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

Thu 25 February 2021, 10:00 - 12:15

Virtual Meeting, via webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

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

02-1.
To receive apologies for absence

David Highton

02-2.
To declare interests relevant to agenda items

David Highton

02-3.
To approve the minutes of the 'Part 1' Trust Board meeting of 28th January 2021

David Highton

Board minutes, 28.01.21 (Part 1).pdf (7 pages)

02-4.
To note progress with previous actions

David Highton

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

02-5.
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

02-6.

Report from the Chief Executive

Miles Scott

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

02-7.
De-escalation and recovery

Sean Briggs and Cheryl Lee

De-escalation and Recovery.pdf (21 pages)

02-8.
Integrated Performance Report (IPR) for January 2021 (incl. an update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for Jan. 2021)

Miles Scott and colleagues

IPR for Jan 2021 (incl. PMRT and planned and actual ward staffing).pdf (45 pages)

Planning and strategy

02-9.
Update on the short-term solution for the transfer of ophthalmology activity to the Trust, and on progress with agreeing the preferred long-term option

Amanjit Jhund

Update on the short-term solution for the transfer of ophthalmology activity to the Trust, and on progress with agreeing the preferred long-term option.pdf (6 pages)

02-10.
Update on the renewal of the staff residential accommodation at Springwood Road, Maidstone

Miles Scott

Update on the renewal of the staff residential accommodation at Springwood Road, Maidstone.pdf (6 pages)

Assurance and policy

02-11.
Infection prevention and control board assurance framework

Sara Mumford

Infection prevention and control board assurance framework - February 2021.pdf (40 pages)

Reports from Trust Board sub-committees

02-12.
People and Organisational Development Committee, 22/01/21 (incl. quarterly report from the Guardian of Safe Working Hours) and 19/02/21

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 22.01.21.pdf (3 pages)
Summary of People and Organisational Development Cttee, 19.02.21.pdf (2 pages)

02-13.
Quality Committee, 10/02/21

Sarah Dunnett

Summary of Quality C'ttee, 10.02.21.pdf (2 pages)

02-14.
Finance and Performance Committee, 23/02/21

Neil Griffiths

Summary of Finance and Performance C'ttee, 23.02.21.pdf (1 pages)

02-15.
To consider any other business

David Highton

02-16.
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 28TH JANUARY 2021, 10 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Cheryl Lee	Director of Workforce	(CL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Blanchard-Stow	Divisional Director of Nursing, Midwifery and Quality (for item 01-12)	(SBS)
	Sarah Flint	Chief of Service, Women's, Children's and Sexual Health (for item 01-12)	(SF)
	Ola Gbadebo-Saba	Deputy Freedom To Speak Up Guardian (for items 01-11 and 01-14)	(OGS)
	Christian Lippiatt	Freedom To Speak Up Guardian (for items 01-11 and 01-14)	(CLi)
Observing:	Sultan Taylor	Vice Chair of the Trust Board at North East London NHS Foundation Trust	(ST)
	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]

01-1 To receive apologies for absence

There were no apologies. DH welcomed ST, who was observing the meeting as part of NHS England/Improvement's (NHSE/I's) Aspirant Chair Programme.

01-2 To declare interests relevant to agenda items

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

[N.B. KC later declared an interest, under item 01-10, as she was Vice-Chancellor of the University of Kent and a partner with Canterbury Christ Church University, who were responsible for the Kent and Medway Medical School]

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

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

01-4 To note progress with previous actions

The submitted report was noted and the following actions were discussed in detail:

- **10-9 ("Consider how the Trust's overseas nursing staff recruitment programme could be evaluated to inform the future plans to meet the needs of overseas recruits and ensure all staff were content to work in the environment in which they were placed.").** COB reported that there had been some progress, but more work was required, as the evaluations from the first round of overseas recruitment had identified accommodation as an issue. COB also reported that staff had identified the need for 'buddy' arrangements so the development of an 'alumni' of overseas nurses would be considered. COB added that nurses wanted more time and practical supervision, so the Business Case submitted under item 01-11 reflected that. COB also noted that nurses would in future be surveyed, although 13 out of 220 nurses that had been recruited had since left, so it would be useful to understand the reasons why. DH asked for confirmation that the action could be closed. This was confirmed.
- **12-9 ("Liaise with the Chair of the Trust Board to establish a Task and Finish sub-group of the Trust Board to oversee the project for the provision of accommodation for students from the Kent and Medway Medical School.").** AJ confirmed that liaison had occurred with DH to establish a Task and Finish sub-group and he would provide further details under item 01-10. It was therefore agreed the action could be closed.

01-5 Report from the Chair of the Trust Board

DH firstly highlighted the following points:
- It had been six weeks since the last Trust Board meeting on 17/12/20 and that had been the most difficult six weeks for the Trust since DH had joined the Trust Board. The size of the second wave peak of COVID-19 cases had been far higher than expected i.e. 3.5 times higher than the first wave peak, but staff had responded excellently to the challenges, which included the provision of mutual aid to other local NHS organisations.
- The Trust had also established its COVID-19 vaccination centre during that period, which had been commended by the Secretary of State for Health and Social Care.

DH then thanked all staff on behalf of the Trust Board and asked that such thanks be relayed to all staff in The Pulse newsletter and in MS' weekly video to staff.

Action: Ensure that the Chair of the Trust Board's thanks to staff for their work during the recent operational pressures features in The Pulse newsletter and the Chief Executive's weekly video message to staff (Director of Strategy, Planning and Partnerships / Chief Executive, January 2021 onwards)

DH then referred to the relevant attachment and highlighted the recent consultant appointments.

01-6 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the following points:
- The Trust had now passed the peak of the second wave of COVID-19 cases, and there had been a significant reduction in staff absence. The number of inpatient COVID-19 cases at the Trust was still however twice the level of the first wave peak, while the Trust's Critical Care capacity was full. Staff from other areas had also been deployed to Critical Care.
- The number of ambulance conveyances had reduced, so it was hoped that South East Coast Ambulance Service NHS Foundation Trust could reinstate ambulance cover to the Crowborough Birth Centre soon.
- The vaccination plans that had been developed by the Emergency Planning team had helped considerably with the establishment of the Trust's COVID-19 vaccination centre.
- Attention would now move to de-escalation but it would not be feasible to recover in a similar way to after the first COVID-19 wave as the focus needed to be on providing quality of care.
- The Trust's cancer pathways had been maintained during the second wave.
- Attention would also be focused towards the new financial year, and the 'strategy deployment' work with Western Sussex Hospitals NHS Foundation Trust continued. A session on that had been scheduled with the Trust Board in February.

01-7 Update on COVID-19

SB reported the following points:

- December and early January had seen the Trust's most operationally challenging conditions, but the response by the staff had been exceptional.
- The impact of the mutual aid the Trust had provided to other local organisations had been considerable. Before Christmas, the Trust had the equivalent of at least two wards of inpatients from outside the Trust's catchment area, but that number had now reduced.
- It had been agreed in December 2020 that routine elective surgery and outpatient appointments would be delayed, to enable staff to be deployed to areas of greater need.
- There had been considerable progress made since then and the Trust was back to being fourth in the country for Emergency Department (ED) 4-hour waiting time target performance.
- The 62-day cancer waiting time target had now been achieved for 18 months in a row, and the waiting list backlog remained small.
- The establishment and efficient operation of the COVID-19 vaccination centre had given staff a much-needed morale boost.
- The recovery needed to be considered carefully and it was clear that a more phased and supportive approach needed to be taken than after the first wave. However, many clinical teams were eager to reinstate outpatients and other services.
- The decision to delay elective activity had not been taken lightly, and the impact on the quality of lives of people who had already waited a long time was understood.

SDu noted that the impact of the second wave on Junior Doctors had been significant, in terms of training and mental wellbeing, so asked for assurance that that would be considered in the Trust's recovery. PM confirmed the impact had been acknowledged and explained the position with regards to the Deanery and Junior Doctors' educational needs, noting that the Deanery had required that certain activities continued. PM also supported SB's point on the the need to 'pause for thought' before reinstating services.

NG highlight the importance, when planning the Trust's recovery, of considering the aspects of practice that should be done differently, so asked how that would be captured, and for some initial thoughts on such aspects. MS confirmed that the issues arising from the second wave included a recognition of emergency planning. SB added that staffing resilience had been emphasised, but it would have been difficult to anticipate the level of sickness absence that had been experienced. PM opined that the second wave had demonstrated the importance of the Same Day Emergency Care (SDEC) pathway, which had had to stop because of the pressures in the second wave, to the Trust's performance. PM added that SDEC could be used for prevent patients coming to hospital.

PM then suggested that the word "plateau" be used instead of "peak", as the latter may lead to complacency. PM also noted that the Trust had learned a lot from the first COVID-19 wave that had been applied to the management of the second wave. PM continued that in terms of innovation, the stroke pathway had prevented two admissions per day; while the importance of system working and the Integrated Care System (ICS) had been demonstrated, particularly in relation to the distribution of 'mutual' aid'. PM finally referred to the Electronic Patient Record (EPR). COB then noted the importance of ensuring staff kept their skills updated to enable them to be deployed outside their normal working areas, which included upskilling to enable ward nurses to work in intensive care.

DH asked whether there had been any COVID-19 modelling for February 2021, to help the Trust prepare for the future, rather than just be reactive to the number of COVID-19 patients that presented. MS confirmed there had been some modelling, but it was difficult to make decisions on such modelling and MS believed the best approach was to be able to respond quickly to events. DH acknowledged the point but suggested it may be helpful to develop a range of responses to specific scenarios. MS agreed but emphasised the importance of being flexible.

CL then noted that the Trust had differed from other NHS organisations as it had not cancelled staff Annual Leave (A/L), and it was important for managers to continue to encourage their staff to take their A/L.

JW asked about the future of the "One Team Runner" initiative that had been introduced. CL confirmed the initiative needed to be evaluated.

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

01-7.2 Demand and capacity modelling

01-7.3 Workforce issues

01-7.4 Vaccinations

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

These items were all covered under item 01-7.

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

MS highlighted the adverse impact the recent pressures had had on performance and then invited his colleagues to report the key highlights for each domain. COB referred to the "Safe" domain and reported the following points:

- The number of falls had been the highest level ever, although many patients had fell more than once. There had also been an increase in falls-related Serious Incidents (SIs). Most of the falls had occurred at Tunbridge Wells Hospital (TWH), and COB had asked that the risk of patients falling be discussed at each daily 'huddle'.
- There was also a deterioration in hospital-acquired pressure damage performance and an increase in the number of incidents involved deep tissue damage.
- Staffing levels had reached an all-time low, and the number reported did not accurately reflect the position experienced 'on the ground'.
- Several of the high number of SIs related to outbreaks of COVID-19, which had created considerable work for the Patient Safety Team.

MC commented that as uncomfortable as it was to hear COB's report, she wanted to commend the staff for their work under such challenging circumstances, which she did not want to 'normalise'. COB noted that she was also keen not to 'normalise' i.e. tolerate certain practices, such as mixed sex accommodation. PM opined that the Trust needed to address the quality issues raised by COB before attempting full recovery.

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

- The Hospital Standardised Mortality Ratio (HSMR) remained acceptable, while the Trust's Summary Hospital-level Mortality Indicator (SHMI) rating had improved.
- Initial clinical coding data had showed that more patients with COVID-19 had died at the Trust than at some other local Trusts, so PM had attended the Mortality Surveillance Group's (MSG's) latest meeting to suggest some areas on which they may wish to focus. The MSG had also been asked to consider mortality among certain high-risk groups, include Black and Asian Minority Ethnic (BAME) patients.
- A COVID-19 virtual ward had been established, to allow patients with COVID-19 to be discharged earlier, with oxygen, and be monitored at home.
- The stroke-related metrics continued to demonstrate strong performance.

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

- The complaints response target of 75% had been exceeded for December, but some reduction in performance was expected in January 2021.
- The response rate to the Friends and Family Test (FFT) had been positive.

DH remarked that he was aware of a 'COVID denier' incident in the neonatal service and asked whether there had been any further incidents. MS confirmed he was not aware of further incidents.

SB then referred to the "Responsive" domain and reported that the Referral to Treatment (RTT) waiting time performance would be the main challenge going forward.

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

- Over 75% of staff had been vaccinated and work was continuing to increase the percentage of BAME staff that had been vaccinated.

- The latest “Pulse” survey had been issued.
- The sickness rate reported in the IPR, of 4.4%, reflected a delay, as it related to November’s data, not December’s, and did not show absence due to self-isolation.
- The latest NHS staff survey results were embargoed, but the Trust’s results were positive.
- CL wanted to thank COB and SB for their support in delivering the One Team Runner and COVID-19 vaccination centre.

SO then referred to the financial aspects of the “Well-led” domain & reported the following points:
- The last few weeks had demonstrated the difficulty involved in spending funds quickly to support staff under the circumstances that had been described at the Trust Board meeting.
- The extent of the second wave of COVID-19 had not been planned for, so there had been increased demand for temporary staff but the Trust struggled to meet that demand, because of problems in securing agency and Bank staff. That had translated, from a financial perspective, to lower than expected expenditure. Some financial incentive schemes had therefore been introduced, along with initiatives such as the One Team Runners. Ensuring clinical staff had access to relevant equipment, including mattresses, had also been a priority.
- The Trust would likely deliver its financial plan for 2020/21.
- It had been confirmed that the financial regime in 2020/21 would be applied to at least the first quarter of 2021/22.

MS noted that the infection control aspects of the IPR had not been covered but proposed SM give an update on the current situation under item 01-13. DH agreed that was sensible.

SDu then noted that an adverse Twitter comment had been made regarding rheumatology so asked for a comment on that service. MS stated that broadly, all outpatients had moved to being virtual, as far as possible, but many patients required infusions, and these had been consolidated at TWH. SDu clarified that the Twitter comment was that there was no rheumatology service at present. SB acknowledged that some patients had expressed concerns regarding their treatment, and work was underway to consider how the current service could be extended, but confirmed that the service still continued.

RF then remarked that the Statistical Process Control (SPC) presentation in the IPR was improving and commended those involved, as it made the situation clearer to follow. The point was acknowledged.

Planning and strategy

01-10 Update on the Kent and Medway Medical School (KMMS) accommodation build at Tunbridge Wells Hospital

AJ referred to the relevant attachment and highlighted the following points:
- It had been confirmed that the Trust would receive the full complement of 40 medical students it had planned for, which was a disproportionate distribution across the county.
- A Non-Executive Director oversight group had been convened with DH, DM and NG, which also involved MS, SO, AJ, PM and the Director of Estates and Facilities. The first meeting had initially been scheduled for 12/02/21, but that would now be brought forward to w/c 01/02/21. The first meeting would aim to agree the preferred preliminary location and design.
- Progress was being made in terms of financial affordability and funding, while the Deputy Director of Finance (Financial Governance) was making headway on the requirement to meet the requirements of the relevant International Reporting Financial Reporting Standards (IFRS), which related to an operating lease agreement.

KC firstly declared an interest in the item as she was Vice Chancellor of the University of Kent and a partner with Canterbury Christ Church University, who were responsible for the KMMS.

KC then commended AJ, PM and others on the progress that that had been made.

DH noted that the staff residential accommodation at Springwood Road, Maidstone, had agreed to be renewed circa two years ago and asked if anyone could give an update on the latest position.

MS and SO confirmed they were unaware of the current situation, so DH asked that an update be provided at the next Trust Board meeting. This was agreed.

Action: Arrange for an update on the renewal of the staff residential accommodation at Springwood Road, Maidstone, to be submitted to the Trust Board meeting in February 2021 (Chief Executive / Trust Secretary, January 2021 onwards)

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

DH referred to the relevant attachment and highlighted that the Finance and Performance Committee had reviewed the Business Case at its meeting on 26/01/21, and had recommended that the Trust Board approve the Case. DH therefore just invited questions or comments.

RF asked for further details of the plans regarding turnover of international recruits, and in particular 'regretted losses'. COB stated that the first issue to understand was why the staff that had left had done so, and explore whether they had equality of opportunity. COB acknowledged that more understanding was required, although the turnover among overseas staff had not been high, and accommodation was likely to be a factor. RF stated that he believed the 'psychological contract' for overseas staff was different than for UK recruits, so asked whether more work was required, to understand the engagement drivers. COB agreed that needed to be considered. CL suggested it may be possible to research and publish such work, as there was likely to be a paucity of published data on 'psychological contract'. COB acknowledged the suggestion.

The Business Case was approved as submitted.

Quality items

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

SBS referred to the relevant attachment and elaborated on the Trust's response to the 12 priorities that had emerged from the review, which had required a response within five working days i.e. "Enhanced Safety", "Listening to Women and their Families", "Staff Training and working together", "Managing complex pregnancy", "Risk Assessment throughout pregnancy", "Monitoring Fetal Wellbeing", "Informed Consent", "NICE Guidance related to maternity" and "Workforce planning". SF added further details.

SDu commended SBS and SF for the work and noted that it had been considered by the Quality Committee, but pointed out that the "Managing complex pregnancy" section stated that "The trust has a plethora of guidance…", which implied there were too many guidelines. SF acknowledged there was a lot of guidance but explained the work that was underway in that regard. SBS suggested that the large number of guidelines was related to the requirements of the previous CNST maternity standards assessment scheme.

SDu also noted that the report was heavily focused on midwifery, so wanted assurance regarding the multidisciplinary nature of maternity care. SF confirmed that there had been multidisciplinary involvement in the production of the response.

MS then remarked that the Trust Board needed to consider the activity and increased bookings in the Women's, Children and Sexual Health Division when setting future priorities, in light of the aforementioned 'strategy deployment' work. The point was acknowledged. MS also commended SF, SBS and their Division for their work during the COVID-19 period, and for SF's and SBS' leadership in particular.

Assurance and policy

01-13 Infection prevention and control board assurance framework

SM first referred to the IPR and highlighted that the Trust's rate of hospital-acquired COVID-19 infections was lower than at some other Trusts, which was considered to be due to the Trust's COVID-19 pathways. SM then gave details of other infections, including gram-negative bloodstream infections, which had reduced by 15%, and which included a 25% reduction in E. coli infections.

SM then referred to the board assurance framework and highlighted the key points therein, which included the emerging risk of Burkholderia aenigmatia infection.

DH referred to the lateral flow device testing and asked if there was still a delay between staff registering and reporting the results. SM replied that there was still such an issue but the situation had improved.

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

CLi firstly introduced OGS, then referred to the relevant attachment and highlighted the key points therein, which included that three concerns had been raised during the last quarter, all of which related to bullying and harassment in clinical areas at Maidstone Hospital. CLi then elaborated on the "Growing the Speaking Up Agenda" section of the report, which included the proposed establishment of "Safe Space Champions". CLi then opined that the reduced number of concerns had likely been due to the COVID-19 pandemic, given the very stoic attitude staff had adopted during the recent operational pressures.

MC then added further detail of the engagement she and COB had undertaken with the Culture and Ethnic Minorities Network in relation to the 'lived experiences' of staff, and noted that some key actions had arisen from the work.

Reports from Trust Board sub-committees

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

EPM referred to the relevant attachment and invited questions or comments. None were received.

01-16 Quality Committee, 13/01/21

SDu referred to the relevant attachment and invited questions or comments. None were received.

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

NG referred to the relevant attachment and highlighted the key points therein, which included that a Business Case for the substantive recruitment of 4.1 Whole Time Equivalent ED Consultants had been approved.

DH then noted that a minor amendment to the Committee's Terms of Reference was requested to be approved, to address an anomaly in the membership. The proposed amendment to the Committee's Terms of Reference was approved as submitted

01-18 To consider any other business

KR asked the Trust Board to delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to make decisions regarding the use of clinical support tools in managing resources in pandemics. The requested authority was duly granted.

01-19 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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'
01-5	Ensure that the Chair of the Trust Board's thanks to staff for their work during the recent operational pressures features in The Pulse newsletter and the Chief Executive's weekly video message to staff.	Director of Strategy, Planning and Partnerships / Chief Executive	February 2021	The communications team included the message in both items.
01-10	Arrange for an update on the renewal of the staff residential accommodation at Springwood Road, Maidstone, to be submitted to the Trust Board meeting in February 2021.	Chief Executive / Trust Secretary	February 2021	The requested update report has been submitted to the Trust Board meeting in February 2021.

Actions not yet due (and still 'open')

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

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

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

Consultant appointments

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

Date of AAC	Title	First name	Surname	Department	Potential / Actual Start date
01/02/2021	Consultant Cardio-Thoracic Radiologist	Naveem	Sharma	Radiology	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. On 11 February, the Department of Health and Social Care published the legislative proposals for a Health and Care Bill. The proposals in the white paper are a combination of:
   - Proposals developed by NHS England to support the implementation of the NHS Long Term Plan
   - Additional proposals that relate to public health, social care, and quality and safety matters, which require primary legislation

The measures set out in the white paper propose to modernise the legal framework to make the health and care system fit for the future and put in place targeted improvements for the delivery of public health and social care. It will support local health and care systems to deliver higher-quality care to their communities, in a way that is less legally bureaucratic, more accountable and more joined up, by bringing together the NHS, local government and partners together.

The summary of the key legislative proposals in the paper are as follows:

- **Working together and supporting integration** – To remove some of the boundaries for collaboration and allow for an easier link-up between the NHS and local government. In particular making ICSs, (integrated care systems), statutory bodies with financial and operational responsibility for the NHS in their area.

- **Reducing bureaucracy** – Ensuring that public, taxpayer value and joined up care are prioritised. Changes will be made to procurement and competition law as applied to the NHS, reducing the requirement for tendering clinical services.

- **Enhancing public confidence and accountability** - Streamlining national bodies meaning the public and Parliament can hold decision makers to account. In particular Ministers will: resume the power of direction over NHS England; have greater oversight of social care; and be able to determine service reconfiguration proposals.

  Further proposals on social care, population health and mental health will be published later in the year.

  Read the full document here.

2. Partners in Kent & Medway are pursuing accreditation as an ICS this Spring. A series of improvement and development priorities has been established for the next year, namely:

   - Ongoing response to the Covid-19 pandemic, including service recovery and the Covid-19 vaccination programme;
   - Delivering the K&M Improvement & Recovery Plan:
     - Mental health services
     - Children and young people's services and safeguarding
     - Local system improvements East Kent and Medway & Swale in relation to: urgent and emergency care; infection prevention and control; and maternity care
   - Increasing diagnostic and elective capacity and managing long waits
   - Developing an 'ICS end state' operating model

- Designing a system-wide approach to population health management
- Implementing strategic change priorities in:
  - Stroke care
  - East Kent transformation
- Taking forward opportunities for further provider collaboration
- Establishing leadership, expertise and capacity for quality and service improvement across the system
- Refreshing the system digital strategy

Each of these priorities will be sponsored by the chair of one of the NHS partner organisations, supported by an executive SRO.

3. The number of Covid-19 patients across the Trust continues to fall, with us now below the first wave peak. However, with the second wave peak over 3.5 times the size of the first, our services have a way to recovery, particularly in critical care which continues to see levels of pressure. We have however, begun to restart some elective and outpatient services and are planning for 1 March as a date to restart further treatments across the Trust. The decline in Covid-19 admissions at the Trust has of course been driven by the lockdown measures, which we thank the public for adhering to, but we are now also beginning to see the impact of the vaccination programme with our analysts detecting a drop in Covid-19 admissions in the over 80's cohort – which were amongst the first people to receive the vaccine.

4. Our vaccination centre at Maidstone Hospital has now vaccinated over 15,000 people with their first dose of the Covid-19 vaccine, including MTW colleagues as well as those from partner organisations such as KCHFT and KMPT, groups of high risk patients and more recently also offering it to friends and family of staff who are either clinically extremely vulnerable or over the age of 70. To date, 82% of all staff at MTW have received their first vaccination. The centre will now remain closed until Monday 8 March as we prepare to roll-out the second doses to staff and patients, whilst still ensuring anyone who hasn't had their first vaccination is still able to do so.

5. Despite the ongoing challenges across our sites, our Emergency Departments continue to be some of the top performing departments in the country and we have continued to sustain our cancer performance throughout the pandemic. Earlier this month our ED's were the top performing departments in the region and the fourth best in the country. In Oncology, we have now achieved the 62 day cancer standard for 17 months in a row and the two week wait standard for 16 months in a row.

6. The Infant Feeding Team have achieved Stage 2 Accreditation from Unicef's UK Baby Friendly Initiative. After starting its Baby Friendly journey in 2014 and achieving Stage 1 the following year, the team set its sights on achieving Stage 2. In order to achieve this recognition the Infant Feeding Team had to undergo a rigorous assessment process which measures the level of knowledge and skills of the Trust's staff members who provide breastfeeding support and care for people prenatal and postpartum as well as their babies, to ensure they deliver the very highest standards of care at all times. The assessment, which was held over two days, involved 35 maternity staff, chosen at random by UNICEF, being interviewed via Microsoft Teams about their infant feeding and parent-baby relationship building knowledge.

7. Five of the THOR UVc decontamination robots have been bought by the Trust to work alongside the Domestic Team to quickly de-contaminate a clean room or ward and fight off any pathogens, such as Clostridium difficile (C.diff), or Covid-19. Current methods means it takes approximately five hours to deep clean and disinfect a room and ensure it is safe for patient use again. Using the THOR UVc decontamination robots reduces the cleaning and disinfection time by more than half as the new UVc system uses lydar technology to scan the room and calculate the exact time required to decontaminate a room ranging from 60 to 90 minutes

depending on the size.

8. We are continuing to recognise excellence in our staff at the Trust with our monthly Employee of the Month scheme across the divisions with our latest winner Midwife, Marina Jeffs. We are also continuing our daily Winter Hero staff award scheme, to recognise the achievements and commitment of staff who go above and beyond to support their colleagues and patients. Nominations for the scheme can continue to be made by contacting The Communications Team on mtw-tr.communications@nhs.net

9. Home birth services have now been reinstated. The service was suspended from 30 December 2020 until Tuesday 2 February 2021 due to pressures on South East Coast Ambulance Service (SECAmb) as a result of the high number of cases of COVID-19. Maidstone Birth Centre remained open throughout this period supported by a dedicated transfer service. However, we had to close Crowborough Birthing Centre temporarily which will now reopen on Monday 8 March.

10. I am pleased to announce that from Monday 8 March 2021, partners will be able to attend 20 week ultrasound scan appointments as planned as a system-wide approach across the region. This will also coincide with the introduction of polymerase chain reaction (PCR) COVID swabbing for both those expecting and their partner in line with the Local Maternity System (LMS).

11. After our graduate scheme advert closed in January, we have now offered (and had accepted) 4 graduate scheme places initially, most likely starting in April within our Cancer Division, along with the potential for a slightly later cohort starting in the summer. The management apprenticeships will run for 24 months, and the course will be provided by Encompass, a private training provider who we use on a number of other fronts. Our grad schemers will form a cohort and learning will be a mix of online courses, classroom sessions, exams and assignments. At the end of the course they will be able to register with the Chartered Management Institute and will have the option to go onto study at a higher level or join the Trust substantively.

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

De-escalation and recovery	**Chief Operating Officer and Director of Workforce**

Please find enclosed the de-escalation and recovery report

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 23/02/21 (AM)
- Executive Team Meeting, 23/02/21 (PM)

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

MTW Recovery Priorities
February 21- September 21

Contents

Summary & Key Points

Over the past year, MTW has faced a huge challenge due to the Covid pandemic, yet has managed to continue treating cancer patients and remain one of the top performing A&Es in the country. Nonetheless, the pandemic has had a massive impact on many services and our staff's health and wellbeing.

This paper aims to set the agenda for the Trust's priorities for recovery over the next 6 months as an interim measure while the Trust wide strategy deployment process is being followed through.

Each recovery priority has also been mapped to a specific True North domain (Quality, Systems, Sustainability or People) to draw on the benefits of this methodology, whilst also appreciating that the strategy deployment process will help set the Trust's priorities and objectives in the longer term.

Next Steps

1. Agreeing the True North Domains
2. Agreeing the list of recovery and divisional priorities
3. Establishing clear 6-month timeframes for each priority
4. Sharing with the Divisions and Directorates
5. Continuing with the strategy deployment with the aim to implement fully in 6 months' time (September 2021)
6. Agreeing the reporting structure going forward

Introduction

During the Winter 2020-21, at MTW we have managed to retain our position as a top performing Emergency Department, often performing 1st in the region and even nationally, despite the enormous pressures during to Covid-19. We have also now passed the 62-day first treatment target for cancer for 18 months in a row, keeping the backlog of patients waiting for their treatment below 70 throughout both waves of the pandemic. This demonstrates the high standards of our teams and the drive to deliver the best patient care even under extremely challenging circumstances.

However, during the second Covid wave, there has been an increased risk to patients on our wards and the quality of care that we can provide due to the impact that Covid-19 has had on staffing and the number of inpatients. Our staff has worked relentlessly over the summer to recover after the first wave and increase activity as quickly as possible, then throughout the winter to provide the best possible level of care for our emergency and cancer patients. RTT was improving significantly during the first recovery however due elective cancellations, has dropped to below 70% with over 500 patients now waiting over a year for treatment. Many staff have been redeployed into new areas to ensure patients have received the best possible care and worked through their annual leave to ensure staff levels are as safe as possible.

Due to the relentless nature of the Covid pandemic in 2020, both physically and physiologically, staff morale will be at the centre of our recovery plan out of the second wave. As a trust, we want to restore patient care as quickly as possible, in a safe way that also supports our staff to be able to continue providing this care in a sustainable way.

This paper provides a brief overview of the strategy deployment process for context, before highlighting the 10 recovery priorities for the next six months and the associated timeframes of actions within each priority.

Strategic Deployment

Following visits to Western Sussex FT, and their presentation to Trust Board last year, it was agreed that they would provide support to us in the adoption of their Strategy Deployment and Patient First Improvement System (PFIS) processes and adapt them for our own use. Strategy Deployment has to go first, as it sets the focus and objectives for the organisation through the True North approach.

There are four main components to work of the first stage of Strategy Deployment:

True North - The key goals of the organisation to achieve by which we know we would be delivering high quality care, in a sustainable way

Breakthrough Objectives - Focus the Organisational Improvement Energy to turn the dial on delivery of True North

Strategic Initiatives - "Must Do Can't Fail" strategic programmes of work to drive forward and support delivery of True North.

Corporate Projects - Start and Finish organisational wide or complex projects that need to deliver this year to help deliver True North

What is the strategic deployment process in the long term?

The first step is to describe the True North strategic themes, their owners and a short descriptor about these themes.

Each theme owner then uses a structured thinking process called "A3" to further explore their strategic theme. Outputs from this phase will be a clear problem statement, vision statement, baseline measures, targets and goals, further analysis and then onto suggested breakthrough objectives, strategic initiatives and corporate projects.

In the longer term, potential strategic initiatives and corporate projects are passed through a "strategic filter" to confirm whether they fit into these categories. All of this is supported with regular coaching sessions with Western Sussex team, weekly project team meetings and Exec to Exec sessions designed to take us through this process.

What are the next steps for strategy deployment?

The plan is to take the outputs of this phase and roll down through the organisation. However at every level, objectives are set in a negotiated fashion allowing for top down and bottom up discussions to occur. Once complete, a clear Board to floor series of objectives for Trust, Division, Directorate and into teams will have been created and agreed.

Strategy Deployment Reviews will then take place monthly between the Executive Team and Divisions – these will be undertaken in a coaching, facilitative way. Divisions will cascade this approach to reviews with Directorates, etc.

A clear, well constructed and resourced communications plan supporting this development, and how it relates to other initiatives, will be fundamental to its success. In particular, the relationship between Strategy Deployment, PFIS and Exceptional Leaders needs to be clear and unambiguous.

What is our True North?

As a first step in the process, we have developed our True North domains across 4 distinct domains with Quality split into 3 more detailed ones:

Quality

Patient Experience

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

Patient Access

All of our patients can access quality care and treatment when they need it.

Patient Safety & Clinical Effectiveness

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

Systems

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

Sustainability

We have a recurrent surplus, where income exceeds costs, allowing us to invest sustainably in high quality services and infrastructure, improving patient experience and outcomes, and providing staff the tools they need to do their job.

People

Our vision is that we recruit and develop exceptional people and create the conditions for success so that they can deliver outstanding care.

Our vision is dependent on an engaged, motivated workforce who love their work and feel well supported.

How does this link to our priorities over the next 6 months?

This paper sets the priorities for the recovery process over the next 6 months as an interim measure, while MTW's True North is being finalised and agreed across the organisation, and the strategic deployment process is being implemented to set to Trust's priorities in the longer term.

True North Domains

Quality

Patient experience

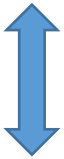
Patient Access

Safety & Clinical Effectiveness

Systems

Sustainability

People



Recovery Priorities

10 priorities for the next 6 months based on recovering from the effects of Covid-19.

Recovery – Key Priorities

True North Domain	Priority	Lead(s)	Key Focus
Quality – Patient Access	**Elective care, Diagnostics and RTT**	Sarah Davis	• Phase in return of elective activity over the next 2 months including private sector activity • Plan to move some routine elective work to private sector to support EPR delivery • Eliminate 52 week breaches by September 21 and begin recovery of RTT performance • Ensure all data quality recommendations are completed by July 21
Quality – Patient Access	**Outpatients**	Katie Goodwin	• Electronic room booking and patient flow – implementing InTouch • Rebuilding clinic templates on Allscripts and developing visible, live reports • Improving the outpatient environment for our patients • Increasing the using of virtual clinics • Building the central outpatients' team
Quality – Patient Safety & Clinical Effectiveness	**Quality Recovery**	Gemma Viner / Sharon Page	• Falls, Length of Stay and Pressure Ulcers • Weekly focus and reporting to the Execs to ensure rapid improvement • Improvement groups to be set up for each area: falls, length of stay and pressure ulcers
Quality – Patient Access	**A&E Delivery and Site Pathways**	Sally Foy	• Reviewing bed configuration including red, amber and purple pathways • Planning for paediatric ED and restarting elective activity • Ensuring Teletracking is fully utilised
Quality – Patient experience	**Patient Communication**	Katie Goodwin	• Reducing the time patient's wait on the phone to get through to MTW (piloting call centre) • Improving communication with our patients - measure this using complaint themes
Systems	**Maternity Demand & Capacity**	Sarah Blanchard Stow / Kym Sullivan	• Calculating demand and capacity using the data available • Writing a business case to ensure capacity meets increased demand
Systems	**Community & Social Care**	Lynn Gray	• Review which services that may be best provided by the community such as stroke, frailty • Reduce non-elective bed days and no patients who could be treated in our community are transferred to our hospital or a tertiary centre
Sustainability	**Space**	Lynn Gray / Doug Ward	• Identifying space constraints and hold a frequently updated central repository to allow comparison of risks and priorities for space going forward.
Sustainability	**Financial Reset**	Steve Orpin	• Target is recurrent surplus and continued delivery of financial plan, • Modern and fit for purpose environment and infrastructure with no backlog maintenance • Interlinked with implementation of estates strategy, EPR, Staffing hub and clinical strategy
People	**Staff Welfare**	John Week on bullet point one Steve/Sean/Cheryl on two. Sue Steen on three.	• Benchmark other NHS trust welfare and wellbeing programme. • Agree tactical year workplan on wellbeing and welfare. • Design long term strategic plan around staff welfare and wellbeing.

Recovery Priorities Timeframes

True North Domains

Quality	Systems	Sustainability	People

Timeframes for Key Priorities - Recovery

These priorities relate specifically to recovering from Covid and are planned to be in force over the next 6 months.

Elective Care, Diagnostics & RTT Recovery – Lead: Sarah Davis
True North Domain: Quality – Patient Access

	February	March	April	May	June	July	August
Elective Activity	Remodel demand and capacity taking into account social distancing, PPE usage. Review patient pathways Ophthalmology Begin to open theatres for electives Ad hoc theatre sessions being offered in line with critical care demand	Prepare recovery plan for the next 6 months. Ensure consistent approach within MTW and IS's in order to keep patients and staff safe. Review of theatre schedule	Continue to review demand in line with NEL, Covid demand and community prevalence				
Endoscopy	Remodel demand and capacity taking into account social distancing, PPE usage. Review patient pathways Bowel screening x 6 sessions open 08/02/21	Prepare recovery plan for the next 6 months. Ensure consistent approach within MTW and IS's in order to keep patients and staff safe.					

Diagnostics	Remodel demand and capacity taking into account social distancing, PPE usage. Review patient pathways	Prepare recovery plan for the next 6 months. Ensure consistent approach within MTW and IS's in order to keep patients and staff safe. Patient vaccinations roll out	Continue to review demand in line with NEL, Covid demand and community prevalence				
52 Week breaches	52 week breaches are currently increasing by 40 per month and most are in the high volume services e.g. Ophthalmology & T&O	Recovery plan to map 52 week breaches in order to clear as soon as possible					Estimate to clear current position is 14 months (taking off 40 breaches per month (Current 52 week breach weekly position stands at 562).
92% Target Plan	Estimation on total WL by March based on the average increases in the WL over the last 2 months = 32481 Estimation to reach 92% by March 22 means clearing 2792 IP and 5109 OP = total of 7902 patients	Plan and costs to reach 92% to be developed and to include IS Prepare recovery plan for the next 6 months.					

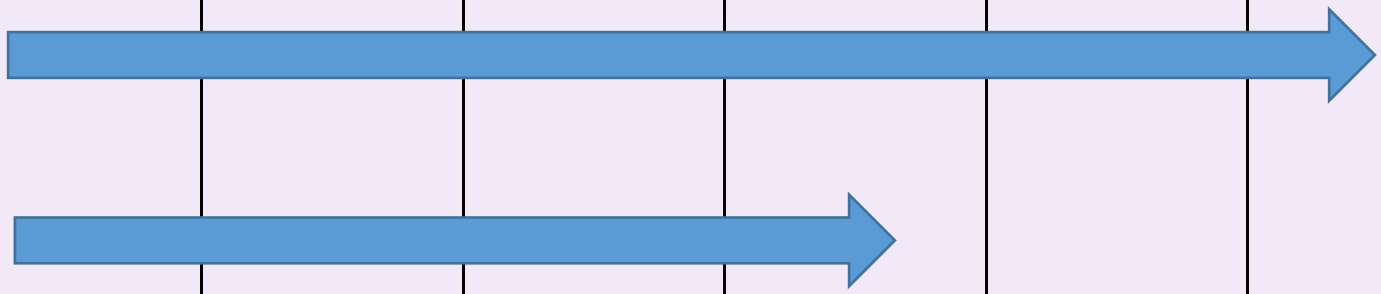
RTT Data Quality	Review of RTT responsibilities for validation	Quattro switched off to reporting New DQ reports to be implemented RCA panel re-instated to capture learning	Redesign of RTTr front page Monthly DQ poster to raise awareness of learning				
RTT Training Team	RTT and Data Quality Intranet page going live Feb 21 New Outcome Clinic poster rolled out	Training team continue to deliver Phase 1 completion by Beg Mar 21 Bite size User guides written and will be available on intranet page	Phase 2 Training- How to Fix errors - starting April 21	New training material for Ward Clerks and Receptionists	Training Team will be walking the floor to support staff	Full training programme to be made available on E-Learning	
Elective Restart Preparation	Patient letter being sent to advise patients of the current situation Addendum to access policy COVID being finalised for West Kent POA increased to support activity increase	Clinical Prioritisation continues for inpatients over 40 weeks					

Outpatients – Lead: Katie Goodwin
True North Domain: Quality – Patient Access

	February	March	April	May	June	July	August
Room Booking and Patient Flow – In Touch	Costing Business Case draft to DDO and CD and submit to execs Flow Screens CSMT Upgrade- roll out	Purchase and roll out plan	Implement Kiosks across Maidstone and Tunbridge Wells				
Re-build all clinics on allscripts	3xWTE Band 5 secondment for 6 months- Medicine, Surgery, W&C and therapies CSMT engagement Data quality- recording clinic appointments GANTT and roll out plan within CAUs Clinical and GM input and support- agree process		Continue rebuild process throughout March and April in preparation for EPR Map progress and present to Execs				
Call Centre and CAU	Recruit 5xWTE B3 bank/FTC- 3 months Find physical space Create training matrix with support of CAUs Netcall phase 1	Agree CAU to begin with- likely T&O Agree process with service Begin pilot Review options for further Netcall investment	Map pilot process and present to Exec				

Power BI Reports	Update on reports Send list of reports required Designated BI reports	Set up working group with GM and RTT involvement to ensure reports work Roll out reports BI team to attend GM meeting					
Environment	Estates at Maidstone and TW Costings Progress report agreed by Estates at Maidstone and TW	Complete phase 1 works- i.e. painting etc	Progress with phase 2 works and follow agreed trajectory				
Virtual Clinics	Cost AA extension Confirm funding for AA extension Review integration of AA with InTouch and Sunrise	Confirm roll out plan for virtual platform					
Centralised Outpatient Teams				Create consultation document for all outpatient receptionists to be managed by Outpatients Create reception training matrix to ensure appropriate training incorporating and supporting EPR roll out		Roll out Consultation document	Review ERS management

Quality Recovery – Leads: Sharon Page & Gemma Viner
True North Domain: Quality – Patient Safety & Clinical Effectiveness

	February	March	April	May	June	July	August
Quality Recovery – Falls, Length of Stay and Pressure Ulcers	Benchmark current performance and issues Leads to set up working groups to focus on improvement Weekly data to be presented at Execs, highlighting any support needed across site						

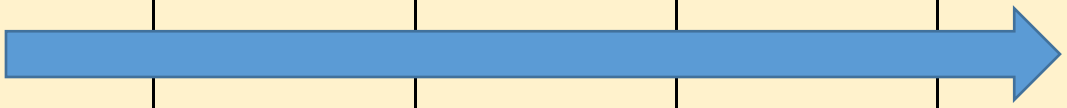
A&E Delivery and Site Pathways – Lead: Sally Foy
True North Domain: Quality – Patient Access

	February	March	April	May	June	July	August
A&E Delivery and Site Pathways	Assess bed configuration across site and continue to ensure green, red and purple pathways in place Review mid-term plans for paediatric ED and elective capacity Continue to ensure ward managers, matrons and general managers are supporting usage of Teletracking	Ensure all additional escalation capacity is closed Ensure all wards are fully compliant with Teletracking and drop box compliance is being used Begin demand & capacity review of site pressures to coincide with restoration of elective activity	Begin to implement findings from demand and capacity review Begin financial review of current ward capacity with a view to inform following year Winter Plan and current budget / ward alignment				

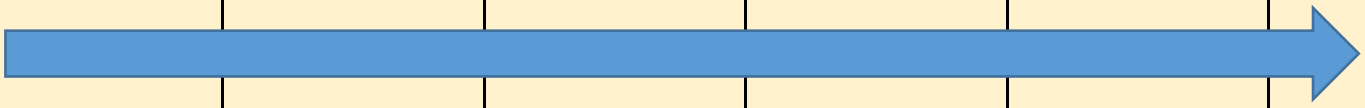
Patient Communication– Lead: Katie Goodwin
True North Domain: Quality – Patient Experience

	February	March	April	May	June	July	August
Patient Phone Calls	Netcall upgrade to increase functionality and visibility for patient phone calls	Begin pilot for centralised call centre with directorate	Continue close monitoring of patient waiting times by directorate Measure success of pilot and implement across further directorates if successful				

Maternity Demand and Capacity – Lead: Sarah Blanchard Stow / Kym Sullivan
True North Domain: Systems

	February	March	April	May	June	July	August
Maternity – Demand and Capacity	Data demonstrates significant increase in maternity demand Establish working group with Business Intelligence support, set up to determine short and long term impact	Demand and capacity business case to be agreed with Execs with full implementation plan to be in place (including any implications to site configuration)					

Community & Social Care – Lead: Lynn Gray
True North Domain: Systems

	February	March	April	May	June	July	August
Community & Social Care	Review which services could go and stay in community like stroke / frailty						

Space – Lead: Lynn Gray / Doug Ward
True North Domain: Sustainability

	February	March	April	May	June	July	August
Space	Understand the issues relating to the lack of space for departments for services to work effectively, clinical and non-clinical, as a result of Covid-19 Write ToR for Space Meeting Engage with stakeholders to propose potential solutions and bring to Executive Meetings for discussion and approval	Hold a monthly Space Meeting, chaired by leads, with Divisional and corporate representation to provide a conduit for all space requirements Hold a central repository of space requirements which is risks assessed to ensure prioritisation of most urgent issues Provide regular briefing papers to ETM					

Financial Reset – Lead: Steve Orpin
True North Domain: Sustainability

	February	March	April	May	June	July	August
Financial Reset							

Staff Welfare – Lead: John Weeks / Cheryl Lee / Steve Orpin / Sean Briggs/ Sue Steen
True North Domain: People

	February	March	April	May	June	July	August
Staff Welfare	Free tea/ coffee/ snacks available to all staff at both sites Winter Hero Awards Free parking for all staff Dedicated fund for divisional teams to purchase item of their choice e.g. coffee machine for office Physiological support available	Reinstate staff welfare working group to collate initiatives from staff on the group and put ideas into action (similar to Dragon's Den) Consider re-vamping catering offer to staff e.g. more variety available Steve/Sean/Cheryl to lead	Consider similar approach to Christmas for Easter Break e.g. equivalent of calendars for all staff	Sue Steen to take over programme			

Support Needed

As recovery and organisational priority programme plans develop, further support and discussion with the Executive team regarding any financial and resourcing implications.

Reporting

There will be an agreement with the leads of reporting for each priority to Executives and key KPIs that will be monitored over a longer time period.

All aspects of recovery will be reported weekly to Executives and incorporated into Monthly Divisional Performance Reviews.

Strategy Deployment Reviews will then take place monthly between the Executive Team and Divisions – these will be undertaken in a coaching, facilitative way. Divisions will cascade this approach to reviews with Directorates, etc.

Integrated Performance Report (IPR) for January 2021 (incl. an update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for Jan. 2021)	**Chief Executive / Members of the Executive Team**

The IPR for month 10, 2020/21, is enclosed, along with the monthly finance report, an update on progress with the Perinatal Mortality Review Tool and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 23/02/21 (IPR)
- Executive Team Meeting, 16/02/21 (IPR)

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

January 2021

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 23 onwards)

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

MTW
exceptional people, outstanding care

Key to KPI Variation and Assurance Icons

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

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

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

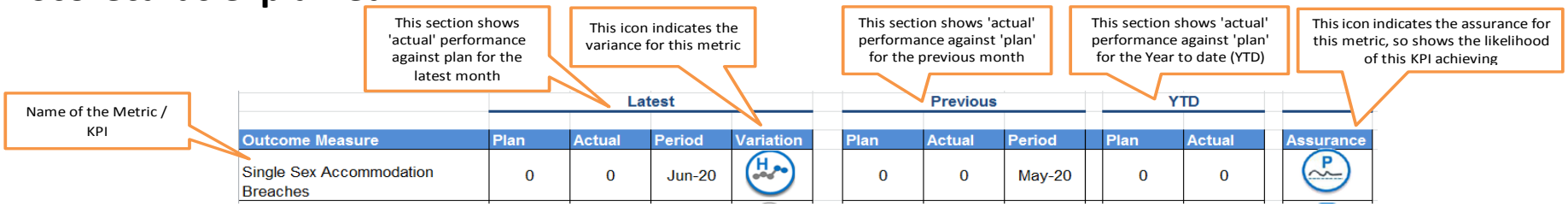
Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Areas are escalated for reporting if:

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

Scorecards explained



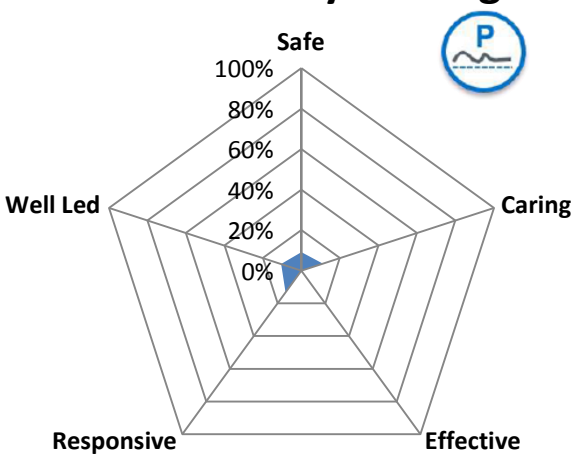
Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Consistently Passing



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

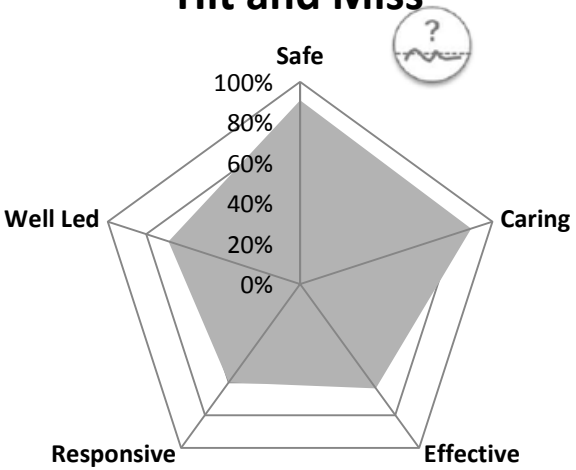
Safe:
- Trust Mortality (HMSR)

Caring:
- Mixed Sex Accommodation Compliance

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

Well-Led:
- Staff Friends & Family % Recommended to Work at MTW
- Mandatory Training Compliance

Hit and Miss



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

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

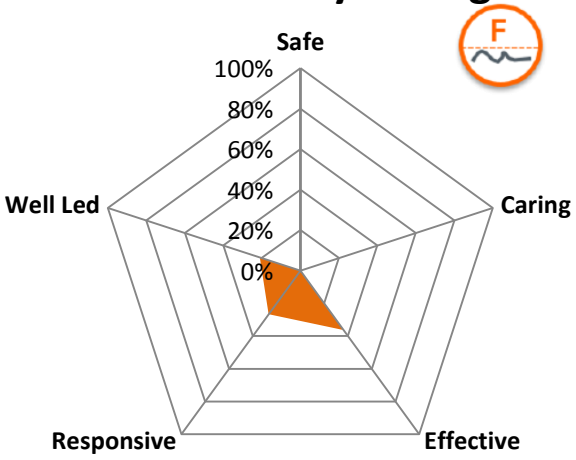
Effective:
- Outpatients DNA Rates and Hospital Cancellations, Readmissions Indicators, Stroke Indicators

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

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

Well-Led:
- Capital Expenditure, Cash Balance, Sickness Rates, Vacancy Rates, Appraisals, Health and Well-Being and Clinical Strategy Indicators

Consistently Failing



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

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

Responsive:
- RTT Number of >40 week Waiters
- RTT Number of >52 week Waiters
- Theatre Utilisation

Well-Led:
- Agency Staff used
- Agency Spend
- Turnover Rate
- Friends & Family Recommended Care
- Percentage of Trust Policies within Review Date

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains									No SPC	
CQC Domain Safe										
Infection Control	2		1	1				4		4
Harm Free Care			2					2		2
Incident Reporting	2							2		2
Safe Staffing	1	1						2		2
Mortality				1		1				1
Safe Total	***5***	***1***	***3***	***2***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	3	1	2		1		4	3		7
Quality & CQC	3				1			4		4
Strategy - Estates									5	5
Effective Total	***6***	***1***	***2***	***0***	***2***	***0***	***4***	***7***	***5***	***16***
CQC Domain Caring										
Complaints	1				1			2		2
Admitted Care	2	2				1		3		4
ED Care									2	2
Maternity Care	1	1						2		2
Outpatient Care	1							1		1
Caring Total	***5***	***3***	***0***	***0***	***1***	***1***	***0***	***8***	***2***	***11***
CQC Domain Responsive										
Elective Access	2	1	2				4	1		5
Acute and Urgent Access	2		1	1				4	1	5
Cancer Access	4					2		2	1	5
Diagnostics Access		1						1		1
Bed Management	1							1		1
Responsive Total	***9***	***2***	***3***	***1***	***0***	***2***	***4***	***9***	***2***	***17***
CQC Domain Well-Led										
Staff Welfare	2							2	4	6
Finance and Contracts	2				1		1	2	3	6
Leadership		1			1	1	1		1	3
Strategy - Clinical and ICC	1		1	3	2		1	6	1	8
Workforce	3		1	1	1	1	2	3		6
Well-Led Total	***8***	***1***	***2***	***4***	***5***	***2***	***5***	***13***	***9***	***29***
Trust Total	***33***	***8***	***10***	***7***	***8***	***6***	***13***	***47***	***18***	***84***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	6		?
S6	Rate of Total Patient Falls	5.80	10.19	H	?
S7	Number of Never Events	0	0		?
S8	Number of New SIs in month	11	19		?
S10	Overall Safe staffing fill rate	93.5%	85.4%	L	?

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	81.7%	87.7%		?
R4	RTT Incomplete Pathway	86.6%	71.0%		F
R6	% Diagnostics Tests WTimes <6wks	99.0%	75.0%	L	?
R7	Cancer two week wait	93.0%	93.1%		P
R10	Cancer 62 day wait - First Definitive	85.0%	85.8%		P

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	86.3	L	P
E3	% Total Readmissions	0.0%	13.4%		?
E6	Stroke: Best Practice (BPT) Overall %	50.0%	50.0%	H	?
R11	Average LOS Non-Elective	6.40	7.73		P
R12	Theatre Utilisation	90.0%	77.4%	L	F

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%	6.2%	L	?
W8	Total Agency Spend	1,749	1,599		F
W10	Sickness Absence	3.3%	7.3%	H	?

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%	86.5%	H	?
C5	IP Friends & Family (FFT) % Positive	95.0%	97.4%		?
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%	85.3%		?

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

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

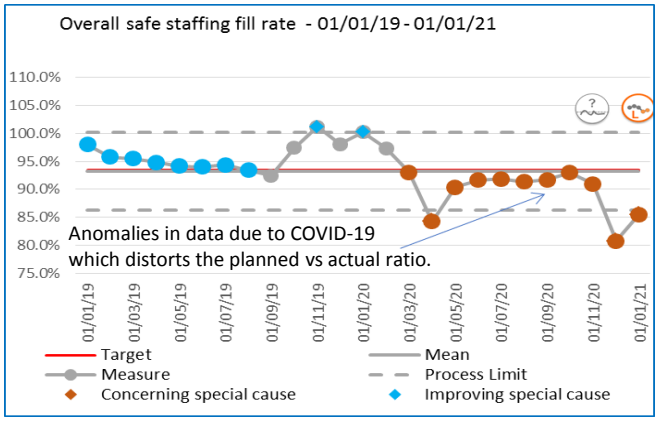
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

Safe - CQC Domain Scorecard

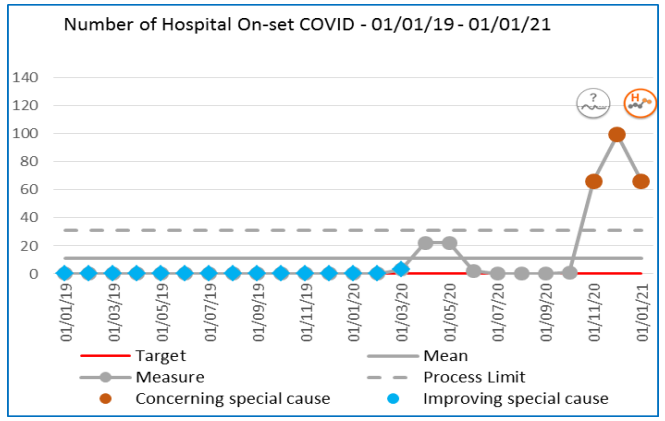
Reset and Recovery Programme: Patient and Staff Safety

Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	85.4%	Jan-21		93.5%	80.8%	Dec-20	93.5%	89.2%	
Sickness Rate - Covid	0.0%	3.2%	Dec-20		0.0%	0.9%	Nov-20	0.0%	1.2%	
Infection Control - Hospital Acquired Covid	0	66	Jan-21		0	99	Dec-20	0	278	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	18.3	30.7	Jan-21		18.3	26.2	Dec-20	22.9	26.5	
Infection Control - Number of Hospital acquired MRSA	0	0	Jan-21		0	0	Dec-20	0	3	
Infection Control - Rate of Hospital E. Coli Bacteraemia	36.6	30.7	Jan-21		36.6	36.6	Dec-20	32.1	28.5	
Number of New SIs in month	11.0	19.0	Jan-21		11	22	Dec-20	110	119	
Rate of Total Patient Falls per 100,000 occupied beddays	5.8	10.2	Jan-21		5.8	9.5	Dec-20	5.8	8.1	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	3.5	Jan-21		2.3	3.2	Dec-20	2.3	2.3	
Standardised Mortality HSMR	100.0	86.3	Jan-21		100.0	88.8	Dec-20	100.0	86.3	
Never Events	0	0	Jan-21		0	0	Dec-20	0	2	

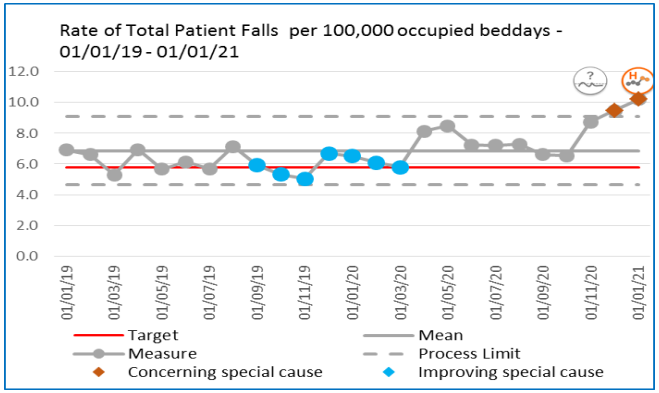
Safe - Reset and Recovery Programme: Patient and Staff Safety



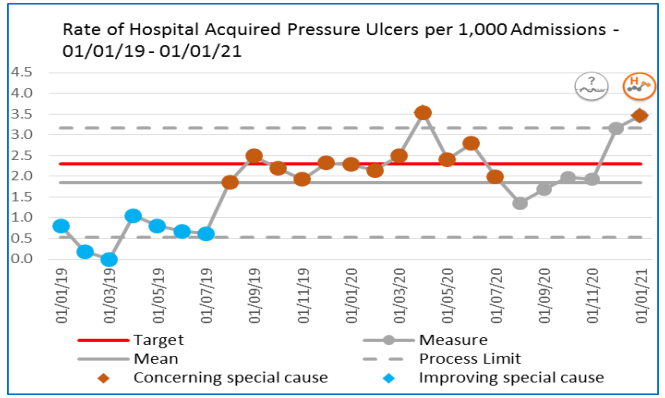
January-21
85.5%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
93.5%
Target Achievement
Metric is experiencing variable achievement



January-21
66
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
0
Target Achievement
Metric is experiencing variable achievement



January-21
10.2
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target
5.8
Target Achievement
Metric is experiencing variable achievement



January-21
3.5
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
5.0
Target Achievement
Metric is experiencing variable achievement

Summary:

The level of **Hospital On-set COVID has** decreased from the high level in December but continues to experience special cause variation of a concerning nature.

Safe Staffing Fill Rate: The level reported has increased by just under 5% from the low levels reported for December but remains below usual levels, continuing to experience special cause variation of a concerning nature. The staffing levels have been significantly impacted due to COVID related absence alongside the requirement to increase capacity, staff escalation areas and deliver care in line with new pathways. There continues to be some anomalies in the data that reflect operational decisions to open and close clinical areas in response to the COVID Pandemic which has distorted the planned vs actual ratio in addition to roster management of staff redeployment.

Falls: The number of Falls has increased further across both sites and the overall rate for the Trust is now once again experiencing special cause variation of a concerning nature.

Pressure Ulcers: The rate of hospital acquired pressure ulcers continues to experience special cause variation of a concerning nature. The increase continues to be mainly in Deep Tissue Injuries (DTIs). Community Acquired Pressure Ulcers also continue to experience special cause variation of a concerning nature.

Actions:

The Trust admitted 598 patients with Covid-19 infection during January, including 66 cases of probable or definite hospital acquired infection (11% of the total). This is a reduction from 13% in December. 6 outbreaks of Covid-19 were identified in January. New variant Covid -19 found to be endemic in Kent and Medway. Key messages on the importance of PPE, social distancing and hand hygiene continue to be raised with staff. Focus on reminding staff to continue with lateral flow testing and registering of results

Twice daily staffing huddles continue which review prospectively the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust; and to ensure joint working between the nursing teams and the Bank office. Bank team members are now engaging with Matrons at the daily afternoon huddle to update on fil rate, key areas to focus on and deployment of staffing from the established Rapid response unit.

Themes and trends for falls in January was discussed at the Falls Group meeting. Wards are encouraged to use the Falls Safety Huddle to highlight patients on the wards who are at risk of falls and measures required to reduce risk.

We have reviewed and amended the process for reporting the weekly reviewed pressure ulcers. We have added detail to the data to enable us to better identify if patients who develop pressure ulcers had any damage noted on admission.

Assurance:

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

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

Continuing to monitor falls across all areas. Themes and trends for falls discussed at Fall Group meeting. To raise awareness and as staffing improves, some of the challenges in implementing preventative measures should ease.

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Non-face to face OP activity / Total activity	40.0%	47.7%	Jan-21		40.0%	39.2%	Dec-20	40.0%	46.9%	
OP Utilisation	85.0%	40.3%	Jan-21		85.0%	44.6%	Dec-20	85.0%	49.4%	
Outpatient DNA Rate	5.0%	6.3%	Jan-21		5.0%	7.4%	Dec-20	5.0%	5.7%	
Outpatient Hospital Cancellation	20.0%	53.5%	Jan-21		20.0%	39.4%	Dec-20	20.0%	30.3%	
Outpatient Cancellations < 6 weeks	10.0%	45.7%	Jan-21		10.0%	31.6%	Jan-21	10.0%	23.2%	
Calls Answereed in under 1 min	75.0%	No data	Jan-21		75.0%	42.5%	Jan-21	75.0%	38.8%	
Calls Answereed in under 3 min	100.0%	No data	Jan-21		100.0%	67.9%	Jan-21	100.0%	63.4%	

Organisational Objectives: Quality and CQC

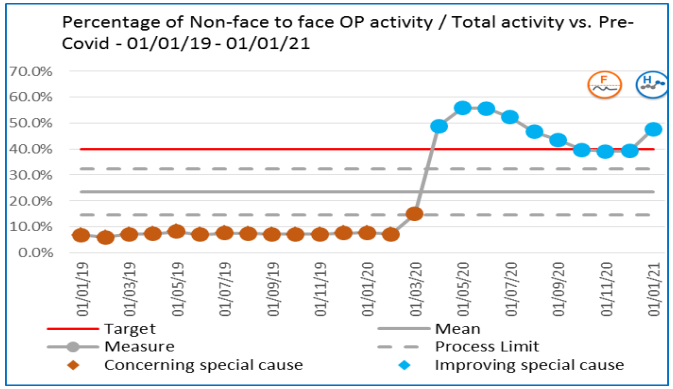
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	13.4%	Dec-20		14.6%	14.1%	Nov-20	14.6%	14.9%	
Non-Elective Readmissions <30 days	15.2%	13.7%	Dec-20		15.2%	14.6%	Nov-20	15.2%	15.2%	
Elective Readmissions < 30 Days	7.8%	5.9%	Dec-20		7.8%	6.9%	Nov-20	7.8%	9.2%	
Stroke Best Practice Tariff	50.0%	50.0%	Jan-21		50.0%	53.5%	Dec-20	50.0%	52.0%	

Effective - CQC Domain Scorecard

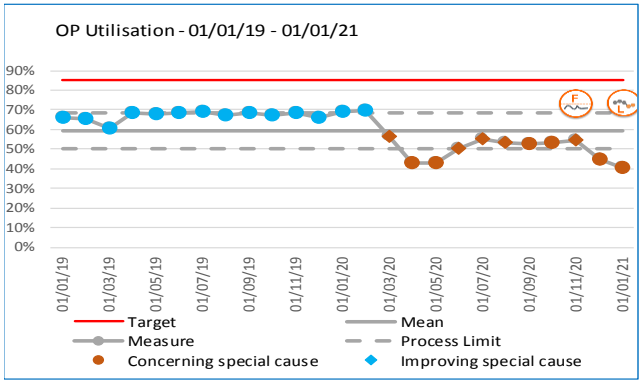
Organisational Objectives: Strategy - Estates

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100:0	Jan-21	No SPC	Under review	100:0	Dec-20	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Jan-21	No SPC	Under review	4.4:1	Dec-20	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Jan-21	No SPC	Under review	5808	Dec-20	Under review	5808	No SPC
Staff occupancy per m2	Under review	23.1	Jan-21	No SPC	Under review	23.2	Dec-20	Under review	23.5	No SPC
Energy cost per staff	Under review	£ 1,082.60	Jan-21	No SPC	Under review	£ 1,071.14	Dec-20	Under review	£ 783.1	No SPC

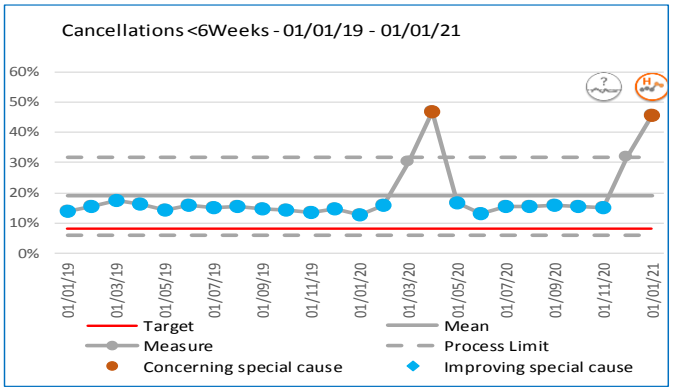
EFFECTIVE- Reset and Recovery Programme: Outpatients



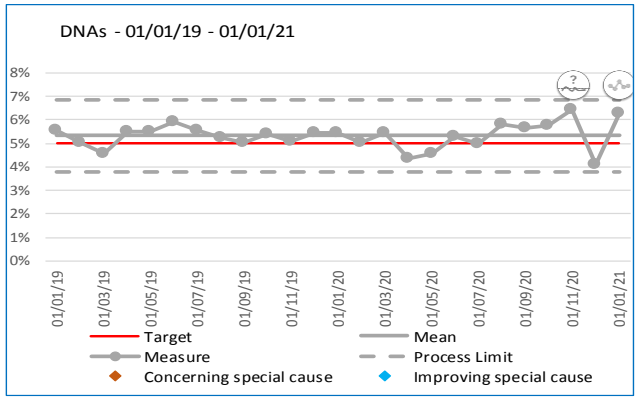
Jan-21
47.7%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
40%
Target Achievement
Metric is constantly failing the target



Jan-21
40.3%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
85%
Target Achievement
Metric is constantly failing the target



Jan- 21
45.7%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
8%
Target Achievement
Metric is experiencing variable achievement.



Jan-21
6.3%
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

Summary:

Following a decreasing trend in recent months the percentage of non-face to face OP Activity has increased and is experiencing special cause variation of an improving nature.

All non urgent outpatient appointments have been cancelled or converted to virtual. This has led to a fall in the volume of consultations and an increase in the number of hospital cancellations.

As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased and remain lower than usual levels.
DNA rates are once again experiencing common cause variation and variable achievement of the target.

Actions:

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

The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients. This includes viewing the clinic templates to ensure that utilisation is a true reflection.

Appointments are being reassessed as to what can be converted and cancelled due to the second wave. Activity is currently being assessed now we are in Opel 3 to see what clinics can start up again.

Assurance:

Outpatient restart and 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 and that activity where clinically appropriate remains virtual.

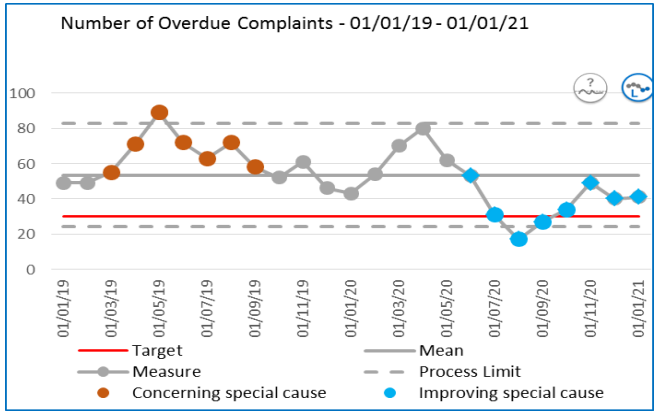
Weekly monitoring of this is being undertaken in the performance meetings to ensure achievement of the target. Weekly meeting with specialties regarding clinics restarting is being undertaken to ensure we operate safety and the most efficient possible.

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	Jan-21		0	0	Dec-20	0	0	P
Rate of New Complaints	3.9	2.2	Jan-21		3.9	1.7	Dec-20	2.9	2.2	?
% complaints responded to within target	75%	86.5%	Jan-21	H	75%	76.9%	Dec-20	75%	77.5%	?
IP Resp Rate Recmd to Friends & Family	25%	3.8%	Jan-21	L	25%	15.3%	Dec-20	25%	0.0%	?
IP Friends & Family (FFT) % Positive	95%	97.4%	Jan-21		95%	98.8%	Dec-20	95%	0.0%	?
A&E Resp Rate Recmd to Friends & Family	15%	No data due to COVID-19	Jan-21	No SPC	15%	No data due to COVID-19	Dec-20	15%	No data due to COVID-19	No SPC
A&E Friends & Family (FFT) % Positive	87%		Jan-21	No SPC	87%		Dec-20	87%		No SPC
Mat Resp Rate Recmd to Friends & Family	25%	11.1%	Jan-21		25%	25.5%	Dec-20	25%	24.9%	?
Maternity Combined FFT % Positive	95%	89.4%	Jan-21	L	95%	98.7%	Dec-20	95%	98.0%	?
OP Friends & Family (FFT) % Positive	84%	85.3%	Jan-21		84%	84.1%	Dec-20	84%	82.6%	?
% VTE Risk Assessment	95%	91.3%	Jan-21	L	95%	94.1%	Dec-20	95%	96.5%	?

CARING- Organisational Objective: Quality and CQC



Jan-21

41

Variance Type

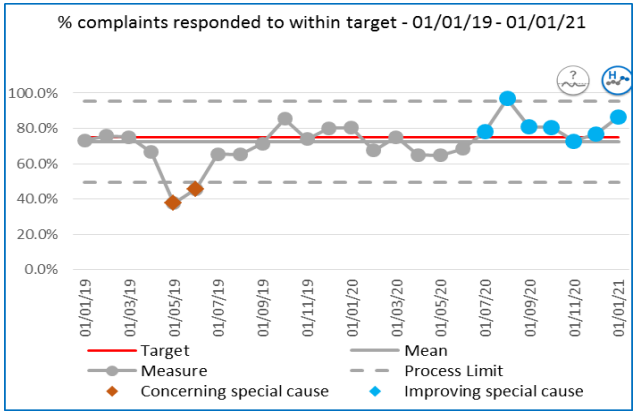
Metric is currently experiencing special cause variation of an improving nature

Max Target (Internal)

60

Target Achievement

Metric is experiencing variable achievement



Aug-20

86.5%

Variance Type

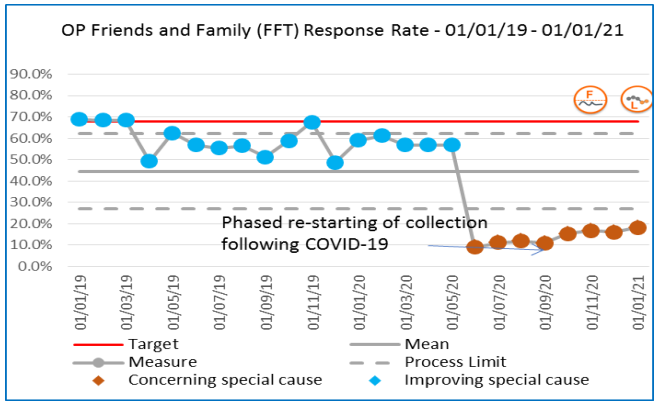
Metric is currently experiencing special cause variation of an improving nature

Target (Internal)

75%

Target Achievement

Metric is consistently achieving the target



Jan-21

18.2%

Variance Type

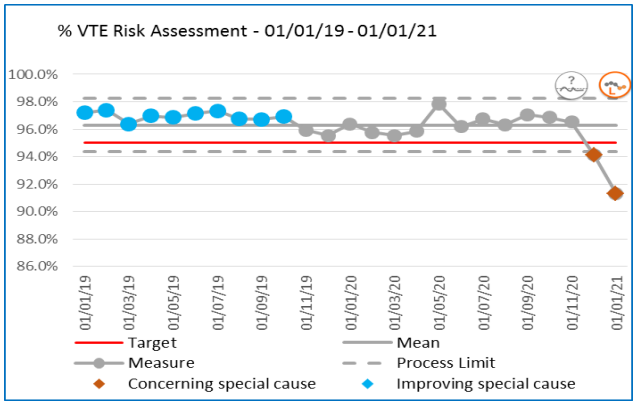
Metric is currently experiencing special cause variation of a concerning nature

Target

68%

Target Achievement

Metric is consistently failing the target



Jan-21

91.3%

Variance Type

Metric is currently experiencing special cause variation of a concerning nature

Target (National)

95%

Target Achievement

Metric is experiencing variable achievement

Summary:

Complaints: The number and rate of new complaints received continues to remain consistent experiencing common cause variation. However performance for both the percentage of complaints responded to within their target date and the number of overdue complaints are once again experiencing special cause variation of an improving nature . YTD compliance is now achieving the target at 77.7%. **Outpatient Friends and Family Response Rate** continues to experience special cause variation of a concerning nature.

VTE Risk Assessment appears to be experiencing special cause variation of a concerning nature , however the percentage is incorrect presently untill all episodes of admission have been coded to correctly identify patients who qualify for a VTE risk assessment.

Actions:

Complaints: Regular meetings with key divisional staff reinstated to monitor progress on open complaints. New format weekly reports issued with particular emphasis on overdue cases.
Realignment of complaints leads' portfolios to address fluctuations in activity between divisions. – under ongoing review.

OP FFT: FFT is beginning to see a slight increase in response rates. FFT monthly meetings to recommence and increase accessibility using online platform to provide feedback

VTE: We are experiencing severe delays in data input due to the wards been under considerable pressure due to significant staffing issues through December and January as well as some delays in Coding. Emails being sent to Matrons and ward managers to complete outstanding data, Communication with Head of Coding for assurance is taking place, Patients notes will be requested by Patient Safety Admin to help with Data input.

Assurance:

Complaints: Continued regular monitoring of all open complaints with reports to CN. Learning and key messages published in the Governance Gazette.
Continued compliance despite operational challenges and no significant reductions in complaint activity.

OP FFT: Monthly FFT meeting to recommence to increase awareness, engage with leads and identify ways to embed FFT into services. . Outpatients FFT % positive at 85.3% against a plan of 84%.

VTE: Continued communication with the Coding Team and Monthly progress updates to clinical areas and leads.

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	86.6%	71.0%	Jan-21		86.6%	73.3%	Dec-20	86.6%	71.0%	F
Number of patients waiting over 40 weeks	0	1919	Jan-21	H	0	2204	Dec-20	0	15421	F
52 week breaches (new in month)	3	335	Jan-21	H	3	144	Dec-20	30	1508	F
Access to Diagnostics (<6weeks standard)	99.0%	75.0%	Jan-21	L	99.0%	76.8%	Dec-20	99.0%	75.0%	?
Average for new appointment	10.0	7.9	Jan-21		10.0	8.8	Dec-20	10.0	7.9	?
Theatre Utilisation	90.0%	77.4%	Jan-21	L	90.0%	85.9%	Dec-20	90.0%	81.9%	F

Reset and Recovery Programme – Acute & Urgent Care

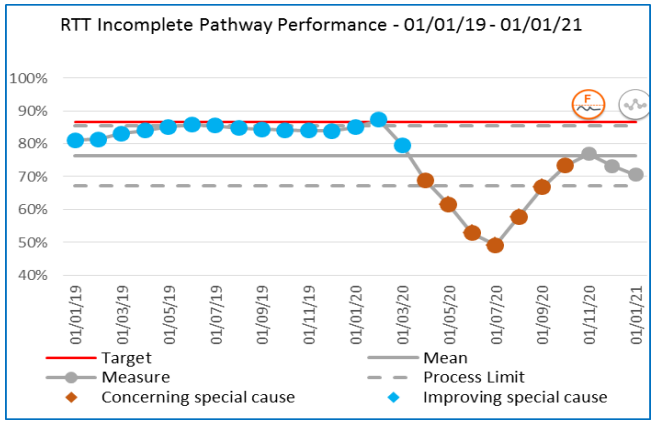
	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Referrals to ED from NHS 111	Coming February 21		Jan-21	No SPC	Coming February 21		Dec-20	Coming February 21		No SPC
A&E 4 hr Performance	82.7%	87.7%	Jan-21		82.7%	81.6%	Dec-20	82.7%	94.4%	?
Super Stranded Patients	80	108	Jan-21	H	80	88	Dec-20	80	108	?
Ambulance Handover Delays Rate > 30mins	7.0%	6.9%	Jan-21	L	7.0%	9.5%	Dec-20	7.0%	6.9%	?
Bed Occupancy	90.0%	93.3%	Jan-21		90.0%	91.6%	Dec-20	90.0%	66.1%	?
E LOS	6.4	7.7	Jan-21		6.4	7.1	Dec-20	6.4	6.2	?

Responsive - CQC Domain Scorecard

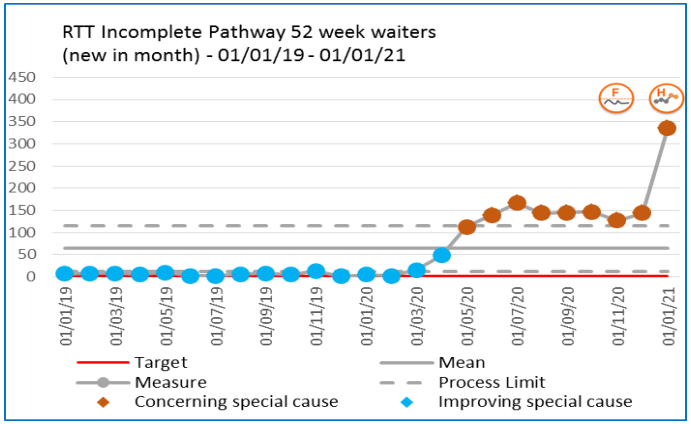
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Cancer - 2 Week Wait	93.0%	93.1%	Dec-20		93.0%	93.1%	Nov-20	93.0%	93.1%	
Cancer - 31 Day	96.0%	97.6%	Dec-20		96.0%	97.6%	Nov-20	96.0%	97.6%	
Cancer - 62 Day	85.0%	85.8%	Dec-20		85.0%	85.8%	Nov-20	85.0%	85.8%	
Size of backlog	30	0	Jan-21		30	0	Dec-20	30	0	
28 day Target	Coming Soon		Dec-20	No SPC	Coming Soon		Nov-20	Coming Soon		No SPC

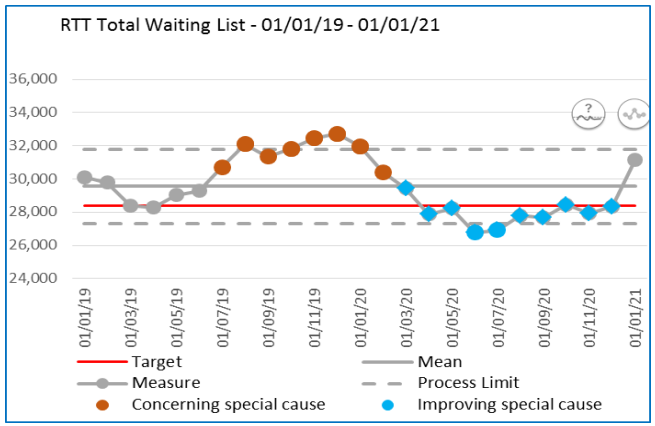
RESPONSIVE- Reset and Recovery Programme: Elective



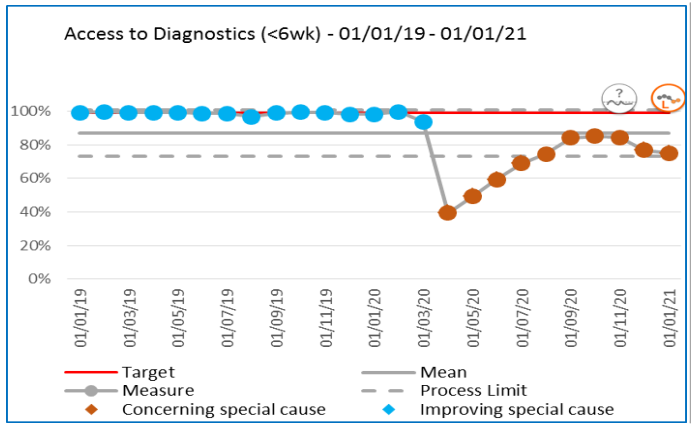
Jan-21
71.0%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
86.3%
Target Achievement
Metric consistently failing the target



Jan-21
335
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
8
Target Achievement
Metric is consistently failing the target



Jan-21
31,157
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
28,412
Target Achievement
Metric is experiencing variable achievement



Jan-21
75%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

Due to the COVID-19 pandemic & the impact of wave 2 the YTD activity remains low for both elective & outpatient appointments which have adversely impacted the RTT performance. The January performance has dropped to 71% the Total Waiting List has increased this month due to the closure of theatres & the cancellation of routine elective activity.
There has also been a significant increase in the number of >52 wk waiters.

Large scale cancellations of elective activity throughout the year has resulted in admitted electives & daycases reducing by 45% compared to normal levels YTD, New Outpatient activity has reduced by around 28% & follow up activity by around 10% YTD compared to normal activity levels.

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

Actions:

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

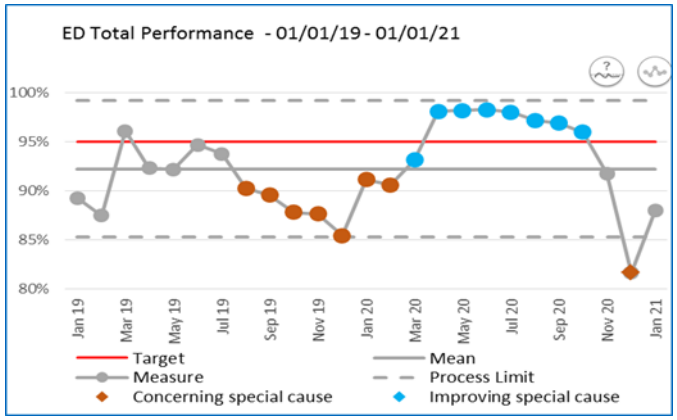
To decrease long waiting patients

Assurance:

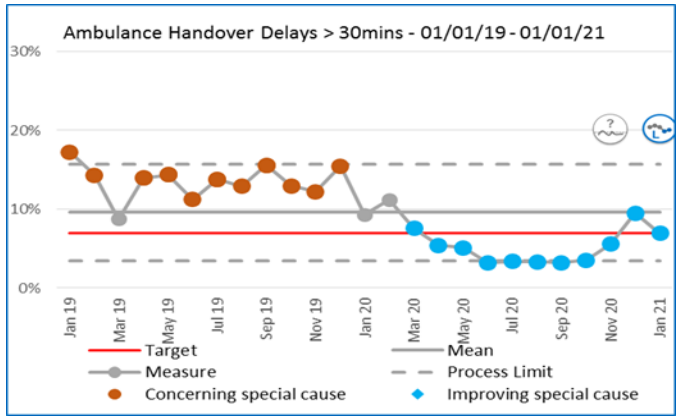
P1 and P2 activity continues. Plans are being developed to increase elective activity in a phased approach from the 1st March both internally and utilising the Independent Sectors. This will incorporate P3 activity.

Long waiting patients continue to be clinically prioritised and will be factored into the developing plans for increasing elective activity in line with critical care de-escalation and Covid community prevalence.

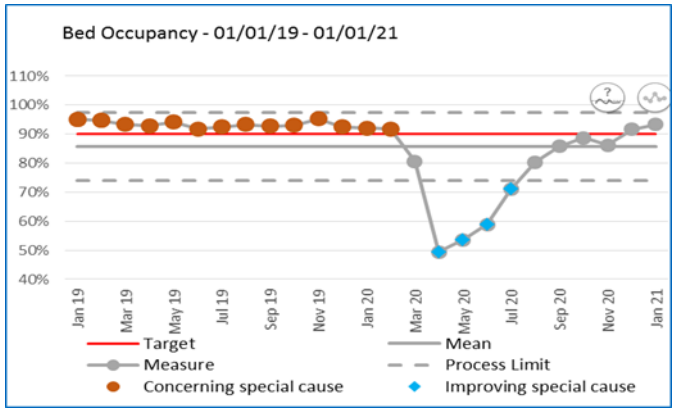
Responsive - Reset and Recovery Programme: Emergency Care



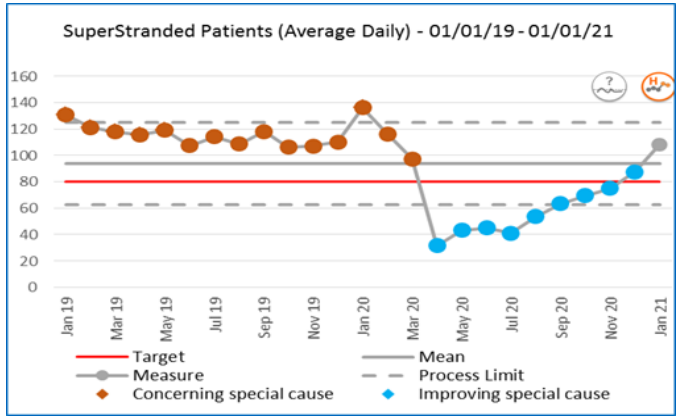
Jan-21
88%
Variance Type
Metric is currently experiencing common cause variation
Target
95%
Target Achievement
Metric is experiencing variable achievement



Jan-21
6.9%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
7.0%
Target Achievement
Metric is experiencing variable achievement



Jan-21
93.3%
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



Jan-21
108
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
80
Target Achievement
Metric is experiencing variable achievement

Summary:

- ED 4hr performance (inc MIU): Following the downward trend seen over the last few months this is now back to experiencing common cause variation at 88% in January. Arrivals (Type 1) were 30.2% below model in January.
- Ambulance delays had settled into 3.0-3.5%, but had been increasing since October due to diverts for mutual aid and Covid (improvement in January).
- Total bed occupancy dropped to under 50% during the first wave of covid but has been steadily increasing to 93.3% in January.
- Superstranded patients came down to less than half it's previous levels, but has been steadily increasing.

Actions:

Interviews 12/2/21 for Flow Coordinator Maidstone to support flow, plus Flow handbook with processes and contact numbers.

Working with CCG/ Finance to embed 111, support OOH referrals and Sevenoaks Urgent Treatment Centre (UTC) to reduce attendances,

Power BI report in development to give daily info on key KPI's. Review of new ED clinical standards.

Increased scrutiny into over 30 min ambulance handovers to support business case for substantive ED consultants to support RAP agreed by Exec/ Finance Committee. Currently out to advert.

Assurance:

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

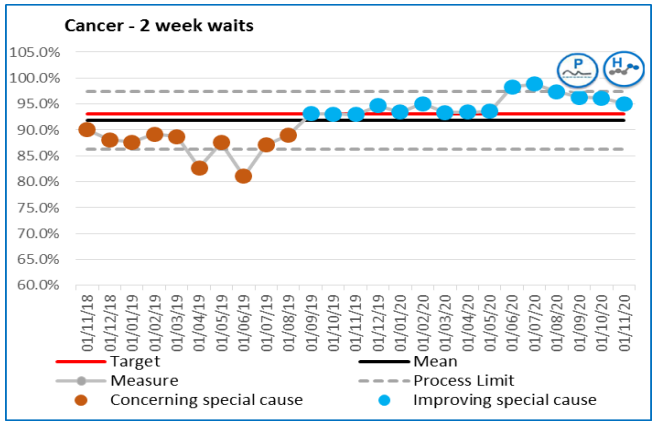
What's App groups in place to promote improved communications with larger team, giving daily performance updates.

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

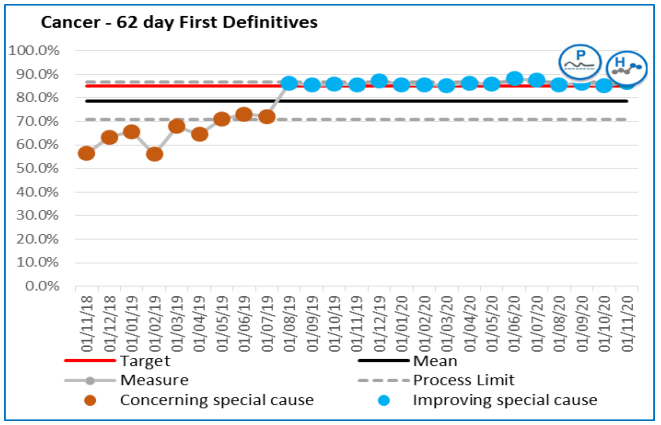
Good working relationship with SECAmb.

Visit from Chief Accountable Officer WKCCG

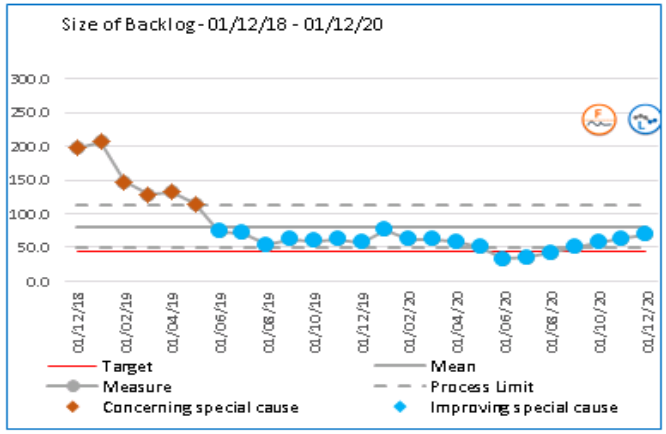
RESPONSIVE- Reset and Recovery Programme: Cancer



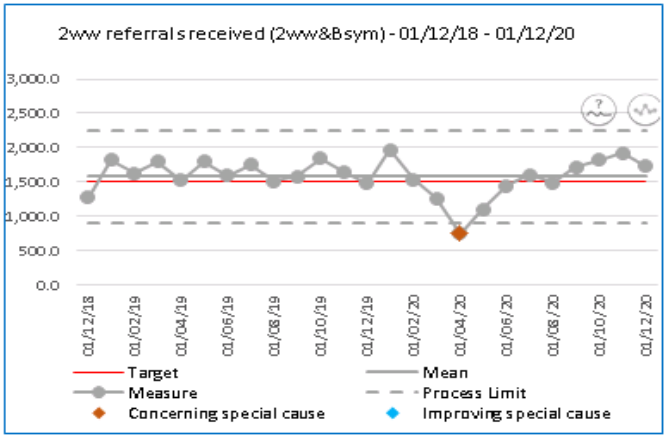
Nov-20
95.0%
Variance Type
Metric is showing Special Cause Variation of an improving nature
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



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



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



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

Summary:

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

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

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

Actions:

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

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

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

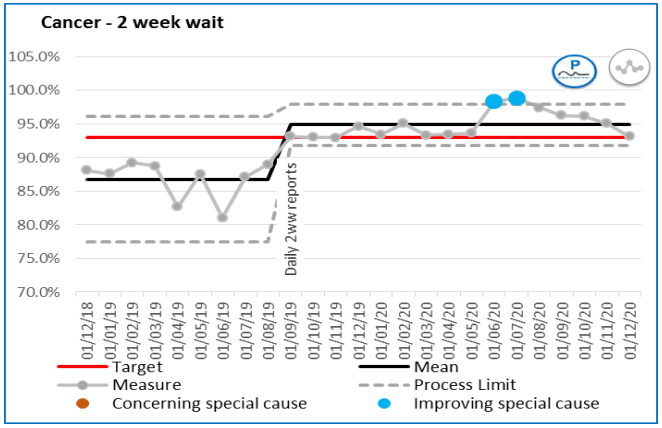
Assurance:

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

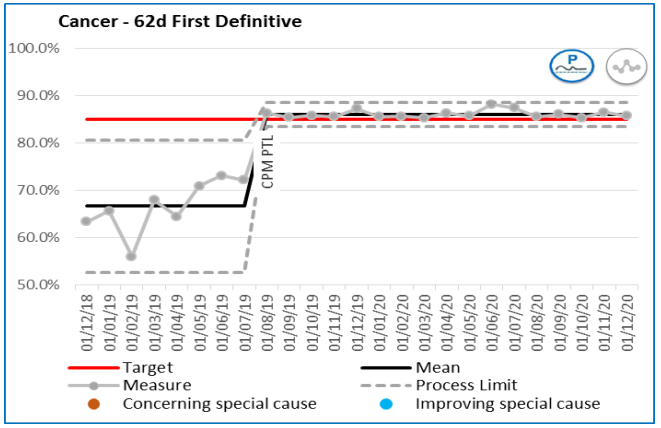
The weekly performance meetings continue to oversee the cancer performance and include funding initiatives and quality assurance i.e. 104 day clinical harm reviews.

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

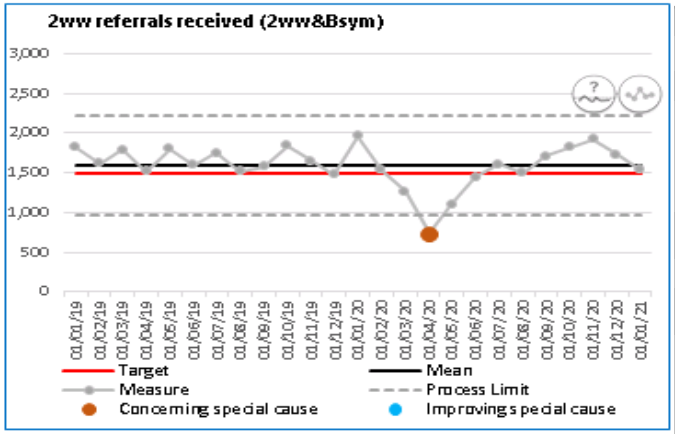
RESPONSIVE- Reset and Recovery Programme: Cancer



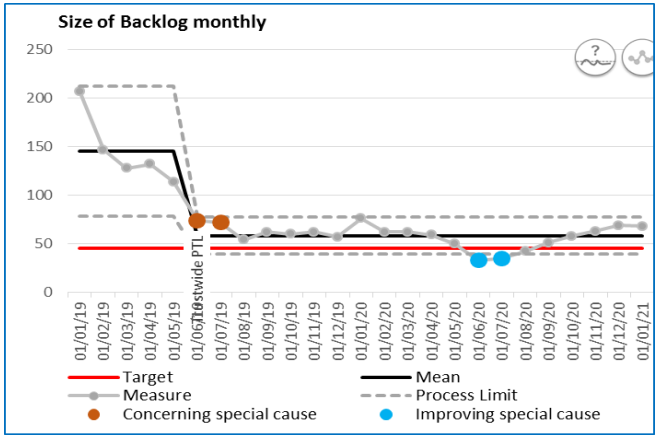
Dec-20
93.1%
Variance Type
Process change Sept 2019 now experiencing common cause variation
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Dec-20
85.8%
Variance Type
Process change Aug 2019 now experiencing common cause variation
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Jan-21
1535
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target
1500
Target Achievement
Metric is experiencing variable achievement of locally set target



Jan-21
68
Variance Type
After improvement in process from June 2019 – metric is experiencing common cause variation
Max Target (Internal)
45
Target Achievement
Metric is experiencing variable achievement of locally set target

Summary:	Actions:	Assurance:
From mid-2019, step changes have been applied after Trust-wide PTL management and engagement of Directorate GMs in Trust PTL & Performance meetings. Prior to this, the 62d standard had a mean of 66.7% up to August 2019 (below the standard required) and is now reporting a mean of 86.1% which is consistently above the target of 85%. Likewise, the 2ww standard had a previous mean of 86.7% but from Sept 2019 this has increased to 94.8% which remains above the 93% target. The 2ww standard reported higher than average in June and July (98.3% & 98.8%) which is likely due to the decreased referrals received from April to Sept 2020	Ongoing work is needed to engage all services further and to ensure that both the 28day FDS and the 62d performance targets can be met. Recruitment of additional roles designed to support the continuation of renewed pathways during Covid is underway. This includes: STT nurses, pathway navigators and oncology flow coordinators. Cancer Covid pathways have been reviewed to ensure the implementation of national guidance and the continuation of effective and efficient cancer diagnostics and treatments	The ongoing daily huddles with each tumour site team are in place and monitoring the growth in the PTL as referral numbers fluctuate. Management of the daily PTLs continues to give oversight and hold services to account for patient next steps. Diagnostic services attend these huddles to escalate booking or reporting delays on the day. The weekly performance meetings continue to oversee the cancer performance and include funding initiatives and quality assurance i.e. 104 day clinical harm reviews. 28 day FDS meetings will be reinstated in preparation for national monitoring of this target – likely from April 2021 Paper to executive team to highlight any changes and key information across each of the cancer pathways.

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	909	Jan-21	No SPC	Improving Quarterly	688	Sep-20	Improving Quarterly	688	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		69.0%	Jan-21	No SPC		67.0%	Sep-20		67.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		71.0%	Jan-21	No SPC		68.0%	Sep-20		68.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		69.0%	Jan-21	No SPC		69.0%	Sep-20		69.0%	No SPC
Health and Wellbeing: How many calls received	40	14	Jan-21		40	22	Dec-20	40	459	?
Health and Wellbeing: What percentage of Calls related to Mental Health Issues	44%	57%	Jan-21		44%	32%	Dec-20	44%	51%	?

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness	3.3%	7.3%	Jan-21	H	3.3%	4.4%	Dec-20	3.3%	4.4%	?
Turnover	10.0%	11.3%	Jan-21		10.0%	11.4%	Dec-20	10.0%	11.9%	F
Vacancy Rates	9.0%	6.2%	Jan-21	L	9.0%	7.0%	Dec-20	9.0%	6.2%	?
Use of Agency	0	224	Jan-21		0	246	Dec-20	0	224	F
Appraisal Completeness	95.0%	90.6%	Jan-21		95.0%	90.4%	Dec-20	95.0%	89.9%	?
Stat and Mandatory Training	85.0%	89.8%	Jan-21	H	85.0%	90.1%	Dec-20	85.0%	89.9%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty	- 677	- 677	Jan-21	No SPC	- 677	665	Dec-20	1,808	1,808	No SPC
CIP Savings	Suspended		Jan-21	No SPC	Suspended		Dec-20	Suspended		No SPC
Cash Balance	43,816	70,170	Jan-21	H	43,816	74,655	Dec-20	43,816	70,170	?
Capital Expenditure	736	3,282	Jan-21		736	1,686	Dec-20	14,405	12,531	?
Agency Spend	1,748,863	1,598,757	Jan-21		1,748,863	1,646,371	Dec-20	11,552,855	14,538,317	F
Use of Financial Resources	2	No data	Jan-21	No SPC	2	No data	Dec-20	No data		No SPC

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Nursing vacancies	13.5%	10.1%	Jan-21	L	13.5%	10.7%	Dec-20	13.5%	0.0%	?
Covid Positive - number of patients	0	598	Jan-21	H	0	734	Dec-20	0	2004	?

Well Led - CQC Domain Scorecard

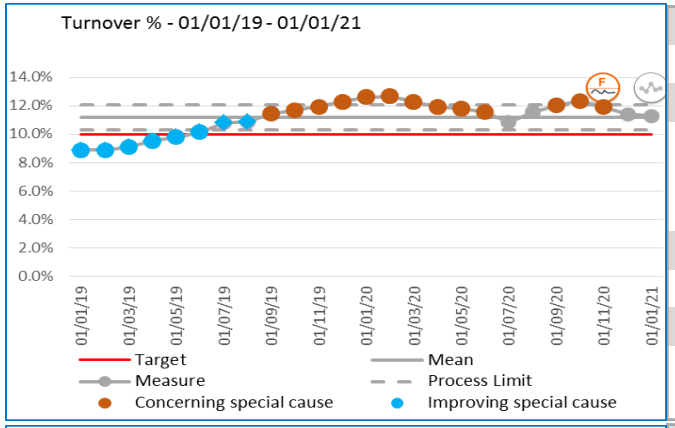
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Jan-21	L	35	30	Dec-20	35	300	?
Elective Spells in London Trusts from West Kent	329	290	Oct-20	L	329	202	Sep-20	329	2,960	?
Service contribution by division	Coming February 21		Jan-21	No SPC	Coming February 21		Dec-20	Coming February 21		No SPC
Research grants (£)	114	163	Jan-21		114	79	Dec-20	114	1,028	?
Number of advanced practitioners	25	31	Jan-21	H	25	31	Dec-20	25	31	?
Percentage of Trust policies within review date	90.0%	82.8%	Jan-21	H	90.0%	78.4%	Dec-20	90.0%	82.8%	F

Organisational Objectives – Exceptional People

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	70.0%	72.2%	Jan-21	L	70.0%	72.2%	Dec-20	70.0%	72.2%	P
Staff Friends and Family % recommended care	80.0%	77.8%	Jan-21	H	80.0%	77.8%	Dec-20	80.0%	77.8%	F
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming April 21		Jan-21	No SPC	Coming April 21		Dec-20	Coming April 21		No SPC

WELL LED- Operational Objective: Workforce



January-21

11.3%

Variance Type

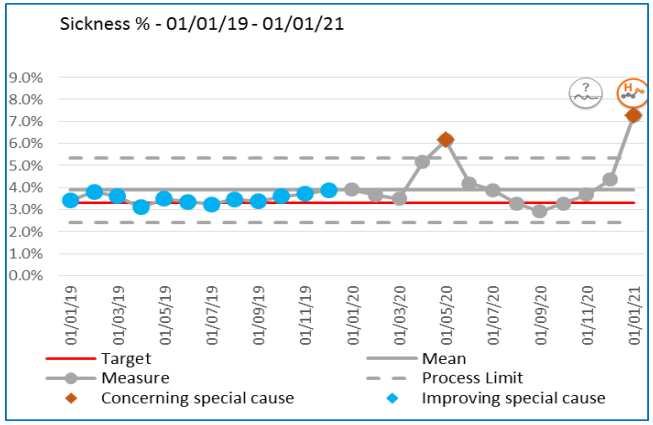
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

10%

Target Achievement

Metric is consistently failing the target



January-21

7.3%
(One Month Behind)

Variance Type

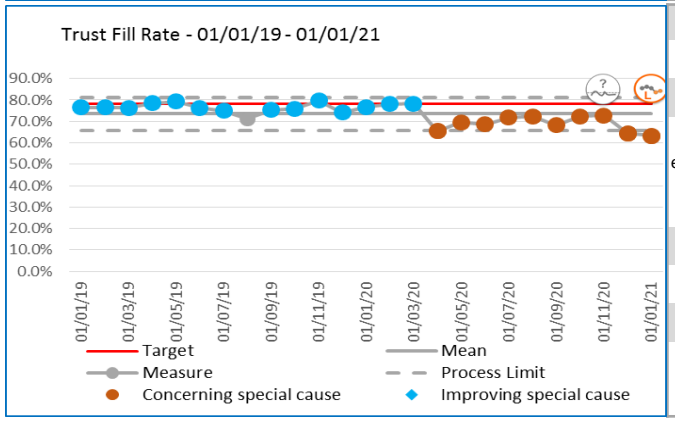
Metric is currently experiencing Special Cause Variation of a concerning nature

Max Target (Internal)

3.3%

Target Achievement

Metric is experiencing variable achievement



January-21

63.2%

Variance Type

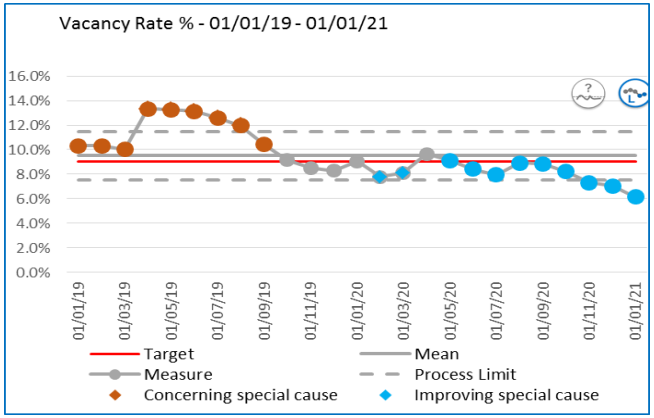
Metric is currently experiencing Special Cause Variation of a concerning nature

Target (Internal)

78%

Target Achievement

Metric is experiencing variable achievement



January-21

6.2%

Variance Type

Metric is currently experiencing Special Cause Variation of an improving nature

Max Limit (Internal)

9.0%

Target Achievement

Metric is experiencing variable achievement

Summary:

The Turnover rate for the last 12 months is now experiencing common cause variation but is consistently failing the target.
The level of Sickness increased significantly in December (data reported one month behind) to 7.3% (of which 3.2% was COVID related sickness) . This indicator is therefore now experiencing special cause variation of a concerning nature.
The level of Agency staff used has again shown a marginal decrease which is understandable given Covid-19 second wave impacts.
The Trust fill Rate remains below the target level of 78% and is experiencing special cause variation of a concerning nature. This has been affected by the lower Nursing Staff Fill Rate . The staffing levels have been significantly impacted due to COVID related absence alongside the requirement to increase capacity, staff escalation areas and deliver care in line with new pathways. There continues to be some anomalies in the data that reflect operational decisions to open and close clinical areas in response to the COVID Pandemic which has distorted the planned vs actual ratio in addition to roster management of staff redeployment.

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

Actions:

Sickness: Inevitably, the Pandemic and winter pressures have impacted. We have been actively monitoring and modelling the impact on staff staffing. We have recently seen sickness level start to fall, quicker than expected and with our high level of vaccination, it is hoped this will continue. The Workforce (People) Function has 4 areas of focus: Temporary Staffing (Staff Hub), Recruitment, Vaccinations and Staff Welfare. We have continued to refine our survey approach to build on the success of the Climate survey and are currently undertaking the next survey. We continue to progress the use of Climate survey data to drive local interventions to aid retention and implementation plans. Turnover can be impacted by quality of managers and leaders and we are working with HRBPs to help managers with this.
In January we continued to see a significant increase in Nursing demand on temporary staffing with 7,746 shifts requested. Bank fill is at its highest level in over 3 years with 4,315 shifts filled but with a reduction of agency supply and the pandemic affecting Agency and Bank staff availability has meant that the overall fill rate fell. Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff. The Covid-19 second wave is impacting as staff may already be working extra shifts and because of Covid-19 illness or self isolation requirements or school closures.

Assurance:

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

The recruitment team are undertaking various initiatives at present to support vacancies: This includes International nurse recruitment. Open events. Contacting any student nurses that have been on placement with MTW over the last three years to encourage them to join our Staff Bank. Contacted all retired nurses (within 2 years) from MTW to invite them back to support the trust during wave 2. Liaising with "hot spot" areas to create a recruitment plan to reduce the vacancy rates. Working closely with the Cancer Directorate to launch the MTW Graduate Scheme (Interviews / assessment days taking place this week) If proven successful this would be encouraged to be rolled out to other departments.

The Trust has developed a Staffing Hub and the bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend. Due to the impact of Covid-19, we are continuing to pay enhanced rates for Bank staff to mitigate staff shortages, encouraging staff to pick up bank shifts and reduce wider agency spend up until 28/02/2021 with a review of future incentives taking place.

Appendices

Supporting Narrative

Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, reporting 85.8% and 93.1% respectively. Following the downward trend seen over the last few months A&E 4hr performance is now back to experiencing common cause variation at 88% in January (highest performance nationally for Acute Trusts). As expected the RTT performance continues to decrease and the RTT waiting list continues to increase due to the impact of only Cancer and clinically urgent patients being facilitated in order to increase ITU surge capacity. Of the constitutional standards the RTT and Diagnostics standards remain the most at risk due to the decrease in capacity (with the impact of social distancing and use of PPE) and the uncertainty as to the likely level of demand. In addition some of the patient safety and quality indicators continue to be adversely impacted due to the high bed occupancy (particularly for older and more complex patients) as well as the current staffing challenges (particularly nursing staff) facing the Trust due to the Pandemic.

Key Performance Items:

- **Infection Control:** Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. The Trust admitted 578 patients with Covid-19 infection during January, including 66 cases of probable or definite hospital acquired infection (11% of the total). This is a reduction from 13% in December. 6 outbreaks of Covid-19 were identified in January. New variant Covid -19 found to be endemic in Kent and Medway. Key messages on the importance of PPE, social distancing and hand hygiene continue to be raised with staff. Patients and visitors wear masks and are encouraged to undertake hand hygiene regularly.

- **Falls:** The number of Falls has increased further across both sites, particularly in the Medical and Care of the Elderly specialties. The overall rate for the Trust continues to experience special cause variation of a concerning nature with the highest level ever reported (10.19). Seven SIs relating to Falls were reported. Continued challenges around staffing impacting on the availability of staff to implement the level of monitoring required for patients at risk of falls. Themes and trends for falls in January was discussed at the Falls Group meeting. Wards are encouraged to use the Falls Safety Huddle to highlight patients on the wards who are at risk of falls and measures required to reduce risk. As staffing improves, some of the challenges in implementing preventative measures should ease.

- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers continues to experience special cause variation of a concerning nature. The increase has mainly been in Deep Tissue Injuries, particularly in the Medical and Care of the Elderly specialties (9 out of the 12 DTIs reported) and there was a higher number of pressure ulcers reported at the TWH site. Process for investigating hospital acquired pressure ulcers has been reviewed and amended. More detail has been added to be able to better identify if patients who develop pressure ulcers had any damage on admission.

- **Incidents and SIs:** The level of SIs reported decreased slightly to 19 in January. 8 of the 19 are COVID-infection and 7 were related to Falls. Due to the significant increase in the declaration of SIs (particularly in relation to COVID Outbreaks) and the current pressures there are challenges regarding the allocation of SIs to lead investigators. A review has taken place of the current COVID Outbreak SIs in line with the national guidance and severity of harm with a view to request downgrades for these from the CCG. In addition, senior members of the Patient Safety team have taken on a caseload of SIs and additional RCA and SI investigators are being called upon to ensure that investigations are completed thoroughly and in a timely manner to support our staff, patients and their families.

- **Stroke:** Performance for January decreased further to 50% which is achieving the Best Practice internal target (may increase with late data recording). This indicator is experiencing special cause variation of an improving nature and inconsistency.

- **A&E 4 hour Standard and Flow:** Following the downward trend seen over the last few months performance increased to 88% in January. The Trust continues to implement the ED improvement action plan to support flow throughout Trust which is proving ever more challenging with the high bed occupancy levels, particularly for COVID patients. A&E Attendances had been fairly steady at around 85% of normal levels but were 30% below model and back to similar levels to the 1st wave of COVID in January. Emergency admissions are 10% to 15% below expected levels. Total Bed Occupancy has been steadily increasing with January at 93.3%. Both Medical Outliers and Super-Stranded Patients are also showing an increasing trend during the 2nd wave of COVID.

- **Ambulance Handover Delays**: This had improved, holding steady at around 3.0-3.5% of all handovers delayed 30 mins or longer, however this has been increasing during the 2nd wave of COVID.

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** As expected due to the COVID-19 pandemic and the need to only facilitate Cancer and clinically urgent patients in order to increase ITU surge capacity, activity levels continue to remain low for both elective and outpatient appointments. This has adversely impacted the RTT performance for January which has decreased further to 71%. There has also been a large increase in patients waiting >52 weeks. Diagnostics waiting <6 weeks performance decreased further to 75% in January.

- **Outpatient Activity Face to Face vs Virtual:** The increased use of Virtual vs Face to Face outpatient appointments (where clinically appropriate) is part of the Trust's Reset and Recovery Programme.

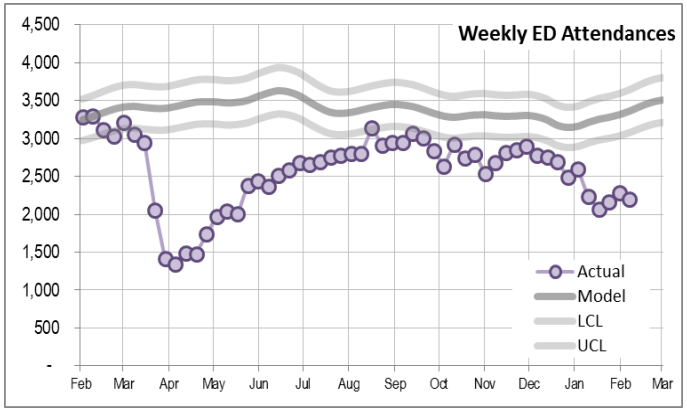
- **Cancer 62 Day:** From August 2019, when the Trust implemented robust PTL management, the 62 day standard has shown an improved performance and has consistently achieved the 85% standard. A process step change has been applied to reflect this and this shows a significant improvement, where the calculated mean up to August 2019 was 66.7% and is now 86.1% - which is consistently above the target of 85% for the 62 day standard. The updated chart now reports common cause variation as confirmation of a currently stable process. Since April 2020, the treatment numbers have been lower than the previous year, likely due to the Covid pandemic, but in December the Trust treated 131 patients which is 100% compared to the average activity recorded for 2019.
- **Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement in the achievement of the 2ww first seen standard, with consistent achievement of the target. The recent 5 months of improved performance is likely due to the lower than expected number of 2ww referrals and the Trust continuing to appoint suspected cancer patients as a priority – utilizing the virtual clinics where possible. A process step change has been applied which shows the improved performance increasing from a calculated mean of 86.7% up to September 2019 to 94.8% currently, consistently above the target of 93%.

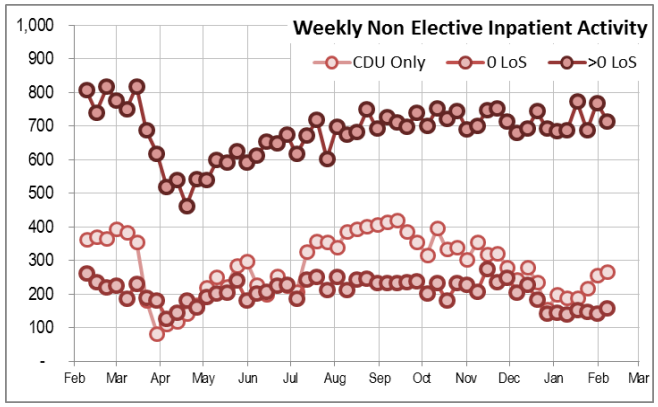
- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, incoming referral numbers have increased through the remainder of 2020, with some months reporting in excess of 114% over the same period in 2019. Overall referrals have returned to expected levels, experiencing common cause variation.

- **Finance:** The Trust has delivered the financial plan generating a £1.8m surplus. The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners, this plan includes an allocation to fund COVID related spend (£11.2m). The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are: Delays in investment associated with Stroke, ITU extension and Recovery and Reset developments (£5.3m), Pay underspends (£3.8m) mainly within Nursing (£3m) due to higher than planned vacancies, Drugs (£3m) mainly due to reduction in Oncology and Ophthalmology high cost drugs and £0.7m underspend within clinical supplies due to reduction in elective activities. These underspends are partly offset by reduction in block payment from commissioners (£1.8m - net underspend), pressures associated with IT Licences (£0.5m), rates review fees (£0.3m), RTA income recovery adjustment for 2016/17 and 2017/18 (£0.4m), EPR project costs (£0.4m), Car Parking (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m) and increase in reserves(£0.2m).

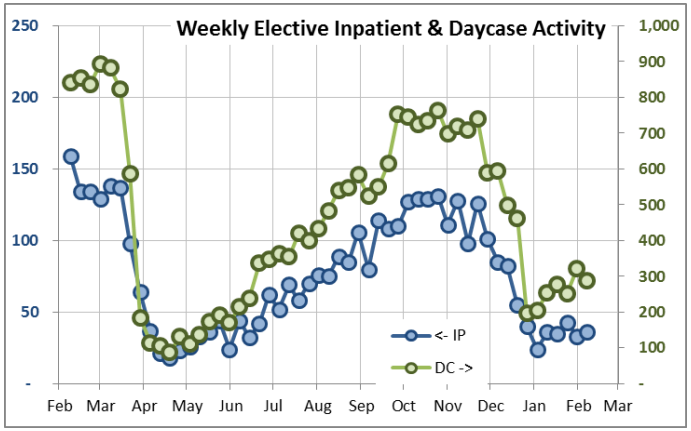
- **Workforce**: The Safe Staffing Nursing Fill Rate has increased but remains below usual levels which has impacted on the overall fill rate. Twice daily staffing huddles with divisional leads and staff bank established to review prospectively the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust. Increased multi professions representation are on the wards to help support the nursing staff. Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff. The Turnover rate has decreased further but is consistently failing the target. Climate survey data is being used to drive local interventions to aid retention. Sickness levels increased further in December (reported one month behind) to 7.3% (of which 3.2% was COVID related sickness) as our Covid patient numbers increased. Early indications are that this has improved in January. The Trust has developed a Staff Hub / Cell to respond to Covid pressures. As community transmission of Covid-19 remained very high during December and January, the ability to respond became more limited.

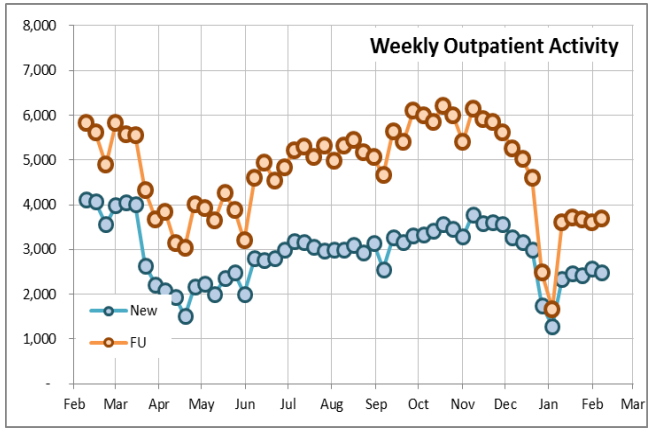
Escalation: COVID-19





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





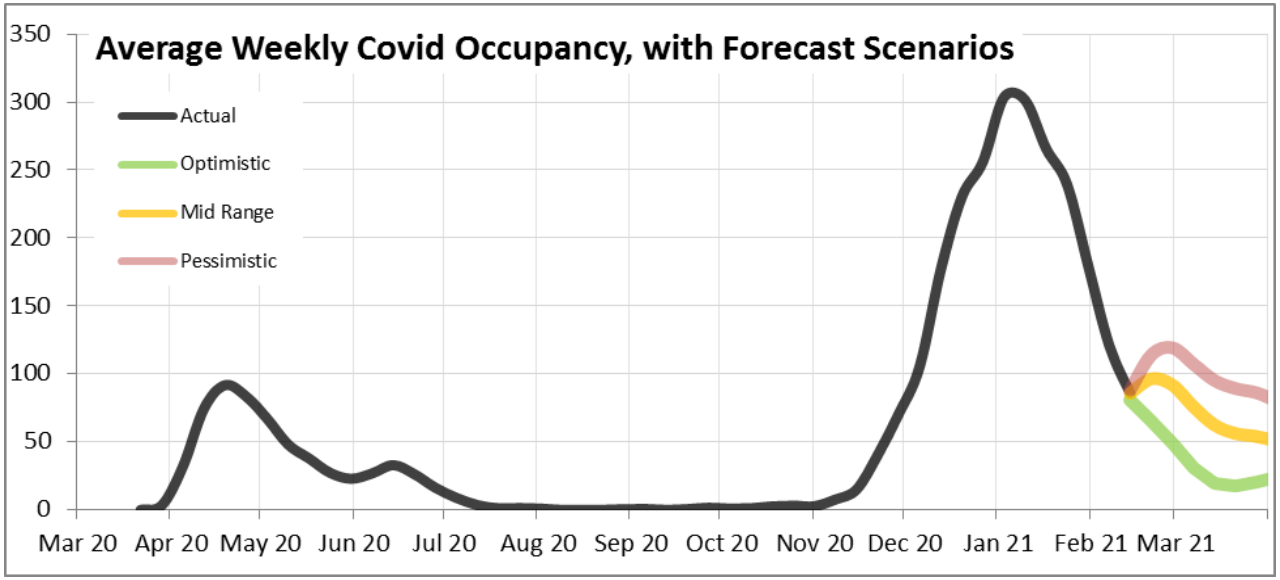
Emergency Admissions: Non-zero emergency admissions had settled in to being around 10% down on normal through the Autumn, and has held fairly constant in the second wave, SDEC activity went back to normal or slightly above, but has come back down, and is around 40& below normal. CDU Only was higher than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

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

Outpatient Activity: Similarly with elective activity, outpatients recovered to a little below normal into the Autumn, but then were reduced back down to around 60% of normal, with a significant dip over Xmas & New Year.

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

Escalation: COVID-19



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

There is now a very clear reduction in both community infection rates & admission numbers, which have allowed occupancy to come down much more than expected, coming under 200 on 27-Jan and under 100 on 07-Feb.

The forecasts have occupancy in the 30-55 range by the end of March – though these are using admission forecasts that we are currently running at 40-60% of

Note that the various long-term forecasts emerging are flagging the potential of a third wave of infections over the summer, driven by schools returning, and increasing social mixing in the younger population who will probably still have very low vaccination rates by then. This is not anticipated to be anywhere near as bad as the winter, as the older & more vulnerable populations will have a greater degree of protection, but it is likely to still be significant.

We are also running the risk that a new variant will emerge that the current vaccines afford less protection against, and that could very rapidly put us back in pre-vaccine conditions.

Forecast Models

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

The three scenarios are :

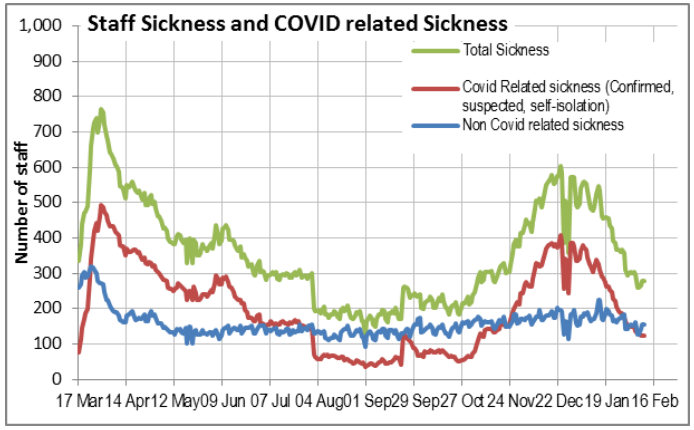
Optimistic (green) based on good compliance with lockdown until March, followed by schools reopening. Vaccination progressing as per government targets

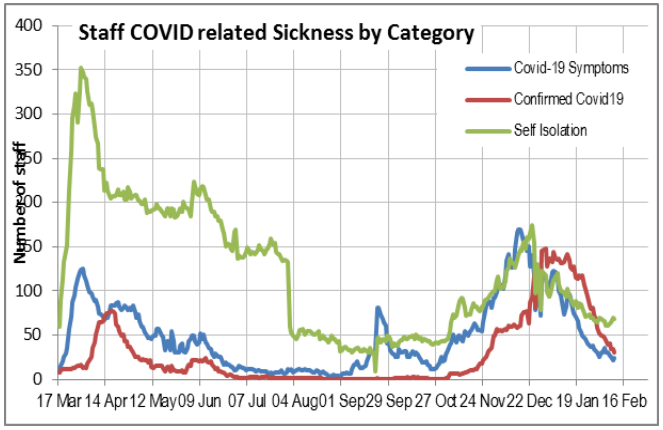
Mid-Range (amber) as optimistic, but with poorer adherence to social distancing.

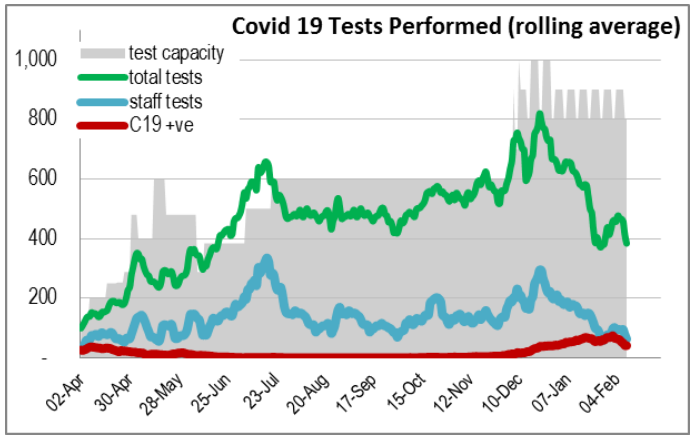
Pessimistic (red) as optimistic, but with a reduction in the overall effect of the vaccination program

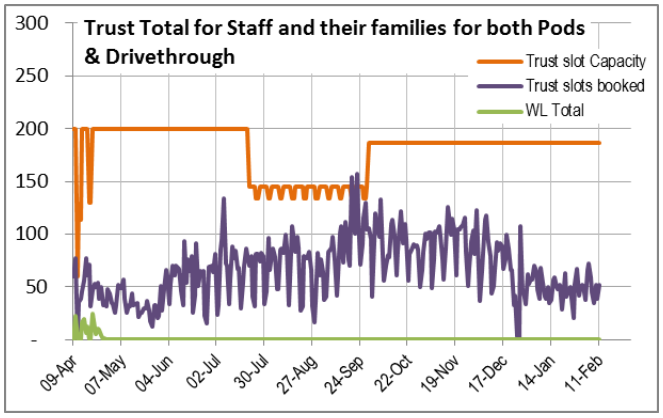
Actual admissions are currently tracking the forecast generated by the most optimistic scenario. However, the scenarios are extremely sensitive to public behaviour & the effectiveness of the vaccine, so it would not take much to change this.

Escalation: COVID-19









Staff Non-Covid related sickness peaked at just over 300 in late March, but is now back at normal levels for the time of year (average 140-170 per day).

Covid-19 Related Sickness: The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply at first, peaking at just under 500 at the end of March, went under 100 over Summer, came back to 350-400 over Xmas, but is now back down to <150. This is a combination of confirmed & unconfirmed symptomatic & self isolation

Self-Isolation: Similar to Covid related sickness, this peaked in early April (~350), fell to under 50 through the Autumn, then came up sharply, peaking at ~170 just before Xmas. It's now at around 160

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

Pathology – COVID-19 Tests Performed: Total tests have again exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just around 400-500 total tests after peaking at ~800 just before Xmas, and now under 100 a day on our staff. The percentage of tests showing positive is now falling again after peaking in late Jan.

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

Additional Metrics – in development

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

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

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

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the year to date (£1.8m surplus) and January financial plan (£0.7m deficit).
- The plan set for October to March was set at a system level with the financial risk held by the commissioner, as a result the Trust is currently assuming the net underspend to plan in the month of £1m will be given back to the commissioner.
- The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position. However from 1st October this has changed to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners. This plan includes an allocation to fund COVID related spend (£11.2m).
- In line with NHSE/I reporting guidance the values reported in this month exclude any impact associated with the Elective incentive scheme. It is currently anticipated this will be managed at a system level.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £31.6m year to date (£4.1m in January).
- The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are:
  - Pay underspends (£3.8m) mainly within Nursing (£3m) due to higher than planned vacancies
  - Delay in investments associated with Stroke, ITU extension and Recovery and Reset (£5.3m)
  - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£3m)
  - Clinical supplies underspend (£0.7m) due to reduction in elective activities.
  - RTA income recovery adjustment for 2016/17 and 2017/18 (£0.4m)
  - Car Parking lights pressure (£0.3m)
  - Reduction in block payment from commissioners (£1.8m - net underspend to plan)
  - IT Licenses (£0.5m)
  - Rates review fees (£0.3m)
  - EPR project costs pressure (£0.4m)
  - Income reductions within Diagnostics relating to independent sector activity (£0.3m)
  - Investments associated with Ive programme and Teletracking (£0.3m)
  - Increase in contingency reserves (£0.2m).
- The key current month variances are as follows:
  - Income excluding Top up income support and pass-through related costs is £1m adverse to plan. Clinical income is £1.5m adverse to plan in month. The key variance relates to payback of Top-Up funding to the CCG of £1m to support delivery of the year to date position. Other key variances relate to underspends on High Cost Drugs (£0.3m) and the Moorfields Ophthalmology service transfer (£0.3m). Other Operating Income excluding pass-through costs were on £0.4m favourable in January. This mainly relates to £0.3m over performance associated with Education income for placement support funding and £0.1m over performance associated with Injury recovery income.
  - Pay budgets adjusted for pass-through items were £0.9m favourable in January which was mainly a result of underspends against the central held budgets for Stroke, ITU Extension and Recovery and Reset developments (£1.6m). The total pay spend in January was the highest spend this financial year (£28.3m) which was an increase of £0.4m between months. The main increase in spend is associated with the increase in ITU beds requiring additional medical and nursing support. These additional beds have also been staffed by redeploying staff from theatres. In turn this has meant cancellations of elective activity which will have to be carried out in the future.
  - Non Pay budgets adjusted for pass through items overspent by £0.2m in January. Elective activity reductions in January generated underspends of £0.7m within Drugs and clinical supplies. These underspends were offset by increase in costs associated with IT Licences (£0.5m) and rates review fees (£0.3m).

- The closing cash balance at the end of January 2021 is £70.2m which is higher than the cash plan of £53.8m. The higher than normal cash balance is due to the Trust receiving February's monthly block SLA income in January from the main CCG's as per the national agreement totalling c.£39.9m. Due to the Trust receiving these advance block payments the cash flow forecast is assuming that it will not receive any block income in March 2021 therefore reducing the cash balance. In addition a further reason for the high cash balance is due to the capital expenditure being back-ended although the Trust is anticipating receiving and paying the associated invoices these are likely to happen in late March. The cash flow is also forecasting to pay March's Tax, NI, Pension and PFI Unitary Payment which would normally be paid in April. The Trust has approached NHSEI to see if there is an opportunity to carry forward a higher closing cash balance (currently £1m) to support the payment of capital invoices that will be received in April that relates to the equipment and IT products the Trust received before the end of the financial year
- Capital spend at the end of month ten is £12.5m; £2.9m relates to Covid-19 equipment, ICT and estates costs – these costs have been confirmed as approved by the NHSEI Regional team during February. The Trust therefore can release the funding it was holding to cover this risk and is now committing the schemes that it has identified as potentially manageable within this financial year which are also high priority. The additional funding released is £2.1m.
- The main other areas of expenditure year to date are £1.5m related to the ongoing EPR programme; £1.5m relating to the IVE Programme; £2.0m on the Urgent and Emergency Care projects (including the new SAU at TWH); £0.8m related to backlog and renewal Estates schemes; and £1.0m relating to general equipment scheme with another £1.7m spent on the endoscopy equipment funded from national PDC.
- A high level of capital spend remains to be made in the two months of the year; some of this is the continuation of schemes already in progress e.g.
  - EPR: £1.2m
  - Estates schemes: £1.1m
  - UEC project: £1.3m

But some significant elements have only been ordered in the last two months, including:
  - ICT spend on additional devices and network access switch costs: £2.4m
  - Linear Accelerator replacement at Canterbury: £2.1m
  - Medical equipment orders including CT SIM for Oncology: £2.1m
  - Breast screening equipment replacement, including additional national funding in month: £1.1m
- All these schemes are projected to be completed by 31st March, and are being actively managed including the schemes particularly dependent on supply chain positions. Some of the equipment and IT kit will be held in storage for the Trust with accompanying letters of ownership or vesting certificates as at the end of the financial year.
- In addition to the Trust's forecast resource of £26.7m (including donated asset forecast spend of £0.4m and PFI lifecycle of £1.0m) the STP has signalled that there is another £1.3m available to the Trust from resources unused within the Kent and Medway system. The Trust will accept this resource as it can utilise it on ICT network equipment and medical equipment.
- The Trust is forecasting to deliver the financial plan (breakeven) before the annual leave carry over accrual. The current assessment for the carry over annual leave accrual is £6.4m which is £1.4m more than the plan value (£5m).

1. Dashboard

January 2020/21

	Current Month						Year to Date						Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	45.9	46.9	(1.0)	(0.1)	(0.9)		445.0	441.5	3.4	(1.0)	4.4		538.4	535.3	3.1	
Expenditure	(44.0)	(44.8)	0.7	0.1	0.7		(417.8)	(414.0)	(3.8)	1.0	(4.8)		(514.1)	(508.9)	(5.2)	
EBITDA (Income less Expenditure)	1.8	2.1	(0.3)	(0.0)	(0.3)		27.1	27.5	(0.4)	(0.0)	(0.4)		24.3	26.3	(2.1)	
Financing Costs	(2.6)	(2.7)	0.1	0.0	0.1		(25.6)	(26.0)	0.4	0.0	0.4		(31.9)	(32.2)	0.3	
Technical Adjustments	0.1	(0.1)	0.2	0.0	0.2		0.3	0.3	(0.0)	0.0	(0.0)		1.2	0.9	0.3	
Net Surplus / Deficit (Incl Top Up funding	**(0.7)**	**(0.7)**	**0.0**	**(0.0)**	**0.0**		**1.8**	**1.8**	**0.0**	**(0.0)**	**0.0**		**(6.4)**	**(5.0)**	**(1.4)**	
Cash Balance	70.2	43.8	26.4		26.4		70.2	43.8	26.4		26.4		1.0	1.0	0.0	
Capital Expenditure (Incl Donated Assets)	3.3	0.7	(2.5)		(2.5)		12.5	14.4	14.4		14.4		26.7	18.4	(8.3)	

Summary Current Month:

- The Trust delivered the financial plan in January by achieving a £0.7m deficit. This includes the assumption that £1m will be given back to the commissioner, this is because the plan set for October to March was at a system level with the financial risk held by the commissioner. Without this adjustment the Trust would have been £0.3m surplus.
- The Trust in January has identified £4.1m of costs associated with COVID 19 this represents an increase of £0.8m between months mainly associated with enhanced bank rates to cover increase in staff sickness and escalation areas and the expansion of ITU beds. Excluding Swabbing and Vaccination centre costs (pass through costs) the level of spend incurred was £0.5m more than the funding incorporated into the plan.
- A shortfall in the available workforce has caused delays to the anticipated investments associated with Stroke, ITU extension and Recovery and Reset developments the Trust underspent by £1.9m against these projects. This underspend to plan has helped to offset the COVID spend above income (£0.5m), £0.5m IT Licences and has enabled the Trust to pass back £1m of top up funding to commissioners.
- In line with national guidance this included £0.8m additional income support associated with COVID swabbing and testing.

Year to date overview:

- The Trust has delivered the financial plan generating a £1.8m surplus. The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners, this plan includes an allocation to fund COVID related spend (£11.2m).
- The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are:

Delays in investment associated with Stroke, ITU extension and Recovery and Reset developments (£5.3m), Pay underspends (£3.8m) mainly within Nursing (£3m) due to higher than planned vacancies, Drugs (£3m) mainly due to reduction in Oncology and Ophthalmology high cost drugs and £0.7m underspend within clinical supplies due to reduction in elective activities. These underspends are partly offset by reduction in block payment from commissioners (£1.8m - net underspend), pressures associated with IT Licences (£0.5m), rates review fees (£0.3m), RTA income recovery adjustment for 2016/17 and 2017/18 (£0.4m), EPR project costs (£0.4m), Car Parking (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m) and increase in reserves(£0.2m).

Forecast:

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

Risks:

- The has the following key income assumptions included within the year to date position.
  - The Trust has £3.3m income included in the position to offset the costs of COVID swabbing which is in line with the guidance. NHSE/I are currently reviewing the cost incurred and will then notify the Trust of payment that will be made. It is understood Octobers and Novembers cost (£1.8m) will be paid during February with Decembers to be received in March.
  - In line with national guidance the financial position does not reflect any impact (positive or negative) associated with the Elective Initiative Scheme (EIS). This scheme will impact the level of income the Trust can recognise and is dependent on delivering the activity levels.

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	28,411

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	3,295
Sick pay at full pay (all staff types)	346
COVID-19 virus testing (NHS laboratories)	2,456
Remote management of patients	45
Support for stay at home models	74
Direct Provision of Isolation Pod	7
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	2,376
Segregation of patient pathways	9,507
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	1,176
Decontamination	281
Backfill for higher sickness absence	2,468
NHS 111 additional capacity	0
Remote working for non patient activites	362
National procurement areas	1,998
Other	698
COVID-19 virus testing- rt-PCR virus testing	3,275
COVID-19 - Vaccination programme'	47

Summary: Loss of income

Total (£000s):	3,222

Breakdown by income type	£s
Car parking income	1,353
Catering	218
Pathology Trade Income	120
Private Patient Income	946
Research and Development	200
Other	385

Grand Total

Total (£000s):	31,633

Commentary:
The Trust has identified the financial impact relating to COVID to be £31.6m, which includes £28.4m associated with additional expenditure and £3.2m due to lost income (mainly commercial income).

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

The Trust has £3.3m income included in the position to offset the costs of COVID swabbing which is in line with the guidance. NHSE/I are currently reviewing Octobers and Novembers cost (£1.8m) and will then notify the Trust of the funding they will receive in February with Decembers (£0.8m) to be notified in March.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality report
February 2021
Covering Quarter 3 Oct –Dec 2020/2021

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Division: Women's and Children's

Specialty: Maternity

1. Introduction

All perinatal deaths are reported to MBRRACE which is a national organisation that collates information and produces reports on learning from deaths. It is the expectation that all perinatal deaths are reviewed in a multidisciplinary forum using the Perinatal Mortality Review Tool. This tool was introduced in 2018 and from December 2018, all eligible cases are reviewed using this questionnaire.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;

- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;

- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life;
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere

2. Overview:

During this quarter there have been 6 losses that fit the PMRT criteria. All have been reviewed with the PMRT tool and there was external support with each of the meetings.

We have had three second trimester losses, one of which was a neonatal death. One family declined post-mortem, no cause of death was found and care was appropriate.

Another patient reported reduced fetal movements at 26+1 week and also declined post mortem. No cause of death was found although the placenta showed an infarct which may have been indicative of a developing preeclampsia (PET). PET is a condition that affects some pregnant women; early signs include hypertension and proteinuria. PET affects the arteries carrying blood to the placenta. In this case the mother was not referred at booking for consultant led care (due to PET in a previous pregnancy).However this omission was not considered to have had any bearing on the outcome as the patient's blood pressure and urine up to and after the diagnosis of stillbirth was normal. The woman was assessed correctly as requiring aspirin at booking as per local and national guidance, this was prescribed. If a Consultant appointment had requested a plan for care for monitoring of blood pressure and urine and serial scans would have been made. The woman was referred for serial scans by the midwife.

The third case was of a mother who sadly had a neonatal death at 24+1. She presented in established labour, rapidly progressing to full dilation and delivery within an hour and a half of arrival on the delivery suite. She had an asymptomatic urine infection and the post mortem confirmed acute chorionamnionitis and Group B Strep on the maternal and baby swabs. These infections would be the likely trigger for premature labour. At no time prior to the attendance in labour had a urine infection been diagnosed. Cause of death was extreme prematurity.

Of note, 2 out of 3 mothers were Covid-19 positive. Regional data is being collated to share with a study reviewing the effect of Covid-19 on pregnancy and outcomes.

There were 3 late third trimester losses.

There was one intrauterine death at 34+5w, which was attributed to a sudden uterine rupture. This was an unforeseeable complication and it was agreed that imaging prior to the event would not have predicted this acute event. The emergency situation was well managed and there were no learning points arising from this case after PMRT and local multidisciplinary review.

One stillbirth at 35+1w was diagnosed on attendance to Triage following an attendance for reduced fetal movements. At 32w she had a scan because she was measuring large for dates and excessive fluid around the baby was seen (polyhydramnios) she had the appropriate investigations and management and the plan was for a repeat scan. Sadly the baby demised prior to this appointment. She had diabetic screening at 28w in view of family history of diabetes. The result was within normal range. Of note, the mother was a smoker and had been referred to the stop smoking service and was appropriately supported. Post mortem was declined and unfortunately the placenta was unable to be sent to GOSH due to an error with the transport medium.

The final case was a neonatal death at 41+6w where the mother presented in latent phase, was admitted and had a rapid labour. She was following a low risk pathway and was being monitored intermittently with a hand held sonic aid device. She requested an epidural and a CTG was commenced which showed a suspicious fetal heart trace requiring escalation to the obstetric team. She was confirmed as being fully dilated and a decision was made for an instrumental delivery. This was unsuccessful due to a lack of pain relief as the epidural was not fully effective. Baby was delivered by caesarean section under general anaesthetic after a bradycardia was present on transfer to theatre. Baby was resuscitated at delivery and transferred to Medway for cooling but sadly died on day 3 of life. This case was referred to the Coroner and a PM is awaited. No maternity care issues were identified in this case however during the review of the resuscitation it was agreed that although it was carried out in line with NLS guidance, there was a delay in securing vascular access therefore adrenaline doses were delayed. Due to the unexpected nature of the fetal collapse it has been declared as a Serious Incident.

In summary the learning points from these 6 cases were:

1. All pregnant persons with a history of PET should be referred at booked to a consultant.

2. Placentas should not be placed in formalin until a decision regarding post-mortem has been decided.

3. Intra-ossous access should be achieved as soon as possible where there has been 2 failed attempts at UVC (umbilical vein catheter). However there is no NLS guidance on this issue. The neonatal Consultant lead for risk has shared the learning with staff.

A review of all 2020 PMRT cases will be undertaken as part of the 2020 Maternity Deep Dive.
The LMS teams are working together to share expert opinion at PMRT reviews. A pool of Neonatal and Obstetric Consultants has been developed to ensure expert external opinion is available at all PMRT reviews.
There are planned multidisciplinary neonatal and midwifery skills drills to commence as soon as possible which will improve communication and effective team working during resuscitation.

Date	Case type	SI declared	PMRT COMPLETED
15/01/20	25+6 Stillbirth	No	PMRT complete
07/02/20	35 Stillbirth	No	PMRT complete
25/02/20	29+3 Stillbirth	No	PMRT complete
26/02/20	41+5 Stillbirth	No	PMRT complete
10/03/20	40 Stillbirth	No	PMRT complete
27/03/20	Term stillbirth. Exact gestation unknown	No	PMRT not required according to MBBRACE as concealed pregnancy, delivery at home with no antenatal care. Learning required from outside agencies, CCG monitoring this learning.
17/08/20	IUD 33+5	No	PMRT report complete
25/08/20	23+6w NND @13 days old at Medway	No	Medway to complete review. Awaiting update from Medway
11/9/20	IUD 32+6 Fetal abnormality, incompatible with life	No	PMRT report complete
13/10/20	IUD 34+5 Sudden Uterine Rupture	No	PMRT report complete
19/10/20	22+4	No	PMRT report complete
20/11/20	NND @ 41+6	Yes	PMRT hosted by Medway. Contribution from MTW. Report in progress
19/12/20	IUD 26+1 Covid positive	No	PMRT meeting held in February. Report in progress
26/12/20	IUD 35+1	No	PMRT meeting held in February. Report in progress
26/12/20	NND 24+1 infection	No	PMRT meeting held in February. Report in progress

4. Learning from cases

Learning from cases	Action	Action required/Completed	Completed
Adequate documentation of review of ultrasound scans.	If ultrasound scans are carried out for women thought to have underlying risk factors then there needs to be clear documented evidence that there has been reviewed and any appropriate action taken. Community midwives are to ensure that there is documented evidence that scan results have been reviewed either by themselves if normal or appropriate obstetric referral if necessary.	1. Rachel Thomas to email the community team leads and the Antenatal clinic team lead to ensure that midwives know that this is the expectation By 31st March 2. Invigorated training for Gap and Grow needs to be undertaken. This will be led by the new in post Fetal Wellbeing midwives that are due to start in April. Till then there is a focus on the online training compliance and feedback to individuals where issues have been identified. <u>Update 15/6/20</u> Fetal Wellbeing Team in place and have commenced virtual and limited numbers in house for Gap and Grow training. An infographic will be sent out shortly as an aid to Midwives in plotting SFH as an interim measure until compliance is up to standard.	<u>Completed</u> 20/3/2020 <u>Update February 2021</u> Compliance now increases to 65% of all staff <u>Completed</u> Emailed to all midwives
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review	1. Nathan Sims/Sarah Mander-McGregor/ Alison Mendes to formulate pathway should there be lack of antenatal clinic appointments Update 15/6/20 This action was on hold due to Covid 19 but is now being addressed. AM has left the organisation and so SMM will lead. This is due to be completed by 15th July 2020 Update 19/11/2020 SMM currently unavailable and will check this has been completed with Matron for ANC/Community	E mail sent to community staff. No further incidents identified since.

The mother should have had an interpreter at every visit and especially at booking. However it was not clear on the referral what language was spoken by the mother and so the midwife would not have known to book one. It is unclear whether the mother understood the information about smoking cessation as she declined intervention.it is documented that she was waiting for a prescription for aspirin at 20w which suggests that she had not fully understood that process for obtaining aspirin and the importance of taking it from 12 weeks. Every effort should be made by the maternity service to ensure that an interpreter is present or that language line	Matrons to be aware of the case and cascade to teams the importance of booking a face to face interpreter. It is difficult when no language is specified on the booking however the appointment should be rebooked with an interpreter is necessary	Email to ensure awareness that interpreters are necessary at every visit Community midwives leads to do an audit to assess whether partners are being used as interpreters. This will be fed back through the Maternity Forum in September	Completed 11/2/2020 November 2020: Action: RT to chase audit Audit unable to be completed as partners unable to accompany women. Telephone interpreters are being used at present if required.
The mother had investigations on the antenatal ward and was discharged before the results were available. There is no pathway for ensuring the results are communicated to the woman until the next contact with a health professional who would be relied upon to look up them up.	The Antenatal ward should formulate a robust system for following up test results and communicating them to the women	Majority of women will have their results before they are discharged. There is a results book now on Antenatal ward which is the responsibility of the Band 7 to check each day to see if any results are communicated. As a failsafe, women are also told to call Triage if they do not hear about their results	Completed 20/3/2020 Louise Jarvis, Deputy Antenatal Ward Manager
Symphysis Fundal Height not correctly plotted on Gap and Grow chart	Invigorate training for Gap and Grow. New Fetal Wellbeing Midwives to start in April who will undertake the training. Random audits to be	Fetal Wellbeing midwife will include SFH training in their remit. In the meantime, midwives are reminded to use the correct methods by their team leads. Update 15/6/20. Delay in commencement of new Fetal Wellbeing team due to Covid 19 and recruitment	Completed Training package has now been launched. Completed 20/3/2020 Email sent to team leads

	undertaken by community leads	issue. The new Gap and Grow training package adapted for Covid 19 has now been launched as a virtual and in house learning. Fetal Wellbeing Team will produce an infographic tool to advise on correct plotting of SFH. This will be in addition to the training package and will support Midwives until all staff are compliant.	Completed and circulated to all midwives
Inadequate assessment on Triage when presenting with abdominal pain at 25+4w	Feedback to individual doctor	Maggie Matthews Consultant Obstetrician	November Update: MM has now retired and DM will ensure that this feedback has occurred and will confirm with evidence Awaiting evidence from DM. Feb 2021. Reminder and notes resent for reflection by Registrar
Understanding the correct route of administration of Mifepristone on initial dose. Error made by staff member, administered vaginally instead of orally	Internal review completed Action plan made. Duty of Candour to patient.	Staff member responsible to write reflective practice and discuss with educational supervisor. Fetal loss guideline to be adjusted to reflect that mifepristone must be given orally. Feedback to pharmacy lead to ensure that correct route of administration is documented on drug chart prior to dispensing.	Completed Reflective work completed by staff member Completed 5/3/20 Guideline adjusted to emphasise route of administration. Completed These learning actions were completed prior to PMRT meeting as the case was reviewed through an internal risk review and learning identified and actioned.
Incorrect plotting of Gap and Grow Chart	Feedback to Midwife Gap and Grow training has been reinvigorated during Training		Completed Action complete and midwife to do further e-training

5. Summary

A perinatal mortality review of cases from 2020 will be undertaken as part of the PMRT deep dive review. There is a national ambition to half the rate of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025.

All families continued to have the opportunity to ask questions about their care and these are added to the terms of reference. This was a recommendation from the recent Ockenden Report. MTW have strengthened the pool of external clinicians available to take part in PMRT by formalising a group of obstetricians, midwives and neonatologists in the local area that are willing to contribute to meetings.

The terms of reference for the PMRT meetings have been refreshed in view of the Okendon Report recommendations.
We have been able to continue robust PMRT reviews regardless of the restrictions due to Covid. These have been carried out remotely.

5 of the 6 cases reviewed in this quarter had no care issues that would have affected the outcome. In the 3 cases where there were learning points, direct feedback has been given to the staff involved. In the case of the NND which is a Serious Incident, the delay of adrenaline may have been a contributory factor. All neonatal staff involved in this case have been asked to complete on line training with regards to intra-ossous access. The Neonatal Clinical Educator has cascaded information to nursing staff. Medical staff have IO training as part of mandatory training

Jan-21		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	75.8%	80.9%	-	100.0%	73.5%	88.5%	-	-	30.3%	44.3%	411	27.24	180	6.3	0.0%	0.0%	16	1	321,623	239,093	82,530
MAIDSTONE	Cornwallis (M) - NS959	99.3%	90.3%	-	100.0%	90.0%	160.2%	-	-	27.4%	9.1%	61	4.18	27	6.5	0.0%	0.0%	5	1	79,076	92,179	(13,103)
MAIDSTONE	Culpepper Ward (M) - NS551	110.2%	90.7%	-	-	121.5%	116.1%	-	-	35.6%	40.4%	162	11.75	101	6.2	0.0%	0.0%	5	0	109,802	103,931	5,871
MAIDSTONE	John Day Respiratory Ward (M) - NT151	102.4%	94.5%	-	-	93.7%	100.0%	-	-	39.8%	24.7%	155	10.43	44	5.9	2.0%	100.0%	3	1	146,351	159,155	(12,804)
MAIDSTONE	Intensive Care (M) - NA251	147.8%	132.5%	-	-	127.9%	170.4%	-	-	24.3%	1.3%	245	15.73	103	26.5	0.0%	0.0%	0	0	226,265	222,099	4,166
MAIDSTONE	Pye Oliver (Medical) - NK259	66.6%	75.8%	-	-	79.6%	98.9%	-	-	23.2%	38.5%	154	9.61	74	5.0	0.0%	0.0%	13	1	120,984	106,052	14,932
MAIDSTONE	Whatman Ward - NK959	76.5%	61.4%	-	100.0%	102.4%	154.8%	-	-	32.5%	28.7%	163	11.65	75	7.2	0.0%	0.0%	4	0	0	0	0
MAIDSTONE	Lord North Ward (M) - NF651	82.3%	55.9%	-	100.0%	76.3%	64.5%	-	-	2.5%	0.0%	5	0.38	2	8.9	0.0%	0.0%	2	0	109,421	110,203	(782)
MAIDSTONE	Mercer Ward (M) - NJ251	101.4%	59.6%	-	-	100.0%	112.9%	-	-	23.6%	43.0%	101	7.03	32	5.7	0.0%	0.0%	3	0	101,697	94,983	6,714
MAIDSTONE	Edith Cavell - NE751	83.1%	77.5%	-	-	67.4%	74.2%	-	-	32.2%	47.7%	139	10.14	75	5.6	5.4%	100.0%	2	1	120,121	105,105	15,016
MAIDSTONE	Acute Medical Unit (M) - NG551	79.9%	71.4%	-	-	116.1%	174.6%	-	-	31.0%	23.3%	150	10.34	71	8.3	0.0%	0.0%	9	0	44,037	72,445	(28,408)
TWH	Ward 22 (TW) - NG332	68.3%	92.6%	-	100.0%	72.9%	79.5%	-	-	26.1%	8.6%	152	11.12	93	4.8	0.0%	0.0%	13	0	153,409	143,730	9,679
TWH	Coronary Care Unit (TW) - NP301	95.7%	83.2%	-	-	72.2%	-	-	-	21.5%	9.3%	103	6.16	52	12.2	30.3%	100.0%	0	0	142,269	129,245	13,024
TWH	Ward 33 (Gynae) (TW) - ND302	103.5%	85.1%	-	-	75.7%	96.8%	-	-	28.5%	6.6%	73	4.82	31	4.2	1.0%	100.0%	1	0	74,317	59,035	15,282
TWH	Intensive Care (TW) - NA201	153.0%	88.2%	-	-	148.5%	83.6%	-	-	35.6%	0.0%	247	16.17	12	21.5	0.0%	0.0%	1	0	111,169	109,033	2,136
TWH	Acute Medical Unit (TW) - NA901	81.4%	67.6%	-	100.0%	82.7%	96.7%	-	-	20.1%	9.0%	174	12.61	97	7.9	25.8%	96.7%	9	1	371,002	369,917	1,085
TWH	Surgical Assessment Unit (TW) - NE701	87.1%	105.9%	-	-	61.6%	58.7%	-	-	8.8%	0.0%	26	1.91	17	59.5	0.0%	0.0%	0	0	201,232	189,087	12,145
TWH	Ward 32 (TW) - NG130	82.0%	81.6%	-	100.0%	62.1%	63.2%	-	100.0%	12.2%	5.0%	66	4.53	33	7.1	0.0%	0.0%	4	1	68,191	70,815	(2,624)
TWH	Ward 10 (TW) - NG131	80.6%	88.7%	-	100.0%	79.3%	95.2%	-	-	25.0%	0.0%	146	10.13	92	5.2	0.0%	0.0%	7	1	131,644	114,871	16,773
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	43.6%	46.0%	-	-	76.5%	80.6%	-	-	48.5%	27.3%	292	19.97	180	4.0	0.0%	0.0%	8	1	124,141	154,013	(29,872)
TWH	Ward 12 (TW) - NG132	80.8%	93.9%	-	100.0%	87.1%	86.0%	-	-	24.2%	14.1%	146	8.98	77	5.5	13.8%	100.0%	23	0	7,056	106,248	(99,192)
TWH	Ward 20 (TW) - NG230	72.9%	101.8%	-	-	60.9%	98.3%	-	-	22.5%	3.8%	171	12.43	120	4.8	31.9%	100.0%	10	0	128,675	139,642	(10,967)
MAIDSTONE	Foster Clarke Ward - NR359	59.0%	69.1%	-	-	89.7%	62.0%	-	-	38.6%	33.9%	159	11.48	73	5.0	0.0%	0.0%	4	0	154,123	126,471	27,652
TWH	Ward 21 (TW) - NG231	89.4%	76.5%	-	100.0%	78.6%	93.5%	-	-	19.1%	8.5%	162	10.53	107	5.3	2.4%	100.0%	6	4	-137	106,377	(106,514)
TWH	Ward 2 (TW) - NG442	60.7%	75.7%	-	100.0%	78.5%	110.7%	-	-	27.9%	4.5%	230	13.69	174	6.2	0.0%	0.0%	14	0	145,708	131,450	14,258
TWH	Ward 30 (TW) - NG330	97.5%	90.5%	-	100.0%	124.4%	90.2%	-	-	35.1%	32.0%	182	11.68	71	6.0	0.0%	0.0%	16	2	142,495	139,478	3,017
TWH	Ward 31 (TW) - NG331	86.5%	69.9%	-	100.0%	62.7%	95.2%	-	-	28.6%	6.4%	176	11.34	102	5.5	0.0%	0.0%	14	2	139,933	153,151	(13,218)
Crowborough	Crowborough Birth Centre (CBC) - NP775	53.3%	99.3%	-	-	87.7%	27.1%	-	-	3.5%	0.0%	14	0.84	0		70.4%	98.7%		0	149,938	140,034	9,904
TWH	Midwifery (multiple rosters)	82.9%	54.2%	-	-	92.4%	87.9%	-	-	17.1%	0.8%	669	37.16	52	24.2			0	0	84,530	85,022	(492)
TWH	Hedgehog Ward (TW) - ND702	130.3%	86.3%	-	-	142.6%	-	-	-	39.0%	47.0%	175	11.59	14	12.8	0.0%	0.0%	0	0	193,997	178,944	15,053
MAIDSTONE	Maidstone Birth Centre - NP751	115.7%	98.5%	-	-	98.6%	100.0%	-	-	9.6%	0.0%	19	0.90	0		0.0%	0.0%	0	0	73,531	73,062	469
TWH	SCBU (TW) - NA102	78.3%	577.8%	-	100.0%	95.1%	-	-	-	18.1%	0.0%	132	7.39	9	20.1	0.0%	0.0%		0	177,213	189,159	(11,946)
TWH	Short Stay Surgical Unit (TW) - NE901	59.2%	64.1%	-	-	54.2%	91.9%	-	-	30.3%	0.0%	72	4.66	30	6.8	0.0%	0.0%	0	0	23,537	42,960	(19,423)
MAIDSTONE	Accident & Emergency (M) - NA351	116.5%	74.2%	-	-	127.5%	146.8%	-	-	55.0%	24.2%	533	36.54	193		0.0%	0.0%	2	0	303,333	283,699	19,634
TWH	Accident & Emergency (TW) - NA301	91.4%	81.5%	-	100.0%	96.3%	115.8%	-	-	47.5%	41.3%	667	45.59	197		0.0%	0.0%	3	0	435,553	503,963	(68,410)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	26.9%	16.9%	-	-	20.6%	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand		0.0%	0.0%	0	0	56,893	38,153	18,740
MAIDSTONE	Peale Ward COVID - ND451	60.5%	48.7%	-	100.0%	102.2%	69.4%	-	-	23.4%	30.7%	212	15.08	143	7.9	0.0%	0.0%	5	0	211,039	95,335	115,704
MAIDSTONE	Respiratory Enhanced Care - NS459	57.7%	90.2%	-	100.0%	62.5%	158.6%	-	-	43.9%	46.3%	273	19.42	169	9.2	0.0%	0.0%	0	0	143,841	90,620	53,221
MAIDSTONE	CPU Medicine	-	-	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand		0.0%	0.0%	0	0	0	0	0
MAIDSTONE	Short Stay Surgery Unit (M) - NE959	67.4%	16.3%	-	100%	85.8%	6.5%	-	-	5%	0	16	1.06	4	15.6	0.0%	0.0%	0	0	58,692	61,695	-3,003
																				6,068,905	6,076,558	(7,653)
																				44,033	39,224	4,809
																				0	0	0
																				-530	-530	0
																				7,847	-2,073	9,920
																				4,379,897	3,932,128	447,769
																				10,500,152	10,045,307	454,845

Cath labs
Whatman
Ward 32 (Wells Suite) (TW)
Chaucer

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%

0

Update on the short-term solution for the transfer of ophthalmology activity to the Trust, and on progress with agreeing the preferred long-term option	**Director of Strategy, Planning and Partnerships**

It was agreed at the 'Part 2' Trust Board meeting in November 2020 that the Director of Strategy, Planning and Partnerships should "submit an "Update on the short-term solution for the transfer of ophthalmology activity to the Trust, and on progress with agreeing the preferred long-term option" report to the Trust Board in February 2021." The enclosed report has been submitted in response.

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 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

Ophthalmology

Update
23rd February 2021

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

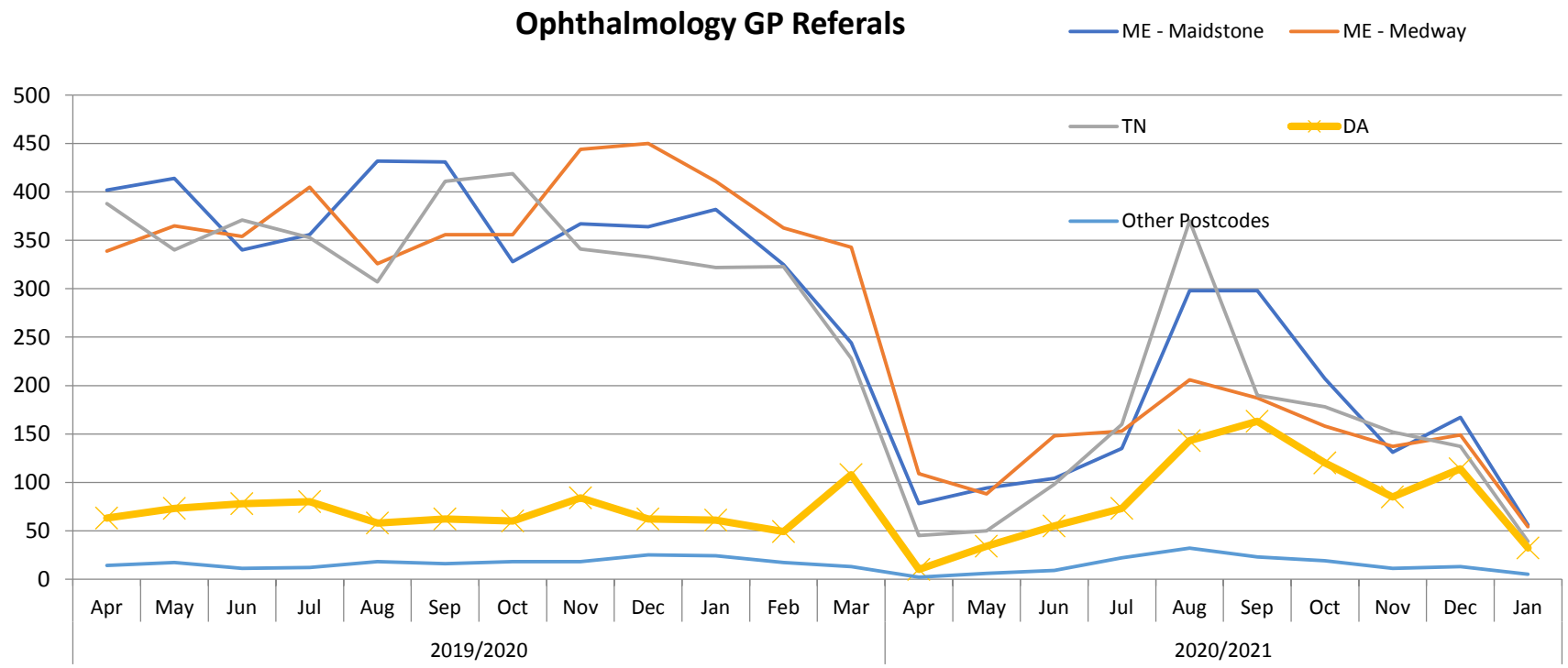
The transfer of ophthalmology activity from DVH to MTW is now underway

- **Patients that have been impacted have been written to individually** to explain the transfer of activity and impact on sessions that have moved from DGS and TWH to Sevenoaks.
- As per the original agreement **184 urgent patients have been transferred by Moorfields Eye Hospital (MEH) and treated by MTW**
- **26 stranded patients remained with Operose Health**, an agreement was originally reached on 29/1/21 that these patients would transfer to MTW, it subsequently **transpired that there were more than 70 stranded patients with a significant number of patients waiting over 52 weeks**. This **activity has not transferred to MTW and remains with Operose Health and the Kent and Medway CCG to manage**.
- First clinic started at Sevenoaks hospital on the 1st of February
- Maidstone and MFT - **Some virtual and urgent clinics have continued during the 2nd wave of Covid**. Laser clinics, Glaucoma clinics and one stop cataract clinics including pre assessment have **restarted on the 8th of February**
- TWH - Planning to start cataract lists as soon as Critical Care have capacity
- **Restarting elective work at MGH** - EMMU 1 x Theatre every morning and All day Thursday, restarting **commenced on the 15th of February**

Only 5 staff (out of 22 originally identified) transferred under TUPE

- **Recruitment underway for all vacant posts** – 3 x nursing, 2.2 AHP, 5 Admin, (4.2 Theatre staff delayed due to theatre closure).
- Consultant posts (1 x Part-time and 1 x Full-time Paediatric Ophthalmologist with Saturday sessions, 2 Medical Retinal Consultants) **JDs agreed internally and now with Royal College for approval.**
- 30 day consultation on 6 day working started on the 1st of February for admin, technical and orthoptic staff

Referrals from Dartford postcodes have increased by around 100% at a time when referrals from all other postcodes have significantly reduced.



While there are mitigations in place we are still working with the CCG to secure the MFT capacity we need for our preffered long term solution

- Interim solution of capacity at **Sevenoaks is available for 12 months rather than the original 6 months**
- **The team have identified additional mitigations** including working with the SPIRE and Beneden to utilise private sector capacity but the **preferred solution is still to utilise MFT Day Surgery Procedure Suite**
- This solution is still **being worked through with the CCG** – Discussions held with Caroline Selkirk (Executive Director of Health Improvement) and **agreement that as part of reset and recovery planning MTW will define the MFT capacity required for the final solution and this will be ring-fenced** for our use during that planning cycle

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the renewal of the staff residential accommodation at Springwood Road, Maidstone

Chief Executive

It was agreed at the 'Part 1' Trust Board meeting in January 2021 that the Chief Executive should arrange for an update on the renewal of the staff residential accommodation at Springwood Road, Maidstone, to be submitted to the Trust Board meeting in February 2021. The report is enclosed.

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

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

Background:

On 28 March 2019, the Trust obtained a land sale receipt for the former Springwood Road accommodation owned by the Trust.

Arising out of the contract of sale of the freehold land a leasehold provision was provided culminating in the umbrella agreement between

Maidstone and Tunbridge Wells NHS Trust

and

Kleinwort Benson (Guernsey) Limited as trustee of the M&G secured lease income fund and Borrowdale Nominees Ltd

Springwood Holdings Ltd

The agreement signed on 28 March 2019 provided for an umbrella agreement for the sale of the leasehold land with leaseback variation, surrender and option at Springwood Road, Barming, Maidstone**,** Kent.

Update on development:

The Trust line of communication is with an appointed property agent appointed by Springwood Holdings Ltd.

At present, the Trust occupies accommodation as shown in the diagram below comprising four units (designated by the number 5 in the proposed staff accommodation campus at Springwood Road).

This accommodation is occupied by 30 medical students, junior doctors, medical consultants, locum medical consultants, radiographers and ad hoc Trust staff on weekend accommodation basis. The Trust currently has a total occupancy provision of 112 rooms. This existing accommodation does not provide for ensuite bathroom facilities and is shared accommodation.

Since the provision of the land sale, the Springwood Road development has progressed with the demolition of two blocks (designated in the diagram below as 1&2).

Block 1, formerly Almond House, has now been demolished. Previously this accommodation provided 28 rooms of shared accommodation.

Block 2, formerly Willow House, has now been demolished. Previously this accommodation provided 30 rooms of shared accommodation.

The construction of the new Willow House (which will provide 40 units of accommodation, all with ensuite facilities) and Almond House (which will provide 120 units of accommodation, all with ensuite facilities) has commenced and is due for occupancy in June 2022.

The construction works have been delayed due to the Covid-19 pandemic.

The lease agreement does not provide any provision for financial relief to the Trust due to late completion.

When these two new units of accommodation are completed, the existing four units of accommodation (designated 5) will be vacated by the Trust, with occupants moving to Almond House and Willow House.

In or around April 2022 the Trust will be given notice to surrender the Tier 1 site and the lease shall be extinguished. The planned completion date for the two new blocks (designated 1&2) are scheduled for practical completion in the first week of May 2022. The Trust will then enter into the Tier 2 lease and relocate to the new accommodation blocks 1&2).

The accommodation blocks designated 5 under planning law have permitted development for the provision of a second floor. There is no contractual obligation or lease provision with the Trust for the four accommodation units currently occupied (designated Unit 5) to be retained by the Trust. Springwood Holdings Ltd via their agent KRE have corresponded with Housing Associations with respect to the accommodation units (5) to be offered for renovation and refurbishment and occupation under lease to housing associations.

KRE have expressed a significant wish to enter into dialogue with the Trust and establish if the existing four buildings (designated 5 in the drawing) could be redeveloped with an additional floor each for occupancy by the Trust with completely refitted ensuite accommodation. In terms of permitted development, KRE have stated that the Trust would be the preferential client and could provide 18 units of accommodation per building.

Recommendation:

It is considered that it would be prudent to open dialogue with KRE in the very near future and explore the options available for additional accommodation provision for Trust staff and medical students. Accommodation continues to be at a premium and refurbished ensuite accommodation provision on the Springwood Road redevelopment is worth pursuing under the Trust's Estates Strategy.

Springwood Road - Proposed Staff Accommodation Campus (NHS)

Proposed Masterplan

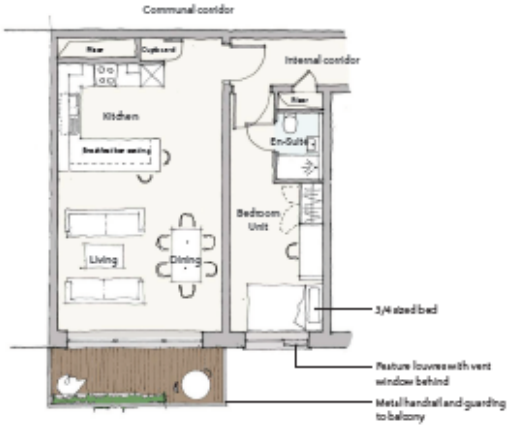
guy hollaway dha ARCHITECTS

KEY

1. Block A - 100 key worker rooms (3 storey)
2. Block B - 60 key worker rooms (3 storey)
3. Bike/bin storage (single storey)
4. Proposed courtyard parking area with 34 parking spaces
5. Existing key worker accommodation
6. Existing parking court retained
7. New Bellway housing development
8. Oakwood Hospital Cemetery
9. Access to proposed parking court
10. Proposed open space / amenity buffer area
11. Existing hedge along Oakapple Lane retained

Key Design Principles

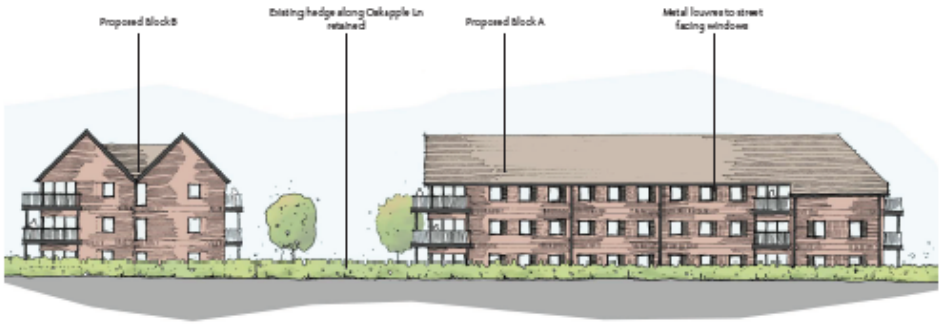
- The proposals provide staff accommodation for 160 doctors and nurses of Maidstone Hospital.
- The 'L' shaped building (Block A) is located to the rear of the site and set back from the boundary and provides accommodation for 100 staff.
- Block B is located to the front of the site and addresses Springwood Road providing accommodation for 60 staff.
- Street facing façades of the proposals have been carefully considered and designed to add visual interest to the area with a contextual, high quality restrained architecture.
- The proposed brick built buildings are three storeys in height using balconies to create visual interest and provide valuable amenity spaces. The pitched roofs relate to the surrounding prevalent roof forms and provide a visual link between the proposed and existing buildings.
- The roofs have hidden flat roof section to help reduce the overall height of the buildings and minimise visual impact. The flat roofs also provide opportunity for integration of photovoltaics with minimal visual impact.
- Cycle and bin stores are located to the rear of the site, providing a secure and concealed location.
- Balconies / amenity spaces are provided for each 'cluster'. To minimise any harmful impact on the immediate neighbours, the buildings are set back at a minimum distance of 21m from neighbouring properties across the Springwood Road.
- A parking court with 34 parking spaces is proposed in the courtyard created between the two buildings. Due to the very close proximity of Maidstone Hospital and the relatively low car ownership associated with this form of accommodation, a reduced number of parking spaces is proposed.



Typical cluster arrangement (floor plan)

Springwood Road - Proposed Staff Accommodation Campus (NHS)

Proposed Block A

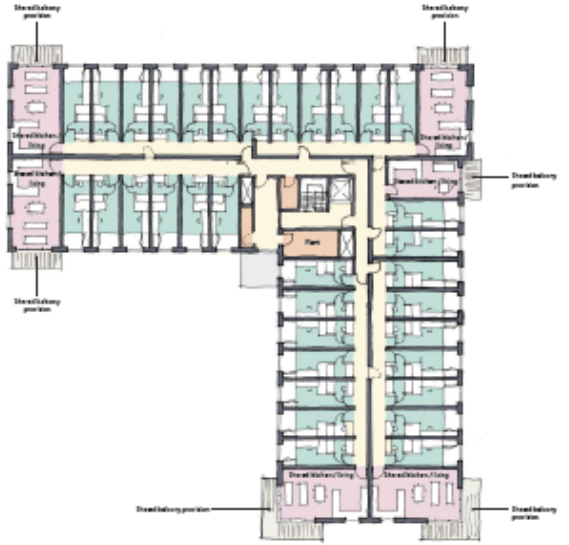


Street Scene: Looking towards the site (south west) from Oakapple Lane

Side Elevation

Ground floor plan (33 beds)

First floor plan (33 beds)



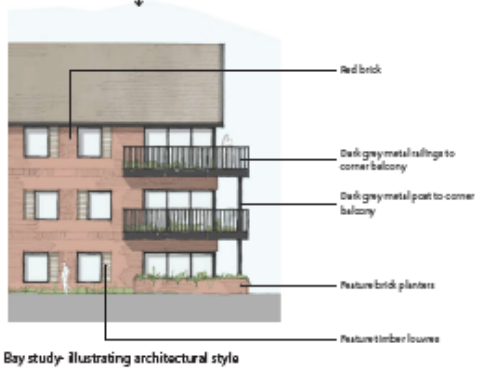
Second floor plan (34 beds)

Springwood Road - Proposed Staff Accommodation Campus (NHS)

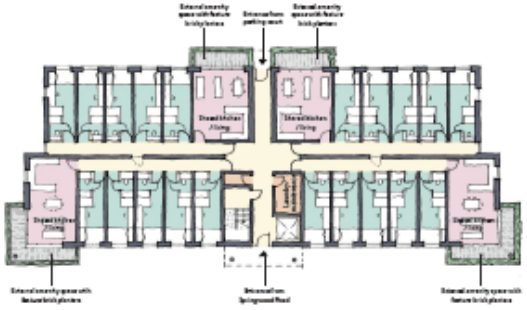
Proposed Block B

Street Scene: Looking towards the site (north west) from Springwood Road

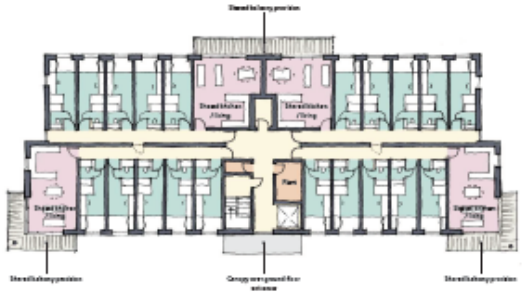
Side Elevation



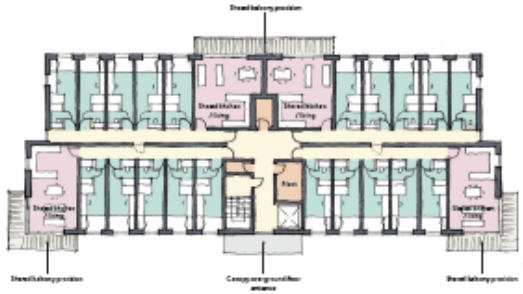
Bay study- illustrating architectural style



Ground floor plan (20 beds)



First floor plan (20 beds)



Second floor plan (20 beds)

NHS Maidstone and Tunbridge Wells NHS Trust

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

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

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

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

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

Infection Prevention and Control board assurance framework

Summary of changes:

Section 1:

- Covid positive patients within 14 days of diagnosis who require discharge to care facility must be discharged to designated centre
- Repeat FIT testing available for those affected by national withdrawal of one type of FFP3 mask
- *Emerging risk of Burkholderia aenigmatica infection associated with the use of multi-use bottles of ultrasound gel on ITU. Information shared with clinicians and sterile single patient use gel implemented* (risk stepped down but recommendations on u/s gel stand)

Section 2:

- Additional robotic UVC resource (Thor) procured
- Cleaning robot for public areas

Section 4:

- Introduction of partners to antenatal scans following risk assessment, vaccination of staff, provision of FFP3 masks for sonographers and pre-scan testing for pregnant woman and partner

Section 6

- Post-vaccine infection followed up with additional swab and blood for antibody testing. Enhanced surveillance forms completed on-line

Section 8

- 24/7 service for near patient testing across the Trust

Section 10

- Occupational Health maintain a list of staff who test positive more than 10 days post-vaccination. Support provided and additional swab and blood tests arranged. Enhanced surveillance completed on-line

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

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

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

	except for those within 3 months of Covid infection • Plan in place to refresh supplies for those running out of kit		
• Training in IPC standard infection control and transmission-base precautions are provided to all staff • IPC measures in relation to Covid-19 should be included in all staff induction and mandatory training	• All staff receive infection control training at induction which includes a section on Covid-19 • National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this. • All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 • Non-clinical staff have bi-annual training (level1) which includes Covid-19 • Additional ad hoc training on ward during IPC visits		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Extensive communication with staff on face masks, hand hygiene and space through staff Pulse publication, posters, social media etc. • All staff wear face masks • Hand hygiene audits reported to IPCC – no concerns		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to PPE that protects them for the	• National guidance on PPE implemented within Trust. FIT testing for FFP3 masks in place with resources identified and PPE project team managing resources on day to day basis. • Dedicated FIT testing team in place on		

appropriate setting and context as per the PHE national guidance	both sites. • New staff FIT tested as part of induction as required • Regular discussion at executive level. • Procurement lead sits in ICC • Active management of stocks by procurement leads. Electronic monitoring system in place • Active monitoring of PPE burn rate and stocks • Reusable masks and air powered respirators available for those who fail FIT testing • All patient facing staff trained in use of PPE and supported by PPE officers • Use of powered air respirators monitored through site offices with documented log and cleaning • Regular updates provided to staff through ICC and daily bulletin • PPE guidance available on Covid page of Trust intranet • Posters and signage with PPE information in donning and doffing areas. • Repeat FIT testing available for those affected by national withdrawal of one type of FFP3 mask		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily		

way	Covid Bulletin and Covid intranet page • DIPC is SRO for Patient and Staff Safety work stream • IPC team support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation • IPC leadership on key work streams • Emerging risk of *Burkholderia aenigmatica* infection associated with the use of multi-use bottles of ultrasound gel on ITU. Information shared with clinicians and sterile single patient use gel implemented (risk stepped down but recommendations on u/s gel stand)		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC is member of exec team and updates as required • Covid update is standing item on Board agenda		
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• ICC risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place and in date for non-Covid-19 infections • Trust compliant with Hygiene Code prior to pandemic. • IPC team reinforce practice at ward		

	level • IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks recognised eg for C. difficile and Covid co-infection • IPC team advising on a case-by-case basis. Variation to some policies required. Documented on ICNet.		
• that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sit rep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff		
• ensure Trust board has oversight of ongoing outbreaks and action plans	• Ongoing outbreaks discussed at daily exec strategic command meetings • Twice weekly outbreak meetings for Trust chaired by deputy DIPC – stood down to weekly in January 21 • DIPC updates to execs and Board at every meeting • IPCC reports to Quality Committee • Daily sitrep of open outbreaks from IPCT		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on both sites including respiratory HDU and ICU escalation areas. • ICU training programme for non-ICU trained staff required to work on ICU. • Consultant anaesthetist rota to provide 24/7 on site ICU cover. • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist. • Covid wards fully staffed. Consultant of the week rota for senior medical cover • IPC team and PPE officer support to Covid wards • Respiratory HDU staffed by respiratory trained nurses and consultants • NIV patients cared for by trained staff		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Cleaning standards in place for cleaning during the pandemic. • Facilities staff trained in donning and doffing PPE and FIT tested where appropriate. • Decontamination and terminal cleaning completed according to national guidelines. • HPV and UVC decontamination available when required • All surfaces cleaned with Diff X including walls • In-house cleaning teams in place		

	• Cleaning audits reported to IPCC and divisions • Lapses in cleaning standards reported as Datix incidents and investigated with shared learning • Deep clean programme for wards as they are de-escalated is being planned • Existing UVC light decontamination technology to be employed • Additional robotic UVC resource (Thor) procured • Cleaning robot for public areas		
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Increased frequency of cleaning complies with national guidance • Regular cleaning audits undertaken and results monitored. • Audits reported to IPCC		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses	• Diff X confirmed as suitable cleaning agent for enveloped viruses by IPCT		
• Manufacturer's guidance and	• Manufacturer's guidance is followed in		

recommended product contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		
• 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• In place since June 20 • Ward staff clean high-touch surfaces including keyboards and telephones • Disinfectant wipes available for cleaning workstations in non-clinical areas		
• Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance. • Pre-existing guidance for clinical areas		
• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Regular twice daily cleaning in place		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards treated as infectious linen • Laundry is compliant with HTM 01-04 • Laundry report goes to IPCC and Health and Safety committee		

• single use items are used where possible and according to Single Use Policy	• Single use items used widely across the Trust. • Policy in place and available to staff on the Trust intranet		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• The provider of surgical reusable instrument decontamination for MTW: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been put in place in line with local, PHE and national policy.		
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Non-clinical areas are part of the cleaning audit schedule. Action plans developed where areas fail audit		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single		

	pass air supply and no recirculation of internal for infection control purposes. • Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical production areas all installed with HTM 03-01 ventilation systems. • Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation		
• there is evidence organisations have reviewed the low risk Covid pathway, before choosing and decision made to revert to general purpose detergents for cleaning as opposed to widespread use of disinfectants	• A Covid-active disinfectant (DiffX) has been used throughout the pandemic response. • Any change would be made only with the approval and recommendation of the DIPC and IPC Team through the IPCC		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has	• Routine ward based audits suspended for April and May 20	• C. difficile PII audits continuing • Reports to IPCC

maintained	continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • Training for new doctors has continued • Ward pharmacists review prescribing • Guidance for antibiotic prescribing in Covid patients issued by ASG • Prescribing of antibiotics is low compared with peer K&M organisations • Audits and reporting restarted and maintained in second wave • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians		reinstated for June 20
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued. • IPCC and DTMMC report to Quality committee		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a	• Visitors permitted only on compassionate grounds and to assist		

care setting	patients with specific needs • Birth partner allowed. Both parents can visit in neonatal unit. Covid testing in place to facilitate this. • Outpatients have accompanying person only when required for care needs • Review of visiting is included in objectives of Patient and Staff Safety work stream • All visitors have temperature checks at the front door • Mask provided to patients and visitors who do not have face coverings • Support in place for relatives to deliver patient property • Ethics committee have reviewed Visiting policy • Viewings of deceased patients have continued in the Trust mortuary including for patients diagnosed with Covid-19 • Visiting suspended at Maidstone Hospital as a result of high numbers of cases during second wave. • Introduction of partners to antenatal scans following risk assessment, vaccination of staff, provision of FFP3 masks for sonographers and pre-scan testing for pregnant woman and partner		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated	• Signage is in place to identify Covid areas and advise on PPE requirements on entry		

in areas clearly marked with appropriate signage and have restricted access	• Restricted access by swipe card only is in place • Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene • Masks are available at the exit of all Covid areas allowing change of mask on leaving the area		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information for staff is available on the Trust intranet Covid page • Coronavirus information for the public can be found at https://www.mtw.nhs.uk/2020/12/latest-information-on-the-coronavirus/	• Easy read version not yet available	• Information currently under review prior to submission to the Accessible Information Standard group for conversion into easy read.
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• For inter-departmental transfer, handover of information by telephone or accompanying nurse • PHE guidance on discharge of patients is implemented. Local guidance based on national guidance is published on trust intranet Covid page and has been shared through ICC bulletin. • Integrated discharge team manages discharge of patients to residential care facilities. • Designated care home beds now available • All patients being discharged to residential care have Covid test 48 hours before expected date of discharge with result available. • Any patients self-isolating following		

	confirmed Covid contact receive a letter explaining their need to self-isolate. Medically fit patients may complete their self-isolation at home • Staff use appropriate PPE for all patient transfers • All patients have EDN on discharge		
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Posters prominently displayed in public areas • Hand, Face and Space logo on trust Covid internet pages • Posters in wards to encourage patients to wear face masks		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Contacts of positive cases tested twice a week for 14 days whilst inpatients • All non-elective admitted patients (suspected and non-suspected) are tested for Covid-19 in ED, SAU, EGAU, Woodlands unit or delivery suite. Suspected medical patients are admitted directly to side rooms on Covid cohort ward awaiting results. Non-suspected patients remain in AAU/AMU until results available. Surgical, T&O, gynae, paediatric and		

	obstetric patients admitted directly to single room on specialty ward pending results. Pathways in place and agreed through CRG and ICC. • All suspected patients who do not require admission are tested prior to discharge from ED. Positive cases are followed up by ED with results to provide anticoagulation therapy. Pathway approved by ICC • Patients screened day 1, 3 and 5-7 • Patients on non-covid pathway have Covid point of care test in A&E.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. • Triage nurse performs infection risk assessment and patient directed through red or green pathway for further assessment and separation. Pathway documented and agreed with CRG and ICC • Red and green pathways are accommodated separately in different zones of ED • Isolation room available for immunocompromised and shielding patients in ED • Temperature check and triage in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and		

• staff are aware of agreed template for triage questions to ask • triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors	ICC • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures • All patients and visitors entering through main entrances have temperature check and are given masks • Paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • All pathways documented and agreed with CRG and ICC and published on Covid page of Trust Intranet • Standard triage template supported y electronic system (Symphony) and printed version • Triage carried out by senior nursing staff. • Immediate allocation of patient to pathway • Obstetric triage in place with senior midwife. Labour ward has designated red and green beds • All patients asked to wear a face mask on entering ED. • All outpatients and visitors wear masks except for those carrying exemption certificates • Masks provided at front entrance if required • Information on Trust website to support		

• facemasks are available for patients with respiratory symptoms • provide clear advice to patients on use of facemasks to encourage the use of surgical facemasks by all inpatients in the medium and high risk pathways if this can be tolerated and does not compromise their clinical care • ideally segregation should be with separate spaces, but there is potential to use screens eg to protect reception staff • for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• Face masks available for all patients • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside • Reception staff are protected with screens in all areas • ED reception has physical separation of staff by Perspex screens • Perspex screens on outpatient reception areas, outpatient pharmacy and main entrance reception • Cubicles in ED majors are separated by solid walls • Social distancing in place in waiting areas • Vaccination centre has been organized with social distancing and separate spaces • Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. The rationale for testing is documented in the patient's notes		

	• Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information and duty of candour letter. Medically fit patients who are discharged to their own home continue to self-isolate at home. • Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care. • Suspected patients who test negative have medical review prior to step down to non-Covid ward. Those who continue to be suspected cases have repeat testing and remain in side room on Covid ward • All patients who test negative on admission are re-tested at 5-7 days in line with national guidance. Additional day 3 swab implemented in November • All laboratory results submitted to PHE for national track and trace		
• patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately	• All outpatients have temperature checking at the front door. • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimize contact between pathways. For example this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas	• Separate entrances for staff and patients • Stay left signs in corridors • Visitors and patients not permitted to use staff catering facilities		
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results recorded and database maintained • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • Online training for medical care of Covid patients • ICU training in place for non-ICU trained staff • PPE officers provide face to face training on wards. • IPC team provide training to staff • Mandatory IPC e-learning package includes Covid-19. National package in use		

• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Donning and Doffing videos available on Trust intranet site. • PPE officers provide workplace training. • PPE helpers available in ICU • Donning and doffing stations provided on Covid wards • FIT testing available for all staff who require it and when available masks change. • Signage and posters displayed in donning and doffing areas		
• a record of staff training is maintained	• Fit testing records maintained • Records maintained for cleaning of reusable masks • Records maintained of formal IPC training • On line learning and development system records mandatory training		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Re-use of visors and cleaning guidelines available and communicated through daily staff bulletin from ICC • Guidelines in place for cleaning of re-useable respirator masks • Individual reusable respirator masks allocated • Site team holds records of reusable air powered respirator use and cleaning • EME support monitoring and management of powered air respirators • Other PPE will only be re-used with		

	ICC and IPC agreement and release of clear guidance		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• All incidents relating to PPE reported as datix incidents • Risk assessments in place for reusable respirator masks and air powered respirators • Incidents investigated and learning shared • ICC monitors incidents and takes urgent action as required		
• adherence to PHE national guidance on the use of PPE is regularly audited	• PPE audits ongoing and reported to IPCC		
Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimize Covid-19 transmission such as:			
• hand hygiene facilities including instructional posters	• Hand wash basins widely available. • Instructions on all splash backs • Sanitising gel widely available including entrances to all clinical areas		
• good respiratory hygiene measures	• All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside		

• maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional breakout areas available • Covid secure offices identified		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Disinfectant wipes available in both clinical and non-clinical areas • I am clean stickers in use • Domestic and nursing cleaning in place on wards • High touch areas frequently disinfected		
• clear advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas	• PPE posters widely displayed • Non-clinical areas assessed for Covid-secure status • Advice widely publicised through staff Pulse magazine and Trust internet and intranet pages		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Ward based audits in place. • Triangulation audits completed monthly by IPCT. • Directorates report to IPCC		
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash	• All hand wash basins are co-located with paper towel dispensers		

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

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

positive cases linked in time and place trigger and outbreak investigation and are reported	Terms of reference developed –under review • Twice weekly outbreak meetings • IIMARCH forms completed for all outbreaks • Outbreaks reported via national online platform		
• Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	• Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Pathways clearly identified and approval process in place • Surgical green pathway implemented and reviewed according to prevalence of infection • Visitors are not permitted in Covid positive areas except in compassionate circumstances		
• Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff	• Signage in place • Wards accessible by swipe access • Restricted access to Covid areas		

understand the different risk areas			
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated cohort wards. Suspected cases are placed in side-rooms until test results are available	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors with swipe card card access. • Not used as staff/visitor throughfare
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Cohort bays have privacy curtains between the beds to minimise opportunities for close contact. • Separated from non-segregated areas by closed doors • Signage displayed warning of the segregated area to control entry • Cohort areas differentiate the level of care (general, respiratory HDU, Covid ICU) • Paediatric confirmed patients isolated in single rooms with en-suite facilities • Windows in all ward areas opened for 15 minutes three times per day to improve ventilation		
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Pre-existing IPC policies continue to apply. • Some variance required to meet the requirements of Covid levels of PPE and co-infected patients • Active management of side room provision by ICP team		
8. Secure adequate access to laboratory support as appropriate			

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

• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place	• All results reported to PHE via Co-surv • All elective patients are tested 24-48 hours prior to admission • Online booking for staff and elective patient testing. • Weekly testing for all patient-facing staff by end of June 2020 • All staff positive results are delivered by Occupational health staff • Staff results sent by text message directly from on-line system • Antibody testing available to all patients and staff on request • Near patient testing available with 8 machines at Maidstone and 4 at TWH • 24/7 service for near patient testing across the Trust • All positive inpatients reported directly to IPC team and site practitioners via email • All staff positives reported to Occupational Health via email • All positives reported to consultant microbiologists • Results directly authorized and available in real time • MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies • All routine diagnostic microbiology		

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

• PPE stock is appropriately stored and accessible to staff who require it	• PPE central stocks held on both main sites • Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place. Managers advised to ensure all staff risk assessed. Risk assessment developed with BAME network and Ethics committee • Redeployment opportunities and working from home enabled for high risk staff • Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support. • Staff sickness phone line in use.		
• that risk assessments are undertaken and documented for any staff members in an at risk shielding group, including Black,	• 93% of BAME staff have risk assessment completed • 80% of 'at risk' staff have had a risk assessment completed		• HRBPs/divisions have plan in place to complete outstanding risk assessments

Asian and minority ethnic (BAME) and pregnant staff	• Weekly return submitted		
• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held in ICC		
• staff who carry out fit test training are trained and competent to do so	• Dedicated FIT testing team in place and fully trained		
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• A database of FIT testing outcomes is maintained. • Staff provided with information identifying the type of mask to be worn		
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• As above • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks • Records are kept and stored electronically		

• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• If all respirator options are unsuitable staff work from home wherever possible • Manager works with HR to identify re-deployment opportunities • New opportunities to work with vaccination teams available		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	• Discussions are documented and records stored electronically		
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• An electronic system is in place to record and store details for risk assessments and any necessary mitigation to support individual members of staff. Any redeployment decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally	• database of all staff maintained and includes record of all FIT testing • Weekly assurance template submitted by divisions against rotas • All staff not tested provided with FIT testing prior to shift • All areas have access to powered air		

held record of results which is regularly reviewed by the board	respirators • ICC and site team receive assurance template for weekend shift		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between panned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Patient and Staff Safety workstream (part of Reset and Recovery programme) has defined the principles to be used when developing elective pathways • Green pathways for elective care developed. • Weekly executive and divisional meeting to discuss progress and interdependencies • Staff screened for Covid-19 • Ward areas maintained as secure with minimal footfall • Theatre SOP in place designating green and red pathways to avoid cross over		
• All staff adhere to national guidance on social distancing wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Staff social distancing in corridors and queues. • Work to ensure that office spaces are socially distanced with risk assessments completed. • CCG review identified good practice in social distancing interventions • Staff working from home wherever possible • Consideration to 7 day working and shifts to reduce the number of staff in non-clinical areas.		

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

• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	communications to re-iterate "hands – face – space" campaign • Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support/ first aiders. • Staff sickness phone line in use and covered daily, 7 days from 1st December 2020, providing advice and information on sickness, swabbing and other COVID sickness questions. • Newly established "staffing hub" designed to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing. • Roll out of lateral flow underway • ICC monitors sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home. Home working toolkit published • All staff able to access testing via on-line booking system • Symptomatic staff can access testing • Weekly asymptomatic testing to be rolled out to all patient facing staff by end of June • Review of cases of staff Covid infection to identify any key themes and learning • Trust-wide Pulse survey in April and May. Results reviewed at executive and divisional level. Learning identified		

• staff that test positive have adequate information and support to aid their recovery and return to work.	• Staff vaccination centre established and vaccine available to all Trust staff and offered to some partner agencies • Occupational health support Covid-positive staff and advise on return to work and re-testing • Psychological support available • Occupational Health maintain a list of staff who test positive more than 10 days post-vaccination. Support provided and additional swab and blood tests arranged. Enhanced surveillance completed on-line		

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 22/01/21 (incl. the latest quarterly update from the Guardian of Safe Working Hours)	**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met on 22nd January (virtually, via webconference).

The key matters considered at the meeting were as follows:

- The Committee received a detailed **update on COVID-19** (including staffing numbers, redeployment, recruitment, vaccinations, contingency, staff welfare and communications), and the Director of Workforce agreed to propose a date when the Committee could receive details of the plans for a 'staff focused recovery'
- The **monthly update on the latest workforce Key Performance Indicators (KPIs)** was reviewed and it was noted demographic data on vaccinations and the latest staff survey data, which was very positive, would be included in the next report.
- Under the **monthly update on recruitment and retention** the Chief Nurse highlighted the positive developments regarding the recruitment of Clinical Support Workers.
- The monthly u**pdate on the plans to improve the Human Resources function** heard about the recruitment of the Trust's new Chief People Officer.
- The **Guardian of Safe Working Hours** attended to give their latest **quarterly update** (covering Oct to Dec. 2020), and agreed to ensure that future quarterly reports included details of trends over time. The report considered at the meeting has been included in full in Appendix 1.
- The **Director of Medical Education (DME)** gave their latest **quarterly update**, which included the latest findings from the latest General Medical Council Trainee Survey, and noted that all educational activities for medical trainees had ceased. The DME therefore agreed to explore whether MidKent College's Maidstone campus, the Oakwood House Conference Centre or a venue at Kent and Medway NHS and Social Care Partnership Trust could be used as an education/training venue for junior doctors i.e. while the Academic Centre was being used as the Trust's vaccination centre.
- The **draft Internal Audit plan for 2021/22** was reviewed and it was agreed to propose that the "Retention of International Nurses" review be included in the 2021/22 plan, and that the "Workforce Planning" review be deferred.
- The **relevant aspects of the Board Assurance Framework (BAF)** were noted, but it was agreed that the Trust Secretary should ensure that the content of the BAF referred to any actions that had been paused as a result of the COVID-19 pandemic and response
- The **recent findings from relevant Internal Audit reviews** were noted.
- The Committee agreed to undertake an **evaluation** for the first time, and also agreed the method of that evaluation (i.e. by a survey by all members and regular attendees).
- Under 'any other business', it was agreed that the Deputy Chief Executive/Chief Finance Officer and Director of Workforce should ensure that the implementation of the Sunrise Electronic Patient Record (EPR) incorporated the appropriate levels of organisational development and training support

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

- The Trust Secretary should forward the Committee's proposed amendments to the draft Internal Audit plan 2021/22 to the Internal Auditors

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

Appendix 1: Quarterly update from the Guardian of Safe Working Hours (covering Oct to Dec. 2020)

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – JANUARY 2021

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (COVERING OCTOBER TO DECEMBER 2020)	**GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period October 2020 to December 2020:

- A total of 106 exception reports were received in this period
- Surgery raised 31 Exception reports.
- Medicine raised 75 Exception reports
- 69 Exception reports were from FY1 doctors
- 33 Exception reports were from FY2
- Exception reports raised are related to excessive workload and reduced staffing levels, secondary to the second wave of the Covid 19 pandemic
- There were no issues with inadequate senior supervision
- No fines were incurred during this period, or work schedule reviews needed

Reason for submission to the People and Organisational Development Committee
Assurance

Reporting Period: October – December 2020

Exception Reports

High-level data:

Number of doctors in training on 2016 TCS (total):	366

a) Exception reports (with regard to working hours)

Exception reports by department: October – December 2020				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	75	71	4
Surgery	0	31	31	0
Total	**0**	**106**	**102**	**4**

Exception reports by grade: October – December 2020				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	69	67	2
F2	0	33	31	2
ST grade	0	4	4	
Total	**0**	**106**	**102**	**4**

Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	0	0	67	4
F2	0	0	31	0
ST grade	0	0	4	0
Total	**0**	**0**	**102**	**4**

- **No work schedule reviews or fines were sanctioned during this period.**

Report Commentary:

For the period October – December 2020 the trust received 106 Exception reports.

Exception reports were raised by 69 FY1, 33 FY2 and 4 ST (3-7), with 75 from Medicine and 31 from Surgery.

All Exception reports raised were due to either late finishes, lack of ability to take appropriate breaks due to the workload intensity, lack of supportive clinical staff on the junior rotas.

This report obviously correlates with the second wave of the Covid 19 pandemic.

A huge strain has been felt across the medical and nursing professions of the trust, mostly on the emergency, acute medicine and ITU wards.

During the period of January 2021 the Guardian for Safe Working and the General Manager for Emergency & Acute Medicine are making weekly visits to the acute wards to monitor the physical and mental well-being of the trainee doctors and ensuring they have appropriate supervision. This is well received and a multitude of suggestions from the junior staff have been acted on.

I make it clear to the trainee doctors that I want them to actively exception report fully during this period, so that I can monitor any specific areas around the Trust that are in difficulty.

I will continue to monitor the well-being of the junior doctors during this time and I am acutely aware of the workload of our medical registrar's on-take, particularly overnight. I have made suggestions to the Chief of Service for Medicine, that our night hours medical staff would likely benefit from a senior medical consultant presence during this time. The Chief of Service is monitoring the situation, day by day and has a rota already drawn up for this to begin.

Summary report from the People and Organisational Development Committee, 19/02/21	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met on 19th February (virtually, via webconference).

The key matters considered at the meeting were as follows:

- The **monthly update on the latest People Key Performance Indicators (KPIs)** (including Employee Assistance Programme (EAP) data) was reviewed and discussions were held on the utilisation rates of the Psychological Support Services available at the Trust and the future recruitment and retention work required at the Trust wherein it was agreed that the Director of Workforce should submit a workforce planning 'mock up' of the recruitment and retention required for one service area at the Trust, other than nursing, to the Committee's meeting in March 2021. It was also agreed that the Organisational Development Consultant should ensure that the "Monthly update on the latest People Key Performance Indicators (KPIs)" report to the Committee's meeting in March 2021 included details of the actions to be taken to improve KPI performance.
- The Committee received a detailed **update on COVID-19** (including COVID-19 demographic data and Black, Asian and Minority Ethnic (BAME) vaccination data), and the Director of Workforce agreed to submit a plan outlining the required actions to support a return to normal for the Trust's Learning and Development function to the Committee's meeting in April 2021.
- The Chief Nurse provide an **update on the patient feedback received in relation to the staffing levels on the wards during the second wave of COVID-19** and it was noted that the overall feedback received from patients had been positive, however it was agreed that the Chief Nurse should liaise with the Chair of the Committee and the Chair of the Patient Experience Committee to consider, and confirm, the method by which the Committee should receive assurance in relation to the patient experience associated with staffing levels at the Trust.
- Under the **Monthly update on the plans to improve the Human Resources function** (including an update on Electronic Staff Record (ESR) data quality) the Committee received details of the data cleansing which had been carried out on the Electronic Staff Record and the shortlisting process for the deputies of the Chief People Officer and it was agreed that the Director of Workforce should submit a further update on Electronic Staff Record (ESR) data quality to the Committee's meeting in March 2021.
- The Associate Director for Organisational Development gave the latest **Bi-monthly update on the Exception People Outstanding Care (EPOC) Programme** (including an update on the Exceptional Leaders programme) during which the importance of the alignment of the Trust's organisational development programmes was emphasised and it was agreed that the Associate Director for Organisational Development should circulate the timeline for the incorporation of organisational development and training support for the Sunrise Electronic Patient Record (EPR) programme to the Chair and Vice Chair of the Committee for review.
- The Director of Workforce provided an **update on the business cases for the Trust's legacy staff welfare initiatives** and it was noted that the business cases would be aligned with the Trust's Health and Wellbeing Strategy which was under development, it was therefore agreed that the Director of Workforce should submit the Trust's Draft Health and Wellbeing Strategy, including the resourcing requirements, to the March 2021 meeting for discussion. It was also agreed that the Director of Workforce should ensure that the financial implications of the Trust's Health and Wellbeing Strategy were provided to the Chair and Vice Chair of the Committee for scrutiny prior to submission for approval.
- The **relevant aspects of the Board Assurance Framework (BAF)** were noted
- The committee received **additional assurance on the Board Assurance Framework (BAF)** objectives allocated to the Committee
- The Director of Workforce provided a **summary of the Trust-wide Human Resources Policies that were beyond their review date and the associated implications** wherein the proposed approach for the Trust's people policies was outlined, however it was noted that any

amendment to the Trust's Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies') would need to be ratified by the Trust Board.

- The Committee reviewed the **relevant aspects of the Risk Register**, wherein it was agreed that the Director of Workforce should submit an updated "Review of the relevant aspects of the Risk Register" report to the Committee's meeting in March 2021, ensuring the report reflected a 'live' position.
- Under the **evaluation of the meeting** the revised approach to the meeting which ensured a discussion focused approach was commended.
- Under '**any other business'** the Director of Medical Education informed the Committee of the plans to utilise funding to refresh the Academic Centre and the Trust's Graduate Management Recruitment scheme and those teams involved were commended by the Non-Executive Directors on their work.

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

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

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

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

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

Summary report from Quality Committee, 10/12/20 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 10th February 2021 (a Quality Committee 'deep dive' meeting).

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

- The **progress with previous actions** was noted
- The Trust Secretary attended for an **Update on progress with policies that have passed their review dates** wherein it was agreed that they would liaise with the Associate Director of Business Intelligence to arrange for a new indicator to be added to the "Well led" domain of the Integrated Performance Report (IPR), relating to the number of Trust-wide policies that had passed their review date to ensure Trust Board oversight of the position.
- The Director of Estates and Facilities attended for a **review of health and safety assurance.** The presentation gave a comprehensive overview of the mechanisms implemented throughout the Trust to provide health and safety assurance, which included the current estates risks, the functioning of the Trust's risk register and a detailed explanation of the utilisation of the Premises Asset Model, it was however agreed that the Director of Estates and Facilities should circulate the findings from the "Mandatory Estates Safety Checks" Internal Audit report to members of the Quality Committee 'Deep Dive' for assurance. It was also agreed that the Assistant Trust Secretary should circulate the "Review of health and safety assurance" presentation to Committee members.
- The Divisional Director of Operations, Cancer Services and colleagues attended for an **Update on the plans to improve outpatient services**. The presentation explained the measures which had been implemented to improve outpatient services thus far, the delays which had been incurred due to COVID-19 and the continuing focus on communication throughout all aspects of the improvement plan, it was then agreed that an "update on the plans to improve outpatient services" should be scheduled at the 'Main' Quality Committee meeting in May 2021.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein the following actions were agreed:
  - The Assistant Trust Secretary should schedule a "Review of the Trust's response to "Never Event – misplaced NG tube (NGT)"" at the Quality Committee 'Deep Dive' meeting in April 2021
  - The Assistant Trust Secretary should schedule a "Review of falls and pressure ulcers" at the Quality Committee 'Deep Dive' meeting in June 2021
  - The Chief Nurse and Medical Director should consider, and confirm, the forum by which the Patient Safety and Clinical Effectiveness aspect of the Quality Improvement domain of the Trust's Exceptional People, Outstanding Care (EPOC) programme should be reviewed
  - The Assistant Trust Secretary should provisionally schedule a "Review of the decision making process for 'clinical design' within the Trust's Digital Transformation programme" at the Quality Committee 'Deep Dive' meeting in December 2021
  - The Assistant Trust Secretary should schedule a "Review of the lessons learned from COVID-19" at the Quality Committee 'Deep Dive' meeting in June 2021
  - The Medical Director and Chief Nurse should ensure that a discussion is held at the Executive Team Meeting (ETM) regarding the potential capital prioritisation within the 2021/22 financial plan for the improvement of the oxygen delivery system at Maidstone Hospital, as it had been identified as a rate limiting factor during the Trust's response to COVID-19

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

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

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

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

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

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Summary report from the Finance and Performance Committee, 23/02/21	**Committee Chair (Non-Exec. Director)**

The Committee met on 23rd February, via a webconference.

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

- The **actions from previous meetings** were reviewed and it was agreed that further details of the plans regarding portering recruitment would be provided.
- The Chief Operating Officer reported on the **month 10 non-finance related performance**, and the delivery of the 62-day cancer waiting time target for 18 months in a row was confirmed. There also remains strong performance against the 4-hour target although achieving Referral to Treatment (RTT) standards continue to present challenges in the current context. The Statistical Process Control (SPC) analysis in the Integrated Performance Report (IPR) is increasingly helpful although further information was requested relating to the 'spider' graphs in the Executive Summary illustrating the difference between local and national targets.
- The **financial performance for month 10** was reviewed, which noted that the Trust had achieved its financial plan for January 2021 and for the year to date. A discussion was also held on the approach to managing the situation for the remainder of 2020/21, and some suggestions were made that were agreed to be considered.
- The Chief Operating Officer reported on the Trust's **recovery and organisational priorities, February to September 2021**, but it was noted that the Executive Team Meeting (ETM) had not yet discussed and agreed the final recovery plans. The Committee was however encouraged by the work done to date.
- An **update on the development of the Trust's draft financial strategy** was given, which explained the various external factors that had prevented the Trust from finalising its strategy as per its originally intended timescale. The development of the system approach to financial management was discussed as this presented potential challenges as the new arrangements are agreed.
- A **Business Case to establish an EPR Business as Usual Team** was approved, and it was agreed that progress reports on the implementation of the Case would be given via the "Update on the implementation of the Electronic Patient Record (EPR)" that were received every two months.
- The programme of **reviews of previously approved Business Cases** covered East Kent oncology, and the reasons for the delays in implementation, when compared to the original timescales, were discussed.
- The relevant aspects of the **Board Assurance Framework (BAF)** were noted, as was the **Committee's forward programme.** It was also confirmed that virtual meetings would continue to be scheduled for 2021, although it was hoped that a face-to-face meeting of the Committee would be able to be held later in the year.

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

- The Trust Secretary should schedule an "Approval of the Trust's capital programme and expenditure for 2020/21" item at the Committee in March 2021

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

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

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