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 | | |

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| | documented and agreed with CRG and ICC<br>• All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures<br>• All patients and visitors entering through main entrances have temperature check and are given masks<br>• Paediatric patients triaged in paediatric assessment area which is zoned for Covid risk<br>• All pathways documented and agreed with CRG and ICC and published on Covid page of Trust Intranet | | |
| • staff are aware of agreed template for triage questions to ask | • Standard triage template supported y electronic system (Symphony) and printed version | | |
| • 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 | • Triage carried out by senior nursing staff.<br>• Immediate allocation of patient to pathway<br>• Obstetric triage in place with senior midwife. Labour ward has designated red and green beds | | |
| • face coverings are used by all outpatients and visitors | • All patients asked to wear a face mask on entering ED.<br>• All outpatients and visitors wear masks except for those carrying exemption certificates | | |

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| | • Masks provided at front entrance if required<br>• Information on Trust website to support | | |
| • individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; | • Criteria in place for admission to haematology ward to ensure only Covid negative patients are on the ward<br>• Staff LFT monitored<br>• CEV patients isolated in A&E and on wards and prioritised for single rooms | | |
| • clear advice on the use of facemasks is provided to patients and all inpatients are encouraged and supported to use surgical face masks (particularly when moving around the ward) provided it is tolerated and is not detrimental to their (physical or mental) care needs | • Face masks available for all patients and patients advised to use them rather than own face coverings<br>• Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside<br>• Posters in ward bays and patient information available | | |
| • Monitoring of inpatients compliance with wearing facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical and mental) care needs | • Inpatient compliance monitored by IPC walk-arounds. No formal audit<br>• Advice given to ward staff as required | | |
| • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use | • Reception staff are protected with screens in all areas<br>• ED reception has physical separation of staff by Perspex screens | | |

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| | screens, e.g. to protect reception staff. | • Perspex screens on outpatient reception areas, outpatient pharmacy and main entrance reception<br>• Cubicles in ED majors are separated by solid walls<br>• Social distancing in place in waiting areas<br>• Vaccination centre has been organized with social distancing and separate spaces<br>• 2m minimum bed spacing in all wards and ED<br>• Outpatients waiting areas are socially distanced | | |
| • | isolation, testing and instigation of contact tracing is achieved for patients with new onset symptoms, 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<br>• Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts<br>• 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.<br>• Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care.<br>• All patients who test negative on admission are re-tested at 5-7 days in line with national guidance. Additional day 3 swab implemented in November | | |

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| | • All laboratory results submitted to PHE for national track and trace | | |
| • 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 | • 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 or quarantine ward<br>• Any patients with new symptoms after admission are tested and isolated until the result is known | | |
| • There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document | • All patients who test negative on admission are re-tested at day 3 then 5-7 days in line with national guidance.<br>• National guidance followed in all cases. Local guidance developed from national guidance and published through daily staff Bulletin and Covid pages on intranet.<br>• Negative patients swabbed within 48 hours of expected discharge date for discharge to residential care facility and result available before transfer<br>• Post-covid patients (14+days since diagnosis) are not re-swabbed prior to discharge unless immunocompromised.<br>• Covid positive patients within 14 days of diagnosis requiring discharge to care facility are only discharged to designated centres<br>• Revised guidance issued removing the need for negative swabs in de-escalated patients and restricting the | | |

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| • patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately | requirement for negative swabs prior to discharge<br>• All outpatients have temperature checking at the front door.<br>• Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook<br>• 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 |
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| Systems and processes are in place to ensure:<br>• 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<br>• Stay left signs in corridors<br>• Visitors and patients not permitted to use staff catering facilities | | |

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| • 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.<br>• Dedicated FIT testing team. All results recorded and database maintained<br>• Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations<br>• Online training for medical care of Covid patients<br>• ICU training in place for non-ICU trained staff<br>• PPE officers provide face to face training on wards.<br>• IPC team provide training to staff<br>• 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.<br>• PPE officers provide workplace training.<br>• PPE helpers available in ICU<br>• Donning and doffing stations provided on Covid wards<br>• FIT testing available for all staff who require it and when available masks change.<br>• Signage and posters displayed in donning and doffing areas<br>• Green pathway PPE now stepped down to Standard Infection Control Precautions plus masks – informal | | |

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| | training on wards by IPCT and circulated through Pulse | | |
| • a record of staff training is maintained | • Fit testing records maintained<br>• Records maintained for cleaning of reusable masks<br>• Records maintained of formal IPC training<br>• 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<br>• Combined hand hygiene and PPE audit in place<br>• Action plans for non-compliance<br>• 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<br>• New risk assessment in July 2021 using hierarchy of controls to allow staff to wear FFP3 masks when giving direct care to Covid positive patients<br>• Provision made for staff with risk factors etc to continue to use FFP3.<br>• Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric | | |

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| | 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.<br>• Instructions on all splash backs<br>• Sanitising gel widely available including entrances to all clinical areas | | |
| • good respiratory hygiene measures | • All staff, outpatients and visitors wear masks<br>• Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside | | |
| • maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care | • Social distancing encouraged<br>• Signage on doors stating maximum occupancy<br>• Additional breakout areas available<br>• Covid secure offices identified<br>• Training events and formal face to face meetings enabled to use 1m+ distancing when seated. Masks to be worn when standing | | |
| • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public | • Staff advised of social distancing rules and to avoid car sharing<br>• Reminders on intranet and in daily Pulse to follow public health advice at all times | | |

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| health guidance outside of the workplace | | | |
| • frequent decontamination of equipment and environment in both clinical and non-clinical areas | • Disinfectant wipes available in both clinical and non-clinical areas<br>• I am clean stickers in use<br>• Domestic and nursing cleaning in place on wards<br>• 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<br>• Non-clinical areas assessed for Covid-secure status<br>• Advice widely publicised through staff Pulse magazine and Trust internet and intranet pages | | |
| • staff regularly undertake hand hygiene and observe standard infection control precautions | • Ward based audits in place.<br>• Triangulation audits completed monthly by IPCT.<br>• Directorates report to IPCC | | |
| • The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance | • All hand wash basins are co-located with paper towel dispensers | | |

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| • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets | • All hand wash sinks have hand washing and drying guidance on back boards in both clinical and public areas | | |
| • staff understand the requirements for uniform laundering where this is not provided for on site | • Scrubs are worn on all Covid wards and several other wards and clinical areas.<br>• Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site<br>• Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page.<br>• Uniform bags gifted to the Trust provided for staff to carry uniform home and launder with uniform.<br>• All staff advised to travel to and from work in their own clothes and change on site<br>• Staff changing and shower facilities provided on both sites | | |
| • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms. | • Staff sickness line available to report symptoms<br>• Information on symptoms of Covid shared widely including posters, staff bulletin and intranet site<br>• 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 | | |

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| | • All staff members testing positive for Covid-19 have their result delivered by occupational health.<br>• Occupational Health support and maintain contact with self-isolating staff<br>• Staff testing positive self-isolate for a minimum of 14 days if symptomatic and 10 days if asymptomatic throughout.<br>• Lateral flow testing available for all clinical staff.<br>• Positive lateral flow tests confirmed by PCR<br>• Post-vaccine infection followed up with additional swab and blood for antibody testing. Enhanced surveillance forms completed on-line | | |
| • A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patients/individuals) | • Community rates of infection are continuously monitored with information disseminated to senior managers<br>• Discussed at strategic command meetings<br>• Daily sitrep analysis available to managers | | |
| • Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger and outbreak investigation and are reported | • Outbreaks declared according to national guidance<br>• All outbreaks are investigated and Serious Incidents declared.<br>• Concise investigation and consistent Terms of reference developed –under review<br>• Twice weekly outbreak meetings | | |

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| • Robust policies and procedures are in place for the identification of and the management of outbreaks of infection | • IIMARCH forms completed for all outbreaks<br>• Outbreaks reported via national online platform<br><br>• Outbreak policy in place<br>• Active management by infection control team<br>• Lab results available in real time via emailed list<br>• 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:<br>• Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff<br><br>• Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff understand the different risk areas | • Pathways clearly identified and approval process in place<br>• Surgical green pathway implemented and reviewed according to prevalence of infection<br>• Visitors are not permitted in Covid positive areas except in compassionate circumstances<br><br>• Signage in place<br>• Wards accessible by swipe access<br>• Restricted access to Covid areas | | |

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| • 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.<br>• 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.<br>• Separated from non-segregated areas by closed doors<br>• Signage displayed warning of the segregated area to control entry<br>• Cohort areas differentiate the level of care (general, respiratory HDU, Covid ICU)<br>• Paediatric confirmed patients isolated in single rooms with en-suite facilities<br>• Windows in all ward areas opened for 15 minutes three times per day to improve ventilation | | |
| • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement | • Pre-existing IPC policies continue to apply.<br>• Some variance required to meet the requirements of Covid levels of PPE and co-infected patients<br>• 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** |

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| There are systems and processes in place to ensure:<br><br>• testing is undertaken by competent and trained individuals | • Testing undertaken by registered BMS staff with documented competencies.<br>• 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<br>• Tests sent to Pillar 2 labs when demand outstrips capacity<br>• Extended laboratory working hours to deliver service<br>• All non-elective patients are tested on admission<br>• All positive patient results are phoned to ward by IPCN and provided to site team and ICC.<br>• All results reported to PHE via Co-surv<br>• All elective patients are tested 24-48 hours prior to admission<br>• Online booking for staff and elective patient testing.<br>• Weekly testing for all patient-facing staff by end of June 2020<br>• All staff positive results are delivered by Occupational health staff<br>• Staff results sent by text message directly from on-line system<br>• Antibody testing available to all patients and staff on request<br>• Near patient testing available with 8 machines at Maidstone and 4 at TWH | | |

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| | • 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<br>• 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<br>• All staff positives reported to Occupational Health via email<br>• All positives reported to consultant microbiologists<br>• 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<br>• All routine diagnostic microbiology continues including C difficile. | | |
| • That all emergency patients are tested for COVID-19 on admission | • All patients on the green (non covid) pathway have point of care (SAMBA) testing on admission<br>• All patients on the red pathway have point of care (LIAT) tests when available and/or PCR | | |

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| • That those inpatients who go on to develop symptoms of COIVD-19 after admission are re-tested at the point symptoms arise | • Any inpatient who develops symptoms of Covid has a laboratory PCR test and clinical review | | |
| • That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission | • All patients who test negative on admission are re-tested in line with national guidance on day 3 and day 5-7<br>• Testing guidance is published in the daily Pulse and available on the intranet | | |
| • That sites with high nosocomial rates should consider testing COVID negative patients daily | • Trust nosocomial rate is in line with national experience.<br>• Daily swabbing has not been implemented<br>• Contacts of Covid patients are swabbed twice weekly for 14 days | | |
| • That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge | • All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home<br>• Results are shared with the receiving care facility<br>• Post-Covid patients are not tested further for 90 days unless they develop new symptoms | | |
| • 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 | • All patients within 14 days of initial diagnosis of Covid who require discharge to a care facility are discharged to a designated care setting. | | |

| | | | |
|---|---|---|---|
| • 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 | • All elective patients are tested 3 days prior to admission and asked to self-isolate until admission<br>• Some patients are required to self-isolate for a longer period due to their underlying illness<br>• 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.<br>• Advice available from IPC team and consultant microbiologists. On call rotas in place.<br>• 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.<br>• Updates shared with staff in daily Covid Bulletin and Covid intranet page<br>• 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.<br>• New guidance for disposal of lateral flow tests and vaccination centres – current practice already in line with guidance<br>• 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<br>• Active management of stock levels by procurement to ensure safe levels of stock<br>• Regular (twice daily) deliveries of PPE to clinical areas.<br>• Central email address for PPE orders.<br>• 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:<br>• staff in 'at-risk' groups are identified and managed appropriately including ensuring | • Staff risk assessment in place. Managers advised to ensure all staff risk assessed. Risk assessment | | |

| | | | |
|---|---|---|---|
| their physical and psychological wellbeing is supported | developed with BAME network and Ethics committee<br>• Redeployment opportunities and working from home enabled for high risk staff<br>• Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support.<br>• 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<br>• 80% of 'at risk' staff have had a risk assessment completed<br>• 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.<br>• Powered air respirators available for staff who fail all fit testing<br>• Individual use reusable respirator masks available<br>• 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 | • All staff required to wear a FFP respirator are fit tested<br>• Fit testing on new models available as required | | |

| | | | |
|---|---|---|---|
| should be repeated each time a different model is used<br>• 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.<br>• 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<br>• Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks<br>• 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<br>• Manager works with HR to identify re-deployment opportunities<br>• New opportunities to work with vaccination teams available | | |
| • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health | • Discussions are documented and records stored electronically | | |
| • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP | • 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 | | |

| | | | |
|---|---|---|---|
| respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record | decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm | | |
| • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board | • database of all staff maintained and includes record of all FIT testing<br>• Weekly assurance template submitted by divisions against rotas<br>• All staff not tested provided with FIT testing prior to shift<br>• All areas have access to powered air respirators<br>• ICC and site team receive assurance template for weekend shift | | |
| • Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between panned and elective care pathways and urgent and emergency care pathways, as per national guidance | • Patient and Staff Safety workstream (part of Reset and Recovery programme) has defined the principles to be used when developing elective pathways<br>• Green pathways for elective care developed.<br>• Weekly executive and divisional meeting to discuss progress and interdependencies<br>• Staff screened for Covid-19<br>• Ward areas maintained as secure with minimal footfall<br>• Theatre SOP in place designating green and red pathways to avoid cross over | | |
| • All staff adhere to national guidance on social distancing | • Staff social distancing in corridors and queues. | | |

| | | | | |
|---|---|---|---|---|
| | wherever possible, particularly if not wearing a facemask and in non-clinical areas | • Work to ensure that office spaces are socially distanced with risk assessments completed.<br>• CCG review identified good practice in social distancing interventions<br>• Staff working from home wherever possible<br>• Consideration to 7 day working and shifts to reduce the number of staff in non-clinical areas.<br>• All ward staff to wear masks at all times on wards from 1 June<br>• Continual mask wearing guidance implemented for patient facing staff from 10 June 2020. Non-patient facing staff from 22 June<br>• Computers on wheels provided in some areas to support social distancing<br>• Managers asked to review all office space to ensure social distancing in COO letter 12 June.<br>• Managers also requested to review staff working patterns and breaks to reduce the number of non-clinical staff working on site at any time<br>• 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.<br>• Maximum occupancy identified on signage<br>• 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<br>• 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.<br>• 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.<br>• Newly established "staffing hub" designed to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing.<br>• Roll out of lateral flow underway<br>• ICC monitors sickness<br>• Occupational health support staff who are self-isolating and shielding.<br>• Managers support staff working from home. Home working toolkit published | | |

| | | | |
|---|---|---|---|
| | • All staff able to access testing via on-line booking system<br>• Symptomatic staff can access testing<br>• Weekly asymptomatic testing to be rolled out to all patient facing staff by end of June<br>• Review of cases of staff Covid infection to identify any key themes and learning<br>• Trust-wide Pulse survey in April and May. Results reviewed at executive and divisional level. Learning identified<br>• 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<br>• Psychological support available<br>• 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

| Integrated Performance Report (IPR) for August 2021 | Chief Executive / Members of the Executive Team |
|---|---|

The IPR for month 5, 2020/21, is enclosed.

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

- Finance and Performance Committee, 21/09/21 (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

## August 2021

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

## Contents


- Key to Icons and scorecards explained — Page 3
- Radar Charts by CQC Domain & Executive Summary — Page 4
- Summary Scorecards — Pages 5-7
- CQC Domain level Scorecards and escalation pages — Pages 8-22


## Appendices (Page 23 onwards)


- Supporting Narrative
- Implementing a Revised Perinatal Tool
- Finance Report
- Safe Staffing Report


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

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# Key to KPI Variation and Assurance Icons

| Variation | | | Assurance | | | |
|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |
| Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values | Special cause of improving nature or higher pressure due to (H)igher or (L)ower values | Common cause - no significant change | 'Pass' Variation indicates consistently - (P)assing of the target | 'Hit and Miss' Variation indicated inconsistency - passing and failing the target | 'Fail' Variation indicates consistently - (F)ailing of the target | Data Currently unavailable or insufficient data points to generate SPC |

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

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

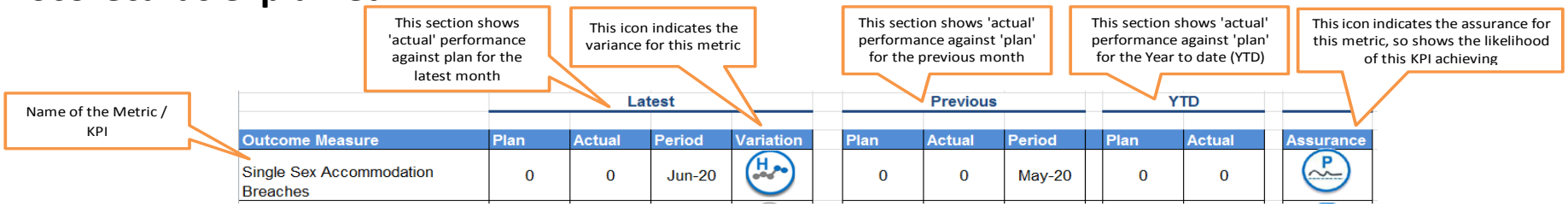
Maidstone and Tunbridge Wells NHS Trust

## Escalation Rules:

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

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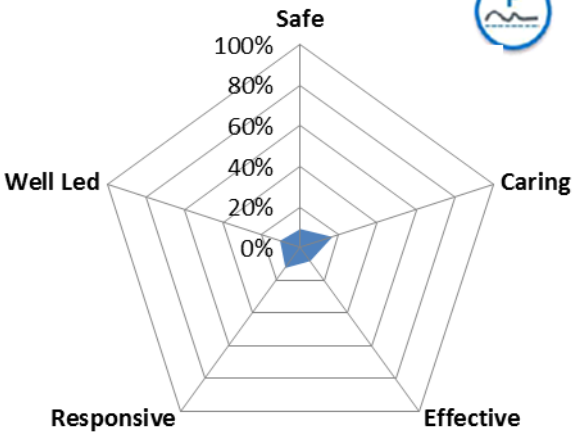
# Executive Summary

## Consistently Passing




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

**Safe:**
- Trust Mortality (HMSR)

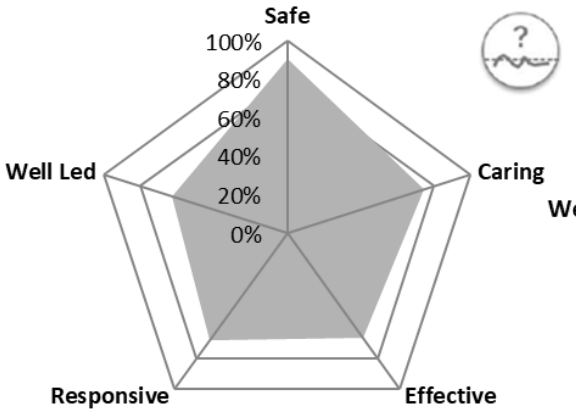
**Caring:**
- Mixed Sex Accommodation Compliance
- % VTE Risk Assessment

**Effective:**
- Percentage of Virtual OP Appointments

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

**Well-Led:**
- Mandatory Training Compliance
- Number of Advanced Practitioners

## 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

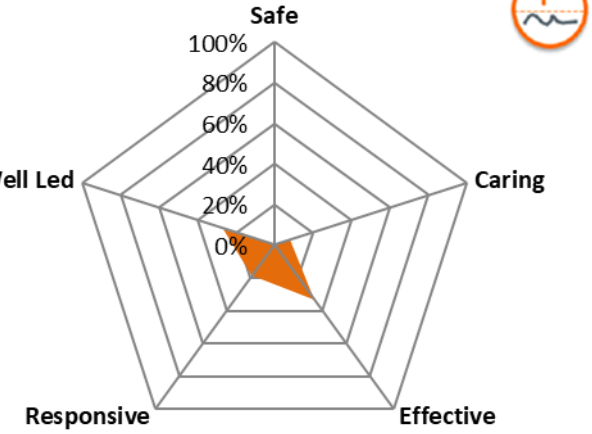
**Effective:**
- Outpatients DNA Rates and Hospital Cancellations, Readmissions & Stroke Indicators

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

**Responsive:**
- RTT Number of >52 week Waiters, Diagnostics Waiting Times, Cancer 31 Day Standard, A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NE LOS, Cancer PTL – size of Backlog

**Well-Led:**
- Capital Expenditure, Agency Spend, Sickness Rates, Vacancy Rates, Appraisals, Staff FFT Recommended to work, Staff FFT Recommended Care and Health and Well-Being

## Consistently Failing




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

**Caring:**
- OP Friends & Family Response Rate

**Effective:**
- Outpatient Utilisation
- Outpatient –Calls answered within 1 min
- Outpatient – Calls Abandoned

**Responsive:**
- RTT performance
- RTT Number of >40 week Waiters
- Theatre Utilisation

**Well-Led:**
- Agency Staff used
- Turnover Rate
- Clinical Strategy Indicators
- Percentage of Trust policies within review date

# Matrix Summary

**August 2021**

| Variance | Assurance: Pass | Assurance: Hit and Miss | Assurance: Fail |
|---|---|---|---|
| Special Cause - Improvement | Stat and Mandatory Training (W) | Infection Control - Hospital Acquired Covid (S),<br>Infection Control - Number of Hospital acquired MRSA (S),<br>A&E Friends & Family (FFT) % Positive (C),<br>Staff Friends and Family % recommended care (W), | Calls Answereed in under 1 min (E)<br>Theatre Utilisation (R)<br>Turnover (W),<br>Percentage of Trust policies within review date (W), |
| Common Cause | Standardised Mortality HSMR (S),<br>Single Sex Accommodation Breaches (C),<br>Cancer - 2 Week Wait (R),<br>Cancer - 62 Day (R),<br>Number of advanced practitioners (W) | **See box (right)** | Percentage of Calls abandoned (E),<br>RTT (Incomplete) performance against trajectory (R),<br>Number of patients waiting over 40 weeks (R),<br>Number of specialist services (W),<br>Use of Agency (WTE) (W) |
| Special Cause - Concern | % VTE Risk Assessment (C)<br>Percentage of Virtual OP Appointments (E) | OP Follow UP DNAs (E)<br>Mat Resp Rate Recmd to Friends & Family (C)<br>A&E 4 hr Performance (R)<br>Size of backlog (R),<br>Nursing vacancies (W)<br>Staff Friends and Family % recommended work (W)<br>Vacancy Rates (W) | Percentage OP Clinics Utilised (slots) (E),<br>OP Resp Rate Recmd to Friends & Family (C), |

**Hit & Miss /**

Never Events (S),
Safe Staffing Levels (S),
Sickness Rate - Covid (S)
Infection Control - Hospital Acquired Covid (S),
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays (S),
Infection Control - Rate of Hospital E. Coli Bacteraemia (S),
Number of New SIs in month (S),
Rate of Total Patient Falls per 100,000 occupied beddays (S),
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions (S),
OP New DNAs (E),
Outpatient Hospital Cancellation (E),
Outpatient Cancellations < 6 weeks (E),
Total Readmissions <30 days (E),
Non-Elective Readmissions <30 days (E),
Elective Readmissions < 30 Days (E),
Stroke Best Practice Tariff (E),
Rate of New Complaints (C),
% complaints responded to within target (C),
IP Resp Rate Recmd to Friends & Family (C),
IP Friends & Family (FFT) % Positive (C),
A&E Resp Rate Recmd to Friends & Family (C),
Maternity Combined FFT % Positive (C),
OP Friends & Family (FFT) % Positive (C),
52 week breaches (including those reported last month) (R)
Access to Diagnostics (<6w eeks standard) (R),
Average for new appointment (R),
Super Stranded Patients (R),
Ambulance Handover Delays Rate > 30mins (R),
Bed Occupancy (R),
NEL LOS (R),
Cancer - 31 Day (R),
28 day Target (R),
Health and Wellbeing: How many calls received (W)
Health and Wellbeing: What percentage of Calls related to Mental Health Issues (W),
Covid Positive - number of patients (W),
Capital Expenditure (£k) (W),
Agency Spend (£k) (W),
Elective Spells in London Trusts from West Kent (W)
Research grants (£) (W)
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:**

**Caring:** OP Response Rate Recommended to Friends and Family, Maternity Response Rate Recommended to Friends and Family

**Effective:** OP Utilisation, OP Follow Up DNAs

**Responsive:** A&E 4 hr Performance,Size of 62 day Cancer backlog

**Well-Led:** Nursing Vacancies, Staff FFT % recommended work, Vacancy Rates

# Executive Summary Scorecard

## Current Month Overview of KPI Variation and Assurance Icons

| | Variation | | | | | Assurance | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Trust Domains | | | | | | | | | No SPC | |
| CQC Domain Safe | | | | | | | | | | |
| Infection Control | 2 | | | 2 | | | | 4 | | 4 |
| Harm Free Care | 2 | | | | | | | 2 | | 2 |
| Incident Reporting | 2 | | | | | | | 2 | | 2 |
| Safe Staffing | 2 | | | | | | | 2 | | 2 |
| Mortality | 1 | | | | | 1 | | | | 1 |
| ***Safe Total*** | ***9*** | ***0*** | ***0*** | ***2*** | ***0*** | ***1*** | ***0*** | ***10*** | ***0*** | ***11*** |
| CQC Domain Effective | | | | | | | | | | |
| Outpatients | 4 | 2 | 1 | | 1 | 1 | 3 | 4 | | 8 |
| Quality & CQC | 4 | | | | | | | 4 | | 4 |
| Strategy - Estates | | | | | | | | | 5 | 5 |
| ***Effective Total*** | ***8*** | ***2*** | ***1*** | ***0*** | ***1*** | ***1*** | ***3*** | ***8*** | ***5*** | ***17*** |
| CQC Domain Caring | | | | | | | | | | |
| Complaints | 2 | | | | | | | 2 | | 2 |
| Admitted Care | 3 | 1 | | | | 2 | | 2 | | 4 |
| ED Care | 1 | | | | 1 | | | 2 | | 2 |
| Maternity Care | 1 | 1 | | | | | | 2 | | 2 |
| Outpatient Care | 1 | 1 | | | | | 1 | 1 | | 2 |
| ***Caring Total*** | ***8*** | ***3*** | ***0*** | ***0*** | ***1*** | ***2*** | ***1*** | ***9*** | ***0*** | ***12*** |
| CQC Domain Responsive | | | | | | | | | | |
| Elective Access | 4 | | | | 1 | | 3 | 2 | | 5 |
| Acute and Urgent Access | 3 | 1 | | | | | | 4 | 1 | 5 |
| Cancer Access | 4 | | 1 | | | 2 | | 3 | | 5 |
| Diagnostics Access | 1 | | | | | | | 1 | | 1 |
| Bed Management | 1 | | | | | | | 1 | | 1 |
| ***Responsive Total*** | ***13*** | ***1*** | ***1*** | ***0*** | ***1*** | ***2*** | ***3*** | ***11*** | ***1*** | ***17*** |
| CQC Domain Well-Led | | | | | | | | | | |
| Staff Welfare | 2 | | | | | | | 2 | 4 | 6 |
| Finance and Contracts | 2 | | | | | | | 2 | 4 | 6 |
| Leadership | | 1 | | | 1 | | | 2 | 1 | 3 |
| Strategy - Clinical and ICC | 5 | | 1 | | 1 | 1 | 2 | 4 | 1 | 8 |
| Workforce | 3 | | 1 | 1 | 1 | 1 | 2 | 3 | | 6 |
| ***Well-Led Total*** | ***12*** | ***1*** | ***2*** | ***1*** | ***3*** | ***2*** | ***4*** | ***13*** | ***10*** | ***29*** |
| ***Trust Total*** | ***50*** | ***7*** | ***4*** | ***3*** | ***6*** | ***8*** | ***11*** | ***51*** | ***16*** | ***86*** |

# Corporate Scorecard by CQC Domain

## Safe

| ID | Key Performance Indicators | Plan | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| S2 | Number of cases C.Difficile (Hospital) | 4 | 7 | | ? |
| S6 | Rate of Total Patient Falls | 6.00 | 8.43 | | ? |
| S7 | Number of Never Events | 0 | 0 | | ? |
| S8 | Number of New SIs in month | 11 | 3 | | ? |
| S10 | Overall Safe staffing fill rate | 93.5% | 86.3% | | ? |

## Responsive

| ID | Key Performance Indicators | Plan | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| R1 | Emergency A&E 4hr Wait | 95.0% | 82.5% | L | ? |
| R4 | RTT Incomplete Pathway | 86.7% | 73.6% | | F |
| R6 | % Diagnostics Tests WTimes <6wks | 99.0% | 77.5% | | ? |
| R7 | Cancer two week wait | 93.0% | 94.7% | | P |
| R10 | Cancer 62 day wait - First Definitive | 85.0% | 85.0% | | P |

## Effective

| ID | Key Performance Indicators | Plan | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| E2 | Standardised Mortality HSMR | Lower conf <100 | 93.2 | | P |
| E3 | % Total Readmissions | 14.6% | 14.8% | | ? |
| E6 | Stroke: Best Practice (BPT) Overall % | 50.0% | 60.2% | | ? |
| R11 | Average LOS Non-Elective | 6.50 | 6.96 | | ? |
| R12 | Theatre Utilisation | 90.0% | 84.3% | H | F |

## Well-Led

| ID | Key Performance Indicators | Plan | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| W1 | Surplus (Deficit) against B/E Duty | 0 | -21 | No SPC | No SPC |
| W2 | CIP Savings (£k) | 434 | 331 | No SPC | No SPC |
| W7 | Vacancy Rate (%) | 9.0% | 14.1% | H | ? |
| W8 | Total Agency Spend (£k) | 1,333 | 1,795 | | ? |
| W10 | Sickness Absence | 3.3% | 4.1% | | ? |

## 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% | 82.9% | | ? |
| C5 | IP Friends & Family (FFT) % Positive | 95.0% | 97.7% | | ? |
| C7 | A&E Friends & Family (FFT) % Positive | 87.0% | 83.3% | | ? |
| C10 | OP Friends & Family (FFT) % Positive | 84.0% | 82.2% | | ? |

| 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 |

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

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

# 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% | 86.3% | Aug-21 | | 93.5% | 88.4% | Jul-21 | 93.5% | 89.6% | |
| Sickness Rate - Covid | 0.0% | 0.2% | Jul-21 | | 0.0% | 0.1% | Jun-21 | 0.0% | 0.2% | |
| Infection Control - Hospital Acquired Covid | 0 | 2 | Aug-21 | | 0 | 10 | Jul-21 | 0 | 0 | |
| Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays | 22.7 | 37.3 | Aug-21 | | 22.7 | 26.6 | Jul-21 | 22.7 | 26.7 | |
| Infection Control - Number of Hospital acquired MRSA | 0 | 0 | Aug-21 | | 0 | 0 | Jul-21 | 0 | 0 | |
| Infection Control - Rate of Hospital E. Coli Bacteraemia | 19.0 | 16.0 | Aug-21 | | 19.0 | 10.6 | Jul-21 | 19.0 | 17.8 | |
| Number of New SIs in month | 11.0 | 3 | Aug-21 | | 11 | 10 | Jul-21 | 55 | 38 | |
| Rate of Total Patient Falls per 1,000 occupied beddays | 6.0 | 8.4 | Aug-21 | | 6.0 | 6.6 | Jul-21 | 6.0 | 7.2 | |
| Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions | 2.3 | 2.5 | Aug-21 | | 2.3 | 2.8 | Jul-21 | 2.3 | 2.7 | |
| Standardised Mortality HSMR | 100.0 | 93.2 | May-21 | | 100.0 | 93.2 | Apr-21 | 100.0 | 93.2 | |
| Never Events | 0 | 0 | Aug-21 | | 0 | 2 | Jul-21 | 0 | 3 | |

# 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 Virtual OP Appointments | 60.0% | 24.8% | Aug-21 | L | 60.0% | 27.1% | Jul-21 | 60.0% | 30.0% | F |
| Percentage OP Clinics Utilised (slots) | 85.0% | 52.0% | Aug-21 | L | 85.0% | 53.4% | Jul-21 | 85.0% | 52.8% | F |
| OP New DNAs | 5.0% | 6.9% | Aug-21 | | 5.0% | 6.9% | Jul-21 | 5.0% | 7.2% | ? |
| OP Follow UP DNAs | 5.0% | 7.9% | Aug-21 | H | 5.0% | 7.9% | Jul-21 | 5.0% | 7.5% | ? |
| Outpatient Hospital Cancellation | 20.0% | 23.4% | Aug-21 | | 20.0% | 22.9% | Jul-21 | 20.0% | 21.4% | ? |
| Outpatient Cancellations < 6 weeks | 10.0% | 18.0% | Aug-21 | | 10.0% | 18.4% | Aug-21 | 10.0% | 16.3% | ? |
| Calls Answereed in under 1 min | 95.0% | 45.6% | Aug-21 | H | 95.0% | 46.4% | Aug-21 | 95.0% | 47.5% | F |
| Percentage of Calls abandoned | 0.0% | 12.1% | Aug-21 | | 0.0% | 12.9% | Aug-21 | 0.0% | 10.8% | F |

## Organisational Objectives: Quality and CQC

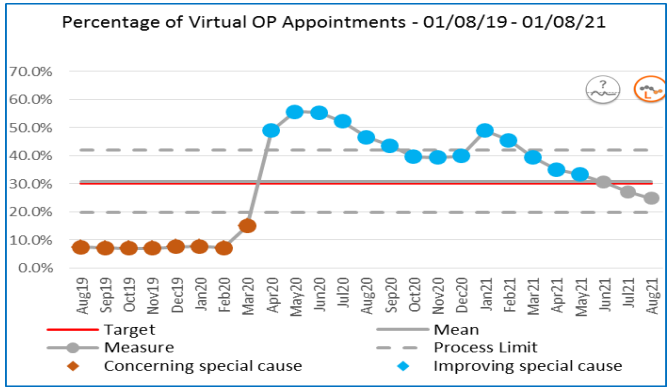
| | Latest | | | | Previous | | | YTD | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| Total Readmissions <30 days | 14.6% | 14.8% | Jul-21 | | 14.6% | 14.9% | Jun-21 | 14.6% | 15.3% | ? |
| Non-Elective Readmissions <30 days | 15.2% | 15.5% | Jul-21 | | 15.2% | 15.5% | Jun-21 | 15.2% | 15.8% | ? |
| Elective Readmissions < 30 Days | 7.8% | 6.9% | Jul-21 | | 7.8% | 7.0% | Jun-21 | 7.8% | 8.8% | ? |
| Stroke Best Practice Tariff | 50.0% | 61.0% | Jul-21 | | 50.0% | 57.6% | Jun-21 | 50.0% | 58.1% | ? |

# Effective - CQC Domain Scorecard

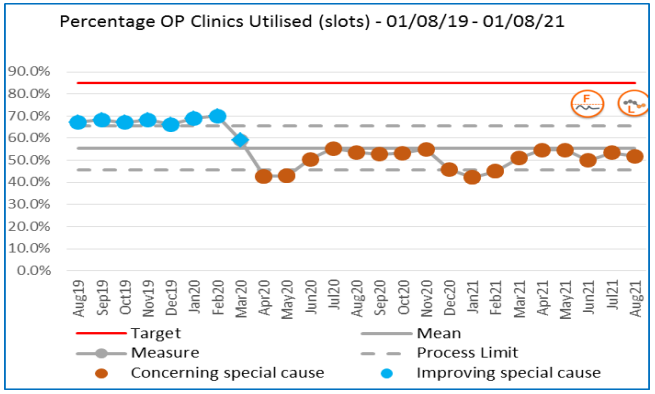
## Organisational Objectives: Strategy - Estates

| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Utilised and unutilised space ratio | Under review | 100 | Aug-21 | No SPC | Under review | 100 | Jul-21 | Under review | 100 | No SPC |
| Footprint devoted to clinical care vs non clinical care ratio | Under review | 4.4:1 | Aug-21 | No SPC | Under review | 4.4:1 | Jul-21 | Under review | 4.4:1 | No SPC |
| Admin and clerical office space in (sqm) | Under review | 5808 | Aug-21 | No SPC | Under review | 5808 | Jul-21 | Under review | 5808 | No SPC |
| Staff occupancy per m2 | Under review | 21.1 | Aug-21 | No SPC | Under review | 21.2 | Jul-21 | Under review | 21.8 | No SPC |
| Energy cost per staff | Under review | £ 510.72 | Aug-21 | No SPC | Under review | £ 624.29 | Jul-21 | Under review | £3,467.5 | No SPC |

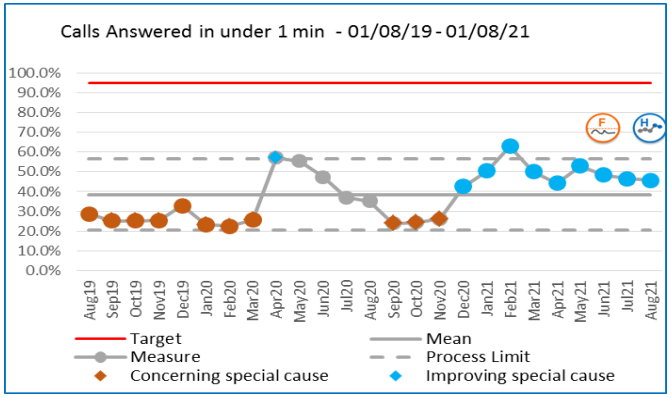
# Effective- Reset and Recovery Programme: Outpatients



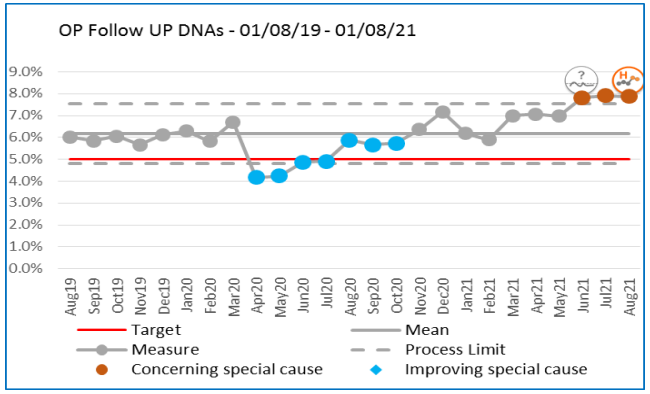

| Aug-21 |
|---|
| 24.8% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (Internal)** |
| 30% |
| **Target Achievement** |
| Metric is consistently failing the target |




| Aug-21 |
|---|
| 52% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (Internal)** |
| 85% |
| **Target Achievement** |
| Metric is consistently failing the target |




| Aug-21 |
|---|
| 45.6% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of an improving nature |
| **Target (Internal)** |
| 95% |
| **Target Achievement** |
| Metric is consistently failing the target |




| Aug-21 |
|---|
| 7.9% |
| **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:

**% Virtual OP Appointments:** The percentage of virtual OP appointments has been dropping month on month, currently experiencing special cause variation of a concerning nature and consistently failing the target

**Calls Answered:** The number of calls answered in less than 1 minute is now experiencing special cause variation of an improving nature but continues to consistently failing the target.

**Outpatient Utilisation:** Continues to experience special cause variation of a concerning nature as well as consistently failing the target

**DNA Rates:** DNA rates for Follow-ups continue to be in special cause variation of a concerning nature and variable achievement of the target. New Appointments remain in common case variation.

## Actions:

**% Virtual OP Appointments:** The current Virtual Platform can be challenging for consultants to use and feel an improved platform would be more beneficial.

**Outpatient Utilisation:** The Clinical System Development Managers have reviewed over 90% of the clinic templates on Allscripts, this includes viewing the individual microsession templates and removing any historic clinics that are no longer required to ensure that utilisation is a true reflection. Once complete the utilisation figures will be correct to do further analysis on how to improve this.

**Calls:** Currently investigating spacing options in which to house call operatives for the outpatient communication centre pilot which will improve this.

## Assurance:

The Outpatient team are currently working with clinicians and patient representatives to demo various virtual platforms to ensure that we find the right fit for MTW and to improve clinician and pathway uptake.

Specialty clinic templates are being reviewed to ensure that all templates are correct and have received GM and CD sign off. Further analysis of utilisation will then be completed to understand the impact and reasonings for DNA's.

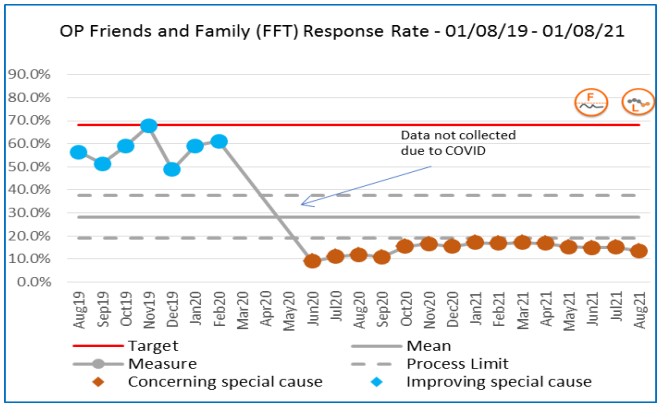
Weekly meeting with specialties are undertaken to go through all of our KPI's to understand areas for improvement and reasonings for poor performance. This includes calls, DNA's and Cancellations.

# Caring - CQC Domain Scorecard

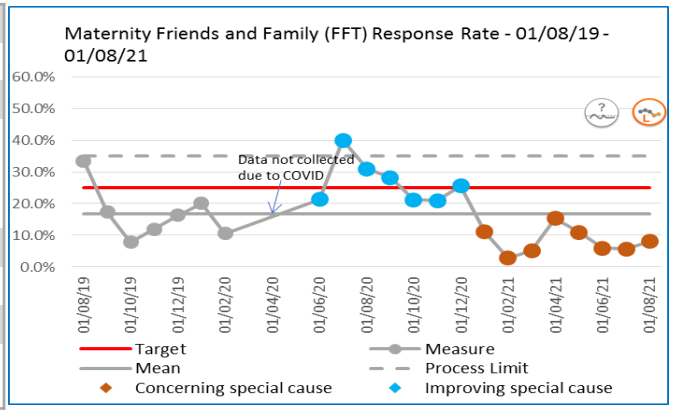
## Organisational Objectives – Quality & CQC

| | Latest | | | | Previous | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| Single Sex Accommodation Breaches | 0 | 0 | Aug-21 | | 0 | 0 | Jul-21 | 0 | 0 | P |
| Rate of New Complaints | 3.9 | 2.1 | Aug-21 | | 3.9 | 2.6 | Jul-21 | 3.9 | 2.8 | ? |
| % complaints responded to within target | 75.0% | 82.9% | Aug-21 | | 75.0% | 61.5% | Jul-21 | 75.0% | 73.5% | ? |
| IP Resp Rate Recmd to Friends & Family | 25.0% | 6.7% | Aug-21 | | 25.0% | 7.5% | Jul-21 | 25.0% | 10.8% | ? |
| IP Friends & Family (FFT) % Positive | 95.0% | 97.7% | Aug-21 | | 95.0% | 98.3% | Jul-21 | 95.0% | 97.8% | ? |
| A&E Resp Rate Recmd to Friends & Family | 15.0% | 0.1% | Aug-21 | | 15.0% | 0.2% | Jul-21 | 15.0% | 2.8% | ? |
| A&E Friends & Family (FFT) % Positive | 87.0% | 83.3% | Aug-21 | | 87.0% | 96.7% | Jul-21 | 87.0% | 96.2% | ? |
| Mat Resp Rate Recmd to Friends & Family | 25.0% | 8.0% | Aug-21 | L | 25.0% | 5.6% | Jul-21 | 25.0% | 9.1% | ? |
| Maternity Combined FFT % Positive | 95.0% | 100.0% | Aug-21 | | 95.0% | 100.0% | Jul-21 | 95.0% | 99.6% | ? |
| OP Friends & Family (FFT) % Positive | 84.0% | 82.2% | Aug-21 | | 84.0% | 81.7% | Jul-21 | 84.0% | 82.5% | ? |
| OP Resp Rate Recmd to Friends & Family | 68.0% | 13.5% | Aug-21 | L | 68.0% | 15.1% | Jul-21 | 68.0% | 15.1% | F |
| % VTE Risk Assessment | 95.0% | 96.1% | Aug-21 | L | 95.0% | 96.7% | Jul-21 | 95.0% | 94.2% | P |

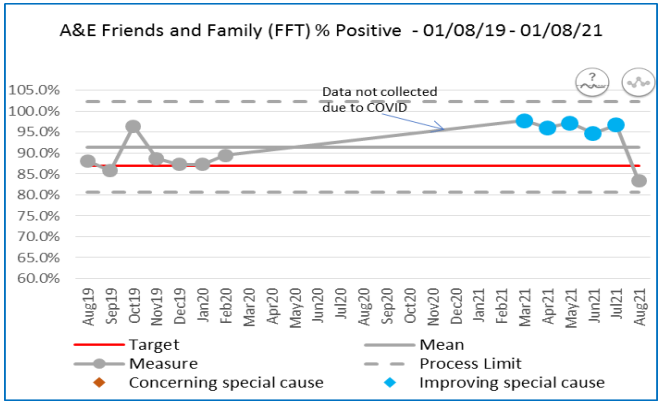
# Caring - Organisational Objective: Quality and CQC



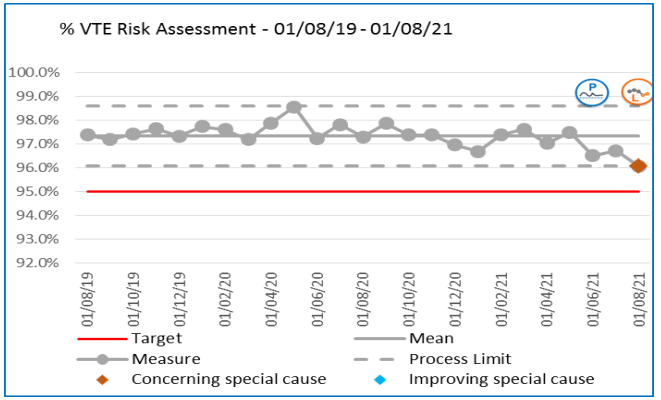

| Aug-21 |
|---|
| 13.5% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Max Target (Internal)** |
| 68% |
| **Target Achievement** |
| Metric is consistently failing the target |




| Aug-21 |
|---|
| 8% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (Internal)** |
| 25% |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 97.7% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of an improving nature |
| **Target** |
| 87% |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 96.1% |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (National)** |
| 95% |
| **Target Achievement** |
| Metric is consistently achieving the target |

## Summary:

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

**A&E Friends and Family % Positive:** Of the responses received those that are positive decreased in August bur remain in common cause variation. The level of those responding remains significantly lower than expected levels (0.1% in August)

**Maternity Friends and Family Response Rate:** The rate of responses remain in special cause variation of a concerning nature.

**VTE:** VTE performance has returned to special cause variation of a concerning nature, however this indicator continues to consistently achieve the national target.

## Actions:

**OP FFT:** IPads about to be installed for face to face appointments and online submission. The target for OP FFT Response Times is being reviewed to ensure that we are aligned with our Regional Colleagues. The Trust is exploring some data issues that may also be having and impact.

**FFT:** General decline in submissions in the month likely due to site pressure. Focusing on increase in online submissions. Streamline process of collection to ensure accurate submission dates.

## Assurance:

**OP FFT:** Communication Hub run by volunteers currently in development. This will assist patients in their use of electronic devises and promote the use of FFT within the Department.

**FFT:** Increased engagement in FFT working group. Update in executive team brief to promote focus on FFT. We are continuing to monitor areas with reduced submissions of FFT

Increasing FFT response rates and maintaining the percentage that are positive are both one of the visions and breakthrough objectives being focussed on for improvement as part of the new Strategy Deployment Improvement Process.

# 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% | 73.6% | Aug-21 | | 86.7% | 73.6% | Jul-21 | 86.7% | 73.6% | F |
| Number of patients waiting over 40 weeks | 222 | 926 | Aug-21 | | 222 | 937 | Jul-21 | 222 | 926 | F |
| 52 week breaches (including those reported last month) | 0 | 49 | Aug-21 | | 0 | 67 | Jul-21 | 0 | 49 | ? |
| Access to Diagnostics (<6weeks standard) | 99.0% | 77.5% | Aug-21 | | 99.0% | 80.0% | Jul-21 | 99.0% | 77.5% | ? |
| Average for new appointment | 10.0 | 7.1 | Aug-21 | | 10.0 | 7.0 | Jul-21 | 10.0 | 7.1 | ? |
| Theatre Utilisation | 90.0% | 84.3% | Aug-21 | H | 90.0% | 84.6% | Jul-21 | 90.0% | 84.3% | F |

## Reset and Recovery Programme – Acute & Urgent Care

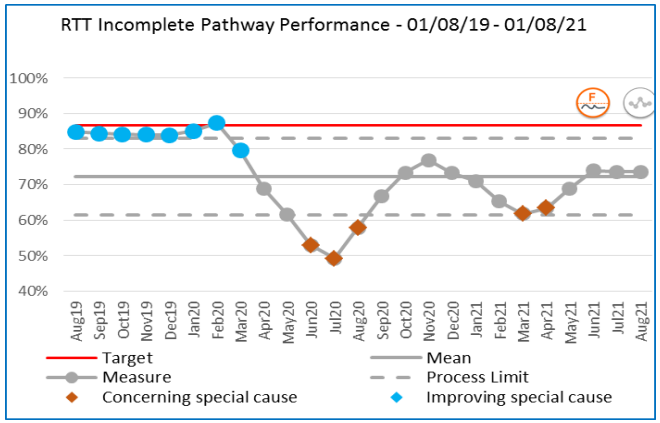
| | Latest | | | | Previous | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| Referrals to ED from NHS 111 | TBC | | Aug-21 | No SPC | TBC | | Jul-21 | TBC | | No SPC |
| A&E 4 hr Performance | 95.0% | 82.5% | Aug-21 | L | 95.0% | 77.2% | Jul-21 | 95.0% | 86.5% | ? |
| Super Stranded Patients | 80 | 90 | Aug-21 | | 80 | 84 | Jul-21 | 80 | 76 | ? |
| Ambulance Handover Delays Rate > 30mins | 7.0% | 10.3% | Aug-21 | | 7.0% | 12.8% | Jul-21 | 7.0% | 8.8% | ? |
| Bed Occupancy | 90.0% | 90.8% | Aug-21 | | 90.0% | 89.2% | Jul-21 | 90.0% | 88.4% | ? |
| NE LOS | 6.5 | 7.0 | Aug-21 | | 6.5 | 6.9 | Jul-21 | 6.5 | 7.0 | ? |

# Responsive - CQC Domain Scorecard

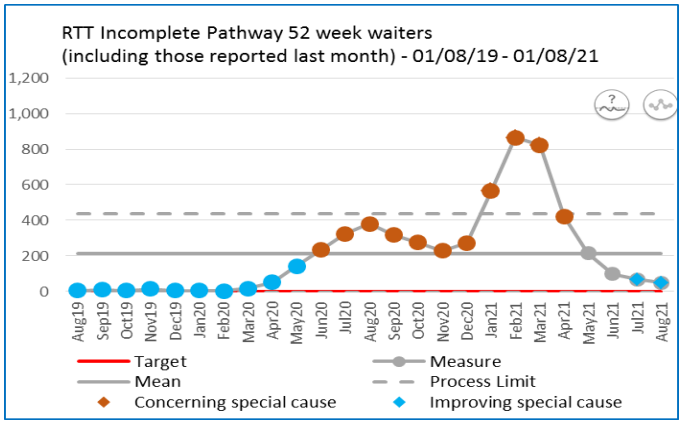
## Reset and Recovery Programme – Cancer Services

| | Latest | | | | Previous | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| Cancer - 2 Week Wait | 93.0% | 94.7% | Jul-21 | | 93.0% | 94.7% | Jun-21 | 93.0% | 94.7% | P |
| Cancer - 31 Day | 96.0% | 97.0% | Jul-21 | | 96.0% | 97.4% | Jun-21 | 96.0% | 97.0% | ? |
| Cancer - 62 Day | 85.0% | 85.0% | Jul-21 | | 85.0% | 85.1% | Jun-21 | 85.0% | 85.0% | P |
| Size of backlog | 30 | 113 | Aug-21 | H | 30 | 95 | Jul-21 | 30 | 113 | ? |
| 28 day Target | 75.0% | 77.5% | Jul-21 | | 75.0% | 79.4% | Jun-21 | 75.0% | 77.5% | ? |

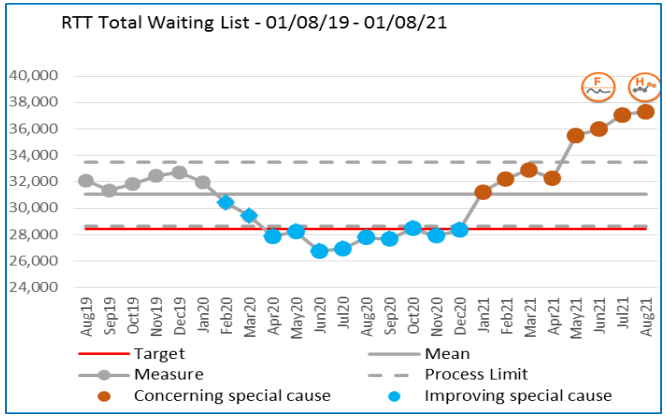
# Responsive - Reset and Recovery Programme: Elective



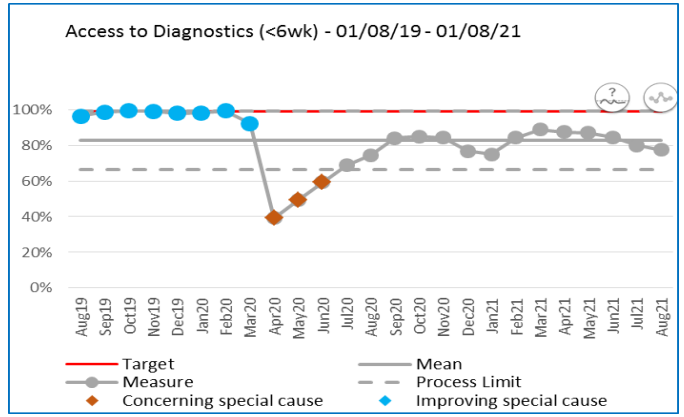

| Aug-21 |
|---|
| 73.59% |
| **Variance Type** |
| Metric is currently experiencing common cause variation |
| **Target (Internal)** |
| 86.3% |
| **Target Achievement** |
| Metric consistently failing the target |




| Aug-21 |
|---|
| 49 |
| **Variance Type** |
| Metric is currently experiencing common cause variation |
| **Max Target (Internal)** |
| 0 |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 37,310 |
| **Variance Type** |
| Metric is currently experiencing special cause variation of a concerning nature |
| **Target (Internal)** |
| 28,412 |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 77.5% |
| **Variance Type** |
| Metric is currently experiencing common cause variation |
| **Target** |
| 99% |
| **Target Achievement** |
| Metric is experiencing variable achievement |

## Summary:

**RTT:** Performance has declined slightly, with August provisional performance sitting at 73.59%.

**RTT 52 wk waiters:** There has been huge efforts made to reduce the number of 52 week waiters since the peak in February reducing by 813 waiters over the last 6 months.

**Elective Activity:** 97% of July elective activity levels were achieved. The current estimate for August (once IS Activity is included) is 93% of August 2019 elective activity levels as endoscopy activity is not at the 1920 levels due to a change in the service. Outpatients are back to 1920 levels overall with first outpatients estimated to be at 92% for August (once the IS activity has been included).

**Diagnostic Activity:** CT Scans in August were at 113% of 2019/20 Activity levels, MRI is at 2019/20 Activity levels and NOUS is running below the national target at 97 however this is an improving position.

**Diagnostic Waiting Times** performance has decreased further mainly due to Echocardiography where staffing shortages are a concern as well as a lack of DEXA capacity.

## Actions:

**RTT:** Continued focus on long waiting patients, pre operative assessment performance, patient cancellations, scheduling and utilisation.

**Efficiency:** Robust monitoring of patients in order to maximise clinic & theatre time & increase productivity. HVLC action plan has been implemented across Ophthalmology, ENT and T&O.

**Diagnostics:** To increase capacity & improve the waiting times for MRI and NOUS. The cardiology team have implemented an improvement plan for ecophysiology. Capital monies has been awarded to radiology in order to purchase a new DEXA machine. The old one is now obsolete.

## Assurance:

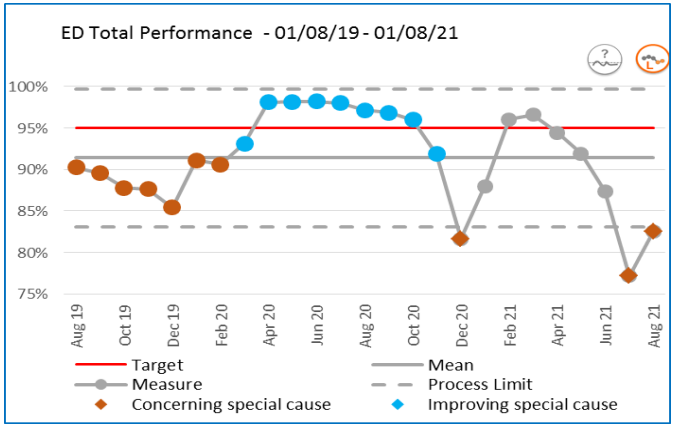
**RTT and Elective Activity:** Weekly performance meeting in progress, 6-4-2 and scheduling meetings, cancellations RCA's completed to identify trends. TUB in progress.

**RTT Long Waiters:** 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.

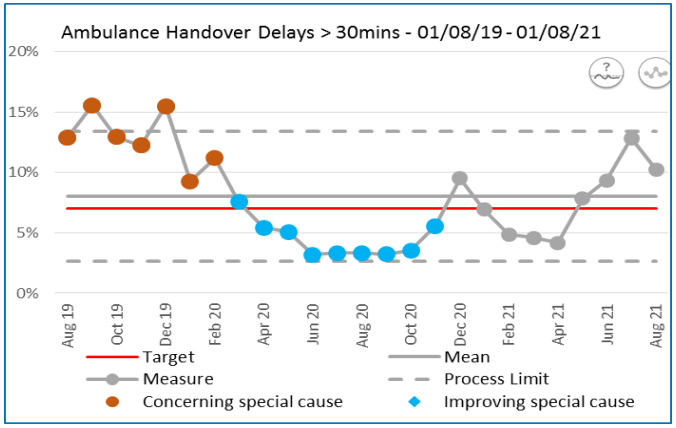
**Diagnostics:** Work is ongoing on the managed MRI project and is on track to deliver. DEXA continues to be outsourced to DGT.

**Elective Activity**: We continue to work closely with ISP partners. Work continues to streamline process and link with ISP where appropriate

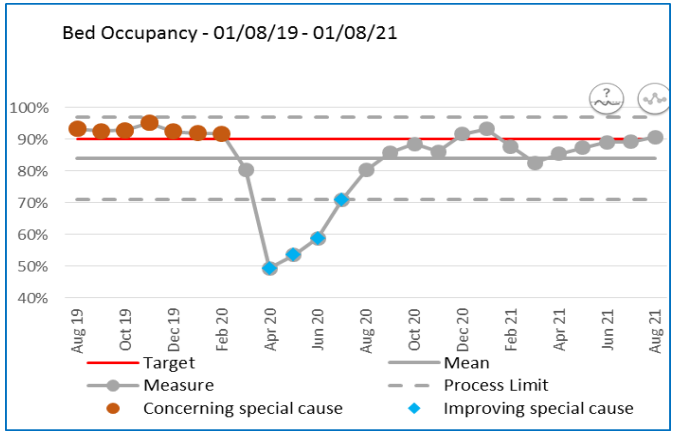
# Responsive - Reset and Recovery Programme: Emergency Care



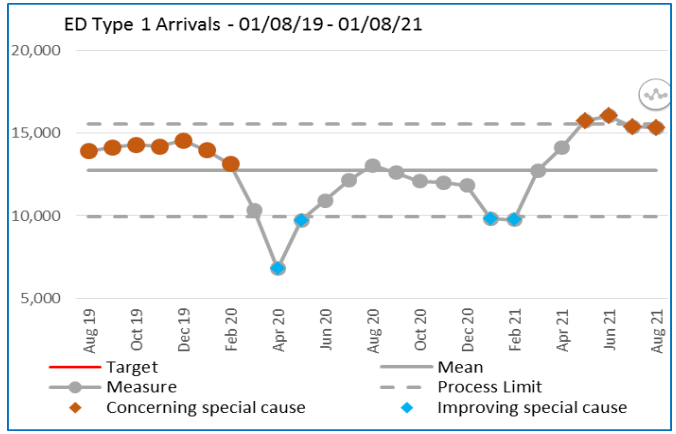

| Aug-21 |
|---|
| 82.5% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation of a concerning nature |
| **Target** |
| 95% |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 10.3% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Max Limit (Internal)** |
| 7.0% |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 90.8% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation of a concerning nature |
| **Max Limit (Internal)** |
| 90% |
| **Target Achievement** |
| Metric is experiencing variable achievement |




| Aug-21 |
|---|
| 15,336 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Max Limit (Internal)** |
| |
| **Target Achievement** |
| N/A |

## Summary:

ED 4hr performance (inc MIU): A&E 4hr performance had seen a deterioration which has been partly due to the implementation of the new Sunrise System as well as the continued high level of attendances. Both sites are slowly recovering but this indicator continues to experience special cause variation of a concerning nature at 82.5% in August.

Ambulance Handover delays continue to experience common cause variation (10.3% in August).

Bed Occupancy remains in common cause variation but is starting to show an increasing trend to above 90% (similar to August 1920).

Type 1 ED Attenders were significantly down on model from mid June to late July, but then held fairly constant in August when they usually fall. August was slightly (non significant) above expected levels

## Actions:

Flow Coordinators to be developed into cover until 2am. Business Case to be submitted for 24/7 cover to support minors flow in addition to majors flow.

111/ UTC – development of direct referral to SDEC pathways

New ED standards – to be reported from beginning of December.

Increased staffing for Minors/ GP on both sites including change in shift pattern.

3 new ED consultants in post. Paramedic recruitment for Resus/ RAP. Development of Band 2/3 Housekeeper post to support nursing workforce.

PIN input earlier in ambulance handover at clinician handover.

## Assurance:

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

New Divisional Governance Matron lead in post

A3 project underway – key areas incl. R&R/ Staff Wellbeing; demand and capacity; Front Door; onward referrals for admitted patients

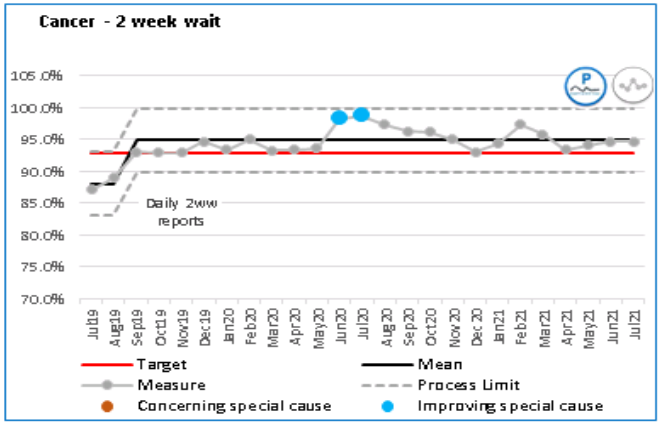
5th Rota Coordinator appointed to support ED nursing rota

Good working relationship with SECAmb and Site Management team

Consultants leading on transformation of referral process

Governance in place to support Sunrise changes where required

# Responsive - Reset and Recovery Programme: Cancer




**July-21**

94.7%

**Variance Type**

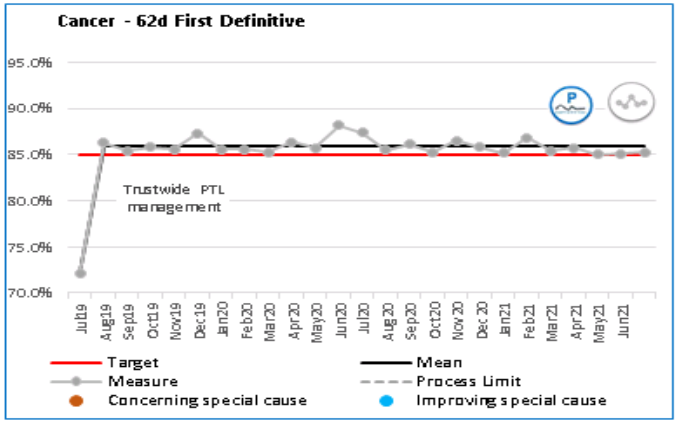
Process change Sept 2019 now showing common cause variation

**Max Target (Internal)**

93%

**Target Achievement**

Metric is currently achieving the target




**July-21**

85.0%

**Variance Type**

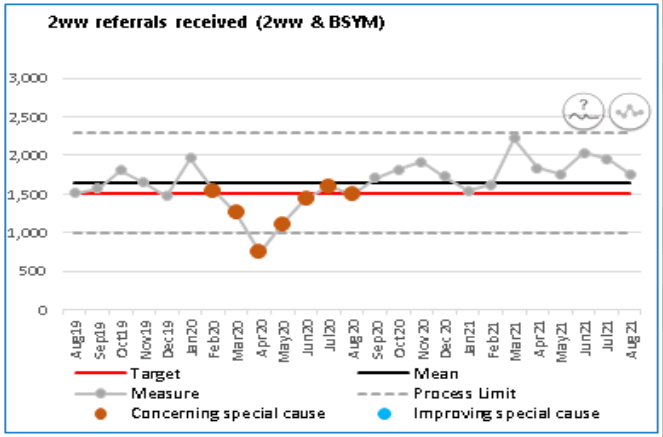
Process change Aug 2019 now showing common cause variation

**Max Target (Internal)**

85%

**Target Achievement**

Metric is currently achieving the target




**Aug-21**

1762

**Variance Type**

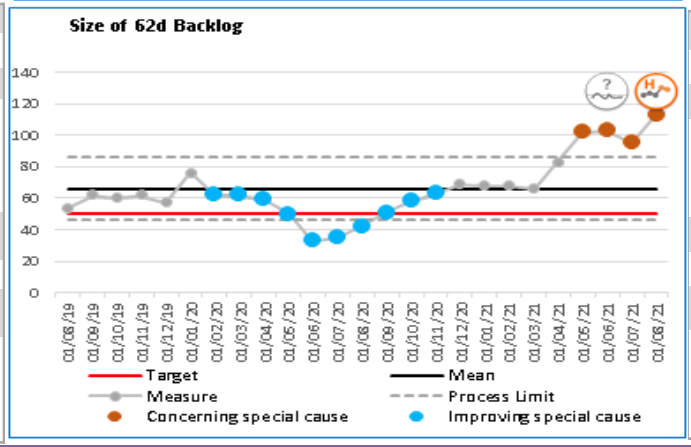
Metric is currently experiencing Common Cause Variation

**Max Target**

1500

**Target Achievement**

Metric is experiencing variable achievement of locally set target




**Aug-21**

113

**Variance Type**

Concerning Special Cause variation with last 4 points above the upper process limit

**Max Target (Internal)**

50

**Target Achievement**

Metric is experiencing variable achievement of locally set target

## Summary:

**2ww:** The 2ww standard continues to achieve the 93% target, and the process remains within expected levels of variation.

**Referrals:** The Trust is receiving higher numbers of 2ww referrals than pre Covid, however these remain within expected variation, reporting 1762 referrals received in August 2021.

**62 day:** The Trust has continued achievement of the 62 day standard for 2 years (from Aug 2019) reporting 85.3% this month.

**62 day PTL Backlog:** As the numbers on the 62d PTL continue to grow, the backlog has seen an increase in the past 5 months. Overall the process is showing concerning special cause variation, with May to August sitting at the upper process limit due to unprecedented 2ww referral numbers. The backlog is currently 6.3% of the total 62 day PTL

## Actions:

**Cancer PTL: 1.)** Increased focus on backlog patients on a daily basis. **2.)** Introduction of F2F PTLs on a Monday afternoon to support services further.

**3.)** Validation of all backlog and tip-over patients this week in order to ensure all patients in the backlog are appropriate referrals and on the right pathway.

**4.)** Training with coordinators and teams to ensure prioritisation and recording of 'risk' patients for demand management within our supporting services.

**Referrals:** Services are reviewing baseline 2ww provision in line with trajectory of demand and implementing various models to support. The CCG and Cancer Alliance have supported in prioritising patient referrals and ensuring we are appropriately appointing those at highest risk of cancer within the national guidelines.

## Assurance:

**Cancer Performance and PTL:** 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.

**28 Day FDS Standard:** 28 day FDS meetings have been implemented to manage data completeness and ensure we are submitting a representative view of our performance.

Weekly triumvirate meetings help to support key areas of concern and give clinical guidance across services. Daily Cancer Performance huddles with the teams and weekly senior MDT coordinator huddles to support the team working.

# 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 | 473 | Aug-21 | No SPC | Improving Quarterly | 634 | Jun-21 | Improving Quarterly | 473 | No SPC |
| Climate Survey - Percentage of staff who feel fully supported in their role | | 52.2% | Aug-21 | No SPC | | 56.4% | Jun-21 | | 52.2% | No SPC |
| Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety | | 53.4% | Aug-21 | No SPC | | 61.9% | Jun-21 | | 53.4% | No SPC |
| Climate Survey - Percentage of staff who feel able to cope with the demands that are being | | 52.2% | Aug-21 | No SPC | | 54.0% | Jun-21 | | 52.2% | No SPC |
| Health and Wellbeing: How many calls received | 40 | 71 | Jul-21 | | 40 | 36 | Jun-21 | 480 | 450 | ? |
| Health and Wellbeing: What percentage of Calls related to Mental Health Issues | 44% | 49% | Jul-21 | | 44% | 40% | Jun-21 | 44% | 46% | ? |

## Organisational Objectives: Workforce

| | Latest | | | | Previous | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| Sickness | 3.3% | 4.1% | Jul-21 | | 3.3% | 3.6% | Jun-21 | 3.3% | 0.0% | ? |
| Turnover | 10.0% | 10.9% | Aug-21 | L | 10.0% | 11.7% | Jul-21 | 10.0% | 10.9% | F |
| Vacancy Rates | 9.0% | 14.1% | Aug-21 | H | 9.0% | 13.9% | Jul-21 | 9.0% | 14.1% | ? |
| Use of Agency (WTE) | 81 | 266 | Aug-21 | | 81 | 186 | Jul-21 | 81 | 266 | F |
| Appraisal Completeness | 95.0% | 55.7% | Aug-21 | | 95.0% | 41.9% | Jul-21 | 95.0% | 55.7% | ? |
| Stat and Mandatory Training | 85.0% | 91.2% | Aug-21 | H | 85.0% | 91.6% | Jul-21 | 85.0% | 91.2% | 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 (£k) | 0 | -21 | Aug-21 | No SPC | - | - 19 | Jul-21 | 0 | -40 | No SPC |
| CIP Savings (£k) | 434 | 331 | Aug-21 | No SPC | 434 | 443 | Jul-21 | 2168 | 1868 | No SPC |
| Cash Balance (£k) | 39,319 | 42,715 | Aug-21 | No SPC | 40,601 | 39,213 | Jul-21 | 39,319 | 42,715 | No SPC |
| Capital Expenditure (£k) | 651 | 364 | Aug-21 | | 654 | 141 | Jul-21 | 2,323 | 1,039 | ? |
| Agency Spend (£k) | 1,333 | 1,795 | Aug-21 | | 1,333 | 2,033 | Jul-21 | 1,333 | 1,795 | ? |
| Use of Financial Resources | No data | | Aug-21 | No SPC | No data | | Jul-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% | 19.3% | Aug-21 | H | 13.5% | 19.7% | Jul-21 | 13.5% | 19.3% | ? |
| Covid Positive - number of patients | 0 | 85 | Aug-21 | | 0 | 111 | Jul-21 | 0 | 243 | ? |

# Well Led - CQC Domain Scorecard

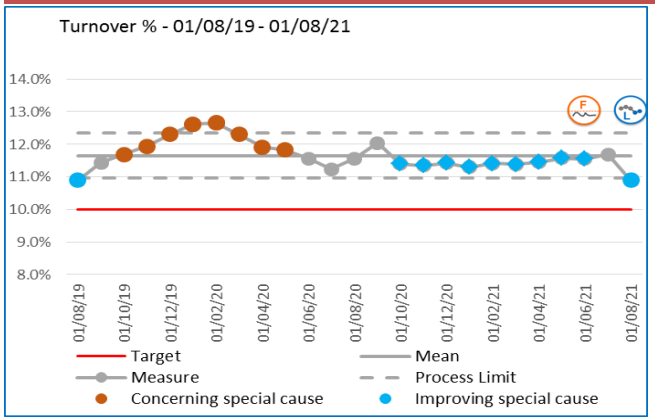
## Organisational Objectives - Strategy – Clinical

| | Latest | | | | Previous | | | YTD | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| Number of specialist services | 35 | 30 | Aug-21 | | 35 | 30 | Jul-21 | 35 | 35 | F |
| Elective Spells in London Trusts from West Kent | 329 | 195 | Aug-21 | | 329 | 325 | Jul-21 | 329 | 195 | ? |
| Service contribution by division | TBC | | Aug-21 | No SPC | TBC | | Jul-21 | TBC | | No SPC |
| Research grants (£) | 114 | 151 | Aug-21 | | 114 | 125 | Jul-21 | 114 | 151 | ? |
| Number of advanced practitioners | 25 | 31 | Aug-21 | | 25 | 31 | Jul-21 | 25 | 31 | P |
| Percentage of Trust policies within review date | 90.0% | 72.6% | Aug-21 | H | 90.0% | 71.1% | Jul-21 | 90.0% | 72.6% | 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% | 62.9% | Aug-21 | L | 70.0% | 62.9% | Jul-21 | 70.0% | 62.9% | ? |
| Staff Friends and Family % recommended care | 80.0% | 81.0% | Aug-21 | H | 80.0% | 81.0% | Jul-21 | 80.0% | 81.0% | ? |
| Equality, Diversity and Inclusion reducing inequalities metrics / dashboard | TBC | | Aug-21 | No SPC | TBC | | Jul-21 | TBC | | No SPC |

# Well Led - Operational Objective: Workforce




**Aug-21**

10.9%

**Variance Type**

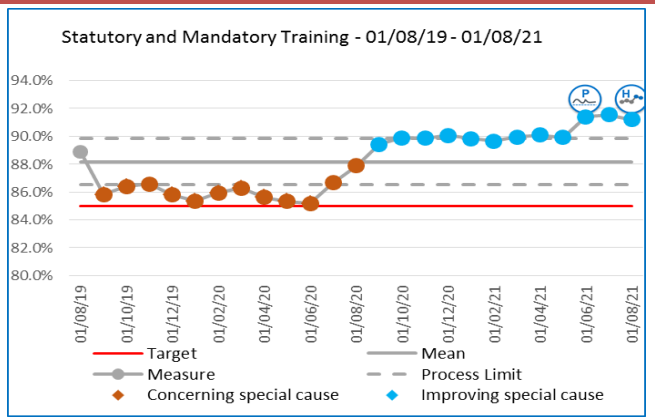
Metric is currently experiencing Special cause variation of an improving nature

**Max Target (Internal)**

10%

**Target Achievement**

Metric is consistently failing the target




**Jul-21**

91.2%

**Variance Type**

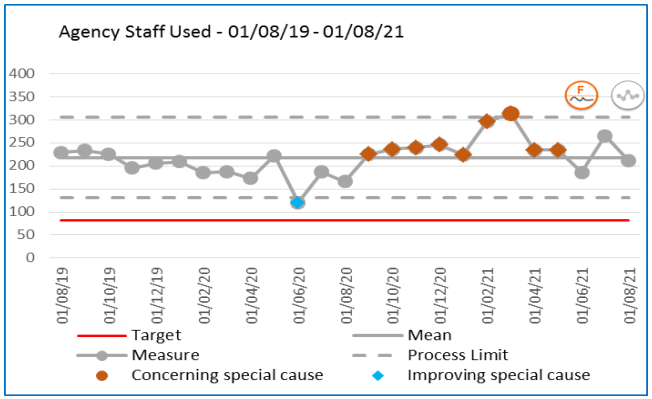
Metric is currently experiencing Special Cause Variation of an improving nature

**Max Target (Internal)**

85%

**Target Achievement**

Metric is consistently passing the target




**Aug-21**

212

**Variance Type**

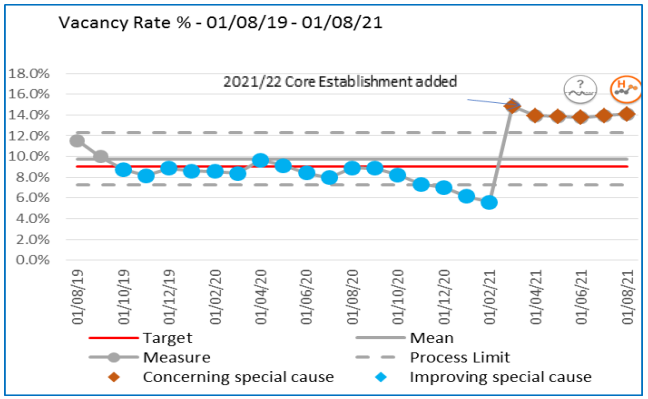
Metric is currently experiencing Common Cause variation

**Target (Internal)**

81

**Target Achievement**

Metric is consistently failing the target




**Aug-21**

14.1%

**Variance Type**

Metric is currently experiencing Special Cause Variation of a concerning nature

**Max Limit (Internal)**

9.0%

**Target Achievement**

Metric is experiencing variable achievement

## Summary:

**Turnover:** The Turnover rate decreased in August and is now experiencing special cause variation of an improving nature but is also consistently failing the target.

**Statutory and Mandatory Training:** This indicator continues to improve and is consistently achieving the target.

**Agency Staff Used:** The level of Agency staff decreased in August. This indicator remains in common cause variation, though consistently failing the target

**Vacancy Rate** : This continues to experience special cause variation of a concerning nature.

## Actions:

**Turnover :** There has been a marginal movement bring the KPI closer to the mean average this month. This will continue to be monitored.

Agency / Vacancy Rate: In August we saw an increase in demand of c.1.2% for Temporary Staffing. Nursing saw an increase of 2% compared to the previous month partly due to shortages within midwifery and ED, the demand level is the second highest month since April 2017 and c.2,500 shifts more than the same period last year. The demand for CSW's increased by 8.5% since July and is the highest ever with bank fill increasing by 5%. Medical demand decreased by c.14% but is comparable to the same period last year. In the last 12 month period we have seen the temporary staffing demand increase by over 37% compared to the same period the year before, with bank fill increasing by 27%. We are beginning to see an upturn in agency usage and often at higher rates due to the shortages in staff and increases in demand across the whole region. A proposal has been submitted to increase the AFC bank rates to help attract more staff and a further update will be provided in the next IPR.

A Weekly Resourcing Task Force has been set up to work through resourcing issues.

## Assurance:

Recruitment are continuing to work with the following "hot spot areas" to assist in improving their vacancy rate: Medicine, ED, Critical Care, Radiology, Midwifery and Pathology.
This includes social media campaigns, virtual events, international recruitment, head hunting and retention strategies.
The trust will be submitting an application to pilot 20 "Kick Start" roles within the people directorate and one team runners. The scheme will create new jobs for 16 to 24 year olds on Universal Credits who are at risk of long term unemployment. If the pilot is successful and the campaign is extended then this will be aimed to be rolled out across the trust.
70 International nurses have commenced with MTW since April and we have a further 24 in the pipeline. We have over 540 international CV's awaiting to be screened however majority wards have explained that they are unable to support larger numbers due to having a junior workforce. For this reason the head of Recruitment is collating what support each directorate needs to overcome this barrier- findings will be submitted to the Senior Nursing team.
A collaborative bid has been submitted to NHSI for the international recruitment of Midwives between MTW, Medway, East Kent and Dartford and Gravesham. MTW is the lead for this project and the outcome will be shared mid October.
The Trust continues to scope out plans for a Staffing Hub to provide a centralised view of staffing across the Trust, to help improve care by providing the resource required and access to real time data. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend including paying enhanced rates for Bank staff working within Rapid Response Pool ward to mitigate staff shortages, with a review of future incentives taking place. Various options are currently being explored to provide support with the additional requirement for RMN's.

# Appendices

# Supporting Narrative

## Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, reporting 85.0% and 94.7% respectively, however achievement of the these standards is becoming increasingly challenging with the continued high number of 2ww referrals and increasing 62 Day Backlog . A&E 4hr performance has seen a deterioration since April 2021 which has been impacted partly by the implementation of the new Sunrise System as well as the continued high level of attendances. Both sites have started to recover (with a ~ 4% improvement overall in August) but this indicator remains in special cause variation of a concerning nature at 82.5%. RTT performance has remained similar in August as elective activity continues to recover. Activity levels (which include the activity being undertaken in the Independent Sector) have been above the national target for April to July (just under for first outpatient attendances in July) and the estimate for August is currently showing 93% of 1920 levels for Elective Activity and 96% for Total outpatients. The high level of non-elective emergency admissions as well as the high level of elective activity being undertaken is therefore putting pressure on the bed capacity across with Trust. Total Bed Occupancy is showing an increasing trend back to pre-Covid levels (90.1% for August 2021). The level of Mothers Delivering is experiencing special cause variation with August at record levels for the last three years (539). Patient safety and quality indicators remain in common cause variation despite the high bed occupancy and challenges in staffing levels.

## 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. A Trust-wide Incidents meeting has been arranged to review the number of cases of C.Difficile. The Trust admitted 85 patients with Covid-19 infection during August, 2 cases of probable or definite hospital acquired infection (2.4%). Assurance of compliance continues through the IPC BAF..

- **Falls:** The overall rate of falls continues to experience common cause variation and variable achievement of the target. One SI relating to Falls was reported. A Stakeholder Event has been arranged for 19th October 2021 to increase awareness and further involve the wider multi-disciplinary teams. Local ad-hoc training continues for staff on multifactorial risk assessment and documentation of assessment and care. Resources for assessment of patient at risk of falls made available to support with early identification of falls risk to aid identification and implementation of measures to reduce risk. Achieving a reduction is Falls in one of the key breakthrough objectives being focussed on for improvement as part of the new Strategy Deployment Improvement Process.

- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers remains in common cause variation and variable achievement of the target. Total pressure ulcers (including inherited) also remains in common cause variation. The Pressure Ulcer group continue to discuss learnings from recent incidents to ensure that they are shared across Directorates. The Trust continues to monitor patients admitted with pressure ulcers and liaise with the local community and neighbouring acute trusts to identify themes and trends.

- **Incidents and SIs:** The level of SIs reported reduced to 3 (1 relating to Falls and 2 related to a diagnostic incident. No Never Events were recorded. Senior members of the Patient Safety Team continue to carry their own caseload of SIs to ensure that investigations are completed thoroughly and in a timely manner to support our staff, patients and their families. The team continue to work with the divisions to allocate investigators to these SIs.

- **Stroke:** The overall Best Practice Indicator continues to experience common cause variation and variable achievement of the target (reported one month behind due to delays in coding).

- **A&E 4 hour Standard and Flow:** Overall ED Performance has improved by ~4% in August but remains in special cause variation of a concerning nature (82.5% in July) driven by continued high attendance volumes and the rollout of Sunrise. The Trust continues to implement the ED improvement action plan to support flow throughout the Trust with all of flow indictors continuing to remain in common cause variation. Development of 111/Urgent Treatment Centre (UTC) is in progress to extend the service. Emergency admissions remain high and have returned to common cause variation following the record levels in July. The level of Same Day Emergency Care (SDEC) attenders continues to rise and is experiencing special cause variation.

- **Ambulance Handover Delays:** Delays reduced in August and continue to experience common cause variation and variable achievement of the target (10.3% in August).

# Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** Performance remained similar at 73.59%. Elective activity continues to recover achieving the targets April to July 21. The estimate for August is 93% for Elective and 96% for total outpatients. Day case activity is being affected by the reduction in endoscopy demand. Improvements in Theatre Utilisation has now moved this metric to special cause variation of an improving nature. There has been huge efforts made to reduce the number of 52 week waiters since the peak in February reducing by 813 waiters over the last 6 months. Diagnostics waiting <6 weeks has decreased further to 77.5% mainly due to Echocardiography staffing shortages and a lack of DEXA Capacity.

- **Cancer 62 Day:** From August 2019 the 62 day standard has shown an improved performance and has consistently achieved the 85% standard (reporting 85.0% for July 2021 ). A process step change was therefore applied. The calculated mean up to August 2019 was 66.7% and is now 85.9% - which is consistently in line with the target of 85% for the 62 day standard. The updated chart now reports a common cause variation as confirmation of a process within expected levels of variation.

- **First Seen Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement in the achievement of the 2ww first seen standard, consistently achieving target (94.7% for July), despite the pressure experienced from the increased numbers of 2ww referrals from March 2021. A process step change has been applied to this metric. The calculated mean up to September 2019 was 86.7% and is now 94.9% , which remains consistently in line with the target of 93% for the 2ww standard.

- **Size of 62 day Backlog**: Following the decrease in 2019 of the number of patients being managed on the 62 day PTL, the PTL numbers have continued to increase again, with an average of 1749 in April, increasing to 1783 in July and currently averaging at 1804 through August 2021. This is impacting on the number of patients being managed with pathways over 62 days. Overall the size of the 62d backlog is in concerning special cause variation, with May, June, July and August being above the upper process limit. Currently the backlog averaged at 113 patients in August 2021 – which is 6.3% of the overall PTL. A continuation of this backlog increase will impact the sustainability of cancer performance in the upcoming months.

- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April 2020 due to COVID-19, the incoming referral numbers have increased through the remainder of 2020, into 2021. Following the significant increase in numbers seen in March 2021, the incoming referral numbers have returned to expected levels of variation, however remain above the calculated mean with 1762 referrals in August 2021. Overall this metric is reporting common cause variation,

- **Finance:** The Trust is on plan generating a breakeven position. The Trusts key favourable variances to plan are:, Pay underspends (£2.6m), underspends within clinical supplies and drugs (£1.8m) due to lower activity than funded levels, additional north Kent ophthalmology income to match expenditure plan (£0.3m), Bowel screening income over-performance (£0.5m), non recurrent income benefit (£0.7m) and ERF over-performance (£0.3m). The Trusts key adverse variances to plan are: Re-phasing of top up and non-recurrent income support (£5.5m) and CIP slippage to stretch target (£1m).

- **Workforce**: The Safe Staffing Nursing Fill Rate reported remains in common cause variation, which impacts the overall fill rate. Regular staffing huddles with divisional leads and staff bank continue to ensure safe staffing levels across the Trust. Increased multi professions representation are on the wards to help support the nursing staff. The Trust is currently reviewing the data held on Healthroster to ensure that it is accurate. The level of Agency staff used continues to reduce. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend. Recruitment continue to work with “hot spot” areas to assist in improving their vacancy rate. This includes social media campaigns, virtual events, international recruitment, head hunting and retention strategies. A Weekly Resourcing Task Force has been set up to work through resourcing issues. The trust will be submitting an application to pilot 20 “Kick Start” roles within the people directorate and one team runners. The scheme will create new jobs for 16 to 24 year olds on Universal Credits who are at risk of long term unemployment. If the pilot is successful and the campaign is extended then this will be aimed to be rolled out across the trust. The Turnover rate decreased in August and is now experiencing special cause variation of an improving nature but also consistently failing the target. Climate survey and the “Moving On” survey data is being used to drive local interventions to aid retention. Sickness levels increased by 0.5% in July but remain in common cause variation at 4.1%. Of the 4.1% reported 0.2% was COVID related sickness. The non-Covid related sickness remains at expected levels.

# Implementing a Revised Perinatal Tool

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

| Maternity Safety Support Programme | No | If No, enter name of MIA (?) |
|---|---|---|

| | 2021 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
| Findings of review of all perinatal deaths using the real time data monitoring tool | 2 cases<br><br>Themes:<br>- Extreme prematurity x 1<br>- HSIB case x 1 | 1 case<br><br>Themes:<br>- HSIB case x 1 | 3 cases<br><br>Themes:<br>- HSIB case x 2<br>- MTOP - fetal anomaly x 1 | 5 cases<br><br>Themes:<br>- MTOP fetal abnormalitiy x 2<br>- Unexplained death x 2<br>- fetal cardiac anomaly x 1 | 1 case<br><br>Themes:<br>- MTOP fetal anomaly x 1 | 3 cases<br><br>Themes:<br>- Prematurity x 4<br>- Unexplained death x 1 | 2 cases<br><br>Themes:<br>- Prematurity x 2<br>- Unexplained death x 2 | 3 cases<br><br>Themes:<br>- Extreme prematurity x 1<br>- Unexplained stillbirth x 1<br>- Term stillbirth - placental abnormalities, GDM on insulin |
| Findings of review of all cases eligible for referral to HSIB | 2 cases<br><br>Themes:<br>Case 1 - Escalation during neonatal resuscitation<br>Case 2 - No safety concerns | 1 case<br><br>Themes:<br>Patient information - fetal movements in labour<br>Guideline for risk assessment in Triage | 2 cases<br><br>Investigations in progress | 0 cases | 1 case<br><br>Investigation in progress | 0 cases | 1 case<br><br>Investigation in progress | 0 cases |
| **Report on:** | | | | | | | | |
| *The number of incidents logged as moderate or above and what actions are being taken | 4 moderate incident<br>1 serious incident<br><br>Learning shared:<br>- MDT Communication<br>- Guidelines updated | 1 moderate incident<br>1 serious incident<br><br>Learning shared:<br>- 1:1 feedback<br>- situational awareness | 1 moderate incident<br>1 serious incident<br><br>Learning shared:<br>- 1:1 feedback<br>- obstetric cover for Triage<br>- review of guideline for care in latent phase of labour | 0 moderate incident<br>1 serious incident<br><br>Learning shared:<br>- reminder to staff to follow fetal growth assessment programme | 5 moderate incident<br>2 serious incident<br><br>Learning shared:<br>- reminder to follow ED pathway for unwell maternity patients<br>- review of process for follow up of investigation results<br>- review of pathway for booking caesarean section<br>- 1:1 feedback | 1 moderate incident<br><br>Learning shared:<br>- importance of timely follow up of urgent investigation results<br>- importance of MDT working and clinical overview | 2 moderate incidents<br>1 serious incident<br><br>Learning shared:<br>- assess risk of bladder injury at LSCS<br>- ensure staff with appropriate experience available for complex surgery | 0 moderate incident<br>0 serious incident |
| *Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills | 66% | 73% | 82% | 91% | 98% | 99% | 98% | 89% |
| *Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour | 50% | 56% | 53% | 53% | 69% | 74% | 68% | 67% |
| *Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively | | | | | | | | |
| **Service User Voice Feedback - number of IQVIA (FFT) responses** | 179 | 74 | 282 | 254 | 243 | 191 | 145 | 106 |
| **Service User Voice Feedback - % positive responses** | 98% | 99% | 96% | 99% | 97% | 97% | 96% | 92% |
| **HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust** | No | No | HSIB quarterly engagement meeting | CQC engagement meeting | Letter from HSIB requesting additional support for staff involved in investigations (based on feedback from one individual)- action plan developed | HSIB quarterly engagement meeting | No | No |
| **Coroner Reg 28 made directly to Trust** | No | No | No | No | No | No | No | No |
| **Progress in achievement of CNST 10** | | | | | | | Declaration of compliance submitted 22/07/2021 | Maternity Incentive Scheme - Year 4 guidance published. Action planning commenced |

| Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually) | 75% |
|---|---|

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

**REVIEW OF LATEST FINANCIAL PERFORMANCE**

- The Trust delivered the year to date and August financial plan by delivering a breakeven financial position.
- In line with NHSE/I guidance additional income (£2.7m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £1.6m to cover the full costs incurred in quarter one.
- The year to date position includes £9.6m associated with the Elective Recovery Fund (ERF), which is £0.3m favourable plan. This is an estimate as the full system value and therefore the Trusts element is still to be finalised. The August position includes a risk assessment to account for the system performance where some providers have not achieved the threshold to trigger ERF payment.
- The key year to date variances is as follows:
  - **Favourable Variances**
    - Pay underspends (£2.6m)
    - Clinical supplies and drugs (£1.8m) due to lower activity than funded levels
    - Non-recurrent income benefits (£0.7m)
    - Bowel screening income overperformance (£0.5m)
    - North Kent Ophthalmology contract adjustment (£0.3m)
    - ERF overperformance (£0.3m)
  - **Adverse Variances**
    - Rephasing of top up and non-recurrent income support (£5.5m)
    - CIP slippage to stretch target (£1m)
- The key current month variances are as follows:
  - Income under performed by £0.9m in August. The main underperformance relates to a risk assessment for ERF (£3.2m). The risk assessment of considers the system performance where some providers have not achieved to the threshold to trigger ERF payment. As a result, the current position removes any ERF for July and August. Discussions are ongoing with Kent and Medway CCG about the final payment to be made. This underperformance is partly offset by £1m top up adjustment (to bring the Trust to a breakeven position), £1m year to date drugs overperformance adjustment associated with specialist commissioning and £0.2m increase to block funding to offset North Kent Ophthalmology service change.
  - Expenditure budgets underspent by £1.1m which is within non pay budgets. The use of the independent sector was £2.3m less than planned although £0.3m is offset by reduction in income for prime provider. This underspend is partly offset by £0.5m of costs incurred relating to the Kent Medical school and £0.4m overspend within drugs.
- The Trust has the following key income assumptions included within the position which are pending confirmation from Kent and Medway CCG
  - Prime Provider (Patient Choice activity) income of £2.7m has been incorporated to offset the costs reported in the month.
- The cash balance at the end of August is £42.7m compared to the closing balance at July of £39.2m. The first 6 months (H1) of SLA block payments are based on 2020/21 quarter 3 position extended for a 6 months period, which covers the initial base position. Discussions are ongoing regarding final adjustments for 2021/22 H1 as well as the H2 income expectation. The current cash flow forecast for H2 is based on similar values to the first 6 months with some minor adjustments; this will be updated alongside the H2 Income & Expenditure planning.
- At present the closing cash balance is assumed at a level of £5m but this will need to be updated to reflect H2 assumptions. The Trust is continuing to work with NHS colleagues to ensure both debtors and creditor balances remain low as well as ensuring all trade suppliers are paid as soon as they are authorised. The Trust is maintaining the two payment runs per week which was implemented during the start of Covid-19 to ensure suppliers are paid promptly.
- The Trust's capital plan agreed with the ICS/STP for 2021/22 is £10.57m comprising of net internal funding £8.9m, PFI lifecycle per Project model of £1.2m and donated assets of £0.4m. In addition to the Plan the STP has agreed to finance £430k of Diagnostic Equipment from the System Diagnostic Fund. The Trust is expecting a Memorandum of Understanding (MoU) from DHSC to confirm this funding. Therefore, the forecast outturn is £11m including donated and PFI Lifecycle assets. The Trust has received notification that NHSE has prioritised the

replacement of one core Linac machine from funding that it is seeking approval from Treasury. In addition, the Trust is applying to the STP for £800k of enabling and ancillary equipment to complete the replacement.

- The year to date capital spend is £1.04m compared to the Plan of £2.2m. The majority of the spend relates to the completion of the MRI installation and the ongoing EPR project, there were also elements of carry forward spend from projects commenced in 2020/21. The variance relates to schemes that have either been delayed or are waiting for business cases

Maidstone and Tunbridge Wells NHS Tr

# 1. Dashboard

August 2021/22

| | Current Month | | | | Year to Date | | | | Annual Forecast / Plan (Month 1-6) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Actual* £m | *Plan* £m | *Variance* £m | *RAG* | *Actual* £m | *Plan* £m | *Variance* £m | *RAG* | *Forecast* £m | *Plan* £m | *Variance* £m | *RAG* |
| Income | 50.3 | 51.2 | (0.9) | | 243.1 | 248.4 | (5.3) | | 293.1 | 298.8 | (5.7) | |
| Expenditure | (47.4) | (48.5) | 1.1 | | (229.5) | (235.0) | 5.5 | | (276.8) | (282.6) | 5.8 | |
| EBITDA (Income less Expenditure) | 2.9 | 2.7 | 0.2 | | 13.6 | 13.4 | 0.2 | | 16.3 | 16.2 | 0.2 | |
| Financing Costs | (3.0) | (2.8) | (0.2) | | (13.8) | (13.7) | (0.1) | | (16.6) | (16.5) | (0.1) | |
| Technical Adjustments | 0.1 | 0.0 | 0.0 | | 0.3 | 0.2 | 0.0 | | 0.3 | 0.3 | 0.0 | |
| **Net Surplus / Deficit (Incl Top Up funding support)** | **0.0** | **0.0** | **0.0** | | **0.0** | **0.0** | **0.0** | | **0.0** | **(0.0)** | **0.0** | |
| Cash Balance | 42.7 | 39.3 | 3.4 | | 42.7 | 39.3 | 3.4 | | 36.4 | 36.4 | 0.0 | |
| Capital Expenditure (Incl Donated Assets) | 0.4 | 0.7 | 0.3 | | 1.0 | 2.3 | 0.3 | | 1.7 | 1.7 | 0.0 | |

**Summary Current Month:**

- The Trust was on plan generating a breakeven position.

- Income under performed by £0.9m in August. The main underperformance relates to a risk assessment for ERF (£3.2m). The risk assessment of takes into account the system performance where some providers have not achieved the threshold to trigger ERF payment. Discussions are ongoing with Kent and Medway CCG about the final payment to be made. This underperformance is partly offset by £1m top up adjustment (to bring the Trust to a breakeven position), £1m year to date drugs overperformance adjustment associated with specialist commissioning and £0.2m increase to block funding to offset North Kent Ophthalmology service change.

- Expenditure budgets underspent by £1.1m which is within non pay budgets. The use of the independent sector was £2.3m less than planned. This underspend is partly offset by £0.5m of costs incurred relating to the Kent Medical school and £0.4m overspend within drugs.

- In line with NHSE/I guidance additional income (£0.6m) has been included in the month 5 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

**Year to date overview:**

- The Trust is on plan generating a breakeven position.
- The Trusts key variances to the plan are:

**Favourable Variances:**

- Pay underspends (£2.6m), underspends within clinical supplies and drugs (£1.8m) due to lower activity than funded levels, additional north Kent ophthalmology income to match expenditure plan (£0.3m), Bowel screening income overperformance (£0.5m), non recurrent income benefit (£0.7m) and ERF overperformance (£0.3m).

**Adverse Variances:**

- Rephasing of top up and non recurrent income support (£5.5m) and CIP slippage to stretch target (£1m).

- In line with NHSE/I guidance additional income (£2.7m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £1.6m in August to cover the full costs incurred in quarter one.

**CIP (Savings)**

- The Trust has a external CIP target of £0.8m (between April and September (H1)) and a stretch CIP target of £2.6m. To date the Trust has identified savings of £1.2m which is £0.4m more than the external target but £1m below the stretch savings target.

**Risks within reported financial position:**

- The Trust has the following key income assumptions included within the position which are pending confirmation from Kent and Medway CCG
    - Prime Provider (Patient Choice activity) income of £2.7m has been incorporated to offset the costs reported in the month.

## 2. COVID 19 Expenditure and Income Impact

### 2020/21 Summary of Cost Reimbursement

**Expenditure**

| Breakdown by Allowable Cost Type | £000s |
|---|---|
| Segregation of patient pathways | 2,896 |
| Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other | 282 |
| Backfill for higher sickness absence | 1 |
| Remote working for non-patient activities | 18 |
| Existing workforce additional shifts to meet increased demand | 61 |
| PPE associated costs | 12 |
| Additional Sick pay at full pay for all staff policy - full pay for COVID-related | 16 |
| Other -Not detailed on NHSI return | 541 |
| Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation) | 1,002 |
| Long COVID | 328 |
| | |
| **Total 'In Envelope'** | **5,156** |
| | |
| COVID-19 virus testing- rt-PCR virus testing | 2,459 |
| COVID-19 - Vaccination Programme - Provider/ Hospital hubs | 4 |
| COVID-19 virus testing - Rapid / point of care testing | 189 |
| COVID-19 virus testing (NHS laboratories) | 0 |
| NIHR SIREN testing - research staff costs | 7 |
| NIHR SIREN testing - antibody testing only | 3 |
| | |
| **Total 'Out of Enevelope'** | **2,663** |
| | |
| **Total Expenditure (£000s):** | **7,820** |

**Income**

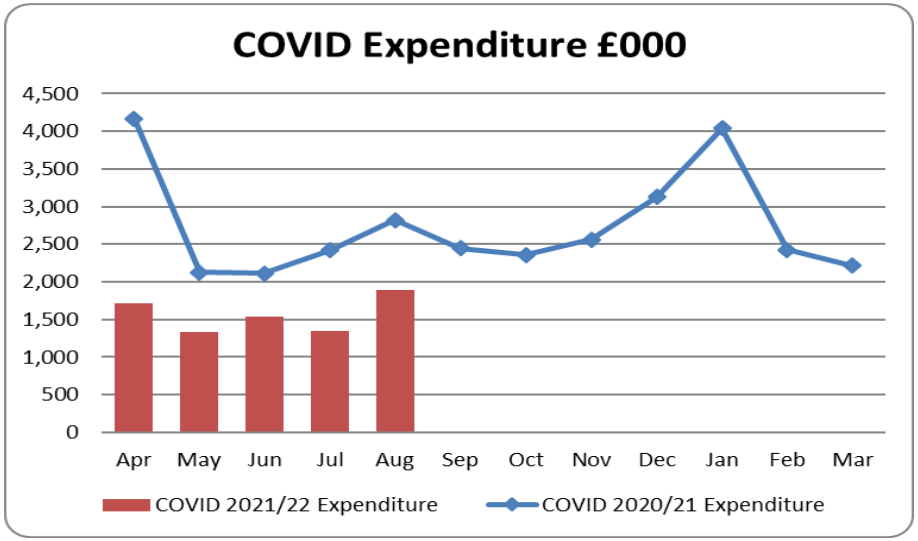
| | |
|---|---|
| Free staff car parking | 237 |
| Catering - Income loss | 23 |
| **Total Income** | **260** |
| | |
| **Grand Total (£000s):** | **8,079** |

**Commentary:**
The Trust has identified the year to date financial impact relating to COVID to be £8.1m.

The main cost includes costs associated with virus testing , staff welfare such as providing meals, additional shifts required in ED to support patient flow and escalation of Edith Cavell and Peale Wards and the expansion of ITU.

Costs deemed to be 'within envelope' are £4.2m less than the baseline funding included within the block payment from Kent and Medway CCG.

The Trust has included £2.7m income in the position to offset the costs for 'Out of envelope' which include COVID swabbing , rapid testing and vaccination programme. NHSE/I has paid in full the costs identified relating to April to June, the remainder is expected to be confirmed over the next few months.



NHS Maidstone and Tunbridge Wells NHS Trust

**To approve the Trust's Estates Strategy** **Director of Estates and Facilities**

Please find enclosed the Trust's Estates Strategy for 2021/22 to 2030/31, for review, and approval.

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

**Reason for submission to the Board (decision, discussion, information, assurance etc.)** [1]
To approve the Trust's Estates Strategy for 2021/22 to 2030/31

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

Maidstone and Tunbridge Wells NHS Trust

# MTW Estates Strategy

*2021/22 - 2030/31*

July 2021

MTW exceptional people, outstanding care

## Version control

| Version | Date | Key changes made | Author |
|---|---|---|---|
| 0.1 | 10/01/21 | Initial document structure | ACW |
| 0.2 | 11/01/21 | Additional text following kick-off call | ACW |
| 0.3 | 13/01/21 | Added strategy section and enablers | ACW |
| 0.4 | 14/01/21 | Section 4 and investment details added | ACW/ GB |
| 1.0 | 14/01/21 | Draft issued for Executive Team | ACW/GB |
| 2.0 | 08/06/21 | Updates in line with clinical strategy, capital plan and post covid recovery | DW/BC/NB |
| 2.1 | 09/06/21 | Updated to reflect current ICS position, Cardiology and CDH schemes | BC |
| 2.2-2.4 | Jun 21 | Additional text and formatting | various |
| 2.4 | 29/06/21 | Updates for Oncology Centre | NB |
| 2.5 | 15/07/21 | Update to reflect Trust Board comments | BC |

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# 1 Executive summary

## 1.1 Introduction to the estate strategy

A clear and concise estates strategy is required which:

- Is consistent with and flows from the Trust and STP's clinical strategy.
- Reflects emerging lessons from the Covid pandemic.
- Enables MTW to maximise the utilisation of estate assets.
- Supports any future change in the range of services provided by the organisation.

This **ten-year strategy** meets these criteria. By taking a longer than normal strategic view, the Trust is given time to address immediate concerns and to lay the foundations for longer-term development. This strategy also presents the immediate issues so that the Trust and its partners are better able to understand and consider investment decisions. By doing so, the estates strategy supports the case for future investment and supports delivery of the system's long-term plan.

**The scope of our estate strategy is all buildings MTW owns or leases**, although inevitably the focus will be on the Trust's two main hospital sites.

The Trust Board of Directors is asked to support this estates strategy.

## 1.2 Vision and principles for the estate

MTW aims to operate from an estate which is fit for purpose and enables delivery of high quality, safe, sustainable and affordable clinical services to its patients. This means an estate which is in a good condition, is functionally suitable for the services being provided, provides a "healing environment", is environmentally sustainable, is accessible to local people, is affordable and is designed around changing service needs.

The Trust has developed the following key principles for how we will ensure our estate supports our service delivery:

- The estate will functionally suitable, comply with the law, and adhere to healthcare standards and codes of practice.
- The estate is an enabler, not a driver, of service delivery.
- The estate will be designed to improve patient experience.
- The Trust will ensure that services within our buildings are in the "right place".
- The Trust will maximise utilisation of its estate.
- The Trust will seek to design in flexibility from its estate through design for deconstruction and disassembly, and designing for reversibility.
- The estate will be environmentally sustainable.
- The Trust will maximise value for money and economic benefit to the taxpayer from the estate.
- The Trust will work with local partners to optimise the use of public-sector estate.

## 1.3 The estate context

On establishment the Trust inherited Maidstone, Kent and Sussex, and Pembury County hospitals. Pembury and, Kent and Sussex hospitals closed in 2011 with the opening of the

Trust's new PFI Hospital on the outskirts of Tunbridge Wells. Maidstone Hospital was opened in 1983 and has been extended several times since. The estate portfolio is shown in the table below.

**Table 1: Estate portfolio**

| Property | Tenure | Gross area $m^2$ |
|---|---|---|
| ***Clinical services*** | | |
| Pembury Hospital | PFI | 65,000 |
| Maidstone Hospital | Owned | 54,962 |
| Abbey Court Medical Centre: diabetes clinic | Leased | 800 |
| Crowborough Birthing Centre | Leased (NHS PS) | 378 |
| ***Non-clinical services*** | | |
| Heronden Road laundry | Leased (full repairing lease) | 2,369 |
| Eldon Way medical records | Leased (full repairing lease) | 1526 |
| Magnitude House MTW Informatics | Leased (full repairing lease) | 1,029 |
| *Staff Residences* | | |
| Birch House | Leased (full repairing lease) | 673 |
| Chestnut House | Leased (full repairing lease) | 673 |
| Hawthorne House | Leased (full repairing lease) | 673 |
| Rowan House | Leased (full repairing lease) | 762 |
| Magnolia House | Leased (full repairing lease) | 479 |
| 32 High Street, Pembury | Leased (full repairing lease) | 1,128 |
| Total PFI | | 65,000 |
| Total owned | | 54,962 |
| Total leased | (Excludes PFI) | 10,489 |
| TOTAL TRUST GIFA | | 130,451 |

Overall, the Trust operates from seven clinical and non-clinical facilities, with a further six properties used for staff residential purposes. The estate extends to 130,451$m^2$ gross internal floor area (GIFA). The age profile of buildings on the two main sites is summarised below.

**Table 2: Estate age profile**

| | **Maidstone** | **Tunbridge Wells** |
|---|---|---|
| Age profile - 2005 to 2014 | 19% | 100% |
| Age profile - 1995 to 2004 | 15% | |
| Age profile - 1985 to 1994 | 24% | |
| Age profile - 1975 to 1984 | 42% | |

The 'performance' of NHS properties is measured using facet surveys which examines the performance of each building against criteria or "facets" covering:

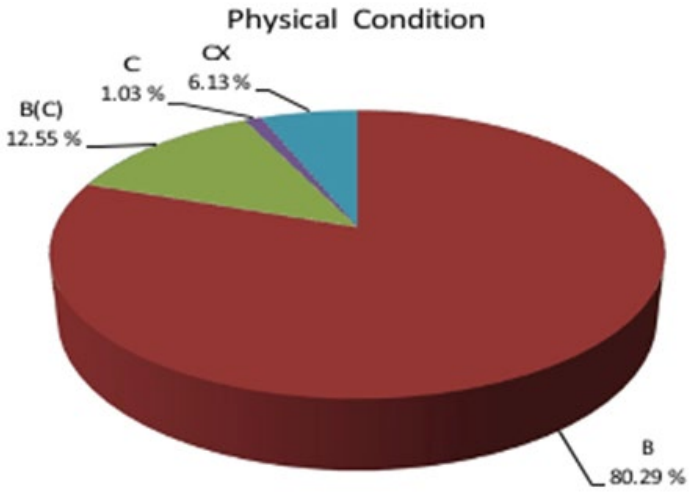
- Physical condition.
- Statutory standards (sub-divided into fire safety compliance and health and safety issues).
- Functional suitability.
- Quality.

- Environmental management.
- Space utilisation.

The Tunbridge Wells Hospital has not been subject to a condition survey but, due to its inherent age and proactive planned maintenance regime under the PFI contract the hospital, at worst it is expected to be in physical condition B, with significant parts being gauged as physical condition A. Given the hospital's age, space utilisation and functional suitability are also gauged as being satisfactory.

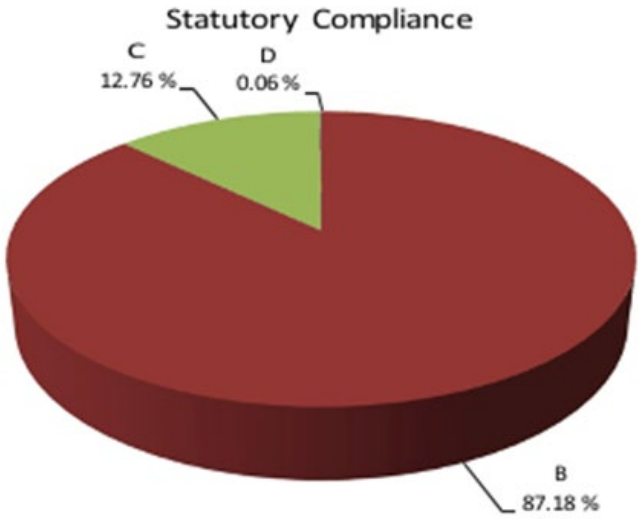
In 2015, the Trust commissioned a six-facet survey of the Maidstone Hospital and several leased properties. Overall the estate surveyed was in the following **physical condition**.

**Figure 1: Physical condition facet survey results (2015)**




The **statutory compliance** of the estate was as follows (also in 2015).

**Figure 2Statutory compliance facet survey results (2015)**




The survey indicated that the total project costs for rectifying physical condition and statutory compliance issues were, in 2015:

- Physical condition and backlog - £8,974k
- Statutory compliance - £437k.

**Functional suitability** was also assessed for the surveyed properties and the various buildings were judged to be in condition B or C. All properties were noted as 'fully occupied' in the **utilisation facet** element of the survey. The division of the sites between clinical and non-clinical use is as follows.

**Table 3: Estate split clincial versus non-clincial space**

| | Maidstone | Tunbridge Wells |
|---|---|---|
| Clinical | 76% | 79% |
| Non-clinical | 24% | 21% |

Both sites are considerably below the Carter target of having less than 35% non-clinical space.

The **quality facet** considers design, amenity, comfort engineering. Most surveyed areas were also rated as a 'B'.

The **environmental management facet** assesses energy, water consumption, waste and transport management, and procurement. The 2015 survey data did not record a category rating for the surveyed properties, reporting only on the costs associated with initiatives to improve environmental management.

Several estate-related risks are noted in the Trust's risk register.

The estate-related costs of the two main sites are shown below.

**Table 4: Estate costs (£000s)**

| £000s | Maidstone | Tunbridge Wells |
|---|---|---|
| Rates | £1,341 | £3,639 |
| Estates & property maintenance | £2,404 | £5,199 |
| Other hard FM | £1,318 | £1,189 |
| Soft FM | £2,306 | £2,306 |
| Estates management | £624 | £620 |
| **Sub-total hard and soft FM costs** | **£7,994** | **£12,952** |
| Interest & depreciation/ unitary charge | £6,523 | £17,459 |
| **Total estate costs** | **£14,517** | **£30,411** |

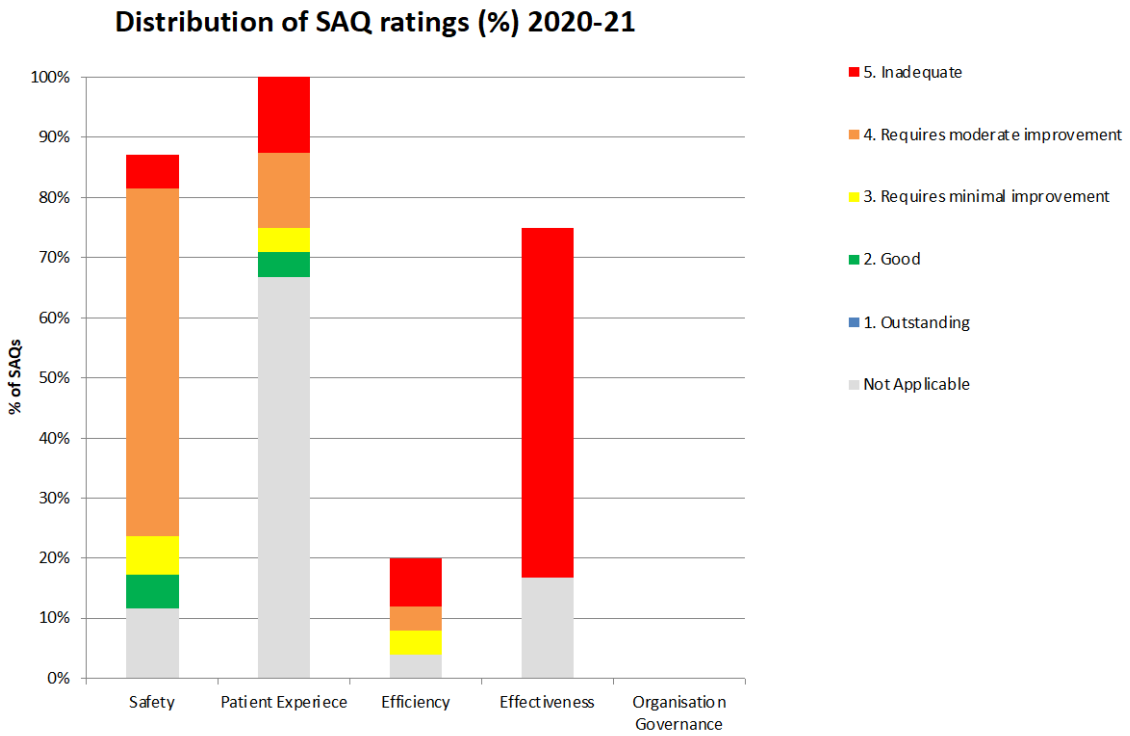
he Premises Assurance Model was last updated in 2020 and looks at the following domains:

- Efficiency
- Safety
- Effectiveness
- Patient experience

- Organisational governance.

The most recent scores are shown below.

**Figure 3 PAM scores**




The sustainability vision of the Trust is, ***"the provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust".***

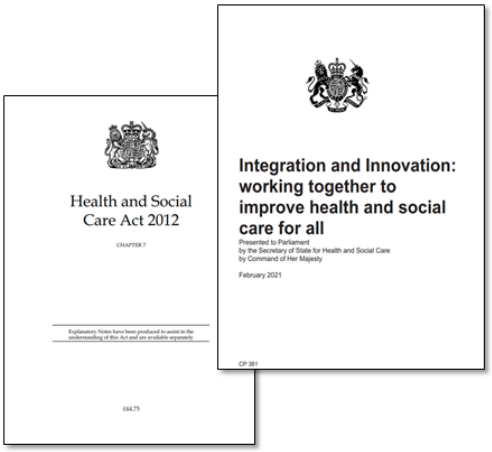
The Trust is committed to providing healthcare and services to the populations of today without compromising the opportunities of the populations of tomorrow. The Trust also recognises that in delivering healthcare services its sites and operations may have adverse impacts on the environment and it is essential that these are minimised through continuous monitoring, mediation and changing culture around the environment and sustainability. The Trust has developed a sustainability strategy that will be implemented through its Sustainable Development Management Plan. The Trust has already made significant investment in low energy technology and continues to make good progress towards achieving both its specific carbon targets and its wider sustainability objectives.

## 1.4 Strategic context

The NHS Long Term Plan (LTP) set out the priorities for healthcare over ten years and the Kent and Medway STP, now to be ICS leads the local response through several workstreams including estates. The estates workstream responds to the needs of the clinical workstreams and is a key enabler. It focuses on supporting care and system transformation across the STP and setting out the plan to meet targets set centrally by NHSEI. The STP estates strategy was originally submitted in 2018 and was rated as 'improving'. Subsequently feedback on the submission has informed ongoing refinement of STP estates plans.

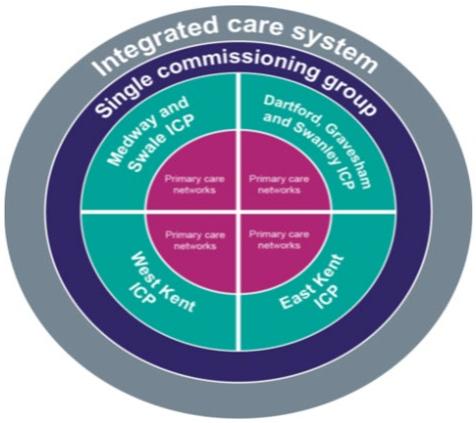
Since 2017/18 the K&M STP has been awarded £26m in STP Capital and £16m for ETTF projects all of which contribute towards achieving system goals, although none of these projects are specifically for MTW to deliver.

In February 2021, building on the NHS Long Term Plan and the national Covid -19 response the DHSC has published proposals for a new Health and Care Bill that aims to:




- Remove barriers to health and care system integration
- Reduce bureaucracy
- Improve accountability and responsiveness

By April 2022, the Kent and Medway Integrated Care System (ICS) will become a statutory body. K&M ICS will be responsible for strategic commissioning to take forward the '**Triple Aim'** of:

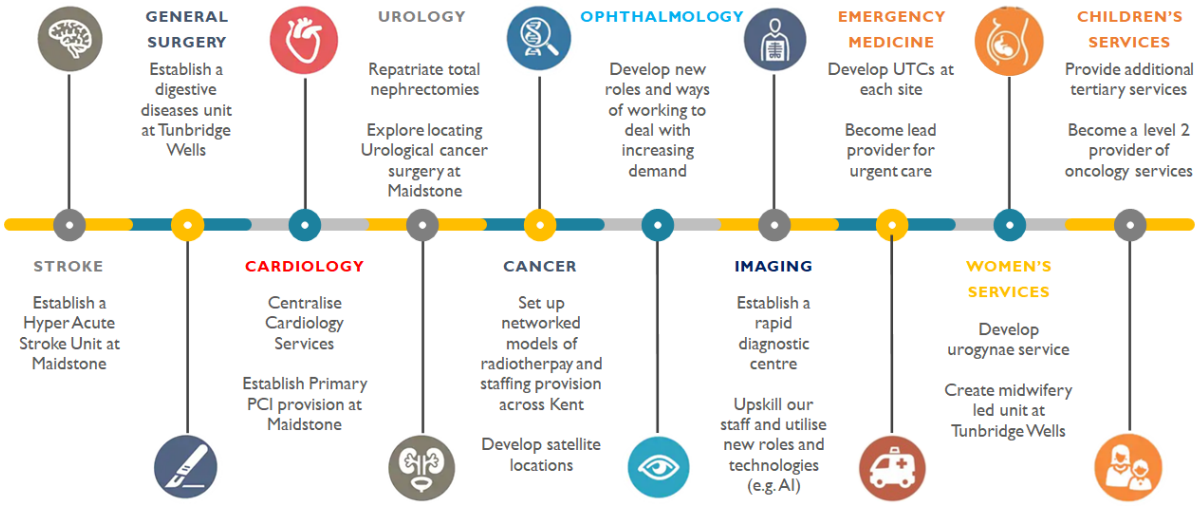



**The Triple Aim**

1. Better health and wellbeing for everyone
2. Better quality of health services
3. Sustainable use of NHS resources.

The Trust's mission and vision will be delivered through a strategic framework consisting seven detailed strategies, which include this estate strategy. Each strategy will also link to the PRIDE values which are at the heart of everything the Trust does, and which help translate the Trust mission and vision into meaningful change. The initial five-year clinical strategy runs from 2019/20 to 2023/24 and covers several the organisation's clinical specialties. It is summarised in the illustration below which shows the key changes each speciality aim to make over the period covered by the strategy.

**Figure 4: Summary of clinical strategy 2019/20 to 2023/24**




Further work is ongoing with the specialties to build upon the strategy illustrated above. The proposals with most relevance to the estate are:

- **Emergency medicine** – following successful implementation of UTC at each site ongoing projects to better manage the growth in emergency attendances and admissions to promote the "Right care, right time, right place", supporting the Trust's development of specialist centres at each hospital site and developing the range of services to assist with streaming our patients from our urgent and emergency front doors. Emergency medicine will develop as a 'Collaborative Lead Provider' for integrated urgent care arrangements in our locality.

- **Stroke** – the STP programme related development of a hyper acute stroke unit and acute stroke unit from the existing acute assessment unit (AAU) and Chaucer Ward at Maidstone Hospital. The decision making for this proposal has been subject to some delay due to a judicial review of the K&M stroke reconfiguration decision making process.
- **Cardiology** – projects to build a new cardiac catheter laboratory and expanded the coronary care unit to centralise complex cardiac work at Maidstone. Looking ahead longer-term these developments have the potential to position MTW to become the second Primary Percutaneous Coronary Intervention (PPCI) centre for the K&M area.
- **General surgery** – Following the successful move of complex inpatient elective surgery to TWH a next step will be to establish a Digestive Diseases Unit and the subsequent co-location of lower gastrointestinal surgery with medical gastroenterology at TWH.
- **Ophthalmology** – projects to manage demand including a shift to more virtual clinics and one-stop clinics and to manage increased demand from around Kent and Medway as MTW takes over elements of ophthalmology previously provided by Moorfields Hospital in the region.
- **Urology** – exploring the potential for the Maidstone site to become the specialist urological cancer centre for West Kent co-locating the urology cancer surgery with the Cancer Centre.

- **Women's services** – the creation of a midwifery-led unit at TWH.
- **Children's services** – plans to improve paediatric emergency facilities, plans to repatriate work from London children's hospitals including specialist orthopaedic and level 2 cancer activity.
- **Cancer** – establishing rapid diagnostic centre pathways through support of and working within a community diagnostic hub model and setting up cancer satellite centres. Improving oncology estates capacity.
- **Imaging** – expanding MRI provision and setting-up an elective diagnostic centre to support cancer and elective care pathway developments following the Richard's Review[1].

The Trust will be a key provider in the region for the clinical training of medical students from the Kent and Medway Medical School (KMMS). KMMS is a new medical school opened in 2020 as part of a government initiative to increase the number of medical students in the UK. Medical students are placed in primary, secondary and community care settings across K&M and require student accommodation and the development of further academic facilities for their five-year undergraduate course. The Trust has successfully worked with partners to achieve local authority planning permission for a new building, for student accommodation and academic facilities on the Tunbridge Wells Hospital site.

**Covid 19 recovery and reset**

The Trust continues to recover and reset from the global pandemic.

The East of England Clinical Senate has published a helpful report about lessons learned from Covid[2]. The report makes several recommendations divided between changes arising from the Covid experience that should be 'adopted' permanently, 'adapted' or 'abandoned'. The recommendations of most relevance to the estate are set out below:

- Adopt: retain and adopt this practice:
  - Increased focus on infection prevention and control across primary and secondary care, social and community care settings.
  - Continue with the protected or 'Green' (non-COVID-19) elective facilities within sites, providing protected elective facilities and pathways.
  - Remote tele-consultation. Tele-consultations should be encouraged, supported by improved patient record sharing, multi-agency and inter-agency working.
- Adapt: practice should be retained subject to some further development or refinement:
  - Empowering health and care professionals to reduce the 'over medicalisation' of care, particularly for the frail elderly, and to understand what the ideal level of care is for the individual.
  - The use of sophisticated methods for prioritisation of care, enabling treatment to be delivered on a priority of need basis rather than a time on a waiting list basis. We need to reconsider the effectiveness of current referral pathways

[1] Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England, December 2020.

[2] The Regional COVID-19 pandemic response and system learning. What have we learned about how health care can be delivered during the last twelve weeks? The East of England Clinical Senate.

and refine them where necessary to deliver the best outcomes to support the management of early-stage diagnosis in cancer.
    - Continue the use of tele-conferencing for team meetings, training etc.
- Abandon:
    - Public fear that attending any healthcare facility had a high risk of resulting in infection. We must ensure that a strong message regarding the safety of protected diagnostic and elective pathways is communicated to the public.
    - Complete separation of frail elderly and other shielded groups from other patient groups.

Building related themes that are emerging which have a direct impact upon the estate of the future are:

- Anticipate fewer face-to-face consultations - 40% non-face-to-face, should be the lower end, with 60% being attainable.
- An increased proportion of activity, particularly at outpatient level, should be conducted in primary care and community care settings.
- Increasing the area allowed for corridors, lifts and stairwells.
- Single directional corridors supporting in- and-out flows.
- Possibly a re-evaluation of outpatient design with patients entering from one side and clinical teams the other.

The pandemic has led to a step change in the number of people, particularly staff in administrative roles, working from home. Nationally surveys report that most staff would welcome the flexibility afforded from being able to work from home for a few days a week and that most employers are willing to make this change. Evidence from other Trusts suggests that some have already reconfigured corporate areas to substantially reduce the space required for corporate functions.

## 1.5 Investment plans

The case for change set out in the estate and wider strategic sections above give rise to a number of proposed estate-related investments. The recommended projects are:

- KMMS Medical School accommodation.
- Stoke – new hyper-acute stroke unit and changes to the acute stroke service.
- Cardiology centralisation at Maidstone.
- The East Kent Oncology Centre.
- Expansion of diagnostics.
- Office and clinical team accommodation.
- Ongoing risk, compliance and backlog work.

## 1.6 Enablers

The estate strategy is an enabler of the MTW clinical and other strategies. At the same time there are dependencies with other strategies and plans principle the digital strategy. The Trust will also continue to work with partners to make the best use of the public-sector estate, looking for opportunities for rationalisation and improvement that benefit the entire public sector and not just the trust.

Finally, this strategy will only work if the trust can change the way it works and the culture across the organisation. Simply investing in new and improved buildings is not enough; the culture of the organisation must change to promote the concept of 'shared space'. For example, eliminating the view that a particular area of a building belongs to one service or another and replacing it with the appreciation that all buildings will need to be accessible to all services. This concept will need to extend to clinic rooms, meeting rooms, individual offices and desks.

## 1.7 Conclusion

The Trust inherited an estate in varying condition much of which was not fit for purpose. The commissioning of the Tunbridge Wells Hospital represented a step change in the quality and functional suitability of the estate when it was opened. This key site remains in a good condition, however, the many elements of the Trust's larger hospital in Maidstone is ageing and has reached the point where it needs significant refurbishment. The challenge of doing so whilst running a fully operational site cannot be under-estimated. Maidstone is also the planned location for some important developments such as the HASU and cardiology expansion making it the likely focus of investment for the next five to ten years. This estate strategy represents the Trust's initial response to the clinical strategy and will need to be refreshed as plans become clearer particularly in light of emerging estate-related lessons from Covid.

# 2 Introduction

## 2.1 Purpose of the estate strategy

A clear and concise estates strategy is essential for Maidstone and Tunbridge Wells NHS Foundation Trust (MTW) to ensure that we have high quality, fit-for-purpose buildings to enable the delivery of safe, efficient and effective healthcare services. We need an estate strategy which:

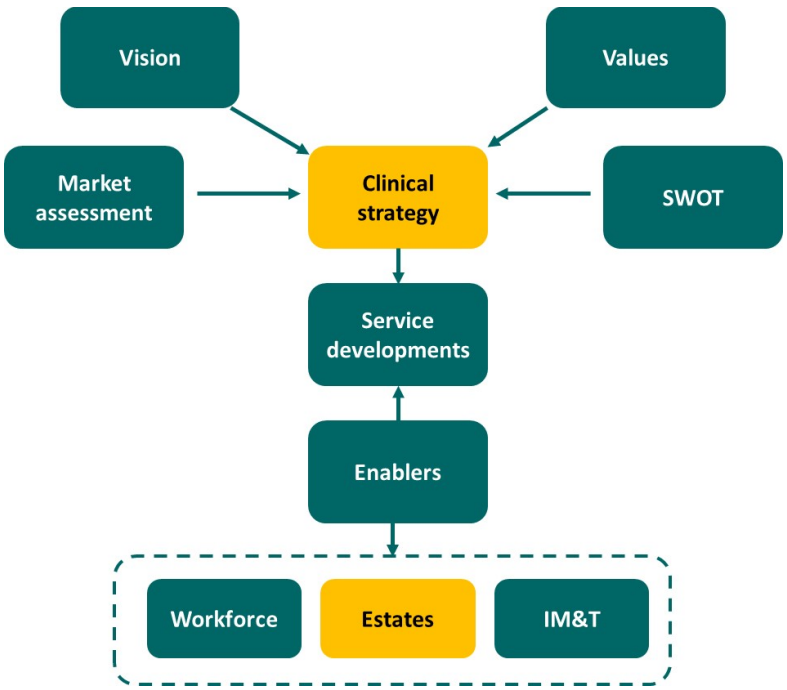
- Is consistent with and flows from the Trust and STP's clinical strategy.
- Reflects emerging lessons from the Covid pandemic.
- Enables MTW to maximise the utilisation of estate assets.
- Supports any future change in the range of services provided by the organisation.

This **ten-year strategy** meets these criteria. No estates strategy can be fixed. As service models develop and patient needs change, so the supporting estates infrastructure will also need to change. This strategy sets out a way forward, where service strategies are clear, and makes recommendations where further work is required.

Our strategy covers the medium to long-term, taken to mean the next five to ten years, allowing us time to address immediate concerns and to lay the foundations for longer-term development. This strategy presents the immediate issues so that the Trust and, our partners and commissioners across the sustainability and transformation partnership (STP) are better able to understand and consider investment decisions. By doing so, the estates strategy supports the case for future investment and supports delivery of the Long-Term Plan (LTP).

The diagram below sets out the link between enablers, including the estate strategy and the clinical strategy which in turn reflects the Trust's vision, values, external and internal influences.

**Figure 5: The estate strategy and the Trust's other strategies**



**The scope of our estate strategy is all buildings MTW owns or leases**, although inevitably the focus will be on the Trust's two main hospital sites.

## 2.2 Introduction to the Trust

MTW is a large acute hospital Trust in the south east of England which provides a full range of general hospital services and specialist complex care to around 590,000 people living in the south of West Kent and the north of East Sussex. The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding areas. The Trust operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury (a Private Finance Initiative (PFI) hospital providing mainly single bedded en-suite accommodation for inpatients). The Trust employs a team of over 5,000. MTW also provides specialist cancer services to around 1.8 million people across Kent and East Sussex via the Kent Oncology Centre, which is sited at Maidstone Hospital, and at Kent and Canterbury Hospital in Canterbury. The Trust also offers services at Sevenoaks, Tonbridge, Crowborough, Uckfield and Hawkhurst community hospitals, and Abbey Court.

The Trust's mission is ***to be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community***. The vision is ***outstanding hospital services delivered by exceptional people***. Both guide this estates strategy.

## 2.3 Structure of the document

The Trust's vision for the estate is set out in Section 3. Section 4 describes estate rationale for change and Section 5 sets out the strategic context the Trust must respond to.

In Section 6 we set out a series of proposed investments before turning to the enablers that support the implementation of the estate strategy in Section 7.

These sections map back to the "traditional" three strategy questions as follows:

- 'Where are we now' is considered in section 4;
- 'Where do we want to be?' is covered in sections 3, 4 and 5;
- 'How do we get there?' is described in sections 6 and 7.

## 2.4 Approvals

The Trust Board of Directors is asked to support this estates strategy.

# 3 Vision and principles

## 3.1 Introduction

This section sets out the vision for the Trust's estate and the underlying principles guiding the development of plans for the estate.

## 3.2 Vision for our estate

MTW aims to operate from an estate which is fit for purpose and enables delivery of high quality, safe, sustainable and affordable clinical services to its patients. This means an estate which is in a good condition, is functionally suitable for the services being provided, provides a "healing environment", is environmentally sustainable, is accessible to local people, is affordable and is designed around changing service needs.

## 3.3 Principles

The Trust has developed the following key principles for how we will ensure our estate supports our service delivery over the next five to ten years. Much of course will be dependent upon availability of financial resources, but overall the intention is to apply each of the following principles:

- The estate will functionally suitable, comply with the law, and adhere to healthcare standards and codes of practice.
- The estate is an enabler, not a driver, of service delivery.
- The estate will be designed to improve patient experience.
- The Trust will ensure that services within our buildings are in the "right place".
- The Trust will maximise utilisation of its estate.
- The Trust will seek to design in flexibility from its estate through design for deconstruction and disassembly, and designing for reversibility.
- The estate will be environmentally sustainable.
- The Trust will maximise value for money and economic benefit to the taxpayer from the estate.
- The Trust will work with local partners to optimise the use of public-sector estate.

Ensuring the estate is **functionally suitable** means making sure building design (at individual room and department level) reflects intended use. The Trust's buildings will meet all legal requirements, for example in relation to fire safety and Equalities Act legislation. Buildings will be safe for patients and staff and will provide accommodation that supports privacy and dignity of individuals. The Trust will also comply with healthcare standards, such as those relating to mixed sex accommodation and The Hygiene Code. The Trust will be cognisant of health building notices (HBNs) when making changes to buildings, recognising that HBNs are guidance only. Similarly, the Trust will aim to comply with guidance produced by the various royal colleges relating to the physical environment. The Trust will also create an environment which is conducive to patient healing and the needs of an increasingly older patient group. Finally the lessons of the Covid pandemic will be learned and the estate will reflect the need separate different patient cohorts, particularly elective and emergency patient flows, as far is possible.

The estate should **enable the delivery of high-quality clinical services**. This means that the estate strategy will respond to the needs of the clinical and other strategies and not vice versa. The estate will need to change to reflect changes in clinical pathways and the introduction of innovations such as agile working and digital outpatient consultation delivery as they occur and to meet changes in the level of demand for Trust services. The estate strategy must also respond to commissioner and partner plans as set out in the Sustainability and Transformation Partnership (STP) as well as the Trust's own clinical strategy.

The Trust will ensure the **estate contributes to improving patient experience** by investing to improve the physical condition of buildings not meeting target condition B, by placing an emphasis on a 'healing environment' (see Section 3.5) as well as ensuring standards relating to the basics such as safety, privacy and dignity are all met.

Ensuring that services within Trust buildings are **in the right place** means making sure, so far is possible, that services are located appropriately to meet patient and service needs. For example, where beneficial, services will be co-located with related Trust services (and related services from other organisations) i.e. beneficial clinical adjacencies will be prioritised through a concept of "zoning" areas within the main hospital. In doing so the Trust will seek to minimise the distances patients have to walk within the hospital to attend different services. Where economically viable to do so services will be provided off site closer to some of the communities served.

**Maximising estate utilisation** will be encouraged by measuring utilisation over 24/7 not 9-5. A culture which views buildings as being a "health community resource" supporting a range of different functions at different times rather than a service "X" facility will be engendered. The need for estate will be minimised wherever possible by adopting agile and mobile working practices, and minimising fixed desk spaces.

Obtaining **maximum flexibility** means an estate that can be altered with the minimum of disruption to accommodate new models of care and collaborative working, as service need, population demand and commissioner service strategy changes. This involves adaptable design philosophies such as designing for reversibility.

Operating an **environmentally sustainable estate** means that the Trust will use the estate to minimise the environmental impact of service delivery. This includes ensuring that building refurbishments include investment in efficient heating, cooling and lighting systems and new builds are designed to minimise their impact on the environment, minimise waste and reduce energy use. Building projects will consider using circular economy principles, the use of modern methods of construction and designing for deconstruction with potential for reuse or recycling of elements on and off site. The Trust will also continue to seek opportunities to develop its own renewable energy supplies and will ensure it contributes towards Net Zero.

**Maximising value for money** and economic benefit to the taxpayer means we will adhere to the principles and objectives set out in the Naylor and Carter reports. Trust buildings will be maintained on a regular basis to avoid higher long-term maintenance costs. Utilisation of the estate will be maximised and any surplus assets will be made available for sale or re-use.

We will **work with partners** to contribute to making sure that the estate across West Kent meets the principles described above particularly to facilitate the partnership working that is fundamental to the success of the STP's clinical services strategy. Where MTW is the

landlord, we will act in a way to assist them in delivering safe, good quality, efficient services from our buildings. We will ensure that all third-party occupancies are recorded and are supported by legally binding contracts making clear the responsibility of the Trust and each tenant.

## 3.4 Zoning / layering the estate

Many healthcare buildings are over-specified, expensive to operate and quickly become not fit for purpose. Hospital design needs to recognise the need to frequently change and adapt buildings, and recognise that different functions require different types of space. One approach is the provision of a base building that comprises principal circulation paths, a fixed main structure and primary mechanical, electrical and engineering services and which can accommodate a variety of functions. Additional buildings can then be attached and constructed in phases at a cost appropriate to their function. The Netherlands Board for Health Care Institutions propose a "layered Hospital". Their concept suggests that a smaller proportion of a hospital needs to be clinically specialised than generally thought and that the design of hospital infrastructure should be according to its function. The main segments of the layered hospital include:

- A 'hot floor' with all the capital-intensive functions unique to the hospital, including operating rooms, diagnostic imaging and intensive care facilities.
- Low care nursing departments where, in addition to care, the residential function plays a primary role. This asset is like a hotel.
- All office facilities, administration, staff departments and outpatient units.
- 'Factory facilities' – this is concerned with production line functions not part of the primary process, such as laboratories and kitchens.

The principles set out in this layered approach would be easy to adopt for a new build, but the Trust obviously needs to live with the buildings it already has. However, the layered approach does support an argument for using zones across the main building and wider site. Zoning could bring the benefits set out above and help patients and staff more easily find their way around the hospital.

## 3.5 A healing environment

The Trust's plans for an estate that provides good quality environment are informed by how the design of physical environments can impact upon healing (as well as efficiency).

Research has identified a range of positive outcomes including reductions in falls, medical errors, pain, patient stress, patient depression and length of patient stay, as well as improvements in staff "outcomes" arising from better physical environments. For example:

- Reducing pain, stress and depression through exposure to views of nature, to higher levels of daylight, displaying visual art and reducing environmental stressors such as noise.
- Reducing falls through design of floors, doorways, handrails and toilets, and decentralised nurse stations.

There is evidence that art, design and environmental enhancements can have a positive impact on health and well-being of patients (and staff) thus speeding the recovery process. For example:

- Architectural design, internally and externally, can be especially important for patients with dementia, helping to simplify wayfinding, reduce anxiety and control 'wandering'.
- Exposure to art in healthcare environments has been found to reduce anxiety and depression.
- Patients suffering from severe depression have been shown to have shorter stays if they had sunny rooms rather than rooms that were always in shade.
- Designing for neurodiversity and inclusivity for both patients and staff can provide a positive increase in overall wellbeing.

With an ageing local population, it is inevitable that the proportion of patients who have dementia will increase – the Kings Fund estimate that 25% of people accessing acute hospital services have dementia and the number of people with dementia is expected to double during the next 30 years. Research into how health facilities need to be redesigned to make them "dementia friendly" has demonstrated that relatively inexpensive interventions, such as changes to lighting, floor coverings and improved wayfinding, can have a significant impact. Evaluation has shown that environmental improvements can have a positive effect on reduction in falls, violent and aggressive behaviours, and staff recruitment and retention. Wherever possible the features discussed above will be designed into buildings as part of the implementation of this estate strategy.

## 3.6 Working with partners to support a place-based system of health and care

The implication of greater collaboration across public sector organisations is that resources and risk are pooled. In estates terms, this may mean, for example:

- Shared use of assets.
- Joint processes for prioritising estates investment, which address system needs as a whole, rather than those of one organisation.
- Capacity planning across more than one provider, to cope more effectively with rising or fluctuating demand, or to overcome operational problems in part of the system.

Local plans to drive forward closer collaboration are set out in STP strategies and plans including those linked to the STP estates workstream – see Section 5.3.

## 3.7 Summary implications for the strategy

This section described the Trust's ambition of having an estate that is in a good condition, is functionally suitable for the services being provided, provides a "healing environment", is environmentally sustainable, is accessible to local people, is affordable and which is designed around changing service needs. In achieving this ambition, the Trust must also adhere to the principles listed.

# 4 Where are we now? *Our current estate context*

## 4.1 Introduction

This section of the estate strategy describes the **"where are we now"** element of the strategy. It starts by providing a brief history of the Trust's estate, then describes the main existing sites before setting out "current estate performance" with reference to the six-facet survey and other estate performance measures.

## 4.2 History of the estate

The Trust was legally established on 14 February 2000 following the merger of the Mid-Kent Healthcare NHS Trust and the Kent and Sussex Weald NHS Trust. At the time it inherited Maidstone, Kent and Sussex, and Pembury County hospitals. Pembury was originally a workhouse designed to accommodate 400 people and opened in 1836. Pembury and, Kent and Sussex hospitals closed in 2011 with the opening of the Trust's new PFI Hospital on the outskirts of Tunbridge Wells. The Tunbridge Wells Hospital was the first in England to be 100% single bedrooms.

Maidstone Hospital was opened in 1983 and has been extended several times since. Additions include a self-contained orthopaedic unit and new ophthalmology and ENT unit in 2003, the Peggy Wood Breast Care Centre opened in 2004, an emergency care centre which opened in 2005 and the Kent Oncology Centre which opened in 2017.

## 4.3 The Trust's estate portfolio

### 4.3.1 Portfolio summary

The estate portfolio is shown in the table below.

**Table 5: Estate portfolio**

| Property | Tenure | Gross area $m^2$ |
|---|---|---|
| ***Clinical services*** | | |
| Pembury Hospital | PFI | 65,000 |
| Maidstone Hospital | Owned | 54,962 |
| Abbey Court Medical Centre: diabetes clinic | Leased | 800 |
| Crowborough Birthing Centre | Leased (NHS PS) | 378 |
| ***Non-clinical services*** | | |
| Heronden Road laundry | Leased (full repairing lease) | 2,369 |
| Eldon Way medical records | Leased (full repairing lease) | 1526 |
| Magnitude House MTW Informatics | Leased (full repairing lease) | 1,029 |
| *Staff Residences* | | |
| Birch House | Leased (full repairing lease) | 673 |

| Property | Tenure | Gross area $m^2$ |
|---|---|---|
| Chestnut House | Leased (full repairing lease) | 673 |
| Hawthorne House | Leased (full repairing lease) | 673 |
| Rowan House | Leased (full repairing lease) | 762 |
| Magnolia House | Leased (full repairing lease) | 479 |
| 32 High Street, Pembury | Leased (full repairing lease) | 1,128 |
| Total PFI | | 65,000 |
| Total owned | | 54,962 |
| Total leased | (Excludes PFI) | 10,489 |
| TOTAL TRUST GIFA | | 130,451 |

Excluded from the table above are Hawkshurst, Tonbridge and Sevenoaks hospitals from which MTW provides some services under informal arrangements.

Overall, the Trust operates from seven clinical and non-clinical facilities, with a further six properties used for staff residential purposes. The estate extends to 130,451$m^2$ gross internal floor area (GIFA). The age profile of buildings on the two main sites is summarised below.

**Table 6: Estate age profile**

| | Maidstone | Tunbridge Wells |
|---|---|---|
| Age profile - 2005 to 2014 | 19% | 100% |
| Age profile - 1995 to 2004 | 15% | |
| Age profile - 1985 to 1994 | 24% | |
| Age profile - 1975 to 1984 | 42% | |

Aerial photographs of the sites are available under separate cover as Appendix One.

### 4.3.2 Tunbridge Wells Hospital - PFI

The Trust's only PFI property is the Tunbridge Wells Hospital. The hospital has a gross internal floor area of 65,000$m^2$ and has 512 beds. The hospital was delivered in several phases: Phase 1a (Women and Children) was handed over in November 2010; Phase 1b (Wards, Accident and Emergency, and the remainder of the hospital) was handed over in May 2011 and the site became operational in September 2011.

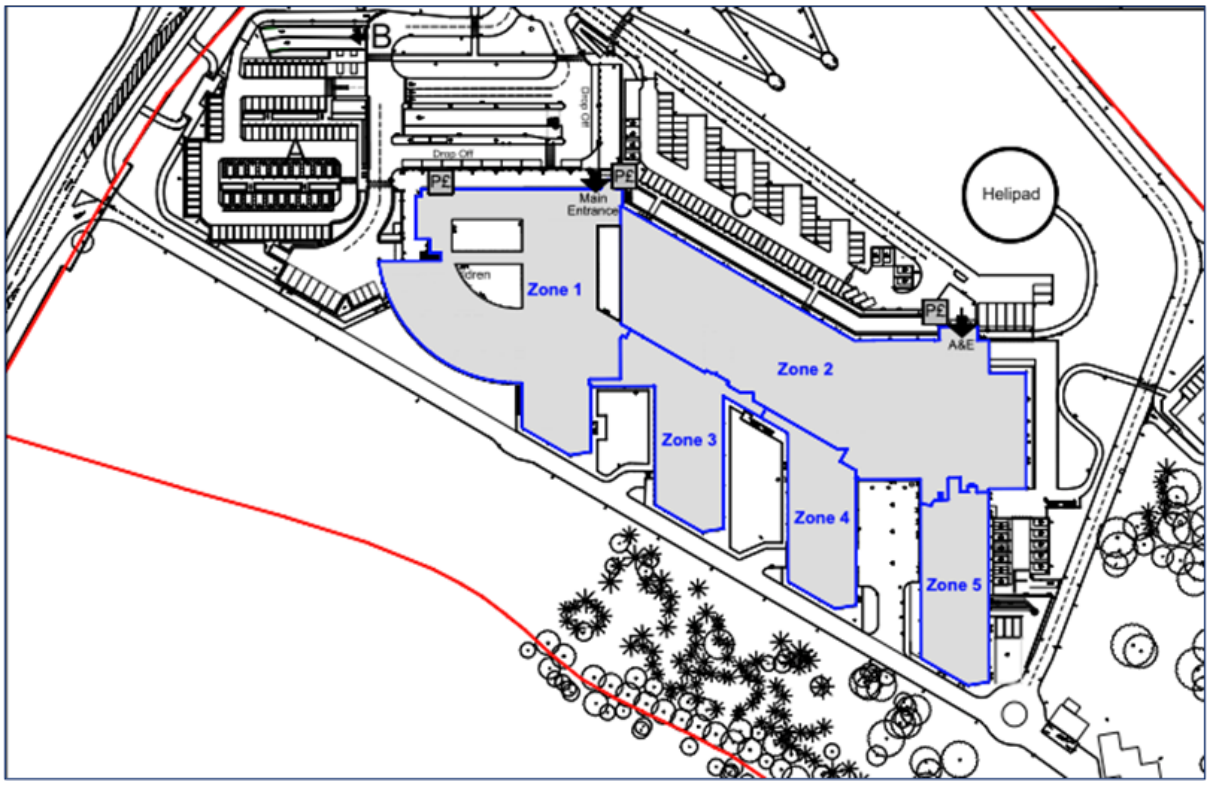
Phase 2 (the demolition of the old hospital and formation of roads and additional car parks and helipad) was completed in September 2012 at which time all services were transferred from the Kent and Sussex Hospital.

The investor consortium originally comprised of John Laing, Innisfree and Interserve. Laing O'Rourke was the contractor responsible for the design and build of the hospital. The project has been sold by John Laing to the John Laing Infrastructure Fund and is managed by John Laing Capital Management.

Interserve FM provide hard facilities management (FM) services throughout the concession, whilst the Trust has retained the provision of soft FM services in-house.

The hospital is organised into several zones with Zone 2 Level 0 housing emergency care and Zone 2 Level 1 housing theatres and intensive/high dependency units. Typically zones 3, 4 and 5 provide outpatient and inpatient services plus additional clinical and non-clinical facilities.

**Figure 6: The Tunbridge Wells Hospital site**

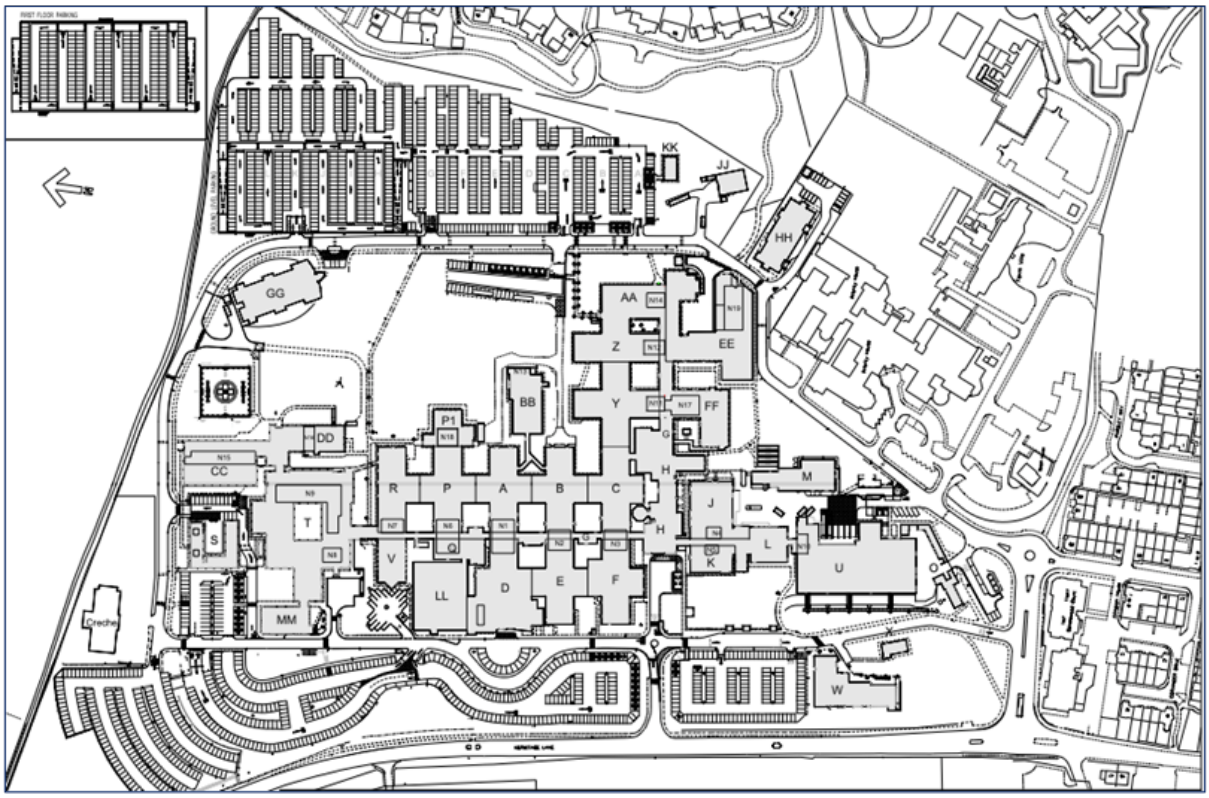



### 4.3.3 Maidstone Hospital

The construction of the Maidstone Hospital, which replaced the old West Kent Hospital, commenced in 1980 with completion in 1983. Planned life cycle refurbishment of some of the original hospital was completed in 2012. However, most of the hospital remains as designed and provides a range of 28-bed nucleus ward templates. The hospital provides 744 beds (March 2020).

The hospital is of a traditional nucleus hospital design, consisting of six full nucleus templates (56 beds/ two wards per template typically), four modified (hybrid) templates and a range of other building configurations. The 2012 refurbishment resulted in an increase in single rooms and a reduction of bays from six beds to four beds resulting in an overall net loss of 20 beds per template. This level of bed base loss was not considered sustainable and no further works of this nature have been undertaken. Consequently, as is typical of many nucleus hospitals of the same vintage, engineering infrastructure remedial works are now required, especially to the hospital's theatre base where not only are modern spatial standards not being met, but theatre plant is close to the end of its economic life.

**Figure 7: The Maidstone Hospital site**




### 4.3.4 Other clinical facilities

The Trust provides services from:

- Abbey Court Medical Centre, which is operated by the Kent Community Health NHS Foundation Trust and which hosts MTW's diabetes clinic.
- Crowborough Birthing Centre, which is at Crowborough War Memorial Hospital, a site operated by Sussex Community NHS FT.

### 4.3.5 Non-clinical facilities

The Trust also leases the following non-clinical facilities and staff accommodation:

- Heronden Road (laundry)
- Eldon Way (medical record storage)
- Magnitude House (informatics)
- Maidstone residences - Birch House, Chestnut House, Hawthorne House, Magnolia House and Rowan House (staff residences)
- 32 High Street, Pembury (junior doctors' accommodation).

The five staff residences properties form Maidstone Residences. The buildings were originally owned by the Trust before being sold in March 2019 on a sale and lease back basis. High Street Pembury was also MTW owned before also being sold and leased back under a separate deal.

### 4.3.6 Recent property disposals

Recent disposals were:

- The Spring
- North farm
- Almond House
- Willow House.

Almond and Willow house sites are being developed by a third-party developer to provide the Trust with an additional 140 units of staff accommodation. The development is scheduled to be completed in 2022. Consequently, when the current leases on Birch House, Chestnut House, Hawthorne House, Rowan House and Magnolia House expire in 2031, it is anticipated that the Trust may transfer tenants in occupation at the time, to the Almond/Willow property development.

## 4.4 Estate performance

### 4.4.1 Fire safety

The Trust is anticipating that there will be changes to fire safety legislation post-Grenfell and it will of course, respond as required.

### 4.4.2 Six-facet survey

The 'performance' of NHS properties is measured using facet surveys which examines the performance of each building against criteria or "facets" covering:

- Physical condition.
- Statutory standards (sub-divided into fire safety compliance and health and safety issues).
- Functional suitability.
- Quality.
- Environmental management.
- Space utilisation.

The following scores are applied to facets other than 'utilisation':

- Condition A - as new, very satisfactory, no change needed.
- Condition B - satisfactory, minor change needed.
- Condition C- not satisfactory, major change needed.
- Condition D - unacceptable in its present condition.
- X - a supplementary rating added to C or D to indicate that nothing except a total rebuild, or relocation will suffice i.e. improvements are either impractical or too expensive to be tenable.

A full set of six-facet definitions can be found in Appendix Two.

#### 4.4.2.1 The PFI estate

The Tunbridge Wells Hospital has not been subject to a condition survey but, due to its inherent age and proactive planned maintenance regime under the PFI contract the hospital, at worst it is expected to be in physical condition B, with significant parts being gauged as physical condition A.

Given the hospital's age, space utilisation and functional suitability are also gauged as being satisfactory.

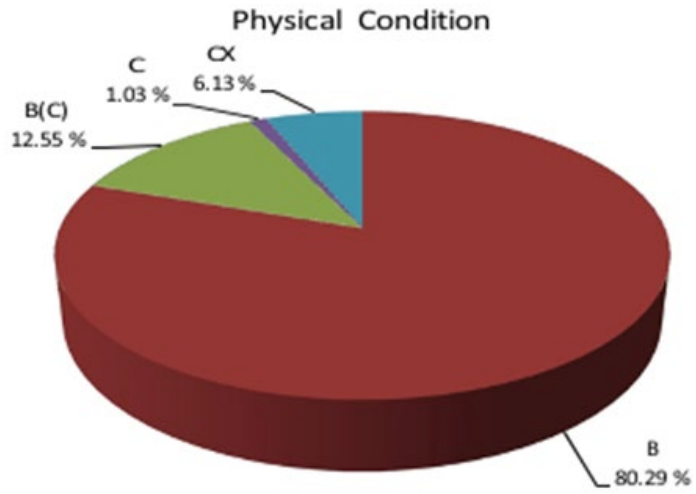
#### 4.4.2.2 The owned and leased estate

In 2015, the Trust commissioned a six-facet survey of the Maidstone Hospital and the following leased properties:

- Almond House (note: Currently under redevelopment)
- Birch House
- Chestnut House
- Hawthorne House
- Rowan House
- Willow House (note: currently under redevelopment)
- Heronden Road (Laundry Unit).

Overall the estate surveyed was in the following **physical condition**.

**Figure 8: Physical condition facet survey results (2015)**




The **statutory compliance** of the estate was as follows (also in 2015).

**Figure 9Statutory compliance facet survey results (2015)**


The survey indicated that the total project costs for rectifying physical condition and statutory compliance issues were, in 2015:

- Physical condition and backlog - £8,974k
- Statutory compliance - £437k.

The physical condition and statutory compliance elements of these forecasts can be divided between low, moderate, significant and high risk to derive a risk adjusted value, as per the table below.

**Table 7: Backlog forecast costs (excluding VAT, fees and contingency[3])**

| Physical Condition | Risk Totals (£) | Statutory Compliance | Risk Totals (£) |
|---|---|---|---|
| Low Risk | £280,160 | Low Risk | £16,000 |
| Moderate Risk | £1,956,793 | Moderate Risk | £234,853 |
| Significant Risk | £417,841 | Significant Risk | £36,407 |
| High Risk | £0 | High Risk | £150,000 |
| **Total Risk Adjusted Backlog Cost** | **£529,689** | **Total Risk Adjusted Backlog Cost** | **£198,950** |

The physical condition survey for Maidstone Hospital reported on a block-by-block basis, recording a wide range of issues requiring rectification, from the condition of window fenestration to non-compliance with statutory infrastructure provision. Typically, nucleus ward and associated facilities are nearing the end of their economic life regarding mechanical and electrical infrastructure, especially the main theatre ventilation plant.

[3] A multiplier of 1.67 should be applied to these figures to cover VAT, fees and contingency.

Similarly, the spatial standards adopted under the nucleus design era are now incompatible with modern health design standards, both from the perspective of single room provision and bedroom and other clinical functional sizes.

Further survey work is required to update the 2015 survey findings.

**Functional suitability** was also assessed for the surveyed properties. This is a subjective room by room process which has limitations. The functional suitability assessment process does not consider the incidence or frequency of room provision (utilisation), nor the location of the room relative to other functional facilities (optimal clinical adjacencies). Consequently, it is possible to score a satisfactory functional suitability rating even though the type of room provided, for example a dirty utility room, is located in an inappropriate position, i.e. too far away from clinical rooms.

In the 2015 survey the detailed assessment ranked all areas at category C (requiring major change), but the survey executive summary, recorded the overall rating as condition B.

All properties were noted as 'fully occupied' in the **utilisation facet** element of the survey. The division of the sites between clinical and non-clinical use is as follows.

**Table 8: Estate split clincial versus non-clincial space**

| | Maidstone | Tunbridge Wells |
|---|---|---|
| Clinical | 76% | 79% |
| Non-clinical | 24% | 21% |

Both sites are considerably below the Carter target of having less than 35% non-clinical space.

The **quality facet** considers design, amenity, comfort engineering. Most surveyed areas were also rated as a 'B'.

**Figure 10 Quality facet survey results (2015)**


The **environmental management facet** assesses not just energy performance, but also the management of the environment such as water consumption, waste and transport management, and procurement.

The 2015 survey data did not record a category rating for the surveyed properties, reporting only on the costs associated with initiatives to improve environmental management.

The executive summary from the 2015 survey is available as Appendix Three.

## 4.5 Estate related risks

The following red rated estate-related risks are noted in the Trust's risk register.

**Table 9: Trust risk register extract – estate related risks**

| Record ID | Title | Unit | Directorate | Specialty |
|---|---|---|---|---|
| 2543 | Fire in a trust building resulting from aging infrastructure and lack of investment based on increase requirment and Hospital ex | MGH | Estates | Maintenance |
| 2551 | Sale of Decontamination Contractor impacting service provision | Trustwide | Decontamination | Decontamination |
| 2542 | Electrical distribution system fails causing a loss of power to vital Hospital clinical services. | MGH | Estates | Maintenance |
| 2616 | Understaffing in security in relation to violence and aggressionecurity in relation to violence and aggression | Trustwide | Facilities | Security |
| 2617 | CCTV at TWH is an outdated system | TWH | Facilities | Security |
| 2618 | CCTV system in MGH is not covering external key areas | MGH | Facilities | Security |

In addition the estates risk register records the following additional red rated risks.

**Table 10: Estates risk register – red risks**

| Record ID | Title | Directorate | Specialty | Location (type) |
|---|---|---|---|---|
| EST23 | Fire Precautions - Oncology | Estates | Maintenance | Oncology Centre |
| EST31 | Fire Alarm Systems | Estates | Projects | Chapel |
| EST 32 | Fire Alarm Systems | Estates | Projects | Stairwells |

## 4.6 Estate costs and metrics

### 4.6.1 Costs

The estate-related costs of the two main sites are shown below – the figures are taken from the most recent ERIC returns (see Appendix four).

**Table 11: Estate costs (£000s)**

| £000s | Maidstone | Tunbridge Wells |
|---|---|---|
| Rates | £1,341 | £3,639 |
| Estates & property maintenance | £2,404 | £5,199 |
| Other hard FM | £1,318 | £1,189 |
| Soft FM | £2,306 | £2,306 |
| Estates management | £624 | £620 |
| **Sub-total hard and soft FM costs** | **£7,994** | **£12,952** |
| Interest & depreciation/ unitary charge | £6,523 | £17,459 |
| **Total estate costs** | **£14,517** | **£30,411** |

The Model hospital metrics based on ERIC returns show a benchmarked cost per square metre of £157.87 for hard FM and £106.20 for soft FM.

### 4.6.2 PLACE scores

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public. PLACE assessments provide a framework for assessing quality against common guidelines and standards to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. PLACE scores for 2019 (the most recently available year) are shown below.

**Table 12: PLACE scores 2019**

| PLACE Criteria | Cleanliness | Food | Privacy and Dignity | Condition, Appearance & Maintenance | Dementia | Disability |
|---|---|---|---|---|---|---|
| National Average | 98.74% | 92.86% | 87.39% | 95.92% | 84.34% | 83.80% |
| Maidstone Hospital | 99.75% | 88.65% | 80.91% | 98.91% | 88.97% | 88.26% |
| Kent Oncology Centre | 100.00% | n/a | 94.74% | 96.55% | 100.00% | 95.65% |
| Crowborough Birth Centre | 100.0% | n/a | 97.14% | 98.15% | n/a | 91.67% |

| PLACE Criteria | Cleanliness | Food | Privacy and Dignity | Condition, Appearance & Maintenance | Dementia | Disability |
|---|---|---|---|---|---|---|
| Tunbridge Wells Hospital | 99.13% | 88.64% | 89.24% | 98.54% | 84.87% | 84.43% |

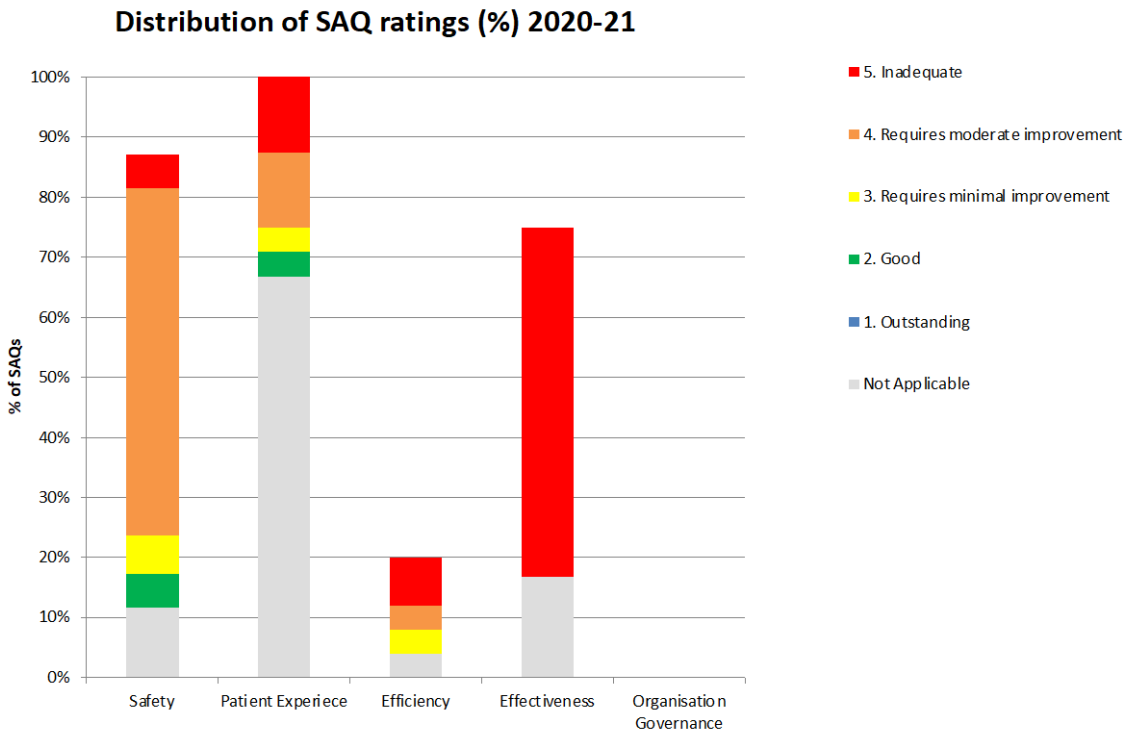
## 4.7 Premises Assurance Model (PAM)

The Premises Assurance Model was last updated in 2020 and looks at the following domains:

- Efficiency
- Safety
- Effectiveness
- Patient experience
- Organisational governance.

The aim of PAM is to allow NHS providers to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises are safe, provide a consistent basis to measure compliance against legislation and to prioritise investment decisions. MTW provided the follow response to PAM.

**Figure 11 PAM scores**




*NB: The term 'Inadequate' when applied to Effectiveness & Efficiency may also mean insufficient data available. Organisation Governance awaiting review (16.04.20).*

The following actions have been proposed to address areas that are rated as inadequate or requiring improvement:

- Target one domain at a time for improvement.
- The safety domain to be targeted first.
- The safety domain is split into two parts, Estates – Facilities.
- The Trust will demonstrate compliance with PAM self-assessment questions (SAQ) by having real time access to information online & paper (where required), via a PAM management tool linked to EFM drives.
- 'Responsible persons' have been appointed to manage SAQ's, ensuring data is correct, that the information on file fulfils the SAQ brief, and that any compliance concerns are escalated to the SAQ's 'accountable person'.
- 'Accountable persons' are allocated domains/SAQ's and are accountable for PAM compliance via the responsible person. Accountable persons are made up of EFM senior managers.

The Trust has made considerable progress in the use of the PAM and using its outputs as evidence to support CQC inspections.

## 4.8 Environmental and sustainability issues

The sustainability vision of the Trust is, ***"the provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust".***

The Trust is committed to providing healthcare and services to the populations of today without compromising the opportunities of the populations of tomorrow. The Trust also recognises that in delivering healthcare services its sites and operations may have adverse impacts on the environment and it is essential that these are minimised through continuous monitoring, mediation and changing culture around the environment and sustainability.

To deliver sustainable healthcare, MTW must achieve positive social impacts, whilst mitigating its impact on the environment whilst also balancing financial efficiency.

The Trust has developed a sustainability strategy that will be implemented through its Sustainable Development Management Plan (Annex One) which has the following six areas of focus:

- Corporate vision and governance
- Leadership, engagement and development
- Healthy, sustainable and resilient communities
- Sustainable clinical care models
- Commissioning and procurement
- Operational management and decarbonisation.

The Trust has already made significant investment in low energy technology and continues to make good progress towards achieving both its specific carbon targets and its wider sustainability objectives. For example MTW is working closely with Kent Wildlife Trust and embarking on a programme of improving biodiversity across its sites.

## 4.9 Other site users

The Trust hosts Kent County Council social services and retail concessions leased to Compass.

# 5 Where do we want to be? *The rationale for change in strategic context*

## 5.1 Introduction

This section sets out the **"where do we want to be?"** element of the estate strategy. It considers the impact of national and local strategy for the services provided by the Trust and the Trust's response as set out in its strategy.

## 5.2 National policy

The NHS Long Term Plan (LTP) sets out the priorities for healthcare over the next ten years. The plan builds upon the Five Year Forward View and Vanguards and further signifies the shift in emphasis from competition to collaboration through integrated care systems. The plan also sets out changes to be made over the first five years of the planning period:

- Increasing the focus on population health and partnership with local authority-funded services through integrated care systems (ICS).
- Boosting 'out-of-hospital' care and ending the historic divide between primary and community health services.
- Redesign to reduce pressure on emergency hospital services.
- Giving individuals more control over their own health, and more personalised care.
- Mainstreaming digitally enabled primary and outpatient care.
- Better care for major conditions.

These changes will significantly influence the way MTW services work in the future. Each of the change areas is discussed below and we have drawn out what this means for the estate strategy.

### 5.2.1 Population health and integrated systems

At the heart of this ambition is the national roll out of ICS which provide the structure within which local organisations come together to redesign care and improve population health, creating shared leadership and action. They are the delivery route for the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

An important element of reform associated with an ICS is changes to contractual form and how funding could flow between organisations, with a move towards system financial control totals. Linked to this is the concept of the "Kent and Medway Pound" and the recognition that the system cannot continue to allow individual organisation's financial interest to destabilise the system.

**Implication for the estate strategy**

- MTW plans will need to be aligned to national and ICS plans which include the integration of heath and care around 'Places' and PCN networks. From an estate perspective, some ICSs are developing community hubs on the same sites as acute services, whilst others are developing community hubs away from acute hospitals.

The optimal model for West Kent will need to be agreed through the West Kent Integrated Care Partnership and Kent & Medway ICS.

### 5.2.2 Boosting out of hospital care

The LTP commits to increasing the share of the NHS budget spent on primary and community health. Primary Care Networks (PCN) represent the new organisational form to drive the boost to out of hospital care. PCNs will drive working at scale and integration with community-based health and care services. Across the country these service model changes are leading to investment in the estate to co-locate GP surgeries with other health and care services.

**Implication for the estate strategy**

- The MTW may need to host PCN/ community-based services and become more of a 'health campus' in the longer term (as above).
- The Trust's clinical teams will need to adapt to new models supporting colleagues based out of acute' which are designed to reduce growth in acute activity. If successful these new pathways should reduce the longer-term need to expand acute-based capacity.

### 5.2.3 Redesign of urgent care pathways

The longstanding desire to reduce the number of people attending hospital emergency departments with conditions that can be treated elsewhere has led to a multitude of alternate services being rolled out. Unfortunately, this has led to a degree of confusion amongst the public about where to attend and service duplication. The LTP aims to redesign urgent and emergency care pathways to bring a greater degree of standardisation cross these community-based alternatives to attendance at emergency departments (ED) whilst recognising that the aim of diverting activity from ED remains the goal. There are several initiatives within this element of the LTP:

- Embedding a single multidisciplinary clinical assessment service within integrated NHS 111, ambulance dispatch and GP out of hours services.
- Implementing the urgent treatment centre model to create a consistent offer for out-of-hospital urgent care.
- Reforming same day urgent and emergency care within acute hospitals.
- Reducing delays to discharge.

**Implications for the estate strategy**

- The Trust is also redesigning same day urgent care and has introduced a Rapid Assessment point (RAP) alongside A&E – these types of facilities are likely to require expansion in the medium-term.

### 5.2.4 Personalised care

The LTP sets out a move from encouraging choice to a more personalised approach to medicine and therapeutic interventions enabled through advances in genomes etc. Overtime this suggests that the interventions available will change, so any new buildings need to be designed with future flexibility in mind. Personalised care also means that people will expect their care to be more joined-up as they receive packages of care from multiple services and organisations - the estate can help enable this more personalised and joined-up approach by providing facilities which co-locate services and which make no distinction between organisations, including providers from the non-statutory sector.

**Implication for the estate strategy**

- This LTP requirement further iterates the importance of out of acute hospital care.

### 5.2.5 Digitally enabled primary and outpatient care

Digital service delivery has made rapid advances across all sectors of the economy, but the NHS has lagged behind. However, the experience of Covid has demonstrated that a substantial proportion of traditionally face-to-face consultations done in both primary care and outpatient settings, can be done remotely by phone, video or online. The LTP set out an aspiration to reduce the number of face-to-face contacts through alternate delivery channels – this aspiration has already been achieved because of the pandemic.

**Implication for the estate strategy**

- Opportunity to redesign the outpatient model and potentially reduce the physical footprint devoted to these services.

### 5.2.6 Better care for major health conditions

The LTP implementation framework sets out targets for delivering improved cancer outcomes, improved mental health services, and shorter waits for planned care. Of particular relevance to this business case are:

**Cancer**: The LTP commits to extending and improving screening and early detection, providing speedier access to treatment and an individualised care plan and support for their wider health and wellbeing, and a follow-up pathway tailored to their needs.

**Cardiovascular disease**: The LTP commits to the earlier detection and management of cardiovascular disease with better support for patients through multi-disciplinary teams as part of primary care networks to improve outcomes and reduce hospital admissions and unnecessary prescribing.

**Stroke**: The LTP recognises the value of 24/7 networked stroke services and heralds the roll out of Integrated Stroke Delivery Networks (ISDNs) involving relevant agencies including ambulance services through to early supported discharge. Further development of higher intensity care models for stroke rehabilitation are expected to reduce hospital admissions and ongoing healthcare provision and improve outcomes.

**Diabetes**: The LTP commits to taking action to prevent diabetes and supporting people with diabetes in managing their own health and supporting primary care delivery to minimise risks of complications.

**Respiratory**: Primary care networks will be used to enhance the diagnosis of respiratory conditions, expanded pulmonary rehabilitation services, support for self-management, improved use of medications, and delivering community-based care as an alternative to hospital admission where appropriate.

**Adult mental health**: The LTP makes a renewed commitment to growing investment in mental health services faster than the NHS budget overall for five years.

**Implication for the estate strategy**

- These LTP initiatives reinforce the implications described above.

### 5.2.7 Diagnostics

The need for radical investment and reform of diagnostic services was recognised in the LTP. In October 2020 NHS England published "*Diagnostics: Recovery and Renewal*", which builds upon the LTP by outlining how the Covid-19 pandemic has further amplified the need for radical change in the provision of diagnostic services, whilst also providing an opportunity for change by recognising that Covid-19 led to many beneficial changes in diagnostic pathways, such as increased use of virtual consultations. The report recommends that emergency and elective diagnostics should be separated where possible and the establishment of Community Diagnostic Hubs (CDH) serving populations of approximately 333k people. CDHs would provide Covid-19 minimal, highly productive elective diagnostic centres for cancer, cardiac, respiratory and other conditions. For patients with suspected cancer, these should incorporate the rapid diagnostic centre service model. Diagnostic modalities envisaged for CDHs include:

- Imaging: CT, MRI, ultrasound, plain X-ray.
- Cardiorespiratory: echocardiography, ECG and rhythm monitoring, spirometry and lung function tests, support for sleep studies, blood pressure monitoring, oximetry, blood gas analysis.
- Pathology: phlebotomy.
- Endoscopy (at some, but not all DCHs).

**Implication for the estate strategy**

- Maidstone or Tunbridge Wells could host a West Kent CDH in a community setting
- Future acute site diagnostic estates requirements will be reduced as patient flows are segmented.

### 5.2.8 NHS policy regarding information technology

Technology, like the estate is an enabler of clinical service transformation. The LTP placed great emphasis on technology, highlighting its role in delivering transformation, such as

enabling patients to access primary care in different ways. National information and communications technology (ICT) strategy focuses on using ICT to support:

- Joined-up care by providing technology that supports integration to place the patient at the centre of a web of care.
- Safe, effective and high-quality care by providing ICT that supports care delivery at the right time and in the right place.
- A sustainable health and care system by using ICT to drive efficiencies in service provision.
- Well-managed services by providing the data and information to aid decision making.
- Innovation by assisting research and continuous improvement.
- Digital delivery of consultations with patients and case discussions between clinicians.

The health industry has lagged other sections of the economy in its pace of adopting new technology, but there are several emerging themes and concepts spanning tele-medicine, tele-care and tele-health, which need to be considered in new building design:

- Making systems infrastructure robust and easy to use - this allows changes to systems to be made now and in the future. This includes cloud and video conferencing.
- Digitally empowered patients. This includes making available digital tools to encourage self-care and active engagement with healthcare services using concepts such as 'hospital without walls'. This Includes patient monitoring and reporting over hand-held and wrist worn devices.
- Digitally enabled staff through making available tools for staff which allow them to work more efficiently and effectively regardless of location. This allows for more effective home working, patient management, staff communications and it reduces the reliance of office space.
- Clinically Enhanced Systems. Clinical systems that support patient management and diagnostics including integrated systems such as radiological information and picture archive and communication systems, room booking and theatre scheduling.
- Smart buildings incorporating technology in facilities to support building operations and security. Smart buildings allow for the management and control of the internal environment such as heating, lighting, humidity and noise.
- Integration of the internet of things and sensor technology for the purpose of connecting and exchanging data with other devices and systems over the internet. Sensor technology can be used to remotely monitor patients in their homes.

The Covid pandemic demonstrated how new technologies can lead to rapid changes in the way that services are delivered, for example the shift to online consultations across primary care and outpatient services achieved in just a few weeks the degree of transformation the NHS had planned to achieve over several years.

**Implication for the estate strategy**

- The key impact on this business case is that ICT as an enabler of a modernised estate.
- Spatial planning should reflect the shift to mobile and home working and the resulting reduction in the need for desk space.

- Health buildings will need space for multi-disciplinary team meetings which use technology to bring colleagues together virtually.
- The recent Covid experience of how technological change can facilitate changes to the way services are delivered must not be lost and instead, should be used to inform the design of the new health and care hub.

### 5.2.9 NHS policy regarding the estate

In March 2017 Sir Robert Naylor published his review[4] into the NHS estate which sets out how the NHS can release up to £2bn of surplus estate to fund the investment required to support plans set out by STPs. The report highlights an STP estate investment need of up to £10bn, made up of £5bn to resolve backlog maintenance issues and a further £5bn to support transformation. The review also makes recommendations about aligning the interests of individual trusts with health communities via STPs and prioritising land vacated by the NHS for the development of residential homes for NHS staff, where there is a need to do so.

Looking beyond the NHS, the One Public Estate programme is a national programme delivered in partnership by the LGA and the Cabinet Office Government Property Unit which seeks to, create economic growth, deliver more integrated, customer-focused services and generate efficiencies, through capital receipts and reduced running costs in line with the Carter Review recommendations. Locally the OPE focus is on seeking opportunities to share estate across public sector partners.

In October 2020 *Delivering a 'Net Zero' National Health Service* was published by NHSEI. This strategy sets out the NHS' response to the health emergency associated with climate change and sets two clear targets:

- For the emissions the NHS directly controls (the NHS Carbon Footprint), a target of net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions the NHS can influence (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Linked to the aim to reduce carbon, the Department of Health and Social Care and NHSEI have adopted a "presumption in favour of modern methods of construction (MMC)" as part of the business case approvals process. Expectations are that new healthcare premises will be designed and constructed using flexible repeatable design and off-site manufactured components.

At both a national and local level, it is recognised that improving the NHS estate is a key enabler to being able to deliver the new models of care outlined in the LTP. There is an explicit awareness that this investment is not just needed to improve or extend existing facilities to bring them up to modern standards and meet increasing demand, but also to be able to develop new spaces that have the flexibility to accommodate new multi-disciplinary teams, innovations in care for patients and the increasing use of technology in healthcare delivery.

**Implication for the estate strategy**

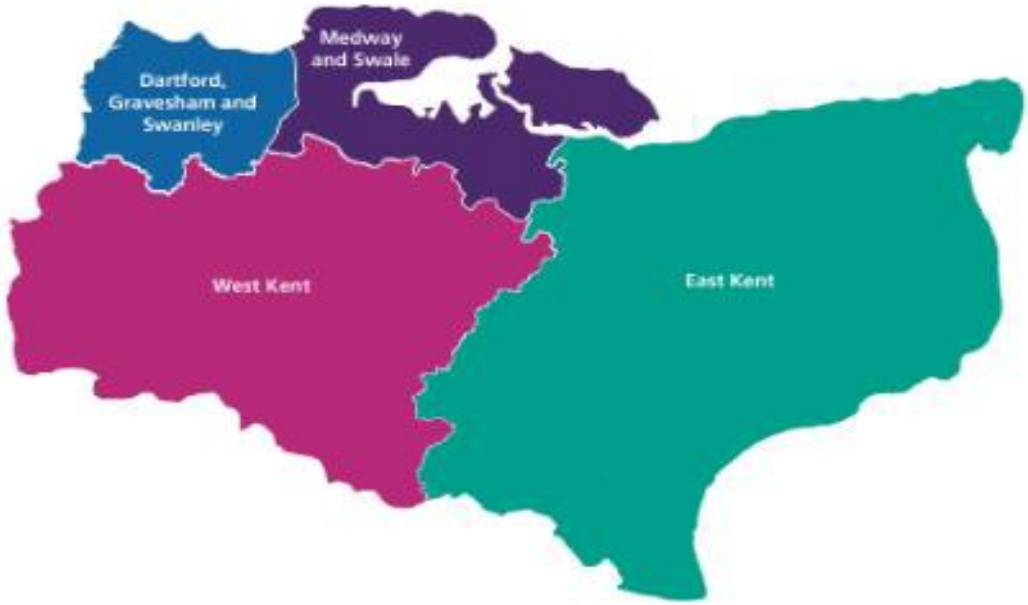
[4] NHS Property and Estates, Sir Robert Naylor, March 2017.

- New facilities will need to be designed to reflect changing models of care and with sufficient flexibility to be adapted in the future as pathways continue to evolve.
- New developments will need to be carbon emissions net neutral and will need to be delivered using 'modern methods of construction' wherever possible.

## 5.3 The Kent and Medway Integrated Care Partnership

The Trust is part of the Kent and Medway Integrated Care System (ICS) which brings together NHS commissioners and providers serving the 1.8m people living within the Kent and Medway system.

**Figure 12: The K&M ICS and ICPs**




The Kent and Medway integrated care system (ICS) was formally designated at the end of March 2021. Within the Kent wide ICS there will be 4 Integrated Care Partnerships (ICP) with MTW within the West Kent ICP. ICS leads the local implementation of national policy, such as the LTP and the local response to resolve K&M performance and financial challenges. The configuration and performance of NHS organisations in K&M will need to continue to adapt to meet the following challenges:

- The local population is growing rapidly.
- People are living longer and older people tend to have additional health needs – the forecast growth in the number of over 65s is over 4 times greater than those under 65.
- Mental health problems disproportionately affect people living in the most deprived areas in Kent and Medway.
- Lots of people are living with long-term conditions - over 528,000 local people live with one or more significant long- term health conditions, many of which are preventable.
- There are unacceptable differences in health across Kent and Medway.

- Too many people are living unhealthy lifestyles and are at risk of developing conditions that are preventable.
- The system cannot meet the current and future needs of local people with existing budgets.
- As many as four in 10 emergency hospital admissions could be avoided if the right care were available outside hospital.
- Even if there was more funding available, there is a shortage of skilled staff.
- Post Covid-19 recovery

In response, the ICS has agreed the vision **"We will work together to make health and wellbeing better than any partner can do alone"**

The ICS recognises that a strong health and social care system is pivotal to achieving this vision, and means that the ICS will:

1. Give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination
2. Help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place
3. Help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years
4. Support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing
5. Ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability
6. Make Kent and Medway a great place for our colleagues to live, work and learn

**Figure 13: ICS approach and goals**

The ICS has identified a number of priority areas for delivery in 2021/22, which are shown in the table below

## Improvement and development priorities

| | |
|---|---|
| **COVID 19 Response** | Continuing to respond effectively to the COVID-19 pandemic as a cohesive system - with partnership working in places and system co-ordination in the form of a system ICC, system wide programme for recovery, and system oversight of the Covid-19 vaccination programme. |
| **K&M Improvement and Recovery Plan** | Delivering against the **K&M Improvement and Recovery Plan**:<br><br>a. Delivering improvement in areas of mental health services, children and young people services and safeguarding.<br><br>b. Developing place based improvement plans for the footprints of East Kent and Medway & Swale, with a particular focus on how partnership working can drive medium to longer term improvement in urgent and emergency care. |
| **Diagnostics** | Working as a system on increasing **diagnostic capacity and elective capacity** including managing long waits for planned care that have arisen as a result of the pandemic. |
| **ICS End State** | Implementing our 'ICS end state' reflecting the likely creation of ICS statutory entities in April 2022 – including further work on ICS governance model, ICS Executive team, system behaviours, ways of working, and development Integrated Care Partnerships and Primary Care Networks. |
| **PHM** | Designing our detailed approach to **population health management**, with the help of the NHSE/I Wave 3 PHM programme. |
| **Strategic Change** | Working with NHSE/I to progress the system's **two strategic change priorities** with necessary pace – the implementation of stroke and East Kent transformation. |
| **Provider collaboration** | Rapidly exploring opportunities for further **provider collaboration** – both clinical and non-clinical, including back office, estates and workforce. |
| **Quality and service improvement** | 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 country alongside intensive or bespoke improvement programmes where indicated. |
| **Digital** | Refreshing the system **digital** strategy, creating system capability for digital through formalised matrix working and implementing our analytics strategy at pace |

The ICS is working towards a model of integrated care based on population health needs and holistic, individualised personal care that covers both planned and unplanned care for both physical and mental illness via integrated pathways across primary, secondary and social care with an emphasis on prevention and care in the community.

Achievement of the ICS plans is driven through the following workstreams:

- System transformation
- Primary Care and Local Care
- Mental Health
- Prevention
- Children
- Stroke
- East Kent Transformation Programme
- Digital
- **Estates**
- Productivity.

The estates workstream responds to the needs of the clinical workstreams and is a key enabler. It focuses on supporting care and system transformation across the STP and setting out the plan to meet targets set centrally by NHSEI. The STP estates strategy was originally submitted in 2018 and was rated as 'improving'. Subsequently feedback on the submission has informed ongoing refinement of STP estates plans.

Since 2017/18 the K&M STP has been awarded £26m in STP Capital and £16m for ETTF projects all of which contribute towards achieving system goals, although none of these projects are specifically for MTW to deliver. Nevertheless ICS future plans for the development of primary care and community schemes, have the potential to impact upon the quantum of activity delivered at the Trust's two acute sites.

## 5.4 Trust strategy

### 5.4.1 Our Strategy: Exceptional People, Outstanding Care

Is often captured in pyramid form...

**The Trust vision** is

- Exceptional People, Outstanding Care

**The Trust PRIDE values** are:

- Patient first
- Respect
- Innovation
- Delivery
- Excellence

**Strategic themes** to help us deliver our vision:

- Patient experience
- Patient safety and clinical effectiveness
- Access
- Systems and partnerships
- Sustainability
- People

Strategic Foundations underpin the delivery of the strategy and objectives

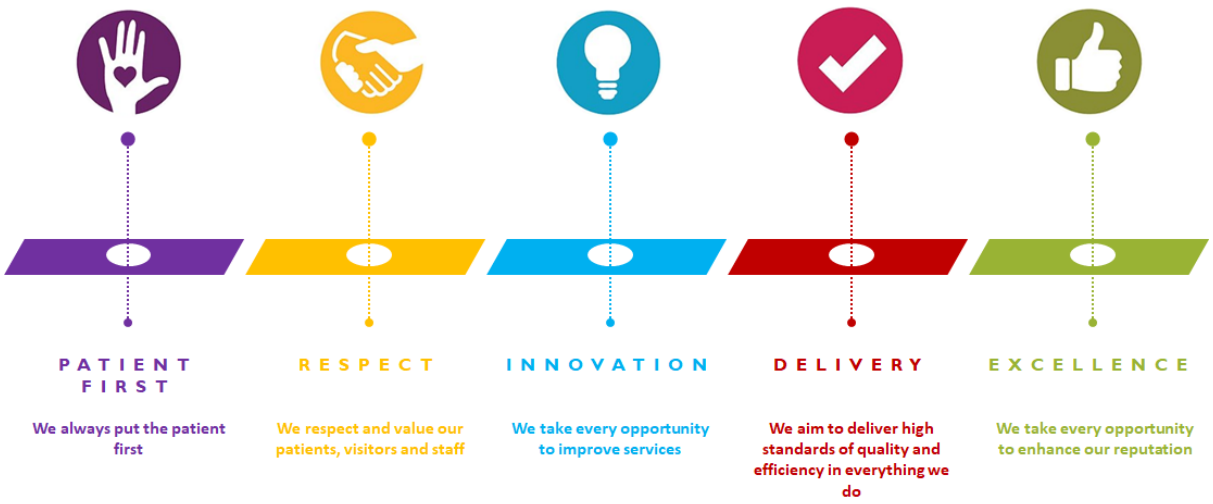
### 5.4.2 The Trust's detailed supporting strategies

The Trust has seven supporting strategies including this estate strategy – see schematic below.

**Figure 14: Trust strategies**


Each strategy will also link to the PRIDE values which are at the heart of everything the Trust does and which help translate the Trust mission and vision into meaningful change.

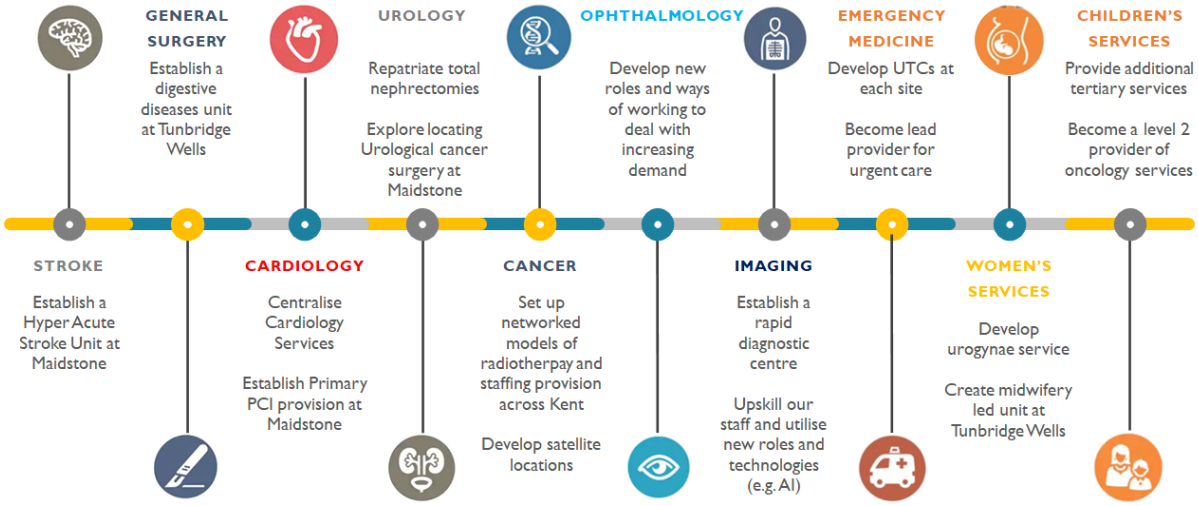
**Figure 15: Trust PRIDE values**



### 5.4.3 The clinical strategy

The initial five-year clinical strategy runs from 2019/20 to 2023/24 and covers several the organisation's clinical specialties. It is summarised in the illustration below which shows the key changes each speciality aim to make over the period covered by the strategy.

**Figure 16: Summary of clinical strategy 2019/20 to 2023/24**




Further work is ongoing with the specialties to build upon the strategy illustrated above. The proposals with most relevance to the estate are:

- **Emergency medicine** – following successful implementation of UTC at each site ongoing projects to better manage the growth in emergency attendances and admissions to promote the "Right care, right time, right place", supporting the Trust's development of specialist centres at each hospital site and developing the range of services to assist with streaming our patients from our urgent and emergency front doors. Emergency medicine will develop as a 'Collaborative Lead Provider' for integrated urgent care arrangements in our locality.

- **Stroke** – the STP programme related development of a hyper acute stroke unit and acute stroke unit from the existing acute assessment unit (AAU) and Chaucer Ward at Maidstone Hospital. The decision making for this proposal has been subject to some delay due to a judicial review of the K&M stroke reconfiguration decision making process.
- **Cardiology** – Consolidation of in-patient and interventional cardiology activity onto the Maidstone campus, involving the expansion of existing facilities to provide co-located cardiac catheter laboratories, day case and recovery recovery facilities, with an expanded coronary care unit, and level one bedstock. Looking ahead longer-term these developments have the potential to position MTW to become the second Primary Percutaneous Coronary Intervention (PPCI) centre for the K&M ICS.
- **General surgery** – Following the successful move of complex inpatient elective surgery to TWH a next step will be to establish a Digestive Diseases Unit and the subsequent co-location of lower gastrointestinal surgery with medical gastroenterology at TWH.

- **Ophthalmology** – projects to manage demand including a shift to more virtual clinics and one-stop clinics and to manage increased demand from around Kent and Medway as MTW takes over elements of ophthalmology previously provided by Moorfields Hospital in the region.
- **Urology** – exploring the potential for the Maidstone site to become the specialist urological cancer centre for West Kent co-locating the urology cancer surgery with the Cancer Centre.
- **Women's services** – the creation of a midwifery-led unit at TWH.
- **Children's services** – plans to improve paediatric emergency facilities, plans to repatriate work from London children's hospitals including specialist orthopaedic and level 2 cancer activity.
- **Cancer** – establishing rapid diagnostic centre pathways through support of and working within a community diagnostic hub model and setting up cancer satellite centres.
- **Imaging** – expanding MRI provision and setting-up an elective diagnostic centre to support cancer and elective care pathway developments following the Richard's Review[5].

### 5.4.4 Training and education

The Trust will be a key provider in the region for the clinical training of medical students from the Kent and Medway Medical School (KMMS). KMMS is a new medical school opened in 2020 as part of a government initiative to increase the number of medical students in the UK. Medical students are placed in primary, secondary and community care settings across K&M and require student accommodation and the development of further academic facilities for their five-year undergraduate course. The Trust has successfully worked with partners to achieve local authority planning permission for a new building, for student accommodation and academic facilities on the Tunbridge Wells Hospital site.

## 5.5 Covid – recovery and reset

The East of England Clinical Senate has published a helpful report about lessons learned from Covid[6]. The report makes several recommendations divided between changes arising from the Covid experience that should be 'adopted' permanently, 'adapted' or 'abandoned'. The focus of the report is on clinical services – it does not seek to replicate the well-evidenced shift to home working for many staff.

The recommendations of most relevance to the estate are set out below:

- Adopt: retain and adopt this practice:
    - Increased focus on infection prevention and control across primary and secondary care, social and community care settings.

[5] Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England, December 2020.

[6] The Regional COVID-19 pandemic response and system learning. What have we learned about how health care can be delivered during the last twelve weeks? The East of England Clinical Senate.

    - Continue with the protected or 'Green' (non-COVID-19) elective facilities within sites, providing protected elective facilities and pathways.
    - Remote tele-consultation. Tele-consultations should be encouraged, supported by improved patient record sharing, multi-agency and inter-agency working. This can offer a much more convenient service for many patients with the additional benefits to the environment in terms of carbon footprint and in terms of the requirement for expensive healthcare facilities and estates. Flexibility may enable more staff to offer out of hours appointments and weekend working with a move towards better seven-day provision.
- Adapt: practice should be retained subject to some further development or refinement:
    - Empowering health and care professionals to reduce the 'over medicalisation' of care, particularly for the frail elderly, and to understand what the ideal level of care is for the individual.
    - The use of sophisticated methods for prioritisation of care, enabling treatment to be delivered on a priority of need basis rather than a time on a waiting list basis. We need to reconsider the effectiveness of current referral pathways and refine them where necessary to deliver the best outcomes to support the management of early-stage diagnosis in cancer.
    - Continue the use of tele-conferencing for team meetings, training etc.
- Abandon:
    - Public fear that attending any healthcare facility had a high risk of resulting in infection. We must ensure that a strong message regarding the safety of protected diagnostic and elective pathways is communicated to the public.
    - Complete separation of frail elderly and other shielded groups from other patient groups.

The report also makes specific recommendations about diagnostic facilities which could impact on this estate strategy:

- We must ensure that we have adequate molecular diagnostic pathology services to ensure sufficient capacity to deliver timely results that, through information technology systems, are accessible across all relevant health and care settings.
- We must ensure that we have adequate diagnostic capacity, including radiological and endoscopic facilities, which is designed to deliver services for patients affected by infectious diseases during pandemics and for protected facilities for those with other conditions.

Building related themes that are emerging which have a direct impact upon the future estate are:

- Anticipate fewer face-to-face consultations - 40% non-face-to-face, should be the lower end, with 60% being attainable.
- An increased proportion of activity, particularly at outpatient level, should be conducted in primary care and community care settings.
- Increasing the area allowed for corridors, lifts and stairwells.
- Single directional corridors supporting in- and-out flows.
- Possibly a re-evaluation of outpatient design with patients entering from one side and clinical teams the other.

As noted above, the shift to homeworking for many staff is not covered by the report. The pandemic has however led to a step change in the number of people, particularly staff in administrative roles, working from home. Nationally surveys report that most staff would welcome the flexibility afforded from being able to work from home for a few days a week and that most employers are willing to make this change. Evidence from other Trusts suggests that some have already reconfigured corporate areas to substantially reduce the space required for corporate functions.

**Implication for this estate strategy**

- The design of MTW buildings will need to reflect changes to service delivery such as:
  - The increase in the use of virtual consultations.
  - Video conferencing for meetings.
  - The need to be able to separate out "Green" activities.
- The move away from "medicalised" care suggests a greater need to provide facilities for social care services.
- Sufficient capacity for additional diagnostics needs to be designed in.
- The space required for offices should significantly reduce with the move to flexible part home-based working.

## 5.6 Estate strategy response

This estate strategy responds to the factors set out in the estate case for change section (section 4) and this strategic context section through a series of investment proposals which are described in the next section.

# 6 How do we get there? *Our Development Control Plan - Delivering the Clinical Strategy and Key Enabling Projects*

## 6.1 Introduction

In this section we set out details of the Clinical Strategy Developments and key enabling projects the Trust intends to implement over the next five years in response to the strategic and operational issues outlined in the previous two chapters – this section is the **"how do we get there"** element of the estate strategy.

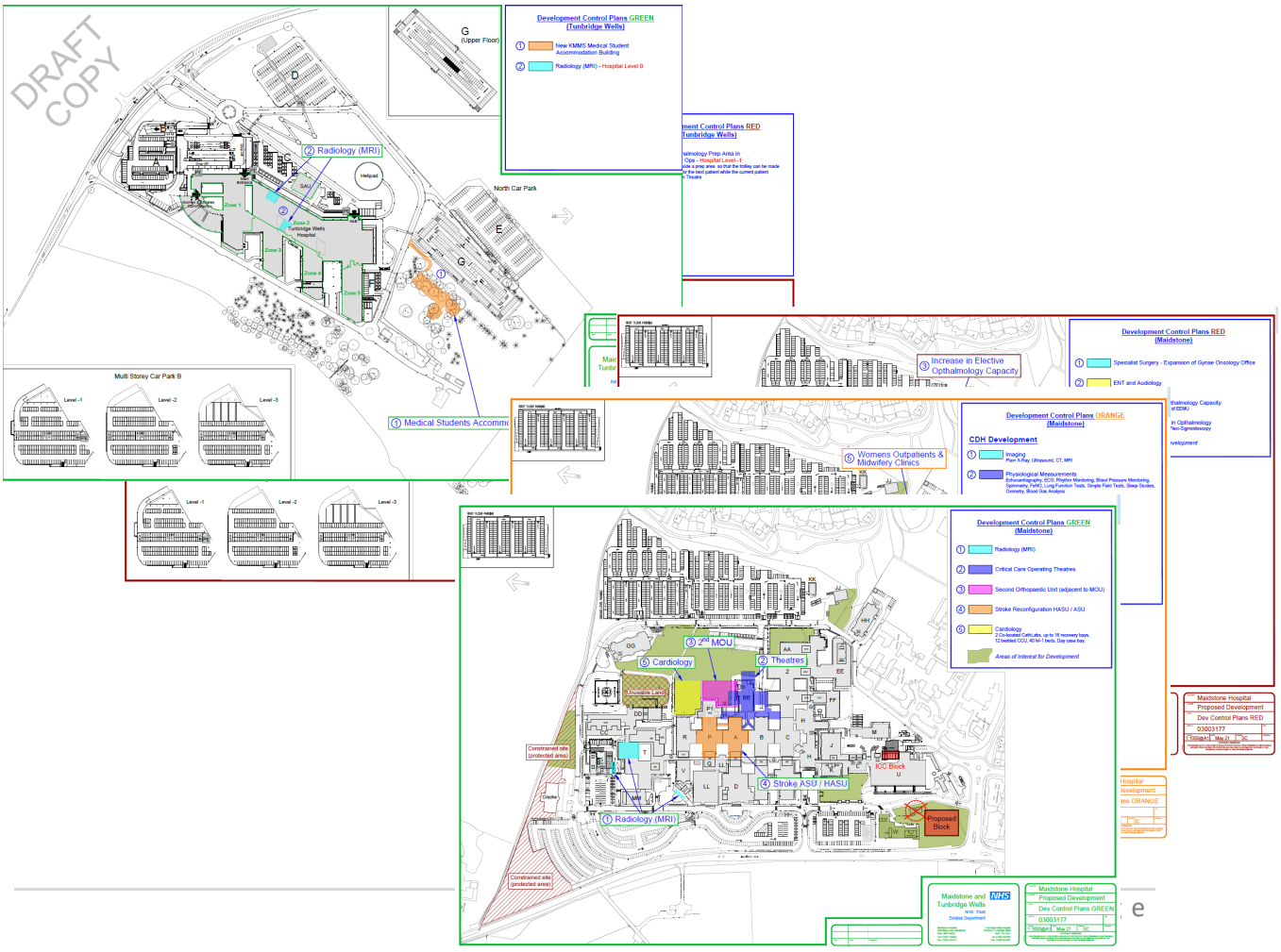
## 6.2 The MTW Estates Development Control Plan

The Development Control Plan (DCP) seeks to manage and control MTW estate development to ensure that development takes place at an appropriate time and place and in such a manner that it conforms to pre determined but continuously developing strategy.

The estates elements of the clinical strategy and enabling projects are coordinated via the Development Control Plan which is a live document and changes as projects go through business case and patient engagement processes and to align with the Trust Capital Plan

The DCP includes a series of drawings showing planned developments with timing information

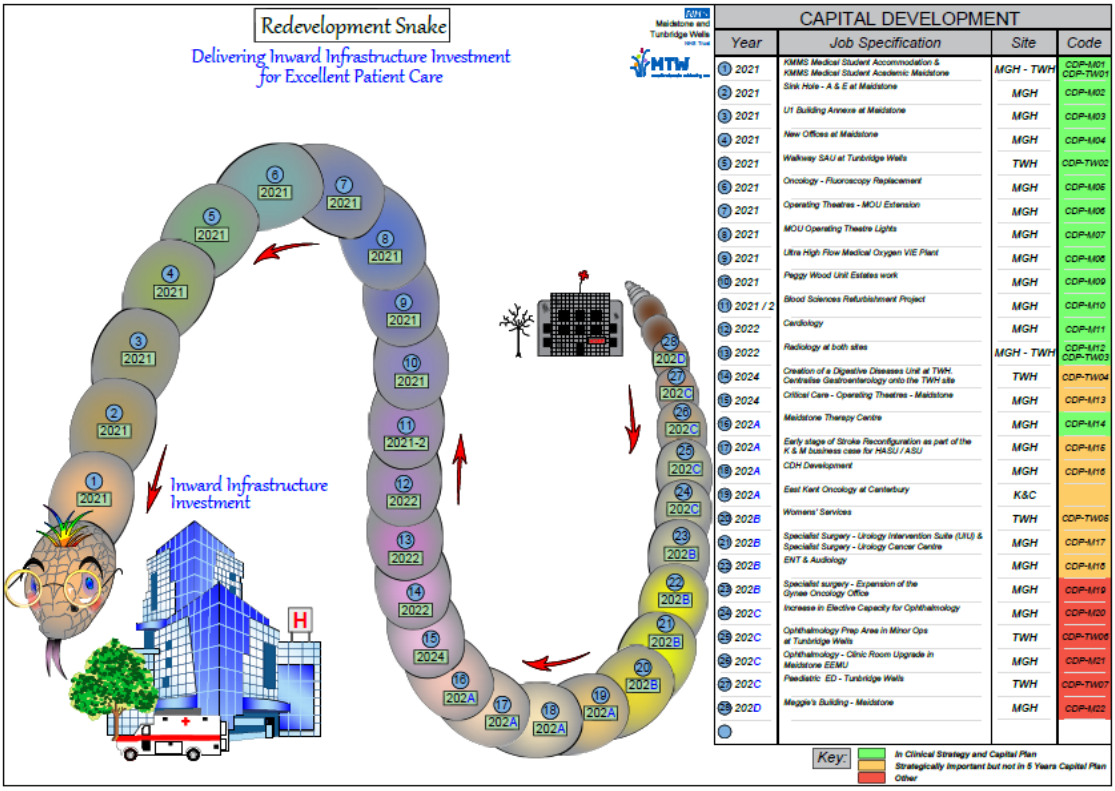
**The DCP – Under separate cover**



## 6.3 Sequencing

The phasing and time sequencing of developments has been mapped to reflect current organisational priorities. The phasing is pictorially Illustrated using a 'snake' diagram

The DCP and phasing are 'live' documents that are updated in response to organisational priority changes and the capital plan. There are number of schemes without a clear funding route yet and this will mean some further prioritisation/identification of funding opportunities is likely to be required




CAPITAL DEVELOPMENT

| Year | Job Specification | Site | Code |
|---|---|---|---|
| 1 2021 | KMMS Medical Student Accommodation & KMMS Medical Student Academic Maidstone | MGH - TWH | CDP-M01 CDP-TW01 |
| 2 2021 | Sink Hole - A & E at Maidstone | MGH | CDP-M02 |
| 3 2021 | U1 Building Annexe at Maidstone | MGH | CDP-M03 |
| 4 2021 | New Offices at Maidstone | MGH | CDP-M04 |
| 5 2021 | Walkway SAU at Tunbridge Wells | TWH | CDP-TW02 |
| 6 2021 | Oncology - Fluoroscopy Replacement | MGH | CDP-M05 |
| 7 2021 | Operating Theatres - MOU Extension | MGH | CDP-M06 |
| 8 2021 | MOU Operating Theatre Lights | MGH | CDP-M07 |
| 9 2021 | Ultra High Flow Medical Oxygen VIE Plant | MGH | CDP-M08 |
| 10 2021 | Peggy Wood Unit Estates work | MGH | CDP-M09 |
| 11 2021 / 2 | Blood Sciences Refurbishment Project | MGH | CDP-M10 |
| 12 2022 | Cardiology | MGH | CDP-M11 |
| 13 2022 | Radiology at both sites | MGH - TWH | CDP-M12 CDP-TW03 |
| 14 2024 | Creation of a Digestive Diseases Unit at TWH, Centralise Gastroenterology onto the TWH site | TWH | CDP-TW04 |
| 15 2024 | Critical Care - Operating Theatres - Maidstone | MGH | CDP-M13 |
| 16 202A | Maidstone Therapy Centre | MGH | CDP-M14 |
| 17 202A | Early stage of Stroke Reconfiguration as part of the K & M business case for HASU / ASU | MGH | CDP-M15 |
| 18 202A | CDH Development | MGH | CDP-M16 |
| 19 202A | East Kent Oncology at Canterbury | K&C | |
| 20 202B | Womens' Services | TWH | CDP-TW05 |
| 21 202B | Specialist Surgery - Urology Intervention Suite (UIU) & Specialist Surgery - Urology Cancer Centre | MGH | CDP-M17 |
| 22 202B | ENT & Audiology | MGH | CDP-M18 |
| 23 202B | Specialist surgery - Expansion of the Gynae Oncology Office | MGH | CDP-M19 |
| 24 202C | Increase in Elective Capacity for Ophthalmology | MGH | CDP-M20 |
| 25 202C | Ophthalmology Prep Area in Minor Ops at Tunbridge Wells | TWH | CDP-TW06 |
| 26 202C | Ophthalmology - Clinic Room Upgrade in Maidstone EEMU | MGH | CDP-M21 |
| 27 202C | Paediatric ED - Tunbridge Wells | TWH | CDP-TW07 |
| 28 202D | Maggie's Building - Maidstone | MGH | CDP-M22 |

Key: In Clinical Strategy and Capital Plan; Strategically important but not in 5 Years Capital Plan; Other

## 6.4 The Trust Capital Plan

The Trust capital plan currently accounts for funding for estates schemes including

- Kent Medical School Accommodation
- Linear Accelerator replacement programme
- Critical Medical Imaging replacement
- Centralised Cardiology Suite
- Maidstone Theatres – (PDC)
- HASU stroke

And further, externally financed, estate schemes including:

- TWH - Lifecycle (IFRIC 12 PFI capital)

- Oncology Site replacement - East Kent – PDC

The Estates DCP and the Capital Plan regularly updated to align with each other, the latest Trust capital plan (abridged) is attached below:

**The MTW Draft 5 Year Capital plan (abridged) v 1.4**

| Capital Spend Plan - all figures £000 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 |
|---|---|---|---|---|---|
| **Estates** | | | | | |
| Estates Projects - b/f commitments | 832 | | | | |
| Backlog maintenance | 1,600 | 2,014 | 3,015 | 3,014 | 3,022 |
| Estates developments | 1,516 | | | | |
| Salix energy scheme - b/f commitment | 83 | | | | |
| | | | | | |
| **ICT** | | | | | |
| ICT - Backlog Wireless renewal | 400 | | | | |
| ICT - Backlog essential Devices | 400 | 500 | 1,000 | 1,000 | 1,199 |
| ICT - Clinical Applications | 153 | 1,300 | 779 | 1,500 | 1,500 |
| ICT - Videoconferencing: TWH Education Centre/MDT | 350 | | | | |
| ICT- network infrastructure | | 1,000 | 1,000 | 1,000 | 1,000 |
| ICT - EPR: contractually committed | 504 | | | 500 | 500 |
| ICT - EPR additional | 545 | 635 | | | |
| | | | | | |
| **Equipment** | | | | | |
| Equipment projects b/f part year impacts | 185 | | | | |
| Backlog equipment replacement | 2,100 | 2,500 | 3,000 | 3,017 | 3,500 |
| | | | | | |
| **System Emergency PDC funded projects** | | | | | |
| Kent Medical School Accommodation | | 22,680 | | | |
| Linear Accelerator replacement programme | | 3,000 | 3,000 | 3,000 | 3,000 |
| Critical Medical Imaging replacement | | 2,300 | 2,300 | 2,300 | 2,300 |
| IT Telephony replacement | | 750 | | | |
| Centralised Cardiology Suite | | 18,940 | | | |
| Maidstone Theatres - PDC | | | | 20,000 | |
| HASU stroke | 280 | 3,960 | 2,000 | | |
| | | | | | |
| **Externally financed projects** | | | | | |
| TWH - Lifecycle (IFRIC 12 PFI capital) | 1,224 | 1,255 | 1,286 | 1,319 | 1,966 |
| Oncology Site replacement - East Kent - PDC | | 42,628 | | | |

Financial options to deliver the Trust estates plan is shown below.

| | Internally generated capital & backlog schemes 2021-2026 | | Revenue schemes p.a. 2021-2026 | | Pure capital schemes | |
|---|---|---|---|---|---|---|
| Schemes | Estates backlog | £19.59M | Project cormorant | £0M | East Kent Cancer | £42.6M |
| | OP additional cost | £1.4M | MRI managed service | £0M | Urology IU | £1-3M |
| | Estates projects | £2.4M | CDH | £TBC | Opthamology | £TBC |
| | ICT | £16.75M | Cardiology * £3.5M | | Linac replacement | £12M |
| | Equipment £14.3M | | KMMS | £0.5M yr0, £0Myr 3 | Equipment | £9.2M |
| | Office enabling cost | £0.13M | | | | |
| | DDU | £0.1-.5M | Offices | £0.43M | | |

## 6.5 Clinical Strategy

A long list of the estate developments to support the Trusts Clinical strategy is shown below

| Estate scale | Facility type | Item description | Estate impact | | | Finance scale - Indicative costing |
|---|---|---|---|---|---|---|
| | | | Maidstone | TWH | Other site | |
| Large scale | Critical Care / Theatres - surgery | **Operating Theatres at Maidstone** - a major development of main theatres to meet modern standards and adjacency | In scoping stage. Potential significant investment new build at the back of the Maidstone Hospital | None | None | 5 year capital plan submission £20M + |
| | Critical Care / Theatres - surgery | **Barn Theatres (dependant on option above and Cormorant)** - Options to include An extra theatre module in MOU at Maidstone /IS capacity/ Incorporate in major development at Maidstone | New build 1 -5 operative theatre unit and 10- 20 elective beds (TBC) | Decrease bed demand . 10 beds (TBC) | Option in scope | £20M+ |
| | Critical Care / Theatres - surgery | **Urology Service** -Expansion include Urology Cancer Surgery for the whole of Kent and Medway | Additional operating theatre capacity | None | None | |
| | Diagnostics | **Community Diagnostics Hub** (CDH) for elective diagnostics geographically separate from current hospital sites | None | None | X-ray, US, CT and MRI + range of elective diagnostics | National revenue funding of £2.1M in 21/22, and £4.9M in 22/23 |

MTW exceptional people, outstanding care

| | | | | | | |
|---|---|---|---|---|---|---|
| | Medicine | **Cardiology**-Co location of inpatient and interventional cardiac services and cardiac diagnostics at Maidstone | Redesign and new build CCU, ward and cath labs and recovery plus admin and diagnostics | Release of 8 lvl 1 medical beds, CCU, cath lab and associated facilities Potential need for assessment area adjacent to ED to stabilise and transfer patients | None | Revenue funding of £3.5-5M p.a. If not achieved a capital pressure of £18.9M. |
| | Oncology | **Oncology unit - East Kent** Site - Co locating radiotherapy, chemotherapy and outpatients for East Kent patients | None | None | None | £42.6M |
| | Oncology | **Oncology Unit - The Maidstone site (Plan B for East Kent development)**. General increase in capacities in line with demand . Also, contingency for linac expansion should East Kent site options be unsuccessful | 3 bunkers with linacs. Outpatients , Chemotherapy , administration | None | None | |
| | Supporting Facilities | **KMMS.** Medical student accommodation at TWH and academic facilities both sites | Extension adjacent to academic centre | New build at TWH near the 'Sunken Garden | None | Revenue of £0.5M yr0 and 1, £0.2M yr 2, £0 yr3 |
| | Surgery | **Urology Intervention Suite** - expansion in line with urology strategic plan | Increase in treatment and outpatient and associated facilities | None | Chronic Pain decant to Cormorant to create UIU footprint | TBC £1-3M |

| Estate scale | Facility type | Item description | Estate impact | | | Finance scale - Indicative costing |
|---|---|---|---|---|---|---|
| | | | Maidstone | TWH | Other site | |
| Medium scale | Critical Care / Theatres - surgery | **Ophthalmology. Expand elective capacity** | Additional theatre capacity requirement. It would be provided through theatre refurb/rebuild program or via capacity released through Cormorant | TBC | Options of capacity at DVH /New unit in North Kent/ Medway | Wrapped up as part of Maidstone theatre build option/ new additional cost |
| | Diagnostics | **MRI capacity** - managed service | None | None | New build off site to accommodate elective / OP MRI activity +/- reporting | Revenue funded, break even vs. existing spend, delivered as part of CDH |
| | Medicine | **K&M Stroke reconfiguration**. A purpose designed HASU/ASU | site at Maidstone - proposal uses current space, and the need for a link corridor | None | None | £5.9M |
| Minor scale | Critical Care / Theatres - surgery | Ophthalmology prep area in Minor ops at TWH | None | To provide a prep area | None | |
| | Medicine | Digestive Diseases Unit at TWH - centralise Gastroenterology onto the TWH Site | Release 10 bed demand from Cornwallis ward | Possible light refurbishment of one ward. Increase in bed demand <10 beds | None | Minimal investment required |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | Supporting facilities | Expansion of the Gynae oncology office to accommodate 4th consultant and their secretary | Office | None | None | |
| | Surgery | Ophthalmology - Clinic room upgrade in Maidstone EEMU | Upgrade rooms for intraocular injections and minor ops procedures | None | None | |
| | Women's | A Midwifery led unit at TWH | None | Reprovision of existing footprint | None | |

## 6.6 Delivering the KMMS Medical School at MTW

MTW Estates has successfully led work with partners to secure local authority planning approval for a new accommodation and teaching block at The Tunbridge Wells Hospital.

The objectives of the KMMS build at TWH are:

- To provide high quality student accommodation for 140 medical students and other healthcare staff.
- To attract students to the hospital
- To give them an attractive well designed environment to live close to their work

The planned opening date of the KMMS building at TWH is April 2022.

There is also an identified requirement for additional teaching space at Maidstone Hospital to manage the intakes of KMMS medical students. Three key space requirements have been identified:

- A multi-purpose Digital Learning Hub
- One simulation suite with control and debrief space
- Small Group Teaching spaces

These developments are included in the Estates Development Control Plan
Funding route is expected to be via the Educational Resource Tariff arrangements in tripartite collaboration with Health Education England and The KMMS Medical School.

## 6.7 Clinical strategy – A Hyper- Acute Stroke Unit at Maidstone Hospital

Over 3,000 people are treated in Kent and Medway for a stroke every year. National evidence shows people having a stroke do best when they are treated in a specialist stroke unit, available 24 hours a day, seven days a week and staffed by specialist doctors, nurses and therapists. Over recent years, a number of areas across the country have reorganised their stroke services to provide such units and have seen significant improvements in patient outcomes as a result.

Following formal consultation on the shape of stroke services Maidstone Hospital was chosen as a location for one of the Kent and Medway hyper-acute stroke units (HASUs). Final approval is pending. MTW Estates has plans in place to deliver the HASU estate and these feature in the DCP.

## 6.8 Clinical Strategy – Inpatient and Interventional Cardiology Centralisation at Maidstone

This investment will see all in patient and cardiac catheter laboratory cardiology services currently split between the Trust's two hospitals, centralised on a hub site. This will release the six bedded CCU, ten general beds and the catheter laboratory from the spoke site.

The hub site will be redeveloped to expand the existing cardiac interventional facility, CCU and Cornwallis wards providing two co-located cardiac catheter laboratories, with associated day case and recovery facilities, a sixteen bedded CCU and upto 42 general beds. This scheme will also seek to co-locate the acute non-invasive cardiology services on the with interventional services, pending CDH development, enabling improvements to privacy and dignity to radiology services in that area to move forwards.

Whilst there is £19M of capital allocation assumed within the Trusts forward capital plans, alternate methods of funding and delivery will be considered as part of the development. Enablers such as provision of Barn theatres to increase surgical capacity and release existing short stay surgical space which is amenable to re-development for this scheme are also being considered.

Once in place, the strengthened consolidated cardiology service will be well placed to be further developed to become the second PPCI service for K&M.

## 6.9 Clinical Strategy – Trust Operating Theatres

The Trust Surgical Division has identified a series of objectives, in particular, in relation to the Maidstone Hospital main operating theatres which are approaching 40 years old.

- The provision of high quality, safe, compliant and reliable operating theatre facilities at the Maidstone District General Hospital
- A design and co adjacency of the operating theatre estate with modern ICT infrastructure that leads to best practice and improved patient flow and service productivity.
- Suitable, sufficient and flexible operating theatre estate capacity to run the required surgical services for the next 25 years at Maidstone DGH as part of the expected overall surgical demand upon MTW Trust.
- Improved physical peri- operative facilities for patients their carers and relatives
- Improved physical working environment for peri- operative staff.
- Improved sustainability and efficiency of surgical service estate through energy efficiency and waste reduction contributing to a reduction in whole life costs

There are two operating theatre projects currently on the Estate Development Control Plan

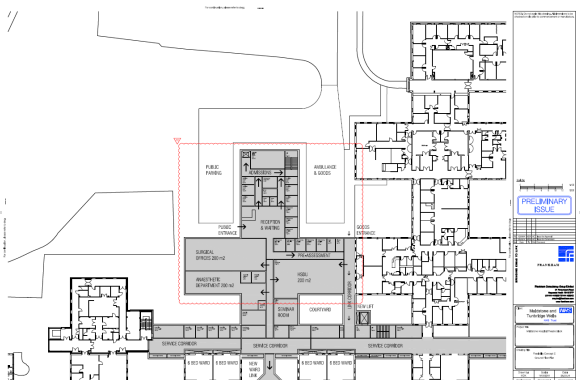
**A new operating theatre block at Maidstone Hospital**

£20M of capital is assigned on the Trust Capital Plan in 2024. The figure was based on a feasibility study for a new build two story, four operating theatre and associated facilities block at Maidstone.

- There is ongoing strategic review within the Surgical Division but the Critical Care directorate have a Strategic Outline Plan to use a space adjoining EEMU for a two story extension that would provide new operating theatres. The capital plan has assigned £20M. This would replace the 4 main theatres at Maidstone, with an ambition that the unit would have space to expand to provide up to 7 theatres. The four main theatres plus two orthopaedic theatres and one extra for urology development. The theatres on first floor and admission lounge on ground floor.

- The future development aim is in the DCP in order that it is taken into consideration during cardiology cath lab / CCU / imaging expansion projects.

  **Operating theatre block at Maidstone** – Early feasibility study drawings illustrating potential location and approximate size




The surgical division, has needed to respond quickly to a pressing need to manage a long waiting list of patients waiting for elective orthopaedic treatment arising from restrictions on operating imposed during the Covid -19 pandemic. Part of this response is plans in development for an orthopaedic operating theatre module adjacent to the Maidstone Orthopaedic Unit (MOU) at Maidstone Hospital.

**A second orthopaedic operating theatre module adjacent to the Maidstone Orthopaedic Unit (MOU) at Maidstone Hospital.**

A business case in in development for an extra orthopaedic operating theatre module adjacent to the Maidstone Orthopaedic Unit (MOU) at Maidstone Hospital and this features on the DCP.

## 6.10 Clinical Strategy - A Digestive Diseases Unit at TWH

Setting up a Digestive Diseases Unit at TWH incorporates the following with associated estates requirements

Centralisation of complex inpatient gastroenterology, co-locating medical and surgical patients with digestive disease. Improving associated research administration facilities.

The introduction of a bariatric (obesity) surgery service at TWH to serve the West Kent population.

## 6.11 Clinical Strategy - Developing Urology Services a Maidstone Hospital

In early strategic planning stage and would be delivered in two/three phases subject to regional planning and enegagement

- First phase is to bring certain kidney operations back to Maidstone from Medway. This is unlikely to need any estates changes

- Second & third phase would bring a significant amount of complex cancer urology surgery from the whole of West Kent to Maidstone. This dependent on an additional main urology operating theatre and significant upgrade/ (double in size) to the Urology Investigation suite (ground floor near EEMU) The new urology suite would incorporate the investigation procedure rooms, out patients and supporting facilities and administration, offices teaching space and be reasonably close to the new urology theatres in the future

### 6.12 Clinical Strategy – The Oncology Centre

**Our cancer outcomes have improved significantly over recent years, including our survival rates, which have never been higher**. However, our work continues to make sure that everyone with cancer receives world-class care, support and treatment.

**The service is experiencing increased pressure from**:

- A growing and aging population
- Increased complexity in a number of pathways and treatments
- Increased survivorship and longer term follow up

**The pressure on the service is compounded by the requirement for faster and earlier diagnosis and treatment** to meet the national cancer standards This requires the service to manage

- Earlier identification
- Timely referral
- Better symptom assessment
- Increased coordinated testing
- Timely diagnosis
- Prompt onward referral
- Excellent coordination and support throughout this process

**A regional review of oncology services is in progress by Carnal Farrar consultancy**
This investment responds to plans to develop cancer satellite centres that will be operated by MTW. The current plan is that the development will not be on either of the Trust's main sites. However, a contingency plan has been included in the DCP.

**The oncology centre at Maidstone is approaching 30 years old** and demand and pathways have changed considerably over that period
The long term estates strategy needs to acknowledge the requirement to expand and modernise each of the Centres functions. This will include:

**Radiotherapy linacs.** Currently 6 bunkers with linacs. **To future proof the service 3 additional bunker spaces could be needed in the short / medium term if East Kent project stalls.**

- If the East Kent goes ahead, **earmarking space for linac expansion is recommended**
- The draft East Kent design ( floor area) fits on the oncology car park and might include a storey above for other services

**Outpatient and Chemotherapy**
There is a possibility, depending on the recommendations of the regional oncology review by Carnall Farrar,, of increased chemotherapy and outpatient demand at the Maidstone site. It is possible that, subject to appropriate engagement, we also look to bring HODU (at the Pembury site) across to Maidstone to further streamline services and free up space in the Pembury site for other service provision.
This would require expansion of chemo and outpatient components and earmarking space in the Estates Development control Plan is strongly recommended
Outpatients are part of a wider review that is underway in the Trust, looking to establish the right level of outpatient capacity and build on lessons learned from Covid. An increase in clinic space above the current 8 rooms needs is to be expected.

**Administration**
Improved coordination across teams and administration of complex and time sensitive cancer pathways requires development of administration facilities
Pressure on administration support has required expansion of office space into a number of spaces in the Centre that are not intended for that purpose. For example in Block T, 15 office desks spaces are temporarily taking the place of Simulator Room, Simulator Control Room, Changing Room and Bereavement Support Room.
A solution to these and similar issues of non-clinical estates space is being developed as part of the Estates Strategy

**Patient Support Facilities**
A Maggie's Centre development is incorporated in the Estate Strategy.
Further patient support facilities to include; breaking bad news spaces , spaces for holistic and multidisciplinary care, space for education and group support.

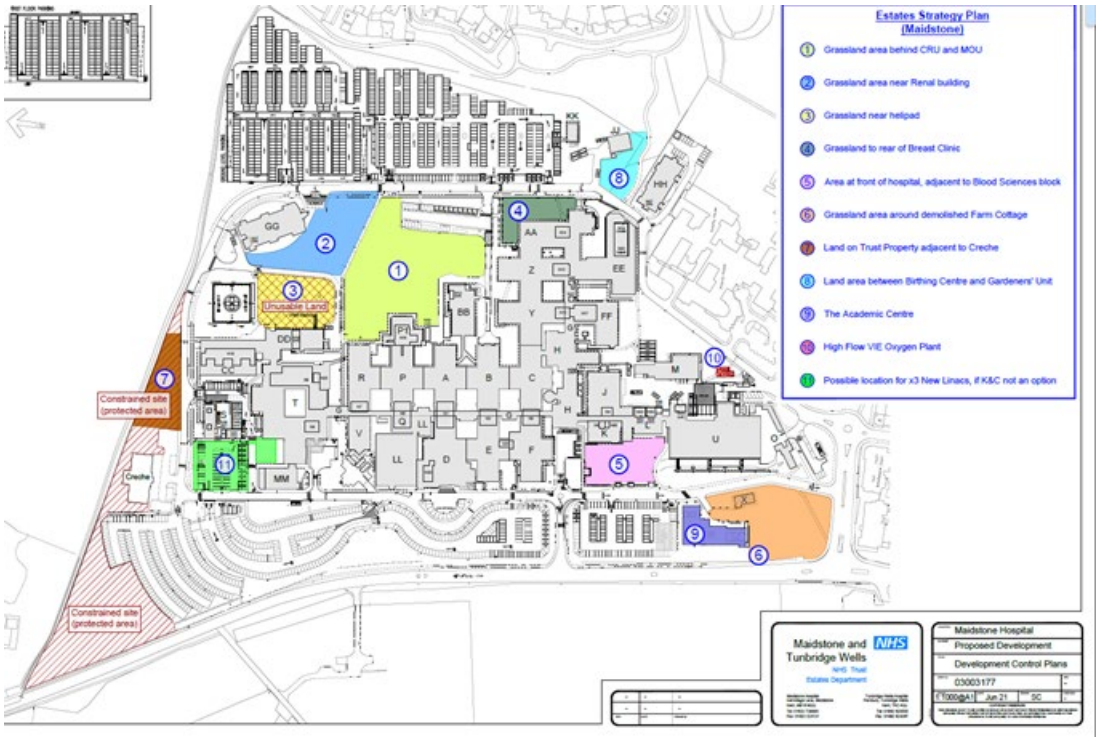
**Staff support**
The oncology centre staff require good quality facilities. This includes space for breaks, adequate kitchen / meeting facilities and fit for purpose office space.

**Note on East Kent Linacs at Canterbury/ Potential for expanding linac capacity at Maidstone**

- A joint project with East Kent Hospitals is underway looking at options to accommodate 3 linacs at Canterbury Hospital site
- If this project stalls or becomes unviable the demand could fall back to the main Maidstone oncology site
- The proposed 3 linac build design at Canterbury has an approximate floor area of 1870 m2 . This floor area has been transposed onto a **potential site at Maidstone to earmark a potential site for development in green**
- Within the MTW estates Development Control Plan a floor area this size has been identified on the small oncology car park which it is recommended be earmarked for potential future linac expansion.
- The design (taken from the East Kent project), has two floor above the linacs for outpatients, chemotherapy and offices. Three stories on the Maidstone site are unlikely

to get planning permission but a 2 story build may. The second floor could have space for outpatients/ chemotherapy / administration

**Potential site at Maidstone to earmark a potential site for oncology development (in green numbered 11)**




## 6.13 Clinical Strategy – Diagnostics

The diagnostics project is currently framed around an October 2020 strategic outline case (SOC) for *Radiology Clinical Strategy Magnetic Resonance Imaging and Cross-Sectional Reporting*. The SOC addresses severe capacity problems relating to MRI and is being developed in the context of important changes in national policy e.g. the Richard's Review which advocates segmentation of inpatient and emergency diagnostic from elective activity through the creation of CDH and '*Transforming imaging services in England: a national strategy for imaging networks*' (2019) which calls for the creation of imaging networks.

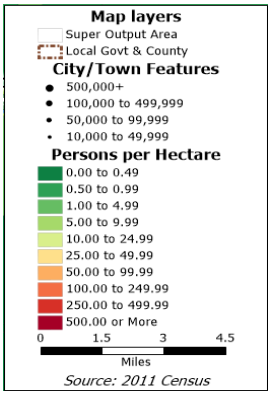
Through a managed service contract arrangement for MRI services refurbishment of the existing MRI facilities on both facilities will improve patient flow, whilst a dedicated off site MRI facility will be provided either in isolation or as part of a community diagnostic hub.

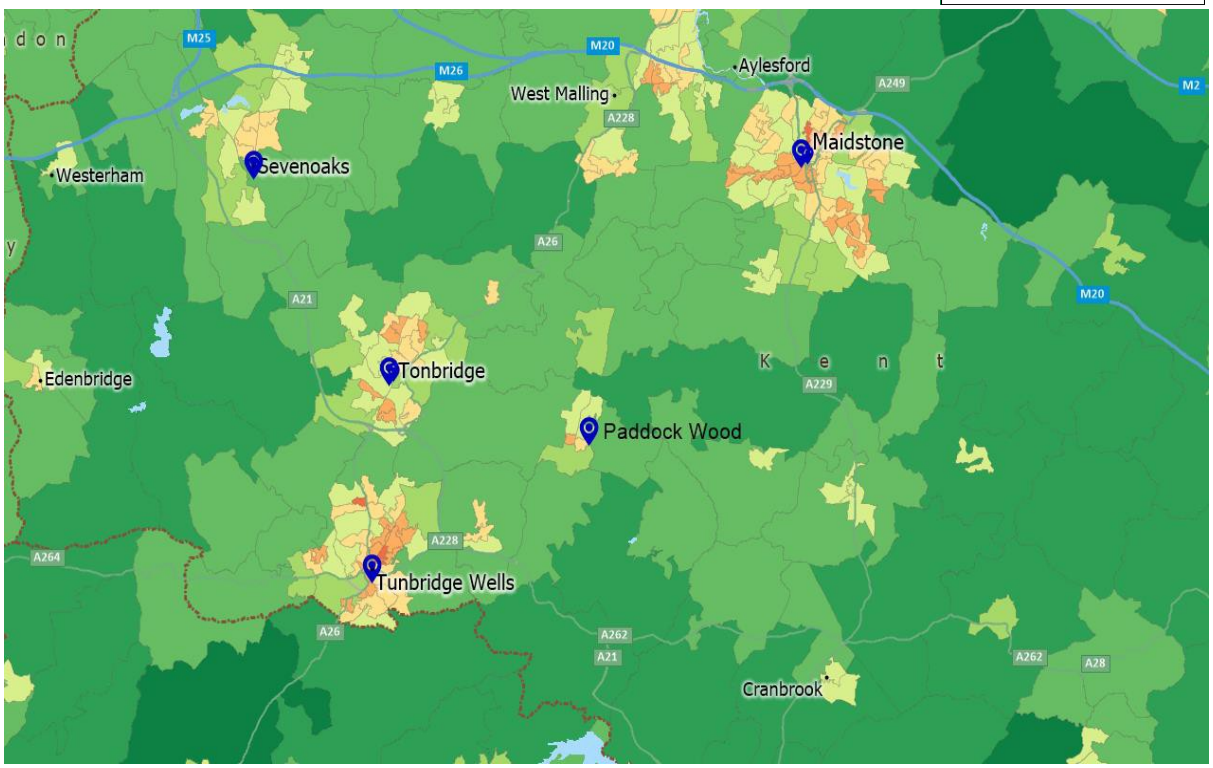
An MTW hosted community diagnostic hub will be built to serve the population of West Kent, with funding through the National CDH development scheme where MTW has submitted a

business case to be an early adopter. Potential locations for a CDH, and population density they would serve is shown below.

## Possible Locations for West Kent Community Diagnostic Hub

| Location | Area | Population | % of ICP |
|---|---|---|---|
| Maidstone | Maidstone | 113,137 | 24% |
| Royal Tunbridge Wells | Tunbridge Wells | 57,772 | 12% |
| Tonbridge | Tonbridge and Malling | 38,657 | 8% |
| Sevenoaks | Sevenoaks | 29,506 | 6% |
| Ditton | Tonbridge and Malling | 25,982 | 5% |
| Swanley | Sevenoaks | 16,226 | 3% |
| Hartley | Sevenoaks | 16,029 | 3% |
| Southborough | Tunbridge Wells | 11,138 | 2% |
| Snodland | Tonbridge and Malling | 10,211 | 2% |
| Edenbridge | Sevenoaks | 8,172 | 2% |
| Paddock Wood | Tunbridge Wells | 7,840 | 2% |
| 6 Towns | All | 4,000-7,500 | 9% |
| Other | Other | 95,966 | 21% |
| **Total** | | **464,000** | |




## 6.14 Post Covid recovery and reset– Non clinical space review

Responding to the lessons learned during the pandemic concerning the ability for staff to work from home or elsewhere balanced against the importance of staff being able to work from their

traditional place of work if they wish and for teams to come together, the Trust instigated a project to review the need for office and meeting space.

## 6.15 Post Covid recovery and reset – Outpatients review

Plans to re-develop outpatients facilities for MTW reflecting a shift towards virtual and non-face modalities and provide estate suitable for our future capacity needs are being developed.

## 6.16 Statutory compliance, risk management and backlog maintenance

The Trust will continue to invest capital funds in 'business as usual' projects to tackle compliance (e.g. Equalities Act compliance, fire safety and legionella projects), risk (e.g. roof repairs, electrical infrastructure upgrade works, upgrades to address PLACE inspection findings etc) and backlog maintenance. The six-facet survey identifies the Trust properties that require investment to bring buildings up to Condition B and to resolve statutory and fire safety compliance issues. The investments outlined above will resolve many of these issues, but where they remain, the Trust intends to invest approximately £2m per annum over the next ten years in a combination of statutory compliance, risk management and backlog maintenance projects.

# 7 Enablers

The estate strategy is an enabler of the MTW clinical and other strategies. At the same time there are dependencies with other strategies and plans. In this section we set out the changes that need to be made across the Trust to help enable delivery of this estate strategy.

## 7.1 Digital and agile working

The pandemic has demonstrated that it is possible to achieve a step change in way so working and how some services are delivered within a matter of days. Most employers including NHS providers, report a substantial shift to non-face to face delivery of consultations, which creates the opportunity to permanently alter the outpatient model. From an estate perspective this creates the further opportunity to reduce and repurpose existing outpatient areas and to introduce more generic consulting rooms (see below for discussion of 'shared space'. The enablers for this change will be cultural change (see below) and technology. Investment in digital is likely to be required because the increase in non-face to face contacts has sometimes been due to greater use of traditional phone calls as opposed to online/ app-based consultations.

Agile working is being encouraged across many Trust services as a way of driving flexibility amongst the workforce but also to manage constraints associated with the estate and the social distancing measures that have been invoked to counter the pandemic.

The success of agile working has varied with some locations having fully embraced it and benefited from it, while other locations still experience pressure on desk space. A ratio of one desk to two employees has been introduced for some staff groups by Trusts, others have adopted a specific approach of desk sharing, whereby specific staff members, on a rota basis operate from a defined, shared desk space. As the legacy impact of the pandemic is identified across a range of sectors, the Trust's approach to agile working will be developed to provide the most appropriate sustainable response.

The wider system estate-based plans to create hubs will also reduce demand for outpatient space at the Trust's hospitals but will also require investment in technology to create digital links to clinicians based in the two hospitals.

A permanent shift to flexible part homeworking should reduce the amount of office space required, however it could require some further investment in digital.

## 7.2 Partnership working

The trust will continue to work with partners to make the best use of the public-sector estate, looking for opportunities for rationalisation and improvement that benefit the entire public sector and not just the trust.

## 7.3 Culture

This strategy will only work if the trust can change the way it works and the culture across the organisation. Simply investing in new and improved buildings is not enough; the culture of the organisation must change to promote the concept of 'shared space'. For example, eliminating the view that a particular area of a building belongs to one service or another and replacing it

with the appreciation that all buildings will need to be accessible to all services. This concept will need to extend to clinic rooms, meeting rooms, individual offices and desks.

# 8 Conclusions

The Trust inherited an estate in varying condition much of which was not fit for purpose. The commissioning of the Tunbridge Wells Hospital represented a step change in the quality and functional suitability of the estate when it was opened. This key site remains in a good condition, however, the many elements of the Trust's larger hospital in Maidstone is ageing and has reached the point where it needs significant refurbishment. The challenge of doing so whilst running a fully operational site cannot be under-estimated. Maidstone is also the planned location for some important developments such as the HASU and cardiology expansion making it the likely focus of investment for the next five to ten years. This estate strategy represents the Trust's initial response to the clinical strategy and will need to be refreshed as plans become clearer particularly in light of emerging estate-related lessons from Covid.

## Annexes

The following annexes are available under separate cover and have been used to inform this strategy.

Annex One – MTW Sustainable Development Management Plan 2019

## Appendices

Appendix One - Aerial views of owned and leased properties (available under separate cover)

Appendix Two – six facet definitions

Appendix Three – Six facet survey executive summary (available under separate cover)

Appendix Four – ERIC return

## Appendix Two – six facet definitions

Physical Condition

A As new and can be expected to perform adequately to its full normal life.

B Sound, operationally safe and exhibits only minor deterioration.

B(C) Sound, operationally safe and exhibits only minor deterioration, but will fall below B within five-years.

C Operational but major repair is currently needed to bring up to condition B.

D Operationally unsound and in imminent danger of breakdown; Repair

CX Operational but major replacement is currently needed to bring up to condition B.

DX Operationally unsound and in imminent danger of breakdown; Replace.

Statutory Compliance

A Complies fully with fire and statutory safety regulation.

B Complies with all necessary fire and statutory safety legislation with minor deviations of a non-serious nature.

B(C) Complies with all necessary fire and statutory safety legislation with minor deviations of a non-serious nature, but will fall below B within five-years as a consequence of unabated deterioration or knowledge of impending legislation.

C Contravention of one or more mandatory fire safety requirements and statutory safety legislation, which falls short of B.

D Dangerously below condition B

Quality

A A facility of excellent quality

B A facility requiring general maintenance investment only.

C A less than acceptable facility requiring capital investment.

CX A less than acceptable facility requiring capital investment; Nothing but a total rebuild, or relocation will suffice.

D A very poor facility requiring significant capital investment or replacement.

DX A very poor facility requiring significant capital investment or replacement; Nothing but a total rebuild, or relocation will suffice.

Environmental Management

A 35-55 GJ per 100m3

B 56-65 GJ per 100m3

C 66-75 GJ per 100m3

CX 66-75 GJ per 100m3

D 76-100 GJ per 100m3

DX 76-100 GJ per 100m3

Functional Suitability

A Very satisfactory, no change needed.

B Satisfactory, minor change needed.

C Not satisfactory, major change needed.

CX Not satisfactory, major change needed; Nothing but a total rebuild, or relocation will suffice.

D Unacceptable in its present condition

DX Unacceptable in its present condition; Nothing but a total rebuild, or relocation will suffice.

Space Utilisation

O Overcrowded, overloaded and facilities generally over-stretched.

F A satisfactory level of utilisation

U Generally under-used, utilisation could be significantly increased.

E Empty or grossly under-used at all times (excluding temporary closure)

## Appendix Four – ERIC return

TrustDataReport.xlsx

NHS Maidstone and Tunbridge Wells NHS Trust

**Quarterly mortality data** **Medical Director**

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

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

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

# Mortality Surveillance Group Report

## August 2021

MTW
exceptional people, outstanding care

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NHS
Maidstone and Tunbridge Wells
NHS Trust


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- CUSUM Alerts — Page 6
- Observed vs Expected Mortality — Page 7
- HSMR Weekend/Weekday Comparison — Page 8-9
- Deaths with Zero Comorbidities — Pages 10-11
- Deaths in Low Risk Diagnosis Groups — Page 12
- Covid Mortality — Page 13
- SHMI Overview — Page 14
- SHMI Contextual Indicator Exception Reporting — Page 15-16
- Clinical Coding Update — Page 17


*Note: Detailed analysis and a deep dive into specific areas are available on request - mtw-tr.informationdepartment@nhs.net*

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# Executive Summary

Maidstone and Tunbridge Wells NHS Trust

- Due to DQ issues with HES Data, T Health (Dr Foster) are currently a month further behind in their data. This is being rectified in their next submission (August 25th)
- HSMR has increased from previous month as we continue into wave 2 of Covid in the dataset – Rolling HSMR currently at **93.2** and still performing well against the standard ratio of 100, currently in the "Low" bracket.
- Monthly HSMR shows an decrease in February 21 (**87.3**), as we move out of wave 2 of Covid.
- As a Trust we continue to perform well amongst our local peers as well as those trusts rated Good or Outstanding by the CQC
- The latest reporting month saw **no** CUSUM alerts
- Deaths with no comorbidities continue reducing on a rolling 12 month basis. Those deaths with no comorbidities focussed on Geriatric and General Medicine
- Covid HSMR for the Trust is higher than our Kent peers, with investigations as to the driver of this continuing
- Trust SHMI continues to perform in the green for the 9th month running

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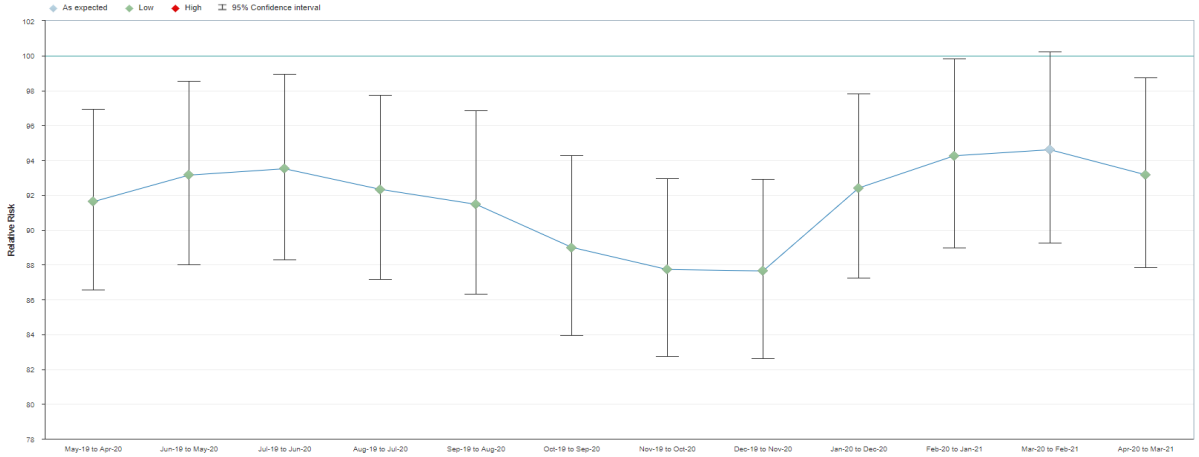
# HSMR Overview

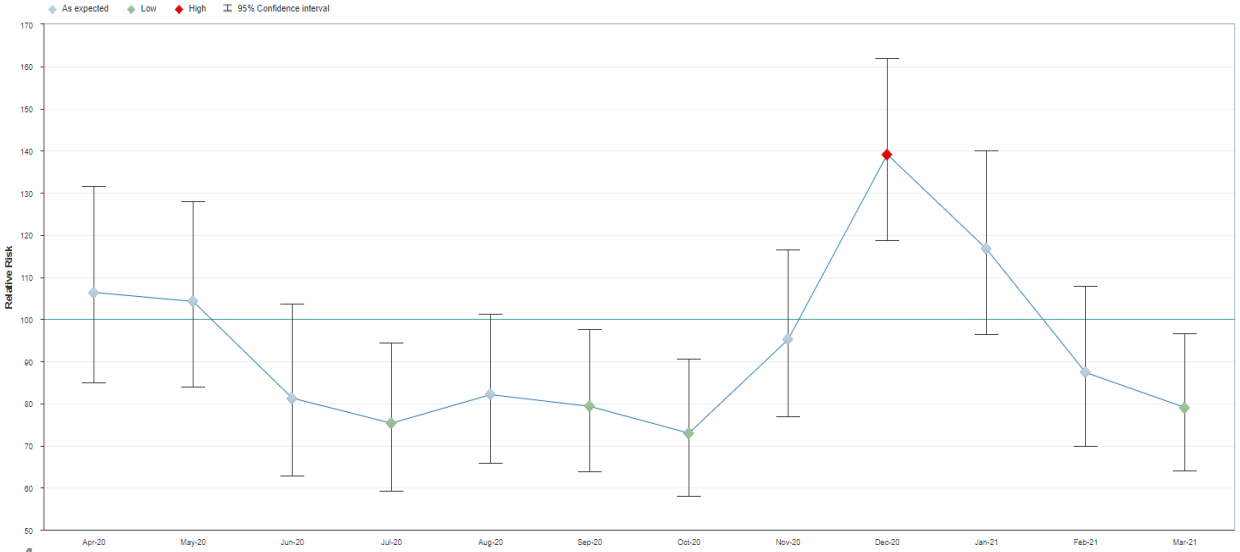
Maidstone and Tunbridge Wells NHS Trust

## Rolling 12 Months




The 12 months **April 2020 to March 2021** show our HSMR to be **93.2**, which is lower than last month's figure of 94.6 and moving into the "Low" bracket of performance

## Monthly View




The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so **February 2021** in this case, shows that the Trust's position has **decreased** to **87.3** from 116.7 in January 2021. This decrease puts the HSMR within the "as expected" bracket.

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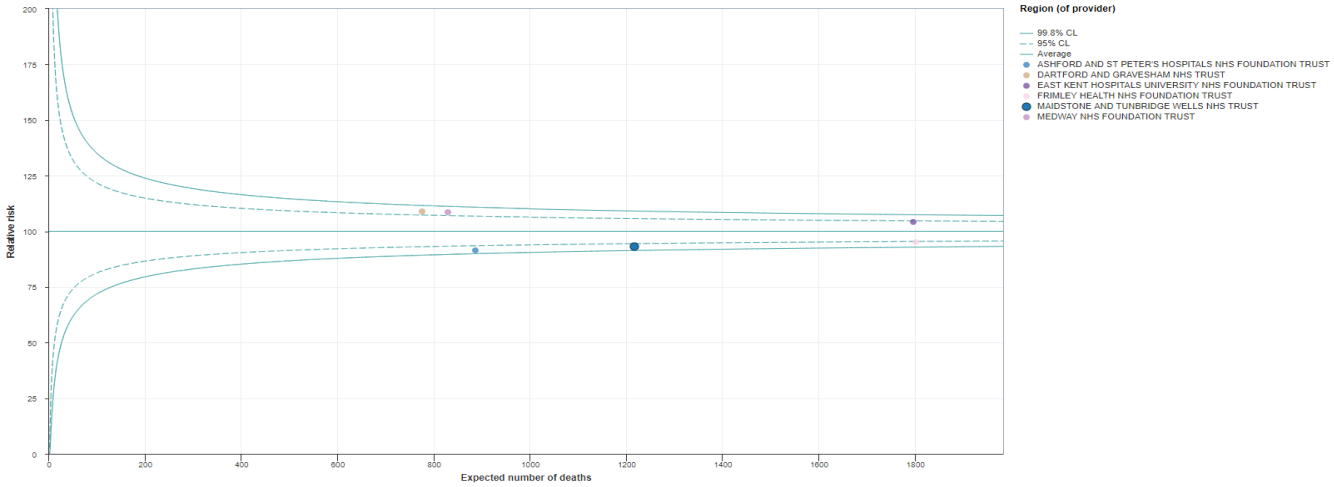
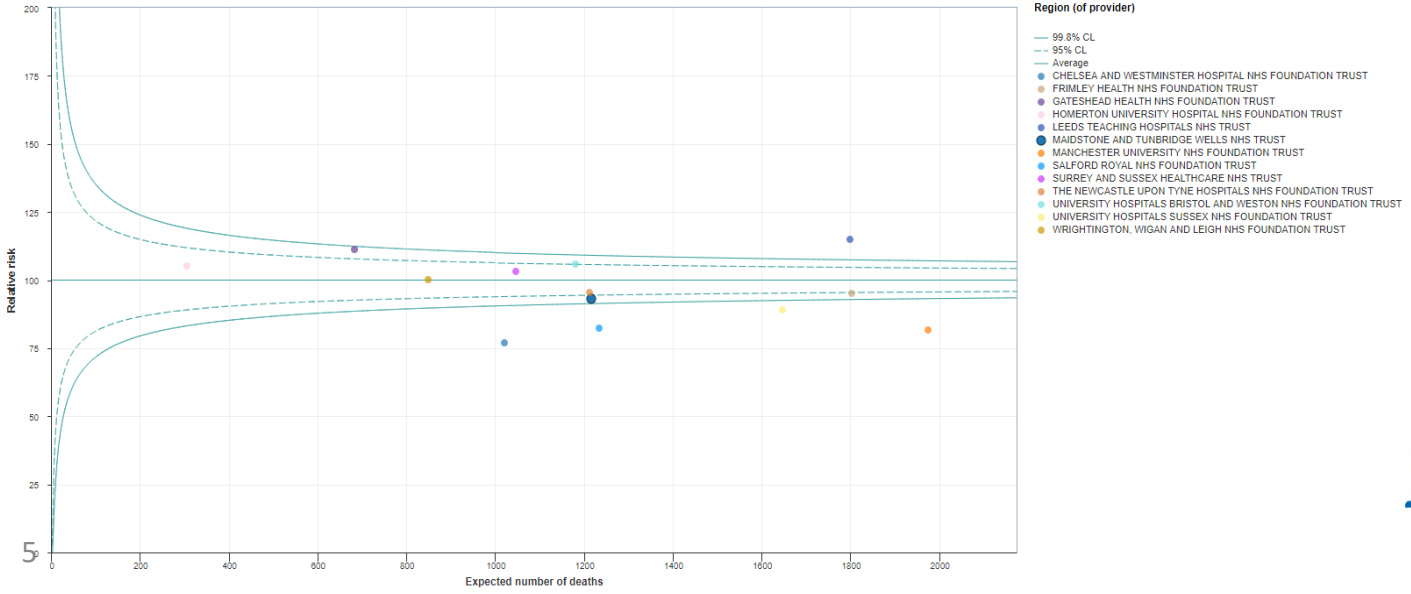
# HSMR – Benchmarking

Maidstone and Tunbridge Wells NHS Trust

## Kent Peers




## Good & Outstanding Trusts




MTW continues to perform well both amongst it's local peers as well as with Good & Outstanding performing Trusts

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# CUSUM Alerts - Overview

NHS
Maidstone and Tunbridge Wells NHS Trust

**Relative risk & CUSUM alerts**

| Title | CUSUM | Vol | Obs | Exp | % | Relative risk | Trend | LOS | Readm. | Peers |
|---|---|---|---|---|---|---|---|---|---|---|
| **All Diagnoses** | 2 6 | 107942 | 1854 | 1711.3 | 1.7 | 108.3 | | | | |
| HSMR (56 diagnosis groups) | 9 2 | 42174 | 1153 | 1213.0 | 2.7 | 95.1 | | | | |
| Asthma | 1 | 224 | 6 | 1.1 | 2.7 | 548.8 | | | | |
| Fluid and electrolyte disorders | | 541 | 30 | 19.6 | 5.5 | 153.1 | | | | |
| Pneumonia | 1 2 | 1217 | 184 | 154.2 | 15.1 | 119.3 | | | | |
| Septicemia (except in labour) | 1 | 737 | 153 | 117.1 | 20.8 | 130.7 | | | | |
| Skin and subcutaneous tissue infections | 1 | 1552 | 25 | 14.1 | 1.6 | 177.4 | | | | |
| Viral infection | 34 | 1990 | 461 | 210.5 | 23.2 | 219.0 | | | | |
| **All Procedures** | 2 7 | 75037 | 1282 | 1222.2 | 1.7 | 104.9 | | | | |
| Diagnostic imaging (except heart) | 6 4 | 12593 | 460 | 465.3 | 3.7 | 98.9 | | | | |
| Extirpation of lesion of external ear | 1 | 6 | 1 | 0.0 | 16.7 | 8028.9 | | | | |
| Other drainage of peritoneal cavity | 1 | 320 | 30 | 19.0 | 9.4 | 158.2 | | | | |
| Rest of Upper GI | 1 8 | 848 | 212 | 152.0 | 25.0 | 139.4 | | | | |
| Surgical arrest of bleeding from internal nose | 1 | 51 | 2 | 0.5 | 3.9 | 429.6 | | | | |
| Total excision of kidney | 1 | 5 | 1 | 0.0 | 20.0 | 3715.1 | | | | |
| Urethral catheterisation of bladder | 1 | 1063 | 122 | 93.3 | 11.5 | 130.8 | | | | |

**Highest observed exceeding expected**

| Title | Rel. risk | Vol | Obs | Exp | O-E |
|---|---|---|---|---|---|
| Viral infection | 219.0 | 1990 | 461 | 210.5 | 250.5 |
| Rest of Upper GI | 139.4 | 848 | 212 | 152.0 | 60.0 |
| Septicemia (except in labour) | 130.7 | 737 | 153 | 117.1 | 35.9 |
| Pneumonia | 119.3 | 1217 | 184 | 154.2 | 29.8 |
| Urethral catheterisation of bladder | 130.8 | 1063 | 122 | 93.3 | 28.7 |

**Highest crude rates**

| Title | Rel. risk | Vol | Obs | % |
|---|---|---|---|---|
| Aortic and peripheral arterial embolism or thrombosis | 237.2 | 8 | 3 | 37.5 |
| Spinal cord injury | 292.4 | 3 | 1 | 33.3 |
| Cardiac arrest and ventricular fibrillation | 50.2 | 29 | 8 | 27.6 |
| Peripheral and visceral atherosclerosis | 132.9 | 66 | 18 | 27.3 |
| Amputation of leg | 444.0 | 4 | 1 | 25.0 |

As the data moves out of wave 2 of Covid we a see the latest month has no CUSUM alerts

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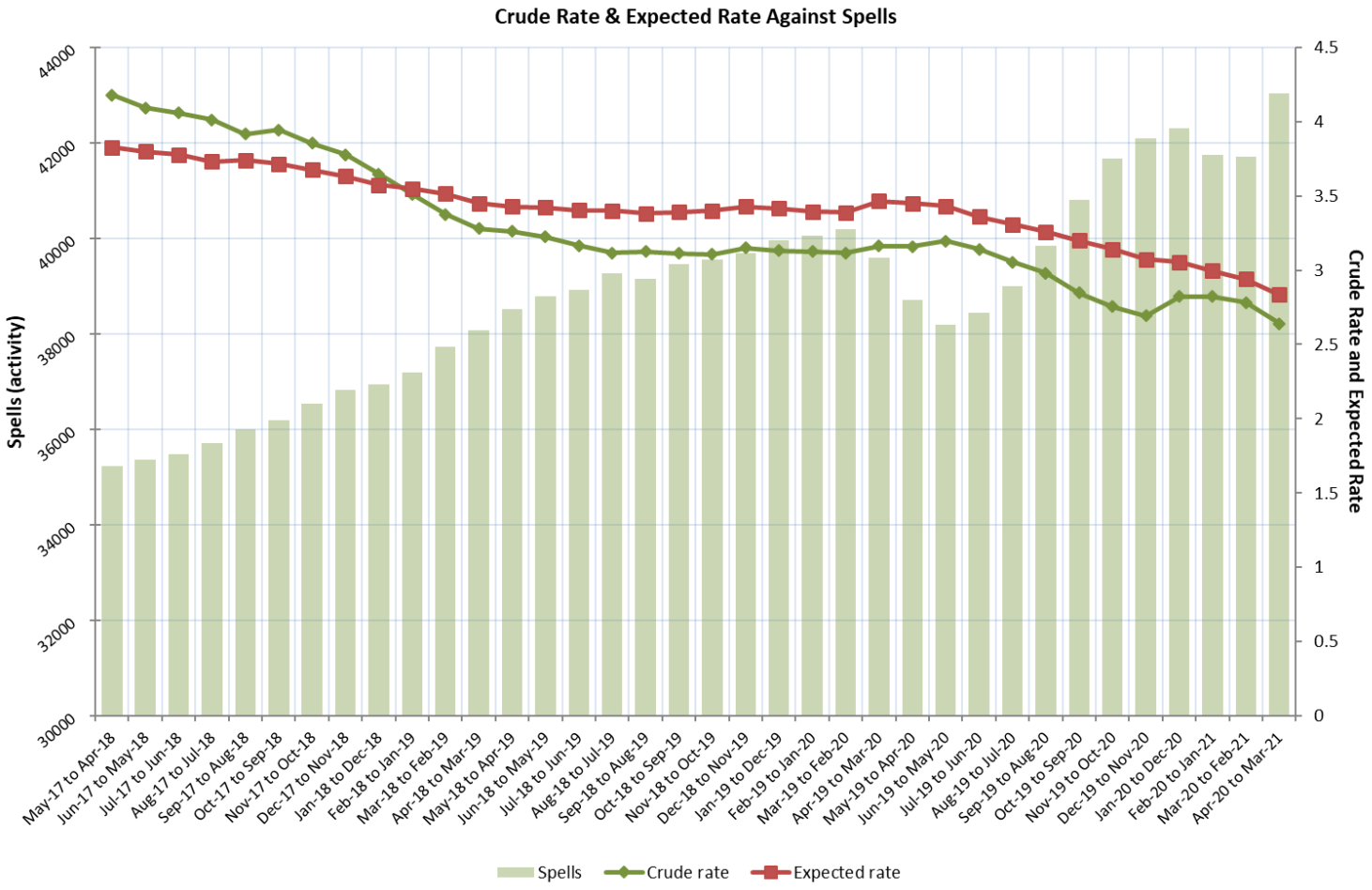
# Crude & Expected Rate Against Spell Comparison

Maidstone and Tunbridge Wells NHS Trust




Crude and Expected Rates continue to improve. Spells increase as we move out of wave 2.

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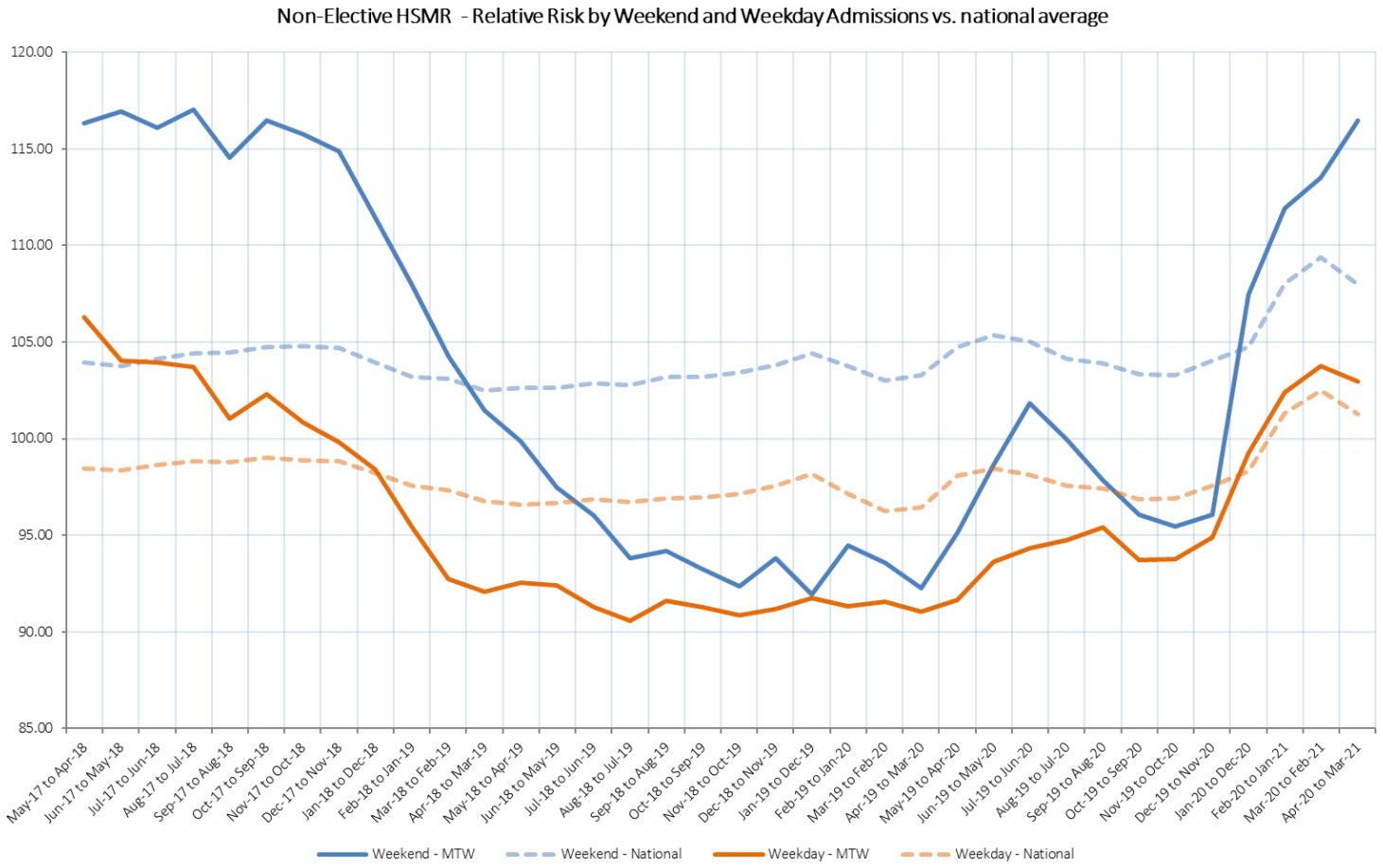
# HSMR – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust




Weekend and Weekday HSMR for non-elective care continue to be above the national average. **Weekend** figures in particular have a larger gap with the national average for the period of **Apr 20 – Mar 21** compared national figures with a relative risk of **116.47** vs **107.99** nationally.

Whilst HSMR does not include Covid, the increase parallels the prevalence of the Kent variant of Covid is a potential contributing factor for being above the national average.

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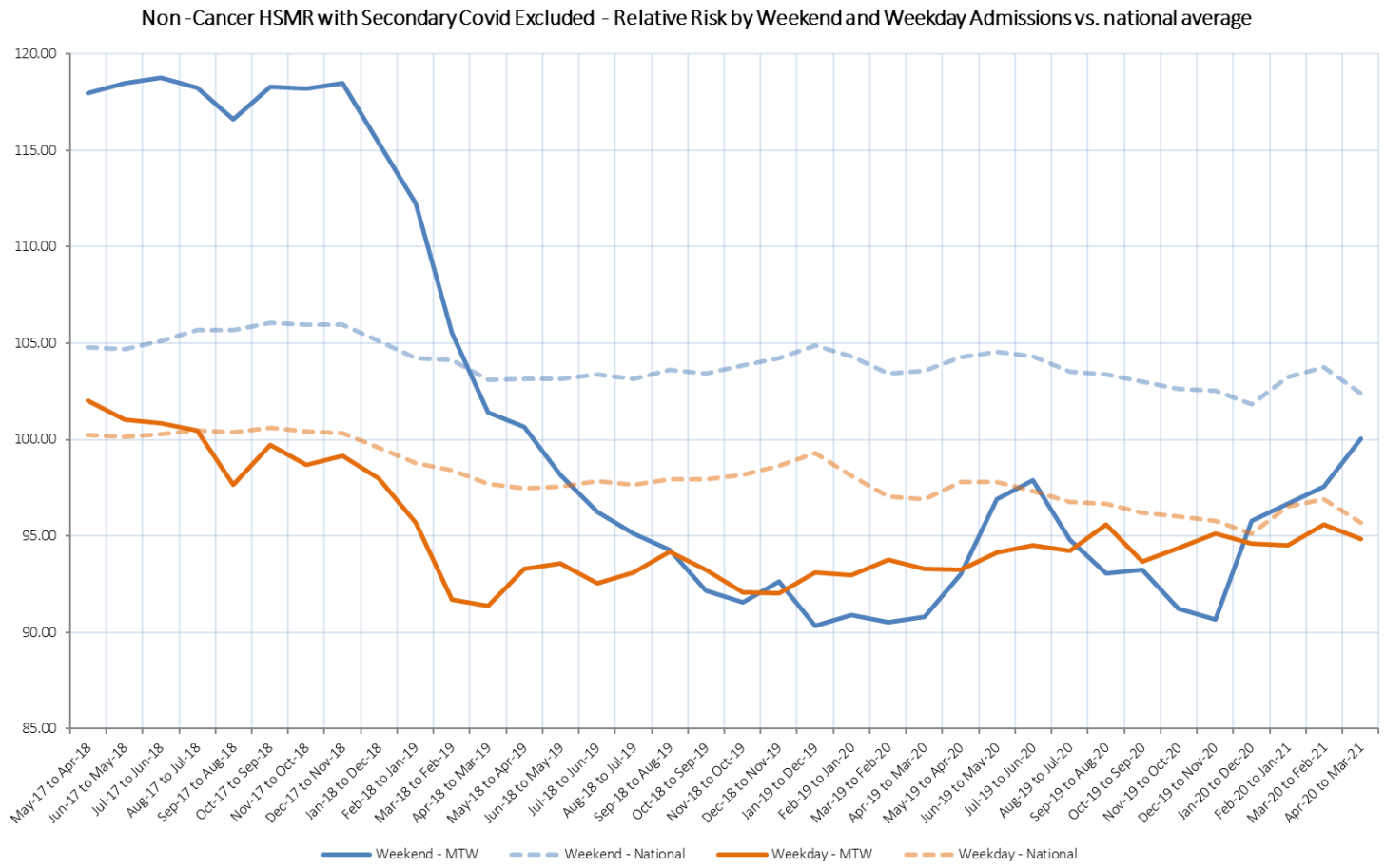
# HSMR – Weekend & Weekday Comparison – Cancer & Covid Exclusions

Maidstone and Tunbridge Wells NHS Trust




A deep dive into the drivers behind Weekend HSMR revealed an impact from being an Oncology Centre as well as secondary Covid diagnoses (increased by the Kent variant).

Excluding cancer and secondary Covid diagnoses show the trust favourably against the national rate, though weekend mortality is closer to national average

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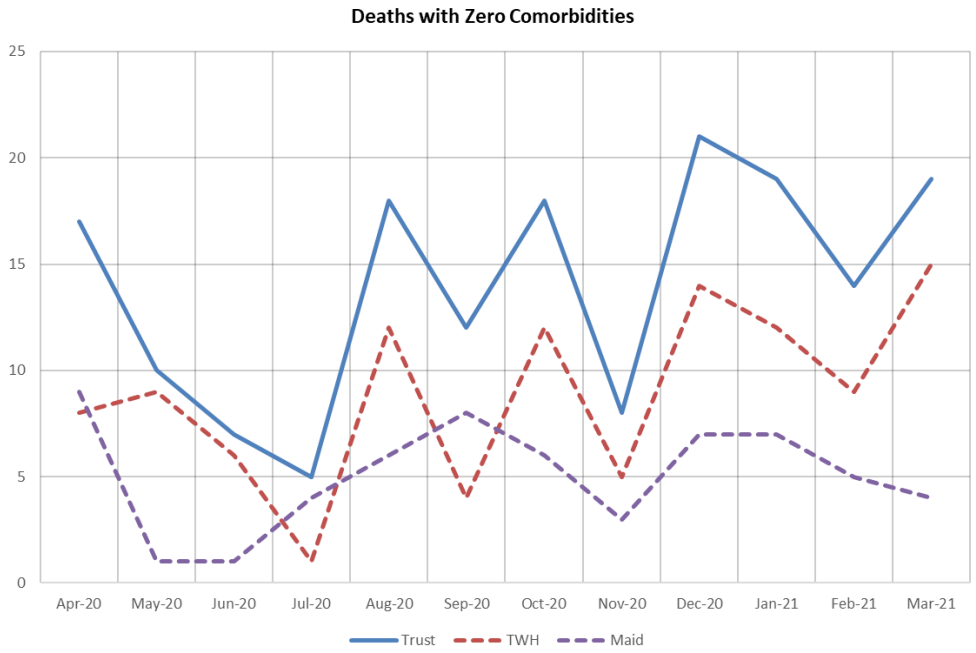
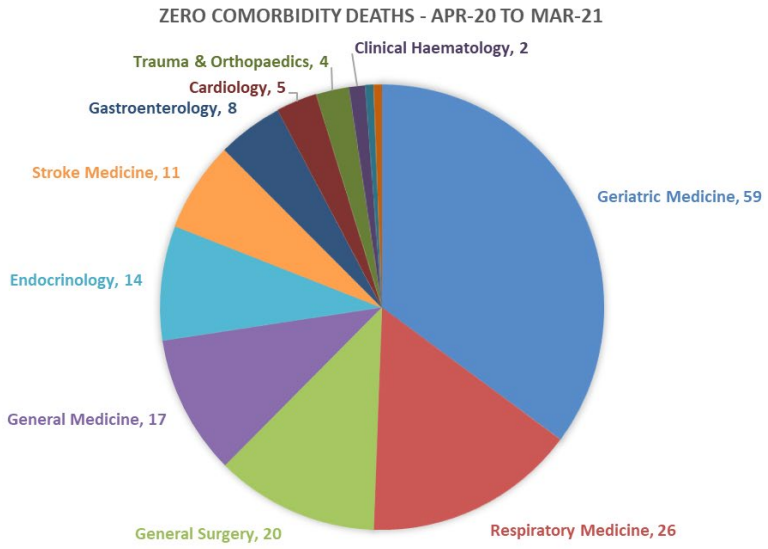
# Deaths with Zero Comorbidities




| Month | Trust | TWH | % | Maid | % |
|---|---|---|---|---|---|
| Apr-20 | 17 | 8 | 47.1 | 9 | 52.9 |
| May-20 | 10 | 9 | 90.0 | 1 | 10.0 |
| Jun-20 | 7 | 6 | 85.7 | 1 | 14.3 |
| Jul-20 | 5 | 1 | 20.0 | 4 | 80.0 |
| Aug-20 | 18 | 12 | 66.7 | 6 | 33.3 |
| Sep-20 | 12 | 4 | 33.3 | 8 | 66.7 |
| Oct-20 | 18 | 12 | 66.7 | 6 | 33.3 |
| Nov-20 | 8 | 5 | 62.5 | 3 | 37.5 |
| Dec-20 | 21 | 14 | 66.7 | 7 | 33.3 |
| Jan-21 | 19 | 12 | 63.2 | 7 | 36.8 |
| Feb-21 | 14 | 9 | 64.3 | 5 | 35.7 |
| Mar-21 | 19 | 15 | 78.9 | 4 | 21.1 |
| **All** | **168** | **107** | 63.7 | **61** | 36.3 |

We can see that the number of deaths with zero comorbidities has increased as wave 2 of Covid continued. Of the **1,133** deaths recorded in the period of **April 2020 to March 2021**, **168** had no comorbidities recorded (**14.83%**). This rolling annual figure has dropped from last month.

# Deaths with Zero Comorbidities – By Specialty

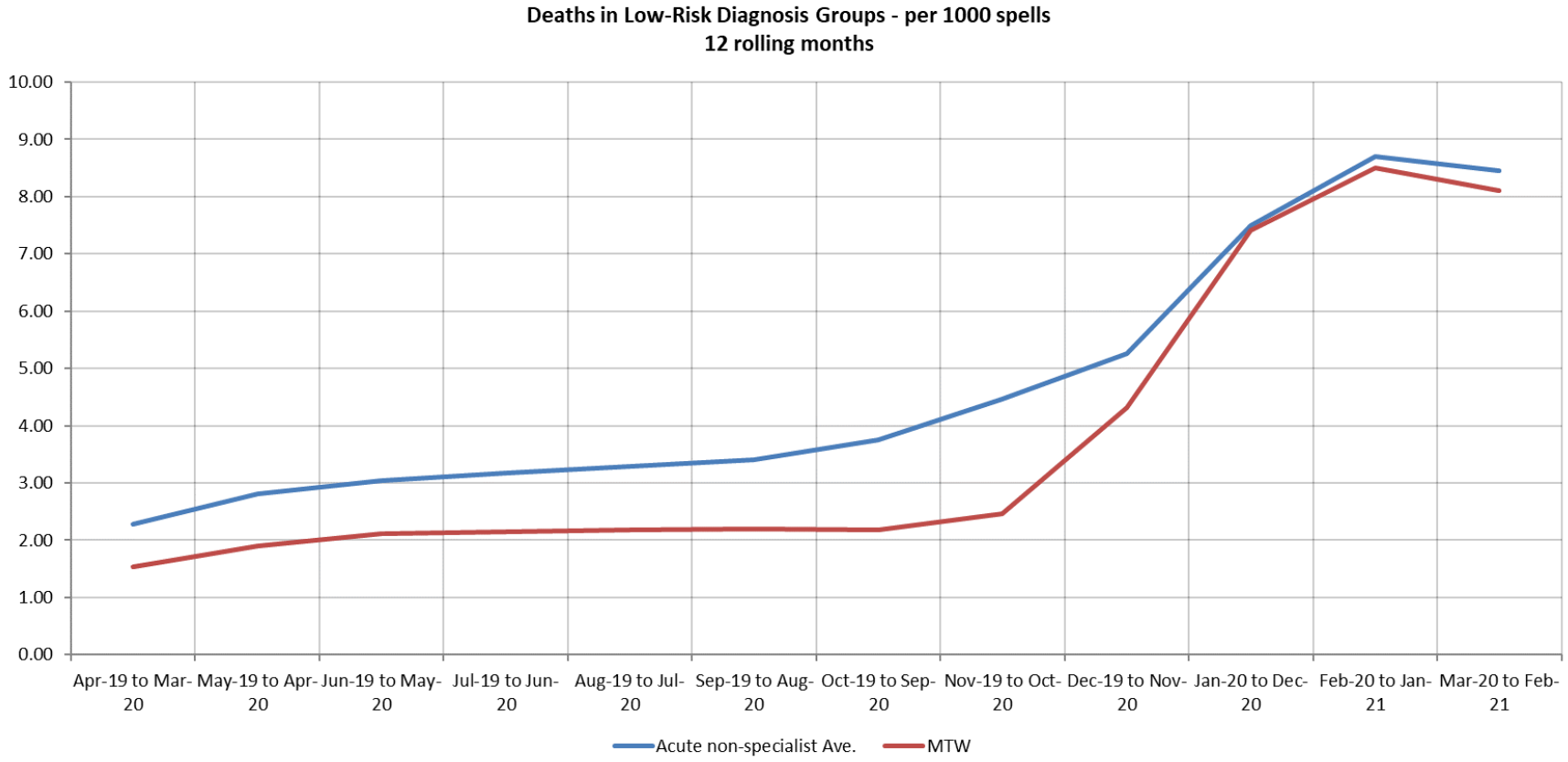



| | Feb-20 Jan-21 | | Mar-20 Feb-21 | | Apr-20 Mar-21 | |
|---|---|---|---|---|---|---|
| **Specialty (of discharge)** | **Deaths** | **%age** | **Deaths** | **%age** | **Deaths** | **%age** |
| Geriatric Medicine | 58 | 33% | 53 | 31% | 59 | 35% |
| Respiratory Medicine | 31 | 17% | 30 | 17% | 26 | 15% |
| General Medicine | 21 | 15% | 20 | 12% | 17 | 10% |
| General Surgery | 16 | 9% | 19 | 11% | 20 | 12% |
| Stroke Medicine | 14 | 9% | 14 | 8% | 11 | 7% |
| Gastroenterology | 12 | 5% | 9 | 5% | 8 | 5% |
| Endocrinology | 14 | 3% | 13 | 8% | 14 | 8% |
| Cardiology | 4 | 2% | 5 | 3% | 5 | 3% |
| Clinical Haematology | 3 | 1% | 3 | 2% | 2 | 1% |
| Trauma & Orthopaedics | 6 | 2% | 5 | 3% | 4 | 2% |
| Anaesthetics | 2 | 1% | 1 | 1% | 1 | 1% |
| Accident & Emergency | 0 | 1% | | 0% | | 0% |
| Paediatrics | 0 | 0% | | 0% | | 0% |
| Neonatology | 0 | 0% | | 0% | | 0% |
| Gynaecology | 1 | 0% | 1 | 1% | 1 | 1% |
| Urology | 0 | 0% | | 0% | | 0% |
| Obstetrics | 0 | 0% | | 0% | | 0% |
| **All** | 182 | | 173 | | 168 | |

Trends continue month on month, with over half of the deaths with zero comorbidities being in the **Geriatric and Respiratory Medicine specialties**. The overall figures are showing a drop in volumes of deaths with zero comorbidities

# Deaths in Low Risk Groups

Maidstone and Tunbridge Wells NHS Trust




As a Trust we continue to be below our peers in acute, non-specialist Trusts in Deaths in Low diagnosis groups per 1000 spells, with the Narrow gap seen in wave 2 widening.

The volume of deaths in low risk diagnosis groups has dropped to **285; 264** of these are attributed to Covid

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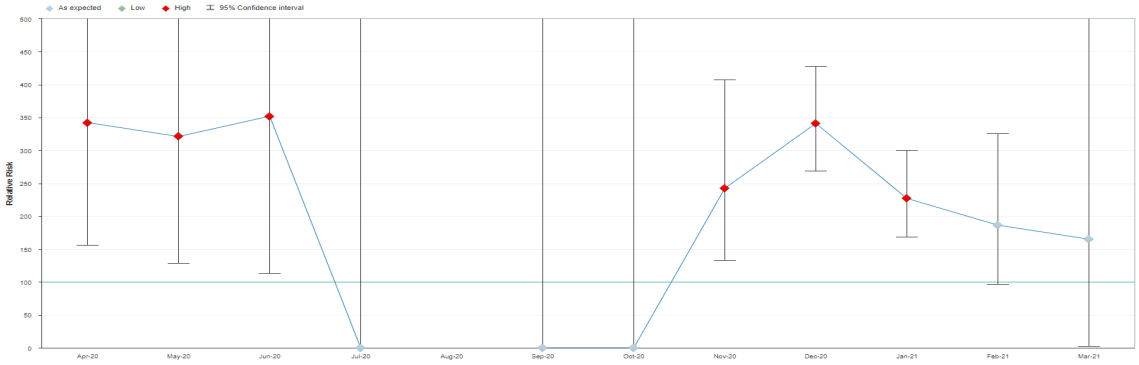
# Covid 19 Mortality

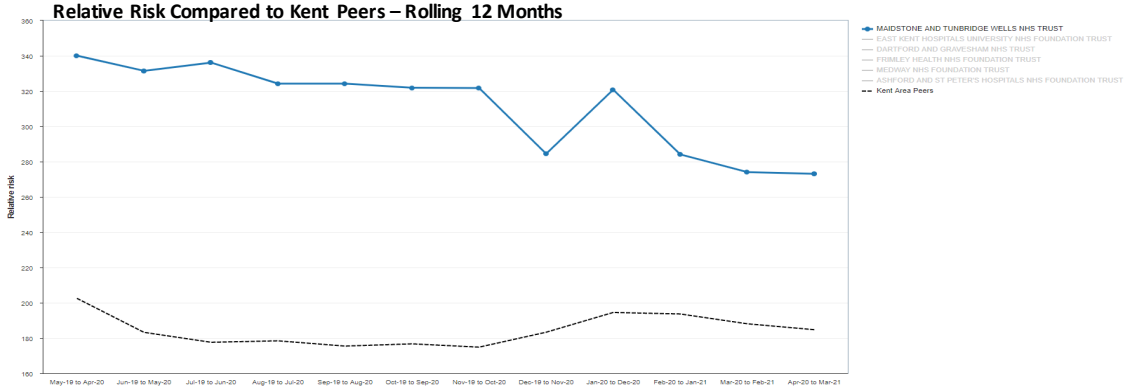
Maidstone and Tunbridge Wells NHS Trust

**Monthly Relative Risk for Covid Diagnoses**



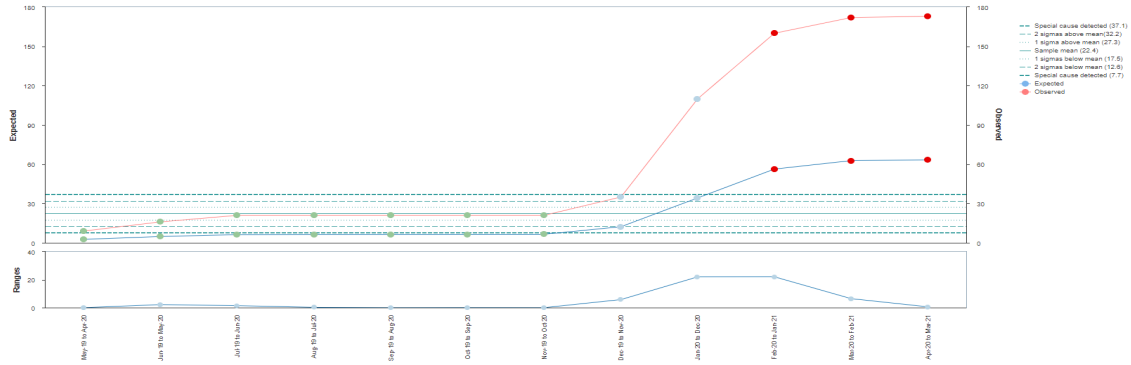

Relative Risk shows the Trust continuing to be "as expected" for Covid deaths in March. The benchmark is of course very unstable and is rebuilt each month by Dr Foster

**Relative Risk Compared to Kent Peers – Rolling 12 Months**




Our Relative Risk continues to be higher than that of our Kent peers at **273.1** against 184.7. The next data upload will see if the trend continues after the 2nd wave.

**Expected Deaths against Observed Deaths – Rolling 12 months**




We can see that as wave 2 of Covid closed, our Observed Covid deaths is continued to be higher than Expected deaths.

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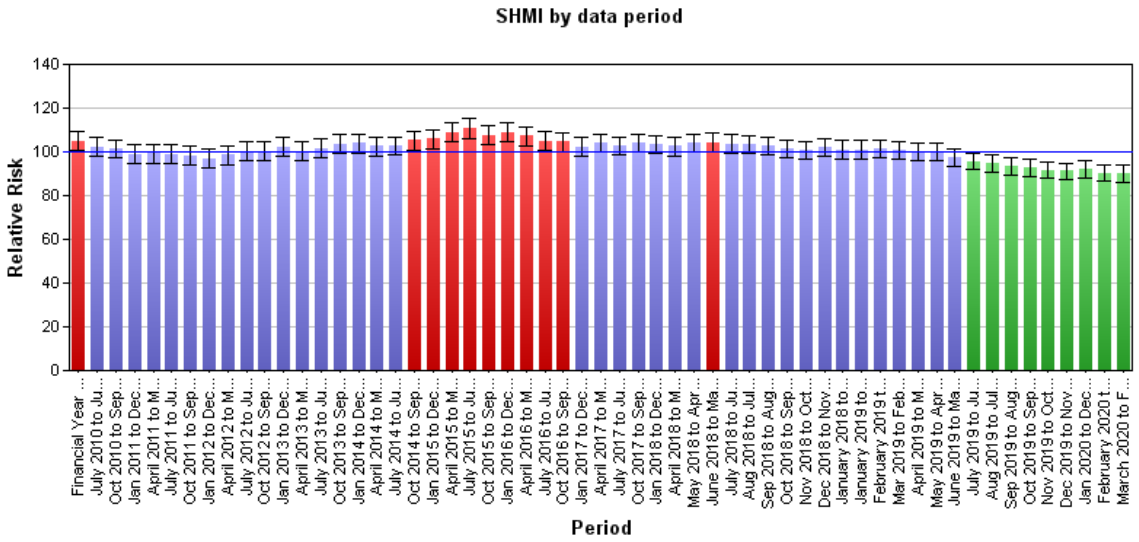
# SHMI




As a Trust, our SHMI continues to be favourable, with a 9th month running being a positive outlier for the period of Mar-20 to Feb-20.

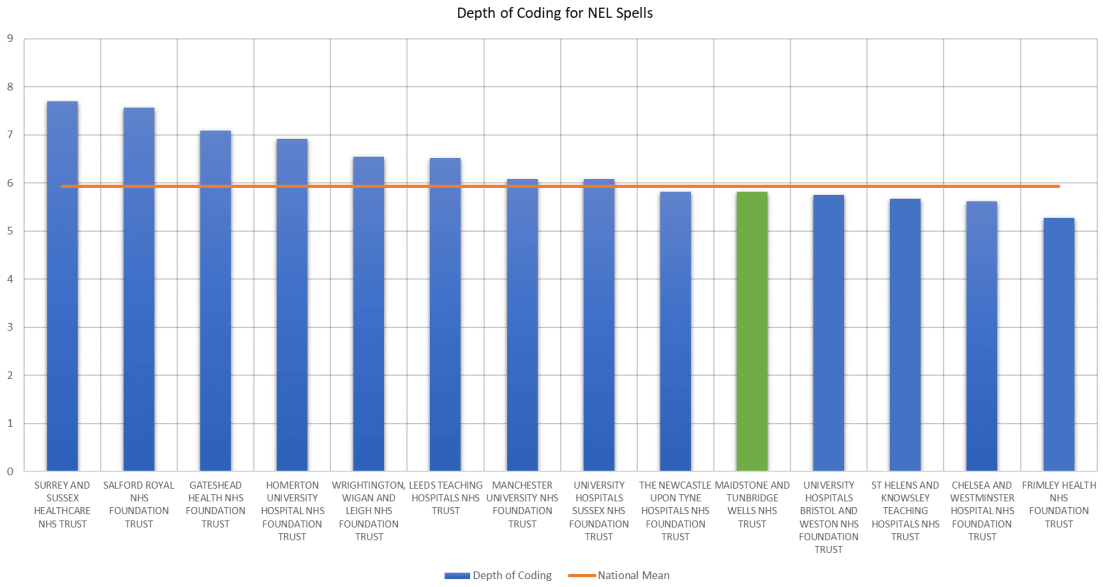
## SHMI contextual indicators

| Indicator | Value | England average |
|---|---|---|
| **Palliative care** | | |
| Percentage of provider spells with palliative care treatment specialty coding | 0.0 | 0.1 |
| Percentage of provider spells with palliative care diagnosis coding | 1.9 | 1.8 |
| Percentage of provider spells with palliative care coding | 1.9 | 1.8 |
| Percentage of deaths with palliative care treatment specialty coding | 0.0 | 2.0 |
| Percentage of deaths with palliative care diagnosis coding | 43.0 | 36.0 |
| Percentage of deaths with palliative care coding | 43.0 | 37.0 |
| **Admission method** | | |
| Crude percentage mortality rate for elective admissions | 1.0 | 1.0 |
| Crude percentage mortality rate for non-elective admissions | 3.3 | 3.5 |
| **In and out of hospital deaths** | | |
| Percentage of deaths which occurred in hospital | 62.0 | 69.0 |
| Percentage of deaths which occurred outside hospital within 30 days of discharge | 38.0 | 31.0 |

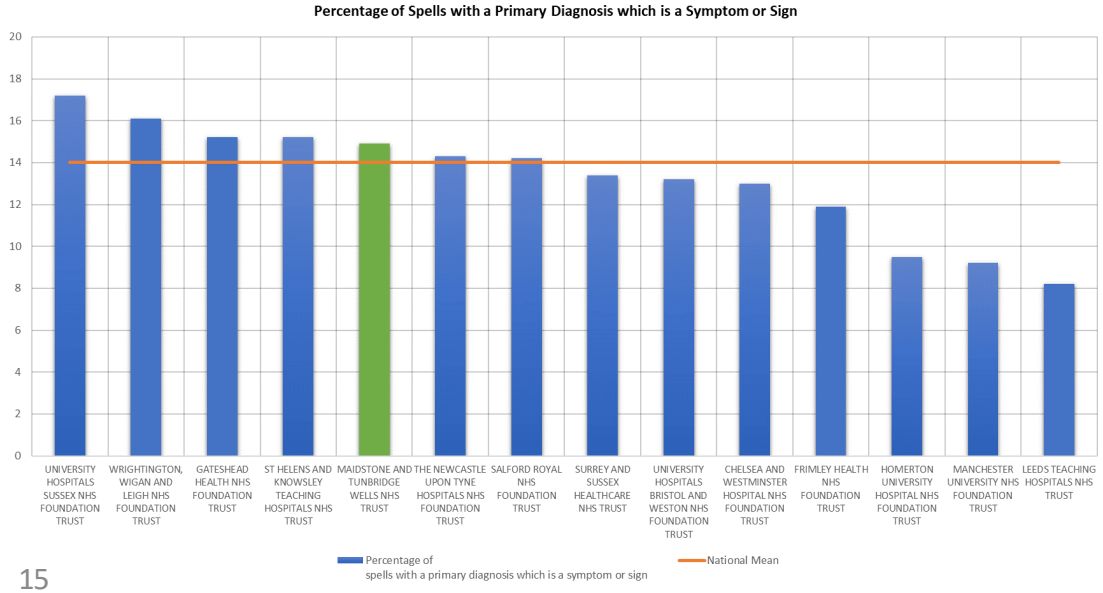
Within the contextual indicators, we continue to be an organisation with fewer deaths in hospital

SHMI Reporting Link

# SHMI – Contextual Indicators



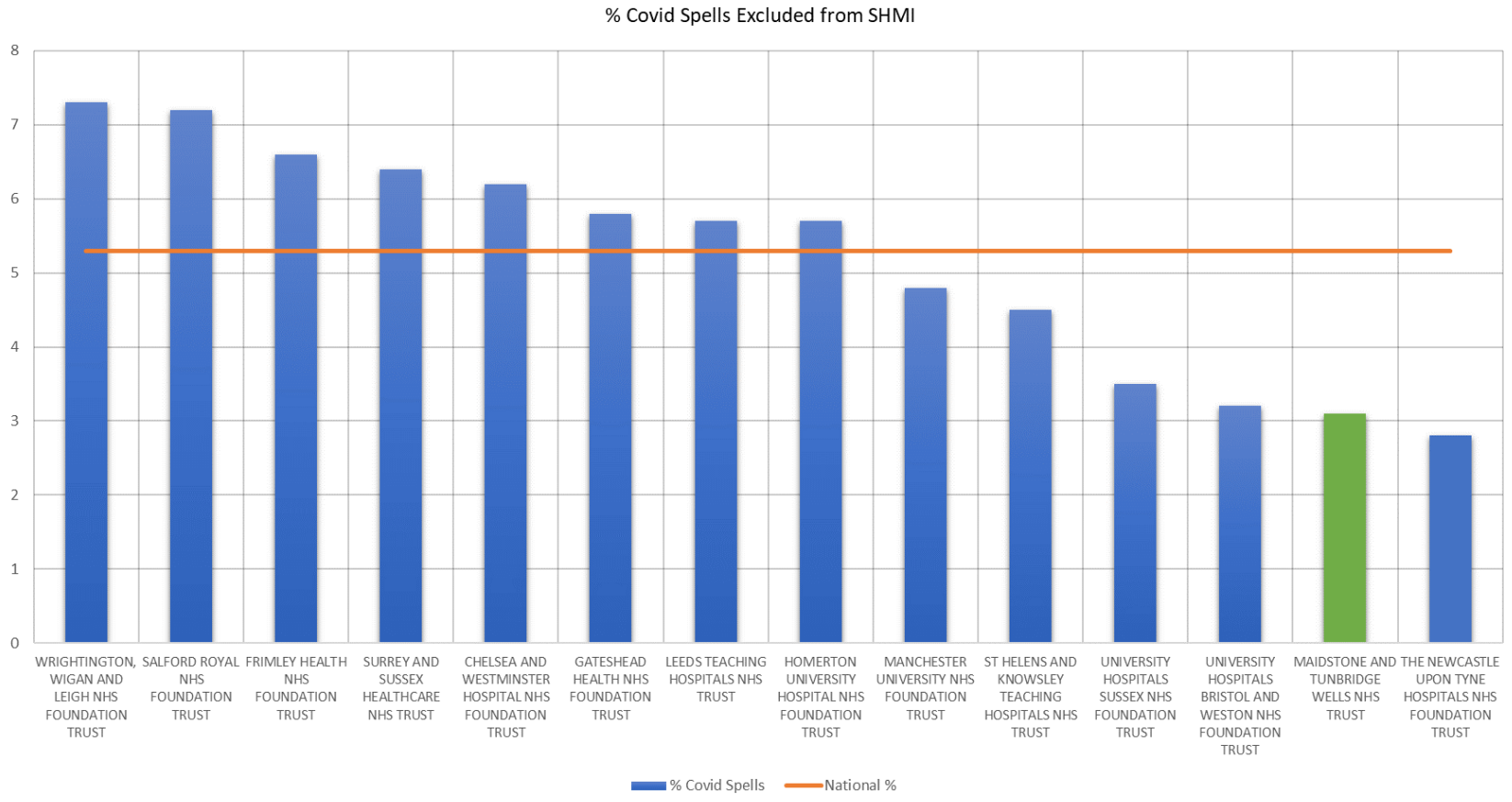

Depth of coding or the trust is below national average and in the lower half of our Outstanding and Good Rated peers, though we have improved on the previous month




The Trust's percentage of spells that have a Primary Diagnosis that is a symptom or sign is above the national average and in the top 3rd amongst our Outstanding and Good rated peers

# SHMI – Contextual Indicators - Covid

Maidstone and Tunbridge Wells NHS Trust




SHMI excludes Covid Spells, but does track spells excluded due to Covid. We are an outlier on the number of spells due to Covid – excluding the 2nd smallest percentage amongst our Good and Outstanding peers. This points further to a recording issue to be resolved

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# Clinical Coding Update

Maidstone and Tunbridge Wells NHS Trust

***Current month's Key activities / events:***

- Audited SHMI patients with R00-R99 in primary diagnosis field
  - These were coded correctly
  - Identified data error where **R69 Unknown and unspecified causes of morbidity** has been submitted as primary diagnosis for a number of cases when this code has not been assigned*
  - Reviewed a number of the **R69 Unknown and unspecified causes of morbidity** cases and it appears to be auto-assigned is the spell is not coded by first sus submission (flex) due to delay in coding

***R69 Unknown and unspecified causes of morbidity** would never be assigned*

***Next month's Scheduled activities / events:***

- Continue to monitor R00-R99 coded in primary position
- Complete COVID Mortality audit as agreed week commencing 07th June

***Summary of key Issues:***

- Lag in coding due to workload at MGH

***Summary of key Risks:***

- Delay in coding leading to an increase of **R69 Unknown and unspecified causes of morbidity** being auto-assigned at first sus submission (flex) due to delay in coding

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# Medical Examiners Service

## ME Service Update

- There has been a rise in the number of deaths scrutinised by the ME Service in June and July 2021, some of which can be attributed to an increase in COVID related deaths within the Trust.
- The ME Service continues to maintain a high performance standard for scrutinising deaths and on average refers 8-10% of scrutinised cases for a Structured Judgement Review (SJR)
- The first reading of the Health and Care Bill was introduced to Parliament on the 6th of July 2021 and aims to put the duties of the Medical Examiner on a statutory footing.
- Risks to the roll out of the Medical Examiners Service to the community have been introduced by administrative staffing issues in the current Service. Works are ongoing to mitigate the risk

| Month | Number of Deaths | Number Scrutinised | % of Deaths Reviewed | Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases) | % Over 3 Calendar Days to Complete |
|---|---|---|---|---|---|
| Sep-20 | 123 | 43 | 35% | 14 | 33% |
| Oct-20 | 105 | 97 | 92% | 11 | 11% |
| Nov-20 | 152 | 149 | 98% | 39 | 26% |
| Dec-20 | 319 | 238 | 75% | 132 | 55% |
| Jan-21 | 353 | 347 | 98% | 245 | 71% |
| Feb-21 | 149 | 147 | 99% | 42 | 29% |
| Mar-21 | 127 | 125 | 98% | 16 | 13% |
| Apr-21 | 122 | 122 | 100% | 30 | 25% |
| May-21 | 99 | 99 | 100% | 24 | 24% |
| Jun-21 | 112 | 108 | 96% | 30 | 28% |
| Jul-21 | 137 | 136 | 99% | 42 | 31% |

## Challenges faced by the ME Service

- Inability of the Service to complete scrutiny within 3 days is an ongoing problem. This is largely due to delays in completion of summaries by doctors/Qualified Attending Practioners (QAPs)
- The Service is now communicating with consultants much earlier in the pathway to increase engagement with the process and improve the timeliness of death summary completions.

# Mortality Surveillance Group (MSG)

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

The Mortality policy has now been approved and ratified by the Mortality Surveillance Group which held in August 2021. The Mortality policy has been updated to reflect the introduction of the Medical Examiners Service introduced in September 2020 and outlines the current Mortality processes and pathways within MTW.

**Learning from Mortality reviews identified the following needs**:

- Poor documentation of communications between MTW and KCH, poor documentation on their part regarding decision not to transfer patient
- Miscommunication in notes between nurses and junior doctors. Doctors to be reminded of the importance of checking basic information on all records
- Missed doses of anti-coagulant pre and post-operatively, this seems to have been a nursing decision and may have contributed to DVT and fatal PE development. This has been discussed and fed back to directorate
- No evidence of medical input over Easter weekend

**The following practice was highlighted in** :

- Consultant lead care with good clear well documented decision making.
- Prompt assessment and management with early senior medical review in ED by Medical Consultant, discussion with next of kin to make further treatment decision in best interest or in line with patient or family wishes
- Joint surgical and medical management was prompt and involved Consultants in all of the three main Specialities involved with patient's care (orthopaedics, orthogeriatric and anaesthetics)

# Mortality Surveillance Group (MSG)

## Structured Judgement Review (SJR)

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

| Year | Outstanding SJRs | Completed SJRs |
|---|---|---|
| Apr 17 to Mar 18 | 0 | 23 |
| Apr 18 to Mar 19 | 6 | 83 |
| Apr 19 to Mar 20 | 13 | 76 |
| Apr 20 to Mar 21 | 14 | 56 |
| Apr 21 to Mar 22 | 20 | 39 |
| SJR Total backlog | **53** | 277 |

- There has been a significant decrease in the backlog as a result of the implementation of our SJR backlog recovery plan.
- The current SJR backlog position is 53, this pertains to SJRs allocated to reviewers, yet to be completed and have exceeded the 4 week stipulated SJR turnaround time.
- There are 7 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 60.

## SJR Backlog Recovery Plan

- A 'deep dive' into the SJR backlog position has concluded. This included a review of all the SJRs within the backlog to determine if an SJR was still required and the status of physical case notes.
- Individual trajectories have been agreed with SJR reviewers on a case by case basis with a view to eradicating the backlog by April 2022
- SJRs continue to be reviewed via the dashboard at monthly MSG meetings
- New SJR reviewers have now been trained and work is ongoing to attract additional SJR reviewers.

# Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

## Summary of 'Poor Care' from SJR Review

| MSG Meeting | No of SJRs | Overall 'Poor care' | Overall 'Very poor Care' |
|---|---|---|---|
| Mar-21 | 10 | 1 | 0 |
| Apr-21 | 9 | 3 | 0 |
| May-21 | 5 | 3 | 0 |
| Jun-21 | 9 | 1 | 0 |
| Jul-21 | MSG cancelled: quorate threshold not met | | |
| Aug-21 | 12 | 4 | 1 |

- In June, there was 1 SJR with an overall assessment of 'Poor care' and no SJR with a 'Very poor care' rating discussed at MSG
- Due to the summer holiday season, attendance at the July MSG meeting did not meet quoracy and was therefore cancelled.
- In August, there were 4 SJRs with a 'Poor care' assessment and 1 SJR with a 'Very poor care' assessment reviewed at the MSG meeting

## Reporting correction

- In March, 10 SJRs were discussed instead of the reported 9 with 1 SJR rated 'Poor care'.
- In April, 9 SJRs were discussed instead of the reported 10, the SJR was discussed in March instead of April as previously reported.
- In May, there where 6 SJRs reported as discussed instead of 5, 1 SJR rolled over to be discussed at the June MSG

## Actions from 'Poor care' SJR Reviews

- All 5 SJRs with an overall assessment of 'Poor care' were discussed at MSG and with the Directorates
- 1 SJR discussed in August with an overall assessment of 'Very poor care' was referred to be reviewed at the Serious Incidents panel to determine if the Serious Incident(SI) threshold has been met to declare an SI
- Learning from these SJRs have been feedback to Directorates through Clinical Governance meetings.

## Next steps

- Continue to work with SJR reviewers to implement the backlog trajectory plan.
- Progress roll out project of the Medical Examiners Service to the Community, the last outstanding item on the TIAA action plan

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NHS Maidstone and Tunbridge Wells NHS Trust

| To approve the Business Case for gastroenterology inpatient centralisation | Director of Strategy, Planning and Partnerships |
|---|---|

The Trust Board is asked to approve the centralisation of the complex inpatient gastroenterology service at Tunbridge Wells Hospital (where it will co-locate with Surgery) at an operationally appropriate date from October 2021. This is a key step towards the formation of a Digestive Diseases Unit at the Trust. Although the costs of the enclosed Business Case do not require Trust Board approval, it has been considered appropriate to ask the Trust Board to approve the Case.

The Kent County Council Health Overview and Scrutiny Committee (HOSC), approached by the Trust and NHS Kent and Medway Clinical Commissioning Group, have decided that the service change is 'minor' and does not require consultation. Plans for mitigating risks are included within the Business Case, and appropriate patient and staff engagement has been completed. Operational planning for the proposed change is progressing well.

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

- Executive Team Meeting (ETM), 14/09/21

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

Approval

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

# Gastroenterology Inpatient Centralisation

To: MTW Executive/ Trust Management Executive/ Kent CCG /Trust Board

From: Lead Clinician and Director of Strategy, Planning and Partnerships

Date: September 2021

Purpose: **To seek approval for Gastroenterology Inpatient Centralisation**

# BUSINESS CASE

# Gastroenterology Inpatient Centralisation

| | |
|---|---|
| **Issue date/Version number** | 04/09/21 |
| **Division** | Medicine and Emergency Care |
| **Directorate** | Gastroenterology |
| **Department/Site** | Trust-wide gastroenterology |
| **Authors** | S Bounds N Baber |
| **Clinical lead/Project Manager** | Dr H Sharma |

| **Approved by** | **Name** | **Signature** | **Date** |
|---|---|---|---|
| **General Manager/Service Lead** | Tim Hubbard | | |
| **Finance manager** | Paula Susan | | |
| **Clinical Director** | Paul Blaker | | |
| **Executive sponsor** | Amanjit Jhund | | |
| **Division Board** | | | |
| **Supported by** | **Name** | **Signature** | **Date** |
| **Estates and Facilities Management (EFM)** | Doug Ward | | |
| **ICT** | Sue Forsey | | |
| **Deputy Chief Operating Officer** | Lynn Gray | | |
| **Diagnostics and Clinical Support Services (DCSS)** | Jelena Pochin | | |
| **Emergency Planning** | John Weeks | | |
| **Human Resources (HR) Business Partner** | Nicola Taylor | | |
| **Procurement** | Bob Murray | | |
| **EME Services Manager** | Michael Chalklin | | |

# Business Case Summary

**Strategic background context and need**

MTW provides a wide range of medical gastroenterological services with two centres of expertise, one at Tunbridge Wells Hospital at Pembury (TWH) and one at Maidstone Hospital (MH).

The service has received accolades for a number of areas of notable good practice including; JAG accreditation of endoscopy on both sites, pre-assessment for endoscopy, reducing on the day cancellations, a QFIT pathway in place and good capacity for CT virtual colonoscopy.

However, running a complex specialist inpatient gastroenterology service, at two hospital sites, with the Maidstone site separate from the gastrointestinal surgery service at TWH, has led to a number of challenges.

Currently, there is no dedicated gastroenterology ward in the Trust. A dedicated ward on each site is not justified in activity numbers split across sites. This reduces the opportunities for developing multidisciplinary and specialised medical, nursing and dietetics teams skilled in complex surgical and medical treatments for patients with digestive disease.

There is a recognised need to reduce the fragmentation of gastroenterology care. Continuity of clinical personnel and clinical information are recognised perquisites for better care. There is a need to reduce unplanned cross site patient transfers for urgent gastrointestinal surgery

The 2021 Gastroenterology GIRFT report recommends the service take steps to reduce unwarranted variation cross-site so the two sites work together and standardise practice. GIRFT also recommend gastroenterology, where practical, work to reduce general medicine commitments, releasing specialist time for gastro clinics and endoscopy lists and so reduce premium rate spend on waiting list initiatives (WLIs), locum or agency costs in Gastro/endoscopy.

A recent survey of trainees has shown there is a need to improve the gastroenterology training experience with more dedicated time for gastroenterology specific experience.

Patient feedback on the service overall is generally good. When surveyed some patients have raised concerns about the frequency of communication with their clinical team and perceived delays to treatment

**Objectives**

1. Develop the dedicated gastroenterology service at MTW to improve the quality of gastroenterology service in terms of safety, effectiveness and patient experience

2. Improve the training experience and recruitment and retention of specialist gastroenterology staff and staff that support them

3. Develop an improved service for patients with digestive disease, working across medical, surgical, diagnostics and clinical support disciplines

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

**Centralise specialty specific inpatient Gastroenterology admissions at Tunbridge Wells. Outpatient and endoscopy services to continue on both hospital sites**

On 21st July 2021 the Kent Local Authority Oversight and Scrutiny (HOSC) assessed these plans and the committee formally agreed '**The Committee does not deem the proposed reconfiguration to be a substantial variation of service.'**

**The proposed service change meets the NHSE five key tests for service change.**
These tests are:

1. Strong engagement as required
2. Consistency with current and prospective need for patient choice.
3. Clear, clinical evidence base.
4. Support for proposals from clinical commissioners
5. Does not significantly reduce bed numbers

**The service clinical leads completed a multi criteria option analysis and have engaged widely on a preferred option to centralise the complex inpatient gastroenterology service at TWH.**

Audit has shown this service change would directly affect the site of care for around 250 patients each year who currently have their inpatient treatment at Maidstone and in future will have their treatment at TWH

The overwhelming majority of patient contacts remain at their current site unchanged. Endoscopy provision outpatients and day case care will continue at both site

This case requires relatively small financial investment. There are no major estate or equipment requirements. There is no additional nursing required. To facilitate appropriate medical cover at Maidstone as the service 'beds in' some investment in locum medics has been arranged.

There is no overall increase in diagnostics required. However, diagnostic and clinical services are looking at how they configure support and may seek some investment in dietetics at TWH. This being worked through and any requirement will be subject to a separate case.

**Main benefits associated with the investment**

| Key Performance Indicator (KPI) | Baseline Position | Future Outcome |
|---|---|---|
| **Improved level of continuity of medical care**. *Measured by patient survey. Expressed through patient's level of satisfaction with 'the number of times the same doctor spoke to me about my treatment'* | Gastro patient feedback June / July 2021<br>12.5% of patients dissatisfied | Minimal (<3%) dissatisfaction |
| **Reduced number of cross site transfers** *Defined as admission site different to discharge site in 2019 where gastro consultant assigned to primary spell* | 29 /yr. patients had an admission spells during which there was at least one transfer (Of the 29, 9 had two cross site transfers) | Target 66% reduction<br><br>Target <10 /yr. cross site transfers during inpatient stay |
| **Improve communication, timeliness and specialist teamwork.** *Enabled by cohorting of complex gastroenterology inpatients on a specialist ward. Measured by audit* | Currently on Pye Oliver and W12 combined less than a third (31.6%) of patients are gastroenterology patients | The new gastroenterology ward to have >50% occupancy of gastroenterology patients with >75% occupancy of patients with Digestive Disease |
| **Increase the number of days a week gastro patients have access to a consultant gastroenterologist who is available on site to manage their care.** *Measured by rota* | Maidstone 3 out of 7 days<br>TWH 5 out of 7 days | Centralised service<br>7 out of 7 days |

**Main risks associated with the investment**

Risk of not doing it

- Delay to surgical treatment for patients pending transfer from Maidstone to TWH
- Unnecessary long length of stay due to dispersed service
- Gastroenterologist capacity overly used on general medical/ care of the elderly type work

Delivery risk

- While overall the service change will streamline pathways and reduce delay, concentrating complex inpatient at TWH presents an increased risk to bed capacity at that site.

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

| Summary of financial impact | Sum(£) | Funding source | Sum(£) |
|---|---|---|---|
| **CAPITAL COSTS** Estates | **0** | Identified in the Trust capital plan | |
| ICT | **0** | Identified in directorate revenue budget | |
| Equipment | **0** | Other *( specify)* | |
| **Total Capital cost of project** | **0** | Additional Info: Locum cost based on rate of £1000 per day and for 12 months. If someone was appointed on a fixed term contract this cost could be reduced to in the region of £140k for a 12 month period. | |
| **REVENUE COSTS** Pay | **(260,000)** | | |
| Non-pay | | | |
| Capital Charges | | | |
| **Total Revenue cost per annum** | **(260,000)** | | |
| **INCOME** SLA | | | |
| Other | | | |
| **Total Income per annum** | | | |
| **Surplus/Loss** | **(260,000)** | | |

**Timetable**

| | |
|---|---|
| CCG and K&M HOSC | Jul 21 |
| Directorate Board | Jul 21 |
| Divisional Board | Jul 21 |
| Trust Board | Sep 21 |
| Go live | Oct 21 |

## Background and context

In spring 2020, following engagement and agreement with a variety of stakeholders including the Kent Commissioning Group and the Kent and Medway Health Oversight and Scrutiny Committee (HOSC), Maidstone and Tunbridge Wells Trust (MTW) centralised some complex gastrointestinal surgical services onto the Tunbridge Wells Hospital site.

An important part of the case for change for the surgical centralisation was that it was a step towards formation of a Digestive Diseases Unit at MTW.

Many hospitals in England have organised their complex gastroenterology medical and gastrointestinal surgical services into one co- located Digestive Diseases Unit (DDU).
A DDU involves a dedicated combined medical and surgical ward where specialist surgeons and physicians and a specialist team of nurses, dieticians and other professional work together to provide joined up care. This is regarded as a highly beneficial multidisciplinary approach to the care of patients with gastroenterological conditions.

## Links to the Kent and Medway Joint Strategic Needs Assessment and the Kent Health and Wellbeing Strategy

**In line with NHSE guidance this service change aligns with the regional Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy (HWBS) strategy**

"For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery"

JSNA 2015

"One of the key issues that we need to tackle is that of public awareness of the changes that will be taking place over the coming years, namely the move to more care being delivered in local communities and away from acute hospitals. **This will inevitably mean major changes to our big hospitals, with the creation of specialist hospitals where good quality care can be provided with specialist trained staff**, with general services provided in the community or at a local hospital as clinically appropriate. **This may mean an increase in journey times to access specialist provision for some people,** but conversely will allow people to access much more of the care they need in community settings"

Priority 4 of the Kent HWBS is to
"Transform services to improve outcomes, patient experience and value for money."

Kent Health and Wellbeing Strategy

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

### Objective 1 Develop the dedicated gastroenterology service at MTW to improve the quality of gastroenterology service in terms of safety, effectiveness and patient experience

**Current situation**: MTW provides a wide range of medical gastroenterological services with two centres of expertise, one at Tunbridge Wells Hospital at Pembury (TWH) and one at Maidstone Hospital (MH). Both sites provide around 4000 outpatient consultations a year and between 8000-10,000 patients for endoscopy per year. Both sites admit 255-360 hundred inpatients to hospital beds per year with the higher volume at TWH. The inpatient service manages complex inpatient care for patients with the following conditions - decompensating liver disease, acute colitis and Crohn's, acute GI bleeds and acute jaundice. Appendix 5 shows the stakeholder analysis of the patient group

An audit of complex gastroenterology in-patients (See appendix 2) showed that 8 beds at MH are used to manage complex gastroenterology patients and 11 beds at TWH. The audit data shows average patient stay (including day of admission and day of discharge) for these patients is 5.5 days and that there are on average less than one admission and discharges (0.7) every day.

Currently, there is no dedicated gastroenterology ward in the Trust. A dedicated ward on each site is not justified in activity numbers split across sites. This reduces the opportunities for developing multidisciplinary and specialised medical, nursing and dietetics teams skilled in complex surgical and medical treatments for patients with digestive disease.

There is a recognised need to reduce the fragmentation of gastroenterology care. Continuity of clinical personnel and clinical information are recognised perquisites for better care. There is a need to reduce unplanned cross site patient transfers for urgent gastrointestinal surgery

The 2021 Gastroenterology GIRFT report recommends the service take steps to reduce unwarranted variation cross-site so the two sites work together and standardise practice. GIRFT also recommend gastroenterology, where practical, work to reduce general medicine commitments, releasing specialist time for gastro clinics and endoscopy lists and so reduce premium rate spend on waiting list initiatives (WLIs), locum or agency costs in Gastro/endoscopy.

**Managing patients with emergency presentation of gastroenterological bleeding**

Acute upper gastrointestinal bleeding is a common medical emergency that has a 10% hospital mortality rate.[1] NICE guidance includes that endoscopy be available for severe acute upper gastrointestinal bleeding immediately after resuscitation. Endoscopy professionals agree that to improve patient safety and optimise care their aim should be to increase the provision of 24/7 services, so all patients have access to emergency services if needed. In practice this requires a 24/7 GI bleed service in endoscopy. This service is already based at The Tunbridge Wells Hospital, supported by on site emergency surgery.

## Objective 2 Improve the training experience and recruitment and retention of specialist gastroenterology and support staff

A recent survey of trainees has shown there is a need to improve the gastroenterology training experience with more dedicated time for gastroenterology specific experience. A recent GMC Survey has identified areas that require improvement with regard to clinical supervision, rota design and overall satisfaction of the role.

Gastroenterology and, in particular, endoscopy units are dealing with an ever-increasing rise in demand, particularly for high volume elective procedures.[2] For all specialist staff, increasing demand, decline in numbers entering the professions and an existing shortfall create a challenge for the service. Opportunities to recruit to gaps are lost as the current fragmented service configuration is not attractive to potential recruits. Lost opportunities to recruit are also costly.

## Objective 3 Develop an improved service for patients with digestive disease, working across medical, surgical diagnostics and clinical support disciplines

The current configuration of services for patients with digestive disease is split across hospital sites for medical gastroenterology, and split between surgical and medical teams. Specialist surgery for these patients is now centralised at the Tunbridge Wells Hospital. The best care for the patient's condition frequently could benefit from input from both surgical and medical teams. A central facility and focussed system for joint care and decision making is not currently in place at MTW.

For the dietetics service the complexity of complex gastroenterology patients means a requirement for more frequent dietetic contact per stay than in general dietetics. It is a highly specialist area of dietetics requiring more frequent input from senior specialist dietitian with highly experienced parenteral nutrition skills, and also increased need for nutrition ward rounds. Over the past year, the service have needed to move more dietetic resource from Maidstone to TWH due to change in demand related to centralisation of lower GI Surgery. Maintaining the full range of specialist dietetic service to support gastroenterology on two sites is a challenge

For patients who require a stoma formed as part of their surgical treatment for digestive disease the role of a stoma nurse is vital. For patients with patients with a colostomy, ileostomy, as well as providing patient support, they are involved in the coordination of treatment including liaising with the surgical team and other members of the

[1] National Institute for Health and Care Excellence (NICE) Acute upper gastrointestinal bleeding in over 16s: management Clinical guideline [CG141]Published date: June 2012 Last updated: August 2016

[2] Acute Upper Gastrointestinal Bleeding Improving Quality NHS An overview of out of hours service provision and equity of access.

multidisciplinary team (MDT). Some patients with digestive disease need ongoing care from a stoma nurses. Centralising care for digestive diseases helps achieve that continuity of care.

## Constraints and dependencies

- Emergency surgery at MTW is provided on the TWH site
- General medical cover must continue to be provided on both hospital sites including provision for specialist gastrointestinal input on both sites
- Specialist gastroenterology endoscopy and outpatient clinics must continue to be provided locally at each hospital site

# Option Evaluation

A clinically led 'multi criteria decision analysis' of potential future service options (see appendix 6) was held on 25th September 2020 and 13th October 2020

Representation at the evaluation sessions included service leads for medicine, emergency and gastroenterology from both sites of the Trust, senior representative from nursing, surgery and diagnostics and service management leads.

**The four key options for the service considered were:**

| | |
|---|---|
| 1 | Do nothing – continue delivering from both sites as currently configured |
| 2 | Continue delivering from two sites, sub specialising elements of service each site. Attempt additional consultant and other specialist recruitment to level required to meet standards at both sites |
| 3 | Centralise specialty specific IP Gastroenterology admissions at Maidstone. OP and endoscopy services continue both sites |
| 4 | Centralise specialty specific IP Gastroenterology admissions at Tunbridge Wells. OP and endoscopy services continues both sites |

**The thirteen criteria each option was assessed against were:**

| | |
|---|---|
| Clinical | Promotes continuity of patient care |
| Clinical | The number of cross site hospital transfers |
| Clinical | Promotes higher (hospital and clinician) patient volumes with associated link to better outcomes |
| Clinical | Provides optimal co location of essential and desirable services e.g. GI Surgery/ Specialist Nutrition/ Specialist Nursing/ 24/7 bleed service |
| Clinical | Promotes opportunities to further research and innovation |
| Patient experience | Patient experience –Impact on patient experience, including travel times |
| Workforce | Workforce – Ability to cover service commitments |
| Workforce | Workforce – Recruitment and retention |
| Workforce | Workforce – Education, training and supervision |
| Strategic | Promotes the longer-term development of excellent gastroenterology services for our population |
| Strategic | Fit with medical divisional strategy other interdependent services; A&E, cancer services, general medicine, critical care and whole hospital winter and COVID resilience |
| Operational | Flexibility, adaptability and resilience to meet the requirements of growth or changes in future demand or change in national policy |
| Operational | Deliverability – Ease of implementation |

| Option evaluation results | Do nothing | Continue both sites with additional recruitment | Centralise IP gastro at Maidstone | Centralise IP gastro at TWH |
|---|---|---|---|---|
| **Criteria** | Final weighted scores | | | |
| Promotes continuity of patient care | 8 | 16 | 16 | 16 |
| The number of cross site hospital transfers | 8 | 8 | 8 | 16 |
| Promotes better patient better outcomes as a result of higher (hospital or clinician) patient volumes | 15 | 15 | 20 | 25 |
| Provides optimal co location of essential and desirable services e.g. GI Surgery/ Specialist Nutrition/ Specialist Nursing/ 24/7 bleed service | 10 | 15 | 15 | 25 |
| Promotes opportunities to further research and innovation | 9 | 9 | 12 | 12 |
| Patient experience –Impact on patient experience, including travel times | 9 | 9 | 9 | 15 |
| Workforce – Efficient use of staff to cover service commitments | 12 | 12 | 16 | 16 |
| Workforce – Recruitment and retention | 8 | 12 | 16 | 20 |
| Workforce – Education, training and supervision | 9 | 9 | 9 | 12 |
| Promotes the longer-term development of excellent gastroenterology services for our population | 12 | 12 | 16 | 16 |
| Fit with medical divisional strategy and interdependent services. A&E, cancer services, gen med, critical care and whole hospital winter and COVID resilience | 6 | 6 | 6 | 12 |
| Flexibility, adaptability and resilience to meet the requirements of growth or changes in future demand or change in national policy | 9 | 9 | 9 | 9 |
| Deliverability – Ease of implementation | 12 | 12 | 9 | 12 |
| **Combined and weighted quality criteria score** | **127** | **144** | **161** | **206** |

**As illustrated in the scoring above the option to centralise at TWH, co-locating of complex inpatient medical and surgical gastroenterology at Tunbridge Wells Hospital. was scored by the clinically led group as the best way forward for the service.**

It was considered that the option will provide the patients with consolidated specialist care and enable continuity of care that is so important for optimum quality services.

The centralisation will pave the way for dedicated Digestive Diseases Unit (DDU)at the Trust. The DDU will wrap the full range of services around the patients with digestive disease

## Engagement with patients and staff

Any proposed service change requires engagement with a range of stakeholders and users of the service.

The Trust has engaged with patients and other stakeholders in a joint approach to planning. The Trust has consulted Kent and Medway CCG about the proposed approach and will be working with the CCG to jointly take the development forward.

The gastroenterology service worked with the Trust Patient Experience Team with link with Health watch to help design appropriate staged approach to engagement. A three-stage process was formulated. (see Appendix 4)

Stage one - General feedback on the current service has been sought from gastroenterology patients from existing documents and from asking for feedback on a bespoke form. (See appendix 1.) The service also undertook a stakeholder analysis an engagement plan and an equality impact assessment.

Stage two – Wider stakeholder engagement and patients invited to help co- design elements of DDU. Developing the case for change in response to feedback following engagement activity and the review of feedback

Stage three – Level of need for further consultation assessed after involvement of CCG and HOSC

On 21st July 2021 the Kent Local Authority Oversight and Scrutiny (HOSC) assessed the plans and the committee formally agreed**:**

‘**The Committee does not deem the proposed reconfiguration to be a substantial variation of service.’**

and so, in line with NHSE guidance, a formal consultation process is not required

A variety of staff engagement activities have taken place including:

- Ward Matrons and Gastroenterology Clinical Nurse Specialists included in Reconfiguration Project Work
- Presentation at Departmental Speciality Meeting and Divisional Clinical Governance Meeting by Gastroenterology Clinical Lead
- Working with Dietetic and diagnostics team
- Project work reports into the DDU Steering Group
- Further work with primary care is planned

## An illustrative patient's story - How will this be different for patients?

***In order to help stakeholders, understand some of the challenges patients might experience from the current service configuration and to understand how a DDU, post gastro centralisation, might change patient experience, senior clinicians drafted the following illustrative patient story. While the story is fictitious, it is based on real patient's experiences.***

### Before complex inpatient gastroenterology reconfiguration, without a Digestive Diseases Unit

James is a 48 year old man, with ulcerative colitis, who has been under the long term care of a consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences an exacerbation of his colitis and presents to the gastroenterology clinic. James is admitted to Maidstone hospital and treatment with intravenous steroids and infliximab is started. On this occasion, James does not respond well to the treatment and becomes increasingly weak with his bowels opening up to 12 times a day and his albumin levels falling.

There are significant delays in the gastroenterology team being able to obtain senior colorectal surgical opinion. James is finally seen on a Friday by a consultant colorectal surgeon, 10 days after his admission, and needs to be transferred to Tunbridge Wells Hospital for emergency surgery.

On arrival at Tunbridge Wells Hospital the surgical team on call, who are not colorectal specialists, feel that James should wait for the colorectal team who will be taking over on Monday.

However, on Sunday James becomes increasingly unwell with severe abdominal pain. He undergoes an emergency laparotomy and total colectomy with end-ileostomy.

After surgery, James requires intensive care. Initially, he makes a good recovery and is returned to the ward. On the 5th post-operative day however, he develops a wound infection requiring the wound to be opened. He has a large wound from the emergency surgery and requires extensive wound management, intravenous antibiotics and the placement of a VAC dressing. He is eventually discharged with the VAC in place which remains for a further 3 weeks. Throughout the admission at Tunbridge Wells he has not seen the gastroenterologist he knows or the surgical consultant who operated on him on Sunday.

### After complex inpatient gastroenterology reconfiguration, with a DDU

James is a 48 year old man, with ulcerative colitis, who has been under the long term care of one of the consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a flare-up of his colitis and presents to the gastroenterology clinic and is admitted to the digestive diseases unit at Tunbridge Wells Hospital.

He remains under the care of the gastroenterologist that he knows, who commences treatment with intravenous steroids. After 72 hours it is clear that James is not responding as well as would be hoped. The gastroenterologist promptly involves one of the colorectal specialist consultant surgeons who visits James with the gastroenterologist. They decide to start 'rescue therapy' with infliximab and closely watch and wait to see if things improve. They both keep him under close observation but by the 7th day of his admission it is decided to perform surgery. He sees a stoma nurse the same day. The consultant surgeon re-arranges a case from his elective operating list and is able to promptly perform an "urgent" laparoscopic sub-total colectomy.

James is returned to ITU. Initially, he makes a good recovery and is returned to the ward. On the 5th post-operative day he develops a wound infection. As the operation was laparoscopic the wound is small and management is relatively simple. James is able to go home with antibiotics the following day.

Throughout his admission the gastroenterologist and surgical consultant that James knows have been involved in his care every day.

## Benefits of the consolidated complex inpatient service

Clinicians have identified a strong clinical need for change and identified the following benefits associated with the proposed solution:

**Improved continuity of clinical personnel**

Co-location of complex medical and surgical gastroenterology will simplify governance, reduce the number of handovers and avoid unnecessary changes of the team in charge of patient's care. These are issues which our clinicians recognise impact upon the quality of care.

Co-location of complex medical and surgical gastroenterology will allow continuity of involvement and most effective use of our Dietetics and Clinical Nurse Specialist Team, giving patients best access to specialist nursing care

**Continuity of Clinical Information**

When patients have been discharged from either Medical or Surgical team and suffer a complication requiring input from the other discipline, separate units entail delays in the full patient information being made immediately available to clinicians for early reassessment.

**Complex Care**

Patients requiring the most complex care and/or with multiple conditions are not getting the quality of service that clinicians know is possible. It is often challenging because of the configuration of services to undertake combined diagnostic and therapeutic procedures leading to a need for patients to have 2 visits and potential for pathway delay in some cancer treatments.

The availability of a nursing and dietetics teams skilled in complex surgical and medical treatments for digestive diseases has synergistic improvement on quality

**Other identified service benefits with include**:

- Improved sustainability of the gastroenterology service including improving compliance with developing seven day service requirements.
- The reconfigured service will provide an emergency service for the patient with digestive disease that has the required workforce, facilities and the support.
- Improved training experience for surgical and medical trainees
- Reduction in the use of locum doctors.
- The work pattern will be considerably more attractive for hard to recruit and retain specialist clinical staff.

# Quality Impact Assessment

**The proposed service change meets the NHSE five key tests for service change.**

These tests are:

1. Strong public and patient engagement.
2. Consistency with current and prospective need for patient choice.
3. Clear, clinical evidence base.
4. Support for proposals from clinical commissioners
5. Does not significantly reduce bed numbers

| **Clinical Effectiveness** |
|---|
| Have clinicians been involved in the service redesign? If yes, list who. |
| Dr Hemant Sharma, Consultant Gastroenterologist and Clinical Lead<br>Gemma Viner, Deputy Director of Nursing for Medicine & Emergency Care Division<br>Sarah Emberson, Senior Matron for Specialist Medicine Directorate<br>Donna Parker, Matron for Gastroenterology Service |
| Has any appropriate evidence been used in the redesign? (e.g. NICE guidance) |
| GIRFT Review – February 2021<br><br>National Institute for Health and Care Excellence (NICE) Acute upper gastrointestinal bleeding in over 16s: management Clinical guideline [CG141]Published date: June 2012 Last updated: August 2016<br><br>Acute Upper Gastrointestinal Bleeding Improving Quality NHS An overview of out of hours service provision and equity of access. |
| Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate. |
| Patient Feedback Survey<br>Reduced No. of Cross-site transfers<br>New gastroenterology ward to have >50% occupancy of gastroenterology patients<br>Centralised service<br><br>7 out of 7 days |
| Are there any risks to clinical effectiveness? If yes, list |
| No |
| Have the risks been mitigated? |
| See page 16 |
| Have the risks been added to the departmental risk register and a review date set? |
| Not required due to mitigation plans |
| Are there any benefits to clinical effectiveness? If yes, list |
| Improved continuity of clinical personnel<br>Improved continuity of clinical information |

| | |
|---|---|
| Improved access to multidisciplinary advice/care | |
| **Patient Safety** | |
| Has the impact of the change been considered in relation to: | |
| Infection Prevention and Control? | Y |
| Safeguarding vulnerable adults/ children? | Y |
| Current quality indicators? | Y |
| Quality Account priorities? | Y |
| CQUINS? | Y |
| Are there any risks to patient safety? If yes, list | |
| None identified | |
| Have the risks been mitigated? | |
| n/a | |
| Have the risks been added to the departmental risk register and a review date set? | |
| N/a | |
| Are there any benefits to patient safety? If yes, list | |
| Improved continuity of clinical personnel<br>Improved continuity of clinical information<br>Improved access to multidisciplinary advice/care | |
| **Patient experience** | |
| Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not. | |
| Yes through a bespoke patient questionnaire | |
| Has the impact of the change been considered in relation to:<br>• Promoting self-care for people with long-term conditions?<br>• Tackling health inequalities? | |
| N/A | |
| Does the redesign lead to improvements in the care pathway? If yes, identify | |
| | |
| Are there any risks to the patient experience? If yes, list | |
| See section on Potential risks and planned mitigation (page 16) | |
| Have the risks been mitigated? | |
| See section on Potential risks and planned mitigation (page 16) | |
| Have the risks been added to the departmental risk register and a review date set? | |
| Mitigation has lowered the risk score so not required. | |
| Are there any benefits to the patient experience? If yes, list | |
| Specialist Ward – improved access to multidisciplinary support and continuity of care with 7 day consultant ward round | |
| **Equality & Diversity** | |
| Has the impact of redesign been subject to an Equality Impact Assessment? | |
| Yes | |
| Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment) | |

| | | | | | |
|---|---|---|---|---|---|
| No | | | | | |
| Has any negative impact been added to the departmental risk register and a review date set? | | | | | |
| No | | | | | |
| **Service** | | | | | |
| What is the overall impact on service quality? – please tick one box | | | | | |
| Improves quality | Yes | Maintains quality | | Reduces quality | |
| Clinical lead comments | | | | | |
| | | | | | |

## Potential risks and planned mitigation

A number of potential risks of centralisation without appropriate planning were identified. Each were assessed for likelihood and severity then mitigation measures planned. Post mitigation scores were then carried out. The result of this work is shown in the table below.

## Table 1 Risk Management

| Risk Description | Pre mitigation Score | Planned mitigation | Post mitigation risk score |
|---|---|---|---|
| Inpatients within MGH require specialist gastroenterological input that is not available or only available after delay | 20 | Gastroenterologist support on the Maidstone site will remain for clinical advice via a referral service. Patients will not be under their clinical review (unless post-take), but weekly on-site advice will be available. | 4 |
| Medical on call rota at MGH put under pressure | 16 | The Gastroenterologist of the Week rota at TW will ensure that it will not affect the on-call commitments of the general medicine on-call service at Maidstone. This will be overseen by the Clinical Director and General Manager for Specialist Medicine and their specialist rota team | 1 |
| The gastroenterology team at Maidstone may have been compensating for shortfall in Surgical specialist input, particularly following surgical centralisation. Without this compensation there may be an increased risk to the surgical patient | 15 | Review of surgical cover in light of proposed changes | 1 |
| Oncology MDMs requiring gastroenterologist input compromised | 15 | Job planning will ensure protected cover for the cancer MDM. An additional Consultant Gastroenterologist will be joining the team to increase the numbers to 9 and will provide extra resource to the cancer work. | 1 |

| Risk Description | Pre mitigation Score | Planned mitigation | Post mitigation risk score |
|---|---|---|---|
| Disruption and or loss of nursing expertise | 15 | Review and reconfiguration of Nursing team | 4 |
| Elective outpatients and endoscopy at Maidstone may suffer if specialists called to cover urgent requirements elsewhere on the site | 15 | Job planning will ensure that access to urgent cover does not clash with elective commitments in endoscopy and outpatients. Business continuity plans are in place if medical cover cannot meet the essential service. This is overseen by the General Manager for Specialist Medicine | 4 |
| Gastroenterology ward /DDU beds at TWH become full with other patients | 9 | Clear pathways agreed within the Division. Daily medical huddles in place to ensure appropriate management and escalation. Recent IT enablers will support with patient flow, ie, tele-tracking/sunrise. | 4 |
| Urgent transfer required from MGH A&E to TWH | 9 | Ambulance pathway. Transfer mechanism and pathways agreed with SECAMB | 4 |
| Stroke and Cardiology service centralised at Maidstone increasing demand (PEG requests and ..) for Gastroenterology input | 9 | Endoscopy Service remains at Maidstone . Formalisation of pathways | 1 |
| Patient transfer increases with associated costs/ resource requirement | 9 | Projected transfers after accounting for redirection pre admissions estimated at 1 per 3 days | 4 |
| Critical care capacity shortfall | 8 | Data review has shown that or the whole of 2019, the total Gastroenterologist led MITU overnights was 43. So the data suggests three to 4 critical care overnights /month change in demand from Maidstone to TWH. Critical Care have improved ability to flex capacity post Covid. | 6 |
| Disruption to or lack of compliance with requirements of the Medical School curriculum | 6 | Early engagement with medical schools / HEE Design (co design) proposed placement | 4 |
| Negative impact in some aspects on patient experience | 6 | Engagement with patient groups and reps to co-design, and highlight risks | 4 |
| Insufficient administration support / appropriate office space | 6 | Trust wide review of space. Additional Admin can be added to business case. | 1 |

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

The Kent CCG were jointly involved with presenting the plan t the Kent Local Authority and have been fully engaged and supportive in relation the proposed service change.

MTW Trust anticipates no change in overall patient flow, SLA activity, to the Trust and no impact on neighbouring Trusts.

## The proposed plan

The table below shows that the planned change would mean different site of care for 255 patients per year. The patients are associated with an increase in bed pressure, **before mitigation,** of 8 beds at TWH

## Table 2 The patient numbers now and following proposed changes

| Patients visiting digestive diseases services at MTW | **TWH** | | **Maidstone** | |
|---|---|---|---|---|
| | Current | Future | Current | Future |
| Outpatient consultations | 4600 | 4600 | 4100 | 4100 |
| Elective endoscopy procedures | 7668 | 7668 | 9448 | 9448 |
| Emergency endoscopy procedures | 693 | 693 | 274 | 274 |
| Gastroenterology complex inpatient admissions | 365 | 620 | 255 | 0 |
| Beds required for specialist IP gastroenterology | 11 | 15 | 8 | 0 |

The project group's working estimate is that 50% of admissions would be directed straight to TWH before arriving at Maidstone. The remainder would require a medical referral to be transferred following agreed acceptance criteria.] This would entail (0.7 admissions / 2 = 0.35 admissions per day, or an average of one patient every three days requiring transfer to TWH.

The patient flow leads in the Trust advise that there are established processes and protocols and contracts for the transfer of patients from one site to the other and that the volume expected as a result of one patient every three days would not be a step change of sufficient scale to entail additional costs

## Capacity plans

Activity audit and plan shown above show an increase bed pressure for non-elective gastroenterology before mitigation at TWH of 8 beds. However, there will be no additional bed capacity required across the Maidstone and Tunbridge Wells site as general medicine/acute & frailty capacity will increase at the Maidstone site by 8 beds.

Non-elective gastroenterology will go directly to the Tunbridge Wells site through agreed transfer pathways with SECAMB. This will be supported by treat and transfer pathways from Maidstone to the gastroenterology central ward at Tunbridge Wells, overseen by the Gastroenterology Consultant of the Week and the site management teams.

## Working patterns and staffing changes

**Workforce impact**

| Staff type & band | Current staffing (WTE) | Change (WTE) | The resulting staffing (WTE) |
|---|---|---|---|
| Consultant Staff | 9.0 | 9.0 | 9.0 |

| | | | |
|---|---|---|---|
| Specialist Registrars | 6.0 | 6.0 | 6.0 |
| IMT Doctors | 3.0 (cross site) | 3.0 (cross site) | 3.0 (cross site) |
| Foundation Year Doctors | 4.0 | 4.0 | 4.0 |
| Clinical Nurse Specialists | 3.5 | 3.5 | 3.5 |
| Ward Nursing Staff Tunbridge Wells (ward 12) | 45.07 | 45.07 | 45.07 |
| Ward Nursing Staff Maidstone (Pye Oliver) | 40.21 | 40.21 | 40.21 |

**Consultant Medical Staff**
There are 9 consultant gastroenterologists at MTW. A gastroenterologist of the week (GOW) rota has been planned to manage the central ward as a 7 day service. During the GOW week the GOW consultant will do a ward round each morning and n the afternoon session, the GOW consultant will receive and manage referrals into the service. Job plans will be adjusted to cancel elective commitments for the consultant during their 1:9 GOW week. Elective commitments will increase during the non-GOW week and be built into the business plan for the service to ensure elective capacity meets demand. Demand and capacity modelling is underway with the business intelligence team to confirm the changes to elective capacity.

**Trainee and junior doctors**
Foundation doctors will remain at Maidstone Hospital and carry on doing GIM (General Internal Medical) at their designated site, but IMTs (all) and SpRs will rotate every 2 months between two sites (acute non acute site) during their 4 months rotation to make sure they have an exposure to acute gastroenterology. On call slots will be attached to gastro rotation rather than to trainee's name and regardless location they will do allocated on calls. Clinic will remain on both sites, so trainee carry on doing it regardless location.

**Nursing**
No change in overall nursing numbers is expected from this proposed service change

**Dieticians**
Currently, there is not a dedicated dietetic service to gastroenterology. There is an acute dietetic team who provide a service to all areas of the hospital including for example; ITU, T&O, medicine, inpatient oncology, elderly care etc as well as gastro. In addition these teams provide an outpatient service for patients referred by MTW consultants. The service at the moment is as below.

**TWH – 1** Band 7 team lead x 1 Band 6 x 3**,** Band 5 x 1

**Maidstone 1** Band 7 team lead x 1, Band 6 x 1 **and** Band 5 x 1

**Cross Site** Band 7 ITU cover x1 - vacancy

A recent audit (see appendix 3) for the dietetic service was carried out and the results indicated that inpatient dietetic consultations for medical gastro patients took 49.5 hours per week for TWH and Maidstone. This does not include outpatient follow up which approximately 50 % of patients would require. If we include the time spent on gastro medical and surgical patients the time for dietetic input was 67.6 hours per week again not including outpatient follow up.

Any dietetic investment will be subject to separate Diagnostics and Clinical Support led business case review

## Financial Impact

No significant financial investment other than to strengthen the dietetics team is required to enable this service change.
That investment will be subject to a separate case from diagnostics and clinical support.

Reduction of unnecessary stay in hospital for many patients will reduce spend for the Trust

| Breakdown of financial impacts (State Financial Year) | | Yr 0 | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|---|---|---|---|---|---|---|---|
| CAPITAL COSTS | Estates | | | | | | |
| | IT | | | | | | |
| | Equipment | | | | | | |
| | VAT | | | | | | |
| | Total Capital Costs | | | | | | |
| REVENUE COSTS | Pay | (130,000) | (130,000) | | | | |
| | Non-pay | | | | | | |
| | Other | | | | | | |
| | Other (non- operating) expenditure | | | | | | |
| | Capital charges | | | | | | |
| | Total Revenue Costs | | | | | | |
| INCOME | SLA | | | | | | |
| | Other (specify) | | | | | | |
| | Surplus/Loss | | | | | | |

Summarise the activity and income assumptions relating to the preferred option

Pay costs relate to locum cover on Pye Oliver Ward for a period of 12 months. Cost is based at £1,000 per day.

| Funding source/ body | Sum(£) & % of total | Secured? If not secured indicate status of negotiation |
|---|---|---|
| Identified in the Trust capital programme | | |
| Identified in directorate revenue budget | | |
| Other *( specify)* | | |

## To assist the management of the patients there will be investments required in:

- Additional staff – Only dietetics
- Equipment – none required
- Bed capacity. The 8 bed pressure at TWH will be partially mitigated by reduction in unnecessary length of stay by improving continuity of care, improved interdepartmental communication and better discharge planning.
- (620 gastro patients and the existing surgical patients all have reduced length of stay and therefore the additional bed pressure at TWH is forecast to be 4 additional beds not 8)
- The 4 remaining bed pressure will be managed by divisional projects, although subject to successful implementation cardiology centralisation would mitigate this pressure.

## The impact on other Divisions and Stakeholders

The division requests diagnostics and clinical support assess and plan for the necessary adjustment to dietetic support

**Critical care**

Data review has shown that or the whole of 2019, the total Gastroenterologist led MITU overnights was 43. This suggests three to 4 critical care overnights /month change in demand from Maidstone to TWH. Critical Care have improved ability to flex capacity post Covid.

**SECAMB**

The Specialist Medicine Management Team are liaising with SECAMB on the plan, seeking their view on any implications of the change and will work with them to confirm and agree the change in pathway.

## Project management arrangements

### Timetable

| Milestone | Date |
|---|---|
| HOSC | 21 July 2021 |
| Divisional Board | 22 July 2021 |
| Trust Board | September 21 |
| SECAMB and CCG formally notified | September 21 |
| Administration processes finalised | September 21 |
| Go live | October 2021 |
| | |

## Conclusion and recommendations

The Medical and Emergency Division consider there is strong clinical case for the centralisation of gastroenterology. There has been strong engagement on the proposal and plans are in place for successful implementation of the change

**The Division seek approval for Gastroenterology Inpatient Centralisation at TWH**

## Arrangements for post project evaluation (PPE)

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.
Name of Division/Directorate
Evaluation manager
Project Title & Reference
Total Cost
Start date
Completion date
Post project evaluation Due Date

**Section 1 INTRODUCTION**
Background (a brief description of the project and its objectives)
Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

**SECTION 2: PROJECT PROCESS EVALUATION**
Project documentation issues
Project execution issues
Project governance issues
Project funding issues
Human resource issues
Information issues
What worked well in developing case?
What could be improved in developing a case?
Summary of recommendations for developing a case

**SECTION 3: ACHEIVEMENT OF OBJECTIVES**
Did this Investment meet objectives?
Objective 1
Objective 2
Objective 3 How were they achieved?

**SECTION 4: BENEFITS**
Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

**SECTION 5: VALUE FOR MONEY**
What methodology was used to assess quality, funding and affordability and value for money of service provided?
What were the conclusions?

**SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED**
What problems were encountered during implementation of the project, and how where such resolved?
What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

Version history

| Version | Issue date | Brief Summary of Change | Owner's Name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Appendices

## Appendix 1 Gastroenterology Patient Feedback Survey Report

# GASTROENTEROLOGY PATIENT SURVEY REPORT

| | |
|---|---|
| **Title of patient survey:**<br>Gastroenterology service patient feedback | |
| **Survey ID: N/A** | **Date: June – July 2021** |
| **Name(s) and title of survey lead and/or person(s) undertaking survey:**<br>**Suzanne Bounds Nikki Lewis Nick Baber** | |
| **Background/Rationale for undertaking survey:**<br>To seek patient feedback on their experience with the gastroenterology service | |
| **Aims:** A better understanding of patient's experience with the service, to use any useful feedback to help with future planning for the service.<br>To seek an expert patient group who would be willing to help with service co -design in the future | |
| **Methodology:**<br>*Via feedback form, designed with help of Patient Experience and Healthwatch Teams*<br>*Nurse leads were distributed forms to give to gastroenterology service Inpatients on discharge. Nurse Specialists were distributed forms to share with regular service users.*<br>*Collection period 5-6 weeks in June July 2021*<br>*Collection via paper form and option of Survey Monkey online collection*<br>*(see form attached at end of report)*<br>*Patients not excluded on any protected characteristic* | |

*24 respondents out of approximately 100 forms distributed*

**Conclusion:**

***Good and very good feedback***

- *78% of patients gave the service the highest possible overall satisfaction score*
- *No patient expressed overall dissatisfaction with the service*
- *Level of respect and privacy afforded to patients received high satisfaction ratings*

***Areas to consider for improvement potential***

- *The item relating to the number of times the same doctor spoke to the patient about their treatment received the most dissatisfied score with 12.5% of patients dissatisfied about this*
- *8.2% of patients were not satisfied with the level of communication between staff about the level of the patient's care*
- *4.3% found the number of transfers between wards / site unsatisfactory*
- *While predominantly satisfied, some dissatisfaction expressed on timeliness, shared goal setting and information about care.*

- *5 patients indicated they would be willing to help co design the service (but didn't leave contact details!)*

**Recommendations:**

1. In future plans look to build in as much **continuity of care as possible so that patients recognise the same doctor following them through their care** where this is possible.

2. In future plans look for ways to enhance a **cohesive gastroenterology service with specialists communicating within the team** to provide 'seamless' care

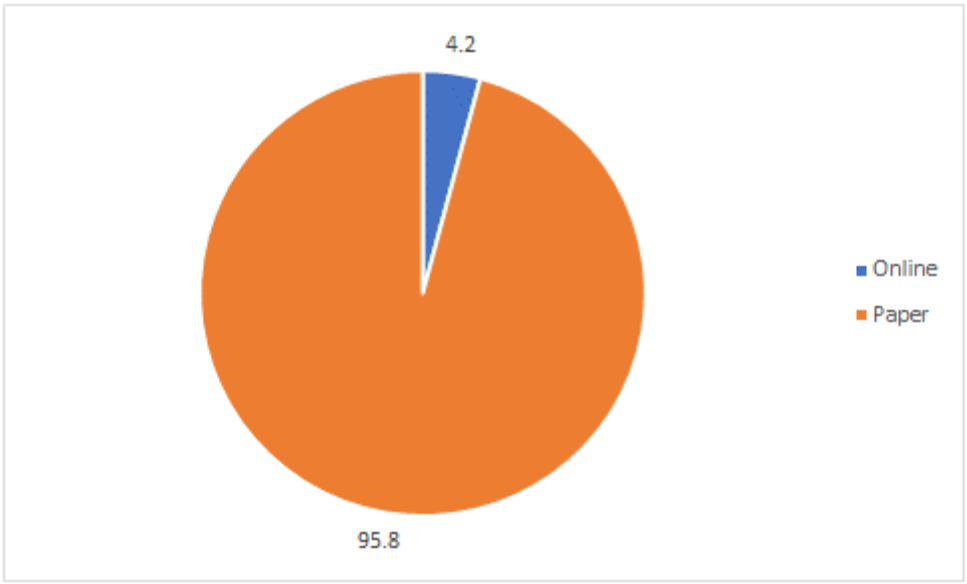
*3.* In future plans look for ways to **reduce transfers of care**

4. Follow up on patients who expressed a wish to be involved in **service co- design** if possible.

**Detail Results:**.

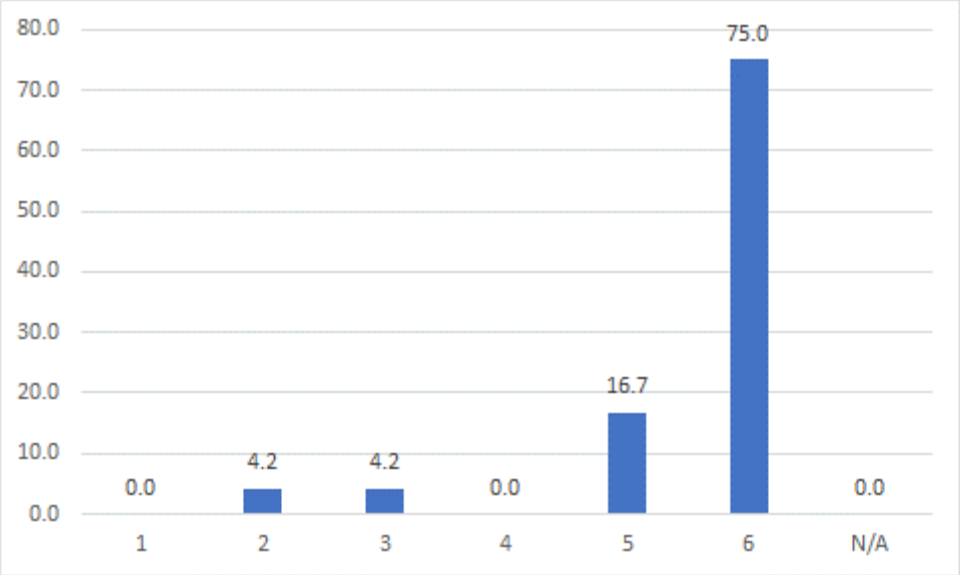
Online or paper forms

| | No | % |
|---|---|---|
| Online | 1 | 4.2 |
| Paper | 23 | 95.8 |
| total | 24 | |



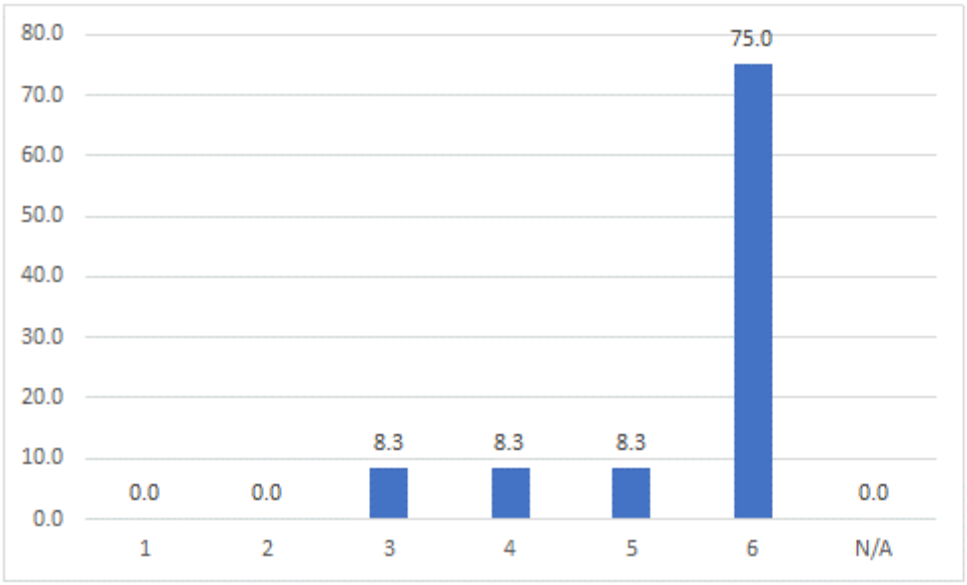
1. The level of respect shown to me by my doctor and other staff was...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 1 | 4.2 |
| 3 | 1 | 4.2 |
| 4 | 0 | 0.0 |
| 5 | 4 | 16.7 |
| 6 | 18 | 75.0 |
| N/A | 0 | 0.0 |
| total | **24** | |



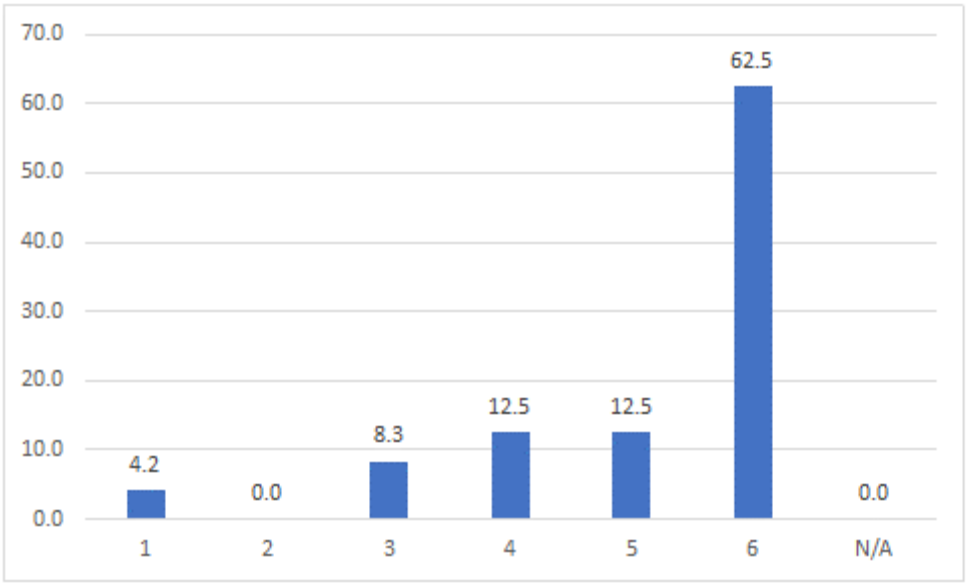
2. The level of privacy available to me was...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 3 | 2 | 8.3 |
| 4 | 2 | 8.3 |
| 5 | 2 | 8.3 |
| 6 | 18 | 75.0 |
| N/A | 0 | 0.0 |
| total | **24** | |



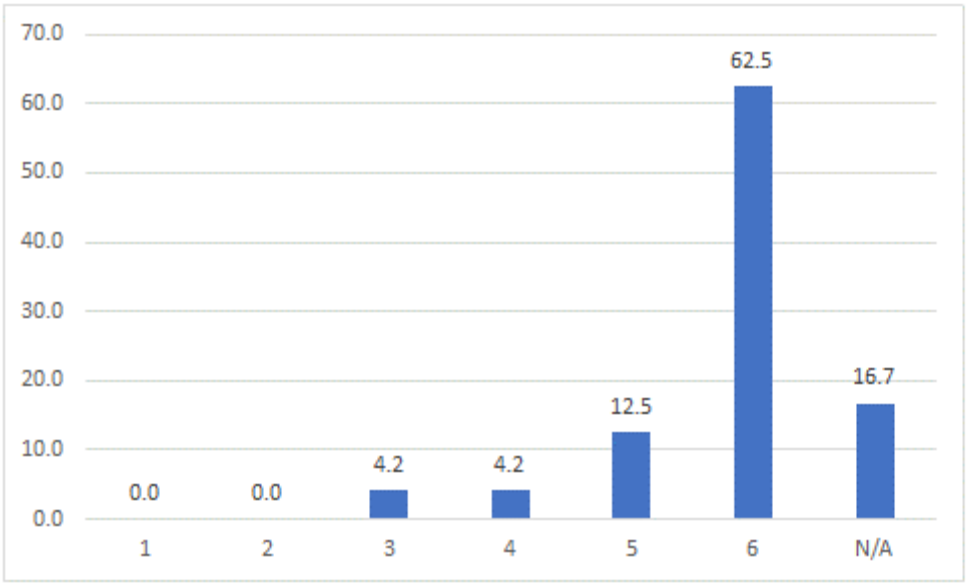
3. The individual communication I received from the service was...

| | NO | % |
|---|---|---|
| 1 | 1 | 4.2 |
| 2 | 0 | 0.0 |
| 3 | 2 | 8.3 |
| 4 | 3 | 12.5 |
| 5 | 3 | 12.5 |
| 6 | 15 | 62.5 |
| N/A | 0 | 0.0 |
| total | **24** | |



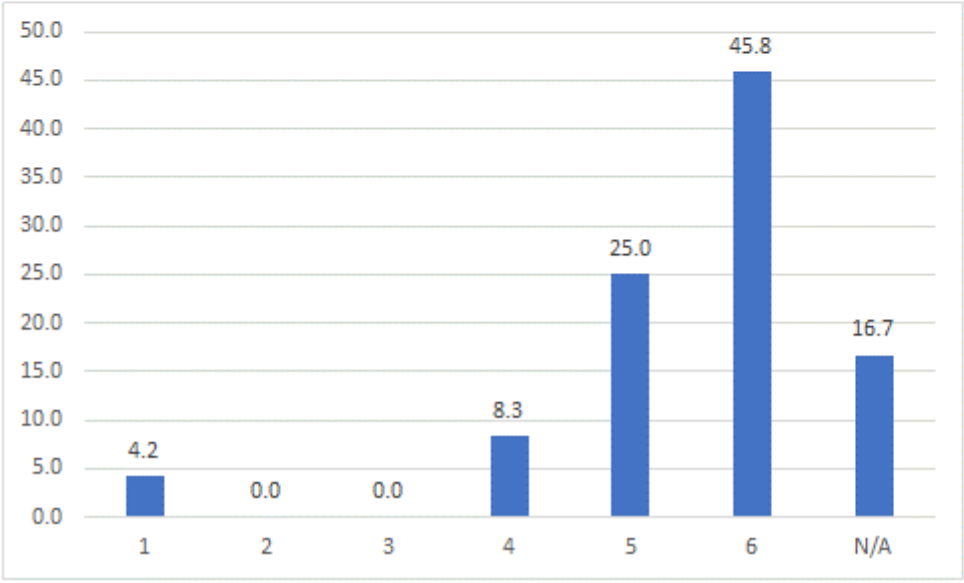
4. The care provided by the service to suit my cultural needs was...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 3 | 1 | 4.2 |
| 4 | 1 | 4.2 |
| 5 | 3 | 12.5 |
| 6 | 15 | 62.5 |
| N/A | 4 | 16.7 |
| total | **24** | |



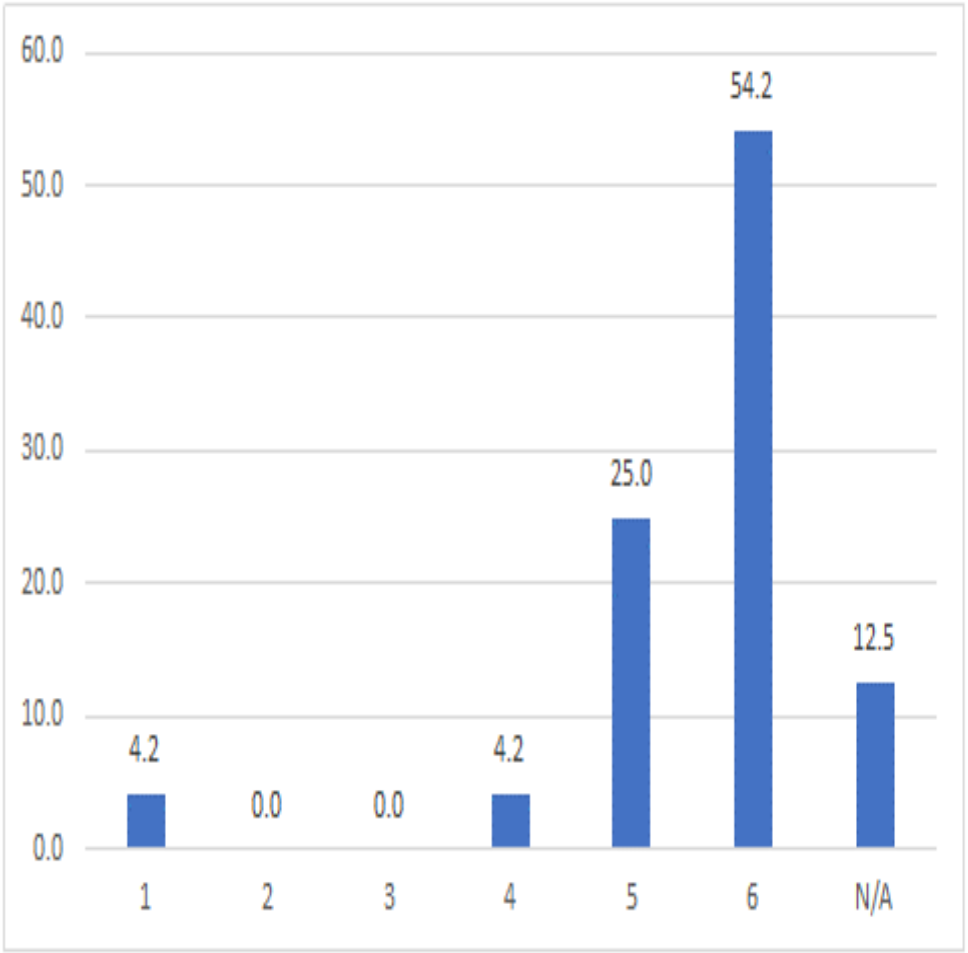
5. My involvement in setting goals and making decisions for my treatment was...

| | NO | % |
|---|---|---|
| 1 | 1 | 4.2 |
| 2 | 0 | 0.0 |
| 3 | 0 | 0.0 |
| 4 | 2 | 8.3 |
| 5 | 6 | 25.0 |
| 6 | 11 | 45.8 |
| N/A | 4 | 16.7 |
| total | **24** | |



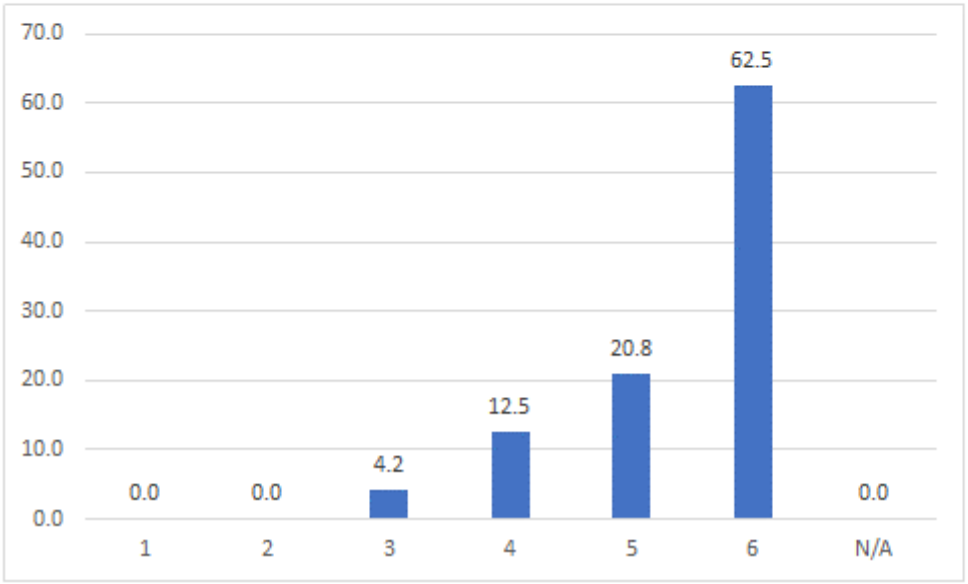
6.The information I received about ways I can manage my own health and wellbeing was...

| | NO | % |
|---|---|---|
| 1 | 1 | 4.2 |
| 2 | 0 | 0.0 |
| 3 | 0 | 0.0 |
| 4 | 1 | 4.2 |
| 5 | 6 | 25.0 |
| 6 | 13 | 54.2 |
| N/A | 3 | 12.5 |
| total | 24 | |



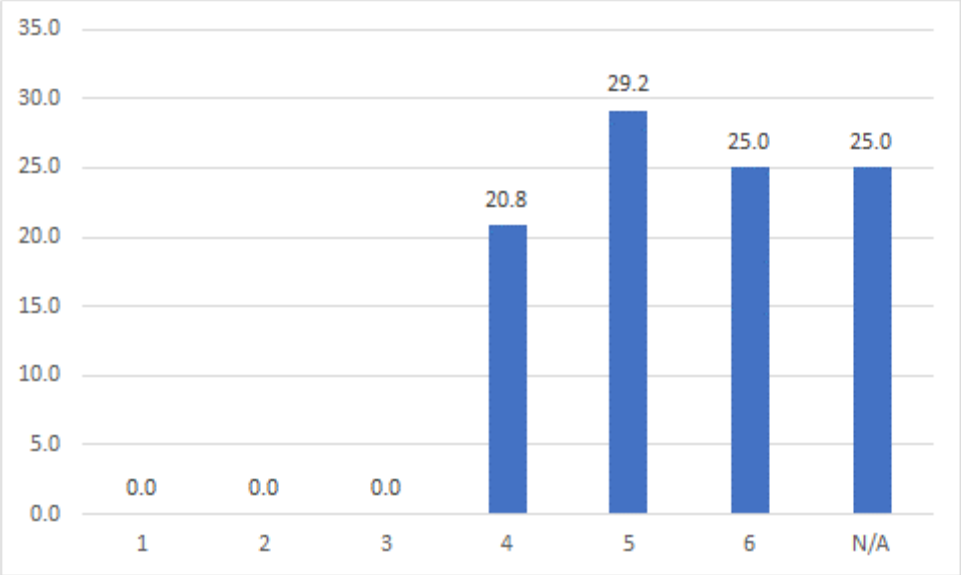
7. The overall service environment and facilities are...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 3 | 1 | 4.2 |
| 4 | 3 | 12.5 |
| 5 | 5 | 20.8 |
| 6 | 15 | 62.5 |
| N/A | 0 | 0.0 |
| total | **24** | |



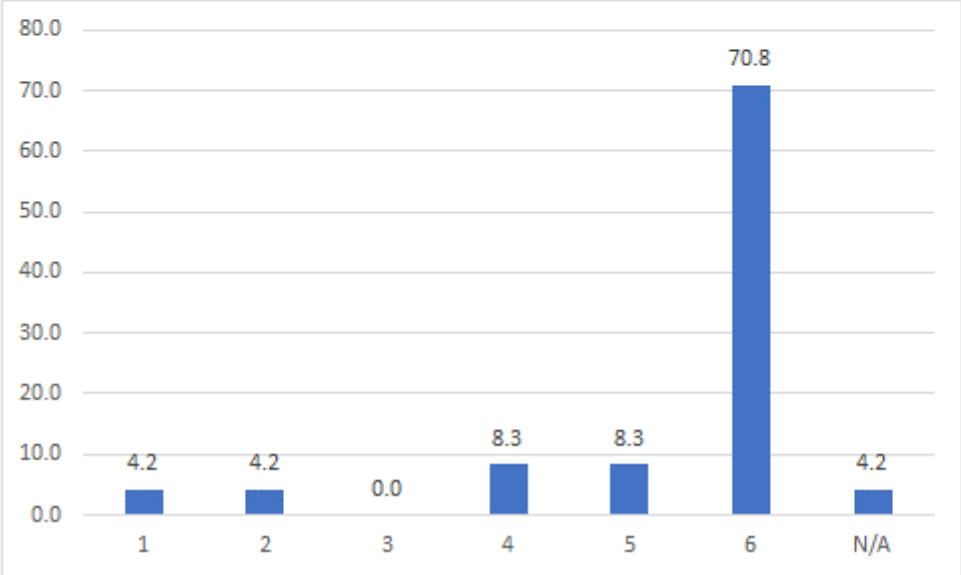
8. My ability to access the service and to receive visits from friends and family was...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 3 | 0 | 0.0 |
| 4 | 5 | 20.8 |
| 5 | 7 | 29.2 |
| 6 | 6 | 25.0 |
| N/A | 6 | 25.0 |
| total | **24** | |



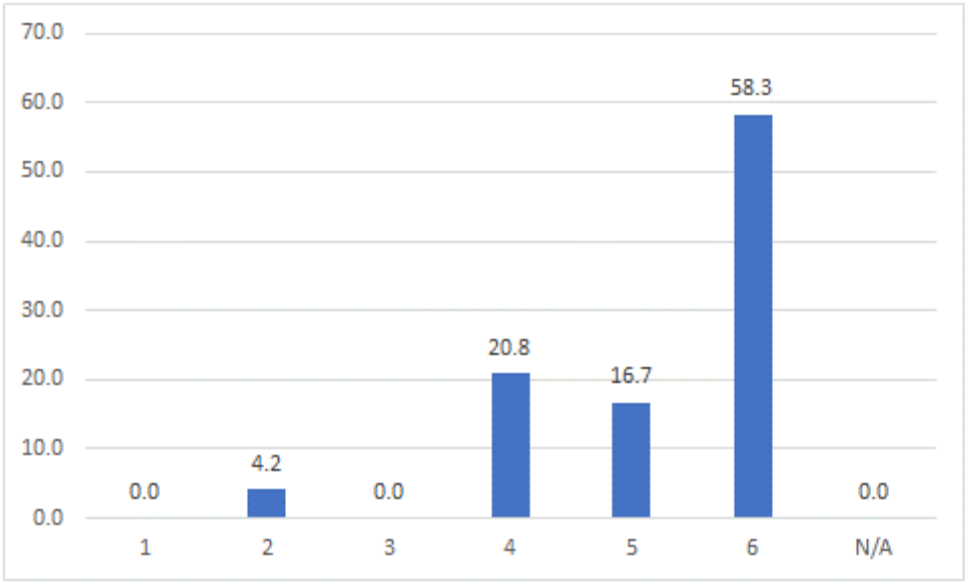
9. The communication between staff about my level of care was...

| | NO | % |
|---|---|---|
| 1 | 1 | 4.2 |
| 2 | 1 | 4.2 |
| 3 | 0 | 0.0 |
| 4 | 2 | 8.3 |
| 5 | 2 | 8.3 |
| 6 | 17 | 70.8 |
| N/A | 1 | 4.2 |
| total | **24** | |



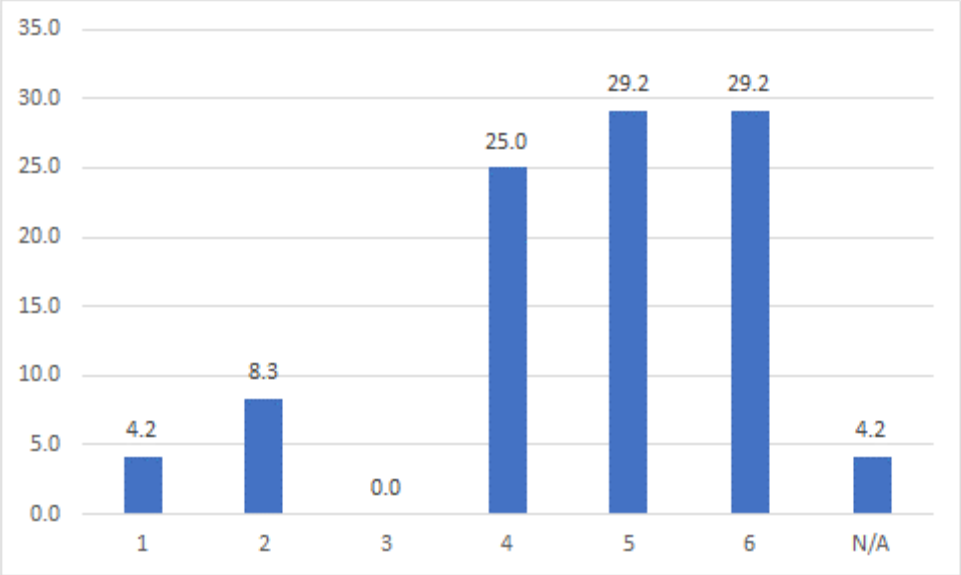
10. The time in which I received my treatment was...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 1 | 4.2 |
| 3 | 0 | 0.0 |
| 4 | 5 | 20.8 |
| 5 | 4 | 16.7 |
| 6 | 14 | 58.3 |
| N/A | 0 | 0.0 |
| total | **24** | |



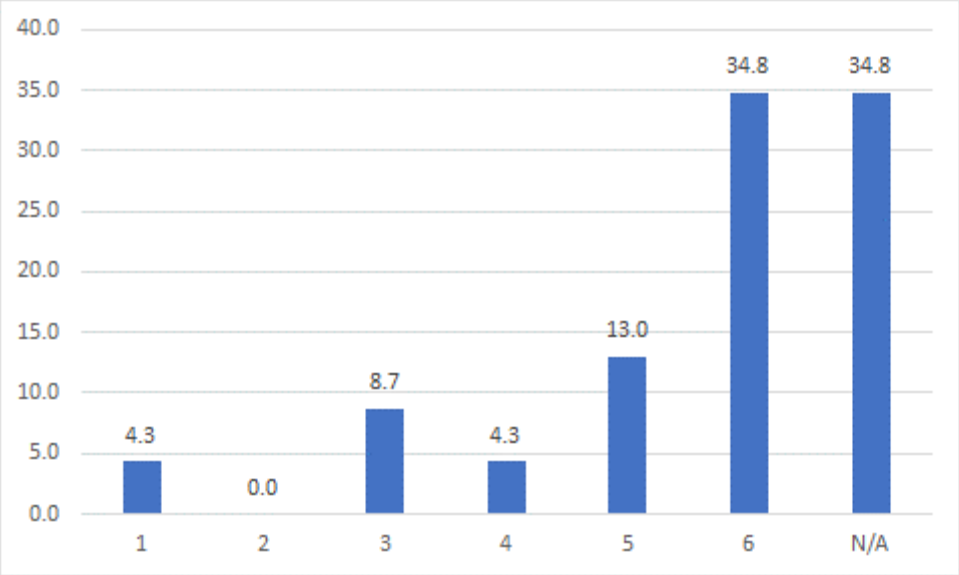
11. The number of times the same doctor spoke to me about my treatment was...

| | NO | % |
|---|---|---|
| 1 | 1 | 4.2 |
| 2 | 2 | 8.3 |
| 3 | 0 | 0.0 |
| 4 | 6 | 25.0 |
| 5 | 7 | 29.2 |
| 6 | 7 | 29.2 |
| N/A | 1 | 4.2 |
| total | **24** | |



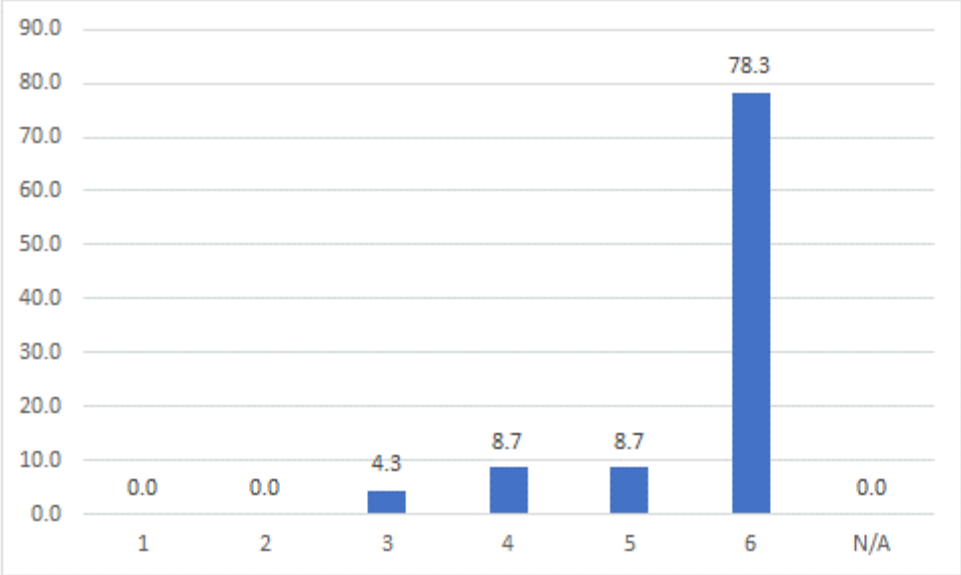
12. If applicable, the number of times I had to move between wards or hospitals during my sta

| | NO | % |
|---|---|---|
| 1 | 1 | 4.3 |
| 2 | 0 | 0.0 |
| 3 | 2 | 8.7 |
| 4 | 1 | 4.3 |
| 5 | 3 | 13.0 |
| 6 | 8 | 34.8 |
| N/A | 8 | 34.8 |
| total | **23** | |



13. My overall experience of the service I received was...

| | NO | % |
|---|---|---|
| 1 | 0 | 0.0 |
| 2 | 0 | 0.0 |
| 3 | 1 | 4.3 |
| 4 | 2 | 8.7 |
| 5 | 2 | 8.7 |
| 6 | 18 | 78.3 |
| N/A | 0 | 0.0 |
| total | **23** | |



14. Are you:

| | NO | % |
|---|---|---|
| Male | 11 | 47.8 |
| Female | 12 | 52.2 |
| total | **23** | |

16. What hospital did you visit?

| | NO | % |
|---|---|---|
| Maidstone | 12 | 52.2 |
| Tunbridge Wells | 9 | 39.1 |
| Both | 2 | 8.7 |
| total | **23** | |

18. What is your age bracket?

| | NO | % |
|---|---|---|
| 0 - 18 | 0 | 0.0 |
| 19 - 35 | 2 | 8.3 |
| 36 - 55 | 5 | 20.8 |
| 56 - 75 | 12 | 50.0 |
| 75+ | 5 | 20.8 |
| total | **24** | |

19. How long have you been a patient of t

| | NO | % |
|---|---|---|
| 6 months | 7 | 31.8 |
| 6 - 12 months | 4 | 18.2 |
| More than a year | 11 | 50.0 |
| total | **22** | |

20. Which site is easier / would you prefer to travel to:

| | NO | % |
|---|---|---|
| Maidstone | 12 | 50.0 |
| Tunbridge Wells | 9 | 37.5 |
| Both are similar | 0 | 0.0 |
| Don't mind | 3 | 12.5 |
| total | **24** | |

MTW Medicine and Emergency Care

# Gastroenterology Department patient feedback form

Dear patient,

As part of our commitment to providing safe high quality care, we welcome and actively ask for feedback from patients to help us identify areas where we can improve our services to better meet patient needs. We would really appreciate feedback on your experience with our gastroenterology service. Your feedback is voluntary, confidential and anonymous.

If you would prefer to take the survey online please visit www.surveymonkey.co.uk/r/YV5KTZV or scan the QR code to the right.

Thank you

**How would you rate your experience with our service?**
Please circle the number which best corresponds to your level of satisfaction with each of the statements below. For example, if you are highly satisfied, circle 6. If you were not at all satisfied, circle 1.

| | | Unsatisfactory ⟷ | | Satisfactory ⟷ | | Better than expected ⟷ | | N/A |
|---|---|---|---|---|---|---|---|---|
| **Part 1: Respect and privacy** These questions relate to the level of respect and privacy shown to you by our service. | | | | | | | | |
| 1. | The level of respect shown to me by my doctor and other staff was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 2. | The level of privacy available to me was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| **Part 2: General** These questions relate to the overall service you have received. | | | | | | | | |
| 3. | The individual communication I received from the service was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 4. | The care provided by the service to suit my cultural needs was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 5. | My involvement in setting goals and making decisions for my treatment was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 6. | The information I received about ways I can manage my own health and wellbeing was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 7. | The overall service environment and facilities are… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 8. | My ability to access the service and to receive visits from friends and family was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |

| | | Unsatisfactory ⟷ | | Satisfactory ⟷ | | Better than expected ⟷ | | N/A |
|---|---|---|---|---|---|---|---|---|
| **Part 3: Co-ordination**<br>These questions relate to how joined up, prompt and well co-ordinated you feel your care was. | | | | | | | | |
| 9. | The communication between staff about my level of care was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 10. | The time in which I received my treatment was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 11. | The number of times the same doctor spoke to me about my treatment was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| 12. | If applicable, the number of times I had to move between wards or hospitals during my stay was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| **Part 4: Overall**<br>This question relates to your overall experience. | | | | | | | | |
| 13. | My overall experience of the service I received was… | 1 | 2 | 3 | 4 | 5 | 6 | N/A |
| **Part 5: Other questions**<br>Please circle as appropriate. | | | | | | | | |
| 14. | Are you: | Male | | | | Female | | |
| 15. | Please describe your ethnic group: | | | | | | | |
| 16. | Which hospital did you visit? | Maidstone | | Tunbridge Wells | | Both | | |
| 17. | Which units or wards did you visit? | Pye Oliver Ward | | Ward 12 | | Outpatients<br>Other: | | |
| 18. | What is your age bracket? | 0 - 18 | 19 - 35 | 36 - 55 | 56 - 75 | 75+ | | |
| 19. | How long have you been a patient of this service? | 6 months | | 6-12 months | | More than a year | | |
| 20. | Which site is easier / would you prefer to travel to: | Maidstone Hospital | | Tunbridge Wells Hospital | | Both are similar | Don't mind | |
| 21. | Would you be interested in helping us make improvements to the gastroenterology service at a later date? If yes, please let one of your nurses know. | | | | | | | |
| Are there any other comments you would like to make about our service, facilities and staff? If so, please comment below: | | | | | | | | |

**Thank you for your time and input.**

Please fold and return this form to the person who gave it to you, or place it in the dropbox or in the envelope provided.

## Appendix 2
## Audit of Gastrointestinal complex inpatients

### Audit of gastro inpatient
### 2 WEEK AUDIT

- TWH
  - Average active gastro pt/day- 11
  - Average discharges/day- 1
  - Average admissions/day- 1
  - Average length of stay – 6.7 days
- MGH
  - Average active gastro pt/day- 8
  - Average discharges/day- 0.7
  - Average admissions/day- 0.7(<1)
  - Average length of stay – 5.5

1- In total average number of gastro beds needed at TWH after centralisation would be- 15 beds

2- The average number of inpatient transfer are anticipated (after the big first move) at- 1 /day

## Appendix 3
## Dietetic audit

**Patients seen by Dietetic Acute Team between 10 – 23rd May 2021**

| Cohort | Number consultations | Total number minutes | Average hours per week | Indirect consultations | Indirect Minutes | Average indirect hours per week | Total time per week for consultation |
|---|---|---|---|---|---|---|---|
| Gastro Medical cross site | 118 (59/week) | 5480 (91 hours) | 45.5 | 11 (5 / week) | 490 (8 hours) | 4 | 49.5 |
| Gastro Medical Maidstone | 20 (10/week) | 835 (14 hours) | 7 | 3 (1 / week) | 345 (6 hours) | 3 | 10 |
| Gastro Medical TWH | 98 (49/week) | 4645 (77 hours) | 38 | 8 (4 / week) | 145 (2.5 hours) | 1.2 | 39.2 |
| Gastro Surgical | 41 (20 week) | 2165 (36 hours) | 18 | 1 | 10 (0.2 hours) | 0.1 | 18.1 |

= 67.6 hours Gastro med / surg inpatient consultation.

In addition to inpatient consultation time

- approx. 50% of medical gastro patients may generate outpatient dietetic follow up – appointment times 1 hour or 30 minutes.
-Number of patients seen who will require dietetic outpatient follow up - 23 (1 Maidstone).

Nutritional Ward round – additional 3 from MGH – may need to consider additional Nutrition Round.

## Appendix 4. The MTW Gastroenterology Engagement Plan (abridged)

### Engagement governance

Oversight from MTW Executive Director AJ, Clinical Directorate, and Digestive Diseases MTW Steering Group. Advice from Healthwatch

### Overview

A jointly owned 3 stage process with Directorate and Trust Patient Experience Team with link to Healthwatch

- Stage one - General feedback on current service sought from gastro patients from existing documents and bespoke form. EQIA completion stakeholder analysis and engagement plan
- Stage two – Wider stakeholder engagement and Patients invited to helping co- design elements of DDU. Case for Change document created following engagement activity and review of feedback
- Stage three – Level of consultation assessed after involvement of CCG and HOSC

## Appendix 5. The MTW Gastroenterology service. Equality information

Understanding the patient group, Stakeholder analysis

### Ethnicity

| | |
|---|---|
| Asian or Asian British - Any other Asian background | 0.7% |
| Asian or Asian British - Bangladeshi | 0.1% |
| Asian or Asian British - Indian | 0.3% |
| Asian or Asian British - Pakistani | 0.1% |
| Black or Black British - African | 0.2% |
| Black or Black British - Any other Black background | 0.3% |

| | |
|---|---|
| Black or Black British - Caribbean | 0.1% |
| Mixed - Any other mixed background | 0.5% |
| Mixed - White and Asian | 0.1% |
| Mixed - White and Black African | 0.1% |
| Mixed - White and Black Caribbean | 0.1% |
| Other Ethnic Groups - Any other ethnic group | 0.6% |
| Other Ethnic Groups - Chinese | 0.1% |
| White - Any other White background | 11.4% |
| White - British | 80.8% |
| White - Irish | 0.4% |
| Not Stated / Not Recorded | 4.2% |

**Religion**

| | |
|---|---|
| Buddhist | 0.2% |
| Christian : C of E | 40.3% |
| Christian : Methodist | 0.5% |
| Christian : RC | 4.9% |
| Christian : z Other | 2.4% |
| Hindu | 0.3% |
| Jewish | 0.1% |
| Muslim | 0.7% |
| Sikh | 0.1% |
| Other | 1.9% |
| Not Religious | 18.3% |
| Unknown / Not Recorded | 30.3% |

**Age**

| | |
|---|---|
| 0 to 9 | 0.0% |
| 10 to 19 | 3.5% |
| 20 to 29 | 11.7% |
| 30 to 39 | 11.4% |
| 40 to 49 | 11.6% |
| 50 to 59 | 13.5% |
| 60 to 69 | 12.3% |
| 70 to 79 | 15.4% |
| 80 to 89 | 15.4% |
| 90 to 99 | 5.0% |
| 100 to 109 | 0.1% |

Sex

| | |
|---|---|
| Female | 57.7% |
| Male | 42.3% |
| Not Known | 0.0% |

MTW Medicine and Emergency Care

## Appendix 6. The future of the MTW Gastroenterology service. The results of the clinically led 'multi- criteria decision analysis'

| Option evaluation results | | Do nothing | | Continue both sites with additional recruitment | | Centralise IP gastroenterology at Maidstone | | Centralise IP gastroenterology at TWH | |
|---|---|---|---|---|---|---|---|---|---|
| **Criteria** | Criteria Weight (0 to 5) | score | weighted | score | weighted | score | weighted | score | weighted |
| Promotes continuity of patient care | 4 | 2 | 8 | 4 | 16 | 4 | 16 | 4 | 16 |
| The number of cross site hospital transfers | 4 | 2 | 8 | 2 | 8 | 2 | 8 | 4 | 16 |
| Promotes better patient better outcomes as a result of higher (hospital or clinician) patient volumes | 5 | 3 | 15 | 3 | 15 | 4 | 20 | 5 | 25 |
| Provides optimal co location of essential and desirable services eg GI Surgery/ Specialist Nutrition/ Specialist Nursing/ 24/7 bleed service | 5 | 2 | 10 | 3 | 15 | 3 | 15 | 5 | 25 |
| Promotes opportunities to further research and innovation | 3 | 3 | 9 | 3 | 9 | 4 | 12 | 4 | 12 |
| Patient experience –Impact on patient experience, including travel times | 3 | 3 | 9 | 3 | 9 | 3 | 9 | 5 | 15 |
| Workforce – Efficient use of staff to cover service commitments | 4 | 3 | 12 | 3 | 12 | 4 | 16 | 4 | 16 |
| Workforce – Recruitment and retention | 4 | 2 | 8 | 3 | 12 | 4 | 16 | 5 | 20 |
| Workforce – Education, training and supervision | 3 | 3 | 9 | 3 | 9 | 3 | 9 | 4 | 12 |
| Promotes the longer term development of excellent gastroenterology services for our population | 4 | 3 | 12 | 3 | 12 | 4 | 16 | 4 | 16 |
| Fit with medical divisional strategy and interdependent services.A&E, cancer services, gen med, critical care and whole hospital winter and covid resilience | 3 | 2 | 6 | 2 | 6 | 2 | 6 | 4 | 12 |
| Flexibility, adaptability and resilience to meet the requirements of growth or changes in future demand or change in national policy | 3 | 3 | 9 | 3 | 9 | 3 | 9 | 3 | 9 |
| Deliverability – Ease of implementation | 3 | 4 | 12 | 4 | 12 | 3 | 9 | 4 | 12 |
| **Combined and weighted quality criteria score** | | 35 | 127 | 39 | 144 | 43 | 161 | 55 | 206 |

| **To approve the Business Case for the development of a Community Diagnostic Hub** | **Deputy Chief Operating Officer** |
|---|---|

Please find enclosed the Business Case for the development of a Community Diagnostic Hub (CDH). The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 21/09/21, to consider the Business Case and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

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

- Finance and Performance Committee, 21/09/21

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

1. To approve the enclosed Business Case

[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

# BUSINESS CASE

Title: **Community Diagnostic Hub for West Kent**

| | |
|---|---|
| **Issue date/Version number** | V2 |
| **ID reference** | |
| **Division** | Diagnostic and Clinical Support Services |
| **Directorate** | Radiology |
| **Department/Site** | Offsite (Hermitage Court) |
| **Author** | Jelena Pochin |
| **Clinical lead/Project** | Ritchie Chalmers |

| **Approved by** | **Name** | **Signature** | **Date** |
|---|---|---|---|
| **General Manager/Service Lead** | Susan White | | |
| **Finance manager** | Seyi Femi-Adeniyi | | |
| **Clinical Director** | Antony Gough Palmer | | |
| **Executive sponsor** | Miles Scott | | |
| **Division Board** | | | |
| **Supported by** | **Name** | **Signature** | **Date** |
| **Estates and Facilities Management (EFM)** | Doug Ward | | |
| **ICT** | Sue Forsey | | |
| **Deputy Chief Operating Officer** | Lynn Grey | | |
| **Diagnostics and Clinical Support Services (DCSS)** | | | |
| **Emergency Planning** | | | |
| **Human Resources (HR) Business Partner** | | | |
| **Procurement** | | | |
| **EME Services Manager** | | | |
| **Outpatients** | | | |

# Business case summary

## Strategic background context and need

Following a review undertaken by Professor Sir Mike Richards and the subsequent publication of the Diagnostics: Recovery and Renewal in October 2020, the need for radical investment and reform of diagnostic services was identified. A large part of this centres around the formation of Community Diagnostic Hubs (CDH) which have six primary aims, these are:

- To improve population health outcomes by reaching earlier, faster and more accurate diagnoses of health conditions.
- To increase diagnostic capacity by investing in new facilities, equipment and training new staff, contributing to recovery from COVID-19 and reducing pressure on acute sites.
- To improve productivity and efficiency of diagnostic activity by streamlining provision of acute and elective diagnostic services where it makes sense to do so; redesigning clinical pathways to reduce unnecessary steps, tests or duplication.
- To contribute to reducing health inequalities driven by unwarranted variation in referral, access, uptake, experience and outcomes of diagnostic provision.
- To deliver a better and more personalised diagnostic experience for patients by providing a single point of access to a range of diagnostic services in the community.
- To support integration of care across primary, community and secondary care.

Regions were asked, where possible, to identify Early Adopter CDHs with the aim of these CDHs starting delivery from Q2. Given this short timescale, it was acknowledged that these were likely to be developed through:

- Expansion or development of existing community diagnostic facilities
- Extending existing contracts with (independent or NHS) providers
- New local contracts (independent or NHS) using existing framework
- Innovative public-private partnerships that can mobilise rapidly through pooled resources.

In order to mobilise quickly, Early Adopters were expected to need only revenue, or rely on locally available capital, to develop into an early CDH. Where Early Adopters were a development of an existing facility, it was expected that there will be an increase in capacity, compared to 2020/21, reflecting the additional diagnostic services provided by the facility as part of the CDH programme.

In all cases, the diagnostic tests and the service model provided was to be consistent with the minimum requirements for a CDH which are:

- **Imaging:** CT, MRI, Ultrasound, Plain X-Ray
- **Physiological measurement:** Echocardiography (ECHO), Electrocardiogram (ECG), including 24 hour and longer tape recordings of heart rhythm monitoring, ambulatory blood pressure monitoring, oximetry spirometry including reversibility testing for inhaled bronchodilators, Fractional exhaled nitric oxide (FeNO), full lung function tests, blood gas analysis via Point of Care Testing (POCT) and simple field tests (e.g. six min walk test)
- **Pathology:** phlebotomy, Point of Care Testing, simple biopsies, NT-Pro BNP, urine testing and D-dimer testing
- For larger CDHs only - **Endoscopy** services including gastroscopy, colonoscopy and flexi sigmoidoscopy

**Alternatively, on an exception basis, be able to show the plan for inclusion of all services from Year 2 onwards.**

In May 2021, West Kent ICP (led by MTW) submitted a bid for Early Adopter status for CDH (see appendix 1). This submission focused primarily on cross sectional radiology capacity with limited physiological measurement activity in phase one and was predicated on the successful progression of Project Cormorant which would provide us with turnkey CDH opportunity with both equipment and staffing immediately available.

This bid was successful and an associated revenue budget allocation of £2,075,000 part year (£5,082,103 full year) was approved and allocated via NHSE/I; this has been transferred to West Kent CCG. (See appendix 1).

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

1. Improve access for patients to diagnostic services by providing earlier access
2. Improve flow for patient by separating acute and elective flow
3. Support the integration of care between primary, secondary and community care

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

We would like to lease a fixed space, Unit A Hermitage Court, to host our CDH development on an mid term basis inclusive of the use of staffed mobile scanners. The following key requirements have been identified (see appendix 2 for further detail):

High level requirements:

- 450m² or so internal space
- Parking spaces for scanners
- Parking spaces for staff
- Public transport accessible
- Available immediately
- 12 month lease
-

This would ensure adequate and appropriate wait and reception space and allow the Trust and CCG partners to explore what additional diagnostics could be included in our interim solution rapidly.

Unit A Hermitage Court offers 6125sq.ft at £24.00 psf and is available from almost immediately. The following risks and benefits have been identified relating to this specific location (see appendix 2 and 3):

- Allocated parking of approx 25 allocated spaces.
- Adequate public transport access
- Large overflow parking areas with agreement of use to house a mobile scanners.
- Currently divided up by the current occupants – could negotiate some of the dividers/fittings to reduce cost
- 5 year leases (or longer) expected for commercial property – risk for 'dead space' longer term should Project Cormorant proceed
- Need healthcare (paramedic / RMO) support to deliver contrast procedures away from existing healthcare facility

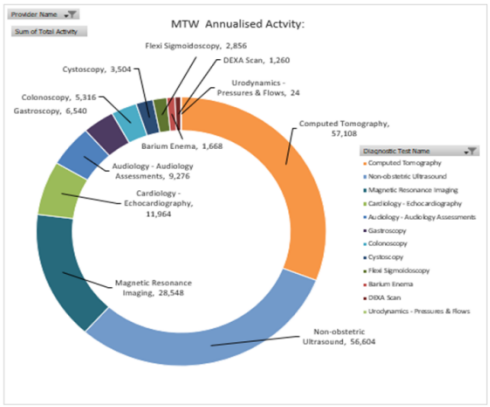
Leasing a fixed space also brings us closer to our CDH bid option and can very clearly be recognised as an away from acute facility, separating our acute and elective flow as recommended in the Richards Review.

Whilst staffing is a rate limiting step currently, recruitment and / or working with partners to secure additional managed service could be rapidly explored to deliver the minimum criteria in the shortest possible time.

As further mitigation, the space could be used to support OP Clinic, swabbing, meeting, clinic and administrative space including InHealth MRI provision which as an aside would potentially smooth the TUPE transfer.

During early adopter phase, our focus will be on the delivery of operationally suitable diagnostics including:
**Imaging:** CT, MRI with potential to explore DEXA and NOUS partnership

Tests and pathways




| Modality | Hospital Trust | CDH | Comments |
|---|---|---|---|
| Plain Film X-Ray | Y | Y | Early Adopter |
| Fluoroscopy | Y | Y | Phase 2 |
| CT | Y | Y | Early Adopter |
| MRI | Y | Y | Early Adopter |
| PET | Y | N | NA |
| NOUS | Y | Y | Early Adopter |
| DEXA | N | Y | Early Adopter |
| Nuclear Medicine | Y | N | NA |
| Interventional Radiology | Y | N | NA |
| Non Invasive Cardiology | Y | Y | Early Adopter |
| Respiratory | Y | Y | Phase 2 |
| Audiology | Y | Y | Phase 2 |
| Endoscopy | Y | Y | Consideration |
| Pain | ? | Y | Consideration |
| UIU | ? | Y | Consideration |

**Monthly-Diagnostics-Web-File-Commissioner-January-2020-Y47MnU – pre-covid activity indication**
https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2019-20/
**West Kent CCG Annualised total activity** from January 2020 data.
As a next step we would work with the region to identify the capacity required for the CDH network. A starting point may be elective/out-patient activity.
Starting assumption is capacity for c100k patients - to be discussed

Phase 2 to include a broader spectrum of cardiology investigations, respiratory investigations, pathology, the pain service and potentially endoscopy. This will then allow us to consider whole diagnostic pathway moves to the CDH, working with our known straight to test and one stop options.
**Imaging:** CT, MRI, Ultrasound, Plain X-Ray

**Physiological measurement:** Echocardiograph (ECHO), Electrocardiogram (ECG), Oximetry, Blood Pressure Monitoring, Spirometry, FeNo and Lung Function Tests , Blood Gas Analysis , Simple Field Tests, Simple pH monitoring

**Pathology:** Phlebotomy, Point of Care Testing, Simple Biopsies, NT-Pro BNP, Urine Testing, D-Dimer

**Main benefits associated with the investment.** *Include here the key benefits the investment would bring to the service.*

| Key performance indicator (KPI) | Baseline position | Future outcome |
|---|---|---|
| Improved DM01 position | | 95% |
| Improved access for elective patients | | |
| Improved onsite flow for acute patients | | |
| | | |
| | | |
| | | |

**Main risks associated with the investment** *Include here the key risks if the project is not undertaken, not undertaken in the timescale you outline and key risks associated with the delivery of the project*

Risk of not doing it:

- Removal of NHSE funding and early adopter status
- Inability to access CDH funding moving forward due to lack of confidence

Delivery risk:

- MTW currently unable to support physiological diagnostics from a staffing perspective without significant recruitment

Residual risk:

- Risk of dead space re: longer term CDH plan
- Delays associated with financial complexities of MRI programme resulting in potential for MRI costs to be at risk

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

| Summary of financial impact | 2021/22 £ | 2022/23 £ | Funding source | Sum(£) |
|---|---|---|---|---|
| **CAPITAL COSTS** Estates | | Unknown pending Capital assessment of lease arrangements. | Identified in the Trust capital plan | |
| ICT | 10,512 | | Identified in directorate revenue budget | |
| Equipment | | | Other *(specify)* | |
| **Total capital cost of project** | **10,512** | | Additional Info: | |
| **REVENUE COSTS** Pay | **226,393** | **325,190** | | |
| Non-pay | **1,841,627** | **3,890,626** | | |
| Capital charges | **1,905** | **3,811** | | |
| **Total revenue cost per annum** | **2,068,020** | **4,215,816** | | |
| **INCOME** SLA | | | | |
| Income – CDH Early adopter (confirmed) | **2,075,000** | | | |
| Income – CDH (TBC – Income based on bid) | | **5,082,000** | | |
| **Total income per annum** | **2,075,000** | **5,082,000** | | |
| **Surplus (+) /Loss (-)** | **6,980** | **866,184** (*assuming recurrent funding received)* | | |

The Trust has received confirmation of early adopter funding for 2021/22 of £2.1m which was inline with the bid submitted. This funding has been given on a non recurrent basis therefore at this stage no funding has been agreed for 2022/23 and beyond.

**Summary 2021/22**

The current forecasted spend associated with this service in 2021/22 is £2.7m which is within the funding allocation. The main costs which are anticipated to be incurred in 21/22 relate to:

- Hire of 2 x CT scanners and 1 x MRI scanner = £1.5m (these are fully staffed scanners)
- Recruitment of 8wte administration staff = £0.2m
- Lease hire of offsite facility = £0.1m

**Summary 2022/23**

The anticipated spend in 2022/23 which is based on the continuation of leasing an offsite unit and the hiring of MRI and CT machines and the permanent recruitment into the administration posts is £4.2m per annum. This is £867k less than the initial bid submitted however the Trust has not received confirmation of funding beyond March 2022.
If the Trust does not receive funding support in 2022/23 the Trust might be in a position of incurring stranded costs relating to signing contracts beyond March 22. This would relate to the off site rental (c£200k per annum) and potentially the hire of CT and MRI scanners (depending upon contract

| | | | |
|---|---|---|---|
| | | | arrangement). The Trust might also have to reassigned any permanent staffing (8wte) to alternative suitable vacancies within the trust.<br><br>**Leasing and Capital Risks**<br><br>**Offsite rental**<br>Hermitage Court building lease needs to be confirmed as an operating lease for 21/22 – lease terms not yet available or market value of building/estimated remaining life. Risk of being a finance lease which would be capital. Low risk if term only 5 years, and no reversion/purchase clauses at lower than market value, or extension options in contract.<br><br>**Diagnostic Equipment**<br>Diagnostic equipment short term rentals/outsourced provisions – rentals from April 2022 likely to be capital costs under new lease accounting standard, so risk of rolling over short term arrangements, or new purchases/arrangements requiring capital funding |

## Timetable

*Include, at a minimum, the expected key milestones, e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.*

| Milestone | Date |
|---|---|
| Mobile scanning provision | 30/9/21 |
| Contract / lease negotiations | Sept - Oct 21 |
| Access for works | Oct 21 > |
| Interim fixed CDH move | Dec 21 -Jan 22 |
| Phase 2 work up | Ongoing |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# The business case

## 1. Strategic context

Following a review undertaken by Professor Sir Mike Richards and the subsequent publication of the Diagnostics: Recovery and Renewal in October 2020, the need for radical investment and reform of diagnostic services was identified. A large part of this centres around the formation of Community Diagnostic Hubs (CDH) which have six primary aims, these are:

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- To increase diagnostic capacity by investing in new facilities, equipment and training new staff, contributing to recovery from COVID-19 and reducing pressure on acute sites.
- To improve productivity and efficiency of diagnostic activity by streamlining provision of acute and elective diagnostic services where it makes sense to do so; redesigning clinical pathways to reduce unnecessary steps, tests or duplication.
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- To deliver a better and more personalised diagnostic experience for patients by providing a single point of access to a range of diagnostic services in the community.
- To support integration of care across primary, community and secondary care.

Regions were asked, where possible, to identify Early Adopter CDHs with the aim of these CDHs starting delivery from Q2. Given this short timescale, it was acknowledged that these were likely to be developed through:

- Expansion or development of existing community diagnostic facilities
- Extending existing contracts with (independent or NHS) providers
- New local contracts (independent or NHS) using existing framework
- Innovative public-private partnerships that can mobilise rapidly through pooled resources.

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This bid was successful and an associated revenue budget allocation of £2,075,000 part year (£5,082,103 full year) was approved and allocated via NHSE/I; this has been transferred to West Kent CCG.

Whilst Project Cormorant remains our preferred solution, unfortunately the timeline associated no longer aligns with the requirements for early adopter status. As such, we need an initial mitigation strategy to manage the risk of early

adopter funding being withdrawn which would also support the development of the West Kent CDH in the longer term should Project Cormorant not be successful.

This business case directly supports the core strategic aims of both the Core Clinical Services Division and the wider Trust, in particular the aspiration for:

- Transforming the way we deliver services so they meet the needs of the patient
- Delivery services that are clinically viable and financially sustainable

85% of patient pathways include a diagnostic investigation and the provision of timely access to cross sectional radiological services is pivotal to the majority of diagnostic and treatment pathways across the Trust in both elective and non-elective settings, and underpins the diagnosis and staging of cancer(s). With the introduction of the 28 day diagnostic standard, the ability to access scanning and reporting with much shorter turnaround times than we have historically provided is required. The radiology service has a significant demand and capacity deficit which has increased over recent years, driven by increased demand and a challenged staffing provision. This has result in a significant volume of outsourcing to independent sector providers.

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

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

1. Improve access for patients to diagnostic services by providing earlier access

2. Improve flow for patient by separating acute and elective flow

3. Support the integration of care between primary, secondary and community care

**Objective 1 – Improve access for patients to diagnostic services by providing earlier access**

**Current situation and risks:** Current timeframes for access to scans and reporting are not where we would like to be and this impacts on both Cancer and RTT targets.

The Trust's DM01 position has worsened over recent months and even the radiological areas achieving the targets are only doing so as a result of high cost outsourcing. The Trust is under increasing pressure by NHSE to improve this position and it is a significant area of scrutiny

**The expected benefits of achieving the change:**
Much improved timely access to cross sectional radiology diagnostics

**Objective 2 – Improve flow for patient by separating acute and elective flow**

**Current situation and risks:** Current flow through diagnostics is consistently impacted by acute requirements both from ED and inpatients. This disrupts planned activity and on occasions results in cancellations.

**The expected benefits of achieving the change**: By separating acute (inc inpatient) and elective activity, this will positively impact both access times for our acute flow and for elective patients. It will also mean

that patients awaiting elective diagnostics do not need to access the main hospital sites which in term will positively impact footfall through the trust, access to parking etc.

**Objective 3 – : Support the integration of care between primary, secondary and community care**
Current situation and risks: Owing to the level of demand within the radiology department, we are unable to support any of the 'Any Qualified Provider' activity via our GP colleagues and indeed we are frequently competing for the same access to outsourced providers resulting in extended waiting times in all areas.

**The expected benefits of achieving the change:** By working with primary and community colleagues to design new pathways, maximise efficiency and increase capacity, we will work in a more cohesive fashion which will benefit the referrers and the patients alike.

## 3. Constraints and dependencies

Recruitment of staff remains a key constraint for rapid progression of CDH projects nationally. Many of the diagnostic specialities are hard to recruit areas and therefore the extension of services is likely to be challenging.

West Kent ICP have started to consider workforce planning, acknowledging the need for:

- Appropriate trained and competent staff to support service
- A flexible multidisciplinary workforce
- Focus on recruitment, retention, teaching, training and development.
- Consistent and appropriate professional structures in place for all aspects of the service
- Modern and effective workflows to maximise workforce efficiency and productivity

This includes:

1. Core rotational team
2. Staffing skill mix appropriate to deliver the range of CDH services and should drive the effective use of new roles that provide development opportunities, including consideration of apprenticeships, physicist and practitioner roles etc
3. Workforce modelling is underway in line with broader demand and capacity to consider growth and deliverability of extended services. Broader workforce solutions including a rolling programme of overseas recruitment, graduate training and apprenticeships is being worked through.
4. Work with ICP and network partners to consider alternate staffing models
5. Continuation of home reporting through broader project workforce to support development
6. Analysis of non-clinical support workforce need including administrative and ancillary

Training and development opportunities considering six mix and network need.

IT connectivity is another key dependency. Work is underway with partners to ensure seamless connectivity between CDH and Primary and Secondary Care including:

- Assessment of need for HSCN network connections or point to point connection.
- Review of necessary infrastructure to connect sites such as firewalls, UPS, wireless, power, networks plus associated hardware

West Kent ICP will also be taking the following considerations for IT, digitisation and connectivity:

1. Mechanism and responsibility for long-term storage of patient information
2. aim to evolve towards a unified system solution for radiology image sharing
3. Ability to receive and process referrals
4. Use of digitally enabled diagnostic equipment should be prioritised to facilitate efficiency and reduce the demand on staff
5. Information sharing between CDH and NHS provider using relevant NHS standards (e.g. DICOM, HL7, National Interim Clinical Imaging Procedures code-set)
6. Patient identification using the NHS number must be used including for all (clinical) data transfers.

This will be critical to; accurately link the patient to their record ensuring safe care, enable integration of patient data and images, enable referrals using the NHS e-Referral Services, enable electronic prescribing

1. Consideration of integration of multiple IT systems, care settings and providers (including NHS and independent sector providers)
2. Systems and solutions must comply with all NHS guidance on security and access control.
3. All requests/referrals* should be received electronically, although capability to receive paper requests/referrals may be required as a form of back-up system only and to provide for patients that do not use digital booking channels.
4. Ability to receive and report on cancer referrals through connection to NHS e-referral system (ERS), with system in place to book the referrals as well as receive them, along with cancer tracking systems in place so that they can record and submit data on Cancer Waiting Times
5. The IT capability to maximise CDH efficiency is critical. IT solutions to identify patients not attending appointments, or to facilitate the pre-appointment process (e.g. automated distribution of instructions the patient must follow prior to a test) should be explored
6. Appropriately coordinate multiple tests to minimise the number of locations and appointments a patient attends
7. Reporting: Accessing results of tests conducted in NHS and independent sector setting will be crucial to enable a seamless patient experience including flagging of urgent results/reports.
8. IT infrastructure to enable offsite working (home reporting) for radiologists and radiographer reporting.

# 4. Short list of options

*Show the short list of alternative ways to meet the objectives you have considered e.g. Variations in scale, quality, technique, location, timing*

**Option 1 Title:** The do nothing option

Description

In May 2021, West Kent ICP (led by MTW) submitted a bid for Early Adopter status for CDH (see appendix 1). This submission focused primarily on cross sectional radiology capacity with limited physiological measurement activity in

phase one and was predicated on the successful progression of Project Cormorant which would provide us with turnkey CDH opportunity with both equipment and staffing immediately available.

This bid was successful and an associated revenue budget allocation of £2,075,000 part year (£5,082,103 full year) was approved and allocated via NHSE/I; this has been transferred to West Kent CCG.

Whilst Project Cormorant remains our preferred solution, unfortunately the timeline associated no longer aligns with the requirements for early adopter status. As such, option 1 (do nothing) would effectively be to acknowledge that we are not in a position to proceed, return the allocating funding and hope to progress the CDH in Year 1 or 2.

## Key activity and financial assumptions

No activity or financial changes – no additional activity would be possible and the trust would continue to need significant outsourced capacity.

Utilisation and efficiency of the cross sectional radiology provision would continue to be significantly impacted by acute flow.

## Non-financial risk associated with the option

| Risk | Baseline risk score | Summary mitigation/ contingency | Mitigated risk score | Lead |
|---|---|---|---|---|
| Staffing | | Ongoing recruitment programme | | Susie White |
| Loss of CDH opportunity | | | | |
| | | | | |
| | | | | |
| | | | | |

## Option 2 Additional offsite mobile provision of radiology capacity at multiple locations plus 'extension' to Managed Service

As part of the dialogue process for the Trusts Managed Service, we ensured that the requirements of the Richards Review were met and ask the suppliers to ensure an offsite provision was agreed and scope for growth as part of CDH programme considered. The approval of the Managed MRI Business case enables us to deliver the additional capacity for MRI required for our CDH identified activity requirements in the short term and additional mobile CT capacity can also be secured and in place.

As an interim solution, locations at existing non acute healthcare facilities have been identified which would ensure we are able to support both contrast and non-contrast imaging.

We would then work with InHealth (preferred supplier) to pursue the permanent MRI build at pace (suggested 20-week TaT once location identified), requesting an extended footprint to enable a CDH positioning (at their risk).

It has been discussed and acknowledged during the MRI project that this would not make InHealth the supplier of all CDH activity but this option would make them master vendor for the building and would allow further discussions around partnerships and activity programmes.

If and when Project Cormorant was to come online, the option for a hub and spoke MRI model would be available.

**Guide estimate timeline:**

| | | | Indicative Dates |
|---|---|---|---|
| 1 | Contract award | | Sep-21 |
| 2 | Go live with mobile scanning provision | | 01-Oct-21 |
| 3 | Identifying location for permanent build | | Sept - Oct 21 |
| 4 | Build Phase | | Oct 21-March 22 |
| 5 | Phase 2 work-up | | Ongoing |

Key activity and financial assumptions

Non-financial risk associated with the option

| Risk | Baseline risk score | Summary mitigation/ contingency | Mitigated risk score | Lead |
|---|---|---|---|---|
| Only able to deliver cross sectional radiology | 4 | Bid was primarily centred on radiology | 2 | |
| Potential loss of control of extension to managed contract | 4 | | | |
| Public perception of privatisation | | | | |
| | | | | |
| | | | | |

£2500 per day

Non-financial benefits associated with the option

| Benefit | Baseline value | Target Value | Measure | Timing | Responsibility |
|---|---|---|---|---|---|
| Managed MRI used as stepping stone | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Option 3 MTW acquired offsite footprint inc mobile provision of radiology capacity

### Description

Work has been undertaken to identify if MTW could lease a fixed space on a temporary basis to host our CDH development on an interim basis inclusive of the use of staffed mobile scanners. The following key requirements have been identified (see appendix 2 for further detail):

High level requirements:

- 450m² or so internal space
- 20 parking spaces for scanners
- 45 parking spaces for staff
- Public transport accessible
- Available immediately
- 12 month lease

This would ensure adequate and appropriate wait and reception space and allow the Trust and CCG partners to explore what additional diagnostics could be included in our interim solution rapidly.

A potential location has been identified in the Maidstone area, Unit A Hermitage Court (see appendix for brochure). This offers 6125sq.ft at £24.00 psf and is available from January 2022. The following risks and benefits have been identified relating to this specific location:

- Allocated parking of approx 25 allocated spaces.
- Adequate public transport access
- Large overflow parking areas with potential for negotiation to use to house a mobile scanner.
- Currently divided up by the current occupants – could negotiate some of the dividers/fittings to reduce cost
- Potential scope to negotiate an earlier occupancy and minimal current usage.
- 5 year leases (or longer) expected for commercial property – risk for 'dead space' longer term should Project Cormorant proceed
- Unable to deliver contrast procedures away from existing healthcare facility – further review required

**Guide estimate timeline:**

| | | | **Indicative Dates** |
|---|---|---|---|
| **1** | Mobile scanning provision | | Sept-21 |
| **2** | Contract / Lease negotiations | | Sept - Oct 21 |
| **3** | Potential early access for works / move of mobile scanners | | Dec-21 |
| **4** | Interim fixed CDH move | | Jan-22 |
| **5** | Phase 2 work up | | Ongoing |

## Key activity and financial assumptions

| | | Total 21/22 | Total 22/23 |
|---|---|---|---|
| **Pay** | | **0** | **0** |
| Management Consultant | £70k/year - 2 to 3days a week | **35,000** | **70,000** |
| Admin Staff at the main site to cover CT and MRI | Assume agency for 3 months | **33,898** | **45,197** |
| 2 booking staff per modality | Assume agency for 3 months | **124,293** | **165,724** |
| Booking Manager | Assume agency for 3 months | **33,202** | **44,269** |
| | | **0** | **0** |
| **Total Pay** | | **226,393** | **325,190** |
| | | **0** | **0** |
| **Non Pay** | | **0** | **0** |
| Rental of offsite foot print | | **88,200** | **176,400** |
| Portable Office (3 months) | | **44,892** | **0** |
| Utilities | | **15,000** | **105,000** |
| Servcie charge and insurance | | **3,250** | **6,500** |
| Rates | | **47,750** | **334,250** |
| CT (Staffing) - Scanner 1 | £3200 per day 7 days per week + VAT | **701,568** | **1,403,136** |
| CT (Staffing) - Scanner 2 | £8750 per week + VAT | **274,050** | **548,100** |
| MRI (Staffed) - Scanner 1 | £2500 per day 7 days per week + VAT | **532,350** | **1,058,400** |
| One off setup costs | | **5,148** | **0** |
| Whisper Generators x 3 | £650 per week | **61,074** | **122,148** |
| Fuel | Estimate £120 per day per machine | **65,772** | **131,544** |
| IT Liciences etc | | **2,574** | **5,148** |
| | | **0** | **0** |
| **Total Non pay** | | **1,841,627** | **3,890,626** |
| | | | |
| Capital Charges | | **1,905** | **3,811** |
| | | | |
| **Total Cost** | | **2,068,020** | **4,215,816** |
| | | | |
| **Income** | | | |
| CDH Funding | | **2,075,000** | **5,082,000** |
| | | **0** | **0** |
| **Total Income** | | **2,075,000** | **5,082,000** |
| | | **0** | |
| **Surplus (+) / Deficit (-)** | | **6,980** | **866,184** |
| | | | |
| *Note income for 2022/23 is not confirmed but is based on initial bid* | | | |

| Modality | Detail | Activity Value per month. | Percentage increase in activity |
|---|---|---|---|
| | £2500 per day | | |
| From Q2: **CT** – Additional offsite capacity | Based on access to additional scanner working **8.00 - 20.00, 7 days per week** | 2136 two scanners (1068 per scanner) | 48% |
| From Q2: **MRI** – Additional Mobile capacity + increased hours onsite | Based on access to additional scanner working **8.00 - 20.00, 7 days per week** | 1250 two scanners (625 per scanner) | 60% |

Non-financial risk associated with the option

| Risk | Baseline risk score | Summary mitigation/ contingency | Mitigated risk score | Lead |
|---|---|---|---|---|
| Risk of dead space | | Space is an issue at MTW, opportunity to convert to office / meeting even OP space | | |
| Staffing for broader diagnostics | | | | |
| IT connectivity | | Several building at Hermitage court are connected to MTW which should support the eased access | | |
| Access to contrast | | Use of paramedic / RMO to support | | |
| | | | | |

Non-financial benefits associated with the option

| Benefit | Baseline value | Target Value | Measure | Timing | Responsibility |
|---|---|---|---|---|---|
| Potential to explore phase 2 rapidly | | | | | |
| Potential for space to be used for alternate options in interim | | | | | |
| Fulfils off site criteria for CDH | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

| **Non - monetary benefits and risks of each option** - *Summarise the non-monetary benefits and risks of each option* | | |
|---|---|---|
| **Option** | **Benefits and risks** | **Option benefit and risk score and/or rank** |

| | | |
|---|---|---|
| **Option 1 Do nothing** | Loss of CDH opportunity | |
| **Option 2** | Provides activity levels. Perception of privatisation and loss of control | |
| **Option 3** | Closer to CDH bid, puts MTW in driving seat. Potential to expand options quickly. | |
| **Option 4** | | |

## 4b. Summary of information on each option

| Category | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| **Capital costs** *(one-off upfront costs)* | | | 10,512 | |
| | | | | |
| A) Annual revenue income (21/22) | | | 2,075,000 | |
| B) Annual costs/ expenses (pay and non-pay) (21/22) | | | 2,068,020 | |
| **Net annual income = ( A –B )** | | | 6,980 | |
| **Benefits** *(non-financial)* score *and or rank of option* | | | | |
| **Risks** score *and or rank of option* | | | | |
| *Summary of option (Preferred / discounted/ deferred)* | | | | |

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

*Has the cost, benefit and risk been identified?*

Whilst the cost of Option 3 is higher, this is obviously to be offset with agreed CDH funding. During the immediate phase, the activity levels will be the same as option 1 however, it secures adequate and appropriate wait space and reception and gives the Trust and CCG the option to rapidly explore what other diagnostic provisions could be housed.

Leasing a fixed space also brings us closer to our CDH bid option and can very clearly be recognised as an away from acute facility, separating our acute and elective flow as recommended in the Richards Review.

Whilst staffing is a rate limiting step currently, recruitment and / or working with partners to secure additional managed service could be rapidly explored to deliver the minimum criteria in the shortest possible time.

As further mitigation, the space could be used to support OP Clinic, swabbing, meeting, clinic and administrative space including InHealth MRI provision which as an aside would potentially smooth the TUPE transfer.

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

# 5. Commercial considerations (preferred option)

### 5.a. Services and/or assets required

IT infrastructure and soft equipment (PCs/ Phones)
Mobile scanners (procured)
Chairs and facilities for wait space
Office equip (part provided)

### 5.b. Procurement route

MRI procurement undertaken and interim option procured
CT procured
Potential for further managed services would result in ongoing procurement processes (up to 6 months)
Lease negotiations ongoing

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

Work is underway with CCG to ensure streamlined pathways. Work will continue to develop broader potential in line with population need alongside the elective recovery plan. Phase 2 considerations include cardio-respiratory diagnostics such as Lung Function Tests, Spirometry, respiratory muscle tests etc alongside the potential for Urology Investigations, Pain Assessments and endoscopy (pending discussions re: 'size' of CDH).

### 5.d. Workforce impact preferred *option*

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

| Staff type & band | Current staffing (WTE) | Change (WTE) | The resulting staffing (WTE) |
|---|---|---|---|
| Management consultant | | | |
| B3 Admin | 0 | 1.5 | 1.5 |
| B3 booking | | 5.5 | 5.5 |
| B5 Team leader | | 1 | 1 |
| | | | |

# 6. Financial impact of the preferred option –
**Full year effect – include VAT unless recoverable**

| Breakdown of financial impacts (State financial year) | | 21/22 | 22/23 |
|---|---|---|---|
| CAPITAL COSTS | Estates | | |
| | IT | 10,512 | |
| | Equipment | | |
| | | | |
| | Total capital costs | 10,512 | |
| REVENUE COSTS | Pay | 226,393 | 325,190 |
| | Non-pay | 1,841,627 | 3,890,626 |
| | Other | | |
| | Other (non- operating) expenditure | | |
| | Capital charges | 1,905 | 3,811 |
| | Total revenue costs | 2,068,020 | 4,215,816 |
| INCOME | SLA | | |
| | CDH Early Adaptor agreed funding | 2,075,000 | |
| | CDH funding (TBA) | | 5,082,000 |
| | Surplus (+) /Loss (-) | 6,980 | 866,184 |

Summarise the activity and income assumptions relating to the preferred option

The Trust has received confirmation of early adopter funding for 2021/22 of £2.1m which was in line with the bid submitted. This funding has been given on a non recurrent basis therefore at this stage no funding has been agreed for 2022/23 and beyond.

**Summary 2021/22**
The current forecasted spend associated with this service in 2021/22 is £2.7m which is within the funding allocation. The main costs which are anticipated to be incurred in 21/22 relate to:

- Hire of 2 x CT scanners and 1 x MRI scanner = £1.5m (these are fully staffed scanners)
- Recruitment of 8wte administration staff = £0.2m
- Lease hire of offsite facility = £0.1m

**Summary 2022/23**
The anticipated spend in 2022/23 which is based on the continuation of leasing an offsite unit and the hiring of MRI and CT machines and the permanent recruitment into the administration posts is £4.2m per annum. This is £867k less than the initial bid submitted however the Trust has not received confirmation of funding beyond March 2022.
If the Trust does not receive funding support in 2022/23 the Trust might be in a position of incurring stranded costs relating to signing contracts beyond March 22. This would relate to the off site rental (c£200k per annum) and potentially the hire of CT and MRI scanners (depending upon contract arrangement). The Trust might also have to reassigned any permanent staffing (8wte) to alternative suitable vacancies within the trust.

**Leasing and Capital Risks**

**Offsite rental**
Hermitage Court building lease needs to be confirmed as an operating lease for 21/22 – lease terms not yet available or market value of building/estimated remaining life. Risk of being a finance lease which

would be capital. Low risk if term only 5 years, and no reversion/purchase clauses at lower than market value, or extension options in contract.

**Diagnostic Equipment**
Diagnostic equipment short term rentals/outsourced provisions – rentals from April 2022 likely to be capital costs under new lease accounting standard, so risk of rolling over short term arrangements, or new purchases/arrangements requiring capital funding

| Funding source/ body | Sum (£) & % of total | Secured? If not secured indicate status of negotiation |
|---|---|---|
| Identified in the Trust capital programme | | |
| Identified in directorate revenue budget | | |
| Other *(specify)* | | |

# 7. Quality impact assessment (preferred option)

| | |
|---|---|
| **Clinical effectiveness** | |
| Have clinicians been involved in the service redesign? If yes, list who. | |
| Yes, Ritchie Chalmers, CoS, Antony Gough Palmer, CD | |
| Has any appropriate evidence been used in the redesign? (e.g. NICE guidance) | |
| Richards Review, radiology guidance | |
| Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate. | |
| | |
| Are there any risks to clinical effectiveness? If yes, list | |
| NA | |
| Have the risks been mitigated? | |
| | |
| Have the risks been added to the departmental risk register and a review date set? | |
| | |
| Are there any benefits to clinical effectiveness? If yes, list | |
| Yes, improved flow for acute patients and more timely access for elective patients | |
| **Patient safety** | |
| Has the impact of the change been considered in relation to: | |
| Infection prevention and control? | Y |
| Safeguarding vulnerable adults/ children? | Y |
| Current quality indicators? | Y |
| Quality account priorities? | Y |
| CQUINS? | Y |
| Are there any risks to patient safety? If yes, list | |
| NA | |
| Have the risks been mitigated? | |
| | |
| Have the risks been added to the departmental risk register and a review date set? | |
| | |
| Are there any benefits to patient safety? If yes, list | |
| | |
| **Patient experience** | |
| Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not. | |
| Patient experience has been at the centre of the project with key objectives centring aroud improving access from a timeliness and convenience perspective | |

| |
|---|
| Has the impact of the change been considered in relation to:<br>• Promoting self-care for people with long-term conditions?<br>• Tackling health inequalities? |
| Health Equity.pdf |
| Does the redesign lead to improvements in the care pathway? If yes, identify |
| Yes, redesign of elective radiology access |
| Are there any risks to the patient experience? If yes, list |
| No |
| Have the risks been mitigated? |
| |
| Have the risks been added to the departmental risk register and a review date set? |
| |
| Are there any benefits to the patient experience? If yes, list |
| |
| **Equality & diversity** |
| Has the impact of redesign been subject to an Equality Impact Assessment? |
| |
| Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment) |
| |
| Has any negative impact been added to the departmental risk register and a review date set? |
| |
| **Service** |
| What is the overall impact on service quality? – please tick one box |

| | | | | | |
|---|---|---|---|---|---|
| Improves quality | X | Maintains quality | | Reduces quality | |

| |
|---|
| Clinical lead comments |
| |

# 8. Project management arrangements

## Timetable

*Include, at a minimum, the expected key milestones, e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.*

| Milestone | Date |
|---|---|
| Provision of offsite mobile scanning capacity | 30/9/21 |
| Contract / lease negotiations | Ongoing |
| Access for works | Oct 21 |
| Step up of CDH work | Jan 22 |
| Phase 2 work up | ongoing |
| | |

# 9. QSIR methodology

# 10. Arrangements for post-project evaluation (PPE)

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.

*Complete the following section now*

Name of Division/Directorate
Evaluation manager
Project title & reference
Total cost
Start date
Completion date
Post-project evaluation due date

*Complete this section by PPE due date*

**Section 1 INTRODUCTION**

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

**SECTION 2: PROJECT PROCESS EVALUATION**

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

**SECTION 3: ACHEIVEMENT OF OBJECTIVES**

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

**SECTION 4: BENEFITS**

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

**SECTION 5: VALUE FOR MONEY**

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

**SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED**

What problems were encountered during implementation of the project, and how where such resolved?
What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

# 11. Appendices

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

Original NHSE submission


Exec CDH paper


Unit A, Hermitage Court Brochure

## Version history

| Version | Issue date | Brief summary of change | Owner's name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

NHS Maidstone and Tunbridge Wells NHS Trust

**Responsible Officer's Annual Report 2020/21** **Medical Director**

As a designated body, the Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer, the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. At Maidstone and Tunbridge Wells NHS Trust medical appraisals are conducted between September and January.

It was agreed at the Trust Board meeting in September 2020 that the Medical Director should 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). The requested information has been included within the enclosed report.

The Board is asked to review the report and approve the Statement of Compliance (Appendix D) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 24th September 2021).

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

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

1. To review the report and;
2. To approve the Statement of Compliance (Appendix D) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation

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

Classification: Official

Publications approval reference: B0614

# A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

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# Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

**Annual Organisational Audit (AOA):**

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

**Board Report template:**

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

**Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

# Designated Body Annual Board Report

## Section 1 – General:

The Board of Maidstone and Tunbridge Wells NHS Trust (MTW) can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer (RO).

| |
|---|
| Action from last year: None<br>Comments: Dr Peter Maskell, Medical Director fulfils these requirements. As required he attends RO updates and training<br>Action for next year: None |

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

| |
|---|
| Action from last year: Sufficient funds and resources are allocated.<br>In 2020 a new appraiser training course was completed; 15 new appraisers were trained. Departments with low appraiser numbers were prioritised.<br>A further targeted appraiser course is planned in 2021 – This is planned for November and will prioritise Oncology, Paediatrics and Pathology.<br>Comments: MTW NHS Trust has 81 appraisers (73 Consultant and 8 SAS doctors).<br>In 2022, MTW predicted appraiser numbers will be 80 Consultant and 11 SAS appraisers.<br>The RO is supported by an Appraisal Lead and an Appraisal Manager.<br>Action for next year: The MAG4 form is to be phased out. The appraisal team hope to introduce a web-based portfolio system for the 2022.2023 appraisal round. |

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

| |
|---|
| Action from last year: None<br>Comments: This is maintained on the GMC Connect website and regularly checked by the Revalidation Manager and Trust Revalidation Lead.<br>Action for next year: Ongoing |

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

| |
|---|
| Action from last year: Ensure that any proposed policy changes are included in the annual report.<br>Comments: An extension to review/update the Medical Appraisal and Revalidation policy in January 2022 was approved by the Joint Consultation Forum in July 2021.<br>Action for next year: Update the policy and include changes made in the annual report. |

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

| |
|---|
| Actions from last year: To repeat and audit in 2021<br>Comments: In August 2021, 20 randomly selected appraisals were reviewed by experienced appraisers. The appraisals were scored against 10 criteria. Each domain was scored 0,1 or 2. Mean scores for the domains varied between 1.6 and 1.95 with a mean across all domains of 1.76.<br>Action for next year: To continue an annual audit of appraisal documentation. |

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

| |
|---|
| Action from last year: None<br>Comments: MTW encourages all doctors to make the most of all development opportunities available to them. In house CPD is accessible to all doctors employed by MTW.<br>All doctors are invited to attend annual appraisal training. This training explains the MTW appraisal system and how to use development opportunities within the Trust. Written information is circulated after the meetings<br>Action for next year: To continue. |

## Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for

any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

| |
|---|
| Action from last year: To continue to highlight the importance of supporting information in appraisee and appraiser update training sessions and to continue with an annual audit.<br>Comments: The importance of supporting information was discussed at appraiser update and appraisee training sessions.<br>The Trust did adopt the 2020 appraisal model. There was less supporting information embedded in the appraisal document but in general the appraiser did document the supporting information that was discussed. This was a part of the annual audit with all the audited appraisals being scored 1/2 or 2/2 for evidence of appropriate supporting information.<br>Action for next year: To continue to highlight the importance of supporting information as a part of the appraisal process. |

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

| |
|---|
| Action from last year: N/A<br>Comments:<br>Action for next year: |

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

| |
|---|
| Action from last year: None<br>Comments: MTW reviews and updates the Medical Appraisal and Revalidation policy every 3 years. Last updated 2019.<br>Action for next year: The policy will be reviewed in January 2022. |

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Review of new appraisers and further training for another 15 approved appraisers, targeting specialities with low appraiser numbers.

Comments: MTW has 81 trained medical appraisers and is organising further appraiser training. This training will be provided for appraisers who work in specialities with low appraiser numbers.

Action for next year: To continually review with the appraisal team, appraiser numbers and the need for new appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continued appraisal review, we will aim to increase appraisee feedback.

Comments: Annual update sessions are held by the Appraisal Lead and there are quality assurance systems that permit feedback of performance to appraisers. Appraisees are asked to give feedback on their appraisals. Completion of feedback forms this year was less than previously possibly due to COVID-19. The Appraisal Lead reviews all appraisals and any deficiencies are fed back to individual appraisers.

Action for next year: Ongoing

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None

Comments: An annual internal audit takes place at MTW of appraisal inputs and outputs. All appraisals are reviewed by the Trust Appraisal Lead and annual data is presented at the appraiser update training sessions.

Action for next year: Ongoing

## Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

| Name of organisation: | |
|---|---|
| Total number of doctors with a prescribed connection as at 31 March 2021 | 488 |
| Total number of appraisals undertaken between 1 April 2020 and 31 March 2021 | 380 |
| Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021 | 108 |
| Total number of agreed exceptions | 105 |

## Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: There are existing processes and MTW will continue to refer individuals where there are fitness to practice concerns, in line with GMC requirements. The Appraisal Lead reviews all on-notice doctors and makes recommendations based on appraisals and a valid 360. These recommendations are ratified by the Chiefs of Service, the Medical Director and the Deputy Medical Director. This year all recommendations were made ahead of the recommendation deadline.

Action for next year: Ongoing

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Review doctors postponed during COVID-19 pandemic and support revalidation for those who are eligible.

Comments: The Revalidation Manager ensures timely recommendations. The Revalidation Lead contacts all doctors for whom a deferral is recommended explaining the reasons for the deferral and working with the doctor to ensure a positive future recommendation. No non-engagement recommendations were made this year.

All doctors whose revalidation was deferred due to the COVID19 pandemic were contacted. Those with sufficient evidence where given the option of requesting an earlier revalidation recommendation.

Action for next year: Ongoing

## Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

| |
|---|
| Action from last year: None<br>Comments: Monitoring doctors' performance and development is a key contributor to clinical governance. Doctors are encouraged to critique their performance, reflect on positive and adverse events in order to learn without fear of persecution or blame, pursue CPD activities and record/analyse outcomes. Doctors may be asked to discuss a specific issue at their appraisal.<br>Action for next year: Ongoing |

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

| |
|---|
| Action from last year: None<br>Comments: Doctors will discuss conduct and performance at their appraisal. We are developing a system to ensure that an appraiser is aware before the appraisal meeting of any complaints or SIs involving a doctor they are due to appraise.<br>Action for next year: Ongoing |

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

| |
|---|
| Action from last year: None<br>Comments: MTW have existing processes for responding to concerns about doctor's fitness to practise.<br>Action for next year: Ongoing |

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent

governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

| |
|---|
| Action from last year: None<br>Comments: MTW have existing processes in place for responding to concerns about doctors.<br>Action for next year: Ongoing |

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

| |
|---|
| Action from last year: None<br>Comments: If there are concerns about a doctor working in this Trust and the doctor works for another provider then the MTW RO will contact any other ROs as required. Transfer of information is conducted via an Medical Practice Information Transfer (MPIT) Form.<br>Action for next year: Ongoing |

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

| |
|---|
| Action from last year: None<br>Comments: MTW have existing processes in place to ensure safeguards exist and are free from bias and discrimination.<br>Action for next year: Ongoing |

## Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

| |
|---|
| Action from last year: None<br>Comments: Processes are in place at MTW to undertake all mandatory pre-employment background checks before an individual's start date to ensure licenced medical practitioners are qualified and experienced for the role.<br>Action for next year: Ongoing |

## Section 6 – Summary of comments, and overall conclusion

**Please use the Comments Box to detail the following:**

**General review of actions since last Board report**

- Actions from the previous annual board report and statement of compliance have been completed.
- Appraiser numbers have been increased with more targeted recruitment planned. Specific training and guidance on the new appraisal system have been introduced.
- Recommendations for those whose revalidation has been delayed by the COVID19 pandemic have been made in a timely manner.

**Actions still outstanding**

- Processes to provide Appraisers with Supporting Information e.g. SI, complaints etc prior to medical appraisal: A process has been introduced to highlight to an appraiser where an appraisee has been involved in an SI. Trust systems currently do not allow the identification of all doctors involved in a complaint (only those upheld). Introduction of EPR should enable all doctors involved in a complaint to be identified.

**Current Issues**

- Ensuring that the appraisal documentation highlights any verbal supporting information that is given.
- Ensuring that all appraisals include key information; completion of mandatory training, Governance forms from non-NHS organisations etc.
- Support for the MAG4 form used by MTW for appraisal will end in 2022.

**New Actions:**

- To introduce a web-based appraisal system.
- To introduce an appraisal checklist to cover key information that should be documented in all appraisals.
- To explore, once a web-based appraisal system is introduced, whether the "appraisal season" should be replaced with appraisals throughout the year. The recent engagement survey suggests that this change would be supported by appraisees.

**Overall conclusion:**

The MTW appraisal system is well supported by appraisers and appraisees, doctors in all specialities are willing to act as appraisers.

All MTW appraisals are reviewed and where needed clarification or correction is requested from the appraiser. This does ensure that all appraisals are satisfactory

Doctors who are due a revalidation recommendation are reviewed by the Revalidation Lead and recommendations are approved by the Medical Director, Deputy Medical Director and Chiefs of Service.

## Section 7 – Statement of Compliance:

The Board of Maidstone and Tunbridge Wells NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body [(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Maidstone and Tunbridge Wells NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.


Publication approval reference: PAR614

**Action: 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)**

438 appraisals reviewed

The majority of doctors used the new shortened version of the MAG4 form. This encourages a more supportive appraisal and allows for verbal supporting information rather than written

The range of appraisals per appraiser was 1 – 12 with a mean of 5

Approximately 1/3 of appraisals were late

Mean PDP planned was 3.5 (3.4 2019.2020) and mean PDP achieved was 60% (71% in 2019.2020)

Key themes from appraisals:

Most doctors did not report that the COVID-19 pandemic had an adverse effect on their health

Comments on feeling unsupported by colleagues and the management team were very rare. Many appraisals commented that they did feel supported

Discussion on quality on of life / work life balance is more frequent with many discussing a potential reduction in workload and clinical sessions

Discussion of early retirement was very rare

CPD activity was significantly reduced. Most had attended some on-line CPD, many had not achieved the annual CPD target

Action Plan for Maidstone and Tunbridge Wells NHS Trust - September 2021

| Action/Issue | Action required | Responsible person | Target Date | Progress |
|---|---|---|---|---|
| To introduce a web-based appraisal system | | Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager | September 2022 | |
| To introduce an appraisal checklist to cover key information that should be documented in all appraisals | | Trust Appraisal & Revalidation Lead | September 2022 | |
| To explore, once a web-based appraisal system is introduced, whether the "appraisal system" should be replaced with appraisal throughout the year | | Trust Appraisal & Revalidation Lead / Appraisal & Revalidation Manager | September 2022 | |

NHS Maidstone and Tunbridge Wells NHS Trust

| **Health & Safety Annual Report, 2020/21 and agreement of the 2021/22 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)** | **Risk and Compliance Manager** |
|---|---|

This report has been prepared by the Trust Competent Persons for the Board.

The Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2021/22
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's Health and Safety performance for 2020/21
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2021/22
- Identifies the strategy and action plan for the next year and going forward

The data shows that around 16.75% of reported incidents of harm relate to staff, contractors and visitors and 83.25% relate to patients. There are many programmes and initiatives focused on patient safety so this report concentrates on issues relating to staff safety only.

It was agreed at the Trust Board meeting in September 2020 that the Chief Operating Officer (via the Risk and Compliance Manager) should ensure that the Health & Safety Annual Report for 2020/21 included content on water-related safety issues. The required information is included within the enclosed report.

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

- N/A

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

1. To discuss the report and note the role of the Board.
2. Information and assurance
3. To accept the work programme for 2021/22

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

**MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST**

# Health and Safety – Annual Board Report and Programme for 2021/22

**Requested/ Required by:** Trust Board and the Trust Management Executive

- Health and Safety at Work etc Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Workplace Health and Safety Standards 2013

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Falls Prevention Practitioner,
Vascular Access Specialist Practitioners
Moving and Handling Advisor
Water Hygiene Manager

**Document lead:** **Chief Operating Officer**
(Board lead for Health and safety)

**Directorate:** Clinical Governance

# Health and Safety – Annual Board Report and Programme for 2021/22

| | |
|---|---|
| **Requirement for document:** | This annual report and programme is:<br>• A review of the Trust's health and safety statistics and performance for 2020/21.<br>• Assessment against objectives and KPI's set in the previous year.<br>• Discussion of the key health and safety issues identified within the year.<br>• Discussion document for the Board to determine the objectives and KPI's for 2021/22.<br>• Identifies the strategy and action plan for the next year and going forward. |
| **Cross references:** | This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974.<br>This report is supported by Trust key policies and procedures:<br>• Health and Safety Policy and Procedure<br>• Risk Management Policy and Procedure |

| **Version Control:** | | |
|---|---|---|
| **Issue:** | **Description of changes:** | **Date:** |
| 12 | First annual Board report | May 2012 |
| 14 | Second annual Board Report | May 2013 |
| 15 | Third annual Board Report | May 2014 |
| 16 | Fourth annual Board Report | May 2015 |
| 17 | Fifth annual Board Report | July 2016 |
| 18 | Sixth annual Board Report | August 2017 |
| 19 | Seventh annual Board Report | August 2018 |
| 20 | Eighth annual Board Report | August 2019 |
| 21 | Ninth annual Board Report | August 2020 |
| 22 | Tenth annual Board report | August 2021 |

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## 1. Executive Summary

### Introduction

The Health and Safety Executive (HSE) advised that the Board should lead and set the agenda for all health and safety requirements across the Trust. This report informs the Board on health and safety performance and provides the level of assurance to lead the strategy moving forward:

- Discuss and agree the Trust's health and safety objectives
- Formerly delegate the management of health and safety performance and strategy to the Health and Safety Committee

This annual report provides:

- A review of the Trust's health and safety statistics and performance for 2020/21.
- Assessment against objectives and KPIs set in the previous year.
- Discussion of the key health and safety areas identified within the year.
- Discussion document for the Board to determine the objectives and KPIs for 2021/22.
- Identifies the strategy and action plan for the next year and going forward.

Staff, Trust and public incident statistics make up 16.75% of the total incidents reported, which is dominated by patient incidents (83.25%). There are many programmes and initiatives for patient safety so this report concentrates on staff, contractor and visitor safety.

### Highlights

Health and Safety Team

A new position of Trust Health and Safety Advisor has recently been appointed into and they will support the Head of Fire and Safety and the Risk and Compliance Manager, this will provide an opportunity for the team to further build on and develop robust health and safety systems within the Trust.

COVID-19

The Trust's health and safety management arrangements in conjunction with the Infection Prevention Control Team and Incident Command Centre, during the COVID pandemic was proactive in the way it reacted to both external national guidance and internal issues. The Trust's actions were dynamic and evolved with the various stages of the national emergency especially during the developing early part of the pandemic.

Health and Safety Directorate Monthly reports

Implementation of Directorate reports informing of the current position of RIDDOR incidents, incidents outstanding investigation, themes and trends of incidents and feedback of learning, the report also includes the current position of compliance with annual risk assessments. Since the monthly reports have been implemented there has been an increase in improvement of compliance with the annual completion of hazard profile checklists and risk assessments for the clinical areas.

Implementation or RIDDOR investigation process

On retrospective review of the completed and outstanding RIDDOR incidents there did not appear to be the level of investigation that would be expected for a moderate/serious staff or public incident. Trial of the new process is ongoing to ensure appropriate root cause, learning and implementation of actions to prevent recurrence.

## Key findings

- Specific objectives have been completed from 2019/20, though there remain some areas where ongoing objectives have been carried over.
- Overall reporting rates have decreased by 11.5% compared with 2019/20.
- There was a decrease of between 11.8% and 19.6% in the five most common harm categories, reflecting the overall downward trend in reports.
- The number of incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) decreased from 24 in 2019/20 to 22 in 2020/21. This does not include the requirement to report COVID-19 occupational disease to the HSE under RIDDOR (924),
- There was a decrease in the number of over 7-day injuries, but an increase in the number of specified injuries.
- Violence, aggression and harassment incidents were the most common type of health and safety-related incidents. There was an overall 16% decrease in harm incidents, with a 24.5% decrease in the overall number of incidents.
- Sharps harm incidents decreased by 13.85% compared with 2019/20.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.
- There was a 19.64% decrease in falls harm incidents when compared with injuries in 2019/20.
- The impact of the COVID-19 pandemic is clear with the reduction in incidents, harm incidents and RIDDOR incidents. However, the principles health and safety management have come to the fore during the pandemic, particularly that of risk assessment and applying hierarchies of risk control.

## Health and Safety Executive (HSE)

HSE will not undertake proactive inspections or visits to health care organisations at the same frequency as higher risk industries. However, they will undertake proactive inspections in line with their own strategy and reactive visits based on intelligence (see **Section 7**).

## 2. Introduction

Health and Safety legislation requires the Trust Board to control the health and safety risks to their employees and others not in their employment. “Others” refers to contractors, volunteers, visitors and includes patients, and it is patients who generally suffer most harm in a clinical environment. There are numerous standards, requirements and bodies whose key role is to protect the safety of patients. This report will focus on staff, as well as public safety, which, in turn, are a key element of patient safety.

Staff, contractor and visitor incident statistics make up 16.75% of the total incidents reported. This group, however, make up 29.2% of the total incidents of harm. These have been divided into groups based on severity:

- Deaths to employees, contractors and visitors (deaths at work).
- Incidents and Injuries reportable to the HSE under RIDDOR.
- All staff and public injuries.

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 86.3% of the total staff, Trust and public incidents of harm fit into these categories. This allows for bench marking against all industry and the health sector:

- Falls (staff and visitor slips, trips and falls)
- Medical Sharps (needle stick injuries)
- Violence and abuse (including physical assault and trauma).
- Struck by or collision with an object
- Moving and handling
- Contact with machinery and hot surface (includes hot liquids)
- Contact with a hazardous substance (includes biological agents)

Reporting rates are important as a reduction in injuries could be a result of improving standards or reduced reporting.

The Trust’s Occupational Health Service undertakes health surveillance on staff to identify or prevent occupational diseases where they may arise from the employee’s work. They also maintain records of referral of staff for workplace illness.

## 3. Review of Objectives and Programme set for 2020/21

In September 2020 the Trust Board agreed a programme for 2020/21:

| Action | Leads | Progress and Comments |
|---|---|---|
| **Health and Safety Management** | | |
| Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers | Head of Fire & Safety | An upgrade of Synbiotix was completed, however the compliance and review reminders did not function accurately and were subsequently disabled. In addition, an action planning function was not available to be used in conjunction. |
| Roll out of Datix reporting H&S Audit | Risk and Compliance Manager | Initially Synbiotix upgrade would have covered the shortfalls that Datix would have covered and preferable as already set up. However, continuing issues with Synbiotix means that the Datix option, which is ready to roll out, is being revisited. |
| Reduce the number of incidents and RIDDOR involving slips, trips and falls | Head of Fire & Safety; | Raised awareness of slips, trips and falls not possible through face to face |

| Action | Leads | Progress and Comments |
|---|---|---|
| through improved awareness, reporting and monitoring. | Compliance Officer (Estates) | statutory and mandatory training, so other communication methods used. However, lower than normal footfall on main Trust sites means that accurate comparison year on year has not been possible. |
| Raise awareness to increase accuracy of incident reporting and quality of investigations for staff/Trust/Public incidents | Risk and Compliance Manager / Head of Fire & Safety | Statutory and mandatory training has been affected by COVID-19. Therefore, online content used and specific messaging around incident reporting not possible. However, efforts have been made to improve the quality of RIDDOR and sharps/splash investigations through the introduction of checklists for investigators. |
| Reduce number of RIDDOR reports submitted outside of HSE timescales | Head of Fire & Safety/Risk and Compliance Manager | If COVID-related RIDDOR reports are not included then there has been an improvement from 62.5% in 2019/20 to 72.7% in 2020/21. Including COVID-related RIDDOR reports would greatly improve the figure, but not be an accurate comparator. Further improvement sought. |
| **Falls** | | |
| Focus work to improve multifactorial risk assessment for patients at risk of falls | Lead Nurse for Falls Prevention; | The focus on specific elements of the multifactorial risk assessment such as lying and standing blood pressure continues with training for staff on method of undertaking the assessment, monitoring of the progress of compliance and sustainability by undertaking monthly audits. Visual impairment is another element that has been focussed on to improve assessment and documentation of assessment.<br>Ad hoc training sessions were delivered when are where required whilst all face to face training were suspended due to COVID-19 pandemic measures. |
| Continue with awareness and training to further reduce staff falls.<br><br>Promote Falls Prevention- participate in Falls Awareness Week (21st to 28th September 2020) | Risk and Compliance Manager/ Head of Fire, Safety and Environment/ Lead Nurse for Falls Prevention<br><br>Lead Nurse for Falls Prevention | Falls awareness week in 2020 was scaled down due to the to COVID-19 pandemic measures. Resources and information packs were sent out to all wards/ units with themes around delirium, vision assessment, patient mobility assessment and the link to falls. Information on post-fall moving and handling was also made available for staff. |
| Environmental Hazards to be reviewed annually by departments and wards | Departmental /Ward Manager | Environmental hazards should be reviewed as part of annual hazard profile checklist, regular H&S inspections, as |

| Action | Leads | Progress and Comments |
|---|---|---|
| | | well as other inspections and checks. Improvements in Synbiotix reporting and planned scheduled inspections will lead to greater assurance (see **Section 9 Objectives**) |
| **Radiation Protection** | | |
| Improve resilience in radiation protection for non-ionising radiations – ultrasound and lasers. | Head of Radiation Physics | Risk assessment completed and action plan is progressing. There are now three individuals signed off for ultrasound quality assurance and one for lasers. There is one individual signed off for lasers and one in training. Business case for scientific non-ionising lead is progressing 2021-22. |
| **Violence and abuse** | | |
| Produce business case for funding for additional security officers | Trust Security Manager | Both car park and security contracts end in 2022. Intention is to merge the two and up provision from three to five staff as well as other certain infrastructure improvements. |
| CCTV has been placed on the risk register for MGH and TWH | Trust Security Manager | Quotes have been obtained for MGH and a business case will be submitted. TWH is more complex as it is a PFI, but costings have been obtained and is awaiting authorisation to proceed. |
| To continue with the education of the security team in relation to dementia, learning disabilities, MHA and MCA | Trust Security Manager and Corps of Security | Face-to-face training affected by COVID pandemic. Security Manager is in consultation with relevant persons to develop training in this area. |
| **Moving and Handling** | | |
| Develop a new training plan for moving and handling that will incorporate a more specific pathway for different areas, including bespoke training and support the monitoring of competencies | Moving and Handling Advisor | Plan has been developed and recruiting a new trainer/facilitator in the near future. Link assessor proposal has been sent to Nursing and Midwifery committee and will be discussed in next meeting (end of June). Competency workshops are planned at present with staff completing e-learning which also includes watching videos of using equipment. Bariatric training will be starting with first session in June. |
| Review moving and handling equipment and resources within the Trust | Moving and Handling Advisor | Working with EME and Procurement to standardise all equipment. Audits being carried out every two months starting this month to look at needs and condition of equipment and resources. |
| Review the standard operating procedures and risk assessments for moving and handling | Moving and Handling Advisor | This has been started but more work is planned to bring this up to a good standard. |
| **Sharps** | | |
| The Safety, Health and Risk Advisory Group (SHRAG) will investigate strategies to change staff attitude and | Head of Fire and Safety | The SHRAG continued to meet virtually. Sharp incidents were discussed. A checklist has been produced to assist in |

| Action | Leads | Progress and Comments |
|---|---|---|
| the embedded medical sharps culture | | improving the quality of investigations. A lack of face-to-face statutory and mandatory training has had an impact on this objective. |
| Continue to review new safety devices in the market place across the Trust. | Vascular Access Specialist Practitioners (VASPs) | We continue to review safety devices. No changes have been made to venepuncture or cannulation devices. There have been difficulties in obtaining Hubber Gripper plus non-coring safety (20g) (3/4 inch) needles to access ports. EZ Huber needles have been obtained to use as an alternative while supplies are poor. This device has been used previously within the trust and the safety device activation mechanism is the most similar to the Gripper plus. Bespoke training has been given to staff in areas where the EZ Hubber needles have been introduced. |
| Continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required | Vascular Access Specialist Practitioners (VASPs) | The Vascular Access team have continued to assist in the root cause analysis on needle stick injuries. Staff are contacted by phone email or in person to discuss the needle stick injury. If needed further training is given to ensure the correct activation of the safety devices, procedural techniques and in the safe disposal of devices. |
| **Occupational Health** | | |
| Raise awareness and encourage staff and their managers to report work related stress and other ill health events through Datix. | Occupational Health Manager / Head of Fire, Safety and Environment / Risk and Compliance Manager | Statutory and mandatory training has been affected by COVID-19. Therefore, online content used and specific messaging around reporting work-related stress and other ill-health events through Datix not possible. However, the COVID-19 pandemic has led to very significant increase in workplace occupational disease reports. |
| Review and raise awareness of risk assessments that do or could identify the need for health surveillance | Occupational Health Manager | Ongoing review and where requirement identified health surveillance provided. For example, classification of certain workers under Ionising Radiation Regulations 2017. |
| Reduce the gap between sharps / splash injuries reported on DATIX and the OH system. | Occupational Health Manager | Shortfall remains (see **Section 6.4.3**). Ongoing monitoring by OH, Health and Safety team and VASPs. |
| Review Latex Policy and Procedure | Occupational Health Manager | Proforma review undertaken October 2020. Policy due for review in 2024. |

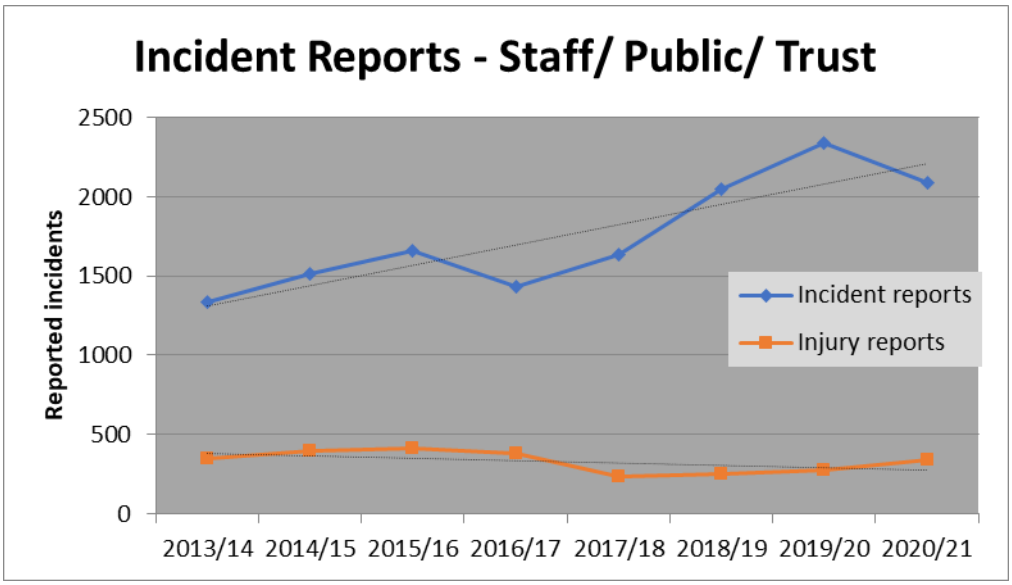
## 4. Statistics for 2020/21

The Datix incident database was interrogated for all non-patient incidents for the period of 01/04/2020 to31/03/2021.

### 4.1. Reporting

There were 2074 staff/ public/ Trust incidents in 2020/21. This is a 11.5% decrease from 2343 reported incidents the previous year, 2019/20. This was expected as footfall from both staff and members of the public decreased within both hospitals due to the COVID-19 pandemic.

The ratio of reports to injuries has decreased to approximately 6.1 reports for every injury from 8.5 reports per injury in 2019/20.




In order to compile Health and Safety statistics for the Health and Safety Committee, an analysis of incident descriptions is undertaken each month. The overall number of injury reports for 2020/21 is based on this analysis.

### 4.2. Reporting of Incidents, Diseases and Dangerous Occurences (RIDDOR) Incidents

The data for 2020/21 has been compared with the data from the previous 4 years.

| RIDDOR Category | Year reported | | | | |
|---|---|---|---|---|---|
| | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| > 7-Day injury | 20 | 16 | 15 | 17 | 12 |
| Specified injury | 14 | 3 | 5 | 5 | 9 |
| Dangerous occurrences | 3 | 4 | 6 | 2 | 0 |
| Occupational Disease (not COVID) | 0 | 0 | 0 | 0 | 1 |
| Accidental death | 0 | 1 | 0 | 0 | 0 |
| | 37 | 24 ↓ | 26 ↑ | 24 ↓ | 22 ↓ |

The Trust submitted 22 RIDDOR reports in the year at an average of 1.8 per month. This is a slight decrease from 24 the previous year.

72.7% were submitted within HSE timescales, which is an increase from 62.5% in 2019/20 but remains a concern. The proportion of over 7-day injuries remains higher than the other categories, which has had an effect on the percentage of reports submitted within HSE timescales, though less so in 2020/21 than in previous years.

54.5% of RIDDOR reports were over 7-day injuries, a reduction from 71% in 2019/20. Of these twelve incidents, seven were primarily caused by moving and handling (five during patient handling, two non-patient handling), two were caused by slips, trips and falls, one was as a result of violence and aggression, one as a result of being struck by something and one trap.

There has been an increase in the number of specified injuries, with nine. All were fractures, with six as a result of slips, trips and falls, two as a result of being struck by something and one suffered during an assault.

There were two RIDDOR incidents involving members of the public, both slips and trips resulting in fractures, compared with none in 2019/20. It should be noted that one of these was an individual working for another employer on Trust premises.

There has been a decrease in the number of dangerous occurrences from two in 2019/20 to none in 2020/21. There was, however, one RIDDOR report for exposure to an Occupational Disease (not COVID).

In addition, the Trust followed the HSE's guidance at the time when determining to report under RIDDOR where there was reasonable evidence of workplace exposure leading to a COVID-19 diagnosis in staff. In total, 924 such reports were made.

Due to the high proportion of staff receiving the vaccine the likelihood of workplace exposure during the third wave is expected to be much lower, therefore the number of COVID-19 related RIDDOR incidents should be significantly reduced in 2021/22.

### 4.3. Categories of incidents resulting in Harm

The eight largest categories, in line with the categories used by the HSE in their national statistics, make up approximately 91.5% of all directly health and safety-related harm incidents. All of these categories have seen a decrease from the previous reporting year.

| | 2019/20 (Harm) | 2020/21 (Harm) | % of total (2019/20) | % of total (2020/21) | Change |
|---|---|---|---|---|---|
| Falls | 56 | 45 | 18% | 17% | -19.64% |
| Sharps (medical) | 65 | 56 | 20% | 21% | -13.85% |
| Violence, abuse and harassment | 75 | 63 | 24% | 23% | -16.00% |
| Collision, trap or struck by an object | 34 | 30 | 11% | 11% | -11.76% |
| Moving and handling | 43 | 36 | 11% | 13% | -16.28% |
| Contact with machinery or hot surface | 3 | 0 | 1% | 0% | -100.00% |
| Contact with hazardous substance | 10 | 4 | 3% | 1% | -60.00% |
| Cuts non-medical sharps | 20 | 14 | 6% | 5% | -30.00% |
| Others | 13 | 23 | 4% | 8% | 76.92% |
| | 319 | **271** | | | |

200 additional harm incidents reported relate to staff COVID-19 reports. Many of these (181) were reported on a daily basis and therefore the number of members of staff included in each report varies.

19 other reports relate to COVID-19 outbreaks among groups of staff. An outbreak would be defined as 2 or more members of staff testing positive for Coronavirus in any one department or ward area.

The number of incidents categorised as 'Other' increased by 77%. All 23 of these incidents relate to reports of pressure damage or irritation from wearing FFP3 masks or other face masks as required for personal protection during the COVID-19 pandemic period. More detailed analysis/comment is given in **Section 6.7.1** below.

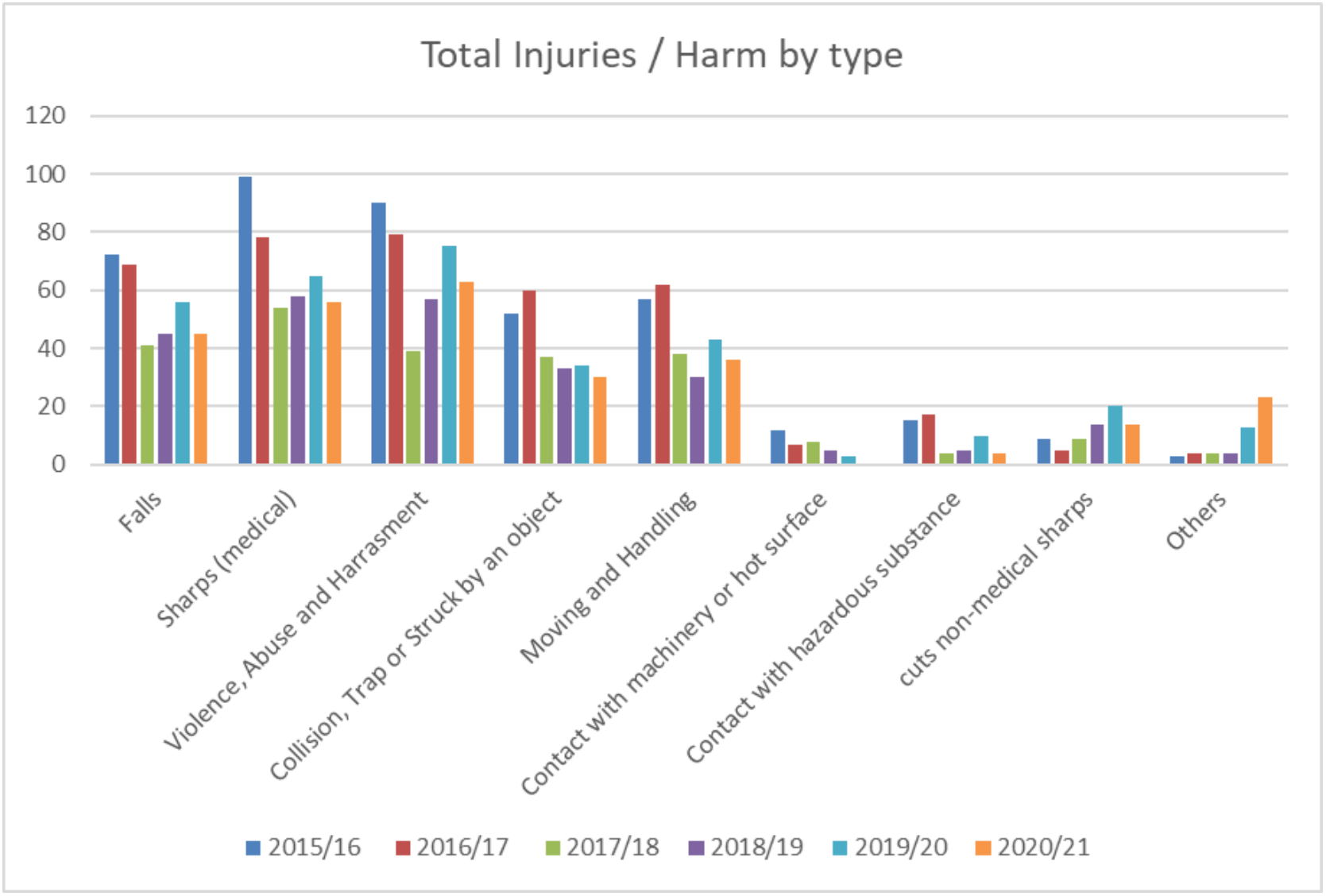
There was a 15% reduction in the number of 'Harm' incidents when compared with 2019/20 if COVID-19 daily staff reports and outbreak reports are discounted. As these reports are largely administrative (so that a specific incident can be linked to RIDDOR reports and SI investigations) discounting these incidents makes for a more accurate comparison. The reduction in 'Harm' incidents reflects the trend of a reduction in overall reports (-11.5%) outlined earlier.

There was a decrease of between 11.8% to 19.6% in the five most common harm categories. Again, this reflects the overall downward trend in reports, and as mentioned previously, for a large extent of the reporting period there was lower footfall on site with fewer staff members and visitors on site. Therefore, a reduction in the number of directly health and safety-related incidents would be expected.

Indeed, for the majority of the categories the relative % of total 'Harm' incidents has not significantly changed, with less than one percent change +/-. The exceptions are moving and handling by 2%, exposure to hazardous substances and the 'other' incidents.

There remains a discrepancy between sharps injuries reported and occupational health attendances (see **Section 6.4.3** below).

The chart below compares 2020/21 incidents of Harm by type with injuries / Harm in the previous five years:


Total Injuries / Harm by type
120
100
80
60
40
20
0
Falls
Sharps (medical)
Violence, Abuse and Harrasment
Collision, Trap or Struck by an object
Moving and Handling
Contact with machinery or hot surface
Contact with hazardous substance
cuts non-medical sharps
Others
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21

### 4.4. Harm incidents by Division and Directorate

The table below shows Health and Safety incidents resulting in Harm by directorate/ specialty:

*(RIDDOR incidents in brackets)
**+** Total includes 3 other Directorates
∞ Includes 4 incidents in Urology Directorate in 2019/20 (none in 2020/21)

| Division | Directorate | Falls | Sharps (medical) | Violence, abuse and harassment* | Collision, trap or struck by an object | Moving and handling | Contact with machinery or hot surface | Contact with hazardous substances | Cuts non-medical sharps | Others | Total Incidents of Harm (2020/21) | *Total Incidents of Harm (2019/20)* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cancer Services** | Clinical Haematology | | 2 | | 1 | | | | | | 3 | *4 (1)* |
| | Oncology | 2 | 2 | | 2 | 2 | | | | | 8 | *13 (2)* |
| | Outpatients | 1 (1)* | | | 1 | | | | | | 2 (1) | *9* |
| | | **3** | **4** | | **4** | **2** | | | | | **13 (1)** | ***26 (3)*** |
| **Corporate Services** | Corporate | 3 | 1 | | | 2 | | | | | 6 | *3* |
| | Estates | 6 (3) | | | | 1 | | | 2 | | 9 (3) | *13 (2)* |
| | Facilities | 3 (2) | 3 | 3 (2) | 10 (2) | 5 (1) | | | 2 | | 26 (7) | *34 (3)* |
| | Finance | 1 | | | | 1 | | | | | 2 | *4 (1)* |
| | Information Technology | 1 | | | 1 | | | | | | 2 | *6* |
| | Nursing | 1 | | | 1 | | | | | | 2 | *3* |
| | Workforce | | | | | 1 | | | | | 1 | *2* |
| | | **15** | **4** | **3** | **12** | **10** | | | **4** | | **48 (10)** | ***68+ (6)*** |
| **Diagnostic** | Imaging | 1 | 5 | 1 | | 3 | | | 2 | | 12 | *13 (1)* |

| Division | Directorate | Falls | Sharps (medical) | Violence, abuse and harassment* | Collision, trap or struck by an object | Moving and handling | Contact with machinery or hot surface | Contact with hazardous substances | Cuts non-medical sharps | Others | Total Incidents of Harm (2020/21) | *Total Incidents of Harm (2019/20)* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **and Clinical Support Services** | Pathology | 3 | 7 | | 1 | | | 1 (1) | 1 | 4 | 17 (1) | *16 (1)* |
| | Pharmacy | 2 | | | | | | 1 | | 1 | 4 | *1* |
| | Therapies | 1 | | 1 | | | | | | | 2 | *9* |
| | | **7** | **12** | **2** | **1** | **3** | | **2** | **3** | **5** | **35 (1)** | ***39 (2)*** |
| **Medicines and Emergency Care** | Acute Medicines and Geriatrics | 1 | 7 | 22 | 2 | 8 (4) | | 1 | 2 | 3 | 46 (4) | *51 (1)* |
| | Emergency Medicine | 1 | 6 | 14 | 3 | 5 | | 1 | | | 30 | *24 (2)* |
| | Medical Specialties | 1 | 3 | 13 | 1 | 2 (1) | | | 1 | | 20 (1) | *28 (4)* |
| | Private Patients | | | | | 1 | | | | | 1 | |
| | | **3** | **16** | **49** | **6** | **15** | | **2** | **3** | **3** | **97 (5)** | ***103 (7)*** |
| **Surgery** | General Surgery | 1 | 2 | | | | | | | | 3 | *13 (1)* |
| | Head and Neck | 1 | 1 | 1 | 1 | 1 | | | 1 | | 6 | *5* |
| | Orthopaedics | | 1 | 3 | 1 | 1 | | | 1 | | 7 | *15* |
| | Surgical Specialties | | 2 | | 1 | | | | | | 3 | *1* |

| Division | Directorate | Falls | Sharps (medical) | Violence, abuse and harassment* | Collision, trap or struck by an object | Moving and handling | Contact with machinery or hot surface | Contact with hazardous substances | Cuts non-medical sharps | Others | Total Incidents of Harm (2020/21) | *Total Incidents of Harm (2019/20)* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Theatres and Critical Care | 5 (1) | 9 | 5 | 2 | 1 | | | 1 | 15 | 38 (1) | *33 (4)* |
| | | **7** | **15** | **9** | **5** | **3** | | | **3** | **15** | **57 (1)** | ***71∞ (5)*** |
| **Women's Children's and Sexual Health** | Children's Services | 1 (1) | 1 | | | 2 | | | 1 | | 5 (1) | *15* |
| | Sexual Health | 1 | | | | | | | | | 1 | *1* |
| | Women's Services | 8 | 4 | | 2 (2) | 1 (1) | | | | | 15 (3) | *10 (1)* |
| | | **10** | **5** | | **30** | **3** | | | **1** | | **21 (4)** | ***26 (1)*** |
| | Totals | **45 (8)** | **56** | **63 (2)** | **30 (4)** | **36 (7)** | | **4 (1)** | **14** | **23** | **271 (22)** | ***333 (24)*** |

The size of the respective divisions and directorates and the activities undertaken has a clear influence on the number and nature of incidents that occur.

- There was a reduction in all Divisions in the overall number of harm incidents. The largest proportionate reduction came in Cancer Services, where the overall number halved. The smallest reduction came in Medicines and Emergency Care where there was a 5.83% reduction.
- Facilities saw the most RIDDOR reportable incidents with seven. Two of the three slips, trips and falls harm incidents reported were RIDDOR reportable and two of the three violence and aggression incidents were RIDDOR reportable. This may indicate under-reporting in this directorate.
- Three of six Estates fall harm incidents were RIDDOR reportable. However, two of these were in communal areas which are classified as Estates incidents, though did not involve Estates staff.
- While the overall figure has declined, the Medicines and Emergency Care Division accounted for 77% of incidents of harm from violence, abuse and harassment, up from 67% of total harm in 2019/20. Acute Medicines and Geriatrics had the most of these types of harm incidents with 34.9% of the total.

- Sharps injuries were shared more evenly, with Medicines and Emergency Care (16), Theatres and Critical Care (15) and Pathology (12) the directorates with the most harm incidents.
- Acute Medicines and Geriatrics had the most moving and handling harm incidents (8) and RIDDOR reportable incidents (4).

These figures are discussed in more detail in **Section 6** below.

## 5. Benchmarking

The HSE uses accident rates to compare organisations. One measure is the number of RIDDOR reportable incidents per 100,000 employees. The HSE publish data for the health sector and for all industries. Data is based on total employee numbers rather than whole time equivalents.

| | RIDDOR rate per 100,000 employees |
|---|---|
| All industries (2019/20) | 238 |
| Human health and social work (2019/20) | 300 |
| MTW 2014/15 | 329 |
| MTW 2015/16 | 324 |
| MTW 2016/17 | 479 |
| MTW 2017/18 | 358 |
| MTW 2018/19 | 370 |
| MTW 2019/20 | 329 |
| **MTW 2020/21** | **255*** |

*This figure does not include COVID-19 occupational disease RIDDOR reports

There has been a decrease in the Trust RIDDOR rate per 100,000. The CCG has set risk levels; rates of <600 are rated as green, 600 to 660 as amber and >660 as red. **MTW is rated as green.**

Further comparison data was obtained from other local trusts. The Healthcare Risk Management Group (HRMG) has members from many trusts in the South East.

| Type of Trust | Total RIDDORs | Employees | RIDDOR Rate (per 100,000 staff) | |
|---|---|---|---|---|
| MTW | 22 | 8614 | **255** | 2020/21 |
| Health sector (HSE national data) | | | **300** | 2019/20 |
| Acute NHS Trust | 12 | 2750 | 536 | 2020/21 |
| Acute & Community NHS Trust | 8 | 3860 | 207 | 2020/21 |
| Acute & Community NHS Trust | 65 | 7300 | 890 | 2020/21 |
| Specialist Hospital NHS Trust | 10 | 8000 | 125 | 2020/21 |
| Mental Health NHS Trust | 21 | 3412 | 616 | 2020/21 |
| Private Hospital | 1 | 469 | 213 | 2020/21 |
| **HMRG Total** | **139** | **34405** | **404** | 2020/21 |

MTW's RIDDOR rate is slightly lower than the health sector average and lower than that of the HRMG. The variety of trusts providing data and the fact that data was available

from just one other acute NHS trusts makes direct comparison difficult, with the closest other comparators acute and community trusts. Benchmarking was only possible against organisations willing to share their data.

## 6. Key Health and Safety Areas

### 6.1 Falls

Falls account for 16.6% of staff/public/Trust incidents of harm, compared with 17.6% of injuries in 2019/20. The number of harm incidents from falls was 45.

The overall number of slips, trips and falls incidents reported (including near misses and no harm incidents) decreased by 9.5% to 86.

Women's Services is the directorate with the most slip, trip and fall injuries, with eight

Eight of the RIDDOR incidents were related to slips, trips and falls. Six of these were specified injuries and two >7-day injuries. Wet floors were a factor in three of the RIDDOR incidents. The management of wet floors, including during cleaning and following spillages and leaks was a key area and are reflected in the objectives for 2020/21. In two of these three incidents all appropriate control measures were in place.

There were just nine incidents involving members of the public compared with 26 in the previous year. This is a significant reduction and reflects fewer numbers of visitors.

Unfortunately, there were two RIDDOR incidents involving members of the public compared to none in 2019/20. One of these, however, did involve someone who works on the MTW for another employer using an unauthorised route. The other was a trip by a member of the public over part of temporary structure erected to assisted with COVID-19 related social distancing.

Falls prevention is a key patient safety agenda item for the Trust. There is therefore, a need to continue to focus on management of environmental hazards in the work place.

### 6.2 Violence and Abuse

Harm incidents from violence, abuse and harassment account for 23.2% of the total, and is the highest single category. The number of harm incidents decrease by 16% from 75 in 2019/20 to 63 in 2020/21.

It remains the highest directly health and safety-related incident category by overall number of incidents. The total number of incidents of violence, abuse and harassment reported (including near misses and no harm incidents) decreased by 24.5% to 203. However, as highlighted previously, this reduction may have been due to the significantly fewer numbers of visitors and others on site during 2020/21.

77% of harm incidents take place in the Medicines and Emergency Care Division. Maintaining a security presence has been a challenge with the conflicting demands of lockdown.

The higher number of harm incidents in Acute Medicines and Geriatrics reflects the number of incidents where patient factors are a contributory factor.

Quotes have been obtained for CCTV infrastructure improvements on the Maidstone site and a business case will be submitted. Tunbridge Wells is more complex as it is a PFI, but costings have been obtained and is awaiting authorisation to proceed.

Both the car park and security contracts end in 2022. The intention is to merge the two and increase provision from three to five security staff as well as other certain infrastructure improvements.

The COVID-19 pandemic has affected the delivery of conflict resolution training. There is an eLearning package which can be accessed via MTW Learning but face-to-face training remains a priority.

### 6.3 Moving and handling

Moving and handling-related incidents account for around 13% of staff incidents of harm. There was a decrease of 16.3% in the number of harm incidents.

Seven RIDDOR reportable incidents were related to moving and handling activities, all >7-day injuries. Moving and handling-related incidents are reviewed by the Moving and Handling Advisor and assistance and guidance is offered to investigators and managers.

The Moving and Handling Policy and Procedure has been revised and published. Work is ongoing in the review of moving and handling standard operating procedures and risk assessments.

A review of moving and handling equipment has begun in 2021/22, with a view to standardise equipment.

Face-to-face training was impacted by the COVID-19 pandemic, though some training was still able to take place, albeit with reduced numbers. There are plans to recruit a moving and handling trainer/facilitator as well as to develop link assessors within departments. These measures will allow for better in-house training and competency assessment.

### 6.4 Sharps/ splash

#### 6.4.1. Medical sharps

Harm incidents from medical sharps decreased by 13.8% when compared to injuries from sharps in the previous year, from 65 to 58. The overall number of reported incidents (including near misses and those recorded as no obvious harm) increased by 5.7% to 111.

In 2019/20 there were two RIDDOR reportable sharps/ splash dangerous occurrences, both needle stick injuries. In 2020/21 there were no RIDDOR reportable dangerous occurrences.

The Vascular Access Specialist Practitioners (VASPs) have continued to review safety devices. No changes have been made to venepuncture or cannulation devices. There have been difficulties in obtaining Hubber Gripper plus non-coring safety (20g) (3/4 inch) needles to access ports. EZ Huber needles have been obtained to use as an alternative while supplies are poor. This device has been used previously within the trust and the safety device activation mechanism is the most similar to the Gripper plus. Be-spoke training has been given to staff in areas where the EZ Huber needles have been introduced.

The SHRAG has continued to discuss where sharps/splash incidents are not being investigated with uniform rigor. The VASPs have monitored Datix sharps reports and investigated these incidents where time constraints allow. In addition, a sharps investigation checklist is sent by the Health and Safety team to investigators of sharps incidents to assist with their investigations.

### 6.4.2 Eye Splash Injury

While only one harm incident was reported, there were 17 eye splash incidents in the Trust including near misses and those recorded as 'No obvious harm', a decrease from the 20 eye splash incidents reported in 2019/20. There weren't any 'splash' incidents reportable under RIDDOR due to exposure to known BBV.

### 6.4.3 Sharps / Splash Injury Comparisons

Occupational Health reported that 120 staff had been referred following sharps (100) and splash (20) injuries. This is a reduction of 18.9% from 2019/20, reflecting the general reduction in incident rates seen elsewhere.

| Month | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OH attendances 2019/20 | 16 | 11 | 8 | 15 | 17 | 13 | 11 | 20 | 9 | 9 | 12 | 7 | **148** |
| OH attendances 2020/21 | 8 | 6 | 11 | 5 | 9 | 9 | 12 | 9 | 16 | 8 | 15 | 12 | **120** |

There were 84 'dirty sharps' incidents and 17 'eye splash' incidents involving staff reported on Datix by incident date in 2020/21. While miss-categorisation may account for some of this difference, the disparity from previous years remains. Further vigilance and education are required on the need to report sharps incidents.

### 6.5 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, housekeeping issues and rushing around and are often associated with moving and handling activities. There were 30 harm incidents in 2020/21 compared with 34 in 2019/20, a 11.8% decrease, again in line with the overall decrease in incident reports.

There has been an increase in RIDDOR incidents from three in 2019/20 to four in 2020/21 (two >7-day injuries, two specified injuries).

### 6.6 Machinery, Hot Surfaces and Fluids

There were no burn/scald injury incidents reported in 2020/21.

### 6.7 Water Hygiene

The Water Hygiene Manager was appointed in May 2021. In addition, a new Authorised Engineer (AE) will shortly be appointed. The AE acts as an independent professional advisor for the Trust.

### 6.7.1 Tunbridge Wells Hospital

It has been identified through routine monitoring that the temperature control measures in the water systems at Tunbridge Wells Hospital (TWH) are not operating as designed to provide effective control of legionella bacteria. Without temperature controls or a secondary control measure, the system risks supporting the growth of legionella bacteria.

Presently, the domestic hot water system is continuing to operate outside of the temperature parameters required to prevent the proliferation of legionella bacteria. Whilst the temperature control problem is being investigated, MTW have put in place a number

of additional water control measures in order to monitor the systems and to mitigate any potential risk, including:

- Weekly additional sampling regime
- Weekly action group meeting attended by the Trust, Mitie and representation from Kent and East Sussex Weald Hospitals Limited (KESWHL) and relevant advisers as required, to review results and discuss required actions
- Ongoing daily flushing regime undertaken by Trust staff
- Monitoring of little used outlets, which are reviewed with clinical staff and recommendations put to the Water Hygiene Manager for approval with the Infection Control Team for removal of water supplies if necessary

Several measures have recently been implemented to ensure information sharing, including:

- Temperature result information currently held in static format is being reviewed for ease for transfer to a searchable and filterable data set
- Review of asset data to consider how best to record results to ensure that the system information can be interpreted at a glance / brief review without the need for immediate reference to drawings

### 6.7.2 Maidstone Hospital

Due to several inconsistency of the sampling undertaken by the previous contractor, Estates Maintenance are now employing a new contractor to undertake the water sampling both legionella and Pseudomonas.

There are still a few ongoing issues with hot water circulation, under-used outlets and low return temperatures. Point of use (POU) filters have been fitted on showers that have failed and thermostatic mixing valves have been stripped and sanitised with further resamples taken.

Failed outlets are currently on the daily flushing regime via Estates Maintenance. A rolling program on TMVs to strip/clean and disinfect has been started. Initially this was concentrated on all the augmented care areas and will continue throughout Maidstone hospital. The Water Hygiene team is making good progress.

### 6.7.3 Actions for 2021/22

The Water Hygiene Manager to work with all relevant parties and be assured that the water systems are working to the current guidelines so that that all systems are safe to use for patients and staff. Specific actions include:

- A programme for new water risk assessment at Maidstone Hospital is currently underway. Trust requirements are being agreed with an external contractor
- MTW water safety management plan updated and re-issued to the Water Hygiene Steering Group (WHSG)
- Planned preventative maintenance tasks to be aligned with the water safety management plan
- Ensuring the water safety plan is aligned to the new code of practice BS8680
- New job descriptions for TWH flushing staff are being prepared

- The implementation and possible use of L8 Guard at TWH is being reviewed
- Scalding risk assessment being reviewed by the water hygiene AE

### 6.8 COVID-related Health, Safety and Well-being

#### 6.8.1 Incidents

The COVID-19 pandemic has had an impact on all areas covered by this report. The Trust followed HSE guidance carefully and determined that where there was reasonably evidence to suggest that '*on the balance of probabilities'* a member of staff contracted COVID as a result of their work activities a RIDDOR report was made.

Consequently, the Trust made 1062 COVID-related RIDDOR reports in 2020/21. Many other Trusts interpreted the guidance differently, even where outcomes have been much worse. The HSE has not challenged our interpretation, With the third wave and the fact that the majority of staff have been vaccinated '*the balance of probabilities'* has shifted and RIDDOR reports will only be made where there has been a clear event, such as an outbreak amongst staff at work or an incident where the risk of exposure is high.

While overall incident report numbers have reduced as a result of the pandemic, there are other areas which have seen an increase. For example, in Theatres and Critical Care there have been 15 incidents reported of pressure damage from wearing respiratory protective equipment for long periods of time when working in 'Red' wards during the pandemic. In addition, there have been other reports, particularly in Pathology, of reactions and irritation associated with wearing face masks for extended periods. Advice and guidance were sought from Tissue Viability Nurses, Occupational Health and Procurement as appropriate when dealing with these incidents.

#### 6.8.2 Risk assessment

In addition, with the need for social distancing and more remote working for those able to there has been the need for departments to undertake COVID risk assessments to assess COVID hazards and introduce controls to safeguard staff. Templates have been produced and advice and guidance given to assist with this. Temporary structures have been erected in numerous locations around the Trust to encourage social distancing which also needed to be assessed to reduce the risk of incident.

Furthermore, guidance and equipment has been provided to those staff members working remotely so that they can assess their home workstation and work more safely and reduce the risk of musculoskeletal injury and other associated issues. See **Section 3** of **Appendix A** for more information and links to guidance.

#### 6.8.3 Well-being

The People and Culture Directorate have worked throughout the pandemic to ensure that staff are well-supported. There are two staff support programmes in place:

**Employee Assistance Programme (EAP)**
The EAP is provided by ***Health Assured*** an independent external organisation. They can provide assessments, short-term counselling/support and referral services for employees and their immediate family.

**Psychological Wellbeing Team**

There is now an in-house Psychological / Psychology service set within Occupational Health.

The wellbeing team is on both sites and they can provide one to one or team support and debriefing following traumatic/distressing events.

## 7. Health and Safety Executive Inspections and Investigations in 2020/21

### 7.1 Trust Inspection

The Care Quality Commission (CQC) have taken over much of the day to day enforcement responsibility from the HSE for health and social care activities. RIDDOR reports are passed on to the CQC from the HSE.

There has been a gradual decline in the number of prosecutions of NHS Trusts and these have been limited to clear and significant health and safety breaches, such incidents involving violence and aggression, window restrictors and failure to assess the ligature risk.

The HSE have undertaken inspections of other organisations' COVID control measures, including NHS trusts. These are shorter inspections than usual and usually in response to intelligence received. The Trust were not subject to any of these inspections.

Although the Trust made 1062 COVID occupational diseases RIDDOR reports, the HSE only made contact once. This was due to a concern raised by a member of staff but the HSE were satisfied with the Trust's response and no further action was taken.

### 7.2 HSE Objectives for 2021/22

The HSE objectives for 2021/22 are largely unchanged. The HSE's key areas for work in their 2021/22 Business Plan are to:

- Lead and engage with others to improve workplace health and safety
- Provide an effective regulatory framework
- Secure effective management and control of risk
- Reduce the likelihood of low frequency, high impact catastrophic events
- Enable improvement through efficient and effective delivery

In the public sector the HSE will lead and engage with others to improve workplace health and safety by:

- Applying the Stress Management Standards through carrying out pilot exercises in healthcare, education, prisons and other parts of the public sector;
- Re-energising the control measures for tackling musculoskeletal disorders in healthcare and identifying any emerging issues and solutions;
- Challenging, at a strategic level, ambulance services' performance in reducing Musculoskeletal Disorders;
- Providing direction and guidance to key stakeholders in health and social care on the management of violence and aggression in the workplace;

- Maintaining existing relationships with influential stakeholders and groups and making new ones where this can improve our understanding of and influence on the sector, particularly in relation to changing structures of service provision.

Therefore, the HSE's priorities in healthcare remain stress, moving and handling and violence and aggression.

## 8 Summary and Conclusions

- Specific objectives have been completed from 2019/20, though there remain some areas where ongoing objectives have been carried over.
- Overall reporting rates have decreased by 11.5% compared with 2019/20.
- There was a decrease of between 11.8% and 19.6% in the five most common harm categories, reflecting the overall downward trend in reports.
- Not including COVID-19 occupational disease RIDDOR reports (1062), the number of incidents reported under RIDDOR decreased from 24 in 2019/20 to 22 in 2020/21.
- There was a decrease in the number of over 7-day injuries, but an increase in the number of specified injuries.
- Violence, aggression and harassment incidents were the most common type of health and safety-related incidents. There was an overall 16% decrease in harm incidents, with a 24.5% decrease in the overall number of incidents.
- Sharps harm incidents decreased by 13.85% compared with 2019/20.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.
- There was a 19.64% decrease in falls harm incidents when compared with injuries in 2019/20.
- The impact of the COVID-19 pandemic is clear with the reduction in incidents, harm incidents and RIDDOR incidents. However, the principles health and safety management have come to the fore during the pandemic, particularly that of risk assessment and applying hierarchies of risk control.

## 9 Objectives for 2021/22

| Objective | Timescale & Targets | Lead | Supported by | Monitoring | KPI's |
|---|---|---|---|---|---|
| **Health and Safety Management (Head of Fire and Safety, Health and Safety Advisor, Risk and Compliance Manager)** | | | | | |
| Health and Safety Inspection programme aligned to Fire Safety Inspections to inspect all departments on main Trust sites | 31/03/2022 | Health and Safety Advisor / Head of Fire and Safety | Risk and Compliance Manager | Health and Safety Committee | At least 65% inspections on each main Trust site by 31/03/22 |
| System that successfully audits Health and Safety performance by location to be operational | 31/03/2022 | Health and Safety Advisor / Head of Fire and Safety | Risk and Compliance Manager | Health and Safety Committee | 85-90% compliance by 31/03/2022 |
| Departments to complete and submit Health and Safety audit information on agreed system and undertake local inspections | From 01/04/2021 to 30/03/2022 | Departmental Managers | Health and Safety Advisor / Head of Fire and Safety / Risk and Compliance Manager / Directorate Risk Leads | Health and Safety Committee | 85-90% compliance by 31/03/2022 |
| RIDDOR incidents to be reported within timescales | Ongoing 01/04/21-31/03/22 | Health and Safety Advisor / Head of Fire and Safety / Risk and Compliance Manager | Directorate Risk Leads / Departmental Managers | Health and Safety Committee / RIDDOR panel | 85% submitted within timescales |
| Reduction in number of RIDDOR incidents which need to go back to investigator for further input before closure | 31/03/22 | Health and Safety Advisor | Investigators / Head of Fire and Safety / Risk and Compliance Manager | RIDDOR panel | Begin measuring proportion – to reduce by 31/03/22 |

| Objective | Timescale & Targets | Lead | Supported by | Monitoring | KPI's |
|---|---|---|---|---|---|
| **Falls (Falls Prevention Practitioner)** | | | | | |
| Reduction in falls resulting in Harm by 5 % (moderate, severe and death) | 31st March 2022 | Lead Nurse for Falls Prevention | All directorate Matrons | Slips, Trips and Falls group. Quality Account | A reduction of falls resulting in harm is evidenced |
| Falls Prevention training to be mandatory for patient facing staff | 30th September 2021 | Lead Nurse for Falls Prevention | Chief Nurse | Slips, Trips and Falls group | Training programme commenced and feedback from staff. |
| National Audit for Inpatient Falls | 31st January 2022 | Lead Nurse for Falls Prevention | | Slips, Trips and Falls group Quality Account | Data submitted for all patients matching criteria. |
| Incorporate Falls as indicator in SafeCare Tool | 1st December 2021 | Lead Nurse for Falls Prevention | Mollie Hills<br>Safe Care Clinical Lead | Slips, Trips and Falls Group | Falls is reflected as one of the Safe Care indicators for all wards |
| **Violence and abuse (Trust Security Manager)** | | | | | |
| To review current policy and practices around restraint and put forward proposals to make changes to better protect staff from extreme violence | | Security and Car Parks Manager | | Health and Safety Committee | Proposal put forward to better protect staff |
| **Moving and Handling** | | | | | |
| To pilot and train link assessors into different departments | March 2022 | Moving and handling advisor | All departments | Training days for link assessors<br>How many staff competencies completed<br>Audits of patients and the records being made<br>Audit to see if slide sheets are | Improved compliance of training and competencies<br>Improved practices<br>Reduction in injury to staff moving patients<br>Reduction in tissue viability issues |
| To improve initial patient handling assessment with new document, which will support more use of slide sheets when moving patients to reduce tissue viability issues and injury to | December 2021 | Moving and handling advisor | Lead nurse for Falls<br>EME co-ordinator | | |

| Objective | Timescale & Targets | Lead | Supported by | Monitoring | KPI's |
|---|---|---|---|---|---|
| staff and patients, as well as reducing falls associated with risk identification | | | | in patient space Audit of equipment used and assessment carried out | |
| To explore equipment that would improve care when moving a Bariatric patient | December 2021 | Moving and handling advisor | EME | | Improved care and practices to support Bariatric patients Reduction in injury to staff moving patients |
| **Sharps/Splash (Safety, Health and Risk Advisory Group)** | | | | | |
| To continue to review new safety devices in the market place across the site | Ongoing – March 2022 | Vascular Access Specialist Practitioners | | | N/A |
| To continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required | Ongoing – March 2022 | Vascular Access Specialist Practitioners | | SHRAG | Qualitative assessment of sharps/splash incident reports; Training records |
| **Radiation Protection** | | | | | |
| Continue to improve resilience in non-ionising radiation protection. | April 2022 – have scientific non-ionising lead appointed plus at least 2 individuals signed off for each modality: ultrasound and lasers. | Trust Radiation Protection Advisor | | Performance monitored against action plan at Trust Radiation Advisory Committees | Non-ionising radiation lead appointed<br>Two individuals signed off for each modality: ultrasound and lasers |
| Improve medical physics support for imaging with ionising radiation to address concerns raised in CQC 2019 annual IR(ME)R report | April 2022 – to improve support in imaging with ionising radiation, plus plan is in place for service | Trust Radiation Protection Advisor | | | Plan for improved Imaging with Ionising Radiation support is |

| Objective | Timescale & Targets | Lead | Supported by | Monitoring | KPI's |
|---|---|---|---|---|---|
| and the Richards' Review, Diagnostics: Recovery and Renewal | delivery. | | | | in place |
| **Occupational Health (Head of Occupational Health / Occupational Health Clinical Nurse Manager)** | | | | | |
| Specify new IT system for OH to replace old one which is no longer supported. Test and implement system into live environment | Specification to be completed by end of June. Testing completed by end of August. Implementation into live environment by end of September | Head of Occupational Health | Occupational Health Clinical Nurse Manager, Director of Health Informatics | | N/A |
| Set up and embed new Psychological / Psychology service within OH. Ensure the Trust not only meets but exceeds its requirement to minimise / mitigate stress at work under the H&S act. | End of July all staff in post. End of August scope and SOP's in place. September fully functioning service | Head of Occupational Health | | | N/A |
| Increase accommodation for OH clinicians to operate on-site face to face services for staff; current accommodation not sufficient for all clinicians. Aim to provide safe, effective, appropriate and timely OH services to managers and staff alike | Business case submitted by end of June. September works on accommodation to start – business case acceptance pending | Head of Occupational Health | Occupational Health Clinical Nurse Manager | | N/A |
| Move all health surveillance questionnaires to on-line forms; ensure greater | Requires new IT system. October / November | Occupational Health Clinical Nurse Manager | Head of Occupational Health | | |

| Objective | Timescale & Targets | Lead | Supported by | Monitoring | KPI's |
|---|---|---|---|---|---|
| governance around surveillance and follow up of issues | | | | | |
| Bring eyecare services back on-site to enable easy access to opticians and sight test. Providing free sight tests to staff and discounted glasses. Ensures Trust wide access and compliance with VDU assessments | July / August – requires eyecare service to have availability and liaise with Estates for on-site parking and power supply | Occupational Health Clinical Nurse Manager | Head of Occupational Health | | N/A |

**Appendix A**

**2021/22 Training update - What does the Board need to know?**

## 1. Health and safety

**1.1.** Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached – members of the board have both collective and individual responsibility for health and safety.

**1.2.** Addressing health and safety offers significant opportunities, including:

1.2.1. Reduced costs and reduced risks – employee absence and turnover rates are lower, accidents are fewer, the threat of legal action is lessened;

1.2.2. Increased productivity – employees are healthier, happier and better motivated

## 2. Legal cases 2020/21

**2.1.** The table below summarises some of the relevant prosecutions that took place in 2020/21:

| Date | Organisation | Incident date(s) | Incident(s) | Penalty | Prosecuted by | Learning |
|---|---|---|---|---|---|---|
| March 2020 | NHS Tayside | Between April 2012 and November 2015 | Patients with suicidal tendencies exposed to risk by having access to ligature points. Death of three patients at Perth's Murray Royal Hospital | £120k | HSE | Numerous failed suicide attempts not properly recorded or reviewed |
| September 2020 | University Hospitals Plymouth NHS Trust | December 2017 | Failure to comply with Health and Social Care Act, duty of candour (Regulation 20) | £11k | CQC | First prosecution of its type. Importance of compliance with duty of candour |
| October 2020 | Vivo Care Choices | June 2017 | Vulnerable resident at | £200k + £20k | CQC | No robust assessment |

| Date | Organisation | Incident date(s) | Incident(s) | Penalty | Prosecuted by | Learning |
|---|---|---|---|---|---|---|
| | Limited | | high falls risks suffered fractured hip and on floor for two hours | costs | | undertaken, no monitoring plan, other controls (falls alarms, monitors and crash mats) not in place – only a call bell which could not be used by resident |
| November 2020 | Sunrise Operations Esher Limited | June 2016 | Male with dementia assaulted frail and vulnerable patient with a Zimmer frame | £100K + £26k | CQC | Resident on resident assault; company failed to provide safe care and treatment |
| November 2020 | Sentinel Health Care Limited | November 2017 | Death of resident from legionella pneumonia. Exposure of other service users to a significant risk of avoidable harm | £75k + £17.5k costs | CQC | First CQC legionella prosecution. Importance of maintaining legionella controls |
| October 2020 | Vivo Care Choices Limited | June 2017 | Vulnerable resident at high falls risks suffered fractured hip and on floor for two hours | £200k + £20k costs | CQC | No robust assessment undertaken, no monitoring plan, other controls (falls alarms, monitors and crash mats) not in place – only a call bell which could not be used by resident |
| January 2021 | Crosfield House, Rhayader | Between September and November | Unsafe use of bedrails – resident had leg trapped | £25k | HSE | No one had received appropriate risk assessment |

| Date | Organisation | Incident date(s) | Incident(s) | Penalty | Prosecuted by | Learning |
|---|---|---|---|---|---|---|
| | | 2018 | six times in three months | | | training and no one reviewed use of bedrails |
| March 2021 | Richmond Psychosocial Foundation International | May 2016 | Failure to provide safe care and treatment – one service user made a suicide attempt resulting in death | £60k | CQC | Removal of therapies destabilised the household contributed significantly to increased anxiety |
| Various | Four care home companies | Various | Falls from unsafe and inadequately restricted windows | £21k, £40k, £80k and £100k | HSE and CQC | Although separate incidents and prosecutions, in all cases risks had not been adequately assessed |

In addition, there was another duty of candour prosecution of a private hospital in April 2021 and another resident on resident assault in a care home in May 2021.

In June there was the prosecution by the HSE of Essex Partnership University NHS Foundation Trust following the death of eleven patients between 2004 and 2015 involving access to fixed ligature points. They were fined £1.5m. Also, in June East Kent Hospitals NHS Foundation Trust was fined £733,000 plus costs in a prosecution brought by the CQC after a series of events in November 2017 which put a mother and her baby at risk of avoidable harm. The baby subsequently died.

The CQC are increasingly involved in health and social care prosecutions and the level of fines from prosecutions brought by the CQC is increasing. While more of the prosecutions in the last year have involved care homes and other private organisations, NHS trusts have been prosecuted as well. The themes of falls, patient/resident on patient/resident assaults and the risk of access to ligature points are all potential areas of incident and the Trust needs to remain vigilant in assessing risk and maintaining controls.

## 3. Ergonomic homeworking

**3.1.** The global COVID-19 pandemic has led to an increase in homeworking. The need to maintain social distancing to reduce transmission has put a premium on desk space meaning more staff are either working most or part of their time at home, depending on job role.

3.1.1. Homeworking has advantages and disadvantages from an occupational health, safety and well-being perspective. People are more likely to adjust their posture, take workstation breaks and move around while at home compared to in the office. It allows for greater flexibility and can improve the work-life balance.

3.1.2. However, there may be a lack of space or suitable equipment which can result in awkward and uncomfortable postures. This can lead to musculoskeletal aches and pains, exacerbating existing conditions and the development of new chronic conditions. For example, a laptop at a dining room table will not be close to eye level and the keyboard is smaller and further away from the body, encouraging a hunched forward, almost squirrel-like posture. In time this could result in lower and upper back pain as well as repetitive strain in the wrists and forearms. In addition, the boundaries between home life and work life can become blurred, with tasks being carried out beyond normal working hours.

3.1.3. Employers have the same health and safety responsibilities for employees working from home as for any other employees, including the duty not to charge for things done or provided to their specific requirements. The Trust must manage the risks to their health from display screen equipment (DSE).

3.1.4. Workers should assess their workstation and adjust both their set up and working practices to reduce risk. Moving an office chair into the dining room, combined with a laptop riser (or even some strategically placed books), a separate keyboard and mouse will make for a much more comfortable set-up more similar to one found in an office.

**3.2. What has the Trust done?**

In response to the COVID-19 pandemic a Social Distancing and Homeworking Group was set up. Part of this group's role was to determine what equipment was required by staff and the kind of assessments that needed to be undertaken. Office chairs and other accessories were provided as required to staff.

3.2.1. The latest version of the Trust's Display Screen Equipment Policy was updated and uploaded in December 2020 to reflect changes. This policy outlines the requirement for DSE users to undertake a DSE self-assessment and the escalation process where required.

3.2.2. In addition, the soon to be published People Policies Manual includes updated information on homeworking, including risk assessment and health, safety and well-being considerations.

### 3.3. Other guidance

3.3.1. There is some general guidance from the HSE on controlling risks associated with homeworking.

3.3.2. The Chartered Institute of Ergonomics and Human Factors has published guidance on how to better set up a home office and other homeworking environments.

## 4. Fire Safety

### 4.1. The Fire Safety Act 2021

Following the Grenfell Tower tragedy, the Fire Safety Act 2021 amends the Regulatory Reform (Fire Safety) Order 2005 (the "FSO") with the intention of improving fire safety in multi-occupancy domestic premises.

4.1.1. The Act provides clarification as to who is accountable for reducing the risk of fires. (In the Trust's case the CEO).

4.1.2. It provides that a 'Responsible Person' who could be, for example, the owner or manager of a multi occupied residential buildings, must assess and mitigate the fire safety risk associated with both (1) the structure and external walls of a building and (2) entrance doors to individual flats and communal parts of the building.

4.1.3. The fire risk assessment for the building must be updated to cover both of the areas referred to above. The Responsible Person can appoint a fire risk assessor to assist with compliance.

4.1.4. Failure to comply with obligations contained within the Act could result in enforcement action being taken against the Responsible Person.

4.1.5. This legislation does not affect the construction works either planned or underway as these considerations have been factored in.

### 4.2. Other works planned but postponed due to the pandemic

4.2.1. Between 2017-2019 a competent contractor was engaged to conduct a fire stopping survey between Whatman and Mercer wards prior to commencement of project works. The survey revealed significant remedial works required. It was the intention to carry out more fire stopping surveys to cover the entire Maidstone Hospital infrastructure, however, the onset of the global pandemic put a halt to any proposed works in this area.

4.2.2. The Head of Fire and Safety has undertaken an unobtrusive survey to estimate the likelihood that the problems that existed in Whatman and Mercer could be exactly replicated across the Maidstone Hospital site. The fire risk assessment was conducted using PAS79-1 as required by law. The outcome confirms that there is every reason to believe that indeed the compartmentation problems identified in Whatman/Mercer could be present elsewhere. A paper has been submitted to request such works are now carried out.

4.2.3. In addition, following recent fire risk assessments, it has become clear that contrary to the Trust's control of contractor policy and procedure that various works have been undertaken across the hospital site that include penetration of fire compartments in many locations and over a long period of time. These

works did not include certified fire stopping as part of the works and therefore gives further evidence of compartmentation breaches. To avoid further such breaches, a notice has been issued to all staff involved in works planning.

NHS Maidstone and Tunbridge Wells NHS Trust

| **Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment** | **Deputy Chief Operating Officer** |
|---|---|

The enclosed report provides information on the Trust's statement of compliance with NHS England / Improvements (NHSE/I) Core Standards on Emergency Planning Response & Recovery for 2020/21. The Trust is fully compliant with all 48 of the Core Standards.

The 'Deep Dive' for 2020/21, as confirmed by NHSE/I, relates to medical gasses and the 'Deep Dive' standards do not contribute to the overall core standards rating. The 'Deep Dive' is designed as an information gathering and status check for NHSE/I.

Deep Dive' for 2020/21 falls under five headings and seven subheadings

- Governance
- Planning
- Workforce
- Escalation
- Systems

Of the five areas the Trust is partially compliant in two of the sub areas. it is recognised by the Estates and Facilities Directorate that this is ongoing work post the COVID-19 response in respect to learning over the last 18 months and the need to document and update plans in respect of this as part of best practice going forward.

The Trust Board is requested to approve the submission of the Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment for 2020/21 to the Kent and Medway Clinical Commissioning Group (CCG).

N.B. the Trust is not required to complete the "Interoperable Capabilities" section.

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

- Trust Resilience Committee

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

To review and approve the Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment submission for 2020/21

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

## 1 Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England and Improvement has published NHS Core Standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met

## 2 Statement of Compliance

As part of the national EPRR assurance process for this year Maidstone & Tunbridge Wells NHS Trust has been required to assess itself against these core standards. The outcome of this self- assessment shows that against 48 of the core standards which are applicable to the organisation the trust is fully compliant with 48 of these core standards

The overall rating is: Fully Complaint

**NHS England and Improvement-South East EPRR Assurance Compliance Ratings:**

To support a standardised approach to assessing an organisation's **overall preparedness rating.**

NHS England and Improvement have set the following criteria:

| Compliance Level | Evaluation and Testing Conclusion |
|---|---|
| **Full** | The organisation is 100% compliant with all core standards they are expected to achieve.<br>The organisation's Board has agreed with this position statement. |
| **Substantial** | The organisation is 89-99% compliant with the core standards they are expected to achieve.<br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| **Partial** | The organisation is 77-88% compliant with the core standards they are expected to achieve.<br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| **Non-compliant** | The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.<br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance. |

## 3 Areas to be considered

The Deep dive this year relates to oxygen supply. The deep dive does not contribute to the Trusts overall rating but is intended as an indication of the NHS position.

| Fully Compliant | Partially complaint | Non-compliant |
|---|---|---|
| 5 | 2 | |

The responsibility for using lessons learnt from the trust response to COVID in relation to the deep dive sits with Director of Estates & Facilities

## 4 Conclusion

The Trust's Emergency Preparedness remains strong and is an essential part of the organisation.
The response by the organisation to Oxygen supply on site has been challenged over the last 18 months from a practical perspective and whilst the organisation continues to keep up with demand it is recognised that documentation and aspects of practice need updating in line with lessons learnt during COVID19 this has been acknowledge by Estates and facilities.

| Ref | Domain | Standard | Detail | Acute Providers | Evidence - examples listed below | Organisational Evidence | Self assessment RAG<br><br>Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.<br><br>Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>Green (fully compliant) = Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Domain 1 - Governance** | | | | | | | | | | | |
| 1 | Governance | Senior Leadership | The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio.<br><br>A non-executive board member, or suitable alternative, should be identified to support them in this role. | Y | • Name and role of appointed individual | Sean Briggs - COO<br>Maureen Choong - Non Exec Director | Fully compliant | | | | |
| 2 | Governance | EPRR Policy Statement | The organisation has an overarching EPRR policy statement.<br><br>This should take into account the organisation's:<br>• Business objectives and processes<br>• Key suppliers and contractual arrangements<br>• Risk assessment(s)<br>• Functions and / or organisation, structural and staff changes.<br><br>The policy should:<br>• Have a review schedule and version control<br>• Use unambiguous terminology<br>• Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested<br>• Include references to other sources of information and supporting documentation. | Y | Evidence of an up to date EPRR policy statement that includes:<br>• Resourcing commitment<br>• Access to funds<br>• Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. | Resilience policy *(RD - 'Resilience Policy')*<br>Dedicated annual budget<br>Dedicated EP team *(RD - 'Organisational Information')* | Fully compliant | | | | |
| 3 | Governance | EPRR board reports | The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually.<br><br>These reports should be taken to a public board, and as a minimum, include an overview on:<br>• training and exercises undertaken by the organisation<br>• summary of any business continuity, critical incidents and major incidents experienced by the organisation<br>• lessons identified from incidents and exercises<br>• the organisation's compliance position in relation to the latest NHS England EPRR assurance process. | Y | • Public Board meeting minutes<br>• Evidence of presenting the results of the annual EPRR assurance process to the Public Board | Went to board 2020<br>Going to board September 2021 | Fully compliant | | | | |
| 5 | Governance | EPRR Resource | The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties. | Y | • EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board<br>• Assessment of role / resources<br>• Role description of EPRR Staff<br>• Organisation structure chart<br>• Internal Governance process chart including EPRR group | Evidence of Resilience committee *(RD - 'Resilience Committee')*<br>Diector of EPRR and communiations reports directly to AEO *(RD - 'Organisational Information')* | Fully compliant | | | | |
| 6 | Governance | Continuous improvement process | The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements. | Y | • Process explicitly described within the EPRR policy statement | Resilence Policy *(RD - 'Resilience Policy')* | Fully compliant | | | | |
| **Domain 2 - Duty to risk assess** | | | | | | | | | | | |
| 7 | Duty to risk assess | Risk assessment | The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers. | Y | • Evidence that EPRR risks are regularly considered and recorded<br>• Evidence that EPRR risks are represented and recorded on the organisations corporate risk register | EPRR Risk Register *(RD - 'Risk and Horizon Scanning')*<br>Minutes from Resilience committee May 2021 *(RD- 'Resilience Committee)*<br>Horizon scanning updates *(RD - 'Risk and Horizon Scanning')* | Fully compliant | | | | |
| 8 | Duty to risk assess | Risk Management | The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks. | Y | • EPRR risks are considered in the organisation's risk management policy<br>• Reference to EPRR risk management in the organisation's EPRR policy document | Resilience Policy *(RD - 'Resilience Policy')*<br>EPRR Risk register *(RD - 'Risk and Horizon Scanning')* | Fully compliant | | | | |
| **Domain 3 - Duty to maintain plans** | | | | | | | | | | | |
| 11 | Duty to maintain plans | Critical incident | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework). | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Critical Incident Plan *(RD - 'Critical Incident Plan')*<br>Recently reviewed to go to resilience before being uploaded on RD 8th September 2021 | Fully compliant | | | | |
| 12 | Duty to maintain plans | Major incident | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework). | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Major Incident Plan *(RD - 'Major Incident Plan')* | Fully compliant | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | Duty to maintain plans | Heatwave | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff. | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Heatwave Plan *(RD - 'Heatwave Planning')* | Fully compliant | | | | |
| 14 | Duty to maintain plans | Cold weather | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves. | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Cold Weather Plan *(RD - 'Winter Planning')*<br>To be reviewed again prior to the 1st November | Fully compliant | | | | |
| 18 | Duty to maintain plans | Mass Casualty | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed). | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Appendix in Major Incident plan<br>Major Incident Plan *(RD - 'Major Incident Plan')* | Fully compliant | | | | |
| 19 | Duty to maintain plans | Mass Casualty - patient identification | The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex. | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Major Incident Plan *(RD - 'Major Incident Plan')*<br>*(RD Triage documentation sheets in assurance )* | Fully compliant | | | | |
| 20 | Duty to maintain plans | Shelter and evacuation | In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary. | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Local area evacuation plans *(Available if requested)* signed of through health and safety committee.<br>As per KRF Evacuation and Shelter Plan *(RD - 'Kent Resilience Forum - KRF Plans')* | Fully compliant | | | | |
| 21 | Duty to maintain plans | Lockdown | In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas. | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Operational Lockdown Procedure *(RD - 'Lockdown Procedure')* | Fully compliant | | | | |
| 22 | Duty to maintain plans | Protected individuals | In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site. | Y | Arrangements should be:<br>• current (although may not have been updated in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | VIP, Protected Persons and celebrity Visits and Admissions and Firearms deployment Policy and Procedure<br>*(RD - 'VIP')* | Fully compliant | | | | |
| **Domain 4 - Command and control** | | | | | | | | | | | |
| 24 | Command and control | On-call mechanism | A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents.<br><br>This should provide the facility to respond to or escalate notifications to an executive level. | Y | • Process explicitly described within the EPRR policy statement<br>• On call Standards and expectations are set out<br>• Include 24 hour arrangements for alerting managers and other key staff. | Command Accreditation Course for all on call managers *(RD - 'Command Accrediation Scheme')*<br>On Call EPRR personel 24/7 365 *(RD - 'Organisational Information')*<br>On Call Executives (Strategic) *(RD - 'Organisational Information')*<br>On Call Managers (Tactical) *(RD - 'Organisational Information')*<br>Everbridge Alerting system for all key roles in a response *(RD - 'Everbridge')* | Fully compliant | | | | |
| **Domain 5 - Training and exercising** | | | | | | | | | | | |
| **Domain 6 - Response** | | | | | | | | | | | |
| 30 | Response | Incident Co-ordination Centre (ICC) | The organisation has Incident Co-ordination Centre (ICC) arrangements | Y | | ICC on each site with an OCC 24/7 | Fully compliant | | | | |
| 32 | Response | Management of business continuity incidents | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework). | Y | • Business Continuity Response plans | Strategic Business Continuity Plan *(RD - 'Business Continuity')*<br>Annual review plan underway by EPRR team of local plans post pandemic *(RD - 'Business Continuity')* | Fully compliant | | | | |
| 34 | Response | Situation Reports | The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents. | Y | • Documented processes for completing, signing off and submitting SitReps | Situational Report SOPs *(RD - 'Situational Report SOPs')* | Fully compliant | | | | |
| 35 | Response | Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events' | Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook. | Y | • Guidance is available to appropriate staff either electronically or hard copies | Hard copies in both Emergency Departments<br>*(RD - 'Major Incident Plan')* | Fully compliant | | | | |
| 36 | Response | Access to 'CBRN incident: Clinical Management and health protection' | Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance. | Y | • Guidance is available to appropriate staff either electronically or hard copies | Hard copies in both Emergency Departments<br>*(RD - 'CBRN')* | Fully compliant | | | | |
| **Domain 7 - Warning and informing** | | | | | | | | | | | |

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| 37 | Warning and informing | Communication with partners and stakeholders | The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident. | Y | • Have emergency communications response arrangements in place<br>• Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes<br>• Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work | Social Media Policy and Procedure *(RD - 'Communications')*<br>Resilience Policy *(RD - 'Resilience Policy')*<br>Tracking process on RD<br>24/7 On Call Communications Team *(RD - 'Organisational Information)*<br>Appendix in MI plan - Media , Warning and Informing *(RD - 'Major Incident Plan')*<br>Dedicate EPRR face book and twitter account | Fully compliant |
| 38 | Warning and informing | Warning and informing | The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents. | Y | • Have emergency communications response arrangements in place<br>• Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies)<br>• Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Setting up protocols with the media for warning and informing | Everbridge - Internall Comms arrangement *(RD - 'Everbridge')*<br>BC arrangement - radios / DR phones / cascades / action cards as per MI plan *(RD - 'Business Continuity')*<br>Media Communicatios and Media Distibution List *(RD - 'Communications')* | Fully compliant |
| 39 | Warning and informing | Media strategy | The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times. | Y | • Have emergency communications response arrangements in place<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Setting up protocols with the media for warning and informing<br>• Having an agreed media strategy | Resilience Policy (RD - 'Resilience Policy')<br>Communications and Engagement Strategy on RD/Media Strategy *(RD - 'Communications')* | Fully compliant |
| **Domain 8 - Cooperation** | | | | | | | |
| 42 | Cooperation | Mutual aid arrangements | The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies.<br><br>These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England. | Y | • Detailed documentation on the process for requesting, receiving and managing mutual aid requests<br>• Signed mutual aid agreements where appropriate | Appendix 14 - Mutual Aid, Major incident plan *(RD - 'Major Incident Plan)* | Fully compliant |
| 43 | Cooperation | Arrangements for multi-region response | Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas. | | • Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs | | |
| 44 | Cooperation | Health tripartite working | Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded. | | • Detailed documentation on the process for managing the national health aspects of an emergency | | |
| 46 | Cooperation | Information sharing | The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents. | Y | • Documented and signed information sharing protocol<br>• Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'. | (RD- *'Information Governance'*) | Fully compliant |
| **Domain 9 - Business Continuity** | | | | | | | |
| 47 | Business Continuity | BC policy statement | The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301. | Y | Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement | Resilience Policy *(RD - 'Resilience Policy')* | Fully compliant |
| 48 | Business Continuity | BCMS scope and objectives | The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. | Y | BCMS should detail:<br>• Scope e.g. key products and services within the scope and exclusions from the scope<br>• Objectives of the system<br>• The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties<br>• Specific roles within the BCMS including responsibilities, competencies and authorities.<br>• The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process<br>• Resource requirements<br>• Communications strategy with all staff to ensure they are aware of their roles<br>• Stakeholders | Strategic Business Continuity Plan *(RD - 'Business Continuity')*<br>Resilience Policy *(RD - 'Resilience Policy')* | Fully compliant |
| 50 | Business Continuity | Data Protection and Security Toolkit | Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis. | Y | Statement of compliance | Data protection tool kit submissions *(RD - 'Information Governance')* | Fully compliant |
| 51 | Business Continuity | Business Continuity Plans | The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:<br>• people<br>• information and data<br>• premises<br>• suppliers and contractors<br>• IT and infrastructure | Y | • Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation | Strategic Business Continuity Plan *(RD - Business Continuity)* | Fully compliant |
| 53 | Business Continuity | BC audit | The organisation has a process for internal audit, and outcomes are included in the report to the board. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers<br>• Audit reports | Evidence *(RD - Business Continuity)* | Fully compliant |

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| 54 | Business Continuity | BCMS continuous improvement process | There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers<br>• Action plans | Resilience Policy *(RD - Business Continuity)* | Fully compliant | | | | |
| 55 | Business Continuity | Assurance of commissioned providers / suppliers BCPs | The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Provider/supplier assurance framework<br>• Provider/supplier business continuity arrangements | Evidence *(RD - Business Continuity)* | | | | | |
| **Domain 10: CBRN** | | | | | | | | | | | |
| 56 | CBRN | Telephony advice for CBRN exposure | Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents. | Y | Staff are aware of the number / process to gain access to advice through appropriate planning arrangements | Within CBRN Plan *(RD - CBRN)* | Fully compliant | | | | |
| 57 | CBRN | HAZMAT / CBRN planning arrangement | There are documented organisation specific HAZMAT/ CBRN response arrangements. | Y | Evidence of:<br>• command and control structures<br>• procedures for activating staff and equipment<br>• pre-determined decontamination locations and access to facilities<br>• management and decontamination processes for contaminated patients and fatalities in line with the latest guidance<br>• interoperability with other relevant agencies<br>• plan to maintain a cordon / access control<br>• arrangements for staff contamination<br>• plans for the management of hazardous waste<br>• stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes | CBRN plans *(RD - CBRN)* | Fully compliant | | | | |
| 58 | CBRN | HAZMAT / CBRN risk assessments | HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation.<br><br>This includes:<br>• Documented systems of work<br>• List of required competencies<br>• Arrangements for the management of hazardous waste. | Y | • Impact assessment of CBRN decontamination on other key facilities | Evidence *(RD - CBRN)* | Fully compliant | | | | |
| 59 | CBRN | Decontamination capability availability 24 /7 | The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week. | Y | • Rotas of appropriately trained staff availability 24 /7 | CBRN database of trained staff in ED *(RD - CBRN)* | Fully compliant | | | | |
| 60 | CBRN | Equipment and supplies | The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.<br><br>• Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx<br>• Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf<br>• Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ | Y | • Completed equipment inventories; including completion date | Secamb Peer reviews *(RD - CBRN)*<br>Booked in for October 2021<br>Check lists in Emergency Departments | Fully compliant | | | | |
| 62 | CBRN | Equipment checks | There are routine checks carried out on the decontamination equipment including:<br>• PRPS Suits<br>• Decontamination structures<br>• Disrobe and rerobe structures<br>• Shower tray pump<br>• RAM GENE (radiation monitor)<br>• Other decontamination equipment.<br><br>There is a named individual responsible for completing these checks | Y | • Record of equipment checks, including date completed and by whom.<br>• Report of any missing equipment | Secamb Peer reviews (RD - CBRN)<br>Booked in for October 2021<br>Check lists in Emergnecy Departments | Fully compliant | | | | |
| 63 | CBRN | Equipment Preventative Programme of Maintenance | There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for:<br>• PRPS Suits<br>• Decontamination structures<br>• Disrobe and rerobe structures<br>• Shower tray pump<br>• RAM GENE (radiation monitor)<br>• Other equipment | Y | • Completed PPM, including date completed, and by whom | In line with Respirex guidance on replacements and twsting programme - replacement of suits | Fully compliant | | | | |
| 64 | CBRN | PPE disposal arrangements | There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance. | Y | • Organisational policy | Disposal of PPE Policy *(RD - 'CBRN')* | Fully compliant | | | | |
| 65 | CBRN | HAZMAT / CBRN training lead | The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training | Y | • Maintenance of CPD records | All trainers undertaken the Secamb delivered train the trainer course *(Available on request)* | Fully compliant | | | | |
| 67 | CBRN | HAZMAT / CBRN trained trainers | The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | Y | • Maintenance of CPD records | Comptency agreemenets / permits to work /<br>Staff registers in Emergency Departments *(RD - CBRN)* | Fully compliant | | | | |

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| 68 | CBRN | Staff training - decontamination | Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | Y | • Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br>• All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/<br>• All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf<br>• A range of staff roles are trained in decontamination technique | Trained under the Kent and Medway Standard latest revsion July 2021<br>Incident involving hazardous materials in Both EDs and EPO office *(RD - CBRN)* | Fully compliant | | | | |
| 69 | CBRN | FFP3 access | Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7. | Y | | Fit testing facility permananet on both sides sites<br>Fit testing qualified staff across the sites daily espcially on high impact areas<br>Clinical site managers 24/7 able to fit test | Fully compliant | | | | |

| Ref | Domain | Standard | Detail | NHS Ambulance Service Providers | Organisational Evidence | Self assessment RAG<br><br>**Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.<br><br>**Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>**Green (fully compliant) =** Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments |
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| **HART**<br>**Domain: Capability** | | | | | | | | | | |
| **H1** | **HART** | **HART tactical capabilities** | Organisations must maintain the following HART tactical capabilities:<br>• Hazardous Materials<br>• Chemical, Biological Radiological, Nuclear, Explosives (CBRNe)<br>• Marauding Terrorist Firearms Attack<br>• Safe Working at Height<br>• Confined Space<br>• Unstable Terrain<br>• Water Operations<br>• Support to Security Operations | Y | | | | | | |
| **H2** | **HART** | **National Capability Matrices for HART** | Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART. | Y | | | | | | |
| **H3** | **HART** | **Compliance with National Standard Operating Procedures** | Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. | Y | | | | | | |
| **Domain: Human Resources** | | | | | | | | | | |
| **H4** | **HART** | **Staff competence** | Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART. | Y | | | | | | |
| **H5** | **HART** | **Protected training hours** | Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period. | Y | | | | | | |
| **H6** | **HART** | **Training records** | Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include:<br>• mandated training completed<br>• date completed<br>• any outstanding training or training due<br>• indication of the individual's level of competence across the HART skill sets<br>• any restrictions in practice and corresponding action plans. | Y | | | | | | |
| **H7** | **HART** | **Registration as Paramedics** | All operational HART personnel must be professionally registered Paramedics. | Y | | | | | | |
| **H8** | **HART** | **Six operational HART staff on duty** | Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times. | Y | | | | | | |
| **H9** | **HART** | **Completion of Physical Competency Assessment** | All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard. | Y | | | | | | |
| **H10** | **HART** | **Mandatory six month completion of Physical Competency Assessment** | All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. | Y | | | | | | |
| **H11** | **HART** | **Returned to duty Physical Competency Assessment** | Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. | Y | | | | | | |

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| **H12** | **HART** | **Commander competence** | Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident. | Y | | | | | | |
| **Domain: Administration** | | | | | | | | | | |
| **H13** | **HART** | **Effective deployment policy** | Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities. | Y | | | | | | |
| **H14** | **HART** | **Identification appropriate incidents / patients** | Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call. | Y | | | | | | |
| **H15** | **HART** | **Notification of changes to capability delivery** | In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence. | Y | | | | | | |
| **H16** | **HART** | **Recording resource levels** | Organisations must record HART resource levels and deployments on the nationally specified system. | Y | | | | | | |
| **H17** | **HART** | **Record of compliance with response time standards** | Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request. | Y | | | | | | |
| **H18** | **HART** | **Local risk assessments** | Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment. | Y | | | | | | |
| **H19** | **HART** | **Lessons identified reporting** | Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database. | Y | | | | | | |
| **H20** | **HART** | **Safety reporting** | Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified. | Y | | | | | | |
| **H21** | **HART** | **Receipt and confirmation of safety notifications** | Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days. | Y | | | | | | |
| **H22** | **HART** | **Change Request Process** | Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable. | Y | | | | | | |
| **Domain: Response time standards** | | | | | | | | | | |
| **H23** | **HART** | **Initial deployment requirement** | Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations. | Y | | | | | | |
| **H24** | **HART** | **Additional deployment requirement** | Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. | Y | | | | | | |
| **H25** | **HART** | **Attendance at strategic sites of interest** | Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region. | Y | | | | | | |
| **H26** | **HART** | **Mutual aid** | Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities. | Y | | | | | | |
| **Domain: Logistics** | | | | | | | | | | |
| **H27** | **HART** | **Capital depreciation and revenue replacement schemes** | Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment. | Y | | | | | | |

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| **H28** | **HART** | **Interoperable equipment** | Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets. | Y | | | | | | |
| **H29** | **HART** | **Equipment procurement via national buying frameworks** | Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement. | Y | | | | | | |
| **H30** | **HART** | **Fleet compliance with national specification** | Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification. | Y | | | | | | |
| **H31** | **HART** | **Equipment maintenance** | Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations. | Y | | | | | | |
| **H32** | **HART** | **Equipment asset register** | Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). | Y | | | | | | |
| **H33** | **HART** | **Capital estate provision** | Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification. | Y | | | | | | |
| **MTFA** | | | | | | | | | | |
| **Domain: Capability** | | | | | | | | | | |
| **M1** | **MTFA** | **Maintenance of national specified MTFA capability** | Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas. | Y | | | | | | |
| **M2** | **MTFA** | **Compliance with safe system of work** | Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work. | Y | | | | | | |
| **M3** | **MTFA** | **Interoperability** | Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country. | Y | | | | | | |
| **M4** | **MTFA** | **Compliance with Standard Operating Procedures** | Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. | Y | | | | | | |
| **Domain: Human Resources** | | | | | | | | | | |
| **M5** | **MTFA** | **Ten competent MTFA staff on duty** | Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff. | Y | | | | | | |
| **M6** | **MTFA** | **Completion of a Physical Competency Assessment** | Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard. | Y | | | | | | |
| **M7** | **MTFA** | **Staff competency** | Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA. | Y | | | | | | |
| **M8** | **MTFA** | **Training records** | Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include:<br>• mandated training completed<br>• date completed<br>• outstanding training or training due<br>• indication of the individual's level of competence across the MTFA skill sets<br>• any restrictions in practice and corresponding action plans. | Y | | | | | | |
| **M9** | **MTFA** | **Commander competence** | Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident. | Y | | | | | | |
| **M10** | **MTFA** | **Provision of clinical training** | The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training. | Y | | | | | | |
| **M11** | **MTFA** | **Staff training requirements** | Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing:<br>• 100% Strategic Commanders<br>• 100% designated MTFA Commanders<br>• 80% all operational frontline staff | Y | | | | | | |
| **Domain: Administration** | | | | | | | | | | |
| **M12** | **MTFA** | **Effective deployment policy** | Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP). | Y | | | | | | |

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| **M13** | **MTFA** | **Identification appropriate incidents / patients** | Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP). | Y | | | | | | |
| **M14** | **MTFA** | **Change Management Process** | Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable. | Y | | | | | | |
| **M15** | **MTFA** | **Record of compliance with response time standards** | Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU). | Y | | | | | | |
| **M16** | **MTFA** | **Notification of changes to capability delivery** | In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners. | Y | | | | | | |
| **M17** | **MTFA** | **Recording resource levels** | Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU. | Y | | | | | | |
| **M18** | **MTFA** | **Local risk assessments** | Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment. | Y | | | | | | |
| **M19** | **MTFA** | **Lessons identified reporting** | Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database. | Y | | | | | | |
| **M20** | **MTFA** | **Safety reporting** | Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified. | Y | | | | | | |
| **M21** | **MTFA** | **Receipt and confirmation of safety notifications** | Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days. | Y | | | | | | |
| **Domain: Response time standards** | | | | | | | | | | |
| **M22** | **MTFA** | **Readiness to deploy to Model Response Sites** | Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation. | Y | | | | | | |
| **M23** | **MTFA** | **10minute response time** | Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation. | Y | | | | | | |
| **Domain: Logistics** | | | | | | | | | | |
| **M24** | **MTFA** | **PPE availability** | Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets. | Y | | | | | | |
| **M25** | **MTFA** | **Equipment procurement via national buying frameworks** | Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets. | Y | | | | | | |
| **M26** | **MTFA** | **Equipment maintenance** | All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards. | Y | | | | | | |
| **M27** | **MTFA** | **Revenue depreciation scheme** | Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment. | Y | | | | | | |
| **M28** | **MTFA** | **MTFA asset register** | Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include:<br>• individual asset identification<br>• any applicable servicing or maintenance activity<br>• any identified defects or faults<br>• the expected replacement date<br>• any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). | Y | | | | | | |
| **CBRN Domain: Capability** | | | | | | | | | | |

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| **B1** | **CBRN** | **Tactical capabilities** | Organisations must maintain the following CBRN tactical capabilities:<br>• Initial Operational Response (IOR)<br>• Step 123+<br>• PRPS Protective Equipment<br>• Wet decontamination of casualties via clinical decontamination units<br>• Specialist Operational Response (HART) for inner cordon / hot zone operations<br>• CBRN Countermeasures | Y | | | | | | |
| **B2** | **CBRN** | **National Capability Matrices for CBRN.** | Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN. | Y | | | | | | |
| **B3** | **CBRN** | **Compliance with National Standard Operating Procedures** | Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments. | Y | | | | | | |
| **B4** | **CBRN** | **Access to specialist scientific advice** | Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7). | Y | | | | | | |
| **Domain: Human resources** | | | | | | | | | | |
| **B5** | **CBRN** | **Commander competence** | Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination. | Y | | | | | | |
| **B6** | **CBRN** | **Arrangements to manage staff exposure and contamination** | Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated. | Y | | | | | | |
| **B7** | **CBRN** | **Monitoring and recording responder deployment** | Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed). | Y | | | | | | |
| **B8** | **CBRN** | **Adequate CBRN staff establishment** | Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times. | Y | | | | | | |
| **B9** | **CBRN** | **CBRN Lead trainer** | Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation. | Y | | | | | | |
| **B10** | **CBRN** | **CBRN trainers** | Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme. | Y | | | | | | |
| **B11** | **CBRN** | **Training standard** | CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work. | Y | | | | | | |
| **B12** | **CBRN** | **FFP3 access** | Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested. | Y | | | | | | |
| **B13** | **CBRN** | **IOR training for operational staff** | Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR). | Y | | | | | | |
| **Domain: administration** | | | | | | | | | | |
| **B14** | **CBRN** | **HAZMAT / CBRN plan** | Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans. | Y | | | | | | |
| **B15** | **CBRN** | **Deployment process for CBRN staff** | Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident. | Y | | | | | | |
| **B16** | **CBRN** | **Identification of locations to establish CBRN facilities** | Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces. | Y | | | | | | |
| **B17** | **CBRN** | **CBRN arrangements alignment with guidance** | Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance. | Y | | | | | | |
| **B18** | **CBRN** | **Communication management** | Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders. | Y | | | | | | |
| **B19** | **CBRN** | **Access to national reserve stocks** | Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain). | Y | | | | | | |
| **B20** | **CBRN** | **Management of hazardous waste** | Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste. | Y | | | | | | |

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| **B21** | **CBRN** | **Recovery arrangements** | Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality. | Y | | | | | | |
| **B22** | **CBRN** | **CBRN local risk assessments** | Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work. | Y | | | | | | |
| **B23** | **CBRN** | **Risk assessments for high risk areas** | Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area. | Y | | | | | | |
| **Domain: Response time standards** | | | | | | | | | | |
| **B24** | **CBRN** | **Model response locations - deployment** | Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation. | Y | | | | | | |
| **Domain: logistics** | | | | | | | | | | |
| **B25** | **CBRN** | **Interoperable equipment** | Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets. | Y | | | | | | |
| **B26** | **CBRN** | **Equipment procurement via national buying frameworks** | Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU. | Y | | | | | | |
| **B27** | **CBRN** | **Equipment maintenance - British or EN standards** | Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations. | Y | | | | | | |
| **B28** | **CBRN** | **Equipment maintenance - National Equipment Data Sheet** | Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item. | Y | | | | | | |
| **B29** | **CBRN** | **Equipment maintenance - assets register** | Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). | Y | | | | | | |
| **B30** | **CBRN** | **PRPS - minimum number of suits** | Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. | Y | | | | | | |
| **B31** | **CBRN** | **PRPS - replacement plan** | Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits. | Y | | | | | | |
| **B32** | **CBRN** | **Individual / role responsible fore CBRN assets** | Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately. | Y | | | | | | |
| **Mass Casualty Vehicles** | | | | | | | | | | |
| **Domain: Administration** | | | | | | | | | | |
| **V1** | **MassCas** | **MCV accommodation** | Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining. | Y | | | | | | |
| **V2** | **MassCas** | **Maintenance and insurance** | Trusts must insure, maintain and regularly run the mass casualty vehicles. | Y | | | | | | |
| **V3** | **MassCas** | **Mobilisation arrangements** | Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment. | Y | | | | | | |
| **V4** | **MassCas** | **Mass oxygen delivery system** | Trusts must maintain the mass oxygen delivery system on the vehicles. | Y | | | | | | |
| **Domain: NHS England Mass Casualties Concept of Operations** | | | | | | | | | | |
| **V6** | **MassCas** | **Mass casualty response arrangements** | Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties* . | Y | | | | | | |
| **V7** | **MassCas** | **Arrangements to work with NACC** | Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties. | Y | | | | | | |
| **V8** | **MassCas** | **EOC arrangements** | Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident. | Y | | | | | | |
| **V9** | **MassCas** | **Casualty management arrangements** | Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts. | Y | | | | | | |
| **V10** | **MassCas** | **Casualty Clearing Station arrangements** | Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation. | Y | | | | | | |

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| **V11** | **MassCas** | **Management of non-NHS resource** | Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources:<br>• Patient Transportation Services<br>• Private Providers of Patient Transport Services<br>• Voluntary Ambulance Service Providers | Y | | | | | | |
| **V12** | **MassCas** | **Management of secondary patient transfers** | Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements. | Y | | | | | | |
| **Command and control**<br>**Domain: General** | | | | | | | | | | |
| **C1** | **C2** | **Consistency with NHS England EPRR Framework** | NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements. | Y | | | | | | |
| **C2** | **C2** | **Consistency with Standards for NHS Ambulance Service Command and Control.** | NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control. | Y | | | | | | |
| **C3** | **C2** | **NARU notification process** | NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained. | Y | | | | | | |
| **C4** | **C2** | **AEO governance and responsibility** | The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards. | Y | | | | | | |
| **Domain: Human resource** | | | | | | | | | | |
| **C5** | **C2** | **Command role availability** | NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area. | Y | | | | | | |
| **C6** | **C2** | **Support role availability** | NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times. | Y | | | | | | |
| **C7** | **C2** | **Recruitment and selection criteria** | NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards.<br><br>No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command).<br><br>This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident. | Y | | | | | | |
| **C8** | **C2** | **Contractual responsibilities of command functions** | Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment. | Y | | | | | | |
| **C9** | **C2** | **Access to PPE** | The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function. | Y | | | | | | |
| **C10** | **C2** | **Suitable communication systems** | The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in. | Y | | | | | | |
| **Domain: Decision making** | | | | | | | | | | |
| **C11** | **C2** | **Risk management** | NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU. | Y | | | | | | |

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| **C12** | **C2** | **Use of JESIP JDM** | NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established. | Y | | | | | | |
| **C13** | **C2** | **Command decisions** | NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU. | Y | | | | | | |
| **Domain: Record keeping** | | | | | | | | | | |
| **C14** | **C2** | **Retaining records** | C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years. | Y | | | | | | |
| **C15** | **C2** | **Decision logging** | C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. | Y | | | | | | |
| **C16** | **C2** | **Access to loggist** | C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise. | Y | | | | | | |
| **Domain: Lessons identified** | | | | | | | | | | |
| **C17** | **C2** | **Lessons identified** | The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards. | Y | | | | | | |
| **Domain: Competence** | | | | | | | | | | |
| **C18** | **C2** | **Strategic commander competence - National Occupational Standards** | Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control. | Y | | | | | | |
| **C19** | **C2** | **Strategic commander competence - nationally recognised course** | Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU). | Y | | | | | | |
| **C20** | **C2** | **Tactical commander competence - National Occupational Standards** | Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control. | Y | | | | | | |
| **C21** | **C2** | **Tactical commander competence - nationally recognised course** | Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. | Y | | | | | | |
| **C22** | **C2** | **Operational commander competence - National Occupational Standards** | Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control. | Y | | | | | | |
| **C23** | **C2** | **Operational commander competence - nationally recognised course** | Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. | Y | | | | | | |
| **C24** | **C2** | **Commanders - maintenance of CPD** | All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards. | Y | | | | | | |

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| **C25** | **C2** | **Commanders - exercise attendance** | All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. | Y | | | | | | |
| **C26** | **C2** | **Training and CDP - suspension of non-compliant commanders** | Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence. | Y | | | | | | |
| **C27** | **C2** | **Assessment of commander competence and CDP evidence** | Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process. | Y | | | | | | |
| **C28** | **C2** | **NILO / Tactical Advisor - training** | Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU). | Y | | | | | | |
| **C29** | **C2** | **NILO / Tactical Advisor - CPD** | Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline. | Y | | | | | | |
| **C30** | **C2** | **Loggist - training** | Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance. | Y | | | | | | |
| **C31** | **C2** | **Loggist - CPD** | Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging. | Y | | | | | | |
| **C32** | **C2** | **Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor** | The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control). | Y | | | | | | |
| **C33** | **C2** | **Medical Advisor of Forward Doctor - exercise attendance** | Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. | Y | | | | | | |
| **C34** | **C2** | **Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures** | Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles. | Y | | | | | | |
| **C35** | **C2** | **Control room familiarisation with capabilities** | Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.) | Y | | | | | | |
| **C36** | **C2** | **Responders awareness of NARU major incident action cards** | Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them. | Y | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Domain: Embedding doctrine** | | | | | | | | | | |
| **J1** | **JESIP** | **Incorporation of JESIP doctrine** | The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts. | Y | | | | | | |
| **J2** | **JESIP** | **Operations procedures commensurate with Doctrine** | All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine. | Y | | | | | | |
| **J3** | **JESIP** | **Five JESIP principles for joint working** | All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working. | Y | | | | | | |
| **J4** | **JESIP** | **Use of METHANE** | All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE. | Y | | | | | | |
| **J5** | **JESIP** | **Joint Decision Model - advocate use of** | All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions. | Y | | | | | | |
| **J6** | **JESIP** | **Review process** | All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine. | Y | | | | | | |
| **J7** | **JESIP** | **Access to JESIP products, tools and guidance** | All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance. | Y | | | | | | |
| **Domain: Training** | | | | | | | | | | |
| **J8** | **JESIP** | **Awareness of JESIP - Responders** | All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually. | Y | | | | | | |
| **J9** | **JESIP** | **Awareness of JESIP - control room staff** | NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually. | Y | | | | | | |
| **J10** | **JESIP** | **Awareness of JESIP - Commanders and Control Room managers / supervisors** | All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting. | Y | | | | | | |
| **J11** | **JESIP** | **Training records - staff requiring training** | NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it. | Y | | | | | | |
| **J12** | **JESIP** | **Command function - interoperability command course** | All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course. | Y | | | | | | |
| **J13** | **JESIP** | **Training records - annual refresh** | All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation. | Y | | | | | | |
| **J14** | **JESIP** | **Commanders - interoperability command course** | Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course. | Y | | | | | | |
| **J15** | **JESIP** | **Participation in multiagency exercise** | Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied. | Y | | | | | | |
| **J16** | **JESIP** | **Induction training** | All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff. | Y | | | | | | |
| **J17** | **JESIP** | **Training - review process** | All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine. | Y | | | | | | |
| **J18** | **JESIP** | **JESIP trainers** | All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers. | Y | | | | | | |
| **Domain: Assurance** | | | | | | | | | | |
| **J19** | **JESIP** | **JESIP self-assessment survey** | All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP. | Y | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| **J20** | **JESIP** | **Training records - 90% operational and control room staff are familiar with JESIP** | All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message. | Y | | | | | | |
| **J21** | **JESIP** | **Exercise programme - multiagency exercises** | All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool. | Y | | | | | | |
| **J22** | **JESIP** | **Competence assurance policy** | All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required. | Y | | | | | | |
| **J23** | **JESIP** | **Use of JESIP exercise objectives and Umpire templates** | All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them. | Y | | | | | | |

| Ref | Domain | Standard | Detail | Evidence - examples listed below | Acute Providers | Mental Health Providers | Community Service Providers | Organisational Evidence | Self assessment RAG<br><br>**Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.<br><br>**Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>**Green (fully compliant) =** Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Deep Dive - Oxygen Supply**<br>**Domain: Oxygen Suuply** | | | | | | | | | | | | | |
| **DD1** | **Oxygen Supply** | **Medical gasses - governance** | The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B. | •□Committee meets annually as a minimum<br>•□Committee has signed off terms of reference<br>•□Minutes of Committee meetings are maintained<br>•□Actions from the Committee are managed effectively<br>•□Committee reports progress and any issues to the Chief Executive<br>•□Committee develops and maintains organisational policies and procedures<br>•□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs)<br>•□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate<br>•□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board | Y | If applicable | If applicable | Evidence *(RD - 'Oxygen)* | Fully compliant | | | | |
| **DD2** | **Oxygen Supply** | **Medical gasses - planning** | The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases | •□The organisation has reviewed and updated the plans and are they available for view<br>•□The organisation has assessed its maximum anticipated flow rate using the national toolkit<br>•□The organisation has documented plans ( agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements.<br>•□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site<br>•□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available)<br>•□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies<br>•□The organisation has breaching points available to support access for additional equipment as required<br>•□The organisation has a developed plan for ward level education and training on good housekeeping practices<br>•□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases | Y | If applicable | If applicable | Audit underetaken by supplier annually last one in 2019 - booked for Sept 2021. ( see RD - *oxygen )*<br>For BC, see site specific operational procedures *(RD - 'Oxygen')*<br><br>Documented pipeline services through Estates and Facilities upon request<br>Plan used during Covid beinging reviewed and updated<br>One manifold back up in place at MGH another one planned going forward . No manifold suystem at TWH - a more modern build with upgraded infrasture such as a ring circuit.<br>Training programmes enhanced during Covid need updateing fomally . . | Partially compliant | | | | |
| **DD3** | **Oxygen Supply** | **Medical gasses - planning** | The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system. | •□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries<br>•□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms<br>•□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes<br>•□Organisation has utilised the checklist retrospectively as part of an assurance or audit process | Y | If applicable | If applicable | Delivery frequency Managed by BOC by telemetry | Fully compliant | | | | |
| **DD4** | **Oxygen Supply** | **Medical gasses -workforce** | The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions. | •□Job descriptions/person specifications are available to cover each identified role<br>•□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work.<br>•□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements<br>•□Medical gas training forms part of the induction package for all staff. | Y | If applicable | If applicable | Evidence *(RD - 'Oxygen -> Workforce Qaulifications')* | Fully compliant | Rotas/ JD's available on request | | | |
| **DD5** | **Oxygen Supply** | **Oxygen systems - escalation** | The organisation has a clear escalation plan and processes for management of surge in oxygen demand | •□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds<br>•□Staff are informed and aware of the requirements for increasing de-icing of vaporisers<br>•□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO | Y | If applicable | If applicable | Evidence *(RD - 'Oxygen')*<br>Supply monitored daily via telemetry Deicing schedules increased through Covid - regular inspections | Partially compliant | | | | |
| **DD6** | **Oxygen Supply** | **Oxygen systems** | Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU) | •□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report | Y | If applicable | If applicable | Evidence *(RD - 'Oxygen')* | Fully compliant | | | | |
| **DD7** | **Oxygen Supply** | **Oxygen systems** | The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6 | •□Organisation has a risk assessment as per section 6.6 of the HTM 02-01<br>•□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review) | Y | If applicable | If applicable | Anuual MPGS audit ( *RD - Oxyge* | Fully compliant | | | | |

NHS Maidstone and Tunbridge Wells NHS Trust

| Summary report from the Charitable Funds Committee, 28/07/21 | Committee Chair (Non-Executive Director) |
|---|---|

The Charitable Funds Committee (CFC) met on 28th July 2021, virtually, via webconference.

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

- The **actions from previous meetings** were noted
- The Committee approved the revised **policy and procedures for charitable funds** as submitted.
- The Committee undertook a **further review of the risk register entries relevant to the Charitable Fund** wherein it was noted that there should be an increased focus on recovery within the risk register and it was agreed that the Trust Secretary should amend the risk register entries relevant to the Charitable Fund to reflect the comments received at the July 2021 Committee meeting and submit a "Review of the risk register entries relevant to the Charitable Fund" report to the November 2021 Committee meeting.
- The Committee reviewed the **draft Charitable Fund Annual Report and Accounts for 2020/21** wherein it the following agreements were reached:
  - That the Head of Financial Services should circulate a Microsoft Word version of the draft Charitable Fund Annual Report and Accounts for 2020/21, to all Committee members, to enable review and comment prior to submission to the Trust's external auditors on the 13th August 2021.
  - That the Trust Secretary should provide the Head of Financial Services with a revised "Risk Management" section, by the 13th August 2021, for inclusion within the draft Charitable Fund Annual Report and Accounts for 2020/21.
  - That the Assistant Trust Secretary should provisionally schedule an Extraordinary Charitable Funds Committee meeting for December 2021, to enable the agreement of the Charitable Fund Annual Report and Accounts for 2020/21 in the event that the "independent examination" has not been concluded by the date of the November 2021 Committee meeting.
- The **financial overview at Month 3** was considered and it was noted that:
  - The fund balance stood at £1,068k, a decrease of £15.9k since 1st April 2021
  - six specific donations had been received exceeding £1k totalling £11.9k. The largest single donation was £4.3k from "much love" anonymous donation to the Critical Care Fund.
  - No requests for expenditure had been refused during the period
  - In total the Trust had received £268.7k from donations for COVID-19
- The Committee reviewed **a proposal for the management and administration fee for 2021/22** and the Committee **approved the proposal** as submitted, however the importance of ensuring the management and administration fee was proportionate to the Trust's Charitable income was emphasised.
- The Committee received an update on the **future of fundraising at the Trust** wherein the Committee welcomed the Associate Director of Fundraising and it was agreed that the Trust Secretary should liaise with the Associate Director of Fundraising to consider and confirm the scheduling of an "outcome of the review of the Trust's fundraising approach and proposals for the future of fundraising at the Trust" item at a future 'Part 1' Trust Board meeting, having first been considered by the Committee.
- The Divisional Director of Operations for Cancer Services provided an update on **proposed partnership with Maggie's Centres** wherein the Committee emphasised the importance of lessons learned from Maggie's to improve the Trust's fundraising approach.
- The Committee reviewed the **findings from the Committee's evaluation for 2021** wherein it was agreed no amendments to the Committee's structure were required.
- Under **"To note the Committee's forward programme"** it was agreed that the Assistant Trust Secretary should schedule an "outcome of the review of the Trust's fundraising approach and proposals for the future of fundraising at the Trust" item at the November 2021 Committee meeting.

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| **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]<br>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

| Summary report from Audit and Governance Committee, 04/08/21 (Incl. the External Audit Annual Report for 2020/21) | Committee Chair (Non-Executive Director) |
|---|---|

The Audit and Governance Committee met on 4th August 2021.

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

- Under the r**eview of actions from previous meetings** it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) and Audit Manager Tiaa Ltd should liaise with the Chief Finance Officer to consider, and confirm, the scheduling of an internal audit review of the delivery of the benefits associated the implementation of the Electronic Patient Record (EPR).
- The latest **details of gifts, hospitality and sponsorship** were noted which included the plan for the implementation of the "My-ESR" self-service portal
- The Trust Secretary and Risk and Compliance Manager provided a **review of the Trust's red-rated risks** which included assurance of the management of individual risks, wherein the following actions were agreed:
  - That the Trust Secretary and Risk and Compliance Manager should liaise with members of the Executive Team to consider the method by which additional assurance could be provided in relation to the underlying process for the review and management of risks at the Trust
  - That the Trust Secretary should amend the Trust's red-rated risks to reflect the comments received at the August 2021 Committee meeting and submit a "Review of the Trust's red-rated risks" report to the November 2021 Committee meeting
  - That the Assistant Trust Secretary should schedule a "Review of the Trust's red-rated risks" item at the November 2021 Committee meeting, and each standard meeting thereafter
- The Associate Director of Procurement attended for the **Limited Assurance Internal Audit review: Assurance review of Roche Managed Service Contract** wherein the Committee was provided assurance that Internal Audit recommendations had been addressed and the intended financial efficiencies would be delivered, however not within the original timeframe.
- The **latest single tender/quote waivers data** were reviewed and the improved utilisation rate by the Estates and Facilities Directorate was noted.
- An **08-9 Update on progress with the Internal Audit plan for 2021/22 (incl. progress with actions from previous Internal Audit reviews)** was reported, wherein the Director of Audit, Tiaa Ltd (Head of Internal Audit) highlighted the finalised Head of Internal Audit's Annual Opinion for 2020/21. The list of recent Internal Audit reviews, is shown below (in section 2)
- The **Counter Fraud Annual Report for 2020/21** was reviewed and the progress against the Counter Fraud Functional Standard Return Submission Requirements was noted.
- The latest **Counter Fraud update** was received which included details of the cases which had been closed since the last Committee meeting
- The **External Audit Annual Report for 2020/21** was reviewed (Appendix 1) and it was agreed that the Chief Finance Officer should review, and confirm to the Director of Audit at Grant Thornton UK LLP, that the "Improvement recommendations" within the "External Audit Annual Report for 2020/21" provided an accurate reflection of the Trust's position. It was also agreed that the Chief Finance Officer should submit a report which outlined the actions taken by the Trust in response to the "Improvement recommendations" within the "External Audit Annual Report for 2020/21" to the Committee's meeting in November 2021.
- The Chief Finance Officer provided a **summary of the latest financial issues** which included details of the Trust's Financial Position.
- The **latest losses & compensations data** was noted.
- The **forward programme** was noted and it was agreed that the Assistant Trust Secretary should schedule a "Private session with the auditors" directly prior to the November 2021 Committee meeting, and annually thereafter.

- Under the **Evaluation of the meeting** the discussions which were held in relation to the review of the Trust's red-rated risks were emphasised.

**2. The Committee received details of the following completed Internal Audit reviews:**

- "Care Quality Commission" (which received a "Reasonable Assurance" conclusion)
- "Data Security and Protection Toolkit (Part 1)" (An "Assurance Opinion" was allocated upon completion of part 2 of the review)
- "Data Security and Protection Toolkit (Part 2)" (which received a "Substantial Assurance" conclusion)
- "Data Quality of Key Performance Indicators" (which received a "Reasonable Assurance" conclusion)
- "Roche Managed Service Contract" (which received a "Limited Assurance" conclusion as the contract had not been agreed at the time of the Internal Audit Review, however it was noted at the Committee that the contract had subsequently been agreed following the Internal Audit Review)

**3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:**

- **"Oncology ICT Healthcheck":** for the Trust to develop and provide copies of its disaster recovery plans for Oncology systems in order to evidence the controls in place; however, an extension was agreed until 01/10/21 as the Responsible Officer had requested additional support from Internal Audit

**4. The Committee agreed that (in addition to any actions noted above):** N/A

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

- The External Audit Annual Report for 2020/21 is enclosed under appendix 1 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

Grant Thornton

# Auditor's Annual Report on Maidstone and Tunbridge Wells NHS Trust

For the period 2020/2021

July 2021

# Contents

We are required under Section 21(3)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the National Audit Office (NAO) requires us to report to you our commentary relating to proper arrangements.

We report if significant matters have come to our attention. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.


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The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the Trust or all weaknesses in your internal controls. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

# Value for Money arrangements

## Revised approach to Value for Money work for 2020/21

On 1 April 2020, the National Audit Office introduced a new Code of Audit Practice which comes into effect from audit year 2020/21. The Code introduced a revised approach to the audit of Value for Money. (VFM)

There are three main changes arising from the NAO's new approach:

- A new set of key criteria, covering financial sustainability, governance and improvements in economy, efficiency and effectiveness
- More extensive reporting, with a requirement on the auditor to produce a commentary on arrangements across all of the key criteria.
- Auditors undertaking sufficient analysis on the Trust's VFM arrangements to arrive at far more sophisticated judgements on performance, as well as key recommendations on any significant weaknesses in arrangements identified during the audit.

The Code require auditors to consider whether the body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. When reporting on these arrangements, the Code requires auditors to structure their commentary on arrangements under the three specified reporting criteria.

### Improving economy, efficiency and effectiveness

Arrangements for improving the way the body delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

### Financial Sustainability

Arrangements for ensuring the body can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years)

### Governance

Arrangements for ensuring that the body makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the body makes decisions based on appropriate information

## Potential types of recommendations

A range of different recommendations could be made following the completion of work on the body's arrangements to secure economy, efficiency and effectiveness in its use of resources, which are as follows:

### Statutory recommendation

Written recommendations to the body under Section 24 (Schedule 7) of the Local Audit and Accountability Act 2014. A recommendation under schedule 7 requires the body to discuss and respond publicly to the report.

### Key recommendation

The Code of Audit Practice requires that where auditors identify significant weaknesses in arrangements to secure value for money they should make recommendations setting out the actions that should be taken by the body. We have defined these recommendations as 'key recommendations'.

### Improvement recommendation

These recommendations, if implemented should improve the arrangements in place at the body, but are not made as a result of identifying significant weaknesses in the body's arrangements

# Executive summary

## Value for money arrangements and key recommendation(s)

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. The auditor is no longer required to give a binary qualified / unqualified VFM conclusion. Instead, auditors report in more detail on the Trust's overall arrangements, as well as key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the Trust's arrangements under specified criteria. As part of our work, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. For 2020/21, we also considered the Trust's arrangements in light of the COVID pandemic. Our consideration of this is included at pages 20 and 21. Our conclusions are summarised in the table below.

| Criteria | Risk assessment | Conclusion |
|---|---|---|
| Financial sustainability | No risks of significant weakness identified | No significant weaknesses in arrangements identified, but improvement recommendation made. |
| Governance | No risks of significant weakness identified | No Significant weaknesses in arrangements identified but improvement recommendation made |
| Improving economy, efficiency and effectiveness | No risks of significant weakness identified | No significant weaknesses in arrangements identified, but improvement recommendation made |

### Financial sustainability

The medium term financial position is currently being worked through at a local system level. Based on the information available currently and given the current uncertainty in the financial funding environment , we did not identify any significant weaknesses in your arrangements. We have identified improvement recommendations including planning for recurrent cost savings for 2022/23 now. Our amber rating reflects the uncertain national financial environment for the NHS in 2021/22. Our findings are set out in further detail on pages 7 to 10.

### Governance

We did not identify any significant weaknesses in your arrangements. You have appropriate arrangements in place. We have identified improvement recommendations. Our findings are set out in further detail on pages 11 to 13.

### Improving economy, efficiency and effectiveness

Appropriate arrangements are in place. There is evidence of successful working within the local Kent and Medway health system. We have identified some improvement recommendations that are focused on best practice we see at other trusts. Our findings are set out in further detail on pages 17 to 21.

# Executive summary

## Value for money arrangements and key recommendation(s)

We have assessed the Trust's Value for Money arrangements across the 3 metrics of:

- Financial Sustainability;
- Governance;
- Improving economy, efficiency and effectiveness;

For 2020/21 we have also assessed arrangements concerning Covid-19.

This assessment has been completed between April and July 2021 with the data available in this timeframe in relation to the financial year 20/21 and 21/22 in respects of planning for future periods. Note has also been given to longer term plans where these are available.

We have conducted this assessment through;

- Interviewing senior management and other key personnel;
- Reviewing financial documents such as budgets, outturn reports and capital plans;
- Reviewing reports completed by Internal Audit
- Reviewing non-financial documents such as Quality Committee reports, staff surveys and internal policies; and
- Incorporating sector, regulator and other market knowledge and experience

We have not identified any significant weaknesses and therefore do not make any key key recommendations. We highlight some improvement recommendations.

### Financial sustainability

We assessed the arrangements concerning Financial Sustainability and raised no indications of potential significant weaknesses.

We did not conduct further risk based work on Financial Sustainability arrangements. Therefore whilst we have raised improvement recommendations, we have raised no key recommendations.

### Governance

We assessed the arrangements concerning Governance and raised no indications of potential significant weaknesses.

We did not conduct further risk based work on Governance arrangements. Therefore whilst we have raised improvement recommendations, we have raised no key recommendations.

### Improving economy, efficiency and effectiveness

We assessed the arrangements concerning the 3E's and raised no indications of potential significant weaknesses.

We did not conduct further risk based work on the 3E's arrangements. Therefore whilst we have raised improvement recommendations, we have raised no key recommendations.

## Opinion on the financial statements

We gave an unqualified opinion on the financial statements on 28 June 2021.

# Commentary on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources

All Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. The Trust's responsibilities are set out in Appendix A.

NHS Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under the Local Audit and Accountability Act 2014, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

The National Audit Office's Auditor Guidance Note (AGN) 3, requires us to assess arrangements under three areas:

### Financial Sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

### Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the NHS Trust makes decisions based on appropriate information.

### Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

Our commentary on each of these three areas, as well as the impact of Covid-19, is set out on pages 6 to 27 Further detail on how we approached our work is included in Appendix A.

# Financial sustainability

We considered how the Trust:

- identifies all the significant financial pressures it is facing and builds these into its plans
- plans to bridge its funding gaps and identify achievable savings
- plans its finances to support the sustainable delivery of services in accordance with strategic and statutory priorities
- ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning
- identifies and manages risk to financial resilience, such as unplanned changes in demand and assumptions underlying its plans.

## Financial management 2020/21

The Trust approved an initial plan for 2020/21 which was submitted to NHS Improvement in March 2020. This set out a planned deficit of £8.8m assuming the achievement of £25.5m of cost improvements savings (CIPs).

The onset of the pandemic resulted in a revised financial architecture for the NHS. NHSE and NHSI (NHSE/I) suspended the operational planning process for 2020/21. NHSE/I provided all NHS providers with a guaranteed minimum level of income reflecting a cost base based on the following:

- Commissioners agreed block contracts with NHS providers with whom they had a contract, to cover the period 1 April to 30 September. This provided a guaranteed monthly payment, based on the average monthly expenditure implied by provider figures within the M9 Agreement of Balances (AoB) return, plus an uplift for the impact of inflation.
- Trusts were also to suspend invoicing for non-contracted activity for the same period (1 April-30 September) with a sum equivalent to the historical monthly average being added to the block contract from the commissioner.
- A national top up payment was then provided to providers to reflect the difference between actual costs and income guaranteed (as above) where the expected cost base was higher. The Financial Recovery Fund (FRF) and associated rules were suspended during this period.

Providers were able to claim for additional costs, where the block payments did not cover actual costs, to reflect genuine and reasonable additional marginal costs arising as a result of the covid-19 pandemic. The overarching aim was to ensure that all Trusts maintained breakeven positions throughout this period, regardless of their prior financial position.

For the second half of the financial year simplified arrangements for payment and contracting were extended, but with a greater focus on system partnership and the restoration of elective services. Systems were issued with funding envelopes comprising funding for NHS providers (equivalent in nature to the previous block and prospective top-up payments) plus a system-wide Covid funding envelope. However, access to retrospective top up ended from September 2020. Written contracts between CCGs and NHS providers for the remainder of 2020/21 were also no longer required. Providers and CCGs were instructed by NHSE/I to achieve financial balance within these envelopes in line with a return to usual financial disciplines. Systems as a whole were expected to breakeven, although individual organisations within the system were permitted by mutual agreement to deliver surplus and deficit positions within the overall system envelope.

The Trust reported a true deficit of £2m for the period ending 31st of March 2021 and an adjusted financial performance monitoring outturn of a surplus of £0.3m. This outturn is in line with Kent and Medway Integrated Care System requirement to break-even. Reporting of the Trust's financial position throughout the year was detailed and comprehensive. In line with previous years, the Finance and Performance Committee (FPC) were updated monthly on the financial performance, with FPC reports amended to incorporate Covid-19 monitoring of related pressures. Increased costs due to the pandemic were some £32.8m. The delivery of the 2020/21 financial plan was appropriately a key objective of the Trust Board.

# Financial sustainability

We considered how the Trust:

- identifies all the significant financial pressures it is facing and builds these into its plans
- plans to bridge its funding gaps and identify achievable savings
- plans its finances to support the sustainable delivery of services in accordance with strategic and statutory priorities
- ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning
- identifies and manages risk to financial resilience, such as unplanned changes in demand and assumptions underlying its plans.

## Capital Outturn

The Trust's capital programme for 2020/21 was system based unlike in previous year. The Kent and Medway ICS/STP capital control total in May was £93.6 with the Trust's initial share agreed as £12.3m. This was subsequently adjusted to £21.7m in Month 5 as the Trust resubmitted its capital plans due to delays in capital approval from Kent and Medway ICS and the approval process for capital plans from NHS England/Improvement (NHSEI). There were £11.4m of other capital schemes funded not through the system allocation. The delays in the capital spend confirmation, meant a further delay in approval and commencement of capital projects, with a significant proportion of the capital spend occurring in the last quarter of the financial year. The final outturn capital outturn position for the Trust was £33.3m.

The capital scheme was appropriately reported to the Finance and Performance Committee monthly by scheme type including a commentary on overall make up of the schemes and notification of additional funding from NHSI and the K&M ICS as they were confirmed. Whilst individual schemes that made up the capital programme for 2020/21 were reported to the Finance and Performance, it was unclear which schemes were at risk of not being achieved in the financial year. (Recommendation 1)

The Trust's ability to deliver successfully a capital programme that was significantly increased late in the financial year demonstrates its robust financial management arrangements.

## Your response to the financial architecture for 2021/22 and your arrangements to plan for longer term financial sustainability

### 2021/22

In April 2021 NHSI set out its guidance on finance and contracting arrangements for April to September 2021. Financing arrangements for NHS providers for the first half of the year are similar to that of the second half of the 2020/21 financial year:

- System funding envelopes are set out, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocations based on October 2020 -March 2021 envelopes, adjusted for known pressures and policy priorities.
- Block payment arrangements will remain in place and signed contracts between NHS commissioners and NHS providers are not required for the first half of 2021/22.
- Block payments for the first half of the financial year with NHS providers will be amended to reflect the changes to system funding envelopes, eg. application of inflation and distribution of additional funding.

Both NHSI and NHSE have nationally calculated CCG and NHS provider organisational plans for the first half of the financial year as a default position for systems and organisations to adopt. NHSE and NHSI have stated that this will allow organisations to have a starting point for budget management without the need to complete extensive planning processes while in recovery from the Covid-19 pandemic. All systems are expected to report back a balanced position. Where systems do not report a balanced position, regions will be required to assess the causes and work with systems to develop a balanced plan.

No further guidance has yet been provided for the second half of the year.

# Financial sustainability

The Trust has submitted plans with the local system to achieve a break even position for the first six months. The plan included £7.2m of medium and high risk items relating to Prime Provider Income of £5.4m (high risk) and CIP requirements of £2.6m (medium risk) The plan assumes income from the Elective Recovery Fund of £2.2m, however, this is dependent on system performance as well as the Trust's own performance. The plan assumes a reduction in Covid spend of £2m.

Senior managers acknowledge that the funding available to the Trust to respond to the pandemic will start to reduce as the year progresses and have started developing Cost Improvement Plans to identify areas of further cost reductions. CIP schemes will need to be identified early in H1, undergo Quality Impact Assessment and risk assessed in terms of delivery in order to be enacted in H2.

Looking further ahead, block funding or aligned incentive contracts are likely to replace 'commissioning'. As funding will be largely fixed, the focus will be on productivity and cost efficiencies. Meeting financial targets will be meaningless if it is only done by reducing activity levels to constrain costs, increasing the backlog. Delivering within financial limits will result in the need to alleviate cost pressures. From 2022/23, the focus on efficiency savings may require a savings programme of some £20m, akin to the levels required in past years. The Trust has typically delivered this level of savings in the past, with on average 30% of savings being non recurrent. Management should take advantage of the slightly longer lead in time to re-energise its planning of a programme of savings that can be delivered recurrently. (Recommendation 2)

The Trust has arrangements in place for the identification of efficiency opportunities. It has a PMO, it uses analytics and benchmarking from the NHSI Model Hospital and 'Getting it right first time' programme to highlight opportunities. Over the last two years, the Trust has demonstrated that its arrangements are effective. In 2018/19 and 2019/20, it delivered cost improvement savings of £13.8m and £22.3m respectively. It finance and transformation teams work in partnership with clinical directorates to improve services. This was recognised in 2020 by the Health Service Journal's Values Awards, where the Trust's work was highly commended.

One area of good practice we have seen in a Kent trust is the presentation by clinical directorates of their efficiency opportunities to the principal sub committee of the Board responsible for finance. This serves two purposes, it reinforces the ownership by clinical directorates of their challenge and also provides greater awareness for the sub committee and improves its oversight and ability to scrutinise proposals presented as part of the annual cost improvement programme. (Recommendation 3)

## Capital Planning 2021/22

The system level allocation for 2021/22 is £77m (£94m in 20/21) Kent and Medway ICS and the Trust's own capital allocation being £9.7m. The total budget is £10.9m and includes an additional £1.2m of PFI lifecycle capital. While the Trust will remain responsible for maintaining its own estate and for setting and delivering their own organisational level capital investment plans, the Trust will need to ensure its plans are consistent with the system envelops and reflect system wide discussions on prioritisations.

## Medium term financial planning

The medium term financial position for the Trust is not yet known. A revised medium term financial plan is currently being drafted to be agreed with the local system in September 2020. The planning assumption is to achieve break even each year with tapering reductions in central top up funding. However subject to discussions within the local system, there is a risk that the Trust may have a budget deficit to address.

# Improvement recommendations

## Financial sustainability

| | Recommendation 1 | Recommendation 2 | Recommendation 3 |
|---|---|---|---|
| **Recommendation** | In the reporting of the capital programme to the oversight committee, include at a scheme level, a risk assessment of whether the scheme will be delivered within the year. | Management should take advantage of the slightly longer lead in time to re-energise its planning of a programme of savings that can be delivered recurrently. | Consider a programme of presentations to the Finance and Performance Committee by clinical directorates of their service improvement opportunities |
| **Why/Impact** | Each project should be Red Amber and Green (RAG) rated, to highlight the delivery risk and improve the information presented for scrutiny. | Planning now for a programme of transformational cost improvements will increase the percentage of recurrent schemes delivered. | This serves two purposes, it reinforces the ownership by clinical directorates of their challenge and also provides greater awareness for the sub committee and improves its oversight and ability to scrutinise proposals presented as part of the annual cost improvement programme |
| **Auditor Judgement** | Whilst individual schemes that made up the capital programme for 2020/21 were reported to the Finance and Performance Committee, it was unclear which schemes were at risk of not being achieved in the financial year. It is important that capital schemes are monitored and controlled. The RAG status of each individual project presented to the Finance and Performance Committee would enhance the awareness of the Committee. Progress of schemes will be visible including corrective action being developed for Amber and Red Schemes. This will be of importance particularly where the Trust is committed to large capital projects and monitoring its own capital spend is consistent with K&M ICS capital priorities. | Cost improvement programmes (CIPs) have typically been considered on an annual basis. Often recurrent savings depend on service transformation which take more time to deliver. | The understanding of improvement opportunities is not visible to the Finance and Performance Committee. |
| **Management Comment** | The recommendation is accepted, in principle. However it is likely that some smaller schemes would need to be grouped. It should be noted that the larger projects already have their own programme boards which report project progress to the Finance and Performance Committee or Board. | The recommendation is accepted and work on this has already started. | The recommendation being considered by the Finance and Performance Committee |

The range of recommendations that external auditors can make is explained in Appendix B.

# Governance

We considered how the Trust:

- monitors and assesses risk and gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud
- approaches and carries out its annual budget setting process
- ensures effectiveness processes and systems are in place to ensure budgetary control
- ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency
- monitors and ensures appropriate standards.

## Effective Governance

Governance is the system by which an organisation is controlled and operates, and the mechanisms by which it and its staff are held to account. It is the system that operates from the top, the Trust Board to the ward. Ethics, risk management, compliance with policies, expected best practice, health and safety and administration are all elements of governance. Effective governance requires both clear and unambigious structures and processes and the effective working by people within the designed framework. Effective governance also requires an open culture that promotes openness, transparency, a willingness to learn and no fear of speaking the truth.

### ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency

The Trust has an established governance framework that is multifacted with appropriate leadership and governance procedures in place. The Trust Board is stable with an appropriate skill mix and experience. Attendance at Board meetings through out the year was high demonstrating a good level of engagement. Major decisions are appropriately approved by the Board after discussion and consideration at the relevant Executive Team Meeting and sub-committees. The discussions, decision, and approvals at board or sub-committee level were sufficiently documented during the year.

The Trust's Finance and Performance Committee's role includes monitoring financial performance against plan, and ensuring corrective actions are taken where appropriate. The reports submitted to the F&P Committee are detailed and it is clear from review of minutes when management have identified slippages or adverse performance and communicated to the committee, schemes or corrective action being developed. Our review of the F&P Committee Reports demonstrated that financial information is reported with adequate and sufficient detail to reach appropriate decisions or conclusions. The level of data or financial information is not overly complex, is balanced and is clearly presented. The F&PC agenda items are presented by relevant managers. For example, business cases are presented to the F&P Committee for review with clear options for members to consider and challenge, highlighting costs, risks, pros and cons of each option under review. Once the business case has been considered, this is forwarded to the board for approval or relevant committee depending size and delegated authority for the decision. Examples of this include the key investment on building accommodation at Tunbridge Wells Hospital for the Kent and Medway Medical School and a business case for the recruitment and retention of registered nurses. It is clear from review of minutes from the F&PC committee, what actions are taken by committee members and those passed to the board for deliberation or approval.

The Audit and Governance Committee critically reviewed the governance and assurance mechanisms in place at the Trust. The Committee meetings encourage different views from members, and there is appropriate challenge of Senior managers relating to internal controls and risk management. We noted clear evidence of a strong willingness to learn from other organisations, with members of the committee sharing their views and experience how other organisations operate.

The Trust's Quality Committee is responsible for providing assurance on the effectiveness of the Trust's structures, systems and process to enable the delivery of the Trust's objectives relating to the quality of care and quality within the clinical divisions. Quality Committee Meetings were held monthly, operating a format of 'Main' Quality Committee meetings and Deep Dive meetings on alternate months. The 'main' meeting covered a broader spectrum with a comprehensive agenda and the Deep Dive meetings more focused on detailed scrutiny on a number of issues/subjects. From our review of committee minutes, we were satisfied that there is appropriate and adequate engagement from members of the committee, effective challenge, decision making and actions taken documented.

# Governance

From our engagement with the Trust, we consider that the Trust Board is overseeing and continuing to develop a positive open culture within the organisation. We note that the 2020 staff survey results support our assessment. Staff satisfaction metrics are improving although there remains more to do.

## Risk Management.

The Trust Board has responsibility for directly, or through its sub-committees, ensuring that strategic risks are identified, assessed, and included within the Board Assurance Framework and / or the relevant Risk Register, and for receiving assurance that risks associated with the Trust's objectives are being managed. The Trust has a clear risk management processes in place to support the identification and management of risks

The BAF is the document through which the Trust Board is appraised of the principal risks to the Trust meeting its key objectives, and to the controls in place to manage those risks. The Board originally agreed the BAF objectives for 2020/21, prior to start of the financial year. However, subsequently, the Trust started to explore how the BAF could be refreshed and synchronised with its new Integrated Performance Report format reporting structure and its new Quality Improvement methodology which aims to focus further the Board's attention on a smaller set of priorities. Furthermore, with the impact of the Covid-19 pandemic, the Board rightfully agreed that objectives and risks required updating to reflect the new challenges and operating environment.

The 2020/21 revised objectives of the BAF were presented to and approved by the Trust Board in July 2020, albeit incomplete due to uncertainty relating to the granular aspects surrounding the high-level project aims (objectives). The fully populated 2020/21 BAF was presented to the board for discussion in November 2020/21 with 9 Objectives (compared to the 12 in 2019/20). Therefore, the 2020/21 BAF was only reported to the Board twice in the financial year compared to the typical 4 times we would expect and in line with previous years. Whilst there was a gap between the Board approving the BAF (July and November), the contents and changes made to the BAF were circulated through other management and scrutiny forums such as Board sub-committees and the Executive Team Meetings. Therefore, members of the board through their involvement in respective sub-committees were sighted of the different elements of the BAF between July 2020 and November 2020. The full BAF was considered by the Audit and Governance Committee on November 2020, prior for consideration to the Board. Organisational objectives have a named Senior Responsible Officer, show the underlying ley workstreams, metrics to measure success and a statement of expected benefits.

It is good practice to report the contents and progress of the BAF on a regular basis to the Trust Board. This important to ensure that the Board has the holistic complete overview of progress against its objectives and the management of risks associated that could impact its objectives. (Recommendation 4)

The Risk Register and BAF is subject to an annual review by Internal Audit as part of its annual programme. Internal Audit noted there were appropriate risk management policies and procedures in place at the Trust (updated 20 October 2020) and there were appropriate arrangements in place for managing and monitoring risks in relation the Covid-19.

The Trust's internal auditor delivers a wide programme of work and reports support the Audit and Governance Committee in assuring itself that systems, processes, and controls are operating effectively. No significant weaknesses have been identified by internal audit in 2020/21. Similarly, the Counter Fraud Specialists undertake a programme of work to support the Audit and Governance Committee, including a mix of proactive and investigatory work. No significant weakness have been identified by Counter fraud.

## approaches and carries out its annual budget setting process and ensures effectiveness processes and systems are in place to ensure budgetary control

There are appropriate arrangements in place for the annual budget setting process at the Trust . The Trust has planned for the first 6 months of 2021/22 as part of the H1 planning guidance working within the emerging system architecture. With greater systems working, the Trust's budget setting process (including capital) appropriately considered system priorities to ensure alignment with financial and capital objectives of the system. There is clear evidence of identification of risks and uncertainty surrounding operational activity and financial impact built into the budget. For example, the draft H1 plan developed in April 2021/22 had a £13.4m gap, and in May this gap had been closed, albeit with £7.2m of high to medium risks appropriately identified by management. The budget process appropriately incorporates workforce data, activity level data, inflationary uplift assumptions. Where values are uncertain the Trust use trends and scenario planning. Budgetary performance is reported to the F&P Committee and the Board. Key variances are identified against the planned position, with commentary and key actions to address unfavourable positions or risks for example, schemes or corrective action being developed or in the pipeline. Additional controls were put in place early in February 2020 and operated throughout 2020/21, to monitor covid-19 related costs and report these internally and externally to stakeholders.

## monitors and ensures appropriate standards.

The Trust has appropriate arrangements in place to monitor compliance with legislation and regulatory standards. Policies and Procedures are in place. At the Board's request, from February 2021, a metric is reported monitoring the percentage of Trust Policies within review date. Arrangements for making declarations of interest are in place at the beginning of all board or committee meetings. Members of the board and other staff classified as 'decision-makers' are required to complete an annual declaration and this is collected by the Trust Secretary.

# Improvement recommendations

## Governance

Recommendation 4

| | |
|---|---|
| **Recommendation** | Present the Board Assurance Framework regularly to the Board. |
| **Why/Impact** | The BAF is a key mechanism for managing risk to the achievement of the Board's strategic objectives and priorities. |
| **Auditor Judgement** | The 2020/21 BAF was only reported to the Board twice in the financial year compared to the typical four times we would expect and in line with previous years. It is good practice to report the contents and progress of the BAF on a regular basis to the Trust Board. This important to ensure that the Board has the holistic complete overview of progress against its objectives and the management of risks associated that could impact its objectives. We understand the BAF will be superseded by the 'Strategy Deployment' work in 2020/21 in terms of monitoring and reporting risks. This work is currently on-going. |
| **Management Comment** | The recommendation is accepted, in principle. However, at its meeting on 25/03/21 the Trust Board 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. The reporting and monitoring arrangements for the Strategy Deployment work are still (at August 2021) being finalised, but it is expected that the Trust Board will receive regular updates on progress |

# Improving economy, efficiency and effectiveness

We considered how the Trust:

- uses financial and performance information to assess performance to identify areas for improvement
- evaluates the services it provides to assess performance and identify areas for improvement
- ensures it delivers its role within significant partnerships, engages with stakeholders, monitors performance against expectations and ensures action is taken where necessary to improve
- ensures that it commissions or procures services in accordance with relevant legislation, professional standards and internal policies, and assesses whether it is realising the expected benefits.

### 1. uses financial and performance information to assess performance to identify areas for improvement

Reporting across both finance and operational performance is comprehensive at both Board and sub-committee level. The Board reviews the full Integrated Performance Report monthly and in addition is provided summary updates from the respective sub-committees that monitor performance. The Finance and Performance Committee and Quality Committee consider both financial and quality performance information, respectively. Performance information is presented in narrative, metric and tabular/graphical format and there is good coverage of a range of key performance indicators (KPI's). The reports present a holistic picture of the Trust's services. Review of Board papers shows that a rounded discussion on performance is held.

There is evidence that performance review is used to drive improvement. The Quality Committee via its various sub-committees in operation, monitor clinical quality performance indicators. Serious Incidents (SI) declared and learning identified from SI are reported to the Main Quality Committee via the Divisional Governance Reports. A separate update on Serious Incidents (incorporating the report from the learning and improvement (SI) panel), are appropriately reviewed by the main Quality Committee. We found the information in the reports was presented in both narrative and metric format. SI data was presented showing the monthly KPI against previous months and a comparison with prior year. Our review of minutes and reports shows there is evidence of the Trust putting in place steps and process to learn from SIs investigations.

The Trust refreshed its Integrated Performance Report in June 2020. The old format required each category within the balance scorecard to be given an overall RAG rating on the rating of the KPIs within each CQC domain. The new IPR format adopted by the Trust uses Statistical Process Control (SPC) charts. NHS England have been advancing for greater use of SPC as part of its making data count drive. Statistical process control is an analytical technique that plots data over time. It helps an understanding of variation and guides management to take the most appropriate action. The main aim of using statistical process control charts is to understand what is different and what is normal to determine where work needs to be concentrated to make a change. It is a methodology that is used by CQC 'outstanding' rated trusts such as Chelsea & Westminster Hospitals NHS Foundation Trust and The Royal Marsden NHS Foundation Trust. Three other Kent NHS provider trusts also use it.

Interviews with managers highlighted that the use of SPC has been well received by the Board despite some initial challenges on transition. The new approach has helped focus discussion on those key variations. In our view, the SPC approach should enable Senior Officers and NEDs to engage on more productive conversations focused on actions to improve performance and services within the Trust and less time overacting to data that indicates no significance.

The Trust is increasingly working in partnership within the local health system and indeed the future policy direction of the NHS is system working. Currently, there are no partnership metrics included in the Trust's performance reports. As partnership working develops, the Board will need appropriate information to both understand performance and to feed back potential improvements. The Trust is alert to this and has identified partnership metrics which are in development.

# Improving economy, efficiency and effectiveness

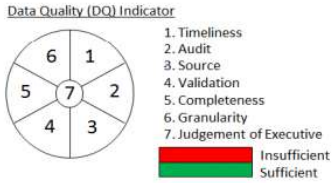
## Data Quality

The Trust has a number of controls and processes in place to ensure the accuracy of data. It has an Information Lifecycle Management Policy and Procedure, which details the Trust's general approach to assure data quality. A Data Quality Steering Group is in operation, led by the Chief Finance Officer, responsible for assuring data quality across the organisation. The Group oversaw the creation of the Data Quality Strategy and workplan to ensure it is in line NHS Digital's Provider Data Quality Assurance Framework. This will assist the organisation in focusing on areas with low data quality.

Internal Audit completed an annual review of the Trust's performance information as part of its programme. The 2019/20 Data Quality of Key Performance Indicators was finalised in September 2020 and focused on two indicators (Stroke Best Practice and 18 Weeks Referral to Treatment incomplete pathway indicators). Internal Audit's overall assessment was "Reasonable Assurance" with some areas of improvement. Senior managers acknowledge that Data Quality in the past has not been as robust as it should, but the Trust is now more focused on improving data quality process.

The transparency of data assurance to the Board is good practice. This is not an area that is well developed by many trusts. We are aware that Nottingham University Hospitals Trust has a particularly well advanced process. Each performance metric has an associated data quality indicator assessing the robustness of the data over 7 domains and is reported as part of each Performance Report. Other trusts achieve the same aim of informing the Board of the robustness of data quality through an annual assurance paper. Given the Trust's renewed focus on data quality, we recommend it considers a way of bringing this to the Board's attention. [Recommendation 5]

Exhibit 1 Data quality indicator used by Nottingham University Hospitals




evaluates the services it provides to assess performance and identify areas for improvement

The Trust was last inspected by the CQC in 2017 and was assessed as "Requires Improvement". The Trust's preparations and planning for future CQC inspection are integrated as part its business as usual quality improvement agenda. This work is overseen by the Quality Improvement Committee, which reports to the Executive Team Meeting and Main Quality Committee. The Trust's ambition is achieve an "Outstanding Rating".

The Trust's Internal Auditors undertook an audit to assess progress against the improvements identified by CQC. Internal audit provided 'reasonable assurance' and confirmed through its work that the Trust has implemented the 'Should Dos' improvement areas.

Senior management are considering an external governance review during 2021/22 to understand where the organisation currently sits against the CQC standards.

# Improving economy, efficiency and effectiveness

Key to ensuring that the Trust delivers high quality clinical services as business as usual and embeds learning as it emerges is its new quality improvement methodology. The Trust's desire to learn and improve led to it engaging and partnering with Western Sussex Hospitals, a CQC outstanding rated trust. Western Sussex Hospitals representatives were invited to the Trust to share experiences and how they embedded very effective ways of aligning strategy, objectives and driving improvement. The Trust is learning from this experience and are tailoring the overarching principles of Western Sussex Hospital's True North approach to ensure they are consistent with MTW's culture. This is a positive step. Adopting a recognised proven quality improvement methodology will help with the continual drive to improve services, but to be successful, adoption will need to be matched with rigorous application. The Trust launched its programme in March 2021.

The Trust has met two of the three national access standards for care. These are important metrics for the public and the national health service leadership. These are waiting times in emergency department from arrival to treatment, waiting times from GP referral to acute treatment across all clinical disciplines and the percentage of cancer patients treated within two weeks. Like many trusts, a backlog of treating patients has developed whilst focus was on managing covid 19 patients, with a consequent reduction in performance against referral to treatment metric. The Trust's own planned target for RTT was part of its reset and recovery programme was 87% (exhibit 2). These metrics are part of the Integrated Performance Report and subjected to scrutiny.

Exhibit 2 Performance against national access targets

| Indicator | standard | Pre pandemic comparative to national performance – December 2019 | 2020/21 comparative to national performance as of Oct 2020 | Trust's March 2021 reported performance March 2021 |
|---|---|---|---|---|
| A&E 4 hour wait | 95% | | 90% | 95% |
| RTT 18 weeks wait | 92% | | 73% | 62% |
| Cancer 2ww | 93% | | 96% | 96% |

# Improving economy, efficiency and effectiveness

ensures it delivers its role within significant partnerships, engages with stakeholders, monitors performance against expectations and ensures action is taken where necessary to improve

There is evidence of an increasing track record of collaborative working amongst health commissioners and providers and local authorities within Kent and Medway. In 2016, in line with national direction, the Kent & Medway Sustainability and Transformation Partnership, a collaboration of all NHS bodies in the local health economy and Kent County Council and Medway Council, was set up. Towards the end of that year, a 'change plan' was prepared with the aim for transformation in the population's heath and wellbeing, the quality of care and the sustainability of the system by targeting intervention in four key areas; care transformation; productivity; system enablers – digital, estates and workforce and system leadership, creating one health commissioner for the area. These themes have been consistent through to 2020/21. A governance framework was developed to plan, co-ordinate, consult and monitor progress against plans across the area. Named senior responsible officers from across the public sector bodies in Kent and Medway were nominated for each key workstream. Regular updates to Medway Council and Kent CC's respective health and well being committees have been shared on progress and developments.

Progress has been made against the longer term key objectives set for improvement in the system. In January 2020, the system confirmed two possible options for service transformation in East Kent. A pre consultation business case was submitted in October 2020 to NHS England for consideration before public consultation commences. The pandemic over the last year has impacted the progression to public consultation. In February 2020, following consideration by the High Court, remaining legal challenges to the creation of three hyper acute stroke units was resolved. Whilst this proposal does not have unanimous agreement across all local public sector bodies, the local health system is now able to control the implementation of its plans for the development of hyper acute stroke units at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital, subject to Secretary of State approval. On the 1 April 2020, the Kent and Medway Clinical Commissioning Group was created from the merger of eight predecessor CCGs, achieving a key milestone in developing a streamlined system commissioning model.

Progress has also been made on operational aspects. The Kent and Medway Care Record which brings together a single view of a patient's record from multiple systems across health and social care was launched in 2021. This is designed to help health and social care providers make better decisions for patients in their care. Chief financial officers from the NHS bodies in the area agreed principles and governance arrangements to manage the 2020/21 financial outturn; the revenue planning cycle for the 2021/22 period, and the preparation of outline capital investment plans for the next 3-5 years. Principles include 'system by default' , 'a deficit in any organisation is a failure of the system' and 'risks faced, shared and managed'. The latter principle builds on earlier work in some parts of the Kent & Medway system, where aligned incentive commissioning contracts (shared risk of fluctuating patient demand between commissioners and providers) were agreed with providers such as East Kent Hospitals FT and Maidstone & Tunbridge Wells NHS Trust. Having agreed principles and governance arrangements should provide a good foundation for managing the future financial environment which is anticipated to be more challenging post pandemic.

As part of the system wide approach to working, four place based integrated care partnerships (ICPs) were established working for their locality under the umbrella of the then Kent & Medway wide Sustainability and Transformation Partnership. The four ICPs are Dartford, Gravesham and Swanley; East Kent; Medway and Swale; and West Kent. Local partnership working within the these ICPs has developing for the last two to three years. As part of our work, we sought the views of a small number of managers working in three of the four ICPs (Dartford, Gravesham and Swanley was not covered). When asked about how they would assess the maturity of system working currently on a scale of 1 immature; 2 developing ; 3 established ; 4 maturing ; 5 fully mature – there was agreement on a rating of 'developing'. We note that the further development of ICPs is one of the priorities agreed by the Kent & Medway integrated care system.

The pandemic demonstrated public services at their best: dynamic, responsive, collaborative, fleet of foot, and truly committed to patients and their community. Working to protect the Kent and Medway public from the pandemic is a key example of successful system working. At the height of the first wave, when protective personal equipment was hard to source, a systems approach coordinated by the CCG was adopted, ensuring scarce resources were evenly allocated. The second wave hit Kent and Medway hard with the Kent variant of the virus. Medway and Swale was a hotspot within Kent and the number of hospitalisations at Medway FT at one point was extreme; patient diverts were accommodated at Maidstone and Tunbridge Wells Hospitals.

# Improving economy, efficiency and effectiveness

In December 2020, both NHS and local authorities focused on the vaccination programme. On the 14th December 2020 the first hospital hub site opened at the William Harvey Hospital for the vaccination programme. This was quickly followed by a further 5 hospital hub sites and 39 GP led local vaccination services. Ultimately, the vaccination programme was and is delivered from 60 sites: 39 GP-led sites covering Kent and Medway's 42 primary care networks; six hospital hubs, vaccinating exclusively health and social care staff, other than Medway Maritime Hospital, which also provided vaccinations for patients; five large vaccination sites in Folkestone, Gravesend, Tonbridge, Thanet and Medway; and fourteen community pharmacies.

The vaccination rates within Kent and Medway compares well to national rates. In March 2021, the Clinical Commissioning Group reported to its governing body that the level of take up for the top four priority groups was 90%, with 581,293 people given a first dose. As at 11 July the CCG reports publicly that 2,222,100 vaccines have been given in total; 92% of top 9 priority groups have had both does; 67% and 57% of 30-39 years and 18-29 years respectively have had first doses.

Over the next six months, whilst continuing to manage the impacts of the pandemic, the local system faces further transition. The NHS Long Term Plan confirmed that all parts of England would be served by an integrated care system from April 2021. Integrated Care Systems are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. Kent and Medway was accredited as an ICS on 1 April 2021. The Health and Social Care Bill currently progressing through the House of Commons will put ICS on a statutory basis. Clinical commissioning groups will cease to exist as a statutory body. From our review of key documents and interviews with selected managers across Kent and Medway, we are aware that a detailed programme of work is in development to establish governance structures and arrangements for the Kent and Medway ICS to be implemented from April 2022. The pace at which the system has to work to be ready for transition has a degree of associated risk. It is too early to determine whether the scale of risk is manageable.

We found no evidence or indication of potential significant weakness regarding the economy, efficiency and effectiveness arrangements at the Trust, as such, no further risk-based work has been performed on this criteria for assessing the arrangements for securing value for money.

# Improvement recommendations

## Improving economy, efficiency and effectiveness

Recommendation 5

| | |
|---|---|
| **Recommendation** | Consider a way of bringing to the Board's attention, on a recurring timeline (to be determined), the data quality of performance metrics reported to the Board and its sub committees. |
| **Why/Impact** | High quality (accurate, complete, reliable, relevant and timely) data is important, as it can lead to improvements in patient care and patient safety. High quality should enhance the decision making and lead to improvements in services. |
| **Auditor Judgement** | The Trust's individual performance metrics that form part of the Integrated Performance Indicator to the Board and its sub-committees does not currently provide context on the data assurance level. The transparency of data assurance to the Board is good practice. This is not an area that is well developed by many trusts. |
| **Management Comment** | The recommendation is accepted, in principle. However it should be noted that progress on a kite mark assurance is already underway as a means to provide the Board assurance on the robustness of each performance metric. |

# COVID-19 arrangements

Since March 2020 COVID-19 has had a significant impact on the population as a whole and how NHS services are delivered.

We have considered how the Trust's arrangements have adapted to respond to the new risks they are facing.

## Financial sustainability

The Trust's financial planning arrangements were adapted to the financial framework that was put in place because of the pandemic.

For 2020/21 the Trust received reimbursement of Covid-19 related costs from NHSE/I which were claimed via a monthly return. Budget holders were responsible for identifying additional COVID-19 costs and reporting additional costs to their Divisional Finance Manager who coordinate with Senior Finance Manager to ensure all additional costs/spend were included in the national return to NHSI. There was on-going analysis and review of budgets by budget holders and finance to identify unexpected variations that could indicate additional covid-19 costs that had not been captured appropriately. Covid-19 transactions were reported to the Finance and Performance Committee throughout 2020/21.

## Governance

The Trust responded appropriately to guidance issued by NHSI/E in March, and immediately reflecting and incorporating the impact of the new business arrangements nationally in response to the pandemic. A paper was prepared by management and submitted to the March 2020 Finance and Performance Committee, primarily focused on Covid-19 requirements and critical service development, review governance and controls and managing risks (including Standing Orders, Delegated Limits), contracting arrangements and business planning.

The Trust maintained appropriate financial governance and controls during the pandemic period. The controls that existed before the pandemic were appropriately reviewed for any weaknesses under the revised working arrangements. Additional expenditure related to covid-19 required approval by the Incident Command Centre with principles agreed, revenue and expenditure items would then approved by Deputy Director of Finance – Performance. Capital expenditure was agreed by the Chief Executive.

The Quality Committee continued to function appropriately during the pandemic. A Covid-19 Ethics Committee was set-up in mid March to identify, consider and advise on ethical considerations arising from the management of Covid-19 at the Trust. A Covid-19 Clinical Reference Group was established in mid-March to act as a source of expert advice on the management of Covid-19 within the Trust and to report on and proactively raise key issues with Trust management. Our review of Quality Committee we noted regular reporting of outputs from both the Covid-19 Ethic Committee and the Covid-19 Clinical Reference Group.

There was evidence of management of risks during the pandemic period, as the Trust adapted its arrangements to respond to the new risks in respect Covid-19. New covid-19 risks were incorporated into divisional risk register, effectively managed and adjusted for accordingly through the RAG ratings and monitored and reported appropriately to the respective Board sub-committees.

The Board was sighted on the Trust's process and management of covid-19, through its sub-committees in operation as well as detailed reports and summaries included in Board packs. For instance, the old and new Integrated Performance Report to incorporate appropriate covid-19 data and other information. The monitoring and reporting of covid-19 metrics during this period were under the CQC domains.

# COVID-19 arrangements

NHSE developed a board assurance framework to support trusts to effectively self-assess their compliance with Public Health and Other Covid-19 related infection and prevention and control guidance to identify risks. The guidance was published in June 2020 and one of the requirements was for the IPC Board Assurance Framework to be reviewed and evidence of assessments are made available and discussed at Trust Board monthly. This did not occur between June 2020 and November 2020. However, in December 2020 and in subsequent months a self-assessment was undertaken and presented to the Board.

## Improving Economy, Efficiency and Effectiveness

The Trust maintained effective controls around expenditure and procurement during the pandemic. As noted earlier, covid-19 related spend went through a robust internal process with appropriate controls in place requiring spend review and approval. Approval limits are clearly set out in the Standing Financial Instructions.

The Trust rightfully started considering the implication of the pandemic on the delivery of its services early on. We noted evidence in our review of board and sub-committee papers and discussions with senior officers, the Trust was acutely aware that non-financial performance would inevitably be impacted by the pandemic and therefore started exploring and developing mitigation proposals in February and March 2020 and this was implemented during 2020/21 with the Trust continually reappraising its operating environment and responding to the challenges presented by the pandemic. For example, putting in place arrangements for cancer waiting times so these were not significantly impacted by covid-19 period, developing, and measuring different metrics during covid-19 period, monitoring number of patients with covid-19 including Intensive Treatment Unit activity as well as its own staff well being and sickness levels. A daily covid-19 related monitoring dashboard was developed and the Integrated and Performance Reports from May onwards incorporated a Covid-19 Summary.

The following are examples of how the Trust responded to the pandemic and reconfigured some of its service:

- Vaccination Centre: The Academic Centre at Maidstone was converted into a vaccination centre in December 2020 to provide Covid-19 vaccinations to Trust staff. The Centre also managed to vaccinate some of our high risk patients with cancer. In total 30,300 vaccinations were administered.
- Covid-19 Virtual Ward: The Respiratory Team, Clinical Systems and Transformation Team established a Covid-19 virtual Ward. This allowed patients who no longer required in hospital care for coronavirus to be monitored remotely from their own home.
- Drive through pharmacy for patients with cancer: This was set-up for patients with cancer could continue to receive vital medication without the need to enter the Trust hospital sites

# Opinion on the financial statements

## Audit opinion on the financial statements

We gave an unqualified opinion on the financial statements on 28 June 2021

## Other opinion/key findings

We had no significant unamended findings in relation to other information produced by the Trust including the Annual Report, the Annual Governance Statement and the Remuneration Report.

## Audit Findings Report

More detailed findings can be found in our AFR, which was published and reported to the Trust's Audit and Governance Committee on 23 June 2021.

## Whole of Government Accounts

To support the audit of Consolidated NHS Provider Accounts, the Department of Health and Social Care group accounts, and the Whole of Government Accounts, we are required to examine and report on the consistency of the Trust's consolidation schedules with their audited financial statements. This work includes performing specified procedures under group audit instructions issued by the National Audit Office.

Our work found no issues.

## Preparation of the accounts

The Trust provided draft accounts in line with the national deadline and provided a good set of working papers to support it. These were provided 28th April 2021 in line with the extended deadline available upon application to all bodies in the sector.

## Issues arising from the accounts:

The key issues were:

- Intangible Asset for the Trust's Electronic Patient Records costs of £7.2m had been misclassified as Property Plant and Equipment.
- Receivables and Trade Payables were both overstated by £4.3m due misclassification of invoices within prepayments (Receivables) and creditors.
- There a number of presentation and disclosure misstatements identified
- One misstatements (£67k) relating to trade payables was extrapolated by the audit team, resulting in a £839k unadjusted misstatement. No requirement was made to adjust, as the error was below materiality.
- We raised 1 control point recommendation to management regarding the review of the Fixed Asset Register.

Management agreed to amend the financial accounts for the misstatements identified during the audit.

## Grant Thornton provides an independent opinion on whether the accounts are:

- True and fair
- Prepared in accordance with relevant accounting standards
- Prepared in accordance with relevant UK legislation

# Appendices

# Appendix A - Responsibilities of the NHS Trust

Role of the directors of the Trust:

- Preparation of the statement of accounts
- Assessing the Trust's ability to continue to operate as a going concern

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The directors of the Trust are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The directors are required to comply with the Department of Health & Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

# Appendix B - An explanatory note on recommendations

The recommendations that can be raised by the Trust's auditors are as follows:

| Type of recommendation | Background | Raised within this report |
|---|---|---|
| Key | The NAO Code of Audit Practice requires that where auditors identify significant weaknesses as part of their arrangements to secure value for money they should make recommendations setting out the actions that should be taken by the Trust. We have defined these recommendations as 'key recommendations'. | None at this stage |
| Improvement | These recommendations, if implemented should improve the arrangements in place at the Trust, but are not a result of identifying significant weaknesses in the Trust's arrangements. | Several recommendations |

# Use of formal auditor's powers

We bring the following matters to your attention:

| | |
|---|---|
| **Statutory recommendations**<br>Under Schedule 7 of the Local Audit and Accountability Act 2014, auditors can make written recommendations to the audited body | Not Applicable |
| **Section 30 referral**<br>Under Section 30 of the Local Audit and Accountability Act 2014, the auditor of an NHS body has a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be referred to the Secretary of State, and/or relevant NHS regulatory body as appropriate | In June 2020, we highlighted the above and issued a section 30 referral to the Secretary of State which covered the financial reporting period 2020/21 as required by the Local Audit and Accountability Act 2014 |
| **Public Interest Report**<br>Under Schedule 7 of the Local Audit and Accountability Act 2014, auditors have the power to make a report if they consider a matter is sufficiently important to be brought to the attention of the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view. | Not Applicable |

NHS Maidstone and Tunbridge Wells NHS Trust

| **Summary report from the Extraordinary Finance and Performance Committee, 25/08/21** | **Committee Chair (Non-Exec. Director)** |
|---|---|

The 'Part 1' Trust Board meeting, on the 29th July 2021, delegated the authority to the Finance and Performance Committee to review and, if appropriate, approve the Full Business Case (FBC) for a managed Magnetic Resonance Imaging (MRI) Service. Therefore, an extraordinary meeting of the Committee was held on the 25th August, via a webconference.

1. **The key matters considered at the meeting were as follows:**
   - The **Full Business Case (FBC) for a managed MRI service** was approved subject to approval by NHS England / Improvement (NHSE/I), as the total expenditure required exceeded the Trust's delegated authority, and the finalisation of the accounting treatment, furthermore the following actions were agreed in relation to the FBC:
     - That the Deputy Director of Finance (Financial Performance) should check and confirm, to Committee members, the potential capital expenditure required to mitigate the potential risks around the building modification component of the FBC for a managed MRI service
     - That the Deputy Director of Finance (Financial Performance) should ensure that the Committee was informed of the outcome of the review of the FBC for a managed MRI service by NHSE/I, and the finalisation of the accounting treatment
     - That the Director of Strategy, Planning and Partnerships should Consider, and confirm the method by which staff engagement with the managed MRI service should be monitored

2. **In addition to the agreements referred to above, the Committee agreed that:** The Assistant Trust Secretary should ensure that the decision, by the Committee, to approve the FBC for a managed MRI service was reported to the 'Part 1' Trust Board meeting on the 23rd September 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

| Summary report from the Finance and Performance Committee, 21/09/21 (incl. approval of revised Terms of Reference) | Committee Chair (Non-Exec. Director) |
|---|---|

The Committee met on 21st September, via a webconference.

1. **The key matters considered at the meeting were as follows:**
   - **Updated Terms of Reference were agreed**, as these were due an annual review. The only major change proposed reflected the decision taken by the Trust Board in July 2021 to establish the Green Committee as a sub-committee of the Finance and Performance Committee. The revised Terms of Reference are required to be approved by the Trust Board, so these are enclosed in Appendix 1, for approval. The proposed changes are shown as 'tracked'.
   - The **month 5 non-finance related performance** was reviewed, which included confirmation that the Trust had achieved the national cancer standard for 62-day performance for 24 months in a row in the face of significantly increased referrals. Focus continued on long waiters; Emergency Department (ED) attendances were at a record high (323 at Maidstone Hospital on 20/09/21), and getting back on track against key staffing challenges was seen as the critical element to longer term recovery and resilience
   - The Chief Operating Officer reported the latest position in relation to the new **28-day cancer faster diagnosis standard** with confirmation of performance above the 75% compliance threshold and at 87% of data completeness (against an 80% target)
   - The **financial performance for month 5** was reviewed, which included reporting of a continued break-even position year to date, and confirmation that the year to date position included £11m associated with the full system value of the Elective Recovery Fund (ERF), with the Trust element still to be finalised. Although the Trust's performance remained strong in months 4 & 5, under-performance by other system providers had resulted in non-achievement of the threshold to trigger the Elective Recovery Fund (ERF) payment for July and August.
   - The Director of Strategy, Planning and Partnerships attended to give an **update on planning for the second half of 2021/22** (i.e. "H2"). It was noted that there had been no formal indication yet of national timeframes or guidance; initial MTW focus was on validation of H1 plans and performance, with identified key lines of enquiry around workforce and activity. Efficiency requirements were still to be confirmed but anticipated at circa 2%. There was focus for H2 on turning plans into high level projections; prioritisation and development of business cases in light of potential capital funding availability for ERF activities; and on supporting the Chief People Officer with the workforce supply project.
   - A representative from the Diagnostics & Clinical Support Services Division attended to present a **Business Case for the development of a Community Diagnostic Hub** (CDH). The Committee supported the Case, which has been submitted for approval by the Trust Board under a separate agenda item.
   - The latest **update on the implementation of the Electronic Patient Record (EPR)** was given and it was noted that implementation to inpatient wards at Tunbridge Wells Hospital had commenced with no significant issues identified to date. Additional deliverables, largely around developing system interfaces, and which had been made possible by the delay of the Electronic Prescribing and Medicines Administration (EPMA) go-live, were noted and supported
   - The Committee confirmed the approach to be taken for the compilation of the mandatory **National Cost Collection submissions**, and noted the sign off process and reporting timetables for the mandatory costing return for 2020/21
   - It was noted under **any other business** that there that there had been reference at the 'main' People and Organisational Development Committee meeting to reconciliation of the financial ledger with Electronic Staff Record (ESR) for establishment control purposes. It was noted that the direction of travel was for future such reconciliations to be automated and to ensure that ESR became the default repository for the establishment data.

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

- The Chief Finance Officer would provide a verbal update to the Trust Board meeting on 23/09/21 on progress with the review of the Full Business Case (FBC) for a managed Magnetic Resonance Imaging (MRI) service by NHS England / Improvement, and the finalisation of the accounting treatment, given the slow progress to date with this process
- The Trust Secretary would liaise with the Director of Estates and Facilities about the Finance and Performance Committee's request to review the Terms of Reference for the Green Committee, and to advise the agreed default position for a written report from the Green Committee to the Finance and Performance Committee on a quarterly basis (with confirmation of the Green Plan within the first such report).

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

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

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

1. Information and assurance
2. To approve the Committee's revised Terms of Reference (see Appendix 1)

**Appendix 1: Revised Terms of Reference (for approval)**

# FINANCE AND PERFORMANCE COMMITTEE

## Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

### 1. Purpose

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

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

### 2. Membership

Membership of the Committee is as follows:

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

Members are expected to attend all relevant meetings.

### 3. Quorum

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

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

### 4. Attendance

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

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

### 5. Frequency of meetings

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

### 6. Duties

The Committee has the following duties:

**Financial Management**

- To review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- To ensure a comprehensive budgetary control framework is in place and operating effectively
- To monitor financial performance against plan, and ensure corrective action is taken where appropriate
- To develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- To review and monitor the Trust's Cost Improvement Programme (CIP)
- To monitor the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations"), and subsequent related publications or national guidance.
- To ensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national initiatives

**Treasury Management**

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

**Capital Expenditure and Investment**

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

**Financial Governance, Reporting, Systems and Function**

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

**Procurement**

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

**Performance**

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

**Informatics (including Information Technology**

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

**Assurance and Risk**

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

## 7. Parent Committees and reporting procedure

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

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

## 8. Sub-Committees and reporting procedure

The Committee has the following ~~no standing~~ sub-committees:

- The Green Committee

Reports from the Committee's sub-committees will be given after each sub-committee meeting (either via submission of the minutes of the meeting, a written summary report or a verbal report from, or on behalf of, the sub-committee Chair).

~~, but~~The Committee may also establish fixed-term working groups, as required, to support the Committee in meeting the purpose and/or duties listed in these Terms of Reference.

## 9. Emergency powers and urgent decisions

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

## 10. Administration

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

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

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

## 11. Review of Terms of Reference and monitoring compliance

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

**History**

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015

- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2019
- Terms of Reference (revised) approved by the Trust Board, September 2019
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2020
- Terms of Reference (revised) approved by the Trust Board, September 2020
- Terms of Reference approved by the Trust Board, January 2021 (to address the anomaly regarding the listing of an “Associate Non-Executive Director” in the membership rather than a third Non-Executive Director)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, September 2021 (annual review, but also to include formalising the Green Committee as a sub-committee of the Finance and Performance Committee)
- Terms of Reference (revised) approved by the Trust Board, September 2021

NHS Maidstone and Tunbridge Wells NHS Trust

| Summary report from the Patient Experience Committee, 02/09/21 | Committee Chair (Non-Executive Director) |
|---|---|

The Patient Experience Committee (PEC) met on 2nd September 2021.

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

- The **actions from previous meetings** were reviewed.
- The Committee reviewed the **Trust's Clinical Strategy, including stakeholder engagement for Cardiology Consolidation and Gastroenterology Centralisation**, wherein Committee members emphasised the importance of a decision from the Secretary of State for Health and Social Care on the reconfiguration of stroke services and it was agreed that the Director of Strategy, Planning and Partnerships should submit an update on "Cardiology Consolidation and Gastroenterology Centralisation" to the Committee's meeting in December 2021.
- The Patient Experience Lead provided a **Patient Experience Update** which included details of the One Team Runner programme, the engagement work which had been implemented at the Trust and the mechanisms to increase Friend and Family Test (FFT) response rates. A discussion was held regarding the opportunities to improve patient services by utilising increased system collaboration within the Kent and Medway Integrated Care System (ICS). A specific example in relation to substance misuse services was raised and consideration given to how the challenges raised could be addressed through the new ICS model.
- The Complaints and PALS Manager provided a comprehensive **review of complaints** wherein it was agreed that the Complaints and PALS Manager should Ensure that a contingency plan was developed to enable public representatives to review the Complaints Annual Report for 2021/22 in the event that face to face/in-person attendance at the Trust was not permitted.
- The General Manager for Facilities provided an in-depth **update on the progress with the Trust's response to the findings from the report of the Independent Review of NHS Hospital Food** which highlighted the intention to develop a digital meal ordering system by 2022 and the actions which would be implemented to support the development of catering staff at the Trust.
- The Divisional Director of Operations for Cancer Services and General Manager for Outpatients attended for an **update on the Trust's outpatient transformation plans** which included the service improvements which had been implemented and the further work that was required. It was agreed that the Patient Experience Lead should liaise with the relevant Public Representative, to investigate whether 'support arms' could be modified for utilisation as flat surfaces for patients at Tunbridge Wells Hospital.
- The Committee considered its **Forward Programme** and the following actions were agreed:
  - That the Assistant Trust Secretary should schedule a "What does it feel like to be in our care environment" item at the Committee's meeting in December 2021.
  - That the Assistant Trust Secretary should schedule a "review of the lessons learned from the management of patient property during COVID-19" item at the Committee's meeting in December 2021.
  - That the Assistant Trust Secretary should schedule a "review of carer access (including a focus on access for carers of dementia patients)" item at the Committee's meeting in December 2021.
  - That the Patient Experience Lead should submit an "update on the mechanisms by which transparency, and volunteer access, at the Trust could be increased" to the Committee's meeting in December 2021
- Under **Any Other Business** Committee members were informed that the Trust's Annual General Meeting (AGM) for 2021 would be held on the 23rd September 2021, at 2pm, virtually, via webconference, and livestreamed to the Trust's YouTube channel.

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

**The issues that need to be drawn to the attention of the Board are as follows:** N/A

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

- N/A

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

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

**Summary report from Quality Committee, 15/09/21** **Committee Chair (Non-Exec. Director)**

The Quality Committee met on 15th September (a 'main' meeting), via virtual means.

1. **The key matters considered at the meeting were as follows:**
   - The issues raised from the **reports from the clinical Divisions** highlighted the challenges associated with staffing vacancies and the recruitment and retention initiatives which would be implemented to reduce the vacancy rate, wherein it was agreed that the Chief of Service and Divisional Director of Nursing and Quality for Surgery should ensure that future Surgery Divisional Governance reports included trend data for staffing vacancies within the Division. The Committee commended the Cancer Services Division on achieving the cancer access standards for two years and the Women's, Children's & Sexual Health Division outlined the challenges associated increased operational pressures. It was also agreed to draw the Trust Board's attention to the continuing challenges with patient flow and the timely discharge of patients from the Trust's ICUs.
   - The Divisional Director of Operations for Surgery attended for the latest **update on harm reviews for patients who have waited a long time** wherein the Committee commended the assurance the harm review process had provided.
   - The Assistant Deputy Chief Nurse gave an **update on the work to achieve an 'Outstanding' CQC rating** wherein the importance of highlighting areas of 'good' and 'outstanding' practice was emphasised.
   - The Medical Director reported the latest **output from the COVID-19 Ethics Committee**, whilst the Chief of Service for Medicine and Emergency Care gave the latest **update on mortality**.
   - The Director of Infection Prevention and Control provided the latest **Update on Serious Incidents (SIs)** (incorporating the report from the Learning and Improvement (SI) Panel) (incl. an update from the Enteral feeding and Nasogastric tube (NGT) placement working group)
   - The **recent findings from relevant Internal Audit reviews** were noted**;** as were the reports from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; The Joint Safeguarding Committee; and the Infection Prevention and Control Committee), it was agreed under the latter that the Chief Nurse should check, and confirm, the intended schedule for the re-introduction of PLACE audits.

2. **In addition to the agreements referred to above, the meeting agreed that:**
   - The Divisional Director of Nursing and Quality for Surgery should Liaise with the relevant Ward Manager to investigate the development of an informational video to disseminate their learning and experience from involvement in the HM Coroner's Court.
   - The Chief Nurse should submit a proposal, which considered the impact on next of kin/patient relatives, for the closure of old patient safety incidents to the November 2021 Committee meeting.

3. **The issues from the meeting that need to be drawn to the Board's attention are:**
   - The continuing challenges with patient flow and the timely discharge of patients from the Trust's Intensive Care Units.

**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, 17/09/21** (incl. approval of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans and national data submissions; and the latest quarterly update from the Guardian of Safe Working Hours)

**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 17th September 2021 (a 'main' meeting).

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

- The Committee reviewed the **actions from previous meetings** and it was agreed that the Chief People Officer should submit the initial findings from the engagement and consultation process for the development of the 'People' and Organisational Development Strategy to the Committee's meeting in November 2021.
- The Committee reviewed the **three 'people' corporate objectives and associated metrics** (Staff Health and Wellbeing strategy, Staff Rostering' and workforce supply) wherein the Committee noted the further work required for the development of the metrics and the Interim Associate Director of Workforce Transformation provided an update on the implementation of the My-ESR Self-Service portal, wherein the importance of a targeted approach to ensure engagement with the roll out process was emphasised and it was agreed that the Interim Associate Director of Workforce Transformation should investigate the mechanisms which could be utilised to support the implementation of the My-ESR self-service portal for 'hard to reach' staffing groups (including the provision of a QR-code for mobile accessibility; and One Team Runner support). The report also provided a detailed update on the Staff Health and Wellbeing Offering with a focus on ensuring a cultural and behavioural change to health and wellbeing wherein it was agreed that the Deputy Chief People Officer for Organisational Development should consider, and confirm, the methods by which the accessibility of the Trust's Health and Wellbeing Offering could be increased for patient facing staffing groups.
- The **monthly update on the latest People Key Performance Indicators (KPIs)** was given, which highlighted then intended development of a revised scorecard and it was agreed that the Deputy Chief People Officer for People and Systems should liaise with the Business Intelligence Team to ensure the revised "monthly update on the latest People Key Performance Indicators (KPIs)" report incorporated the feedback received at the 'Main' People and Organisational Development Committee meeting on the 17th September 2021.
- The Chief People Officer presented the **focus on recruitment and retention** report which included the development of a 'workforce supply taskforce', the initial focus on the winter period to ensure the continued delivery of safe, quality patient care, and the need to streamline the recruitment process, wherein the Committee emphasised the operation critical nature of the programme of work and the impact of the Trust's vacancy rate on staff.
- The Deputy Chief People Officer for Organisational Development provided the latest **quarterly review of the findings from staff exit interviews** wherein it was noted that further work was required to ensure appropriate insight into the root causes for staff leaving the Trust.
- The Committee reviewed the **structure of the people function** and it was agreed that the Chief People Officer should consider, and confirm, to the Assistant Trust Secretary, the intended scheduling of a "further review of the structure of the 'People' function" item at the 'Main' People and Organisational Development Committee.
- The Deputy Chief People Officer for Organisational Development provided the latest **update on Equality, Diversity and Inclusion (EDI),** wherein it was agreed that the Deputy Chief People Officer for Organisational Development should confirm the proposed frequency by which mandatory Equality, Diversity and Inclusion (EDI) training should be refreshed; and the Committee recommended that the Trust Board approve the WRES and WDES action plans and national data submissions which are enclosed in Appendix 1. However, the Committee emphasised that the timelines associated with the WRES and WDES action plans should be reviewed to ensure they were deliverable.

- The Deputy Chief People Officer for Organisational Development provided the latest **update on employee engagement and associated communication plans** (Including progress with Divisional engagement plans and latest 'Climate Survey' findings), wherein it was agreed that the Deputy Chief People Officer for Organisational Development should liaise with the Associate Director of Communications to investigate the mechanisms which could be implemented to ensure continued engagement with future 'Climate' surveys. It was also agreed that the Deputy Chief People Officer for Organisational Development should consider, and confirm, the mechanisms which could be implemented to increase the feedback received from 'hard to reach' staffing groups.
- The Director of Strategy, Planning and Partnerships attended to provide the latest **quarterly review of internal communications** wherein it was agreed that the Director of Strategy, Planning and Partnerships should liaise with the Associate Director of Communications and Chief People Officer to confirm the proposed utilisation of social media platforms for the Trust's recruitment initiatives. It was also agreed that the Director of Strategy, Planning and Partnerships should check, and confirm, the mechanisms which would be implemented to increase the response rate for the national NHS staff survey for 2021.
- The **Guardian of Safe Working Hours** attended to give their latest **quarterly update** (covering April to June 2021). The report considered at the meeting has been included in full in Appendix 2.
- The **quarterly update from the Director of Medical Education (DME)** was noted.
- The **Committee evaluation** at the end of the meeting acknowledged the need to ensure a refined agenda at future Committee meetings.

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

- That the Assistant Trust Secretary should schedule an "update on recruitment and retention" item at each 'Main' Committee meeting from November 2021 onwards.
- That the Director of Strategy, Planning and Partnerships should develop a targeted approach for the provision of Internal Communications to the Trust's various service areas.

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

- The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans and national data submissions were reviewed and are enclosed in Appendix 1, for the Trust Board's approval
- The latest quarterly update from the Guardian of Safe working Hours (covering April to June 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

**'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – SEPTEMBER 2021**

NHS Maidstone and Tunbridge Wells NHS Trust

| **UPDATE ON EQUALITY, DIVERSITY AND INCLUSION (EDI)** | **DEPUTY CHIEF PEOPLE OFFICER, ORGANISATIONAL DEVELOPMENT** |
|---|---|

Please find enclosed the latest update on Equality, Diversity and Inclusion (EDI).

The Committee is requested to review and, if appropriate, recommend the enclosed Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans, and national data submissions, to the Trust Board for approval, to enable publication on the Trust's website and submission to the Kent and Medway Clinical Commissioning Group by 30th September 2021.

**Reason for circulation to Workforce Committee** (decision, discussion, information, assurance etc.)
Information and assurance

## 1.0 WORKFORCE RACE EQUALITY STANDARD (WRES)

### 2.0 2021 WRES DATA

2.1 National WRES data team spreadsheet attached to this report.

### 3.0 2021/22 WRES ACTION PLAN

Our priorities for the coming year will be:

- Education about race including developing further cohorts of reverse mentoring
- Focus on recruitment by supporting managers to identify diversity gaps in their teams, develop successful recruitment campaigns and roll out the use of EDI recruitment reps across the organisation
- Setting up talent panels including supporting staff to access CPD and discuss career pathways and development with their managers

| Action | Lead | Due Date | Activity |
|---|---|---|---|
| Ensure ESMs own the agenda, as part of culture changes in organisations, with improvements in BAME representation (and other under-represented groups) as part of objectives and appraisal by:<br>a) Setting specific KPIs and targets linked to recruitment.<br>b) KPIs and targets must be time limited, specific and linked to incentives or sanctions | Head of Staff Engagement & Equality<br>HR Business Partners | End October 2021 | • WRES data and race disparity data to be provided to each Division to develop action plans focussing on improvements in BAME representation<br>• Action plans to be reviewed and refreshed in collaboration with HR Business Partners and reported back to the Trust Board through the People and Organisational Development Committee |
| Introduce a system of 'comply or explain' to ensure fairness during interviews<br>This system includes requirements for diverse interview panels, and | Head of Resourcing | November 2021 | • Enhance current recruitment SOP to include the need for diverse interview panels, comply or explain process and spot-checking<br>• Spot-checking of 10 jobs per week to review diversity of panels and 'comply or explain'<br>• Pilot of EDI recruitment representatives on all band 7 and above roles in Women's, Children's |

| Action | Lead | Due Date | Activity |
|---|---|---|---|
| the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair. | | | and Sexual Health<br>○ Post pilot EDI recruitment reps for all areas where race disparity ratio is worst |
| Organise talent panels to:<br>a) Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments must be advertised to all staff<br>b) Agree positive action approaches to filling roles for under-represented groups<br>c) Set transparent minimum criteria for candidate selection into talent pools | Head of Learning and Development | December 2021 | **CPD (Divisional Development & Talent Panels)**<br>• Develop support for BAME staff to identify career development opportunities and how to complete a successful CPD application<br>• Use the race disparity ratio data, created a ring-fenced budget for BAME staff development<br>• Update the CPD application form to include<br>○ Personal development<br>○ Career progression with clear links to PDP as part of appraisal process<br>• Develop scoring matrix to remove bias from initial sign off of applications<br>• EDI recruitment reps to attend DDTMs to address any issues of bias<br><br>**Talent Pool**<br>• Using the Talent Pool element of Trac, develop a talent pool using appraisal/PDP/role readiness for progression conversations |
| Enhance EDI support available to:<br>a) Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies<br>b) Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews. | Head of Staff Engagement & Equality<br>People Directorate leads on JDs<br>Head of Resourcing | December 2021 | • Develop an EDI Strategy with support from the system wide EDI lead<br>• Provide guidance to recruiting managers on what EDI work/legacy looks like with examples of interview questions and standards expected in response<br>• Job descriptions to be revised to include EDI involvement as an essential criteria for Band 8a and above<br>• Recruitment and selection training to include EDI –make R&S training mandatory |
| Overhaul interview processes to incorporate:<br>a) Training on good practice with | Head of Resourcing | December 2021 | • Introduction of values based recruitment<br>• Create guidance for recruiting managers – provide examples to managers of both good and poor |

| Action | Lead | Due Date | Activity |
|---|---|---|---|
| instructions to hiring managers to ensure fair and inclusive practices are used.<br>b) Ensure adoption of values based shortlisting and interview approach<br>c) Consider skills-based assessment such as using scenarios | | | practices.<br>• Shortlisting criteria to be reviewed by the recruitment team to ensure it is measurable against the application form. Standardise interview templates for managers to ensure that values based selection is incorporated within the questions and is consistent throughout the organisation.<br>• Employ more skills based exercises during the selection process such as presentations, group exercises and stake holder events – particularly for senior roles (band 7 above). Provide guidance of skills assessments dependent on banding |
| Adopt resources, guides and tools to help leaders and individuals have productive conversations about race | Head of Staff Engagement & Equality | February 2022 | • Deliver training in "Let's talk about race", "Being anti-racist" and deliver a White Ally Programme<br>• Develop future cohorts of Reverse Mentoring for Triumvirates and other managers |

# WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

**4.0 2021 WDES DATA**

4.1 National WDES data team spreadsheet attached to this report.

| | 2021 | |
|---|---|---|
| Relative likelihood of non disabled staff being appointed from shortlisting compared to disabled staff | 1.27 | |
| Relative likelihood of disabled staff entering the formal capability process compared to white staff | 0.00 | |
| | 2020 national NHS Staff Survey | |
| | Disabled | Non Disabled |
| Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | 37.1% | 26.5% |
| Percentage of staff experiencing harassment, bullying or abuse from manager staff in the last 12 months | 20.6% | 10.7% |
| Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months | 26.3% | 18.4% |
| Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | 44.5% | 41.9% |
| Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion | 77.6% | 86.2% |
| Percentage of staff saying that the have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | 33.8% | 24.0% |
| Percentage of staff saying that they are satisfied with the extent to which their organisation values their work | 40.5% | 54.8% |
| Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work | 76.3% | N/A |
| Staff engagement score for disabled staff compared to non disabled staff and the overall engagement score for the organisation | 6.8 | 7.3 |
| Has your organisation taken action to facilitate the voices of your Disabled staff to be heard (Trust declaration) | YES | |

**5.0 2021/22 WDES ACTION PLAN**

Our priorities for the coming year will be:

- Education across the organisation about disabilities and supporting staff with disabilities
- Equity of recruitment and career progression for staff with disabilities
- Improving ESR data with disability declaration

| Action | Lead | Due Date | Activity |
|---|---|---|---|
| Education available for all about disabilities and how to support staff with disabilities in the workplace | Head of Staff Engagement & Equality | February 2022 | • Launch a cohort of reverse mentoring for senior managers and staff with disabilities as mentors<br>• Create formal agreement with Kent Supported Employment to deliver disability awareness training, job carving and organise and support working interviews<br>• Launch the health passport with associated support for staff and managers<br>• Launch the disability leave policy with associated support for staff and managers<br>• Provide equitable access to reasonable adjustments by implementing a central budget |
| Equity of recruitment and career progression | Head of Staff Engagement & Equality<br>Head of Resourcing | December 2021 | • Use of EDI recruitment representatives in areas where disability rates are lowest including higher banded roles in both clinical and non clinical roles<br>• Spot-checking of 10 jobs per week to review diversity of panels and 'comply or explain'<br>• Implement support for staff with disabilities to identify career development opportunities and how to complete successful CPD applications |
| Improving ESR data for disability declaration | EDI Team | Ongoing | We understand that staff with disabilities won't always declare their disability – they may not recognise that they have a disability; don't want to label themselves or have concerns about the impact of doing so on their employment.<br><br>• Work with the network to develop a series of communications demonstrating the benefits of declaring disability<br>• Create tool kit for ESR self service specifically for updating disability status |

# Workforce Race Equality Standards Annual Collection

## as at March 2021

For any technical clarification relating to the collection, please contact -
england.wres@nhs.net

For any queries or additional clarification relating to the SDCS and the
data.collections@nhs.net

# SubmissionTemplate
# Workforce Race Equality Standards 2020/21 template

| | |
|---|---|
| | Answer Required |
| | Auto Populated |
| | N/A |

| INDICATOR | | DATA ITEM | | MEASURE | 2020 | | | 2021 | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | WHITE | BME | ETHNICITY UNKNOWN/NULL | WHITE | BME | ETHNICITY UNKNOWN/NULL | |
| | | | **1a) Non Clinical workforce** | | **Verified figures** | **Verified figures** | **Verified figures** | **Verified figures** | **Verified figures** | **Verified figures** | |
| 1 | **Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce** | 1 | Under Band 1 | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 2 | Band 1 | Headcount | 18 | 23 | 0 | 18 | 19 | 0 | |
| | | 3 | Band 2 | Headcount | 468 | 180 | 47 | 471 | 185 | 64 | |
| | | 4 | Band 3 | Headcount | 335 | 31 | 16 | 358 | 42 | 25 | |
| | | 5 | Band 4 | Headcount | 318 | 20 | 11 | 327 | 24 | 16 | |
| | | 6 | Band 5 | Headcount | 92 | 10 | 4 | 116 | 11 | 0 | |
| | | 7 | Band 6 | Headcount | 90 | 13 | 4 | 97 | 11 | 6 | |
| | | 8 | Band 7 | Headcount | 60 | 9 | 1 | 67 | 9 | 3 | |
| | | 9 | Band 8A | Headcount | 52 | 7 | 1 | 51 | 6 | 0 | |
| | | 10 | Band 8B | Headcount | 24 | 1 | 1 | 35 | 3 | 3 | |
| | | 11 | Band 8C | Headcount | 12 | 0 | 0 | 12 | 1 | 1 | |
| | | 12 | Band 8D | Headcount | 11 | 0 | 0 | 13 | 0 | 0 | |
| | | 13 | Band 9 | Headcount | 7 | 0 | 0 | 6 | 0 | 0 | |
| | | 14 | VSM | Headcount | 6 | 1 | 1 | 5 | 1 | 1 | |
| | | | **1b) Clinical workforce** of which Non Medical | | | | | | | | |
| | | 15 | Under Band 1 | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 16 | Band 1 | Headcount | 0 | 1 | 0 | 0 | 0 | 0 | |
| | | 17 | Band 2 | Headcount | 311 | 143 | 37 | 321 | 143 | 48 | |
| | | 18 | Band 3 | Headcount | 266 | 43 | 21 | 286 | 59 | 40 | |
| | | 19 | Band 4 | Headcount | 126 | 6 | 4 | 142 | 11 | 11 | |
| | | 20 | Band 5 | Headcount | 490 | 453 | 66 | 471 | 435 | 88 | |
| | | 21 | Band 6 | Headcount | 620 | 139 | 22 | 595 | 161 | 38 | |
| | | 22 | Band 7 | Headcount | 533 | 70 | 18 | 559 | 78 | 17 | |
| | | 23 | Band 8A | Headcount | 129 | 24 | 6 | 136 | 28 | 10 | |
| | | 24 | Band 8B | Headcount | 33 | 4 | 1 | 41 | 5 | 1 | |
| | | 25 | Band 8C | Headcount | 12 | 0 | 0 | 14 | 0 | 0 | |
| | | 26 | Band 8D | Headcount | 7 | 0 | 1 | 8 | 0 | 1 | |
| | | 27 | Band 9 | Headcount | 2 | 1 | 0 | 2 | 1 | 0 | |
| | | 28 | VSM | Headcount | 2 | 0 | 0 | 1 | 1 | 0 | |
| | | | *Of which Medical & Dental* | | | | | | | | |
| | | 29 | Consultants | Headcount | 177 | 100 | 9 | 191 | 103 | 13 | |
| | | 30 | *of which Senior medical manager* | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 31 | Non-consultant career grade | Headcount | 35 | 95 | 9 | 32 | 88 | 10 | |
| | | 32 | Trainee grades | Headcount | 146 | 195 | 22 | 168 | 209 | 20 | |
| | | 33 | Other | Headcount | 9 | 0 | 1 | 9 | 0 | 1 | |
| 2 | **Relative likelihood of staff being appointed from shortlisting across all posts** | 34 | Number of shortlisted applicants | Headcount | 3801 | 1588 | 228 | 3299 | 1793 | 464 | |
| | | 35 | Number appointed from shortlisting | Headcount | 1432 | 370 | 147 | 1144 | 514 | 392 | |
| | | 36 | Relative likelihood of appointment from shortlisting | Auto calculated | 37.67% | 23.30% | 64.47% | 34.68% | 28.67% | 84.48% | |

# SubmissionTemplate
# Workforce Race Equality Standards 2020/21 template

| | |
|---|---|
| | Answer Required |
| | Auto Populated |
| | N/A |

| INDICATOR | | DATA ITEM | | MEASURE | 2020 | | | 2021 | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | WHITE | BME | ETHNICITY UNKNOWN/NULL | WHITE | BME | ETHNICITY UNKNOWN/NULL | |
| | | 37 | Relative likelihood of White staff being appointed from shortlisting compared to BME staff | Auto calculated | 1.62 | | | 1.21 | | | |
| 3 | **Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation**<br><br>**Note: This indicator will be based on data from a two year rolling average of the current year and the previous year** | 38 | Number of staff in workforce | Auto calculated | 4391 | 1569 | 303 | 4552 | 1634 | 417 | |
| | | 39 | Number of staff entering the formal disciplinary process | Headcount | 78 | 21 | 4 | 35 | 9 | 7 | |
| | | 40 | Likelihood of staff entering the formal disciplinary process | Auto calculated | 1.78% | 1.34% | 1.32% | 0.77% | 0.55% | 1.68% | |
| | | 41 | Relative likelihood of BME staff entering the formal disciplinary process compared to White staff | Auto calculated | | 0.75 | | | 0.72 | | |

# SubmissionTemplate
# Workforce Race Equality Standards 2020/21 template

| | |
|---|---|
| | Answer Required |
| | Auto Populated |
| | N/A |

| INDICATOR | | DATA ITEM | | MEASURE | 2020 | | | 2021 | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | WHITE | BME | ETHNICITY UNKNOWN/NULL | WHITE | BME | ETHNICITY UNKNOWN/NULL | |
| 4 | **Relative likelihood of staff accessing non-mandatory training and CPD** | 42 | Number of staff in workforce | Auto calculated | 4391 | 1569 | 303 | 4552 | 1634 | 417 | |
| | | 43 | Number of staff accessing non-mandatory training and CPD: | Headcount | 299 | 56 | 3 | 187 | 77 | 36 | |
| | | 44 | Likelihood of staff accessing non-mandatory training and CPD | Auto calculated | 6.81% | 3.57% | 0.99% | 4.11% | 4.71% | 8.63% | |
| | | 45 | Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff | Auto calculated | 1.91 | | | 0.87 | | | |
| 9 | **Percentage difference between the organisations' Board voting membership and its overall workforce**<br><br>**Note: Only voting members of the Board should be included when considering this indicator** | 46 | Total Board members | Headcount | 17 | 1 | 2 | 17 | 1 | 1 | |
| | | 47 | *of which: Voting Board members* | Headcount | 11 | 0 | 0 | 11 | 0 | 0 | |
| | | 48 | *: Non Voting Board members* | Auto calculated | 6 | 1 | 2 | 6 | 1 | 1 | |
| | | 49 | Total Board members | Auto calculated | 17 | 1 | 2 | 17 | 1 | 1 | |
| | | 50 | *of which: Exec Board members* | Headcount | 1 | 0 | 0 | 1 | 0 | 0 | |
| | | 51 | *: Non Executive Board members* | Auto calculated | 16 | 1 | 2 | 16 | 1 | 1 | |
| | | 52 | Number of staff in overall workforce | Auto calculated | 4391 | 1569 | 303 | 4552 | 1634 | 417 | |
| | | 53 | Total Board members - % by Ethnicity | Auto calculated | 85.0% | 5.0% | 10.0% | 89.5% | 5.3% | 5.3% | |
| | | 54 | Voting Board Member - % by Ethnicity | Auto calculated | 100.0% | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% | |
| | | 55 | Non Voting Board Member - % by Ethnicity | Auto calculated | 66.7% | 11.1% | 22.2% | 75.0% | 12.5% | 12.5% | |
| | | 56 | Executive Board Member - % by Ethnicity | Auto calculated | 100.0% | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% | |
| | | 57 | Non Executive Board Member - % by Ethnicity | Auto calculated | 84.2% | 5.3% | 10.5% | 88.9% | 5.6% | 5.6% | |
| | | 58 | Overall workforce - % by Ethnicity | Auto calculated | 70.1% | 25.1% | 4.8% | 68.9% | 24.7% | 6.3% | |
| | | 59 | Difference (Total Board -Overall workforce ) | Auto calculated | 14.9% | -20.1% | 5.2% | 20.5% | -19.5% | -1.1% | |

## SubmissionTemplate
## Workforce Race Equality Standards 2020/21 template

| INDICATOR | | DATA ITEM | | MEASURE | 2020 WHITE | 2020 BME | 2020 ETHNICITY UNKNOWN/NULL | 2021 WHITE | 2021 BME | 2021 ETHNICITY UNKNOWN/NULL | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce | | 1a) Non Clinical workforce | | Verified figures | Verified figures | Verified figures | Verified figures | Verified figures | Verified figures | |
| | | 1 | Under Band 1 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 2 | Band 1 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 3 | Band 2 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 4 | Band 3 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 5 | Band 4 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 6 | Band 5 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 7 | Band 6 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 8 | Band 7 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 9 | Band 8A | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 10 | Band 8B | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 11 | Band 8C | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 12 | Band 8D | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 13 | Band 9 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 14 | VSM | Headcount | OK | OK | OK | OK | OK | OK | |
| | | | 1b) Clinical workforce | | | | | | | | |
| | | | *of which Non Medical* | | | | | | | | |
| | | 15 | Under Band 1 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 16 | Band 1 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 17 | Band 2 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 18 | Band 3 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 19 | Band 4 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 20 | Band 5 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 21 | Band 6 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 22 | Band 7 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 23 | Band 8A | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 24 | Band 8B | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 25 | Band 8C | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 26 | Band 8D | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 27 | Band 9 | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 28 | VSM | Headcount | OK | OK | OK | OK | OK | OK | |
| | | | *Of which Medical & Dental* | | | | | | | | |
| | | 29 | Consultants | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 30 | *of which Senior medical manager* | Headcount | | | | | | | |
| | | 31 | Non-consultant career grade | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 32 | Trainee grades | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 33 | Other | Headcount | OK | OK | OK | OK | OK | OK | |
| 2 | Relative likelihood of staff being appointed from shortlisting across all posts | 34 | Number of shortlisted applicants: | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 35 | Number appointed from shortlisting: | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 36 | Relative likelihood of shortlisting/appointed: | Auto calculated | | | | | | | |
| | | 37 | **Relative likelihood of White staff being appointed from shortlisting compared to BME staff:** | Auto calculated | | | | | | | |
| 3 | Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year | 38 | Number of staff in workforce: | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 39 | Number of staff entering the formal disciplinary process: | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 40 | Likelihood of staff entering the formal disciplinary process: | Auto calculated | | | | | | | |
| | | 41 | **Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:** | Auto calculated | | | | | | | |

## SubmissionTemplate
## Workforce Race Equality Standards 2020/21 template

| INDICATOR | | DATA ITEM | | MEASURE | 2020 | | | 2021 | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | WHITE | BME | ETHNICITY UNKNOWN/NULL | WHITE | BME | ETHNICITY UNKNOWN/NULL | |
| 4 | Relative likelihood of staff accessing non-mandatory training and CPD | 42 | Number of staff in workforce: | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 43 | Number of staff accessing non-mandatory training and CPD: | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 44 | Likelihood of staff accessing non-mandatory training and CPD: | Auto calculated | | | | | | | |
| | | 45 | **Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:** | Auto calculated | | | | | | | |
| 9 | Percentage difference between the organisations' Board voting membership and its overall workforce<br>Note: Only voting members of the Board | 46 | Total Board members | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 47 | *of which: Voting Board members* | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 48 | *: Non Voting Board members* | Autocalculated | | | | | | | |
| | | 49 | Total Board members | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 50 | *of which: Exec Board members* | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 51 | *: Non Executive Board members* | Autocalculated | | | | | | | |
| | | 52 | Number of staff in overall workforce | Headcount | OK | OK | OK | OK | OK | OK | |
| | | 53 | **Total Board members - % by Ethnicity** | Auto calculated | | | | | | | |
| | | 54 | **Voting Board Member - % by Ethnicity** | Auto calculated | | | | | | | |
| | | 55 | **Non Voting Board Member - % by Ethnicity** | Auto calculated | | | | | | | |
| | | 56 | **Executive Board Member - % by Ethnicity** | Auto calculated | | | | | | | |
| | | 57 | **Non Executive Board Member - % by Ethnicity** | Auto calculated | | | | | | | |
| | | 58 | **Overall workforce - % by Ethnicity** | Auto calculated | | | | | | | |
| | | 59 | **Difference (Total Board -Overall workforce )** | Auto calculated | | | | | | | |

# Workforce Disability Equality Standard
# Annual Collection for NHS trusts and NHS Foundation trusts

**July and August 2021**

**This spreadsheet is an optional way to collate information before it is entered into the Data Collection Framework (DCF) system.**
The DCF is a new system to record all data needed for the WDES, and this is how data must be entered.
Please refer to the **Technical Guidance Document** before filling this in.

For any queries relating to the WDES data, please contact: england.wdes-datahelpdesk@nhs.net

| | |
|---|---|
| | **Data that is mandatory in the DCF - to be populated by each organisation. (Enter a value of '0' if value is unknown or blank.)** |
| | **Optional - Populated by Organisation** |
| | **Auto-Calculated** |
| | **No data required** |

# WDES Data Collection 2021 Template

**Data for 2021 needs to be entered into the Data Collection Framework (DCF) system.**
**This spreadsheet is designed to capture data so it can be used as a template to enter the information into the DCF, and to use subtotals and totals to ensure the data has been entered correctly. (This has been requested by some trusts.)**

**Data should be recorded in the yellow cells which turn white when filled.**
**Green cells are automatically calculated. Blue cells are for notes.**

**Snapshot of data as at 31st MARCH 2021**

| Metric | Indicator | | Measure | Disabled staff: # Disabled | Disabled staff: % Disabled | Non-disabled staff: # Non-disabled | Non-disabled staff: % Non-disabled | Disability Unknown or Null: # Unknown/Null | Disability Unknown or Null: % Unknown/Null | Overall: Total | Notes | Data Errors<br>This column will highlight potential problems with the data |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.** | **1a) Non Clinical Staff** | | | | | | | | | | |
| | | Under Band 1 | Headcount | 0 | | 0 | | 0 | | 0 | | |
| | | Bands 1 | Headcount | 1 | 2.7% | 25 | 67.6% | 11 | 29.7% | 37 | | |
| | | Bands 2 | Headcount | 38 | 5.3% | 469 | 65.1% | 213 | 29.6% | 720 | | |
| | | Bands 3 | Headcount | 24 | 5.6% | 291 | 68.5% | 110 | 25.9% | 425 | | |
| | | Bands 4 | Headcount | 18 | 4.9% | 268 | 73.0% | 81 | 22.1% | 367 | | |
| | | Bands 5 | Headcount | 8 | 6.3% | 101 | 79.5% | 18 | 14.2% | 127 | | |
| | | Bands 6 | Headcount | 4 | 3.5% | 89 | 78.1% | 21 | 18.4% | 114 | | |
| | | Bands 7 | Headcount | 1 | 1.3% | 59 | 74.7% | 19 | 24.1% | 79 | | |
| | | Bands 8a | Headcount | 3 | 5.3% | 50 | 87.7% | 4 | 7.0% | 57 | | |
| | | Bands 8b | Headcount | 1 | 2.4% | 29 | 70.7% | 11 | 26.8% | 41 | | |
| | | Bands 8c | Headcount | 0 | 0.0% | 11 | 78.6% | 3 | 21.4% | 14 | | |
| | | Bands 8d | Headcount | 0 | 0.0% | 10 | 76.9% | 3 | 23.1% | 13 | | |
| | | Bands 9 | Headcount | 0 | 0.0% | 5 | 83.3% | 1 | 16.7% | 6 | | |
| | | VSM | Headcount | 0 | 0.0% | 6 | 75.0% | 2 | 25.0% | 8 | | |
| | | Other (e.g. Bank or Agency) Please specify in notes. | Headcount | 0 | 0.0% | 9 | 100.0% | 0 | 0.0% | 9 | | |
| | | Cluster 1: AfC Bands <1 to 4 | Auto-Calculated | 81 | 5.2% | 1053 | 68.0% | 415 | 26.8% | 1549 | | |
| | | Cluster 2: AfC bands 5 to 7 | Auto-Calculated | 13 | 4.1% | 249 | 77.8% | 58 | 18.1% | 320 | | |
| | | Cluster 3: AfC bands 8a and 8b | Auto-Calculated | 4 | 4.1% | 79 | 80.6% | 15 | 15.3% | 98 | | |
| | | Cluster 4: AfC bands 8c to VSM | Auto-Calculated | 0 | 0.0% | 32 | 78.0% | 9 | 22.0% | 41 | | |
| | | Total Non-Clinical | Auto-Calculated | 98 | 4.9% | 1422 | 70.5% | 497 | 24.6% | 2017 | | |
| | | **1b) Clinical Staff** | | | | | | | | | | |
| | | Under Band 1 | Headcount | 0 | | 0 | | 0 | | 0 | | |
| | | Bands 1 | Headcount | 0 | | 0 | | 0 | | 0 | | |
| | | Bands 2 | Headcount | 20 | 3.91% | 359 | 70.12% | 133 | 25.98% | 512 | | |
| | | Bands 3 | Headcount | 10 | 2.60% | 235 | 61.04% | 140 | 36.36% | 385 | | |
| | | Bands 4 | Headcount | 8 | 4.88% | 118 | 71.95% | 38 | 23.17% | 164 | | |
| | | Bands 5 | Headcount | 38 | 3.82% | 657 | 66.10% | 299 | 30.08% | 994 | | |
| | | Bands 6 | Headcount | 37 | 4.66% | 582 | 73.30% | 175 | 22.04% | 794 | | |
| | | Bands 7 | Headcount | 20 | 3.06% | 462 | 70.64% | 172 | 26.30% | 654 | | |
| | | Bands 8a | Headcount | 5 | 2.87% | 129 | 74.14% | 40 | 22.99% | 174 | | |
| | | Bands 8b | Headcount | 1 | 2.13% | 31 | 65.96% | 15 | 31.91% | 47 | | |
| | | Bands 8c | Headcount | 0 | 0.00% | 10 | 71.43% | 4 | 28.57% | 14 | | |
| | | Bands 8d | Headcount | 0 | 0.00% | 7 | 77.78% | 2 | 22.22% | 9 | | |
| | | Bands 9 | Headcount | 0 | 0.00% | 3 | 100.00% | 0 | 0.00% | 3 | | |
| | | VSM | Headcount | 0 | 0.00% | 2 | 100.00% | 0 | 0.00% | 2 | | |
| | | Other (e.g. Bank or Agency) Please specify in notes. | Headcount | 0 | | 0 | | 0 | | 0 | | |
| | | Cluster 1: AfC Bands <1 to 4 | Auto-Calculated | 38 | 3.6% | 712 | 67.1% | 311 | 29.3% | 1061 | | |
| | | Cluster 2: AfC bands 5 to 7 | Auto-Calculated | 95 | 3.9% | 1701 | 69.7% | 646 | 26.5% | 2442 | | |
| | | Cluster 3: AfC bands 8a and 8b | Auto-Calculated | 6 | 2.7% | 160 | 72.4% | 55 | 24.9% | 221 | | |
| | | Cluster 4: AfC bands 8c to VSM | Auto-Calculated | 0 | 0.0% | 22 | 78.6% | 6 | 21.4% | 28 | | |
| | | Total Non-Clinical | Auto-Calculated | 139 | 3.7% | 2595 | 69.2% | 1018 | 27.1% | 3752 | | |
| | | Medical & Dental Staff, Consultants | Headcount | 5 | 1.63% | 187 | 60.91% | 115 | 37.46% | 307 | | |
| | | Medical & Dental Staff, Non-Consultants career grade | Headcount | 1 | 0.77% | 93 | 71.54% | 36 | 27.69% | 130 | | |
| | | Medical & Dental Staff, Medical and dental trainee grades | Headcount | 15 | 3.78% | 340 | 85.64% | 42 | 10.58% | 397 | | |
| | | Total Medical and Dental | Auto-Calculated | 21 | 2.52% | 620 | 74.34% | 193 | 23.14% | 834 | | |
| | | Number of staff in workforce | Auto-Calculated | 258 | 3.91% | 4637 | 70.23% | 1708 | 25.87% | 6603 | | |
| 2 | **Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.**<br><br>Note:<br>i) This refers to both external and internal posts.<br><br>ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme.<br><br>This information will be collected on the WDES Online Survey to ensure comparability between organisations. | Number of shortlisted applicants | Headcount | 276 | | 4532 | | 342 | | | | |
| | | Number appointed from shortlisting | Headcount | 69 | | 1438 | | 273 | | | | |
| | | Likelihood of shortlisting/appointed | Auto-Calculated | 0.25 | | 0.32 | | 0.80 | | | | |
| | | Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff | Auto-Calculated | 1.27 | | | | | | | A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting. | |
| 3 | **Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**<br><br>Note:<br>This Metric will be based on data from a two-year rolling average of the current year and the previous year (April 2019 to March 2020 and April 2020 to March 2021). | Average number of staff entering the formal capability process over the last 2 years. (i.e. Total divided by 2.) | Headcount | 0 | | 9 | | 8 | | | | |
| | | Likelihood of staff entering the formal capability process | Auto-Calculated | 0.00 | | 0.00 | | 0.00 | | | | |
| | | Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff | Auto-Calculated | 0.00 | | | | | | | A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process. | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Please note, metrics 4 to 9a are sourced from the NHS Staff Survey. The WDES team can access this information directly, so are not asking trusts to submit this data separately in 2021. The follow section is therefore included for any trust that wants to have all the information stored in one place.** | | | | | | | | | | |
| 4 | **a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:**<br>**i. Patients/service users, their relatives or other members of the public**<br>**ii. Managers**<br>**iii. Other colleagues**<br><br>**b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. The data for this Metric should be a snapshot as at 31 March 2020.** | % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months | Percentage | | | | | | | | |
| | | % of staff experiencing harassment, bullying or abuse from managers in the last 12 months | Percentage | | | | | | | | |
| | | % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months | Percentage | | | | | | | | |
| | | % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months | Percentage | | | | | | | | |
| 5 | **Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion.** | % of staff believing that their organisation provides equal opportunities for career progression or promotion. | Percentage | | | | | | | | |
| 6 | **Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** | % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. | Percentage | | | | | | | | |
| 7 | **Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.** | % staff saying that they are satisfied with the extent to which their organisation values their work. | Percentage | | | | | | | | |
| 8 | **Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.** | % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. | Percentage | | | | | | | | |
| 9 | **a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation** | The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. | Score | | | | | | | | |
| 9b | **b) Has your organisation taken action to facilitate the voices of your Disabled staff to be heard? (yes) or (no)**<br><br>Note: For your response to b):<br><br>If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples can be found in the WDES 2019 Annual Report. | Has your organisation taken action to facilitate the voices of your Disabled staff to be heard? (yes) or (no) | (yes) or (no) | Yes | | | | | | | |
| 10 | **Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:**<br><br>• By Voting membership of the Board<br><br>• By Executive membership of the Board<br><br>This is a snapshot as of at 31st March 2020. | Total Board members | Headcount | 0 | 0.00% | 17 | 100.00% | 0 | 0.00% | 17 | |
| | | *of which: Voting Board members* | Headcount | 0 | 0.00% | 11 | 100.00% | 0 | 0.00% | 11 | |
| | | *: Non Voting Board members* | Auto-Calculated | 0 | 0.00% | 6 | 100.00% | 0 | 0.00% | 6 | |
| | | *of which: Exec Board members* | Headcount | 0 | 0.00% | 9 | 100.00% | 0 | 0.00% | 9 | |
| | | *: Non Executive Board members* | Auto-Calculated | 0 | 0.00% | 8 | 100.00% | 0 | 0.00% | 8 | |
| | | Difference (Total Board - Overall workforce ) | Auto-Calculated | | -4% | | 30% | | -26% | | |
| | | Difference (Voting membership - Overall Workforce) | Auto-Calculated | | -4% | | 30% | | -26% | | |
| | | Difference (Executive membership - Overall Workforce) | Auto-Calculated | | -4% | | 30% | | -26% | | |

**'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – SEPTEMBER 2021**

NHS Maidstone and Tunbridge Wells NHS Trust

| **QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (APRIL TO JUNE 2021)** | **GUARDIAN OF SAFE WORKING HOURS** |
|---|---|

The enclosed report covers the period April to June 2021

- 64 Exception reports were raised in the period
- 54 General Medicine and 5 in Surgery
- 55 from FY1 doctors, 1 FY2 and 8 from ST2
- All exception reports related to excessive hours worked.
- No work schedules were review or fines generated in the quarter.
- Educational supervisors need to be responsive to replying to overdue exception reports.

**Reason for submission to the People and Organisational Development Committee**
Assurance

**Reporting Period: April – June 2021**

**Exception Reports**

**High-level data:**

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

**a) Exception reports (with regard to working hours)**

| **Exception reports by department: April – June 2021** | | | | |
|---|---|---|---|---|
| Specialty | Carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| Acute Medicine | 0 | 2 | 0 | 2 |
| General Medicine | 0 | 54 | 27 | 27 |
| Surgery | 0 | 5 | 0 | 5 |
| Anaesthetics | 0 | 1 | 1 | 0 |
| Geriatric | 0 | 1 | 0 | 1 |
| Obs & Gynae | 0 | 1 | 1 | 0 |
| **Total** | **0** | **64** | **29** | **35** |

| **Exception reports by grade: April – June 2021** | | | | |
|---|---|---|---|---|
| Grade | Carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| F1 | 0 | 55 | 28 | 27 |
| F2 | 0 | 1 | 1 | 0 |
| ST grade | 0 | 8 | 0 | 8 |
| **Total** | **0** | **64** | **29** | **35** |

**Report Commentary:**

For the period April – June 2021 the trust received 64 Exception reports.

During the period of my last report January – March the Trust received 146 Exception Reports. This was a particularly challenging period for all acute medical staff.

I am delighted to report, over the most recent reporting period exception reporting has halved. This is in keeping with previous years, in the last quarter of the trainees year block.

It should be noted that during the current period no Exception Reports were raised with regard to inadequate supervision. This a pleasing result. All exception reports were related to excessive hours worked above the trainees planned work schedules.

The reasons for the excessive hours include:

- Excessive workload
- Jobs unsuitable to handover at end of shift
- Staff sickness
- Lack of locums available to fill rota gaps etc

There has been an excessive number of exception reports that have not been responded to within an appropriate time frame by Educational Supervisors. Clinical consultants have experienced a large rise in the volume of their workload post 2nd wave of Covid19, this will have impacted on their capacity to review Exception reports. Educational Supervisors will be supported by the Guardian for Safe Working to address the outstanding reports.