NHS
Maidstone and Tunbridge Wells NHS Trust

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

22 October 2020, 09:45 to 13:00
Virtual meeting, via webconference

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).

10-1
To receive apologies for absence

David Highton

10-2
To declare interests relevant to agenda items

David Highton

10-3
To approve the minutes of the 'Part 1' Trust Board meeting of 24th September 2020

David Highton

Board minutes 24.09.20 (Part 1).pdf (9 pages)

10-4
To note progress with previous actions

David Highton

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

10-5
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

10-6
Report from the Chief Executive

Miles Scott

Chief Executive's report October 2020.pdf (2 pages)

10-7
Integrated Performance Report (IPR) for September 2020 (incl. planned and actual ward staffing for Sept. 2020)

Miles Scott and colleagues

IPR for Sept 2020 (incl. planned and actual ward staffing).pdf (32 pages)

Planning and strategy

10-8
Update on Phase three (of NHS response to COVID-19) performance, the OPEL and COVID-19 escalation framework, and 16-week plan (incorporating the winter plan)

N.B. This item has been scheduled for 10.15am

Sean Briggs and Lynn Gray

Update on Phase three etc.pdf (63 pages)

10-9

Review of nurse staffing for Ward and non-Ward areas (mid-year update)

Claire O'Brien

Review of nurse staffing (mid-year report).pdf (20 pages)

10-10

The Kent and Medway Integrated Care System (ICS) status application

N.B. This item has been scheduled for 11am

Wilf Williams

The Kent and Medway Integrated Care System (ICS) status application.pdf (4 pages)

10-11

To approve the Digital Transformation Strategy

N.B. This item has been scheduled for 11.30am

Jane Saunders

Digital Transformation Strategy.pdf (28 pages)

Quality items

10-12

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

Sara Mumford

DIPC Annual Report.pdf (49 pages)

Assurance and policy

10-13

Six-monthly update on Estates and Facilities (incl. update on the response to the external Estates and Facilities review)

Miles Scott

Estates and Facilities October 2020 Board Report.pdf (8 pages)

10-14

Approval of the Workforce Race Equality Standard (WRES) action plan

N.B. This item has been scheduled for 12.10pm

Jo Garrity and Rantimi Ayodele

WRES action plan.pdf (13 pages)

10-15

Quarterly report from the Freedom to Speak Up Guardian

N.B. This item has been scheduled for 12.20pm

Christian Lippiatt

FTSU Board Report October 2020.pdf (4 pages)

10-16

To ratify a revised Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

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Kevin Rowan

Proposed changes to the policy for policies.pdf (39 pages)

Reports from Trust Board sub-committees

10-17
Workforce Committee, 18/09/20 and 15/10/20 (including approval of proposed changes to the Committee's Terms of Reference)

N.B. The meeting on 15/10/20 will be primarily covered via a verbal report (as a written report from that meeting will be submitted to the Board in November)

Emma Pettitt-Mitchell

Summary of Workforce Cttee, 18.09.20.pdf (2 pages)

Updated Workforce Committee ToR.pdf (4 pages)

10-18
Quality Committee, 16/10/20

This will be a verbal report.

Sarah Dunnett

10-19
Finance and Performance Committee, 20/10/20

N.B. The report will be issued after the meeting on 20/10/20.

Neil Griffiths

10-20
To consider any other business

David Highton

10-21
To approve the motion (to enable the Board to convene its 'Part 2' meeting) that...

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

David Highton

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 24th SEPTEMBER 2020, 9.45 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director (from item 09-7)	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Cheryl Lee	Director of Workforce	(CL)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Blanchard-Stow	Divisional Director of Midwifery, Nursing and Quality (for item 09-9)	(SBS)
	Lynn Gray	Deputy Chief Operating Officer (for item 09-10)	(LG)
	Rob Parsons	Risk and Compliance Manager (for item 09-13)	(RP)
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]

09-1 To receive apologies for absence

No apologies were received, but it was noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance. DH then welcomed CL to her first Trust Board meeting since joining the Trust as (interim) Director of Workforce.

09-2 To declare interests relevant to agenda items

No interests were declared.

09-3 To approve the minutes of the 'Part 1' Trust Board meeting of 23rd July 2020

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

09-4 To note progress with previous actions

The circulated report was noted. Questions were invited. None were received.

09-5 Report from the Chair of the Trust Board

DH firstly acknowledged the challenging environment the Trust's staff were working in at present, and gave his appreciation for the innovative ways such staff had responded. DH then referred to the relevant attachment, highlighted the appointment of an acute physician and colorectal surgeon, and added that he hoped further appointments would be made in the future.

09-6 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the key points therein, which included that all of the Trust's services were 'open for business' and the Trust was focusing on addressing any waiting list backlogs that had developed during the COVID-19 period, as well as preparing for the second wave of COVID-19, which would likely affect Kent further in the near future. MS added that the rising anxiety and tension that was palpable in society was also evident within the Trust. DH added that the impact of the UK's impending complete exit from the EU was also a key consideration for Kent. MS agreed, and gave assurance that considerable preparations had undertaken for that exit, and the Trust Board would need to consider such preparations in the future, perhaps at its meeting in October 2020.

MS then continued and highlighted that the Trust had achieved a number of recent successes, including the continued delivery of the cancer access targets; being the top-rated performer in the country on the Emergency Department (ED) 4-hour waiting time target, being recognised in the HSJ Values Awards; and the Joint Advisory Group (on Gastrointestinal Endoscopy) (JAG) accreditation.

MS then noted that only circa eight of the Trust's staff were shielding from COVID-19, and then concluded the item by highlighting that the context he had provided should be borne in mind when considering the other reports on the agenda. DH acknowledged the point.

09-7 Integrated Performance Report (IPR) for August 2020 (incl. planned and actual ward staffing for July and August 2020)

MS referred to the relevant attachment and introduced the item by highlighting the importance of the Trust having effective patient flow arrangements, which was not the case at some other Trusts, whose bed occupancy was rising. MS commended SB and his team for their efforts in that regard.

MS then commended the contribution that COB's leadership had made to the improvement in complaints response performance, but noted that the performance on staff appraisal completion still required attention.

COB then referred to the "Safe" domain and highlighted the improved performance regarding pressure ulcers, but noted that a higher number of falls had been seen, particularly at Tunbridge Wells Hospital (TWH). COB added that the Trust's falls lead was working closely with falls 'hotspot' areas, while liaison was continuing with the Business Intelligence team on the falls data.

PM then referred to the "Effective" domain, highlighted that data for the "% Total Readmissions" indicator was incorrect, and apologised for not identifying the errors before the IPR had been issued. PM then reported on the "Stroke: Best Practice (BPT) Overall %" indicator and the Sentinel Stroke National Audit Programme (SSNAP) rating and stated that he was confident that performance would improve, as the data indicated that the Stroke Unit was currently performing at a SSNAP Level 'A', but that had not been confirmed.

PM then noted that mortality would be covered under item 09-8, but reported the latest position regarding the infection prevention and control indicators. SDu referred to the latter and noted that the "Infection Control - Number of Hospital acquired Covid" indicator data was listed as "Coming Soon", so asked when that would be available, as reporting such data may allay any concerns the public had about returning to the Trust's hospitals for treatment. PM replied that the issues had been discussed at the daily COVID-19 conference call held earlier that morning, and he hoped that the data would be reported in the October IPR. MS added that he believed that such data was already available, as he understood the Trust compared favourably with other local Trusts, and it would therefore possible to report that data.

COB then referred to the "Caring" domain and provided further details of the aforementioned complaints response performance. COB commended all the staff involved in the improved performance, which had been influenced by stability in the Complaints Team, increased engagement with clinical staff, and the timely signing of complaints response letters by members of

the Executive Team. COB however highlighted the challenges associated with the Friends and Family Test (FFT) performance and noted that the situation would continue to be monitored.

SO then referred to the financial aspects of the “Well Led” domain and reported that the financial position was break-even for the month. SO also reported the latest details of the national financial regime and COVID-19-related costs, and noted that the current regime would continue in September, but an elective activity incentives framework would commence soon. SO added that the national financial regime would then change in October, so it was intended to submit a detailed forecast for 2020/21 to the Trust Board’s meeting in October 2020.

SO then reported the latest position on capital funding, and noted that the Trust was awaiting the outcome of the bids it had made for the central funding that was available. SO added that the Trust was also discussing the situation with the Sustainability and Transformation Partnership (STP). SO also reported on the latest cash position, noting that some adjustments would be made, but these were not expected to be significant. NG remarked that the Finance and Performance Committee had, at its meeting on 22/09/20, acknowledged that the Trust had taken a pragmatic approach, but registered concern over the uncertainty of the future position and looked forward to clarity being provided over the coming weeks.

CL then referred to the workforce aspects of the “Well Led” domain and noted that some data regarding nursing recruitment had been provided to Trust Board members. CL also acknowledged MS’ earlier remarks regarding appraisal compliance and gave assurance that work was underway to review the appraisal system, which included ensuring that individual objectives were linked to the Trust’s objectives, and preparing for the start of the next cycle of appraisals, which would commence in April 2021. CL added that the Associate Director of Organisational Development was involved in that work.

SB then referred to the “Responsive” domain and highlighted the challenges with restarting elective activity, which included the fact that the Trust would have its first admission of a COVID-19 positive patient later that day. SB then commended the achievement of all those who had contributed to the Trust being the best in the country for ED 4-hour waiting time target performance. SB however noted the caution regarding inpatient activity and bed occupancy but highlighted the continued delivery of the 62-day cancer waiting time target. SB also noted the importance of keeping the cancer waiting list backlog low. SB then concluded by noting that he expected data on the performance against the 28-day ‘Faster Diagnosis Standard’ for cancer to be included in the IPR from next month, but the Trust continued to perform very well on the standard.

DH commended the performance and noted that preparations regarding the second wave of COVID-19 cases would be discussed under item 09-10.

Quality items

09-8 Quarterly mortality data

PM referred to the relevant attachment, noted that the report had already been considered by the ‘main’ Quality Committee, and highlighted the key points therein, which included the increase in the Hospital Standardised Mortality Ratio (HSMR), both for the one-month and 12-month rolling average; and the latest Intensive Care National Audit & Research Centre (ICNARC) data.

PM also reported that the local system had reviewed COVID-19-related mortality. PM noted the differences between community-related deaths and hospital-related deaths and opined on the potential reasons for such differences. PM then referred to the Summary Hospital-level Mortality Indicator (SHMI) and elaborated on the work that had taken place to understand the latest position, including the work on clinical coding, but acknowledged that more needed to be done.

PM then referred to the work that the Mortality Surveillance Group had undertaken on deprivation, but acknowledged the significant efforts that were required to improve the completion of mortality reviews, although the new Medical Examiner role would support such efforts.

DH noted the adverse impact of COVID-19-related deaths on mortality rates and asked whether it would be possible to exclude such deaths from the data. PM replied that he believed Dr Foster would adjust the mortality rates for COVID-19-related deaths, but if they did not, he would ask them to do so.

09-9 Update on progress against the CNST maternity incentive scheme standards

DH welcomed SBS to the meeting, who then referred to the relevant attachment and highlighted that NHS Resolution had paused the CNST maternity incentive scheme because of COVID-19. SBS also confirmed that the report that had been submitted to the Trust Board would not be submitted as part of the CNST Scheme.

SBS did however report that the underlying actions to achieve the standards had continued, which included the continuation of quarterly Perinatal Mortality Review Tool reporting to the Trust Board. SBS also acknowledged that the Trust had struggled to have a full 'gap and grow' service, but gave assurance that the issue was receiving focused attention.

SBS then also acknowledged the difficulties in complying with the "Skills Drills" mandatory training, but added that a further training day had been held, so compliance was now 60%. SBS also gave assurance regarding future training compliance. SBS then concluded by noting that the Trust had continued to provide a near-normal maternity service during the COVID-19 period. COB commended SBS & her colleagues and gave further assurance regarding the "PROMPT" training.

DH asked for further details of how the Healthcare Safety Investigation Branch (HSIB) had worked during the COVID-19 period. SBS provided the requested details and confirmed that the Trust's relationship with the HSIB had improved in recent times.

Reset and recovery

09-10 The Trust's Phase three (of NHS response to COVID-19) planning; plan for the forthcoming winter; contingencies for a second wave of COVID-19 cases; lessons learned from the first COVID-19 wave; and the latest position re overseas nursing recruitment

DH referred to the relevant attachment and noted that the delay in the issue of the central guidance had meant that the original intention to submit a full report to the Trust Board had not been feasible, as much of the intended content was 'work in progress', and unsuitable for being in the public domain. DH added that a report had however been considered in detail at the Finance and Performance Committee meeting on 22/09/20. MS acknowledged DH's remarks and noted that the documents to which members of the Executive Team would refer during the discussion had been made available to Trust Board members via the "Admincontrol" meetings portal.

SB then reported the following points:

- One of the main challenges had been the allocation of physical space, and in particular the locations of the Surgical Assessment Unit (SAU), Short Stay Surgical Unit (SSSU), and a second, 'red' (i.e. COVID-19) ICU, but the various moves required had now been agreed. It had also recently been agreed that a prefabricated SAU would be installed at TWH by December 2020, although the practical aspects had not yet been confirmed.
- SB had increased confidence regarding elective activity, although there were some issues with endoscopy, which included the effect of the introduction of the Quantitative Faecal Immunochemical Test (qFIT), which had reduced the need for endoscopies in some patients.

MS added that the aforementioned documents on "Admincontrol" had formed the basis of the Phase three (of NHS response to COVID-19) submission the Trust had already made. DH acknowledged the point.

SDu remarked that she understood that the cancer treatment choices that were available during the COVID-19 period had been limited and asked whether that was still the case. SB acknowledged that some Trusts had opted not to provide certain treatments, but the Trust had ensured that all clinicians had tailored pathways, and any patients that had received alternative

treatments during the COVID-19 period had been subject to regular reviews. SB added that all of the Trust's pre-COVID-19 pathways had now been reintroduced and there was no evidence of any harm arising from the use of alternative treatments.

DH asked what the current arrangements were for the testing and isolation of surgical patients. SB replied that patients were tested before being admitted, but acknowledged that the arrangements were not as flexible as they were before the COVID-19 period, in relation to asking patients to be ready to be admitted at short notice, in the event of a theatre slot becoming available. PM added further details regarding the more stringent arrangements that were in place for high-risk patients.

NG then asked SB to report on the issues affecting outpatients that had been discussed at the Finance and Performance Committee meeting on 22/09/20. SB obliged and elaborated on the factors that had hindered the efforts to transform outpatients during recent months. SB also outlined the challenges to be addressed, which included some of the administrative processes, and in particular the 'cashing up' process, which related to patients being discharged from outpatient clinics. SB then gave further details of the scrutiny that would be applied to the plans to improve, at the Executive Team Meeting and Quality Committee 'deep dive' meeting. DH emphasised the importance of using data to transform any service. The point was acknowledged.

DH then asked for details on the winter plan, noting that a more detailed report would be considered at the Trust Board meeting in October 2020. LG duly reported that a draft winter plan had been discussed at the Finance and Performance Committee meeting on 22/09/20 and highlighted the main aspects of that plan, which included details of the bed modelling and assumptions. LG also noted that the bed shortfall was currently anticipated to be circa 60 beds, but work was continuing to mitigate that shortfall. LG then reported details of the Trust's relationships with partner organisations, including with South East Coast Ambulance Service NHS Foundation Trust, and highlighted the positive impact of the national discharge policy that had recently been issued by the Department of Health and Social Care. LG continued that the Trust had established a Full Capacity Plan for the first time that year, and gave brief details of the work to prepare for the forthcoming flu season and EU exit. DH commended the work on the winter plan and noted that he looked forward to discussing a more detailed report at the October 2020 Trust Board meeting.

DH then stated that the Non-Executive Directors wanted to ensure that the Trust's recovery efforts and response to the second wave of COVID-19 cases did not place an undue burden on the Trust's middle managers, so asked what support would be provided in that regard. MS explained that the Trust intended to implement a phased approach and not apply the same approach to non-COVID-19 services that occurred during the first COVID-19 wave. MS continued that the members of the Executive Team were also applying a proportionate response to priorities, & gave assurance that the importance of having clarity on priorities, and undertaking appropriate engagement with middle managers, was fully acknowledged. SO added further details, which included the approach that had been taken to performance oversight through the Divisional Performance Reviews. CL also conveyed her own observations from the short time she had been at the Trust.

DH confirmed that he had been assured that the Trust was applying the positive and supportive management style that was wanted, but cautioned against the pressure faced by senior staff being transferred disproportionally to more junior staff. RF added that a further key aspect was to ensure that anyone who had concerns felt comfortable in raising these. MS replied that he believed, based on the number of direct contacts and emails that he and members of the Executive Team received from staff, that the Trust had made real progress on that aspect.

DH then noted that the Finance and Performance Committee meeting on 22/09/20 had not considered workforce aspects, as the data had not been available, so invited such aspects to be discussed. COB therefore reported the latest details on nursing staffing levels and recruitment, and emphasised that the situation was dynamic, so although the headline numbers may seem alarming, there was a healthy recruitment pipeline. COB then reported on the status of overseas recruitment, which included the national support being offered following recent communication from the NHS' Chief Nursing Officer. COB then elaborated on the work needed to improve nursing supervision.

CL then added further details, including the consideration being given to extending overseas recruitment to non-nursing positions. CL also noted the importance of considering turnover data when judging the Trust's recruitment efforts, as well as focusing on reducing such turnover. CL then summarised that there needed to be a review of Divisional workforce plans that extended beyond nursing staff; along with a review of capacity and capability in the Human Resources team.

DH acknowledged the desire to reduce the use of expensive overseas recruitment agencies, but stated that although that was understandable, caution should be exercised before applying a disproportionate response, and thereby risk a return to employing lots of expensive agency staff. The point was acknowledged.

EPM asked whether the plans described by COB reflected a continuation or re-start of the Trust's recruitment efforts. COB confirmed that it was the former, as the Trust's recruitment plans were dynamic and ongoing. EPM stated that it would be beneficial to consider a plan regarding the Trust's recruitment intentions at the next Workforce Committee meeting. CL and COB agreed.

Action: Submit a plan to the October 2020 meeting of the Workforce Committee regarding the Trust's recruitment intentions, following on from the discussion at the 'Part 1' Trust Board meeting on 24/09/20 (Director of Workforce / Chief Nurse, October 2020)

09-11 The allocation of resources and funding as part of the 'reset and recovery' programme

SO referred to the relevant attachment and noted that a version of the report had been considered at the Finance and Performance Committee meeting in August 2020, and was being submitted to the Trust Board in September because the Trust Board did not meet in August.

SO then highlighted that the investments described in the report did not depend on the Trust receiving any external funding; and while the individual investments were below the financial threshold at which the Finance and Performance Committee's or Trust Board's approval was required, the overall programme was significant, so the Trust Board was therefore asked to approve that programme. SO added that the one exception was the Business Case for 7 Day Services in Medicine, and therefore the Trust Board was asked to approve the first year of that Case, on the understanding that a detailed Business Case would be submitted in due course.

DH clarified that the Trust Board was being asked to approve an investment programme, in the same way that it may, in a non-COVID-19 year, be asked to approve a budget, and therefore not approve the individual components of that programme, as that level of approval would be given by members of the Executive Team. SO confirmed that was correct.

DH asked where the costs of the first year of the 7 Day Services Business Case were described in the report. SO answered that the costs were included within the "Acute and Urgent Care" costs on page 2 of 4.

DH then noted the Discharge Lounge was only available five days per week, so asked whether it was intended to extend the days, to align with the 7 Day Services Business Case. SB confirmed that it was intended to extend the Discharge Lounge to seven days and PM added further context.

DM referred to page 3 and noted that the £1.7m "Other funding available" was not carried through to 2021/22 so asked for an explanation. SO confirmed that the £1.7m was for non-recurrent funding, and although an assumption could have been made that similar funding would be available in 2021/22, a prudent approach had been taken. DM stated that he would expect the Full Year Effect (FYE) column to include all funding. SO confirmed that the FYE column should only include recurrent funds.

The Trust Board approved the overall approach to investments to support reset and recovery (which included the first year of the Business Case for 7 Day Services in Medicine). The Trust Board also approved the recruitment to critical roles to support the reset and recovery programme as submitted.

Assurance and policy

09-12 Responsible Officer's Annual Report 2019/20

PM referred to the relevant attachment and highlighted the key points therein, which included that the medical appraisal process had not been too affected by the COVID-19 period, but next year's process would be more affected. PM added further details on the changes that would be applied to the process.

RF noted that the report contained lots of statistics, but asked what key messages had emerged from the appraisals. PM explained that the wide range of scope of practice among medical staff meant that the Personal Development Plans (PDPs) were very wide, so PM would need to discuss that issue with the Trust's medical Appraisal Lead for inclusion in the 2020/21 Annual Report.

Action: Arrange for the Responsible Officer's Annual Report for 2020/21 to include details of the key messages arising from medical staff appraisals (rather than just the statistics associated with such appraisals) (Medical Director, September 2021)

CL commended PM's success, given the high appraisal rate, and stated that she hoped to repeat that level of compliance among non-medical staff.

DH asked how often an appraisal resulted in changes to a person's scope of clinical practice. PM noted that the appraisal process for doctors relied on a high level of insight, and stated that DH's point would hopefully be addressed in the action he had agreed to undertake in response to RF's earlier query.

EPM asked whether there was any way that the output from the appraisals could be linked to the Trust's Black and Asian Minority Ethnic (BAME) community. PM replied that medical appraisal was a professional appraisal, and while 'push' objectives could be considered, these would be owned by the General Medical Council (GMC). MS noted that the Trust had committed to have a specific BAME section in the new talent management arrangements and gave further details. MC then gave her own observations while JW asked for PM to comment on how the appraisal process had been adapted for doctors who had worked outside of their usual scope of practice during the COVID-19 period. PM noted that some flexibility had been indicated by the GMC, but in reality, the level of acceptable standards was unchanged.

09-13 Health & Safety Annual Report, 2019/20 and agreement of the 2020/21 programme (incl. Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

DH welcomed RP to the meeting. RP then referred to the relevant attachment and highlighted the key points therein, which included that some of the objectives from 2019/20 would be carried forward in 2020/21; and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents had been stable, although work was required to improve the timelines of reporting such incidents to the Health and Safety Executive (HSE).

RP continued that there had been an increase in the number of harm incidents, due to a change in methodology, so although comparisons with previous years could still be made, these would be more meaningful in future years. RP also noted that the different approaches that Trusts had taken to report COVID-19-related RIDDORs would likely affect the future comparison between Trusts.

RP then provided details of the sharps-related incidents and the response to try and reduce these; as well as the violence and aggression-related incidents. RP noted that the Trust's new Security and Car Parking Manager had made some improvements, including on conflict resolution training.

RP then referred to the objectives for 2020/21 and also outlined the key aspects of Appendix A, which constituted the Trust Board's annual refresher training on health & safety, fire safety, and moving & handling, and which included the concept of "Safety-I" and "Safety-II" ("Safety Differently") as well details of relevant healthcare prosecutions.

SDu asked why water safety was not included in the Annual Report. RP explained that water safety had historically been considered via the Infection Prevention and Control framework, but it

could be included in the Health & Safety Annual Report if required. COB confirmed that she supported the inclusion of water safety in the Health & Safety Annual Report.

Action: Ensure that the Health & Safety Annual Report for 2020/21 included content on water-related safety issues (Chief Operating Officer (via the Risk and Compliance Manager), September 2021)

MC commended the positive approach RP had taken towards Health and Safety, including the efforts to promote a safe reporting culture.

COB then acknowledged the violence and aggression incidents and noted the work required in relation to the use of Body Worn Cameras by Security staff, and on clarifying the thresholds for when staff who were faced with incidents should call for support.

DM welcomed the "Safety-II" approach, which was dependent on a mindset, and asked whether there was anything the Trust Board could do to propagate the right mindset. RP stated that he believed the Trust Board should continue to promote a positive reporting culture.

RF also commended RP for the balance that the report struck between "Safety-I" and "Safety-II", but asked what further action could assist with the aim. COB replied that opportunities were taken to promote the culture of learning when things went wrong, and to raise the profile of safety, although more could always be done. RP added that staff were regularly encouraged to report incidents and undertake risk assessments, but agreed that more could always be done.

DH thanked RP for the presentation of the Annual Report and for his continued hard work.

The Health and Safety programme for 2020/21 was approved as submitted.

Reports from Trust Board sub-committees

09-14 Workforce Committee, 17/07/20 (incl. quarterly report from the Guardian of Safe Working Hours) and 18/09/20

EPM deferred to RF, who referred to the relevant attachment and invited questions or comments. None were received.

09-15 Charitable Funds Committee, 21/07/20

DM referred to the relevant attachment, highlighted the key points therein, and invited questions or comments. None were received.

09-16 Audit and Governance Committee, 30/07/20 (incl. the Annual Audit Letter for 2019/20)

DM referred to the relevant attachment and highlighted the key points therein, which included that the action regarding the effectiveness of the data received by the Trust's management for decision-making had led to a discussion at the Finance and Performance Committee meeting on

09-17 Quality Committee, 13/08/20 and 16/09/20

SDu referred to the relevant attachment, highlighted the key points therein, and noted that the Trust Board was asked to approve two changes to the Quality Strategy, which had been considered and agreed by the Quality Committee. The proposed amendments to the Quality Strategy were approved as submitted.

09-18 Finance and Performance Committee, 25/08/20 (incl. approval of revised Terms of Reference) and 22/09/20

NG referred to the relevant attachment, highlighted the key points therein, and invited questions or comments. None were received. KR then pointed out that the Trust Board was asked to approve the revised Terms of Reference, which had been included in the summary report from the meeting held on 25/08/20. The revised Terms of Reference were duly approved as submitted.

09-19 Patient Experience Committee, 03/09/20

MC referred to the relevant attachment, highlighted the key points therein, and invited questions or comments. None were received.

09-20 To consider any other business

DH noted that Baroness 'Dido' Harding had sent a message to the NHS Chairs' WhatsApp group, of which DH was a member, to announce that the NHS COVID-19 App had now been launched.

09-21 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
09-10	Submit a plan to the October 2020 meeting of the Workforce Committee regarding the Trust's recruitment intentions, following on from the discussion at the 'Part 1' Trust Board meeting on 24/09/20	Director of Workforce / Chief Nurse	October 2020	An "Update on recruitment and retention" report was considered at the Workforce Committee meeting on 15/10/20.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
09-12	Arrange for the Responsible Officer's Annual Report for 2020/21 to include details of the key messages arising from medical staff appraisals (rather than just the statistics associated with such appraisals)	Medical Director	September 2021	
				The report is not scheduled to be considered at the Trust Board until September 2021
09-13	Ensure that the Health & Safety Annual Report for 2020/21 included content on water-related safety issues	Chief Operating Officer (via the Risk and Compliance Manager)	September 2021	
				The report is not cheduled to be onsidered at the Trust Board until September 2021

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

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

The last month has seen extraordinary efforts by our staff teams to increase activity levels across our services back toward our historic pre-pandemic levels and in planning how to increase even further in coming months. However, this work is against a backdrop of an expected growth in COVID-19 hospital admissions and the normal seasonal increase in demand for our services. Coupled with uncertainty about the potential impact of EU Exit arrangement in Kent after December 31 2020, there is an obvious requirement to plan a range of scenarios over the next six months. I have been impressed with the range of escalation planning which our teams have been undertaking, led by our Executive Team, and the recognition that the staff of the Trust are our most vital resource as we face the expected pressures over coming months.

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and the Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and two other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

Date of AAC	Title	First name	Surname	Department	Potential / Actual Start date
14/10/2020	Consultant Geriatrician	Chee Kin	Soo	Care of The Elderly	To be confirmed

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. Cases of coronavirus continue to rise in all age groups nationally and locally. For the first time since early summer, we have seen a small increase in admissions of patients who have tested positive for Covid-19 to our hospitals. The numbers are small - on average about two to four patients every week- but we know from previous experience this can change quickly and we are not complacent. Our leadership teams are actively reviewing our Covid plans and they are developing further measures to provide more support in dealing with a second wave, while also managing normal winter pressures and ensuring we maintain elective, day case and outpatient activity. These plans focus on a number of critical areas, including:
   - staff welfare and psychological support;
   - workforce planning;
   - creating additional red-pathway ITU capacity at Tunbridge Wells Hospital;
   - reviewing space for waiting, administrative and clinical areas.

   Clear escalation steps that match the level of local infection we are dealing with at any one point have also been introduced. For example, as infection levels rise changes such as restricting visiting and asking more staff to work from home will be made. We'll step these back down when infections reduce.

   Activity in both diagnostics and elective care is continuing to increase in line with last year's levels by scheduling extra sessions both in the evenings and weekends as well as working in partnership with the private sector. MTW is working hard to ensure our hospital associated Covid infection rates remain low through the continual surveillance and monitoring of cases and putting in place stringent infection control and prevention measures. As a result our hospitals are safe to visit and we would strongly encourage people not to delay getting the healthcare help they need.

2. This month we distributed over 8,000 Covid-19 appreciation certificates and commemorative badges to staff and volunteers to thank them for their huge contribution and outstanding work during the ongoing Covid-19 pandemic. Feedback from colleagues has been very positive with many expressing gratitude and thanks for being recognised for their efforts.

3. To mark Black History Month, MTW's Cultural and Ethnic Minority Network (CEMN) held its first inclusivity conference this month. The Power of Us featured a range of high profile speakers who presented on a range of topics about how individuals and organisations can work together to be inclusive and to encourage people to understand other points of view. The conference supports the Trust's Workforce Race Equality Standard (WRES) action plan which sets out MTW's vision to become an inclusive workplace. This includes introducing reverse mentoring for the Trust Board and introducing clear procedures that encourage diversity in the Trust's recruitment processes.

4. A huge thank you to the East and West Kent Freemason Provinces for their generous donation of £11,621, which will be used to fund equipment, including an additional IsoLoader. The money will enable MTW to expand its pioneering prostate Brachytherapy service and treat more patients. The Trust is incredibly grateful to the Freemasons for their ongoing support, which will help MTW to continue to lead the way with treatment in this field.

5. Last year MTW set a vision for the organisation: Exceptional People, Outstanding Care. MTW has an ambitious trust strategy, with a clear focus on: achieving a CQC 'Outstanding' rating; implementing an innovative clinical strategy with new services and specialist areas of expertise; having the highest levels of staff engagement in the national NHS staff survey; and maximising the opportunities as a system leader in the West Kent Integrated Care Partnership and as a cancer centre for Kent and Medway. Five strategic pillars of work are helping us achieve this:

- Exceptional Leaders programme
- Cultural Change (launched)
- Strategy deployment
- Patient First Improvement System (PFIS)
- Digital Transformation (launched)

This month the strategy deployment and PFIS pillars were rolled out. Western Sussex Hospitals Chief Executive Dame Marianne Griffiths and Director of Strategy and Delivery Pete Landstrom visited the trust to share their experiences and help support these programmes of work. Their trust embedded a very effective way of aligning their strategy with their objectives, and the actions they need to take. MTW is learning from this and using some of those processes to make positive change, and help refine and improve our systems and processes so that the Trust can confidently and sustainably move forward. MTW also launched a new leadership development and training programme to give our senior leaders the skills to support our ambition and vision.

6. A former MTW stroke patient officially opened a garden at Maidstone Hospital this month following a recent makeover. Hannah's Garden was created seven years ago after former stroke patient Hannah Green raised £5,000 to transform a small grassy area into a tranquil space for stroke patients to have somewhere quiet to sit and enjoy the sunshine, or have physiotherapy sessions outside as part of their rehabilitation process.

   Over time the garden had become tired looking so it was given a new lease of life with the help of a group of volunteers and donations from the local community. As well as two new benches, multi-surface paths, plants and landscaping work, the newly renovated garden also includes a bespoke mural of a natural landscape painted by talented artist Luiza Jordan. Thank you to everyone who has helped with this project, which is already bringing much joy to our stroke patients.

7. Five pieces of artwork celebrating the NHS, carers, keyworkers, volunteers and society for overcoming issues raised during the coronavirus pandemic, are now on display in the main reception area of Tunbridge Wells Hospital. Named The Lockdown Banners, they were created by renowned artist and photographer Ian Beesley, with the help of Tony Husband – a British cartoonist, and Martyn Hall – who works as a senior creative designer for the Joseph Rowntree Foundation. A poem penned by British poet Ian McMillan also sits beneath each of the banners to support the artwork.

8. Seven delivery rooms at Tunbridge Wells Hospital have been refurbished to create a home from home feel for people in labour thanks to a generous donation. Soft lighting, cushions, plants, yoga mats and birthing mats, a coffee table, and pictures have been installed along with motivational quotes on the walls of the low risk birthing rooms to help create a calm environment for parents as they prepare to bring their new born into the world. Thank you to former MTW Matron Sarah Woodward, who donated £350 towards the cost with an additional £550 coming from Maternity Voices – a working group consisting of parents, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

9. MTW marked Baby Loss Awareness Week this month with a special video from Chaplain Stephen Baker and bereavement midwife Ruth Paul featuring poems and readings. MTW also set up a small tree in the multi-faith centres for families to hang the name of their baby who was sadly born sleeping or lost through miscarriage.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 6, 2020/21, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 20/10/20 (IPR)
- Executive Team Meeting, 22/09/20 (IPR)

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

September 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 24 onwards)

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

MTW
exceptional people, outstanding care

Kev 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	Variation Indicates consistently (P)assing of the target	Variation Indicates inconsistently passing and falling short of the target	Variation Indicates consistently (F)alling short of the target	Data Currently unavailable or insufficient data points to generate SPC

Special Cause - 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 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

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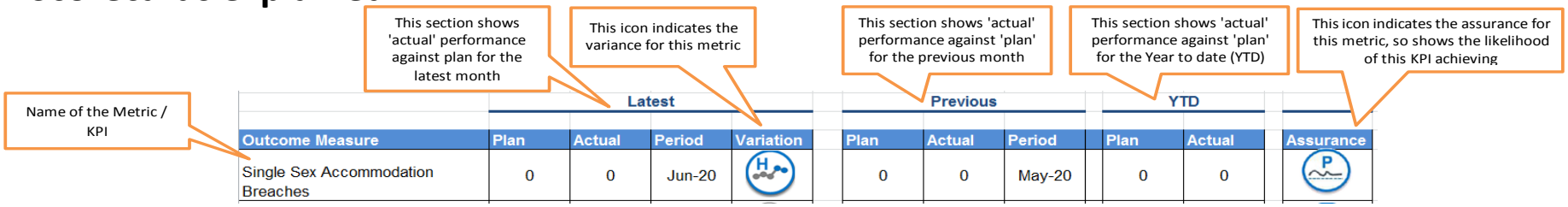
Escalation Rules:

Areas are escalated for reporting if:

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

Scorecards explained



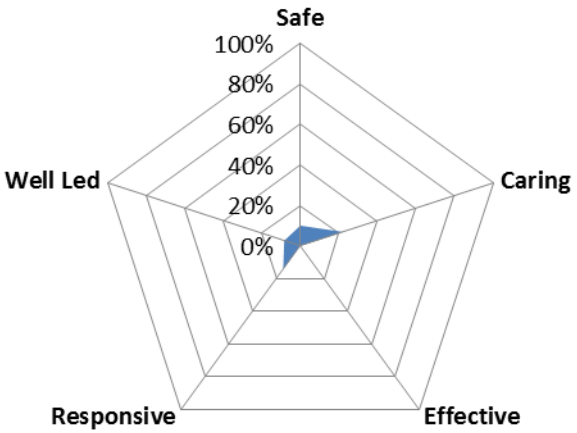
Further Reading / other resources

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

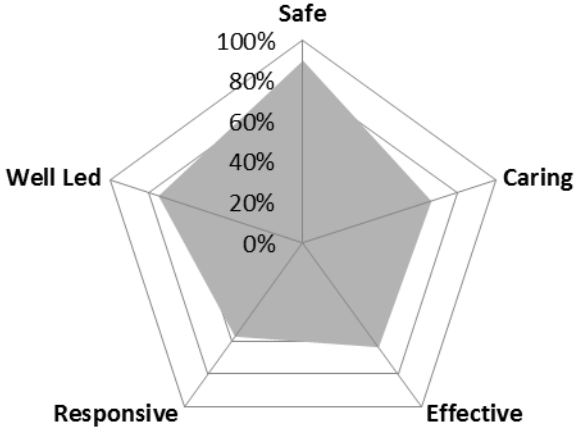
MTW exceptional people, outstanding care

Executive Summary

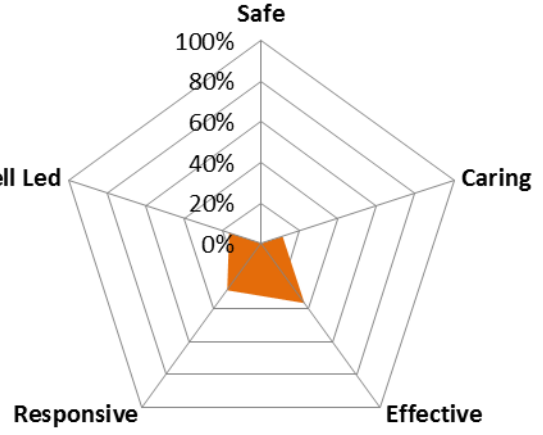
Favourable Assurance



Common Cause Assurance



Adverse Assurance



Favourable Assurance:
Trust Mortality (HMSR), Mixed Sex Accommodation Compliance, VTE Risk Assessment and Mandatory Training Compliance are consistently passing the target. The Cancer Waiting Times 2 week wait and 62 Day indicators are also now consistently passing the target.

Common Cause Assurance:
All of the Safe and Caring Indicators are experiencing common cause variation and inconsistency (passing or falling short of target) indicating that performance is not stable with the exception of those highlighted above (Favourable) or below (Adverse). The majority of the Urgent Care and Flow Workstream indicators continue to experience special cause variation – data outside of control limits (in a positive way) and inconsistency (passing or falling short of target) due to the impact of the COVID-19 Pandemic, however A&E Attendances have now increased enough in August and September to be experiencing common cause variation.

Most of the Workforce Indicators are experiencing common cause variation and inconsistency (passing or falling short of target) indicating that performance is unstable with the exception of Mandatory Training compliance (which is consistently achieving the target) and those metrics highlighted below (as Adverse).

Readmissions within 30 Days of discharge indicators and the Stroke Best Practice Indicator continue to experience common cause variation and inconsistency (passing or falling short of target), however the Trust has achieved the overall best practice for stroke internal target for three consecutive months.

Adverse Assurance:
In the Well Led domain, Agency Staff used, Agency Spend and the Turnover Rate are consistently failing the target and in the Caring domain the Friends and Family Response Rate for Inpatients is failing the target. The majority of the efficiency indicators for the outpatient workstream are showing as consistently failing the target with the exception of the DNA Rates and Hospital Cancellations, however the percentage of outpatient that is non face to face (virtual) and the number of calls answered within 1 minute are experiencing special cause variation of an improving nature. Most of the Elective Care workstream indicators are experiencing special cause variation and consistently failing the target due to the impact of the COVID-19 Pandemic.

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains		L	H	L	H	P	F	?	No SPC	
CQC Domain Safe										
Infection Control	4							4		4
Harm Free Care	1			1				2		2
Incident Reporting	1			1				2		2
Safe Staffing	1	1						2		2
Mortality	1					1				1
Safe Total	***8***	***1***	***0***	***2***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	3	1			3		4	3		7
Quality & CQC	4							4		4
EPR									5	5
Strategy - Estates									5	5
Strategy - ICP / External									5	5
Effective Total	***7***	***1***	***0***	***0***	***3***	***0***	***4***	***7***	***15***	***26***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	4					2	1	1		4
ED Care									2	2
Maternity Care	2							2		2
Outpatient Care	1							1		1
Caring Total	***9***	***0***	***0***	***0***	***0***	***2***	***1***	***6***	***2***	***11***
CQC Domain Responsive										
Elective Access	2	1	2				4	1		5
Acute and Urgent Access				2	1			3	2	5
Cancer Access	4					2		2	1	5
Diagnostics Access		1						1		1
Bed Management				1				1		1
Responsive Total	***6***	***2***	***2***	***3***	***1***	***2***	***4***	***8***	***3***	***17***
CQC Domain Well-Led										
Staff Welfare									10	10
Finance and Contracts	2				1		1	2	3	6
Leadership and Education	1	1						2	6	8
Strategy - Clinical and ICC	2				1			3	6	9
Workforce	5				1	1	2	3		6
Well-Led Total	***10***	***1***	***0***	***0***	***3***	***1***	***3***	***10***	***25***	***39***
Trust Total	***40***	***5***	***2***	***5***	***7***	***6***	***12***	***41***	***45***	***104***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	5	2		
S6	Rate of Total Patient Falls	5.80	6.60		
S7	Number of Never Events	0	0	L	
S8	Number of New SIs in month	11	6		
S10	Overall Safe staffing fill rate	93.5%	91.7%	L	

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	89.6%	96.9%	H	
R4	RTT Incomplete Pathway	83.8%	62.6%	L	F
R6	% Diagnostics Tests WTimes <6wks	99.0%	84.0%	L	
R7	Cancer two week wait	93.0%	97.4%		P
R10	Cancer 62 day wait - First Definitive	85.0%	85.5%		P

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	94.9		P
E3	% Total Readmissions	14.6%	15.2%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	50.0%		
R11	Average LOS Non-Elective	6.60	5.97	L	
R12	Theatre Utilisation	90.0%	79.9%		

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	No data	No data	No SPC	No SPC
W2	CIP Savings	Suspended due to COVID-19		No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	8.8%		
W8	Total Agency Spend	745	1,588		F
W10	Sickness Absence	3.3%	2.9%		

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		P
C3	% complaints responded to within target	75.0%	80.8%		
C5	IP Friends & Family (FFT) % Positive	95.0%	96.5%		
C7	A&E Friends & Family (FFT) % Positive	87.0%	No data due to COVID-19	No SPC	No SPC
C10	OP Friends & Family (FFT) % Positive	84.0%	80.3%		

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	Variation Indicates consistently (P)assing of the target	Variation Indicates inconsistently passing and falling short of the target	Variation Indicates consistently (F)alling short of the target	Data Currently unavailable or insufficient data points to generate SPC

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

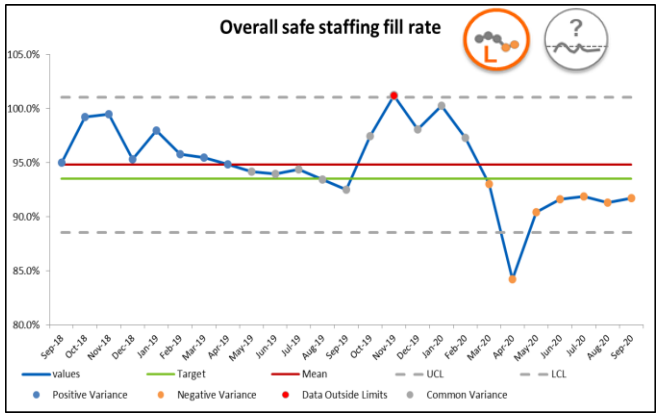
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

Safe - CQC Domain Scorecard

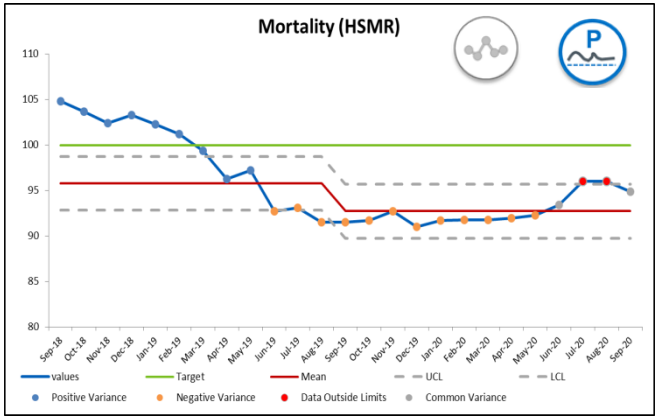
Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	91.7%	Sep-20		93.5%	91.3%	Aug-20	93.5%	90.3%	
Sickness Rate - Covid	0.0%	0.2%	Sep-20		0.0%	0.3%	Aug-20	0.0%	0.8%	
Infection Control - Hospital Acquired Covid	0	0	Sep-20		0	0	Aug-20	0	0	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	25.0	12.6	Sep-20		25.0	6.4	Aug-20	24.7	20.6	
Infection Control - Number of Hospital acquired MRSA	0	0	Sep-20		0	0	Aug-20	0	3	
Infection Control - Rate of Hospital E. Coli Bacteraemia	55.1	37.7	Sep-20		55.1	19.3	Aug-20	31.3	29.6	
Number of New SIs in month	11.0	6.0	Sep-20		11	7	Aug-20	66	51	
Rate of Total Patient Falls per 100,000 occupied beddays	5.8	6.6	Sep-20		5.8	7.3	Aug-20	5.8	7.4	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	1.7	Sep-20		2.3	1.4	Aug-20	2.3	2.2	
Standardised Mortality HSMR	100.0	94.9	Sep-20		100.0	96.0	Aug-20	100.0	94.9	
Never Events	0	0	Sep-20		0	0	Aug-20	0	0	

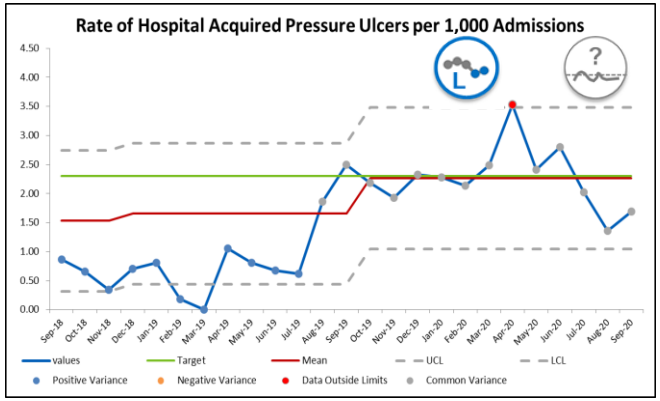
SAFE- Reset and Recovery Programme: Patient and Staff Safety



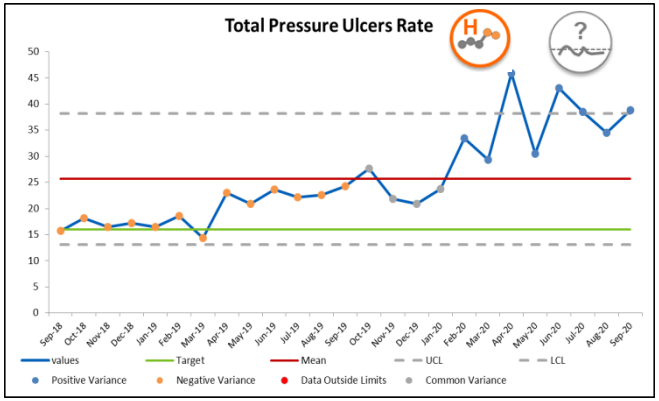
September-20
91.7%
Variance Type
Metric is currently experiencing special cause variation: trend is showing a negative performance below the mean
Target (Internal)
93.5%
Target Achievement
Metric is experiencing variable achievement



September-20
94.9
Variance Type
Metric is currently experiencing common cause variation
Max Target
100
Target Achievement
Metric is consistently achieving the target



September-20
1.7
Variance Type
Metric is currently experiencing special cause variation: trend is showing a positive performance below the mean
Max Target
2.3
Target Achievement
Metric is experiencing variable achievement



June-20
38.8
Variance Type
Metric is currently experiencing special cause variation: trend is showing a negative performance above the mean
Max Target (Internal)
16.0
Target Achievement
Metric is experiencing variable achievement

Summary:

Safe Staffing Fill Rate: The level reported has remained similar but remains below usual levels. This metric is now experiencing special cause variation – negative performance below the mean. There has not been any staffing level risk to wards. There are anomalies in the data that reflect operating decisions to open and close clinical areas in response to the COVID Pandemic which distorts the planned vs actual ratio.

Pressure Ulcers: The level of hospital acquired pressure ulcers (HAPU) reduced further in September with 5 reported equating to a rate of 0.8. This metric is now experiencing special cause variation of an improving nature. However, the total rate of pressure ulcers (including those already having pressure ulcers on admission) is increasing

Mortality (HSMR): continues to consistently achieve the target.

Actions:

The Tissue Viability Service are monitoring the increased incidence of community acquired pressure damage.

We are considering appropriate actions to liaise with partner organisations regarding the increase in all pressure ulcers (including those already having pressure ulcers on admission)

We are working collaboratively with the PDN's and our industry colleagues to help provide pressure ulcer prevention training via Microsoft teams as we are still unable to deliver face to face training.

Assurance:

We have established a monthly meeting with the staff bank and are reviewing the use of temporary staff for all areas. The Trust has launched "Safe Care" which will help monitor the acuity of patients more effectively and therefore guide decisions around staffing. Staffing levels for every shift, every day are monitored by the Senior Leadership Team and appropriate moves are made to ensure safe staffing.

We continue to triangulate pressure ulcer incidence in COVID positive patients alongside our requirements for data collection from NHS England. International Stop the Pressure day is 19th November 2020 and we are organising a new Pressure Ulcer group for Matrons and Ward Managers to discuss recent trends and themes in Hospital Acquired pressure ulcers. We have an online Tissue Viability Champions day planned with support from our industry colleagues on 13th November 2020.

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Non-face to face OP activity / Total activity	75.0%	42.7%	Sep-20		75.0%	46.4%	Aug-20	75.0%	50.4%	
OP Utilisation	85.0%	50.6%	Sep-20		85.0%	53.1%	Aug-20	85.0%	49.4%	
Outpatient DNA Rate	5.0%	5.4%	Sep-20		5.0%	5.7%	Aug-20	5.0%	5.1%	
Outpatient Hospital Cancellation	20.0%	22.3%	Sep-20		20.0%	20.6%	Aug-20	20.0%	28.3%	
Outpatient Cancellations < 6 weeks	10.0%	16.5%	Sep-20		10.0%	16.5%	Sep-20	10.0%	20.7%	
Calls Answereed in under 1 min	75.0%	36.0%	Sep-20		75.0%	36.0%	Sep-20	75.0%	45.1%	
Calls Answereed in under 3 min	100.0%	61.0%	Sep-20		100.0%	61.0%	Sep-20	100.0%	70.3%	

Organisational Objectives: Quality and CQC

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	15.2%	Aug-20		14.6%	14.6%	Jul-20	14.6%	15.2%	
Non-Elective Readmissions <30 days	15.2%	15.5%	Aug-20		15.2%	15.1%	Jul-20	15.2%	15.4%	
Elective Readmissions < 30 Days	7.8%	9.2%	Aug-20		7.8%	9.0%	Jul-20	7.8%	10.6%	
Stroke Best Practice Tariff	50.0%	50.0%	Sep-20		50.0%	37.3%	Aug-20	50.0%	45.0%	

Effective - CQC Domain Scorecard

Organisational Objectives: EPR

					Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Reduction in number of paper blood and X-ray requests received within MTW	Revised metrics, working through data collection process		Sep-20	No SPC	Revised metrics, working through data collection process		Aug-20	Revised metrics, working through data collection process		No SPC
Reduction in number of requests for paper records from health records			Sep-20	No SPC			Aug-20			No SPC
Reduction in print costs for pre-printed paperwork			Sep-20	No SPC			Aug-20			No SPC
Reduction in missing records reported as incidents			Sep-20	No SPC			Aug-20			No SPC
Reduction in duplicate tests being ordered			Sep-20	No SPC			Aug-20			No SPC

Organisational Objectives: Strategy - Estates

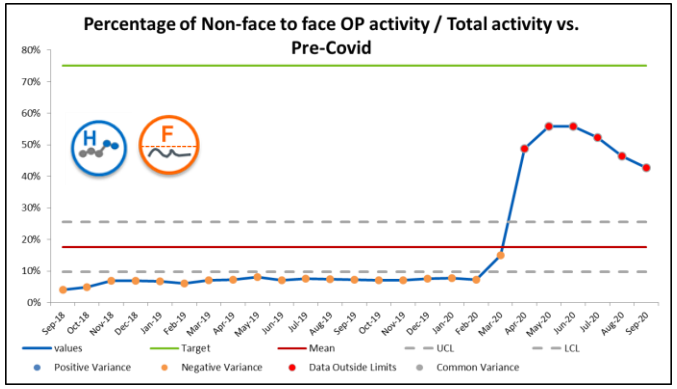
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100:0	Sep-20	No SPC	Under review	100:0	Aug-20	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Sep-20	No SPC	Under review	4.4:1	Aug-20	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Sep-20	No SPC	Under review	5808	Aug-20	Under review	5808	No SPC
Staff occupancy per m2	Under review	23.6	Sep-20	No SPC	Under review	23.7	Aug-20	Under review	Available nx month	No SPC
Energy cost per staff	Under review	£ 612.91	Sep-20	No SPC	Under review	£ 615.42	Aug-20	Under review	Available nx month	No SPC

Effective - CQC Domain Scorecard

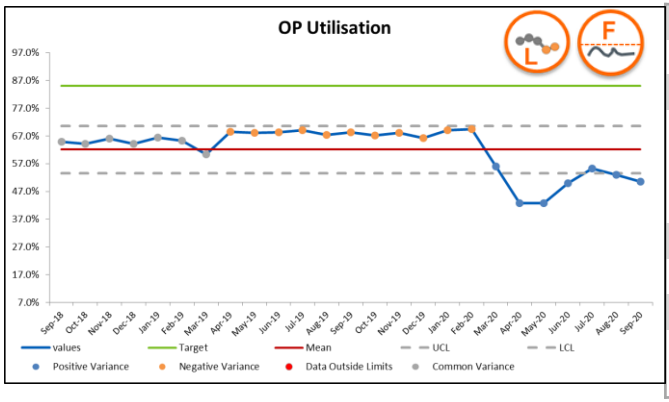
Organisational Objectives: Strategy – ICP/External

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Dementia rate	Liaising with KCC Public Health to obtain data		Sep-20	No SPC	Liaising with KCC Public Health to obtain data		Aug-20	Liaising with KCC Public Health to obtain data		No SPC
Mental health – Children – Hospital admissions as a result of self harm (age 10-24)			Sep-20	No SPC			Aug-20			No SPC
Frailty – Admissions due to falls			Sep-20	No SPC			Aug-20			No SPC
System financial performance (£)	Liaising with Sytem Partners to obtain data		Sep-20	No SPC	Liaising with Sytem Partners to obtain data		Aug-20	Liaising with Sytem Partners to obtain data		No SPC
West Kent estates footprint (sqm)	Liaising with Estates across West Kent to obtain data		Sep-20	No SPC	Liaising with Estates across West Kent to obtain data		Aug-20	Liaising with Estates across West Kent to obtain data		No SPC

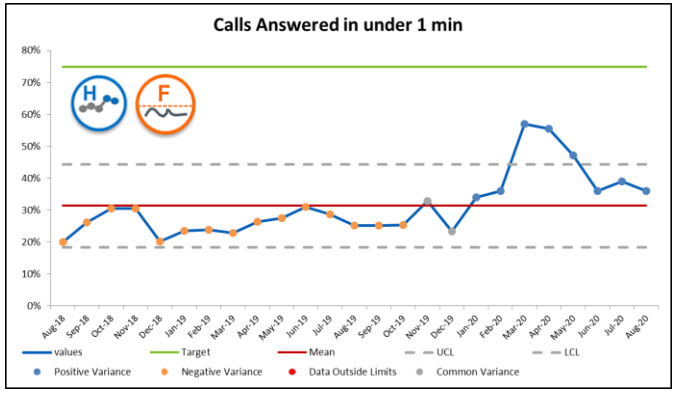
EFFECTIVE- Reset and Recovery Programme: Outpatients



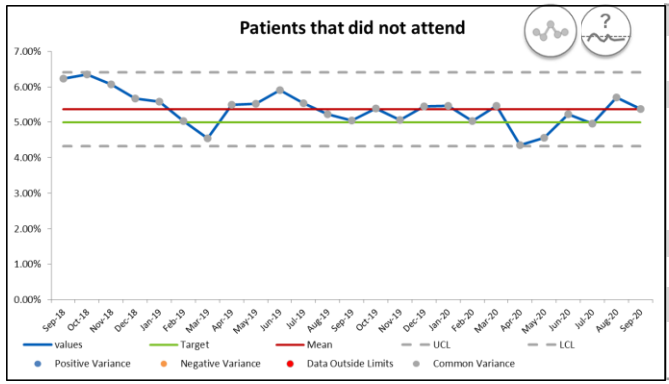
Sep-20
42.7%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Sep-20
50.6%
Variance Type
Metric is currently experiencing special cause variation – negative performance below the mean
Max Target (Internal)
85%
Target Achievement
Metric is constantly failing the target



Sep-20
36%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Sep-20
5.4%
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

Summary:	Actions:	Assurance:
As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased., this began to increase however due to annual leave in august has fallen again. The number of calls that is answered within 1 minute is constantly failing the target , this has started to increase however is still far off the target. DNA rates remain consistent but are experiencing variable achievement of the target.	Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs. The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients.	Outpatient recovery plan is being considered with the different speciality teams and will be implemented with support from PMO. The demand and capacity remodelling has been completed and shared with the divisions. This is being reviewed to ensure we are aiming to achieve the phase 3 targets. Weekly monitoring of these is being undertaken in the performance meetings to ensure we achieve the target.

Caring - CQC Domain Scorecard

Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Single Sex Accommodation Breaches	0	0	Sep-20		0	0	Aug-20	0	0	P
Rate of New Complaints	3.9	2.7	Sep-20		3.9	1.3	Aug-20	3.0	2.0	?
% complaints responded to within target	75%	80.8%	Sep-20		75%	96.8%	Aug-20	75%	76.5%	?
IP Resp Rate Recmd to Friends & Family	25%	7.4%	Sep-20		25%	1.4%	Aug-20	25%	7.2%	F
IP Friends & Family (FFT) % Positive	95%	96.5%	Sep-20		95%	97.3%	Aug-20	95%	96.8%	?
A&E Resp Rate Recmd to Friends & Family	15%	No data due to COVID-19	Sep-20	No SPC	15%	No data due to COVID-19	Aug-20	15%	No data due to COVID-19	No SPC
A&E Friends & Family (FFT) % Positive	87%		Sep-20	No SPC	87%		Aug-20	87%		No SPC
Mat Resp Rate Recmd to Friends & Family	25%	28.2%	Sep-20		25%	30.9%	Aug-20	25%	30.1%	?
Maternity Combined FFT % Positive	95%	99.1%	Sep-20		95%	99.3%	Aug-20	95%	99.1%	?
OP Friends & Family (FFT) % Positive	84%	80.3%	Sep-20		84%	81.7%	Aug-20	84%	81.0%	?
% VTE Risk Assessment	95%	96.3%	Sep-20		95%	96.3%	Aug-20	95%	96.5%	P

Responsive- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
RTT (Incomplete Pathways) performance against trajectory	83.8%	62.6%	Sep-20	L	83.8%	57.8%	Aug-20	83.8%	62.6%	F
Number of patients waiting over 40 weeks	0	1979	Sep-20	H	0	1730	Aug-20	0	8122	F
52 week breaches (new in month)	8	175	Sep-20	H	8	144	Aug-20	48	785	F
Average for new appointment	10.0	10.2	Sep-20		10.0	10.3	Aug-20	10.0	10.2	F
Theatre Utilisation	90.0%	79.9%	Sep-20		90.0%	78.2%	Aug-20	90.0%	78.6%	?

Reset and Recovery Programme – Acute & Urgent Care

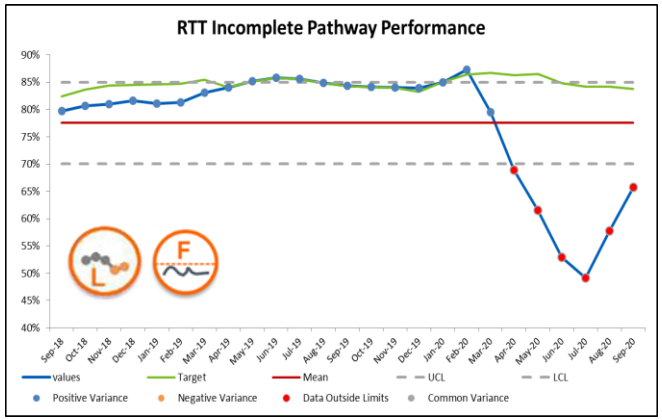
	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Referrals to ED from NHS 111	Coming December 20		Sep-20	No SPC	Coming December 20		Aug-20	Coming December 20		No SPC
A&E 4 hr Performance	89.6%	96.9%	Sep-20	H	89.6%	97.2%	Aug-20	89.6%	97.5%	?
Super Stranded Patients	80	63	Sep-20	L	80	63	Aug-20	80	63	?
Delayed Transfers of Care	3.6%	No data	Sep-20	No SPC	3.6%	No data	Aug-20	3.5%	0.0%	No SPC
Bed Occupancy	90.0%	85.8%	Sep-20	L	90.0%	80.3%	Aug-20	90.0%	66.1%	?
GE LOS	6.6	6.0	Sep-20	L	6.6	5.8	Aug-20	6.6	5.7	?

Responsive - CQC Domain Scorecard

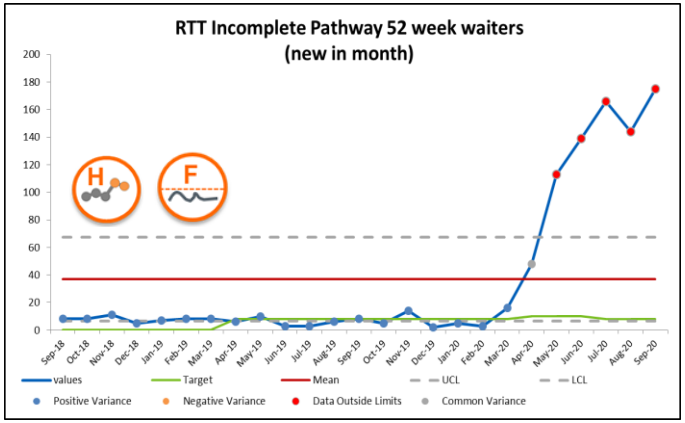
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Cancer - 2 Week Wait	93.0%	97.4%	Aug-20		93.0%	97.4%	May-20	93.0%	97.4%	P
Cancer - 31 Day	96.0%	98.7%	Aug-20		96.0%	98.7%	May-20	96.0%	98.7%	?
Cancer - 62 Day	85.0%	85.5%	Aug-20		85.0%	85.5%	May-20	85.0%	85.5%	P
Size of backlog	30	42	Aug-20		30	42	May-20	30	42	?
Access to Diagnostics (<6weeks standard)	99.0%	84.0%	Sep-20	L	99.0%	84.0%	Jun-20	99.0%	84.0%	?
28 day Target	Coming Soon		Aug-20	No SPC	Coming Soon		May-20	Coming Soon		No SPC

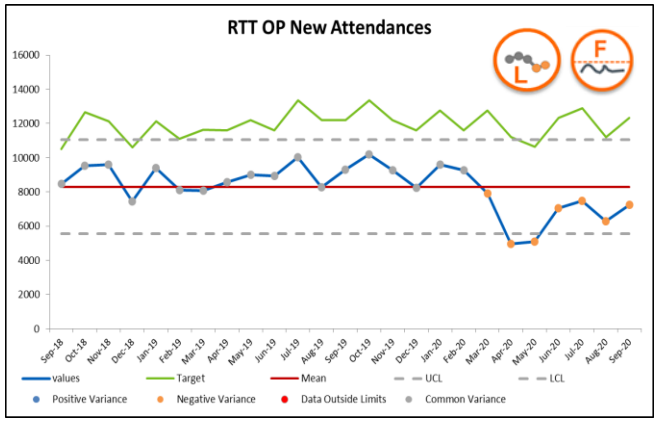
RESPONSIVE- Reset and Recovery Programme: Elective



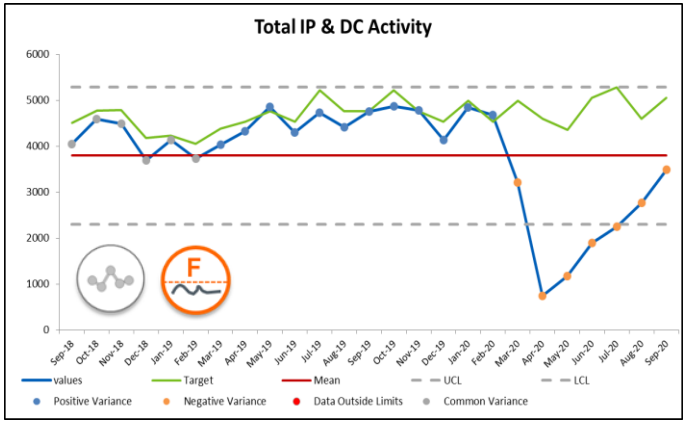
Sep-20
65.7%
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
86.3%
Target Achievement
Metric is consistently failing the target



Sep-20
175
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
8
Target Achievement
Metric is consistently failing the target



Sep-20
7,246
Variance Type
Metric is currently experiencing Common cause variation – negative performance outside limit
Max Target (Internal)
12,334
Target Achievement
Metric is consistently failing the target



Sep-20
3,499
Variance Type
Metric is currently experiencing Common cause variation – positive performance outside limit
Max Target (Internal)
5,055
Target Achievement
Metric is consistently failing the target

Summary:

Although elective activity levels have significantly increased in September, due to the COVID-19 pandemic the YTD activity remains low for both elective and outpatient appointments which have adversely impacted the RTT performance. However the September performance has improved to 65.7% (unvalidated version).

The elective activity levels have increased by 15% (excluding IS activity) in September compared to August. Large scale cancellations of elective activity has resulted in admitted electives & daycases reducing by 55% on normal levels YTD but with an improvement in September 2020.

The OP New activity levels have slowly increased since July, 667 appts seen per working day in July to 692 seen per working day in September. New Outpatient activity has reduced by around 30% & follow up by around 10% YTD on normal activity levels, OP FUP activity levels increased by 16% in September which equated to an extra 70 appts seen per working day compared to August.

Actions:

Due to the COVID response most of the elective activity ceased for 3 weeks apart from cancer and urgent cases. The Independent Sector were procured by NHSE to facilitate and assist with NHS activity.

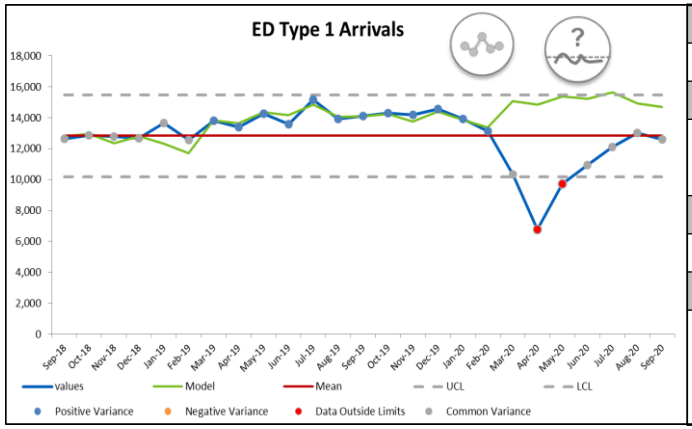
To decrease the 52 week breaches

Assurance:

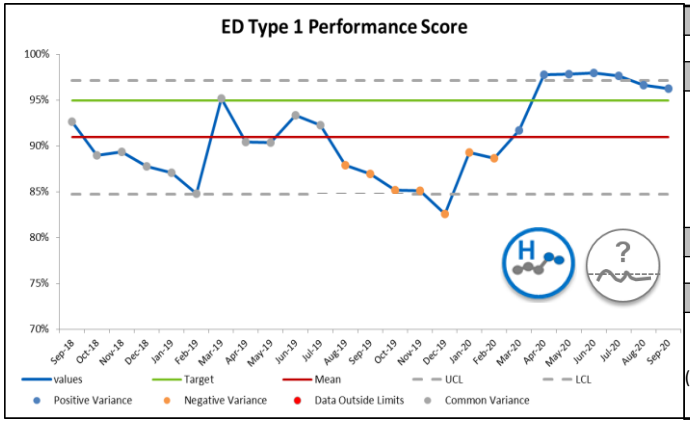
Phase 3 has been deployed which means that with the de-escalation of intensive care provision, the Trust has opened all theatres to allow increased activity for cancer, urgent and long waiting patients following guidance from NHSE. The Short Stay Surgical Unit has opened at TWH in order to increase the internal day case activity. Plans for Phase 3 include increasing the activity sent to the IS by sending whole patient pathways.

The speciality teams are planning treatment dates for these patients as well as those at 40+ weeks in order to stop patients tipping over in to 52 weeks before treatment.

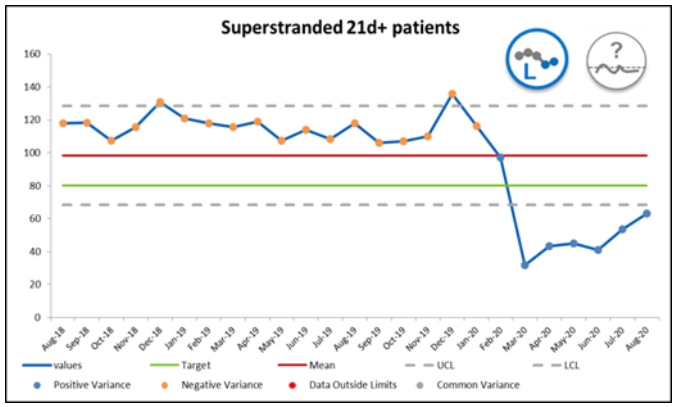
RESPONSIVE- Reset and Recovery Programme: Emergency Care



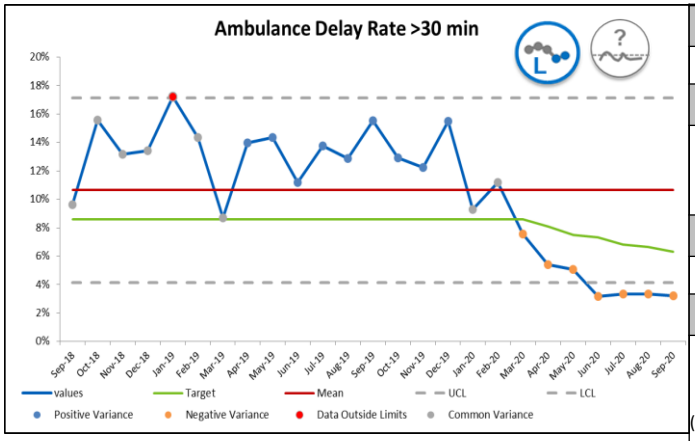
Sep-20
12,597
Variance Type
Metric is currently experiencing Common Cause Variation
Model
14,693
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Sep-20
96.25%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target
95%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Sep-20
63
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target
80
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Sep-20
3.2%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target
7.3%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Summary:

- ED arrivals (Type 1) dropped by 55-60% at the height of the pandemic. September came in at 14.4% below model
- ED 4hr performance (inc MIU) had been above 98.0% for 4 months, but dipped to 96.87% in Sep
- Stranded patients over 21 days has come down to less than half it's previous levels, but rose slightly to 63.2 in September.
- Diverts to Primary Care are now higher than levels before the height of the pandemic.
- Ambulance delays have been generally improving since New Year, with 3.2% of all handovers delayed 30 mins or longer in September

Actions:

Continue to embed improvements in ambulance handovers resulting in meeting targets this year.
Continue to book patients into minors/ GP clinics
New system on daily basis to review individual breaches and identify appropriate actions, specifically looking at Specialty delays.
AEC Sprint week took place on both sites to support improved number of suitable patients from ED to AEC, with multi disciplinary team; presented at Clinical Governance for AMU and ED with improved numbers.
Planning to increase AEC length of day for 1 month as trial. However AMU has been escalated by 5 beds on a number of occasions limiting the flow this month.

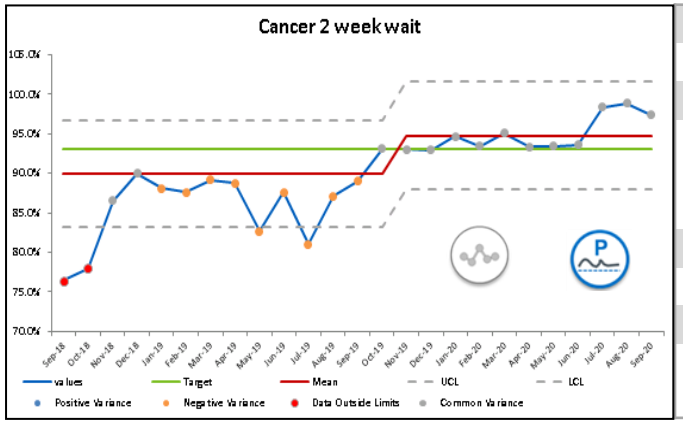
Preparation for COVID second surge underway

Assurance:

Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard –Increased profile on breaches and key themes eg diagnostic availability or specialty review. Focused bed meetings on actions. System call put in on a daily basis where required when system is tight.

Think 111 First to be implemented from Nov to support triage by minors patients by 111. Key risks re implementation of digital solution which is not yet fully tested and the appetite of the public to use the service.

RESPONSIVE- Reset and Recovery Programme: Cancer



Aug-20

97.4%

Variance Type

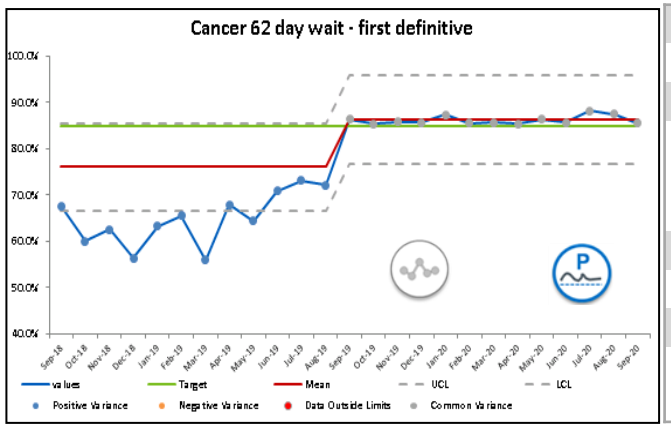
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

93%

Target Achievement

Metric is consistently achieving the target



Aug-20

85.5%

Variance Type

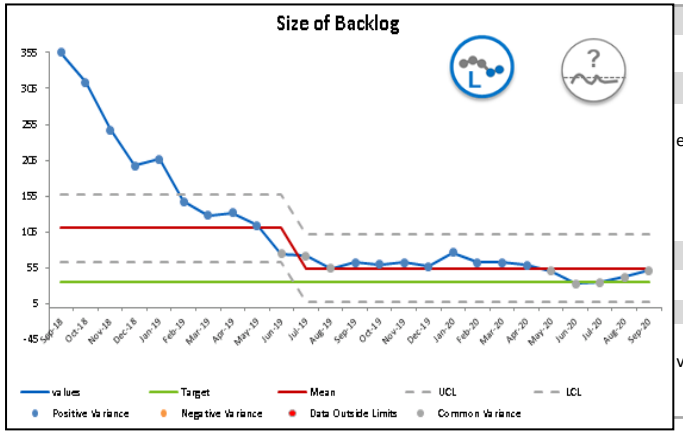
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

85%

Target Achievement

Metric is consistently achieving the target



Sept-20

51

Variance Type

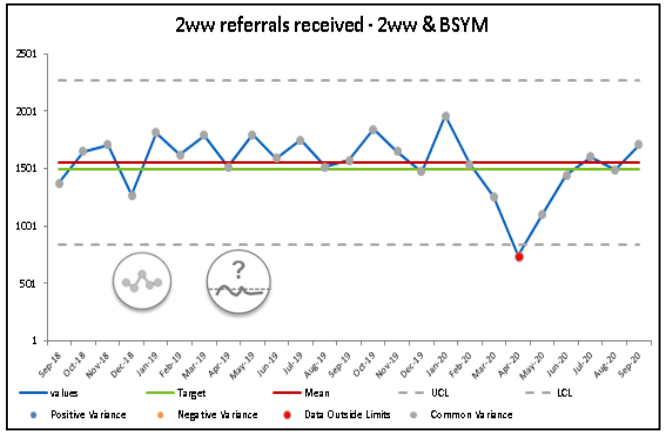
Metric is currently experiencing Special Cause Variation – trend is showing a positive performance below the mean

Max Target

35

Target Achievement

Metric is experiencing variable achievement (will achieve target some months and fail others)



Sept-20

1710

Variance Type

Metric is currently experiencing Common Cause Variation

Max Target (Internal)

1500

Target Achievement

Metric is experiencing variable achievement (will achieve target some months and fail others)

Summary:

The Trust has continued to achieve both the 62 day First Definitive treatment and the 2 week wait first seen target, with 85.5% and 97.4% respectively

The number of incoming 2ww referrals has continued to rise in September and the average is now 103% of pre covid-19 numbers compared to January / February 2020.

Although the Total PTL numbers have risen to above 1400, the overall size of the backlog is being maintained with an average of 51 patients in September (4.0% of the total PTL)

Actions:

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

Services that were stopped during Covid-19 have recommenced (e.g. endoscopy and major surgery) and we continue to see increased activity

Following initial delays due to Covid-19, we are continuing with recruitment to STT nursing roles to support the new pathways that have been developed, and scoping the need for additional roles to support the sustainability of the cancer 62 day target.

Assurance:

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

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

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	738	Jun-20	No SPC	Improving Quarterly	850	Apr-20	Improving Quarterly	738	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		72.0%	Jun-20	No SPC		69.0%	Apr-20		72.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		71.0%	Jun-20	No SPC		67.0%	Apr-20		71.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		76.0%	Jun-20	No SPC		70.0%	Apr-20		76.0%	No SPC
Health and Wellbeing metrics	Coming Nov-20		Sep-20	No SPC	Coming Nov-20		Apr-20	Coming Nov-20		No SPC

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	2.9%	Sep-20		3.3%	3.3%	Aug-20	3.3%	4.2%	?
Turnover	10.0%	12.0%	Sep-20		10.0%	11.6%	Aug-20	10.0%	12.0%	F
Vacancy Rates	9.0%	8.8%	Sep-20		9.0%	8.9%	Aug-20	9.0%	8.8%	?
Use of Agency	80	225	Sep-20		80	166	Aug-20	80	225	F
Appraisal Completeness	95.0%	72.9%	Sep-20		95.0%	43.2%	Aug-20	95.0%	72.9%	?
Stat and Mandatory Training	85.0%	89.4%	Sep-20	H	85.0%	87.9%	Aug-20	85.0%	89.4%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty	No data		Sep-20	No SPC	No data		Aug-20	No data		No SPC
CIP Savings	Suspended		Sep-20	No SPC	Suspended		Aug-20	Suspended		No SPC
Cash Balance	33,452	61,878	Sep-20	H	33,452	64,408	Aug-20	33,452	61,878	?
Capital Expenditure	3,012	568	Sep-20		3,012	1,265	Aug-20	7,893	4,318	?
Agency Spend	745,180	1,587,849	Sep-20		745,180	1,303,663	Aug-20	4,610,770	7,865,729	F
Use of Financial Resources	2	No data	Sep-20	No SPC	2	No data	Aug-20	No data		No SPC

Reset and Recovery Programme: Social Distancing / Home Working

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of staff home working against plan	Coming Soon		Sep-20	No SPC	Coming Soon		Aug-20	Coming Soon		No SPC
Staff swabbing compliance against guidelines	Coming Soon		Sep-20	No SPC	Coming Soon		Aug-20	Coming Soon		No SPC
Compliance with risk assessments e.g. BAME / at-risk staff / VDU	Coming Soon		Sep-20	No SPC	Coming Soon		Aug-20	Coming Soon		No SPC
Use of associated technology e.g. MS Teams	Coming Soon		Sep-20	No SPC	Coming Soon		Aug-20	Coming Soon		No SPC
Staff reporting having the equipment they need to comply with rules	Coming Soon		Sep-20	No SPC	Coming Soon		Aug-20	Coming Soon		No SPC

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Implementation of Teletracking	Coming December 20		Sep-20	No SPC	Coming December 20		Aug-20	Coming December 20		No SPC
PPE availability	Coming November 20		Sep-20	No SPC	Coming November 20		Aug-20	Coming November 20		No SPC
Nursing vacancies	Coming November 20		Sep-20	No SPC	Coming November 20		Aug-20	Coming November 20		No SPC
Covid Positive - number of patients	0	4	Sep-20		0	2	Aug-20	0	341	

Reset and Recovery Programme - Education / KMMS

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of medical students at Trust	Further Defining Metrics		Sep-20	No SPC	Further Defining Metrics		Aug-20	Further Defining Metrics		No SPC
Number of clinical academic posts			Sep-20	No SPC			Aug-20			No SPC
Number of non-medical educators			Sep-20	No SPC			Aug-20			No SPC
% of students reporting a good or better educational experience			Sep-20	No SPC			Aug-20			No SPC
% of medical students retained as FY1s			Sep-20	No SPC			Aug-20			No SPC

Well Led - CQC Domain Scorecard

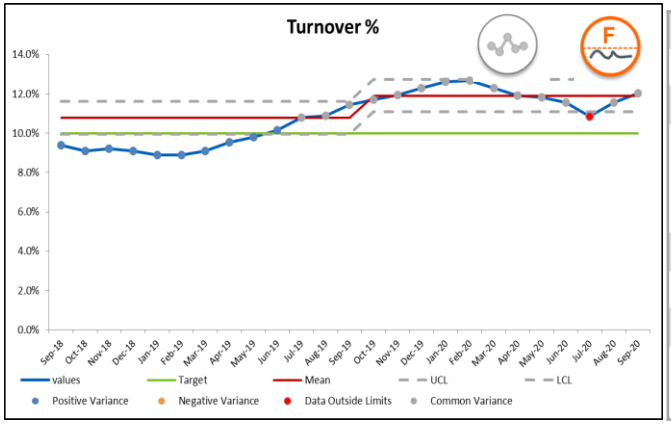
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services per directorate	Coming November 20		Sep-20	No SPC	Coming November 20		Aug-20	Coming November 20		No SPC
Volume of activity being sent to London	Coming November 20		Sep-20	No SPC	Coming November 20		Aug-20	Coming November 20		No SPC
Service contribution by division	Coming November 20		Sep-20	No SPC	Coming November 20		Aug-20	Coming November 20		No SPC
Research grants (£)	114	137	Sep-20		114	74	Aug-20	114	541	?
Number of advanced practitioners	25	31	Sep-20	H	25	27	Aug-20	25	31	?

Organisational Objectives – Exceptional People

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

WELL LED- Operational Objective: Workforce

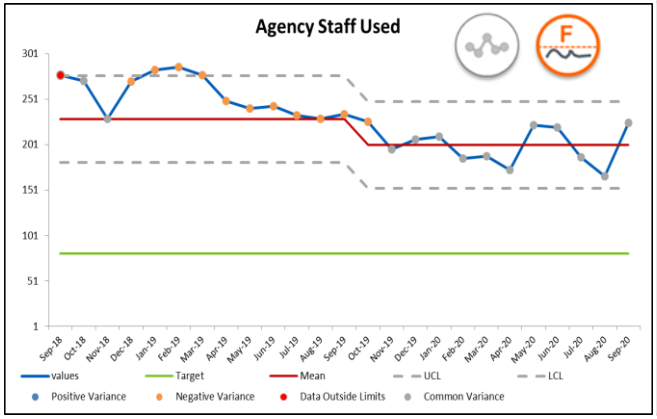


September-20
12%

Variance Type
Metric is currently experiencing Common Cause Variation

Max Target (Internal)
10%

Target Achievement
Metric is consistently failing the target

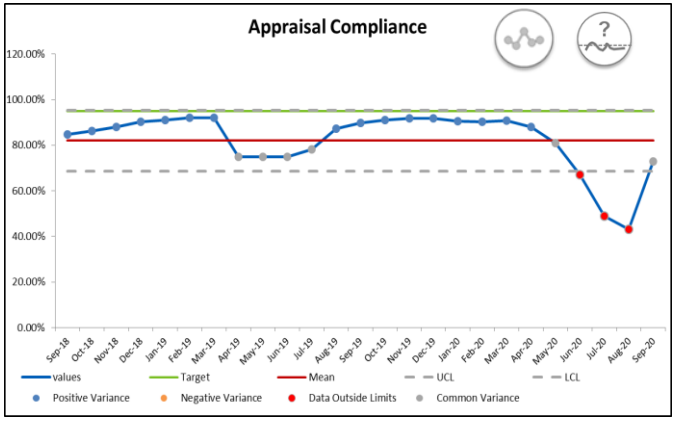


September-20
225

Variance Type
Metric is currently experiencing Common Cause Variation

Max Target (Internal)
81

Target Achievement
Metric is consistently failing the target

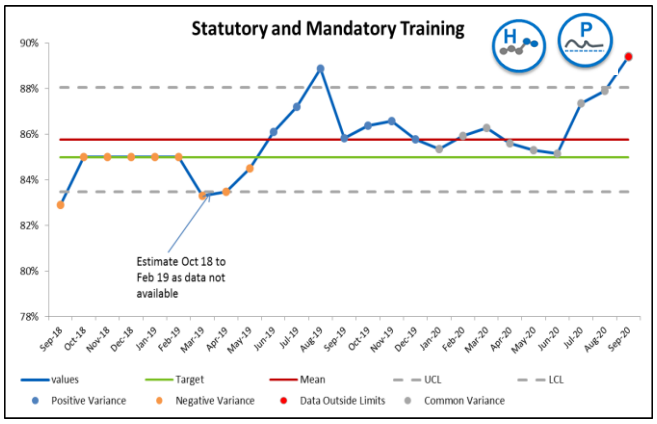


September-20
72.9%

Variance Type
Metric is currently experiencing Common Cause Variation

Target (Internal)
95%

Target Achievement
Metric is experiencing variable achievement



September-20
89.4%

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

Target (Internal)
85%

Target Achievement
Metric is consistently achieving the target

Summary:

The Turnover rate for the last 12 months is 12%. This indicator is experiencing common cause variation (after the limits had been re-set to a new norm) and is consistently failing the target.

The level of Agency staff used is consistently higher than plan.

Appraisal compliance has increased in September and is therefore now experiencing common cause variation and variable achievement of the target.

Performance for Statutory and Mandatory Training has improved further to 89.4% in September and is therefore now experiencing special cause variation of an improving nature and is consistently achieving the target of 85%.

Actions:

The Workforce Committee focused on retention and turnover in the October Meeting. Steps are being taken within the workforce team to secure resource to focus on retention, building on the successes that have been seen in nursing such as the Itchy Feet Campaign.

The Trust deadline for completion of appraisals has been extended to the end of October and therefore performance is expected to increase.

Assurance:

Delivery of 2020/21 Workforce plans will be supported by the HRBP and workforce information teams. Divisions are reviewing existing workforce and recruitment plans in light of changes driven by COVID reset and recovery work.

Staff engagement and retention work will be supported by divisional action plans for the national staff survey and local pulse checks. Progress against these action plans will be reviewed in Divisional Performance reviews.

Appendices

Supporting Narrative

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% each month for over a year now at 85.5%. The 2 week wait cancer waiting time target has remained above target for each month for a whole year now with Breast Symptoms also achieving the target. In addition, September performance remained high at 96.86% for the A&E 4hr standard, with the Trust remaining one of the best performing Trusts in the UK despite the steady rise in attendances. The RTT performance increased further in September as we implement the Trust's Reset and Recovery Programme. Performance for the Diagnostics Waiting Times target also increased further in September. Whilst the activity levels remained lower than usual in September elective activity has increased (+15% compared to August) and first outpatient activity as remained similar to August (based on working days). The lower activity levels continue to adversely impact the RTT performance and of the constitutional standards the RTT and Diagnostics standards are most at risk in future months due to the decrease in capacity (with the impact of social distancing and use of PPE) and the uncertainty as to the likely level of demand.

Key Performance Items:

- **Infection Control:** There were 2 cases of C.Diff reported in September and the Trust remains on trajectory. Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. Cases of Gram Negative Bacteraemia and MSSA have remained lower than last year.

- **Falls:** The rate of Falls for the Trust has reduced in September with both Maidstone and Tunbridge Wells levels just above the mean. The level of occupied bed days remained lower in September due to COVID-19 (similar level to August). Occupied beds are now at 80% of the level in September last year). Falls awareness week on 21st to 27th September; focus for clinical staff on multifactorial risk assessment for patients at risk of falling. Information disseminated electronically to link nurses and ward managers on key topics; lying and standing blood pressure assessment, vision assessment, delirium screening and patient handling assessment.

- **Pressure Ulcers:** The level of hospital acquired pressure ulcers (HAPU) has reduced further in September with 5 reported equating to a rate of 0.8 against a maximum limit of 2.3. Following the decrease seen in the level of admissions due to COVID-19 September levels are now similar to the levels seen in September last year This metric is now experiencing special cause variation of an improving nature. International Stop the Pressure day is 19th November 2020. A new Pressure Ulcer group for Matrons and Ward Managers to discuss recent trends and themes in Hospital Acquired pressure ulcers is being organised. An online Tissue Viability Champions day is planned for 13th November 2020, with support from our industry colleagues. The rate of all pressure ulcers (including those who already had a pressure ulcer on admission) is increasing and we are considering appropriate actions to liaise with partner organisations.

- **Stroke:** Performance for September improved further to 50%, therefore achieving the 50% Best Practice internal target which has now been achieved for three consecutive months. All of the three stroke indicators achieved the internal targets in September and are all experiencing common cause variation and inconsistency.

- **A&E 4 hour Standard:** Performance in September reduced slightly to 96.86% but remains high. Despite the attendance numbers increasing and now being almost back to previous levels the Trust is still achieving the national standard. There have been considerable changes to working practices and patient pathways in response to the COVID-19 Pandemic. One of the key improvements is the assessment of all patients at the front door on both sites by the First Contact Practitioner to stream the patients effectively or redirect to MIUs. The Trust remains one of the best performing Trusts in the UK for the 4hr standard. The pandemic reduced A&E attendance to 55-60% of the normal levels in early April. They have since been steadily increasing to around 88% of normal levels in September. Minor attendances have been reduced more than major attendances and ambulance arrivals are now almost back to normal levels. Emergency Admissions are now only 5% lower than normal levels, despite ED attendances still being 10-15% lower than normal. The total bed occupancy has increased from 42% in April to 85.8% in September.

- **Ambulance Handover Delays**: The ambulance handover scores improved significantly in the weeks before the pandemic, and although they improved significantly during the pandemic, they have continued to improve as activity has been returning to normal. Ambulance handover delays are now at 3.2% of all handovers delayed 30 mins or longer. This is therefore experiencing special cause variation of an improving nature.

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** As expected due to the COVID-19 pandemic activity levels continue to remain low for both elective and outpatient appointments, however the elective activity has increased (+15% compared to August) and first outpatient attendances have remained similar compared to August (based on working days). This has adversely impacted the RTT performance. September performance has improved to 62.6% and diagnostics waiting < 6 weeks performance has increased to 84% in September (both still being finalised).

- **Outpatient Activity Face to Face vs Virtual:** As the number of Covid-19 patients has decreased, the number of face to face outpatient appointments has been able to increase again. Additionally from the increased use of Attend Anywhere and telephone appointments the non-face to face activity levels have increased. The increased use of Virtual vs Face to Face outpatient appointments (where clinically appropriate) is part of the Trust's Reset and Recovery Programme.

- **Cancer 62 Day:** The Trust has continued with 13 consecutive months of achieving the 62 day standard, reporting 85.5% for August 2020. August has historically seen a decrease in treatment numbers and the current number of treatments for August 2020, 86.5 accountable treatments , is 76% of the average monthly accountable treatments from 2019-20 (2019-20 had 114.2 accountable average per month).

- **Cancer 2weeks (2ww):** The Trust has maintained achievement of the 2ww standard from September 2019, and is now reporting 12 consecutive months of achievement with 97.4%% for August 2020. Breast Symptoms has also reported an achievement for August with 93.3% and is a continued improvement over the same period last year where only 81.7% of Breast Symptoms patients had their first seen appointment within the 14 day standard

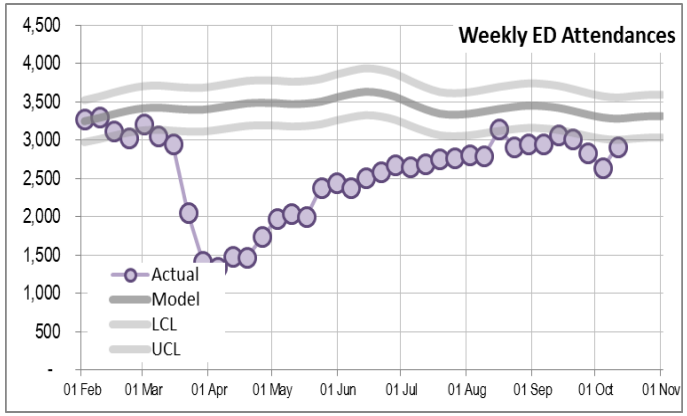
- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, the Kent & Medway Cancer Alliance predicted a significant increase in referral numbers through September 2020. Although this significant increase has not been seen at MTW, the referral numbers have continued to increase weekly through September and we are receiving up to 104% of the average daily referrals from January / February 2020.

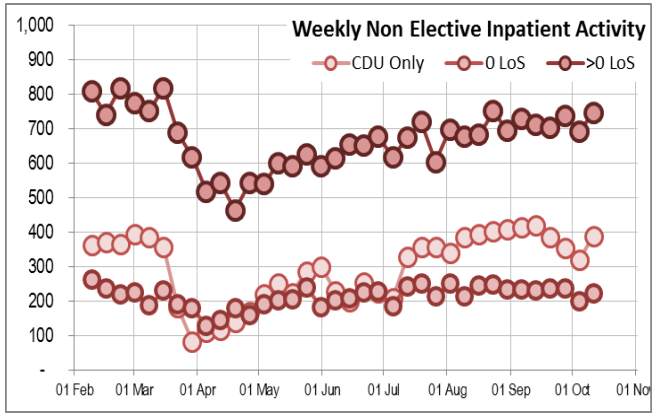
- **Finance:** The Trust has delivered a breakeven financial position which includes £13.8m retrospective top up income support. The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £19.1m, the Trust plan assumed £2.8m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £8.1m have been made to net down the impact to £13.8m. The key underspends to plan are: Drugs (£3m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£4.7m) mainly within Nursing (£1.6m), STT (£1.6m), A&C (£1.3m) and Support to clinical staff (£0.7m) staff groups due to higher than planned vacancies, £1.7m underspend within clinical supplies due to reduction in elective activities and £0.3m underspend within independent sector usage. These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m), increase in reserves(£0.1m) and £0.1m 2019/20 clinical income contract settlement.

- **Workforce - Various:** The Safe Staffing Nursing Fill Rate remained similar in September but remains below usual levels and is now experiencing special cause variation – negative performance below the mean. This has impacted on the overall fill rate being below usual levels. There has not been any staffing level risk to wards. Agency staff usage has increased and remains above the desired levels. The Turnover rate has increased and is consistently failing the target. Sickness levels have reduced further in September to 2.9%, achieving the target of 3.3%, but the Trust are anticipating an increase given a potential second wave for COVID-19. The proportion that is due to COVID-19 currently has also reduced to less than 0.5%. September Vacancy rate reduced slightly to 8.8% and continues to achieve the target. Performance for Statutory and Mandatory Training has improved further and is now experiencing special cause variation of an improving nature and consistently achieving the target.

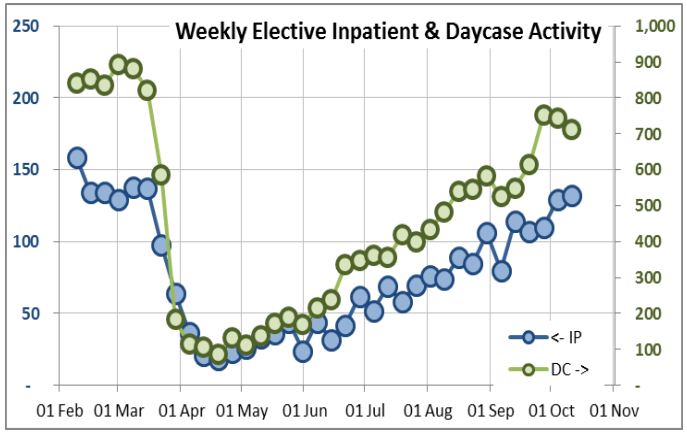
- **COVID-19 Tests:** There has been a gradual increase in the levels of testing and capacity has been increased to support the need. Total tests have now technically exceeded testing capacity, as we are now outsourcing some of our tests. The percentage of tests showing positive remains low.

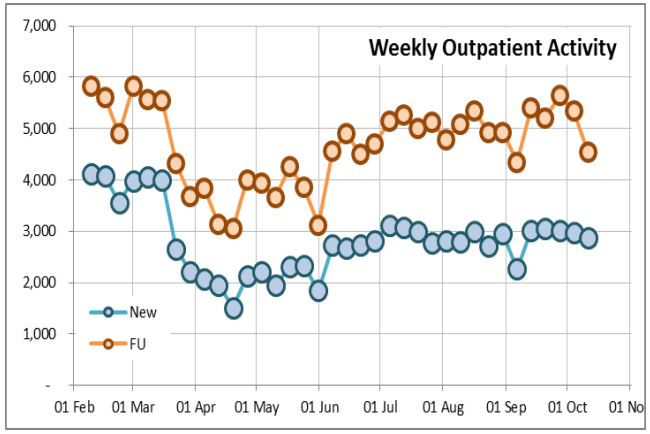
Escalation: COVID-19





ED Attendances: Attendances fell by around 60% against model at the height of the pandemic, but have since been recovering steadily. Sep attendance were 14.4% down on model, and the week ending 04-Oct was 20.0% down, probably on account of unusually bad weather. Ambulance arrivals dropped by around 30% in April, and have recovered more strongly, with the last few weeks being close to normal. Assessment at the door of ED is now occurring, which is reducing attendance from the more minor cases.





Emergency Admissions: Non-zero emergency admissions have been around 8% down on normal over the past 3 weeks, whilst zero LoS admissions are pretty much back to normal & CDU Only is now higher than normal pre-pandemic levels, despite ED attendances still being 10-15% down.

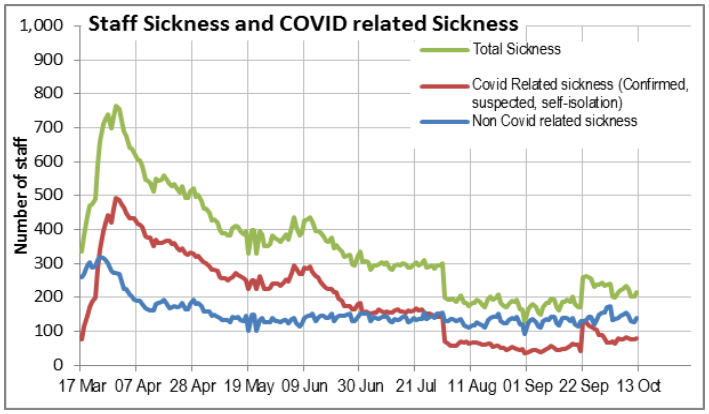
Elective / Daycase Activity: Large scale cancellations of elective activity has resulted in admitted electives reducing by 75-80% on normal levels, and daycases also 80-85%. They have both recovered steadily – both are now just 10-15% down on where they would normally be expected to be.

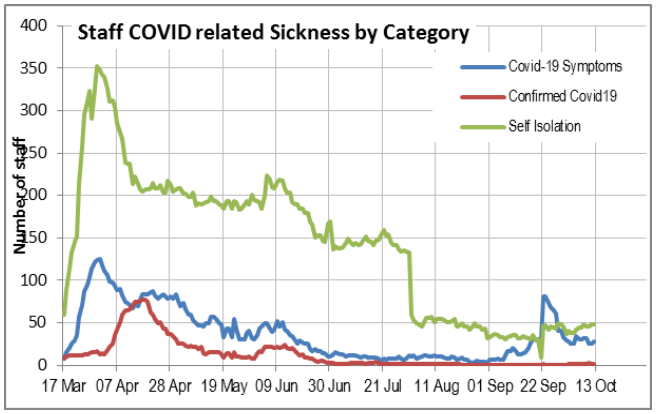
Outpatient Activity: New Outpatient activity seems to have settled down to 25-30%, whilst FU is coming back up, and is 5-10% down, though some of this may be subject to an undercount, with some uncashed appointments still in the system. As with elective activity, the week-by-week reduction has been slower than seen in emergency activity.

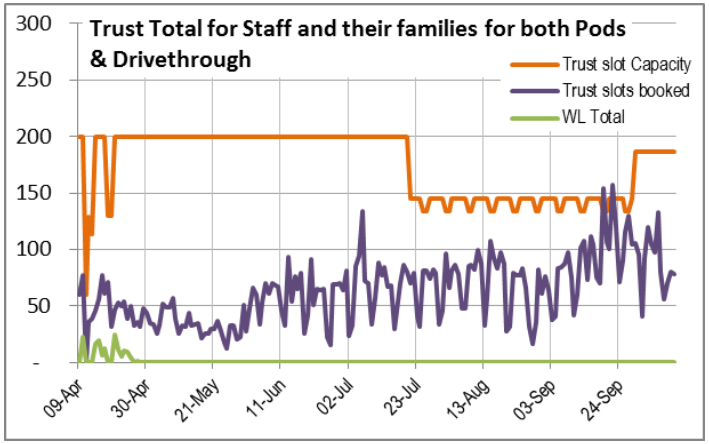
Summary : All activity is down, but recovering steadily

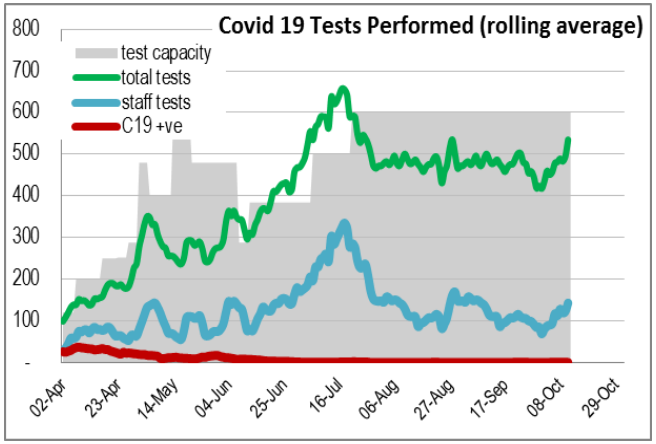
- ED attendances now 10-15% down
- Emergency admissions down around 5%
- Daycase 35% down & elective 25-30% down
- Total Outpatient activity down 25-30%, with new down a little more than FU

Escalation: COVID-19









Staff Non-Covid related sickness peaked at just over 300 in late March, but is now back at normal levels (average 120-160 per day).

Covid-19 Related Sickness: This includes confirmed cases, suspected cases & self-isolation Peaked at just under 500 at the end of March but is now back under 100. Step changes on 01-Aug & 22-Sep suggest changes in counting methodology

Self-Isolation: Similar to Covid related sickness, this peaked in early April (~350), fell & stabilised in May (200-220), increased a little in June when our admissions came back up, and have since fallen back to a steady 140-150 per day. These also step-changed down on 01-Aug to 50-60

Swabbing: Overall Trust slot capacity for staff and their families increased throughout April and is currently at 200 slots available per day (a slot could have 1 to 6 people attending depending how many in the family require swabbing). The number of tests booked has begun to increase over the past few days.

Pathology – COVID-19 Tests Performed: Total tests have now technically exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just around 500 total tests, and around 125 a day on our staff. The percentage of tests showing positive has dropped to zero.

Summary: Summary: Non-Covid related sickness is back to the sort of levels we expect, and both Covid related sickness & self isolation rose in early June along with hospital admissions, indicating a local infection hotspot around that time. Testing has is picking up again, and positive rests are again being seen after dropping to near zero in July

Review of the latest financial performance

- The Trust delivered the year to date and September's financial position by achieving a breakeven position. In line with national guidance this included retrospective top up income support from NHSE/I (£13.8m YTD, £4.6m in September). This funding is designed to cover the incremental step changes of COVID 19 above the baseline funding (November to January average) but is capped to the level of funding which is required for the Trust to breakeven.
- In line with NHSE/I reporting guidance the values reported in this month exclude any impact associated with the Elective incentive scheme. It is currently anticipated this will be managed at a system level.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £18.5m year to date (£2.8m in September). The Trust plan assumed a £2.8m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £7.5m have been made to net down the impact of COVID 19 costs to £13.8m.
- The key year to date variances (excluding COVID related pressures) to plan are as follows:
    - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£3m)
    - Pay underspends mainly within Nursing (£1.6m), STT (£1.6m), A&C (£1.3m) and Support to clinical staff (£0.7m) staff groups due to higher than planned vacancies (£4.7m)
    - Clinical supplies underspend (£1.7m) due to reduction in elective activities.
    - Reduction in independent sector usage (£0.3m)
    - Car Parking lights pressure (£0.3m)
    - Laundry increase in dilapidation reserve (£0.2m)
    - EPR project costs pressure (£0.3m)
    - Income reductions within Diagnostics relating to independent sector activity (£0.3m)
    - Investments associated with Ive programme and Teletracking (£0.3m)
    - Increase in contingency reserves (£0.1m).
- The key current month variances are as follows:
    - The amount claimed for retrospective top up in September (£4.6m) was the highest level this financial year, this was due to backdated medical pay award and increase in costs associated with return to elective work.
    - Income excluding Top up income support and pass-through related costs is £0.7m adverse to plan however this pressure has been included in the COVID impact schedule. The main pressures related to the reduction in catering and car parking income (£0.3m), £0.2m adverse variance relating to private patients and £0.1m reduction in Pathology independent sector charges.
    - Pay budgets adjusted for pass-through items were £1.9m adverse in September which includes £0.7m arrears of pay relating to medical staffing pay award. The level of pay spend adjusted for the pay award increased by £0.7m between months, this increase was across all staff groups. The main increase in spend were associated with A&C (£0.3m) due to redundancy costs and senior leadership changes within HR, increase in spend associated with Stroke service c£0.2m and Paediatric nursing pressures associated with providing additional RMN nursing support.
    - Non Pay budgets adjusted for pass through items overspent by £1.6m in September which included £1m COVID related costs therefore a net £0.6m overspend within budgets. The key underspends to budget are: Drugs (£0.2m) mainly due to a increase in Healthcare at Home drug issues, £0.3m costs associated with implementation of Ive and Teletracking which were agreed after the plan was set.

- The closing cash balance at the end of September 2020 is £61.9m which is similar to the closing cash balance at the end of August (£64.4m). The higher than normal balance is due to the Trust receiving a double block SLA payment in April from the six main CCG's as per the national agreement totalling c.£36.6m. The Trust is assuming the repayment of the "advance" element of the block income in March 2021 within the cash flow forecast.

- Capital spend by the end of month six is £4.3m of which £2.0m relates to Covid 19 equipment, ICT and estates costs – these costs have all been submitted to NHSEI Regional team as part of the funding claims. NHSEI have notified the Trust that £322k has been approved by DHSC. The remaining Phase 1 schemes (£2.5m) are still under consideration along with the Phase 2 bids, we have been informed that the Phase 1 spend will take priority for additional funding. The Trust has received £412k of CRL relating to the 2019/20 C-19 spend, this reduces the risk of the remaining funding requirement to £2.1m. The main other areas expenditure are £0.8m related to the ongoing EPR programme, £0.9m relating to the IVE Programme and £0.2m related to Estates schemes running across the year end (e.g. the RAP scheme in A&E).

- In addition to the previously notified national PDC awards, the Trust has also been notified of £1.7m of capital PDC for endoscopy equipment.

- The STP has confirmed to the Trust an additional £2.8m of system capital funding (a combination of release of ring fenced reserve and slippage in other Trusts) to cover critical care, ophthalmology and radiology homeworking. This has not yet been transacted and so is not included in the reported Month 6 figures.

Sep-20		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	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	153.3%	166.3%	-	100.0%	238.6%	241.7%	-	-	89.2%	46.9%	356	25.07	204	18.7	0.0%	0.0%	0	0	Increased fill rate in line with increase in ASU bed base which has required flexing up to 56. Staff allocation also from Chaucer but health roster not yet realligned.	121,912	274,745	(152,833)
MAIDSTONE	Cornwallis (M) - NS959	91.5%	73.2%	-	100.0%	92.2%	86.4%	-	-	11.6%	8.1%	23	1.37	3	10.9	52.2%	95.7%	1	0	Bed occupancy between 2-15. Enhanced care required on 6 episodes of care.	82,427	79,050	3,377
MAIDSTONE	Culpepper Ward (M) - NS551	89.6%	103.9%	-	-	98.3%	96.7%	-	-	15.3%	24.8%	48	3.36	15	7.8	56.8%	96.0%	3	0	2 x falls above threshold	106,191	109,802	(3,611)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	100.8%	98.9%	-	-	102.2%	123.3%	-	-	32.8%	12.0%	81	5.43	22	6.8	23.4%	100.0%	5	1	Ward at full bed occupancy throughout the month. Enhanced care and increased dependency across 19 episodes of care however, requests for additional staffing not always met with 22 unfilled shifts.	146,096	146,351	(255)
MAIDSTONE	Intensive Care (M) - NA251	91.0%	91.5%	-	-	70.8%	73.3%	-	-	7.0%	9.1%	76	4.29	4	64.7	75.0%	66.7%	0	0		166,033	176,442	(10,409)
MAIDSTONE	Pye Oliver (Medical) - NK259	102.4%	85.1%	-	-	112.3%	97.8%	-	-	23.7%	42.6%	101	6.35	46	6.0	54.2%	80.8%	0	4	Ward at full bed occupancy throughout the month. RMN requirements across 5 episodes of care. 46 unfilled shifts	119,488	132,083	(12,595)
MAIDSTONE	Chaucer Ward (M) - NS951	0.0%	0.0%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0.0	0.0%	0.0%	0	0	Chaucer bed occupancy recorded however, now part of overall ASU. See increased fill rate for ASU.	162,784	33,846	128,938
MAIDSTONE	Whatman Ward - NK959	96.6%	88.8%	-	100.0%	150.0%	103.3%	-	-	32.5%	23.1%	85	5.92	30	9.0	15.3%	100.0%	1	0	Predominantly reporting a bed occupancy of 20 . Night escalation throughout the month with increased RN fill rate at night to ensure safe staffing levels.	94,806	105,263	(10,457)
MAIDSTONE	Lord North Ward (M) - NF651	101.7%	96.1%	-	100.0%	95.5%	100.0%	-	-	12.2%	2.6%	26	1.68	1	8.4	39.4%	92.3%	2	0		98,164	99,597	(1,433)
MAIDSTONE	Mercer Ward (M) - NJ251	110.3%	83.8%	-	-	108.9%	123.7%	-	-	23.2%	30.8%	58	3.84	30	6.4	55.0%	90.9%	2	0	Ward at full bed occupancy throughout the month. RMN and enhanced care requirements reported across the month.	107,103	120,121	(13,018)
MAIDSTONE	Edith Cavell (M) - NS459	79.5%	73.5%	-	100.0%	84.2%	180.6%	-	-	63.3%	37.6%	154	10.86	92	7.4	23.5%	100.0%	4	0	1 x fall above threshold. Bed occupancy between 13 - 22. Reduced fill rate due to 92 shifts unfilled.Staff redeployed to support organisation satffing levels establishing new team.	0	91,432	(91,432)
MAIDSTONE	Acute Medical Unit (M) - NG551	89.3%	85.6%	-	-	133.3%	190.0%	-	-	29.0%	37.7%	131	8.83	53	12.4	2.0%	87.5%	5	0	1 x fall above threshold. Reduced fill rate during the day due to unavailable temporary staff. Increased fill rate at night to support escalation however unfilled shifts reported. Bed ocupancy between 8-20.	151,755	147,015	4,740
TWH	Ward 22 (TW) - NG332	88.6%	112.6%	-	100.0%	121.1%	112.5%	-	-	46.4%	30.2%	156	10.98	70	6.5	0.0%	0.0%	13	0	6 x falls above threshold. Reduced fill rate during the day due to lack of available temprary staff across 70 shifts. RMN and enhanced care requiremnets reported throughout the month associated with increase fill rate at night.	145,443	141,529	3,914
TWH	Coronary Care Unit (TW) - NP301	114.6%	92.1%	-	-	120.0%	-	-	-	34.4%	22.0%	99	6.07	18	13.1	181.8%	100.0%	1	0	1 x fall above threshold. CCU Central Monitor issues across 3 days agreed for additional RN to maintain safety and additional monitoring.	71,559	74,317	(2,758)
TWH	Ward 33 (Gynae) (TW) - ND302	96.6%	104.1%	-	-	100.0%	97.7%	-	-	12.5%	0.0%	42	2.36	0	14.3	0.0%	0.0%	0	0		112,501	111,170	1,331
TWH	Intensive Care (TW) - NA201	97.6%	189.0%	-	-	95.2%	106.7%	-	-	2.5%	0.0%	24	1.42	0	42.5	0.0%	0.0%	0	0	Increased CSW fill rate in line with supporting COVID pathways.	232,328	238,844	(6,516)
TWH	Acute Medical Unit (TW) - NA901	92.6%	76.9%	-	100.0%	97.2%	107.7%	-	-	20.5%	34.6%	157	10.68	51	9.2	0.0%	0.0%	7	0	1 x fall above threshold. Bed occupancy between 16 - 33. 9 epidoes of care requireing either enhacned care or RMN support.	221,364	194,414	26,950
TWH	Surgical Assessment Unit (TW) - NE701	101.4%	97.7%	-	-	98.3%	100.0%	-	-	26.8%	0.0%	26	1.71	0	98.3	0.0%	0.0%	0	0		69,051	70,890	(1,839)
TWH	Ward 32 (TW) - NG130	98.7%	96.1%	-	100.0%	98.3%	70.9%	-	100.0%	8.4%	2.4%	26	1.74	1	8.8	0.0%	0.0%	1	0	Unit opened at night on 5 episodes.	145,285	131,178	14,107
TWH	Ward 10 (TW) - NG131	120.4%	99.2%	-	100.0%	101.5%	108.3%	-	-	14.1%	17.3%	54	3.60	12	7.0	0.0%	0.0%	2	0		124,828	124,099	729
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	6.7%	0.0%	-	-	15.2%	20.0%	-	-	10.9%	48.2%	26	1.98	9	4.5	0.0%	0.0%	0	0	Ward 11 opened to support opeational demand and capacity - fill rates reflective of requirements.	0	7,058	(7,058)
TWH	Ward 12 (TW) - NG132	104.9%	81.4%	-	100.0%	100.1%	100.0%	-	-	15.9%	9.3%	32	2.08	8	6.4	37.9%	92.0%	11	0	5 x falls above threshold. Staff sickness reported during the month - self isolating.	136,263	126,669	9,594
TWH	Ward 20 (TW) - NG230	154.5%	102.4%	-	No Hours	113.4%	105.8%	-	-	45.2%	31.4%	161	10.94	56	6.2	85.0%	100.0%	8	0	1 x fall above threshold. Ward at full occupancy throughout the month. Increased fill rate due to RMN requirements however, 56 unfilled RN shifts in total.	128,047	151,965	(23,918)
TWH	Ward 21 (TW) - NG231	97.4%	98.0%	-	100.0%	97.3%	93.3%	-	-	25.0%	23.0%	122	7.61	31	6.8	24.7%	94.7%	7	2	1 x fall above threshold. Bed occupancy between 26 - 30.	139,367	143,551	(4,184)
TWH	Ward 2 (TW) - NG442	106.2%	106.8%	-	100.0%	103.3%	136.4%	-	100.0%	32.2%	6.4%	85	5.35	12	8.4	21.3%	69.2%	7	0	Increased fill rate at night due to escaltion into frailty on 5 nights. Mulitple enhanced care and high dependency requirements throughout the month	132,182	138,319	(6,137)
TWH	Ward 30 (TW) - NG330	100.8%	95.3%	-	100.0%	93.2%	99.0%	-	-	21.6%	14.6%	91	5.57	16	7.3	42.4%	92.0%	4	1	Bed occupancy between 24 - 31. 2 episodes of enhanced care requirements.	127,230	139,905	(12,675)
TWH	Ward 31 (TW) - NG331	99.8%	92.1%	-	100.0%	98.8%	102.0%	-	-	26.3%	20.4%	97	5.70	30	7.1	0.0%	0.0%	7	2	1 x fall above threshold. Ward reported at full occupancy throughout the month. RMN requirements across 4 episodes of care.	133,265	149,873	(16,608)
Crowborough	Crowborough Birth Centre (CBC) - NP775	55.7%	109.1%	-	-	100.8%	100.0%	-	-	4.6%	0.0%	18	1.05	0		50.0%	100.0%		0	Reduced fill rate during the day due to lack of available temproary staff but a considered action to prioritise the night with Community teams support during the day.	69,332	84,530	(15,198)
TWH	Midwifery (multiple rosters)	83.3%	48.9%	-	-	89.6%	75.9%	-	-	12.2%	3.7%	495	28.52	16	19.7	24.6%	99.0%	0	0	Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. Increase in unfilled shifts this month.	**707,252**	**677,385**	**29,867**
TWH	Hedgehog Ward (TW) - ND702	126.9%	37.8%	-	-	138.0%	-	-	-	50.4%	75.0%	267	18.70	176	13.9	0.0%	0.0%	0	0		152,869	193,997	(41,128)
MAIDSTONE	Maidstone Birth Centre - NP751	101.8%	94.0%	-	-	96.0%	94.9%	-	-	11.7%	0.0%	20	1.10	0		0.0%	0.0%	0	0		72,755	73,532	(777)
TWH	SCBU (TW) - NA102	77.0%	842.1%	-	100.0%	98.1%	-	-	-	13.9%	0.0%	98	5.42	0	14.8	0.0%	0.0%		0	Fill rate in line with bed occupancy which is reported between 8 - 17 throughout the month. 9 x amber days, 4 red and 2 balck escalations recorded otherwise remained green. Increased CSW fill rate as these numbers are inclusive of B4 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand.	175,775	180,815	(5,040)
TWH	Short Stay Surgical Unit (TW) - NE901	41.2%	18.8%	-	-	31.8%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	1.7	0.0%	0.0%	0	0	Staffing in line with levels of activity. Location moved to facilitate COVD pathways.	88,253	22,319	65,934
MAIDSTONE	Accident & Emergency (M) - NA351	107.4%	64.4%	-	-	132.7%	110.0%	-	-	39.8%	31.3%	347	23.10	88		0.0%	0.0%	1	0	MH - 1 x fall above threshold . Increased fill rate to support COVID pathways. 88 unfilled shifts reported.	209,396	267,831	(58,435)
TWH	Accident & Emergency (TW) - NA301	96.5%	98.9%	-	100.0%	111.7%	164.6%	-	-	47.3%	41.3%	477	32.68	194		0.0%	0.0%	3	0	TWH - 3 x falls above threshold. Increased RN fill rate however, not representative of unfilled shifts due to the increase in staffing requirements to manage new COVID pathways.	332,468	431,554	(99,086)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	69.0%	92.1%	-	100.0%	100.0%	-	-	-	22.2%	13.4%	44	3.01	7	18.5	0.0%	0.0%	1	0	1 x fall above threshold. Staffing in line with bed occupancy between 1 and 7.	52,889	56,894	(4,005)
MAIDSTONE	Peale Ward COVID - ND451	81.0%	101.1%	-	100.0%	98.9%	88.3%	-	-	23.2%	9.2%	60	4.12	8	23.6	2.9%	100.0%	2	0	1 x fall above threshold. Reducd fill rate with 8 unfilled shifts recorded.	0	81,228	(81,228)
MAIDSTONE	Chronic Pain Escalation - NE959	87.3%	67.4%	-	100.0%	90.0%	13.3%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	24.2	0.0%	0.0%	0	0	Staffing in line with lower bed occupancy	68,543	20,316	48,227
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	98.0%	76.2%	-	-	75.0%	-	-	-	10.9%	34.8%	21	1.38	7	27.4	0.0%	0.0%	0	0	Increasing activity with increase in elective work. Continue to staff in line with requirements.	46,531	44,037	2,494
																				Total Established Wards	**5,251,535**	**5,593,828**	**(342,293)**
																				Additional Capacity beds Cath labs	44,549	48,417	-3,868
																				Whatman	0	0	0
																				Ward 32 (Wells Suite) (TW) - PP010	0	-530	530
																				Other associated nursing costs	3,663,365	3,503,630	159,735
																				Total	8,959,449	9,145,345	(185,896)

Checks

RAG Key

Under fill

Overfill

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

RAG Key

↓ Reduction of greater than 5

↑ Increase of greater than 5

↗→ Remains equal to Or less than a difference of 5

Update on Phase three (of NHS response to COVID-19) performance, the OPEL and COVID-19 escalation framework, and 16-week plan (incorporating the winter plan)	**Chief Operating Officer / Deputy Chief Operating Officer**

The enclosed report provides information on Phase three (of NHS response to COVID-19) performance, the OPEL and COVID-19 escalation framework, and 16-week plan (incorporating the winter plan). It also includes details of preparations for the end of the UK's EU exit transition period, following the brief discussion on that that occurred at the 'Part 1' Trust Board meeting on 24/09/20.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 20/10/20

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

Discussion

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

Phase 3 Activity
October Update

Electives
Diagnostics
Outpatients

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Summary

Electives	Outpatients	Diagnostics	Cancer
• September currently at 76% against a target of 80% • Currently on track to meet the Phase 3 activity target in October (90%) • 52 week patients have decreased	• Target 100% in September and October (compared to 2019 activity) • Actual (not yet submitted) for September is currently 98% with 1218 appointments to cash up. • We are on track to meet 100% in October	• CT – on track to exceed target in October as already back to 100% capacity • NOUS – on track depending on recruitment • Endoscopy have made significant progress and are now on track to meet 80-90% for October (target is 90%). • MRI – increasing capacity using temporary mobile scanner and outsourcing.	• All patients since Covid have started their treatment and the backlog of patients waiting for first treatment remains below 50. • Referral numbers and number of treatments are back to pre-Covid levels. • We are one of two Trusts in the country to have continued to treat over 85% of patients with 62 days for 12 months in a row.

Elective Activity

What is the objective?

Phase 3: "In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);"

How have we performed so far?

- We achieved 64% in August against a target of 70%. This was largely driven by endoscopy activity being below plan
- September is currently at 76% against a target of 80%

		August				September			
		2019 Actuals (Excl Endos)	Target at 70% of Aug-19	2020 Actuals	% achieved	2019 Actuals (Excl Endos)	Target at 80% of Sep-19	2020 Actuals	% achieved
Division	Specialty	100%	70%	Aug-20	Aug-20	100%	80%	Sep-20	Sep-20
Surgery		**1533**	**1073**	**696**	**45%**	**1614**	**1291**	**1045**	**65%**
Medicine & Emergency Care		**729**	**510**	**636**	**87%**	**766**	**613**	**742**	**97%**
Women, Children and Sexual Health		**255**	**179**	**170**	**67%**	**273**	**218**	**238**	**87%**
Cancer Services		**198**	**139**	**217**	**110%**	**197**	**158**	**158**	**80%**
Diagnostics & Clinical Support Services		**171**	**120**	**143**	**84%**	**201**	**161**	**160**	**80%**
Total (excluding endoscopies)		**2886**	**2020**	**1862**	**65%**	**3051**	**2441**	**2343**	**77%**
(incl Endos)	GENERAL SURGERY	966	676	735	**76%**	1090	872	914	**84%**
(incl Endos)	GASTROENTEROLOGY	688	482	334	**49%**	650	520	443	**68%**
Total (including endoscopies)		**4226**	**2958**	**2702**	**64%**	**4489**	**3591**	**3428**	**76%**

Electives - October

Are we on track for October?

- Now we have resolved the issues with endoscopy, we anticipate being on plan to achieve 90% of 2019's elective activity in October.

What is the plan to address any shortfall?

- Surgical Division plan being mobilised (not all activity booked has been uploaded to theatre man) should deliver 90% of Phase 3 plan
- New RTT Operational Lead in place to monitor activity plans via a daily PTL meeting
- Pre-op assessment virtual clinics implemented and capacity reviewed
- Vascular surgery has not re-commenced due to Vascular guidance.
- Pain activity is being provided in the IS due to capacity issues internally (40 patients per week)
- Whole patient pathways being transferred to the IS
- Decisions made regarding future space investments at both sites are a big support in increasing activity for EL /DC.

		Oct-19 Actuals (Exc Endos)	Target for Oct at 90% of Oct-19	Weekly Aim	Actual Activity (exc IS Activity)	
Division	Specialty		90%		04-Oct	% of 2019
Surgery	TRAUMA & ORTHOPAEDICS	256	230	58	69	120%
	OPHTHALMOLOGY	543	489	122	130	106%
(excl Endos)	GENERAL SURGERY	232	209	52	65	125%
	UROLOGY	200	180	45	39	87%
	ENT	178	160	40	19	47%
	PAIN MANAGEMENT	140	126	32	0	0%
	ORTHOPAEDIC PAEDS	29	26	7	4	61%
	BREAST SURGERY	79	71	18	8	45%
	VASCULAR SURGERY	13	12	3		
	GYNAECOLOGICAL ONCOLOGY	21	19	5	6	127%
Surgery Total		1691	1522	380	340	89%
Medicine & Emergency Care	GENERAL MEDICINE	288	259	65	80	123%
(excl Endos)	GASTROENTEROLOGY	72	65	16	20	123%
	CARDIOLOGY	140	126	32	15	48%
	THORACIC MEDICINE	57	51	13	2	16%
	CARE OF THE ELDERLY	5	5	1	0	0%
	RHEUMATOLOGY	119	107	27	29	108%
	NEUROLOGY	12	11	3	0	0%
	STROKE MEDICINE	1	0.9	0.225		
	ENDOCRINOLOGY	28	25	6	5	79%
Medicine & Emergency Care Total		722	650	162	151	93%
Women, Children and Sexual Health	GYNAECOLOGY	180	162	41	48	119%
	PAEDIATRICS	80	72	18	27	150%
Women, Children and Sexual Health Total		260	234	59	75	128%
Cancer Services	ONCOLOGY	32	29	7	7	97%
	HAEMATOLOGY	120	108	27	16	59%
Cancer Services Total		152	137	34	23	67%
Diagnostics & Clinical Support Services	INTERVENTL RADIOLOGY	214	193	48	1	2%
Diagnostics & Clinical Support Services Total		214	193	48	1	2%
Total (excluding endoscopies)		3039	2735	684	590	86%
(incl Endos)	GENERAL SURGERY	1065	959	240	267	111%
(incl Endos)	GASTROENTEROLOGY	795	716	179	96	54%
Total (including endoscopies)		4595	4136	1034	868	84%

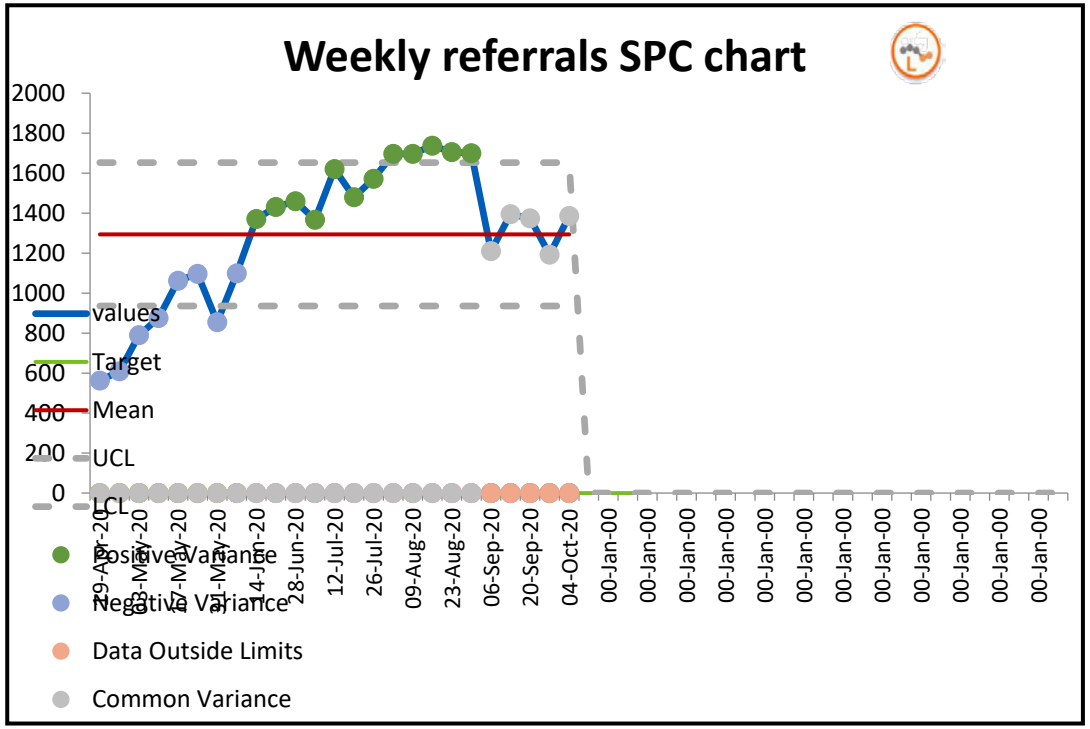
RTT Weekly Performance – 52 week patients

	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Trajectory	396	386	355	372	331	314	278	209
Actual	380							

Weekly performance		
Waiting list size	Backlog	Performance
27,837	10,179	63.43%

40 plus week waits	13/09/2020	05/10/2020
40-52	1723	1842
Over 52 weeks	392	373

- Significant Trust focus on managing and treating patients over 40 weeks
- Internal debate taking place on how we can improve the below trajectory
- Substantial progress in the last two weeks in improving the 52 week position, with over fifty patients treated and removed from the backlog.
- Minor tweaks in clinical harm review process, as discussed in Quality Committee, 40+ week harm review audit to be completed in the next month.
- Mapped treatment plans for 52 week patients
- Speciality teams will be focusing on 45+ week patients to avoid tip ins



Date recorded is date of referral, some referrals not on PAS yet. Reduction in last few weeks is likely to be due to time delay rather than true reduction.

RTT Performance – Trajectory and IS

The tables on the left show the RTT trajectory for the current financial year, including a best case scenario if we can secure additional funding to create additional capacity in IS.

Most Likely? - Assumes a reduced level of internal capcity and assumes reduced level of demand in early months ramping up (and new level being sent to IS)

Scenario 3	Feb-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Waiting List	30414	27869	28220	26765	26924	25249	25061	24039	24077	24802	25575	26907	28712
Total Backlog	3817	8675	10865	12613	13701	12402	12399	12045	12424	13321	14304	15769	17638
% Performance	87.4%	68.9%	61.5%	52.9%	49.1%	50.9%	50.5%	49.9%	48.4%	46.3%	44.1%	41.4%	38.6%

Best?- Assumes a reduced level of internal capcity and demand in early months ramping up (and new level being sent to IS) but also additional capacity (in IS)

Scenario 4	Feb-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Waiting List	30414	27869	28220	26765	26924	25190	24560	21900	20324	19482	18209	17961	18309
Total Backlog	3817	8675	10865	12613	13701	11111	9309	7294	6516	6337	6269	6580	7200
% Performance	87.4%	68.9%	61.5%	52.9%	49.1%	55.9%	62.1%	66.7%	67.9%	67.5%	65.6%	63.4%	60.7%

The tables below show MTW activity carried out in the Independent Sector (IS) - split into surgery only in IS and whole pathway (first outpatient appt and treatment). The numbers are rolling and will only be updated when a patient is discharged and the information is sent back to MTW.

SURGERY ONLY Activity by Independent Sector	Plan per week	04/10/2020	11/10/2020	18/10/2020	25/10/2020	01/11/2020	08/11/2020
TOTAL KIMS	53	35	48	27	37	19	0
TOTAL NUFFIELD	19	1	3	0	0	22	0
TOTAL HORDER	10	6	0	0	0	0	0
TOTAL SPIRE TWH	25	0	0	0	7	0	0
TOTAL BENENDEN	16	2	2	0	0	0	0
TOTAL SPIRE ALEX	0	0	0	0	0	0	0
TOTAL MCINDOE	0	0	0	0	0	0	0
TOTAL BMI CHELSFIELD PARK	0	0	0	0	0	0	0
TOTAL WILL ADAMS	0	0	0	0	0	0	0
TOTAL	123	44	53	27	44	41	0

NEW OPA WHOLE PATHWAY ONLY Activity by Independent Sector	Plan per week	04/10/2020	11/10/2020	18/10/2020	25/10/2020	01/11/2020	08/11/2020	15/11/2020	22/11/2020	29/11/2020	06/12/2020	13/12/2020	20/12/2020	27/12/2020
TOTAL KIMS	18	5	17	12	11	10	5	3	3	0	0	0	0	0
TOTAL NUFFIELD	15	0	5	19	14	12	4	0	1	1	0	0	0	0
TOTAL HORDER	22	15	18	45	14	10	0	10	0	5	0	1	0	0
TOTAL SPIRE TWH	12	1	4	4	1	0	3	0	0	0	3	0	4	2
TOTAL BENENDEN	17	2	21	28	0	3	19	6	2	13	2	0	0	0
TOTAL SPIRE ALEX	4	0	2	3	2	3	0	0	0	0	0	0	0	0
TOTAL MCINDOE	7	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL BMI CHELSFIELD PARK	0	1	1	4	3	4	3	1	0	0	0	0	0	0
TOTAL WILL ADAMS	7	0	0	0	2	0	0	0	0	0	0	0	0	0
TOTAL	102	24	69	116	48	43	34	20	6	19	5	1	4	2

Activity Plan - Diagnostics

What was the objective?

Phase 3: "This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October."

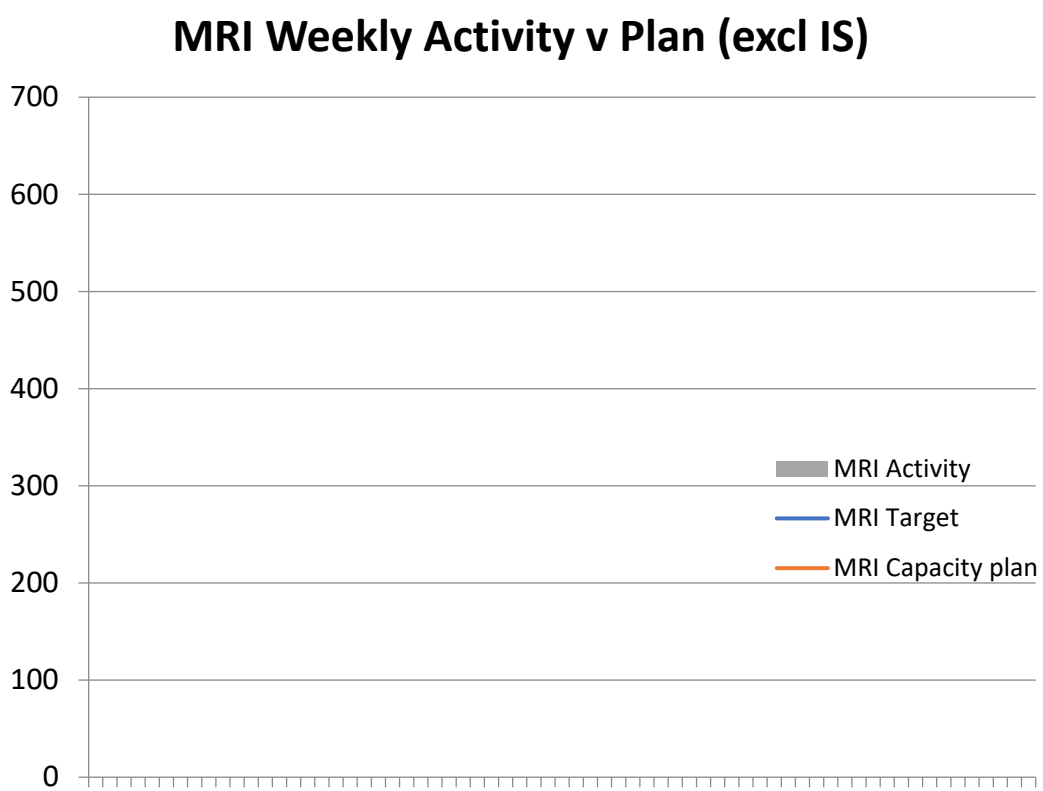
How have we performed so far?

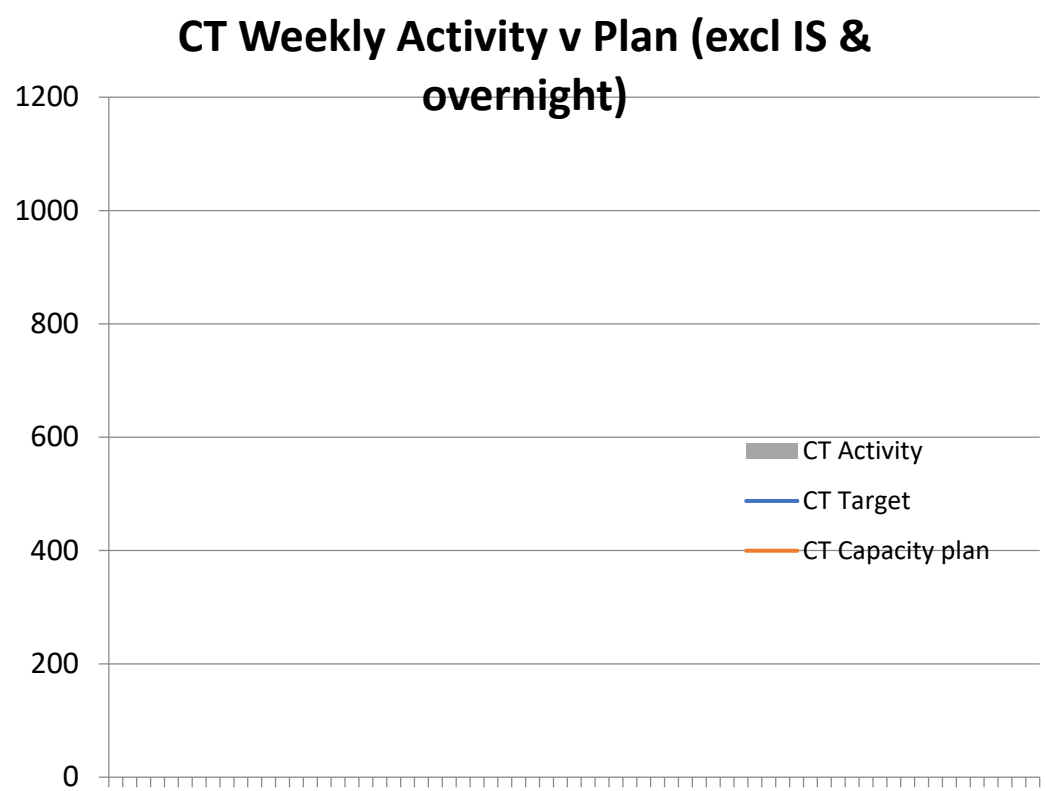
- CT and non-obstetric ultrasound activity were above plan and met the 90% target in August and September.
- MRI capacity was below plan and below the 90% target in August but recovered slightly in September (although the no. of scans in th target was lower for September).

		Aug-20		Sep-20	
		% of 2019	No. of scans	% of 2019	No. of scans
MRI	Target	90%	2106	90%	1996
	Actual	74%	1722	89%	1975
CT	Target	90%	3542	90%	3503
	Actual	95%	3736	94%	3673
Non-obstetric US	Target	90%	4106	90%	4168
	Actual	89%	4044	90%	4146

	Target based on 1920 actuals (80% Aug, 90% Sep, 100% thereafter)								
September – Weekly Activity	Weekly Aim	Week beginning							
		31/08/2020		07/09/2020		14/09/2020		21/09/2020	
MRI	**465**	442	80%	480	96%	478	98%	447	85%
CT	**818**	811	97%	862	92%	839	86%	864	97%
NOUS	**984**	758	74%	977	83%	932	85%	947	90%

Diagnostic Activity – MRI and CT





Diagnostic Activity – October

	Target based on 1920 actuals (80% Aug, 90% Sep, 100% thereafter)										
October		**Week beginning**									
	Weekly Aim	28/09/2020		05/10/2020		12/10/2020		19/10/2020		26/10/2020	
MRI	**524**	385	78%	115							
				467	89%	467	83%	467	86%	467	95%
CT	**922**	877	95%	197							
				751	84%	751	77%	751	88%	751	77%
NOUS	**1085**	1005	92%	195							
				812	76%	812	73%	812	79%	812	73%

Future weeks for CT and MRI are based on capacity plans, not current bookings

Next steps for radiology:

- Deep dive into turnaround times and how efficiency can be improved.
- Review of administrative bookings process
- Discussion with CCG regarding extra funding for additional MRI capacity

Endoscopy

This week: 86.8% (584/673 units) – expected to increase as booking for Saturday/Sunday slots is still ongoing

October Total: On track to perform 80-90% of last year's activity for endoscopy, with a large increase compared to September's activity.

Radiology Performance

DM08 position as at end of August

- 81% compliant with standard (post covid at 60%)
- 13W plus waiters (618, was 749 July 2020)
  - MRI 44 patient (1764 undertaken in Aug)
  - CT 216 patients (4636 undertaken in Aug)
  - NOUS 358 patients (3957 undertaken in Aug)
- Additional staff being recruited for cleaning in between patients treatment to increase slot availability

Outpatients Activity - September

What is the objective?

Phase 3: "100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August)."

How have we performed so far?

- We hit the target in September, performing the same level of OP activity as September last year
- Split into new and follow ups: we were above the target for follow ups but slightly below 100% for news in September. For most specialties, this is due to a decrease in referrals through the Covid period.

Phase 3 - September	05/09/2020		12/09/2020		19/09/2020		26/09/2020	
	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019
General Surgery	640	124%	863	120%	782	108%	888	123%
Urology	322	102%	452	102%	440	100%	512	116%
Trauma & Orthopaedics	668	96%	869	89%	833	85%	901	92%
Ear, Nose & Throat (ENT)	332	127%	371	101%	324	89%	340	93%
Ophthalmology	1070	99%	1379	91%	1370	90%	1378	91%
General Medicine	13	46%	20	50%	25	63%	27	68%
Gastroenterology	135	100%	221	117%	185	98%	192	101%
Clinical Haematology	108	111%	150	110%	239	175%	207	152%
Cardiology	283	131%	332	110%	339	112%	376	124%
Thoracic Medicine	215	122%	188	76%	186	75%	229	93%
Neurology	203	131%	210	97%	190	88%	234	108%
Rheumatology	155	101%	191	89%	231	107%	221	103%
Paediatrics	542	135%	691	123%	680	121%	653	117%
Geriatric Medicine	99	201%	89	129%	76	110%	68	99%
Gynaecology	323	150%	386	128%	311	103%	420	139%
OtherTFCs	463	71%	638	70%	574	63%	606	66%
Total	**5571**	**108%**	**7050**	**98%**	**6785**	**94%**	**7252**	**101%**

*Other includes: gynae-onc, audiology, diabetes, endocrinology

Outpatients Activity - October

Are we on track for October?

- We are on track to meet the Phase 3 target (100% - to carry out the same level of OP appts as October 2019).
- As a live snapshot, on Tuesday 13th October, we have already booked in 75% of 2019's activity for October, which is better than the equivalent snapshot on the same day in September.
- The percentage of booked appointments for October is increasing by 2% each day

Where are the current shortfalls?

- The weekly snapshot on the right is an underestimate, as some appointments, especially nurse-led and echo clinics in cardiology and respiratory, are recorded on Allscripts retrospectively so are not captured until later.
- Ophthalmology is our highest volume specialty and activity has improved significantly over the past week, with 97% booked in for the current week ending 17/10/20.
- T&O have lost clinic space at Maidstone due to the green A&E pathways, but there is a plan to carry out more activity virtually to recover outpatient activity.

Phase 3	Weekly Aim	Week end: 10/10/2020	
		Booked in	% of 2019
General Surgery	865	908	105%
Urology	431	502	116%
Trauma & Orthopaedics	926	818	88%
Ear, Nose & Throat (ENT)	418	292	70%
Ophthalmology	1620	1437	89%
General Medicine	40	22	55%
Gastroenterology	222	220	99%
Clinical Haematology	175	154	88%
Cardiology	351	241	69%
Thoracic Medicine	260	193	74%
Neurology	213	259	122%
Rheumatology	246	254	103%
Paediatrics	640	508	79%
Geriatric Medicine	84	92	109%
Gynaecology	343	389	113%
Other TFCs	1037	622	60%
Total:	**7871**	**6911**	**88%**

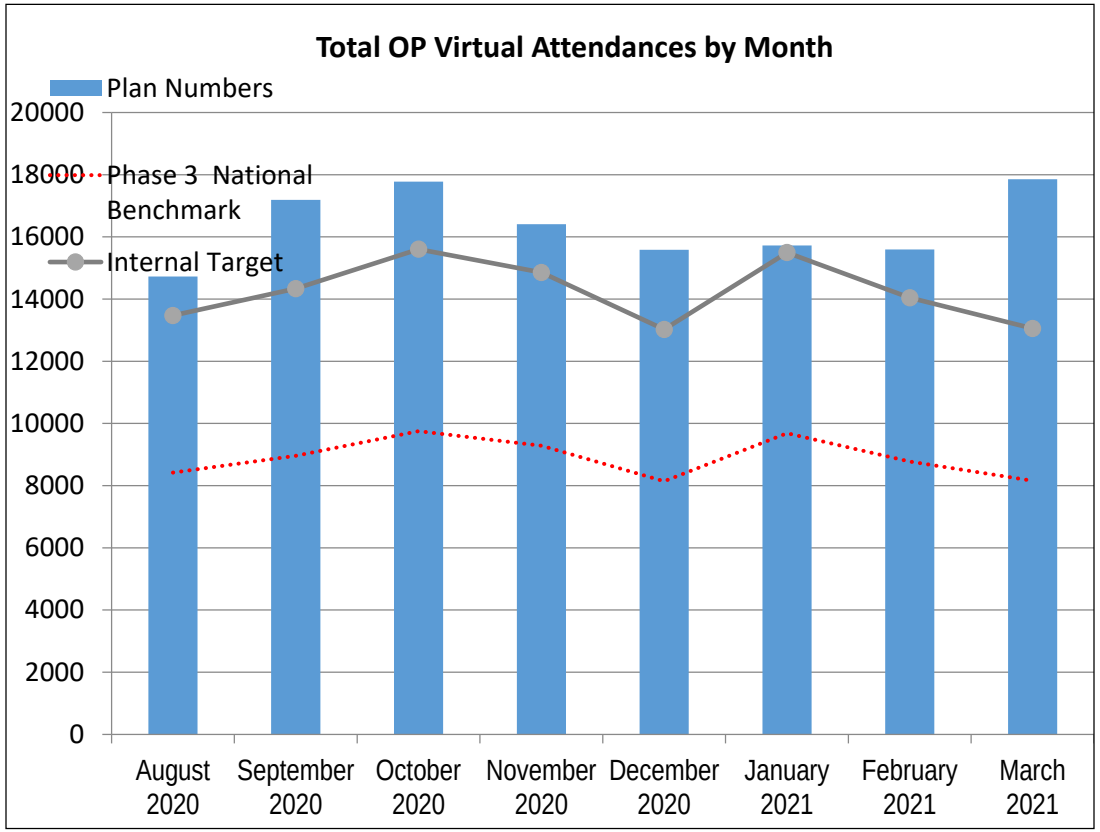
*Other includes: gynae-onc, audiology, diabetes, endocrinology

Outpatients – Virtual Clinics

Trajectories for Virtual Clinics

Phase 3 letter:

*"Where an outpatient appointment is clinically necessary, the national benchmark is that **at least** 25% could be conducted by telephone or video including 60% of all follow-up appointments."*



Cancer Performance

Wait to First Seen (2 week wait)

- We have increased capacity to ensure patients referred in can be seen within 14 days, despite the increasing number of referrals. Median wait to be seen has reduced by 2 days, from 11 days to 9 days.
- The national standard is for 93% of patients referred in with suspected cancer to be seen within 14 days.
- In July, 98.8% of our patients were seen within 14 days and 97.7% in August.
- Referrals are back up to pre-Covid levels – we received 1 377 referrals in July and 1 024 in August.

62 day First Definitive Treatment

- There are less than 40 patients waiting in the backlog for treatment for over 62 days since they were referred.
- Every patient that had their treatment postponed due to Covid has now been treated.
- We achieved 87.4% in July, against a national standard of 85%. We are now one of only two Trusts in the country to have hit the standard for 12 months in a row.
- The number of treatments in July and August is 90% of pre-covid levels (over 90 treatments for both months and are expected to be over 100 for September).

28 day Faster Diagnosis (shadow monitoring)

- 75% of 1 177 patients in July were told if they do or do not have cancer within 28 days of being referred, August numbers are currently being validated however we expect performance to be similar to August.
- The introduction of this standard was delayed at a national level but we have continued to monitor performance internally.

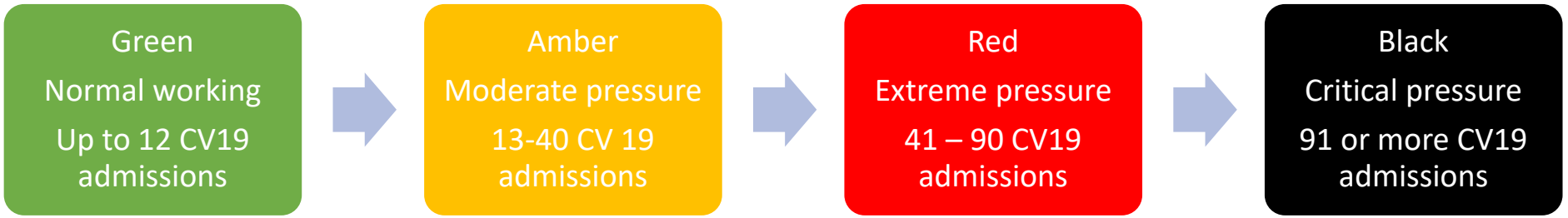
Winter Planning

Covid Escalation Triggers
Winter /16 week plan
EU Transition
Space

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Covid Escalation Triggers



Local level

- Based on bed pressures, number of Covid positive inpatients (+ ITU) and staffing levels
- Critical constraints include the anaesthetic rota to support increased ITU capacity
- Clinical Reference Groups restarted – including lessons learned from Wave 1
- Merging OPEL and Covid escalations

Regional level

- Trigger points and mitigations discussed at winter planning exercise on 14th Oct with all system partners
- Prevalence at local level incorporated into triggers
- Minimum of twice weekly system calls, stepping up to daily if needed

National level

- Reviewing of PHE information daily (e.g. around testing and isolation periods before treatment).
- Incorporating national guidance alterations (e.g. Tier 1, 2, 3 lockdown changes).

OPEL and Covid Escalation Triggers

Level Green = Normal Working

Covid-19

OPEL One	Local prevalence	No. of patients admitted	No. of staff
Demand for services within normal parameters - Trust is able to maintain patient flow and is able to meet anticipated demand within available resources	Tier 1: Less than 100 cases per 100 000 National restrictions e.g. rule of 6	Up to 12 Covid-19 positive treated as inpatients across both sites (up to 4 requiring ITU)	Staff absences within normal limits and not causing operational problems
Maintain routine active monitoring of external risk factors including flu, weather Ensure all pressures are communicated regularly to all local partners	Review PHE information and circulate to senior leaders Swabbing asymptomatic staff in super green areas	Notify system partners in twice weekly calls ICC on site 8am-6pm Mon-Fri (on call weekends) Sitreps from key departments to ICC to identify trends and escalate if necessary	Review and alert ICC is numbers are indicating worsening position over the next 48 hours

OPEL and Covid Escalation Triggers

Level Amber = Moderate Pressure

OPEL 2

Anticipated pressure in facilitating ambulance handovers within 60 minutes;

Insufficient discharges to create capacity for the expected elective and emergency activity; Lack of beds across the Trust;

Opening of escalation beds likely (in addition to those already in use); ED patients with DTAs and no action plan;

Lower levels of staff available, but are sufficient to maintain services;

Infection control issues emerging;

Capacity pressures on intensive care and specialist beds

Undertake additional ward rounds to maximise rapid discharge of patients;

Clinicians to prioritise discharges and accept outliers from any ward as appropriate;

Implement measures in line with Trust Ambulance Handover Plan;

Notify CCG on-call Director to ensure the appropriate operational actions are taken;

Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases

Covid-19

Local prevalence

Tier 2: More than 100 cases per 100 000

National and regional restrictions e.g. ban on household meetings

Review PHE information and circulate to senior leaders

Swabbing asymptomatic staff in surgical areas to commence

No. of patients admitted

Between 13 and 40 Covid-19 positive treated as inpatients across both sites (up to 8 requiring ITU)

Alert CCG, COP and Pulse published daily for staff

ICC to consider extending on site hours (inc. weekends), on call manager to be based in ICC

Review PPE levels, FIT Testing team, oxygen use

Visitor policy, restrict all non-essential visiting and carers attending

No. of staff

Staff absences causing some operational problems but safe care continues to be delivered

Review staffing levels for next 48 hours and take action to ensure safe cover in all areas

Review staffing for next 7 days to enable forward planning to take place

OPEL and Covid Escalation Triggers

Level Red = Extreme Pressure

OPEL 3

Actions at Amber failed to deliver capacity;

Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours);

Patients awaiting handover from SECAMB within 60 minutes significantly compromised;

Patient flow significantly compromised;

Unable to meet transfer from; Acute Hospitals within 48 hours timeframe;

Awaiting equipment causing delays for a number of patients; Significant unexpected reduced staffing numbers;

Serious pressures on intensive care capacity; Problems reported with support services (IT, Transport, Estates, Pathology) that can't be rectified within 2 hours

ED senior clinical decision maker to be present in ED 24/7 where possible;

Contact on-take and ED on-call senior decision makers to offer support to staff and to ensure emergency patients are assessed rapidly;

Enact process of cancelling day cases and staffing day beds overnight if appropriate;

Open additional beds on specific wards, where staffing allows; ED to open an overflow area for emergency referrals, where staffing allows;

Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure;

Alert Social Services on-call managers to expedite care packages and Hilton capacity;

Alert Community Trust to expedite community beds and virtual capacity;

Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases

Local prevalence

Tier 3: Significantly more than 100 cases per 100 000

Potential for full lock down to be declared

Amber escalations +

ICC hours increased to 8am – 8pm 7/7, on call manager to be based in ICC

Site Director and Tactical Commander to meet daily after 4pm site meeting

Strategic call 7/7, led by CEO/Director on call out of hours

Review 14 day isolation period pre surgery

Local review of staff risk assessments and action to protect vulnerable employees

Increase swabbing capacity in line with business case

No. of patients admitted

Between 41 and 90 Covid-19 positive treated as inpatients across both sites (up to 25 requiring ITU)

Amber escalations +

PPE expert to be based in ICC

Review elective work and consider cancelling non-urgent cases

Review outpatient activity – consider reduction in F2F consult – for urgent/cancer only

Swabbing of all patient facing staff

Review Red, Amber, Green pathways and signage

Estates & Facilities to provide daily sitrep to ICC

Ensure oncology pathways are Covid secure

Review use of scrubs and changing areas

Consider intra trust transfer or mutual aid for ITU patients

All ward visiting to cease except EOLC

No. of staff

Staff absences causing significant operational challenges and risk to patient safety

Amber escalations +

Workforce lead based in ICC

Consider cancelling SPA time, study leave, non-essential meetings and re-deployment or staff.

Cancellation of all non-essential mandatory training

Review of bank rates to support clinical areas

Consider appropriate staff welfare actions*

Increased staff accommodation sourced

Removal of all volunteers/work experience from site – voluntary shops - outlets to be closed

Covid-19

OPEL and Covid Escalation Triggers

Level Black = Critical Pressure

OPEL 4

Actions at Red failed to deliver capacity;

No capacity across the trust; Severe SECAmb handover delays; Unable to offload ambulances within 120 minutes;

Emergency care pathway significantly compromised;

Unexpected reduced staffing causing compromises in service provision / patient safety;

Severe capacity pressures on intensive care beds; Infectious illness, Norovirus, Severe weather and other pressures in Acute Trusts;

Problems reported with support services (IT, Transport, Estates, Pathology) that can't be rectified within 4 hours

All actions from previous levels continue;

ED senior clinical decision maker to be present in ED 24/7, where possible;

Contact on-take and ED on-call Senior decision makers to offer support to staff and to ensure emergency patients are assessed rapidly;

Surgical senior clinical decision makers to be present on wards, in theatres and in ED 24/7, where possible;

Executive Director to provide support to site 24/7, where possible

*An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG

Local prevalence

Tier 2: More than 100 cases per 100 000

National lockdown in place

All red escalations +

Executive Director to be on site in ICC

ICC operational 24/7

Establish operational control centres on both sites

Strategic call 7/7 to be led by CEO/Deputy

No. of patients admitted

More than 91 Covid-19 positive treated as inpatients across both sites (50 requiring ITU)

All red escalations +

Consider cancelling all elective cases and all outpatient appts (including non F2F)

Demand for critical care exceeds maximum expanded capacity; need to transfer critically ill covid-19 patients to external facilities

Increased symptomatic swabbing capacity to support demand

No. of staff

Staff absences causing major operational challenges and patient safety cannot be assured

All red escalations +

Consider stopping all but essential Trust functions and redeploy staff to clinically critical areas

Cancel SPA time, study leave, non-essential meeting and redeployment of staff

Consider cancelling planned annual leave

Covid-19

Winter/ 16 week plan

Key risks for winter

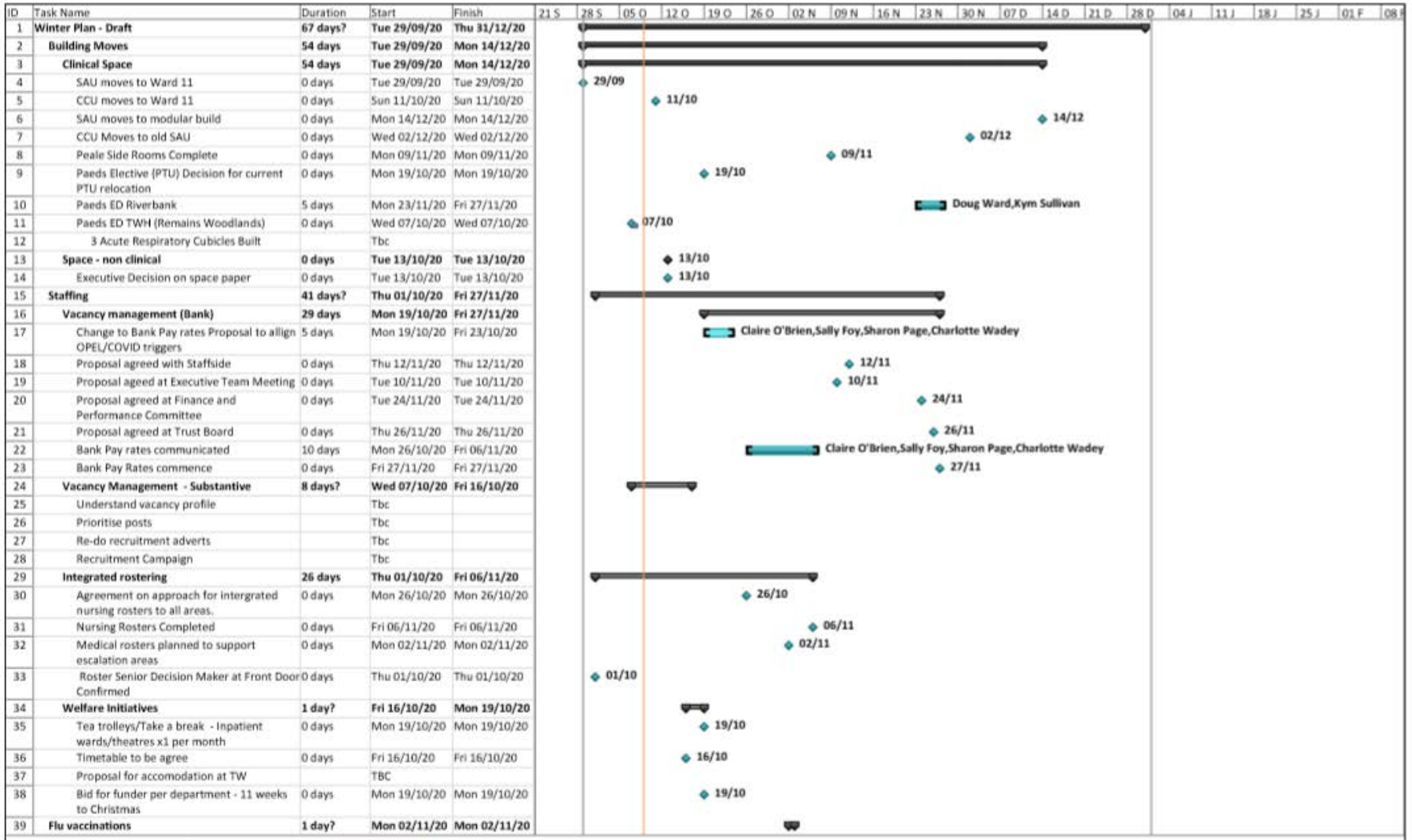
- Capacity modelling indicates 118 non – elective beds short without escalation
- Workforce gaps
- Elective work
- Maintaining sufficient capacity to meet demand in Red, Amber and Green pathways
- Insufficient capacity in community and social care settings to support discharges
- Staff morale and wellbeing
- Space challenges
- Disruption from severe weather, flu, and EU transition

Mitigations

- Implementation of DHSC 'Hospital Discharge Policy'
- Winter plan – open up escalation wards
- Working with KCHFT in ensuring sufficient capacity in all pathways to support timely discharges
- Teletracking – goes live in November
- UTC model operational from December
- Planning for winter aligned across whole system
- Senior decision maker at the front door
- Clinical space decisions (new SAU for example)
- EU transition plan

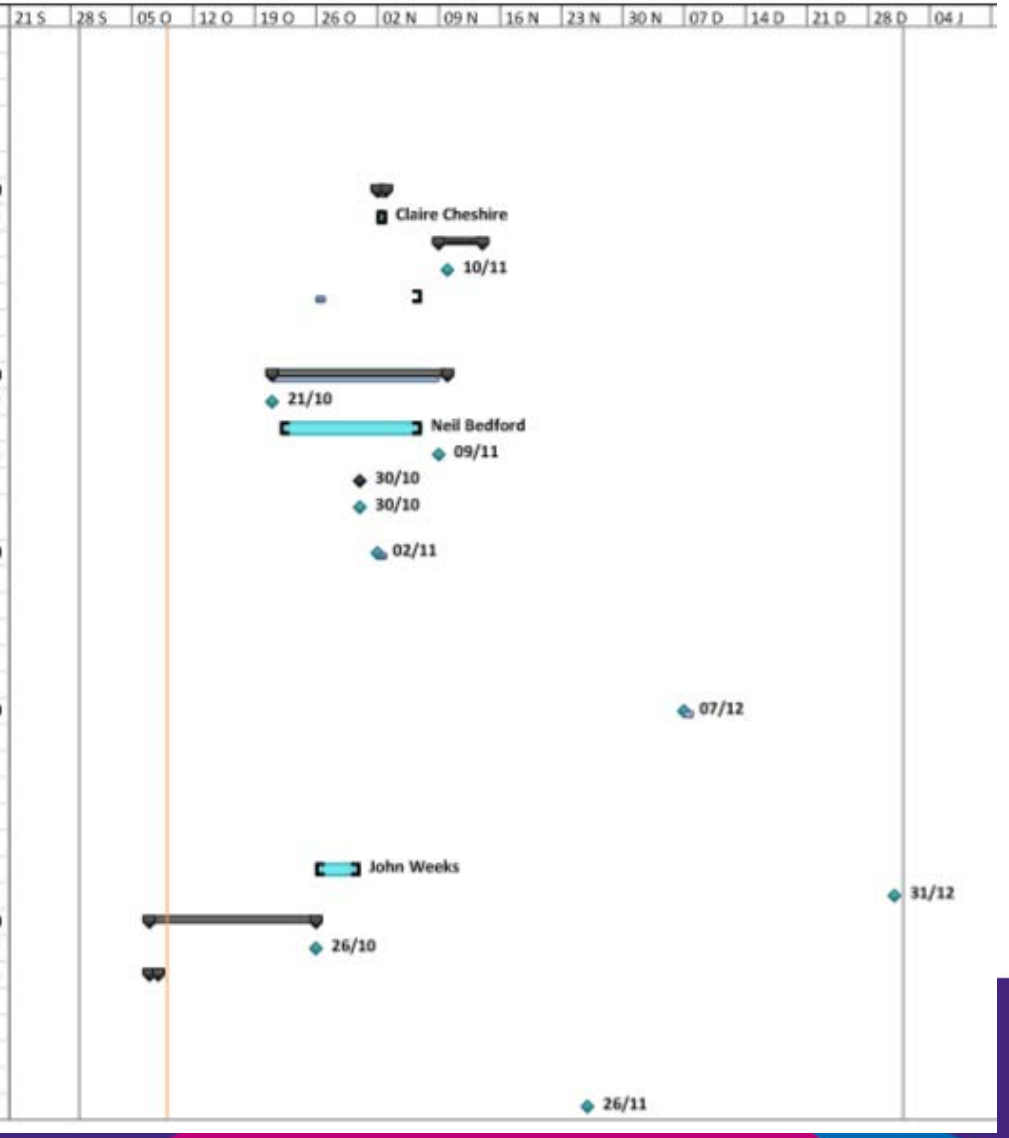
16 week plan

ID	Task Name	Duration	Start	Finish
1	**Winter Plan - Draft**	**67 days?**	**Tue 29/09/20**	**Thu 31/12/20**
2	**Building Moves**	**54 days**	**Tue 29/09/20**	**Mon 14/12/20**
3	**Clinical Space**	**54 days**	**Tue 29/09/20**	**Mon 14/12/20**
4	SAU moves to Ward 11	0 days	Tue 29/09/20	Tue 29/09/20
5	CCU moves to Ward 11	0 days	Sun 11/10/20	Sun 11/10/20
6	SAU moves to modular build	0 days	Mon 14/12/20	Mon 14/12/20
7	CCU Moves to old SAU	0 days	Wed 02/12/20	Wed 02/12/20
8	Peale Side Rooms Complete	0 days	Mon 09/11/20	Mon 09/11/20
9	Paeds Elective (PTU) Decision for current PTU relocation	0 days	Mon 19/10/20	Mon 19/10/20
10	Paeds ED Riverbank	5 days	Mon 23/11/20	Fri 27/11/20
11	Paeds ED TWH (Remains Woodlands)	0 days	Wed 07/10/20	Wed 07/10/20
12	3 Acute Respiratory Cubicles Built		Tbc	
13	**Space - non clinical**	**0 days**	**Tue 13/10/20**	**Tue 13/10/20**
14	Executive Decision on space paper	0 days	Tue 13/10/20	Tue 13/10/20
15	**Staffing**	**41 days?**	**Thu 01/10/20**	**Fri 27/11/20**
16	**Vacancy management (Bank)**	**29 days**	**Mon 19/10/20**	**Fri 27/11/20**
17	Change to Bank Pay rates Proposal to allign OPEL/COVID triggers	5 days	Mon 19/10/20	Fri 23/10/20
18	Proposal agreed with Staffside	0 days	Thu 12/11/20	Thu 12/11/20
19	Proposal ageed at Executive Team Meeting	0 days	Tue 10/11/20	Tue 10/11/20
20	Proposal agreed at Finance and Performance Committee	0 days	Tue 24/11/20	Tue 24/11/20
21	Proposal agreed at Trust Board	0 days	Thu 26/11/20	Thu 26/11/20
22	Bank Pay rates communicated	10 days	Mon 26/10/20	Fri 06/11/20
23	Bank Pay Rates commence	0 days	Fri 27/11/20	Fri 27/11/20
24	**Vacancy Management - Substantive**	**8 days?**	**Wed 07/10/20**	**Fri 16/10/20**
25	Understand vacancy profile		Tbc	
26	Prioritise posts		Tbc	
27	Re-do recruitment adverts		Tbc	
28	Recruitment Campaign		Tbc	
29	**Integrated rostering**	**26 days**	**Thu 01/10/20**	**Fri 06/11/20**
30	Agreement on approach for intergrated nursing rosters to all areas.	0 days	Mon 26/10/20	Mon 26/10/20
31	Nursing Rosters Completed	0 days	Fri 06/11/20	Fri 06/11/20
32	Medical rosters planned to support escalation areas	0 days	Mon 02/11/20	Mon 02/11/20
33	Roster Senior Decision Maker at Front Door Confirmed	0 days	Thu 01/10/20	Thu 01/10/20
34	**Welfare Initiatives**	**1 day?**	**Fri 16/10/20**	**Mon 19/10/20**
35	Tea trolleys/Take a break - Inpatient wards/theatres x1 per month	0 days	Mon 19/10/20	Mon 19/10/20
36	Timetable to be agree	0 days	Fri 16/10/20	Fri 16/10/20
37	Proposal for accomodation at TW		TBC	
38	Bid for funder per department - 11 weeks to Christmas	0 days	Mon 19/10/20	Mon 19/10/20
39	**Flu vaccinations**	**1 day?**	**Mon 02/11/20**	**Mon 02/11/20**



16 week plan

ID	Task Name	Duration	Start	Finish
40	Staff Task and Finish group set up			
41	Resource to complete data input itdenfied			
42	Daily data reported against trajectory			
43	Agree process for Monitoring of GP vaccination			
44	Patients Task and Finish Group Set up			
45	**Urgent Treatment Centres**	**1 day**	**Mon 02/11/20**	**Mon 02/11/20**
46	Go Live UTCs	1 day	Mon 02/11/20	Mon 02/11/20
47	**Teletracking**	**5 days**	**Mon 09/11/20**	**Fri 13/11/20**
48	Go Live	0 days	Tue 10/11/20	Tue 10/11/20
49	**Stroke Rehab**	**10 days?**		**Fri 06/11/20**
50	Pathways agreed for Sevenoaks Hospital		TBC	
51	Pathways agreed for Hilton		TBC	
52	**Rapid Testing**	**14 days**	**Wed 21/10/20**	**Mon 09/11/20**
53	Equipment arrives	0 days	Wed 21/10/20	Wed 21/10/20
54	Testing/validation of equipment	12 days	Thu 22/10/20	Fri 06/11/20
55	Rapid testing go live	0 days	Mon 09/11/20	Mon 09/11/20
56	**OPEL**	**0 days**	**Fri 30/10/20**	**Fri 30/10/20**
57	Escalation Ladders for Medicine and Surgery to be confirmed	0 days	Fri 30/10/20	Fri 30/10/20
58	**Perfect Patient Pathway (PPP) event (KCHFT)**	**0 days**	**Mon 02/11/20**	**Mon 02/11/20**
59	Criteria Led Discharge			
60	Twice Daily Board Rounds			
61	Senior decision makers at the front door			
62	Impact on Diagnostics			
63	Impact on Portering			
64	**Perfect Patient Pathway (PPP) event (KCHFT)**	**0 days**	**Mon 07/12/20**	**Mon 07/12/20**
65	Criteria Led Discharge			
66	Twice Daily Board Rounds			
67	Senior decision makers at the front door			
68	Impact on Diagnostics			
69	Impact on Portering			
70	**GP Hot Hubs - identify location**	**5 days**	**Mon 26/10/20**	**Fri 30/10/20**
71	**EU Transition**	**0 days**	**Thu 31/12/20**	**Thu 31/12/20**
72	**Communication Of Winter Plan**	**13 days?**	**Wed 07/10/20**	**Mon 26/10/20**
73	Staffing Forum (Matrons/GMs)	0 days	Mon 26/10/20	Mon 26/10/20
74	Intranet page	1 day?	Wed 07/10/20	Wed 07/10/20
75	Full Hospital Capacity			
76	Winter Plan Document			
77	Winter Plan			
78	OPEL - COVID Status			
79	Winter plan sign off - Trust Board	0 days	Thu 26/11/20	Thu 26/11/20



EU Transition

Background and National Situation

- Transition period up to 31 December 2020
- If no trade agreement met – will have to adhere to World Trade Organisation rules
- Confirmed on 12th June that no extension will be accepted
- Anticipated to be 'Day 1 No Deal' situation
- Possible delays at the border from January 2021, even if a deal is agreed.

Kent and Medway Planning

- Mike Gilbert is lead exec for the CCG for EU Exit planning, with Matt Capper acting a deputy (day to day ops and reporting)
- A 'Day 1 No Deal' debrief was conducted in Feb 2020 and there are 37 recommendations out of these, including the greater use of mobile technologies e.g. MS Teams
- Exercise LUNDY III took place on 22nd September
- Review of EU Exit plans were delayed due to Covid but underway and K&M Execs are briefed monthly.

Covid-19 and EU Exit threat and risk assessment

- K&M are currently facing 2 concurrent incidents: Covid and EU Exit.
- Each has been risk assessed but it's important the two are considered together as response actions may conflict.
- See risk table on the next slide
- Mitigation plans were tested during Exercise Lundy III.
- A full threat and risk analysis will be included in the next NHS Kent and Medway CCG Exec briefing.
- MTW Divisional Directors asked to review EU Exit Business Continuity Plans

EU Transition

Very High Risk

- Severe weather and winter pressures are concurrent risks that would impact both the EU Exit response and Covid-19 response/recovery. The winter period will also see the arrival of the planned seasonal flu and increased respiratory complaints

High Risk

- High Social care provider failure (contained within the national risk assessment). Impacts on communities, which includes disruption to the provision of social care and long-term detrimental impact to social care providers. Included under previous 'no deal' Brexit planning assumptions,. Smaller providers impacted within 2-3 months, larger providers within 4-6 months. Impact on patient discharge and flow Risk
- Additional health checks may be required at borders which could impact on NHS resources to undertake them.
- Organisations will still be in the Covid-19 recovery phase, both operationally and financially, or still in response for a second or third wave at the end of the transition period
- Staffing disruption and delays for patients caused by freight operation queuing on motorways and reduced use of public transport leading to increase road vehicles

Medium Risk

- Organisations may not be able to allocate resource to EU Exit planning due to responding to Covid-19 pandemic.
- Another wave of Covid-19 in a third country could occur at the same time as end of transition. If this country closes its borders, as was the case in the first wave, there could be an impact on the delivery of key items to the UK. This would be happening at a time when new border controls and customs declarations would be required to bring goods into the UK

Low Risk

- Organisations may not be able to access mutual aid. Mutual aid was necessary for some organisations in previous 'no deal' Brexit scenarios in order to provide a 24/7 response

Space

- To safeguard elective activity and Trust flow from a potential second wave decision made to purchase additional pre-fabricated SAU at TWH. This will support in creating additional critical care capacity. This should be in place by December.
- Agreement reached to keep paediatric ED out of A&E at TWH, again to support second wave planning with estate modifications now taking place.
- Decision made to increase side room capacity at Maidstone Peale Ward and Estates looking to implement before December.
- Decision taken to move more staff home or to off site location to free up space at Maidstone.
- Investment to create separate entrance to MOU to keep elective orthopaedic pathway open even with red ITU patients at Maidstone.
- Investment into estates work to Chartwell Unit to maintain super green clinical area for haematology patients.

NHS
Maidstone and Tunbridge Wells NHS Trust

Winter Response Plan

2020/2021

MTW
Exceptional people, outstanding care

Contents

1. Executive summary

Purpose

- The purpose of the Winter Plan is to bring together all relevant activities across the Trust which relate to planning for winter 2020/21, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned

Development of the Winter Plan

- The Plan is a live document that will be continuously updated as plans are further consolidated and in light of developing circumstances, particularly Covid-19
- The Trust's Winter Plan is overseen by the Winter Resilience Strategic Group and led by the Deputy Chief Operating Officer. More detailed work is undertaken by each Division, who hold their own Winter Planning meetings
- The usual Winter De-Brief was cancelled due to Covid-19 however Lessons Learnt from the winter period have been collated and fed into the planning process
- A System Exercise Event, which the Trust leads, took place on 14th October and involved all partners, including local authorities. The exercise worked through the four key risks identified by NHSE I for this winter; Covid-19, flu, EU transition and severe weather
- All Divisions have provided leads that have been supporting the development of the Trust Winter Plan
- The Plan is under constant review and development and identifies the actions that will maintain patient safety and clinical quality over the period of expected surge in demand during winter
- The Draft Trust Winter Plan has been shared with K&M CCG colleagues and has been developed using the regional framework for Winter Operating Model 2020/21

Executive summary (cont.)

- The Trust recognises that the winter period will be challenging with anticipated high demand and impacts from a potential second wave of Covid-19, flu, EU Transition and severe weather. The Trust is committed to working together to manage these challenges, learning from our experience of previous winters and the Covid-19 pandemic.
- **Data driven management**: we will use real-time information systems to anticipate capacity pressures and manage them effectively to support best possible flow through our sites for all patients
- **Effective co-ordination**: This year, as a result of the Covid-19 pandemic the Trust established an Incident Control Centre (ICC). This function will continue over the winter period to ensure maximum use of resources, clear communication, rapid resolution to incidents and issues and promote effective partnership working
- **Proactive communications:** We will work with system partners to implement a Communications Plan which includes promotion of alternatives to the Emergency Department through targeted use of social media and other channels for specific population groups
- **Demand management:** we will continue to build on demand management initiatives including introduction of the NHS 111UTC model
- **Acute capacity:** we will increase acute bed capacity over winter whilst continuing work to reduce length of stay and > 21 day stranded patients. Work will be undertaken to maximise Same Day Emergency Care
- **Hospital Flow and discharge**: we will build on positive progress with partners to implement the standards laid out in the recently published national Hospital Discharge Policy and keep stranded patient numbers low by improving complex and simple discharges
- **Festive weeks:** we will produce detailed operational plans for the Christmas and New Year period
- **Covid-19:** assumptions of the timing, impact and management of a resurgence of Covid-19 cases within the acute trust will be detailed within the Winter Plan
- **EU transition:** we will ensure that there is coordination across the Winter Plan to manage possible impacts of EU transition
- **Flu:** Details of the vaccination programme will be incorporated within the Winter Plan
- **Severe weather:** Notification of adverse weather will be proactively communicated by the Emergency Planning team

2. Emergency Department (ED) Activity

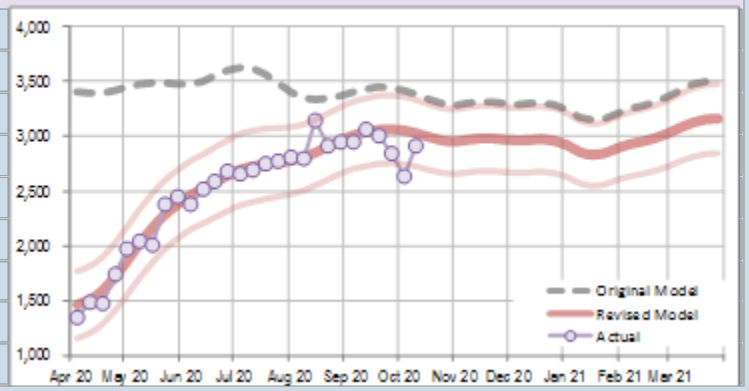
The Covid pandemic has significantly altered ED attendances since March 2020 resulting in activity for the remainder of the year being difficult to model. Factors including a potential second peak of Covid, public confidence and behavior, success of the Think 111 First campaign, flu and severe weather will all impact on the level of attendances.
In order to give a range of planning assumptions for this winter, 4 scenarios have been used ranging from 10% less ED attendances than over the same period 19/20 to 10% more. We have also included activity being the same as the same period in 19/20 and growth of 4.6% (commissioned level). These are being tracked by the Business Intelligence Unit to understand which is most representative of actual demand in ED.

Table 1 – Current activity tracked against original and revised models

Type 1 ED Attendance

Type 1 Attendance at Maidstone & TWH				Total	Change on 2019/20
Factors					
Apr-20	41.0%	Fixed	2020/21 Q1	27,050	-35.8%
Jul-20	72.0%	Change	2020/21 Q2	37,761	-12.2%
Oct-20	90.0%	Change	2020/21 Q3	39,179	-7.6%
Jan-21	90.0%	Change	2020/21 Q4	38,327	-9.4%
Apr-21	90.0%	Change	2020/21 Year	142,318	-16.2%

Factor estimates include a switch to critical & booked attendance only, and a second wave in the winter



3. Trust ED attendances split by Ambulance – GP – Walk In Activity

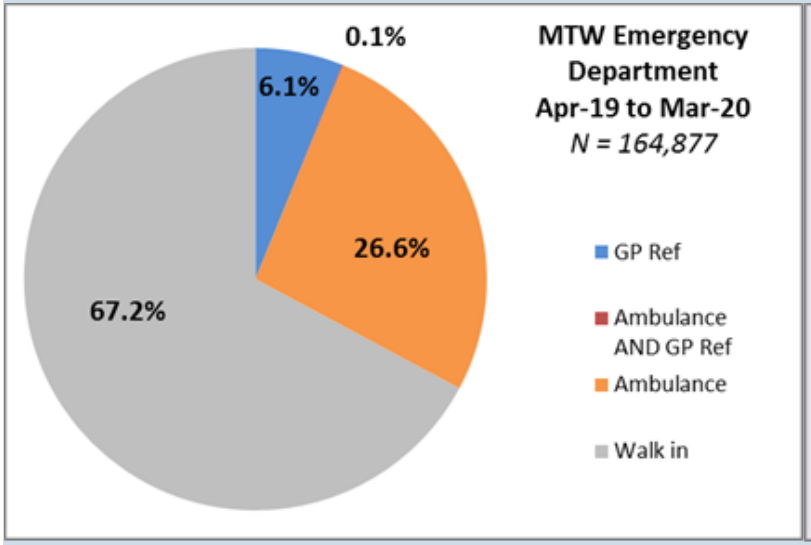


Table 1: Trust ED attendance by source April 19 – March 20

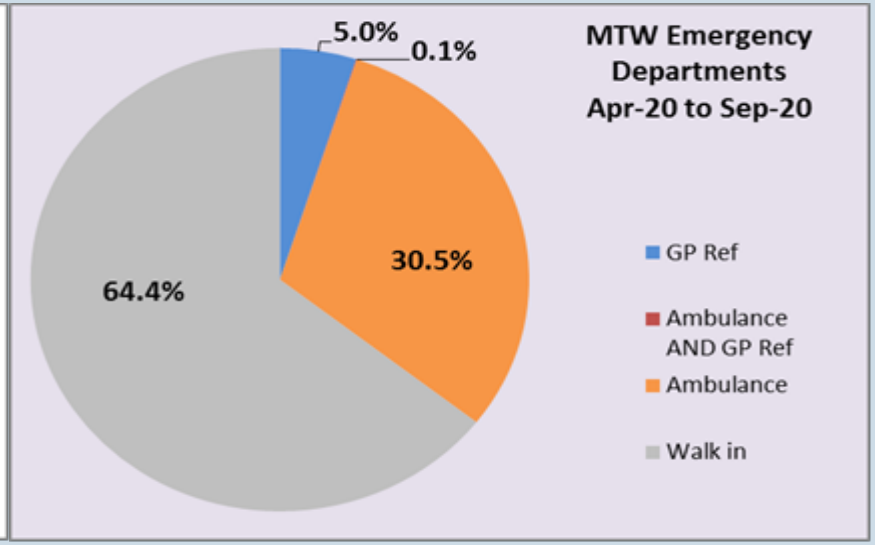
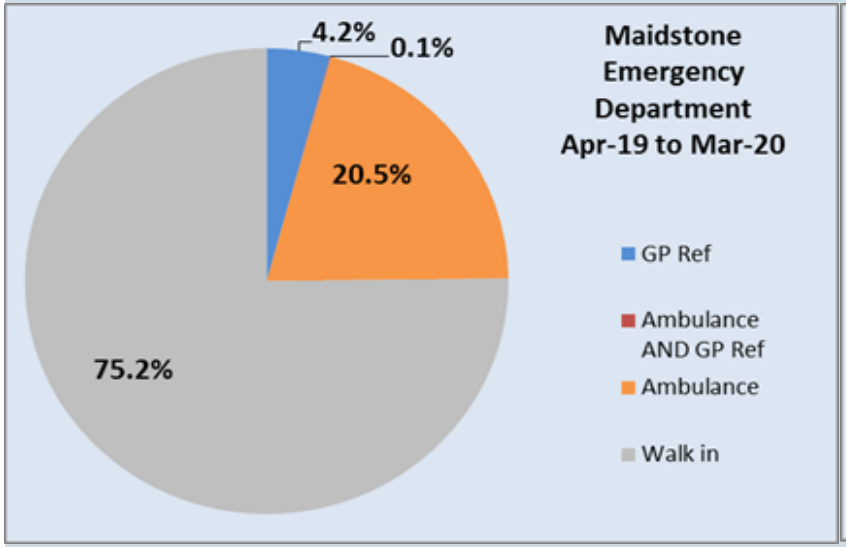


Table 2: Trust ED attendances by source April 20 – September 20

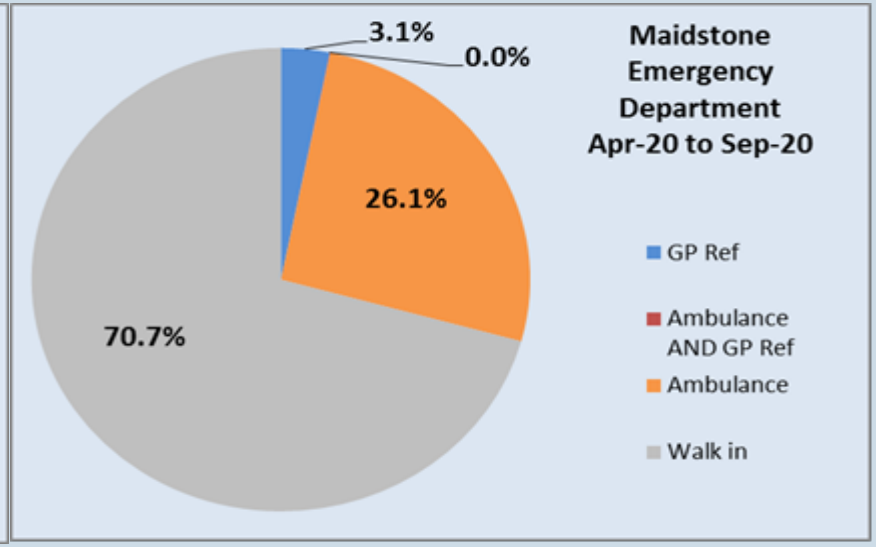
4. Maidstone ED attendances split by Ambulance – GP – Walk In Activity

Table 3: Maidstone ED attendances by source April 19 – March 20



GP Ref	3,250	4.2%
Ambulance AND GP Ref	47	0.1%
Ambulance	15,724	20.5%
Walk in	57,597	75.2%
Total	**76,618**	

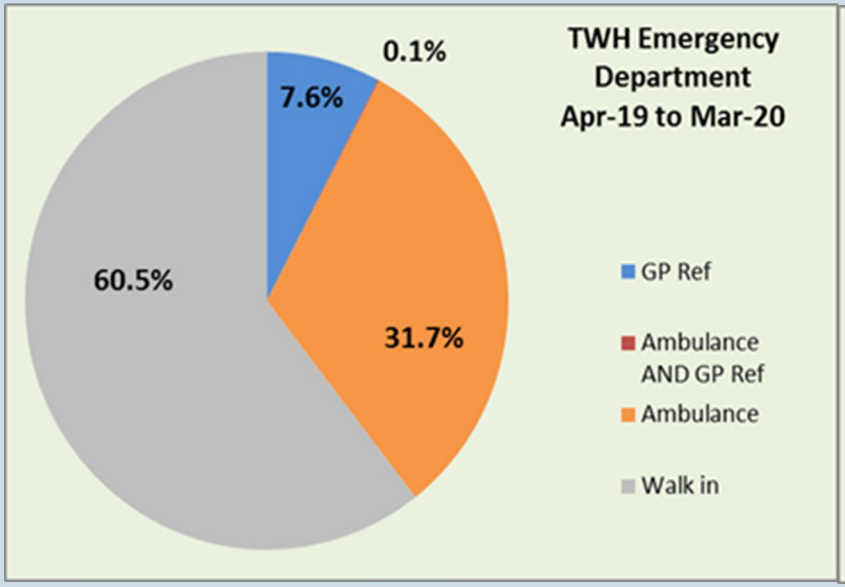
Table 4: Maidstone ED attandances by source April 20 – September 20



GP Ref	963	3.1%
Ambulance AND GP Ref	14	0.1%
Ambulance	8,100	26.1%
Walk in	21,958	70.7%
Total	**31,035**	

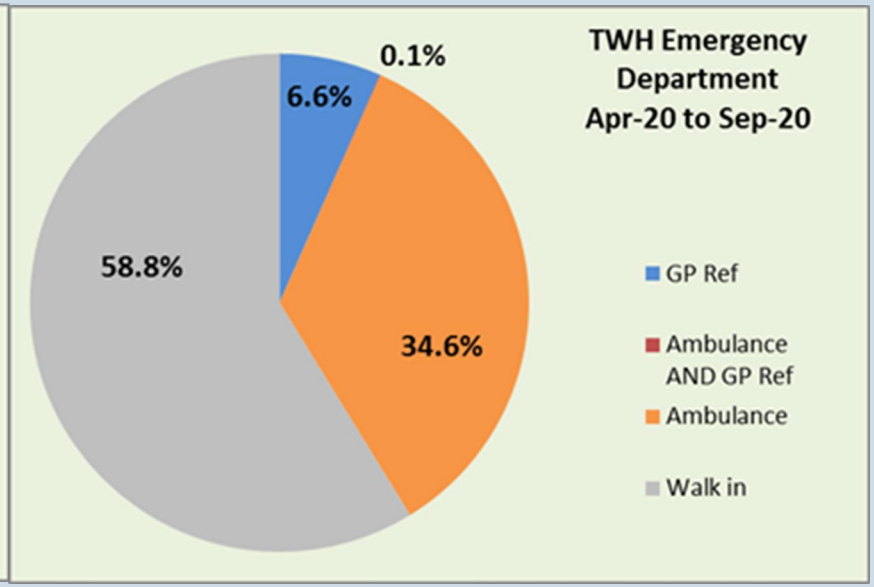
5. Tunbridge Wells ED attendances split by Ambulance – GP – Walk In Activity

Table 5: TW ED attendances by source April 19 – March 20



GP Ref	6,731	7.6%
Ambulance AND GP Ref	87	0.1%
Ambulance	28,016	31.7%
Walk in	53,425	60.5%
Total	**88,259**	

Table 6: TW ED attandances by source April 20 – September 20



GP Ref	2,229	6.6%
Ambulance AND GP Ref	23	0.1%
Ambulance	11,802	34.6%
Walk in	20,080	58.8%
Total	**34,134**	

6. Walk in Attendances

Introduction

The way that self-presenting patients attend the ED is changing due to the introduction of the Urgent Treatment Centres (UTC) which has been mandated centrally by NHS England. There will be a National campaign entitled “Think 111 First” which will require all members of the public who feel they need urgent care to contact either 111 or 999 and they will be referred to the appropriate service. There will be an appointments system in place for 111 to book patients into the most appropriate treatment centre via a timed booking. 999 will be managed in the current format. Within West Kent there are three UTCs, one at each Acute Trust Site and one at Sevenoaks Hospital.

Timeline

UTC is due to commence on the 2nd November 2020 with the direct booking element from 111 also going live on 2nd November

System Approach

MTW has been working with system partners to develop an approach to the delivery of UTC. Currently Urgent Care is delivered across West Kent by:

- 71 pharmacies
- 54 GP Practices
- Two primary care units based at Maidstone Hospital and Tunbridge Wells Hospital.
- Same Day Emergency Care units including Ambulatory and frailty units
- Home First
- Home Treatment Service
- Rapid Response
- High Intensity Therapy Team (HITS)
- Therapy Assisted Discharge Service (TADS)
- Two minor injury units (Sevenoaks and Edenbridge)
- Four community hospitals (Tonbridge, Sevenoaks, Hawkhurst and Edenbridge)
- Social care services
- One ambulance service providing both 999 & 111
- Two emergency departments (on the Maidstone and Tunbridge Wells hospital sites)
- Mental health acute liaison service
- Mental health crisis intervention and home treatment services

Walk in Attendance (cont.)

As can be appreciated, this approach is confusing for patients and healthcare professionals alike. By filtering all requests for Urgent Care through 111 and as the Direct Booking system develops 111 will be able to direct patients to the most appropriate service for their needs reducing the pressure on the Acute Trust sites ED's.

Modelling

Modelling is currently underway with WSP who will provide a west Kent slide pack containing the following

1) Current west Kent urgent care data flows (111/ED/MIU etc. and flows through to urgent care services, SDEC, GP in A&E, OOH etc.)
2) Our changes to services in the future months (i.e. October 20, new 111/CAS service and 3 UTCs at ED front door and S/Oaks etc.)
3) New modelling numbers based on the above assumptions and principles
4) New modelling broken further into 4 hour bands (8am-12, 12 noon till 4pm etc.)
5) K&M modelling projections (based on data and statements planning and assumptions across K&M)

This will then ratified by the system, and a review of the costs by finance colleagues.

Risks

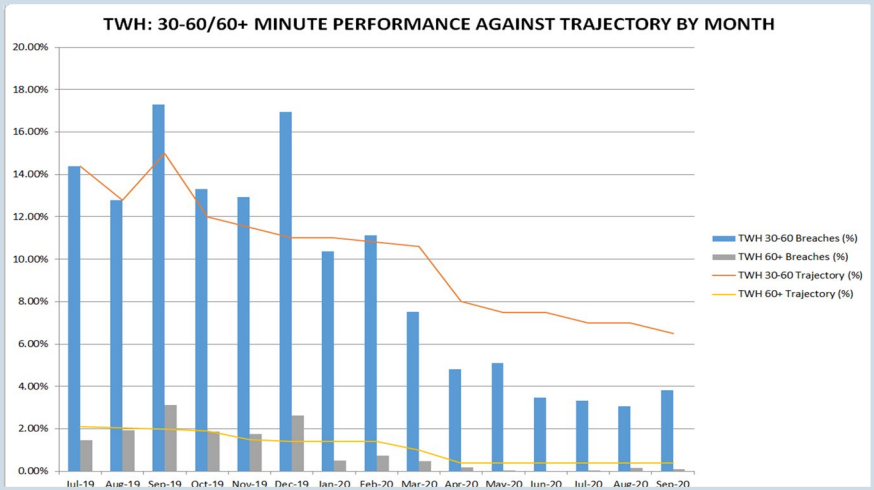
- Public engagement through the "Think 111 First" campaign, public may not adhere to this new way of approaching care. This is mitigated by First Contact Practitioners at the front door of each ED who will book patients an appointment to be seen the same as 111.
- GP provision at Sevenoaks. Currently there is no GP provision but this will be required as part of a UTC.
- IT Interoperability. MTW have procured an IT solution by WASP to enable Direct Booking from 111 into MTW, KCHFT and procured on behalf of MFT and MCHT. This is currently in development but is not a current working solution.

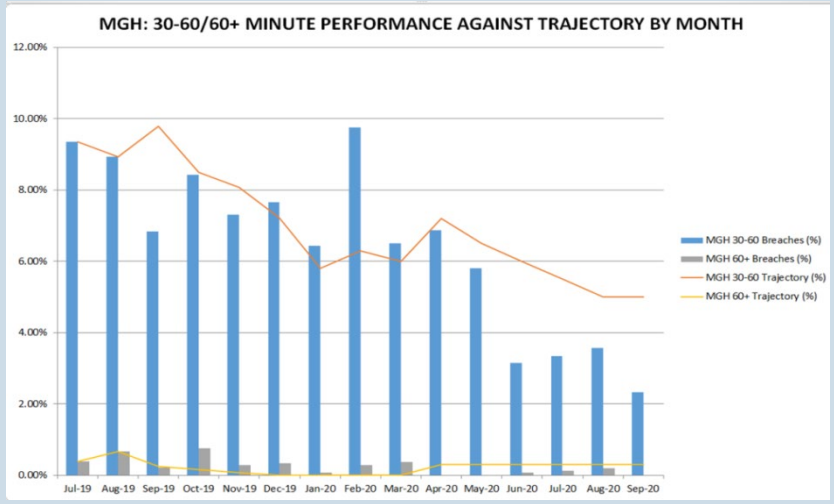
7. Ambulance Attendances

Focused work has been undertaken by the Trust and South East Coast Ambulance Trust (SECAmb) to improved handover delays at both ED sites over the past 2 years. Significant improvement has been made and the intention for the winter is to continue this trajectory.
Monthly meetings take place with SECAmb to monitor performance, evaluate new processes and ensure handovers are minimised.
SECAmb present a report at the Local A&E Delivery Board.

Plans to support offloading ambulances without delay over the winter period include:

- Ensuring consultant or senior registrar presence in RAP to assess patients, document and enact a management plan and triage patient to the most appropriate area of ED for their on-going care
- The flow from RAP is not impeded by a lack of major cubicles and that any patients needing admission are allocated a bed and transferred as quickly as possible
- The Clinical Site Team are responsible for allocating beds once a Decision to Admit is made to keep flow within the ED and avoid ambulance handover delays.





8. Bed Modelling

Conversion rate from ED attendance to admission>24hours has remained consistent at around 26%, therefore the beds required for non-elective patients this winter are shown in Table 1. This is the total for the Trust and all specialties. The model suggests peak bed requirement of 600 beds during January and February. Total bed occupancy has continued to run within the ranges of the revised model, and is now around 10% down on what would have been expected without Covid.

Table 1: Total non-elective beds required at Trust level – updated 12th October 2020

Bed Modelling (cont.)

Table 2: Maidstone Hospital non elective beds required

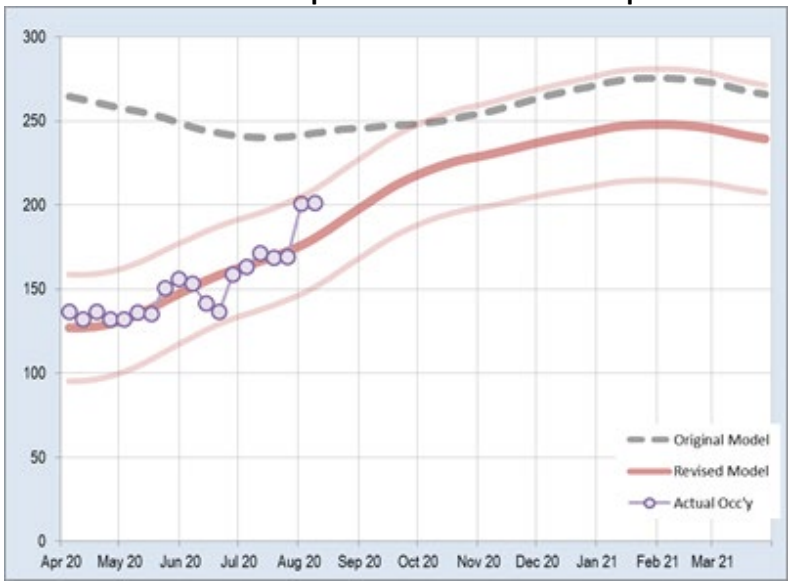
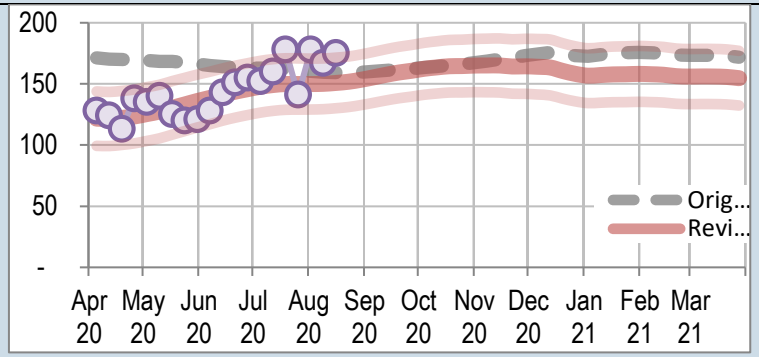
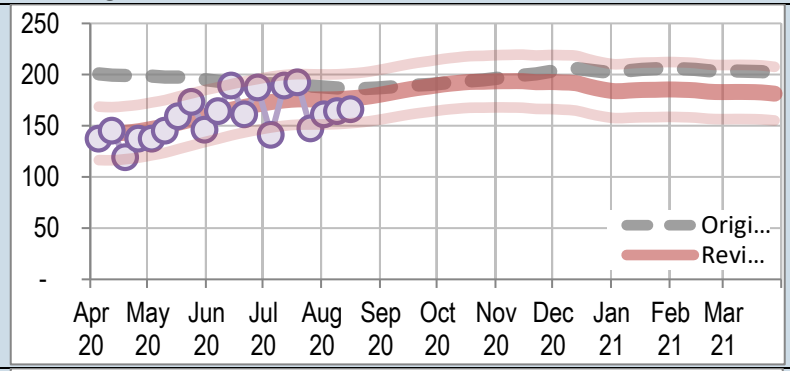
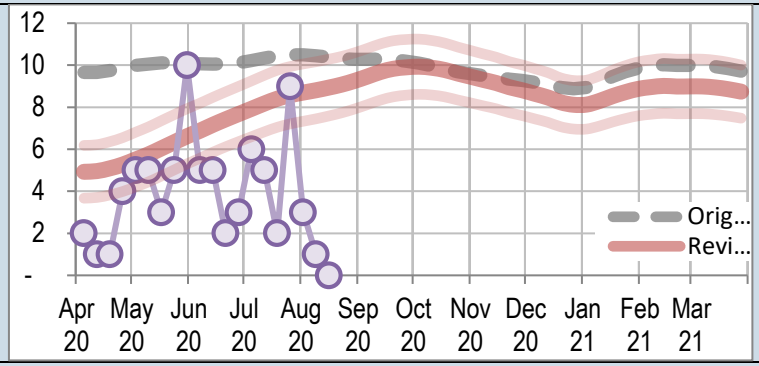
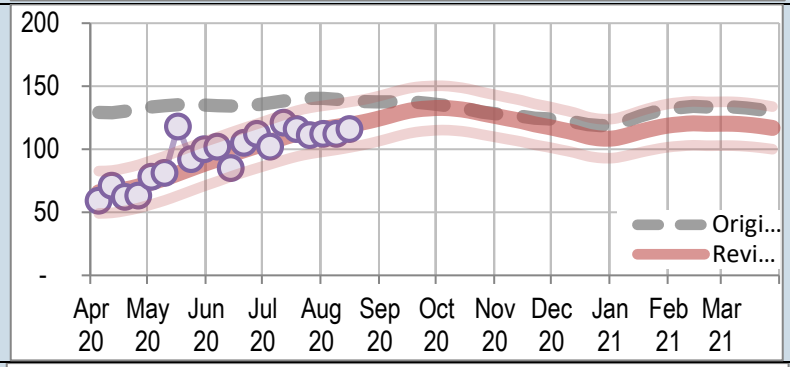
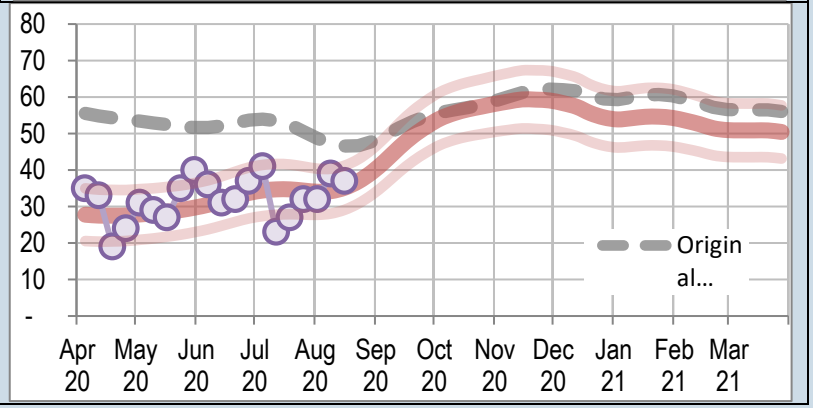


Table 3: Tunbridge Wells Hospital non elective beds required

Bed Modelling (cont.)

	Maidstone	Tunbridge Wells
Medicine		
Surgery		
Womens and Childrens		

9. Elective Modelling

Summary of all elective spells below

	April 2020	May 2020	Jun-20	Jul-20	Aug-20	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
Electives												
Ordinary spells	56	76	110	147	333	364	381	349	333	333	333	381
Day case Spells	575	797	1281	1653	3268	3603	3767	3441	3273	3289	3272	3741
Total Elective spells	631	873	1391	1800	3601	3967	4148	3790	3606	3622	3605	4122

Please See embedded file for the detail to meet the Phase 3 Elective plan

Phase 3 Elective Only.xlsx

10. Bed Capacity

Tunbridge Wells - Core Medical Beds		Maidstone Core Medical Beds		Tunbridge Wells Core Surgical non-elective Beds	
AMU	28	John Day	30	W10	30
CCU	8	Culpepper	13	W30	30
W12	30	CCU	6		
W2	26	Mercer	26		
W20	30	Pye Oliver	28		
				Maidstone Core Surgical non-elective Beds	
W21	29	AAU	14		
W22	32	Stroke Unit	22		
Total	**183**	Chaucer	33	Cornwallis	12
		Whatman	20		
Plus escalation Ward - W11	30	Edith Cavell	13	**Total**	**72**
		Peale	19		
		Total	**224**		
		Plus escalation Ward - Foster Clark	28		
Winter Total	**213**	**Winter Total**	**252**		

OVERALL WINTER NON ELECTIVE CAPACITY 537 AGAINST DEMAND OF 600 = SHORTFALL OF 63 BEDS

11. Closing the Gap – Mitigation of Shortfall

On the modelling undertaken to date, the Trust has a shortfall of non-elective beds of approximately 60 beds

This includes use of both W11 at TW and Foster Clark at MH as escalation ward from Dec through to end of March. A phased opening of these areas will be planned in line with expected demand.

A number of initiatives will be in operation over the winter to maintain flow by keeping the average non-elective Length of Stay no higher than 6.2 days. These include:

- Senior Decision Makers at the front door for all specilaties – ED and Same Day Emergancy Care (SDEC)
- Full utilisation of Hospital @ Home
- Teletracking – goes live in November
- Increasing hours of opening in all SDEC areas (SAU/ AFU/ AEC)
- Twice daily Board Rounds with at least one being consultant led
- SAFER approach to Board Rounds
- Criteria for Discharge documented in medical notes
- Clear and accurate documentation of Medically Optimised For Discharge recorded in medical records
- Implementation of the principles outlined in the Hospital Discharge Policy
- Close working with KCHFT and KCC to ensure sufficient capacity in all Discharge to Assess pathways at all times
- Forward Planning meetings weekly to monitor progress of plan and mitigate any unforeseen issues that may arise which will impact flow
- ICC in operation 24/7 over the winter period

12. Live Data Systems

Smarties

- Real time view of all ED Metrics to support capacity management and flow.
- Real time view of CUR tools to identify delays in the patient pathway
- Key managers provided access through mobile app and web browser can be used both on and off site
- Displayed on Ops Centre and reviewed by managers during the day and whilst on call to understand the site pressure. All metrics RAG rated for easy view

What is SHREWD Resilience

- SHREWD Resilience is a real time view of system pressure, which informs system response and individual provider actions
- SHREWD Resilience enables front line teams and operational leaders including the CCG to identify 'where' pressure is across the health system within a few seconds.
- Data is captured live or in real time wherever possible and shared with all providers across the health economy.
- Data is accessible on any computer, smart phone or tablet

- Currently not fully embedded in use by operational teams however work being undertaken to promote this system and its benefits particularly over winter when on call managers participate on system calls as necessary

Power BI

- Dashboards developed within this platform to allow review of:
  - Current Staffing
  - Detailed view of ED Position by site
  - COVID 19 Dashboard
  - Current Oxygen usage by ward area
- Key managers provided access through mobile app and web browser can be used both on and off site
- Currently not fully embedded in use by operational teams however work being undertaken to promote this system and its benefits particularly over winter when on call managers participate on system calls as necessary

Live Data Systems (cont.)

TeleTracking

- Currently implementing a live Capacity Management System to identify real time bed state and automation of discharge processes and bed cleaning and allocation
- Real time reporting available to key managers via mobile app and web browser
- Creation of the Care Coordination Centre (CCC) to facilitate bed placement for both acute trust sites from one central place. This will facilitate reduced idle bed time and improved patient placement leading to improved patient experience and care
- Within Q4 we will gain real time visibility of Community Bed availability allowing for improved discharge planning and reduced LoS in the Acute hospital
- Development of the CCC will allow for one single point of referral for all patients into the Acute Trust which will further facilitate better capacity management
- ROI Benefits identified in the approved business case will begin to be realized in Q4 and has been modelled into demand and capacity assumptions

13. Full Hospital Capacity Protocol

The provision of 'High Quality, Safe Healthcare' leading to good patient experience is a key organisational priority. This should be at the forefront of our work at all times, however, organisational pressures and operational workload can limit the ability of key areas to provide this along with expected patterns of care. When this pressure inhibits normal daily functioning, it significantly increases the risk of failure in care occurring.

When the Trust begins to operate at a heightened escalation status, the Trust as a whole needs to adapt and operate differently. This balances and shares the clinical risk across the whole of the Trust as risk mitigation is part of the organisation's key action in upholding its duty of care to patients. Escalation of the Trust's response however should begin independently of the Trusts OPEL status depending on the apparent risk, rather than waiting for a specific escalation status or level.

Unlike many departments and clinical areas, the ED is unable to cap demand and close its doors when all available patient care spaces are occupied. The risk of serious incidents happening not only increases with every additional patient that arrives over and above capacity but this is concentrated in one geographical area. This represents a significant risk to all that is described above. As such the risk needs to be shared across the whole organisation and the Trust response is one from the whole organisation and not just the ED.

In order to effectively manage the above scenario, the Full Hospital Capacity Protocol has pulled together the various strands of work that has supported improved flow over the past 3 years at MTW into one document that details specific escalation triggers, roles and responsibilities and actions to be taken in order to resume 'flow' as soon as possible.

MTW Full Capacity Protocol 1.8 (3).docx

14. Incident Control Centre (ICC)

Purpose:

- This year, as a result of the Covid-19 pandemic the Trust established an ICC. This function will continue over the winter period to ensure maximum use of resources, clear communication, rapid resolution to incidents and issues and promote effective partnership working
- This unit will if recruitment is successful be able to function 24/7 in conjunction with the Teletracking Care Co-ordination Centre allowing access to real time data, with rapid decision making and the ability to identify issues that are developing before they become a major operational issue.
- It will also become a single point of contact for partners and trust departments to impart information and allow rapid dissemination of information across the organisation.
- It will also have a horizon scanning function to be able to identify potentially disruptive issues such as travel delays, adverse weather, industrial action, supplies shortages and other factors
- It will be the first line co-ordination and management of incidents up to major incidents
- In conjunction with the Care coordination function it will produce real time reports to assist divisions with planning.

15. COVID-19

The Covid-19 pandemic has caused significant changes to the way we all work within the Trust. With no certainty that a vaccine will be available for this winter, planning has to include how we manage the usual winter surge in demand as well as ensuring a Covid-19 secure environment for both patients and staff. An Escalation Framework has been agreed for Covid triggers and is embedded below.

The Trust receives Covid-19 modelling assumptions from a range of sources, both national and local, and Business Intelligence Unit is reviewing the data and applying modelling to forecasts each week which are reviewed at Forward Planning and on the daily Executive Huddle to ensure we have as much time as possible to put measures in place for any resurgence of hospitalisations.

Covid-19 areas of focus that will continue over the winter:

- Red, Amber and Green pathways are well established on each site although remain under constant review
- Ensuring resilience in PPE stock and understanding the 'burn rate'
- FIT testing all relevant staff and maintaining accurate records
- Swabbing Directorate overseeing all requirements for swabbing and antibody testing
- Ensuring all public areas are covid-19 secure in terms of waiting areas, temperature checks at the front door
- Visiting policy responds to the needs of patients whilst protecting visitors, staff and patients
- Home working staff are supported
- Additional space required for clinical services is sourced
- Daily Executive Covid-19 Huddle at 08.45 each morning well established
- ICC is point of contact for external agencies for all Covid-19 related issues
- On call management, if escalation of Covid-19 cases is seen, undertaken by Head of ICC
- Daily update on Covid-19 position within the Trust circulated
- Rapid Testing to be introduced on each site in November with daily tests available as below:

	Samba II	DNANudge	Total
October 2020	38	51	89
November 2020	50	83	133
December 2020	61	115	176
January 2021	61	176	237

OPEL and COVID-19 Escalation Framework

16. Flu

This winter, in the likely absence of an effective COVID-19 vaccine, it is almost certain that influenza strains will circulate in conjunction with COVID-19. If both viruses are circulating, they could co-infect a person increasing the risk of complications and hospital admissions. Unfortunately, those most at risk from flu are also those most vulnerable to COVID-19. It is anticipated that concerns about COVID-19 will significantly increase demand for the flu vaccination in all groups this year.
NHSE/I and PHE have tasked Trusts to vaccinate 95% of all staff and to schedule the campaign with completion by the end of November, where possible.
The Trust placed an initial order of 3,500 quadrivalent vaccines back in March and have managed to obtain a further 1300, plus 200 trivalent vaccines (for workers aged 65+) = total 5000
Further supply has been secured and therefore there will be sufficient vaccines for all staff although delivery is expected to be phased. As such we aim to initially prioritise and target frontline staff. Staff with patient contact will be the first wave to be offered the vaccine. As more vaccine is received the program will expand to include business critical staff essential to maintaining core services such as switchboard, IT desktop support, EME etc. Divisions have been asked to identify their business critical staff and have been supplying Occupational Health (OH) with those details.

In previous seasons we have not encouraged staff eligible to receive the vaccine from their GP to do so. This season we will very much encourage that to help preserve our own supply to reach more staff.

The challenge will also be around delivery of the vaccines. We have been informed that the vaccines are going to be delivered to Trusts in 4 batches from mid-September to the end of October. We will have just over half our order by mid-October; the remainder being delivered at the end of October and the first week of November;

Maidstone Delivery Schedule

18th Sept – 580
28th Sept (end of the week) – 1,000
9th Oct – 460
23RD Oct – 580
6th Nov – 680

Flu

Tunbridge Wells Delivery Schedule
18th Sept – 380
9th Oct - 300
23rd Oct – 380
6TH Nov - 440

Funding has been secured for 4 WTE nurses during October and November to administer the vaccinations and they will work early mornings (to capture night staff), days, evenings and weekends to maximise cover across the Trust.

OH are working with our Workforce Colleagues to utilise ESR to directly record staff vaccines, this will enable better reporting ability and weekly reports on uptake by staff group within departments (this is due to an ageing OH system currently in the process of applying for replacement). This in turn will enable better targeting of the flu vaccinator to areas with lower uptake. The ability to achieve 90-95% uptake of the vaccine is dependent upon both delivery dates and supply. With this in mind, our weekly percentage target will be as follows;

Week 1	19.3%
Week 2	28.6%
Week 3	35.6%
Week 4	39.1%
Week 5	58.1%
Week 6	69.8%
Week 7	83.7%
Week 8	90.7%
Week 9	92.6%
Week 10	93.0%
Week 11	94.0%
Week 12	95.0%

NHS National Flu immunisation program

Updated information from 10th October indicates 25% of frontline staff have been vaccinated to date. The current flu plan also supports delivery of a potential Covid vaccination plan as there is a period of time required between staff receiving a flu vaccine and a covid vaccine (believed to be in the region of 7 days currently although this is subject to further details being made available). It is understood that a vaccine may be available for front line staff from December.

17. EU Transition

The United Kingdom left the EU on December 31st 2019 and is now in a transition period. Negotiations are still ongoing between the UK & the EU to secure a deal before the transition period end on December 31st 2020.

The Trust recognises that if no deal is achieved then there is a risk of disruption. Considerable planning was carried out in 2019 to mitigate these

The trust is preparing with partner organisations to consider the disruption caused by road transport disruption. The introduction of any of the strategic road operations by the Police can result in significant disruption to the M20 and this combined with any of road incident or bad weather can present a significant challenge.

The Procurement Team are monitoring supply chain issues and ensuring that the latest information on risks are highlighted at Winter Planning Group

The Pharmacy Team are monitoring medicines supply and ensuring the latest information on risks are highlighted at the winter planning group.

The trust will book hotel accommodation for the disruption period to mitigate both severe weather and EU Exit disruption for staff. In addition, the considerable working from home investment and culture change has meant that significant members of staff can now continue to work off site.

The Cancer Division has been asked to draw up contingency plans for the services at Kent & Canterbury Hospital due to the close proximity with East Kent and the channel ports.

18. Severe Weather

The trust has considered adverse winter weather as part of its winter planning for many years. The Incident Coordination Centre will ensure both severe weather and flood warning information is cascaded to staff in a timely way to ensure maximum amounts of preparedness.

The Trust has several areas probe to severe flooding – staff living in these areas are well prepared, but the Trust will support them in whatever way it can. The ICC will ensure staff know the extent of flooding, so the Trust does not discharge back to a flooded area.

In the event of severe winter weather resulting in transport disruption the Trust can:

- Use the existing 4WD vehicles the Trust has with Estates staff and deploy one to each main site at the disposal of the Clinical Site Manager
- Use the MOU with Kent 4WD to use local trained volunteers with 4WD to assist in getting critical staff in
- Access the Kent Surrey Sussex Air Ambulance, Children's Air Ambulance and HM Coastguard to transfer patients or emergency supplies
- Utilise hotel accommodation for stranded staff
- Provide hot food and drink for staff at no charge

Estates & Interserve have plans to keep the access roads clear and the helipad deiced.

The ICC will liaise with Kent Highways to ensure gritting & snow ploughing is carried to maintain essential access to sites.

19. Workforce

Vacancy Position by division and profession							
	Cancer & Haematology	Diagnostics & Clinical Support	Surgery	W&C and SH	Medicine & Emergency	Estates & Facilities	TOTAL
Consultants		3	8	2	7		20
Specialty and Associate Specialist Drs					7		7
SHO & Registrar			7.5				7.5
Nursing	33.2		39.85*	18.84	307.5		399.39
Scientific and Technical (Pharmacy)		6.54					6.54
Allied health professionals	3	25.23			1		29.23
Health Care scientists (Scientific Therapy & Tech Staff)	11.4	53.5		1	9.5		75.4
Support to Clinical				17.28		52.59	69.87
Support to STT & HCS Staff	9.48	20.78	1				31.26
Infrastructure Support	0						0
Management	3	1		1	1		6
Admin & Clerical	5.8	8.48	17.27	12.15	1	1.47	46.17
CSW							278.97

Nursing gaps, particularly in Medicine & Emergency Care, is a concern as we approach winter. The opening of escalation wards, the impact of securing Covid-19 safe pathways and obvious challenges with the continued overseas recruitment this year, has exacerbated the vacancy rate.
The senior nursing teams continue to work with the recruitment lead to ascertain current vacancy levels and predict month by month WTE turnover. HRBPs and the senior Workforce team will continue to collaborate with nursing colleagues to ensure that the plan is “live” and responds to changing needs and demands. Staffing is reviewed weekly at the Forward Planning meeting to ensure decision making around staff allocation is planned and responds safely to the demands faced.

20. Out of Hospital Capacity

The Hospital Discharge Policy was published by the Department of Health & Social Care on 21st August 2020. This document provides a new framework for implementation of the Discharge to Assess model that was successfully used at the beginning of the Covid-19 pandemic to clear beds in acute hospitals.
The policy gives a national picture of the numbers of patients discharged on Pathways 0 – 3 and work is being undertaken with partners to confirm if this split is representative of West Kent.

Hospital_Discharge_
Policy.pdf

Discharge to Assess pathway model:
Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home

Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care
For MTW this would be use of TADs, HIT and Hilton (commissioned via KCC)

Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting
For MTW this would be use of community beds managed by KCHFT

Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals
For MTW, commercial care home beds are used across a number of settings to provide ongoing care and assessment. These beds are funded via the CCG but managed by the MTW Discharge Manager.

The importance of ensuring safe yet timely discharges from MTW is recognised as an integral part of the Trust's Winter Plan. The focus will be on the following actions to ensure the principles of the Discharge Policy are fully adopted in all clinical areas:

- All patients on Pathway 0 are the responsibility of MTW. It should be noted that the current model enables the wards to directly refer for Pathway 1. The Integrated Discharge Team (IDT) do not have sufficient capacity to deal with all Pathway 1 referrals and this would also cause a slowing of the process, which would be a deviation from the national guidance

- Board rounds need to take place twice daily with at least one of those having a consultant in attendance

Out of Hospital Capacity (cont.)

- COVID-19 swabs need to be undertaken for all patients being discharged into a care home setting and in addition those receiving packages of care from agencies. Currently this is taking 24 hours however with the new equipment and arrangements coming online in October this should enable us to facilitate same day discharges
- Increased use of the Discharge Lounge facilities is expected in order to release beds earlier in the day. This should be supported with the introduction of the Teletracking system
- For simple discharges there is an expectation that the patient should be discharged from the discharge area in around 2 hours
- The policy describes a new way of follow up with a lead professional or MDT team visiting a patient at home on the day of discharge or the day after to coordinate what support is needed in the home environment. This needs to be further investigated in relation to our Pathway 1 patients to identify if the care provided by Hilton is sufficient to meet this requirement
- The operating model provides standardised letters for patients to describe the discharge process and what they can expect in the way of support and our expectations of them as patients
- Patients should be given the direct number of the discharging ward to call back for advice, i.e. not going to their GP or coming to A&E
- Telephoning discharges the following day to check all is well and offer reassurance and advice, if needed. Arranging dedicated staff to support and manage people on Pathway 0 needs further consideration
- Therapy staff are expected to work across acute and community boundaries in order to facilitate discharge. There is particular emphasis on reducing the amount of assessment that is done within the acute trust and assisting patients within their own homes. It is expected that this is a 7 day service
- Escalation routes will need to be more clearly defined. If there is a lack of capacity within the system in order to facilitate the discharge of patients there will need to be a system wide approach to escalation

Out of Hospital Capacity (cont.)

- Criteria led discharge to become normal practice with documented, clear, clinical criteria for discharge that can be enacted by the appropriate junior doctor, qualified nurse or allied health professional without further consultant review. Arrangements to be in place to contact the consultant directly for clarification about small variances from the documented clinical criteria.

- MTW will need to clarify the role of 'Case managers' in the acute trust (every person will be allocated a case manager as soon as the decision to discharge is made by the consultant). The duties described are a mix of Flow co-ordinator, IDT and P3 Team

The Trust Discharge Manager and Deputy Chief Operating Officer are the Discharge Leads within MTW and are working with partner agencies, in particular, KCHFT, who is the Lead Organisation across Kent & Medway for Discharges.

Super stranded patients (those who have spent 21 nights or longer in an acute bed) are also monitored closely and there are new processes being established with the Medicine & Emergency Care and Planned Care Divisions to review these patients twice weekly, which is overseen by the relevant Chiefs of Service.

Performance on a number of key standards are reviewed weekly by the senior operation team at the Forward Planning meeting.

21. Festive Period Plans (including Easter)

Christmas and New Year and Easter Targeted planning:

- A Trust Plan for Christmas and New Year and the Easter period, which supports the Kent & Medway ICS plan is produced and is circulated accordingly. This Plan contains more detail such as shift patterns, contact details, alternative services to support staff during bank holiday breaks and is well recognised as a valued and helpful document to have available to staff, particularly on call managers and directors.
- The Plans are compiled well ahead of each Bank Holiday and include input from each Division and corporate service in terms of holiday planning, together with shift patterns - which aren't known until nearer the date of the holiday. The Trust also takes into account the week before and week after the bank holidays as evidence shows increased surge patterns at these times.
- Our approach will be to maximise complex and simple discharges and reduce acute bed occupancy in the run up to the Festive period, anticipating the buildup in pressure across the weekends and Bank Holidays. This will include our Integrated Discharge Teams working with community partners to create a stock of community beds in the pre-Festive period as well.

22. Risk Register

Embedded below is the full Risk Register for Winter 2020-21

23. Finance

As part of the Reset & Recovery programme, allocation of revenue has been agreed to support remobilization of services.

This includes £1.88m for Winter and work is underway with operational teams to understand likely cost pressures that will need to be funded from this allocation.

Winter Pressures need to be linked in with the benefits from Teletracking, 7 day services and UTC implementation. Bed Savings will be achieved as per the Teletracking business case from Jan 2021.

Weekly meetings are arranged from December 2020 through to April 2021 for the Head of Financial Management and the Chief Operating Officer and Deputy to review spend against the allocation and put in mitigation, if possible.

Appendix 1: Divisional Winter Action Plans


WC& SH Winter Plan 2021.docx


Medicine Winter Action Plan 2020.doc


Planned Care Winter Action Plan.docx


Escalation winter 2020.21.therapy


BCP Phlebotomy Team expansion


Cancer Services division Winter


Diagnostics and Clinical Support

Appendix 2: Phase 3 Letter

Phase-3-letter-July-31-2020 (2).pdf

Review of nurse staffing for Ward and non-Ward areas (mid-year update) **Chief Nurse**

The enclosed report provides the Trust Board with a Mid-Year update on work undertaken and ongoing to ensure Safe Staffing is in place for our Nursing and Midwifery workforce.

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

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

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

Introduction:

The purpose of this report is to provide the Trust Board with a Mid-Year update on work undertaken and ongoing to ensure Safe Staffing is in place for our Nursing and Midwifery workforce.

The paper follows the comprehensive review of the staffing establishments that was undertaken in non-ward areas, ward areas and specialities across the organisation during September 2019 – January 2020. The Trust Board considered the outcome of this review in March 2020; the report identified some Key recommendations which will be referred to this in paper.

It is critical that the Trust has the right level of staff in place to support the on-going ability of the nursing and midwifery workforce to deliver high quality care. The following report provides an update on the response and continuous work to implement the recommendations from the last safe staffing review and progress on implementing the recommendations of the 'Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).

Context:

The requirement for Trust to conduct Safe staffing reviews are set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016). A further document 'Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing' was published in October 2018, this document includes recommendations on workforce safeguards to strengthen the commitment to the provision of safe, high quality care in the current climate. NQB's guidance states that providers:

- must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- must use an approach that reflects current legislation and guidance where it is available.

This process is formally embedded into safe staffing reviews ensuring the following three components are engrained within the process:

- The use of evidence based tools (where they exist)
- Professional Judgement
- Outcomes

The safe staffing reviews are completed annually and is supported by this mid-year review to have considerations of

- Patient acuity and dependency using an evidence-based tool
- Activity levels
- Seasonal variation
- Service developments
- Contract commissioning
- Service changes
- Staff supply and experience issues

- Where temporary staff have been required above the set planned establishment
- Patient and staff outcome measures

The Professional Judgement (Telford) model, (endorsed by the National Audit Commission and the RCN) is embedded in our safe staffing reviews;

For inpatient wards the Carter Model is applied to include consideration of Care hours Per Patient.

There is an expectation that the reviews should include a 'bottom-up' approach that is informed by the Ward / Unit / Speciality team led by the Ward Sister / Unit manager , and 'top-down'; informed by the Chief Nurse, Divisional Directors of Nursing and Quality and Head of Midwifery.

The review meetings in MTW included the following key members of staff the Ward / Unit Manager, Matron, Finance Manager, Divisional Director of Nursing and Quality and the Deputy Chief Nurse. In the reviews a range of data is reviewed including a triangulation of ward quality indicators (pressure injury, falls, nursing care complaints and FFT results), performance and incidence and information on the workforce including skill mix. The template for review and discussion can be found in appendix 1.

Outline of the key recommendation summary following the annual safe staffing reviews (set out in the March 2020 report to Trust Board)

- New roles and apprentices to be considered across all areas to include the Trainee Nursing Associate (TNA) and integrating the Nursing Associate (NA) role in further workforce planning. Backfill of CSW workforce to areas supporting apprenticeships, new roles and new learners
- Integrate TNA and NA roles into the nursing workforce structure across the organisation and ensure finance and Healthroster are aligned to incorporate a new nursing line within the workforce structure.
- The ongoing roll out of continuity of care model for maternity will require a significant uplift of midwifery posts within maternity in order to achieve the 20% compliance target. Nationally there is a requirement for us to achieve 35% in the forthcoming year.
- Business cases to increase clinical activity MUST include nursing establishment reviews.
- Any change to service redesign or development of new pathways of care must include a Safe staffing review of the nursing workforce to deliver safe, effective and high quality care and in line with workforce recommendations
- The 2020 / 21 safe staffing forward work plan will focus on the continued move towards compliance with the recommendations set out the NHSi Developing workforce safeguards to include;
    - Consideration to new roles and integrating these into workforce plans,
    - Implementation of Safe Care through Healthroster which will provide evidence based method of acuity measurement through collecting patient numbers, acuity and dependency data that is real time and can be used for the optimum deployment of substantive staff.
    - Further collaborative working with other healthcare professionals to ensure a multi professional approach to safe staffing

Current Position:

MTW pre covid Position / ongoing monitoring: Staffing levels are closely monitored daily in real time, at site meetings and through weekly staffing huddle conference calls, weekly bank and agency usage monitoring and weekly recruitment activity progress. A monthly report and publication return to NHSI / E indicating 'planned' and 'actual' nurse staffing by ward is submitted with the inclusion of Trainee Nursing Associates and Nursing Associates. The safe staffing paper is published monthly at Trust Board and shared with Divisional Nursing and Midwifery Leads.

COVID19 response: Staffing levels are continued to be closely monitored daily in real time and at site meetings. Healthroster management remains in place and decisions on staffing requirements are made locally with the support of the ward manager and matron according to the acuity and dependency requirements of the ward / unit to ensure that we maintain safe staffing levels. More recently this has included consideration of any specific ward closures and support of specific pathways to ensure prevention of transmission of COVID, managing and supporting redeployed staff, managing any sickness in teams including support for any requirements to self-isolate. The requirement to report to NHS I/ E on a monthly basis was stood down during COVID however, MTW continued to complete this data in real time and ongoing monthly reporting to trust Board was maintained.

Reset and Recovery Position: Staffing levels continue to be closely monitored daily in real time and at site meetings. Monthly reporting to NHS I / E was re-established including the requirement to back date data for COVID period of which MTW were compliant with. A weekly recruitment update call is in place which is chaired by the Chief Nurse with representation from our recruitment team, operational divisional leads and corporate services including the Professional Standards team. Monthly staffing meeting established to monitor:

- E-Roster Reports/Compliance
- Bank and Agency Usage
- High Cost Agency
- Upcoming Staffing Issues
- Evaluate Roster Roles
- Planning for Safe Care Module implementation plan.

Progress to date:

During 2019 – 2020 we have continued to focus on workforce to ensure that we maintain safe staffing and drive forward the changes required to sustain our workforce in the future. Key focus areas to support this have included:

- A high priority and extensive work stream which had a key focus on nurse recruitment to reduce the previously significant gaps in vacancies and a reliance on temporary workforce. Through this key work stream, MTW saw the successful recruitment of 221 overseas nurses, regional collaborative working to agree agency costs and weekly monitoring of agency requirements and staffing huddles.
- MTW also worked to pilot a successful OSCE ready programme, which will support overseas recruitment moving into the next financial year. Following the success of this pilot a formal tender process for contracting has been undertaken and we anticipate that

this process will shortly be finalised therefore securing the recruitment of OSCE ready nurses to the Trust.

- Established operational working groups to ensure effective staff deployment and workforce planning for Maidstone and Tunbridge Wells NHS Trust. We have agreed that when there is any service redesign that considers the introduction of new roles and ways of working, we will require the completion of a quality impact assessment to ensure that any impact on the provision of safe staffing is clearly understood. Services continue to need to consider the integration of new roles and apprenticeships as we begin to map out what a future nursing workforce looks like with the inclusion of roles including the Trainee Nursing Associates, Nursing Associates, CSW apprenticeships and potential apprenticeships in development.
- The following information provides progress to date reports for Trainee Clinical support workers, Trainee Nursing Associates / Nursing Associates and Advanced Clinical Practice.
    - **Trainee Clinical Support Workers (TCSW) current position:**

      MTW began its TCSW programme of employment in March 2018 with employment opportunities across multiple specialities including the general wards, ICU, Theatres, Maternity, A&E, UIU, Admissions Unit and Pre Assessment Unit with more areas embracing these new roles. The length of the TCSW apprenticeship has been reviewed to ensure adequate time for completing the End Point Assessment and now offers a substantive contract on completion of training.

Total TCSW's Employed by MTW to date	TCSW currently on apprenticeship programme	Completed apprenticeship programme	Applied / undertaking TNA apprenticeship	Attrition rate
85	45	23	7	17

    - **Trainee Nursing Associates / Nursing Associate (TNA / NA)**

      The West Kent Consortium Nursing Associate Consortium was formally established on October 2017 and is now well into its successful 3rd year. The Consortium is made up of the following organisations:
      Maidstone and Tunbridge Wells NHS Trust (MTW NHS)
      Kent and Medway Social Care Partnership (KMPT)
      Kent Community Health Foundation Trust (KMPT)
      Heart of Kent Hospice
      Hospice in the Weald
      Kent County Council
      Skills for Care
      Health Education, Kent, Surrey & Sussex (HEKSS) (now Kent & Medway STP)
      Kent Education Network

      Maidstone and Tunbridge Wells NHS Trust continue as the lead organisation with priorities to include; developing and managing the project plan, risks and issues log, Leading the recruitment process for trainees, Chairing and

administration of the Steering Group, Acting as the key link in Health Education England (HEE) monitoring, support, governance and communications and managing the budget for HEE funding arrangements.

The Consortium is now supporting its 3rd cohort of trainee Nursing Associates who commenced in September 2020. The Consortiums' first cohort of trainee nursing associates is due to complete their training and register as nursing Associates by February 2021.

The consortium are currently supporting the following trainees:

Cohort	Total No. TNA's	MTW TNA's
December 2018	19	12
September 2019	19	8
September 2020	24	12

- **Advanced Clinical Practice (ACP)**
  The Trust continues to further its work on Advanced Clinical Practice following publication of the competency framework. The governance for ACP is now in place through the Advanced Practice Assurance Group (APAG). A launch and initial scoping project was completed to map the Nursing workforce against the competencies. This work is a key enabler for MTW to move towards a standardised position and definition of titles and competencies for ACP that will influence the development and deployment of new advanced roles that will enhance our patient pathways but also support us in meeting the wider workforce needs. A summary of key findings and recommendations can be found in Appendix 2.

  Following completion of the in house survey the Trust actively participated in a survey conducted by Health Education England, in partnership with NHS I/E about advanced clinical practice role to help develop and improve policies relating to advanced clinical practice – outcomes from this survey are currently awaited.

  During COVID the ACP working group temporarily paused to support organisational priorities but are now working to restart activity. The ACP working group are ready to finalise the refined survey to scope ALL registered health care professionals practising beyond their level of initial registration. A job description is currently being agreed to consider an ACP (project) Lead who will work in partnership with clinical, medical and nursing managers to lead the completion of the Trusts ACP scoping project across all registered health care professionals and lead the development of the Trusts workforce strategy for Advanced Clinical Practitioners to MTW.

- **Maternity;** The Birthrate Plus framework for workforce planning and strategic decision-making which has been in variable use in UK maternity units for a significant number of years was used to review, benchmark and make recommendations for Maternity services within Maidstone and Tunbridge Wells previously in November 2018. This framework is based upon an understanding of the total midwifery time

required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the RCM and RCOG. The safe staffing reviews for Maternity across the Trust for 2020 will be subject to the outcome of this year's 2020 Birthrate Plus framework review.
The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. In addition, the Trust continues to work towards compliance of the continuity of carer model. The national expectation is to achieve 35% compliance by March 2021 which has been reset in recognition of COVID and its impact (pre COVID this was set at 51%).

At the time of reporting MTW is meeting 10% through the Crowborough Birth Centre. Plans are proposed to launch continuity of carer through a teenage group in January 2021 at 5%, a 3% homebirth rate in community and an integrated diabetes team to stretch compliance beyond 20%.

- **Development of Staffing Assessment and Escalation Protocol for Nursing Teams at MTW;** During 2019 / 2020 extensive work was undertaken to further embed a consistent and sustainable approach to safe staffing across the organisation. As part of this ongoing work the process by which Maidstone and Tunbridge Wells NHS Trust acknowledges its responsibility under statutory legislation to ensure a safe environment for patients, staff and visitors to the Trust as far as it is reasonably practicable was set out in a protocol to provide definition and guidance regarding assessment and actions that are required by various staff to ensure that departments, localities and teams are staffed safely to meet all of the patients care and safety needs. The SOP is aimed at nursing teams, managers and all clinical staff that work within the trust (substantive and temporary) and sets out the following to:
  - identify a methodology for identifying a team has enough staff to provide the care required by patients
  - clarify staff roles and responsibilities when responding to perceived staff shortages
  - maintain optimum staffing and ensure patient safety is not compromised
  - ensure that all staff have an understanding of their roles and responsibilities in regard to safe staffing levels.
  - Ensure that there is escalation of staffing levels that are considered to be unsafe

  The full version of the draft SOP can be seen in Appendix 3 and 3(a) of this report.

- **NHS E/I small scale review of the Developing Workforce Safeguards (Oct 2018);** Maidstone and Tunbridge Wells NHS Trust proactively engaged in a review and table top exercise commissioned by the Chief Nursing Officer to understand the extent to which NHS providers had implemented the recommendations contained within the publication and to identify if there are any key themes arising from the review which require further action at a national level. The review covered Nursing/

Midwifery, AHP and medical staffing groups. MTW was one of 11 Trusts Nationally that participated

A desk top review of the required information provided by MTW was undertaken prior to the NHS I / E site visit using the majority of the KLOEs within the "safer staffing insights pack" previously developed by the NHSE/I nursing directorate workforce team and used for Safe Staffing deep dive reviews. This includes KLOE against the Quality, workforce and Financial domains. It is important to note that this was not a full deep dive process into MTW or any other of the 11 Trusts who participated. MTW welcomed the HON: Nursing Led Clinical Improvement Programme who had coordinated the development of the DWS document in 2018 in March 2020 to complete the table top review for MTW. This visit and review had some focus on a strategic and operational approach to safe staffing, the "Board to ward" approach within each Trust and how effective this was in practice.

A summary report has been shared with all 11 Trusts which participated so whilst it is not possible to extrapolate the specific findings for MTW, the report recognised the significant programmes of work underway to achieve compliance within provider settings and identified key actions for the National team to take forward to support and strengthen these work programmes including;

- the development of integrated services with multi-professional teams across settings, describing how DWS can be applied to such services.
- further update of the document to strengthen and support the work.
- a clear statement from NHSE/I circulated to relevant providers indicating what the implications on non-compliance would mean for the individual providers.
- Work being led by the NHSE/I medical directorate to address the development of evidence based tools for AHP staff and also an approach to the development of outcome measures.

Next Steps / Key Priorities:

- **COVID**: Due to new requirements to deliver care adhering to COVID pathways; to maintain the safety and wellbeing of patients and staff, the Divisions have undertaken significant and ongoing work to review and map new pathways and staffing requirements. To support a range of new pathways across specialities alongside the requirements to increase capacity in speciality areas such as ITU has a substantial impact on current staffing levels. The requirements for additional staffing establishment across the organisation will necessitate a substantial uplift in the current nursing establishments. A business case to meet this new recruitment need is in progress and will have a phased approach in recruiting to these vacancies with a variety of options to support recruitment on a large scale including; MTW ongoing recruitment as business as usual and in line with predicted turnover, overseas recruitment, OSCE ready nurse recruitment, return to practice opportunities, supporting MTW CSW's with previous RN registration to RTP / complete OSCE training and continuing to offer employment to qualifying Student Nurses and Midwives on completing required competencies.

- **Annual Safe Staffing Reviews;** these are now underway and continue to embed the multi professional approach and adhere to the key methodology as set out in the context of this report through; Professional Judgement, the NQB and NHSi Developing Workforce Standards and utilising the revised template (Appendix 1) which incorporates consideration of COVID, the impact on safe staffing in managing new pathways / processes and further inclusion of AHPs, new roles and volunteers. The annual safe staffing reviews are now planned to compliment business planning and to ensure any key recommendations can be aligned and incorporated into divisional business plans.

- **Nursing Structure:** MTW's first cohort of TNA's are now in their final months of their trainee apprenticeship and on successful completion of this training, will be able to register with the NMC as a Nursing Associate with effect from February 2021. These roles are now being mapped into the nursing workforce structure and will continue to be formally introduced and embedded into nursing establishments. The Professional Standards Team is supporting areas to clearly define the role of the Nursing Associate on registering and the value of this new role in the nursing family.

- **External reporting and compliance:** Our currently monthly report and publication returns to NHSI / E indicating 'planned' and 'actual' staffing rates includes nursing staff by ward with the inclusion of Trainee Nursing Associates and Nursing Associates. The Developing Workforce Compliance guidance requires a multi professional approach to ensure we are considering care delivery as a "whole" service. Part of this will include how we are able to capture the contribution of Allied Health Care Professionals in the total delivery of care including understanding a planned v actual roster for fill rates and the CHPPD this would equate to. Work has now commenced with AHP leads, Healthroster partners, Business intelligence and Corporate Nursing to progress this.

- **Safe Care**: MTW currently uses Allocate to facilitate e-rostering across the organisation. The Safe Care functionality within e-rostering is available to us at MTW and is a widely used resource for other providers and agencies. It offers support in the effective management of safe staffing through the ability to align staffing levels to patient demand whilst avoiding over and under staffing offering:
    - Visibility of staffing levels across the organisation as a whole
    - Supports decision making for redeploying staff in line with patient need and with full visibility of wider impact
    - Records patient acuity and dependency levels of care calculated to CHPPD
    - Reporting of key staff metrics and Safer Staffing for NHSI
    - View live staffing status by hours short/excess, missing skills, missing charge cover, skill mix and unfilled duties.
    - See all staff rostered on a shift, including skills and attendance status.

  Implementation of the safe care module to realise these key benefits and to support effective safe staffing across the organisation is a key priority. Key stakeholders have been involved in initial meetings to have oversight of the programme functionality and demonstration of this and it has been formally agreed to proceed with the

implementation of Safe Care. The project plan has been shared, project and clinical leads confirmed with an imminent start date for project launch October 2020.

- **Nursing Structure:** The nursing structure for clinical environments has long been established through core nursing roles of Registered Nurses and Non registered clinical support roles. As health care continues to evolve and the way we deliver care changes services too need to consider the integration of new roles and apprenticeships as we begin to map out what a future nursing workforce looks like but also to consider the service as a whole and all the roles that deliver care within this. A small working group has formed to begin a review and mapping exercise as to what a potential “new model” of workforce structure could look like. The initial work will focus on the respiratory speciality on John Day Ward to scope out current requirements and explore feasibility for new ways of establishing a ward environment.

- **Registered Nurse Degree Apprenticeships (RNDA):** Until recently, the primary route into nursing has been the university degree education to train as a Registered Nurse (RN). However, the development of the Nursing Associate role and other initiatives are providing employers with alternative opportunities. There is now the introduction of the Registered Nurse Degree Apprentice which will attract potential RNs who want to ‘earn as they learn’, benefiting those for whom a full-time university course is not practical or preferred. Offering this route into nursing will further support MTWs workforce and propose an attractive recruitment and retention offer. The RNDA is at its infancy with University providers currently seeking NMC approval for programmes of study and a wide tendering process. MTW have committed to an expression of interest to support the role out of the RNDA in a limited pilot initially but to offer an alternative route to become a graduate registered nurse that doesn't require full-time study at university.

Summary:

- This mid-year safe staffing review has provided an oversight of Maidstone and Tunbridge Wells current position highlighting the key successes in the work progress to date, the challenges for this reporting period during COVID but also the extensive programme of work which is being undertaken in achieving compliance or partial compliance where work is still in progress, in addressing the Key recommendations from the annual safe staffing review presented to Trust Board in March 2020.
- Key priorities and next steps are clearly set out to continue efforts and achieve full compliance to embed the recommendations of the Developing Workforce Safeguards.
- Guiding Principles for ward establishments remains:
  RN:CSW = 65/35, RN:PT 1:5 – 1:8
  Supervisory time for ward managers - 4 days per week for larger wards and 3 days for smaller wards
  Ward Clerk – not included in nursing numbers
  Headroom allowance 21% (to cover mandatory training, annual leave and sickness)

Care Hours Per Patient Day:

	Dec 2019	**July 2020**
National Median:	8.0	10.5
Peer Mean:	8.2	11.3
MTW:	**8.8** (Above Average)	**11.5** (Above Average)

The Care Hours Per Patient Day in the most recent reporting period is reported at 11.5 and is in quartile 4 - Highest 25%. This increase is directly correlated to staffing levels and the lower bed occupancy following the first wave of COVID and is not reflective of the planned v actual establishments.

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SAFE STAFFING REVIEWS SEPTEMBER 2020

Data period to cover last 6 months

Date:

Site:

Ward:

Review team:

	Detail
WTE Establishment: **WTE Vacancies**	
Budget **YTD** **Variance**	
Beds/Rooms:	
Shift Profile: **Early:** **Late:** **Night:**	

Ratios: **RN/CSW split** **RN/Pt:** **Current Staffing:** **CSW** **Apprentices (TCSW / TNA / RNDA / other)** **Trainee Nurse Associates** **Nursing Associates**	**Planned v Actual**
E-Roster KPIs over last 6 months to include: **Sickness/Annual leave profile** **Staff turnover**	
Safe Staffing Acuity & Dependency (AUKUH) requirements:	
COVID Pathways in Ward / Dept: **Super Green / Green / Amber / Red**	
Activity/Turnover of patients (admits/discharges/escorts average per day – should be included in Acuity & Dependency)	
Quality and Safety Dashboard: **Last 6 months**	
Number of : SI's **Number of : MSSA Bacteraemia** **Number of : E.coli** **Number of : C - Diff**	
Pressure Ulcers:	
Falls:	
Nursing Care Complaints:	

FFT: Percentage response rate and positive responses	
AHP / Therapy contribution to ward: Consider % of patients in Ward / Dept that require therapy inputs **Response / access times of therapy:**	
New Roles: **e.g ACP / Therapy Assistant**	
Volunteer Roles currently in Ward / Dept: **Possible Role for Volunteer in Ward / Dept:**	

Discussion:

Conclusion/recommendation:

Name of project: **Advanced Clinical Practice Scoping Project**

Project lead: Gemma Craig (Deputy Chief Nurse) **Programme Officers: Vickie Gadd & Diane Barton**

MTW NHS Trust

What were our aims?

1.Survey AfC Bands 6-8 **nursing** workforce with a permanent contract of employment at MTW NHS Trust, mapping against the HEE Multi-Professional Framework for Advanced Clinical Practice (2017)

2.Identify numerous specialist job titles

3.Identify academic qualifications

4.Formulate a working methodology that can be utilised to map all AHP's within the Trust

Why is this important to service users and carers?

This project is essential to both our service users and staff. By implementing the recommendations within the national Advanced Clinical Practice Framework, MTW NHS Trust has the ability to build an expert workforce of senior nurses and AHP's that are able to deliver MTW's strategic ambition to deliver safe, expert, effective, quality care in the right place and at the right time for our service users. This project contributes to the 5 work streams of the Best Care Programme - Best Workforce

There are currently 40,000 nursing vacancies across England and 32.3% nursing vacancy rate within MTW. Offering a structured career pathway to progress to advanced clinical practice level may contribute to successful recruitment and retention strategies

Our recommendations and tests of change

Using the PSDA cycle throughout this and future improvement projects will allow Project Officers to implement a staged approach to change, monitoring its effect on service delivery before embedding within the workforce structure. To maintain momentum, the following is required;

- Secure appropriate funding and resources to continue this essential project work
- Review survey questionnaire and it's transferability across all AHP disciplines
- Trust wide workforce mapping to identify where ACP roles can be integrated within Directorate teams
- Review the numerous job titles currently in existence, map against AfC Banding criterion and NHS Careers Framework, agree standardised job titles matched against job description
- Develop ACP Policy, Core Capabilities and Specialist Clinical Competency skill sets

The tools we used (Driver diagram, Fishbone etc)

Approved QSIR tools were utilised to engage key stakeholders, perform data analysis and present the final results;

- Brainstorming - APAG Group members identified the survey aims and contributed to development of the questionnaire. A questionnaire that had been successfully utilised in other major teaching hospitals, that had introduced ACP roles, was adapted to meet the project aims. The final set of questions were agreed and piloted prior to the survey launch, which yielded good quality data
- Data collection tools -Survey Monkey was utilised for ease of participants completion - one click link and save function. Results were easily quantifiable and allowed stratification into sub categories of specific themes within the ACP framework
- Excel Spreadsheets - quantitative data was transferred to Microsoft Excel Spreadsheets allowing complex filters to be applied
- Independent content analysis - qualitative data was subjected to content analysis and subsequent axial coding using a validated analysis tool (Scribante et al)

Results / How did we do / Anticipated Outcome

- Overall Response Rate 35% (236/680), Band 6 = 19%, Band 7 = 49%, Band 8 = 60%. This response rate was anticipated prior to the survey, advanced practice may be considered more relevant to senior health professionals. There was a good spread of responses from each of the clinical divisions
- 150 different job titles identified - these were categorised into 17 distinct job titles according to job role
- 20% do not have a Maths qualification and 12% do not have an English qualification at GCSE Grade C or above - essential to enrol within an Apprenticeship Programme for ACP training. 13 have completed an MSc in ACP/Advanced Practice, 11 have completed a PG Dip and 10 have completed a PG Cert
- 6 Registered Nurses have completed the required core theoretical modules and could apply for an ACP position. 59 have completed 2-3 core modules, and could continue their educational pathway at Masters Degree Level and become eligible for trainee ACP roles. 95% of respondents aged between 31-50 were interested in undertaking training towards ACP qualification
- At the start of the questionnaire, 52% considered they were working at advanced practice level. At the end of the questionnaire, 35% considered they were working at advanced practice level and 42% partially. There was some misunderstanding of the ACP role and it's required capabilities
- Details of the methodology used for this project are recorded on the Trust intranet drives. Access can be granted to future Project Officers to continue this work
- The survey results may be subjective and results biased towards respondents who are keen to advance their practice to this new level of expertise

What we learned and what's next

This 18 week project afforded the opportunity to network with national forums, share information and documentation and begin the process for change within MTW;

- Project Officers were able to clearly define the short, medium and long term aims in introducing ACP roles within the Trust
- The questionnaire was piloted and revised before launch, which yielded the required information to meet the project aims
- There was initial staff disengagement which was overcome by discussions at staff forums and face to face dialogue. There is a great interest from senior practitioners in moving the ACP agenda forward and introduce these roles within MTW Trust
- Robust Clinical Governance strategies need to be developed to protect staff and service users from litigation and reduce clinical risk
- Engagement with with HR & IT departments is essential to assist with survey participant recruitment and data analysis
- Short, mid-term and long term recommendations have been defined. It is hoped these will be carried forward enabling service users to realise the benefits of this new level of practice

Safe Staffing Assessment and Escalation Protocol for Nursing Teams at MTW

Summary

Maidstone and Tunbridge Wells NHS Trust acknowledges its responsibility under statutory legislation to ensure a safe environment for patients, staff and visitors to the Trust as far as it is reasonably practicable. This Protocol relates to nursing services within Maidstone and Tunbridge Wells NHS Trust. It will provide guidance regarding assessment and actions that will need to be taken by various staff to ensure that the localities and teams are staffed safely to meet all of the patients care and safety needs.

Scope and Purpose of SOP

The purpose of this SOP is to describe the daily assessment of staffing levels for nursing teams and to describe the process for obtaining temporary staff to try to ensure safe staffing levels.

The development of this SOP is to act as a guide for managers and staff to ensure safe staffing levels should staffing levels cause concern. It outlines measures the team and local manager can take, and then describes the stepped escalation procedure.

The SOP is aimed at nursing teams, managers and all clinical staff that work within the trust (substantive and temporary).

The SOP will

- identify a methodology for identifying a team has enough staff to provide the care required by patients
- clarify staff roles and responsibilities when responding to perceived staff shortages
- maintain optimum staffing and ensure patient safety is not compromised
- ensure that all staff have an understanding of their roles and responsibilities in regard to safe staffing levels

Risks Addressed

This SOP covers the risk that may present due to an increase in demand due to a change in the acuity and dependency of patients ,an increased demand on the service due to external pressures or when staffing levels fall below the substantive quota of staff planned for a shift due to the following:

- Staff sickness
- Staff vacancies
- Staff covering for other teams who may be short staffed

Introduction

This SOP outlines the procedure to be followed should staffing levels cause concern. It describes:

- the assessment of staffing levels within the trust acute nursing teams
- the process for obtaining temporary staff to ensure safe staffing levels
- the process for escalation

The SOP provides guidance to managers and nursing staff in order to maintain safe staffing levels as activity and/or patient dependency increases, or if there are short-term shortfalls in staffing levels. Each nursing team within the trust has an agreed staffing

level and skill mix. The skill mix and numbers are based on establishments agreed with the Chief Nurse, Chief Operating Officer, Divisional Director of Nursing and Quality, Matron and Ward/Department managers for each ward/department. This represents optimum staffing levels and should not be exceeded, or less than planned, except in exceptional circumstances.

The SOP will:

- clarify staff roles and responsibilities when responding to perceived staff shortages
- maintain optimum staffing and prevent a level whereby minimum staffing levels are breached and thus patient safety is compromised,
- ensure that a safe environment is maintained at all times
- ensure that all staff have an understanding of their roles and responsibilities in regard to safe staffing levels
- benefit patients who may have additional care needs because they are older, have a disability, or have specific beliefs as staff will have adequate time to provide individualised care

Roles and Responsibilities

The Chief Nurse

The Chief Nurse is the Executive Director responsible for the development of this SOP

The Chief Nurse and Medical Director

The Chief Nurse and Medical Director are responsible for the signing of the agreed safe staffing levels for the trust.

The Chief Operating Officer and Chief Nurse

The Chief Operating Officer and Chief Nurse are the Executive Directors responsible for implementation of this SOP.

Divisional Directors of Nursing and Quality (DDNQ's) and Divisional Director of Operations (DDO)

DDNQ's and DDO's are responsible for

- ensuring that, within their areas of responsibility, staff are aware of the SOP and that they have read and understood the SOP and its requirements
- ensuring that the duty rosters are robust and are completed within a timely manner
- checking that when a team requests extra staff that the process for escalation and patient assessments have been undertaken
- the approval of bookings for extra staff should the team encounter a decrease in staff, or an increase in workload or patient dependency and acuity.

Matrons/Charge Nurses/Team Leaders/Ward sisters

Matrons/Charge Nurses/Team Leaders are responsible for

- ensuring that all staff within their team are aware of the SOP and that they comply with the requirements
- Completion of the duty roster via the e-rostering system. The rota should be completed six weeks in advance

- adherence to e-roster guidance regarding annual leave

Assessment of staff

The process for reporting safe staffing relates to an assessment by the Ward/Department Manager assessing the number of staff on duty that day and their ability to provide clinical care for the patients within their ward/department. It should take into account the context of the patient s present and the Ward/departments professional opinion regarding whether the staffing levels are safe. There are circumstances when staffing can be less than planned and still be safe, for example if the ward has less patients than its allocated number i.e. empty beds.

The assessment relies on the safe staffing levels as agreed by the staff staffing reviews (performed annually). These reviews look at and agree how many patients each band of staff is expected to care for each day. This allows for an overall establishment to be agreed and budgeted for which takes into account annual leave, sick leave, maternity leave and study leave.

Staffing numbers assessed as being safely staffed taking into consideration workload patient acuity and dependency

When a concern arises- Concern

If staffing numbers are not adequate OR staffing numbers are as expected but due to patient acuity and dependency, and/or increased demand, Additional staff are required and situation can be resolved by one or more of the following actions:

- Staff Bank can supply additional staff
- Staff can be moved from another ward/department within the division
- Staff from other divisions can be moved at the discretion of the matron, if safe to do so
- Staff can be taken off a study/training day
- Bank can provide agency cover (with authorisation)
- Auxiliary volunteers who have be appropriately trained can be deployed.

If the service remains unsafe- Unsafe

If staffing levels cannot be increased and staffing levels remain inadequate with current needs, the following actions will be required.

Action:

If staffing levels cannot be increased and staffing levels remain inadequate with current need

- Ward/department in hours escalate to the directorate matron, out of hours to the site manager.
- DDNQ informed who escalate to the Chief nurse and Chief Operating Officer
- Report on Datix
- All staff who have clinical skills are deployed to support wards/department i.e. Clinical Nurse Specialists.
- The Chief Operating Officer and Chief Nurse will review activity and decide on the next steps which may be:
    - *Implementation of the business continuity plan with escalation to commissioners?*

If Out of Hours- Senior Manager on call (Tactical) to escalate to the Strategic on call as required.

Escalation Flow Chart

SAFE

Staffing numbers are assessed as being safely staffed taking into consideration workload patient acuity and dependency

Action : None

↓

CONCERN

Staffing numbers are not adequate OR staffing numbers are as expected but due to patient acuity and dependency and increased demand, additional staff are required and situation can be resolved by one or more of the following actions:

- **Staff Bank can supply additional staff**
- **Staff can be moved from another ward/department within the division**
- **Staff from other divisions can be moved at the discretion of the matron, if safe to do so**
- **Staff can be taken off a study/training day**
- **Bank can provide agency cover (with authorisation)**
- **Auxiliary volunteers who have been appropriately trained can be deployed.**

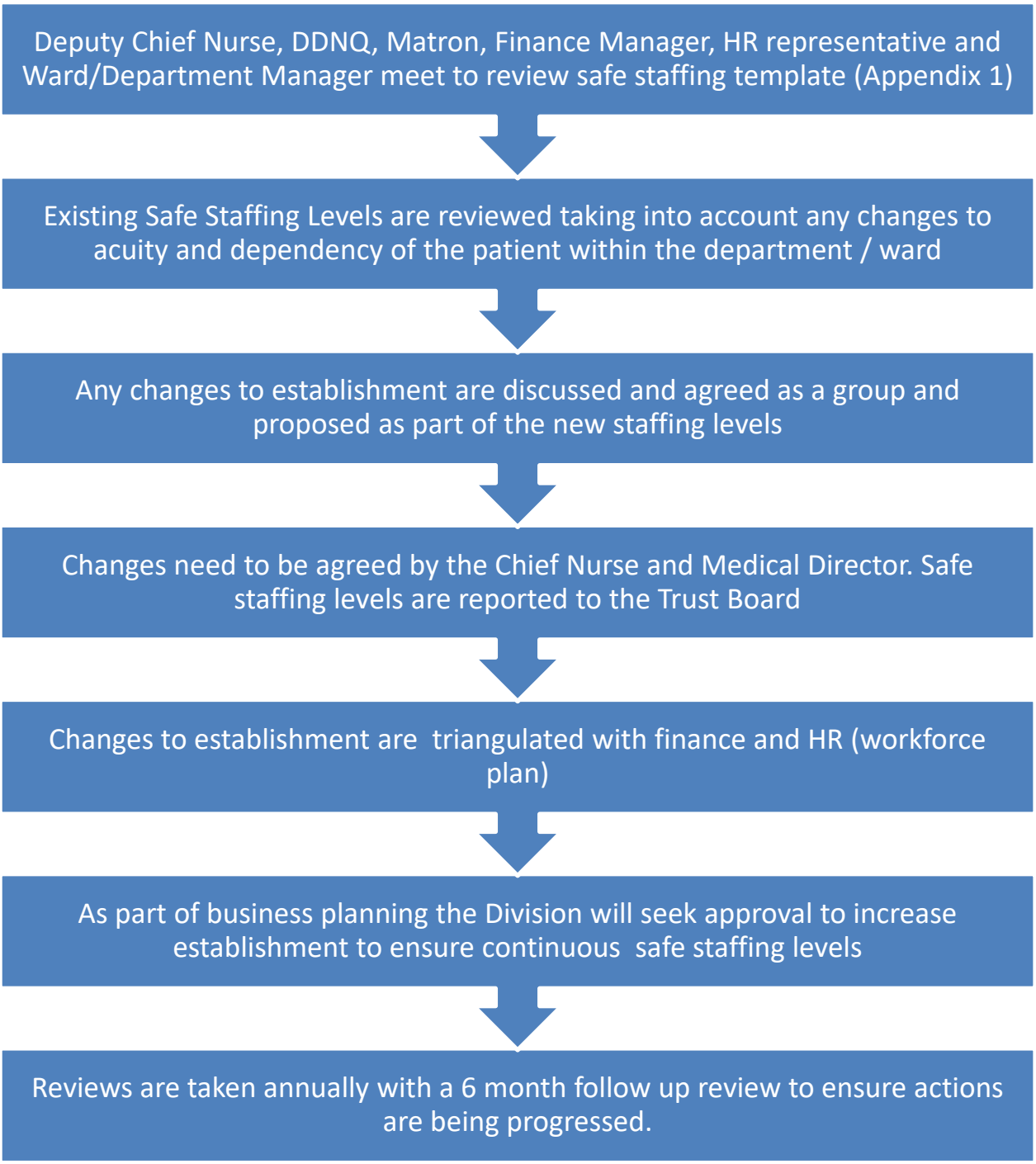
↓

UNSAFE

If staffing levels cannot be increased and staffing levels remain inadequate with current needs

- Ward/department in hours escalate to the directorate matron, out of hours to the site manager.
- DDNQ informed who escalate to the Chief nurse and Chief Operating Officer
- All staff who have clinical skills are deployed to support wards/department i.e. Clinical Nurse Specialists.
- Report on Datix
- The Chief Operating Officer and Chief Nurse will review activity and decide on the next steps which may be:
    - Implementation of the business continuity plan with escalation to commissioners?

Process for safe staffing Reviews within Maidstone and Tunbridge Wells NHS Trust



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The Kent and Medway Integrated Care System (ICS) status application	Accountable Officer, NHS Kent and Medway Clinical Commissioning Group

Please find enclosed "The Kent and Medway Integrated Care System (ICS) status application" report.

The following supplementary documents are available on Admincontrol (Trust Board/Documents/Trust Board (Part 1)/2020/10.22.10.20/ The Kent and Medway Integrated Care System (ICS) status application supplementary reports), however the supplementary documents do not form part of the main meeting pack and therefore Trust board members are not required to review these:

1) Integrated Care Partnership narratives
2) Kent and Medway Integrated Care System accreditation submission to NHS England and NHS Improvement
3) Appendices to the Kent and Medway Integrated Care System accreditation submission to NHS England and NHS Improvement

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

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

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

Purpose

The Board is asked **to NOTE** Kent and Medway's submission to be accredited as an Integrated Care System. The submission is being shared with Boards for **INFORMATION** only.

Context

- The 'Kent & Medway ICS accreditation submission' has been prepared for NHS England and NHS Improvement (NHSE/I). Currently, the Kent and Medway system is a Sustainability and Transformation Partnership (STP). ICSs are more advanced forms of STPs, with greater responsibilities for working as a system and for holding regionally delegated authorities/autonomies (as agreed with NHSE/I) that further facilitate the integration of care.
- The NHS Long Term Plan, published in January 2019, set out the intention that all systems across England would become Integrated Care Systems by April 2021. The onset of the COVID-19 pandemic delayed the submission of K&M's application to be accredited as an ICS, and it was jointly agreed between the STP Partnership Board and NHSE/I that a submission would be made in the autumn of 2020.
- As this document has been prepared for NHSE/I it is technical in nature. At the point of being accredited as an Integrated Care System, we will publish an accessible and meaningful summary of what being an ICS will mean in K&M and the benefits for our population.
- This document has been developed to demonstrate evidence of our readiness for accreditation against the NHSE/I minimum operating requirements and ICS Maturity Matrix. It is therefore necessarily comprehensive.
- The document also provides helpful context about the system's achievements to date, direction of travel as a system, and on-going development activities. The document was endorsed by the STP/ICS Partnership Board at the meeting on 18th September.
- In evidencing our readiness to be accredited as an integrated care system, the main submission contains the building blocks of a strategy and plan. However, it is important to note that this submission is not our refreshed strategy or full plan. In our response to the Long Term Plan in autumn 2019, we committed to a strategy refresh process planned to commence in spring 2020. Due to the COVID-19 pandemic, the timeframe has been amended to Q3/Q4 of this year.

How our ICS accreditation has been developed

- The submission is a reflection and summation of the work to date of the Kent and Medway STP. In setting out our readiness to be accredited as an Integrated Care System, we have needed to describe the achievements and progress to date of the STP. Much of this was set out in our draft Strategy Delivery Plan 2019/20 to 2023/24 – our local response to the national NHS Long Term Plan. There is therefore clear alignment between the ICS accreditation submission and our Strategy Delivery Plan.
- Following its development by a large range of stakeholders, our Strategy Delivery Plan was submitted to NHSE/I in the autumn of 2019. Publication and discussion of the plan at our Health & Wellbeing Boards was impacted by both the 2019 election (purdah) and the COVID-19 pandemic, with systems being advised by NHSE/I to delay publication. As outlined above, locally we will be producing a refreshed ICS strategy in Q3/Q4 of this year and we will liaise with NHSE/I to understand the national process for future publication and discussion.
- The ICS accreditation was discussed at a dedicated workshop of the K&M STP/ICS System Development Group on 8th September. The System Development Group is comprised of membership from each of our four ICPs, the Kent and Medway CCG, Kent County Council, Medway Council and the Local Medical Committee. Included within the ICS accreditation is a vision, purpose and set of principles to guide our system development, which was developed by the System Development Group in dedicated workshops in July and August.

Key messages from the ICS accreditation submission

"We have a clear vision for system working across the system, Integrated Care Partnerships and Primary Care Networks. A key enabler is to agree the delegation of authority and responsibility to the system from NHSE/I that will allow system leaders to align incentives, sanctions and decision making.

This is essential in order to secure progress towards our vision. The system has developed considerably in recent years and now meets the 'maturing level' of the NHSE/I ICS maturity matrix.

"We will work together to make health and wellbeing better than any partner can do alone"

Structure and features of our Integrated Care System

- **Primary Care Networks (PCNs) are the foundational building blocks of the ICS** – Primary care needs to be resilient and built on a strong foundation. However, PCNs are about more than integrated primary and community care – we will develop networks around neighbourhoods working closely with local government and the third sector. The delivery of Local Care (our K&M banner name for care closer to home) is also heavily dependent on a strong community services infrastructure at both the neighbourhood level and at higher levels of scale/critical mass where this is necessary to provide effective and high quality care.
- **Integrated Care Partnerships (ICPs) are the engine room for change** – increasingly we will see decisions made at place level to re-align available resources to enhance integration and improve outcomes with clinical input at the heart of these decisions. ICPs are focusing on redesigning pathways so that patients get the best care from the most appropriate services, delivered in the right place. Out of hospital care will be the default, to the benefit of both patients and the system. This will drive improvements in the health and wellbeing of local populations through prioritising keeping people safely at home, independent and self-managing; with the need to visit a hospital kept to circumstances when emergency or specialist care is required.
- **The ICS/STP Partnership Board will become the decision making forum of the ICS** *(within applicable statutory boundaries)*, providing oversight of whether the ICS is achieving its vision, purpose and priorities. It will be supported by a System Delivery Group (initially focused on COVID-19 recovery of services) and a System Development Group. The separation of these groups is to ensure sufficient focus on these two important agendas. The 'end state' governance for the ICS is currently being developed and will involve looking at the interactions between CCG committees and future committees of the ICS, to ensure the governance is streamlined.
- **We will apply the principle of subsidiarity, by which we mean that tasks and decisions should only be undertaken at system level when these cannot effectively or meaningfully be performed at local level**. Examples of areas needing a system approach are where we are likely to need a critical mass of scale or expertise beyond the place level; where all places are experiencing similar challenges (potentially to different degrees) which may benefit from collective problem solving; where we believe that working together will create greater power / influence / impact than working alone. Underpinning all of these circumstances, is the underlying driver that by working together as a system we will deliver better outcomes for our population.
- **The Health and Wellbeing Board and oversight and scrutiny committees** will remain a critical part of our infrastructure for strategy setting, decision making and oversight. Local authorities and the NHS, through the CCG, will continue to have a duty to prepare a joint strategic needs assessment and health and well-being strategies for the population, overseen by the Joint Health and Well-Being Board. Scrutiny Committees will continue to examine the provision of health and care services, act as a critical-friend and where required hold organisations to account in ensuring the care needs, quality and experiences of local people are fully considered.
- **The CCG will act as a servant and enabler of system working** – beyond its statutory responsibilities the CCG now has a central role in supporting and resourcing development of the system; this will be through a clear focus on 'central' resources supporting wider system development and the increasing alignment of staff to work as part of ICPs. The system developer role will become a core purpose for the new CCG. Key areas for focus are supporting PCN development; supporting the service transformation agenda both at place level and for a small number of issues at ICS level; reducing formal financial contracting activity to a minimum.

Key ways of working

An increased focus on addressing variation
The best systems focus on standardisation and directly address unwarranted variation – this needs to cover differences in outcomes/quality, differences in access and differences in productivity and cost base. We will achieve this through:

- *A data driven and data supported approach to improvement* – this is a fundamental building block which will be supported through sharing of data through a common platform having a single source of truth
- *A common approach and system wide framework for Quality Improvement* – all partners agree that a Quality Improvement approach is essential and most organisations have or are considering adopting a single methodology (with many ogranisations adopting the NHSE/I Act Academy's Quality, Service Improvement and Redesign approach - QSIR). Clinical and patient-engagement will be a central thread, along with understanding root causes.
- *A new approach to commissioning* – Commissioning will be about transformation and not transaction. It will be light touch, focused on service improvement and increasingly shifting to a population health management approach that sets outcomes as the target for services. Resources are being aligned progressively with ICPs and this has already commenced following the creation of ICP facing resources as part of the merger of the eight legacy CCGs.

Living by a ICS values and behaviours
We have started work on our ICS values and behaviours, including a dedicated leadership event on this in September 2020. We have been working with NSHE/I and the NHS Leadership Academy on a programme of work for system wide organisational development which has been approved.

Greater integration leads to better quality of care and better outcomes for our population – Our overriding focus will be integrated service delivery for defined populations, with an agnostic view on how integration is achieved in organisational terms, identifying opportunities for shared budgets and aligned workforce approaches across employers where possible but with the main focus being on integrated care delivery. Integration is being pursued across organisations and sectors, with integration of physical and mental health and with health and social care. Together, the system can be more than the sum of the parts and we will achieve more for the health and wellbeing of our population by maximising the integration of services.

Clinical and service professional engagement must be at the heart of what we do – Strategic initiatives should be led / supported by clinical and professional leaders across health and social care; we will develop and nurture clinical alliances and networks as a means of driving change with a focus on shared learning and improvement founded in a desire to eliminate unwarranted variation, ensure safety and maximise quality. We are building on the work to date of the STP Clinical and Professional Board and recent appointment of system wide clinical leads for services/programmes.

Engaging with and meaningfully supporting the third sector – The voluntary sector plays an important role in care delivery and integration and is a vital link to local communities. As Primary Care Networks further develop we will place the involvement of the voluntary sector very much at its heart. This will include the need to consider the impact that COVID-19 has had on the viability of some voluntary and third sector partners and how we can best support them.

Meaningful and realistic engagement with local government – Local government are critical members of the Integrated Care System and our councils are longstanding members of our STP/ICS Partnership Board and groups throughout our governance structure. We have many examples of great integration initiatives in both commissioning and delivery of services, but we recognise that there is more we can do, both strategically and operationally to drive greater integration. Initial discussions with both KCC and Medway Council suggest that we can further align around Health and Wellbeing strategies as the focus for agreeing our areas of strategic common focus for Kent and Medway as a whole.

<u>Previous committees where the K&M accreditation has been discussed in detail</u>

- K&M STP/ICS System Development Group – 8th September
- STP/ICS Partnership Board – 18th September – where the submission was endorsed.

<u>Next steps</u>

- This document was submitted to NHSE/I on 19th October. The next step is a regional assessment discussion on 4th November; further assessment processes will be determined following the discussion on 4th November. The outcome of our bid to be accredited will likely be communicated in December (TBC by NHSE/I).

To approve the Digital Transformation Strategy	**Programme Director for EPR (Sunrise) and Digital Transformation**

The Digital Transformation strategy, sets out MTW's vision for an e-Hospital, underpinned by an electronic patient record (EPR) and investment in IT systems and infrastructure to transform services for our patients over the next year years. This has been developed in conjunction with our staff over the last 12 months.

The strategy is divided into 4 chapters

- Chapter 1 - Sets out our vision to develop an e-hospital across all our clinical areas including ED, outpatients, theatres, wards, maternity and oncology. In addition, we outline our intention to providing our patients the ability to use technology to access services and support their care both within hospitals and the community. It also outlines how we will support our workforce to carry out their work in more efficient ways both at work and at home. Our vision includes our back-office functions to use digital technology to further support improvements to processes and how we contribute to developments both regionally and nationally.
- Chapter 2 – sets out our strategy for delivering 'digitally seamless enhanced patient care', through four pillars, with clear aims and design principles that will be used in decision making.
- Chapter 3 – focuses on how we will support our strategy, through roles being put in place, training being provided, investment in hardware, teams and infrastructure as well as the governance and prioritisation of programmes of work.
- Chapter 4 – provides a high-level road map of how we intend to deliver our strategy aligning initiatives and aspirations to our Trust values of PRIDE, through nine streams of work which will supported by the development of a strategic outline business case.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 13/10/20
- Finance and Performance Committee, 20/10/20

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

Approval

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


NHS
Maidstone and
Tunbridge Wells
NHS Trust
MTW Digital
Transformation
Strategy
2020-2030

MTW Digital Transformation Strategy **2020–2030**

Our Trust mainly relies on paper patient records and multiple aged and legacy IT systems with limited integration and capability. We want all clinical areas across both of our hospitals to be completely transformed.

We want data-driven care and improvements to safety using advanced digital technology. We also want to ensure all our support staff have access to the right technology and software to deliver their roles efficiently and effectively. This digital transformation will enable us to achieve our vision of both our main hospital sites becoming eHospitals delivering digitally seamless enhanced patient care.

A digital revolution

There is a clinical desire to move away from paper-based and manual clinical processes, to fully digitalised ways of recording and accessing information, to support the provision of outstanding patient care. We will do this by combining a fully integrated Electronic Patient Record (EPR) with a refresh of the computing estate, and the introduction of integrated mobile devices.

The Trust's EPR will give the ability to access comprehensive electronic health records, at the touch of a button. It will allow our staff to view and record all clinical information, in real-time, wherever and whenever they need it. All clinical teams across our hospitals will be able to see the same information about a patient in our EPR, which is vital to patient care and safety.

To support this, we will focus on introducing technology that meets the needs of our users to support their working processes by being reliable and resilient, as well as ensuring they have the right technology available at the right time. We will also ensure the IT infrastructure in the Trust meets the needs of the organisation both now and in the future.

We want to develop the ability to share data across our partner organisations, and with patients and carers directly, with the aim of improving care and the patient experience through data collaboration. We will have access to all the data we hold, promoting audit and good clinical governance and intelligent reporting dashboards. MTW will become a leader within Kent for sharing information across organisations, empowering our staff to access patient records whenever and wherever they need to. We will also start to promote patients having access to their own data – involving them more in their own care will help us all.

Our ultimate aim with this strategy is to develop an eHospital which will help us to revolutionise the way our clinical teams care for their patients. It is important to note that this strategy sets out our aspirations for digital transformation and we recognise that it may not be possible to deliver everything in the short to medium term. However, MTW is committed to aspiring to deliver outstanding care supported by the latest technology and this document sets out how our organisation would like to look in the future.

Digital Transformation Achievements
Oct 2017- Apr 2020

We have already begun our journey towards digital transformation and this timeline highlights the work done to April 2020.

October 2017

- **Oct 2017** – Allscripts PAS upgrade completed
- **Nov 2017** – Introduction of Global Rostering System for staff in ED
- **Jan 2018** – Trust printer fleet replaced with new devices and a more centralised printing solution
- **Apr 2018** – Expansion into Custodian data centre
- **May 2018** – EPR business case approved by Trust Board. Procurement commenced
- **May 2018** – ERS rolled out across all clinics
- **July 2018** – EPR contract awarded to Allscripts Sunrise
- **Aug 2018** – Managed 'Follow me' print service introduced
- **Sept 2018** – Fax machines eradicated from use
- **Oct 2018** – Upgrade of Symphony A&E system
- **Oct 2018** – Trust invests in enhanced cyber security technology
- **Jan 2019** – Introduction of Docman providing electronic correspondence to GPs
- **Sept 2019** – Single sign on technology introduced to ED and outpatients roll out started
- **Feb 2019** – 35 workstation on wheels deployed across the Trust
- **Apr 2019** – Freshservice launched as the new service desk portal for all staff
- **May 2019** – Successfully moved from N3 to HSCN
- **June 2019** – Installation of new, faster storage with increased capacity
- **June 2019** – My PreOp go live
- **Sept 2019** – PAS upgrade completed
- **Sept 2019** – Maidstone Core Network Upgrade
- **Nov 2019** – Upgrade of the blood tracing system to Blood360
- **Nov 2019** – Video Consultation Appointment (VCA) Pilot
- **Feb 2020** – Managed Hardware Service (IVE) business case approved
- **Mar 2020** – 65 workstation on wheels deployed across the Trust
- **Mar 2020** – Go-live of new AMU building at MGH
- **Mar 2020** – COVID-19 response: Video conferencing software and additional remote access licences introduced to allow working from home
- **April 2020** – Whiteboard usage to capture real time in-patient data
- **April 2020** – Teletracking business case approved
- **April 2020** – VCA roll out accelerated (8000% increase)
- **April 2020** – in-patients given access to iPads to help communication with family and friends

April 2020

Chapter 1

Our eHospital

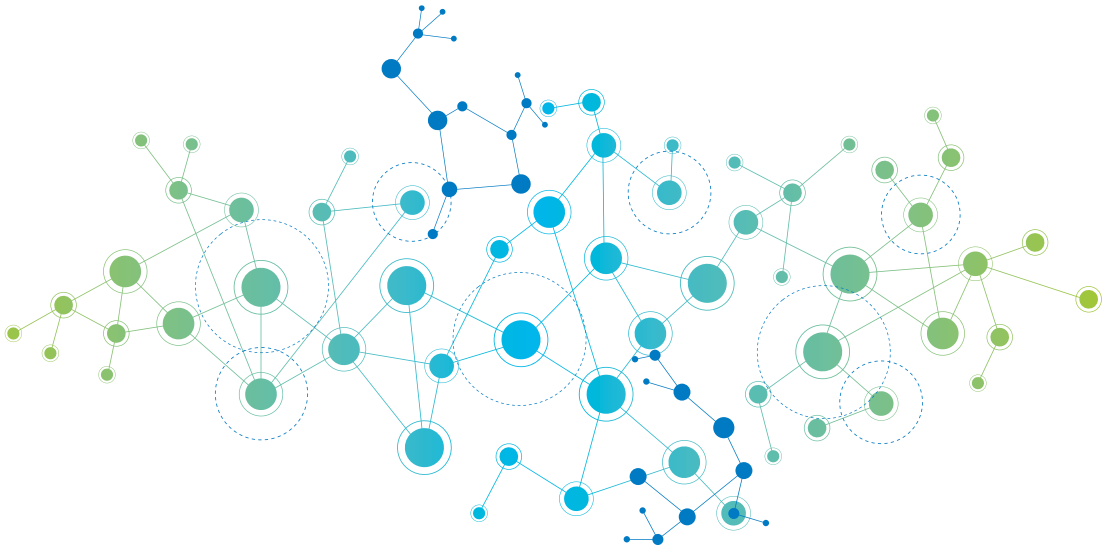
Our Digital Hospital

Our Digital Hospital will focus on technology meeting the needs of our users. We need to become more agile as an organisation to ensure we can respond to change quickly, supporting our clinical teams through technology.

We will assess how users can gain easier access to information from wherever they are and if they have the right technology to meet their needs. As part of a programme of significant investment we aim to address our environments to ensure the IT infrastructure meets the workflows of our users, as well as promoting new devices that are easy to use, with the latest software, to reduce the time wasted accessing information, and reducing support calls.

We will look not only towards improving the user experience regarding end user devices, but also accessing Trust systems such as the EPR and departmental systems through single sign-on and customised screens. This means that instead of replacing devices like for like, we aim to understand the change in working practices to adopt a paper-lite approach, as well as supporting other service transformation taking place within the organisation. The Trust will also begin to review other organisations' approaches to end user technology, look at innovative new technology that is coming to the market and how this can be used within our hospitals, whilst allowing the device types and deployment approach to be driven by users through the Clinical Digital Design Authority.

We have already seen improvements such as additional screens in outpatients, faster logon speeds, and single sign-on being rolled out across the Trust. On our wards we've invested in more computers on wheels providing patient data at the patient's bedside, and touchscreen PCs to aid bed management and access patient results. The introduction of video outpatient consultation and telemedicine had begun before the COVID-19 pandemic, but has seen significant progress since, and will continue to be rolled out within the organisation.



The Trust is also looking to adopt technology to improve productivity and in turn patient care. Examples of this include the introduction of voice recognition in some departments for the creation of correspondence, reducing admin time for staff and improving the turnaround time of letters within the Trust.

Instant messaging applications have become common within everyday life and are becoming an important part of how our staff communicate with each other to manage operations. However, we are starting to see examples of how these applications are being used to directly manage patient care. Before we introduce such technology, we will ensure that we meet our information governance requirements for patient data.

We believe strongly that by working with our partner organisations across Kent and into London we can deliver better, more efficient care.

Globally we are seeing companies such as IBM and Google continue to develop Artificial Intelligence (AI) functionality, with the benefits now starting to be utilised within healthcare. Beyond the roll out of the EPR, the Trust would like to explore adopting AI functionality in the following areas: further decision support tool for clinicians; automate management of patient pathways; and support the Trust with process management, including in non-clinical areas, alerting, implementing plans and supporting analysis of population health data.

Our Digital Outpatients

Using technology and the expertise of our internal IT teams we are already changing the way we work in outpatient areas to improve patient care, safety and experience, and to make the running of our busy clinics much more effective and efficient.

Our aim is to move towards a 'paper-lite' organisation by April 2021 by increasing our eNotes capacity. This includes ensuring all new patients to MTW are automatically created eNotes from the beginning of their care ahead of implementing our EPR system. We also intend to see that all documents created electronically, including GP referrals and correspondence from other Trusts, are available within eNotes without the need for printing.

Currently our clinical patient-related data and information is collected in paper patient records and clinical staff access numerous systems on individual computers, making accessing and sharing information difficult and time consuming. When our EPR is fully deployed it will act as a portal (through tab integration) to a number of systems such as Pathology, Radiology, eNotes, Cardiology, Endoscopy and Kent Oncology System, with others planned as it matures. This means records will be completed and accessible by all members of a patient's clinical team at any time, at any place. There will be no more 'pulling' of fragmented sets of paper notes from the Health Records Library, putting a stop to delays when waiting for records to arrive before our patients are seen in clinic.

There are a number of digital initiatives already planned or underway in preparation for EPR in outpatients:

- Electronic referrals for outpatients appointments
- Patient Hub
- Clinic room scheduling system
- Digital self-check-in
- Virtual Outpatient Clinics
- Virtual Fracture Clinic
- Digital referrals and test ordering
- My Pre-Op

Electronic referrals for outpatient appointments

All first patient referrals made by GPs to our consultant-led clinics and services are already received electronically via the NHS e-Referral Service. The next step will be to make sure these referrals are triaged and accessible within our

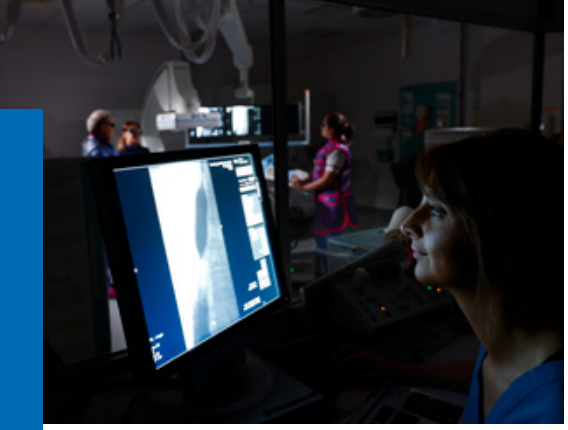
EPR by integrating these into our eNotes system so they can be viewed easily. This will improve efficiency by further streamlining our referral process and reducing the variation of referral routes so that appointments are booked for our patients as soon as the electronic referral is received.

Using our clinic rooms efficiently to improve utilisation and reduce waiting times

We will be introducing a web-based scheduling system that allows our administrative teams to easily visualise room resources at the click of a button. The system will revolutionise our clinic room booking process by enabling staff to be able to see and request available rooms and cancel booked rooms. It will reduce emails and telephone calls significantly decreasing administrative time and allowing clinic rooms to be re-utilised quickly and efficiently, thus reducing waiting times for patients for outpatient appointments at any one of our sites.

Digital self-check-in

Patients who arrive at Tunbridge Wells Hospital are presented with digital check-in kiosks, connected to our PAS, allowing them to self-check-in for their clinic appointment. They can also utilise the on-screen maps and directions showing them how to get to their clinic, helping them to find their way around the hospital and wait in areas such as restaurants or cafes before they are called. These kiosks have already helped to reduce queues and administrative check-in tasks at clinic reception desks, as well as preventing our patients' personal and confidential details from being overheard by other people in the clinic waiting area. Our aim is to roll out the same system at Maidstone Hospital.



Virtual Fracture Clinic

MTW's Fracture Clinic used to be one of our busiest clinics. In 2018 we set up a 'Virtual Fracture Clinic' to help with service demand and improve patient care and experience. Before then, patients with a suspected fracture would come to our Emergency Department (ED) and receive an x-ray. If a fracture was confirmed, the patient would be given a temporary plaster cast and an appointment made for them to attend the hospital's fracture clinic a few days later to discuss follow-up care and treatment. With the Virtual Fracture Clinic, our therapists and consultants study patients' case notes and x-rays within their records after receiving an electronic referral from ED before contacting patients to discuss their follow-up care. Only those patients who need to come back into hospital to attend the fracture clinic for further treatment receive an appointment. This will be enhanced further once our EPR system is fully functional.

Anytime Anywhere – Virtual outpatient clinics

The NHS aims to avoid up to a third of face-to-face outpatient visits by 2025. Virtual outpatient clinics are crucial for reducing unnecessary outpatient visits, saving time for patients and our clinical teams as well as contributing to reducing our overall carbon footprint. The technology used facilitates virtual waiting rooms, from which patients can be seen at set times, via the web, using video consultation for their appointment. We have already introduced this system into a number of specialities and this was codesigned with patient involvement and feedback. Our aim is to now roll this out to all specialities, to complement our pre-existing telephone consultations giving patients and staff options for how appointments can be facilitated without the need to visit hospital on every occasion.

Digitally ordering tests and making referrals

We have enabled our clinical teams to order blood tests and x-rays for inpatients electronically for some time. With the introduction of our new EPR this facility will be extended to all our outpatient areas as well. The EPR will also make accessing the results and images easier as they can be viewed in one place for each individual patient, with the added benefit of reducing the amount of paper relating to test results circulating within the Trust. In addition, referrals made within the Trust between departments will no longer need to be printed and will be accessed electronically, in real time, reducing delay.

My Pre-op

Our patients are already able to complete pre-appointment questionnaires electronically within 'My Pre-op', with the results discussed with the pre-assessment team. The nurses can then assess which clinic is most appropriate, for example, telephone assessment or face to face, or which patient needs a more detailed anaesthetic clinic. This makes appointments much more effective as our patients and clinicians spend more time discussing care and treatment plans together for their forthcoming surgery.

eConsent

We plan to introduce eConsent which will allow doctors to consent patients in clinic using a ready-made form that can be adjusted to suit the needs of the individual consultation. These consent forms will ensure the correct type of consent (based on mental capacity) is assessed, as well as provide a complete list of risks and benefits for each procedure, and each patient and or their representative will receive the most recent versions of any associated information leaflets. This will ensure that all patients and their representatives can access clear documentation regarding their forthcoming operation which can also be accessed via a link to an electronic copy if requested.

OpenEyes

OpenEyes is an open source electronic patient record designed by ophthalmologists to work intuitively with the unique ways ophthalmologists record and manage eye conditions. It has grown and evolved over the last decade into a fully functioning ophthalmic EPR. We have been using this in patients with macular degeneration for around eight years and have developed innovative sharing of this EPR with community optometrists to create a shared care scheme.

Over the next few months we are expanding the use of OpenEyes into the cataract service followed by the other sub-specialities over the next few years. This development is part of the Kent Opthalmology Record which will allow information about patients' eye conditions to be shared across trusts, opticians, general practices and other primary eye care providers to create a fully integrated eye care system for all patients in the south east of England.

Our Digital Correspondence

Automated letter creation

Clinical documentation is already being recorded electronically in some of our clinics. With the advent of EPR clinicians will be able to utilise data quickly and easily formulate letters, rather than having to manually re-type information into a letter after the clinic. This means that in some areas, patients could receive their clinic letter before they even leave the room, or will receive the correspondence via email.

Voice recognition

Our clinical teams have started to implement voice recognition for clinical correspondence in some departments to speed up the turnaround of letters, reducing delays in patients' diagnosis or treatment. This will release time for our administrative staff to continue to provide a high-quality service for patient enquiries.

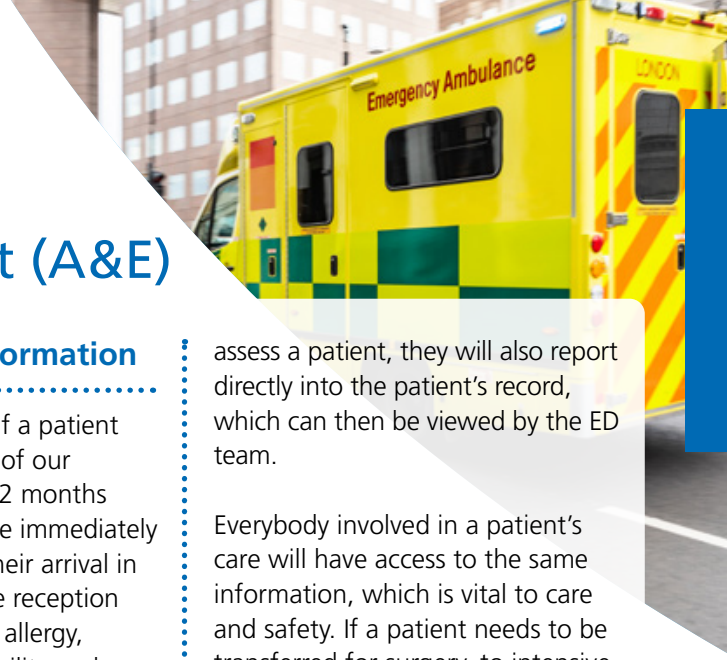
Remote reporting of x-ray images

Our radiologists and radiographers have been enabled to report x-ray images from home, which will improve reporting capacity and flexibility. This will help us to make the service more efficient, flexible and able to react to our patient's needs, including quicker cancer diagnosis, as well as improve our staff work life balance.

Automated coding of outpatient procedures

Currently, our clinicians document on paper the procedures they have performed during an outpatient or emergency visit, then submit this paper documentation to our clinical coding department for transcription in order to collect payment from our commissioners. When the EPR is deployed, this will become automated. For example, our clinicians will document in our EPR any procedures undertaken. This will be easily accessible for our clinical coding department to view to ensure that the correct information is passed onto our commissioners for the care we have undertaken. As an interim measure during 2020, we will be introducing to Maidstone Hospital the electronic clinic outcome forms already used at Tunbridge Wells Hospital.

Our Digital Emergency Department (A&E)



Rapid access to information

Once our EPR goes live, if a patient has been treated by any of our services within the last 12 months their health record will be immediately available to staff upon their arrival in ED. When they reach the reception desk their demographic, allergy, infection screening, disability and GP information contained in their electronic record is available to receptionists, making registration and checking of information much faster. Upon seeing the triage nurse, the patient's assessment will be documented in their electronic health record by a triage nurse using a mobile device – usually a workstation on wheels.

Single source of the truth

Wherever a patient is being treated within the ED (high dependency, resuscitation, low dependency, minor injuries) their entire clinical team will be able to simultaneously document information in their electronic health record. If speciality-specific clinicians that work outside of the ED (for example, surgeons, anaesthetists, neurologists) have been requested to assess a patient, they will also report directly into the patient's record, which can then be viewed by the ED team.

Everybody involved in a patient's care will have access to the same information, which is vital to care and safety. If a patient needs to be transferred for surgery, to intensive care, or for specialist care on a ward, their entire ED health record, including all the care received and documented whilst in the ED, will be immediately available for clinicians in the receiving areas. This will allow them to plan the patient's care appropriately before they are actually transferred to their area of care.

The administrative burden of urgently sourcing paper records for patients arriving in our ED will be eliminated. Letters are already automatically sent to the patient's GP when they are admitted to an inpatient area from the ED and this will continue. In the future there will be no need to wait for paper notes to be released from the ED before follow-up appointments can be booked.

Real-time information for effective management

With the EPR in place, the current status of the ED (at any point of time) can be viewed on a dashboard. Staff can see, at a glance, colour coded information about each patient: waiting time, which area and bed they are in, acuity level, early warning score, status of their emergency care pathway, when they were last reviewed by a clinician, when assessments were completed. This snapshot helps with the effective and efficient management of the ED and ensures that our patients are receiving the appropriate and timely care that they need. In the future clinicians will be able to automatically add the key details about a patient's condition, accident or trauma into their health record in our EPR so that the entire clinical team has quick and easy access to the data when the patient arrives, avoiding potential life-threatening delays to their care. This vital information is currently handwritten on paper, making it difficult to quickly share with an entire clinical team.

Electronic alerts

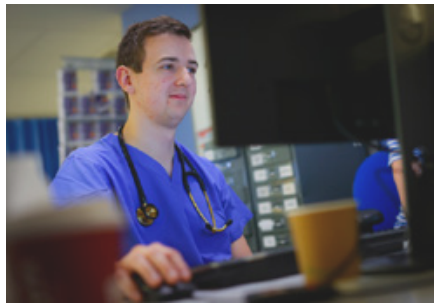
We are designing our EPR system so that alerts can be triggered to make appropriate staff aware if a patient is a frequent ED attender with an emergency management plan (for example, a paediatric asthmatic patient), as well as infection control status or acute kidney injury, or if they need to be seen more urgently as a result of their early warning score, for example if there is an indication of sepsis. This early warning score is automatically calculated in our EPR from their initial triage assessment.

eTriage

We are aiming to introduce eTriage within our ED departments. On arrival, patients will be asked to enter information via a tablet device detailing their symptoms and reason for their visit. They will input their demographic data, before completing a simple set of triage questions. Based on the patient's response, the eTriage will be pushed immediately into the clinical system and patients will be listed by priority according to their clinical need, including being referred to see the GPs on site. This will save time for both reception and emergency staff as patients will be streamed to the most appropriate care quickly.

Our Digital Wards

Gone will be the days of paper drug charts hanging at the end of patient beds, doctors documenting in paper notes during their ward rounds, nurses having to wait for a patient's set of notes to become available before they can write in them to record regular observations, multiple trips back and forth to pharmacy to submit paper medication prescriptions… The list goes on.



Just like in our clinics and ED, the inpatient team caring for a patient will be able to see the patient's health record within our EPR. A patient's notes will always be available and accessible electronically, with multiple clinicians able to contribute to a record simultaneously, avoiding any unnecessary delays to care. As the system matures, clinicians will be able to access other clinical records stored in systems such as eNotes, TOMCAT (Cardiology), Endobase (Endoscopy), and the Kent Oncology Management System (KOMS), via tab integration with our EPR.

Recording care at the bedside using mobile devices

Our doctors and nursing staff use mobile and handheld devices on our wards to view and record information about their patients, in real-time, at the bedside. In the future, we would like to bring technology as part of our EPR that will enable nurses to use handheld devices with an in-built barcode scanner in a medical grade waterproof casing. Nurses will scan a barcode on the patient's wristband to access their electronic health record, allowing the patient's observations to be recorded (temperature, blood pressure, pulse) directly into their record in our EPR, in real-time, at their bedside.

Workstations-on-wheels are already used in a number of our wards to view results and x-rays as well as record information during ward rounds. The amount that can be recorded will substantially increase when our EPR system is launched enabling clinical teams to update patient care, any medication changes or further tests/procedures required. All of these will be documented and ordered in real-time, ready for action by nursing staff and other clinicians involved in the patient's care.

Patients do not stay in hospital for longer than necessary

Discharge summaries are completed within an electronic system and are used to dispense the drugs patients need to take home with them, as well as being sent electronically to the patient's GP as soon as they are discharged from our hospitals. Eventually this will be incorporated within our new EPR system reducing the time taken to complete these documents and allowing our doctors to secure access to the patient's record wherever they happen to be, avoiding any unnecessary delays to their care or discharge.

Improving flow and capacity within the hospitals

When a patient is discharged or transferred, our nurses can update our live bed management system using electronic touchscreen whiteboards. This gives real time information to assist with the management of high occupancy areas and the planning of upcoming patient discharges. During 2020 we will introduce Teletracking technology that will enable staff to track the movement of patients to identify delays that can be avoided and indicate to ward staff the type of bed clean that should be ordered based upon the departing patient's clinical status. This will further help improve patient flow, bed capacity and efficiency across our wards. This technology will also be applied to enable us to tag medical equipment across the Trust, allowing staff to find and move devices to where they are needed more rapidly.

Automation of vital patient data from medical devices

All of our physiological monitors will eventually be directly connected to our EPR. This means that the data generated from medical devices will be automatically and continuously recorded into their health record in our EPR, removing the need for manual transcription and associated errors. Medical device integration improves safety allowing our clinicians to spend more quality time at the bedside caring for their patients, instead of spending time manually capturing and recording data on paper every 5-10 minutes, day and night, for each patient.

Effective transfers of care

When our EPR system is implemented in all areas, all information about the patient will be available to staff in a ward area before the patient arrives. From within the patient's record in our EPR, the team will see, for example, which medications the surgeon/doctor has prescribed to be administered. They will also easily see the information that has been recorded by previous teams treating the patient, from operation details, surgical notes and anaesthesia information, to procedures performed and medications prescribed.

Rapid response

We already have an electronic system in place so that if any of our patients on any of our wards start to deteriorate or suddenly become acutely unwell, the Trust's Outreach Team (a dedicated team of nurses) can immediately respond with critical care expertise. The team are alerted to any patients whose vital signs cause concern (using the NEWS 2 algorithm) so that they can visit the patient's bedside and, if necessary, move the patient straight to the intensive care unit for round-the-clock care and attention. This will eventually be incorporated into our EPR giving clinical teams easy access to the patient's relevant clinical history.

Electronic prescribing and administration of medicine

As part of our EPR system we will be introducing e-prescribing to further enhance the safe administration and dispensing of medicines. Clinical teams will be able to prescribe patient drugs on the ward round electronically using workstation on wheels, before being automatically transmitted to the Pharmacy Department to process. The same system will also aid clinical teams to complete discharge letters more efficiently thus reducing the time patients have to wait for drugs to take home. Nurses on the wards and in departments will administer and record drugs given electronically within EPR, except chemotherapy which will be carried out via an existing dedicated e-prescribing system.

Our Digital Theatres

Efficient use of our Theatres

We have a well-established electronic theatre management system that allows our staff to record all activity that is captured whilst the patient is undergoing surgery and this includes real-time data capture. It allows us to schedule and manage patients, use resources effectively and efficiently, and record supplies used during surgery.

Our EPR will eventually replace this system, providing us with a single record that covers the whole surgical patient journey from admission to discharge. This will also be integrated with our administrative systems to further enhance the efficiency of the booking process. We will also be investing in the longer term to implement an anaesthetic record system which can be integrated with our EPR.

Intensive care

We are working closely with our intensive care team to ensure that this area has the right IT system that meets the specific needs of the patients in both of our units, to complement the EPR system being rolled out across the Trust.

Ensuring patients waiting for trauma surgery are managed effectively

We have developed a system that allows our Orthopaedics team to track and plan the trauma cases both within the hospital and those waiting at home. This has ensured patients are managed more effectively via a single 'Trauma Board' and has reduced waiting times for surgery. This is planned to be rolled out to cover all emergency surgery.

Our Digital Maternity

Ensuring mother and baby are supported through every step

We have a well-established electronic system which the maternity team use to record notes from the first antenatal appointment until postnatal discharge, in both the hospital and community settings. Future developments will increase the points of contact when data is captured to include early pregnancy and enhanced care. We are currently working with the system supplier to develop a Maternity Personal Health Record portal which will give women digital access to their maternity records and reduce the need for paper notes. A recent update of our website pages and greater use of social media provides a wealth of information for women regarding pregnancy, childbirth and beyond. The introduction of online self-referral has enabled direct access to maternity care, improving choice, personalisation and timely referrals to the appropriate pathway.

We will also as part of our EPR programme provide additional devices so the whole obstetric service can order tests electronically and review images. In addition, we will be looking to enhance our mobile devices so that midwives in the community can also access the information they need when they need it.

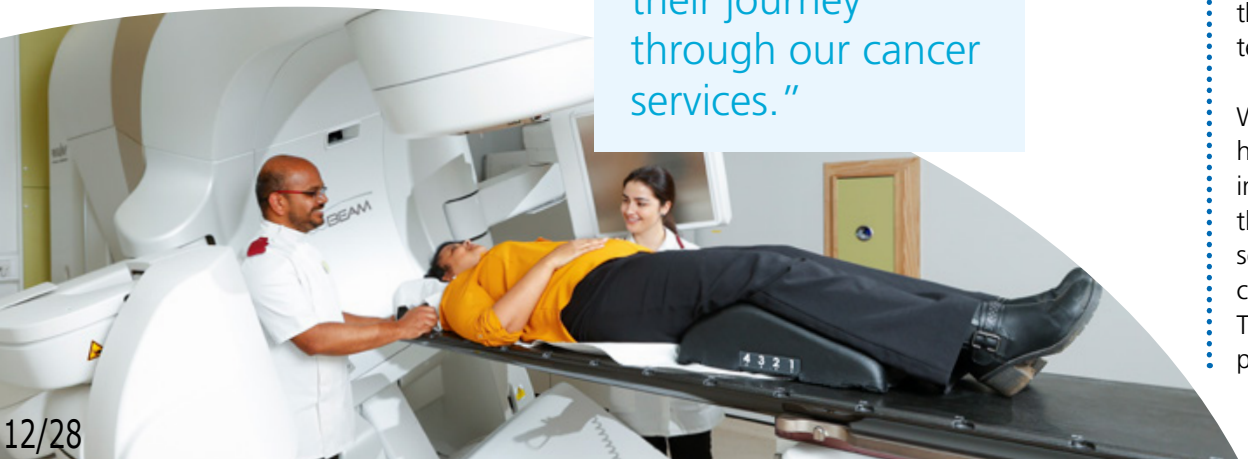
Our Digital Oncology Service

Our Kent Oncology Centre (KOC) works in partnership with other healthcare organisations to provide cancer services across Kent, Medway and into East Sussex. Clinician access to high-quality information throughout the region is essential to the delivery of our services.

We already have in place existing systems that support electronic prescribing of chemotherapy, planning of radiotherapy, and the Kent Oncology Management System (KOMS) to support clinicians in treating cancer. These will continue to be developed by our Computer Science team to respond to the needs of the organisation, including integration with EPR and eNotes projects to ensure that excellent care is provided to our patients irrespective of where they are interacting with our cancer services. Research into the use of information technology to personalise the management of patient care is beginning to show improvements in patient outcomes. In radiotherapy, for example, it is now possible to adapt the delivery of radiotherapy treatment in near real-time and the KOC will look to implement similar techniques.

Our clinicians will need access to advanced decision-making tools when delivering personalised healthcare more widely. These tools are often complex and involve machine learning techniques applied to large cohorts of patient data.

"We want to ensure our patients have access to clear and relevant information before, during and after their journey through our cancer services."



In imaging, for example, machine learning is beginning to support the interpretation of CT scans used in cancer pathways, but there are a number of challenges to overcome, including those relating to information governance and clinical assurance, which will require us to work with partner organisations to introduce these developing digital technologies.

We want to ensure our patients have access to clear and relevant information before, during and after their journey through our cancer services. This is an area where clinician validated apps have a role. The Breast Cancer Kent Patient App produced by the MTW Breast Unit is one example and we will work to ensure that other appropriate apps and resources are available to our oncology patients.

The cancer team will continue to support investment in safe and secure IT solutions that will allow our services to be delivered in new and innovative ways where these are of benefit to our patients and staff, including extending remote working where this is appropriate and ensuring that staff have access to the information and resources they need to function as a single integrated team, even when they are working from multiple sites.

Our Digital Patients

Allowing our patients digital access via a patient portal

Living in a digital society, people are accustomed to accessing services and personal information (finances/ banking, shopping, social media) on computers, laptops, smartphones and tablets, so why should they not be able to access their health information in a digital way too? Research shows that patients want to be more involved in, and more informed about, their healthcare and treatment, particularly those with long-term health conditions. We plan to implement a patient portal so that our patients can access the following documentation electronically instead of it being posted to them:

- **Appointment letters / past appointment details**
- **Clinic letters / clinical correspondence**

The aim is that patients will also be able to use the patient portal to contact the hospital to change or cancel appointments, as well as update us with their latest contact details. We will also ensure any IT systems introduced for patients' use adhere to the accessible information standards involving them in the design and implementation. The Trust is already working to bring a system that will enable maternity patients to hold their own records electronically and contribute to their health information without having to make unnecessary visits to our hospitals.

Eventually we would like to see this developed and extended to cover all patients, including functionality that enables patients to:

- **upload health trends, for example, their blood pressure, weight, blood glucose;**
- **arrange e-visits with their clinicians;**
- **Proxy access for parents, relatives of elderly patients, power of attorney circumstances;**
- **integration with wearable devices such as FitBit and Apple HealthKit.**
- **Introducing specific apps to support patient care**

Keeping patients in touch with their family and friends

Patients want to be informed, they want access to the internet, and they want to connect with their family at home whilst they are in hospital. We are committed to supporting as many of our patients in hospital by offering a number of mobile devices so they can keep in touch. In the future these devices could be used to enable patients to update their clinical information such as recording how they feel, food they have consumed, etc.

Putting patients at the heart of their care

With timely medical record sharing a challenge across the NHS, our ambition as a digital trust is to create integrated technology to:

- enable our hospital staff to see a single unified view of a patient's health record, electronically, in its entirety (Sunrise EPR);
- give our patients the ability to view their electronic health record held at our hospitals, to involve them more in their care and support them with the management of their health conditions (patient portal);
- enable the sharing of key clinical information with other hospitals and patients GPs via the Kent & Medway Care Record.

Our Digital Workforce

Remote access and enabling working from home

MTW is committed to implementing the technology our workforce needs in order to help them to achieve a work-life balance. This includes providing staff with the technology that supports remote access working from home, including video conferencing facilities for meetings so that teams can keep in touch, progress projects and provide input to care without the need for travelling.

Smartcards and single sign-on

All staff across the Trust, interacting with patients, will be issued a Smartcard to access clinical IT systems, alongside using a single sign-on password. This allows our staff to quickly access and create electronic health records, or to gather and document treatment for all our patients whilst in our care.

Removal of Bleep systems

Messaging applications for clinical use will be explored to see how the Trust can remove the legacy 'bleep' system for non-emergency communication, in line with national requirements. This means our staff will no longer have to 'bleep' a number and wait by a phone for someone to call them back. This will release time, for both our nurses and doctors, to care for patients.

Our Digital Enablers

MTW is committed to extending the benefits of digital technology to all of our 'back office functions' to enable the continuous improvement of services for all our staff and patients. This includes reducing reliance on paper processes, increasing automation to free up resources to support expert tasks, introducing systems to support remote working, as well as streamlining legacy IT systems to provide real-time data that supports decision making.

Human Resources

MTW already has introduced a number of systems to improve the processes within HR. This includes an online recruitment system for managers covering all stages of the recruitment process. We have also introduced an electronic rostering system for all non-medical staff to help managers allocate shifts more effectively, and record time and attendance data, whilst also reducing bank and agency staff usage. A further module is also due to be implemented this year in order to match staffing levels to patient acuity. In addition, we will shortly be commencing the rollout of a Trust-wide medical e-rostering system alongside a regional Collaborative Medical Bank.

Our staff are now able to view their payslips and P60s online via a specific app which they can register to and log on to make any payroll related queries. Alongside this we have implemented ePay to enable our employees to claim their expenses electronically, with plans to further utilise the Employee Staff Record (ESR) system to provide a self-service model for our employees and managers. Our staff can now access and complete their appraisal through the MTW learning portal which has reduced the need for manual data entry within HR.

Finance

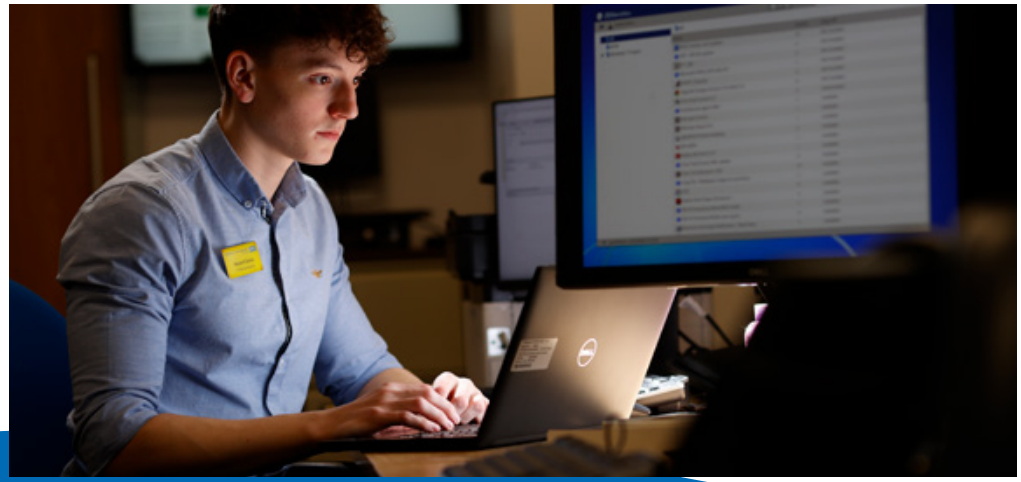
Our Finance Department aims to automate transactions and invoicing to reduce reliance on paper and routine manual data entry. This will release resources to support our clinical areas and allow us to introduce systems, such as patient level costing, that will actively support decision making by using real-time data to ensure our services continue to be financially sustainable.

Procurement

Ensuring we have the right product, for every member of staff at the right time is critical to providing safe effective care. Therefore, we will be ensuring digital transformation supports our procurement team to work more efficiently with suppliers to ensure quality and affordability of all the products we use within the Trust. This will include refining existing IT systems that support automation of stock management, facilitate e-tendering, provide e-catalogues for staff to choose from and links with the national procurement systems.

Business Intelligence

It is very clear that improvements can be made to the way that information and data is made available and used across the organisation. Our strategy is to implement information management systems that can be utilised to enhance the organisation's ability to understand its performance and work with 'one version of the truth'. This will include streamlining our systems, whilst ensuring consistency of output, using statistical process control methodology and introducing mechanisms for managers to access information through self-service portals and performance dashboards. This will not only improve workflow within our teams, but will support delivery of the objectives of our Quality Improvement Strategy. Robust training of staff for all clinical systems will be provided with regular refresher updates. Frequent data quality reports will be run to pick up any errors or omissions, so prompt action can be taken to rectify any problems ensuring that digital information recorded is accurate at the time of entry.



Estates

Our Estates and Facilities Management Team uses various digital systems and associated hardware. This includes a specialist facilities management helpdesk and maintenance system, auditing and reporting software packages, biometric attendance systems, online car parking applications and automatic number plate recognition. These provide our team with the ability to record and document activity across the Trust in order to evidence compliance with national standards and legislative requirements.

We are planning to bring in new technology to help patient flow, particularly to ensure beds are released to our EDs as soon as patients are discharged home. We also plan to bring in new audit software to help our cleaning teams keep our hospitals cleaned to high standards. Our staff will see new software recording their attendance in health roster saving time for managers to manually update systems. Those who have hospital accommodation will be able to book and manage their tenancy through an electronic system. All visitors to the Trust will be able to benefit from new car parking software similar to RingGo making it much more convenient than queuing at payment machines.

Communications

Communication with our staff and patients is fundamental to providing outstanding care. It is crucial for our communications team to be able to target specific communications to specific teams or groups within the organisation. We also need to enable them to analyse receipt of information, such as whether individuals click on links provided, to make sure the communications is effective.

We are committed to investing in a new intranet site, as well as hosting webinars and live events. We also aim to bring in live media screens to digitalise messaging used within the Trust.

Enhancing Digital Care

Within our region and beyond

MTW recognises the importance of accurate and timely access to clinical information across Kent and Medway – for patients themselves, for our hospital clinicians and clinical teams, for a patient's primary care providers and for other hospitals involved in a patient's care. Working with our healthcare partners, developing and utilising the extensive capabilities of our clinical IT systems, we aim to innovatively share electronic clinical data and information to enable joined-up healthcare to benefit our patients.

Our digital connection with other hospitals and GPs in Kent

MTW already has a good working relationship with our local system partners. We collaborate with partners at various levels, including across the Kent & Medway Strategic Transformation Programme (STP), with other providers across Kent, within the Integrated Care Partnership (ICP) and locally via the West Kent Alliance.

With the increasing need to collaborate with our health and social care partners, there is a requirement to ensure that we are providing our clinical staff not just with MTW patient data, but data from any health or social care provider, to ensure the best possible care. Currently, there is no easy way for the clinical teams to share vital clinical information with one another in a timely way.

To further support multidisciplinary teams working across organisations and support the vision of the STP, a key programme for the region is delivering a Kent & Medway Care Record (KMCR) over the next three to five years. Through the KMCR and utilising all the EPRs across providers, clinicians in Kent will be able to view the latest information about their patients, from conditions, tests and procedures, to results, treatments, clinical letters and recommended follow-up care. For example, if a patient visited our ED department and then went to one of Kent's GP surgeries the following day or later, their GP would know everything about the care they received at our hospitals and any follow-up care or treatment that is required. The aim is to provide a clinical portal containing a complete care record across the county. This would also include access for patients and carers and the ability to add to their patient record, improving patient engagement and outcomes.

Alongside this we are working with the STP which is focusing on developing a Kent-wide approach to Pathology services, this will include implementing a Kent region LIM system for processing, capturing and sending out blood test / sample results.

Integrating patient records across the county

The local West Kent Integrated Health Partnership (ICP) is in the process of developing its own supportive strategy. We will continue to collaborate with our partners to deliver the best solutions for our

communities. We will learn from each other and share our experiences so that we can all improve digital technology for the benefit of our patients wherever they are treated. As the West Kent ICP develops we will see integrated service models developed that also align clinical IT systems so that users' experience is seamless even when services are provided by multiple organisations. The Trust will also be involved in utilising patient data to support population health analysis, aiding further service transformation across the ICP.

Although ICP development is in an early stage it is key that our IT team engages at an early stage to act as an enabler in the process. A Digital Collaboration group is being established initially reporting via the West Kent Alliance, but eventually to the ICP board which contains IT and Information leads from all providers and the CCG within West Kent. The aim will be to ensure our strategies align, and to support our users in sharing of data between organisations and the group through both system integration and consolidation to support both the wider West Kent transformation and integrated care system vision.

There is also a need to share data with our patients and their carers to both inform and support patient care. This will improve engagement with patients and their carers, promote data quality and provide additional opportunities to improve patient care. Providing access to Trust services via apps, accessing appointment information via email and video consultations are also key to improving patient interaction and providing improved services.

We will need to ensure that our long-term external patient interaction aligns with both the Kent and Medway STP and NHSX in the form of building upon the KMCR and solutions, such as the NHS App. However, in the interim we will look to embrace specialist products, working with suppliers to integrate and shape these solutions to achieve our long-term strategy. Examples include patient appointment letters being replaced by electronic correspondence, patient record portals for long term condition management, allowing patients to enter information on their condition which will aid their treatment, and an increase in video consultations.

The Trust has also recently embarked on the implementation of a 'virtual ward', allowing patients to be managed remotely. It is anticipated that this type of practice will be implemented further and, due to technology enablers now available, the workstream will also look at real-time remote monitoring of patients via provided devices and patients' own equipment, such as smart phones, to improve remote patient care.

National drivers for change

Alongside our work in the region, we will ensure that our local digital transformation incorporates national IT initiatives as they are made available to us, such as those that:

- help patients to manage their care in the community, including Apps;
- enable NHS staff to work more effectively from home;
- support clinical decision making using AI; and,
- improve security and interoperability of national systems used to share data across healthcare.

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Chapter 2

Our Digital Future

Through the use of digital technology, we are seeing huge improvements to patient care, safety and quality, but it has the potential to go beyond this. Digital technology offers solutions to some of the most complex challenges facing the NHS and we want to fully embrace this over the years to come.

A digital revolution in healthcare

Like many other sectors, healthcare is experiencing the 'digital revolution', having recognised the potential that technology has to support and transform the delivery of care. To date, this has most notably been done through digitalised health records. Building on our success, this strategy enables us to further explore and develop the use of digital technology to fundamentally change the way we deliver healthcare in West Kent.

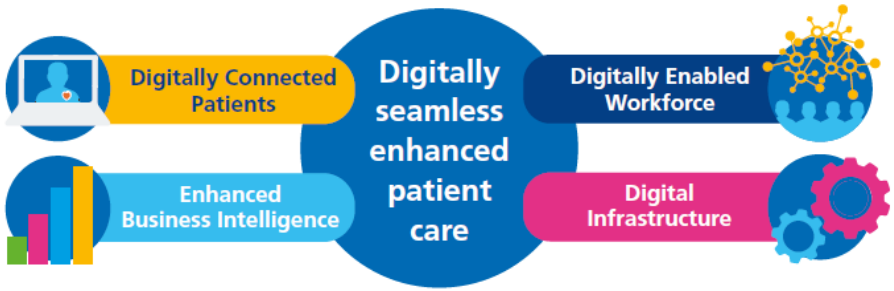
Our digital vision for the future

The 'NHS Long Term Plan' sets out that we, as the NHS, need to continuously adapt to take advantage of the opportunities offered by technology, to continue to serve our patients and to meet future challenges and demand.

The aim of our eHospital model is to help treat patients more effectively by giving healthcare staff easier access to a single version of up-to-date information, to improve care through decision support tools, giving healthcare staff the functionality and data needed to be safer and more efficient. It also opens opportunities for working differently across boundaries, to improve care and how our services are provided by different teams across organisations.

MTW's vision for Digital Transformation is to provide:

'DIGITALLY SEAMLESS ENHANCED PATIENT CARE'



Our digital transformation strategy focuses on four areas:

Patients: who will be able to access their information more easily via patient portals to receive correspondence via email as well as inform us about their condition via apps or through virtual clinics.

Staff: who will be supported to access clinical records quickly and simply, from various systems to ensure they can assess and treat patients more effectively.

Infrastructure: Single sign on and bring your own device will be introduced as well as significant investment in new computers and technology to support this transformation of care.

Information: Data collection will be used to reduce duplication of work, minimise manual data entry and audits, as well as support improvements in patient care and research.

Our **digital transformation** aims to:

FURTHER IMPROVE PATIENT JOURNEYS

Pathways will be more streamlined, outcomes improved, and patients will have greater involvement and engagement with their care. Digitally supported transformation will be business as usual.

STRENGTHEN THE ORGANISATION

Digital processes will be embedded across our organisation as our default way of working, and we will be financially and operationally resilient in our delivery of this.

WORK WITH OUR COMMUNITIES

MTW will play a leading role in establishing Kent as an exemplar region for sharing healthcare data in real-time.

CONTRIBUTE NATIONALLY TO FURTHER DIGITAL TRANSFORMATION IN THE NHS

To be internationally recognised as a centre of excellence for digital innovation in healthcare collaborating with industry, academia and other healthcare providers. We will continue to support other NHS trusts with their advancements in digital maturity by sharing our journey and successes through a series of digital 'blueprints' for others to adopt, and through Trust visits and collaborative activities.

Embracing advancements in technology

There are a number of well-recognised opportunities in digital healthcare which we are keen to embrace further by advancing our digital technology and extending the capabilities of our EPR, including:

- Patient self-management facilitated through access to their own records
- Increasing patient access to information via the internet
- Mobile and remote medicine
- Use of devices for care and management
- Wearable devices
- Robotics Process Automation (RPA)
- Artificial intelligence

Understanding the true value of digital data

As a data-rich healthcare trust our aim is to move away from simply 'analysing' data, to instead understanding the true value of the information we hold on our patients, bringing profound benefits for them and their clinicians alike. Combining clinical data with social and genomic data, for example, will generate comprehensive information that will help to support patients through the delivery of more personalised forms of care in the future, ideally moving from a reactive system to one where maintaining health is a proactive programme.

Extending our cloud-based services with Microsoft Office 2019

Windows 10 and Microsoft Office 2019 will work alongside our IT systems to enhance the administrative side of our work, speeding up many processes from conferencing to communication, helping us to work even more efficiently and effectively across MTW to ultimately benefit our patients. It will also save us valuable time and money.

Office

Our Digital Design Principles

Digital technology is constantly changing and evolving and as a Trust we will be flexible and open to new opportunities. Though we already have key programmes planned, it is important to outline the principles on which we will all be developing digital technology. No single team can deliver digital transformation in isolation, and a number of individuals and teams across the organisation are responsible for developing solutions and implementing improvements.

Digital transformation will continue to be driven from multiple sources, but there is a need for greater cohesion to ensure that we are all moving in the same direction and collectively can meet our digital vision. The Design Principles are a statement of our collective values for the development of digital technology in the future. They have been produced following discussion with staff, patients and partners and have been informed by the Trust Board, the IT Department and with partner IT colleagues in the organisation.

The Design Principles will:

- Provide **governance and oversight** of all digital initiatives, ie, when proposals come to the Business Case Review Sub-Committee they will need to meet each of the five principles in order to be approved.
- Act as a **consultation and engagement tool** to create better conversations around the possibilities for digital transformation.
- Provide **guidance and support** for digital programmes or improvement initiatives that are in planning, development, implementation or review stages, ie, they can be considered success criteria against which a digital programme can be deemed to be effective.

Technology and digital solutions should be Simpler; Connected; Faster; Enabling; and Secure:

Simpler	• We will rationalise the number of systems in use. • We will not replicate complex processes digitally.
Connected	• We will create tools and systems that bring together information from disparate systems. • We will not create closed systems which create silos of information
Faster	• We will develop digital solutions that streamline work for clinicians, improving their speed and efficiency, whilst enhancing the patient experience. • We will not develop inefficient solutions that detract from the patient experience.
Enabling	• We will create digital solutions to transform care pathways. • We will not create solutions in isolation and will learn from others to accelerate implementation.
Secure	• We will develop digital solutions that are safe and secure, and meet our security standards. • We will not support any solutions that put patient data at risk.

For example, if we take desktop technology, the design principles would be applied as below.

Simpler	• Desktop tap-and-go technology simplifies the user's experience, bringing their workspace to them, wherever they are in the hospital.
Connected	• Single sign-on is a user session and authentication service, providing access to multiple applications through one set of login credentials.
Faster	• Desktop provides a modern end-user workspace, utilising enterprise-class technologies to deliver faster access to the tools a member of staff needs to do their job releasing time to care.
Enabling	• Staff will be able to access their workspace from as many devices the application can run from, at anytime, anywhere, even remotely, enabling more efficient ways of working. • By providing access to clinical tools to allow easier access to the clinical information required to better manage care pathways.
Secure	• A shared environment provides a single place for deployment of security updates, impacting all users of the platform. This provides greater protection against vulnerability as inconsistencies between devices are minimised. • Ensuring the standard practice that all files are saved to secure network locations is continued.

Chapter 3

Supporting Our Digital Transformation Strategy

Underpinning the digital transformation strategy our IT infrastructure must meet the needs of the organisation both now and in the future. This includes focusing on our capacity, availability, speed and security. We have projects aimed at increasing storage, providing more applications across the Trust and increase communications (voice, data, video) around the organisation.

Digital transformation is everyone's responsibility, but the IT Department will have a clear role to play and are supportive of change. There are three functions within the IT team to help deliver our future priorities and deliver on the Design Principles.

Clinical Systems Management

Our Clinical Systems Management team is responsible for coordinating engagement with clinicians, staff, patients and partners for a number of key clinical systems. It encompasses all aspects of the successful project and programme delivery of digital solutions, including business analysis, project governance, quality assurance and testing, whilst keeping to budget, adhering to policy, and communicating with teams affected. In addition to this team there are specific system administrators who help support other applications across the Trust.

Digital Services & Infrastructure

This team oversees all current technology in the organisation by coordinating all digital services, including the service desk, network and operations centre, infrastructure, information and data, and training and education. This team also assess and ensures implementation of the appropriate architecture, to mitigate the organisation's risk, ensuring compliance relating to technical security. This team is supported by project managers to ensure specific programmes are delivered.

Our commitment

Our team is already well known for providing excellent support, but we want to build on this and become the enablers to transformation. We want to bring our technical expertise to life in new ways and will be appointing new roles and promoting new skillsets in our teams to achieve this.

We want to be involved at every stage of solution delivery, from identifying the problem to assessing options through to implementation and review. We know that the best results will come where we collaborate and that no single individual or team has the answer. We will work in collaboration with clinicians, staff, and other enabling functions to do what is best for the Trust and patient care.

We will ensure that we tell the 'story' of digital change in a way that helps people understand what benefits they will see, by improving the ways in which we engage with people. As far as possible training should occur where people work and given at the right time rather than in a remote classroom on set days.

We will build and continue to engage with staff patients and partners to deliver the Digital Transformation Strategy. We will build engagement into the way in which we deliver all of our programmes of work. In collaboration with other enabling functions we will lead and support the digital transformation of pathways and new ways of working across the organisation.

Our request

We want to work with staff at every stage of the digital transformation journey. Where we are leading digital transformation we are asking everyone in the Trust to engage with us throughout planning, development and implementation. We want to collaborate to ensure that we get feedback and insights so that we can build solutions that meet the needs of our staff and patients. Not all digital transformation will be led by the IT Department. We want to be working with Trust teams from the time that you first begin to identify a problem. Though it won't be possible to meet all aspirations we want to focus on the good that we can do together.

New leadership and engagement model

In order to support the new Digital Transformation Strategy, the Director of IT, supported by the Programme Director for EPR and Digital Transformation, will provide leadership on digital health and care, across technology and information and set standards and priorities for the Trust. They are our advocates to ensure the importance of digital transformation is considered in every aspect of what we are aiming to achieve in our organisation. They will take a leadership role regionally and nationally, representing the Trust at the highest levels.

We already have a **Chief Clinical Information Officer**, supported by deputies, who is responsible for ensuring that the design, implementation and use of digital technology is done safely and efficiently. In addition, we will be appointing a **Deputy Clinical Information Officer**, recognising the key role that nursing professionals already play in digital transformation and design. These leadership positions will be supported by a nominated triumvirate of **Digital Transformation Leads** for each Division (Clinical Lead, Matron and General Manager). All these roles will have dedicated time allocated to supporting digital transformation. These roles will be a key point of contact for other clinicians and staff. They will provide guidance and leadership and have a central role to play in delivering the Digital Transformation Strategy.

Our IT team will provide guidance and technical expertise to ensure the right solutions are in place for services and that they are developed and implemented through clinicians in order for them to be truly successful. In addition, the IT team will work closely with Transformation and Quality Improvement colleagues to support change across the organisation.

We also have dedicated teams for implementing EPR and also supporting our key clinical systems within the Trust. Eventually, these two teams will merge providing expertise as we move away from our legacy systems towards a single point of information via our EPR portal alongside eNotes.

We have established a **Clinical Digital Design Authority** (replacing the Clinical Advisory Group, CAG). This group, with representation from all clinical areas and divisions, will oversee the Digital roadmap to guide the priorities and projects to deliver the Digital Strategy. They will also own and drive standards throughout the organisation ensuring the digital principles are upheld.

Skillsets and training

To support the structure and the establishment of new roles, we acknowledge that individuals may need training and support.

The use of digital technology will play an increasingly large part in all roles in the NHS. The recent Topol Review estimated that within 20 years, 90% of all jobs in the NHS will require some element of digital skills. The majority of staff will be very digitally adept in their own lives, but this does not always translate to confidence with use of digital technology at work. Part of this is driven by the user-unfriendliness of systems, which are much less intuitive than most current personal technology. We will be working hard to address this over the next 10 years to 2030, including developing a **Digital Transformation Hub** on both sites.

To increase digital confidence, we need to ensure that we are recruiting for the right skills, giving new staff appropriate induction and supporting skilled staff with the right training to develop others. We know that it can be difficult for staff to take time away from their day-to-day roles so we will be looking at how we can deliver technical training differently. We will prioritise training on the ward, rather than in the classroom, where appropriate and will focus on delivering practical training at the right time for users.

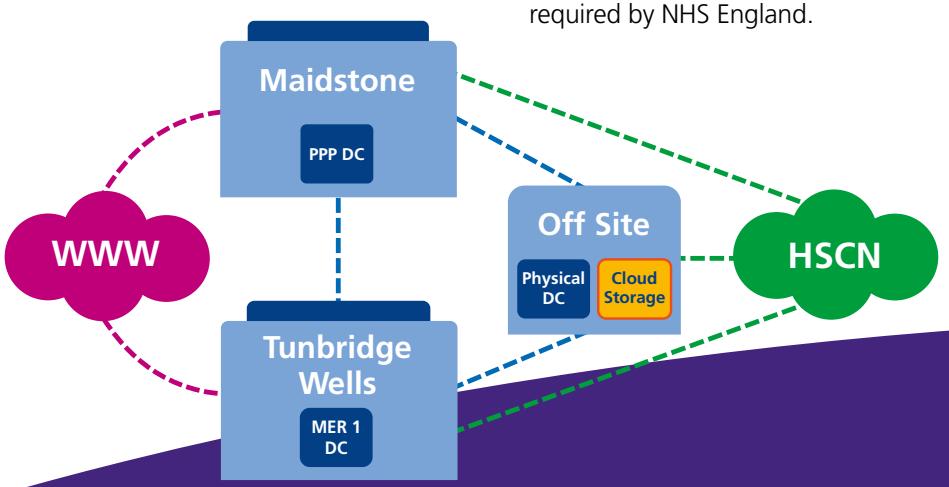
Strengthening our infrastructure

The Health and Social Care Network (HSCN) has allowed us to improve the resilience of our Trust systems, whilst providing the ability to expand its IT capacity in the future. It provides us a platform for further solutions to support our users. Examples include the introduction GovRoam across Kent, which will make it easier for staff to contact to any care network to access network drives and systems, without an additional layer of authentication. This will benefit users such as multi-disciplinary teams, and community midwifes.

The infrastructure developed will also maintain options for collaborative working and/or IT outsourcing opportunities with other NHS organisations moving forwards as well as providing increased resilience for the IT team for specialist roles.

The Trust is required to migrate from Windows 7 and Microsoft Server 2008 by the end of 2020. We will also use this as an opportunity to focus on end user devices. All hardware or software replacement, migration or upgrade will be completed with the clear objective of ensuring that the IT estate maintains a warranted environment, based on Microsoft and Cisco best practice to ensure it is manageable and sustainable in the future.

We will also focus on cyber security, ensuring that all solutions have the latest security patches installed and being proactive in addressing new vulnerabilities. This includes ensuring that the Trust obtains the Cyber Essentials Plus accreditation, as required by NHS England.



Our Digital Prioritisation

In order to address the Trust's current digital maturity challenges and to deliver a strong foundation for the future, a significant amount of work must be done. We have heard from our staff that technology is outdated and hard to use, and there are areas where improvements need to be made to keep pace, as well as the need for more innovative forward-looking technology. Digital initiatives can be described as falling into three stages:

- **Maintain**: necessary work that needs to occur to address immediate issues and prevent problems from occurring;
- **Improve**: work to improve current systems and ways of working; and
- **Transform**: work that fundamentally changes how we work and operate.

While work will need to be undertaken to address current issues, solely focusing on these activities will not help us to achieve our goals or keep pace with technological change. The IT department has a prioritisation approach, and has worked closely with clinicians, care groups and partners to understand key priorities. This takes a balanced approach to rank priorities using weighted categories to ensure that we are focusing on things that will make the biggest impact. These categories include:

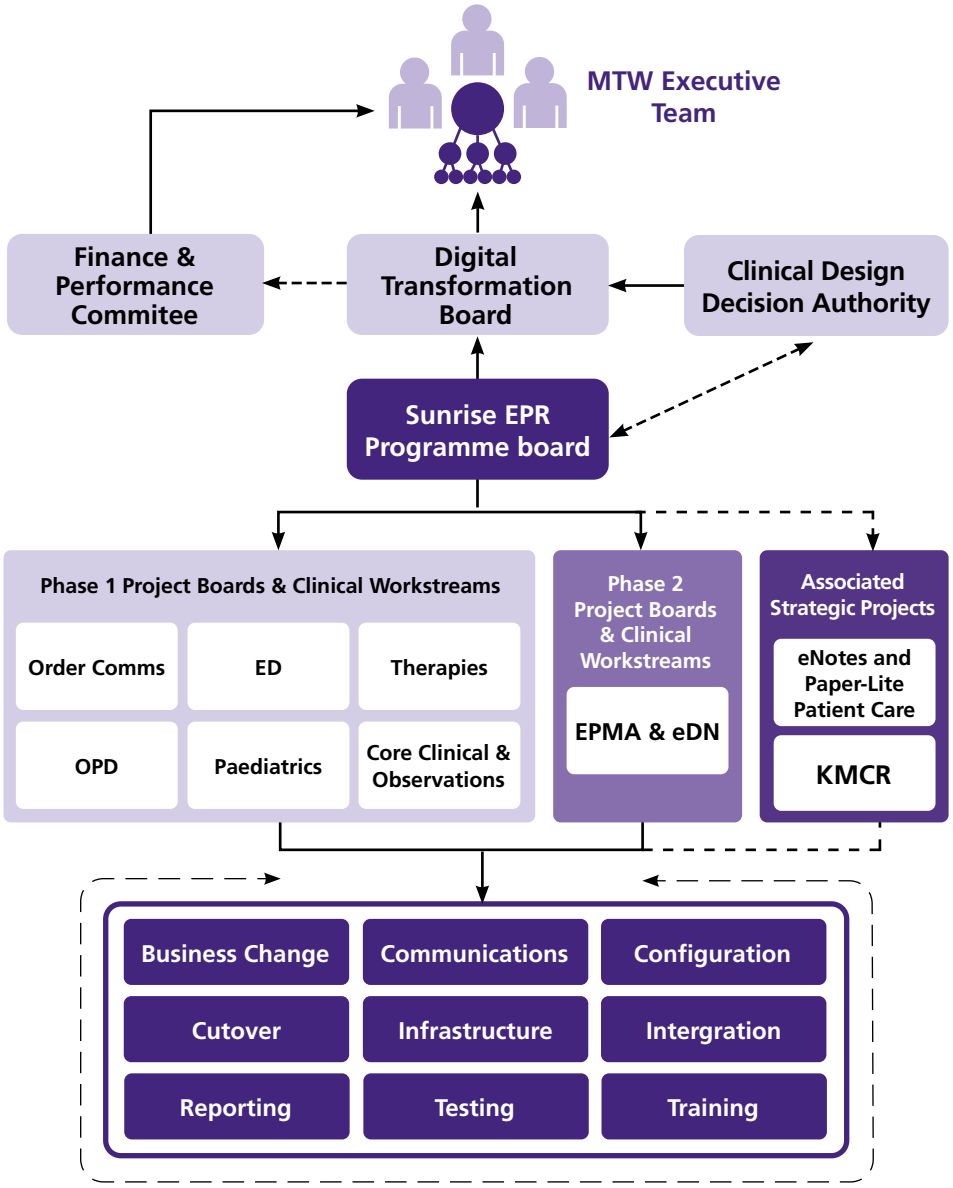
- **Risk**: level of corporate and clinical risk of not implementing
- **Benefit/Return on investment:** level of corporate and clinical benefit delivered against investment
- **Business imperative:** meeting Executive and Board priority and national mandates
- **Time criticality:** on phasing of implementation
- **Funding availability:** for implementation and support
- **Resource consumption:** required to implement

We will continue to work directly with clinicians to review this approach across the life of the Digital Transformation Strategy to ensure we are pursuing the right priorities.

Robust governance

We have identified that as a Trust there is too much fragmentation and diversity in the digital solutions we have in place, and the ways in which they are used. The Design Principles outlined earlier identify the standards that the Trust will collectively work towards and this will be supported by robust governance.

There is a clear line of governance and oversight from the Board downwards (see overleaf for diagram). We know there are additional key governance forums not shown on this diagram and there must be consistent messaging across the Trust.



Enabling Workstreams

All proposals for digital investment will be reviewed at the Business Case Review Panel. Business cases for IT must demonstrate how they meet the Design Principles, in addition to existing requirements to show alignment with the Trust's strategic aims and good programme management. Guidance and advice will be provided to assist with developing business cases through the Digital Transformation Board.

Chapter 4

Delivering Our Digital Transformation Strategy

The Trust's vision is to be more responsive and focused on improvement, to fulfil its potential and be the high performing organisation its patients and staff deserve. The aim is to be a Trust where patients choose to be treated and the best people aspire to work.

The Trust aims to deliver the vision through its values:

- **Patient First** we keep the patient at the heart of everything we do
- **Respect** we respect and value our patients, visitors and staff
- **Innovation** we take every opportunity to improve services
- **Delivery** we aim to deliver high standards of quality and efficiency in everything we do
- **Excellence** we take every opportunity to enhance our reputation

IT systems and infrastructure, information and data sharing, are identified as central to ensuring that teams have the tools and support they need to succeed. The Trust Strategy identifies the importance of IT and system investment, addressing current gaps and issues, and ensuring that solutions are integrated across the community, and beyond.

To deliver against this aim, a number of programmes of work have been identified and will form part of a ten-year implementation plan. These programmes are designed to organise the many strands of work that need to be completed, and the implementation plan will be used to organise resources and plan for the future. This high-level plan outlines our intention to meet our Digital Transformation Strategy building on work done so far. A further detailed plan will be made available at the start of each year to deliver the roadmap ensuring that we remain agile to respond to the latest technology that is available and to provide the right solution for patient care at all times.

Digital transformation is an important foundation upon which greater transformation can occur. The implementation plan will deliver benefits against all of the Trust's strategic aims. The below diagram outlines each of the programmes of work, and highlights where each programme delivers benefits against the Trust's values.

	Patient First	Respect	Innovation	Delivery	Excellence
Delivering the Strategy				x	x
Enabling the patients	x	x	x	x	x
Enabling the workforce		x	x	x	x
Digital records & interoperability	x		x	x	x
Protecting patient information	x	x			x
Strengthening digital health care systems	x		x	x	x
Strengthening infrastructure	x		x	x	x
Enabling patient flow & integrated care	x	x	x	x	x
Beyond MTW	x		x	x	x

On the next few pages you will find a summary about each programme of work including the desired outcomes and key projects. More detail about the programmes can be found in the supporting implementation plan.

Delivering the Digital Strategy

Why	Outcomes to Achieve	Highlight
The Digital Transformation Strategy begins with this document and work will need to be undertaken to make sure that it is embedded in the organisation and structures are put in place for the objectives to be realised.	• Launch and communicate the Digital Strategy to support successful delivery of the objectives • Establish necessary governance and prioritisation arrangements to support the Digital Transformation Strategy • Create the teams and skillsets to support the delivery of the Digital Strategy • Engage with staff, partners and patients to support the delivery of the Digital Transformation Strategy • Regular measurement of benefits delivered and review of progress against the Digital Transformation Strategy • Develop strategic outline business case for investment over 10 years to deliver our eHospital	Launch and embed the new governance structure and roles Produce a clear two-year rolling roadmap for investment in digital transformation which is responsive to technology advancements

Enabling Patients

Why	Outcomes to Achieve	Highlight
Patients are keen to see improvements in current technology, and in exploring how digital improvements could change the way in which they receive care, enabling them to take the lead and giving them more choice.	• Enable patients to have more choice over how they receive care and provide options to access their personal information • Improve patient and visitor navigation around the Trust • Continually improve patient and visitor Wi-Fi throughout the Trust • Support divisions and specialities to implement tools and technology to support research and innovation • Provide patients with more opportunities to access information and give feedback	Deployment of the patient portal Development of personal health record through which patients will be able to directly access information about their healthcare e-referrals for Outpatient appointments to be triaged electronically and stored in eNotes Digital self-check-in to be deployed at Maidstone Hospital Introduce Apps to support patient care and remote monitoring Provide mobile devices for patients to stay in contact with family and friends

Enabling the Workforce

Why	Outcomes to Achieve	Highlight
We have heard from staff that many of our current systems and technology are a point of frustration and provide a barrier to delivering great patient care. **We know that we need to plan for different ways of working in the future, and are aware of the digital capabilities, training and culture we need to create.**	• Enable staff to document patient care within a single electronic patient record • Enable staff to prescribe and manage medicines safely and digitally by delivering a Trust-wide medicines administration solution • Enable staff to communicate and collaborate more quickly, reliably and securely • Provide the necessary infrastructure to enable mobile working • Support staff to work differently utilising new digital innovations to address fundamental workforce challenges	Move towards a fully managed service which will see total replacement of legacy hardware with roll out of Windows 10 & Microsoft Office 2019 Introduce EPR system within the Trust that has tab integration to provide a portal into key clinical systems Introduce Trust-wide electronic prescribing and medicines management, enabling staff to prescribe and manage medicines safely Expand remote access to allow improved working from home for employees as well as introduce a catalogue of approved conference call facilities, such as Webex or Microsoft Teams that works best for meetings / providing clinical care Invest in improved finance and procurement systems Introduce improved communications tools and analysis technology; Develop and fully utilise ESR self-service for managers Introduce single sign on for all staff

Digital Records and Interoperability

Why	Outcomes to Achieve	Highlight
The Trust has significant number of applications of which there are over over 40 clinical systems, many of which are silos of information that some clinicians cannot access. **Where systems can be accessed there are many to navigate with time-consuming logins and access obstacles to overcome. Systems may contain different versions of the same data, which could lead to inconsistencies and potential safety concerns.**	• Deliver a single clinical information portal, giving a unified clinical view of patient care data for staff, with information from a variety of clinical systems • Improve our digital maturity as a Trust and start our journey to reach HIMS level 6 by 2030	Continued evolution of the EPR system to providing staff with a unified clinical view using tab integration as required Further develop and enhance eNotes to support our paper light Trust strategy Implement new RIS system which is tab integrated with the EPR Implement a mechanism to safely store medical photography images which can be accessed via the EPR Consider the introduction of AI and RPA technology

Protecting Patient Information

Why	Outcomes to Achieve	Highlight
Following the 2017 WannaCry attack cyber security in healthcare is high on the national agenda. NHS England has initiated a cyber programme of work to address serious security failings within the NHS. It is important that patients know that their personal information and data is kept safe.	• Deliver a safe and secure Security Architecture which protects the Trust's data and assets	Deliver a robust cyber security strategy covering governance arrangements, data classification and data handling, cultural improvements and the establishment of a Cyber Security Operations Centre

Strengthening Digital Healthcare Systems

Why	Outcomes to Achieve	Highlight
There are systems in use around the Trust which are either out of date, unsupported, or lack key functionality. Any change in clinical systems should be led by the Design Principles with support from the IT Department to ensure we are meeting our strategic ambitions.	• Support the replacement and improvement of priority clinical information systems • Collaborate with divisions and teams to identify appropriate decisions in relation to end-of contract and end-of-life digital healthcare systems	Develop and implement a roadmap for the EPR and systems currently supporting clinical speciality areas

Enabling Hospital Flow and Integrated Care

Why	Outcomes to Achieve	Highlight
Managing the flow of patients through the hospital efficiently, especially those admitted via the Emergency Department for unscheduled or urgent care, is critically important.	• Deliver digital solutions to enable improved patient flow • Digitise workflow to support and enhance patient care across the Trust	Introduce touchscreen technology to enhance live bed management system Introduce patient tracking and RFID technology Enable eTriage within ED at both sites Extend Trauma Board for emergency surgery

Strengthening Digital Infrastructure

Why	Outcomes to Achieve	Highlight
In order to deliver the ambitions of the Digital Strategy the Trust needs to invest in the necessary hardware and software infrastructure.	• Maintain and improve the Trust's data centre and network capability, capacity and performance • Support patient care through the management and tracking of medical equipment and devices, ensuring they are in the right place at the right time	Refresh the Trust's data centres, servers and networks Replacing end-of-life equipment and providing the digital infrastructure to support the Trust Introduce Windows 10 across the organisation Introduce a Trust-wide asset tracking system and management solution for medical equipment and devices

Beyond Maidstone and Tunbridge Wells Hospitals

Why	Outcomes to Achieve	Highlight
Our patients, staff and partners report frustration with the difficulty of sharing information with organisations beyond MTW. **We and our system partners are committed to improving the use of digital technology to enable us to share clinical information with our care partners more effectively, helping to improve care for patients wherever they receive treatment.**	• Support the implementation of STP-wide solutions which create greater system integration and digital interoperability • Support the delivery of the Local Digital Roadmap for the ICP • Enable staff to connect securely to digital healthcare systems from wherever they provide patient care	Implement STP-wide digital systems for Pathology Enrich the KMCR, improving access to patient information, supporting clinical decision making

What this Means for Me

Patients will be able to say:

- I have more information and know more about my care and what to expect. I have the opportunity to access my information in a way that suits me and have confidence that it will be kept private and secure.
- I can tell my story once and know that my information will follow me around the hospital and beyond.
- Technology helps me to do more, for example navigating around the hospital sites, managing my appointments and supporting the management of my long-term condition.
- Technology helps me to have more choice and control over my care, and where appropriate I have flexibility around where and how I receive treatment.

Staff will be able to say:

- Digital technology helps me to do my job well now and in the future.
- I am able to access relevant information at the right time and in the right place. It is easy for me to find the information I need, without having to access multiple systems.
- I have confidence that the data I access can be trusted and know that all my colleagues have the same information.
- Doing things digitally helps to make everything we do more efficient, and I do not have to waste time or duplicate effort. This makes more time for me to focus on the work that really matters.
- Digital technology helps us to work together and collaborate with partners to deliver the care and experiences that are best for patients, wherever that care is delivered.
- I have the support I need to get the best out of digital technology. I know who to speak to when I want to know more about what digital transformation can do for me and my team.

What this will mean for the Trust and the healthcare system:

- Information can be easily and safely shared with other health and care organisations. This will support joint working and deliver more responsive and safer communication centred on the patient.
- We continue to improve our digital maturity which will help us to realise our potential as a digital leader providing state-of-the-art digitally enabled healthcare.
- We are integrated with our local partner organisations. We are strategically aligned and moving in the same direction. We learn from each other, share insights and collaborate to deliver the right solutions for our communities.
- Digital technology helps us to deliver care differently in the community and wider healthcare system that meets the population's needs now and in the future. It helps to remove boundaries between organisations to ensure that patients are receiving care in a way that best meets their needs improving wellbeing and delivering a sustainable system.

NHS
Maidstone and Tunbridge Wells NHS Trust

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

The Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training) 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]

Assurance (and to provide Trust Board members with the annual infection control refresher training)

[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

2019/20 Annual Infection Prevention and Control Report

and

2020/21 Healthcare Associated Infection Reduction Plan

Director of Infection Prevention and Control Annual Report to the Board
Author: Dr Sara Mumford
October 2020

Maidstone and Tunbridge Wells NHS Trust

2019/20 Annual Infection Prevention and Control Report and 2020/21 Healthcare Associated Infection Reduction Plan

Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2019/20 and the broad plan of work for 2020/21 to reduce the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI for patients.

A zero tolerance approach continues to be taken by the Trust to all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the number of infections. Additionally the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements including commissioning CCGs, SECAMB, other local NHS Trusts and the members of the Kent and Medway STP HCAI and antimicrobial stewardship steering group and its subcommittees

Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's IPC activity in 2019/20. In addition it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The report also provides a briefing and training for Board members on the key information they need to fulfil their duties with respect to infection prevention and control.

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control strategy and programme of activities including national initiatives for the reduction of infection rates.

The Infection Prevention and Control Team (IPCT) advises and co-ordinates activities to prevent and control infection; however, it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPCT also works closely with other stakeholders in relation to strategies for

prevention of infection including NHSI, Commissioning CCGs, Public Health England and Regional Specialist Laboratories.

There are national contractual reduction objectives for *Clostridium difficile* infections and there are five other infections for which mandatory reporting to Public Health England is in place.

Clostridioides difficile infections

Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections

Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

Eschericia coli (E. coli) bloodstream infections

Klebsiella spp blood stream infections

Pseudomonas aeruginosa blood stream infections

In March 2020, SARS-CoV2 (COVID-19) was added to the list of reportable infections mandated by Public Health England.

In addition, MTW became a Sentinel site for reporting Influenza infection in October 2019 and also reports on cases of Respiratory Syncytial Virus (RSV) through the same reporting route.

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

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

Governance and Monitoring

1.1 IPC Governance

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

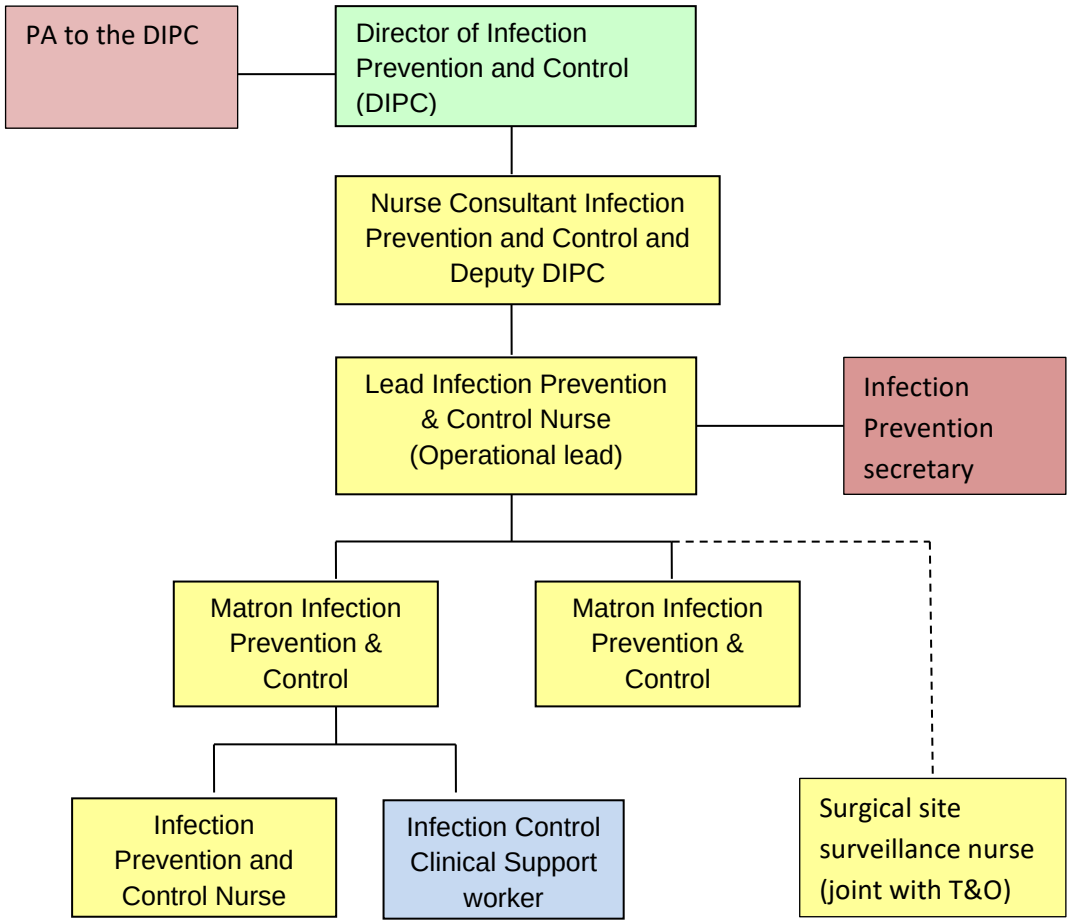
The Director of Infection Prevention and Control (DIPC) is a consultant microbiologist and reports directly to the Chief Executive Officer

The DIPC is supported by the Deputy DIPC (Nurse Consultant in Infection Prevention and Control) and the IPCT (Fig 1). The team welcomed Charlotte Campbell as a B6 infection control nurse during the year

The DIPC delivers an Annual Report to the Board of Directors and the forthcoming HCAI Reduction Delivery Plan based on the national and local quality goals.

The Trust Board receives a monthly IPC report, more frequently or on an ad hoc basis if required. *C. difficile* and MRSA and *E.coli* blood stream infection numbers and rates are detailed on the Board level dashboard together with MRSA screening rates.

Fig 1: Structure of the Infection Prevention and Control Team



Directorates report to the Infection Prevention and Control Committee on IPC matters. The structured reports delivered by the directorate representatives include ward audit results, triangulation audits provided by the infection prevention team and antimicrobial audits provided by the antimicrobial pharmacist. The reports are also used to feedback to directorate clinical governance meetings on infection prevention matters.

West Kent CCG was MTW's main commissioning organisation during 2019/20. IPC is a key element of quality commissioning and forms part of the joint commissioning quality schedule.

The *C. difficile* panel meets monthly on each hospital site and reviews root cause analysis reports from all Trust attributable cases of *C. difficile* and MSSA blood stream infections. The panel reports to the main Learning and Improvement (Serious Incident) panel and also sends an annual summary report to the IPCC.

MRSA blood stream infections are declared as Serious Incidents and reports go directly to the main Learning and Improvement Panel

1.2 Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets bi-monthly. The committee has wide representation from services within the Trust and has external representation from West Kent CCG and Public Health England. The Chief Nurse is the Executive Director member of the committee

The IPCC reports to the Quality Committee, a sub-committee of the Board

The clinical directorates report to the IPCC on all aspects of infection prevention and antimicrobial stewardship. Additional reports are received from estates and facilities, the vascular access team, the antimicrobial pharmacist, occupational health, risk manager, decontamination lead and others as required.

The objectives of the IPCC include:

- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Quality Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC requirements as set out in the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).
- To inform the Quality Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control

The IPCC reviews the IPC related risks in the risk register and receives reports from the risk manager three times per year.

1.3 Surveillance

The IPCT undertakes continuous surveillance of target organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precaution for each case and monitors overall trends.

The IPCT uses the ICNet surveillance system.

The IPCT actively participates in national surveillance schemes, submitting epidemiological data on all *C. difficile* cases, MRSA, MSSA, *E. coli, Klebsiella* and *Pseudomonas* blood stream infection patients and selected surgical site infections to Public Health England (PHE).

The IPC team visit patients at regular intervals according to their infection or possible infection. Such infections/conditions are listed below:

1.3.1 Alert organisms

MRSA

Clostridioides difficile infection (CDI)

Group A *Streptococcus*

Salmonella spp

Campylobacter spp

Mycobacterium tuberculosis

Glycopeptide-resistant *Enterococci*

Multi-resistant gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL)producers

Carbapenem resistant and Carbapenemase-producing Enterobacteriaceae (CRE/CPE)

Neisseria meningitidis

Aspergillus

Hepatitis A

Hepatitis B

Hepatitis C

Influenza

Norovirus

1.3.2 Alert Conditions

Measles

Mumps

Chicken pox and Shingles

Scabies

Two or more possibly related cases of acute infection e.g. gastroenteritis such as norovirus

HCAI Reduction Priorities for 2019/20

The national HCAI objectives for MTW for 2019/20 set by NHSE were:

- MRSA – a continued zero tolerance to all MRSA blood stream infections
- CDI – to have no more than 55 patients with Trust-attributable CDI.

In addition the HCAI action plan set out to:

- Maintain low levels of MSSA blood stream infection
- Reduce gram-negative blood stream infection

1.4 *Staphylococcus aureus*

All *Staphylococcus aureus* blood stream infections, whether sensitive to Meticillin (MSSA) or resistant to Meticillin (MRSA), are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System (DCS). The Trust's incidence of MSSA and MRSA cases is reported on the fingertips data base together with other HCAI data https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/0/gid/1938133070/pat/158/par/NT_trust/ati/118/are/RWF

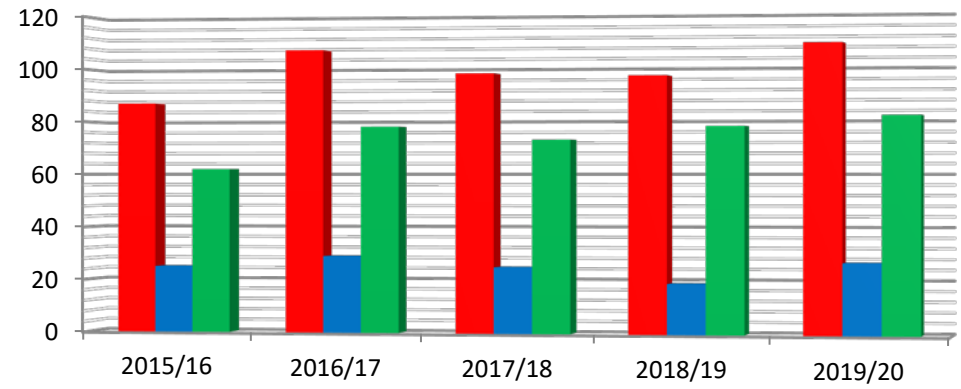
The incidence of these cases is reported publicly as acute Trust attributable or otherwise. The reduction of all avoidable blood stream infections including MSSA and MRSA continues to be an aim of the Trust

1.4.1 MSSA

There is no national objective set for MSSA bacteraemia.

All Trust-attributable (those occurring from day 2 after admission) cases of MSSA blood stream infection have a post – infection review including root cause analysis and presentation of the case at the Infection Control Review Panel.

Fig 2: MSSA bacteraemia cases

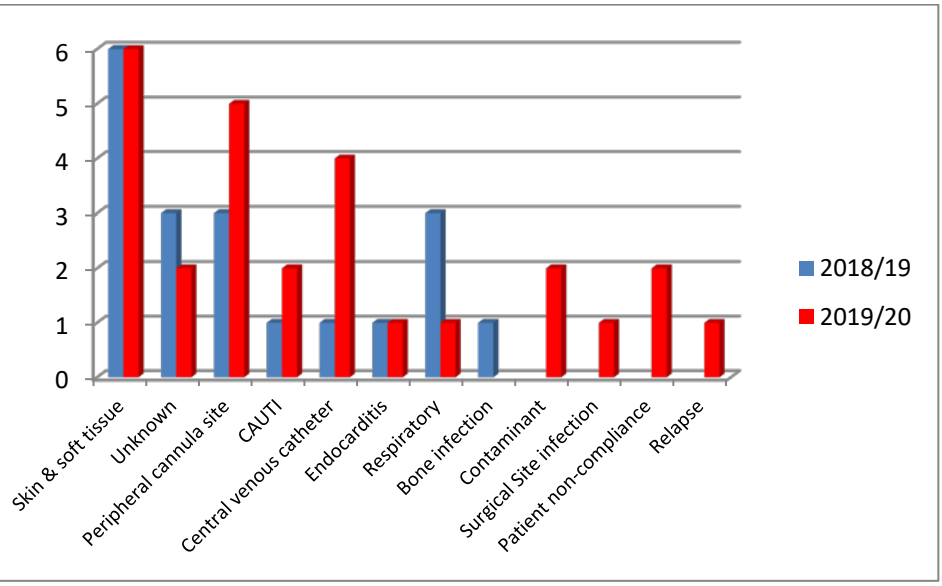


	2015/16	2016/17	2017/18	2018/19	2019/20
Total	87	107	98	97	109
Trust cases	25	29	25	19	27
Non-Trust cases	62	78	73	78	82

The improvements of the previous year were not sustained and the number of hospital acquired cases increased by eight cases. Eleven cases were found to be avoidable including two contaminants and seven device related infections.

Figure 3 shows the root causes of infections compared with 2018/19

Figure 3: MSSA bacteraemia provenance 2018/19 – 2019/20



1.4.2 MSSA screening

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

1.4.3 MRSA

There was no national HCAI objective for MRSA blood stream infections for 2019/20. However there was an expectation that no avoidable infections would be seen.

Cases are initially defined as non-trust apportioned if blood cultures are collected on the day of admission or the next day. All other cases are apportioned to the Trust. The national requirement for MRSA Post Infection Review (PIR) was withdrawn this year; however the Trust and WKCCG continued to use the process to apportion cases.

In line with the PIR process the Trust investigates every MRSA blood stream infection in collaboration with other care providers associated with the case. This process identifies lessons to be learned across the patient's pathway and determines the final assignment of the case to the CCG, Trust or Third Party.

The Trust has reported five non Trust apportioned cases and two Trust apportioned cases pre-PIR. The final assignment of cases is shown in Table 1. Following the PIR of all of the cases, two were finally assigned to the Trust. The Trust apportioned cases were declared as Serious Incidents and further investigated through the SI process.

Table 1: MRSA Apportionment and Final Assignment

Month	Apportioned		Final assignment		
	Non trust	Trust	CCG	Trust	Third Party
April	1		1		
May					
June					
July	1			1	
August	2	1	1	1	1
September					
October					
November					
December					
January					
February					
March	1	1	1		1

1.4.4 MRSA screening

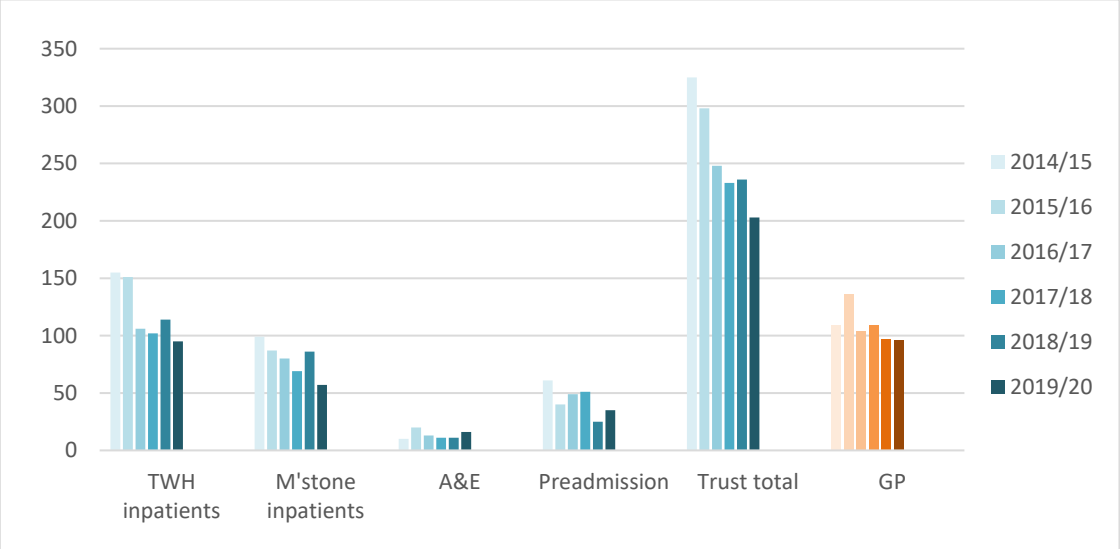
The Trust continues to use a robust approach to screening the majority of patients, either pre-operatively or on admission. Since 2009, it has been Trust policy to screen all

elective admissions (except for certain excluded groups) to comply with Department of Health policy. New guidance was published by the Department of Health in June 2014 (*Implementation of modified admission MRSA screening guidance for NHS* (2014). The guidance outlines a more focussed, cost-effective approach to MRSA screening. Following the publication of the guidance the screening at MTW was reviewed and revised. The revised policy was implemented in November 2014. As a consequence of this there has been no increase in the incidence of MRSA bacteraemia within the Trust and further revision has not been required

New patients who are colonised are usually identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. Colonised patients are also identified as a result of clinical samples. In turn, this allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients. Patients who remain in hospital for more than a week are rescreened on a weekly basis.

Patients who are known to be colonised are commenced on the decolonisation protocol on admission

Figure 4: New MRSA colonisations 2014-20



Screening compliance is monitored on a monthly basis. During 2019/20 the elective MRSA screening was maintained at or above 98%. Non-elective screening compliance (within 24 hours of admission) was maintained at or above 90%.

The number of patients who may have acquired MRSA colonisation in hospital is also monitored. For 2019/20, 17 such cases were identified at Maidstone Hospital and 14 cases at TWH. There were several investigations into possible cross infection. None of these was found proven.

1.4.5 Periods of Increased Incidence

Where two or more new (post 48 hour) acquisitions (whether related or not) of MRSA colonisation are identified by screening on the same ward, a Period of Increased Incidence (PII) is declared for the ward where the acquisitions occurred. A single case of MRSA bacteraemia will also trigger a PII.

When the PII is declared the following actions are taken:

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

1.5 *Clostridioides difficile* infection (CDI)

The CDI PHE objective for MTW for 2019/20 was no more than 55 cases. This is a significant increase on the previous year's limit of 26. The reason for this is the change in definition and apportioning of *C. difficile* cases

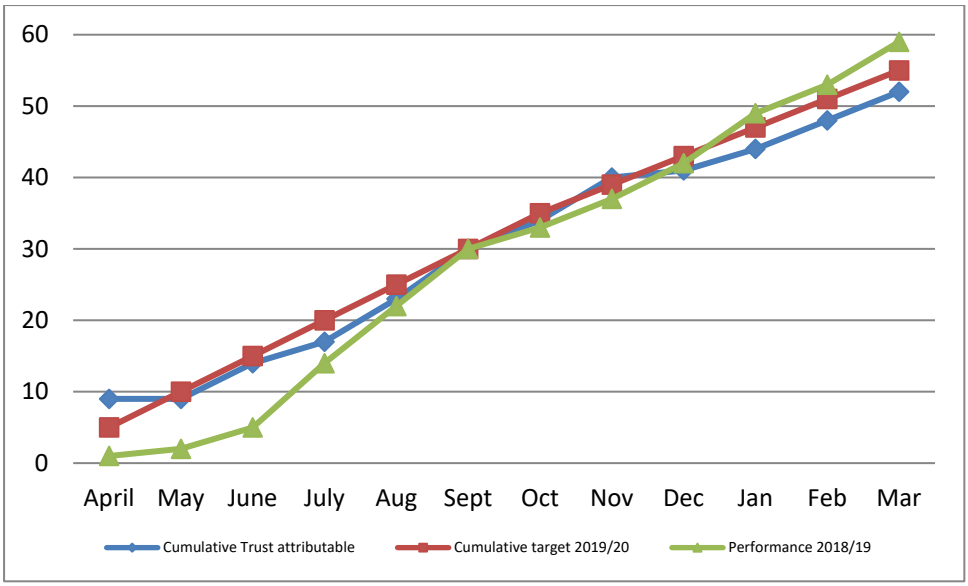
Cases are now split into one of four groups:
Hospital-onset healthcare-associated (HOHA) - Date of onset is ≥ 2 days after admission (where day of admission is day 1)
Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode
Community-onset indeterminate association (COIA) - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode
Community-onset community-associated (COCA) - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

Only healthcare in acute Trusts counts towards the definitions.

For 2018/19 there were 40 Trust-attributable cases under the criteria at that time. If those cases were reassessed under the new criteria there would have been 46 HOHA cases and 13 COHA cases, a total of 59 Trust-attributable cases

In 2019/20 a total of 52 Trust attributable cases were seen, 37 HOHA cases and 15 COHA cases, a total rate of 21.4 cases per 100 000 bed days (compared with 22.8 for the previous year).

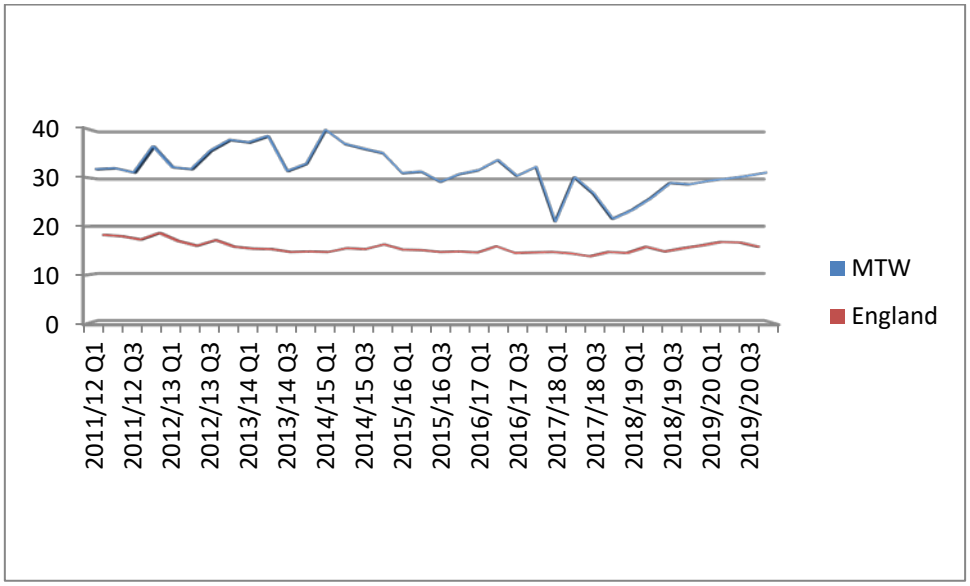
Figure 5: C. difficile performance against trajectory (new definitions)



1.5.1 Laboratory Diagnosis

C. difficile tests are processed on diarrhoea samples from all inpatients aged 2 years or over, all GP patients aged 65 and over and all other GP patients aged 2 and over where symptoms suggestive of *C. difficile* infection or antibiotic use are included on the request form, whether or not the test is specifically requested. During 2019/20, the microbiology laboratory processed 6642 samples for *C. difficile* including those from GP patients, inpatients in acute or community settings, MTW A&E and outpatient attenders.

Figure 6: C. difficile toxin tests per 1000 bed days compared with England average

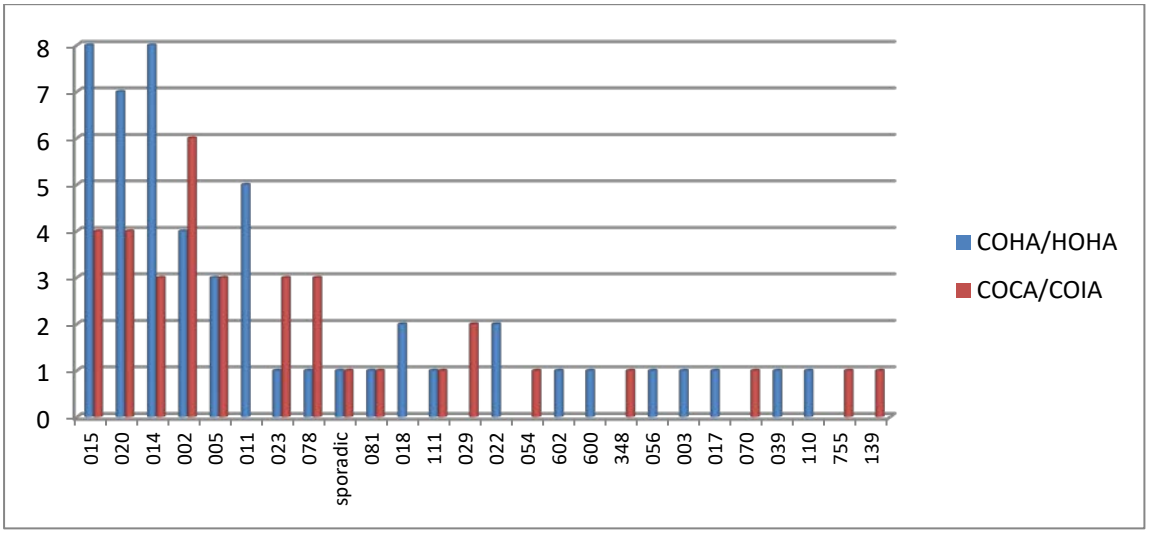


109 patients were newly identified as carriers of toxigenic *C. difficile* (143 in 2018/19). A treatment algorithm is in place to enable identified carriers at high risk to be treated to avoid progression to acute infection.

All toxin positive cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Further testing can be requested where a link between cases is possible.

Typing of hospital cases tends to reflect those types prevalent in the community. Type 014 tends to be related to a higher rate of relapse and is prevalent in both hospital and community cases. The monitoring of ribotypes will continue in order to detect any trends or cross infection and to give an early warning of any new epidemic strains emerging.

Fig 7: Ribotyping of *C. difficile* cases 2019/20



1.5.2 Case review

All cases of *C. difficile* infection (CDI), both community acquired and in-patient, are assessed by root cause analysis investigation. The IPCT works collaboratively with the CCG infection control teams to investigate COHA cases.

Root cause analysis multidisciplinary meetings are held for all HOHA and COHA cases. This enables any lessons associated with cases arising in the community to be learned and ensures that the impact of inpatient treatment on patients is understood. Following the multidisciplinary meeting the case goes to the *C. difficile* panel where the RCA is examined by the DIPC and Chief Nurse or their deputies. There is an expectation that the ward manager and consultant for the case will attend as a minimum.

The panel considered 51 of the 52 hospital-attributable cases. The case not considered was a patient who repeated relapsed and had two previous RCAs.

Table 2: Outcomes of root cause analysis

Treatment failure	Inappropriate antibiotics	Immuno-suppression	Community antibiotics	Appropriate antibiotics
2	11	1	1	35

One case of treatment failure was due to a failed faecal transplant in a case of recurrent relapse. Eleven cases were found to be avoidable, ten due to inappropriate antibiotics and one due to incomplete treatment leading to a relapse.

Twenty four cases were found to have lapses of care which may have affected their outcome. These include delayed stool sampling (13), Antibiotic guidance not followed (14), and delay in isolation (3). Six cases had more than one lapse of care.

Actions plans were developed in response to all identified issues. The wards are monitored by infection prevention team audits and antibiotic prescribing audits throughout the periods of increased incidence (PII) and are subject to spot checks after the PII has been stepped down to ensure that sustainable change has been made.

1.5.3 Periods of Increased Incidence

The concept of Periods of Increased Incidence was introduced in the 2009 HPA/DH guidance '*Clostridium difficile* – How to deal with the problem'.

The guidance recommends that a PII should be declared when two cases occur in the same clinical area within a 28 day period. At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed. This increased response to a single case was implemented to identify and resolve any issues on the ward or associated with antibiotic prescribing in a timely way and has been successful in mitigating the risk of a second case occurring.

In response to the PII declaration, several actions have to be taken:

- Weekly audits of antibiotic prescribing by the antimicrobial pharmacist
- Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time
- If poor audit scores are seen, an escalation meeting is held between the ward manager, matron and infection prevention to assess the need for additional support and training from the IPT
- Increased cleaning with throughout the ward with all single rooms decontaminated on discharge by either UV-C light or HPV fogging (depending on risk)
- Daily review by the infection control team
- When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained. If a ward fails a spot check, the PII is re-declared

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

Additional actions taken when an incident is declared include holding a multidisciplinary investigation meeting and intensive infection prevention team support.

During 2019/20, thirty five PIIs were declared for *C. difficile*, sixteen at Maidstone and nineteen at TWH. Five wards had two PIIs during the year, three wards had three and one ward had five. The PIIs lasted an average of five weeks with the longest period being nine weeks. The majority of wards achieved the standard required in four weeks or less.

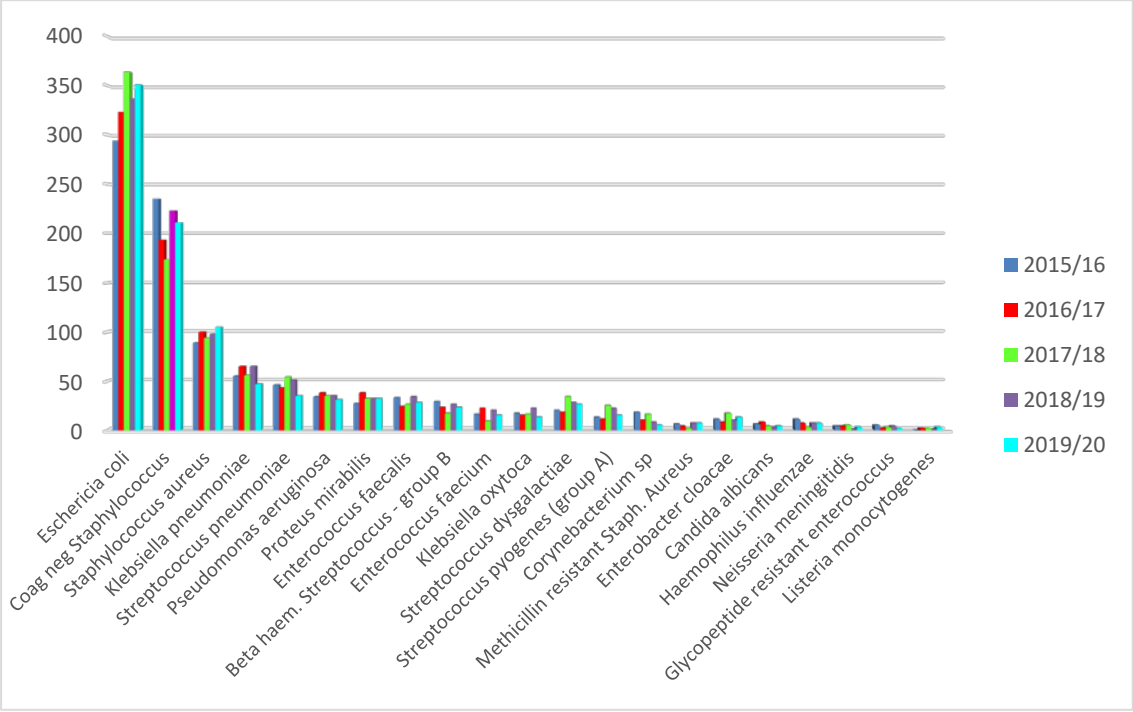
1.5.4 Non-Trust attributed CDI cases

There was a decrease in the number of patients with non-Trust attributable CDI from 47 cases in 2018/19 to 36 cases in 2019/2020

1.6 Blood stream infections

A total of 1103 patients had positive blood cultures during 2019/20, a small decrease (7 patients) on the previous year. *E. coli* is the commonest organism causing blood stream infection in the Trust accounting for around 32% of all positive cultures.

Figure 8: Commonest significant isolates from Blood cultures 2015-2020



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

1.6.1 Gram negative blood stream infections

In June 2017, NHS Improvement set a national ambition to reduce healthcare associated gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021. These include:

- *E. coli*
- *Klebsiella species*
- *Pseudomonas aeruginosa*

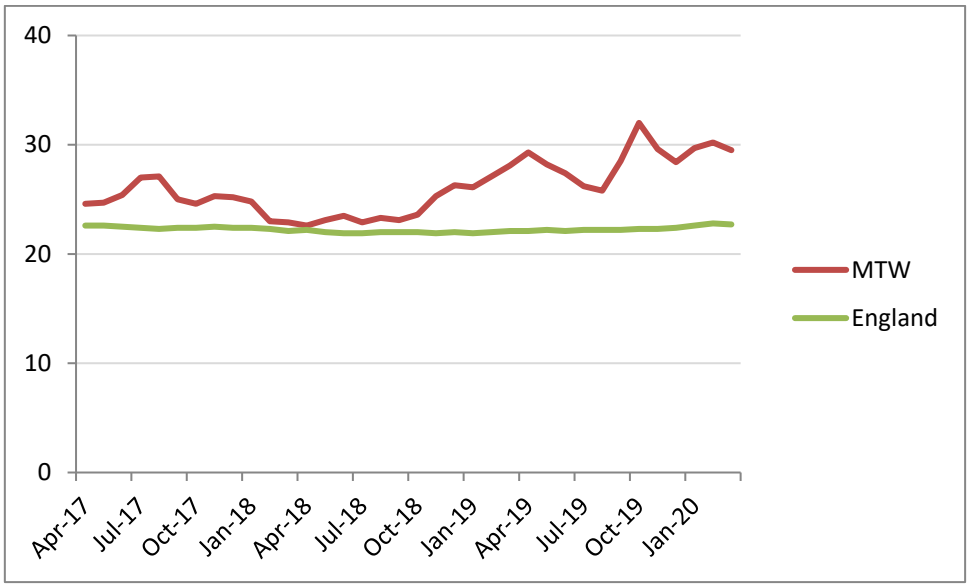
The Trust has been submitting *E. coli* surveillance data to PHE for many years and from April 2017 *Klebsiella species* and *Pseudomonas aeruginosa* data was also required

1.6.2 *Eschericia coli (E. coli)* bacteraemia

E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli* and while some live harmlessly in the intestine, others may cause a variety of diseases. *E. coli* bacteraemia may be caused by primary infections such as urinary tract infections, biliary tract infections and others, spreading to the blood. The MTW rate of *E. coli* infections for 2019/20 was 30.9/100 000 bed days compared with an England rate of 22.7/100 000 bed days. *E. coli* is the commonest cause of bacteraemia (all sources) seen in MTW

The 12 month rolling average of cases shows that the Trust has made no impact on reducing Trust-attributable *E.coli* infection. The national rate has also remained steady throughout this period

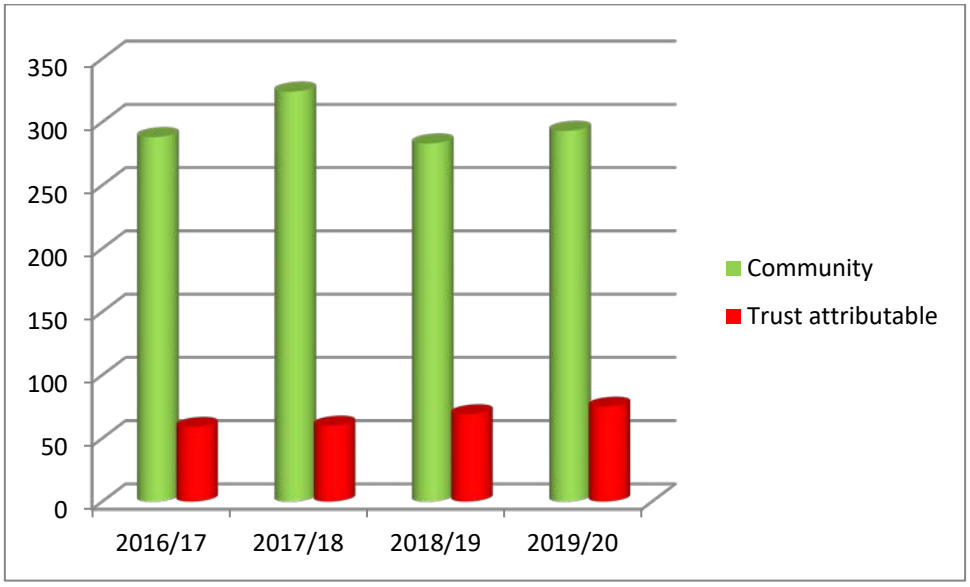
Figure 9: Twelve month rolling average of E.coli infections



There has been a slow but constant increase in gram negative bacteraemia despite interventions such as improvements in urinary catheter management. The trend analysis suggests that about 29% of *E. coli* sepsis is due to urinary tract infection sepsis in the

last year. The range of causes has increased in year with an increase in hepatobiliary disease and neutropenic sepsis

Figure 10: *E. coli* bacteraemia 2016-2020



Actions taken to reduce the rate of *E. coli* bacteraemia in 2019/20 include:

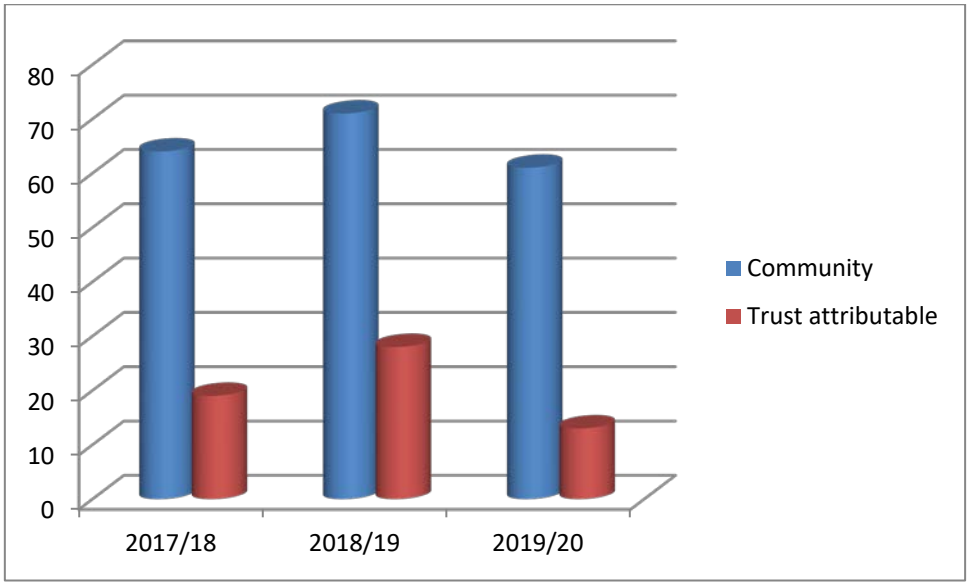
- Universal antimicrobial prophylaxis for ERCP patients implemented
- Hydration project – rolled out across the Trust ensuring that patients are fully hydrated whilst in hospital
- Re-introduction of revised catheter passport across Kent and Medway
- High impact intervention including HOUDINI risk assessment for urinary catheters with an audit programme.
- Full root cause analysis undertaken where data collection raises concerns
- All interventions audited to assess impact
- All epidemiological data entered onto PHE Data Capture System to support the national ambition
- Lessons learned identified and shared through IPCC and clinical governance
- Participating in the national gram negative reduction support programme
- DIPC and deputy DIPC working with the STP DIPC and colleagues across K&M STP
- Implementation of the Kent and Medway Catheter Insertion and Management guidelines
- Review of cholecystitis pathway to ensure standardised antimicrobial treatment

Further measures are outlined in the HCAI reduction plan for 2020/21.

1.6.3 *Klebsiella* species bacteraemia

Klebsiella species are gram negative rod-shaped bacteria which are ubiquitous in the environment and are found in the human gut. Three main species cause the majority of human infection; *K. pneumoniae, K. oxytoca* and *K. aerogenes.* Common infections include pneumonia, wound infections and urinary and biliary tract infections. Numbers of infections have continued to rise both in the community and the hospital setting

Figure 11: *Klebsiella* bacteraemia cases 2017-20

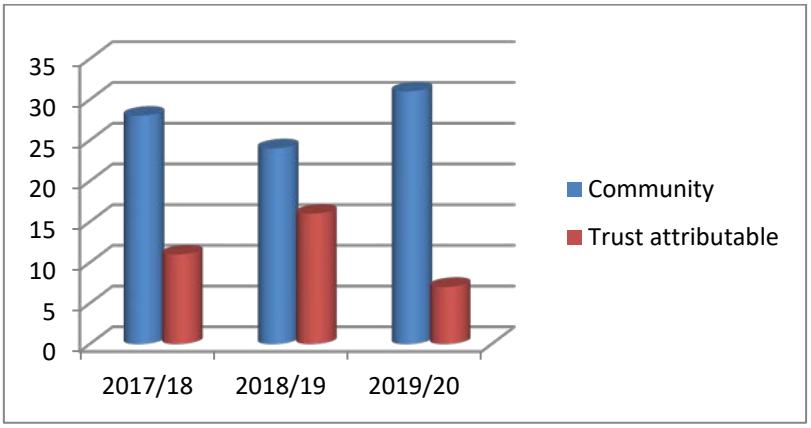


There has been a significant 54% decrease in the number of healthcare acquired *Klebsiella* blood stream infections during the year

1.6.4 *Pseudomonas aeruginosa* bacteraemia

Pseudomonas aeruginosa is an opportunistic pathogen that infrequently causes infection in healthy individuals. It can cause a wide range of infections, similar to other gram negative organisms.

Figure 12: *Pseudomonas aeruginosa* bacteraemia 2017-20



In a healthcare setting pseudomonas can contaminate devices that remain moist such as respiratory equipment and catheters but also ice-making machines and equipment with a water reservoir. It also causes outbreaks in neonatal units.

Cases of healthcare associated *Pseudomona*s sepsis are low and have decreased by more than 50% compared with the previous year.

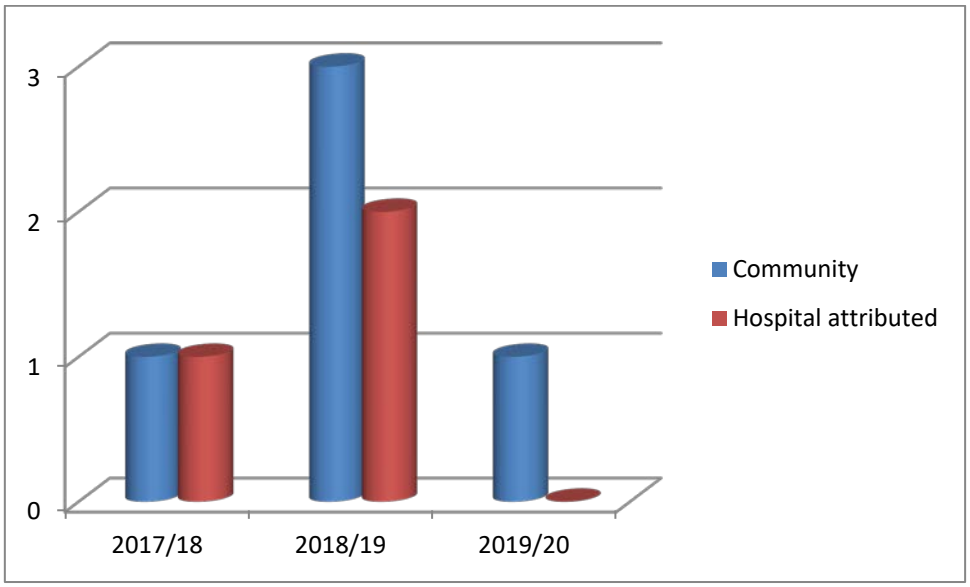
1.7 Glycopeptide resistant Enterococci (GRE)

Glycopeptide-resistant enterococci are resistant to at least two important antibiotics widely used to treat infection in immunosuppressed patients. They are of particular concern in haematology patients who can be severely immunosuppressed as a result of both their underlying disease and chemotherapy.

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%. 25 carriers of GRE were newly identified from April 2019 – March 2020. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status, improving patient safety.

Although the incidence of GRE infection has always been very low at MTW, with no healthcare associated blood stream infections recorded in 2019/20, it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism.

Figure 13: GRE bacteraemia 2017-20

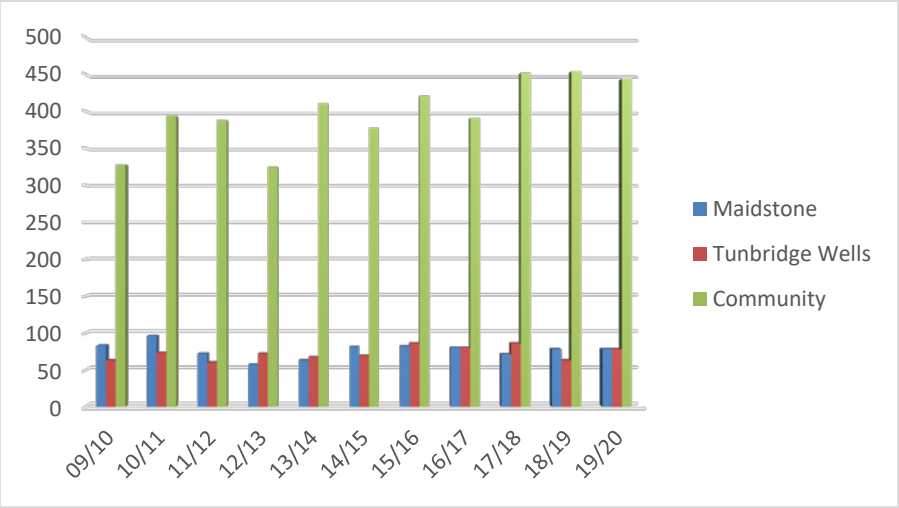


1.8 Extended Spectrum *Beta*-lactamase producing organisms (ESBLs)

ESBL organisms have the capability to produce enzymes which break down some of the more commonly used antibiotics. The numbers of patients developing infections with

these organisms has been rising steadily over the last few years. A number of these organisms also have other mechanisms of resistance which can in some cases severely restrict the choice of antibiotic and may lead to admission to hospital for intravenous antibiotics because there are no options for oral treatment.

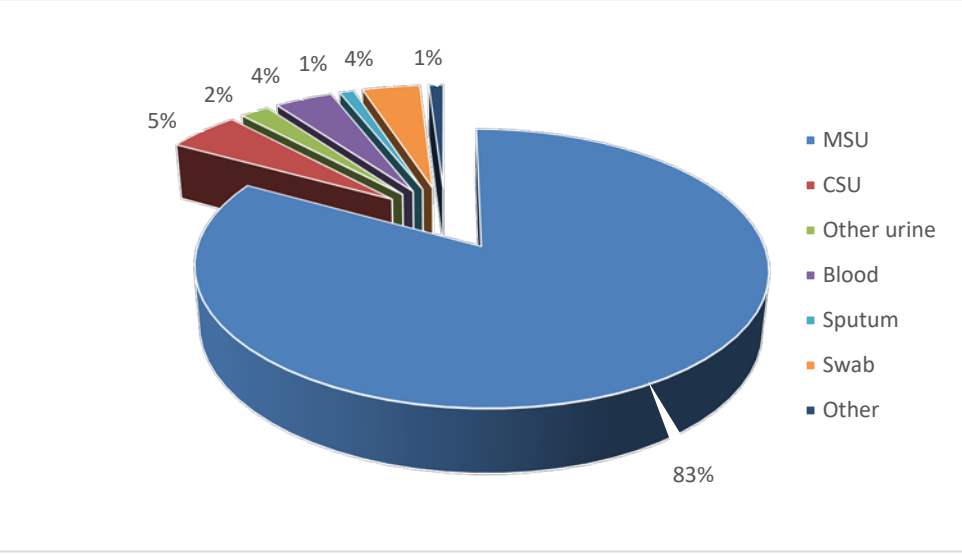
Figure 14: New ESBL isolates 2009-2020



Surveillance has been ongoing in the Trust since 2007. Earlier retrospective data shows that these organisms were seen at the Tunbridge Wells end of the Trust earlier than at Maidstone although the numbers seen at each hospital are equal now and the number of new acquisitions is staying steady.

There is no significant seasonal variation or trend in the number of cases seen. Most patients affected will carry the organism in their gut and as a result, urinary tract infections are the most commonly seen and account for 90% of cases. Long term catheterisation is recognised as a risk factor for carriage of ESBL organisms, likely due to the treatment of recurrent infection with broad spectrum antibiotics, selecting out resistant strains in the patient's gut forming a reservoir of infection

Figure 15: New ESBL isolates by specimen type 2019-20



1.9 Carbapenem resistant / Carbapenemase producing Enterobacteriaceae (CRE/CPE)

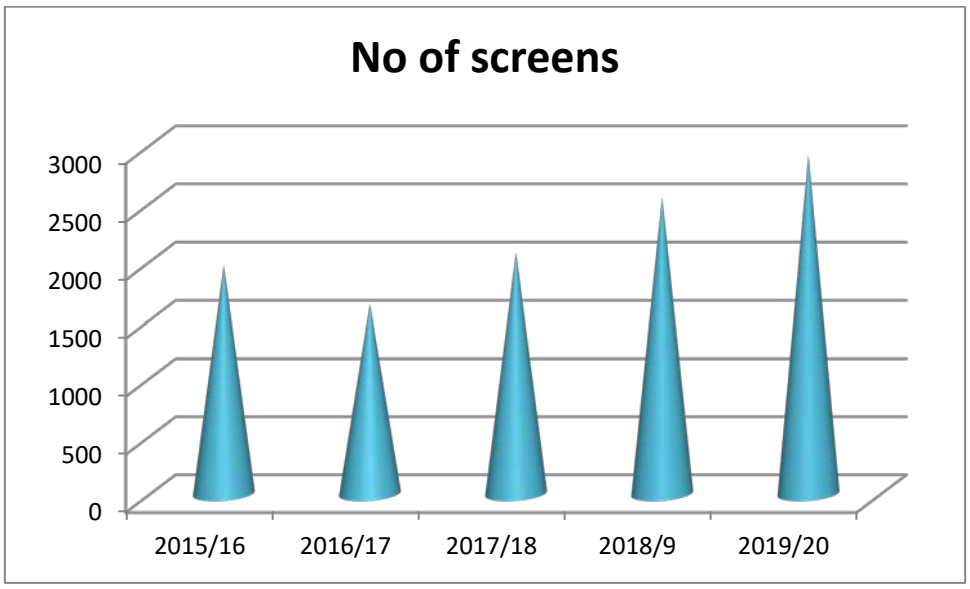
CPE and CRE are gram negative organisms found in the gut which are resistant to virtually every antibiotic including the Carbapenem group of antibiotics. They represent a major cross infection risk. Some of these organisms have the ability to transfer their resistance genes from one bacterium to another, even across species.

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2019/20, 2910 CRE/CPE screening swabs were processed, around 400 more than the previous year.

Patients are identified as requiring screening by risk assessment – focussing on screening patients transferred in from healthcare abroad and patients who are transferred from (or have recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates.

Patients requiring screening are identified on or before admission and are screened by three rectal swabs on different days. Whilst awaiting the outcome of the screening swabs patients are isolated with enhanced barrier nursing precautions including the use of long-sleeved gowns. Neonates are screened by three faecal swabs, the third being at least 48 hours after transfer from another unit. These precautions inevitably put pressure on areas with limited side room provision, especially the neonatal unit, but are necessary to prevent an outbreak of these multi-resistant organisms.

Figure 16: CRE/CPE screens 2015-20



Twelve adult patients were identified as carriers on screening, six had been inpatients in hospitals outside the UK, five had recently been inpatients in London hospitals and one

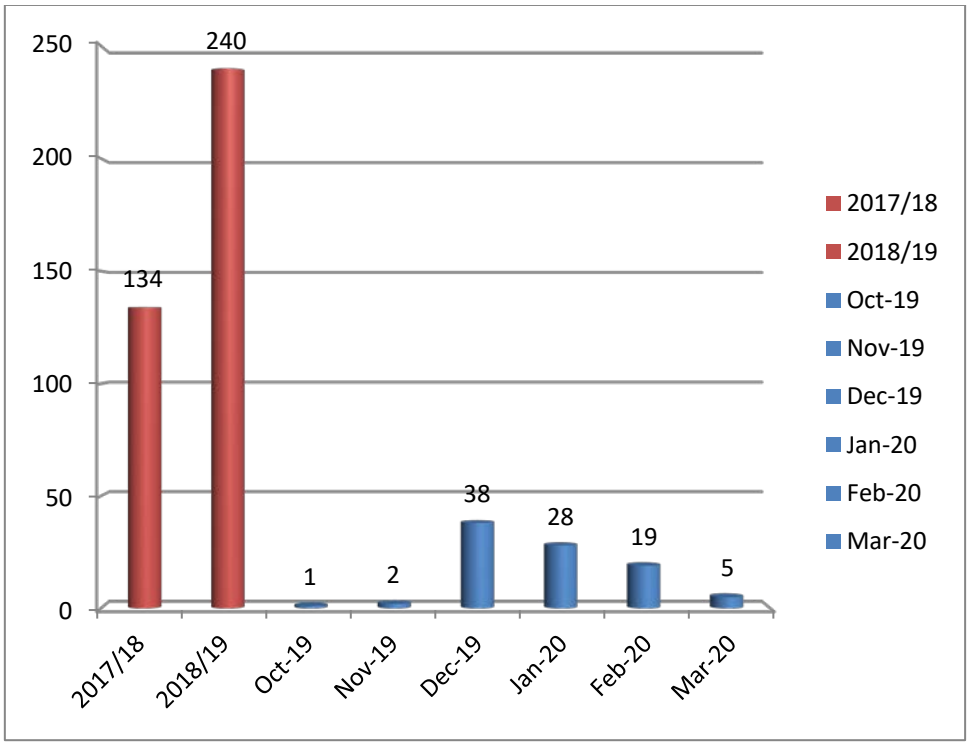
was a known carrier. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

One new case was identified from a clinical sample with the risk factor of recent admission to a London hospital.

1.10 Influenza

From October 2019 to March 2020, 93 patients with Influenza were admitted to the Trust. This is compared to 240 patients the previous year.

Figure 17: Influenza cases 2019/20



Five patients required ITU admission – a total of 69 days (average 13.8 ITU bed days).

All of the infections were due to Influenza A, with no Influenza B seen.

Increased support and communications regarding identification and management of influenza was in place including:

- Daily side room reports including influenza patients
- Information shared at the site team meetings
- National reporting to NHS England on cases of flu.

The Trust is a Sentinel reporting site for influenza, reporting on all cases admitted to the Trust irrespective of level of care.

1.11 Norovirus

There were just two ward based incidents due to norovirus in 2019/20. The table below provides a summary of the wards affected.

Table 3: Summary of Norovirus incidents 2019/20

Month	Ward	Patients affected	Staff affected	Bed days lost	Closure	Days closed
October 19	Whatman	16	7	33	Ward	15
November 19	Chaucer	15	4	8	Ward	5

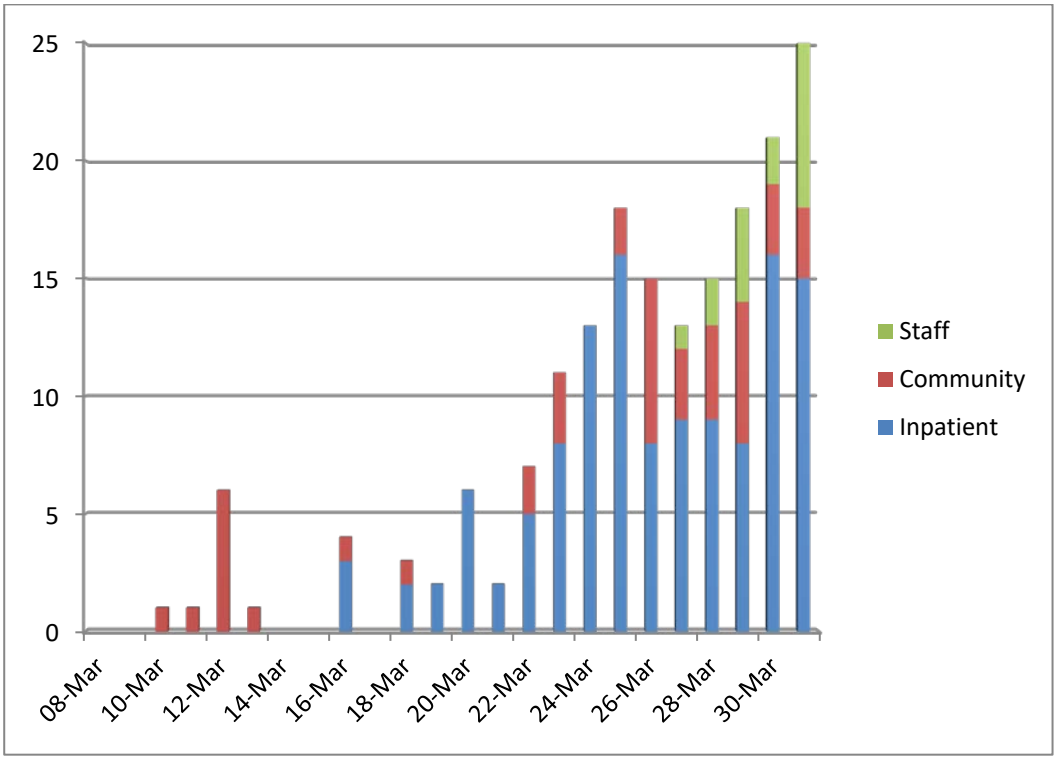
1.12 SARS-CoV-2 (COVID-19)

Planning meetings to manage a potential outbreak of Covid-19 in the Trust began in January 2020**.**

The first patient in MTW to test positive for coronavirus was on 16 March 2020 following admission on the previous day. A total of 115 Covid positive patients had been admitted by the end of March 2020. Fifteen patients died following a diagnosis of Covid-19 in the same period.

The Trust provided testing for symptomatic staff and for partner organisations.

Figure 18: Covid Positive in March 2020



1.13 Surgical Site Infection

Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter.

The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

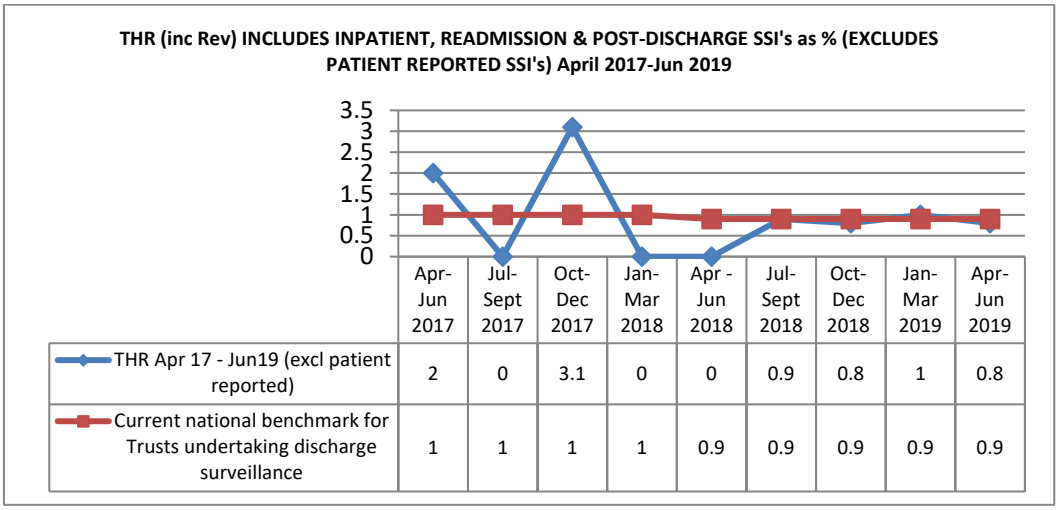
The PHE web based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. Since December 2015 only the mandatory orthopaedic surveillance has been completed.

Patients are monitored for the first 60 days and infection rates monitored for up to one year post operatively. Monitoring is completed on inpatients and also by post-discharge surveillance through hospital readmission, outpatient review and patient discharge questionnaires. MTW completes the modules mandatory surveillance of elective total hip and total knee surgery, fractured neck of femur continuously throughout each year. Patient-reported SSIs are not included in the SSI performance data produced by PHE as no infection has been proven. However these infections are monitored and captured as part of the ongoing surveillance reports to PHE.

Further investigation is ongoing to determine if the pathway changes last year to comply with NICE guidance, which were initially successful in maintaining low levels of infection, are sustainably embedded

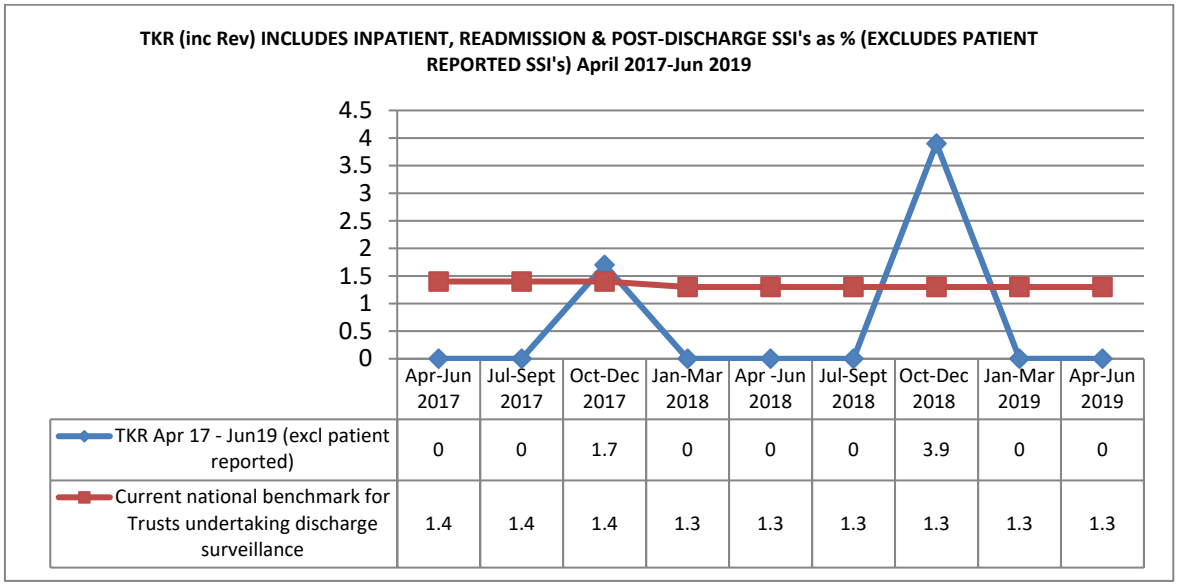
Due to the long term sickness of the surveillance nurse, only the first quarter of the year has been completed. This is the minimum requirement for Trusts.

Fig 19: Results for elective hips and knees



	Apr-Jun 2017	Jul-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Apr - Jun 2018	Jul-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
THR Apr 17 - Jun19 (excl patient reported)	2	0	3.1	0	0	0.9	0.8	1	0.8
Current national benchmark for Trusts undertaking discharge surveillance	1	1	1	1	0.9	0.9	0.9	0.9	0.9

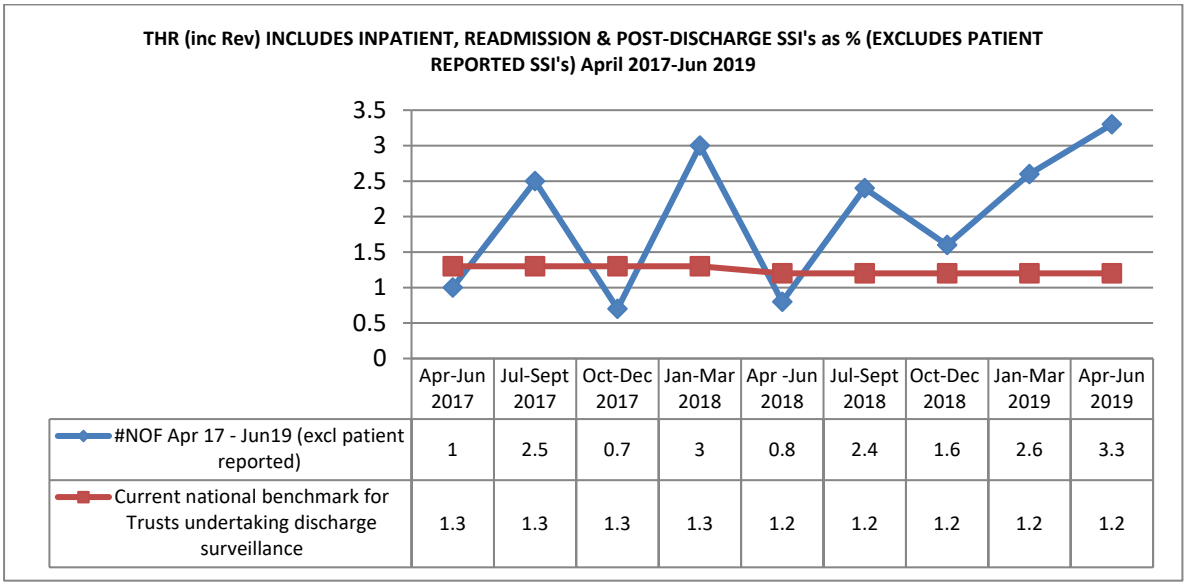
For the period April 2019 to June 2019 the overall SSI rate for elective hips dipped below the national average. 127 procedures were carried out during this period, a higher number than each of the previous two quarters.



	Apr-Jun 2017	Jul-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Apr -Jun 2018	Jul-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
TKR Apr 17 - Jun19 (excl patient reported)	0	0	1.7	0	0	0	3.9	0	0
Current national benchmark for Trusts undertaking discharge surveillance	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.3

84 procedures were completed during the first quarter, the highest number for a single quarter since 2015.

Figure 20: Results for repair of fractured neck of femur



	Apr-Jun 2017	Jul-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Apr -Jun 2018	Jul-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
#NOF Apr 17 - Jun19 (excl patient reported)	1	2.5	0.7	3	0.8	2.4	1.6	2.6	3.3
Current national benchmark for Trusts undertaking discharge surveillance	1.3	1.3	1.3	1.3	1.2	1.2	1.2	1.2	1.2

The infections represent four cases out of a total of 120 procedures.

Further work is being undertaken in this area to improve the infection rate including a case review to identify patient related risk factors and learning.

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Refurbishment and New Builds

2.1 Estates

The Estates and Facilities Department ensure that the IPC Team have been regularly involved, consulted and engaged in the planning stage of numerous work projects. This has enabled the team to actively influence improvements to infection prevention and control in the built environment providing input in two broad aspects of work:

- Planning – The IPCT are asked for input in reviewing plans to ensure that any refurbishments or new builds offer the best facilities to reduce the risk of infections in line with any relevant Health Building Notes and Health Technical Memorandum
- Operation – The IPCT are asked to review methods to reduce the risk of any infections presented by the actual refurbishment/build process.

Projects with which the IPCT have been involved include the plans for the new stroke unit and the new AAU at Maidstone Hospital and the Covid preparations for ITU on both sites

Estates report biannually to the IPCC on current and recently completed projects

Decontamination

2.2 Decontamination

The Decontamination Committee meets quarterly to consider all aspects of decontamination within the Trust. Sub-committees for each of the areas of responsibility have been formed to focus on departmental requirements and ensure ongoing HTM compliance and reporting back to the main committee

All decontamination and sterilisation of reusable surgical instruments is carried out off-site by an external provider. During the year the performance has been closely monitored and twice yearly reports are submitted to the IPCC. No major concerns have been raised and the service is compliant with HTM 01-01.

Decontamination and high level disinfection of flexible endoscopes is carried out in the endoscopy departments on both sites. The departments have JAG accreditation which was renewed in February 2019. Endoscopy is compliant with HTM 01-06.

The Trust laundry unit located off site at Parkwood continues to provide linen service to both of the Trust's hospital sites and Darent Valley Hospital, processing a total of over 7

million items per year. There are also a number of smaller community contracts. Annual audits are undertaken. The laundry is compliant with HTM 01-04

Cleaning arrangements

2.3.1 Monitoring

Domestic services report to the IPCC three times per year, providing details of audits of cleaning standards. The audit programme is regularly reviewed with infection control and audits are carried out weekly, monthly or bi- monthly, depending on the risk level, with unannounced visits to wards & areas by Facilities Management to maintain a consistent approach.

All audits have shown good compliance with standards of cleanliness and achieved the target scores of 95-98% for very high-risk areas and 85-95% for high risk areas. The high-risk scores were consistently above 95% for the year.

2.3.1.1 PLACE inspection

Due to the changes criteria for the annual 2019 PLACE assessment, the results are not directly comparable with previous years. NHSI asked Trusts to ensure that the PLACE programme is about identifying areas for potential improvement rather than monitoring score increases. To support this message, planned training and upskilling of our team of assessors took place prior to the assessment detailing the changes for 2019 and supporting them with the tools required for a successful result for the Trust. The question set has been significantly revised and brought up to date with a lot of background work going into standardising and refining definitions and guidance. The Trust scored highly with an overall score of 99.41% for cleanliness and 98.66% for condition, appearance and maintenance.

2.3.2 Cleaning levels

The facilities department provide a very high level of support to the Infection Prevention and Control Team and are able to respond quickly to infection prevention issues such as urgent deep cleans and hydrogen peroxide (HPV) fogging.

A range of cleaning levels have been in place in the Trust for many years and these are regularly reviewed to ensure that they are fit for purpose and enable the most efficient turnaround times.

Table 4: Annual cleans for Maidstone and Tunbridge Wells Hospitals 2019-20

Tunbridge Wells

Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
38,874	2928	841	762

Maidstone

Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
7432	7892	360	345

MTW

Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
46306	10820	1201	1107

Discharge cleans at Maidstone are completed by nursing rather than facilities staff although there has been an increase in facilities taking over this role during the year.

2.3.3 Deep Cleaning

There is a rolling deep clean programme across the Trust. The Estates department are usually able to combine the deep cleans with maintenance works to reduce disruption,

2.3.4 Training

The IPC team delivered training sessions in correct handwashing/hygiene to all Portering staff across both sites.

Additional training was provided to facilities staff as part of the preparations for Covid to enable them to work safely.

Water Safety

2.4 Water Safety

The quarterly Water Hygiene Steering Group (WHSG) meets to discuss the relevant water hygiene policies and procedures, plus improvement works being carried out within the MTW Trust.

Legionella water sampling is undertaken twice yearly at Maidstone Hospital. Legionella sampling at TWH is carried out on a quarterly basis by Interserve. Samples for both legionella and pseudomonas are taken from various outlets and supplies such as water tanks and calorifiers. The sampling points at Maidstone Hospital have been reviewed and reconfigured so that every water system within the hospital is tested over a period of a year. Positive counts are recorded on the resampling action tracker, and recommendations undertaken in a timely manner. Prompt action to rectify issues identified enables all areas to return to operational use. Until these works are completed, suitable control measures are in place to ensure safe water system. Works have included the removal of little used outlets, showers, and long dead legs. All works have been in agreement with Infection Control.

Compliance Criterion	What the registered provider will need to demonstrate
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Antimicrobial Stewardship

3. Antimicrobial Stewardship Group (ASG)

The Trust multidisciplinary Antimicrobial Stewardship Group (ASG) is responsible for promoting and monitoring the prudent use of antimicrobials as outlined in the DoH guidance “Antimicrobial Stewardship - Start Smart then Focus” and recommendations from NICE guidelines (NG15). The ASG meets monthly to ensure the Trust antimicrobial stewardship programmes are implemented and review issues relating to antimicrobial use. The group members include consultant microbiologists, antimicrobial pharmacists, deputy chief pharmacist and WK CCG antimicrobial pharmacist. The group reports to the Drugs, Therapeutics and Medicines Management committee (DTMMC) and provides reports to the IPCC of which the antimicrobial pharmacist is a member.

Clinicians are invited to attend the meetings to discuss specialist guidelines.

The group regularly review the Trust antimicrobial guide (on the trust intranet page) to ensure it is accessible and up to data. Existing guidelines are updated and new guidance developed in consultation with the relevant lead clinicians.

The group works collaboratively with the WKCCG antimicrobial pharmacist and a MTW consultant microbiologist sits on the WKCCG antimicrobial stewardship group..

The group also reviews any issues arising from the daily meetings between consultant microbiologists and pharmacists and medicines incidents involving antibiotics.

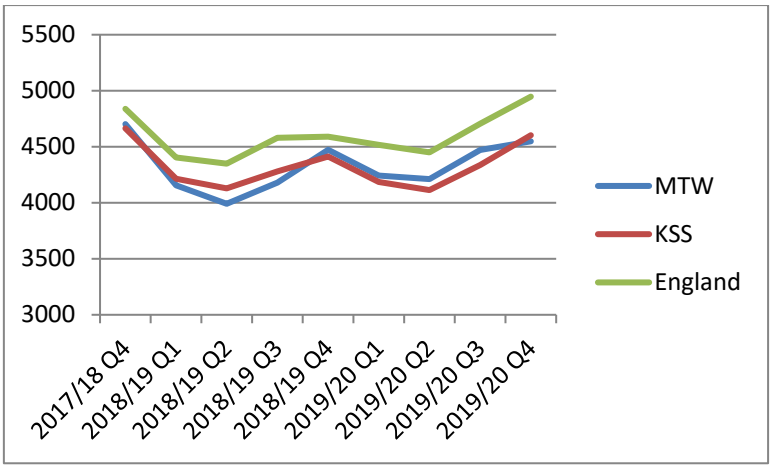
3.1 Antimicrobial Usage

The antimicrobial usage data in defined daily doses (DDD) per 1000 admissions is monitored by the group. Any unusual patterns of usage are followed up with clinicians.

Particular interest is taken in the prescribing of Piperacillin/Tazobactam (Tazocin) and Meropenem in the Trust. These are two broad spectrum antibiotics that are used in sepsis but are also associated with a higher risk of *C. difficile* infection. Meropenem is one of the Carbapenem antibiotics, resistance to which is becoming a significant problem nationally as discussed in section 1.9 of this report.

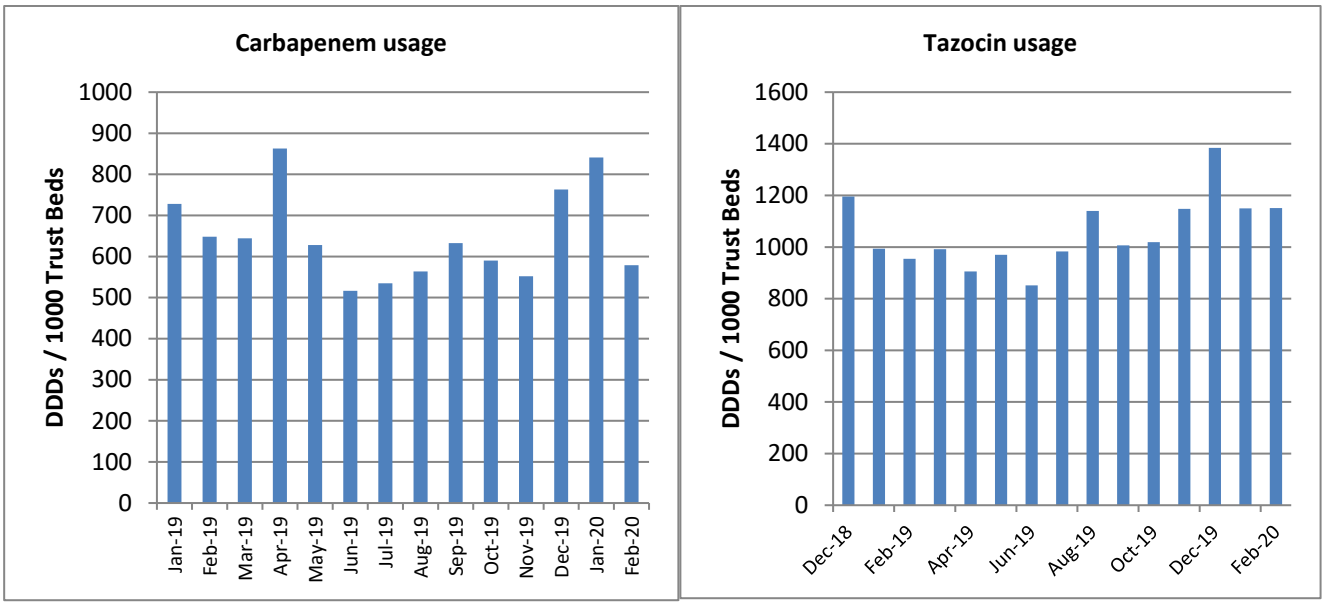
There is an overall downward trend in the use of these antibiotics although there is usually as seasonal increase in the winter due to the increased acuity of patients admitted.

Fig 21: Total antibiotic prescribing DDDs per 1000 admissions by quarter



MTW remains below the national average for antimicrobial prescribing.

Fig 22: Piperacillin/Tazobactam & Carbapenem usage in DDDs/1000 admissions



Some seasonal variation is seen but no overall trend (up or down) is evident.

3.2 Antimicrobial training and Education

A number of education sessions were delivered by the antimicrobial pharmacists and consultant microbiologists to medical staff and pharmacists. Education sessions include induction sessions for all new doctors, FY1 and FY2 teaching sessions and more advanced sessions for core medical trainees.

The team has also attended various clinical governance and directorate meetings to discuss topics including surgical prophylaxis, UTI management, audit results and the antimicrobial CQUIN.

In addition, antimicrobial information leaflets are issued to new locum doctors and FY1 as part of their induction welcome packs.

3.3 Antimicrobial Audit

The pharmacists complete bi-monthly audits against the Antimicrobial prescribing policy. The audit results are reported to individual consultants, directorates and to the IPCC through the directorate triangulation reports. Following the introduction of the antimicrobial resistance and stewardship AMS CQUIN goals from NHS England evidence of 72 hours review is now included in this audit.

In addition, weekly audits against the policy are carried out on wards where there is a PII in place.

3.4 AMR CQUIN 2019/20

For 2019/20 the AMR CQUIN was to improve adherence to national antibiotic guidance in treatment of lower urinary tract infections in older people and antibiotic prophylaxis in elective colorectal surgery.

The aim was to support the long term priority of reducing antimicrobial resistance and improving stewardship. Steps were outlined for UTI intended to reduce inappropriate antibiotic prescribing, improve diagnosis (reducing the use of urine dip stick tests) and improve treatment and management of patients with UTI.

Implementing NICE guidance for surgical prophylaxis was intended to reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines, delivering safer patient care, increasing effective antibiotic use and in turn, improving both patient mortality and length of stay.

Both CQUINs had a target of 60-90% compliance. MTW achieved both targets, having over 90% compliance by Q2.

Compliance Criterion	What the registered provider will need to demonstrate
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.

The Trust provides all service users with information as required. This includes infection prevention information in the form of information leaflets, posters and resource folders for staff, and information leaflets and posters for patients and visitors.

In outbreak situations or infection prevention incidents, duty of candour is completed for all patients affected either directly or indirectly.

Staff are also provided with policies, clinical guidelines and care pathways for specific conditions.

There are Infection Prevention resources on the Trust intranet and Internet sites.

Information is provided to external partners as appropriate including:

- Notifications of *C. difficile* cases and gram negative blood stream infections to the relevant CCG HCAI lead
- Electronic discharge notifications include MRSA status
- Inter-hospital transfer forms include information relevant to IPC
- Patients identified as *C. difficile* carriers or with *C. difficile* infection are issued with a 'green card' which advises other healthcare providers of their diagnosis and the importance of prudent antimicrobial prescribing
- IPC information is shared with GPs for information on a case by case basis

The infection prevention team attend the site meeting at least daily to share information regarding IPC risks and concerns. A daily side room report is shared widely to ensure the safe isolation of infectious patients.

From the beginning of the Covid pandemic, the IPCT attended the Incident Control Centre meetings daily and participated in daily executive and divisional calls to share information and update teams on the latest IPC guidelines and advice.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop and infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmitting the infection to other people.

The Infection Prevention Team provides a 7 day service and an on call microbiology service (laboratory and consultant) is available out of hours. The laboratory also provides 7 day working. The team regularly visit the wards and review patients with infectious diseases.

All urgent microbiology results are telephoned to clinicians to ensure prompt treatment and review.

Side rooms are actively managed by the Infection Prevention team and the Isolation Policy, including risk assessments for side room requirement and leaving doors open is available on the Trust intranet.

The IPT performs risk assessments for any potential infectious disease incident in the Trust. Contact tracing for both staff and patients is facilitated by the IPT working with Occupational Health where necessary.

Policies are also available for the management of patients with diarrhoea and a wide range of infectious diseases.

Patients are screened for MRSA, MSSA, GRE, CRE/CPE as appropriate (see Criterion 1).

An outbreak policy is in place and colleagues in Public Health England are available to assist with outbreak control if required.

At the start of the pandemic response the IPCT provided on site cover 7 days per week and a 24/7 on call service.

Compliance Criterion	What the registered provider will need to demonstrate
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.

Staff Development and Training

The infection control team undertakes both formal and informal teaching as part of its training and education role. The formal sessions take place in lecture/class rooms organised in advance. These take the form of induction/welcome days, mandatory updates, link network and student training. Informal training is undertaken in the workplace on an ad hoc basis as the need arises.

An on-line package is available for staff to use to fulfil the requirement for annual training. It is recommended that staff attend face to face training one year and access online training the next.

For 2019/20, 5973 clinical and non-clinical staff members are up to date with Infection Control training; a total of 84.4 % of staff.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

Other bespoke practical training sessions have been developed to provide targeted training to facilitate learning in staff who may not have English as a first language.

A resource pack has been developed for the wards containing a wide range of handbooks for various staff groups (temporary and substantive) and exemplars of how to complete IC documentation.

Link nurse meetings are held monthly on alternate sites. The programme is replicated on each site to enable more staff to attend. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition a

Link nurse study day is held annually with invited speakers and this is also open to MTW staff who are not Link nurses and healthcare staff from other organisations.

The DIPC teaches on the DIPC development programme and aspiring DIPC training course, both run by the Hospital Infection Society.

Within the IPCT members of the team are actively encouraged to pursue educational opportunities.

What the Board needs to know in order to fulfil its responsibilities in respect of Infection Prevention and Control

6.1 History

Infection prevention and control has been an area of focus within MTW since 2006 when the Trust suffered one of the largest *C. difficile* outbreaks in the UK which was subsequently investigated by the Healthcare Commission and described in their report: *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*, October 2007. The report estimated that 90 deaths were directly due to C. difficile and a further 241deaths had occurred where *C. difficile* had been a contributory factor.

Crucially the report identified that management systems had failed to provide patient safety and introduced the concept of board-to-ward accountability and responsibility.

The Trust's response to the report was positive and a year later the Healthcare Commission reported that there were encouraging signs of improvement. This improvement has continued and ten years on from the publication of the report, MTW is seen as a high performing Trust for Infection Prevention and Control.

The Trust Board has recognised and agreed collective responsibility for minimising the risk of infection and has delegated responsibility for the strategic and operational leadership to the Director of Infection Prevention and Control.

6.2 Key points

- All employees of the Trust have infection control responsibility detailed within their job description
- Infection prevention and patient safety remain key priorities for the Trust
- There is wide engagement with the infection prevention agenda throughout the Trust
- A challenge culture has been encouraged within the Trust to ensure that all staff comply with infection prevention policies and processes.
- A wide range of infection prevention policies and procedures have been developed and are regularly reviewed and updated

- Emphasis has been placed on the clinical environment and cleanliness. The infection prevention team works closely with the facilities management team. The Trust has been innovative in the introduction of cleaning methods such as Hydrogen Peroxide vapour (HPV) in 2007 and UV-C light in 2016. Cleaning standards are audited regularly and reported through the Trust including to the IPCC.

- *C. difficile* has been reduced to consistently low levels across the organisation

6.3 Hygiene Code compliance

The Health Act 2008, now superseded by the Health and Social Care Act 2013, contains a Code of Practice usually referred to as the Hygiene Code. The Code was most recently updated in 2015. The 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance.

The Trust declared compliance with the Hygiene Code in March 2009 and continues to remain compliant, maintaining evidence files and undertaking self-assessment of compliance on an annual basis, reporting the outcome to the IPCC.

For 2019/20 the IPCT was involved in the preparations for CQC and undertook a KLOE self-assessment

There is a compliance statement on the Trust Website

The compliance criteria and some examples (not comprehensive) of how we comply in addition to this report are shown in the table below;

Table 8: Hygiene code compliance criteria (2015)

Compliance criteria		**Examples of how we comply**
1	Systems to manage and monitor the prevention and control of infection.	• Governance and reporting structure • DIPC in post - reports to CEO • Infection prevention team • IPCC ToR • Annual work programme and action plan • Mandatory training • Link nurse network • Annual IC audit programme • IC policies and procedures in place • Side room management • Board level risk register • Outbreak policy • Surveillance systems • This report • Covid measures in place
2	Provide and maintain a clean and appropriate environment in managed	• Director of Estates and Facilities reports to IPCC

	premises that facilitates the prevention and control of infections.	• Policies for decontamination, cleaning and laundry in place including record keeping processes • Cleaning processes agreed with Infection Prevention • Cleaning audits reported to IPCC • Deep clean programme • Hand hygiene facilities, signage and audit • JAG accreditation • Commode audits • Uniform policy • Changes in cleaning frequency to support Covid management
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Antimicrobial stewardship group meets monthly • Antimicrobial prescribing policy • Antimicrobial prescribing guidelines • Antimicrobial pharmacists in post • ASG reports to IPCC • 'Start smart then focus' in place • Antimicrobial training for doctors
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.	• Range of information leaflets for patients and relatives • Regular communication with CCG HCAI lead • EDN includes MRSA status • Switchboard messages on norovirus • IC messages on internet site for visitors and patients including numbers of infections • Information for patients on antimicrobials • IC information shared with GPs on case by case basis • ICT attendance at daily site meetings • Participation in Covid ICC meetings
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.	• Urgent microbiology results telephoned to clinicians • Isolation policy • Active side room management by ICT • Risk assessments carried out • Screening in place for MRSA, MSSA, GRE, CRE/CPE as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to PHE in place • Temperature and symptom checks at front doors. • Triage for Covid-19 at the front door

		of emergency departments • Separation of flow into green, amber and red pathways to ensure Covid and non-Covid streams do not mix • Cohorting of patients pending Covid test results to reduce nosocomial spread of infection
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.	• Mandatory training for all staff and volunteers • Information provided to contractors • Temporary staff handbooks and competency • Bespoke training for certain groups of staff, eg porters, domestics • Handbooks for various staff groups • Exemplars of documentation provided to wards • IC resource folders on all wards – currently being converted to electronic format • Infection control responsibility included in all job descriptions • Facing to face ward based training for new nurses
7	Provide or secure adequate isolation facilities.	• Isolation policy • Negative pressure rooms available – A&E at TWH and John Day at Maidstone • Active management of side room provision • Clear isolation signage • Covid signage to identify red, amber and green wards
8	Secure adequate access to laboratory support as appropriate	• Microbiology laboratory on Maidstone site • KPIs monitored • ISO 15189 accredited • All referral labs accredited • Telepath system interfaced with ICNET • Covid PCR and antibody testing available on site. • Testing PODS on both sites
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Standard infection control policy • Policies for a range individual infections • Outbreak policy • Other policies in place to meet the requirements of the Code • Audit programme in place to monitor compliance with policies

		• All policies available on Trust intranet site • Covid measures in place. • PHE guidance followed
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• Immunisation of staff policy in place • All staff can access on site occupational health services • Influenza vaccination offered to all staff and volunteers with achievement of annual targets for frontline staff • Risk based screening for communicable diseases and assessment of immunity • OH arrangements in place in respect of blood borne viruses • Covid testing available for all staff • Covid antibody testing available as needed

6.4 Governance and Assurance

The Board receives assurance through the governance reporting structure described at 1.2, and directly from the DIPC who attends Board meetings to provide updates on infection control and new guidance relevant to the Trust.

C. difficile and MRSA and gram negative bacteraemia numbers and rates are on the Board level dashboard together with MRSA screening rates.

6.5 National Priorities

There are three key national priorities related to Infection Prevention and Control

Antimicrobial resistance – The next phase UK 5 year antimicrobial resistance strategy was published in 2019. The plan has been designed to ensure progress towards the 20-year vision on AMR, in which resistance is effectively contained and controlled. It focusses on three key ways of tackling AMR:

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access

To support these aims there are actions across 15 ‘content areas’, ranging from reducing infection and strengthening stewardship to improving surveillance and boosting research. The plan also sets out four measures of success to ensure progress towards the 20-year vision. These include, among others, targets to:

- Halve healthcare associated gram-negative blood stream infections
- Reduce the number of specific drug-resistant infections in people by 10% by 2025

- Reduce UK antimicrobial use in humans by 15% by 2024
- Reduce UK antibiotic use in food-producing animals by 25% between 2016 and 2020 and define new objectives by 2021 for 2025
- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

Reducing healthcare associated gram negative blood stream infections by 50% by 2020/21.

This initiative was announced at the end of 2016 by the former Secretary of State, Jeremy Hunt. About 35% of these infections are related to poorly managed urinary tract infections and catheter care. The target applies across the whole healthcare economy and the infection prevention and control teams across Kent and Medway, primary and secondary care, local authorities and social care are working together to develop a strategy to reduce these infections.

At MTW we have increased our data collection on epidemiology of these infections and active submit data to the national Public Health England database. See section 1.6 of this report for further information on the Trust's response to this target.

Covid-19

The national Covid-19 pandemic is having a major impact on the way healthcare is provided in the UK.

The infection prevention team is committed to continuing to support the Trust to ensure that the safety of our staff and patients is maintained throughout whilst delivering national requirements and adhering to national guidelines.

Compliance Criterion	What the registered provider will need to demonstrate
7	Provide or secure adequate isolation facilities

Isolation Facilities

The Isolation policy is published on the Trust Intranet, together with the standard infection control policy which includes the use of personal protective equipment.

The Trust has a high proportion of single rooms although there is a disparity between the two sites with Tunbridge Wells Hospital having over 95% of beds in side rooms and Maidstone Hospital with 49 side room beds. Overall 53.2% of the beds in the trust are in single rooms with 50.4% en suite, compared with 29.9% single rooms in England, 17.9% en suite.

The target time for isolating patients with unexplained and potentially infectious diarrhoea (Pathway 1) is two hours. A rapid risk assessment is in place for all patients with diarrhoea

Active management of side room provision continues. The Infection Prevention team produce isolation lists on a daily basis to support the bed managers and ensure the best use of the side rooms available at Maidstone Hospital and to alert staff of infection control issues at Tunbridge Wells Hospital. Information includes advice on which patients may be de-isolated if necessary and prioritises lower risk patients who would benefit from isolation and the level of cleaning required when the patient is moved out of isolation.. The list also alerts site practitioners to community issues such as outbreaks of norovirus in local nursing homes and community hospitals and any wider outbreaks which may result in patients attending A&E.

All *C. difficile* patients are isolated on diagnosis, if not already in a side room, and remain in isolation throughout their admission. In addition, those identified as carriers are isolated whilst they are symptomatic and for at least 48 hours after they become asymptomatic.

There are planned facilities in both Emergency Departments for isolating highly infectious individuals such as those suspected of having Ebola virus. The pathway for these patients is practised regularly to ensure that staff are aware of the enhanced precautions and how to don and doff the protective suits. These plans were also used in the early weeks of Covid-19, prior to the first cases emerging in the UK and more extensive plans being developed to separate the Covid and non-Covid patients.

Compliance Criterion	What the registered provider will need to demonstrate
8	Secure adequate access to laboratory support as appropriate

Laboratory Services

In house microbiology laboratory services are based at Maidstone Hospital The laboratory has ISO 15189 accreditation.

The laboratory is open 7 days a week and provides a 24 hour service with on call facilities from 6pm to 8am. More recently the hours have been extended to 11pm to enable Covid-19 PCR testing.

Reference laboratory support is available at all times from both the Public Health England reference laboratories and other commercial laboratories which provide additional rapid diagnostics.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

The Trust has policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. The documents are reviewed on a rolling programme and published on the Trust Intranet site.

The documents are monitored using a variety of audit tools to measure staff compliance with guidance.

Audit Programme

The infection control team have worked closely with the audit department to develop a comprehensive audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust. Audits are reported to the IPCC. Formal audits included:

- Audit of catheter associated urinary tract infections and compliance with the HOUDINI criteria.
- Re-audit of compliance with screening for Carbapenemase producing enterobacteriaceae (CPE).
- Audit of compliance with the documentation of the MRSA care bundle and decolonisation therapy
- Audit of compliance with the Policy and Procedure for the Assessment of Patients Presenting with Diarrhoea
- HCAI Prevalence audit

In addition to these audits the IPT undertakes bi-monthly triangulation audits which are compared with the monthly ward audits and reported as a performance report to the IPCC by the directorate matrons.

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene including patient hand hygiene prior to meals
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening
- Waste management

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

Compliance Criterion	What the registered provider will need to demonstrate
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

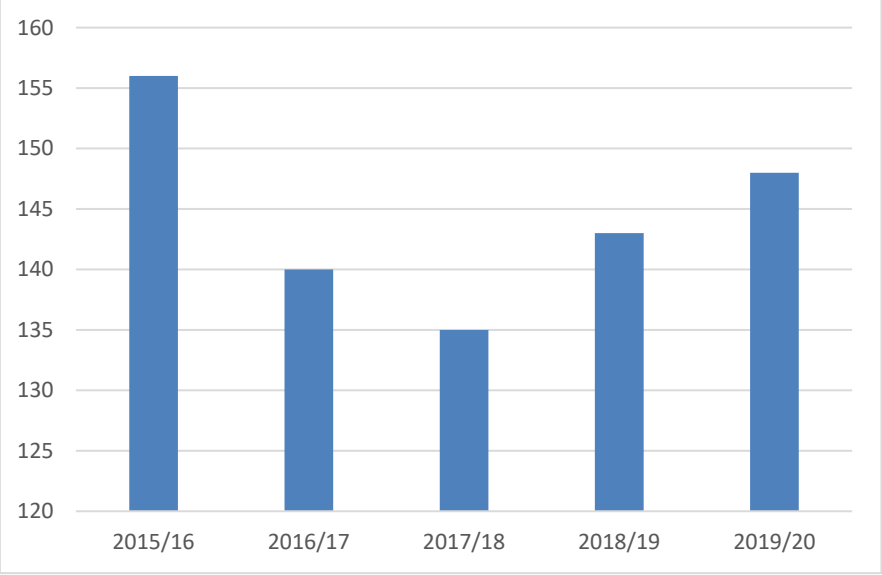
Occupational Health

The Occupational Health service provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff.

10.1 Sharps/Splash Injuries

There were 148 sharp/splash injuries in 2019/20 – a similar number to previous years. The occupational health department continues to review sharps injuries and examine ways to reduce the incidence with the Health and Safety team and the Sharps Working group.

Fig 23: Sharps and Splash injuries 2014-2019

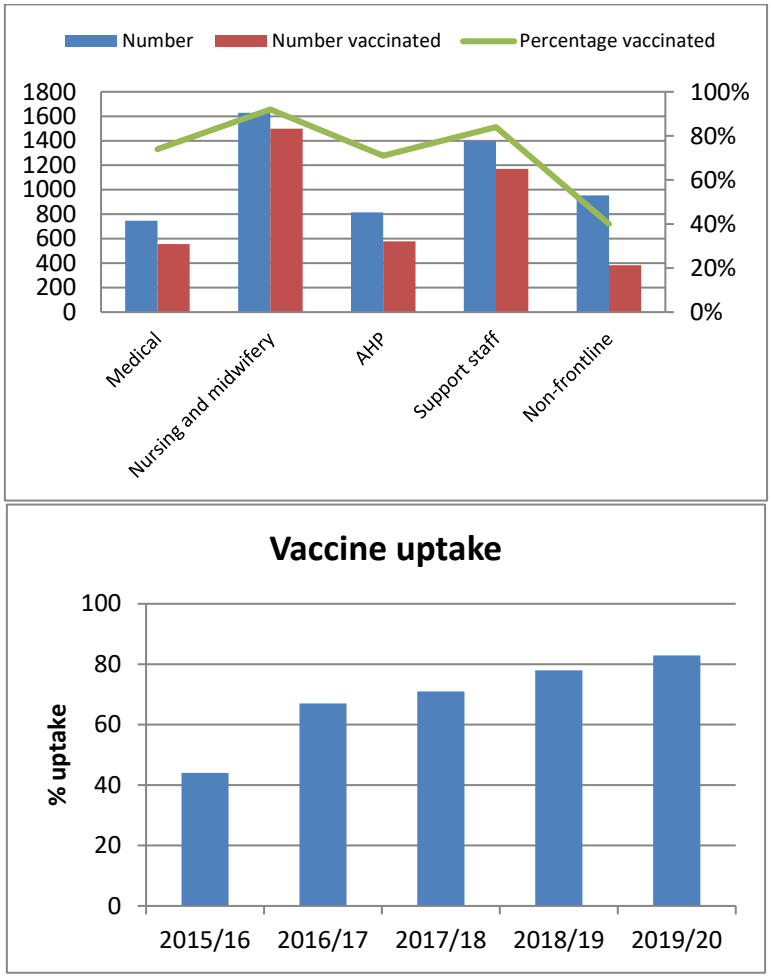


10.2 Influenza vaccination

The Occupational Health department leads the seasonal flu vaccination campaign. For 2019/20 the CQUIN target was 80% of frontline staff vaccinated. The campaign was launched in September and used a peer vaccination programme to outreach into clinical

areas. The Trust achieved a vaccination level of 82.9% which is the highest level achieved in recent years.

Fig 23: Vaccine uptake by staff group 2019/20 and 5 year comparison



Recommendations

The Trust Board is asked to note the progress in reducing healthcare associated infections and the Infection Prevention and Control Annual Work plan for 2020/21 (appendix 1)

APPENDIX 1

MTW Infection Prevention and Control
exceptional people, outstanding care

INFECTION PREVENTION AND CONTROL WORK PLAN 2020/2021

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Workplan quarter	Owner
CULTURE AND ENGAGEMENT							
CE-001	Apr 20	APW	Improved attendance and engagement to the IPC Link workers programme and meetings	1) Monthly Link worker Meetings to be held on alternate sites allowing for social distancing - via WebEx or Microsoft teams - Where meeting are difficult to arrange a IPC Link worker newsletter is to be provided 2) Link worker attendance to be monitored, fed back to divisions and monitored through IPCC 3) Summary report to be presented to IPCC	Mar-21	Q4	Clair Taylor (IPCN)
CE-002	Apr-20	APW	Compliance with IPC practice and procedures	1) IPC team working with wards where non-compliances are identified, providing additional training and support - PPE compliance is monitored by the PPE officers (See SA -006) 2) findings from PII investigations followed up and monitored 3) Audit programme developed and available on the Q drive. Also see Audit and Surveillance section of this work plan	Mar-21	Q4	Lesley Smith
CE-003	Apr-20	APW	All medical devices and equipment to meet IPC requirements for use	1) IPC team to work with procurement to provide IPC advice on new products being considered 2) Attend and advice at the PPE meeting	Mar-21	Q4	Lesley Smith
CE-004	Apr-20	APW	Continue to raise the profile of Infection Prevention and Control	1)IPC attendance at ward managers and Matrons meetings 2) IPC team to visit wards & department daily 3) Participate in national and local initiatives to promote IPC. (Global Hand hygiene day, glove awareness week, International Infection Prevention week) 4) Use of social Media to promote IPC team and deliver key messages	Mar-21	Q4	Lesley Smith
CE-005	Apr-20	KLOEs	Develop process of gaining	1) Process to be agreed	Dec-20	Q3	Danny Moore

			patient feedback / experience of IPC	2) Discuss proposed process with patient representatives and seek agreement.			(IPCN)
SAFE, CLEAN ENVIRONMENT							
SCE-001	Apr-20	APW	Safe water systems	1) IPC representation at the Water Safety Meeting 2) All water sampling results to be sent to the IPC team for follow up 3) Pseudomonas risk assessment reviewed and updated yearly.	Mar-21	Q4	Lesley Smith
SCE-002	Apr-20	KLOEs (S1)	Improved compliance with the completion of the isolation risk assessment (CPE audit compliance 17%)	Full review of isolation risk assessment to be undertaken. Process to be revised and re-implemented	Dec-20	Q3	Jacqui Griffin (Lead Nurse IPC)
SCE-003	Apr-20	KLOEs (S1)	Bed and Trolley mattresses to be clean and systems in place to ensure that checked, condemned and replaced if needed	1) Bed and Trolley Mattress audits to be carried out and reports presented to IPCC 2) Bed cleaning SOP to be revised and implemented (Completed) 3) Review of trolley mattress to ensure they are cost effective and met the correct specification 4) Work with PMO to develop QIPs to address areas that require improvement 5) IPC team to attend the teletracking meeting that will support the tracking and cleaning of beds	Mar-21	Q4	Lesley Smith
SCE-004	Apr-20	KLOEs (S1)	Systems in place to ensure that patient equipment is clean between use and assurance that standards are maintained	1) Process for the cleaning of patient equipment within the wards and department to be reviewed 2) Revised cleaning process to be agreed and implemented to ensure and consistent approach across the Trust	Mar-21	Q4	Danny Moore (IPCN)
SCE-005	Apr-20	KLOE & BAF (S1)	Greater involvement in environmental audits to provide assurance of standards being reported	1) Ward / Department staff to attend the environmental audits that are undertaken by the domestic supervisor 2) IPC team to attend a number of environmental audits for assurance	Mar-21	Q4	Jacqui Griffin (Lead Nurse IPC)
SCE-006	Apr-20	KLOE (S2)	Improved compliance with the documentation of MRSA decolonisation	1) MRSA decolonisation paperwork to be reviewed 2) Alternative process to be evaluated and implemented	Mar-21	Q4	Jacqui Griffin (Lead Nurse IPC)
SURVEILLANCE AND AUDIT							
SA-001	Apr-20	APW	Programme of audit to be developed and completed for 20/21	1) Audit programme to be developed and agreed at IPCC 2) Re audit of MRSA care bundle (July 20) 3) Compliance of best practice guidance to reduce the risk of	Mar-21	Q4	IPCT

				Pseudomonas and legionella in augmented care (August 20) 4) Re-audit of CPE (Sept 20) 5) Outbreak preparedness (Fit testing) (Sept 20) 6) Environmental audits 7) PII audits of MRSA and CDI			
SA-002	Apr-20	APW	Mandatory reporting of surgical site surveillance	1) SSS to be reported 6 monthly to IPCC 2) Quarterly reports to PHE 3) Feedback of findings to orthopaedic directorate 4) Business case to be submitted to reflect the increase in service requirement	Mar-21	Q4	Linda Baker (surveillance nurse) & Lesley Smith
SA-003	Apr-20	APW	No avoidable > 48 hour MSSA / MRSA bacteraemia	1) All pre and post 48 hours MSSA / MRSA bacteraemia to be reported on the DCS 2) RCAs to be completed on all > 48 hour MSSA/MRSA bacteraemia within 5 days and presented to the monthly panel for sign off 3) Trends and lessons learnt to be shared within the directorate	Mar-21	Q4	Lesley Smith
SA-004	Apr-20	APW & KLOE	50% reduction in gram negative blood stream infections by 2024/25 Gram neg 18/19 E coli 69 Kleb 28 Pseudo 16 Total 113 Gram neg 19/20 Ecoli 75 Kleb 13 Pseudo 7 Total 95 Gram neg 20/21 (31/07/20) Ecoli 14 Kleb 7 Psuedo 2 Total 23	1) Attend Kent and Medway HCAI Improvement group meetings with CCG 2) Patient indwelling catheter cards to be provided to patients going home with indwelling catheters (E1.5) 3) Preventing CAUTI cards which promote Houdini (E1.5) 4) Laminated 'tea cup posters to be provided to ward to promote the hydration of patients (E1.5) 5) Continue to promote catheter passport 6) Report all > 48hr & <48 hr E.coli, Klebsiella and Pseudomonas aeruginosa bacteraemia on the National Data Capture System 7) RCAs to be completed on all gram negative bacteraemia which are considered avoidable and / or identify areas for learning 8) Volunteers to support additional drinks rounds to assist in promoting hydration. 9) Monitor trends against the national PHE fingertip data 10) Gram negative reduction meetings to be held 11) utilisation of GNBSI reduction plan tools and plan available at: https://improvement.nhs.uk/resources/gram-negative-bloodstream-infection-reduction-plan-and-tools/	Mar-21	Q4	Jacqui Griffin (Lead Nurse IPC)
SA-005	Apr-20	APW	Clostridium difficile Trust attributable infections to be within the Trust Limit of 55 (19/20 we had 52 cases against a limit of 55)	1) Monitor trends from the RCA & PIIs and act on findings 2) All RCAs are to be completed in 5 working days and presented to the monthly panel for agreement and sign off. 3) All samples to be sent for Ribotyping 4) Monitor for any evidence of transmission of infection	Mar-21	Q4	Lesley Smith

SA-006	Jun-20	BAF	Assurance of PPE compliance in accordance with the national guidance	1) PPE observational audits undertaken by the PPE safety officers 2) Audit findings to be shared with Divisions and presented at IPCC	Mar 21	Q4	Lesley Smith
SA-007	Aug-20	APW	Introduction of the updated ICNet system	1) ICNet advanced training to be delivered to IPC team 2) IPC team to implement the new ICNet system into their day to day work	Mar-21	Q4	Lesley Smith
SA-008	Apr-20	APW	Support the introduction of the electronic audit programme	1) IPC team to attend and participate in the IVQIA meeting 2) Submit audit templates for conversion to electronic versions 3) Trial of electronic versions using iPads	Mar-21	Q4	Jacqui Griffin (Lead Nurse IPC)
TRAINING AND EDUCATION							
TE-001	Apr-20	APW	All training to be updated to reflect local and national guidelines	1) IPC training handbook to be updated	Aug-20	Q2	Jacqui Griffin (Lead Nurse IPC)
TE-002	Jun-20	BAF	All training to be updated to include COVID 19 requirements	Update: 1) Online training package 2) Face to Face training	Dec-20	Q3	IPCT
NATIONAL AND LOCAL STANDARDS							
NLS-001		APW	Delivery of the local Antimicrobial Resistance Strategy	1) ASG to report to the IPCC 6 monthly 2) AMR CQUIN for lower urinary tract infections in older people to be delivered	Mar-21	Q4	Helen Burn & Lesley Smith
NLS-002		APW / KLOE	Demonstrate Shared learning from lesson learned from RCAs and incidents	1) Lessons learnt from RCAs to be identified and shared 2) Trends to be monitored and reported for wider shared learning 3) Closing the loops of RCAs - Actions from RCAs to be monitored through the IPCC to ensure that all actions have been completed (W4)	Mar-21	Q4	Lesley Smith
NLS-003		APW	Support the Implementation of the Annual Flu plan	1) Peer vaccinators to recruited to support the 95% of frontline staff vaccination 2) Adequate stock of viral swabs, masks and anti-viral medicines 3) Fit testing of front-line staff 4) Flu Campaign 5) Surveillance of flu cases 6) Timely raising awareness emails to be sent regarding signs and symptoms of flu and differential diagnosis	Mar-21	Q4	IPCT
NLS-004		APW	Revise IPC policies due for update during 20/21	1) Candida auris (New) SM 2) Notification of Infection (New) SM 3) Animal Visitors (April 19) LS 4) Scabies policy (July 19) CT 5) TSE (July 19) DM	Mar-21	Q4	IPCT

				6) Norovirus (Sept 19) CT 7) Isolation (August 19) JG 8) Control of resistant organisms (Sept 19) LS 9) Blood borne viruses (April 20) (LS) 10) Environmental disinfection (Jan 20) DM 11) Laundry (Jan 20) DM 12) CPE (March 20) JG 13) Decontamination of Mattresses (April 20) DM 14) Single use medical devices (June 20) DM 15) Infection Prevention and Control (July 20) LS 16) TB (Oct 20) SM 17) VZV (Oct 20) SM 18) Outbreak of communicable disease (Oct 20) SM 19) Ward closure (Oct 20) LS 20) Hand hygiene (Oct 20) LS			
NLS-005		CCG	Deliver CCG KPIs	1) KPIs to be agreed 2) Agreed KPIs to be monitored through the IPCC meeting	Mar-21	Q4	Lesley Smith
NLS-006		APW	Determine compliance with the code of practice the prevention and control of HCAIs	Self-assessment tool for prevention and control of HCAIs to be completed and reviewed quarterly	Mar-21	Q4	Lesley Smith
NLS-007		APW	Revise all IPC leaflets due of update during 20/21	All leaflets that require updating for 20/21 to be reviewed 1) Hand hygiene information for staff - August 20 2) CPE - information for patients (Standard and Large print) - April 20 3) Clostridium difficile - Easy read - Dec 20 4) MRSA - Easy read - Dec 20 5) Hand Hygiene - Easy read - Dec 20 6) MRSA - how to apply decol - Standard and large print) - April 21 7) Flu - April 21	Mar-21	Q4	Lesley Smith
NLS-008		APW	Seek opportunities to publicise and promote the work undertaken by the IPC team both locally and nationally	1) Utilise social media to promote the IPC service and team 2) Consider areas for innovation 3) Undertake QI projects and present findings	Mar-21	Q4	Lesley Smith

Key	
APW	Annual Programme of Work
KLOE	Key Lines of Enquiry
BAF	Board assurance Framework

NHS
Maidstone and Tunbridge Wells NHS Trust

Six-monthly update on Estates and Facilities (incl. update on the response to the external Estates and Facilities review)

Chief Executive

It has previously been agreed that the Trust Board should receive a Six-monthly update on Estates and Facilities. It was then agreed at the Part 2 Trust Board on 25/06/20 that an update on the response to the external Estates and Facilities review report should be submitted to the 'Part 1' Trust Board meeting in September or October 2020 (on the basis that the more specific oversight of that review response should be led by the Finance and Performance Committee). The enclosed report therefore covers both aspects.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 13/10/20
- Trust Management Executive (TME), 14/10/20

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

Information and assurance

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

Introduction

At the time of issue of the last six monthly report the Covid 19 Pandemic was surging. The course of events that followed presented unparalleled challenges for the Estates and Facilities Directorate, diverting onto a path of activities that could not have possibly been conceived at the start of the year.

This report highlights the activities and progress that has been made during 2020. This includes the commissioning and opening of the car park decks at Maidstone Hospital and Tunbridge Wells Hospital. In addition there has been significant activity in modifying both the acute hospitals into Covid Red and Green areas and expanding the ITU capacity on both sites.

Early into the pandemic it was clear that Maidstone Hospital was facing a very serious potential capacity of medical oxygen for the therapeutic treatment of Covid patients. The Trust received considerable support from NHSi Estates and the British Oxygen Company. This activity is further highlighted in the report.

As well as the foregoing the Estates and Facilities Department has been making substantial progress following the Estates and Facilities Transformation studies that were undertaken last year by external management consultants. The translation of the management consultants report has resulted in a number of workstreams being developed to bring into place delivery improvements and cost savings. These workstreams are highlighted further in the report.

Out of all adversity the Directorate has been very fortunate to receive considerable commercial financial support during this most difficult period from Mrs. Lorraine Mills., Financial Improvement lead in the Trust Finance Directorate. It is appropriate that Lorraine is thanked for her very substantial input into the Directorate and ongoing support which has enabled many issues to be addressed and improved that have been outstanding for a very long time.

As the year draws to a close the Estates and Facilities Directorate is embarking on an exciting programme of clinical space reconfiguration and providing support to our clinical colleagues in their delivery of medical and surgical care in a demanding environment of a pandemic.

Hannah's Garden Maidstone Hospital

Hannah Green a former stroke patient at Maidstone Hospital undertook a campaign to raise money for the creation of a garden at Maidstone Hospital for the quiet enjoyment of patients and staff. The garden has now been created with a mural painted by artist Luzia Jordan. Hannah Green is pictured in the photograph at the opening of the tranquil garden which is situated at the rear of Maidstone Hospital. The project was co-ordinated by Facilities Manager Mrs Maria Fabian who has brought about a superb result from the funds available.

Maidstone Hospital Front Entrance Fish Pond

The Maidstone Hospital front entrance has now benefitted from the generous donation of charitable funds to refurbish and recommission the fish pond at the front entrance to the hospital.

The project has involved the plastic relining of the former pond and the upgrading of the aquatic life and filtration system. This addition of the fish pond is an enhanced environmental improvement for the enjoyment of staff, visitors and patients.

A plastic herons has also been strategically placed (look in the top right hand corner) to deter real herons from a generous free lunch of goldfish.

Maidstone and Tunbridge Wells Car Park Single Storey Decks

The Trust undertook a fast track three month contract to construct new car parking decks concurrently at Maidstone Hospital and Tunbridge Wells Hospital.

The new car parking decks have been completed and are now in serviceable use for the use of staff. The entire car parking arrangements at both Maidstone and Tunbridge Wells Hospitals have been reconfigured to provide additional car parks to both patients and staff arising out of the new car park deck constructions.

The Tunbridge Wells car park deck design incorporates a “warmer lighting” specification. The warmer lighting luminaires are environmentally suitable for a Bat population that occupies areas of the adjacent woodland. The project has received support from local councillors in both boroughs. Over the coming months developments will be undertaken to provide green walls to the car parks and to improve the environment and sustainable contribution required for the additional car parks. A favourable response has been received from staff with regard to the improved car parking arrangements at both hospitals.

Medical Oxygen Upgrade Maidstone Hospital

During the Covid 19 pandemic the Trust faced significant risk with the provision of medical oxygen supplies generated on site by a liquid oxygen vacuum operated evaporator and oxygen vaporisers. It was found that the Trust could only generate 1,600 l/minute of medical oxygen to Maidstone Hospital. Following representations from the Chief Executive Officer and engagement of the Director Estates & Facilities a case was presented to NHSi Estates requesting agreement and authorisation for an increase in oxygen supply to Maidstone Hospital to meet impending clinical needs with the Covid 19 pandemic.

The representation was approved and the Trust engaged with the British Oxygen Company to modify the medical oxygen vaporisers on the Maidstone Hospital site from 1,600 l/m to 2,800 l/m.

The task involved splitting the existing medical oxygen vaporisers in the liquid oxygen compound at Maidstone Hospital and installing a new manifold to facilitate the increased supply. The British Oxygen Company provided full support and co-operation. The liquid oxygen plant main vacuum insulated evaporator was decommissioned and emergency supply of medical oxygen was provided by the reserve insulated evaporator. The engineering exercise was completed within four hours (with components being pre made prior to the shutdown).

The main vacuum insulated evaporator was then recommissioned and tested for flow rates and oxygen purity. The task was a total success and the medical oxygen capacity at Maidstone Hospital has now been increased to a maximum flow rate of 2,800 l/m.

The Trust extends its thanks to the British Oxygen Company and NHSi Estates in facilitating this improvement in medical oxygen supply capacity.

Maidstone Hospital Vacuum Insulated Liquid Oxygen Evaporator and Vaporiser Plant

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Staff Welfare Catering and Parking

With the onset of the Covid 19 pandemic the Trust Board and Executive kindly put in place free parking for staff and patients and a range of food for the sustenance of staff in the Trust who were working under exceptionally difficult decisions. The food has been provided in the staff canteens, Education Centres and Wingman Marquees. Staff have been able to benefit from a selection of food, water and beverages to enable them to carry out their arduous tasks during the pandemic.

Clinical and Office Accommodation Developments

The Covid 19 pandemic has placed significant pressures on the Trust to develop Green and Red Covid 19 areas in both the acute hospitals. The imposition of social distancing has had a significant impact on both clinical accommodation and office accommodation at both the acute hospitals within the Trust.

Our colleagues in the Information Technology Directorate have provided many laptop computers enabling staff to work from home. Social distancing n all office accommodation areas has been implemented since the inception of lock down.

The Trust has been fortunate in obtaining additional office accommodation at the Oast House which is situated in Hermitage Lane from the Kent Community Health Foundation Trust (KCHFT) have provided this additional accommodation. The Trust RTT Team are to be relocated to the Oast House which will greatly assist the surgical directorate in the endeavours of the RTT Team.

There have been a number of clinical moves at both Maidstone and Tunbridge Wells Hospital which are now intrain to assist the winter pressures that the Trust is imminently facing.

The Tunbridge Wells hospital PFI company and the Tunbridge Wells District Council Planning directorate have been most supportive in assisting the Trust going forward with the provision of the planned build of a £1.5 m temporary Surgical Admissions Building. It is proposed that the building will be erected on the car park adjacent to the A&E department.

The project subject to approval, will result in a 500 m sq single storey pre-fabricated surgical admissions unit equipped to a high standard to treat surgical admission patients. This building will provide relief space in the Tunbridge Wells hospital to meet the pressures of clinical accommodation needs. The sourcing programme for the new temporary building has involved searching the temporary building market with over 16 companies being approached. The photograph below is of sectional components of the proposed new Surgical Admissions Unit. This building is bolted together in sections and mounted on pressure pads.

Geotechnical studies have been underway to establish the suitability of the soil for pressure loading of the new building. It is anticipated that the new building can be delivered to site in three and a half weeks from placement of order. The building shall then be subjected to an internal carcassing fit out and the provision of engineering services including lighting, electrical power, water, drainage, sanitation and IT provision. The fast track programme subject to approval, is projected to be completed by mid December 2020.

External Management Consultants Estates & Facilities Transformation Programme

Last year external management consultants undertook a detailed study of the full range of Estates & Facilities functions carried out in the Trust. The report delivered to the Trust provided a number of opportunities for the Trust to obtain significant productivity improvements, service improvements and cost reductions. The external management consultants report has been developed into a transformation programme involving six workstreams comprising of:

- Laundry
- Porters
- Domestics and Cleaning
- Catering
- Estates
- Waste Management

The Estates & Facilities Directorate has received managerial and commercial support from the Finance Directorate and Project Management Office in the delivery of the transformation streams.

Staff from the Project Management Office and Financial Improvement are leading on the workstreams. Individual Estates & Facilities managers, staff side officers and staff champions are engaged in the workstreams.

It is projected that the workstreams transformations shall crystallise in full in the very early new year and so deliver benefit in cost reduction, service improvement and quality outcomes for the Trust.

Water Safety Management Operations and Governance Reinforcement

A substantial study of the water safety management at both Maidstone Hospital and Tunbridge Wells Hospital has been ongoing since February of 2020. Significant reinforcement of the requirements of the Health and Safety Executive Approved Code of Practice for Legionella Management L8 and the NHS Health Technical Memoranda 04-01 criteria has now been updated to place the Trust in a position of best practice guidance going into the future. The process has involved the approval and addition of a full time water treatment manager, two additional plumbers and two additional full time operatives to flush the water systems at Maidstone Hospital.

The provision of legionella management at Tunbridge Wells Hospital is the responsibility of the PFI company KESWHL. Issues on performance in this area have been taken up with the PFI company and their supply chain provider Interserve. Over the last week significant progress on rectifying shortfalls in water safety management by the PFI company have been addressed. The author is confident that the improvements will continue to provide a robust water management system which will be incorporate in respect of reporting to a newly formed water steering group comprising of:

Microbiologist
Infection Control Staff
Estates Staff
Facilities Management Staff
PFI Facilities Management Staff
Water Safety Duty Holder at both Maidstone and Tunbridge Wells Hospital (respectively)
The external authorising water safety engineer

A sum of £150k has been approved for transfer from the Estates Non Pay Budget to the Pay Budget for the appointment of the additional water safety staff. The Trust will now benefit from a full time member of staff dedicated entirely to the co-ordination and management of water safety in the Trust.

The implementation of the appointments and changes shall take four months from the date of issue of this report.

Approval of the Workforce Race Equality Standard (WRES) action plan	**Head of Staff Engagement & Equality / Chair of the Culture and Ethnic Minorities Network**

It was agreed at the Workforce Committee on 17/07/20 that the Workforce Race Equality Standard (WRES) action plan should be approved by the Trust Board, in October 2020 (having first been considered by the Workforce Committee on 18/09/20).

The enclosed report sets out the clear intentions of the Trust to increase diversity and inclusivity enabling us to deliver services for all people within our communities.

We have reviewed the 2019/20 WRES data for MTW along with a 5 year review from the WRES Implementation Team at NHS England. We recognise the enormity of the impact of Covid-19 and the death of George Floyd on our BME staff.

There are some key pieces of work required to provide our current and future BME workforce with assurances that they will not face discrimination during recruitment processes, that they will be supported throughout their working lives at MTW and receive career development advice, guidance and support to develop their career here.

1. Increase the percentage of BME staff being recruited into the Trust using methods which actively seek to fulfil gaps in the diversity of teams
2. Starting at Executive level, provide opportunities for white staff to learn from the lived experiences of BME staff enabling them a greater understanding of the impact of discrimination on BME staff and the patients they care for
3. Increase career progression and promotion of our BME staff, including a focus on senior positions including improved access to non-mandatory training and CPD for BME staff
4. Reduce the percentage of BME staff experiencing harassment, bullying or abuse from colleagues, patients and managers

The Trust Board has committed to supporting these activities.

Which Committees have reviewed the information prior to Board submission?

- Workforce Committee, 17/07/20 and 18/09/20
- Executive Team Meeting (ETM), 20/10/20

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

Approval

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

WORFORCE RACE EQUALITY STANDARD

1.0 INTRODUCTION

1.1.1 The Workforce Race Equality Standard (WRES) was introduced in April 2015 and is mandated as part of the NHS Standard Contract.

1.1.2 The Trust also sees this as a vital component as we strive to improve and deliver our obligations under the Public Sector Equality Duty to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

1.1.3 This report contains the Trust's fifth WRES report which is published on our website, shared with NHS England, our local commissioners as well as being reviewed as part of our CQC inspection.

1.1.4 The data submitted has demonstrated an increased gap in BAME staff representation at Band 8a and above compared to the number of BAME staff in our workforce, with no improvement at the most senior levels in the organisation. Issues around recruitment, career development and support will be the focus for the year ahead.

2.0 IMPACT OF COVID-19 ON OUR BME STAFF

2.1.1 Public Health England published a report in June 2020 on the impact of Covid-19 on our BAME population. It looked at the increased risk factors for BAME people, and heard from stakeholders about health inequalities which pre-existed Covid-19 and were exacerbated by it. It looked at a range of factors ranging from social and economic inequalities, racism, discrimination, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, CVD and asthma.

2.1.2 Whilst MTW focussed efforts of the risk assessment tool on BAME staff, concerns were raised about the completion of the assessments. Some were completed without the involvement of the individual and some had risks reduced by the managers. This left some of our BAME staff fearful and mistrusting of the process. Both the Head of Staff Engagement and CEMN Chair were approached by 7 members of staff where their risk assessment was completed for them in their absence. This information was relayed to Miles Scott, CEO and he responded by addressing this in his weekly update.

3.0 REVIEW FROM WRES IMPLEMENTATION TEAM – 5 YEARS ON

3.1.1 In February 2020, Yvonne Coghill, Director of the WRES Implementation Team at NHS England, recognised the work needed to change the culture in an organisation as big as the NHS where processes and systems are embedded and change is slow. The team have helped to shine a light on the importance of race inequality in the NHS, how it benefits staff and ultimately patients.

3.1.2 It was reported that, year on year, the gap between BME and white experiences for indicators 2, 3 and 4 is closing. This means that nationally the NHS is becoming fairer when it comes to recruitment, entry into formal disciplinary processes and non-mandatory training.

WRES Indicator	2016	2017	2018	2019
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.57	1.60	1.45	1.46
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.56	1.37	1.24	1.22
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	1.11	1.22	1.15	1.15

3.1.3 The focus on harassment, bullying, opportunities for career progression and discrimination has, however, remained more or less static for the past five years.

WRES Indicator		2016	2017	2018	2019
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in past 12 months	**BME**	29.1%	28.4%	28.5%	29.8%
	White	28.1%	27.5%	27.7%	27.8%
6. Percentage of staff experiencing harassment, bullying or abuse from staff in past 12 months	**BME**	27.0%	26.0%	27.8%	29.0%
	White	24.0%	23.0%	23.3%	24.2%
7. Percentage of staff believing that trust provides equal opportunities for career progression or promotion	**BME**	73.4%	73.2%	71.9%	69.9%
	White	88.3%	87.8%	86.8%	86.3%
8. Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	**BME**	14.0%	14.5%	15.0%	15.3%
	White	6.1%	6.1%	6.6%	6.4%

3.1.4 Nationally, there has been an increase in the number of Board members, non-executives and executives from BME backgrounds which now sits at 8.4%. This is still significantly lower than the proportion of the BME workforce across all NHS Trusts and CCGs in England (19.9%). In numbers, BME board members in Trusts have increased by 35 which comprises an additional 18 executive and 17 non-executive board members. There has also been a decrease in the number of trusts with no BME representation on the board and there are now 30 trusts with three or more BME board members compared to 16 in 2016.

WRES Indicator	2016	2017	2018	2019
9. BME board membership	7.1%	7.0%	7.4%	8.4%

4.0 MTW WRES DATA 2019/20

4.1.1 The proportion of BME staff in the Trust is 24%, which is higher than the national average for the number of staff employed. The gap is also larger than the national average which is 8%. There has been a considerable increase in band 5 appointments which is down to an increase in international recruitment over the previous year. The figures for non clinical staff at Band 6 include operational management with only 1 in 10 being BME when nearly a quarter of the Trust is BAME.

4.1.2 It is disappointing to note the significant increase in likelihood of white staff being appointed from shortlisting.

	2020	2019	2018
Proportion of BME Staff in Trust	24%	24% (21-26%)	23% (21-26%)
Proportion of BME Staff Bands 8A and Above	10.5%	12% (10-14%)	12% (10-13%)
Gap	13.5%	12% (11 – 12%)	11%
Proportion of BME Staff Band 5 Clinical	43%	34% (31-37%)	31% (31-33%)
Proportion of BME Staff Band 6 Clinical	17%	17% (15-18%)	16% (14-17%)
Proportion of BME Staff Band 1-5 Non-Clinical	17%	20% (18-23%)	20% (18-22%)
Proportion of BME Staff Band 6 and above Non- Clinical	10%	11% (8-13%)	10% (8-12%)
Proportion of Consultant Staff BME	34%	33% (31-35%)	34%
Proportion of Staff Senior Medical BME *Defined as Chiefs of Service*	0%	0%	0%
Proportion of VSM	14%	20%* (12-29%)	0%
Data taken from ESR April 2018 – March 2019			
Relative likelihood of white staff being appointed from shortlisting compared to BME staff	1.62	1.20	1.31
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	0.77	1.04	0.93
Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	1.86	1.58	1.06

	2019 national NHS Staff Survey		2018 national NHS Staff Survey	
	BME	White	BME	White
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	26.9%	25.8%	24.5%	25.6%
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	74.2%	86.7%	77.7%	90.6%
Percentage of staff personally experienced discrimination at work from manager/team leader or other colleague	13.3%	6.0%	18.3%	7.9%

4.1.3 There are some anomalies in the data compared to last year as noted below:

	2019			2020		
	White	BME	Unknown	White	BME	Unknown
Number of shortlisted applicants	3966	2413	223	3801	1588	228
Number appointed from shortlisting	167	85	68	1432	370	147

4.1.4 The number of staff appointed from shortlisting has increased dramatically compared to 2019

On review, the Recruitment team believe the incorrect pro-forma was used when the report was run for 2018-19. They are unable to re-run the report for 2018 as the data is no longer held in Trac. The recruitment team (including medical staffing) will document the process for gathering the data to ensure the same approach is used each year.

4.1.5 Number of staff entering the formal disciplinary process has increased significantly.

Further investigation is needed but first thoughts are that the way "entering the formal disciplinary process" was recorded may be different this year. All staff networks annually review disciplinary cases collectively where themes and trends will be highlighted as areas of focus going forwards.

4.1.6 Likelihood of BAME staff accessing non mandatory training has decreased significantly

There has been a change in the LMS but this system may be capable of more robust data than previously.

L&D have been approached for clarification though it is suspected this is to do with the way the data is now recorded within the Learning Management System

5.0 ACTIVITY OVER THE LAST YEAR

5.1.1 Over the last year, we have seen the Cultural and Ethnic Minorities Network grow in number and strength. From 47, there are now over 100 staff who are on the mailing list, attendance at network meetings has increased from 5 to 25 – this has been improved by introducing virtual meetings and varying timings. The network now has a dedicated committee of 9 people, there are regular meetings with external speakers including Helen Grant

5.1.2 The effects of Covid-19 and the killing of George Floyd have had a huge impact on our BAME staff. The CEMN swiftly responded to the needs of our BAME community and stepped up the support provided by scheduling weekly evening online events. The events were not only supportive to BAME staff but powerful and emotional, enabling white allies to understand more of the lived experiences and fears of their BAME colleagues.

5.1.3 The Trust CEO has pledged not only to embark upon self-education but has visibly supported our BAME colleagues by leading a 2 minute silence in respect of the killing of George Floyd. They have pledged to fully support the activities of the CEMN and has recognised and backed the need for the Trust to lead on activities that will help to create further diversity and bring equality to the forefront at MTW. This senior level support is the start of a journey for MTW with an ambition that all staff within the Trust embrace equality, diversity and inclusion.

5.1.4 With the backdrop of Covid-19 and the issues now regularly raised with the CEMN by staff who are experiencing bullying, harassment and discrimination at the Trust, the network are re-focussing. Their primary aim going forwards will be to provide support to our BAME staff, to give them a voice and confidence to seek help, to help them recognise and deal with B&H and discrimination. There are clear links between the support they will provide and the work the Trust has embarked upon as a result of the HR review in terms of bullying and harassment. They will provide advice and guidance to the Trust on the WRES action plan. They will celebrate diversity by hosting events and share their lived experiences with white allies.

5.1.5 The WRES action plan has been updated for 2020/21 which reflects delays caused by Covid-19 and brings into focus other areas of focus for development. Recruiting for Difference and reverse mentoring have been delayed but are now back on track. A focus on staff welfare due to Covid-19 has delayed the review and update of the B&H/grievance policy and focus on development of the Safe Space Champions and mediation but this is now in the pipeline. Additions to the plan this year include the appointment of a Deputy FTSU Guardian and the White Ally plan of education – linking into the White Ally Programme delivered by KMPT with a view to developing across the system.

6.0 WRES ACTION PLAN

Comments from the Chair of the Cultural and Ethnic Minorities Network
Ms Rantimi Ayodele BSc, MBBS, MSc, DLSHTM, FRCSEd(Tr&Orth),

When I took over the leadership of the CEMN in summer 2019, I was aware that it would be a challenging and rewarding role. I could not have foreseen the extent of the growth of the role and the Network and the issues that have come to play in the last year. My experience in this role and indeed as a black woman in the last year has left me feeling both heartbroken and encouraged, weary and optimistic. I am extremely proud of what the CEMN has achieved over the last year, but there is much work to do. I am thankful for having an amazing colleague with Mildred Johnson as the Deputy Chair, and having a Committee that is full of ideas and energy.

Achievements and Progress

With the support of Miles Scott, CEO and the board we have led the Trust in big strides against last year's action plan. We have brought in Diversity by Design to spearhead our recruiting for difference strategy to review our recruitment processes. We are still in the process of moving forward with this pilot. We have supported our BAME staff during these difficult times with weekly online meetings that were well attended and received. This enabled us to have opportunities for reflection and support for BAME staff and allies.

We have been involved in the national NHS offerings from the Chief People Officer for BAME Network chairs, which enabled us to respond quickly in collaborating over the development of an appropriate stratified risk assessment. The collaboration on a National and a regional level has enabled us to benchmark the Network and the Trust in the work that we are doing. We are now a founding member of the Kent and Medway System BAME Strategy Board.

We are currently solidifying the maturity of the Network by finalising our Terms of Reference, having our AGM, moving to have exec committee members with protected time and career development to work on the Network. We will be delivering a virtual conference, "The Power of Us" with a panel of distinguished speakers in celebration of Black History Month. We will also be deli

Ongoing Concerns

It is important to reflect however, that our data shows that if there is progress, it is slow. There is work to do. We need to note that we have diminished representation for BAME staff in non-clinical higher bands. We have a large pool of Band 5 clinical staff (made larger by our recent International recruitment), we need to ensure that career progression for BAME staff is transparent and supported in these areas. Myself and Mildred are regularly contacted by BAME staff who report harassment which they feel is racial in nature. I have myself experienced microaggression within the Trust. As we move forward in our Reset and Recovery and Culture and Leadership programmes it is still important to highlight the staff who report that they have not experienced compassionate leadership in their return to work from shielding or in the flexibility of work that we might have hoped would occur. Neither ourselves in the Network, nor, I feel the Trust in general has effectively grabbed the engagement of those staff in the lower AfC bands (1-4).

Moving Forward

We have made some changes to the Action Plan and we are still in the process of delivering so much of this work. In response to what has happened over the last few months an Allyship Programme is being developed to help raise awareness for our BAME Allies. A further addition is moving on training to develop EDI Recruitment Panel Advisors. This is particularly important as our data shows white staff are 1.62 more likely to be appointed from shortlisting that BAME staff. We are also developing a Kent System wide "Stepping Up" programme aimed at BAME staff as well as collaborating with the CCG OD team to develop a BAME Chairs leadership development day. We are about to embark upon the Reverse Mentoring programme in conjunction with KPMT (and now as a proof of concept for other Trusts in the system). We are collaborating and supporting the recruitment of a Deputy FTSU who is BAME focussed.

All of this highlights areas in we still need to work together to ensure that MTW is truly as amazing as it can be and continues its growth as an outstanding place to work. We would like the Trust to continue to ensure that as it reviews areas of PPE, Risk Assessment, Wellbeing conversations and flexibility in working that it has a particular view on how these areas can highlight unconscious bias in how the plans are managed for our BAME staff and colleagues.

We welcome the robust insight of the Board as they seek assurance on these WRES Action Plan

6.1.1 The 2020/21 WRES action plan aims to deliver the priorities of improving BAME representation across the workforce, improving the experiences of our BAME colleagues and supporting them to develop their career here at MTW.

Action	Lead	Due Date	Activity
Starting at Executive level, provide opportunities for white staff to learn from the lived experiences of BME staff enabling them a greater understanding of the impact of discrimination on BME staff and the patients they care for	Head of Staff Engagement and Equality	January 2021	• Pilot Reverse Mentoring with Executive and Non Executive Team • Create a White Ally programme of education (in collaboration with KMPT who are already delivering this training) o Learning from BAME staff of lived experiences o Recognising unconscious bias o Developing skills and confidence to challenge behaviour and attitudes of staff and patients o Create a book club
Indicator 1 Increase the % of BME staff in each of the AfC Bands 1 – 9 and VSM (compared with the % of staff in the overall workforce) **Indicator 7** Increase % of BME staff believing the Trust provides equal opportunities for career progression or promotion *Increase career progression and promotion of our BME staff, including a focus on senior positions including improved access to non mandatory training and CPD for BME staff*	Head of Equality Head of L&D CEMN Committee Head of Learning & Development HR	February 2021	• Deliver "The Power of Me", a half day workshop for staff focussing on career development - actively targeting BAME staff to attend – • Provide job interview skills workshops for BAME staff – designed and delivered internally • CEMN Chair to mentor a member of the CEMN to lead to wider Mentorship programme being established • Develop Talent Boards within each Division working in collaboration with HR Business Partners to set up to identify and support talent management and succession planning ensuring that assessment of BAME staff is identified and supported – • Create a central repository of BAME talent within the Trust
Indicator 2 Increase the relative likelihood of BME staff being appointed from shortlisting	Head of Staff Engagement and Equality	January 2021	• Complete pilot of "Recruiting for Difference" with Head of Performance and 3 x General Manager roles for Medicine and Emergency Care. Following the pilot and review this process will

compared to white staff From white staff being 1.6 times more likely to be appointed than BME staff to the likelihood of BME staff being appointed being the same as white people *Increase the percentage of BME staff being recruited into the Trust using methods which actively seek to fulfil gaps in the diversity of teams*	Recruitment		be rolled out to all 8a and above posts including Consultant posts. • Develop diverse interview panels for all bands 8a and above plus Consultant appointments - training being scoped in conjunction with Kent and Medway BAME strategy board to provide EDI recruitment panel advisors training – cost to be confirmed and offset against NHS Charities budget allocation to the CEMN • Develop a robust recruitment practice, linked with RfD, for all 8A and above roles plus Consultants that utilises the Rooney Rule whereby at least one BAME person will be shortlisted and interviewed. This will provide a definite increase in the diversity of the interviewees
Indicator 6 Reduce % of BME staff experiencing harassment, bullying or abuse from staff so that BME staff are not more likely to experience it more than white people *Reduce the percentage of BME staff experiencing harassment, bullying or abuse from colleagues, patients and managers*	Head of Occupational Health Head of Staff Engagement and Equality	October 2020 November 2020 December 2020 December 2020 December 2020	• Develop a robust way to promote dignity and respect at work for all staff where staff are supported in their working environment and can bring forward concerns for resolution in an effective and timely manner o Review and revamp the Bullying & Harassment policy and the Grievance policy to focus on the promotion of dignity and respect at work. o Appointment of Deputy FTSU Guardian o Development of around 25 or more Safe Space Champions to provide listening and appropriate signposting including appropriate training delivered internally o Development of a more robust mediation process to enable staff to have another forum for dealing with work difficulties, avoiding grievances where possible o Development of a process to support staff through disciplinary processes led by the Head of Occupational Health and supported by the HR team

REVERSE MENTORING - UPDATE

It is widely recognised that reverse mentoring can be successful in enabling leaders and senior managers to stay in touch with their organisations and the outside world. It can help to improve the leaderships understanding of minority issues, including those of LGBT+ and ethnic minority groups.

The value of reverse mentoring is that those in more senior positions (mentees) can often lose touch with the reality of life at the sharp end and with the experiences, concerns and ideas of staff and people who use our services. At the same time, more junior mentors can gain insight into how the leader thinks, giving them a more strategic perspective, enhanced networking and exposure – overall an opportunity to educate and to have a voice. It helps more junior colleagues to feel comfortable in speaking about the truth to those in power. So with that in mind, we need to have a practical programme that will help us agree a focus and clear aims and outcomes that are linked to supporting and informing key strategies and priorities like the culture and leadership programme.

REVERSE MENTORING

1.0 PROGRAMME DESIGN AND DELIVERY

1.1 The London Ambulance Trust and KCHFT have delivered reverse mentoring programmes. Before the Covid-19 pandemic, KMPT engaged with The Performance Coach who has supported the London Ambulance Service with a reverse mentoring programme for a number of years. KMPT approached them for a proposal which includes testimonials from both mentors and mentees together the detailed structure and suggested costs as set out below.

1.2 We are now working with KMPT to deliver a programme of reverse mentoring. KMPT and MTW have submitted bids to the STP for funding based on 16 and 17 respectively pairings of mentors/mentees. Our CEO has pledged to underwrite the cost of the programme should our bid be unsuccessful.

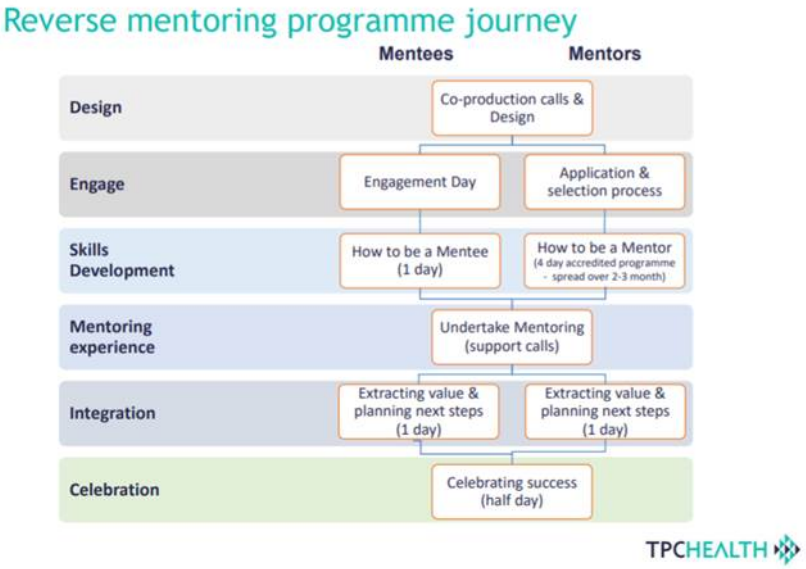
1.3 Our Procurement Team have been able to negotiate a 15% discount on the original cost provided by TPC, bringing it in at £46,736.40. The costs include

- Design and co-production phase
- Engagement phase
- Development phase
- Mentoring phase
- Integration phase
- Celebration phase

1.4 Programme

Step 1 **Purpose**	Clear and considered intent for the programme. How could this programme shape strategy? What do we want to achieve and where will it be most helpful? What learning would we hope each party will acquire? The focus will be primarily on the lived experiences of our BAME staff in light of the disproportionate impact of Covid-19 on BAME people, the death of George Floyd and increased numbers of B&H claims from our BAME community. The reverse mentoring programme should also include other areas of diversity going forwards to include disability, age, gender, LGBT+.
Step 2 **Design and preparation**	Agree programme design, scope and areas of focus. Identify any concerns and think about practicalities and logistics. Develop the process for promoting the initiative and inviting participation in the programme together with the matching process.
Step 3 **Engagement Event**	Engage all stakeholders in understanding the purpose of the programme and clarity in how it will work eg duration of programme, training and support for mentors and mentees, contracting (including confidentiality and boundaries), etc.
Step 4 **Training**	For mentees (how to be a mentee, areas of focus, identifying learning goals) – 1 day For mentors (how to be a mentor, how to share your experience) -2 days
Step 5 **Mentoring**	Contracting between mentor and mentee at outset to agree clear outcomes. Clear guidelines on length of programme, number of sessions (eg at least 3

	sessions of 2.5 hours) Mid programme check in on experience of mentors and mentees
Step 6 **Integration**	Day designed to reflect on, process and share learning, identify outcomes and plan actions and next steps. Safe environment crucial for honest conversations about learning (may be helpful to run separate mentor and mentee sessions before bringing all participants together).
Step 7 **Celebration**	Celebrate and recognise the contribution of those involved and the outputs and disseminate learning to the wider organisation.



2.0 NEXT STEPS

2.1 Whilst we are commissioning the reverse mentoring programme with KMPT, there will be elements which will work together and others that we will undertake independently.

2.2 All MTW Executive Directors and Non Executive Directors have been invited to attend a 30 minute reverse mentoring update and next steps meeting with Head of Staff Engagement & Equality and Inclusion Management Graduate. The aim of the sessions are to explain the next steps and for the mentees to start preparing for the Engagement Event.

2.3 Meeting scheduled with KMPT and TPC 18th September 2020 with a view to setting the Engagement Event dates. The Engagement Event will be an opportunity for MTW Executive Directors and Non Executive Directors to work through the focus of the programme, considering how this might shape Trust strategy and what personal and work related learning is required.

2.4 Following the Engagement event, we can then start to plan how to promote and invite participation from our BAME colleagues to enable a mentor/mentee match that is suitable.

2.5 We are aware that as Executives, the role of mentee could be a new experience that may require developing new skills and thinking about things in a different way. Mentees will receive one day of training with TPC who will help to identify how to be a mentee, what the learning outcomes are, develop active listening skills. This will take place in collaboration with KMPT Executives and Associate Directors.

2.6 Mentors are likely to require more support to build confidence, learn how to engage and share experiences. This will happen over 4 days which also provides accreditation for the mentors. Again this will take place alongside mentors from KMPT.

2.7 Training can take place either face to face or virtually – this will be assessed as the Covid-19 situation progresses. We hope to schedule the training prior to Christmas which will enable the relationships to develop over the Winter and Spring months.

2.8 The mentoring relationships will take place over a period of 6 to 9 months, dependent on a potential second wave of Covid-19. Whilst the pressures of Winter and threat of a second wave are present, it has been highlighted by the Trust Chair that these are in fact times when reverse mentoring may be most needed and important. We would prefer not to place the programme on hold should this happen and would encourage relationships to continue during the Winter and Spring months.

2.9 Mentors and mentees will be provided with support by TPC during that period of time and an extended support network with KMPT will provide addition support. Any potential issues with a lack of engagement from mentees due to operational or other pressures will be managed by our Trust Chair with the support of TPC.

2.10 As the mentoring programme draws to a close, the aim is to bring KMPT and MTW together in a celebration event to recognise achievements and disseminate learning into the organisation.

2.11 The close of the mentoring programme does not necessarily mean that the reverse mentoring relationships have to cease, if there is the desire to continue and ongoing learning is identified.

3.0 REVERSE MENTORING IN THE FUTURE

3.1 The aim is that this cohort of reverse mentoring is just the first of what will be a long standing programme of learning for MTW. The programme builds in an element of Train the Trainer to enable us to facilitate future cohorts internally, with the potential to develop this across the system.

3.2 The ambition of future cohorts is to include mentors from other minorities groups including disability, LGBT+, age and gender and to reach out to other identified mentees at MTW.

3.3 An end point assessor has been allocated for a Coaching Apprenticeship which we would look to engage future mentors onto, providing them with an opportunity to develop their skills and gain a qualification to aid career progression.

NHS
Maidstone and Tunbridge Wells NHS Trust

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

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

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

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

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report

Action Requested / Recommendation

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

Summary

A Deputy Freedom To Speak Up Guardian has been appointed 22.5 hours per week, starting mid to late November.

23 concerns raised in the last quarter mostly relating to bullying and harassment and the COVID-19 pandemic.

Author; Christian Lippiatt, Freedom To Speak Up (FTSU) Guardian

Date; 16th October 2020

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

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

By ensuring that;

- Workers are supported in speaking up

National Guardians Office (NGO)_Case Reviews

- There has been no case review since the previous Board report.
- The National Guardian has currently suspended face to face training, but is offering new post holders a 2 hour remote session one to one. This must still be supplemented by the full training day as and when they are up and running again. We are still awaiting an on-line release for training / awareness for NHS staff in general.

Themes / Issues

We have seen 23 concerns raised during the last quarter. 11 of these concerns relate to infection control processes not being followed which we would relate directly to the COVID-19 pandemic. Of these, there are 6 cases relating to one specific clinical area.

Of the 12 other cases, 10 relate to bullying and harassment concerns 6 of which are on the Tunbridge Wells Hospital site.

The pandemic has inevitably increased the number of speaking up concerns due to heightened levels of anxiety and fear, particularly in relation to the ability to socially distance, and with people not wearing face masks either in the building or when in very close proximity on the hospital grounds.

The theme of bullying and harassment is being addressed on a wider scale within the organisation and specifically through the review of the Workforce Division. Workforce now has a clear agenda within it's Operational department and Learning and Organisation Development department to help change the culture of the organisation from the centre. To better reflect the nature of the issues being raised, and in order to help defuse and resolve them, this particular work stream will emphasise dignity and respect. At this time however, the National Guardian retains the term "bullying and harassment" in its reporting and recording process.

The Trusts Bullying and Harassment Policy will be reviewed in line with the move to incorporate mediation and conciliation into our processes and refer to the terms dignity and respect to help reduce the defensive aggressive response to being accused of bullying, as opposed to being informed that an individual felt they were not treated with dignity or respect. This follows the findings and reporting of previous FTSU reports as a change in approach and language in order to reduce the number of cases progressing to a formal investigation and process resulting in a "winner" and a "loser" of that process.

The reason for staff continuing to access the Speaking Up route rather than following what should be HR / Employee Relations support remains the same as in previous reports and as outlined above. Staff do not wish to end up in a formal process of investigations and disciplinary hearings. They simply want the issue acknowledged and for changes in behaviour to be seen. We believe that over a period of the next 6 months changes in approach and language from within our Workforce Division will very much change, but that it could take a further year after that for this change in culture to be truly felt within the workforce at large. Organisational culture change takes time to embed and be felt and believed by staff at all levels.

Growing the Speaking Up Agenda

We have completed the recruitment process for a Deputy Freedom To Speak Up Guardian and hope to have the new recruit in place around mid to late November. At that point we will promote and publicise the new post and individual widely. During their first 3 months the focus will be on introducing them to and embedding them into staff networks as well as working with learning and development and medical education to make them as visible as possible at physical events – within the constraints of the pandemic. As noted at the beginning of the report, they will be able to access initial basic training from the National Guardians Office and will be linked in with other Guardians in the region for peer support.

Wider promotion and publicity of the speaking up agenda will be able to follow their appointment as the Trust will have greater capacity to address an inevitable increase in contacts. In order to reach the wider workforce, posters and leaflets will be created along with opportunities for brief introductions at team meetings, clinical audit sessions etc. as appropriate.

Data Collection; Concerns Raised

2020/21

20/21 Month	No. of contacts	Anonymous	All Open Cases
April	3	0	0
May	1	0	1
June	2	0	2
July	7	5	2
August	5	3	2
September	11	0	11
October			
November			
December			
January			
February			
March			
Total	**29**	**8**	**18**

Staff Group		Theme	
Estates & Facilities	2	Patient Safety	0
Nursing	7	Bullying/ Harassment	15
Midwifery		Fraud	1
Medical	2	Health & Safety	10
AHP's	8	Other	3
Clinical Support		**Total**	29
A&C	4		
Unknown	6		
Total	29		

2019/2020 Details

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

Staff Group	Number
Estates & Facilities	3
Nursing	4
Midwifery	0
Medical	1
AHP's	1
Clinical Support	10
A&C	10
Unknown	10
Total	**39**

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

To ratify a revised Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')	**Trust Secretary**

The Trust's current Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies'), which was ratified by the Trust Board on 30/04/20, applies a two-stage process whereby Trust-wide policies are "Approved" by the most appropriate Committee (for the policy's subject matter), and then "Ratified" by the Policy Ratification Committee (PRC). The PRC's role is to consider how well the policy is written (and reads), and PRC members are asked to advocate for the most junior members of staff that are expected to read, make sense of, and follow, Trust-wide policies.

The Policy for Policies defines a "Review date" as "The date by which a Trust-wide policy and procedure is required to be fully reviewed, and, if appropriate, the revised version uploaded". The default "Review date" period is four years. However, the Trust currently has a significant number of Trust-wide policies that have passed their review dates. The Executive Team Meeting (ETM) considered this issue on 29/09/20, and approved a proposal to amend the "Policy for Policies" to remove the requirement for a "Mandatory detailed review" to be undertaken every four years, and enable policies that have been previously ratified by the PRC (which was established in July 2014) to be reviewed, and for the policy "Author" and "Owner" to confirm whether the document is still a) needed (including whether it should still be a Trust-wide policy, or some other form of corporate document, such as a "Plan"); and if so, b) fit for purpose (notwithstanding any 'housekeeping' changes needed to reflect changes in job titles, committees etc.). If both are confirmed, the review date would be extended for a further four years. Policies no longer needed would be archived (this is already part of the current Policy for Policies), but if a policy is not fit for purpose, it should, as a priority (and in accordance with the Author's assessment of the level of risk), be fully revised, consulted on, approved, and ratified, via the process in the current "Policy for Policies". This change would mean that older policies that remain fit for purpose would likely not conform to the latest template for Trust-wide policies, but that is not considered to be a major concern. The change described above would, in the first instance, involve a Policy Review Proforma being sent to the Author and Owner, to direct them to the issues they need to consider. New policies, and policies that have not previously been ratified by the PRC, would, if they are still considered to be needed as Trust-wide policies, be subject to full development/revision, consultation, approval and ratification, via the process in current "Policy for Policies".

The Reservation of Powers and Scheme of Delegation reserves the ratification of the "Policy for Policies" to the Trust Board, so the Trust Board is asked to ratify the proposed amendments to that policy, as described above (and which are shown as 'tracked' in the following pages. N.B. for brevity, the unchanged Appendices of the Policy for Policies have not been submitted). It is expected that this change will leave a manageable number of policies that require review at the PRC, and the PRC is then likely to deploy its ability to ratify policies by virtual i.e. electronic means over the coming weeks and months, to ensure that 100% of policies are within their review date.

A further change is also proposed, regarding the approach to be taken for policies during periods of exceptional disruption (such as occurred during the COVID-19 period). It is proposed the ETM is given the authority to amend, suspend or replace any Trust-wide policy and procedure during such periods, on the basis that the ETM's powers and authority may, when an urgent decision is required between meetings, be exercised by the Chief Executive. The ETM (or Chief Executive) may, for example, wish to delegate the responsibility for ratifying temporary policies and procedures to an Incident Command Centre (as, de facto, occurred during the COVID-19 period).

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 29/09/20 (for the proposals relating to policy review dates)
- Policy Ratification Committee (PRC), 08/10/20

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

Ratification of the proposed changes to the "Policy for policies"

[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

Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

Target audience:	All Trust staff involved in the production or review of Trust-wide policies and procedures
Author:	Kevin Rowan, Trust Secretary **Contact details:** Ext. 28698
Other contributors:	Corporate Governance Assistant Assistant Trust Secretary Members of the Policy Ratification Committee (PRC)
Owner:	Chief Executive
Directorate:	Corporate
Specialty:	Corporate
Supersedes:	Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 7.0: April 2020]
Approved by:	Executive Team Meeting, ~~18th February~~ 29th September 2020
Recommended for ratification by:	Policy Ratification Committee, ~~13th March~~ 8th October 2020
Ratified by:	The Trust Board, ~~30th April~~ 22nd October 2020
Review date:	April 2024

Document history

Requirement for document:	• To comply with national recommendation for good practice. • To ensure a clear and robust approach and system is in place for the production, approval and ratification of Trust-wide policies and procedures.
Cross references (external):	1. The Freedom of Information Act 2000. 2. NICE Style Guide Corporate document [ECD1]. National Institute for Health and Care Excellence (NICE), 2016. 3. Inclusive language: words to use and avoid when writing about disability. The Department for Work & Pensions and the Office for Disability Issues, 2018 4. Care and Support Jargon Buster. Think Local Act Personal?, 2020 5. Writing for NICE: a guide to help you write more clearly. National Institute for Health and Care Excellence, 2016 6. Scientific Nomenclature. The Centers for Disease Control and Prevention, 2020. 7. Bureau International des Poids et Mesures (BIPM). International System of Units, 2020.
Associated documents (internal):	• Policy Ratification Committee (PRC) pre-submission checklist [available from the Assistant Trust Secretary]. • Publication Scheme available at www.mtw.nhs.uk/freedom-of-information/publication-scheme/. • Standing Orders [RWF-OPPCS-NC-TM23]. • Terms of Reference of the Policy Ratification Committee (PRC) [available from the Trust Secretary's office]. • Trust Committee Structure [RWF-OPPCS-NC-TM23].

Keywords:	Ratification	Consultation	PRC
	Approval	Trust-wide	Procedure
	Policy for policies	Policy policy	Author
	Policy Ratification Committee	Owner	SOP

Version control:		
Issue:	**Description of changes:**	**Date:**
6.0	Complete revision of policy, to reflect the revised ratification process approved by the Trust Board in May 2014 including: • Clearer definitions (of 'Policy', 'Trust-wide' etc.). • The exclusion of clinical guidance documents from the policy. • Clarity regarding the various steps in the process (including 'approval' and 'ratification'). • The existence and functioning of the Policy Ratification Committee (PRC). • Clarification that a review date is not an expiry date (and that a policy and procedure does not become	October 2017

Version control:		
Issue:	**Description of changes:**	**Date:**
	automatically unfit for purpose solely because its Review date has passed). • The processes for considering amendments or withdrawals. • All Trust-wide policies and procedures being ratified for 4 years (unless a shorter period is required).	
6.1	Clarification added on the requirement for an approving committee to be Trust-wide.	January 2018
6.2	Amended consultation sections 5.3.2 and 5.3.4 to clarify that Corporate Governance Assistant must complete the post-consultation check after all other consultation feedback has been addressed.	September 2018
7.0	• Amendments to clarify the required process when a policy is ratified with content that directly affects the content of another policy (section 5.3.3 and 5.9.3, and Policy template in Appendix 5). • Updated section 5.5.1 to reflect current Trust committee structure with respect to approval authority. • Addition of new appendix (Appendix 6: Style guide for Trust-wide policies and procedures). • Amended definition of 'Trust-wide policy' to be a policy that covers the method of working across more than one Division (rather than one Directorate). • Amended definition of a 'Local policy (and procedure)' to be a policy (and procedure) that covers the method of working within a single Division (and the staff therein) (rather than a single Directorate). • Inclusion of the definition of a Division. • Formalisation of the Policy Ratification Committee's determination on the use of gender specific language (described within the new style guide in Appendix 6). • Replacement of 'Executive Lead' for a policy with 'Owner' (to enable 'Owners' to include persons other than members of the Executive Team). • Inclusion of the definition of Standard Operating Procedure (SOP). • Confirmation that policy documents and any appendices that are primarily linked to that policy must be reviewed in full by the approving committee (and thereby removing the option of the approving committee only receiving a synopsis of a policy) • Further precision being described for the steps required when documents no longer wish to be regarded as Trust-wide policies	April 2020
8.0	• Removal of the requirement for a "Mandatory detailed review" to be undertaken every four years, and	October 2020

Version control:		
Issue:	**Description of changes:**	**Date:**
	enable policies that have been previously ratified by the Policy Ratification Committee to be extended for a further four years if the Author and Owner confirm that the document is still needed and fit for purpose. • Addition of a further Appendix (a Policy Review Proforma, to enable the Owners and Authors to confirm the need for a policy to be considered again by the Policy Ratification Committee) • Granting of the authority to the Executive Team Meeting to amend, suspend or replace any Trust-wide policy and procedure during periods of exceptional disruption.	

Summary for

Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Division.

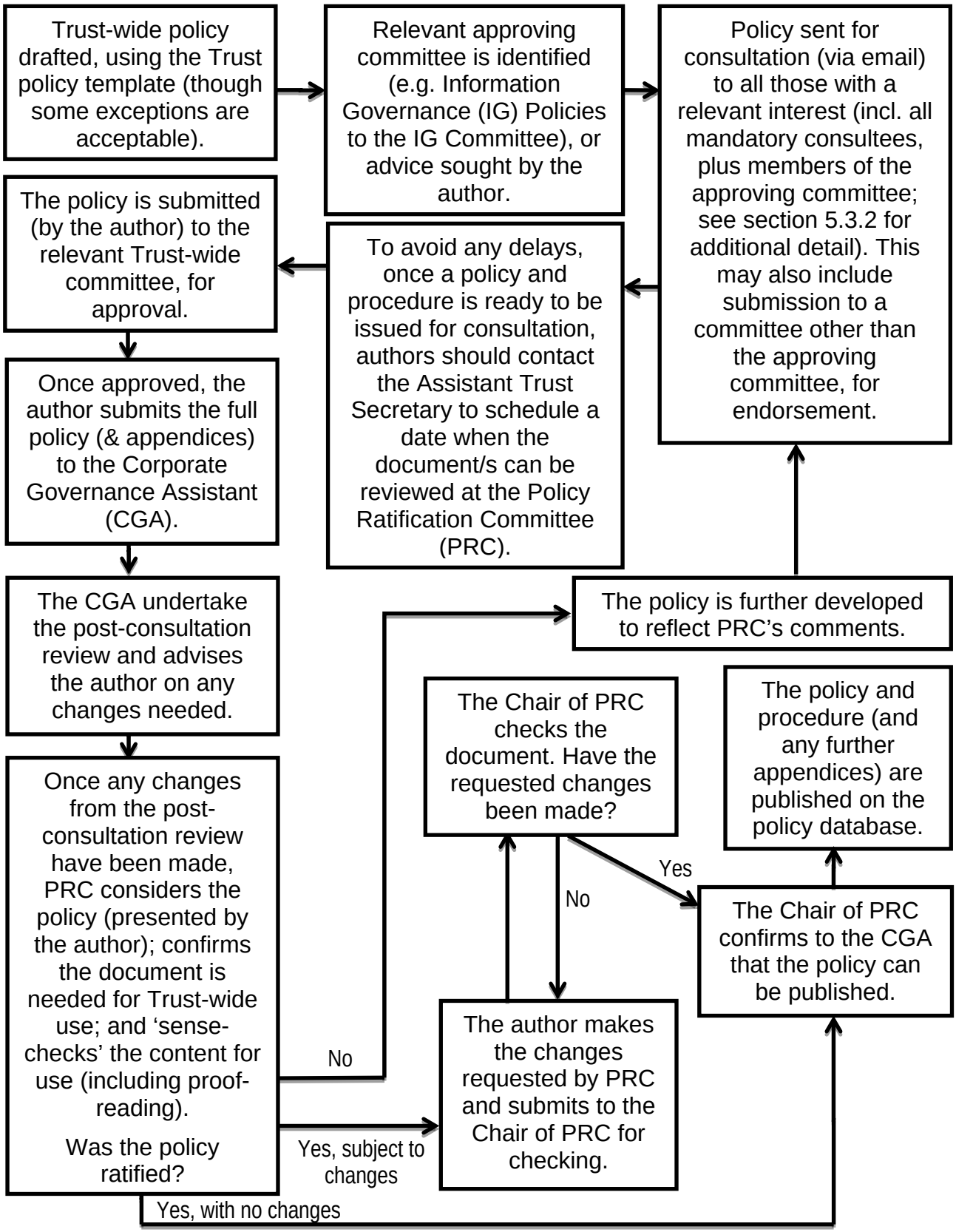
All NHS organisations need a robust process to ensure the policies and procedures they expect their staff to follow:

- are developed with due rigour
- take account of appropriate external guidance and internal opinion
- are well-written
- meet the needs of staff and the organisation
- meet expected equality standards.

This policy describes the Trust's approach to ensuring that Trust-wide policies and procedures are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

Content

Overview of procedure to be followed
(Refer to the policy and procedure for the full details and requirements of each step)



1.0 Introduction, purpose and scope

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Division.

All NHS organisations need a robust process to ensure the policies and procedures they expect their staff to follow:

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- take account of appropriate external guidance and internal opinion
- are well-written
- meet the needs of staff and the organisation
- meet expected equality standards.

This policy describes the Trust's approach to ensuring that Trust-wide policies and procedures are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

This policy and procedure applies to all Divisions, Directorates and locations within the Trust. However, this policy does not apply to the following documents:

- Local policies (i.e. those that are not 'Trust-wide'). These should be produced and approved or ratified in accordance with local procedures.
- Corporate strategy documents. These will differ in format, according to their content, but any strategy affecting the whole Trust should be approved or ratified by the Trust Board (having been subject to appropriate consultation beforehand).
- Clinical guidance documents. A separate process is in place. For advice refer to the Trust Intranet or Governance Team/Deputy Director of Quality Governance.
- Trust-wide plans. These can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Plans may or may not be required to be formally approved but this should be considered by the person with overall responsibility for implementing the plan.

Documents may have different titles, which may be influenced by convention, external requirements, local considerations or previous precedent. It is therefore the intent, and not the title, that should determine whether this policy and procedure applies to a particular document, taking into account the definitions in section 2.0. In this context, documents that 'look and feel' like Trust-wide policies and procedures should not be labelled as 'plans' or 'strategies' to avoid having to comply with this policy and procedure.

1.1. Principles

This policy and procedure has been developed in accordance with the following principles:

- The Trust will only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.
- Trust-wide policies and procedures are matters for the Trust 'Executive'. Therefore, although it may be appropriate to include Non-Executive Directors (and the committees on which they sit) as part of the consultation on a particular policy, the default position is that policies and procedures will be approved by Executive-led committees (unless expressly agreed otherwise by the Trust Board or one of its sub-committees).
- All Trust-wide policies and procedures are to be ratified for four years unless a shorter period is required. Regardless of this, all policies and procedures should be revised within that four year period to reflect changes as and when they arise.
- Policies should be reviewed and revised (as required) before their review date is exceeded.
- Policies should be ~~reviewed and~~ revised before the next review date if significant changes are made to the regulation, guidance or best practice on which the policy is based.
- Once ratified, non-material changes to a Trust-wide policy and procedure can be made without seeking re-approval and re-ratification.
- All Trust-wide policies and procedures should have a target audience identified in recognition that not all Trust-wide policies are of relevance to all Trust staff.
- All Trust-wide policies and procedures should be written in the current policy and procedure template (Appendix 5) and follow Trust guidance for style and formatting (Appendix 6).
- All Trust-wide policies and procedures should be well-written (including ensuring appropriate grammar, format and style, see Appendix 6), be clear to follow, and contain as much information as is required to provide the appropriate support to its target audience.
- All Trust-wide policies will be available to the public, on request (in accordance with the requirements of the Freedom of Information Act 2000 and the Trust's associated publication scheme).

2.0 Definitions / glossary

Term	Definition
Appendix	An additional document, with subsidiary information relating to the main body of a policy and procedure that is required or expected to be read by the target audience, but which is not optimally located within the main body of a policy and procedure. Examples include forms, flowcharts, posters, standard operating procedures (SOPs), and registers.
Approval	Official agreement by an appropriate committee that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure: • meets applicable national and regional standards • meets the standards of this policy • is suitable to be submitted for ratification. Approval is the penultimate step before a policy and procedure is issued for use. Approval can only be given by the appropriate formal Trust-wide committee.
Author	The employee who drafts the policy, procedure and appendices (and subsequent updates or revisions) in accordance with the requirements of this policy and procedure. Staff will be designated as the author of a policy and procedure according to the role they are employed to perform.
Clinical guidance	Any document designed to guide clinical practice. This includes clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc. Such documents are recommendations of good practice, which are expected to be applied, but which permit exceptions, based on the judgement of the practitioner. Clinical guidance documents allow individuals to use their professional judgement and decision making skills. Such documents are excluded from this policy and procedure.
Consultee	A person or group who has been sent a policy and procedure, prior to it being submitted for approval, to enable that person or group to comment or propose amendments.
Division	A grouping of two or more 'Clinical Directorates' into a single operating unit, for the purposes of oversight. However, for the purposes of this policy (and the definitions of Trust-wide and local policies in particular), corporate areas (i.e. Finance, IT, Human Resources, Corporate Nursing) should also be considered as Divisions.
Endorsement	The provision of formal support to a policy and procedure (and thereby acknowledgement that the content is fit for purpose and ready for approval), by a group/committee, prior to its approval. Endorsement can be provided by more than one group/committee, if relevant. Endorsement is not compulsory, but authors or approving committees may wish to seek endorsement to support the process of approval.

Term	Definition
Hyperlink	A link from text in one document to another internet location, usually activated by clicking on a highlighted word or image.
Local policy (and procedure)	A policy (and procedure) that does not meet the definition of being 'Trust-wide' i.e. which covers the method of working within a single Division (and the staff therein).
Mandatory consultee	A person identified by the PRC as needing to be included in the consultation of all Trust-wide policies (or all Trust-wide policies covering a particular subject). The list of mandatory consultees is contained within the policy template.
Material change	A change to an existing Trust-wide policy and procedure that fundamentally affects what staff are expected to do under that policy. Examples of material changes include: • changes that have resource implications that cannot be applied in a straightforward manner • changes that may be contentious or require debate • changes that would result in the 'target audience' considering the changed policy as being different to the existing policy.
Non-material change	A change to an existing Trust-wide policy and procedure that does not fundamentally affect what staff are expected to do under that policy. Non-material changes should not be contentious or require debate. Examples of non-material changes include: • changes to the names of jobs, roles, contact details, committees, clinical areas, locations • corrections to typographical errors, formatting etc. • minor changes to policy-related documentation (such as requests for small amounts of additional information on forms).
Other contributors	Individuals who are closely involved in the production or review of a policy and procedure but who are not the author. Such persons will be listed on the front cover of each Trust-wide policy and procedure.
Owner	The most senior employee responsible for the content of a policy and procedure (and for ensuring the policies under their specific areas of responsibility have been developed in accordance with this policy and procedure). Owners must be a member of the Executive Team Meeting. Owners will be allocated policies and procedures according to the areas/subjects within their area of responsibility/portfolio. Advice and clarification can be obtained from the Trust Secretary.
Plan	Plans can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Such documents are excluded from this policy and procedure.
Policy	A statement of corporate intent explicitly stating responsibility and accountability, and containing details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Some documents may involve a mixture of 'policy' and 'guidance'. The determination of whether a document should

Term	Definition
	be considered a 'policy' therefore depends on the extent of that mix i.e. if the substance of the document is mostly concerned with content that employees are expected to adhere to, the document should be regarded as a policy. If the substance of the document is mostly concerned with recommendations of good practice, the document should be regarded as guidance.
Policy database	The database that holds the master versions of all Trust-wide ratified policies and appendices. The current system used for the database is called 'Q-Pulse'.
Policy template	A Word document that describes the format, style and layout that Trust-wide policies and procedures should use. The 'Policy template' is set by the Policy Ratification Committee (PRC) - see Appendix 5. A style guide is provided in Appendix 6.
Policy Ratification Committee (PRC)	The committee authorised to ratify policies for use in the Trust. PRC members are a pool of committed staff from clinical and non-clinical departments who have responded to invitations to be involved in PRC. PRC members are deliberately not representing their department or area of work, nor are they experts in the subject matter covered by most policies.
Post-consultation check	A review undertaken by the Corporate Governance Assistant, prior to documents being submitted to the PRC, to determine whether the documents meet the requirements of this policy and procedure, including the latest policy template (see Appendix 5).
Procedure	A standardised method of performing a task/s. A procedure related to a policy defines the specific course of action relevant employees are expected to follow.
Process	A series of interconnected activities that transform an input into an output.
Q-Pulse	The software used by the Trust for uploading various documents. Local documents are uploaded to the eight local Q-Pulse databases by local administrators. Trust-wide policies, and other Trust-wide documents, are uploaded to the Organisational Wide Documentation Q-Pulse database.
Ratification	Final authorisation for use within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board. Ratification consists of: • checking that the policy and procedure has been subject to an appropriate consultation and approval process • 'sense-checking' the policy and procedure, to assess whether it makes sense, flows well, is internally consistent etc. • checking the policy and procedure complies with the format, style and layout requirements of the latest 'Policy template' and • proof-reading the policy and procedure for errors.

Term	Definition
Review	The process of examining the content of an existing policy, procedure or appendix, to determine whether it is still required and that the information is current, adequate and comprehensible to ensure consistent application by its target audience.
Review date	The date by which a Trust-wide policy and procedure is required to be fully reviewed, and, if appropriate, the revised version uploaded. A review date is not however an expiry date, and a policy and procedure does not become automatically unfit for purpose solely because its review date has passed.
Standard operating procedure (SOP)	A document that provides accurate and detailed instructions on how to perform a defined process or procedure to ensure consistency and standardisation. The purpose is to eliminate variations in processes which need to be completed the same way every time. Policies and procedures may contain SOPs (even if they are not labelled as SOPs), and the decision as to whether an SOP falls under the scope of this policy and procedure depends on whether the SOP is Trust-wide
Strategy	A document outlining a long-term goal/s (with details of how the goal is intended to be achieved). Such documents are excluded from this policy and procedure.
Trust-wide policy	A policy that covers the method of working across more than one Division.
Uploading	Placing a document on the policy database, to enable it to be accessed by Trust staff.

3.0 Duties

Person/Group	Duties
Trust Board	• Responsible for ensuring the Trust has a robust approach to ensuring the policies and procedures staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the Trust .This responsibility will be met by ratifying this policy (and seeking assurance on compliance, as required). • Responsible for ratifying certain Trust-wide policies (see 5.6.6).
Chief Executive	Responsible for ensuring there are sufficient resources in place to implement this policy and procedure.
Executive Team Meeting (ETM)	To authorise the amendment, suspension or replacement of any Trust-wide policy and procedure during periods of exceptional disruption to the Trust's standard functioning (such as major incidents or national emergencies)
Policy Ratification Committee (PRC)	• Responsible for ratifying Trust-wide policies and procedures in accordance with this policy and procedure. • Be the arbiter of any decisions relating to the approval or ratification of Trust-wide policies and procedures.

Person/Group	Duties
	• Agreeing the 'Policy template' applicable to Trust-wide policies and procedures.
Trust Management Executive (TME)	Overseeing the process described in this policy and procedure, via monitoring the work of its sub-committee, the PRC.
Approving committee	Responsible for ensuring that the content of policies and procedures they approve have been properly considered, that the content matches the best practice in relation to the subject matter of the policy, and that the policy and procedure is suitable for ratification.
Owner	• Ensuring the policies and procedures under their specific areas of responsibility have been developed in accordance with this policy and procedure. • Ensuring that an author is appointed to each policy and procedure under their specific areas of responsibility (and re-appointing if an author leaves or moves role).
Author	Responsible for ensuring their policies and procedures are produced, consulted, approved and ratified in accordance with this policy and procedure. This includes any subsequent revisions.
Trust Secretary	• Responsible for implementing this policy and procedure. • Chairing the PRC, and ensuring it complies with its Terms of Reference. • Providing advice on the implementation of this policy and procedure.
Assistant Trust Secretary	• Scheduling of the policies to be reviewed at the PRC. • Ensuring that authors respond to the post-consultation check.
Corporate Governance Assistant (CGA)	• Administering the policy database. • Uploading policy documents to the policy database. • Issuing reminders to authors in relation to review dates. • Providing advice on the implementation of this policy and procedure. • Undertaking a post-consultation check of policies and procedures. • Providing reports to the PRC, as required.

4.0 Training and competency requirements

There are no training or competency requirements at this time. However, advice and guidance is available from the Trust Secretary, Ext. 28698. 'Frequently Asked Questions' (FAQs) (see Appendix 4) and a style guide (see Appendix 6) are also available.

5.0 Procedure

Refer to the flow diagram on page 7 for an overview of the standard process. The specific steps required are as follows:

5.1 Identifying and confirming the need for a Trust-wide policy and procedure

5.1.1 New policy content

The Trust should only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.

The need for a new Trust-wide policy and procedure may be identified via a number of different sources, such as a requirement from external agencies, incidents, complaints or other events; internal audit reviews; in-house or external assessment etc.

However, before concluding that a completely new policy is required, a search of existing policies and procedures should be undertaken, via Q-Pulse, and consideration should be given as to whether it is feasible to extend the scope of an existing policy and procedure to incorporate the new content.

If it is considered feasible to extend the scope, liaison should occur with the author of the existing policy and procedure, and agreement should be reached as to who the author of the revised/extended policy and procedure should be. That person will be responsible for ensuring the revised/extended policy and procedure complies with this policy and procedure.

If it is not considered feasible to extend the scope of an existing policy and procedure, a new policy and procedure should be proposed to be produced. However, before that document is drafted, the proposed Owner should be identified and approached (by the intended author of the new policy), to obtain their written confirmation that they believe a completely new policy and procedure is required. Email confirmation will suffice.

5.1.2 Existing policies and procedures

The Trust should only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties. There should therefore be a regular assessment of whether existing policies and procedures are still required, as it is possible that the rationale for the policy being produced has changed or ended. This assessment can occur at any time, but will be formally required (by authors) six months before the review date of each existing Trust-wide policy and procedure.

If a policy and procedure is assessed as no longer being required, it should be withdrawn from publication and archived (see section 5.11.1).

If a policy is assessed as still being required, it should be reviewed in accordance with section 5.8.

5.2 Drafting a new policy and procedure / reviewing and revising an existing policy and procedure

5.2.1 New policies and procedures

The author should firstly download the latest 'Policy template' [RWF-OP-DocTemp-Policy1] from the policy database. The author should then draft the policy and procedure using the 'Policy template', and follow the guidance therein (including that for format, style, and layout; also see Appendix 6). The Chair of the PRC may defer policies and procedures not using the latest 'Policy template' from being reviewed at the PRC. There may however be exceptions to using the 'Policy template' (see section 5.2.3).

5.2.2 Existing policies and procedures

The author should firstly download the latest 'Policy template' [RWF-OP-DocTemp-Policy1] from the policy database. The author should then critically review the content of the existing policy and procedure and amend/update as required. The revised policy and procedure will need to adhere to the latest 'Policy template', and should therefore follow the guidance therein (including that for format, style and layout; also see Appendix 6). The Chair of the PRC may defer policies and procedures not using the latest 'Policy template' from being reviewed at the PRC. There may however be exceptions to using the 'Policy template' (see section 5.2.3).

5.2.3 Exceptions to using the 'Policy template'

Some policies and procedures may be exempt from adhering to the 'Policy template'. These may be policies that are required or expected to be produced in a specific format or style, for example because they are national, or local, 'model' policies, or because they have been agreed in conjunction with several external agencies.

In such circumstances, prior to drafting a new policy, or revising an existing policy (that has not already been authorised to be exempt from using the 'Policy template'), the author should email the Chair of the PRC requesting an exemption from using the 'Policy template', and explaining the reasons for the exemption. The request will be assessed and if an exemption is considered to be warranted, the author will be authorised to add a sentence to the cover page of the policy and procedure stating that "This policy and procedure has been confirmed to be exempt from strictly adhering to the Trust's 'Policy template'."

However, the policy will still need to include certain elements of the 'Policy template', to enable it to be recognised as a policy of the Trust. These elements are as follows:

- Cover page
- 'Document history', 'Keywords' and 'Version control'
- 'Summary'
- Table of contents
- Appendices 1 to 3.

If the request for an exemption is rejected, the author will need to draft or revise the policy and procedure using the latest 'Policy template'.

5.2.4 Appendices

The decision as to whether a document should be included as an appendix to a policy and procedure, or just be listed as either a 'Cross reference' (if an external document) or 'Associated document' (if an internal document) depends on the author's expectations regarding that document.

If the document is not required or expected to be read by the target audience, and is listed in case they wish to, for example, find out more about the rationale or background to the policy and procedure, this should be listed as a 'Cross reference' or 'Associated document'.

If the document is expected to be read and understood by the policy and procedure's target audience, the document should be included as an appendix.

If an appendix is in a format that is unable to be included as a separate document (such as a web-based form), consideration should be given to having an appendix that shows the original appendix as a 'screen shot', and signposts readers to the location of the appendix (i.e. a website/URL, with a hyperlink if suitable).

If an appendix is produced externally (i.e. published by a body other than the Trust), it may still meet the above criteria for being included as an appendix, although it is accepted that revisions to the document might not be possible. See section 5.10 for further details.

5.3 Consultation

Consulting with the key individuals and groups who have an interest in a policy and procedure is important. It enables the content to be reviewed by those who have detailed knowledge of the subject matter, as well as enabling the document/s to be 'sense checked' by those who have not been directly involved in their production.

5.3.1 Scheduling at the Policy Ratification Committee (PRC)

To avoid any delays, once a policy and procedure is ready to be issued for consultation, authors should contact the Assistant Trust Secretary (Ext. 26411) to schedule a date when the document/s can be reviewed at the PRC. The dates of PRC are listed on the Intranet.

5.3.2 Consultation period

The default period for consultation is four weeks. This recognises that those asked to review and comment on a policy and procedure will likely have to accommodate this whilst performing their own duties. This period also takes account of any potential annual (or other) leave such individuals may have.

There may however be occasions when a reduced consultation period is required. This would usually be expected to apply if a policy was required to be produced or revised by a specified deadline (for example for a forthcoming external assessment or inspection). In addition, it is acceptable to apply a reduced consultation period for policies that are reviewed annually, on the basis that staff will have had an opportunity to comment on the document within the past year.

A consultation period should not however be less than two weeks, and the author should ensure, before submitting the policy and procedure for approval, that the approving committee is content to consider approving in the context of a reduced consultation period.

Consultation periods less than two weeks can only be authorised by the Owner for the relevant policy and procedure, and such authorisation should be confirmed in writing to the author. The author should also ensure, before submitting the policy for approval, that the approving committee is content to consider approving in the context of a further reduced consultation period. The aforementioned authorisation will be sought by the PRC when it reviews the policy and procedure, and absence of such authorisation is likely to result in PRC deferring the policy and procedure, to enable a longer period of consultation to occur.

It may also be beneficial to consult in stages, to allow those with a more direct interest in the policy and procedure (and who are more likely to propose amendments that will be accepted) to be consulted first, before issuing the policy and procedure to a larger number of consultees.

Once all consultation feedback has been addressed the policy and appendices should be emailed to the Corporate Governance Assistant for final consultation. Once the final consultation feedback has been agreed the author can proceed with submitting the documents for endorsement or approval.

5.3.3 Consultees

Appendix 2 of the 'Policy template' contains the list of persons who have been identified as mandatory consultees. The PRC may change this list, for example, to reflect changes in the Trust's structure, and therefore authors should consult the latest version of the 'Policy template' prior to any consultation.

In addition to the mandatory consultees, authors should include the following within the consultation:

- All members of the approving committee.
- All persons or groups who, by the nature of their role/duties, could reasonably be expected to have a specific interest in the policy. This involves a judgement by the author, but it is an important consideration, as excluding a person or group who has a specific interest is likely to result in PRC deferring the policy for further development, and the author being required to re-consult.
- Authors of other policies which contain an overlap in content, e.g. where a new system or process is introduced by the Trust and described in the policy under development, and is also referred to or described within another policy or policies. Wherever possible, these other policies should adopt the wording of the policy under development, once it has been ratified.

It may also be appropriate to include external parties in a consultation (for example, other NHS Trusts) if the policy and procedure is likely to have a significant effect on that party's practice.

5.3.4 Response to consultation

When issuing a policy and procedure for consultation, authors are providing consultees with the opportunity to review, comment, and propose amendments. Consultees are under no obligation to respond to this offer, but if they choose not to do so, any subsequent critique is likely to be dismissed (unless the content identified as unsafe or not fit for purpose – see section 5.11.2).

Authors are expected to give due consideration to any comments or proposed amendments arising from the consultation. However, they are not obliged to make the proposed amendments if they disagree, unless the issues raised are a matter of ensuring that Trust template requirements have been met. Any contentious issues arising from the consultation are expected to be resolved, by the author, before the policy and procedure is submitted for approval.

A record of the consultation should be kept by the author and this should be documented within the relevant mandated appendix (authors should refer to the latest 'Policy template').

5.4 Endorsement

Policies and procedures need only be submitted to one committee for approval, but certain policies and procedures may be of interest to more than one committee. If the author or the Chair of that committee regards the committee's interest as sufficiently important, the policy and procedure may be formally submitted to that committee, to obtain the committee's support. This support will be considered to be 'endorsement', and if obtained, should be recorded on the front cover of the policy and procedure. Endorsement can be provided by more than one group/committee, if relevant, but such endorsement should occur before approval is sought.

The version of the policy and procedure submitted for endorsement should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered before the document/s are submitted.

It is up to the endorsing committee to determine whether it wishes to receive the full policy and procedure document (plus all appendices) when considering whether the policy and procedure should be endorsed. Certain committees may, for example, only wish to receive a synopsis of the policy, outlining the key content and perhaps any changes made to the previous version. There is no standard format for this synopsis, and this can therefore be set by the endorsing committee.

5.5 Approval

Policies and procedures submitted for approval should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered before the document/s are submitted.

5.5.1 Approving committee

The approving committee should be a formal Trust-wide committee of the Trust (i.e. where the membership is not limited to staff from one Division), and should be the committee with the most relevant role in relation to the content of the policy and procedure.

For most policies, the approving committee should be obvious, but if authors are uncertain, advice can be sought from the Chair of the PRC. The precedent set by previous, similar, policies may also be useful. The following list should be considered as a guide only, for illustrative purposes.

Type of policy	Approving Committee
Human resources/workforce	The Joint Consultative Forum
Clinical operational	Clinical Operations and Delivery Committee
Information governance	Information Governance Committee
Health and safety, fire, Estates and Facilities	Health & Safety Committee
Infection prevention and control	Infection Prevention and Control Committee
Policies which: • Set the overall framework of major clinical or corporate governance matters (e.g. Risk Management Policy and Procedure, Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures etc.). • Have significant implications in relation to widespread changes of practice among staff. • Have significant resource implications. • Are likely to be contentious.	Executive Team Meeting
General clinical policies (for which there is no specific Trust-wide forum)	Clinical Operations and Delivery Committee
Medicines-related policies	The Drugs, Therapeutics and Medicines Management Committee

The list of Trust-wide committees can be obtained from viewing the Trust Committee Structure chart.

5.5.2 Approval by a Trust Board sub-committee

In accordance with the principles listed in section 1.0, policies would not ordinarily be expected to be approved at a Trust Board sub-committee. However, any Trust Board sub-committee may undertake the role of an approving committee if the Trust Board or sub-committee formally confirms that it wishes to undertake this role.

5.5.3 The documents to be considered for approval

The policy document and any appendices that are primarily linked to that policy must be reviewed in full by the approving committee, as part of the formal agenda and reports for the meeting.

This is because in approving a document, the approving committee is officially agreeing that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure:

- meets applicable national and regional standards
- meets the standards of this policy
- is suitable to be submitted for ratification.

By not considering the documents in full, the approving committee therefore risks approving documents that are not well-written and contain (for example) consistency errors.

5.5.4 Documenting approval

Approval should be documented in the minutes of the approving committee meeting at which the policy and procedure was considered.

5.5.5 Approval of sub-standard documents

If the PRC considers that an approving committee is repeatedly approving policies and procedures that are sub-standard, i.e. that are poorly-written, not complying with this policy and procedure, or not adhering to the 'Policy template', the Chair of PRC will contact the Chair of the approving committee to make this known, and request that the approving committee consider whether the processes it applies when approving policies and procedures is sufficiently robust to enable the approving committee to fulfil its duties under this policy and procedure.

5.6 Ratification

Ratification is the authorisation for the use of a policy and procedure within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board (see section 5.6.5).

5.6.1 The documents to be considered for ratification

The documents submitted to PRC should include:

- The full version of the main policy and procedure document.
- The full version of any further appendices that have that policy and procedure as their primary policy (see section 5.10).

5.6.2 The ratification process

Before a policy and procedure can be reviewed at PRC, the author should liaise with the Assistant Trust Secretary and complete a PRC pre-submission checklist, to confirm that all necessary steps have been taken.

Policies and procedures are reviewed in detail at the PRC, and therefore someone who is familiar with the content needs to attend PRC when their policy and procedure is being reviewed, to respond to any queries/proposed amendments. This is expected to be the author, but if they are unavailable, they may send a representative who is able to speak on their behalf.

Ratification consists of the following aspects:

- Checking that the policy and procedure has been subject to an appropriate consultation and approval process.
- 'Sense-checking' the policy and procedure, to assess whether it makes sense, flows well, is internally consistent etc.
- Checking the policy and procedure complies with the format, style and layout requirements of the latest 'Policy template' (or that an exemption has been obtained in the correct manner – see section 5.2.3).
- Proof-reading the policy and procedure for errors.

The PRC may propose amendments to the policy and procedure. Authors are expected to consider proposed amendments, but are not obliged to accept them. Any objections should be raised by the author at the PRC meeting and debated, to enable a conclusion to be reached. However, if the PRC believes that the amendment is essential to ensuring that the policy and procedure is fit for purpose, it may insist that such amendments are made before the policy and procedure is ratified. This position should be made clear within the PRC meeting. Any disputes will be considered according to the principles within section 5.6.5.

5.6.3 Outcome of the ratification process

At the end of the review by the PRC, the policy and procedure will either be ratified (as submitted, or subject to changes) or deferred for further development. This latter option will be chosen if the PRC believes that the policy and procedure is not fit for purpose or is not substantially compliant with this policy and procedure.

If ratified, the author will be asked to make any changes that have been agreed, and submit the final version of the policy and procedure (including any further appendices) to the Chair of the PRC. All amendments must be made within three months of the date of review by the PRC, or the policy and procedure would require re-submission to PRC. Discretion may however be applied by the Chair of the PRC, to take account of any extenuating circumstances for missing this three month deadline.

If authors have chosen not to make certain changes proposed by PRC, this should be explained. The Chair of the PRC, or the Chair's nominated representatives, will then check that the requested changes have been made, or whether the rationale for not making any changes had been provided (and is credible), and if this is the case, will confirm the documents can be uploaded (at which point the Corporate Governance Assistant will be asked to upload them to the policy database).

If the Chair of the PRC concludes, after checking, that the changes requested by PRC have not been made, and a rationale for this has not been provided, the author will be notified, asked to make the changes requested by PRC, and submit to the Chair of the PRC again, for checking.

The Chair, or the Chair's nominated representatives, will then check that the requested changes have been made, and if this is the case, will confirm the documents can be uploaded (at which point the Corporate Governance Assistant will be asked to upload them to the policy database).

If the policy and procedure is deferred for further development, the author will need to amend the document/s to reflect PRC's comments, and then follow the processes described earlier for consultation, approval and ratification.

Any disputes will be considered according to the principles within section 5.6.5.

5.6.4 Documenting the ratification decision

The ratification decision should be documented in the minutes of the PRC meeting at which the policy and procedure was considered.

5.6.5 Resolution of disputes

If an author fundamentally disagrees with an amendment proposed by the PRC, PRC will determine, by a majority verdict, whether it regards the amendment as essential to ensuring that the policy and procedure is fit for purpose. If this is confirmed, the author will be invited to reconsider their position. If the author maintains their position, the policy and procedure will be unable to be ratified at that PRC meeting, and should therefore be deferred, pending further discussion.

The author should then discuss the proposed amendment with the Owner for the policy and procedure. The Chair of the PRC should also provide the Owner with the rationale for the PRC's view. The Owner should be asked to confirm whether they support the author's view or the view of the PRC. The Owner's decision will then be followed (and the policy and procedure re-scheduled for a PRC meeting, to enable formal ratification, reflecting the decision made), unless the Chair of the PRC feels that a further discussion, with the Chief Executive, is required. In this case, the Chair of the PRC will arrange for a meeting between the Chief Executive, the Owner and themselves, to consider the matter. The decision of the Chief Executive will be final. The policy and procedure should then be re-scheduled for a PRC meeting, to enable formal ratification, reflecting the Chief Executive's decision.

5.6.6 Policies ratified by the Trust Board

Certain policies may be required or desired to be ratified by the Trust Board, because of an external requirement to do so, or because the Owner or approving committee regards the policy as important enough to warrant this.

It would be inappropriate for PRC to consider such policies after the Trust Board (as the most senior forum in the Trust) had ratified them. Such policies and procedures would therefore be expected to be ratified at the Trust Board having first been reviewed and 'Recommended for ratification' by the PRC. Such policies and procedures would still be required to be approved by the appropriate committee.

5.7 Publication

Trust-wide policies and procedure will be uploaded to the Trust's policy database, which is accessible via the Trust's Intranet, to ensure that they are available to all relevant staff.

Staff will be notified of any newly-uploaded policies and procedure via the 'Policy & guideline updates' page on the Intranet.

Hard copy versions of Trust-wide policies and procedures should not be circulated, as there can be no guarantee that the hard copy is the latest version to be uploaded.

The Trust does not currently publish its Trust-wide policies and procedures on its public website. However, in the interests of openness and accountability, staff are permitted to share uploaded versions of Trust-wide policies and procedures with any external party, including patients and staff from other Trusts.

5.8 Review of policies

5.8.1 Review dates

All Trust-wide policies and procedures will be ratified for four years, unless a shorter period (one, two, or three years) is required by an external agency, the author, or the approving committee.

Policies should be reviewed and revised (as required) before their review date is exceeded. To ensure this, the Corporate Governance Assistant will issue reminder emails to authors at the following points:

a. Six months before the review date. The email will first ask for confirmation as to whether the policy is still needed. If the policy and procedure is still required, the email will remind the author of the steps involved in reviewing, approving and ratifying the document/s, and request that the process commences. If the policy and procedure is no longer required, the process described in section 5.11.1 should be followed.

b. Three months before the review date. This email is only required if the reply to the six month prompt (see step 1. above) confirms the policy and procedure is still required. The email should again remind the author of the steps involved in reviewing, approving and ratifying the document/s, and request that the process commence if this is not already the case. The email will also state that if the author does not believe that the process will be completed by the review date, the approving committee should be asked to request a short extension to the review date. This extension can be for a maximum of six months, to allow the policy and procedure to be reviewed, consulted, approved and ratified.

This request can be made via email (from the Chair of the approving committee), or via formal discussion at one of the committee's meetings. The email or minutes of the relevant meeting will therefore need to be provided to the Corporate Governance Assistant. The email will also state that if there is no clear plan to enable the revised policy to be uploaded by any extended review date, the policy and procedure may be withdrawn from publication when that review date is reached.
The author will therefore be asked to reply to the email, confirming their intended course of action.

c. At the review date. This email is only likely to be required if there has been no clear indication of a plan for reviewing the policy and procedure. The email will state that the policy and procedure will be withdrawn from publication two weeks from the date of the email. The author will therefore be asked to reply to the email as soon as possible confirming their intended course of action. If the author does not want the policy to be withdrawn, the approving committee will need to request a short extension to the review date. This extension can be for a maximum of six months, to allow the policy and procedure to be reviewed, consulted, approved and ratified. This request can be made~~done~~ via email (from the Chair of the approving committee), or via formal discussion at one of the Committee's meetings. The email or minutes of the relevant meeting will therefore need to be provided to the Corporate Governance Assistant. The email will also state that, at the end of the extension, if there is still no clear plan to enable the revised policy and procedure to be uploaded this will be drawn to the attention of the a~~A~~pproving c~~C~~ommittee and the Owner, who will also be advised that policy and procedure will be withdrawn from publication when the extended review date is reached. See section 5.11.3.

5.8.2 Reviews for policies previously ratified at the PRC~~Mandatory detailed reviews~~

Policies that have been previously ratified by the PRC should, before the "Review date" is reached, be reviewed, and the author and owner should confirm whether the policy is still a) needed (including whether it should still be a Trust-wide policy, or some other form of corporate document); and if so, b) fit for purpose (notwithstanding any non-material changes). The Policy Review Proforma in Appendix 7 should be used to document the review and its outcome. If both are confirmed, the review date should be extended for a further four years (or less, if required by an external agency, the author, or the approving committee).

Policies confirmed as no longer needed should be archived (see section 5.11).

Policies not considered fit for purpose should, as a priority (and in accordance with the author's assessment of the level of risk), be fully revised, consulted on, approved, and ratified in accordance with the process in section 5.2.

~~Each Trust-wide policy and procedure should be subject to a detailed review, consultation, approval and ratification at least once every four years. The full process should be applied even if the author believes that the existing policy and procedure requires no or few changes. The application of this periodic detailed review will ensure that the author's view is subject to appropriate challenge (thereby protecting the Trust against over-reliance on an individual's views) and validated.~~

~~**5.8.3 Light-touch reviews**~~

~~For Trust-wide policies and procedure that have been allocated a review date of one, two or three years, if the author reviews the document and confirms (in writing, to the Chair of the PRC) that no material changes are required, the review date can be extended to the next period (i.e. another one or two years) without the document/s requiring to be re-approved or re-ratified.~~

~~For policies with a one-year review date, this process can occur up to three times (i.e. at year one, year two, and year three). At year four, a mandatory detailed review (see section 5.8.2) would be required.~~

~~For policies with a two and three year review date, this process can only occur once (i.e. at years two and three respectively). At year four, a mandatory detailed review (see section 5.8.2) would be required.~~

5.9 Changes to existing policies and procedures

5.9.1 Non-material changes

Non-material changes to existing policies and procedures can be made any time these are identified as being needed. Ordinarily, the author would be expected to identify the need for such changes, but there may be occasions when others identify this need (in which case this should be brought to attention of the author).

If the need for non-material changes is identified, the author should email the Chair of the PRC giving details of the change/s required. If the Chair of the PRC agrees that the change is non-material, they will email the Corporate Governance Assistant to formally request that the change be made. The author will then be authorised to make the change/s, update the 'Version control' table, and email this to the Corporate Governance Assistant who will then check, and upload the updated document/s.

Requests for amendments from individuals who are not the named author will not be accepted unless the author or the Owner has confirmed the amendment can be made, in writing (via an email to the Corporate Governance Assistant).

5.9.2 Material changes

Material changes to policies and procedures can only be made with the approval of the relevant a~~A~~pproving c~~C~~ommittee. In such circumstances, the author should arrange for the a~~A~~pproving c~~C~~ommittee to consider, and approve, the proposed changes, and if approval is granted, confirmation should be provided, in writing, to the Chair of the PRC.

All material changes to policies and procedures are then required to be re-ratified at PRC (but the PRC will only be required to ratify the sections of the policy and procedure that have changed).

5.9.3 Changes as a result of ratified content in a newer policy or appendix

Changes to an existing policy or appendix that result from newer ratified content in another policy or appendix do not require further approval or ratification. The author of the existing policy or appendix should make the required changes, adopting the newer ratified wording wherever possible, and email this to the Corporate Governance Assistant who will then check, and upload the updated document/s.

5.10 Policy appendices

All appendices to policies and procedures should be numbered sequentially, and must be referred to within the body of the policy and procedure, including appropriate text. Appendices 1 to 3 are standard and should be incorporated within the main policy document. All subsequent appendices should be listed within the policy document (in accordance with the latest 'Policy template'), but should be uploaded as separate documents.

Whether the relevant content of a policy and procedure should be incorporated within the main policy document or treated as an appendix will depend on the nature of the policy and procedure, and it is therefore acknowledged that a 'one size fits all' approach is not appropriate. The author should however adopt the approach they believe would result in the best understanding by the target audience, and result in the best 'flow' of the main policy document. The PRC may override the views of the author or approving committee if the PRC feels that the understanding of the target audience would be impaired by the submitted approach.

Each separate appendix document can be an appendix to more than one policy and procedure. However, each appendix should be primarily linked to only one policy and procedure. This primary policy and procedure should be identified in the list of 'Further appendices' that appears at the end of each main policy document.

Appendices are to be treated in the same way as the primary policy and procedure to which they are linked, i.e. such appendices should be reviewed, revised, consulted on, approved, and ratified at the same time as their primary policy and procedure. The same process for applying changes (as stated in section 5.9) also applies to appendices.

Appendices are not required to conform to specific template requirements, but must be in Arial font and must include the following:

1. The Trust logo in the header
2. The Trust footer (i.e. that used for main policy and procedure documents)
3. The Trust disclaimer (i.e. that used for main policy and procedure documents)

Appendices that are linked to policies and procedures being reviewed and revised, but which are not the appendices' primary policy and procedure, are not required to be included in that review process. Such appendices are therefore not required to be submitted for review by the PRC when the policy and procedure is considered for ratification.

If an appendix is an externally-produced document (i.e. published by a body other than the Trust), its place within the policy and procedure should be approved, and ratified, although it is accepted that revisions to the document might not be possible. In such circumstances, authors would be expected to relay any identified errors to the body who publishes the document, but it is accepted that the Trust may not be able to influence the correction of such errors.

5.11 Withdrawing Trust-wide policies and procedures from use

5.11.1 Policies no longer required

If an existing policy and procedure is no longer considered to be required, it can be archived. For this to happen, the Chair of the approving committee for the current policy and procedure will need to confirm that the document/s is no longer required. This can be done via email (from the Chair to the author, Chair of the PRC and Corporate Governance Assistant), or via formal discussion at one of the committee's meetings. If the latter route is chosen, the minutes of the relevant meeting will need to be provided to the Chair of the PRC or Corporate Governance Assistant.

On receipt of the confirmation, the Corporate Governance Assistant will archive the policy and procedure.

If the approving committee no longer exists, the most appropriate alternative committee should be asked to provide the relevant confirmation, via either of the methods listed above. If there is no appropriate alternative committee, the Owner for the current policy should be asked to provide the relevant confirmation, via email (to the Chair of the PRC and Corporate Governance Assistant).

5.11.2 Policies identified as unsafe ~~or not fit for purpose~~

If an existing, uploaded, policy and procedure is identified by any member of Trust staff (including the policy author) as being unsafe ~~or not fit for purpose~~, that member of staff should email the Chair of the PRC as soon as possible, explaining the rationale. The Chair of the PRC will consider the matter as soon as possible (which may involve liaison with the author) and if there is felt to be any credence to the claim, will ask the Corporate Governance Assistant to withdraw the policy and procedure from the policy database.

The Chair of the PRC will then ask the author to liaise with the person raising the concerns and change the policy and procedure to address such concerns (or just change the policy if it was the author that made the request). The process described in section 5.9 should then be followed.

When a policy and procedure is withdrawn in such circumstances, it should be replaced (on the policy database) with a notice explaining that the policy has been withdrawn for a temporary period, and advising staff which staff member or department they can contact for advice until the policy and procedure is amended and re-uploaded.

5.11.3 Policies with no clear intention to be reviewed

As noted in section 5.8.1, a policy and procedure may be withdrawn from publication when its review date is reached, and there has been no clear indication of a plan for reviewing the policy and procedure. Such circumstances are exceptional, and the author and Owner for the policy and procedure should do all they could to prevent it being withdrawn. However, if the Chair of the PRC does not receive satisfactory assurances, they will notify the author, Owner and Chair of the aApproving cCommittee of the intention to withdraw the policy and procedure. If the Chair of the PRC still receives no satisfactory response after two weeks they will ask the Corporate Governance Assistant to withdraw and archive the policy and procedure. In such circumstances, the author, Owner and Chair of the aApproving cCommittee will be notified by the Chair of the PRC that the policy has been withdrawn.

5.11.4 Documents that no longer wish to be regarded as Trust-wide policies

There may be occasions when a document that has previously been considered to be a Trust-wide policy and procedure is still required, but which is no longer considered appropriate to be regarded as such. This may be because of changes to the emphasis of the document, or the way the document is perceived. It may also be related to the fact that the document is, or acts like, an operational plan. The key consideration should be whether the content of the document/s is sufficiently different from the definition of a 'Trust-wide policy' to warrant it being excluded from the policy ratification process.

In such circumstances, the Owner for the document should confirm (to the Chair of the approving cCommittee) that they are content for the document to be removed from being regarded as a Trust-wide policy. The approving committee should then be asked to formally approve the proposal. It should be made clear to both that if the proposal proceeded, the document could, if desired, remain uploaded to the policy database, but it would no longer be subject to the monitoring process applied to Trust-wide policies. In this regard, the author would not be reminded of the document review date, or pursued to ensure this review occurs. The document would also not be obliged to adhere to the Trust's 'Policy template'. If the approval is granted, the Chair of the aApproving cCommittee should arrange for the Corporate Governance Assistant to be notified, to enable the document/s to be removed from the policy database.

If the author or Owner wants the document/s to remain uploaded to the policy database, this is possible, but the author should ensure that the documents are not also uploaded to other locations (such as the Intranet or shared folders that can be accessed by the target audience). This will avoid the risk of alternative versions of the document/s being accessed. The format of the document/s must also be amended, so that it could not be reasonably perceived by readers to be a Trust-wide policy. If the author wishes to promote the awareness of the document/s by making reference to these on, for example, a dedicated Intranet page, the page

should just contain hyperlinks to the document/s that are uploaded to the policy database.

5.11.4.1 Trust-wide policies that are requested to become guidelines

If the Owner of a Trust-wide policy wants the document to become a guideline, and the aAapproving cCommittee approves the proposal for the document to no longer be a Trust-wide policy, the document must either complete the guideline approval and ratification process (which is overseen by the Deputy Director of Quality Governance), or complete the process to become a guideline as an appendix to an appropriate policy (see sections 5.9 and 5.10 of this policy).

5.12 Authors leaving the Trust

If an author leaves the Trust, the responsibility for the policies and procedures they authored will be transferred to their successor. A list of policies and procedures under the original author's name can be generated, to share with the new appointee, by the Corporate Governance Assistant, on request. Please note that the Corporate Governance Assistant cannot update the policy database to reflect the new author's name unless they are informed of the new appointment.

Where no successor is appointed, or where there is a gap between an individual leaving and their successor starting in post, responsibility will transfer to the original author's line manager. In the event of a dispute, the Owner will appoint an author.

5.13 Policies without procedures

Some Trust-wide documents consist of policy but no accompanying procedures. Such documents should not therefore include 'procedures' in their title. The format of the document should also be amended to remove any references to 'procedures'. Although this would technically constitute an exception to the 'Policy template' (see section 5.2.3) (which assumes that there would be 'procedures', and includes a section for this), the front cover of such policies is not required to state that "This policy and procedure has been confirmed to be exempt from strictly adhering to the Trust's 'Policy template'."

5.14 Exceptions to this policy and procedure

This policy and procedure aims to cover all circumstances relating to the production, consultation, approval and ratification of Trust-wide policies and procedures. It is however recognised that there may be some circumstances that warrant exceptional arrangements. In the event of such circumstances arising, which necessitate a request to deviate from this policy and procedure, such requests should be made, in writing, to the Chair of the PRC for their consideration, and potential authorisation. The Chair of PRC should take into account the circumstances, and make a judgement in the best interests of the Trust. Any authorised exceptions should be reported to the next available meeting of the PRC, and then reported to the next meeting of the TME.

5.15 Policies during periods of exceptional disruption

The Executive Team Meeting (ETM) is authorised to amend, suspend or replace any Trust-wide policy and procedure during periods of exceptional disruption to the Trust's standard functioning (such as major incidents or

national emergencies). The terms of such amendments, suspensions or replacements shall be determined by the ETM. The ETM may also delegate such authority to other parties, including, for example, Incident Command Centres.

Such amendments, suspensions or replacements should be notified to the Trust Secretary, who will request that the Corporate Governance Assistant updates the policy database and the front covers of any affected policies.

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the policy database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is uploaded on the Trust intranet under 'Policies & guidelines'; notification of the posting is included on the intranet 'News Feed' and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy and procedure will also be subject to an all-users email, to draw attention to the documents and ensure the expectations are made clear to the target audience.

2.0 Monitoring compliance with this document

- A summary report of the output from each Policy Ratification Committee (PRC) will be submitted to the TME at the earliest opportunity.
- The PRC will receive regular reports on the review status of each Trust-wide policy and procedure, and agree any action to be taken (including escalating issues to the relevant Owner or TME).

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every four years, following the procedure set out in this policy [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require material changes to be made, a full review, approval and ratification must be undertaken. Refer to the content of this policy for further details.

If non-material changes are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Refer to the content of this policy for further details.

4.0 Archiving

The policy database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Trust Secretary

By date: 17th January 2020

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff must be included in all consultations:				
Corporate Governance Assistant	20/12/19	28/01/20	Y	Y
Counter Fraud Specialist Manager (tiaa)	20/12/19			
Head of Fire, Safety and Environment	20/12/19			
Chief Pharmacist and Formulary Pharmacist	20/12/19			
Staff-Side Chair	20/12/19			
Complaints & PALS Manager	20/12/19			
Emergency Planning Team	20/12/19			
Head of Staff Engagement and Equality	20/12/19	30/12/19	Y	Y
Health Records Manager	20/12/19			
All individuals listed on the front page	20/12/19			
All members of the approving committee (the Executive Team Meeting).	20/12/19			
Other individuals the author believes should be consulted				
Divisional Directors of Nursing & Quality	20/12/19			
Divisional Directors of Operations	20/12/19			
Clinical Directors	20/12/19			
Chief Internal Auditor	20/12/19	14/01/20	Y	Y
Chief Finance Officer	20/12/19			
Chair of the Trust Board	20/12/19			
Non-Executive Directors	20/12/19			
Associate Non-Executive Directors	20/12/19			
Risk and Compliance Manager	20/12/19	03/01/20	Y	Y
Head of Information Governance	20/12/19			
Deputy Director of Quality Governance	20/12/19			
Head of R&D	20/12/19			
Clinical Lead for Research	20/12/19			
Deputy Director of Finance	20/12/19			

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
(Financial Governance)				
Deputy Director of Finance (Financial Performance)	20/12/19			
Deputy Medical Director	20/12/19			
Director of IT	20/12/19			
Director of Estates and Facilities	20/12/19			
Head of Employee Relations	20/12/19			
HR Business Partners	20/12/19			
Head of Fire, Safety & Environment	20/12/19			
Head of Financial Services	20/12/19	20/01/20	Y	Y
Assistant Director of Business Intelligence	20/12/19			
Associate Director of Procurement	20/12/19			
Deputy Chief Nurses	20/12/19			
Director of Medical Physics	20/12/19			
Director of Infection Prevention and Control (DIPC)	20/12/19			
Nurse Consultant for Infection Prevention	20/12/19			
Transformation Programme Director	20/12/19			
Director of Medical Education	20/12/19			
E.M.E. & Technical Services Manager	20/12/19			
Head of Delivery Development	20/12/19			
Heads of Performance & Delivery	20/12/19			
Legal Services Manager	20/12/19			
Trust Lawyer	20/12/19			
General Managers	20/12/19			
Chief Clinical Information Officer	20/12/19			
Trust Lead Cancer Clinician	20/12/19			
Freedom to Speak Up Guardian	20/12/19			
The following staff have given consent for their names to be included in this policy and its appendices: Ruth Dickens, David Kenealy, Mark Vince, Stephanie Smith, Mildred Johnson, Amanda LePage, Jo Garrity, Louise Dunkley, Angela Savage, Kevin Rowan, Daryl Judges				

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')
What are the aims of the policy or practice?	To ensure the policies and procedures Trust staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the organisation
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** No If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
Pregnant women and individuals on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document.

FURTHER APPENDICES

The following appendices are published as related links to the main policy/procedure on the policy database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Policy ratification - frequently asked questions (FAQs)	RWF-COR-COR-APP-1	This policy
5	Policy template	RWF-OP-DocTemp-Policy1	This policy
6	Style guide for Trust-wide policies and procedures	RWF-COR-COR-APP-4	This policy
7	Policy Review Proforma (for policies that have previously been ratified by the Policy Ratification Committee (PRC))	TBC	This policy

Policy Review Proforma (for policies that have previously been ratified by the Policy Ratification Committee (PRC))

Maidstone and Tunbridge Wells NHS Trust

The content of this Proforma should be confirmed with the policy Owner before submission.

Title of current Trust-wide policy:	
RWF number:	
Approving Committee:	
Date ratified by the PRC:	
Name of Owner: (i.e. the member of the Executive Team Meeting responsible for the policy's content (and ensuring the policy has been developed as per the 'Policy for Policies').	
Name of Author: (i.e. the employee who drafts the policy, procedure and appendices (& any revisions))	
Originating Division:	

Date of this Policy Review (dd/mm/yy)**:**	

1. Is the document listed above still required at the Trust? Yes ☐ No ☐

a. If "No", please give further details and explain why:

If you have replied "No", to question 1, you do not need to answer any further questions, but the Owner or Author should arrange for the document to be archived, as follows:

- The Chair of the Approving Committee (see above) should be asked to confirm that the document/s is no longer required. This can be done via email (from the Chair to the Author, Chair of the PRC (kevinrowan@nhs.net) and Corporate Governance Assistant (CGA) (ruthdickens@nhs.net), or via formal discussion at one of the Committee's meetings.
- If the option of having a formal discussion at one of the Committee's meetings is chosen, the minutes of the meeting should be emailed to the Chair of the PRC or CGA (see addresses above).
- On receipt of the confirmation, the CGA will archive the policy and procedure.

2. If the document *is* still required at the Trust…

a. Should it still be a "policy"[1]? Yes ☐ No ☐

If "No", what should the document be?

Clinical guidance[2]? ☐

A contingency/resilience-based "Plan"? (like the Major Incident Plan & Heatwave Plan") ☐

Something else? ☐

If "Something else", please state what:

b. If the response to question 2a was "Yes", does the policy cover the method of working across more than one Division? Yes ☐ No ☐

If you have replied "No", to question 2b, you do not need to answer any further questions, as the document is not a Trust-wide policy, and the 'Policy for Policies' does not apply. The policy will therefore be removed from the list of Trust-wide policies, and responsibility for the review and maintenance of the policy will be transferred to the originating Division (as stated above).

[1] A "Policy" is "A statement of corporate intent explicitly stating responsibility and accountability, and containing details which relevant Trust employees are expected to adhere to, as part of their terms of employment".

[2] Clinical guidance is any document designed to guide clinical practice i.e. clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc. For information on clinical guideline development and governance see http://mtwintranet/policies/

3. Is the content of the current policy still fit for purpose? (including any Appendices, but excluding any non-material[3] changes that may be needed)	Yes ☐ No ☐	
a. If "No", please give further details and explain why:		
b. If "No" (to question 3), does the current policy need to be withdrawn from use now?	Yes ☐ No ☐	
c. If "Yes" to question 3b, please give further details and explain why:		

If you have replied "Yes" to question 3, the policy (and procedure) will have a new "Review date" applied, which will be four years from the date (month) of this Policy Review. The Author should however update the current master copy of the policy (including its Appendices) (which can be located via the Trust's policy database) with any non-material[3] changes (ensuring these changes are shown as 'tracked'), and email the updated documents to the CGA (ruthdickens@nhs.net). If these changes are confirmed as non-material they will just be applied.

If you have replied "No" to question 3, the policy will need to be fully revised, consulted on, approved, and ratified, via the process in the Trust's Policy for Policies. To allow time for this to happen, the Approving Committee should be asked to request a six-month extension to the review date. This request can be made via email (from the Chair of the Approving Committee to the Chair of the PRC). The current policy will remain active during the six-month review date extension period

Declaration by policy Owner

I confirm, as the Owner of the policy, that I agree with the responses given to the questions on this Proforma — Yes ☐ No ☐

When complete, please return this Proforma to kevinrowan@nhs.net

Any queries on how to complete this Proforma should be directed to Kevin Rowan, Trust Secretary (Ext. 28698 / kevinrowan@nhs.net).

[3] A change to an existing Trust-wide policy and procedure that does not fundamentally affect what staff are expected to do under that policy. Non-material changes should not be contentious or require debate. Examples of non-material changes include changes to the names of jobs, roles, contact details, committees, clinical areas, locations; corrections to typographical errors, formatting etc.; and minor changes to policy-related documentation (such as requests for small amounts of additional information on forms).

NHS
Maidstone and Tunbridge Wells NHS Trust

Summary report from Workforce Committee, 18/09/20	Committee Chair (Non-Exec. Director)

The Workforce Committee met on 18th September 2020.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Interim Director of Workforce provided their **initial reflections on the Trust's Human Resources Function** and it was emphasised that the appointment process for a substantive Director of Workforce and associated Deputies within the Workforce Directorate should be expedited to ensure resilience in the Workforce Directorate.
- The Committee reviewed an **update on the relevant aspects of the 'reset and recovery' programme** and it was agreed that the Interim Director of Workforce should Investigate the concerns raised at the 'main' Quality Committee meeting on 16/09/20 regarding the staffing levels among diagnostic staff (and particularly the MRI scanner at Tunbridge Wells Hospital).
- An update was received on progress against the **workforce strategic 'roadmap' (incl. a review of the "We are the NHS: People Plan for 2020/21 - action for us all")** wherein it was outlined that the Trust's focus would be on short to medium term objectives in accordance with the "We are the NHS: People Plan for 2020/21 - action for us all" and the importance of interconnectedness across the wider health and social care system was emphasised.
- The Head of Staff Engagement and Equality provided an **update on the Workforce Disability Equality Standard (WDES) (incl. review of the Trust's national data submission and the Trust's action plan)** and the Committee noted the importance of ensuring reasonable adjustments were made for staff working from home.
- The Chair of the Cultural and Ethnic Minorities Network attended to give an **update on the Workforce Race Equality Standard (WRES) (incl. review of the Trust's national data submission; an update on plans regarding reverse mentoring; and review of the Trust's action plan)**.
- The Committee reviewed and agreed the **proposals for the involvement of the staff networks in the Workforce Committee**. It was also agreed that the Trust Secretary should Liaise with the Chair of the Trust Board to consider whether the "Patient Experience" and "Staff Experience" items, which had been suspended in spring 2020 due to COVID-19, should be reinstated
- The Associate Director for Organisational Development gave an **Exceptional Leaders programme update** wherein the Committee noted the need to ensure adjustments were made to the working environment to support the development of staff.
- The Interim Director of Workforce provided an **update on employee engagement (to include details of Divisional engagement plans).**
- The Freedom to Speak Up Guardian attended to give their latest **quarterly update** report and it was agreed that the Interim Director of Workforce should liaise with the Chair of the Trust Board to consider the allocation of the "wellbeing guardian" role, as outlined in the "We are the NHS: People Plan for 2020/21 - action for us all", to an appropriate Non-Executive Director.
- The Committee reviewed the **Flu vaccination campaign plan** and it was agreed that the Head of Occupational Health should ensure that the Chair of the Workforce Committee is kept informed of the situation in relation to the number of doses of the influenza vaccination that were available to the Trust and the percentage of Trust staff that would be able to be vaccinated.
- The Committee undertook a **review of the relevant aspects of the Risk Register** and it was agreed that the Trust Secretary should Liaise with the Interim Director of Workforce to ensure the underlying content of the "Review of the relevant aspects of the Risk Register" report was reviewed and updated, taking into consideration the appropriateness and relevance of the risks that were included.
- The **summary report from the** Committee's only sub-committee, the **Health & Safety Committee**, was noted.
- The Committee's **forward programme** was noted.

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Approval of proposed changes to the Workforce Committee's Terms of Reference	**Chair of Workforce Committee**

At its meeting on 15/10/20, the Workforce Committee agreed two changes to its Terms of Reference:

1. A change of name, to the "People and Organisational Development Committee" (to better reflect the terminology that is now commonly used e.g. in the "NHS People Plan")
2. The removal of the "Inclusion Committee" as a sub-committee. The Workforce Committee approved a proposal to establish an "Inclusion Committee", as one of its sub-committees, in March 2020. The production of the draft Terms of Reference for that Committee was however then delayed by the COVID-19 response, and it has since been agreed that the Trust's staff networks will report to the Workforce Committee annually (and that there will be a report from one of the networks each quarter). This called the need to establish an Inclusion Committee into question, so the Committee agreed to reverse its previous decision.

The Trust Board is asked to approved the proposed changes (which are 'tracked' on the following pages).

Which Committees have reviewed the information prior to Board submission?
- Workforce Committee, 15/10/20

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

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

~~Workforce~~ People and Organisational Development Committee

Maidstone and Tunbridge Wells NHS Trust

Terms of Reference

1 Purpose

The Workforce Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement.

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

2 Membership

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

Members can send an appropriate deputy if they are unable to be present at Workforce Committee meetings.

3 Quorum

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

Deputies sent by members will count towards these quorum requirements.

4 Attendance

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

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

5 Frequency of meetings

The Committee will generally meet every month. The Chair can call a meeting at any time if issues arise.

6 Duties

To provide assurance to the Trust Board on:

- workforce planning and development, including alignment with business planning and development;
- equality and diversity in the workforce;
- employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- staff recruitment, retention and satisfaction;
- employee engagement
- terms and conditions of employment, including reward;

- organisation development, organisational change management and leadership development in the Trust;
- training and development activity in the Trust including prioritisation;
- reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training)
- The Trust's Freedom to Speak Up Guardian (FTSUG) arrangements

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

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

7 Parent committees and reporting procedure

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

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

8 Sub-committees and reporting procedure

The following Committees report to the Workforce Committee through their respective chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:

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

9 Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Workforce Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Committee members who are members of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Workforce Committee, for formal ratification

10 Administration

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

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

11 Review of Terms of Reference and monitoring compliance

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

Terms of Reference agreed by Workforce Committee: 29th September 2016
Terms of Reference approved by Trust Board: 19th October 2016
Terms of Reference agreed by Workforce Committee: 30th October 2017
Terms of Reference approved by Trust Board: 29th November 2017
Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)
Amended Terms of Reference approved by Trust Board: 1st March 2018

Terms of Reference agreed by Workforce Committee: 28th March 2019
Amended Terms of Reference approved by Trust Board: 25th April 2019
Amended Terms of Reference approved by Trust Board, 31st October 2019 (to add the Health and Safety Committee as a sub-committee)
Terms of Reference agreed by Workforce Committee: 26th March 2020 (as part of the annual review, and to include the Inclusion Committee as a sub-committee, to add the Deputy Medical Director as a member, and to reflect the agreement that members can send deputies if they are unable to be present)
Terms of Reference approved by Trust Board: 30th April 2020 (as part of the annual review)
Amended Terms of Reference agreed by Workforce Committee: 15th May 2020 (to withdrawn the membership of the Chief Operating Officer and to add the Chief Finance Officer as a member)
Amended Terms of Reference approved by Trust Board: 21st May 2020
Change approved by the Trust Board, 25th June 2020, to increase the frequency of meetings to monthly
Change of the Committee's name and removal of the Inclusion Committee as a sub-committee, agreed by the Workforce Committee, 15th October 2020