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

Thu 30 June 2022, 09:45 - 13:00

Virtually, via Webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

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

06-11
To receive apologies for absence

David Highton

06-12
To declare interests relevant to agenda items

David Highton

06-13
To approve the minutes of the 'Part 1' Trust Board meetings of 26th May 2022 and 16th June 2022

David Highton

- Board minutes, 26.05.22 (Part 1).pdf (10 pages)
- Extraordinary Board minutes, 16.06.22 (Part 1).pdf (3 pages)

06-14
To note progress with previous actions

David Highton

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

06-15
Report from the Chair of the Trust Board

David Highton

- Report from the Chair of the Trust Board.pdf (1 pages)

06-16
Report from the Chief Executive

Miles Scott

Chief Executive's report June 2022.pdf (4 pages)

Reports from Trust Board sub-committees

06-17
Quality Committee, 08/06/22

Maureen Choong

Summary of Quality C'ttee, 08.06.22.pdf (1 pages)

06-18
Finance and Performance Committee, 28/06/22

Neil Griffiths

Summary of Finance and Performance C'ttee 28.06.22.pdf (1 pages)

06-19
People and Organisational Development Committee, 24/06/22

Richard Finn

Summary of People and Organisational Development Cttee, 24.06.22.pdf (1 pages)

06-20
Patient Experience Committee, 09/06/22

Maureen Choong

Summary of Patient Experience Committee 09.06.22.pdf (2 pages)

06-21
Audit and Governance Committee, 16/06/22

Neil Griffiths

Summary of Audit and Governance Cttee, 16.06.22.pdf (1 pages)

Integrated Performance Report

06-22
Integrated Performance Report (IPR) for May 2022

Miles Scott and colleagues

Integrated Performance Report (IPR) for May 2022.pdf (41 pages)

Quality Items

06-23
Quarterly mortality data

Peter Maskell

Quarterly mortality data.pdf (19 pages)

06-24
To approve the Trust's long term plan for Maternity Continuity of Carer

Sarah Blanchard-Stow

N.B. This item is scheduled for 11:30am

To approve the Trust's long term plan for Maternity Continuity of Carer.pdf (12 pages)

06-25
Infection prevention and control board assurance framework

Sara Mumford

Infection prevention and control board assurance framework.pdf (32 pages)

Planning and strategy

06-26
To approve the corporate objectives for 2022/23

Rachel Jones and Steve Orpin

To approve the corporate objectives for 202223.pdf (17 pages)

06-27
Annual approval of the Trust's Green Plan

Mark Hope and Stu Meades

N.B. This item is scheduled for 12:10pm

Green Plan.pdf (18 pages)

06-28
To receive an update on the updated Outline Business Case (OBC) for Increasing Elective Orthopaedic Capacity

Sean Briggs

N.B. This will be a verbal report.

Assurance and policy

06-29
To approve the Trust’s proposed submission for the Data Security and Protection Toolkit (DSPT) for 2021/22

Joanna Haworth

To approve the Trust’s proposed submission for the Data Security and Protection Toolkit (DSPT) for 202122.pdf (3 pages)

06-30
To consider any other business

David Highton

06-31
To respond to any questions from members of the public

David Highton

Questions should relate to one of the agenda items above, and be submitted in advance of the Trust Board meeting, to Kevin Rowan, Trust Secretary, via kevinrowan@nhs.net.

Members of the public should also take note that questions regarding an individuals patient's care and treatment are not appropriate for discussion at the Trust Board meeting, and should instead be directed to the Trust's Patient Advice and Liaison Service (PALS) (mtw-tr.palsoffice@nhs.net).

06-32
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 26th MAY 2022, 9:45 AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director (from item 05-7)	(DM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director (from item 05-11 – refer to minute for specific details)	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Bob Cook	Deputy Director of Strategy, Planning and Partnerships (for items 05-13 and 05-14)	(BC)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

05-1 To receive apologies for absence

Apologies were received from Neil Griffiths (NG), Non-Executive Director. It was also noted that Karen Cox (KC), Associate Non-Executive Director would not be in attendance. DH added that EPM would be joining later in the meeting.

05-2 To declare interests relevant to agenda items

No interests were declared.

05-3 To approve the minutes of the meeting of 28th April 2022

The minutes of the meeting of 28th April 2022 were approved as a true and accurate record of the meeting.

05-4 To note progress with previous actions

The content of the submitted report was noted.

05-5 Report from the Chair of the Trust Board

DH reported that there had been no consultant appointments made within the reporting period; the reduction in the prevalence of COVID-19 within the community and by extension the Trust; the reduction in COVID-19 related sickness absence rates; and the continued significant operational pressures associated with Emergency Department attendances. DM then commended the continued focus by Trust staff on the delivery of outstanding patient care.

05-6 Report from the Chief Executive

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

- Although urgent and emergency care demand at the Trust had continued to achieve record levels, overall operational pressures had reduced due to a reduction in COVID-19 related attendances;

an improvement in the Trust's staffing position; and a reduction in the number of patients that no longer met the criteria to reside for inpatient care, which was associated with an enhanced focus on patient flow.
- The Trust's elective activity was behind the Trust's original operational trajectory; however, a recovery plan had been developed for the first quarter of 2022/23.
- The Infection Prevention and Control Team had conducted reviews of the Trust's various wards and departments to consider the approach by which the Trust should operate in the 'new normal' and that significant progress had been made in relation to visiting arrangements
- The continued focus on the implementation of the Trust's Corporate and Clinical Strategy and service developments, which included details of the adjustments required to the provision of the stroke services to reflect the level of attendances at the Trust.
- Local members of parliament had attended Tunbridge Wells Hospital on the 13th May 2022 for the formal opening of the Surgical Assessment Unit (SAU) and that their visit had included a tour of the new Paediatric Emergency Department and presentations in relation to key developments at the Trust.
- Local members of parliament had expressed their support for the continued focus on the delivery of high-quality patient care despite the additional challenges experience by the NHS

Reports from Trust Board sub-committees

05-7 Quality Committee, 11/05/22 (incl. approval of the revised Terms of Reference (annual review))

MC referred to the submitted report and highlighted the following points:
- Assurance was provided in regards to the challenges with the Trust's Domestic Hot Water Supply at Tunbridge Wells Hospital and it was agreed the Committee would continue to monitor such issues.
- A discussion had been held regarding the consistency of training and the associated monitoring process for the safe use of medical oxygen training.
- A revised reporting template which had been developed for the Trust's Clinical Divisions had been commended.
- A 'deep dive' was required into the management of Health and Safety at the Trust.

MC then highlighted that the Committee's revised terms of reference had been submitted to the Trust Board, for approval. The revised Terms of Reference were approved as submitted.

05-8 Finance and Performance Committee, 24/05/22 (incl. approval of revised Terms of Reference)

DM informed the Trust Board that a Fundraising Manager had been appointed and that their tenure was due to commence imminently. DM added that the support which could be provided for falls prevention by the Trust's Charitable Fund was under investigation. DM then referred to the submitted report and highlighted the following points:
- The Terms of Reference had been submitted to reflect the change to the 'parent' Committee for the Green Committee; although noted that the Finance and Performance Committee would continue to review Trust's Green Plan and subsequently the performance against the Trust's Green Plan
- A discussion had been held regarding the potential expenditure by the Trust to reduce the number of Medically Optimised for Discharge (MOFD) patients within the Trust's bed base.

The revised Terms of Reference were approved as submitted.

05-9 People and Organisational Development Committee, 19/05/22 (incl. quarterly report from the Guardian of Safe Working Hours)

RF referred to the submitted report and highlighted the following points:
- The People Vision had been revised to focus on high-quality leadership development across the Trust which would be key to delivery of the People and Culture Strategy
- Robust assurance had been received regarding the continued focus on recruitment and retention at the Trust.

- Disclosure and Barring Service (DBS) checks had been discussed and further consideration was required as to whether the Trust funded the implementation of the DBS update subscription service for specific staff groups.
- The findings from the Advanced Clinical Practitioner (ACP) workforce project were reviewed and the importance of continued career development was emphasised.
- The latest quarterly update from the Guardian of Safe Working Hours was reviewed and has been submitted to the Trust Board, for assurance.

05-10 Audit and Governance Committee, 16/05/22

DM referred to the submitted report and highlighted the following points:
- The Trust's External Auditors had confirmed they were on target to submitted their findings within the intended deadline.
- The Annual governance statement for 2021/22 had been reviewed, and supported as submitted.
- The performance of the Committee, the Internal Audit Service, the External Audit Service and the Counter Fraud Service were reviewed and no significant issues were identified.
- The Committee had expressed concerns over the findings of the "consent" Internal Audit review and as such the Medical Director had been invited to the Committee's next meeting to provide further assurance.

Integrated Performance Report

05-11 Integrated Performance Report (IPR) for April 2022

MS referred to the Executive Summary and highlighted the key themes for escalation. SS referred to the "People" Strategic Theme and explained the latest position in relation to the "Climate Survey Responses" metric and highlighted the key points therein which included the proposed amendments to the "Vision Goals" and "Breakthrough Objective"; the improvement in the response rate for the latest climate survey, although such a response rate remained below the Trust's target; the root causes for the below target climate survey response rate; details of the action plan which had been developed in response to the findings of the latest climate survey; and the importance of an enhanced focus on leadership development.

SS continued and explained the latest position in relation to the "Vacancy Rate" and "Turnover Rate" metrics and reported that the Trust's vacancy rate had improved over the previous twelve months due to the continued focus of Divisional Leads and the Recruitment Team which had developed innovative approaches to recruitment; there had been an increase in staff leaving the NHS nationally following the COVID-19 pandemic; the Trust's had a turnover rate of 13.9% which was below the 15.7% average for the Kent and Medway Integrated Care System (ICS); and that there was a dedicated focus on career development to reduce the Trust's turnover rate.

[N.B. EPM joined the meeting at this point]

SS then continued and explained the latest position in relation to the "Sickness Rate" metrics and reported that the Trust's sickness rate metrics had been recalibrated to a 5% target to reflect the average sickness absence rate across the Kent and Medway ICS although acknowledged the sickness absence rate for the South East of England was 5.8% and outlined the leading causes.

WW asked if any key themes had emerged in relation to the Trust's turnover rate. SS replied that the 'Moving on' survey had illustrated that staff were leaving the Trust due to insufficient career development opportunities; a feeling of a lack of involvement in the decision-making process for services; and for retirement purposes. SS then noted the focus on the development of the retire and return programme and the accessibility of career development opportunities at the Trust.

WW asked whether exit interviews were held with staff leaving the Trust. SS replied that Trust staff were offered the opportunity to attend an exit interview however such interviews were not mandatory. WW queried whether exit interviews would be implemented as part of the Trust's retention programme. SS replied that the retention programme would all methods of data capture; however, the climate survey and NHS staff survey provided key insights into the 'lived experience' of Trust staff.

WW queried whether the Trust Board should be informed of the Trust's performance against the Workforce Race Equality Standard (WRES). SS outlined the reporting arrangements for the WRES to the People and Organisational Development Committee and highlighted the intention for 19% of senior positions at the Trust to be held by staff from Black, Asian and Minority Ethnic (BAME) backgrounds by 2024/25. WW emphasised the importance of ensuring the Trust board had robust assurance on the Trust's performance against the WRES. SS agreed to consider the method by which the Trust Board should be kept apprised of the Trust's performance against the Workforce Race Equality Standard (WRES)

Action: Consider the method by which the Trust Board should be kept apprised of the Trust's performance against the Workforce Race Equality Standard (WRES) (i.e. as a direct report to the Trust Board; as a metric within the Integrated Performance Report; or as an appendix to the summary report from the People and Organisational Development Committee) (Chief People Officer, May 2022 onwards)

PM referred to the "Patient Safety & Clinical Effectiveness" Strategic Theme and explained the latest position in relation to the "Falls Rate" and "Harm" metrics and highlighted the key points therein, which included the findings of the analysis of the correlation between staffing levels and the rate of falls at the Trust; the impact of patients that no longer met the criteria to reside for inpatient care on the number of incidents resulting in harm; the review which had been commissioned into those wards which benchmarked above average compared to the Trust's falls rate performance; details of the key initiatives which had been implemented to reduce the rate of falls at the Trust which included the 'Think Yellow' campaign; that a Business Case for Falls Alarm Monitor Device had been developed and funding sought from the Trust's charitable fund; and that discussions had been held with JH to develop an improvement trajectory for the rate of falls at the Trust.

SB referred to the "Patient Access" Strategic Theme and explained the latest position in relation to the "RTT Performance", "Diagnostics <6 weeks", "A&E Performance", "Outpatient Calls answered <1 minute", "Outpatient Clinic Utilisation", "Ambulance Handovers >30 minutes", "Super-Stranded Patients", "% Emergency Admissions to Assessment Areas", and "Ensuring Activity Levels Match those Pre-Covid – Inpatients & Outpatients, MRI & NOUS" metrics and highlighted the key points therein, which included that April 2022 had been the most operationally challenge in the history of the Trust; the Trust had maintained the 52-weeks wait position for elective surgery and that priority one and two patients continued to be addressed within one month; approval of the Business Case for a managed Magnetic Resonance Imaging (MRI) service remained outstanding with NHSE/I; the enhanced focus which had been afforded to patient flow and the associated patient flow events which had been implemented; the continued focus on recruitment and retention by the People and Culture Team; the additional support which had been provided by Trust Board members; the three key areas of focus to improve the Trust position (i.e. admission avoidance; expedited discharge where feasible; and an enhanced focus on those patients no longer met the criteria to reside for inpatient care); and the impacts of increased operational pressures on the Trust's elective and outpatient activity for April 2022. SB expressed concerns in relation to the available capacity to address the increase in referrals for colorectal, urological and breast cancers.

MC commended the candour which had been provided in relation to the Trust's operational pressures and acknowledged that demand for services was expected to continue to increase. MC asked whether any further actions could be implemented in conjunction with the Kent and Medway ICS and primary care providers to provide assurance to patients that they remained on the correct treatment pathway. SB outlined the significant challenges currently experienced by primary care providers and noted that the key challenge in relation to patients referred to cancer services was that such patients were not always informed that they had been referred for suspected cancer which had resulted in an increase in the unavailability of such patients to attend their initial appointment. SB continued that robust mitigations had been implemented to prevent increased waiting times for cancer referrals and provided assurance that there were currently no concerns in relation to such waiting times; although acknowledged that further work was required to address the increase in cancer referrals received by the Trust. SB then outlined the programme of work which had been implemented with the Primary care networks (PCNs) to address the number of inappropriate cancer referrals and noted the significant resourcing requirements to triage such referrals. SB concluded by

providing assurance that there was a robust tracking and communication programme for cancer referrals. SB added that further concerns may be raised in due course in relation to patients not being aware of the severity of the conditions for which they had been referred.

JW queried whether there had been an increase in the number of Did Not Attends (DNAs) due to conflicting priorities following the COVID-19 pandemic and asked if the Trust had developed any innovative approaches to patient follow-up appointments. SB replied that there had not been a significant increase in DNAs within cancer services; however, there had been an increased DNA rate within outpatient services due to the enhanced focus on the operational pressures associated with urgent and emergency care. SB acknowledged that further work was required to address the Trust's DNA rate and noted that there had been an increase in the DNA rate during the COVID-19 pandemic. JW opined that the 'cost of living crisis' would impact the availability of patients to attend follow-up appointments and noted that further flexibility was required in relation to the accessibility of outpatient appointments. SB replied that the implementation patient-initiated follow-ups (PIFU) enabled patients to determine if, and when, a follow up appointment was required which provided increased flexibility in conjunction with the utilisation of virtual clinics; although noted that further work was required in relation to the development of virtual clinics.

WW asked whether the increased operational pressures reflected a 'new normal' in terms of demand and if so, at what point demand would become unsustainable both for the Trust and across the wider Kent and Medway ICS. WW then asked for details of the root causes for the increase in urgent and emergency care presentations. SB replied that a survey was conducted for patients attending the Trust's EDs on a bi-monthly basis and had highlighted an increase in attendances related to minor ailments and injuries due to the availability of primary care appointments; however, acknowledged the significant operational pressures currently also being experienced by primary care providers and the additional support which was required. SB then highlighted the challenges associated with forecasting whether the increase in urgency and emergency care demand reflected a 'new normal' although noted that the Trust had experienced at 22% increase in activity compared to 2019. SB speculated that the Trust would experience another wave of COVID-19 but noted that mitigations of the associated impacts had been developed. SB continued that there would be significant challenges associated with winter pressures however operational planning had included additional capacity and virtual wards would alleviate some operational pressures. SB opined that the NHS would respond to any and all increases in demand, however noted that an increase in patients that no longer met the criteria to reside for inpatient care had adverse impacts on the Trust's patient flow and therefore ability to respond to such increases in demand.

WW asked whether the current NHS operating system was appropriately designed to address peaks in activity combined with a continued increase in demand. MS acknowledged that consideration was required in relation to root causes for increased urgent and emergency care demand; although noted that the Trust had previously agreed that patients would not be redirected to alternative locations and that the key areas of focus was on how best the Trust could respond to such additional demand which included the employment of General Practitioners within the Trust EDs. MS continued that initial data indicated that there would be a continued increase in demand; but noted that the Trust continued to implement service developments and additional capacity to address increases in demand. MS continued that, in response to the previous question of if operational pressures would become unsustainable, a multivariant analysis was required to consider each factor that would impact the Trust's ability to deliver patient care and noted that a robust decision-making process was utilised by PM, JH, SM and SB to consider the appropriate response to any increases in operational pressures. MS acknowledged the importance of demonstrating to the Trust Board that the risks associated with increased operational pressures were sufficiently managed.

DM queried what, if any, mechanisms were available for patients to raise concerns in relation to not being informed of the severity of the suspected conditions they had been referred for. PM replied that the Kent and Medway Health and Care Partnership (HCP) facilitated meetings between primary and secondary care organisations to discuss areas of improvement; however, noted the challenges associated with raising such issues with primary care providers due to the independent contracting approach which was adopted and the difficulties in ensuring the information was disseminated to all

primary care providers. PM continued that such issues were also discussed at the quarterly Kent Local Medical Committee (LMC) meeting.

DH noted the introduction and associated monitoring arrangements of the "percentage of patients spending more than 12 hours in A&E" standard by NHS England / Improvement (NHSE/I) and requested that SB ensure that future Integrated Performance Reports include details of the Trust's performance against the "percentage of patients spending more than 12 hours in A&E" standard which had been implemented by NHSE/I.

Action: Ensure that future Integrated Performance Reports include details of the Trust's performance against the "percentage of patients spending more than 12 hours in A&E" standard which had been implemented by NHS England / Improvement (Chief Operating Officer, May 2022 onwards)

SB referred to the "Systems" strategic theme, and the "Reduction in non-elective bed days" metric, and highlighted the key points therein, which include the challenges associated with the accessibility of community care capacity and the further work which was required to ensure the Trust had sufficient resilience during the winter period; and the enhance focus on the discharge of pathway 0 patients.

JH referred to the "Patient Experience" Strategic Theme and explained the latest position in relation to the "Friends & Family Response Rates" metrics and highlighted the key points therein, which included the continued challenge in relation to the Friends and Family Test (FFT) response rates for inpatients and the Emergency Department (ED); that the Information Governance Committee had approved the implementation of a text messaging system for the FFT within the Trust's ED; the continued challenges associated with the accessibility of the FFT although the impact of an improved staffing position was acknowledged; and the intention for the "breakthrough objective" to be revised.

JH then continued and explained the latest position in relation to the "Complaints" metric and highlighted the key points therein which included that a 'deep dive' had been commissioned into the Trust's complaints performance; details of the robust action plan which had been developed to recover the Trust's complaints performance; the new process which had been implemented within the Medicines and Emergency Care Division to support the closure of outstanding complaints; and that the Trust's unvalidated position for May 2022 indicated an improvement in the Trust's complaints performance.

RF queried whether communication remained the key theme emerging from the complaints received and what the Trust's action plan was to address such issues. JH confirmed that communication remained a key theme, and outlined the intended focus on the improvement of all aspects communication across the Trust which would be supported by the revised breakthrough objective for the "Patient Experience" Strategic Theme which was under development.

EPM asked where the accountability resided for ensuring a long-term sustainable change to communication. JH confirmed that they were the accountable officer. EPM then requested further details of the mechanisms which would ensure the success of the revised approach to communications. JH replied that an in-depth review into the challenges associated with communication had been conducted to ensure the contributing factors were addressed and noted that Director of Quality Governance would support for the programme of work. EPM asked what, if anything, would prevent progression of the programme of work. JH replied that the key challenges were associated with staffing levels and that the programme of work was currently supported by a number of temporary staff, the continued requirement of which would be re-evaluated at the end of June 2022.

SO informed Trust Board members that a review of the "Assurance RADAR Charts" had been commissioned to consider whether an alternative approach should be adopted; and that further details would be reported to the June 2022 'Part 1' Trust Board meeting

SO then explained the latest position in relation to the "sustainability" metric and highlighted the key points therein, which included the impact of the underperformance against the elective activity plan for April 2022 on the financial position for 2021/22; the further guidance which had been issued by

NHSE/I; the significant challenge associated with the delivery of the Cost Improvement Programme (CIP) for 2021/22; the confidence interval for the delivery of those identified CIPs had increased; the increased expenditure on temporary staffing in response to operational pressures and the anticipated impact of the Trust's recruitment and retention initiatives on the requirement for temporary staff; that the Trust's agency expenditure had increased to c.£60m since 2019/20 due to COVID-19, the increased requirement for escalation capacity and the additional patient pathways which had been implemented; the root causes as outlined within the "stratified data"; and the expected transition to a special cause of a reduction nature. SO then outlined the announcement from NHSE/I regarding the provision of additional inflationary funding and the associated reintroduction of NHS agency staffing spend controls and controls in relation consultancy expenditure and non-clinical agency usage and noted that assurance in relation to such controls would be provided to the NHSE/I and monitored by the Finance and Performance Committee.

EPM acknowledged the impact of external factors on the Trust's premium workforce expenditure; but, asked whether there were any further actions which could be implemented by the Trust to reduce premium workforce expenditure. SO replied a programme of work had been completed to identify where premium workforce expenditure was localised to due to staff shortages or operational pressures; however, noted that some issues were related to ensuring the appropriate disciplines were reinstated which required further work. EPM noted that any relevant disciplines should be reported to the People and Organisational Development Committee, as required. SO confirmed that would be the case.

JW asked where the main areas of consultancy expenditure were expected to occur. SO replied that consultancy expenditure related specifically to management consultancy which was primarily utilised to provide external support for the developed of strategic initiatives at the Trust; and outlined the specific scenarios which were exempt from such controls. JW asked whether the Trust was required to reduce consultant expenditure, or where possible, completely eliminate such expenditure. SO replied that any consultancy expenditure over £50k required agreement by NHSE/I. JW asked if there were any incidents where the Trust had exceeded the consultancy spending approval criteria. SO confirmed that there was currently no such expenditure at the Trust; although acknowledged that such expenditure had been utilised previously. SO queried whether the quarterly "Analysis of Consultancy use" report to the Finance and Performance Committee. JW supported the proposed approach however, noted that such a decision should reside with the Chair of the Finance and Performance Committee.

Action: Liaise with the Chair of the Finance and Performance Committee to consider whether the quarterly "Analysis of Consultancy use" report should be reinstated (Deputy Chief Executive / Chief Finance Officer, May 2022 onwards)

WW acknowledged the operational pressures which had been experience in April 2022 and the associated impact on elective activity at the Trust and asked what actions would be introduced to mitigate the impact of winter pressures on the Trust's financial plan. SO replied that a reduction in operational activity within the winter period had been assumed as part of the development of the financial plan for 2022/23; however noted that if the impact on elective activity was reflective of April 2022 the total loss of income during the winter period would be c.£2.7m. SO continued that the key mitigations to reduce the impact of winter pressures included implementation of proposed service developments and ensuring a robust process for the management of patient flow, which was under consideration by the Finance and Performance Committee. DH opined that the mechanism by which the Elective Recovery Fund (ERF) was accessed may be amended if NHS Trusts were unable to achieve forecast elective activity levels due to operational pressures. WW emphasised the importance of ensuring that the services provided by the Trust were sufficient for the Trust's service users.

Planning and strategy

05-12 <u>Update on the Nursing and Midwifery staffing review</u>

JH referred to the submitted report and highlighted the key points therein which included an in-depth update on the progress against the actions reported to the November 2021 'part 1' Trust Board meeting; the support afforded by the approval of the Business Case for International Recruitment;

the findings of the review of night staffing levels and the associated response; details of the Trust's current staffing position; the challenges associated with the Trust's turnover rate and the focus on career development to reduce such turnover rates; the daily escalation process which had been developed to inform key stakeholders of actual staffing levels; and the proposed establishment review cycle. JH then provided further context to appendix 1 ("Safe Staffing Escalation Action Card – All Adult areas") and appendix 2 ("Nursing e-Roster Confirm and Support Meetings, KPI's and Performance Compliance Framework").

DH noted the impact of the redeployment of nursing staff at short notice and queried whether the reinstatement of the NHS agency staffing spend controls would impact the utilisation of Rapid Response Nurses. DH then asked whether the prevalence of the redeployment of nursing staff had impacted the Trust's turnover rate. JH replied that the Rapid Response Nurses were employed by the Trust and therefore would not be impacted by the NHS agency staffing spend controls; although, noted that pay enhancements would continue to be used for the Rapid Response Nursing Team. JH opined that the redeployment of Trust staff had impacted the Trust's turnover rate or at a minimum staff morale and that an action plan to address such issues was under development by the Retention Team to ensure an equitable approach to the redeployment of Trust staff.

WW commended the focus on recruitment and retention. WW then asked what measures had been introduced to integrate and support the retention of new starters at the Trust. JH outlined the programme of work which had been developed to support international recruits prior to arrival at the Trust, which included weekly meetings with key stakeholders; increased availability of clinical skills facilitator; and the implementation of staff forums. JH then detailed the feedback which had been received from Clinical Support Workers regarding the additional support which could be provided by the Trust. JH continued that a schedule of meetings had been developed to enable a further understanding of the challenges experienced by various staff groups within the Nursing and Midwifery profession.

05-13 <u>Update on 2022/23 planning</u>

SO outlined the discussions which had been held at the April 2022 'Part 1' Trust Board; the amendments which had been made to the financial plan for 2022/23; the potential impact of the additional inflationary funding; and the further operational planning submission which was required on the 20th June 2022. DH stated that discussions would be noted discussions would be held with the Trust Secretary, external to the meeting, to consider the scheduling of an "Approval of the Trust's operational planning for 2022/23" item, prior to submission to NHSE/I on the 20th June 2022

Action: Liaise with the Trust Secretary to consider the scheduling of an "Approval of the Trust's operational planning for 2022/23" item, prior to submission to NHS England / Improvement on the 20th June 2022 (Chair of the Trust Board, May 2022 onwards)

BC then referred to the submitted report and highlighted the key points therein which included that no further amendments had been made to the activity and workforce submissions which were approved by the Trust Board in April 2022; the challenges associated delivery of the activity plan; the further guidance which was awaited in relation to resubmission of operational planning for 2022/23 to the regional NHSE/I Team; and an update on the progress with the requested adjustment of the Trust's baseline endoscopy activity levels.

DH noted the discussions which had been held with regional representatives from NHSE/I regarding the adjustment of the Trust's baseline endoscopy activity levels and that National Institute for Health and Care Excellence (NICE) guidance was awaited. DH then stated that MS and himself would escalate the issue the South East Regional Director for NHSE/I if required. DH supported the potential provision of additional inflationary funding.

05-14 <u>Update on the development of the corporate objectives for 2022/23</u>

BC referred to the submitted report and highlighted the key points therein which included that the Senior Responsible Officers for each of the six strategic themes would review the strategic goals and associated breakthrough objectives to ensure that return on investment was optimised; that weekly discussions to support the development of the corporate objectives for 2022/23 would be

held at the Executive Team Meeting (ETM); and that the corporate objectives for 2022/23 were intended to be submitted to the July 2022 'part 1' Trust Board meeting for approval.

SO added that the Corporate Projects would also be reviewed, and that any amendments would be informed by the lessons learned, and key areas of focus which had been identified by the monthly ETM Strategy Deployment Review and Divisional Strategy Deployment Review processes. SO then outlined the intended content of the "update on the development of the corporate objectives for 2022/23" report to the June 2022 Trust Board meeting.

DH noted that the 'catch ball' process was not expected to conclude until August 2022, and queried whether the associated timelines for the implementation of the corporate objectives for 2022/23 posed a risk to the delivery of the Trust's operational plan for 2022/23. SO replied that the Trust's existing objectives would be compatible with the delivery of the Trust operational plan; although acknowledged that specific areas would be amended to reflect the Trust current position. SO continued that the Patient Experience and People strategic themes would undergo a more significant adjustment, however such strategic themes supported the delivery of the Trust's operational plan and were expected to provide a longer term impact. SO provided assurance that such amendments would not place delivery of the operational plan at risk.

JW requested that the Trust's corporate objectives for 2022/23 be amended to appropriately reflect that a proportion of the Trust's patients resided in East Sussex. SO agreed.

Action: Ensure that the Trust's corporate objectives for 2022/23 appropriately reflected that a proportion of the Trust's patients resided in East Sussex (Deputy Chief Executive / Chief Finance officer, May 2022 onwards)

05-15 <u>To approve the draft People and Culture Strategy, 2022 - 2025</u>

SS firstly informed the Trust Board of the members of the People and Culture function that had been recognised as part of International Human Resources Day 2022. SS then referred to the submitted report and highlighted the key points therein, which included details of the engagement programme which had been implemented to support the development of the People and Culture Strategy; the six strategic priorities which had been identified; the key areas which would support the delivery of the People and Culture Strategy; the governance arrangements which included the monitoring process for the 'people dashboard' by the ETM and People and Organisational Development Committee; and the next steps for the People and Culture Strategy which included the development of a communications plan and the inclusion of an executive summary.

DM queried whether the Trust had sufficient data to support the development of individual members of staff, to ensure that such staff achieved their potential. SS confirmed that such data was available within the Electronic Staff Record (ESR) and that additional data would be available within the Trac recruitment system; although outlined the challenges associated with the lack of system integration. SS then outlined the importance of a holistic approach to the collection and utilisation of data and subsequent development of the 'people dashboard'. DM acknowledged the point.

EPM commended the development of the People and Culture Strategy. EPM asked whether there were sufficient resources available to deliver the People and Culture Strategy and for further clarification as to how the People and Culture Strategy would be communicated to Trust staff in an accessible manner. SS replied that the approval of the approve the Business Case for the People and Culture Structure and Operating Model provided sufficient resources to support the delivery of the People and Culture Strategy; although acknowledged that phase three would not be implemented until December 2022. SS noted the potential impact of external factors on the delivery of the People and Culture Strategy. SS then provided details of the associated communication plan, and the importance of ensuring Trust staff were aware of the key contacts within the People and Culture Function.

WW asked what, if any, support was required from Trust Board members in relation to the delivery of the strategic priorities. SS replied that the initial support had been the approval of the associated business case and that from a Trust Board perspective the key areas of focus were ensuring adequate support for the Trust's Divisions to deliver the People and Culture Strategy; ensuring that

the ‘people agenda’ was a key area of consideration as part of relevant discussions; and awareness of potential resource limitations. SS continued that support should be afforded to the continued development of staff through training and robust appraisals. MS emphasised the importance of Trust Board members understanding the alignment between the People and Culture Strategy and the various programmes of work at the Trust.

The Trust board approved the People and Culture Strategy for 2022 to 2025 as submitted.

Assurance and policy

05-16 NHS provider license Self-certification for 2021/22

MS referred to the submitted report and highlighted the key points therein. The Trust Board approved the NHS provider license Self-certification for 2021/22 as submitted.

05-17 To consider any other business

There was no other business.

05-18 To respond to questions from members of the public

DH confirmed that no questions had been received.

05-19 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.

MINUTES OF THE EXTRAORDINARY TRUST BOARD MEETING ('PART 1')
HELD ON THURSDAY 16TH JUNE 2022, 10:30 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	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)
	Jo Webber	Associate Non-Executive Director	(JW)
In attendance:	Helen Callaghan	Director of Quality Governance	(HC)
	Karen Cox	Associate Non-Executive Director	(KC)
	Ainne Dolan	Deputy Chief People Officer, Organisational Development	(AD)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	The meeting was livestreamed on the Trust's YouTube channel.		

06-1 To receive apologies for absence

Apologies were received from Jo Haworth (JH), Chief Nurse, but it was noted that HC was attending in JH's place. It was also noted that Sue Steen (SS), Chief People Officer, would not be in attendance, but AD was attending in SS' place.

06-2 To declare interests relevant to agenda items

DM declared that his son worked for Grant Thornton LLP, who were the Trust's external auditors, but they did not work in Grant Thornton's public sector function.

Reports from Trust Board sub-committees

06-3 Audit and Governance Committee, 16/06/22 (incl. the Committee's 2021/22 Annual Report)

DM referred to the submitted report and also reported the following points:

- The Audit and Governance Committee had met earlier that day, to consider the Annual Report and Annual Accounts for 2021/22.
- The Annual Report and Accounts had therefore been reviewed twice by the Audit and Governance Committee, and the Committee was content to recommend that the Trust Board approve both documents, subject to the incorporation of some changes described in one of the submitted reports, as well as the Management Representation Letter.
- The Value for Money aspect of the external audit had led to some recommendations, all of which had been accepted by the Trust's management, and many of which reflected the Trust's intended course of action on the associated issue. Such recommendations included the Trust Board's oversight of the delivery of the Cost Improvement Programme (CIP) and expenditure on agency staff usage.
- The external auditors would issue the Trust with an unqualified audit opinion.

Annual Report and Accounts

06-4 To approve the Trust's Annual Report, 2021/22 (incl. Annual Governance Statement)

KR referred to the submitted report and highlighted that although the Audit and Governance Committee had recommended that the Trust Board approve the Annual Report, it had also agreed to some minor changes to the text of the Report, which would be made before the final version was published. The point was acknowledged.

Questions or comments were then invited. None were received. The Annual Report for 2021/22 was then approved, subject to the incorporation of the minor changes referred to by KR, and the changes described in the "Changes to the Annual Accounts (and Annual Report) for 2021/22" report that had been submitted under item 06-5.

06-5 To approve the Trust's Annual Accounts 2021/22

SO referred to the submitted reports, which included the "Changes to the Annual Accounts (and Annual Report) for 2021/22" report that had been issued on the evening of 15/06/22, and highlighted that the one major change to the Accounts related to the Trust's receipt of some income towards the end of 2021/22, as although the Trust's intended accounting approach had been to bring the expenditure forward from 2022/23, instead of deferring that income to 2022/23, it had been agreed, following discussions with the external auditors, to defer the income to 2022/23. SO added that there was however no net change to the Statement of Comprehensive Income, nor to the overall Statement of Financial Position (i.e. the Balance Sheet).

Questions or comments were then invited. None were received. The Annual Accounts for 2021/22 were then approved, subject to the incorporation of the changes described in the "Changes to the Annual Accounts (and Annual Report) for 2021/22" report that had been submitted under item 06-5.

06-6 To approve the Management Representation Letter, 2021/22

DH referred to the submitted report and invited questions or comments. None were received. The Management Representation Letter for 2021/22 was then approved as submitted.

KR then thanked DJ for his work on the Annual Report for 2021/22, on which DJ had led with minimal input from KR. DH echoed KR's thanks to DJ and asked that this be recorded in the minutes of the meeting.

Quality items

06-7 To approve the Trust's Quality Accounts, 2021/22

HC referred to the submitted report and highlighted the key points therein, which included that the Quality Accounts were required to be published by 30/06/22. HC also thanked the members of her team, and in particular the Clinical Audit & Regulatory Compliance Lead, along with various members of clinical staff, for their work on the Quality Accounts.

Questions or comments were invited. None were received. The Quality Accounts for 2021/22 were then approved as submitted, and subject to any final minor alterations that were made ahead of the publication date.

Planning and strategy

06-8 To approve the Trust's updated planning submissions for 2022/23

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

- The activity and workforce sections of the plan had not changed from the version previously considered by the Trust Board.
- The Trust had received some funding for inflationary cost pressures, although that funding had not covered the full impact of such pressures.

- The plan was required to be submitted by 20/06/22, and no challenges had been received from the Kent and Medway Clinical Commissioning Group/Integrated Care System, after the draft plan had been submitted to them on 10/06/22.

SO added that the gap in inflationary funding that RJ had referred to had increased the level of risk associated with the delivery of the plan; while the size of the CIP, and the delivery of the elective activity plans represented additional risks. SO noted that he was however aware that SB and his team were actively working to reduce the risk regarding elective activity. DH acknowledged the risks, but commended the Trust's approach in aiming to achieve a break-even financial position, rather than plan for a financial deficit, as DH believed that approach would help motivate staff to deliver the plan. DH added that submitting a compliant plan would also enable the Trust to access capital funding. The points were acknowledged.

Questions were invited. None were received. The updated planning submissions for 2022/23 were then approved as submitted.

06-9 To consider any other business

There was no other business.

06-10 To respond to questions from members of the public

KR confirmed that no questions had been received.

DH then noted that no 'Part 2', i.e. non-public, Trust Board meeting had been scheduled for that day, so declared the meeting closed.

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]
05-11c	Liaise with the Chair of the Finance and Performance Committee to consider whether the quarterly "Analysis of Consultancy use" report should be reinstated.	Deputy Chief Executive / Chief Finance Officer	May 2022 onwards	A verbal update will be given at the meeting.
05-14	Ensure that the Trust's corporate objectives for 2022/23 appropriately reflected that a proportion of the Trust's patients resided in East Sussex.	Deputy Chief Executive / Chief Finance Officer	May 2022 onwards	A verbal update will be given at the meeting.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
05-11a	Consider the method by which the Trust Board should be kept apprised of the Trust's performance against the Workforce Race Equality Standard (WRES) (i.e. as a direct report to the Trust Board; as a metric within the Integrated Performance Report; or as an appendix to the summary report from the People and Organisational Development Committee).	Chief People Officer	June 2022	A review will be provided through the People and Organisational Development Committee, via an annual report. A timescale for the report will be agreed in liaison with the Head of Staff Engagement & Equality and the Chair of the People and Organisational Development Committee.
05-11b	Ensure that future Integrated Performance Reports include details of the Trust's performance against the "percentage of patients spending more than 12 hours in A&E" standard which had been implemented by NHS England / Improvement.	Chief Operating Officer	June 2022	The data has already been included in the site report, and will be included in future Integrated Performance Reports.
05-13	Liaise with the Trust Secretary to consider the scheduling of an "Approval of the Trust's operational planning for 2022/23" item, prior to submission to NHS England / Improvement on the 20th June 2022.	Chair of the Trust Board	May 2022	Liaison occurred and it was agreed to schedule the item at the extraordinary Trust Board meeting on 16/06/22.

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

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**

I would like to welcome our new Director of Strategy, Planning and Partnerships, Rachel Jones, to her first full Board meeting. I am sure that her previous role in the Kent and Medway Clinical Commissioning Group team will be invaluable to the Trust as the new Integrated Care Board comes into being on 1st July 2022 and new governance and collaboration structures start to embed within the system. With effect from July 2022, the Trust Board agenda will include an agenda item covering Systems and Place.

I am also delighted to inform the Board that our Non-Executive Director, Emma Pettit-Mitchell, has been reappointed to the Board for a further term of office, until August 2025. Emma chairs our People and Organisational Development Committee and we are all pleased that we will continue to benefit from energy and expertise.

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:

- We are still continuing to see high levels of attendances at our Emergency Departments (ED). As I mentioned last month, on Monday 16 May we saw our busiest ever day in our ED's, with 667 attendances across both our sites in a 24-hour period. Over the past month the average daily attendance figure has been 572, this compares with a pre-pandemic daily high of 560 on 20 May 2019 and an average daily figure for the equivalent time period in 2019 of 515.This demand has led to considerable operational pressures in the Trust, however work by our teams to help improve flow has progressed well and staff are also working collaboratively with agencies in the community, including Involve Kent, and county and borough councils, to ensure patients who no longer need to be in an acute hospital can be discharged quickly.

- We're also continuing to care for around 20 COVID-19 patient figures across our sites and, given these numbers, we have now extended our visiting hours from 12pm to 7pm daily. Two visitors are allowed at the bedside at any time but patients are not restricted to only two visitors throughout the day. Full details of visiting are available on our website.

- On Monday 20 June we also moved away from the requirement of all staff, patients and visitors to wear face masks. Instead we are operating a risk based approach which will mean that staff caring for the most vulnerable patients, and patients with respiratory symptoms or infections, must continue to wear masks and those patients will also be encouraged to wear masks themselves. This will include staff and patients in our Emergency Departments and COVID-19 wards. Masks will continue to be available for any staff, patients and visitors who wish to use them.

- The final change we have made is the phasing in of lateral flow tests rather than PCR tests for our elective patients undergoing general anaesthetic. This is being phased in over the next couple of weeks so that by the beginning of July all elective patients who need a test will do lateral flow tests for three days prior to admission.

- To support the ongoing pressures our focus on workforce planning remains a priority. I'm delighted that MTW is seen as a good organisation to work for and this is reflected in both the quality and number of applicants applying for jobs with us. We currently have 781 vacancies undertaking recruitment activity, including 238 who are undergoing pre-employment checks. To build on these positive developments, our Recruitment Team are planning a further 25 recruitment and promotional events in the second half of this year. On 11 June we held a Healthcare Support Worker recruitment event at Tunbridge Wells Hospital – more than 40 candidates attended and 25 received job offers on the day.

- Our Chief Nurse, Jo Haworth, has been meeting with trainee clinical support workers, clinical support workers, theatre support workers, maternity support workers and health care assistants across the Trust as part of a series of "Meet Jo" listening events. The purpose of the events is to hear what MTW is getting right and what we could do to support staff better.

- On Thursday 26 May, our new Oncology Outpatients Suite at Maidstone Hospital was opened by Helen Grant, MP for Maidstone and The Weald, and Tracey Crouch, MP for Chatham and Aylesford, who has received care from staff within the Kent Oncology Centre, was also at the opening of the new facility. The new building is next to the current oncology outpatient area at the Kent Oncology Centre and provides us with nine new clinic rooms. This ensures patients can see consultants, registrars, cancer nurse specialists and radiographers in a 'super clinic' where multi-disciplinary teams work together to provide smooth and quick care. The new facility

also includes two specialist clinic rooms and increases our capacity for additional face-to-face consultations.

- On the subject of Oncology, on 26 May our amazing Brachytherapy team celebrated treating their 1000th patient using prostate LDR seed brachytherapy. The specialist technique targets the radiation to the prostate, helping to reduce side effects for our cancer patients.

- Recently I also visited the new staff accommodation block near Maidstone Hospital. Two old blocks on the site have been replaced with new, larger modern buildings, providing 160 individual en-suite rooms for nurses, medical students, junior doctors and other staff, our high-quality, energy-efficient accommodation welcomes its first residents this month. Another example of a project that plays a key part in helping us deliver our MTW clinical strategy. A huge thank you to all the teams involved in these projects – from clinical staff through to Estates, Finance and Procurement.

- At the Trust, ensuring we use the best available technology and digital systems is one of our key priorities, as we constantly look to improve our services and enhance the experience of our patients. On Friday 17 June we marked the one year anniversary of one of our key developments within digital transformation - our Sunrise EPR system which has helped revolutionise our care to patients and also streamline our services for staff. In the year since we went live, we have seen a significant reduction in time taken for inputting data, supporting more effective processes. Key highlights include: 2.9 million documents have been created, just over 1.1 million specimens have been collected and some 4 million results sent through to Sunrise. A big thank you to everyone who has worked so hard on this project over the last year (and before that during the planning stages) and we look forward to seeing the programme go from strength to strength.

- I am pleased to report that the Trust has been confirmed as the endoscopy training hub for Kent and Medway, part of the South East Academy. The Trust has also been awarded JAG training provider accreditation status and is now one of the national centres commissioned to improve endoscopy training in England. The training hub will open its doors to the first trainees on Monday 4 July. As part of the service expansion, Maidstone Hospital has taken delivery of a state-of-the-art virtual reality simulator to help trainee clinical endoscopists in an immersive virtual environment. Virtual reality simulation plays a key role in endoscopic training, with benefits including the improvement of patient safety and optimisation of valuable endoscopy time. MTW has a team of 54 staff working across both sites at the Trust providing endoscopy services for patients seven days a week, carrying out on average 1300 procedures every month. In August 2020 the Trust had some 2000 patients waiting for an endoscopy procedure. Currently the Trust has no patients waiting for treatment, which is an incredible feat against the backdrop of the COVID-19 pandemic. A big thank you to all those involved in bringing this project to fruition.

- To mark the Queen's Platinum Jubilee, I was delighted to plant a commemorative tree with our Grounds & Gardens team at Maidstone Hospital. Other celebrations included our hospital radio team entertaining our patients and visitors at the Kent Oncology Centre at Maidstone Hospital, live music from one of our chemotherapy nurses, and a cake stall for staff, patients and visitors to enjoy.

- I am delighted to report that the Trust's Care Coordination Centre Team has been selected as a regional winner in the Future NHS category of the Parliamentary Awards. Nominated by local MP Greg Clark, the Care Coordination Centre Team introduced an automated bed management system that has provided the Trust with the ability to manage its patient flow more effectively, significantly improve its bed turnaround times and provide patients with the right care, in the right place, at the right time. The national winners will be announced on Wednesday 6 July. Congratulations to all those working in our Care Coordination Centre Team, this award is recognition of the dedication and hard work of everyone involved.

- Congratulations to MTW Senior Radiographer Richard Flood, who has recently completed his level 1 HCSE (Health Care Systems Engineering) qualification. Richard is currently the only practising radiographer in the UK with HCSE level 1. This is a huge achievement not only for Richard but also the whole MTW Imaging team, who are leading on this improvement work with the Kent and Medway Imaging Network across the South East. A huge well done to Richard and the Radiology team for this fantastic work!

- Our staff networks continue to play a key role in supporting staff across MTW. At the start of the month, our Cultural and Ethnic Minorities Network (CEMN) hosted an engagement week. The aim was to meet staff and raise awareness of the network, hold career workshops, and highlight all the work the network does to support colleagues and staff across the Trust to continue developing a diverse and inclusive organisation. It was a very successful week with many more staff members signing up to join the network. Our Rainbow Badge assessment closed mid-June and we hope to be able to share the results very soon. Our Disability Network continues to be very active within the Trust, with regular meetings taking place – the last meeting focused on Fibromyalgia Awareness – and this month the network hosted our first autism working group to make changes to support our autistic staff and patients within the Trust.

- At the start of this month we celebrated Volunteers' Week – highlighting the amazing contribution of the (almost) 300 volunteers we have supporting us across the Trust. I was delighted to meet some of our volunteers on 30 May at a thank you afternoon tea gathering, organised by our Voluntary Services team. With our volunteers ranging in age from 16 to 96, we shared some of their stories on our social media channels throughout the week. You can read more here.

- I'm pleased to be able to share the latest update from the West Kent Health and Care Partnership (HCP):

    - **Virtual Ward Development:** The 2022/2023 Operational Planning Guidance provided a clear objective for virtual ward capacity of 40–50 virtual beds per 100,000 population. West Kent Health & Care Partnership stakeholders, led by MTW's Medical Director, Dr Peter Maskell, are working with the HCP team to establish a West Kent Virtual Ward offer that will provide technology enabled virtual ward capacity for up to 220 clinically appropriate patients. This initiative means patients will be treated near home or at home instead of an acute inpatient bed. The West Kent HCP Virtual Ward programme is planning to meet the 220 target by December 2023, initially the work will focus on delivering Frailty and Respiratory virtual ward places but in the longer run the multi-agency team hope to include other specialities.

    - **Population Health Management:** Partners in the HCP have been developing a shared understanding of Population Health Management (PHM) in action and how they will jointly tackle the health inequalities identified in West Kent. The HCP has two local initiatives where they are putting population health management into practice: 1) In Maidstone the borough council are leading multi-agency work with residents in Parkwood and Shepway, the two most deprived wards in West Kent, and developing an initiative to support them to access healthy food and income support in various forms. 2) The other is being led by Weald Primary Care Network who are working with partners across the HCP to develop an integrated response to people who are frequent attenders in their practices (many of whom have mental health presentations). These pilots are giving the HCP an opportunity to test the PHM approach on a small scale in the first instance by sourcing data to identify cohorts of patients or residents who are disproportionately disadvantaged in health or care outcomes and target support to address those inequalities in outcomes. A key feature of this work is engaging directly with the patients or residents identified and developing a bespoke response with them to address their needs. The HCP are keen to measure the impact of these interventions before they scale them up across the area.

- Congratulations to the winner of the Trust's Employee of the Month scheme for May, Ruth Parker, Deputy Head Orthoptist. Ruth is a very knowledgeable clinician who always strives to put her patients first and is known for always going the extra mile to ensure patients have the best possible experience in the Orthoptic clinic with a high standard of treatment. Ruth is a well-liked member of the Orthoptic team and her hard work and support is highlighted as invaluable to the team. On behalf of the Trust Board I would like to say thank you to Ruth for her 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 performanc

Summary report from Quality Committee, 08/06/22 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 8th June 2022 (a Quality Committee 'deep dive' meeting).

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

- The Medical Director provided a brief **update on the Trust's response to the rate of falls** wherein the additional training that would be provided to Trust staff was outlined and the Committee acknowledged the impact of the increased number of Medically Optimised for Discharge patients within the Trust's bed base on the associated rate of falls.
- The Chief Operating Officer and Risk and Compliance Manager attended for a **review of the management of health and safety at the Trust** wherein the Committee emphasised the further training which was required for senior managers and it was agreed that the Director of Quality Governance should liaise with the Risk and Compliance Manager to investigate the inclusion of Health and Safety training as part of the NHS Patient Safety Syllabus training for Trust Board members. It was also agreed that the Assistant Trust Secretary should schedule a "Review of the next steps for the management of Health and Safety at the Trust" item at the July 2022 'main' Quality Committee meeting.
- The Director of Quality Governance presented the latest **review of adverse patient outcomes** (a mid-year review) which provided Committee members with comprehensive details of the adverse patient outcomes and the associated root causes and it was agreed that the Assistant Trust Secretary should ensure that future "Review of adverse patient outcomes" items were scheduled for consideration at the 'main' Quality Committee meeting.
- The Director of Quality Governance presented an **In-depth review of risk ID 2498 – Learning from incidents – the failure to learn.** The presentation provided a comprehensive overview the measures which had been implemented to ensure that lessons learned from incidents were appropriately captured and the further work which was required.
- The Chief of Service, Women's, Children's & Sexual Health Services; Deputy Head of Midwifery and Maternity Transformation Matron attended for a **review of the long-term plan for Maternity Continuity of Carer**, which has been submitted to the Trust Board under a separate agenda item for approval. The Committee emphasised importance of ensuring the Trust maintained flexibility to adapt to new methods of patient care and outlined the need for robust metrics to examine the efficacy of the maternity continuity of carer approach. The Committee also noted the challenges associated with the recruitment of midwives in the United Kingdom.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein it was agreed that the Assistant Trust Secretary should schedule a "Review of the progress with the improvement of the management of sepsis at the Trust" item at the August 2022 Quality Committee 'deep dive' meeting. It was also agreed that the Assistant Trust Secretary should reschedule the "The findings from the audit to test staff learning" item from the August 2022 Quality Committee 'deep dive' meeting to the October 2022 Quality Committee 'deep dive' meeting.

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

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

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

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

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

Trust Board Meeting – 30th June 2022

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 28/06/22	**Committee Chair (Non-Exec. Director)**

The Committee met on 28th June, via a webconference.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were reviewed, which included confirmation of the approval, by NHS England/Improvement, of the Full Business Case (FBC) for a managed MRI service. The Deputy Chief Executive/Chief Finance Officer agreed to check and confirm whether the Trust needed to go through a procurement process to appoint a supplier for the managed MRI service, or whether that had been covered within the FBC.
   - The Chief Operating Officer gave a verbal **update on the development of the options to address the current patient flow-related challenges**, & confirmed the intention to submit a report to the Committee's meeting in July, as part of the preparations for the forthcoming winter.
   - **The Patient Access strategic theme metrics** for month 2 were reviewed as part of the Integrated Performance Report (IPR), which acknowledged the marked improvement in performance on Diagnostic Waiting Times, but acknowledged the continued challenges regarding elective activity and the Referral to Treatment (RTT) target.
   - The **financial performance for month 2** was reviewed, and it was noted that this was broadly on plan, but there were pressures on pay budgets, particularly on medical staffing, and facilities staff. The risks relating to the delivery of the Cost Improvement Programme (CIP) and the receipt of Elective Recovery Fund (ERF) income were also discussed, as was the need to try and reduce the level of COVID-19-related expenditure.
   - The Deputy Director of Finance (Finance Performance) gave an **update on the Costing Transformation Programme (CTP).**
   - The Director of Improvement & Delivery and Head of the Programme Management Office attended **to present an updated proposed revised approach for the oversight of previously approved Business Cases**, and it agreed that they should submit an update on the Cases that had been previously approved by the Committee or Board in July 2022.
   - The Chief Operating Officer reported on the latest position regarding the **Outline Business Case (OBC) for Increasing Elective Orthopaedic Capacity**, and it was noted that the process to approve the updated OBC should be finalised at the Trust Board meeting on 30/06/22.
   - The Committee noted **the approval of Business Case ID888 ("Business Case for staff accommodation") under the Committee's "Emergency powers and urgent decisions" provisions**, and it was agreed that the Chief Executive should range for a strategic overview to be undertaken in relation to the Trust's future staff accommodation needs.
   - The Trust Secretary shared the **recent findings from relevant Internal Audit reviews**, and notified the Committee **of the uses of the Trust Seal** since the last meeting.
   - The Committee agreed that Business Case regarding the future of the Trust's laundry service could be developed as a combined OBC and FBC, as that would enable the Trust to meet the required timescale, as the process would involve obtaining the approval of external agencies.

2. **In addition to the agreements referred to above, the Committee agreed that:**
   - The Chief Operating Officer should arrange for the Counter Measure Summary "Action Plan" section of the "Ensure Elective Activity Levels match those pre-Covid" project/metric in future IPRs to reflect the fact that monitoring activity and observing change was not an action.
   - The Chief Operating Officer, Deputy Chief Executive/Chief Finance Officer and Trust Secretary should liaise to agree which Divisions should be invited to the new Finance and Performance Committee 'deep dive' items, which would be scheduled from July 2022; while the Chief Executive and Trust Secretary should liaise to consider how the new 'deep dive' items could address some of the points raised at the Trust Board 'Away Day' on 10/06/22.

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 24/06/22	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on 24th June 2022 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were reviewed, and one the 'closed' actions, which related to the development of Human Resources Business Partners (HRBP) was discussed in detail. This led to two further actions being agreed: for the Deputy Chief People Officer, People and Systems to share the details of the HRBP development sessions with the Committee's Vice Chair; and for a "The outcome of the HRBP development sessions held during summer 2022" item to be scheduled at the Committee in October or November 2022.
- The Head of Resourcing attended for the latest **update on recruitment and retention** which included the action plan from the Retention Team in response to leaver information and staff survey data. A helpful discussion was held and it was agreed that the Trust Secretary would liaise with the Deputy Chief Nurse, Workforce and Education to arrange for the Committee to receive details of the work of the Retention Programme Board; and to schedule some time for the Committee to hear about the work taking place to capture employees' anecdotal concerns, particularly in relation to recruitment and retention. The Deputy Chief Nurse, Workforce and Education also gave a report on "Effective Rostering in Nursing & Midwifery", and it was agreed to schedule an "Update on the review of the eRostering programme" in December 2022.
- The Deputy Chief People Officer, Organisational Development; Interim Head of Learning and Development; and Organisational Development Consultant attended for a **review of the Trust's leadership development approach and outputs from the Exceptional Leaders Programme**, which included details of the development of an Exceptional Leaders programme for all staff bands. Again, a beneficial discussion was held, and it was agreed that an "Update on the continued evaluation of Exceptional Leaders Programme participants" should be scheduled at the Committee in December 2022. It was also agreed that the Deputy Chief People Officer, Organisational Development should submit further details of the plans to extend the Exceptional Leaders programme to other staff to the Committee, once such plans had been developed.
- The Deputy Chief People Officer, People and Systems and HR Policy & Employee Relations Advice Manager presented a further **review of the key themes and lessons learned from employee relations cases**, wherein the Committee agreed that a benchmarking exercise should be undertaken, to assess how the Trust's performance on employee relations cases compared to other Trusts.
- The Committee conducted an **evaluation of the meeting** which commended the quality of the submitted reports, and the insights provided by the presenters.

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

- Details of the future scheduled Exceptional Leaders sessions should be circulated to Committee members, as part of the open invitation for Committee members to attend such sessions.
- The Committee Chair should liaise with other members of the Committee to finalise the agenda for the Committee's meeting in September 2022 (this was done immediately after the Committee meeting)

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

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

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

Summary report from the Patient Experience Committee, 09/06/22	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 9th June 2022, virtually, via webconference

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed and it was agreed that Deputy Director of Strategy, Planning and Partnerships should provide the Administration Assistant, Trust Secretary's Office with appropriate contact details for circulation to Committee members to enable further feedback on the engagement material for the cariology consolidation programme.
- The Chief Nurse provided a **review of the revised Patient Experience Strategic Theme** which included details of the proposed update to the Strategic Theme; wherein it was agreed that the Administration Assistant, Trust Secretary's Office should schedule a "Review of the revised Patient Experience Strategic Theme" to the Committee's meeting in September 2022 and to each meeting thereafter, and the Chief Nurse should ensure that this report informed Committee members of the process by which the Vision Statement and Breakthrough Objectives would be achieved. It was also agreed that the Patient Experience Lead should liaise with the General Manager, Facilities to ensure that the "Update on the progress with the Trust's response to the findings from the report of the Independent Review of NHS Hospital Food" report to the Committee's meeting in September 2022 included an in-depth update on the implementation of digital menus to increase accessibility for patients with disabilities.
- The Divisional Director of Midwifery, Nursing & Quality for Women's, Children's and Sexual Health provided an **update from the Children's Directorate (incl. the changes to Paediatric Service provisions at Tunbridge Wells Hospital)** which outlined the success of the recently opened Paediatric Emergency Department and the service developments to support Mental Health pathways.
- The Patient Experience Lead provided an **update on the Trust's visiting arrangements** which outlined the changes that were made in May 2022 and it was agreed that the Patient Experience Lead should submit a "Further update on the Trust's visiting arrangements" report to the Committee's meeting in September 2022.
- The Complaints and PALS Manager attended for a **review of the complaints annual report 2021/22** wherein it was agreed that the Chief Nurse and Complaints and PALS Manager should investigate the methods by which complaints and Patient Advice and Liaison Service (PALS) feedback could be incorporated into the appraisal process for Trust staff.
- The Complaints and PALS Manager then briefed the Committee **on the new National complaints framework** which outlined the new structure for the complaints process and it was agreed that Complaints and PALS Manager should liaise with the communications team to investigate what, if any, social media and web-based platforms could be utilised to support the PALS and complaints process, including raising the awareness of such processes. It was also agreed that the Complaints and PALS Manager should ensure that the "Review of Complaints" report to the Committee's meeting in September 2022 included an update on the gap analysis of the Trust's compliance with the NHS Complaints Standard for 2021.
- The Committee noted the **Trust's response to the findings from the Care Quality Commission Maternity survey 2021** and it was agreed that the Administration Assistant, Trust Secretary's Office should liaise with the Chair of the Committee and the Divisional Director of Midwifery, Nursing and Quality to confirm the scheduling of a further update on the Trust's response to the findings from the Care Quality Commission Maternity survey 2021 and that the Divisional Director of Midwifery, Nursing and Quality for Women's, Children's and Sexual Health should share the feedback from the Maternity Voices partnership with the Complaints and PALS Manager.
- The Committee considered its **Forward Programme** and confirmed the items which had been scheduled at the September 2022 meeting.
- Under **Any Other Business** it was agreed that the Administration Assistant, Trust Secretary's Office should schedule an "Update on the patient partner programme and progress with

increasing 'lay member' representation at the Committee's meetings" item at the Committee's meeting in September 2022.

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: 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 the Audit and Governance Committee, 16/06/22	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 16th June 2022, virtually via web conference. A verbal update on the meeting was given at the Trust Board held later the same day, but this written report has been submitted for completeness.

1. **The key matters considered at the meeting were as follows:**
   - The **Audit Findings Report ('Report to those charged with governance') for 2021/22** from the External Auditors was reviewed and no significant issues were raised
   - The draft **External Audit Annual Report for 2021/22** was reviewed and the improvement recommendations were supported by the Committee
   - The final draft **Annual Report and Annual Accounts for 2021/22** (including the Governance Statement) were reviewed, and the Committee agreed to recommend that these be approved by the Trust Board. Trust Board Members will be aware that these were duly approved on 16/06/22
   - The **2021/22 Draft Management Representation Letter** was reviewed, and the Committee agreed to recommend that this be approved by the Trust Board. The letter was subsequently approved by the Trust Board on 16/06/22.
   - Under the **Evaluation of the meeting** (incl. confirmation of any "spotlight on…" items) a "Spotlight on the findings of the Internal Audit review of "Consent"" was confirmed for the Committee's meeting in July 2022.

2. **The Committee agreed that (in addition to any actions noted above):** N/A

3. **The issues that need to be drawn to the attention of the Board are as follows:** The audited Annual Report and Accounts for 2021/22 were submitted to NHS England / Improvement on 22/06/22

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

Integrated Performance Report (IPR) for May 2022	**Chief Executive / Members of the Executive Team**

The IPR for month 2, 2022/23, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 28/06/22, Finance and Performance Committee, 28/06/22

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

May 2022

MTW
exceptional people, outstanding care

Contents

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

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

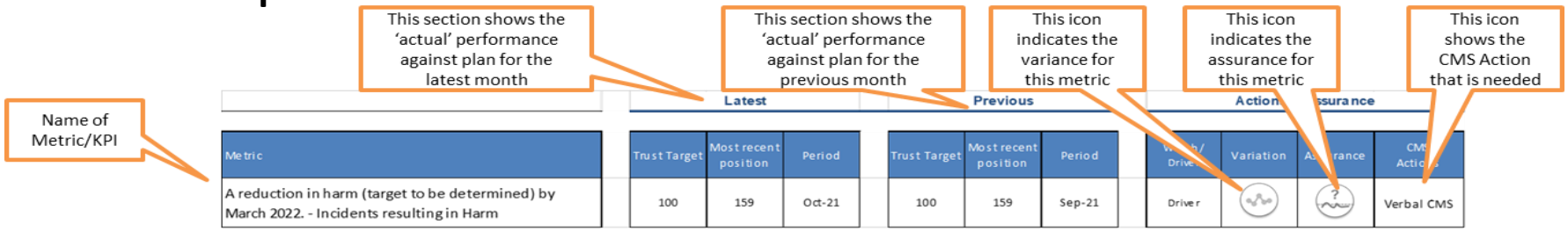
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Executive Summary

This report has been developed further to incorporate the Trust Strategy Deployment Review (SDR) process which has been implemented during this highly challenging period of time. This process is in the early stages currently and therefore some of the processes are still being embedded. The full Counter Measure Summaries (CMSs) will therefore develop and improve once these processes are fully embedded across the Trust.

The Trust Vacancy Rate continues to consistently fail the target and is experiencing common cause variation. Agency use and spend is consistently failing the target. Sickness is in variable achievement (with the new target) and Safe Staffing levels remain in escalation as have not achieved the target for more than six months which is impacting on key quality indicators.

The rate of inpatient falls continues to experience common cause variation. This indicator, along with the Hospital on-set of COVID indicator have not achieved the target for more than six months and have therefore been escalated. These indicators also impact the Incidents resulting in harm indicator which has also not achieved the target for more than six months.

Diagnostic Waiting Times is now experiencing special cause variation of an improving nature at 95.6% for May 2022. RTT performance is experiencing common cause variation and has not achieved the trajectory target for more than six months. We continue to be a Trust with no 52 week waiters (one of the first Acute Trusts to have cleared these long waiters). Elective, first outpatient and MRI activity levels have failed the trajectory target for the last six months but are showing signs of improvement. The high level of emergency admissions and delayed discharges continues to put pressure on the bed capacity.

A&E 4hr performance is experiencing common cause variation at 84.0% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers also remains in full escalation. The Trust continues to achieve the National Cancer 62 Day Standard (85.7%), however the 2 Week Wait (2WW) Standard was not achieved in April (89.5%). Achievement of these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and the number of patients on the 62 day backlog.

The Trust's level of responses received from the Friends and Family (FFT) surveys remains low, with all areas currently not achieving the target and the complaints response rate has also experienced variable achievement of the target for more than six months.

Escalations by Strategic Theme:

People:

- Climate Survey Responses (P.8)
- Vacancy Rate (P.9)
- Sickness Rate (P.9)

Patient Safety & Clinical Effectiveness:

- Falls Rate (P.11)
- Safe Staffing (P.13)
- Incidents Resulting in Harm (P.12)
- Infection Control (P.13)

Patient Access:

- RTT Performance (P, 16)
- *Diagnostics <6 weeks (P.21)
- A&E Performance (P.22)
- Outpatient Calls answered <1 minute (P.23)
- Outpatient Clinic Utilisation (P.23)
- Ambulance Handovers >30 minutes (P.22)
- Super-Stranded Patients (P.22)
- % Emergency Admissions to Assessment Areas (P.22)
- Ensuring Activity Levels Match those Pre-Covid – Inpatients, Outpatients, MRI & NOUS (P.16-20)

Patient Experience:

- Friends & Family Response Rates (P.24)
- *Complaints (P.25)

Systems:

- Reduction in non-elective bed days (P.27)

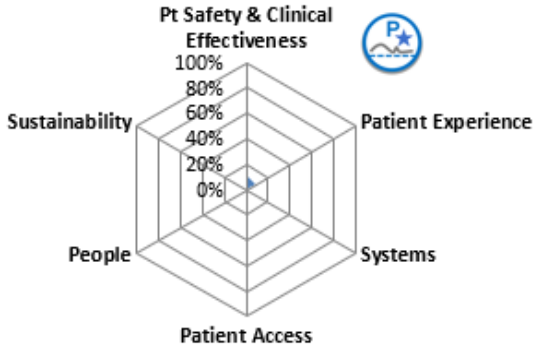
Sustainability

- Use of Agency (P.29)

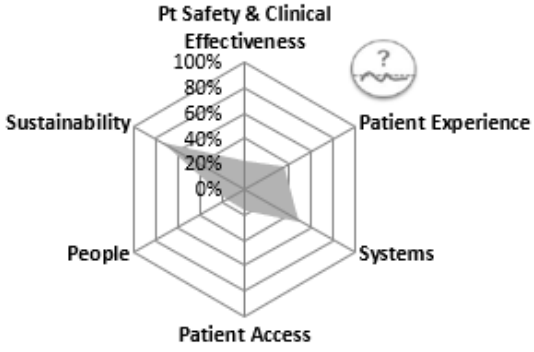
*Escalated due to the *rule* for being in Hit or Miss for more than six months being applied

Assurance RADAR Charts by Strategic Theme

Consistently Passing

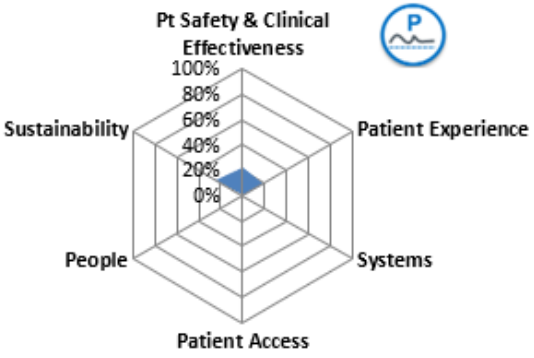


Hit and Miss



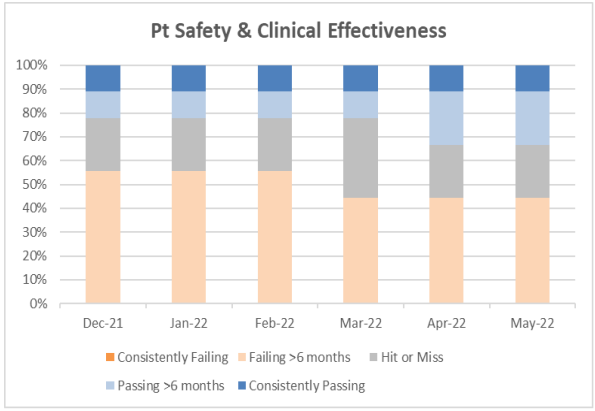
Consistently Failing

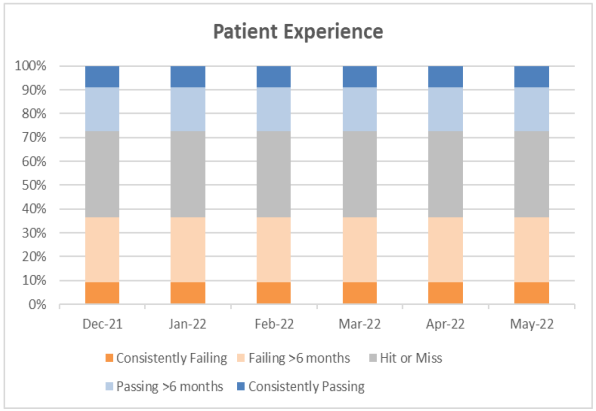
Achieved Target > 6 months

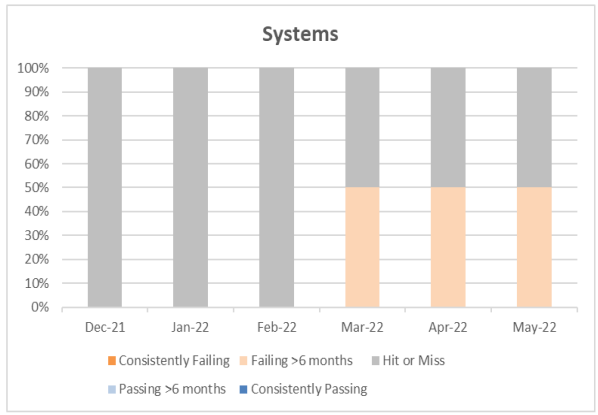


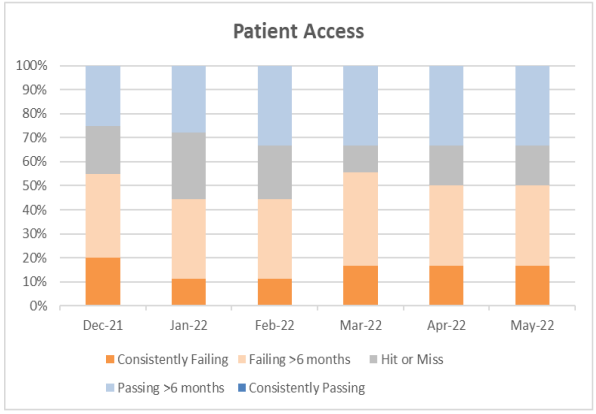
Not Achieved Target > 6 months

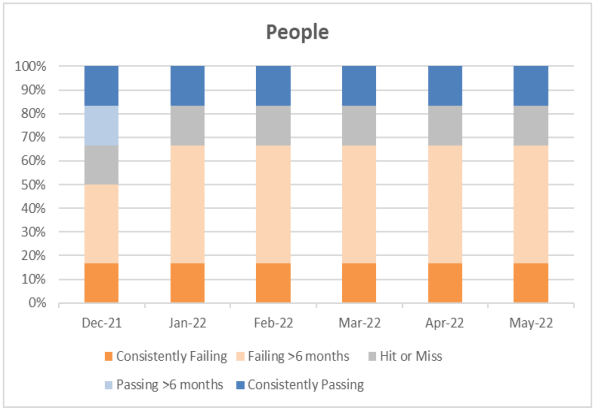
Assurance Stacked Bar Charts by Strategic Theme

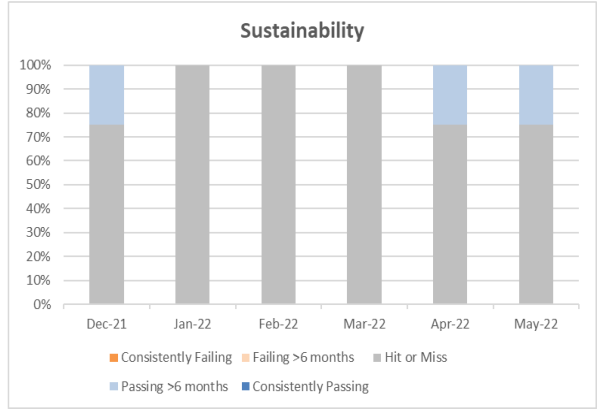












Matrix Summary

May 2022

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement		RTT >52 wk Waiters Flow: % of Emergency Admissions that are zero LOS (SDEC), Never Events	Access to Diagnostics (<6weeks standard),	Flow: % of Emergency Admissions into Assessment Areas	Transformation: CAU Calls answered <1 minute
Common Cause		FFT positive response: Inpatients, FFT positive response: A&E, FFT positive response rate: Matenity, FFT positive response rate: Outpatients, Complaints Rate, Cancer 62 Day Standard Cancer - 2 Week Wait	Activity levels match those pre-Covid - Follow Ups & MRI, NOUS, CT Reduce average non-elective bed days relating to patients with high and very high AEC conditions by 10%, IC- Rate of C.Difficile IC - Number of Hospital acquired MRSA, Complaints Rate,	Achieve the RTT standard , Incidents resulting in Harm, Reduction in slips, trips and falls, Activity levels match those pre-Covid - Elective, OP New, Increase FFT response rates: Inpatients, Safe Staffing Levels, A&E 4 Hour Performance, % complaints responded to within target	Transformation: % OP Clinics Utilised (slots), Vacancy Rate, Flow: Ambulance Handover Delays >30mins Ensure activity levels for diagnostics match those pre-Covid - MRI
Special Cause - Concern	Statutory and Mandatory Training		% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Survey, Cash Balance (£k), Capital Expenditure, FFT Response Rate - Maternity, Standardised Mortality HSMR, Sickness Absence	Increase Climate Survey response rates, Super Stranded Patients Reduction in Non-Elective Beddays, Agency Spend, Appraisal Completeness	FFT Response Rate: A&E & Outpatients

Strategic Theme: People

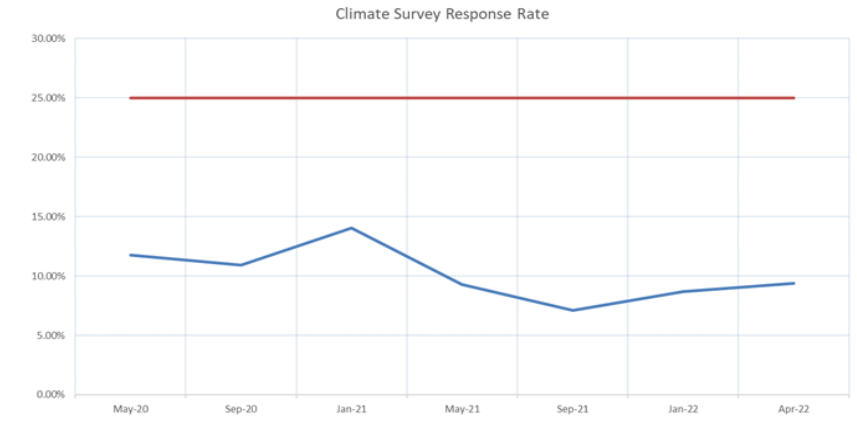
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Surveys	80%	60.3%	Apr-22	80%	64.4%	Jan-22	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Increase Climate Survey response rates to provide a larger sample base to be able to assess those that recommend MTW as a place to work.	25%	9.40%	Apr-22	25%	8.70%	Jan-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Vacancy Rate	9.0%	14.2%	May-22	9.0%	14.6%	Apr-22	Driver			Escalation
	Well Led	Sickness Absence	4.5%	5.2%	Apr-22	4.5%	5.3%	Mar-22	Driver			Not Escalated
	Well Led	Appraisal Completeness	95.0%	15.3%	May-22	95.0%	79.0%	Apr-22	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	86.2%	May-22	85.0%	82.8%	Apr-22	Driver			Not Escalated

Breakthrough Objective: Counter Measure Summary

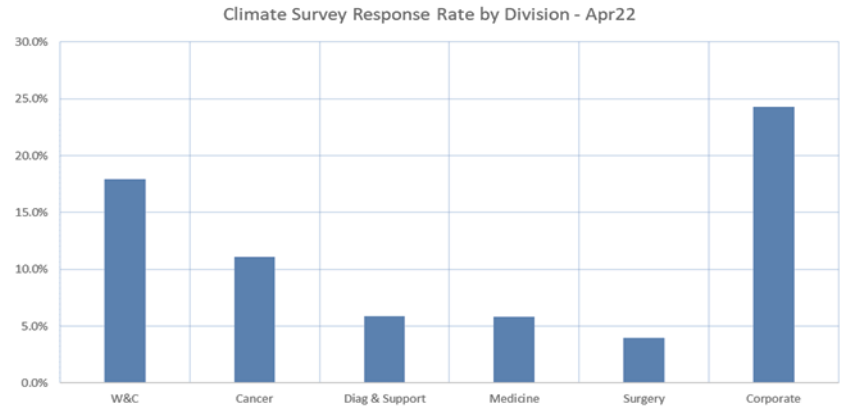
Metric Name – Increase Climate Survey Response to provide a larger sample base

Owner: Sue Steen
Metric: Climate Survey Responses
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



2. Stratified Data



4. Action Plan Updates – May 2022

Engagement Workshops

- Divisions / Directorates to develop action plans for the top 3 staff survey issues - by Mid July 2022.
- WC&SH to pilot the workshop process - June 2022.
- Engagement targets in all Divisional SDR plans (ongoing)

Incivility

- Bullying, harassment, kindness and respect are areas that require a focus across the whole Trust.
- We are implementing various eLearning and training which includes:

❖ Kindness into Action eLearning – July 2022.
❖ Respectful Resolution – Training by A Kind Life – September 2022.
❖ OD team development programmes in Divisions in response to key feedback from staff survey (ongoing)
❖ Multi-team approach to support team diagnostics – FTSU/Wellbeing/HRBP/Occupational Health. (Ongoing)

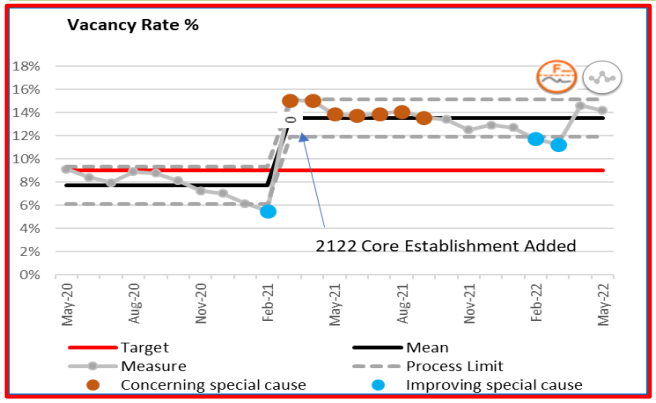
Exceptional Leaders

- Suite of leadership development for all people leaders to ensure clarity and communication
- Piloting - Affina Team Journey - tool to support Team Leaders. – June 2022
- L&D are reviewing and refreshing management skills training – August 2022.
- Full range of appraisal toolkits for people leaders available on MTW Learning – April 2022
- Focus on wellbeing and development/aspirations conversations-April 2022

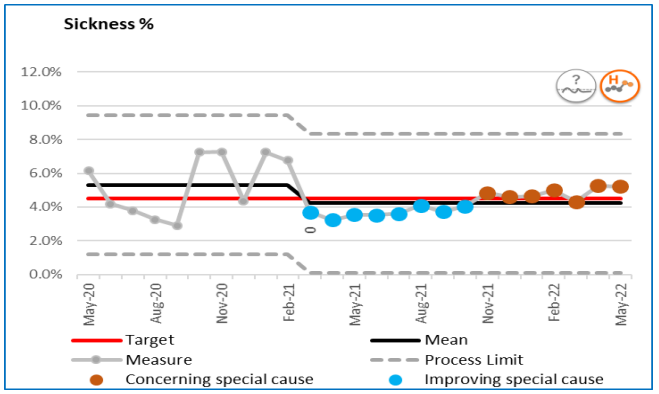
Personal and Career Development

- Developing a talent management approach which will de-bias access to CPD and link career development to appraisal. – July 2022
- Create talent pools, using TRAC to self promote skills, centralise the CPD process – June – December 2022.
- Talent management – December 2022
- Reviews of the pilots and programmes – January – June 2023
- Key driver from NHSEI is race equality, 19% BAME representation at all levels by 2025

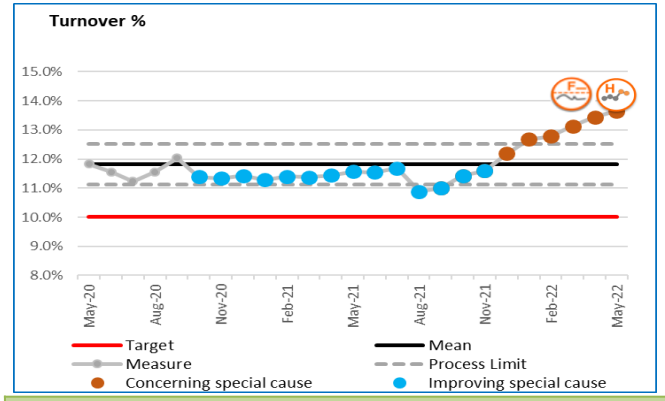
People – Workforce: CQC: Well-Led



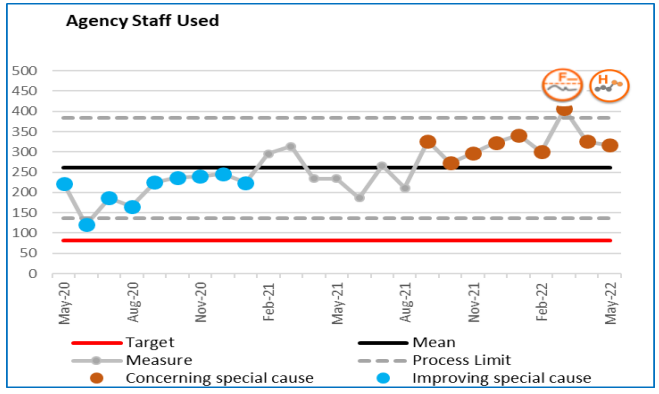
May-22
14.1%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an concerning nature and consistently failing the target
Max Limit (Internal)
9%
Business Rule
Full Escalation



Apr-22
5.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and not achieving the target for > 6 months
Max Target (Internal)
4.5%
Business Rule
Full Escalation as not achieving the target > 6 months



May-22
14.2%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and is consistently failing the target
Max Limit (Internal)
10%
Business Rule
For Information as linked to Vacancy Rate



May-22
317
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning and consistently failing the target
Target (Internal)
81
Business Rule
For Information as linked to Vacancy Rate

Summary:

Vacancy Rate % - This metric to experience Special Cause Variation of a Concerning nature, but is consistently failing the target

Sickness % - It has been agreed that the target will change to 4.5% from Apr-22 to reflect the impact of Covid on the new expected sickness absence rate, this metric is now experiencing Common Cause Variation and variable achievement of the Target for over 6 months

Turnover: Shown for information as linked to Vacancy Rate and is consistently failing the target. The Therapies, Pathology, Imaging, Womens' Services and Acute Medicine + Geriatrics Directorates have the highest Turnover Rates.

Agency Staff Used: Shown for information as linked to Vacancy Rate and is consistently failing the target. The Medical and Emergency and ICT Directorates have the highest Agency Spend.

Actions:

Vacancy Rate: The new financial year has meant that some budgets have increased meaning that the current vacancy figure is 1032WTE (a reduction of 31WTE from last month). Nursing and Midwifery remains our largest resourcing challenge- however we have a healthy pipeline of candidates joining the trust within the next three months, and strong resourcing plans for the remainder of the year. We currently have over 399WTE going through pre-employment checks or with start dates booked, with Nursing and Midwifery having highest the level of recruitment activity. There are currently 98.7 vacancies currently advertised, which evidences that recruiting managers are not pro-actively advertising all there vacancies..

Sickness: Absence rate remains at or around the target, having returned from the high levels seen over the winter period, in particular due to Covid absence.

Turnover: This is a 12 month indicator and the last few months have seen fewer leavers, which will in time reduce our rate. That said, interventions have been put in place e.g. welfare support, and a retention lead now to be recruited following the approval of the business case for this. With positive recruitment pipeline numbers, turnover is the priority issue to address.

Assurance & Timescales for Improvement:

Vacancy Rate % - Recruitment pipeline shows high level of candidates at offer and check stages, we therefore expect the metric to continue to improve.

HCSW recruitment event was held in June which resulted in 25 attendee's appointed.

AHP recruitment event was held in May which resulted in 5 leads.

The recruitment team also attended a event in Bluewater in May which resulted in 36 leads.

The focus for the marketing campaign in June is HCSW, Staff Nurses, Occupational Therapist and Speech and Language Therapist.

76 International Educated Nurses are in the pipeline due to commence within the next few months. There are 2 International recruitment trips being planed (Philippines and Caribbean) for Nursing. The retention team are looking at ways to improve the leaver process including paperwork to hopefully improve the data that is analysed on a monthly basis.

Sickness % - monitoring of Covid-related absence will continue (as a seasonal reduction is expected from March onwards).

Strategic Theme: Patient Safety & Clinical Effectiveness

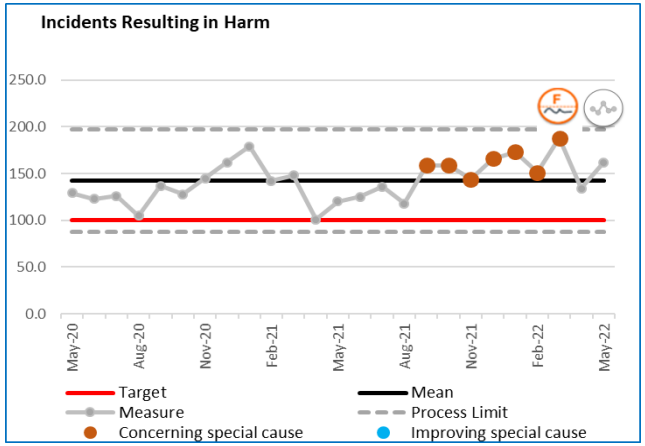
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	100	162	May-22	100	134	Apr-22	Driver		F	Full CMS
Breakthrough Objectives	Safe	Reduction in slips, trips and falls (Rate per 1,000 Occupied Beddays)	6.0	6.9	May-22	6.0	7.4	Apr-22	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	8	May-22	11	6	Apr-22	Driver		?	Not Escalated
	Safe	Standardised Mortality HSMR	100.0	97.1	Feb-22	100.0	94.1	Jan-22	Driver	H	?	Not Escalated
	Safe	Never Events	0	0	May-22	0	0	Apr-22	Driver	L	P	Not Escalated
	Safe	Safe Staffing Levels	93.5%	92.5%	May-22	93.5%	87.7%	Apr-22	Driver		F	Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	33	May-22	0	15	Apr-22	Driver		F	Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	15	May-22	22.7	15	Apr-22	Driver		?	Not Escalated
	Safe	IC - Number of Hospital acquired MRSA	0	0	May-22	0	0	Apr-22	Driver		?	Not Escalated

Breakthrough Objective: Counter Measure Summary (Hit & Miss >6 months)

Project/Metric Name – Reduction in harm : Incidents resulting in harm

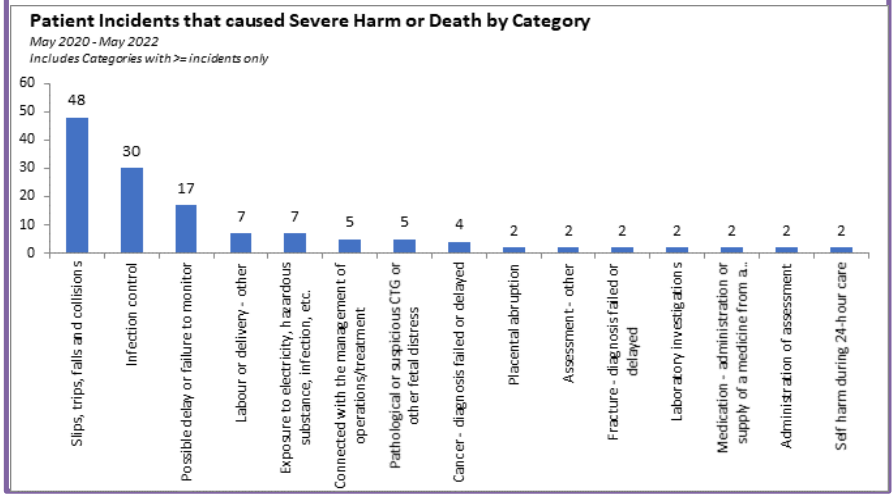
Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

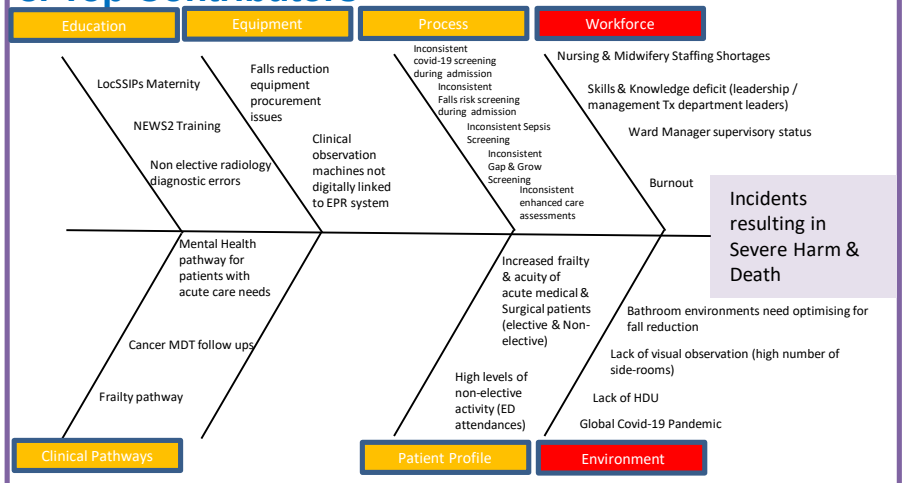


May-22
162
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for more than 6 months
Max Target (Internal)
100
Business Rule
Full Escalation as not achieved target for 6+ months

2. Stratified Data



3. Top Contributors



4. Action Plan

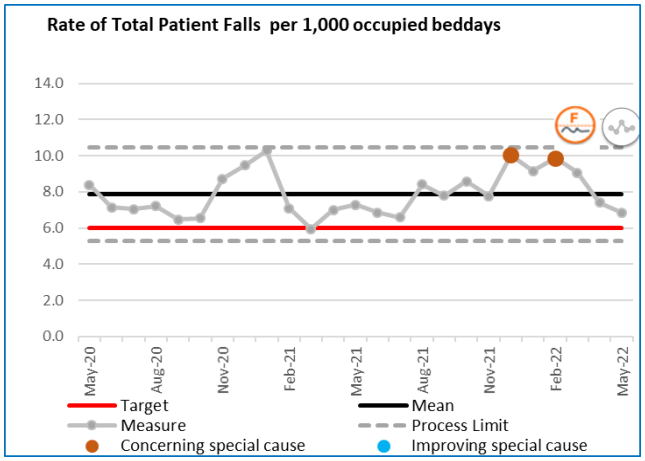
Contributor	Solution / Countermeasure	Owner	Due by?
Environment	Trust wide Falls QI workstream	Medical Director & Deputy CNO	Launched and Ongoing
	Options Appraisal HDU		
Workforce	Safer Staffing Review (drive to 95% fill rate substantive staff & assurance safe staffing models in place)	CNO	June 2022
	Wellbeing workstream	Chief People Officer	
	Leadership & OD Training Plan		

Breakthrough Objective: Counter Measure Summary (Hit & Miss >6 months)

Project/Metric Name – Reduction in slips, trips and falls (Rate per 1,000 Occupied Bed days)

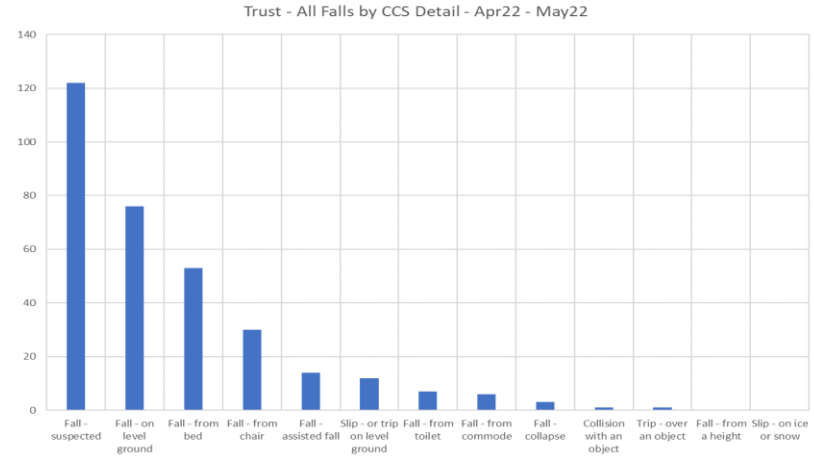
Owner: Peter Maskell
Metric: Falls Rate per 1,000 Occupied Beddays
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

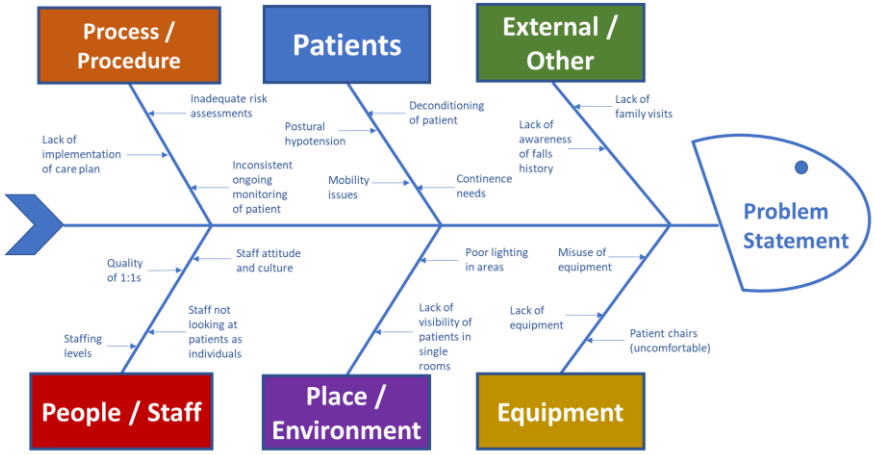


May-22
6.85
Variance / Assurance
Metric is currently experiencing common cause variation and has not achieved the target for more than 6 months
Max Target (Internal)
6.0
Business Rule
Full Escalation as not achieved target for 6+ months

2. Stratified Data



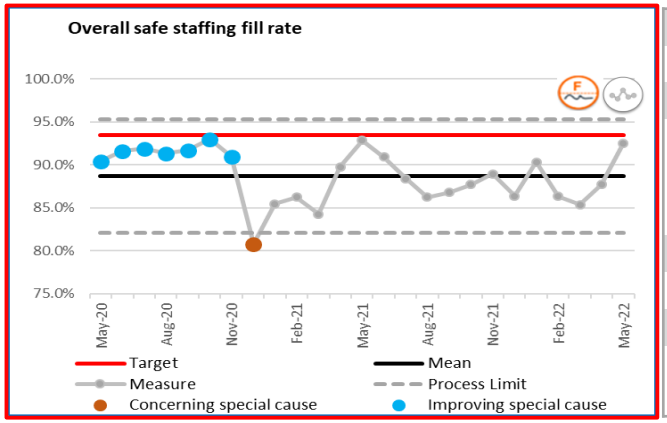
3. Top Contributors



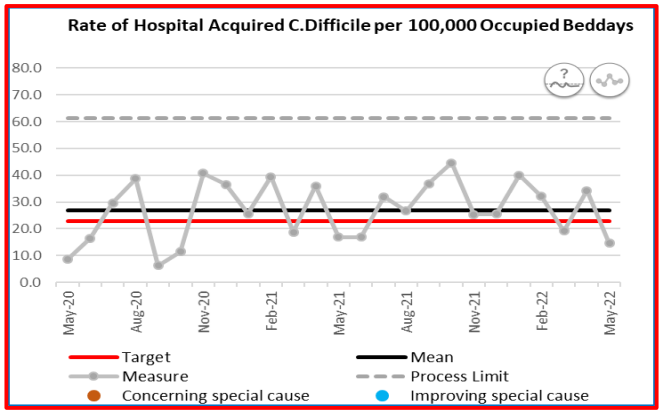
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Equipment-lack of / faulty / incorrect use	Resource/ Finance/ historical organizational working.	Leads on Working Group A has completed the ward equipment audit on the six target wards and results report to be produced and shared with the group to determine next steps	Falls Working group A	23/06/22
Equipment-lack of / faulty / incorrect use	Resource/ Finance/ historical organizational working.	Falls Alarm monitor replacement- Business case submitted for presentation to panel on 14/06/22 for approval.	Lead Nurse for Falls prevention	14/06/22
Inconsistent monitoring of patients	assessment not specific to ED	ED specific assessment documents being drawn up. 'Think Yellow' 3 month trial recommenced on 21/05/22 following resolution of stock issues.	ED Matrons /Falls Lead Nurse	22/07/22
Multiple ward moves/ inappropriate bed allocation	High risk patient and appropriate beds for high risk patient on wards not identified.	Implemented high risk falls room so the CCC can allocate the most appropriate patients into those rooms. Discussion to support Project on no more than three moves to be held.	Working Group B	28/06/22
Lack of capacity to support and deliver services in the clinical setting	Finance and staff numbers/ workload	Recruitment for Falls Prevention Practitioner to support the falls prevention agenda and focus work. Candidate employment checks successful. Start date 18/07/2022 to be confirmed.	Lead Nurse for Falls prevention	17/06/22

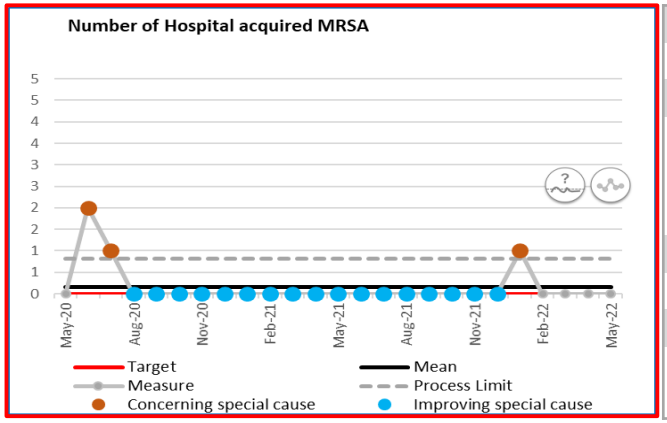
Patient Safety and Clinical Effectiveness: CQC: Safe



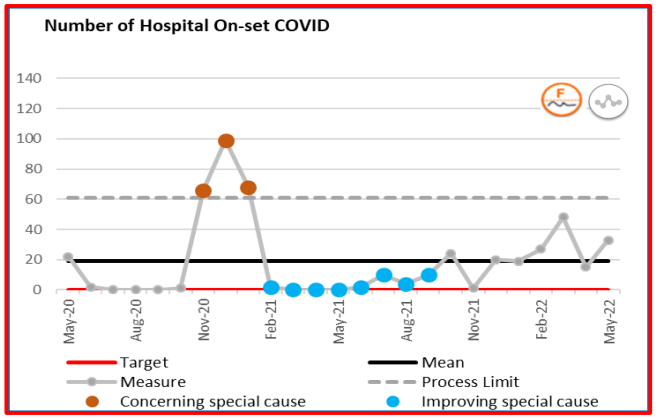
May-22
92.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Target (Internal)
93.3%
Business Rule
Full Escalation as has not achieved the target for > 6 months



May-22
14.6
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
22.7
Business Rule
Full Escalation as Hit or Miss > 6 months



May-22
0
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target
0
Business Rule
Full Escalation as Hit or Miss > 6 months



May-22
33
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6 months
Max Target (Intern
0
Business Rule
Full Escalation as has not achieved the target for > 6 months

Summary:

Safe Staffing Fill Rate: The level reported continues to experience common cause variation and has not achieved the standard for more than six months.

Rate of C.Difficile: continues to experience common cause variation and variable achievement of the target.

MRSA: The level of MRSA has stayed at o and is in common cause variation and variable achievement of the target

Hospital on-set COVID: This indicator is experiencing common cause variation and has failed to achieved the target of zero for more than six months.

Actions:

Safe Staffing Fill Rate: Daily staffing huddles review nursing and midwifery rosters. The temporary staffing team continue to attend site meetings. The Matrons afternoon staffing huddle are supported by the Bank team and Senior corporate nursing team. There is ongoing focus on Recruitment Activity, including International Recruitment. Recruitment trips to the Philippines and the Caribbean have been arranged. Retention Committee working groups continue to focus on the reduction of Nursing, Midwifery and Clinical Support Workers (CSWs) turnover rates. Focused work on roster performance has commenced to mitigate staffing risks going forward. 'Confirm and Support' meetings are being held to ensure compliance with rostering KPI's and to assist clinical teams with effective rostering.

Infection Control: The Trust has seen an increase in numbers of Trust attributable C.difficile cases, and has breached our trajectory of 58 cases. A large proportion of were deemed to be unavoidable on RCA, those cases that were deemed to be avoidable were largely due to inappropriate antimicrobial prescribing which has been feedback to teams. We continue to drive the appropriate prescribing of antimicrobials and the completion of C.difficile risk assessments. During April the IPC team will undertake rapid C.difficile RCA and table top reviews to support and release staff time on the wards.

The Trust is experiencing a number of Covid outbreaks which has seen a fairly high transmission rate in bays where a Covid positive patient has been identified, this is reflective of increasing community Covid rates and staff positives. Outbreaks are managed through Trust wide outbreak meetings which identify areas for action.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Regular staffing huddles with Divisional leads and Staff Bank review substantive and temporary staffing requirements across all areas. All staffing levels are reviewed, with oversight and appropriate redeployment monitored by the Senior Nurse Leadership Team. Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. This is now recorded through a share point to ensure accuracy of data. Incentive packages were closed on the 6th June 2022. The Trust continues to roll out SafeCare and now has 19 units live with 7 in the implementation stages. All inpatient units are now in live or roll out phase of SafeCare. Phase 2, operational embedding for the SafeCare project will be actioned within the next two weeks. Recruitment activity continues to move at pace with a focus on International recruitment. Projected mapping up until December 2022 is underway to inform recruitment numbers required. Face to face recruitment events have recommenced and have had good attendance.

Infection Control: The Infection prevention team will continue to monitor and escalate where infection and nosocomial rates are rising, RCA scrutiny will continue for alert organisms including C.difficile.

Covid-19 outbreak management meetings continue to be a high priority in the Trust, and we continue with precautions to help minimise the spread of infection such as restricted visiting, patients screening and staff LFD testing.

Strategic Theme: Patient Access

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	We will ensure no patient waits longer than 52 week for treatment by April 2022	0	0	May-22	0	0	Apr-22	Driver			Note Performance
	Responsive	We will achieve the RTT Submitted Trajectory	73.8%	71.1%	May-22	72.3%	69.8%	Apr-22	Driver			Full CMS
Breakthrough Objectives	Responsive	Ensure activity levels match those pre-Covid - Total Elective Activity (Plan and Actual) as a % of 1920 Activity	91.5%	85.2%	May-22	93.2%	94.6%	Apr-22	Driver			Full CMS
	Responsive	Ensure activity levels match those pre-Covid - Total First Outpatients Activity (Plan and Actual) as a % of 1920 Activity	112.2%	96.1%	May-22	109.3%	85.5%	Apr-22	Driver			Full CMS
	Responsive	Ensure activity levels match those pre-Covid - Total Follow Up Outpatients Activity (Plan and Actual) as a % of 1920 Activity	88%	104%	May-22	87%	96%	Apr-22	Driver			Verbal CMS
	Responsive	Ensure activity levels match those pre-Covid - Total MRI Activity (Plan and Actual) as a % of 1920 Activity	146%	137%	May-22	117%	119%	Apr-22	Driver			Full CMS
	Responsive	Ensure activity levels match those pre-Covid - Total CT Scan Activity (Plan and Actual) as a % of 1920 Activity	122%	137%	May-22	120%	132%	Apr-22	Driver			Verbal CMS
	Responsive	Ensure activity levels match those pre-Covid - Total NOUS Activity (Plan and Actual) as a % of 1920 Activity	98%	104%	May-22	93%	83%	Apr-22	Driver			Verbal CMS

Strategic Theme: Patient Access - continued

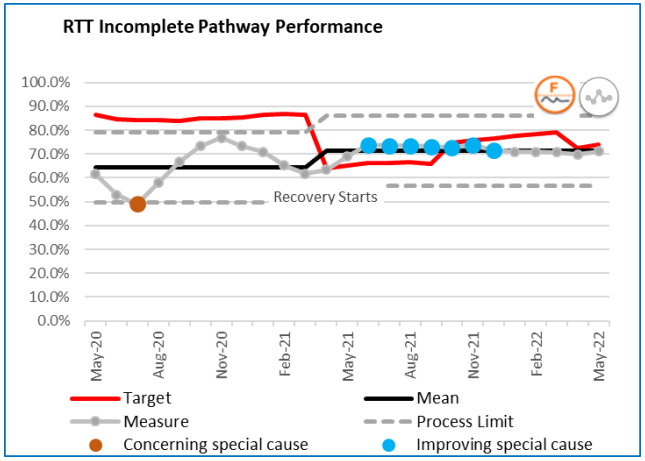
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	56.4%	May-22	85.0%	53.5%	Apr-22	Driver			Escalation
	Responsive	Access to Diagnostics (<6weeks standard)	85.6%	95.9%	May-22	87.0%	82.3%	Apr-22	Driver			Not Escalated
	Responsive	A&E 4 hr Performance	91.3%	84.0%	May-22	89.5%	79.8%	Apr-22	Driver			Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	89.5%	Apr-22	93.0%	94.2%	Mar-22	Driver			Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.7%	Apr-22	85.0%	85.3%	Apr-22	Driver			Not Escalated
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	3.2%	May-22	1.5%	2.5%	Apr-22	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	69.9%	May-22	90.0%	62.6%	Apr-22	Driver			Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	7.0%	11.8%	May-22	7.0%	14.6%	Apr-22	Driver			Escalation
	Effective	Flow: Super Stranded Patients	80	171	May-22	80	138	Apr-22	Driver			Escalation
	Effective	Flow: % of Emergency Admissions that are zero LOS (SDEC)	35.0%	47.1%	May-22	35.0%	44.7%	Apr-22	Driver			Not Escalated
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	62.3%	May-22	65.0%	59.1%	Apr-22	Driver			Escalation
	Effective	Patients not meeting the criteria to reside (MFFD)	TBC	208	May-22	TBC	166	Apr-22	Driver	No SPC	No SPC	
	Effective	Bed Days not meeting the criteria to reside (MFFD)	TBC	1385	May-22	TBC	1324	Apr-22	Driver	No SPC	No SPC	

Vision: Counter Measure Summary

Project/Metric Name – By April 2022 we will achieved the RTT National Standard

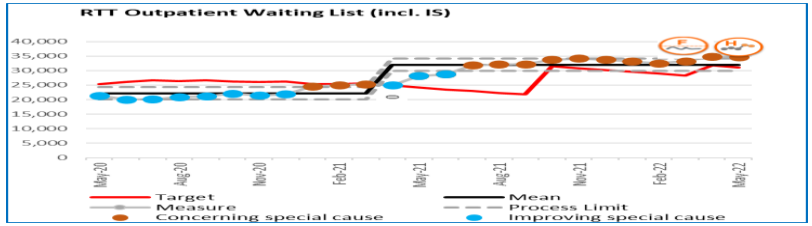
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

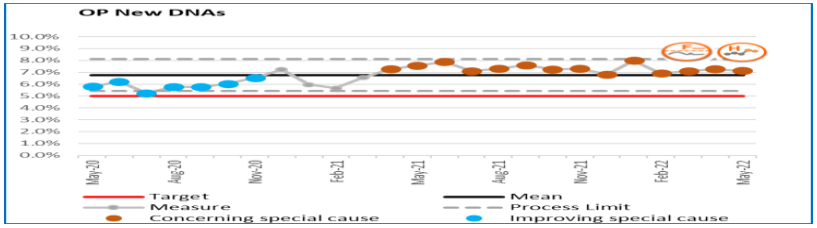
1. Historic Trend Data



May-22
71.1%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
73.8%
Target Achievement
Metric has failed the target for >6 months

2. Stratified Data





3. Top Contributors

This counter measure summary is under review and a revised summary slide will be completed by June 22.

4. Action Plan

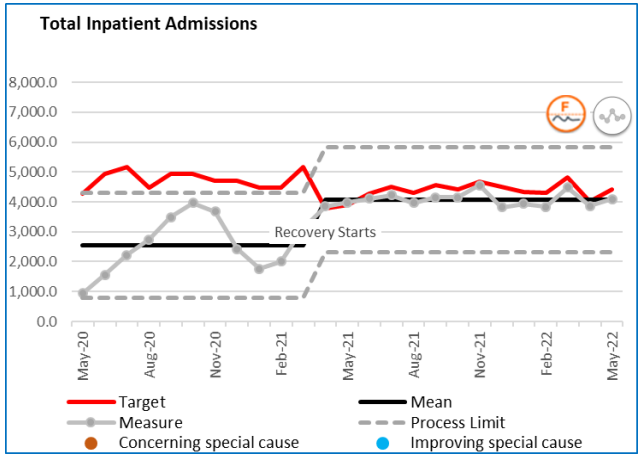
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
New Outpatient backlog	Reduced capacity due to pandemic	Implementing 104% activity targets Reduction in DNA's	DDO's, GM's	Ongoing
Reduction in clinic utilisation (target 90%)	Increase in DNA rates	Directorates to review DNA rates and any over 10% to implement an improvement action plan	GM's	Ongoing
Booking process	Correct booking process not robustly being followed	Action to be agreed	GM's, DDO's RTT Training Team	Ongoing

Breakthrough Objective: Counter Measure Summary

Project/Metric Name –Ensure Elective Activity Levels match those pre-Covid: Total Elective

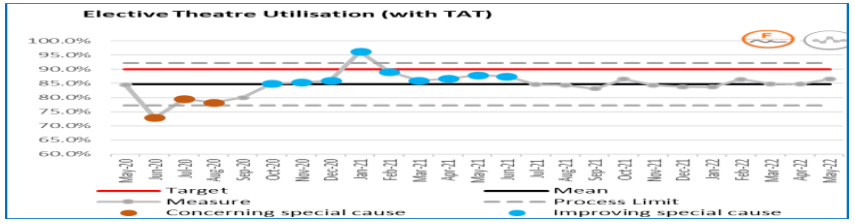
Owner: Sean Briggs
Metric: Elective Activity: Total Elective
Desired Trend: 7 consecutive data points above the mean

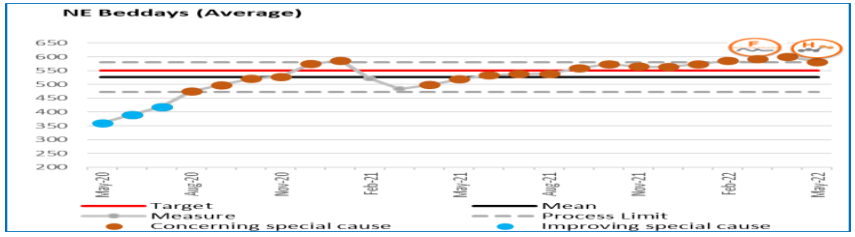
1. Historic Trend Data



May-22
4096
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4431
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data





3. Top Contributors

This counter measure summary is under review and revised summary slide will be completed by June 22.

4. Action Plan

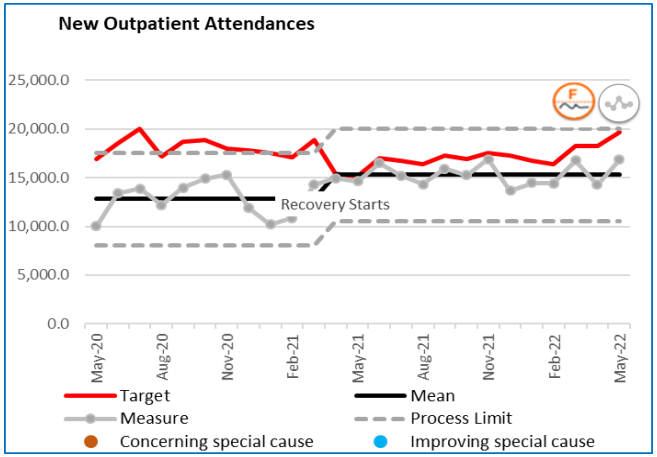
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Closure of 1 theatre at TW due to staffing and increased NEL demand	Activity monitored weekly and day case activity increased. Theatre plan to reopen after following the Improving Flow weeks at the beginning of May.	GM's	June 22
Outsource activity below plan	Lack of capacity and reduction in workforce due to covid sickness	Activity monitored weekly. Weekly operational meetings with the IS	DDOO Surgery	On-going
Cancelled Operations	POA not signed off	Monitored weekly at Directorate PTL and through theatre scheduling meetings	GM's	In progress
Theatre Utilisaton	Theatres not utilised to 85% trajectory without TAT	Monitored weeks at Directorate PTL Monitored at monthly TUB	GM's/PM	
List Under booked	Operating times on NCR form does not always match the clinicians average operating time taken from Theatreman.	Bookers to confirm operating time with clinician and adjust theatre schedule accordingly.	CAU's	In progress

Breakthrough Objective: Counter Measure Summary

Project/Metric Name – Ensure Elective Activity Levels match those pre-Covid: New Outpatients

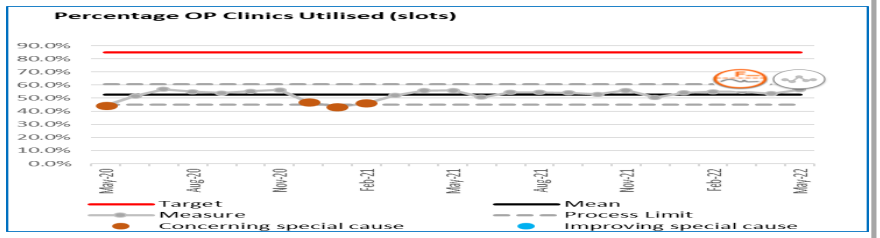
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

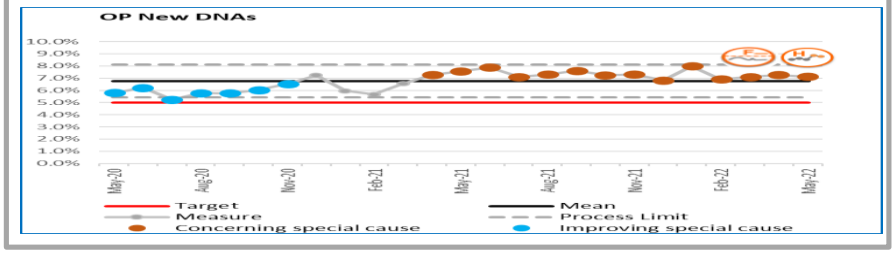
1. Historic Trend Data



May-22
16,856
Variance Type
Metric is currently experiencing Common Cause Variation
Target
19,662
Target Achievement
Metric is consistently failing the target

2. Stratified Data





3. Top Contributors

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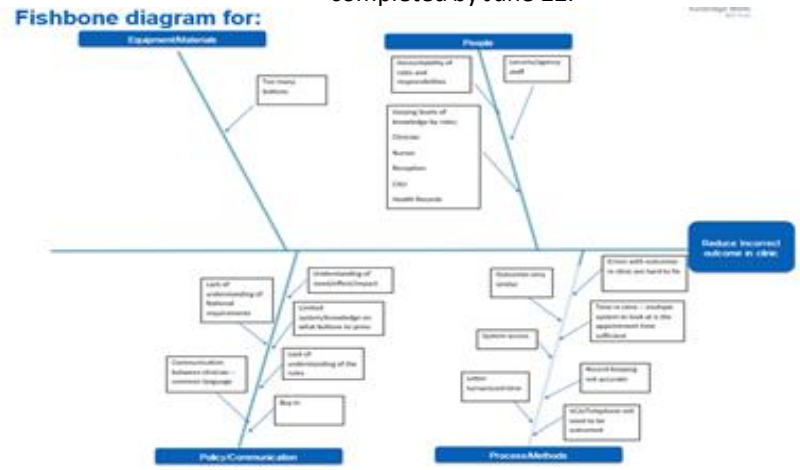


4. Action Plan

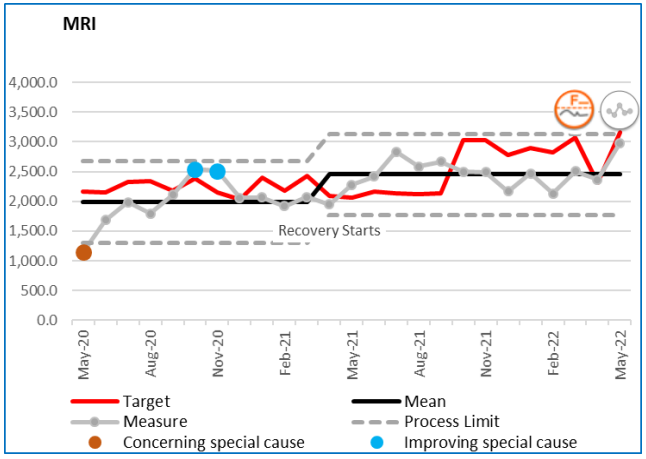
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Clinics not cancelled with 6 weeks notice if specialty cant utilise	Activity monitored weekly. Weekly OPA scheduling meeting.- including the 6-4-2 process Monitored weekly at Directorate PTL	GM's	In progress
Outsource activity below plan	Lack of capacity and reduction in workforce due to covid sickness	Activity monitored weekly. Weekly operational meetings with the IS	DDOO Surgery	In progress
Reduction in clinic utilisation (target 90%)	Increase in DNA rates	Directorates to review DNA rates and any over 10% to implement an improvement action plan	GM's/TL	In progress
DNA's	Communication	Review of wording on clinic letters	RTT Op Lead	Implemented

Breakthrough Objective: Counter Measure Summary

Project/Metric Name –Ensure Diagnostic Activity Levels match those pre-Covid: MRI

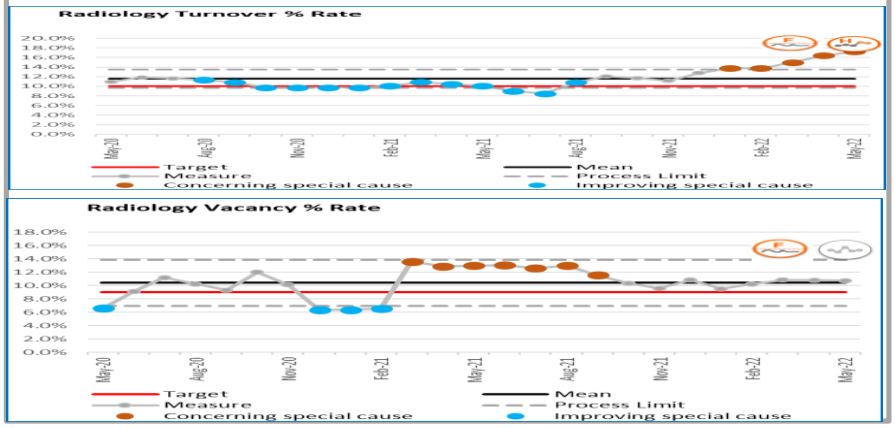
Owner: Sean Briggs
Metric: Diagnostic Activity: MRI
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data

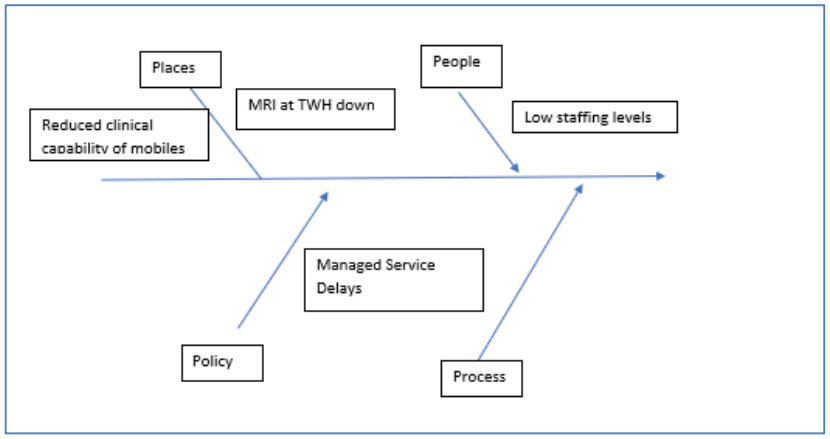


May-22
2982
Variance Type
Metric is currently experiencing Common Cause Variation
Target
3167
Target Achievement
Metric has failed the target for >6 months

2. Stratified Data



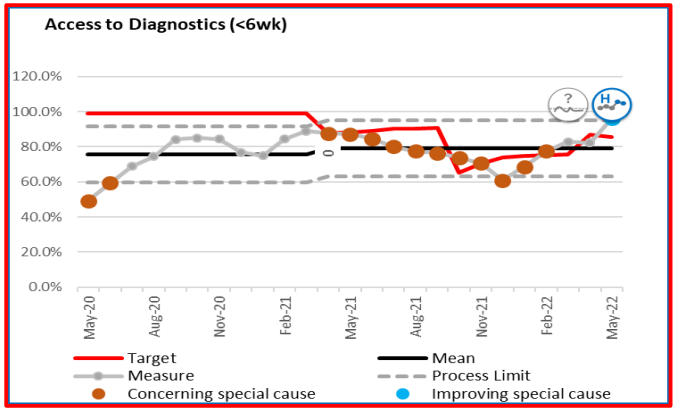
3. Top Contributors



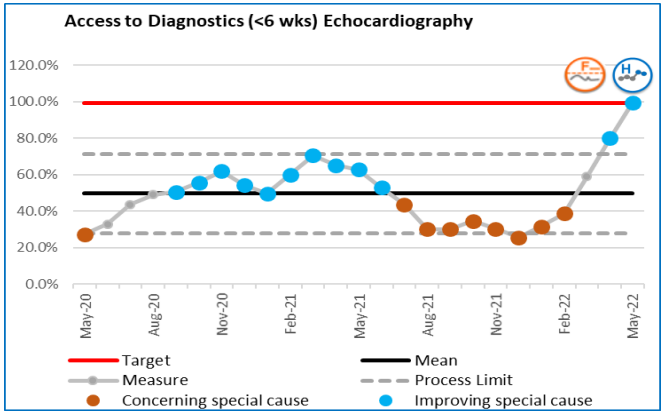
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Setting up of new Community Diagnostic Centre (CDC)	CDC capacity not yet optimized due to • Limited contrast cover • Limited protocols on old scanner from Inhealth. Poor through put on old scanner technology. • No expansion in booking staff at start up of CDC • Layout of scanners not optimal for efficient patient flow	• Capacity meetings with both providers in CDC to improve through put. • Recruitment of booking staff • Recruitment of helpers to improve patient flow • Newer MRI scanner delivered on 6th June will improve TaTs • AAT software being loaded onto in house scanners = 40% efficiencies forecast by NHSEi		July 2022
Staffing vacancies and less outsourcing	Loss of staff associated with concerns re managed service proposal – unable to recruit locally due to poor reputation Low staff moral – evidenced by lower uptake of voluntary weekends.	Managed service business case approved by NHSE – working towards 3 month implementations		Sept 2022

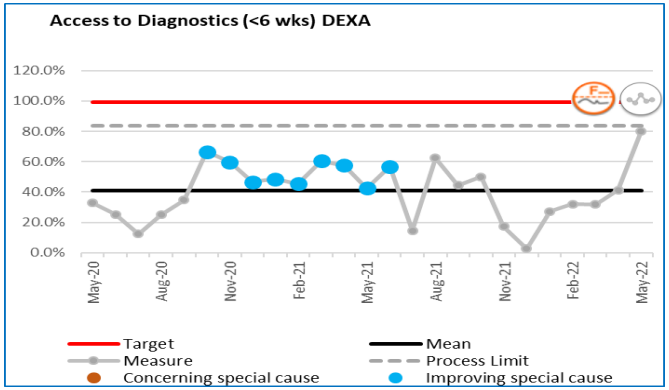
Patient Access – Diagnostics Waiting Times: CQC Responsive



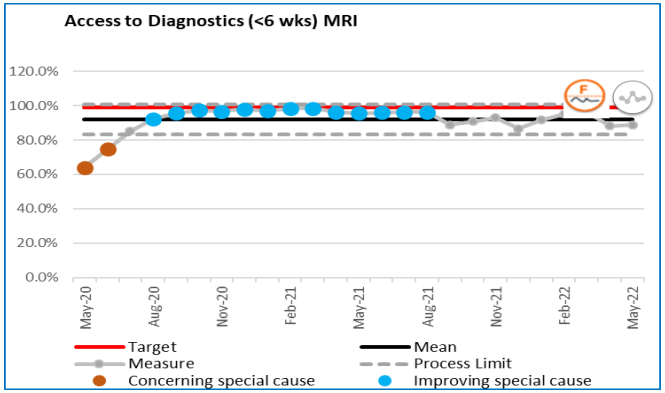
May-22
95.9%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and variable achievement of the target
Target (Internal)
85.6%
Business Rule
Full Escalation as Hit or Miss > 6 months



May-22
99.3%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
99%
Business Rule
For Information as Contributor to Overall



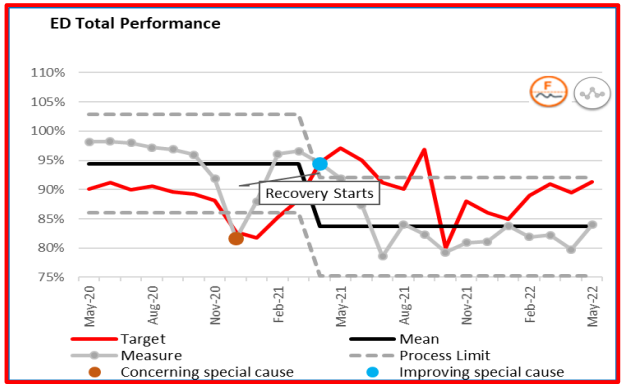
May-22
80%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
99%
Business Rule
For Information as Contributor to Overall



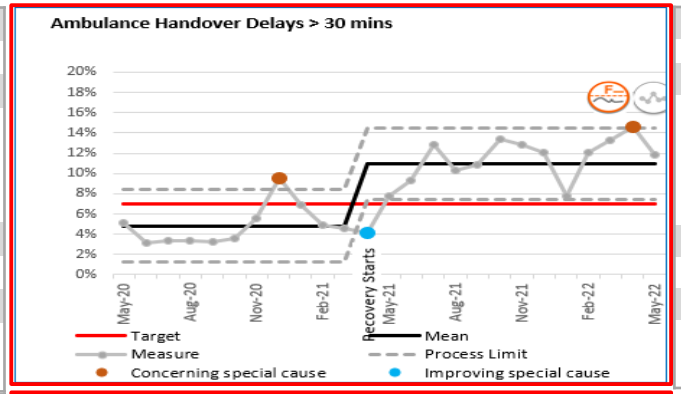
May-22
88.8%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for more than six months
Target (Internal)
99%
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Diagnostic Waiting Times: Performance is now experiencing special cause variation of an improving nature and variable achievement of the target. This three biggest contributors to the improvement are Echocardiography, DEXA and MRI. **MRI:** is experiencing common cause variation but has now failed the target for more than six months. **Echocardiography:** is experiencing special cause variation of an improving nature and consistently failing the target but has seen a significant increase in performance for April 22. **DEXA:** is experiencing common cause variation and consistently failing the target largely due to a lack of capacity.	**Echocardiography:** The cardiology team have implemented an improvement plan. **DEXA:** New DEXA in place at TWH and activity commenced. Additional outsourcing agreement with Medway agreed and implemented. **MRI:** Progression of Managed MRI contract alongside CDC efficiency work	**Echocardiography:** Insourcing has commenced to support the internal recovery plan. Plan is monitored weekly with DCOO. **DEXA:** Recovery plan in progress and is monitored weekly with DCOO. The plan is on track to be DM01 compliant by the end of July 22 – slippage due to staff sickness and outsourcing issues. **MRI:** Scanner arrived w/comm 14/03/22 and is a managed service providing an additional 183 slots per week. Managed MRI FBC approved by NHSE. Implementation work to begin with 3 month aimed target time.

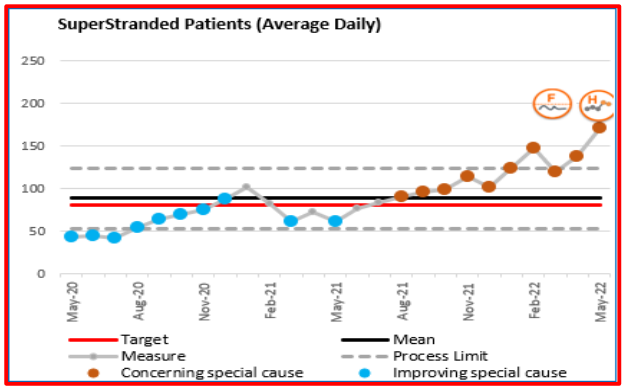
Patient Access – Hospital Flow: CQC: Responsive



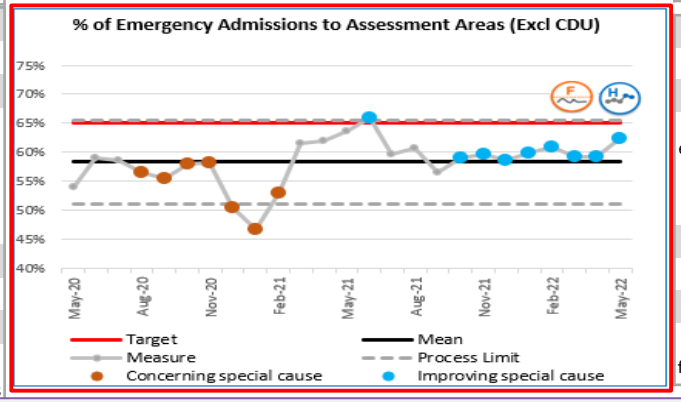
May-22
84.0%
Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months
Target (Internal)
91%
Business Rule
Full Escalation as has failed the target for > 6 months



May-22
11.8%
Variance / Assurance
Metric is currently experiencing Common Cause variation and is consistently failing the target
Max Limit (Internal)
7%
Business Rule
Full Escalation as is consistently failing the target



May-22
171
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months
Max Limit (Internal)
80
Business Rule
Full Escalation as has failed target for >6 months



May-22
62.3%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and has failed the target for >6 months
Target
65%
Business Rule
Full Escalation as has failed target for >6 months

Summary:

ED 4hr performance (inc MIU): This indicator is now experiencing common cause variation and has failed the target for more than six months

Ambulance Handover Delays of >30 minutes is experiencing common cause variation and is consistently failing the target.

Super Stranded Patients: is experiencing special cause variation of a concerning nature and has failed the target for more than six months

% of Emergency Admissions to Assessment Areas: is experiencing special cause variation of an improving nature, the AEC service has reached it performance target for > 6 months. Since the decision to de-escalate the AEC space in TWH, the Trust has seen an increase in its combine performance, the combined services have managed for stay over the targeted value of 33% of the medical take, the service at Maidstone has also extended its operation hours to finish at 10pm Monday to Friday.

Actions:

ED 4hr performance (inc MIU): The trust has maintained a strong position regionally and nationally. Improved work in SDEC areas will support sustained improvement.

Ambulance handover delays: Process of PIN entry now embedded , capacity issues remain in TW ED. Ambulance handovers undergoing an A3 approach, discussions in progress regarding digital solution.

Super-Stranded Patients : Performance improved this month but this has not been maintained. The main discharge block is domiciliary care for LT packages of care. Slow down in nursing home admissions caused by covid.

% of Emergency Admissions to Assessment Areas: Maidstone AEC is currently fully established with medical staff. We have also recruited international doctors to all our vacant post in TWH, currently going through pre-employment checks. The plan is to extend the operating hours to match MH when the substantive doctors arrive.

Assurance & Timescales for Improvement:

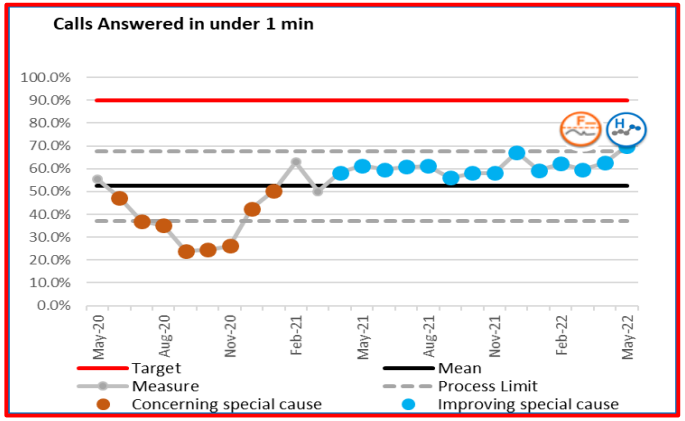
ED 4hr performance (inc MIU): Continue with ED improvement huddles

Ambulance handovers delays: Maidstone performed at 92.8% and TW 85.4%. Improved performance in May compared with April. Daily review of breaches maintained.

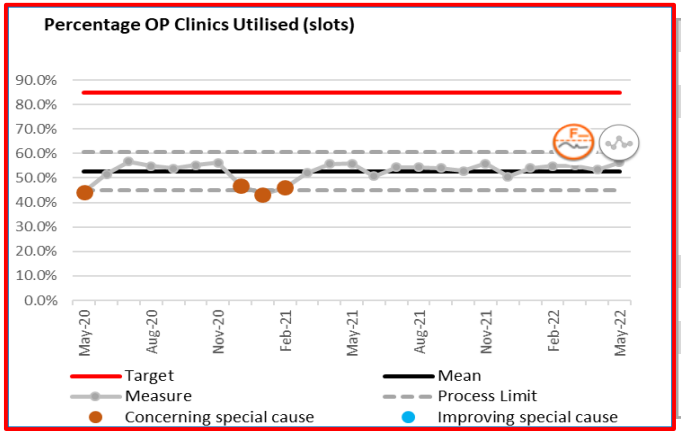
Super stranded patients: Monthly MADE events to bring an MDT approach. Improved understanding of pathways and introduction of resource packages.

% of Emergency Admissions to Assessment Areas: A weekly review of the AEC performance dashboard is done within the operational team to monitor performance. This information is shared with the clinical team that they may be aware of how well or poor they are performing. Any areas identified for improvement is discussed in the monthly performance meeting between the operational team and the clinicians. Currently receive recruitment update on a weekly basis that we may be able to monitor the progress of the recruited staff going through pre-employment checks.

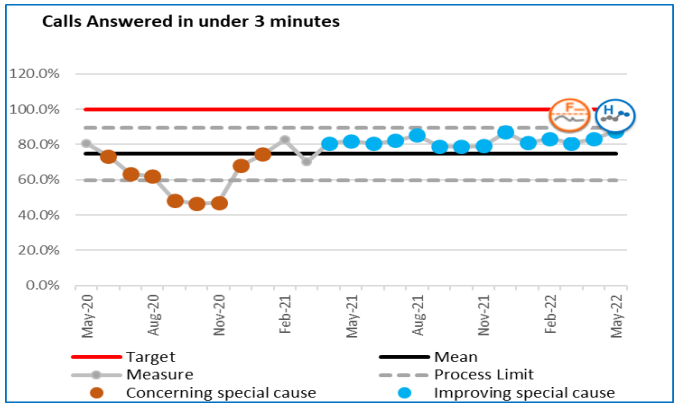
Patient Access – Transformation: Outpatients: CQC: Responsive



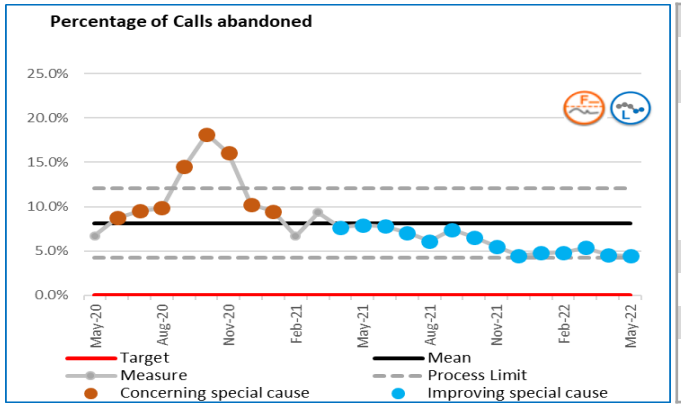
May-22
69.9%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Mar-22
56.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation



Mat-22
87.6%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
100%
Business Rule
For Information as linked to Calls <1min



May-22
4.4%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
0%
Business Rule
For Information as linked to Calls <1min

Summary:

Calls Answered: The number of calls answered in less than 1 minute is experiencing special cause variation of an improving nature and remains consistently failing the target.

Outpatient Utilisation: This indicator continues to experience common cause variation and consistently failing the target

Actions:

Calls Answered: Investigating spacing options in which to house call operatives for the outpatient communication centre pilot to improve this. Continuous monitoring of the CAU's. Pilot with T&O- two bank staff to support the T&O CAU acting as first point of contact to screen calls is being implemented and other CAUSs are being contacted to discuss the option of extra support. July 2022. Looking to introduce a web-based patient outpatient appointment form for re-booking/cancelling appointments to reduce CAU call volume – July 2022

Outpatient Utilisation: The Clinical System Development Managers reviewed over 99% of the clinic templates on Allscripts, and removed historic clinics that were no longer required. Following the completion of the work above a review of nurse led clinics across specialities will be undertaken which have been identified as having low utilisation rates. August 2022

Assurance & Timescales for Improvement:

Weekly meeting with specialties are undertaken to go through call KPIs to understand areas for improvement and reasonings for poor performance. Further actions are being progressed, detailed in the Escalation Page

Outpatient Utilisation: Further analysis of utilisation is being completed to understand reasonings and a number of options are being explored and actioned by the Clinical System Development Managers to improve utilisation. Comprehensive plan to be developed to address clinic slot utilisation. July 2022

Strategic Theme: Patient Experience

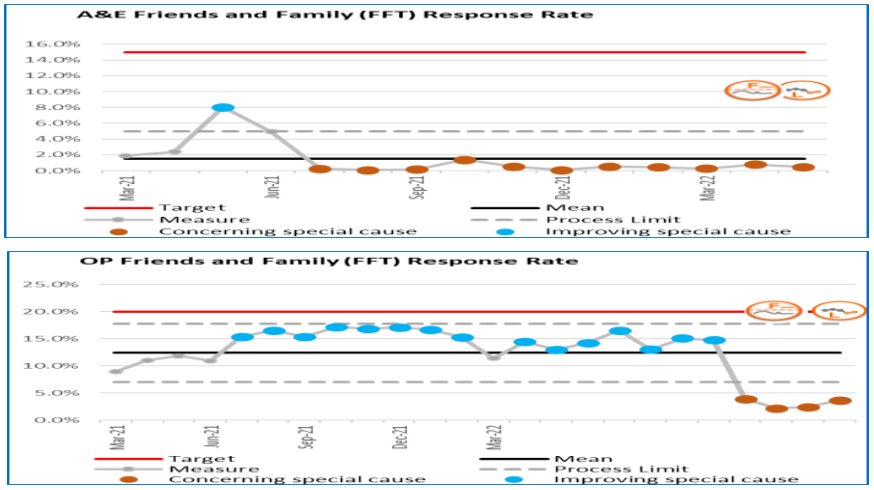
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	Maintain the National FFT positive response rate. Inpatients	95.0%	98.7%	May-22	95.0%	97.0%	Apr-22	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. A&E	87.0%	90.4%	May-22	87.0%	93.4%	Apr-22	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. Maternity	95.0%	100.0%	May-22	95.0%	98.3%	Apr-22	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. Outpatients	84.0%	85.6%	May-22	84.0%	89.9%	Apr-22	Driver		P	Note Performance
Breakthrough Objectives	Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target : Inpatients	25.0%	14.3%	May-22	25.0%	16.0%	Apr-22	Driver		F	Full CMS
	Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target A&E	15.0%	0.5%	May-22	15.0%	0.8%	Apr-22	Driver	L	F	Full CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Maternity	25.0%	9.4%	May-22	25.0%	12.7%	Apr-22	Driver	L	?	Verbal CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Outpatients	20.0%	3.7%	May-22	20.0%	2.4%	Apr-22	Driver	L	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	3.0	May-22	3.9	2	Apr-22	Driver		P	Not Escalated
	Caring	% complaints responded to within target	75.0%	66.7%	May-22	75.0%	22.7%	Apr-22	Driver		F	Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	95.3%	Apr-22	95.0%	96.0%	Mar-22	Driver		?	Verbal CMS

Breakthrough Objective: Counter Measure Summary

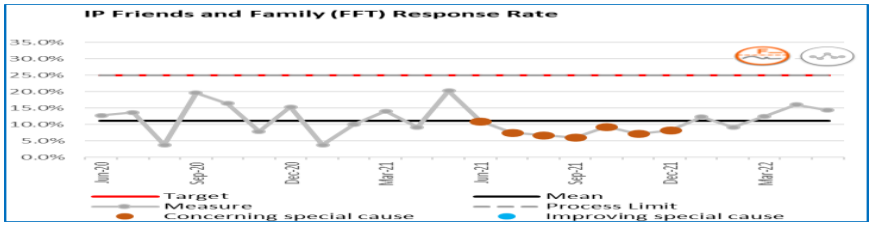
Metric Name – Increase Friends and Family Response Rates for A&E, Outpatients, Inpatients and Maternity

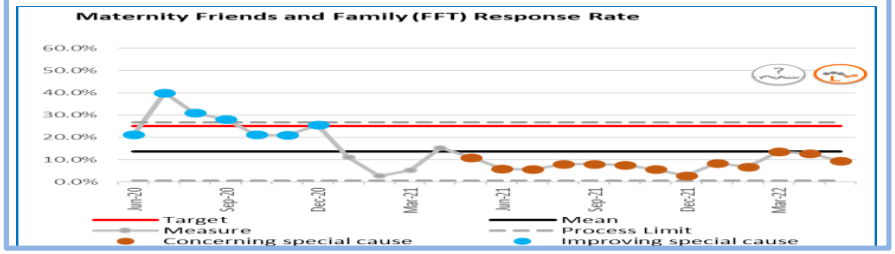
Owner: Joanna Haworth
Metric: FFT Response Rate – A&E, OP, IP, Mat
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data

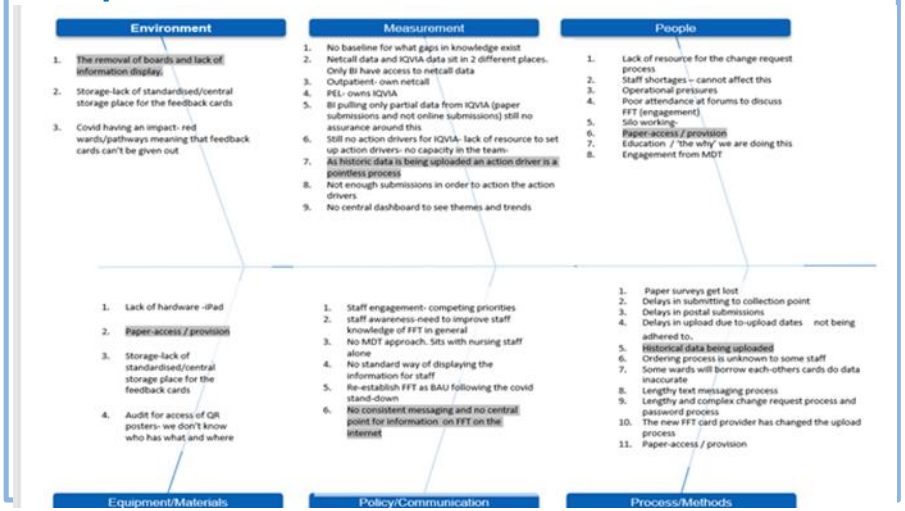


1. Historic Trend Data





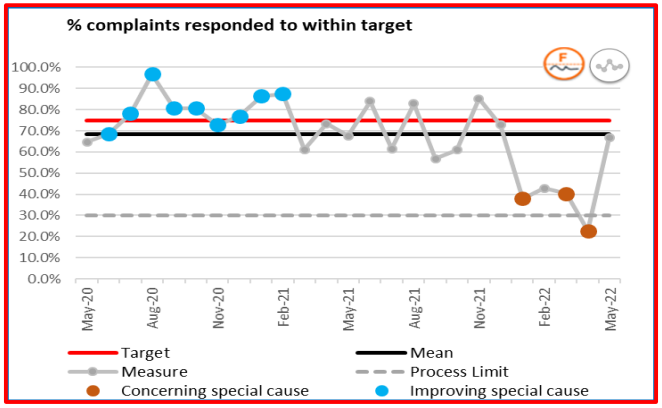
3. Top Contributors



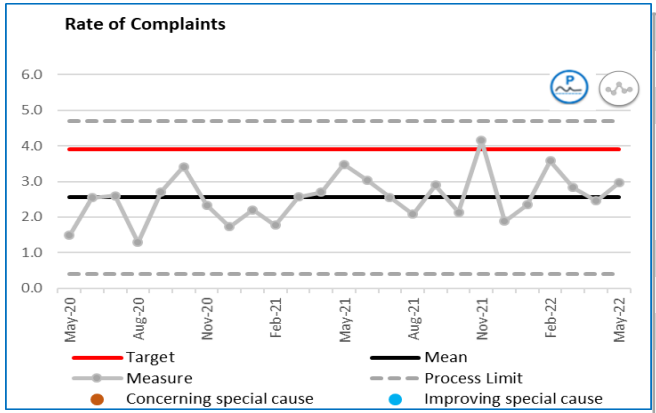
4. Action Plan

Contributor	Potential Root Cause	Solution/Countermeasure	Owner	Due by?
Reduction in Netcall OPD data	Patching did not resolve this issue	Comms ongoing with Netcall to resolve with OPD / IT. Update 14.06.22 – PE lead raised PO to procure contract to bring SMS into scope with Netcall. Testing to commence w/c 20.06.22	NL/SH / RS / CC /CM /JR	30.06.22
Poor responses in ED	Access to SMS text	Testing ongoing - support provided by SW in Med directorate Task and finish group to be set up between dept leads	NL/SW /MW / CM/JR	30.06.22
Service leads not accessing reports frequently	Push reporting not available / in correct format	NH creating action driver alert with IQVIA and requesting support from IQVIA to reformat reports. Update 14.06.2022 – testing has commenced in women's and children's division	NL/NH	30.06.22

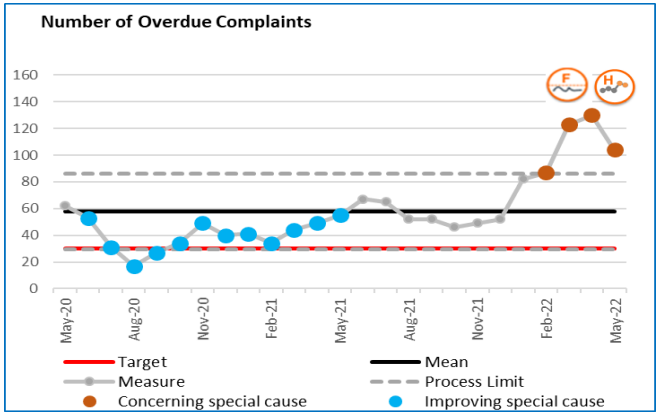
Patient Experience: CQC: Caring (Hit or Miss >6 months)



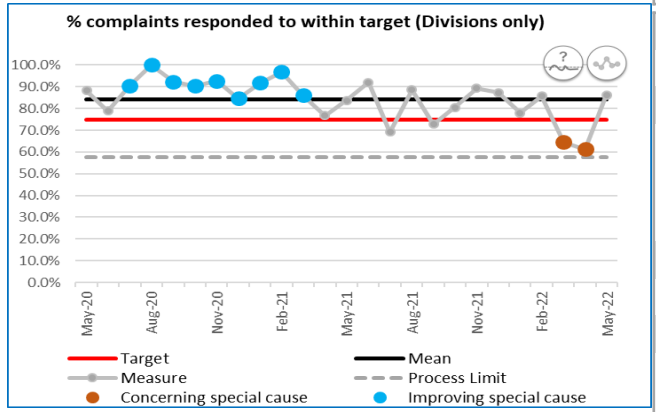
May-22
66.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Target (Internal)
75%
Business Rule
Full Escalation failed the target 6+ months



May-22
3.0
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
3.9
Business Rule
For information as is now passing the target for 6+ months



May-22
104
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Max Limit (Internal)
30
Business Rule
For Information as linked to % Complaint Responded



May-22
86.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
75%
Business Rule
For Information as linked to % Complaint Responded

Summary:

% Complaints responded to within Target: this indicator is experiencing special cause variation of a concerning nature and has been experiencing variable achievement of the target (Hit & Miss) for more than six months.

Rate of Complaints: This indicator has passed the target threshold once

Actions:

% Complaints responded to within Target:
Complaints performance recovery and stabilisation actions include;

- Recovery plan presented to ETM May 2022
- Additional temporary resource in place up to mid Sept 2022
- Complaints leads have weekly meetings with directorates / divisions who have the biggest outstanding volume
- Business case for revised complaints model (meeting new 2022 National framework) to be finalised by July 2022
- Briefing re: new national framework to be shared at Patient Experience Committee

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Expect upward shift in performance from June and stabilised performance from September 2022

Strategic Theme: Systems

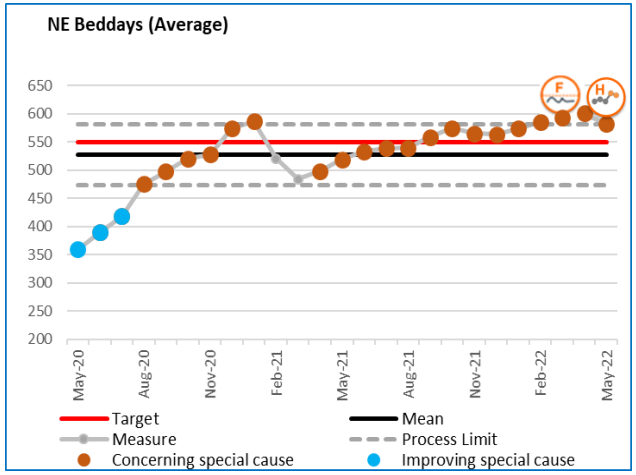
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).	550	581	May-22	550	601	Apr-22	Driver			Full CMS
Breakthrough Objectives	Effective	The target is to reduce the average non-elective bed days relating to patients with high and very high AEC conditions by 10%	3.90	4.27	May-22	3.90	2.78	Sep-21	Driver			Verbal CMS

Vision: Counter Measure Summary

Project/Metric Name – To reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).

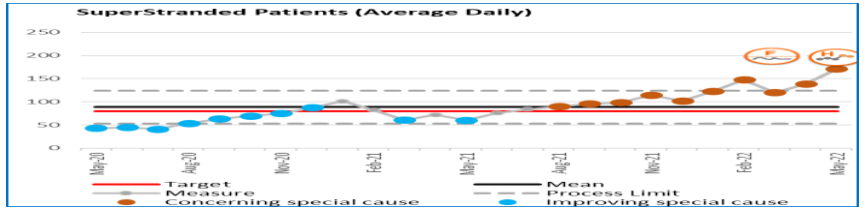
Owner: Rachel Jones
Metric: non-elective bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



May-22
581
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
550
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data



3. Top Contributors

	Top Contributor
1.	Out of Hospital Capacity - Pathway 3 Social Services
2.	Increased workforce gaps.
3.	Long length of stay mental health patients / patients waiting specialist beds.
4.	Increased ED Attendances

4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Lack of out of hospital capacity	Pathway 3 capacity	Daily system calls Discharge pathways working group.	LG	Ongoing
mental health	Lack of mental health beds and specialist neuro beds	Identify or purchase Neuro rehab beds – Mental health working group	SC	
Critical Staffing Levels	Increased Sickness	Staffing data validated Twice daily staffing huddles in place Robust plan to close escalation	HT	
Increased ED Attendances	Lack of capacity in Primary Care	Increased ED hot clinics Improve hospital avoidance schemes (home treatment service)	Amanjit Jhund	

Strategic Theme: Sustainability

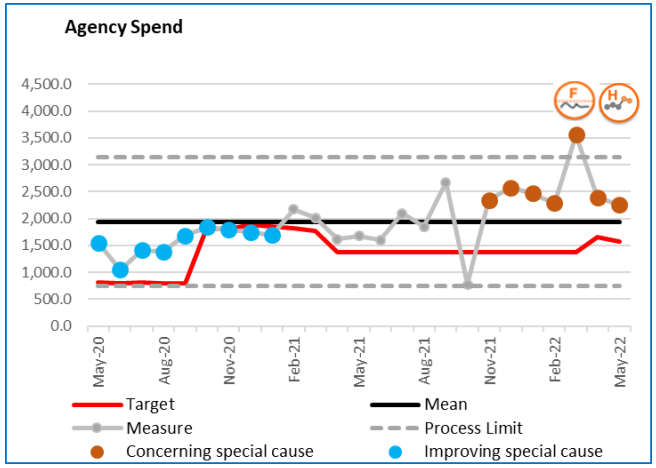
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	-2,604	-2,599	May-22	-1,528	-1528	Apr-22	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000	1580	2253	May-22	1654	2398	Apr-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	298	317	May-22	298	209	Apr-22	Driver			Not Escalated
	Well Led	Cash Balance (£k)	25375	25375	May-22	25375	22355	Apr-22	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	260	176	May-22	260	200	Apr-22	Driver			Not Escalated

Vision: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000

Owner: Steve Orpin
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

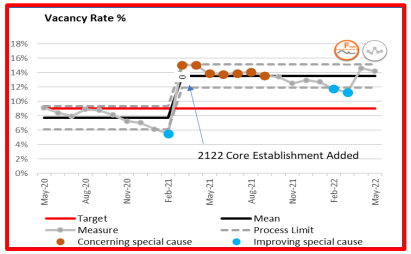
1. Historic Trend Data

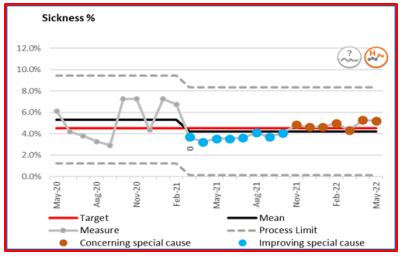


May-22
2,252
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
1,654
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data

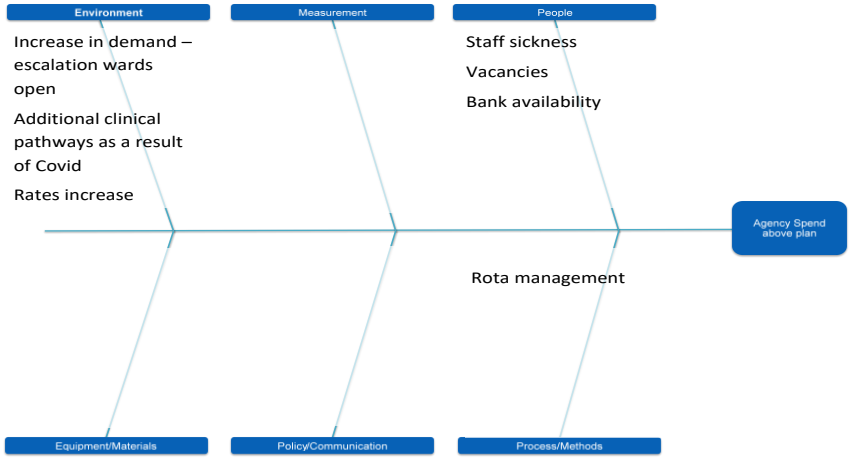
Reason	
Vacancy	48%
Back Filling	23%
Escalation / Demand	13%
COVID-19 Related	5%
Patient Special / Escort	5%
Other	4%
Sickness	3%





3. Top Contributors

Fishbone diagram for:



4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Increase in demand	Root cause to be identified using data	MEC Division to create action plan to understand increase in bookings	MEC leadership team	16/6/22
Rota Management	Specialties not all on same roster system	Roll out of rostering for medical taking place, all specialties to be added by end of June 22	Nicky Sharpington	30/6/22
People	Root cause to be identified using data	More analysis required to understand impact of short notice sickness and bank availability	MEC leadership team	16/6/22
Rates Increase	Shortage in staff leads to higher rates from agencies	Work with other K&M providers to avoid artificial price increases. Improve recruitment to reduce demand		

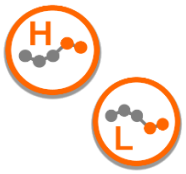
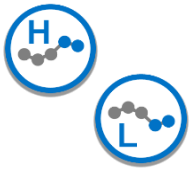
NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

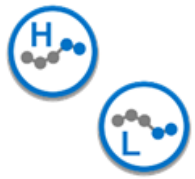
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is showing a Special Cause for Concern. A full CMS is required to support actions and delivery of a performance improvement. Consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is in Common Cause variation. A verbal CMS is required, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric

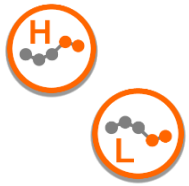
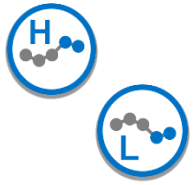
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance	Metric is in Common Cause, but is showing a Special Cause for Concern. **Note performance**, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is in Common Cause variation. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance	Metric is Hitting & Missing the Target and is in Common Cause variation. **Note performance**, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target and blue outline indicates this has continued for 6 months or more.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target, but is showing a Special Cause for Concern. A verbal CMS is required to support continued delivery of the target	Metric is Passing the Target, but is showing a Special Cause for Concern. Note performance, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is in Common Cause variation. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is in Common Cause variation. Note performance
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

A metric achieving the target for 6 months or more will be flagged as passing

Metrics that are **hit and miss** have:

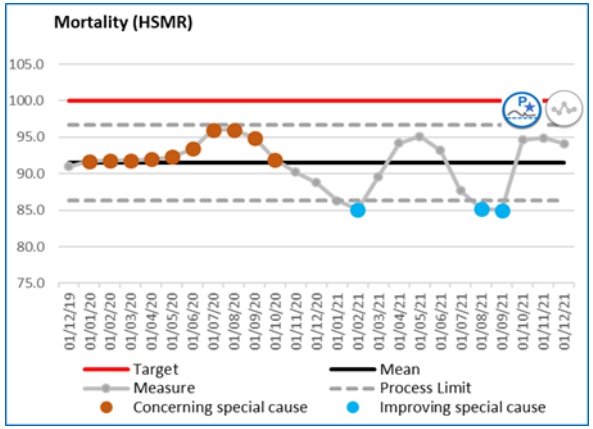
The **target** line **between** the **upper** and **lower** control limit for all metric types

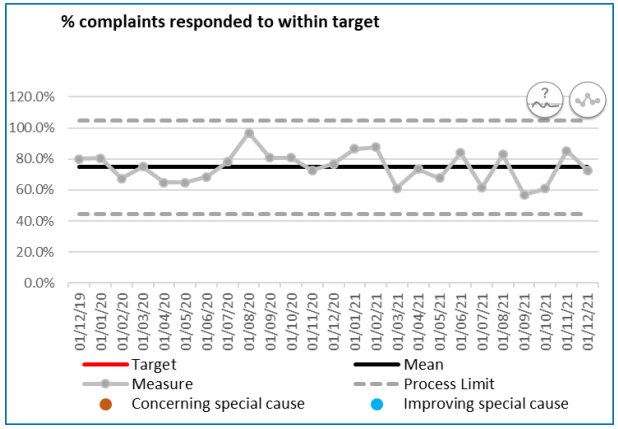
Metrics that consistently **fail** have:

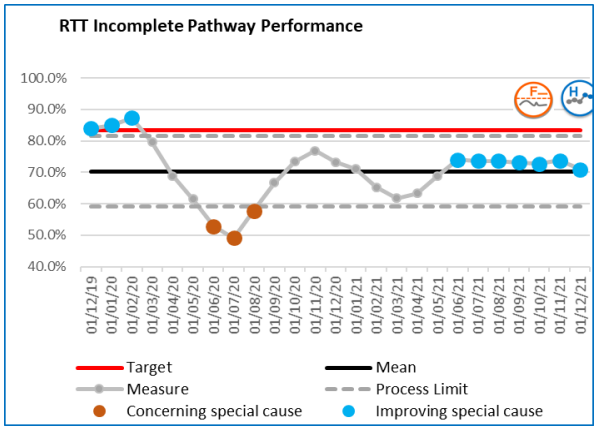
The **lower** control limit **above** the target line for metrics that need to be **below the target**

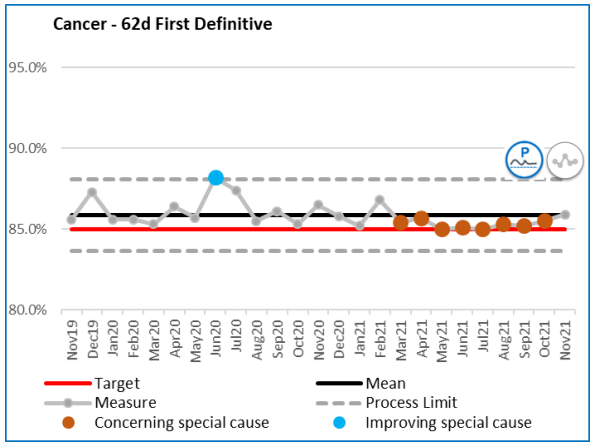
The **upper** control limit **below** the target line for metrics that need to be **above the target**

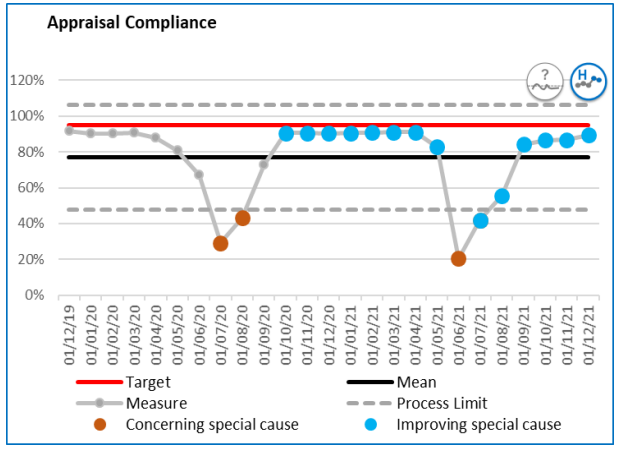
A metric not achieving the target for 6 months or more will be flagged as failing

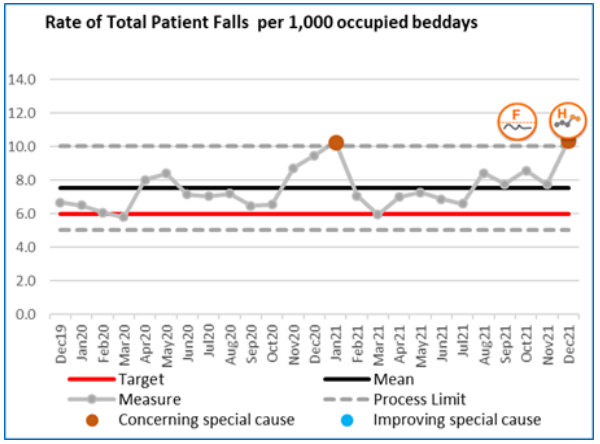












Executive Summary

- The Trust has delivered the May Plan and the Year to Date plan by delivery a deficit of £2.6m in month and £4.1m year to date.
- The key pressure is within pay budgets which are adverse to plan by £1.4m, this is mainly driven by overspends within Emergency Medicine medical staffing (£1.2m) and facilities staffing (£0.6m).
- The Trust has had to release £0.9m from reserves to help to part offset the pay pressures incurred.
- Cost Improvement Plans (CIP) are slightly behind plan with a year to date adverse position of £0.1m. The CIP plans are phased with further stepped increases required in July and October.
- There is a risk of £2.5m associated with Elective Recovery Fund (ERF) clawback as the Elective Activity in April and May was below 104% of 2019/20 levels. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Therefore, the month 2 position does not assume any ERF clawback.

Year to Date Financial Position

- The Trust was on plan, generating a £4.1m deficit.
- The Trust has released £0.3m of the general contingency reserve to offset the agreed continuation of enhanced bank rates.
- In line with NHSE/I guidance additional income (£0.8m) has been included in the position to offset additional costs for PCR swabbing and Rapid testing.
- The key year to date variances is as follows:
    - **Adverse Variances**
        - Pay budgets overspent by £1.4m. The main pressures continue to be within Emergency Medicine medical staffing (£1.2m) and facilities staffing (£0.6m). These pressures were partly offset by underspends within support to clinical staff (£0.4m) and Nursing (£0.1m).
        - Cost Improvement Plans were £0.1m adverse to plan which mainly related to delay in oncology provider to provider contract arrangements.
    - **Favourable Variances**
        - Release of £0.9m from reserves. The following reserves have been released: £0.4m from growth reserve to offset unfunded waiting list initiatives incurred, £0.3m from contingency and £0.2m from service developments to part offset some pay pressures in April.
        - Underspends within Clinical supplies and Elective outsourcing due to Elective activity below budget (£0.6m)

Risks

- Elective Activity in April and May was below 104% of 2019/20 levels which could result in an Elective Recovery Fund clawback of c£2.5m. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Therefore, the month 2 position does not assume any ERF clawback.

Current Month Financial Position

- The Trust was on plan generating a £2.6m deficit in the month.
- The Trust has released £0.1m of the general contingency reserve to offset the agreed continuation of enhanced bank rates.
- The key current month variances are as follows:
    - **Adverse Variances**

- Pay budgets overspent (net of £0.2m underspend against winter budget) by £0.7m. The main pressures continue to be within Emergency Medicine medical staffing (£0.6m), and £0.3m pressure within facilities, these pressures are partly offset by underspends within support to clinical staff (£0.2m).
- Non recurrent pressures within non pay (£0.3m) relating to MRI repair (£0.15m) and increase in doubtful debt (£0.15m)

- **Favourable Variances**
  - Release of reserves (£0.45m), £0.1m from general contingency, £0.15m from the growth reserve to offset unfunded waiting list initiatives incurred in May and £0.2m underspend against winter budget.
  - Non pay budgets underspends in the month by £0.5m mainly due to Pathology reagents (£0.35m) and elective outsourcing being less than plan (£0.1m)

Cashflow

- The closing cash balance at the end of May 2022 was £25.4m which is an increase by £3m from the April cash position of £22.4m, the increase is primarily due to K&M CCG paying slightly more than the agreed SLA income value, this will be corrected by the CCG from month 3.
- The cash flow is updated daily to ensure that the Trust can meet all its commitments as well as working towards ensuring prompt payment is made to suppliers. Within the April and May the Trust has paid £4m of capital invoices from the outstanding year end creditors of £5.8m.

Capital Position

- The Trust's capital plan, excluding IFRS 16 items, agreed with the ICS for 2022/23 is £41.3m comprising:
- Net Internal funding (£8.6m):
  - £19.5m depreciation
  - less £2.5m in-year cash surplus (balancing to ICS control total)
  - less £8.4m of PFI finance and capital investment loan repayment
- PFI lifecycle per Project model of £1.3m - actual spend will be notified periodically by the Project Company.
- Donated Assets of £0.4m relating to forecast donations in year.
- System PDC of £1.95m for HASU (to be approved) and
- National PDC of £29m for Barn Theatre (to be approved)
- The Plan figure of £41.3m includes:
- Estates: Enabling schemes include contractual commitments from 21/22 relating to enabling works for Linacs and SPECT CT equipment, as well as MRI enabling/build works at MGH and TWH (relating to In-Health proposed contract). Backlog schemes includes carry forward spend from projects that commenced in 2021/22 e.g. Annexe and Oncology OPD. Works for ventilation systems and chiller units at MGH.
- ICT: ICT schemes include EPMA costs relate to contractual commitments, IT for KMMS, iPro Anaesthetics, EPR infrastructure upgrade, eChemo prescribing, PACS replacement and devices replacement.
- Equipment: Includes contractual commitments from 21/22 relating to schemes that could not be delivered by 31st March due to supplier issues. Other equipment schemes are now being re-prioritised.
- Externally Funded schemes: Includes £1.9m for the HASU and £29m for the Barn Theatre (includes estates, ICT and equipment), both are waiting for the business cases to be approved.
- The Year to date spend on capital is £0.4m which is in line with in the plan. The majority of this relates to Estates and Equipment Backlog carry forward spend from projects commenced in 2021/22 e.g. Annexe & Oncology OPD and kitchen dishwasher.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 2
2022/23

Maidstone and Tunbridge Wells NHS Trust

Dashboard

May 2022/23

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-through	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	51.5	51.8	(0.3)	(0.4)	0.0	102.9	103.7	(0.7)	(0.7)	(0.0)
Expenditure	(50.4)	(50.7)	0.3	0.4	(0.0)	(99.6)	(100.3)	0.6	0.7	(0.0)
EBITDA (Income less Expenditure)	1.1	1.2	(0.0)	0.0	(0.0)	3.3	3.4	(0.1)	0.0	(0.1)
Financing Costs	(3.8)	(3.8)	0.0	0.0	0.0	(7.5)	(7.6)	0.1	0.0	0.1
Technical Adjustments	0.1	0.1	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0
Net Surplus / Deficit (Incl Top Up funding support)	**(2.6)**	**(2.6)**	**0.0**	**0.0**	**0.0**	**(4.1)**	**(4.1)**	**0.0**	**0.0**	**0.0**
Cash Balance	25.4	25.4	0.0		0.0	25.4	25.4	0.0		0.0
Capital Expenditure (Incl Donated Assets)	0.2	0.3	0.1		0.1	0.4	0.4	(0.0)		(0.0)
Cost Improvement Plan (Internal £30m target)	0.3	0.3	0.0		0.0	0.5	0.6	(0.1)		(0.1)

Summary Current Month:

- The Trust was on plan generating a £2.6m deficit in the month.
- The Trust released £0.1m from the general contingency in the month to offset the agreed continuation of enhanced bank rates.
- The Trusts key variances to the plan are:

Adverse Variances:

- Pay budgets overspent (net of £0.2m underspend against winter budget) by £0.7m. The main pressures continue to be within Emergency Medicine medical staffing (£0.6m), and £0.3m pressure within facilities, these pressures are partly offset by underspends within support to clinical staff (£0.2m).
- Non recurrent pressures within non pay (£0.3m) relating to MRI repair (£0.15m) and increase in doubtful debt (£0.15m)

Favourable Variances:

- Release of reserves (£0.45m), £0.1m from general contingency, £0.15m from the growth reserve to offset unfunded waiting list initiatives incurredin May and £0.2m underspend against winter budget.
- Non pay budgets underspends in the month by £0.5m mainly due to Pathology reagents (£0.35m) and elective outsourcing being less than plan (£0.1m)

Year to date overview:

- The Trust was on plan generating a £4.1m deficit year to date.
- The Trust has released £0.3m from the general contingency to offset the agreed continuation of enhanced bank rates.
- The Trusts key variances to the plan are:

Adverse Variances:

- Pay budgets overspent by £1.4m. The main pressures continue to be within Emergency Medicine medical staffing (£1.2m) and facilities staffing (£0.6m). These pressures were partly offset by underspends within support to clinical staff (£0.4m) and Nursing (£0.1m).
- Cost Improvement Plans were £0.1m adverse to plan which mainly related to delay in oncology provider to provider contract arrangements.

Favourable Variances:

- Release of £0.9m from reserves. The following reserves have been released: £0.4m from growth reserve to offset unfunded waiting list initiatives incurred, £0.3m from contingency and £0.2m from service developments to part offset some pay pressures in April.
- Underspends within Clinical supplies and Elective outsourcing due to Elective activity below budget (£0.6m)

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2022/23 of £20m but a internal savings requirement of £30m. Against the £30m internal target the Trust has delivered £0.5m savings year to date which is £0.1m adverse to plan. This slippage is mainly associated with the delay in re negotiating oncology provider to provider contracts.
- The CIP phasing increased to £1.5m from July and then increases further to £4.1m from October.

Risks

- ERF Clawback (£2.5m). The Trust has underperformanced against the Elective Recovery Fund (ERF) baseline (104% of 19/20 activity) which equates to £2.5m. The Trust has not reflected this clawback in the YTD position becasue the baselines and methodology has not been confirmed or the interaction with the K&M ICS and NHSEI.

May-22		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	97.8%	112.6%	-	100.0%	111.7%	113.0%	-	100.0%	38.8%	30.4%	272	19.27	50	6.8	11.9%	100.0%	10	1	274,239	319,880	(45,641)
MAIDSTONE	Cornwallis (M) - NS959	68.5%	74.6%	-	100.0%	123.7%	254.5%	-	-	64.7%	39.4%	177	12.46	55	6.4	0.0%	0.0%	6	0	104,605	106,191	(1,586)
MAIDSTONE	Culpepper Ward (M) - NS551	142.0%	73.0%	-	-	164.9%	183.9%	-	-	55.4%	42.2%	98	6.88	22	6.3	0.0%	0.0%	0	1	109,875	148,724	(38,849)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	99.9%	92.4%	-	-	117.5%	122.6%	-	-	39.3%	45.4%	183	12.93	41	6.6	34.3%	83.3%	4	2	165,555	171,636	(6,081)
MAIDSTONE	Intensive Care (M) - NA251	109.1%	99.9%	-	-	102.7%	91.9%	-	-	6.2%	11.7%	60	3.43	9	36.8	0.0%	85.7%	1	0	259,600	252,246	7,354
MAIDSTONE	Pye Oliver (Medical) - NK259	94.6%	103.1%	-	-	134.4%	96.8%	-	-	33.6%	60.6%	158	10.91	49	6.6	7.8%	100.0%	7	1	128,790	146,202	(17,412)
MAIDSTONE	Whatman Ward - NK959	104.3%	86.4%	-	-	129.0%	222.6%	-	-	81.4%	48.2%	183	12.82	26	6.6	24.0%	100.0%	4	1	97,267	138,339	(41,072)
MAIDSTONE	Lord North Ward (M) - NF651	98.2%	79.7%	-	-	99.1%	100.0%	-	-	13.7%	16.7%	42	2.91	11	8.1	48.0%	100.0%	6	2	111,138	115,524	(4,386)
MAIDSTONE	Mercer Ward (M) - NJ251	92.6%	88.9%	-	100.0%	124.5%	117.7%	-	-	33.5%	60.3%	125	8.77	34	5.8	29.4%	100.0%	9	4	108,840	124,625	(15,785)
MAIDSTONE	Edith Cavell - NS459	96.5%	76.2%	-	100.0%	105.4%	92.7%	-	-	36.8%	32.1%	65	4.54	14	6.5	22.7%	100.0%	7	0	112,597	96,004	16,593
MAIDSTONE	Acute Medical Unit (M) - NG551	102.8%	102.0%	-	100.0%	158.8%	225.8%	-	-	39.8%	52.9%	167	11.64	51	10.2	14.3%	100.0%	4	0	151,449	192,127	(40,678)
TWH	Ward 22 (TW) - NG332	70.5%	84.8%	-	100.0%	103.9%	99.4%	-	-	39.6%	38.7%	188	13.85	108	5.1	0.0%	0.0%	9	0	139,368	139,310	58
TWH	Coronary Care Unit (TW) - NP301	82.4%	74.7%	-	-	70.3%	-	-	-	18.2%	14.9%	65	4.74	44	10.2	0.0%	0.0%	3	0	70,950	65,424	5,526
TWH	Ward 33 (Gynae) (TW) - ND302	97.5%	84.5%	-	-	93.5%	90.8%	-	-	26.4%	2.1%	42	2.68	6	7.2	27.7%	100.0%	0	0	107,918	114,977	(7,059)
TWH	Intensive Care (TW) - NA201	106.9%	116.3%	-	-	105.1%	90.3%	-	-	12.1%	0.0%	138	8.59	10	34.8	300.0%	100.0%	0	0	389,871	368,958	20,913
TWH	Acute Medical Unit (TW) - NA901	66.6%	56.2%	-	100.0%	81.4%	54.5%	-	-	17.7%	33.7%	225	16.70	150	7.5	3.8%	100.0%	5	0	242,483	178,190	64,293
TWH	Surgical Assessment Unit (TW) - NE701	101.6%	150.9%	-	-	53.9%	82.9%	-	-	26.9%	8.7%	80	5.48	32	16.8	5.8%	100.0%	1	0	73,332	64,882	8,450
TWH	Ward 32 (TW) - NG130	89.1%	71.9%	-	100.0%	54.9%	80.0%	-	-	17.5%	18.0%	120	8.71	75	6.8	27.0%	100.0%	2	1	143,173	124,932	18,241
TWH	Ward 10 (TW) - NG131	74.1%	122.7%	-	-	92.7%	136.1%	-	-	41.3%	34.0%	195	12.64	74	6.0	4.9%	100.0%	1	0	141,361	155,591	(14,230)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	80.4%	78.3%	-	-	116.5%	77.3%	-	-	64.5%	37.9%	258	16.65	89	5.6	0.0%	0.0%	7	0	125,239	132,648	(7,409)
TWH	Ward 12 (TW) - NG132	80.9%	78.4%	-	100.0%	113.0%	99.4%	-	-	39.4%	38.0%	185	11.90	84	5.7	0.0%	0.0%	5	0	141,487	149,357	(7,870)
TWH	Ward 20 (TW) - NG230	75.3%	76.5%	-	-	119.4%	103.1%	-	-	20.2%	31.1%	124	8.44	66	5.9	0.0%	0.0%	6	0	166,313	162,558	3,755
TWH	Ward 21 (TW) - NG231	83.1%	108.9%	-	-	92.3%	98.5%	-	-	28.3%	38.5%	166	11.34	89	6.4	0.0%	0.0%	8	1	144,683	149,811	(5,128)
TWH	Ward 2 (TW) - NG442	75.7%	88.6%	-	100.0%	102.1%	121.5%	-	-	32.8%	24.5%	136	9.06	90	6.8	0.0%	0.0%	20	1	173,054	150,858	22,196
TWH	Ward 30 (TW) - NG330	96.9%	74.8%	-	100.0%	90.3%	102.9%	-	-	37.8%	26.2%	201	13.56	92	5.4	5.0%	100.0%	8	0	121,432	149,086	(27,654)
TWH	Ward 31 (TW) - NG331	95.8%	75.3%	-	100.0%	68.5%	152.7%	-	-	32.9%	21.4%	155	10.04	52	6.1	43.5%	90.0%	3	1	134,458	150,813	(16,355)
Crowborough	Crowborough Birth Centre (CBC) - NP775	68.4%	83.0%	-	-	53.2%	93.5%	-	-	11.3%	0.0%	40	2.16	0	155.9	104.8%	100.0%		0	140,259	86,522	53,737
TWH	Midwifery (multiple rosters)	79.3%	55.2%	-	-	87.1%	84.0%	-	-	14.8%	4.1%	701	40.41	176	11.5	9.4%	100.0%	0	0	763,349	861,435	(98,086)
TWH	Hedgehog Ward (TW) - ND702	115.5%	208.2%	-	-	145.6%	-	-	-	66.8%	74.9%	281	20.06	42	12.1	0.0%	0.0%	0	0	140,986	212,826	(71,840)
MAIDSTONE	Maidstone Birth Centre - NP751	104.8%	80.0%	-	-	104.0%	95.8%	-	-	24.4%	0.0%	32	1.73	0	51.4	62.9%	100.0%	0	0	72,788	94,671	(21,883)
TWH	SCBU (TW) - NA102	83.1%	-	-	100.0%	94.6%	-	-	-	19.8%	0.0%	99	5.49	1	15.0	0.0%	0.0%		0	194,672	198,581	(3,909)
TWH	Short Stay Surgical Unit (TW) - NE901	83.1%	66.8%	-	100.0%	56.5%	99.8%	-	-	9.4%	11.3%	26	1.81	6	11.1	5.8%	95.5%	1	0	77,966	81,999	(4,033)
MAIDSTONE	Accident & Emergency (M) - NA351	100.5%	93.4%	-	100.0%	97.7%	79.9%	-	-	35.6%	41.8%	405	28.69	60		0.9%	89.7%	2	0	367,872	441,883	(74,011)
TWH	Accident & Emergency (TW) - NA301	97.9%	90.2%	-	100.0%	98.6%	88.3%	-	100.0%	42.5%	52.9%	484	33.77	42		0.1%	100.0%	2	0	394,618	509,119	(114,501)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	76.6%	80.1%	-	100.0%	80.6%	-	-	-	15.0%	3.3%	21	1.40	3	15.9	46.2%	100.0%	0	0	56,166	59,271	(3,105)
MAIDSTONE	Peale Ward COVID - ND451	88.3%	94.0%	-	100.0%	118.5%	109.7%	-	-	25.0%	52.4%	83	5.98	39	9	44.8%	100.0%	3	0	119,714	101,123	18,591
MAIDSTONE	Foster Clarke Ward - NR359	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		0	0	-2,294	2,294
MAIDSTONE	Foster Clark - NS251	83.3%	89.4%	-	100.0%	103.1%	87.1%	-	-	22.9%	47.7%	136	9.28	55	7.5	9.8%	100.0%	0	1	155,606	166,529	(10,923)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	99.9%	89.6%	-	-	97.7%	-	-	-	20.7%	12.2%	18	1.19	1	19.8	50.9%	99.0%	0	0	54,433	57,703	(3,270)
																Total Established Wards				6,477,506	6,938,264	(460,758)
																Additional Capacity beds	Cath Labs			18,579	41,487	(22,908)
																	Chaucer			0	-356	356
																Other associated nursing costs				5,088,584	4,623,950	464,634
																				11,584,669	11,603,344	(18,675)

Under fill

Overfill

Green: equal to or greater than 90% but less than 110%
Amber Less than 90% OR equal to or greater than 110%
Red equal to or less than 80% OR equal to or greater than 130%

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?
- 'Main' Quality Committee, 11/05/22

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Mortality Surveillance Group Report

May 2022

MTW
exceptional people, outstanding care

Contents

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

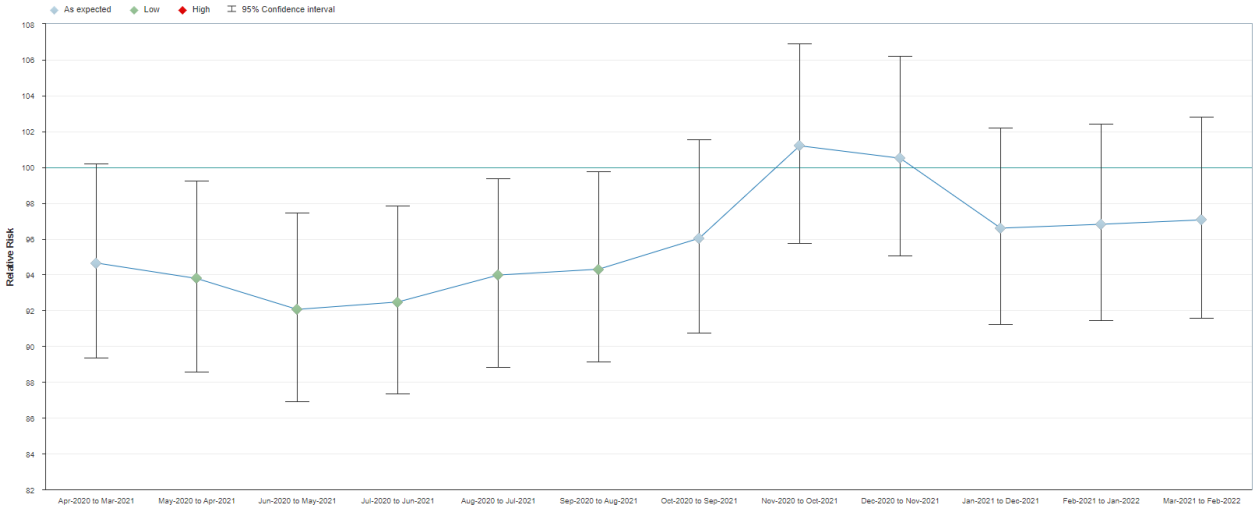
Executive Summary

- T Health (Dr Foster) have updated on schedule. Published data is up to **February 2022**.
- HSMR has reduced from the previous period– Rolling HSMR currently at **97.1** and is performing well against the standard ratio of 100. We are in the "as expected" bracket.
- Monthly HSMR shows an increase in January 22 (120.9), in the "high" bracket
- 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 **zero** CUSUM alerts
- Weekend HSMR is has returned to above the national average, but is in the "as expected" bracket.
- Deaths with no comorbidities on a rolling 12 month basis have increased slightly from the last published dataset. Those deaths with no comorbidities focussed on Geriatric and Respiratory Medicine
- Covid HSMR for the Trust is higher than our Kent peers, driven by depth of coding around Covid.
- Trust SHMI continues to perform in the green.

HSMR Overview

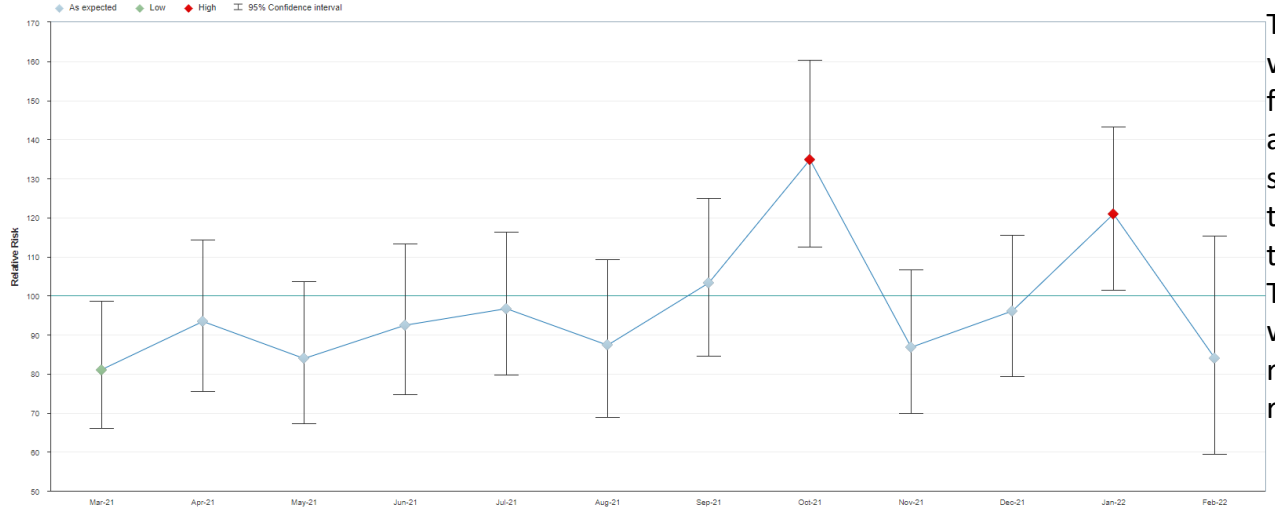
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Months



The 12 months **March 2021 to February 2022** show our HSMR to be **97.1**, an increase on last month's figure of **96.8**. The This places the Trust in the "as expected" bracket

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 **January 2022** in this case, shows that the Trust's position has increased to **120.9** from **96.0** in December 2021. The monthly view should be taken with caution, however, with a the rolling 12 month view a much more robust view of HSMR

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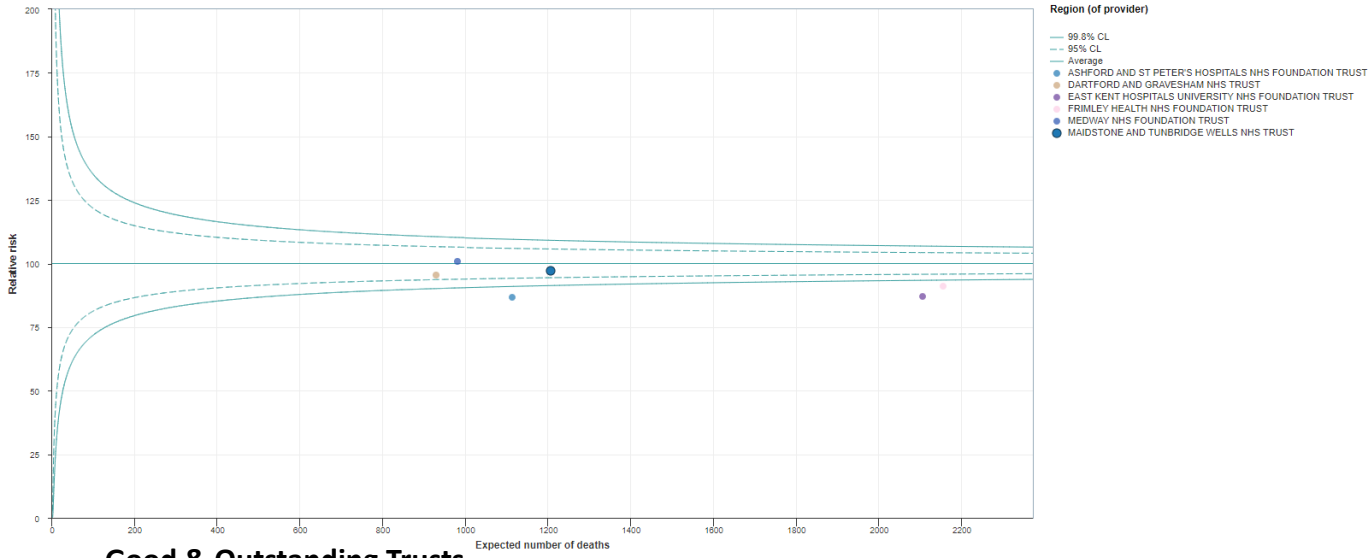
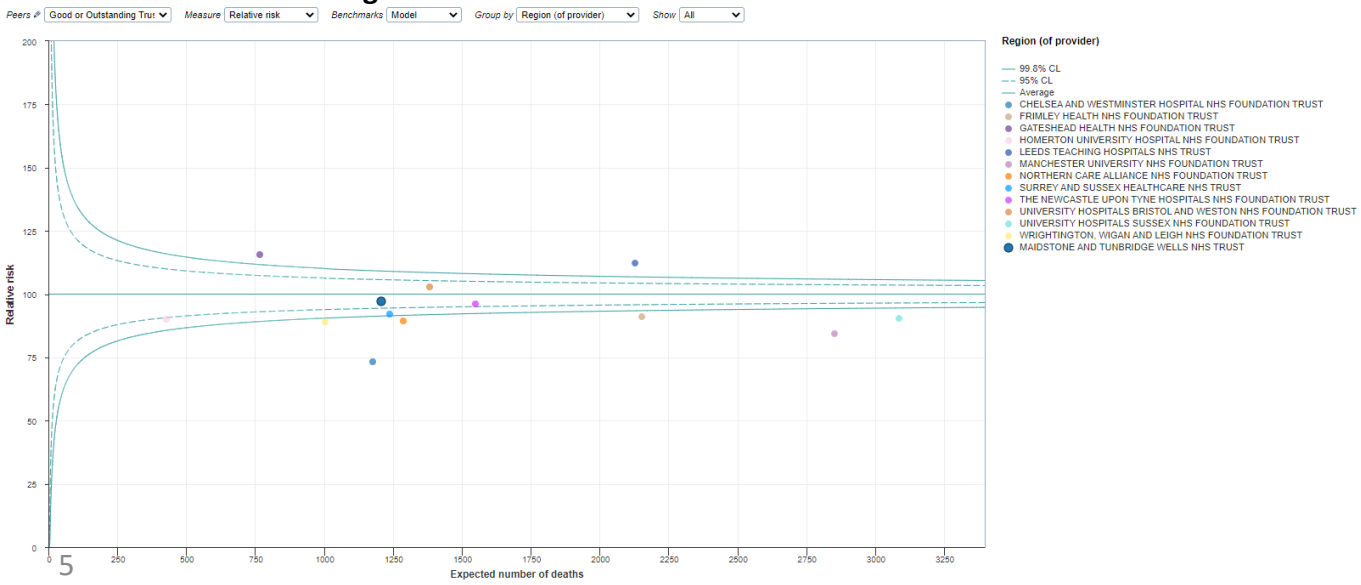
HSMR – Benchmarking

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 4	126654	1532	1620.9	1.2	94.5				
HSMR (56 diagnosis groups)	5	40185	1171	1206.5	2.9	97.1				
Intestinal infection	1	909	18	9.6	2.0	188.4				
Occlusion or stenosis of precerebral arteries	1	5	1	0.1	20.0	1541.8				
Other upper respiratory infections		412	3	0.4	0.7	851.0				
Residual codes, unclassified	2 1	6116	81	80.6	1.3	100.5				
Septicemia (except in labour)	1	707	126	107.1	17.8	117.6				
All Procedures		79131	1066	1163.4	1.3	91.6				
Rest of Operations covering multiple systems		60	3	0.5	5.0	596.0				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Pneumonia	109.2	1589	232	212.4	19.6
Septicemia (except in labour)	117.6	707	126	107.1	18.9
Congestive heart failure, nonhypertensive	124.8	684	84	67.3	16.7
Aspiration pneumonitis, food/vomitus	115.5	227	69	59.7	9.3
Intestinal infection	188.4	909	18	9.6	8.4

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	83.2	30	12	40.0
Aspiration pneumonitis, food/vomitus	115.5	227	69	30.4
Respiratory failure, insufficiency, arrest (adult)	103.6	78	18	23.1
Nervous system congenital anomalies	549.0	5	1	20.0
Occlusion or stenosis of precerebral arteries	1541.8	5	1	20.0

We have no CUSUM alerts this reporting period

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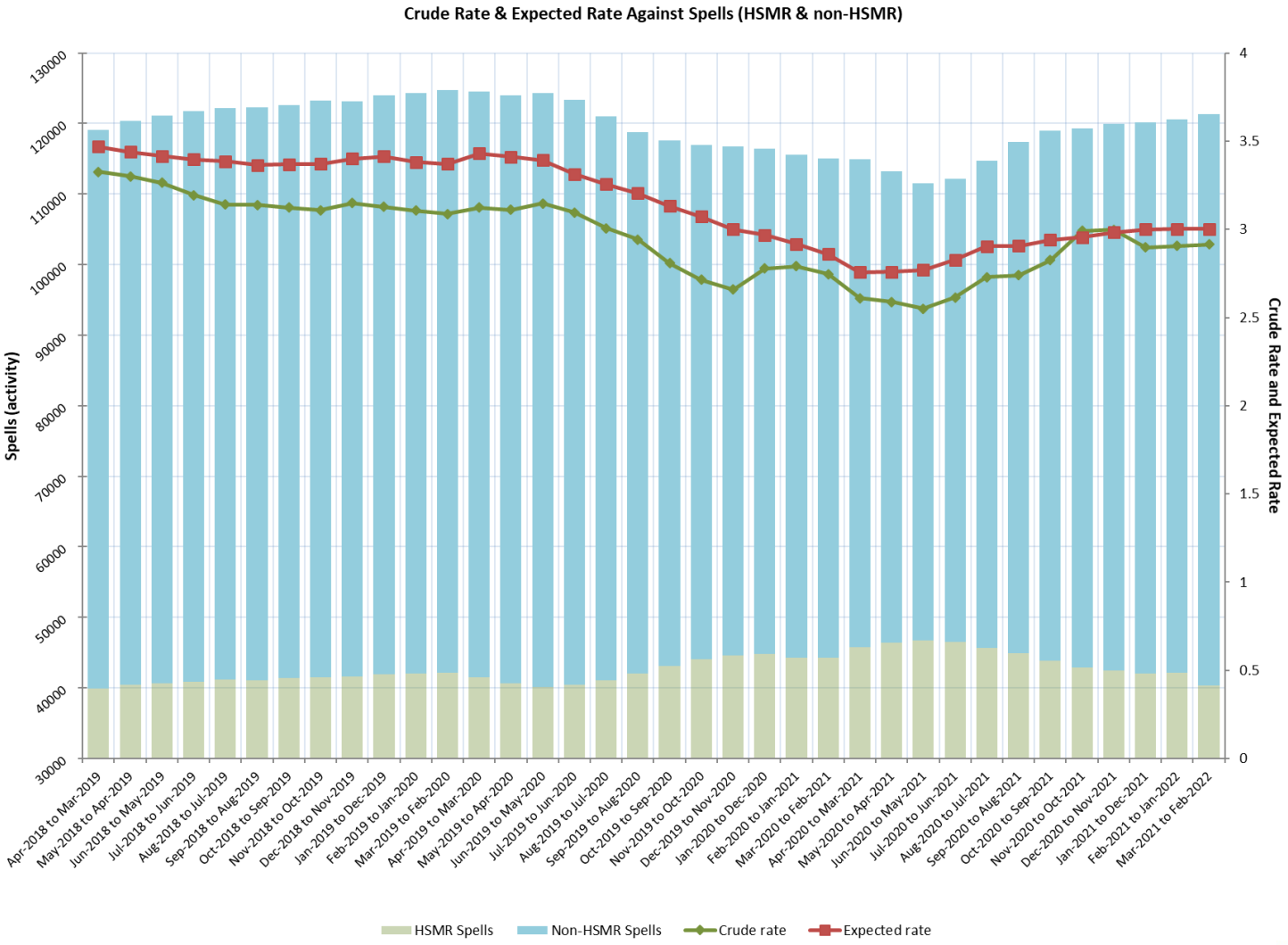
Crude & Expected Rate Against Spell Comparison

Maidstone and Tunbridge Wells NHS Trust



Crude mortality continues to be lower than the expected rate, despite increasing volumes of spells

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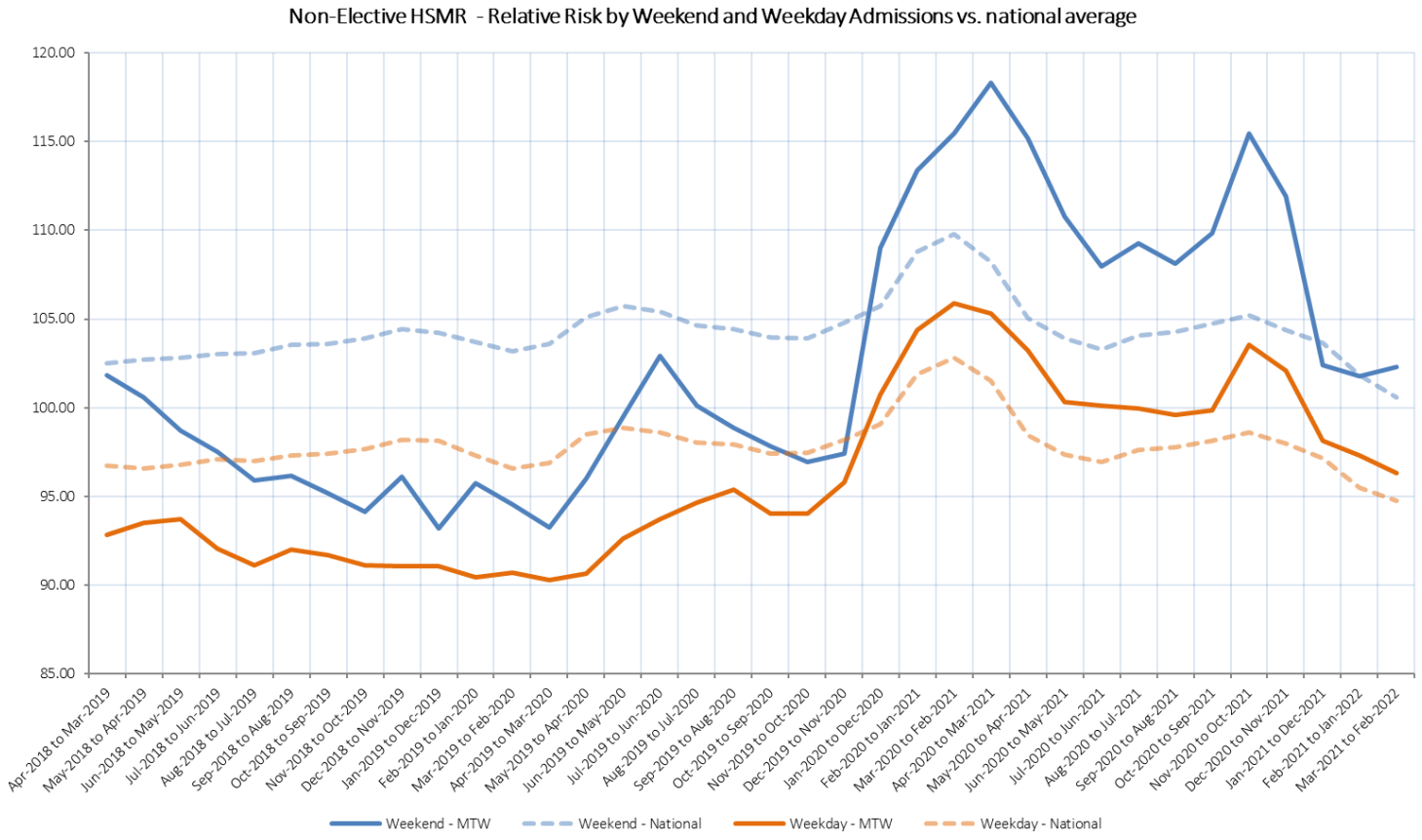
HSMR – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



Weekend and Weekday HSMR for non-elective care are slightly above the national average, with relative risks of **102.29** and **96.33** respectively. Whilst above the national average, these remain in the "as expected" bracket.

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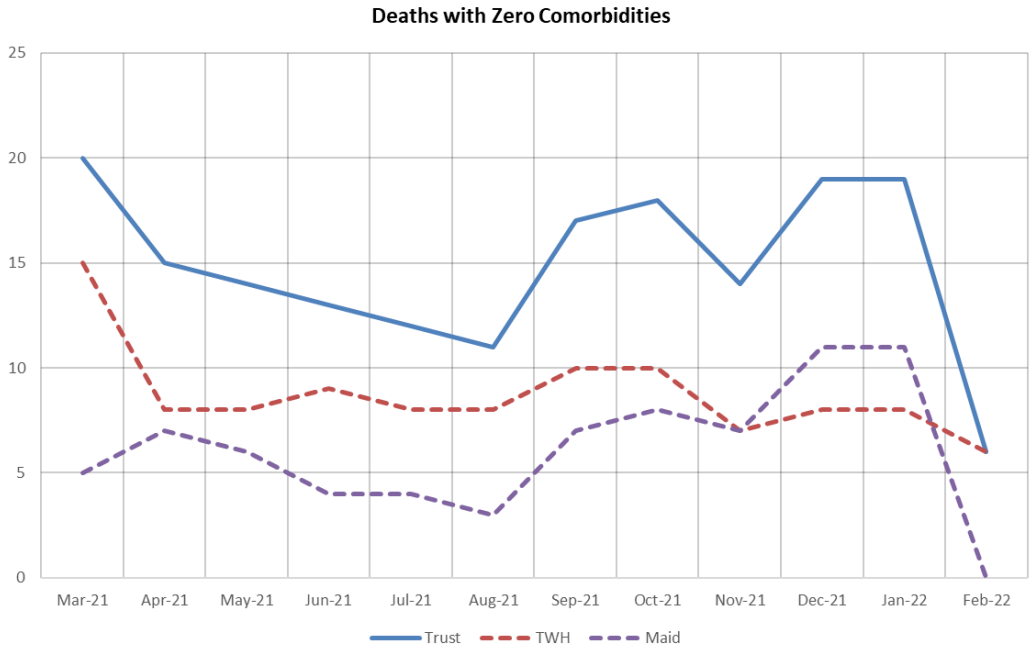
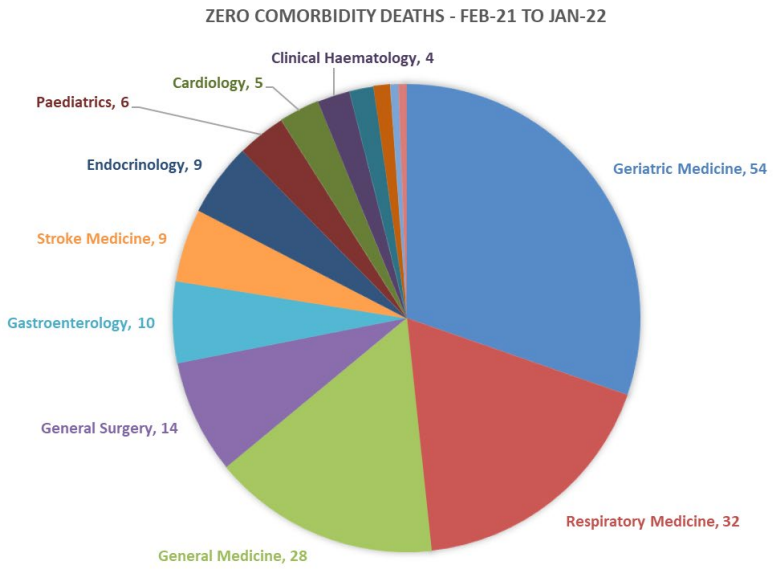
Deaths with Zero Comorbidities



Month	Trust	TWH	%	Maid	%
Mar-21	20	15	75.0	5	25.0
Apr-21	15	8	53.3	7	46.7
May-21	14	8	57.1	6	42.9
Jun-21	13	9	69.2	4	30.8
Jul-21	12	8	66.7	4	33.3
Aug-21	11	8	72.7	3	27.3
Sep-21	17	10	58.8	7	41.2
Oct-21	18	10	55.6	8	44.4
Nov-21	14	7	50.0	7	50.0
Dec-21	19	8	42.1	11	57.9
Jan-22	19	8	42.1	11	57.9
Feb-22	6	6	100.0	0	0.0
All	**178**	**105**	59	**73**	41.0

Of the **1139** deaths recorded in the period of **March 2021 to February 2022**, **178** had no comorbidities recorded (**15.2%**). The volume of deaths recorded with no comorbidities has increased slightly (174 in previous period)

Deaths with Zero Comorbidities – By Specialty



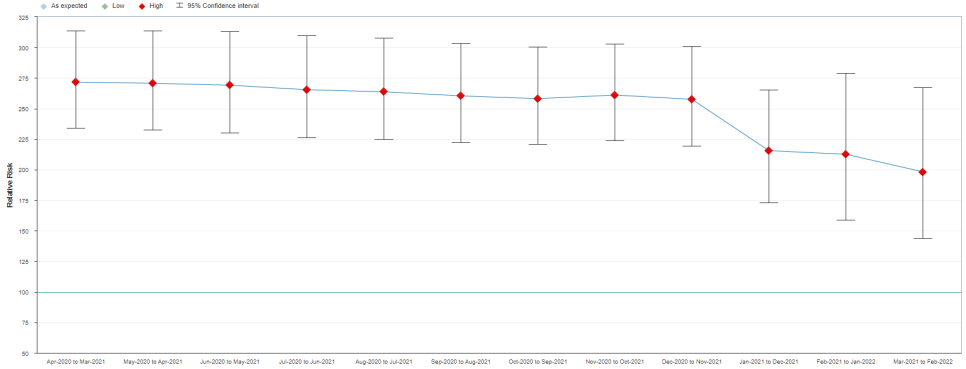
	Dec-20 Nov-21		Feb-21 Jan-22		Mar-21 Feb-22	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	62	34%	53	30%	54	30%
Respiratory Medicine	27	15%	32	18%	32	18%
General Medicine	20	11%	19	11%	28	16%
General Surgery	21	11%	17	10%	14	8%
Stroke Medicine	12	7%	10	6%	9	5%
Gastroenterology	7	4%	9	5%	10	6%
Endocrinology	14	8%	11	6%	9	5%
Cardiology	6	3%	7	4%	5	3%
Clinical Haematology	4	2%	4	2%	4	2%
Trauma & Orthopaedics	2	1%	2	1%	3	2%
Anaesthetics	1	1%	1	1%	1	1%
Accident & Emergency	2	1%	2	1%	2	1%
Paediatrics	5	3%	6	3%	6	3%
ENT	1	1%	1	1%	1	1%
Gynaecology		0%		0%		0%
Well Babies		0%		0%		0%
Urology		0%		0%		0%
All	184		174		178	

The majority of zero comorbidity deaths continue to be in **Geriatric Medicine and Respiratory Medicine Specialties**.

Covid 19 Mortality

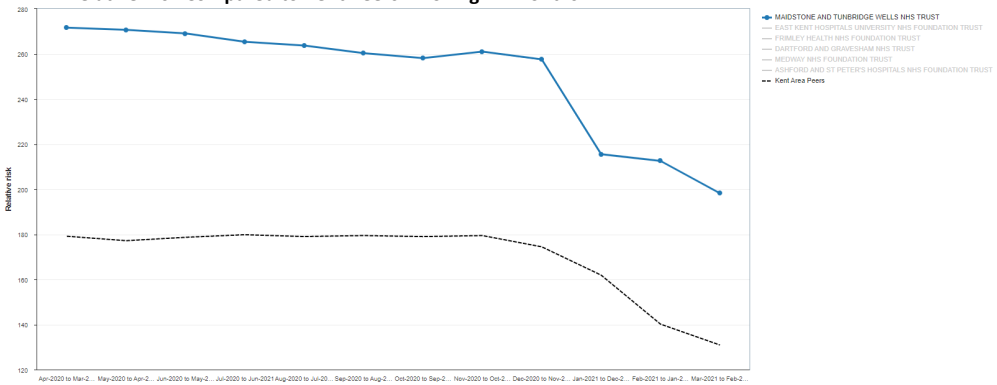
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Month Relative Risk for Covid Diagnoses



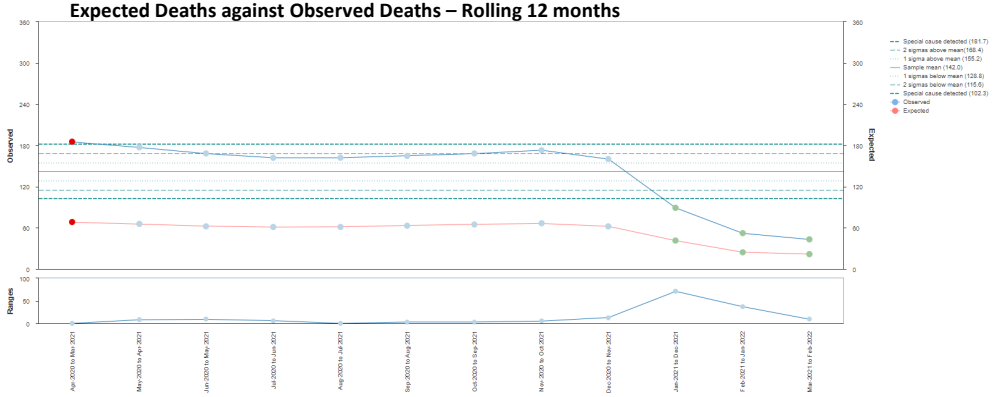
Relative Risk for Covid has dropped, remaining in the "high" bracket however, with the period of **Mar 21 to Feb 22** at **198.2**

Relative Risk Compared to Kent Peers – Rolling 12 Months



Our Relative Risk continues to be higher than that of our Kent peers at **198.2** against **130.9**. This continues to reduce over previous reporting periods

Expected Deaths against Observed Deaths – Rolling 12 months



Our Observed Covid deaths continues to be higher than Expected deaths. The gap continues to converge, however

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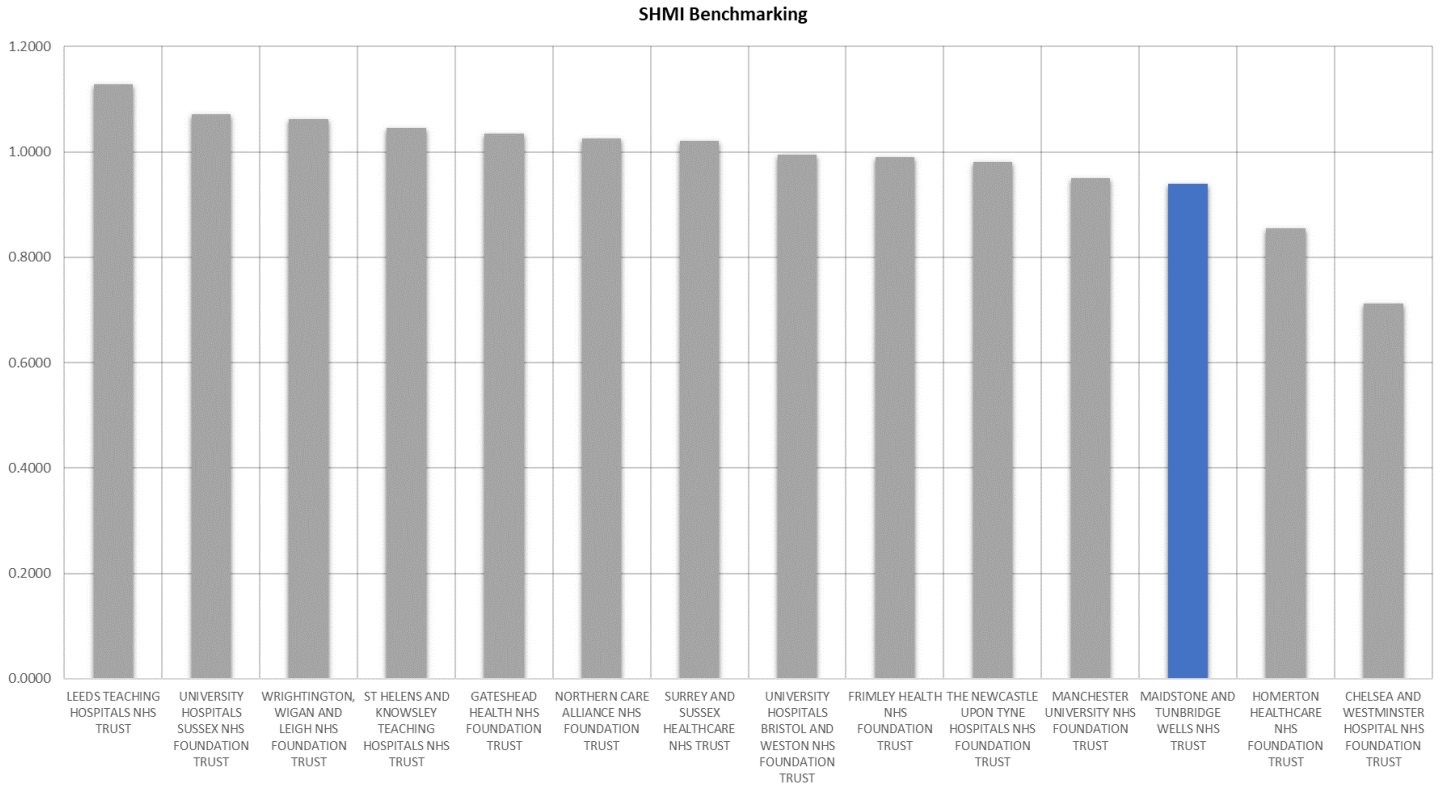
SHMI

Maidstone and Tunbridge Wells NHS Trust



As a trust we are performing favourably against our peers on SHMI – with a SHMI of **0.94** for the period of **January 2021 to December 2021.**

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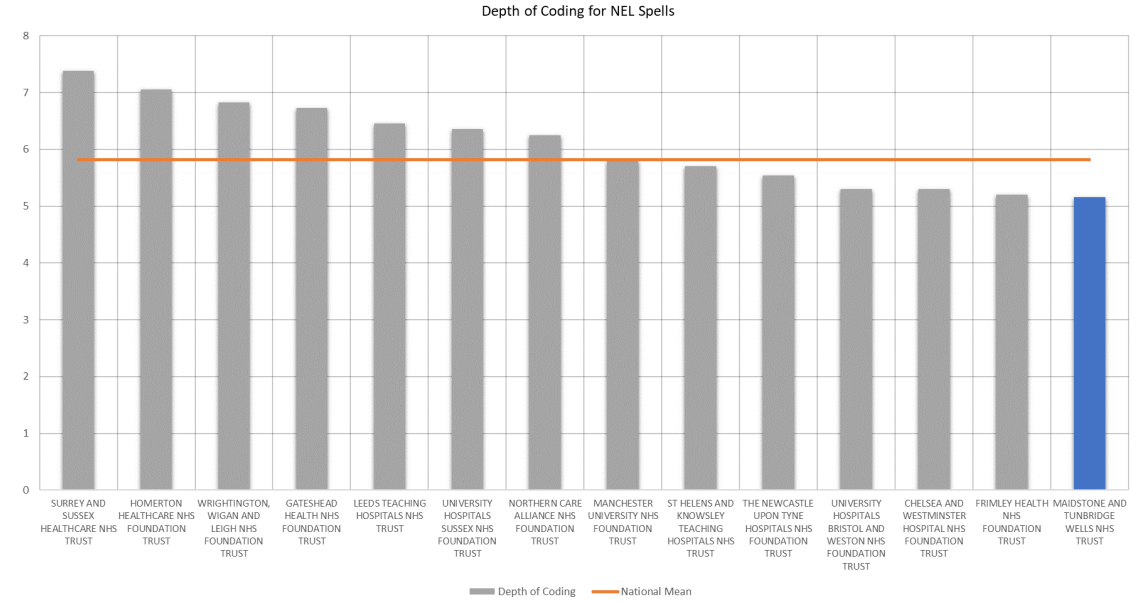
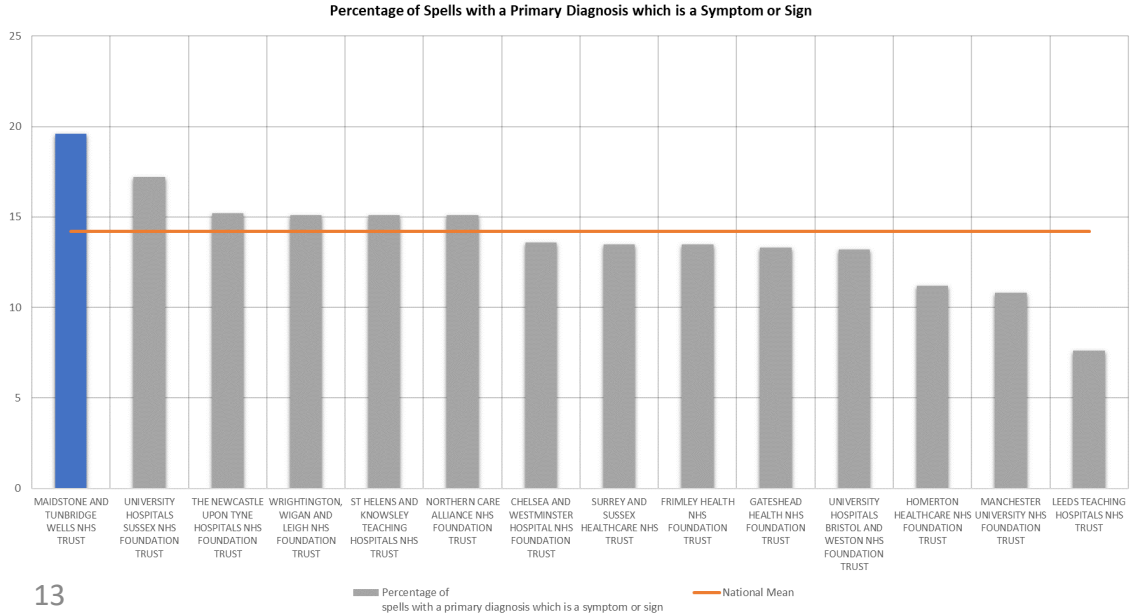
SHMI – Contextual Indicators

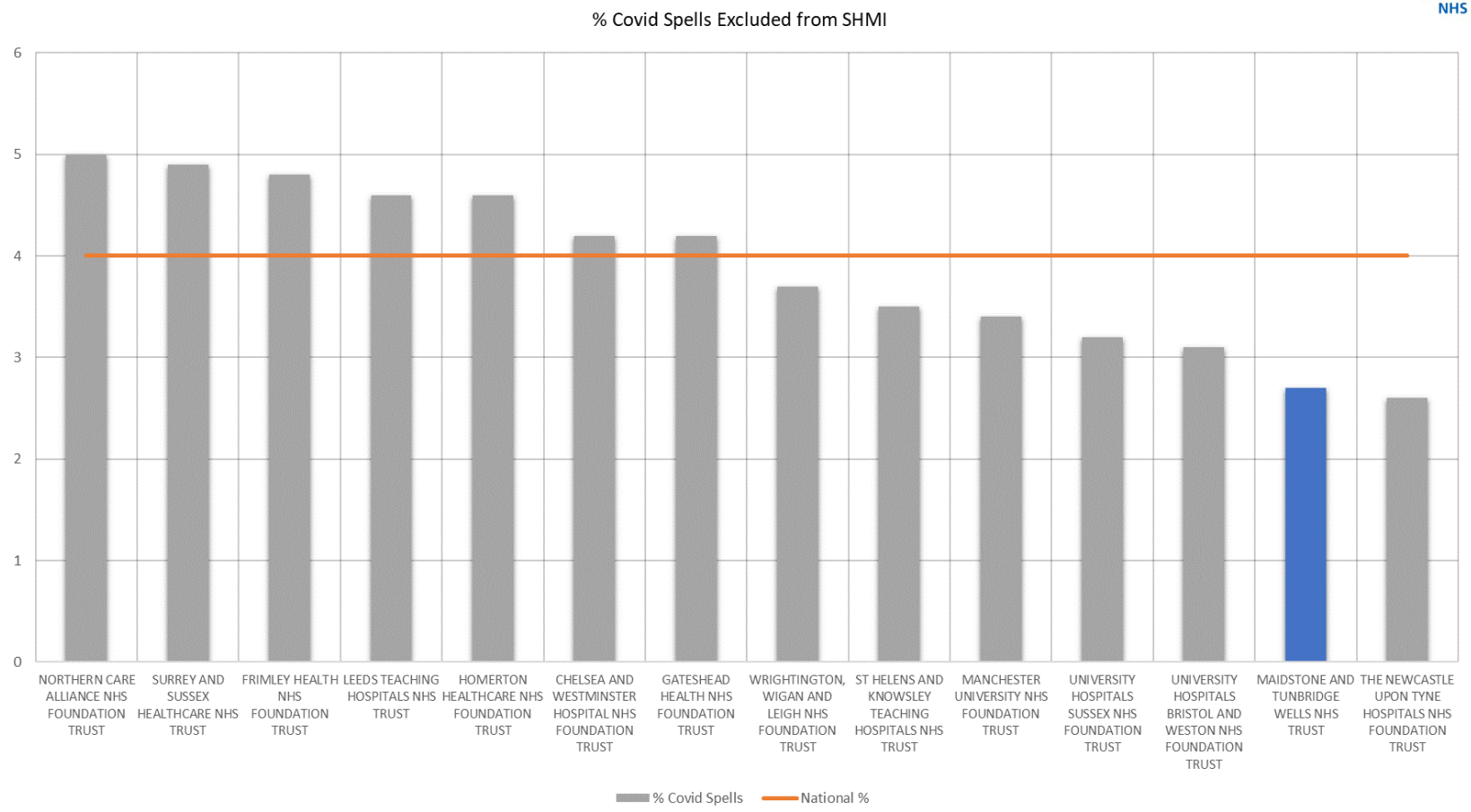


Depth of coding for the Trust remains below national average and in the lowest quartile of our Outstanding and Good Rated peers. This is primarily an indicator of the level of coding that is in the patient notes, prior to reaching the coding team



The Trust's percentage of spells that have a Primary Diagnosis that is a symptom or sign is above the national average and has the highest percentage amongst our Outstanding and Good rated peers. October 2021 saw deaths being coded by external contractors less familiar with local policy which resulted in a spike in these spells. As the volumes of deaths in this metric are very low in the Trust, this led to an increase in the percentage. An audit of episodes from Jan 2022 onwards is in progress to provide further assurance

SHMI – Contextual Indicators - Covid



SHMI excludes Covid Spells, but does track spells excluded due to Covid. We continue to be an outlier on the number of spells excluded due to Covid – the 2nd smallest percentage amongst our Good and Outstanding peers. The Coding team get regular data on Covid admissions to ensure accurate coding – the result of audits of this data indicates that most Covid patients at MTW have a Covid diagnosis in a secondary position and so are not picked up by SHMI reporting

Medical Examiner Service

ME Service Update

- There is a downward trend in the numbers of cases scrutinised by the Service month on month due to a reduction in hospital deaths, however the Service consistently performs well scrutinising 99% of cases monthly.
- The ME Service continues to engage with West Kent GP practices to support the roll out of the Medical Examiners Service to the community.
- The contract has now be signed to procure the Emis viewer license required to access GP primary care records, an important part of the community roll out project.

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 Calender Days to Complete
Dec-21	165	162	98%	72	44%
Jan-22	173	173	100%	83	48%
Feb-22	141	141	100%	55	39%
Mar-22	157	154	98%	50	32%
Apr-22	150	149	99%	53	36%
May-22	134	133	99%	47	35%

Challenges faced by the ME Service

- The funding envelope provided by NHSE/I to implement the ME Service does not adequately cover for running the Service. The funding envelope provides for staffing alone, funding for IT equipment and licenses required to access community care records to enable the roll out of the Service to the community needs to be secured.
- The ongoing theme around timelines of death summary continues to impact on the Service. Rate of scrutiny performance is consistently between 98-100% whilst scrutiny completed within the 3 working day target is between 50-60%.

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.

Engagement has begun with Primary Care GP practices as part of the roll out of the Medical Examiner Service to the community. The community roll out will commence with a pilot of Two GP practices, hospice and community hospital deaths. Enabling the Service to optimise it processes as it expands into the community

Learning from Mortality reviews identified the following needs:

- Better communication between senior clinical staff could have prevented delays, and a more effective transfer to specialist care provider, which may not have prevented the outcome but may have provided the opportunity for alternative treatment options.
- Concern from case review at a Tertiary Unit asked for local review of case management within MTW to learn from poor practice
- In acute admissions, particularly where medication changes or changes to feeding regimens are undertaken, routine bloods during inpatient stay should be considered
- Teams/staff members need to be prepared to work cross site when transfer of a patient to a preferred site is not possible or unsafe.
- Appending an initial clerking 6 days later, by another doctor, is poor practice.

The following practice was highlighted in :

- Good initial and prompt assessment and regular medical review during admission with escalation to consultant when patient deteriorated
- Good sepsis 6 bundle care, with early discussion with microbiology.
- Good communication with family, and updates given.

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

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
Apr 18 to Mar 19	2
Apr 19 to Mar 20	6
Apr 20 to Mar 21	9
Apr 21 to Mar 22	27
Apr 22 ro Mar 23	9
SJR Total backlog	53

- Criteria which instigate an SJR have increased in the last year coupled with the fact that the introduction of the ME Service has resulted in 98-100% scrutiny of all non coronial deaths in the hospital. Both factors have resulted in an increase in no of SJRs being raised.
- Additional SJRs are being raised from concerns highlighted by loved ones of deceased patients over care provision.
- The current SJR reviewer capacity has not increased to match the demand surge for SJR reviews. Therefore the progress made in the reduction of the backlog is not reflective in the current position due to the increase in demand for SJR reviews.
- The current SJR backlog position is 53, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4 week stipulated SJR turnaround time.
- There are 8 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 61.

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor
Apr-22	7	1	0
May-22	13	3	0

- In April, there was 1 SJR with an overall assessment of 'Poor care' and no SJRs with a 'Very poor care' rating discussed at MSG.
- In May, there were 3 SJRs with 'Poor care' and no SJRs with a 'Very poor care' assessment reviewed at the MSG meeting.
- Learning from both poor care and good practices highlighted from cases reviewed at MSG continue to be fed back to directorates

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

Actions from 'Poor care' SJR Reviews

- The 4 SJRs with an overall assessment of 'Poor care' were discussed at MSG and with the Directorates
- No SJRs resulted in an SI being raised
- Learning from all SJRs have been feedback to Directorates through Clinical Governance meetings.

Next steps

- Continue to work with SJR reviewers to reduce the backlog
- Continue to progress the Medical Examiner community roll out project.

MTW exceptional people, outstanding care

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Trust's long term plan for Maternity Continuity of Carer	Divisional Director of Midwifery, Nursing & Quality Women's, Children's & Sexual Health

The report is enclosed.

Which Committees have reviewed the information prior to Board submission?
- Quality Committee 'deep dive', 08/06/22

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

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

Maidstone and Tunbridge Wells NHS Trust

Maternity Paper to Trust Board			
Agenda item:		**Enclosure Number:**	
Date:	30th June 2022		
Title:	**Plan to Board for Default Midwifery Continuity of Carer (MCoC)**		
Author /Sponsoring Director/Presenter	Sarah Blanchard-Stow Sarah Mander-McGregor		

Purpose of Report		Tick all that apply ✓	
To provide assurance	√	For discussion and debate	√
For information only		For approval	√
To highlight an emerging risk or issue		For monitoring	√

Summary of Report:

This paper outlines:

- Background
- Current position including
  - Activity
  - Imports and exports
  - Current staffing
- Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
- Framework of activities that will ensure readiness to implement and sustain MCoC
- Time frame and monitoring process.

Recommendation:

- Approve the contents of this report
- National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review
- Consideration will be given to altering this plan, in light of any new national publications or guidance that may arise requiring an alternative model of midwifery care

Background:

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the

NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks (see appendix/ A for assurance framework) are in place this should be achieved by March 2024 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

Alternative timescales will be accepted on a case-by-case basis, where it is clear that full staffing cannot be achieved by March 2024. These revised timescales will be assessed and agreed through regional assurance.

What does it mean to offer Midwifery Continuity of Carer as the 'default model of care'?

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be in a position to receive continuity of carer, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

As a first step, Local Maternity Neonatal Systems must by 15th June agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2024; so that Continuity of Carer is the default model of care offered to all women. This plan will include:

- The **number of women** that can be expected to receive continuity of carer, when offered as the default model of care
- **When** this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision, that is phased alongside the fulfilment of safe staffing levels
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity
- How **rollout will be prioritised** to those most likely to experience poor outcomes, including the development of enhanced models of continuity of carer
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set (MSDS)
- **Building blocks** that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.

Current position:

Maidstone and Tunbridge Wells NHS Trust booked 6958 women between 2020/21, with 5539 births under our care in the same period. Of the 5539 births 56% were born by vaginal delivery, 31% by caesarean section and 12% by instrumental delivery. We have two free-standing birth centres associated with the Trust who achieved 13% out of hospital births (including homebirths). A large proportion of our women are cared for within the main obstetric unit which increases the likelihood of intervention for most women during labour and birth; this has been supported with the Robson data that we produce locally to support us in our decision making and audit work.

Maternity services at MTW are currently configured to provide a traditional care model as default, with antenatal and postnatal care provided by team midwives, and intrapartum care provided by core staff. The current exception to this is those under the care of our existing continuity of carer team for young parents, Phoenix team, who are projected to care for 3.6% of the eligible caseload.

The Plan:

The plan for continuity to become the default model would encapsulate approximately 90% of all women birthing at Maidstone and Tunbridge Wells NHS Trust, with identified specialist care pathways continuing for Diabetic women (not gestational), multiple pregnancies and women who live out of our Trust geographical area but choose to birth with us. It will also include provision of care via the traditional community model for those women who live within our Trust geographical area but choose to birth with another Trust.

Within the MTW locality approximately 5% of births were women from Black, Asian or Mixed ethnicity. This caseload of women is spread across the geographical area and therefore challenging to prioritise. Full implementation is required to capture this, however roll out is projected to prioritise the geographical area with the highest percentage.

Work completed regarding postcode areas within the lowest 10% most deprived in England identified areas within the MTW locality, ME15 7, 8 ,9. Provision of continuity of carer will be prioritised for this group in the second wave of the plan, following re-establishment of previously active teams within the Crowborough geographical area.

The planning guidance sets out that building blocks need to be in place prior to and during rollout of MCoC. They are set out as a readiness to implement and sustain MCoC assessment framework (appendix A of the planning guidance and this document). These building blocks are the key elements in the plan to roll out MCoC from the current position to default MCoC for most women.

Safe staffing:

The midwifery staffing structure has been reviewed to identify safe staffing based on Birthrate+ recommendations, external review and compliance with the national standards for establishment of continuity teams.

The MTW midwifery establishment is current funded for a clinical workforce 196.49 WTE midwifery hours. This excludes all midwives of specialist services and management. For full

implementation of the proposed safe staffing structure within our Trust there is a requirement of 239.1 WTE clinical midwives, indicating a further staffing uplift of 42.61 WTE midwives.

In order to implement wave 1 within the current financial year, an investment of 6.53wte midwives is required. External funding options are being explored, but should this not occur, the Trust would be asked to invest, in order to implement wave 1.

Planning spreadsheet

The plan consists of 8 waves or phases establishing safe staffing across all settings, with a total of 21 continuity teams at full implementation. With exception of the existing Phoenix team, all future teams will be mixed risk geographically based teams as per evidence based national guidance. The plan supports the re-establishment of continuity of carer within the Crowborough locality, followed by prioritised geographical areas based on BAME and deprivation population.

The plan details the required uplift in staffing budget and recruitment prior to commencing the next wave. At each stage of the implementation a PDSA cycle will be completed to ensure stability and sustainability prior to proceeding. Challenges in rapid or mass roll out have been identified nationally through networking and lessons learned, therefore each stage will require careful implementation and monitoring, as per national implementation guidance. It is scoped that each team will require a 4-month implementation period, covering recruitment, upskilling supernumerary time, team building and establishment of service. This will enable a yearly roll out of approximately 3 teams. Full implementation is phased over an 8-year period, however it is recognised that this will be influenced by a number of factors including successful recruitment. We recognise that recruitment is our main challenge, therefore a robust internal recruitment campaign and an increase in student numbers is required to fulfil this demand. This does not rely on midwifery attraction from surrounding areas and supports an internal drive for midwifery uplift. As per the recommended process, the plan will be reviewed quarterly as a minimum and accelerated or delayed based on achieving the required building blocks and dependant on the recruitment achieved.

Communication and engagement plan

In preparation for previous and existing continuity teams at MTW, staff engagement and workshops were held prior to implementation. Communication and engagement are a key building blocks to the implementation and success of large-scale change. This will be developed in partnership with staff unions, HR and the Maternity Voices Partnership.

Skill mix planning

A band 7 team leader will oversee a number of teams (approximately 3) and be responsible for skill mix allocation. Present guidance regarding preceptee allocation to continuity/community setting is being reviewed in light of recent National Reports into maternity services.

Training

Each midwife will have their own training needs analysis which will be completed prior to joining a continuity team. A bespoke orientation package will be developed, supported by the continuity team lead and the practice development midwives.

Linked Obstetrician

In line with National guidance, each team of midwives will have a linked Consultant Obstetrician. This process is already in place for our existing team. Obstetricians are likely to be linked to more than one team and ongoing collaboration is required to enable this within the Consultant job planning.

Standard operating Policy (SOP)

The Phoenix Midwifery Team – continuity of carer SOP is currently awaiting ratification and approval. A separate SOP will be required for the mixed risk geographical based teams, however will mirror a number of process that are not specific to the specialised caseload.

Midwifery Pay

The RCM requests that no midwife should be financially disadvantaged for working in this way. A review is required in conjunction with HR and finance to support changes to the pathway care as described in this document. This includes current staff configurations and future staffing models. Appropriate uplift, mileage expenses, protected on calls and a review of the current escalation process will also be addressed.

A review of the current roster service is also required to enable accurate capture and reflection of the new flexible way of working. Discussions are in progress with the Trusts workforce team and HR departments.

Estate and equipment

Hubs and service provision premises are being explored as an LMNS and has been escalated as a project risk to the CCG: this may demonstrate a cost saving and a more streamlined approach in community services. Alternative venues and maximisation of property utilisation is currently being explored. This will be reviewed and agreed at each phase of the roll out, taking into consideration facilities within the specific geographical area.

The new model of care requires an increased percentage of the workforce to be based outside the acute setting and within the community of the women for which they provide care. There will therefore be an investment required to enable remote working.

Review Process

Quarterly review at board for assurance and escalation. Oversight via Maternity and Neonatal Assurance Group, LMNS, Integrated Care Board (ICB) and region for assurance. This includes linkage with CNST standards and how this is monitored in our organisation

Appendix A Readiness to implement and sustain MCoC assessment framework:

Item	Detail/Notes	RAG
Presentation of Plan to Trust Board	The plan needs to presented to board for approval and submitted to the LMNS. LMNS submission to the national team by 15th June 2022	In progress within time frames
Planning spreadsheet	Midwifery deployment plan for MCoC including timescales and recruitment plan for a phased scale up to default position (Appendix B)	complete
Safe Staffing	Birthrate Plus completed October 2020 Workforce/establishment review with external expert completed April 2022 Recruitment plans are being progressed	In progress within time frames
Communication and engagement	Communication strategy to be developed	Required Action
Skill mix	Review of skill mix based on national guidance and recent Maternity Service Reports	In progress within time frames
Training	Training Needs Analysis (TNA) is currently under development led by the LMNS. Each midwife will	In progress within

	require support from the PDM and Team lead prior to joining a team.	time frames
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working.	In progress within time frames
Linked Obstetrician	Obstetric involvement and linked obstetrician identified to be formalised and recorded in SOP	In progress within time frames
Standard Operating Policy (SOP)	Each Trust needs a SOP that outlines roles and responsibilities to support delivery of care in this way, it should pass through the maternity service governance processes as with other guidance documents.	In progress within time frames
Pay	Review of payment structure required	Required Action
Estate and equipment	Estate provision under review and escalated to CCG Equipment provision to be identified for each phase	In progress within time frames
Evaluation	Local reporting under development based on current national guidance	In progress within time frames
Review Process	Trust Board quarterly reviews to be scheduled following initial review of this plan	In progress within time frames

Appendix B – Staffing deployment plan to deliver MCoC with dates and recruitment plan.

21% uplift Trust multiplier = 5.35	BirthRate+	Funded clinical RM	Actual	deployment	Continuity pathway	remaining women (booked)	receipt (delivery)	remaining women delivery		time scale
starting position	244-29.11 MSW =221.71 mw minus 20.15 SMW = 194.77	**196.49**			**0.0%**	**6500**	**0.0%**	**5555**		in the beginning
Continuity team										
DS	57.88	60.56						4804		
Maidstone MLU	10.84	10.7						452		
Crowborough MLU+CMW	10.84	17.17						169		
triage/phone	15.36	15.62								
DAU	1.77	1.53								
ANC	6.81	8								
AN ward	10.84	10.7								
PN ward	17.8	24.8								
community	62.63	47.41		1 to 137				130		
TOTAL	**194.77**	**196.49**								
Budget increase and recruitment required for wave 1			**6.53wte**							
Wave 1	**3 teams**	**3 teams**			**13%**		**13%**	**4830**		Mar-23
Continuity team		21.3		3	845		725			Phoenix, North & South
DS	57.88	48.15		9				4209		
Maidstone MLU	10.84	10.7		2				431		
Crowborough MLU+CMW	10.84	7.35		1				81		
triage/phone	15.36	15.62								
DAU	1.77	1.53								
ANC	6.81	6.81								
AN ward	10.84	10.7		2						
PN ward	17.8	24.8		4						
community	62.63	56.06	+2 cbc	1 to 98		5655		109		
TOTAL	**194.77**	**203.02**								
Budget increase and recruitment required for wave 2			**3.5wte**							
Wave 2	**6 teams**	**6 teams**			**27%**		**27%**	**4055**		Mar-24
Continuity team		42.8		6	1755		1500			Teams 1 (BAME), 2 & 3 (deprived)
DS	57.88	42.8		8				3579		
Maidstone MLU	10.84	10.7		2				307		
Crowborough MLU+CMW	10.84	7.35		1				81		
triage/phone	15.36	15.62								
DAU	1.77	2.1								

ANC	6.81	6.81								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	41.16	+2 cbc	1 to 110		4745		88		
TOTAL	**194.77**	**206.52**								
Budget increase and recruitment required for wave 3			**7.5wte**							
wave 3	**9 teams**	**9 teams**			**40.4%**		**40.4%**	**3310**		Mar-25
Continuity team		63.5		9	2626		2245			Teams 8,4 & 16 (maidstone)
DS	57.88	37.45		7				2978		
Maidstone MLU	10.84	10.7		2				173		
Crowborough MLU+CMW	10.84	7.35		1				81		
triage/phone	15.36	15.62								
DAU	1.77	2.1								
ANC	6.81	6.81								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	33.31	+2 cbc	1 to 110		3874		78		
TOTAL	**194.77**	**214.02**								
Budget increase and recruitment required for wave 4			**5wte**							
wave 4	**12 teams**	**12 teams**			**54%**		**54%**	**2570**		Mar-26
Continuity team		84.1		12	3510		2985			Teams 19,6 & 7 (t.wells)
DS	57.88	32.1		6				2319		
Maidstone MLU	10.84	8.7		1.5				135		
Crowborough MLU+CMW	10.84	7.35		1				60		
triage/phone	15.36	15.62								
DAU	1.77	2.1								
ANC	6.81	6.81								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	25.06	+2 cbc	1 to 110		2990		56		
TOTAL	**194.77**	**219.02**								
Budget increase and recruitment required for wave 5			**5wte**							
wave 5	**14 teams**	**14 teams**			**62%**		**62%**	**2106**		Mar-27
Continuity team		97		14	4030		3449			Teams 5&9 (t.wells)
DS	57.88	32.1		6				1886		
Maidstone MLU	10.84	5.35		1				121		
Crowborough MLU+CMW	10.84	7.35		1				51		

triage/phone	15.36	15.62								
DAU	1.77	2.1								
ANC	6.81	6.8								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	20.52	+2 cbc	1 to 110		2470		48		
TOTAL	**194.77**	**224.02**								
Budget increase and recruitment required for wave 6			**2.5wte**							
wave 6	**16 teams**	**16 teams**			**70%**		**70%**	**1632**		Mar-28
Continuity team		110.2		16	4550		3923			Teams 12&15
DS	57.88	26.75		5				1458		
Maidstone MLU	10.84	5.35		1				95		
Crowborough MLU+CMW	10.84	7.35		1				39		
triage/phone	15.36	15.62								
DAU	1.77	2.1								
ANC	6.81	6.2								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	15.77	+2 cbc	1 to 110		1950		40		
TOTAL	**194.77**	**226.52**								
Budget increase and recruitment required for wave 7			**10.5wte**							
wave 7	**19 teams**	**19 teams**			**83%**		**83%**	**942**		Mar-29
Continuity team		129.3		19	5395		4613			Teams 14,17 &10
DS	57.88	26.75		5				854		
Maidstone MLU	10.84	5.35		1				33		
Crowborough MLU+CMW	10.84	7.35		1				38		
triage/phone	15.36	15.62								
DAU	1.77	2.1								
ANC	6.81	5.6								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	7.77	+2 cbc	1 to 113		1105		17		
TOTAL	**194.77**	**237.02**								
Budget increase and recruitment required for wave 8			**2.08wte**							
wave 8	**21 teams**	**21 teams**			**90%**		**90%**	**533**		Mar-30 in the end
Continuity team		140.6		21	5854		5022			Teams 11&13
DS	57.88	21.4		4				480		
Maidstone MLU	10.84	5.35		1				19		

Crowborough MLU	10.84	7.35		1				34		
triage/phone	15.36	15.62								
DAU	1.77	2.1								
ANC	6.81	5.6								
AN ward	10.84	12.38		2.5						
PN ward	17.8	24.8		4						
community	62.63	3.9	+2 cbc	1 to 110		646		0		
TOTAL	**194.77**	**239.1**								

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 regular basis during the Covid-19 pandemic
Changes are highlighted in red in the document. In some areas of the BAF text is struck through to enable to board to fully understand changes made

For this reporting period the changes are marked in red in the main document and summarised here

Section 1
- Temperature checks to be stepped down at front door of ED as not effective in identifying asymptomatic Covid patients
- Respiratory pathway provision can be flexed depending on demand. High levels of attendances in ED currently for non-covid indications
- Ongoing work to look at increased provision of side rooms at MDGH
- Universal mandatory mask wearing stood down from 20/6/22. High risk areas identified for continuing mask wearing
- Patients and visitors encouraged to wear masks, especially those with respiratory symptoms

Section 4
- Further extension from 20 June. Open visiting from midday to 7pm. Maximum of two visitors at the bedside
- Two birth partners allowed. Both parents and grandparents can visit in neonatal unit. Two visitors on antenatal and post-natal
- Outpatients have accompanying person plus a carer when needed

Section 5
- Lateral flow tests for all elective admissions to be implemented by 1 July. Tests for three days up to and including day of admission
- Staff not required to wear a facemask unless caring for patients in ED, caring for Covid patients, caring for patients with respiratory symptoms, working on Lord North

Section 6
- Social distancing now returned to pre-pandemic levels

Section 7
- Ongoing work and training of staff to enable patients at TWH to remain on specialty wards if they become Covid positive to improve standard of care.
- Seating has returned to pre-pandemic spacing

Section 8
- All elective patients to have LFTs for three days up to and including day of admission. PCR will not be available after 1 July for these patients

Section 9
- Seating in staff canteen returned to pre-pandemic spacing

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	• POCT in place for all admissions including Covid-19, Influenza A & B, RSV. Integrated with Pathology LIMS (Telepath). Also available for essential staff (following contact) and selected patients as required • Streaming in place for respiratory and non-respiratory pathways in ED with front door triage. • Isolation facilities and Covid cohort areas/wards in place. Red (Covid) ITU in place • 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. • Temperature checks to be stepped down at front door of ED as not effective in identifying asymptomatic Covid patients • Escalation plan in place. Plan in place to flex in-patient Covid capacity as required. • Respiratory pathway provision can be flexed depending on demand. High levels of attendances in ED currently for non-covid indications • Winter planning meetings held and attended by MDT • Ongoing work to look at increased provision of side rooms at MDGH		

• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	• Universal mandatory mask wearing stood down from 20/6/22. High risk areas identified for continuing mask wearing • Patients and visitors encouraged to wear masks, especially those with respiratory symptoms • Twice weekly LFT implemented for patient facing staff • Non-patient facing staff test if symptomatic • PCR testing no longer available on request for staff (from 9.4.22) • Social distancing encouraged for staff • Meetings remain online wherever possible • Working from home facilitated • All changes in practice communicated through team brief, huddles and the daily Pulse publication • Workplace risks identified, risk assessed and action plans in place		
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff.	• Hierarchy of Controls risk assessment template in place and available on the Trust intranet • Risk assessment for the use of FFP3 masks in place and available on the staff intranet. Updated for Omicron variant • All staff caring for Covid positive patients wear FFP3 masks • Communicated to staff via the Pulse and team briefs/huddles		
• safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• Safe systems of working in place following national guidance • IPCT attend weekly system and regional IPC meetings • DIPC chairs K&M IPC leadership forum		

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	• All changes of guidance discussed at system and regional level and reviewed at IPCC • National guidance followed however local decisions made around delaying standing down some precautions due to local risk assessments – discussed at IPCC and ETM • FFP3 masks worn by all staff caring for Covid positive patients – risk assessment in place • Staff who are contacts of household cases return to work and take daily LFTs (national guidance states twice weekly) • Isolation (cohorting) of inpatients exposed to Covid for 10 days continues (national guidance is to isolate only if symptomatic). 10 days remains in place as 30% of contacts develop infection between 7-10 days after exposure. This is currently under review • Risk assessments completed by ward managers in collaboration with IPCT		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	• FFP3 masks in use for all staff caring for Covid positive patients • Work is ongoing to reduce the number of moves for patients to a maximum of 3 unless discussed with manager on call. Moves have been necessitated to enable co-horting of infectious patients and maximum use of beds due to capacity pressures. • Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from ICU care only.		

• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas. • resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff • Execs and senior managers visit clinical and non-clinical areas regularly • IPC audit plan in place and is included in the annual work plan. • Additional auditing undertaken for ward-based periods of increased incidence of C. difficile and Meticillin sensitive *Staphylococcus aureus*. • All staff receive infection control training at induction which includes a section on Covid-19 • National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this. • All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 • Non-clinical staff have bi-annual training (level1) which includes Covid-19 • Additional ad hoc training on ward during IPC visits • Junior doctors have induction training including Covid delivered by DIPC • IPC booklet available for bank and agency staff. • Contractors required to adhere to appropriate IPC measures including mask wearing • Hand hygiene audited as part of monthly ward and IPCT triangulation audits		

• the application of IPC practices within this guidance is monitored, eg: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination.	• PPE audits completed by the fit testing and PPE team • Cleaning and decontamination audited as part of the National Standards of Cleanliness audits using the My Audit platform		
• the IPC 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 • From July 2021, BAF to be reviewed by Board when new guidance is published or there is significant change to report		
• the Trust Board has oversight of ongoing outbreaks and action plans.	• Outbreak meetings take place weekly. • Summary reports reviewed at IPCC and reported to Board through the Quality committee • Executive team receives the daily outbreak sitrep		
• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Made FFP3 masks are available to users as required.	• A range of FFP3 masks are available to staff including UK made masks. Staff fit tested against a minimum of two masks. • Reusable masks and air powered respirators available for those who fail FIT testing		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	• Implementation plan completed and National standards in use across the Trust. • Implementation was monitored through the IPCC and reported to Board through Quality committee		

• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	• Communications in place using Teletracking • IPCT liaise closely with operational and facilities teams		
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	• Cleaning audits completed according to national standards. Action plans created as required. • All standards exceeded with >90% achieved in all areas (95% in high risk areas) • Bespoke MyAudit platform developed by collaboration between MTW and parent company.		
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by 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 (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	• Cleaning levels well established and implemented for all areas. • Covid areas have enhanced cleaning as routine • Diff X is cleaning/disinfecting agent used in the Trust. Confirmed as active against respiratory viruses and enveloped viruses including Covid • Decision made in collaboration with IPCT		
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		

• a minimum of twice daily cleaning of:
  ○ patient isolation rooms.
  ○ cohort areas.
  ○ Donning & doffing areas
	• Increased frequency of cleaning complies with national guidance for isolation rooms, cohort areas and donning and doffing areas		

○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea.	• Frequently touched surfaces cleaning in place since June 2020 • Increased frequency in place • Commode cleaning audited with triangulation audits in addition. Reported to IPCC		
• A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	• Level 3 clean plus UVC decontamination for areas/rooms stepped down from Covid to non-covid • Terminal clean of single rooms based on infectivity of patient. Information on levels of cleaning widely available. • Disposable curtains used throughout the Trust with criteria in place for replacement • Following AGP level 3 terminal clean plus UVC decontamination completed		
• reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	• Re-usable non-invasive care equipment decontaminated according to the Trust policy. • Pre-existing guidance remains in place for clinical areas • Disinfectant wipes used which are active against Covid-19. • DiffX used for commode cleaning		
• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	• Commode cleaning audited with triangulation audits in addition. Reported to IPCC • Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks		

• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single pass air supply and no recirculation of internal for infection control purposes. • Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical production areas all installed with HTM 03-01 ventilation systems.		
• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	• Estates team work closely with IPCT on risk assessments for ventilation		
• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	• Review has been undertaken. Risk not mitigated by ventilation controls in Covid areas		
• where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation		
• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	• Additional ventilation brought into some areas. Hybrid model of partial recirculation with UVC cleaning of air implemented in ED RAP area and to be extended to other areas		
• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	• Screen and partitions in widespread use. Cleaning in place		

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 that: • arrangements for antimicrobial stewardship are maintained	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • Ward pharmacists review prescribing • Prescribing of antibiotics is low compared with peer K&M organisations • Audits and reporting restarted and maintained in second wave • Ward based audits were suspended in March and April 2020 but reinstated for May 2020 and have continued		
• previous antimicrobial history is considered	• Training for new doctors has continued and includes advice on taking into account previous antibiotic history		
• the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing ○ to ensure patients with infections are treated promptly with correct antibiotic.	• Antimicrobial guidelines in place • Certain antibiotics controlled and can only be prescribed with permission of the microbiologist • Empirical guidance in place • Sepsis pathway in place • Guidelines for antibiotic treatment of Covid patients issued by ASG		
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	• Mandatory reporting of antimicrobial usage has continued. • IPCC and DTMMC report to Quality committee		

• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	• Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians • Antimicrobial resistance monitored • Systems in place to screen for CRE/CPE and MRSA • ITU staff wear short sleeved gowns to ensure 'bare below the elbows' and hand hygiene can be maintained in Covid areas • Regular screening of ITU patients for potentially infectious organisms		
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 that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	• Routine visiting re-started from 29 March 21 and extended 17 May 21. One hour per patient each day • Further extension from 20 June. Open visiting from midday to 7pm. Maximum of two visitors at the bedside • Two birth partners allowed. Both parents and grandparents can visit in neonatal unit. Covid testing using LFT in place to facilitate this. Two visitors on antenatal and post-natal • Outpatients have accompanying person plus a carer when needed • Surgical mask provided to patients and visitors as required • Extended visiting for compassionate reasons e.g end of life • iPads available to assist patients in maintaining contact with loved ones		

	• Regular review undertaken		
• national guidance on visiting patients in a care setting is implemented.	• Local decisions based on risk assessment.		
• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	• Visiting not permitted on outbreak wards unless for compassionate/end of life reasons • Limited visiting to covid positive patients possible using PAR hoods		
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	• Posters prominently displayed in public areas • Graphics on trust Covid internet pages • Posters in wards to encourage patients to wear face masks		
• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	• PPE guidance for visitors available – ward staff advise individual visitors. Non-Covid infectious patients able to have visitors. • Covid patients do not have visitors except for compassionate/end of life reasons		
• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	• Visitors asked about respiratory symptoms on arrival and turned away if they are symptomatic unless compassionate reasons etc. Arrangements for video call made as required		
• visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	• Visitors are not present during AGPs unless essential carers or for compassionate /end of life		
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted 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 that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	• Signage displayed at main entrance, oncology entrance and ED entrance. • Covid status and other diagnoses included on electronic discharge notification. • Also included in handover documents for ward to ward transfers and transfers to other care facilities • Standard triage template supported by EPR system (Sunrise) and printed version ~~• Elective patients having general anaesthetic, C. section and UGI endoscopy continue to have PCR tests 72 hours prior to admission~~ • Lateral flow tests for all elective admissions to be implemented by 1 July. Tests for three days up to and including day of admission ~~• Pre-admission LFT being phased in for patients not having GA. Test for three days prior to and including day of procedure~~ • Triage and screening by questioning for patients attending ED and out patient clinics.		

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 or other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	• Triage carried out by senior nursing staff. • Immediate allocation of patient to pathway • Obstetric triage in place with senior midwife. Labour ward has designated red and green beds • All patients encouraged to wear face masks as long as tolerated • Patients tested on admission, day 3 and day 5-7. • All inpatient testing continues to be by PCR (National guidance is to test using LFT at day 3 & Day 5-7) • Weekly testing introduced February 2022 in response to increasing nosocomial risk – Now stood down		
• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	• All patients are provided with FRSM and encouraged to wear them where it can be tolerated. • All patients encouraged to wear masks when moving away from their bed space.		
• patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	• Patients with respiratory symptoms move through the ED respiratory pathway and are separated from other non-respiratory patients • Patients on this pathway have rapid Covid test. Where negative and Covid still suspected, a laboratory PCR test is also taken. • Patients isolated whilst awaiting results		
• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	• Patients with respiratory symptoms are isolated pending results of tests		
• patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their	• Criteria in place for admission to haematology ward to ensure only Covid negative patients are on the ward		

families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • 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.	• Staff LFT monitored • CEV patients isolated in ED and on wards and prioritised for single rooms • In place. Clinical review determines risk vs benefit of proceeding with treatment in symptomatic or recently Covid positive patients • All patients asked to wear a face mask on entering ED. • All outpatients and visitors encouraged to wear masks except for those carrying exemption certificates • Masks provided at front entrance if required • Information on Trust website to support ~~• All staff wear masks unless in a Covid secure area~~ • Staff not required to wear a facemask unless caring for patients in ED, caring for Covid patients, caring for patients with respiratory symptoms, working on Lord North • All beds at a minimum of 2m spacing • Cubicles in ED separated by solid walls • Seating in waiting areas now returning to pre-pandemic spacing following national guidance. • All patients and visitors are encouraged to wear face masks in waiting areas • Reception staff protected with screens • 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		

• isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	• Any patients with new symptoms after admission are tested and isolated until the result is known • Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. The rationale for testing is documented in the patient's notes • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information and duty of candour letter. (this is contrary to national guidance which advises that isolation is no longer necessary for asymptomatic contacts) Medically fit patients who are discharged to their own home continue to self-isolate at home. • Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care. • All laboratory results submitted to PHE • Contacts are screened twice per week for 10 days • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook • Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
• appropriate infection prevention education is provided for staff, patients, and visitors.	• Patients and visitors are advised on basic infection control including hand hygiene and mask wearing. • All staff have access to IPC education		
• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results recorded and database maintained • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • PPE officers provide face to face training on wards. • IPC team provide training to staff • Mandatory IPC e-learning package includes Covid-19. National package in use • Donning and Doffing videos available on Trust intranet site.		
• 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 put it on and remove it;	• PPE officers provide workplace training. • Donning and doffing stations provided on Covid wards • FIT testing available for all staff who require it and tested on a minimum of two masks • Signage and posters displayed in donning and doffing areas		
• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE audits ongoing and reported to IPCC		

	• Combined hand hygiene and PPE audit in place • Action plans for non-compliance • Local decision to use FFP3 masks for all direct patient care of Covid positive patients since late December 2020. Decision kept under review and stepped down to national guidance 14 April 21 in view of low numbers of patients and high uptake of vaccine amongst staff • 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 • Provision made for staff with risk factors etc to continue to use FFP3. • Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric ultrasound, and these variations will continue		
• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	• All wards use Standard Infection Control Precautions (plus masks where appropriate) – informal training on wards by IPCT and circulated through Pulse		
• 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.	• Hand air dryers are not in use in the Trust • All hand wash basins are co-located with paper towel dispensers		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	• Staff advised of social distancing rules • Social distancing now returned to pre-pandemic levels • Reminders posted on intranet and in daily Pulse		
• staff understand the requirements for uniform laundering where this is not provided for onsite.	• Scrubs are worn on all Covid wards and several other wards and clinical areas.		

	• Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on both sites		
• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	• Guidance in place for staff regarding household infections and contacts. • Guidance regularly updated and cascaded to managers. Published in Pulse and on intranet Covid pages • Return to work guidance also in place advising daily LFTs for 10 days, • Risk assessment for return to work in place and available on the intranet • Staff sickness line available to report symptoms • Information on symptoms of Covid shared widely including posters, staff bulletin and intranet site • All symptomatic staff have access to LFTs through the gov.uk website		
• to monitor compliance and reporting for asymptomatic staff testing	• Rapid tests no longer required for staff coming onto shift – LFTs used as alternative		
• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	• All patient facing staff have access to LFT through the gov.uk website • Compliance with testing and reporting by asymptomatic staff is monitored		

• 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 an outbreak investigation and are reported.	• Email reminders sent to staff who are late in submitting results • Surveillance by BI at system level with local data and shared with senior managers and discussed at daily strategic command meetings. • Nosocomial infections closely monitored • Daily outbreak sitrep widely available • Daily staff sickness rates reviewed at strategic command call daily • IPCT monitor all Covid positive inpatient results • Outbreaks declared according to national guidance • All outbreaks are investigated and Serious Incidents declared. • Concise investigation and consistent Terms of reference developed –under review • Weekly outbreak meetings • Outbreaks no longer reported via national online platform		
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: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting	• All in-patients advised to wear face masks where this can be tolerated and especially when moving away from their bed space • Monitoring not done as this is now optional • Clinic schedules designed to have telephone appointments between face to face appointments to reduce the number	• Audits not consistently in place	• TWH is >90% single roomed hospital • No capacity to undertake additional audit

times in reception areas and avoid mixing of infectious and non-infectious patients.	of patients in the waiting room at any time • Seating has returned to pre-pandemic spacing • Patients advised to wear FRSM to reduce risk of infection		
• patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	• Clear pathways in place to segregate Covid positive patients and others with infectious respiratory pathogens • Theatre pathway in place for Covid positive patients • Facilities in place for chemotherapy to be given to recovering Covid patients and ensure separation from other patients • Covid treatment pod set up to give community high risk patients approved treatments • Patients cared for in single rooms wherever possible or cohorted together depending on infecting organism • Ongoing work and training of staff to enable patients at TWH to remain on specialty wards if they become Covid positive to improve standard of care.		
• patients are appropriately placed ie, infectious patients in isolation or cohorts.			
• ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	• Ongoing reviews take place depending on demand for beds • Beds never less than 2m apart on wards		
• standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	• Standard infection control precautions used for all patients on the green (non-Covid) pathway		
• the principles of SICPs and TBPs continued to be applied when caring for the deceased	• Use of SICPs and transmission-based precautions (and when they should be used) detailed in the care of the Dying and Deceased policy		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals.	• Testing undertaken by registered BMS staff with documented competencies • Method validated prior to diagnostic testing		
• patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	• In house testing turnaround time of less than 24 hours • Extended laboratory working hours to deliver service • All non-elective patients are tested on admission • All positive patient results are phoned to ward by IPCN and provided to site team and ICC. • All results reported to PHE via Co-surv • All elective patients are tested by lateral flow test for three days up to and including admission • Online booking for staff and elective patient testing. • POCT available in both EDs • 24/7 service for near patient testing across the Trust		
• staff testing protocols are in place	• All patient facing staff have access to LFT • PCR testing for staff has been stood down • All symptomatic staff have access to LFTs through the gov.uk website • Staff testing protocols available on the intranet and changes are published in the Pulse and cascaded to managers • Turnaround times closely monitored		

• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	• Results usually available within 24 hours • All positive inpatients reported directly to IPC team and site practitioners via email • All staff positives reported to Occupational Health via email • All positives reported to consultant microbiologists and IPCT • Results directly authorised and available in real time • Internal quality control completed on every test run • MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies • All routine diagnostic microbiology continues including C difficile • Rapid POCT for other respiratory viruses available in ED for respiratory patients • Any inpatient who develops symptoms of Covid has a laboratory PCR test and clinical review • All patients who test negative on admission are re-tested in line with national guidance on day 3 and day 5-7 • All routine and diagnostic inpatient testing is by PCR • Patient LFT is used to facilitate step down of post covid patients • Testing guidance is published in the daily Pulse and available on the intranet • Weekly testing for patients who stay for longer than a week implemented February 2022 – now stepped down		

• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	• Trust nosocomial rate is in line with national experience. • Daily swabbing has not been implemented although consideration to alternate day testing when nosocomial rate is high depending on lab capacity • Contacts of Covid patients are swabbed twice weekly for 14 days		
• that those being discharged to a care home are 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 organisation prior to discharge.	• All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home • Results are shared with the receiving care facility • Post-Covid patients are not tested further for 90 days unless they develop new symptoms		
• those patients being discharged to a care facility within their 10-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	• All patients within 10 days of initial diagnosis of Covid who require discharge to a care facility are discharged to a designated care setting		
• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	• ~~All surgical patients are assessed for the need to self-isolate prior to admission~~ • Patients within 90 days of positive test are not retested unless they develop new symptoms • PCR testing well set up and working efficiently with good patient uptake • All elective patients to have LFTs for three days up to and including day of admission. PCR will not be available after 1 July for these patients		
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 • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	• See section 1 page 3		
• staff are supported in adhering to all IPC policies, including those for other alert organisms.	• All pre-covid policies remain in place where they don't conflict with Covid policies		
• safe spaces for staff break areas/changing facilities are provided.	• Break out areas available. • ~~Staff canteen has socially distanced seating~~ • Changing facilities and showers available on both sites • Seating in staff canteen returned to pre-pandemic spacing		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	• Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list • Outbreaks declared as Serious Incidents • Outbreak report to IPCC		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B (orange) clinical waste stream. • New guidance for disposal of lateral flow tests and vaccination centres –current practice already in line with guidance • All linen from patients on amber and red pathways treated as infectious linen		
• PPE stock is appropriately stored and accessible to staff who require it.	• PPE central stocks held on both main sites		

	• Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas during times of high usage. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
• staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	• Guidance for staff is available on the Trust Intranet, daily Pulse, through team brief and daily huddles • Staff guided towards staff absence line, occupational health and managers for advice • IPCT available for advice to managers		
• bank, agency, and locum staff follow the same deployment advice as permanent staff.	• Advice applies equally to permanent, bank and agency staff		
• staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	• Staff who are contacts of Covid-19 return to work and take daily LFTs prior to shift (national guidance states twice weekly testing) • An exception exists for staff providing clinical care to CEV patients such as those working on the haematology ward • Risk assessment in place to determine if staff can attend their normal area of work or be redeployed		
• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	• Staff are trained in safe systems of working including the use of PPE		

	• Regular updates provided through daily huddles, the Pulse, staff intranet, etc		
• a fit testing programme is in place for those who may need to wear respiratory protection.	• The fit testing team is part of the IPCT • All clinical staff required to be fit tested annually • Ongoing programme in place • Urgent fit testing can be facilitated if required • New staff fit tested during induction		
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness and absence.	• System in place to monitor staff illness and absence • Dedicated staff absence reporting phone line		
o facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce	• Occupational health work closely with IPCT and microbiologists to facilitate treatment as necessary for non-covid infections. • Covid testing directorate manages vaccination programme for Covid		
o lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	• Monitoring systems in place. • Occupational health work closely with HR, Covid testing directorate and IPCT		
o encourage staff vaccine uptake.	• Staff uptake of vaccine encouraged. • Current data: o Covid One dose 97.14% o Covid Two doses 95.36% o Covid Booster 92.44% o Influenza 69.85%		
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to	• Clear guidance given to staff to ensure infection control precautions followed by		

follow the infection control precautions, including PPE, as outlined in national guidance.
 	
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.
  ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;
  ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications.
  ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.
  ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.
• vaccination and testing policies are in place as advised by occupational health/public health.
 	
• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.
 	
• staff who carry out fit test training are trained and competent to do so.
	staff who have been vaccinated and/or recovered from Covid.
	• National guidance followed
	
	• Risk assessments carried out for all staff in at risk categories including pregnant women.
	
	• Risk assessments completed through discussion between staff and line managers
	• Advice is widely available through the Trust intranet pages
	• Updates shared through intranet, Pulse, team brief and staff huddles
	• Bank, agency and locum staff follow the same advice
	
	• Risk assessments completed as required.
	
	• Vaccination and testing advice and protocols in place. Multi-disciplinary approach to decision making
	
	• FIT testing in place including training on fit, maintenance and cleaning.
	• Powered air respirators available for staff who fail all fit testing
	• Individual use reusable respirator masks available
	• FIT testing register held on central database
	
	• Dedicated Fit testing team in place and fully trained
	• Line managed by Deputy DIPC/ Nurse consultant in IPC		

• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	• All staff required to wear a FFP3 respirator are tested on at least two different masks		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• A database of fit testing outcomes is maintained • Staff are provided with information identifying the type of mask to be worn		
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• As above • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks • Records are kept and stored electronically		
• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	• Re-usable masks and hoods are available for staff who fail fit testing with disposable masks • Training is given in care and decontamination of the re-usable mask or hood.		
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	• If all respirator options are unsuitable staff work from home wherever possible • Manager works with HR to identify re-deployment opportunities • New opportunities to work with vaccination teams available		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	• Discussions are documented and records stored electronically		

• 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 • Any staff not tested and required to wear FFP3 provided with FIT testing prior to shift • All areas have access to powered air respirators		
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	• Clear principles established in the development of elective pathways • Green pathway for elective care in place • Theatre SOP and pathways in place to enable treatment of Covid positive patients if required in an emergency		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• All non-clinical areas assessed for Covid security. • Maximum occupancy identified on signage • Disinfectant wipes available to staff in non-clinical areas to clean workstations • Homeworking support package including training and IT kit in place for staff who now work at home • Space committee established to maximise use of space and provide secure on-site workplaces with social distancing		
• 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 free food, breakout areas, psychological support/ first aiders. • Staff sickness phone line in use and covered daily, providing advice and information on sickness, swabbing and other COVID sickness questions. • Ongoing work to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing.		

• staff who test positive have adequate information and support to aid their recovery and return to work.	• ICC reports staff sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home. Home working toolkit published • All staff able to access testing via on-line booking system • Symptomatic staff can access testing same day • Twice weekly LFT required • Trust-wide Pulse survey results reviewed at executive and divisional level. Learning identified • Staff vaccination available as required. • Occupational health support Covid-positive staff and advise on return to work and re-testing • Psychological support available		

To approve the corporate objectives for 2022/23	**Director of Strategy, Planning & Partnerships and Chief Finance Officer / Deputy Chief Executive**

Please find enclosed the report for approval of the corporate objectives for 2022/23.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 21/06/22

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

For approval

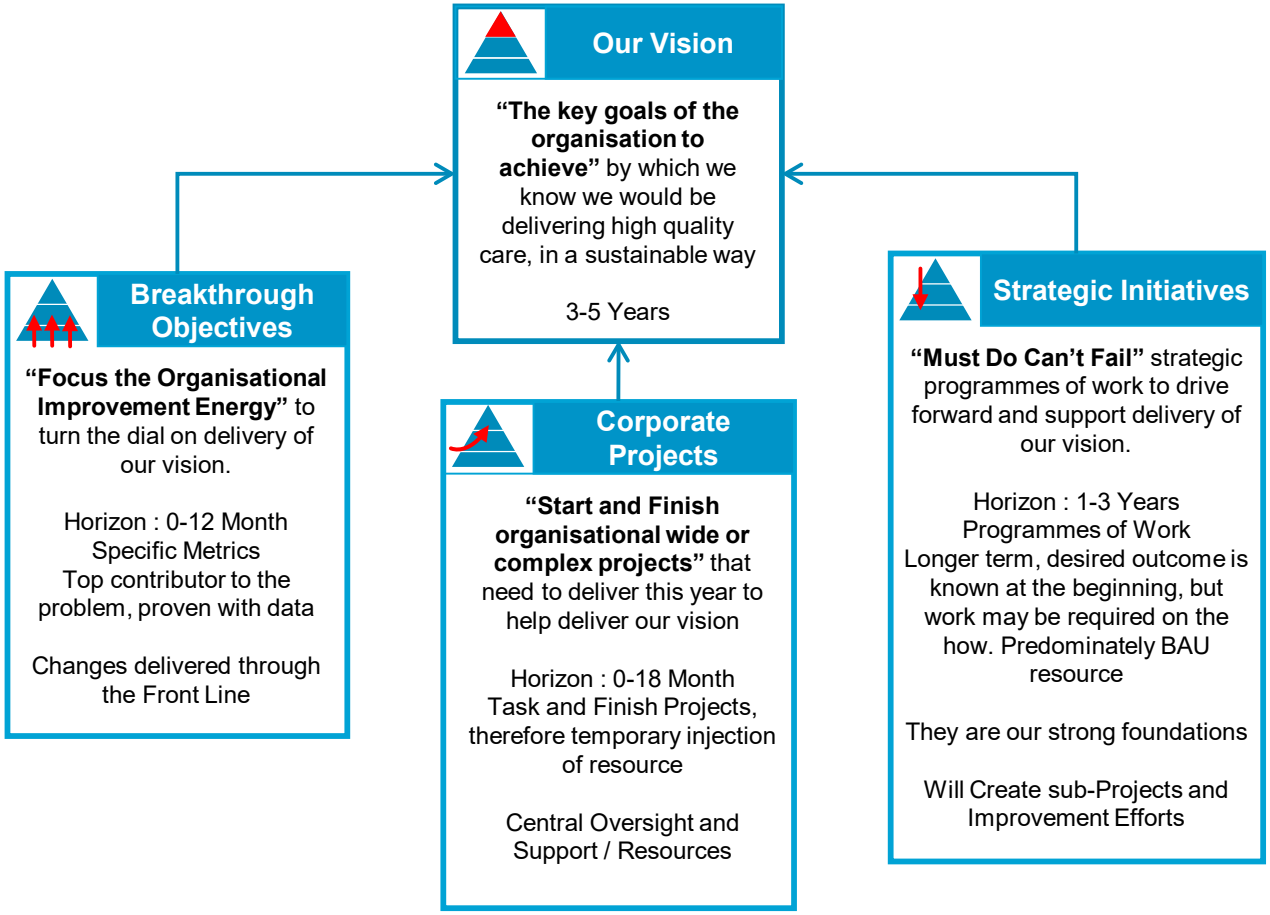
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; 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

Corporate Objectives 2022/23

Rachel Jones
Executive Director Strategy, Planning & Partnerships

June 2022

This document covers the Corporate Objectives for 2022/23 using the strategy deployment framework to support delivery of the trust vision.



Our corporate objectives are made up of breakthrough objectives and corporate projects which move us towards our vision over the next 12-18months.

- Breakthrough Objectives- focus our improvement energy. Tackling the top contributor to an identified problem and make sure we are focussing on the thing that will have the biggest impact on the problem.

- Corporate projects– start and finish project across organisational wide. Have a clear link to Our Vision and are part of how we know we are delivering on our key goals

Progress to date

- The PMO and Transformation Teams have worked Executive Directors and their teams to develop the goals, targets and breakthrough objectives for the 6 organisational strategic themes (slide 5).

- A number of additional corporate services projects have also been identified (slide 6 & 7).

- An initial executive view of additional divisional priorities has been scoped (slide 8).

- The projects needed to deliver the breakthrough objectives (corporate projects) are in the process of being identified and have been run through the project filter. High level detail is included on the Strategic A3s (slides 11 to 16).

We have a clear understanding of the priorities which our corporate objectives must focus on, in addition to progressing the corporate strategy.

- Recruitment & retention (and for partners supporting discharge pathways)
- Improving flow with focus on in patient cohorts whose care could be delivered in another setting (reducing no longer right to reside volumes)
- Financial sustainability

To be successfully deliver the goal we must deliver the target and breakthrough objectives.

Quality

Strategic Theme	Goal	Target	Breakthrough Objective
Patient Experience	A sustained, downward trajectory of concerns in relation to all aspects of communication/information provision. To provide assurance that all concerns relating to communication have been addressed and fed back to the patients. To have 0 occurrence of communication themed complaints	To reduce the number of incidents or concerns relating to communication each month.	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.
Patient Safety and Clinical effectiveness	Zero harm episodes	Reduction in incidents resulting in harm by 7.5% by June 2023	Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023
Patient Access	To ensure we are achieving all constitutional patient access standards.	Achieve the Trust RTT Trajectory by March 2023	To achieve the planned levels of new outpatient activity
Systems & Partnerships	No patient resides in an acute hospital bed who needs care that can be provided in another setting.	Decrease the number of occupied bed days relating to delayed discharges from our hospitals	Internal- to increase discharges by noon External- To provide appropriate care capacity to enable timely discharge of patients to other settings
Sustainability	Continued delivery of financial plan, with a modern and fit for purpose environment and infrastructure	Delivery of 2022/23 financial plan, including operational delivery of capital investment plan	Reduce the amount of money the Trusts spends on premium workforce spend
People	Achieve a Trust wide vacancy level of 9% over three years - by financial year 2025-6	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	Reduce turnover to 12% by March 2023

Our Corporate Projects enable delivery of our priorities, progress our corporate strategy and are aligned with the strategic themes

Proposed Corporate Projects 2022/23	1st Project Goal	Project SRO	Project Roadmap/Timescales
Outstanding Care	Set up and deliver self assessments in line with CQC domains	Jo Haworth	Aug 2022
Safer Better Sooner	Review weekend discharge processes to increase weekend discharge rates	Sean Briggs	Systems event 20th July 22
Out patient pathways & procedures	Embed consistent delivery of new standard operating procedures for OP across all OP services	Sean Briggs	Initial plan all directorates July 22 Focus specialties defined August 22 Resource and support plan complete Aug/Sept 22 Initiate plan actions from June 22
EPMA	Roll out testing of EPMA	Pete Maskell	Training commenced 6th June 22
PFIS	Implementation of training in CI to front line teams	Steve Orpin	Communication and Engagement June/July 2022 1st Cohort September 2022

We have identified a number of important pieces of work to be taken forward as corporate service projects

Proposed Corporate Service Projects	Corporate Division	Initial Project Goal	Project Road Map/Timescales
Hybrid & Remote Working	People	Develop the organisational policy and change management approach for hybrid & remote working	Project Inception July 22 Transfer to BAU March 23
Leadership Development	People	Evolve the Exceptional Leadership programme to extend to all people leaders in the Trust (Band 3 upwards) Align all people development processes e.g. appraisals, training needs analysis, talent and succession planning Develop Divisional Level Organisational Development Plans that focus on key areas for improvement identified via performance data and the staff survey. Improve staff experience of being led and line managed.	
Staff Rostering	People	Implement medical staff e-rostering AFC health roster; control processes, medical health rostering and appropriate temporary staffing solution trust wide. Workforce systems infrastructure Trust wide solution for delivery of an effective and timely provision of temporary staffing to ensure rosters are filled.	Health roster embedding – Aug 22 Data Gathering – Aug 22 Rebuild all units for interface – Aug 22 Roster training - ongoing

Initial scoping of Divisional Improvement Projects – further work required

Proposed Divisional Projects	Division	Initial Project Goal	Project Roadmap/Timescales
Community Diagnostic Centre	Diagnostics	Segmentation of elective diagnostic pathways Increase diagnostic capacity	Ongoing
Cardiology	Urgent & Emergency Care	Consolidation of I/P cardiac services on a single site	TBC
EK Oncology Development	Cancer	Develop OBC for EK cancer centre	East Kent Oncology project's objective is to provide a fit for purpose Oncology Services facilities for East Kent cancer patients . The Outline business case development led by EKHT management. This requires progression to secure funding and agreements.
Ockenden Review	Women & Children's	Implementation Ockenden action plan	**Phase 1** Ockenden is near completion with **Phase 2** Ockenden and Kirkup review findings is due to start in July
Maidstone Orthopaedic Unit	Surgery	Move adult elective orthopaedics from TW to Maidstone Unit and provide orthopaedic capacity for the K&M system.	Unit Handover from contractors – Oct Dec 22 Unit opens Jan – Mar 23 Benefits realisation Apr – Mar 23/24
PACS	Diagnostics	Replacement of existing PACS & LIMS systems as part of ICS wide plan	12-18 months

Following approval, the next steps are:

1. Work with divisions to agree their goals, targets and objectives by mid July
2. Finalise the complete organisational list of goals, targets and objectives using the catch ball process by end July
3. Ensure delivery capacity requirements can be met – this may result in some corporate projects being delayed as we focus on those that make the most impact.
4. Update integrated score card to reflect 22/23 BTOs, targets and corporate projects
5. Create draft divisional scorecards
6. Move into implementation phase

NB Given potential risks relating to further covid-19 waves, industrial action & staffing, a quarterly review process is proposed to provide the ability to reflect upon capacity and ability to deliver to agreed timescales.

Appendix 1: Strategic A3s

Our Vision A3

MTW Exceptional people, outstanding care

Our Vision Category – Patient Experience To deliver on our vision of exceptional people, outstanding care, by ensuring that patient experience is the golden thread that runs through the organisation and is everyone's business; that every patient, their family members and carers receive the best possible experience of care at MTW

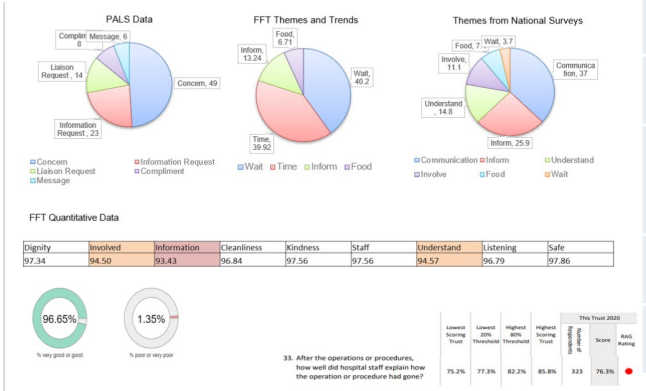
1) Problem statement

We know that not all of our patients have a good experience of care within our organisation.
This is reflected in complaints and other forms of feedback that MTW receive.
This feedback tells us that our patients are not always receiving the information they need and communication isn't always satisfactory or effective
Patient experience is a key indicator of quality and poor patient experience profoundly impacts on patient outcomes, the reputation of the organisation and staff morale.

2) Vision statement

To provide outstanding care and experience where patients are at the centre of all that we do. Communicating in an effective and timely way, Keeping patients, families or their carers' fully informed and updated throughout each step of their journey.

3) Current state and proposed measures for baseline



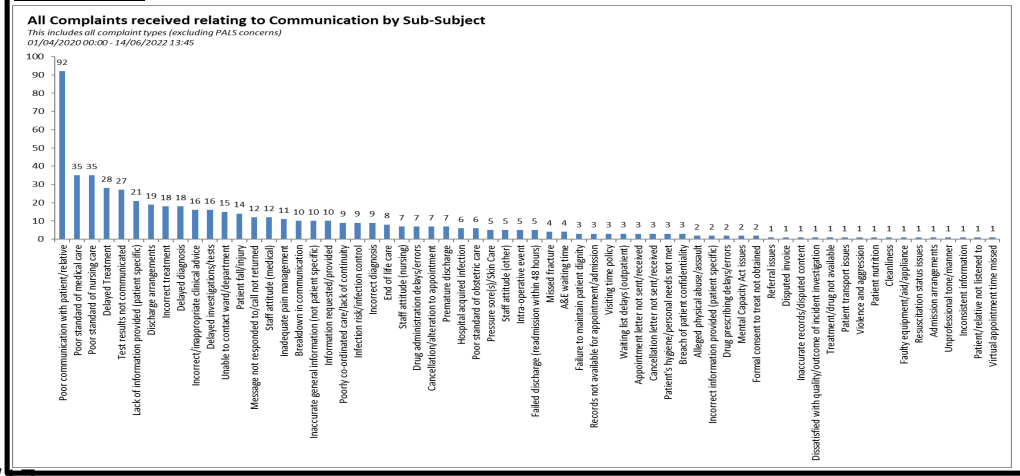
Data Sources
Friends and Family Feedback
Friends and Family Themes and Trends
National In-Patient Survey
Complaints and PALS

4) Target and goal

Target:
To reduce the overall number of complaints or concerns by 3 inpatient complaints by Datix each month

Goal:
A sustained, downward trajectory of concerns in relation to all aspects of communication/information provision.
To provide assurance that all concerns relating to communication have been addressed and fed back to the patients.
To have 0 occurrence of communication themed complaints

5) Analysis



6) Implementation plan

Breakthrough Objective:
To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.

Corporate project: Outstanding Care Programme. Trust wide KLOE self assessment role out.

Strategic Initiative: Patient and carer strategy

Our Vision A3

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

1) Problem statement

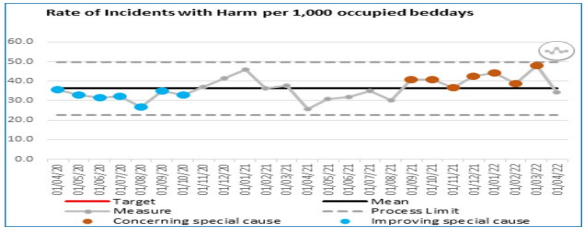
Patients should not experience harm whilst under our care. We achieve this in the majority of cases but some patients are suffering avoidable harm, and we can't be certain we learn from these events. This has a significant impact on patients, staff and the organisation.

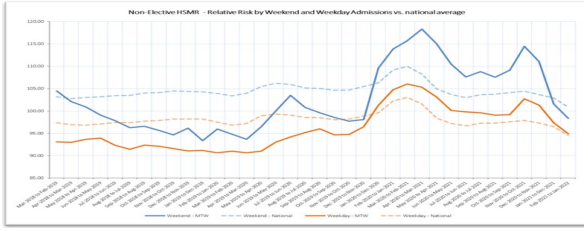
2) Vision statement

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

3) Current state and proposed measures for baseline

- On average 15% of all incidents reported have caused moderate to severe harm. Slips, trips and falls as well as pressure ulcers constitute majority of harm.
- With the exception of one quarter, the NRLS has indicated MTW is potentially under-reporting incidents since 2014. We do not review incidents in a timely manner. There are a high number of incidents currently open more than 7 days
- Our HMSR is low, with a small difference in weekday and weekend rates.





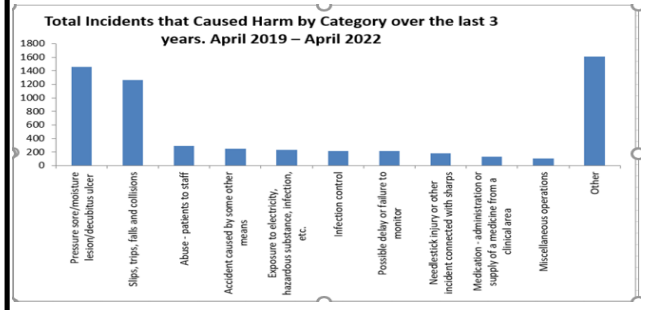
4) Target and goal

Target:. Reduction in incidents resulting in harm by 7.5% by June 2023

Goal: Zero harm episodes

5) Analysis

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



SI Reported Apr-19 to Apr-22	Total
Slips, trips, falls and collisions	90
Infection control	53
Possible delay or failure to monitor	39
Fracture - diagnosis failed or delayed	18
Cancer - diagnosis failed or delayed	16
Connected with the management of operations/treatment	15
Labour or delivery - other	9
Pressure sore/moisture lesion/decubitus ulcer	8
Self harm during 24-hour care	8
Images for diagnosis (scan/x-ray)	8
Exposure to electricity, hazardous substance, infection, etc.	8
Other (Less than 8 SIs reported, split by 52 total categories)	102

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

6) Implementation plan

Breakthrough Objective:

Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023

Our Vision A3

Our Vision Category Patient Access – Ensuring all of our patients have access to the care they need to ensure they have the best chance of getting a good outcome

1) Problem statement

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

2) Vision statement

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

3) Current state and proposed measures for baseline

Constitutional Standards other than RTT

Cancer standards maintained performance despite operational challenges

4 Hour performance and Ambulance A&E 4hr performance is experiencing common cause variation at 79.7% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally

Diagnostic waits it remains in escalation and has been hit and miss over the last 6 months at 80%

RTT

Impacted by the second wave due to cancelling electives

18 weeks - 92% target, March 70.79% rolling 25 month is 70%

52 week breaches target for March 162 actual 0

Overall W/L size – Plan 33000 actual 38715

RTT over 40 week waiters failing target and in special cause of an improving nature.

With the current state of all constitutional standards taken into account, the RTT standard is the one that would benefit with the most focus on.

Metric	Latest Performance	Rolling 25 Months
4 Hour Performance	79.7%	83.7%
Ambulance Handovers	10.5%	10.6%
Cancer 14 Days	94.2%	95%
Cancer 62 Days	85.3%	85.8%
Diagnostics DM01	82.8%	78.2%

4) Target and goal

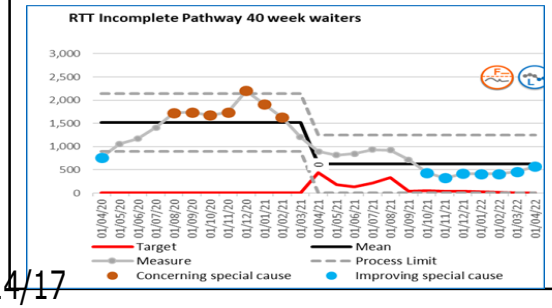
Target: Achieve the Trust RTT Trajectory by March 2023

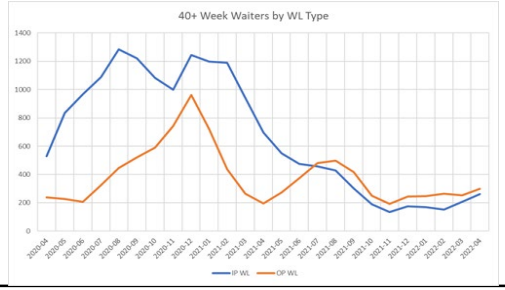
Goal: To ensure we are achieving all constitutional patient access standards.

5) Analysis

RTT

Outpatients have the largest volume of waiters over 18 weeks, however inpatient performance has not improved. Whilst the larger proportion of the RTT waiting list is outpatients, the inpatient cohort has similar volumes of 40+ week waiters as outpatients. Combined with elective impatient activity being lower than the planned trajectory suggests that a focus on RTT performance against the planned trajectory is a good approach for this vision.





6) Implementation plan

Breakthrough Objective: To achieve the planned levels of new outpatients activity (shown as a % 19/20)

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

Our Vision A3

Our Vision Category - Systems & Partnerships
Working with partners to provide the right care & support, in the right place, at the right time.

1) Problem statement

People in West Kent & parts of East Sussex are not always receiving the right care & support, in the right place, at the right time. As a consequence, some people are experiencing delayed transfers of care and spending too long in an acute hospital setting. This can lead to poor patient outcomes, experience and ineffective use of health and care resources.

2) Vision statement

People receive timely care from the right care provider in the most appropriate setting and avoid unnecessary transfer of care delays.

3) Current state and proposed measures for baseline

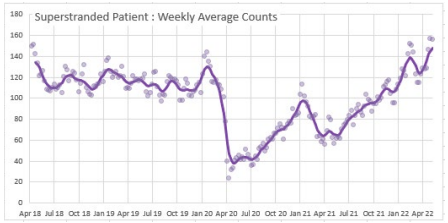
A&E attendances are rising faster than planned, however we have fewer over night non elective admissions than we did in 2019. This is in part due to the success of pathways such as UTCs and AEC.

Despite admitting fewer patients we are using more beds (and bed days) for these patient groups. The impact of this is high and sustained use of escalation beds, creating challenges with maintaining hospital flow, sustainable safe care and delivery of elective activity.

There is evidence that an increasing proportion of patients who are medically ready to be discharged from hospital are not able to be discharged in a timely manner. Of the four main discharge pathways those patients awaiting care support in their own home, and those needing specialist care are experiencing the biggest delays in discharge. We have relatively few people being discharged with no support needs (pathway 0).

Additionally we are not achieving our ambitions around discharges before noon, this further impacts on bed availability and hospital flow.

Proposed baseline measures are the number of patients within each discharge pathway, and the proportion who are medically fit for discharge, & discharges before noon.



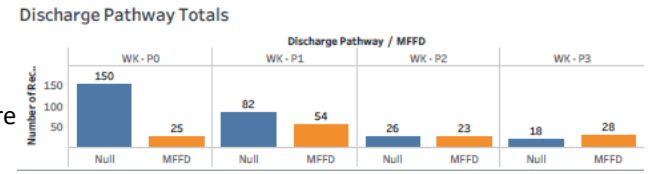
4) Target and goal

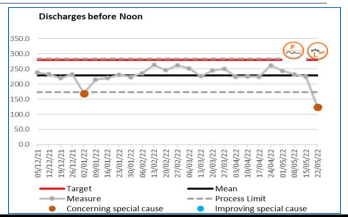
Goal: No patient resides in an acute hospital bed who needs care that can be provided in another setting.

Target: Decrease the number of occupied bed days for patients identified as medically fit for discharge.

5) Analysis

- No single view of patients needs to support discharge
- Lack of availability of care in patients own homes, due to high levels of vacancies in the care sector (some care home have also closed or reduced capacity).
- Increase in percentage of stroke patients since MTW became the receiving hospital for Medway, and delays in transfers.
- Pathway changes resulting in higher caseloads of those being assessed for care homes
- Care home capacity for those with higher levels of need.
- Discharge before noon attainment rates





6) Implementation plan

Breakthrough Objectives:

Internal

- To increase the number of patients leaving our hospitals by noon on the day of discharge

External System Support

- To provide appropriate care capacity to enable timely discharge of patients to other settings

Corporate Project

Safer Better Sooner- To reduce the number of patients experiencing discharge delays from our hospitals

Our Vision A3

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

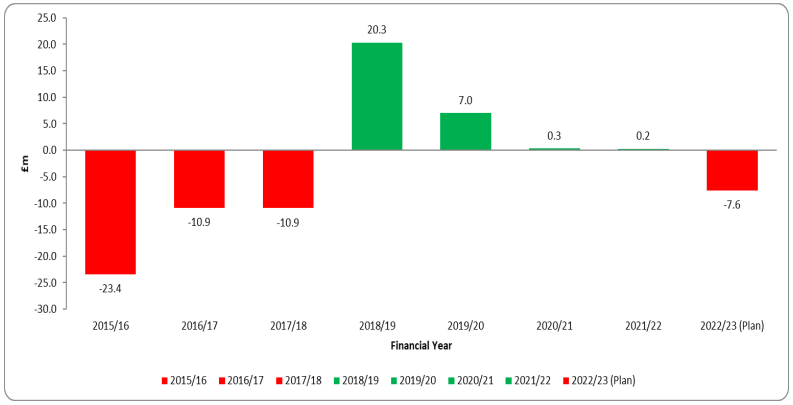
1) Problem statement

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

2) Vision statement

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

3) Current state and proposed measures for baseline



A further planning round has taken place in June with the expectation of break even.

4) Target and goal

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

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

5) Analysis

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

	Actual Spend £m			Movement £m			Movement %		
Grouping	2019/20	2020/21	2021/22	2020/21 V 2019/20	2021/22 V 2020/21	2021/22 v 2019/20	2020/21 V 2019/20	2021/22 V 2020/21	2021/22 v 2019/20
Sunstantive	249.6	285.4	306.0	35.8	20.7	56.4	14%	7%	23%
Premium Staffing	50.3	57.5	69.3	7.1	11.8	18.9	14%	21%	38%
Total Pay	**299.9**	**342.8**	**375.3**	**42.9**	**32.5**	**75.4**	**14%**	**9%**	**25%**

Premium Staffing Includes: Agency, Bank, Overtime, Waiting List Initiatives

6) Implementation plan

Breakthrough Objectives:
To reduce the amount of money the Trusts spends on premium workforce spend

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

SI – Clinical Strategy / People and Culture Strategy
Major capital funding needs to be found to support clinical strategy imperatives
Long term recruitment and retention of skilled workforce to remove use of premium temp staffing

Our Vision A3

Our Vision Category - People: Creating an inclusive, compassionate and high performing culture where our people can thrive and be their best self at work.

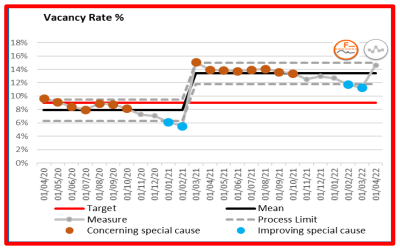
1) Problem statement

To deliver our ambition of exceptional people outstanding care we need to ensure that we have a workforce that is resourced with the right skills, in the right place at the right time. To achieve this we need to have a good pipeline of attraction, high quality recruitment and onboarding as well as high levels of retention and development to ensure that our patients and our staff have a good experience. The Trust has high levels of vacancies as well as an increasing and concerning retention issue. Our staff provide feedback on their levels of engagement, morale and draw attention to a lack of personal development and varying experiences of leadership that does not always align to our values or leadership expectations.

2) Vision statement

Delivery of a robust workforce plan and pipeline supply that meets our operational plan so that our people are well supported and are able to provide high quality patient care. People leaders will support and coach people by setting clear objectives, encourage and support learning, communicate effectively and with compassion in line with our leadership framework..

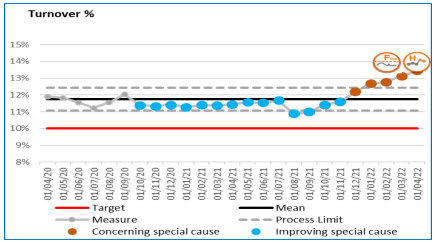
3) Current state and proposed measures for baseline



Vacancy Rate % - This metric is experiencing Common Cause Variation and is consistently failing the target This indicator is being reviewed with regards to the way the impact of the new financial year is taken into account.

Turnover: Shown for information as linked to Vacancy Rate and is consistently failing the target. The Therapies, Pathology, Imaging, Women's' Services and Acute Medicine + Geriatrics Directorates have the highest Turnover Rates.

Department	Authorisation	Advert	Longlisting	Shortlisting	Interview	Offer pending	Employment checks	Checks done	Total
Additional Clinical Services	8.1	44.2	0	1	13.1	3	36.29	17.16	122.85
Additional Professional Scientific and Technical	2	7	0	0	3	0	0	1	13
Administrative and Clerical	20.4	38.6	0	7.6	25	0	15.04	20	126.64
Allied Health Professionals	6	10.6	1	5.9	15	0	25	19.24	82.74
Estates and Ancillary	10.3	1	1	2	14.7	0	12.54	3	44.54
Healthcare Scientists	2.6	2	0	6.2	13.6	3	9	6.6	43
Nursing and Midwifery Registered	16.9	30.6	1.8	9.4	35.2	4	94.18	59.7	251.78
Totals	66.3	134	3.8	32.1	119.6	10	192.05	126.7	684.55
			355.8				328.75		



Recruitment Pipeline

	Authorisation	Advert	Longlisting	Shortlisting	Interview	Offer pending	Employment checks	Checks done	Total
CSW/TCSW/HCSW	7	13.8	0	1	11.5	2	34.18	20.83	90.31
Medical Staffing Pipeline	1	7	0	3	9	82	11	19	135

4) Goal:

Achieve a Trust wide vacancy level of 9% over three years - by financial year 2025-6

Target:

Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3

6) Implementation plan –

Breakthrough Objectives:

1. Reduce turnover to 12% by March 2023

Corporate Projects

1.Leadership development

- Evolve the Exceptional Leadership programme to extend to all people leaders in the Trust (Band 3 upwards)
- Align all people development processes e.g. appraisals, training needs analysis, talent and succession planning
- Develop Divisional Level Organisational Development Plans that focus on key areas for improvement identified via performance data and the staff survey.

2. **Corporate Project: Workforce planning/supply to support the breakthrough objective**

- Continue joint working between HR and divisions on both effective, regular and timely workforce planning and recruitment

3. Staff e-Rostering

- AFC health roster; control processes, medical health rostering and appropriate temporary staffing solution trust wide.
- Workforce systems infrastructure
- Trust wide solution for delivery of an effective and timely provision of temporary staffing to ensure rosters are filled.

5) Analysis

Turnover: This chart shows that turnover has been increasing since September 2021 across the Trust with spikes in a variety of staffing groups including nursing, additional clinical services, admin and clerical and healthcare scientist.

Turnover Rate Row Labels	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Add Prof Scientific and Technic	13.45%	12.38%	14.48%	14.40%	13.19%	13.07%	13.56%	14.20%	13.00%	11.76%
Additional Clinical Services	18.08%	12.55%	12.63%	13.07%	14.12%	14.62%	14.96%	14.87%	15.34%	15.99%
Administrative and Clerical	10.75%	11.44%	12.07%	12.69%	12.94%	13.67%	13.67%	14.33%	15.04%	15.62%
Allied Health Professionals	10.60%	11.45%	11.99%	11.50%	11.62%	13.00%	13.17%	12.86%	12.70%	12.73%
Estates and Ancillary	7.58%	8.06%	7.66%	7.64%	7.60%	8.27%	8.97%	9.77%	9.71%	10.51%
Healthcare Scientists	6.58%	7.60%	6.62%	7.54%	7.99%	8.76%	9.18%	9.18%	11.02%	13.40%
Medical and Dental	12.19%	9.99%	9.75%	9.45%	9.68%	11.08%	10.52%	10.34%	9.67%	8.82%
Nursing and Midwifery Registered	10.43%	10.72%	10.52%	11.31%	11.06%	11.24%	12.49%	12.14%	12.63%	12.62%
Grand Total	11.68%	10.89%	11.00%	11.42%	11.59%	12.19%	12.68%	12.78%	13.14%	13.44%

Annual approval of the Trust's Green Plan	**Director of Estates / Energy and Sustainability Consultant**

The Trust's Green Plan is enclosed, for approval, as part of the annual process (the Plan was last approved by the Trust Board in May 2021).

The updated Green Plan has been considered by the Executive Team Meeting (ETM) on 10/05/22, and by the Finance and Performance Committee, on 24/05/22. The Plan was supported by the ETM, but it was noted that the Plan would likely to be subject to in-year development during 2022/23, to ensure it fully aligned with all aspects of the Trust's operations, and incorporated other non-carbon related issues such as the use of plastic", which related to the intention for the Plan to reflect wider Environmental, Social, and Governance (ESG) considerations. It was also noted that the incoming Director of Strategy, Planning and Partnerships was currently the ESG lead at the Clinical Commissioning Group, so she would be able to help develop the Green Plan at the Trust.

The Plan was also supported by the Finance and Performance Committee, but it was acknowledged that the Plan contained some aspirational aspects, and it was requested that the next iteration of the Plan should ensure any 'mission critical issues' went beyond just a commitment to action. It was also agreed that the Finance and Performance Committee should receive an annual report on progress against the Green Plan, in addition to reviewing the Green Plan itself each year. This has duly been incorporated into the Finance and Performance Committee's forward programme.

Trust Board members will note that the enclosed Plan refers to the establishment of a Green Committee. The Trust Board had previously agreed that this should be a sub-committee of the Finance and Performance Committee. However, subsequent discussions led to the conclusion that it would be better for the Green Committee to be a sub-committee of the ETM instead, with the Finance and Performance Committee's role being focused on scrutiny and oversight. The Finance and Performance Committee agreed to this change, and the Trust Board approved the required change to the Finance and Performance Committee's Terms of Reference at its meeting on 24/05/22.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 10/05/22
- Finance & Performance Committee, 24/05/22

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

For approval

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

Maidstone and Tunbridge Wells NHS Trust

Green Plan

Contents

1. Vision, Strategy and Scope

1.1. Sustainability Vision

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”

1.2. Sustainability Strategy

The Trust 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 and maintained as such through continuous monitoring, mediation and changing culture around the environment and sustainability. 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 recognises that, to deliver sustainable healthcare, it must achieve positive social impacts, must mitigate its impacts on the environment and must achieve a level of financial efficiency and effectiveness.

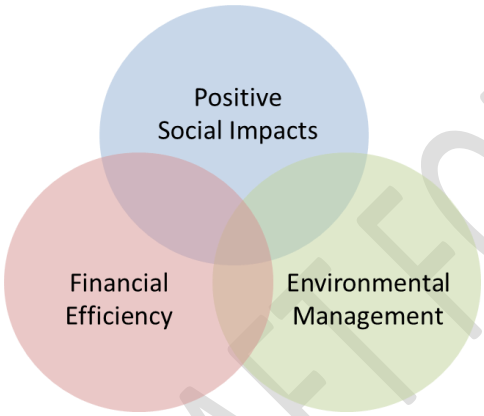


Figure 1: Components of Sustainability

The Trust has developed a Sustainability Strategy that will be implemented through a Green Plan that comprises of 8 key areas of focus:

1. Workforce and System Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Food and Nutrition
8. Adaption

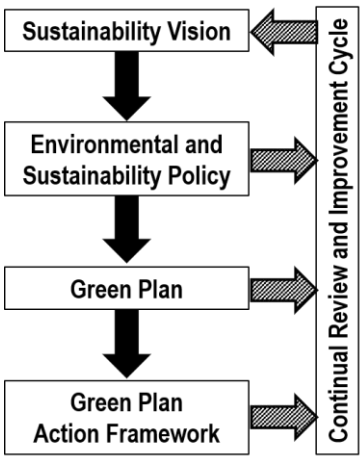


Figure 2 shows the relationship between the Vision, the Policy, the Green Plan and the Green Plan Action Framework to form the sustainability strategy.

Figure 2: Relationship of the components of the Sustainability Strategy

1.3. Scope of the Plan

This Plan is applicable across the entire geographical extent of the Trust where the Trust has direct operational responsibility

2. Drivers for Change

The key drivers for producing a green plan can be divided into 4 categories, financial, environmental, legislative and social:

2.1. Financial Drivers

- **NHS Long Term Plan**
  The NHS Long Term Plan sets out the expectation that by 2023–24 no trust will be reporting a deficit.

- **Energy and Water Costs**
  The costs of using energy, water and emitting carbon are predicted to rise in the medium to long term. The wholesale energy price is dependent upon many natural and geopolitical variables, none of which are within the immediate control of the Trust.

- **Funding Deficits and the need to generate savings**
  Trusts are under ever increasing pressure to reduce costs, generate savings and close the gap between the increasing demand for service and the funding available.

2.2. Legislative Drivers

- **Climate Change Act 2008 (2050 target amendment) order 2019**
  The Climate Change Act (2008) was introduced to ensure the UK cuts its carbon emissions by 80% by 2050. The 80% target was set against a 1990 baseline.
  The act was amended in 2019 to give a 100% target by 2050 against the same baseline.
  The act enables the UK to become a low carbon economy. It sets in place a legally binding framework allowing the government to introduce measures which will achieve carbon reduction and mitigate and adapt to climate change.

- **NHS Carbon Reduction Target**
  As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet the targets which are entrenched in law.
  The NHS has responded to the amended Climate Change Act by committing to be net zero by 2040 for the emissions that are directly controlled, called the NHS carbon footprint, and the net zero by 2045 for the emissions that are influenced, called the NHS carbon footprint plus. For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 (Measured against a 1990 baseline). For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 (Measured against a 1990 baseline).

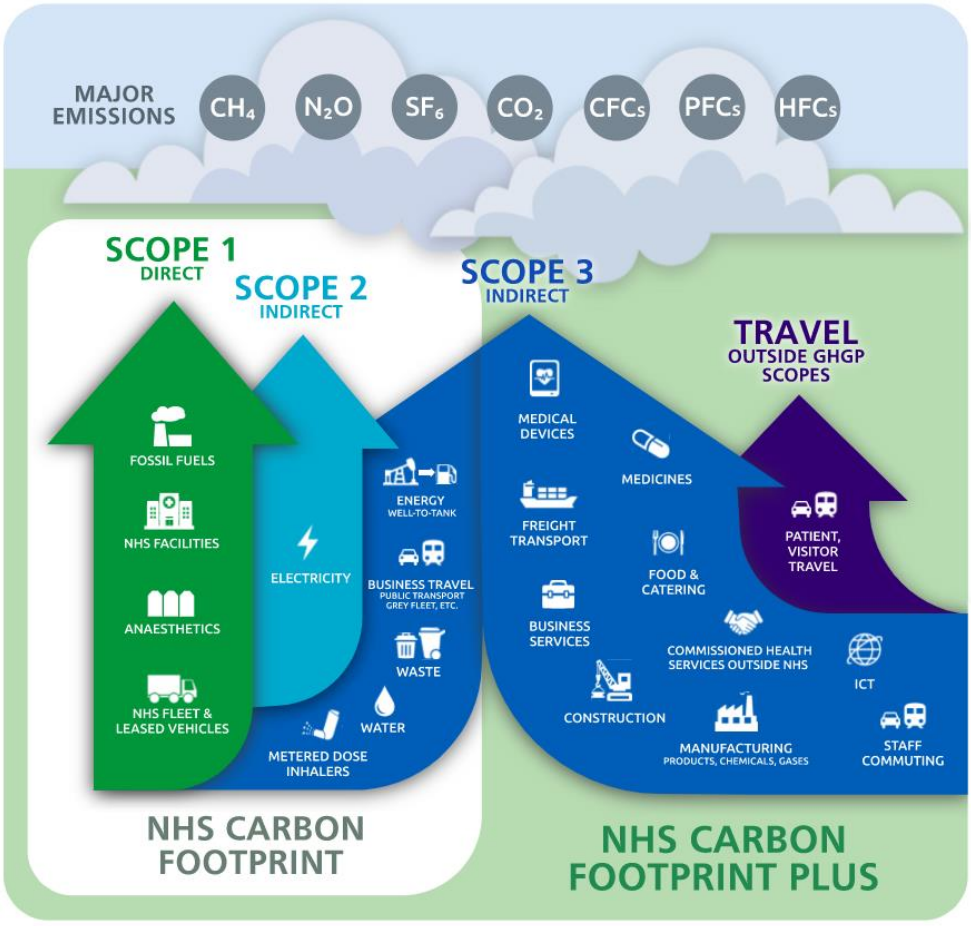


Figure 3: NHS Carbon Footprint and Carbon Footprint Plus

- **Public Services (Social Value) Act 2012**
  The Public Services (Social Value Act) was passed at the end of February 2012 and came into force in January 2013. Under the Act, for the first time, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

2.3. Environmental Drivers

- **Natural resources**
  Natural resources are essential to human life and civilisation, their loss threatens human wellbeing and economic stability and development

- **Threats to Public Health**
  Public health is adversely affected by pollution to air, land and water as well as being jeopardised by extreme weather events associated with Climate Change.

2.4. Social Drivers

- **Changing Demographics**
  Using resident populations for the districts of Maidstone, Sevenoaks, Tonbridge & Malling and Tunbridge Wells, the following changes are predicted over the next 20 years:
  The overall population of the four districts is expected to increase, with the highest increases in Maidstone for 65 years or over (11% increase) and Tonbridge & Malling for people aged over 85 years (26%).

  This population increase has serious implications for health and care delivery from both a financial and activity perspective.

  Older people have the greatest risk of their health being affected by cold temperatures. The majority of excess winter deaths are in people 75 years old

  The prevalence of multi-morbidity increases substantially with age

  The prevalence of dementia increases with age and these patients need additional elements in their care

- **Public Opinion**
  There is a large and growing expectation amongst the public and staff members that the NHS should do more to address its environmental impacts and take action to reduce them.

3. Specific Areas of Focus and Related Targets

3.1. Workforce and System Leadership

The Trust aspires will be a demonstrable leader within the provision of sustainable healthcare and is committed to engaging and partnering at all levels, both locally, regionally and nationally to deliver this ambition. The Trust will ensure that the Green Plan is adopted by Heads of Department and Senior Management Team members and is cascaded through the lines of control

The Trust will make carbon reduction and sustainable development corporate responsibilities and will ensure that they are integrated into the governance and reporting mechanism.

The Trust will have a clear vison of its Sustainability Goals and will ensure that responsibility and accountability for sustainable development is clear within its organisational structures.

The Trust will produce evidence of its progress towards targets to satisfy the requirements of its regulators and commissioners. In addition the Trust will publish performance information to provide assurance to its stakeholders that the Trust is managing its corporate responsibility commitments.

The Trust will establish a Green Committee. The Green Committee will be responsible for developing innovative ideas and techniques to support the implementation of this Green Plan and the achievement of the targets within it.

The trust recognises its own staff members are essential and intrinsic to the delivery of sustainable healthcare and is committed to supporting and developing its staff to have the competencies and skills to deliver sustainable healthcare within their specific areas of operation and to challenge and rectify practices that are not complementary to this aim. This will be achieved through the mainstreaming of sustainability into job descriptions and daily activities and ensuring that all staff have access to information and training to inform their decision making and clinical practice to become more sustainable.

Related Targets and Current Progress

1 The Trust has a clear vision of its Sustainability Goals

2 Responsibility and accountability for carbon reduction and sustainable development is clear in the Trust

3 Green Committee established within appropriate Governance Structure

4 Staff have access to suitable training and awareness to mainstream sustainability through their roles

3.2. Sustainable Clinical Care Models

The Trust is committed to the transformation of its service to deliver improved health outcomes coupled with social and environmental benefits.

The Trust recognises that the way that healthcare services are delivered will need to change to accommodate the changes associated with rising costs, changing population intensities, demographics and locations. Financial and budgetary pressures will continue to challenge the service provision as well as the ever changing and evolving structure of NHS services within the local and regional setting.

The Trust will ensure that environmental and social sustainability assessments are included as a standard within the templates for business case and service redesign templates and will review the models of care and patient pathways to take into account the overhead use of resources and carbon footprint.

The Trust will consider the most appropriate locations of services and facilities to minimise internal travel and will seek to maximise the opportunities presented by technology to facilitate remote and distance meetings.

The Trust is committed to working in partnership with all stakeholders within the newly formed Integrated Care System (ICS) to collaborate on projects and initiatives, to share and develop best practice and to establish more efficient and sustainable methods of working.

Related Targets and Current Progress

5 Environmental and Social Sustainability Assessments are included as standard within business cases and service redesign plans.

6 The Trust is participating within the ICS collaborative structures

3.3. Digital Transformation

The Trust is committed to fully engaging to maximise the use of technology to support patient care to ensure the effectiveness and efficiency of the services being provided whilst minimising the environmental impacts of vehicle journeys.
The Trust recognises the 2021/22 planning guidance that where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.

The Trust is committed to working in partnership with all stakeholders within the newly formed Integrated Care System (ICS) to collaborate on projects and initiatives related to the digitalisation of services, to share and develop best practice with other parties and to ensure that the digital transformation of service provision is fully considered at all possible avenues of service review.

Related Targets and Current Progress

7 The Trust is delivering 25% of outpatient activity remotely

8 The Trust is participating within the ICS collaborative structures related to digital transformation of services

3.4. Travel and Transport

The Trust is committed to reducing the emissions associated with staff and patient transport and strives to provide efficient low carbon transport services across its operational environment and is taking measures in the following areas:

Trust Owned Fleet

The Trust is committed to a process of the life cycle replacement of all fleet vehicles with zero emission, fully electric models.

The Trust will replace 14 vans and 2 pool cars in 2022 with electric alternatives and will install 16 commercial EV charge points across both sites to power these vehicles.

This program will affect 16 vehicles with an annual mileage total of 170,000 miles.

The leases on the Trust's fleet of 7 trucks expires in 2024, and these vehicles will also be exchanged for fully electric alternatives at this juncture.

In addition to this the Trust commits that no new fossil fuelled vehicles will be purchased or leased by the Trust from 1st January 2022.

Staff Travel

In December 2019 the Trust entered into an arrangement with Arriva which allows staff free travel on the Arriva services for hi frequency journeys between Maidstone town centre and Maidstone Hospital and also to and from Tunbridge Wells Hospital on presentation of their ID badges.

This service has proved to be very popular with staff and the Trust are committed to its retention and a periodic review of potential areas of expansion. Whilst there has been an understandable drop in use of public transport by staff due to the Covid 19 pandemic this program will remain in place to act as a role model for other similar organisations to adopt.

Travel Survey

The Trust is committed to undertaking periodic staff travel surveys in order to track and monitor staff travel patterns and to ensure that the Trust is accurately reflecting the needs of its staff.

Cycle to Work Scheme

The Trust operates a salary sacrifice cycle to work scheme and are committed to retaining this option for staff and to ensuring that the facilities for cyclists are sufficient and appropriate to accommodate the needs of their users.

Electric Vehicle Charge Points

The Trust has already installed 8 charge bays at Maidstone Hospital and 4 at Tunbridge Wells Hospital, and are committed to increasing this number significantly across all sites by 2030.

Collaborative working with other ICS stakeholders

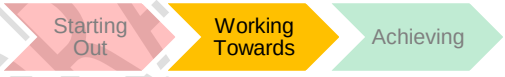
The Trust is committed to working in partnership with all stakeholders within the newly formed Integrated Care System (ICS) to collaborate on projects and initiatives, to share and develop best practice and to establish more efficient and sustainable methods of working in relation to sharing capacity and planning for more efficient use of transport.

Green Travel Plan

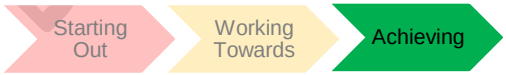
The Trust maintains a detailed green travel plan and is committed to updating this on a regular basis.

Related Targets and Current Progress

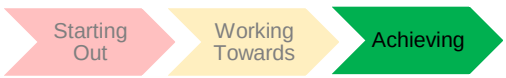
9 Life cycle replacement of all Trust owned fleet vehicles with zero emission electric vehicles by 2024



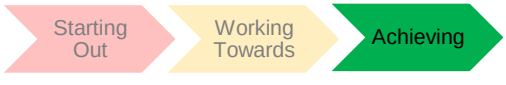
10 The Trust maintains a provision of free bus travel for staff to and from Hospital sites



11 The Trust conducts periodic Staff Travel Surveys

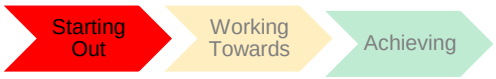


12 The Trust has an active Cycle to Work Scheme

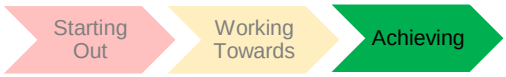


13 The Trust has installed EV Charge points in all permanent sites

14 The Trust is participating within the ICS collaborative structures



15 The Trust has a valid and up to date Green Travel Plan



3.5. Estates and Facilities

Energy Efficiency

The Trust is committed to operating in a manner that eliminates unnecessary energy and water use, utilises equipment and materials effectively, reduces waste production, maximises waste recycling, accurately assesses and mitigates impacts to the environment and causes no environmental damage through accidental discharges or spills.

The Trust has already upgraded 95% of the lights at Maidstone Hospital and 60% of the lights at Tunbridge Wells Hospital to LED. The Trust is committed to ensuring that all lighting in the Trust is upgraded to LED by 2025.

The Trust will monitor and report upon its energy and water usage and its Scope 1 and Scope 2 emissions on an annual basis and will set internal targets with the aim of reducing the carbon emissions associated with its activities in line with the NHS Carbon Reduction Targets.

The Trust will create a tangible culture that is intolerant of energy and water wastage, will optimise equipment and systems for efficient operation and will monitor, record and report on the energy and water performance of different geographical areas and buildings within the hospital sites.

Decarbonisation of Heat and Hot Water

The Trust is committed to decarbonising the provision of heat and hot water across its operational estate and will identify opportunities for capital replacement and upgrade of equipment and infrastructure that will have an energy and water saving benefit.

The Trust is actively planning the de-steaming of the Maidstone Hospital site and is developing a detailed multi phase strategy for the installation of a Low Temperature Hot Water network to replace the existing steam network. (see figure 4)

The Trust is undertaking feasibility assessments of alternative heat sources for the eventual replacement of the gas boilers at the site, this includes geothermal energy, heat pumps and connections to local or district heating schemes. The Trust is engaged with Kent County Council in the exploration of these strategic opportunities.

Tunbridge Wells Hospital is a more modern building and already utilises an LTHW Network, which means that the site is already in phase 2 of the decarbonisation strategy (see figure 4)

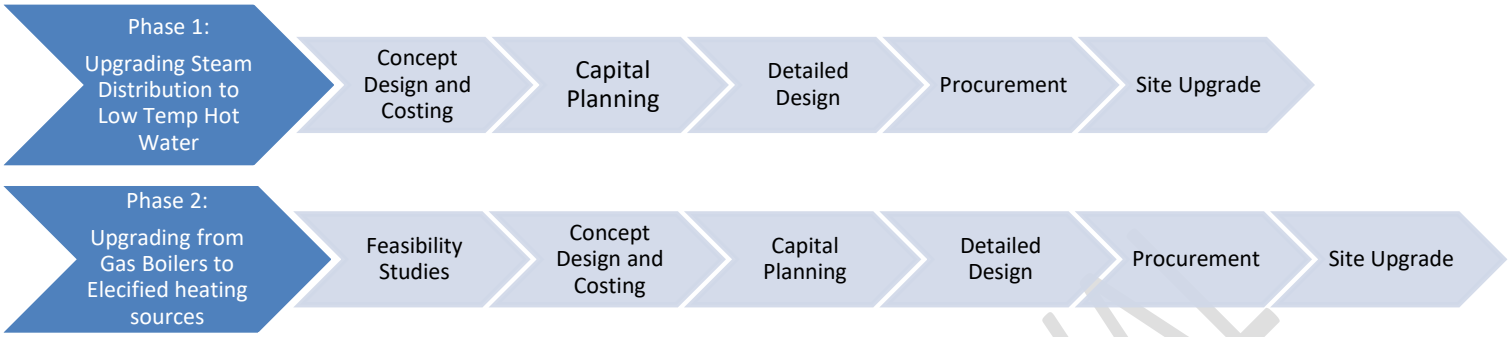


Figure 4: 3 Phase Decarbonisation strategy for Heat and Hot Water

Waste Management and Circular Economy

The Trust is committed to applying the waste hierarchy in all aspects of its operation, including those of subcontractors, to ensure that none of its waste is send to landfill and to maximising the recycling of waste that is produced. We recognise that we have lost ground due to the pandemic and will launch a new recycling campaign in 2022.

The Trust is committed to reusing existing items where this is possible to prevent unwarranted disposal and to engaging with regional stakeholders in the development of wider reuse schemes.

The Trust will maintain a waste management strategy that will contain targets for improving the levels of recycling and reused items.

Building Design and Refurbishments

The Trust is committed to ensuring that all new building projects and refurbishments achieve a minimum of a BREAAM Very Good assessment.

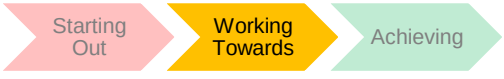
Green Spaces

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy.

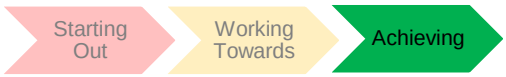
The Trust will improve access to its green spaces and natural environments for stakeholders and will maintain and enhance the biodiversity capacity of its managed estate.

Related Targets and Current Progress

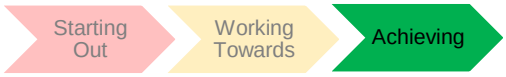
16 The Trust has upgraded all lighting to LED by 2025



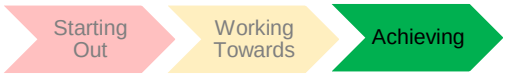
17 The Trust monitors and reports upon energy and water consumption for different geographical areas and buildings within the hospital sites.



18 The Trust has in place a valid strategy for the decarbonisation of heat and hot water.



19 The Trust has a valid and up to date Waste Management Strategy



20 The Trust is enhancing its green spaces

3.6. Medicines

The Trust recognises that the manufacture and use of medicines has a high carbon footprint and is committed to reducing this where possible whilst maintaining high levels of patient care.

Anaesthetic Gasses

The Trust has now significantly reduced Desflurane use across all operations, and replaced this harmful anaesthetic gas with other, more environmentally friendly products. The Trust is committed to further reducing desflurane use to the absolute minimum in the next year.

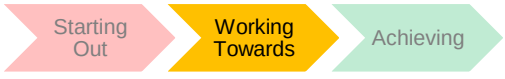
Inhalers

The Trust recognises that pressurised Metered Dose Inhalers (pMDI's) have a high carbon footprint and the Trust is committed to replacing these with low carbon alternatives where this is clinically viable. The Trust is actively promoting the prescribing of greener inhalers and is committed to engaging with all stakeholders, internally and within the wider ICS community, in the continuing rollout of this important initiative.

Related Targets and Current Progress

21 The Trust has reduced Desflurane use to the absolute minimum.

22 The Trust is actively promoting the prescribing of low carbon inhalers internally



23 The Trust is participating within the ICS collaborative structures related to low carbon medicines

3.7. Supply Chain and Procurement

The Trust is committed to engaging with all members of the supply chain to ensure that all aspects of procured goods and services are conducted in an environment that strives to reduce embedded carbon, and that our supply chain partners are fully compliant and supportive of local, regional and national initiatives.
The Trust is creating a new sustainability buyer role within the procurement department which will be responsible for taking the lead in ensuring that all aspects of the supply chain are analysed and opportunities to improve are leveraged.

The Trust will actively engage with suppliers to reduce the level of single use plastic that is being procured and used on a day to day basis.

The Trust is committed to ensuring that social value is measured as an essential component of the evaluation of bids for services, and that the environmental impact, carbon footprint and carbon reduction plans of suppliers will be considered when contracts for goods and services are being awarded.

The Trust further recognises that the NHS family is large and commits to engage in partnership working with our partner Trusts throughout the ICS to ensure that maximum benefit is leveraged from the scale of procurement opportunities in the county healthcare supply chain.

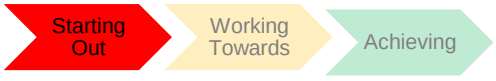
Related Targets and Current Progress

24 The Trust has a full time Sustainability Buyer in post.

25 The Trust measures social value in the evaluation of bids for goods and services

26 The Trust considers the carbon footprint and carbon reduction plans of suppliers in the evaluation of bids for goods and services

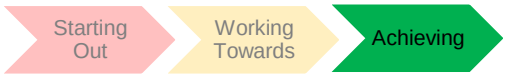
27 The Trust is participating within the ICS collaborative structures related to low carbon procurement



3.8. Food and Nutrition

The Trust recognises the carbon footprint of the being procured, prepared and served to patients and staff and is committed to reducing this where possible.
The Trust is already engaging local suppliers and ensuring that all fresh meat, vegetables, dairy and bakery products are procured locally to ensure that food miles are minimised as far as possible.
Where products are not fresh and are procured from further afield, such as frozen or tinned items, the Trust is reviewing supply contracts and ensuring that local procurement clauses are inserted to these where this is commercially viable and that suppliers of these items are meeting the procurement guidelines in terms of social value and carbon reduction plans.

28 The Trust buys all fresh ingredients locally.



29 The Trust ensures that non fresh items are procured from suppliers who meet social value and in the evaluation of bids for goods and services

3.9. Adaption

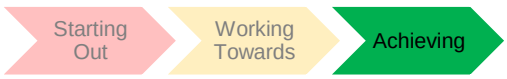
The Trust recognises that the process of climate change is leading to the normal patterns of weather changing and severe weather events becoming more frequent and prolonged. These include heatwaves, drought and water shortage, extreme cold events and associated snowfall, extreme rainfall and associated fluvial (surface water) flooding, changes to groundwater levels and associated groundwater flooding, severe storms and high winds.

The effects of climate change to the Trust have the potential to be severe, and the organisational risk register will be updated to include the appraisal of the legal, financial, infrastructure and service related risks and action plans will be developed to manage the risks that have been identified. The Trust will use standard risk assessment tools and externally available guidance and support to assist with the risk assessment process.

The Trust will ensure that any redevelopment or new development of its facilities appraises the potential changes to the climate, the potential effects of those changes on the facility and seeks to mitigate them at the design stage.

The Trust will prepare plans for the risks identified and will integrate the process of planning with the existing processes for Emergency Planning and Business Continuity.

30 The trust understands and minimises the current and future risks to the organisation from climate change



31 Adaptation plans are in place that link to business continuity and emergency planning processes

4. Scope 1 and 2 Emissions Target

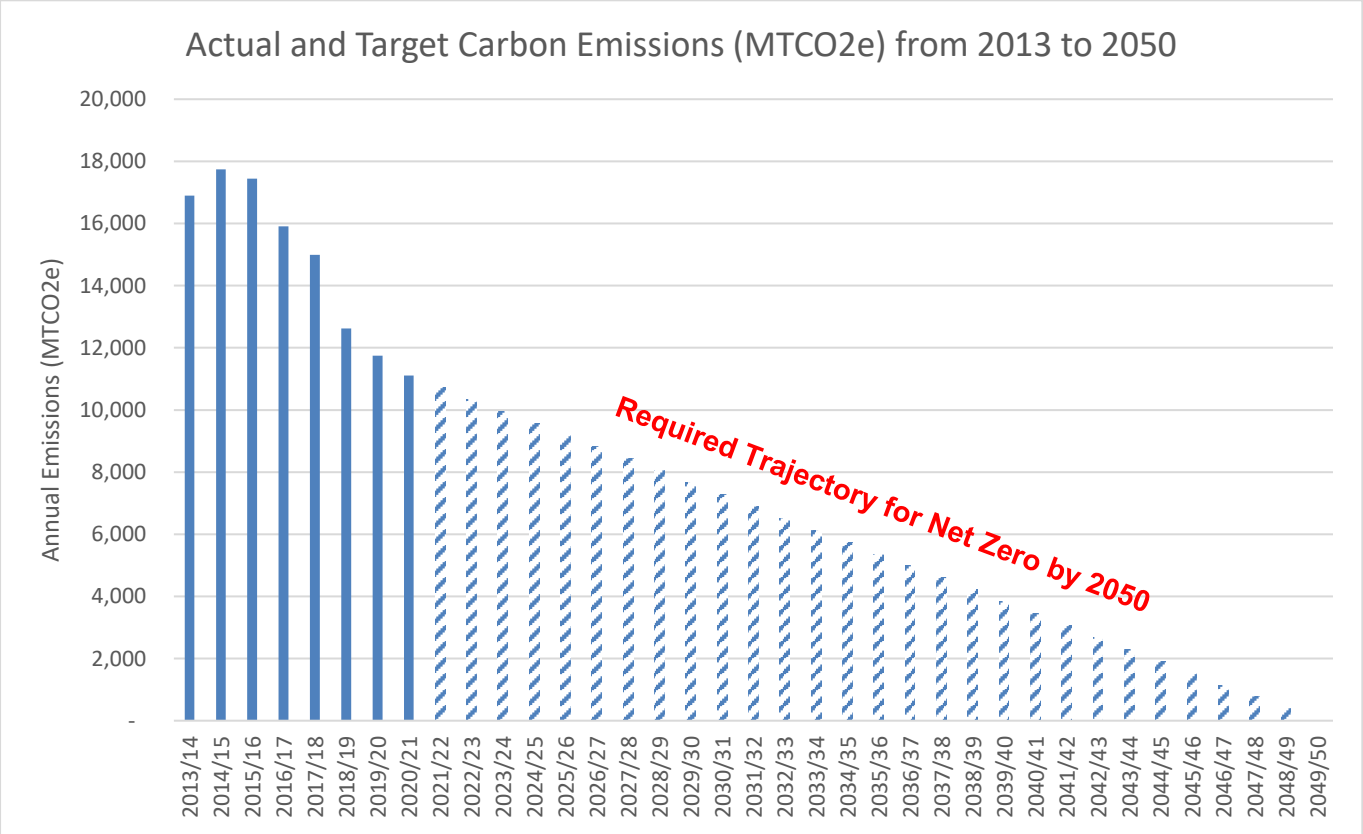
In 2016 the Trust set a target of a 28% reduction in scope 1 and 2 carbon emissions by 2020/2021 against a 2013/14 baseline.

The Trust exceeded this target a year early, in March 2020.

The Graph below shows the scope 1 and 2 emissions of the Trust since 2013/14, the progress to date and the required decarbonisation trajectory to meet the NHS targets of zero emissions by 2050. The graph clearly shows that the current emissions trajectory of the Trust is highly favourable.

The Trust has undertaken a significant number of projects and initiatives since 2016 and the scope 1 and 2 emissions have reduced by 36.3% in the last 5 years since the 2015/16 period.

The future targets for carbon reduction have been set in line with the path to zero emissions by 2050, and this equates to an annual reduction of circa 3.5%.



5. Green Plan Action Framework

Specific actions arising from and related to this Green Plan will be tracked through the Green Plan Action Framework.

All actions within the framework will have a member of the committee assigned as lead for the action and will have timeframes for implementation and review timeframes established and recorded.
Progress against actions contained within the framework will be reviewed by the Green Committee on a quarterly basis.

6. Review

This plan will be reviewed and ratified on an annual basis by the Green Committee, The Financial and Performance Committee and the Trust Board

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve the Trust's proposed submission for the Data Security and Protection Toolkit (DSPT) for 2021/22 — **Chief Nurse**

Please find enclosed the "To approve the Trust's proposed submission for the Data Security and Protection Toolkit (DSPT) for 2021/22" report.

The Board is asked to authorise the submission of the 'standards met' Toolkit year-end submission.

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

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

1. Background and Scope

The purpose of this paper is to provide the Board with a recommendation in relation to the mandatory Data Security and Protection Toolkit submission which is required to be made by close of play on 30 June 2022.

2. What the Board needs to know

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisation to measure their performance against the National Data Guardian's 10 data security standards.

The 10 standards are as follows:

1 Personal Confidential Data
All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

2 Staff Responsibilities
All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

3 Training
All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

4 Managing Data Access
Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.

5 Process Reviews
Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

6 Responding to Incidents
Cyber-attacks against services are identified and resisted and security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.

7 Continuity Planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

8 Unsupported Systems
No unsupported operating systems, software or internet browsers are used within the IT estate.

9 IT Protection
A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually

10 Accountable Suppliers
IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

The 10 Data Security Standards detailed above are devolved into mandatory and supplementary 'assertions'.

The Toolkit, this year, is broken down into 38 Assertions, which are further broken down into mandatory and non-mandatory evidence requirements.

In order to achieve a fully compliant DSP Toolkit, all mandatory evidence requirements across the 38 assertions must be achieved by the organisation. These standards address modern data security threats as well as inherent information governance processes developed over time in NHS organisations.

All organisations that have access to NHS patient data and systems are required to use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The Board are advised that the Trust has completed the work of gathering evidence to support the 109 mandatory evidence items of this year's Toolkit. We have been able to complete 107 of the 109 mandatory requirements.

TIAA were requested to undertake an independent audit of the organisation's 10 Data Security Standards. The audit coverage was aligned to the mandatory scope and framework methodology as set out by NHS Digital for 2021-2022.

The overall conclusions contained within the report include one priority finding which gives an overall assurance opinion of Moderate.

The Audit report from TIAA has been reviewed and agreed.

The DSPT submission will be considered by the CQC as part of the Well-Led inspections.

3. Recommendation

It is recommended that the Trust makes a 'Standards Not Met' submission on 30 June 2022, supported by an improvement plan for the mandatory assertion that has not been met.

As per the national guidance the Trust has informed Daniel Oliver, the NHSD Regional Security Lead, of the position and is working with him on the plan and timeline for completion of the follow-on actions.

The Board are asked to support this position.